

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176736

Admit Date : 21-Jul-2026

Admit Time : 09:49 PM **UHID** : BAH-00662371

Patient Details :
Patient Name : Baby Of ERVYCHETTY JAHNAVI

Age : 0 D

Guardian : Mr YALAVARTI SRIMUKHA

DOB : 21-07-2026 08:31 PM

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : #A504, PRISTGE ST.JOHN WOODS APTS
 APTS TAVAREKERE MAIN ROAD Taverekere
 Bangalore Karnataka INDIA 560029

Phone No : 8147547696/ 8123000821

E-mail : nomailid@gmail.com

Admission Details :
Bed Type : NICU

Bed No : NICU 252

Ward Name : 2F-NICU 2

Room No : NICU 252

Admission Type : First Visit

Contact Details :
Name : Mr YALAVARTI SRIMUKHA

Relationship : Father

Contact Address : #A504, PRISTGE ST.JOHN WOODS APTS
 APTS TAVAREKERE MAIN ROAD Taverekere
 Bangalore Karnataka INDIA 560029

Phone No : 8147547696 / 8123000821


Signature
Doctor Details :
Doctor Name : Dr. NALINIKANTA PANIGRAHY

Specialisation : NEONATOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

New Born Screening	:	
TFT	:	
OAE	:	
Mother's Blood Group	:	
Baby's Blood Group	:	
Anomaly Scan	:	
Vaccination	:	given-20/7

given - 22/7/26 Diego
(BCG, OPV, Hep B)

[illegible]

ACTIVITY RECORD FOR BILLING

Name : B10 Jahnavi

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
22/7/26	3:30pm	NICU	325, 3rd floor	At

Cross Consultation Visit

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

[illegible]

RBS

Yours

RB

42

X Ray

yang

CBP, CRP

21

[illegible]

21/7

Inv. monitor

9:15pm

000971534

yauf

2117

UP

Q: 15 pm

009715841

404

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00662371
Baby Of ERVYCHETTY JAHNAVI
21-07-2026
Dr. NALINIKANTA PANIGRAHY
IP5-00176736
0 Y 0 M 0 D 2 H (M)

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 Ervychetty Jhanavi
Gender : ☒ M ☐ F Blood Group : B+ve
Date of Birth : 21/7/26 Time of Birth : 08:31 PM
Place of Birth : RCH Bayana
Mother's Blood Group : B positive
Birth Weight (gms) : 2.775 kg Length (cms) : 2.775 kg (2.775 kg)
OFC (cms) :
Estimated Gesth Age : 38+4 wks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 31y Ht : Wt : BMI : Married Life : LMP : EDD :

Conception : Spontaneous or with Rx :

Booked at what GA : AN Steroids Drugs / Doses :

Last Scans Details : 12/7 - 37+1/c/cephalic, 28/11 (27-1-), AC(8-1-), Doppler (N)

TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs
Consanguinity : ☐ Yes ☒ No
If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3
H/o PIH (after 20 weeks) / PE
How many Drugs / Doses / Since how long :
H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) :
IUGR - when detected :
Doppler (Increased Resistance / ADEF / REDF / Redistrbution in MCA) / Ductus Venosus :
AFI :

H/o GDM/ pre GDM/ on diet or insulin
Controlled or not, recent values, HbA1 values :
Compliance with Rx :
Scans : LGA, TIFFA, Fetal Echo :
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 :

PAST OBSTETRIC HISTORY

P: A: L:

S	B.W	Gender	Significant	Details

PERINATAL HISTORY

Treating Obstetrician : Dr. Prashanthi Reddy Hospital : RCH Bangalore ☒ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication : SV

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitation : ☐ Yes ☐ No

Cord ABG : 7.12.8 / 58.1 / kc 9.1 / Ban - 9.3

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
<u>0</u>	<u>1</u>	<u>1</u>
<u>2</u>	<u>2</u>	<u>2</u>
<u>2</u>	<u>2</u>	<u>2</u>
<u>1</u>	<u>2</u>	<u>2</u>
<u>1</u>	<u>2</u>	<u>2</u>
<u>6/10</u>	<u>9/10</u>	<u>9/10</u>

TOTAL

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

Snapee II Score

	Score
Mean BP (mmHg)	> 30 (0) 20-29 (9) < 20 (19)
Lowest Temp (oF)	> 96 (0) 96-95 (8) < 95 (15)
Pao2 / Fio2 (mmHg%)	> 2.49 (0) 1-2.49 (5) 0.3-0.99 (15) < 0.3 (28)
Lowest Serum PH	> = 7.2 (0) 7.1-7.19 (7) < 7.1 (16)
Multiple Seizures	No (0) Yes (19)
U. Output (ml / kg / hr)	> = 1 (0) 0.1-0.9 (5) < 0.1 (18)
Apgar Score	> = 7 (0) < 7 (18)
Birth Weight	> = 1kg (0) 750 - 999 (10) < 750 (17)
SGA	> 3rd percentile (0) < 3rd (12)
Total	<u>25</u>

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

IP5-00178736
 BAH-00662371
 Baby Of ERVYCHETTY JAHNAVI
 21-07-2026 0 Y 0 M 0 D 2 H (M)
 Dr. NALINIKANTA PANIGRAHY

History of Present Illness:

Baby delivered by SVD

↓
 Cried after birth - developed respiratory distress
 in the form of audible grunting,
 retractions and tachypnea.

HR > 100/min
~~SpO₂ 90%~~

↓
 Started on Positive pressure ventilation
~~on NeoPAP~~ (DR-CPAP)

↓
 Grunting settled, Tachypnea & retractions
 persisted
 SpO₂ at 5 min - 90%.

↓

Investigation details in previous Hospital:

Baby was shifted to NICU for
 observation

Given 1mg
 vit K
 at delivery Room

Feeding History:



Past History

Family History :



Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Distress ⊕

VITALS : Temperature : 36.5°C HR : 142/min RR : 70/min NIBP : CFT : 3 sec

Color of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 90% at 5m

ANTHROPOMETRY: Birth Weight : 2.775 kg Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :

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

| (N)

FACIES :

(Any Facial
Dysmorphism)

| No dysmorphism

NECK and CLAVICLES :

Range of Motion :
Asymmetry :
Masses :

| (N)

EYES :

Symmetry :
Red Reflex :
Discharge :

| To be checked

EARS, NOSE MOUTH and THROAT :

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

| (N)

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 :

| (N)

2A + 1 vein

GENITALIA :

Labia / Hymen :
Testicles/penis :
Anus :

| B/L testes descended

HERNIAL ORIFICES

(N)

TRUNK and SPINE :

(N)

SKIN LESIONS :

(N)

EXTREMITIES :

Fingers / Toes :
Deformities :
Hip Joint Examination :

| (N)

Arms / Legs :
Mobility :



SYSTEMIC EXAMINATION

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 40/m SCR ICR / See - Saw breathing :

Scoring of respiratory distress if present (Silverman or Downe's) : 5

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

Settings :

SpO₂: 90.1 Auscultation: clear lungs Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 142/m BP :

Precordial Activity : (A)

Femoral Pulses : 1 to be checked

Murmurs :

Other Peripheral Pulses :

Signs of Cardiac Failure : Nil

ABDOMEN:

Shape :

Hernia orifice : (A)

Palpation : (A)

Anal Patency : Patent

Palpable masses :

Umbilical Cord : 2A+1 Ven

Abdominal girth :

First urine passed : 1 Nil

Meconium passed :

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness : cry, tone (A)

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone : 1 (A)

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR :

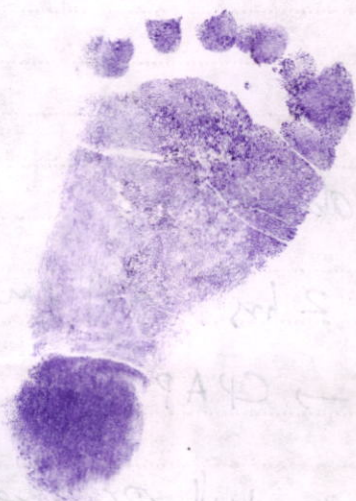
ATNR : Skull and Spine :



Diagnosis : Term (38+4 wks) | AGA (2.775 kg) | SVD | RD - Delayed transition

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

[Signature]
Dr. Neehu
21/7/26

Consultant :

Signature :

Name :

Date & Time :

[Signature]
Dr. NALINIKANTA PANIGRAHY
Reg. No. TSMC/AN/03005

PLEASE FILL UP THE FOLLOWING DETAILS

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



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic :

Medications :

CVS



Plan during ward follow up :

- 1) Shift to NICU for observations
- 2) Repeat OBG after 2 hrs @ 11 pm
- 3) Start low flow → CPAP SOS
- 4) Tx - 60 cc/kg/day - full OA feeds 14 ml 2hrly
- 5) Clinical jaundice assess at 24 HCL
- 6) Monitor vitals - W/F ↑ WOB / desaturation / bradycardia

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Doctor Signature (Handover Given): Doctor Signature (Handover Taken):

Doctor Name: Doctor Name:

Date & Time: Date & Time:

DEFICIENCY CHECK LIST OF CASE SHEET

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



ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

BAH-00662371

IP5-00176736

Baby Of ERVYCHETTY JAHNAVI
21-07-2026 0Y0M0D2H (M)
Dr. NALINIKANTA PANIGRAHYRainbow®
Children's
Hospital
It takes a lot to treat the little.BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/07/26 12:30 AM	<u>Night Rounds</u> Baby on minilow flow @ 0.05 L/min Distress improving. Tachypnea persisting No Refractorys.	<u>Plan</u> 1) Wean off O ₂ as tolerated 2) Tu - 60cc/kg/day 14ml 2hly full O ₂ feeds 3) W/F ↑ WOB Bradycardia/ desaturation. 4) Monitor vitals 5) GRBS BD (prepared)
	Repeat VBG - 7.33/39.1/50.2 LC - 5 BE - -4.7 HCO ₃ - 20.4 pH - 7.42 RR - 70/min SpO ₂ - 98% BP. WS - 5 - 6	Noted by Yamuna.



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

Day in NICU: Day of Life: 12 H 02 PMA:

Term ☐ Preterm ☐ Gestation: 38+4 wky Corrected Gestational Age: Today's Weight: 2.775

Overview	Problems		
	S.No.	Current	Past Problems
Overview	1.	Term / AGA (2.775kg) / SVD	
	2.	BD - Delayed transit -	
	3.		
	4.		
	5.		
	6.		
Clinical Assessment	Baby on nasal low flow @ 0.1 L/min Tachypnea persisting, Retractors settled. No apnea / bradycardia, Desats Tolerating full feeds 14 ml 2hly, No vomiting		
	Medications Used Passed urine & Meconium 7.12 / 58.1 / 14.1 / 9.3 / Lac = 9.1 7.33 / 39.1 / 20.1 / 4.7 / Lac = 5.0. CRBS - 12 mg / kg. HR - 131 / min. RR - 42 / min. SpO ₂ - 95% BP - 65 / 45 (50)		

Plan of Care:

- 1) Wean off O₂ as tolerated. Target SpO₂ 90-95% FiO₂ 21
- 2) TV - 60 cc/kg/day, 14 ml 2hly & 0.9 feeds. Rlv Pll adf. Once distends settle. Target SpO₂ 90-100% FiO₂ 21
- 3) CBP, CRP at 12 H 02, CXR m.c.
- 4) Clinical transferee assessment at 24 H 02
- 5) CRBS BD (Pre-feed)
- 6) w/f ↑ WOB, Apnea, Brady / Desats

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

Signature: _____

Date & Time: 22/7/26

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

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

Signature: _____

Date & Time: 22/7/26

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

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 10:30 AM		Plr seen by Dr. Nalinikanta Try Palladay feeds from now Dress the baby Plan to shift out by evening GRBS BD (prefeed) Trace CBP, CRP TX - 60 cc/kg/day - 14ml 2hrly till Palladay feeds
22/7/26 @ 2pm	Baby on Room air Hemodynamically Stable. CFT - ~ 2sec. Per - Warm, Pink No Resp. distress vitals HR = 123/min RR = 63/min SPO ₂ = 96% Accepted Paladay feeds well	Shifting Notes. Plan 1) Direct Breast feeding / Paladay feeds : 15ml 2nd hrly 2) Dress the baby Gibrace 3) Vaccination BCG, OPV, Hep B OAC at Room today GRBS - BD (Prefeed) 4) w/f - RD feeding Temperature 5) No charting 6) Jaundice assessment at 24 Hrs

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 5:45 PM	ds/B RESIDUAL	
	22H01 38+4 WKS SVD C1A8 PD-	Delayed transition / 2.77 kg
	B+ UP ✓ B+ MV ✓	Plan
	on room air	1. DEF / 2nd hourly -
	No LD.	if baby is not satisfied
	Enteral / Pink.	then Top up 10-12ml / 2nd
	cold stock ⊕	hourly feed.
	icterus: Face	2. SBR / NBC / OAE - T/M
	vitals - stable	
	Vaccines ✓	3. w/F ED / apnea
		4. Temp. monitoring 4H
		5. RBS 12th hourly prefeed
		noted by Laurie
		Shits



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7 8:20 9am	C/B <u>RESIDENT</u> .	
	36H04 38+4 wks / SVD / C/AB / ED-delayed transition / 2.77kg	
	TWT: 2612 (5.9-f).	<u>Plan</u>
	BT 7-8	1. DBF and honey.
	BT 7-7	Lactation review today.
	on born air	
	also ED -	2. SBR / WBS at 8pm today.
	Gut healthy / pink	
	C/4 as good	3. Temp monitoring 4H.
	RBS: 62 mg/dl.	
	Vaccines: ✓	4. RBS - 12H proceed
		Noted by Subhendu
		Plan TCBR < 28 < 8 - 9
		① d/c today
		② Saturday morning 10
		with SBR
		WBS
		AABR.

Dr. NALINIKANTA PANIGRAHY
 23/7/26

[illegible]

[illegible]

BAH-00662371 IP5-00176736
Baby Of ERVYCHETTY JAHNAVI
21-07-2026 O Y O M O D 2 H (M)
Dr. NALINIKANTA PANIGRAHY




RBS CHART

[illegible]

BAH-00662371 IP5-00176736
 Baby Of ERVYCHETTY JAHAVAL
 21-07-2026 0 Y 0 M 0 D 2 H (M)
 Dr. NALINIKANTA PANIGRAHY



RESULT SHEET

Date	20/7/26				
Time	10Am.				
Hb	17.9				
PCV	52.4				
RBC	4.98				
WBC	15.73				
N/L	69.7				
Platelets	234				
CRP	5				
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

NURSING INITIAL ASSESSMENT FOR NICU

Date of Admission: 21/7/26

Source of Admission: ☐ OPD ☐ Ward ☒ Labor Ward ☐ Other:

Reason for Admission: observation

Admission Diagnosis: RDS

Accompanied By: ☒ Parent ☐ Guardian ☐ Other Name:

Primary Language: ☒ Telugu ☐ English ☐ Hindi ☐ Other Specify

Do you require an interpreter? ☐ Yes ☐ No

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:

If yes, identify

Source of Information: ☐ Family ☐ Others, Specify

Past Medical History	Past Surgical History	Last Hospital Admission
NA	NA	

Significant History	Family History:
---------------------	-----------------------

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☐ No

If yes please list,

Was the child's birth normal? ☒ Yes ☐ No If No, please describe problems:

Are the child's immunization up to date? ☐ Yes ☒ No

Current Medications	Taking Medications? ☐ Yes ☐ No If yes, Fill the reconciliation form Medicine brought to the hospital? ☐ Yes ☐ No
---------------------	--

Observations:

Birth Weight: 2.475 kgs Head Circumference: cm Length: cm

☒ Term ☐ Pre-Term ☐ Post-Term

Blood Group: Mother: B+ve Baby: B+ve

Feeding: ☐ Breast Feeding ☒ Formula ☐ Both

Maternal Details: Age: 31.4 years, PARA: Gestation: 38* Weeks, 4 Days

Risk Factors: ☐ PROM ☐ Fetal Distress ☐ Diabetes Mellitus / Gestational Diabetes

☐ PH / Pre Eclampsia ☐ Others, Specify:

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

Indication:

BAH-00662371

IP5-00176736

Baby Of ERVYCHETTY JAHNAVI

21-07-2026

0 Y 0 M 0 D 2 H

(M)

Dr. NALINIKANTA PANIGRAHY



MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
21/7/26 10pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Baby needs warm care.	To baby Raping	To provided warm care.	<i>[Signature]</i>	☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ 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:

BAH-00662371 IP5-00176736
Baby Of ERVYCHETTY JAHNAVI
21-07-2026 0 Y 0 M 0 D 2 H (M)
Dr. NALINIKANTA PANIGRAHY



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 - I.

Patient's / Learner Language: Telugu 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		
21/7/26	10 pm	warm call	provided information regarding -ng warm providence.	1	1	0	1	1	-	BT

Part - III: CODES

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

BAH-00662371 IP5-00176736
Baby Of ERVYCHETTY JAHNAVI (M)
21-07-2026 0 Y 0 M 0 D 2 H
Dr. NALINIKANTA PANIGRAHY

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

21/7/26

TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart

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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

[illegible]

Temperature (°F)

Time	Temperature (°F)	Temperature (°C)
0	97.0	36.1°C
1	97.3	36.5°C
2	97.1	36.6°C
3	97.3	36.4°C
4	97.1	36.3°C
5	97.1	36.3°C

Heart Rate (bpm)	120	130	135	124	130	134
190						
180						
170						
160						
150						
140						
130						
120						
110						
100						
90						
80						
70						
60						
50						
Heart Rate (Number)	124	130	135	124	130	134

[illegible][illegible][illegible][illegible]

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

Date :	Time:	8		10		12		2		4		6		8		10		2		6	
Doctor / Nurse / Family Concern?		Am		pm		pm		pm		pm		pm		pm		pm		Am		Am	

Hand-drawn graph on grid paper showing temperature (°C) vs. time (min) for a cooling curve. The y-axis is labeled "Temperatur (°C)" and ranges from 94 to 104. The x-axis is labeled "Zeit (min)" and ranges from 0 to 10. The curve starts at (0, 103.5), decreases linearly to (4, 97.5), then levels off at 97.5°C from 4 to 6 minutes, and finally decreases linearly to (10, 94.5). Data points are marked with asterisks and labeled with their coordinates.

Zeit (min)	Temperatur (°C)
0	103.5
1	102.5
2	101.5
3	100.5
4	97.5
5	97.5
6	97.5
7	96.5
8	95.5
9	94.5
10	94.5

Hand-drawn diagram on graph paper showing a path with four segments. The path starts at (0, 100) and ends at (100, 100). The segments are labeled with their lengths and directions: 45 (up), 130 (right), 125 (down), and 150 (right). The total distance is 450. The path is marked with red 'X' symbols at each segment boundary. The graph paper has a grid with x and y axes ranging from 0 to 190.

[illegible]

vere					N		N		N		N
ild											
	95%	96%	97%	99%	99%		98%		99%		100%
I	N	N	N	N	N		N		N		N
	C	C	C	C	L		15(15)		15(15)		15(15)

[illegible]

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)

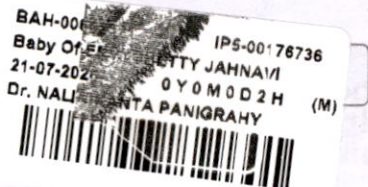
FLUID CHART

Sheet No. :

TV = 60 ccl/kg/day
 BW = 2.775 kg
 TF = 14ml

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										
	09:00 am										
	10:00 am										
	11:00 am										
	12:00 pm										
	01:00 pm										
Total Intake :					Total Output :						
	02:00 pm										
	03:00 pm										
	04:00 pm										
	05:00 pm										
	06:00 pm										
	07:00 pm										
Total Intake :					Total Output :						
	08:00 pm										
	09:00 pm										
	10:00 pm										
	11:00 pm	new pro			14ml				10ml	1	4ml
	12:00 am									0	
	01:00 am	new pro			14ml				12ml	1	
Total Intake :					Total Output :						
	02:00 am										
	03:00 am	new pro			14ml				8ml	1	
	04:00 am										
	05:00 am	new pro			14ml				10ml	0	4ml
	06:00 am										
	07:00 am	new pro			14ml				12ml	1	
Total Intake : 84 ml					Total Output : 52ml						
Total 24 hrs. Intake		84 ccl/kg/day									
Total 24 hrs. Output		0.0 ccl/kg/day									



FLUID CHART



Sheet No. :

22/7/26

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
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	O.G							
22/7	08:00 am											
	09:00 am	Nan pro			14ml		passed			10ml		
	10:00 am											
	11:00 am	Nan pro			14ml		passed			9ml		
	12:00 pm											
	01:00 pm	Nan pro			14ml		—			10ml		
Total Intake :						Total Output :						
22/7	02:00 pm											
	03:00 pm	DBF										
	04:00 pm						✓			✓		
	05:00 pm	DBF										
	06:00 pm											
	07:00 pm	DBF					✓			✓		
Total Intake :						Total Output : 14 20 2						
22/7	08:00 pm											
	09:00 pm	DBF					✓			✓		
	10:00 pm											
	11:00 pm	DBF										
	12:00 am											
	01:00 am	DBF										
Total Intake :						Total Output : 14 20 2						
23/7	02:00 am						✓			✓		
	03:00 am	DBF										
	04:00 am											
	05:00 am	DBF										
	06:00 am						✓			✓		
	07:00 am	DBF										
Total Intake :						Total Output : 14 20 2						
Total 24 hrs. Intake		Taken										
Total 24 hrs. Output		14 20 2										

①

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/7/26

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
9pm	*Assess the General Condition of the baby	9:15pm	*Assessed - the General Condition of the baby	New baby is stable
10pm	*monitor vital signs	10pm	*monitored vital signs	
12Am	*provide Comfortable position	12pm	*provided Comfortable position	
4Am	*Given 2nd hourly feeding	1Am	*Given 2nd hourly feeding	
8Am	*Ensure Baby Safety	8Am	*Ensured baby safety	

Re-Assessment: Done

Special Notes: RBS - DD

Nurse Signature: yuf

Nurse Name: ymua

Date & Time: 22/7/26 @ 8Am



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: Baby is on RA

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	8:00Am	→ Assessed the baby general condition	Now baby is stable
10Am	→ maintain the Dlo chart	10:00Am	→ maintained Dlo chart	
12Pm	→ give 2nd hourly feed	12:00Pm	→ given 2nd hourly feed	
2Pm	→ monitor the vital signs	2:00Pm	→ monitored vital signs	
4Pm	→ maintain personal Hygiene	4:00Pm	→ maintained personal Hygiene	
6Pm	→ maintain fluid balance	6:00Pm	→ maintained fluid balance	
7Pm	→ prevent infection	7:00Pm	→ prevented infection	
8Pm	→ ensure safety	8:00Pm	→ Ensure safety	

Re-Assessment: Re-Assessment done

Special Notes:

Nurse Signature:

Nurse Name: Bobonya

Date & Time: 22/7/26

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/7/25 @ 8 PM

Assessment: Baby is on loose stool

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 PM	→ Assess the general condition of the baby and measure vitals.	8 PM	→ Assessed the general condition of the baby and measured vitals.	Baby is stable
10 PM	→ Giving feeding and nappy and burping.	10 PM	→ Given feeding and nappy and burped.	
12 AM	→ Giving warm bottle.	12 AM	→ Given warm bottle.	
6 AM	→ Maintaining personal hygiene. → Encouraging urine output.	6 AM	→ Maintained personal hygiene. → Encouraged urine output.	
8 AM	→ Ensure safety.	8 AM	→ Ensured safety.	

Re-Assessment: Baby under observation

Special Notes: G.R.B.S. B.D

Nurse Signature: Piyu Nurse Name: Piyu

Date & Time: 23/7/25 @ 8 AM



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature: Nurse Name: Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nik Department: 3rd Floor Date of Admission: 22/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
	<u>New born</u>								
BACKGROUND	Area	Shift Time	<u>3rd Floor</u> <u>3rd Floor</u> <u>4PM-8PM</u>	<u>3rd Floor</u> <u>8PM-11PM</u>					
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>					
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ 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	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98.4°F</u>	<u>98.2°F</u>					
		Res:	<u>38b/m</u>	<u>36b/m</u>					
		SpO ₂ :	<u>99%</u>	<u>100%</u>					
		Pulse:	<u>132b/m</u>	<u>126b/m</u>					
		BP:	<u>-</u>	<u>-</u>					
	Fall Risk Score:	<u>0/10</u>	<u>0/10</u>						
Pain Score:	<u>0</u>	<u>-</u>							
Recommendations	Safety Needs:	<u>Side rail</u>	<u>Side rail</u>						
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NA</u>	<u>NA</u>						
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>						
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>						
Handed Over By Name :		<u>Priya</u>	<u>Priya</u>						
Signature :		<u>Priya</u>	<u>Priya</u>						
Date:		<u>22/7</u>	<u>23/7</u>						
Time:		<u>@8PM</u>	<u>8AM</u>						
Taken Over By Name :		<u>Priya</u>	<u>Subhankar</u>						
Signature :		<u>Priya</u>	<u>Subhankar</u>						
Date:		<u>22/7</u>	<u>23/7</u>						
Time:		<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							
BACKGROUND	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:								

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA : 21/7/26		Diagnosis : ROS		Surgery / Procedures :	
	Allergies :				Post OP Day :	
	Date :	21/7/26	22/7/26			
	Area	N2	N2			
	Shift Time	8am to 8pm	8am to 8pm			
	Diet :	NAN PRO	NAN PRO			
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)		ILF	RIA		
	1.					
	2.					
	3.					
ASSESSMENT	4.					
	Infusions / Transfusions		NA	NA		
	PU Prophylaxis		NA	NA		
	DVT Prophylaxis		NA	NA		
	Vitals	BP	70/40 (62)	71/46 (63)		
		PR	111	140b/m		
		RR		36b/m		
		SpO ₂	97%	97%		
		Temp	36.5°C	36.5°C		
	Pain Score		1/10	1/10		
	LOC (Alert, Conscious, Confusion, Unconscious)		Alert	Alert		
	Skin Integrity (Intact / Bedsore / Any other condition)		Intact	Intact		
	Restraints If any	Physical	NA	NA		
		Chemical	NA	NA		
	Fall Risk (Vulnerable (Y/N) if yes score)		yes	yes		
(Ambulation, walking, moving with assistance, bed ridden)		moving	moving			
ADL (Dependent / Non-Dependent)		dependent	dependent			
Critical Lab Test / Values (if any)		NA	NA			

RECOMMENDATIONS	Investigations Procedures	Date :	21/7/26	21/7/26				
		Area	N2	N2				
		Shift Time	8pm to 8Am	8pm to 8Am				
		Ordered / Planned						
		Due						
Reports Pending								
Referrals (If any)								
	Remarks (Special Interventions like, Drainage Tube flushing etc.)	NA	NA					
Handed Over By Name :		Ypus	lobanya					
Signature :		Ypus	lobanya					
Date :		21/7/26	21/7/26					
Time :		@ 8Am	@ 8pm					
Taken Over By Name :		lobanya						
Signature :		lobanya						
Date :		22/7/26						
Time :		@ 8Am						

BAH-00662371
Baby Of ERVYCHETTY JAHNAVI
21-07-2026
Dr. NALINIKANTA PANIGRAHY

IPS-00176736

(M)

BRADEN 'Q' SCALE

					Date : 22/7			
					Time : 6:00			
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.	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			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3			
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."	3			
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			
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			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	18		
					Evaluator's Name	Piya		

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



1

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4		
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2		
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3	3		
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	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	2	2	2		
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	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		
TOTAL			17	17	17		

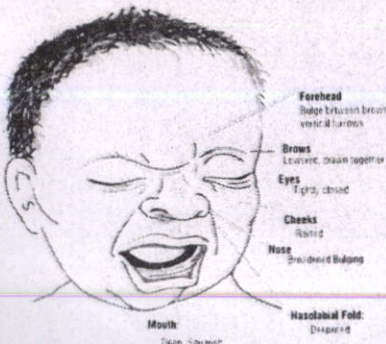
Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	Yes		
Call device within reach		✓	✓	Yes		
Wheels Locked		✓	✓	Yes		
Room free of clutter		✓	✓	Yes		
Adequate Lighting		✓	✓	Yes		
Wheel Chair Support		✓	✓	No		
Other Intervention(s) Specify		✓	✓	No		
Nurse's Name :		Yamini	Yamini	Purk		
Signature :		Yamini	Yamini	Purk		
Date :		21/7	21/7	24/7		
Time :		10pm	10pm	10pm		

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
						21/7 10pm	21/7 8pm						
						Procedure → RBG MM							
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						
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						
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	1	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						
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						
 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	38w4d	38w4d					
						Total Pain / Agitation Score	1/10	0/10					
						Intervention	Non PRD	-					
						Effectiveness	Good	-					
						Signature	Yash Raj						

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.



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					
21/7/26 @ 10 PM	Rt Abd	Rt hand	supine	Given	Given	OD	NA	Given	NA	yaf
22/7/26 @ 12 AM	Rt Abd	Rt hand	supine	Given	Given	OD	NA	Given	NA	yaf
22/7/26 @ 2 AM	Rt Abd	Rt hand	supine	Given	Given	OD	NA	Given	NA	yaf
22/7/26 @ 4 AM	Rt Abd	Rt hand	supine	Given	Given	OD	NA	Given	NA	yaf
22/7/26 @ 6 AM	Rt Abd	Rt hand	supine	Given	Given	OD	NA	Given	NA	yaf
22/7/26 @ 12 PM	Rt Abd	Rt hand	supine	Given	Given	OD	NA	Given	NA	huc



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					
22/7/26 @ 2pm	Rt Abd	lt hand	supine	given	given	OD	NA	given	NA	<i>[Signature]</i>

Patient Sticker

PROBS AND POSITIONS CHART


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


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

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					

Patient Sticker

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					

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: estimated date

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☒ Yes ☐ No

☐ Eating ☒ Yes ☐ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: explain about condition

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Name]

Date and Time: 22/7 @ 3:50pm

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00662371 IP5-00176736 Baby Of ERVYCHETTY JAHAVALI 21-07-2026 0 Y 0 M 0 D 18 H (M) Dr. NALINIKANTA PANIGRAHY 		Date & Time of Admission 21/7/26 9:50 pm	Date & Time of Transfer Order 22/7/26 @ 3:30 pm
		Transfer Ordered by Dr. N.K. Sir.	Reason for Transfer observation.
From Unit NICU	To Unit 3 rd floor 325	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20.	Number of Imaging Films 2.	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	D - water .		
2.	Nas pro.		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Lokanya.		Name of Person Ordered Transfer Dr. N.K Sir.	
Patient & Clinical Records Received by : S.S. Lanya			
Date & Time of Patient Received : 22/7/26 @ 3:45 pm			

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

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