Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176146 **Admit Date** : 09-Jul-2026 **Admit Time** : 12:42 PM **UHID** : BAH-00661093

Patient Details :

Patient Name : Baby Of SAI MANOGNA GOLLAPUDI
Guardian : Mr SRI DATTA RAGHAVA BHARADWAJ STHANAM
Gender : Female
Occupation :
Address (H) : FLAT NO 7540, JANA PRIYA APARTMENTS Erragadda Hyderabad Telangana INDIA 500018

Age : 0 Y 0 M 4 D
DOB : 05-07-2026 01:00 AM
Religion :
Martial Status : Single
Phone No : 8801668836/ 9391915793
E-mail : STHANAMBHARADWAJ@GMAIL.COM

Admission Details :

Bed Type : DELUXE ROOM **Bed No** : DLX 326 **Ward Name** : 3F-ZONE C
Room No : DLX 326 **Admission Type** : First Visit

Contact Details :

Name : Mr SRI DATTA RAGHAVA BHARADWAJ **Relationship** : Father
Contact Address : FLAT NO 7540, JANA PRIYA APARTMENTS Erragadda Hyderabad Telangana INDIA 500018 **Phone No** : 8801668836

Signature

Doctor Details :

Doctor Name : Dr. DINESH KUMAR CHIRLA **Specialisation** : GENERAL PEDIATRICS
Referral Doctor : Self **Phone No** :
Co-Consultant :

Payment Details :

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
9/7/26	88PT	2:30PM		9694730	Priya

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

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.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00661093 IP5-00176146
Baby Of SAI MANOGNA GOLLAPUDI
05-07-2026 0 Y 0 M 4 D (F)
Dr. DINESH KUMAR CHIRLA

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NEWBORN MONITORING FORM

Date of Birth : .....
Time of Birth : .....
Mode of Delivery : .....
Birth Weight : .....
Head Circumference : .....
Length : .....
Red Reflex : .....

New Born Screening : .....
TFT : .....
OAE : .....
Mother's Blood Group : .....
Baby's Blood Group : .....
Anomaly Scan : .....
Vaccination : .....

Date	Weight	Type of Feed	Quantity	Temperature	Signature
09/07/26	(ward wt) 2.828kg	DBF	–	–	Priya
10/7/26	2.958kg	DBF	–	98.0	

Date	Time	Investigation	Result	Order No.	Signature

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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00661093 IPS-00176146
Baby Of SAI MANOGNA GOLLAPUDI
05-07-2026 0 Y 0 M 4 D (F)
Dr. DINESH KUMAR CHIRLA

Patient Name: B/O Sai Manogna

UHID ID:

Department:

Consultant:

BAH-00661093 IP5-00176146
Baby Of SAI MANOGNA GOLLAPUDI
05-07-2026 0 Y 0 M 4 D (F)
Dr. DINESH KUMAR CHIRLA

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment:

Desired goals of the treatment :

Planned Labs:

SBR - TIM.

Planned Management

- SSPT @ Eyes & genitals Covered.
- Measured feeds - 30ml/2nd hrly. 45ml/3rd hrly.

EBM/ formula.

Signature of the Doctor: Ramya
Name of the Doctor: Dr. RAMYA
Date & Time: 9/7/26; 12:30pm.

Signature of the Consultant:
Name of the Consultant:
Date & Time: 9/7/26

DR. DINESH KUMAR CHIRLA
Registration No: 66221

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 1:00pm	C/S/B Resident	
	Δ: Neonatal Jaundice	(Place of Delivery - KIMS Secc) on 5/7/26).
	4DOL/NVD/CIAB/NO NICU stay/3016g/Primi/mat hypothyroidism	
	Baby on room air Yellowish discolouration of skin T.wt - 2.98kg 2% ↓	SBR - 14.3 < 0.2 / 14.1 } outside report TCBR - 16.1/17.5 (KIMS cuddles)
	M/O+ B/O+ U/✓ M/✓	Plan ① SSPT & eyes & genitals covered
	Baby on EBF latching well cry, tone, activity } good femorals ⊕ CRT < 3sec	② Measured Iced 30 ml/2nd hrly or 45 ml/3rd hrly. EBM/FF ③ monitor vitals. noted by Phy 2PM Soluble

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 5:20pm	C/S/B Resident	
	D Neonatal Jaundice	Plan
	Baby on room air	(1) SSPT c eye & genital covered
	doing well	
	Tone, cry, activity } good	(2) Measured feed 30ml 2nd hrly or 45ml 3rd hrly
	feed well	(3) Monitor vitals
		(4) SBR T/m after round
		Sohel
9/7/26 6pm	C/S/B - Dr. DK.	
		Plan
		- Repeat SBR - @ 6am T/m
		- Continue SSPT
		Pavan

Docu. No. : RCHBH /FRM / CLINICAL / 088

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 10:00pm		Plan
		- cont SSPT c̄ eyes & genitalia covered
	- parental concern about of retinal / phototherapy exposure to light ↓ Reassured	- cont measured feeds 30ml - 2nd hourly or 45ml 3rd hourly
	- Baby stable Euthermic feeding well	- SBR - 7/H after rounds
		- w/f vitals inform SOS
		Noted by [illegible] 10:39pm [illegible]

Docu. No. : RCHBH /FRM / CLINICAL / 088

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/4/26 8:20am	C/S/B Resident	
	Δ: Neonatal Jaundice	
	5 DOL | NVB | CIAB | 3016g | Mat Hypothyroid	
	Baby on room air	Plan
	M | O+ / B | O+ — V | ✓ (2) / M | ✓ (7)	① SSPT with eye and genitals covered.
	Twt → 2.958 2.9↓ (Bogt)	
	Yellowish discolouration↓	② Measured feed 30-35 ml 2nd hrly or 40-45 ml 3rd hrly
	Euglycemic Euthermic - Pink Cry Tone activity } good	③ SBR ~~after~~ 11.5 ~~rounds~~ today
	SBR → 14.3 (on admission) TCBR → ₹ 17.5 "	④ Monitor vitals
		SOAPIE
10/4/26 10:20am	C/S/B - D3 · DK	
		Plan
	SBR - 11.5	→ discharge - FU - on monday - Vit - D3 - 0.5ml OD
		Paras

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RESULT SHEET

Date	10/7/26					
Time	7AM					
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj	11.5 / 1.3					
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.,) : .....

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05-07-2025 0 Y 0 M 4 D (F)
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NURSING DEPARTMENT
NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/O. Sai manogna. Mother's Name: Mrs. Sai manogna

Date of Birth: ..... Time of Birth: ..... Gender: ☐ Male ☐ Female

Birth Weight: ..... Kgs HC: ..... cm Lenght: ..... cm

Meconium in Liquor: ☑ Yes ☐ No Cried at Birth: ☐ Yes ☐ No

Term / Pre-term / Post-term: .....

Resuscitated: ☐ Yes ☐ No Blood Group: Mother: ..... Baby: .....

Feeding: ☑ Breast Feeding ☐ Formula ☐ Both First Feed Time: .....

AFFIX MOTHER'S IDENTIFICATION LABEL

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

Indication: .....

Physical Assessment of New Born:

Temp: 98.4°F °C HR: 138 b/M /Min RR: 36 b/M /Min BP: — SpO2: 99%

Pain Score: 0/10 (Follow N Pass)

Fall Risk Assessment: ☐ **Yes** ☐ **No** **Score:** 0/10 (Fill the Humpty Dumpty Sheet)

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

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

Findings:

General Appearance: Posture : ☐ Well-Flexed ☐ Asymmetry

Skin: ☐ Pink ☑ Meconium Stain ☐ Others, Specify: .....

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

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

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / ~~No~~

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / ~~No~~
2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / ~~No~~
3. Socio History: Siblings Yes / No

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

Newborn Screening Discussed: Yes / ~~No~~

Nurse Name: Ramya Signature: Ramya Date &Time: 9/7 @ 1:30PM

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Pa
Pati ..... Telugu Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: ☑ Yes ☐ No Healthcare Literacy: ☑ Yes ☐ No

Identi... Education Needs:

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social & Rehabilitation Needs
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		
9/7/26	12:30pm	✓	Infection Control measures	f	1	0	1	1	NA	Abhishe

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
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: NEONATAL JAUNDICE

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
9/7/26	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	PHOTO THERAPY		MONITER VITAL		☐ Nursing ☐ Others:
9/7/26 1 pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	pho thumphy		Monishor vitals	Ablis	☐ 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:

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: Ward.

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ramya

Date & Time : 9/7/26 ; 12:40pm

Nurse Name & Signature: Abhishek

Date & Time : 9/7/26 @ 12:40pm

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DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name .... Signature

Patient Sticker

REGULAR PRESCRIPTIONS

Weight. 2.98kg. Ward. ....

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

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

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

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

Patient Sticker

Weight. ..... Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses

Signature .....

VERIFIED BY : Name .....

Patient Sticker

I.V. FLUIDS CHART

Weight. 2.98kg. Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
9'									

Signature .....

VERIFIED BY : Name .....

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05-07-2026 0 Y 0 M 4 D (F)
Dr. DINESH KUMAR CHIRLA

9/7

. No. : RCH / FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: ..... Time:	1:30 PM	6 PM	10 PM	2AM	8AM
Doctor/Nurse/Family Concern?					
Temperature (F)	97.9F	98.0F	98.0F	97.9F	98.1F
Heart Rate (bpm) and Blood Pressure (mmHg) *					
Heart Rate (Number)	132b/M	140b/m	138b/m	142b/m	138b/m
Resp. Rate (bpm) (Over 1 Minute) *					
Resp Rate (Number)	35b/M	38b/m	42b/m	42b/m	34b/m
Resp Distress: Mod/ Severe / None / Mild	N	N		N	N
Receiving O_2 (l/min) O_2 Saturations (%)	99%	100%	99%	99%	100%
Conscious Level: Normal / Altered	N	N			
GCS *	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	1	1	1
Pain Score	0	0	0	0	0
Observer's Initials					

Note: BP does not score in early warning scoring

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.

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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-00661093 IP5-00176146
Baby Of SAI MANOGNA GOLLAPUDI (F)
05-07-2026 0 Y 0 M 4 D
Dr. DINESH KUMAR CHIRLA

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FLUID CHART

Sheet No. : 09/01/26

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.

Date	Time	Intake: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	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		DBF									
	03:00 pm						✓			✓	NO	Piya
	04:00 pm		DBF								IV	Piya
	05:00 pm									✓		Piya
	06:00 pm		DBF				✓				Canula	Piya
	07:00 pm									✓		Piya
Total Intake :		Taken				Total Output :	V=3			M=2		
	08:00 pm		DBF									
	09:00 pm		DBF				✓			✓	NO	Shirly
	10:00 pm		DBF									
	11:00 pm						✓			✓	IV	Shirly
	12:00 am		DBF				✓					Shirly
	01:00 am											
Total Intake :		Taken				Total Output :	V- 2			M- 3		
	02:00 am		DBF									Shirly
	03:00 am						✓			✓	NO	
	04:00 am		DBF									Shirly
	05:00 am						✓				IV	Shirly
	06:00 am		DBF							✓		Shirly
	07:00 am											
Total Intake :		Taken				Total Output :	V- 2			M- 2		

Total 24 hrs. Intake	Taken	Total 24 hrs. Output	V- 7 M- 7

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FLUID CHART

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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.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.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											
	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**	

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NURSING CARE RECORD

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Shift: ☐ Morning ☑ Afternoon ☐ Night

Date: 09/07/26 @ 2pm

Assessment: Baby under phototherapy.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the general condition of the baby and checking vitals.	2:10pm	→ Assessed the general condition of the baby and checked vitals.	Baby is stable
3pm	→ plan for checking ward weight not.	3:10pm	→ checked ward weight now.	
4pm	→ Continue EBPT as advised	4:10pm	→ Continued phototherapy as advised.	
5pm	→ Giving measured feeds 30ml and hourly.	5:10pm	→ Given measured feeds 30ml 2nd hourly and burped.	
6pm	→ checking urine output.	6:10pm	→ checked urine output.	
7pm	→ Ensure safety.	7:10pm	→ Ensured safety.	

Re-Assessment:

Special Notes: SBR thm

Nurse Signature: Priya Nurse Name: Priya Date & Time: 09/07/26 @ 8pm

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NURSING CARE RECORD

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BirthRight BY RAINBOW HOSPITALS
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Shift: ☐ Morning ☐ Afternoon ☑ Night

Date: 9/7/26

Assessment: NNJ

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assessed the Baby general condition & vitals	8pm	→ Assessed the Baby general condition	ensure Safety
10pm	→ 2nd hrly feeding & Burping	20 10Am	→ 2nd hrly feeding & Burping	
1Am	→ Provide warm call	20 1Am	→ provided warm call	
3Am	→ continue SSPT covered with eyes & genital area.	20 3Am	→ continued SSPT covered with eyes & genital area	
5Am		10 5Am		
7Am	→ SBR Tomorrow 6Am to 7Am	20 7Am	→ SBR Tomorrow at 6Am	

Re-Assessment: ...

Special Notes: SBR Hm 6Am

Nurse Signature: Shilpa Nurse Name: Shilpa Date & Time: 10/7/26 @8Am

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Dinesh Kumar Department: ER Date of Admission: 9/7/26

SITUATION

Diagnosis: Neonatal Jaundice

Any Infection: ☐ Yes ☐ No ☑ Not Known
If Yes Specify: ....

BACKGROUND	Area / Shift Time	ER 1:20pm	3rd floor 1:30pm - 8PM	3rd floor 2pm-8pm	3rd floor 8pm to 8AM		
	Medical Condition (Any special condition to be noted):	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°F	98.0°F	98.2F	98.0F		
	Res:	38b/m	32b/m	36b/m	40		
	SpO_2:	98%	99%	100%	99		
	Pulse:	135b/m	136b/m	142b/m	138		
	BP:		—	-	—		
	Fall Risk Score:	12	12	12	12		
	Pain Score:	0/10	0	0/0	0/10		
Recommendations	Safety Needs:	4Y	crib care	Crib care	Crib care		
	Physiotherapy	~~☐ Yes ☐ No~~	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	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		
Post Operative Procedure Special Orders:		NA	NA	NA	NA		
Handed Over By Name :		Abhishek	Ramya	Priya	Shilpa		
Signature :		Abh	Ramya	Priya	Shilpa		
Date:		9/7/26	9/7	9/7/26	10/7/26		
Time:		1:30pm	@2PM	8PM	@8AM		
Taken Over By Name :		Ramya	Priya	Shilpa	[illegible]		
Signature :		Ramya	Priya	Shilpa	[illegible]		
Date:		9/7	9/7/26	9/7/26	10/7		
Time:		@1:30pm	2PM	@8pm	8AM		

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

BAH-00661093 IP5-00176146
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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 9/7	DATE 10/7	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1			
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			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	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			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1			
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	10	10			
	TOTAL		12	12			

Intervention : -Fall Risk : Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		✓	✓			
	Call device within reach		✓	✓			
	Wheels Locked		✓	✓			
	Room free of clutter		✓	✓			
	Adequate Lighting		✓	✓			
	Wheel Chair Support		✓	✓			
	Other Intervention(s) Specify		✓				
	Nurse's Name :		Abhilasha				
	Signature :		Abhi				
	Date :		9/7	10/7			
	Time :		1:00 pm	10 am			

Docu. No. RCHBH / FRM / CLINICAL / 005

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BRADEN 'Q' SCALE

					Date : 9/7 / Time : 1 pm	10/7 / 8 am		
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4		
"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	4		
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.	3	3		
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	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	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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
				TOTAL SCORE	22	22		
				Evaluator's Name	Abhilash	Das		

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for **"At Risk"** Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for **"Moderate Risk"** Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for **"High Risk"** Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: Estimated del

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: .....
Nurse Name: .....
Date and Time: 9/7 @1:30pm

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00661093 IP5-00176146 Baby Of SAI MANOGNA GOLLAPUDI 05-07-2026 0 Y 0 M 4 D (F) Dr. DINESH KUMAR CHIRLA	9/5/26 @	9/7/26 @
	Transfer Ordered by DR Ramya	Reason for Transfer Admission
From Unit ER	To Unit F/Ward	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 13	Number of Imaging Films NIL	Personal belongings including clinical documents. If any handed over to attendant OP File Yes ☐ No ☐ If yes, what ? Mobile

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
DR. Ramya	DR. Abhinaya

Patient & Clinical Records Received by :
Sis. Ramya

Date & Time of Patient Received : 9/7/26 @ 1:30 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

Rainbow Children's Hospital - Banjara Hills
8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176146 **Admit Date** : 09-Jul-2026 **Admit Time** : 12:42 PM **UHID** : BAH-00661093

Patient Details :

Patient Name	: Baby Of SAI MANOGNA GOLLAPUDI	**Age**	: 0 Y 0 M 4 D
Guardian	: Mr SRI DATTA RAGHAVA BHARADWAJ STHANAM	**DOB**	: 05-07-2026 01:00 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO 7540, JANA PRIYA APARTMENTS Erragadda Hyderabad Telangana INDIA 500018	**Phone No**	: 8801668836/ 9391915793
		E-mail	: STHANAMBHARADWAJ@GMAIL.COM

Admission Details :

Bed Type : DELUXE ROOM **Bed No** : DLX 326 **Ward Name** : 3F-ZONE C

Room No : DLX 326 **Admission Type** : First Visit

Contact Details :

Name : Mr SRI DATTA RAGHAVA BHARADWAJ **Relationship** : Father

Contact Address : FLAT NO 7540, JANA PRIYA APARTMENTS Erragadda Hyderabad Telangana INDIA 500018 **Phone No** : 8801668836

Signature

Doctor Details :

Doctor Name : Dr. DINESH KUMAR CHIRLA **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ BAH-00661093 IP5-00176146 Baby Of SAI MANOGNA GOLLAPUDI 05-07-2026 0 Y 0 M 4 D (F) Dr. DINESH KUMAR CHIRLA _Consultant: _____ Dept : _____

Date of Admission: _ _Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/7/26	1:20pm	ER	326	Abhishek

Cross Consultation Visit

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

Date	Investigations	Order No.	Signature