

**ADMISSION SHEET**

**Registration Details :**

Admission No : IP5-00174313      Admit Date : 25-May-2026      Admit Time : 07:45 PM      UHID : BAH-00657277

**Patient Details :**

Patient Name	: Baby Of NAGA LAXMI SRIPRADA HOTA	Age	: 0 D
Guardian	: Mr AKELLA RAVITEJA DATTA	DOB	: 25-05-2026 06:04 PM
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: FLAT NO C 201, GHR TAITANIA, CENTRAL PARK Kondapur Hyderabad Telangana INDIA 500084	Phone No	: 7337064141/ 7799900877
		E-mail	: sripradahota@gmail.com

**Admission Details :**

Bed Type : BASINET      Bed No : CRDL-MICU-426-1      Ward Name : 4F-BIRTHING CENTRE  
 Room No : CRDL-MICU-426-1      Admission Type : First Visit

**Contact Details :**

Name : Mr AKELLA RAVITEJA DATTA      Relationship : Father  
 Contact Address : FLAT NO C 201, GHR TAITANIA, CENTRAL  
PARK Kondapur Hyderabad Telangana INDIA  
500084      Phone No : 7337054141 /

  
Signature

**Doctor Details :**

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

**Payment Details :**

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







## NEONATAL IN-PATIENT MEDICAL RECORD

### ADMISSION INFORMATION

Mother's Name : Nagalaxmi Age : 33 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 Nagalaxmi Mother's Blood Group : A+ve  
 Gender :  M  F Blood Group : ..... Birth Weight (gms) : 2.706 Length (cms) : 34  
 Date of Birth : 25/5/26 Time of Birth : 6:04PM OFC (cms) : 48cm  
 Place of Birth : RCH-B Estimated Gesth Age : 38+1

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 33 Ht : ..... Wt : 58 BMI : ..... Married Life : ..... LMP : 31/8/25 EDD : 7/6/26

Conception : Spontaneous or with Rx : .....

Booked at what GA : 12wks AN Steroids Drugs / Doses : .....

Last Scans Details : 8/4/26 - 37+1, cephalic, 1.57SLg, 12.6cm AFI, doppler @  
TIFFA - single intracardiac echogenic focus in @ ventricle; NIPT - low risk.  
 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 ? hemorrhoids 2 months

( Anemia, SLE, Jaundice, CHD, Heart Disease )

Infection : H/O, Fever  
 (  Malaria  UTI  TORCH  TB  HIV  HBV )

UTI : when : ..... Any culture : .....

PPROM: Duration : .....  Uterine Tenderness  Foul Smelling Liquor  HVS (if taken) - Results : .....

Medication during Pregnancy : ..... Duration : .....

**PAST OBSTETRIC HISTORY**

P: 1 A: 1 L: 1

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
G1	2021	34+5	2.2	Male	LSCS - complete placenta previa	WVW + 3 days
G2	2025	MERPP 10 wks				- sublingual thyroid
G3	PP					

**PERINATAL HISTORY**

Treating Obstetrician : Dr. Swathi Hospital : RCH  Inborn  Outborn

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

**APGAR SCORE**

Gestational Age : *38+1* Weeks : .....

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

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

**TOTAL**

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

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

**POSTNATAL / HISTORY OF PRESENT ILLNESS**

Chief Complaints :



H

Equipment check done



Baby cried immediately

Delayed cord clamping done ~ 60 sec



Routine newborn care done

Hy vit k 1ml 0.5ml given



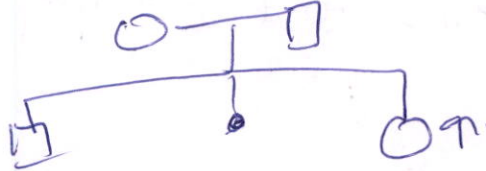
shifted to mother's side

Investigation details in previous Hospital :

Feeding History :



Family History :



Socio Economic History :

**GENERAL EXAMINATION ON ADMISSION**

General Disposition :

VITALS : Temperature : 36.4 HR : 143 RR : 36 NIBP : - CFT : 23x22

Color of the extremities : pink

Jaundice : - Pallor : - SpO2 : 98%

ANTHROPOMETRY: Birth Weight : 2.706 Length : ..... HC : ..... Present Weight : .....

Ponderal Index : ..... AGA : ..... SGA : ..... LGA : .....



**HEAD TO TOE EXAMINATION**

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

(N)

**FACIES :**  
(Any Facial  
Dysmorphism)

(N)

**NECK and  
CLAVICLES :**

Range of Motion :  
Asymmetry :  
Masses :

(N)

**EYES :**

Symmetry :  
Red Reflex : *to be checked*  
Discharge :

**EARS, NOSE  
MOUTH and  
THROAT :**

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

(N)

**THORAX and  
BREASTS :**

Shape of Thorax :  
Position of Nipples and Number :

(N)

**ABDOMEN and  
UMBILICUS :**

Shape :  
Organomegaly :  
Bowel Sounds :  
Umbilical Stump : *2A + 1W*  
Discharge :

**GENITALIA :**

Labia / Hymen :  
Testicles/penis :  
Anus :

**HERNIAL ORIFICES**

**TRUNK and SPINE :**

(N)

**SKIN LESIONS :**

**EXTREMITIES :**

Fingers / Toes :  
Deformities :  
Hip Joint Examination :

Arms / Legs :  
Mobility :



### SYSTEMIC EXAMINATION

**Breathing Pattern :**  Regular     Periodic     Shallow     Gaspig

Mention If baby has Respiratory distress: RR: 30    SCR / ICR / See - Saw breathing : .....

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

Mention if baby is on :     Hood box     CPAP     Ventilator (N)

Settings : room air .....

SpO<sub>2</sub>: 98.7    Auscultation: .....    Breath Sounds: .....    Added Sounds: .....

### CARDIOVASCULAR SYSTEM :

HR : (M)    BP : (F) .....

Precordial Activity : .....

Femoral Pulses : (M) (F) .....

Murmurs : (M) .....

Other Peripheral Pulses : .....

Signs of Cardiac Failure : .....

### ABDOMEN:

Shape : (M) .....

Hernia orifice : .....

Palpation : (M) .....

Anal Patency : (F) .....

Palpable masses : (M) .....

Umbilical Cord : .....

Abdominal girth : .....

First urine passed : ✓ .....

Meconium passed : X .....

### NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : .....

State of wakefulness : .....

Prechtle Score : .....

Nerves : very Home (activity) - good .....

### MOTOR SYSTEM:

Passive Tone : .....

Active Tone : .....

Neonatal Reflexes : .....

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

Moro's : .....    DTR : .....

ATNR : .....    Skull and Spine : .....

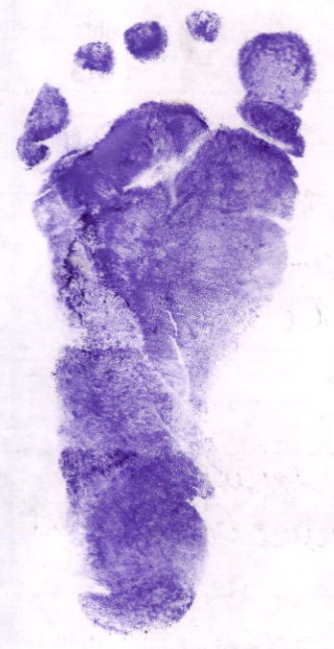
Any C



Diagnosis : Term / ~~low~~ female / AUA / EL UCG (prev UCG) / h3 L A  
mother i w/o hemorrhoids / TFFA - intracardiac echogenic  
focus in left ventricle / NIPT low risk

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : Dr Ashwaryn

Name : [Signature]

Date & Time : 25/5/26 at 6.30 AM

Consultant :

Signature : [Signature] Dr. VIJAYANAND JAMALPURI  
Reg. No: 40526

Name : Dr. Vijayanand Jamalpur

Date & Time : 25/5/26 at 6.30 AM

PLEASE FILL UP THE FOLLOWING DETAILS

- Name of the referring Doctor : .....
- Name of the referring Hospital : .....  
Address : .....
- Contact Numbers : .....
- Contact Details of the referring Doctor : .....  
Mobile No. : ..... E-mail ID : .....
- Name of the Doctor in Rainbow Team : .....  
..... on whose name the patient is being referred.



**AT THE TIME OF TRANSFER TO THE WARD**

Final Diagnosis : .....

Neonatal condition at the time of Transfer: .....

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

Any Oxygen requirement : .....

Systemic : .....

Medications : .....

- Plan
- ① Shift to mother side
  - ② initiate breastfeeds
  - ③ keep baby warm
  - ④ trace baby blood group
  - ⑤ 24Hr clinical jaundice assessment
  - ⑥ USH2 - SRR

Plan during ward follow up :

- A/B/S
- OAE
- ⑦ Daily wt check.
- ⑧ ⑨ TIFFA reports
- ⑩ vaccinate - BCG

Feeding Plan at the time of shifting : .....

6:34 pm to 7:44 pm  
 - OPV  
 - Hep B!

Screenings done during NICU Stay :

NSG : .....

Hearing Screen : .....

ROP : .....

TFT : .....

NP2 : .....

Doctor Signature (Handover Given): Dr. Adwanya Doctor Signature (Handover Taken): N. Prashanth

Doctor Name: Dr. Adwanya Doctor Name: N. Prashanth

Date & Time: 28/5/26 6:30 PM Date & Time: 28/5/26 6:30 pm

BAH-00657277 IP: 00174  
 Baby Of NAGA LAXMI SRIPADA  
 25-05-2026 0 Y 11 M 0 L 2 H  
 Dr. VIJAYANAND JAMALPUR



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

**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 8:15 AM	14/204 Germ/female/Inta (adhaa echogenic foci/AGA)	Plan
		→ regular feedings Qmly - 03 mls
	(AGA Baby)	→ feeding assessment
		→ NBR @ 24 Hrs. @ 6 PM
		→ BCG, OPV, Hep B
		→ SBR, NBS, OAD @ 28 Hrs
		→ Plot the weight chart
		Noted by poornima

Dr. VIJAYANAND JAMALPUR  
 Reg. No. 40526



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/28 11:40 AM	<u>Lactation notes</u>	
	Lactation consulting done position shown particularly Colostrum as seen baby is latching well feed adequate with deep latch more than 20-25 min each side. (Adv) DOF	
	nalan (nalan)	
26/5/28 2pm	seen by Dr. N. Devaraju (DNB Resident) 19402 Term 2.706 kg TFFA on DBF LSCS wt - 2.001	Intra (cardiogenic) echogenic Burs, PLL Plan
AT AT	(105 gm wt loss)	continue Regula feeding
	olive - (2)	2. BCG, OPV, Hib B today ✓
	Stool - (2)	3. Review - 2 DECHO
	Deeply Colostrum feeds	
	Sucking good	4. clinical assessment of Jaundice at 24HOL
	Latching good	5. monitor vitals

Dr. N. Devaraju  
(N. Devaraju)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 3 PM	2/1 HOUR of life	seen by Dr. vijayanand
		1. Regular feeds!
		2. Jaundice assessment at 24 HR 6 PM.
		3. R/O Echo on follow up.
		4. 3CG, OPV, Hep B to date done on 26/5/26
		Dr. Vijayanand Jamalpuri Reg. No: 40526 noted by [signature]
27/5/26 7:25 AM	Seen by Dr. Bharath (Resident) 37 HR   38+1   2.706 Kg	El. LSCS / Intracardiac echogenic focus in LV
	Bi. wt - 2706 gm	Plan -
M / AT B / AT	Today. wt - 2466 gm 246 gm (↓ 8.6%)	- Continue DBF fib burping @ 2-3 hourly Feeding assessment
	Motion - 3 times	- Warmth care
	Urine - 8 times	- SBR ? @ 48 HR 6 PM NBS Secum NAT
		- OAE Tomorrow
		- w/ f feeding difficulties, doll activity
		- Monitor vitals and Inform SOS
		- 20 Echoon follow-up.
		- Recheck weight in Bharath evening



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26	Seen by Dr. Bharath (Resident)	
2:15 PM	44HOL/38+1/2.706kg/21.2scs/	Intracardiac echogenic focus in LV
M/A+		Plan:-
B/A+	[8.6% wt. loss]	- Continue DBF flb burping
		every 2 to 3 hourly
		- Warmth cell
		- SBR } 6 PM Today.
		NBS } Scrum Nat }
		- watch for feeding difficulties
		- Monitor vitals and
		Inform SOS
		- 2D Echo on follow up
		* Recheck weight in
		evening
		Noted by <u>Bharath</u>
27/5/26	Seen by Dr. vijayanand	<u>Sujeeto</u>
3:00 PM		
	Feeding better	Plan:-
		- Proctogard -T ointment
		- Regular feeding
		Noted
		by <u>Sujeeto</u>



Patient Sticker

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26	Seen By Dr. Bharath (Resident)	
2:00pm		
		Plan:-
		- Discharge now
		- Flu saturday.
		* Measured feeds
		TV - 100 ml/kg/day
		20-25 ml every 2hrly (od)
		30-35ml every 3hrly.
		Bharath



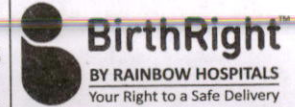


# MULTI-DISCIPLINARY PLAN OF CARE FORM

*new born baby*

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
<i>7pm</i>	<input checked="" type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	<i>New born baby</i>	<i>Breast feeding</i>	<i>2-3<sup>rd</sup> hourly</i>	<i>Dr Prathiba</i>	<input type="checkbox"/> Nursing <input checked="" type="checkbox"/> Others:
<i>8pm 25/5/26</i>	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	<i>New born - baby</i>	<i>⇒ To encourage Breast Feeding</i>	<i>⇒ Feeding by 2-3<sup>rd</sup> hourly</i>		<input checked="" type="checkbox"/> Medical <input type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:

# PATIENT / FAMILY EDUCATION RECORD



**Part - I,**  
 Patient's / Learner Language : ..... Patient / Learner Literacy :  Read  Write  Speak Willingness to Learn :  Yes  No Healthcare Literacy :  Yes  No

**Identified Education Needs :**

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

**Part - II**

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barries	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
25/5/26	8pm	7	Infection control Measures pt F.M	1	0	1	1			Reel

**Part - III : CODES**

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

BAH-006 7277 IP5-001743  
Baby Of NAGA LAXMI SRIPRADA  
25-05-2026 0 Y 0 M 0 D 2 H  
Dr. VIJAYAN AND JAMALPURI



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

BY RAINBOW HOSPITAL  
Your Right to a Safe Delivery

## NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: .....

Mother's Name: Mrs. Naga Lakshmi

Date of Birth: 25/5/26

Time of Birth: 6:04 pm

Gender:  Male  Female

Birth Weight: 2.706 Kgs

HC: 34 cm

Length: 48 cm

Meconium In Liquor:  Yes  No

Cried at Birth:  Yes  No

Term / Pre-term / Post-term: Term

Resuscitated:  Yes  No

Blood Group: Mother: A+ve

Baby: .....

Feeding:  Breast Feeding

Formula

Both

First Feed Time: 6:34 pm to 7:44 pm

AFFIX MOTHER'S  
IDENTIFICATION LABEL

Mode of Delivery:  Normal

LSCS - Emergency/ Elective

Instrumental

AVD

Indication: .....

### Physical Assessment of New Born:

Temp: 38.2 °C HR: 110 /Min RR: 24 /Min BP: --- SpO<sub>2</sub>: 100%

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment:  Yes  No Score: 16 (Fill the Humpty Dumpty Sheet)

Risk in Pressure Sore:  Yes  No (Braden Q Score) (Fill the Braden Q Sheet)

Behaviour Status on admission:  Sleeping  Crying  Calm  Drowsy

### Findings:

General Appearance: Posture:  Well-Flexed  Asymmetry

Skin:  Pink  Meconium Stain  Others, Specify: .....

Nursing Management: (Please strike through if not applicable e.g. Yes / ~~No~~)

Vitamin K 1 mg IM Administered: Yes / No

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

All information obtained from  Mother  Father  Other Family Member

Newborn Screening Discussed: Yes / No

Nurse Name: Sushma

Signature: [Signature]

Date & Time: 25/5/26 8 pm

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

**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: 23/05/26 Time: 6:10 PM 10 PM 6 PM

Doctor/Nurse/Family Concern?

Temperature (F)	104			
	103			
	102			
	101			
	100			
	99	<u>98.2</u>	<u>98.5</u>	<u>98.8</u>
	98			
	97			
	96			
	94			

Heart Rate (bpm) and Blood Pressure (mmHg) *	190			
	180			
	170			
	160			
	150			
	140	<u>138</u>	<u>138</u>	<u>138</u>
	130			
	120			
	110			
	100			

Heart Rate (Number) 138 138 138

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

Resp Rate (Number) 40 40 40

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 0 0 0

Conscious Level Normal Altered

GCS \* 13 13 13

**TOTAL SCORE** Number of shaded boxes 0 0 0

Pain Score 0 0 0

Observer's Initials VS VS VS

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

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

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> 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)



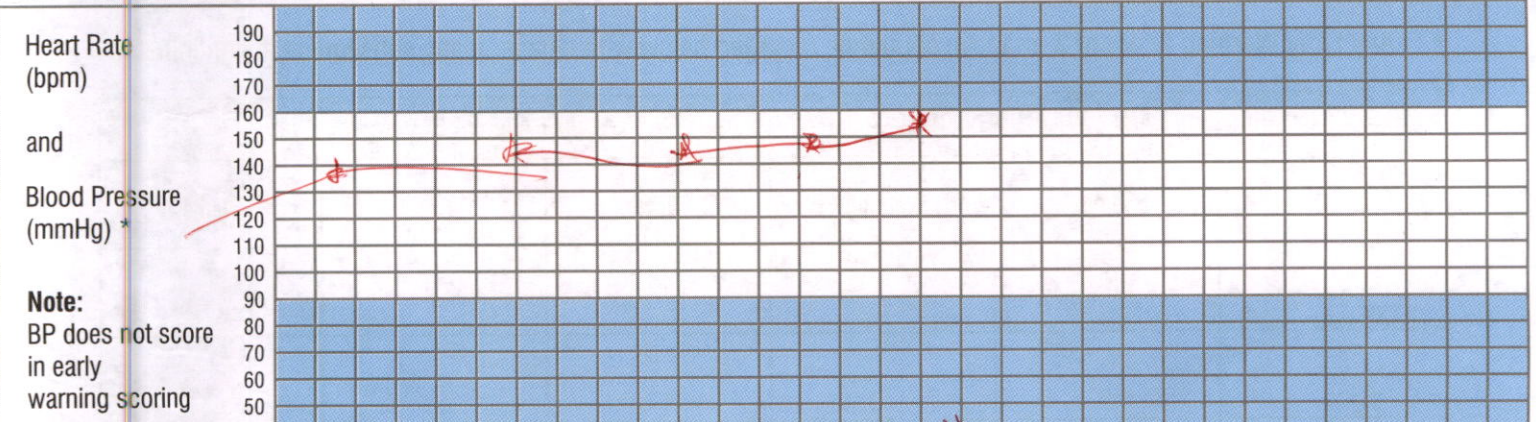
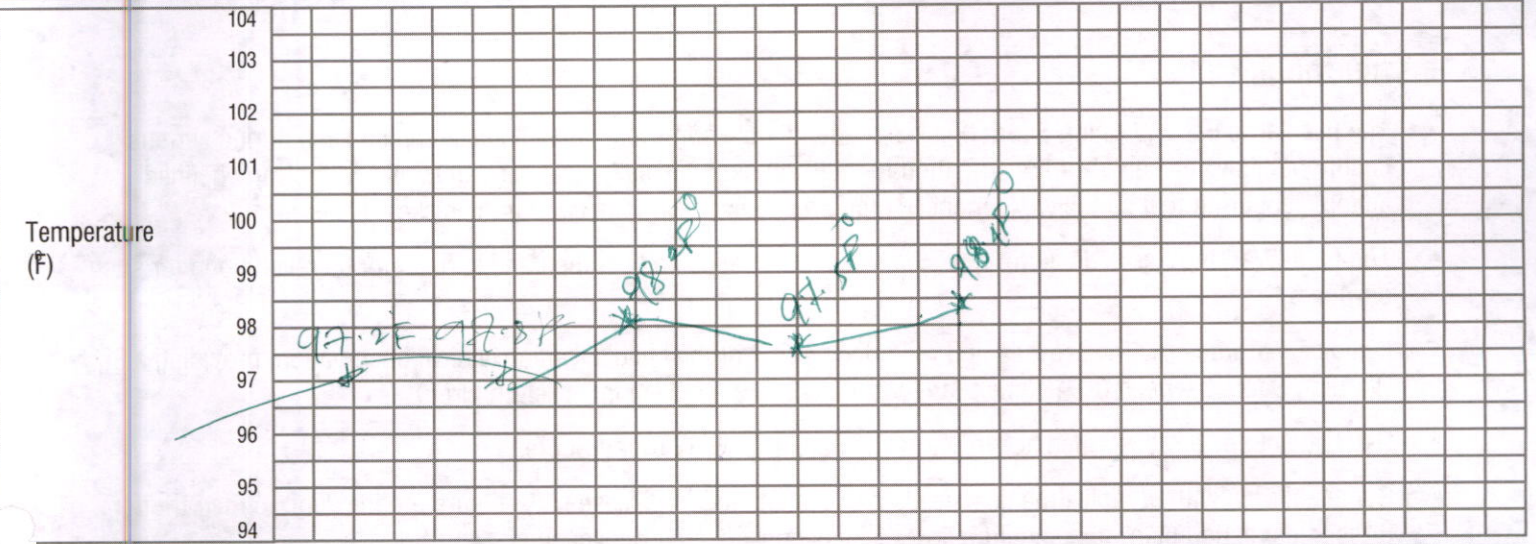
26/5/26  
 Doc. No. : RCHBH / FRM / CLINICAL / 124

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

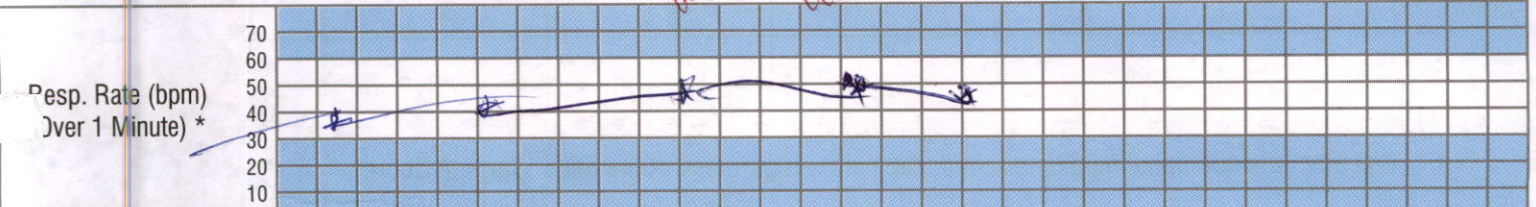
**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: ..... Time: 10 AM 5 PM 9:30 PM 12 AM 3 AM

Doctor/Nurse/Family Concern? .....



Heart Rate (Number) 132b/min 133b/min 141b/min 142b/min 148b/min



Resp Rate (Number) 38b/min 40b/min 42b/min 42b/min 38b/min

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 100% 98% 97% 97% 98%

Conscious Level Normal Altered

GCS \* 15/15 15/14 (15/15) (15/15) 15/15

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

**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:

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

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<b>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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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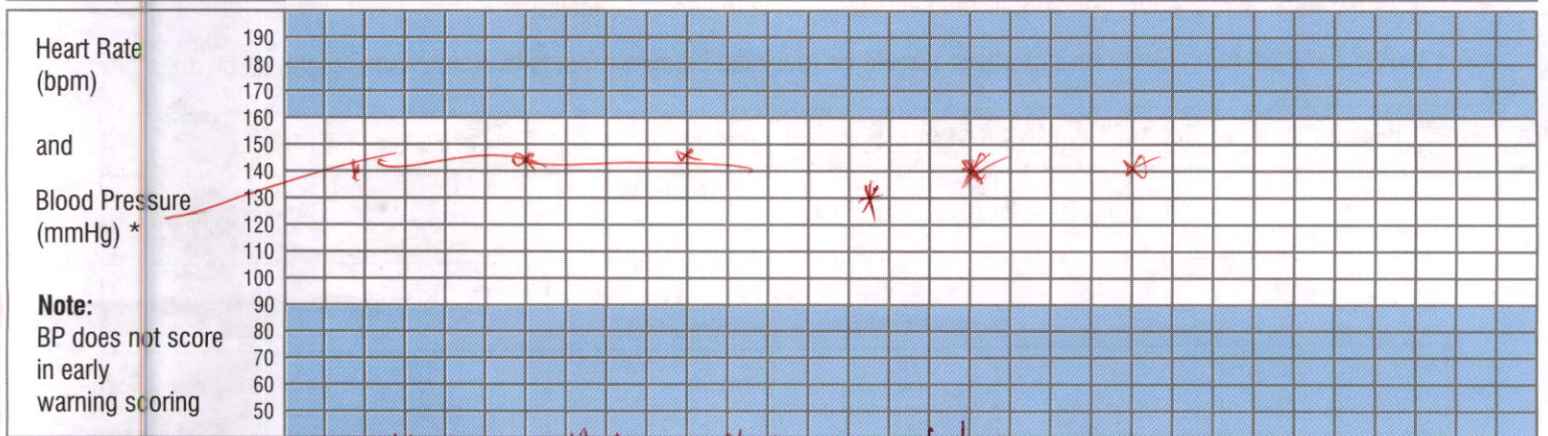
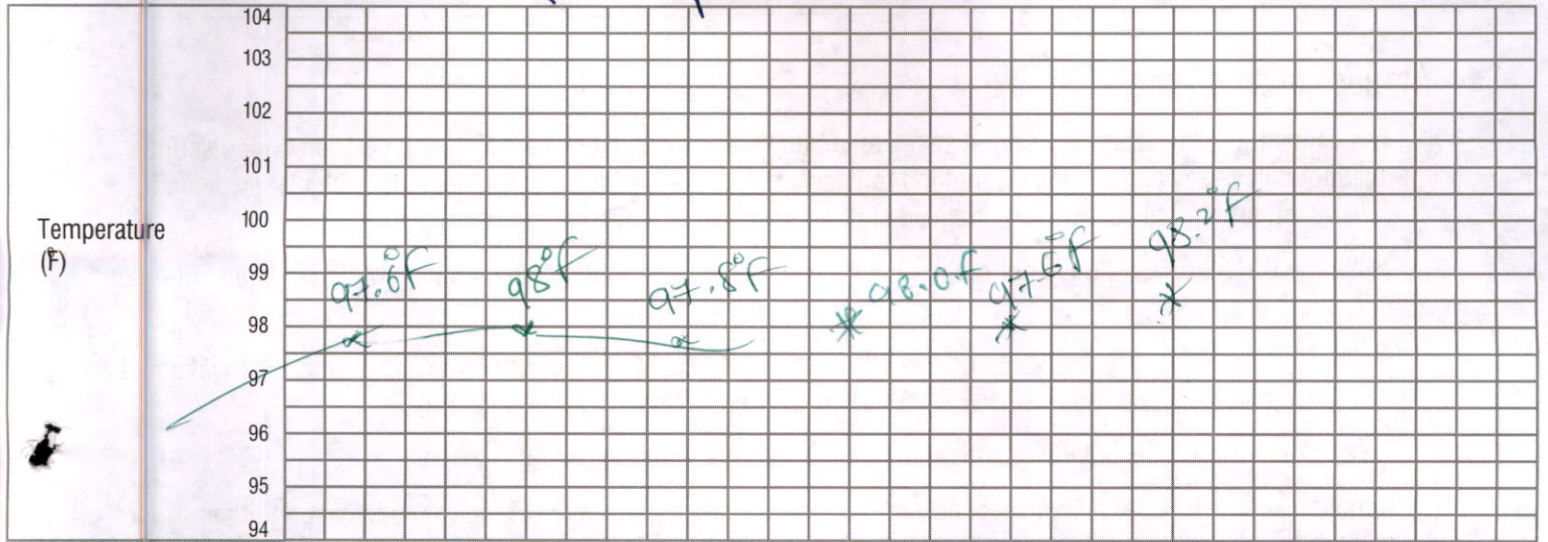
27/5/26

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



**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: 27/5 Time: 10 am 1 pm 5 pm 10 pm 2 AM 6 AM  
 Doctor/Nurse/Family Concern?



**Note:**  
 BP does not score in early warning scoring

Heart Rate (Number) 140b/min 142b/min 148b/min 130b/min 138b/min 140b/min



Resp Rate (Number) 38b/min 36b/min 40b/min 40b/min 38b/min 40b/min

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 99% 99% 99% 100% 98% 99%

Conscious Level Normal Altered

GCS \* 15/15 15/15 15/15 15/15 15/15 15/15

**TOTAL SCORE** Number of shaded boxes 0 0 0 0 0 0

Pain Score 0 0 0 0 0 0

Observer's Initials [Signatures]

**ACTIONS**

Score 1	: Continue normal observation by staff nurse
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## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00657277 IPF-00174  
 Baby OF NAGA LAXMI SRIPRADA  
 5-05-2026 0 Y 0 M 0 D 2 H  
 Dr. VIJAYANAND JAMALPURI



# FLUID CHART

Sheet No. : ①

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b> Talak						<b>Total Output :</b> Not passed							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b> Talak						<b>Total Output :</b> passed Not - 0							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b> 0-1 ml							

**Total 24 hrs. Intake** : Talak

**Total 24 hrs. Output** : 0-2 ml



26/05/26

# FLUID CHART




Sheet No. : ..... (2) .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
26/05/26	08:00 am	DBF								✓	NA	Poppi	
	09:00 am									✓	NA	Poppi	
	10:00 am										NA	Poppi	
	11:00 am	DBF									NA	Poppi	
	12:00 pm										NA	Poppi	
	01:00 pm	DBF									NA	Poppi	
<b>Total Intake :</b>						<b>Total Output :</b> U-2 M-0							
	02:00 pm									✓	NA	Poppi	
	03:00 pm	DBF									NA	Poppi	
	04:00 pm										NA	Poppi	
	05:00 pm	DBF								✓	NA	Poppi	
	06:00 pm										NA	Poppi	
	07:00 pm	DBF									NA	Poppi	
<b>Total Intake :</b>						<b>Total Output :</b> U-2 M-1							
	08:00 pm											Suck	
	09:00 pm	DBF										Suck	
	10:00 pm											Suck	
	11:00 pm	DBF										Suck	
	12:00 am											Suck	
	01:00 am	DBF										Suck	
<b>Total Intake :</b>						<b>Total Output :</b> M-2 U-2							
	02:00 am											Suck	
	03:00 am	DBF								✓		Suck	
	04:00 am											Suck	
	05:00 am	DBF								✓		Suck	
	06:00 am											Suck	
	07:00 am	DBF										Suck	
<b>Total Intake :</b>						<b>Total Output :</b> M-0 U-2							

**Total 24 hrs. Intake**

**Total 24 hrs. Output** M-3 U-8

Baby Of NAGA LAXMI SRIPRADA  
 25-05-2028 0 Y 0 M 2 D (F)  
 Dr. VIJAYANAND JAMALPURI  


# FLUID CHART



Sheet No. : (3) 27/5/26

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am									1		Swage
	09:00 am	DBF				✓				1		Swage
	10:00 am									1	NO cannula	Swage
	11:00 am	DBF								1		Swage
	12:00 pm					✓				1		Swage
	01:00 pm	DBF								1		Swage
<b>Total Intake :</b>					<b>Total Output : V - 2 M - 2</b>							
	02:00 pm									1		Swage
	03:00 pm	DBF				✓				1		Swage
	04:00 pm									1	NO cannula	Swage
	05:00 pm	DBF								1		Swage
	06:00 pm					✓				1		Swage
	07:00 pm	DBF								1		Swage
<b>Total Intake :</b>					<b>Total Output : V - 2 M - 2</b>							
	08:00 pm	DBF								1		Swage
	09:00 pm									1		Swage
	10:00 pm	DBF								1		Swage
	11:00 pm									1		Swage
	12:00 am	DBF				✓				1		Swage
	01:00 am									1		Swage
<b>Total Intake :</b>					<b>Total Output : M - 10 - 1</b>							
	02:00 am	DBF								1		Swage
	03:00 am					✓				1		Swage
	04:00 am	DBF								1		Swage
	05:00 am									1		Swage
	06:00 am	DBF				✓				1		Swage
	07:00 am									1		Swage
<b>Total Intake :</b>					<b>Total Output : M - 20 - 1</b>							

**Total 24 hrs. Intake** 200 ml

**Total 24 hrs. Output** M - 20 - 6

28/5/26

# FLUID CHART

Sheet No. : .....

- All measurements in ml.
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Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am											NA	Pooja
	09:00 am	DBF										NA	Pooja
	10:00 am											NA	Pooja
	11:00 am	DBF										NA	Pooja
	12:00 pm											NA	Pooja
	01:00 pm	DBF										NA	Pooja
<b>Total Intake :</b>						<b>Total Output :</b> v — m							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

Patient Sticker

# FLUID CHART



Sheet No. : .....

1. All measurements in ml.
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Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse		
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine				
	08:00 am													
	09:00 am													
	10:00 am													
	11:00 am													
	12:00 pm													
	01:00 pm													
<b>Total Intake :</b>						<b>Total Output :</b>								
	02:00 pm													
	03:00 pm													
	04:00 pm													
	05:00 pm													
	06:00 pm													
	07:00 pm													
<b>Total Intake :</b>						<b>Total Output :</b>								
	08:00 pm													
	09:00 pm													
	10:00 pm													
	11:00 pm													
	12:00 am													
	01:00 am													
<b>Total Intake :</b>						<b>Total Output :</b>								
	02:00 am													
	03:00 am													
	04:00 am													
	05:00 am													
	06:00 am													
	07:00 am													
<b>Total Intake :</b>						<b>Total Output :</b>								
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>								

Patient Sticker



# FLUID CHART

Sheet No. : .....

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>							