

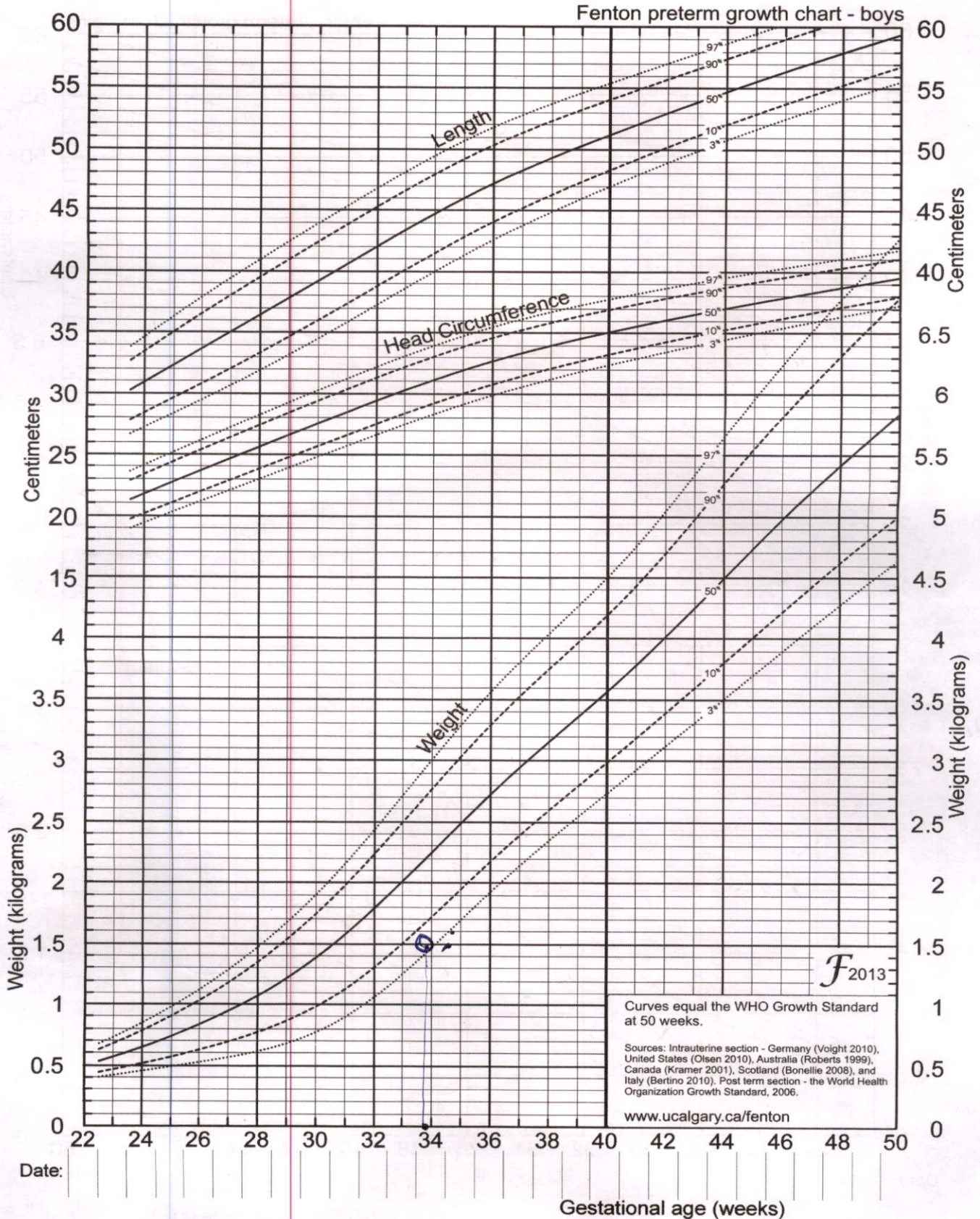
BAH-00655578 IP5-00173415
 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 0 D 2 H (M)
 Dr. NITASHA BAGGA

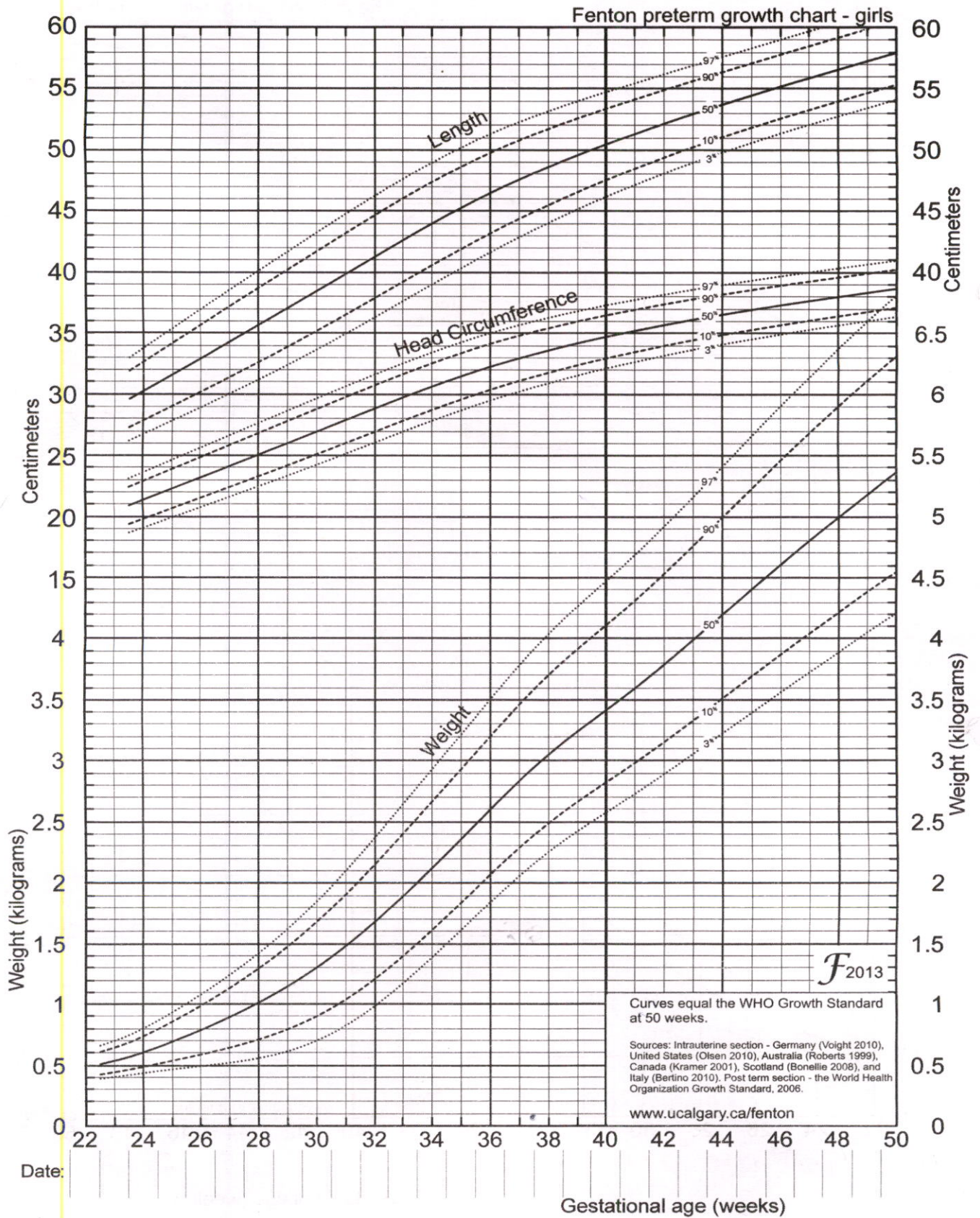


B.W = 1.089

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

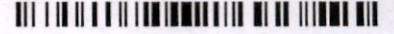
BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery





ADMISSION SHEET

Registration Details :



Admission No : IP5-00173415 Admit Date : 05-May-2026 Admit Time : 07:18 PM UHID : BAH-00655578

Patient Details :

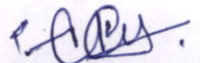
Patient Name : Baby Of JUNTIPALLY KAVERI TWIN 2 Age : 0 D
Guardian : Mr GADDAM PALLY PRASHANTH REDDY DOB : 05-05-2026 07:17 PM
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : H NO 1-13, BALANAGAR MANDAL,
THIRUMALAPUR, Nawabpeta Mahabubnagar
Telangana INDIA 509340 Phone No : 7986616106/ 8374171504
E-mail : KARTHIKREDDYJ8374@GMAIL.COM

Admission Details :

Bed Type : NICU Bed No : NICU 256 Ward Name : 2F-NICU 2
Room No : NICU 256 Admission Type : First Visit

Contact Details :

Name : Mr GADDAM PALLY PRASHANTH REDDY Relationship : Father
Contact Address : H NO 1-13, BALANAGAR MANDAL,
THIRUMALAPUR, Nawabpeta Mahabubnagar
Telangana INDIA 509340 Phone No : 7986616106 / 8374171504

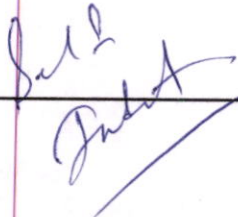

Signature

Doctor Details :

Doctor Name : Dr. NITASHA BAGGA Specialisation : NEONATAL INTENSIVE CARE
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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



GENERAL CONSENT FOR TREATMENT

Patient Name: **Baby Of JUNTIPALLY KAVERI TWIN 2** Age : **0 Y 0 M 0 D 0 H**
IP No: **IP5-00173415** Sex: **Male**
Consultant: **Dr. NITASHA BAGGA** Ward/Bed No: **2F-NICU 2/NICU 256**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient. Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:

- 1 We do not allow use of medication brought from outside by the patient.
- 2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....)
- 3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
- 4 Financial and billing counseling has been done to me.

Signature of Patient/Relative: *[Signature]*

Name: *Pooja Kalyan*

Relationship: *R*

Date: *05/05/2026*

Witness Name: *L*

Witness Signature: *[Signature]*

Time: *7:20 PM*

Patient Address:
H NO 1-13, BALANAGAR MANDAL,
THIRUMALAPUR, Nawabpeta
Mahabubnagar Telangana INDIA
509340

BAH-00655578 IP5-00173415
Baby Of JUNTIPALLY KAVERI TWIN 2
05-05-2026 0 Y 0 M 0 D 0 H (M)
Dr. NITASHA BAGGA



BAH-00655578 IP5-00173415
Baby Of JUNTIPALLY KAVERI TWIN 2
05-05-2026 0 Y 0 M 0 D 2 H (M)
Dr. NITASHA BAGGA

Twin - II

(P)

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

BirthRight
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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Mrs. Juntipally Kaveri - II Age : 30y Father's Name : Age :
Date of Birth : Date of Admission : UHID No :
NICU Consultant : as per note 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 Juntipally Kaveri Mother's Blood Group : A +ve
Gender : M F Blood Group : +ve
Date of Birth : 5/5/26 Time of Birth :
Place of Birth : RCM Banjara Estimated Gesth Age : 30+3

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : Ht : Wt : BMI : Married Life : LMP : 11/10/25 EDD : 11/7/26

Conception : Spontaneous or with Rx : T.O.V.F. conception (Confidential) Primie

Booked at what GA : AN Steroids Drugs / Doses : Received 2 doses

Last Scans Details : SCDA twins Twin I 1449g - Cephalic @ 8:30 pm 7/5/26 @ 8:30 am 5/5/26
Twin II 1508g breech

MATERNAL RISK FACTORS

Age : <18 yrs > 35yrs
Consanguinity : Yes No Y
If yes, degree of consanguinity : 1 2 3
H/o PIH (after 20 weeks) / PE X
How many Drugs / Doses / Since how long : X
H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : X
IUGR - when detected :
Doppler (Increased Resistance / ADEF / REDF / Redistribution in MCA) / Ductus Venosus : X
AFI :

H/o GDM/ pre GDM/ on diet or insulin
Controlled or not, recent values, HbA1 values : X
Compliance with Rx :
Scans : LGA, (TFFA), Fetal Echo : (N) NT = (N) Double marker - (N)
H/o Hypothyroidism : when diagnosed ? Medication?
Any other Chronic Medical Problems, when detected drugs ? e/o white discharge, foul smelling (Anemia, SLE, Jaundice, CHD, Heart Disease)
Infection : H/O, Fever Cervical stitch, macdonald's @ 22+3 weeks
(Malaria UTI TORCH TB HIV HBV)
UTI : when : Any culture :

PPROM: Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results : to be traced.
Medication during Pregnancy : Duration :



HISTORY OF PRESENT ILLNESS.

Equipment Checked

Baby delivered by LSCS - ETAB → but
had poor cry, → ~~so~~ cord cut
Immediately → received ↓ plastic wrap
→ airway cleared, started with DREAPAP

Involved severe respiratory distress

SAS Baby had - Tachypnea +
Marked retraction

Crackles
~~SPO2~~ $FiO_2 \approx 10.1$

SAS score. > 6

Baby shifted to N2CU in DREAPAP support.

Investigation details in previous Hospital :

Feeding History :



F

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Marked resp. distress

VITALS : Temperature : 36.5 HR : 168 RR : 60 NIBP : — CFT : 2 Bee

Color of the extremities : ~~pink~~ pale acrocyanotic

Jaundice : Pallor : SpO2 : 92.1 %
2 REPAP @ FiO2 40

ANTHROPOMETRY: Birth Weight : 1.6 Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :	Fontanelles : Sutures Shape / Moulding : Edema / Bruising : Size - (H.C.) :	(N)
FACIES : (Any Facial Dysmorphism)		(NO)
NECK and CLAVICLES :	Range of Motion : Asymmetry : Masses :	(N) deppo
EYES :	Symmetry : Red Reflex : Discharge :	Needs to be seen
EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Periauricular Pits / Tags : Nasal shape / Patency : Palate : Gums : Lips : Tongue :] (N) No cleft
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number :	(N)
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : Discharge :	No 2A 1V
GENITALIA :	Labia / Hymen : Testicles/penis : Anus :	appropriate for Gestation
HERNIAL ORIFICES		free
TRUNK and SPINE :		(N)
SKIN LESIONS :		(No)
EXTREMETIES :	Fingers / Toes : Deformities : Hip Joint Examination :	Arms / Legs : Mobility : Normal



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : Regular Periodic Shallow Gasping

Mention if baby has Respiratory distress: RR: 65 4+ SCR / ICR / See - Saw breathing :

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

Mention if baby is on : Hood box CPAP Ventilator

grouching

Settings : DRCPAP - 6 PEEP

SpO₂: Auscultation: Breath Sounds: Added Sounds: grunts

CARDIOVASCULAR SYSTEM :

HR : 150 BP : -

Precordial Activity : (N)

Femoral Pulses : | good

Murmurs : | NO

Other Peripheral Pulses : | good

Signs of Cardiac Failure : | NO

ABDOMEN:

Shape : | (N)

Hernia orifice :

Palpation : | (N)

Anal Patency : present

Palpable masses :

Umbilical Cord : 2 A 1 v

Abdominal girth :

First urine passed : |

Meconium passed : | to be seen

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : Alert

State of wakefulness :

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone : | hypotonic

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

ATNR : Skull and Spine :

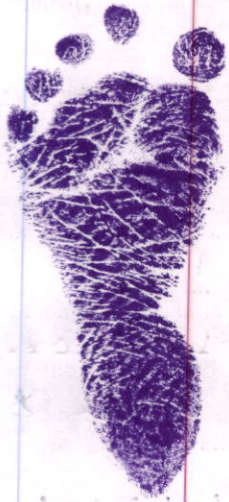


No gross congenital anomalies.....

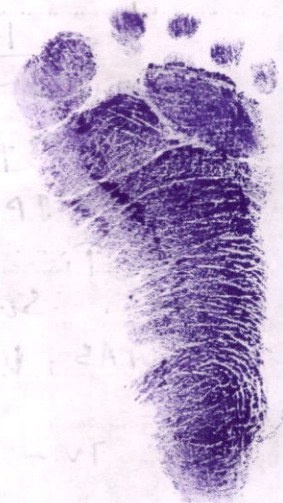
Diagnosis : 30+3 / male / DCD A - Twin - II / SGA (1.6 kg) / pre term
onset of labour & maternal chorioamnionitis / RDS

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *[Signature]*

Name : *Rupijal*

Date & Time : *5/5/26*

Consultant :

Signature : *[Signature]*

Name :

Date & Time :

PLEASE FILL UP THE FOLLOWING DETAILS

- Name of the referring Doctor :
- Name of the referring Hospital :
- Address :
- Contact Numbers :
- Contact Details of the referring Doctor :
- Mobile No. : E-mail ID :
- Name of the Doctor in Rainbow Team :

..... on whose name the patient is being referred.



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic :

Medications :

Plan
① ~~T₁ 80~~
SIMV + PS -
- PIP - 15, PEEP - 5, Rate - 40
Ti - 0.33
- Surfactant administration.
- GAS, GRSS @ 10pm then 8hr marks

Plan during ward follow up :

- Tv - 60 cc / kg / day 10% D + Ca₃
- Feed - 3ml - 2 hourly DSM
OK feed ↑ 1ml 8hr marks
- Plan extubation by T₁/h

Feeding Plan at the time of shifting :

- CBP
Culture
Gas, GRSS

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

- No fentanyl sedation.

Doctor Signature (Handover Given): Doctor Signature (Handover Taken):

Doctor Name: Doctor Name:

Date & Time: Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/5/26		
8:00 PM	<p style="text-align: center;"><u>Intubation notes</u></p> <p>- Under strict aseptic conditions Baby was intubated with 3 size ET and fixed at 7cm.</p>	
	<p style="text-align: center;"><u>Surfactant notes</u></p> <p>- Under strict aseptic conditions, Surfactant Suel given via two aliquots and connected to ventilator.</p>	
5/5/26		
12:00 AM	<p style="text-align: center;"><u>Night records</u></p> <p>- On SIMV + PS,</p> <p>FiO_2 - 25%, 15/5/ RR - 40</p> <p>SpO_2 - 96% PR - 144/min RR - 65/min</p>	<p style="text-align: center;"><u>Plans</u></p> <p>- Continue Current ventilation</p> <p>- TV - 60 ml/kg/day ↓ 10% Dextrose + Calcium 3ml/kg</p> <p>- Feed 3ml 2nd help ↓ ↑ 1ml feed 8th hourly</p>



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 19 hours PMA: 30+3

Term Preterm Gestation : 30+3 Corrected Gestational Age: B.W = 1.6

OVERVIEW	Problems :	
	S.No.	Current
1.	<u>Very pre-term / U/LBW</u>	
2.	<u>SCA / RDS / I's</u>	
3.	<u>MV</u>	
4.		
5.		
6.		

Today's Weight :

RESPIRATORY SYSTEM

Ventilatory Support : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV iNO PPM

Ventilator Settings : PIP.....PEEP.....VG.....Rate.....FiO₂.....Oxygen :L/min

Last CXR : Spo₂ :

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours: - Baby was intubated I's was
Fixe ppe given
- Baby on SIMV + PS
P67 - 15/5, Rate 40 > 35 -

CARDIO VASCULAR SYSTEM

Plan of Care :

HR = 120

SPO₂ = 100

RR = 55

BP = 48/39 (38)

CNS

Neurological Examination :

Sedation:

Last Neurosonogram : Any Seizures: 1/0

FLUIDS STATUS NUTRITION

NPO NG Feeds Wt. Gain: Head Circumference:

Input : / (+/-) Output : ml/k/d Urine Output : ml/kg/hr Stools :

IV Fluids - Type of IVF : @ ml / hr

Feeding: EBM Formula Donor BM Volume: Frequency:

TPN : Yes No - If yes, details : Calories:

Abdominal Examination:

Other Systems : Haematology / Nephrology / Metabolic / Endo / NNJ - PT / OPTH / RICKETS

.....

.....

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:

Blood culture Urine culture ET culture Fungal Culture LP CSF :

INFECTION

Sl.No.	Drugs	Days
1.	inj Piperacillin + tazobactam	D1
2.	inj fluconazole	D1
3.		

inj Caffeine

Plan of Treatment:

- ⇒ continue current ventilation → PS mode
- ⇒ Plan to extubate to CPAP
- ⇒ TV - 60 cc / k / day - 10% insp + exp
- ⇒ GRBS - ^{6th} hourly
- ⇒ GAS - new, 3 BD
- ⇒ I/O chart 6th hourly
- ⇒ NPI @ 24 hours.
- ⇒ N/F ↑ RD, FiO₂ requirement more than 40%.

P-15/3
Ball my vate - 25
TTP mix - 0.50

Doctor's Name (Handover given) : R. Rajal

Signature : R. Rajal

Date & Time : 6/5/20

Doctor's Name (Handover taken) : Y. Sreha

Signature : Y. Sreha

Date & Time : 6/5/20



3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/5/26 @ 9:20am		Seen by Dr. Nitasha
		1) Blood gas - B.D.
		2) If Spont efforts good ↓ Plan extubation.
		3) Extubate to to CPAP PEEP=6 NIV = 16/5 Rate = 30 ↓
		4) NP, at 24HOL
		5) NSG - Today
		6) feeds - Constant at 4ml 2nd hrly.
		7) I/O charting
	<p>Noted by Vishnu Priya 01901 6/5/26 @ 9:20am</p>	<p><u>me</u> Jeeha resident</p>

BAH-0065578 IP5-00173415
 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 0 D 2 H (M)
 Dr. NITASHA BAGGA

4



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/5/26 @ 1:00pm	<u>Extubation Notes</u>	
	Baby after proper Suctioning of ET tube extubated taken on NIV with mask on NIV	
	PIP = 16, PEEP = 5.	
	Rate = 35/min	Plan
	FiO ₂ = 30%	
	Ti = 0.45	1) Continue NIV
	<u>Vitals</u> HR = 127/min	Taper FiO ₂
	RR = 41/min	To target SpO ₂ 90-95%
	SpO ₂ = 95%	2) Gas
	BP = 60/49 (53)	NP. } at HPM
		3) w/f - Perfusion
		Brady, desat
		Noted by
		Vishnu Priya
		@ 1900
		6/5/26 @ 1pm
		Sneha



5

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/5/26 2:30pm	<p style="text-align: center;"><u>Afternoon Rounds</u></p>	
	<p>30+3 / 20 H/L / 1.6 kg Bwt</p> <p>Post Extubation - NO brady, desat, tachy distress</p>	<p><u>Plan:</u></p> <ul style="list-style-type: none"> Continue NIV \bar{c} $F_iO_2 = 23\%$, PEEP = 5, RR = 35/min; PC above PEEP (Target SpO_2 - 90-95%)
	<ul style="list-style-type: none"> Accepting feeds well. (OG feeds - DSM) 	<ul style="list-style-type: none"> Continue 4ml/2nd/ly feeds. Plan to tsc feeds t/m
	<p>HR = 125/min</p>	
	<p>RR = 31/min</p>	<ul style="list-style-type: none"> Gas, NP1 @ 4pm.
	<p>$SpO_2 = 100\%$ on NIV</p>	<ul style="list-style-type: none"> w/p brady, desat, No chesty
	<p>NSA (N)</p>	<p>Noted by</p>
		<p>Vishnepriya 019011</p>
		<p>Dr. Ranjy</p>
<p>6/5/26 3:15pm</p>	<p>Seen by <u>Dr. Nitasha mem</u></p>	
		<p><u>Plan:</u></p>
		<ul style="list-style-type: none"> Tr 2 6oml/ly/day.
		<ul style="list-style-type: none"> NP1, Gas @ 4pm
		<ul style="list-style-type: none"> wcen g to CPAP by T/m.
		<p>Noted by</p>
		<p>Vishnepriya 019011</p>
		<p>Dr. Ranjy</p>
<p>6/5/26</p>	<p>21/6</p>	<p>6/5/26 @ 3:15pm</p>
	<p>Sp. Bil 5.2</p>	<p>Adv</p>

6

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/5/26 @ 3:30 am	Night Rounds	
	Baby on NIV with mask.	Plan
	PIP = 14, PEEP = 5 Rate = 30/min	1) Cont NIV ↓
	FiO ₂ = 22%	Review to change to CPAP T/m.
	No Brady / desaturate	
	No Resp. distress	2) $TIV = 80 \text{ ml/kg/day}$ ↓
	Intermitt - Bradypnea (+)	Umb 2nd 10% D+ brly 3ml/kg ca
	Vitals HR = 128/min RR = 43/min	3) Cont SSPT for 24 hrs
	SPO ₂ = 95% BP = 52/35 (uo)	4) Gas-OD GRBS = 8th brly.
	P/A - Soft	
	vomiting = 2epi	5) 8th Target SPO ₂ 90-95%
	Small large	6) Trochantur
	light yellow asp	7) w/f - Desat, Brady
		Sneha

BAH-00655577 IP5-00173414
 Baby Of JUNTIPALLY KAVERI TWIN 1
 05-05-2026 0 Y 0 M 4 D (F)
 Dr. NITASHA BAGGA



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 38 H 0 L PMA:

Term Preterm Gestation : 30+3 Corrected Gestational Age:

OVERVIEW	Problems :	
	S.No.	Current
1.	<u>Very Preterm / LBW</u>	
2.	<u>RDS - 1^o Surfactant</u>	
3.	<u>MV → Niv</u>	
4.	<u>NNS</u>	
5.		
6.		

Today's Weight :

RESPIRATORY SYSTEM

Ventilatory Support : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV iNO PPM

Ventilator Settings : PIP..... PEEP..... VG..... Rate..... FiO₂..... Oxygen : L/min

Last CXR : SpO₂.....

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours..... Baby on

CARDIO VASCULAR SYSTEM

Plan of Care :

HR = 132/min

RR = 41/min

SpO₂ = 95%

BP = 49 / 32 (36)

NO Bradycardia

NO desaturation.

vomiting episodes (+)

CNS

Neurological Examination :

..... Sedation.....

Last Neurosonogram : Normal Any Seizures.....

FLUIDS STATUS NUTRITION

NPO NG Feeds Wt. Gain: Head Circumference:

Input: / (+/-) Output: ml/k/d Urine Output: ml/kg/hr Stools:

IV Fluids - Type of IVF: @ ml/hr

Feeding: EBM Formula Donor BM Volume: Frequency:

TPN: Yes No - If yes, details: Calories:

Abdominal Examination: **U/O -**

GRBS

207 Other Systems : Haematology / Nephrology / Metabolic / Endo / NNJ - PT / OPTH / RICKETS

PLA - soft, mild desken

vomelungs

INFECTION

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:

Blood culture Urine culture ET culture Fungal Culture LP CSF :

Antibiotic	Sl.No.	Drugs	Days
	1.	Inj - piperacillin	D ₂
	2.	Tazobac	
	3.	Inj - fluconazole	D ₂

Inj - Caffeine

Plan of Treatment:

- 1) Cont - Target SpO₂ 90-95%
- 2) T_v = 80ml/kg/day
Umb 2nd hrly + 10% D + 3ml/kg ca-glu
- 3) Cont SSPT for 24 hrs
- 4) Gas - OD
GRBS - 8th hrly
- 5) Ifo chaiting 6th hrly
- 6) w/f - Desat, Brady
- 7) Trace B/c/s
- 8) Trace mekrenal HUG

Doctor's Name (Handover given) : **Y. Snelia**

Signature : **Snelia**

Date & Time: **7/5/26**

Doctor's Name (Handover taken) : **Romy**

Signature : **Romy**

Date & Time: **7/5/26, 9am**



②

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>7/5/2026 @ 8:38 AM</p>		<p>Seen by Dr. NB</p> <p>1) Constant feeds until 2nd hly</p> <p>2) TV = 80 ml/kg/day</p> <p>3) Cont - CPAP</p> <p>4) Cont SSP T</p> <p>5) RBS - 8th hly Blood gas - OD</p> <p>Noted by Vishnu Priya Date 019011 7/5/26 @ 8:38 PM</p>
<p>7/5/2026 2:00 PM</p> <p>On CPAP @ Gem</p> <p>Fio₂ - 21%</p> <p>- Baby is stable</p> <p>NO tachypnea / NO SEA</p> <p>- Intermittent Bradypnea</p> <p>- 24h Blood eps - NO growth</p> <p>- OG - aspirate + light yellow (3-m)</p>	<p>Seen by Resident</p>	<p>Adv</p> <p>- Plan to continue CPAP @ Gem</p> <p>- Plan to wean to sen by evening if baby is stable</p> <p>- TV - 80 cc/kg/day continue 4ml/2 hourly constant feed</p> <p>- W/F abd distension</p> <p>- G RBS - 8th hourly</p> <p>- GAS - OD</p> <p>Noted by Vishnu Priya Date</p>

BAH-00655578 IP5-00173415
 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 0 D 14 H (M)
 Dr. NITASHA BAGGA



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/5/26 3pm		Seen by Dr. Nitasha mem
		<ul style="list-style-type: none"> • Use CPAP - 4 in night • RIV stop antibiotics after CIS reports. - 7mg • Continue 4ml/2nd baby feeds
		Noted by Vishnu Praga Dr. Ranj
		7/5/26 @ 3pm
7/5/26 10:45pm	Night Rounds	
		Plan:
		<ul style="list-style-type: none"> • Continue CPAP, PEEP = 4 • TV = 80ml/kg/day 4ml/2nd feeds (ESM → DBM)
		Dr. Ranj

3AH-00655577 IP5-00173414
 Baby Of JUNTIPALLY KAVERI TWIN 1
 15-05-2026 0Y0M0D2H (F)
 Dr. NITASHA BAGGA



①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Seen by Dr. Nilesh
5/5/26 9:30pm		Start CPAP, PEEP - 6 TV - 60cc/kg/day 10% D + Ca ₃
		<ul style="list-style-type: none"> 2x Pip-lax 2x Fucinar nasal. therapy dry Caffeine
		<ul style="list-style-type: none"> URAS - 8H GeAC - 3D
		<ul style="list-style-type: none"> next gas - T/na or SO₂
		<ul style="list-style-type: none"> Feeds 3ml - 2h
		<ul style="list-style-type: none"> 1ml every 4h feed (3H)
		<ul style="list-style-type: none"> Gas
		<ul style="list-style-type: none"> CRAB
		<ul style="list-style-type: none"> CBP
		<ul style="list-style-type: none"> Culture
		<ul style="list-style-type: none"> Blood group
		<ul style="list-style-type: none"> CR
		<ul style="list-style-type: none"> Clay wrap

N. Nilesh

Patient Sticker

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: PMA:

Term Preterm Gestation: Corrected Gestational Age: Today's Weight:

Overview	Problems	
	S.No.	Current
1.		
2.		
3.		
4.		
5.		
6.		

Clinical Assessment	
---------------------	--

Medications Used	
------------------	--

Plan of Care:

Doctor's Name (Hand over given):

Doctor's Name (Hand over taken):

Signature:

Signature:

Date & Time:

Date & Time:



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	5/5/26	
	12:00am	Night records Seen by dr. Nilesh
	- on CPAP,	
	Fio ₂ - 28%,	Plan:-
	PEEP - 6	
	SpO ₂ - 96%	- continue CPAP -
	PR - 170/min	- Surfactant 50s
	RR - 45/min	if Fio ₂ > 30% /
	Issue: - surfactant	PEEP - 6
	- tachypnoea ⊕	- TV - 60ml/kg/day
		↓ 10% O ₂ + Ca ₃
		- feeds 3ml 2nd help
		[GBM / DBM]
		↑ feed 1ml every
		4th hourly,
		[TF = 7ml]
		- RBS 8th hourly.
		- Blood Gas BD
		↳ Blood Gas 7th
		mon

[Signature]
 Nilesh

BAH-00655577 IP5-00173414
 Baby Of JUNTIPALLY KAVERI TWIN 1
 05-05-2026 0Y0M0D6H (F)
 Dr. NITASHA BAGGA



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 12402 PMA: 30+3

Term Preterm Gestation : 30+3 Corrected Gestational Age:

Problems :		
S.No.	Current	Past Problems
1.	<u>Very preterm / ULBW</u>	
2.	<u>R SGA / RDS on</u>	
3.	<u>CPAP / Suspected</u>	
4.	<u>Sepsis</u>	
5.		
6.		

Today's Weight :

RESPIRATORY SYSTEM

Ventilatory Support : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV iNO PPM

Ventilator Settings : PIP..... PEEP..... VG..... Rate..... FiO₂..... Oxygen : L/min

Last CXR : Spo₂ :

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours: ON CPAP @ PEEP - 6.5

Baby Tachycardic

- Minimal ~~to~~ ser
- NO grunts
- NO hypoxia

CPAP @ 5
FiO₂ to maintain
SpO₂ - 95-95

CARDIO VASCULAR SYSTEM

Plan of Care :

HR - 139

RR = 70

SpO₂ = 97%

BP = 63/35 (43)

CNS

Neurological Examination : (N)

Sedation :

Last Neurosonogram : Any Seizures : (N)

FLUIDS STATUS NUTRITION

NPO NG Feeds Wt. Gain: Head Circumference:
 Input: / (+/-) Output: ml/k/d Urine Output: 1.2 ml/kg/hr Stools: NOT yet passed
 IV Fluids - Type of IVF: @ ml/hr
 Feeding: EBM Formula Donor BM Volume: Frequency:
 TPN: Yes No - If yes, details: Calories:
 Abdominal Examination: P/A - soft, gurgles tolerated

Other Systems : Haematology / Nephrology / Metabolic / Endo / NNJ - PT / OPTH / RICKETS
 GRBS

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :
 Sepsis screen:
 Blood culture Urine culture ET culture Fungal Culture LP CSF :

INFECTION	Antibiotic	Sl.No.	Drugs	Days
		1.	Inj Piperacillin + tazobactam	
2.	Inj fluconazole			
3.				

Plan of Treatment :

- Continue CPAP @ 5cm FiO₂ to maintain SpO₂ - 90-95%.
- TV - 60cc/kg/day - 10% Dextrose + Ca₃
- NP, - @ 24 hours
- GRBS - 8th namey, GAS - now 2 GRBS.
- R/V Gas frequency
- w/f apnea brady disat.
- TRACE MATERNAL HNS report.

Doctor's Name (Handover given) : Rajjale
 Signature : [Signature]
 Date & Time : 6/5/20

Doctor's Name (Handover taken) : V. Subh
 Signature : [Signature]
 Date & Time : 6/5/20

BAH-00655577 IP5-00173414
 Baby Of JUNTIPALLY KAVERI TWIN 1
 05-05-2026 QYOMOD2H (F)
 Dr. NITASHA BAGGA



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/5/26		Seen by Dr. Nitasha Plan
@ 9:15am		
		1) TV = 60ml/kg/day 5 ml 2nd half to continue.
		2) NP1 at 24 Hours
		3) NSG - Today
		4) ↑ feeds from tomorrow
		5) Cont PEEP-5
		6) Gas - OD.
		Noted by Vishneeya 019011 6/5/26 @ 9:15am
		<u>Ants</u>
6/5/26		
2:30pm	30 F3 → 20 HOL	Aftersoon Rounds Plan:
	No breath, dist, distress, tecky.	• Continue CPAP PEEP-5, FiO ₂ = 21%
	On CPAP, PEEP = 5.	• Continue 60ml/kg/day, 5ml/2nd half DDM
	Accepting & tolerating feeds well (DDM)	• NP1 @ 6:30pm
	HR = 120/min	• Plan to ↑ feeds from 7/1m
	RR = 22/min	• Gas - OD
	SPO ₂ = 100% on CPAP.	• O/A breath, dist
		• Trace meturnal H/S report

Dr. Ramya



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/5/26 3:15 pm		Seen by <u>Nitesha</u> mom
		<p>Wcen of CPAP - 4cm NP1 @ 4 pm today → <u>Noted by</u> <u>Vishnu Priya</u> 0190111 6/5/26 @ 3:20 pm</p>
6/5/26 8:17 PM	<p>210/6 S.Bil: 7 < ^{0.1} 6.9 (PT range: 5)</p>	<p><u>Plan</u></p> <ol style="list-style-type: none"> Start ASPT i Eyes/genitals covered Monitor S.Bil in Blood gas TV. 60ml/kg/day
7/5/26 3 AM	<p><u>Night Rounds</u></p> <p>on CPAP 5cm mask. No brady / desat. HR - 137/min RR - 25/min SpO2 - 100-1. tolerating feeds PA - soft stool passed.</p>	<p><u>Plan</u></p> <ol style="list-style-type: none"> CPAP 4cm mask TV = 80 ml/kg/day Oral 92H rest 107 dextrose Oas OD CURSBD Trace maternal HUS

1/5/16

Patient Sticker



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : HOL 36 PMA: 30+4

Term Preterm Gestation : 30+3 Corrected Gestational Age:

OVERVIEW	Problems :	
	S.No.	Current
1.	<u>UPT / VLBW</u>	
2.	<u>SCA / RDS - CPAP</u>	
3.	<u>Suspected sepsis</u>	
4.	<u>NNT</u>	
5.		
6.		

Today's Weight : 1.423 (↑ 16 gm)

Respiratory System

Ventilatory Support : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV iNO PPM

Ventilator Settings : PIP.....PEEP.....VG.....Rate.....FiO₂.....Oxygen :L/min

Last CXR :SpO₂.....

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours: CPAP 4cm mask
NO brady / desat

NSU - (N)

Cardio Vascular System

Plan of Care :

HR - 138/min
SpO₂ - 100%
RR - 35/min

CNS

Neurological Examination :

Sedation:

Last Neurosonogram : (N) Any Seizures:

FLUIDS STATUS NUTRITION

NPO NG Feeds Wt. Gain: Head Circumference:

Input: / (+/-) Output: ml/k/d Urine Output: ml/kg/hr Stools: **+**

IV Fluids - Type of IVF: @ ml/hr

Feeding: EBM Formula Donor BM Volume: **5ml** Frequency: **Q2H**

TPN: Yes No - If yes, details: Calories:

Abdominal Examination: **soft, non distended**

Other Systems : Haematology / Nephrology / Metabolic / Endo / NNJ - PT / OPTH / RICKETS

CBR - 7.0 → ↓ DEPT.

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:

Blood culture Urine culture ET culture Fungal Culture LP CSF :

INFECTION	Antibiotic	Sl.No.	Drugs	Days
		1.	1mg Piptaz D ₂	1mg caffeine
2.	1mg fluconazole.			
3.				

Plan of Treatment :

- ① cont CPAP 4cm
- ② trial of HFNC (R) | Trial off to low flow.
- ③ IV = 80ml/kg/day
5ml Q2H, (R) T feed
Rest 107.0
- ④ CRBS ~~BD~~ BD
was OD
- ⑤ Trace maternal HUS

Doctor's Name (Handover given) : **Dr Adams**

Signature : **[Signature]**

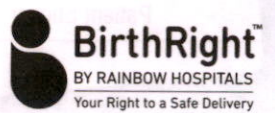
Date & Time: **7/5/20**

Doctor's Name (Handover taken) : **[Signature]**

Signature : **Rupinder**

Date & Time: **7/5/20**

BAH-00655577 IP5-00173414
 Baby Of JUNTIPALLY KAVERI TWIN 1
 03-05-2026 0 Y 0 M 0 D 2 H (F)
 Dr. NITASHA BAGGA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/25		seen by Dr. Nitasha → trial to low flow oxygen
	NSG → (N)	
		→ Trial maternal divs.
		→ feeds → +1ml orally
		→ TV-gaze 1/15/day
		→ GRBS BD Gas OD
		→ Gas @ 12pm.
		→ Noted by Vishney Bagga @ 1901
		7/6 Gas @ 8:30pm
7/5/25 10:15 am	seen by resident	
	24 hrs blood e/s	
	negative	
	7/5/25	
	7:12pm - Gas - (N)	



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/5/20 2:00 pm	seen by Resident (Rupanjali)	<u>Adv</u> - Continue. minilow - feeds as tolerated
	- on low flow O ₂	
	- No brady, desat	- TV - 80cc/kg/dx Gme - 2hmb
	- GAS - 7.39 30 61 1.4 -5.5 20.2	EBM 4 DBM (2 DBM + 1 EBM H1 new)
	Current vitals HR - 146 SPO ₂ - 97% Tolerating feed.	- I/O chart 6h hmb
	Edema (+)	- Juice HVS - NO GAS
		- GRBS - BD
		- SBR] T/M. CBP CRP Rupanjali
		Seen by Dr. Nitasha
7/5/20 3:00 pm		- SBR] T/M CBP CRP
		- GRBS Noted by Vishnupriya 09/05/20 7/5/20 @ 8 PM Enrin

BAH-00655577 IP5-00173414
 Baby Of JUNTIPALLY KAVERI TWIN 1
 05-05-2026 0 Y 0 M 0 D 6 H (F)
 Dr. NITASHA BAGGA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/5/26 10:45pm	Night Rounds	
	On low flow O ₂ - 0.01 Lt/min No breath, desat	Plan:
	Accepting feeds well	• Continue low flow
	HR = 154/min RR = 60/min SPO ₂ = 97% on low flow	• SNR } T/m. CSP } CRP }
<p>Dr. Ragu</p> <p>Noted by Sradha 8/05/26</p>		

BAH-00655578 IP5-00173415
 Baby Of JUNTIPALLY KAVERI TWIN 2
 03-05-2026 0 Y 0 M 0 D 14 H (M)
 Dr. NITASHA BAGGA



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 3 PMA: 30+6

Term Preterm Gestation : 30+3 Corrected Gestational Age:

OVERVIEW	Problems :	
	S.No.	Current
1.	Very Puckum / LBW	
2.	RDS - 1 ^o surfactant	
3.	MV → NIV → CPAP	
4.	NNO	
5.		
6.		

Today's Weight : 1.640 (↓ 10gms)

VENTILATORY SUPPORT : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV iNO PPM

Ventilator Settings : PIP..... PEEP..... VG..... Rate..... FiO₂..... Oxygen : L/min

Last CXR : Spo₂.....

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours..... On CPAP PEEP = 4, FiO₂ = 21%
No brady, desat episodes.

.....
Accepting OR feeds well. - Constant constant feeds.

Plan of Care :

HR = 138/min	U ₁₀ =
RR = 57/min	S ₁₀ =
SPO ₂ = 93% on CPAP	RBS =
BP = 52/36 (40) mmHg	*

Neurological Examination : } CTA fair

Sedation..... NO

Last Neurosonogram : Any Seizures... NO

BAH-0065578 IP5-00173415
 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 0 D 14 H (M)
 Dr. NITASHA BAGGA



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Seen by <u>Dr. Nitasha mem</u>
8/5/26 10am		<ul style="list-style-type: none"> a Wean off CPAP. a TV 2 100ml/kg/day ↑ Time 6th hly feeds. Stop DBS Phototherapy
		- SBR } on Sunday
		TFT }
		GRBS - BD
		<u>Meds</u>
		Rupa



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Seen by Dr Nitasha
9/5/26		→ 120 cc / day (TF - 16m)
8 AM		→ Complete OG feeds
		→ SBR, TFT send now
		<u>Order</u>
9/5/26	<u>Seen by Resident</u>	<u>Adv</u>
12:05	<ul style="list-style-type: none"> • Baby on room • comfortable • NO RD • Tolerating feeds • No vomiting, aspirate 	① - Total volume 120 cc / ks / day - (TF - 16m)
		↑ feed 1ml 4th hour
		② N/F apnea, brady desat
	<u>Current vitals</u>	
	HR = 144	③ SBR, TFT Send
	SPO ₂ = 90	On next prick
	RR = 40	Trace TFT.
	48 hour blood e/s	④ R/v on antibiotics
	- NO cross	Noted by Nagalaxmi

BAH-00655578 IP5-00173415
 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 2 D (M)
 Dr. NITASHA BAGGA



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: 4 PMA: 39

Term Preterm Gestation: 30W3 Corrected Gestational Age: Today's Weight: 1.627kg

		Problems	
		S.No.	Current
Overview	1.	VPT / LBW	
	2.	RDS - 2 ^o surfactant	
	3.	MV → NIV → CPAP → low flow → RA	
	4.	NNS	
	5.		
	6.		
Clinical Assessment	On room air Accepting & tolerating feeds well HR = 130/min RR = 42/min SpO ₂ = 97% on RA		
	Meds Used: Inj Piptaz - D ₄ Inj Flucon - D ₅ Inj Caffeine		
Plan of Care: <ul style="list-style-type: none"> • Continue TV = 120ml/kg/day. (9ml/2nd hly) (TF = 16ml/2nd hly) • (↑ feed = 2ml 4th hly) • W/P apnea, brady, desat • Monitor vitals • Informs. 			

(↓ 13gm)

Doctor's Name (Hand over given): Dr Ranjan
 Signature: [Signature]
 Date & Time: 9/5/26; 8:30am

Doctor's Name (Hand over taken):
 Signature:
 Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/5/26 2pm	<p style="text-align: center;"><u>Afternoon Rounds</u></p> <p>TFT → T₃ = 77.3° T₄ = 7.7° TSH = 0.552</p> <p>SBR → 8.9 < 0.1 <small>8.8.</small> No distress, bradycy, tachy HR = 125/min RR = 65/min SpO₂ = 95% on RA</p>	<p><u>Plan:</u></p> <ul style="list-style-type: none"> ✓ Continue TV = 120ml/kg/day (TR = 16ml/2nd hwy) 10ml/2nd hwy (EBM + DBM) 04 feeds. ✓ feed 1ml/4th hwy. ✓ RIV - SSPT start ✓ monitor vitals ✓ 2/0 Chestty <p>Noted by Nagelbanni R. Ranga</p>
10/5/26 9am	<p>05/30 + 3 - 139 + 1</p> <p>Room air laboratory feeds. on 10ml/2h</p> <p>mt - 1.612 ↓ 130</p>	<p><u>Plan</u></p> <ul style="list-style-type: none"> 1) TV - 130ml/kg/day 10ml/2h feeds ↑ 1ml/4th hwy till 17ml 2) GRS - 0) 3) Trace Metformin 43 and stop antibiotic 4) caffeine 20 - 30ml 5) plan HMR - 1hr 6) CBP CRP Tm <p style="text-align: right;">MUSA</p>



(Handwritten signature/initials)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/5/26 8am	<p style="text-align: center;"><u>Morning Rounds</u></p> <p>Day 5 / 30+3 → 31+1 PMA / T-Wt = 1.612kg (+15gm)</p>	
	<p>A's: VPT / VLBSW</p> <p>RDS - 1° surfactant</p> <p>MV → NIV → CPAP → lowflow → RA</p> <p>NNS</p>	<p><u>Plan:</u></p> <ul style="list-style-type: none"> • Continue. TV = 130ml/kg/day • 10ml/2nd hly feeds. (TP = 18ml/2nd hly)
	<p>on room air</p> <p>Accepting feeds well.</p> <p>HR = 160/min</p> <p>RR = 54/min</p> <p>SpO₂ = 94% on RA</p> <p>• Inj Piptaz - DS</p> <p>Inj Flucon; Glycerine suppos.</p>	<ul style="list-style-type: none"> • Start of Continue SSPT for 24 hrs. • Trace Maternal HVS report, ^{Eyes & genitalia covered.} • Stop antibiotics. • Glycerine Plan HMF T/M • CBP } T/M • CRP } T/M
		<p style="text-align: right;">Dr. Ranjeet</p> <p style="text-align: center;">Noted by Gowd 11/5/26</p>



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/5/26 8:10 am	Morning exam	
	DOL - 6 / 30+3 → 31+2 ATOT / PDS / 1 st surfactant MV - 10W - CPAP - Low flow - RA	plm on 18 ml @ 2 hourly @ a feed (TV - 130 ml / kg / day) Continue (TF - 18 ml) Review to ↑ TV - 140 ml.
	maternal NNT HVS - E. coli ⊕ Today wt: 1.645 (33 gm wt loss)	- Trace reports
	In room air	- Monitor vitals
	SpO ₂ - 99%	- Monitor SpO ₂
	HR - 154/min	- Review antibiotics.
	PlA - soft to distension	- Reassess
	(ESPT - appeared in the stomach. Brenda 24 hours.	
	on Uj - Pictor 20 by Anwar 30	
	CPB - 11	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>11/5/25</u>		Seen by Dr. NCL
	Septic markers negative	→ Stop Antibiotics
		→ ↑ TV - 140cc/ryday
		→ TRAF → add time 1/2
		→ Remove IV camera
<u>11/5/20</u> 2:00pm		Seen by Resident Adv
	<ul style="list-style-type: none"> - Baby on room air - No hypoxia, RD - P/A - soft - palpating fat - Entemic 	<ul style="list-style-type: none"> - TV - 140cc / 4/dw - 19ml - 2mumf - EBM + 1/2 HMF
		- W/F apnea Brady dead
<u>11/5/26</u> 9pm		Seen by Dr. Rupa Nitesh
		- HMF HMF
		<ul style="list-style-type: none"> 2/3rd from T/A - cling wrap cap

Running noted by critical care



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5/26	Morning Note	
7:40am	DOL - 7 (30+3 - 31+3)	Adv
	T.W = 1.630 (↓15gm)	- TV - 150 cc/kg/day
	Mod - pt / RDS / SGA ↓ CDA - Twin - II	- 20ml EBM + 2/3rd HMF
	- on room air	- N/F feet vomiting
	- Feeds tolerated	- N/F brady, desat.
	- NO brady desat	- Cling wrap
		- Cur/M.
		Noted by Sri Lakshmi 12/5/26
	12/5/26 8:30pm 1.615gm wts.	1/1am
		<ul style="list-style-type: none"> 1) Buds 19 → 20ml/granly HMF 1/2 → 1/3 granly 2) prone nursing 3) Dressed the baby.
	<p>Noted by Anshu 12/5/26</p>	<p style="text-align: right;">ng Nisha</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/05/26	Afternoon rounds	Pln
3:30 PM	DOL-7 30+3 → 31+3	
	On room air	+ Continue - TV - 150 ml/kg/day
	Tolerating feeds well	20ml CEBON @ 2 hours + 2/3 HMF ON FEEDS
	HR - 140/min	- prone on tummy
	RR - 53/min	- Swing wrap
	PIA - no distension	- w/f Apnea, Desat
	YHA - good colour - pink	- Dress the baby
		(Dr. N. Praveen)
12/05/26 5 PM	Seen by Dr. Sarethi	Plan:
	DOL-7 30+3 → 31+3 1.630 kg	• Continue TV = 150 ml/kg/day, feed on feeds + 2/3rd HMF
	1 Desat ⊕ during KMC On room air	• Continue KMC • Dress the baby
		• W/f distress, tachypnea, bradycardia
		• If persistent vomitings → hold HMF
	Noted by Nashita 12/05/26 e sn	Dr. Ramp

BAH-00655578 IP5-00173415
 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 5 D (M)
 Dr. NITASHA BAGGA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/5/26	<p>(*)</p> <p>Twin - 1</p>	<p>B/O Kaveri 1/II</p>
	<p>→ We have removed CPAP</p>	<p>Twin - 2</p>
	<p>→ Feeding digestion (+)</p>	<p>→ CPAP - now</p>
	<p>→ jaundic treatment</p>	<p>→ we will try clean respiration</p>
		<p>→ Feeds digestion & problem</p>
	<p>(*) Nature & prognosis of the disease condition explained</p>	

BAH-00655578 IP5-00173415
 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 5 D (M)
 Dr. NITASHA BAGGA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/5/26	<u>B/O Kaveri</u>	<u>-Twin-1 / II</u>
	<u>Twin-1</u>	<u>twin-II</u>
	<ul style="list-style-type: none"> - Baby - is off O₂ - full feeds resume 	<ul style="list-style-type: none"> - Baby is on CPAP - we will ↑ feed today - No vomiting overnight
	(*) Baby must stay will be attended	
	Baby Babies will require 2-3 weeks hospitalization	
	<ul style="list-style-type: none"> - All risk & complications - during due to pre-maturity explained. 	
	<ul style="list-style-type: none"> - Prognosis explained. 	
	<ul style="list-style-type: none"> - KMC will be started 	
	<ul style="list-style-type: none"> - NNS will be started 	
	<ul style="list-style-type: none"> - palada will be started ≈ 33 weeks. 	

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 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 0 D 6 H (M)
 Dr. NITASHA BAGGA



RESULT SHEET

Date	5/5/26	6/5/26	9/5/26	11/5/26		
Time	9 pm	4 pm	11 am			
Hb	16.7	16.2		16		
PCV	51.6	49.1				
RBC	4.73	4.64		4.71		
WBC	10.81	10.44		11.26		
N/L	47.2/43.8	60.0/25.1				
Platelets	277	210		267		
CRP		6		11.0		
ESR						
PCT						
RBS						
Na		136				
K		5.6				
Cl		110				
Ca/Mg		7.7				
Phosphate						
Urea		29				
Creatinine		0.9				
ALP						
SGPT						
SGOT						
T.Bill/Conj		5.2 < 5.1	8.9 < 8.8	7.3 < 7.2		
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date	9/5/26				
Time	11:43 AM				
CUE - Alb					
CUE - Sugar					
CUE - Ketones					
CUE - PUS Cells					
CUE - RBC Cells					
CUE					
Stool Pus Cell					
OVA / Cyst					
Occult Blood					
	TEL				
	T ₃	77.30			
	T ₄	7.71			
	TSH	0.552			

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :

1

ACTIVITY RECORD FOR BILLING

Name : BAH-00655578 IP5-00173415
Baby Of JUNTIPALLY KAVERI TWIN 2
05-05-2026 0 Y 0 M 0 D 6 H (M)
UHID No. Dr. NITASHA BAGGA



----- Consultant: ----- Dept : -----
----- Date of Discharge : ----- Time: -----

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

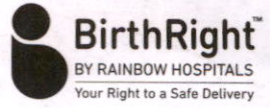
WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

BAH-00655578 IP5-00173415
 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 0 D 6 H (M)
 Dr. NITASHA BAGGA



Sheet No:

REGULAR PRESCRIPTIONS

Weight 1.6 kgs - Ward

DRUG : HMF				Date Time	12/5															
Dose	Route	Frequency	Start Dt.																	
	PO	Each feed	12/5																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
2/3rd HMF in each feed																				
Daily Doctor's Endorsement by a Sign																				

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

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

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

VERIFIED BY : Name Signature

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

Signature
Name



DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY - Name Signature

REGULAR PRESCRIPTIONS

Weight.1.6..... Ward.



VERIFIED

VERIFIED

VERIFIED

DRUG: Inj PIPERACETIN + TAZOBACTAM

Date	Time	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5
Dose	Route	Frequency	Start Date						
160 mg	I.V	12th hourly	5/5/26						

Name & Signature of the Doctor Starting the Drugs:
Rupanjali

Additional Instructions:
100 mg / ks / dose
12th hourly

Daily Doctor's Endorsement by a Sign: [Signatures]

Stop 11/5/21
Empiret

DRUG: Inj FLUCONAZOLE

Date	Time	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5
Dose	Route	Frequency	Start Date						
10mg	I.V	once a day	5/5						

Name & Signature of the Doctor Starting the Drugs:
Rupanjali

Additional Instructions:
6 mg / ks / dose
Once a day

Daily Doctor's Endorsement by a Sign: [Signatures]

Stop 11/5/21
Ranje

DRUG: Inj CAFFEINE CITRATE

Date	Time	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5
Dose	Route	Frequency	Start Date						
8mg	I.V	once a day	5/5/26						

Name & Signature of the Doctor Starting the Drugs:
Rupanjali

Additional Instructions:
5 mg / ks / day

Daily Doctor's Endorsement by a Sign: [Signatures]

changed. 7/5/26

DRUG: ORAL CAFFEINE CITRATE

Date	Time	10/5	12/5						
Dose	Route	Frequency	Start Date						
800mg	PO	OD	10/5						

Name & Signature of the Doctor Starting the Drugs:
N-Prathibha

Additional Instructions:
5 mg / ks / day

Daily Doctor's Endorsement by a Sign: [Signatures]

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 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 0 D 6 H (M)
 Dr. NITASHA BAGGA

Weight: 10.4 kg. Ward:



Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :	Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.	
Start Date	Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor	Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:	Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE	Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :	Dose		Dose		Dose		Dose
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Dose		Dose		Dose		Dose
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Start Date	Dose		Dose		Dose		Dose
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor	Dose		Dose		Dose		Dose
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:	Dose		Dose		Dose		Dose
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
5/5/26	7:30 pm	Survanta	4ml / ks	Endo tracheal	@	#Bony
5/5/26	7:30 pm	2mg CAFFEINE CITRATE	Endo tracheal @ 20mg / ks	I.V	@	#Bony
6/9/26	9 AM	2mg CAFFEINE CITRATE	5mg / kg	BV		Vishnu

VERIFIED BY: Signature

I.V. FLUIDS CHART

Weight: 1.4 kg Ward:



Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
<u>5/5/26</u>	<u>8:30pm</u>	TU - 60cc / kg / day 10% Dextrose + Ca ₃	IV IV	2.5ml	Dr	Nurse	<u>6/5/26</u>		<u>Dr</u>
<u>6/5/26</u>	<u>8pm</u>	TU - 80cc / kg / day 10% D + 3ml / kg / d	I.V	2ml	Dr	Nurse	<u>7/5/26</u>		Nurse
<u>7/5/26</u>	<u>8pm</u>	TU - 80cc / kg / day 10% D + 3ml / kg / day	I.V	3.3ml	Dr	Nurse	<u>8/5/26</u>		Nurse
<u>8/5/26</u>	<u>8pm</u>	TU - 100cc / kg / day 10% Feo - P + Ca ₃	I.V	3ml	Dr	Nurse	<u>7/5</u>		Nurse
<u>9/5/26</u>	<u>8pm</u>	TU - 120cc / kg / day 10% Feo - P + Ca ₃	I.V	3ml	Dr	Nurse			

VERIFIED BY : Name : Signature :

BAH-00655578 IP5-00173415
 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 3 D
 Dr. NITASHA BAGGA (M)

globe



FLUID CHART

Tv: - 120 ccl/kg/day.
TF: - (60ml)
Bwt: - 1.68 kgs.

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			NG	Diarrhoea	Vomit	Output			IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	IV	NG				Drainage	Urine			
	08:00 am												
	09:00 am	DBM		2.3ml	8ml		-			12ml			
	10:00 am			2.3ml									
	11:00 am	DBM		2.3ml	8ml		-			8ml			
	12:00 pm			2.3ml									
	01:00 pm	DBM		3.5ml	9ml		Passed			7ml			
Total Intake :			Total Output :										
	02:00 pm			3.5ml									
	03:00 pm	DBM		3.5ml	9ml		Passed			9ml			
	04:00 pm			3.5ml									
	05:00 pm	DBM		3ml	10ml		-			10ml			
	06:00 pm			3ml									
	07:00 pm	DBM		3ml	10ml		Passed			8ml			
Total Intake :			Total Output :										
	08:00 pm												
	09:00 pm	DBM		3ml	10ml								
	10:00 pm			3ml			-			10ml			
	11:00 pm	DBM		3ml	10ml								
	12:00 am			3ml			-						
	01:00 am	DBM		3ml	10ml					6ml			
Total Intake :			Total Output :										
	02:00 am			3ml									
	03:00 am	DBM		3ml	10ml					9ml			
	04:00 am			3ml									
	05:00 am	DBM		3ml	10ml		passed			8ml			
	06:00 am			3ml									
	07:00 am	DBM		3ml	10ml					8ml			
Total Intake : 179.2			Total Output : 95ml										
Total 24 hrs. Intake			Total 24 hrs. Output										
			112 ccl/kg/day						2.4 ccl/kg/day				

BAH-0065578 IP5-00173415
 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 3 D (M)
 Dr. NITASHA BAGGA



FLUID CHART



Sheet No. :

10/5/26

TV = 120 ccl/kg/day
 TF = 18ml
 B.W = 1.612 (158m)

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 Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	OG	NG	Diarrhoea	Vomit	Drainage	Urine		
10/5	08:00 am			101.58g	OG					8ml		
	09:00 am	DBM	1.5	2.7ml	12ml							
	10:00 am			2.7ml								
	11:00 am	DBM		2.7ml	12ml	2x				10ml		
	12:00 pm	DBM		2.7ml	2ml							
	01:00 pm	DBM		2.2ml	13ml							
Total Intake :						Total Output :						
10/5	02:00 pm			2.2ml	13ml							
	03:00 pm	DBM		2.2ml	13ml	2x				11ml		
	04:00 pm		5x	2.2ml								
	05:00 pm	DBM		2.7ml	14ml							
	06:00 pm			1.7ml						11ml		
	07:00 pm	DBM		1.7ml	14ml							
Total Intake :						Total Output :						
10/5	08:00 pm			1.7ml								
	09:00 pm	DBM		1.7ml	14ml	2x				12ml		
	10:00 pm		10x	1.7ml								
	11:00 pm	DBM		1.7ml	15ml							
	12:00 am			1.2ml								
	01:00 am	DBM		1.2ml	15ml					8ml		
Total Intake :						Total Output :						
10/5	02:00 am			1.2ml	15ml							
	03:00 am	DBM		1.2ml	15ml	2x				10ml		
	04:00 am		10x	1.2ml								
	05:00 am	DBM		1.2ml	15ml							
	06:00 am			1.2ml								
	07:00 am	DBM		1.2ml	15ml					12ml		
Total Intake :			43.8 16x			Total Output :						

Total 24 hrs. Intake 210.8 ccl/kg/day

Total 24 hrs. Output 21 ccl/kg/day

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 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 5 D (M)
 Dr. NITASHA BAGGA



FLUID CHART

11/5/26

TV: -
 TF: -
 B.kid: -

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am	DBM			18ml					10ml		
	10:00 am											
	11:00 am	DBM			18ml		passed			11ml		
	12:00 pm											
	01:00 pm	EBM			18ml					12ml		
Total Intake : 54ml					Total Output : 33							
	02:00 pm											
	03:00 pm	EBM			19ml					10ml		
	04:00 pm						passed					
	05:00 pm	EBM			19ml					10ml		
	06:00 pm											
	07:00 pm	EBM			19ml					9ml		
Total Intake :					Total Output : 29							
	08:00 pm											
	09:00 pm	EBM			19ml		passed			9ml		
	10:00 pm											
	11:00 pm	EBM			19ml		-			8ml		
	12:00 am											
	01:00 am	DBM			19ml		-			9ml		
Total Intake :					Total Output : 27							
	02:00 am											
	03:00 am	DBM			19ml		-			10ml		
	04:00 am											
	05:00 am	DBM			19ml		passed			9ml		
	06:00 am											
	07:00 am	DBM			19ml		-			9ml		
Total Intake : 225ml					Total Output : 28.117ml							
Total 24 hrs. Intake		100cc/kg/day										
Total 24 hrs. Output		3.0cc/kg/day										



FLUID CHART



Sheet No. :

12/5/26

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	OG							
	08:00 am										}	
	09:00 am	OBM			19ml				6ml			
	10:00 am											
	11:00 am	OBM			19ml				8ml			
	12:00 pm											
	01:00 pm	OBM			19ml				6ml			
Total Intake :					Total Output :							
	02:00 pm										}	
	03:00 pm	EBM			19ml		passed		10ml			
	04:00 pm											
	05:00 pm	EBM			19ml				-			
	06:00 pm											
	07:00 pm	EBM			19ml				6ml			
Total Intake :					Total Output :							
	08:00 pm										}	
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am										}	
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00655578 IP5-00173415
 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 0 D 6 H (M)
 Dr. NITASHA BAGGA

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NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA :	Diagnosis :						Surgery / Procedures :					
	Allergies :	Post OP Day :											
	Date :	5/5/26	5/5/26	5/5/26	5/5/26	5/5/26	5/5/26						
Area	Shift Time	N2 8pm-8am	N2 8am-8pm	N2 8pm-8am	N2 8pm-8am	N2 8pm-2am	N2 8AM-5PM						
		DBM	DBM	DBM	DBM+EBM	E+D	ZBM+DBM						
Ventilation (RA, NP, NIV, VENTI)		venti	NIV	NIV	EBM	CPAP	LI?						
INVASIVE LINES	1.	NG ⊕	OG ⊕	SA ⊕	OG	OG ⊕	OG ⊕						
	2.	IV ⊕	IV ⊕	IV ⊕	IV ⊕	IV ⊕	IV ⊕						
	3.												
	4.												
ASSESSMENT	Infusions / Transfusions	10% Dentin	10% Dentin	10% Dentin	10% Dentin + Ca ₂	10% Dentin + Ca ₂	10% Dentin + Ca ₂						
	PU Prophylaxis	YNA	NA	YNA	NA	YNA	NA						
	DVT Prophylaxis	YNA	NA	YNA	NA	YNA	NA						
Vitals	BP	68/42(55)	50/36(40)	52/36(38)	50/32(38)	62/42(40)	51/30(38)						
	PR	152b/m	149b/m	123b/m	151b/m	150b/m	142b/m						
	RR	62b/m	44b/m	44b/m	32b/m	45b/m	43b/m						
	SpO ₂	97%	99%	97b/m	99%	97%	99%						
	Temp	36.5°C	36.6°C	36.6°C	36.6°C	36.5°C	36.6°C						
Pain Score	1/10	1/10	2/10	2/10	2/10	1/10							
LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert	Alert	Alert							
Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact	Intact	Intact							
Restraints If any	YNA	YNA	YNA	NA	YNA	YNA							
Fall Risk (Vulnerable (Y/N) if yes score)	Yes	Yes	Yes	Yes	Yes	Yes							
(Ambulation, walking, moving with assistance, bed ridden)	Moving	Moving	Moving	Moving	Moving	Moving							
ADL (Dependent / Non-Dependent)	Dependent	Dependent	Dependent	Dependent	Dependent	Dependent							
Critical Lab Test / Values (if any)	NA	NA	NA	NA	NA	NA							

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :	5/5/26	6/5/26	7/5/26	8/5/26	8/5/26	8/5/26	
		Area	N2	N2	N2	N2	N2	N2	
		Shift Time	8pm-8am	8am-8pm	8pm-8pm	8am-8pm	8pm-8am	8am-8pm	
		Ordered / Planned	RBS-B th Gas BD	RBS-BD Gas-BD	RBS-BD Gas-BD	RBS-B th Gas-BD	RBS-B th Gas-BD	RBS-BD TFT SBR on Sunday	
		Due	NA	NA	NA	NA	NA	NA	
		Reports Pending		NP Bloodcl	NP Bloodcl	NA	NA	Blood cl	
		Referrals (If any)	NA	NA	NA	NA	NA	NA	
		Remarks (Special Interventions like, Drainage Tube flushing etc.)	NA	NA	NA	NA	NA	NA	
		Handed Over By Name :	Z. Bony	Abhinav	Abhinav	Abhinav	Abhinav	Saurav	Nagabeni
		Signature :							
Date :	6/5/26	6/5/26	7/5/26	7/5/26	8/5/26	8/5/26	8/5/26		
Time :	@8pm	@8pm	@8pm	@8pm	@8pm	@8pm	@8pm		
Taken Over By Name :	Abhinav	Abhinav	Abhinav	Saurav	Nagabeni	Abhinav	Abhinav		
Signature :									
Date :	6/5/26	6/5/26	7/5/26	7/5/26	8/5/26	8/5/26	8/5/26		
Time :	@8am	8pm	@8pm	@8pm	@8am	@8am	@8pm		

BAH-00655578 IP5-00173415
 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0 Y 0 M 5 D (M)
 Dr. NITASHA BAGGA

(5)

NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift. Morning Afternoon Night

Date: 12/5/26

Assessment: Asses the baby condition

- Goals**
- Maintain Airway and Oxygenation
 - Relieve Pain & Discomfort
 - Maintain Fluid Balance
 - Improve Activity Tolerance
 - Maintain Good Nutritional Status
 - Maintain Skin Integrity
 - Maintain Personal Hygiene
 - Prevent Infection
 - Meet Elimination Needs
 - Ensure Safety
 - Early Ambulation Reduce Anxiety
 - Patient & Family Education
 - Identify Potential Complications
 - Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
8am	Asses the baby condition.	8:10am	Assesed the baby condition.	Baby is stable
10am	Maintain Good nutritional status.	10:41am	Maintained nutritional status giving 2nd baby feed.	
12pm	Prevent Infection	12:31pm	Followed Infection control practice	
2pm	Monitor vitals	2:36pm	Monitored 2nd baby vitals	
5pm	Maintain I/O chart	5:33pm	Maintained I/O chart 6th baby	

Re-Assessment: Baby is on RLA w/f deal

Special Notes: GPRS OP.

Nurse Signature: *[Signature]* Nurse Name: Nandini Date & Time: 12/5/26 @ 5pm

BAH-0065578
 Baby Of JUNTIPALLY KAVERI TWIN 2
 05-05-2026 0Y0M6D (M)
 Dr. NITASHA BAGGA



16

NURSING CARE RECORD



Shift: Morning Afternoon Night

Date:

Assessment:

Goals

- Maintain Airway and Oxygenation
- Maintain Personal Hygiene
- Identify Potential Complications
- Relieve Pain & Discomfort
- Prevent Infection
- Any Others. Specify.....
- Maintain Fluid Balance
- Meet Elimination Needs
- Improve Activity Tolerance
- Ensure Safety
- Maintain Good Nutritional Status
- Early Ambulation Reduce Anxiety
- Maintain Skin Integrity
- Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

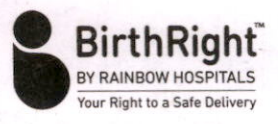
Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

BAH-00655578 IP5-00173415
Baby Of JUNTIPALLY KAVERI TWIN 2
05-05-2026 0 Y 0 M 0 D 6 H (M)
Dr. NITASHA BAGGA



CONSENT FOR SURGICAL PROCEDURES

Patient Name : B/O Karim - twin II Gender: Male Female

UHID No : Department : Date :

I S / D / W / O

Here by give consent for procedure of : Endotracheal intubation

For my patient, Named :

The doctors have clearly explained to me that the procedure has following possible complications:
.....
.....
.....

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :
.....
.....

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure:

Patient Attendant :
Signature : [Signature]
Name : J. K. Sathish Reddy
Relationship with Patient : Brother
Date & Time : 9:30 pm

Witness :
Signature : [Signature]
Name : K. B. Sany
Date & Time : 5/5/26 @ 9:30 pm

Doctor (who is taking the consent) :
Signature : [Signature]
Name : Rupjale
Date & Time : 5/5/26

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం పురుషుడు స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

BAH-00655578
Baby Of JUNTIPALLY KAVERI TWIN 2
05-05-2026
Dr. NITASHA BAGGA
IP5-00173415
0 Y O M 0 D 6 H (M)



CONSENT FORM - PROCEDURES

Patient Name : B/O Kavuri - Twin - II Gender: Male Female

UHID No : Department : Date :

I S/D/W/O

Here by give consent for procedure of : Surfactant administration

For my patient, Named :

The doctors have clearly explained to me that the procedure has following possible complications:

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure:

Patient Attendant :

Signature : [Signature]

Name : J. Kaarthika Reddy,

Relationship with Patient: Biopthery

Date & Time : 9:30pm

Witness :

Signature : [Signature]

Name : K. Blenny

Date & Time : 5/5/26 9:30pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Rupanjali

Date & Time : 5/5/26

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం పురుషుడు స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము