Rainbow Children's Hospital

BirthRight by Rainbow

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 : IP5-00176199 **Admit Date** : 10-Jul-2026 **Admit Time** : 09:52 AM **UHID** : BAH-00661172

Patient Details :

Patient Name	: Baby Of NAAILAH SADAF	**Age**	: 0 D
Guardian	: Mr ABRAR YAZDANI	**DOB**	: 10-07-2026 09:22 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: H.NO-16-3-988/1,NEAR BY KIMS BIBI HOSPITAL , Chaderghat Hyderabad INDIA 500024	**Phone No**	: 6300319269/ 9121886747
		E-mail	: NAAILAHSADAF@GMAIL.COM

Admission Details :

Bed Type : BASINET **Bed No** : CRDL-SW-414-1 **Ward Name** : 4F-BIRTHING CENTRE

Room No : CRDL-SW-414-1 **Admission Type** : First Visit

Contact Details :

Name : Mr ABRAR YAZDANI **Relationship** : Father

Contact Address : H.NO-16-3-988/1,NEAR BY KIMS BIBI HOSPITAL , Chaderghat Hyderabad INDIA 500024 **Phone No** : 6300319269 / 9121886747

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

Patient Sticker

AH-00661172 IP5-00176199
aby Of NAAILAH SADAF
)-07-2026 0Y0M0D5H (F)
r. ANNAPOORNA TADAVARTHY

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NEWBORN MONITORING FORM

Date of Birth : 10/7/26.
Time of Birth : 9:22 Am
Mode of Delivery : Cwhsls.
Birth Weight : 2.918.
Head Circumference : 34cm
Length : 49cm
Red Reflex :

New Born Screening : Nadi CN of wrist ng)
TFT :
OAE :
Mother's Blood Group : O+ve.
Baby's Blood Group :
Anomaly Scan :
Vaccination : OPV.1 BCG.1 Hep-B Given on 11/7/26 SIS. Yadav 11/7/26

Date	Weight	Type of Feed	Quantity	Temperature	Signature
10/7/26.	(morning) 2.918.	DBf	—	98.1°f	Sumy.
10/7/26	2.814 (4:00pm)	DBF+FF	—		
11/7/26	2.796 kg	DBF+FF	—	98°f	Soubhanu
12/7/26	2.735kg	DBF+FF		98.1°f	Soubhanu

Date	Time	Investigation	Result	Order No.	Signature
10/7/26	10Am	Blood group		26068960	[illegible]
12/7/26	9:30am	SBR	10.0mg/dl	26069718	Satya

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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 - Naailah Sadaf.

Gender : ☐M ☑F Blood Group : .....

Date of Birth : 10/7/26 Time of Birth : 9:22am

Place of Birth : RCH, BH

Mother's Blood Group : O+ve.

Birth Weight (gms) : 2.918kg Length (cms) : 49cm

OFC (cms) : 34cm

Estimated Gesth Age : 36^{+4} wks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 31yrs Ht : ..... Wt : 105kg BMI: ..... Married Life : ..... LMP : 15/10/25 EDD : 31/8/26

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

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

Last Scans Details : @ 34^{+3} wks – Cephalic – ~~2.66~~ 2665gm, AC-67, AFI-12.1cm, placenta-post high, doppler-(N).

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 Resistence / ADEF / REDF / Redistrbution 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 : (N).

H/o Hypothyriodism : when diagnosed ? Medication?

.....

Any other Chronic Medical Problems, when detected drugs ? Calculus Cholecystitis @ 23wk

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

Infection : H/O, Fever

(☐Malaria ☐UTI ☐TORCH ☐TB ☐HIV ☐HBV)

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

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

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

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PAST OBSTETRIC HISTORY

G: 6 P: 3 A: 2 L: 3

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1.	2017	FT	LSCS (post dates)		3.3Kg	/ MCH
2.	2019	39+3	LSCS		2.3Kg	/ Rch
3.	2021	6 wk	- Sp. mis carriage			
4.	2023	8 wk	- MTP PC 2.			
5.	2024	FT	LSCS	M	3Kg	
6.	PP	S. concept.				

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 : Prev. LSCS

Specify the reason : .....

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL : .....

Resuscitaion : ☐ Yes ☐ No

Cord ABG : .....

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

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : ..... Weeks : .....

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

1 Minute	5 Minutes	10 Minutes
1	2	
2	2	
2	2	
2	2	
2	2	
TOTAL 9 (IC)	10 (IC)	

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)			
Brith Weight	> = 1kg (0)	750 - 999 (10)	< 750 (17)		
SGA	> 3rd percentile (0)	< 3rd (12)			
				Total	

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

G6 P3 L3 A2 / 36+4 wks / prev LSCS /
high BMI / calculus cholecystitis
for elective LSCS + tubectomy

Preheated warmer
Equipment check done
↓
female baby delivered
Via - El. LSCS
↓
Baby CRIB
↓
delayed cord clamp
@ 60 sec
↓
Routine cares given
↓
Inj Vitamin K given
↓
Shifted to mothers
side.

Investigation details in previous Hospital :

Feeding History :

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Family History :

G6 P5 L3 A2

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5° HR : 140/min RR : ..... NIBP : ..... CFT : .....

Color of the extremities : acrocyanosis → pink.

Jaundice : ..... Pallor : ..... SpO2 : .....

ANTHROPOMETRY: Birth Weight : 2.910 Length : ..... HC : ..... Present Weight : .....

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

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HEAD TO TOE EXAMINATION

HEAD :	Fontanelles : Sutures Shape / Moulding : Edema / Bruising : Size - (H.C.) :	(N)
FACIES : (Any Facial 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)
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number :	(N)
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : Discharge :	(N)
GENITILIA :	Labia / Hymen : Testicles/penis : Anus :	(N) female gen
HERNIAL ORIFICES		
TRUNK and SPINE :		(N)
SKIN LESIONS :		
EXTREMETIES :	Fingers / Toes : Deformities : Hip Joint Examination :	(N) Arms / Legs : Mobility :

SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☐ Regular ☐ Periodic ☐ Shallow ☐ Gasping

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

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

Mention if baby is on : ☐ Hood box ☐ CPAP ☐ Ventilator

Settings : On room air

SpO_2: 98% Auscultation: ..... Breath Sounds: ..... Added Sounds: .....

CARDIOVASCULAR SYSTEM :

HR : 140/min BP : .....

Femoral Pulses : .....

Other Peripheral Pulses : .....

Precordial Activity : .....

Murmurs : NAD

Signs of Cardiac Failure : .....

ABDOMEN:

Shape : .....

Palpation : (N)

Palpable masses : .....

Abdominal girth : .....

Hernia orifice : .....

Anal Patency : (+)

Umbilical Cord : 2A, 1V(+)

First urine passed : not passed

Meconium passed : not passed

NERVOUS SYSTEM:

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

State of wakefulness : CTTA - good

Prechtle Score : .....

Nerves : .....

.....

MOTOR SYSTEM:

Passive Tone : .....

Active Tone : .....

Neonatal Reflexes : .....

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

Moro's : ..... DTR : .....

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

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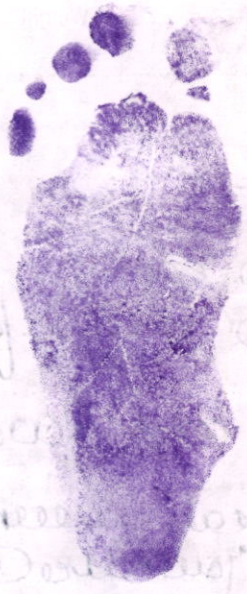
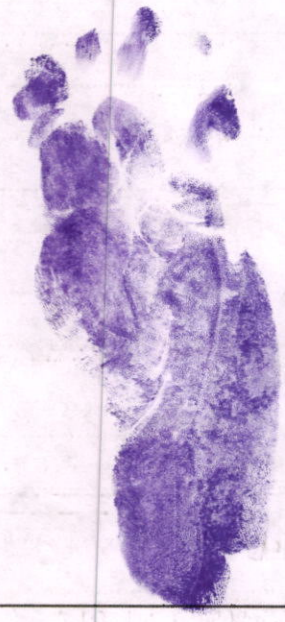
Diagnosis : 36^{+4} wks / EL.LSCS / 2.9 kg / Fch / CIAB

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : Pawan

Name : Pawan

Date & Time : 10/7/26

Consultant :

Signature :

Name : A.P.T.

Date & Time : 10/7/26 7p.

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.

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ANNAPOORNA TADAVARTHY

AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis : ....

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

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

Any Oxygen requirement : ....

Systemic : ....

Plan

Medications : ....

- warm care
- DBF 2nd hrly followed by cupping
→ Send cord blood for BG
→ clinical assessment of jaundice @ 24 Hrs
→ BCG/OPV/Hep B today
→ SBR/NBS/OAE @ 48 HRL

Plan during ward follow up :

Feeding Plan at the time of shifting : ....
9:40am to 9:55am.

Screenings done during NICU Stay :

NSG : ....

Hearing Screen : ....

ROP : ....

TFT : ....

NP2 : ....

Doctor Signature (Handover Given): Pava

Doctor Name: Pavani

Date & Time: 10/7/26

Doctor Signature (Handover Taken): ....

Doctor Name: ....

Date & Time: ....

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aby Of NAAILAH SADAF
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/01/26 3:30pm	O/S/B Resident.	
	6 HOL / $G_6P_3L_3A_2$ / 36^{+4} / EL-LSCS (Prev. LSCS)	2.918kg) F ch / CIAB.
	Baby on room air	Plan.
	M / O+ve ; B / Trace ; U/x ; S/x	① DBF 2nd hly Hb keeping.
	TWt / BWt – 2918g	
	Establish feeds.	② warm care
	- Euthermic – Pink	
	- Euglycemic	③ Vaccination Tm.
	hemodynamically stable	OPV, BCG, Hep B
	- Parents denied vaccination for today.	
	Cry, Tone, activity } good	④ Monitor vitals
		⑤ Establish feeds
		⑥ Nasoclear drops.
	Femorals ⊕	⑦ SBR, NBS, OAE } @ 48HOL
	Peripheries warm	
	Sneez ⊕.	
		Sohel
		NB Seema
	P/S/B Dr Anj.	
6p		1) Establish feeds
		[signature]

o. : RCHBH /FRM / CLINICAL / 088

AH-00661172 IP5-00176199
Baby Of NAAILAH SADAF
0-07-2026 0Y0M0D5H (F)
Dr. ANNAPOORNA TADAVARTHY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 9:00am	C/S/B Resident	
	23HOL/ 36+4/2918/ Feh/ C/AB/ $G_6P_3L_3A_2$/ Sl LSCS	
	M/O+ B/O+ V/✓(6) M/✓(3)	Plan
	Baby on room air	(1) DBF 2nd hrly ttb burping
	TWt → 2796g 4%↓	(2) warm care
	Feeding & latching well Euthermic - Pink Euglycemic	(3) Vaccination today OPV ✓ BCG ✓ HepB ✓ Given on 11/7/26 [illegible]
	Cry, Tone, activity } good. Peripheries warm CRT <3sec.	(4) Monitor vitals (5) Clinical Jaundice evaluation (6) SBR, WBS, OAE T/m 9am Soheb
10Am	P/S/B Dr Anup.	1) [illegible] [illegible] establish feeds. Anup.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 1 am	Lactation notes - Mother is confident with feeding doesn't need lactation support. - not willing	(Do not charge) Dr Deepika
11/7/26 3:30pm	CS/B Resident.	
	29HOL/36+4/2918/Fch/CIAB/El LSCS.	
	M/O+ B/O+ U/✓ M/✓.	Plan TCBR - 6.6 mg/dl 24 hrs
	Baby on room air wt → 2796 g Feeding well Cry Tone activity good. CRT <3sec. Peripheries warm Vitals stable	(1) measured feed + FF 10-14ml/ 2nd hr OR 20 mls 2nd hrly (2) To do vaccination today. (3) SBR, NBS, OAE } T/M 9a.m (4) monitor vitals Sohith N.B Kalyani

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/7/26 9.00am	cfs/b Resident	
	48HOL/36+4/2918/FCH/CIAB/SL LSCS	
	M/OT B/OT V/NAD M/✓	Plan SBR-10.0 mg/dl
	Baby on room air	① Measured feeds + FT 20ml 2nd hrly OR 30ml 3rd hrly
	Twt → 2735g.	
	Euthermic - Pink Euglycemic	② Warm care.
	Cry / Tone / activity } good	③ SBR, NBS - Today 9a.m.
	Peripheries warm CRT <3sec.	④ OAE TFM
		⑤ Monitor vitals
	AV	Tuesday morning Soluble

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 10/7/26 Time:	10 am	1 pm	6 pm	10:30 pm	6 am	
Doctor/Nurse/Family Concern?						
Temperature (F) 104 103 102 101 100 99 98 97 96 95 94	*	*	98.0 F *	97.9 F *	98 F *	
Heart Rate (bpm) 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 and Blood Pressure (mmHg) * **Note:** BP does not score in early warning scoring	*	*			132	
Heart Rate (Number)	144	143	138 bpm	140 bpm	132 bpm	
Resp. Rate (bpm) (Over 1 Minute) * 70 60 50 40 30 20 10	*	*				
Resp Rate (Number)	44	43	40 bpm	41	40	
Resp Distress: Mod/ Severe / None / Mild						
Receiving O_2 (l/min) O_2 Saturations (%)	99 %	98 %	100 %	99 %	98 %	
Conscious Level: Normal / Altered						
GCS *	14/15	14/15	15/15	15/15	15/15	
TOTAL SCORE Number of shaded boxes			0	0	0	
Pain Score	0	0	0	0	0	
Observer's Initials	RM	RM	[illegible]	L	[illegible]	

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

* 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.

Patient Sticker

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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)

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INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: ..... Time:	11 am	6pm	10pm	6am	
Doctor/Nurse/Family Concern?					
Temperature (F)	98.1 F	98.1 F	98.7 F	98.1 F	
Heart Rate (bpm) and Blood Pressure (mmHg) *					
Heart Rate (Number)	139 bt/m	135 bt/m	140 bt/mt	132	
Resp. Rate (bpm) (Over 1 Minute) *					
Resp Rate (Number)	41 br/m	40 br/m	40 br/mt	40 br/mt	
Resp Distress: Mod/ Severe / None / Mild					
Receiving O_2 (l/min) O_2 Saturations (%)	99%	97%	99%	99%	
Conscious Level: Normal / Altered					
GCS *	15/15	15/15	15/15	14/15	
TOTAL SCORE Number of shaded boxes	0	0	0	0	
Pain Score	0	0	0	0	
Observer's Initials					

Note: BP does not score in early warning scoring

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.

Patient Sticker

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

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-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 0 Y 0 M 0 D 2 H (F)
Dr. ANNAPOORNA TADAVARTHY

FLUID CHART

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
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Sheet No. : 6

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.

10/7/26.		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											
	09:00 am											
	10:00 am		DBM.								NO	Sy
	11:00 am										IV	Sy
	12:00 pm		DBM								Canula	Sy
	01:00 pm											Sy
Total Intake :			tab ctn			Total Output :					NOT passed.	
	02:00 pm									✓	✓	
	03:00 pm		DBF								NO	
	04:00 pm											Seema
	05:00 pm		DBF				NB				IV	
	06:00 pm											
	07:00 pm	FF	10ml									
Total Intake :						Total Output :				M-0 U-1		
	08:00 pm											
	09:00 pm											
	10:00 pm	FF	12ml				~			~		
	11:00 pm										nn	Soushy
	12:00 am	FF	DBM 25ml									
	01:00 am									~		
Total Intake :						Total Output :				M-1	U-2	
	02:00 am	Ff	25ml				~					
	03:00 am											
	04:00 am		DBM									
	05:00 am	Ff	25ml								nn	Soushy
	06:00 am						~			~		
	07:00 am											
Total Intake :						Total Output :				M-	U-	

Total 24 hrs. Intake	.	Total 24 hrs. Output	M-3 U-4

BAH-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 0 Y 0 M 0 D 11 H (F)
Dr. ANNAPOORNA TADAVARTHY

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Your Right to a Safe Delivery

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: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
11/7/26												
	08:00 am						✓			✓		
	09:00 am	FF	25ml									
	10:00 am										NA	Satya
	11:00 am						✓					
	12:00 pm		DBF							✓		
	01:00 pm	FF	10ml									
Total Intake :								**Total Output :** M-2 U-2				
	02:00 pm											
	03:00 pm	FF	15ml									
11/7	04:00 pm						✓			✓	NA	
	05:00 pm											
	06:00 pm	DBF + FF (20ml)					✓			✓		
	07:00 pm											
Total Intake :							M:2	**Total Output :** U 22				
	08:00 pm											
	09:00 pm		DBM									
	10:00 pm									~		
	11:00 pm	FF	25ml				M				NA	Sathya
	12:00 am											
	01:00 am		DBM									
Total Intake :								**Total Output :** M- U-				
	02:00 am	FF	28ml							~		
	03:00 am											
	04:00 am						M				NA	Sathya
	05:00 am		DBM									
	06:00 am									~		
	07:00 am	FF	25ml									
Total Intake :								**Total Output :**				

Total 24 hrs. Intake	DBM+FF	Total 24 hrs. Output	M-4 U-7

BAH-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 0 Y 0 M 0 D 11 H (F)
Dr. ANNAPOORNA TADAVARTHY

FLUID CHART

Rainbow® Children's Hospital
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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
12/7/26	08:00 am											
	09:00 am		DBF									
	10:00 am	ff	25ml									
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :** H - U -						
	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-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 0 Y 0 M 0 D 11 H (F)
Dr. ANNAPOORNA TADAVARTHY

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Your Right to a Safe Delivery

FLUID CHART

Sheet No. : .....

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

		Intake				Output						
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											
	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-00661172
Baby Of NAAILAH SADAF
10-07-2026 0 Y 0 M 0 D 2 H
Dr. ANNAPOORNA TADAVARTHY

NURSING CARE RECORD

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

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 10/7/26.

Assessment: new born 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
9.30 AM	* warm care.	9:35 am	* Baby weighing done.	Baby is well & ambulating.
10:00 am	* DBM & burping 2nd ly.	10:10 am	* DBM & burping given Every 2nd ly.	
11:00 am	* Cord care Advised.	11:10 am	* Cord care given.	
12pm.	* c/f U/O.	12:10 pm	* U/O Not passed.	
2pm	=> Recharting.	2:10pm	=> maintained Bo chart	

Re-Assessment: Reassesses done.

Special Notes: Vaccination today.

Nurse Signature: Suchi. Nurse Name: Suresh Date & Time: 10/7/26 2pm.

AH-00661172 IPS-00176199
aby Of NAAILAH SADAF
)-07-2026 0Y0M0D5H (F)
r. ANNAPOORNA TADAVARTHY

NURSING CARE RECORD

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

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 10/1/26

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 condition	2:30 pm	* Assessed the baby condition baby is steable.	* Baby is well
3pm	* plan to monitor vitals	3:10 pm	* monitor vitals steeble.	
4pm	* plan to maintain H/o chant.	4:30 pm	* maintain H/o chant.	
5pm	* plan to warm care	5:20 pm	* provide warm care for baby.	
7pm	* plan to vaccination T/m	7:30 pm	* vaccination T/m due.	
8pm	* plan to feeding 2-3rd hourly.	8pm	* Given feeding support 2-3rd hourly.	

Re-Assessment: provide warm care for baby.

Special Notes: vaccination T/m

Nurse Signature: Seema Nurse Name: Seema Date & Time: 10/1/26 @ 8pm

BAH-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 0 Y 0 M 0 D 11 H (F)
Dr. ANNAPOORNA TADAVARTHY

NURSING CARE RECORD

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BirthRight BY RAINBOW HOSPITALS
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☐ on ☐ Night

Date: 10/7/26

Assessment: Newborn baby observation for feeding & temp monitoring

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess to the baby condition	8.15pm	Assessed to the baby on sleep	
10pm	TO maentaen y/o chart.	11pm	monidor intake out put.	
12AM	vitals monidor	12.20 AM	Monitored vitals.	
2AM	plan to keep warm the baby	3AM	cover the baby with cloth	Baby well & active.
4AM	plan to give feed every 2to3rd hrly.	4.20 AM	provided feeding every 2to3rd hrly given.	
6AM	plan to give nasoclear drops	6.10AM	Nasoclear drops given.	
6.30 AM	parent's asking for Formula feeding	7AM	Formula feeding given	

Re-Assessment: Reassessment after 2 hrs baby well

Special Notes: SIBR, NBS, OAE, CHD.

Nurse Signature: Nurse Name: Soundhasini Date & Time: 11/7/26 @ 8AM

BAH-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 0 Y 0 M 0 D 11 H (F)
Dr. ANNAPOORNA TADAVARTHY

NURSING CARE RECORD

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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☑ Morning ☐ Afternoon ☐ Night

Date: 11/7/26

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
8am →	Assess the baby general condition	8.10am →	baby is stable and active	baby is stable
9am →	Encourage feeding 2nd and 3rd hrly	9.10am →	feeding provided	
10am →	TO provide warm care	10.10a →	provide warm care	
11am →	TO monitor vitals	11.10a →	vitals stable	
12pm →	monitor I/O chart	12.30p →	monitored I/O chart documented	

Re-Assessment: Re-assessed after 2hrs baby

Special Notes: 4 & HOL SBR | NBS

Nurse Signature: Satya Nurse Name: Satya Date & Time: 11/7/26 @ 2p.m.

BAH-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 0 Y 0 M 0 D 11 H (F)
Dr. ANNAPOORNA TADAVARTHY

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Your Right to a Safe Delivery

NURSING CARE RECORD

Shift: ☐ Morning ☑ Afternoon ☐ Night

Date: 11/7/26

Assessment: New Born 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	→ To assess the general condition of the baby	2:30pm	→ Assessed the general condition of the baby	Baby is stable
4pm	→ To monitor vital signs	4:20 pm	→ Monitored vitals and	Vitals normal
5pm	→ To do vaccination	5:05 pm	→ Vaccination done	
6pm	→ To encourage oral intake	6:30pm	→ PBF and FF every 2 to 3rd hrly	
7pm	→ To maintain I/O chart	7:15pm	→ Maintained I/O chart	

Re-Assessment: After proper position, has good latching and sucking

Special Notes:

Nurse Signature: [signature] Nurse Name: Kalyani Date & Time: 11/7 at 8pm

Docu. No: RCHBH /FRM / CLINICAL / 148

BAH-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 0 Y 0 M 0 D 11 H (F)
Dr. ANNAPOORNA TADAVARTHY

NURSING CARE RECORD

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

Shift: ☐ Morning ☐ Afternoon ☑ Night

Date: 10/7/26

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
8pm	⇒ Assess the Baby general condition	8:30 pm	⇒ Assessed the Baby general condition on crib	⇒ Baby is stable
10pm	⇒ To monitor vitals	10:30 pm	⇒ monitored Baby vitals	
12am	⇒ To monitor I/o chart	12:30 am	⇒ monitored Baby I/o chart	
2am	⇒ To plan DBf feeding	2:30 am	⇒ DBf feeding every 2nd hourly	
4am	⇒ To provide Crib care	4:30 am	⇒ provided Baby Crib care	
6am	⇒ To plan ensure safety	6:30 am	⇒ given Baby ensure safety	

Re-Assessment: Re-assessment has done cross Baby Suckling well

Special Notes: SBR. NBS OAE 9:am

Nurse Signature: Soubhasini Nurse Name: Soubhasini Date & Time: 11/7/26 @8am

BAH-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 0 Y 0 M 0 D 2 H (F)
Dr. ANNAPOORNA TADAVARTHY

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Annapoorna Department: B/C Date of Admission: 10/7/26

SITUATION

Diagnosis: New born baby.

Any Infection: ☐ Yes ☑ No ☐ Not Known
If Yes Specify: .....

BACKGROUND / ASSESSMENT / Recommendations	Area / Shift Time	OBS 10am-2pm	3rd floor 8pm	3rd floor 8AM	3rd floor 2PM	3rd floor 8pm	3rd floor 8PM
BACKGROUND	Medical Condition (Any special condition to be noted):	NA	NB	NB	NB	NB	NB
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
ASSESSMENT	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ASSESSMENT	Vital Signs: Temp:	98.1°F	98.2°F	98°F	97.9°F	98°F	98.7°F
ASSESSMENT	Res:	44	30bpm	41	39	42bpm	40b/m
ASSESSMENT	SpO_2:	99%	100%	98	99.1	100%	100%
ASSESSMENT	Pulse:	149	138bpm	131	141	132b/m	145b/m
ASSESSMENT	BP:	—	—	—	—	—	—
ASSESSMENT	Fall Risk Score:	16	16	10	10	16	16
ASSESSMENT	Pain Score:	0	0/10	0/10	0/10	0	0
Recommendations	Safety Needs:	Yes	yes	yes	yes	Cribb Care	yes
Recommendations	Physiotherapy	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No
Recommendations	Others Specify:	NA	NO	NA	NA	NA	NA
Recommendations	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Recommendations	Other Special Orders / Medications:	NA	Vaccination TIM	vaccination today	vaccination today	NA	SBR NBS OAE TIM
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA
Handed Over By Name :		Sony	Seema	Soubhagini	Satya	Kalyani	Soubhagini
Signature :		Sony					
Date:		10/7/26	10/7/26	11/7/26	11/7/26	11/7	12/7
Time:		2pm	@8pm	@8AM	2pm	8pm	8am
Taken Over By Name :		Seema	Soubhagini	Satya	Kalyani	Soubhagini	
Signature :							
Date:		10/7/26	10/7/26	11/7/26	11/7	10/7	
Time:		2pm	@8pm	8am	2pm	8pm	

Docu. No. : RCHBH /FRM / CLINICAL / 097

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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It takes a lot to treat the little.

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BRADEN 'Q' SCALE

					Date : 10/7	11/7	12/7	
					Time : 8AM&9PM	6AM	6AM	
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	2	2	2	
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1	1	
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.	4	4	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.	4	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	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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	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.	4	4	4	
				TOTAL SCORE	23	19	19	
				Evaluator's Name	[illegible]	Soumya	Soumya	

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

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

BAH-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 0Y0M0D2H (F)
Dr. ANNAPOORNA TADAVARTHY

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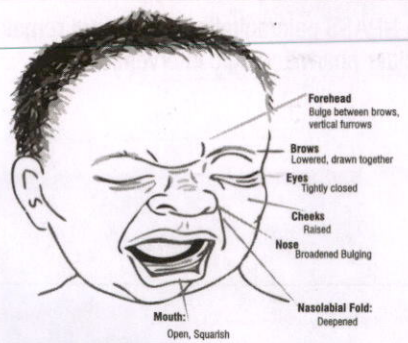
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date
						10/7/26	11/7	12/7					
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
						5am	5AM	9am					
					Procedure →	-2pm.							
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					
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					
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	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					
Vital Signs HR RR, BP, SaO_2	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					



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	36 wks	36+4 wks	36+1 wks
Total Pain / Agitation Score	0	0	0
Intervention	NA	NA	NA
Effectiveness	NA	NA	NA
Signature			

(P.T.O)

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-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 0 Y 0 M 0 D 2 H (F)
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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	10/7/26 DATE	11/7/26 DATE	12/7 DATE	DATE	DATE
Age	Less than 3 years old	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		
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		
Cognitive Impairments	Not aware of Limitations	3	3				
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4		4	4		
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3	3	3	3		
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3	3				
	Within 48 hours	2					
	More than 48 hours/ None	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		
	Total		15	15	15		

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		Yes	NA	NA		
	Call device within reach		Yes	NA	NA		
	Wheels Locked		Yes	yes	yes		
	Room free of clutter		NO	yes	yes		
	Adequate lighting		Yes	yes	yes		
	Wheel chair support		Yes	NA	NA		
	Other Intervention(s) Specify		NA	NA	NA		
	Nurse's Name:		Sup	Sudha	Sandy		
	Signature:		Sup				
	Date:		10/7/26	11/7/26	12/7/26		
	Time:		2pm	@8pm	8am		

Docu. No. : RCHBH /FRM / CLINICAL / 005

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NURSING DEPARTMENT
NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Bio. Naailah Sadaf. Mother's Name: .....

Date of Birth: 10/7/26. Time of Birth: 9:22Am. Gender: ☐ Male ☐ Female

Birth Weight: 2.916 Kgs HC: 34cm cm Lenght: 49 cm

Meconium in Liquor: ☐ Yes ☐ No Cried at Birth: ☐ Yes ☐ No

Term / Pre-term / Post-term: .....

Resuscitated: ☐ Yes ☐ No Blood Group: Mother: O+ve. Baby: .....

Feeding: ☐ Breast Feeding ☐ Formula ☐ Both First Feed Time: 9:40Am - 9:55Am

AFFIX MOTHER'S IDENTIFICATION LABEL

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

Indication: .....

Physical Assessment of New Born:

Temp: ..... ℃ HR: 144 /Min RR: 44 /Min BP: ..... SpO_2: 99%

Pain Score: ..... (Follow N Pass)

Fall Risk Assessment: ☐ **Yes** ☐ **No** **Score:** ..... (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: ..... Signature: ..... Date &Time: 10/7/26 11AM

BAH-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 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: Estimated

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	Need Assistance.
☐ Walking	☐ Yes	☐ No	
☐ Dressing	☐ Yes	☐ No	
☐ Toileting	☐ Yes	☐ No	

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: Education about hand hygiene.
   ☐ Patient's Educational Topic/s discussed with the:
   ☐ Patient ☐ Family Member ☐ Others: .....

Nurse Signature: .....
Nurse Name: Sruthi.
Date and Time: 10/7/26 1pm

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00661172 IP5-00176199 Baby Of NAAILAH SADAF 10-07-2026 0Y0M0D2H (F) Dr. ANNAPOORNA TADAVARTHY	10/7/26, 9:52 AM	10/7/26, 2:45 PM
	Transfer Ordered by Dr. Annapoorna	Reason for Transfer Observation.
From Unit OBS	To Unit Room (320)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 40	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Swathi	Dr. Annapoorna

Patient & Clinical Records Received by : Sis. 10/7/26 2:50 pm

Date & Time of Patient Received :

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

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BREASTFEE[illegible]M

BAH-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 0 Y 0 M 0 D 11 H (F)
Dr. ANNAPOORNA TADAVARTHY

Mother's Name: MY[illegible] Baby's Name: B/O Date of Birth: 10/7/26

Reason for consultation: Lactation counselling for Mother

1. Baby's feeding now (ask all these points)	Breastfeeds Yes How often 2-2½ hrly Length of breastfeeds 15-20min Longest time between feeds 2-2½ hr (time mother away from baby) One breast or both breasts Both Complements (and water) NO What given When started How much How is it given	Day	Night Pacifier (Yes / NO)
2. Baby's health and behaviour (ask all these urine output (more/less than points))	Birth weight 2.918 Premature Term Urine output (more/less than 6 times per day) Stools (soft and yellow/brown; or hard or green; frequency) Feeding behaviour Good Illnesses	Weight now 2.796. Twin Abnormalities YES	Growth
3. Pregnancy, birth, early feeds	Antenatal care (attended/not) Delivery: Normal / C – section Rooming – in Yes / No Prelacteal feeds Yes / No (If Yes,) What given Formula samples given to the mother Yes / No Postnatal help available for breastfeeding Yes / No	Breastfeeding discussed? Yes / No Early contact (First – 1 hour) Yes / No Time first breast feed (if not within 1st hour) Yes How given	
4. Mother's condition and family planning	Age 31 yrs Family planning method	Breast condition Normal Motivation to breastfeed Yes Alcohol, smoking, coffee, other drugs Yes / no	
5. Previous infant feeding experience	Number of previous babies G1G. How many breastfeed Any bottles used NO	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 Positive	Literacy status Educated Counselled about DBF	

Lactation Consultant:

Signature: ..... Name: Supreeja Date & Time: 11/7 10Am

LACTATION ASSESSMENT FORM

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Mother's details: Mrs. NAILAH SADAF

Baby details: B/o. NAILAH SADAF

Delivery: Vaginal ☐ Cesarean ☑ Vaccum ☐ Forceps ☐ Gravida ☑ GA ☑ 36 + 4 wks

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

BF previous baby: 4y Previous BF difficulty: ND

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 / latchHold nipple in mouth	Grasps breast tongue downlips flanged Rythmical sucking						
AUDIBLE SWALLOWING	None	A few with stimulation	Spontaneous & Intermittent						
TYPE OF NIPPLE	Inverted	Flat	Everted (After stimulation)						
COMFORT	Engorged cracked Bleeding large Blisters bruises	Filling reddened small blisters / bruises	Soft Non tender						
HOLD	Full Assist	Minimal assist	No assist						
			Total Score						

BABY WEIGHT CHART							FIRST FEED	
Date	11/7/26						Breast Feed	Top Feed
Weight	2.790							

Teaching Instructions: Deep latch

Discharge Instructions: urine output & weight monitor

Feed Frequency Duration: 2 - 2½ hr

Feeding techniques: cross cradle

Assessment of output: Good

Sources of BF assistance at home: Handout

Next Follow up: 1 week

Lactation Consultant: Name: Supriya Signature: Date & Time: 11/7.

Docu. No: RCHBH/ FRM/ CLINICAL/ 282

BAH-00661172 IPS-00176199
Baby Of NAAILAH SADAF
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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	4			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	2			
7	Nursing plan of care and handover sheets	4			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
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				
18	Consent for ~~MTP~~	1			
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia 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	2			
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				
		1			
	Total No. of Pages	27			

Signature and Date : 12/2/26

(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

BAH-00661172 IP5-00176199
Baby Of NAAILAH SADAF
10-07-2026 0 Y 0 M 0 D 11 H (F)
Dr. ANNAPOORNA TADAVARTHY

BREASTFEEDING OBSERVATION CHART

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Please tick ☑ for Yes, ☒ for No and leave ☐ blank for Not Applicable:

Observation Parameters	Date & Time	11/7	11/7	11/7	11/7																				
	No. of Feeds	1	1	1	1																				
Body Position	• **Mother relaxed and comfortable**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Shoulders tense, leans over baby	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Baby's head and body in straight line**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Baby's head and body is not straight line	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Baby's body close to mother's**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Baby's body not close to mother's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Baby's back**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Only shoulder or head supported	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Breast well supported** (optional)	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Breast supported in scissor hold or nipple being pushed in baby's mouth	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Supine**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Sitting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Responses	• **Baby roots for breast**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• No rooting observed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Baby explores breast with tongue**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Baby not interested in breast	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Baby calm and alert at breast**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Baby restless or crying	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Baby stays attached to breast**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Baby slips off breast	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Signs of milk ejection, (leaking, after - pain)**	☑	☐	☐	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• No signs of milk ejection	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

(P.T.O)

Emotional Bonding	• **Secure, confident hold**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Nervous or limp hold	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Face-to-face attention from mother**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• No mother/baby eye contact	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Much touching by mother**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Little touching or Shaking or poking baby	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anatomy	• **Breasts soft after feed**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Breasts engorged	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Nipples average size**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Nipples large / flat/ inverted	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **No lump in breast**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Lump in breast	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suckling	• **Mouth wide open**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Mouth not wide open, points forward	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Chin touching the breast and nose close to breast**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Chin and nose away from the breast	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Lower lip turned outwards**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Lower lip turned in	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Cheeks round**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Cheeks tense or pulled in	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• **Slow deep sucks, bursts with pauses**	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	• Rapid sucks only	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Baby Suckled for (in Minutes)	Left:	20mins	20mins	20mins	20mins																					
	Right:	20mins	20mins	20mins	20mins																					
EBM (in ML)		NO	NO	NO	NO																					
Formula Feeds		NO	NO	NO	NO																					
Birth Weight		2.918	2.918	2.918	2.918																					
Present Weight		2.796	2.796	2.796	2.796																					
Weight Loss		0.122kg	0.122kg	0.122kg	0.122kg																					
Nurse Signature:		Vale	Vale	Vale	Vale																					
Nurse Name:		Vale	Vale	Vale	Vale																					