

BAH-00660640
Baby Of KEERTHI
29-06-2026 0 Y 0 M 7 D (M)
Dr. VIJAYANAND JAMALPURI
IP5-00175944

2

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name : _____

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

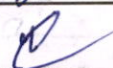
	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
14/7/26	Nebulization	(2)	9203666	B
15/7	Neb	(2)	9204802	
16/7/26	Nebulization	(2)	9205996	B
16/7	Nebulization	(2)	9206596	
17/7/26	Nebulization	(2)	9207130	B
18/7/26	Nebulization	(2)	9208866	B

ANY OTHER INFORMATION

.....

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.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00660840 IP5-00175944
 Baby Of KEERTHI
 29-06-2026 0 Y 0 M 5 D (M)
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WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	DR. Rameh	6/2/26	9890547	L
2	Dr. vidhi	8/1/26	9693275	hyn
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
3/7/26	NPI, MgSO ₄ , IFT	26066790	}
"	PTA PTT, Blood C/s Blood Gr	"	
"	oufing	"	
"	VBG, RBS	26066789	
"	CXR — (1)	R265-033136	}
	VBC GRB	26067090	
	Ammonia	26066958	
	CEC	033323	
	NBS	26067064	Deeny
4/7/26	Urine GCMS	26067161	}
	CBP,	26067233	
	VBG, RBS	26067232	
6/7/26	VBC, RBS	26067469	}
	chest - x-ray abdomen	265-033453	
	RBS	26067759	
7/7/26	RBS, VBC	26067794	}
7/7/26	CBP, CRP, SBR	26067798	
8/7/26	VBC, RBS		}
9/7/26	SBR, RBS	26068485	
11/7/26	RBS	26069257	}
12/7/26	RBS	26069649	
13/7/26	BA 260699 RBS	26069928	}
14/7/26	RBS	26070354	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
4/7/26	Inv monitor	3/7/26		9686484	}
"	Ventilator	"		9686484	
"	Syp pump	"		9686484	
4/7/26	SSPT	.			Deen
5/7/26	Inv monitor	3/7/26		9686484	}
"	Ventilator	"		9686484	
"	Syp pump	"		9686484	
"	SSPT	4/7/26		9688063	
6/7/26	Inv. monitor	3/7/26		9686484	}
	ventilator	"		9686484	
	Syp pump	"		9686484	
	C-PAD	5/7/26		9689443	}
	oxygen	"		"	
	SSPT	11:30pm 6/7/26		9696825	Q
7/7/26	Inv. monitor	3/7/26		9686484	}
	C-PAD	6/7/26			
	O2			9689443	
	Syp pump	3/7/26		9686484	
	SSPT	6/7/26		9990825	2
8/7/26	Inv. monitor	3/7/26		9686484	}
	C-PAD	7/5/7/26		9689443	
	oxygen				
8/7/26	SSPT	6/7/26	8/7/26 4:20pm	9990825	Nauf

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

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.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor.



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 : IP5-00175944

Admit Date : 03-Jul-2026

Admit Time : 10:56 PM UHID : BAH-00660640

Patient Details :

Patient Name : Baby Of KEERTHI
Guardian : Mr BASAVENI SURENDAR
Gender : Male
Occupation :
Address (H) : #68-379 2ND ZONE Mandamarri Coll
Adilabad Telangana INDIA 504231

Age : 0 Y 0 M 4 D
DOB : 29-06-2026 01:00 AM
Religion :
Marital Status : Single
Phone No : 9502550632/ 9959035375
E-mail : nomailid@gmail.com

(upto 18)
961835 5528

Admission Details :

Bed Type : NICU
Room No : NICU 272

Bed No : NICU 272
Admission Type : First Visit

Ward Name : 2F-NICU 3

Contact Details :

Name : Mr BASAVENI SURENDAR
Contact Address : #68-379 2ND ZONE Mandamarri Coll Adilabad
Telangana INDIA 504231
Relationship : Father
Phone No : 9502550632 / 9959035375

Signature

Doctor Details :

Doctor Name : Dr. VIJAYANAND JAMALPURI
Referral Doctor : SELF
Co-Consultant :

Specialisation : NEONATAL INTENSIVE CARE
Phone No :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00
Payor Name : SELF PAY



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 Keerthi Mother's Blood Group : A ⊖ ve
Gender : ☒ M ☐ F Blood Group : AB ⊖ ve Birth Weight (gms) : 2.07 kg Length (cms) :
Date of Birth : 29/6/26 Time of Birth : 9:30 PM OFC (cms) :
Place of Birth : Suraksha Hospital Jamnukunta Estimated Gesth Age : 36 weeks, 37 weeks
Current Obstetric History : (Booked / Unbooked Case)
Maternal Age : 34 yrs Ht : Wt : BMI : Married Life : 2016 LMP : 9/10/25 EDD : 16/7/26
Conception : Spontaneous or with Rx : Spontaneous
Booked at what GA : AN Steroids Drugs / Doses :
Last Scans Details : 17/6/26 → 34 + 4, AFI - 10.9 cm,
TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ < 18 yrs ☐ > 35 yrs TIFFA - ⊖
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 ?

(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 :

Patient Sticker

PAST OBSTETRIC HISTORY

G: 4 P: 3 A: 1 L: 1 D-1

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
G1	2017	→	IUD at 8 months			
G2	2019	→	MISOP at 5 months	1W/O	THFA	No heart beat
G3	2019	→	Full term	Female	→ 6 yrs	→ AGH

PERINATAL HISTORY

Treating Obstetrician: G4 → PP Hospital: ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS: ☐ Elective ☒ Emergency Indication:

Specify the reason: in v/o. oligohydramnios

Augmentation of Labour: ☒ Induced ☐ Assisted VaginalCTG: ☐ Normal ☐ Suspicious ☐ Pathological

MSL:

Resuscitation: ☐ Yes ☐ No

Cord ABG: Required Base must for 1 min.

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

NEONATAL RESCUSTITATION DETAILS

APGAR SCORE

Gestational Age: Weeks:

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

1 Minute	5 Minutes	10 Minutes
5/10	Not known	6/10

TOTAL

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

Snares II Score

Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints:

- Fej vit-K given at birth.

HEAD TO TOE EXAMINATION

HEAD :

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

} ②

FACIES :

(Any Facial
Dysmorphism)

} ②

NECK and
CLAVICLES :

Range of Motion :
Asymmetry :
Masses :

} ②

EYES :

Symmetry :
Red Reflex :
Discharge :

} B/L pupils equal & reactive
to light.

EARS, NOSE
MOUTH and
THROAT :

Ear set / Shape :
Periauricular Pits / Tags :
Nasal shape / Patency :
Palate :
Gums :
Lips :
Tongue :

} ②

THORAX and
BREASTS :

Shape of Thorax :
Position of Nipples and Number :

} ②

ABDOMEN and
UMBILICUS :

Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump :
Discharge :

} ②

GENITILIA :

Labia / Hymen :
Testicles/penis :
Anus :

} .

HERNIAL ORIFICES

} free

TRUNK and SPINE :

} ②

SKIN LESIONS :

} ②

EXTREMITIES :

Fingers / Toes :
Deformities :
Hip Joint Examination :

Arms / Legs :

Mobility :

SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☐ Regular ☐ Periodic ☐ Shallow ☐ Gasping

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

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

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

Settings :

SpO₂: 96% on MV Auscultation: 4 S2 ⊕ Breath Sounds: BL air entry ⊕ Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 120/min BP : Precordial Activity : NO

Femoral Pulses : felt Murmurs : NO

Other Peripheral Pulses : Signs of Cardiac Failure :

ABDOMEN:

Shape : Hernia orifice :

Palpation : Anal Patency : present

Palpable masses : Umbilical Cord :

Abdominal girth : First urine passed : passed

Meconium passed : passed

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness : Encephalopathic

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone :

Active Tone : ↑ tone in all limbs

Neonatal Reflexes :

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

Moro's : DTR :

ATNR : Skull and Spine :

History of Present Illness:

DOL-1 → Delivered by Em. LSCs at Suraksha Hospital, Jamnukunta

↓
Did not cry immediately after birth, Required bag & mask for 1 min. ↓

Shifted to Krishna Hospital, Jamnukunta immediately, where baby was on low flow oxygen, IV bleed, minimal feeds. ↓

At 22 HOD (30/6/26) → Baby was referred to Amrutha Hospital 11/10. RD and poor sensorium.

Started on CPAP support, IV bleed and minimal feeds.

DOL-2 → NSG - Normal,

1/7/26 → Started on phototherapy 11/10. jaundice. (SBR-12.9),
NBS done ^{TMS} - Normal
DCT - negative, Retic count - 1.5,

DOL-3 (2/7/26) → on CPAP, 1 episode of seizure noticed and loaded with levipil and continued on maintenance dose of levipil.
Ammonia - 105 mcg/dl, urine for reducing sugars - Normal
~~Lactate - 27 mg/dl~~

Investigation details in previous Hospital:

DOL-4 (3/7/26) → In view of altered sensorium and depressed breathing pattern, intubated $\bar{c}$ 3 size ETG fixed at 8.5 cm.

Feeding → on DOL-2, Started on minimal feeds,
In view of encephalopathy on NPO from DOL-3.

Feeding History:

Sepsis → started on DOL-2 with Meropenem & Amikacin.
Added Vancomycin on DOL-4 (3/7/26).

2DEcho → mild TR,
Small PDA

Past History :

	<u>1/7/26</u>	<u>2/7/26</u>	<u>3/7/26</u>
30/1/26	Hb-16g	Hb-15g/l	Hb-15g
Hb-16	WBC-14,600	WBC-11,000	WBC-8,500 (63% / 30%)
WBC-15,600	Plt-114k	Plt-98,000	Plt-114k
Plt-93,000			CRP-14 mg/L (0 to 6 mg/L)

Family History :

CPP-7 mg/dl	SBR-13 mg/dl (0.6 CC) (12.4)	Urea-36
PT-18	p-Amino-105 mg/dl	creat-0.6
INR-1.5	lac-27 mg/dl	SBR-13.8
APTT-39		SGOT-135
SBR-9.9		SGPT-62

Socio Economic History :

AST-33
ALT-18

GENERAL EXAMINATION ON ADMISSION

General Disposition :

General Disposition : [Faint handwritten notes]

VITALS : Temperature : 36.5° HR : 120 RR : 30/min NIBP : CFT : 3 sec

Color of the extremities : pink

Jaundice : Pallor : SpO2 :

ANTHROPOMETRY: Birth Weight : 2070 g Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

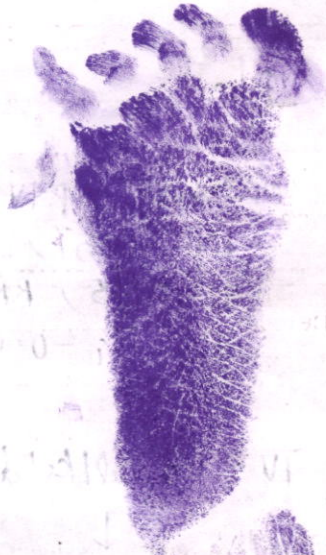
Any Congenital Anomalies :

Diagnosis :

Term / EM-1SCS / LGA / Birth Asphyxia / ? HIE-III /
 Thrombocytopenia / Suspected sepsis

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : Dr. Azeem

Name : Dr. Azeem

Date & Time : 3/7/26, 7:00 pm

Consultant :

Signature : Dr. VIJAYANAND JAMALPURI
Reg. No. 40526

Name : DR. VIJAYANAND JAMALPURI

Date & Time : 3/7/26 7PM

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 :

- On RRT arrival ,

Plan:

Medications :

on PTV mode,

fio₂ - 25%;

14/5,

RR - 25/uein

Ti - 0.40

- Continue PTV mode

fio₂ - 25%;

14/5, RR - 30/uein,

Ti - 0.40

Plan during ward follow up :

VBG - pH - 7.33/38/56

HCO₃ - 11,

Base excess - -5

RBS - 93 mg/dL

SPO₂ - 96%.

RR - 12/uein

RR - 30/uein

Bp - 76/50/60

- TV - 110 uL/kg/day

↓

10% Iso pt

3 uL/kg calcium
gluconate

Feeding Plan at the time of shifting :

RR - 12/uein

RR - 30/uein

Bp - 76/50/60

- Send NP, Magnesium

LFT, Blood c/s,

Blood Blood gas

grouping, RBS, coagulation profile

CXR.

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

- MRI Brain Tomorrow

- Neuro opinion tomorrow.

- Rlv EEG.

- Continue Meropenem,

- Rlv antibiotics after
NP1 reports. levipil.

Doctor Signature (Handover Given):

Doctor Signature (Handover Taken):

Doctor Name:

Doctor Name:

Date & Time:

Date & Time:



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

Day in NICU: Day of Life: 18 PMA:
Term ☐ Preterm ☐ Gestation: 37 Corrected Gestational Age: 27 Today's Weight: 2.435 (110g)

	Problems		
	S.No.	Current	Past Problems
Overview	1.	Term Birth Asphyxia	NAJ.
	2.	HIE Stage III Neonatal encephalopathy	Suspected sepsis
	3.	Neonatal Seizure.	Thrombocytopenia.
	4.	Aspiration pneumonia	
	5.	2 IEM	
	6.	Dysmorphism	
Clinical Assessment	on low flow 0.6 L/min. RD: tachypnea (+) / ICE (+). hypertonia (+) / spasticity (+) oral Suctioning: (+) HR: 152/min. SpO₂: 100% Rps 67/37 mmHg		
Medications Used	Cefepim Lacosamide. Bt-lad. vitamin D3 Calamex + ly. Amoxiclav D3.		
Plan of Care:	1. ct low flow 0.6 L/min - Target SpO₂ 90-95%. 2. chest physiotherapy 3. oral pre feed 4. Suctioning as needed		

Doctor's Name (Hand over given): Dr. White

Signature: [Signature]

Date & Time: 18/7/23

Doctor's Name (Hand over taken):

Signature:

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/9	cls & <u>ASV9</u>	Plan
		1. wean O ₂ support as tolerated
		2. w/f seizures.
	<u>Peripheral IV line: D₅</u>	3. IF cannula out then oral abx - total 7 days.
		4. omc.
		5. O ₂ feeds
		6. Plw parents for transfer of care
		

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7 2:30 PM	C/S/B RESIDENT. DOL-18 PMG: 39+4.	Plan 1. On low flow 0.2lit/min. target SpO ₂ 90-95.
	on low flow - 0.2lit/min.	
	RD: tachypnea (+) ScR (+) ICE (+)	2. W/F apnea/seizures.
	oral secretions (+)	3. TD Tr: 150ml/kg/day. 28-30ml/2nd hourly or feeds
	No Seizures/apnea. on OG Feeds	4. Chest physio.
	Fls soft distended.	5. OMS prefeed.
	HR: 162/min	6. IF cannula is out, change N antibiotics to oral abx.
	SpO ₂ : 98	7. Suctioning as needed
	Rps 68/41mmHg	
	Noted by Yyune 18/7/26 @ 3:50 PM	
		Seen by Dr. Vijayanand
		- Wean O ₂ as tolerated
		- Cont-antibiotics
		- Full OG feed



Q1

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/1/12		
10/1/12		
6:30 am		
	Pre fed sugar = 47 mg/dl	Plan
		⇒ Give 10% Dextrose bolus @ 2ml/kg
		⇒ Give 30ml feed
		⇒ Recheck sugar then.
		Rup



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/24		Sanby Dr. Nish
	↑ 1 bms Poor suck	→ Continue low flow oxygen → bms b/f each feed → Plan transfer of care
19/7/24 5pm	Evening Rounds	Plan
	Baby on low flow 0.2 L/min tachypnea ⊕ SCA ⊕ Secretions ⊕ B/L pedal edema ⊕ HR - 152/min SpO ₂ - 92% RR - 69/min BP - 66/44 (54) mmHg CRBS - 22mg/dL	→ continue low flow oxygen - +V-150cc/12/day 28-30ml/2hr/kg - full oxygen - suctioning as needed - continue medications - chest physiotherapy - CRBS - BD - pre feed → Change position R to L
		Pause

Date & Time	Progress Notes	Doctor's Order
19/7/26	on low flow	<u>Keepy B&N</u>
9pm	B/L pedal edema (+)	→ continue low flow
		→ one before each feed
		→ Transfer of care
		<i>AK</i>

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

Day in NICU: Day of Life: 19 PMA:

Term ☐ Preterm ☐ Gestation: 37 Corrected Gestational Age: Today's Weight: 2.454 (116gms)

Problems		
S.No.	Current	Past Problems
1.	Term / Birth Asphyxia	NAI
2.	HIE Stage III / Neonatal encephalopathy	Suspected Sepsis
3.	Neonatal Seizures.	Thrombocytopenia.
4.	Aspiration pneumonia	
5.	GIEM	
6.	Dysmorphism.	

Clinical Assessment
on low flow O₂ sat 90%. ↓ lateral nursing. RD: tachypnea ⊕ / SCL ⊕. Secretions ⊕. Distal clonus ⊕ Hypotonia + Spasticity + HR: 150/min SpO₂: 100%. Had 1 c/o hypoglycemia in the morning, ?

Medications Used
Paripal Amoxiclav 1.7. Levosimide 3-NAcl Vitamin D3 Caldmax +

Plan of Care:
1. ct low flow O₂ sat 90-95% Target SpO₂ 90-95% 2. chest physiotherapy 3. IV: 150ml/kg/day - 28-30ml/2nd hourly full of feeds 4. RBS - BD. prefeed. 5. Suctioning as needed 6. change position every 4hrs

Doctor's Name (Hand over given): Dr. V. K. Srinivas

Signature: [Signature]

Date & Time: 12/7/22

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:

Patient Sticker

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

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

		Problems	
		S.No.	Current
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Signature:

Date & Time:

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:

20/7/2026

Weekly wt: 129 grams
Hct 35
L: 48cm

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

Day in NICU: Day of Life: 20 PMA:

Term ☐ Preterm ☐ Gestation: 37 Corrected Gestational Age: Today's Weight: 2.521 (↑ 96 gms)

Problems		
S.No.	Current	Past Problems
1.	Term Birth asphyxia	N/A
2.	AIE stage III / Neonatal Encephalopathy	Suspected sepsis
3.	Neonatal seizures	Thrombocytopenia
4.	Aspiration pneumonia	
5.	? IEM	
6.	Dysmorphism / Bilateral pedal edema	

Clinical Assessment
on low flow 0.2 lit/min. Tachypnea (+); Ice (+) Secretions: (+) / thick. Bilateral pedal edema. Hypertonia (+) / spasticity (+) No further seizures W/O: RRS: 61 mg/dl. HR: 147/min Spo2: 96% Bp: 81/45 mmHg

Medications Used
Levetiracetam Lacosamide. Sf. Nal. Amoxicillin Vitamin D3 Celamex +

Plan of Care:
1. low flow 0.2 lit/min. Target Spo2 90-95%. 2. TR: 15ml/kg/day : 20-30ml/2nd hourly or feeds. 3. chest physiotherapy 4. RRS - BD prefeed. 5. Suctioning as needed, left 6. change position ← 2hrs up - 2hrs right up.

Doctor's Name (Hand over given): Dr. Vishith

Signature: [Signature]

Date & Time: 20/7/26

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken): Dr. Arishwarya

Signature: [Signature]

Date & Time: 20/7/26

Patient Sticker

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

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

	Problems		
	S.No.	Current	Past Problems
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Signature:

Date & Time:

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

42



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

42

[illegible]

IP5-00175944

Baby Of KEERTHI

29-06-2026

0 Y 0 M 19 D

(M)

Dr. VIJAYANAND JAMALPURI



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



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

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

①

RESULT SHEET

Date	4/7/26	5/7/26	7/7/26	9/7/26	14/7/26	
Time	1 am	8 am	6 am		9:30 pm	
Hb	17.5	17.4	17.6			
PCV	54.2	54.8	55.5			
RBC	5.46	5.49	5.60			
WBC	5.86	9.46	7.85			
N/L	36.2 / 40.5	30.0 / 46.9	23.4 / 63.1			
Platelets	82	89	133			
CRP	19		6			
ESR						
PCT						
RBS						
Na	141				133	
K	4.9				4.9	
Cl	116				107	
Ca/Mg	2.5				8.1 / 1.6	
Phosphate						
Urea	28					
Creatinine	0.6					
ALP	191					
SGPT	21					
SGOT	54					
T.Bill/Conj	14.3 < 1.2		14.2 < 1.0	9.7 < 0.14	9.3	
T.Protein	5.1					
S.Albumin	2.7					
S.Globulin	2.4					
A/G Ratio	2.4					
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR	17 / 1.3					
APTT	37					
CSF Protein / Sugar						
Cells						
N/L						



DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY: Name Signature



REGULAR PRESCRIPTIONS

Weight. 2kg Ward.

DRUG : INJ. MEROPENEM

Dose	Route	Frequency	Start Date
80mg	IV	Q8H	3/3/24

Name & Signature of the Doctor Starting the Drugs:

Dr. Poojitha

Additional Instructions:

4mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG : INJ. LEVIFALL

Dose	Route	Frequency	Start Date
30mg	IV	Q8H	3/3/24

Name & Signature of the Doctor Starting the Drugs:

Dr. Poojitha

Additional Instructions:

15mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG : Syr. LEVIPIL

Dose	Route	Frequency	Start Date
0.3ml	PO	8/24hr	8/2/24

Name & Signature of the Doctor Starting the Drugs:

Dr. Aneela

Additional Instructions:

1ml = 100mg
15mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG : Vitamin D3 drops

Dose	Route	Frequency	Start Date
0.5ml	PO	OD	9/2/24

Name & Signature of the Doctor Starting the Drugs:

Dr. Aneela

Additional Instructions:

1ml = 800 IU

Daily Doctor's Endorsement by a Sign

Ward

DRUG : <u>Syn-AUGMENTIN Duo</u>				Date <u>19/7</u>
Dose <u>1ml</u>	Route <u>P/O</u>	Frequency <u>12H</u>	Start Dt. <u>19/7</u>	Time <u>12/1</u>
Name & Signature of the Doctor Starting the Drugs: <u>[Signature]</u>				<u>[Signature]</u>
Additional Instructions: <u>22.5mg/kg/dose</u> <u>5ml/200mg (Amoxicillin)</u> <u>200mg (Pot-clarithromycin)</u>				<u>6 PM</u> <u>[Signature]</u>
Daily Doctor's Endorsement by a Sign				<u>[Signature]</u>

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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

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

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

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

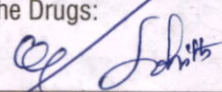
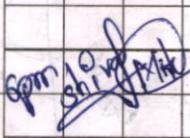
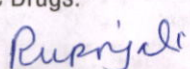
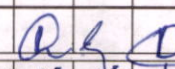
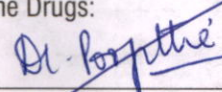
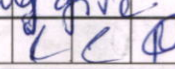
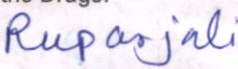
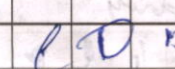
VERIFIED BY : Name Signature

Sheet No:

REGULAR PRESCRIPTIONS

Weight 0.25

Ward

DRUG : Neb BUDECORT				Date	Time															
Dose	Route	Frequency	Start Dt.	10/7	11/7	12/7														
0.25mg	Neb	12H	10/7	6pm	X	X														
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				Respuce = 0.5mg → to give 1/2 respuce																
Daily Doctor's Endorsement by a Sign																				
DRUG : 3.1. Nael				Date	Time															
Dose	Route	Frequency	Start Dt.	11/7	12/7	13/7	14/7	15/7	16/7	17/7	18/7	19/7	20/7							
100ml	Neb	6H	11/7	10am	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				2.5ml 3.1. Nael																
Daily Doctor's Endorsement by a Sign																				
DRUG : T. GLYCOPYRROLATE				Date	Time															
Dose	Route	Frequency	Start Dt.	11/7	12/7	13/7	14/7	15/7	16/7	17/7	18/7	19/7	20/7							
10mg	PO	Q8H	11/7	6am	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				(1 tab = 1mg) 50mg/kg/dose 1 tab + 10ml D. water → 1ml = 100mcg → take 1.1ml of it and give.																
Daily Doctor's Endorsement by a Sign																				
DRUG : SYPLEVIRIL				Date	Time															
Dose	Route	Frequency	Start Dt.	12/7	13/7	14/7	15/7	16/7	17/7	18/7	19/7	20/7								
0.3ml	PO	3H	12/7	6am	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)	(M)
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				15mg/kg/dose.																
Daily Doctor's Endorsement by a Sign																				

Sheet No:

REGULAR PRESCRIPTIONS

Weight ^{2.5} 2.5 kg Ward

DRUG : SyPLALOSAMIDE				Date Time	15/7	16/7	17/7	18/7	19/7	20/7	21/7	22/7	23/7	24/7	25/7	26/7	27/7	28/7	29/7	30/7	31/7	1/8	2/8	3/8	4/8	5/8	6/8	7/8	8/8	9/8	10/8	11/8	12/8	13/8	14/8	15/8	16/8	17/8	18/8	19/8	20/8	21/8	22/8	23/8	24/8	25/8	26/8	27/8	28/8	29/8	30/8	31/8	1/9	2/9	3/9	4/9	5/9	6/9	7/9	8/9	9/9	10/9	11/9	12/9	13/9	14/9	15/9	16/9	17/9	18/9	19/9	20/9	21/9	22/9	23/9	24/9	25/9	26/9	27/9	28/9	29/9	30/9	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10	11/10	12/10	13/10	14/10	15/10	16/10	17/10	18/10	19/10	20/10	21/10	22/10	23/10	24/10	25/10	26/10	27/10	28/10	29/10	30/10	31/10	1/11	2/11	3/11	4/11	5/11	6/11	7/11	8/11	9/11	10/11	11/11	12/11	13/11	14/11	15/11	16/11	17/11	18/11	19/11	20/11	21/11	22/11	23/11	24/11	25/11	26/11	27/11	28/11	29/11	30/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12	8/12	9/12	10/12	11/12	12/12	13/12	14/12	15/12	16/12	17/12	18/12	19/12	20/12	21/12	22/12	23/12	24/12	25/12	26/12	27/12	28/12	29/12	30/12	31/12
Dose	Route	Frequency	Start Dt.																																																																																																																																																																											
10mg	PO	BD	15/7																																																																																																																																																																											
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Daily Doctor's Endorsement by a Sign																																																																																																																																																																														
DRUG : SyP-CALCIMAX +				Date Time	15/7	16/7	17/7	18/7	19/7	20/7	21/7	22/7	23/7	24/7	25/7	26/7	27/7	28/7	29/7	30/7	31/7	1/8	2/8	3/8	4/8	5/8	6/8	7/8	8/8	9/8	10/8	11/8	12/8	13/8	14/8	15/8	16/8	17/8	18/8	19/8	20/8	21/8	22/8	23/8	24/8	25/8	26/8	27/8	28/8	29/8	30/8	31/8	1/9	2/9	3/9	4/9	5/9	6/9	7/9	8/9	9/9	10/9	11/9	12/9	13/9	14/9	15/9	16/9	17/9	18/9	19/9	20/9	21/9	22/9	23/9	24/9	25/9	26/9	27/9	28/9	29/9	30/9	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10	11/10	12/10	13/10	14/10	15/10	16/10	17/10	18/10	19/10	20/10	21/10	22/10	23/10	24/10	25/10	26/10	27/10	28/10	29/10	30/10	31/10	1/11	2/11	3/11	4/11	5/11	6/11	7/11	8/11	9/11	10/11	11/11	12/11	13/11	14/11	15/11	16/11	17/11	18/11	19/11	20/11	21/11	22/11	23/11	24/11	25/11	26/11	27/11	28/11	29/11	30/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12	8/12	9/12	10/12	11/12	12/12	13/12	14/12	15/12	16/12	17/12	18/12	19/12	20/12	21/12	22/12	23/12	24/12	25/12	26/12	27/12	28/12	29/12	30/12	31/12
Dose	Route	Frequency	Start Dt.																																																																																																																																																																											
2ml	PO	12H	15/7																																																																																																																																																																											
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DRUG : SyP-CALCIMAX +				Date Time	15/7	16/7	17/7	18/7	19/7	20/7	21/7	22/7	23/7	24/7	25/7	26/7	27/7	28/7	29/7	30/7	31/7	1/8	2/8	3/8	4/8	5/8	6/8	7/8	8/8	9/8	10/8	11/8	12/8	13/8	14/8	15/8	16/8	17/8	18/8	19/8	20/8	21/8	22/8	23/8	24/8	25/8	26/8	27/8	28/8	29/8	30/8	31/8	1/9	2/9	3/9	4/9	5/9	6/9	7/9	8/9	9/9	10/9	11/9	12/9	13/9	14/9	15/9	16/9	17/9	18/9	19/9	20/9	21/9	22/9	23/9	24/9	25/9	26/9	27/9	28/9	29/9	30/9	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10	11/10	12/10	13/10	14/10	15/10	16/10	17/10	18/10	19/10	20/10	21/10	22/10	23/10	24/10	25/10	26/10	27/10	28/10	29/10	30/10	31/10	1/11	2/11	3/11	4/11	5/11	6/11	7/11	8/11	9/11	10/11	11/11	12/11	13/11	14/11	15/11	16/11	17/11	18/11	19/11	20/11	21/11	22/11	23/11	24/11	25/11	26/11	27/11	28/11	29/11	30/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12	8/12	9/12	10/12	11/12	12/12	13/12	14/12	15/12	16/12	17/12	18/12	19/12	20/12	21/12	22/12	23/12	24/12	25/12	26/12	27/12	28/12	29/12	30/12	31/12
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Daily Doctor's Endorsement by a Sign																																																																																																																																																																														
DRUG : Tab LANSOPRAZOLE				Date Time	15/7	16/7	17/7	18/7	19/7	20/7	21/7	22/7	23/7	24/7	25/7	26/7	27/7	28/7	29/7	30/7	31/7	1/8	2/8	3/8	4/8	5/8	6/8	7/8	8/8	9/8	10/8	11/8	12/8	13/8	14/8	15/8	16/8	17/8	18/8	19/8	20/8	21/8	22/8	23/8	24/8	25/8	26/8	27/8	28/8	29/8	30/8	31/8	1/9	2/9	3/9	4/9	5/9	6/9	7/9	8/9	9/9	10/9	11/9	12/9	13/9	14/9	15/9	16/9	17/9	18/9	19/9	20/9	21/9	22/9	23/9	24/9	25/9	26/9	27/9	28/9	29/9	30/9	1/10	2/10	3/10	4/10	5/10	6/10	7/10	8/10	9/10	10/10	11/10	12/10	13/10	14/10	15/10	16/10	17/10	18/10	19/10	20/10	21/10	22/10	23/10	24/10	25/10	26/10	27/10	28/10	29/10	30/10	31/10	1/11	2/11	3/11	4/11	5/11	6/11	7/11	8/11	9/11	10/11	11/11	12/11	13/11	14/11	15/11	16/11	17/11	18/11	19/11	20/11	21/11	22/11	23/11	24/11	25/11	26/11	27/11	28/11	29/11	30/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12	8/12	9/12	10/12	11/12	12/12	13/12	14/12	15/12	16/12	17/12	18/12	19/12	20/12	21/12	22/12	23/12	24/12	25/12	26/12	27/12	28/12	29/12	30/12	31/12
Dose	Route	Frequency	Start Dt.																																																																																																																																																																											
2.5mg	PO	OD	15/7																																																																																																																																																																											
Name & Signature of the Doctor Starting the Drugs:																																																																																																																																																																														
Additional Instructions:																																																																																																																																																																														
Daily Doctor's Endorsement by a Sign																																																																																																																																																																														

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
6/7/16	6pm	Glycexine	0.3ml + 0.3ml x 2	p/r	<i>[Signature]</i>	<i>[Signature]</i>
14/7	9pm	Inj LACOSAMIDE	5mg/kg	I.V	<i>[Signature]</i>	<i>[Signature]</i>
16/7	11:00 am	Inj Lasix	0.1mg/kg	over 30 min I.v	<i>[Signature]</i>	<i>[Signature]</i>
17/7		Inj Dextrose				
19/7	7pm	10% Dextrose	0.2ml/kg	I.V slowly over 3-5 min	<i>[Signature]</i>	<i>[Signature]</i>



I.V. FLUIDS CHART

Weight. Ward.

[illegible]

Signature _____



Patient Sticker

I.V. FLUID CHART

[illegible]



Date	Time	RBS (mg/dl)	IVF %	Signature
3/7/26	11:30 pm	87 mg/dl	10% Isop	R
3/7/26	8:00 AM	83 mg/dl	10% Isop	R
4/7/26	6 PM	77 mg/dl	10% feed	R
5/7/26	6 am	85 mg/dl	10% Isop	R
6/7/26	6 am	74 mg/dl	10%	R
7/7/26	6 AM	78 mg/dl	10% Isop	R
8/7/26	6 am	70 mg/dl	full feed	R
9/7/26	6 AM	70 mg/dl	full feed	R
10/7/26	6 AM	86 mg/dl	full feed	R
11/7/26	6 AM	90 mg/dl	full feed	R
12/7/26	6 AM	85 mg/dl	full feed	R
13/7/26	6 AM	84 mg/dl	Full feed	R
14/7/26	6 AM	81 mg/dl	Full feed	R
15/7/26	6 AM	90 mg/dl	Full feed	R
16/7/26	6 AM	101 mg/dl	Full feed	R
17/7/26	6 AM	91 mg/dl	Full feed	R
19/7/26	6 AM	47 mg/dl	Full feed	R
19/7/26	7:45 AM	82 mg/dl	"	R
20/7/26	6 AM	761 mg	Full feed	R

Patient Sticker



RBS CHART

[illegible]

BAH-00660640 IP5-00175944
 Baby Of KEERTHI
 29-06-2026 0 Y 0 M 5 D (M)
 Dr. VIJAYANAND JAMALPURI



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

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 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

NEONATAL WEIGHT CHART

Birth Weight:

Admission Weight:

Discharge Weight:

NICU:

Month	Day	Date	Weight (gms)	Length (cm)
	3	17/26	not checked	
	4	17/26	not checked	
	5	17/26	2.1	49cm
	6	17/26		
	7	17/26		
	8	17/26		
	9	17/26	2.150kg	
	10	17/26	2.180kg	
	11	17/26	2.224gms	
	12	17/26	2.240gms	
	13	17/26	2.372gms	48cm
	14	17/26	2.381gm	
	15	17/26	2.409gms	
	16	17/26	2.451gms	
	17	17/26		
	18	17/26		
	19	17/26		
	20	17/26	2.501gms	48cm
	21	17/26		
	22	17/26		
	23	17/26		
	24	17/26		
	25	17/26		
	26	17/26		
	27	17/26		
	28	17/26		
	29	17/26		
	30	17/26		
	31	17/26		
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	38	17/26		
	39	17/26		
	40	17/26		
	41	17/26		
	42	17/26		
	43	17/26		
	44	17/26		
	45	17/26		
	46	17/26		
	47	17/26		
	48	17/26		
	49	17/26		
	50	17/26		
	51	17/26		
	52	17/26		



INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: AB-ve Baby's Blood Group: AB-ve Sheet No: 5
 Gest Age: 37 weeks Birth Weight: 2.07 kg

Date: <u>16/7/26</u>	Date: <u>17/7/26</u>	Date: <u>18/7/26</u>
DOL <u>≠ D8</u> Weight <u>≠ 2.45 ↑ 142g</u>	DOL <u>≠ D9</u> Weight <u>≠ 2.428 ↓ 230g</u>	DOL <u>≠ D20</u> Weight <u>≠ 2.438 ↑ 10g</u>
Problems: <u>≠ Team/RDS</u>	Problems: <u>≠ Team/RDS</u>	Problems: <u>≠ Team/RDS</u>
Rs. <u>≠ 30-60 bpm</u> Exam <u>≠ Done</u> Vent. Setting <u>≠ LIP</u> ABG <u>]</u> CXR <u>]</u>	Rs. <u>≠ 30-60 bpm</u> Exam <u>≠ Done</u> Vent. Setting <u>≠ LIP</u> ABG <u>]</u> CXR <u>]</u>	Rs. <u>≠ 30-60 bpm</u> Exam <u>≠ Done</u> Vent. Setting <u>≠ LIP</u> ABG <u>]</u> CXR <u>]</u>
CVS <u>≠ Normal</u> HR <u>≠ 120-160 bpm</u> BP Map Cap Refil	CVS <u>≠ Normal</u> HR <u>≠ 120-160 bpm</u> BP Map Cap Refil <u>≠ 2-3 sec</u>	CVS <u>≠ Normal</u> HR <u>≠ 120-160 bpm</u> BP Map Cap Refil <u>≠ 2-3 sec</u>
F/E/N <u>≠ 150cc/kg/day</u> T. Fluids <u>≠ 384 ml</u> CC/kg/day <u>≠ 160cc/kg/day</u> I/O/RBS: <u>≠ 101mg/dl</u> U Output: <u>≠ 1.6cc/kg/hr</u> Exam <u>≠ Done</u> T. Bil/D <u>133</u> Na <u>≠ Hc03</u> K <u>≠ BUN</u> Cl <u>≠ Crea</u> Hemat HB: <u>≠ 17.6</u> WCC <u>≠ 7.85</u> Plats <u>≠ 133</u> Transfusion	F/E/N <u>≠ 150cc/kg/day</u> T. Fluids <u>≠ 368 ml</u> CC/kg/day <u>≠ 152cc/kg/day</u> I/O/RBS: <u>≠ 91mg/dl</u> U Output: <u>≠ 1.9cc/kg/hr</u> Exam <u>≠ Done</u> T. Bil/D <u>133</u> Na <u>≠ Hc03</u> K <u>≠ BUN</u> Cl <u>≠ Crea</u> Hemat HB: <u>≠ 17.1</u> WCC <u>≠ 7.85</u> Plats <u>≠ 133</u> Transfusion	F/E/N <u>≠ 150cc/kg/day</u> T. Fluids <u>≠ 384 ml</u> CC/kg/day <u>≠ 160cc/kg/day</u> I/O/RBS: <u>≠ 74mg/dl</u> U Output: <u>≠ 1.8cc/kg/hr</u> Exam <u>≠ Done</u> T. Bil/D <u>133</u> Na <u>≠ Hc03</u> K <u>≠ BUN</u> Cl <u>≠ Crea</u> Hemat HB: <u>≠ 17.6</u> WCC <u>≠ 7.85</u> Plats <u>≠ 133</u> Transfusion
C/s Results CRP <u>≠ 6</u> Antibiotics	C/s Results CRP <u>≠ 6</u> Antibiotics <u>≠ Amoxicillin</u>	C/s Results CRP <u>≠ 6</u> Antibiotics <u>≠ amoxicillin</u>
Med <u>≠</u>	Med <u>≠</u>	Med <u>≠</u>
Neuro: <u>≠</u>	Neuro: <u>≠</u>	Neuro: <u>≠</u>
Assessment <u>≠ Done</u>	Assessment <u>≠ Done</u>	Assessment <u>≠ Done</u>
Plan <u>≠ RBS</u>	Plan <u>≠ RBS</u>	Plan <u>≠ RBS</u>

BAH-00660640
Baby Of KEERTHI
29-06-2026 0 Y 0 M 19 D (M)
Dr. VIJAYANAND JAMALPURI



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INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

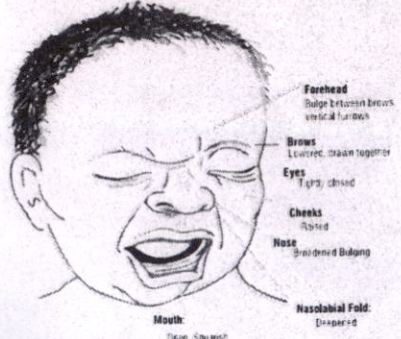
Maternal Blood Group: A.B +ve Baby's Blood Group: AB +ve Sheet No: (6)
Gest Age: 37 weeks Birth Weight: 2.07 kg

Date: <u>19/7/26</u>	Date: <u>20/7/26</u>	Date:
DOL <u>D21</u> Weight <u>2.454 ↑ 16gs.</u>	DOL <u>D22</u> Weight <u>2.500 ↑ 46gs</u>	DOL Weight
Problems: <u>term/RDS</u>	Problems: <u>Term/PPS</u>	Problems:
Rs. <u>30-60 blm</u> Exam <u>norm</u> Vent. Setting <u>LIP</u> ABG CXR	Rs. <u>30-60 blm</u> Exam <u>norm</u> Vent. Setting <u>LIP</u> ABG CXR	Rs. Exam Vent. Setting ABG CXR
CVS <u>Normal</u> HR <u>120-160 blm</u> BP <u>63/37 Map (45)</u> Cap Refil <u>C2-3s</u>	CVS <u>Normal</u> HR <u>120-160</u> BP <u>78/48 Map (58)</u> Cap Refil <u>(2.3s)</u>	CVS HR BP Map Cap Refil
F/E/N <u>150 cc/kg/day</u> T. Fluids <u>38 ml</u> CC/kg/day <u>160 cc/kg/day</u> I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>150 cc/kg/day</u> T. Fluids <u>6</u> CC/kg/day I/O/RBS: <u>61 mg/dl</u> U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results CRP Antibiotics <u>Amoxycillin</u>	C/s Results CRP Antibiotics <u>NA</u>	C/s Results CRP Antibiotics
Med Neuro:	Med Neuro: <u>Amoxycillin</u>	Med Neuro:
Assessment <u>DOM</u>	Assessment <u>norm</u>	Assessment
Plan <u>RBS</u>	Plan <u>RBS OP</u>	Plan



2

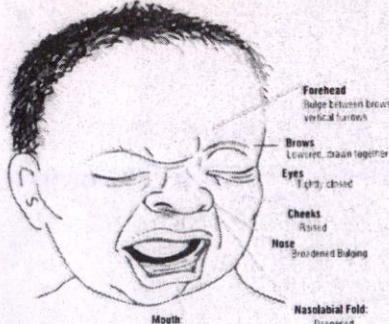
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

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		
						12/7/26	14/7	14/7	14/7	15/7	18/7	18/7	20/7		
						2 pm	12 pm	8 am	6 pm	4 pm	1 pm	6 pm			
	Procedure →														
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0	0	0	0	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	2	2	2	2		
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	1	1	1	1	1	1	1	1		
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	1	1	1	1	1	1	1	1		
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	1	1	1	1	1	1	1	1		
 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	34 wks	37 w	34 weeks	37 w	32 w	37 w	37 w		
						Total Pain / Agitation Score	2/10	2/10	2/10	2/10	2/10	1/10	1/10	1/10	
						Intervention	EBM	Formula	Formula	EBM + EBM	EBM	EBM	EBM	EBM	
						Effectiveness	Good	Good	Good	Good	Good	Good	Good	Good	
						Signature									

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.

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessm Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	19/7 Time	Time	Time	Time	Time	Time	Time	Time	Time
						12:30 PM								
						Procedure →	suck							
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	1								
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								
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	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								
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								
 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	1							
						Total Pain / Agitation Score	2/10							
						Intervention	One							
						Effectiveness	yes							
						Signature	VR							

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.

THE HUMPTY DUMPTY SCALE

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	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	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					
	Patient Placed in Bed	2	2	2	2	2	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			12	12	12	12	12

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
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 :		Shirley	Shirley	Shirley	Shirley	Shirley
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		12/2	18/7	18/7	18/7	20/7
Time :		12:30pm	10:15am	10:15am	10:15am	10:15am



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	9	10	12	2	4	6	8	10	12	2	4	6	
Doctor/Nurse/Family Concern?		AN	AN	AN	AN	AN	AN	AN	AN	AN	AN	AN	AN	
Temperature (F)	104													
	103													
	102													
	101													
	100													
	99													
	98													
	97													
	96													
	95													
	94													
	Heart Rate (bpm) and Blood Pressure (mmHg) *	190												
		180												
		170												
160														
150														
140														
130														
120														
110														
100														
90														
80														
70														
60														
50														
Heart Rate (Number)		151	154	150	159	151	150	156	161	159				
Resp. Rate (bpm) (over 1 Minute) *	70													
	60													
	50													
	40													
	30													
	20													
	10													
Resp Rate (Number)		18	45	52	62	43	33	34	54					
Resp Distress	Mod/ Severe													
Receiving O ₂ (l/min)														
O ₂ Saturations (%)		89%	100%	91%	97%	92%	98%	98%	95%	98%				
Conscious Level	Normal / Altered	ALF	ALF	ALF	ALF	ALF								
GCS *		0.02	0.02	0.02	0.03	0.02	0.5	0.5						
TOTAL SCORE														
Number of shaded boxes		1	1	1	1	1	1	1	1	1				
Pain Score														
Observer's Initials														

ACTIONS

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA :		Diagnosis :		Surgery / Procedures :			
	Allergies :				Post OP Day :			
	Date :		19/7/26					
	Area		N3					
	Shift Time		8PM-8PM					
	Diet :		GNTM					
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)		L10					
	1.		O2					
	2.							
	3.							
	4.							
ASSESSMENT	Infusions / Transfusions		JNA					
	PU Prophylaxis		JNA					
	DVT Prophylaxis		JNA					
	Vitals	BP	68/38/48					
		PR	134					
		RR	54					
		SpO ₂	98%					
		Temp	36.6c					
	Pain Score		1/10					
	LOC (Alert, Conscious, Confusion, Unconscious)		Alert					
	Skin Integrity (Intact / Bedsore / Any other condition)		Int					
	Restraints If any		Physical	JNA				
			Chemical					
	Fall Risk (Vulnerable (Y/N) if yes score)		Yes					
(Ambulation, walking, moving with assistance, bed ridden)		mild						
ADL (Dependent / Non-Dependent)		Dep						
Critical Lab Test / Values (if any)		W/D						

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :	19/7/26					
		Area	N3 8pm-8pm					
		Shift Time						
		Ordered / Planned						
		Due						
		Reports Pending						
Referrals (If any)								
Remarks (Special Interventions like, Drainage Tube flushing etc.)		NA						
Handed Over By Name :		Agarwal						
Signature :		(Signature)						
Date :		20/7/26						
Time :		8 AM						
Taken Over By Name :								
Signature :								
Date :								
Time :								

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA :	Diagnosis :		Surgery / Procedures :		
	Allergies :			Post OP Day :		
	Date :					
	Area					
	Shift Time					
	Diet :					
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)					
	1.					
	2.					
	3.					
	4.					
ASSESSMENT	Infusions / Transfusions					
	PU Prophylaxis					
	DVT Prophylaxis					
	Vitals	BP				
		PR				
		RR				
		SpO ₂				
		Temp				
	Pain Score					
	LOC (Alert, Conscious, Confusion, Unconscious)					
	Skin Integrity (Intact / Bedsore / Any other condition)					
Restraints If any	Physical					
	Chemical					
Fall Risk (Vulnerable (Y/N) if yes score)						
(Ambulation, walking, moving with assistance, bed ridden)						
ADL (Dependent / Non-Dependent)						
Critical Lab Test / Values (if any)						

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :						
		Area						
		Shift Time						
		Ordered / Planned						
		Due						
		Reports Pending						
		Referrals (If any)						
	Remarks (Special Interventions like, Drainage Tube flushing etc.)							
Handed Over By Name :								
Signature :								
Date :								
Time :								
Taken Over By Name :								
Signature :								
Date :								
Time :								

BAH-0080640
Baby KEERTHI
29-06-1926
Dr. VIJAYANAND JAMALPURI
0 Y 0 M 19 D
(M)
IP5-00175944

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7/26

Assessment: Baby is on L/R

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 condition	8pm	Assessed the baby condition	Baby is on L/R
10pm	monitor vitals	10pm	monitored vitals	
12Am	maintain I/O Chart	12Am	maintain I/O Chart	
2Am	Give Feed 2nd hourly	2Am	give feed 2nd hourly	
4Am	provided comfortable position	4Am	provided comfortable position	
6Am	Give medication	6Am	give medication	

Re-Assessment: Done

Special Notes: ROS OD

Nurse Signature: [Signature]

Nurse Name: Rajeshi

Date & Time: 19/7/26

Date:

Assessment:

☐ 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
	1. Patient is a 45-year-old male with a history of hypertension and hyperlipidemia. He is currently on amlodipine 10mg daily and atorvastatin 40mg daily. He has been admitted to the hospital for a routine check-up and blood work. 2. The patient is currently on amlodipine 10mg daily and atorvastatin 40mg daily. He has been admitted to the hospital for a routine check-up and blood work. 3. The patient is currently on amlodipine 10mg daily and atorvastatin 40mg daily. He has been admitted to the hospital for a routine check-up and blood work.		1. The patient is currently on amlodipine 10mg daily and atorvastatin 40mg daily. He has been admitted to the hospital for a routine check-up and blood work. 2. The patient is currently on amlodipine 10mg daily and atorvastatin 40mg daily. He has been admitted to the hospital for a routine check-up and blood work. 3. The patient is currently on amlodipine 10mg daily and atorvastatin 40mg daily. He has been admitted to the hospital for a routine check-up and blood work.	1. The patient is currently on amlodipine 10mg daily and atorvastatin 40mg daily. He has been admitted to the hospital for a routine check-up and blood work. 2. The patient is currently on amlodipine 10mg daily and atorvastatin 40mg daily. He has been admitted to the hospital for a routine check-up and blood work. 3. The patient is currently on amlodipine 10mg daily and atorvastatin 40mg daily. He has been admitted to the hospital for a routine check-up and blood work.

Re-Assessment:

Special Notes:

Nurse Signature: _____ Nurse Name: _____ Date & Time: _____

**CONSENT FOR ADMISSION
IN NEONATAL INTENSIVE CARE UNIT**

Name: B/o Keerthi Age: 7 dy Gender: Male ☒ Female ☐

UHID.No : Date:

I S/o, D/o, W/o hereby
declare that our patient Mr. / Ms. who is related to me as is
getting admitted in the Neonatal Intensive Care Unit of Rainbow Children's Hospital on

The doctors have explained to me in a language understood by me that my child has following health related issues :

The doctors have clearly explained to me that my patient B/o during his / her stay
in the Neonatal Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical
ventilation, Umbilical Artery Catheter, Umbilical Vein and Arterial Lines, Peripherally Inserted Central Catheter Line and arterial line
placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure
shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is
implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Neonatal Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Neonatal Intensive Care Unit with multiple medical and surgical procedures
performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of
infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child B/o
in the Neonatal Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various
procedures, high risk medications and infections in the Neonatal Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature : [Signature]

Name :

Relationship with Patient:

Date & Time : 4/1/26 3pm

Witness :

Signature : [Signature]

Name : Devera

Date & Time : 4/1/26 3pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Keerthi

Date & Time : 4/1/26 3pm

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యు) సమ్మతి పత్రం

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రోగి పేరు వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి బి

నేను బి

అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రేయిన్స్టి బిల్డ్ ఆసుపత్రి లోని నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్లో తేదీ

..... నాడు పూర్తి సమ్మతితో చేర్చితిని. మా బాలుడి / బాలికలో. ఈ క్రింద తెలిపిన ఆరోగ్య సమస్యల గురించి వైద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించాడు.

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ లో మా పాప /బాబుకు వైద్య పరంగా అవసరమగు అన్ని రకాల చికిత్స విధానాలకు మరియు ప్రక్రియలను (ఉదా కృత్రిమ శ్వాస వెంటిలేటర్, ధమని మార్గం, సింట్రిల్ టైప్ చెస్ట్ డ్రైయిన్, పెరిటోనియల్ డ్రైయిన్ ఇంకనర్హన్ వంటి ప్రక్రియలను డాక్టరు గారు నాకు అర్థమగు భాషలో వివరించారు.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైనప్పటికీ, పైన తెలుపబడిన శస్త్ర ప్రక్రియలు చేసేముందు సమ్మతి తీసుకునే వీలు లేని చో వీరైనా ప్రాణాంతక అత్యవసర పరిస్థితులు ఏర్పడినప్పుడు మా బాలుడు / బాలికను కాపాడుటకు అవసరమైన వైద్య శస్త్ర ప్రక్రియలు మా సమ్మతి లేకుండానే చేయవచ్చని నేను సమ్మతిస్తున్నాను.

ఆరోగ్య సమస్యలతో బాధపడుతున్న మా బాలుడికి / బాలికకు రుగ్మతలచే ప్రాణహాని కలుగవచ్చిన నాకు వైద్యుడు అర్థమగు భాషలో వివరించితిరి

మా బాలుడు / బాలిక నవజాత శిశువు ఇంటెన్సివ్ కేర్ యూనిట్ లో ఉన్నప్పుడు ఎన్నో విధాల వైద్య మరియు శస్త్ర ప్రక్రియలు ఇంకా వివిధ చికిత్స విధానాలు అవసరం పడతాయని మరియు వాటివల్ల దుష్పరిణామాలు కలగవచ్చని అర్థం చేసుకున్నాను. ఆ పరిణామాలు ఎటువంటివి అనగా నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన సమస్యలు, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు.

మా బాలుడిని/బాలికను అడ్మిట్ చేయుటకు మరియు ఎన్.ఐ.సి.యు. లో ఉన్నప్పుడు జరుగు చికిత్స విధానాలు మరియు శస్త్ర ప్రక్రియలు వలన కలిగే అపాయాలను నేను అంగీకరిస్తున్నాను. మా పేషంట్ ను తగిన విధంగా చికిత్స చేయడానికి వైద్యునికి నాపూర్తి అంగీకారం తెలియజేస్తున్నాను. వైద్యుడు నాకు అర్థమగు భాషలో అంతా వివరించారు.

మా బాలుడు / బాలిక ను ఇన్టీబెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ప్రవ్రతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి
సంతకము
పేరు
తేదీ మరియు సమయము

CONSENT FOR DONOR BREAST MILK

Patient Name : B/o Keeshi Age : 7 day Gender : ☒ Male ☐ Female
UHID No : Department : NICU - 4 Date : 04/07/26
I Mr / Mrs. : aged years, hereby declare that I have
admitted my ☐ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on
..... I hereby give consent for Donor Breast Milk for my child. Doctors have explained me
about the Donor Breast Milk feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : [Signature]
Name :
Relationship with Patient :
Date & Time : 4/1/26 PM

Witness :

Signature : [Signature]
Name : [Signature]
Date & Time : 4/1/26 PM

Doctor (who is taking the consent) :

Signature : [Signature]
Name : D. J. Ashu
Date & Time : 4/1/26 PM

CONSENT FOR FORMULA FEEDS

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Patient Name : B/o Keerthi Age : Gender : ☒ Male ☐ Female

UHID No : Reg. No. : Department : NICU Date : 10/7/26

I Mr / Mrs. : aged years, hereby declare that I have

admitted my ☐ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on

..... I hereby give consent for formula feed for my child. Doctors have explained me

about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : [Signature] oral consent
(circle)

Name : B. Sundar

Relationship with Patient:

Date & Time :

Witness :

Signature : [Signature] Shivani

Name : [Signature]

Date & Time : 10/7/26

Doctor (who is taking the consent) :

Signature : [Signature]

Name : D. Lohar

Date & Time : 10/7/26

డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. రిజిస్ట్రేషన్ నెం.: విభాగము

తేదీ

నేను శ్రీ / శ్రీమతి వయస్సు సంవత్సరాలు

నా కుమార్తె / కుమారుడు రెయిన్ఫో ఆసుపత్రిలో నవజాత శిశువుల ఇంటెన్సివ్ కేర్ లో అడ్మిట్ చేసినాము మరియు (ఫార్ములా

ఫీడ్) డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుచున్నాను. డాక్టర్లు డబ్బా పాలు త్రాగించడం వల్ల కలుగు

ఉపయోగాలు, ప్రత్యామ్నాయాలు, మరియు నష్టాలు గురించి నాకు అర్థమైన భాషలో వివరించారు.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

BREASTFEEDING HISTORY FORM

Mother's Name: Baby's Name: Date of Birth:

Reason for consultation: lactation consulting for mothers

1. Baby's feeding now (ask all these points)	Breastfeeds How often Length of breastfeeds Longest time between feeds (time mother away from baby) One breast or both breasts Complements (and water) 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 Premature Urine output (more/less than 6 times per day) Stools (soft and yellow/brown; or hard or green; frequency) Feeding behaviour Illnesses	Weight now Twin Growth Abnormalities
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 1 st hour) How given
4. Mother's condition and family planning	Age Family planning method	Breast condition <u>Good</u> Motivation to breastfeed Alcohol, smoking, coffee, other drugs Yes / no
5. Previous infant feeding experience	Number of previous babies How many breastfeed Any bottles used	Experience good or bad Reasons
6. Family and social situation	Working / Home maker Father's attitude towards breastfeeding Other family members attitude towards breastfeeding Help with child care What others say about breastfeeding	Literacy status <u>educated</u> <u>positive</u> <u>consulted about importance of expressed milk.</u>

Lactation Consultant:

Signature: Nalini Name: Nalini Date & Time:

LACTATION ASSESSMENT FORM

Mother's details:

Baby details:

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

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

BF previous baby: Previous BF difficulty:

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 Rhythmic 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				Breast Feed			Top Feed		
Weight									

Teaching Instructions:

Discharge Instructions:

Feed Frequency Duration:

Feeding techniques:

Assessment of output:

Sources of BF assistance at home:

Next Follow up:

Lactation Consultant: Name: Signature: Date & Time:



NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA :		Diagnosis :		Surgery / Procedures :		
		Allergies :		Post OP Day :				
Date :		17/7/26	17/7/26	18/7/26	18/7/26	19/7/26		
Area		NICU 3	N3	N3	N3	N3	N3	
Shift Time		Day	8pm-8am	8am-2pm	2pm-8pm	8pm-8am		
Diet :		BBM+EBM	EBM+Pom	EBM+Pom	EBM+Pom	EBM+Pom		
Ventilation (RA, NP, NIV, VENTI)		LF	LF	LF	LF	LF		
INVASIVE MONITORS	1.	OG-①	OG	OG-①	OG-①	OG-①		
	2.	IV-line	IV-line	IV-line	IV-①			
	3.							
	4.							
ASSESSMENT	Infusions / Transfusions	NA	NA	NA	NA	NA		
	PU Prophylaxis	NA	NA	NA	NA	NA		
	DVT Prophylaxis	NA	NA	NA	NA	NA		
	Vitals	BP	71/44	71/43 (53)	64/42 (62)	61/35 (44)	70/43 (52)	
		PR	126	131	164	161	157/64	
		RR	46	39	48	50	52/44	
		SpO ₂	99%	93%	95%	96%	96%	
		Temp	36.6°C	36.2°	36.6°C	36.4°C	36.5°C	
	Pain Score	2/10	2	1/10	4/10	2/10		
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert	Alert		
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact	Intact		
	Restraints If any	NA	NA	NA	NA	NA		
Fall Risk (Vulnerable (Y/N) if yes score)	yes	yes	yes	yes	yes			
(Ambulation, walking, moving with assistance, bed ridden)	Bed ridden	Bed ridden	Bed ridden	Bed ridden	Bed ridden			
ADL (Dependent / Non-Dependent)	Dependent	Dependent	Dependent	Dependent	Dependent			
Critical Lab Test / Values (if any)	nil	NA	NA	NA	NA			

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :	17/7/26	18/7/26	18/7/26	18/7/26		19/7/26
		Area	N3	N3	N3	N3		N3
		Shift Time	Day	Evening	8am-2p	2pm to 8pm		8am-2p
			RBS-OD	RBS-OD	RBS-OD	RBS-OD		RBS-OD
		Ordered / Planned						
		Due	n/o Due	NA	NA	} NA		
		Reports Pending	n/o Reports pending	NA	} NA	} NA		
		Referrals (If any)	n/o Referrals	NA	NA	} NA		
		Remarks (Special Interventions like, Drainage Tube flushing etc.)	n/o Remarks	NA	NA	NA		NA
		Handed Over By Name :	Koushik	Ashwath	Shivani	Yamuna		Yamuna
Signature :								
Date :	17/7/26	18/7/26	18/7/26	18/7/26		19/7/26		
Time :	@ 8pm	8am	@ 2pm	@ 8pm		@ 8pm		
Taken Over By Name :	Ashwath	Shivani	Yamuna					
Signature :								
Date :	18/7/26	18/7/26	18/7/26					
Time :	8pm	@ 2pm	@ 2pm					

BAH-00660840 IP5-00175944
 Baby Of KEERTHI
 29-06-2026 0 Y 0 M 18 D (M)
 Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

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

Date: 19/7/28

Assessment: Baby is O/Lf

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
09/	=> To Assess the baby general condition 11/ => To monitor vitals 12/ => To maintain I/O chart 3p/ => To provide comfortable position 4p/ => To give 2nd baby feed 7p/ => To give medication as per Doctor order	10/	=> Assessed the baby general condition 12p/ => monitored the vitals 2p/ => maintained I/O chart 4p/ => provided comfortable position 6p/ => given 2nd baby feed 8p/ => given medication as per Doctor order	=> Baby is stable

Re-Assessment: Re-Assessment - Done

Special Notes: RBS-01

Nurse Signature: [Signature] Nurse Name: Burles Date & Time: 19/7/28



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 18/7/26

Assessment: Baby is on L/P

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the baby condition	8pm	Assessed the baby condition	Baby is on stable
10pm	monitored vitals	10pm	monitored vitals	
12pm	maintain I/O Chart	12pm	maintain I/O Chart	
2pm	give feed and hold	2pm	give feed and hold	
4pm	provided comfortable position	4pm	provided comfortable position	
6pm	give medication	6pm	give medication	

Re-Assessment: RBS done

Special Notes: RBS

Nurse Signature: [Signature]

Nurse Name: Agathi

Date & Time: 18/7/26

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 18/6/26	Time:	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?		8 AM	10 AM	12 PM	2 PM	4 PM	6 PM	8 PM	10 PM
Temperature (F)		36.6°C	36.7°C	36.6°C	36.5°C	36.6°C	36.6°C	36.6°C	36.6°C
Heart Rate (bpm)		67	68	66	61	68	68	68	65
Blood Pressure (mmHg) *		(47)	(56)	(49)	(40)	(49)	(50)	(50)	(39)
Note: BP does not score in early warning scoring		38	40	40	35	39	40	50	52
Heart Rate (Number)		164	159	171	161	161	169	170	154
Resp. Rate (bpm) (Over 1 Minute) *		47	42	38	42	45	48	46	38
Resp Mod/ Severe Distress None / Mild									
Receiving O ₂ (l/min) O ₂ Saturations (%)		100%	100%	100%	100%	98%	96%		
Conscious Level Normal Altered		N	N	N	N	N	N	N	N
GCS *								0	0
TOTAL SCORE		0	0	0	0	0	0	0	0
Number of shaded boxes		0	0	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0	0	0
Observer's Initials		S	S	S	Y	Y	Y	S	S
ACTIONS		Score 1 : Continue normal observation by staff nurse							
		Score 2 : Shift in charge nurse to be informed and continue hourly observations							
		Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.							
		Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see							
		Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed							

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



FLUID CHART

Sheet No. : 9

Wt - 1500/1kg
 B. wt - 2.4
 T.F - 32

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am	EBM			32 ml					15 ml		
	10:00 am											
	11:00 am	EBM			32 ml	Passed						
	12:00 pm											
	01:00 pm	N/A PRO			32 ml					17 ml		
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm	EBM			32 ml	passed				11 ml		
	04:00 pm											
	05:00 pm	N/A PRO			32 ml							
	06:00 pm											
	07:00 pm	N/A PRO			32 ml					19 ml		
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm	EBM			32 ml					12 ml		
	10:00 pm											
	11:00 pm	Pre-nan			32 ml							
	12:00 am									12 ml		
	01:00 am	Pre-nan			32 ml							
Total Intake :						Total Output :						
	02:00 am											
	03:00 am	Pre-nan			32 ml					10 ml		
	04:00 am											
	05:00 am	Pre-nan			32 ml							
	06:00 am									13 ml		
	07:00 am	Pre-nan			32 ml							
Total Intake : 359 ml						Total Output : 109 ml						
Total 24 hrs. Intake		1600 cc/kg/24										
Total 24 hrs. Output		15 cc/kg/24										



18/2/26

FLUID CHART

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Sheet No. : (10)

TV :- 150 c/kg/day
B.wt :- 2.240 kgs
TF :- 30ml

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	B.G							
	08:00 am											
	09:00 am	pre nano							10ml			
	10:00 am											
	11:00 am	pre nano							15ml			8/2/26
	12:00 pm											
	01:00 pm	EBM							13ml			
Total Intake :					Total Output :					38		
	02:00 pm											
	03:00 pm	pre nano							10ml			
	04:00 pm											
	05:00 pm	pre nano							14ml			9/2/26
	06:00 pm											
	07:00 pm	EBM							12ml			
Total Intake :					Total Output :					36 ml		
	08:00 pm											
	09:00 pm	pre nano							10ml			
	10:00 pm											
	11:00 pm	EBM							9ml			
	12:00 am											
	01:00 am	EBM							10ml			
Total Intake :					Total Output :					29 ml		
	02:00 am	pre nano										
	03:00 am	pre nano							5ml			
	04:00 am	pre nano										
	05:00 am	pre nano							10ml			
	06:00 am	pre nano										
	07:00 am	pre nano							8ml			
Total Intake :					Total Output :					124 ml		

Total 24 hrs. Intake 1500 ckg/day

Total 24 hrs. Output 1200 ckg/day

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 11 pm		Plan
		→ Continue PC mode
		→ TV - 110cc/kg/day 5ml/2nd hly (EBM/DBM) + Rest 10-12 hr
		→ Start Neurophenam
		→ MRI Brain - 1/m
		→ R/V EEG 1/m
		→ Neuro opinion 1/m
		→ Trace reports
	Dr. [Signature]	
		Noted by Dipak 017039 3/7/26



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4/7/26

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 4 PMA:

Term ☐ Preterm ☐ Gestation : 37 weeks Corrected Gestational Age:

OVERVIEW		Problems :	
S.No.	Current	Past Problems	
1.	Term SGA		
2.	Birth asphyxia / HIE III		
3.	2 Encephalopathy		
4.	Suspected Sepsis		
5.	Thrombocytopenia		
6.	NNJ		

Today's Weight :

RESPIRATORY SYSTEM	CARDIO VASCULAR SYSTEM
Ventilatory Support : ☐ Yes ☐ No - Day # of Vent : Mode of Ventilation : HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ INO ☐ PPM ☐ Ventilator Settings : PIP..... PEEP..... VG..... Rate..... FiO ₂ Oxygen : L/min Last CXR : Spo ₂ : ET Secretions : Clear ☐ Thick ☐ Yellow ☐ Last ABG : Change over the Last 24 Hours : <u>on SIMV + PSC9</u> <u>FiO₂ - 25%, 12/7, Rate - 35</u> <u>No brady / desat.</u>	Plan of Care : HR - 149/min RR - 40/min SpO ₂ - 95% BP - 82/59 (67) U/O -
Neurological Examination : Sedation Last Neurosonogram : Any Seizures	

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

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

INFECTION	Risk of Sepsis / Suspected Sepsis / Proven Sepsis :			
	Sepsis screen:.....			
	Blood culture ☐ Urine culture ☐ ET culture ☐ Fungal Culture ☐ LP ☐ CSF :.....			
	Antibiotic	Sl.No.	Drugs	Days
	1.	2.	3.	
				<i>Levupl</i>

Plan of Treatment :	• Continue current ventilation • Dr - 120cc/kg/day - 10% IsoP + Gas • 5ml/2nd hly feed - • MRI Brain today. • R/v EEG & Neurology opinion • Gas } 6th hly. • RBS } • No chocking 6th hly. • Monitor vitals
---------------------	--

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

Signature : *[Signature]*

Date & Time : *4/8/26*

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

Signature : *[Signature]*

Date & Time : *4/8/26*

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/26 10 AM	Term / SGA / Birth asphyxia encephalopathy	Seen by Dr. Vijayanand A plan
		Continue current ventilation 12/5 Rate -30 PS-9
	of E - Pupils - equal reacting to light	2) CBG BD BD
	Hypertonia (+)	3) Neurology review
	p/A - full, soft	4) EEG today
		5) TV - 100cc/kg/day
		6) Adjust ET position
		7) Start 3 ml 3hly EBM/DBM feeds
		8) Trace MRI report
		9) CBP T/m
		10) Drug, fluid, Just check chest.
		11) Send Ammonia NBS Urgent sample.
		12) Continue SSPT

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26	Afternoon rounds	
2:00pm		
	- on SIMV + PS (9),	Plan:
	PiO ₂ - 21%, 12/5,	Continue current ventilation
	RR - 30/min	
	SpO ₂ - 94%,	TV - 100 ml/kg/day ↓
	PR - 110/min	Feed 3ml 3rd hly
	RR - 30/min	+ Rest 10% ISO-p
	PIA - soft	Blood gas } PBC } BD
	- NO aspirate;	
	- Stool - passed	- Trace NBS.
	- Urine -	To send Urine GCMS NBS
	ET - pushed in by 0.5 to 1 cm.	Continue SSPT C eyes & genitalia covered.
	- Ammonia - megald	Bedside EEG today.
		Trace MRI report

(5)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Monitor Bilirubin in blood gas.
		Nobby Derug 6/10/26 4/1/26
		Seen by Dr. Vijayanand
4/1/26		Plan 1) Continue current ventilation 2) CBP T/M
		Dr. BirthRight
4/1/26	ET pull out note	
	ET was pulled out 0.5 cm & fixed @ 9 cm. Procedure was successful	
		Dr. BirthRight
		CBP T/M;

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 9:10pm		
	SIB- <u>Dr. Nilesh</u>	
		Plan
	- NO further seizure	- continue ST+ current ventilation
	- no further vomits	- gas / ARBS - OD
	- tolerating 3ml feeds	- Trace EEG report
	- comm cns stability	- low lig level / neuro phys
		- TV - 120cc/kg/day
		- feeds to - 5ml / 2nd hly
		↑ to 8ml - Tlm - morning @ 6am
		→ CBP - Tlm
		→ Trace NB'S
		Noted by Diff 017039 4/7/26 Q 9:20pm

BAH-00660840

IP5-00175944

Baby Of KEERTHI

29-06-2026

0 Y 0 M 5 D

(M)

Dr. VIJAYANAND JAMALPURI



5/7/26

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DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 5 PMA:

Term ☐ Preterm ☐ Gestation : 37 wks Corrected Gestational Age:

Problems :		
S.No.	Current	Past Problems
1.	Term / SGA	
2.	Birth asphyxia / HIE - III	
3.	2 Cephalopathy	
4.	Suspected Sepsis	
5.	Thrombocytopenia	
6.	NNS	

Today's Weight :

RESPIRATORY SYSTEM	
Ventilatory Support :	☐ Yes ☐ No - Day # of Vent :
Mode of Ventilation :	HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ INO ☐ PPM ☐
Ventilator Settings :	PIP PEEP VG Rate FiO ₂ Oxygen : L/min
Last CXR :	SpO ₂ :
ET Secretions :	Clear ☐ Thick ☐ Yellow ☐ Last ABG:
Change over the Last 24 Hours:	Baby on SIMV+PS - PIP - 12 PEEP - 5, RR - 30/min, PS - 9, FiO ₂ - 23%.
	ongoing SSPT

CARDIO VASCULAR SYSTEM	
Plan of Care :	
HR = 118/min	No Brady/desat
RR = 30/min	
SpO ₂ - 98%	Hypertonia of LL > UL (+)
BP - 60/42 (ua)	No further Seizures.

CNS	
Neurological Examination :	 Sedation
Last Neurosonogram :	 Any Seizures

FLUIDS STATUS NUTRITION

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

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

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

INFECTION

Antibiotic	Sl.No.	Drugs	Days
	1.	Trg. Meroopenem	
	2.		
	3.		

levetiracetam.

Plan of Treatment :

- 1) Cont. Current ventilation
Target SpO_2 90-95% if $FIO_2 \geq 21\%$
- 2) $Tv = 100ml/kg/day$
Feed - 8mb 3rd hrly + Rest 10% ISO-4
- 3) Blood Gas, RBS - BD
- 4) Trace - CBP.
- 5) To trace - NBS, urine GCM S.
- 6) Trace EEG report ✓
- 7) w/f - Seizures
- 8) Target HBP monitor Bilirubin or Blood gas

Doctor's Name (Handover given) : Y. Sneh

Signature : Sneh

Date & Time : 5/2/2026

Doctor's Name (Handover taken) : A. Pappu

Signature : A. Pappu

Date & Time : 5/2/26

BAH-00660640 IP5-00175944
 Baby Of KEERTHI
 29-06-2026 0 Y 0 M 5 D (M)
 Dr. VIJAYANAND JAMALPURI



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26 8am.		Seen by Dr. Vijayanand
		Cont. Current Ventilator
		↑ Feed 5ml 6th hourly.
		Trace EEG.
		Aim to extubate Tomorrow.
		Trace CBP.
		Dr. VIJAYANAND JAMALPURI Reg. No: 40526
5/7/26 3pm	Afternoon rounds Baby on cmv+tr PAP 12; PEEP 5; PS 9cm Fio ₂ 25% RR: 30/min No R/L underaeration Tolerating well feeds No vomiting SpO ₂ 97% PR: 119mm RR: 30/min CRT < 3sec BP: 73/55 (60mmHg)	plan 1. Continue cmv+tr - 12/14; PEEP 5cm - Fio ₂ 23% 2. Tr = 10cm H ₂ O/day 13ml Rgt + Rest stop ↑ 5ml 6th hourly (TF = 25ml) 3. Trace EEG 4. CBG 7 BD 5. Aim to extubate tomorrow 6. Vial monitoring

Noted by Dr. 17039 S/7/26
 23

BAH-00660840
Baby Of KEERTHI
29-08-2026 0 Y 0 M 5 D (M)
Dr. VIJAYANAND JAMALPURI

IP5-00175944

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26	<u>Extubation notes</u>	
6:30pm	Baby self extubated @ 6:30pm	
	↓	
	Baby was taken on NIV 15/6 cm	
		Fio ₂ 30%.
		RR: 40/min
	↓	
	Baby tolerating well	
	↓	
	<u>Plan</u> to continue current NIV - 15/6	
		RR: 40
		FiO ₂ : 30%
		Apnea: 0-45
	4 RR CBG after 2 hours,	
	31 CCR 201	
5/7/26		dy Saitapa
8:30pm	CBG after 2 hours	
	PH 7.31 49.9 / 1.2 / 1.1 / 22.5	
		NIV - 16/6
		→ RR: 40/min
		→ Fio ₂ 30%.
		→ T _p → 0.45 sec

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26 10:30pm	Night rounds Baby on NIV - 16/6 - FiO ₂ 30% RR: 40/min r/o Rpt/ no desaturation Tolerating feeds well No bradycardia SpO ₂ : 99% PR: 149/min RR: 41/min BP: 74/56 (63) mmHg CRT < 3 sec Urine output → 2 cc/kg/hr	plan 1. Continue NIV - 16/6 FiO ₂ 30% RR: 40/min 2. IV = 100cc/kg/day 18ml @ 3H ↑ 5ml 6th hourly till Target feed (TF = 25ml) 3. CBC, GRRs 4. Trace NBS Urine Gcms 5. Monitor bilirubin in blood gas
		Noted by Aiffu 07/07/26 5/7/26 @ 10:35pm
		Sing Sai

VIJAYANAND JAMALPURI

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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 6 PMA:

Term ☒ Preterm ☐ Gestation : 37 weeks Corrected Gestational Age:

OVERVIEW	Problems :		
	S.No.	Current	Past Problems
	1.	term / SGA	NNJ
	2.	Birth Asphyxia	
	3.	HIE - III	
	4.	Neonatal Encephalopathy	
	5.	Suspected sepsis	
	6.	Thrombocytopenia	

Today's Weight : 2.1 kg

RESPIRATORY SYSTEM	Ventilatory Support : ☐ Yes ☐ No - Day # of Vent :
	Mode of Ventilation : HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ INO ☐ PPM ☐
	Ventilator Settings : PIP PEEP VG Rate FiO ₂ Oxygen : L/min
	Last CXR : <u>3/7/26</u> Spo ₂ :
	ET Secretions : Clear ☐ Thick ☐ Yellow ☐ Last ABG : <u>7.31/49/75, 60/12, HCO₃-22.5</u> <u>(5/7/26)</u> RBS-7mg/dl
Change over the Last 24 Hours : <u>Extubated to NIV,</u> <u>FiO₂-21%, 16/6, RR-30/min</u>	

CARDIO VASCULAR SYSTEM	Plan of Care : <u>SpO₂-92%</u> <u>PR-119/min</u> <u>RR-20/min</u> <u>Tssclear</u> <u>- Bradypnoea</u>
------------------------	---

CNS	Neurological Examination : Sedation Last Neurosonogram : Any Seizures :
-----	---

FLUIDS STATUS NUTRITION	☐ NPO ☐ NG Feeds Wt. Gain: Head Circumference:		
	Input : / (+/-) Output : ml/kg/d Urine Output : <u>2</u> ml/kg/hr Stools <u>passed</u>		
	IV Fluids - Type of IVF : @ ml/hr		
	Feeding: EBM ☐ Formula ☐ Donor BM ☐ Volume: Frequency:		
	TPN : ☐ Yes ☐ No - If yes, details : Calories:		
Abdominal Examination: <u>pb - soft</u>			
Other Systems : Haematology / Nephrology / Metabolic / Endo / NNJ - PT / OPTH / RICKETS			
INFECTION	Risk of Sepsis / Suspected Sepsis / Proven Sepsis : <u>Blood clc - no growth after 48 hrs.</u>		
	Sepsis screen:		
	Blood culture ☐ Urine culture ☐ ET culture ☐ Fungal Culture ☐ LP ☐ CSF :		
	Antibiotic	Sl.No.	Drugs
	1.	2.	3.
<u>Taj. meropenem</u> <u>D3</u> <u>levipil.</u>			
<u>Plan of Treatment :</u> - continue NIV, 16/6, RR-30 - TV - 100ml/kg/day ↓ <u>25ml 25ml 3rd hourly</u> - Blood gas OD - RBS 12th hourly - Trace EEG report, NBS, Urine GCMS report. - Monitor Bilirubin in blood gas. - Ilo. charting 6th hourly - R/V CBP, SBR tomorrow			

Doctor's Name (Handover given) : Dr. Anand
 Signature : [Signature]
 Date & Time : 6/12/20

Doctor's Name (Handover taken) : Dr. Anand
 Signature : [Signature]
 Date & Time : 6/12/20

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 10:30AM		Seen by Dr. Vijayanand
		Plan:
		→ Continue NIV
		→ Blood gas OD
		→ Trace EEG, NBS, Urine GCMS -
		→ Chest X-ray & abdomen USG abdomen of today.
		→ To give Glycine stat.
		→ CBP CRP SBR } 7/11 morning.
		→ Start SSPT & eye G genitalia covered.
		Noted by Alphonso 6/7/26 @ 10:45 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26	Afternoon rounds	
2:30 pm		
	on NW	Plaus
	$FiO_2 - 25\%$ 16 → 15 PEEP-6 PR-30 cmH ₂ O	- continue NIV → Rv to change to CPAP
	SPO ₂ -96% PR-115 mmHg PR-45 mmHg	- TV - 100 ml/kg/day ↓ give one half feed [13 ml 2nd half]
	PA-soft	↓ if tolerating give 25 ml 2nd half next feed.
	Stool passed	
		→ Blood gas on
	NBS report → by night	→ RBS 12th hourly
	Urine GCMS → after 2 days	- Trace EEG report.
		→ continue SST.
	USG abdomen → spine mobility Bowel (2)	CBP CPAP 7m monitor SBR.
	Blood clc - no growth after 48 hours	Noted by Alphonsa 6/7/26 3:00 pm Araf



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 2:45pm		seen by Dr. Vijayand
		- NPO for 24 hours
		Noted by Aphae @ 3:00 PM 6/7/26
	- EEG - slo. moderate encephalopathy	- "
6/7/26 11:45pm		
	night records	
	- stable on NIV	Plans
	SpO ₂ - 96%	- ↓ PIP to 15,
	PR - 108/min	- continue NIV,
	RR - 24/min	- ↓ RR to 25,
	BP - 80/54 (63)	- ↓ RR to 20 by this morning.
	PA - sat	- CBP } this morning
	Stools passed	- CCR } this morning
		- SBR } this morning
		- Blood gas
		- Continue NPO for 24 hours
		Admitted by Subina @ 2:45 PM

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DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 7 PMA:

Term ☒ Preterm ☐ Gestation : 37 weeks Corrected Gestational Age:

OVERVIEW	Problems :		
	S.No.	Current	Past Problems
	1.	Term / SGA	NNJ
	2.	Birth asphyxia	
	3.	HIE - III	
	4.	Neonatal Encephalopathy	
	5.	Suspected sepsis	
	6.	Thrombocytopenia	

Today's Weight : 2.115 (↑15 gms)

RESPIRATORY SYSTEM	Ventilatory Support : ☐ Yes ☒ No - Day # of Vent :
	Mode of Ventilation : HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ INO ☐ PPM ☐
	Ventilator Settings : PIP..... PEEP..... VG..... Rate..... FiO ₂ Oxygen : L/min
	Last CXR : <u>6/7/26</u> SpO ₂ :
	ET Secretions : Clear ☐ Thick ☐ Yellow ☐ Last ABG : <u>7.33 / 52 / 36 / 1.7 / 24.1</u>
	Change over the Last 24 Hours : <u>On NNJ,</u> <u>FiO₂ - 23%, 16 > 15,</u> <u>RR - 20/min</u>

CARDIO VASCULAR SYSTEM	Plan of Care : <u>SpO₂ - 96%,</u> <u>PR - 111/min</u> <u>RR - 18/min</u> <u>ECG - moderate</u> <u>Ischaemia</u> <u>encephalopathy</u> <u>(Diffuse slowing)</u> <u>- Bradypnoea</u> <u>→ tone in all limbs,</u>
------------------------	---

CNS	Neurological Examination :
	Sedation : Last Neurosonogram : Any Seizures :

FLUIDS STATUS NUTRITION	☐ NPO ☐ NG Feeds Wt. Gain: _____ Head Circumference: _____
	Input: _____ / (+/-) _____ Output: _____ ml/kg/d Urine Output: <u>26</u> ml/kg/hr Stools: <u>passed</u>
	IV Fluids - Type of IVF: _____ @ _____ ml/hr
	Feeding: EBM ☐ Formula ☐ Donor BM ☐ Volume: _____ Frequency: _____
	TPN: ☐ Yes ☐ No - If yes, details: <u>PIA - 500</u> Calories: _____
Abdominal Examination: _____	

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

Risk of Sepsis / Suspected Sepsis / Proven Sepsis : _____

Sepsis screen: _____

Blood culture ☐ Urine culture ☐ ET culture ☐ Fungal Culture ☐ LP ☐ CSF: _____

INFECTION	Antibiotic	Sl.No.	Drugs	Days
		1.	2.	3.
		1.	Inj. Meropenem 6g	by Levipil
		2.		
		3.		

Plan of Treatment :

- continue NIV, FiO₂ - 23%, 15/6, RR - 20
- TV - 100ml/kg/day
↓
2-10% ISO-P;
- continue NPO
- R/V to start feeds 5ml 2nd half
- Blood gas on
- RBS 12th hourly
- Ilo charting 6th hourly
- stop SST after 24 hours

Doctor's Name (Handover given) : Dr. Arant
 Signature : Dr. Arant
 Date & Time: 1/7/26

Doctor's Name (Handover taken) : Dr. Nathan
 Signature : [Signature]
 Date & Time: 1/7/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/1/26 10:10		Seen by Dr. vijayanand
		- change to CPAP - PEEP 6
		- w/ APnea/bradycardia
		- Trace NBS, Urine for organic feeds
		- Start 10ml 3hly feeds, ↑ 5ml 3hly (30ml 3hly) each feed
	NBS =	- Tv - 120 c/kg/day
		- Upstart Neurology review and counselling
		- Continue SSPT
		- Trace blood c/s
		- Checklist
7/1/26 3:27	Afternoon Rounds. Baby Stable on CPAP - 6 23.1. Extended NBS - (N). Urine GCMS - will take 5 days (Sent on 5/1).	Dr. VIJAYANAND JAMALPURI Reg. No: 40526 Plus
	No episodes of bradycardia/ desaturation	1) Continue CPAP - PEEP 6 Target SpO ₂ - 90-95% if FiO ₂ > 21% 90-100% if FiO ₂ ≤ 21% 2) Tv - 120 c/kg/day ↑ feeds 5ml 3hly each feed upto 30ml 3hly

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Preterm baby 15 ml/2hly No vomit Activity better slightly. No active cry. Hypotonia (+)	3) CPG OP GRBS BD
	SE-HR-124/min RR-46/min SPO₂-98% BP-60/40 (4.7)	4) Continue SSPT
	UO-1.7 cc/kg/h	5) R/L Counselling of parents by Dr. Ramen Konaki in OPD 1/min
	Blood c/s - 48 hr no growth	6) 2/0 chesty & hly
7/7/26 4pm	Seen by Dr. Vijayanand.	1) Continue CPAP @ PEEP 5 2) Continue SSPT



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/22/26 9pm	Night Round.	
	Baby is on CPAP & Pamb	
	PEEP - 8, FiO ₂ - 21%.	
	Under SSPT.	
	Plan.	
	Vitals:	
	HR - 138/min.	Continue CPAP.
	RR - 48/min.	
	SpO ₂ - 97%.	Continue SSPT &
	BP - 77/60 (65)	eyes & genitals
	U/O - 2 wet/kg/hr.	covered.
	P/A - soft.	TV - 120cc/kg/day.
	Activity poor.	25ml 3rd hly
	Hypertonic.	↑ 5ml 3rd hly
		(TF - 30ml).
		CBG - OD
		RBS - BD
		Trace wire GCMS
		Menu Counselling
		tomorrow.
	Dr. for the	Noted by Nancy
		8/22/26
		@ 9pm

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r. VIJAYANAND JAMALPURI




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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

8/7/26

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : 8 PMA:

Term ☐ Preterm ☐ Gestation : Corrected Gestational Age:

Problems :		
S.No.	Current	Past Problems
1.	Term LGA	LWS
2.	Birth asphyxia	
3.	HIE-III	
4.	Neonatal encephalopathy	
5.	Suspected Sepsis	
6.	Thrombocytopenia	

Today's Weight : 2.127 (↑ 12gms)

RESPIRATORY SYSTEM	
Ventilatory Support :	☐ Yes ☐ No - Day # of Vent :
Mode of Ventilation :	HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ INO ☐ PPM ☐
Ventilator Settings :	PIP PEEP VG Rate FiO ₂ Oxygen : L/min
Last CXR :	Spo ₂
ET Secretions :	Clear ☐ Thick ☐ Yellow ☐ Last ABG:
Change over the Last 24 Hours:	on CPAP 2 Rami, PEEP-6, FiO ₂ -21% No desat / beady Under CSPT

CARDIO VASCULAR SYSTEM	
Plan of Care :	HR - 137/min RR - 48/min SpO ₂ - 93% BP - 74/49(58)

CNS	
Neurological Examination :	dull activity, hypertonica
Sedation:	
Last Neurosonogram :	Any Seizures.....

FLUIDS STATUS NUTRITION

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

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

IV Fluids - Type of IVF: @ ml/hr

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

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

Abdominal Examination: *P/A - soft*

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

INFECTION

Risk of Sepsis / Suspected Sepsis / Proven Sepsis :

Sepsis screen:

Blood culture ☐ Urine culture ☐ ET culture ☐ Fungal Culture ☐ LP ☐ CSF :

Antibiotic	Sl.No.	Drugs	Days
	1.	<i>Oral Meropenam</i>	<i>Ds</i>
	2.		
	3.		

Oral Levipil

Plan of Treatment :

- Continue CPAP, PEEP-6.*
- TV - 1200ml/day - 30ml/3ed hly. full O2 feed.*
- Trace wire GCMS*
- Neurology counselling today.*
- CBG-OD*
- RBS-BD.*
- Monitor vitals*
- w/Lt seizures*
- Continue SSPT.*

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

Signature : *[Signature]*

Date & Time: *8/7/26 2am*

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

Signature : *[Signature]*

Date & Time: *8/7/26*

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 10 AM		Seen by Dr. Vijayamand. Trial of CRAP. W/F Apnea / Seizures TV - 120 c/kg/day - 30 ml slowly OG feeds - OMS - SDR T/M - Continue SSPT. - If cannula is out - no further packs - Oral Levipil - Ongoing Neurological - Meropenem x 5 days - RBS OD.
8/7/26 1:15 PM	Afternoon rounds - on SSPT, - on room air, SpO ₂ - 94% PR - 135/min RR - 51/min	Plan: - TV - 140 ml/kg/day ↓ 25 ml and help full OG feed; - Continue OMS,

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

Day in NICU: Day of Life: 9 PMA:

Term ☐ Preterm ☐ Gestation: 37 wks Corrected Gestational Age: Today's Weight: 2.150 kg (P23)

		Problems		
		S.No.	Current	Past Problems
Overview	1.	Term	SSA	NA
	2.	Birth asphyxia		
	3.	HIE - III, neonatal	moderate encephalopathy	
	4.	Suspected	hypoxia	
	5.	Thrombocytopenia		
	6.			
Clinical Assessment	Baby on low flow O ₂ @ 0.1 L/min Episodes of desaturation, on stopping oxygen - to apnea / bradycardia Tolerating feeds 25 ml 2 hourly - OA feeds. OMS - Suck, swallow incoordination (+).			
	SBR-9.7 HR - 120/min RR - 56/min SpO ₂ - 97% BP - 74/52 (58)			
Medications Used	Oral leuprol Vitamin D3 drops.			

Plan of Care:

- 1) Trial of low flow O₂ if SpO₂ > 95%.
- 2) CRBS OD
- 3) OMS before each feeds.
- 4) Continue full OA feeds 25 ml 2 hourly (TV-140 cc/kg/day)
- 5) Continue oral leuprol
- 6) W/F apnea, Bradycardia, desaturation

Doctor's Name (Hand over given): Dr. Nalin

Signature: [Signature]

Date & Time: 9/7/26

Docu. No.: RCHB / FRM / CLINICAL / 290

Doctor's Name (Hand over taken): Dr. Anusha

Signature: [Signature]

Date & Time: 9/7/26

Patient Sticker

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

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

	Problems		
	S.No.	Current	Past Problems
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Signature:

Date & Time:

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:

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

Day in NICU: Day of Life: 10 PMA:

Term ☐ Preterm ☐ Gestation: 37 Corrected Gestational Age: Today's Weight: 2.170 (920 grams)

Problems		
S.No.	Current	Past Problems
1.	Tecor C64	N/A
2.	Birth Asphyxia	
3.	HIE Stage III, Neonatal encephalopathy	
4.	Suspected Sepsis	
5.	Thrombocytopenia	
6.		
Overview		
Clinical Assessment	on low flow 0.1 lit/min. no desat/Brady. Tolerating feeds well Hemodynamics are stable HR: 127/min. SpO2 94% Bp 64/40 mmHg	
Medications Used	Cevipil. vitamin D3	
Plan of Care:	on low flow 0.1 lit/min. target spo2 90-94%. 2. Tr: 140ml/kg/day - 25ml (2nd hourly) of feed - onsp feed 3. GABs - OD - 4. at Cevipil	

Doctor's Name (Hand over given): J. Shetty

Signature: [Signature]

Date & Time: 10/7/26

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:

Patient Sticker

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

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

	Problems		
	S.No.	Current	Past Problems
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Signature:

Date & Time:

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:

BAH-0060840
 Baby Of KEERTHI
 29-06-2026
 Dr. VIJAYANAND JAMALPURI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 2:30 PM	<u>Afternoon Rounds</u> Baby on low flow O₂ @ 0.1 L/min Frank apnea needing stimulation & desaturation upto 65% No bradycardia (Levent triggered during 90s) SpO₂ - 126% RR - 56/min SpO₂ - 94% BP - 72/52 (59) Tolerating feeds 25ml 2hrly No vomiting	plm 1) Trial of O₂ as tolerated. 2) Tx - 140 cal/kg/day 25ml 2hrly on feeds OMS before each feed. 3) GRBS ON 4) Continue oral levet. 5) W/F bradycardia discharge / apnea
		Noted by Sir. shivani 10/7/26 @ 2:40 pm

BAH-00660640

IP5-00175944

Baby Of KEERTHI

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29-06-2026

Dr. VIJAYANAND JAMALPURI



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7	16/7 08:13 0.05ml/kg/h Cortical thromb (+) All four limbs hypotonia on DBM -	Plan 1. min low flow @ 0.05ml/min 2. chest physio. 3. Budecort nebs. 4. lateral/ prone nursing 5. ons before feeding 6. Change to formula
10/9 4:10 PM	10/9 4:10 PM clab <u>RECIDENT</u> D10 38 +2 - PMA on min low flow - 0.05ml/min No brady / apneus. Intermittent decats. Sp: tachypnea (+) / mild Recessions. Tolerating OG Feeds. HR: 184/min. SpO2: 99+ Bp: 72/44 mmHg	Plan 1. ct low flow @ 0.05ml/min. - Target SpO2 90-95% 2. Trs 140ml/kg/day -25ml/2nd hourly OG Feed. 3. To do ons prefeed. 4. lateral / prone nursing 5. 2RS - DD - 6. trial off O2 as tolerated Noted by Sis. shivani

25

(P.T.O)

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(M)

29-06-2026

Dr. VIJAYANAND JAMALPURI



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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

Day in NICU: Day of Life: 11 PMA:
 Term ☐ Preterm ☐ Gestation: 35 3/4 Corrected Gestational Age: Today's Weight: 2.223

Problems		
S.No.	Current	Past Problems
1.	Lorn / SGA	NN?
2.	Birth asphyxia	
3.	MIE - Stage - III neonatal	
4.	encephalopathy	
5.	unsuspected sepsis	
6.	Intraventricular	

Clinical Assessment
- On room air - maintain Intermittent desat - Full feeds - @ 140cc / K/day - 25ml - Chances - off 2 hours on feeds

Medications Used
- Levipil - Vit - D3 - Budecort Neb <u>Plan</u> - @ 2 min low flow - SOS to keep SpO2 target 90-95%

Plan of Care:
- Remove cannula. - now - IV - 140cc / K/day - 25ml - <u>chance</u>, <u>Off feeds</u> - <u>ONS</u> - ARBs - OD - Continue levipil. - Frequent oro-nasal suctioning. - R/v - 3x nasal - Trace Nebulisation - <u>Trace</u> - <u>urine</u>

Doctor's Name (Hand over given): Dr. Vijayanand

Doctor's Name (Hand over taken):

Signature: Dr. Vijayanand

Signature:

Date & Time: 11/7/26

Date & Time:



(27)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 9:53am		Seen by Dr Vijayan
		→ Conti OMS
		→ consult e Dr. Radha seema devi madan
		→ consider sodium glyco pyralate aband low
		→ 3:1. Nacl Nebs.
11/7/26 12pm	Noted by Mitu 11/7/26 Afternoon Doh-II → POST-HIF-III Current issue copious secretions	Plan - cont. O ₂ - min flow 10 - keep SPO ₂ target 90-95% - TV - 140 cc./kg/dt → 25 ml/2 hour - OMS
	⇒ Consulted e Dr. Raneadwi man	
	⇒ Urine - GMS non specific.	

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Date & Time	Progress Notes	Doctor's Order
	- HA - 129 - SP_O₂ - 100 - BP - 84/56 (c7)	- Cont - 3L nasal Nebs - Ono-nasal suction - Attach MRT Repne
	<u>Evening</u>	<u>Plan</u>
11/1/26 5:30pm	- Baby on 0.5 L/min nasal flow - intermittent desat with self pick - Issue of oral suction - Feeds tolerated	- Continue O₂ - minilaw 3L nasal Nebs - flb gentle ono-nasal suction - TV - 140 cc/kg/day 25ml - 2 hourly flb - On feed ↓ - R/V ↑ 150 cc/kg/day - Cont - OMS - N/F apnea, bradycardia

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/7/26 10:15am	DOH - 12	Seen by Dr Vijayanand
	Term / Birth	
	asphyxia / NIE - III /	- N/F Seizures.
	Neonatal Seizure /	
	neonatal encephalopathy	- OMS
	T.W - 2.246 (↑ 18gn)	- continue glycoperalat
	HA - 145 / m	- continue suction as needed
	SpO ₂ - 100%	
	RR - 64 / m	
	BP = 69 / 42 (SI)	- let teach mother in OMS & care of ab. baby
	- 1000 ↓ Suction post - tab glycoperalat	- continue full OG
		- TV - 150cc / ks / day ↓ 28 ml - 2 hourly
		Rupanjali
	Noted by Suchitra	

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

Day in NICU: Day of Life: 12. PMA:
Term ☐ Preterm ☐ Gestation: 37 Corrected Gestational Age: Today's Weight: 2.24g (13gm)

Problems	
S.No.	Current
1.	Term SGA
2.	Birth Asphyxia
3.	HIE - Stage II encephalopathy.
4.	Expected Sepsis.
5.	Thrombocytopenia.
6.	

Overview	Past Problems

Clinical Assessment
on miniflow 0.08 lit/min. mild RDS tachypneal $\text{sc} \oplus$. Tolerating on feeds well stools soft/distended. HR: 166/min. SpO₂: 96%. Bp: 68/43 mmHg Spontaneous $\oplus$

Medications Used
Syp. Levipil. r. Glycopyrrlate 3-12h Neb. Budecort drops. vitamin D₃

Plan of Care:
1. TNC 150 ml/kg/day - 28ml/2nd hourly. OF Feeds. 2. ONS. prc feed 3. Suction as needed

Doctor's Name (Hand over given): Dr. Ashish

Signature: [Signature]

Date & Time: 12/2/26

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken): Dr. Ashwini

Signature: [Signature]

Date & Time: 12/2/26



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

Day in NICU: Day of Life: Day - 13 PMA:

Term ☐ Preterm ☐ Gestation: 37 Corrected Gestational Age: Today's Weight: 2.372

Overview	Problems	
	S.No.	Current
	1.	Term / Birth asphyxia
	2.	HIE + 3 / Neonatal
	3.	Seizure / Neonatal
	4.	encephalopathy
	5.	
	6.	

HC = 34 cm
Length = 45 cm
Weight = 1260 gm

Clinical Assessment	- On 0.2 L/min min flow O₂ - intermittent desat & pick up. - secretions ↓ed. in interest intensity - No seizure - Feeds tolerated - GRBS - 84 ml/de
---------------------	--

Medications Used	• 3.1. Nacl NEBS • Syt derivit • Vit-D3 oral • Tab clycaprylate
------------------	--

Plan of Care: Plan → Cont. min low flow target
 - TV - 150 cc/kg/day - 28ml - 30ml SPO₂ - 90-95
 - OMG before each feed, PHOTICURE at bed side
 - Involve mother in care.
 - Suction as per need.

Doctor's Name (Hand over given): Dr. Anurag

Signature: Ranjat

Date & Time: 13/7/26

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken): Dr. Anurag

Signature: [Signature]

Date & Time: 13/7/26

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Date & Time	Progress Notes	Doctor's Order
13/07/26 11:55 AM	Morning HR	See plan
		(1) Wean low flow as tolerated
		(2) Try one supervised feed
		(3) OMS
		Noted by madhava
		f
	Afternoon	plan
13/7/26 3:00 PM	Baby did not accept bottle feeds well - Intermittent desat during feeds - Took very slowly - Sucking poor. HR - 160 SpO ₂ - 98-1	- Cont. minilow flow - Tappet as tolerated - TV - 150 cc / ks / der - 30 ml - 2 channel full OG feeds - Suction as needed - W/F apneic, brady - Infirm SpO ₂ 50% - N/P any seizure

Noted by Akash

(P.T.O)



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7/26 11:41	WT = 2.381 (gms)	Seen by Dr. Vijayanand
		Cont Low flow, wear as salinated
		Continue OG feed
		discuss e the family
		Noted by monday 14/7/26
		plan
14/07/26 1830	No further seizures	(1) Watch for seizure
		(2) Start Lacosamide as per Neuro team
		(3) SE, Ca, Mg ⁺⁺ , CRBS
		(4) Sit IV line.
		(5) Continue low flow

BAH-00660840 IP5-00175944
 Baby Of KEERTHI
 29-08-2026 0 Y 0 M 12 D (M)
 Dr. VIJAYANAND JAMALPURI



(32)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/4/26		Plan
		Try Lacosamide loading
		@ 5mg/kg T.V over
		30 mins
		↓
		if maintained
		after 12 hours
		@ 4mg/kg/day in
		two divided doses.
		Ranjana

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

Day in NICU: Day of Life: 15 PMA:
 Term ☐ Preterm ☐ Gestation: 37 Corrected Gestational Age: Today's Weight: 2.407 (128gms)

Problems	
S.No.	Current
1.	Term Birth Asphyxia
2.	HIE - Stage II Neonatal encephalopathy
3.	Neonatal Seizures
4.	
5.	
6.	

Past Problems	
	NALJ.
	Expected Sepsis
	Thrombocytopenia.

Overview	

Clinical Assessment	
	on 0-4 lit/min - low flow ↑ed work: tachypnea ⊕ / Suprasternal retractions ⊕ 1 ep seizure - loaded with ^{central} - ? Hypotonia. ly- leucosamide - on OG Feeds. HR 144/min Sps 97% Sps 78/46 mmHg Spontaneity. ↑ed tone in all limbs.

Medications Used	
	2. Naloxone Levetiracetam leucosamide Vitamin D3 T. Glycopyrrolate

Plan of Care:	
	1. ct min flow - target Sps 90-95/- 2. TRS 150ml/kg/day - 28-30ml/2nd hourly OG Feeds. 3. BMS prefed. 4. mother to be involved in care. 5. Suctions as needed.

Doctor's Name (Hand over given): Dr. Vishith

Signature: [Signature]

Date & Time: 15/7/26

Doctor's Name (Hand over taken): Dr. Ashwarya

Signature: [Signature]

Date & Time: 15/7/26

IP5-00175944

0 Y 0 M 14 D (M)

29-06-2026

0 Y 0 M 14 D

(M)

Dr. VIJAYANAND JAMALPURI



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7 4:30 PM	CLB RESIDENT DOL-15 PMA 39+1	Plan 1. ct ^{low} Flow - 0.4lit/min target SpO2 90-95%
	Birth Asphyxia / Neonatal Seizure / IEM-	2. TVL 150ml / kg / day - 30ml / 2nd hourly Full OG feeds
	on low flow 0.4lit/min. RD: tachypnea (+) / ICA (+) on OG Feeds. Bloody Suction material from mouth.	3. oms proceed. 4. Suction as needed
	Sponticity / Hypertonia HR: 158/min RR: 71/53 min SpO2 100%	5. (E) CBP, PT/APTT/INR t/m 6. chest physiotherapy.
	EEG: mild cerebral dysfunction.	① Shift
15/7/26 4 PM		Seen by Dr. Vijayana → TO add Telazol → If further bleed → send CBP, Coagulation Profile platelet count Hb/Hct

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[illegible]



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

Day in NICU: Day of Life: 16 PMA:
Term ☐ Preterm ☐ Gestation: 37 Corrected Gestational Age: Today's Weight: 2.451 (↑ 42)

Problems		
S.No.	Current	Past Problems
1.	Term Birth Asphyxia	Nx1.
2.	HIE Stage III / Neonatal encephalopathy	Suspected Sepsis
3.	Neonatal Seizure	Thrombocytopenia
4.	? IEM	
5.		
6.		

Clinical Assessment	on Nitroline - low flow RD: tachypnea ⊕ / icr ⊕ / ace ⊕ No further seizures Spasticity ⊕, hypertonia ⊕ Tolerating OR feeds. No further episode of bleeding. HRs 120/min SpO₂: 100% Bp: 65/42 mmHg
Medications Used	3. atad nebs. Levipil Lacosamide vit-D3 asycopporlate Calcimax +
Plan of Care:	1. ct low flow - Nitroline Target SpO₂ 90-95% 2. Chest physiotherapy. 3. TR: 150ml/kg/day - 28-30ml/2nd hourly OR feeds. 4. one pre-feed 5. Suctioning as needed 6. lateral nursing

Doctor's Name (Hand over given): Dr. Chait

Doctor's Name (Hand over taken):

Signature: [Signature]

Signature:

Date & Time: 16/7/26

Date & Time:

Patient Sticker

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

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

	Problems		
	S.No.	Current	Past Problems
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Signature:

Date & Time:

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/7/26 10:26 AM		Seen by Dr. Vijayanand
	No further bleed	- D/N Dr. Ranaadri maam
		- Do CVP now → R/V antibiotic
		- Cont Low flow
		- Ongoing neurological reviews.
		- Leix - 1mg/kg/day
		- Cont dexamethasone
		- Cont OHS
		- R/V genetic testing.
		Reviewed
		Noted by Keerthi

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7 2:00 PM	CLAB INCIDENT. DRL-16 Segmental collapse in left lung. RD: tachypnea (+) Emphysematous retractions (+) Hyperemia (+) / Spontaneity (+) Tolerating OG feeds Suction: (+) secretions HR: 149/min SpO2: 100% BP: 75/44 mmHg	Plan 1. at low flow @ 1lit/min. 2. Omb prefeed 3. chest physiotherapy 4. left - up 2hrs / right - up 2hrs. 5. TVI 150ml/kg/day - 28 - 30ml/2nd hourly 6. Suctioning as needed P. John
16/7	Afternoon CXR - patchy changes in left lung	Seen by Dr. Vijayanand S: R/F Seizure, apnea cont Levipil, Lasix Start I.V co-amoxi. co-amoxyclov noted by Nandini



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/7/26. 10PM		Seen by Dr. Peatyush
	→	↓ TV - 140cc / log / day
	P/A - soft firm discomfort ⊕	→ R/U USC abdomen tender.
	at poor sensorium	→ to low flow to 0.5lit
	→	Withhold next dose of glycopyrrate
	→	Do Lung ultrasound now.
		(As per 12)



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

Day in NICU: Day of Life: 17 - PMA:

Term ☐ Preterm ☐ Gestation: 37..... Corrected Gestational Age:..... Today's Weight: 2-428/128

	Problems					
S.No.	Current			Past Problems		
1.	Term Birth Asphyxia			NNTJ.		
2.	HIE stage III Neonatal encephalopathy.			Suspected Sepsis		
3.	Neonatal Seizures			Thrombocytopenia		
4.	Aspiration pneumonia.					
5.	TREM.					
6.	Dysmorphism					
Clinical Assessment	↓ lateral pt. RR: tachypnea (+) / icc (+) ↓ O₂ sat/min trachea soft & tickled thickened secretions. No further seizures. Ht: 152 cm SpO₂: 98% BP: 71/41 mmHg					
Medications Used	Bf. Nacel tabs Curipil. Lacosamide Vitamin D3 Glyceryl stearate - held Calcein + D/N to hold Bf. Nacel tabs. Im. amoxicillin D2					
Plan of Care:	1. ct low flow - 0.6 lit/min target spo₂ 90-95%. 2. Chest physiotherapy 3. ons premed 4. Endotracheal as needed 5. lateral ap ← sit up 2hrs. ↑ sit up 2hrs					

Doctor's Name (Hand over given): Dr. Lohmeyer

Signature:

Date & Time: 17/7/21

Doctor's Name (Hand over taken):

Signature:

Date & Time: _____



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7 11:50 AM	CLB Pr vj	Am 1. ct low flow O-Sat/min wear as tolerated 2-w/f apnea/seizure. 3- If cannula is out then remove 4. ct levipil / lacosamide 5- DO USG abdomen / MSK screening 6. Stop - T. Amyoprodol
17/7 5:00 PM	CLB RESIDENT. DOI-17 on min flow - O-Sat/min tachypnea (+) / CX (+) No seizure / apnea / Brady Hs soft distended. Rt lateral position. HR: 147/min SpO2 = 99% Rr:	Am 1. ct low flow O-Sat/min wear as tolerated 2. I/O urinary catheterisation 3- W: 150ml/kg/day 28-80ml/2nd hourly - 25 feed - 4. Enction as needed
	Noted	Shrth

Dr. VIJAYANAND JAMALPURI



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BY RAINBOW HOSPITALS
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Date & Time	Progress Notes	Doctor's Order
17/2	G 11938P^{ms} stable on low flow 0.6cc/L to creatinine feeds $\frac{1}{2}$ maraulla	

INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: AB - Baby's Blood Group: A - Sheet No: 1
Gest Age: 37 week Birth Weight: 2.07

Date: <u>4/7/26</u>	Date: <u>5/7/26</u>	Date: <u>6/7/26</u>
DOL <u>D6</u> Weight <u>2 kg</u>	DOL <u>D7</u> Weight <u>Not checked</u>	DOL <u>D8</u> Weight <u>2.1 kg</u>
Problems: <u>Term / RDS</u>	Problems: <u>Term / RDS</u>	Problems: <u>Term / RDS</u>
Rs. <u>30-60b/m</u> Exam <u>Done</u> Vent. Setting <u>Vent</u> ABG <u>Done</u> CXR <u>Done</u>	Rs. <u>30-60b/m</u> Exam <u>Done</u> Vent. Setting <u>Vent</u> ABG <u>Done</u> CXR <u>Not Done</u>	Rs. <u>30-60b/m</u> Exam <u>Done</u> Vent. Setting <u>vent</u> ABG <u>Done</u> CXR <u>Not done</u>
CVS <u>Normal</u> HR <u>120-160b/m</u> BP <u>63/47 Map (52)</u> Cap Refil <u>L2-3 sec</u>	CVS <u>Normal</u> HR <u>120-160b/m</u> BP <u>65/48 Map (54)</u> Cap Refil <u>L2-3 sec</u>	CVS <u>Normal</u> HR <u>120-160b/m</u> BP <u>65/38 Map (47)</u> Cap Refil <u>L2-3 sec</u>
F/E/N <u>X</u> T. Fluids <u>X</u> CC/kg/day <u>X</u> I/O/RBS: <u>X</u> U Output: <u>X</u> (CC/kg/hr) <u>X</u> Exam T. Bil/D Na-Hc03 <u>141</u> K-BUN <u>4.9</u> Cl-Crea <u>116</u> Hemat HB: <u>17.5</u> WCC <u>5.86</u> Plats <u>82</u> Transfusion <u>NA</u>	F/E/N <u>X</u> <u>120cc/kg/day</u> T. Fluids <u>X</u> <u>2124</u> CC/kg/day <u>X</u> <u>106</u> I/O/RBS: <u>X</u> <u>85</u> U Output: <u>X</u> (CC/kg/hr) <u>X</u> <u>4cc/kg/hr</u> Exam T. Bil/D Na-Hc03 <u>141</u> K-BUN <u>4.9</u> Cl-Crea <u>116</u> Hemat HB: <u>17.5</u> WCC <u>5.86</u> Plats <u>82</u> Transfusion <u>NA</u>	F/E/N <u>X</u> <u>120cc/kg/day</u> T. Fluids <u>X</u> <u>210 ml</u> CC/kg/day <u>X</u> <u>105 cc/kg/day</u> I/O/RBS: <u>X</u> <u>74 mg/dl</u> U Output: <u>X</u> (CC/kg/hr) <u>X</u> <u>2.0</u> Exam <u>X</u> T. Bil/D <u>X</u> Na-Hc03 <u>141</u> K-BUN <u>4.9</u> Cl-Crea <u>116</u> Hemat HB: <u>17.5</u> WCC <u>5.86</u> Plats <u>82</u> Transfusion <u>NA</u>
C/s Results <u>NA</u> CRP <u>19</u> Antibiotics <u>Ij - Meropenem</u>	C/s Results <u>NA</u> CRP <u>19</u> Antibiotics <u>Ij - Meropenem</u>	C/s Results <u>NA</u> CRP <u>19</u> Antibiotics <u>Ij meropenem</u>
Med <u>Ij - Levipil</u> Neuro: <u>Normal</u>	Med <u>Ij - Levipil</u> Neuro: <u>Normal</u>	Med <u>Ij levipil</u> Neuro: <u>Normal</u>
Assessment <u>Done</u>	Assessment <u>Done</u>	Assessment <u>Done</u>
Plan <u>GRBST/IDG-TP</u>	Plan <u>GRBS ODG-OD</u>	Plan <u>GRBS 5' G-00</u>

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CRP <u>19</u> Antibiotics <u>Ij meropenem</u>	Antibiotics <u>Ij meropenem</u> Med <u>Ij Levipil</u> Neuro: <u>Done</u>	Med Neuro: <u>Done</u> Assessment <u>Done</u>
Med <u>Ij meropenem</u> Neuro: <u>Ij Levipil</u> Assessment <u>Done</u>	Assessment <u>Done</u> Plan <u>RBS OD WB4-OD</u>	Plan <u>RBS OD</u>
Plan <u>CB1, CB2, SBR</u>		

Docu. No. : RCHB/FRM / CLINICAL / 183

CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: AB

DATE	TIME	LOCATION	PROVIDER	CHIEF COMPLAINT	HISTORY OF PRESENT ILLNESS	PHYSICAL EXAM	LABORATORY	IMAGING	ASSESSMENT	PLAN
10/1/14	11:00	Room 111	Dr. [Name]	Abdominal pain	Onset of pain at 10:00 AM, sharp, localized to RLQ.	Abdominal exam: Tenderness at RLQ, no guarding or rebound.	WBC 12,000, Hemoglobin 12.0	Ultrasound: No free fluid.	Acute appendicitis	Admit to hospital, IV fluids, antibiotics, and surgical consult.
10/1/14	14:00	Room 111	Dr. [Name]	Continued abdominal pain	Pain persists, now rated 8/10.	Exam: Increased tenderness at RLQ.	WBC 13,500		Acute appendicitis	Continue current treatment, surgical consult on call.
10/1/14	18:00	Room 111	Dr. [Name]	Worsening abdominal pain	Pain is now constant and severe.	Exam: Marked tenderness at RLQ, mild guarding.	WBC 15,000		Acute appendicitis	Emergency surgery scheduled for tomorrow morning.
10/2/14	08:00	Operating Room	Dr. [Name]	Undergoing appendectomy	Procedure completed without complications.	Post-operative exam: Stable.	WBC 10,000		Post-operative status	Monitor vital signs, pain management, and wound care.
10/2/14	10:00	Room 111	Dr. [Name]	Post-operative recovery	Pain well managed with oral analgesics.	Exam: No tenderness at surgical site.	WBC 9,500		Post-operative status	Discharge planning initiated.
10/2/14	14:00	Room 111	Dr. [Name]	Discharge	Patient is stable and ready for home.	Exam: No abnormalities.	WBC 8,500		Discharge	Discharge instructions provided, follow-up in 2 weeks.



INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: ABC- Baby's Blood Group: ABC- Sheet No: 2

Gest Age: (37 weeks) Birth Weight: 2.07 kg

Date: <u>13/7/26</u>	Date: <u>14/7/26</u>	Date: <u>15/7/26</u>
DOL <u>D15</u> Weight <u>2.372 gms</u>	DOL <u>D16</u> Weight <u>2.381 gms</u> <u>1 gms</u>	DOL <u>17</u> Weight <u>2.409</u> <u>↑ 28 gms</u>
Problems: <u>Tomy/RDS/LBW</u>	Problems: <u>Tomy/RDS/LBW</u>	Problems: <u>From RDS/LBW</u>
Rs. <u>30-60b/m</u> Exam <u>Done</u> Vent. Setting <u>LIF</u> ABG } <u>nil</u> CXR } <u>nil</u>	Rs. <u>30-60b/m</u> Exam <u>Done</u> Vent. Setting <u>LIF</u> ABG } <u>nil</u> CXR } <u>nil</u>	Rs. <u>30-60b/m</u> Exam <u>Done</u> Vent. Setting <u>LIF</u> ABG } <u>nil</u> CXR } <u>nil</u>
CVS <u>Normal</u> HR <u>150</u> BP <u>90/40</u> Map Cap Refil <u>2-3 sec</u>	CVS <u>Normal</u> HR <u>160b/m</u> BP <u>80/40</u> Map Cap Refil <u>2-3 sec</u>	CVS <u>Normal</u> HR <u>120-160b/m</u> BP Map Cap Refil <u>2-3 sec</u>
F/E/N <u>120cc/kg/day</u> T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam <u>Done</u> Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>150cc/kg/day</u> T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam <u>Done</u> T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>150cc/kg/day</u> T. Fluids <u>360 ml</u> CC/kg/day <u>151cc/kg/day</u> I/O/RBS: <u>90mg/dl</u> U Output: (CC/kg/hr) <u>1.04cc/kg</u> Exam <u>Done</u> T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: <u>17.6</u> WCC <u>7.85</u> Plats <u>133</u> Transfusion
C/s Results CRP Antibiotics	C/s Results CRP Antibiotics	C/s Results CRP <u>6</u> Antibiotics <u>Nil</u>
Med <u>Syp Leupil</u> Neuro: <u>NA</u>	Med <u>Syp Leupil</u> Neuro: <u>NA</u>	Med <u>NA</u> Neuro: <u>NA</u>
Assessment <u>Done</u>	Assessment <u>Done</u>	Assessment <u>Done</u>
Plan <u>RBS-OB</u>	Plan <u>RBS-OB</u>	Plan <u>RBS</u>



THE HUMPTY DUMPTY SCALE

10/2 15/2 16/2 17/2 18/7

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	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	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					
	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	14	14	14

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓	✓
Wheel Chair Support		✓	✓	✓	✓	✓
Other Intervention(s) Specify		✓	✓	✓	✓	✓
Nurse's Name :		Shirva	Shirva	Shirva	Shirva	Shirva
Signature :		Shirva	Shirva	Shirva	Shirva	Shirva
Date :		15/2	15/2	16/2	17/2	18/7
Time :		5pm	5pm	5pm	5pm	2pm



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 3/7			DAY-2 4/7			DAY-3 5/7			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			1	1	1	1	1	1	1	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			1	1	1	1	1	1	1	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			1	1	1	1	1	1	1	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			1	1	1	1	1	1	1	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			1	1	1	1	1	1	1	
Signature of the Nurse						1	1	1	1	1	1	1	

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Soukarni Name : Soukarni

Signature of Ward In Charge :

Signature : Shiraleel Name : Shiraleel

2

CHECKLIST FOR THROMBOPHLEBITIS

6/7/26

7/2

8/7

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-	-	-	
Signature of the Nurse				Megha	Deep	Deep	Deep	Deep	Deep	Deep	Deep	Deep	

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Shilpa Name : Shilpa

Signature of Ward In Charge :

Signature : Shivalaksh Name : Shilpa



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-	-	-	
Signature of the Nurse				LAKSHMI	AD	Re Site	AD	AD	AD	AD	AD	AD	

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-					
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-					
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-					
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-					
Signature of the Nurse				[Signature]			[Signature]			[Signature]			

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

BAH-00660640

IP5-00175944

Baby Of KEERTHI

29-06-2026

0 Y 0 M 5 D

(M)

Dr. VIJAYANAND JAMALPURI



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 :	3/7	4/7	5/7	6/7
					Time :	11pm	10AM	10P.	10Am
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.		2	2	2	2
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		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.		3	3	3	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		2	2	2	2
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	14	15	15	15
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Q	1	10	12

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



BRADEN 'Q' SCALE

					Date :	6/2/24	7/2	8/2	8/2
					Time :	10 AM	10 PM	6 AM	10 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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.	2	2	2	2	
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2	2	2	2	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	3	2	1	1	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	2	2	3	3	
TOTAL SCORE					14	13	13	13	
Evaluator's Name					De	De	Deep	Deep	

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-00660640 IP5-00175044

Baby Of KEERTHI

29-06-2026 0 Y 0 M 9 D (M)

Dr. VIJAYANAND JAMALPURI



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 :	9/7/26	9/7	8/7	10/7
				Time :	2:00pm	1:00pm	2:00pm	6:00am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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.	2	2	2	2
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2	2	2	2
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	1	2	1	1
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.	3	3	3	3
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23								
Docu. No. : RCHBH /FRM / CLINICAL / 119								
TOTAL SCORE					13	13	13	13
Evaluator's Name					Navega	Laksh	KA	RE

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

BRADEN 'Q' SCALE

					Date :	10/7/26	10/7/26	11/7	11/7
					Time :	10 AM	10 PM	2 PM	8 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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.	2	2	2	2	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2	2	2	2	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	1	1	1	1	
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.	3	3	3	3	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	13	13	13	13
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	8/2	8/2	8/2	8/2

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-00660840
Baby Of KEERTHI
29-08-2026
Dr. VIJAYANAND JAMALPURI

IP5-00175944

0 Y 0 M 14 D (M)



BRADEN 'Q' SCALE

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					Date :	13/7/26	13/7/26	13/7/26	14/7
					Time :	1Am	8Am	2 pm	12Am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:tremitry 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.	2	2	2	2	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2	2	2	2	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	1	1	1	1	
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.	3	3	3	3	
TOTAL SCORE					13	13	13	13	
Evaluator's Name					Deva	AK	AD	Deva	

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



PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
11/7/26 @8am	Rt abdomen	left hand	Side Lying	Given	Given	OD	Given	Given	Given	Wah
11/7/26 @12pm	Rt abdomen	left hand	side Lying	Given	Given	OD	Given	Given	Given	Wah
11/7/26 @6pm	Rt abdomen	Rt hand	Side Lying	Given	Given	OD	Given	Given	Given	Wah
12/7/26 @12AM	Rt Abdomen	Left hand	Side Lying	Given	Given	OD	Given	Given	Given	Wah
12/7/26 @6AM	Rt Abdomen	Right hand	Side Lying	Given	Given	OD	Given	Given	Given	Wah
12/7/26 @8AM	Lft Abdomen	Left hand	Side Lying	Given	Given	OD	Given	Given	Given	Wah



PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
12/7/26 @ 2pm	Right Abdomen	Left hand	Side Lying	Given	Given	OD	Given	Given	Given	
12/7/26 @ 8pm	Rt Abdomen	Rt hand	lt up	Given	Given	OD	Given	Given	Given	
1										

BAH-00660640

IP5-00175944

Baby Of KEERTHI

29-06-2026

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(M)

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3

PROBS AND POSITIONS CHART

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Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
15/7/26 6 AM	Rt Abd	Rt hand	supine	gilln	gilln	on	gilln	gilln	gilln	L
15/7/26 10 PM	Rt Abd	Rt leg	supine	gilln	gilln	on	gilln	gilln	gilln	R
16/7/26 2 AM	Lt Abd	Lt leg	supine	gilln	gilln	on	-	gilln	-	R
16/7/26 6 AM	Lt Abd	Rt hand	supine	gilln	gilln	on	-gilln	gilln	gilln	R
16/7/26 10 PM	Lt Abd	Rt hand	supine	gilln	gilln	on	gilln	gilln	gilln	R
17/7/26 2 AM	Lt Abd	Lt leg	supine	gilln	gilln	on	-	gilln	gilln	R



Q

PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
17/7/26 6am	Rt Abd	Rt femoral	supine	given	given	on	given	given	given	B
17/7/26 10pm	Rt Abd	Lt hand	supine	given	given	on	given	given	given	B
18/7/26 2am	Rt Abd	Rt leg	supine	given	given	on	-	given	-	B
18/7/26 6am	Rt Abd	Rt leg	supine	given	given	on	given	given	given	B
18/7/26 @ 10am	Right Abd	left leg	supine	given	given	on	given	given	given	<u>Shivani</u>
18/7/26 @ 1pm	Right Abd	Right leg	supine	given	given	on	given	given	given	<u>Shivani</u>

BAH-00660640
Baby Of KEERTHI
29-08-2026 0 Y 0 M 5 D (M)
Dr. VIJAYANAND JAMALPURI

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THE HUMPTY DUMPTY SCALE

3/7 4/2 5/7 5/2 6/7

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	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	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					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	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			15	15	15	15	15

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓	✓
Wheel Chair Support		x	+	x	x	x
Other Intervention(s) Specify		x	+	x	x	x
Nurse's Name :		Dipika	Dipika	Megha	Dipika	Megha
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		3/7	4/2	5/7	5/2	6/7
Time :		11pm	10pm	10pm	10pm	10pm

2

THE HUMPTY DUMPTY SCALE

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	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	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					
	Patient Placed in Bed	2	2	2	2	2	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			12	12	12	12	12

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓	✓
Wheel Chair Support		✓	✓	No	x	x
Other Intervention(s) Specify		x	x	No	x	x
Nurse's Name :		Suvar	Suvar	NO	Navya	Deepa
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		6/7/24	7/7	8/7/24	8/7	8/7
Time :		10:00	10:00	8:00	10:00	10:00



THE HUMPTY DUMPTY SCALE

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	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	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					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	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 sage	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			17	17	17	17	17

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
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 :		Navika	lasty	madhu	Rashmi	Shivam
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		9/7/26	9/7	9/7	10/7	10/7/26
Time :		6:00 AM	9:00 AM	2:00 PM	6:00 AM	10:00 AM



2

THE HUMPTY DUMPTY SCALE

10/7/26 11/7 11/7 26/12/7 13/7

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	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2	2	2	2	2	2
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1	1	1
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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			13	13	13	13	13

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
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 :		Akanksha	Mitu	Akanksha	Suchita	Debananda
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		10/11/26	11/7	11/7	12/7	12/7
Time :		8pm	@8pm	@8pm	@8Am	8pm



THE HUMPTY DUMPTY SCALE

13/7/26 13/7/26 14/7 14/7

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	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2	2	2	2	2	2
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1	1	1
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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			13	13	13	13	13

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓	✓
Wheel Chair Support		X	X	X	X	X
Other Intervention(s) Specify		X	X	✓	X	X
Nurse's Name :		Madhavi	Anand	Seeta	Madhavi	Rashmi
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		13/7/26	13/7/26	14/7	14/7	14/7
Time :		8am	2pm	10am	8am	6pm

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	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					
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					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	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					
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					
TOTAL							

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position						
Call device within reach						
Wheels Locked						
Room free of clutter						
Adequate Lighting						
Wheel Chair Support						
Other Intervention(s) Specify						
Nurse's Name :						
Signature :						
Date :						
Time :						

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	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					
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					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	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					
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					
TOTAL							

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position						
Call device within reach						
Wheels Locked						
Room free of clutter						
Adequate Lighting						
Wheel Chair Support						
Other Intervention(s) Specify						
Nurse's Name :						
Signature :						
Date :						
Time :						

BAH-00660640

IP5-00175944

Baby Of KEERTHI

29-06-2026

0 Y 0 M 5 D

(M)

Dr. VIJAYANAND JAMALPURI



Rainbow®
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It takes a lot to treat the little.

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NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	
	-2	-1	0	1	2	3/7	4/7	6/7	6/7	7/7	7/7	8/7	9/7	
						Time	Time	Time	Time	Time	Time	Time	Time	
						11pm	10pm	6am	6pm	6am	12pm	10pm	10am	
						Procedure	Carla Sedib	RBS	RBS	RBS	RBS	RBS	RBS	
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	+1	0	0	0	0	0	0	1	
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	+1	0	0	0	
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	+1	+1	+1	+1	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	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	+1	+1	0	0	+1	+1	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	+1	+1	0	0	+1	+1	+1	+1
						Total Pain / Agitation Score	+4	+3	+1	+1	+2	+2	+2	+2
						Intervention	OMC	OMC	OMC	OMC	OMC	OMC	OMC	OMC
						Effectiveness	Yes	Yes	Good	Good	Good	Good	Good	Good
						Signature	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]

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.



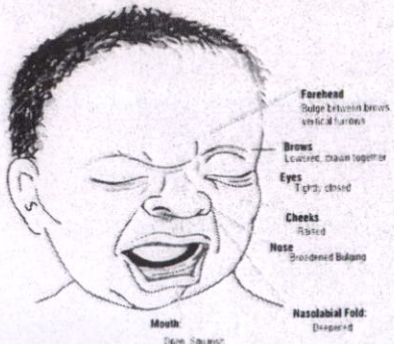
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

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		
							10/7/26	10/7/26	11/7	11/7	12/7	13/7/26	13/7/26		
							6am	1pm	8pm	8am	8pm	4pm	2Am		
							RBS	Suction	RBS	RBS	Suction	RBS	RBS		
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	1	1	1	1	1	1	1	1		
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	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	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	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	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	37wk	37 wk	37 weeks	37 weeks	37 week	37 week	37 wks	37 weeks	37 weeks
						Total Pain / Agitation Score	4/10	1/10	1/10	1/10	1/10	1/10	1/10	1/10	1/10
						Intervention	EBM	EBM	EBM	Non EBM	Non EBM	Non EBM	Non EBM	Non EBM	Non EBM
						Effectiveness	Good	Good	Good	Good	Good	Good	Good	Good	Good
						Signature									

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.

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
Procedure →													
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable								
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)								
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual								
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								
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								
 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							
						Total Pain / Agitation Score							
						Intervention							
						Effectiveness							
						Signature							

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.
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VENTILATOR CARE BUNDLE CHECK LIST

Date of Intubation: 3/7/26

No of Days on Ventilation: 1

Date of Tracheostomy: NA

Parameters	Date	Shift Time	3/7/26 8pm-8am	3/7/26 8pm-8am	4/7/26 8pm-8am	5/7/26 8am-8pm	5/7/26 8pm-8am		
Ready for Extubation today? (Discuss during the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Sedation holiday discussed? (Discuss during the clinical round)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Ventilator Circuit visibly soiled? (If Yes - Please Change)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Suction container visibly Soiled? (If Yes - Please Change)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Inline Suction Used?			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Is AMBU bag soiled? (If Yes - Please Change)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Check AMBU bag kept in a clean, Non-Sealed plastic bag? (If No - please change)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there condensate in the ventilatory circuit? (If Yes - drain away from the patient)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Head End elevated by 15°-30° (for neonates 10°-15°)? (If No - please change)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Oral and Nasal Care every 4 Hrs			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mouth Care with EBM (Only for Neonatal Patient)			☐ Yes ☒ No ☐ NA	☐ Yes ☒ No ☐ NA	☐ Yes ☒ No ☐ NA	☐ Yes ☒ No ☐ NA	☐ Yes ☒ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
Is ET / Oral Suction needed (2nd hrly)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sterile Suctioning Done			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse			Riff	Devy	Riff	Megha	Dippi		
Signature of the Nurse									

BAH-00660640
Baby Of KEERTHI
29-06-2026
Dr. VIJAYANAND JAMALPURI

IP5-00175944

0 Y 0 M 3 D (M)



VENTILATOR CARE BUNDLE CHECK LIST

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It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date of Intubation:

No of Days on Ventilation:

Date of Tracheostomy:

Parameters	Date	Shift Time						
Ready for Extubation today? (Discuss during the clinical round)	6/8/24	8 AM	☒ Yes ☐ No	21/2/26	8 AM to 8 PM	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Sedation holiday discussed? (Discuss during the clinical round)			☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Ventilator Circuit visibly soiled? (If Yes - Please Change)			☐ Yes ☒ No			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Suction container visibly Soiled? (If Yes - Please Change)			☒ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Inline Suction Used?			☐ Yes ☒ No			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is AMBU bag soiled? (If Yes - Please Change)			☐ Yes ☒ No			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check AMBU bag kept in a clean, Non-Sealed plastic bag? (If No - please change)			☒ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there condensate in the ventilatory circuit? (If Yes - drain away from the patient)			☐ Yes ☒ No			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Head End elevated by 15°-30° (for neonates 10°-15°)? (If No - please change)			☒ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Oral and Nasal Care every 4 Hrs			☒ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mouth Care with EBM (Only for Neonatal Patient)			☒ Yes ☐ No ☐ NA			☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
Is ET / Oral Suction needed (2nd hrly)			☐ Yes ☒ No			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sterile Suctioning Done			☒ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis			☐ Yes ☒ No			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse			Submita					
Signature of the Nurse								



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	8	10	12	2	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?		am	am	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm
Temperature (°F)	104												
	103												
	102												
	101												
	100	36.5°C	36.6°C	36.6°C	36.5°C	36.6°C	36.4°C	36.4°C	36.4°C	36.4°C	36.4°C	36.5°C	
	99												
	98												
	97												
	96												
	95												
	94												
Heart Rate (bpm)	190												
	180												
	170												
	160	155	171	176	179	172	171	170	150	172	159	172	
and	150												
Blood Pressure (mmHg) *	140	141	56	64	62	56	55	53	(51)	(51)	(48)	(54)	(54)
	130												
	120												
	110												
	100	41	48	59	53	48	46	44	42	57	56	46	44
	90												
	80												
	70												
	60												
	50												
Note: BP does not score in early warning scoring													
Heart Rate (Number)		132	147	146	150	141	146	151	152	152	142	159	146
Resp. Rate (bpm) (Over 1 Minute) *	70												
	60												
	50												
	40												
	30												
	20												
	10												
Resp Rate (Number)		47	51	46	41	43	57	65	66	37	26	30	58
Resp Mod/ Severe Distress None / Mild													
Receiving O ₂ (l/min) O ₂ Saturations (%)													
		100%	95%	97%	94%	94%	93%	88%	95%	92%	98%	94%	92%
Conscious Level Normal Altered		LIF	LF	LIF	LIF	LIF	LIF	LIF	LIF	LIF	LIF	LIF	LIF
		N	N	N	N	N	N	N	N	N	N	N	N
GCS *		C	C	C	C	C	C	C	C	C	C	C	C
TOTAL SCORE		0	0	0	0	0	0	0	0	0	0	0	0
Number of shaded boxes		0	0	0	0	0	0	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials		M	M	M	M	M	M	M	M	M	M	M	M

ACTIONS

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

NB: Scores 3 should be recorded overleaf

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

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Date	Time	Early Warning Score	Date	Time	Name

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10/7/26

Docu.No. : RCHBH/ FRM / CLINICAL / 127

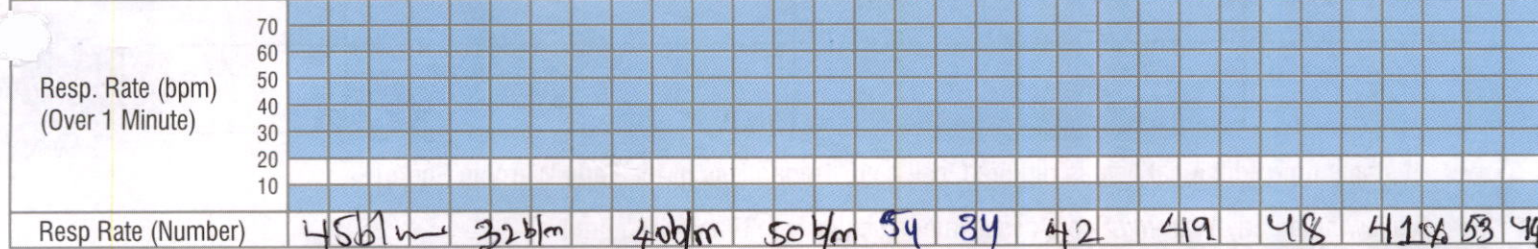
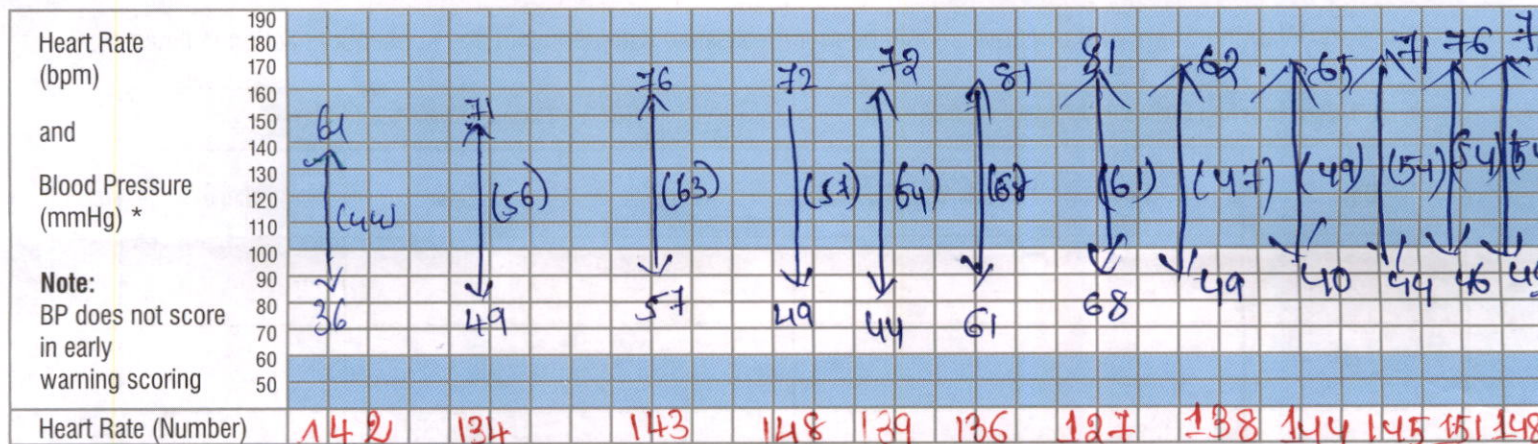
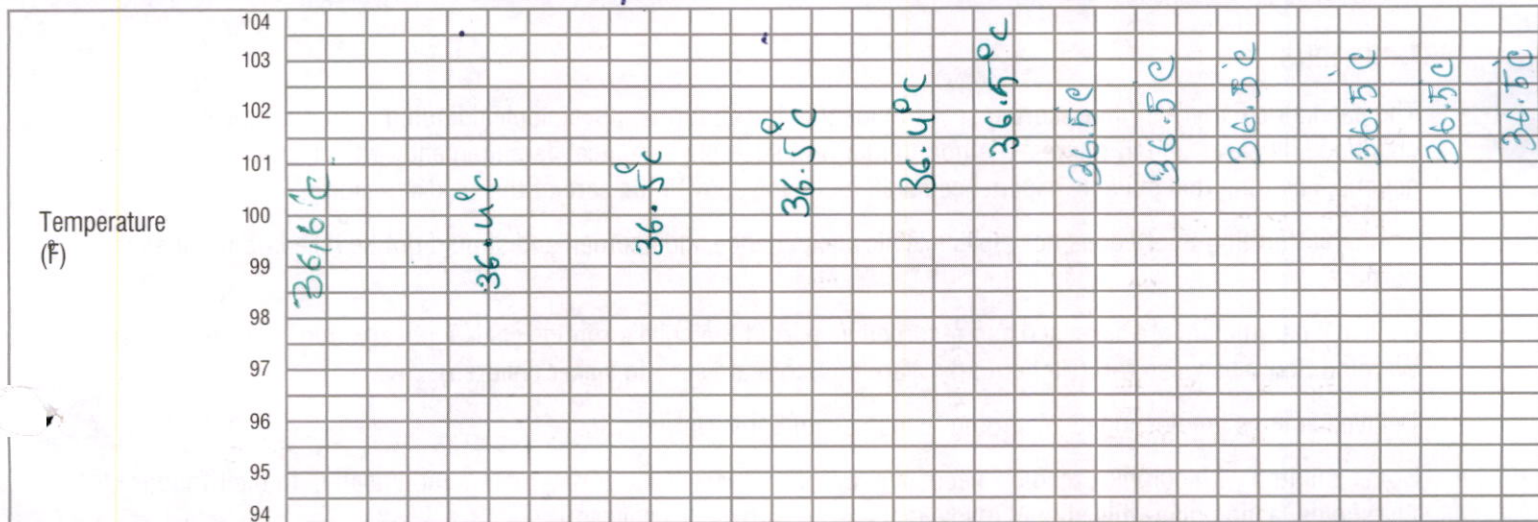
TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

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 : 10/7/2026. Time: 8 AM 10 AM 12 PM 2 PM 4 PM 6 PM 8 PM 10 PM 12 PM 2 PM 4 AM 6 AM
 Doctor / Nurse / Family Concern?



Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)	1 lit	changed to m/L 0.05
O ₂ Saturations (%)	88%	89%, 97%, 83%, 98%, 96%, 96%, 99%, 98%, 91%, 97%
Conscious Level	Normal	Altered
GCS *	N	N, N, N, N, N, N, N, N, N, N, N

TOTAL SCORE	0	0	0	0	0	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	+	+	+	+	+	+	+	+	+	+	+

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

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TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	8Am	10Am	12pm	2pm	4pm	6pm	8pm	12	4	6	
Doctor / Nurse / Family Concern?												
Temperature (F)	104											
	103											
	102											
	101											
	100											
	99	36.5 F	36.5 F	36.7 F	36.5 F	36.5 F	36.6 F	36.5 F	36.6 F	36.6 F	36.6 F	
	98											
	97											
	96											
	95											
	94											
	Heart Rate (bpm) and Blood Pressure (mmHg) *	190										
		180										
170												
160												
150												
140												
130												
120												
110												
100												
90												
80												
70												
60												
50												
Note: BP does not score in early warning scoring												
Heart Rate (Number)		150b/m	135b/m	157b/m	130b/m	144b/m	143b/m	143	142	130b/m	130b/m	
Resp. Rate (bpm) (Over 1 Minute)	70											
	60											
	50											
	40											
	30											
	20											
	10											
	Resp Rate (Number)											
		40b/m	33b/m	50b/m	38b/m	35b/m	41	51	55	59	40	40b/m
	Resp Distress	Mod/ Severe										
	None / Mild											
	Receiving O ₂ (l/min)		0.1lit		0.1lit	0.1lit	0.1lit	0.1lit	0.1lit	0.1lit	0.1lit	0.1lit
	O ₂ Saturations (%)		99%	95%	97%	95%	98%	92%	92%	92%	92%	92%
Conscious Level	Normal	N	N	N	N	N	N	N	N	N	N	
Altered												
GCS *		15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15	15/15	
TOTAL SCORE		0	0	0	0	0	0	0	0	0	0	
Number of shaded boxes		0	0	0	0	0	0	0	0	0	0	
Pain Score		0	0	0	0	0	0	0	0	0	0	
Observer's Initials		Py	Py	Py	Py	Py	Py	Py	Py	Py	Py	
ACTIONS	Score 1 : Continue normal observation by staff nurse											
	Score 2 : Shift in charge nurse to be informed and continue hourly observations											
	Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.											
	Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see											
	Score 5 & 6 : Shift in charge AND PICU fellow or PICU consultant to be informed.											

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	8	10	12	2	4	6	8	10 PM	12 AM	2 AM	4 AM	6 AM	8 AM
Doctor / Nurse / Family Concern?		Am	Am	Pm	Pm	pm	pm	pm						
Temperature (F)	104													
	103													
	102													
	101													
	100													
	99													
	98													
	97													
	96													
	95													
	94													
Heart Rate (bpm) and Blood Pressure (mmHg) *	190													
	180													
	170													
	160													
	150													
	140													
	130													
	120													
	110													
	100													
	90													
	80													
	70													
	60													
50														
Heart Rate (Number)		156	159	165	161	174	175		140	148	152	161	158	148
Resp. Rate (bpm) (Over 1 Minute)	70													
	60													
	50													
	40													
	30													
	20													
	10													
Resp Rate (Number)		46	55	39	51	53	74		42	48	68	48	52	50
Resp Distress														
Mod/ Severe Distress														
Receiving O ₂ (l/min)														
O ₂ Saturations (%)		97%	90%	98%	98%	98%	97%		98%	98%	98%	96%	99%	99%
Conscious Level		N	N	N	N	N	N							
Normal Level														
Altered														
GCS *		1	1	1	1	1	1		1	1	1	1	1	1
TOTAL SCORE														
Number of shaded boxes		0	0	0	0	0	0		0	0	0	0	0	0
Pain Score		0	0	0	1	1	1		1	1	1	1	1	1
Observer's Initials		2	2	2	2	2	2		2	2	2	2	2	2

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④ 13/7/26

TEENAGE (12 + years)
Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	8	10	12	2	4	6	8	10	12	2	4	6	8
Doctor / Nurse / Family Concern?		Am	Am	Pm	Pm	Pm	Pm	Pm	Pm	Am	Am	Am	Am	Am
Temperature (F)		36.5°C	36.4°C	36.5°C	36.5°C	*36.5°C	*36.5°C	*36.5°C	36.6°C	36.7°C	36.6°C	36.7°C	36.8°C	36.8°C
Heart Rate (bpm)		62	71	74	61	79	70	70	68	68	78	78	80	69
Blood Pressure (mmHg) *		105/65	104/64	105/50	105/62	110/65	103/64	103/64	104/60	102/60	102/60	102/60	102/60	102/60
Note: BP does not score in early warning scoring														
Heart Rate (Number)		140	149	156	132	142	140	140	148	148	150	148	147	159
Resp. Rate (bpm) (Over 1 Minute)														
Resp Rate (Number)		55	45	41	47	39	45	45	68	42	52	54	68	67
Resp Mod/ Severe Distress None / Mild														
Receiving O ₂ (l/min) O ₂ Saturations (%)		26%	25%	23%	27%	29%	28%	28%	24%	24%	26%	28%	24%	24%
Conscious Level		N	N	N	N	N	N	N	C	C	C	C	C	C
GCS *		1	1	1	1	1	1	1	1	1	1	1	1	1
TOTAL SCORE		0	0	0	0	0	0	0	0	0	0	0	0	0
Pain Score		1	1	1	1	1	1	1	1	1	1	1	1	1
Observer's Initials		MA	MA	MA	MA	MA	MA	MA	MA	MA	MA	MA	MA	MA

ACTIONS

NB: Scores 3 should be recorded overleaf

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

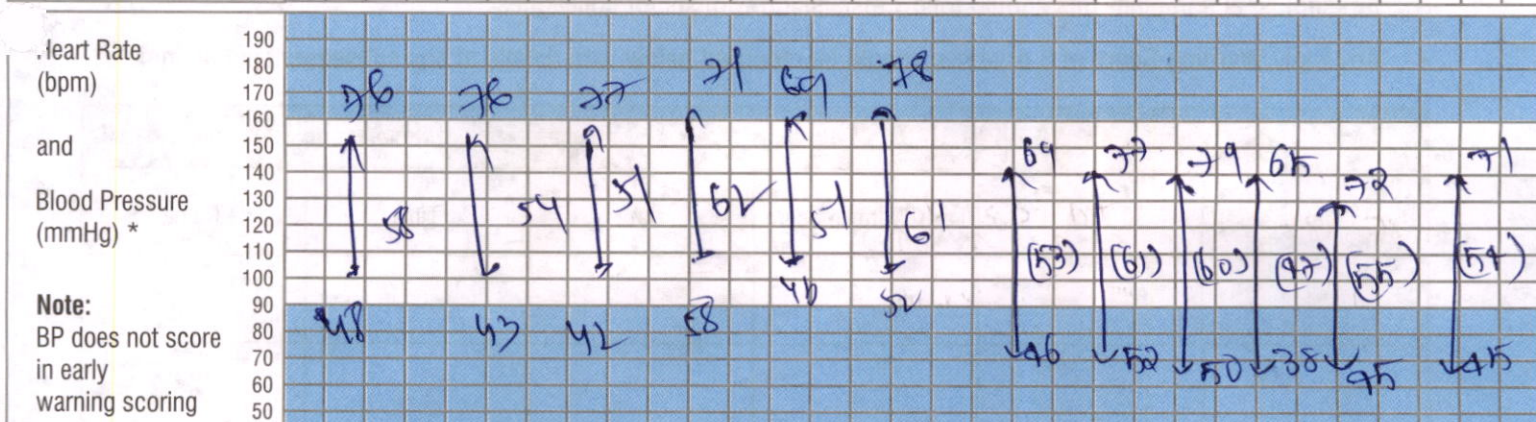
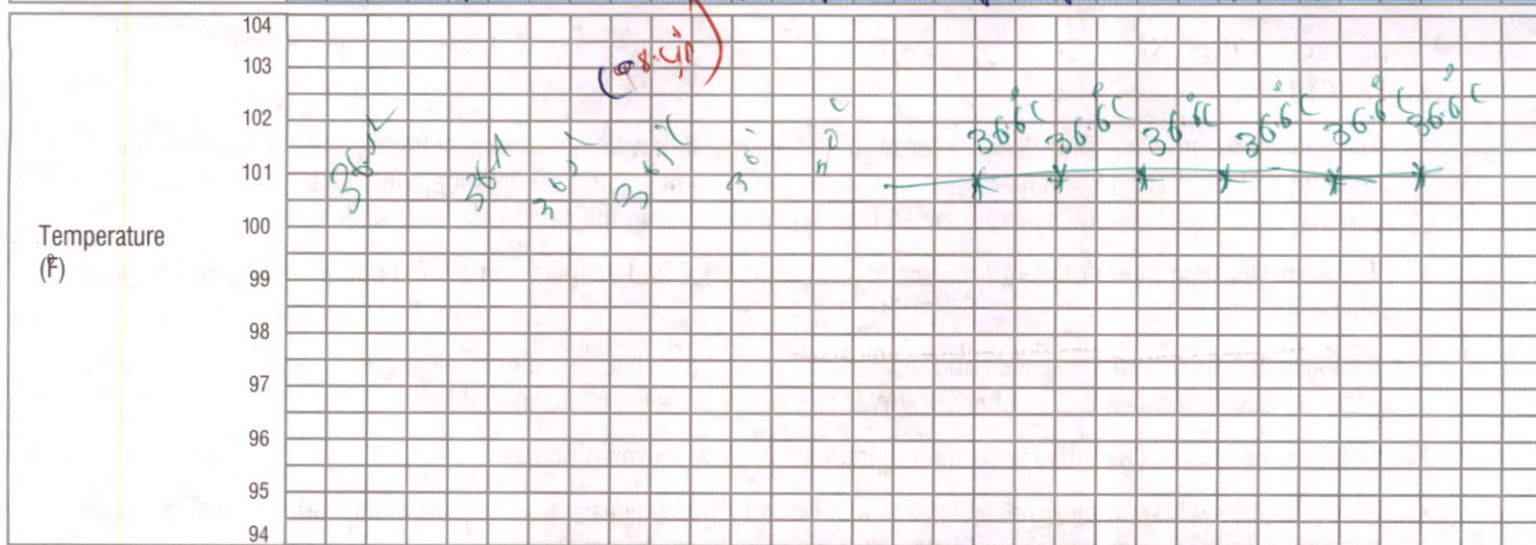
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 15/7/26 Time: 8 AM 10 AM 12 PM 2 PM 4 PM 6 PM 8 PM 10 PM 12 AM 2 AM 4 AM 6 AM
Doctor/Nurse/Family Concern? * * * * *



Heart Rate (Number) 168 161 150 168 171 142 166 149 159 153 151 139

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

Resp Rate (Number) 53 52 41 51 52 29 63 56 47 53 63 50

Resp Distress Mod/ Severe None / Mild LIF LIF LIF LIF LIF LIF LIF LIF LIF LIF LIF LIF

Receiving O₂ (l/min) O₂ Saturations (%) 99 99 99 97 99 99 91 95 98 97 93 100

Conscious Level Normal Altered L

GCS * 11 11 11 11 11 11 11 11 11 11 11 11

TOTAL SCORE Number of shaded boxes 4

Pain Score 0 0 0 0 0 0 0 0 0 0 0 0

Observer's Initials [Signature]

ACTIONS
Score 1 : Continue normal observation by staff nurse
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7

Docu.No. : RCHBH/ FRM / CLINICAL / 127

TEENAGE (12 + years)

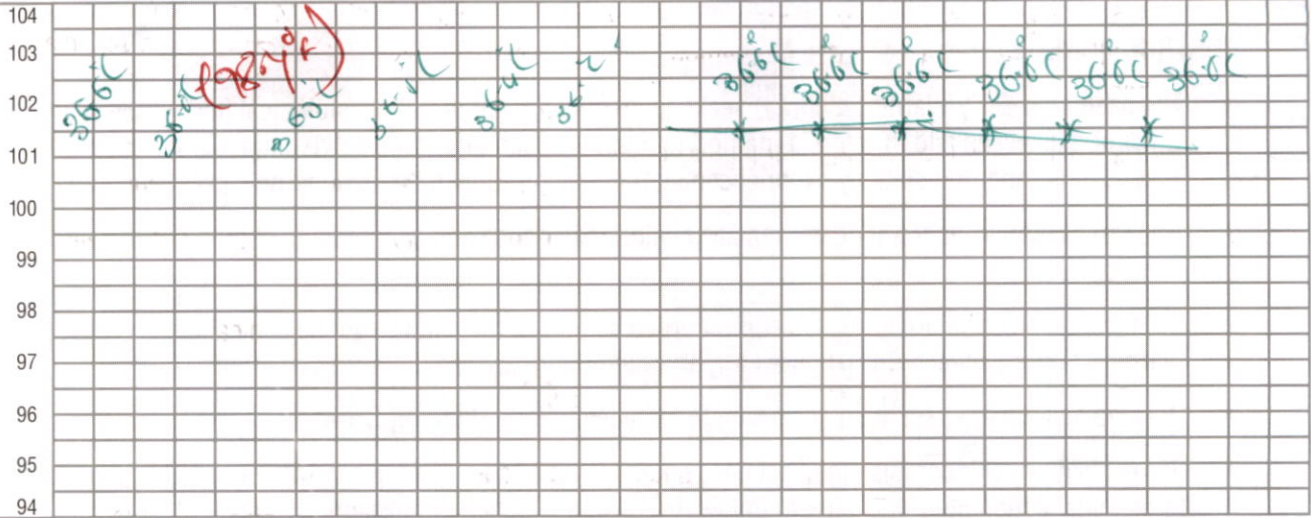
Children's Observation & Early Warning Scoring Chart

Pratiksha
Rainbow
Children's
Hospital
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Your Right to a Safe Delivery

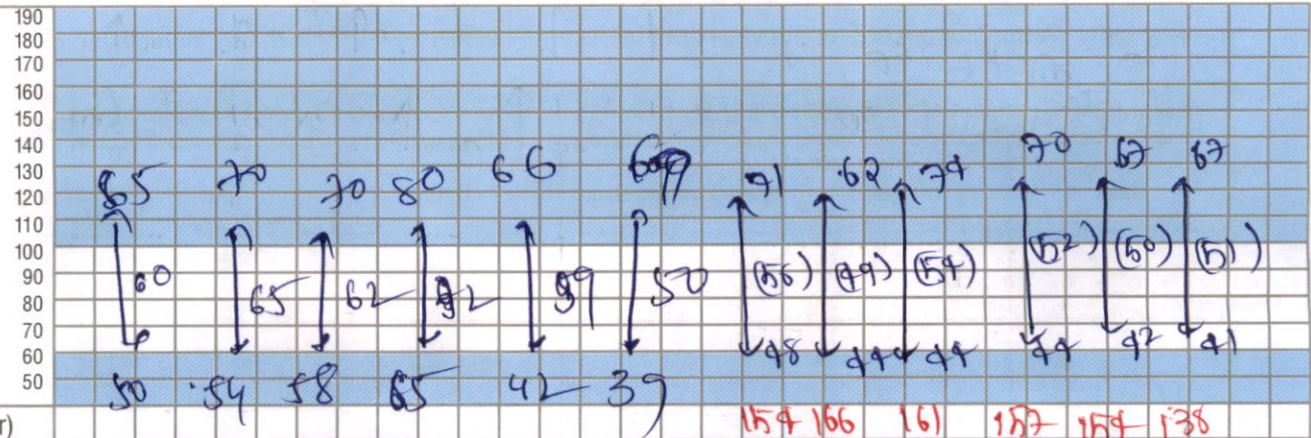
EARLY WARNING SCORE: CHILDREN'S UNIT

Date : 16/2/26 Time: 8 AM 10 AM 12 PM 2 PM 4 PM 6 PM 8 PM 10 PM 12 AM 2 AM 4 AM 6 AM

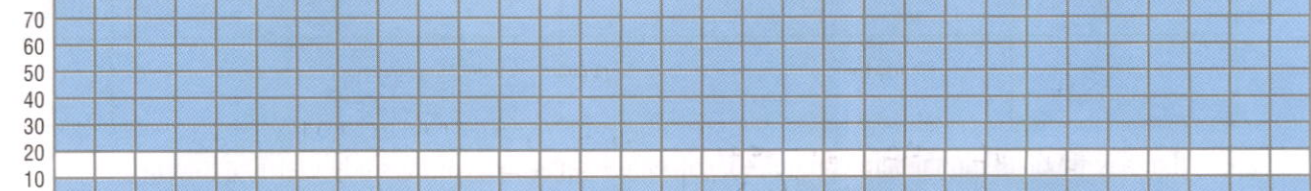
Doctor / Nurse / Family Concern? (Signature)

Temperature
(F)Heart Rate
(bpm)

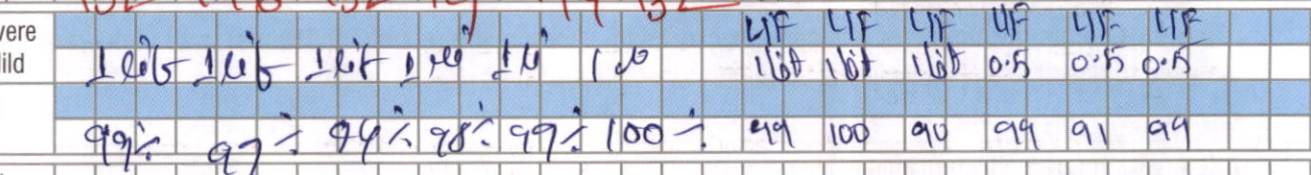
and

Blood Pressure
(mmHg) *Note:
BP does not score
in early
warning scoring

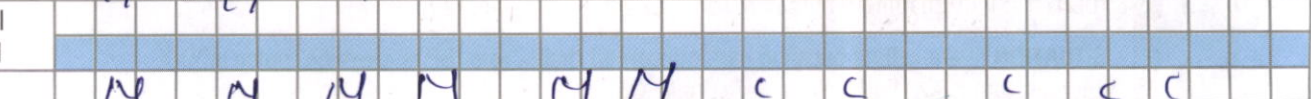
Heart Rate (Number)

Resp. Rate (bpm)
(Over 1 Minute)

Resp Rate (Number)

Resp Mod/ Severe
Distress None / MildReceiving O₂ (l/min)
O₂ Saturations (%)Conscious Level
Normal Altered

GCS *

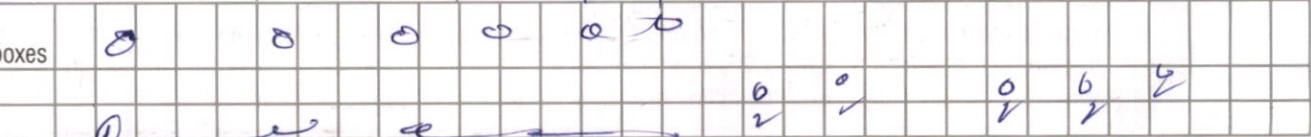


TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials



ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

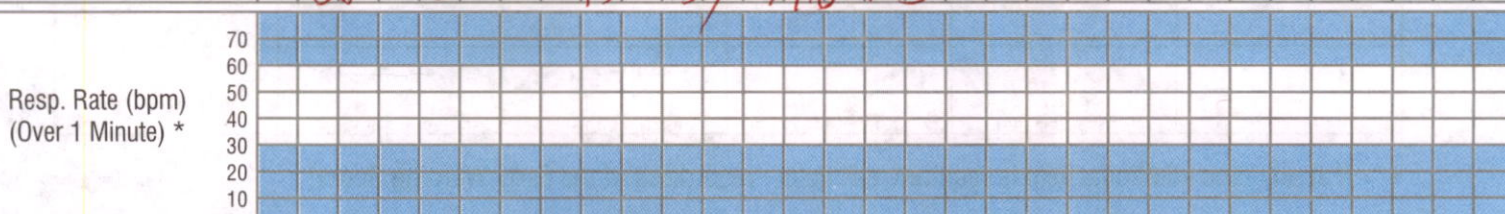
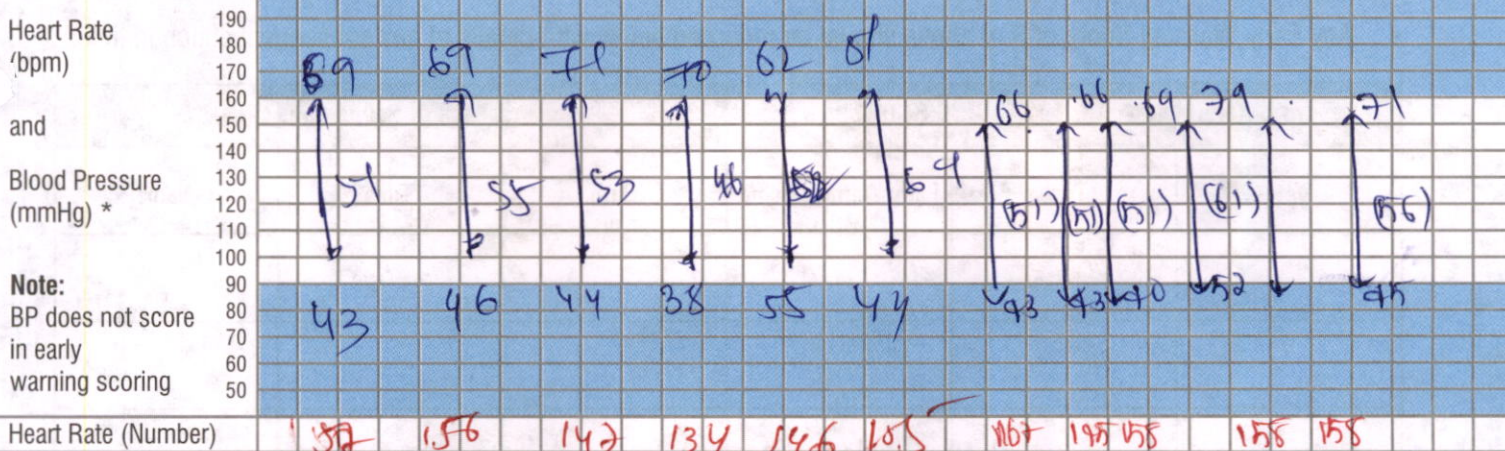
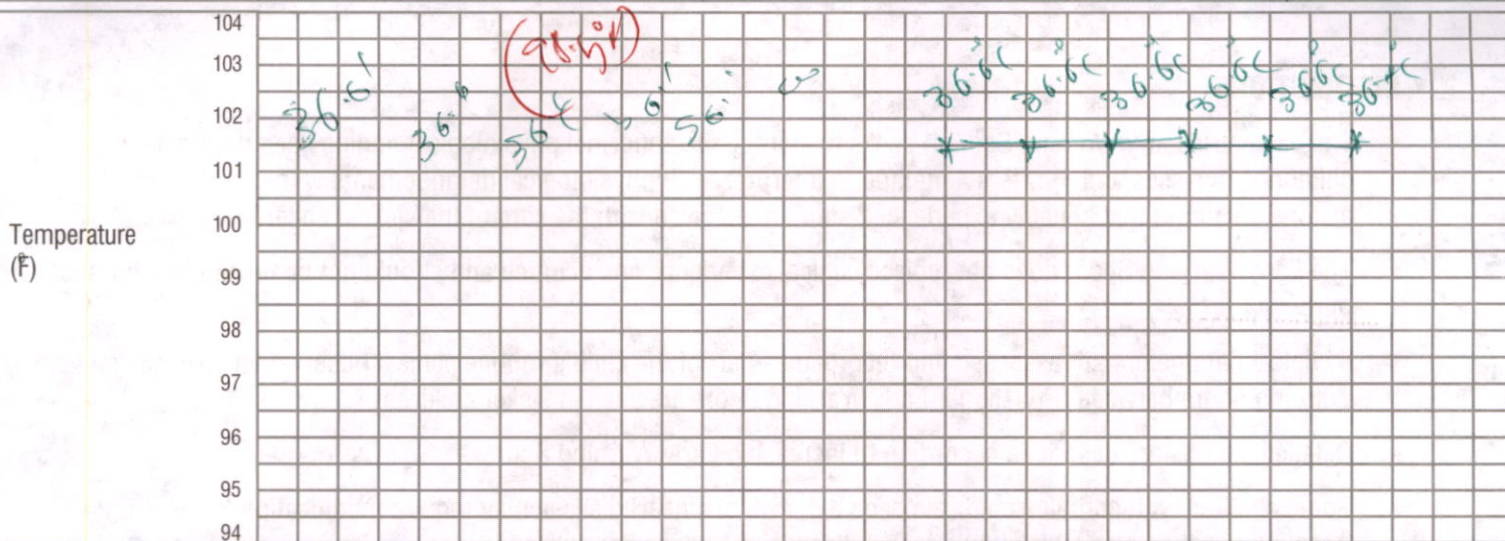


8

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 17/9/26 Time: 18 AM 10 AM 12 PM 2 PM 4 PM 6 PM 8 PM 10 PM 12 AM 2 AM 4 AM 6 AM
 Doctor/Nurse/Family Concern? Per Per Per Per Per Per



esp Rate (Number)		45	49	53	62	72	34	44	51	45	24	58	71
Resp	Mod/ Severe							HF	HF	HF	HF	HF	
Distress	None / Mild							99	95	43	98	96	100
Receiving O ₂ (l/min)													
O ₂ Saturations (%)								0.6	0.6	0.6	0.6	0.6	0.6
Conscious	Normal	N	N		N	N	N	N	N	N	N	N	N
Level	Altered												
GCS *													

TOTAL SCORE	0	0	0	0	0	0	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0	0	0	0	0	0	0
Pain Score												
Observer's Initials	U	U	U	U	U	U	U	U	U	U	U	U

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

9/7/20

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					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	O.G							
	08:00 am	DBM			25ml		-			150ml	0	lathya
	09:00 am										0	
	10:00 am	DBM			25ml		passed little			10ml	0	lathya
	11:00 am										0	
	12:00 pm	DBM			25ml		-			15ml	0	lathya
	01:00 pm										0	
Total Intake :						Total Output : 40ml						
	02:00 pm											
	03:00 pm	DBM			25ml		Passed			10ml		
	04:00 pm						-					
	05:00 pm	DBM			25ml		-			120ml		
	06:00 pm											
	07:00 pm	DBM			25ml							
Total Intake :						Total Output : 22ml						
	08:00 pm											
	09:00 pm	DBM			25ml		Passed			10ml	0	R
	10:00 pm										0	
	11:00 pm	DBM			25ml		passed			9ml	0	up
	12:00 am											
	01:00 am	DBM			25ml		-			8ml		
Total Intake :						Total Output : 27ml						
	02:00 am						-				0	
	03:00 am	DBM			25ml		Passed			10ml	0	up
	04:00 am										0	
	05:00 am	DBM			25ml		-			8ml	0	up
	06:00 am											
	07:00 am	DBM			25ml		Passed			9ml	0	up
Total Intake :						Total Output : 18ml						
Total 24 hrs. Intake :						Total 24 hrs. Output :						
645						92ml						
Total 24 hrs. Intake :						Total 24 hrs. Output :						
645						92ml						

FLUID CHART

Sheet No. : 2

10/7/26

TV :- 140 C

B.Wt :- 2.224

TF :-

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		
			Mouth	I.V	O.G							
	08:00 am										1	}
	09:00 am	DBM			25ml		passed		10ml	0		
	10:00 am											
	11:00 am	DBM			25ml		passed		12ml	1		
	12:00 pm											
	01:00 pm	DBM			25ml		-		9ml	1		
Total Intake :					Total Output : U :- 31ml m :- 2 hrs							
	02:00 pm									1	}	
	03:00 pm	DBM			25ml		passed		10ml	0		
	04:00 pm											
	05:00 pm	DBM			25ml		passed		13ml	1		
	06:00 pm											
	07:00 pm	FF			25ml		-		11ml	1		
Total Intake :					Total Output : U :- 34ml m :- 2							
	08:00 pm										}	
	09:00 pm	FF			25ml		Passed		10ml			
	10:00 pm											
	11:00 pm	FF			25ml		Passed		9ml			
	12:00 am											
	01:00 am	FF			25ml		-		8ml			
Total Intake :					Total Output :							
	02:00 am										}	
	03:00 am	FF			25ml		Passed		8ml			
	04:00 am											
	05:00 am	FF			25ml		Passed		10ml			
	06:00 am											
	07:00 am	FF			25ml		Passed		12ml			
Total Intake : 300 ml					Total Output : 122 ml							
Total 24 hrs. Intake		5.6 cc/Kg										
Total 24 hrs. Output		2.2 cc/Kg										

BAH-00660640
Baby Of KEERTHI
29-06-2026 0 Y 0 M 12 D (M)
Dr. VIJAYANAND JAMALPURI

IP5-00175944

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FLUID CHART

Sheet No. : 3

TV - 140 cc
B.W → 2.240

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	OG							
	08:00 am											
	09:00 am	Nan			25ml		Passed			12ml		(M)
	10:00 am											
	11:00 am	Nan			25ml					10ml		(M)
	12:00 pm											
	01:00 pm	Nan			25ml		Passed			9ml		(M)
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm	Nan			25ml					10ml		(M)
	04:00 pm											
	05:00 pm	EBM			25ml		Small amount			10ml	6	(M)
	06:00 pm											
	07:00 pm	Nan			25ml		Passed			12ml		(M)
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm	Nan			25ml		small			9ml		(M)
	10:00 pm											
	11:00 pm	Nan			25ml		Passed			10ml		
	12:00 am											
	01:00 am	Nan			25ml		Passed			12ml		
Total Intake :					Total Output :							
	02:00 am											
	03:00 am	Nan			25ml		Passed			15ml		(M)
	04:00 am											
	05:00 am	Nan			25ml					10ml		
	06:00 am											
	07:00 am	Nan			25ml		Passed			9ml		
Total Intake : 300 ml					Total Output : 128 ml							
Total 24 hrs. Intake		5.5 cc/kg										
Total 24 hrs. Output		2.3 cc/kg										



FLUID CHART

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Sheet No. : 6

Wt - 1500 kg
 B. wt - 2038
 TF - 30 ml

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

Date	Time	Nature of Fluid	Intake			Output						IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	O.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am	EBM			30ml					10ml			
	10:00 am												
	11:00 am	Pre nano			30ml					7ml			
	12:00 pm												
	01:00 pm	EBM			30ml					10ml			
Total Intake :			80ml			Total Output :						27ml	
	02:00 pm												
	03:00 pm	Benon			30ml					5ml			
	04:00 pm												
	05:00 pm	Pre nano			30ml					5ml			
	06:00 pm												
	07:00 pm	Pre nano			30ml					5ml			
Total Intake :			60ml			Total Output :						1	
	08:00 pm												
	09:00 pm	EBM			30ml					10ml			
	10:00 pm												
	11:00 pm	Pre nano			30ml								
	12:00 am												
	01:00 am	Pre nano			30ml					11ml			
Total Intake :			90ml			Total Output :						22ml	
	02:00 am												
	03:00 am	Pre nano			30ml					9ml			
	04:00 am												
	05:00 am	Pre nano			30ml								
	06:00 am									12ml			
	07:00 am	Pre nano			30ml								
Total Intake :			90ml			Total Output :						21ml	
Total 24 hrs. Intake			1500 kg/day			Total 24 hrs. Output			1400 kg/day				

FLUID CHART

Sheet No. : 7

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am											}	
	09:00 am	EBM			32ml		pus			10ml			
	10:00 am												
	11:00 am	EBM			32ml		pus			12ml			
	12:00 pm												
	01:00 pm	EBM			32ml					09ml			
Total Intake :						Total Output :							
	02:00 pm											}	
	03:00 pm	pus			32					12ml			
	04:00 pm												
	05:00 pm	pus			32		pus			09ml			
	06:00 pm												
	07:00 pm	EBM			32								
Total Intake :						Total Output :							
	08:00 pm											}	
	09:00 pm	Prenan			32ml					10ml			
	10:00 pm												
	11:00 pm	Prenan			32ml								
	12:00 am									11ml			
	01:00 am	EBM			32ml								
Total Intake :						Total Output :							
	02:00 am											}	
	03:00 am	Prenan			32ml					12ml			
	04:00 am						pus (green)						
	05:00 am	Prenan			32ml								
	06:00 am									11ml			
	07:00 am	Prenan			32ml								
Total Intake :						Total Output :							

Total 24 hrs. Intake

160 ccl/kg/day

Total 24 hrs. Output

1.6 ccl/kg/day



16/7/26

FLUID CHART

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Sheet No. : 8

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am	PBF NAN			32					12ml		
	10:00 am											
	11:00 am	EBM			32							
	12:00 pm											
	01:00 pm	PBF NAN			32		passed			21ml		
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm	EBM			32					11ml		
	04:00 pm											
	05:00 pm	PBF NAN			32		passed					
	06:00 pm											
	07:00 pm	PBF			32					20ml		
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm	PBF NAN			32ml					10ml		
	10:00 pm						passed (yellow)					
	11:00 pm	PBF NAN			32ml							
	12:00 am									9ml		
	01:00 am	PBF NAN			32ml							
Total Intake :						Total Output :						
	02:00 am						Passed yellow.					
	03:00 am	EBM			32ml					12ml		
	04:00 am											
	05:00 am	PBF NAN			32ml							
	06:00 am									10ml		
	07:00 am	PBF NAN			32ml							
Total Intake : 368 ml						Total Output : 110 ml						
Total 24 hrs. Intake			1.93 cll/kg/day									
Total 24 hrs. Output			1.9 cll/kg/day									

2

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA :	3/7/26		Diagnosis :	TAMM / SEPSIS / DRUGS		Surgery / Procedures :	PNA		
	Allergies :							Post OP Day :	PNA	
	Date :	6/7/26	7/7/26	8/7/26	8/7/26	9/7/26	9/7/26			
	Area	NY	NY	NY	NY	NY	NY			
	Shift Time	8pm-8am	8pm-8am	8pm-8am	8pm-8am	8pm-8am	8pm-8am			
	Diet :	NP.O	DBM	DBM	DBM	DBM	DBM			
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)	NEO	CPAP	CPAP	CPAP	CPAP	Eor			
	1.	OG-①	OGT	OG-①	OG-①	OG-①	OG-①			
	2.	IV-①	IV-①	IV-①	IV-①	IV-①	IV-①			
	3.									
ASSESSMENT	Infusions / Transfusions	BP	66/46	70/46	70/46	67/55	69/58	61/41		
		PR	102	125	102	143	140	138		
		RR	28	28	28	39	40	40		
	Vitals	SpO ₂	98%	97%	98%	97%	98%	99%		
		Temp	36.5°C	36.7°C	36.6°C	36.3°C	36.5°C	36.5°C		
		Pain Score	+2	+2	+2	+2	+2	+2		
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert	Alert	Alert			
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact	Intact	Intact			
	Restraints If any	Yes	Yes	NA	NA	NA	NA			
	Fall Risk (Vulnerable (Y/N) if yes score)	Yes	Yes	Yes	Yes	Yes	Yes			
	(Ambulation, walking, moving with assistance, bed ridden)	Bed ridden	Bed ridden	Bed ridden	Bed ridden	Bed ridden	Bed ridden			
	ADL (Dependent / Non-Dependent)	Dependent	Dependent	Dependent	Dependent	Dependent	Dependent			
Critical Lab Test / Values (if any)	NA	NA	NA	NA	NA	NA				

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS		Investigations Procedures						
		Date :	Area	Shift Time	Ordered / Planned	Due	Reports Pending	Referrals (If any)
		8/17/26	NY	8pm-8am	1000 8pm-8am CBI CRD SBR	NA	NA	NA
		7/17/26	NY	8pm-8am	PAS VBS	NA	NTD	NA
		8/17/26	NY	8pm-8am	RBS VBS	NA	NA	NA
		8/7	NY	8pm-8am	RBS VBS	NA	NA	NA
		9/7/26	NY	8pm-8am	RBS OD	NA	NA	NA
		9/7/26	NY	8pm-8am	RBS OD	NA	NA	NA
	Remarks (Special Interventions like, Drainage Tube flushing etc.)	NA	NA	NA	NA	NA	NA	NA
	Handed Over By Name :	hussmita	Nirupama	Nayya	Dippi	Susma Aruna	Latta	
	Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
	Date :	8/17/26	7/17/26	8/17/26	8/7	9/7/26	9/7	
	Time :	@ 8pm	@ 8pm	@ 8pm	@ 8pm	@ 6pm	@ 2pm	
	Taken Over By Name :	Nirupama	Nayya	Dippi	Susma Aruna	Latta	Madhama	
	Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
	Date :	7/17/26	7/17/26	8/7	8/7/26	9/7	9/17/26	
	Time :	8am	@ 8am	@ 8am	@ 8pm	@ 8am	@ 2pm	

BAH-00660640 IP5-00175944
 Baby Of KEERTHI
 29-06-2026 0 Y 0 M 5 D (M)
 Dr. VIJAYANAND JAMALPURI



THE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 3/7/26	Diagnosis : Term / Sepin		Surgery / Procedures : 2nd		
		Allergies :		Post OP Day : 2nd			
Date :		3/7/26	4/7/26	4/7/26	5/7/26	5/7/26	
	Area	Ny 8pm-8am	Ny 8pm-8am	Ny 8pm-8am	Ny 8pm-8am	Ny 8pm-8am	
Shift Time		Ny 8pm-8am	Ny 8pm-8am	Ny 8pm-8am	Ny 8pm-8am	Ny 8pm-8am	
	Diet :	NPO	NPO	DBM	DBM	DBM	
Ventilation (RA, NP, NIV, VENTI)		Vent	Vent	Vent	NIV	NIV	
INVASIVE LINES	1.	CGH 9	CGH 9	CGH 9	CGH 9	CGH 9	
	2.	IV Line 2-0	IV Line 2-0	IV Line 2-0	IV	IV -1	
	3.						
	4.						
ASSESSMENT	Infusions / Transfusions		10% Isop	10% Isop	10% Isop	10% Isop	
	PU Prophylaxis		NA	NA	NA	NA	
	DVT Prophylaxis		NA	NA	NA	NA	
	Vitals	BP	67/43(52)	65/48(54)	71/51(58)	63/38(47)	70/48(56)
		PR	119	120	126b/m	126b/m	121b/m
		RR	38	42	30b/m	60b/m	59b/m
		SpO ₂	97%	93	98%	95%	96%
		Temp	36.6C	36.6C	36.4C	36.6C	36.6C
	Pain Score		+2	+2	+2	+1	1/10
	LOC (Alert, Conscious, Confusion, Unconscious)		Alert	Alert	Alert	Alert	Alert
	Skin Integrity (Intact / Bedsore / Any other condition)		Intact	Intact	Intact	Intact	Intact
	Restraints If any		NA	NA	NA	NA	NA
Fall Risk (Vulnerable (Y/N) if yes score)		Yes	Yes	Yes	Yes	Yes	
(Ambulation, walking, moving with assistance, bed ridden)		Bedridden	Bed	Bedridden	Bedridden	Bedridden	
ADL (Dependent / Non-Dependent)		Dep	Dep	Dep	dependent	Dep	
Critical Lab Test / Values (if any)		NA	NA	NA	NA	NA	

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

		Date :	3/7/26	4/7/26	5/7/26	6/7/26	7/7/26	
		Area	Ny 8pm-8am	Ny 8pm-8am	Ny 8pm-8am	Ny 8pm-8am	Ny 8pm-8am	Ny 8pm-8am
RECOMMENDATIONS	Investigations Procedures	Shift Time						
		Ordered / Planned	IV-1100g Feeds Tupak	IV-1200g Feeds Tupak	IV-1200g Feeds Tupak	IV-1200g Feeds Tupak	IV-1200g Feeds Tupak	IV-1200g Feeds Tupak
		Due						
		Reports Pending						
		Referrals (If any)						
Remarks (Special Interventions like, Drainage Tube flushing etc.)								
Handed Over By Name :		Dippi	Dippi	Dippi	Megha	Dippi	Alphane	
Signature :								
Date :		4/7/26	4/7/26	5/7/26	5/7/26	6/7/26	6/7/26	
Time :		8pm	8pm	8pm	8pm	8pm	8pm	
Taken Over By Name :		Dippi	Dippi	Megha	Dippi	Alphane	Susra	
Signature :								
Date :		4/7/26	4/7/26	5/7/26	5/7/26	6/7/26	6/7/26	
Time :		8pm	8pm	8pm	8pm	8pm	8pm	

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA: 3/7/26		Diagnosis: Term sepsis/RDS		Surgery / Procedures:	
		Allergies:		Post OP Day:			
INVASIVE LINES	Date:	01/7/26	01/7/26	10/7/26	10/7/26	11/7/26	11/7/26
	Area	NU 2pm-8pm	NU 8pm-8am	NU 8pm-8pm	KMC room 8pm-8am	KMC room 8am-8pm	KMC room 8pm-8am
ASSESSMENT	Shift Time						
	Diet:	DBM	DBM	FF	FF	EBM+FF	BF
	Ventilation (RA, NP, NIV, VENTI)	LIF	LIF	LIF	LIF	LIF	LIF
	1.	OG-①	OG-①	OG-①	OG-①	OG-①	OG-①
	2.	IV-①	IV-①	W-①	IV-①		
	3.						
	4.						
	Infusions / Transfusions	NA	NA	NA	NA	NA	NA
	PU Prophylaxis	NA	NA	NA	NA	NA	NA
	DVT Prophylaxis	NA	NA	NA	NA	NA	NA
Vitals	BP	69/58(50)	74/50(59)	68/57(49)	71/42(52)	71/48	69/90(58)
	PR	100b/m	151b/m	160b/m	145b/m	138b/m	165b/m
	RR	42b/m	53b/m	29b/m	30b/m	54b/m	62b/m
	SpO ₂	96%	96%	97%	98%	97%	99%
	Temp	36.5°C	36.6°C	36.5°C	36.5°C	36.6°C	36.6°C
	Pain Score	2/10	2/10	2/10	2/10	2/10	2/10
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert	Alert	Alert
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact	Intact	Intact
	Restraints If any	NA	NA	NA	NA	NA	NA
	Fall Risk (Vulnerable (Y/N) if yes score)	yes	yes	yes	yes	yes	yes
ADL (Dependent / Non-Dependent)	(Ambulation, walking, moving with assistance, bed ridden)	moving	moving	moving	moving	moving	moving
	ADL (Dependent / Non-Dependent)	dependent	dependent	dependent	dependent	dependent	dependent
	Critical Lab Test / Values (if any)	NA	NA	NA	NA	NA	NA

Note: RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :	9/7/26	9/7/26	10/7/26	10/7/26	11/7/26	11/7/26
		Area Shift Time	Ny 2pm-8pm	Ny 8pm-8am	Ny 8pm-8pm	KMC Room 8pm-8am	KMC 8am-8pm	KMC 8pm-8am
	Ordered / Planned		RBS OD	RBS -OD	RBS OD	RBS OD	RBS OD	RBS-OD Nasal suction
	Due		NA	NA	NA	NA	NA	NA
	Reports Pending		NA	NA	NA	NA	NA	NA
	Referrals (If any)		NA	NA	NA	NA	NA	NA
	Remarks (Special Interventions like, Drainage Tube flushing etc.)		NA	NA	NA	NA	NA	NA
Handed Over By Name :		Madhavi	Reshmita	Shivani	Akansha	Mitu	Akansha	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date :		9/7/26	10/7/26	10/7/26	10/7/26	11/7/26	12/7/26	
Time :		@8pm	@8am	@8pm	@8am	@8pm	@8am	
Taken Over By Name :		Reshmita	Shivani	Akansha	Mitu	Akansha	Sichitra	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date :		9/7/26	10/7/26	10/7/26	11/7	11/7	12/7	
Time :		8pm	@8am	@8pm	@8am	@8pm	@8am	



NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA : 3/7/26	Diagnosis : Term/SCPSIS/RDS		Surgery / Procedures :			
	Allergies :			Post OP Day :			
	Date :	12/7/26	12/7/26	13/7/26	13/7/26	14/7/26	
	Area	KMC	KMC	KMC	KMC	KMC	
	Shift Time	8Am-2pm	2pm-8pm	8Am-2pm	2pm-8pm	8Am-2pm	
	Diet :	EBM+FF	EBM+FF	FF+EBM	EBM+FF	FF+EBM	
	Ventilation (RA, NP, NIV, VENTI)	L/F	L/F	L/F	L/F	L/F	
INVASIVE LINES	1.	OG-①	OG-①	OG-①	OG-①	OG-①	
	2.						
	3.						
	4.						
ASSESSMENT	Infusions / Transfusions	NA	NA	NA	NA	NA	
	PU Prophylaxis	NA	NA	NA	NA	NA	
	DVT Prophylaxis	NA	NA	NA	NA	NA	
	Vitals	BP	69/44 (52)	74/55 (61)	70/42 (53)	66/40 (52)	69/48 (52)
		PR	157 blm	147 blm	153 blm	146 blm	143 blm
		RR	38 blm	24 blm	43 blm	50 blm	60 blm
		SpO ₂	98.6%	99%	94%	95%	98%
		Temp	36.5°C	36.4°C	36.6°C	36.5°C	36.6°C
	Pain Score	2/10	1/10	1/10	1/10	1/10	
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert	Alert	
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact	Intact	
	Restraints If any	NA	NA	NA	NA	NA	
	Fall Risk (Vulnerable (Y/N) if yes score)	Yes	Yes	Yes	Yes	Yes	
		(Ambulation, walking, moving with assistance, bed ridden)	Moving	Moving	Moving	Moving	Moving
ADL (Dependent / Non-Dependent)	Depend	Dependent	Dependent	Dependent	Dependent		
Critical Lab Test / Values (if any)	NA	NA	NA	NA	NA		

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :	12/7/26	12/7/26	13/7/26	13/7/26	13/7/26	14/7/26
		Area	KMC	KMC	KMC	KMC	KMC	KMC
		Shift Time	8Am-2Pm	2pm-8pm	8Am-8Am	8pm-2pm	2pm-8pm	8pm-8Am
		Ordered / Planned	RBS-OD	RBS-OD	RBS-OD	RBS-OD	RBS-OD	RBS-OD
			Nasal				Nasal	Nasal
			oral				Suction	Suction
			Suction					
		Due	NA	NA	NA	NA	NA	NA
		Reports Pending	NA	NA	NA	NA	NA	NA
		Referrals (If any)	NA	NA	NA	NA	NA	NA
Remarks (Special Interventions like, Drainage Tube flushing etc.)	NA	NA	NA	NA	NA	NA		
Handed Over By Name :	Suchitra	Lavanya	Sipa	Maddana	Akasha	Sipa		
Signature :								
Date :	12/7/26	12/7/26	13/7/26	13/7/26	13/7/26	14/7/26		
Time :	@ 2 Pm	@ 8pm	@ 8Am	@ 2pm	@ 8pm	@ 8Am		
Taken Over By Name :	Lavanya	Sipa	Maddana	Akasha	Sipa	Maddana		
Signature :								
Date :	12/7/26	12/7/26	13/7/26	13/7/26	13/7/26	14/7/26		
Time :	@ 2pm	@ 8Am	@ 8Am	@ 2pm	@ 8pm	@ 8Am		

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NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA :		Diagnosis :		Surgery / Procedures :		
		Allergies :		Post OP Day :				
Date :		14/7/26	14/7/26	15/7/26	15/7/26	16/7/26	16/7/26	
	Area	KMC	KMC	ICU	ICU	ICU	ICU	
Shift Time		8am-9pm	8am-9pm	8am-9pm	8am-9pm	8am-9pm	8am-9pm	
Diet :		FF + IBM	FF + IBM	FF + IBM	FF + IBM	FF + IBM	FF + IBM	
Ventilation (RA, NP, NIV, VENTI)		Flow 1 ltr	L/F	L/F	L/F	L/F	L/F	
INVASIVE LINES	1.	ou-1	ou-1	ou-1	ou-1	ou-1	ou-1	
	2.							
	3.							
	4.	NA	NA	NA				
ASSESSMENT	Infusions / Transfusions	NA	NA	NA	NA	NA	NA	
	PU Prophylaxis	NA	NA	NA	NA	NA	NA	
	DVT Prophylaxis	NA	NA	NA	NA	NA	NA	
	Vitals	BP	70/42/54	62/42/49	69/42/51	60/39/45	68/39/45	71/44/52
		PR	136b/min	146b/min	166b/min	131	139b/min	151
		RR	60b/min	65b/min	60b/min	41	58b/min	44
		SpO ₂	100%	100%	100%	93%	97%	100%
		Temp	36.4°C	36.5°C	36.5°C	36.6°C	36.6°C	36.6°C
	Pain Score	1/10	1/10	1/10	2	2/10	2	
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert	Alert	Alert	
Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact	Intact	Intact		
Restraints If any	Physical	Physical	Physical	Physical	Physical	Physical		
Fall Risk (Vulnerable (Y/N) if yes score)	Yes	Yes	Yes	Yes	Yes	Yes		
(Ambulation, walking, moving with assistance, bed ridden)	moving	moving	moving	Bed ridden	Bed ridden	Bed ridden		
ADL (Dependent / Non-Dependent)	Dependent	Dependent	Dependent	Dependent	Dependent	Dependent		
Critical Lab Test / Values (if any)	NA	NA	NA	NA	NA	NA		

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)



RECOMMENDATIONS

Investigations Procedures

Date :	Area		Shift Time	Ordered / Planned	Due	Reports Pending	Referrals (If any)	Remarks (Special interventions like, Drainage Tube flushing etc.)
14/11/26	14/11/26	14/11/26	14/11/26	14/11/26	14/11/26	14/11/26	14/11/26	14/11/26
15/11/26	15/11/26	15/11/26	15/11/26	15/11/26	15/11/26	15/11/26	15/11/26	15/11/26
16/11/26	16/11/26	16/11/26	16/11/26	16/11/26	16/11/26	16/11/26	16/11/26	16/11/26
17/11/26	17/11/26	17/11/26	17/11/26	17/11/26	17/11/26	17/11/26	17/11/26	17/11/26
18/11/26	18/11/26	18/11/26	18/11/26	18/11/26	18/11/26	18/11/26	18/11/26	18/11/26
19/11/26	19/11/26	19/11/26	19/11/26	19/11/26	19/11/26	19/11/26	19/11/26	19/11/26
20/11/26	20/11/26	20/11/26	20/11/26	20/11/26	20/11/26	20/11/26	20/11/26	20/11/26
21/11/26	21/11/26	21/11/26	21/11/26	21/11/26	21/11/26	21/11/26	21/11/26	21/11/26
22/11/26	22/11/26	22/11/26	22/11/26	22/11/26	22/11/26	22/11/26	22/11/26	22/11/26
23/11/26	23/11/26	23/11/26	23/11/26	23/11/26	23/11/26	23/11/26	23/11/26	23/11/26
24/11/26	24/11/26	24/11/26	24/11/26	24/11/26	24/11/26	24/11/26	24/11/26	24/11/26
25/11/26	25/11/26	25/11/26	25/11/26	25/11/26	25/11/26	25/11/26	25/11/26	25/11/26
26/11/26	26/11/26	26/11/26	26/11/26	26/11/26	26/11/26	26/11/26	26/11/26	26/11/26
27/11/26	27/11/26	27/11/26	27/11/26	27/11/26	27/11/26	27/11/26	27/11/26	27/11/26
28/11/26	28/11/26	28/11/26	28/11/26	28/11/26	28/11/26	28/11/26	28/11/26	28/11/26
29/11/26	29/11/26	29/11/26	29/11/26	29/11/26	29/11/26	29/11/26	29/11/26	29/11/26
30/11/26	30/11/26	30/11/26	30/11/26	30/11/26	30/11/26	30/11/26	30/11/26	30/11/26
1/12/26	1/12/26	1/12/26	1/12/26	1/12/26	1/12/26	1/12/26	1/12/26	1/12/26
2/12/26	2/12/26	2/12/26	2/12/26	2/12/26	2/12/26	2/12/26	2/12/26	2/12/26
3/12/26	3/12/26	3/12/26	3/12/26	3/12/26	3/12/26	3/12/26	3/12/26	3/12/26
4/12/26	4/12/26	4/12/26	4/12/26	4/12/26	4/12/26	4/12/26	4/12/26	4/12/26
5/12/26	5/12/26	5/12/26	5/12/26	5/12/26	5/12/26	5/12/26	5/12/26	5/12/26
6/12/26	6/12/26	6/12/26	6/12/26	6/12/26	6/12/26	6/12/26	6/12/26	6/12/26
7/12/26	7/12/26	7/12/26	7/12/26	7/12/26	7/12/26	7/12/26	7/12/26	7/12/26
8/12/26	8/12/26	8/12/26	8/12/26	8/12/26	8/12/26	8/12/26	8/12/26	8/12/26
9/12/26	9/12/26	9/12/26	9/12/26	9/12/26	9/12/26	9/12/26	9/12/26	9/12/26
10/12/26	10/12/26	10/12/26	10/12/26	10/12/26	10/12/26	10/12/26	10/12/26	10/12/26
11/12/26	11/12/26	11/12/26	11/12/26	11/12/26	11/12/26	11/12/26	11/12/26	11/12/26
12/12/26	12/12/26	12/12/26	12/12/26	12/12/26	12/12/26	12/12/26	12/12/26	12/12/26
13/12/26	13/12/26	13/12/26	13/12/26	13/12/26	13/12/26	13/12/26	13/12/26	13/12/26
14/12/26	14/12/26	14/12/26	14/12/26	14/12/26	14/12/26	14/12/26	14/12/26	14/12/26
15/12/26	15/12/26	15/12/26	15/12/26	15/12/26	15/12/26	15/12/26	15/12/26	15/12/26
16/12/26	16/12/26	16/12/26	16/12/26	16/12/26	16/12/26	16/12/26	16/12/26	16/12/26
17/12/26	17/12/26	17/12/26	17/12/26	17/12/26	17/12/26	17/12/26	17/12/26	17/12/26
18/12/26	18/12/26	18/12/26	18/12/26	18/12/26	18/12/26	18/12/26	18/12/26	18/12/26
19/12/26	19/12/26	19/12/26	19/12/26	19/12/26	19/12/26	19/12/26	19/12/26	19/12/26
20/12/26	20/12/26	20/12/26	20/12/26	20/12/26	20/12/26	20/12/26	20/12/26	20/12/26
21/12/26	21/12/26	21/12/26	21/12/26	21/12/26	21/12/26	21/12/26	21/12/26	21/12/26
22/12/26	22/12/26	22/12/26	22/12/26	22/12/26	22/12/26	22/12/26	22/12/26	22/12/26
23/12/26	23/12/26	23/12/26	23/12/26	23/12/26	23/12/26	23/12/26	23/12/26	23/12/26
24/12/26	24/12/26	24/12/26	24/12/26	24/12/26	24/12/26	24/12/26	24/12/26	24/12/26
25/12/26	25/12/26	25/12/26	25/12/26	25/12/26	25/12/26	25/12/26	25/12/26	25/12/26
26/12/26	26/12/26	26/12/26	26/12/26	26/12/26	26/12/26	26/12/26	26/12/26	26/12/26
27/12/26	27/12/26	27/12/26	27/12/26	27/12/26	27/12/26	27/12/26	27/12/26	27/12/26
28/12/26	28/12/26	28/12/26	28/12/26	28/12/26	28/12/26	28/12/26	28/12/26	28/12/26
29/12/26	29/12/26	29/12/26	29/12/26	29/12/26	29/12/26	29/12/26	29/12/26	29/12/26
30/12/26	30/12/26	30/12/26	30/12/26	30/12/26	30/12/26	30/12/26	30/12/26	30/12/26
31/12/26	31/12/26	31/12/26	31/12/26	31/12/26	31/12/26	31/12/26	31/12/26	31/12/26

Handed Over By Name :

Signature :

Date :

Time :

Taken Over By Name :

Signature :

Date :

Time :

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment: Brady desaturation Apma feed

- 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	To maintain I/o chart	8pm	Maintained I/o chart	Baby is stable
10pm	To monitor vital signs	10pm	Monitored vital signs	
12am	Plan to start feed	12am	Feed not started	
2am	Plan to CXR	2am	CXR done	
4am	GRRBS TID Gas TID	4am	Gas TID Gas TID	
6am	Administer medication as per doctor order	6am	Administered medication as per doctor order	

Re-Assessment:

Special Notes: GRRBS TID Gas TID MRI T/m

Nurse Signature: [Signature] Nurse Name: Riffa Date & Time: 4/7/26 08am

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NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 24/8/26

Assessment: baby Neonatal seizures, Respiratory Distress
baby now Simultaneous mode

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 condition	8AM	Assess the baby condition	baby now Simultaneous mode maintaining * feed 3ml w/ oromifly
9AM	monitor vitals	9AM	monitor vitals 2hrs	
10AM	Plan to suction	11AM	suction done & changed	
12PM	medication	1PM	medication given as per order	
2PM	I.O chart	3PM	I.O chart done & OK	
4PM	IV 100cc/kg	5PM	IV 100cc/kg by 10/20cc	
6PM	VBG CRRB	7PM	VBG CRRB B.O. done	

Re-Assessment:

Special Notes: ECG, NBS, MRR done

Nurse Signature: Deena

Nurse Name: Deena

Date & Time: 24/8/26

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NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26

Assessment: Brady desaturation Spms feeding Oxygen Suppl

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	To maintain I/o chart	8pm	Maintained I/o chart	Baby is stable
10pm	To monitor vital signs	10pm	Monitored vital signs	
12am	Give feed eng 3rd hly	12am	Given feed eng 3rd hly	
2am	Plan to ET & Oral suction	2am	ET & Oral suction done	
4am	sample send	4am	Sample send	
6am	Administer medication as per doctor order	6am	Administered medication as per doctor order	

Re-Assessment:

Special Notes: GRS OD Gm OD

Nurse Signature: D

Nurse Name: Dipi

Date & Time: 5/7/26 @ 8am

4

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby is on SIMV

- 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 general condition to the Baby	8Am	Assessment the general condition to the Baby	Baby is on SIMV
10Am	Monitor vitals	10Am	Monitored Vitals	
12Pm	Monitor I/o chart	12Pm	Monitored I/o chart	
2Pm	Given feed 2nd hourly	2Pm	Given feeding 2nd hourly	
4Pm	Administer medication as per Doctor order	4Pm	Administered medication as per Doctor order	
6Pm	Eeg & General area is covering	6Pm	Eeg as general area is covering	

Re-Assessment:

Re-Assessment

Special Notes:

Gas RBS - OD

Nurse Signature: (M)

Nurse Name: Megha

Date & Time: 5/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Brady desaturation Apnea feeding oxygen support

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	To maintain Ilo chart	8pm	maintained Ilo chart	Baby is stable
10pm	To monitor vitals	10pm	monitored vitals	
12pm	give feeds every 3rd hourly	12Am	given feeds every 3rd hourly	
2pm	To do suctioning	2Am	suctioning done	
4pm	give medication	4Am	medication given as per order	
6Am	To provide eye, oral & skin care	6Am	provided eye, oral & skin care	

Re-Assessment:

Special Notes: GROS - OD, GRI - OD

Nurse Signature:

Nurse Name: Dippi

Date & Time: 6/7/26 0800

AH-00660640

IP5-00175944

aby Of KEERTHI

9-06-2026

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(M)

r. VIJAYANAND JAMALPURI



⑦

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: 5/7/26

Assessment: Baby is an NIV

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	8am	Assessed the baby general condition	Baby is Tolerating feed well.
10am	Monitor vitals	10am	Monitored vitals	
12pm	Maintain I/O chart	12pm	Maintained I/O chart	
2pm	To provided position	2pm	To give positions	
4pm	To give medication	4pm	To give medications	
6pm	as per doctor order	6pm	as per doctor order	
	Baby is an NPO		keep NPO for 24 hrs	

Re-Assessment: Re - Assessment Done

Special Notes: RBS OD, Gas OD CBP, CRP, SBR - T/m

Nurse Signature:

Nurse Name: Apoorva

Date & Time: 5/7/26 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/2/26

Assessment: Baby, obese, feeding intolerance

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 PM	→ Assess to the baby condition	8 PM	→ assessed to the baby condition	→ Baby on NIV
10 PM	→ monitor vital signs	10 PM	→ monitor vital signs	→ maintain air way
12 AM	→ maintained IV fluids	12 AM	→ maintained IV fluids	→ NO breast & secer.
2 AM	→ 2nd hour of on Aspirin	2 AM	→ NPO	
4 AM	→ medication	4 AM	→ medication given as per doctor's order	→ Baby was stable now
6 AM	→ position	6 AM	→ provided comfort as per position	→ Baby on NPO
8 AM	→ suction	8 AM	→ rechecked SPT	→ No vomit & abdomen
10 AM	→ medication	10 AM	→ rechecked CRP, SBR	→ fine
12 AM	→ CBP, CRP, SBR			

Re-Assessment:

Special Notes:

CBP, CRP, SBR 7 PM & EEH 26/2

Nurse Signature:

Nurse Name:

Date & Time:



8

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 7/7/26

Assessment: Hypertension

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 general condition of the baby.	8:30 am	→ Assessed the general condition of the baby.	Baby stable on CPAP
10am	→ Monitor vitals	10:30 am	→ Monitored vitals	
12pm	→ Maintain I/O chart	12:30	→ Maintained I/O chart	
2pm	→ To do suction	2:30	→ oral & nasal suction done.	
4pm	→ To do Feeding	4:30	→ Initiated feeding.	
6pm	→ To do position.	6:30	→ position given.	
	→ To do medication		→ Medication given	

Re-Assessment: Re-Assessment done

Special Notes: RRS / VBG

Nurse Signature: [Signature]

Nurse Name: Nirupama

Date & Time: 7/7/26



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 07/07/26 @ 8pm

Assessment: TERM / HIE / THROMBOCYTOPENIA / SEPSIS

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	→ IV 120cc 10% dextrose	8pm	→ IV 120cc 10% dextrose	Baby is stable on CPAP.
10pm	→ maintain SpO2 chart	10pm	→ maintained SpO2 chart	
	→ monitor the vitals		→ monitored the vitals	
12AM	→ Given feed 3rd baby	12AM	→ Given feed 3rd baby	
2AM	→ stop IV fluids	2AM	→ stop IV fluids	
4AM	→ oral and nasal suction	4AM	→ oral and nasal suction done	
6AM	→ Administered the medications	6AM	→ Administered the medications as per doctors orders.	

Re-Assessment: Watch for desaturations

Special Notes: PPS, Gas - OD

Nurse Signature: [Signature]

Nurse Name: B. Nanya

Date & Time: 08/07/26 @ 8AM



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 8/7

Assessment: Baby is here with

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 general condition of baby.	8am	* Assessed the baby condition.	Baby is stable now
10am	* Monitor vital signs	10am	* vitals checked & documented.	
12pm	* Maintain ≥ 10 chest	12pm	* ≥ 10 chest maintained	
2pm	* Administer the medications as per chart	2pm	* Stop cpap.	
4pm	* w/f for desat & tachycardia.	4pm	* DO Nasal suction.	
6pm	* Continue SSPT.	4pm	* Administered the medications as per chart	
		6pm	* SSPT continue till 4hr.	

Re-Assessment: Baby is comfortable & maintaining SpO2

Special Notes: SBR 4hr, w/f for SpO2.

Nurse Signature: D

Nurse Name: D/Ph

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



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/2026

Assessment: Baby on cpap

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general condition of the baby.	9pm	Assessed the general condition of the baby.	Baby on cpap and maintaining
10pm	plan to continue the cpap	11pm	continued cpap and maintaining	
1am	provide feed as per the advice	2am	provided feed and moly.	
3am	provide comfortable position & wlf any abnormalities	4am	provided comfortable position to the baby.	
6am	Administered medications as per the drug chart.	7am	Administered medications as per the drug chart	

Re-Assessment: Re-Assessment Done.

Special Notes:

Nurse Signature: *Navya*

Nurse Name: *Navya*

Date & Time: 9/7/26 @ 9pm.

5

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/7/26

Assessment: Baby T 02

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 general condition	8:10am	* Assessed the general condition	Baby is stable
9am	* monitor vitals and Record	9:10am	* monitored vitals and Recorded	
10am	* maintain I/O chart	10:10am	* maintained I/O chart	
11am	* Feeding every 2nd hdy (log)	11:10am	* feeding every 2nd hdy	
12pm	* medication administered as per chart	12:10pm	* medication administered as per chart	
1pm	* Ensure safety	1:10pm	* Ensured safety	

Re-Assessment:

Baby is doing well saturation maintained $\approx 0_2$

Special Notes:

RBS on

Nurse Signature: Latha

Nurse Name: Latha

Date & Time: 9/7/26 @ 2pm



1

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: Baby is on L/F

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8:00	Assess general Condition of baby	8:10	Assessed general Condition of baby	Baby is on L/F 0.1 ml
10:00	Monitor vitals and record	10:20	Monitored vitals & Recorded	
12:00	Maintain Ilo chart	12:15	Maintained Ilo chart	
2:00	Provide comfortable position	2:20	Provided Comfortable position	
4:00	check weight of baby	4:15	checked weight of baby	
6:00	Administer medications as per drug chart	6:10	Administered medication as per drug chart	
8:00	Ensure Safety	8:00	Ensured Safety	

Re-Assessment: Re-Assessment done

Special Notes: RB1 - DD

Nurse Signature: [Signature]

Nurse Name: Raysonitha

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

BAH-00660640 IP5-00175944
Baby Of KEERTHI
29-06-2026 0 Y 0 M 7 D (M)
Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

Rainbow
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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment: Baby on L/F

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 General condition of baby	2:30pm	Assessed the General condition of baby.	Baby is Stable
4pm	provide comfortable position	4:30pm	provided comfortable position.	
6pm	monitor I/O chart & vitals	6pm	monitored I/O chart & vitals	
7pm	Give medication as per doctor orderly	7:30pm	Given medication as per doctor orderly	

Re-Assessment: Reassessment done.

Special Notes: GRBS - OD

Nurse Signature:

Nurse Name: Madhavi

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



3

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 10/7/2026

Assessment: Baby is on L/F

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 General Condition	8:15	→ Assessed General Condition	Now the Baby is maintaining well on m L/F (0.05 L/F)
10am	→ monitor vitals	10:30	→ monitored vitals	
12pm	→ Administer the medication	12:40	→ Administered medication	
2pm	→ Continue formula feed	2pm	→ Continued formula	
4pm 6pm 8pm	→ maintain skin integrity	4:30pm 6:45pm 8pm	→ maintained skin integrity	

Re-Assessment: Re Assessment was done

Special Notes: Changed L/F to m L/F @ 12:30 pm

Nurse Signature:

Nurse Name: Shivani

Date & Time: 10/2/26 @ 8am-8pm

4

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/26

Assessment: Baby is on LIF

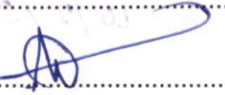
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the Baby Condition	8pm	Assess the baby condition	pt is good now.
10pm	Provide Comfortable position	10pm	provided Comfortable position	
12Am	Monitor vital signs	12Am	vital signs Monitored	
2Am	Maintain I/O chart	2Am	I/O chart Maintained	
4Am	Given medications as Per doctor chart.	4Am	Medication given as Per as doctor chart	
6Am	Ensure Safety	6Am	Ensured Safety.	

Re-Assessment: RBS - OD

Special Notes:

Nurse Signature: 

Nurse Name: Akansha

Date & Time: 10/07/26



5

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 11/7/26

Assessment: Baby is LIF

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 condition	@8am	Assess the baby condition	Now baby Stable on LIF
@10am	Monitor the vital sings	@10am	Monitor the vital sings	
@2pm	Given feeding 2nd hourly	@2pm	Given feeding 2nd hourly	
@4pm	Provide comfortable position to the baby	@4pm	Provide comfortable position	
@6pm	Administered medication as per doctor order	@6pm	Administered medication as per doctor order	

Re-Assessment: Done

Special Notes: RBS - OD

Nurse Signature: Mitu

Nurse Name: Mitu

Date & Time: 11/7/26 @ 8am-8pm



6

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 11/7/26

Assessment: Pt is on Lf

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 Condition	8pm	Assessed the Baby Condition	Now baby is good
10pm	Provide Comfortable position.	10pm	provided Comfortable position.	
12 am	Monitor vital signs.	12 am	vital signs Monitored.	
2 am	Maintain I/o chart.	2 am	I/o chart Maintained	
4 am	Suction done	4 am	Suction done	
6 am	Given medications as per as doctor order	6 am	Medications given as per as doctor order.	

Re-Assessment: done

Special Notes: Do suction & RBS-00

Nurse Signature:

Nurse Name: Akansha

Date & Time: 11/7/26

BAH-00660640

IP5-00175944

Baby Of KEERTHI

29-06-2026

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(M)

Dr. VIJAYANAND JAMALPURI



7

NURSING CARE RECORD

**Rainbow[®]
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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 12/7/26

Assessment: Pt is now L/F

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
8 Am	⇒ Assess the baby condition	8 Am	⇒ Assessed the baby condition	now baby is stable
10 Am	⇒ Monitor vital sign	10 Am	⇒ Monitored vital sign	
12 Pm	⇒ Provide comfortable position	12 Pm	⇒ Provided comfortable position.	
2 Pm	⇒ Given Medication as per doctor order.	2 Pm	⇒ Given Medication as per doctor order.	

Re-Assessment: Done

Special Notes: Suction and RBS - OD

Nurse Signature: (Signature)

Nurse Name: Suchitpa

Date & Time: 12/7/26 @ 8Am-2Pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 12/7/26

Assessment: Baby is on L/F

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 condition	2pm	Assessed the baby condition	Baby is stable
3pm	Maintain I/o chart	3pm	maintained I/o chart	
4pm	Monitor the vitals	4pm	monitored the vitals	
5pm	Give feed 2nd hourly	5pm	Given feed 2nd hourly	
6pm	Administrese medication as per doctor order.	6pm	Administrese medication as per doctor order.	

Re-Assessment: Re-Assessment done

Special Notes: RBS - OD

Nurse Signature: [Signature]

Nurse Name: Lavanya

Date & Time: 12/7/26 @ 2pm - 8pm

6

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date:

Assessment:

Baby on RDS / LF

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

Time	Plan of Care	Time	Implementation	Evaluation
8Pm	Assess the General Condition of the baby	8Pm	Assess the General Condition of the baby	Baby is well now
9Pm		10Pm	Maintained vital signs of the baby	
10Pm	Maintain vital signs of baby	12Am	Maintained vital signs of the baby	
12Am	Maintained no chard	2Am	Maintained no chard	
2Am	Provided comfortable position	4Am	Provided comfortable position	
3Am	To Give all medication	5Am	Maintained personal hygiene of the baby	
5Am	Maintain personal hygiene of the baby	6Am	All medication administered	
7Am		7Am		

Re-Assessment:

Special Notes:

Nurse Signature: Devi

Nurse Name: Devi

Date & Time: 13/7/26 (2Am)

AH-00660640 IP5-00175944
 Baby Of KEERTHI
 9-06-2026 0 Y 0 M 14 D (M)
 Mr. VIJAYANAND JAMALPURI



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: 13/7/26

Assessment: Baby on L/F

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	→ Assessed the General condition at baby	8:30 am	→ Assessed the General condition at baby.	Baby is Stable.
10 AM	→ Give 2 nd hourly feed	10:30 AM	→ Given 2 nd hourly feed.	
12pm	→ Provide comfortable position	12:30 pm	→ Provided comfortable position	
1:30 pm	→ Ensure Safety	1:30 pm	→ Ensured Safety	

Re-Assessment: Re-assessment Done

Special Notes: CIRBS - OD

Nurse Signature:

Nurse Name: Muddamma

Date & Time: 13/7/26 @ 2pm

IAH-00660840 IP5-00175944
 Baby Of KEERTHI
 19-06-2026 0 Y 0 M 14 D (M)
 Dr. VIJAYANAND JAMALPURI



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: 13/7/26

Assessment: Baby is on LIF

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 pt Condition	2pm	pt Condition assessed	Baby is now Stable.
4pm	Maintain I/O chart	4pm	Maintained I/O chart.	
6pm	Provide Comfortable Position.	6pm	Provided Comfortable Position.	
8pm	Ensure Safety	8pm	Ensured Safety	

Re-Assessment: De-assessment Done.

Special Notes: Do suction.

Nurse Signature:

Nurse Name: Akansha

Date & Time: 13/7/26 @ 2pm



NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Baby on L/F

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 General Condition of the baby	8Am	Assess the General Condition of the baby	Baby is well now
10Am	Maintain vital signs	10Am	Maintained vital signs	
12Am	Maintain w chart of the baby	12Am	Maintained w chart of the baby	
2Am	All medication administration	2Am	All medication administered	
4Am	provided comfortable position	4Am	provided comfortable position	
6Am	Maintain personal hygiene	6Am	Maintain personal hygiene	
7Am		7Am		

Re-Assessment:

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sipa

Date & Time: 14/8/26 (6Am)



10

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 14/7/26

Assessment: Baby on L/F

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 General condition of the baby	8:30 AM	→ Assessed the General condition at baby.	Baby is stable.
10am	→ Maintain I/o chart and vitals	10:30 AM	→ Maintained I/o chart and vitals.	
12pm	→ Administered medications as per doctor order	12:30 PM	→ Administered medications as per doctor order	
1pm	→ Ensure safety	1:30pm	→ Ensured safety	

Re-Assessment: Re-assessment Done.

Special Notes: CRBS - OD

Nurse Signature: H

Nurse Name: Madhanna

Date & Time: 14/7/26 @ 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 14/7/26 @ 2pm-8pm

Assessment: Baby is on LF

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
2 PM	Assess the general condition of baby	2:30 PM	Assessed general condition of baby	Baby is stable and having edema
3 PM	Monitor vital signs	3:10 PM	monitored vital signs	
4 PM	maintain 2lo chart	4:30 PM	Maintained 2lo chart	
5 PM	Administer medication	6:40 PM	Administered medication	

Re-Assessment: Reassessment Done

Special Notes: RBS-OD, ECG Done

Nurse Signature: [Signature]

Nurse Name: Rashmi

Date & Time: 14/7/26 @ 8 PM

12

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 15/7/26

Assessment: Tachybrdia, Edema, on LP baby need oxygen support

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
9pm	* TL-150cc/kg/day	9pm	* TL-150cc/kg/day	* New baby on
11pm	* To monitor vitals	11pm	* Monitored vitals	LP maintaining
12am	* To maintain I/O chart	12am	* maintained I/O chart	
2am	* Given feeds	2am	* Given feeds and hourly	
5am	* plan to give nebulization	5am	* Given nebulization	
6am	* plan to give medication	7am	* Given medications	

Re-Assessment: Re Assessment done

Special Notes: RBY OD

Nurse Signature: [Signature]

Nurse Name: Bhargavi

Date & Time: 16/7/26 8am



13

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 16/7/26

Assessment: HYDROCEPHALUS -

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 AM	① TO ASSESS the general condition of the Baby	8 AM	① Assessed the general condition of the Baby	Baby is stable on rooming in but NO sleep
10 AM	② Administer medicine to the Baby	10 AM	② Administered medicine to the Baby	
12 PM	③ Apply ointment	12 PM	③ Apply ointment	
2 PM	④ Give comforter position	2 PM	④ Give comforter position	
4 PM	⑤ Give chest physiotherapy	4 PM	⑤ Give chest physiotherapy	
6 PM	⑥ Administer med	6 PM	⑥ Give nebulizer	

Re-Assessment:

same

Special Notes:

started receiving, 10 right up of up (send gene for sample to med) (send gene for sample to med)

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 16/7/26

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 15/7/26

Assessment: desaturation, on LF baby need oxygen support

- 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
9am	* Nil - 150cc/kg/day	9am	* Nil - 150cc/kg/day	* Now baby on
11am	* To monitor vitals	11am	* Monitored vitals	LF maintaining
12pm	* To maintain I/O chart	12pm	* maintained I/O chart	
2pm	* plan to give nebulization	2pm	* given nebulization	
5pm	* plan to give medication	5pm	* given medications	
7pm	* plan to give feeding	7pm	* given feeds and bath	

Re-Assessment: re-assessment done

Special Notes: ct LF 1-lit RBS - 00

Nurse Signature: 

Nurse Name: Sharathi

Date & Time: 15/7/26 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date:

Assessment: *PPH, HEMODYNAMIC PROBLEM*

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 AM	① Assess the general condition of the Baby	8 AM	① Assessed the general condition of the Baby	<i>Baby is stable but no defecation</i>
10 AM	② Administer medication to the Baby	10 AM	② Administered medication to the Baby	
12 PM	③ Doing oral and nasal suction	12 PM	③ Done Oral & Nasal suction	
2 PM	④ Give feed to the Baby	2 PM	④ Given feed to the Baby	
4 PM	⑤ Change diaper to dry	4 PM	⑤ Changed diaper to dry	

Re-Assessment: *Re-assess on alert*

Special Notes: *Doing suction blood coming if again heavy send PT, PPR & Serum*

Nurse Signature: *[Signature]* Nurse Name: *[Signature]* Date & Time: *15/7/26*



19

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 16/7/26

Assessment: mild abdominal distension, Tachypnea

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

Time	Plan of Care	Time	Implementation	Evaluation
9pm	* TIL-1500ml/kg/day	9pm	* TIL-1500ml/kg/day	* New baby on
11pm	* TO monitor vitals	11pm	* monitored vitals	LIF maintaining
12am	* TO maintain I/O chart	12am	* maintained I/O chart	
3am	* plan to give medication	3am	* given medications	
5am	* plan to give nebulization	5am	* given nebulization	
6am	* plan to give feeding	6am	* given feeds and hourly	

Re-Assessment: Re-Assessment done

Special Notes: RBS -00

Nurse Signature: [Signature]

Nurse Name: Bharathi

Date & Time: 17/7/26 8am

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 17/7/26

Assessment: Baby is on low flow.

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 AM	⇒ Assess the baby general condition	9 AM	⇒ Assessed the baby general condition	⇒ All plans are implemented.
10 AM	⇒ monitor vital signs	11 AM	⇒ monitored vital signs	
12 pm	⇒ maintain ilo chart	1 pm	⇒ maintain ilo chart	
2 pm	⇒ provide comfortable position	3 pm	⇒ provide comfortable position	
4 pm	⇒ plan to give feed	5 pm	⇒ Given feed 2nd baby	
6 pm	⇒ Administer medication as per doctors order	7 pm	⇒ Administered medication as per doctors order	

Re-Assessment: Re-assessment done

Special Notes: RBS - OD

Nurse Signature: Kaushik

Nurse Name: Kaushik

Date & Time: 17/7/26 @ 8 pm



16

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 17/7/26

Assessment: Feeder and Grower

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
9pm	* Nil-10cc/kg/day	9pm	* Nil-10cc/kg/day	* Now baby on
11pm	* To monitor vitals	11pm	* Monitored vitals	LIF maintaining
12am	* To maintain S/O chest	12am	* Monitored S/O chest	
2am	* plan to give nebulization	2am	* given nebulization	
5am	* plan to give medication	5am	* given medications	
6am	* plan to give feeding	6am	* given feeds and hourly	

Re-Assessment: Re-Assessment done

Special Notes: RBS - 00

Nurse Name: Bhargathi

Date & Time: 18/7/26 8 am

BAH-00660640

IP5-00175944

Baby Of KEERTHI

29-08-2026

0 Y 0 M 15 D

(M)

Dr. VIJAYANAND JAMALPURI



17

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: 12/7/26

Assessment: Baby is on low flow.

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
	* IV - 150ml/kg/day. * Assess the baby general condition. * Monitor the vital signs * Maintain I/O chart - * Giving feeds 2nd hourly. * Administer the medications as per doctor order.		* IV - 150ml/kg/day. * Assessed the baby general condition. * Monitored the vital signs * Maintained I/O chart - * Given feeds 2nd hourly. * Administered the medications as per doctors order.	Now the baby is on low flow.

Re-Assessment: Re assessment is done.

Special Notes: RBS - OP.

Nurse Signature: _____

Nurse Name: _____

Date: _____

Nurse Signature: _____

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date:

Assessment: Baby is on I/F.

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.	8Am	Assess the Baby general Condition.	Baby is now stable.
10Am	maintain Ilo chart	10Am	maintained Ilo chart.	
12pm	give the feed 2 nd Hourly	12pm	given feed 2 nd Hourly.	
4pm.	Provide Comfortable Position.	4pm	Provided Comfortable Position.	
2pm	give Medication as per doctor order.	2pm	given medication as per doctor order	

Re-Assessment: Re-Assessment Done.

Special Notes: Re-OP

Nurse Signature: Shivani

Nurse Name: Shivani

Date & Time: 18/7/20 @ 2pm.

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 18/7/26

Assessment: Baby is LF

- 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 General Condition of the baby	2pm	*Assessed the General Condition of the baby	Baby is stable now
	*monitor vital signs	4pm	*monitored vital signs	
4pm	*provide comfortable position		*provided comfortable position	
6pm	*maintain Ilo chart	6pm	*maintained Ilo chart	
	*administer medication as per doctor Order		*administered medication as per doctor orders	
8pm	*ensure safety	8pm	*ensured safety	

Re-Assessment: Done

Special Notes: RBS - OP

Nurse Signature: [Signature]

Nurse Name: yamuna

Date & Time: 18/7/26 @ 2pm to 8pm