

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174623 Admit Date : 02-Jun-2026 Admit Time : 12:03 AM UHID : BAH-00657844

Patient Details :

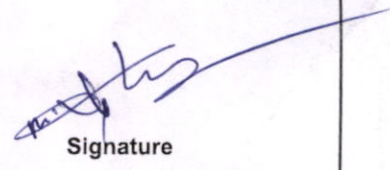
Patient Name	: Baby Of MANJU BALASREE DINTYALA	Age	: 0 D
Guardian	: Mr MATHIGETTA VAMSI KRISHNA	DOB	: 01-06-2026 11:11 PM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (U)	: H NO: 8-3-1114/101, KANAKA DHARAS RAMA KRUPA ENCLAVE, FLAT NO 101, KESHAVA NAGAR, Srinagar Colony Hyderabad Telangana INDIA 500073	Phone No	: 9494154913
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : BASINET Bed No : CRDL-SW-416-1 Ward Name : 4F-BIRTHING CENTRE
 Room No : CRDL-SW-416-1 Admission Type : First Visit

Contact Details :

Name : Mr MATHIGETTA VAMSI KRISHNA Relationship : Father
 Contact Address : H NO: 8-3-1114/101, KANAKA DHARAS RAMA KRUPA ENCLAVE, FLAT NO 101, KESHAVA NAGAR, Srinagar Colony Hyderabad Telangana INDIA 500073 Phone No : / 9494154913



Signature

Doctor Details :

Doctor Name : Dr. NITASHA BAGGA Specialisation : NEONATOLOGY
 Referral Doctor : Self Phone No :
 Co-Consultant :

Payment Details :

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



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 Manju Balasree Dintyab Mother's Blood Group : A +ve
 Gender : M F Blood Group : Birth Weight (gms) : 2969g Length (cms) :
 Date of Birth : 16/26 Time of Birth : 11:14pm OFC (cms) :
 Place of Birth : RCH-Banjara Estimated Gesth Age : 38+5 wks.

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 28y Ht : Wt : BMI : Married Life : LMP : 7/8/25 EDD : 10/6/26
 Conception : Spontaneous or with Rx : Spontaneous
 Booked at what GA : @ shree hospital AN Steroids Drugs / Doses :
 Last Scans Details : 25/26 - 37+4 wks / cephalic / AFI - 8 - 9cm / Doppler - (N)
 TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

<p>Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs Consanguinity : <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 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 :</p>	<p>H/o GDM/ pre GDM/ on diet or insulin Controlled or not, recent values, HbA1 values : Compliance with Rx : Scans : LGA, TIFFA , Fetal Echo : <u>(N)</u> H/o Hypothyroidism : when diagnosed ? Medication? Any other Chronic Medical Problems, when detected drugs ? (Anemia, SLE, Jaundice, CHD, Heart Disease) Infection : H/O, Fever (<input type="checkbox"/> Malaria <input type="checkbox"/> UTI <input type="checkbox"/> TORCH <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> HBV) UTI : when : Any culture :</p>
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PPROM: Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

P: A: L:

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
	Primigravida					

PERINATAL HISTORY

Treating Obstetrician : Hospital : Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig)</p> <p>Second stage (> 2 hours after dilation) <i>NPL</i></p> <p>LSCS : <input type="checkbox"/> Elective <input checked="" type="checkbox"/> Emergency Indication :</p> <p>Specify the reason :</p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input type="checkbox"/> Normal <input checked="" type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL :</p> <p>Resuscitaion : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Cord ABG :</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :</p>
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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
<i>8</i>	<i>10</i>	<i>10</i>

TOTAL

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

Snapee II Score

Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



History of Present Illness:

equipment check done



Baby delivered via Em-LSCS



Baby C/A/B



Dried & secretions cleared



Cord clamped & cut - 20A, 10V ⊕



Oral vit K 1mg IM given.



Uneventful transition



Baby shifted to mother's side.

Dec @
60 sec

Investigation details in previous Hospital :

Feeding History :

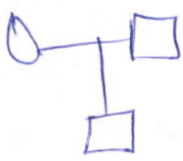
BAH-00657844 IP5-00174623
Baby Of MANJU BALASREE
01-06-2026 0 Y 0 M 0 D 2 H (M)
Dr. NITASHA BAGGA

Past H



Handwritten notes in the top section of the form.

Family History :



Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Active

VITALS : Temperature : 36.5 HR : 158 RR : 52 NIBP : CFT : 3 sec

Color of the extremities : acrocyanosis → pink

Jaundice : Pallor : SpO2 : 98%

ANTHROPOMETRY: Birth Weight : 2969g Length : HC : Present Weight :

Ponderal Index : AGA : ✓ SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :	Fontanelles : Sutures Shape / Moulding : <i>Caput (+)</i> Edema / Bruising : Size - (H.C.) :
FACIES : (Any Facial Dysmorphism)	<i>(N)</i> <i>periorbital edema (+)</i>
NECK and CLAVICLES :	Range of Motion : Asymmetry : <i>3 (N)</i> Masses :
EYES :	Symmetry : Red Reflex : <i>To be checked</i> Discharge :
EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Periauricular Pits / Tags : Nasal shape / Patency : Palate : Gums : Lips : Tongue : <i>(N)</i> <i>No cleft</i>
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number : <i>(N)</i>
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : <i>20A, 10V (+)</i> Discharge :
GENITALIA :	Labia / Hymen : Testicles/penis : <i>B/L testicles descended, penis (N)</i> Anus :
HERNIAL ORIFICES	<i>free</i>
TRUNK and SPINE :	<i>(N)</i>
SKIN LESIONS :	<i>No</i>
EXTREMITIES :	Fingers / Toes : Deformities : <i>(N)</i> Hip Joint Examination : Arms / Legs : Mobility :



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : Regular Periodic Shallow Gasping

Mention If baby has Respiratory distress: RR: 52 SCR / ICR / See - Saw breathing :

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

Mention if baby is on : Hood box CPAP Ventilator

Settings :

SpO₂: 98% Auscultation: BAE ⊕ Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 154 BP : Precordial Activity : ⊕

Femoral Pulses : Bl. equally felt Murmurs : No.

Other Peripheral Pulses : palpable Signs of Cardiac Failure : NO

ABDOMEN:

Shape : ⊕ Hernia orifice : felt

Palpation : left Anal Patency : patent

Palpable masses : NO Umbilical Cord : 2VA, 1UV ⊕

Abdominal girth : First urine passed : ✓

Meconium passed : x

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score : CT/A - good.

Nerves :

MOTOR SYSTEM:

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

ATNR : Skull and Spine :

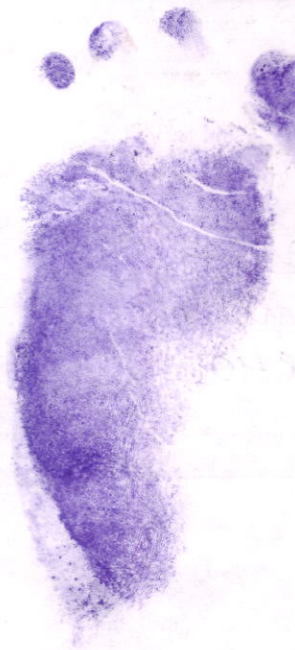


Any Congenital Anomalies : NO

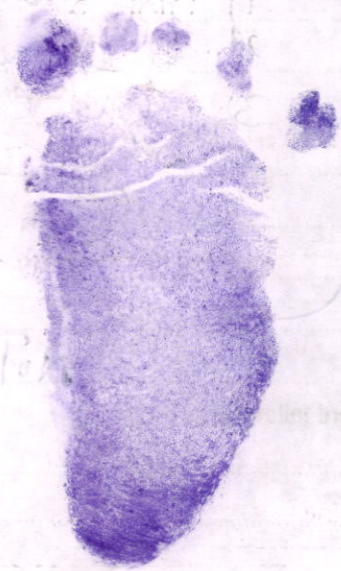
Diagnosis : DOL-1 (Term) / ARIA (male) / 2.9kg

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *[Signature]*

Name : Poojitha

Date & Time : 1/6/26 11:30pm

Consultant :

Signature : *[Signature]*

Name : Dr. NITASHA BAGGA

Date & Time : Reg. No. 66260

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 : Plan

Systemic : 1) DBF and help Alb burping
2) ~~to~~ keep baby warm

Medications : 3) Send Cord blood for BCGT

4) BCG, OPV, Hep B tomorrow.

5) SBR, NBS, OAE @ 48HOL

6) Monitor vitals

Noted by [Signature]

Plan during ward follow up :

Feeding Plan at the time of shifting :

11:30pm to 11:40pm

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:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/21	Seen by Resident	
	19/10/21 20/10/21 / 28-15 wk / 2969 gm /	Emergency / CASH NPL
M/AT B 10 ⁺ Trz.	Bt. wt - 2969 gm Today's wt - 2889 gm 80gms (2.6%)	Plan
	Unw pained - 2 times Stool - Not pained	DBF 2nd hourly to cont.
	Extreme	Force blood group of baby
	Abdo Rm'h	Bely OPV } Today keep B
	Pen thorax warm Ktals stable	
	Spine (N)	SBR NBS } 18/10/21 OAE
	No facial dysmoph Af - open	Clinical Assessment of Jandice @ 11pm today
	Noted by Swella	

Noted by
 Dr. NITASHA BAGGA
 Reg. No: 66260



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6 10 AM	<p><u>Lactation case plan:</u></p> <ul style="list-style-type: none"> - Peemi - well formed breast and nipples - colostrum seen - suck good. 	
	<p><u>Advice:</u></p> <ul style="list-style-type: none"> - Direct breast feeding. - Aim for deep latch as demonstrated. - make baby suck for 15-20 min on each side. - Demand feeding not exceeding 2-2 1/2 hours 	<p><i>[Signature]</i></p>
2/6 4 PM	<p><u>C/S/B Resident</u> <u>Dr. Srinivasan</u></p>	
	<p><u>V/S</u> <u>S</u></p> <p>Euthemic Vitals stable Perineum warm P/A soft.</p>	<p>DBF → 2nd hourly</p> <p>Clinical assessment of jaundice at 11pm today</p> <p>SBR NBS DAE } 48 Hrs (T/M)</p> <p><i>[Signature]</i></p> <p>Noted stable</p>

BAH-00657844
 Baby Of MANJU BALASREE
 01-06-2026 0 Y 0 M 1 D
 Dr. NITASHA BAGGA (M)



NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6 8am	Seen by Resident 33HOL 38+5wk / 2969gm / Emergen NPL Hg / CI AB	
M/A 12/07	At wt - 2969 Yest. - 2859 Today 2722 2979m (8.3% ↓)	Plan DBT → 2 nd hourly
	TCBR (24h) - 6.3	SRR NBS VAS } Today - 1st
	Vaccines taken	9pm
	U / 5 times S / 5 times	vital monitoring
	Euthermic Pink Peripheric warm Vtch stable P/A soft	
		3/6/26 OAE - New born hearing screening. Bilateral response all present - Bilateral Pass 3/6/26

Dr. NITASHA BAGGA
 Reg. No: 66260



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6	<p><u>Lactation care plan:</u></p> <ul style="list-style-type: none"> - Suck improved, more active - continue direct breast feeding with deep latch. - Do not give long gap inbetween the feeds 	<p><i>[Signature]</i></p>
3/6 3pm	<p><u>Seen by Resident</u> <u>Dr. Agushman</u></p>	
M/A 7 B/O 7	<p><i>[Signature]</i></p> <p>Euthenic link vital stable Renfunction was</p> <p><i>[Signature]</i></p>	<p><u>Plan</u></p> <ul style="list-style-type: none"> • SBK MSS OAE } Today qm • DBF → 2 hourly to cont. • vital monitoring <p><i>[Signature]</i></p> <p>Noted by <i>[Signature]</i></p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p><u>Y/B</u> F 26 am</p>	<p><u>Seen by Resident</u> <u>Dr. Anshuman</u></p>	
	<p>58 mL / 38 + 5 wk / 29.69 gm / <u>Emergency USG / CAP</u> <u>Plan</u></p>	
<p><u>M/A+</u> R/O+</p>	<p><u>SBR - 11</u></p>	<p>o CP</p>
	<p>wt - 2969 Yct wt - 2722 Today - 2626 <u>wt</u> 343 (11.5% ↓)</p>	<p><u>Plan</u></p> <ul style="list-style-type: none"> o DBF to cont. o Vitals monitoring o R/r d/c today o P/U → T/M
	<p><u>U</u> <u>5 times</u> <u>S</u> <u>2 times</u></p>	<p>→ <u>measured</u></p>
	<p>Enteric Pink Vitals stable Penphena non P/A - soft.</p>	<p><u>Feed</u> [TV - 60 ml/kg/day]</p>
		<p><u>Dr. N</u></p>
		<p>Dr. NITASHA BAGGA Reg. No: 66260</p>

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: RCHBH / FRM / CLINICAL / 124

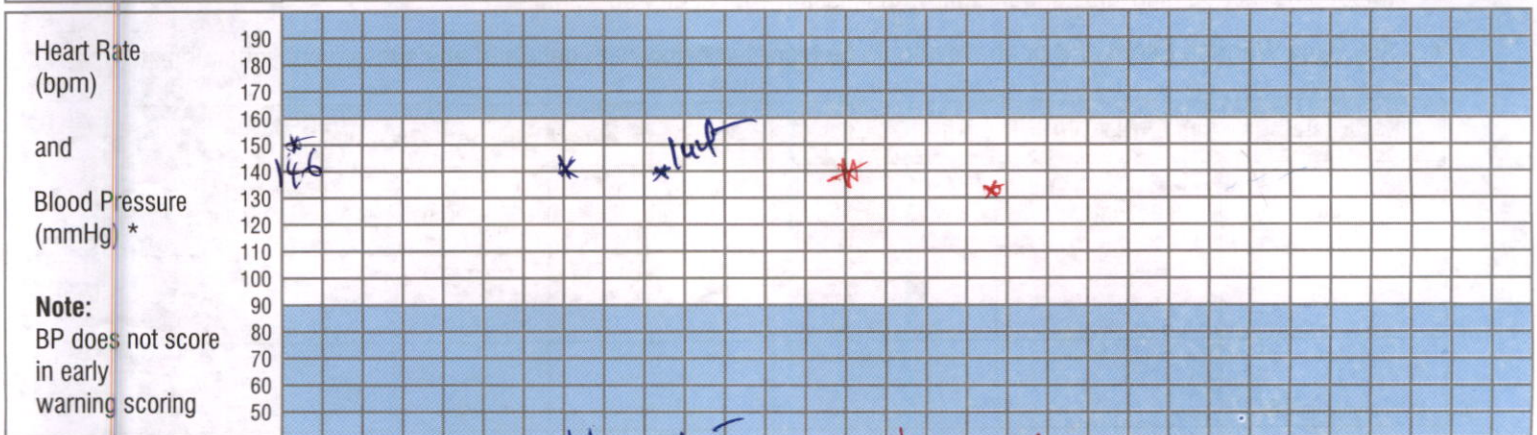
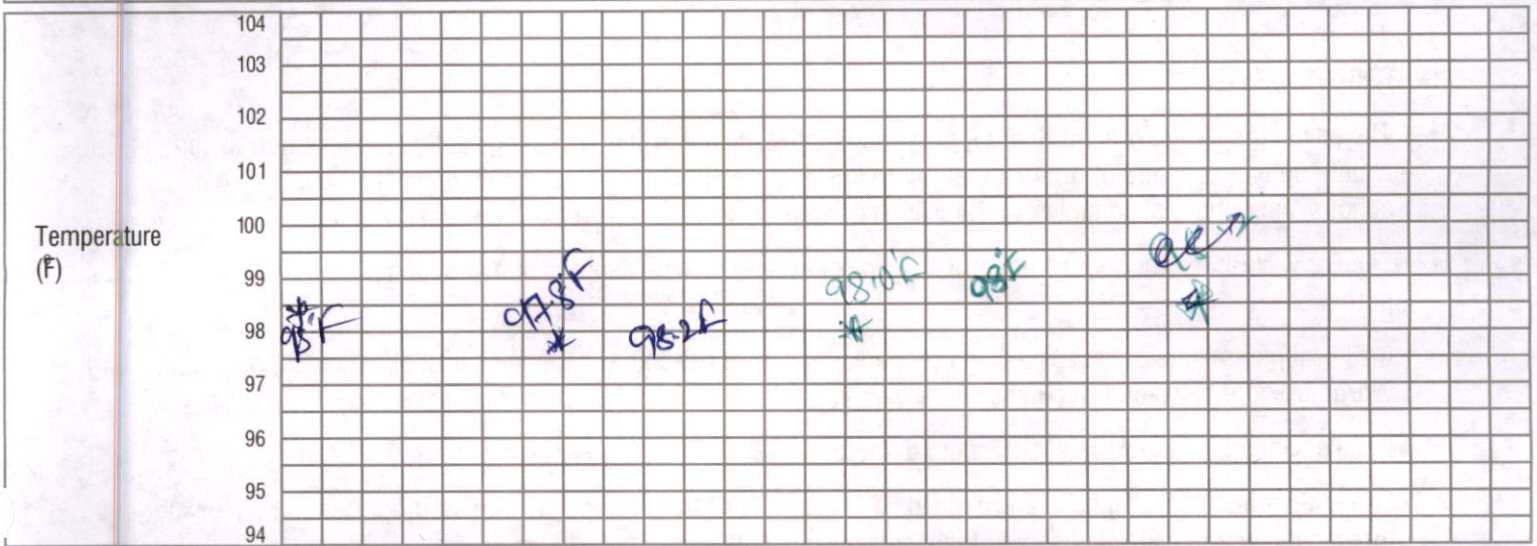
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

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

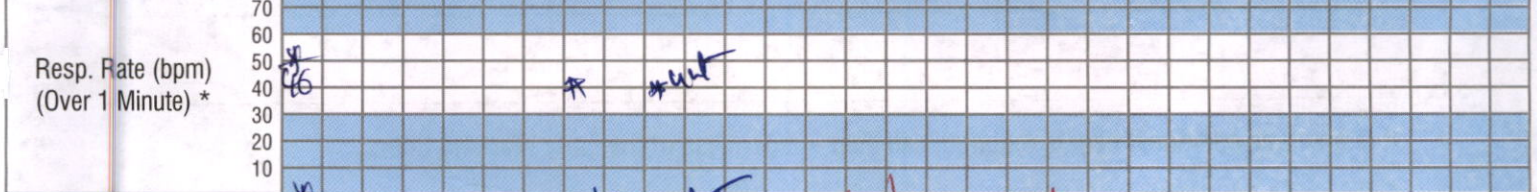
BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 1/6/26..... Time: 11:30pm 8AM 5AM ≠ 10 AM 3AM 6AM
 Doctor/Nurse/Family Concern? Am



Heart Rate (Number) 146 140b/min 140b/min 136b/min



Resp Rate (Number) 46 40b/min 40b/min 30b/min

Resp Distress	Mod/ Severe None / Mild					
Receiving O ₂ (l/min)						
O ₂ Saturations (%)		<u>98%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>	
Conscious Level	Normal / Altered			<u>N</u>	<u>N</u>	
GCS *				<u>15/15</u>	<u>15/15</u>	

TOTAL SCORE						
Number of shaded boxes	<u>-</u>			<u>0</u>	<u>0</u>	
Pain Score	<u>0</u>			<u>0</u>	<u>0</u>	
Observer's Initials	<u>PA</u>	<u>AK</u>	<u>P</u>	<u>P</u>		

ACTIONS

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

NB: Scores 3 should be recorded overleaf

* 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)

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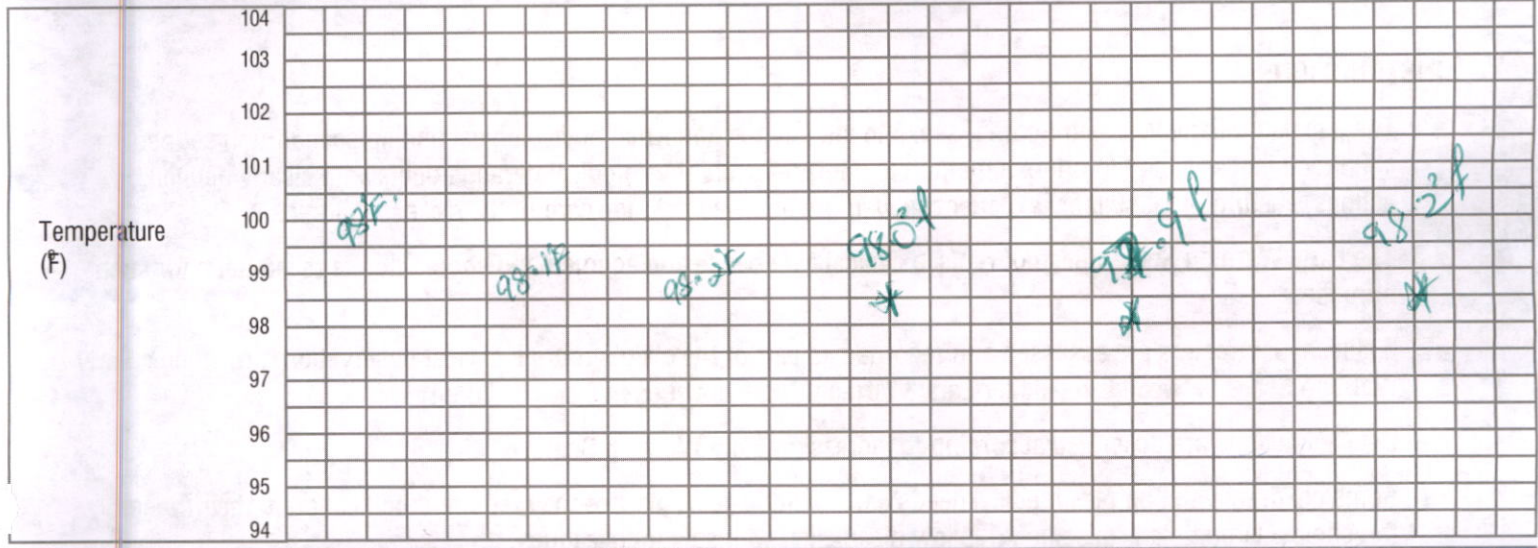
INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 2/6/26 Time: 10 am 1 pm 6 pm 10 pm 2 am 6 am
 Doctor/Nurs/Family Concern?



Heart Rate (bpm)	190					
	180					
and	170					
	160					
Blood Pressure (mmHg) *	150					
	140	x	x	x	x	x
Note: BP does not score in early warning scoring	130					
	120					
	110					
	100					
	90					
	80					
	70					
	60					
	50					

Heart Rate (Number) 136b/m 121b/m 115b/m 130b/m 142b/m 138b/m

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

Resp Rate (Number) 32b/m 30b/m 29b/m 38b/m 40b/m 42b/m

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 100% 100% 99% 98% 100% 99%

Conscious Level Normal / Altered N N N N N N

GCS * 15/15 15/15 15/15 15/15 15/15 15/15

TOTAL SCORE						
Number of shaded boxes	0	0	0	1	1	1
Pain Score	0	0	0	0	0	0
Observer's Initials	<u>NS</u>	<u>NS</u>	<u>NS</u>	<u>NS</u>	<u>NS</u>	<u>NS</u>

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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)

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

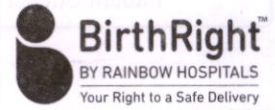
Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- 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-00657844 IP5-00174623
 Baby Of MANJU BALASREE
 01-06-2026 0 Y 0 M 0 D 2 H (M)
 Dr. NITASHA BAGGA



FLUID CHART

Sheet No. : 11

01/06/26

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

Date	Time	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												
	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	DBF											
	12:00 am												
	01:00 am	DBF											
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am	DBF											
	05:00 am												
	06:00 am	DBF											
	07:00 am												
Total Intake :						Total Output :							

1/6/26

2/6/26

Taken

Passed, No IV Site

No IV cannula, No signs of pain

Total 24 hrs. Intake *taken*

Total 24 hrs. Output *U= 21, M=0*

FLUID CHART

Sheet No. : (2) 2/6/2026.

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	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
2/6/2026			Mouth	I.V	N.G							
	08:00 am	DBF										
	09:00 am					✓			✓			
	10:00 am	DBF										
	11:00 am											
	12:00 pm	DBF										
	01:00 pm											
Total Intake : taken					Total Output : U-1 M-							
2/6/26	02:00 pm	DBF										
	03:00 pm											
	04:00 pm	DBF				✓			✓			
	05:00 pm											
	06:00 pm	DBF										
	07:00 pm											
Total Intake : taken					Total Output : m-1 a-)							
2/6/26	08:00 pm	DBF										
	09:00 pm								✓			
	10:00 pm	DBF				✓						
	11:00 pm											
	12:00 am	DBF							✓			
	01:00 am											
Total Intake : taken					Total Output : U-2 M-1							
2/6/26	02:00 am											
	03:00 am	DBF				✓						
	04:00 am											
	05:00 am	DBF				✓			✓			
	06:00 am											
	07:00 am	DBF										
Total Intake : taken					Total Output : U-1 M-2							
Total 24 hrs: Intake		taken										
Total 24 hrs: Output		U-5 M-3										

BAH-00657844 IP5-00174623
 Patient Baby Of MANJU BALASREE
 01-06-2026 0 Y 0 M 1 D (M)
 Dr. NITASHA BAGGA



FLUID CHART

Sheet No. : (3)

3/6/2026 .

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
3/6/26	08:00 am	DBF										Sushanti
	09:00 am										NO	
	10:00 am	DBF					NP			NP	IV	
	11:00 am											
	12:00 pm	DBF										
	01:00 pm											
Total Intake : Taken						Total Output : m-np u-np.						
3/6/26	02:00 pm											Sushanti
	03:00 pm	DBF										
	04:00 pm								✓		NO	
	05:00 pm						NP				IV	
	06:00 pm	DBF										
	07:00 pm											
Total Intake : Taken						Total Output : m-Np. u-01.						
3/6/26	08:00 pm											Sushanti
	09:00 pm	DBF										
	10:00 pm								✓		NO	
	11:00 pm	DBF					✓				IV	
	12:00 am	DBF										
	01:00 am											
Total Intake : Taken						Total Output : m-1 U-2						
3/6/26	02:00 am	for 11ml										Sushanti
	03:00 am	DBF										
	04:00 am										NO	
	05:00 am						✓			✓	W	
	06:00 am	DBF										
	07:00 am									✓		
Total Intake : Taken						Total Output : m-1 U-2						

Total 24 hrs. Intake : Taken

Total 24 hrs. Output : m-2 U-5

BAH-00657844 IP5-00174623
 Baby Of MANJU BALASREE
 01-06-2025 0 Y 0 M 1 D (M)
 Dr. NITASHA BAGGA



FLUID CHART



Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	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												
	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