



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176154

Admit Date : 09-Jul-2026

Admit Time : 02:14 PM UHID : BAH-00661112

Patient Details :

Patient Name : Baby Of VIDYALA PUJITHA

Age : 0 D

Guardian : DR. JATIN YEGURLA

DOB : 09-07-2026 12:38 PM

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : FLAT NO. 1202, WEST SIDE, SHAIKPET,
Golconda Hyderabad Telangana INDIA
500008

Phone No : 8333026969/ 9959142144

E-mail : DRJATIN.Y@GMAIL.COM

Admission Details :

Bed Type : BASINET

Bed No : CRDL-SW-419-1

Ward Name : 4F-BIRTHING CENTRE

Room No : CRDL-SW-419-1

Admission Type : First Visit

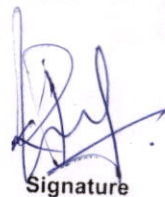
Contact Details :

Name : DR. JATIN YEGURLA

Relationship : Father

Contact Address : FLAT NO. 1202, WEST SIDE, SHAIKPET,
Golconda Hyderabad Telangana INDIA 500008

Phone No : 8333026969 / 9959142144


Signature

Doctor Details :

Doctor Name : Dr. ANNAPOORNA TADAVARTHY

Specialisation : NEONATOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY

BAH-00661112 IP5-00176154
Baby Of VIDYALA PUJITHA
09-07-2026 0 Y 0 M 0 D 2 H (M)
Dr. ANNAPOORNA TADAVARTHY



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Mrs. VIDYALA PUJITHA Age : 35y 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 : Dr. Blo - Dr. Poojitha Mother's Blood Group : B+ve

Gender : ☒ M ☐ F Blood Group : AB+ Birth Weight (gms) : 2.747kg Length (cms) :

Date of Birth : 9/7/26 Time of Birth : 12:38pm OFC (cms) :

Place of Birth : RCH, B+H Estimated Gesth Age : 37 wks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 35y Ht : Wt : BMI : Married Life : LMP : 15/10/25 EDD : 30/7/26

Conception : Spontaneous or with Rx :

Booked at what GA : AN Steroids Drugs / Doses :

Last Scans Details : 36⁺ WK - EFW - 2.6 kg, AL - 22%, AFI - 15.7,

Placenta - posterior upper segment, 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 /

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?

gestational hypothyroid

Any other Chronic Medical Problems, when detected
drugs ?

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

Infection : H/O, Fever Bleeding PV

(☐ 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

2 P: 1 A: 1 L: 1

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1.	2019	-RT/NVD	-		Ren 13.2kg	Ag 1/1
2.	2020	-PP.				

PERINATAL HISTORY

Treating Obstetrician : Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication : SVD

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitation : ☐ 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	10/10	
2	10/10	
3	10/10	
4	10/10	
5	10/10	
6	10/10	
7	10/10	
8	10/10	
9	10/10	
10	10/10	

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					

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

G2 P1 L1 / 37 wks / E preterm NVD



preheated warmer.
↓
equipment check done.
↓

Male baby delivered
via SVD
↓

CIRB
↓

delayed cord clamp
↓ @ 60 sec.

Routine care given
↓

Inj Vitamin K 0.5ml given
↓

Shifted to mother
side

Investigation details in previous Hospital :

Feeding History :



Presenting complaint
mild fever, irritability

Family History :

Non-consanguineous marriage
No consanguinity
No family history of genetic disorders
No family history of chronic diseases

Socio Economic History :

Family income is adequate
Family is well educated
Family is well settled
Family is well settled in the community

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5° HR : 160/min RR : NIBP : CFT :

Color of the extremities : Acrocyanosis $\rightarrow$ pink

Jaundice : Pallor : SpO2 : 93%

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.) :	(N)
FACIES : (Any Facial Dysmorphism)		
NECK and CLAVICLES :	Range of Motion : Asymmetry : Masses :	(N)
EYES :	Symmetry : Red Reflex : Discharge :	to be checked.
EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Periauricular Pits / Tags : Nasal shape / Patency : Palate : Gums : Lips : Tongue :	(N)
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number :	(N)
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : Discharge :	(N)
GENITALIA :	Labia / Hymen : Testicles/penis : Anus :	(N) male genitalia Bil - descended testes
HERNIAL ORIFICES	(N)	
TRUNK and SPINE :	(N)	
SKIN LESIONS :	(N)	
EXTREMITIES :	Fingers / Toes : Deformities : Hip Joint Examination :	(N) Arms / Legs : Mobility :

SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 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 : room air

SpO₂: 93% Auscultation: Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 160/min BP : Precordial Activity :

Femoral Pulses : Murmurs : NAD.

Other Peripheral Pulses : Signs of Cardiac Failure :

ABDOMEN:

Shape : Hernia orifice :

Palpation : Anal Patency : (+)

Palpable masses : Umbilical Cord : 2A, 1V (+)

Abdominal girth : First urine passed : passed

Meconium passed : not passed

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : CTRLA - good

State of wakefulness :

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone : ✓

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR :

ATNR : Skull and Spine :



Diagnosis :

37wks / Bleeding PV . | SVD | mch |
2° Hg | C/A

FOOT PRINTS

Left Side :

Right Side :

Resident Doctor :

Signature :

Name :

Date & Time :

Panani
Panani
9/7/26

Consultant :

Signature :

Name :

Date & Time :

L
Anup. P.
10/7/26 10 AM

PLEASE FILL UP THE FOLLOWING DETAILS

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



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

Feeding Plan at the time of shifting :

10:25 to 1:35 pm

Wrote by
Pavani

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:

2AH-00661112
Baby OF VIDIYALA PUJITHA
19-07-2026
Dr. ANNAPOORNA TADAVARTHY (M)
IP5-00176154
0 Y 0 M 0 D 0 H

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/07/26 11:00pm	CLS/B Resident	
	4HOL/37W/ SVD/Mch/ 2747kg/	CIAB/Gest hypothyroidism
	Baby on room air	Plan
	AP/B ⁺ U/not passed	① DBF 2nd hly Flb
	B/Trace M/not passed	burping
	Feed initiated	② warm care
	Euglycemic	③ monitor vitals
	Euthermic - Pink	④ vaccination OPV, BCG, Hep
	Cry } good	⑤ SBR } @ 48HOL.
	Tone } good	MBS
	Reactivity } good	OAE
	Femorals (+)	
	Peripheral Pulses ⊕	
		noted by S. Sathya
		at 11:30pm @ 11:30pm
		Solich

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 9:30pm	C/S/B Resident	
	21HOL 3TW MCH SVD 2747g UAB gest hypothyroid	
	Baby on room air	
		Plan
	M/BT B/ABT	① DBF 2nd hly flb bup
	U/V (6) M/V (4)	② warm case
		③ monitor vitals
	Feeds taking well Euthemic - Pink Suglyemic	④ SBR } NBS } 7/m OAE } 12:40pm
	Twt → 2608g (5% ↓)	⑤ clinical Jaundice assessment
		Soheli
	1/S/B or amep.	
10/7/26	T/M/AAA SVD.	7) SBR } NBS } 11/7/26 OAE } safe d/c.
		. 2nd hly feeds
		4
		AT.

81112 IP5-00176154

VIDIYALA PUJITHA

18 0 Y 0 M 0 D 18 H (M)

Pa POORNA TADAVARTHY



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/11 10:00pm	<u>Lactation notes:</u> - Well formed breasts and nipples - colostrum seen - Suck good.	
	<u>Advice:</u> - Direct breast feeding. - dem for deep latch as demonstrated in cradle hold. - Make baby suck for 15-20min on each side. - Demand feeding not exceeding 2-2 1/2 hours	<u>Dr. Suresh</u>
10/11/26 4:30pm	<u>CS/B Resident</u> 28WOL/37W/mch/SVD/2747/4AB	
	Baby is on room air	<u>Plan</u> (1) DBF and fully flb bumping (2) Warm Care
	Feeding & latching good.	(4) Monitor vitals
	Euthermic - Pink	
	Euglycemic	
	Cry	(3) SBR } T1m NBS } 11a.m OAE }
	Tone } good.	
	activity }	

Noted by Sohel
Swagat / 07692



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/2020 7	1/Sp as Amf.	1) into sac 4 5
10/7/2020 2:30pm	CSIB Resident 44HOL/37W/MCH/SVD(2747) CIAB Baby on room air m/At B/AB ⁺	Plan ① DBF 2nd July flb keeping
	Taking feeds well Euthemic - Pink Euglycemic TWt → 2478g (9.7.1.1)	② warm care ③ SBR } Today NBS } 11 a.m. OAE }
	eng } tone } good activity } Peripheries warm.	④ monitor vitals solih

661112

IP5-00176154

VIDIYALA PUJITHA

2026

0 Y 0 M 2 D

(M)

ANAPPOORNA TADAVARTHY



PROGRESS NOTES AND DOCTOR'S ORDER

ate Time	Progress Notes	Doctor's Order
		11/17/26 OAE Newborn hearing screening Bilateral responses deep print Bilateral Pass Rupprecht 11/17/26
	10:00 AM 11/8/26 Dr. Annapurna	SBR, NBS no. Hv d/c L A1
	12:00 PM 11/8/26 Resident	
	48HOL 1SBR - 13.2	
	Case d/w Dr. Annapurna man.	
		① Start DSPT with eyes & genitalia covered
		② warm cue.
		③ monitor v/o during photo therapy.
		④ DBP 2nd hly (SOS) PP
		⑤ SBR T/m 10am 10am

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5:00pm	C/S/B Resident	
	D: Neonatal Jaundice	SBR-13.2mg/dl. -
	53 HOL/Mch/37W/SVD/2747	@ 48HOL
		CAB
	m At B AB+	Plan
	Yn M ✓	
	Baby on room air	① DBF / measured
	Twt 2747g	feed 2nd + FF (Sol)
	Euthermic	22 - 25m / 2nd baby
	Feeding to continue.	or
		30 - 33m / 3rd baby
	Cry Tone } good	② DSPT with
	activity } good	eyes & genitals
	Peripheries warm	concerned.
	CRT & 3sec	③ SBR T/m 12pm
		④ Monitor feeds
		% during Phototherapy
		Soluble
		Noted by Jannu
	P/S/B or Anp	P) 25e 3hry.
		4
		A7.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/1/26 9:20am	CSIB Resident Δ: Neonatal Jaundice	
	10404 mch 137w 150D 2747/11AB	
	m AT B AB+	Plan SBR - 11.7 mg/dl.
	U U m ✓	
	Twt → 2.482 kg	① DBF 2nd huly + FF 25ml 2nd huly 35ml 3rd huly
	Baby on room air Euthemic - Euplycemic	② DSPT with eyes and genitals covered.
	Cry Tone } good activity } peripheries warm CRT < 3sec.	③ SBR @ 12 pm today
		④ Monitor feeds & v/o
		Soheli.
12/1/26 P/S/B Dr Arif. P2T.		P) Trace SBR - 11.7 +U tuesday
		2 07.

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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

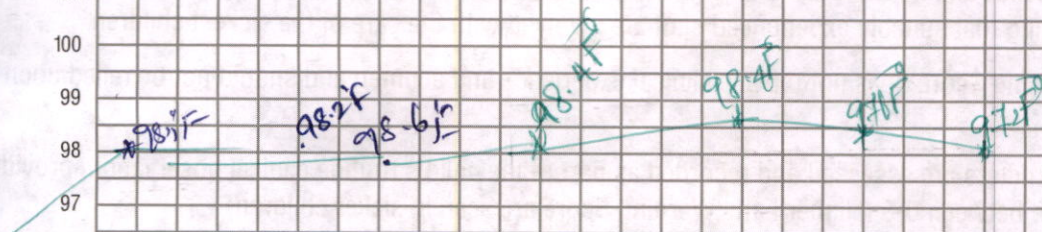
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 9/7 Time: 2pm 4pm 5pm 10pm 12pm 3pm 6pm

Doctor/Nurse/Family Concern?

Temperature
 (F)

104
103
102
101
100
99
98
97
96
95
94



Heart Rate
 (bpm)

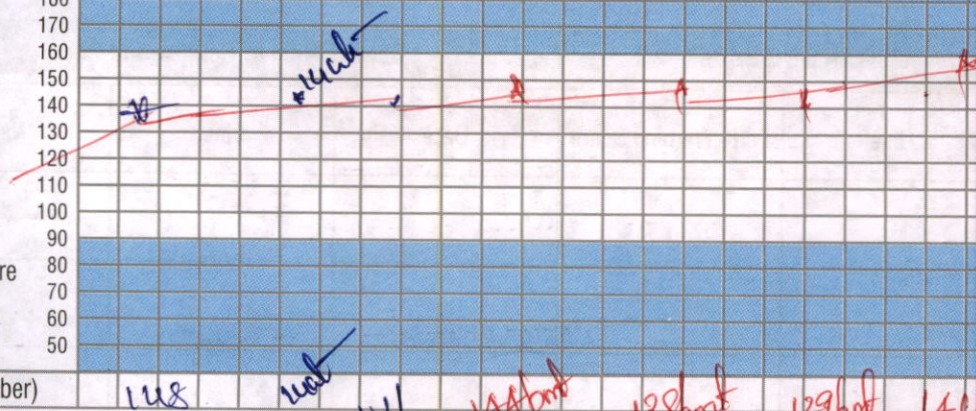
and

Blood Pressure
 (mmHg) *

Note:

BP does not score
 in early
 warning scoring

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

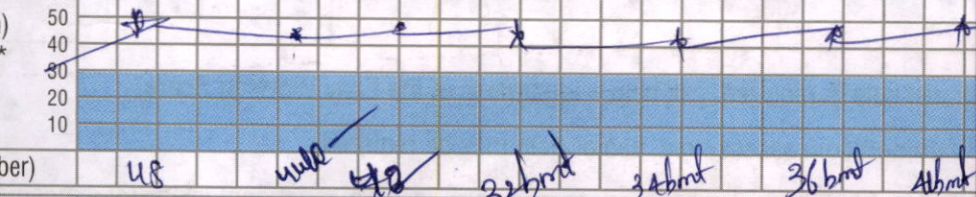


Heart Rate (Number)

148 141 141 138 129 141

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

70
60
50
40
30
20
10



Resp Rate (Number)

48 40 40 32 34 36 41

Resp Mod/ Severe
 Distress None / Mild

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

99% 98% 99% 99% 98% 99% 98%

Conscious Level
 Normal Altered

GCS *

13/15 15/15 15/15 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0 0 0 0 0
 0 0 0 0 0 0 0
 [Signature] [Signature] [Signature] [Signature] [Signature] [Signature] [Signature]

ACTIONS

NB: Scores 3 should be
 recorded overleaf

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

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

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)

00661112
IP5-00176154
OF VIDHYALA PUJITHA
0 Y 0 M 0 D 18 H (M)
2026
JINAPOORNA TADAVARTHY

10/
IM / CLINICAL / 124

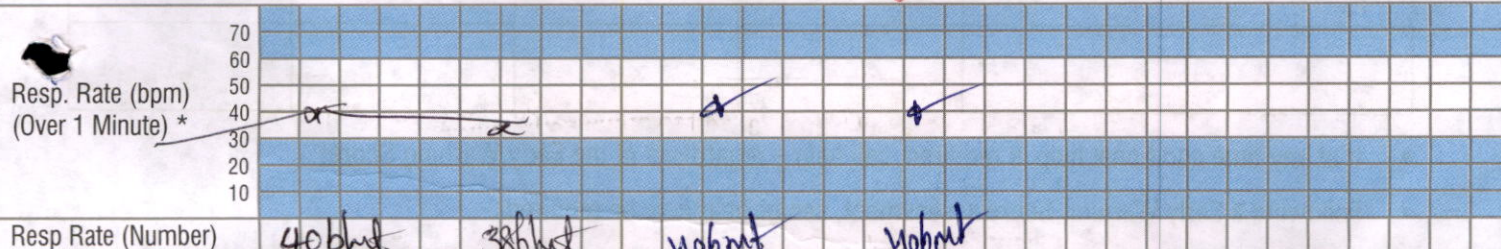
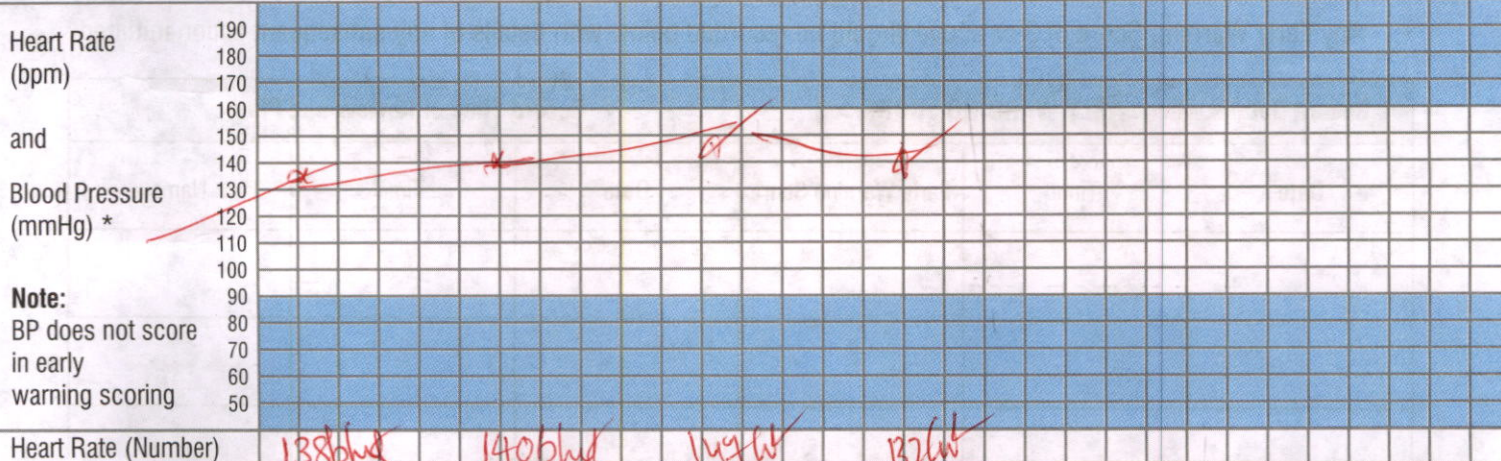
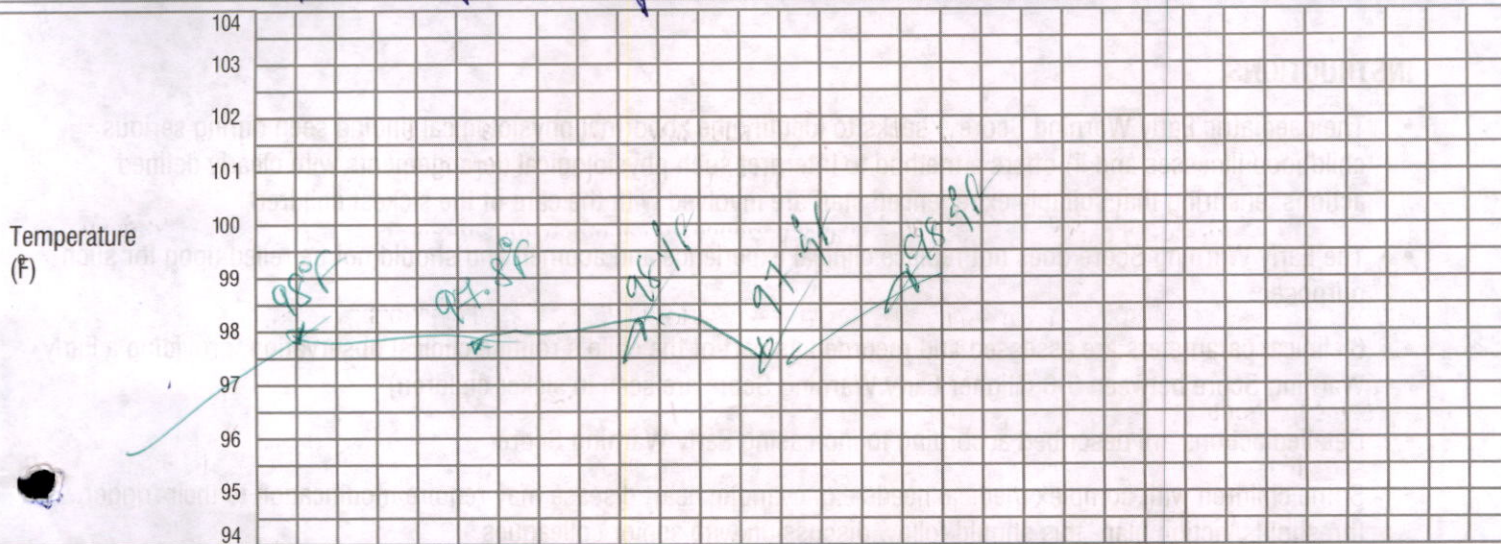
INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 9 AM 1 PM 6 PM 10 PM 6 AM
Doctor/Nurse/Family Concern? ☒ ☒ ☒ ☒ ☒



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		
Conscious Level	Normal	
	Altered	
GCS *		

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

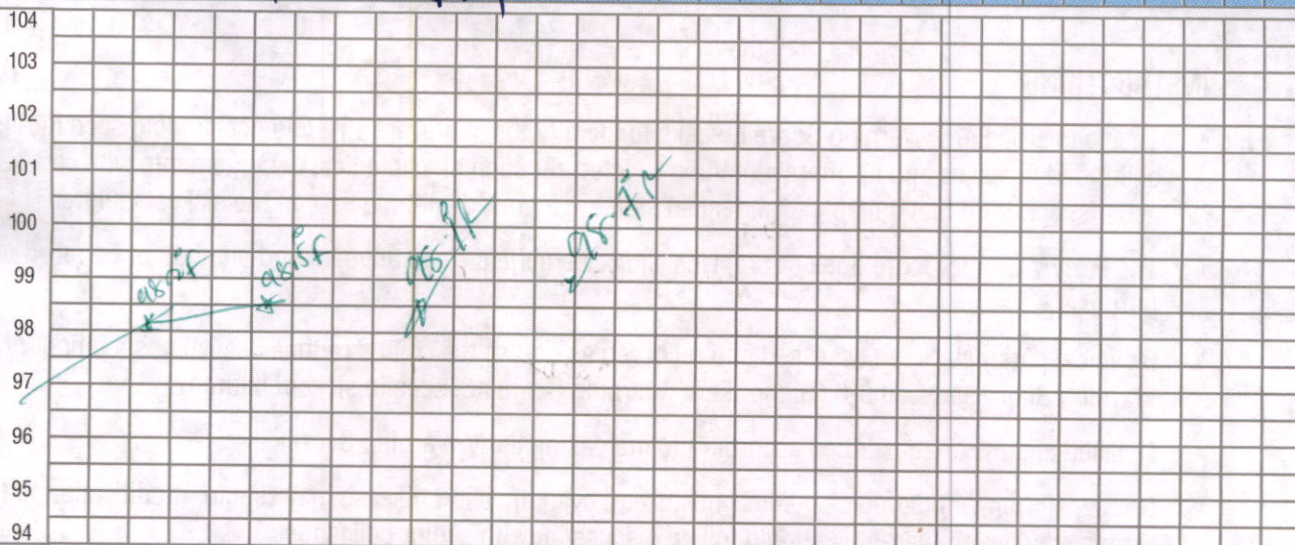
11/7/26

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 10 AM 4 PM 10 PM 6 AM
Doctor/Nurse/Family Concern?

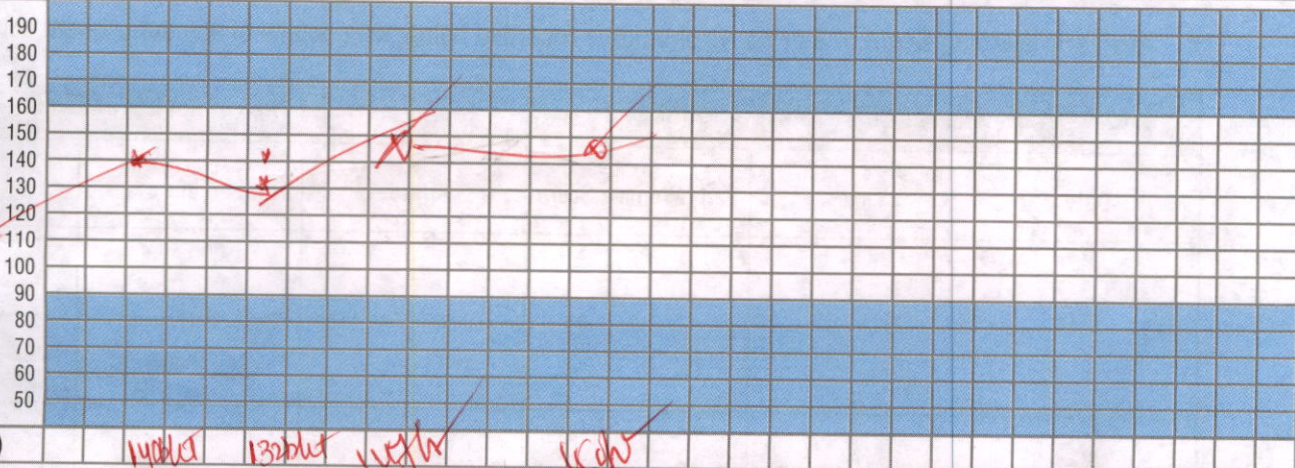
Temperature
(F)



Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

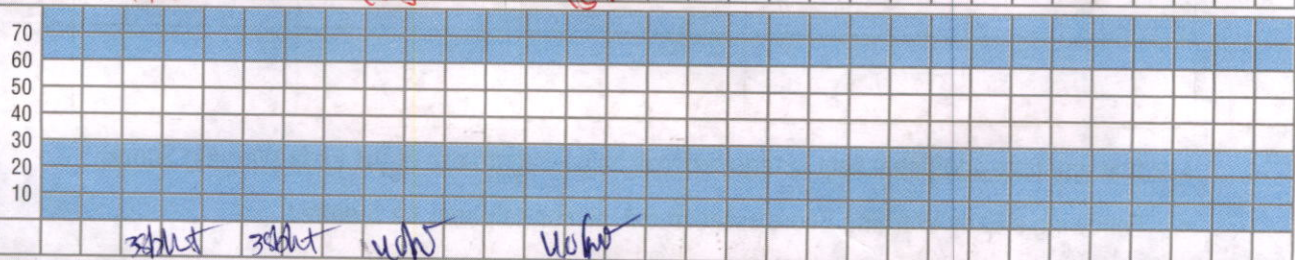


Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

140bpm 135bpm 145bpm 140bpm

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



Resp Rate (Number)

30bpm 30bpm 35bpm 35bpm

Resp Mod/ Severe
Distress None / Mild

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

100% 100% 100% 100%

Conscious Level
Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Score

Observer's Initials

0 0 0 0
R S J S

- 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

If the SpO₂ is <92 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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time: 10AM
Doctor/Nurse/Family Concern?	
Temperature (F)	104 103 102 101 100 99 98 97 96 95 94
Heart Rate (bpm)	190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
Blood Pressure (mmHg) *	
Note: BP does not score in early warning scoring	
Heart Rate (Number)	136
Resp. Rate (bpm) (Over 1 Minute) *	70 60 50 40 30 20 10
Resp Rate (Number)	26
Resp Mod/ Severe Distress None / Mild	
Receiving O ₂ (l/min) O ₂ Saturations (%)	99%
Conscious Level Normal Altered	
GCS *	14/15
TOTAL SCORE	
Number of shaded boxes	0
Pain Score	0
Observer's Initials	

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00661112 IP5-00176154
Baby Of VIDYALA PUJITHA
09-07-2026 0 Y 0 M 0 D 2 H (M)
Dr. ANNAPOORNA TADAVARTHY



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FLUID CHART

Sheet No. : 13

- All measurements in ml.
- 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		
			Mouth	I.V	N.G						
9/7/26	08:00 am										
	09:00 am										
	10:00 am										
	11:00 am										
	12:00 pm										
	01:00 pm	DBM	-								
Total Intake : taken			Total Output : Not Passed								
	02:00 pm										
	03:00 pm										
	04:00 pm	DBM									
	05:00 pm										
	06:00 pm										
	07:00 pm										
Total Intake : 400g			Total Output : Passed, M. Not								
	08:00 pm										
	09:00 pm	DBM									
	10:00 pm										
	11:00 pm	DBM									
	12:00 am										
	01:00 am	DBM									
Total Intake :			Total Output : M-2 U-3								
	02:00 am										
	03:00 am	DBM									
	04:00 am										
	05:00 am	DBM									
	06:00 am										
	07:00 am	DBM									
Total Intake :			Total Output : M-2 U-2								

Total 24 hrs. Intake

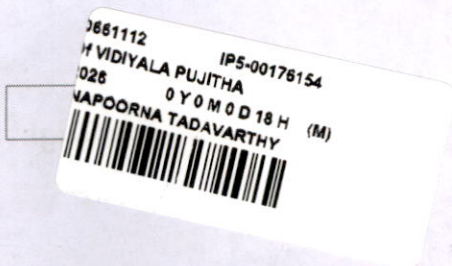
Total 24 hrs. Output M-4 U-6

FLUID CHART

Sheet No. : (2) 10/7/26

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am	DBF					✓			✓		Swaps
	10:00 am										No IV cannula	Swaps
	11:00 am											Swaps
	12:00 pm	DBF					✓			✓		Swaps
	01:00 pm											Swaps
Total Intake :						Total Output : U - 2 M - 2						
	02:00 pm											Swaps
	03:00 pm	DBF					✓			✓		Swaps
	04:00 pm										No IV cannula	Swaps
	05:00 pm	DBF										Swaps
	06:00 pm						✓			✓		Swaps
	07:00 pm	DBF										Swaps
Total Intake :						Total Output : U - 2 M - 2						
	08:00 pm	DBF										Yann
	09:00 pm	DBF					✓			✓		Yann
	10:00 pm	DBF									no	Yann
	11:00 pm										to	Yann
	12:00 am	DBF					✓			✓	can	Yann
	01:00 am											Yann
Total Intake :						Total Output : U 2 M 2						
	02:00 am											Yann
	03:00 am	DBF					✓			✓		Yann
	04:00 am										no	Yann
	05:00 am	DBF									IV	Yann
	06:00 am						✓			✓	can	Yann
	07:00 am	DBF										Yann
Total Intake :						Total Output : U 3 M 2						
Total 24 hrs. Intake			DBF			Total 24 hrs. Output			U 8 M 8			



FLUID CHART

Sheet No. :

11/7/26.

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.

		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								✓	↓	No	Tulli
	09:00 am	DBF				✓				IV	canula	Tulli
	10:00 am											Tulli
	11:00 am	DBF							✓	↑		Tulli
	12:00 pm					✓						Tulli
	01:00 pm	DBF										Tulli
Total Intake :					Total Output : U - 2 M - 2							
	02:00 pm									↓		Tulli
	03:00 pm	DBF							✓	NO		Tulli
	04:00 pm					✓				IV		Tulli
	05:00 pm	DBF							✓	canula		Tulli
	06:00 pm									↑		Tulli
	07:00 pm	DBF										Tulli
Total Intake :					Total Output : U - 2 M - 1							
	08:00 pm	DBF								↓		Rimo
	09:00 pm								✓			Rimo
	10:00 pm	DBF								NO		Rimo
	11:00 pm									IV		Rimo
	12:00 am	IF				✓			✓	canula		Rimo
	01:00 am									↑		Rimo
Total Intake :					Total Output : U - 2 M - 2							
	02:00 am									↓		Rimo
	03:00 am	DBF							✓			Rimo
	04:00 am									NO		Rimo
	05:00 am	DBF				✓				IV		Rimo
	06:00 am	IF							✓	canula		Rimo
	07:00 am									↑		Rimo
Total Intake :					Total Output : U - 2 M - 2							
Total 24 hrs. Intake		DBF 11/7/26			Total 24 hrs. Output		U - 8 M - 7					



FLUID CHART

Sheet No. :

12/7/26

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	N.G							
	08:00 am										1	same
	09:00 am	DBF								✓	NO	same
	10:00 am						✓				IV	same
	11:00 am	DBF									canal	same
	12:00 pm										1	same
	01:00 pm										1	so
Total Intake :					Total Output : U- M-							
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/6/26

Assessment: New born baby

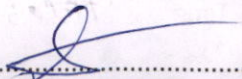
Goals

- | | | | | | |
|---|---|--|---|---|--|
| ☒ 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
2pm	Assess the patient general condition and record vitals	2:30 pm	Assessed the patient general condition and recording vitals.	
3pm	Maintaining I/O chart	3:30 pm	Maintaining I/O charting	
4pm	provide DB on feed	4:30 pm	DB on feeding given	TO know
5pm	provide comfortable position	5:30 m	to 3rd hourly	Baby comfortable
6pm	provide education	7pm	provided education about New born care	

Re-Assessment: Re - Assessment after 6 hours

Special Notes: Nil

Nurse Signature: 

Nurse Name: Sneha

Date & Time: 9/7/26, 8

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: New born baby care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the baby condition and vitals check	8:30 pm	* Assessed the baby condition and vitals checked	* new baby condition is stable
10pm	* monitor the I/O chart	10:30 pm	* monitored the I/O chart	
12Am	* provide warm care	12:30 am	* provided warm care	
6Am	* every 2nd hourly 2-3 grms	6:30 am	* every 2nd hourly 2-3 grms	
7Am	* Ensure safety.	7:30 am	* Ensured safety	

Re-Assessment: Assess the condition of the baby now it is stable

Special Notes: nil

Nurse Signature: Sneh

Nurse Name: Sneh - 607635

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

BAH-00661112 IP5-00176154
Baby Of VIDYALA PUJITHA
09-07-2026 0 Y 0 M 3 D (M)
Dr. ANNAPOORNA TADAVARTHY



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: 18/7/26

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
8pm	Assess the general condition of the Baby.	8:30pm	Assessed the general condition of the Baby.	
10pm	Monitor the vital.	10:30pm	vital checked and recorded.	Now is
11pm	Plan for DBF.	11:30pm	Every 2nd-3rd only feeding given	Baby feeding
2Am	Plan for warm care.	2:30Am	Provided the warm care.	Good.
7Am	Ensure the safety.	7:30Am	Provided the cribe care.	

Re-Assessment: Re-Assessment Done wth only vitals.

Special Notes: SBR T/m 12pm

Nurse Signature:

Nurse Name: Rima

Date & Time: 18/7/26 @ 8Am



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 11/7/26

Assessment: Baby is under DSPT

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	* Assess the Baby condition	9AM	* Assessed the Baby condition	Baby is well
10AM	* monitor vitals	11AM	* monitored vitals.	
12PM	* maintain personal hygiene	1PM	* maintained personal hygiene	
2PM	* ensure safety	3PM	* provided crib care	
4PM	* Plan for DBF + burping	5PM	* given DBF + burping 2nd bdy.	
6PM	* Plan for warm care	7PM	* provided warm care.	

Re-Assessment: Re-assessment done every 6th hly.

Special Notes: BBR TIM

Nurse Signature: [Signature]

Nurse Name: Juvra (605525)

Date & Time: 11/7/26 @ 8PM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/4/26

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
8pm	Assess the Baby's General condition	8:30pm	Assessed the Baby's General condition	New Baby is stable
10pm	Plan for DBF & Burping every 3rd hourly	10:15pm	Plan for DBF & Burping every 3rd hourly	
12am	Plan for Diaper change	12:30am	Planned for Diaper change	
3am	Plan for vital signs	3:30am	Maintained vital signs	
7am	Ensure safety	7:30am	Ensured safety	

Re-Assessment: Re-assessment done every 3rd hourly

Special Notes: SBR, MBS, DAT @ 11am, 11/7/26

Nurse Signature: [Signature]

Nurse Name: Yasmine @ 606208

Date & Time: 11/7/26 @ 6am

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 10/7/20

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
8am	Assess the general condition of the baby	10am	Assessed the general condition of the baby	Baby is stable
11am	plan for vitals	11:20am	checked vitals	
12pm	plan for Ilo chart	12:10pm	Maintain Ilo chart	
2pm	Continue feeding every 2nd hly flb burping	2:15pm	continued feeding every 2nd hly flb burping	
4pm	plan for warm care	4:20pm	provide warm care	
5pm	Maintain personal hygiene	5:15pm	Maintained personal hygiene	
7pm	Ensure safety	7:30pm	provide crib care	

Re-Assessment:

vitals checked & recorded

Special Notes:

GR, MBS are TLM @ 11am TCBR @ 12:40pm 6.8mg/dl

Nurse Signature:

Swaps

Nurse Name:

Swaps 1010692

Date & Time:

10/7/20 @ 8pm

BAH-00661112 IP5-00176154
 Baby Of VIDYALA PUJITHA
 09-07-2026 0 Y 0 M 3 D (M)
 Dr. ANNAPOORNA TADAVARTHY



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:

Patient Sticker

NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

- Goals
- ☐ Maintain Airway and Oxygenation

☐ Maintain Personal Hygiene

☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort

☐ Prevent Infection

☐ Any Others. Specify.....
- ☐ Maintain Fluid Balance

☐ Meet Elimination Needs
- ☐ Improve Activity Tolerance

☐ Ensure Safety
- ☐ Maintain Good Nutritional Status

☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity

☐ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature: Nurse Name: Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Annapoorna Tadavartthy Department: Neonatology Date of Admission: 9/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:					
	New born baby							
BACKGROUND	Area	Shift Time	0830-1200	1200-0200	0200-0800	0800-1200	1200-0200	0200-0800
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	NA	NA
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:	98.1°F	98.4°F	98.8°F	98.1°F	98.8°F	97.5°F
	Res:	38b/m	38b/m	40b/m	42b/m	40b/m	38b/m	
	SpO ₂ :	99%	97%	99%	100%	100%	100%	
	Pulse:	146b/m	148b/m	140b/m	147b/m	140b/m	145b/m	
	BP:	—	—	—	—	—	—	
Fall Risk Score:	15	15	15	15	15	15		
Pain Score:	0	0	0	0	0	0		
Recommendations	Safety Needs:		Crib case	Crib case	Crib case	Crib case	Crib case	Crib case
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		NA	NA	NA	NA	NA	NA
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		NA	NA	NA	NA	NA	NA
Post Operative Procedure Special Orders:			NA	NA	NA	NA	NA	NA
Handed Over By Name :			Serilath	Suehu	Swag	Yunio	Yunio	Rim
Signature :			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:			9/7/26	10/7/26	10/7/26	11/7/26	11/7/26	12/7/26
Time:			8pm	8am	8pm	8am	8pm	8am
Taken Over By Name :			Suehu	Swag	Yunio	Yunio	Rim	Swag
Signature :			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:			9/7/26	10/7/26	10/7/26	11/7/26	11/7/26	12/7/26
Time:			8pm	8am	8pm	8am	8pm	8am

BAH-00661112 IP5-00176154
Baby Of VIDYALA PUJITHA
09-07-2026 0 Y 0 M 0 D 2 H (M)
Dr. ANNAPOORNA TADAVARTHY



TRANSFERRING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Annapoorna Department: Be Date of Admission: 9/7

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:					
Recommendations	Safety Needs:							
	Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:							
	Special Diet:		☐ 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

9/7/2026 10/7/2026 11/7/2026 11/7/2026

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

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes	yes	yes
Call device within reach	no	yes	yes	yes	yes
Wheels Locked	yes	yes	yes	yes	yes
Room free of clutter	yes	yes	yes	yes	yes
Adequate lighting	yes	yes	yes	yes	yes
Wheel chair support	no	no	no	no	no
Other Intervention(s) Specify	yes	yes	yes	yes	no
Nurse's Name:	Smriti	Smriti	Smriti	Smriti	Smriti
Signature:	Smriti	Smriti	Smriti	Smriti	Smriti
Date:	9/7	10/7	10/7	11/7	11/7
Time:	8pm	8pm	8pm	8pm	8pm



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4				
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1				
Response to Surgery / Sedation Anesthesia	Within 24 hours	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				
TOTAL			16				

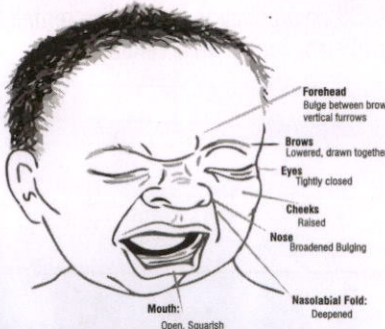
Intervention :

-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 :		Rim			
Signature :		Rim			
Date :		12/7			
Time :		8 AM			

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
						9/7	10/7	10/7	11/7	11/7	12/7		
						2pm	8pm	8pm	6pm	8pm	8am		
						0	0	0	0	0	0		
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0	0	0	0	0	0		
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0	0	0	0		
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0	0	0	0		
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0	0	0		
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	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	38wks	38wks	38wks	38wks	38wks	38wks	
	Total Pain / Agitation Score	0	0	0	0	0	0						
	Intervention	NA	NA	NA	NA	NA	NA						
	Effectiveness	NA	NA	NA	NA	NA	NA						
	Signature	S. Suresh	Suresh	Suresh	Suresh	Suresh	Suresh						

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.

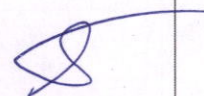
Patient Sticker

MULTI-DISCIPLINARY PLAN OF CARE FORM

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

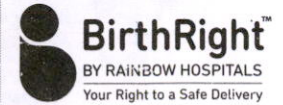
BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Diagnosis: 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:
9/2/16	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	new born baby	decreased Infection	=> monitor vitals => newborn care => D/Bon feed		☐ 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:

Patient Sticker

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD



Part - I.

Patient's / Learner Language: 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		
9/7	2pm	7.9	Infection control	107	1	0	1	1	-	

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									

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00661112 IP5-00176154 Baby Of VIDIYALA PUJITHA 09-07-2026 0 Y 0 M 0 D 2 H (M) Dr. ANNAPOORNA TADAVARTHY 		Date & Time of Admission 9/7/26 @ 2.14 PM	Date & Time of Transfer Order 9/7/26 @ 9:10 PM
		Transfer Ordered by Dr. Pavan	Reason for Transfer Observation
From Unit OBG	To Unit Srd floor	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 20	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Srs. Sri Latha		Name of Person Ordered Transfer Dr. Pavan	
Patient & Clinical Records Received by : After 9:15 PM			
Date & Time of Patient Received : Sneha			

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

BREASTFEEDING HISTORY FORM

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

Reason for consultation:

- | | | | |
|---|---|--|--------|
| 1. Baby's feeding now (ask all these points) | Breastfeeds <u>yes</u>
How often <u>2-2 hrs</u>
Length of breastfeeds <u>15-20 mins</u>
Longest time between feeds (time mother away from baby) <u>2-2 hrs</u>
One breast or both breasts <u>Both</u>
Complements (and water) }
What given }
When started } <u>NO</u>
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
Urine output (more/less than 6 times per day) <u>✓</u>
Stools (soft and yellow/brown; or hard or green; frequency) <u>✓</u>
Feeding behaviour <u>✓</u>
Illnesses | Weight now
Twin
Abnormalities <u>NO</u> | Growth |
| 3. Pregnancy, birth, early feeds | Antenatal care (attended/not) <u>✓</u>
Delivery: Normal / C - section
Rooming - in Yes / No <u>✓</u>
Prelacteal feeds Yes / No (If Yes,) <u>✓</u>
What given <u>NO</u>
Formula samples given to the mother Yes / No <u>✓</u>
Postnatal help available for breastfeeding Yes / No <u>✓</u> | Breastfeeding discussed? Yes / No
Early contact (First - 1 hour) Yes / No
Time first breast feed (if not within 1st hour)
How given | |
| 4. Mother's condition and family planning | Age
Family planning method | Breast condition <u>Good</u>
Motivation to breastfeed <u>yes</u>
Alcohol, smoking, coffee, other drugs Yes / no <u>✓</u> | |
| 5. Previous infant feeding experience | Number of previous babies
How many breastfeed
Any bottles used | Experience good or bad
Reasons | |
| 6. Family and social situation | Working / Home maker
Father's attitude towards breastfeeding
Other family members attitude towards breastfeeding
Help with child care
What others say about breastfeeding | Literacy status <u>Educated</u>
<u>Unemployed</u> <u>about DBP</u> | |

Lactation Consultant:

Signature: Name: Supriya Date & Time: 10/7 10 am

LACTATION ASSESSMENT FORM

Mother's details:

Baby details:

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

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

BF previous baby: Previous BF difficulty:

Present Lactation:

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

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

Expressed / Pallada feeding: Yes ☐ No ☐

LATCH Assessment:

	0	1	2	SCORE					
				D-1	D-2	D-3	D-4	D-5	D-6
LATCH	Too sleepy not sustained LATCH / suck	Repeated attempts for suck / latchHold nipple in mouth	Grasps breast tongue downlips flanged 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							Breast Feed	Top Feed	
Weight									

Teaching Instructions: Deep latch

Discharge Instructions: use our & weight

Feed Frequency Duration: 2-2.5 hrs

Feeding techniques: cradle hold

Assessment of output: Good

Sources of BF assistance at home: Halima H

Next Follow up: 1 weeks

Lactation Consultant: Name: Supriya Signature: [Signature] Date & Time: 10/7 10 am

[illegible]