

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175821 Admit Date : 01-Jul-2026 Admit Time : 12:36 PM UHID : BAH-00660399

Patient Details :

Patient Name	: Baby Of BARIRA FAREED	Age	: 0 D
Guardian	: MR FAIZAN AHMED	DOB	: 01-07-2026 12:01 PM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: MEDCHAL Medchal Hyderabad Telangana INDIA 501401	Phone No	: 9949661907
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : BASINET Bed No : CRDL-SW-416-1 Ward Name : 4F-BIRTHING CENTRE
Room No : CRDL-SW-416-1 Admission Type : First Visit

Contact Details :

Name : MR FAIZAN AHMED Relationship : Father
Contact Address : MEDCHAL Medchal Hyderabad Telangana Phone No : 9949661907
INDIA 501401


Signature

Doctor Details :

Doctor Name : Dr. DINESH KUMAR CHIRLA Specialisation : NEONATAL INTENSIVE CARE
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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

[illegible]

BAH-00660399 IP5-00175821
Baby Of BARIRA FAREED
01-07-2026 0 Y 0 M 0 D 5 H (M)
Dr. DINESH KUMAR CHIRLA




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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
7/7/26	3:35pm	NRU-II	3B	malaynari

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
1/7	Root Grappling	26065012 ✓	(Signature)
	RBS	26065871 ✓	(Signature)
	CRP	632736	(Signature)
	RBS	26065958 ✓	(Signature)
2/7/26	RBS	26066087 ✓	(Signature)
"	RBS	26066456 ✓	(Signature)
3/7/26	RBS	26066686 ✓	(Signature)
4/7/26	RBS	26066856 ✓	(Signature)
	SRP	26066855 ✓	(Signature)
4/7/26	NBS	26066930 ✓	(Signature)
5/7/26	CRBS	26067238 ✓	(Signature)
5/7/26	RBS	26067823 ✓	(Signature)
2/7	NPI	26066627 ✓	(Signature)
2/7	CRBS	26066003 ✓	(Signature)
			(Signature)
			(Signature)
			(Signature)
			(Signature)
			(Signature)
			(Signature)
8/7/26	CRBS	26068123	(Signature)

[illegible]

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

Mother Is refusing to give Bath checking weight
of the Baby.

Date :Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

8/2/26

Mother is refusing to give bath checking weight of the baby.

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. Barika Fareed Mother's Blood Group : B+ve
 Gender : ☒ M ☐ F Blood Group : AB+ve Birth Weight (gms) : 1.623kg Length (cms) :
 Date of Birth : 1/7/26 Time of Birth : 12:01 PM OFC (cms) :
 Place of Birth : RCH, Bangalore Estimated Gesth Age : 33+5

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 31 yrs Ht : Wt : BMI : Married Life : 4 yrs LMP : 10/1/25 EDD : 14/8/28
 Conception : Spontaneous or with Rx : Spontaneous IVF conception → 46 hours before delivery
 Booked at what GA : 23 weeks AN Steroids Drugs / Doses : 2 doses Betamethasone on 29/6/26
 Last Scans Details : 1/7/26 → 33+5, Doppler - @ AFJ - 9.9, MCA - redistribution, Uterine artery ↑ resistance
 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 :
PE since 33+ weeks

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 :
GDM on diet @ 27 weeks

Compliance with Rx :

Scans : LGA, TIFFA, Fetal Echo :

H/o Hypothyroidism : when diagnosed ? Medication?

Any other Chronic Medical Problems, when detected
 drugs ?

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

Infection : H/O, Fever

(☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)

UTI : when : Any culture :

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

Medication during Pregnancy : Duration :



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

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

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 12:45pm	Baby received in NICU-2. Temp - 94°F. HR - 131/min. RR - 52/min. SpO2 - 100% on RA. CRBS - 97°F. 68 mg/dl.	<u>Plan.</u> → Warmer care - Set temp - 36.5°C → TV - 60cc/kg/day 8 ml 2nd hely full OA feed (EBM/DBM) → Check CRBS now RBS - 6th hely. → Send cord sample for baby blood group. → Monitor vitals.
21/7/26 2:30pm	Dr. Poojitha RR - 61/min.	Seen by Dr. Peatyush. → Do Chest X-Ray now. → Document LOS. → Trace baby blood group. Dr. Poojitha

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 01-07-2026 0 Y 0 M 0 D 7 H (M)
 Dr. DINESH KUMAR CHIRLA

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

Day in NICU: Day of Life: 20 HCL PMA: 33+5 wks
 Term ☐ Preterm ☐ Gestation: 33+5 wks Corrected Gestational Age: Today's Weight: 1540g (483g)

		Problems	
		S.No.	Past Problems
Overview	Current	1. <u>Mod. Preterm / VLBW</u>	
		2. <u>Preterm care</u>	
		3. <u>maternal GDM / PE</u>	
		4.	
		5.	
		6.	
Clinical Assessment	on RA Hemodynamically stable. on full OG feed. urine - 1.2 cc/kg/hr. meconium passed. HR - 125/min. RR - 42/min SpO₂ - 98%. BP - 56/42/47 CRBS - 85mg/dl. BBQT - AB+ve. MBQT - B+ve.		
	Medications Used		
Plan of Care: <u>TV - 60cc/kg/day → 8ml/2nd hly full OG feed (EBM/DBM)</u> <u>↑ 80cc/kg/day after 12pm.</u> <u>warmer care.</u> <u>RBS - 6th hly.</u> <u>Monitor vitals.</u> <u>R/v NP, @ 24 HCL.</u>			

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

Signature: [Signature]

Date & Time: 2/7/26 Sam

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

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

Signature: [Signature]

Date & Time: 2/7/26

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.	Past Problems
Overview	1.	
	2.	
	3.	
	4.	
	5.	
	6.	
Clinical Assessment		
Medications Used		
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: P

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/12/26 3pm.	Afternoon Note	Plan
	Baby ↓ SSPT hemodynamically Stable - HR - 134/min SpO ₂ - 92% - tried paladai feeds - took cin 15 min - passing urine (stool) P/A - soft	- continue SSPT every 4 genitels covered - TV - 100 cc/kg/day - 13ml/kg/hly try - 2-3 paladai today wet - ok - feeds
	CRBS - 84 mg/dL	→ CRBS - 6thly - 1 for T/O Charting 6thly - RIV - CRBS - OD RW - formula feeds
3/12/26	Seen by Dr. PR	Review
		- continue DBM/EBM - CRBS - ON - try 2-3 paladai feeds wet ok.
		Plan



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

Day in NICU: 2 Day of Life: 45 H 0 L PMA: 33'

Term ☐ Preterm ☐ Gestation: 33¹⁵ wk Corrected Gestational Age: Today's Weight: 1.55 kg (189g)

		Problems		
		S.No.	Current	Past Problems
Overview	1.		mod. protein / VLBW	
	2.		preterm care.	
	3.		maleic acid 90m/PE	
	4.			
	5.			
	6.			
Clinical Assessment	on room air hemodynamically stable full on feeds passed meconium/ urine No vomitings			HR ~137/min SpO ₂ ~98% RR ~35/min CRBS - 80mg/dl
	Medications Used			
Plan of Care: - TV - 80 ccl/day - 11ml @ 2Hly - full on feeds → CRBS - 86H → RIV - Trying paladai feeds				

Doctor's Name (Hand over given): Pawan

Signature: Pawan

Date & Time: 3/7/26

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:

4/2/26

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

Day in NICU: 4 Day of Life: 69 PMA: 40

Term ☐ Preterm ☒ Gestation: 33¹⁵ Corrected Gestational Age: 38 Today's Weight: 1.517kg
(409g)

Problems		
S.No.	Current	Past Problems
1.	Mod. preterm / VLBW	
2.	Preterm care	
3.	Mat. ADM/PG	
4.	- NNT	
5.		
6.		

Clinical Assessment
M/B Active Baby on SSP (TCBR - 9.6 → SBR - 5.5) hemodynamically stable C. w/ 100% HR - 144/min SPO₂ - 95% passing urine / stool PIA - soft

Medications Used
GRBS - 90mg/d NBS - ✓

Plan of Care:
→ STOP - phototherapy → TV - 100 cc/kg/day - 13ml/kg/day R₃ Try - paladai feeds - <u>6/10</u>

Doctor's Name (Hand over given): Panwar

Signature: Panwar

Date & Time: 4/2/26

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 2 PM	Afternoon Rounds	Plan
	Baby on room air hemodynamically stable → ongoing KMC HR - 148/min SpO ₂ - 98% RR - 50/min - tolerating feeds well	→ TV - 120 cal/kg/day - 16ml @ 21hly / EBM / DM → Continue KMC / OMS / NNG → 3-4 paladai feeds meet 04 feeds → GRBS-OD → HO - charting @ 6Hly
4/7/26 8:20 PM	Night Rounds S/B-D - Nishu	Noted by Rokanya
	Plan	Paran
	- took - 3 paladai each feed - 30min NO Grassy / disatored - hemodynamically stable - tolerating feeds well	→ continue full 04 over night → 2-3 paladai under day Noted by Aradhana
		Paran

5/7/26

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

Day in NICU: Day of Life: 40th Day 5 PMA:

Term ☐ Preterm ☐ Gestation: 33¹⁵ Corrected Gestational Age: Today's Weight: 1.052 kg
 (A49g)

Problems	
S.No.	Current
1.	mod. preterm (VLBW)
2.	preterm
3.	mat. GDM/PE
4.	NAI
5.	
6.	

Clinical Assessment	
Baby on room air +ve AB+ve. hemodynamically stable + good paladar feeds took well!	1+R-154/min SpO₂-96% RR-40/min BP-100/60

Medications Used	
	NBS- ✓

Plan of Care: 130
 +V-100cc/kg/day - 1st/182cc/kg
 RIV- Txy - paladar - feeds - 6, rest 4
 - Continue KMC/oms/NNS.
 - GRBS-OD

Doctor's Name (Hand over given): Pawan

Signature: Pawan

Date & Time: 5/7/26

Doctor's Name (Hand over taken): D. Netha

Signature: D. Netha

Date & Time: 5/7/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/8/26 8:30 AM.	CLS/B- Dr. DK / Dr. Pratyush	
		Plan.
		- 17ml/24hrs
		- TV - 20 ccl/kg/day
		- CBM / DBM full protocol
		- continue KMC.
		- encourage. Paladar feeds
		- 4-6 feeds
		- meet: all OA feeds
		Noted by Akansha.
		Pancy
		→ R/v to add
		supplements
		tomorrow.
		Noted by Akansha

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes				Doctor's Order		
6/7/26	Nutrition Round.						
	Max. wt - 1.623 kg						
	TV - 140cc/kg/day $\Rightarrow$ 227 ml.						
	HMF $\times 2/3 \Rightarrow$ 8 sachets.						
	Cal	Pro	Ca ²⁺	PO ₄ ⁻	Fe	D3.	
EBM. [6/7/1.1/15 2.8/0.2]	152	2.49	34	17.7	0.45	—	
HMF. [3.33/0.27/15.8 2.9/0.3/13.2]	26.9	2.16	126.4	63.2	2.4	1056	
Total.	178.9	4.65	160.4	80.9	2.85	1056	
	110.2	2.86	98.8	49.8	1.75	650.	
	1.98:1						

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 2pm	Afternoon Round	
	Baby is on RA. Hemodynamically stable. Accepting paladay feed.	
	TCBR - 10.5 (13.5) Not in PT range.	Plan.
	Vitals HR - 152/min. RR - 51/min SpO2 - 99% U - ✓ S - ✓	→ TR - 140cc/kg/day 19ml/2nd hly + HMF. Full paladay feed. C(HMF + 25ml EBM) → give 19ml, rest 6ml next feed.
	P/A - soft	→ Feeding assessment by Dr. Vidhu
	NSG - (N)	→ Involve mother in feeding
		→ RBS - OD
		→ Crib care
		→ Monitor vitals
		→ Start fortification.
	Dr. Bopithe	Noted by malegaur @ 6 PM 6/7/26

AH-00660399

IP5-00175821

aby Of BARIRA FAREED

1-07-2026

0Y0M5D

(M)

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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

22/26

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

Day in NICU: Day of Life: 7 PMA: 34⁵ wks
 Term ☐ Preterm ☒ Gestation: 33¹ SWK Corrected Gestational Age: Today's Weight: 1.541 (1149g)

		Problems	
		S.No.	Current
Overview			Past Problems
	1.		
	2.	Mod. preterm / VLBW	
	3.	Maternal DM / PE	
	4.		
	5.		
Clinical Assessment	Baby on room air hemodynamically stable - 1st 24hrs - full paladei - NO vomiting / spitout - each feed - (10-15ml) - Passing - urine / stool.		HR - 136/min SPO ₂ 100% CRBS - 9.3ns/kg KMC - 2 1/2 hrs NSH - (N)
	Medications Used		
Plan of Care: TV - 140 cal/kg/day - 19ml / 2nd half - EBM / full paladei + HMF - 1g sachet - in 25ml - give 19ml 4 rest 6ml in next feed → RIV - shift out → CRBS - OD - NO - cherting @ 6H. - RIV - vaccination / NBS / Hearing assessment after shift out			

Doctor's Name (Hand over given): Pawan

Signature: Pawan

Date & Time: 7/7/26

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:

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			
Medications Used			
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:



18

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 11:15am.	Shifting Note.	
	DOL-7 → 33+5 wk. PMA → 34+5 wks B.wt 1.6kg.	Plan.
	On RA. Hemodynamically stable Accepting full paladay feed.	→ TV - 160 c/kg/day 21 ml/2nd half full paladay feed. (25ml CBM + 1HMF) give 21ml of it, rest 4ml in next feed.
	D6 - NSG (N) TCBR - 10	→ BCG, OPV, Hep B today. done on 7/7/26 Cani
		→ AABR today
		→ Trace NBS report.
		→ ROP after DOL-21
		→ NP2 @ 40 wks PMA NSG
		→ Wt & Icterus.
		→ Ilo charting 6th half + Temp charting 4th half
		→ GPRS - OD

Dr. Parag Mehta

Noted by
 note @ 7pm
 (P.T.O)

79

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/26 @ 4:30pm	Vaccination - done	Seen by Dr. Dinesh 1) Keep Head end elevation
		2) Continue measured feeds.
		3) Trace NBS report
		4) APBR - Today / Tomorrow
		5) ROP - DOI-21 NB } at 40 weeks PMA. NSG }
		6) Warm Care.
		7) GIBBS - OD.
		8) Training in Baby care
		9) Rlv on discharge Tomorrow.
		10)

noted by written 08/08/26



200

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 10 AM	<u>See Morning Round</u> Self ventilating on KA. Vitality stable tolerating oral feeds PA-sept Passed stools U/O - adequate. vaccine ✓ AABR - pending NBS ✓ weight - not checked today NICU wt = 1.54 ward wt = 1.55 birth wt = 1.6	<u>Plan</u> ① (K) discharge today ② AABR today ③ ROP - DOZ 21 NP2 } 40 wks PMA NCH } ④ BLS training ⑤ head end elevation ⑥ TUV = 160ml/kg/day 21ml q2H EBM + IHMF/ feed paladay/ bottle. <i>[Signature]</i>
8/7/26 10 am.	C/S/B - D/DK	<u>Plan</u> - Trace NBS → AABR - today → Check wgt go today → discharge today F/U - on Friday. - ROP @ 36 wks - Vitamin D3 Zincovit → continue GMP

IP5-00175821

1-07-2026

QYOMSD

(M)

DINESH KUMAR CHIRLA



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[illegible]

BAH-00660399 IP5-00175821
 Baby Of BARRA FAREED
 01-07-2026 0 Y 0 M 0 D 5 H (M)
 Dr. DINESH KUMAR CHIRLA



①

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RESULT SHEET

Date	21/7/2026	4/7/26			
Time	3:33				
Hb	19.4				
PCV	57.7				
RBC	5.65				
WBC	6.46				
N/L	57.35				
Platelets	224				
CRP	5				
ESR					
PCT					
RBS					
Na	143				
K	5.8				
Cl	118				
Ca/Mg	8.8				
Phosphate					
Urea	31				
Creatinine	1.0				
ALP					
SGPT					
SGOT					
T.Bill/Conj	6.05 ^{0.1} 5.9	5.5 ^{0.1} 5.4			
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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

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.

[illegible][illegible][illegible]



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG : <i>HMF sachet</i>				Date Time	<i>07</i>	<i>27</i>															
Dose	Route	Frequency	Start Date																		
	<i>PO</i>	<i>each</i> <i>2ad</i>	<i>6/7/26</i>		<i>-</i>	<i>-</i>															
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Deepthi</i>					<i>-</i>	<i>-</i>															
					<i>-</i>	<i>-</i>															
					<i>-</i>	<i>-</i>															
Additional Instructions: <i>1 Sachet + 25ml ^{max} _{FBM}</i>					<i>-</i>	<i>-</i>															
					<i>-</i>	<i>-</i>															
					<i>-</i>	<i>-</i>															
Daily Doctor's Endorsement by a Sign																					

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

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

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

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.

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

I.V. FLUIDS CHART

Weight. Ward.

Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign



1/7/26

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time: 12:30	2	4	6	8	10	12	2	4	6	8
Doctor/Nurse/Family Concern?	PM	PM	PM	PM	PM	PM	PM	AM	AM	AM	AM

Temperature (F)	104											
	103											
	102											
	101	98.5	96.5	96.5	96.5	96.5	96.5	96.5	96.5	96.5	96.5	
	100	*	*	*	*	96.5	96.5	96.5	96.5	96.5	96.5	
	99					*	*	*	*	*	*	
	98											
	97											
	96											
	95											
94												

Heart Rate (bpm)	190										
	180										
and	170										
	160										
Blood Pressure (mmHg) *	150	155	152	152	50	57	52	56	79	52	
	140	37	43	40	(42)	(46)	(42)	(45)	(58)	(40)	
Note: BP does not score in early warning scoring	130										
	120										
	110										
	100	33	29	32	38	40	35	39	46	35	
	90										
	80										
	70										
	60										
	50										

Heart Rate (Number)	131	141	142	146	138	130	128	133	133	119
---------------------	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

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

Resp Distress	Mod/ Severe									
	None / Mild									
Receiving O ₂ (l/min)										
O ₂ Saturations (%)		98%	98%	98%	95%	96%	94%	95%	100%	100%
Conscious Level	Normal / Altered	N	N	N	N	C	C	C	C	C
GCS *		C	C	C	C	N	N	N	N	N
TOTAL SCORE		1	1	1	1	1	1	1	1	1
Number of shaded boxes		1	1	1	1	1	1	1	1	1
Pain Score		0	0	0	0	0	0	0	0	0
Observer's Initials		→	→	→	→	→	→	→	→	→

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- 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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

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

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

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

9/7/26

Doctor/Nurse/Family Concern?

Temperature
(°F)Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp	Mod/ Severe
Distress	None / Mild

Receiving O ₂ (l/min)	O ₂ Saturations (%)
0	95.0
1	95.0
2	95.0
3	95.0
4	95.0
5	95.0
6	95.0
7	95.0
8	95.0
9	95.0
10	95.0
11	95.0
12	95.0
13	95.0
14	95.0
15	95.0
16	95.0
17	95.0
18	95.0
19	95.0
20	95.0
21	95.0
22	95.0
23	95.0
24	95.0
25	95.0
26	95.0
27	95.0
28	95.0
29	95.0
30	95.0
31	95.0
32	95.0
33	95.0
34	95.0
35	95.0
36	95.0
37	95.0
38	95.0
39	95.0
40	95.0
41	95.0
42	95.0
43	95.0
44	95.0
45	95.0
46	95.0
47	95.0
48	95.0
49	95.0
50	95.0
51	95.0
52	95.0
53	95.0
54	95.0
55	95.0
56	95.0
57	95.0
58	95.0
59	95.0
60	95.0
61	95.0
62	95.0
63	95.0
64	95.0
65	95.0
66	95.0
67	95.0
68	95.0
69	95.0
70	95.0
71	95.0
72	95.0
73	95.0
74	95.0
75	95.0
76	95.0
77	95.0
78	95.0
79	95.0
80	95.0
81	95.0
82	95.0
83	95.0
84	95.0
85	95.0
86	95.0
87	95.0
88	95.0
89	95.0
90	95.0
91	95.0
92	95.0
93	95.0
94	95.0
95	95.0
96	95.0
97	95.0
98	95.0
99	95.0
100	95.0

Conscious Level	Normal Altered
-----------------	-------------------

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1 : Continue normal observation by staff nurse

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Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

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Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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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)

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 4/7/26	Time: 8am	10am	12pm	2pm	4pm	6pm	8pm	10pm	12pm	2am	4am	6am
Doctor/Nurse/Family Concern?						pm	pm	pm	pm	Am	Am	Am
Temperature (F)	99.6°C	99.6°C	99.5°C	99.8°C	99.8°C	99.5°C	99.5°C	99.5°C	99.5°C	99.5°C	99.6°C	99.4°C
Heart Rate (bpm)	60	60	60	60	60	60	60	60	60	60	60	60
Blood Pressure (mmHg) *	133/43	133/43	133/43	133/43	133/43	133/43	133/43	133/43	133/43	133/43	133/43	133/43
Note: BP does not score in early warning scoring												
Heart Rate (Number)	138	142	142	163	144	139	140	145	149	150	158	141
Resp. Rate (bpm) er 1 Minute) *	63	64	60	45	46	55	47	40	40	38	45	65
Resp Rate (Number)	63	64	60	45	46	55	47	40	40	38	45	65
Resp Mod/ Severe Distress None / Mild												
Receiving O ₂ (l/min) O ₂ Saturations (%)	94%	94%	94%	98%	100%	98%	100%	97%	99%	100%	99%	99%
Conscious Level Normal Altered												
GCS *	4	4	4	4	4	4	4	4	4	4	4	4
TOTAL SCORE	0	0	0	0	0	0	0	0	0	0	0	0
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	ah	h	g	os	os	A	A	A	A	A	A	A

ACTIONS

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	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	pm	pm	pm	pm
Temperature (F)		36.6	36.6	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5
Heart Rate (bpm)		142	138	134	134	125	130	140	150	139	144	140	142
Blood Pressure (mmHg) *		94/54	95/52	95/43	95/43	95/43	95/43	95/43	95/43	95/43	95/43	95/43	95/43
Resp. Rate (bpm) (Over 1 Minute) *		54	43	52	39	10	52	45	53	60	41		
Receiving O ₂ (l/min)													
O ₂ Saturations (%)		96%	98%	98%	95%	96%	95%	95%	97%	98%	99%	100%	
Conscious Level		N	N										
GCS *		C	C	C	C	C	C	C	C	C	C	C	C
TOTAL SCORE		1	1	1	1	1	1	1	1	1	1	1	1
Number of shaded boxes		1	1	1	1	1	1	1	1	1	1	1	1
Pain Score		0	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials		CD	CD	CD	CD	CD	CD	CD	CD	CD	CD	CD	CD

ACTIONS

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NB: Scores 3 should be recorded overleaf

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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
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INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	8	10	12	2	4	10	12	2	4	
Doctor/Nurse/Family Concern?		dm	dm	pm	pm	pm	pm	Am	Am	Am-Am	
Temperature (F)	104										
	103										
	102										
	101										
	100	36.7C	36.6C	Cribbe Care	Care	98.4F	98.4F	98.6F	98.2F	98.8F	
	99										
	98										
	97										
	96										
	95										
94											
Heart Rate (bpm) and Blood Pressure (mmHg) *	190										
	180										
	170										
	160										
	150										
	140										
	130										
	120										
	110										
	100										
Note: BP does not score in early warning scoring	90										
	80										
	70										
	60										
	50										
	Heart Rate (Number)	146	192	136dm	140G/m	132	142	146	132	146	
	Resp. Rate (bpm) (Over 1 Minute) *	70									
		60									
		50									
		40									
30											
20											
10											
Resp Rate (Number)		63	40	Cribbe care	40 rate						
Resp Distress		Mod/ Severe									
None / Mild											
Receiving O ₂ (l/min)											
O ₂ Saturations (%)	92%	93%	99%	99%	98%	98%	98%	98%	98%		
Conscious Level	Normal	N	N	N	N	N	N	N	N		
Altered											
GCS *		C	C	C	C	C	C	C	C		
TOTAL SCORE		1	1	1	0	0	0	0	0		
Number of shaded boxes											
Pain Score		0	0	0	0	0	0	0	0		
Observer's Initials		DP	DP	DP	DP	DP	DP	DP	DP		
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.									
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	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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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:	Time:	8	10	12	3	6pm	10pm	2pm	6Am
Doctor/Nurse/Family Concern?		Am	Am	Pm	Pm				
Temperature (°F)	104								
	103								
	102								
	101								
	100								
	99	98.5	98.5	98.5	98.5	98.5	98.5	98.5	98.5
	98								
	97								
	96								
	95								
94									
Heart Rate (bpm)	190								
180									
170									
160									
150									
140									
Blood Pressure (mmHg) *	130	100/60	100/60	100/60	100/60	100/60	100/60	100/60	100/60
120									
110									
100									
90									
80									
70									
60									
50									
Note:									
BP does not score in early warning scoring									
Heart Rate (Number)		120bpm	136bpm	140bpm	160bpm	130bpm	140bpm	140bpm	130bpm
Resp. Rate (bpm) (Over 1 Minute) *	70								
60									
50									
40									
30									
20									
10									
Resp Rate (Number)									
Resp Distress	Mod/ Severe								
None / Mild									
Receiving O ₂ (l/min)									
O ₂ Saturations (%)		100%	100%	100%	99%	99%	99%	98%	98%
Conscious Level	Normal	N	N	N	N	N	N	N	N
Altered									
GCS *		1	1	1	1	1	1	1	1
TOTAL SCORE									
Number of shaded boxes		1	1	1	1	0	0	0	0
Pain Score		0	0	0	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							

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00660399 IP5-00175821
 Baby Of BARIRA FAREED
 01-07-2026 0 Y 0 M 0 D 7 H (M)
 Dr. DINESH KUMAR CHIRLA



FLUID CHART

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 It takes a lot to treat the little.

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Sheet No. :

1/7/26

TV 0
 Baf 0
 To 7 0

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	NG							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm	DBM		8ml								
	06:00 pm											
	07:00 pm	DBM		8ml					10ml			
Total Intake : 16ml					Total Output :							
	08:00 pm											
	09:00 pm	DBM		8ml		passed			7ml	1		
	10:00 pm											
	11:00 pm	DBM		8ml					7ml	0		
	12:00 am											
	01:00 am	DBM		8ml		passed			8ml	1		
Total Intake : 24ml					Total Output :							
	02:00 am											
	03:00 am	DBM		8ml					7ml	1		
	04:00 am											
	05:00 am	DBM		8ml		passed			8ml	0		
	06:00 am											
	07:00 am	DBM		8ml					8ml	1		
Total Intake : 24ml / 60ml					Total Output : 23ml							
Total 24 hrs. Intake		40 ccl/kg/day.										
Total 24 hrs. Output		1.2 ccl/kg/hr.										

02/07/2026



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	NG						
	08:00 am										
	09:00 am	DBM			8ml				7ml		
	10:00 am										
	11:00 am	DBM			8ml	Passed			9ml		
	12:00 pm										
	01:00 pm	DBM			8ml				7ml		
Total Intake :					Total Output :						
	02:00 pm										
	03:00 pm	DBM			10ml	—			10ml		
	04:00 pm										
	05:00 pm	DBM			10 ml.	passed			8ml.		
	06:00 pm										
	07:00 pm	DBM			10ml	—			10ml		
Total Intake :					Total Output :						
	08:00 pm										
	09:00 pm	DBM			10ml	—			10ml		
	10:00 pm										
	11:00 pm	DBM			10ml				7ml		
	12:00 am										
	01:00 am	DBM			10ml	passed					
Total Intake :					Total Output :						
	02:00 am										
	03:00 am	DBM			10ml	passed			6ml		
	04:00 am										
	05:00 am										
	06:00 am										
	07:00 am										
Total Intake :					Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. : 3

TV. 800g
B.Wt. 1.53 kg
Tf - 13ml.

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	OG							
	08:00 am											
	09:00 am	DBM			13ml		Passed			9ml	1	②
	10:00 am											
	11:00 am	DBM			13ml		-			8ml	1	②
	12:00 pm											
	01:00 pm	DBM			13ml		Passed			6ml	1	②
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm	DBM	13ml				-			8ml	1	②
	04:00 pm											
	05:00 pm	DBM	13ml				Passed			10ml	0	②
	06:00 pm											
	07:00 pm	DBM	13ml				-			6ml	1	②
Total Intake :					Total Output :							
	08:00 pm	DBM	13ml				Passed			7ml		②
	09:00 pm											
	10:00 pm	DBM	13ml				-			6ml		②
	11:00 pm											
	12:00 am	DBM	13ml				Passed			8ml		②
	01:00 am											
Total Intake :					Total Output :							
	02:00 am	DBM	13ml				-			9ml		②
	03:00 am											
	04:00 am	DBM	13ml				Passed			8ml		②
	05:00 am											
	06:00 am	DBM	13ml				Passed			6ml		②
	07:00 am											
Total Intake : 156 ml					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							

4/7/26

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.

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	NG						
	08:00 am										
	09:00 am	DBM	13ml			passed			9ml		
	10:00 am										
	11:00 am	DBM	16ml						10ml		
	12:00 pm										
	01:00 pm	DBM	16ml						10ml		
Total Intake :					Total Output :						
	02:00 pm										
	03:00 pm	DBM	16ml			passed			12ml		
	04:00 pm										
	05:00 pm	DBM	16ml			passed			8ml		
	06:00 pm										
	07:00 pm	DBM	16ml						9ml		
Total Intake :					Total Output :						
	08:00 pm										
	09:00 pm	EBM		16ml					10ml		
	10:00 pm										
	11:00 pm	EBM		16ml		passed			10ml		
	12:00 am										
	01:00 am	EBM		16ml					8ml		
Total Intake :					Total Output :						
	02:00 am								12ml		
	03:00 am	DBM		16ml		passed					
	04:00 am										
	05:00 am	DBM		16ml					5ml		
	06:00 am										
7/30am	07:00 am	DBM		16ml		passed			10ml		
Total Intake :					Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

5/7/26

FLUID CHART

Sheet No. : 5

Tv → 120 cc/kg
 B:W → 1.53 kg
 Tf - 14 ml

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	NG							
	08:00 am											
	09:00 am	DBM	14 ml				Passed		10 ml			
	10:00 am											
	11:00 am	DBM	14 ml						10 ml			
	12:00 pm											
	01:00 pm	DBM	14 ml				Passed		10 ml			
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm	EBM	17 ml						14 ml			
	04:00 pm											
	05:00 pm	EBM	17 ml				Passed		8 ml			
	06:00 pm											
	07:00 pm	EBM	17 ml						12 ml			
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm	DBM	17 ml				Passed		10 ml			
	10:00 pm											
	11:00 pm	EBM	17 ml						5 ml			
	12:00 am											
	01:00 am	EBM	17 ml						7 ml			
Total Intake :					Total Output :							
	02:00 am											
	03:00 am	EBM	17 ml						10 ml			
	04:00 am											
	05:00 am	EBM	17 ml						8 ml			
	06:00 am											
	07:00 am	DBM	17 ml						4 ml			
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							



6/7/26

FLUID CHART

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Sheet No. : 6

Tr. - 100cc/kg/day
 B. wt - 1.5 kg
 Tr. - 19 ml

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										
	08:00 am														
	09:00 am	EBM	4ml				passed			10ml					
	10:00 am														
	11:00 am	EBM	17ml				passed			9ml					
	12:00 pm														
	01:00 pm	EBM	17ml				passed			8ml					
Total Intake :						Total Output :									
	02:00 pm														
	03:00 pm	EBM	17ml				passed			8ml					
	04:00 pm														
	05:00 pm	EBM	10ml												
	06:00 pm														
	07:00 pm	EBM	10ml				passed			12ml					
Total Intake :						Total Output :									
	08:00 pm														
	09:00 pm	EBM	10ml				passed			8ml					
	10:00 pm														
	11:00 pm	EBM	10ml							6ml					
	12:00 am														
	01:00 am	EBM	10ml				passed								
Total Intake :						Total Output :									
	02:00 am														
	03:00 am	EBM	10ml							8ml					
	04:00 am														
	05:00 am	EBM	10ml				passed			6ml					
	06:00 am														
	07:00 am	EBM	10ml							8ml					
Total Intake : 220ml						Total Output : 83ml									
Total 24 hrs. Intake			142cc/kg/day												
Total 24 hrs. Output			2.3cc/kg/day												

AH-00660399 IP5-00175821
 Baby Of BARIKA FAREED
 1-07-2026 0 Y 0 M 5 D (M)
 R. DINESH KUMAR CHIRLA



7/7/26

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FLUID CHART

Sheet No. : (2)

TV -
 B.Wt -
 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 Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am	EBM 19ml					passed			10ml			
	10:00 am									9ml			
	11:00 am	EBM 19ml					-						
	12:00 pm												
	01:00 pm	EBM 19ml					passed			10ml			
Total Intake :						Total Output :						m:	
	02:00 pm												
	03:00 pm	EBM 19ml					✓			✓			
	04:00 pm												
	05:00 pm	EBM 19ml					✓			✓			
	06:00 pm												
	07:00 pm	EBM 19ml											
Total Intake :						Total Output :						m: 2	
	08:00 pm												
	09:00 pm	EBM 19ml					✓			✓			
	10:00 pm												
	11:00 pm	EBM 19ml											
	12:00 am												
	01:00 am	EBM 19ml											
Total Intake :						Total Output :						m: 1	
	02:00 am												
	03:00 am	EBM 19ml					✓			✓			
	04:00 am												
	05:00 am	EBM 19ml											
	06:00 am												
	07:00 am	EBM 19ml											
Total Intake :						Total Output :						m: 1	
Total 24 hrs. Intake													
Total 24 hrs. Output		U-7 m-6											

Patient Sticker

FLUID CHART

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Sheet No. :

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

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

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26

Assessment: Baby on e/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
8pm	→ Assess the general condition of baby	8:30pm	→ Assessed, General condition of baby	Baby is Stable.
12:pm	→ Provide comfortable position	12:3pm	→ Provided comfortable position.	
2 PM	→ Ensure safety	2:30pm	→ Ensured safety	
3:AM	→ Give feed 2nd hourly	3:30am	→ Given feed 2nd hourly	
6:AM	→ maintain I/O chart	6:30am	→ maintained I/O chart	

Re-Assessment: Done.

Special Notes: RBS - OD

Nurse Signature: [Signature]

Nurse Name: Madhava

Date & Time: 4/7/26 @ 8am



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

Assessment: Baby on 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
2pm	→ Assess the baby condition.	2:35pm	→ Assessed the baby condition.	Baby is now stable.
4pm	→ Monitor vital signs.	4:30pm	→ Monitored vital signs.	
5pm	→ provide comfortable position.	5:15pm	→ provided comfortable position.	
6pm	→ Maintain I/O chart.	6:10pm	→ Maintained I/O chart.	
7:30 pm	→ Administer medication as per doctor's order	8:00pm	→ Administered medication as per doctor's order.	

Re-Assessment: RBS - ~~DD~~ Re-Assessment done

Special Notes: RBS - DD

Nurse Signature:

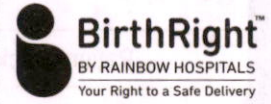
Nurse Name: Lokanya

Date & Time: 4/7/26 @ 2pm-8pm

BAH-00660399 IP5-00175621
 Baby Of BARIKA FAREED
 01-07-2026 0 Y 0 M 1 D (M)
 Dr. DINESH KUMAR CHIRLA

3

NURSING CARE RECORD



Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: baby on R/L

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the baby condition	8am	Assessed the baby condition	baby on stable.
10am	maintain I/O chart	10am	maintained I/O chart.	
12pm	provide comfortable position	12pm	provide comfortable position.	
2pm	administer medication as per doctor advice.	2pm	Administer medication as per doctor advice.	

Re-Assessment: Re-Assessment done

Special Notes: RBS - OD

Nurse Signature: [Signature]

Nurse Name: ABhi

Date & Time: 4/7/26 @ 8am-2pm



4

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 03/07/26

Assessment: Baby 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 General Condition baby	8 Pm	=> Assessed the General Condition baby	Baby is stable
10 Pm	=> Monitor vital Signs	10 Pm	=> Monitored vital signs	
12 Am	=> Provide feed (EBM or DBM) 2nd hourly	12 Pm	=> Provided feed (EBM or DBM) 2nd hourly.	
2Am	=> Provide comfortable Position	2Am	=> Provided comfortable Position	
8Am	=> Ensure Patients Safety	8 Am	=> Ensured Patient Safety	

Re-Assessment: Re - Assessment done

Special Notes: RBS - OD

Nurse Signature: [Signature]

Nurse Name: Suchitra

Date & Time: 04/07/26@8Pm-8Am

AH-00660399 IP5-00175821
 Baby Of BARIRA FAREED
 1-07-2026 0 Y 0 M 5 D (M)
 r. DINESH KUMAR CHIRLA



NURSING CARE RECORD

Rainbow Children's Hospital
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BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 3/7/24

Assessment: baby on R/O

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
	- Assess the baby General Condition - monitor vital signs. - maintain I/O chart - provide comfortable position. - Administer medication as per doctor advice. - ensure safety.		- Assess the baby General Condition - monitor vital signs. - maintain I/O chart - provide comfortable position. - Administer medication as per doctor advice. - ensure safety.	baby on R/O

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

[Signature]

[Signature]

3/7/24 @ 6pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/7/26

Assessment: Baby on R/A

- 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:pm	→ Assess the General condition of baby	8:30pm	→ Assessed the General condition of baby.	→ Baby is stable
10:pm	→ monitor for vital signs	10:10pm	→ monitored vital signs	→ Tolerated
12pm	→ provide feeds (EBM or DBM) 2 nd hourly as tolerated	12:pm	→ DBM feeds given 2 nd hourly	Feed
2:pm	→ Ensure patient's safety	2pm.	→ ensured patient safety	
4:pm	→ Provide comfortable position	4:30pm	→ provided comfortable position	
6:Am	→ oral care and diaper change	6:Am	→ oral care and diaper change	

Re-Assessment: Done.

Special Notes: feeding 2nd hourly, monitor vital signs.

Nurse Signature: Al Nurse Name: Madhavi Date & Time: 2/7/26 8pm-8am

BAH-00660399 IP5-00175821
 Baby Of BARIRA FAREED
 01-07-2026 QYOMOD7H (M)
 Dr. DINESH KUMAR CHIRLA



2

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: 1/7/26

Assessment: Baby on 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
8pm	⇒ Assess the baby condition.	9pm	⇒ Assessed the baby condition.	Baby is stable
10pm	⇒ Monitor the vitals.	11pm	⇒ Monitored the vitals.	
12AM	⇒ Feeds give 2nd hourly.	1AM	⇒ Feeds given 2nd hourly.	
2AM	⇒ Ensure safety.	3AM	⇒ Ensure safety.	
4AM	⇒ Maintain skin integrity.	5AM	⇒ Maintained skin integrity.	
6AM	⇒ provide comfortable position.	7AM	⇒ provided comfortable position.	

Re-Assessment: Re-assessment done

Special Notes: GRBS - 6th hourly

Nurse Signature:

Nurse Name: Navaneetha

Date & Time: 1/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 1/7/26

Assessment: Pt, LBW, on OG feed,

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
1pm	* To receive the baby.	1pm	* Received the baby and	* To maintain feed
2pm	* To monitor vital signs.	2pm	* performed assessment done.	well.
3pm	* To provide feed.	2pm	* Monitored vital signs and documented every way.	* Maintaining spo2
5pm	* To provide oral care.	5pm	* provided bath feed.	well.
7pm	* To monitor urine output.	7pm	* Monitored & intake output.	

Re-Assessment:

Done on asse.

Special Notes:

Watch for cramp, asse, apnea,

Nurse Signature:

Karuj

Nurse Name:

Karuj

Date & Time:

1/7 @ 8pm

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 02.07.2026

Assessment: Baby is on room air

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
* 8:00 AM	Assess the baby's condition	8 AM.	1) Assessment done properly	Stable
* 10:00 AM	Monitor for vital signs	9:00 AM	monitored vital signs	
* 12:00 PM	Provide feeds (EBM/for DBM) 2nd hourly as tolerated.	12:00 PM	DBM feeding given 2 hourly as tolerated feeds	
* 02:00 PM	Ensure patient's safety	2 PM	patient safety ensured	
* 04:00 PM	Positioning the baby comfortably.			
* 6:00 PM	oral care and diaper change			

Re-Assessment: Done

Special Notes: keep feeding 2nd hourly, monitor vital signs

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 2/7/26 @ 20:58 PM

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 2/7/26

Assessment: Baby on R/L

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 condition	2:15pm	* Assessed the baby condition.	Baby is now stable.
4pm	* Monitor vital signs	4:15pm	* Monitored vital signs.	
5:00 pm	* Provide comfortable position.	5:30pm	* provided comfortable position.	
6pm	* Give feeds 2nd hourly	6:30pm	* Given feeds 2nd hourly	
7pm	* Maintain skin safety	7:30pm	* Maintained skin safety	

Re-Assessment: Done.

Special Notes: RBS - BD

Nurse Signature: Lokanjan

Nurse Name: RA

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



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby is on 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 general condition.	8 Am	Assessed the baby general condition.	Baby is Stable Now.
10 Am	Monitors vitals signs and Maintain I/O chart	10 Am	Monitored vitals signs and maintain I/O chart.	
12 pm	provide Comfortable position	12 pm	provided Comfortable position.	
2 pm	given feeding every two hours.	2 pm	given feeding every two hours.	

Re-Assessment: Re-Assessment

Special Notes: RBS- BD

Nurse Signature: Akasha Nurse Name: Akasha Date & Time: 5/07/26 @ 2 pm.

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby is on RA

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 General Condition of the baby	2pm	*Assessed the General Condition of the baby	Baby is stable
4pm	*monitored vital signs	4pm	*monitored vital signs	
6pm	*maintained Ilo chart	6pm	*maintained Ilo chart	
8pm	*Give feeding 2nd hourly	8pm	*provided comfortable position	
	*provide comfortable position		*Ensured safety	

Re-Assessment: Done

Special Notes: RBS - OP

Nurse Signature: [Signature]

Nurse Name: Yamuna

Date & Time: 5/07/26 @ 2pm

BAH-00660399 IP5-00175821
 Baby Of BARIJA FAREED
 01-07-2026 0 Y 0 M 4 D (M)
 Dr. DINESH KUMAR CHIRLA



25

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

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 Your Right to a Safe Delivery

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Baby is on 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:pm	Assess the General Condition of the baby	8:30pm	→ Assessed the General Condition of baby.	Baby is Stable now
11:pm	monitor vitals & I/O chart	11:30pm	→ maintained vitals & I/O chart	
3:pm	Given feed 2nd hourly	3:10pm	→ Given feed 2nd hourly	
6:pm	Ensure safety	6:10pm	→ Ensured safety.	
8:Am.	Provide comfortable position	8:am	→ Provide comfortable position	

Re-Assessment: Done.

Special Notes: RBS - OD

Nurse Signature: A

Nurse Name: Moddama

Date & Time: 6/7/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date:

Assessment: Baby is on 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 general condition.	8 Am	Assessed the baby general condition.	Baby is stable now.
10 Am	Monitor the vitals signs.	10 Am	monitored vitals signs.	
12 pm	Provide Comfortable position.	12 pm	Provided Comfortable position.	
2 pm	give the feed 2 nd hly	2 pm	give the feed 2 nd hly.	
4 pm	Ensure Safety	4 pm	Ensured safety	

Re-Assessment: Re-Assessment Done.

Special Notes: RBS-OD. 5 feeds given mother given 5 feeds feed 2 mother 3 Grand mother

Nurse Signature: Malleswari

Nurse Name: Malleswari

Date & Time: 6/7/20 @ 8 pm.

15

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 06/02/26 @ 8pm

Assessment: PT/RDS (CNS case)

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	→ TV - 120cc 10% Day	8pm	→ TV - 120cc 10% Day	Baby is stable. Maintaining temperature.
10pm	→ maintain SIO chart	10pm	→ maintained SIO chart	
12am	→ monitor core vitals	12am	→ monitored core vitals	
2am	→ Give feed 2nd body	2am	→ Given feed and body	
4am	→ provide comfortable position	4am	→ provided comfortable position	
6am	→ Administer the medications	6am	→ Administered the medications as per doctors orders	

Re-Assessment:

watch for hypokalemia

Special Notes:

PBS-OD

Nurse Signature:

[Signature]

Nurse Name:

B. Nanya

Date & Time:

02/02/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 7/7/26

Assessment: Baby is on 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
8Am	→ Assess the baby general condition	8:10Am	→ Assessed the general condition	Now baby is maintaining well
10Am	→ maintain I/O chart	10:12Am	→ maintained I/O chart	
12Pm	→ monitor the vital signs	12:20Pm	→ monitored the vital signs	
2Pm	→ give 2nd hourly feed	2:10Pm	→ given 2nd hourly feed	
4Pm	→ maintain personal Hygiene	4:15Pm	→ maintained personal Hygiene	
6Pm	→ Administer the medication as per doctors order	6:30Pm	→ Administered the medication as per doctors order	
7Pm	→ Prevent infection	7:10Pm	→ prevented infection	
8Pm	→ Ensure safety	8:10Pm	→ Ensure safety	

Re-Assessment: Re assessment done

Special Notes: full partially feed

Nurse Signature: [Signature] Nurse Name: Mallikarjuna Date & Time: 7/7/26

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Dinesh Kumar Department: 3rd floor Date of Admission: 1/7/26

SITUATION	Diagnosis: <u>ELW = preterm</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	Area						
BACKGROUND	Shift Time	<u>3rd floor 3pm-8pm</u>	<u>3rd floor 8pm-8am</u>				
	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	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>97.1 F</u>	<u>97.1 F</u>			
		Res:	<u>42b/m</u>	<u>42b/m</u>			
		SpO ₂ :	<u>97%</u>	<u>97%</u>			
		Pulse:	<u>130b/m</u>	<u>130b/m</u>			
		BP:	<u>-</u>	<u>-</u>			
	Fall Risk Score:	<u>-</u>	<u>-</u>				
Pain Score:	<u>-</u>	<u>-</u>					
Recommendations	Safety Needs:	<u>Care</u>	<u>Care</u>				
	Physiotherapy	☐ 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	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>				
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>				
Handed Over By Name :		<u>biresh</u>	<u>Sangal</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>7/7/26</u>	<u>8/7</u>				
Time:		<u>8pm</u>	<u>8am</u>				
Taken Over By Name :		<u>Sangal</u>	<u>pooya</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>7/7</u>	<u>9/7/26</u>				
Time:		<u>8pm</u>	<u>8am</u>				

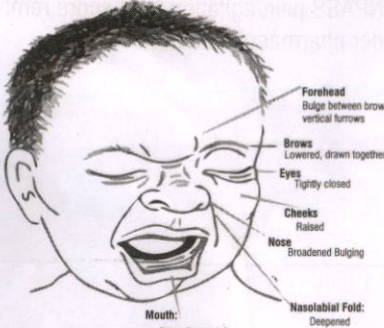


NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

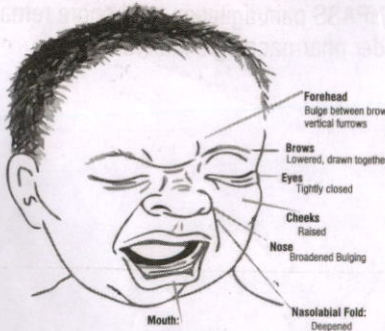
Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time	Time
						1Pm	6Am	6pm	8Pm	6pm	8Am	2pm	8pm	6Am
	Procedure →					-						RBS	RBS	RBS
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	1	1	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)	0	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	0	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	0
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0	0	0	0	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 33+5 Wks 33+5 Wks 33+5 Wks 33+5 Wks 33+5 Wks 33+5 Wks 33+5 Wks 33+5 Wks +1								
						Total Pain / Agitation Score 2 1/10 1/10 1/10 1/10 1/10 1/10 1/10 2/10								
						Intervention ORC DBM DBM DBM DBM DBM DBM DBM								
						Effectiveness Good Good Good Good Good Good Good Good								
						Signature [Signatures]								

NPASS: Neonatal Pain, Agitation & Sedation Scale

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



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
						4/7/26	5/7/26	5/7/26	5/7/26	6/7/26			
								2pm	8pm	8Am			
						Procedure → RBS RBS 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	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)	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	1	1	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	0			
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0	0			
 Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention						Gestational Age / Corrected Age	2	2	2	2	2		
						Total Pain / Agitation Score	2/10	1/10	1/10	1/10	1/10		
						Intervention	DBM FBM	DBM FBM	DBM FBM	DBM FBM	FBM		
						Effectiveness	Good	Good	Good	Good	Good		
						Signature	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		

NPASS: Neonatal Pain, Agitation & Sedation Scale

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



BRADEN 'Q' SCALE

					Date :	17/26	27/26	27/26	31/26
					Time :	18:00	@6am	6pm	
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.		2	2	2	2
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		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.		2	2	2	2
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.		4	4	4	4
FRICITION-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 of 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.		2	2	2	2
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
TOTAL SCORE						18	18	18	18
Evaluator's Name						Katoo	Shr	Shr	Shr

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



BRADEN 'Q' SCALE

(2)

					Date :	3/7	4/7	9/7	11/7/26
					Time :	8pm	@10am	6pm	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: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	2	2	2	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	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.	2	2	2	2	
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.	4	4	4	4	
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	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.	2	2	2	2	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
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	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for "At Risk" Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for "Moderate Risk" Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for "High Risk" Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BAH-00660399 IP5-00175821
Baby Of **BARIRA FAREED**
01-07-2026 0 Y 0 M 4 D (M)
Dr. **DINESH KUMAR CHIRLA**



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 :	5/7/26	8/7	6/7	7/7
					Time :	2pm	3pm	3AM	6AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:tremitry position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	2	2	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 insic'e 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.	2	2	2	2	
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.	4	4	4	2	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	3	3	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	2	2	2	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
TOTAL SCORE					14	14	14	20	
Evaluator's Name					Yaf	noel	W	AB	

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	• 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
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Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

Patient ID

BRADEN 'Q' SCALE

					Date :	7/12			
					Time :	8 AM			
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:remity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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				
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2				
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	2				
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."	4				
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4				
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4				
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	20			
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	20			

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
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Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

①

THE HUMPTY DUMPTY SCALE

1/7 2/7 2/7 2/7/26 3/7

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					
	More than 48 hours / None	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					
TOTAL			15	15	16	16	16

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 :		Barika	Barika	Barika	Barika	Barika
Signature :		Barika	Barika	Barika	Barika	Barika
Date :		1/7	2/7	2/7	2/7/26	3/7
Time :		2pm	6am	6pm	8pm	8pm

THE HUMPTY DUMPTY SCALE

3/7 4/7 4/7 4/7 5/7

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					
	More than 48 hours / None	1					
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			16	16	16	16	16

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
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 :		Schibho	Mary	Lobay	padma	afzal
Signature :		Q	Q	Q	Q	Q
Date :		3/7	4/7	4/7	4/7	5/7
Time :		8pm	8pm	6pm	8pm	8pm



3

THE HUMPTY DUMPTY SCALE

5/7 5/7 6/7 7/7 7/7

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					
	More than 48 hours / None	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

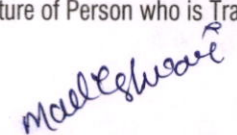
Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		/	/	/	/	/
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 :		Yamuna	Madhu	Kallu	Neeraj	Yash
Signature :		Yash	Madhu	Kallu	Neeraj	Yash
Date :		5/7	5/7	5/7	5/7	5/7
Time :		2pm	2pm	2pm	2pm	2pm

PATIENT TRANSFER FORM

3AH-00660399 IP5-00175821 Baby Of BARIRA FAREED 11-07-2026 0 Y 0 M 4 D (M) Dr. DINESH KUMAR CHIRLA 		Date & Time of Admission 17/7/26	Date & Time of Transfer Order 7/7/26
DR. Dinesh		Transfer Ordered by DR. Dinesh sir	Reason for Transfer stable
From Unit NICU	To Unit 3rd floor [3]	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	diapers	(1)	
2.	wipes	(1)	
3.	feeding bottle	(5)	
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer	
Patient & Clinical Records Received by : Lichitha			
Date & Time of Patient Received : 3:55pm 7/7/26			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- ☐ Unavailable Bed
 ☐ Nurse not Available
 ☐ Available Bed not ready

NEONATAL WEIGHT CHART

Birth Weight:

Admission Weight:

Discharge Weight:

NICU:

Month	Date	Day	Weight (g)	Weight (g)	Weight (g)	NICU
	2	7/26	1054.0			
	3	7/26	1558.1			
	4	7/26	1051.5			
	5	7/26	96.9			
	6	7/26	96.9			
	7	7/26	96.9			
	8	7/26	96.9			
	9	7/26	96.9			
	10	7/26	96.9			
	11	7/26	96.9			
	12	7/26	96.9			
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	4	7/26	96.9			
	5	7/26	96.9			
	6	7/26				

Admission Vitals

R.Wt: 162.3 kg

Temp: 98°F

HR: 132 bpm

RR: 55 bpm

SPO₂: 95%

BP: 45/33 (27)

GRS: -

Pain: (42)

BAH-00660399 IP5-00175821
 Baby Of BARIRA FAREED
 01-07-2026 0 Y 0 M 0 D 7 H (M)
 Dr. DINESH KUMAR CHIRLA

INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: B+ve Baby's Blood Group: Sheet No: (1)
 Gest Age: 33+5 wks Birth Weight: 1.623 kgs

Date: <u>2/7/26</u>	Date: <u>3/2/26</u>	Date: <u>4/7/26</u>
DOL <u>D1</u> Weight <u>1.540 (↓83gms)</u>	DOL <u>D2</u> Weight <u>1.558 gm (↑18gm)</u>	DOL <u>D3</u> Weight <u>1.517 (↓40gms)</u>
Problems: <u>PT/LBW</u>	Problems: <u>PT/LBW</u>	Problems: <u>PT/LBW</u>
Rs. <u>30-60 b/min</u> Exam <u>Done</u> Vent. Setting <u>R/A</u> ABG } <u>NA</u> CXR } <u>NA</u>	Rs. <u>30-60 b/min</u> Exam <u>Done</u> Vent. Setting <u>R/A</u> ABG } <u>NA</u> CXR } <u>NA</u>	Rs. <u>30-60 b/min</u> Exam <u>Done</u> Vent. Setting <u>R/A</u> ABG } <u>NA</u> CXR } <u>NA</u>
CVS <u>Normal</u> HR <u>120-160 b/min</u> BP <u>53/35 Map (43)</u> Cap Refil <u><2-3 seconds</u>	CVS <u>Normal</u> HR <u>120-160 b/min</u> BP <u>53/35 Map (40)</u> Cap Refil <u><2-3 sec</u>	CVS <u>Normal</u> HR <u>120-160 b/min</u> BP <u>53/35 Map (48)</u> Cap Refil <u><2-3 seconds</u>
F/E/N <u>60cc/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 } <u>Nil</u> K BUN } Cl Crea } Hemat HB: WCC Plats Transfusion	F/E/N <u>60cc/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>60 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 } <u>Nil</u> K BUN } Cl Crea } Hemat HB: WCC Plats Transfusion
C/s Results } <u>Nil</u> CRP Antibiotics	C/s Results } <u>Nil</u> CRP Antibiotics	C/s Results } <u>Nil</u> CRP Antibiotics
Med <u>Nil</u> Neuro: <u>NA</u>	Med <u>Nil</u> Neuro: <u>NA</u>	Med <u>Nil</u> Neuro: <u>NA</u>
Assessment <u>Done</u>	Assessment <u>Done</u>	Assessment <u>Done</u>
Plan <u>GRBS - 6th hourly</u>	Plan <u>GRBS 6th hourly</u>	Plan <u>GRBS OD</u>

CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

INTENSIVE CARE UNIT

Sheet No.

Est. Blood Group

Maternal Blood Group

Gest Age

Birth Weight

Date: 11/1/12	Date: 11/1/12	Date: 11/1/12
DOC: [Signature]	DOC: [Signature]	DOC: [Signature]
Weight: 1.517 (3400g)	Weight: 1.525 (3400g)	Weight: 1.510 (3300g)
Problems: 1. Low	Problems: 1. Low	Problems: 1. Low
Exam: 30-80-100	Exam: 30-80-100	Exam: 30-80-100
Vent: 20-20-20	Vent: 20-20-20	Vent: 20-20-20
ABG: [Signature]	ABG: [Signature]	ABG: [Signature]
CXR: [Signature]	CXR: [Signature]	CXR: [Signature]
CVS: Normal	CVS: Normal	CVS: Normal
HR: 120-160/min	HR: 120-160/min	HR: 120-160/min
BP: 50/30-80/40	BP: 50/30-80/40	BP: 50/30-80/40
Cap Refl: 2-3 sec	Cap Refl: 2-3 sec	Cap Refl: 2-3 sec
Eye: 6-8 cm	Eye: 6-8 cm	Eye: 6-8 cm
T-Fixes	T-Fixes	T-Fixes
CO: 10-15/day	CO: 10-15/day	CO: 10-15/day
UO: 1-2/day	UO: 1-2/day	UO: 1-2/day
Exam: 20-20-20	Exam: 20-20-20	Exam: 20-20-20
T-Bild	T-Bild	T-Bild
Na: 130-140	Na: 130-140	Na: 130-140
K: 3.5-4.5	K: 3.5-4.5	K: 3.5-4.5
Cl: 1.0-1.5	Cl: 1.0-1.5	Cl: 1.0-1.5
Hemat Hb	Hemat Hb	Hemat Hb
WCC	WCC	WCC
Plate	Plate	Plate
Transition	Transition	Transition
C/S Results	C/S Results	C/S Results
CRP	CRP	CRP
Anti-tox	Anti-tox	Anti-tox
Med: [Signature]	Med: [Signature]	Med: [Signature]
Neuro: [Signature]	Neuro: [Signature]	Neuro: [Signature]
Assessment: 1. Low	Assessment: 1. Low	Assessment: 1. Low
Plan: 1. Low	Plan: 1. Low	Plan: 1. Low

11/1/12



INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: B+ve Baby's Blood Group: Sheet No: (2)
Gest Age: 33+5 weeks Birth Weight: 1.623 kgs

Date: <u>5/7/26</u>	Date: <u>6/7/26</u>	Date: <u>07/07/26</u>
DOL <u>D4</u> Weight <u>1.521 kgm (14gm)</u>	DOL <u>D5</u> Weight <u>1.521 kgm (14gm)</u>	DOL <u>D6</u> Weight <u>1.501 kgm (14gm)</u>
Problems: <u>PT/LBW</u>	Problems: <u>PT/LBW</u>	Problems: <u>PT/LBW/RDS</u>
Rs. <u>30-60 bpm</u> Exam <u>Done</u> Vent. Setting <u>RIA</u> ABG CXR <u>NA</u>	Rs. <u>30-60 bpm</u> Exam <u>Done</u> Vent. Setting <u>RIA</u> ABG CXR <u>NA</u>	Rs. <u>30-60 bpm</u> Exam <u>Done</u> Vent. Setting <u>RIA</u> ABG <u>NA</u> CXR <u>NA</u>
CVS <u>normal</u> HR <u>120-160 bpm</u> BP <u>52/35 Map (48)</u> Cap Refil <u><2-3 Sec</u>	CVS <u>normal</u> HR <u>120-160 bpm</u> BP <u>52/35 Map (48)</u> Cap Refil <u><2-3 Sec</u>	CVS <u>Normal</u> HR <u>120-160 bpm</u> BP <u>62/46 Map (52)</u> Cap Refil <u><2-3 Sec</u>
F/E/N <u>120cc/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>120cc/kg/day</u> T. Fluids CC/kg/day I/O/RBS: <u>73mg/dl</u> 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>120cc/kg/day</u> T. Fluids <u>220ml</u> CC/kg/day <u>142cc/kg/day</u> I/O/RBS: <u>93mg/dl</u> U Output: <u>2.3 (CC/kg/hr)</u> <u>2.3cc/kg/day</u> Exam <u>Done</u> T. Bil/D <u>6.0</u> Na <u>Hc03 143</u> K <u>BUN 5.8</u> Cl <u>Crea 118</u> Hemat HB: <u>19.4</u> WCC <u>6.46</u> Plats <u>224</u> Transfusion <u>NA</u>
C/s Results CRP Antibiotics	C/s Results CRP Antibiotics	C/s Results <u>Done</u> CRP <u>5.0</u> Antibiotics <u>NA</u>
Med <u>nil</u> Neuro: <u>NO</u>	Med <u>nil</u> Neuro: <u>NO</u>	Med <u>7.4mmf</u> Neuro: <u>NA</u>
Assessment <u>done</u>	Assessment <u>done</u>	Assessment <u>Done</u>
Plan <u>CRBS OD</u>	Plan <u>CRBS-OD</u>	Plan <u>RBS-OD</u>

Patient Sticker

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD



Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
1/7	12:40pm	1	Explains about diagnosis and treatment.	C	1	0	1	1	Good	

Part - III: CODES

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

Patient Sticker

MULTI-DISCIPLINARY PLAN OF CARE FORM



Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Nursing ☐ Others:
1/7/26	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	* Preference. * LBD * waterman care	* To start waterman care	* To start 4 waterman care. * To start 4 OG feed		☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

[illegible]



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ADMISSION CRITERIA – NICU

Admission / Transfer from:

- ☐ Emergency ☐ Outpatient (OPD) ☐ Ward ☒ Operation Theater ☐ Others:

Tick (✓) any of the following criteria requiring admission / transfer to NICU

~~Prematurity and Low Birth Weight Babies:~~

- ☒ Respiratory Distress
- ☐ Congenital Heart Disease
- ☐ Suspected or CONFIRMED SEPTICAEMIA
- ☐ Suspected or Diagnosed Meningitis
- ☐ UTI
- ☐ Septic Arthritis or Osteomyelitis
- ☐ Congenital Infections (Varicella, Pneumonia)
- ☐ Acquired Viral Illness
- ☐ Hyperbilirubinemia
- ☐ Severe Dehydration
- ☐ Bleeding Manifestations
- ☐ Neonatal Seizures
- ☐ Birth Asphyxia
- ☐ Surgical Problems
- ☐ Suspected Metabolic Disorders
- ☐ Dysmorphic Features
- ☐ Congenital Serious Cutaneous Disorder

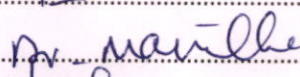
Major Surgical Problems:

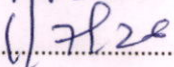
- ☐ Congenital Hydrocephalus
- ☐ Neural Tube Defects
- ☐ Choanal Atresia
- ☐ Trachea- Esophageal Fistula
- ☐ Esophageal Atresia
- ☐ Congenital Diaphragmatic Hernias
- ☐ Eventration of Diaphragm
- ☐ Congenital Cystic Adenomatoid Malformation
- ☐ Intestinal Atresias
- ☐ Gastric Volvulus
- ☐ Cleft lip or Cleft Palate
- ☐ Omphalocele / Gastroschisis
- ☐ Anorectal Malformations
- ☐ Gross Hydronephrosis
- ☐ Posterior Urethral Valves
- ☐ Congenital Tumors
- ☐ Cystic Hygromas

Criteria for shifting inborn babies from wards to NICU:

- ☐ Any Baby with Lethargy, Poor Feeding, Gross Weight Loss and Dehydration
- ☐ Any Baby with Severe Jaundice Requiring Exchange Transfusion
- ☐ Any Baby with Blood Sugar Abnormalities (Hypo or Hyperglycaemia)
- ☐ Any Baby with Temperature Instability
- ☐ Any Baby with Signs of Sepsis
- ☐ Any Baby with Seizures
- ☐ Out Born Babies: (Including Walk in Patients to the Emergency Room / Neonatal Transports)

Signature of the Doctor: 

Name of the Doctor: 

Date & Time: 

Patient Sticker

DISCHARGE CRITERIA – NICU

Discharge to:

- ☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☐ Others:

Tick (✓) any of the following criteria requiring discharge / transfer from NICU

- ☐ The clinical status of the patient no longer warrants constant medical and nursing monitoring or specialized services originally required.
- ☐ Preterm baby once attained weight of >1.5kgs and crossing the PMA of >35 weeks of gestation.
- ☐ Preterm babies maintaining normal temperatures (36.5-37.5°C) in room temperature.
- ☐ All preterm, low birth weight babies and babies who had critical course in the NICU

Signature of the Doctor:

Name of the Doctor :

Date & Time:

AH-00660399 IP5-00175821
Baby Of BARIRA FAREED
1-07-2026 0 Y 0 M 5 D (M)
R. DINESH KUMAR CHIRLA
[Barcode]

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CROSS

FORM

Doctor Name: Dr. Vidli Navandher Date: 6/7/26 Time: 2:00pm

Diagnosis: (1) feeding difficulties & prematurity

Hospital: RCH; Baripana

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:

Findings and Recommendations: Thanks for the referral.

* Infant was well active

* CRME assessed & revealed structurally & functionally adequate

* Tone, symmetry & reflexes are expected within age limits

* matured sucking & suck-swallow coordination

* Initiated with spoon feeding

* Grandmother was trained with feeding related techniques with frequent cupping

* To make the baby active before feeding

* Flap

Consultant :

Name: Dr. Vidli

Signature: [Signature]

Date & Time: 06/07/26





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NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA : 1/7/26		Diagnosis : LBW		Surgery / Procedures : NFI			
	Allergies : NFI				Post OP Day : NFI			
	Date :	1/7/26	1/7/26	2/7/26	2/7/26	2/7/26	3/7/26	
	Area	N2	N2	N2	N2	N2	N2	
	Shift Time	8am-8pm	8pm-8am	8am-2pm	2pm-8pm	8pm-8am	8am-8pm	
	Diet :	DBM+EBM	EBM+DBM	DBM	DBM/EBM	DBM/EBM	DBM/EBM	
	Ventilation (RA, NP, NIV, VENTI)	RA	R/A	R/A	R/A	R/A	R/A	
VE LINES	1.	OG-①	OG-①	OG-①	OG-①	OG-①	OG-①	
	2.							
	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	99/85(40)	56/43(42)	54/42(40)	62/46(52)	57/41(42)	50/42(42)
		PR	132	138b/min	133	125	125	102b/min
		RR	76	39b/min	57	61	uu	52b/min
		SpO ₂	96%	100%	96%	95%	98%	95%
		Temp	36.7°c	36.5°c	36.7°c	36.5°c	36.5°c	36.5°c
	Pain Score	1/10	1/10	2/10	1/10	1/10	1/10	
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert	Alert	Alert	
	Skin Integrity (Intact / Bed sore / Any other condition)	Intact	Intact	Intact	Intact	Intact	Intact	
Restraints If any	Physical	NA	NA	NA	NA	NA	NA	
	Chemical	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)	Depend	Dependent	Dependent	Dependent	Dependent	Dependent		
Critical Lab Test / Values (if any)	NA	NA	NA	NA	NA	NA		

RECOMMENDATIONS	Investigations Procedures	Date :	1/7/26	1/7/26	2/7/26	2/7/26	2/7/26	3/7/26	
		Area	N2	N2	N2	N2	N2	N2	N2
		Shift Time	8pm-8am	8pm-8am	8am-2pm	2pm-8pm	8pm-8am	8am-8pm	8am-8pm
		Ordered / Planned	RBS-6th	RBS-6th house	RBS-6th house	RBS-6th house	RBS-6th house	RBS-6th house	RBS-6th house
		Due	NA	NA	NA	NA	NA	NA	NA
		Reports Pending	NA	NA	NA	NA	NA	NA	NA
		Referrals (If any)	NA	NA	NA	NA	NA	NA	NA
		Remarks (Special Interventions like, Drainage Tube flushing etc.)	NA	NA	NA	NA	NA	NA	NA
		Handed Over By Name :	Kach	Nalanthan	Nalanthan	Lokanath	Nalanthan	Song	Song
		Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	1/7/26	2/7/26	2/7/26	2/7/26	2/7/26	3/7/26	3/7/26		
Time :	@ 8pm	@ 8am	@ 2pm	@ 8pm	@ 8am	@ 8am	@ 8pm		
Taken Over By Name :	Nalanthan	Nalanthan	Lokanath	Nalanthan	Song	Suchitra	Suchitra		
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date :	1/7/26	2/7/26	2/7/26	2/7/26	3/7/26	3/7/26	3/7/26		
Time :	@ 8pm	@ 8pm	@ 2pm	@ 8pm	@ 8am	@ 8pm	@ 8pm		

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 1/7/26		Diagnosis : LBW		Surgery / Procedures : Nil		
		Allergies : Nil		Post OP Day : Nil				
Date :		3/7/26	4/7/26	4/7/26	4/7/26	5/7/26	5/7/26	
	Area	N2	N2	N2	N2	N2	N2	
Shift Time		8pm-8am	8am-2pm	2pm-8pm	8pm-8am	8am-2pm	2pm-8pm	
Diet :		DBM/EBM	DBM/EBM	DBM	DBM/EBM	EBM	EBM/DBM	
Ventilation (RA, NP, NIV, VENTI)		R/A	R/A	R/A	R/A	R/A	R/A	
INVASIVE LINES	1.	OG-0	OG-0		OG-0		OG-0	
	2.							
	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	68/35(46)	59/40(46)	60/43(47)	61/38(47)	61/48(52)	61/44
		PR	125 b/m	149 b/m	149 b/m	155 b/m	153 b/m	156 b/m
		RR	25 b/m	42 b/m	39 b/m	32 b/m	41 b/m	42 b/m
		SpO ₂	97%	96%	97%	98%	99%	99%
	Temp	36.5°C	36.5°C	36.5°C	36.5°C	36.6°C	36.6°C	
	Pain Score	1/10	1/10	1/10	1/10	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 :	3/7/26	4/7/26	4/7/26	4/7/26	5/7/26	5/7/26
		Area	N3	N2	N2	N2	N2	N2
		Shift Time	8pm-8am	8am-4pm	2pm-8pm	8pm-8am	8am-2pm	2pm-8pm
		Ordered / Planned	RBS	RBS	RBS	RBS	RBS	RBS
			OD	OD	OD	OD	OD	OD
		Due	NA	NA	NA	NA	NA	NA
		Reports Pending	NA	NA	NA	NA	NA	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 :		Suchitra	Abhinami	Lokanya	Maddan	Akash	Yamun	
Signature :								
Date :		4/7/26	4/7/26	4/7/26	5/7/26	5/7/26	5/7/26	
Time :		@ 8 AM	@ 4pm	8pm	2am	@ 2pm	@ 5pm	
Taken Over By Name :		Abhinami	Lokanya	Maddan	Akash	Yamun	Maddan	
Signature :								
Date :		4/7/26	4/7/26	4/7/26	5/7/26	5/7/26	5/7/26	
Time :		@ 8pm	@ 2pm	@ 8pm	@ 8 AM	@ 2pm	@ 8 pm	

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 1/7/26		Diagnosis : LBW		Surgery / Procedures : nil		
		Allergies : nil		Post OP Day : nil				
INVASIVE LINES	Date :	5/7/26	6/7/26	6/7/26	7/7/26			
	Area							
	Shift Time	12pm-5pm	8am-3pm	2pm-8pm	8am-2pm			
	Diet :	EBM+DBM	EBM+DBM	E+D	EBM.			
Ventilation (RA, NP, NIV, VENTI)		OC1 FD	OC1 FD	RIA	2/A			
ASSESSME	1.							
	2.							
	3.							
	4.							
	Infusions / Transfusions							
	PU Prophylaxis							
	DVT Prophylaxis							
	Vitals	BP	61/44	74/46(55)	76/48(60)	crib fare		
		PR	156/61/m	139/61/m	138/61/m	140/61/m		
		RR	42/6/m	45/6/m	42/6/m	40/6/m		
SpO ₂		99%	97%	98%	99%			
Temp		36.5°C	36.5°C	36.5°C	36.6°C			
Pain Score	to	1/10	2/10	4/10				
LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert				
Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact				
Restraints If any	Physical	Physical	Physical	Physical				
Fall Risk (Vulnerable (Y/N) if yes score)	yes	yes	yes	yes				
(Ambulation, walking, moving with assistance, bed ridden)	moving	moving	bed ridden	bed ridden				
ADL (Dependent / Non-Dependent)	dependent	dependent	dependent	dependent				
Critical Lab Test / Values (if any)	NA	NA	NA	NA				

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

RECOMMENDATIONS	Investigations Procedures	Date :	5/7/26	6/7/26	7/7/26	7/7/26		
		Area	N2	N2	N2	N2		
		Shift Time	8pm-8am	8Am-8pm	8pm-8am	7Am-7pm		
		Ordered / Planned	Rv					
			RBS	RBS				
			OD	OD	RBS-OD	RBS-OD		
		Due	NA	NA	NA	NA		
		Reports Pending	NA	NA	NA	NA		
Referrals (If any)	NA	NA	NA	NA				
	Remarks (Special Interventions like, Drainage Tube flushing etc.)	NA	NA	NA	NA			
Handed Over By Name :		Malleswari	Malleswari	Malleswari	Malleswari			
Signature :		[Signature]	[Signature]	[Signature]	[Signature]			
Date :		6/7/26	6/7/26	7/7/26	7/7/26			
Time :		@8am	@8pm	@8am	@8pm			
Taken Over By Name :		Malleswari	Malleswari	Malleswari	Malleswari			
Signature :		[Signature]	[Signature]	[Signature]	[Signature]			
Date :		6/7/26	6/7/26	7/7/26				
Time :		@8am	@8pm	@8am				

CONSENT FOR ADMISSION IN NEONATAL INTENSIVE CARE UNIT

BAH-00660399 IP5-00175821
Baby Of BARIRA FAREED
01-07-2026 0 Y 0 M 0 D 3 H (M)
Dr. DINESH KUMAR CHIRLA
Barcode

bow
dren's
pital
it to treat the little.

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Name: B/o. Barira Fareed. Age: 1/13 Gender: Male ☒ Female ☐

UHID.No: 660399 Date: 1/12/26

I Fareed Ahmed S/o, D/o, W/o hereby
declare that our patient Mr. / Ms. B/o. Barira Fareed who is related to me as Son
getting admitted in the Neonatal Intensive Care Unit of Rainbow Children's Hospital on 01/12/2026

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 BARIRA FAREED 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 BARIRA FAREED.

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 : [Signature]

Name : Fareed Ahmed

Relationship with Patient : father

Date & Time : 1/12/26 @ 12:30 PM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Poojika

Date & Time : 1/12/26 12:30 PM

Docu. No. : RCHBH / FRM / CLINICAL / 012

Witness :

Signature : [Signature]

Name : Kayal

Date & Time : 1/12/26 @ 12:30 PM

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

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రోగి పేరు వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి బి
నేను

అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రేయిన్నో బిల్లన్ ఆసుపత్రిలోని నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్లో తేదీ

..... నాడు పూర్తి సమ్మతితో వేర్పాడిని. 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 చికిత్స విధానాలకు మరియు ప్రక్రియలను (ఉదా కృత్రిమ శ్వాస వెంటిలేటర్, ధమని మార్గం, సింట్రిల్ లైన్ వెన్ట్ డ్రైయిన్, పరిటోనియల్ డ్రైయిన్ ఇంసర్షన్ వంటి ప్రక్రియలను డాక్టరు గారు నాకు అర్థమగు భాషలో వివరించారు.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైన్నప్పటికీ, వైన తెలుపబడిన శస్త్ర ప్రక్రియలు చేసేమందు 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 చికిత్స విధానాలు అవసరం పడతాయని మరియు వాటివల్ల దుస్థితిగొనవచ్చని కలగవచ్చని 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 అడ్మిట్ చేయుటకు మరియు ఎన్.ఐ.సి.యు. లో ఉన్నప్పుడు జరుగు చికిత్స విధానాలు మరియు శస్త్ర ప్రక్రియలు వలన కలిగే అపాయాలను నేను అంగీకరిస్తున్నాను. మా పేషెంట్ ను తగిన విధంగా చికిత్స చేయడానికి వైద్యునికి నాపూర్తి అంగీకారం తెలియజేస్తున్నాను. వైద్యుడు నాకు అర్థమగు భాషలో అంతా వివరించారు.

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

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు

CONSENT FOR DONOR BREAST MILK

BAH-00660399 IP5-00175821
Baby Of BARIRA FAREED
01-07-2026 0 Y 0 M 0 D 7 H (M)
Dr. DINESH KUMAR CHIRLA

Patient Name : seed. Age : DI Gender : ☒ Male ☐ Female
UHID No : 0107/2026 Department : NEON Date : 1/7/26
I Mr / Mrs. : M/B aged M/B years, hereby declare that I have
admitted my ☒ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on
01/07/2026 I hereby give consent for Donor Breast Milk for my child. Doctors have explained me
about the Donor Breast Milk feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : [Signature]
Name : Faizun Ahmed
Relationship with Patient : FATHER
Date & Time : 01/07/2026 @ 12:30 PM

Witness :

Signature : [Signature]
Name : Kaush
Date & Time : 1/7/26 @ 12:30 PM

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Dr. Rajit
Date & Time : 1/7/26 ; 12:30pm