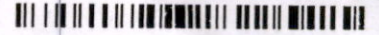


ADMISSION SHEET

Registration Details :



Admission No : IP5-00175741

Admit Date : 29-Jun-2026

Admit Time : 01:02 PM UHID : BAH-00660193

Patient Details :

Patient Name : Baby Of SIRIMALLE RAJITHA

Age : 0 Y 0 M 2 D

Guardian : Mr PEKUDA SHIVA KUMAR

DOB : 27-06-2026 01:00 AM

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO :3-3-180, KOTA GALLY, Nizamabad
Nizamabad Telangana INDIA 503001

Phone No : 8142541141/ 7731913964

E-mail : PSHIVAKUMAR153@GMAIL.COM

Admission Details :

Bed Type : NICU

Bed No : NICU 279

Ward Name : 2F-NICU 4

Room No : NICU 279

Admission Type : First Visit

Contact Details :

Name : Mr PEKUDA SHIVA KUMAR

Relationship : Father

Contact Address : H NO :3-3-180, KOTA GALLY, Nizamabad
Nizamabad Telangana INDIA 503001

Phone No : 8142541141


Signature

Doctor Details :

Doctor Name : Dr. NALINIKANTA PANIGRAHY

Specialisation : NEONATAL INTENSIVE CARE

Referral Doctor : DR SAI SANKEERTH RAO

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

①

BAH-00660193 IP5-00175741
Baby Of SIRIMALLE RAJITHA
27-06-2026 0 Y 0 M 2 D (M)
Dr. NALINIKANTA PANIGRAHY



rainbow
children's
spital
a lot to treat the little.

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ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ Consultant : _____ Dept : _____

Date of Admission : _____ Time : _____ Date of Discharge : _____ Time : _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
01/7/26	2/PM	NICU	335	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
29/06	Blood c/s, Blood grouping	26065215	Dejeskumar
	NP, PT/APTT		
	VBG, RBS	2606516	
	Thiamine (Vit B1)	26065217	
	CXR	32301	
	2D ECHO	32493	
	NSG	32492	
30/6/26	↓ BP, RBS	26065319	D
30/6/26	↓ BP, RBS	26065379	
30/6/26	VBG, RBS	26065586	D
1/7/26	CBP, CRP	26065684	D
1/7/26	↓ BP, RBS	26065683	
1/7/26	VBG, RBS	26065662	D
1/7/26	SBR	26065748	D
1/7/26	X-Ray	032752	D
2/7/26	VBG, RBS	26066071	D
2/7/26	SBR, CRP, Ca ²⁺ , ngs on	26066201	D
2/7/26	RBS	26066200	D
3/7/26	RBS, VBG	26066478	D
4/7/26	RBS, VBG	26066889	D
5/7/26	RBS, VBG, NP	26067185	D
6/7/26	NP	26067186	D
6/7/26	VBG, RBS	26067450	Chop

D BS

26067850

R

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
29/6	Intr monitor	1:20 pm		9679948	[Signature]
	Ventilator				
	Syr. Pump (2)				
	Nitric oxide				
30/6/26	Intr. monitor	1:20 pm		9679948	Bherathi
	Ventilator				
	Syr. Pump - (2)				
	Nitric oxide				
1/7/26	Intr. monitor	1:20 pm		9679948	Bherathi
	Ventilator				
	Syr. Pump - (2)				
1/7/26	DSPT	12:30 pm	1/7/26 3 pm	9682503	(1) [Signature]
	SSPT	1/7/26 3 pm	2/7/26 3 pm	9682814	[Signature]
	CPAP	1/7/26 11 am		9682814	[Signature]
	Oxygen	1/7/26		9683033	[Signature]
4/7/26	SSPT	4/7/26 @ 5:30 pm	SPM	9687960	[Signature]
5/7/26	SSPT, CPAP	1/7/26 4/2/26	SPM	9682894 9682960	[Signature]
6/7/26	Intr monitor	1:20 pm		9679948	ch
	Oxygen	1/7/26		9683033	ch
	Syringe pump	1:20 pm		9681434	

[illegible]

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

2

ORDER FOR BILLING

BAH-00660193 IP5-00175741
Baby Of SRIMALLE RAJITHA
27-08-2026 0 Y 0 M 9 D
Dr. NALINIKANTA PANIGRAHY (M)

Consultant: Dept :

Date of Admission: Time : Date of Discharge : Time:

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



NEONATAL 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 Rajitha Mother's Blood Group : B POSITIVE
Gender : ☒ M ☐ F Blood Group : O POSITIVE Birth Weight (gms) : 3kg Length (cms) :
Date of Birth : 27/6/2026 Time of Birth : 6:10pm OFC (cms) :
Place of Birth : Balaji Hosp, Nizambad Estimated Gesth Age : 36wks - 37+6wks
Current Obstetric History : (Booked / Unbooked Case) Scanned 21/7/26
Maternal Age : 30y Ht : 155 Wt : BMI : Married Life : LMP : 8/10/25 EDD : 15/7/26
Conception : Spontaneous or with Rx :
Booked at what GA : AN Steroids Drugs / Doses : 2 doses at 34 wks
Last Scans Details : 17/6/26 Cephalic, 3LUF, EFW - 2775, I/V threatened preterm
Polyhydramnios AFI-22, FHR-152, ± 27.5g Doppler - (N) 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 : NO ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results :
Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

G: 2 P: 1 A: L: 1

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
		Gr- female 12.5 yrs				

PERINATAL HISTORY

Treating Obstetrician : Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☒ Elective ☐ Emergency Indication : E. Pres. LSCS

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitation : ☐ Yes ☐ No

Cord ABG :

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

NEONATAL RESCUSTITATION 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
8/10	9/10	10/10

TOTAL

Snapee II Score

Score

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

Resuscitation

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



Baby delivered by Elec. LSCS (ilv/o Prev. LSCS)

CTAB → shifted to mother side

at 30 min - RD⊕, Grunting - Shifted to Sai Ayush NICU

Started low flow O_2

at 4 HOL - ilv/o T RD - ventilated, intubated 3.5 cm

Started on SIMV+PS - PIP-15, PEEP-5

↓

Asynchrony ⊕

@ 36 HOL - Asynchrony continued with desaturate poor perfusion - started dopamine, dobutamine

↓ @ 5 μ g/kg/min

Cardiac - 2 Decho - Small PFO

Sepsis - 2 fever spikes (~ 30 HOL)

CRP - 35, WBC - 14,100

Initial started - piptaz, Gentamicin, fluconazole
 upgraded to meropenem

No Blood transfusions given

ON RRT arrival - Baby on SIMV+PS $Ti=0.6$
 PIP - 22 PEEP - 6, Rate - 45/min

Investigation details in previous Hospital :

FiO_2 - 100% ; HR - 180/min

RR - 90/min

↓

SpO_2 - 75%

Started iNB - 20 > 24 > 20 ppm.

BP - 68/32 (4r)

SIPPV = 24/6, Rate - 50, $Ti=0.4$

Feeding History :

VBG - 7.25/50.5/56/19.9/-5.4

(DNS)

Stopped dopamine, transported on dobutamine - 2 μ g/kg/min

GRBS - 123 mg/dl

O/E = hepatomegaly - 4 cm ↓ RCM



BP in transport = 52/25 (35) on dobutamine - 6 mcg/kg/min
started Adrenaline - 0.1 mcg/kg/min
↓ (3 mcg/kg)

Family History :

CBP
Hb - 13.7
WBC - 14,100
N/L - 68/27
Plt = 1.73 lakh
CRP = 35 mg/dl
T8B - 8.6 < 10
urea - 18
Creat = 0.7
BP = 72/36 (49) + hypoten
HR = 163, SpO₂ = 95%
0.1 → 0.2 → 0.3 Stopped dobut
Na⁺/K⁺/Cl⁻ = 138/4.4/99
iCa²⁺ = 1.12

Socio Economic History :

upper middle class

GENERAL EXAMINATION ON ADMISSION

General Disposition :

	5 th	25 th	50 th	95 th
SBP	59	67	75	90
DBP	29	36	43	60
MBP	39	47	54	70

VITALS : Temperature : 37.3°F HR : 140/min RR : 50/min NIBP : 53/35 (42) CFT : 28 sec.

Color of the extremities : Pink

Jaundice : — Pallor : — SpO₂ : 96%

ANTHROPOMETRY: Birth Weight : 3kg Length : — HC : — Present Weight : —

Ponderal Index : — AGA : ✓ SGA : — LGA : —



HEAD TO TOE EXAMINATION

HEAD :

Fontanelles :

Sutures

Shape / Moulding :

Edema / Bruising :

Size - (H.C.) :

AF - open & flat .

FACIES :

(Any Facial
Dysmorphism)

No dysmorphism

NECK and CLAVICLES :

Range of Motion :

Asymmetry :

Masses :

No asymmet

EYES :

Symmetry :

Red Reflex :

Discharge :

Need to be assessed

EARS, NOSE MOUTH and THROAT :

Ear set / Shape :

Periauricular Pits / Tags :

Nasal shape / Patency :

Palate :

Gums :

Lips :

Tongue :

No cleft palate

THORAX and BREASTS :

Shape of Thorax :

Position of Nipples and Number :

3 (N)

ABDOMEN and UMBILICUS :

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump :

Discharge :

Hepatomegaly - 4cm below RCM

4

GENITALIA :

Labia / Hymen :

Testicles/penis :

Anus :

male genitalia testis B/C palpable

HERNIAL ORIFICES

Free

TRUNK and SPINE :

(N)

SKIN LESIONS :

NO

EXTREMITIES :

Fingers / Toes :

Deformities :

Hip Joint Examination :

Arms / Legs :

Mobility :

(N)

(N)



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 50/min SCR / ICR / See - Saw breathing : mild SCR (+)

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

Mention if baby is on : ☐ Hood box ☐ CPAP ☒ Ventilator

Settings : PIP-24, PEEP-6, Rate-50/min Ti=0.4,

SpO₂: Auscultation: Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 140/1 BP : 53/35 (u2)

Precordial Activity : (+)

Femoral Pulses : well palpable

Murmurs : NO

Other Peripheral Pulses :

Signs of Cardiac Failure : Hepatomeg (+)

ABDOMEN:

Shape :

Hernia orifice : free

Palpation :

Anal Patency : (+)

Palpable masses : Hepatomeg 4cm x 4cm

Umbilical Cord :

Abdominal girth :

First urine passed : Passed

Meconium passed : Passed

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : ~~conscious~~

State of wakefulness : 9

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone : (+)

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR : Not elicitable

ATNR : Skull and Spine : (+)



ventilated + iNO

Diagnosis: Term / AGIA / Male / RD-Pneumonia / 2 PPHN / Sepsis /
(37+6wks) (8kg) shock - Inotropes / To rule out Cardiac disease

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

Consultant :

Signature :

Name :

Date & Time :

Dr. NALINIKANTA PANIGRAHY

Reg. No: TSMC/DMR/03605

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 :

- 1) Cont Ventilation.
PIP-24, PEEP-6, $Ti=0.4$,
RR-50/min
Target SpO_2 92-96%
Cont $IND=20ppm$

Plan during ward follow up :

- 2) $Tu=60$ ~~80~~ $60 \mu g/kg/day$ - $1/2$ DNS + $30 \mu g/kg$ Ca gluconate
- 3) - Rlv - Surfactant
- 4) - Continue Adrenaline
- 5) Start meropenem
Review on antifungals, antibiotics

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Doctor Signature (Handover Given):

Doctor Name:

Date & Time:

Doctor Signature (Handover Taken):

Doctor Name:

Date & Time:



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not
willing

New Born Screening	:	
TFT	:	
OAE	:	
Mother's Blood Group	:	
Baby's Blood Group	:	
Anomaly Scan	:	
Vaccination	:	

[illegible]

[illegible]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/26 28 th	<u>Surfactant administration</u> Under all aseptic conditions, baby was given Surfactant - Survanta (4ml/kg) in 4 aliquots. Baby was stable throughout the procedure. <u>Post procedure vitals</u> HR - 150/min RR - 62/min SpO₂ - 94-1. BP - 60/43 (49)	
29/6/26 31.30 PM	<u>Afternoon Rounds</u> on PIV mode + INO. INO → 20 PPM PIP → 22 PEEP → 6. RR → 58 FI - 21.40. HR - 133/min RR - 52/min SpO₂ - 93% BP → 56/38/43. One dose Surfactant Given	<u>Plan</u> → Continue PIV + INO. → TV - 60cc/kg/day 10% D G₂. → Trace NPi, Thromb blood & coagulation profile. → Continue Adrenaline. → CARBS, CBH } O₂ only

2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	on Adrenaline @ 0.1 mcg/kg	→ Target SpO ₂ 90-95, P ₁₀₀ > 20%
	2 Delta → mod-mod PPH	90-100%, P ₁₀₀ = 20%
		MBP → 39-47 mmHg
		U.O → 2-4 cc/kg/hr
		GRBS → 60-100/100
		→ IV Antibiotics
		→ trace bloods
		noted by Dr. Nalinikanta 09/09/2026 Seen by Dr. Nalinikanta
29/6/26 Winofm		→ ↓ PIP → 20
		PIEP → 5
		RR → 50/min
		→ 5ml/kg body EBM/DBM
		→ C&B orally GRBS orally
		→ when Nifedipine goes to 5 PM, Reduce

MAHENDR KANTA PANIGRAHY



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LESS NOTES AND DOCTOR'S ORDER

Dr. NALINIKANTA PANIGRAHY
Reg. No. TSMC/FMR/03605
23/6/22

~~Noted By~~

~~Sagshwei~~

~~0999 0~~

~~SPM~~

MIANT Bonds

~~Noted by~~
~~Deputy~~
~~0000~~

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 3 PMA:

Term ☐ Preterm ☐ Gestation : 37+6 Corrected Gestational Age:

OVERVIEW	Problems :		
	S.No.	Current	Past Problems
	1.	Term / ALGA	
	2.	moderate severe PPHN	
	3.	Suspected sepsis	
	4.	Shock Requiring inotropes	
	5.	ARDS → PS → MV + INO	
	6.		

Today's Weight :

RESPIRATORY SYSTEM	Ventilatory Support : ☐ Yes ☐ No - Day # of Vent :
	Mode of Ventilation : HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ INO ☐ PPM ☐
	Ventilator Settings : PIP PEEP VG Rate FiO ₂ Oxygen : L/min
	Last CXR : Spo ₂ :
	ET Secretions : Clear ☐ Thick ☐ Yellow ☐ Last ABG:
	Change over the Last 24 Hours: <u>On PIV AINO</u>
	<u>100 → 20715 → 10 → 5 PPM PIP - 20 → 19</u> <u>PEEP - 5</u> <u>1 dose suspected Aien</u> <u>RR → 40 → 35</u> <u>SpO₂ → 94%</u>

CARDIO VASCULAR SYSTEM	Plan of Care : <u>BP - 41/40/47</u> <u>on Adrenaline 0.1mcg/kg/min v.i.v</u> <u>AS</u>
------------------------	--

CNS	Neurological Examination :
	Sedation <u>Keptanyl</u>
	Last Neurosonogram : <u>(N)</u> Any Seizures <u>NO</u>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/2026 @ 10:40am	FIO₂ - ↑50% RR-35, PIP=19. PEEP-5. Ti=0.40 ↓ VT=12 = 4ml/kg	1) Suctioning to be done. 2) ↓ fentanyl to 0.2mg/hr
	on adrenaline 0.1ug/kg/min BP = 54/34 (u)	3) Trace - Bile noted by Digvijay 09990 Sreha
	on meperidone - D₂ OI = 8.8	
30/6/26 11 AM		seen by Dr. Nalinikanta
	Extravasation injury - left leg.	1) change to SIMV + PS PS-10, PIP=18, PEEP-5. Rate=30, PIP=17, FIO₂=40% Every hour ↓ iNO by 1ppm mon NO iNO-4ppm.
		2) TV=↑80 cc/kg/day ↑ feeds - 10ml 3rd hrly each feed ↑ 2ml (EBM/DBM)
		3) Stop Sedation fentanyl.
		4) Adrenaline once iNO stops
		5) iNO ⇒ wean by 1ppm every 1hr

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Date & Time	Progress Notes	Doctor's Order
		Keep FiO_2 - 40% ↓ once INO Stopped wean FiO_2 wean Stop adrenaline-
		if Bp/s - subrs No grow ↓ Shift to NCV-3 SBR } CBP, CRP } T/m CBG } GURBS } BD
		Noted by Digeshwari 09990

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26	Seen by Dr. Nalinikanth	1) Stop - INO $\Rightarrow$ Nitric oxide
		2) Change to Psv mode. Back up Rate - 25 $\rightarrow$ 30 PIP - 18 $\rightarrow$ 16 PEEP - 5 Tmax = 0.50.
		3) if maintaining well.
		Plan of extubal
		4) if $SpO_2 > 95\%$ tape.
		5) Stop adrenaline.
		6) monitor VT.
		7) Shift to Nicu-3.
		8) 7mb each feed T/m - T/v = 100ml/kg/day
		9) if needed Iv line.
		Place 24G - Iv cannula.

Noted by
 Digeshwar
 09/09/26

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/2026 @ 6pm	<u>Evening Rounds</u>	
	Baby on Ventilator. PSV mode. PIP = 16, PEEP = 5, $T_{max} = 0.50$ RR = 30/min. $FiO_2 = 35\%$, VT = 16ml. Spont trigger @, Stopped iNO.	<u>Plan</u> 1) Cont - Ventilator. PSV mode. PIP = 16, PEEP = 5, $T_{max} = 0.5$, RR = 30/min. $FiO_2 = 40\%$. Nt monitor
	No desaturations.	2) Tn = 80ml/tgl day Feeds 12ml 3rd hly ↑ 2ml each feed Rest 10% D + Ca ₃ Mg
	<u>Vitals</u> : HR = 128/min. SPO ₂ = 93% RR = 36/min BP = 59/39 (ub)	3) Stool charting 6th hly
	VBG = 7.37 / 40.8 / 38.2 / 22.8 / -1.4 lac -1.4	4) Adrenaline stopped
	⊙ P/A - Soft.	5) CBP, CRP - T/m
		6) CBG / BD GRBs
		7) Rlu for extubation Thn
		<u>Sneha</u>



9

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/2026. @ 11 pm	<u>Night Rounds</u> Baby on Ventilator. Psv mode Rate - 30, PIP-16, PEEP-5 T _{imax} = 0.50 F _{IO₂} = 40 → 35% ↓ ET, oral secretions (+) VT = 5ml/kg No desaturations. off Adrenaline. vitals : HR = 146/min SPO ₂ = 93% RR = 30/min BP = 58/38(45) P/A - Soft Tolerating feeds. 14ml 3rd hrly feeds - Tolerated well.	<u>Plan.</u> 1) Cont. Ventilator. Psv mode. PIP-16, PEEP-5. T _{imax} - 0.5. Target SPO ₂ 90-95% monitor & document VT 2) TV = 80ml/kg/day ↓ 14ml 3rd hrly Rest 10% + Ca ₃ Mg 0.2 T2ml each feed. 3) Plan of extubation T/m 4) Trace - B/L/S 5) CBP, CRP - T/m. 6) CBG } BD GIRBS 7) No churning R/S for extub 6th hrly 8) ↑ TV = 100ml/kg/day T/m morning 9) w/g - apnea, Bradys desat Sruha

Noted by
Bhaskar
30/6/26
11:30 pm

10

[illegible]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/8/26		seen by Dr. Nalinika
		→ change to CPAP 5L
		→ hold Sildenafil
	Hypotension. (P)	→ 25mg Thiamine IV QD
	↓ Requiring Adrenaline	→ Ask maternal Thiamine levels.
		→ Steech today
		→ ↑ TV - 120 c/min/day
		→ 2ml each feed
		→ Stop IV fluids
		→ SB BP stable next 3-4 hrs, stop Adrenaline
		→ Head end 30° elevation
		→ prone nursing
		→ Stop Phototherapy
		→ SBR, CRP, SGPT, mg
		→ 2 day
		→ CRP 80
		→ RBS 12h

Dr. NALINIKANTA PANIGRAHY
 Reg. No. TSMC/FMR/03605
 2/2/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/12/26	<u>Afternoon Rounds</u> On CPAPs b. HR - 163/min RR - 51/min SpO₂ 93% BP → 64/38/42 on Adrenaline 0.1ml/min to kidney feeds U.O → 1.8ml/kg/min Added Thiamine w/h → sildenafil echo → 0/NO PPHW	Plan → Continue CPAPs b → IV - 120ml/kg/day 38 ml/kg of feeds 12ml each feed TR - 45ml → Prone Nursing → Stop Adrenaline → Trace maternal Thiamine levels → Head end 30° elevation → Prone Nursing → CBR OD → LRRS BD. → Target SpO₂ 90-100% for 2-26 90-93%, HR 120-140 MBP 45-50mm U.O → 2-4ml/kg GRS → 60-100g/kg
		Signature



11

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/26		Seen by Dr. Nalinikanta
		→ Extubate to NIV. (Term line cannula) 16/5, 18/6, RR-40, ti-0.50 Flow 45% ti-0.50 → ↑ 2ml each feed. → Dr. Antibiotic x 5 Days → The Tumor level to trace → Spk free.
1/7/26 11:30 AM	Dr. NALINIKANTA PANIGRAHY Reg. No: 253605 <u>EXTUBATION NOTES</u> Under sterile aseptic conditions, suctioning of mouth followed by ET tube, baby was extubated to NIV. Baby remained stable. <u>Plan</u> → connect to NIV 18/6, RR-40, ti-0.50 → CBA @ 2.30 & 1:30 PM → chest X-ray (C/S)	Noted by [Signature]



12

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26	Afternoon Round	
2:30 PM	Excluded to NW. On NW → 18/6 RR-40 HR-120	Plan → Continue NIV 18/6. ↓ RR → 35/min HR → 100-120
	Post extubation CDR 7.34 49 102 246 tolerating feeds	→ Continue DSPT → 8L → 46
	HR-120/min RR-40/min SpO ₂ → 94% PR → 63/37/46 UO → 2.2u/4h/1h GRRS → 90ms/dL	→ IV-100cc/1h/day Sun 12hrs ↓ 2ml each feed PR → 38ml Rest 10% Play mgor
	SPR → 15 → started DSPT oral Sildenafil added.	→ IV Abx for 5 days → Trace Humane levels → CDR, WRRS BD → T chart (6 hrs) → Trace Bw dL → Target MBP → 47-57mm UO → 2-4cc/4h GRRS → 60-70ms/dL
		→ PLV chest xray @ 6hr if after

related by
 11/7/26 3PM



13

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/26 3pm		Seen by Dr. Nalinikanta PIP - 17 → PIP - 17 PEEP - 6.5
		→ In night tapes PIP & PEEP Keep Fio2 upto 30-40%
		→ 2 Delhottu.
		→ Change to CPAP - 7
		→ Change to SST - 5
		Noted by Dr. Nalinikanta 1/7/26 3:30pm
1/7/26 7:30pm		Place:
	SpO ₂ - 98 to 90% On CPAP, Not maintaining saturation	- Change to NIV, PIP - 16, PEEP - 5
		- To start Adrenaline infusion sos.
		If MBP < 40 mmHg - <u>Agreed</u>



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26		<u>Night records</u>
11:00 AM		
	- ON NW, FiO_2 - 35%, 16/5, RR - 35/min T_i - 0.50	Plane continue NW, FiO_2 - 35%, 16/5, RR - 35/min
	- ON SSPT SpO_2 - 92%, PR - 127/min RA - 30/min BP - 59/25(35) CRT - 3sec	- TV - 100ml/kg/day ↓ 28ml 3rd hly (↑ 2ml each feed) TP = 38ml + Rest 10% D on 3 mg
	urine output - 2.2ml/kg stool - passed	- To start Adrenaline infusion Co. pulch
		- Target MBP - 45 to 55 mmHg.
		- wean off Adrenaline if MBP > 55 mmHg.
		- 2DEcho Am.

15



1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

[illegible]

1H-00660193
 IDY OF SRIMALLE RAJITHA
 -06-2026
 NALINIKANTA PANIGRAHY (M)

2/7/26

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 6 PMA:

Term ☒ Preterm ☐ Gestation : 37+6 weeks Corrected Gestational Age:

| OVERVIEW | Problems : | | |
|----------|------------|----------------------|---------------|
| | S.No. | Current | Past Problems |
| | 1. | Term / AGA | St |
| | 2. | RD - pneumonia | |
| | 3. | Severe PPHN - MV-INO | |
| | 4. | Suspected sepsis | |
| | 5. | Shock | |
| | 6. | | |

Today's Weight :

| RESPIRATORY SYSTEM | Ventilatory Support : ☐ Yes ☐ No - Day # of Vent : |
|--------------------|---|
| | Mode of Ventilation : HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ INO ☐ PPM ☐ |
| | Ventilator Settings : PIP..... PEEP..... VG..... Rate..... FiO ₂ Oxygen : L/min |
| | Last CXR : <u>1/7/26</u> Spo ₂ : |
| | ET Secretions : Clear ☐ Thick ☐ Yellow ☐ Last ABG : <u>7.37 / 42.9 / 42, lac-2.3,</u> |
| | Change over the Last 24 Hours : <u>HCO₃-24</u> |
| | <u>Extubated to CPAP > NIV</u>
<u>FiO₂-30%,</u>
<u>16/5,</u>
<u>RR-35, Ti-0.50</u> |

| CARDIO VASCULAR SYSTEM | Plan of Care :
<u>Ovens</u>
<u>bolus</u>
<u>given</u>
<u>SPO₂-93%</u>
<u>PR-148mm</u>
<u>RR-35/min</u>
<u>BP-78/44(56)</u>
<u>-Issue of Hypotension</u>
<u>↓</u>
<u>Started on Adrenaline</u>
<u>infusion</u>
<u>0.1mcg/kg/min → 0.2mcg/kg/min</u> |
|------------------------|---|
| | |

| CNS | Neurological Examination : |
|-----|---|
| | Sedation :
Last Neurosonogram : <u>normal</u> Any Seizures : |

FLUIDS STATUS NUTRITION

☐ NPO ☐ NG Feeds Wt. Gain: Head Circumference:
 Input: / (+/-) Output: ml/kg/d Urine Output: 2ml ml/kg/hr Stools: passed
 IV Fluids - Type of IVF: @ ml/hr
 Feeding: EBM ☐ Formula ☐ Donor BM ☐ Volume: Frequency:
 TPN: ☐ Yes ☐ No - If yes, details: Calories:
 Abdominal Examination:
Plt - soft,
bleeding freely

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

RBS - 160mg/dL

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:

Blood culture ☐ Urine culture ☐ ET culture ☐ Fungal Culture ☐ LP ☐ CSF :

| INFECTION | Antibiotic | Sl.No. | Drugs | Days | |
|-----------|------------|--------|----------------------|----------------|--|
| | | | | | |
| | | 1. | <u>Aug Meropecem</u> | <u>4/10/25</u> | <u>oral. sildenafil</u>

<u>warmer → D3</u>
<u>feeding → D3</u>
<u>2D2</u>
<u>white</u> |
| | | 2. | | | |
| | | 3. | | | |

Plan of Treatment :

- Continue NIV, FiO_2 - 30%, 16/5, RR - 35
- TV - 100 uel 1/3/day
 ↓
 34 uel feed 3rd hourly + Rest 10% O₂ cas
 [↑ 2ml each feed] (Target feed = 38ml) ^{Mg_{0.2}}
- Blood gas } 12th hourly
 RBS
- Target SpO₂ - 90 to 95%
 MBP - 47 to 55 mmHg.
 RBS - 60 to 150 uel/dL
 Urine output - 1 to 5 uel/kg/hr.
- Tlb charting 6th hourly
- Trace Thiamine levels
- Continue SST C eyes & genitalia covered for 24 hrs.
- 2D Echo today.
- RLV Antibiotics

Doctor's Name (Handover given) : Dr. Anusha

Signature : [Signature]

Date & Time: 2/10/25

Doctor's Name (Handover taken) : Dr. Anusha

Signature : [Signature]

Date & Time: 2/10/25



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-----------------|---|---|
| 2/7
05:44 PM | | seen by Nalinikant sir |
| | | |
| | | ↓ CPAP - to 5 by Nalinikant sir |
| | | ↓ (5 AM) |
| | | |
| | | CR4 after 2 hours |
| | | |
| | | ↓
12. Nalinikant |
| 3/7/26
2 AM | Night Rounds
Baby hemodynamically stable on CPAP - PEEP 6
No evidence of bradycardia / desaturation
A/E - HR - 140/min
RR - 62/min
SpO ₂ - 97%
BP - 64/42 (49)
Potentially feeds 38 ml 3hly | Plan
1) Change PEEP - 5 @ 5 AM
↓
CBC @ 7 AM
2) IV - 120 cc/kg/day
38 ml 3hly → ↑ feeds 2ml each feeds, upto 45 ml 3hly
3) Pause sunny
4) Head incl 30° dorsob
5) Place maternal thiamine levels |

[illegible]

3/7/26

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 7 PMA: 38⁺6

Term ☐ Preterm ☐ Gestation : 37⁺6 Corrected Gestational Age:

| OVERVIEW | Problems : | | |
|----------|------------|--|---------------|
| | S.No. | Current | Past Problems |
| | 1. | Term/AGA | Shock. |
| | 2. | Rol pneumonia | |
| | 3. | Severe PPHN → MWD NO → NIV | |
| | 4. | CPAP
Suspected sepsis | |
| | 5. | Shock low SVD gall | |
| | 6. | Thiamine deficiency | |

Today's Weight : 3.049 (↑ 39gms)

| | |
|--------------------|---|
| RESPIRATORY SYSTEM | Ventilatory Support : ☐ Yes ☐ No - Day # of Vent : |
| | Mode of Ventilation : HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ iNO ☐ PPM ☐ |
| | Ventilator Settings : PIP.....PEEP.....VG.....Rate.....FiO ₂Oxygen :L/min |
| | Last CXR : Spo ₂ : |
| | ET Secretions : Clear ☐ Thick ☐ Yellow ☐ Last ABG: |
| | Change over the Last 24 Hours: <u>ON CPAP 5</u>
<u>HR-142</u>
<u>RR-28/min</u>
<u>SpO₂-95%</u>
<u>BP-61/34/44.</u> |

| | |
|------------------------|----------------------|
| CARDIO VASCULAR SYSTEM | Plan of Care : |
|------------------------|----------------------|

| | |
|-----|---|
| CNS | Neurological Examination : |
| | Sedation: <u>NO</u> |
| | Last Neurosonogram : <u>2</u> Any Seizures: <u>NO</u> |

| | |
|-----------------------------|---|
| FLUIDS STATUS NUTRITION | ☐ NPO ☐ NG Feeds Wt. Gain:..... Head Circumference:..... |
| | Input:..... / (+/-)..... Output:..... ml/k/d Urine Output:..... ml/kg/hr Stools:..... |
| | IV Fluids - Type of IVF:..... @..... ml/hr |
| | Feeding: EBM ☐ Formula ☐ Donor BM ☐ Volume:..... Frequency:..... |
| | TPN: ☐ Yes ☐ No - If yes, details:..... Calories:..... |
| Abdominal Examination:..... | |

to breast feed
CRRBS → 6A

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

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:.....

Blood culture ☐ Urine culture ☐ ET culture ☐ Fungal Culture ☐ LP ☐ CSF :.....

| INFECTION | Antibiotic | Sl.No. | Drugs | Days | |
|-----------|------------|--------|-------------|-------|-------------|
| | | 1. | 2. | 3. | |
| | | 1. | Sig maxipen | PSTDs | my Thiamine |
| | | 2. | | | |
| | | 3. | | | |

Washers Dy.
Tubing 30g
Washers Dy.

Plan of Treatment :

→ continue CPAP → 6A

→ IV 120cc/kg/day 43ml Q3hrly → 12-45ml
↑ 2nd each feed

→ prone nursing.

→ Head end elevation

→ Bare medial Thiamine

→ CRBS OD

→ CRBS BD

→ target SpO₂ 90-95% ; FiO₂ 20-21
90-100% ; If FiO₂ = 21

m BP → 45-55mmHg

U.O → 2-4cc/kg/h

CRRBS → 60-80% / h

Doctor's Name (Handover given) : *Far*

Signature : *u/7/26*

Date & Time : *u/7/26*

Doctor's Name (Handover taken) : *A Ashwarye*

Signature : *u/7/26*

Date & Time : *u/7/26*

PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------|---|--|
| | | Afternoon Rounds |
| 3:27 PM | On Flow 6 L/min | Plan |
| 2:30 PM | mild retractions @
occasional
tachypnea @ | → continue flow 6 L/min |
| | olerating feeds | → TV - 16 cef/14/dg
45ml each, 12ml
each feed, T ₁ 52ml |
| | SpO ₂ - 95% | → Prone Nursing |
| | RR - 59/min | → Trace maternal
fetal levels |
| | HR - 70/49/61 | → Stop Abx after
15 doses of mesper |
| | U.O - 1.3 cc/14/hr | → Dochart obly |
| | | → Target mBP → 45-50 |
| | | SpO ₂ 90-95, FiO ₂ > 21 |
| | | 90-100% FiO ₂ 21 |
| | | U.O → 2.4 cc |
| | | CRBS 760-180.7/ |
| | | → Stable & Flow 6 L/min
obly |



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|----------------|--|---|
| 3/7/26
5pm | Bed sore noted
below occiput near
nape of neck.

1 up - grade I bed sore | Plan
→ Apply t-bact locally
→ position change.
→ SOS PCM drops. |
| | | San by Dr. Walish |
| | | → Sp Rr > 60/min
inform doctor. |
| | | Noted by
Pokanga. |
| 3/7/26
11pm | <u>Night</u>
on bed sore
Tachypnea
Retractions
RR - 143/min
Rr - 68/min
SpO ₂ 94%
BD - 77/143/55 | <u>Rounds</u>
<u>Plan</u>
→ Change to CPAP
→ IV - 160cc/14/day
52ml orally
→ Prone Nursing
→ Place maternal than
→ Rr > 60/min
→ CBH DD
→ CBBS BD (Refer)
J |

[illegible]

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 5 PMA:

Term ☐ Preterm ☐ Gestation : 37+6 wks Corrected Gestational Age:

| OVERVIEW | Problems : | | |
|----------|------------|----------------------------|------------------|
| | S.No. | Current | Past Problems |
| | 1. | Term/ AGA | Shock- Inotropes |
| | 2. | RD-Pneumonia + Severe PPHN | |
| | 3. | MV + iNO (stopped) | |
| | 4. | Suspected Sepsis | |
| | 5. | | |
| | 6. | | |

Today's Weight :

| RESPIRATORY SYSTEM | Ventilatory Support : ☐ Yes ☐ No - Day # of Vent : |
|--------------------|---|
| | Mode of Ventilation : HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ iNO ☐ PPM ☐ |
| | Ventilator Settings : PIP PEEP VG Rate FiO ₂ Oxygen : L/min |
| | Last CXR : Spo ₂ : |
| | ET Secretions : Clear ☐ Thick ☐ Yellow ☐ Last ABG: |
| | Change over the Last 24 Hours: <u>Stopped iNO at 4pm Yesterday</u> |
| | <u>@ changed PTV → PSV mode</u>
<u>Backup Rate : 30 > 25</u>
<u>PIP - 16, PEEP - 5</u>
<u>FiO₂ 30% - 35%</u> |

| CARDIO VASCULAR SYSTEM | Plan of Care : |
|------------------------|--|
| | <u>HR = 136/min</u>
<u>FiO₂ = 30%</u>
<u>RR = 47/min</u>
<u>SpO₂ = 91%</u>
<u>BP = 60/34</u>
<u>Adrenaline } Stopped</u>
<u>fentanyl }</u>
<u>iNO</u> |

| CNS | Neurological Examination : |
|-----|--|
| | Sedation: <u>NO</u>
Last Neurosonogram : <u>Normal</u>
Any Seizures: <u>NO</u> |

FLUIDS STATUS NUTRITION

☐ NPO ☐ NG Feeds Wt. Gain: Head Circumference:
 Input : / (+/-) Output : ml/k/d Urine Output : ml/kg/hr Stools :
 IV Fluids - Type of IVF : @ ml / hr
 Feeding: EBM ☐ Formula ☐ Donor BM ☐ Volume: Frequency:
 TPN : ☐ Yes ☐ No - If yes, details : Calories:
 Abdominal Examination: *Tolerating feeds* *U/O 1.4 ml/kg/hr*
Aspirates - Nil *GRBS - 93 ml/dl*
Stool - Passed

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

INFECTION

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

| Antibiotic | Sl.No. | Drugs | Days |
|------------|--------|---------------------------------|--------------|
| | 1. | <i>Tri-Neop enem</i> | <i>Day 1</i> |
| | 2. | | |
| | 3. | | |

*Tubings ?
 Waena } P4.
 Pulm - D2*

Plan of Treatment :

*Continue PSP RR=25, Tima-50, P/P/PCOP
 Target SPO₂ 90-95% if FIO₂ 21%
 2) TV=100ml/kg/day → 22ml 3rd hrly
 (TF=38ml) (EBM/DBM)
 Rest 10% D + C₃Mg 0.2
 ↑ feeds - 2ml each feed
 3) Rlv on extubation today
 4) CBP, CRP to trace
 5) CBG } BD
 GRBS }
 6) I/O charting 6th hrly
 7) Trace finab blood cts
 8) Target MIBP 47-50mmHg
 GRBS 60-150mmHg
 U/O 1-5ml/kg/hr*

SBR in next 24h

Doctor's Name (Handover given) : *N. Sneh a*
 Signature : *Sneh a*
 Date & Time : *21/7/26*

Doctor's Name (Handover taken) : *FA2*
 Signature : *FA2*
 Date & Time : *21/7/26*



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|------------------------|---|---|
| 5/7/2026
@ 11:30 PM | Night Rounds | Seen by Dr. Niteesh
Plan |
| | Baby on CPAP - PEEP 5
FIO ₂ - 26% - 28%
min 1
Desaturations (+),
↑ FIO ₂ to 30%
No Respiratory distress
Vitals = HR - 165/min
SPO ₂ - 89-92%
RR - 34/min
ongoing - SSPT.
U/O = 2.5cc/kg/hr
+ 161ml
Tolerating full feeds | 1) Cont CPAP.
PEEP - 5
Target SPO ₂ 90-95%
if FIO ₂ > 21%
2) TV = 140mb/kg/day
52mb 3rd h & 1y
full oral feeds.
3) GIBBS - OD, CBG - OD
KMC.
4) NP ₁ - T/m
Trace - maternal
Thiamine levels.
5) monitor Bleeding in
Gaes
Sneha
Natal
Rajathi
5/7/26 |



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PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|------------------|---|--|
| 4/7/26
4:20pm | <p>Afternoon rounds</p> <p>Baby on CPAP $\angle$ fio₂ 25%
PEEP 5cm</p> <p>No desaturation</p> <p>Intermittent tachypnea</p> <p>Accepting & tolerating feeds well</p> <p>SpO₂: 93%</p> <p>PR: 142/min</p> <p>RR: 43/min</p> <p>Bp: 77/48 (56)mmHg</p> <p>CR: 18cc</p> <p>Passed urine & stool</p> | <p>Plan</p> <p>1. Continue CPAP $\angle$ fio₂ 21%
PEEP 5cm</p> <p>2. GR = 140 cc/kg/day
↓
52 ml @ 3H OG feed</p> <p>3. GRBI OD</p> <p>4. KMC</p> <p>5. prone nursing</p> <p>6. NP, (T/m)</p> <p>7. Trace maternal thiamine level</p> |
| 4/7/26
5pm | <p>Chemical assessment of Jaundice + 15mg/dl</p> | <p>Plan</p> <p>1. start Sept with eye and genital care</p> <p>Noted by
mallekwan
@ 5pm
4/7/26</p> <p>by
Sai</p> |

9/7/20.

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 9 PMA: 39+1 weeks

Term ☐ Preterm ☐ Gestation : 37+6 wks Corrected Gestational Age:

| OVERVIEW | Problems : | | |
|----------|------------|-------------------------------------|---------------------|
| | S.No. | Current | Past Problems |
| | 1. | Term/AGA | Suspected sepsis |
| | 2. | RDI pneumonia | Shock on ionotropes |
| | 3. | Severe PPHN → MV + iNO → NIV → CPAP | |
| | 4. | Thiamine deficiency | |
| | 5. | Bed Sore Grade I | |
| | 6. | | |

Today's Weight : 3020g (415g)

| RESPIRATORY SYSTEM | Ventilatory Support : ☐ Yes ☐ No - Day # of Vent : |
|--------------------|---|
| | Mode of Ventilation : HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ iNO ☐ PPM ☐ |
| | Ventilator Settings : PIP.....PEEP.....VG.....Rate.....FiO ₂Oxygen :L/min |
| | Last CXR : Spo ₂ : |
| | ET Secretions : Clear ☐ Thick ☐ Yellow ☐ Last ABG: |
| | Change over the Last 24 Hours: <u>Baby is on CPAP, PEEP - 4.</u> |
| | <u>TCBR - 15mg/dl at 5pm yesterday → SSPT.</u> |
| | <u>Desaturations ⊕ requiring FiO₂ - 3.0.</u> |

| CARDIO VASCULAR SYSTEM | Plan of Care : <u>HR - 170/min</u> |
|------------------------|------------------------------------|
| | <u>RR - 54/min</u> |
| | <u>SpO₂ - 93%</u> |
| | <u>BP - 75/46 (56)</u> |
| | <u>U/O - 1.3cc/kg/hr</u> |
| | |

| CNS | Neurological Examination : |
|-----|--|
| | Sedation..... |
| | Last Neurosonogram : Any Seizures..... |

| | |
|-----------------------------|---|
| FLUIDS STATUS NUTRITION | ☐ NPO ☐ NG Feeds Wt. Gain:..... Head Circumference:..... |
| | Input : / (+/-) Output : ml/k/d Urine Output : ml/kg/hr Stools : |
| | IV Fluids - Type of IVF : @ ml / hr |
| | Feeding: EBM ☐ Formula ☐ Donor BM ☐ Volume:..... Frequency:..... |
| | TPN : ☐ Yes ☐ No - If yes, details : Calories:..... |
| Abdominal Examination:..... | |

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

| | | | | |
|-----------|---|-------|------|---|
| INFECTION | Risk of Sepsis / Suspected Sepsis / Proven Sepsis : | | | |
| | Sepsis screen:..... | | | |
| | Blood culture ☐ Urine culture ☐ ET culture ☐ Fungal Culture ☐ LP ☐ CSF : | | | |
| | Sl.No. | Drugs | Days | Inj. Thiamine.
T. Bact ointment for U/A. |
| | 1. | | | |
| 2. | | | | |
| 3. | | | | |

| | |
|---|--|
| Plan of Treatment: <ul style="list-style-type: none"> Continue CPAP, PEEP-4
R/v to de-escalate if WOB improves. TV - 140 ccl/kg/day - 5m 52ml/3rd hely.
full on feed. Trace NP, report Trace maternal thiamine levels. Continue kmc CRBS & OD
CBG ✓ Do charting 6th hly. wf steady / desat Stop SSPT at 5pm today. | Targets:
SpO ₂ : 90-95% if FiO ₂ > 21%
90-100% if FiO ₂ < 21%
MBP - 45-50 mm Hg.
U/O - 2-4 ccl/kg/hr.
RBC - 60-150 mg/dl. |
|---|--|

Doctor's Name (Handover given) : Dr. Poojitha
 Signature : [Signature]
 Date & Time : 5/7/26 10:30am

Doctor's Name (Handover taken) : Dr. Poojitha
 Signature : [Signature]
 Date & Time : 5/7/26

| Date & Time | Progress Notes | Doctor's Order |
|---------------|---|---|
| | | seen by Dr. Valius, Kait |
| | | → Cowper |
| | | → prone - messy |
| | | Noted by Diaphony 5/7/26 @ 5 |
| 5/7/26
5pm | Afternoon rounds | ↓ 5 min |
| | Baby on gpr ^{fig 21.1} PEEP 4cm | Plan |
| | No R/L no desaturation
Tolerating OG feeds
No bradycardia
SpO ₂ : 99%
PR: 143/mm
RR: 47/min
BP: 77/50(61) mmHg
CRT C3 sec
passed urine & stool | 1. Start on low flow 0.84 min
Target SpO ₂ 90-95%
2. Prone turning
3. CRBS } on
CBG }
4. IV 240 cc/kg/day
Sign at 23H of feeding
5. I/O Charting 26H
6. w/f R/L desaturation |
| | | Noted by Diaphony 5/7/26 |

PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|----------------|---------------------------|---------------------------------------|
| 5/7/26
11pm | <u>Night rounds</u> | |
| | | <u>plan</u> |
| | - Baby on low flow | 1. low flow 0.5L/min |
| | 0.6L/min | Target spo ₂ 90-95% |
| | - No PO / no desaturation | 2. prone nursing |
| | spo ₂ : 99% | 3. Trace mother thiamine levels |
| | PR: 151b/min | |
| | RR: 40b/min | |
| | BP: 71/42 (5) mmHg | |
| | CRT < 2 sec | |
| | | Noted by
Chandana
5/7/26 @ 11pm |
| | | Sai |

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

Day in NICU: Day of Life: 10 PMA: 39¹²
 Term ☐ Preterm ☐ Gestation: 32¹⁶ Corrected Gestational Age: Today's Weight: 2.98kg 34gms

| Overview | Problems | | |
|----------|----------|--|---------------------------|
| | S.No. | Current | Past Problems |
| | 1. | Term / AGA | suspected sepsis |
| | 2. | R/L pneumonia | check required for sepsis |
| | 3. | severe pphr → HFO + iVo → MV → NIV → CPAP → IF | |
| | 4. | Bed sore grade I | |
| | 5. | Thiamine deficiency | |
| | 6. | | |

| Clinical Assessment | Baby on low flow
0.5 L/min
mild tachypnea
minimal Retraction
NO Desaturation
No vomiting
Tolerating feeds well | aRRS → 83w/chr
SpO ₂ : 97%
PR: 146/min
RR: 56/min
BP: 66/39 (51) mmHg
CRT < 3sec
wane → Pz
WHe → Ps |
|---------------------|--|---|
| | | |

| Medications Used | 2yr - Thiamine
T-BACT ointment | |
|------------------|-----------------------------------|--|
| | | |

| Plan of Care: | 1) Continue low flow 0.5 L/min
2) Prone nursing
3) Tr = 140cc/kg/day → 52ml @ 3H
4) Continue kmc
5) GRS, CRA on | Target SpO ₂ 90-95% FiO ₂ > 21
90-100% FiO ₂ = 40%
full o/a feed
6) I/O charts @ 6H
7) Wf R/L Desaturation
8) to change WHe. |
|---------------|---|--|
| | | mBP → 45-50mmHg
u.o → 2-4cc/kg |

Doctor's Name (Hand over given): Sai

Signature: *[Signature]*

Date & Time: 6/7/26

Docu. No.: RCHB / FRM / CLINICAL / 290

Doctor's Name (Hand over taken): PMA

Signature: *[Signature]*

Date & Time: 6/7/26

Patient Sticker

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

Day in NICU: Day of Life: PMA:

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

| | Problems | | |
|---------------------|--|---------|---------------|
| | S.No. | Current | Past Problems |
| Overview | 1. | | |
| | 2. | | |
| | 3. | | |
| | 4. | | |
| | 5. | | |
| | 6. | | |
| Clinical Assessment | <p>Wasting of food
 12-15%
 10-15%
 10-15%
 10-15%
 10-15%</p> | | |
| Medications Used | <p>1. 10-15%
 2. 10-15%</p> | | |
| Plan of Care: | | | |

Doctor's Name (Hand over given):

Signature:

Date & Time:

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time: 25/6/19

BAH-00660193 IP5-00175741
 Baby Of SRIMALLE RAJITHA
 27-08-2026 0 Y 0 M 9 D (M)
 Dr. NALINIKANTA PANIGRAHY

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PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|------------------|---|---|
| 6/7/26 | | C/D/w → Benile |
| | | → To start Lact |
| | | → TV-150cc/kg/day
56ml 0.3ml/kg 0.6 feeds |
| | | → To allow KMC |
| | | 5 (KMC) |
| | | Noted by |
| | | Lokanyan |
| 6/7/26
5:15pm | Afternoon Rounds | Plan |
| | Baby on low flow.
0.5L/min - Day 2
hemodynamically stable.
HR - 145/min
SpO ₂ - 99%
RR - 40/min
peripheries - pink
- full on feeds tolerating well
- passing - urine/stool
KMC - 1/2 kg | (Target SpO ₂ - 90-95)
→ Change to 0.3L/min
continue 0.3L/min Oxyg
TV - 150cc/kg/day -
56ml 0.3ml/kg 0.6 feeds
→ prone nursing
→ continue KMC.
→ GRBS/et GRBS - OD
→ CBG - alt day
- I/O charting & etl
- W/LP - RD / clusalus |

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



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Sankey & Walinik

- Change feed ~~only~~
- Night or
- TV - 1500 kg 1 day
38 ml 2nd day.
Next feed paladay
- Rest on in night

Noted by
Suchitra



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

Day in NICU: Day of Life: 11 PMA: 39⁺3
 Term ☐ Preterm ☐ Gestation: 37⁺6 Corrected Gestational Age: Today's Weight: 2.970 (↓ 16gm)
5 days → 80gm

| Problems | | |
|----------|--|------------------|
| S.No. | Current | Past Problems |
| 1. | Term/AGA | Suspected sepsis |
| 2. | R/L pneumonia | Shock |
| 3. | Severe pPHN → HFO + iNO → MV → NBV → CPAP + RA | |
| 4. | Bed sore grade I | |
| 5. | Thiamine deficiency | |
| 6. | | |

| Clinical Assessment | Medications Used |
|---|---------------------------------|
| Baby on Room air since morning
NO R/L NO desaturation
mild tachypnea
no vomiting
Tolerating feeds well
1cmC → 1 1/2 hrs
SpO ₂ : 97.1
PR: 161/min
RR: 62/min
BP: 68/42 (71) mmHg
CRT: 3 sec
ARBS - 9am/12m | T-BACT ointment
Im. Thiamine |

| Plan of Care: |
|---|
| 1) Tr = 150 cc/kg/day → 56 ml Q3H OA feed
2) prone nursing
3) 1cmC
4) ARBS on
CBA alternate date
5) wlf R/L desaturation
6) Bed sore care
7) 2/0 charting Q6H
8) IMV Thiamine oral. |

Doctor's Name (Hand over given): Rupai
 Signature: [Signature]
 Date & Time: 7/7/26
 Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken): Jaiteja
 Signature: [Signature]
 Date & Time: 7/7/26

Patient Sticker

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

Day in NICU: Day of Life: PMA:

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

| | Problems | | |
|--|---|---------|---------------|
| | S.No. | Current | Past Problems |
| Overview | 1. | | |
| | 2. | | |
| | 3. | | |
| | 4. | | |
| | 5. | | |
| | 6. | | |
| Clinical Assessment | <p>Handwritten clinical notes in the Clinical Assessment section.</p> | | |
| Medications Used | <p>Handwritten medication notes in the Medications Used section.</p> | | |
| <p>Plan of Care: Handwritten plan of care notes.</p> | | | |

Doctor's Name (Hand over given):

Signature:

Date & Time:

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:

BAH-00660193 IP5-00175741
 Baby Of SIRIMALLE RAJITHA (M)
 27-06-2026 0 Y 0 M 7 D
 Dr. NALINIKANTA PANIGRAHY

PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------|-------------------------|---|
| | <u>B/P Centiles</u> | |
| | 5th 25th 50th 75th 95th | |
| SBP | 66 69 72 78 91 | |
| DBP | 30 32 44 60 | |
| MBP | 40 48 55 70 | |
| | | Seen by Dr. Nalinikanta |
| 7/2/26 | | → After meal, off oxygen & keep in prone nuzzling |
| 11:50 AM | | → Change to oral
thiamine 25mg
5ml BP |
| | | → Calceimax Plus 70
add |
| | | → Day Paladay feed to be given |
| | | → Press the belly
→ ARBS or (Puffee) |

Dr. NALINIKANTA PANIGRAHY
 Reg. No. TS/MS/FMR/03605
 7/2/26

PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------------|---|---|
| 27/8/26
2:30pm | afternoon Round | Plan |
| | Baby on room air
maintaining SpO ₂ - 91%
HR - 147/min
RR - 49/min
hemodynamically stable
NO RD / desaturations
NO vomitings
tolerating feeds well | → off Oxygen trail
→ prone nursing
→ Target SpO ₂ - 90-95%
→ TV - 150 cc/kg/day
56ml 8 th hly - GBM
→ try paladai - feeds in day
roughly over
→ continue KMC.
- Dress the baby
- CRBS-OD
- WIF - RD / desaturation
- ILO - charting 86 th hly
- heel sore care
→ target SpO ₂ 90-100%
mvt → 25-50 mth |
| 4:30pm | took paladai well
HR - 134
RR - 51/min
SpO ₂ - 92% | Patient
Plan
→ R/L for full paladai
feeds
→ dress the baby
→ prone nursing
→ Iml → 6 th hly
x R/R |



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

Day in NICU: Day of Life: 12 PMA: 39+1

Term ☐ Preterm ☐ Gestation: 37+6 Corrected Gestational Age: Today's Weight: 2.944/30

| | | Problems | |
|---------------------|---|------------------------------------|------------------------|
| | | Current | Past Problems |
| Overview | S.No. | | |
| | 1. | <u>Term / AQA / RD / pneumonia</u> | <u>Expected sepsis</u> |
| | 2. | <u>Severe pPHN</u> | <u>Shock</u> |
| | 3. | <u>Bed sore grade I</u> | |
| | 4. | <u>Thiamine deficiency</u> | |
| | 5. | | |
| Clinical Assessment | <ul style="list-style-type: none"> - Baby on Room air - No RD no desaturation - Comfortable in prone nursing - No Tachypnea - Passed urine & stool | | |
| | <p>SP02: 96%
PR:</p> | | |
| Medications Used | | | |
| | <p>① TV - 150 cc / ks / day - 38ml - 2haukr.
EBM</p> | | |
| Plan of Care: | <p>② Day palada, night OC</p> | | |
| | <p>③ Continue KME</p> | | |
| | <p>④ GRBS - OD</p> | | |

Doctor's Name (Hand over given):

Signature:

Date & Time:

Doctor's Name (Hand over taken): Dr. Rajitha

Signature: Rajitha

Date & Time: 8/7/26



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------|----------------------------|---|
| 8/7/26 | | seen by <u>Dr. Nalinikanta</u> |
| | | → Day paladi + night OG feed |
| | | → Remove IV cannula |
| | | → KME |
| | | → Crib evening |
| | | → <u>R/V</u> Shift to Room <u>Tim</u> |
| | | → Home today |
| | Noted by
Suchita | |
| | <u>Afternoon / Evening</u> | <u>Plan</u> |
| 8/7/6 | - Baby on room air | (X) TV - 150cc/K/d |
| | - Haemodynamically stable | - 38 ml - 2 hourly |
| | Feeds - tolerated | day palada - Night OG |
| | - Took palada well | ⇒ Continue KME |
| | | ⇒ Crib care in evening |
| | | ⇒ Start palada from morning feeds again |
| | | ⇒ R/V shift t/M. |
| | | ⇒ Involve mother in baby's feeding & care |
| | | Enriched. |

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

Day in NICU: Day of Life: 13 PMA: 37+4.
 Term ☐ Preterm ☐ Gestation: 37+0 Corrected Gestational Age: Today's Weight: 2.921 (↓15 g)

| Problems | |
|----------|-------------------------------------|
| S.No. | Current |
| 1. | Feed establishment. |
| 2. | crib care. |
| 3. | Severe PPHN |
| 4. | Term / AEA / ED / Pneumonia |
| 5. | Severe PPHN / Bed sore grade 4 |
| 6. | Thiamine deficiency. S/P Subcutant. |

| Past Problems | |
|-----------------------------|--|
| Suspected sepsis shock. | |
| Severe PPHN / RD / m / s/o. | |

| Overview | |
|----------|-------------------------------------|
| 1. | Feed establishment. |
| 2. | crib care. |
| 3. | Severe PPHN |
| 4. | Term / AEA / ED / Pneumonia |
| 5. | Severe PPHN / Bed sore grade 4 |
| 6. | Thiamine deficiency. S/P Subcutant. |

| Clinical Assessment | |
|---------------------|--------------------------------|
| on room air | Tolerating paladai feeds well. |
| DE: RR: 22 | SAE ⊕ / NO added soude. |
| NO R.D. | NO vomiting |
| PA: soft/distended. | GRBS - 100% W |

| Medications Used | |
|-----------------------|--|
| → Calceinax - 5ml BD. | |
| → Tab. Thiamine | |
| → T. Bact | |

| Plan of Care: | |
|---|-------------------------|
| 1. Tr: 150ml/kg/day ← 38ml / 2nd hourly | → Day paladai night or. |
| 2. Continue KMC | |
| 3. GRBS - OD - | |
| 4. Rv shift to room today. | |
| 5. Train mother in feeding | |
| 6. Full Paladai feeds today | |

Doctor's Name (Hand over given): Dr. Shri

Signature: [Signature]

Date & Time: 9/7/26 : 9:00am

Docu. No. : RCHB/FRM / CLINICAL / 290 (26)

Doctor's Name (Hand over taken):

Signature:

Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---------------------|---|--|
| 8/7/26
@ 10:20pm | <p><u>Night Rounds</u></p> <p>Baby on Room air
↓
No desaturation
No Tachypnea
Accepted day
Paladay well</p> | <p>Night OG Feeds
↓
From morning
Give paladay feeds</p> <p><u>Noted by</u>
Akansha <u>Sahu</u></p> |

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 8 PMA: 39 week
 Term ☐ Preterm ☐ Gestation : 37+6 Corrected Gestational Age:

| OVERVIEW | Problems : | | |
|----------|------------|-----------------------------------|-------------------|
| | S.No. | Current | Past Problems |
| | 1. | Term/PPH | Suspected Sepsis |
| | 2. | RO/Pneumonia | Shock on multiple |
| | 3. | Severe PPHN ⇒ MV ⇒ INO ⇒ NOW CPAP | |
| | 4. | Thrombocytopenia | |
| | 5. | Bed Sore grade I | |
| | 6. | | |

Today's Weight : 3.049 (1349gms)

VENTILATORY SUPPORT : ☐ Yes ☐ No - Day # of Vent :
 Mode of Ventilation : HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ INO ☐ PPM ☐
 Ventilator Settings : PIP PEEP VG Rate FiO₂ Oxygen : L/min
 Last CXR : Spo₂ :
 ET Secretions : Clear ☐ Thick ☐ Yellow ☐ Last ABG :
 Change over the Last 24 Hours : was on HFNC ⇒ Had RO ⇒ tachypnea
Chaged back to CPAP

Plan of Care : U/D ⇒ GRBS, 8hrs/d
HR - 168/min
RR - 34/min
SpO₂ - 95%
BP - 63/35/43

Neurological Examination :
 Sedation : NO
 Last Neurosonogram : (N) Any Seizures : NO

| | |
|--|---|
| FLUIDS STATUS NUTRITION | ☐ NPO ☐ NG Feeds Wt. Gain:..... Head Circumference:..... |
| | Input:..... / (+/-)..... Output:..... ml/kg/d Urine Output: <u>1.3</u> ml/kg/hr Stools:..... |
| | IV Fluids - Type of IVF:..... @..... ml/hr |
| | Feeding: EBM ☐ Formula ☐ Donor BM ☐ Volume:..... Frequency:..... |
| | TPN: ☐ Yes ☐ No - If yes, details:..... Calories:..... |
| Abdominal Examination:..... <u>Soft tolerating feeds</u> | |

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

| | | | | |
|-----------|--|--------|-------|------|
| INFECTION | Risk of Sepsis / Suspected Sepsis / Proven Sepsis : | | | |
| | Sepsis screen:..... | | | |
| | Blood culture ☐ Urine culture ☐ ET culture ☐ Fungal Culture ☐ LP ☐ CSF :..... | | | |
| | Antibiotic | Sl.No. | Drugs | Days |
| | 1. | | | |
| 2. | | | | |
| 3. | | | | |

Inj Thiamine
8. Bactrim

IV line → D4
warmer → D5
feeding → D6

| | |
|---------------------|---|
| Plan of Treatment : | <p>→ continue CPAP → 6</p> <p>→ TV - 140cc/day 52ml O2/hly O2</p> <p>→ Prone positioning</p> <p>→ Head end elevation</p> <p>→ Do chest physio</p> <p>→ CBA OD, ARBS BD (preferred)</p> <p>→ track maternal Thiamine level</p> <p>→ Target SpO2 90-95% if Pao2 > 21</p> <p>90-100% Pao2 > 21</p> <p>mBp → 45-50 mmHg</p> <p>U.O → 2 ml/kg/h</p> <p>ARBS → 60-150 ml/dl</p> |
|---------------------|---|

| | |
|---|---|
| Doctor's Name (Handover given) : <u>BAC</u> | Doctor's Name (Handover taken) : <u>A. A. M. M.</u> |
| Signature : <u>[Signature]</u> | Signature : <u>[Signature]</u> |
| Date & Time : <u>4/7/20</u> | Date & Time : <u>4/7/20</u> |

BAH-00660193

IP5-00175741

Baby Of SIRIMALLE RAJITHA

27-06-2026

0 Y 0 M 13 D

(M)

Dr. NALINIKANTA PANIGRAHY



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PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------------|--|--|
| 9/7/26
10 AM | | Seen by Dr. Nalinika |
| | | → Train mother in feeding |
| | | → Shift to Room 11 |
| | | → Note of Day |
| | Dr. NALINIKANTA PANIGRAHY
Reg. No: 15462/FMR/03605
9/7/26 | |
| | Shifting Notes | |
| 9/7/26
2:00 PM | DOL-13 37+6 → 39+9 | 1. Tr: 150 ml/kg/day
- 38 ml / 2nd hourly Paladai Feeds - EBM. |
| | Issues: RD / Pneumonia,
Severe PPHN,
Bed sore grade 1
Thiamine deficiency
Suspected + Shock / Sepsis | 2. Continue KMC on ward
3. GRBS - OD -
4. Vaccines - OPV / BCG / Hep-B - t/m
5. Warm care
6. Temperature monitoring 4th. |
| | on Room air.
No RD. | 7. NBS / HARE - t/m. |
| | Tolerating Oral Paladai Feeds
Euthermic | 8. Vitals monitoring
9. Inform LOS. |



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Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Dr. Vidali Narandhar Date : 08/07/26 Time : 12:47pm

Diagnosis : Feeding difficulties & prematurity

Hospital : RCH; Bangalore

Type of Referral :

☐ Emergency

☐ Urgent

☒ Non Urgent

Referred for : ☒ Opinion ☐ Co-Management ☐ Transfer of care

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

Feeding & Swallowing Assessment Signature: Dr. Vidali

Findings and Recommendations : Thanks for the referral

- * Infant was well active & cooperative
- * ~~OPINE~~ was evaluated & revealed
- Structurally & functionally adequate
- * Tone, Symmetry & reflexes are expected within
- normal limits
- * Matured sucking reflex
- * Matured suck-swallow breathe coordination.
- * Initiated oral feeds using spoon
- were for oral movements were observed
- with (1) episode of choking maybe due
- to autoflow spoon.
- * Mother was trained in feeding techniques

Consultant :

Name : Dr. Vidali Signature : Dr. Vidali Narandhar Date & Time : 12:47pm

* Rending techniques

1. Posture maintenance (up^o) angle
2. Pace feeding method
3. Frequent burping
4. Span feeding skills
5. Sleep

26065684

BAH-00660193 IP5-00175741
 Baby Of SIRMALLE RAJITHA
 27-06-2026 0 Y 0 M 2 D (M)
 Dr. NALINIKANTA PANIGRAHY



BBG - Ome

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RESULT SHEET

| | | | | | |
|---------------------|--------------------|-----------|--------------------|--------------------|--------------------|
| Date | 29/6/26 | 1/7/26 | 1/7/26 | 2/7/26 | 5/7/26 |
| Time | 2pm | 7:35Am | 10:31Am | 12:57pm | 6:39Am |
| Hb | 14.6 | 14.1 | | | 14.9 |
| PCV | 42.4 | 40.4 | | | 44.0 |
| RBC | 4.15 | 3.98 | | | 4.31 |
| WBC | 12.83 | 7.25 | | | 13.61 |
| N/L | 64.1/25.3 | 46.6/37.1 | | | 19.0/27.8 |
| Platelets | 271 | 293 | | | 459 |
| CRP | 29 | 6 | | 10 | 5.0 |
| ESR | | | | | |
| PCT | | | | | |
| RBS | | | | | |
| Na | 140 | | | 141 | 137 |
| K | 5.0 | | | 4.5 | 5.6 |
| Cl | 112 | | | 111 | 104 |
| Ca/Mg | 9.2/2.2 | | | 10.2/2.3 | 10.2 |
| Phosphate | | | | | |
| Urea | 25 | | | | 6 |
| Creatinine | 0.7 | | | | 0.3 |
| ALP | | | | | |
| SGPT | | | | | |
| SGOT | | | | | |
| T.Bill/Conj | 10.4 < 0.1
10.3 | 1 | 15.1 < 0.1
15.0 | 11.6 < 0.1
11.5 | 12.6 < 0.1
12.5 |
| T.Protein | | | | | |
| S.Albumin | | | | | |
| S.Globulin | | | | | |
| A/G Ratio | | | | | |
| Uric Acid | | | | | |
| S.Amylase | | | | | |
| Sr.Lipase | | | | | |
| Blood Lactate | | | | | |
| S.Cholesterol | | | | | |
| PT/INR | 19/1.5 | | | | |
| APTT | 34 | | | | |
| CSF Protein / Sugar | | | | | |
| Cells | | | | | |
| N/L | | | | | |



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RBS CHART

[illegible]



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Patient Sticker

RBS CHART

[illegible]



MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: NICU3 Shifted to: 3rd

| S.No | MEDICATION NAME
(GENERIC NAME CAPITAL LETTERS) | DOSE
(mg, mcg) | ROUTE
(PO, NG, SC, IV) | FREQUENCY | LAST DOSE
Date / Time | ON
ADMISSION
/ SHIFTING |
|------|---|-----------------------|---------------------------|-----------|--------------------------|--|
| 1 | T. Bact ointment | For Local application | | 8H. | | ☐ C ☐ DC |
| 2 | Syr CALCIUM PLUS. | 5ml | P/O | 12H | | ☐ C ☐ DC |
| 3 | Tab- Thiamine | 25mg | P/O | OD | | ☐ C ☐ DC |
| 4 | | | | | | ☐ C ☐ DC |
| 5 | | | | | | ☐ C ☐ DC |
| 6 | | | | | | ☐ C ☐ DC |
| 7 | | | | | | ☐ C ☐ DC |
| 8 | | | | | | ☐ C ☐ DC |
| 9 | | | | | | ☐ C ☐ DC |
| 10 | | | | | | ☐ C ☐ DC |

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. John

Date & Time : 9/7/26

Nurse Name & Signature: Suchitra

Date & Time : 9/7/26 3:45 Pm

0660193 IP5-00175741
 Of SIRIMALLE RAJITHA
 -2026 0 Y 0 M 2 D (M)
 ALINIKANTA PANIGRAHY

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meet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG: T-bact OINTMENT

Date/Time 3/7 4/7 5/7 6/7 7/7 8/7 9/7 10/7

Dose LA Route 98H Frequency 3/7 Start Dt.

6am X 12pm 12pm 12pm 12pm 12pm 12pm 12pm

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: Syp CALCIMAX P

Date/Time 3/7 4/7

Dose 5ml Route PO Frequency 3/12H Start Dt.

6am 6pm

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: Tab THIAMINE

Date/Time 3/7 4/7 5/7 6/7 7/7 8/7 9/7 10/7

Dose 25mg p/o Route OD Frequency 7/7 Start Dt.

6am 12pm 12pm 12pm 12pm 12pm 12pm 12pm

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: CALCIMAX PLUS

Date/Time 7/7 8/7 9/7

Dose 5ml Route p/o Frequency BD Start Dt.

10am 12pm 12pm 12pm 12pm 12pm 12pm 12pm

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

Signature
VERIFIED BY : Name



DRUG CHART

Date of Admission: 29/6 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: | | | | | | | | | | | | | | | | | | | |

Weight. 3 kg Ward. NICU

| | | | | | | | | | |
|---|-------|-----------|------------|--------------|--------|------|-----|-----|-----|
| DRUG : INO · MEROPENEM | | | | Date
Time | 29/6 | 2019 | 1/7 | 2/7 | 3/6 |
| Dose | Route | Frequency | Start Date | | | | | | |
| 120mg | IV | 8hly | 29/6 | | | | | | |
| Name & Signature of the Doctor
Starting the Drugs: | | | | | | | | | |
| Additional Instructions: | | | | | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | | | | | |
| DRUG : S · SILDENAFIL | | | | Date
Time | | | | | |
| Dose | Route | Frequency | Start Date | | | | | | |
| 50mg | PO | TID | | | | | | | |
| Name & Signature of the Doctor
Starting the Drugs: | | | | | | | | | |
| Additional Instructions: | | | | | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | | | | | |
| DRUG : SILDENAFIL SYRUP | | | | Date
Time | 1/7/26 | 2/7 | | | |
| Dose | Route | Frequency | Start Date | | | | | | |
| 0.3ml | PO | TID | 1/7/26 | | | | | | |
| Name & Signature of the Doctor
Starting the Drugs: | | | | | | | | | |
| Additional Instructions: | | | | | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | | | | | |
| DRUG : INTJ · TH/AMIN | | | | Date
Time | 2/7/26 | 3/7 | 4/7 | 5/7 | 6/7 |
| Dose | Route | Frequency | Start Date | | | | | | |
| | IV | OD | 2/7/26 | | | | | | |
| Name & Signature of the Doctor
Starting the Drugs: | | | | | | | | | |
| Additional Instructions: | | | | | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | | | | | |



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

| Date | Time | Medication | Dosage & Other Instructions | Route | Signature | Nurses |
|---------|------|------------|-----------------------------|-------|-----------|-----------|
| 29/6/26 | 2pm | SURVANTA | 4mg/kg | IT | h | Devesh |
| 3/7/26 | | PCM DROPS | 15mg/kg | IV | db | not given |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |



Weight. Ward.

[illegible]

Signature _____

NURSING INITIAL ASSESSMENT FOR NICU

Date of Admission: 27/06/2026
 Source of Admission: ☒ OPD ☐ Ward ☐ Labor Ward ☐ Other:
 Reason for Admission: Term/ RD/ PPHN
 Admission Diagnosis: PPH
 Accompanied By: ☐ Parent ☒ Guardian ☐ Other Name:
 Primary Language: ☒ Telugu ☒ English ☐ Hindi ☐ Other Specify
 Do you require an interpreter? ☐ Yes ☐ No
 Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:
 If yes, identify yes
 Source of Information: ☒ Family ☐ Others, Specify

| Past Medical History | Past Surgical History | Last Hospital Admission |
|--|---|-------------------------|
| <u>NA</u> | <u>NA</u> | |
| Significant History | Family History: | |
| Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No
If yes please list,
Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems:
Are the child's immunization up to date? ☐ Yes ☐ No | | |
| Current Medications | Taking Medications? ☐ Yes ☒ No
If yes, Fill the reconciliation form
Medicine brought to the hospital? ☐ Yes ☐ No | |
| Observations:
Birth Weight: <u>3</u> kgs Head Circumference: cm Length: cm
☒ Term ☐ Pre-Term ☐ Post-Term
Blood Group: Mother: <u>B⁺ve</u> Baby: <u>O⁺</u>
Feeding: ☒ Breast Feeding ☐ Formula ☐ Both
Maternal Details: Age: years, PARA: Gestation: <u>37⁺6</u> Weeks, Days
Risk Factors: ☐ PROM ☐ Fetal Distress ☐ Diabetes Mellitus/ Gestational Diabetes
☐ PH/ Pre Eclampsia ☐ Others, Specify:
Mode of Delivery: ☒ Normal ☐ LSCS - Emergency/ Elective ☐ Instrumental ☐ AVD
Indication: | | |

BAH-00660193 IP5-00175741
Baby Of SRIMALLE RAJITHA
27-06-2026 0 Y 0 M 9 D (M)
Dr. NALINIKANTA PANIGRAHY



6/2/26
Io. : RCHBH / 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: 6/2/26 | Time: 8 | 10 | 12 | 2 | 4 | 6 | 8 | 10 | 12 | 2 | 4 | 6 |
| Doctor/Nurse/Family Concern? | Am | Am | Pm | Pm | Pm | Pm | Pm | Pm | Am | P | P | P |
| Temperature (°F) | 36.5°C | 36.6°C | 36.7°C | 36.4°C | 36.5°C | 36.5°C | 36.7°C | 36.7°C | | | | |
| Heart Rate (bpm) | 68 | 68 | 73 | 77 | 85 | 85 | 70 | 68 | 73 | 65 | 59 | 65 |
| Blood Pressure (mmHg) * | (50/41) | (54/41) | (34/45) | (32/47) | (33/45) | (33/45) | (42/39) | (52/44) | (42/53) | (35/46) | (31/40) | (45/50) |
| Note:
BP does not score
in early
warning scoring | | | | | | | | | | | | |
| Heart Rate (Number) | 160 | 157 | 160 | 153 | 148 | 161 | 144 | 155 | 152 | 145 | 139 | 130 |
| Resp. Rate (bpm)
(Over 1 Minute) * | | | | | | | | | | | | |
| Resp Rate (Number) | 53 | 43 | 30 | 33 | 13 | 43 | 65 | 39 | 30 | 48 | 49 | 28 |
| Resp Mod/ Severe
Distress None / Mild | | | | | | | LF | RA | | | | |
| Receiving O ₂ (l/min)
O ₂ Saturations (%) | 94% | 93% | 93% | 92% | 96% | 96% | 96% | 92% | 96% | 89% | 90% | 87% |
| Conscious Level
Normal / Altered | N | N | N | N | N | N | N | N | | | | |
| GCS * | C | C | C | C | C | C | C | C | C | C | C | C |
| TOTAL SCORE
Number of shaded boxes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pain Score | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Observer's Initials | P | P | P | P | P | P | P | P | P | P | P | P |

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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- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

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

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

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

| Date: 27/7/26 | Time: 8 | 10 | 12 | 2 | 4 | 6 | 8 | 10 | 12 | 2 | 4 | 6 | 8 |
|--|---|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Doctor/Nurse/Family Concern? | am | am | pm | pm | pm | pm | pm | pm | pm | am | am | am | am |
| Temperature (°F) | 104 | | | | | | | | | | | | |
| | 103 | | | | | | | | | | | | |
| | 102 | | | | | | | | | | | | |
| | 101 | | | | | | | | | | | | |
| | 100 | 36.5°C | 36.6°C | 36.4°C | 36.5°C | 36.5°C | 36.5°C | 36.5°C | 36.5°C | 36.5°C | 36.5°C | 36.5°C | 36.5°C |
| | 99 | * | * | * | * | * | * | * | * | * | * | * | * |
| | 98 | | | | | | | | | | | | |
| | 97 | | | | | | | | | | | | |
| | 96 | | | | | | | | | | | | |
| | 95 | | | | | | | | | | | | |
| 94 | | | | | | | | | | | | | |
| Heart Rate (bpm) and Blood Pressure (mmHg) * | 190 | | | | | | | | | | | | |
| | 180 | | | | | | | | | | | | |
| | 170 | | | | | | | | | | | | |
| | 160 | 142 | 149 | 148 | 149 | 147 | 140 | 145 | 147 | 145 | 141 | 140 | 142 |
| | 150 | (10) | (50) | (51) | (49) | (85) | (75) | (45) | (41) | (47) | (55) | (49) | (50) |
| | 140 | | | | | | | | | | | | |
| | 130 | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | |
| | 100 | 99 | 93 | 94 | 98 | 77 | 68 | 61 | 52 | 37 | 44 | 32 | 38 |
| 90 | | | | | | | | | | | | | |
| 80 | | | | | | | | | | | | | |
| 70 | | | | | | | | | | | | | |
| 60 | | | | | | | | | | | | | |
| 50 | | | | | | | | | | | | | |
| Heart Rate (Number) | 146 | 149 | 148 | 143 | 165 | 152 | 141 | 159 | 161 | 159 | 152 | 149 | |
| Resp. Rate (bpm) (Over 1 Minute) * | 70 | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | |
| | 50 | | | | | | | | | | | | |
| | 40 | | | | | | | | | | | | |
| | 30 | | | | | | | | | | | | |
| | 20 | | | | | | | | | | | | |
| | 10 | | | | | | | | | | | | |
| | Resp Rate (Number) | 57 | 37 | 57 | 48 | 36 | 36 | 52 | 52 | 34 | 34 | 52 | 30 |
| | Resp Mod/ Severe Distress None / Mild | | | | | | | | | | | | |
| | Receiving O ₂ (l/min) O ₂ Saturations (%) | 86% | 88% | 95% | 93% | 97% | 95% | 89% | 92% | 95% | 93% | 91% | 94% |
| Conscious Level Normal / Altered | N | N | N | N | N | N | N | N | N | N | N | N | |
| GCS * | C | C | C | C | C | C | C | C | C | C | C | C | |
| TOTAL SCORE | | | | | | | | | | | | | |
| Number of shaded boxes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Pain Score | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| Observer's Initials | b | b | b | e | e | e | n | n | n | n | n | n | |

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

* 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. |
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8/7/26

Docu.No. : RCHBH/ FRM / CLINICAL / 127

TEENAGE (12 + years)
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 : 8/7/26 | Time: 8 | 10 | 12 | 2 | 4 | 6 | 8 | 10 | 12 | 2 | 4 | 6 | 8 |
| Doctor / Nurse / Family Concern? | Am | Am | Pm | Pm | Pm | Pm | Pm | Pm | Am | AM | AM | AM | AM |

| | | | | | | | | | | | | | |
|-----------------|-----|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|--|
| Temperature (F) | 104 | | | | | | | | | | | | |
| | 103 | | | | | | | | | | | | |
| | 102 | * 36.5C | * 36.5C | * 36.5C | * 36.5C | * 36.5C | * 36.5C | * 36.5C | * 36.5C | * 36.5C | * 36.5C | * 36.5C | |
| | 101 | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | |
| | 99 | | | | | | | | | | | | |
| | 98 | | | | | | | | | | | | |
| | 97 | | | | | | | | | | | | |
| | 96 | | | | | | | | | | | | |
| | 95 | | | | | | | | | | | | |
| | 94 | | | | | | | | | | | | |

| | | | | | | | | | | | | | |
|---|-----|-----|-----|-----|-----|-----|--|--|--|--|--|--|--|
| Heart Rate (bpm) | 190 | | | | | | | | | | | | |
| | 180 | | | | | | | | | | | | |
| | 170 | | | | | | | | | | | | |
| | 160 | | | | | | | | | | | | |
| | 150 | | | | | | | | | | | | |
| | 140 | | | | | | | | | | | | |
| | 130 | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | |
| | 90 | | | | | | | | | | | | |
| | 80 | | | | | | | | | | | | |
| | 70 | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | |
| | 50 | | | | | | | | | | | | |
| Note:
BP does not score
in early
warning scoring | | | | | | | | | | | | | |
| Heart Rate (Number) | | 154 | 154 | 152 | 141 | 155 | | | | | | | |

| | | | | | | | | | | | | | |
|-------------------------------------|----|----|----|----|----|----|--|--|--|--|--|--|--|
| Resp. Rate (bpm)
(Over 1 Minute) | 70 | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | |
| | 50 | | | | | | | | | | | | |
| | 40 | | | | | | | | | | | | |
| | 30 | | | | | | | | | | | | |
| | 20 | | | | | | | | | | | | |
| | 10 | | | | | | | | | | | | |
| Resp Rate (Number) | | 30 | 31 | 41 | 46 | 31 | | | | | | | |

| | | | | | | | | | | | | | |
|----------------------------------|-------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Resp Distress | Mod/ Severe | | | | | | | | | | | | |
| | None / Mild | | | | | | | | | | | | |
| Receiving O ₂ (l/min) | | | | | | | | | | | | | |
| O ₂ Saturations (%) | | 99% | 99% | 95% | 92% | 99% | 97% | 98% | 99% | 93% | 92% | 91% | 92% |
| Conscious Level | Normal | N | N | N | N | N | N | N | N | N | N | N | N |
| | Altered | | | | | | | | | | | | |
| GCS * | | C | C | C | C | C | C | C | C | C | C | C | C |
| TOTAL SCORE | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Number of shaded boxes | | | | | | | | | | | | | |
| Pain Score | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Observer's Initials | | e | e | e | e | e | e | e | e | e | e | e | e |

| | |
|---------|---|
| ACTIONS | Score 1 : Continue normal observation by staff nurse |
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| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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

EARLY WARNING SCORE: CHILDREN'S UNIT

| | | | | | | | | |
|--|---------|--------|--------|--------|--------|--------|----------------------------|--------|
| Date: 9/2/28 | Time: 2 | 10 | 12 | 2 | 6 | 10 | 2 | 6 |
| Doctor/Nurse/Family Concern? | Am | Am | Am | Am | PM | PM | Am | Am |
| Temperature (F) | 36.4°C | 36.6°C | 36.6°C | 36.2°C | 97.9°F | 97.7°F | 97.6°F (Home given 1 hour) | 97.6°F |
| Heart Rate (bpm) | 154 | 161 | 141 | 150 | 150b/m | 123b/m | 143b/m | 138b/m |
| Blood Pressure (mmHg) * | | | | | | | | |
| Note: BP does not score in early warning scoring | | | | | | | | |
| Resp. Rate (bpm) (Over 1 Minute) * | 39 | 48 | 65 | 69 | 42b/m | 32b/m | 34b/m | 32b/m |
| Resp Distress | | | | | | | | |
| Mod/ Severe None / Mild | | | | | N | N | N | N |
| Receiving O ₂ (l/min) | | | | | | | | |
| O ₂ Saturations (%) | 99% | 98% | 99% | 100% | 99% | 97% | 97% | 100% |
| Conscious Level | N | N | N | N | N | N | N | N |
| Normal / Altered | | | | | | | | |
| GCS * | C | C | C | C | 15/15 | 15/15 | 15/15 | 15/15 |
| TOTAL SCORE | | | | | 0 | 0 | 0 | 0 |
| Number of shaded boxes | | | | | | | | |
| Pain Score | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 |
| Observer's Initials | A | A | A | A | A | A | A | A |

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
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| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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6/7/26

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

TV-150cc
B.Wt-2986
Jf-

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 | Sign. Nurse |
|----------------------|----------|-----------------|---------------|-----|----------------------|-----------|--------|----------|-------|-------------------------|-------------|
| Date | Time | Nature of Fluid | Route | | NG | Diarrhoea | Vomit | Drainage | Urine | Thrombo-phlebitis Score | |
| | | | Mouth | I.V | O.G | | | | | | |
| | 08:00 am | | | | | | | | | | |
| | 09:00 am | EBM | | | 52ml | | passed | | 10ml | | |
| | 10:00 am | | | | | | | | | | |
| | 11:00 am | EBM | | | | | | | | | |
| | 12:00 pm | EBM | | | 52ml | | passed | | 15ml | | |
| | 01:00 pm | | | | | | | | | | |
| Total Intake : | | | | | Total Output : | | | | | | |
| | 02:00 pm | | | | | | | | | | |
| | 03:00 pm | EBM | | | 56ml | | passed | | 12ml | | |
| | 04:00 pm | | | | | | | | | | |
| | 05:00 pm | | | | | | | | | | |
| | 06:00 pm | EBM | | | 56ml | | passed | | 15ml | | |
| | 07:00 pm | | | | | | | | | | |
| Total Intake : | | | | | Total Output : | | | | | | |
| | 08:00 pm | | | | | | | | | | |
| | 09:00 pm | EBM | | | 56ml | | passed | | 10ml | | |
| | 10:00 pm | | | | | | | | | | |
| | 11:00 pm | | | | | | | | | | |
| | 12:00 am | EBM | | | 56ml | | — | | 15ml | | |
| | 01:00 am | | | | | | | | | | |
| Total Intake : | | | | | Total Output : | | | | | | |
| | 02:00 am | | | | | | | | | | |
| | 03:00 am | EBM | | | 56ml | | passed | | 10ml | | |
| | 04:00 am | | | | | | | | | | |
| | 05:00 am | | | | | | | | | | |
| | 06:00 am | EBM | | | 56ml | | — | | 11ml | | |
| | 07:00 am | | | | | | | | | | |
| Total Intake : 424ml | | | | | Total Output : 108ml | | | | | | |
| Total 24 hrs. Intake | | | 125 cckg/day | | | | | | | | |
| Total 24 hrs. Output | | | 13.3 cckg/day | | | | | | | | |

Patient Sticker

BAH-00660193 IP5-00175741
 Baby Of SRIMALLE RAJITHA
 27-05-2025 0 Y 0 M 9 D (M)
 Dr. NALINIKANTA PANIGRAHY



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. : 2

21/7/26

TV → 150 cc/kg
 B.W → 2.944 kg
 TF →

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 Thrombo-phlebitis Score | Sign. Nurse | | |
|-----------------------|----------|-----------------|-----------|-----|------|----------------------|--------|----------|------------|--|---------------------------------|-------------|--------|--|
| | | | Mouth | I.V | NG | Diarrhoea | Vomit | Drainage | Urine | | | | | |
| | | | | | OG | | | | | | | | | |
| | 08:00 am | | | | | | | | | | | | | |
| | 09:00 am | EBM 56 | | | 56ml | | passed | | | | 15ml | | | |
| | 10:00 am | | | | | | | | | | | | | |
| | 11:00 am | | | | | | | | | | | | | |
| | 12:00 pm | EBM | | | 56ml | | passed | | | | 10ml | | | |
| | 01:00 pm | | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | | |
| | 02:00 pm | | | | | | - | | | | | | | |
| | 03:00 pm | EBM | | | 56ml | | - | | | | | | ② | |
| | 04:00 pm | | | | | | | | | | | | ② | |
| | 05:00 pm | | | | | | | | | | | | | |
| | 06:00 pm | EBM | | | 56ml | | Passed | | | | 9ml | | ② | |
| | 07:00 pm | | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | | |
| | 08:00 pm | | | | | | | | | | | | | |
| | 09:00 pm | EBM 38ml | | | | | Passed | | | | 10ml | | } Alan | |
| | 10:00 pm | | | | | | | | | | | | | |
| | 11:00 pm | EBM 38ml | | | | | Passed | | | | 10ml | | | |
| | 12:00 am | | | | | | | | | | | | | |
| | 01:00 am | EBM 38ml | | | | | Passed | | | | 9ml | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | | |
| | 02:00 am | | | | | | | | | | | | } AD | |
| | 03:00 am | EBM 38ml | | | | | Passed | | | | 10ml | | | |
| | 04:00 am | | | | | | | | | | | | | |
| | 05:00 am | EBM 38ml | | | | | Passed | | | | 11ml | | | |
| | 06:00 am | | | | | | | | | | | | | |
| | 07:00 am | EBM 38ml | | | | | Passed | | | | 10ml | | | |
| Total Intake : 452 ml | | | | | | Total Output : 94 ml | | | | | | | | |
| Total 24 hrs. Intake | | | 6.4 cc/kg | | | Total 24 hrs. Output | | | 11.3 cc/kg | | | | | |



8/7/26

FLUID CHART

TV → 150 cc/kg/day
B.W → 2.944 kg
TF →

Sheet No. : 3

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 | OG | | | | | | |
| | 08:00 am | | | | | | | | | | |
| | 09:00 am | EBM | | | 38ml | Passed | | | 9ml | | ② |
| | 10:00 am | | | | | | | | | | |
| | 11:00 am | EBM | 38ml | | | Passed | | | 7ml | | ② |
| | 12:00 pm | | | | | | | | | | |
| | 01:00 pm | EBM | 38ml | | | - | | | 9ml | | ② |
| Total Intake : | | | | | Total Output : | | | | | | |
| | 02:00 pm | | | | | | | | | | |
| | 03:00 pm | EBM | 38ml | | | Passed | | | 9ml | | ② |
| | 04:00 pm | | | | | | | | | | |
| | 05:00 pm | EBM | 38ml | | | Passed | | | 8ml | | ② |
| | 06:00 pm | | | | | | | | | | |
| | 07:00 pm | EBM | 38ml | | | - | | | 8ml | | ② |
| Total Intake : | | | | | Total Output : | | | | | | |
| | 08:00 pm | | | | | | | | | | |
| | 09:00 pm | EBM | 38ml (OG) | | | Passed | | | 10ml | | } AA |
| | 10:00 pm | | | | | | | | | | |
| | 11:00 pm | EBM | 38ml (OG) | | | Passed | | | 9ml | | |
| | 12:00 am | | | | | | | | | | |
| | 01:00 am | EBM | 38ml (OG) | | | Passed | | | 9ml | | |
| Total Intake : | | | | | Total Output : | | | | | | |
| | 02:00 am | | | | | | | | | | |
| | 03:00 am | EBM | 38ml (OG) | | | Passed | | | 15ml | | } AA |
| | 04:00 am | | | | | | | | | | |
| | 05:00 am | EBM | 38ml (OG) | | | Passed | | | 16ml | | |
| | 06:00 am | | | | | | | | | | |
| | 07:00 am | EBM | 38ml (OG) | | | Passed | | | 10ml | | |
| Total Intake : 456 ml | | | | | Total Output : 92 ml | | | | | | |
| Total 24 hrs. Intake | | 57 cc/kg | | | | | | | | | |
| Total 24 hrs. Output | | 11.5 cc/kg | | | | | | | | | |



FLUID CHART

Sheet No. : 19

9/7/26

TV-150 cc/kg/d
 B.W-2.929 Kg

TF →

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 | | | | | | |
| 9/7/26 | 08:00 am | | | | | | | | | | |
| | 09:00 am | EBM | 39ml | | | Poised | - | - | 9ml | | |
| | 10:00 am | | | | | | | | | | |
| | 11:00 am | EBM | 38ml | | | - | | | 10ml | | |
| | 12:00 pm | | | | | | | | | | |
| | 01:00 pm | EBM | 38ml | | | Poised | | | 10ml | | |
| Total Intake : Taken | | | | | Total Output : | | | | | | |
| 9/7/26 | 02:00 pm | | | | | | | | | | |
| | 03:00 pm | EBM | 38ml | | | | | | | | No In |
| | 04:00 pm | | | | | | | | | | Pain |
| | 05:00 pm | EBM | 38ml | | | | | | | | Pain |
| | 06:00 pm | | | | | | | | | | Canula Pain |
| | 07:00 pm | EBM | 38ml | | | | | | | | Pain |
| Total Intake : Taken | | | | | Total Output : u=1 m=1 | | | | | | |
| 9/7/26 | 08:00 pm | | | | | | | | | | |
| | 09:00 pm | EBM | 38ml | | | | | | | | No IV |
| | 10:00 pm | | | | | | | | | | Sustained |
| | 11:00 pm | EBM | 38ml | | | | | | | | Sustained |
| | 12:00 am | | | | | | | | | | |
| | 01:00 am | EBM | 38ml | | | | | | | | |
| Total Intake : Taken | | | | | Total Output : u=1 m=2 | | | | | | |
| 9/7/26 | 02:00 am | | | | | | | | | | |
| | 03:00 am | EBM | 38ml | | | | | | | | No IV |
| | 04:00 am | | | | | | | | | | Sustained |
| | 05:00 am | EBM | 38ml | | | | | | | | Sustained |
| | 06:00 am | | | | | | | | | | |
| | 07:00 am | EBM | 38ml | | | | | | | | |
| Total Intake : Taken | | | | | Total Output : u=1 m=1 | | | | | | |

Total 24 hrs. Intake : Taken

Total 24 hrs. Output : u-6, m-6

BAH-00660193 IP5-00175741
 Baby Of SIRMALLE RAJITHA
 27-06-2026 0 Y 0 M 2 D (M)
 Dr. NALINIKANTA PANIGRAHY



①

NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 29/6/26

Assessment: on ventilator, Nidic style, Term/ RPS

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 | → to Assess condition of the baby | 2pm | → Assessed condition of the baby | Baby is on ventilator + INO |
| 3pm | → to send advised sample | 3pm | → provided comfortable position | |
| 5pm | → to administer surfactant | 5pm | → surfactant given | |
| 6pm | → to start IV Antibiotics | 6pm | → medication given. | |
| 6pm | → plan to place picc line | | → suction done | |
| 7pm | → to monitor vitals | 7pm | → checked vitals and accepted | |

Re-Assessment:

Special Notes: wait for hypotension

Nurse Signature: Digeshwari

Nurse Name: Digeshwari

Date & Time: 29/06/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 29/6/26

Assessment: Hypotension, on ventilator baby need oxygen support

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 | * Tl - 60 c/kg/day | 9pm | * Tl - 60 c/kg/day | * Now baby Pst-H10 |
| 11pm | * To monitor vitals | 11pm | * monitored vitals | maintaining |
| 12am | * To maintain SpO2 chart | 12am | * maintained SpO2 chart | * on Admin chart |
| 2am | * plan to do suction | 2am | * suction done | maintaining blood |
| 3am | * plan to give feeding | 3am | * given feeds | pressure |
| 5am | * plan to give medication | 5am | * given medications | |
| 7am | * plan to do blood gas | 7am | * blood gas done | |

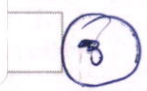
Re-Assessment: Re-assessment done

Special Notes: ↓ no SpO2 blood gas done

Nurse Signature:

Nurse Name: Bhensathi

Date & Time: 30/6/26 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 30/06/26

Assessment: on ventilator, PPHN, RD

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 condition of the baby | 8am | → Assessed condition of the baby | Baby is on PSV P mode maintaining well. |
| 10am | → to provide comfortable position | 10am | → provided comfortable position | |
| 1pm | → to administer medication | 1pm | → given feed and medication as advised. | |
| 3pm | → to stop INO, Adrenaline | 3pm | → stopped INO | |
| 7pm | → to monitor vitals. | 7pm | → checked vitals and recorded | |

Re-Assessment:

Special Notes: wash for vitals

Nurse Signature: Digeshwari

Nurse Name: Digeshwari

Date & Time: 30/06/26



9

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 30/6/26

Assessment: on ventilator baby need oxygen support

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 | * Nil - so callsgl day | 9pm | * Nil - so callsgl day | * Noo baby on |
| 11pm | * To monitor vitals | 11pm | * monitored vitals | ventilator maintaining |
| 12am | * To maintain No chart | 12am | * maintained No chart | |
| 2am | * plan to give feeding | 2am | * given feeds 3rd hourly | |
| 5am | * plan to do suction | 3am | * suction done | |
| 6am | * plan to give medication | 6am | * given medications | |
| 7am | * plan to do blood gas | 7am | * blood gas done | |

Re-Assessment: Re-Assessment done

Special Notes: blood gas done

Nurse Signature:

Nurse Name: bhavathi

Date & Time: 17/26 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 1/7/26 @ 8 AM

Assessment: Distress / Retractions / ventilated

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 | To monitor the vital | 8am | Maintain a/c Charting | 1) Baby is stable |
| 10am | maintained a/c Charting | 10am | monitored the vital | 2) Maintaining SpO2. |
| 12pm | Plan to do extubation. | 12pm | extubated to NIV, maintain | |
| 4pm | To do x-ray, Gas. | 4pm | ned well changed to cpcp. | |
| 6pm | To give feeding | 6pm | post extubation gas, x-ray | |
| | To give medication | | Done. | |
| | | | after 2 hours half feed given | |
| | | | medication given as per doctor's order | |

Re-Assessment: Re-Assessment done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 1/7/26 8 PM

6

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 11/7/26

Assessment: Baby is N/V

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 | 8pm | Assessed the baby Condition | Baby is on N/V |
| 10pm | monitored vitals | 10pm | monitored vitals | |
| 12pm | maintain I/O Chart | 12pm | maintained I/O Chart | |
| 2Am | give 1st and 3rd hourly | 2Am | give 1st and 3rd hourly | |
| 4Am | provided comfortable position | 4pm | provided comfortable position | |
| 6Am | give medication | 6Am | give medication | |

Re-Assessment:

Special Notes: DRS - BD GRS - BD

Nurse Signature: AN

Nurse Name: Rajathi

Date & Time: 11/7/26

BAH-00660193 IP5-00175741
 Baby Of SIRMALLE RAJITHA
 27-06-2026 0 Y 0 M 4 D (M)
 Dr. NALINIKANTA PANIGRAHY



NURSING CARE RECORD



Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 2/7/26

Assessment: Hypotension, Desaturation

- | | | | | | | |
|--------------|--|--|--|---|--|---|
| 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 | plan to Monitor vitals | 8pm | Monitored vitals and | |
| | 2/6 chd 60% | | 2/6 chd 60% | |
| 10pm | Administered Meclizine as per | 10pm | Administered Meclizine as per | |
| | doctor order | | doctor order | |
| 12pm | feeding 30% | 12pm | feeding 30% | |
| 2pm | plan to stop Administer w/lt | 2pm | stopped adminline 1/10/12 50% | |
| | syn. Sildenafil | | Sildenafil | |
| 4pm | provide pro re nlu | 4pm | provided pro re nlu | |
| 6pm | provide drink core | 6pm | provide drink core | |

Re-Assessment: Re-assessed done, w/f Hypotension, Desaturation

Special Notes: RRR-Bn, Gm - 00

Nurse Signature: [Signature] Nurse Name: Dr. Nalinikanta Date & Time: 2/7/26 8pm

BAH-00660193 IPS-00175741
Baby Of SIRIMALLE RAJITHA
27-06-2026 0 Y 0 M 4 D (M)
Dr. NALINIKANTA PANIGRAHY



8

NURSING CARE RECORD

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

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

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/7/26

Assessment:

Baby is on CPAP

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 | 8pm | Assessed the baby condition | Baby is on
CPAP |
| 10pm | monitor vitals | 10pm | monitored vitals | |
| 12pm | maintain I/O chart | 12pm | maintained I/O chart | |
| 2am | give 1st and 3rd hourly | 2am | given 1st and 3rd hourly | |
| 4am | provided comfortable position | 4am | provided comfortable position | |
| 6am | give medication | 6am | give medication | |

Re-Assessment:

Done

Special Notes:

RBS OD

Nurse Signature:

Nurse Name:

Agasti

Date & Time:

2/7/26 8pm

BAH-00660193 IP5-00175741
Baby Of SRIMALLE RAJITHA
27-06-2026 0 Y 0 M 4 D (M)
Dr. NALINKANTA PANIGRAHY

NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 3/7/26

Assessment: Baby is on CPAP

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 condition | 8 Am | Assessed the baby condition | Baby is stable |
| 10 Am | monitors the vitals | 10 Am | monitored the vitals | |
| 12pm | Maintain I/o chart | 12pm | Maintained I/o chart | |
| 1pm | Given feed 3 rd hourly | 1pm | Given feed 3 rd hourly | |
| 2pm | Administer medication as per doctor order. | 2pm | Administered medication as per doctor order. | |

Re-Assessment: Re-Assessment done

Special Notes: RBS - BD, Gas - OD

Nurse Signature: [Signature]

Nurse Name: Lavanya

Date & Time: 3/7/26 @ 8 Am - 2pm

BAH-00660193
 Baby Of SIRIMALLE RAJITHA
 27-06-2026 0 Y 0 M 6 D
 Dr. NALINIKANTA PANIGRAHY (M)

NURSING CARE RECORD



Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment: Baby is on HANC

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 |
|------|---|------|--|-------------------|
| | => Assess the baby general condition
=> To monitor the vitals
=> To maintain the Ilo and
=> Provide comfortable position
=> give 2nd hly feed
=> give medication as per Doctor order | | => Assessed the baby general condition
=> monitored the vitals
=> maintained Ilo and
=> provided comfortable position
=> given 2nd hly feed
=> given medication as per Doctor order | => Baby is stable |

Re-Assessment: Re-Assessment Done

Special Notes: RBS - DD

Nurse Signature: [Signature] Nurse Name: Lokanya Date & Time: 3/7/26 @ 2pm - 8pm

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Baby is on CPAP

Date: 4/7/26

Assessment:

Goals

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

| Time | Plan of Care | Time | Implementation | Evaluation |
|-------|--|----------|--|------------------------------|
| 8 AM | => Assess the baby general condition. | 8:10 AM | => Assessed the baby general condition | New baby is maintaining well |
| 10 AM | => monitor the vital signs | 10:15 AM | => monitored the vital signs | |
| 12 PM | => maintain D/c chart | 12:20 PM | => maintained D/c chart | |
| 2 PM | => give 3rd hourly feed | 2:10 PM | => given 3rd hourly feed | |
| 4 PM | => Administered the medication as per doctor's order | 4:10 PM | => Administered medication as per doctor's order | |
| 6 PM | => maintain Personal Hygiene | 6:10 PM | => maintained Personal Hygiene | New baby is maintaining well |
| 7 PM | => provide comfortable position | 7:15 PM | => provided comfortable position | |
| 8 PM | => ensure safety | 8:10 PM | => ensured safety | |
| | | | | |
| | | | | |

Re-Assessment:

Re-assessment done

Special Notes:

Nurse Signature: 

Nurse Name:

Mallekumar

Date & Time:

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: baby is on CPAP

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 |
|------|-------------------------------|------|-------------------------------|----------------------------|
| 8pm | Assess the baby condition | 8pm | Assessed the baby condition | Baby is on stable and CPAP |
| 10pm | monitor vitals | 10pm | monitored vitals | |
| 12AM | maintain I/O Chart | 12AM | maintained I/O chart | |
| 2pm | give Pcd 3rd hourly | 2pm | give Pcd 3rd hourly | |
| 4pm | provided comfortable position | 4pm | provided comfortable position | |

Re-Assessment: Done

Special Notes: Pcd 3rd hourly

Nurse Signature: [Signature]

Nurse Name: Ngusti

Date & Time: 3/7/26 8pm

3AH-00660193
Baby Of SIRMALLE RAJITHA
27-06-2026 0 Y 0 M 7 D
Dr. NALINIKANTA PANIGRAHY (M)

NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby is on CPAP

- 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 condition | 8 Am | Assessed the baby condition | Baby is stable |
| 10 Am | Monitor the vitals | 10 Am | monitored the vitals | |
| 12pm | Maintain I/O chart | 12pm | Maintained I/O chart | |
| 1pm | Give feed 3 rd hourly | 1pm | Give feed 3 rd hourly | |
| 2pm | Administse medication as per doctor order. | 2pm | Administred medication as per doctor order. | |

Re-Assessment: Re - Assessment done

Special Notes: RBS - OD, Gas - OD

Nurse Signature: [Signature] Nurse Name: Lavanya Date & Time: 5/7/26 @ 8 Am - 2pm

NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26

Assessment: Baby in on CPAP

- 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 |
|------|-------------------------------|------|-------------------------------|-----------------|
| 8pm | Assess the baby condition | 8pm | Assessed the baby condition | Baby is on CPAP |
| 10pm | maintain vitals | 10pm | maintain vitals | |
| 12pm | maintain I/O Chart | 12AM | maintain I/O chart | |
| 2AM | give Rd 3rd hourly | 2AM | give Rd 3rd hourly | |
| 4AM | provided comfortable position | 4 pm | provided comfortable position | |
| 6AM | give medication | 6 AM | give medication | |

Re-Assessment: Done

Special Notes: ABCs OK

Nurse Signature: [Signature]

Nurse Name: Agasti

Date & Time: 4/7/26

BAH-00660193
Baby Of SRIMALLE RAJITHA
27-06-2026
Dr. NALINIKANTA PANIGRAHY
IP5-00175741
(M)

NURSING CARE RECORD

Rainbow
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BirthRight™
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Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Baby is on low flow

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 | → to assess the baby general condition | 9pm | → Assessed the baby general condition | Baby vitals are maintained on low flow |
| 10pm | → to monitor vital signs | | → monitored vital signs | |
| 12pm | → to give feed 3rd hourly | | → given feed 3rd hourly | |
| 2pm | → to provide comfortable position | | → provided comfortable position | |
| 4pm | → to monitor I/O chart 6th hourly | | → monitored I/O chart 6th hourly | |

Re-Assessment:

Special Notes:

Nurse Signature: chand

Nurse Name: RBS-00 chandana

Date & Time: 6/7/26 @ 2pm

BAH-00660193 IP5-00175741
 Baby Of SRIMALLE RAJITHA
 27-06-2026 0 Y 0 M 9 D (M)
 Dr. NALINIKANTA PANIGRAHY



NURSING CARE RECORD

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 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby is on CPOP - change LF

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 | 2pm | *Assessed the baby general condition | *Baby is tolerably feed |
| 3pm | monitor vitals | 3pm | maintained to chart | |
| 4pm | maintain I/O chart | 4pm | monitored vitals | |
| 5pm | feed given and hourly | 5pm | provided comfortable position | |
| 6pm | Provide comfortable position | 6pm | to give medication | |
| 7pm | to give medication | | | |

Re-Assessment: Re - Assessment Done

Special Notes: RBS-00, Gas on

Nurse Signature: [Signature]

Nurse Name: Alphonso

Date & Time: 5/7/26

BAH-00660193
 Baby Of SIRMALLE RAJITHA
 27-08-2026 0 Y 0 M 9 D
 Dr. NALINKANTA PANIGRAHY (M)
 IPS-00175741

1

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NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 6/2/26

Assessment: Baby on L/F

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 |
|-------|---------------------------------|----------|----------------------------------|-----------------------|
| 8 AM | → Assess the baby condition. | 8:15 AM | → Assessed baby condition | Baby is
Stable now |
| 10 AM | → Monitor vital signs | 10:30 AM | → Monitored vital signs | |
| 12 PM | → provide comfortable position. | 12:30 PM | → provided comfortable position. | |
| 2 PM | → Give feed 3rd hourly | 2:30 PM | → Given feeds 3rd hourly | |
| 4 PM | → Give medication. | 4:30 PM | → Given medication | |

Re-Assessment: Done

Special Notes: RBS - DD

Nurse Signature: [Signature]

Nurse Name: Lokanya

Date & Time: 6/2/26 @ 8 AM - 8 PM

2

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/26

Assessment: Baby is on L/P

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 | 8pm | Assessed the baby condition | Baby is on L/P |
| 10pm | monitor vitals | 10pm | monitored vitals | |
| 12pm | maintain I/O chart | 12pm | maintain I/O chart | |
| 2pm | give feed 2nd hourly | 2pm | given feed 3 hourly | |
| 4pm | provided comfortable position | 4pm | provided comfortable position | |
| 6pm | give medication | 6pm | give medication | |

Re-Assessment: done

Special Notes: RBS

Nurse Signature: [Signature]

Nurse Name: Rajasri

Date & Time: 6/7/26

3AH-00660193
Baby Of SIRIMALLE RAJITHA
27-08-2026 0 Y 0 M 7 D
Dr. NALINIKANTA PANIGRAHY (M)

3

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NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 7/8/2026

Assessment: Baby on L/F

- 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 baby condition | 8:15am | → Assessed baby condition. | Baby is now stable. |
| 10am | → Monitor vital signs | 10:30am | → Monitored vital signs. | |
| 12pm | → Give feed 3rd hourly. | 12:15pm | → Given feed 3rd hourly | |
| 1pm | → change LP to R/L. | 1:30pm | → changed LP to R/L. | |
| 2pm | → Administer medication as per doctor's order. | 2:15pm | → Administered medication as per doctor's order. | |

Re-Assessment: Done.

Special Notes: RBS - OD.

Nurse Signature: [Signature] Nurse Name: Lokanya Date & Time: 7/8/26 @ 8am - 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 2 Pm-8 Pm

Assessment:

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 | Asses Baby condition | 2:30pm | Assesed Baby condition | Baby is stable |
| 4pm | Monitor vital sign | 4:30pm | monitored vital signs | |
| 6pm | Give feed 2nd hourly | 6:30pm | Gave feed 2nd hourly | |
| 8pm | Administrt medication As per the doctors order | 8:30pm | Adminstred medication as per doctors order. | |

Re-Assessment:

Special Notes: Done RBS - OD

Nurse Signature: ②

Nurse Name: Suchitra

Date & Time: 7/7/26 2 Pm-8 Pm



5

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 07/07/26

Assessment: Patient is on RIA

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 pt Condition | 8pm | Assessed the pt Condition | Now pt is good. |
| 10pm | Provide Comfortable Position. | 10pm | provided Comfortable position | |
| 12am | Given 2nd Hourly feeding | 12am | 2nd Hourly feeding given | |
| 2am | Ensure safety | 2am | Ensured safety. | |
| 4am | Monitor vital Signs | 4am | vital Signs Monitored | |
| 6am | Given medications | 6am | Medic | |

Re-Assessment: done

Special Notes: BBS-OD

Nurse Signature:

Nurse Name: Alanksha

Date & Time: 07/07/26



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 8/7/26

Assessment: Baby is R/A

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 condition | 8 Am | => Assessed the baby condition | Baby now stable |
| 10 Am | => Monitor vital signs | 10 Am | => Monitored vital signs | |
| 12 Pm | => I/o chart Maintain | 12 Pm | => I/o chart Maintain | |
| 2 Pm | => Give feed 2nd hourly | 2 Pm | => Gived feed 2nd hourly | |
| 4 Pm | => Provide comfortable position | 4 Pm | => Provided comfortable position | |
| 6 Pm | => Administer Medication as per doctor order. | 6 Pm | => Administered Medication as per doctor order | |
| 8 Pm | => Ensured stable | 8 Pm | => Ensured stable | |

Re-Assessment: Done

Special Notes: RBS - OD

Nurse Signature:

Nurse Name: Suchitra

Date & Time: 8/7/26 8Am-8Pm

BAH-00660193 IP5-00175741
 Baby Of SIRMALLE RAJITHA
 27-08-2026 0 Y 0 M 10 D (M)
 Dr. NALINIKANTA PANIGRAHY



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NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/26

Assessment: Patient is on RIA

- 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 |
|------|--------------------------------------|------|--|------------------------|
| 8pm | Assess the baby Condition | 8pm | Assessed baby Condition | Patient is stable now. |
| 10pm | Provide Comfortable position. | 10pm | comfortable position provided | |
| 12am | Monitor vital Signs. | 12am | vital sign's Monitored | |
| 2am | Maintain I/O chart. | 2am | I/O chart Maintained. | |
| 4am | Given 2 nd Hourly feeding | 4am | 2 nd Hourly feeding Givened | |
| 6am | Given medication-for doctor's order | 6am | Medications givened doctor's order. | |

Re-Assessment:

Done

Special Notes:

RBS - OD

Nurse Signature:

Nurse Name: Akansha

Date & Time: 08/07/26

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment: Baby is R/A

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's general condition | 8 AM | Assessed the baby's condition | Baby is now stable |
| 10 AM | Monitor the vital signs | 10 AM | Monitored the vital signs | |
| 12 PM | Maintain I/O chart | 12 PM | Maintain I/O chart | |
| 2 PM | Give 2nd hourly feed | 2 PM | Gave 2nd hourly feed | |
| 4 PM | Administer the medication as per doctor | 4 PM | Administered the medication as per doctor | |
| 6 PM | Ensure the safety | 6 PM | Ensured the safety | |

Re-Assessment:

Special Notes: RBS - OD, MBS, AABR - HM

Nurse Signature: [Signature] Nurse Name: [Signature] Date & Time: 09/07/26 6 PM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26 @ 9pm

Assessment: Baby is on Room Air.

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 Baby's condition | 8:10 pm | Assessed Baby's condition. | Baby is stable. |
| 10pm | Ensure safety. | 10:10 pm | Provided cribcare. | |
| 12am | monitor vitals. | | monitored vitals. | |
| 2am | maintain good nutritional. | 12:10 am | Feeding assessment. | |
| 4am | Prevent infection. | 2:10 am | EBM - 38ml. | |
| 6am | KMC to be. | 4:10 am | Followed infection control. | |
| 8am | Daily weight monitoring. | 6:10 am | Documented weight | |
| | GRBS - OD. | 8:10 am | Planned & checked. | |

Re-Assessment: NA

Special Notes: ABR, NBS, Vaccination Tm.

Nurse Signature: *[Signature]*

Nurse Name: Sushanti

Date & Time: 10/7/26 @ 8am

BAH-00660193 IP5-00175741
Baby Of SIRIMALLE RAJITHA
27-06-2026 0 Y 0 M 13 D (M)
Dr. NALINIKANTA PANIGRAHY

NURSING CARE RECORD


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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

S. ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

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 |
|------|--------------|------|----------------|------------|
| | | | | |

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nalinikanta Department: 3rd Floor Date of Admission: 27/6/26

| | | | | | | | |
|-----------------------|---|---|--|--|--|--|--|
| SITUATION | Diagnosis:
<u>Respiratory distress</u> | | Any Infection: ☐ Yes ☐ No ☒ Not Known
If Yes Specify: | | | | |
| | Area | Shift Time | | | | | |
| BACKGROUND | Medical Condition
(Any special condition to be noted): | <u>NA</u> | <u>NA</u> | | | | |
| | | | | | | | |
| 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: <u>98.0F</u> | <u>98.1F</u> | | | | |
| | Res: | <u>38b/m</u> | <u>32b/m</u> | | | | |
| | SpO ₂ : | <u>99%</u> | <u>100%</u> | | | | |
| | Pulse: | <u>140b/m</u> | <u>132b/m</u> | | | | |
| | BP: | <u>-</u> | <u>-</u> | | | | |
| | Fall Risk Score: | <u>-</u> | <u>-</u> | | | | |
| | Pain Score: | <u>0/10</u> | <u>0/10</u> | | | | |
| | Safety Needs: | <u>CRIB C/NP</u> | <u>CRIB CASE</u> | | | | |
| Recommendations | Physiotherapy | ☐ Yes ☒ No | ☐ Yes ☒ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Others Specify: | <u>NA</u> | <u>NA</u> | | | | |
| | Special Diet: | ☐ Yes ☒ No | ☐ Yes ☒ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Other Special Orders / Medications: | <u>NA</u> | <u>NBS
APR
Vacc:</u> | | | | |
| | Post Operative Procedure Special Orders: | <u>NA</u> | <u>NA</u> | | | | |
| Handed Over By Name : | <u>Pijs</u> | <u>Sushant</u> | | | | | |
| Signature : | <u>Pijs</u> | <u>Sushant</u> | | | | | |
| Date: | <u>27/6</u> | <u>27/6</u> | | | | | |
| Time: | <u>8PM</u> | <u>@ 8am</u> | | | | | |
| Taken Over By Name : | <u>Sushant</u> | <u>Laksh</u> | | | | | |
| Signature : | <u>Sushant</u> | <u>Laksh</u> | | | | | |
| Date: | <u>27/6</u> | <u>27/6</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

<div style="text-align: right;">Shift Time</div> | | | | | | |
| | Medical Condition
(Any special condition to be noted): | | | | | | |
| ASSESSMENT | Allergy: ☐ Yes ☐ No
Tubes/Drains/Catheter: ☐ Yes ☐ No

Vital Signs: Temp: ☐ Yes ☐ No
Res: ☐ Yes ☐ No
SpO ₂ : ☐ Yes ☐ No
Pulse: ☐ Yes ☐ No
BP: ☐ Yes ☐ No
Fall Risk Score: ☐ Yes ☐ No
Pain Score: ☐ Yes ☐ No | | | | | | |
| Recommendations | Safety Needs: ☐ Yes ☐ No
Physiotherapy ☐ Yes ☐ No
Others Specify: ☐ Yes ☐ No
Special Diet: ☐ 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: | | | | | | |



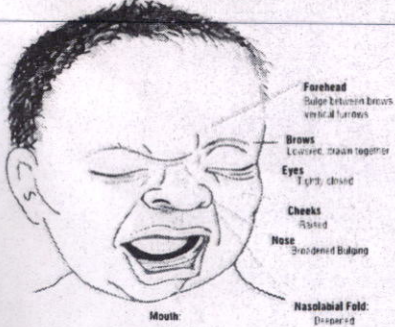
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

| 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 |
| | | | | | | 30/6 | 30/6 | 1/7 | 2/6 | 3/6 | 5/7 | 6/2 | 6/7 |
| | | | | | | 10am | 3pm | 6am | 10Am | 7h | 10Am | 6Am | 6pm |
| | | | | | | Procedure | 1BP | N/I | coner | Gm | RBS | RBS | RBS |
| 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 | -1 | -1 | 0 | 0 | 0 | 0 | 1 | 1 |
| 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 | 0 |
| Facial Expression | Mouth is lax
No expression | Minimal expression with stimuli | Relaxed Appropriate | Any pain expression intermittent | Any pain expression continual | -1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| 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 | 1 | 1 | 0 | 0 |
| Vital Signs HR
RR, BP, SaO ₂ | 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 | 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 | | | | | Gestational Age / Corrected Age
37+6 37+6 38 32 37+1 37-1 37+1 37+1 37+1 | | | | | | | |
| | | | | | | Total Pain / Agitation Score
-1 -1 0 0 1/10 1/10 1/10 +2/10 +1/10 | | | | | | | |
| | | | | | | Intervention
Fenbupropion Fenbupropion Fenbupropion Fenbupropion Fenbupropion Fenbupropion Fenbupropion Fenbupropion Fenbupropion | | | | | | | |
| | | | | | | Effectiveness
Yes Yes Yes Yes Good Good Good Good Good | | | | | | | |
| | | | | | | Signature
 | | | | | | | |

NPASS: Neonatal Pain, Agitation & Sedation Scale

| | Sedation | Pain / Agitation |
|-----------------------------------|--|--|
| How to use | <ul style="list-style-type: none"> 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. | <ul style="list-style-type: none"> Observe the infant for a minute before selecting a score for each behavior. Select only one numeric value per behavior. |
| Scoring/
Documentation | <ul style="list-style-type: none"> 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. | <ul style="list-style-type: none"> 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 | <ul style="list-style-type: none"> Desired levels of sedation vary according to the situation. Discuss and determine sedation goal with provider. <ul style="list-style-type: none"> "Deep sedation": goal score of -10 to -5 <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> The premature infant's response to prolonged or persistent pain/stress Neurologic depression, sepsis, or other pathology | <ul style="list-style-type: none"> Does not provide pain intensity rating. Any score greater than 3 indicates the possibility of the presence of pain in the infant <ul style="list-style-type: none"> 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. |

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

| Assessment Criteria | Sedation | | Normal | Pain / Agitation | | Date | Date | Date | Date | Date | Date | Date | Date | |
|---|---|---|---|--|---|---------------------------------|------|------|------|------|------|------|------|------|
| | -2 | -1 | 0 | 1 | 2 | 7/7 | 7/7 | 7/7 | 7/7 | 8/7 | 8/7 | 9/7 | 9/7 | |
| | | | | | | Time | Time | Time | Time | Time | Time | Time | Time | |
| | | | | | | 6pm | 2pm | 4pm | 8pm | 8AM | 8pm | 8AM | 10pm | |
| | | | | | | Procedure → | | | | | | | | |
| 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 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| 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) | 6 | 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 | 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 | 0 | |
| Vital Signs HR
RR, BP, SaO ₂ | 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 | 0 | |
|  <p>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</p> <p>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</p> | | | | | | Gestational Age / Corrected Age | 37+6 | 37+6 | 37+6 | 37+6 | 37+6 | 37+6 | 37+6 | 37+6 |
| | | | | | | Total Pain / Agitation Score | +1/0 | 1/0 | 1/0 | 1/0 | 1/0 | 1/0 | 1/0 | 1/0 |
| | | | | | | Intervention | EBM | EBM | EBM | EBM | EBM | EBM | EBM | EBM |
| | | | | | | Effectiveness | Good | Good | Good | Good | Good | Good | Good | Good |
| | | | | | | Signature | Agar | Agar | Agar | Agar | Agar | Agar | Agar | Agar |

NPASS: Neonatal Pain, Agitation & Sedation Scale

| | Sedation | Pain / Agitation |
|-----------------------------------|--|--|
| How to use | <ul style="list-style-type: none"> 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. | <ul style="list-style-type: none"> Observe the infant for a minute before selecting a score for each behavior. Select only one numeric value per behavior. |
| Scoring/
Documentation | <ul style="list-style-type: none"> 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. | <ul style="list-style-type: none"> 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 |
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BAH-00660193

IP5-00175741

Baby Of SIRIMALLE RAJITHA

27-06-2026

O Y O M 2 D

(M)

Dr. NALINIKANTA PANIGRAHY



BRADEN 'Q' SCALE

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

| | | | | | Date : | 30/6 | 17 | 20 | 3/7/26 |
|--|--|--|---|--|--------|------|------|-----|--------|
| | | | | | Time : | 10am | 10am | 8am | 8am |
| 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 extremity position independently. | 4. No limitations:
Makes major and frequent changes in position without assistance. | 1 | 1 | 1 | 1 | |
| "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 | 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. | 1 | 1 | 1 | 1 | |
| 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. | 3 | 3 | 3 | 3 | |
| 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." | 3 | 3 | 3 | 3 | |
| 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. | 3 | 3 | 3 | 3 | |
| 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. | 3 | 3 | 3 | 3 | |
| TOTAL SCORE | | | | | 15 | 15 | 15 | 15 | |
| Evaluator's Name | | | | | Dr | Ar | Dr | Dr | |

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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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-00660193 IPS-00175741
 Baby Of SRIMALLE RAJITHA
 27-08-2026 0 Y 0 M 4 D (M)
 Dr. NALINKANTA PANIGRAHY

BRADEN 'Q' SCALE

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

| | | | | | Date : | 4/7 | 5/25/17 | 5/7 |
|---|--|--|---|--|-------------|-------------|-------------|-------------|
| | | | | | Time : | 2PM | 8AM | 2PM |
| 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.tremity position independently. | 4. No limitations:
Makes major and frequent changes in position without assistance. | 1 | 1 | 1 | 3 |
| "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 | 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. | 1 | 1 | 1 | 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. | 3 | 3 | 3 | 3 |
| FRICION-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." | 3 | 3 | 3 | 2 |
| 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. | 5 | 3 | 3 | 3 |
| 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. | 3 | 3 | 3 | 3 |
| TOTAL SCORE | | | | | 15 | 15 | 15 | 18 |
| Evaluator's Name | | | | | [Signature] | [Signature] | [Signature] | [Signature] |

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

| 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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
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BRADEN 'Q' SCALE

| | | | | | Date : | 6/7 | 7/7 | 7/7 | 7/7 |
|--|--|--|---|--|--------|-----|-----|-----|-----|
| | | | | | Time : | 6pm | 8am | 2pm | 8pm |
| 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:
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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 | 2 | 2 |
| Nutritional Usual food intake pattern | 1. Very Poor:
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| 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. | | 3 | 3 | 3 | 3 |
| TOTAL SCORE | | | | | | 18 | 18 | 18 | 18 |
| Evaluator's Name | | | | | | 6/1 | 6/1 | 6/1 | 6/1 |

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

| 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 |

BRADEN 'Q' SCALE

| | | | | | Date : | 8/7 | 8/7 | 9/7 | 9/7 |
|---|--|--|---|--|--------|------|------|------|-------|
| | | | | | Time : | 8 AM | 8 pm | 8 am | 10 pm |
| 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. | 3 | 3 | 3 | 3 | |
| "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 | 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 | 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. | 3 | 3 | 3 | 3 | |
| FRICION-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 | 2 | 2 | |
| 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. | 3 | 3 | 3 | 3 | |
| 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. | 3 | 3 | 3 | 3 | |
| TOTAL SCORE | | | | | 18 | 18 | 18 | 18 | |
| Evaluator's Name | | | | | ② | ② | ② | ② | |

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

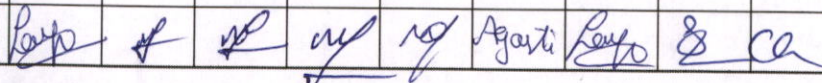
| Risk Score | Category | Action | Support Surfaces
(Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice) |
|-------------|---------------|--|--|
| 15-18 | At Risk | <ul style="list-style-type: none"> • Regular Turning 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 |

Baby Of SIRMALLE RAJITHA
27-08-2026 0 Y 0 M 4 D
Dr. NALINIKANTA PANIGRAHY (M)

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

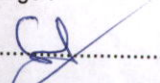
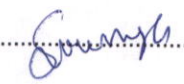
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Your Right to a Safe Delivery

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 | 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 cordpyrexia | Advanced stage of
thrombophlebitis /
Initiate treatment Re site
Cannula | 5 | - | - | - | - | - | - | - | - | | |
| Signature of the Nurse | | | |  | | | | | | | | | |

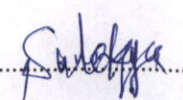
NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature :  Name : 

Docu. No. : RCHBH / FRM / CLINICAL / 137

Signature of Ward In Charge :

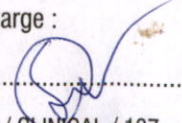
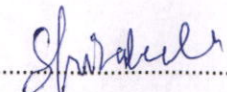
Signature :  Name : 

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 | 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 | * | - | 0 | - | - | - | - | - | - | changed |
| 3 | Two of the following Signs are evident:
Pain at IV site Redness | Early stage of phlebitis /
Resite Cannula | 2 | - | - | - | - | - | - | - | - | - | New cannula |
| 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 cordpyrexia | Advanced stage of
thrombophlebitis /
Initiate treatment Re site
Cannula | 5 | - | - | - | - | - | - | - | - | - | |
| Signature of the Nurse | | | | Car | Car | | De | De | | De | De | | |

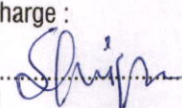
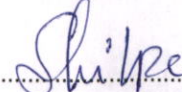
NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature :  Name : 

Docu. No. : RCHBH / FRM / CLINICAL / 137

Signature of Ward In Charge :

Signature :  Name : 



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 | 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 cordpyrexia | Advanced stage of
thrombophlebitis /
Initiate treatment Re site
Cannula | 5 | - | - | - | - | - | - | - | - | | |
| Signature of the Nurse | | | | <i>[Signature]</i> | <i>[Signature]</i> | <i>[Signature]</i> | <i>[Signature]</i> | <i>[Signature]</i> | <i>[Signature]</i> | <i>[Signature]</i> | <i>[Signature]</i> | | |

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 : *[Signature]* Name : *[Signature]*

Signature of Ward In Charge :

Signature : *[Signature]* Name : *[Signature]*

BAH-00660193 IP5-00175741
 Baby Of SIRMALLE RAJITHA
 27-06-2026 0 Y 0 M 2 D (M)
 Dr. NALINIKANTA PANIGRAHY



THE HUMPTY DUMPTY SCALE

| PARAMETER | CRITERIA | SCORE | DATE | DATE | DATE | DATE | DATE |
|---|---|-------|------|------|------|------|------|
| Age | Less than 3 years old | 4 | 29/6 | 30/6 | 30/6 | 1/6 | 2/6 |
| | 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 | 2 | 2 | 2 |
| | Female | 1 | | | | | |
| Diagnosis | Neurological Diagnosis | 4 | | | | | |
| | Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.) | 3 | 3 | 3 | 3 | 3 | 3 |
| | Psych / Behavioral Disorders | 2 | | | | | |
| | Other Diagnosis | 1 | | | | | |
| Cognitive Impairments | Not Aware of Limitations | 3 | | 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 | | | | | |
| | Patient Placed in Bed | 2 | 2 | 2 | 2 | 2 | 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 | 1 | 1 | 2 |
| Medication Usage | Sedatives (excluding ICU patients sedated and paralyzed) | 3 | 3 | | | | |
| | Hypnotics | 3 | | | | | |
| | Barbiturates | 3 | | | | | |
| | Phenothiazines | 3 | | | | | |
| | Antidepressants | 3 | | | | | |
| | Laxatives / Diuretics | 3 | | | | | |
| | Narcotics | 3 | 3 | | | | |
| | One of the Meds listed above | 2 | | | | | |
| | Other Medications / None | 1 | 1 | 1 | 1 | 1 | 1 |
| TOTAL | | | 24 | 17 | 1 | 12 | 12 |

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

| | | | | | | |
|-------------------------------|--|-------------|-------------|-------------|-------------|-------------|
| Bed in low position | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Call device within reach | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Wheels Locked | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Room free of clutter | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Adequate Lighting | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Wheel Chair Support | | X | X | X | X | X |
| Other Intervention(s) Specify | | X | X | X | X | X |
| Nurse's Name : | | Phonal | Seegha | Phonal | Quib | Quib |
| Signature : | | [Signature] | [Signature] | [Signature] | [Signature] | [Signature] |
| Date : | | 29/6 | 30/6 | 30/6 | 1/6/2 | 2/6/2 |
| Time : | | 9pm | 10am | 11am | 8pm | 8pm |

BAH-00660193 IP5-00175741
 Baby Of SRIMALLE RAJITHA
 27-06-2026 0 Y 0 M 4 D (M)
 Dr. NALINIKANTA PANIGRAHY



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 Hospital
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 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

3/7/2026 5/12 5/12 5/12 5/12

| PARAMETER | CRITERIA | SCORE | DATE | DATE | DATE | DATE | DATE |
|---|--|-------|------|------|------|------|------|
| Age | Less than 3 years old | 4 | 4 | 4 | 4 | 4 | 4 |
| | 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 | 2 | 2 | 2 |
| | Female | 1 | | | | | |
| Diagnosis | Neurological Diagnosis | 4 | | | | | |
| | Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc. | 3 | 3 | 3 | 3 | 3 | 3 |
| | Psych / Behavioral Disorders | 2 | | | | | |
| | Other Diagnosis | 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 | | | | | |
| | Patient Placed in Bed | 2 | 2 | 2 | 2 | 2 | 2 |
| | Outpatient Area | 1 | | | | | |
| Response to Surgery / Sedation Anesthesia | Within 24 hours | 3 | | | | | |
| | Within 48 hours | 2 | 2 | 2 | 2 | 2 | |
| | More than 48 hours / None | 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 | | | 12 | 12 | 12 | 12 | 12 |

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

| | | | | | | |
|-------------------------------|--|----------------------------|---|---|-----|---|
| Bed in low position | | X | / | / | Yes | ✓ |
| Call device within reach | | / | / | / | Yes | ✓ |
| Wheels Locked | | / | / | / | Yes | ✓ |
| Room free of clutter | | / | / | / | Yes | ✓ |
| Adequate Lighting | | / | / | / | Yes | ✓ |
| Wheel Chair Support | | X | X | X | No | X |
| Other Intervention(s) Specify | | X | X | X | No | X |
| Nurse's Name : | | [Signature] | | | | |
| Signature : | | [Signature] | | | | |
| Date : | | 3/6/26 3/7 5/7 5/2 5/12/26 | | | | |
| Time : | | 8 PM 8 PM 8 PM 8 PM 8 PM | | | | |



THE HUMPTY DUMPTY SCALE

6/7 7/7 7/7 7/7 8/7

| PARAMETER | CRITERIA | SCORE | DATE | DATE | DATE | DATE | DATE |
|---|--|-------|------|------|------|------|------|
| Age | Less than 3 years old | 4 | 4 | 4 | 4 | 4 | 4 |
| | 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 | 2 | 2 | 2 |
| | Female | 1 | | | | | |
| Diagnosis | Neurological Diagnosis | 4 | | | | | |
| | Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc. | 3 | 3 | 3 | 3 | 3 | 3 |
| | Psych / Behavioral Disorders | 2 | | | | | |
| | Other Diagnosis | 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 | | | | | |
| | Patient Placed in Bed | 2 | 2 | 2 | 2 | 2 | 2 |
| | Outpatient Area | 1 | | | | | |
| Response to Surgery / Sedation Anesthesia | Within 24 hours | 3 | | | | | |
| | Within 48 hours | 2 | 2 | | | | |
| | More than 48 hours / None | 1 | 1 | 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 | | | 12 | 15 | 17 | 17 | 17 |

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

| | | | | | | |
|-------------------------------|--|-------------|-------------|-------------|-------------|-------------|
| Bed in low position | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Call device within reach | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Wheels Locked | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Room free of clutter | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Adequate Lighting | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Wheel Chair Support | | x | x | x | x | x |
| Other Intervention(s) Specify | | x | x | x | x | x |
| Nurse's Name : | | Lokang | Lokang | Suchitra | Akash | Suchitra |
| Signature : | | [Signature] | [Signature] | [Signature] | [Signature] | [Signature] |
| Date : | | 6/7/26 | 7/7/26 | 7/7/26 | 7/7/26 | 8/7/26 |
| Time : | | 6pm | 8AM | 2pm | 8pm | 8AM |



THE HUMPTY DUMPTY SCALE

8/7/26 9:17 9/7

| PARAMETER | CRITERIA | SCORE | DATE | DATE | DATE | DATE | DATE |
|---|--|-------|------|------|------|------|------|
| Age | Less than 3 years old | 4 | 4 | 4 | 4 | | |
| | 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 | 2 | | |
| | Female | 1 | | | | | |
| Diagnosis | Neurological Diagnosis | 4 | | | | | |
| | Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc. | 3 | 3 | 3 | 3 | | |
| | Psych / Behavioral Disorders | 2 | | | | | |
| | Other Diagnosis | 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 | | |
| Environmental Factors | Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room) | 3 | | | | | |
| | Patient Placed in Bed | 2 | 2 | 2 | 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 | 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 | | |
| TOTAL | | | 14 | 12 | 12 | | |

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

| | | | | | | |
|-------------------------------|--|-------------|-------------|-------------|--|--|
| Bed in low position | | ✓ | ✓ | ✓ | | |
| Call device within reach | | ✓ | ✓ | ✓ | | |
| Wheels Locked | | ✓ | ✓ | ✓ | | |
| Room free of clutter | | ✓ | ✓ | ✓ | | |
| Adequate Lighting | | x | x | x | | |
| Wheel Chair Support | | x | x | x | | |
| Other Intervention(s) Specify | | x | x | x | | |
| Nurse's Name : | | AKASH | ajay | num | | |
| Signature : | | (Signature) | (Signature) | (Signature) | | |
| Date : | | 8/7/26 | 8/7/26 | 8/7 | | |
| Time : | | 8 PM | 8 PM | 10 PM | | |





(1)

PROBS AND POSITIONS CHART

| Date | Temp. Probe | SpO ₂ Probe | Positioning | Mouth Care | Eye Care | RBS | Nebulization | Feeding | Medication | Nurse sign |
|-----------------|--------------|------------------------|-------------|------------|------------|---------------|--------------|---------|------------|--------------|
| | 6th Hourly | 6th Hourly | 3rd Hourly | 3rd Hourly | 3rd Hourly | | | | | |
| 20/6/26
10pm | Lt
Abd | Rt
hand | supine | Apikn | Apikn | 6th
hourly | Nil | Apikn | Apikn | 20/6/26
B |
| 20/6/26
8Am | Lt
Abd | Rt
leg | supine | Apikn | Apikn | 6th
hourly | Nil | Apikn | - | 20/6/26
B |
| 20/6/26
6Am | Rt
Abd | Rt
hand | supine | Apikn | Apikn | 6th
hourly | Nil | Apikn | Apikn | 20/6/26
B |
| 30/6/26
9am | Right
abd | Right
hand | Supine | gives | gives | BD | Nil | gives | gives | 30/6/26
L |
| 30/6/26
3pm | Right
abd | Right
hand | Supine | gives | gives | BD | Nil | gives | gives | 30/6/26
P |
| 30/6/26
7pm | Right
abd | Right
hand | Supine | gives | gives | BD | Nil | gives | gives | 30/6/26
S |

BAH-00660193

IP5-00175741

Baby of SIRIMALLE RAJITHA

27-06-2026 0 Y 0 M 2 D (M)

Dr. NALINIKANTA PANIGRAHY



PROBS AND POSITIONS CHART

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

| Date | Temp. Probe | SpO ₂ Probe | Positioning | Mouth Care | Eye Care | RBS | Nebulization | Feeding | Medication | Nurse sign |
|-----------------|-------------|------------------------|-------------|------------|------------|-----|--------------|---------|------------|------------|
| | 6th Hourly | 6th Hourly | 3rd Hourly | 3rd Hourly | 3rd Hourly | | | | | |
| 30/6/26
10pm | Rt
Abd | Rt
leg | Supine | Nil | Nil | BD | Nil | Nil | Nil | B |
| 1/7/26
2AM | Lt
Abd | Lt
leg | supine | Nil | Nil | BD | Nil | Nil | - | B |
| 1/7/26
6AM | Lt
Abd | Rt
Hand | supine | Nil | Nil | BD | Nil | Nil | Nil | B |
| 1/7/26 | Rt
Abd | Rt
leg | Sup | Nil | Nil | BD | Nil | Nil | Nil | B |
| 1/7/26 | Rt
Abd | left
leg | Sup | Nil | Nil | BD | Nil | Nil | Nil | B |
| | | | | | | | | | | |



1

VENTILATOR CARE BUNDLE CHECK LIST

Date of Intubation:

No of Days on Ventilation:

Date of Tracheostomy:

| Parameters | Date | Shift Time | | | | | | |
|---|---------|------------|--|---------|---------|--|---------|---------|
| Ready for Extubation today?
(Discuss during the clinical round) | 29/6/26 | 8pm-8pm | ☐ Yes ☒ No | 30/6/26 | 8pm-8pm | ☐ Yes ☒ No | 30/6/26 | 8pm-8pm |
| Is Sedation holiday discussed?
(Discuss during the clinical round) | | | ☐ Yes ☒ No | | | ☐ Yes ☒ No | | |
| Is Ventilator Circuit visibly soiled?
(If Yes - Please Change) | | | ☐ Yes ☒ No | | | ☐ Yes ☒ No | | |
| Is Suction container visibly Soiled?
(If Yes - Please Change) | | | ☐ Yes ☒ No | | | ☐ Yes ☒ No | | |
| Inline Suction Used? | | | ☐ Yes ☒ No | | | ☐ Yes ☒ No | | |
| Is AMBU bag soiled?
(If Yes - Please Change) | | | ☐ Yes ☒ No | | | ☐ Yes ☒ No | | |
| Check AMBU bag kept in a clean, Non-Sealed plastic bag?
(If No - please change) | | | ☒ Yes ☐ No | | | ☒ Yes ☐ No | | |
| Is there condensate in the ventilatory circuit?
(If Yes - drain away from the patient) | | | ☐ Yes ☒ No | | | ☐ Yes ☒ No | | |
| Is Head End elevated by 15°-30° (for neonates 10°-15°)?
(If No - please change) | | | ☒ Yes ☐ No | | | ☒ Yes ☐ No | | |
| Oral and Nasal Care every 4 Hrs | | | ☒ Yes ☐ No | | | ☒ Yes ☐ No | | |
| Mouth Care with EBM (Only for Neonatal Patient) | | | ☐ Yes ☐ No ☐ NA | | | ☐ Yes ☐ No ☐ NA | | |
| Is ET / Oral Suction needed (2nd hrly) | | | ☐ Yes ☒ No | | | ☐ Yes ☒ No | | |
| Sterile Suctioning Done | | | ☒ Yes ☐ No | | | ☒ Yes ☐ No | | |
| DVT Prophylaxis | | | ☐ Yes ☒ No | | | ☐ Yes ☒ No | | |
| Name of the Nurse | | | Bharathi | Digeshi | | Bharathi | Dewesh | |
| Signature of the Nurse | | | B | D | | B | D | |

RECOMMENDATIONS

Investigations Procedures

| Date : | 29/6 | 29/6/26 | 30/6/26 | 30/6/26 | 1/7/26 | 1/7/26 |
|---|-------------|---------------------|---------------------|------------------|--------------|------------|
| Area | N1 | N1 | N1 | N3 | N3 | N3 |
| Shift Time | 8pm-8pm | 8pm-8pm | 8pm-8pm | 8pm-8pm | 8pm-8pm | 8pm-8pm |
| Ordered / Planned | CBG
RBS | blood
gas
RBS | blood
gas
RBS | blood
gas | blood
gas | RBS
CBG |
| Due | Nil | NA | NA | NA | NA | NA |
| Reports Pending | blood
CS | blood
culture | blood
CS | blood
culture | blood
CS | NA |
| Referrals (If any) | NA | NA | NA | NA | NA | NA |
| Remarks
(Special Interventions like, Drainage
Tube flushing etc.) | NA | NA | NA | NA | NA | NA |
| Handed Over By Name : | Dipeshwar | Bharonath | Dipeshwar | Bharonath | Dipeshwar | Agarwal |
| Signature : | | | | | | |
| Date : | 29/6/26 | 30/6/26 | 30/6/26 | 1/7/26 | 1/7/26 | 2/7/26 |
| Time : | 8pm | 8pm | 8pm | 8pm | 8pm | 8pm |
| Taken Over By Name : | Bharonath | Dipeshwar | Bharonath | Dipeshwar | Agarwal | Dipeshwar |
| Signature : | | | | | | |
| Date : | 29/6/26 | 30/6/26 | 30/6/26 | 1/7/26 | 1/7/26 | 2/7/26 |
| Time : | 8pm | 8pm | 8pm | 8pm | 8pm | 8pm |

2

NURSE HAND OFF COMMUNICATION - ICU

| SITUATION & BACKGROUND | | DOA : 28/7/26 | | Diagnosis : Gen / RDIPPHN | | Surgery / Procedures : | | | | |
|---|-------|--------------------------|---------|---------------------------|-----------|------------------------|-----------|---------|-----------|-----------|
| | | Allergies : | | Post OP Day : | | | | | | |
| Date : | | 2/7/26 | 3/7/26 | 4/7/26 | 5/7/26 | 6/7/26 | 7/7/26 | | | |
| Area | | N3 | N3 | N3 | N3 | N3 | N3 | | | |
| Shift Time | | 8PM-8AM | 8AM-2PM | 2PM-9PM | 9PM-8AM | 8AM-8PM | 8PM-8AM | | | |
| Diet : | | GBM | EBM | EBM | GBM | EBM | EBM | | | |
| Ventilation (RA, NP, NIV, VENTI) | | ON | OG-1 | OG-1 | OG-1 | OG-1 | OG-1 | | | |
| INVASIVE LINES | | 1. | IV-1 | IV-1 | IV-1 | IV-1 | IV-1 | | | |
| | | 2. | | | | | | | | |
| | | 3. | | | | | | | | |
| | | 4. | | | | | | | | |
| ASSESSMENT | | Infusions / Transfusions | | NA | | NA | | | | |
| | | | | NA | | NA | | | | |
| | | | | NA | | NA | | | | |
| | | | | NA | | NA | | | | |
| | | PU Prophylaxis | | NA | | NA | | | | |
| | | DVT Prophylaxis | | NA | | NA | | | | |
| | | Vitals | | BP | 69/45(53) | 67/35(45) | 72/39(51) | 74/40 | 62/25(31) | 75/45(65) |
| | | | | PR | 154 | 140 b/m | 145 b/m | 163 b/m | 132 b/m | 138 b/m |
| | | | | RR | 29 | 59 b/m | 33 b/m | 64 b/m | 31 b/m | 64 b/m |
| | | | | SpO ₂ | 94% | 95% | 99% | 95% | 95% | 96% |
| Temp | 36.6C | | | 36.2C | 36.9C | 36 | 36.6C | 36.3C | | |
| Pain Score | | 1/10 | | 1/10 | | 1/10 | | | | |
| LOC (Alert, Conscious, Confusion, Unconscious) | | Alert | | Alert | | Alert | | | | |
| Skin Integrity (Intact / Bedsore / Any other condition) | | Intact | | Intact | | Intact | | | | |
| Restraints If any | | NA | | NA | | NA | | | | |
| Fall Risk (Vulnerable (Y/N) if yes score) | | Yes | | Yes | | Yes | | | | |
| (Ambulation, walking, moving with assistance, bed ridden) | | moving | | moving | | moving | | | | |
| ADL (Dependent / Non-Dependent) | | Dependent | | Dependent | | Dependent | | | | |
| Critical Lab Test / Values (if any) | | NA | | NA | | NA | | | | |

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

| | | | | | | | | |
|----------------------|---------------------------|---|-------------------|---------|---------|--------|---------------|---------|
| RECOMMENDATIONS | Investigations Procedures | Date : | 3/7/26 | 3/7/26 | 3/7/26 | 3/7/26 | 4/7/26 | 4/7/26 |
| | | Area | N3 | N3 | N3 | N3 | N3 | N3 |
| | | Shift Time | 8pm-8pm | 6am-2pm | 2pm-8pm | | 2am-7pm | 8pm-8pm |
| | | Ordered / Planned | RBS-OD
Case no | RBS-OD | RBS-OD | Q | RBS
RBS/OD | |
| | | Due | NA | NA | Nil | NA | NA | NA |
| | | Reports Pending | | NA | Nil | NA | NA | NA |
| | | Referrals (If any) | | NA | Nil | | | |
| | | Remarks
(Special Interventions like, Drainage
Tube flushing etc.) | NA | NA | Nil | NA | NA | NA |
| | | Handed Over By Name : | Agasti | Lorany | Lorany | Agasti | naresh | Agasti |
| | | Signature : | Agasti | Lorany | Lorany | Agasti | naresh | Agasti |
| Date : | 3/7/26 | 3/7/26 | 3/7/26 | 4/7/26 | 4/7/26 | 5/7/26 | | |
| Time : | 8am | @2pm | @8pm | 8pm | 2pm | 8am | | |
| Taken Over By Name : | Lorany | Lorany | Agasti | naresh | Agasti | Lorany | | |
| Signature : | Lorany | Lorany | Agasti | naresh | Agasti | Lorany | | |
| Date : | 3/7/26 | 3/7/26 | 3/7/26 | 4/7/26 | 4/7/26 | 5/7/26 | | |
| Time : | @8am | @2pm | 8pm | @2am | 8pm | @8am | | |

Patie



NURSE HAND OFF COMMUNICATION - ICU

| SITUATION & BACKGROUND | | DOA : 29/6/26 | | Diagnosis : PPHN / sepsis | | Surgery / Procedures : NA | | |
|---|--|------------------|-----------|---------------------------|-----------|---------------------------|-----------|-----------|
| | | Allergies : NA | | Post OP Day : NA | | | | |
| Date : | Area | Shift Time | | Shift Time | | Shift Time | | |
| | | 5/7/26 | 5/7/26 | 5/7/26 | 6/7/26 | 6/7/26 | 7/7/26 | |
| Diet : | | EBM | EBM | EBM | EBM | EBM | EBM | |
| Ventilation (RA, NP, NIV, VENTI) | | CPAP | CPAP | LIF | LIF | LIF | LIF | |
| 1. | | OG-① | OG-① | OG-① | OG-① | OG-① | OG-① | |
| 2. | | IV-① | IV-① | IV-① | IV-① | IV-① | IV-① | |
| 3. | | | | | | | | |
| 4. | | | | | | | | |
| ASSESSMENT | Infusions / Transfusions | NA | NA | NA | NA | NA | NA | |
| | PU Prophylaxis | NA | NA | NA | NA | NA | NA | |
| | DVT Prophylaxis | NA | NA | NA | NA | NA | NA | |
| | Vitals | BP | 75/45(55) | 91/71(38) | 76/40(40) | 68/41(50) | 64/41(49) | 58/41(48) |
| | | PR | 145b/m | 149 | 143b/m | 167b/m | 147b/m | 142b/m |
| | | RR | 37b/m | 63b/m | 22b/m | 25b/m | 21 | 57b/m |
| | | SpO ₂ | 98% | 100% | 95% | 98% | 98% | 94% |
| | | Temp | 36.2°C | 36.2°C | 36.4°C | 36.5°C | 36.6°C | 36.5°C |
| | Pain Score | 1/10 | 1/10 | +2/10 | +2/10 | 1/10 | 1/10 | |
| | LOC (Alert, Conscious, Confusion, Unconscious) | Alert | Alert | Alert | Alert | Alert | Alert | |
| Skin Integrity (Intact / Bedsore / Any other condition) | Intact | Intact | Intact | Intact | Intact | Intact | | |
| Restraints If any | NA | NA | NA | NA | NA | NA | | |
| Fall Risk (Vulnerable (Y/N) if yes score) | Yes | Yes | Yes | Yes | Yes | Yes | | |
| (Ambulation, walking, moving with assistance, bed ridden) | Moving | Moving | Moving | Moving | Moving | Moving | | |
| ADL (Dependent / Non-Dependent) | Dependent | Dependent | Dependent | Dependent | Dependent | Dependent | | |
| Critical Lab Test / Values (if any) | NA | NA | NA | NA | NA | NA | | |

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

| RECOMMENDATIONS | Investigations Procedures | Date : | 5/7/26 | 5/7/20 | 5/7/26 | 6/7/26 | 6/7/26 | 7/7/26 |
|--|---------------------------|-------------------|----------|----------|---------|---------|----------|---------|
| | | Area | N3 | N3 | N3 | N3 | N3 | N3 |
| | | Shift Time | 8Am-2pm | 2pm-8pm | 8pm-8am | 8pm-8am | 8pm-8am | 8am-2pm |
| | | Ordered / Planned | RBS-OD | | RBS-OD | RBS-OD | RBS-OD | 2BS-OD |
| | | | Gas-OD | | Gas-OD | Gas-OD | Gas-OD | |
| | | | | | | | | |
| | | Due | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | Reports Pending | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Referrals (If any) | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Remarks
(Special Interventions like, Drainage Tube flushing etc.) | | NA | NA | NA | NA | NA | NA | |
| Handed Over By Name : | | Lakanya | Alphons | Chandana | Lokanya | Agasti | Lakanya | |
| Signature : | | | | | | | | |
| Date : | | 5/7/26 | 5/7/26 | 6/7/26 | 6/7/26 | 7/7/26 | 7/7/26 | |
| Time : | | @2pm | 8pm | @8am | 8pm | 8Am | 8Am | |
| Taken Over By Name : | | Alphoryn | Chandana | Lokanya | Agasti | | Suchitaa | |
| Signature : | | | | | | | | |
| Date : | | 5/7/26 | 5/7/26 | 6/7/26 | 6/7/26 | | 7/7/26 | |
| Time : | | 2pm | @8pm | 8pm | 8pm | | 2Pm | |

NURSE HAND OFF COMMUNICATION - ICU

| | | | |
|------------------------|---|---------------------------|---------------------------|
| SITUATION & BACKGROUND | DOA : 29/6/26 | Diagnosis : PPHN / SCPSIS | Surgery / Procedures : NA |
| | Allergies : NA | Post OP Day : NA | |
| | Date : | 7/7/26 | 7/7/26 |
| | Area | N3 | N3 |
| | Shift Time | 2Pm-8Pm | 8Pm-8am |
| INVASIVE LINES | Diet : | EBM | EBM |
| | Ventilation (RA, NP, NIV, VENTI) | | |
| | 1. | | |
| | 2. | RA | NA |
| | 3. | | |
| ASSESSMENT | 4. | | |
| | Infusions / Transfusions | NA | NA |
| | PU Prophylaxis | NA | NA |
| | DVT Prophylaxis | NA | NA |
| | BP | 67/36(46) | 66/37(47) |
| | PR | 145b/m | 142b/m |
| | RR | 62b/m | 62b/m |
| | SpO ₂ | 95% | 95% |
| | Temp | 36.5°C | 36.5°C |
| | Pain Score | 1/10 | 1/10 |
| | LOC (Alert, Conscious, Confusion, Unconscious) | Alert | Alert |
| | Skin Integrity (Intact / Bedsore / Any other condition) | Intact | Intact |
| | Restraints If any | NA | NA |
| | Fall Risk (Vulnerable (Y/N) if yes score) | Yes | Yes |
| | ADL (Dependent / Non-Dependent) | Dependent | Dependent |
| | Critical Lab Test / Values (if any) | NA | NA |

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

| | | Date : | 7/7/26 | 7/7/26 | 8/7/26 | 8/7/26 | 9/10/26 |
|-----------------|---------------------------|--|----------|----------|----------|---------|---------|
| | | Area | N3 | N3 | N3 | N3 | N3 |
| | | Shift Time | 2pm-8pm | 8pm-8am | 8pm-8am | 8pm-8am | 8pm-8am |
| RECOMMENDATIONS | Investigations Procedures | Ordered / Planned | RBS-OD | RBS-OD | RBS-OD | RBS-OD | RBS-OD |
| | | Due | NA | NA | NA | NA | NA |
| | | Reports Pending | NA | NA | NA | NA | NA |
| | | Referrals (If any) | NA | NA | NA | NA | NA |
| | | Remarks
(Special Interventions like, Drainage Tube flushing etc.) | NA | NA | NA | NA | NA |
| | Handed Over By Name : | | Suchitra | Akansha | Suchitra | Akansha | Ajay |
| | Signature : | | @ | @ | @ | @ | @ |
| | Date : | | 7/7/26 | 8/7/26 | 8/7/26 | 8/7/26 | 9/10/26 |
| | Time : | | 8pm | @ 8am | @ 8pm | @ 8pm | 8pm |
| | Taken Over By Name : | | Akansha | Suchitra | Akansha | | |
| Signature : | | @ | @ | @ | @ | @ | |
| Date : | | 7/7/26 | 8/7/26 | 8/7/26 | 9/10/26 | | |
| Time : | | @ 8pm | @ 8am | @ 8pm | 8pm | | |

INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: B+ve Baby's Blood Group: O+ve Sheet No: (1)
 Gest Age: 37+6 weeks Birth Weight: 3 kg

| | | |
|--|---|---|
| Date: <u>30/6/26</u> | Date: <u>1/7/26</u> | Date: <u>9/7/26</u> |
| DOL <u>+ Day-3</u>
Weight <u>+ 3 kg</u> | DOL <u>+ Day-4</u>
Weight <u>+</u> | DOL <u>DS</u>
Weight <u>3.015 kg 15 gms</u> |
| Problems: <u>+ PPHN / sepsis</u> | Problems: <u>+ PPHN / sepsis</u> | Problems: <u>PPH / supps</u> |
| Rs. <u>+ 30-60 b/m</u>
Exam <u>+ Done</u>
Vent. Setting <u>+ Vent + 1 NO</u>
ABG <u>] Done</u>
CXR <u>] Done</u> | Rs. <u>+ 30-60 b/m</u>
Exam <u>+ Done</u>
Vent. Setting <u>+ Vent</u>
ABG <u>] Done</u>
CXR <u>] Done</u> | Rs. <u>30-60 b/m</u>
Exam <u>Done</u>
Vent. Setting <u>NIV</u>
ABG <u>] Done</u>
CXR <u>] Done</u> |
| CVS <u>+ Normal</u>
HR <u>+ 120-160 b/m</u>
BP <u>Map</u>
Cap Refil <u>+ 2-3 sec</u> | CVS <u>+ Normal</u>
HR <u>+ 120-160</u>
BP <u>Map</u>
Cap Refil <u>+ 2-3 sec</u> | CVS <u>Normal</u>
HR <u>120-160 b/m</u>
BP <u>Map</u>
Cap Refil <u>2-3 sec</u> |
| F/E/N <u>+ 60 cc/kg/day</u>
T. Fluids <u>+ 134.6 ml</u>
CC/kg/day <u>+ 44.8 cc/kg</u>
I/O/RBS: <u>+ 92 mg/dl</u>
U Output: <u>+ 109 (CC/kg/hr) + 2.1 cc/kg</u>
Exam <u>+ Done</u>
T. Bil/D <u>1.0</u>
Na <u>140</u> Hc03
K <u>5</u> BUN
Cl <u>112</u> Crea <u>+ 0.7</u>
Hemat HB: <u>+ 14.6</u>
WCC <u>+ 12.53</u>
Plats <u>+ 271</u>
Transfusion | F/E/N <u>+ 80 cc/kg/day</u>
T. Fluids <u>+ 244.8 ml</u>
CC/kg/day <u>+ 81 cc/kg/day</u>
I/O/RBS: <u>+ 98 mg/dl</u>
U Output: <u>+ 1.4 cc/kg</u>
Exam <u>+ Done</u>
T. Bil/D <u>1.0</u>
Na <u>140</u> Hc03
K <u>5</u> BUN
Cl <u>112</u> Crea <u>0.7</u>
Hemat HB: <u>+ 14.6</u>
WCC <u>+ 12.83</u>
Plats <u>+ 271</u>
Transfusion | F/E/N <u>100</u>
T. Fluids <u>244.8 ml</u>
CC/kg/day <u>100 cc/kg/day</u>
I/O/RBS: <u>162 mg</u>
U Output: <u>(CC/kg/hr)</u>
Exam <u>Done</u>
T. Bil/D
Na Hc03
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion |
| C/s Results
CRP <u>+ 29 -29/6</u>
Antibiotics <u>+ Moxopram</u> | C/s Results <u>+</u>
CRP <u>+ 29 -29/6</u>
Antibiotics <u>+ Moxopram</u> | C/s Results
CRP
Antibiotics |
| Med <u>+</u>
Neuro: <u>+</u> | Med <u>+</u>
Neuro: | Med
Neuro: |
| Assessment <u>+ Done</u> | Assessment <u>+ Done</u> | Assessment <u>Done</u> |
| Plan <u>+ VBT, RBS</u> | Plan <u>+ VBT, RBS</u> | Plan <u>VBT DS</u> |



INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: B +ve Baby's Blood Group: O +ve Sheet No: (2)
 Gest Age: 37+6 wk Birth Weight: 3.4kg

| | | |
|--|---|--|
| Date: <u>3/7/26</u> | Date: <u>4/7/26</u> | Date: <u>5/7/26</u> |
| DOL <u>D6</u>
Weight <u>3.049 ↑ 34gms</u> | DOL <u>D6</u>
Weight <u>3.035 ↓ 14gms</u> | DOL <u>D6</u> <u>3.020 ↓ 15gms</u> |
| Problems: <u>PPH / Sx</u> | Problems: <u>PPH</u> | Problems: <u>PPH</u> |
| Rs. <u>30-60 blm</u>
Exam <u>Done</u>
Vent. Setting <u>CPAP</u>
ABG
CXR | Rs. <u>30-60 blm</u>
Exam <u>Done</u>
Vent. Setting <u>CPAP</u>
ABG <u>Done</u>
CXR | Rs. <u>30-60 blm</u>
Exam <u>Done</u>
Vent. Setting <u>CPAP</u>
ABG <u>Done</u>
CXR |
| CVS <u>Normal</u>
HR <u>120-160</u>
BP <u>60/45</u> Map <u>(53)</u>
Cap Refil <u>(2-3s)</u> | CVS <u>Normal</u>
HR <u>120-160 blm</u>
BP <u>60/40</u> Map <u>(52)</u>
Cap Refil <u>(2-3s)</u> | CVS <u>Normal</u>
HR <u>120-160</u>
BP <u>71/38</u> Map <u>(49)</u>
Cap Refil <u>(2-3s)</u> |
| F/E/N
T. Fluids
CC/kg/day <u>100CC/kg</u>
I/O/RBS:
U Output: (CC/kg/hr)
Exam <u>Done</u>
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion | F/E/N
T. Fluids
CC/kg/day
I/O/RBS: <u>84blm</u>
U Output: (CC/kg/hr)
Exam <u>Done</u>
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion | F/E/N
T. Fluids
CC/kg/day <u>140CC/kg/day</u>
I/O/RBS:
U Output: (CC/kg/hr)
Exam
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion |
| C/s Results

CRP
Antibiotics | C/s Results

CRP
Antibiotics | C/s Results

CRP
Antibiotics |
| Med

Neuro: <u>INS maromax</u> | Med

Neuro: <u>INS maromax</u> | Med

Neuro: |
| Assessment <u>Done</u> | Assessment <u>Done</u> | Assessment <u>Done</u> |
| Plan <u>RBS</u> | Plan <u>RBS coes</u> | Plan <u>RBS cas</u> |



INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: B+ve Baby's Blood Group: O+ve Sheet No: (3)
Gest Age: 37+6wks Birth Weight: 3.1kg

| | | |
|--|--|--|
| Date: <u>6/7/26</u> | Date: <u>7/7/26</u> | Date: <u>8/7/26</u> |
| DOL <u>D7</u>
Weight <u>2.986 ↓ 34gms</u> | DOL <u>D7</u>
Weight <u>2.970 ↓ 16gms</u> | DOL <u>D8</u>
Weight <u>2.944 ↓ 26gms</u> |
| Problems: <u>PPH</u> | Problems: <u>PPH</u> | Problems: <u>PPH</u> |
| Rs. <u>30-60b/m</u>
Exam <u>done</u>
Vent. Setting <u>LLF</u>
ABG <u>-</u>
CXR <u>NA</u> | Rs. <u>30-60b/m</u>
Exam <u>done</u>
Vent. Setting <u>LIF</u>
ABG <u>-</u>
CXR <u>-</u> | Rs. <u>30-50</u>
Exam <u>done</u>
Vent. Setting <u>RIF</u>
ABG <u>-</u>
CXR <u>-</u> |
| CVS <u>Normal</u>
HR <u>120-160b/m</u>
BP <u>25/42 Map (56)</u>
Cap Refil <u>2-3sec</u> | CVS <u>Normal</u>
HR <u>120-160b/m</u>
BP <u>62/44 Map (52)</u>
Cap Refil <u>2-3sec</u> | CVS <u>Normal</u>
HR <u>120-160b/m</u>
BP <u>64/32 Map (43)</u>
Cap Refil <u>2-3sec</u> |
| F/E/N <u>140cc/kg/day</u>
T. Fluids
CC/kg/day
I/O/RBS:
U Output: (CC/kg/hr)
Exam <u>done</u>
T. Bil/D
Na Hc03
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion | F/E/N <u>140cc/kg/day</u>
T. Fluids
CC/kg/day
I/O/RBS:
U Output: (CC/kg/hr)
Exam <u>done</u>
T. Bil/D
Na Hc03
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion | F/E/N <u>150cc/kg/day</u>
T. Fluids
CC/kg/day
I/O/RBS:
U Output: (CC/kg/hr)
Exam <u>done</u>
T. Bil/D
Na Hc03
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion |
| C/s Results
CRP
Antibiotics | C/s Results
CRP
Antibiotics | C/s Results
CRP
Antibiotics |
| Med
Neuro: | Med
Neuro: | Med
Neuro: |
| Assessment <u>done</u> | Assessment <u>done</u> | Assessment <u>Done</u> |
| Plan <u>RBS-OD</u> | Plan <u>RBS-OD</u> | Plan <u>RBS-OD</u> |



INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: B⁺ve Baby's Blood Group: O⁺ve Sheet No: (4)
Gest Age: 37 + 6 weeks Birth Weight: 3 kg

| | | |
|---|--|--|
| Date: <u>9/7/26</u> | Date: | Date: |
| DOL <u>D9</u>
Weight <u>2.929 ↓ 15 gms</u> | DOL
Weight | DOL
Weight |
| Problems: <u>PPH</u> | Problems: | Problems: |
| Rs. <u>30-60 blm</u>
Exam <u>done</u>
Vent. Setting <u>RA</u>
ABG } <u>NA</u>
CXR } | Rs.
Exam
Vent. Setting
ABG
CXR | Rs.
Exam
Vent. Setting
ABG
CXR |
| CVS <u>Normal</u>
HR <u>120-160 blm</u>
BP <u>8</u> Map
Cap Refil | CVS
HR
BP Map
Cap Refil | CVS
HR
BP Map
Cap Refil |
| F/E/N <u>150 cc/kg/day</u>
T. Fluids
CC/kg/day
I/O/RBS:
U Output: (CC/kg/hr)
Exam <u>Done</u>
T. Bil/D
Na Hc03
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion | F/E/N
T. Fluids
CC/kg/day
I/O/RBS:
U Output: (CC/kg/hr)
Exam
T. Bil/D
Na Hc03
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion | F/E/N
T. Fluids
CC/kg/day
I/O/RBS:
U Output: (CC/kg/hr)
Exam
T. Bil/D
Na Hc03
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion |
| C/s Results
CRP
Antibiotics } <u>NA</u> | C/s Results
CRP
Antibiotics | C/s Results
CRP
Antibiotics |
| Med } <u>calcium Syrup</u>
Neuro: } | Med
Neuro: | Med
Neuro: |
| Assessment <u>Done</u> | Assessment | Assessment |
| Plan <u>RBS OD</u> | Plan | Plan |

BAH-00660193 IP5-00175741
Baby Of SIRIMALLE RAJITHA
27-06-2026 O Y O M 2 D (M)
Dr. NALINIKANTA PANIGRAHY



NEONATAL WEIGHT CHART

NICU:

Month
Date
Day

WEIGHT IN GRAMS

4500
4400
4300
4200
4100
4000
3900
3800
3700
3600
3500
3400
3300
3200
3100
3000
2900
2800
2700
2600
2500
2400
2300
2200
2100
2000
1900
1800
1700
1600
1500
1400
1300
1200
1100
1000
900
800
700

weekly weight gain $\downarrow$ 36gms

HC - 35cm
LC - 40cm

P/c Rajitha

CHECKLIST FOR MAINTAINING CPAP / HFNC / NIV

Date: *11/7/26*

| | CRITERIA MET / NOT MET ☐ Yes ☐ No | | | Comments by Duty Registrar |
|--|---|--------------------|--------------------|----------------------------|
| | Morning | Evening | Night | |
| CIRCUIT and BUBBLER: | | | | |
| Blended Air / Oxygen Gas Supply | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Flow Between 5-7 Litres / Min | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Humidifier Temperature Correct (36.5-37.5°C) | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Humidifier Water Level Correct | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Proper Oxygen Tubing From Blender to Humidifier. | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Tubing Correctly Placed (Position & Leak) | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Excess Fainout (Afferent Tubing) Drained | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Excess Rainout (Efferent Tubing) Drained | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Temperature Probe away from Heat / Cover with Aluminium Foil | <i>+</i> | <i>+</i> | <i>X</i> | |
| Gas Bubbling Continuously | <i>Stebor</i> | <i>slc</i> | | |
| Water Level at Desired Level in Bubble Chamber. | <i>Stebor</i> | <i>slc</i> | | |
| INTERFACE: | | | | |
| Nasal Prong / Mask Correct Size | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Nasal Prong/ Mask Correctly Placed | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Hat Fits Snugly | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Moustache Suitable and Effective | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Nasal Bridge Intact | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Septum Intact | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| POSITION: | | | | |
| Head Position Correct | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Head Roll - Correct Size and Position | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| MONITORING/ SUCTIONING | | | | |
| SpO ₂ Probe Monitoring | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Oro Nasal Suctioning Documentation | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| OG Tube in SITU | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Baby Comfortable | <i>✓</i> | <i>✓</i> | <i>✓</i> | |
| Chest Retractions | <i>med</i> | <i>med</i> | <i>med</i> | |
| Name of the Nurse: | <i>Rajitha</i> | <i>Rajitha</i> | <i>Rajitha</i> | |
| Signature of the Nurse: | <i>[Signature]</i> | <i>[Signature]</i> | <i>[Signature]</i> | |
| Date & Time: | <i>11/7/26</i> | <i>11/7/26</i> | <i>11/7/26</i> | |

*If CPAP is being given through Dragger ventilator then make sure that Flow to be set at 5 litres/min & PIP to be set between 12-15 cm.



CHECKLIST FOR MAINTAINING CPAP / HFNC / NIV

Date: 21/7/26

| | CRITERIA MET / NOT MET ☐ Yes ☐ No | | | Comments by
Duty Registrar |
|--|---|-----------|-------|-------------------------------|
| | Morning | Evening | Night | |
| CIRCUIT and BUBBLER: | | | | |
| Blended Air / Oxygen Gas Supply | ✓ | ✓ | ✓ | |
| Flow Between 5-7 Litres / Min | ✓ | ✓ | ✓ | |
| Humidifier Temperature Correct (36.5-37.5°C) | ✓ | ✓ | ✓ | |
| Humidifier Water Level Correct | ✓ | ✓ | ✓ | |
| Proper Oxygen Tubing From Blender to Humidifier. | ✓ | ✓ | ✓ | |
| Tubing Correctly Placed (Position & Leak) | ✓ | ✓ | ✓ | |
| Excess Fainout (Afferent Tubing) Drained | ✓ | ✓ | ✓ | |
| Excess Rainout (Efferent Tubing) Drained | ✓ | ✓ | ✓ | |
| Temperature Probe away from Heat / Cover with Aluminium Foil | ✗ | ✗ | ✗ | |
| Gas Bubbling Continuously | See below | See below | | |
| Water Level at Desired Level in Bubble Chamber. | See below | See below | | |
| INTERFACE: | | | | |
| Nasal Prong / Mask Correct Size | ✓ | ✓ | ✓ | |
| Nasal Prong/ Mask Correctly Placed | ✓ | ✓ | ✓ | |
| Hat Fits Snugly | ✓ | ✓ | ✓ | |
| Moustache Suitable and Effective | ✓ | ✓ | ✓ | |
| Nasal Bridge Intact | ✓ | ✓ | ✓ | |
| Septum Intact | ✓ | ✓ | ✓ | |
| POSITION: | | | | |
| Head Position Correct | ✓ | ✓ | ✓ | |
| Head Roll - Correct Size and Position | ✓ | ✓ | ✓ | |
| MONITORING/ SUCTIONING | | | | |
| SpO ₂ Probe Monitoring | ✓ | ✓ | ✓ | |
| Oro Nasal Suctioning Documentation | ✓ | ✓ | ✓ | |
| OG Tube in SITU | ✓ | ✓ | | |
| Baby Comfortable | ✓ | ✓ | | |
| Chest Retractions | ✓ | ✓ | | |
| Name of the Nurse: | Daniel | Daniel | | |
| Signature of the Nurse: | De | De | | |
| Date & Time: | 21/7/26 | 21/7/26 | | |

*If CPAP is being given through Dragger ventilator then make sure that: Flow to be set at 5 litres/min & PIP to be set between 12-15 cm.

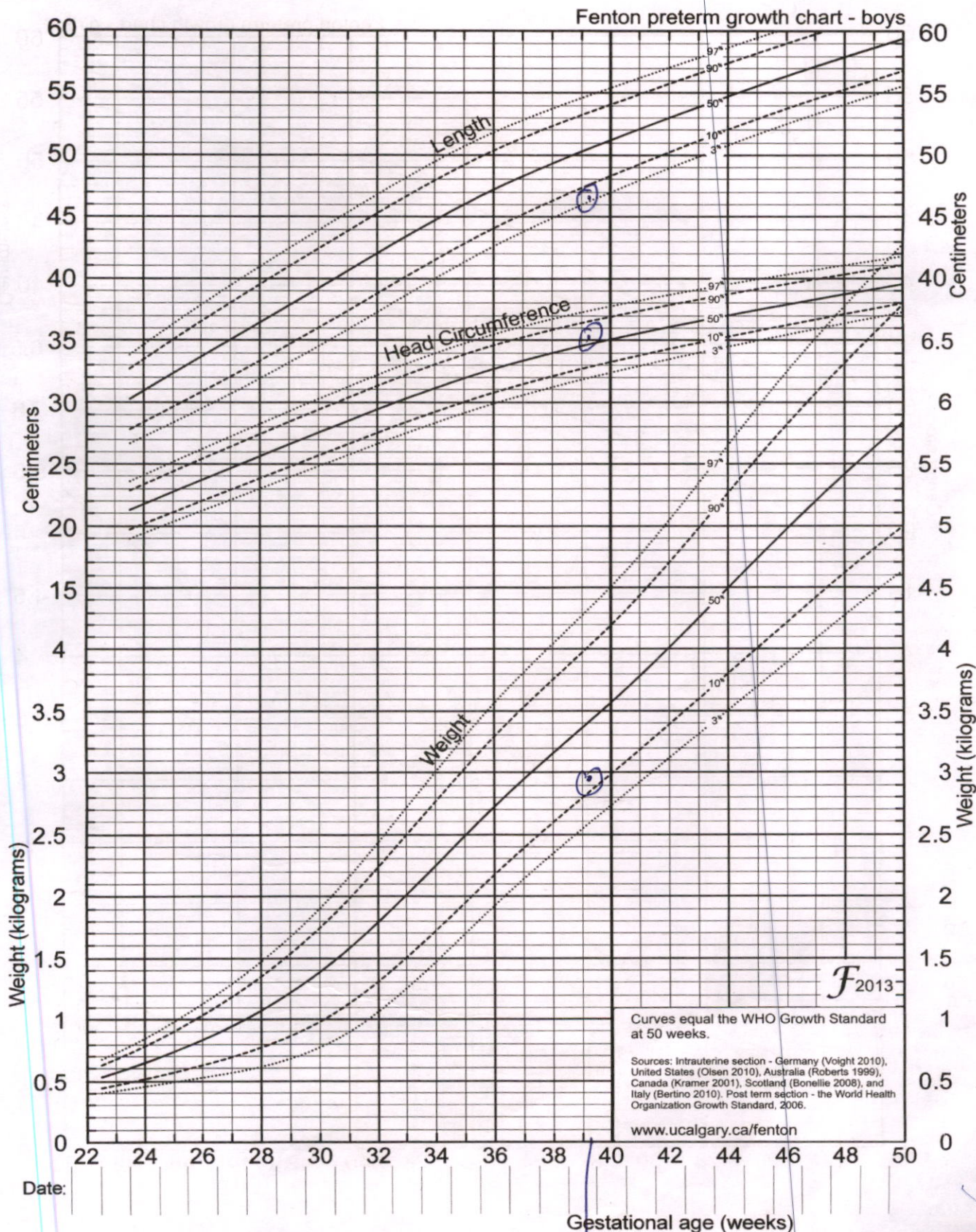


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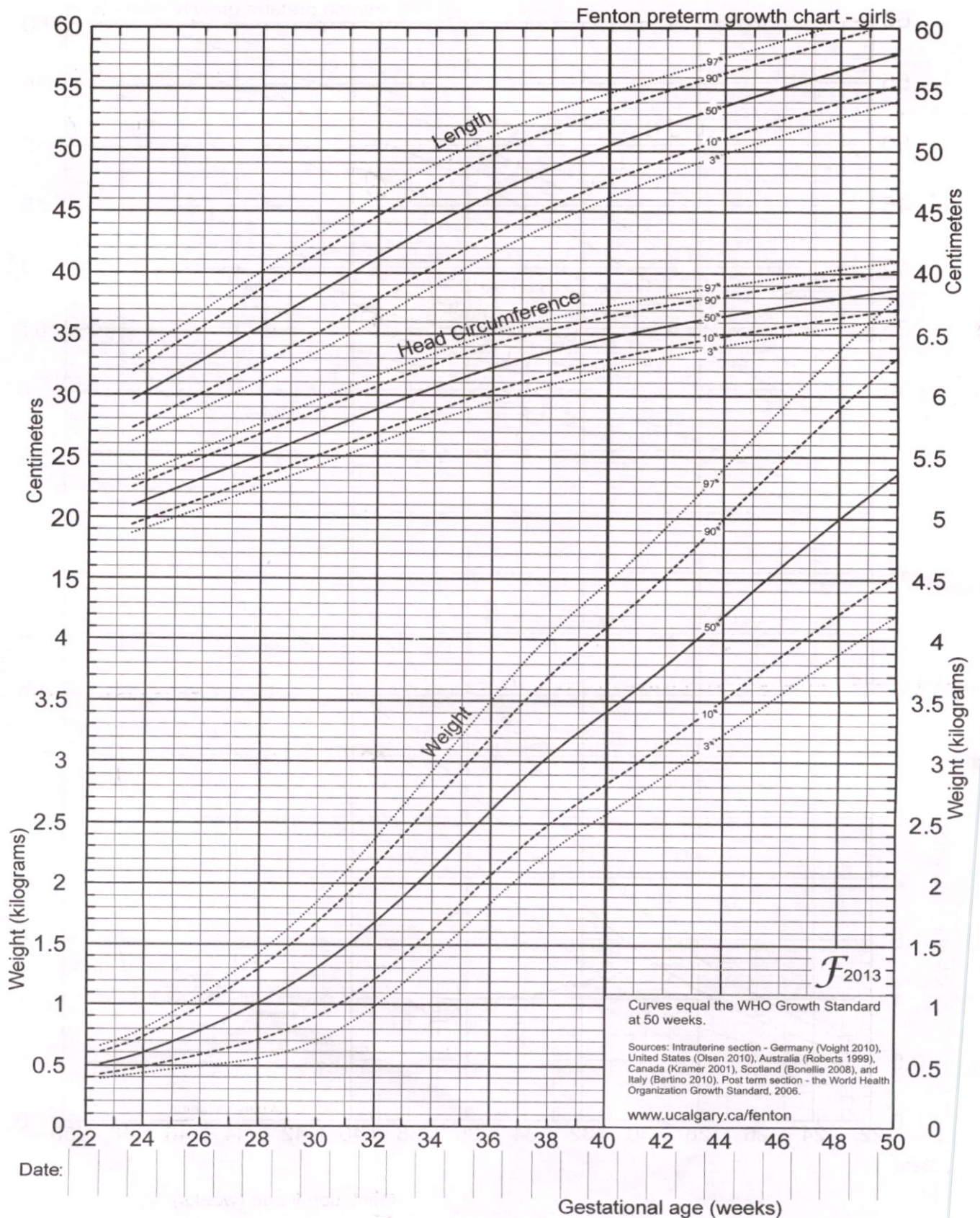
BLOOD COLLECTION CHART - NICU

[illegible]

BAH-00660193 IP5-00175741
 Baby Of SIRMALLE RAJITHA
 27-06-2026 0 Y 0 M 2 D (M)
 Dr. NALINIKANTA PANIGRAHY



36.42
 (30.6 → 10)



| Gestational Age: | | Birth Weight: | |
|------------------|------|---------------------|--------------------------|
| Date | Day | Problem | Treatment |
| 29/6/20 | 29/6 | RD | Surfactant |
| 29/6/20 | | RD | PV mode 100% |
| 30/6/20 | | RD | 100 stopped |
| 1/7/20 | | RD | Extubation to NIV |
| 1/7/20 | | RD | NIV → CPAP |
| 3/7/20 | | RD | CPAP → HFNC |
| 2/7/20 | | Thiamine deficiency | Thiamine supplementation |
| 3/7/20 | | | HFNC → CPAP |
| 5/7/20 | | | CPAP → RM |

Blood Culture:

| S.No | Date | DOL | Specimen | Findings | Antibiotics |
|------|---------|-----|----------|----------|-------------|
| 1) | 22/6/26 | | Blood | NL xlp | Meropenem |
| | | | | | |
| | | | | | |
| | | | | | |

Neurosonogram:

| S.No | Date | DOL | Findings |
|------|---------|-----|----------|
| 1) | 29/6/26 | | (15) |
| | | | |
| | | | |
| | | | |

ROP Screening:

| S.No | Date | DOL | Findings |
|------|------|-----|----------|
| | | | |
| | | | |
| | | | |
| | | | |

2D ECHO:

| S.No | Date | DOL | Findings |
|------|---------|-----|--------------------------------------|
| 1) | 29/6/26 | | Dilate RA/RV, TR, mild-moderate PPHN |
| 2) | | | RVOPHN |
| | | | |
| | | | |

Thyroid Function:

| S.No | Date | DOL | Findings |
|------|------|-----|----------|
| | | | |
| | | | |
| | | | |
| | | | |

Hearing Screening: Date

Results:

- Supplements:
- | | | |
|--------------|------------------|----------------------------|
| 1) Calcium | 2) Multivitamins | 3) HMF |
| 4) Iron | 5) Vitamin D | 6) 3% NaCl |
| 7) Vitamin A | 8) Caffeine | 9) Fluconazole Prophylaxis |





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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]

Docu. No. : RCHBH /FRM / CLINICAL / 171

| RAINBOW HOSPITAL NICU HIC CHECK LIST | | | | | | | | | |
|--------------------------------------|------|------|------|------|------|------|------|-------|----|
| No | Room | Ward | Room | Ward | Milk | Room | Ward | No of | No |

[illegible]

RAINBOW HOSPITAL NICU NIC CHECK LIST

[illegible]



CONSENT FOR SPECIAL PROCEDURES

Patient Name : B/o Rajitha Gender: ☒ Male ☐ Female

UHID No : 660193 Department : New . 4 Date : 29/6/26

I P. Shiva Kumar S/D/W/O

Here by give consent for procedure of : Picc line

For my patient, Named : B/o Rajitha

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

phlebitis, thrombosis, Infections

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

to avoid multiple prick.

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

Name of the Doctor performing the procedure:

Patient Attendant :

Signature : P. Shiva Kumar

Name : P. Shiva Kumar

Relationship with Patient: father

Date & Time : 29/6/26 2PM

Witness :

Signature : [Signature]

Name : Deveshwarai

Date & Time : 29/6/26 2pm

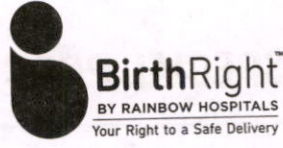
Doctor (who is taking the consent) :

Signature : [Signature]

Name : [Signature]

Date & Time : 29/6/26 2PM

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

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

.....

.....

.....

.....

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

.....

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

.....

సహాయకుడు(అటెండెంట్)

సంతకము పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము తేదీ మరియు సమయము

పేరు

.....

CONSENT FOR SPECIAL PROCEDURES

Patient Name : B/o Rajitha Gender: ☒ Male ☐ Female
UHID No : Department : New - 4 Date : 29/6/26
I S/D/W/O

Here by give consent for procedure of :

For my patient, Named :

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

Serofast administration

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

Benefit - Will improve oxygenation

s/e. Bradycardia, Temporary oxygen Desaturation, ET blockage

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

Name of the Doctor performing the procedure: Dr. Neetha

Patient Attendant :

Signature : p. Ravi

Name : p. Shiva Kumar

Relationship with Patient: Father

Date & Time :

Witness :

Signature : Digeshwar

Name : Digeshwar

Date & Time : 29/6/26

Doctor (who is taking the consent) :

Signature : Dr. Neetha

Name : Dr. Neetha

Date & Time : 29/6/26

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

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

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.....

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

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

CONSENT FOR SPECIAL SEDATION

Patient Name: B/o Rajitha Gender: ☒ Male ☐ Female

UHID No: 660193 Department: Nico-4 Date: 29/6/26

I P. Shwamyar S/D/W/O

Here by give consent for procedure for my patient: B/o Rajitha

The doctors have explained to me in language known to me the details of sedation as follows:

• Type of Sedation: Fentanyl

• Possible complications from the procedure of sedation:

Hypotension, Respiratory depression

The doctors have explained to me about the benefits, risk, alternative of the procedure.

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

Patient Attendant :

Signature: P. Shwamyar

Name: P. Shwamyar Kumar

Relationship with Patient: Father

Date & Time: 29/6/26 PM

Witness :

Signature: [Signature]

Name: Degeshwari

Date & Time: 29/6/26 2pm

Doctor (who is taking the consent) :

Signature: [Signature]

Name: D. Datta

Date & Time: 29/6/26 PM

ప్రత్యేక మత్తు కోసం సమ్మతి

రోగి పేరు : వయస్సు లింగం పు ☐ స్త్రీ ☐

యు.హెచ్.ఐ.డి. విభాగము

తేదీ

నేను కుమారుడు / కుమార్తె / భార్య

..... అను విధానంకై పూర్తి అంగీకారం తెలుపుతున్నాను.

వైద్యులు నాకు తెలిసిన భాషలో మత్తుమందు వివరాలను ఈ క్రింది విధంగా వివరించారు:

● సెడేషన్ రకం

● మత్తు ప్రక్రియ నుండి తలెత్తు సమస్యలు:

.....

.....

ప్రక్రియ యొక్క ప్రయోజనాలు, ప్రమాదం, ప్రత్యామ్నాయం గురించి వైద్యులు నాకు వివరించారు.

నేను పైన పేర్కొన్న విషయాన్ని నాకు తెలిసిన భాషలో అర్థం చేసుకున్నాను మరియు మత్తుమందు ఇవ్వడానికి సమ్మతిని ఇచ్చాను.

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు

CONSENT FOR ADMISSION IN NEONATAL INTENSIVE CARE UNIT

LH-00660193 IP5-00175741
by Of SIRIMALLE RAJITHA
-06-2026 0 Y 0 M 2 D (M)
NALINIKANTA PANIGRAHY

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eat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: B/o Rajitha Age: 2 day Gender: Male ☒ Female ☐
UHID.No : bb0193 Date: 29/6/26

I Srija Kumar S/o, D/o, W/o hereby
declare that our patient Mr. / Ms. B/o RAJITHA who is related to me as SON is
getting admitted in the Neonatal Intensive Care Unit of Rainbow Children's Hospital on 29/6/2026

The doctors have explained to me in a language understood by me that my child has following health related issues :

The doctors have clearly explained to me that my patient B/o Rajitha during his / her stay
in the Neonatal Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical
ventilation, Umbilical Artery Catheter, Umbilical Vein and Arterial Lines, Peripherally Inserted Central Catheter Line and arterial line
placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure
shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is
implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Neonatal Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Neonatal Intensive Care Unit with multiple medical and surgical procedures
performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of
infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child B/o Rajitha
in the Neonatal Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various
procedures, high risk medications and infections in the Neonatal Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature : P. Shiva Kumar
Name : P. Shiva Kumar
Relationship with Patient: Father
Date & Time : 29/6/26 2PM

Witness :

Signature : [Signature]
Name : Deveshwar
Date & Time : 29/6/26 @ 2pm

Doctor (who is taking the consent) :

Signature : [Signature]
Name : B. Rajitha
Date & Time : 29/6/26 2PM

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.య) సమ్మతి పత్రం



రోగి పేరు వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి బి

నేను బి

అనే బాలుడు / బాలిక యొక్క బికిట్సు మేరకు రేయిన్స్ బిల్డున్ ఆసుపత్రి లోని నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్లో తేదీ

నాడు పూర్తి సమ్మతితో చేర్చితిని. మా బాలుడి / బాలికలో, ఈ క్రింద

తెలిపిన ఆరోగ్య సమస్యల గురించి వైద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ లో మా పాప /బాబుకు వైద్య పరంగా అవసరమగు అన్ని రకాల బికిట్సు విధానాలకు మరియు ప్రక్రియలను (ఉదా కృత్రిమ శ్వాస వెంటిలేటర్, ధమని మార్గం, సింట్రిల్ లైన్ చెస్ట్ డ్రైయిన్, పరిటోనియల్ డ్రైయిన్ ఇంకా వంటి ప్రక్రియలను డాక్టరు గారు నాకు అర్థమగు భాషలో వివరించారు.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైనప్పటికీ, పైన తెలుపబడిన శస్త్ర ప్రక్రియలు చేసేముందు సమ్మతి తీసుకునే వీలు లేని చో ఏదైనా ప్రాణాంతక అత్యవసర పరిస్థితులు ఏర్పడినప్పుడు మా బాలుడు / బాలికను కాపాడుటకు అవసరమైన వైద్య శస్త్ర ప్రక్రియలు మా సమ్మతి లేకుండానే చేయవచ్చని నేను సమ్మతిస్తున్నాను.

ఆరోగ్య సమస్యలతో బాధపడుతున్న మా బాలుడికి / బాలికకు రుగ్మతలచే ప్రాణహాని కలుగవచ్చిన నాకు వైద్యుడు అర్థమగు భాషలో వివరించితిరి

మా బాలుడు / బాలిక నవజాత శిశువు ఇంటెన్సివ్ కేర్ యూనిట్ లో ఉన్నప్పుడు ఎన్నో విధాల వైద్య మరియు శస్త్ర ప్రక్రియలు ఇంకా వివిధ బికిట్సు విధానాలు అవసరం పడతాయని మరియు వాటివల్ల దుష్ప్రతిజ్ఞామాల కలుగవచ్చని అర్థం చేసుకున్నాను. ఆ పరిణామాలు ఎటువంటివి అనగా నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన సమస్యలు, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు.

మా బాలుడిని/బాలికను ఆడ్మిట్ చేయుటకు మరియు ఎన్.ఐ.సి.యి. లో ఉన్నప్పుడు జరుగు బికిట్సు విధానాలు మరియు శస్త్ర ప్రక్రియలు వలన కలిగే అపాయాలను నేను అంగీకరిస్తున్నాను. మా పేషెంట్ ను తగిన విధంగా బికిట్సు చేయడానికి వైద్యునికి నాపూర్తి అంగీకారం తెలియజేస్తున్నాను. వైద్యుడు నాకు అర్థమగు భాషలో అంతా వివరించారు.

మా బాలుడు / బాలిక ను ఇన్ఫిల్మిన్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యి) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండ్ నెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము