

SELF INDENT

ADMISSION SHEET



Registration Details :

Admission No : IP5-00173990 Admit Date : 18-May-2026 Admit Time : 09:09 PM UHID : BAH-00656641

Patient Details :

Patient Name : Baby Of JETTURI RAVALIKA Age : 0 Y 0 M 5 D
Guardian : Mr VADLA VIJAY KUMAR DOB : 13-05-2026 01:00 AM
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : H NO - 20-73/5, NEAR M R O OFFICE KOSGI , Phone No : 7997693261/ 9866382072
Kosgi Mahabubnagar Telangana INDIA E-mail : NOMAIL@GMAIL.COM
509339

Admission Details :

Bed Type : NICU Bed No : NICU 263 Ward Name : 2F-NICU 2
Room No : NICU 263 Admission Type : First Visit

Contact Details :

Name : Mr VADLA VIJAY KUMAR Relationship : Father
Contact Address : H NO - 20-73/5, NEAR M R O OFFICE KOSGI , Phone No : 7997693261 / 9866382072
Kosgi Mahabubnagar Telangana INDIA 509339

Vijay Kumar
Signature

Doctor Details :

Doctor Name : Dr. VIJAYANAND JAMALPURI Specialisation : NEONATAL INTENSIVE CARE
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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

3AH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 14 D (M)
 Dr. VIJAYANAND JAMALPURI



ACTIVITY RECORD FOR BILLING

Name : B10 Jetturi Ravalika

UHID No. : 656841 IP No : 178990 Consultant : Dr. VJ Dept : NICU

Date of Admission : 13/5/26 Time : 9.09pm Date of Discharge : _____ Time : _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/6/26	5.30pm	NICU	2nd floor	[Signature]

Cross Consultation Visit

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

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 : BIO RAVALIKA Mother's Blood Group : B POSITIVE
 Gender : M F Blood Group : O POSITIVE Birth Weight (gms) : 2.5kg Length (cms) :
 Date of Birth : 13/5/26 Time of Birth : 7:20 AM OFC (cms) :
 Place of Birth : KAVITHA NURSING HOME Estimated Gesth Age : 35 weeks

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age 26yrs Ht : Wt : BMI : Married Life : LMP : EDD :
 Conception : Spontaneous or with Rx :
 Booked at what GA : AN Steroids Drugs / Doses :
 Last Scans Details :
 TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : <18 yrs > 35yrs
 Consanguinity : Yes No
 If yes, degree of consanguinity : 1 2 3
H/o PIH (after 20 weeks) / PE
 How many Drugs / Doses / Since how long :
 H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) :
 IUGR - when detected :
 Doppler (Increased Resistance / ADEF / REDF / Redistribution in MCA) / Ductus Venosus :
 AFI :

H/o GDM/ pre GDM/ on diet or insulin
 Controlled or not, recent values, HbA1 values :
 Compliance with Rx :
 Scans : LGA, TIFFA , Fetal Echo :
H/o Hypothyroidism : when diagnosed ? Medication?
 Any other Chronic Medical Problems, when detected drugs ? H/o Asthma, H/o PVT → Heparin
 (Anemia, SLE, Jaundice, CHD, Heart Disease)
 Infection : H/O, Fever
 (Malaria UTI TORCH TB HIV HBV)
 UTI : when : Any culture :

PPROM: Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

P: 3 A: 1 L: 2

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1)	Gyna	Renale	LSCS	A&H		
2)	2 1/2 yrs	Renale	A&H	12.25 kg		
3)	MTP					

PERINATAL HISTORY

Treating Obstetrician : Hospital : Inborn Outborn

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

APGAR SCORE

Gestational Age : Weeks :

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

1 Minute	5 Minutes	10 Minutes
<i>NOT KNOWN</i>		

TOTAL

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

Snapee II Score

Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

History of Present illness.

RESPIRATORY - Baby was delivered in nursing home had respiratory distress, shifted to Sushruth hospital @ 3406, SAS was 5. initially connected to CPAP ^{for 2 hrs} → Intubated connected to SIMV mode 15L5, upto 25% FiO₂ requirement, + say mild time, on POL of extubation trial was given → baby was reintubated I/V/O ↑ WOB

FEEDING → Baby was started on trophic feeds ^{on Day 1}, later escalated ~~50ml/day~~ (feeds) 15ml orally @ 10 feeds.

SEPSIS → Baby was started on Piptaz, upgraded to meropenem @ Amikacin on Day of life 3

USG 15/5/26 → (N)

Necho → mild TR, small lfto.

Investigation details in previous Hospital :

Feeding History :

13/5/26 (N)
FC → 16,300
P.C → 2054 Labh
Hb → 12.9 on Day 3
CRP → 1.92 → 10



Past History :

[Faint handwritten text in Telugu script]

Family History :

[Faint handwritten text in Telugu script]

Socio Economic History :

[Faint handwritten text in Telugu script]

GENERAL EXAMINATION ON ADMISSION

General Disposition :

[Faint handwritten text in Telugu script]

VITALS : Temperature : HR : RR : NIBP : CFT :

Color of the extremities :

Jaundice : Pallor : SpO2 :

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

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD : Fontanelles : }
Sutures : }
Shape / Moulding : } 2
Edema / Bruising : }
Size - (H.C.) : }

FACIES :
(Any Facial Dymorphism)

NECK and CLAVICLES : Range of Motion : } 2
Asymmetry : }
Masses : }

EYES : Symmetry : need to be checked
Red Reflex :
Discharge :

EARS, NOSE MOUTH and THROAT : Ear set / Shape : }
Periauricular Pits / Tags : }
Nasal shape / Patency : }
Palate : }
Gums : }
Lips : }
Tongue : }
stomatocel

THORAX and BREASTS : Shape of Thorax :
Position of Nipples and Number :

ABDOMEN and UMBILICUS : Shape : }
Organomegaly : }
Bowel Sounds : }
Umbilical Stump : }
Discharge : }

GENITALIA : Labia / Hymen : }
Testicles/penis : } B/L descended testes
Anus : }

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS : no

EXTREMITIES : Fingers / Toes : }
Deformities : }
Hip Joint Examination : }
Arms / Legs :
Mobility :



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : Regular Periodic Shallow Gasping

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

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

Mention if baby is on : Hood box CPAP Ventilator

Settings :

SpO₂: 95% Auscultation: BAS (A) Breath Sounds: CS (A) Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 132/min BP : Precordial Activity :

Femoral Pulses : Murmurs : -

Other Peripheral Pulses : Signs of Cardiac Failure :

ABDOMEN:

Shape : no Hernia orifice : free

Palpation : soft Anal Patency :

Palpable masses : Umbilical Cord : -

Abdominal girth : First urine passed : ✓

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : Alert

State of wakefulness :

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone : 13

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

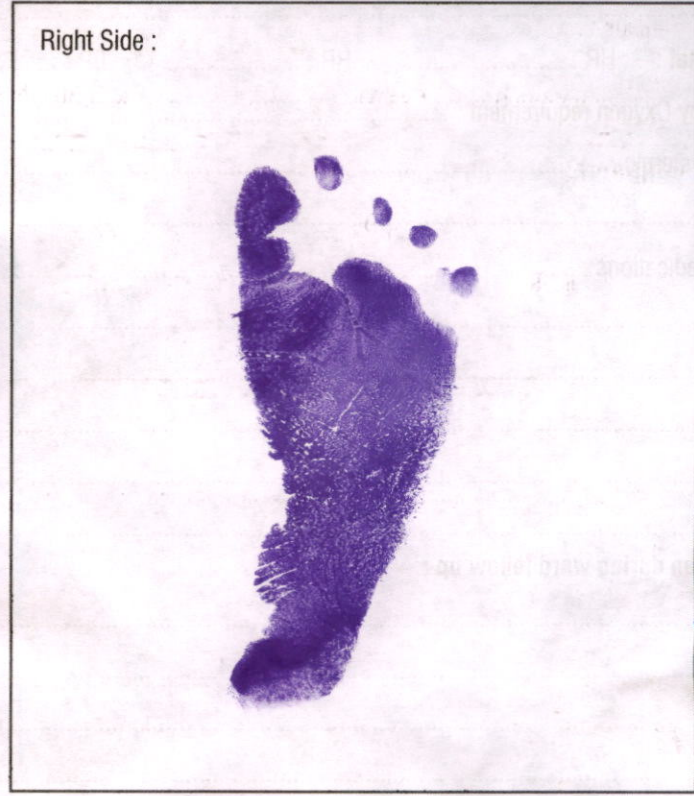
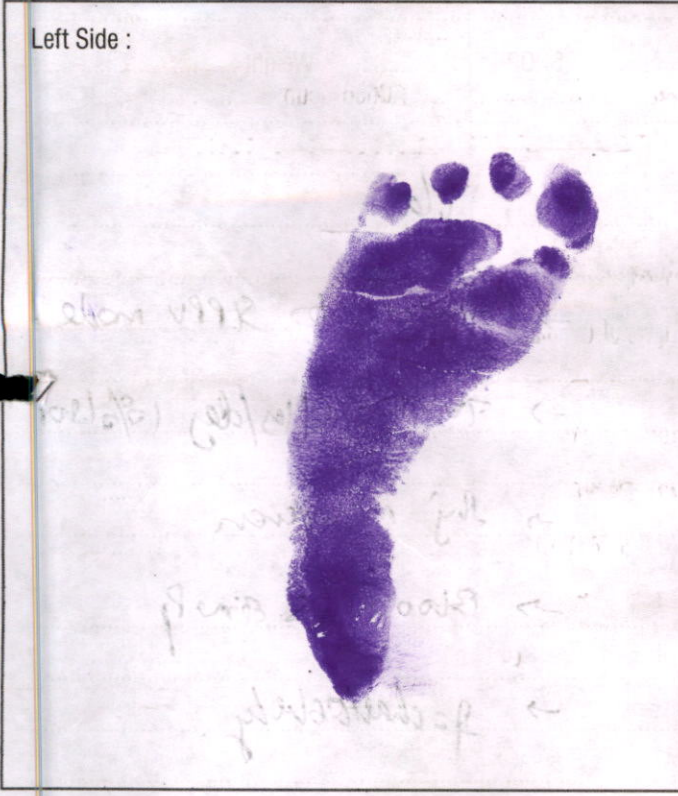
Moro's : DTR :

ATNR : Skull and Spine :

BAH-00656641 IP5-00173990
Baby Of JETTURI RAVALIKA
13-05-2026 0 Y 0 M 11 D (M)
Dr. VIJAYANAND JAMALPURI

Diagnosis : Late Preterm / RD / MV / Boy

FOOT PRINTS



Resident Doctor :
Signature : [Signature]
Name : PAU
Date & Time : 18/5/26

Consultant : VIJAYANAND JAMALPURI
Signature : [Signature]
Name : DR. Vijayanand. Damesh Pr
Date & Time : 18/5/26

PLEASE FILL UP THE FOLLOWING DETAILS

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

BAH-00656641 IP5-00173990
Baby Of JETTURI RAVALIKA
13-05-2026 0 Y 0 M 11 D (M)
Dr. VIJAYANAND JAMALPURI



AT THE TIME OF TRANSFER TO THE WARD

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic :

Medications :

Plan

→ Connect to SPPV mode.

→ IV - 120cc / 100 / day 10% Bof

→ Ibg meropenem

Plan during ward follow up :

→ Blood cbs & smp

→ Procharitobely

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:



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

Day in NICU: Day of Life: 17 PMA: 37+3
 Term Preterm Gestation: 35 Corrected Gestational Age: Today's Weight: 2.520
74 gm

S.No.	Problems	
	Current	Past Problems
1.	<u>LPT/RDS</u>	<u>VAP-acinetobacte(CR)</u>
2.		
3.		
4.		
5.		
6.		

Clinical Assessment
 on RA, no body (desat taken 2 paladay well.
 ↳ post feed tachypnea ⊕
 scr ⊕.
 PA-soft; no distension
 HR - 154/min
 RR - 53/min
 SpO₂ - 96%.

Medications Used
 vit D₃
 lorazepam
 Domstal

Plan of Care:
 ① TV = 150 ml/kg/day → 33ml q2h
 (R) ↑ paladay today.
 ② CRBS OD
 ③ Prone nursing

Doctor's Name (Hand over given): Dr. Adhwarup
 Signature: [Signature]
 Date & Time: 31/5/26

Doctor's Name (Hand over taken): Dr. Soumya
 Signature: [Signature]
 Date & Time: 31/5/26



63

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5 7:48 AM		seen by Dr. Pratyesh six
		try - (8) palladiya feed
		cont anti-reflex
		Noted by Kaaya 8/5/26 @ 8 AM Pr in maula
8/5/26	<u>Night rounds</u>	
8:00 PM	Given Spaladai today - 1 Hourly	plan
	taken well NO vomiting NO tachypnea resuscitation	① N-150 ml/day 33 ml O24 (Neocate/EBM) Give OG feeds now
		② CRBI OD ③ prone nursing ④ continue Domperidone ⑤ Cansopresole Noted by Dr. Kaaya 8/5/26 8 AM Reddanna

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 18 D (M)
 Dr. VIJAYANAND JAMALPURI



1/6/26

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

Day in NICU: Day of Life: 18 PMA: 37+4
 Term Preterm Gestation: 35 Corrected Gestational Age: Today's Weight: 2566
 (↑46g)

S.No.	Problems	
	Current	Past Problems
1.	Late preterm	
2.	RDS	
3.	VAP - Acinetobacter (Carbapenem resistant)	
4.		
5.		
6.		

Clinical Assessment
- on room air, - accepted & paladar feeds well SpO ₂ - 96% PR - 124/min RR - 38/min BP - 87/47 (61)

Medications Used
Vit D3 Domstal Anzal

Plan of Care:

- Tn - 150ml/kg/day → 35ml 2nd hourly & paladar + Rest OK feeds
- RW full paladar feeds today
- PPS OD
- Ilo. chatty & hoarse
- prone needs
- involve mother in feeds

Doctor's Name (Hand over given): Dr. Arun
 Signature: Dr. Arun
 Date & Time: 1/6/26

Doctor's Name (Hand over taken): Dr. Pojithe
 Signature: Dr. Pojithe
 Date & Time: 1/6/26 9am



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/5 10:21 AM		seen by Dr. vijayanand Sis
		- full pallada
		- crib care
		- Shift to room L to room
		- ABR
		vaccination in the room
		- continue Antiepileptic medication
		Dr. Navanetha
	Afternoon rounds	Noted by Sis. Navanetha
16/5 2 PM	<ul style="list-style-type: none"> - Baby on room - received - Pallada - GDM + Nan m. - 33 ml/2nd - accepting well - no vomilegs 	<ul style="list-style-type: none"> - full pallada feed - crib care - Shift to room to 11m - ABR/Vaccination in room

Receives

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 16 D (M)
 Dr. VIJAYANAND JAMALPURI

66



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>1/6/26 9:30pm</p>	<p>Afternoon</p>	<p>CLSI/BP results to <u>Plan</u></p>
	<p>taking breast day feeds well</p>	<p>Continue full breast feeds</p>
		<p># <u>Prn</u></p>
		<p>Noted By K. Bony 1/6/26 @ 9:40pm</p>

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 19 D (M)
 Dr. VIJAYANAND JAMALPURI



2/6/26

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

Day in NICU: Day of Life: 19 PMA: 37 1/4

Term Preterm Gestation: 35 Corrected Gestational Age: Today's Weight: 2.6 kg (1425g)

S.No.	Problems	
	Current	Past Problems
1.	late preterm	
2.	RDS	
3.	VAP - Acinetobacter	
4.	(Carbapenem resistant)	
5.		
6.		

Clinical Assessment
 - on room air
 SpO₂ - 94%
 HR - 120/min
 RR - 38/min, BPS
 - accepted 10 paladai feeds well
 - no episodes of vomiting

Medications Used
 Vit - D₃
 Dometaf
 Lanzol

Plan of Care:
 - TV - 150cc/kg/day - 35ml - 2ml hourly (GBM)
 - full paladai feeds
 - crib care
 - shift to room today
 - AAPR / vaccination in room to be given in room
 - continue anti-reflux medication

Doctor's Name (Hand over given): Pauri V.

Doctor's Name (Hand over taken):

Signature: Pauri

Signature:

Date & Time: 2/6/26

Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26 2/6/26 9:45 am		
	Seen by - Dr. VJ	
		<u>Plan</u>
	accepting	- Shift out
	- full feeds	- Crib care.
		→ AABR / Vaccines / NBS
		after shift out
		→ anti-reflex med to be continue
2/6/26 1:30 pm	<u>Afternoon notes</u>	
	Late Preterm (RDS) VAP- CRAB	<u>Plan</u>
	- Baby hemodynamically stable on air.	1) Shift to room
	Palliating feeds 35ml 2hrly,	2) Crib care
	no vomiting	3) Vaccinations, AABR Bv
	Cry time/ activity - normal	after shifting to room
	98 - HR - 142/min	4) FU - 160 cc/kg/day =
	RR - 36/min	feeds 35ml 2hrly - full
	SpO ₂ - 98% iRA	palliating feeds?
		5) Monitor vitals

Dr. VIJAYANANDA IYER
Reg. No. - 1026

[Signature]

67

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26	Shipping Note	
	Late PT / RDS / VAP	SBI Plan TV - 160cc/kg/day - Bull Palada 35ml. 2hamsy
		- Vaccination BCG, OPV, Hep-B T/M
		- AABR } T/M NBS }
		Monitor vital s. infant - ses
		- Give anti-reflux medication Rurit
		Noted by aswothy.

69

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/26		Seen by Dr. Vijayanand
		→ Terace NBS
	D/D	→ Discharge today
		→ AABR today
		→ Discharge to
		→ LOP tomorrow
		→ D/S tomorrow.
		flu Dr. kiyanka
		after 2 days
		Mahabodh nagar
		- BCG DPV ncp13 Rsv (50mg)
		today } division
		3/6/26 } 3/5/26
		AABR - Hearing Assessment
		Bilateral responses are present. Bilateral Normal
		No Ecd by Latts
		3/6/26

VIJAYANAND JAMALPURI
 Reg. No: 40526

69

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/26	<p><u>Morning Rounds</u> LFT / RDS / VAP - CRAB.</p>	
	<p>DOB 21 / 35 - 37 + 5.</p>	
	<p>wt - 2.518 Tm gm.</p>	<p><u>Plan</u></p>
	<p>Extremities</p>	<p>① Trace NBS</p>
	<p>Bulk</p>	<p>② ROP today</p>
	<p>self ventilation on KA.</p>	<p>③ Discharge</p>
	<p>Admission by feeds</p>	<p>④ Rx E. Dr. Prayanka</p>
	<p>PA - soft.</p>	<p>in 2 days</p>
	<p>vitality stable.</p>	<p>⑤ start zincvit 0.5ml</p>
		<p>toniflex drops 0.5ml</p>
	<p>AABB - (2)</p>	<p><i>[Signature]</i></p>

Dr. VIJAYANAND JAMALPURI
Reg. No: 40526

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 21 D (M)
 Dr. VIJAYANAND JAMALPURI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	21/5/26	B/o. Ravalika
	<ul style="list-style-type: none"> - Add Tigecycline & colistin - explained about infection in & c/s. - Explained about need for re-intubation s/s 	

Patient S

BAH-00656641 IP5-00173990
Baby Of JETTURI RAVALIKA
13-05-2026 0 Y 0 M 22 D (M)
Dr. VIJAYANAND JAMALPURI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>19/5/26</u>	B/o <u>Ravalika</u>	
	→ Condition of baby explained.	
	→ Currently on mechanical ventilator	
	→ Plan to extubate if stable	
	blood gas	
	→ On IV antibiotics	
	→ On O ₂ feeding.	V. Kishore

Patie

BAH-00656641 IP5-00173990
Baby Of JETTURI RAVALIKA
13-05-2026 0 Y 0 M 22 D (M)
Dr. VIJAYANAND JAMALPURI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/26	B/o Ravallika	
	→ Baby is improving	
	weaned from NIV to CPAP	
	→ To continue antibiotics	
	→ Condition & prognosis of baby explained	

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 5 D (M)
 Dr. VIJAYANAND JAMALPURI

①

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	18/5	20/5/26			
Time		6am			
Hb	14	14.9			
PCV	42.4	44.8			
RBC	4.27	4.68			
WBC	10.30	12.41			
N/L	39.5/39.5	40.3/34.3			
Platelets	350	431			
CRP	05	7.			
ESR					
PCT					
RBS					
Na	145				
K	5.7				
Cl	114				
Ca/Mg	10.6				
Phosphate					
Urea	3.4				
Creatinine	0.5				
ALP					
SGPT					
SGOT					
T.Bill/Conj	11.4E	0.2/1.2			
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						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 19 D (M)
 Dr. VIJAYANAND JAMALPURI



MEDICATION RECONCILIATION FORM

Drug Allergies: Nil Not known any Drug Allergies

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

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

Shifting From: NICU Shifted to: 323C

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
	VITAMIN D3 DROPS	0.5ml	P.O	OD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	TAB. LAN/SOPRAZOLE	1 tab 15ml/Dose ↳ give 0.8ml	P.O	OD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	SUSP. DOMPERIDONE	0.5mg	P.O	TID		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Neelam

Date & Time: 02/06/26 7.50 pm

Nurse Name & Signature: Amrathy

Date & Time: 02.06.26 @ 4.50pm



DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:																					

DRUG :				Date Time																		
Dose	Route	Frequency	Start Date																			
Doctor's Signature		Valid Period	Pharm.																			
Additional Instructions:																						

VERIFIED BY : Name

REGULAR PRESCRIPTIONS

Weight. 2.5kg. Ward.

DRUG : <u>Amg MICROBENAM</u>				Date Time	18/5/26 10:30 AM
Dose	Route	Frequency	Start Date		
100mg	IV	Q12H	18/5/26		
Name & Signature of the Doctor Starting the Drugs: Dr Ramya				Stop 20/5/26	
Additional Instructions: 4mg/kg/dose				10pm 10am 11am 12pm 1pm 2pm 3pm 4pm 5pm 6pm 7pm 8pm 9pm 10pm 11pm 12am	
Daily Doctor's Endorsement by a Sign				d d	
DRUG : <u>Amg PIPERACILLIN TAZO</u>				Date Time	20/5/26 10:30 AM
Dose	Route	Frequency	Start Date		
250mg	IV	Q12H	20/5/26		
Name & Signature of the Doctor Starting the Drugs: Poopthe				Stop 21/5/26	
Additional Instructions: 100mg/kg/dose				6pm 8pm 10pm 12pm 2pm 4pm 6pm 8pm 10pm 12am	
Daily Doctor's Endorsement by a Sign				d d	
DRUG : <u>Neb. c BUDECORT</u>				Date Time	20/5/26 10:30 AM
Dose	Route	Frequency	Start Date		
2ml	Neb	Q12H	20/5/26		
Name & Signature of the Doctor Starting the Drugs: Poopthe					
Additional Instructions: 2ml + 2ml NS					
Daily Doctor's Endorsement by a Sign				d d	
DRUG : <u>Neb c MUCOMAX</u>				Date Time	20/5/26 10:30 AM
Dose	Route	Frequency	Start Date		
1/2 respude	Neb	Q8H	20/5/26		
Name & Signature of the Doctor Starting the Drugs: Poopthe				Stop 24/5/26	
Additional Instructions: 1/2 respude				2pm 4pm 6pm 8pm 10pm 12am	
Daily Doctor's Endorsement by a Sign				d d	

VERIFIED

VERIFIED

VERIFIED

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 5 D (M)
 Dr. VIJAYANAND JAMALPURI

Sheet No:

REGULAR PRESCRIPTIONS

Weight 2.5 kg · Ward

VERIFIED

DRUG	Dose	Route	Frequency	Start Dt.	Date Time
Neb ^c ADRENALINE	1.2ml	Neb	Q12H	20/5	20/5 21/5 22/5
Name & Signature of the Doctor Starting the Drugs: Poopilly					6am X 8am
Additional Instructions: 0.5ml/kg					9pm 11pm 10pm 8pm
Daily Doctor's Endorsement by a Sign					STOP 22/5 D. Manjunath

DRUG	Dose	Route	Frequency	Start Dt.	Date Time
Inf. CORTISOL	100,000IU	IV	Q8H	21/5/26	6am X 12/5 2/5 3/5 4/5 5/5 6/5 7/5
Name & Signature of the Doctor Starting the Drugs: Poopilly					9pm 10pm
Additional Instructions: 40,000IU/kg/dose					Private Ward
Daily Doctor's Endorsement by a Sign					STOP 22/5 Dr. Subh

DRUG	Dose	Route	Frequency	Start Dt.	Date Time
Inf. TIGECYCLINE	1.5mg/kg				
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions: 1.5mg/kg					
Daily Doctor's Endorsement by a Sign					

1 vial (50mg) + 5.3ml D. water ⇒ 5ml = 50mg ⇒ 1ml = 10mg
 Take 0.5ml of it + 1ml + 10ml

DRUG	Dose	Route	Frequency	Start Dt.	Date Time
Inf. TIGECYCLINE	2.5mg	IV	Q12H	22/5/26	
Name & Signature of the Doctor Starting the Drugs: Poopilly					
Additional Instructions: 1.5mg/kg/dose					
Daily Doctor's Endorsement by a Sign					

1 vial (50mg) + 5.3ml 5% D ⇒ 5ml = 50mg ⇒ 1ml = 10mg
 Take 1ml of it + 9ml 5% D ⇒ 1ml = 1mg ⇒ 3.8ml of it

VERIFIED

3AH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 10 D (M)
 Dr. VIJAYANAND JAMALPURI



Sheet No:

REGULAR PRESCRIPTIONS

Weight 2.5 kg Ward

DRUG: Fej-TIGACYCLINE Date/Time: 21/5, 22/5, 23/5, 24/5, 25/5, 26/5, 27/5

Dose	Route	Frequency	Start Dt.
2.5mg	IV	12 hourly	21/5

Name & Signature of the Doctor Starting the Drugs: *A. Anesh*

Additional Instructions: *1mg/kg/dose*

Daily Doctor's Endorsement by a Sign: *[Signature]*

DRUG: Neb-COUSTIN. Date/Time: 23/5, 24/5, 25/5, 26/5, 27/5

Dose	Route	Frequency	Start Dt.
100,000IU	Neb	Q8H	23/5, 26

Name & Signature of the Doctor Starting the Drugs: *Poojitha*

Additional Instructions: *100,000IU/kg/dose*

Daily Doctor's Endorsement by a Sign: *[Signature]*

DRUG: CANDID mouthpaint Date/Time: *[Blank]*

Dose	Route	Frequency	Start Dt.
<i>[Blank]</i>	<i>[Blank]</i>	<i>[Blank]</i>	<i>[Blank]</i>

Name & Signature of the Doctor Starting the Drugs: *[Blank]*

Additional Instructions: *4A over tongue*

Daily Doctor's Endorsement by a Sign: *[Blank]*

DRUG: CANDID mouthpaint Date/Time: 23/5, 24/5, 25/5, 26/5, 27/5, 28/5, 29/5, 30/5, 31/5, 01/6

Dose	Route	Frequency	Start Dt.
4A	QA	Q8H	23/5, 26, 6am

Name & Signature of the Doctor Starting the Drugs: *Poojitha*

Additional Instructions: *4A over tongue*

Daily Doctor's Endorsement by a Sign: *[Signature]*

VERIFIED

VERIFIED

VERIFIED BY: Name

VERIFIED

VERIFIED BY: Name

Sheet No:

REGULAR PRESCRIPTIONS

Weight 2.5 kg Ward

DRUG : SIP VITAMIN D3				Date					
				Time					
Dose	Route	Frequency	Start Dt.						
Name & Signature of the Doctor Starting the Drugs:									
Additional Instructions:									
Daily Doctor's Endorsement by a Sign									
DRUG : VITAMIN D3 DROPS				Date					
				Time					
Dose	Route	Frequency	Start Dt.						
0.5ml	PO	OD	29/5	2/6	3/6	5/6	1/6	2/6	3/6
Name & Signature of the Doctor Starting the Drugs:				10pm 10am 8 10pm 10am me fm					
Additional Instructions:				1ml = 800 IU					
Daily Doctor's Endorsement by a Sign				10pm 10am 8 10pm 10am					
DRUG : TAB. LAN SOPRAZOLE				Date					
				Time					
Dose	Route	Frequency	Start Dt.						
	PO	OD	30/5	3/5	3/5	1/6	2/6	3/6	
Name & Signature of the Doctor Starting the Drugs:				10pm 10am 8 10pm 10am me fm					
Additional Instructions:				$25mg + 5ml DW \Rightarrow 2ml = 3mg$ \rightarrow give 0.8 ml (2mg/kg/day)					
Daily Doctor's Endorsement by a Sign				10pm 10am 8 10pm 10am					
DRUG : DOMPERIDONE SYP				Date					
				Time					
Dose	Route	Frequency	Start Dt.						
0.5mg	PO	BH	30/5	6 Am	3/5	5/5	0/6	2/6	3/6
Name & Signature of the Doctor Starting the Drugs:				2 10 10am 10pm me fm					
Additional Instructions:				$(1ml = 2mg)$ $0.2mg/kg/day$					
Daily Doctor's Endorsement by a Sign				2 10 10am 10pm me fm					

Signature
Verified by Name

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 17 D (M)
 Dr. VIJAYANAND JAMALPURI



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

VERIFIED BY : Name Signature



VARIABLE DOSE

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

VARIABLE DOSE

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
20/5	11:00 AM	Daj. LASIX	0.5mg/kg	IV	[Signature]	moysis Vidya
20/5	11:10 AM	Daj. DEXAMETHASONE	0.15mg/kg	IV	[Signature]	moysis Vidya
20/5	11:05 AM	Neb. ADRENALINE	1.2 ml + 2ml NS	Neb.	[Signature]	moysis Vidya
20/5	9pm	3% NaCl	2ml	Neb.	[Signature]	Sachin
20/5	10:45 AM	Daj. TICHECLINE	2mg/kg	IV	[Signature]	Vidya moysis Sachin
			Mix IV cal + 5.3ml D ₅ W, 5ml = 50mg 1ml = 10mg → Take 1ml of it			
			mix 5 9ml D ₅ W → 1ml = 1mg NS			
			Give 5ml of it over 30min.			

VERIFIED BY : Signature

I.V. FLUIDS CHART

Weight..... Ward.....



	Position 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
18/5/26 8pm	TV = 120 ml/kg/day 10:1-150-P	IV	50ml	N.P.D	mu		R	mu Sachin
18/5/26	Iv- HEP-NS 2ml + 8ml NS	IV		N.P.D				
18/5 8pm	Iv- FENTANYL 2ml + 8 ml NS	IV	0.5ml	N.P.D	mu	19/5/26	R	Sachin mu
20/5 3pm	INT DEXMEDETO MIDINE-0.5ml + 49.5ml 5% D	IV	0.2	mu	mu	21/5/26		mu vidy
21/5 3pm	Iv- DEXMEDETOMIDINE 0.5ml + 49.5ml 5% D	IV	0.4ml	mu	mu		mu	
22/5 6pm	Iv- DEXMEDETOMIDINE 0.5ml + 49.5ml 5% D	IV	0.4ml	mu	mu	23/5/26	R	mu mu

VERIFIED BY: Name Signature

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 18 D (M)
 Dr. VIJAYANAND JAMALPURI



1/6/26

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

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

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 8 10 12 2 4 6 8 10 12 2 4 6
 Doctor/Nurse/Family Concern? Am Am Pm Pm Pm Pm Pm Pm Am Am Am Pm

Temperature (F)	104																
	103																
	102																
	101	36.4°C	36.4°C	36.7°C	36.7°C	36.4°C	36.4°C	36.2°C	36.2°C	36.2°C	36.3°C	36.3°C	36.3°C				
	100																
	99																
	98																
	97																
	96																
	95																
	94																

Heart Rate (bpm) and Blood Pressure (mmHg) *	190																
	180																
	170																
	160																
	150	89	89	61	78	62	76										
	140	↑	↑	↑	↑	↑	↑										
	130	(61)	(61)	(116)	(53)	(110)	(53)										
120	↓	↓	↓	↓	↓	↓											
110																	
100	48	48	102	48	36	43											
90																	
80																	
70																	
60																	
50																	

Cribboard

Heart Rate (Number) 129 129 123 143 141 141 126 132 140 132 136 128

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

Resp Rate (Number) 47 43 38 45 46 48

Resp Distress	Mod/ Severe																
	None / Mild	RA	RA	RA	RA	RA	RA										

Receiving O ₂ (l/min)	O ₂ Saturations (%)	100	97	95	100	100	98	99%	99%	100%	99%	100%	99%
----------------------------------	--------------------------------	-----	----	----	-----	-----	----	-----	-----	------	-----	------	-----

Conscious Level	Normal / Altered	C	C	C	C	C	C	N	N	N	N	N	N
-----------------	------------------	---	---	---	---	---	---	---	---	---	---	---	---

GCS *		15	15	15	15	15	15	15	15	15	15	15	15
-------	--	----	----	----	----	----	----	----	----	----	----	----	----

TOTAL SCORE	Number of shaded boxes	1	1	1	1	1	1	1	1	1	1	1	1
-------------	------------------------	---	---	---	---	---	---	---	---	---	---	---	---

Pain Score	Observer's Initials	AN	AN	AN	AN	AN	AN	AN	AN	AN	AN	AN	AN
------------	---------------------	----	----	----	----	----	----	----	----	----	----	----	----

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

NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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-00652717 IP5-00174018
 Mrs MAHIMA KOMARABATHINI
 07-10-1995 30 Y 7 M 26 D (F)
 Dr. ANNIE PRANUTHA P

3/6

No. : RCHBH / FRM / CLINICAL / 124

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

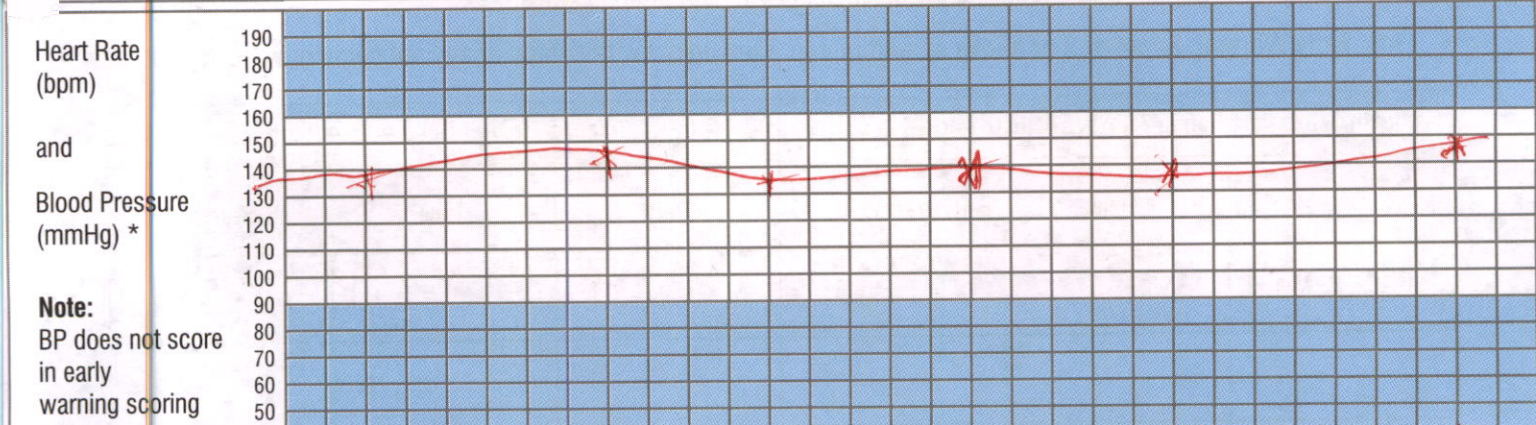
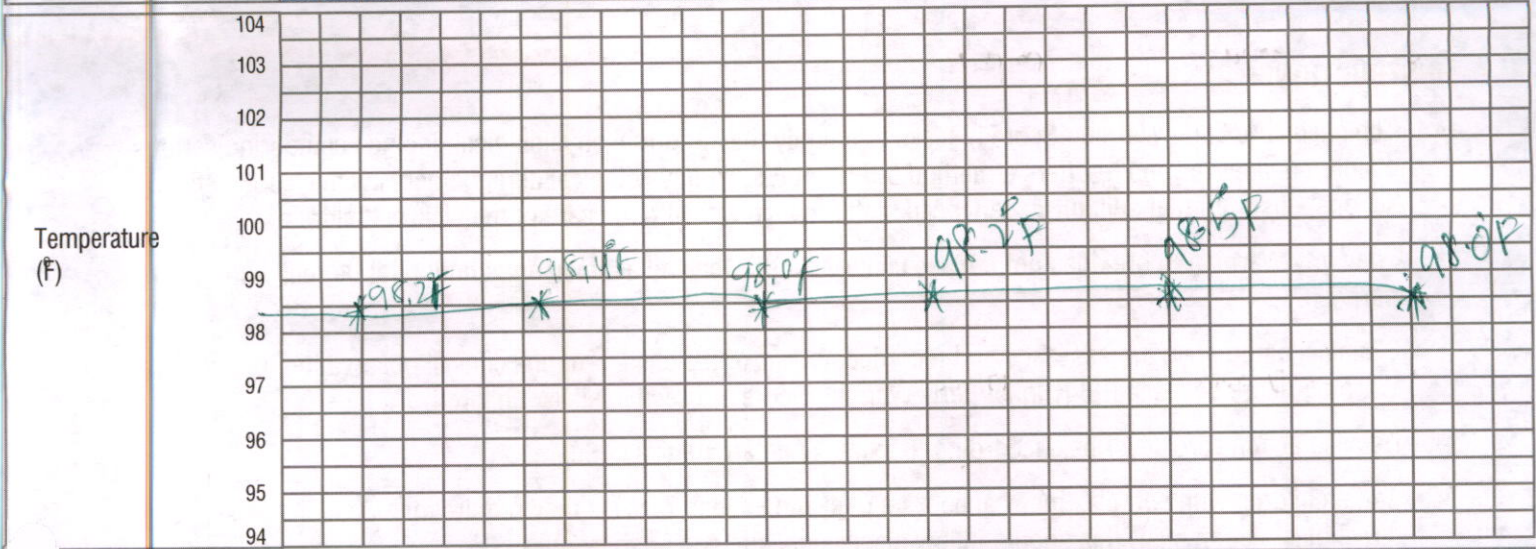
Pratiksha
Rainbow Children's Hospital
 It takes a lot to treat the little.

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

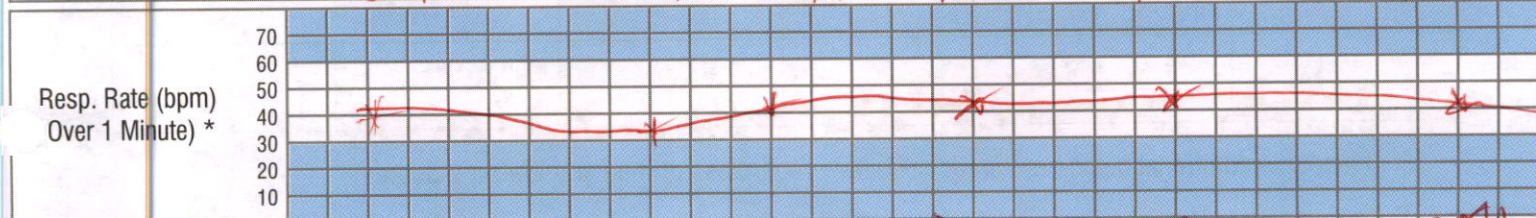
Date: Time: 10am 2pm 6pm 10pm 11am 6am

Doctor/Nurse/Family Concern?



Note:
 BP does not score in early warning scoring

Heart Rate (Number) 136b/m 144b/m 133b/m 142b/m 138b/m 145b/m



Resp Rate (Number) 40b/m 36b/m 43b/m 36b/m 36b/m 35b/m

Resp Mod/ Severe Distress None / Mild N N N N N N

Receiving O₂(l/min) O₂Saturations (%) 98% 99% 100% 98% 100% 98%

Conscious Level Normal Altered N N N N N N

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

TOTAL SCORE Number of shaded boxes 0 0 0 2 1 1

Pain Score 6 0 0 0 0 0

Observer's Initials AN AN AN AN AN AN

ACTIONS

Score 1	: Continue normal observation by staff nurse
Score 2	: Shift in charge nurse to be informed and continue hourly observations
Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
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* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

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Date	Time	Early Warning Score	Date	Time	Name

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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)

31/5/26

FLUID CHART

TV = 150cc/kg/day
 TF = 41ml
 B.wt = 9.5 kg

Sheet No :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
10/05/26	08:00 am												
	09:00 am	Naspro	33ml				passed			10ml			B
	10:00 am												
	11:00 am	Naspro	33ml				-			15ml			B
	12:00 pm												
	01:00 pm	Naspro	33ml							13ml			B
Total Intake : 99ml						Total Output : 2.5cc/kg/hr.							
	02:00 pm												
	03:00 pm	EBM	33ml				passed			10ml			B
	04:00 pm												
	05:00 pm	EBM	33ml							10ml			B
	06:00 pm												
	07:00 pm	Naspro	33ml				passed			13ml			B
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm	EBM	33ml				-			8ml			B
	10:00 pm												
	11:00 pm	EBM	33ml				passed			12ml			B
	12:00 am												
	01:00 am	EBM	33ml							6ml			B
Total Intake :						Total Output :							
	02:00 am						-						
	03:00 am	Naspro	33ml							13ml			B
	04:00 am												
	05:00 am	Naspro	33ml				Passed			10ml			B
	06:00 am												
	07:00 am	Naspro	33ml				-			18ml			B
Total Intake : 396ml						Total Output : 138ml							

Total 24 hrs. Intake 158.4cc/kg/day

Total 24 hrs. Output 2.3cc/kg/day

BAH-00656641
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 18 D
 Dr. VIJAYANAND JAMALPURI (M)

11/6/26
FLUID CHART



Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	O.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am	NanPro	35ml		35ml					6ml			
	10:00 am												
	11:00 am	GBM	35ml					Passed		12ml			
	12:00 pm												
	01:00 pm	EBM	35ml							10ml			
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm	NanPro	35ml							12ml			
	04:00 pm												
	05:00 pm	GBM	35ml					Passed					
	06:00 pm									18ml			
	07:00 pm	GBM	35ml										
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm	E											
	10:00 pm	EBM	35ml							12ml			
	11:00 pm												
	12:00 am	EBM	35ml					Passed		8ml			
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am	EBM	35ml					Passed		10ml			
	04:00 am												
	05:00 am	NanPro	35ml							16ml			
	06:00 am												
	07:00 am	NanPro	35ml					Passed		8ml			
Total Intake : 385ml						Total Output : 106ml							

Total 24 hrs. Intake : 154cc/kg/day

Total 24 hrs. Output : 107cc/kg/day

2/6/26

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	NG	Diarrhoea	Vomit	Drainage	Urine				
	08:00 am				0.G								
	09:00 am	Nanpro			35ml		passed			10ml			
	10:00 am												
	11:00 am	DBF			3ml		-			7ml			
	12:00 pm												
	01:00 pm	Nanpro			35ml		passed			10ml			
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm	Nanpro			35ml		passed			9ml			
	04:00 pm												
	05:00 pm	Nanpro			35ml		-			7ml			
	06:00 pm												
	07:00 pm	DBF					✓			✓			
Total Intake :						Total Output :					0-3 m-2		
	08:00 pm												
	09:00 pm	DBF					✓			✓			As per
	10:00 pm												
	11:00 pm	DBF					✓			✓			As per
	12:00 am												
	01:00 am	DBF								✓			As per
Total Intake :			Taken			Total Output :					0-3 m-2		
	02:00 am												
	03:00 am	DBF					✓			✓			As per
	04:00 am												
	05:00 am	DBF								✓			As per
	06:00 am												
	07:00 am	DBF								✓			As per
Total Intake :			Taken			Total Output :					0-3 m-2		
Total 24 hrs. Intake		Taken											
Total 24 hrs. Output		0-10 m-6											



FLUID CHART



Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am									✓	1	Laksh
	09:00 am	DBF									NO	
	10:00 am									✓	IV	Laksh
	11:00 am	DBF								✓	1	Laksh
	12:00 pm											
	01:00 pm	DBF										Laksh
Total Intake :					Total Output :					U-2 M-2		
	02:00 pm									✓	1	Laksh
	03:00 pm	DBF								✓	NO	
	04:00 pm											
	05:00 pm	DBF								✓	IV	Laksh
	06:00 pm									✓		Laksh
	07:00 pm	DBF										Laksh
Total Intake :					Total Output :					U-2 M-3		
	08:00 pm									✓		
	09:00 pm	DBF								✓		
	10:00 pm									✓		
	11:00 pm	DBF								✓		
	12:00 am									✓		
	01:00 am	DBF										
Total Intake :					Total Output :					U-3 M-3		
	02:00 am											
	03:00 am	DBF								✓		
	04:00 am											
	05:00 am	DBF								✓		
	06:00 am											
	07:00 am	DBF								✓		
Total Intake :					Total Output :					U-3 M-3		

Total 24 hrs. Intake *Taku*

Total 24 hrs. Output *U-10 M-11*



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5/26 8:20 pm	Seen by Dr. Nilesh sir	
		Plan:
	<ul style="list-style-type: none"> ✓ No trigger ✓ Deeply sedated Baby 	<ul style="list-style-type: none"> Start continuous SIMV - PS mode (I2) PIP = 16 PEEP = 6 Relt = 40 Ti = 0.39
	<p>O/E HR = 170/min</p>	
	RR = 40/min	
	SpO ₂ = 95% on SIMV	<ul style="list-style-type: none"> • ABG CBA (Blood gases)
	BP = 58/38 (44) mmHg	<ul style="list-style-type: none"> RBS NPI Blood Gs CXR
	On SIMV - PS mode started now	<ul style="list-style-type: none"> Send Now
		<ul style="list-style-type: none"> • TV = 120 ml/kg/day, 10% Iso P
		<ul style="list-style-type: none"> • After consult, start 10ml/3rd hly OG feeds
		<ul style="list-style-type: none"> • Start 1g Meropenam R/v antibiotics after septic screenng.
		<ul style="list-style-type: none"> • No sedation
		<ul style="list-style-type: none"> • 2D Echo, NSG → TIM

~~noted by Koushik 18/5/26 am~~

BAH-00656641

IP5-00173990

Baby Of JETTURI RAVALIKA

13-05-2026 0 Y 0 M 5 D (M)

Dr. VIJAYANAND JAMALPURI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5 12:50 PM	Night rounds	
	Baby on SIMN+PS	seen by Dr. Hilesh's
	14/5	
	Sate - 40	→ Continue SIMN+PS
	PS - 10	PEEP ↓ 5
	f ^o 2 - 24.1	→ cut ET - tube
	gas - 7.39 41.9 0.8 24.8	→ TV - 120ml/kg/day feed - 10ml slowly
	C → HR - 153 bpm	T - 5ml slowly
	BP - 75/47 (56)	set 10% creep
	v/a	→ echo] T1a1
	PIA - no distension	NSG]
	to creating feed	→ PPS] BD
		→ monitor vitals
		sum \downarrow mantle
		noted by Koushik 12/5 Hilson

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA (M)
 13-05-2026 OYOMSD
 Dr. VIJAYANAND JAMALPURI



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

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DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 6 PMA: 35+6 wks.

Term Preterm Gestation : 35 wks. Corrected Gestational Age:

OVERVIEW	Problems :	
	S.No.	Current
1.	<u>Late Preterm</u> R	
2.	<u>RD → MV</u>	
3.		
4.		
5.		
6.		

Today's Weight :

VENTILATORY SUPPORT : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV iNO PPM

Ventilator Settings : PIP 15 PEEP 5 VG Rate 40 ^{PC mode} FiO₂ 22% Oxygen : L/min

Last CXR : Tl = 0.39 Spo₂ :

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours:

Desat episodes - 2 ⊕ upto 80%, self pick up

Plan of Care :

HR = 148/min

RR = 36/min

SPO₂ = 92% on SIMV

U/O = 2.1 ml/kg/hr

Stool = Passed 2 times

Neurological Examination :
 Last Neurosonogram :
 Sedation }
 Any Seizures } NO

FLUIDS STATUS NUTRITION

NPO NG Feeds Wt. Gain: Head Circumference:

Input : / (+/-) Output : ml/k/d Urine Output : ml/kg/hr Stools :

IV Fluids - Type of IVF : @ ml / hr

Feeding: EBM Formula Donor BM Volume: Frequency:

TPN : Yes No - If yes, details : Calories:

Abdominal Examination:
PA: soft / NT.

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

PA: soft / NT.

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:

Blood culture Urine culture ET culture Fungal Culture LP CSF :

INFECTION	Antibiotic	SI.No.	Drugs	Days
		1.	Ivj Muprenam	D1
	2.			
	3.			

Plan of Treatment :

- Continue ~~NOV~~ SIMV - PS mode with same settings (Target SPO₂ = 90-95%)
- Continue TV = ¹⁴⁰ ~~120~~ ml/kg/day → 10% I&OP (Rest)
→ 15ml (Q2H) ; 5ml ↑ 6Hly.
- Echo } Today
NSA } Today
- RBS
Blood Gas } BD.
- Monitor vitals.
- No sedation.
- I/O checking Q6H

Doctor's Name (Handover given) : Dr. Ranjy
Signature :
Date & Time : 19/5/26

Doctor's Name (Handover taken) : Pojitha
Signature :
Date & Time : 19/5/26 9am

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA (M)
 3-05-2026 0 Y 0 M 5 D
 Dr. VIJAYANAND JAMALPURI

3



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/12/26. 10:07 am		Seen by Dr. Vijayanand
	SIMV + PS	→ Continue Current ventilation
	Wt's, PS - 8.	
	Tubings - Day 1	→ Review extubation today.
		→ 2D Echo today. NSG today
		→ Suction as needed.
		→ CBP, CRP, TFT - tomorrow
		→ TV - 140cc/kg/day. 15ml/2nd hely. 5ml (6th hely). CTF - 25ml
		→ Blood gas at 10pm
		and then 8-12th hely.
		→ Stop Fentanyl after suction
		<p>noted by submitted 01348 19/12/26 @ 11 AM.</p>

Dr. VIJAYANAND JAMALPURI
 Reg. No: 49526

(11)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/26 2:35pm		<u>Afternoon Round</u>
	Baby is currently on Simv + PS	<u>Plan.</u>
	15/5, PS - 8 Rate - 90	→ Continue current Ventilation
	No Sedation	
	<u>Vitals</u>	→ TV - 140cc/kg/day 20ml 2nd hely.
	HR - 157/min	↑ 5ml/6th hely (TF - 25ml)
	RR - 55/min	+ Rest 10% Insp
	SpO2 - 92%	→ 2D ECG today
	BP - 64/28(40)	→ Trace NSG report
	U/O -	→ CBP, CRP, TAT - tomorrow
	P/A - soft	→ Trace culture report
	thick ET secretions (+)	→ Review extubation
		→ E/o charting - 6th hely Monitor vitals R/v to send ET culture

note by
 Sushanta
 013/26
 19/5/26
 2:35pm

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA (M)
 13-05-2026 0 Y 0 M 5 D
 Dr. VIJAYANAND JAMALPURI

3



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/26 3:10 PM		<p>Seen by Dr. Vijayanand</p> <p>→ Extubate to NIV E Rams</p> <p>→ Send ET secretions for culture.</p> <p>→ NPO for extubation.</p> <p>→ Restart feeds post extubation.</p> <p>→ TV - 120cc/kg/day.</p> <p>→ CBP, CRP, TFT tomorrow.</p> <p>→ w/f beady / desaturation</p>
		<p>dictated by</p> <p>Dr. VIJAYANAND JAMALPURI</p> <p>01344</p> <p>19/5/26</p> <p>@ 3:10 PM</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/26 5:40 pm	<u>Extubation Notes</u>	
	Under strict aseptic conditions, baby has been extubated and taken on NIV with	
	PIP- 12, PEEP-6	
	Rate-40, FiO2-30%	
	ET secretions sent for culture	
		<u>Prophylaxis</u>
		<u>Plan</u>
		→ Trace ET c/s
		→ Blood gas at 6:30 pm
		→ Chest x-ray - Tfm at 6 am.
		<u>Prophylaxis</u>
		NOTE: by
		submit 19/5/26
		@S.com

Patient Sticker

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 7 PMA: 36 wks

Term Preterm Gestation : 35 wks Corrected Gestational Age:

Problems :		
S.No.	Current	Past Problems
1.	LAT PDS	
2.	intubation failure	
3.	suspected sepsis	
4.		
5.		
6.		

Today's Weight :

Ventilatory Support : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV INO PPM

Ventilator Settings : PIP.....PEEP.....VG.....Rate.....FiO₂ 25% Oxygen : L/min

Last CXR : Spo₂.....

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours.....

On MV - 20/c rate - 40

Plan of Care :

Neurological Examination :

..... Sedation..... —

Last Neurosonogram : — Any Seizures..... —

FLUIDS STATUS NUTRITION

NPO NG Feeds Wt. Gain: Head Circumference:

Input : / (+/-) Output : ml/k/d Urine Output : ml/kg/hr Stools :

IV Fluids - Type of IVF : @ ml / hr

Feeding: EBM Formula Donor BM Volume: Frequency:

TPN : Yes No - If yes, details : Calories:

Abdominal Examination: *soft to creaking feeds*

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

.....

.....

INFECTION

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:

Blood culture Urine culture ET culture Fungal Culture LP CSF :

Antibiotic	Sl.No.	Drugs	Days
	1.	<i>meropenam</i>	<i>D2</i>
	2.		
	3.		

Plan of Treatment :

- ① continue NIV - 20/6 sure - 40
target SpO_2 - 90-95%.
- ② TV - 140u/kg/day 25ml 2 hourly
full of feed
- ③ EtOchalling 6 hourly
- ④ RBS } 12 hourly
gas }
- ⑤ trace cardiovascular assessment

Doctor's Name (Handover given) : *D. Mantha*

Signature : *[Signature]*

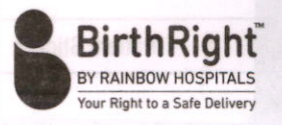
Date & Time : *20/5/20*

Doctor's Name (Handover taken) : *[Signature]*

Signature : *[Signature]*

Date & Time : *20/5/20*

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 5 D (M)
 Dr. VIJAYANAND JAMALPURI



PROGRESS NOTES AND DOCTOR'S ORDER

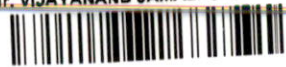
Date & Time	Progress Notes	Doctor's Order
20/5/26 8:30am		Seen by <u>Dr. Vijayanand</u>
	late preterm / RDS /	<ul style="list-style-type: none"> → Continue NIV. 14/6, Rate 40 Decrease PIP as tolerated. → Prone nursing. → Nasal and oral care. → TV - 120cc / tgl day full feeds → CRBS - BD. → ASIC SBR in same sample. → Cardiovascular assessment to face. → Trace peripheral smear → Change to <u>PI Reg A 40526</u>
		Noted by vidya 20/5/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Seen by Dr. Pratyush
		→ Change to NIV with mask.
		→ Stat dose.
		Lasix
		Dexamethasone
		Dr. Navilan
		evening rounds
20/5		
@ 3:37 PM	578 LMP	Plan
	V → NIV - mode 20/6	→ continue NIV
	rate - 40	20/6
	FiO ₂ - 27%	Target - SpO ₂ 90-95%
	gas - 7.37 / 44.6 / 11.24.8	→ IV - 190ul/kg/day
	C → HR - 136 bpm	full on feet
	Bp - 65/55 (59)	renal ultrasound
	U/D - 2ul/kg/hr	- Trace echo - report
	PE - cold	
	P/A - soft	→ Cover peripheral embolism
	to creating feeds	

Abd by V. K. 20/5 @ 4 PM



PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
19/5/26	Rt Abd	Rt Hand	Supine	Given	Given	BD	nil	Given	Given	<i>[Signature]</i>
19/5/26	Rt Abd	Rt Hand	Rt up	Given	Given	BD	nil	Given	Given	<i>[Signature]</i>
20/5/26 2pm	Rt Abdomen	Rt Leg	Rt up	given	given	BD	NA	given	given	<i>[Signature]</i>
20/5/26 8pm	Rt Shoulder	Left Hand	Lt up	given	given	BD	NA	given	given	<i>[Signature]</i>
21/5/26 12 AM	Rt Shoulder	Rt Leg	Lt up	given	given	BD	NA	given	given	<i>[Signature]</i>
21/5/26 6pm	Lt Shoulder	Rt hand	Rt up	given	given	BD	NA	given	given	<i>[Signature]</i>

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 5 D (M)
 Dr. VIJAYANAND JAMALPURI



1

PROBS AND POSITIONS CHART



Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
18/5/26 8 AM	Rt Abd	Rt Abd	Supine	Given	Given	B.D	NA	Given	NA	
19/5/26 3 AM	Rt Abd	Left Abd	Supine	Given	Given	B.D	NA	Given	NA	
19/5/26 7 AM	Rt Abd	Left Left	Supine	Given	Given	B.D	NA	Given	NA	
19/5/26 9 AM	Rt Abdomen	Lt neg	Supine	Given	Given	B.D	N/A	Given	N/A	
19/5/26 4 PM	Rt Abdomen	Lt hand	Supine	Given	Given	B.D	NA	Given	N/A	
19/5/26 7 PM	Rt Abdomen	Lt neg	Supine	Given	Given	B.D	N/A	Given	N/A	

9

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		gas PBS JBD
		+ fluctuating blood
		- mouth white
		for - manually
20/5/26 5:30pm		Seen by Dr. Nilesh
		→ Continue NIV Uran salt
		→ Continue Dexmed.
	ECHO (N)	→ If inevitable consider Pam's
	Copious nasal secretions (F)	→ Gas - OD / sos.
		→ Trace culture reports Blood & ET:
		→ Nasal suction now
		→ CBC, X-Ray now.
		→ Nasal suction & oral suction stuhely. ↓ with saline

Noted by
 Vidyut
 20/5/26
 @ 5:40pm

10

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/26 10:30pm	Night Round	
	Baby is on NIV \bar{c} mask.	→ 15/7, Rate 40, PEEP 4-5%
	No Tachypnea upto 85.	
	Desat upto 85%.	Seen by Dr - Sarat
	SCR ⊕	Plan.
	Baby is irritable on Dexmed sedation.	→ Continue NIV \bar{c} mask.
	<u>Vitals</u>	Target SpO ₂ 90-95% PEEP 7 → 6
	HR - 190/min	→ Regular nasals & oral suction
	RR - 59/min	→ TV - 120cc/kg/day
	SpO ₂ - 91%	10% Iso P.
	BP - 64/46(51)	NPO 1/1/0 S/S intubation
	peripheries - cold.	→ Continue nebulisations
	P/A - soft.	→ Gas - OD / S/S RBS - OD.
	Thick oral & nasal secretions.	→ No w/f ↑ distress observations
	Neb - Mucomix	Prophylax
	3% NaCl.	Noted baby Sarat ⊕ 20/5/26
	Adrenaline.	

BAH-00658641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 7 D (M)
 Dr. VIJAYANAND JAMALPURI



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 7 PMA:

Term Preterm Gestation : 35 weeks Corrected Gestational Age:

OVERVIEW	Problems :	
	S.No.	Current
1.	Late PTL RDS	
2.	extubation failure	
3.	Suspected sepsis	
4.		
5.		
6.		

Today's Weight :

RESPIRATORY SYSTEM

Ventilatory Support : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV iNO PPM

Ventilator Settings : PIP.....PEEP.....VG.....Rate.....FiO₂.....Oxygen :L/min

Last CXR : Spo₂ :

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours.....
on NIV - 20/6

CARDIO VASCULAR SYSTEM

Plan of Care : U/O

HR - 150/min
 RR - 49/min
 Spo₂ - 96%
 BP - 56/33 (42)

CNS

Neurological Examination :

Sedation: Dexmedetomidine

Last Neurosonogram : Any Seizures:

FLUIDS STATUS NUTRITION

NPO NG Feeds Wt. Gain: Head Circumference:

Input: / (+/-) Output: ml/k/d Urine Output: ml/kg/hr Stools:

IV Fluids - Type of IVF: @ ml/hr

Feeding: EBM Formula Donor BM Volume: Frequency:

TPN: Yes No - If yes, details: Calories:

Abdominal Examination:

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

.....

.....

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:

Blood culture Urine culture ET culture Fungal Culture LP CSF :

INFECTION	Antibiotic	Sl.No.	Drugs	Days	
		1.	Mercopenam	D3	
2.	Piptary	D2			
3.					

Plan of Treatment :

- Continue current ventilation
- TV - 120cc/kg/day. → full OA feed.
- Continue nebulisations
- Trace ET culture.
- Gas γ OD
HBS
- Bp charting 6th hly
- Monitor vitals

Doctor's Name (Handover given) : Poojitha

Signature : [Signature]

Date & Time: 21/5/26

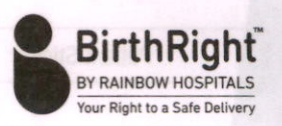
Doctor's Name (Handover taken) : [Signature]

Signature : [Signature]

Date & Time: 21/5/26

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 7 D (M)
 Dr. VIJAYANAND JAMALPURI

11



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/5/26		Seen by Dr. Vijayanand
10:10 AM		
		→ Continue NIU mean FiO ₂ as tolerated
		→ Mean Rate to 30 then ↓ Pressure -
		→ Blood gas - BD RBS - BD
		→ TV - 140cc/kg/day full oil feed
		→ Continue Dexmed. 1/1
		Dr. VIJAYANAND JAMALPURI Reg. No: 40526
	ES culture (+) for Acinetobacter	→ Add Colistin Tigecycline
		noted by vidya
		021143
		01/5/26
		@ 10:10 AM

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 Baby Of JETTURI RAVALIKA (M)
 13-05-2026 0 Y 0 M 7 D
 Dr. VIJAYANAND JAMALPURI

12

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/5/26		
1:45 PM		<u>Afternoon socendy</u>
		<u>Plan:</u>
	- on NIV,	- Continue NIV,
	Fio ₂ - 40% [↑ requirement upto 45%]	- Intubation SOS if ↑ distress,
	- 20L RR - 40/min;	if ↑ Fio ₂ requirement.
		- TV - 120ml lts/day
	<u>Issues:</u> - labile saturation	↓ 25ml 2nd hly full of feeds
	- mild SCrP	
	- nasal secretions ⊕ oral.	- Blood gas - BD
	- 2 episodes of large vomitings;	- RBS - OD
	- Intermittent desaturation	- Ilo. charty 6th hourly
	GTDs - Acinetobacter	- Rlv Repeat Cardiac assessment today.

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 Baby Of JETTURI RAVALIKA (M)
 13-05-2026 0 Y 0 M 7 D
 Dr. VIJAYANAND JAMALPURI

13



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	- Ongoing dexmed subcut	- Target SpO ₂ - 90 to 95%
		<u>Aneel</u>
<u>21/5/26</u> 2:45 PM	- 2 episodes of large vomit	Seen by Dr. vijayanand <u>Plans</u> - continue NIV - wean FiO ₂ and rate as tolerated; - If further episodes of Vomit, to add domper. <u>noted by</u> vidya 091143 21/5/26 @ 2:45 pm
	Pha - soft	<u>Aneel</u>
		Dr. VIJAYANAND JAMALPURI Reg. No: 40526

14

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/15/26 @ 9pm	<u>Night Rounds</u>	Plan
	Baby on Niv. PIP = 20, PEEP - 6 RR = 40/min SpO ₂ - FiO ₂ - 30% ↓	1) Cont Current Settings Target SpO ₂ 90-95% at FiO ₂ > 21%
	ⓐ Gas 7.38/55.2/50.6/29.4/7.2 Tac - 2.2	2) TV = 120ml/kg/day 25ml 2nd hrly Full OR feeds
	ⓑ <u>vitals</u> : HR = 139/min RR = 54/min Scr (+) ICR (+)	3) Blood gas - BD RBS - OD
	SpO ₂ = 94% BP = 97/26 (48) ↓	4) I/O charting b7h hrly 5) If any episodes of vomiting ↓ Stool Dematol
	Ⓒ p/A - Soft No vomitings.	6) w/f - Brady, desat RD.
	Intermittent desaturation	Snel

22/5/26

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 8 PMA:

Term Preterm Gestation : 35 weeks Corrected Gestational Age:

Problems :		
S.No.	Current	Past Problems
1.	(late PT) RDS	
2.	Extubation failure	
3.	VAP - carbapenem resistant	
4.	Acinetobacter	
5.		
6.		

Today's Weight : 2.392 (↓83gms)

Ventilatory Support : Yes No - Day # of Vent : ?

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV INO PPM

Ventilator Settings : PIP.....PEEP.....VG.....Rate.....FiO₂.....Oxygen :L/min

Last CXR : Spo₂ :

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours:

ON NIV, FiO₂ - 30% + 20%.

Issues:

- Respiratory Distress (P)

- oral nasal secretions carriage -

SPO₂ - 96%

PR - 148/min

RR - 50/min

- 3 episodes of small vomitages.

Plan of Care :

Neurological Examination :

Sedation : Ongoing dexmed

Last Neurosonogram : (N) Any Seizures : Intubation

FLUIDS STATUS NUTRITION

NPO NG Feeds Wt. Gain:..... Head Circumference:.....

Input : / (+/-) Output : ml/k/d Urine Output : 1.8 ml/kg/hr Stools: *paned*

IV Fluids - Type of IVF : @ ml / hr

Feeding: EBM Formula Donor BM Volume:..... Frequency:.....

TPN : Yes No - If yes, details : Calories:.....

Abdominal Examination:.....

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

plA - stable

INFECTION

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:.....

Blood culture Urine culture ET culture Fungal Culture LP CSF :

SI.No.	Drugs	Days	
1.	<i>Trj - colistin</i>	<i>D1</i>	<i>neb - Adrenaline</i>
2.	<i>Trj - Tigecycline</i>	<i>D1</i>	<i>neb - Miconazole, Skin Refugy -</i>
3.			<i>subling - D4</i>
			<i>Th-</i>

Plan of Treatment :

- continue NIV, 20/6
- wear off FiO2 and rates as tolerated
- Target SpO2 90 to 95%.
- TV - 120 uel / day
 ↓
 25 uel and help full O2 feed.
- Blood Gas }
 RBS } op
- No. chattering 6th hourly

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

Signature : *[Signature]*

Date & Time : *22/5/25*

Doctor's Name (Handover taken) : *Mr. Mulla*

Signature : *[Signature]*

Date & Time : *22/5/25*

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 -2026 0 Y 0 M 10 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5 @ 10:31 AM		seen by Dr. vijayananda BIV
		<p>→ NIV - 18/6 scale - ↓ TI - 0.5 evening</p>
		<p>→ continue deametero duplid</p>
		<p>→ continue Antibiotic</p>
		<p>→ TV - 140 ul/kg/day</p>
		<p>→ add colistin 1ml</p>
	<p>Noted by Vishnu Raja @ 19:01 22/5/26</p>	<p>Dr. Manu</p>
	<p>@ 10:31 AM</p>	<p>→ TV - 140 ul/kg/day 29ml 2nd half full Oq feed.</p>

Dr. VIJAYANAND JAMALPURI
 Reg. No. 40528

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5/26	Afternoon Round	
	On NIV - 18/6. Rate - 35. mild SCRF	
	Vitals	Plan
	HR - 147/min.	→ Continue NIV
	RR - 52/min	RfV wean Rate & PIP
	SpO ₂ 96%	
	BP - 65/44 (SI)	→ TV - 140cc/kg/day
	P/A - soft.	29ml 2nd only full O ₂ feed
	On Dexmedetomidine sedation.	→ Continue antibiotic
		→ Wt ↑ was work of breathing
		→ Monitor vitals
		Poplite seen by Dr. Vijayendra & se seen - 30 night PIP - 16 W
22/5/26	Noted by Vishnu Kumar 22/5/26 Dr. Vijayendra	Dr. Manu

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 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 9 D (M)
 Dr. VIJAYANAND JAMALPURI



37



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Night Rounds</u>	
22/5/26 11:50pm		Seen by Dr. Vineela
	En. NIV = 18/6 FiO ₂ = 30% Relv = 30/min	<u>Plan:</u>
	Accepting full OA feeds. (ESM + Non pro)	• Continue NIV → 16/6 FiO ₂ = 30%. Relv = 30/min ↓
	HR = 168/min RR = 51/min SpO ₂ = 96% on NW BP = 70/48(55) mmHg.	• Maintaining well then continue w/ F deset / bready, techyp. • W/ F need work of breathing. • I/O check 961+ • Monitor vitals
		noted by Aravathy 22/5/26 @11:50pm. Dr. Ranj



23/5/26

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 9 PMA:

Term Preterm Gestation : 35 wks Corrected Gestational Age:

Problems :		
S.No.	Current	Past Problems
1.	Letu P1 / RDS	
2.	Extubation failure	
3.	VAP - Carbapenem resistant	
4.	Acinetobacter	
5.		
6.		

Today's Weight : 2.369 (+29gms)

RESPIRATORY SYSTEM

Ventilatory Support : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV INO PPM

Ventilator Settings : PIP.....PEEP.....VG.....Rate.....FiO₂.....Oxygen :L/min

Last CXR : Spo₂.....

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours..... on NIV - PEEP = 6, RR = 30/min
 PIP = 16, FiO₂ = 27%.

SCR (+) Intermittent resp. distress (+)
 oral & nasal secretions (+)

CARDIO VASCULAR SYSTEM

Plan of Care : HR = 166/min
 RR = 41/min
 SPO₂ = 92% on NIV
 BP = 72/54 (68) mmHg.

1 large vomity - morning.

CNS

Neurological Examination : } CTA fav
 Sedation..... } on going Denmed.
 Last Neurosonogram : Any Seizures..... }

FLUIDS STATUS NUTRITION

NPO NG Feeds Wt. Gain: Head Circumference:

Input : / (+/-) Output : ml/k/d Urine Output : ml/kg/hr Stools :

IV Fluids - Type of IVF : @ ml / hr

Feeding: EBM Formula Donor BM Volume: Frequency:

TPN : Yes No - If yes, details : Calories:

Abdominal Examination:
PA : soft, no distension

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

.....
P

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:

Blood culture Urine culture ET culture Fungal Culture LP CSF :

INFECTION

Antibiotic	Sl.No.	Drugs	Days	
	1.	Inj Colistin	D2	<i>Neb Adrenaline</i> <i>Neb. Mucormit</i> <i>neb Colistin - D1</i>
	2.	Inj Tigecyclin	D2	
	3.			

Plan of Treatment :

- Continue NIV (16/6) RR = 30/min, FiO₂ = 27%
 (Target SpO₂ 90-95%)
- Continue TV = 140ml/kg/day, 29ml @ 2H full OG feed.
- W/R t sed work of breathing, distress
- Blood Gas }
 RBS } OD
- I/O Charting Q6H
- Monitor vitals.

(Handover given) : *Dr. Ranje*

Doctor's Name (Handover taken) : *Dr. Nandha*

Signature : *[Signature]*

Date & Time : *23/5/20*

(P.T.O.)

L3/5/20

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 Baby Of JETTURI RAVALIKA (M)
 13-05-2026 0 Y 0 M 9 D
 Dr. VIJAYANAND JAMALPURI

38



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	23/5/26	seen by Dr. vijayanand
	10:00 AM	Plans
	Issues - SCR ⊕	- Continue CPAP,
	ole	- Blood gas alternate day
	- oral thrush ⊕	- TV - 150ml/kg/day
		↓ - full OG feeds 33ml 2 hourly
	- candida - Df	- Decrease dexmed injection.
		- Examine for - Add candida mouth paint <i>sub</i>
		- continue antibiotics for one week.

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 Reg. No: 40526

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Baby Of JETTURI RAVALIKA

0 Y 0 M 9 D

13-05-2026

Dr. VIJAYANAND JAMALPURI



(M)

39



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/26 11:30pm	Afternoon Round	
	on CPAP, PEEP 6 FiO ₂ - 25%.	
	No bradyl/desat. No Resp. distress.	
		Plans.
	<u>Vitals</u>	
	HR - 132/min.	→ Continue CPAP - 6
	RR - 49/min	Target SpO ₂ 90-95%.
	SpO ₂ - 92%.	
	BP - 64/50(54)	→ TV - 150 cc/kg/day
		33ml 2nd hly
		full O ₂ feed
	P/A - soft	
	tolerating feed well.	→ Wean + Stop
		Dexmedetomidine
	weaning Dexmed.	
		→ w/ bradyl/desat
	oral through ⊕	
		→ Adjust nasal
		mask to avoid
		leak.
		Propofol

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 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 9 D (M)
 Dr. VIJAYANAND JAMALPURI



40

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/26 3:20pm		Seen by <u>Dr. Vijayanaad</u>
	→	Continue CPAP
	→	No routine blood gas
	→	Stop Dexmedetomidine
	<p><u>Propranolol</u></p>	
		<p>Dr. VIJAYANAND JAMALPURI Reg. No: 40526</p>
24/5/26 1:00 AM	<p><u>Nitrocead</u></p>	
	- on CPAP,	<p><u>Plans</u></p>
	Stable on CPAP	- Continue CPAP
		- Plan to wean off CPAP tomorrow
	SpO2 - 96%	
	PR - 62/min	- Continue till OK feeds.
	RR - 60/min	
		- oral & nasal suction s/s



24/5/26

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 10 PMA:

Term Preterm Gestation : 35 weeks Corrected Gestational Age:

Problems :		
S.No.	Current	Past Problems
1.	<u>late preterm / RDS</u>	
2.	<u>Extubation failure</u>	
3.	<u>VAP - carbapenem</u>	
4.	<u>resistant Acinetobacter</u>	
5.		
6.		

Today's Weight : 2.391 (5.22gms)

Respiratory System

Ventilatory Support : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV iNO PPM

Ventilator Settings : PIP..... PEEP..... VG..... Rate..... FiO₂..... Oxygen : L/min

Last CXR : Spo₂.....

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours.....

on CPAP,
FiO₂ - 25%,
PEEP - 6,

Cardio Vascular System

Plan of Care :

SpO₂ - 96%
PR - 145/ucm
RR - 45/ucm

Thick secretions
nasal

CNS

Neurological Examination :

..... Sedation.....

Last Neurosonogram : (N) Any Seizures.....

FLUIDS STATUS NUTRITION

NPO NG Feeds Wt. Gain: Head Circumference:

Input : / (+/-) Output : ml/k/d Urine Output : ml/kg/hr Stools : *passed*

IV Fluids - Type of IVF : @ ml / hr

Feeding: EBM Formula Donor BM Volume: Frequency:

TPN : Yes No - If yes, details : Calories:

Abdominal Examination:

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

plA - sat

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:

Blood culture Urine culture ET culture Fungal Culture LP CSF :

INFECTION

Antibiotic	Sl.No.	Drugs	Days
	1.	<i>Fuj' collistin</i>	<i>D3/7</i>
	2.	<i>Fuj' Tiscycline</i>	<i>D3/7</i>
	3.		

web - Adrenaline
web - Mecorax
web - collistin

Plan of Treatment :

- continue CPAP, PEEP 6
- RTV to ~~wean off~~
- TV - 150 ml/kg/day
↓
Full OG feeds
33 ml 2nd hourly
- RBS OD
- Flo. chabing 6th hourly
- w/H vitals
- oral suctioning SOS

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

Signature : *Aneeb*

Date & Time : *24/5/26*

Doctor's Name (Handover taken) : *Poojit*

Signature : *Poojit*

Date & Time : *24/5/26 9am*



46

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>24/5/26</u>	<u>Seen by Dr. Vijayanand</u>
	<u>9:30 AM</u>	Plan:
		- Continue C/A
		PEEP - 6
		- TV - 150 ml/kg/day
		↓ full OG feeds
		- oral nasal suction as needed.
		- RBS OD
		- CXR T/M Anand
		(6) SDS
		- Stop neomax
		nebulas stop
		Dr. VIJAYANAND JAMALPURI
		Reg. No: 40526



(42)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/5/26	Night Round	
10pm	on CPAP-6	
	Intermittent tachypnea	
	mild SCR (+)	
	<u>Vitals</u>	<u>Plan</u>
	HR - 163/min	→ Continue CPAP-6.
	RR - 49/min	Target SpO ₂ 90-95%
	SpO ₂ - 96%	→ TV - 150ml/kg/day
	BP - 66/28(42)	33ml 2nd hly.
	P/A - soft, stools	full O ₂ feed
	passed	→ I/O charting 6th hly
		→ CURBS - 00
		→ Chest X-Ray - T/M
		6am
		→ Oral & nasal suction
		SOS
		Respite

H-00656641 IP5-00173990
 by Of JETTURI RAVALIKA
 05-2026 0 Y 0 M 10 D (M)
 VIJAYANAND JAMALPURI

43



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/5/26 11:45pm		Seen by <u>Dr. Nulesti</u>
	→	Continue CPAP- 6
	→	R/v to change to Rami's cannula tomorrow
	→	Chest x-ray → 11m 6am
	<p>↓ Poplite</p>	<p>→ Continue full O₂ feed</p> <p><i>Dr. Nulesti</i></p>

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Baby Of JETTURI RAVALIKA

13-05-2026 0 Y 0 M 11 D (M)

Dr. VIJAYANAND JAMALPURI



46

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		- Blood gas SOS
	SpO ₂ - 96%	- PBS on
	PR - 165 beats	- positionally
	RR - 54 breaths	<ul style="list-style-type: none"> - Rt. OP - Lt. OP - Supine
		} 15 mins each
		- No. cholesty 6 to hourly
		- oral & nasal suctioning SOS.
		<i>Asub</i>
	seen by Dr Vijayanand	
	<u>Plan</u>	
		① cont CPAP & remain
		② ensure adequate delivery
		③ cont Abx
	<i>Asub</i>	
		Noted by Ses. Bushra 25/5/26 @ 3pm



45

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5/26 9:50 AM	seen by Dr. Vijayanand	Plan
		① CPAP 6cm
		② blood gases SOS only
		③ cont colistin vials
	Tubing D ₀ 7.	④ cont new + colistin.
	In cannula D ₀ .	⑤ Trial of prong CPAP 6-7cm
	Rx New	⑥ cont antibiotics
	Tigecycline	for 7 days total.
		⑦ Antibiotic justification form.

[Signature]
 Dr. Vijayanand

Dr. VIJAYANAND JAMALPURI
 Reg. No: 40526

25/5/26
 12:25 PM

Afternoon rounds

Plan.

- ON CPAP,
 FiO₂ - 23%,
 PEEP 6

- continue CPAP,
 PEEP 6, FiO₂ - 23%
 - Target SpO₂ - 90 to 95%
 - TV - 150 ml/kg/day
 ↓
 33ml 2nd hourly
 full O₂ feeds.

FLUIDS STATUS NUTRITION

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

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

P/A - soft

INFECTION

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

Antibiotic	Sl.No.	Drugs	Days
	1.	Inj. Colistin	D4/A
	2.	Inj. Tigecycline	D4/A
	3.		

Meb. Colistin

Plan of Treatment :

- Continue CPAP, PEEP 6cm H₂O
- TV - 150ml/kg/day → 33ml/24hrly full OG feed.
- RBS - OD
- I/O charting 6hrly
- oral suctioning SOS.
- Get X-Ray film

Doctor's Name (Handover given) : Respirthe
 Signature : [Signature]
 Date & Time : 25/12/26 7am

Doctor's Name (Handover taken) : [Signature]
 Signature : [Signature]
 Date & Time : 25/12/26



25/5/26

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 11 PMA:

Term Preterm Gestation : 35 weeks Corrected Gestational Age:

OVERVIEW	Problems :	
	S.No.	Current
1.	<u>late preterm / RDS</u>	
2.	<u>extubation failure</u>	
3.	<u>VAP - Carbapenam</u>	
4.	<u>resistant Acinetobact.</u>	
5.		
6.		

Today's Weight : 2406g (↑15g)

RESPIRATORY SYSTEM

Ventilatory Support : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV iNO PPM

Ventilator Settings : PIP..... PEEP..... VG..... Rate..... FiO₂..... Oxygen : L/min

Last CXR : Spo₂ :

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours: on CPAP - 6.
No heady / desat
RR intermittent tachypnea
Thick oral secretions (F)

CARDIO VASCULAR SYSTEM

Plan of Care :
HR - 141/min
RR - 23/min
SpO₂ - 93%
BP - 91/80 (84)

CNS

Neurological Examination :


Sedation:

Last Neurosonogram : (N) Any Seizures:

3AH-00656641
Baby Of JETTURI RAVALIKA
13-05-2026
Dr. VIJAYANAND JAMALPURI (M)
IP5-00173990
0 Y 0 M 11 D

47

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Night Rounds</u>	
28/5/26 11 PM	on CPAP 6cm Rams. HR - 143/min SpO ₂ - 95%. RR - 48/min SUR (+). nasal 2 oral suctions (+). tolerating full O ₂ feeds PA - soft stools passed	<u>Plan</u> ① cont CPAP 6cm Rams ② nasal to oral suction now 2 SORS ③ if SUR persist, TPEEP ④ TV = 150ml/kg/day 33ml q2h full O ₂ ⑤ blood gas 505 CURBS OD ⑥ IVO GBH ⑦ Positioning Rt up Lt up supine
	Colistin Tigecycline } D4/7	
		
		Noted by Sri. Navaneetha 25/5/2026



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 12 PMA:

Term Preterm Gestation : 35 weeks Corrected Gestational Age:

OVERVIEW	Problems :	
	S.No.	Current
1.	LPT / RDS.	extubation failure
2.	VAP - ceftazidime	
3.	resistant acinetobacter	
4.		
5.		
6.		

Today's Weight : 2.438 (T32gm)

RESPIRATORY SYSTEM

Ventilatory Support : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV iNO PPM

Ventilator Settings : PIP..... PEEP..... VG..... Rate..... FiO₂..... Oxygen : L/min

Last CXR : Spo₂.....

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours..... CPAP 7cm / 23-7.
mask → Cann
tolerated well.
nasal & oral suction (+)
intermittent SCR (+)

CARDIO VASCULAR SYSTEM

Plan of Care :

HR - 160/min
SpO₂ - 92%
RR - 27/min

CNS

Neurological Examination :

..... Sedation.....

Last Neurosonogram : (N) Any Seizures.....

CRBS - 24.

FLUIDS STATUS NUTRITION

NPO NG Feeds Wt. Gain: Head Circumference:

Input: / (+/-) Output: ml/k/d Urine Output: 2.4 ml/kg/hr Stools: ++

IV Fluids - Type of IVF: @ ml / hr

Feeding: EBM Formula Donor BM Volume: 33ml Frequency: Q2H

TPN: Yes No - If yes, details: Calories:

Abdominal Examination: soft, non distended

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

.....

.....

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:

Blood culture Urine culture ET culture Fungal Culture LP CSF :

INFECTION	Antibiotic	SI.No.	Drugs	Days
		1.	Colistin] 0.5g
2.	Tigecycline			
3.				

colistin neb

Tubings - D₈

IV line - D₁

Plan of Treatment :

① cont CPAP 7cm ramp / 237.

② TV = 150ml / 4/day
33ml Q2H on feed.

③ FiO₂ 0.6H.

④ CRBS OD

⑤ NO routine gas.

⑥ Positioning - Rt up
Lt up
supine } 4hrs each.

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

Signature : [Signature]

Date & Time : 26/5/26

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

Signature : [Signature]

Date & Time : 26/5/26 9am

3AH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 13 D (M)
 Dr. VIJAYANAND JAMALPURI



49

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 10:30 AM	seen by Dr. Vijayanand	Plan
		<ul style="list-style-type: none"> ① cont CPAP 7cm ② no routine blood gas ③ cont antibiotics antibiotics
	<p>Noted by Hemabhatla 26/5/26 @ 10:40 AM</p> <p>Dr. Vijayanand</p>	
26/5/26 1 PM	Afternoon Round	Dr. VIJAYANAND JAMALPURI Reg. No.: 40520
	<p>on CPAP, PEEP-7 SCR (+), irritability</p>	Plan
	<p><u>Vitals</u></p> <p>HR - 141/min RR - 52/min SpO2 - 92% BP - 77/41(54)</p>	<ul style="list-style-type: none"> → Continue CPAP-7 → TV - 150ml/kg/day 33ml 2nd help. full OG feed.
	P/A - soft	→ No routine blood gas
		→ Continue antibiotics for total 7 days
	<p>Noted by Hemabhatla 26/5/26 @ 1:20 PM</p> <p>Dr. Vijayanand</p>	→ w/f respiratory distress

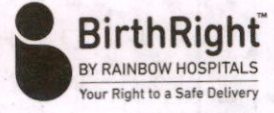


30

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 5:40pm		Seen by Dr. Vijayanand
	<p>→ Continue CPAP - 7</p> <p>→ Full O₂ feeds</p> <p>Dr. Poojitha</p> <p>Noted by Homalatha 01/06/26 @ 6pm</p>	<p>Handover taken by Dr Remya</p> <p>Handover given by Dr. Poojitha 26/5/26 @ 6pm</p> <p>Dr. VIJAYANAND JAMALPURI Reg. No. 00226</p>
26/5 @ 2:17AM		<p>seen by Dr. Nalini Babu Sir</p>
		<p>→ CPAP - 6 used</p> <p>→ 2 feeds</p> <p>Noted by Srs. Navaneetha 26/5/26 @ 2:17AM</p>

27/5/26



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 13 PMA: 36 + 6 wks

Term Preterm Gestation : 35 wks Corrected Gestational Age: 2.481 (143gms)

Problems :		
S.No.	Current	Past Problems
1.	LPT/RDS	
2.	VAP → Carbapenam resistant	Extubation failure
3.	acinetobacter.	
4.		
5.		
6.		

Today's Weight : 2.481 (143gms)

RESPIRATORY SYSTEM

Ventilatory Support : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV iNO PPM

Ventilator Settings : PIP..... PEEP..... VG..... Rate..... FiO₂..... Oxygen : L/min

Last CXR : Spo₂.....

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours..... On CPAP + PEEP = 7's FiO₂ = 23%.
↓ PEEP 6 (@ night rounds)
NO tachy, brady, apnea.
NO vomitngs
oral secretions thick @, but improving.

CARDIO VASCULAR SYSTEM

Plan of Care : HR = 140/min V₁₀ = 2.5ml/kg/hr
 RR = 40/min S₁₀ = passed
 SPO₂ = 98% on R CPAP. RBS - 114cc/kg
 BP = 63/33(44)mm Hg.

CNS

Neurological Examination : } CIA fair Sedation..... } NO
 Last Neurosonogram : Any Seizures.....

FLUIDS STATUS NUTRITION

NPO NG Feeds Wt. Gain: Head Circumference:

Input : / (+/-) Output : ml/k/d Urine Output : ml/kg/hr Stools :

IV Fluids - Type of IVF : @ ml / hr

Feeding: EBM Formula Donor BM Volume: Frequency:

TPN : Yes No - If yes, details : Calories:

Abdominal Examination:
 PA: Soft / No distension

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

.....

.....

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:

Blood culture Urine culture ET culture Fungal Culture LP CSF :

INFECTION	Antibiotic	SI.No.	Drugs	Days	Candid mouth paint - D5 Tubercys - D1 cannula - D2
		1.	Iuj colistin	D5 / 7	
2.	Iuj Tigecyclin	D5 / 7	7		
3.	Neb colistin	D5			

Plan of Treatment :

- Continue CPAP → PEEP = 6 , FiO₂ = 23%
 Target SpO₂ if FiO₂ > 21% - 90-95%.
- Continue TV = 150ml/kg/day ; 33ml Q2H full OG feed (EBM + formula)
- W/P resp. distress, tachy, @
- I/O Charting Q6H
- GRBS - OD
- No routine gas.
- Positioning →

→ Rt up	} 4hr each.
→ left up	
→ supine	
- ~~Stop~~ Tigecycline after today's night dose.
- * ~~Stop~~ colistin after tomorrow's morning dose.

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

Signature : *[Signature]*

Date & Time: 27/5/26, 8am

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

Signature : *[Signature]*

Date & Time: 27/5/26

3AH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA (M)
 13-05-2026 0 Y 0 M 13 D
 Dr. VIJAYANAND JAMALPURI

51

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26 11:40 AM	Seen by Dr. Vijayanand	Plan
		① CPAP 5cm.
		② Rx antibiotics 4/m cont tigecycline & colistin till then.
		③ cont candid mouth paint for 7 days.
	<p>Noted by Hemalatha 016699 27/5/26 @ 11:50 PM</p>	<p>Dr. VIJAYANAND JAMALPURI Reg. No. 40525</p>
27/5/26	Afternoon rounds	Plan:-
11:50 PM	<p>- on CPAP, FiO₂ - 24%, PEEP - 5</p> <p>SpO₂ - 96% PR - 160/min RR - 35/min</p>	<p>- continue CPAP, PEEP - 5</p> <p>- Tv - 15ml/kg/day ↓ Full OG feeds 33ml/kg/day</p>

52

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		<ul style="list-style-type: none"> → PRS OD → Blood gas SAs → Posturing → RT UP } 4 hrs → CP UP } each → Sepsis
		<ul style="list-style-type: none"> → Nasal cannula → Suctioning SAs → Stop Tigecycline after today's night dose
	<p>Noted by Hemalatha 016699 23/5/26 @ 2PM</p>	<p>Dr. Anusha</p>
27/5/26 AM		<p>Seen by Dr. Vijayanand</p> <ul style="list-style-type: none"> → Continue CPAP - 5 → IV - 150ml/kg/day 33ml 2nd hly full O2 feed
	<p>Noted by Hemalatha 016699 23/5/26 @ 3:30 AM</p> <p>Ch Poop like</p>	

1

BED SIDE CHECK LIST FOR NURSES

Date:	10/5	19/5/14	19/5/15	20/5	21/5	21/5	22/5	23/5	24/5
Doctor's Orders	Follow	Follow	yes	✓	✓	✓	✓	yes	yes
Carried out or not	yes	yes	yes	✓	✓	✓	✓	yes	yes
Bed Side									
Structured Handover done	yes	yes	yes	✓	✓	✓	✓	yes	yes
IV Site	yes	yes	yes	✓	✓	✓	✓	yes	yes
Central Lines	NO	NO	NO	X	X	X	X	NO	NO
Arterial Lines	NO	NO	NO	X	X	X	X	NO	NO
Feeding Catheter	yes	yes	yes	✓	✓	✓	✓	yes	yes
Urinary Catheter	NO	NO	NO	X	X	X	X	NO	NO
Skin Care	yes	yes	yes	✓	✓	✓	✓	yes	yes
Eye Care	yes	yes	yes	✓	✓	✓	✓	yes	yes
Mouth Care	yes	yes	yes	✓	✓	✓	✓	yes	yes
Sterillum Bottle, Stethoscope	yes	yes	yes	✓	✓	✓	✓	yes	yes
Suction Bottle (Should be clean & empty)	yes	yes	yes	✓	✓	✓	✓	yes	yes
Intubation Tray	NO	NO	NO	X	X	X	X	NO	NO
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	Ambu	Ambu	Ambu	Ambu	Ambu	Ambu	Ambu	Ambu	Ambu
Ventilator Tubing, (Any Water, Blood)	NO	NO	NO	X	X	X	✓	NO	NO
Humidification	NO	NO	NO	✓	✓	✓	✓	yes	yes
Check all Infusion (Labelling, Correct Preparation)	yes	yes	yes	✓	✓	✓	✓	yes	yes
Chest Physio & Neb	NO	NO	NO	X	X	X	X	NO	NO
Handed Over By Name :	Koushik	Srinath	Ashu	Vidya	Sudha	Vidya	Sudha	Aravind	Naradit

Checked & Handover given by
 Name of the Nurse :
 Signature :
 Date & Time :
 Doc. No. : RCHBH/FRM/GENERAL /088

Checked & Handover taken by
 Name of the Nurse :
 Signature :
 Date & Time : 19/5/15 @ 8 AM

53

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>22/5/26</u>	<u>Night Round</u>	
	on CPAP, PEEP-5 No desat/beady NO RD.	
		<u>Plan</u>
	<u>Vitals</u>	
	HR - 133/min	→ Continue CPAP-5
	RR - 50/min	→ Target SpO ₂ 90-95%
	SpO ₂ = 92%	
	BP - 73/44(54)	→ TV - 150ml/kg/day
		33ml 2nd hly.
	P/A - soft	full O ₂ feed
	Abundant feed.	
		→ Stop Tigecycline
		after night dose
		→ Do not replace
		IV line if out
		→ w/f SpO ₂
	<u>Poplite</u>	→ Monitor vitals
		→ Positioning
		Rup
		Supine
		4 hrs each

BAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 13-05-2026 0 Y 0 M 13 D (M)
 Dr. VIJAYANAND JAMALPURI

28/5/26



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 14 PMA: 36w 37wks
 Term Preterm Gestation : 35wks Corrected Gestational Age: 2.527 (1468g)

Problems :		
S.No.	Current	Past Problems
1.	late preterm / RDS	
2.	VAP - Carbapenam resistant	Extubation failure
3.	Acinetobacter	
4.		
5.		
6.		

Today's Weight : 2.527 (1468g)

RESPIRATORY SYSTEM

Ventilatory Support : Yes No - Day # of Vent :

Mode of Ventilation : HFNC CPAP Conventional Ventilation : SIMV A/C VG HFOV INO PPM

Ventilator Settings : PIP.....PEEP.....VG.....Rate.....FiO₂.....Oxygen : L/min

Last CXR : Spo₂.....

ET Secretions : Clear Thick Yellow Last ABG:

Change over the Last 24 Hours: on CPAP - PEEP 5cm
No desat / brady

CARDIO VASCULAR SYSTEM

Plan of Care :
HR - 130/min
RR - 43/min
SpO₂ - 92%
BP - 65/37(47)

CNS

Neurological Examination :

Sedation.....

Last Neurosonogram : (N) Any Seizures.....

FLUIDS STATUS NUTRITION

NPO NG Feeds Wt. Gain: Head Circumference:

Input: / (+/-) Output: ml/k/d Urine Output: ml/kg/hr Stools:

IV Fluids - Type of IVF: @ ml/hr

Feeding: EBM Formula Donor BM Volume: Frequency:

TPN: Yes No - If yes, details: Calories:

Abdominal Examination: *P/A - soft*

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

.....

.....

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:

Blood culture Urine culture ET culture Fungal Culture LP CSF :

INFECTION	Antibiotic	SI.No.	Drugs	Days	
		1.	<i>Meb Ceftriaxone</i>	<i>D0/D1</i>	
2.		<i>D0</i>			
3.					

Plan of Treatment :

- Continue CPAP → PEEP 5.
- TV - 150cc/kg/day → 33ml/2nd hly full or feed (EBM+FF)
- Positioning - Rtlup
Ltlup
Supine } *2hrs each*
- RBS - OD
- *Do* Nasal suction *cos*
- monitor vitals

Doctor's Name (Handover given) : *Dr. Progethe*

Signature : *[Signature]*

Date & Time: *28/5/20, 7am*

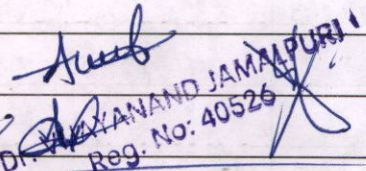
Doctor's Name (Handover taken) : *Dr. Arent*

Signature : *[Signature]*

Date & Time: *28/5/20, 9:00am*

55

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26 10:15 AM		seen by Dr. vijayanand
		plan
		- wear off CPAP
		- prone nursing
		TV - 150ml/kg/day
		↓ full of feeds.
		noted by 28/5/26 @ 10:15 AM
		 DR. VIJAYANAND JAMALPURI Reg. No: 40526
28/5/26 2 PM	Afternoon Rounds	
	on low flow 0.4l/min tolerating well comfortable in prone No distress. HR - 149/min SpO ₂ - 100%.	plan ① cont low flow w/ distress ② TV = 150ml/kg/day 30ml q2H.

noted by
subm
28/5/26
@ 2 PM

3AH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA (M)
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56

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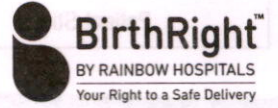
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26 2PM	RR - 40/min tolerating on feeds PA - soft stools passed. no vomit	EBM IFF full on feed ③ positiony @ up } 4hrs @ up } prone } ④ RBS OD ⑤ prone nursing ⑥ Nasal suction as required
		noted by submit 9 25/5/26 @ 2PM
28/5/26 3:30 PM	seen by Dr. Vijayanand	Plan ① prone nursing ② cont low flow. ③ on feeds.
		noted by submit 9 24/5/26 @ 3:30pm.

Dr. VIJAYANAND JAMALPURI
 13-05-2026

2AH-00656641
 Baby Of JETTURI RAVALIKA
 3-05-2026 0 Y 0 M 13 D (M)
 Dr. VIJAYANAND JAMALPURI


57



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>28/5/26</u>	<u>Night rounds</u>	
		<u>Plan:-</u>
	- on low flow	
	SpO ₂ - 96%	✓ w/h 1 distal
	PR - 88/min	✓ wean off low flow as bleed
	RR - 35/min	Noted by Kousha 29/5/26 @ 8AM
		✓ <u>Asst</u>

IAH-0065664 IP5-00173990
 Baby Of JETTURI RAVALIKA
 3-05-2026 0 Y 0 M 14 D (M)
 Dr. VIJAYANAND JAMALPURI



59
 29/5/26

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

Day in NICU: Day of Life: 15 PMA: 37+1

Term Preterm Gestation: 35 weeks Corrected Gestational Age: Today's Weight: 2.449 (2.289)

Problems		
S.No.	Current	Past Problems
1.	Late preterm / RDS	Extubation failure
2.	VAP - carbapenem resistant	
3.	Acinetobacter	
4.		
5.		
6.		

Clinical Assessment
 - @ weaned off to room air; tolerated well.
 SpO₂ - 96%
 PR - 128/min
 RR - 44/min
 NO IV line

Medications Used
 - ~~neb colistin~~
 - candid mouth paint [till 30/5/26]
 RBS - 102mg/dl

Plan of Care:
 - low flow SOS
 - TW - 150ml/kg/day → 33ml 2nd half full OG feeds
 - prone necessary
 - RBS OD
 - nasal & oral suction SOS
 - N/A & do incontinence dressing. R/W to add vit-D3 drops.

Doctor's Name (Hand over given): Anub
 Signature: Anub
 Date & Time: 29/5/26

Doctor's Name (Hand over taken): Dr. Ashwalya
 Signature: [Signature]
 Date & Time: 29/5/26



60

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/05/26		Plan
10hr		
	<ul style="list-style-type: none"> Self ventilating in room air 	<ul style="list-style-type: none"> ① Watch for desat / Brady / apnea
	<ul style="list-style-type: none"> Full OG feeds. 	<ul style="list-style-type: none"> ② Try Palada feeds
	<ul style="list-style-type: none"> DE - No recessions Chest - ✓ 	<ul style="list-style-type: none"> ③ Start Vitamin D drops
		<p>noted by submitted 01341/29/26 2107hr</p> <p>VIJAYANAND JAMALPURI Reg. No: 40526</p>
29/5/26 2PM	Afternoon Round	
	<ul style="list-style-type: none"> on room air NO apnea / brady / distress HR - 130/min RR - 30/min SpO₂ - 95% 	<p>Plan</p> <ul style="list-style-type: none"> ① IV = 150ml/kg/day 33ml q 2H rest on feeds today ② Prone nursing ③ FIO 0.21 ④ CRBC OD
	<ul style="list-style-type: none"> taken 2 paladay over morning post feed tachypnea + retractions then settled PA soft. 	<ul style="list-style-type: none"> ⑤ nil if distress <p>noted by submitted 01341/29/26 2PM</p>

IAH-00656641 IP5-00173990
 Baby Of JETTURI RAVALIKA
 3-05-2026 0 Y 0 M 14 D (M)
 Dr. VIJAYANAND JAMALPURI



61



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>29/5/26 5:30PM</p>	<p>Seen by <u>Dr Vijayanand</u></p>	<p>Plan</p> <ol style="list-style-type: none"> ① Rest on feeds today ② (R) paracetamol qm ③ w/c clothes <p>Dr. Vijayanand</p> <p>noted by S015126@5:30 PM 013/05/26 29/5/26 @5:30 PM</p>
<p>29/5/26 10:30PM</p>	<p>Seen by <u>Dr Nilosh</u></p> <p>comfortable in prone vitaly stable</p>	<p>Plan</p> <ol style="list-style-type: none"> ① prone nursing ② on feeds <p>Dr. Nilosh</p> <p>added by kausar S015126@8AM</p> <p>by Mum</p>

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

Day in NICU: Day of Life: 16 PMA: 37+2
 Term Preterm Gestation: 35 Corrected Gestational Age: Today's Weight: 2.516
 69 gms wt/gc

		Problems	
		S.No.	Past Problems
Overview	Current	1. LPT / RDS	VAP - acinetobacter (CR)
		2. ~	Extubation failure
		3.	
		4.	
		5.	
		6.	
Clinical Assessment	on RA, no brady / desat occ tachypnea ⊕ taken 3 paladay ~ 20-30mls but e/b tachypnea & bradycardia PA-soft.		HR - 155/min SpO2 - 99% RR - 40/min
	Medications Used	candid mouth paint (stop today) vit. D3.	
Plan of Care:			
① cont RA			
② IV = 150ml / 17y/day → 33ml q4h on feeds Ⓜ paladay by senior sister.			
③ CRBS OD			
④ prone nursing			

Doctor's Name (Hand over given): Dr. Ashwarya
 Signature: [Signature]
 Date & Time: 30/5/26.

Doctor's Name (Hand over taken): Dr. V. Prathish
 Signature: [Signature]
 Date & Time: 30/5/26, 10:26 am

BAH-00656641

IP5-00173990

Baby Of JETTURI RAVALIKA

13-05-2026

0 Y 0 M 17 D

(M)

Dr. VIJAYANAND JAMALPURI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/5/26 10:40 am		Seen by Dr. Vijayanand.
		Full paladay feeds.
		→ Add Lansoprazole & Pompeidone.
		→ Try 3-4 paladay feeds if taking without distress then give full paladay feeds.
	AFTERNOON ROUND DOL-18 37+2 (PMA)	P. N. Praveen
30/5/26 1:30 PM	On room air	Continue N- 150 ml/kg/day
	took 2 Paladay feeds well	33ml @ 2H Full OR feeds.
	vitals 1 spo2-96%	CRBS ON
	HR-160/min	
	RR-39/min	Pneumonia
	Bp-84/56 (62)	Monitor vitals.
	Post feed tachypnoea ESCRB Pt soft no distension.	Mr. P. Praveen

Noted by
Sis. Navarathna 30/5/26 @ 1:30 PM

BAH-00656641 IP5-00173990
Baby Of JETTURI RAVALIKA
13-05-2026 0 Y 0 M 9 D (M)
Dr. VIJAYANAND JAMALPURI



ACTIVITY RECORD FOR BILLING

Name : Blo jetturi Ravalika

UHID No. : 656841 IP No. : 173990 Consultant: Dr. VJ Dept : NICU

Date of Admission: 13/5/20 Time : 9:09pm Date of Discharge : _____ Time: _____

Room / Bed No : N4 Ward : NICU Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

MEDICAL EQUIPMENT (WARD & ICU)

PROCEDURE

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
23/5/26	Inv. monitor	18/5/26	18/5/26	9615144	}
	Syringe pump	18/5/26		9615144	
	CPAP	19/5/26		9616332	
	O2	19/5/26		9616332	
21/5/26	Inv. Monitor	18/5/26		9615144	} <i>Nay</i>
	Syringe pump	18/5/26		9615144	
	CPAP	19/5/26		9616332	
	O2	19/5/26		9616332	
25/5/26	Inv. Monitor	18/5/26		9615144	} <i>Nay</i>
	Syringe pump	18/5/26		9615144	
	CPAP	19/5/26		961332	
	Oxygen	19/5/26		961332	
26/5/26	Inv. Monitor	18/5/26		9615144	} <i>Nay</i>
	Syringe pump	18/5/26		9615144	
	CPAP	19/5/26		961332	
	Oxygen	19/5/26		961332	
23/5/26	Inv. Monitor	} 18/5/26		} 9615144	} <i>Nay</i>
	Syringe pump				
	CPAP	} 19/5/26		} 961332	
	Oxygen				
28/5/26	Inv. Monitor	} 18/5/26		} 9615144	} <i>Nay</i>
	Syringe pump				
	CPAP	} 19/5/26		} 961332	
	Oxygen				
			28/5/26 @ 10:30		
			29/5/26 @ 8:30		

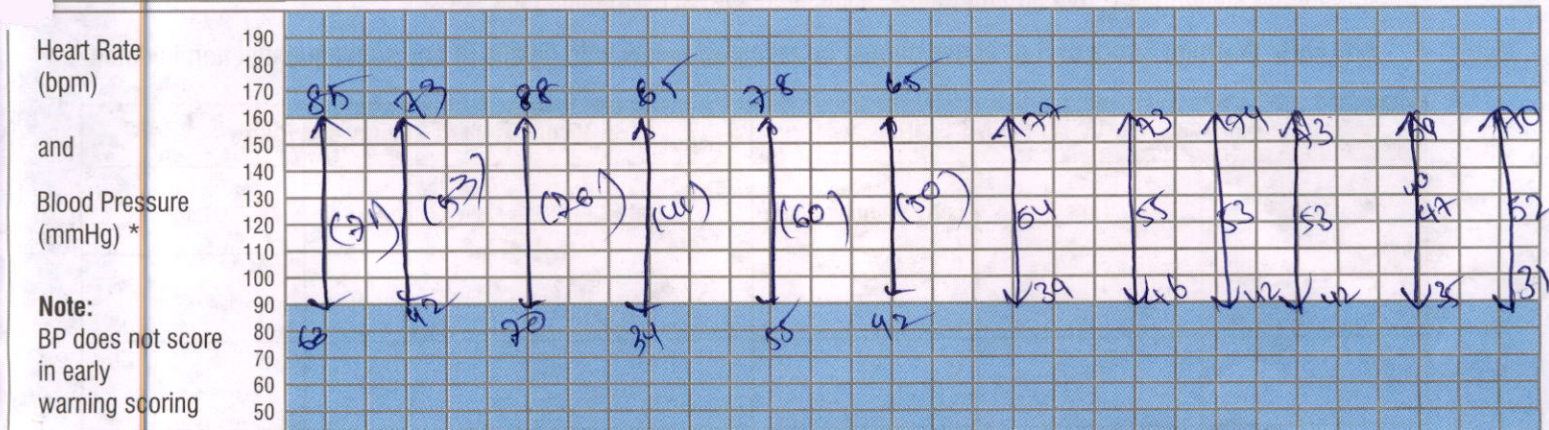
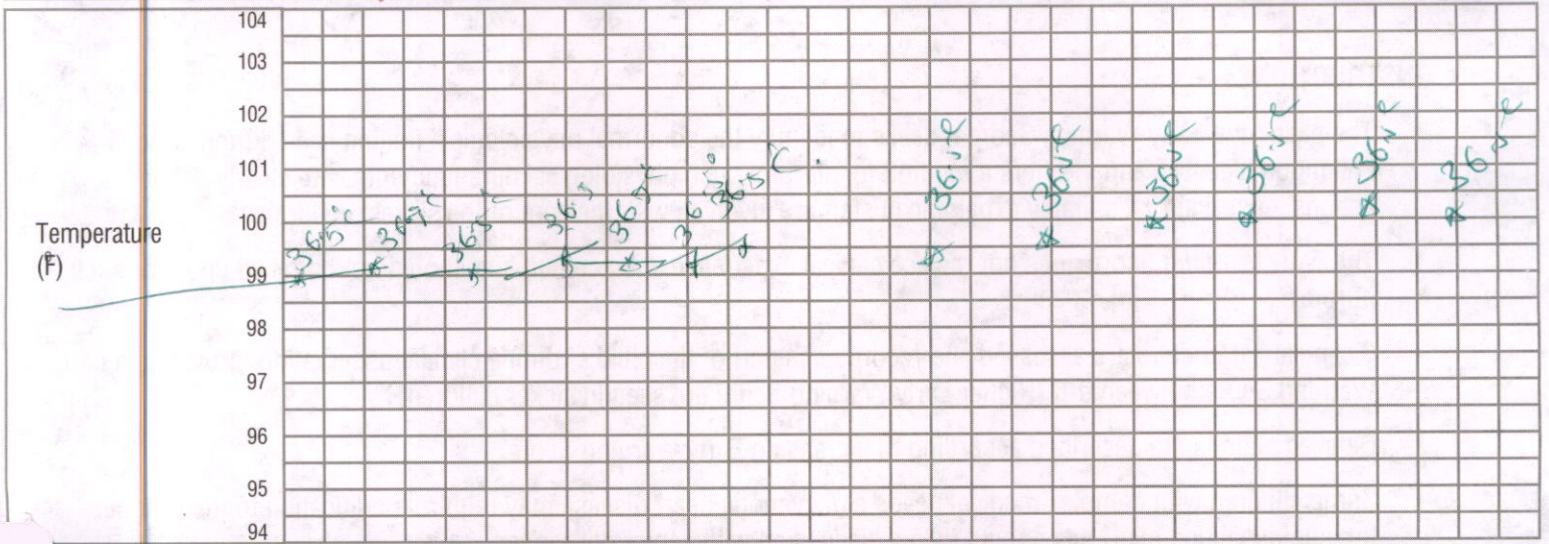
29/5/26

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

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

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	Am	Am	Am	Am	Am	Am	Am	Am	Am	Am



Heart Rate (Number)	126	139	128	137	132	139	155	147	155	142	153
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Resp. Rate (bpm) per 1 Minute *	36	49	63	48	45	46	57	48	50	40	63	51
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Resp Distress	Mod/ Severe	None / Mild										
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Receiving O ₂ (l/min)	RIA	RIA	RIA	RIA	RIA	RIA						
O ₂ Saturations (%)	100%	98%	100%	97%	99%		96%	96%	98%	95%	95%	99%

Conscious Level	Normal	Altered	N	N	N	N	N	N	N	N	N	N
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GCS *			E	E	E	E	E	E	E	E	E	E
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TOTAL SCORE												
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	B	B	A	E	E	E	A	A	S	-	-	-

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

30/5/26

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

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	Am	Am	Am	Am

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

Heart Rate (bpm)	190												
	180												
and Blood Pressure (mmHg) *	160												
	150												
Note: BP does not score in early warning scoring	140												
	130												
	120												
	110												
	100												
	90												
	80												
	70												
	60												
	50												

Heart Rate (Number)	157	163	157	130	130	155	140	120	140	144	147		
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Resp. Rate (bpm) (Over 1 Minute) *	70												
	60												
Resp Rate (Number)	50												
	40												
	30												
	20												
	10												

Resp Mod/ Severe Distress	None / Mild	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		
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Receiving O ₂ (l/min)	O ₂ Saturations (%)	96	100	99	100	100	97	99%	100%	99%	100%	96%	
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Conscious Level	Normal / Altered	C	C	C	C	C	C	C	C	C	C		
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GCS *		N	N	N	N	N	N	N	N	N	N		
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TOTAL SCORE		1	1	1	1	1	1	1	1	1	1		
Number of shaded boxes													
Pain Score		0	0	0	0	0	0	0	0	0	0		
Observer's Initials		(N)	(N)	(N)	(N)	(N)	(N)	(N)	(N)	(N)	(N)		

ACTIONS	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.
	Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
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* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

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)

31/5/26

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

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

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	Am	Am	Am

Temperature (F)	104											
	103											
	102											
	101	36.4°C	36.8°C	36.4°C	36.6°C	36.7°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C
	100											
	99											
	98											
	97											
	96											
	95											
	94											

Heart Rate (bpm) and Blood Pressure (mmHg) *	190												
	180												
	170												
	160												
	150	64	67	73	78	74	65	61	74	83	92	90	76
	140												
	130	113	115	117	116	116	112	113	114	115	115	115	115
	120												
	110												
	100	31	33	33	57	45	45	32	46	50	45	31	49
	90												
	80												
70													
60													
50													

Heart Rate (Number)	136	147	147	160	145	135	146	157	143	155	149	138
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Resp. Rate (bpm) over 1 Minute *	70												
	60												
	50												
	40												
	30												
	20												
	10												
	0												
	Resp Rate (Number)	45	39	52	52	50	53	60	32	44	49	39	38

Resp Distress	Mod/ Severe None / Mild	RA	RA	RA	RA	RA						
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Receiving O ₂ (l/min)	O ₂ Saturations (%)	99	97	96	99	95	95	98%	99%	94%	96%	100%	100%
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Conscious Level	Normal / Altered	C	C	C	C	C	C	N	N	N	N	N	N
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GCS *		N	N	N	N	N	N	C	C	C	C	C	C
-------	--	---	---	---	---	---	---	---	---	---	---	---	---

TOTAL SCORE	Number of shaded boxes	1	1	1	1	1	1	1	1	1	1	1
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Pain Score	Observer's Initials	0	0	0	0	0	0	0	0	0	0	0
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3AH-00656641 IP5-00173090
 Baby Of JETTURI RAVALIKA
 13-05-2028 0 Y 0 M 13 D (M)
 Dr. VIJAYANAND JAMALPURI

① 29/5/26

FLUID CHART

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

TV = 150 cc / day
 TF = 2.5 bag
 Bwt 3300g

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route	(200ml)	NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	0.G							
	08:00 am											
	09:00 am	NAN PRO			33ml	nil	passed			35ml		
	10:00 am											
	11:00 am	EBM	33ml									
	12:00 pm						not passed			30ml		
	01:00 pm	EBM	33ml									
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm	NAN PRO	33ml				not passed			30ml		
	04:00 pm											
	05:00 pm	NAN PRO	33ml				passed					
	06:00 pm									36ml		
	07:00 pm	NAN PRO	33ml									
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm	NAN PRO	33ml				not passed					
	10:00 pm											
	11:00 pm	EBM	33ml							13ml		
	12:00 am						passed					
	01:00 am	EBM	33ml							20ml		
Total Intake :					Total Output :							
	02:00 am											
	03:00 am	NAN PRO	33ml							18ml		
	04:00 am											
	05:00 am	NAN PRO	33ml									
	06:00 am						not passed			26ml		
	07:00 am	NAN PRO	33ml									
Total Intake : 396ml					Total Output : 208ml							

Total 24 hrs. Intake 158 cc / kg / day

Total 24 hrs. Output 3.4cc / kg / day



30/5/26



FLUID CHART

TV: 150cc/kg/day
 TF: 41ml
 BW: 2.5kg

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	NG	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am	Naspro			33ml		passed	-		15ml			Nar
	10:00 am												
	11:00 am	Naspro	33ml							10ml			Nar
	12:00 pm												
	01:00 pm	Naspro	15ml		18ml		passed			15ml			Nar
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm	Naspro			33ml					15ml			Nar
	04:00 pm												
	05:00 pm	Naspro			33ml		passed			15ml			Nar
	06:00 pm												
	07:00 pm	EBM Naspro			33ml					10ml			Nar
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm	EBM			33ml					13ml			
	10:00 pm						passed						
	11:00 pm	EBM			33ml								
	12:00 am												
	01:00 am	Naspro			33ml					15ml			
Total Intake :						Total Output :							
	02:00 am												
	03:00 am	Naspro			33ml		passed			16ml			
	04:00 am												
	05:00 am	Naspro	33ml	5min	33ml					8ml			
	06:00 am						not passed						
	07:00 am	Naspro	33ml	8min	33ml					11ml			
Total Intake : 396						Total Output : 143ml							

Total 24 hrs. Intake 158

Total 24 hrs. Output 2.3