

ADMISSION SHEET



Registration Details :

Admission No : IP5-00175834 Admit Date : 01-Jul-2026 Admit Time : 05:03 PM UHID : BAH-00660431

Patient Details :

Patient Name	: Baby Of VADLA GAYATHRI	Age	: 0 D
Guardian	: MR BODDEPALLI THARUN	DOB	: 01-07-2026 03:51 PM
Gender	: Male	Religion	:
Occupation	:	Marital Status	: Single
Address (H)	: FLAT NO 306, LIG BLOCK NO 12, CHITRAPURI COLONY, Manikonda Hyderabad Telangana INDIA 500089	Phone No	: 8499840414/
		E-mail	: THARUNBODDEPALLI@gmail.com

Admission Details :

Bed Type : BASINET Bed No : CRDL-BC-DC-418-1 Ward Name : 4F-BIRTHING CENTRE
Room No : CRDL-BC-DC-418-1 Admission Type : First Visit

Contact Details :

Name : MR BODDEPALLI THARUN Relationship : Father
Contact Address : FLAT NO 306, LIG BLOCK NO 12, CHITRAPURI COLONY, Manikonda Hyderabad Telangana INDIA 500089 Phone No : / 8499840414

Chandurani

Signature

Doctor Details :

Doctor Name : Dr. KAPIL BHAGWATRAO SACHANE Specialisation : NEONATOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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

Page 1 of 2

Date of Birth	11/7/06
Time of Birth	9:51
Mode of Delivery	NVD
Birth Weight	3.070kg
Head Circumference	32cm
Length	50cm
Red Reflex	

New Born Screening	: V. Gayathri (Willing)
TFT	:
OAE	:
Mother's Blood Group	: O positive
Baby's Blood Group	: Ove
Anomaly Scan	:
Vaccination	: OPV, BCG, Hep-B
Done on 27/7/26 By Sis. Kareni	

Docu. No. : RCHBH /FRM / CLINICAL / 132

[illegible]

BAH-00660431 IP5-00175834
Baby Of VADLA GAYATHRI
01-07-2026 0 Y 0 M 0 D 3 H (M)
Dr. KAPIL BHAGWATRAO SACHANE


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


BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Vadla Gayathri Age : 29 Father's Name : Age :
Date of Birth : Date of Admission : UHID No. :
NICU Consultant : Referring Consultant :
Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward
Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : B/D Gayathri Mother's Blood Group : o+ve - Positive
Gender : ☒ M ☐ F Blood Group : Birth Weight (gms) : 3070 grams Length (cms) : 49cm
Date of Birth : 17/26 Time of Birth : 3:51 pm OFC (cms) : 34cm
Place of Birth : RCH: BH. Estimated Gesth Age : 40wks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 29 Ht : Wt : BMI : Married Life : LMP : 25/9/25 EDD : 2/7/26

Conception : Spontaneous or with Rx :

Booked at what GA : 19+2

AN Steroids Drugs / Doses :

Last Scans Details : 8/5 : SLNIF / 32+3 Cephalic / 1945 / AC: 26.1 / AF: 21.3

(A) Dopplers.

TIFFA : (A)

TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs

Consanguinity : ☐ Yes ☐ No

If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long :

H/o value of recent BP recording, proteinuria, edema,

oliguria, any investigations (LFT, platelet count) :

IUGR - when detected :

Doppler (Increased Resistance / ADEF / REDF /

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

G : P : A : L :

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
			— Polmi —			

PERINATAL HISTORY

Treating Obstetrician : Dr. Southi Reddy Hospital : LCH-BH ☒ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation) AVD

LSCS : ☐ Elective ☐ Emergency Indication :

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitaion : ☐ Yes ☐ No

Cord ABG :

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

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : 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	
1	2	
8	9	

TOTAL

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

Snapee II Score

Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



History of Present Illness:

Equipment check done.



Baby was received in a prewarmed linen.



Baby cried immediately after birth



Baby dried/warmed



Suctioning done



Noisy breathing + Supraclavicular

Retractions noted



Settled



Shifted to mother side

Investigation details in previous Hospital :

Feeding History :



Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Euthermic Acrocyanotic
 dT/A: good
 hemodynamically stable

VITALS : Temperature : ~~Euthermic~~ HR : 157/min RR : 49/min NIBP : CFT : 23

Color of the extremities : ~~Acrocyanotic~~

Jaundice : Pallor : SpO2 : 97%

ANTHROPOMETRY: Birth Weight : 3073 Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

HEAD :

Fontanelles :

Sutures

Shape / Moulding :

Edema / Bruising :

Size - (H.C.) :

Caput / cephal hematoma?

FACIES :

(Any Facial
Dysmorphism)

— Nil —

NECK and
CLAVICLES :

Range of Motion :

Asymmetry :

Masses :

Nil

EYES :

Symmetry :

Red Reflex :

Discharge :

to be checked

conjunctival congestion
notedEARS, NOSE
MOUTH and
THROAT :

Ear set / Shape :

Periauricular Pits / Tags :

Nasal shape / Patency :

Palate :

Gums :

Lips :

Tongue :

NO cleft lip/palate

THORAX and
BREASTS :

Shape of Thorax :

Position of Nipples and Number :

— Nil —

ABDOMEN and
UMBILICUS :

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump : 2A + IV

Discharge :

GENITILIA :

Labia / Hymen :

Testicles/penis :

Anus :

Nil

HERNIAL ORIFICES

— Nil —

TRUNK and SPINE :

— Nil —

SKIN LESIONS :

— Nil —

EXTREMITIES :

Fingers / Toes :

Deformities :

Hip Joint Examination :

Arms / Legs :

Mobility :

Nil



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 49/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: 97% Auscultation: RAET Breath Sounds: NVBS Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 157/min BP:

Precordial Activity :

Femoral Pulses : 2e well felt

Murmurs :

Other Peripheral Pulses :

Signs of Cardiac Failure :

ABDOMEN:

Shape :

Hernia orifice :

Palpation :

Anal Patency : looks patent

Palpable masses :

Umbilical Cord : 2A + IV

Abdominal girth :

First urine passed : -

Meconium passed : -

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtl Score :

Nerves :

MOTOR SYSTEM:

Passive Tone :

Active Tone : active good

Neonatal Reflexes :

Grasp : ☒ Palmar ☒ Plantar ☒ Sucking ☐ Rooting ☐ Crossed adductor :

Moro's : be symmetrical DTR :

ATNR :

Skull and Spine :

Any Corruptions :

Diagnosis : Posmi / 40wks / AVO - Rini / mch / CIAB / 3073 / Cephalhematoma

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time : 01/07/26

Consultant :

Signature :

Name :

Date & Time :

PLEASE FILL UP THE FOLLOWING DETAILS

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

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



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

Vital : HR : RR : BP : SP02 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

Plan
1. Send cord blood for blood grouping.

2. vaccines $\frac{OPV}{RCG}$ $\frac{Hep-B}{Hep-B}$ | today tomorrow

Plan during ward follow up :

3. DBF/2nd hourly

4. SBR/NBS/OAE @ ABHOL

5. Warm care

Feeding Plan at the time of shifting :

U: 28pm U: 4.5pm

6. W/F Respiratory distress/
Feed intolerance.

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:

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 Baby Of VADLA GAYATHRI
 01-07-2026 0 Y 0 M 4 D (M)
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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record				
6	Doctors progress sheets	7			
7	Nursing plan of care and handover sheets	8			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed	1			
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation				
24	Emergency Triage record				
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	5			
30	Intake and Out take chart (fluid chart)	3			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)				
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	2			
38	Braden Q Scale	2			
39	Bed side check list				
40	PICU bed formula Dilution feeds	2			
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	<i>Subtotal</i>	<i>1</i>			
	<i>Grand Total</i>	<i>24</i>			
	Total No. of Pages				

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

Docu. No. : RCHBH /FRM / CLINICAL / 088

noted by
Sgt. Kolyan
06-24-88
at (P.T.O.)

[illegible]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/26 4pm	Seen by Resident 24 Hrs Baby on Room air Tolerating feeds well Sucking: good CRT < 3 sec Vitals: stable Euthermic Euglycemic Clinical jaundice 24 Hrs 9 mld	Plan 1. DBF / DBF 2nd hourly feed 20ml Topup feed 2. Start SSPT with eye Chord genital care 3. vital monitoring 2nd hourly
27/26 8:50am	cl & B RESIDENT Apt test / Bsmi / 4000K / AND - Rini / QAB / 3073. B-Wt: 3073 5.7 TWE: 2892 h v 8T m 8T Euthermic PNE - cl & A: good hemodynamically stable Good perfusion.	Plan 1. DBF / 2nd hourly. 2. SBR / NBS at 3pm today. 3. DAE today. 4. SSPT to continue

Dr. Kapil Bhagwatrao Sachane
Reg. No. TSMC/FMR/19525

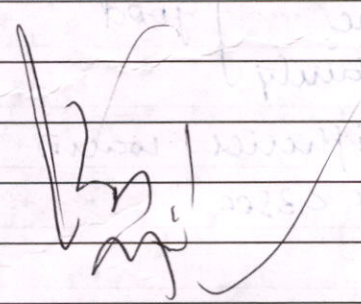


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7 5:30pm	C/SIB Resident	
	49HOL Pimi AVD CIAB 3.073kg.	
		IBR - 13mg/dl
	Bwt → 3.073kg	Plan:
	Twt → 2.89kg	
		① DBF 2hly
		② monitor feeds & urine output
		③ SPT to continue. Eyes
		④ vitals to monitor genital
		3hly
	Eutheemic	
	Euglycemic	
	cup tone activity } good	Soluh
		1. ③ solubhasini

Date & Time	Progress Notes	Doctor's Order
4/7/26 5:00 pm	C/S/B Resident	
	75 HOL / Primi / AUD / C/PB / 3073g 40W	Plan SBR - 14.1
	TWT : 2.855	(1) DSPT continue with eye gen con
	M / ✓ V / ✓	(2) DBF 2nd July
	Euthermic-Pink Euglycemic	(3) Formula feed . 20-25ml 2nd July
	Buky on room air	(4) monitor feed & warm care
	cry tone activity } good.	Soheli
4/7 5:30 pm	SBR: 14.1 ← 13.5 ↓ 0.6	Plan 1. CT DSPT. 2. Regular feeding 3. Same sample exp. 4. T/M - 8am - SBR / CBP / DCT / Retic count / extra plain. 5. monitor vitals.
		[Signature]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/2 12:00 PM	dt/B dr. kapil sir Cathartic dt/as good Warm peripheries. Good perfusion	1. SRR/cep → 1/2 m 8:00 AM LFT/cep 2-ct sept with eyes and genitalia covered 2-trace blood c/s. 4. USA abdomen 4/m — (Hold) 5. Lactation consult
	Dr. Kapil Bhagwatrao Sachane Reg. No. TSMC/FMR/19525	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/16 5pm	<u>Afternoon rounds</u>	
	Baby on Room air Ongoing phototherapy Hemodynamically stable Euthermic Cry } Tone } Good Activity }	<u>Plan</u> 1. Dsf 2nd hourly + Topup 25-30ml O ₂ A 2. Continue 2ij pipha 3. Trace blood cl 4. Retic count (Tm) morning will be updated 5. Continue SLP T with eye and genital care 6. CRP, CRP } (Tm) 8am LFT * dry sar Noted by Shirley 6/7/16
	CRP < 3sec Peripheral → warm Passed urine & stool Dx → negative CRP → 21	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 8:45am	S/B Resident	
	SDOL Primi AVD CDB 3073g 40wks	
		Plan SBR-12-9
	M/O ⁺ U/C B/O ⁺ M/✓	① DBF # 25-30ml 2nd day FF 2adhr
	Baby in room air	② Inj PPptaz (2)
	- On formula Acids + DBF	
	- Sucking well / latchig good	③ SSPT with eyes & genital care
	Twt + 2.93 Kg 4'6" 1.↓	
	Cry tone } good	④ Trace Refr count Bld cl
	activity }	
	Peripheries warm	Sohib
	Seen by Nicu resident	
	B/ds - 24hrs No growth.	
	CRP decreasing trend (21/10) (6/7)	→ Rlv on antibiotics post Bld cl
	CBP = Hb 19.8 19.8	of 48 hrs
	WBC 7.98 5.83	
	Plt 1.89 1.57	
	LFT - AST - 45 ALP 154	→ Vaccination on flup
	ACT - 23	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	TSB 1 13.6 > 14.1 > 18.8 > 12.9	R/v Plan of discharge
		Continue DBF with measured feeds.
		Trace - B/c's of 48hrs AABR
		<u>Sacha</u>
		Perpheral smear
		Discharge (H45L34)
		to 4
		her Bunt water
		Surp
		N-B- Amanur

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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:																			



REGULAR PRESCRIPTIONS

Weight. 3Kg Ward.

DRUG : <u>PIPERACILLIN</u>				Date Time																
Dose <u>300mg</u>	Route <u>IV</u>	Frequency <u>Q12H</u>	Start Date <u>4/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>P. Sachane</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

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

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

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

Patient Sticker

I.V. FLUIDS CHART

Weight. Ward.

[illegible]



INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 1/1/20 Time: 10:10

[illegible]

A graph on grid paper showing four data points plotted at approximately (40, 98.1), (50, 98.2), (60, 98.3), and (70, 98.4). Each point is labeled with a handwritten number and an asterisk.

Point	X-coordinate (approx.)	Y-coordinate (approx.)	Label
1	40	98.1	*78.1
2	50	98.2	*79.2
3	60	98.3	*80.3
4	70	98.4	*81.4

A grid of 20 rows and 100 columns. The grid is divided into three horizontal bands: a blue band at the top (rows 180-190), a white band in the middle (rows 100-170), and a blue band at the bottom (rows 50-90). The middle white band contains the handwritten text "x140" in row 140, column 45, and a small asterisk "*" in row 135, column 60.

[illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible]

Handwritten notes on a grid background, including the word "Handwritten" and some illegible scribbles.

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)
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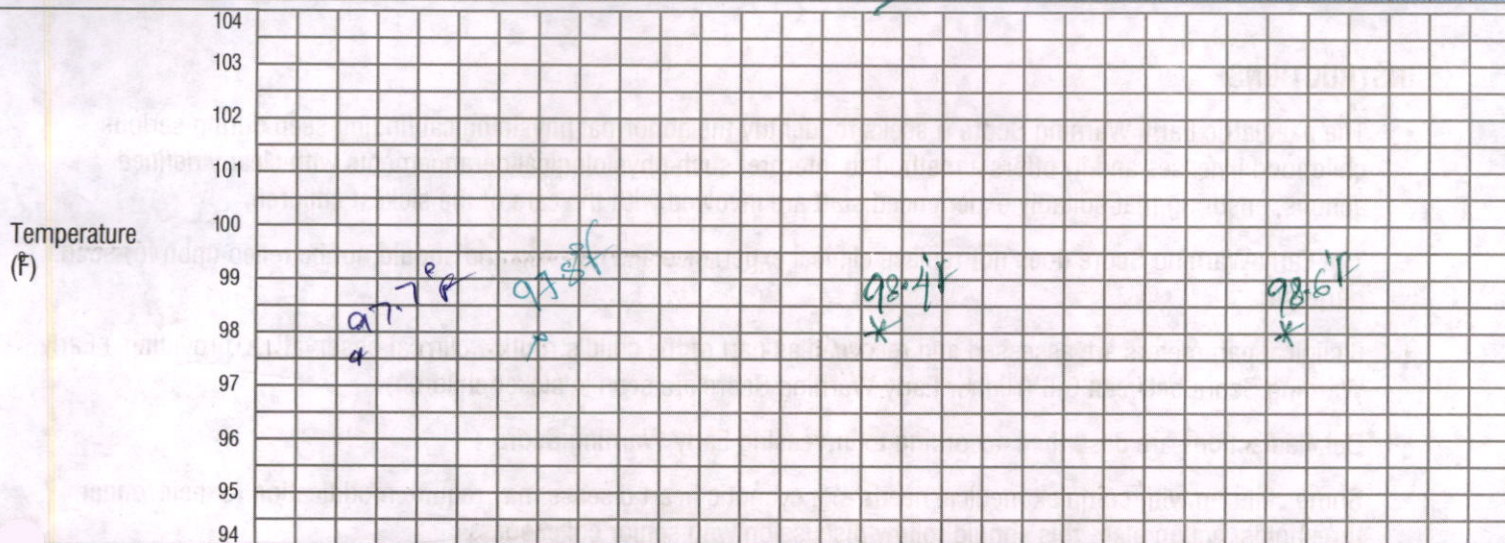


21/7/26

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 21/7/26 Time: 11am 10:50 AM
 Doctor/Nurse/Family Concern?



Heart Rate (bpm)

and

Blood Pressure (mmHg) *

Note:

BP does not score in early warning scoring

Heart Rate (Number)

130b/m

128b/m

136b/m

142b/m

Resp. Rate (bpm) or 1 Minute) *

Resp Rate (Number)

40b/m

41

38b/m

40b/m

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%)

100%

97%

100%

99%

Conscious Level Normal Altered

GCS *

15/15

15/15

15/15

15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

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.
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- 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!
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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.

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BAH-00660431 IP5-00175834
Baby Of VADLA GAYATHRI
01-07-2026 0 Y 0 M 0 D 6 H (M)
Dr. KAPIL BHAGWATRAO SACHANE



No. : RCH / FRM / CLINICAL / 124

5/7/24
INFANT (<1 year)

Children's Observation &
Early Warning Scoring Chart

Pratiksha
Rainbow
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 12pm 5000 10:30 6am

Doctor/Nurse/Family Concern?

Temperature
(°F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
(Over 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%)

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

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.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Date	Time	Early Warning Score	Date	Time	Name

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417126

Children's Observation & Early Warning Scoring Chart

Date:		Time: <u>11 AM</u>		<u>5pm</u>		<u>11pm</u>		<u>2am</u>		<u>6am</u>	
Doctor/Nurse/Family Concern?											
Temperature (F)	104										
	103										
	102										
	101										
	100										
	99										
	98										
	97										
	96										
	95										
94											
Heart Rate (bpm)	190										
	180										
	170										
	160										
	150										
	140										
	130										
	120										
	110										
	100										
and Blood Pressure (mmHg) *	90										
	80										
	70										
	60										
	50										
	40										
	30										
	20										
	10										
	0										
Note: BP does not score in early warning scoring											
Heart Rate (Number)		<u>145b/m</u>		<u>135b/m</u>		<u>130b/m</u>		<u>136b/m</u>			
resp. Rate (bpm) (Over 1 Minute) *											
Resp Rate (Number)		<u>100b/m</u>		<u>100b/m</u>		<u>90b/m</u>		<u>92b/m</u>			
Resp Distress	Mod/ Severe None / Mild										
Receiving O ₂ (l/min) O ₂ Saturations (%)		<u>100%</u>		<u>99%</u>		<u>99%</u>		<u>97%</u>			
Conscious Level	Normal Altered										
GCS *		<u>15/15</u>		<u>15/15</u>		<u>15/15</u>		<u>15/15</u>			
TOTAL SCORE		<u>0</u>		<u>0</u>		<u>0</u>		<u>0</u>			
Number of shaded boxes		<u>0</u>		<u>0</u>		<u>0</u>		<u>0</u>			
Pain Score		<u>0</u>		<u>0</u>		<u>0</u>		<u>0</u>			
Observer's Initials		<u>[Signature]</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>[Signature]</u>			

NB: Scores 3 should be recorded overleaf

- | | |
|-------------|---|
| 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. |
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| 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:

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BAH-00660431 IPS-00175834
Baby Of VADLA GAYATHRI
01-07-2026 0 Y 0 M 3 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

Doc. No. : RCH / FRM / CLINICAL / 124

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

Pratiksha
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Children's
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:

Doctor/Nurse/Family Concern?

Temperature
(°F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
per 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%)

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Level Altered

GCS *

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BAH-00660431
Baby Of VADLA GAYATHRI
01-07-2026 0 Y 0 M 4 D (M)
Dr. KAPIL BHAGWATRAO SACHANE

RCH / FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

Pratiksha
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Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 11:30 AM

Doctor/Nurse/Family Concern?

Temperature
(F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
(Over 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%)

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Level Altered

GCS *

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BAH-00660431 IP5-00175834
 Baby Of VADLA GAYATHRI
 01-07-2026 0 Y 0 M 0 D 3 H (M)
 Dr. KAPIL BHAGWATRAO SACHANE

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 Children's
 Hospital
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 Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

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.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	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 :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm	DBF											
	05:00 pm												
	06:00 pm												
	07:00 pm	DBF											
Total Intake : <i>as per Tabey</i>						Total Output : <i>as per</i>							
	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 : <i>m - 0 u - 0</i>							
	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 : <i>m - 2 u - 2</i>							
Total 24 hrs. Intake													
Total 24 hrs. Output			<i>m - 3 u - 3</i>										

BAH-00660431
 Baby Of VADLA GAYATHRI
 01-07-2026 0 Y 0 M 0 D 6 H (M)
 Dr. KAPIL BHAGWATRAO SACHANE

IP5-00175834

FLUID CHART

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Sheet No. :

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	N.G							
2/7/26	08:00 am											
	09:00 am	DBF					✓			✓		
	10:00 am											
	11:00 am	DBF								✓		
	12:00 pm						✓			✓		
	01:00 pm	DBF										
Total Intake :						M=2 Total Output : U=2						
	02:00 pm											
	03:00 pm											
	04:00 pm	DBF					✓					
	05:00 pm											
	06:00 pm	DBF										
	07:00 pm											
Total Intake :						Total Output : M=1 U=2						
	08:00 pm											
	09:00 pm											
	10:00 pm	EBM 3ml										
	11:00 pm	f.f. 10ml										
	12:00 am											
	01:00 am	f.f. 20ml										
Total Intake :						Total Output : M=0 U=0						
	02:00 am											
	03:00 am	f.f. 20ml					✓					
	04:00 am											
	05:00 am	DBF										
	06:00 am						✓					
	07:00 am	f.f.										
Total Intake :						Total Output : M=2 U=2						
Total 24 hrs. Intake		f.f. 752ml										
Total 24 hrs. Output		M=5 U=4										

BAH-00660431 IP5-00175834
 Baby Of VADLA GAYATHRI
 01-07-2026 0Y 0M 0D 3H (M)
 Dr. KAPIL BHAGWATRAO SACHANE

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 It takes a lot to treat the little.

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 Your Right to a Safe Delivery

FLUID CHART

Sheet No. :

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse			
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine					
2/7/26	08:00 am		DBF									NA } Seema			
	09:00 am														
	10:00 am		DBF												
	11:00 am	FF	15ml				✓								
	12:00 pm														
	01:00 pm		DBF				✓			✓					
Total Intake :						Total Output : M-2 U-1									
	02:00 pm	FF	25ml									NA } Seema			
	03:00 pm														
	04:00 pm														
	05:00 pm	FF	10ml				✓			✓					
	06:00 pm														
	07:00 pm	FF	15ml												
Total Intake :						Total Output : M-1 U-1									
	08:00 pm						✓			✓		NA } Seema			
	09:00 pm														
	10:00 pm		DBF												
	11:00 pm	f.f.	5ml												
	12:00 am														
	01:00 am						✓			✓					
Total Intake :						Total Output : M-0 U-									
	02:00 am		25ml									NA } Seema			
	03:00 am														
	04:00 am	f.f.	15ml				✓			✓					
	05:00 am														
	06:00 am						✓			✓					
	07:00 am	f.f.	15ml												
Total Intake :						Total Output : M-2 U-2									
Total 24 hrs. Intake		f.f. 125ml										Total 24 hrs. Output		M-7 U-6	

BAH-00660431 IP5-00175834
 Baby Of VADLA GAYATHRI
 01-07-2026 0 Y 0 M 0 D 6 H (M)
 Dr. KAPIL BHAGWATRAO SACHANE



FLUID CHART

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Sheet No. :

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 Thrombophlebitis Score	Sign. Nurse												
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage			Urine											
			Mouth	I.V	N.G																		
4/7/26	08:00 am						✓				1												
	09:00 am	f-f	25ml							✓	1												
	10:00 am						✓				1												
	11:00 am	f-f	20ml							✓	1												
	12:00 pm	DBF					✓			✓	1												
	01:00 pm	f-f	20ml								1												
Total Intake :						m - u - Total Output : m - 30 - 2																	
	02:00 pm						✓			✓	1												
	03:00 pm										1												
	04:00 pm	f-f	10ml				✓			✓	1												
	05:00 pm										1												
	06:00 pm						✓			✓	1												
	07:00 pm	f-f	16ml								1												
Total Intake :						Total Output : m - 30 - 3																	
4/8	08:00 pm						✓				0												
	09:00 pm									✓	0												
	10:00 pm	f-f 5ml + DBF									0												
	11:00 pm										0												
	12:00 am										0												
	01:00 am		f-f (15ml)				✓			✓	0												
Total Intake :						Total Output :																	
5/2	02:00 am										0												
	03:00 am	f-f (15ml)									0												
	04:00 am										0												
	05:00 am	f-f (20ml)									0												
	06:00 am						✓			✓	0												
	07:00 am	DBF f-f 15ml									0												
Total Intake :						Total Output :																	
Total 24 hrs. Intake												Total 24 hrs. Output											

M = 9, 028



FLUID CHART

Sheet No. :

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	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
											0	
	08:00 am						✓	✓		✓	0	Amrakesh
	09:00 am	DBF 10ml									0	
	10:00 am										0	
	11:00 am	f.f. 15ml					✓		✓		0	
	12:00 pm										0	
	01:00 pm	ff 25ml					✓		✓		0	
Total Intake :						M-3 Total Output : 0-3						
	02:00 pm	ff 20ml									0	Shivika
	03:00 pm						✓		✓		0	
	04:00 pm	ff 10ml									0	
	05:00 pm						✓				0	
	06:00 pm	exb 20ml							✓		0	
	07:00 pm						✓		✓		0	
Total Intake :						Total Output : M-3 0-3						
	08:00 pm										0	Kalyani
	09:00 pm	DBF							✓		0	
	10:00 pm						✓				0	
	11:00 pm	ff 30ml									0	
	12:00 am								✓		0	
	01:00 am						✓				0	
Total Intake :						Total Output :						
	02:00 am	FF 30ml									0	Kalyani
	03:00 am								✓		0	
	04:00 am	FF 30ml					✓				0	
	05:00 am										0	
	06:00 am	FF 30ml					✓		✓		0	
	07:00 am										0	
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

M=9, 0=10



FLUID CHART

Sheet No. :

6/2/26

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am						✓			✓	0	} Anne	
	09:00 am	f-f. 20ml									0		
	10:00 am										0		
	11:00 am	f-f. 40ml					✓			✓	0		
	12:00 pm										0		
	01:00 pm										0		
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
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-00660431
Baby Of VADLA GAYATHRI
01-07-2026 0 Y 0 M 0 D 3 H (M)
Dr. KAPIL BHAGWATRAO SACHANE

IP5-00175834

NURSING CARE RECORD

Rainbow
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☐ Morning ☑ Afternoon ☐ Night

Date: 2/7/26 @

Assessment: newborn Baby

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
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
4pm	Assess baby general condition	4:10 pm	Assessed baby general condition	pt is stable.
5pm	monitored vital	5:10 pm	Bp SpO2 pulse checked and recorded	
6pm	DBF + Burping	6:10 pm	DBF + Burping given	
7pm	warm care	7:10 pm	warm care provided	
8pm	Ensure safety	8:10 pm	Ensure safety provided	

Re-Assessment: Re Assessment done

Special Notes: vaccination T/M

Nurse Signature: [Signature]

Nurse Name: Shobha

Date & Time: 2/7/26 @ 8pm

BAH-00660431
 Baby Of VADLA GAYATHRI
 01-07-2026
 Dr. KAPIL BHAGWATRAO SACHANE
 IPS-00175834
 0 Y 0 M 0 D 3 H (M)

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 11/7/26

Assessment: New born baby Care

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
8 pm	→ Assess the General Condition of the baby	8:5 pm	→ Assessed the General Condition of the baby	* Baby is Stable.
9 pm	→ Monitor vitals	9:10 pm	→ Vitals monitored & Recorded	
10 pm	→ plan to maintain I/O chart.	10:30 pm	→ maintain I/O chart	
6 am	→ plan to warm care	6:40 am	→ provide warm care for baby.	
7 am	→ plan to feeding 2-3rd hourly.	7 am	→ Given Feeding Support 2-3rd hourly.	

Re-Assessment: provide warm care for baby

Special Notes: vaccination today

Nurse Signature: [Signature]

Nurse Name: Seema

Date & Time: 11/7/26 8 AM

BAH-00660431
Baby Of VADLA GAYATHRI
01-07-2026 0 Y 0 M 0 D 3 H (M)
Dr. KAPIL BHAGWATRAO SACHANE

NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 27/2/26

Assessment: New Born Baby

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
8am	→ To assess the general condition of the baby	8:10 am	→ Assessed the general condition of the baby	Baby is stable Vitals normal Has good intake
10am	→ To monitor vital signs	10:10 am	→ Monitored vitals and documented	
11am	→ To encourage oral intake	11:20 am	→ DBF every 2 to 3rd hly	
12pm	→ To maintain I/O chart	12:30 pm	→ Maintained I/O chart	
1pm	→ To provide warm care	1:15 pm	→ Provided warm care	

Re-Assessment:

After proper position, has good latching, sucking
TCBR at 24 H.O.L

Special Notes:

Vaccination today

Nurse Signature: 

Nurse Name: Kalyani

Date & Time: 27/2/26 at 2pm

BAH-00660431 IP5-00175834
 Baby Of VADLA GAYATHRI
 01-07-2026 0 Y 0 M 0 D 6 H (M)
 Dr. KAPIL BHAGWATRAO SACHANE

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: TCBR level 8.8 mg/dl related

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
2pm	Assess to the baby condition	2:15pm	Assessed to the baby on sleep	Baby well
3pm	TO Maentaen i/o chart.	3:30pm	Maentaend i/o chart.	
4pm	TO monitor vitals.	4:30pm	Monitored vitals.	
5pm	TO check TCBR 3:30pm		TCBR 8.8 mg/dl inform to Dr. Saiteja. He said start SSPT.	
6pm	Plan to start SSPT with cover of eye & genital area.	5:00pm	SSPT started with cover of eye & genital area	
7pm	Plan to give feed every 2nd hrly	6:30pm	provided feeding every 2nd hrly.	
		7:20pm		

Re-Assessment:

Special Notes: Assessment after 2 hr baby well
 Ct SSPT till 7:15 rounds of doctor.

Nurse Signature:

Nurse Name: Jeebhagini

Date & Time: 2/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 31/7/26

Assessment: Neonatal jaundice & DSPT

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
8pm	* Assess the baby condition	8:30 pm	* Assessed the baby condition	* Baby is stable.
10pm	* plan to monitor vitals			
11pm	* plan to maintain Ho chart.	10:20 pm	* monitor vitals stable.	
		11:5 pm	* maintain Ho chart	
12am	* plan to c-t. DSPT	12:40 Am	* Baby sleeping under the DSPT.	
7am	* plan to warm care	7:40 Am	* provide warm care for baby.	
8am	* plan to Feeding 2-3ml hourly.	8am	* Given Feeding support 2-3ml hourly.	

Re-Assessment:

provide warm care for baby.

Special Notes:

NA

Nurse Signature:

(Signature)

Nurse Name:

Seema

Date & Time:

31/7/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/2/26

Assessment: Baby under DSPT

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
8 AM	Assess the Baby General condition	8:05 AM	Assessed the Baby General condition on crib	Baby is stable
9 AM	To monitor vitals	9:05 AM	monitored Baby vitals	
10 AM	To monitor I/O chart	10:05 AM	monitored Baby I/O chart	
11 AM	To plan for DBF -ff	11:00 AM	every 2nd hourly DBF -ff	
12 PM	To plan ensure safety	12:00 PM	given Baby ensure safety	
1 PM	plan for warm care	1:00 PM	given Baby Raping care	

Re-Assessment: Re-assessment as per Baby Sunlighter well after 2 hrs baby sleeping now.

Special Notes: SBR -

Nurse Signature: Annamma

Nurse Name: Annamma

Date & Time:

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 7/7/25

Assessment: Neonatal Jaundice & DSPT

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
2pm	Assess the Baby General condition.	2:05pm	Assessed the Baby General condition.	Baby was stable.
3pm	Monitor the vitals.	3:05pm	monitored the vitals.	
4pm	Maintain I/O chart.	4:05pm	maintained I/O chart.	
5pm	Provide comfortable position to Baby.	5:05pm	provided comfortable position to Baby.	
6pm	provide 2 nd hourly feeding and Burping.	6:05pm	provided 2 nd hourly feeding and Burping.	
7pm	Ensure safety.	7:05pm	Ensured safety.	
7:10pm	SBR done. and intored to Lokin Sir.	7:15pm	CRP also sent in same sample.	

Re-Assessment: Baby was stable - same

Special Notes: SBR done. CRP sample sent in same sample

Nurse Signature: [Signature]

Nurse Name: A Shish

Date & Time: 7/7/25 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Baby under dsPT and having Antibiotics

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
9pm	→ Assess the Baby general condition	8:30 pm	→ Assessed the Baby general condition under the light	→ Baby was slept under the light
10pm	→ To monitor vitals	10:30 pm	→ monitored vitals	and Baby
12am	→ To maintain Ilo chart	12:30 am	→ maintained Ilo chart	feeding well
1am	→ To continue dsPT and Antibiotics	1:30 am	→ continued dsPT and Antibiotics	
2am	→ To provide crib care	4:30 am	→ provided crib care	
7am	→ To administer the medication	7:30 am	→ administered the medication	

Re-Assessment:

Re-assessment has done after 1 hour Baby was slept under the light (dsPT)

Special Notes:

Continue dsPT and continue antibiotics

CBP, OCT, Pctcount, SBR has sented Trace the report

Nurse Signature:

Nurse Name:

Kalyani

Date & Time:

5/7/26 @ 8am

BAH-00660431 IP5-00175834
 Baby Of VADLA GAYATHRI
 01-07-2026 0 Y 0 M 3 D (M)
 Dr. KAPIL BHAGWATRAO SACHANE



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Baby under DSPT and having Antibiotic

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	assess the Baby General condition	8:30 am	Assessed the Baby General condition on bed	⇒ Baby is stable
9am	to monitor vital	9:18 am	monitored Baby vitals	
10am	to monitor I/O chart	10:30 am	monitored Baby I/O chart	
11am	to continue dspt and antibiotics	11:30 am	continued dspt and antibiotic	
12pm	to provide crib care	12:30 pm	provided crib care	
1pm	to plan DBT ft feed	1:30 pm	every 2nd hourly feeding burping	

Re-Assessment: Re-assessment done Baby sucking well

Special Notes: continue dspt

Nurse Signature: Annamma

Nurse Name: Annamma

Date & Time: 5/7/26 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby was under SSPT and antibiotic.

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
2pm	Assess the Baby General Condition	2:05pm	Assessed the Baby. General condition	Baby was stable.
3pm	monitor the vitals.	3:05pm	Monitored the vitals.	
4pm	Maintain I/O chart.	4:05pm	Maintained I/O chart.	
5pm	provide comfortable position to Baby.	5:05pm	provided comfortable position to Baby.	
6pm	continue SSPT to Baby.	6:05pm	continued SSPT to Baby.	
6:30pm	To Administer medications	6:35pm	Administer medications.	
7pm	To provide warm care	7:05pm	provided warm care.	

Re-Assessment: after feeding baby was sleeping under SSPT well.

Special Notes: continue medication till order.
 T/m SBR, CBP, CRP, LFT +/m T/m

Nurse Signature: 

Nurse Name: shish

Date & Time: 5/7/26 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Yellowish discoloration of skin and eyes

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
8pm	→ To assess the general condition of the baby.	8:10pm	→ Assessed the general condition of the baby.	Baby is stable under SSPT Vitals normal
11pm	→ To continue SSPT	11:30pm	→ Continues SSPT	
1am	→ To encourage oral intake	1:10am	→ DBF → FF every 2 to 3rd hrly	
3am	→ To maintain Sfo chart	3:15 am	→ Maintained Sfo chart	
5am	→ To administer medicines	5:20 am	→ Administered IV medications	
7am	→ To collect blood samples	7:10 am	→ Sent blood samples	

Re-Assessment: After proper position, has good latching and sucking.

Special Notes: Continues SSPT
Trace reports

Nurse Signature:

Nurse Name: Kalyani

Date & Time: 5/7 at 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

Assessment: new born Baby case (Under SSPT)

- 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
8am	Assess the Baby general condition	8:30 am	Assessed the Baby general condition on (Basis)	→ Baby is stable
9am	To monitor vitals	9am	monitored Baby vitals	
10am	To monitor I/O chart	10:15 am	monitored Baby I/O chart	
11am	To provide cribe care	11:15 am	provided baby cribe care	
12pm	To plan for 1st feed	12:15 pm	given every 2nd hourly 1st breastfeed.	

Re-Assessment:

Special Notes:

Nurse Signature: Anna Maria

Nurse Name: Anna Maria

Date & Time: 6/7/26

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Kapil B Department: BB-III Date of Admission: 1/7/26

SITUATION		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:						
BACKGROUND	Area	Shift Time						
	Medical Condition (Any special condition to be noted):	BB-III 8pm	3rd Floor 8am	3rd 2pm	3rd Floor 8pm	3rd Floor 8am	3rd 2pm	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.6°F	98.2°F	97.7°F	97.8°F	98.2°F	97.9°F
		Res:	20	30b/m	40b/m	40	39b/m	40b/m
		SpO ₂ :	100%	98%	100%	97	100%	98%
		Pulse:	140b/m	145b/m	130b/m	138	132b/m	130b/m
		BP:	—	—	—	—	—	—
	Fall Risk Score:	0	16	16	16	16	16	
Pain Score:	0	0/10	0	0/10	0/10	0		
Recommendations	Safety Needs:	yes	yes	crib case	yes	yes	crib case	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	vaccination today	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Shobha	Seemra	Kalyani	Soubhanni	Seemra	Kalyani	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		1/7/26	2/7/26	2/7	2/7/26	3/7/26	3/7	
Time:		8pm	8am	2pm	8am	8am	2pm	
Taken Over By Name :		Seemra	Kalyani	Soubhanni	Seemra	Kalyani	Soubhanni	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		1/7/26	2/7	2/7/26	2/7/26	3/7	2/7/26	
Time:		10pm	8am	2pm	8pm	8am	2pm	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. Kapil. B. Department: 3rd floor Date of Admission: 1/7/26

SITUATION		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:						
BACKGROUND	Area							
	Shift Time	3rd floor 2pm	3rd floor 8am	3rd floor 8am	3rd floor 2pm	3rd floor 8am	3rd floor 8am	
ASSESSMENT	Medical Condition (Any special condition to be noted):	NNT						
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.7	98.2	98.7	98.1	97.9	98.7
		Res:	39	40b/m	40b/m	40b/m	40b/m	40b/m
		SpO ₂ :	99	100%	100%	100%	98%	98
		Pulse:	110	142b/m	148b/m	135b/m	130b/m	135b/m
		BP:	NA	NA	NA	NA		
		Fall Risk Score:	15	16	15	15	15	15
	Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10	
Recommendations	Safety Needs:	yes	yes	yes	yes	crib care	crib care	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	ct sspt	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Pooja	Shreya	Ananya	Shrishti	Kalyani	Ananya	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		3/7/26	4/7/26	4/7/26	4/7/26	5/7/26	5/7/26	
Time:		8pm	8am	8pm	8pm	8am	2pm	
Taken Over By Name :		Shreya	Ananya	Shrishti	Kalyani	Ananya	Shrishti	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		3/7/26	4/7/26	4/7/26	4/7/26	5/7/26	4/7/26	
Time:		8pm	8am	8pm	8pm	8am	2pm	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. Kapil Department: PCCU Date of Admission: 1/7/26

SITUATION	Diagnosis: <u>Neonatal Jaundice</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Area	Shift Time	<u>3rd 1000 8pm</u>	<u>3rd 8am</u>		
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>nil</u>	<u>NB</u>		
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:	<u>98.1F</u>	<u>98.1F</u>		
		Res:	<u>40b/m</u>	<u>40b/m</u>		
		SpO ₂ :	<u>99.1</u>	<u>98%</u>		
		Pulse:	<u>130b/m</u>	<u>128b/m</u>		
		BP:	<u>-</u>	<u>-</u>		
		Fall Risk Score:	<u>15</u>	<u>16</u>		
Pain Score:		<u>0/10</u>	<u>0</u>			
Recommendations	Safety Needs:		<u>CRIB case</u>	<u>CRIB case</u>		
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		<u>nil</u>	<u>NA</u>		
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:		<u>nil</u>	<u>na</u>		
Post Operative Procedure Special Orders:		<u>nil</u>	<u>na</u>			
Handed Over By Name :		<u>Shinde</u>	<u>Kalyani</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>5/7/26</u>	<u>6/7</u>			
Time:		<u>12:30pm</u>	<u>8am</u>			
Taken Over By Name :		<u>Kalyani</u>	<u>Ananya</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>5/7</u>	<u>5/7</u>			
Time:		<u>8pm</u>	<u>8am</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy: ☐ Yes ☐ No Tubes/Drains/Catheter: ☐ Yes ☐ No Vital Signs:	☐ Yes ☐ No ☐ Yes ☐ No Temp: Res: SpO ₂ : Pulse: BP: Fall Risk Score: Pain Score:	☐ Yes ☐ No ☐ Yes ☐ No 	☐ Yes ☐ No ☐ Yes ☐ No 	☐ Yes ☐ No ☐ Yes ☐ No 	☐ Yes ☐ No ☐ Yes ☐ No 	☐ Yes ☐ No ☐ Yes ☐ No
Recommendations	Safety Needs: Physiotherapy Others Specify: Special Diet:	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
	Other Special Orders / Medications:						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						



IE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	11/7/26	11/7/26	2/2	3/2	4/2
	3 to less than 7 years old	3	4	4	4	4	4
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope/ Dizziness, etc.	3					
	Psych/ Behavioral Disorders	2					
	Other Diagnosis	1			1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture/ Lighting (Tripled Room)	3			3	3	3
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3	3	3			
	Within 48 hours	2	2	2			
	More than 48 hours/ None	1			1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives/ Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications/ None	1	1	1	1	1	1
Total			16	16	16	16	16

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	X	X	NO	NO	NO
Call device within reach	X	X	NO	NO	NO
Wheels Locked	✓	✓	YES	YES	YES
Room free of clutter	✓	✓	YES	YES	YES
Adequate lighting	✓	✓	YES	YES	YES
Wheel chair support	X	X	NO	NO	NO
Other Intervention(s) Specify	✓	✓	NO	NO	NO
Nurse's Name:	Shobu Ajali	Shobu Ajali	Shobu Ajali	Shobu Ajali	Shobu Ajali
Signature:	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:	11/7/26	11/7/26	2/2	3/2	4/2
Time:	8pm	8am	8am	8am	8am

BAH-00660431
Baby Of VADLA GAYATHRI
01-07-2026 0 Y 0 M 2 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	5/7	6/7			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4	4	4			
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3	3	3			
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
TOTAL			11	16			

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

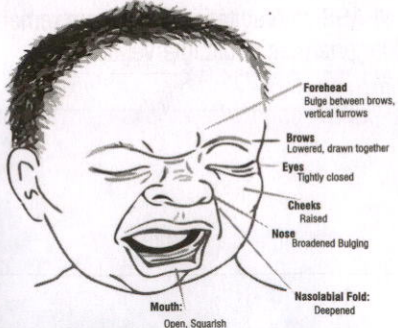
Bed in low position		NO	NO			
Call device within reach		NO	Yes			
Wheels Locked		Yes	Yes			
Room free of clutter		Yes	Yes			
Adequate Lighting		Yes	Yes			
Wheel Chair Support		NO	NO			
Other Intervention(s) Specify		NO	NO			
Nurse's Name :		Kalyani Kalyani				
Signature :		[Signature]				
Date :		5/7/26	6/7			
Time :		10:00 AM	6:00 AM			

BAH-00660431
Baby Of VADLA GAYATHRI
01-07-2026 0 Y 0 M 0 D 3 H (M)
Dr. KAPIL BHAGWATRAO SACHANE

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

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Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time	
						17	17	9/7	3/7	9/7	4/7	6/7		
						Time	Time	Time	Time	Time	Time	Time	Time	
						8pm	8pm	8Am	8Am	8Am	8Am	6am		
						Procedure → GPRB								
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0	0	0	0	0	0	0		
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0	0	0	0	0		
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0	0	0	0	0		
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0	0	0	0		
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0	0	0	0		
 Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention					Gestational Age / Corrected Age	40 weeks	40 weeks	40 weeks	40 weeks	40 weeks	40 weeks	40 weeks		
					Total Pain / Agitation Score	0	0	0	0	0	0	0		
					Intervention	NA	NA	NA	NA	NA	NA	0		
					Effectiveness	NA	NA	NA	NA	NA	NA	NA		
					Signature	Shobh	Aydi	6	6	6	6	6		

NPASS: Neonatal Pain, Agitation & Sedation Scale

	Sedation	Pain / Agitation
How to use	- Observe the infant for a minute before selecting a score for each behavior. - Stimulate the infant and observe and select a score for each behavior. - Select only one numeric value (Highest) per behavior.	- Observe the infant for a minute before selecting a score for each behavior. - Select only one numeric value per behavior.
Scoring/ Documentation	- Sedation scores are negative scores only - Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age) - NPASS Sedation total score has a range from 0 to -10 possible. - Document total NPASS Sedation score in the medical record.	- Pain/Agitation scores are positive scores only - Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria. - Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score. - NPASS Pain/Agitation total score has a range from 0 to 13 possible. - Document the total NPASS Pain/Agitation score in the medical record
Interpretation	- Desired levels of sedation vary according to the situation. - Discuss and determine sedation goal with provider. "Deep sedation": goal score of -10 to -5 - Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea "Light sedation": goal score of -5 to -2 - Reassess patient per frequency in local sedation policy - A negative score without the administration of opioids/ sedatives may indicate: - The premature infant's response to prolonged or persistent pain/stress - Neurologic depression, sepsis, or other pathology	- Does not provide pain intensity rating. - Any score greater than 3 indicates the possibility of the presence of pain in the infant - Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological). - Reassess patient per frequency of local pain policy. - If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention.



BRADEN 'Q' SCALE

					Date :	1/7/26	11/2/26	2/7	3/7
					Time :	8pm	8pm	2am	2am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e: extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	2	2	2	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	2	2	1	1	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2	3	3	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	2	2	2	2	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2	2	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	20	20
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Shobu Ajale	seema	seema	

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BAH-00660431 IP5-001
 Baby OF VADLA GAYATHRI
 01-07-2026 0 Y 0 M 0 D 3 H (M)
 Dr. KAPIL BHAGWATRAO SACHANE



BRADEN 'Q' SCALE

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					Date :	9/7	5/7	6/7	
					Time :	8am	8am	6am	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		2	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		1	1	1	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		3	3	3	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		2	4	4	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be < 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	
					TOTAL SCORE	20	24	24	
					Evaluator's Name	Sachane	Kalyan	Kalyani	

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Docu. No. : RCHBH /FRM / CLINICAL / 119

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

CHECKLIST FOR THROMBOPHLEBITIS

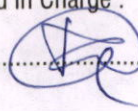
S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0			
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-	-			
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	-	-	-			
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-	-	-	-	-			
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-	-	-	-			
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-			
Signature of the Nurse						Kalyani			Shruti Kalyani				

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature :  Name : Soubhagshi

Signature of Ward In Charge :

Signature :  Name : Rizwan

CONSENT FOR FORMULA FEEDS

BAH-00660431 IP5-00175834
Baby Of VADLA GAYATHRI
01-07-2025 0 Y 0 M 0 D 6 H (M)
Dr. KAPIL BHAGWATRAO SACHANE



Patient Name : Age : Gender : ☐ Male ☐ Female

UHID No : Department : Date :

I Mr / Mrs. : aged years, hereby declare that I have
admitted my ☐ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on
..... I hereby give consent for formula feed for my child. Doctors have explained me
about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : B. Tharun

Name : B. THARUN

Relationship with Patient: HUSBAND

Date & Time : 21/7/26 10pm

Witness :

Signature : V. Gayathri

Name : V. Gayathri

Date & Time : 21/7/26 @ 10pm

Doctor (who is taking the consent) :

Signature : Saiteja

Name : Saiteja

Date & Time : 21/7/26 10pm

BAH-00660431 IP5-00175834
 Baby Of VADLA GAYATHRI
 01-07-2026 0 Y 0 M 0 D 3 H (M)
 Dr. KAPIL BHAGWATRAO SACHANE

MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Diagnosis: New born Cesarean

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Nursing ☐ Others:
11/7/26 9pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	DBF + Bupring	warm care	Vaccination	Shobha	☐ Medical ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

Patient Sticker

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Part - I.

Patient's / Learner Language: Telugu Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: ☐ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
17	9pm	7	Infection control measure	-	-	-	-	-	-	Shiva

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)									
Learning Barriers: 1. No Learning Barriers 4. Language Barrier 7. Impaired Thought Process/Cognitive limitations 10. Financial Difficulties 13. Cultural/Religion Practice 2. Physical Impairment 5. Educational Level 8. Responsibilities at Home 11. Beliefs and Values 14. Others (Specify) 3. Emotional Barriers 6. Desire / Motivate to Learn 9. Cultural Differences 12. Impaired Vision/ or Hearing									
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s: 1. None 3. Reassurance & Support 5. Respect values & beliefs 7. Other, Specify 2. Obtain translator 4. Teach Family / Others 6. Respect Cultural / Religion Preference									
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review									

BAH-00660431
 Baby Of VADLA GAYATHRI
 01-07-2026
 Dr. KAPIL BHAGWATRAO SACHANE
 IP5-00175834
 0 Y 0 M 0 D 3 H (M)

DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: 31/07/26

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☒ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☒ Medication	☒ Yes	☐ No
☒ Bathing	☐ Yes	☐ No
☒ Eating	☒ Yes	☐ No
☒ Walking	☐ Yes	☐ No
☒ Dressing	☒ Yes	☐ No
☒ Toileting	☒ Yes	☐ No

Need Assistance

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Regarding Feeding

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☐ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Seema

Date and Time: 11/7/26 10 pm

BAH-00660431 IP5-00175834
Baby Of VADLA GAYATHRI
01-07-2026 0 Y 0 M 0 D 3 H (M)
Dr. KAPIL BHAGWATRAO SACHANE



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NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Mother's Name:

Date of Birth: 1/7/26 Time of Birth: 3:51 pm Gender: ☒ Male ☐ Female

Birth Weight: 3070 kg Kgs HC: 34 cm cm Length: 50 cm cm

Meconium in Liquor: ☐ Yes ☒ No Cried at Birth: ☒ Yes ☐ No

Term / Pre-term / Post-term: Term

Resuscitated: ☐ Yes ☒ No Blood Group: Mother: O positive Baby:

Feeding: ☐ Breast Feeding ☐ Formula ☐ Both First Feed Time: 4:28 pm

AFFIX MOTHER'S
IDENTIFICATION LABEL

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

Indication:

Physical Assessment of New Born:

Temp: 98.6 °C HR: 140 /Min RR: 40 /Min BP: — SpO₂: 100

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☐ Yes ☒ No Score: 16 (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

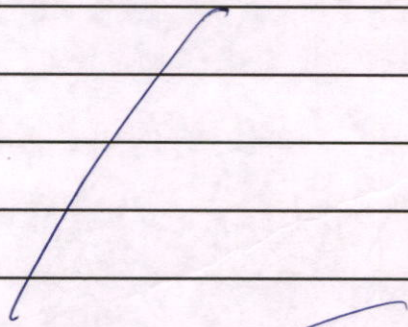
Newborn Screening Discussed: Yes / No

Nurse Name: shbbkg

Signature: [Signature]

Date & Time: 1/7/26

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660431 IPS-00175834 Baby Of VADLA GAYATHRI 01-07-2026 0 Y 0 M 0 D 3 H (M) Dr. KAPIL BHAGWATRAO SACHANE 		Date & Time of Admission 11/7/26 @ 3 pm	Date & Time of Transfer Order 11/7/26 @ 9:30 pm
		Transfer Ordered by Dr. Kapil	Reason for Transfer obsevation
From Unit BB-111	To Unit 3rd floor	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Sis Shobha		Name of Person Ordered Transfer Dr. Kapil	
Patient & Clinical Records Received by : Seems 11/7/26 @ 9:50 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

BREASTFEEDING HISTORY FORM

Mother's Name: Mrs. GAYATHRI Baby's Name: B/o. GAYATHRI Date of Birth: 17/26

Reason for consultation: Lactation counselling for mother

- 1. Baby's feeding now (ask all these points)**

Breastfeeds Yes Day Night

How often 2-2 1/2 hr

Length of breastfeeds 15-20 min

Longest time between feeds 2-2 1/2 hr (time mother away from baby)

One breast or both breasts Both

Complements (and water) NO

What given

When started

How much

How is it given

Pacifier (Yes / NO)
- 2. Baby's health and behaviour (ask all these urine output (more/less than points))**

Birth weight 3070 gm Weight now 2.960 kg Growth

Premature Term Twin

Urine output (more/less than 6 times per day)

Stools (soft and yellow/brown; or hard or green; frequency)

Feeding behaviour good

Illnesses

Abnormalities NO
- 3. Pregnancy, birth, early feeds**

Antenatal care (attended/not)

Delivery: Normal / C-section

Rooming-in Yes / No

Prelacteal feeds Yes / No (If Yes,)

What given

Formula samples given to the mother Yes / No

Postnatal help available for breastfeeding Yes / No

Breastfeeding discussed? Yes / No

Early contact (First - 1 hour) Yes / No

Time first breast feed (if not within 1st hour) Yes

How given
- 4. Mother's condition and family planning**

Age 29 yr Breast condition Good

Family planning method Motivation to breastfeed Yes

Alcohol, smoking, coffee, other drugs Yes / no
- 5. Previous infant feeding experience**

Number of previous babies Primi

How many breastfeed

Any bottles used NO

Experience good or bad

Reasons
- 6. Family and social situation**

Working / Home maker

Father's attitude towards breastfeeding

Other family members attitude towards breastfeeding

Help with child care

What others say about breastfeeding Positive

Literacy status Educated

Counselled about DBF

Lactation Consultant:

Signature: [Signature] Name: [Signature] Date & Time: 2/2

LACTATION ASSESSMENT FORM

Mother's details: Mrs. GAYATHRI

Baby details: Blo. GAYATHRI

Delivery: Vaginal ☐ Cesarean ☐ Vacuum ☐ Forceps ☐ Gravida ☒ GA 40 wk

Reason for Visit: BF rounds ☒ Doctor Reference ☐ Patient Request ☐

BF previous baby: NO Previous BF difficulty: NO

Present Lactation:

Colostrum: Yes ☒ No ☐ Breast: Normal ☒ Engorged ☐ Soft ☐ Tender ☐

Nipples: Flat ☐ Inverted ☐ Everted ☒ Direct BF: Yes ☒ No ☐

Expressed / Pallada feeding: Yes ☐ No ☒

LATCH Assessment:

	0	1	2	SCORE					
				D-1	D-2	D-3	D-4	D-5	D-6
LATCH	Too sleepy not sustained LATCH / suck	Repeated attempts for suck / latch Hold nipple in mouth	Grasps breast tongue down lips flanged Rhythmic sucking	1	1				
AUDIBLE SWALLOWING	None	A few with stimulation	Spontaneous & Intermittent	2	1				
TYPE OF NIPPLE	Inverted	Flat	Everted (After stimulation)	2	2				
COMFORT	Engorged cracked Bleeding large Blisters bruises	Filling reddened small blisters / bruises	Soft Non tender	2	2				
HOLD	Full Assist	Minimal assist	No assist	0	1				
Total Score				7	9				
BABY WEIGHT CHART				FIRST FEED					
Date	<u>2/7/26</u>	<u>2/8</u>					Breast Feed	Top Feed	
Weight	<u>2.960kg</u>	<u>2.892</u>							

Teaching Instructions: Deep latch

Discharge Instructions: urine output & weight monitor

Feed Frequency Duration: 2-2 1/2 hrs

Feeding techniques: cradle

Assessment of output: Good

Sources of BF assistance at home: Handout

Next Follow up: 1 week

Lactation Consultant: Name: Supriya Signature: [Signature] Date & Time: 2/2

[illegible]