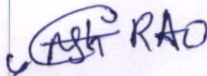


[illegible]

		Rainbow Children's Hospital - Banjara Hills 8-2-120/103/1,2,3,4 and 5, Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034. TEL NO :+91-40-4466 5555 WEB : https://rainbowhospitals.in	
ADMISSION SHEET			
Registration Details :			
Admission No : IP5-00176167	Admit Date : 09-Jul-2026	Admit Time : 06:11 PM	UHID : BAH-00661146
Patient Details :			
Patient Name : Baby Of RISHIKA RAO KANAKANDULA Guardian : Mr SNEHITH RAO Gender : Female Occupation : Address (H) : #113, SARK-II , MOKILA , SHANKARPALLY Marpallikalan Ranga Reddy Telangana INDIA 501203	Age : 0 D DOB : 09-07-2026 04:36 PM Religion : Martial Status : Single Phone No : 8002231339/ 9908812315 E-mail : nomailid@gmail.com		
Admission Details :			
Bed Type : BASINET	Bed No : CRDL-SW-418-1	Ward Name : 4F-BIRTHING CENTRE	
Room No : CRDL-SW-418-1	Admission Type : First Visit		
Contact Details :			
Name : Mr SNEHITH RAO Contact Address : #113, SARK-II , MOKILA , SHANKARPALLY Marpallikalan Ranga Reddy Telangana INDIA 501203	Relationship : Father Phone No : 8002231339 / 9908812315		
 Signature			
Doctor Details :			
Doctor Name : Dr. ANNAPOORNA TADAVARTHY	Specialisation : NEONATOLOGY		
Referral Doctor : SELF	Phone No :		
Co-Consultant :			
Payment Details :			
Payment Mode : Cash	Deposit Amount : 0.00 Payor Name : SELFPAY		

ACTIVITY RECORD FOR BILLING

Name : _____

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

[illegible]

Signature

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00661146 IP5-00176167
Baby Of RISHIKA RAO
09-07-2026 0Y0M0D2H (F)
Dr. ANNAPOORNA TADAVARTHY



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Rishika Rao Kanakandula Age : 27y Father's Name : Age :
Date of Birth : Date of Admission : UHID No.:
NICU Consultant : Referring Consultant :
Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward
Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : B/o Rishika Rao Kanakandula Mother's Blood Group : B Positive
Gender : ☒ M ☐ F Blood Group : O+ve Birth Weight (gms) : 3.038 kg Length (cms) : 50
Date of Birth : 9/7/20 Time of Birth : 04-36 pm OFC (cms) : 8y
Place of Birth : BCH Bangalore Estimated Gesth Age : 38+6 weeks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 27y Ht : Wt : BMI : Married Life : LMP : EDD :

Conception : Spontaneous or with Rx :

Booked at what GA : 7 weeks

AN Steroids Drugs / Doses :

Last Scans Details : 12/6 → 35 wks, 2.2 kg, AFI-11.3 cm, posterior upply
Dopplers (N) TIFFA (N) NI Scan (N) TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs

Consanguinity : ☐ Yes ☐ No

If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long :

H/o value of recent BP recording, proteinuria, edema,
oliguria, any investigations (LFT, platelet count) :

IUGR - when detected :

Doppler (Increased Resistance / ADEF / REDF /

Redistribution in MCA) / Ductus Venosus :

AFI :

H/o GDM/ pre GDM/ on diet or insulin

Controlled or not, recent values, HbA1 values :

Compliance with Rx :

Scans : LGA, TIFFA, Fetal Echo : TIFFA (N), NI Scan (N)

H/o Hypothyroidism : when diagnosed ? Medication?

Any other Chronic Medical Problems, when detected
drugs ?

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

Infection : H/O, Fever

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

UTI : when : Any culture :

PPROM: Duration : PRom x 12h ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results :

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
Primi						

PERINATAL HISTORY

Treating Obstetrician : Dr. Himabindu Hospital : Red Bangara ☒ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☒ Emergency Indication : Fetal distress

Specify the reason : 1st - Early deceleration

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL : 1st - Early deceleration

Resuscitation : ☐ Yes ☐ No

Cord ABG :

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

NEONATAL RESCUSTITUTION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

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

TOTAL

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

Snapee II Score

Shape II Score					
Mean BP (mmHg)	> 30 (0)	20-29 (9)	< 20 (19)		6
Lowest Temp (oF)	> 96 (0)	96-95 (8)	< 95 (15)		6
Pao2 / Fio2 (mmHg%)	> 2.49 (0)	1-2.49 (5)	0.3-0.99 (15)	< 0.3 (28)	0
Lowest Serum PH	> = 7.2 (0)	7.1-7.19 (7)	< 7.1 (16)		0
Multiple Seizures	No (0)	Yes (19)			0
U. Output (ml / kg / hr)	> = 1 {0}	0. 1-0.9 (5)	<0.1 (18)		0
Apgar Score	> = 7 (0)	< 7 (18)			6
Brith Weight	> = 1kg (0)	750 - 999 (10)	< 750 (17)		6
SGA	> 3rd percentile (0)	< 3rd (12)			6
Total					

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

Primi / 38+0 wks / GROM / Fetal distress



Baby delivered via Em-LSC

↓
cared soon after birth, doc done
↓

routine care given

↓
inj. vit K 0.5 ml IM given

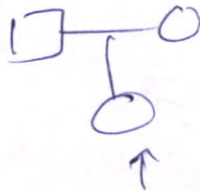
↓
shifted to mother's side

Investigation details in previous Hospital :

Feeding History :



Family History :



Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Pink, warm

VITALS : Temperature : 36.5°C HR : $152/\text{m}$ RR : $46/\text{m}$ NIBP : CFT : 3su

Color of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 96%

ANTHROPOMETRY: Birth Weight : 3.038kg Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

Head :

Sutures

Shape / Moulding :

Edema / Bruising :

Size - (H.C.) :

caput (+)

FACIES :

(Any Facial
Dysmorphism)

No dysmorphism

**NECK and
CLAVICLES :**

Range of Motion :

Asymmetry :

Masses :

(N)

EYES :

Symmetry :

Red Reflex :

Discharge :

To be checked

**EARS, NOSE
MOUTH and
THROAT :**

Ear set / Shape :

Periauricular Pits / Tags :

Nasal shape / Patency :

Palate :

Gums :

Lips :

Tongue :

(N) no cleft palate

**THORAX and
BREASTS :**

Shape of Thorax :

Position of Nipples and Number :

(N)

**ABDOMEN and
UMBILICUS :**

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump :

Discharge :

(N)

2A + 1 very

GENITALIA :

Labia / Hymen :

Testicles/penis :

Anus :

Female external genitalia

HERNIAL ORIFICES

(N)

TRUNK and SPINE :

(N)

SKIN LESIONS :

Nil

EXTREMITIES :

Fingers / Toes :

Deformities :

Hip Joint Examination :

Talipes (+)
(N) leg

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: Auscultation: Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 152/min BP :

Femoral Pulses : No bc checked

Other Peripheral Pulses :

Precordial Activity : (S)

Murmurs : Nil

Signs of Cardiac Failure : Nil

ABDOMEN:

Shape : (C)

Palpation : (C)

Palpable masses :

Abdominal girth :

Hernia orifice :

Anal Patency : patent

Umbilical Cord : 2A + 1 vein

First urine passed : -

Meconium passed : at delivery room

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : (C)

State of wakefulness : (C)

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone : (C)

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR :

ATNR : Skull and Spine :



Diagnosis : Term (38+6 wk) / AGA (3.038 kg) / Female / Gen. LSCG
1/1/0 fetal dlns

FOOT PRINTS

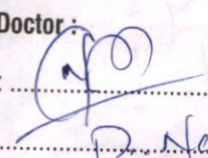
Left Side :



Right Side :



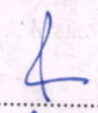
Resident Doctor :

Signature : 

Name : D. Neethan

Date & Time : 09/07/26

Consultant :

Signature : 

Name : Dr. Anupama

Date & Time : 10/7/26 10A

DR. ANUPAMA
Registration No: 60853

PLEASE FILL UP THE FOLLOWING DETAILS

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



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic :

Medications :

Plan

1) Routine newborn care

2) DBF 2hly flb burping

Plan during ward follow up :

3) BCG, OPV, Hep B today/tomorrow

4) Clinical paediatric assessment at 24 Hrs

5) SBR / NBS / OAE at 48hrs glyc

Feeding Plan at the time of shifting :

4:55 to 5:05 PM

6) temperature, vitals monitoring @ 4H

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:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 9:20am	CSIB Resident	
	17HOL / 38 th / Feb / 3038g	Em LSCS (total distich) / CI AB Plan
	B/O th ue m/B th ue	① DBF 2nd hely flb bumping
	Twet → 2.989kg 2%↓ Baby on room air	② Vaccination today
	Euglycemic Euthemic Feed initiated	OPV ✓ BCG ✓ HepB ✓ Today given 10/7/26 DWG
	Cry } Tone } good activity }	③ warm care
	temorals (+) Pulse Peripheries - warm	④ Monitor vitals
	CRT < 3 sec	⑤ SBR } NBS } 11m @ 48HOL OAE } 4:30pm
		Sohel
10/7/26 1/5p	for Annapur	• TCR - 24hr. • vaccine tray • Enteral feeds

DR. ANNAPOORNA
 Registration No: 50845
 10/7/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 10 AM	<u>lactation notes:</u> - Peeni - Well formed breasts and nipples - colostrum seen - Areola good. <u>Advice:</u> - Direct breast feeding - Ask for deep latch as demonstrated. - Make baby suck for 15-20 min on each side - Demand feeding not exceeding 2-3 hrs	
10/7/26 4:20 PM	CS/B Resident 24 HOU 38th / Fch / 3038 / ^{Em} LSCS B / 0th / U / V m / Bth / m / ✓ doing well Feed & latching good Euthemic Englyemic Tone, cry, activity good	CIAB <u>Plan</u> (TCBR-8.5) @ 24 HOU ① DBF 2nd hly flb burping ② warm care ③ monitor vitals SBR, OAE, NBS - 7M

Date & Time	Progress Notes	Doctor's Order
7/1/16	1/S/B or Amp.	1) conti care ↓ A
		Dr. Taddavarty Annapoorna Reg. No. 53054 Noted by Likhitha Rathi @ 8pm
7/1/16 8:30am	C/S/B Resident	
	40HOL / 38+6 / Feb / 3038g EmLSCS / CAB	
B/O +ve m/B+	V/r m/L	Plan
- Baby on room air		① DBF 2nd hily. (measured feed) + FF (20ml - 25) ↑ to 25-
- Wt → 2.675kg. (12% ↓)		② warm ear
- Feed ↓		③ monitor vitals
- TO start FF		④ weight to check. by 5:00pm.
- Sothermic - Pink		
Tone } good		⑤ SBR } Today 12:00
cry }		NBS }
activity }		OAE - today
Reflexes warm		Solu

BAH-00861146
Baby Of RISHIKA RAO
09-07-2026
Dr. ANNAPOORNA TADAVARTHY (F)
IP5-00176167
0Y0M0D6H

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

BirthRight®
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		11/7/26 DAE - New born lung sound Bilateral respiration clear Bilateral full
		<i>[Signature]</i> 11/7/26
10:00	1/5/3 or 2/1/1	12p - 100% NBS
		DR. ANUPAMA Y Registration No: 50853 Measured 27 Fed 25-30 ml/hr
11/7 11Am	Lactation care plan: - Colostrum good - counselled about expressed milk to give it as top feed - dim for sleep latch as demonstrated	<i>[Signature]</i> Super



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 5:00pm	95/B Resident	
	48HOL 38 th Fch 3038 ^{Em} LSCS CIAB	
	B Othe U v m Bthe m v	Plan SBR-12.3
	Baby on room air	① SSPT with eyes & genitals covered
	Twt - 2675g.	② ^{measured} DBF + FF (20-22ml) 2nd hly or 25-30ml 3rd hly
	Euglycemic, euthermic yellowish skin discoloration	
	Cry } good activity	③ monitor vitals
	Peripheries warm.	④ monitor U/O & feeds
		<u>Solih</u>
		Noted by Surgeon @ 6:00pm @ 8:14
		Dr. Tadavarthi Annapurna Reg. No: 53054

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/1/26 8:10am	C/S/B Resident	
	65104 38 th Feb 3038 Em LSCB C/AB	
	B / other M / B + the	U / ✓ M / ✓
		(Plan)
	Baby on room air	① SSPT with eyes & genitals covered
	wt → 2.775 Kg (8.6.1)	② measured feed + FF 20ml 2nd huly or 30ml 3rd huly.
	Euglycemic Euthermic feed well by Done. } good actively	③ SBR @ 2pm
	Peripheries warm no S/O dehydration	④ monitor vitals
		<u>Soluh</u>
HA	P/S/P Ar Amp.	
		p) sbr - now of dlc flu Tuesday
		A.T.

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 9/6	Time: 6pm	9pm	3AM	6AM
Doctor/Nurse/Family Concern?				
Temperature (°F)				
Heart Rate (bpm)				
Blood Pressure (mmHg) *				
Note: BP does not score in early warning scoring				
Heart Rate (Number)	140	142	138	137
Resp. Rate (bpm) (Over 1 Minute) *				
Resp Rate (Number)	40	40	36	34
Resp Distress	None / Mild			
Receiving O ₂ (l/min)	98%			
O ₂ Saturations (%)	98%	99%	99%	99%
Conscious Level	Normal / Altered			
GCS *	13/15	14/15	(14/15)	(14/15)
TOTAL SCORE	0			
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	2	2	2	2

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN’S OBSERVATION
and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
 - Following a Early Warning Score assessment, senior help may be required
- The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child’s clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)’s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child’s normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don’t know what’s wrong but I am really worried.
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-00661146 IP5-00176167
Baby Of RJSHIKA RAO
09-07-2026 0 Y 0 M 0 D 6 H (F)
Dr. ANNAPOORNA TADAVARTHY



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

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

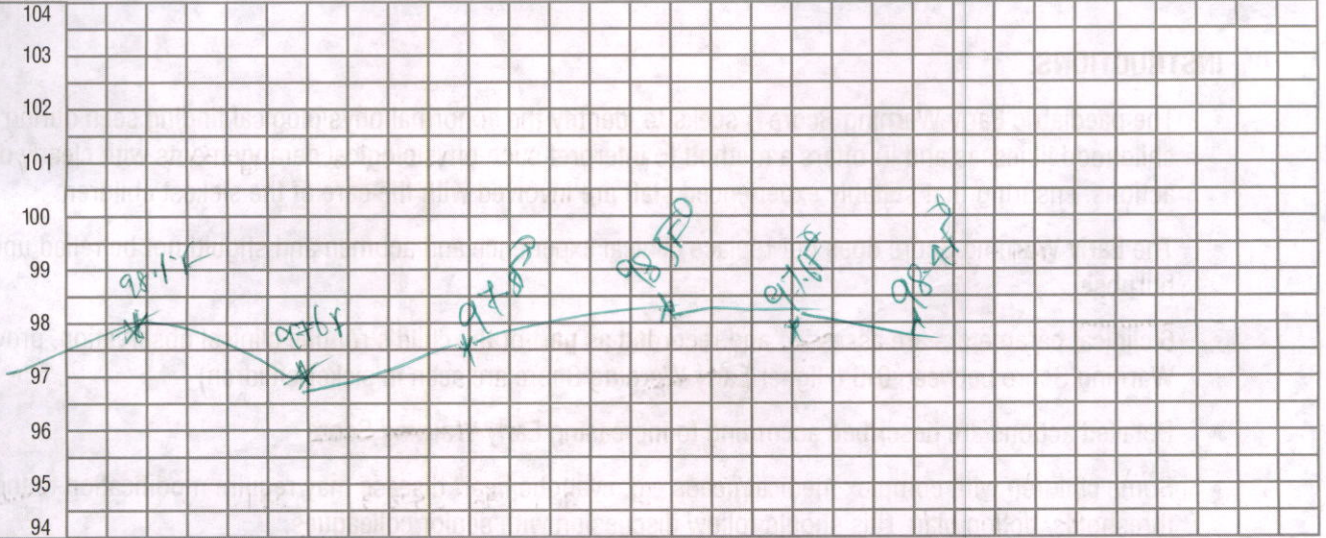
Date: Time:

10pm 7pm 9pm 12AM 3AM 6AM

Doctor/Nurse/Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

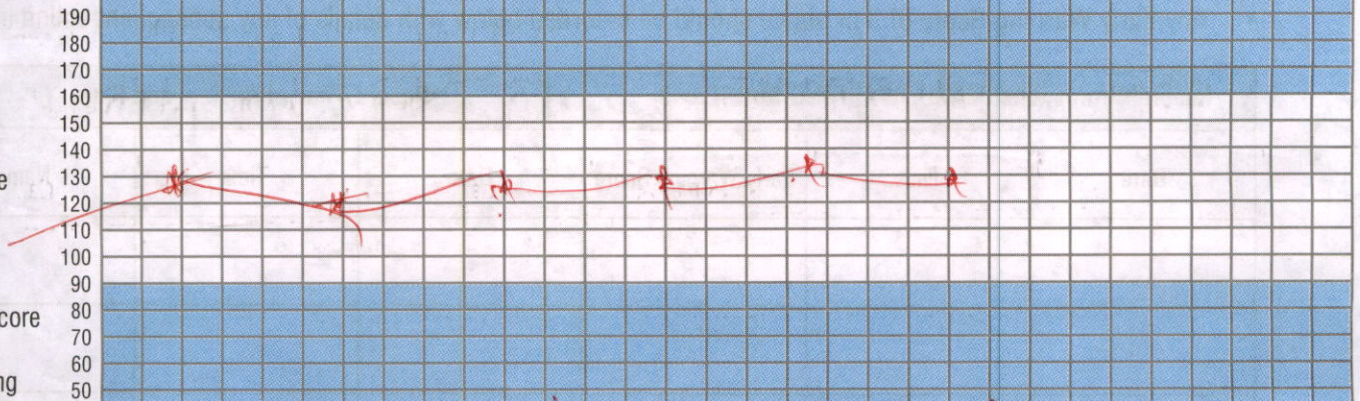


Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50



Note:

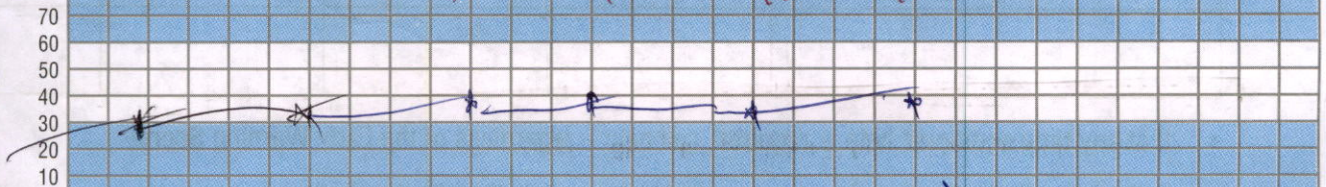
BP does not score
in early
warning scoring

Heart Rate (Number)

130bpm 120bpm 125bpm 125bpm 130bpm 128bpm

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

70
60
50
40
30
20
10



Resp Rate (Number)

30bpm 30bpm 38bpm 36bpm 34bpm 42bpm

Resp Mod/ Severe
Distress None / Mild

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

0l 0l 0.8l 0.9l 0.8l 0.9l

Conscious Normal
Level Level
Altered

GCS *

(N) (N) (N) (N) (N) (N)

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0 0 0 0
0 0 0 0 0 0
B B B B B B

ACTIONS

NB: Scores 3 should be
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- Following a Early Warning Score assessment, senior help may be required

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

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 11/7/26 Time: 10:45 AM

Doctor/Nurse/Family Concern?

Temperature
(°F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Level
Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

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)
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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)

BAH-00661146
Baby Of RISHIKA RAO
09-07-2026 0 Y 0 M 0 D 2 H (F)
Dr. ANNAPOORNA TADAVARTHY

IP5-00176167

FLUID CHART

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. : ①

9/7/26

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

		Intake			Output							
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am			NA								
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm	DBF										
9/7	06:00 pm											
	07:00 pm											
Total Intake : Taken						Total Output : 0-0 M-0						
	08:00 pm	DBF										small
	09:00 pm	DBF										small
	10:00 pm											small
	11:00 pm											small
	12:00 am	DBF										small
	01:00 am											small
Total Intake :						Total Output : 0-1 M-1						
	02:00 am											small
	03:00 am	DBF										small
	04:00 am											small
	05:00 am	DBF										small
	06:00 am											small
	07:00 am	DBF										small
Total Intake :						Total Output : 0-1 M-1						
Total 24 hrs. Intake												
Total 24 hrs. Output		0-2 M-2										

10/7/26

FLUID CHART

Sheet No. : 2

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
10/7/26	08:00 am	DBF										
	09:00 am											
	10:00 am	DBF										
	11:00 am											
	12:00 pm	DBF										
	01:00 pm											
Total Intake :					Total Output : U=1 M=0							
	02:00 pm	DBF										
	03:00 pm											
	04:00 pm	DBF										
	05:00 pm											
	06:00 pm	DBF										
	07:00 pm											
Total Intake :					Total Output : U=1 M=0							
	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 : M=2 U=2							
	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 : M=2 U=2							
Total 24 hrs. Intake					Total 24 hrs. Output M=4 U=6							



FLUID CHART

Sheet No. : 3 ul 7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse			
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine					
11/7	08:00 am	1									1	Sanger			
	09:00 am	DBF+FF									1	Sanger			
	10:00 am	1/2									1	Sanger			
	11:00 am	3/4	DBF+FF								1	Sanger			
	12:00 pm	1/2									1	Sanger			
	01:00 pm	1	DBF+FF								1	Sanger			
Total Intake :						Total Output :						U-2 m-2			
11/7	02:00 pm	1									1	Sanger			
	03:00 pm	DBF+FF									1	Sanger			
	04:00 pm	1/2									1	Sanger			
	05:00 pm	1/2	DBF+FF								1	Sanger			
	06:00 pm	1									1	Sanger			
	07:00 pm	1	DBF+FF								1	Sanger			
Total Intake :						Total Output :						U-2 m-2			
	08:00 pm										1	Yann			
	09:00 pm	DBF+FF									1	Yann			
	10:00 pm										1	Yann			
	11:00 pm	1/2									1	Yann			
	12:00 am										1	Yann			
	01:00 am	EBM									1	Yann			
Total Intake :						Total Output :						U-2 m-2			
	02:00 am										1	Yann			
	03:00 am	DBF									1	Yann			
	04:00 am										1	Yann			
	05:00 am	DBF									1	Yann			
	06:00 am										1	Yann			
	07:00 am	1/2									1	Yann			
Total Intake :						Total Output :						U-1 m-1			
Total 24 hrs. Intake		DBF+FF EBM										Total 24 hrs. Output		U-8 m-8	

BAH-00681146 IP5-00176167
 Baby Of RISHIKA RAO
 09-07-2026 0 Y 0 M 2 D (F)
 Dr. ANNAPOORNA TADAVARTHY



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.

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

BAH-00661146 IP5-00176167
 Baby Of RISHIKA RAO
 09-07-2026 0 Y 0 M 0 D 2 H (F)
 Dr. ANNAPOORNA TADAVARTHY



NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/17/26

Assessment: new born Baby care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
5pm	→ assess the Baby condition	5:20pm	→ assessed Baby condition	→ Baby stable
5:30pm	→ monitor vitals	5:40pm	→ monitored vitals	
5:45pm	→ ensure safety	5:30pm	→ Provided crib care	
6pm	→ warm care	6pm	→ warm care Provided	
7pm	→ DBF & Burping	7:10pm	→ DBF given	
8pm	→ No chart monitoring	8pm	→ No chart monitored	

Re-Assessment:

Special Notes: CBR: NBS OAE @ 72 hrs

Nurse Signature:

Nurse Name: Swapna

Date & Time: 9/17/26 @ 8pm

BAH-00661148 IP5-00176167
Baby Of RISHIKA RAO
09-07-2026 0 Y 0 M 0 D 6 H (F)
Dr. ANNAPOORNA TADAVARTHY



NURSING CARE RECORD

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

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

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: Baby having Hypothermic

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
9PM	→ ASSESS the Baby condition.	9PM	→ Assessed the Baby condition.	Baby is stable
11PM	→ vital chart maintain	11PM	→ 2nd hourly feeding	
12AM	→ 2nd hourly feeding	2AM	→ vital chart maintain	
8AM	→ warm care	4AM	→ warm care	
		8AM		

Re-Assessment: Baby taken 2nd hourly feeding

Special Notes: TCBR T/M 4:36 PM

Nurse Signature:

Nurse Name: Suman

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

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 10/7/26

Assessment: new born baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8:00 AM	→ Assess the baby condition	8:30 AM	→ Assessed the baby condition	→ now baby look better
10:00 AM	→ plan for vitals	10:30 AM	→ vitals checked & recorded	
12:00 PM	→ every 2nd hr given feeding	12:30 PM	→ every 2nd hr given feeding	
3:00 PM	→ maintain 8/10 chart	3:30 PM	→ maintained 8/10 chart	
6:00 PM	→ plan for vitals	6:30 PM	→ vitals checked & recorded	
8:00 PM	→ Ensure baby safety	8:10 PM	→ provided safe care	

Re-Assessment:

Special Notes: Re-assessed & OK

Nurse Signature: [Signature] Nurse Name: Cicer Date & Time: 10/7/26

BAH-00661146 IP5-00176167

Baby Of RISHIKA RAO

09-07-2026 0Y0M0D6H (F)

Dr. ANNAPOORNA TADAVARTHY



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

☒ Night

Date: 10/7/26

Assessment: New born baby care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the baby Condition and vitals check	8:30 pm	* Assessed the baby Condition and vitals checked	* new baby Condition is stable
10pm	* monitor the I/O chart	10:30 pm	* monitored the I/O chart	
12pm	* provide warm care	12:30 AM	* provided warm care	
3pm	* every 2nd DBF and Burping	3:30 pm	* every 2nd DBF and Burping	
6pm	* ensure safety	6:30 pm	* ensured safety	

Re-Assessment: Assess the baby condition, now it's stable

Special Notes: SBR, NRS, DAE @ 4:30 PM T/d

Nurse Signature: Sushu

Nurse Name: Sushu - 607628

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



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 11/2/26

Assessment: New Born Baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8Am	Assess the patient's general condition.	8:30Am	Assessed the pt's general condition.	Baby is stable
10Am	monitor vitals	10:30Am	monitor vitals	
12pm	do chart maintenance	12:30pm	do chart maintenance	
2pm	Administer medication as per order	2:30pm	Administered medication as per chart	
3pm	Ensure safety	3:30pm	ensured safety	
6pm	DBF & Burping and hwy	6:30pm	DBF & Burping and hwy	

Re-Assessment: Baby is stable

Special Notes: Nil

Nurse Signature:

Nurse Name: Sangetha @ 601128

Date & Time: 11/2/26 @ 8pm

BAH-00001148

IPS-00176

Baby Of RISHIKA RAO

09-07-2026 0 Y 0 M 2 D (F)

Dr. ANNAPOORNA TADAVARTHY



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 11/7/26

Assessment: Baby under SSPT

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the Baby's General condition	8:30pm	Assessed the Baby's General condition	Now Baby is stable
10pm	Plan for DBT Burping every 2nd hourly	10:30pm	Planned for DBT Burping 2nd hourly	
12am	Plan for No clut	12:30am	Planned for No clut	
3am	Plan for vital signs	3:30am	Planned for vital signs	
7am	Assess safety	7:45am	Assessed safety	

Re-Assessment: Re-Assessment done every 3rd hourly.

Special Notes:

Nurse Signature:

Nurse Name: Yamuna @ 606255

Date & Time: 12/7/26 @ 8am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Annapurna Department: OBS Date of Admission: 9/7/26

SITUATION		Diagnosis: <u>new born baby all</u>						Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time						Shift Time					
	Medical Condition (Any special condition to be noted):	<u>OBS 8PM-8PM</u>	<u>3rd floor 8PM-8PM</u>	<u>3rd floor 8PM-8PM</u>	<u>3rd floor 8PM-8PM</u>	<u>3rd floor 8PM-8PM</u>	<u>3rd floor 8PM-8PM</u>	<u>3rd floor 8PM-8PM</u>	<u>3rd floor 8PM-8PM</u>	<u>3rd floor 8PM-8PM</u>	<u>3rd floor 8PM-8PM</u>	<u>3rd floor 8PM-8PM</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.1F</u>	<u>98.1F</u>	<u>97.1F</u>	<u>97.5F</u>	<u>97.3F</u>	<u>97.8F</u>	<u>97.3F</u>	<u>97.8F</u>	<u>97.3F</u>	<u>97.8F</u>	
		Res:	<u>40b/m</u>	<u>38b/m</u>	<u>40b/m</u>	<u>42b/m</u>	<u>42b/m</u>	<u>42b/m</u>	<u>42b/m</u>	<u>42b/m</u>	<u>42b/m</u>	<u>42b/m</u>	
		SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	
		Pulse:	<u>140</u>	<u>138b</u>	<u>140b/m</u>	<u>144b/m</u>	<u>144b/m</u>	<u>144b/m</u>	<u>144b/m</u>	<u>144b/m</u>	<u>144b/m</u>	<u>144b/m</u>	
		BP:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Fall Risk Score:												
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
	Recommendations	Safety Needs:	<u>COB call</u>	<u>COB call</u>	<u>COB call</u>	<u>COB call</u>	<u>COB call</u>	<u>COB call</u>	<u>COB call</u>	<u>COB call</u>	<u>COB call</u>	<u>COB call</u>	
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No		
Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No		
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Suvarna</u>	<u>Sumana</u>	<u>Liana</u>	<u>Sushu</u>	<u>Sangeeta</u>	<u>Yamini</u>	<u>Suvarna</u>	<u>Sumana</u>	<u>Liana</u>	<u>Sushu</u>		
Signature :		<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>		
Date:		<u>9/7/26</u>	<u>10/7/26</u>	<u>10/7/26</u>	<u>10/7/26</u>	<u>11/7</u>	<u>12/7</u>	<u>9/7/26</u>	<u>10/7/26</u>	<u>10/7/26</u>	<u>10/7/26</u>		
Time:		<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8PM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>		
Taken Over By Name :		<u>Sumana</u>	<u>Liana</u>	<u>Sushu</u>	<u>Sangeeta</u>	<u>Yamini</u>	<u>Sumana</u>	<u>Liana</u>	<u>Sushu</u>	<u>Sangeeta</u>	<u>Yamini</u>		
Signature :		<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>	<u>Su</u>		
Date:		<u>9/7/26</u>	<u>10/7/26</u>	<u>10/7/26</u>	<u>11/7</u>	<u>11/7</u>	<u>12/7</u>	<u>9/7/26</u>	<u>10/7/26</u>	<u>10/7/26</u>	<u>10/7/26</u>		
Time:		<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8PM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8AM</u>		

Treating Doctor: Department: Date of Admission:

BAH-00661146
Baby Of RISHIKA RAO
09-07-2026
Dr. ANNAPOORNA TADAVARTHY

IPS-00176167

Q Y O M O D 2 H (F)

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THE HUMPTY DUMPTY SCALE

9/10/24 ult ult

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4	4	4	4	
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3	3	3	3	3	
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
Total			15	15	15	15	

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		x	NA	NA	✓	
Call device within reach		x	NA	NA	✓	
Wheels Locked		✓	YES	YES	✓	
Room free of clutter		✓	YES	YES	✓	
Adequate lighting		✓	YES	YES	✓	
Wheel chair support		x	NA	NA	x	
Other Intervention(s) Specify		x	NA	NA	4	
Nurse's Name:		Sy	suman	Sushu	suman	
Signature:		S	S	Sushu	S	
Date:		9/17	10/2	ult	ult	
Time:		6pm	8A	8am	8am	

BRADEN 'Q' SCALE

					Date :	Time :			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	07/7	8pm	10/7/26	24	14th
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1		1		1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2		2		2
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	2		2		2
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4		8		4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4		8		4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4		8		4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23									
Docu. No. : RCHBH /FRM / CLINICAL / 119									
					TOTAL SCORE				
					Evaluator's Name				
					18				
					8/				
					18				
					8/				

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

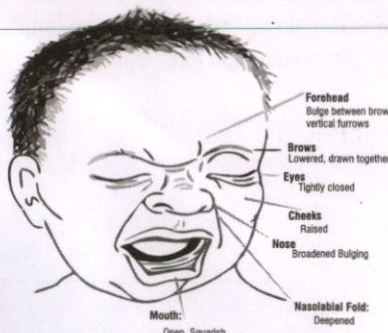
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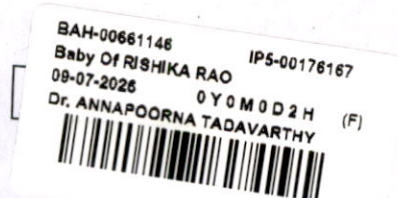
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NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	
	-2	-1	0	1	2	9/7	10/7	11/7	12/7					
						Time	Time	Time	Time	Time	Time	Time	Time	
						6pm	8A	8M	8M					
	Procedure →													
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0	0	0	0					
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0	0					
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0	0					
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0					
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0					
 Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention						Gestational Age / Corrected Age	38+6	38w 7d	38w 14d	38w 14d				
						Total Pain / Agitation Score	NA	NA	NA	NA				
						Intervention	NA	NA	NA	NA				
						Effectiveness	NA	NA	NA	NA				
						Signature	NA	NA	NA	NA				

NPASS: Neonatal Pain, Agitation & Sedation Scale

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



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Blo Rishika Mother's Name: mr. Rishika
Date of Birth: 9/7/2026 Time of Birth: 4:36 pm Gender: ☐ Male ☒ Female
Birth Weight: 3.028 kg Kgs HC: 34 cm Length: 50 cm
Meconium in Liquor: ☐ Yes ☒ No Cried at Birth: ☒ Yes ☐ No
Term / Pre-term / Post-term: _____
Resuscitated: ☐ Yes ☒ No Blood Group: Mother: B+ve Baby: _____
Feeding: ☒ Breast Feeding ☐ Formula ☐ Both First Feed Time: 4:55 to 5:5 pm

AFFIX MOTHER'S
IDENTIFICATION LABEL

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

Physical Assessment of New Born:

Temp: 98.8 °C HR: 140 /Min RR: 40 /Min BP: NA SpO₂: 99%
Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☐ Yes ☐ No Score: 15 (Fill the Humpty Dumpty Sheet)

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

Behaviour Status on admission: ☐ Sleeping ☒ Crying ☐ Calm ☐ Drowsy

Findings:

General Appearance: Posture: ☒ Well-Flexed ☐ Asymmetry

Skin: ☒ Pink ☐ Meconium Stain ☐ Others, Specify: _____

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

Vitamin K 1 mg I.M Administered: Yes / No

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No
2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No
3. Socio History: Siblings Yes / No

All information obtained from ☒ Mother ☐ Father ☐ Other Family Member

Newborn Screening Discussed: Yes / No

Nurse Name: Swapne

Signature: Se

Date & Time: 9/7/26 5:20 pm

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
9/11	5pm	7	Infection control measures	PT's	1	0	0	01	0	<i>[Signature]</i>

Part - III: CODES

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

BAH-00661146
Baby Of RISHIKA RAO IP5-00176167
09-07-2026 0 Y 0 M 0 D 2 H (F)
Dr. ANNAPOORNA TADAVARTHY

MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis:

New born Baby Care

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Nursing ☐ Others:
9:45 AM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	→ warm care	→ Provide warm care	→ to reduce hyperthermia	[Signature]	☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

Patient Sticker

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD



Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		

Part - III: CODES

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

BAH-00661146 IP5-00176167
 Baby Of RISHIKA RAO
 09-07-2026 0 Y 0 M 0 D 2 H (F)
 Dr. ANNAPOORNA TADAVARTHY

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DISCHARGE PLANNING FORM

Nationality: Indian

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: 11/7/2026

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication	☐ Yes	☐ No
☐ Bathing	☐ Yes	☐ No
☐ Eating	☐ Yes	☐ No
☐ Walking	☐ Yes	☐ No
☐ Dressing	☐ Yes	☐ No
☐ Toileting	☐ Yes	☐ No

No need assistance

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hand Hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: Sy

Nurse Name: Swapne

Date and Time: 11/7/2026 @ 5:30 pm

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00661146 IP5-00176167 Baby Of RISHIKA RAO 09-07-2026 0Y0M0D5H (F) Dr. ANNAPOORNA TADAVARTHY 		Date & Time of Admission 9/7/26 @ 6:11 PM	Date & Time of Transfer Order 9/7/26 @ 9:45 PM
		Transfer Ordered by Dr. Rupanjali	Reason for Transfer Observation
From Unit ORW	To Unit Room (302)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 30	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Ruma		Name of Person Ordered Transfer Dr. Rupanjali	
Patient & Clinical Records Received by : Sumand			
Date & Time of Patient Received : 9/7/26 @ 10 PM			

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

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

302

BREASTFEEDING HISTORY FORM

Mother's Name: Leshu Leo Baby's Name: Slo Leshu Leo Date of Birth: 9/7

Reason for consultation: Lactation counselling for mother

- | | | | |
|---|---|---|-----------------------------------|
| 1. Baby's feeding now (ask all these points) | Breastfeeds <u>yes</u>
How often <u>2-2 y 2 bxs</u>
Length of breastfeeds <u>15-20 mins</u>
Longest time between feeds (time mother away from baby) <u>2-2 y 2 bxs</u>
One breast or both breasts <u>Both</u>
Complements (and water) <u>NO</u>
What given
When started
How much
How is it given | Day
Night | Pacifier (Yes / NO) <u>✓</u> |
| 2. Baby's health and behaviour (ask all these urine output (more/less than points)) | Birth weight
Premature <u>✓</u>
Urine output (more/less than 6 times per day)
Stools (soft and yellow/brown; or hard or green; frequency)
Feeding behaviour <u>✓</u>
Illnesses | Weight now
Twin | Growth
Abnormalities <u>NO</u> |
| 3. Pregnancy, birth, early feeds | Antenatal care (attended/not) <u>✓</u>
Delivery: Normal / C - section
Rooming - in Yes / No <u>✓</u>
Prelacteal feeds Yes / No (If Yes,) <u>✓</u>
What given <u>NO</u>
Formula samples given to the mother Yes / No <u>✓</u>
Postnatal help available for breastfeeding Yes / No <u>✓</u> | Breastfeeding discussed? Yes / No
Early contact (First - 1 hour) Yes / No
Time first breast feed (if not within 1 st hour) | How given |
| 4. Mother's condition and family planning | Age
Family planning method | Breast condition <u>Good</u>
Motivation to breastfeed <u>yes</u>
Alcohol, smoking, coffee, other drugs Yes / no <u>✓</u> | |
| 5. Previous infant feeding experience | Number of previous babies
How many breastfeed
Any bottles used | Experience good or bad
Reasons | |
| 6. Family and social situation | Working / Home maker
Father's attitude towards breastfeeding
Other family members attitude towards breastfeeding
Help with child care
What others say about breastfeeding | Literacy status <u>Educated</u>
<u>unassisted</u>
<u>DBP</u> | <u>Positive</u> |

Lactation Consultant:

Signature: [Signature] Name: Supriya Date & Time: 10/7 10 Am

LACTATION ASSESSMENT FORM

Mother's details: Reshika Rao

Baby details: B/o Reshika Rao

Delivery: Vaginal ☒ Cesarean ☐ Vacuum ☐ Forceps ☐ Gravida ☐ GA ☐

Reason for Visit: BF rounds ☒ Doctor Reference ☐ Patient Request ☐

BF previous baby: Previous BF difficulty: No

Present Lactation:

Colostrum: Yes ☒ No ☐ Breast: Normal ☒ Engorged ☐ Soft ☐ Tender ☐

Nipples: Flat ☐ Inverted ☐ Everted ☒ Direct BF: Yes ☒ No ☐

Expressed / Pallada feeding: Yes ☐ No ☐

LATCH Assessment:

	0	1	2	SCORE					
				D-1	D-2	D-3	D-4	D-5	D-6
LATCH	Too sleepy not sustained LATCH / suck	Repeated attempts for suck / latch Hold nipple in mouth	Grasps breast tongue down lips flanged Rhythmic sucking	2	2				
AUDIBLE SWALLOWING	None	A few with stimulation	Spontaneous & Intermittent	2	2				
TYPE OF NIPPLE	Inverted	Flat	Everted (After stimulation)	2	2				
COMFORT	Engorged cracked Bleeding large Blisters bruises	Filling reddened small blisters / bruises	Soft Non tender	2	2				
HOLD	Full Assist	Minimal assist	No assist	0	1				
Total Score				8	9				

BABY WEIGHT CHART						FIRST FEED	
Date	9/7	10/7	11/7			Breast Feed	Top Feed
Weight	3.03kg	2.98kg	2.67kg				

Teaching Instructions: Deep latch

Discharge Instructions: we're out put & weight monitoring

Feed Frequency Duration: 2-2.5 hrs

Feeding techniques: Cradle hold

Assessment of output: Good

Sources of BF assistance at home: Home visits

Next Follow up: 1 week

Lactation Consultant: Name: Supriya Signature: [Signature] Date & Time: 10/7

[illegible]