

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175844

Admit Date : 01-Jul-2026

Admit Time : 09:51 PM **UHID** : BAH-00660444

Patient Details :
Patient Name : Baby Of SARASWATHI

Age : 0 Y 0 M 9 D

Guardian : Mr SHIVARATHRI RAJU

DOB : 22-06-2026 01:00 AM

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : H.NO-5-40, CHINTA NEEKKONDA Nekkonda
Warangal Telangana INDIA 506122

Phone No : 9908193955/ 9705643325

E-mail : NO@GMAIL.COM

Admission Details :
Bed Type : NICU

Bed No : NICU 271

Ward Name : 2F-NICU 3

Room No : NICU 271

Admission Type : First Visit

Contact Details :
Name : Mr SHIVARATHRI RAJU

Relationship : Father

Contact Address : H.NO-5-40, CHINTA NEEKKONDA Nekkonda
Warangal Telangana INDIA 506122

Phone No : 9908193955 / 9705643325

Signature
Signature

Doctor Details :
Doctor Name : Dr. VIJAYANAND JAMALPURI

Specialisation : NEONATAL INTENSIVE CARE

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELF PAY

BAH-00660444 IP5-00175844
 Baby Of SARASWATHI (M)
 22-06-2026 0 Y 0 M 12 D
 Dr. VIJAYANAND JAMALPURI

2

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ACTIVITY RECORD FOR B

Name : _____

UHID No. : _____ IP No. : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
6/7/26	LP	1	9696734	②

ANY OTHER INFORMATION

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.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

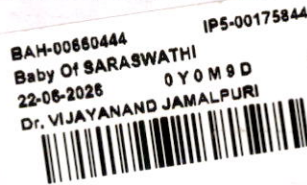
ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP : _____ (M) nt: _____ Dept : _____

Date of Admission: _____ Discharge : _____ Time: _____

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



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/7/26	10:15 pm	ER	NICU	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
01/7/26	RBS, VBA	26065982	}
	X-ray - same - same	265-032767	
	NP, Blood culture, Blood group	26065981	
2/7/26	RBS	26066289	}
2/7/26	CBP	26066165	
2/7/26	SBR, PT, APTT	26066290	
2/7/26	NSU	265-032812	
2/7/26	VSU	265-032842	}
2/7/26	Reticulocyte count	26066105	
2/7/26	RBS - (3)	26066077	
2/7/26	VBU, RBS	26066058	
"	DCT	26065999	}
"	VBU, RBS	26066056	
"	VBU, RBS	"	
"	Ca ⁺ , S/E, Hemoglobin, SBR	26066057	
1/7/26	X-ray	265-032761	}
3/7/26	SBR	26066425	
3/7/26	RBS	26066424	
4/7/26	NP,	26066894	
	RBS	26066893	}
4/7/26	Blood clt	26066986	
4/7/26	Pungat M2	26067165	
	CBP, SBR - RW	26067192	

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
2/2/26	erradication	(1)	26066001	J. Heng
2/7/26	umbilical venous catheter	(1)	9683434	
2/7/26	IV placement	1	9683208	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Age : 36y 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. Saraswathi TWIN-II Mother's Blood Group : O-
Gender : ☒ M ☐ F Blood Group : A+ Birth Weight (gms) : 1.9kgs Length (cms) :
Date of Birth : 22/6/26 Time of Birth : 10:00Am OFC (cms) :
Place of Birth : Lathuri Narasimha, Warangal Hosp Estimated Gesth Age : 33
Current Obstetric History : (Booked / Unbooked Case)
Maternal Age : 36yrs Ht : Wt : BMI: Married Life : LMP : EDD :
Conception : Spontaneous or with Rx : NF conception
Booked at what GA : AN Steroids Drugs / Doses :
Last Scans Details :

TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs 36y
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 :
Chronic Hypertension
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 :
G.D.M (+)
Compliance with Rx : insulin
Scans : LGA, TIFFA, Fetal Echo : + OAI A
H/o Hypothyroidism : when diagnosed ? Medication?
Chronic hypothyroidism
Any other Chronic Medical Problems, when detected
drugs ?
(Anemia, SLE, Jaundice, CHD, Heart Disease)
Infection : H/O, Fever
(☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)
UTI : when : Any culture :

PPROM: Duration : ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results :
Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

P : A : L :

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

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 :

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitaion : ☐ Yes ☐ No

Cord ABG :

Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

1 Minute	5 Minutes	10 Minutes

TOTAL

Snapee II Score

Score

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

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

33+1 weeks - Twin - II, ~~DA~~ DEDA - twins.

BN - 1.9 kg

Now - 20h - 9, WT = 1.6 kg

Baby born out of LSCS → CIA → RD → 1° S
 given → CPAP support → Nasal prong
 2 days

→ R/A

- (*) External feeding started
 after 3-4 days of NPO.
- ↓
- Small vomiting, green yellowish, brownish aspirates
 - Passed stool
 - ↓
 - kept NPO
 - OG aspirates done.
 - Antibiotic started -

Investigation details in previous Hospital :

evaluated for ~~and~~ intestinal obstruction
 Invo persistent aspirates ref to
 RCH bangalore.

Feeding History :

- 23/06/22 (20h-2)
- MB = 21.6 gm
 - Total WBE = 10,000
 - CRP - (-ve)
 - S. Cal - 9.1

- Day - 3 23/06/22

2D echo - (N)

NSG - (6/L PV flair)

25th June

USG abd - (Normal)



25/06/20
Na⁺ = 136
K⁺ = 5.0

25/06
Total Bil - 8.2
Direct Bil
Indirect Bil - 7.6mg

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5 HR : RR : NIBP : CFT : 2 sec

Color of the extremities :

Jaundice : Pallor : Icteric SpO2 : 100% pre-ductal

ANTHROPOMETRY: Birth Weight : 1.9 Length : HC : Present Weight : 1.6

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :	Fontanelles : Sutures Shape / Moulding : Edema / Bruising : Size - (H.C.) :	N
FACIES : (Any Facial Dymorphism)		No
NECK and CLAVICLES :	Range of Motion : Asymmetry : Masses :	N
EYES :	Symmetry : Red Reflex : Discharge :	Needs to be seen
EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Periauricular Pits / Tags : Nasal shape / Patency : Palate : Gums : Lips : Tongue :	N No cleft
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number :	N
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : Discharge :	- Abdomen Soft - No organomegally - umbi - stump - detached - No visible peristalsis
GENITILIA :	Labia / Hymen : Testicles/penis : Anus :	N male genitalia
HERNIAL ORIFICES		N
TRUNK and SPINE :		N
SKIN LESIONS :		N
EXTREMETIES :	Fingers / Toes : Deformities : Hip Joint Examination :	Arms / Legs : Mobility :



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☐ Regular ☐ Periodic ☐ Shallow ☐ Gasping

B/L EAF

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 :

SpO₂: Auscultation: Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 130 BP :

Precordial Activity :

Femoral Pulses : 1/2

Murmurs : 1/2

Other Peripheral Pulses : 1/2

Signs of Cardiac Failure : 1/2

ABDOMEN:

Shape : 1/2

Hernia orifice : free

Palpation : soft

Anal Patency : patent

Palpable masses : NO

Umbilical Cord : 2A 1V

Abdominal girth :

First urine passed : 1/2

Meconium passed : not passed

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness : alert

Prechtl Score :

Nerves :

MOTOR SYSTEM:

Passive Tone : 1/2

Active Tone : 1/2

Neonatal Reflexes :

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

Moro's : 1/2 DTR : 1/2

ATNR : 1/2 Skull and Spine : 1/2

No external congenital anomaly found

Diagnosis : Moderate PT / AGA / male / RD / Feed intolerance
Suspected Sepsis / NNT

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *[Signature]*
Name :
Date & Time : 2/7/26

Consultant: VIJAYANAND JAMALPURI
Reg. No. 40526

Signature : *[Signature]*
Name : Dr. Vijayanand Jamalpur
Date & Time : 2/7/26 @ 10am

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 : SP02 : Weight :

Any Oxygen requirement : Plan

Systemic :
- Continue on room air, keep NPO
- TV = 150 cc / kg / day - 10-15 cc - P

Medications :
- i/g Meropenem
- Surgical review
- Det R. Leulange sent
Plan during ward follow up :
 no O/A+

Feeding Plan at the time of shifting :
- Seed NP1,

Screenings done during NICU Stay :
NSG :
coagulation profile
PT Blood clc,
CXR, Blood gas,
 PES

Hearing Screen :
ROP :
TFT :
NP2 :
Rmich.

Doctor Signature (Handover Given): Doctor Signature (Handover Taken):
Doctor Name: Doctor Name:
Date & Time: Date & Time:

[illegible]

BAH-00860444
 Baby Of SARASWATHI
 22-08-2026
 Dr. VIJAYANAND JAMALPURI
 0 Y 0 M 9 D
 (M)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Start plan
	- S. bill - 25.7	cc
	- Maternal Blood group O-ve	- Start intensive phototherapy
	Baby blood group A+ve	- Prepare for D/KET.
		- Send DCT, Retic
	Exchange range - 19.	- Double volume exchange transfusion
		300ml
		200ml LPBC
		100ml FF
		Noted by Rajhansa 1.7/26
		Exchange transfusion
2/7/26		
7:00 AM	- under strict aseptic conditions vvc of size 4 french inserted into and fixed at 6 cm. Backflow present	

BAH-00660444
Baby Of SARASWATHI
22-08-2026
Dr. VIJAYANAND JAMALPURI
IP5-00175844
0 Y 0 M 10 D
(M)

2/7/26

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

Day in NICU: Day of Life: 10 PMA:

Term ☐ Preterm ☐ Gestation: 33 Corrected Gestational Age: 34+3 Today's Weight: 1'

Problems	
S.No.	Current
1.	Moderate preterm
2.	LBW
3.	Suspected sepsis
4.	Rh Ove pregnancy,
5.	OA Incompatibility
6.	post Double volume exchange transfusion.

Clinical Assessment
- Issues of: light green NG aspirates. RCT-negative SPO₂ - 97% PR - 145/min RR - 35/min, BP - 53/41(45)

Medications Used
- Inj. Meropenem (DI)

Plan of Care:
- TV - 150ml/kg/day 150ml/kg/day ↓ 10% Iso-p + 3ml/kg calcium gluconate - Continue NPO - Continue intensive phototherapy; - Plv USS abdomen, NSG today; - Plv UVC removal.

Plan of Care:
- Plv Rpt SBR, afternoon coagulation profile; - Trace Retic Count - peripheral smear;

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

Doctor's Name (Hand over taken):

Signature: Dr. Aneel

Signature:

Date & Time: 2/7/26

Date & Time:

Patient Sticker

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

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

Overview	Problems		
	S.No.	Current	Past Problems
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Doctor's Name (Hand over taken):

Signature:

Signature:

Date & Time:

Date & Time:

BAH-00680444 IP5-00175844
 Baby Of SARASWATHI
 22-05-2026 0 Y 0 M 9 D (M)
 Dr. VIJAYANAND JAMALPURI

3

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26 11:10 AM		Seen by Dr. Vijayanand
		<u>Plan:</u>
		- Continue intensive phototherapy.
		- w/o apnoea brady, Desat.
		- T ₀ = 150ul/kg/day ↓ Start feeds 3ml 2nd hourly, + Rest 10% Iso-p
		- SBR Coagulation profile evening 4pm
		- USSG & NSG and - Abdominal assessment.
		- Ilo. charting 6th hourly
		- Trace Retic count Peripheral smear

Noted by
 Hemalatha
 2/7/26
 @ 11:20 AM

VIJAYANAND JAMALPURI
 Reg. No. 40520

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26	Afternoon Round.	
	Baby is on Room air Under DRT TSPT Underwent DVE-T last night.	Plan.
M/O B/A	Vitals: HR - 162/min RR - 40/min SpO ₂ - 97% BP - 55/34(40) U/O - Stool -	Continue TSPT & eyes & genitalis covered.
	P/A - soft 3ml - milky green aspirate pre feed.	TV - 150ml/kg/day 10% IsoP + Cas 3ml/2nd hely feed.
	NSG - (N) @Lc	Send SBR } at PT, APTT } 4pm INR }
	Peripheral Smear: not Sfo active	w/ + brady/desat apnea.
	Analysis noted by Hemolab 2/7/26 3pm	→ Ifo charting 6th hely → R/r to Send NBS.
	Dr. Poojithe	

IP5-00175R44

Baby Of SARASWATHI

22-06-2026

0 Y 0 M 10 D

(M)

[illegible]



31/12/26

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

Day in NICU: Day of Life: 11 PMA:
 Term ☐ Preterm ☐ Gestation: 33 Corrected Gestational Age: 34+4 Today's Weight: 1.752kg

Problems		
S.No.	Current	Past Problems
1.	Moderate preterm	
2.	LBW	
3.	Suspected sepsis	
4.	Rh isoimmunisation	
5.	OA setup,	
6.	post DVET	

Clinical Assessment
UVC - Day 1 Aspirates - 5ml Retic count - 2.5 Stool - passed Urine - 3.3 ml/kg SpO₂ - 97% PR - 142/beat RR - 48/min - ON TSPT > D SSPT

Medications Used
Inj. Meropenem (D2) SBR - 25 > 10.8 > 11 → 7.7 ↓ Last SBR blood clts - no growth 24 hrs.

Plan of Care:
- continue SSPT - IV - 150ml / 1 day ↓ 10% ISO-P + Ca3 - feed 5ml 2nd hourly - I/O charting 6th hourly - R/V to send NBS

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

Signature: *Anish*

Date & Time: 31/12/26, 8:30 AM

Doctor's Name (Hand over taken):

Signature:

Date & Time:

Date & Time	Progress Notes	Doctor's Order
3/1/26		Seen by Dr. Vijayanand
9:00 AM		Placer
		TV - 150 ml/kg/day ↓ Feed 5ml 2nd hly ↑ 1ml feed 8th hourly [TF = 24ml] ← continue SSP ↑
	PA - soft	
	stools - passed	Remove UVC & inserted peripheral cannula Add Domperidone NP, tomorrow RV shifting after tomorrow reports
	Noted by Hemalatha 016699 3/1/26 @ 9:20 AM	Dr. V. K. JAMALPURI Reg. No. 40526

BAH-00660444 IP5-00175844
 Baby Of SARASWATHI
 22-06-2026 0 Y 0 M 10 D (M)
 Dr. VIJAYANAND JAMALPURI



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 1:15 PM	<u>Afternoon rounds</u>	
		<u>Plan:</u>
		<u>Continue</u>
	PIA - soft	TV - 150ml 1/8/day
	Stools passed.	↓
	- No vomiting	6ml 2nd hly
	- No apirats	(↑ 1ml 6th hourly)
		[TF = 24ml]
		<u>Continue SSP T.</u>
	UVC removed.	<u>NP, tomorrow.</u>
		<u>Trace Blood c/s.</u>
		<u>Ant</u>
		<u>+</u>
	Noted by Hemalatha 3/7/26 @ 3:30 PM	



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It takes a lot to treat the little.

[illegible]



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

Day in NICU: Day of Life: 12 PMA:
 Term ☐ Preterm ☐ Gestation: 33 Corrected Gestational Age: 34⁺⁵ Today's Weight: 1.747 (↓5g)

Problems		
S.No.	Current	Past Problems
1.	Moderate Preterm / LBW	
2.	Suspected sepsis	
3.	Rh isoimmunisation - DA seps	
4.	Post DUE	
5.		
6.		

Clinical Assessment	Medications Used
Baby hemodynamically stable on air on CPPT Tolerably feeds 9ml orally, ↑ 1ml orally No vomiting. S/E - HR - 115/min RR - 32/min SPO ₂ - 96% BP - 60/32 (41) 24 hr Blood gases - stable	IV line - D ₂ NG aspirate 0-5 U.O - 3 cc/kg/d Stool - Passed 026
Ing. Meropenem - D ₂ Domperidone	

Plan of Care:

1) Continue SSPT 2) IV - 150 cc/kg/day - 3) Trace NPI 4) 10 cc/kg orally	↑ feeds 1ml orally, Post 10-1150 + CA ₃ 5) Trace 48 hr blood cells 6) w/o vomiting, abdominal distension, Bx for Discharge
---	---

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

Signature: [Signature]

Date & Time: 4/7/26

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

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

Signature: [Signature]

Date & Time: 4/7/26

Patient Sticker

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

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

Overview	Problems	
	S.No.	
	Current	Past Problems
1.		
2.		
3.		
4.		
5.		
6.		

Clinical Assessment

Medications Used

Plan of Care:

Doctor's Name (Hand over given):

Signature:

Date & Time:

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:

Day in NICU: Day of Life: 13 PMA:
 Term ☐ Preterm ☐ Gestation: 33 wks Corrected Gestational Age: 34 + 6 Today's Weight: 1756 (199g)

Doctor's Name (Hand over given): Dr. Bogette
Signature: [Signature]
Date & Time: 5/2/26 11 AM

Doctor's Name (Hand over taken): Dr. Neef
Signature: [Signature]
Date & Time: 5/7/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/2026 @ 4:45 am		Seen by Dr. Vyayan
		1) ↑ feeds 1ml 6hrly
		2) w/f apnea, Brady, desat.
		3) Stop meopenen Cont = lipo Ampho - 8
		noted by SUSMITHA 9/3/26
		Dr. VIJAYANAND JAMALPURI Reg. No.: 0526
5/7/26 4pm	Afternoon Rounds	
	Baby hemodynamically stable on air	Plan
	No apnea/bradycardia/desat	1) IV - 150cc/kg/day ↑ feeds 1ml 6hrly
	Tolerating feeds 16ml 2hrly, Tolerating	2) w/f apnea, Bradycardia, Desat
	HR - 118bpm RR - 38bpm SpO2 - 97% BP - 61/39 (50)	3) Trace green blood c/s & repeat blood c/s
		4) R/U LP T/m
		5) CRBS on

BAH-00660444

IP5-00175844

Baby Of SARASWATHI

22-06-2026

0 Y 0 M 9 D

(M)

Dr. VIJAYANAND JAMALPURI



10

Rainbow Children's Hospital
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
04/07/26 9:45 AM		Seen by Dr. vijayanand
		1) w/f Apnea, Brady cardia / desatms
		2) ↑ feeds 1 m / hourly
	peripher line - D, one prick for sampling	3) Trace SBR → R/v phototherapy
		4) Trace blood cfs and R/v slightly to view 3
		5) CBP, SBR TM
		6) Complete Denial of fluid Noted by AKANSHA
		Dr. VIJAYANAND JAMALPURI Reg. No. 40526
04/7/26 11:25 PM		2/11/26 D. Vijayanand
	SBR - G.8	1) Stop Phototherapy ✓
	Blood cfs - Budding yeast cell growing (verbal report)	2) Send repeat blood cfs and start liposomal Amphot B

AKANSHA
(A.T.O)



10

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
07/07/26 2:00pm	Baby hemodynamically stable on air. SSPT stopped around 11 AM Plenty feeds 11 ml 2hly One episode of small vomit HR - 156/min RR - 38/min SpO₂ - 98% BP - 70/51 (58) On O₂ feeds, 10 ml 2hly One episode of small vomit (greenish) during cannulation	<u>Afternoon Round</u> <u>Pls.</u> 1) TV - 150cc/kg/day Hold one feed. Restart feeds from 5 PM 2) CBP T/M 3) w/F Apnea, Brady Cardia, Desaturations 4) Trace blood gas 5) I/O charting 6hly Noted by akash <i>B. Nishu</i>
4/7/26 4:45pm	Might Round S/O Dr. Nishu 1 episode of vomiting Baby on 81% FiO₂ PIP 17/15, Rate 40 FiO₂ 21%	<u>Plan</u> - continue full O₂ feed - Trace fung at clt → Raise fung at MIC. → CBP SBR - T/M. → LP on Monday Noted by Sugnet <i>Sugnet</i> <i>Pavan</i>

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26 10-30pm	<u>Night Rounds</u> Baby Stable on exam. No episodes of bradycardia/ desaturation Tolerating feeds 1st and 2nd w/o vomiting.	<u>Plan</u> 1) IV - 150 cc/kg/day ↑ feeds 1ml/kg/hr TF - 24ml/kg/day
	HR - 129/min RR - 33/min SpO ₂ - 96+ BP - 67/36(50)	2) Trace of focal blood clots and suspect blood clot
		3) R/v LP 1/m
		4) CRBS 01
		5) w/t apnea, Bradycardia, desaturation
		6) R/v regarding fungal evaluation → abd organ
		7) <i>[Signature]</i>
		Noted by Abhinav 5/7/26 10:30 PM

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BAH-00660444
Baby Of SARASWATHI
22-06-2026
Dr. VIJAYANAND JAMALPURI
IP5-00175844
(M)
0 Y 0 M 13 D

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

Day in NICU: Day of Life: 14 PMA:

Term ☐ Preterm ☐ Gestation: 38w6d Corrected Gestational Age: 35 wks Today's Weight: 1.751 kg
(↑ 15g)

Problems	
S.No.	Current
1.	Moderate Proteinuria / LBW
2.	Suspected sepsis
3.	Rh isoimmunisation - Post DVT
4.	Fungal sepsis
5.	
6.	

Overview	Past Problems

Clinical Assessment
Baby currently clinically stable on air. Tolerating feeds 18ml 2hrly, No vomiting No apnoea / Bradycardia / desaturations S - HR - 127/min RR - 26/hr SpO₂ - 95%.

Medications Used
Inf. Liposome / Ampicillin B D₃ Susp. Domperidone

Plan of Care:
1) IV - 150 cc/kg/day - 18ml 2hrly + Rest 10-1. 150 P + Ca₃ TF (24ml 2hrly) → 12ml 6hrly 2) 9kcc fresh blood qd → R/V regarding fungal exclusion q 10 days 3) 4hr LP today 4) Monitor vitals 5) RBS qd

Doctor's Name (Hand over given): [Signature]

Doctor's Name (Hand over taken):

Signature: [Signature]

Signature:

Date & Time: 6/7/26

Date & Time:

BAH-00660444
Baby Of SARASWATHI
22-08-2026
Dr. VIJAYANAND JAMALPURI
IP5-00175844 (M)

(u)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/9/26		Seen by Dr. Vijayanand
10:57 AM		Plans
		- IV - 150ml/day
		↓
		Feed 18ml 2nd ml
		↑ 1ml 4th hourly.
		- IP today.
		- Trace final blood cts.
		- Continue Meropenem
		Asst
		Dr. VIJAYANAND JAMALPURI
		Reg. No. 6
6/9/26		Lumbar puncture ndy
12:00 PM		- under strict aseptic conditions
		IP done and CFS sent for analysis
		& culture & sensitivity



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	RBS - 88mg/dl Cef glucose - 42mg/dl.	<u>Acad</u>
6/10/26		
2:15 PM	Afternoon rounds	
	- Tolerating feeds.	<u>Plan</u>
	- No vomitings	- Tr - 150ml/kg/day
	PA - soft	↓ feed 19ml 2nd half [↑ 1ml 4th hourly] [TF = 24ml]
	First Blood culture - candida [species not identified non-albicans]	- Trace Cef analysis & culture report.
	2nd blood clt - no growth by today.	- R/V to stop meropenem
		- R/V CBP tomorrow.
		- Trace blood clt.
		<u>Acad</u>



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

Day in NICU: Day of Life: 15 PMA:
 Term ☐ Preterm ☐ Gestation: 33 wks. Corrected Gestational Age: 35⁺ Today's Weight: 1.764 (↑ 7g)

	Problems		
	S.No.	Current	Past Problems
Overview	1.	Moderate prem LBW	
	2.	Fungal sepsis - Candida in blood cfs	
	3.	Rh isoimmunization - post PNET	
	4.		
	5.		
	6.		
Clinical Assessment	Baby hemodynamically stable on air. Tolerating feeds 24ml 2hly, No vomiting. No apnea/ bradycardia/ desaturations SpE - HR-132/min RR-34/min SpO ₂ -100%		
Medications Used	Ing. Liposomyl Ampho B D ₄ Ing. Meropenem D ₆ Sup. Domperidone Blood cfs - No growth (4h) after 4sh		

Plan of Care:

- 1) IV-150 cfs/day - 24 ml 2hly to continue
- 2) Trace feed & repeat blood cfs, CSF cfs.
- 3) CRBS OD
- 4) KIU regarding fungal evaluation good organs
- 5) Monitor vitals
- 6) Trace, CBF, RR, SBR

Doctor's Name (Hand over given): Dr. Anitha D. - Anusha Doctor's Name (Hand over taken): Dr. Anitha

Signature: Anusha Signature: [Signature]

Date & Time: 11/7/26 Date & Time: 11/7/26

Patient Sticker



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

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age:..... Today's Weight:

Overview	Problems		
	S.No.	Current	Past Problems
	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Signature:

Date & Time:

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:



Date & Time	Progress Notes	Doctor's Order
7/12/26 10 AM		Seen by Dr. vijayanand Jm
		1) Start palladai feeds 2) Crib care 3) Discuss antibiotics in ID so
	Noted by Hemalatha 7/12/26 @ 10:20 AM	Dr. VIJAYANAND JAMALPURI Reg. No: 40526
7/12/26 2:30 PM	Afternoon Rounds Jm	
	Baby hemodynamically stable in room air. Tolerating palladai feeds, No vomiting	1) Continue palladai feeds 24 ml/2hr TV - 150cc/kg/day
	S/C - HR - 119/min RR - 30/min SPO ₂ - 95% BP - 44/33 (37)	2) Continue high-dose R/V or antibiotic & antifungal in ID rounds
	(01/17) - Candida Parapsilosis Blood c/s - No growth after 48 hrs (4/1) noted by	3) Crib care 4) W/F bradycardias, desat

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 3:45 PM		Seen by Dr. Vyayand
		1) Continue full palliative feeds today
		2) Plan to shift to room T/M.
		3) R/v - antibiotics / antifungal T/M
		4) Discuss regarding NBS T/M.
	Noted by Hemabala 7/7/26 @ 4 PM	
8/7/26 10 AM		Seen by Dr. Vyayand
		1) w/f Apnea, Bradycardia, Desaturation
		Full palliative feeds - involve parents
		2) Peace blood c/s, LFT c/s
		3) Janice assessment today
		4) Shift out Now if parents agree to go
		5) Discuss regarding NBS today carefully

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

Day in NICU: Day of Life: 16 PMA:

Term ☐ Preterm ☐ Gestation: 33 wbs Corrected Gestational Age: 35 +2 Today's Weight: 1.777 (9.13g)

		Problems	
	S.No.	Current	Past Problems
Overview	1.	Moderate Preterm LBW	Coagulopathy
	2.	Fungal Sepsis - Candida parapsilosis	
	3.	Rh isoimmunisation - Post DVT	
	4.		
	5.		
	6.		
Clinical Assessment	Baby hemodynamically stable on an Tubing full palladi feeds 24ml 2hly, No vomiting & Two episodes of desaturation during feeding - self pickup No apnea/Bradycardia desaturation On incubator, comfortable, warm		
	Inj. Liposomal Ampic B D5 Inj. Meropenem D7 Susp. Domperidone		
Medications Used	Blood cts - no growth (4h) after 4ch CSF cts -		
Plan of Care: 1) TV - 150 cts/kg/day. Palladi feeds 24ml 2hly → Parents to be involved in feeding → If parents confident, plan to start today 2) Trace Blood cts, CSF cts. 3) CRBS OD 4) Monitor for Apnea/Bradycardia/Desaturation			

Name (Hand over given): Dr. Anitha Poopathy
[Signature]
8/7/26

Doctor's Name (Hand over taken): Dr. Anitha
[Signature]
Date & Time: 8/7/26

BAH-00660444

IP5-00175844

Baby Of SARASWATHI

22-06-2026

0 Y 0 M 16 D

(M)

Dr. VIJAYANAND JAMALPURI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 10:45 AM	TCBR - 13.8 (Cut-off - 13.5)	Plan 1) Start SSPT
8/7/26 2 PM	Aftershow Rounds Baby hemodynamically stable on air No apnea/desaturation/ bradycardia SSPT ongoing. Tolerating Pallada feeds 24ml 2hrly SpO ₂ - 100% RR - 36/min HR - 126/min Csf c/s - (shunt all over) Blood c/s	Plan 2) Continue SSPT x 24h 3) full pallada feeds 24ml 2hrly TV-150 cal/kg/day 3) Pricks to come and give pallada feeds ↓ if confident shift out today 4) R/v SBR 1/m 5) Continue antibiotic & antibiotic total 7 days
		noted by Alphina 8/2/26 @ 2:30 PM

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26	(233) Morning Note Moderate preterm/LBW / DOZ 1b. Fungal sepsis - candida parapsilosis Rh isommunisation - post DVT. SBR.	wt - 1.801 kg.
	TCBR - 13.8 > SSTF 78.8.	Plan
	Self ventilating. on RA vitaly stable.	① TV = 150 ml / kg / day 24 ml paladay. EB / PF.
	tolerating full oral feeds RA - soft stools passed.	② trace final blood & CSF cl
	meropenem D7. Fluconazole D ₍₅₎ + 2	③ stop meropenem after 28 dose
	IV cannula D ₁ .	④ cont flucon for 7 days total of antifungals
	wt = 1.9 → 1.783 → 1.801 (52.1. BW) (18 gm)	⑤ stop SSTF.

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

Date & Time	Progress Notes	Doctor's Order
9/7/20 5:50pm	C/S/B - <u>Recurrent</u>	
	Baby on room air hemodynamically stable PIA - soft. CT/A - good. Pulse 100 / stool No vomit	Plan → IV-ISO 1 day 24 ml / 2nd half - EBM / P → 1mg Fluconazole H'll T/m - monitor → plan discharge - T/m → monitor temp / vitals as 4th half → RV-vaccination - T/m
	Blood cts. / - no gross CS F.	
	→ Not received birth dose	Noted by Papa
		<u>Papa</u>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 9:50am		
	CS/B-Review	
	md preterm / LBW / DO L=16 - fungal sepsis - Candida / Rh-iso	
	Baby on room air	Post DVT
	hemodynamically stable	
	CTHA good	Post
	- feeding well	→ IV - 150ml/kg/day - 24ml / 150ml
	no vomiting	→ 1st fluconazole today
	PIA soft	→ Riv - discharge bag
	7. wgt - 1.801 kg, (↑ 28 g)	on - BCG / OPV / Hep B
		follow up
		Flu - on monday
		- vaccination / ABR / NBS on
		Paucor follow up

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



CROSS CONSULTATION FORM

Doctor Name : Dr. Jyothi Date : 1/7/26 Time : 11:30 pm

Diagnosis :

Hospital : Rainbow Children's Hospital
Bannara Hill

Referred for : ☒ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral :

☐ Emergency

☐ Urgent

☒ Non Urgent

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

c/s/b Dr Nikhita
Cas discussed & Dr Jyothi

Thanks for the referral,
History noted.

9 day IM child /moderate preterm (33+1 wk) / LSCS / CIAB
developed respiratory distress after birth → started on
CPAP → respiratory distress improved &

Child weaned off CPAP.

Child initiated on OG feeds, but developed
recurrent brown OG aspirates → Child kept NPO.

O/E - Child active

Vitals - HR: 142 bpm
BP:

SpO₂ - 97% RA

S/E - P/A - soft,
no visible peristalsis
passing stools

(1/7/26)
Xray Abd -
no pneumoperitoneum

Adv

① NPO

② OG aspirate 2nd hly
+ free continuous drainage

③ Repeat xray abd &
pelvis tomorrow
morning (2/7/26)

Dr Nikhita
1/7/26
11:30 pm

Consultant :

Name : Dr. Jyothi Signature : [Signature] Date & Time : 1/7/26
11:30 pm

[illegible]

Patient Sticker

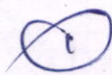


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RBS CHART

[illegible]

BAH-00680444 IP5-00175844
 Baby Of SARASWATHI
 22-08-2026 0 Y 0 M 9 D (M)
 Dr. VIJAYANAND JAMALPURI



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RESULT SHEET

Date	1/7/26	2/7/26	2/8/26	2/8/26	3/7/26	4/7/26
Time	10:00pm	7:00am	11:40am	4pm	@ 6:30pm	
Hb	18.5	13.1	16.8			15
PCV			50.0			45.7
RBC	5.16		4.68			5.28
WBC	12.12		13.70			8.34
N/L	63.6/26.0		56/36			24/63
Platelets	141		135			96 ↓
CRP	34.0					71
ESR						
PCT						
RBS						
Na	133	137				135
K	4.8	3.7				4.8
Cl	107	102				110
Ca/Mg	9.7	9.3				10/
Phosphate						
Urea	8					4
Creatinine	0.7					0.5
ALP						
SGPT						
SGOT						
T.Bill/Conj	25.7 < 1.2 24.5	10.8 < 0.1 10.7		11.0 < 0.4 10.6	7.7 < 0.4 7.4	6.8 < 0.1 6.7
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR	31 / 2.5			19 / 1.4		
APTT	56			51		
CSF Protein / Sugar						
Cells						
N/L			Redicount	2.5		

BAH-00660444 IP5-00175844
 Baby Of SARASWATHI
 22-08-2026 0 YOM 12 D (M)
 Dr. VIJAYANAND JAMALPURI



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RESULT SHEET

Date	05/07/26	6/7/26	7/7/26	9/7/26		
Time	@ 6:30 AM	8:30	5:54			
Hb	14.9		14.1			
PCV	45.7		43.9			
RBC	5.25		4.93			
WBC	9.52		9.15			
N/L	23.4/648		23.7/64.0			
Platelets	112		153			
CRP			5.0			
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj	7.6 < 0.3		10.7 < 0.4	8.8 < 0.3		
T.Protein						
S.Albumin						
G.Globulin						
G Ratio						
Acid						
Amylase						
Lipase						
Lactate						
Cholesterol						
/ Sugar	125/48	125/48				
		8 cells				
		All lymphocytes				



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: NICU

Shifted to: 823-A

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	DOMPERIDONE SUSPENSION	0.4mg	PO	Q8H	8/7 6PM	☒ C ☐ DC
2	INS FLUCONAZOLE	16mg	IV	OD	8/7 10PM	☒ C ☐ DC
3	INS MEROPENEM	80mg	IV	TDS	8/7 10PM	☒ 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. Anurag

Date & Time: 8/7/26

Nurse Name & Signature: Hafsa

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

RESEARCH OF THE UNIVERSITY OF CALIFORNIA

1961

1	100	100	100	100	100
2	100	100	100	100	100
3	100	100	100	100	100
4	100	100	100	100	100
5	100	100	100	100	100
6	100	100	100	100	100
7	100	100	100	100	100
8	100	100	100	100	100
9	100	100	100	100	100
10	100	100	100	100	100

University of California

1961

BAH-00860444 IPS-00175844
 Baby Of SARASWATHI
 22-06-2026 0 Y 0 M 9 D
 Dr. VIJAYANAND JAMALPURI (M)

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Sheet No:

REGULAR PRESCRIPTIONS

Weight 1.6 kg Ward Ny

DRUG : <u>INJ. FLUCONAZOLE</u>				Date Time	<u>6/7</u>	<u>9/7</u>	<u>10/7</u>
Dose <u>10mg</u>	Route <u>IV</u>	Frequency <u>OD</u>	Start Dt. <u>8/7</u>				
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anurag</u>				<u>10/7/26</u> <u>30m pm</u>			
Additional Instructions: <u>10mg/kg/dose</u>							
Daily Doctor's Endorsement by a Sign							
DRUG : <u>INJ. MEROPENEM</u>				Date Time	<u>8/7</u>	<u>9/7</u>	
Dose <u>80mg</u>	Route <u>IV</u>	Frequency <u>TID</u>	Start Dt. <u>8/7/26</u>	<u>6am</u>	<u>X</u>	<u>Prall</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Anurag</u>				<u>24pm</u> <u>10/7/26</u>			
Additional Instructions: <u>40mg/kg/dose</u>				<u>10pm</u> <u>10/7/26</u>			
Daily Doctor's Endorsement by a Sign							
DRUG :				Date Time			
Dose	Route	Frequency	Start Dt.				
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							
DRUG :				Date Time			
Dose	Route	Frequency	Start Dt.				
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							
DRUG :				Date Time			
Dose	Route	Frequency	Start Dt.				
Name & Signature of the Doctor Starting the Drugs:							
Additional Instructions:							
Daily Doctor's Endorsement by a Sign							

VERIFIED

Signature

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

Signature

VERIFIED BY : Name

DRUG CHART

Date of Admission: Drug Allergies: N/A ☐ 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 **I** 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:				

REGULAR PRESCRIPTIONS

Weight. 1.6 kg Ward. Ny

DRUG: Inj MERUCLON

Dose: 76 mg
 Route: I.V
 Frequency: TID
 Start Date: 27/12

Name & Signature of the Doctor
Starting the Drugs:

Dr. Anurha

Additional Instructions:

40 mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG: DOMPERIDONE

Dose: 0.4 mg
 Route: P/O
 Frequency: 6th hourly
 Start Date: 31/12

Name & Signature of the Doctor
Starting the Drugs:

Dr. Anurha

Additional Instructions:

0.2 mg/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG: LIPOSOMAL AMPHOTERICIN B

Dose: 8 mg
 Route: IV
 Frequency: OD
 Start Date: 1/1

Name & Signature of the Doctor
Starting the Drugs:

Dr. Neethu

Additional Instructions:

5 mg/kg/dose

50 mg vial - Reconstitute by adding 10 ml sterile water. (1 ml = 5 mg)
Take 1.6 ml at 1.4 ml 5-1.2 over 1 hr.

Daily Doctor's Endorsement by a Sign

DRUG: Inj MEROPENEM

Dose: 80 mg
 Route: IV
 Frequency: TID
 Start Date: 6/12

Name & Signature of the Doctor
Starting the Drugs:

Dr. Anurha

Additional Instructions:

40 mg/kg/dose

Daily Doctor's Endorsement by a Sign

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[illegible]

I.V. FLUIDS CHART

Weight. Ward.

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
2/7/26	2 AM	TV - 150ml/kg/day ↓ 10% ISO + 3ml/kg calcium gluconate	W	10ml/hr		3/7/26		
3/7/26	8 AM	TV - 150ml/kg/day 10% ISO + 3ml/kg calcium gluconate	UVC	8ml	Hang			
3/7/26	8 AM	Fuj. Hep - NS 1.5ml + 48.5ml 1/2 NS	UVC	0.3ml	Hang			
4/7/26	8 AM	TV - 150ml/kg/day 10% ISO + 3ml/kg calcium gluconate	IV					SD
4/7/26	12 AM	Fuj. Hep - NS 1.5ml + 48.5ml 1/2 NS	IV			4/7/26		
5/7/26	8 AM	TV - 150ml/kg/day 10% ISO + 3ml/kg Calcium	IV					g

Signature

VERIFIED BY: Name:

BAH-00660444 IP5-00175844
 Baby Of SARASWATHI
 22-06-2026 0 Y 0 M 9 D (M)
 Dr. VIJAYANAND JAMALPURI



MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Nursing ☐ Others:
2/7/26	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	→ pt Need in intensive phototherapy	→ put the NJ.	→ provide intense phototherapy light → covered genital area		☐ 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:

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Telugu Patient / Learner Literacy: ☒ Read ☒ Write ☒ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
after	10AM	1,2	explain about feeding, baby condition.	1	1	0	1	1	Good	Heng

Part - III: CODES

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

BAH-00660444

IP5-00175844

Baby Of SARASWATHI

22-06-2026 0 Y 0 M 16 D (M)

Dr. VIJAYANAND JAMALPURI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/o Saraswathi? Mother's Name: Mrs. Saraswathi

Date of Birth: 22/6/26 Time of Birth: — Gender: ☒ Male ☐ Female

Birth Weight: 1.9 Kgs HC: 30cm cm Length: 44 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: 98.1 °C HR: 132 /Min RR: 32 /Min BP: — SpO₂: 100

Pain Score: 0/10 (Follow N Pass)

Fall Risk Assessment: ☐ Yes ☐ No Score: 16 (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: Sushanthi

Signature: Sush

Date & Time: 8/7/26

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

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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 is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



2/7/26

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

EARLY WARNING SCORE: CHILDREN'S UNIT

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

Temperature (°F)	104												
	103												
	102												
	101	36.5	36.5	36.6	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5
	100												
	99												
	98												
	97												
	96												
	95												
	94												

Heart Rate (bpm)	190												
	180												
	170												
	160												
	150	86	84	60	62	65	81	56	58	51	52	96	64
and Blood Pressure (mmHg) *	140	43	51	45	45	29	38	(42)	(42)	(35)	(40)	(64)	(40)
	130												
	120												
	110												
	100	36	43	40	38	30	31	34	36	30			
	90												
	80												
	70												
	60												
	50												

Heart Rate (Number)	141	192	152	162	158	151	145	166	149	135	146	148
---------------------	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

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

Resp Rate (Number)	35	37	39	56	46	29	47	39	39	39	45	40	37
--------------------	----	----	----	----	----	----	----	----	----	----	----	----	----

Resp Distress	Mod/ Severe	None / Mild	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
---------------	-------------	-------------	----	----	----	----	----	----	----	----	----	----	----

Receiving O ₂ (l/min)	O ₂ Saturations (%)	100%	99%	99%	99%	99%	96%	96%	100%	96%	97%	95%	94%
----------------------------------	--------------------------------	------	-----	-----	-----	-----	-----	-----	------	-----	-----	-----	-----

Conscious Level	Normal / Altered						N	N	N				
-----------------	------------------	--	--	--	--	--	---	---	---	--	--	--	--

GCS *		C	C	C	C	C	C	C	C	C	C	C	C
-------	--	---	---	---	---	---	---	---	---	---	---	---	---

TOTAL SCORE	Number of shaded boxes	1	1	1	1	1	1	1	1	1	1	1	1
-------------	------------------------	---	---	---	---	---	---	---	---	---	---	---	---

Pain Score		0	0	0	0	0	0	0	0	0	0	0	0
------------	--	---	---	---	---	---	---	---	---	---	---	---	---

Observer's Initials		B	B	B	B	B	B	B	B	B	B	B	B
---------------------	--	---	---	---	---	---	---	---	---	---	---	---	---

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:

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	6	10	12	2	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?		AM	AM	PM	PM	PM	PM	PM	PM	AM	AM	AM	AM
Temperature (°F)		36.5	36.6	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5	36.5
Heart Rate (bpm)		135	142	133	141	148	134	153	135	121	120	167	137
Blood Pressure (mmHg) *		91/34	90/34	91/34	91/36	91/28	91/36	91/36	91/36	91/36	91/36	91/36	91/36
Resp. Rate (bpm) (Over 1 Minute) *		45	36	27	32	40	28	36	40	31	38	40	28
Resp Distress		None	None	None	None	None	None	None	None	None	None	None	None
Receiving O ₂ (l/min)		0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
O ₂ Saturations (%)		97	97	96	97	96	96	97	97	97	97	97	97
Conscious Level		Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal
GCS *		15	15	15	15	15	15	15	15	15	15	15	15
TOTAL SCORE		1	1	1	1	1	1	1	1	1	1	1	1
Number of shaded boxes		0	0	0	0	0	0	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0	0	0	0	0	0	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											

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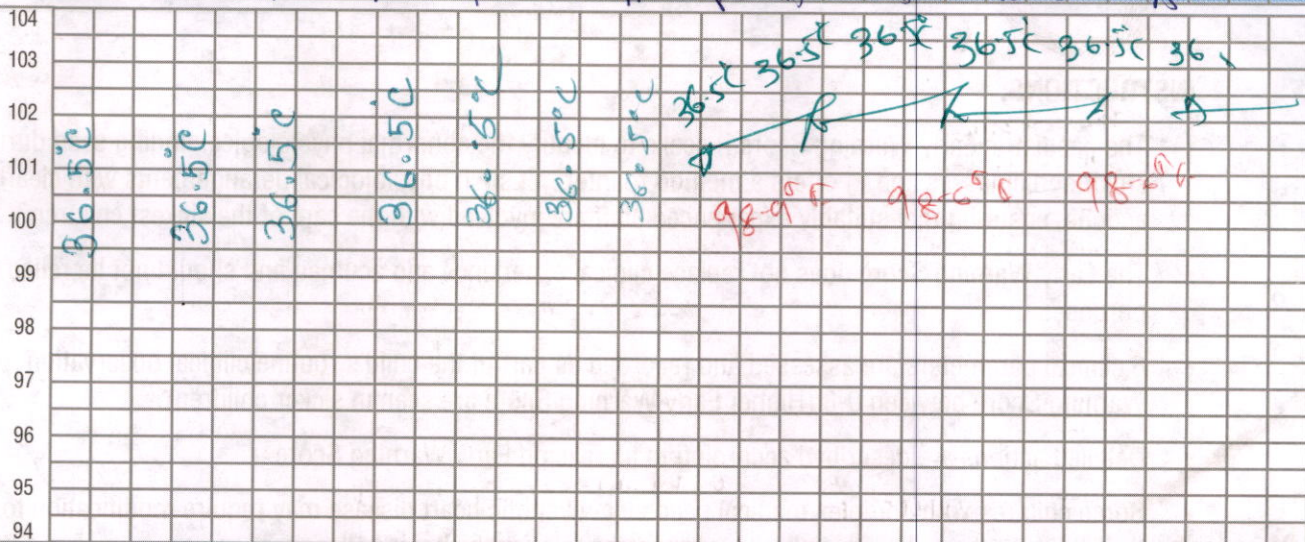


INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 11/7/26 Time: 8 10 12 2 PM 4 PM 6 PM 8 10 12 2 4 6 AM
 Doctor/Nurse/Family Concern? am am pm pm pm pm pm pm pm pm pm pm pm pm pm pm

Temperature
 (F)

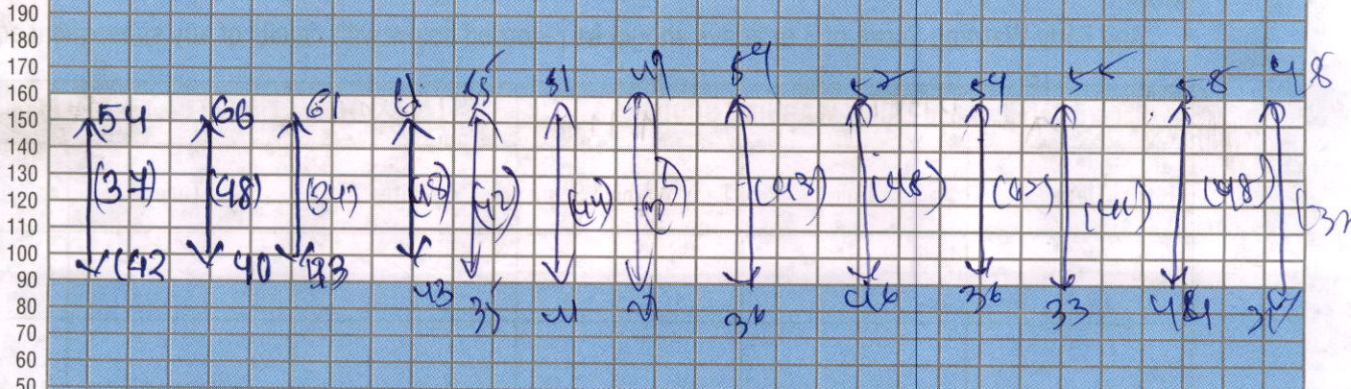


Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

Note:
 BP does not score
 in early
 warning scoring



Heart Rate (Number) 130 118 129 120 129 121 132 132 134 134 134 134 134 134 134

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

Resp Rate (Number) 39 32 31 31 31 33 33 26 28 38 38 41 42

Resp Mod/ Severe
 Distress None / Mild

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

Conscious Normal
 Level Altered

GCS * C C C C C C C C C C C C C C C

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
 recorded overleaf

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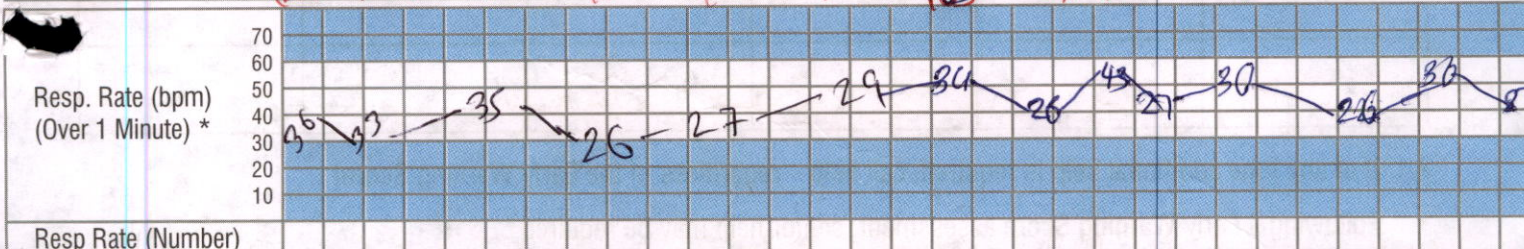
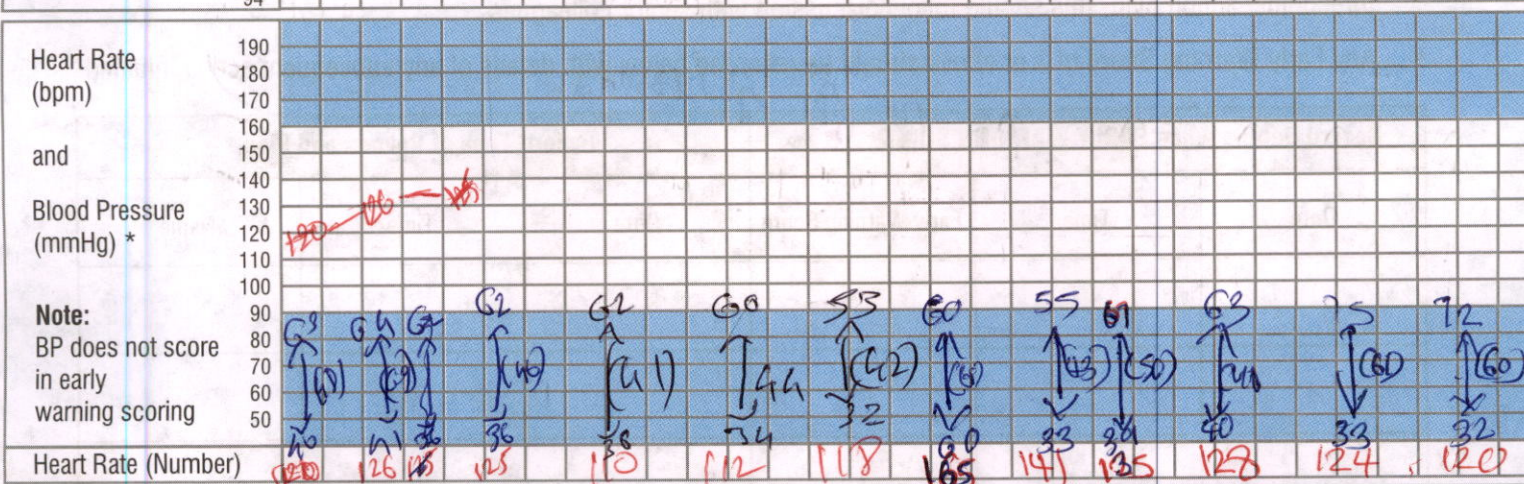
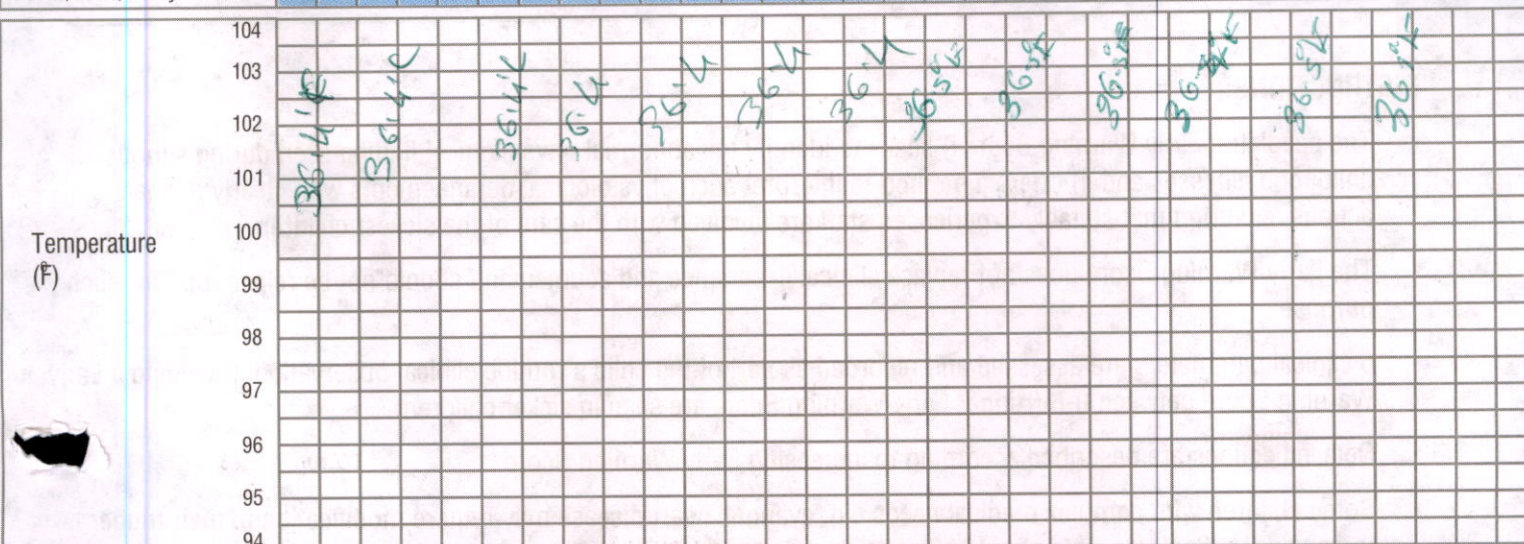
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[illegible][illegible][illegible][illegible]

GCS *	A	A	A	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
-------	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

[illegible]

Pain Score	3	6	9	12	15	18	21	24	27	30	33	36	39	42	45	48	51	54	57	60
------------	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

Observer's Initials	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
---------------------	---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

ACTIONS	Score 1	: Continue normal observation by staff nurse	
	Score 2	: Shift in charge nurse to be informed and continue hourly observations	

NB: Scores 3 should be recorded overleaf	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.
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	Score 5 & 6	: Shift in charge and PICU/NICU fellow or PICU/NICU consultant to be informed

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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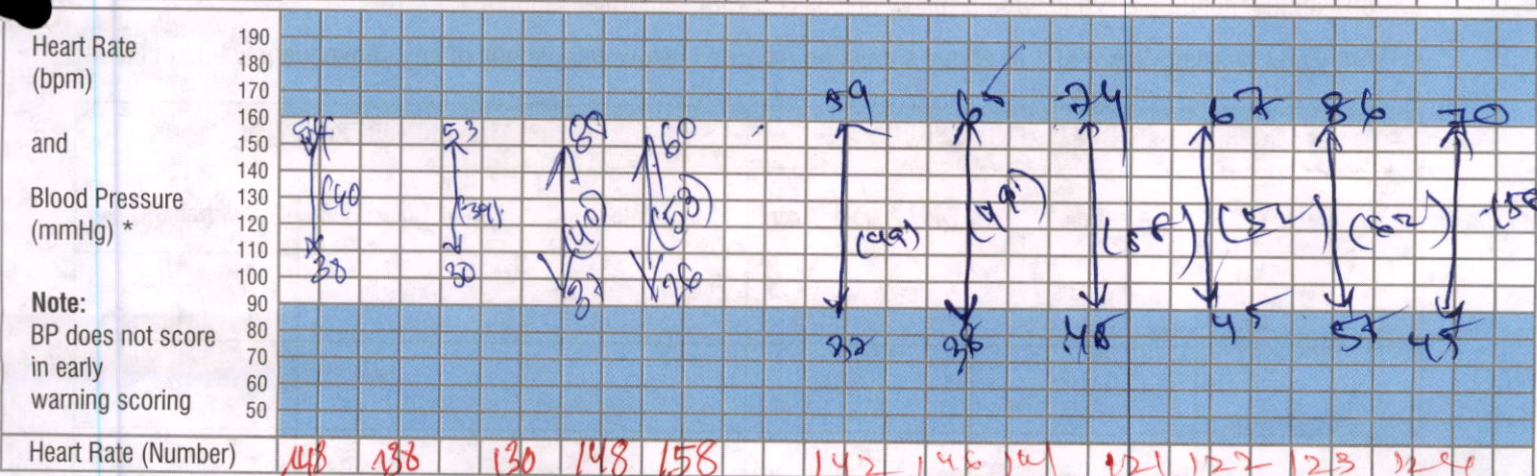
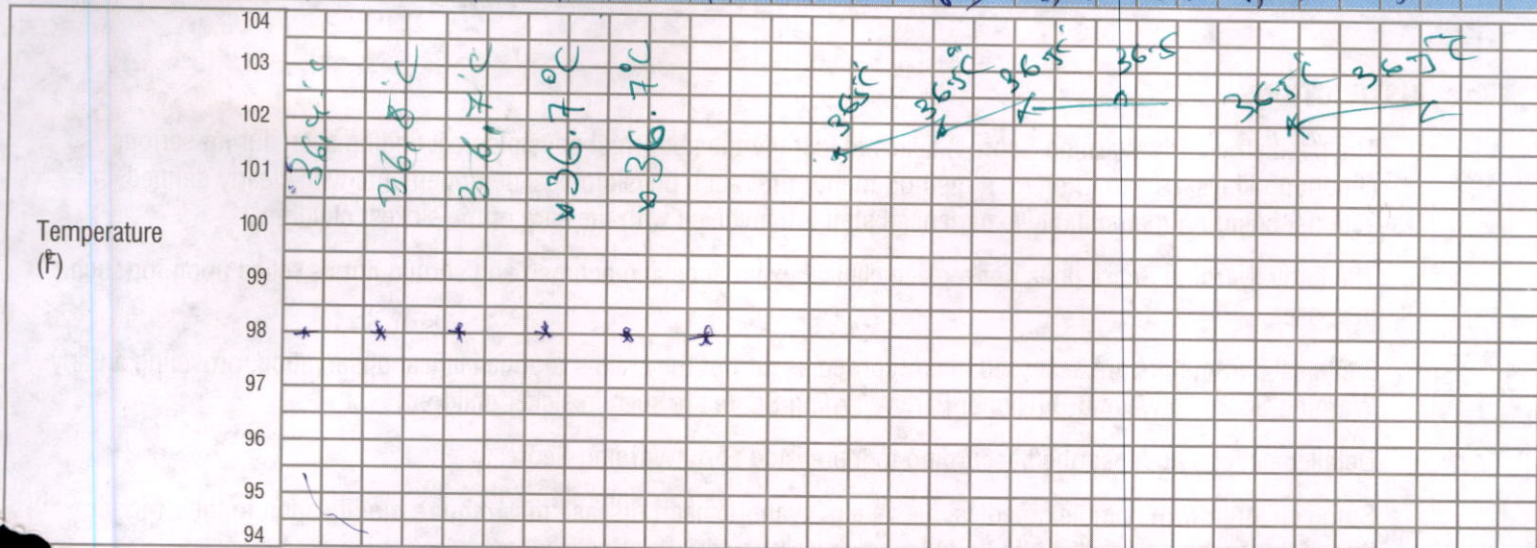
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INFANT (<1 year)
 Children's Observation &
 Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

6/7/26

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



Resp. Rate (bpm) (Over 1 Minute) *	44	32	35	40	45	36	28	42					
Resp Rate (Number)	148	153	158	160	158	142	146	141	121	122	123	124	

Resp Distress	Mod/ Severe	None / Mild											
Receiving O ₂ (l/min)													
O ₂ Saturations (%)	97%	98%	99%	99%	99%	99%	99%	99%	99%	99%	99%	100%	
Conscious Level	Normal	Altered	N	N	N	N	N	N	N	N	N	N	
GCS *													
TOTAL SCORE													
Number of shaded boxes													
Pain Score													
Observer's Initials													

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
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BAH-00660444
Baby Of SARASWATHI
22-08-2026
Dr. VIJAYANAND JAMALPURI
0 Y 0 M 14 D
IP5-00175844
(M)

u.No. : RCHBN/FRM/CLINICAL/127

TEENAGE (12 + years) 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:	8	10	12	2	4	6	8	10	12	2	4	6							
Doctor / Nurse / Family Concern?		am	am	pm	pm	pm	pm	pm	pm	am	am	am	am							
Temperature (°F)	104																			
	103																			
	102																			
	101	36.5	36.5	36.6	36.5	36.5	36.5		36.6	36.5	36.6	36.5	36.5							
	100																			
	99																			
	98																			
	97																			
	96																			
	95																			
	94																			
	Heart Rate (bpm) and Blood Pressure (mmHg) *	190	84	95	53	57	46													
		180																		
170																				
160																				
150																				
140																				
130																				
120																				
110																				
100																				
90																				
80																				
70																				
60																				
50																				
Heart Rate (Number)		162	127	128	171	128	132		142	130	137	127	142	132						
esp. Rate (bpm) (Over 1 Minute)	70																			
	60																			
	50																			
	40																			
	30																			
	20																			
	10																			
	Resp Rate (Number)		39	40	45	47	28													
	Resp Distress																			
	Mod/ Severe None / Mild																			
	Receiving O ₂ (l/min) O ₂ Saturations (%)		92	97	97	94	98	95		94	100	97	95	98	97					
	Conscious Level																			
	Normal Altered																			
GCS *		c	c	c	c	c	c		c	c	c	c	c	c						
TOTAL SCORE		1	1	1	1	1	1		1	1	1	1	1	1						
Number of shaded boxes		1	1	1	1	1	1		1	1	1	1	1	1						
Pain Score		0	0	0	0	0	0		0	0	0	0	0	0						
Observer's Initials		a	a	a	a	a	a		a	a	a	a	a	a						

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
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

8/7/26

Date :	Time:	8	10	12	2	4	6	8	10	12	1	3	5	7	9	11	1	3	5	7	9	11	
Doctor / Nurse / Family Concern?		am	am	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm	
Temperature (F)	104																						
	103																						
	102																						
	101																						
	100	97.5°F	36.5°C	36.6°C	36.5°C	36.4°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C
	99																						
	98																						
	97																						
	96																						
	95																						
94																							
Heart Rate (bpm) and Blood Pressure (mmHg) *	190																						
	180																						
	170																						
	160																						
	150																						
	140																						
	130																						
	120																						
	110																						
	100																						
Note: BP does not score in early warning scoring	90																						
	80																						
	70																						
	60																						
	50																						
	40																						
	30																						
	20																						
	10																						
	0																						
Heart Rate (Number)	136	140	141	139bpm	127bpm	152bpm	151bpm	136bpm	142bpm														
Resp. Rate (bpm) (Over 1 Minute)	70																						
	60																						
	50																						
	40																						
	30																						
	20																						
	10																						
	0																						
	Resp Rate (Number)	38bpm	40bpm	42bpm	32bpm	32bpm																	
	Resp Distress Receiving O ₂ (l/min) O ₂ Saturations (%)	Mod/ Severe None / Mild				N	N	N	N	N	N												
Receiving O ₂ (l/min)																							
O ₂ Saturations (%)		99%	96%	97%	99%	97%	96%	96%	97%	98%													
Conscious Level		C	C	C	N	N	N	N	N	N													
Normal Altered																							
GCS *		15	15	15	15	15	15	15	15	15													
TOTAL SCORE		0	0	0	0	0	0	0	0	0													
Number of shaded boxes		0	0	0	0	0	0	0	0	0													
Pain Score		0	0	0	0	0	0	0	0	0													
Observer's Initials																							
ACTIONS	Score 1	Continue normal observation by staff nurse																					
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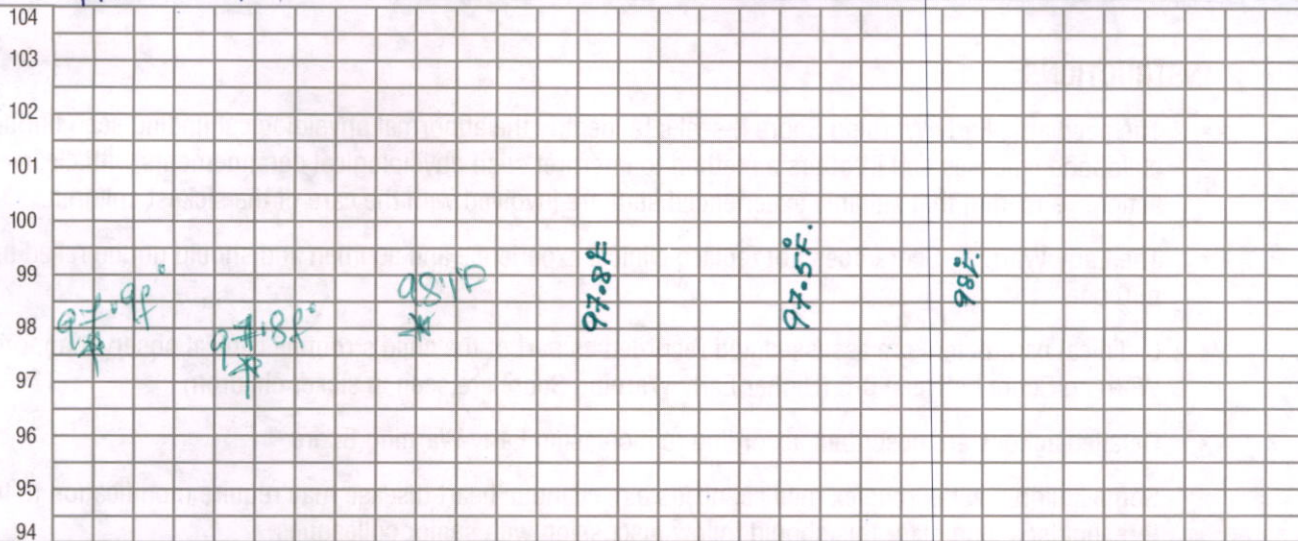


INFANT (<1 year)
 Children's Observation &
 Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 10 9 6 10 2 6
 AM PM PM PM AM AM
 Doctor/Nurse/Family Concern?

Temperature
 (F)

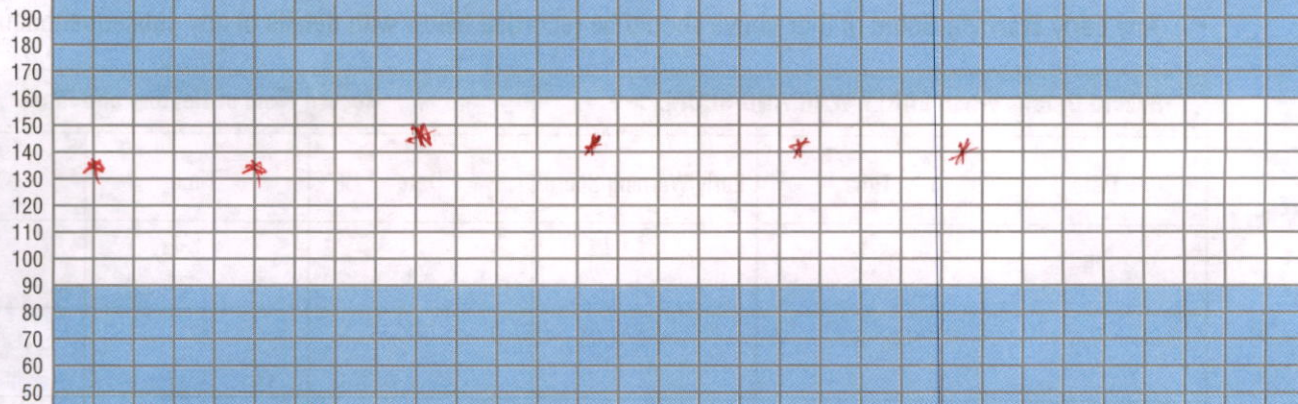


Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

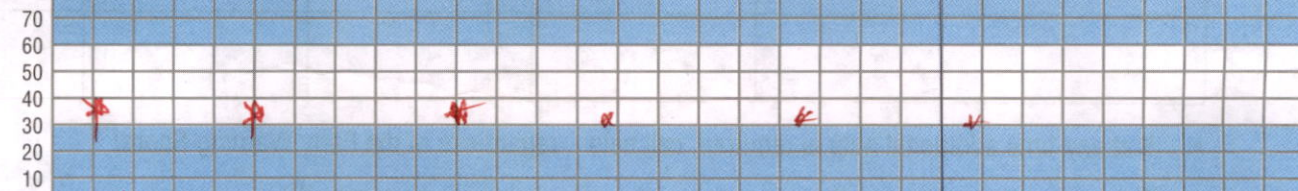
Note:
 BP does not score
 in early
 warning scoring



Heart Rate (Number)

132b/m 134b/m 145b/m 126b/m 122b/m 140b/m

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



Resp Rate (Number)

36b/m 36b/m 38b/m 32b/m 30b/m 32b/m

Resp Mod/ Severe
 Distress None / Mild

N N N N N N

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

99% 99% 100% 97% 97% 98%

Conscious Normal
 Level Altered

N N N N N N

GCS *

15/15 15/15 15/15 15/5 15/5 15/15

TOTAL SCORE

Number of shaded boxes

0 0 0 0 0 0

Pain Score

0 0 0 0 0 0

Observer's Initials

V A A A A A

ACTIONS

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BAH-00660444 IP5-00175844
Baby Of SARASWATHI
22-06-2026 0 Y 0 M 16 D (M)
Dr. VIJAYANAND JAMALPURI



Doc. No. : RCH / FRM / CLINICAL / 124

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:

Doctor/Nurse/Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

190
180
170
160

and

150
140

Blood Pressure
(mmHg) *

130
120
110
100

Note:

BP does not score
in early
warning scoring

90
80
70
60
50

Heart Rate (Number)

Rate (bpm)
(Over 1 Minute) *

70
60
50
40
30
20
10

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
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Date	Time	Early Warning Score	Date	Time	Name

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

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

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



FLUID CHART

Sheet No. : ①

1/7/26

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	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score		
			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		0.3 ml	11.8 ml		passed			10 ml			
	11:00 pm		0.3 ml	11.8 ml								
	12:00 am		0.3 ml	11.8 ml		passed						
	01:00 am		0.3 ml	11.8 ml								
Total Intake : <i>taken</i>					Total Output : <i>m-2 u-10ml</i>							
	02:00 am		0.3 ml	11.8 ml								
	03:00 am		0.3 ml	11.8 ml								
	04:00 am		0.3 ml	11.8 ml								
	05:00 am		0.3 ml	11.8 ml								
	06:00 am		0.3 ml	11.8 ml								
	07:00 am		0.3 ml	11.8 ml		passed			20 ml			
Total Intake : <i>taken</i>					Total Output : <i>m-1 u-20ml</i>							
Total 24 hrs. Intake			<i>taken.</i>			Total 24 hrs. Output			<i>m-3 u-30ml</i>			



FLUID CHART

Sheet No. : 2

TV - 150 cc/kg/day
 B.Wt - 1.9 kg
 TF - 23ml

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	(mc) Route	NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth I.V. O.G								
	08:00 am	N	0.3ml 11.5ml								
	09:00 am	P	0.3ml 11.5ml								
	10:00 am	O	0.3ml 11.5ml					15ml			
	11:00 am		0.3ml 11.5ml								
	12:00 pm		0.3ml 11.5ml								
	01:00 pm	DBM	0.3ml 10ml 3ml	3ml green clear	Passed			10ml			
Total Intake :					Total Output : 2.1 cc/kg/hr						
	02:00 pm		0.3ml 10ml								
	03:00 pm	DBM	0.3ml 10ml 3ml		Passed			12ml			
	04:00 pm		0.3ml 10ml								
	05:00 pm	DBM	0.3ml 10ml 3ml					20ml			
	06:00 pm		0.3ml 10ml								
	07:00 pm	DBM	0.3ml 9ml 15ml		Passed			14ml			
Total Intake :					Total Output : 4.0 cc/kg/day						
	08:00 pm		0.3ml 9ml								
	09:00 pm	DBM	0.3ml 9ml 5ml		Passed			18ml			
	10:00 pm		0.3ml 9ml								
	11:00 pm	Hold	0.3ml 11.5ml Hold					10ml			
	12:00 am		0.3ml 11.5ml								
	01:00 am	DBM	0.3ml 9ml 5ml					20ml			
Total Intake :					Total Output : 4.2 cc/kg/day						
	02:00 am		0.3ml 9ml								
	03:00 am	DBM	0.3ml 9ml 5ml		Not passed			12ml			
	04:00 am		0.3ml 9ml								
	05:00 am	DBM	0.3ml 9ml 5ml					10ml			
	06:00 am		9ml		Not passed						
	07:00 am	DBM	0.3ml 9ml 5ml					14ml			
Total Intake : 236.7 ml					Total Output : 3.1 cc/kg/day (155ml)						

Total 24 hrs. Intake

145 cc/kg/day

Total 24 hrs. Output

3.3 cc/kg/day

08/7/2026

FLUID CHART

TU - 150ml/kg/day
 BW: 1.9 Kg.
 TF - 23ml

Sheet No. : 3

- 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	
			W.C. Mouth	Route	NG	Diarrhoea	Vomit	Drainage	Urine			
				W.C. Mouth	Route							
	08:00 am		0.3ml	8.5ml								
	09:00 am	DBM	0.3ml	8.5ml	6ml				18ml			
	10:00 am		0.3ml	8.5ml								
	11:00 am	DBM	0.3ml	8.5ml	6ml		passed		7ml			
	12:00 pm		0.3ml	8.5ml								
	01:00 pm	DBM	0.3ml	8.5ml	6ml				5ml			
Total Intake :						Total Output : 2.6 ccl/kg/hr						
	02:00 pm		Stop	8.8ml								
	03:00 pm	DBM		8.3ml	7ml				20ml			
	04:00 pm			8.3ml								
	05:00 pm	DBM		8.3ml	7ml							
	06:00 pm			8.3ml								
	07:00 pm	DBM		8.3ml	7ml				18ml			
Total Intake :						Total Output : 3.3 ccl/kg/hr						
	08:00 pm			8.3ml								
	09:00 pm	DBM		7.8ml	8ml							
	10:00 pm			7.8ml					15ml			
	11:00 pm	DBM		7.8ml	8ml		Not passed		20ml			
	12:00 am			7.8ml								
	01:00 am	DBM		7.8ml	8ml				6ml			
Total Intake :						Total Output : 3.5 ccl/kg/day						
	02:00 am			7.8ml								
	03:00 am	DBM		7.3ml	9ml (0.5ml plane)		Not passed		8ml			
	04:00 am			7.3ml								
	05:00 am	DBM		7.3ml	9ml				10ml			
	06:00 am			7.3ml								
	07:00 am	DBM		7.3ml	9ml		Not passed		12ml			
Total Intake : 283.4ml						Total Output : 139ml						
Total 24 hrs. Intake			149 ccl/kg/day			Total 24 hrs. Output			30 ccl/kg/day			



FLUID CHART

Sheet No. : (4)

TV → 150 cc/kg
 B.W → 1.9 kg
 T.F → 24 ml

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	NG						
	08:00 am				Asphat						
	09:00 am	DBM	↑	6.8ml	↑ 10ml		Passed		12 ml		
	10:00 am			6.8ml							
	11:00 am	DBM		6.8ml	↑ 10ml		Passed	Vomit	10 ml		
	12:00 pm			6.8ml							
	01:00 pm	DBM		6.3ml	↑ 11ml		Passed		10 ml		
Total Intake :			64.5ml			Total Output :					
	02:00 pm			6.3ml							
	03:00 pm			6.3ml	HOLD		Passed	Vomit			
	04:00 pm			6.3ml							
	05:00 pm	DBM		5.8ml	↑ 12ml		Passed		10 ml	1	
	06:00 pm			5.8ml							
	07:00 pm	DBM		5.8ml	12ml				6 ml	1	
Total Intake :			60.3ml			Total Output :					
	08:00 pm			5.8ml							
	09:00 pm	DBM		5.8ml	12ml				13ml		
	10:00 pm			5.8ml							
	11:00 pm	DBM		5.3ml	↑ 13ml		Passed				
	12:00 am			5.3ml					12ml		
	01:00 am	DBM		5.3ml	13ml		not passed				
Total Intake :			71.3ml			Total Output :					
	02:00 am			5.3ml							
	03:00 am	DBM		5.3ml	13ml		not passed		14ml		
	04:00 am			5.3ml							
	05:00 am	DBM		4.1ml	↑ 14ml		passed				
	06:00 am			4.1ml					16ml		
	07:00 am	DBM		4.1ml	14ml						
Total Intake :			265.5ml			Total Output :			103ml		
Total 24 hrs. Intake			139.6 cc/kg/day								
Total 24 hrs. Output			2.2 cc/kg/day								

FLUID CHART

Sheet No. : 13

5/7/26.

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.

Date	Time	Nature of Fluid	Intake			NG	Diarrhoea	Vomit	Output		IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G				Drainage	Urine			
	08:00 am			4.8ml							0		
	09:00 am	DBM		9.8ml	18ml					12ml	0		
	10:00 am			4.8ml							0		
	11:00 am	DBM		4.3ml	15ml						0		
	12:00 pm			4.3ml							0		
	01:00 pm	DBM		4.3ml						10ml	0		
Total Intake :						Total Output :						2.0cc/kg/hr	
	02:00 pm			4.1							0		
	03:00 pm	DBM		4.1	15ml					18ml	0		
	04:00 pm			4.4							0		
	05:00 pm	DBM		3.8	16ml						0		
	06:00 pm			3.8						12ml	0		
	07:00 pm	DBM		3.8	16ml						0		
Total Intake :						Total Output :						2.8cc/kg	
	08:00 pm										0		
	09:00 pm	DBM		3.8	16ml					18ml	0		
	10:00 pm			3.8ml							0		
	11:00 pm	DBM		3.3ml	12ml						0		
	12:00 am			3.3ml							0		
	01:00 am	DBM		3.3ml	12ml						0		
Total Intake :						Total Output :						2.7cc/kg	
	02:00 am			3.3ml	18ml						0		
	03:00 am	DBM		3.3ml	17ml						0		
	04:00 am			3.3ml							0		
	05:00 am	DBM		3.0ml	18ml					22ml	0		
	06:00 am			3.0ml							0		
	07:00 am	DBM		3.0ml	18ml						0		
Total Intake : 250.4						Total Output : 87.4						0.20cc/kg/day (92)	
Total 24 hrs. Intake			8.1 cc/kg/hr			Total 24 hrs. Output			2.1 cc/kg/hr				

FLUID CHART

Sheet No. : 6

6/7/20

TV = 1500 cc
 B.Wt = 1.9 kg.
 P.F = 24 ml

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										
	09:00 am	DBM		3.3	18ml		Not Passed		7ml		
	10:00 am			3.3							
	11:00 am	DBM		3.3	18ml		Passed		10ml		
	12:00 pm			3.3							
	01:00 pm	DBM		2.0	19ml		Not Pass		8ml		
Total Intake :			89.2ml			Total Output :					
	02:00 pm			2.0							
	03:00 pm	DBM		2.0	19ml		Not Passed		10ml		
	04:00 pm			2.8							
	05:00 pm	DBM		1.8	20ml		Passed		10ml		
	06:00 pm			1.8							
	07:00 pm	DBM		1.8	20ml		Not Pass		8ml		
Total Intake :			89.6ml			Total Output :					
	08:00 pm			1.8ml							
	09:00 pm	DBM		1.8ml	20ml		Not Passed		21ml		
	10:00 pm			1.8ml							
	11:00 pm	DBM		1.3ml	21ml						
	12:00 am			1.3ml					11ml		
	01:00 am	DBM		1.3ml	21ml		Not Pass				
Total Intake :			68.5ml			Total Output :					
	02:00 am			1.3ml							
	03:00 am	DBM		1.3ml	21ml		Not Passed		16ml		
	04:00 am			1.3ml							
	05:00 am	DBM		0.8ml	22ml						
	06:00 am			0.8ml					15ml		
	07:00 am	DBM		0.8ml	22ml		Not Pass				
Total Intake :			71.3ml			Total Output :			116ml		
Total 24 hrs. Intake			146.6cc			Total 24 hrs. Output			2.5cc		

2/8/26

FLUID CHART

Sheet No. 2

TV = 150 cc/kg/day
 BW = 1.9 kg
 PEF = 24 ml

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	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	Route	Other	NG	Diarrhoea	Vomit	Drainage	Urine		
				I.V	O.G							
	08:00 am			0.8ml								
	09:00 am	DBM		Stop	24ml		Passed			13ml		
	10:00 am											
	11:00 am	DBM		24ml								
	12:00 pm											
	01:00 pm	DBM		24ml						25ml		
Total Intake :						Total Output : 3.3 cc/kg/hr						
	02:00 pm											
	03:00 pm	DBM		24ml			Passed			15ml		
	04:00 pm											
	05:00 pm	DBM		24ml						9ml		
	06:00 pm											
	07:00 pm	DBM		24ml			Passed			10ml		
Total Intake :						Total Output : 2.9 cc/kg/hr						
	08:00 pm											
	09:00 pm	DBM		24ml			passed 8 to 10 ml			-		
	10:00 pm											
	11:00 pm	DBM		24ml			passed			9ml.		
	12:00 am											
	01:00 am	DBM		24ml			passed			7ml.		
Total Intake :						Total Output :						
	02:00 am											
	03:00 am	DBM		24ml			passed			-		
	04:00 am											
	05:00 am	DBM		24ml			passed			-		
	06:00 am											
	07:00 am	DBM		24ml			passed			7ml		
Total Intake : 288.8 ml						Total Output : 95ml						

Total 24 hrs. Intake

152 cc/kg/day

Total 24 hrs. Output

20 cc/kg/day



FLUID CHART

Sheet No. : 8/7/26 @ 8

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							
8/7	08:00 am											
	09:00 am	DBM	24ml				passed			6ml	Na	
	10:00 am										n	
	11:00 am	DBM	24ml				passed			7ml	0	
	12:00 pm										0	Alphayn
	01:00 pm	DBM	24ml								0	
Total Intake :			Taken			Total Output : $\sqrt{=}$ 13 ml						
8/7	02:00 pm											
	03:00 pm	DBM	24ml				passed			10ml	1	Group Amplified Phy Phy Phy
	04:00 pm										0	
	05:00 pm	DBM	24ml								0	
	06:00 pm										0	
	07:00 pm	DBM	24ml				Passed			10ml	0	
Total Intake :			Taken			Total Output : $\sqrt{=}$ 20 ml						
8/7	08:00 pm										0	
	09:00 pm	FF	24ml				passed			10ml	0	suckling
	10:00 pm										0	
	11:00 pm	FF	24ml								0	
	12:00 am										0	
	01:00 am	FF	24ml				✓				0	
Total Intake :			Taken			Total Output : m - 2 u - 2						
8/7	02:00 am										0	suckling
	03:00 am						✓				0	
	04:00 am	FF	24ml								0	
	05:00 am										0	
	06:00 am	FF	24ml				✓				0	
	07:00 am										0	suckling
Total Intake :			Taken			Total Output : m - 2 u - 1						
Total 24 hrs. Intake		Taken			Total 24 hrs. Output		m - 8 u - 7					



FLUID CHART

Sheet No. :

9/7

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

		Intake			Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G						
9/7/26	08:00 am									0	Dey
	09:00 am	FF 30ml				✓			✓	0	
	10:00 am									0	
	11:00 am	FF 30ml				✓			✓	0	
	12:00 pm									0	
	01:00 pm	FF 30ml				✓			✓	0	
Total Intake : Taken					Total Output : M-3 U-3						
9/7/26	02:00 pm									0	Pige
	03:00 pm	FF 30ml				✓			✓	0	
	04:00 pm									0	
	05:00 pm	FF 30ml								0	
	06:00 pm									0	
	07:00 pm	FF 30ml				✓			✓	0	
Total Intake : Taken					Total Output : V-2 m-2						
9/7/26	08:00 pm									0	Sankar
	09:00 pm	FF 30ml								0	
	10:00 pm					✓			✓	0	
	11:00 pm	FF 30ml								0	
	12:00 am									0	
	01:00 am	FF 30ml				✓			✓	0	
Total Intake : Taken					Total Output : U-2 m-2						
9/7/26	02:00 am									0	Sankar
	03:00 am	FF 30ml								0	
	04:00 am					✓			✓	0	
	05:00 am	FF 30ml								0	
	06:00 am									0	
	07:00 am	FF 30ml								0	
Total Intake : Taken					Total Output : U-1 m-1						
Total 24 hrs. Intake		Taken			Total 24 hrs. Output		U-8 m-8				

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.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	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							



①

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: Baby is on CPAP

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	→ To Assess the Baby's general condition	8pm	→ Assessed the Baby's general condition	* Baby is Stable and maintaining
10pm	→ To Maintain Airway & Oxygenation	10pm	→ Maintained Airway & Oxygenation	
12pm	→ To Maintain Personal Hygiene	12am	→ Maintained Personal Hygiene	
2am	→ To Maintain Fluid Balance	2am	→ Maintained Fluid Balance	
4am	→ To Maintain Nutritional Status	4am	→ Maintained Nutritional Status	
6am	→ To Administer the medication as per the drug chart	6am	→ Administered the drugs as per the drug chart	

Re-Assessment: Done

Special Notes: RBS-BD NP Sent

Nurse Signature: Z. Bony

Nurse Name: Z. Bony

Date & Time: 4/7/26 @ 8am

BAH-00660444 IPS-00175844
 Baby Of SARASWATHI
 22-06-2026 0 Y 0 M 12 D (M)
 Dr. VIJAYANAND JAMALPURI

2

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: 04/06/26

Assessment: Patient is on RIA

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 patient Condition	8am	pt. Condition assessed	Now pt was good.
10am	provide comfortable position.	10am	comfortable position provided.	
12pm	Maintain vital signs	12pm	vital signs maintained	
2pm	Given medications as per as doctor prescription	2pm	Givened Medications as per as doctor prescription	

Re-Assessment:

Special Notes: CBP & SBR TIM

Nurse Signature: 

Nurse Name: Akansha

Date & Time: 04/06/26 @ 2pm

BAH-00660444 IP5-00175844
 Baby Of SARASWATHI
 22-06-2026 0 Y 0 M 9 D (M)
 Dr. VIJAYANAND JAMALPURI



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: 2/7/26

Assessment: Baby is on R/O

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the baby general condition	8 pm	Assessal the baby general condition	
10pm	Monitor vitals	10pm	Monitored vitals	* Baby is maintain BP
12am	LRBS Transfusion plan	12am	multiple transfusion done	
2am	To give comfort table position	2am	To give position	
4am	To give medication			
6am	exchange Transfusion done	4am	To give medication	

Re-Assessment: assess the baby general condition, start LRBS Transfusion done, phototherapy on

Special Notes: RBS on

Nurse Signature: [Signature]

Nurse Name: Alphonse

Date & Time: 2/7/26



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 31/7/26

Assessment: Discolorations / vomittings / Aspirations / seps

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
8am	→ to monitor the vitals	8am	→ monitored the vitals	Baby is stable on
10am	→ to provide feeds	10am	→ provided feeds 2ndry	
12pm	→ to plan TV	12pm	→ TV - 150 c/kg 1dy	
2pm	→ to plan ↑ feeds	2pm	→ ↑ feeds 1ml 6thry	
4pm	→ to provide cluster care	4pm	→ provided cluster care	
6pm	→ to plan Remove urc	6pm	→ removed urc by Dr. Anush	
8pm	→ to give medications → to maintain Ib chart	8pm	→ medication given as per doctor order → maintaining Ib chart 6thry	

Re-Assessment: Re-assess done

Special Notes: wash for discolorations / Bradycardia
RBS - DD / TV - 150 c/kg 1dy / continue seps / 10m - NP, / ↑ 1ml feed 6thry / If culture Negative shift to 4m N3

Nurse Signature:

Nurse Name: Hemalatha

Date & Time: 31/7/26 @ 8pm



2

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/2/26

Assessment: Baby is on R/A

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 baby condition	2pm	Assessed the baby condition	Baby is now stable
4pm	Maintain vital signs	4pm	Maintained vital signs	
6pm	Give medication as per doctor order	6pm	Given medications per doctor order.	
8pm	Provide comfortable position.	8pm	Provided comfortable position as per doctor order.	

Re-Assessment:

Special Notes: CBP & SBR T/m

Nurse Signature:

Nurse Name: Ajay

Date & Time: 4/2/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26

Assessment: Baby is on Rb

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	→ To Assess the Baby's condition	8pm	→ Assessed the Baby's condition	Baby is stable and maintaining
10pm	→ To Monitor vitals hourly	10pm	→ Monitored vitals hourly	
12pm	→ To Maintain Dto chart	12pm	→ Maintained Dto chart	
4am	→ To Give feeds 2nd hourly	4am	→ Feeds given 2nd hourly	
6am	→ To Administer the medication as per the chart-	6am	→ Administered the medication as per the drug chart	

Re-Assessment: Done

Special Notes: RBS - BD

Nurse Signature: Rushintha Nurse Name: Sh Date & Time: 5/7/26 @ 8am

BAH-00660444 IP5-00175844
Baby Of SARASWATHI
22-06-2026 0 Y 0 M 12 D (M)
Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

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

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Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Baby is on O.R.

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
	→ Assess the baby condition → maintain vitals → maintain I/O chart → give to not feed 2 hour → to Administer the medication per the doctor order		→ Assess the baby condition → maintain vitals → maintain I/O chart → feed given 2nd hour → administered the medication given to the baby	Baby is stable and maintaining

Re-Assessment: Re-assessment done

Special Notes: C.M.F. Admined

Nurse Signature: [Signature]

Nurse Name: Abhinav

Date & Time: 6/7/2026 8 AM

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby 1 on room 612

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 am	To assess the general condition of the baby	8 am	Assessed the general condition of baby.	All plans are implemented
10 pm	To check vitals of baby	10 pm	checked vitals of baby	
12 pm	To give NG 2nd hly	12 pm	NG feed given 2nd hly.	
4 pm	To Administer medication as per doctor's order	4 pm	Administered medication as per doctor's order.	
7 pm	To give comfortable position	7 pm	given comfortable position	

Re-Assessment: Done

Special Notes: N/A

Nurse Signature: [Signature]

Nurse Name: Matthew T. J

Date & Time: 5/7/26 pm

9

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

Assessment: Baby is on R/A

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
8A~	Assess the baby of general condition to the Bab	8A~	Assess the general condition to the Baby	Baby is Stable
10A~	Monitored vitals to the Babu	10A~	Monitored vitals	
12p~	Give feeding 2nd hour to the 20m	12p~	Given feeding 2nd hour to the 2m	
2p~	Administer medicine as per Doctor an	2p~	Administer medical as per Doctor an	

Re-Assessment: Re-Assessment

Special Notes: RBS-00

Nurse Signature: 

Nurse Name: Megha

Date & Time: 6/7/26 @ 8



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/12/26

Assessment: Body, Respiration, Feeding, Intake

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 pm	→ Assess to the baby condition.	8 pm	→ Assess to the baby condition.	→ Baby on room
10 pm	→ Monitor vital sign resp.	10 pm	→ Monitor vital sign resp.	→ Air monitoring
12 am	→ Maintained I/O chart	12 am	→ Maintained I/O chart	→ well no breath.
2 am	→ 2nd hourly on feed.	2 am	→ 2nd hourly feeds give.	→ Respi.
4 am	→ 1st utb hourly	4 am	→ Medication given as per	→ Baby is stable
6 am	Medication	6 am	doctor's order.	bow.
8 am	→ position	8 am	→ provided comfortable	→ Baby one time
	→ suction		position.	→ vomit infrom
	→ CBP, CRP, SBR PM		→ CBP, CRP, SBR send.	to dr.
	→ RVS (OI)		→ RIS COD en.	

Re-Assessment:

Special Notes: CBP, CRP, SBR send.

* 1 episode vomit infrom to dr.

Nurse Signature: [Signature]

Nurse Name: Sumita

Date & Time: 6/12/26



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 7/7/26

Assessment: pt / sepsis / disorientation / vomiting / tachycardia

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	→ to monitor the vitals	8am	→ monitored the vitals	Baby is stable on <u>AB</u>
10am	→ to plan TV	10am	→ TV - 150 c/kg ldy	
12pm	→ to provide feeds	12pm	→ provided feeds early sum	
2pm	→ to plan crib care	2pm	→ crib care done	
4pm	→ to provide position	4pm	→ provided comfortable position	
6pm	→ to plan give medication	6pm	→ medication given as per doctors orders	
8pm	→ to maintain I/O chart	8pm	→ maintaining I/O chart	

Re-Assessment: AC Assessment Done

Special Notes: wash for disorientation, bradycardia
ROS - AD / TV - 150 c/kg ldy / crib care done / started pallada feeds

Nurse Signature: [Signature]

Nurse Name: Hemalatha

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



Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26 @ 8pm.

Assessment: Baby is on crib 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 Baby's general condition	8:10 pm	Assessed Baby's condition stable.	Baby on crib care.
10pm	Ensure safety.	10:10 pm	Provided crib care.	
12am	monitor vitals.	12:10 am	monitored vitals & documented	
2am	Prevent infection.	2:10 am	Followed infection control protocols.	
4am	maintain good nutritional status.	4:10 am	Baby is on 24ml DBM parada feed.	
6am	Shift to Room tomorrow.	6:10 am	planned & informed about shifting.	
8am	GRBS OD.	8:10 am	GRBS OD to be.	

Re-Assessment: - NA -

Special Notes: Shift to Room

Nurse Signature: Sushantri

Nurse Name: Sushantri

Date & Time: 7/7/26 @ 8am.

BAH-00660444 IP5-00175844
 Baby Of SARASWATHI
 22-06-2026 0 Y 0 M 16 D (M)
 Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

Rainbow
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It takes a lot to treat the little.

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Your Right to a Safe Delivery

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 20/6/2026

Assessment: Baby 9S on RIA

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the baby general condition	8am	Assessed the baby general condition	
10am	Monitor vitals	10am	Monitored vitals	* Baby 9S on
12pm	Maintain I/O chart	12pm	Maintained I/O chart	Stable BP. 110/70
2pm	Feed given and hourly	2pm	Feed given and hourly	
6pm	to give medication	6pm	to give medication	

Re-Assessment: Re - Assessment Done

Special Notes: RBS ON SBT - 1st Morning

Nurse Signature: [Signature]

Nurse Name: Alphonsa

Date & Time: 20/6/2026 2:30 PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/8/26 @ 12am

Assessment: Baby on SSPT

Goals

- ☐ Maintain Airway and Oxygenation
☐ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify.....

- ☐ Maintain Fluid Balance
☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
☒ Ensure Safety

- ☒ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess Baby's general condition.	8:10 pm	Baby is active, feeding well.	Baby is stable.
10 pm	Ensure safety.	10:10 pm	Provided cribcare.	
12 am	Prevent infection	12:10 am	Followed infection control protocols.	
2am	maintain good nutrition.	2:10 am	EBM + FF 24ml. feeding assessment.	
4am	monitor vitals.	4:10 am	monitored vitals.	
8am	patient family education.	8:10 am	educated patient about hospital procedure	

Re-Assessment: NA.

Special Notes: SBR - T/m, T/acc, Antibiotic stop - 2pm.

Nurse Signature: SW

Nurse Name: Sushaneta

Date & Time: 9/2/26 @ 8am.

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/7

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
8AM	* Assess the general condition of baby.	8:10AM	* Assessed the baby condition.	Baby is stable now
10AM	* Monitor vital signs	10:15AM	* vitals checked & recorded	
12PM	* Administer the medication till 4PM.	12:10PM	* I/O chart maintained	
	* for and hly to burping well.		* Administered the medications -	
2PM	* Ensure safety.	2PM	* and hly feeding given.	

Re-Assessment:

Baby is well doing.

Special Notes:

IV antibiotics till 4PM dose.

Nurse Signature: *[Signature]*

Nurse Name: *[Signature]*

Date & Time: 9/7 @ 2PM

NURSING CARE RECORD

Shift: ☐ Morning

☐ Night

Date: 9/17/26 02PM

Assessment: Baby is on room air

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 check vital signs.	2:10PM	→ assessed the general condition of the baby and checked vital signs.	Baby is stable
3PM	→ Continue medication as advised.	3:10PM	→ continued medication as advised.	
4PM	→ Giving feeding and nappy and burping.	4:10PM	→ Given feeding and nappy and	
5PM	→ Giving room air.	5:10PM	→ Given room air.	
6PM	→ checking urine output.	6:10PM	→ checked urine output.	
7PM	→ Ensure safety.	7:10PM	→ ensured safety.	

Re-Assessment: Baby under observation

Special Notes: Trace lab reports

Nurse Signature: Piyu

Nurse Name: Piyu

Date & Time: 9/17/26 05PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26 @ 8pm

Assessment: Baby is on Room Air.

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 Baby's general condition.	8:10 pm -	Assessed Baby's general condition.	Baby is stable.
10pm -	Ensure safety.	10:10 pm -	Provided crib care.	
12am -	Prevent infection.	12:10 am -	Followed infection control protocols.	
2am -	GRBS OD. to be.	2:10 am -	GRBS - OD planned.	
4am -	Daily weight monitoring.	4:10 am -	Documented daily weight.	
6am -	Plan D/C tomorrow	6:10 am -	Affect Fluconazole due. etc.	
8am -	Maintain good nutritional status.	8:10 am -	Feed assessment formula feed.	

Re-Assessment: NE

Special Notes: R/V - vaccination.

Nurse Signature: *[Signature]*

Nurse Name:

Date & Time: 10/7/26 @ 8am.

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

BAH-00660444
Baby Of SARASWATHI
22-06-2026 0 Y 0 M 16 D (M)
Dr. VIJAYANAND JAMALPURI

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr vijayanand Department: 3rd Floor (NICU) Date of Admission: 22/6/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known				
	PT, NNTJ, feeding Intolerance.		If Yes Specify: <u>NA</u>				
BACKGROUND	Area	Shift Time	3rd Floor 11pm-8pm	3rd Floor 8am-2pm	3rd Floor 2pm-8pm	3rd Floor 8pm-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	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.1	98.18°	98.10F	98.1F	
		Res:	32	34b/m	38b/m	32b/m	
		SpO ₂ :	100	99%	100%	99%	
		Pulse:	138	132b/m	140b/m	132b/m	
		BP:	-	-	-	-	
	Fall Risk Score:	16	16	16	16		
Pain Score:	0/10	0/10	0/10	0/10			
Recommendations	Safety Needs:	crib on	crib care	crib care	crib care		
	Physiotherapy	☐ 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	
	Other Special Orders / Medications:	sera	NA	NA	NA		
Post Operative Procedure Special Orders:		NA	NA	NA	NA		
Handed Over By Name :		Sushant	Ranj	Rij	Sushanta		
Signature :		S	Ranj	Rij	S		
Date:		9/7/26	9/7	9/7/26	10/7/26		
Time:		@ 8am	@ 8pm	8pm	@ 8am		
Taken Over By Name :		Ranjya	Rij	Sushanta			
Signature :		Ranjya	Rij	S			
Date:		9/7	9/7/26	9/7/26			
Time:		@ 8am	8pm	@ 8pm			

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-00660444 IP5-00175844
 Baby Of SARASWATHI
 22-06-2026 0 Y 0 M 9 D (M)
 Dr. VIJAYANAND JAMALPURI



NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	Date	
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time	Time	
						21/6/26	21/6/26	30/6/26	30/6/26	4/7/26	4/7/26	5/7/26	5/7/26	21/7/26	
						4PM	6am	11AM	8am	2PM	6am	8am	6am		
						Leads	Samles	RBS	Camel	RBS	RBS	RBS	RBS	Scare	
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	1	1	1	1	1	1	1	1	+1	
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)	1	1	1	1	1	1	1	1	0	
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	1	1	1	1	1	1	1	1	1	
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	1	1	1	1	1	1	1	1	+1	
Vital Signs HR, RR, BP, SaO ₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0	0	0	0	0	+1	
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 33 weeks +1 +1 +1 +1 +1 +1 +1 +1		Total Pain / Agitation Score 2/10 +5/10 +5/10 +5/10 +5/10 +5/10 +5/10 +5/10 +5/10		Intervention CBM CBM CBM CBM CBM CBM CBM CBM CBM		Effectiveness good good good good good good good good good		Signature [Signatures]	

NPASS: Neonatal Pain, Agitation & Sedation Scale

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

BAH-00660444

IP5-00175844

Baby Of SARASWATHI

22-06-2026 0 Y 0 M 12 D

(M)

Dr. VIJAYANAND JAMALPURI



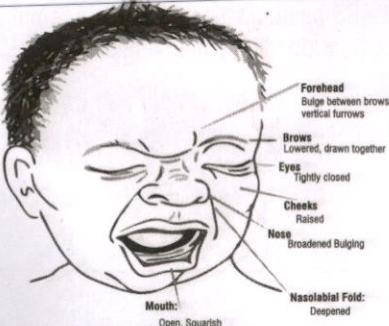
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

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	
						7/7/26	7/7/26	8/8/26	8/8/26	9/9/26	9/9/26			
						2:10pm	2:10pm	10am	10pm	2PM	10pm			
						Procedure	Dipe	RBS	RBS	RBS	NA	NA		
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	1	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	1	1	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	+1	+1	+1	+1	-	-		
						Total Pain / Agitation Score	+0/10	0/10	0/10	0/10	0/10	0/10		
						Intervention	BBM	DBM	DBM	BBM	-	FE		
						Effectiveness	good	good	good	good	-	-		
						Signature	Ang	Sush	Ang	Ang	Piy	Sush		

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.
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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
	Procedure →												
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable								
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						Total Pain / Agitation Score							
						Intervention							
						Effectiveness							
						Signature							

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THE HUMPTY DUMPTY SCALE

2/7/26 2/7/26 3/7/26 3/7/26

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	2	2			
	Other Diagnosis	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			2	2	2
	Outpatient Area	1	1	1			
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	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	1	1	1	1	1
TOTAL			14	14	15	15	15

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	X	X	X	X
Other Intervention(s) Specify	No	X	X	X	X
Nurse's Name :	apna	Hemang	K. B. B. Hemang	K. B. B. Hemang	K. B. B. Hemang
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	2/6/26	2/7/26	2/7/26	3/7/26	3/7/26
Time :	8pm	2pm	4pm	4pm	4pm

BAH-00660444 IP5-00175844

Baby Of SARASWATHI

22-06-2026

O Y O M 9 D

(M)

Dr. VIJAYANAND JAMALPURI



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THE HUMPTY DUMPTY SCALE

4/7/26 5/9/26 6/12/26 7/17/26

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					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	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	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	1	1	1	1	1
TOTAL			11	11	11	11	11

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		x	x	x	x	x
Other Intervention(s) Specify		x	x	x	x	x
Nurse's Name :		M	A	R	A	H
Signature :		A	A	A	A	A
Date :		4/7/26	5/9/26	6/12/26	7/17/26	7/17/26
Time :		5:00pm	5:00pm	5:00pm	5:00pm	5:00pm

BAH-00660444 IP5-00175844
 Baby Of SARASWATHI
 22-06-2026 0 Y 0 M 16 D (M)
 Dr. VIJAYANAND JAMALPURI

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	7/7	8/7	8/7	9/7	9/7
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3				4	
	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					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	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	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					1
	Other Medications / None	1	1	1	1	1	1
TOTAL			11	11	11	11	11

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	✓	Yes	✓	Yes	Yes
Call device within reach	✓	Yes	✓	Yes	Yes
Wheels Locked	✓	Yes	✓	Yes	Yes
Room free of clutter	✓	Yes	✓	Yes	Yes
Adequate Lighting	✓	Yes	✓	Yes	Yes
Wheel Chair Support	X	No	X	NA	NA
Other Intervention(s) Specify	X	No	X	NA	NA
Nurse's Name :	Sushant	Sushant	Sushant	Sushant	Sushant
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	7/7/26	8/7/26	8/7	9/7	9/7
Time :	@ 10pm	8AM	@ 10pm	2PM	@ 10pm

BAH-00660444 IP5-00175844
 Baby Of SARASWATHI (M)
 22-06-2026 0 Y 0 M 18 D
 Dr. VIJAYANAND JAMALPURI

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THE HUMPTY DUMPTY SCALE

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

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High Risk Humpty Dumpty Score = 12 or above

Bed in low position							
Call device within reach							
Wheels Locked							
Room free of clutter							
Adequate Lighting							
Wheel Chair Support							
Other Intervention(s) Specify							
Nurse's Name :							
Signature :							
Date :							
Time :							

BAH-00660444

IP5-00175844

Baby Of SARASWATHI

22-06-2026 0 Y 0 M 9 D

(M)

Dr. VIJAYANAND JAMALPURI



BRADEN 'Q' SCALE

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It takes a lot to treat the little.

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					Date :	27/12/26	31/12/26	4/1/27
					Time :	@ 10 AM	@ 9 AM	@ 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	2	2	2
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	1	1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2	2	2
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	1	3	3	3
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2	2	2	2
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	3	2	2	2
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.	3	4	4	4
TOTAL SCORE					10	16	16	16
Evaluator's Name					Dr. Vijayanand	Vijayanand	Vijayanand	Vijayanand

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

Docu. No. : RCHBH / FRM / CLINICAL / 119

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
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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

Patient ID

BRADEN 'Q' SCALE

					Date : 5/12/26	Time : 8:00 AM	6/12/26	Time : 8:00 AM	6/12/26	Time : 8:00 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 e:tremitry position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	2	2	2	2	2
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1	1	1	1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2	2	2	2	2
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3	3	3	3	3	3
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2	2	2	2	2	2
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	2	2	2	2	2	2
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	4	4
TOTAL SCORE					16	16	16	16	16	16
Evaluator's Name					5	5	5	5	5	5

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
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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

BAH-00660444 IP5-00175844
 Baby Of SARASWATHI
 22-06-2026 0 Y 0 M 14 D (M)
 Dr. VIJAYANAND JAMALPURI



BRADEN 'Q' SCALE

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

BirthRight
 BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	7/7/26	8/7/26	8/7
					Time :	2:00 PM	2:58 PM	10 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	2	2	2
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1	1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2	2	2
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3	3	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	3	3
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Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	19	19	19
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Harish	Seetha	Seetha

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BAH-00660444

IP5-00175844

Baby Of SARASWATHI

22-06-2026

0 Y 0 M 16 D

(M)

Dr. VIJAYANAND JAMALPURI



BRADEN 'Q' SCALE

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	9/7	9/7	9/7	
					Time :	8:45 AM	9:15 AM	10 PM	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	2	2		
"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	1	1		
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Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	19	19	19	
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Red	Pigs	Sad	

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BRADEN 'Q' SCALE

					Date :				
					Time :				
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					TOTAL SCORE				
					Evaluator's Name				

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

Docu. No. : RCHBH /FRM / CLINICAL / 119

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-	-	-	
Signature of the Nurse				Homa	Homa	Homa	Homa	Homa	Homa	Homa	Homa	Homa	

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Saunya Name : Saunya

Docu. No. : RCHBH /FRM / CLINICAL / 137

Signature of Ward In Charge :

Signature : Shivabeela Name : Shivabeela



CHECKLIST FOR THROMBOPHLEBITIS

5/7/26 6/2/20

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0	0	0		
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-	-	-	-		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-	-	-		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-	-	-		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-	-	-		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-	-	-		
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Silpa Name : Sis. Silpa

Signature of Ward In Charge :

Signature : Shivalika Name : Sis. Shivalika



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0		0	0	0	0				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	1	-	-	-					Cannula Swelling changed Cannula
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-				
Signature of the Nurse				<i>Alphon</i> <i>hij</i> <i>Subh</i> <i>Subh</i> <i>hij</i> <i>Subh</i>									

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personnel ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 1/7/26		Diagnosis : SEPALS		Surgery / Procedures : nil		
		Allergies : nil		Post OP Day : nil				
INVASIVE	Date :	1/7/26	2/7/26	2/7/26	3/7/26	3/7/26	4/7/26	
	Area	N4	N4	N4	N4	N4	N4	
	Shift Time	8pm-8am	8am-8pm	8pm-8am	8am-8pm	8pm-8am	8am-2pm	
	Diet :	EBM	DBM	DBM	DBM	DBM	DBM	
	Ventilation (RA, NP, NIV, VENTI)	R/A	R/A	R/A	R/A	R/A	RA	
	1.		OU-①	OU-①	OU-①	OU-①	OU-①	
	2.		UVC-①	UVC-①	UVC-①	UVC-①	IV-①	
ASSESSMENT	3.		IV-②	IV-①				
	4.							
	Infusions / Transfusions	HepNs Isop	HepNs 10% D50P	HepNs 10% D50P	HepNs 10% D50P JEC93	HepNs 10% D50P + Galkidat		
	PU Prophylaxis	NA	NA	NA	NA	NA	NA	
	DVT Prophylaxis	NA	NA	NA	NA	NA	NA	
	Vitals	BP	56/36(43)	54/36(42)	51/30(34)	53/33(40)	53/34(48)	54/37(42)
		PR	141b/m	168b/m	132b/m	131b/m	124b/m	124b/m
		RR	35b/m	38b/m	36b/m	49b/m	44b/m	30b/m
		SpO ₂	100%	95%	100%	99%	99%	94%
		Temp	36.5°C	36.5°C	36.5°C	36.5°C	36.0°C	36.5°C
	Pain Score	2/10	+5/10	+3/10	+3/10	+2/10	+2/10	
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert	Alert	Alert	
	Skin Integrity (Intact / Bedsores / Any other condition)	Intact	Intact	Intact	Intact	Intact	Intact	
	Restraints If any	Physical NA	Physical NA	Physical NA	Physical NA	Physical NA	Physical NA	
	Fall Risk (Vulnerable (Y/N) if yes score)	Yes	Yes	Yes	Yes	Yes	Yes	
(Ambulation, walking, moving with assistance, bed ridden)	moving	bedridden	moving	moving	moving	moving		
ADL (Dependent / Non-Dependent)	dependent	dependent	dependent	dependent	dependent	dependent		
Critical Lab Test / Values (if any)	NA	NA	NA	NA	NA	NA		

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

Date :		1/7/26	2/7/26	2/7/26	3/7/26	3/7/26	4/7/26	
Area		N4	N4	N4	N4	N4	N4	
Shift Time		8pm-10pm	8am-8pm	8pm-8am	8am-8pm	8pm-8am	8am-2pm	
RECOMMENDATIONS	Investigations Procedures	Ordered / Planned	RBS-00	RBS-BD IV-180cc strak feeds 3ml	RBS-BD SBR-Sent	RBS-0D NP-5m T1ml feeds 6mly	RBS-BD TPM	RBS-BD
		Due	} no dup	} NA	} NA	} NA	} NA	} NA
		Reports Pending	} no pending	} blood cl	} NA	} NA	} NA	} NA
		Referrals (If any)	no referrals	NA	} NA	} NA	} NA	NA
		Remarks (Special Interventions like, Drainage Tube flushing etc.)	no	NA	NA	NA	#Bessy NA	Akanksha NA
		Handed Over By Name :	Alphonsa	Hemalatha	#Bessy	Hemalatha	#Bessy	Akanksha
Signature :								
Date :	1/7/26	2/7/26	3/7/26	3/7/26	4/6/26	4/6/26		
Time :	8pm	@8pm	@8am	@8pm	@8pm	@2pm		
Taken Over By Name :	Hemalatha	#Bessy	Hemalatha	#Bessy	Akanksha	Gray		
Signature :								
Date :	2/7/26	2/7/26	3/7/26	3/7/26	4/7/26	4/7/26		
Time :	@8am	@8pm	@8am	@8pm	@8am	@2pm		

2

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 11/7/26		Diagnosis : Sepsis		Surgery / Procedures : Nil		
		Allergies :		Post OP Day :				
Date :		4/7/26	4/7/26	5/7/26	5/7/26	6/7/26	6/7/26	
	Area	NY	NY	NY	AR	NY	NY	
Shift Time		2pm-8pm	8pm-8am	Day	8pm-8am	8am-8pm	8pm-8am	
Diet :		DBM	DBM	DBM	DBM	DBM	DBM	
Ventilation (RA, NP, NIV, VENTI)		RA	RA	RA	RA	RA	RA	
INVASIVE	1.	OGD	OGD	OGD	OGD	OGD	OGD	
	2.	IV-O	IV-O	IV	IV-O	IV-O	IV-O	
	3.			curb				
	4.							
ASSESSMENT	Infusions / Transfusions		10% BSA Pca3	10% BSA Pca3	NA	NA	10% BSA Pca3	
	PU Prophylaxis		NA	NA	NA	NA	NA	
	DVT Prophylaxis		NA	NA	NA	NA	NA	
	Vitals	BP	54/32 (42)	54/32 (42)	52/32		53/30	59/34 (42)
		PR	128b/m	134b/m	125	132	129b/m	132
		RR	34b/m	64b/m	30	29	35	32
		SpO ₂	95%	97%	98%	99%	98%	98%
		Temp	36.5°C	36.5°C	36.5°F	36.5°C	36.5°C	36.5°C
	Pain Score		2/10	2/10	1/10	0/10	0/10	1/10
	LOC (Alert, Conscious, Confusion, Unconscious)		Alert	Alert	Alert	Alert	Alert	Alert
Skin Integrity (Intact / Bedsore / Any other condition)		Intact	Intact	Intact	Intact	Intact	Intact	
Restraints If any		NA	NA	NA	NA	NA	NA	
Fall Risk (Vulnerable (Y/N) if yes score)		Yes	Yes	Yes	Yes	Yes	Yes	
(Ambulation, walking, moving with assistance, bed ridden)		moving	moving	moving	moving	moving	moving	
ADL (Dependent / Non-Dependent)		Dependent	Dependent	Dependent	Dependent	Dependent	Dependent	
Critical Lab Test / Values (if any)		NA	NA	NA	NA	NA	NA	

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :	4/7/26	4/7/26	4/7/26	5/7/26	6/7/26	6/7/26
		Area	Ny	Ny	Ny	Ny	Ny	Ny
		Shift Time	2pm-8pm	8pm-8am	8pm-8am	8pm-8am	Day	8pm
		Ordered / Planned	RBS-BD	RWS B-D	RBS-BD	Blind Jacobus Sdr	Followed down Sdr	RBS -OD
		Due	NA	N/A	NA	NA	NA	NA
		Reports Pending	NA	N/A	NA	NA	NA	NA
		Referrals (If any)	NA	N/A	NA	NA	NA	NA
		Remarks (Special Interventions like, Drainage Tube flushing etc.)	NA	N/A	NA	N/A	NA	N/A
		Handed Over By Name :	Ajay	Sudhmita	Sudhmita	Nubert	Abhinav	Megha
		Signature :	Ajay	Sudhmita	Sudhmita	Nubert	Abhinav	Megha
Date :	4/7/26	5/7/26	5/7/26	5/7/26	6/7/26	6/7/26		
Time :	8pm	8am	8pm	8pm	8am	8pm		
Taken Over By Name :	Sudhmita	Sudhmita	Abhinav	Abhinav	Megha	Sudhmita		
Signature :	Sudhmita	Sudhmita	Abhinav	Abhinav	Megha	Sudhmita		
Date :	4/7/26	5/7/26	5/7/26	5/7/26	6/7/26	6/7/26		
Time :	8pm	8am	8pm	8pm	8pm	8pm		

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 18/28		Diagnosis : LFT / ODS / SURG.		Surgery / Procedures :		
		Allergies :		Post OP Day :				
INVASIVE LINES	Date :	6/7/26	7/7/26	7/7/26	8/7/26	8/7/26		
	Area	N4	N4	N4	N4	N4		
	Shift Time	8pm-8am	8am-8pm	8pm-8am	8am-8pm	8pm-8am		
	Diet :	DBM	DBM	DBM	DBM	FF		
	Ventilation (RA, NP, NIV, VENTI)	RIA	RIA	RIA	RIA	RIA		
INVASIVE LINES	1.	0.50	IR-1	IR-1	IR-1	IR-1		
	2.	1.50	IR-1	IR-1	IR-1	IR-1		
	3.							
	4.							
ASSESSMENT	Infusions / Transfusions	1000ml	NA	NA	NA	NA		
			NA	NA	NA	NA		
			NA	NA	NA	NA		
			NA	NA	NA	NA		
	PU Prophylaxis	NA	NA	NA	NA	NA		
	DVT Prophylaxis	NA	NA	NA	NA	NA		
	Vitals	BP	59/34(40)	40/32(36)	46/33(36)	-	-	
		PR	125	121	140	139bpm	139	
		RR	48	45b/min	45b/min	-	-	
		SpO ₂	98%	97%	94%	93%	96%	
		Temp	36.5	36.0	36.6°C	36.6°C	36.4°C	
	Pain Score	2/10	1/10	1/10	1/10	2/10		
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert	Alert		
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact	Intact		
	Restraints If any	Physical	NA	NA	NA	NA		
Chemical	NA	NA	NA	NA	NA			
Fall Risk (Vulnerable (Y/N) if yes score)	4/4	Yes	Yes	Yes	Yes			
(Ambulation, walking, moving with assistance, bed ridden)	bed ridden	Bed ridden	Bed ridden	Bed ridden	moving			
ADL (Dependent / Non-Dependent)	Dependent	Dependent	Dependent	Dependent	Dependent			
Critical Lab Test / Values (if any)	NA	NA	NA	NA	NA			

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :	6/27/26	7/7/26	7/7/26	8/2/20	8/7/20
		Area	N4 8:00-8:30	N4 8:00-8:30	N4 8:00-8:30	N4 8:00-8:30	N4 8:00-8:30
Shift Time							
Ordered / Planned		TV-1500	TV-1500	TV-1500			
		CBR CDD	Crib cane	Crib cane	RBS-OD	RBS-OD	
		SDR	Pallada	Pallada		CBR/T/m	
		RBS (01)	Leads	Leads			
Due			RBS-OD				
Reports Pending							
Referrals (If any)							
Remarks (Special Interventions like, Drainage Tube flushing etc.)							
Handed Over By Name :			Sushanti	Hemalatha	Sushanti	Alphonsa	Hajer
Signature :							
Date :			7/7/26	7/7/26	7/7/26	8/2/20	8/7/20
Time :			@ 8:00	@ 8pm	@ 8pm	8pm	LODR
Taken Over By Name :			Hemalatha	Sushanti	Alphonsa	Hajer	Lukhmi
Signature :							
Date :			7/7/26	7/7/26	8/2/20	8/7/20	8/7/20
Time :			@ 8am	@ 8pm	8pm	8pm	@ 8pm



PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
2/7/26 @ 11 AM	Rt Abdomen	Lt hand	supine	given	given	BD	NA	MPO	given	
2/7/26 @ 6 PM	Rt abdomen	Lt leg	supine	given	given	BD	NA	given	given	Hansa
2/7/26 @ 10 PM	Rt Abdomen	Left Leg	Supine	Given	Given	BD	NA	Given	Given	Ba
3/7/26 @ 6 AM	Rt Abdomen	Left hand	Supine	Given	Given	BD	NA	Given	Given	Ba
3/7/26 @ 12 PM	Rt Abdomen	Rt hand	supine	given	given	BD	NA	given	given	Hansa
3/7/26 @ 6 PM	Rt Abdomen	Lt leg	supine	given	given	OD	NA	given	given	Hansa

BAH-00660444 IP5-00175844
 Baby Of SARASWATHI
 22-06-2026 0 Y 0 M 11 D (M)
 Dr. VIJAYANAND JAMALPURI



PROBS AND POSITIONS CHART

Rainbow
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 Hospital
 It takes a lot to treat the little.

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
3/7/26 @10pm	Rt Abdomen	Right hand	Supine	Given	Given	BD	NA	Given	Given	<i>[Signature]</i>
4/7/26 @6am	Left Shoulder	Left hand	Left up	Given	Given	BD	NA	Given	Given	<i>[Signature]</i>
4/7/26 @12 pm	Rt Abd.	Right hand	Left up	Given	Given	BD	NA	Given	Given	<i>[Signature]</i>
4/7/26 @2pm	Right Abd.	Right hand	left up	given	given	BD	NA	given	given	<u>Akasha</u>
4/7/26 @4pm	Rt Abd	Right hand	left up	given	given	BD	NA	Given	Given	<i>[Signature]</i>
4/7/26 @6Am	Rt Abd	Rt hand	Left up	given	Given	BD	NA	Given	Given	<i>[Signature]</i>

BAH-00660444

IP5-00175844

Baby Of SARASWATHI

22-08-2026 0 Y 0 M 12 D (M)

Dr. VIJAYANAND JAMALPURI



3

PROBS AND POSITIONS CHART

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Your Right to a Safe Delivery

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
4/7/26 @ 10 PM	RT abdomen	RT hand	Supine	given	given	OD	Nil	given	given	
5/7/26 1 PM	RT abdomen	LT hand	Supine	given	given	OD	Nil	given	given	
5/7/26 @ 7 PM	RT abdomen	LT hand	Supine	given	given	OD	Nil	given	given	
5/7/26 @ 11 AM	RT abdomen	LT hand	Supine	given	given	OD	Nil	given	given	
6/7/26 @ 12 PM	RT Abd	RT hand	Supine	given	given	OD	Nil	given	given	
6/7/26 @ 6	RT Abd	RT Leg	Supine	given	given	OD	Nil	give	give	



PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
6/2/26 @ 10am	Rt Abdom.	Rt hand	Supine	given	given	OD	nil	given	given	
2/2/26 @ 10am	Rt Abdomen	Lt hand	Supine	given	given	OD	nil	given	given	
2/2/26 @ 2pm	Rt Abdomen	Rt hand	Supine	given	given	OD	nil	given	given	
2/2/26 @ 11am	Rt Abdom	Rt hand	Supine	given	given	OD	NA	given	given	Hema
2/2/26 @ 6pm	Rt Abdom	Rt Leg	Supine	given	given	OD	NA	given	given	Hema
2/2/26 @ 9pm	Rt Abdomen	Rt Leg	Supine	given	given	OD	NA	given	given	Sub.

BAH-00660444 IP5-00175844

Baby Of SARASWATHI
22-06-2026 0 Y 0 M 16 D (M)
Dr. VIJAYANAND JAMALPURI



PROBS AND POSITIONS CHART

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Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
7/7/26. @ 1am	Ret crib care	Right hand.	Supine	given	given	OD	N/A	given	given	seeth
7/7/26. @ 6am	crib care.	Right hand.	Supine	given	given	OD	N/A	given	given	Sush
8/7/26 8 Am	crib care	Rt hand	Supine	given	given	OD	NA	given	given	dlp
8/7/26 11Am	crib care	Rt hand	Supine	given	given	OD	NA	given	given	dlp

Patient Sticker

PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
1/20/20	36.5	98	NA	CO	gives	gives	gives	right breast	100% CO	AP/10 10/10
1/20/20	36.5	98	NA	CO	gives	gives	gives	right breast	100% CO	AP/10 10/10
1/20/20	36.5	98	NA	CO	gives	gives	gives	right breast	100% CO	AP/10 10/10
1/20/20	36.5	98	NA	CO	gives	gives	gives	right breast	100% CO	AP/10 10/10

CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Type of Line: ☐ PICC Line ☐ UAC ☒ UVC ☐ Other Date of Initial Line Insertion: 2/7/26 Duration of Central Line:

- Always perform hand hygiene before accessing central line
- Use Sterile gloves for handling central line
- Clean the hub with antiseptic solution every time before & after it is accessed
- Consider – antibiotic via central line before removal of the line
- Inspect Central line in each shift for the following

Parameters	Date	Shift Time	2/7/26 8am-8pm	2/7/26 8pm-8am					
Can we remove Central Line today (Discuss in the clinical round)			☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No
Central line changed on			2/7/26	K. Bessy					
Name of the Nurse			Hema	Dr. Anjali					
Signature of the Nurse			[Signature]	2/7/26					



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Birth Weight: 1.9/29 Admission Weight: Discharge Weight: NICU: Nu

[illegible]

BAH-00800444
Baby Of SARA WATHI
22-05-2026
Dr. VIJAYANAND JAMALPURI
IP5-00175844
(M)

ADMISSION CRITERIA – NICU

Admission / Transfer from:

☐ Emergency ☐ Outpatient (OPD) ☐ Ward ☐ Operation Theater ☐ Others:

Tick (✓) any of the following criteria requiring admission / transfer to NICU

Prematurity and Low Birth Weight Babies:

- ☐ Respiratory Distress
- ☐ Congenital Heart Disease
- ☐ Suspected or CONFIRMED SEPTICAEMIA
- ☐ Suspected or Diagnosed Meningitis
- ☐ UTI
- ☐ Septic Arthritis or Osteomyelitis
- ☐ Congenital Infections (Varicella, Pneumonia)
- ☐ Acquired Viral Illness
- ☐ Hyperbilirubinemia
- ☐ Severe Dehydration
- ☐ Bleeding Manifestations
- ☐ Neonatal Seizures
- ☐ Birth Asphyxia
- ☐ Surgical Problems
- ☐ Suspected Metabolic Disorders
- ☐ Dysmorphic Features
- ☐ Congenital Serious Cutaneous Disorder

Major Surgical Problems:

- ☐ Congenital Hydrocephalus
- ☐ Neural Tube Defects
- ☐ Choanal Atresia
- ☐ Trachea- Esophageal Fistula
- ☐ Esophageal Atresia
- ☐ Congenital Diaphragmatic Hernias
- ☐ Eventration of Diaphragm
- ☐ Congenital Cystic Adenomatoid Malformation
- ☐ Intestinal Atresias
- ☐ Gastric Volvulus
- ☐ Cleft lip or Cleft Palate
- ☐ Omphalocele / Gastrochiasis
- ☐ Anorectal Malformations
- ☐ Gross Hydronephrosis
- ☐ Posterior Urethral Valves
- ☐ Congenital Tumors
- ☐ Cystic Hygromas

*Feed intolerance
- suspected sepsis*

Criteria for shifting inborn babies from wards to NICU:

- ☐ Any Baby with Lethargy, Poor Feeding, Gross Weight Loss and Dehydration
- ☐ Any Baby with Severe Jaundice Requiring Exchange Transfusion
- ☐ Any Baby with Blood Sugar Abnormalities (Hypo or Hyperglycaemia)
- ☐ Any Baby with Temperature Instability
- ☐ Any Baby with Signs of Sepsis
- ☐ Any Baby with Seizures
- ☐ Out Born Babies: (Including Walk in Patients to the Emergency Room / Neonatal Transports)

Signature of the Doctor:

Name of the Doctor:

Date & Time:

BAH-00660444 IP5-00175844
Baby Of SARASWATHI
22-06-2026 0 Y 0 M 9 D (M)
Dr. VIJAYANAND JAMALPURI




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DISCHARGE CRITERIA – NICU

Discharge to:

☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☐ Others:

Tick (✓) any of the following criteria requiring discharge / transfer from NICU

- ☐ The clinical status of the patient no longer warrants constant medical and nursing monitoring or specialized services originally required.
- ☐ Preterm baby once attained weight of >1.5kgs and crossing the PMA of >35 weeks of gestation.
- ☐ Preterm babies maintaining normal temperatures (36.5-37.5°C) in room temperature.
- ☐ All preterm, low birth weight babies and babies who had critical course in the NICU

Signature of the Doctor:

Name of the Doctor :

Date & Time:



INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: O^{ve} Baby's Blood Group: A^{ve} Sheet No: ①
 Gest Age: 33 weeks Birth Weight: 1.9 kgs

Date: <u>03/7/26</u>	Date: <u>04/7/26</u>	Date: <u>05/7/26</u>
DOL <u>D11</u> Weight <u>1.752 kgs</u>	DOL <u>D12</u> Weight <u>1.747 (↓ 5gms)</u>	DOL <u>D13</u> Weight <u>1.756 ↑ 9 gms</u>
Problems: <u>PT / AGA / RDS / NNT</u>	Problems: <u>PT / AGA / RDS / NNT</u>	Problems: <u>PT / AGA / RDS</u>
Rs. <u>30-60b/m</u> Exam <u>Done</u> Vent. Setting <u>R/A</u> ABG <u>YNA</u> CXR <u>YNA</u>	Rs. <u>30-60b/m</u> Exam <u>Done</u> Vent. Setting <u>R/A</u> ABG <u>YNA</u> CXR <u>YNA</u>	Rs. <u>30-60b/m</u> Exam <u>Done</u> Vent. Setting <u>R/A</u> ABG <u>YNA</u> CXR <u>YNA</u>
CVS <u>Normal</u> HR <u>120-160b/m</u> BP <u>50/30</u> Map <u>(37)</u> Cap Refil <u><2-3Sec</u>	CVS <u>Normal</u> HR <u>120-160b/m</u> BP <u>70/40</u> Map <u>(56)</u> Cap Refil <u><2-3Sec</u>	CVS <u>Normal</u> HR <u>120-160b/m</u> BP <u>64/42</u> Map <u>(49)</u> Cap Refil <u><2-3Sec</u>
F/E/N <u>150cc/kg/day</u> T. Fluids CC /kg /day I/O /RBS: U Output: (CC/kg/hr) Exam <u>Done</u> T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>150cc/kg/day</u> T. Fluids CC /kg /day <u>283ml</u> I/O /RBS: <u>14am / 14g/kg/day</u> U Output: <u>139 (CC/kg/hr) 30cc/kg/day</u> Exam <u>Done</u> T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>150cc/kg/day</u> T. Fluids <u>→ 265ml</u> CC /kg /day <u>139cc</u> I/O /RBS: <u>87mg/dl</u> U Output: <u>2.2 (CC/kg/hr) 162ml</u> Exam <u>Done</u> T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results <u>YNA</u> CRP Antibiotics <u>Brj Meropenam</u>	C/s Results <u>YNA</u> CRP Antibiotics <u>Brj Meropenam</u>	C/s Results <u>YNA</u> CRP Antibiotics <u>Brj Meropenam</u>
Med <u>YNA</u> Neuro: <u>YNA</u>	Med <u>YNA</u> Neuro: <u>YNA</u>	Med <u>YNA</u> Neuro: <u>YNA</u>
Assessment <u>Done</u>	Assessment <u>Done</u>	Assessment <u>Done</u>
Plan <u>RBS - BD</u>	Plan <u>RBS - BD</u>	Plan <u>RBS - BD</u>



INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: O-ve Baby's Blood Group: A+ve Sheet No: (2)
 Gest Age: 23 weeks Birth Weight: 1.9 kg

Date: <u>06/7/26</u>	Date: <u>21/7/26</u>	Date: <u>8/7/26</u>
DOL <u>D14</u> Weight <u>1.7557 ↑ 190ms</u>	DOL <u>→ D15</u> Weight <u>→ 1.764 ↑ 7 gm.</u>	DOL <u>→ D16</u> Weight <u>→ 1.777 ↑ 13gms</u>
Problems: <u>PT/ANA/RDS</u>	Problems: <u>→ PT/ANA/RDS</u>	Problems: <u>PT/AGA/RDS</u>
Rs. <u>30-60b/m</u> Exam <u>done</u> Vent. Setting <u>RA</u> ABG <u>} NA</u> CXR <u>} NA</u>	Rs. <u>30-60b/m</u> Exam <u>→ done</u> Vent. Setting <u>RA</u> ABG <u>not done</u> CXR <u>not done</u>	Rs. <u>30-60b/m</u> Exam <u>done</u> Vent. Setting <u>RA</u> ABG <u>} NA</u> CXR <u>} NA</u>
CVS <u>normal</u> HR <u>120-160b/m</u> BP <u>64/41</u> Map <u>49</u> Cap Refil <u>12-3 sec</u>	CVS <u>normal</u> HR <u>120-160b/m</u> BP <u>59/37</u> Map <u>46</u> Cap Refil <u>12-3 sec</u>	CVS <u>Normal</u> HR <u>120-160b/m</u> BP <u>63/42</u> Map <u>49</u> Cap Refil <u>12-3 sec</u>
F/E/N <u>150 cc/kg/d</u> T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam <u>done</u> T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>150 cc/kg/day</u> T. Fluids <u>276cc</u> CC/kg/day <u>146cc</u> I/O/RBS: <u>81</u> U Output: <u>2.5</u> (CC/kg/hr) <u>116cc</u> Exam <u>done</u> T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results <u>} NA</u> CRP Antibiotics <u>INJ LIPOSOMAL</u>	C/s Results CRP <u>→</u> Antibiotics <u>→ INJ meropenem</u>	C/s Results <u>} NA</u> CRP Antibiotics <u>Inj. Meropenem</u>
Med <u>} NA</u> Neuro: <u>} NA</u>	Med <u>INJ LIPOSOMAL</u> Neuro:	Med <u>Domepidone</u> Neuro: <u>} NA</u>
Assessment <u>done</u>	Assessment <u>→ done</u>	Assessment <u>done</u>
Plan <u>RBS-BD</u>	Plan <u>RBS (BD)</u>	Plan <u>RBS-OD</u>

BAH-00660444

Baby Of SARASWATHI
22-06-2000

IP5-00175B44

22-06-2026

0Y0M9D

(M)

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BLOOD COLLECTION CHART - NICU

[illegible]



BED SIDE CHECK LIST FOR NURSES

Date:	2/7/26	2/7/26	3/7/26	3/6/26	4/7/26	5/7/26	5/7/26	6/7/26	6/6/26
Doctor's Orders	Followed	Followed	Followed	Followed	Followed	Followed	Followed	Followed	Followed
Carried out or not	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bed Side									
Structured Handover done	Done	Done	Done	Done	Done	Done	Done	Done	Done
IV Site	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Central Lines	Yes	Yes	Yes	No	No	No	No	No	No
Arterial Lines	No	No	No	No	No	No	No	No	No
Feeding Catheter	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Urinary Catheter	NO	No	NO	No	No	No	NO	No	NO
Skin Care	given	Given	given	Given	Given	Given	Given	Given	Given
Eye Care	given	Given	given	Given	Given	Given	Given	Given	Given
Mouth Care	given	Given	given	Given	Given	Given	Given	Given	Given
Sterillum Bottle, Stethoscope	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Suction Bottle (Should be clean & empty)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Given	Given
Intubation Tray	Yes	No	NO	No	No	No	NA	NA	NA
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA	No.	NO	No	No	No	NO	No	No
Ventilator Tubing, (Any Water, Blood)	NO	No.	NO	No	No	No	NO	No	No
Humidification	NO	No.	NO	No	No	No	NO	No	No
Check all Infusion (Labelling, Correct Preparation)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Chest Physio & Neb	NA	NA	NA	NA	NA	NA	NA	NA	NA
Handed Over By Name :	Hemang	K. Bony	Hemang	K. Bony	A	Sushita	Abhinav	AB	B

Checked & Handover given by

Name of the Nurse : K. Hemalatha

Signature :

Date & Time : 2/7/26 @ 8pm

Doc. No. : RCHBH/FRM/GENERAL /088

Checked & Handover taken by

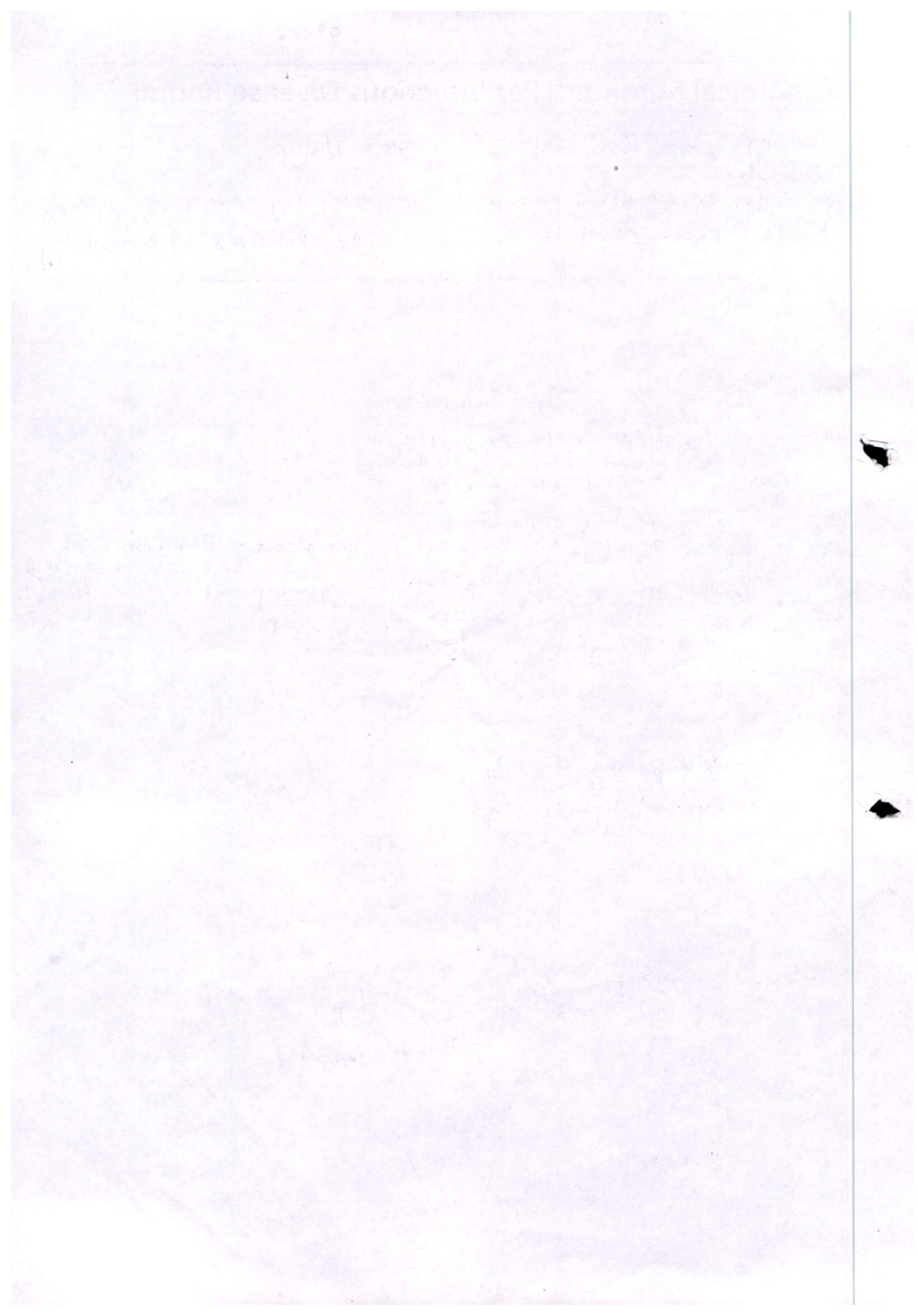
Name of the Nurse : K. Blessy

Signature :

Date & Time : 2/7/26 @ 8pm

Clinical Summary For Infectious Disease Round

NAME: B/o Sansaathu T2		Date: 7/7/20																															
BACKGROUND: Age: 15 days Birth GA0.: 33 wks PMA: 35+1 Birth weight: 1.9 kg Current weight: 1.764 kg Moderate prematurity LBW Rh isoimmunisation (O+) - Post DVET. Coagulopathy																																	
Last ID rounds discussion																																	
Infectious Disease Concerns																																	
Clinical	LSC → PT 32 nd → RDS → CSAB → CPAP → NP. feed intolerance → brownish aspirate & vomiting → (Day 8) O/A - 25.7 → DVET / PTNR 31/2.5																																
	<table border="1"> <thead> <tr> <th></th> <th>01/7</th> <th>2/7</th> <th>4/7</th> <th>7/7</th> </tr> </thead> <tbody> <tr> <td>CBP</td> <td>18.5</td> <td>16.8</td> <td>15</td> <td>14.1</td> </tr> <tr> <td>WBC</td> <td>12.12</td> <td>16.8</td> <td>8.34</td> <td>9.15</td> </tr> <tr> <td>CRP</td> <td>0.31/26</td> <td>5.6/36</td> <td>2.4/28</td> <td>23.7/64</td> </tr> <tr> <td>PCT</td> <td>14.1</td> <td>135</td> <td>96k</td> <td>153</td> </tr> <tr> <td>CSF</td> <td>34</td> <td></td> <td></td> <td>5</td> </tr> </tbody> </table>				01/7	2/7	4/7	7/7	CBP	18.5	16.8	15	14.1	WBC	12.12	16.8	8.34	9.15	CRP	0.31/26	5.6/36	2.4/28	23.7/64	PCT	14.1	135	96k	153	CSF	34			5
	01/7	2/7	4/7	7/7																													
CBP	18.5	16.8	15	14.1																													
WBC	12.12	16.8	8.34	9.15																													
CRP	0.31/26	5.6/36	2.4/28	23.7/64																													
PCT	14.1	135	96k	153																													
CSF	34			5																													
Investigations:	Urine culture → 01/7 → candida perapslosis → SL to Amphi B fluoro de vancomycin Blood culture: → No growth after 48h. CSF culture: → No growth Other cultures: → No growth PCR:																																
Antibiotic Diary	Antibiotic	Days	Reason																														
	Meropenem	D#																															
	Upasoma / Amphi B	D#																															
Discussion	Stop Amphi B Start Fluoro de. (total 7 days) Antibiotic fungal																																
Suggested plan																																	



RAINBOW HOSPITAL NICU HIC CHECK LIST

IP5-00175844

0 Y 0 M 10 D

0 Y 0 M 10 D

(M)

[illegible]

RAINBOW HOSPITAL NICU HIC CHECK LIST

[illegible]



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Remarks if any: