

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176095 Admit Date : 08-Jul-2026 Admit Time : 08:11 AM UHID : BAH-00660978

Patient Details :

Patient Name	: Baby Of ALUGANI MADHURI .	Age	: 0 D
Guardian	: Mr GEEDI BHARAT RAJ GOUD	DOB	: 08-07-2026 07:18 AM
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: #H.NO:6-69,SRI RAMA NILAYAM NEAR RAM MANDIR, K.V RANGAREDDY Malkajgiri Hyderabad Telangana INDIA 500047	Phone No	: 9959603233/ 9948408862
		E-mail	: nomailid@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 GEEDI BHARAT RAJ GOUD Relationship : Father
Contact Address : #H.NO:6-69,SRI RAMA NILAYAM NEAR RAM Phone No : 9959603233 / 9948408862
MANDIR, K.V RANGAREDDY Malkajgiri
Hyderabad Telangana INDIA 500047

G. Pruthvi Raj
Signature

Doctor Details :

Doctor Name : Dr. NALINIKANTA PANIGRAHY Specialisation : NEONATOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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

Date	Time	Investigation	Result	Order No.	Signature
8/7/26	8:39 AM	Blood group DCT, Retic count SBR, CRP	OTV.	26068989	Shinshu
8/7/26		DCT.	Negative.		Shinshu
10/7/26	7 AM	SBR	13.2 mg/dl	26068849	Shinshu
10/7/26	11 AM	SSPT		26068849	Shinshu
10/7/26	'	UAE		26068849	Shinshu
10/7/26	5 pm	NRBS		26069118	Shinshu
11/7/26	8 AM	SBR	12.9 < 0.1	26069281	Shinshu

BAH-00660978 IP5-00176095
Baby Of ALUGANI MADHURI.
08-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. NALINIKANTA PANIGRAHY



Rh negative

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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 Madhuri Mother's Blood Group : O negative
Gender : ☒ M ☐ F Blood Group : Birth Weight (gms) : 3492g Length (cms) : 49 cm
Date of Birth : 8/7/26 Time of Birth : 7:15 am OFC (cms) : HC-34 cm
Place of Birth : RCH - Banjara Estimated Gesth Age : 39+3 wks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 32y Ht : Wt : BMI : Married Life : LMP : 5/10/25 EDD : 12/2/26
Conception : Spontaneous or with Rx : Spontaneous
Booked at what GA : 13+1 wks AN Steroids Drugs / Doses :
Last Scans Details : 15/5/26 → 31+5 wks / 1727g / AFI-14.4 cm, Doppler (D)
TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ < 18 yrs ☐ > 35yrs

Consanguinity : ☐ Yes ☐ No

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

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long :

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

IUGR - when detected :

Doppler (Increased Resistance / ADEF / REDF /

Redistribution in MCA) / Ductus Venosus :

AFI :

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

Controlled or not, recent values, HbA1 values :

Compliance with Rx :

Scans : LGA, TIFFA , Fetal Echo :

H/o Hypothyroidism : when diagnosed ? Medication?

Any other Chronic Medical Problems, when detected
drugs ? Rh-v.e, Anti D taken at 28 wks

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

Infection : H/O, Fever

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

UTI : when : Any culture :

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

Medication during Pregnancy : Duration :



PAST ORSTETRIC HISTORY

2 P: 1 A: L: 1

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1.	2y	Term	3.4kg	Male	2m USCS (NPL) →	Anti D given

PERINATAL HISTORY

Treating Obstetrician : Dr. Lavanya Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation) prev. USCS

LSCS : ☒ Elective ☐ Emergency Indication :

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	
9	10	

TOTAL

Snapee II Score

Score

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

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



Baby delivered via Elective LSCS



cried immediately



Routine newborn care done



Hy vit K given IM O. smel



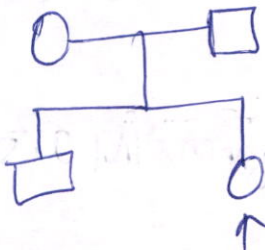
shifted to mother's side.

Investigation details in previous Hospital :

Feeding History :



Family History :



Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Active.

VITALS : Temperature : 36.5°C HR : 158 RR : 57 NIBP : CFT : 28 sec

Color of the extremities : Cyanosis

Jaundice : Pallor : SpO2 : 95%

ANTHROPOMETRY: Birth Weight : Length : 34.2 cm HC : Present Weight :

Ponderal Index : AGA : ✓ SGA : LGA :



HEAD TO TOE EXAMINATION

Fontanelles :

Sutures

Shape / Moulding :

Edema / Bruising :

Size - (H.C.) :

} 0

FACIES :

(Any Facial
Dysmorphism)

(N)

**NECK and
CLAVICLES :**

Range of Motion :

Asymmetry :

Masses :

} (N)

EYES :

Symmetry :

Red Reflex : To be checked .

Discharge :

**EARS, NOSE
MOUTH and
THROAT :**

Ear set / Shape :

Periauricular Pits / Tags :

Nasal shape / Patency :

Palate :

Gums :

Lips :

Tongue :

} (N)
NO cleft

**THORAX and
BREASTS :**

Shape of Thorax :

Position of Nipples and Number :

(N)

**ABDOMEN and
UMBILICUS :**

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump : 2VA, 10V (+)

Discharge :

GENITILIA :

Labia / Hymen :

Testicles/penis :

Anus :

-(N) female genitalia noted

HERNIAL ORIFICES

free

TRUNK and SPINE :

(N)

SKIN LESIONS :

No

EXTREMITIES :

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: 57 SCR / ICR / See - Saw breathing :

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

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

Settings :

SpO₂ : 95% Auscultation : BAE(+) Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 158 BP :

Femoral Pulses : B/L equal

Other Peripheral Pulses : (+)

Precordial Activity : (N)

Murmurs : No

Signs of Cardiac Failure : No

ABDOMEN:

Shape : (N)

Palpation : Soft

Palpable masses : No

Abdominal girth :

Hernia orifice : free

Anal Patency : patent

Umbilical Cord : 20A, 10V (+)

First urine passed : ?

Meconium passed : No

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtl Score :

Nerves : 4/5A - good

MOTOR SYSTEM:

Passive Tone :

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR :

ATNR : Skull and Spine :



No. 100

Diagnosis : DOL-1 / Term / AGA / Female / Rh-ve pregnancy

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name : Dr. Poojithe

Date & Time : 8/2/26

Consultant :

Signature :

Name : DR. NALINIKANTA PANIGRAHY

Date & Time : Registration No: TSMC/FMR/03605

PLEASE FILL UP THE FOLLOWING DETAILS

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



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic :

Medications :

- Plan
- 1) DOP 2nd hly flb burping
 - 2) Send cord blood for BCT, CBP, SBR, DCT
Retic count - Trace
 - 3) BCG, OPV, Hep B today
 - 4) ~~SBR~~ TCB at 12 HCL, R/V SBR
 - 5) NBS, OAE @ 48 HCL

Plan during ward follow up :

Feeding Plan at the time of shifting :

7:30am to 7:40am

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:

Date & Time	Progress Notes	Doctor's Order
8/11/26 12p	4HOL / TUMM (29W) CSCS flh negative set up. Baby BCG: 0 +ve DCT: -ve Retic: u-sz. Took breakfasts STDA, urine not passed yet.	plans (1) DRP flh biopsy 2-3mly. (2) clinical jaundice assessment @ 12HOL & 24HOL, TBR SCS, (3) warmth care (4) BCG OPV. hepatitis B today (5) NBS, DCE @ 48HOL. NR MCMC NB by Ashw

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
08/07/26 3:30pm	ds/B Resident	
	8 HOL / Term / 39 wks / LSCS / Rh -ve mother	2nd child
	$\frac{M}{B} \frac{0}{0} \frac{-ve}{+ve}$ $\frac{U}{m} \frac{5}{1}$	Plan
	Baby on room air	① Direct breast feed 2nd half
	B. wt → 3.492 kg	
	- Feeds established	
	DBF	② Clinical Jaundice / assessment @
	- Euthemic - Pink	12 HOL @ 1 P.M
	Euglycemic.	24 HOL @ 1 A.M T/M
	$\left. \begin{array}{l} \text{Cry} \\ \text{Tone} \\ \text{activity} \end{array} \right\} \text{good.}$	TCBR (SOS) → inform
	Peripheries - warm	③ Vaccination given
	CRT < 3 sec.	④ warm care
	no s/o Jaundice.	⑤ Monitor vitals
	1st child Male - O+	inform SOS.
	Red Reflex → B/L	⑥ NBS } 48 HOL.
	Equal	SBR } OAE }
		Solid
	no by plan	8/7/26
		On



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7 2:30pm	<u>Lactation case plan:</u> - Well formed breast and nipples - Colostrum seen - Suck good. <u>Advice:</u> - Direct breast feeding. - Aim for deep latch as demonstrated in cradle hold. - Make baby suck for 15-20 min on each side. - Demand feeding not exceeding 2-2½ hr	Super



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 5:00pm	C/S/B Resident	
	36WOL Term 39w LSCS Rh- mother 2nd child 3492g	
	- Baby on room air	<u>Plan</u>
	- on Direct Breast feed	① Measured breast feed
	- Crying after feed.	22-25ml/ feed
	- Euthermic - Pink	EBF preferred 2ndr.
	Euglycemic	± Formula feed.
	- Hemodynamically stable	② warm care.
	- vitals - stable	③ TCBL (sac)
		④ SBR } T/m 7:00am
		NBS } OAE }
		⑤ Inform my s/o Hemodyns (SOS)
		<u>Solich</u>
		NB - Karathi 9065003

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/4/26 8:30am	CLB Resident	
	49 HOU Term 39w LSC Rh- mother 2nd child Fch 3492g.	
	Baby on room air m/o-ue B/o-ue	Plan SBR < 0.1 13.2 13.1 ① Measured feed 20-22 ml / hr EBF 13.2
	Twrt 3.168kg 9% ↓	
	Euthermic Euglycemic cry } good Tone } activity } vitals → stable	② warm case ③ OAE - Today ④ monitor vitals ⑤ SPT c eyes & genital soles covered
	SPO ₂ - 98% @ Room air	
	DR. NALINIKANTA PANIGRAHY Registration No: TSMC/FMR/03605	SSPT x 24 hr SBR, 13.2 Th
	10/4/26	

[illegible]

Date & Time	Progress Notes	Doctor's Order				
11/7/26 9:05am	<u>Q4B Resident</u>					
	T4 HOL Term 39W LSCS Rh- Fch 3492					
	Baby on room air	Plan: SBR - 12.9				
	<table border="0"> <tr> <td>M / 0-ue</td> <td>V / ✓ (8)</td> </tr> <tr> <td>B / 0-ue</td> <td>M / ✓ (4)</td> </tr> </table>	M / 0-ue	V / ✓ (8)	B / 0-ue	M / ✓ (4)	① SSPT E eyes 2 genitab. closed
M / 0-ue	V / ✓ (8)					
B / 0-ue	M / ✓ (4)					
	Twrt → 3.135 kg (10% ↓) wt loss 30g from 10/7/26 Feeding well Euthemic - Pink Suglycemic. cry tone activity } good. Peripheries warm Vitals: Stable	② warm care ③ Measured feed 25-30ml 2nd hly or 40-45ml 3rd hly ④ warm care monitor vitals ⑤ SBR Tm 8a.m Soch				

BAH-00660978 IP5-00176095
Baby OF ALUGANI MADHURI .
08-07-2026 0 Y 0 M 0 D 6 H (F)
Dr. NALINIKANTA PANIGRAHY



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Dr. NALINIKANTA PANIGRAHI



[illegible]

BAH-00660978 IP5-00176095
Baby Of ALUGANI MADHURI.
08-07-2026 O Y O M 2 D (F)
Dr. NALINIKANTA PANIGRAHY



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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 Baby Of ALUGANI MADHURI.
 08-07-2026 0 Y 0 M 0 D 2 H (F)
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RESULT SHEET

Date	8/7/26	10/7/26	11/7/26			
Time	8.35 AM		8 AM			
Hb	13.4					
PCV	41.3					
RBC	3.80					
WBC	17.10					
N/L						
Platelets	2.48					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj	2.1 < 0.1 2.0	13.2 < 0.1 13.1	12.9 < 0.1 12.8			
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: New born baby

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:
8/7/26 @ 8Am	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Warm Care	provide warm Care	Baby well wrapped	Tunge	☒ 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:

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Baby Of ALUGANI MADHURI.
08-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. NALINIKANTA PANIGRAHY

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

Patient's / Learner Language: Telegu 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		
8/7/26	8AM	7	Explain about infection control	F, M	4, 1	①	1	1	-	Tunne

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:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								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	
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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:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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Understanding:	<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
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NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/O madhuri Mother's Name: Mrs. Madhuri
Date of Birth: 8/7/26 Time of Birth: 4:18 am Gender: ☐ Male ☒ Female
Birth Weight: 3.492 Kgs HC: 34 cm Length: 49 cm
Meconium in Liquor: ☐ Yes ☒ No Cried at Birth: ☒ Yes ☐ No
Term / Pre-term / Post-term: Term
Resuscitated: ☐ Yes ☒ No Blood Group: Mother: O -ve Baby: _____
Feeding: ☒ Breast Feeding ☐ Formula ☐ Both First Feed Time: 7:30 to 7:40 am

AFFIX MOTHER'S
IDENTIFICATION LABEL

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

Indication: _____

Physical Assessment of New Born:

Temp: 36 °C HR: 142b /Min RR: 40 b /Min BP: NA SpO₂: 99.1

Pain Score: 0 (Follow N Pass)

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

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

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

Findings:

General Appearance: Posture: ☒ Well-Flexed ☐ Asymmetry

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

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

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

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

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

Newborn Screening Discussed: Yes / No

Nurse Name: Arvins

Signature: Arvins

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 8/7/26	Time: 6am	9am	12pm	3pm	6pm	10pm	6am
Doctor/Nurse/Family Concern?				pm			
Temperature (°F)	98.8	98.4	98.1	97.5	98.8	98.1	98.8
Heart Rate (bpm)	136bpm	144	143	140	130bpm	135bpm	130bpm
Blood Pressure (mmHg) *	130	130	130	130			
Note: BP does not score in early warning scoring							
Resp Rate (Number)	46bpm	44	43	40	46bpm	40bpm	40bpm
Receiving O ₂ (l/min)	2.5l	2.5l	2.5l	100%	100%	99%	100%
O ₂ Saturations (%)	98%	98%	99%	100%	100%	99%	100%
Conscious Level	13/15	14/15	14/15	14/15	15/15	15/15	15/15
GCS *	13/15	14/15	14/15	14/15	15/15	15/15	15/15
TOTAL SCORE	0	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	Tamra	Hy	Hy				
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!
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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-00660978 IP5-00176095
Baby Of ALUGANI MADHURI .
08-07-2026 0 Y 0 M 0 D 6 H (F)
Dr. NALINKANTA PANIGRAHY

FRM / CLINICAL / 124

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

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 9/3/26 Time:

Doctor/Nurse/Family Concern?

Temperature
(F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Level Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

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

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BAH-00660978 IP5-00176095

Baby OF ALUGANI MADHURI.

08-07-2026

0 Y 0 M 0 D 6 H (F)

FRM / CLINICAL / 124

Dr. NALINKANTA PANIGRAHY



INFANT (<1 year)

Children's Observation &
Early Warning Scoring Chart
 Pratiksha
Rainbow
Children's
Hospital
It takes a lot to treat the little.

 BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Y WARNING SCORE: CHILDREN'S UNIT

Date: 10/2/25 Time: 11 PM 3 PM 10 PM 6 AM

Doctor/Nurse/Family Concern?

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

98.3 F

98.5 F

98.1 F

98.0 F

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

Heart Rate (Number)

120b/m

120b/m

120b/m

121b/m

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

Resp Rate (Number)

20b/m

20b/m

40b/m

40b/m

Resp Mod/ Severe
Distress None / MildReceiving O₂ (l/min)
O₂ Saturations (%)

100% 100%

99%

100%

Conscious Level
Normal
Altered

GCS *

15/5

15/5

15/5

15/5

TOTAL SCORE

Number of shaded boxes

0

0

0

0

Pain Score

0

0

0

0

Observer's Initials

A

R

A

A

ACTIONS

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BAH-00660978 IPS-00176095
Baby Of ALUGANI MADHURI .
08-07-2026 0 Y 0 M 2 D (F)
Dr. NALINKANTA PANIGRAHY



FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 10/7/26 Time: 10 AM

Doctor/Nurse/Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

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

Heart Rate (Number)

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

Resp Rate (Number)

Resp Distress

Mod/ Severe
None / Mild

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

Conscious Level

Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

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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

8/7/26.

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

8/7/26		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							
8/7/26	08:00 am	DBF				↓				NO IV	Tunnal	
	09:00 am									CG	Emp	
	10:00 am	DBF								NA	Emp	
	11:00 am									LA	Emp	
	12:00 pm										Emp	
	01:00 pm	DBF								↓	Emp	
Total Intake : Taken					Total Output : NOT PASSED					M-1-H		
8/7	02:00 pm									↓	Diags	
	03:00 pm											
	04:00 pm	DBF				✓			✓			
	05:00 pm											
	06:00 pm											
	07:00 pm	DBF										
Total Intake : taken					Total Output : m-1 u-1							
	08:00 pm					↓				↓	NA	
	09:00 pm											✓
	10:00 pm	DBF										
	11:00 pm						✓					
	12:00 am											
	01:00 am	DBF										
Total Intake : Taken					Total Output : m-0 u-2							
	02:00 am					✓				↓	NA	
	03:00 am	DBF										✓
	04:00 am											
	05:00 am	DBF										
	06:00 am						✓					✓
	07:00 am	DBF										
Total Intake :					Total Output : m-2 u-2							
Total 24 hrs. Intake			Taken			Total 24 hrs. Output			m-3 u-5			



FLUID CHART

Sheet No. : 2

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
9/7/26	08:00 am											
	09:00 am	DBF					✓			✓		
	10:00 am											
	11:00 am											
	12:00 pm	DBF										
	01:00 pm											
Total Intake :						Total Output : M-1 U-2						
9/7/26	02:00 pm	DBF										
	03:00 pm											
	04:00 pm	DBF										
	05:00 pm						✓					
	06:00 pm	DBF										
	07:00 pm	GBM 12ml										
Total Intake :						Total Output : M-1 U-2						
	08:00 pm											
	09:00 pm	DBF										
	10:00 pm											
	11:00 pm	DBF										
	12:00 am											
	01:00 am	DBF										
Total Intake :						Total Output : M-1 U-2						
	02:00 am											
	03:00 am	DBL										
	04:00 am											
	05:00 am	DBF										
	06:00 am											
	07:00 am	DBF										
Total Intake :						Total Output : M-2 U-2						
Total 24 hrs. Intake						Total 24 hrs. Output						



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	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score		
10/7			Mouth	I.V	N.G							
	08:00 am											
	09:00 am	DBF										
	10:00 am											
	11:00 am								✓	NA	Reath	
	12:00 pm	DBF										
	01:00 pm											
Total Intake :					Total Output : m-0 u-1							
10/7	02:00 pm	DBF										
	03:00 pm								✓			
	04:00 pm	DBF							✓			
	05:00 pm						✓				NA	Reath
	06:00 pm	DBF							✓			
	07:00 pm											
	Total Intake :					Total Output : 023 m=1						
	08:00 pm											
	09:00 pm	DBF										
	10:00 pm						✓		✓			
	11:00 pm	DBF									NA	stomach
	12:00 am								✓			
	01:00 am	DBF					✓					
	Total Intake :					Total Output : M-20-2						
	02:00 am											
	03:00 am	DBF							✓			
	04:00 am											
	05:00 am	DBF					✓				NA	stomach
	06:00 am								✓			
	07:00 am	DBF										
	Total Intake :					Total Output : M-20-3						
Total 24 hrs. Intake		Total 24 hrs. Output										
		M-40-8										

BAH-00660978 IP5-00176095
Baby Of ALUGANI MADHURI
08-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. NALINIKANTA PANIGRAHY



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: 8/7/26

Assessment: New born baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8:00am	⇒ Assess the baby	8:30am	⇒ Assessed the baby	Baby is fine
9:00am	⇒ DBF + Burping	9:30am	⇒ DBF + Burping given	
10:00am	⇒ provide warm care	10:30am	⇒ Baby wellrapped.	
11:00am	⇒ Ensure Safety	11:30am	⇒ crib Care provided.	
12:00pm	⇒ U/O monitoring	12:30pm	⇒ U/O monitoring done	
1:00pm	⇒ Prevent prevent infection	2:00pm	⇒ Hand Hygiene maintained	

Re-Assessment:

Special Notes: vaccination today
Trace baby blood group, vaccination today.

Nurse Signature: TM

Nurse Name: Tanna

Date & Time: 8/07/26 @ 2:00am

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 8/12/26

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
2 pm	→ ASSES the Baby condition	2:30 pm	→ ASSES the Baby condition	Baby is stable
3 pm	→ Monitor vital	3:30 pm	→ Vitals checked & Recorded	
4 pm	→ DBF and hourly	4:30 pm	→ DBF given and hourly	
5 pm	→ Maintain ILO chart	5:30 pm	→ Maintained ILO charting	
6 pm	→ maintain personal hygiene	6:30 pm	→ Maintained personal hygiene	
7 pm	→ ENSURE safety	7:30 pm	→ Ensured safety	

Re-Assessment: Re-assessment

Special Notes: 24 hour vitals TCBL, US scan, BSR, NBS, OAG

Nurse Signature: [Signature] Nurse Name: [Signature] Date & Time: 8/12/26 @ 8 pm

BAH-00660978 IP5-00176095
 Baby Of ALUGANI MADHURI .
 08-07-2026 0 Y 0 M 0 D 6 H (F)
 Dr. NALINIKANTA PANIGRAHY

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: ☐ Afternoon ☒ Night

Date: 8/7/26 @ 8pm.

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
8pm	Assess Baby's general condition.	8:10 pm	Assess Baby general condition.	Baby is stable.
10 pm	ensure safety.	10:10 pm	provided outcare	
	monitor vitals.		monitored vitals.	
12am	maintain fluid balance.	12:10 am	maintained I/O charting	
2am	maintain good nutritional status.	2:10 am	Feeding assessment done.	
4am	Patient family education.	4:10 am	educated family about hospital procedure.	
6am		6:10 am		

Re-Assessment: NA.

After Feeding Baby was stable.

Special Notes: LBR, NBC - HELD.

Nurse Signature: [Signature]

Nurse Name: Shins L

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

NURSING CARE RECORD

Shif ☒ Night

Assessment: new born Baby care

BAH-00660978
IPS-00176095
Baby of ALUGANI MADHURI.
08-07-2026 0 Y 0 M 0 D 6 H (F)
Dr. NAJUNIKANTA PANIGRAHY

Date: 9/7/24

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	=> Assess the patient Baby General condition	8:10 AM	=> Assessed the Baby General condition	
10am	=> Assess the Baby vitely signs	10:20 AM	=> Assessed the Baby vitely signs	Baby is stable
12pm	=> To maintain I/O chart	12:10 pm	=> maintained I/O chart	
1pm	=> To provide warmth care	1:15 pm	=> provided warmth care	
2pm	=> Ensure safety	2:10 pm	=> ensure safety	

Re-Assessment:

Special Notes: Baby is Good

SBH, NRS, OAC, 48 hrs

Nurse Signature: Deep Nurse Name: Deep

Date & Time: 9/7/24 @ 2pm

BAH-00660978 IP5-00176095
 Baby OF ALUGANI MADHURI.
 08-07-2026 0 Y 0 M 0 D 6 H (F)
 Dr. NALINIKANTA PANIGRAHY



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

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	1:30 pm	→ Assessed the Baby general condition on the crib	→ Baby was active & good feeding well
4pm	→ To monitor vitals	4:30 pm	→ monitored vitals	
5pm	→ To maintain Ilo chart	5:30 pm	→ maintained Ilo chart	
7pm	→ To give asb and crib care	7:30 pm	→ Given asb 2nd hly and provided crib care	

Re-Assessment:

Re-assessment has done after 1 hour the Baby was crying b/c of insufficient milk

Special Notes: Give the formula milk if parents demand after dr. advice

SBR, NB), asb @ 1hr 7am, It parents informed to the Supanjali mam she advised only

Nurse Signature:

Nurse Name: Perathi

Date & Time: 9/7/26 @ 8pm DBR

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: New born Baby care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	⇒ Assess the Baby 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	
12 Am	⇒ To monitor I/O chart		⇒ monitored Baby I/O chart	
2 Am	⇒ To plan DBF feed	12:10 Am	⇒ given every 2nd hourly feeding & burping	
4 Am	⇒ To plan warm care	2:10 Am	⇒ given Baby warm care	
6 Am	⇒ To plan ensure safety	4:10 Am	⇒ given Baby ensure safety	
8 Am	⇒ plan for SBR	6:10 Am	⇒ Done SBR	

Re-Assessment: Re-assessment has done Baby sucking well after 1 hour Baby was sleeping

Special Notes: True Represents Reports

Nurse Signature: Shrinika

Nurse Name: [Signature]

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

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/7/26

Assessment: Neonatal 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
8am	→ Assess the Baby General Condition	8:10 Am	→ Assessed the Baby General Condition	Baby is stable
10 Am	→ Assess the Baby vitals	10:20 Am	→ Assessed the patient vitals	
12pm	→ To maintain Ilo chart	12:10 pm	→ maintained Ilo chart	
1pm	→ To provide warmth care	1:10 pm	→ provided warmth care	
2pm	→ Establish for feeds	2:10 pm	→ Established for feeds	
	→ Encouraging Saffy		→ Encourage Saffy	

Re-Assessment:

Baby is Good

Special Notes:

SBR, RN

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 10/7/26 @ 2pm

BAH-00660978 IP5-00176095
 Baby Of ALUGANI MADHURI.
 08-07-2026 0 Y 0 M 0 D 16 H (F)
 Dr. NALINIKANTA PANIGRAHY

NURSING CARE RECORD

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Shift: ☒ Afternoon ☐ Night

Date: 10/7/26

Assessment: Baby under sspt (single surface phototherapy)

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 under sspt	
4pm	→ To monitor vitals	4:30 pm	→ monitored vitals	
5pm	→ To maintain Ilo chart	5:30 pm	→ maintained Ilo chart	
6pm	→ To continue sspt	6:30 pm	→ continued sspt for the Baby	
7pm	→ To provide crib care and feeding	7:30 pm	→ provided crib care and given feed 2nd baby	

Re-Assessment:

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

Special Notes:

SBR @ nmg 8am

Nurse Signature:  Nurse Name: Kevathi

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

BAH-00660978 IP5-00176095
 Baby Of ALUGANI MADHURI.
 08-07-2026 0 Y 0 M 0 D 6 H (F)
 Dr. NALINIKANTA PANIGRAHY

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/2

Assessment: (New) Baby under SSPT (Neonate 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
8pm	Assess the Baby General condition	8:05pm	Assessed the Baby General condition.	Baby well stable
10pm	Monitor the vitals.	10:05pm	monitored the vitals.	
12AM	Maintain Ilo chart.	12:05AM	Maintained Ilo chart.	
2AM	Provide comfortable position to Baby.	2:05AM	provided comfortable position to Baby.	
4AM	provide 2nd bowel. DBF and Burping	4:05AM	provided 2nd hourly DBF and Burping.	
7AM	Ensure safety.	7:05AM	Ensured safety.	

Re-Assessment: After feeding Baby was sleeping well under SSPT.

Special Notes: SBR done. Trace. Reports.

Nurse Signature: [Signature]

Nurse Name: Shishu

Date & Time: 11/7/26 0AM

BAH-00660978
Baby Of ALUGANI MADHURI .
08-07-2026 0 Y 0 M 0 D 6 H (F)
Dr. NALINIKANTA PANIGRAHY

IP5-00176095



Shift:

NURSING CARE RECORD



☐ Night

Date:

Assessment:

- 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

Re-Assessment:

Special Notes:

Nurse Signature: Nurse Name: Date & Time:

BAH-00660978 IP5-00176095
Baby Of ALUGANI MADHURI.
08-07-2026 0 Y 0 M 0 D 6 H (F)
Dr. NALINIKANTA PANIGRAHY



NURSING CARE RECORD


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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:

BAH-00660978

IP5-00176095

Baby OF ALUGANI MADHURI .

0 Y 0 M 0 D 6 H (F)

08-07-2026

Dr. NAJINIKANTA PANIGRAHY

Shift:

☐ Day ☐ Night

Assessment:

NURSING CARE RECORD

- 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. N. N. Panigrahy Department: 4w. Date of Admission: 9/7/26

SITUATION		Diagnosis: <u>New born baby.</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known		If Yes Specify: _____		
BACKGROUND	Area	<u>CRS</u> <u>2pm-7pm</u>	<u>OBS</u> <u>256 Pn</u>	<u>3rd floor</u> <u>8pm-2am</u>	<u>3rd floor</u> <u>2pm</u>	<u>3rd floor</u> <u>2pm-8pm</u>	<u>3rd floor</u> <u>8pm-2am</u>	
	Shift Time							
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.1°F</u>	<u>98.2°F</u>	<u>98.1°F</u>	<u>98.1°F</u>	<u>97.8°F</u>	
		Res:	<u>44</u>	<u>40b/m</u>	<u>40b/m</u>	<u>40b/m</u>	<u>40b/m</u>	
		SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	
		Pulse:	<u>143</u>	<u>140</u>	<u>140</u>	<u>130b/m</u>	<u>139b/m</u>	
		BP:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	
	Fall Risk Score:	<u>-</u>	<u>6</u>	<u>16</u>	<u>10</u>	<u>10</u>	<u>10</u>	
	Pain Score:	<u>0</u>	<u>0</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	
	Safety Needs:	<u>Yes</u>	<u>Crib care</u>	<u>Crib care</u>	<u>Yes</u>	<u>Crib care</u>	<u>Yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No		
Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>Vaccination</u> <u>Tealony</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	
Signature :		<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	
Date:		<u>9/7/26</u>	<u>9/7/26</u>	<u>9/7/26</u>	<u>9/7/26</u>	<u>9/7/26</u>	<u>10/7</u>	
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	
Signature :		<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	<u>Shirisha</u>	
Date:		<u>9/7/26</u>	<u>9/7/26</u>	<u>9/7/26</u>	<u>9/7/26</u>	<u>9/7/26</u>	<u>10/7/26</u>	
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Shrutthi Reddy Department: 3rd floor Date of Admission: 8/1/26

SITUATION	Diagnosis: <u>NB</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	<u>3rd floor</u> <u>2pm</u>	<u>3rd floor</u> <u>2pm</u> <u>8pm</u>	<u>3rd floor</u> <u>8pm</u> <u>6Am</u>			
	Shift Time						
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>NB</u>	<u>NB</u>	<u>NB</u>			
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>99.0°F</u>	<u>98.0</u>	<u>98.1</u>			
	Res:	<u>20b/m</u>	<u>40b/m</u>	<u>40b/m</u>			
	SpO ₂ :	<u>99b/m</u>	<u>100%</u>	<u>100%</u>			
	Pulse:	<u>120b/m</u>	<u>120b/m</u>	<u>121b/m</u>			
	BP:	<u>-</u>	<u>-</u>	<u>-</u>			
	Fall Risk Score:	<u>-</u>	<u>-</u>	<u>-</u>			
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>			
RECOMMENDATIONS	Safety Needs:	<u>yes</u>	<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>	<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>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>Divya</u>	<u>Ravathi</u>	<u>Shruthi</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>10/7/26</u>	<u>10/7/26</u>	<u>11/7/26</u>			
Time:		<u>@ 2pm</u>	<u>@ 8pm</u>	<u>@ 8am</u>			
Taken Over By Name :		<u>Ravathi</u>	<u>Shruthi</u>	<u>Divya</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>10/7/26</u>	<u>10/7/26</u>	<u>11/7/26</u>			
Time:		<u>@ 2pm</u>	<u>@ 8pm</u>	<u>@ 8am</u>			

BAH-00660978 IP5-00176095
 Baby Of ALUGANI MADHURI.
 08-07-2026 0 Y 0 M 0 D 1 H (F)
 Dr. NALINIKANTA PANIGRAHY

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THE HUMPTY DUMPTY SCALE

8/1/26 8/1/26 8/7 9/7 10/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	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	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3	3	3	3	3	3
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			14	14	19	19	19

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	X	X	X	X	X
Call device within reach	X	X	X	X	X
Wheels Locked	✓	✓	✓	✓	✓
Room free of clutter	✓	✓	✓	✓	✓
Adequate Lighting	✓	✓	✓	✓	✓
Wheel Chair Support	X	X	X	X	X
Other Intervention(s) Specify	X	X	X	X	X
Nurse's Name :	Rune	ppp	St	St	St
Signature :	TM	Th	Q	flw	St
Date :	8/1/26	8/1/26	8/7/26	9/7	10/7
Time :	8AM	2PM	10PM	2PM	8AM

BAH-00840244
Mrs ALUGANI MADHURI .
06-06-1994 32 Y 2 M 1 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

THE HUMPTY DUMPTY SCALE

PATIENT	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	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					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	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				
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3	3				
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1				
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	2				
	Other Medications / None	1	1				
Total			11				

Intervention:

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

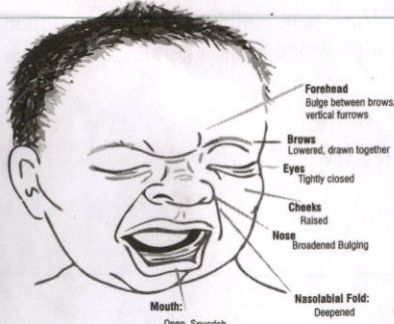
High Risk Humpty Dumpty Score = 12 or above

Bed in low position		x				
Call device within reach		x				
Wheels Locked		✓				
Room free of clutter		✓				
Adequate lighting		✓				
Wheel chair support		x				
Other Intervention(s) Specify		x				
Nurse's Name:		Shruti				
Signature:		Shruti				
Date:		11/9/2				
Time:		2AM				

BAH-00660978 IP5-00176095
 Baby Of ALUGANI MADHURI .
 08-07-2026 0 Y 0 M 0 D 1 H (F)
 Dr. NALINIKANTA PANIGRAHY



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
						8/17/2026	8/17/2026	8/17/2026	10/7/2026	11/9/2026			
						8 AM	8 PM	6 AM	6 AM	6 AM			
						NA	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	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	0			
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0	0	0			
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0	0			
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0	0			
 Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention						Gestational Age / Corrected Age	39+3 wks	39+3 wks	39+3 wks	39+3 wks	39+3 wks		
						Total Pain / Agitation Score	0	0	0	0	0		
						Intervention	NA	NA	NA	NA	NA		
						Effectiveness	NA	NA	NA	NA	NA		
						Signature	Tunh	Wjs	NA	NA	NA		

NPASS: Neonatal Pain, Agitation & Sedation Scale

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

BAH-00660978

IP5-00176095

Baby Of ALUGANI MADHURI.

08-07-2026 0 Y 0 M 0 D 6 H (F)

Dr. NALINIKANTA PANIGRAHY



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 :	8/7/26	8/7/26	8/7/26	9/7/26
					Time :	8 AM	2 to 5 PM	1 PM	6 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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		2	2	2	2
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		1	1	1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		2	2	2	2
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		3	3	3	3
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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		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.		4	4	4	4
					TOTAL SCORE	18	18	18	18
					Evaluator's Name	Tunne	Mi	8	8

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

Docu. No. : RCHBH / FRM / CLINICAL / 119

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

Patient ID

BRADEN 'Q' SCALE

				Date :	10/7	11/7		
				Time :	6am	6AM		
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"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		
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TOTAL SCORE					18	18		
Evaluator's Name					S	8		

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

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PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660978 IP5-00176095 Baby Of ALUGANI MADHURI. 08-07-2026 0 Y 0 M 0 D 5 H (F) Dr. NALINIKANTA PANIGRAHY		Date & Time of Admission 8/7/26 8:11 AM	Date & Time of Transfer Order 8/7/26 @ 4:10 PM
		Transfer Ordered by Dr. Nalinikanta.	Reason for Transfer obscuranticy
From Unit ORS	To Unit Room (339)	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.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Sis. priya		Name of Person Ordered Transfer Dr. Nalinikanta.	
Patient & Clinical Records Received by : Dingy			
Date & Time of Patient Received : 8/7/26 @ 4:20 PM			

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

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

BAH-00660978 IP5-00176095
Baby Of ALUGANI MADHURI .
08-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. NALINIKANTA PANIGRAHY

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 10/7/26

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 baby needs assistance -

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Infection Control

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: TM

Nurse Name: Gunna

Date and Time: 8/7/26 @ 8 AM