

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176568 Admit Date : 18-Jul-2026 Admit Time : 01:42 PM UHID : BAH-00662069

Patient Details :

Patient Name	: Baby Of DIVYA SRI	Age	: 0 D
Guardian	: Mr M SAI KUMAR	DOB	: 18-07-2026 12:52 PM
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: #FLAT NO 506, ROAD NO 1 ALAKPOOR TOWNSHIP Manikonda Hyderabad Telangana INDIA 500089	Phone No	: 9666930885 / 7207140090
		E-mail	: mantramurthysaikumar@gmail.com

Admission Details :

Bed Type	: BASINET	Bed No	: CRDL-SW-415-1	Ward Name	: 4F-BIRTHING CENTRE
Room No	: CRDL-SW-415-1	Admission Type	: First Visit		

Contact Details :

Name	: Mr M SAI KUMAR	Relationship	: Father
Contact Address	: #FLAT NO 506, ROAD NO 1 ALAKPOOR TOWNSHIP Manikonda Hyderabad Telangana INDIA 500089	Phone No	: 9666930885 / 7207140090

Sri Krishna
Signature

Doctor Details :

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

Payment Details :

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



NEWBORN MONITORING FORM

Date of Birth : 18/7/26
 Time of Birth : 12:52 PM
 Mode of Delivery : Normal
 Birth Weight : 2.957 kg
 Head Circumference : 33 cm
 Length : 48 cm
 Red Reflex :

New Born Screening : willing (uncle)
 TFT :
 OAE :
 Mother's Blood Group : O+ve
 Baby's Blood Group :
 Anomaly Scan :
 Vaccination : BCG, OPV, Hep-B given on 18/7/26

Date	Weight	Type of Feed	Quantity	Temperature	Signature
18/7/26	2.957 kg	DBF	-	36.5°C	Sunitha
18/7/26	2.945 kg	DBP	-	97.9°F	Revathi
19/7/26	2.886 kg	DBF	-	97.9°F	Satya
20/7/26	2.772 kg	DBF	-	98.1°F	Lakshmi
21/7/26	2.731 kg	DBF + BP	-	97.9°F	Satya

[illegible]

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

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

BIRTH INFORMATION

Name : B/o Divya Sri Mother's Blood Group : O positive
Gender : ☐ M ☒ F Blood Group : O positive Birth Weight (gms) : 2957gm Length (cms) : 48cm
Date of Birth : 18/7/26 Time of Birth : 12:52pm OFC (cms) : 33cm
Place of Birth : RCH BH Estimated Gesth Age : 38⁺3

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 27 year Ht : Wt : BMI : Married Life : 5 years LMP : 22/10/25 EDD : 29/7/26

Conception : Spontaneous or with Rx : OI conception

Booked at what GA : 12⁺5 week AN Steroids Drugs / Doses :

Last Scans Details : 9/6/26: 32⁺1 week, cephalic, AFI 11.7cm, EFW 2134gm, placenta

Anterior, high; poppler normal 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 :

Screen @ PE → Tab. Ecospirin

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 : 11.7cm

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

Controlled or not, recent values, HbA1 values :

Type 2DM Since 2 years

Compliance with Rx :

Scans : LGA, TIFFA, Fetal Echo : TIFFA ⊕
Fetal echo ⊕

H/o Hypothyroidism : when diagnosed ? Medication?

Geist Hypothyroid 12.5mcg

Any other Chronic Medical Problems, when detected

drugs ? P, OM → on OHA & Insulin

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

Infection : H/O, Fever Thrombocytopenia → 1.19 lakh

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

UTI : when : Any culture : Prev cul 1.6 > 1.6

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

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

G: 2 P: A: 1 L:

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1	Biochemical pregnancy → OI conception					

PERINATAL HISTORY

Treating Obstetrician : Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication :

Specify the reason :

Augmentation of Labour : ☒ Induced ☒ Assisted Vaginal
Vacuum assisted

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitation : ☐ Yes ☐ No

Cord ABG :

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

NEONATAL RESCUSTITATION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

1 Minute	5 Minutes	10 Minutes
1	1	2
2	2	2
2	2	2
1	2	2
2	2	2
8/10	9/10	10/10

TOTAL

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

Snapee II Score

Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5°C HR : 156/min RR : 49/min NIBP : CFT : $< 3\text{sec}$

Color of the extremities : Acrocyanotic $\rightarrow$ pink

Jaundice : Pallor : SpO2 : 100% ERA

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

Ponderal Index : AGA : SGA : LGA :



Histi

Equipment checked



Preheated warmer



Delivered female baby through vacuum assisted vaginal delivery
cried immediately after birth



Delayed cord clamping done @ 60 seconds

Cord cut



Inj. Vitamin K 1mg IM STAT

Routine care given



Baby developed mild respiratory distress @ 5 min
in form of subcostal retraction & tachypnea

DRCPAP given for 2 mins

Ro settled



Investigation details in previous Hospital :

Observed for 30 minutes



Shift to mother side

Feeding History :



HEAD TO TOE EXAMINATION

HEAD :

Fontanelles :

Af 2cm x 2cm

Sutures

Shape / Moulding :

Soft, boggy swelling over Right occipital area
! Cant

Edema / Bruising :

Size - (H.C.) :

FACIES :

(Any Facial
Dysmorphism)

No dysmorphism

NECK and CLAVICLES :

Range of Motion :

Asymmetry :

Masses :

1 (N)

EYES :

Symmetry :

Red Reflex :

Discharge :

1 To be checked

EARS, NOSE MOUTH and THROAT :

Ear set / Shape :

Periauricular Pits / Tags :

Nasal shape / Patency :

Palate :

Gums :

Lips :

Tongue :

1 (N)

THORAX and BREASTS :

Shape of Thorax :

Position of Nipples and Number :

1 (N)

ABDOMEN and UMBILICUS :

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump :

Discharge :

1 (N)

GENITILIA :

Labia / Hymen :

Testicles/penis :

Anus :

1 (N) External female genitalia

HERNIAL ORIFICES

free

TRUNK and SPINE :

1 (N)

SKIN LESIONS :

no

EXTREMITIES :

Fingers / Toes :

Deformities :

Hip Joint Examination :

Arms / Legs :

Mobility :



SYSTEMIC EXAMINATION

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 49/min 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: 100% @ RA

Auscultation:

Breath Sounds:

Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 156/min BP :

Precordial Activity : NO

Femoral Pulses : well felt

Murmurs : NO

Other Peripheral Pulses : palpable

Signs of Cardiac Failure : NO

ABDOMEN:

Shape : (N)

Hernia orifice : free

Palpation : soft

Anal Patency : patent

Palpable masses : NO

Umbilical Cord : 2 Artery, 1 vein

Abdominal girth :

First urine passed : not passed

Meconium passed : passed

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score : (N)

Nerves :

MOTOR SYSTEM:

Passive Tone :

Active Tone :

Neonatal Reflexes : (N)

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

Toro's :

TNR :

DTR :

Skull and Spine :

Any C



Diagnosis : Term / 38¹³ / 31 week / G2 A1 / AVP / Female / 2957gm / CIAB / AGA
maternal Gestational hypothyroidism
Type 2 DM on OHA & Insulin

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name : Saiteja

Date & Time : 18/7/26

Consultant :

Signature :

Name : Dr. DINESH KUMAR CHIRLA

Date & Time : 18/7/26

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.

AT THE TIME OF TRANSFER TO THE WARD

Diagnosis :

atal condition at the time of Transfer:

: HR : RR : BP : SPO2 : Weight :

Oxygen requirement :

Systemic :

Plan

Medications :

1. Warmth care
2. DBF every 2nd hourly flb Bumping

3. GRBS monitoring 1st 40L Post feed
3, 6, 12, 24, 36, 48 H0L Pre feed

Plan during ward follow up :

inform if GRBS < 50mg/dL 1st GRBS - 68mg/dL

4. Trace baby blood grouping

Feeding Plan at the time of shifting :

1:20pm to 1:30pm

5. clinical assessment of jaundice @ 24 H0L
6. GRBS
NBS
OAC } @ 48 H0L

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:

BAH-00662069
Baby Of DIVYA SRI
18-07-2026
Dr. DINESH KUMAR CHIRLA
0Y0M2D
IP5-00176568
(F)



EFFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	6			
6	Doctors progress sheets	4			
7	Nursing plan of care and handover sheets	5			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed	1			
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation				
24	Emergency Triage record				
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	4			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)				
32	Investigation Values (result sheet)				
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Total No. of Pages	21			

Doc. No. : RCHBH/ FRM / GENERAL / 126

Signature and Date :

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

Date & Time	Progress Notes	Doctor's Order
18/1/26 5:00pm	CSIB Resident	
	4 HOL 38 ⁺³ G ₂ A ₁ AVD Fch	2957g CIAB Type II D.m on Plan
	$\frac{m}{\theta} 0^+$	$\frac{m}{V} x$
	Baby on room air	① DBF 2nd hly Ab keeping FF + 10ml - 12ml 2nd hly if GRBS $\leq$ 50mg Post Feed.
	GRBS @ 3 HOL $\rightarrow$ 48mg/dl	② 1.5ml ^{Dextrose} (Sucrose) gel and check GRBS after 1hr. Inform if GRBS $\leq$ 50mg/dl
	Euthemic - Pink	③ warm care
	Cry Tone } good	④ GRBS monitoring as scheduled for GDM baby.
	activity }	
	axillary Pulses (+)	⑤ clinical Jaundice assessment T/m 1pm.
	Peripheries warm	⑥ monitor vitals $\rightarrow$ Inform if GRBS $\leq$ 50
	Ant. Fontanelle $\rightarrow$ leveled.	⑦ Trace baby bld group. mg
	CRT $\leq$ 3sec	
		Solih
		Noted by Revathi

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26	Seen by Dr. Dinesh	
	→ 12gm loss	→ DBf 2nd hourly
		→ GRBS monitoring
		→ clinical assessment @ 24 Hrs 1pm
		→ dry faeces
19/7/26	Seen by Resident	
9AM	20 Hrs / Term / 38 ¹³ / G2 A1 / 2957gm / fch	
	maternal T2 DM / screen @ PE / Gest Hypothyroid plan	
	Baby on Room air	
7.20 AM	2886g Euthermic	1. DBf 2nd hourly flb Burping
	(7.1gm) Fully cemic	2. GRBS monitoring @ 24, 36, 48 Hrs
	Vitals: Stable	3. Clinical assessment of Jaundice @ 24 Hrs 1pm
	Accepting feeds well	4. SpO2 documentation @ 24 Hrs
	passed Urine & stool	5. SBR 7
	CRT < 3 sec	NBS @ 48 Hrs
	Peripheries: Warm	OAE
	Last GRBS 105mg/dl	If discharge → Plan on (flu)
	Vaccination done	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 8:20am	CH/B Resident	
	44 HOL 38 ⁺ 3 92A 2957g Fch nat T ₂ DM PE screened AVD / cephal hematoma	
	MA OF B OF MP V	Plan
	Twt + 2772g (6%↓)	① DBF 2nd huly flb bump
	cry Tone activity good Euthemic	② SBR } T/m NBS } ② 12:00 pm OAE }
	Eemolumic	③ monitor vitals
	Euglycemic → GRBS	④ GRBS monitor continue
	cephal hematoma @ 36 HOL + 71mg/dl	⑤ SSPT eyes genitalb, <u>solch</u> covered
20/7/26 9:30am	S/B Dinesh sir 44 HOL / Term / NNJ	Plan
	de	① SSPT with eyes genitalb covered
	cephal hematoma + → Paralt measured	② GRBS to continue
		③ SBR, NBS T/m 10 am

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 10am	<u>Lactation notes</u> - Lenn - colostrum lately seen - Suck good with shield	
	<u>Advice:</u> - Direct Breast feeding - Aim for deep latch as demonstrated - Make baby suck for 15-20 min on each side - Demand feeding not exceeding 2-2½ hours	
20/7/26 Afternoon		<i>[Signature]</i>
	ST HOL 38 ⁺ 3/G ₂ A ₁ /2957g/Fch/mat T ₂ DM/PE screen ⊕ AUD/Cephalhematoma/NNJ (TCBR - 1.6mg/dl) M/ot B/ot M/V V/V on phototherapy TCBR @ 24HOL - 1.6 13.0 mg/dl Twt → 2772g GRBS → 4HOL → 6.8mg/dl cry tone } good activity }	<u>Plan</u> ① DBF 2nd help flb bump +FF 25ml Q2H (or) 35ml Q3H ② SBPT with eyes & genitals covered. ③ GRBS monitor stop. ④ watch for feed/V/O/Vitals ⑤ SBR, NBS, OAE TIm 26m

BAH-00662069 IP5-00176568
 Baby Of DIVYA SRI
 18-07-2026 0 Y 0 M 2 D (F)
 Dr. DINESH KUMAR CHIRLA

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
21/7/26 10am		Plan
	TCBR @ 24HOL 7.6 under SSPT.	→ Continue SSPT c eyes & genitals covered
	SBR sent now.	→ Trace SBR report - NBS.
		→ OAE today.
	Dr. Poornima	
10:15am		Seen by Dr. Dinesh Sir
	→	Trace SBR
		aps - today. flu on Thursday at LB Nagar
	→	Trace NBS
	→	OAE } before Red reflex } d/t



(F)



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



INFANT (<1 year)

Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 18.7.26	Time: 2pm	5pm	6pm	7pm	11pm	6am	
Doctor/Nurse/Family Concern?							
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99						
	98	36.5°C	36.4°C	36.4°C	36.4°C	36.4°C	
	97						
	96						
	95						
94							
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
and Blood Pressure (mmHg) *	90						
	80						
	70						
	60						
	50						
	Note: BP does not score in early warning scoring						
	Heart Rate (Number)	156b/m	137b/m	127b/m	130b/m	141	
	Resp. Rate (bpm) or 1 Minute) *	70					
		60					
		50					
40							
30							
20							
10							
Resp Rate (Number)		44b/m	44b/m	40b/m	39b/m	39b/m	
Resp		Mod/ Severe					
Distress		None / Mild					
Receiving O ₂ (l/min)							
O ₂ Saturations (%)	100%	100%	99%	99%	99%		
Conscious	Normal						
Level	Altered						
GCS *	14/15	14/15	14/15	15/15	15/15		
TOTAL SCORE							
Number of shaded boxes	0	0	0	0	0		
Pain Score	0	0	0	0	0		
Observer's Initials	SP	SP	R	SP	V		

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)

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time: 10PM	6 PM	10PM	6AM	
Doctor/Nurse/Family Concern?					
Temperature (°F)	104				
	103				
	102				
	101				
	100				
	99	98.1	98.1	98.3	98.2
	98	*	*	*	*
	97				
	96				
	95				
Heart Rate (bpm)	190				
	180				
	170				
	160				
	150				
	140				
	130				
	120				
	110				
	100				
Note: BP does not score in early warning scoring	90				
	80				
	70				
	60				
	50				
	40				
	30				
	20				
	10				
Heart Rate (Number)	125b/m	135b/m	143b/m	136b/m	
Resp. Rate (bpm) (r 1 Minute) *	70				
	60				
	50				
	40				
	30				
	20				
	10				
	Resp Rate (Number)	40b/m	40b/m	40b/m	38b/m
Resp Distress	Mod/ Severe				
	None / Mild			N	N
Receiving O ₂ (l/min)					
	O ₂ Saturations (%)	100%	99%	100%	99%
Conscious Level	Normal				
	Altered			N	N
GCS *		15/16	15/15	15/15	15/15
TOTAL SCORE					
Number of shaded boxes		0	0	0	0
Pain Score		0	0	0	0
Observer's Initials		q	k	q	q

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)



20/7/26
INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart

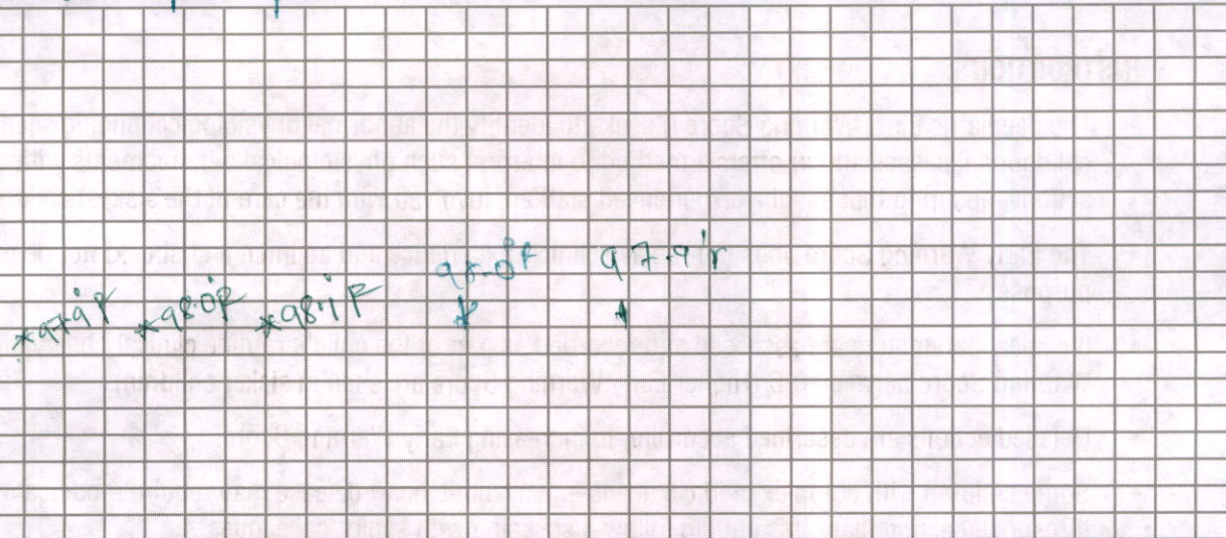
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 11 am 2 pm 7 pm 11pm 6am

Doctor/Nurse/Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94



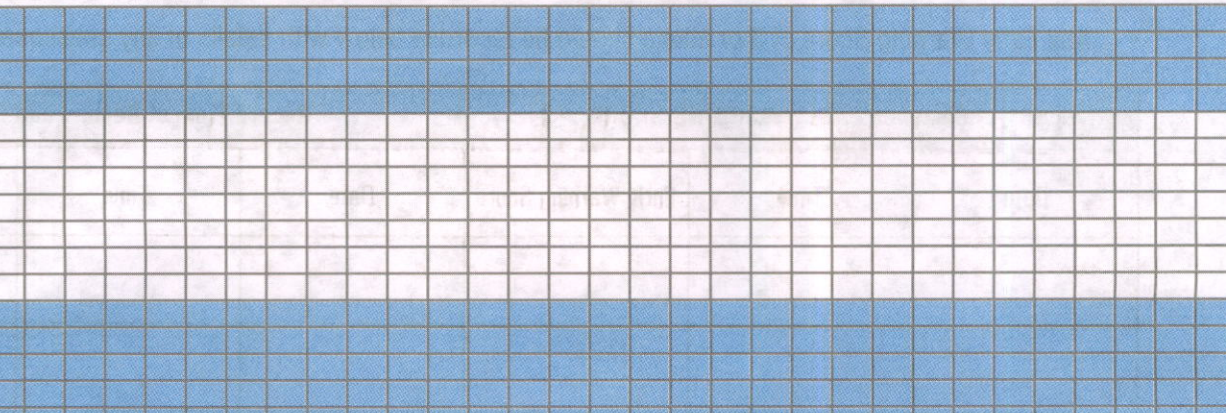
Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

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

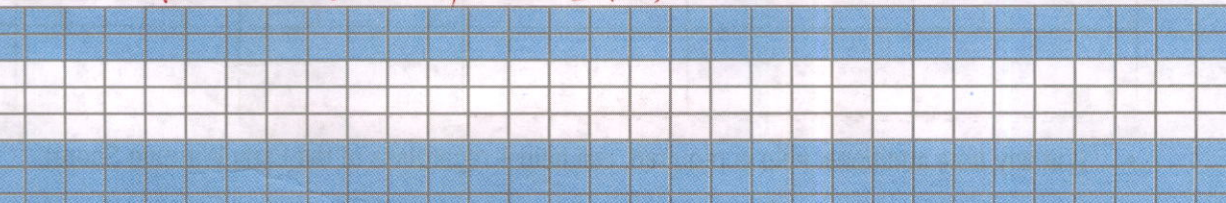


Heart Rate (Number)

130bpm 128bpm 126bpm 141 139bpm

Respiratory Rate (bpm)
(over 1 Minute) *

70
60
50
40
30
20
10



Resp Rate (Number)

40bpm 40bpm 39bpm 39bpm 39bpm

Resp Mod/ Severe
Distress None / Mild

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

98% 100% 100% 99% 99%

Conscious Level
Normal Altered

GCS *

15/5 15/5 15/5 15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0 0 0
2 2 2 2 2
[Initials]

ACTIONS

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

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A	ASSESSMENT : I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

4 / FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

Pratiksha  TM
**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: 11 AM		
Doctor/Nurse/Family Concern?				
Temperature (F)	104			
	103			
	102			
	101			
	100			
	99	98.1		
	98	*		
	97			
	96			
	95			
Heart Rate (bpm)	190			
	180			
	170			
	160			
	150			
	140			
	130			
	120			
	110			
	100			
Blood Pressure (mmHg) *	90			
	80			
	70			
	60			
	50			
	40			
	30			
	20			
	10			
	0			
Note: BP does not score in early warning scoring				
Heart Rate (Number)		130b/w		
Resp. Rate (bpm) for 1 Minute *	70			
	60			
	50			
	40			
	30			
	20			
	10			
	0			
	Resp Rate (Number)		40b/w	
	Resp Distress	Mod/ Severe None / Mild		
Receiving O ₂ (l/min) O ₂ Saturations (%)		99%		
Conscious Level	Normal Altered			
GCS *		15/15		
TOTAL SCORE				
Number of shaded boxes		0		
Pain Score		0		
Observer's Initials		EL		

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. |
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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)



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	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
18/7	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am									NA		
	12:00 pm											
	01:00 pm	DBF										
Total Intake :					Total Output :							
19/7	02:00 pm											
	03:00 pm											
	04:00 pm	DBF				✓				DO IV		Sanitha
	05:00 pm											
	06:00 pm					✓						
	07:00 pm	DBF										
Total Intake :					Total Output : U-2 M-2							
20/7	08:00 pm											
	09:00 pm	DBF								✓		
	10:00 pm	DBF				NP						Satyaj
	11:00 pm									NA		
	12:00 am											
	01:00 am	DBF										
Total Intake :					Total Output : M-0 U-1							
21/7	02:00 am									✓		
	03:00 am											
	04:00 am	DBF				NP						Satyaj
	05:00 am	DBF								NA		
	06:00 am									✓		
	07:00 am											
Total Intake :					Total Output : M-0 U-2							
Total 24 hrs. Intake					Total 24 hrs. Output					M-0 U-3		



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.

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
18/7	08:00 am						1					
	09:00 am	DBF								✓		
	10:00 am						NP					
	11:00 am	DBF								✓		
	12:00 pm						1					
	01:00 pm	DBF										
Total Intake :						Total Output : 14-0v-2						
19/7	02:00 pm											
	03:00 pm	DBP								✓		
	04:00 pm											
	05:00 pm	DBP					✓					
	06:00 pm									✓		
	07:00 pm											
Total Intake :						Total Output : 14-0v-2						
	08:00 pm	DBF					1					
	09:00 pm									✓		
	10:00 pm	DBF										
	11:00 pm						NP			✓		
	12:00 am						1					
	01:00 am	DBF										
Total Intake :						Total Output : 14-0v-2						
	02:00 am											
	03:00 am	DBF					1			✓		
	04:00 am											
	05:00 am						NP					
	06:00 am	DBF								✓		
	07:00 am											
Total Intake :						Total Output : 14-0v-2						
Total 24 hrs. Intake		taken				Total 24 hrs. Output		14-8m-02				



FLUID CHART

Sheet No. :

20/7/26

- All measurements in ml.
- 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							
20/7	08:00 am											penathi
	09:00 am	DBP										
	10:00 am						✓			NP	NA	
	11:00 am	DBP										
	12:00 pm											
	01:00 pm	DBP										
Total Intake :						Total Output : M-1 U-0						
20/7	02:00 pm											naga rewarthi
	03:00 pm	DBP										
	04:00 pm						✓			✓		
	05:00 pm	DBP										
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output : M-1 U-1						
	08:00 pm	DBP					✓					Satya
	09:00 pm											
	10:00 pm	DBP								✓	NA	
	11:00 pm						✓					
	12:00 am	DBP										
	01:00 am											
Total Intake :						Total Output : M-2 U-2						
	02:00 am	FF	10M									Satya
	03:00 am						✓					
	04:00 am									✓	NA	
	05:00 am	FF	20M									
	06:00 am									✓		
	07:00 am						✓					
Total Intake :						Total Output : M-2 U-2						
Total 24 hrs. Intake		Total 24 hrs. Output										
		M-6 U-5										

BAH-00662069 IP5-00176568
 Baby Of DIVYA SRI
 18-07-2026 0 Y 0 M 0 D 3 H (F)
 Dr. DINESH KUMAR CHIRLA



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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
21/2/26	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 :						
	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-00662069 IP5-00176568

Baby Of DIVYA SRI

18-07-2026 0 Y 0 M 0 D 3 H (F)

Dr. DINESH KUMAR CHIRLA



NURSING CARE RECORD

Rainbow Children's Hospital
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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 18/7/2026

Assessment: Newborn baby

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
2pm	* Assess the baby General Condition	2:10 pm	* Assessed the baby General condition	baby is stable
4pm	* provide monitor vitals	4:15 pm	* provided monitor vitals	
6pm	* provide DBF and Barfi	6:15 pm	* provided DBF and Barfi	
7pm	* provide warm care	7:10 pm	* provided warm care	
7pm	* provide comfortable position	7:10 pm	* provided comfortable position	
8pm	* provide baby safety	8:15 pm	* provided baby safety	

Re-Assessment: Re-Assessment is done

Special Notes:

GRBS monitoring
Baby having low sugar levels, So sheela mam advised to give sucralose 1.5ml. 1 given. check after 1 hour and inform to the N/C
Dr. Purnajali

Nurse Signature: SelfNurse Name: Santhi

Date & Time:

18/7/20 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 18/7/24

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 general condition	8.10pm	→ baby is stable and active	baby is stable/active
9pm	→ TO check URBS	9pm	→ URBS 56mg/dl	
10pm	→ TO provide warm care	10.10pm	→ provided warm care	
11pm	→ TO monitor vitals	11.10pm	→ vitals stable and documented	
6am	→ TO monitor & to chart	6.10a	→ monitored & to chart documented	
7am	→ TO encourage feeding 2nd and 3rd hrly	7.30am	→ feeding provided	

Re-Assessment: Re-assessment after 2 hrs baby stable

Special Notes: TUBA 11m 1pm

Nurse Signature: Satya

Nurse Name: Satya

Date & Time: 19/7/24 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 19/07/26

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	→ To assess the general condition of the baby	8:00am	→ Assessed the general condition of the baby	Baby is stable Vitals normal
9am	→ To monitor vital signs	9:30am	→ Monitored vital and recorded	
10am	→ To encourage oral intake	10:20am	→ DBF every 2 to 3rd hrly	
11am	→ To check TCBR	11:40am	→ Checked TCBR levels	
12pm	→ To check GRBS	12:15pm	→ Checked GRBS levels	
1pm	→ To maintain I/O chart		→ Maintained I/O chart	

Re-Assessment:

Special Notes: after proper position, has good latching and sucking
 GRBS monitoring

Nurse Signature: *[Signature]*

Nurse Name: Chirsha

Date & Time: 19/07/26 at 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 19/7/26

Assessment: newborn baby monitoring jaundice Assessment

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the Baby general condition	2:30 pm	→ Assessed the Baby general condition in the crib	→ Baby was active & good feeding well
4pm	→ To monitor vitals	4:30 pm	→ monitored vitals	
5pm	→ maintain Ilo chart	5:30 pm	→ maintained Ilo chart	
6pm	→ To give feed 2nd only	6:30 pm	→ Given DFP 2nd only	
7pm	→ To provide crib care	7:30 pm	→ provided crib care to the Baby	

Re-Assessment: Re assessment key done after 1 hour the Baby was active & good

Special Notes: assess monitoring and SBR, WBS, ASE @ 4 hr

Nurse Signature:

Nurse Name: Kerathi

Date & Time: 19/7/26 @ 8pm

BAH-00662069 IP5-00176568
 Baby OF DIVYA SRI
 18-07-2026 0 Y 0 M 0 D 3 H (F)
 Dr. DINESH KUMAR CHIRLA



NURSING CARE RECORD

Rainbow Children's Hospital
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 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7/26

Assessment: Newborn Baby under observation

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the general condition	8:10pm	* Assessed the general condition	Baby is doing well and stable
10pm	* monitor vitals and Record	10:10pm	* monitored vitals and Recorded	
12am	* monitor GRBS as per advice	12:10am	* monitored GRBS as per advice	
4am	* SBR, NBS, OAE 48 hours of life	4:10am	* SBR, NBS, OAE 7/1m 1pm	
6am	* Ensure safety	6:10am	* Ensured safety	

Re-Assessment: Re-assessment done Baby Feeding positioning good latching good

Special Notes: SBR, NBS, OAE 48 hours of life of Baby

Nurse Signature: Latha

Nurse Name: Latha

Date & Time: 20/7/26 @ 6am

BAH-00662069

IP5-00176568

Baby Of DIVYA SRI

18-07-2026 0Y0M0D3H (F)

Dr. DINESH KUMAR CHIRLA



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: 20/7/26

Assessment: neonatal jaundice, Baby under SSPT

Goals

☐ Maintain Airway and Oxygenation
☒ Maintain Personal Hygiene
☐ Identify Potential Complications

☐ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify

☐ Maintain Fluid Balance
☐ Meet Elimination Needs

☐ Improve Activity Tolerance
☒ Ensure Safety

☐ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

☐ Maintain Skin Integrity
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the Baby general condition	8:30 am	→ Assessed the Baby general condition in the crib	→ Baby was active & good and slept under the light
10am	→ To monitor vitals	10:30 am	→ monitored vitals	
2pm	→ To maintain Ilo chart	2:30 pm	→ maintained Ilo chart	
6pm	→ To continue SSPT	6:30 pm	→ continued SSPT to the baby	
7pm	→ To give feed 2nd only	7:30 pm	→ given OBP 2nd only	

Re-Assessment:

Re-assessment has done after 1 hour the baby was slept under the light

Special Notes:

continue SSPT
Stop CRRS monitoring, SBR, NBS, OAC after roundly

Nurse Signature:

Nurse Name: Peravali

Date & Time: 20/7/26 @ 8pm

BAH-00622447
Mrs DIVYA SRI
04-08-1998 27 Y 11 M 14 D (F)
Dr. K BHARGAVI REDDY

IP5-00176541

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: 20/7/26

Assessment: neonatal jaundice baby under ssps

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 general condition	8.10pm	baby is stable (active)	baby is stable
9pm	to monitor vitals	9.10pm	vitals monitored & documented	
10pm	to monitor Flo chart	10.10pm	monitored Flo chart documented	
11pm	to continue ssps	11.10pm	ssps continue	
6am	to provide warm care	6.10am	provided warm care	
7am				

Re-Assessment: Re-assessed after 2 hrs baby is stable

Special Notes: SBR after 9 rounds

Nurse Signature: Satya

Nurse Name: Satya

Date & Time: 21/7/26 @ 8am

BAH-00662069 IP5-00176568
Baby Of DIVYA SRI
18-07-2026 0 Y 0 M 2 D (F)
Dr. DINESH KUMAR CHIRLA



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:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Dinesh Kumar Department: BB-5U Date of Admission: 18/7/26

SITUATION		Diagnosis: <u>now baby baby.</u> Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: _____						
BACKGROUND	Area	BB-5U 1pm-8pm 3rd floor 5pm-8pm 3rd floor 8am 3rd floor 2pm 3rd floor 2pm-8pm 8th floor 6pm-8am						
	Medical Condition (Any special condition to be noted):	NA	NB	NB	NB	WB	NB	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	36.5°C	98.6°F	97.9°F	96.4°F	97.9°F	98.1°F
		Res:	49b/m	40b/m	41b/m	40b/m	40b/m	40b/m
		SpO ₂ :	100%	99	99	100%	99.1	100%
		Pulse:	156b/m	127b/m	121b/m	128b/m	135b/m	147b/m
		BP:	—	—	—	—	—	—
Fall Risk Score:	0	0	0	16	16	16		
Pain Score:	2/6	1/6	1/6	0	0	0/10		
Recommendations	Safety Needs:	yes	side rails	yes	Gib care	crib care	crib care	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NO	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Sunitha	Kavathi	Satya	Shirisha	Kavathi	Kavathi	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		18/7/26	18/7/26	19/7/26	19/7	19/7/26	20/7	
Time:		5:30pm	@ 8pm	8am	@ 2pm	@ 8pm	@ 8am	
Taken Over By Name :		Kavathi	Satya	Shirisha	Kavathi	Kavathi	Kavathi	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		18/7/26	18/7/26	19/7	19/7/26	19/7	20/7/26	
Time:		@ 8pm	8pm	8am	@ 2pm	@ 8pm	@ 8am	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Dinesh Department: 3rd Floor Date of Admission: 18/7/26

SITUATION	Diagnosis: <u>NNT</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	Shift Time	<u>3rd Floor</u> <u>8am</u> <u>8pm</u>	<u>3rd Floor</u> <u>8am</u>			
	Medical Condition (Any special condition to be noted):		<u>NNT</u>	<u>NNT</u>			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>97.9°F</u>	<u>97.9°F</u>				
	Res:	<u>20b/m</u>	<u>20b/m</u>				
	SpO ₂ :	<u>98%</u>	<u>98%</u>				
	Pulse:	<u>135b/m</u>	<u>131b/m</u>				
	BP:	<u>—</u>	<u>—</u>				
	Fall Risk Score:	<u>16</u>	<u>16</u>				
Recommendations	Pain Score:	<u>6/10</u>	<u>0/10</u>				
	Safety Needs:	<u>crib care</u>	<u>crib care</u>				
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>NA</u>	<u>NA</u>				
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>				
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>				
Handed Over By Name :		<u>Walter</u>	<u>Saty 9</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>20/7/26</u>	<u>21/7/26</u>				
Time:		<u>@ 8pm</u>	<u>8am</u>				
Taken Over By Name :		<u>Saty 9</u>	<u>Shweta</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>20/7/26</u>	<u>21/7/26</u>				
Time:		<u>8pm</u>	<u>8am</u>				



NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time	
						18/7	19/7	20/7	21/7					
						2pm	8pm	8am	9am	8am				
						NA	NA	NA	NA					
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	39 ³ / ₄ wks	39 ³ / ₄ wks	39 ³ / ₄ wks					
						Total Pain / Agitation Score	0	0	0/10	0/10				
						Intervention	NA	NA	NA	NA				
						Effectiveness	NA	NA	NA	NA				
						Signature	Santosh Satya							

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.

BAH-00662069 IP5-00176568
Baby Of DIVYA SRI
18-07-2026 0 Y 0 M 0 D 3 H (F)
Dr. DINESH KUMAR CHIRLA



BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	18/7	19/7	20/7	21/7
					Time :	2 pm 20/7	8 am	SP 20/7	8 am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		3	3	3	3
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
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	4
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.		1	1	1	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		2	2	2	2
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	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.		2	2	2	2
					TOTAL SCORE	18	18	18	18
					Evaluator's Name	Sunitha	Satya	Latha	Satya

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

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



THE HUMPTY DUMPTY SCALE

18/7/2026 29/7/2026

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					
	Patient Placed in Bed	2	2	2	2	2	
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3	3	3	3	3	
	Within 48 hours	2					
	More than 48 hours / None	1	0	0	0	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			16	16	16	16	

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	X	4	✓	✓	
Call device within reach	X	4	✓	✓	
Wheels Locked	X	4	✓	✓	
Room free of clutter	✓	✓	✓	✓	
Adequate Lighting	✓	✓	✓	✓	
Wheel Chair Support	X	7	X	7	
Other Intervention(s) Specify	X	7	X	7	
Nurse's Name :		Bhushan Satish	18/7/26	19/7/26	
Signature :		[Signature]	18/7/26	19/7/26	
Date :		18/7/26	19/7/26	20/7/26	
Time :		2pm	8am	10pm	



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Nursing ☐ Others:
	☒ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	baby OBF and Barking	provided warm care	plan for baby care, and safety	<i>Smith</i>	☐ 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:

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		
18/7	2pm	7	Infection Control measures	P.T.	1	0	1	+	-	Sumitha

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-00662069 IP5-00176568
 Baby Of DIVYA SRI
 18-07-2026 0 Y 0 M 0 D 3 H (F)
 Dr. DINESH KUMAR CHIRLA



DISCHARGE PLANNING FORM

Nationality: India

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

1. Anticipated Date of Discharge:

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

Yes Assessment

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: [Signature]

Nurse Name: Sunitha

Date and Time: 18/7/26 @ 2pm

PATIENT TRANSFER FORM

BAH-00662069 IP5-00176568
Baby Of DIVYA SRI
18-07-2026 0 Y 0 M 0 D 3 H (F)
Dr. DINESH KUMAR CHIRLA



Date & Time of Admission <i>18/7/26 @ 6 PM</i>		Date & Time of Transfer Order <i>18/7/26 @ 6 PM</i>
Transfer Ordered by <i>Dr. Dinesh Kumar</i>		Reason for Transfer <i>observation</i>
From Unit <i>BB-II</i>	To Unit <i>3rd floor (337)</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films		

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	<i>NA</i>	<i>NA</i>
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☒

Name & Signature of Person who is Transferring <i>Sis. Sanitha</i>	Name of Person Ordered Transfer <i>Dr. Dinesh Kumar</i>
Patient & Clinical Records Received by : <i>Sis. Parvathi</i>	
Date & Time of Patient Received : <i>18/7/26 @ 6 PM</i>	

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

CONSENT FOR FORMULA FEEDS

BAH-00662069 IP5-00176568
Baby Of DIVYA SRI
18-07-2026 0 Y 0 M 2 D (F)
Dr. DINESH KUMAR CHIRLA

Patient Name : Age : Gender : ☐ Male ☐ Female

UHID No : Department : Date :

I Mr / Mrs. : aged years, hereby declare that I have
admitted my ☐ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on
..... I hereby give consent for formula feed for my child. Doctors have explained me
about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : B. Ghandi

Name :

Relationship with Patient : Grandmother

Date & Time : 21/7/26 @ 2am

Witness :

Signature : Satya

Name : Satya

Date & Time : 21/7/26 @ 2am

Doctor (who is taking the consent) :

Signature : Sohel

Name : Dr. Sohel

Date & Time : 21/7/26 2AM