

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176116

Admit Date : 08-Jul-2026

Admit Time : 04:23 PM UHID : BAH-00661053

Patient Details :

Patient Name : Baby Of AAKANKSHA ARUN

Age : 0 D

Guardian : Mr PRATHEEK RAMKUMAR

DOB : 08-07-2026 03:37 PM

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : VASUDEVA BLOOM FIELD ECSTASY, VILLA 6,
 PHASE 1, LANCO HILLS ROAD, KHAJAGUDA
 Manikonda Hyderabad Telangana INDIA
 500089

Phone No : 9966464491

E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : NICU

Bed No : NICU 244

Ward Name : 2F-NICU 1

Room No : NICU 244

Admission Type : First Visit

Contact Details :

Name : Mr PRATHEEK RAMKUMAR

Relationship : Father

Contact Address : VASUDEVA BLOOM FIELD ECSTASY, VILLA
 6, PHASE 1, LANCO HILLS ROAD,
 KHAJAGUDA Manikonda Hyderabad Telangana
 INDIA 500089

Phone No : 9966464491

Signature

Doctor Details :

Doctor Name : Dr. DINESH KUMAR CHIRLA

Specialisation : NEONATAL INTENSIVE CARE

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

[illegible]

ACT AH-00661053 IP5-00176116 NG
aby Of AAKANKSHA ARUN
3-07-2026 0 Y 0 M 0 D 1 H (M)
Nam r. DINESH KUMAR CHIRLA



UHID _____ 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
8/2	20:PM	NW 2	BPP	

Cross Consultation Visit

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

[illegible]

Investigations

Order No.

Signature

8/2/26

VBQ, RBS

26068372

3a

812126

Blood clp, CBR, CRP

26068373

8/7/25

Blood grouping

21226

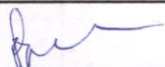
X-Ray

339 48

ch

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
8-7-26	IV placement	1	9693464	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Blo. Aakanksha Arun Mother's Name: Aakanksha
Date of Birth: 8-7-26 Time of Birth: 3:37 PM Gender: ☒ Male ☐ Female
Birth Weight: 2.210 Kgs HC: 34 cm Length: 50 cm
Meconium in Liquor: ☒ Yes ☐ No Cried at Birth: ☒ Yes ☐ No
Term / Pre-term / Post-term: Term
Resuscitated: ☐ Yes ☒ No Blood Group: Mother: A+ Baby: _____
Feeding: ☐ Breast Feeding ☒ Formula ☐ Both First Feed Time: _____

AFFIX MOTHER'S
IDENTIFICATION LABEL

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

Indication: SVD

Physical Assessment of New Born:

Temp: 98.6 °C HR: 144 /Min RR: 44 /Min BP: NA SpO₂: 100%

Pain Score: 0 (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: [Signature]

Signature: [Signature]

Date & Time: 8-7-26 4 PM



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Age : Father's Name : Age :
Date of Birth : Date of Admission : UHID No. :
NICU Consultant : Referring Consultant :
Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward
Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : B/o - Aakanksha Arun Mother's Blood Group : A+ve
Gender : ☒ M ☐ F Blood Group : Birth Weight (gms) : 3220g Length (cms) : 50cm
Date of Birth : 8/7/26 Time of Birth : 3:37pm OFC (cms) : 34cm
Place of Birth : RCH, B-H Estimated Gesth Age : 38wk

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 31yrs Ht : Wt : 100kg BMI : Married Life : LMP 17/10/25 EDD : 22/7/26
Conception Spontaneous or with Rx :
Booked at what GA : 6 wks AN Steroids Drugs / Doses :
Last Scans Details : 36⁺2 - Cephalic, 3.156kg, AC - 82%, AF - 13.2cm
Placenta - at lateral, doppler @ TT Immunization and Iron/ Folic Acid : TIFFA - @

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs Consanguinity : ☐ Yes ☐ No If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3 H/o PIH (after 20 weeks) / PE How many Drugs / Doses / Since how long : H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : IUGR - when detected : Doppler (Increased Resistance / ADEF / REDF / Redistribution in MCA) / Ductus Venosus : AFI :	H/o GDM/ pre GDM/ on diet or insulin Controlled or not, recent values, HbA1 values : Compliance with Rx : Scans : LGA, TIFFA, Fetal Echo : H/o Hypothyroidism : when diagnosed ? Medication? Any other Chronic Medical Problems, when detected drugs ? <u>fibroid - 33x20x34mm</u> <u>post right lobe</u> (Anemia, SLE, Jaundice, CHD, Heart Disease) <u>Inflammation</u> Infection : H/O, Fever (☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV) UTI : when : Any culture :
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PROM: Duration : 28 hrs ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results :
Medication during Pregnancy : clear liquor / NO H/O fever / post menses liquor / Duration :

PAST OBSTETRIC HISTORY

G: 2 P: A: 1 L:

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1.	2025	-			Liochemical pregnancy	
2.	2 PP.					

PERINATAL HISTORY

Treating Obstetrician : Dr. Shruuthi Radele Hospital : RCTI ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication : SVD.

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

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
1	2	
2	2	
2	2	
2	2	
2	2	
9/10	10/10	

TOTAL

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

Snapee II Score

Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

History of Present Illness:

- Preheated warmer
↓
equipment check done

↓
Male baby delivered
via SVD

↓
Baby CIAB

↓
delayed cord clamp
@ 60 sec

↓
Routine care given

↓
Inj Vitamin K 0.5ml given

↓
Baby developed RD i/P/O - Tachypnea
4, grunt & retraction
free flow oxygen
DR CPAP - given for 20 mins

↓
Shifted to NICU
for observation

Investigation details in previous Hospital :

Feeding History :



Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5°P HR : RR : NIBP : CFT :

Color of the extremities : acrocyanosis → pink

Jaundice : Pallor : SpO2 : 90%

ANTHROPOMETRY: Birth Weight : Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

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



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☐ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 65/min 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 : free flow - oxygen

SpO₂ : Auscultation: Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 160/min BP : Precordial Activity :

Femoral Pulses : Murmurs : NAD

Other Peripheral Pulses : Signs of Cardiac Failure :

ABDOMEN:

Shape : Hernia orifice :

Palpation : (N) Anal Patency : +

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

Abdominal girth : First urine passed : Passed

Meconium passed : not passed

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : clear - good

State of wakefulness :

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone : ✓

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR :

ATNR : Skull and Spine :



Diagnosis :

38wk / SVD / male / 3.2kg / Respiratory distress
PROM - 28 hrs 2TTNB

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

Pavan
Pavan
8/7/26

Consultant :

Signature :

Name :

Date & Time :

Dr. Ramesh
Ramesh
8/7/26

PLEASE FILL UP THE FOLLOWING DETAILS

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



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic :

Medications :

Plen
→ Shift to NICU for observation
→ ~~low~~ low flow oxygen
→ CBP / CRP @ 12Hr
→ Chest X Ray if tachypnoea

Plan during ward follow up :

→ if chitrous perils
Start - OA feeds
- TV - 60 cal/kg / day - full OA feeds
16ml / 2nd hrs - then pro
→ Chest X Ray & gas @ 2Hr
ABG

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 11:30pm	Seen by Dr. DK	
	H/O - PROM - 28 hrs O/E - Tachypnea (+)	Plan → Send CBP / CRP / Blood c/s Now → Start IV PIPTAZ. → if clinically persist + chest XRay after 1hr.
8/7/26 @ 9pm	<u>Shifting Notes</u> Baby accepted feed well. No Resp. distress RR = 11/min RR = 52/min SpO ₂ = 95%.	Power 1) Shift to mother side 2) Direct Breast feeding if demanding. @ Top up formula feeds 15ml. Slightly Burping. 3) Trace Bld S 4) Cont. Antibiotic.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 2pm	cl/B Resistant	
	- 23HC / 38WK / SVD / 3-2K Plan	
	Baby on room air hemodynamically stable Cl T/A good	- Warm care DBF 2nd hly → burping → cont Inj PIP/AZ - Trace Blood Cls → NDEcho Today → NP, @ 3pm. - NSU - before discharge
9/7/26 5pm	Antenatal scan - @ 29wks - left lateral ventricle - 8.5mm	
	2DEcho: Small PDA @ L→R sh.	Plan
	PRO - @ L→R sh. → DBF 2nd hly → burping Normal Card. chambers → Trace NP, reports good ventricles for → Trace Blood Cls NO PAM.	→ cont Inj PIP/AZ. → NSU - before discharge
		Parent
		Parent



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

PROGRESS NOTES AND DOCTOR'S ORDER

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

BAH-00661053 IP5-00176116
 Baby Of AAKANKSHA ARUN
 08-07-2026 0 Y 0 M 2 D (M)
 Dr. DINESH KUMAR CHIRLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/07/26 9:30pm	CL/B - Resident 48HOL / 38wks / SVD / 3.2kg Baby on room air hemodynamically stable Cl + CA - good Peripheries - warm T. wgt - 3.124 (210g) 2.5% - on DBF + FF - passing urine / stool. Blood cl - No growths so far.	<u>Plan</u> → @ warm care. → DBF 2nd hly → burping → RWS Trace - 13 blood cl. → Continue Inj PIPTAZ → SBR / NBS @ 48HOL vaccination. → NSG - today → Vaccination on followup
10/07/26	CL/B Resident 51 HOL / 38w / SVD / 3220g / TTNB / PROM 28hs Baby on room air - DBF + FF - U / m - Bld cl - NG 28hs. my tone activity } good	<u>Plan</u> SBR - 10.3 @ 48HOL NSG - Normal study - remove cannula DBF 2nd hly flb burping + FF ② Continue Inj PIPTAZ ③ Trace Bld cl ④ SBR } 10.3 NBS } @ 48HOL done ⑤ OAE T/m ⑥ Vaccinatn 24v on solute



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		11/2/16 OAE - New born hearing screen Bilateral responses are present Bilateral Pass [Signature]
11/7/16 am	<u>Morning Notes</u> HOL SS / term / SVD. PRROMx 28 hrs. septic screen & bloods - negative wt = 3.22 → 3.124 → 2.985 (7.3.1.Bbw) (↓ 140gm ydays) vitality stable on RA Euthermic on DBF + FF. C/T/A good. S/S PA soft.	<u>Plan</u> ① cont DBF f/b FF as needed ② Vaccination before ① - BCG, OPV, Hep B ③ Plan ① today
	OAE - B/L pass. NSU - (N) 2D echo - (N) NBS - sent SBR - 10.3	[Signature]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

[illegible]

Patient Sticker

RBS CHART

[illegible]

BAH-00661053 IP5-00176116
 Baby Of AAKANKSHA ARUN
 08-07-2026 0 Y 0 M 0 D 7 H (M)
 Dr. DINESH KUMAR CHIRLA



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 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	8-7-26	9/7				
Time	4 PM					
Hb	16.9 ✓	19.7				
PCV	51.8	54				
RBC	4.68	5.3				
WBC	16.75 ✓	15,630				
N/L		60/26				
Platelets	210 ✓	2.41 lakhs				
CRP	5.0	5				
ESR						
PCT						
RBS						
Na		140				
K		4.7				
Cl		107				
Ca/Mg		9.2				
Phosphate						
Urea		26				
Creatinine		0.7				
ALP						
SGPT						
SGOT						
T.Bill/Conj		6.6/0.1				
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						



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:

Shifted to:

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	INS PIPERACILLIN TAZOBACTAM	320mg	IV	Q12H	8/7 6PM	☒ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Adhwanth

Date & Time: 8/7/26 9PM

Nurse Name & Signature: Preethi

Date & Time: 8/7/26 9PM



BRADEN 'Q' SCALE

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

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

BAH-00661053

IP5-00176116

Baby Of AAKANKSHA ARUN

08-07-2026 0 Y 0 M 0 D 10 H (M)

Dr. DINESH KUMAR CHIRLA



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 :	8/7	9/7	9/7	9/7
					Time :	8pm	11am	2pm	8pm
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.	1	1	4	1	
"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	4	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.	2	2	2	2	
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	
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 of 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	3	3	3	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
TOTAL SCORE					10	16	16	16	
Evaluator's Name					2	Anita	Caelli	Ro	

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
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

B/C Aakanksha

Patient Sticker

BAH-00661053

IP5-00176116

Baby Of AAKANKSHA ARUN

08-07-2026 0 Y 0 M 0 D 16 H (M)

Dr. DINESH KUMAR CHIRLA



DRUG CHART

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

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:																			

Weight. 3.2 kg Ward. 528

Page: 2/4

[illegible]

Weight. Ward.

[illegible]



CHECKLIST FOR THROMBOPHLEBITIS

8/7/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2 9/7			DAY-3 10/7			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										removed
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 : Name :

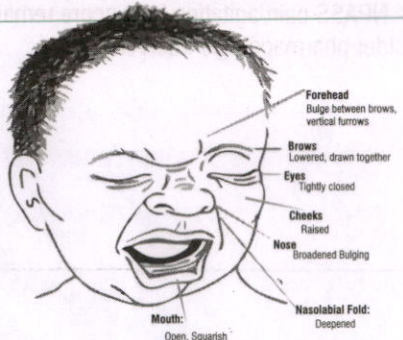
Docu. No. : RCHBH / FRM / CLINICAL / 137

Signature of Ward In Charge :

Signature : Name :



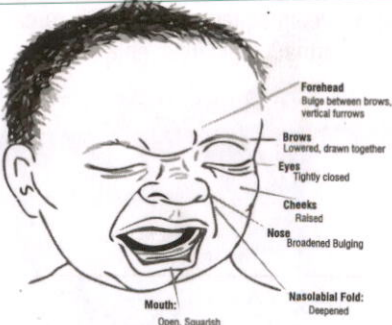
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

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
						8/7	8/7	9/7	9/7	9/7	10/7	10/7	
						5pm	8pm	11am	2pm	3pm	8pm	10pm	
						Procedure	Cumulative	Cumulative	-	-	-	-	
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	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	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	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	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	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	34wks	38wks	38wks	38wks	38wks	38wks	38wks
						Total Pain / Agitation Score	+2/10	+2/10	+2/10	2/10	2/10	2/10	0
						Intervention	-	-	-	-	-	-	-
						Effectiveness	-	-	-	-	-	-	-
						Signature	Ch	Ch	Ch	Ch	Ch	Ch	Ch

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.

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								
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)								
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual								
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								
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								
 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							
						Total Pain / Agitation Score							
						Intervention							
						Effectiveness							
						Signature							

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.



THE HUMPTY DUMPTY SCALE

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	3	3	3	3	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	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3			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					
TOTAL			12	16	18	18	15

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✗	✗	✗	✗
Call device within reach		✓	✗	✗	✗	✗
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓	✓
Wheel Chair Support		✗	✗	✗	✗	✗
Other Intervention(s) Specify		✗	✗	✗	✗	✗
Nurse's Name :		ilanda	Am	Anika	Amala	Am
Signature :		ch	α	Ⓢ	Ⓢ	2
Date :		8/26	8/27	9/7	9/7	9/7
Time :		6pm	8pm	11am	2pm	8pm



THE HUMPTY DUMPTY SCALE

10/7/17

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3				
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1		1			
Cognitive Impairments	Not aware of Limitations	3	3				
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4	4			
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3	3	3			
	Patient Placed in Bed	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				
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			
Total			16	16			

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position			X			
Call device within reach			X			
Wheels Locked			✓			
Room free of clutter			✓			
Adequate lighting			✓			
Wheel chair support			X			
Other Intervention(s) Specify			X			
Nurse's Name:			Shruti			
Signature:			Shruti			
Date:			10/7/17			
Time:			8 AM			

AH-00661053 IP5-00176116
aby Of AAKANKSHA ARUN
3-07-2026 0 Y 0 M 0 D 1 H (M)
r. DINESH KUMAR CHIRLA



Jocu.No. : RCHBH/ 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:	5	6	8	11:30pm	6am
Doctor / Nurse / Family Concern?		Pm	pm	pm		

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

Heart Rate (bpm) and Blood Pressure (mmHg) *	190					
	180					
	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
	90					
Note: BP does not score in early warning scoring	80					
	70					
	60					
	50					
Heart Rate (Number)		162	161	139	160	

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

Resp Distress	Mod/ Severe					
	None / Mild					
Receiving O ₂ (l/min)						
O ₂ Saturations (%)		92%	93%	94%	100%	95%
Conscious Level	Normal	N	N	N		
	Altered					
GCS *		C	C	C		

TOTAL SCORE						
Number of shaded boxes		0	0	0	1	2
Pain Score		0	0	0		
Observer's Initials		ca	ca	ca		

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00661053
Baby Of AAKANKSHA ARUN
08-07-2026 0 Y 0 M 0 D 16 H (M)
Dr. DINESH KUMAR CHIRLA



: RCH / FRM / CLINICAL / 124

9/7/26

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

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time: 10:30am	1pm	6pm	6pm	6pm	6pm	
Doctor/Nurse/Family Concern?							
Temperature (°F)	104						
	103						
	102						
	101						
	100						
	99	97.6	98.0	98.2	98.0	98.1	
	98						
	97						
	96						
	95						
	94						
Heart Rate (bpm)	190						
	180						
	170						
	160						
and	150	*	*	*			
	140						
Blood Pressure (mmHg) *	130						
	120						
	110						
	100						
	90						
	80						
	70						
	60						
	50						
Note: BP does not score in early warning scoring							
Heart Rate (Number)	149b/m	146b/m	not	144	144	144	
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40	*	*	*			
	30						
	20						
	10						
	Resp Rate (Number)	40b/m	40b/m	not	44	44	44
	Resp Distress	Mod/ Severe					
		None / Mild					
	Receiving O ₂ (l/min)						
O ₂ Saturations (%)	100+	98	100+	100+	100+	100+	
Conscious Level	Normal						
	Altered						
GCS *	12/15	12/15	12/15	13/15	13/15	13/15	
TOTAL SCORE							
Number of shaded boxes	0	0	0	0	0	0	
Pain Score	0	0	0	0	0	0	
Observer's Initials	Dr	Dr	Dr	Dr	Dr	Dr	

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 10/7/26 Time: 11AM 3PM 7PM 10PM 2AM 6AM

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)

Resp Rate (bpm)
(Over 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Level
Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

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BAH-00661053

IP5-00176116

Baby Of AAKANKSHA ARUN

08-07-2026 0 Y 0 M 3 D (M)

Dr. DINESH KUMAR CHIRLA

No. : RCH / FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation &
Early Warning Scoring ChartPratiksha
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:

Doctor/Nurse/Family Concern?

Temperature
(°F)104
103
102
101
100
99
98
97
96
95
94Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *190
180
170
160
150
140
130
120
110
100**Note:**BP does not score
in early
warning scoring90
80
70
60
50

Heart Rate (Number)

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

Resp Rate (Number)

Resp Mod/ Severe
Distress None / MildReceiving O₂ (l/min)
O₂ Saturations (%)Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

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FLUID CHART

TV - 60cc/kg/day
 But - 3-3kg
 T-f - 15ml

Sheet No. : ①

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	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	16ml											ce
	06:00 pm												
	07:00 pm	16ml					passed			13ml			ca
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm	16ml					passed			16ml			
	10:00 pm												
	11:00 pm	DBM											
	12:00 am	FF 16ml											
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am	DBM											
	04:00 am	FF 16ml											
	05:00 am												
	06:00 am												
	07:00 am	DBM											
Total Intake :						Total Output :							
Total 24 hrs. Intake		Total 24 hrs. Output											



FLUID CHART

Sheet No. : (2)

9/7/26

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	
9/7/26			Mouth	I.V	N.G							
	08:00 am	FFISul									0	Anita
	09:00 am						✓				0	
	10:00 am									✓	0	Anita
	11:00 am	DBF									0	
	12:00 pm	FFISul					✓				0	Anita
	01:00 pm									✓	0	
Total Intake : Taken						Total Output : 0-2 m-2						
	02:00 pm										0	Suresh
	03:00 pm	DBF					✓				0	
	04:00 pm	FF-15ml									0	Suresh
	05:00 pm										0	
	06:00 pm	DBF									0	Suresh
	07:00 pm	FF-10ml					✓			✓	0	
Total Intake : Taken						Total Output : 0-2 m-2						
10/7/26	08:00 pm										0	Pur
	09:00 pm										0	
	10:00 pm	DBF					✓			✓	0	Pur
	11:00 pm	FF-20ml					✓				0	
	12:00 am										0	Pur
	01:00 am										0	
Total Intake :						Total Output :						
	02:00 am	DBF								✓	0	Pur
	03:00 am	FF-25ml					✓			✓	0	
	04:00 am						✓				0	Pur
	05:00 am	DBF									0	
	06:00 am										0	Pur
	07:00 am	FF-10ml					✓				0	
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. : (3)

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								
10/7	08:00 am	DBF									0	Surekha	
	09:00 am	FF-25ml									0	Surekha	
	10:00 am										0	Surekha	
	11:00 am										0	Surekha	
	12:00 pm	DBF									0	Surekha	
	01:00 pm										0	Surekha	
Total Intake :					Total Output :								
	02:00 pm	DBF									0	Surekha	
	03:00 pm										0	Surekha	
	04:00 pm	DBF									0	Surekha	
	05:00 pm	FF-20ml									0	Surekha	
	06:00 pm										0	Surekha	
	07:00 pm										0	Surekha	
Total Intake : Taken					Total Output : Passed								
	08:00 pm										1	Sangeeta	
	09:00 pm	DBF									1		
	10:00 pm	DBF									20		
	11:00 pm	DBF									20		
	12:00 am	FF 30ml									1		
	01:00 am										1		
Total Intake : Taken					Total Output : Passed								
11/7	02:00 am										1	Sangeeta	
	03:00 am										1		
	04:00 am	DBF									20		
	05:00 am										1		
	06:00 am										1		
	07:00 am	DBF									1		
Total Intake : Taken					Total Output : Passed								
Total 24 hrs. Intake		Total 24 hrs. Output											

FLUID CHART

Sheet No. :

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

Patient Sticker

FLUID CHART

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. :

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

		Intake				Output					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												
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	11:00 am												
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	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												
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	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							

Patient Sticker

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	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							

AH-00661053
 Baby Of AAKANKSHA ARUN
 3-07-2026 0 Y 0 M 0 D 1 H (M)
 R. DINESH KUMAR CHIRLA


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: 8/7/26

Assessment: Baby on R/A

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
5:pm	→ Assess the General condition of baby	5:30pm	→ Assessed the General condition of baby.	Baby is now stable.
6:pm	→ pro connect to cannula	6:30pm	→ Connected cannula.	
7:pm	→ provide comfortable position	7:10pm	→ provided comfortable position.	
8:pm	→ Ensure safety	8:pm	→ Ensured Safety	

Re-Assessment: Re-assessment Done.

Special Notes:

Nurse Signature: chendhara

Nurse Name: chendhara

Date & Time: 8/7/26 8pm

BAH-00661053 IP5-00176116
 Baby Of AAKANKSHA ARUN
 08-07-2026 0 Y 0 M 0 D 7 H (M)
 Dr. DINESH KUMAR CHIRLA



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: 8-7-26

Assessment: New born 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
8 PM	2) Monitor vitals and recorded	9 PM	1) Monitoring vitals and keep	Baby is well
10 PM	1) Given warm care	11 PM	1) Given warm care	
12 AM	1) Plan for DBF + FF & Burping	1 AM	1) Done DBF + FF Burping	
2 AM	1) Plan for crib care	3 AM	1) Given crib care	
4 AM	1) Plan for Diaper changing	5 AM	1) Done Diaper changing	
6 AM	1) Plan for weight checking	8 AM	1) weight checking done	

Re-Assessment: reassessed done

Special Notes: weight checking

Nurse Signature:

Nurse Name: Preema

Date & Time: 8-7-26 2 PM

BAH-00661053 IP5-00176116
 Baby Of AAKANKSHA ARUN
 08-07-2026 0 Y 0 M 0 D 16 H (M)
 Dr. DINESH KUMAR CHIRLA



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: 9/7/26

Assessment: baby 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
8am	* Assess the baby General Condition.	8:10am	* Assessed the baby General Condition	baby is stable.
9am	* provide monitor vitals	9:10am	* provided monitor vitals	
10am	* provide DBF and Barfing	10:30am	* provided DBF and Barfing	
10:30am	* provide DLO chart	10:45am	* provided DLO chart	
11am	* provide warm care	11:30am	* provided warm care.	
12pm	* provide comfortable position	12:30pm	* provided comfortable position	
1:30pm	* provide baby is safety	2pm	* provided baby is safety.	

Re-Assessment: RE-Assessment is done, baby vitals is good.

Special Notes: (3pm NP1021 hy of life) and 2D Echo Today

Nurse Signature: [Signature]

Nurse Name: Anitha

Date & Time: 9/7/26 @ 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment: New born baby case

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the general condition of the baby.	2pm	→ Assessed the general condition of the baby.	Baby is stable.
3pm	→ Warm care.	3pm	→ Provided warm care.	
4pm	→ 2d echo.	4pm	→ 2d echo done.	
5pm	→ Yo chat.	5pm	→ maintained Yo chat.	
6pm	→ DBF T burping.	7pm	→ DBF given Every 2-3rd hly.	

Re-Assessment: Baby is sleeping

Special Notes: 2d echo report done

Nurse Signature: [Signature]

Nurse Name: Sushila

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

IP3-00176116
 0 Y 0 M 1 D
 HANISH KUMAR CHIRLA
 1-2026

NURSING CARE

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10-7-26

Assessment: New born care

- Goals**
- ☐ Maintain Airway and Oxygenation
 - ☐ Relieve Pain & Discomfort
 - ☐ Maintain Fluid Balance
 - ☐ Improve Activity Tolerance
 - ☐ Maintain Good Nutritional Status
 - ☐ Prevent Infection
 - ☐ Meet Elimination Needs
 - ☐ Ensure Safety
 - ☐ Early Ambulation Reduce Anxiety
 - ☐ Patient & Family Education
 - ☐ Any Others. Specify

Plan of Care	Time	Implementation	Evaluation
vitals and Recorded	9pm	u Monitoring vitals and Recorded	Baby is well
care	11pm	u Given warm care	
care	12am	u Done DBP & RR 5 Burping	
	3Am	u Given warm care	
	5Am	u Done crib care	
	7Am	u Done weight checking	

Date & Time: 10-7-26 2pm

AH-00661053
 Baby Of AAKANKSHA ARUN
 05-07-2026
 Dr. DINESH KUMAR CHIRLA
 IP5-00176116
 0 Y 0 M 3 D
 (M)

Shift: ☒ Morning ☐ Afternoon
 Assessment: ☐ Morning ☒ Afternoon

NURSING CARE RECORD



Date: 10/7/26

new born baby Case

- Goals
- ☐ Maintain Airway 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

Plan of Care

Implementation

Time	Plan of Care
8am	Assess the general condition of the baby.
11Am	Warm Care.
2pm	DBF to burping.
4pm	NSG.
6pm	Prevent infection
7pm	Yo chat

Time	Implementation
8AM	Assessed the general condition of the baby.
30 11am	Provided warm care.
10 2pm	DBF given to burp baby.
30 4pm	NSG done.
30 6pm	Preventing infection by using hand rub.
30 7pm	Maintained Yo chat.

Re-Assessment:

Special Notes:

Nurse Signature:

Docu. No: RCHBH / FRM / CLINICAL / 148

Nurse Name:

[Signature]

Baby is comfortable
 OAE T/T

BAH-00661053 IP5-00176116
Baby Of AAKANKSHA ARUN
08-07-2026 0 Y 0 M 3 D (M)
Dr. DINESH KUMAR CHIRLA



NURSING CARE RECORD

Rainbow
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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

New Born Baby care

Date: 10/7/2026

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
8pm	→ assess the Baby condition	8:30pm	→ assessed The Baby condition	→ Baby Stable
	→ monitor vital	10:30pm	→ monitored vitals	
12Am	→ ensure safety	12:00am	→ provided crib care	
2Am	→ Ifo chart monitoring	2:30Am	→ Ifo chart monitored	
4Am	→ warm care	4:00am	→ warm care Provided	
6Am	→ DBF and Burping	7Am	→ DBF given Burping done	
8Am	→ weight checking.	8Am	→ weight checked Recorded	

Re-Assessment: Done Baby Stable

BAE Tomorrow

Special Notes:

Nurse Signature:

Nurse Name: Swapna

Docu. No: RCHBH / FRM / CLINICAL / 148

Date & Time: 11/7/2026 8Am

Special Notes:

Nurse Signature:

Docu. No: RCHBH / FRM / CLINIC

IP5-00661053
Baby of AAKANKSHA A
03-07-2026 0 Y 0 M
OF DINESH KUMAR CHIRL

Shift: ☐ Morning

Assessment:

Goals

- ☐ Maintain Airway and O
- ☐ Maintain Personal Hygi
- ☐ Identify Potential Comp

Time

Re-Assessment:

Special Notes:

Nurse Signature:

Goals

Re-Asse

Special I

Nurse Sig

Rainbow®
Children's

గతా పాటు పట్టించుటకు సమర్థి పతం

BAH-00661053 IP5-00176116
 Baby Of AAKANKSHA ARUN
 08-07-2026 0 Y 0 M 3 D (M)
 Dr. DINESH KUMAR CHIRLA



NURSING CARE RECORD

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 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/12/2026

Assessment:

New Born Baby case

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ assess the Baby condition	8:30pm	→ assessed The Baby condition	→ Baby Stable
10pm	→ monitor vital	10:30pm	→ monitored vitals	
12Am	→ ensure safety	12:00am	→ provided crib care	
2Am	→ Ipo chart monitoring	2:30Am	→ Ipo chart monitored	
4Am	→ warm care	4:00am	→ warm care Provided	
6Am	→ DBF and Burping	7Am	→ DBF given Burping done	
8Am	→ weight checking.	8Am	→ weight checked Recorded	

Re-Assessment:

Done Baby Stable

Special Notes:

BAE Tomorrow

Nurse Signature:

[Signature]

Nurse Name:

Swapna

Date & Time:

11/12/2026 8Am

BAH-00661053 IP5-00176116
 Baby Of AAKANKSHA ARUN
 08-07-2026 0 Y 0 M 3 D (M)
 Dr. DINESH KUMAR CHIRLA

NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

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:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. D.K. Department: BRP Date of Admission: 8-7-26

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known		If Yes Specify:		
BACKGROUND	Area	Shift Time		BRP 8PM-8AM	BRP 8AM-8PM	BRP 8PM-8AM	BRP 8AM-8PM	
	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.6F	98.0F	98.2F	98.4F	98.2F	98.1F
		Res:	44	40b/min	44	44	40b/min	40b/min
		SpO ₂ :	100%	98%	99%	99%	100%	98%
		Pulse:	144	146b/min	142	146b/min	142	140
		BP:	-	-	-	-	-	-
	Fall Risk Score:	-	18	18	16	16	16	
Pain Score:	-	2/10	1/10	1/10	1/10	0		
Recommendations	Safety Needs:	NA	NA	NA	NA	NA	NA	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NP 1 24 H 0.2 3pm 2D Echo today	NP 1 24 H 0.2 3pm	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Prey	Anita	Surekha	Prey	Surekha	Swapna	
Signature :								
Date:		9/7/26	9/7/26	9/7/26	10/7/26	10/7/26	11/7/26	
Time:		8AM	2PM	8PM	8AM	8PM	8AM	
Taken Over By Name :		Anita	Surekha	Prey	Surekha	Swapna		
Signature :								
Date:		9/7/26	9/7/26	9/7/26	9/7/26	10/7/26		
Time:		8AM	2PM	8PM	8AM	8:10PM		

BAH-00661053 IP5-00176116
Baby Of AAKANKSHA ARUN (M)
08-07-2026 0 Y 0 M 3 D
Dr. DINESH KUMAR CHIRLA



SING 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-00661053 IP5-00176116
Baby Of AAKANKSHA ARUN
08-07-2026 0 Y 0 M 0 D 21 H (M)
Dr. DINESH KUMAR CHIRLA



CONSENT FOR FORMULA FEEDS

Patient Name : B/O - Aakanksha Arun Age : Gender : ☒ Male ☐ Female

UHID No : Reg. No. : Department : NICU Date : 8/7/26

I Mr / Mrs. : aged years, hereby declare that I have
admitted my ☐ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on
..... I hereby give consent for formula feed for my child. Doctors have explained me
about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : [Signature]

Name : fat

Relationship with Patient : father

Date & Time : 8/7/26

Witness :

Signature : [Signature]

Name : chandan

Date & Time : 8/21/26

Doctor (who is taking the consent) :

Signature : Pawan

Name : Pawan

Date & Time : 8/7/26

డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. రిజిస్ట్రేషన్ నెం.: విభాగము

తేదీ

నేను శ్రీ / శ్రీమతి వయస్సు సంవత్సరాలు

నా కుమార్తె / కుమారుడు రెయిన్ఫో ఆసుపత్రిలో నవజాత శిశువుల ఇంటెన్సివ్ కేర్ లో అడ్మిట్ చేసినాము మరియు (ఫార్ములా

ఫీడ్) డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుచున్నాను. డాక్టర్లు డబ్బా పాలు త్రాగించడం వల్ల కలుగు

ఉపయోగాలు, ప్రత్యామ్నాయాలు, మరియు నష్టాలు గురించి నాకు అర్థమైన భాషలో వివరించారు.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

PATIENT TRANSFER FORM

AH-00661053 IP5-00176116 aby Of AAKANKSHA ARUN 3-07-2026 0 Y 0 M 0 D 1 H (M) r. DINESH KUMAR CHIRLA 		Date & Time of Admission <i>8/1/26</i>	Date & Time of Transfer Order <i>8/1/26 2:00 PM</i>
<i>Dr. D.K.</i>		Transfer Ordered by <i>Dr. D.K.</i>	Reason for Transfer <i>observation</i>
From Unit <i>NICH</i>	To Unit <i>BRP</i>	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File <i>8</i>	Number of Imaging Films <i>8</i>	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.	<i>new pao</i>	<i>①</i>	
3.	<i>bottles</i>	<i>②</i>	
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring <i>Sis. Abhye</i>		Name of Person Ordered Transfer <i>Dr. D.K.</i>	
Patient & Clinical Records Received by : <i>Purna 8/1/26 10 PM</i>			
Date & Time of Patient Received :			

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

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

BAH-00661053

IP5-00176116

Baby Of AAKANKSHA ARUN

08-07-2026

0 Y 0 M 0 D 10 H (M)

Dr. DINESH KUMAR CHIRLA



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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 11/7/262. Destination Post Discharge: ☐ Home ☒ Family Members Notified (Person Contacted)☐ Transfer
Hospital Facility Notified (Person Contacted)3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance☐ Needs Assistance In:☐ Medication☒ Yes☐ No☐ Bathing☒ Yes☐ No☐ Eating☒ Yes☐ No☐ Walking☒ Yes☐ No☐ Dressing☒ Yes☐ No☐ Toileting☒ Yes☐ No

Remarks

Need An Assistance

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:☐ Patient☒ Family Member☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient☒ Family Member☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s:

Maintain Personal Hygiene

☐ Patient's Educational Topic/s discussed with the:☒ Patient☐ Family Member☐ Others:Nurse Signature: PreenaNurse Name: PreenaDate and Time: 11/7/26 11PM

Children's
Hospital

DISCHARGE PLANNING FORM

W. J. ...

DATE

W. J. ...

W. J. ...

W. J. ...

W. J. ...

W. J. ...