

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176028 Admit Date : 06-Jul-2026 Admit Time : 12:46 PM UHID : BAH-00660817

Patient Details :

Patient Name	: Baby Of FATIMA BASHMAIL	Age	: 0 D
Guardian	: Mr SHAIK ABDUL RASHEED	DOB	: 06-07-2026 10:42 AM
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO 9-4-132/6, MEHBOOB GARDEN COLONY, Tolichowki Hyderabad Telangana INDIA 500008	Phone No	: 9959939950/ 9392004989
		E-mail	: fatimabashmail06@gmail.com

Admission Details :

Bed Type : BASINET Bed No : CRDL-SW-414-1 Ward Name : 4F-BIRTHING CENTRE
Room No : CRDL-SW-414-1 Admission Type : First Visit

Contact Details :

Name : Mr SHAIK ABDUL RASHEED Relationship : Father
Contact Address : H NO 9-4-132/6, MEHBOOB GARDEN
COLONY, Tolichowki Hyderabad Telangana
INDIA 500008 Phone No : 9959939950 / 9392004989

Signature

Doctor Details :

Doctor Name : Dr. FAISAL B NAHDI Specialisation : NEONATOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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

[illegible]

BAH-00660817 IP5-00176028
 Baby Of FATIMA BASHMAIL
 06-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. FAISAL B NAHDI



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]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

8/7/26.
Mother is refused to give bath to Baby,
also not refused to check weight of the
Baby.
Jalman

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Mrs. Fathima Bashmail 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 : Blo Fathima Bashmail Mother's Blood Group : B POSITIVE
Gender : ☐ M ☒ F Blood Group : Birth Weight (gms) : 2.778 Length (cms) : 49cm
Date of Birth : 6/7/2026 Time of Birth : 10:42am OFC (cms) : 34cm
Place of Birth : RCH, Banjara Estimated Gesth Age : 37+6wks
Current Obstetric History : (Booked / Unbooked Case)
Maternal Age : Ht : 157cm Wt : 43.9 BMI : Married Life : LMP : 15/10/25 EDD : 27/7/2026
Conception : Spontaneous or with Rx :
Booked at what GA : 5+5wks AN Steroids Drugs / Doses : EFW : 2.563
Last Scans Details : 17/6/26 - 8wv, 35+1, Cephalic, AFI-18.5cm, AC-60%, Doppler (N)
Central placenta Previa - 12+6wks Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ < 18 yrs ☐ > 35yrs Fetal 2D Echo
Consanguinity : ☐ Yes ☐ No (R+) aberrant
If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3 Subclavian artery

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? (1:2022)
on 25mcg Thyronorm

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 :



PAST OBSTETRIC HISTORY

G: 4 P: 2 A: 1 L: 2

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
		G ₁ - 2020	- 39 wks	- NVD	- ♂	- 2.832 Kg
		G ₂ - 2022	- miscar	@ 6.7 wks	-	- MERPC
		G ₃ - 2023	- 38 wks	- NVD	- Girl	- 2.7 kgs

PERINATAL HISTORY

Treating Obstetrician : Dr. P. P. Rathayusha Reddy Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig) Dec. 19CS
Second stage (> 2 hours after dilation)
LSCS : ☐ Elective ☐ Emergency Indication :
Specify the reason :
Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological
MSL :
Resuscitaion : ☐ Yes ☐ No
Cord ABG :
Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :)

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

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

TOTAL

Snapee II Score

Score

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

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



Predelivery equipment check done.
Baby delivered by - Clecuscs.

↓
Cried immediately after birth
Delayed Cord clamping done at 1min

↓
Taken under warmer
Oral, Nasal Secretions cleared

↓
Umbilical Cord clamped cut
2A+1V noted

↓
Trij. vit K given - IM

↓
• Initial desaturations present
required Supplemental Oxygen

↓ for 1min
Vitals Stable, No RD

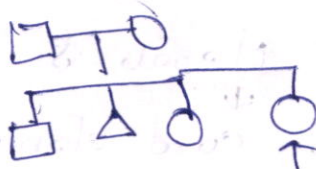
Shifted to mother side.

Investigation details in previous Hospital :

Feeding History :



Family History :



Socio Economic History :

upper middle class

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.7°C HR : 145/min RR : 43/min NIBP : CFT : <3 sec

Color of the extremities : Acrocyanosis > Pink

Jaundice : Pallor : SpO2 : 98%

ANTHROPOMETRY: Birth Weight : 2.74 kg Length : HC : Present Weight :

Ponderal Index : AGA : ✓ SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :

Fontanelles :

Sutures

Shape / Moulding :

Edema / Bruising :

Size - (H.C.) :

AF open at level

FACIES :

(Any Facial
Dysmorphism)

No dysmorphism

NECK and CLAVICLES :

Range of Motion :

Asymmetry :

Masses :

No asymmetry

EYES :

Symmetry :

Red Reflex :

Discharge :

Need to be assessed

EARS, NOSE MOUTH and THROAT :

Ear set / Shape :

Periauricular Pits / Tags :

Nasal shape / Patency :

Palate :

Gums :

Lips :

Tongue :

No cleft palate

THORAX and BREASTS :

Shape of Thorax :

Position of Nipples and Number :

N

ABDOMEN and UMBILICUS :

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump :

Discharge :

Prominent loop of Bowel - dilated
(? Divaricated Rectus muscle)
- 2A + 1U

GENITILIA :

Labia / Hymen :

Testicles/penis :

Anus :

Female genitalia

- Patent

HERNIAL ORIFICES

Free

TRUNK and SPINE :

N

SKIN LESIONS :

NO

EXTREMITIES :

Fingers / Toes :

Deformities :

Hip Joint Examination :

Arms / Legs :

Mobility :

N



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 45/min SCR / ICR / See - Saw breathing :

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

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

Settings : on room air

SpO₂ : Auscultation: BAC (+) Breath Sounds: clear Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 145/min BP :

Femoral Pulses : well felt

Other Peripheral Pulses :

Precordial Activity : (N)

Murmurs : NO

Signs of Cardiac Failure :

ABDOMEN:

Shape : (N) distended

Palpation :

Palpable masses :

Abdominal girth :

Hernia orifice : Free

Anal Patency : Patent

Umbilical Cord : 2A+1V

First urine passed : Not passed

Meconium passed :

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness : awake

Prechtl Score : active

Nerves :

MOTOR SYSTEM:

Passive Tone : (N)

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR : (N)

ATNR : Skull and Spine : (N)



Diagnosis :

Term / AGA / female / ELUSC / CIAB / ^{Fetalecho Abnormal} ^{RT} Subclavian artery
(37+6wks) (2.77kg) (Pl. previa)

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

Sneha

Y. Sneha

6/7/26

Consultant :

Signature :

Name :

Date & Time :

Dr. M. N.

M. N.

6/7

5pm

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 : *Asphyxia neonatorum / mild hypoxic ischemic encephalopathy*

Neonatal condition at the time of Transfer: *Stable*

Vital : HR : *120* RR : *20* BP : *90/60* SP02 : *98%* Weight : *3.5 kg*

Any Oxygen requirement : *Plan*

Systemic : *1) Warm care*

Medications : *2) Direct Breast feeding by Bumping every 2nd hrly*

3) Cord blood for Blood grouping

4) NBS OAC SBR at 48 HOL

5) wff-feeding, suckling, colour

Breathing pattern

Plan during ward follow up :

Feeding Plan at the time of shifting : *11:10 to 11:20am*

Screenings done during NICU Stay :

NSG : *Done*

Hearing Screen : *Done*

ROP : *Done*

TFT : *Done*

NP2 : *Done*

Doctor Signature (Handover Given): *[Signature]*

Doctor Name: *Y. Srecha*

Date & Time: *6/7/26*

Doctor Signature (Handover Taken): *[Signature]*

Doctor Name: *in RN*

Date & Time: *6/07 10pm*

(P.T.O)

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7 3:20 PM	CLB RECEIVED: STAD 27+6wks / LSCS - Placenta previa / QAB / RT. absent Subclavian (A) / 2-77 Rg / SUPRAU.	
VI - M -	B+	1. Trace blood group.
	Enteroamid Pink CL/AS good warm peripheries Good perfusion	2. Vaccines - OPV / BCG / Hep. B (given 6/7/20) Durgu
		3. SBE / NBS / DAE @ LHSTOT.
		4. DRE / 2nd monthly
6/7	8/11/19 found	
1/11/19	CL/ST/TA found	Center found
1/11/19	Genal found @	
		AB Yacoma



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/17/26 8:00am	cf/B Resident	
	22 HOL / Term / 37 +6 / LSCS - Placenta previa / CIAB / Rt abbaent SCA / 2.77kg / G4 P2 A1 L2	
M / B+	M / ✓ (3)	
B / O+	V / ✓ (4)	
	<u>Plan</u>	
	Twt → 2.541 kg. 8% ↓	① DBF 2nd July
	Baby on room	② vaccination done
	Eutheimic - Pink	③ SRR } 11m 10:30am NBS OAE
	Euglycemic	
	On EBM	④ monitor urine output 2 vitals
	sucking & latching good	
	Tone } good	
	cry }	
	actively }	
	Peripheries warm	<u>Soluh</u>
	CRt c3 sec	
	<u>Seen by Dr Faisal</u>	<u>plan 2D</u>
	clnd ceng me	Adv,
	land um Moha	1) 2D Echo after 1 week
	vanter Dor	2) Recheck weight in evening
		3) DBF 2 July



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 11:30am	<u>Lactation Notes.</u> Lactation Counseling <u>Refund.</u> position Shows partially Colostrum as seen Baby is Latching well feed adequate with deep latch max 15-20min each side. Baby D&F mother is confident in feeding. <u>Natural</u>	
4/7/26 @ 2:30pm	<u>Afternoon Rounds</u> 28WOL / Term / 37+6 / Placenta Previa / CIAB (R) Subclavian art. abnormant. / 2.71kg / G4P2L2A1 (C) Baby on Room air Euthermic CFT < 38cc. Sucking, latching good accepting feeds well. Icterus - only face. Vaccination - dose. Urine } passed Stool }	<u>Plan</u> 1) Continue Direct Breast feeding flby Bumping 2) SBR } NBS } Tm 10:30am GAE } 3) 2D Echo after Lmk. 4) Recheck wt in evening 5) monitor vitals, <u>Snk</u> (P.T.O)

10



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00660817 IP5-00176028

Baby Of FATIMA BASHMAIL

06-07-2026 0 Y 0 M 0 D 22 H (F)

Dr. FAISAL B NAHDI

RCH / FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation &
Early Warning Scoring ChartPratiksha
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: 7/7 Time: 9 AM Day 1 PM 3 PM 6 PM 10 PM 2 AM 6 AM

Doctor/Nurse/Family Concern?

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

and

Blood Pressure
(mmHg) *

Note:

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

Heart Rate (Number)

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

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 /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.

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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



FLUID CHART

Sheet No. : ①

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											
	10:00 am											
	11:00 am	DBF								0		Shah
	12:00 pm									0		
	01:00 pm	DBF								0		Shah
Total Intake : Taken					Total Output :							
	02:00 pm	DBF								0		Yammy
	03:00 pm									1		Yammy
	04:00 pm											Yammy
	05:00 pm	DBF					✓			NO IV		Yammy
	06:00 pm									Cannula		Yammy
	07:00 pm									1		Yammy
Total Intake : Taken					Total Output : 0 - 14 - 1							
	08:00 pm									N		} suwanda
	09:00 pm	DBF								0		
	10:00 pm						✓			2v		
	11:00 pm									N		
	12:00 am	DBF								0		
	01:00 am	DBF								IV		
Total Intake : taken					Total Output :							
	02:00 am									1		} suwanda
	03:00 am									0		
	04:00 am	DBF								1		
	05:00 am									✓		
	06:00 am									NO		
	07:00 am	DBF					✓			2v		
Total Intake : taken					Total Output : passed							

Total 24 hrs. Intake

Total 24 hrs. Output

M - 3 times
U - 4 times



FLUID CHART

Sheet No. : (2)

7/6/26

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

		Intake			Output					IV Site	Sign.
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	Nurse
			Mouth	I.V	N.G						
7/7	08:00 am										
	09:00 am	DBF							✓		Long
	10:00 am	DBF									Long
	11:00 am										Long
	12:00 pm	DBF									Long
	01:00 pm					✓			✓		Long
Total Intake : Tabey					Total Output : passed u-2 m-1						
7/7	02:00 pm					✓					Sub
	03:00 pm	DBF									Sub
	04:00 pm								✓		Sub
	05:00 pm	DBF				✓					Sub
	06:00 pm								✓		Sub
	07:00 pm	DBF									Sub
Total Intake :					Total Output : U-2 M-2						
7/7	08:00 pm										Alekya
	09:00 pm	DBF									Alekya
	10:00 pm										Alekya
	11:00 pm	DBF				✓			✓		Alekya
	12:00 am										Alekya
	01:00 am	DBF									Alekya
Total Intake :					Total Output : U-1 M-1						
8/7	02:00 am										Alekya
	03:00 am	DBF									Alekya
	04:00 am								✓		Alekya
	05:00 am	DBF				✓					Alekya
	06:00 am										Alekya
	07:00 am	DBF									Alekya
Total Intake :					Total Output : U-1 M-1						
Total 24 hrs. Intake			Total 24 hrs. Output								
			U-6 m-5								

BAH-00660817 IP5-00176028
 Baby Of FATIMA BASHMAIL
 06-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. FAISAL B NAHDI



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: 6/7/26

Assessment: Neonatal care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
11am	Assess baby general condition	11 ¹⁵ am	Assessed baby general condition	Baby is Stable
	monitor vital	11 ³⁰ am	Spo2 pulse checked and recorded	
11 ³⁰ am	DBF + Burping	12pm	DBF + Burping given.	
12pm	warm care.	1pm	warm care provided	
1pm	Ensure safety	2pm	Ensure safety provided	

Re-Assessment: Re Assessment 2nd hourly

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Shobin

Date & Time: 6/7/26

BAH-00660817 IP5-00176028
 Baby Of FATIMA BASHMAIL
 06-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. FAISAL B NAHDI



NURSING CARE RECORD

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

BirthRight™
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 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☒ Night

Date: 6/1/26

Assessment: New Born Baby Care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the general condition of the baby	3pm	→ Assessed general condition of the baby	→ Baby is calm and
3pm	→ monitor vitals.	4pm	→ monitored vitals.	
4pm	→ DBF and Burping	5pm	→ DBF and Burping done.	
5pm	→ monitor I/O chart	6pm	→ monitored I/O chart	
6pm	→ Warm care	7pm	→ warm care done by swaddling	
7pm	→ Ensure safety	8pm	→ Ensured safety by crib care	

Re-Assessment: Baby is latching and sucking well.

Special Notes: BPR, NBS, CAC @ 48 Hrs.

Nurse Signature: Yousif

Nurse Name: Yousif

Date & Time: 6/1/26 @ 8pm

BAH-00660817 IP5-00176028
 Baby Of FATIMA BASHMAIL
 06-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. FAISAL B NAHDI



NURSING CARE RECORD

Rainbow
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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

☐ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

Assessment:

new born baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8PM	* assess to condition.	9PM	* assessed to baby condition.	* baby is comfortable
10PM	* I/O record	11PM	* I/O record monitoring done.	
12PM	* DBF	1PM	* DBF record hourly done	
2PM	* warm care	3PM	* warm care done.	
5PM	* burping	6PM	* burping after feed done	
8PM	* Saddle	8PM	* saddle rails provided	

Re-Assessment: DBF record hourly done

Special Notes:

SBP NBS GAE 98/102

Nurse Signature:

[Signature]

Nurse Name:

Sunada (606249)

Date & Time:

7/7/26 8PM



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 7/7/26

Assessment: New born baby

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the Baby general Condition	8:30 AM	Assessed the Baby general Condition	Baby is stable
10am	warm Care	10:30 pm	warm Care provided	
12pm	monitor vitals	12:30 m	monitoring vitals, BP, PR, RR, SpO2, Unclotted & Redness	
3pm	DBT feeding	3:30 pm	DBT feeding Every 2 to 3rd hr	
6pm	Burping	6:30 m	Burping done after feed	
7pm	Ensure safety	7:30 m	Ensure safety provided	

Re-Assessment: New condition is stable

Special Notes: SRR, NBS, OAE 4.8 Hz

Nurse Signature: [Signature]

Nurse Name: Song

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

BAH-00660817
Baby OF FATIMA BASHMAIL
06-07-2026
Dr. FAISAL B NAHDI (F)
IP5-00176028
0 Y 0 M 0 D 4 H

NURSING CARE RECORD

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

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26

Assessment: Baby is having discomfort

Goals

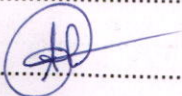
- ☒ Maintain Airway and Oxygenation ☒ Relieve Pain & Discomfort ☒ Maintain Fluid Balance ☐ Improve Activity Tolerance ☒ Maintain Good Nutritional Status ☐ Maintain Skin Integrity
☒ Maintain Personal Hygiene ☒ Prevent Infection ☒ Meet Elimination Needs ☒ Ensure Safety ☒ Early Ambulation Reduce Anxiety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

Time	Plan of Care	Time	Implementation	Evaluation
8 pm	→ Baby is	8:30 pm	→ Assessed the baby general condition	Baby is stable now
10:30 pm	→ Assess the baby general condition	12 Am	→ Assessed the baby	
2 Am	→ Assess the baby vitals	4:30 Am	→ Assessed the baby in a comfortable position	
5:30 Am	→ Assess the baby in a comfortable position	6 Am	→ Assessed baby hygiene	
6:30 Am	→ Assess baby hygiene	7 Am	→ Assessed baby hygiene	

Re-Assessment: Baby is having stable

Special Notes:

NA SRR, NBS, OAE @ 10:30 am today

Nurse Signature: 

Nurse Name: Alekya @ 66820

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

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: OBS Date of Admission: 6/7/26

SITUATION		Diagnosis: <u>Newborn care</u> Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	OBS 8am-2pm OBS 2pm-8pm OBS 8pm-2am OBS 2am-8am 2nd floor 8am-2pm 3rd floor 2pm-8am					
	Shift Time						
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>NA</u> <u>NA</u> <u>NA</u> <u>NA</u> <u>NA</u> <u>NA</u>					
	Allergy: ☐ Yes ☒ No Tubes/Drains/Catheter: ☐ Yes ☒ No Vital Signs: Temp: <u>98.0°F</u> <u>98.1°F</u> <u>98.3°F</u> <u>98.3°F</u> <u>98.4°F</u> <u>98.0°F</u> Res: <u>40</u> <u>40b/m</u> <u>42b/m</u> <u>40b/m</u> <u>42b/m</u> <u>40b/m</u> SpO ₂ : <u>100</u> <u>100%</u> <u>99%</u> <u>100%</u> <u>99%</u> <u>99%</u> Pulse: <u>140</u> <u>138b/m</u> <u>140b/m</u> <u>142b/m</u> <u>146b/m</u> <u>140b/m</u> BP: <u>-</u> <u>-</u> <u>-</u> <u>-</u> <u>-</u> <u>-</u> Fall Risk Score: <u>-</u> <u>15</u> <u>16</u> <u>16</u> <u>16</u> <u>16</u> Pain Score: <u>-</u> <u>0/10</u> <u>0/10</u> <u>0/10</u> <u>0/10</u> <u>0/10</u>						
Recommendations	Safety Needs:	<u>yes</u> <u>yes</u> <u>said to be safe</u> <u>said to be safe</u> <u>said to be safe</u> <u>crib care</u>					
	Physiotherapy	☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No					
	Others Specify:	<u>NA</u> <u>NA</u> <u>NA</u> <u>NA</u> <u>NA</u> <u>NA</u>					
	Special Diet:	☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No ☐ Yes ☒ No					
	Other Special Orders / Medications:	<u>NA</u> <u>NA</u> <u>NA</u> <u>NA</u> <u>NA</u> <u>NA</u>					
Post Operative Procedure Special Orders:		<u>NA</u> <u>NA</u> <u>NA</u> <u>NA</u> <u>NA</u> <u>NA</u>					
Handed Over By Name :		<u>Shobu</u> <u>Yammy</u> <u>Suanda</u> <u>Song</u> <u>Suhu</u> <u>Allyya</u>					
Signature :		<u>[Signature]</u> <u>[Signature]</u> <u>[Signature]</u> <u>[Signature]</u> <u>[Signature]</u> <u>[Signature]</u>					
Date:		<u>6/7/26</u> <u>6/7/26</u> <u>6/7/26</u> <u>6/7/26</u> <u>6/7/26</u> <u>6/7/26</u>					
Time:		<u>2pm</u> <u>8pm</u> <u>8pm</u> <u>2pm</u> <u>8pm</u> <u>8am</u>					
Taken Over By Name :		<u>Yammy</u> <u>Suanda</u> <u>Song</u> <u>Suhu</u> <u>Allyya</u> <u>Pooja</u>					
Signature :		<u>[Signature]</u> <u>[Signature]</u> <u>[Signature]</u> <u>[Signature]</u> <u>[Signature]</u> <u>[Signature]</u>					
Date:		<u>6/7/26</u> <u>6/7/26</u> <u>6/7/26</u> <u>6/7/26</u> <u>6/7/26</u> <u>6/7/26</u>					
Time:		<u>2pm</u> <u>8pm</u> <u>8pm</u> <u>2pm</u> <u>8pm</u> <u>8am</u>					

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area							
	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		Fall Risk Score:						
		Pain Score:						
	Recommendations	Safety Needs:						
Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Others Specify:								
Special Diet:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Other Special Orders / Medications:								
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								



THE HUMPTY DUMPTY SCALE

6/7/2026 12/26 1/7 8/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4	4	4	4	
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1	1	
Response to Surgery / Sedation Anesthesia	Within 24 hours	3	3	3	3	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	
Total			15	15	15	15	

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		x	x	x	x
Call device within reach		x	x	x	x
Wheels Locked		✓	✓	✓	✓
Room free of clutter		x	✓	✓	✓
Adequate lighting		x	✓	✓	✓
Wheel chair support		x	x	x	x
Other Intervention(s) Specify		✓	x	x	x
Nurse's Name:		Shobkyimma sona	Shobkyimma sona	Shobkyimma sona	Shobkyimma sona
Signature:		[Signature]	[Signature]	[Signature]	[Signature]
Date:		6/7	6/7	7/7	8/7
Time:		12pm	5pm	12pm	8pm



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-00660817 IP5-00176028
Baby Of FATIMA BASHMAIL
06-07-2026 0 Y 0 M 0 D 4 H (F)
Dr. FAISAL B NAHDI



BRADEN 'Q' SCALE

Rainbow
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It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	6/7/2026 6/26/27			
					Time :	9pm 5pm 8am 8am 2pm			
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.	2	2	2	2	
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.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
TOTAL SCORE					18	18	18	18	
Evaluator's Name					Shobha Gargi Suman Sana				

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

BRADEN 'Q' SCALE

BAH-00660817 IP5-00176028
Baby Of FATIMA BASHMAIL
06-07-2026 0 Y 0 M 0 D 22 H (F)
Dr. FAISAL B NAHDI



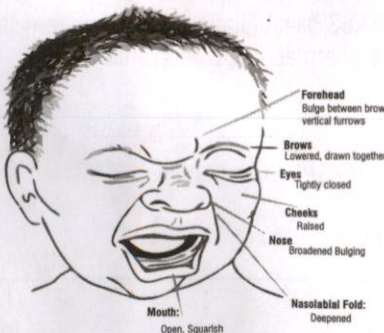
				Date : 8/7			
				Time : 8 AM			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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.	2		
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		
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		
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		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4		
TOTAL SCORE					18		
Evaluator's Name					Aleka		

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



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	
						6/7 6:14 PM	6/7 6:17 PM	6/7 6:17 PM	7/7 8:17 AM	8/7 8:17 AM				
						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				
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0	0	0				
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0	0	0				
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0	0				
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0	0				
 Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention						Gestational Age / Corrected Age	37+6	37+6	37+6	37+6	37+6			
						Total Pain / Agitation Score	0	0	0	0	0			
						Intervention	NA	NA	NA	NA	NA			
						Effectiveness	NA	NA	NA	NA	NA			
						Signature	Shob	Kumar	Suresh	Song	Alkya			

NPASS: Neonatal Pain, Agitation & Sedation Scale

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

BAH-00660817
Baby Of FATIMA BASHMAIL
06-07-2026
Dr. FAISAL B NAHDI

IP5-00176028

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

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

Part
Patient

Language: Arabic

Patient / Learner Literacy: ☐ Read ☐ Write ☒ Speak

Willingness to Learn: ☐ Yes ☐ No

Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
6/7	12pm	7	Infection control measures							Shobly
6/10	2PM									

Part - III: CODES

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

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

New born baby

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Nursing ☐ Others:
<i>6/11/26 apm</i>	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☒ Modified ☐ Per-Op ☐ Post Op	<i>DBF ↑ worse case</i>	<i>to DBF and hourly</i>	<i>a burping after feed done</i>	<i>Sunanda</i>	☐ Medical ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BREASTFEEDING HISTORY FORM

Mother's Name: MRS. SHAIKH ABDUL RASHEED Baby's Name: B/o FATIMA BASHMA Date of Birth:

Reason for consultation: Lactation Counselling for Mother

- | | | | |
|---|---|--|--------|
| 1. Baby's feeding now (ask all these points) | Breastfeeds <u>4x</u>
How often <u>2-2 1/2 hr</u>
Length of breastfeeds <u>15-20 min</u>
Longest time between feeds <u>2-2 1/2 hr</u> (time mother away from baby)
One breast or both breasts <u>Both</u>

Complements (and water) } <u>NO</u>
What given
When started
How much
How is it given | Day | Night |
| 2. Baby's health and behaviour (ask all these urine output (more/less than points)) | Birth weight
Premature <u>Term</u>
Urine output (more/less than 6 times per day)
Stools (soft and yellow/brown; or hard or green; frequency)
Feeding behaviour <u>Good</u>
Illnesses | Weight now
Twin | Growth |
| 3. Pregnancy, birth, early feeds | Antenatal care (attended/not)
Delivery: Normal / C - section
Rooming - in <u>Yes</u> / No
Prelacteal feeds Yes / No (If Yes,)
What given
Formula samples given to the mother Yes / No
Postnatal help available for breastfeeding Yes / No | Abnormalities <u>no</u>

Breastfeeding discussed? <u>Yes</u> / No
Early contact (First - 1 hour) <u>Yes</u> / No
Time first breast feed (if not within 1 st hour) <u>yes</u>

How given | |
| 4. Mother's condition and family planning | Age

Family planning method | Breast condition <u>normal</u>
Motivation to breastfeed <u>yes</u>
Alcohol, smoking, coffee, other drugs
Yes / no | |
| 5. Previous infant feeding experience | Number of previous babies }
How many breastfeed }
Any bottles used <u>no</u> | 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>Counselled about DBF</u> | |

Lactation Consultant:

Signature: Nabeela Name: Nabeela Date & Time: 02/12/2010

LACTATION ASSESSMENT FORM

Mother's details: My

Baby details: Blo

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

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

BF previous baby: Previous BF difficulty: ND

Present Lactation:

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

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

Expressed / Pallada feeding: Yes ☐ No ☒

LATCH Assessment:

	0	1	2	SCORE					
				D-1	D-2	D-3	D-4	D-5	D-6
LATCH	Too sleepy not sustained LATCH / suck	Repeated attempts for suck / latchHold nipple in mouth	Grasps breast tongue downlips flanged Rythmical sucking						
AUDIBLE SWALLOWING	None	A few with stimulation	Spontaneous & Intermittent						
TYPE OF NIPPLE	Inverted	Flat	Everted (After stimulation)						
COMFORT	Engorged cracked Bleeding large Blisters bruises	Filling reddened small blisters / bruises	Soft Non tender						
HOLD	Full Assist	Minimal assist	No assist						
Total Score									
BABY WEIGHT CHART				FIRST FEED					
Date	<u>7/7/26</u>						Breast Feed	Top Feed	
Weight									

Teaching Instructions: Deep latch

Discharge Instructions: urine output & weight monitor

Feed Frequency Duration: 2-2 1/2 hrs

Feeding techniques: cradle

Assessment of output: Good

Sources of BF assistance at home: Handout

Next Follow up: 1 week

Lactation Consultant: Name: Shanti K... Signature: Shanti K... Date & Time: 07/26/26 11:00

BREASTFEEDING OBSERVATION CHART



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

Observation Parameters	Date & Time	No. of Feeds	9/12/26	12/26	1/27	2/27	3/27	4/27	5/27	6/27	7/27	8/27	9/27	10/27	11/27	12/27	1/28	2/28	3/28	4/28	5/28	6/28	7/28	8/28	9/28	10/28	11/28	12/28
Body Position	• Mother relaxed and comfortable		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Shoulders tense, leans over baby		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Baby's head and body in straight line		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Baby's head and body is not straight line		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Baby's body close to mother's		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Baby's body not close to mother's		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Baby's back		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Only shoulder or head supported		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Breast well supported (optional)		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Breast supported in scissor hold or nipple being pushed in baby's mouth		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Supine		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
Responses	• Sitting		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Baby roots for breast		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• No rooting observed		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Baby explores breast with tongue		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Baby not interested in breast		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Baby calm and alert at breast		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Baby restless or crying		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Baby stays attached to breast		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Baby slips off breast		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Signs of milk ejection, (leaking, after - pain)		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• No signs of milk ejection		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒

Baby Suckled for (in Minutes)		Left:		Right:		EBM (in ML)		Formula Feeds		Birth Weight		Present Weight		Weight Loss		Nurse Signature:		Nurse Name:	
		10 min	15 min	10 min	15 min	10 min	15 min	10 min	15 min	10 min	15 min	10 min	15 min	10 min	15 min	10 min	15 min	10 min	15 min
Emotional Bonding	• Secure, confident hold	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Nervous or limp hold	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Face-to-face attention from mother	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• No mother/baby eye contact	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Much touching by mother	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
Anatomy	• Little touching or Shaking or poking baby	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Breasts soft after feed	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Breasts engorged	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Nipples average size	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Nipples large / flat / inverted	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
Sucking	• No lump in breast	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Lump in breast	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Mouth wide open	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Mouth not wide open, points forward	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Chin touching the breast and nose close to breast	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
Baby Suckled for (in Minutes)	• Chin and nose away from the breast	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Lower lip turned outwards	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Lower lip turned in	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Cheeks round	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Cheeks tense or pulled in	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
Baby Suckled for (in Minutes)	• Slow deep sucks, bursts with pauses	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Rapid sucks only	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒
	• Birth Weight	9.778	9.778	9.778	9.778	9.778	9.778	9.778	9.778	9.778	9.778	9.778	9.778	9.778	9.778	9.778	9.778	9.778	9.778
	• Present Weight	9.541	9.541	9.541	9.541	9.541	9.541	9.541	9.541	9.541	9.541	9.541	9.541	9.541	9.541	9.541	9.541	9.541	9.541
	• Weight Loss	0.237	0.237	0.237	0.237	0.237	0.237	0.237	0.237	0.237	0.237	0.237	0.237	0.237	0.237	0.237	0.237	0.237	0.237
Nurse Signature:		[Signature]																	
Nurse Name:		[Name]																	

BAH-00660817 IP5-00176028
Baby Of FATIMA BASHMAIL
06-07-2026 0 Y 0 M 0 D 4 H (F)
Dr. FAISAL B NAHDI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/o Fathima Bashmail Mother's Name: Mrs. Fathima Bashmail
Date of Birth: 06/07/26 Time of Birth: 10:42 am Gender: ☐ Male ☒ Female
Birth Weight: 2.778 Kgs HC: 34 cm Length: 49 cm
Meconium in Liquor: ☐ Yes ☒ No Cried at Birth: ☒ Yes ☐ No
Term / Pre-term / Post-term: Term
Resuscitated: ☐ Yes ☒ No Blood Group: Mother: B +ve Baby: _____
Feeding: ☒ Breast Feeding ☐ Formula ☐ Both First Feed Time: 11:16^{am} to 11:20^{am}

AFFIX MOTHER'S
IDENTIFICATION LABEL

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

Indication: _____

Physical Assessment of New Born:

Temp: 97.6°F HR: 140 b /Min RR: 43 b /Min BP: NA SpO₂: 98%

Pain Score: 0 (Follow N Pass)

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

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

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

Findings:

General Appearance: Posture: ☒ Well-Flexed ☐ Asymmetry

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

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

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

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

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

Newborn Screening Discussed: Yes / No

Nurse Name: S. Swathi

Signature: Swathi

Date & Time: 06/07/26 @ 11:

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660817 IP5-00176028 Baby Of FATIMA BASHMAIL 06-07-2026 0 Y 0 M 0 D 4 H (F) Dr. FAISAL B NAHDI		Date & Time of Admission 6/12/26 12:46 PM	Date & Time of Transfer Order 7/12/26 @ 10:50 AM
		Transfer Ordered by DR. FAISAL	Reason for Transfer OBS
From Unit OBS	To Unit (309)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 28	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films 0			

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring Sis. Sora	Name of Person Ordered Transfer DR. FAISAL B NAHDI
Patient & Clinical Records Received by : Sr. Sora	
Date & Time of Patient Received : 7/12/26 @ 11 AM	

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

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