

BAH-00657469 IP5-00174437
 Baby Of G SREENIKA REDDY
 28-05-2026 0 Y 0 M 0 D 5 H (F)
 Dr. VIJAYANAND JAMALPURI



NEWBORN MONITORING FORM

Date of Birth : 28/5/26
 Time of Birth : 10 AM
 Mode of Delivery : EL- LSCS
 Birth Weight : 3.461 kgs
 Head Circumference :
 Length :
 Red Reflex :
 New Born Screening :
 TFT :
 OAE :
 Mother's Blood Group : O POSITIVE
 Baby's Blood Group : O +ve
 Anomaly Scan :
 Vaccination : BCG, OPV, Hep B

Date	Weight	Type of Feed	Quantity	Temperature	Signature
28/5/26	3.461 kgs	DBF	Drop's	98.2 F	Syl
29/5/26	3.260 kgs	DBM+RF	Drop's	97.8 F	Redha
30/5/26	3.242 kgs	DBM+RF	"	97.6 F	Redha
31/5/26	3.209 kgs	DBM	"	97.6 F	Redha
1/6/26	3.225 kgs	DBM+RF	"	97.8 F	Redha

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HOSPITAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

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

BIRTH INFORMATION

Name : B/o Shreenika Reddy . G Mother's Blood Group : O positive
 Gender : M F Blood Group : Birth Weight (gms) : 3.461 kg Length (cms) :
 Date of Birth : 28/5/26 Time of Birth : 10 AM OFC (cms) :
 Place of Birth : RCH - BH Estimated Gesth Age : 38 + 4 wks

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 36 yrs Ht : 160cm Wt : 89.1kg BMI : Married Life : LMP : 2/9/25 EDD : 9/6/26
 Conception : Spontaneous or with Rx : Spont Conception
 Booked at what GA : 13 weeks AN Steroids Drugs / Doses :
 Last Scans Details : 18/5/26 : 37+1 / 3024gm (47%) AFI = 1 Doppler - (N)
AC = 39% / Fetal 2DEcho - Mittal TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

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



PAST OBSTETRIC HISTORY

G: 2 P: A: 1 L:

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1)	2025	IVF / 17 wks			Pre-viable rupture of membranes	TOP in vivo Anhydramnios
					SERPC + Hysteroscopy done; Placenta cl - Klebsiella Pneumonia	
2)		Present pregnancy				

PERINATAL HISTORY

Treating Obstetrician : Hospital : RCH - B H Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig)</p> <p>Second stage (> 2 hours after dilation)</p> <p>LSCS : <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</p> <p>Specify the reason :</p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL :</p> <p>Resuscitation : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cord ABG :</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :</p>
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NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

SIGN	0	1	2
COLOUR	Blue or Pale	Acrocyanotic	Completely Pink
HEART RATE	Absent	< 100 Minutes	> Minutes
REFLEX IRRITABILITY	No Response	Grimace	Cry or Active Withdrawal
MUSCLE TONE	Limp	Some Flexion	Active Motion
RESPIRATION	Absent	Weak Cry; Hypoventilation	Good, Crying

1 Minute	5 Minutes	10 Minutes
1	1	
2	2	
2	2	
2	2	
2	2	
9/10	9/10	

TOTAL

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

Snapee II Score

	Score		
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)
Apgar Score	>= 7 (0)	< 7 (18)	
Birth Weight	>= 1kg (0)	750 - 999 (10)	< 750 (17)
SGA	> 3rd percentile (0)	< 3rd (12)	
Total			

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :
 G2 A1 (38+4 wks) Gest DM on diet / Cervical cerclage in situ /
 Fibroid uterus / Previous myomectomy.



equipment checked done
↓
Baby delivered by LBS
↓
Baby CIAS.
↓
Baby dried, secretions cleared
Delayed cord clamping & cut given (2A + 1 vein) present
↓
Inf- vit k long IAS given
↓
Bebystable
Hence shifted to mother side

Investigation details in previous Hospital :

Feeding History :

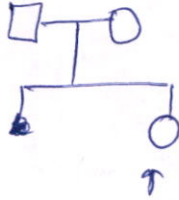
Patient

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Past History :

Family History :



Socio Economic History :

Upper middle class

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 97.2°P HR : 147/min RR : 52/min NIBP : CFT :

Color of the extremities : Acrocyanosis → Pink

Jaundice : Pallor : SpO2 :

ANTHROPOMETRY: Birth Weight : 3461gms Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

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HEAD TO TOE EXAMINATION

HEAD :

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

} (N)

FACIES :
(Any Facial
Dysmorphism)

No facial dysmorphism

**NECK and
CLAVICLES :**

Range of Motion :
Asymmetry :
Masses :

} (N)

EYES :

Symmetry :
Red Reflex : → Not checked
Discharge :

**EARS, NOSE
MOUTH and
THROAT :**

Ear set / Shape :
Periauricular Pits / Tags :
Nasal shape / Patency :
Palate :
Gums :
Lips :
Tongue :

} (N)

**THORAX and
BREASTS :**

Shape of Thorax :
Position of Nipples and Number :

} (N)

**ABDOMEN and
UMBILICUS :**

Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump : → 2A + 1 vein
Discharge :

} (N)

GENITALIA :

Labia / Hymen :
Testicles/penis :
Anus : Patent

} Female ext genitalia present

HERNIAL ORIFICES

Free

TRUNK and SPINE :

(N)

SKIN LESIONS :

(N)

EXTREMITIES :

Fingers / Toes :
Deformities :
Hip Joint Examination :

} (N)

Arms / Legs :
Mobility :

} (N)

SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : Regular Periodic Shallow Gasping

Mention If baby has Respiratory distress: RR: 48/min SCR / ICR / See - Saw breathing :

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

Mention if baby is on : Hood box CPAP Ventilator

Settings :

SpO₂: 95% on RA Auscultation: S1S2(1) Breath Sounds: B/LAE(1) Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 142/min BP :

Precordial Activity : Nil(1)

Femoral Pulses : (1)

Murmurs : Nil(1)

Other Peripheral Pulses : (1)

Signs of Cardiac Failure : Nil

ABDOMEN:

Shape : (1)

Hernia orifice : Free

Palpation : (1)

Anal Patency : Patent

Palpable masses : (1)

Umbilical Cord : 2A + 1v

Abdominal girth :

First urine passed : Passed

Meconium passed : - Not yet

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : (1)

State of wakefulness : (1)

Prechtle Score : (1)

Nerves :

MOTOR SYSTEM:

Passive Tone : (1)

Active Tone : (1)

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : (1) DTR : (1)

ATNR : (1) Skull and Spine : (1)



Any Congenital Anomalies

Diagnosis : 38+4 / F1 / Female / 3.46kg / Lecs / CAB / AUA

Fetal 2D Echo - ~~Normal~~ ^{Cordicomyelia}, Mild dilated RA; Good biventricular function.

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *Ramy*

Name : Dr. RAMYA

Date & Time : 28/5/26 : 10:30 am

Consultant :

Signature : *Vijayanand*

Name : VIJAYANAND

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 : SPO2 : Weight :

Any Oxygen requirement :

Systemic : BP pacuette

Medications : ~~5m~~ ~~25m~~ ~~50m~~ ~~9~~

Plan during ward follow up :

- 1.) Warm care
- 2.) Exclusive breast feeding + burping - 2-3rd hly
- 3.) OPV, BCG, Hep B @ today
- 4.) NBS, SBR, OAE @ 48HOL
- 5.) Cord blood - Blood grouping & typing today

Feeding Plan at the time of shifting : 6.) Clinical assessment of jaundice @ 24 HOL

7.) Glucose monitoring @ 11, 3, 6, 12, 18, 24, 36, 48, 72 HOL
prefered, inform if < 50 mg/dl

Screenings done during NICU Stay : 8.) R/v 2D Echo before discharge

NSG : 9.) Monitor vitals → HR, BP, SPO2 (2nd hly)

Hearing Screen :
ROP : BP Targets → MBP → 35-46 mmHg
SBP = 46-61 mmHg
DBP = 30-46 mmHg

TFT : *newborn*
NP2 : SPO2 targets = 90-100%
Target HR = 100-200/min.

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

Doctor Name: Dr. RAMYA Doctor Name:

Date & Time: 28/5/26 ; 10:30am Date & Time:

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CONSENT FOR FORMULA FEEDS

Patient Name : Age : Gender : Male Female


UHID No : Reg. 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 : 

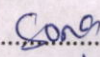
Name :

Relationship with Patient:

Date & Time : 28/5/26 @ 4pm


Witness :

Signature : 

Name : 

Date & Time : 28/5/26 @ 4pm

Doctor (who is taking the consent) :

Signature : 

Name : PA12.

Date & Time : 28/5/26 @ 4pm

BAH-00544465 IP5-00174417
 Mrs G SREENIKA REDDY
 30-08-1989 36 Yrs M 2E D (F)
 Dr. PRANATHI REDDY A




PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26 11:12AM	Seen by Dr. Vijayanand.	
	O/E	Plan- - Regular feeding
	Looks well, pink	- OPV, BCG } Today - Hep-B } Today
	Chest - clear	
	S ₁ S ₂ (+) heard	- clinical assessment of Jaundice @ 24 H/L
	Femoral pulse - palpable	- Monitor vitals and Inform
		- 2D Echo before discharge
		Bhasath B
28/5/26 2:30PM	Seen by Dr. Bhasath (Resident)	
	4 H/L 38+4 3.46 Kg 60m (IOM) / cervical cerclage in situ	Fibroid uterus Previous myomectomy
	LSCS / Fch / CIAB	Fetal 2D Echo - Hydromegaly mild dilated RA, good biventricular function
	RBS - 44	Plan- - Give direct breast feeding and check GRBS after 1 hour If GRBS < 50 give formula feed 17ml every 2 hourly. ^{5 Spoon.}
		- 2D Echo 2D Echo before discharge
		- Trace baby blood group.
		Bhasath

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/05/26		plan
1639		
	<ul style="list-style-type: none"> GRBS = 43, 46 	①. Regulate feeding 1.7ml x 2hrly 2.5ml x 3hrly
	<ul style="list-style-type: none"> URINE ✓ 	②. GRBS
	<ul style="list-style-type: none"> BW ✓ 	↓ 1hr after feed If improves prefer GRBS @ 6W
		③. Monitor vitals.
		④. Vaccinate as plan.
	noted by Dr. Suresh	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/26	Term	Plan
7:45 AM	Maternal ROM	
		①. Regular feeding
Weight ↓ 200g ↓ ≈ 6%	Feeding ↓ Measured	②. Feeding Assessment
—	fed ↓	③. GRBS monitoring 12 hourly
Blood ↓ group	Diet feed and weight	④. Monitor vitals.
Mother + Bilirubin ↓	• Blood Sugar 56 to 55 mg/dl	⑤. Jaundice Assess @ 24 hr.
— Ome	last 15L.	
	URINE ✓	
	Bowel ✓	
29/5/26		
3 PM	Term) 3-4 bil us / BotoL / GDM	Plan
	CF/A-load	→ Regular feeding & check.
	CF/L3sec	→ GRBS monitoring @ 12 hourly
	1/5 Passed.	→ 2D echocardiogram
		→ OATF SBF ~ BS @ USHOL
		→ warmth & care
		4 (Faint)

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 Dr. VIJAYANAND JAMALPURI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/26 8:30 AM	Seen by Dr. Vijayanand	Plan:- - Regular feeding - Feeding assessment - SBR (Today 10 AM) NBS (Today 10 AM) - OAE Today - 2D Echo Today
		<u>Bharath</u>
		NP Sumanada
20/5/26 9:15 AM	Seen by Dr. Bharath (Resident) 47 HO2 / 38+4 wk / 3.461 kg / LSCS / FH / CIAB	GDM (IDM) / cervical cerclage msr.
m / ot B / ot	Bt. wt - 3461 gm Yest wt - 3260 gm Today wt - 3242 gm +18 gm (↓ 6.3%)	Plan:- - Regular feeding - Feeding assessment - OAE today - 2D Echo today - SBR (Today 10 AM) NBS (Today 10 AM) - Warmth care - Monitor vitals and Inform SOS
		<u>Bharath</u>
		NP Sumanada

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 28-05-2026 0 Y 0 M 2 D
 Dr. VIJAYANAND JAMALPURI (F)

Patient



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		<p><u>30/5/26</u></p> <p>OAE - New born hearing screen Bilateral responses are present Bilateral Pass</p> <p><i>[Signature]</i> 30/5/26</p>
30/5/26 3:10 PM	<p>Seen by Dr. Bhareeth (Resident)</p> <p>53 HOL / 38 + 4 / 3-461kg / GDM (IOM) / 2 s c s / Fch</p> <p>Today wt = 3242 gm (+6.3%)</p> <p>SBR - 10-6</p>	<p>Plan:-</p> <ul style="list-style-type: none"> - Continue DBF + SOSFFE spoon every 2-3 hourly flb burping - Warmth care - 2D Echo today - Monitor vitals and Inform SOS.
M/O+ B/O+		
30/5/26 3:20 PM	<p>Seen by Dr. Vijayarana</p>	<p><u>Bhareeth</u></p> <p>Plan:-</p> <ul style="list-style-type: none"> - Regular feeding - Faecal assessment @ Rounds Tomorrow.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
31/5/26 8:10 AM	<p>Seen by Dr. Bharath (Resident)</p> <p>70 HO2 / 38+4 / 3.461 kg / 6.0 cm (10 cm) / cervical cerclage</p> <p>LSCS / Fh / CIAB</p>	<p>Plan -</p> <p>- Continue DBF + SOSFF</p> <p>- Spoon @ 2-3 hourly</p> <p>- warmth care</p> <p>- w/ feeding difficulties, dull activity</p> <p>- Monitor vitals and</p> <p>- Inform SOS</p> <p>- TCBR before discharge</p> <p>- Blv discharge</p>
M OT B OT	<p>Bt-wt - 3461g</p> <p>Yest wt - 3242g</p> <p>Today wt - 3209g</p> <p>↓ 33g (7.2% ↓)</p> <p>urine - 6 times</p> <p>motion - 2 times</p>	<p>Bharath</p>
31/5/26 10:10 AM	<p>Seen by Dr. Nilesh</p> <p>umbilical discharge</p> <p>Systemic toxicum</p> <p>Ecchymosis on legs</p> <p>Temp - 15, 14.1, 13.7</p>	<p>- Start Phototherapy (SSFR)</p> <p>- SBR Tlm 6 AM</p> <p>- Mupirocin for CA</p> <p>work for redness,</p> <p>take picture of discharge.</p>
		<p>NB Swetha 31/5/26 @ 10:30 AM</p>

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
01/06/26	Day 3	plan
9:15hr	Team	
	Bw 3.461	①. Stop phototherapy
	NNJ.	②.
	Mabland Crm	③. Discharge
	• Feeding - well	④. Rx on
	• URINE - ✓	Wed' day
	• Bowel - ✓	⑤. Pradgard - T entml -
	• SBR - 11.4	fr nappy
	• weight ↑ 16g	Acc. _____
	• 2 DECNO ↓	
	Tmy PDA	
	Z.	

~~NB Susha
 1/6/26 @ 9:20 AM~~

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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: 28/5/26 Time of Birth: 10 AM Gender: Male Female
 Birth Weight: 3.461 Kgs HC: cm Length: cm
 Meconium in Liquor: Yes No Cried at Birth: Yes No
 Term / Pre-term / Post-term:
 Resuscitated: Yes No Blood Group: Mother: Baby:
 Feeding: Breast Feeding Formula Both First Feed Time:

AFFIX MOTHER'S IDENTIFICATION LABEL

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

Physical Assessment of New Born:

Temp: 98.2 °C HR: 140 /Min RR: 40 /Min BP: 57/25/37 SpO₂: 100%

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: Yes No Score: 14 (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: Sona Signature: [Signature] Date & Time: 28/5/26 @

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

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

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 28/5 Time: 10 AM 2pm 6pm 11pm Jan

Doctor/Nurse Family Concern?

Temperature (F)	104					
	103					
	102					
	101					
	100					
	99					
	98	98.2	98.2	98.2	98.2	98.6
	97					
	96					
	95					

Heart Rate (bpm)	190					
	180					
and	150					
	140	140	140	140	142	132
Blood Pressure (mmHg) *	130					
	120					
Note:	90					
	80					
BP does not score in early warning scoring	70					
	60					
	50					

Heart Rate (Number) 140bpm 140bpm 140bpm 142 132

Resp. Rate (bpm) (Over 1 Minute) *	70					
	60					
Resp Rate (Number)	40	40bpm	39bpm	40bpm	39	42
	30					
	20					
	10					

Resp Mod/ Severe Distress None / Mild 0 0 0 1 0

Receiving O ₂ (l/min) O ₂ Saturations (%)	100	100	100	99	100%
	100	100	100	99	100%

Conscious Level	Normal	Altered			
GCS *			15/15	15/15	15/15

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

- ACTIONS**
- Score 1 : Continue normal observation by staff nurse
 - Score 2 : Shift in charge nurse to be informed and continue hourly observations
 - Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
 - Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
 - Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed
- NB: Scores 3 should be recorded overleaf

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

BAH-00657469 IP5-00174437
 Baby Of G SREENIKA REDDY
 28-05-2026 0 Y 0 M 0 D 5 H (F)
 Dr. VIJAYANAND JAMALPURI



ic. No. : RCHBH / FRM / CLINICAL / 124

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

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 11 AM 3 PM 7 PM 10 PM 7 PM
 Doctor/Nurse/Family Concern? _____

Temperature (F)	104					
	103					
	102					
	101					
	100					
	99					
	98	<u>98.2</u>	<u>98.1</u>	<u>98.1</u>	<u>97.7</u>	<u>97.7</u>
	97					
	96					
	95					
	94					

Heart Rate (bpm)	190					
	180					
	170					
	160					
	150					
and	140	<u>140</u>	<u>*</u>	<u>*</u>	<u>140</u>	<u>140</u>
Blood Pressure (mmHg) *	130					
	120					
	110					
	100					
	90					
	80					
	70					
	60					
	50					

Note:
 BP does not score in early warning scoring

Heart Rate (Number) 140 140 140 140 140

Resp. Rate (bpm) (Over 1 Minute) *	70					
	60					
	50	<u>40</u>	<u>40</u>	<u>*</u>	<u>39</u>	<u>40</u>
	40					
	30					
	20					
	10					

Resp Rate (Number) 40 40 40 39 40

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 99% 100% 100% 99% 99%

Conscious Level Normal Altered

GCS * 13/15 14/15

TOTAL SCORE Number of shaded boxes 0 0 0 0 0

Pain Score 0 0 0 0 0

Observer's Initials S S S S S

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.
- 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

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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.
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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

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B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

BAH-00657459 IP5-00174437
 Baby Of G SREENIKA REDDY
 28-05-2026 0 Y 0 M 2 D (F)
 Dr. VIJAYANAND JAMALPURI

Patient



RM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 28/5/26 Time: 8:30 AM 12:30 PM 4 PM 7 PM 9 AM 4 PM

Doctor/Nurse/Family Concern?

Temperature (F)	104						
	103						
	102						
	101						
	100						
	99		*		*		
	98	*		*	*	97.2	97.8
	97						
	96						
	95						

Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140		*	*	*		
	130	*				142	140
	120						
	110						
	100						

Heart Rate (Number) 138 bpm 140 140 bpm 138 bpm 142 140

Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50			*	*		
	40	*	*			39	42
	30						
	20						
	10						

Resp Rate (Number) 42 40 40 bpm 38 bpm 39 42

Resp Mod/ Severe Distress None / Mild - - - -

Receiving O₂ (l/min) O₂ Saturations (%) - - - - 100% 100%

Conscious Level Normal Altered - - - -

GCS * 14/15 13/15

TOTAL SCORE						
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	SS	SS	Z	Z	Z	Z

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
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* 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.

CH anc

OBSERVATION EARLY WARNING SCORING TOOL

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BAH-00657469 IP5-00174437
 Baby Of G SREENIKA REDDY
 28-05-2026 0 Y 0 M 3 D (F)
 Dr. VIJAYANAND JAMALPURI

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

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

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 30/5/26 Time: 11 AM 3 PM 4 PM 12 AM 7 AM

Doctor/Nurse/Family Concern?

Temperature (°F)	104					
	103					
	102					
	101					
	100					
	99					
	98	98.2	98.2	98.2		
	97				97.6	97.5
	96					
	95					
	94					

Heart Rate (bpm) and Blood Pressure (mmHg) * Note: BP does not score in early warning scoring	190					
	180					
	170					
	160					
	150					
	140	*	*	*		140
	130					
	120					134
	110					
	100					
	90					

Heart Rate (Number) 140bpm 140bpm 140bpm 134 140

Resp. Rate (bpm) (Over 1 Minute) *	70					
	60					
	50	*	*	*		
	40					38
	30					
	20					
	10					

Resp Rate (Number) 40bpm 40bpm 40bpm 38 38

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 100% 100% 100% 100% 100%

Conscious Level Normal / Altered

GCS * 12/15

TOTAL SCORE Number of shaded boxes 0 0 0 0 0

Pain Score 0 0 0 0 0

Observer's Initials [Signatures]

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
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BAH-00657469 IP5-00174437
 Baby Of G SREENIKA REDDY
 28-05-2026 0 Y 0 M 0 D 5 H (F)
 Dr. VIJAYANAND JAMALPURI



FLUID CHART

Sheet No. : ①

28/5/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
28/5/26	08:00 am										1	Sone	
	09:00 am										NO	Sone	
	10:00 am	DBF									IV	Sone	
	11:00 am										Cannula	Sone	
	12:00 pm											Sone	
	01:00 pm	DBF					✓			✓	1	Sone	
Total Intake : Taken						Total Output : Passed U=1 M=1							
28/5	02:00 pm	DBF									1	Sone	
	03:00 pm	DBF					✓			✓		Sone	
	04:00 pm	ff-10 ml									NO	Sone	
	05:00 pm						✓			✓	IV	Sone	
	06:00 pm										Cannula	Sone	
	07:00 pm	DBF								✓	1	Sone	
Total Intake : Taken						Total Output : Passed U=2 M=2							
28/5	08:00 pm	ff 5ml											
	09:00 pm											NO Pkch	
	10:00 pm											IV	
	11:00 pm	DRM					✓			✓		Cannula Pkch	
	12:00 am												
	01:00 am												
Total Intake : Taken						Total Output : U=1 M=1							
28/5	02:00 am												
	03:00 am	DRM								✓		NO Pkch	
	04:00 am												
	05:00 am											NO	
	06:00 am	DRM					✓			✓		Cannula Pkch	
	07:00 am												
Total Intake : Taken						Total Output : U=2 M=1							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART



Sheet No. : 2.....

29/5/26

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am	DBM								0	Sureka	
	10:00 am					✓			✓	0	Sureka	
	11:00 am	FF 30ml								0	Sureka	
	12:00 pm											
	01:00 pm											
Total Intake : <u>taken</u>					Total Output : <u>passed</u>							
	02:00 pm	DBF								0	Sing	
	03:00 pm	FF 25ml								0	Sing	
	04:00 pm									0	Sing	
	05:00 pm									0	Sing	
	06:00 pm	DBF							✓	0	Sing	
	07:00 pm	DBF								0	Sing	
Total Intake : <u>taken</u>					Total Output : <u>passed</u>							
	08:00 pm									0		
	09:00 pm	DBM							✓	0	Polly	
	10:00 pm	FF 30ml								NO	Polly	
	11:00 pm									IV	Polly	
	12:00 am									can't	Polly	
	01:00 am											
Total Intake : <u>taken</u>					Total Output : <u>0 - M</u>							
	02:00 am	DBM								0	Polly	
	03:00 am	FF				✓			✓	NO	Polly	
	04:00 am									IV		
	05:00 am											
	06:00 am	DBM				✓				can't	Polly	
	07:00 am											
Total Intake : <u>taken</u>					Total Output : <u>0 - M</u>							

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00657469
 Baby Of G SREENIKA REDDY
 28-05-2026
 Dr. VIJAYANAND JAMALPURI (F)
 IPS-00174437
 0 Y 0 M 2 D



FLUID CHART

Sheet No. : (3)

30/5/26

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
30/5/26	08:00 am	FFSML				✓			✓	N	Sunanda	
	09:00 am									0	Sunanda	
	10:00 am	DBF								1	Sunanda	
	11:00 am	DBF								✓	Sunanda	
	12:00 pm									N	Sunanda	
	01:00 pm	DBF								0	Sunanda	
Total Intake : taken.					Total Output : 0-1 M=1 passed							
30/5/26	02:00 pm									IV	Song	
	03:00 pm										Song	
	04:00 pm	DBF						✓		no IV	Song	
	05:00 pm									line	Song	
	06:00 pm										Song	
	07:00 pm	DBF							✓			Song
Total Intake : Taken					Total Output : Passed 0-1 M=							
30/5/26	08:00 pm											
	09:00 pm											
	10:00 pm									no IV	Push	
	11:00 pm	DBM							✓	IV	Push	
	12:00 am										can't push	
	01:00 am											
Total Intake : Taken					Total Output : 0-1 M=0							
30/5/26	02:00 am											
	03:00 am	DBM							✓	no IV	Push	
	04:00 am									IV		
	05:00 am											
	06:00 am											
	07:00 am	DBM					✓		✓		can't push	
Total Intake : Taken					Total Output : 0-2 M=1							

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART



Sheet No. : W.....

31/5/26

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
31/5	08:00 am									0	sdh	
	09:00 am	DBM								0	sdh	
	10:00 am									0	sdh	
	11:00 am	DBMFF				✓				0	sdh	
	12:00 pm									0	sdh	
	01:00 pm	DBF							✓	0	sdh	
Total Intake : taken					Total Output : passed u=1ml							
31/5	02:00 pm									0	sdh	
	03:00 pm							✓		0	sdh	
	04:00 pm	DBF FF-20ml						✓		0	sdh	
	05:00 pm					✓				0	sdh	
	06:00 pm									0	sdh	
	07:00 pm									0	sdh	
Total Intake : Taken					Total Output : passed u=2ml							
31/5	08:00 pm											
	09:00 pm	DBMFF							✓	NO		
	10:00 pm											
	11:00 pm	FF 25ml				✓			✓	EV		
	12:00 am	DBM									Conch	
	01:00 am											
Total Intake : Taken					Total Output : NO - M							
31/5	02:00 am	DBM										
	03:00 am							✓		NO		
	04:00 am											
	05:00 am	FF-25ml								EV		
	06:00 am										Conch	
	07:00 am	DBM					✓			✓		
Total Intake : Taken					Total Output : NO - M							

Total 24 hrs. Intake

Total 24 hrs. Output

**Rainbow Children's Hospital - Banjara Hills**

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

ADMISSION SHEET**Registration Details :**

Admission No : IP5-00174437 Admit Date : 28-May-2026 Admit Time : 10:55 AM UHID : BAH-00657469

Patient Details :

Patient Name : Baby Of G SREENIKA REDDY Age : 0 D
Guardian : Mr SUSHANTH REDDY DOB : 28-05-2026 10:47 AM
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : FLAT NO. 102, SRI RAM APARTMENTS, NANDI NAGAR, ROAD NO. 14 Banjara Hills Hyderabad Telangana INDIA 500034 Phone No : 9951797136/ 9951797136
E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : BASINET Bed No : CRDL-SUITE424-1 Ward Name : 4F-BIRTHRIGHT PREMIUM
Room No : CRDL-SUITE424-1 Admission Type : First Visit

Contact Details :

Name : Mr SUSHANTH REDDY Relationship : Father
Contact Address : FLAT NO. 102, SRI RAM APARTMENTS, NANDI NAGAR, ROAD NO. 14 Banjara Hills Hyderabad Telangana INDIA 500034 Phone No : 9110555506 / 9494481125

Signature

Doctor Details :

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

Payment Details :

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