Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176042 **Admit Date** : 06-Jul-2026 **Admit Time** : 03:05 PM **UHID** : BAH-00660853

Patient Details :

Patient Name	: Baby Of BATTULA SHRUTHI	**Age**	: 0 D
Guardian	: Mr SAI SREERAM GADIPARTHI	**DOB**	: 06-07-2026 02:21 PM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: PLOT NO. 35, ROAD NO. 71, NAVA NIRMAN NAGAR, Jubilee Hills Hyderabad Telangana INDIA 500033	**Phone No**	: 8056299505/ 9849797959
		E-mail	: SUJATHASHRUTHI1975@YAHOO.COM

Admission Details :

Bed Type : BASINET **Bed No** : CRDL-SW-415-1 **Ward Name** : 4F-BIRTHING CENTRE

Room No : CRDL-SW-415-1 **Admission Type** : First Visit

Contact Details :

Name	: Mr SAI SREERAM GADIPARTHI	**Relationship**	: Father
Contact Address	: PLOT NO. 35, ROAD NO. 71, NAVA NIRMAN NAGAR, Jubilee Hills Hyderabad Telangana INDIA 500033	**Phone No**	: 8056299505 /

Signature

Doctor Details :

Doctor Name	: Dr. ANNAPOORNA TADAVARTHY	**Specialisation**	: NEONATOLOGY
Referral Doctor	: Self	**Phone No**	:
Co-Consultant	:		

Payment Details :

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

BAH-00660853 IP5-00176042
Baby Of BATTULA SHRUTHI
06-07-2026 0Y0M0D1H (M)
Dr. ANNAPOORNA TADAVARTHY

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NEWBORN MONITORING FORM

Date of Birth	: 6/7/26	New Born Screening	:
Time of Birth	: 2:21 pm	TFT	:
Mode of Delivery	: normal	OAE	:
Birth Weight	: 3.050 kgs	Mother's Blood Group	: B+ve
Head Circumference	: 34 cm	Baby's Blood Group	:
Length	: 49 cm	Anomaly Scan	:
Red Reflex	:	Vaccination	: given-6/7/26-Dr (BCG, OPV, HepB)

Date	Weight	Type of Feed	Quantity	Temperature	Signature
6/7/26	3.050 kgs	DBF	1	98°F	Anjali
6/7/26	ward wt 3.015 Kgs	DBF	-	-	Lakshmi
7/7/26	2.940 kg	DBF	-	98.0°F	Sheik

Date	Time	Investigation	Result	Order No.	Signature
6/7/26	3:27 pm.	Bloodgrouping	O+ve.	26067668	Anjali

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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Battula Shruthi. Age : 30 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 Shruthi

Gender ☑ M ☐ F Blood Group : .....

Date of Birth : 6/7/26 Time of Birth : 2:21 pm

Place of Birth : RCHBH

Mother's Blood Group : B+

Birth Weight (gms) : 3050. Length (cms) : 49

OFC (cms) : 34

Estimated Gesth Age : 39+5

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 30 Ht : ..... Wt : ..... BMI: ..... Married Life : ..... LMP : 5/10/25 EDD 5/9/26

Conception : Spontaneous or with Rx. : .....

Booked at what GA. : 22+2 weeks. AN Steroids Drugs / Doses : .....

Last Scans Details : 15/5 : 31+5 | Breech | wt: 1998 - 58 | AC: 37 | AFI: 16.2

(N) Doppler

TT Immunization and Iron / Folic Acid : .....

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs

Consanguinity : ☐ Yes ☐ No

If yes, degree of consanguinity : ☐1 ☐2 ☐3

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long : .....

.....

H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : .....

.....

IUGR - when detected : .....

Doppler (Increased Resistence / ADEF / REDF / Redistrbution 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 Hypothyriodism : when diagnosed ? Medication?

.....

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 : .....

Patient Sticker

PAST OBSTETRIC HISTORY

G : ..... P : ..... A : ..... L : .....

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

PERINATAL HISTORY

Treating Obstetrician : D. m. Rathnyusha Reddy Hospital : RCH: BH ☑ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig) SVD.

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
1	1	
2	2	
2	2	
2	2	
1	2	
8	9.	

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)			
Brith Weight	> = 1kg (0)	750 - 999 (10)	< 750 (17)		
SGA	> 3rd percentile (0)	< 3rd (12)			
				Total	

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

Patient Sticker

History of Present Illness:

Equipment check done

↓

Baby was received in a prewarmed linen

↓

Dried/ warmth/ cleared

↓

Suctioning was done

↓

Inj. vitamin K 0.5ml. IM.

↓

vitals stable

↓

Shifted to mothers side

Investigation details in previous Hospital :

–

Feeding History :

–

Patient Sticker

Past History :

-

Family History :

-

Socio Economic History :

-

GENERAL EXAMINATION ON ADMISSION

General Disposition : Euthecomic pink
c/c/A: good
warm peripheries.

VITALS : Temperature : Euthecomic HR : 129/min RR : 44/min NIBP : ..... CFT : <2

Color of the extremities : Acrocyanotic

Jaundice : ..... Pallor : ..... SpO2 : 97%

ANTHROPOMETRY: Birth Weight : 3050 Length : ..... HC : ..... Present Weight : .....

Ponderal Index : ..... AGA : ✓ SGA : ..... LGA : .....

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HEAD TO TOE EXAMINATION

HEAD :
Fontanelles :
Sutures
Shape / Moulding : Caput (+)
Edema / Bruising :
Size - (H.C.) :

FACIES : (Any Facial Dysmorphism) —

NECK and CLAVICLES :
Range of Motion : —
Asymmetry :
Masses :

EYES :
Symmetry :
Red Reflex : ~~+ve~~ to be checked
Discharge :

EARS, NOSE MOUTH and THROAT :
Ear set / Shape :
Periauricular Pits / Tags :
Nasal shape / Patency :
Palate :
Gums : ~~2A + W~~ No cleft lip/palate
Lips :
Tongue :

THORAX and BREASTS :
Shape of Thorax :
Position of Nipples and Number : ← Nl —

ABDOMEN and UMBILICUS :
Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump : 2A + W
Discharge :

GENITILIA :
Labia / Hymen :
Testicles/penis : N
Anus :

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS : N

EXTREMETIES :
Fingers / Toes :
Deformities :
Hip Joint Examination : N
Arms / Legs :
Mobility :

Patient Sticker

SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☑ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 48/min SCR / ICR / See - Saw breating : .....

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

Mention if baby is on : ☐ Hood box ☐ CPAP ☐ Ventilator

Settings : .....

SpO_2: 98+ Auscultation: BAE (+) Breath Sounds: NVBS (+) Added Sounds: .....

CARDIOVASCULAR SYSTEM :

HR : 129/min BP : .....

Femoral Pulses : Rt wall Felt

Other Peripheral Pulses : .....

Precordial Activity : .....

Murmurs : N

Signs of Cardiac Failure : .....

ABDOMEN:

Shape : .....

Palpation : .....

Palpable masses : N

Abdominal girth : .....

Hernia orifice : —

Anal Patency : looks patent

Umbilical Cord : 2A +1V

First urine passed : ✓

Meconium passed : —

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : .....

State of wakefulness : .....

Prechtle Score : .....

Nerves : N

.....

MOTOR SYSTEM:

Passive Tone : .....

Active Tone : c/z/A : good

Neonatal Reflexes : .....

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

Moro's : ✓ DTR : .....

ATNR : ..... Skull and Spine : .....

Patient Sticker

Any Congenital Anomalies : .....

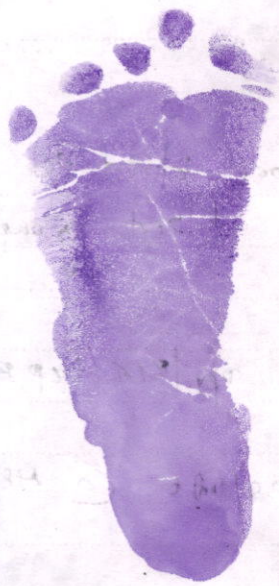
.....

Diagnosis : 39+5 | primi | SVD | mch | 3050-

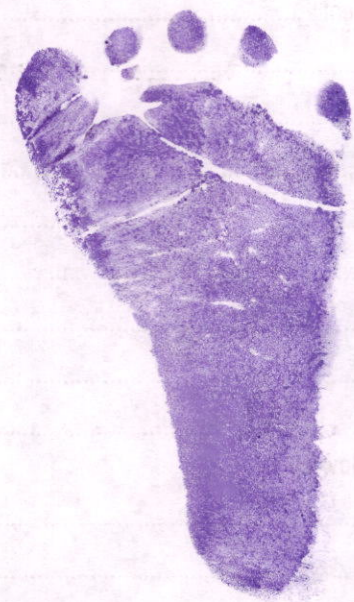
.....

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : .....

Name : Dr Lohith

Date & Time : 6/2/26

Consultant :

Signature : .....

Name : Dr Tadavarthy Annapoorna Reg.No: 53054

Date & Time : 6/2/26

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.

Patient Sticker

AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis : .....

.....

.....

Neonatal condition at the time of Transfer: .....

.....

.....

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

Any Oxygen requirement : .....

Systemic : .....

.....

Medications : .....

.....

.....

.....

.....

.....

Plan during ward follow up :

.....

.....

.....

.....

.....

Plan

1. Send Cord blood for blood grouping

2. Vaccines OPV/BCG/Hep B today

3. CRP/NBS/DAE @ 48hrs of.

4. Warm Cot

5. DBF/ 2nd thoughts.

Feeding Plan at the time of shifting : .....

.....

first feeding time 2:5pm to 3pm

Screenings done during NICU Stay :

NSG : .....

Hearing Screen : .....

ROP : .....

TFT : .....

NP2 : .....

Doctor Signature (Handover Given): .....

Doctor Name: .....

Date & Time: .....

Doctor Signature (Handover Taken): .....

Doctor Name: .....

Date & Time: .....

BAH-00660853 IP5-00176042
Baby Of BATTULA SHRUTHI
06-07-2026 0Y0M0D1H (M)
Dr. ANNAPOORNA TADAVARTHY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/07/26 3.45pm	S/B Resident	
	1.5 HOL / 39+5 / Primi / SVD / NCh / Caput+ / 3050	
	Mothers B+	Plan
	Baby is doing well	(1) DBF 2nd hrly
	1st feed given	(2) Vaccination OPV, BCG, Hep B } today. given 6/7/26
	baby is Euthermic Euglycemic.	(3) Trace blood group.
	hemodynamically stable	(4) Monitor for urine & stools.
		(5) warm care.
		NB Anjali @ NICU Soluch.
	8:50pm R/S/B Dr Annapu.	P) Vacca today
	M / B+	Establish feeds.
	B / O+ve.	
		Dr. Tadavarthy Annapoorna Reg. No: 53054

BAH-00660853 IP5-00176042
Baby Of BATTULA SHRUTHI
06-07-2026 0 Y 0 M 0 D 7 H (M)
Dr. ANNAPOORNA TADAVARTHY

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 6:00am	c/s IB Resident	
	IB HOL | Term | 39+5 | Primi | SVD	mch | caput+ | 3050g / ~~3050 kgm~~
	m | B+ / B | O+ ; m | V (4) / V | ✓ (4)	Plan TCBR @ 20 HOL-5.5
		① DBF 2nd hrly
	T.wt → 2.940 kg.	
	Baby euthermic - Pink euglycemic.	② warm care
		③ NBS SBR DAE | T/m 2:00pm
	Feeding & latching good	
	cry | tone | activity | good	④ monitor vitals
	B/L red reflex + Equal	
	Peripheries - warm	Soluda
	~~Femoral Pulses~~ +	
	CRT < 3 sec	
	Red spot → (Rt) Forearm	
10Am	P/S/B Dr Annapoorna	
		P) D/c today. F/U wednesday evening
		Dr. Tadavarthy Annapoorna Reg. No: 53054

BAH-00660853 IP5-00176042
Baby Of BATTULA SHRUTHI
06-07-2026 0 Y 0 M 0 D 1 H (M)
Dr. ANNAPOORNA TADAVARTHY

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NURSING DEPARTMENT
NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: ..... Mother's Name: Battula Shruthi

Date of Birth: 6/7/26 Time of Birth: 2:21pm Gender: ☑ Male ☐ Female

Birth Weight: 3.050 Kgs HC: 34 cm Lenght: 49 cm

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

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

Resuscitated: ☐ Yes ☐ No Blood Group: Mother: B+ve Baby: .....

Feeding: ☑ Breast Feeding ☐ Formula ☐ Both First Feed Time: 3pm

AFFIX MOTHER'S IDENTIFICATION LABEL

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

Indication: .....

Physical Assessment of New Born:

Temp: 98 ℃ HR: 140 /Min RR: 40 /Min BP: - SpO_2: 100

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☐ **Yes** ☐ **No** **Score:** 11 (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: Anjali Signature: ..... Date &Time: 6/7/26 3pm

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Baby Of BATTULA SHRUTHI
06-07-2026 0 Y 0 M 0 D 1 H (M)
Dr. ANNAPOORNA TADAVARTHY

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

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

Pratiksha Rainbow Children's Hospital
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 6/7/26 Time:	3pm	6pm	10pm	2Am	6Am
Doctor/Nurse/Family Concern?					
Temperature (F)	98F	98.2F	98.6F	97.9F	98.6F
Heart Rate (bpm) and Blood Pressure (mmHg) *	140	142	140bpm	136bpm	145bpm
Resp Rate (bpm) (Over 1 Minute) *	40	44	40bpm	48bpm	40bpm
Resp Distress: Mod/ Severe / None / Mild	✓	—			
Receiving O_2(l/min) O_2Saturations (%)			99%	100%	99%
Conscious Level: Normal / Altered	✓	—		*	
GCS *			15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	1	1	1
Pain Score	0	0	0	0	0
Observer's Initials					

Note: BP does not score in early warning scoring

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

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00660853 IP5-00176042
Baby Of BATTULA SHRUTHI
06-07-2026 0 Y 0 M 0 D 7 H (M)
Dr. ANNAPOORNA TADAVARTHY

7/7

H / FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Parameter	
Date: .... Time:	10am
Doctor/Nurse/Family Concern?	
Temperature (°F) (scale 94–104)	*98.5F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)	*
Note: BP does not score in early warning scoring	
Heart Rate (Number)	148b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)	*
Resp Rate (Number)	42b/m
Resp Distress – Mod/ Severe	
Resp Distress – None / Mild	N
Receiving O_2 (l/min)	
O_2 Saturations (%)	100%
Conscious Level – Normal	N
Conscious Level – Altered	
GCS *	15/15
TOTAL SCORE Number of shaded boxes	0
Pain Score	0
Observer's Initials	[illegible]

ACTIONS

NB: Scores 3 should be recorded overleaf

Score	Action
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.
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INSTRUCTIONS:

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

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

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

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

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

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Baby Of BATTULA SHRUTHI
06-07-2026 0Y0M0D1H (M)
Dr. ANNAPOORNA TADAVARTHY

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FLUID CHART

Sheet No. : 1

6/7/26

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	Intake: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am				NA							
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
6/7	02:00 pm											
	03:00 pm		DBF							✓		Anjali
	04:00 pm		DBF									Anjali
	05:00 pm										NA	Anjali
	06:00 pm		DBF				✓					Anjali
	07:00 pm						✓			✓		
Total Intake :						**Total Output :** U-2 M-1						
	08:00 pm											
	09:00 pm		DBF				✓				No	Sruthi
	10:00 pm									✓		
	11:00 pm		DBF								IV	Sruthi
	12:00 am											
	01:00 am		DBF				✓					Sruthi
Total Intake :		Refers				**Total Output :** U-1 M-2						
	02:00 am											
	03:00 am		DBF							✓	No	Sruthi
	04:00 am						NP					
	05:00 am		DBF								IV	Sruthi
	06:00 am						1					
	07:00 am		DBF									Sruthi
Total Intake :		Take				**Total Output :** U-1 M-0						

Total 24 hrs. Intake	Take	Total 24 hrs. Output	U-4 M-4

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FLUID CHART

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Sheet No. : 7/7/26

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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am										1	Lakshmi
	09:00 am		DBF				✓			✓	NO IV	Lakshmi
	10:00 am											
	11:00 am		DBF								1	Lakshmi
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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NURSING CARE RECORD

Shift: ☐ Morning ☑ Afternoon ☐ Night

Date: 6/7/26

Assessment: New born baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
3pm	→ Assess the General Condition of the baby boy	3:10pm	→ Assessed the General Condition of the baby boy	
4pm	→ Monitor vitals	4:5pm	→ vitals Monitored & Recorded	Baby was stable
5pm	→ DBF	5:10pm	→ DBF 2nd hourly done	
6pm	→ Maintain I/o Chart	6:05pm	→ I/o Chart maintained	
6:30pm	→ Maintain fluid balance	6:35pm	→ Fluid Balance maintained	
7pm	→ Ensure safety	7:30pm	→ Safety provided	

Re-Assessment: Re-assessment done baby was stable

Special Notes: DBF Every 2nd hourly

Nurse Signature: Anjali Nurse Name: Anjali Date & Time: 6/7/26 @ 8pm

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Baby Of BATTULA SHRUTHI
06-07-2026 0 Y 0 M 0 D 7 H (M)
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NURSING CARE RECORD

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Shift: ☑ Morning ☐ Afternoon ☐ Night

Date: 7/7/26

Assessment: Newborn care

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	8:10AM	# Assessed the general condition	Baby is stg
9AM	# monitor vitals and record	9:10AM	# monitored vitals and Recorded	
10AM	# TO do TCBR as per doctor order	10:10AM	# done TCBR	
11AM	# Ensure safety	11:10AM	# Ensured safety	

Re-Assessment: Baby is doing well taking Feed well

Special Notes:

Nurse Signature: Lalty Nurse Name: Lalty Date & Time: 7/7/26 @ 2pm

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Annapoorna Department: OBS Date of Admission: 6/7/26

SITUATION

Diagnosis: New born baby

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

BACKGROUND

Area / Shift Time	BB-II 2pm-8pm	3rd floor 8pm to 8am	3rd floor 8am 11am			
Medical Condition (Any special condition to be noted):	NA	NA	NA			

ASSESSMENT

Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	98°F	98.0	98.1°F			
Res:	40 b/m	38 b/m	40 b/m			
SpO_2:	100%	99	100%			
Pulse:	140 b/m	138	142 b/m			
BP:	—	—	—			
Fall Risk Score:			—			
Pain Score:	0	0	0/10			

Recommendations

Safety Needs:	Cribe Cote	Crib cote	Crib Cote			
Physiotherapy	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Others Specify:	NA	NA	NA			
Special Diet:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:	NA	NA	NA			
Post Operative Procedure Special Orders:	NA	NA	NA			
Handed Over By Name :	Anjali		Lalitha			
Signature :			Lalitha			
Date:	6/7/26	7/7/26	7/7			
Time:	8pm	@8AM	@11AM			
Taken Over By Name :	Shilpa	Lalitha				
Signature :	Shilpa	Lalitha				
Date:	6/7/26	7/7				
Time:	@8pm	@8AM				

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

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

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

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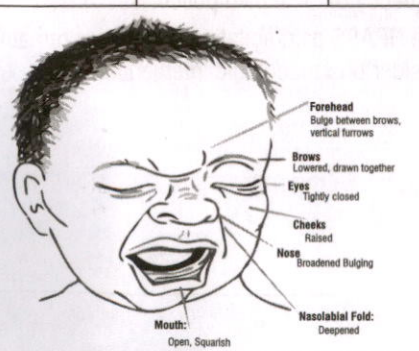
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	Date
						6/7/26	7/2/26							
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time	Time
						3pm	8A							
					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	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							
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	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							
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							



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	39+5 wks	39+5 wks												
Total Pain / Agitation Score	0	0												
Intervention	0	0												
Effectiveness	—	—												
Signature														

Docu.No: RCHBH/FRM/CLINICAL/094

(P.T.O)

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.

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 6/7/26	DATE 7/7/26	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					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	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			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1			
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
	Total		11	11			

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		✓	✓			
	Nurse's Name:		Anjali	Nurse			
	Signature:		Anjali	Nurse			
	Date:		6/7/26	7/7/26			
	Time:		3pm	9am			

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BRADEN 'Q' SCALE

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				Date :	6/7/26	7/7/26		
				Time :	2pm-8pm	8am-2pm		
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		
"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.	2	2		
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		
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		
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."	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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
				TOTAL SCORE	18	18		
				Evaluator's Name	Anjali	Shruthy		

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

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

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DISCHARGE PLANNING FORM

Nationality: India

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

1. Anticipated Date of Discharge: 2 days

2. *Destination Post Discharge:* ☑ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☑ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

			Remarks
☐ Medication	☐ Yes	☐ No	
☐ Bathing	☐ Yes	☐ No	
☐ Eating	☐ Yes	☐ No	No needs assistance
☐ Walking	☐ Yes	☐ No	
☐ Dressing	☐ Yes	☐ No	
☐ Toileting	☐ Yes	☐ No	

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☑ Family Member ☐ Others: .....

5. Discharge Planning Discussed with the:

☐ Patient ☑ Family Member ☐ Others: .....

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hand Hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient ☑ Family Member ☐ Others: .....

Nurse Signature: .....

Nurse Name: Anjali

Date and Time: 6/7/26 @ 4pm

PATIENT TRANSFER FORM

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00660853 IP5-00176042 Baby Of BATTULA SHRUTHI 06-07-2026 0Y0M0D1H (M) Dr. ANNAPOORNA TADAVARTHY	6/7/26 @ 3.5 pm	6/7/26 @ 6:35pm
	Transfer Ordered by Dr. Annapoorna	Reason for Transfer Observation
From Unit BB-11	To Unit Room (330)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File - 30-	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Anjali	Dr. Annapoorna

Patient & Clinical Records Received by : Latha

Date & Time of Patient Received : 6/7/26 @7pm

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