

ADMISSION SHEET


Registration Details :

Admission No : IP5-00175893 Admit Date : 02-Jul-2026 Admit Time : 09:29 PM UHID : BAH-00660538

Patient Details :

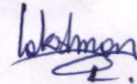
Patient Name	: Baby Of SATYA YAMINI PEMMARAJU	Age	: 0 D
Guardian	: MR LAKSHMAN TEJA LATTIPALLY	DOB	: 02-07-2026 08:17 PM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: FLAT NO 1107, KSR TOGETHERMENTS, NEAR SITARA GRAND MIYAPUR Hyderabad Telangana INDIA 500049	Phone No	: 8756793989/ 9573856269
		E-mail	: psyamini9@gmail.com

Admission Details :

Bed Type : NICU Bed No : NICU 257 Ward Name : 2F-NICU 2
Room No : NICU 257 Admission Type : First Visit

Contact Details :

Name : MR LAKSHMAN TEJA LATTIPALLY Relationship : Father
Contact Address : Phone No : / 8756793989


Signature

Doctor Details :

Doctor Name : Dr. VIJAYANAND JAMALPURI Specialisation : NEONATAL INTENSIVE CARE
Referral Doctor : SELF Phone No :
Co-consultant :

Payment Details :

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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

[illegible]

[illegible]

BAH-00660538 IP5-00175893
Baby Of SATYA YAMINI PEMMARAJU
02-07-2026 0 Y 0 M 0 D 2 H (M)
Dr. VIJAYANAND JAMALPURI



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name : _____

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/7/26	4pm	NICU	339	Shirisha

Cross Consultation Visit

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

[illegible]

Signature





②



①



12

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00660538 IP5-00175893
Baby Of SATYA YAMINI PEMMARAJU
02-07-2026 0 Y 0 M 0 D 2 H (M)
Dr. VIJAYANAND JAMALPURI



ADMISSION CRITERIA – NICU

Admission / Transfer from:

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

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

Prematurity and Low Birth Weight Babies:

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

Major Surgical Problems:

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

Criteria for shifting inborn babies from wards to NICU:

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

Signature of the Doctor:

Name of the Doctor:

Date & Time: 27/2/2026 10pm

Patient Sticker

DISCHARGE CRITERIA – NICU

Discharge to:

☐ HDU / Step down ICU

☐ Ward

☐ Outside Facility

☐ Others:

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

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

Signature of the Doctor:

Name of the Doctor :

Date & Time:

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Satya Yamini Pemmaraju Age : 30y 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 Satya Yamini Pemmaraju Mother's Blood Group : B positive
Gender : ☒ M ☐ F Blood Group : O+ve Birth Weight (gms) : 03188 kg Length (cms) :
Date of Birth : 02/07/26 Time of Birth : 08:17 PM OFC (cms) :
Place of Birth : RCH Bangalore Estimated Gesth Age : 38+4 weeks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 30y Ht : Wt : 60 kg BMI : Married Life : LMP : EDD :

Conception : Spontaneous or with Rx :

Booked at what GA : AN Steroids Drugs / Doses :

Last Scans Details : 15/6 + 36+3 wks, SLUG, 2.5 kg, AC ~12%, Duppl (N)

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 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 : TIFFA (N)

H/o Hypothyroidism : when diagnosed ? Medication?

Hypothyroid x 1 yr

Any other Chronic Medical Problems, when detected

drugs ?

(Anemia, SLE, Jaundice, CHD, Heart Disease)

Infection : H/O, Fever

(☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)

UTI : when : Any culture :

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

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

P: A: L:

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
P1						

PERINATAL HISTORY

Treating Obstetrician : Dr. Hamsabudha Hospital : Reth Bryan ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☒ Emergency Indication :
Specify the reason :
Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitaion : ☐ Yes ☐ No

Cord ABG :

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

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

1 Minute	5 Minutes	10 Minutes
1	1	2
2	2	2
2	2	2
2	2	2
2	2	2
8/10	9/10	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)	0
Lowest Temp (oF)	> 96 (0)	96-95 (8)	< 95 (15)	0
Pao2 / Fio2 (mmHg%)	> 2.49 (0)	1-2.49 (5)	0.3-0.99 (15)	0
Lowest Serum PH	> = 7.2 (0)	7.1-7.19 (7)	< 7.1 (16)	0
Multiple Seizures	No (0)	Yes (19)		0
U. Output (ml / kg / hr)	> = 1 (0)	0. 1-0.9 (5)	< 0.1 (18)	0
Apgar Score	> = 7 (0)	< 7 (18)		0
Brith Weight	> = 1kg (0)	750 - 999 (10)	< 750 (17)	0
SGA	> 3rd percentile (0)	< 3rd (12)		0
Total				0

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

Pain grade 5 35+4 hrs & ↓ fetal movements & non reassuring NST



Baby delivered by emergency LSCS

↓
Baby cried soon after birth, Dec fan

↓
Developed tachypnoea & mild SRR after birth

↓
Started DR-CPAP, distal improved

↓
Intubated to gastric

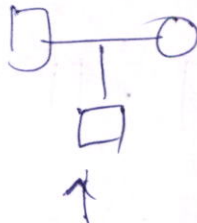
↓
Shifted to NIV + DR-CPAP for observation

Investigation details in previous Hospital :

Feeding History :



Family History :



Socio Economic History :

Middle class

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Mt Baby alert
Distress (+)

VITALS : Temperature : 36.5°C HR : 142/min RR : 62/min NIBP : CFT : 3 sec

Color of the extremities : Pink

Jaundice : Pallor : SpO2 : 96%

ANTHROPOMETRY: Birth Weight : 3.188 kg Length : HC : Present Weight :

Ponderal Index : AGA SGA : LGA :



HEAD TO TOE EXAMINATION

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

AFC @ Cerv

FACIES :
 (Any Facial
 Dysmorphism)

No 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 - No cleft palate

**THORAX and
 BREASTS :**

Shape of Thorax :
 Position of Nipples and Number :

N

**ABDOMEN and
 UMBILICUS :**

Shape :
 Organomegaly :
 Bowel Sounds :
 Umbilical Stump :
 Discharge :

2A + 1 vein

GENITALIA :

Labia / Hymen :
 Testicles/penis :
 Anus :

Male external genitalia.
 B/L testes descended

HERNIAL ORIFICES

N

TRUNK and SPINE :

N

SKIN LESIONS :

N

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: 62/min SCR / ICR / See - Saw breathing : SCR (+)

Scoring of respiratory distress if present (Silverman or Downe's) : 3

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

Settings :

SpO₂: 96.1 Auscultation: Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 142/min BP :

Precordial Activity : (+)

Femoral Pulses : 1 to be checked

Murmurs : nil

Other Peripheral Pulses :

Signs of Cardiac Failure : nil

ABDOMEN:

Shape : (+)

Hernia orifice :

Palpation : (+)

Anal Patency : Patent

Palpable masses :

Umbilical Cord : 2A fibres

Abdominal girth :

First urine passed :

Meconium passed :

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score : Alert, activity - good

Nerves : OK

MOTOR SYSTEM:

Passive Tone : Tone (+)

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR :

ATNR : Skull and Spine :



Diagnosis :

Term (38+4 wks) / AGA (3-188 kg) / LSCS / Male / RTA
Delayed transition.

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

Consultant :

Signature :

Name :

Date & Time :

Dr. VIJAYANAND JAMALPURI
Reg. No: 40526

Dr. VIJAYANAND JAMALPURI

02/06/2026

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 :

Plan

1) low flow SOS.

Plan during ward follow up :

2) Give 1 OG feeds → till reassess
 → if distress settles
 palladai feeds

16 ml/2hly (goodtly plan)

Feeding Plan at the time of shifting :

3) w/f tachypnea, ↑ Retractions, ↑ WOP

4) Plan to shift to mother's milk if
 distress settles

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

5) Check baby blood group.

5) chest x Ray SOS if
 distress persists > 6 hrs

(Signature)

(9800)

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:

BAH-00660538 IP5-00175893
 Baby Of SATYA YAMINI PEMMARAJU
 02-07-2026 0 Y 0 M 3 D (M)
 Dr. VIJAYANAND JAMALPURI



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

BirthRight
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 Your Right to a Safe Delivery

EMERGENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1+1			
4	Patient Transfer form	1			
5	In-patient Medical record				
6	Doctors progress sheets	4			
7	Nursing plan of care and handover sheets	2x5			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed	1			
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation				
24	Emergency Triage record				
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	4			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)				
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)	2			
36	Consent for Admission in PICU / NICU	1			
37	The Humpty dumpty scale	1			
38	Braden Q Scale	2			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart	1			
	measoon	1			
	Bdhan	2			
	Other	2			
	Total No. of Pages				

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/3/26 8:40am	Seen - by Dr. VJ	Plan
		- repeat every now - W/F - briefly / closed / apnea - full OR feeds - try paladai after 2hr - NP₁ - @ 24HOL - CRBS monitoring - BG hely : - RIV - shift out in afternoon
3/3/26 1:30pm	Afternoon Rounds	Noted by G. Aloys 3/3/26 Dr. VIJAYANAND JAMALPURI Reg. No. 40526 18HOL (38th wk (3.18kg) / delayed transition Plan Baby on. vroom in hemodynamically stable. HR - 130/min SpO₂ - 95% Peripheries - warm passing urin/stool/ RBS - 78mg/dL accepting paladai feeds - RIV - 70-80cc/kg/day - RIV - TV - 80cc/kg/day - NP₁ - @ 24HOL - CRBS - monitoring BG HOL - RIV - chest x ray



2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/26 2:40 PM		
		Plan
		→ Start loco flow 0.5L/min Oxygen
		→ TV: 60 cels/day
		- OA feeds - 16ml/2hrs.
		- W/A - RD
		- NP, - @ 24 HCL.
		Dr. VIJAYANAND JAMALPURI Noted by 40526
		3/3/26 2pm



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

Day in NICU: 1 Day of Life: 121 Hrs PMA: 38⁵ wks
 Term ☒ Preterm ☐ Gestation: 38⁴ wks Corrected Gestational Age: Today's Weight:

Problems	
S.No.	Current
1.	Term / AAA / Mch / ems / Non reactive NST
2.	RD
3.	
4.	
5.	
6.	

Clinical Assessment	
M/Bt. - Passed urine Stool → on OA - feeds → NO signs of RD	HR - 118/min SpO ₂ - 98% periphery - warm Chest X Ray

Medications Used	
Plan of Care: RIV - 60cc/kg/day - 16ml/2 hrs - Paladai feeds → Trace BBG - RIV - shift to mother side	

Doctor's Name (Hand over given): Pavan

Signature: Pavan

Time: 3/7/26

Doctor's Name (Hand over taken):

Signature:

Date & Time:

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

Day in NICU: 2 Day of Life: 36 HOURS PMA:

Term ☐ Preterm ☐ Gestation: 38⁺4 wk Corrected Gestational Age: Today's Weight: 3.224kg

		Problems	
		S.No.	Current
Overview		1.	Term / AetM / Mch /
		2.	Premomediastinum
		3.	
		4.	
		5.	
		6.	
Clinical Assessment	Baby on low flow - 0.5 L/min - hemodynamically stable - on O₂ feeders - passing - urine / stool P/A - soft HR - 127/min SPO₂ - 96%		
	Medications Used		
Plan of Care: → RIV - Tapering O₂ → TU - 80 CC/kg/day - 21 ml - 82 Hly Paladar feed - RIV - shift out			

Doctor's Name (Hand over given): Pawan

Signature: Pawan

Date & Time: 4/2/26

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/2/26 9 am	Morning Rounds	
		Plan
	NP ₁ - remained	XRay - Now
		- WIF - apnea / bradycardia / desat
		→ Paladar feeds
		- TV - 80 cc/kg/day
		- 21 ml / @ 2 Hrs
		- CRBS - @ 6 Hrs
		→ RIV - SBR / NBS @ 48 Hrs
		Pawan
4/2/26 1.20 pm	Afternoon Rounds	
		Plan
	42 Hrs / AuA / mech.	→ continue low flow O ₂
	Pneumothorax	→ TV - 80 cc/kg/day
	- on low flow - 0.5 L/min	- 21 ml / @ 2 Hrs
	- HR - 44 / 120/min	- Paladar feeds
	SpO ₂ - 95%	→ CRBS - @ 6 Hrs
	→ tolerating feeds well	→ RIV - SBR / NBS - @ 48 Hrs
	- PIA - soft	→ IIO - Changing @ 6 Hrs
	episode of <u>uric</u>	

Dr. VIJAYANAND JAMALPURI
 Reg. No: 40526

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 @ 8:50pm		Seen by Dr. Vijayan
		1) Start paladary feeds.
	1epi of vomiting	2) clinical assessment.
		2) SBR } @ 48 H.O.L. NBS } @ 8:30 pm
		3) Cont. low flow O ₂ at 1L/min
	Noted by Sona 4/7/26 @ 4pm	Sona
4/7/26 @ 8:30pm	Night rounds S/B: Dr. HJ Nilesh	
	- Baby on low flow 1L/min	Plan
	hemodynamically stable tolerates feeds well No further vomiting	→ cont. low flow O ₂ → Repeat X-ray - T/m. → continue paladary feeds - w/f - desat during feeding if desat - O ₂ - SOS.
	Noted by Jeevanani 4/7/26	Paras 4/7/26

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

Day in NICU: 3 Day of Life: 60+04 PMA: 38 14 w 14
 Term ☐ Preterm ☐ Gestation: 38 14 w 14 Corrected Gestational Age: 38 14 w 14 Today's Weight: 3.220 kg

	Problems	
	S.No.	Current
Overview	1.	Term 1st inch
	2.	pneumothorax
	3.	
	4.	
	5.	
	6.	
Clinical Assessment	Baby on low flow - 1L/min hemodynamically stable accepts feeds well. passing - urine/stool.	
	HR - 90/min 118/min SpO ₂ - 97%	
Medications Used	SIBR-10.1 @ 400mg	
	Plan of Care: → cont. low flow O₂ → CO 70-80 cc/kg/day → RIV-TU-100cc/kg/day → Trace chest xray → RIV-shift out	

Doctor's Name (Hand over given): Pavan
 Signature: Pavan
 Date & Time: 5/12/26
 Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken): Dr. S. S. S.
 Signature: S. S. S.
 Date & Time: 5/12/26

Patient Sticker

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

Day in NICU: Day of Life: PMA:

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

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

Doctor's Name (Hand over given):

Signature:

Date & Time:

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26 7:40am	Seen by Dr. VJ	
		Plan
		- off O ₂ .
		→ full paladi feed
		→ Shift out.
		→ clinical assessment of jaundice @ in evening
		Noted by Naveya Vadi 5/7/26
		Dr. VIJAYANAND JAMALPURI Reg. No: 40526
5/7/26 3pm	<u>Shifting notes</u>	
		Plan
	Baby on Room air	1. Continue on Room air
	no RDL no desaturation	2. Trz 100 ctk/1 day
	Accepting and tolerating full paladi feed	3. Shift to Room
	Spo ₂ : 98.1	4. Clinical assessment of jaundice @ 6pm
	PR: 146/hr	5. Vaccination after shifting to Room
	RR: 53/min	
	CRT 2 sec	
	PIA = soft	
	Passed urine & stool	5. R/R Heavy screen

BAH-00660538 IP5-00175893
 Baby Of SATYA YAMINI PEMMARAJU
 02-07-2026 0 Y 0 M 0 D 2 H (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
05/07/26 9:50 AM	Morning WR ~~~~~	Seen by Dr. Vijayanand
	• Feeding - Accepting well	1) Nasocele drops
	• URINE -	2) SBR AABR - Hearing asses } Today
	• Bowels -	Review on NBS 3) Trace NBS.
	Weight - 3.090.	4) Feeding assessment Lactation Counselling
	Nose Block (+) R/S - clear No Recession	5) if Discharge Today flup on wednesday
		6) if SBR > 15 - Start phototherapy
		7) Vaccination } Today BCG, HepB, OPV

DR. VIJAYANAND JAMALPURI
 Registration No: 40528

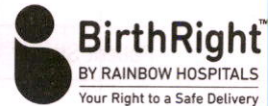
BAH-00660538 IP5-00175893
 Baby Of SATYA YAMINI PEMMARAJU
 02-07-2026 0 Y 0 M 3 D (M)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		6/7/26
		AABR-Hearing Assessment
		Bilateral responses are present
		Bilateral Normal
		<i>[Signature]</i> 6/7/26
6/7 10 AM	<u>Lactation notes:</u>	
	- Peini	
	- well formed breast,	
	- nipples slightly everted.	
	- Baby is crying when getting to breast and was able to latch with shield.	
	<u>Advice</u>	
	- Direct breast feeding.	
	- Aim for deep latch as demonstrated.	
	- Make baby suck for 15-20 min on each side.	
	- Demand feeding not exceeding 2-2½ hours	
		<i>[Signature]</i> Superv

[illegible]



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RESULT SHEET

Date	03/7/26	4/7/26			
Time	10:30pm	9pm			
Hb	22.4				
PCV	63.9				
RBC	6.56				
WBC	19.20				
N/L	66.3/20.8				
Platelets	257				
CRP	7.0				
ESR					
PCT					
RBS					
Na	135				
K	5.7				
Cl	108				
Ca/Mg	9.3				
Phosphate					
Urea	14				
Creatinine	0.8.				
ALP					
SGPT					
SGOT					
T.Bill/Conj	6.6	10.1 unconj	10.1	10.1 unconj	
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc..) :

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 Baby Of SATYA YAMINI PEMMARAJU
 02-07-2026 0 Y 0 M 0 D 2 H (M)
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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD



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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
3/9	9am	10	Fall Risk Education.	—	—	—	—	—	—	

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C Caregiver O: Other (Specify)

Learning Barriers:

1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

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

Mechanism/s to overcome barrier/s:

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

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

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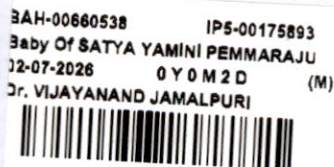
MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
2/7	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Term / Acft. R-D	hemor. stabilis	SOS-low flow	Per	☐ Nursing ☒ Others:
2/7	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Term / Acft. x10 keep LF RDS.		*low flow connected	D	☒ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Satya Yamini Mother's Name: Satya Yamini

Date of Birth: 21/7/26 Time of Birth: 8:17 PM Gender: ☒ Male ☐ Female

Birth Weight: 3.188 Kgs HC: cm Length: cm

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

Term / Pre-term / Post-term:

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

Feeding: ☐ Breast Feeding ☒ Formula ☐ Both First Feed Time:

AFFIX MOTHER'S
IDENTIFICATION LABEL

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

Indication:

Physical Assessment of New Born:

Temp: 98.1 °C HR: 120 /Min RR: 40 /Min BP: SpO₂: 99%

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: Shinsh

Signature: [Signature]

Date & Time: 5/7/26 8 PM

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 Baby Of SATYA YAMINI PEMMARAJU
 02-07-2026 0 Y 0 M 0 D 2 H (M)
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Doc. No. : RCH / FM / CLINICAL / 124

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time: 12 AM 2 AM 4 AM 6 AM
Doctor/Nurse/Family Concern?	

Temperature (F)	104				
	103				
	102				
	101				
	100	36.2°C	36.5°C	36.4°C	36.5°C
	99				
	98				
	97				
	96				
	95				
	94				

Heart Rate (bpm) and Blood Pressure (mmHg) *	190				
	180				
	170				
	160				
	150				
	140				
	130				
	120				
	110				
	100				
	90				
	80				
	70				
	60				
	50				

Heart Rate (Number)	129	132	145	139
---------------------	-----	-----	-----	-----

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%	95%	96%	95%

Conscious Level	Normal				
	Altered				
GCS *		14	14	14	14

TOTAL SCORE				
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	ke	ke	ke	ke

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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 Baby Of SATYA YAMINI PEMMARAJU 0 Y 0 M 0 D 2 H (M)
 02-07-2026 Dr. VIJAYANAND JAMALPURI

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 7 11 1 3 5 8 10 12 2 4 6

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)

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

Resp Rate (Number)

Resp Mod/ Severe
 Distress None / Mild

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

Conscious Level Normal
 Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
 recorded overleaf

Score 1 : Continue normal observation by staff nurse

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 hlf hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or Oncallight duty consultant to see

Score 5 & 6 : Shift incharge and PICU / NICU fellow or PICU/NICU consultant to beformed

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

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Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
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I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
	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.
	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. Sp he fluid/ repeat observation)

IP5-00175893

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

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 4/7/26 Time:

9AM 11AM 1PM 3PM 5PM 8PM 8 10 12 2 4 6

Doctor/Nurse/Family Concern?

Am Am PM

Temperature
(°F)[illegible]

Heart Rate
(bpm)

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

and

Blood Pressure
(mmHg) *

Note:

BP does not score in early warning scoring

Heart Rate (Number)

101 120 111 104 111 113 110 152 160 148 132 108

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

70
60
50
40
30
20
10

Resp Rate (Number)

Resp	Mod/ Severe
Distress	None / Mild

$N \quad N \quad N \quad N \quad R/r \quad R/r \quad R$

Receiving O ₂ (l/min)	O ₂ Saturations (%)
0	95.0
1	95.0
2	95.0
3	95.0
4	95.0
5	95.0
6	95.0
7	95.0
8	95.0
9	95.0
10	95.0
11	95.0
12	95.0
13	95.0
14	95.0
15	95.0
16	95.0
17	95.0
18	95.0
19	95.0
20	95.0
21	95.0
22	95.0
23	95.0
24	95.0
25	95.0
26	95.0
27	95.0
28	95.0
29	95.0
30	95.0
31	95.0
32	95.0
33	95.0
34	95.0
35	95.0
36	95.0
37	95.0
38	95.0
39	95.0
40	95.0
41	95.0
42	95.0
43	95.0
44	95.0
45	95.0
46	95.0
47	95.0
48	95.0
49	95.0
50	95.0
51	95.0
52	95.0
53	95.0
54	95.0
55	95.0
56	95.0
57	95.0
58	95.0
59	95.0
60	95.0
61	95.0
62	95.0
63	95.0
64	95.0
65	95.0
66	95.0
67	95.0
68	95.0
69	95.0
70	95.0
71	95.0
72	95.0
73	95.0
74	95.0
75	95.0
76	95.0
77	95.0
78	95.0
79	95.0
80	95.0
81	95.0
82	95.0
83	95.0
84	95.0
85	95.0
86	95.0
87	95.0
88	95.0
89	95.0
90	95.0
91	95.0
92	95.0
93	95.0
94	95.0
95	95.0
96	95.0
97	95.0
98	95.0
99	95.0
100	95.0

100%	97%	100%	93%	98%	99%	97%	99%	95%	96%	97%
------	-----	------	-----	-----	-----	-----	-----	-----	-----	-----

Conscious Level	Normal Altered
-----------------	-------------------

[illegible]

GCS *

C	C	C	C	C	C		C	C	C	C	C	C
---	---	---	--------------	---	---	--	---	---	---	---	---	---

TOTAL SCORE

Number of shaded boxes

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

Pain Score

7		\		/	/	/	o		o	o	o	o	o	o	o
---	--	---	--	---	---	---	---	--	---	---	---	---	---	---	---

Observer's Initials

~~1~~ ~~2~~ ~~3~~ ~~4~~ ~~5~~ ~~6~~ ~~7~~ ~~8~~ ~~9~~ ~~10~~ ~~11~~ ~~12~~ ~~13~~ ~~14~~ ~~15~~ ~~16~~ ~~17~~ ~~18~~ ~~19~~ ~~20~~ ~~21~~ ~~22~~ ~~23~~ ~~24~~ ~~25~~ ~~26~~ ~~27~~ ~~28~~ ~~29~~ ~~30~~ ~~31~~ ~~32~~ ~~33~~ ~~34~~ ~~35~~ ~~36~~ ~~37~~ ~~38~~ ~~39~~ ~~40~~ ~~41~~ ~~42~~ ~~43~~ ~~44~~ ~~45~~ ~~46~~ ~~47~~ ~~48~~ ~~49~~ ~~50~~ ~~51~~ ~~52~~ ~~53~~ ~~54~~ ~~55~~ ~~56~~ ~~57~~ ~~58~~ ~~59~~ ~~60~~ ~~61~~ ~~62~~ ~~63~~ ~~64~~ ~~65~~ ~~66~~ ~~67~~ ~~68~~ ~~69~~ ~~70~~ ~~71~~ ~~72~~ ~~73~~ ~~74~~ ~~75~~ ~~76~~ ~~77~~ ~~78~~ ~~79~~ ~~80~~ ~~81~~ ~~82~~ ~~83~~ ~~84~~ ~~85~~ ~~86~~ ~~87~~ ~~88~~ ~~89~~ ~~90~~ ~~91~~ ~~92~~ ~~93~~ ~~94~~ ~~95~~ ~~96~~ ~~97~~ ~~98~~ ~~99~~ ~~100~~ ~~101~~ ~~102~~ ~~103~~ ~~104~~ ~~105~~ ~~106~~ ~~107~~ ~~108~~ ~~109~~ ~~110~~ ~~111~~ ~~112~~ ~~113~~ ~~114~~ ~~115~~ ~~116~~ ~~117~~ ~~118~~ ~~119~~ ~~120~~ ~~121~~ ~~122~~ ~~123~~ ~~124~~ ~~125~~ ~~126~~ ~~127~~ ~~128~~ ~~129~~ ~~130~~ ~~131~~ ~~132~~ ~~133~~ ~~134~~ ~~135~~ ~~136~~ ~~137~~ ~~138~~ ~~139~~ ~~140~~ ~~141~~ ~~142~~ ~~143~~ ~~144~~ ~~145~~ ~~146~~ ~~147~~ ~~148~~ ~~149~~ ~~150~~ ~~151~~ ~~152~~ ~~153~~ ~~154~~ ~~155~~ ~~156~~ ~~157~~ ~~158~~ ~~159~~ ~~160~~ ~~161~~ ~~162~~ ~~163~~ ~~164~~ ~~165~~ ~~166~~ ~~167~~ ~~168~~ ~~169~~ ~~170~~ ~~171~~ ~~172~~ ~~173~~ ~~174~~ ~~175~~ ~~176~~ ~~177~~ ~~178~~ ~~179~~ ~~180~~ ~~181~~ ~~182~~ ~~183~~ ~~184~~ ~~185~~ ~~186~~ ~~187~~ ~~188~~ ~~189~~ ~~190~~ ~~191~~ ~~192~~ ~~193~~ ~~194~~ ~~195~~ ~~196~~ ~~197~~ ~~198~~ ~~199~~ ~~200~~ ~~201~~ ~~202~~ ~~203~~ ~~204~~ ~~205~~ ~~206~~ ~~207~~ ~~208~~ ~~209~~ ~~210~~ ~~211~~ ~~212~~ ~~213~~ ~~214~~ ~~215~~ ~~216~~ ~~217~~ ~~218~~ ~~219~~ ~~220~~ ~~221~~ ~~222~~ ~~223~~ ~~224~~ ~~225~~ ~~226~~ ~~227~~ ~~228~~ ~~229~~ ~~230~~ ~~231~~ ~~232~~ ~~233~~ ~~234~~ ~~235~~ ~~236~~ ~~237~~ ~~238~~ ~~239~~ ~~240~~ ~~241~~ ~~242~~ ~~243~~ ~~244~~ ~~245~~ ~~246~~ ~~247~~ ~~248~~ ~~249~~ ~~250~~ ~~251~~ ~~252~~ ~~253~~ ~~254~~ ~~255~~ ~~256~~ ~~257~~ ~~258~~ ~~259~~ ~~260~~ ~~261~~ ~~262~~ ~~263~~ ~~264~~ ~~265~~ ~~266~~ ~~267~~ ~~268~~ ~~269~~ ~~270~~ ~~271~~ ~~272~~ ~~273~~ ~~274~~ ~~275~~ ~~276~~ ~~277~~ ~~278~~ ~~279~~ ~~280~~ ~~281~~ ~~282~~ ~~283~~ ~~284~~ ~~285~~ ~~286~~ ~~287~~ ~~288~~ ~~289~~ ~~290~~ ~~291~~ ~~292~~ ~~293~~ ~~294~~ ~~295~~ ~~296~~ ~~297~~ ~~298~~ ~~299~~ ~~300~~ ~~301~~ ~~302~~ ~~303~~ ~~304~~ ~~305~~ ~~306~~ ~~307~~ ~~308~~ ~~309~~ ~~310~~ ~~311~~ ~~312~~ ~~313~~ ~~314~~ ~~315~~ ~~316~~ ~~317~~ ~~318~~ ~~319~~ ~~320~~ ~~321~~ ~~322~~ ~~323~~ ~~324~~ ~~325~~ ~~326~~ ~~327~~ ~~328~~ ~~329~~ ~~330~~ ~~331~~ ~~332~~ ~~333~~ ~~334~~ ~~335~~ ~~336~~ ~~337~~ ~~338~~ ~~339~~ ~~340~~ ~~341~~ ~~342~~ ~~343~~ ~~344~~ ~~345~~ ~~346~~ ~~347~~ ~~348~~ ~~349~~ ~~350~~ ~~351~~ ~~352~~ ~~353~~ ~~354~~ ~~355~~ ~~356~~ ~~357~~ ~~358~~ ~~359~~ ~~360~~ ~~361~~ ~~362~~ ~~363~~ ~~364~~ ~~365~~ ~~366~~ ~~367~~ ~~368~~ ~~369~~ ~~370~~ ~~371~~ ~~372~~ ~~373~~ ~~374~~ ~~375~~ ~~376~~ ~~377~~ ~~378~~ ~~379~~ ~~380~~ ~~381~~ ~~382~~ ~~383~~ ~~384~~ ~~385~~ ~~386~~ ~~387~~ ~~388~~ ~~389~~ ~~390~~ ~~391~~ ~~392~~ ~~393~~ ~~394~~ ~~395~~ ~~396~~ ~~397~~ ~~398~~ ~~399~~ ~~400~~ ~~401~~ ~~402~~ ~~403~~ ~~404~~ ~~405~~ ~~406~~ ~~407~~ ~~408~~ ~~409~~ ~~410~~ ~~411~~ ~~412~~ ~~413~~ ~~414~~ ~~415~~ ~~416~~ ~~417~~ ~~418~~ ~~419~~ ~~420~~ ~~421~~ ~~422~~ ~~423~~ ~~424~~ ~~425~~ ~~426~~ ~~427~~ ~~428~~ ~~429~~ ~~430~~ ~~431~~ ~~432~~ ~~433~~ ~~434~~ ~~435~~ ~~436~~ ~~437~~ ~~438~~ ~~439~~ ~~440~~ ~~441~~ ~~442~~ ~~443~~ ~~444~~ ~~445~~ ~~446~~ ~~447~~ ~~448~~ ~~449~~ ~~450~~ ~~451~~ ~~452~~ ~~453~~ ~~454~~ ~~455~~ ~~456~~ ~~457~~ ~~458~~ ~~459~~ ~~460~~ ~~461~~ ~~462~~ ~~463~~ ~~464~~ ~~465~~ ~~466~~ ~~467~~

ACTIONS

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

* 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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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



FLUID CHART

Sheet No. :

2/7

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am	NAN DND			16 ml					15 ml			
	01:00 am												
Total Intake :						Total Output :							
	02:00 am	NAN DND			16 ml		passed						
	03:00 am												
	04:00 am	NAN DND			16 ml					25 ml			
	05:00 am												
	06:00 am	NAN DND			16 ml					15 ml			
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART

Sheet No. :

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	NG							
	08:00 am	Naespo							10ml			
	09:00 am	Naespo			16ml		passed					
	10:00 am	Naespo										
	11:00 am	Naespo			16ml		passed					
	12:00 pm	Naespo							8ml			
	01:00 pm	Naespo			6ml							
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm	Naespo			16ml				10ml			
	04:00 pm											
	05:00 pm	Naespo			16ml				6ml			
	06:00 pm											
	07:00 pm	Naespo			16ml		passed		10ml			
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm	Naespo			16ml				9ml			
	10:00 pm											
	11:00 pm	Naespo			16ml		passed		8ml			
	12:00 am											
	01:00 am	Naespo			16ml				7ml			
Total Intake :					Total Output :							
	02:00 am											
	03:00 am	Naespo			16ml				8ml			
	04:00 am						passed					
	05:00 am	Naespo			16ml				9ml			
	06:00 am											
	07:00 am	Naespo			16ml				7ml			
Total Intake :					Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output



4/7/26

FLUID CHART

TV: 60 ccl/kg/day
 B.W: 3.188 Kgs
 TF: 16 ml

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am	Naupso			15ml					7cm 15ml		
	10:00 am									passed		
	11:00 am	Naupso	21ml							cm		0
	12:00 pm									.		
	01:00 pm	Naupso	21ml							9ml 13ml		
Total Intake : 63ml						Total Output : 24ml						
	02:00 pm											
	03:00 pm	Naupso	21ml				Passed			10ml		
	04:00 pm											
	05:00 pm	Naupso	21ml				-			8ml		
	06:00 pm											
	07:00 pm	Naupso	21ml				Passed			12ml		
Total Intake : 63ml						Total Output : 80ml						
	08:00 pm											
	09:00 pm	Naupso	21ml							8ml		
	10:00 pm											
	11:00 pm	Naupso	21ml				passed			7ml		
	12:00 am											
	01:00 am	Naupso	21ml				-			6ml		
Total Intake : 63ml						Total Output : 21ml						
	02:00 am											
	03:00 am	Naupso	21ml				passed			8ml		
	04:00 am											
	05:00 am	Naupso	21ml				-			9ml		
	06:00 am											
	07:00 am	Naupso	21ml				-			10ml		
Total Intake : 252ml						Total Output : 102ml						

Total 24 hrs. Intake 60 ccl/kg/day

Total 24 hrs. Output 1.3 ccl/kg/day



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. : 20

5/7/26.

FF: 80 cal/kg/day
 B.W: 3.1 kg
 FF: 21ml

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	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am	efm 5ml										
	09:00 am	Alap 21ml					passed			10ml		
	10:00 am											
	11:00 am	Alap 21ml					passed			8ml		
	12:00 pm											
	01:00 pm	Wanpr 21ml										
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm	Wanpr 21ml								15ml		
	04:00 pm											
	05:00 pm	ff 21ml					✓			✓	NA	
	06:00 pm											
	07:00 pm	ff 21ml										
Total Intake :						Total Output : M - 2 ✓ 2						
	08:00 pm											
	09:00 pm						✓			✓		
	10:00 pm	FF (20) (10ml)								✓		
	11:00 pm											
	12:00 am											
	01:00 am	30ml								✓		
Total Intake :						Total Output :						
	02:00 am											
	03:00 am	20ml										
	04:00 am											
	05:00 am	30ml					✓			✓	NA	
	06:00 am											
	07:00 am	20ml										
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

M = 5, U = 7



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 03/07/26

Assessment: baby is 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
8 PM	-> Assess the General condition.	8 PM	=> Assessed the General condition	Baby is stable
10 PM	=> Monitored vital	10 PM	=> Monitored vital	
12 AM	=> I/O chart maintain	12 AM	=> I/O chart maintain	
2 AM	=> Administer as per doctor order	2 AM	=> Administer as per doctor order	
8 AM	=> 2nd hourly feed	8 AM	=> 2nd hourly feed	

Re-Assessment: Re-Assessment done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Jivamani

Date & Time: 04/07/26 8 PM 8 AM

BAH-00000538 IP5-00175893
 Baby Of SATYA YAMINI PEMMARAJU
 02-07-2026 0 Y 0 M 0 D 13 H (M)
 Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 11/3/26

Assessment: Baby is on Rb

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	Assess the baby's Condition.	8:30 AM	Assessed baby's Condition	Baby is stable
9 AM	monitor the vitals	9:30 AM	monitored the vitals.	
10 AM	maintain Rb chest	10:30 PM	maintained Rb chest	
11 AM	give feed and hourly	11:30 AM	given feed and hourly	
12 PM	Administer medication as per doctor orders	1 PM	Administered medication as per doctor orders.	

Re-Assessment: Done

Special Notes: RBS - BD

Nurse Signature: [Signature]

Nurse Name: Naveen C

Date & Time: 9 PM / 11/3/26



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

Assessment: Baby is on nas. L/E

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 baby general condition	2pm	Assessed the baby general condition	Baby is stable
3pm	maintain I/O chart	3pm	maintained I/O chart	
4pm	monitor vitals	4pm	monitored I/O chart	
5pm	Feed gube every 2 hours	5pm	Feed gube every 2 hours	
6pm	Administer medication as per the doctor's order	6pm	Administered medication as per the doctor's order	
7pm	Ensure safety	7pm	Ensured safety	

Re-Assessment: Re-Assessment Done

Special Notes: RBS BD, B

Nurse Signature: [Signature] Nurse Name: Sonu Date & Time: 4/7/26 @ 8pm-8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26 @ 8pm

Assessment: Baby is on L/P

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	To Assess the baby general condition.	8pm	Assessed baby general condition	Baby is Stable on L/P
10pm	To monitor vitals & maintain I/O chart	10pm	monitored vitals & maintain I/O chart	
12AM	To Give 2nd Hourly feed	12AM	Given 2nd Hourly feed	
2AM	To provide comfortable position	2AM	provided comfortable posi	
4AM	To Administer provided wear	4AM	Administered wear	
6AM	care	6AM	provided wear care to baby	
7AM	Ensure safety.	7AM	Ensured safety.	

Re-Assessment:

Done

Special Notes:

RBS - 080

Nurse Signature: [Signature]

Nurse Name: Jeevanani

Date & Time: 5/7/26 @ 8AM



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 5/2/26

Assessment: Baby is on RIA

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the baby's condition	9pm	Assess baby's condition	Baby is stable in RIA
10pm	monitor the vitals	11pm	monitored the vitals	
12pm	maintain Pb chest	1pm	maintained Pb chest	
2pm	give feed and handle	3pm	given feed and handle	
3pm	train parents to give paddy feed	3:30pm	trained mother & father to give feed.	

Re-Assessment: Done

Special Notes: RBS - BD

Nurse Signature:

Nurse Name: Naveen S

Date & Time: 5/2/26 @ 4pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Baby on room air

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ To assess the general condition of the baby.	8:30pm	→ Assessed the general condition of the baby.	Baby is stable Vitals normal
11pm	→ To monitor vital signs	11:10pm	→ Monitored vital signs	
1am	→ To encourage oral intake	1:40 am	→ DBE + FF 20 to 30ml 2 to 3rd July.	
3am	→ To check GRBS	3:20am	→ Checked GRBS OB	
5am	→ To provide warm care	5:10am	→ Provided warm care	
7am	→ To maintain I/O chart	7:35am	→ Maintained I/O chart	

Re-Assessment: Has good oral intake

Special Notes: Vaccination - 1m

Nurse Signature: [Signature]

Nurse Name: Kalyani

Date & Time: 6/7 at 8am

BAH-00660538 IP5-00175893
 Baby Of SATYA YAMINI PEMMARAJU
 12-07-2026 0 Y 0 M 2 D (M)
 Dr. VIJAYANAND JAMALPURI



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: V.T Department: 3rd 41007 Date of Admission: 2/7/26

SITUATION	Diagnosis: <u>NB</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area	<u>3rd 41007</u>	<u>3rd 41007</u>			
	Shift Time	<u>8pm</u>	<u>8am</u>			
	Medical Condition (Any special condition to be noted):	<u>NB</u>	<u>NB</u>			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>98.1°</u>	Temp: <u>98°</u>			
	Res:	<u>20b/m</u>	<u>20b/m</u>			
	SpO ₂ :	<u>100%</u>	<u>100%</u>			
	Pulse:	<u>140</u>	<u>136b/m</u>			
	BP:	<u>-</u>	<u>-</u>			
	Fall Risk Score:	<u>0/2</u>	<u>16</u>			
Recommendations	Pain Score:	<u>0/10</u>	<u>0</u>			
	Safety Needs:	<u>NA</u>	<u>NA</u>			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>NA</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>			
	Post Operative Procedure Special Orders:	<u>NA</u>	<u>NA</u>			
	Handed Over By Name :	<u>Shirish</u>	<u>Kalyani</u>			
	Signature :	<u>[Signature]</u>	<u>[Signature]</u>			
	Date:	<u>8/7/26</u>	<u>8/7</u>			
	Time:	<u>8pm</u>	<u>8am</u>			
	Taken Over By Name :	<u>Kalyani</u>				
	Signature :	<u>[Signature]</u>				
	Date:	<u>8/7</u>				
	Time:	<u>8pm</u>				



BRADEN 'Q' SCALE

					Date :	2/2	3/2	3/2	4/2
					Time :	8:00am	2pm	6pm	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:tremitry position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	3	3	3	3	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1	1	1	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	3	3	3	3	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3	3	3	3	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	3	3	3	
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.	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.	3	3	3	3	
TOTAL SCORE					19	19	19	19	
Evaluator's Name					WV	WV	WV	WV	

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



BRADEN 'Q' SCALE

					Date : 6/7			
					Time : 6am			
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.	34			
"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.	3			
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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			
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Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	23		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Kalman		

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
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Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4		5/7			
	3 to less than 7 years old	3		4	4		
	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	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		
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					
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				16	16		

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position			✓	No		
Call device within reach			✓	Yes		
Wheels Locked			✓	Yes		
Room free of clutter			✓	Yes		
Adequate lighting			✓	Yes		
Wheel chair support			X	No		
Other Intervention(s) Specify			X	No		
Nurse's Name:						
Signature:						
Date:			5/7	6/7		
Time:			11:00	6:00		



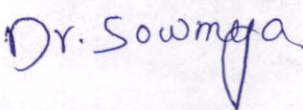
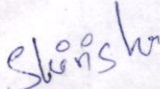
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

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
						02/07/2026	03/07/2026	04/07/2026	05/07/2026	06/07/2026	07/07/2026	08/07/2026	09/07/2026
						2PM	2PM	6PM	6PM	6PM	6PM	6PM	6PM
						RPS	RPS	RPS	RPS	RPS	RPS	RPS	RPS
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)	0	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	0	0	0	0	0	0	0	0
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0	0	0	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	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					Gestational Age / Corrected Age 0 0 0 0 0 0 0 0 35+4 weeks							
	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					Total Pain / Agitation Score 1/4 1/10 1/10 1/10 1/10 1/10 1/10 1/10 0							
						Intervention w FR ff FE FF FF FF FF PPT 0							
						Effectiveness u NA NA NA NA NA NA NA NA NA							
						Signature e [Signature] [Signature] [Signature] S [Signature] [Signature] [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.

PATIENT TRANSFER FORM

Patient Name & IHD No. 3AH-00660538 IP5-00175893 Baby Of SATYA YAMINI PEMMARAJU 12-07-2026 0 Y 0 M 2 D (M) Dr. VIJAYANAND JAMALPURI 		Date & Time of Admission 2/7/26 9:29pm	Date & Time of Transfer Order 5/7/26 @ 4:20pm
		Transfer Ordered by Dr. vijayanand Sir.	Reason for Transfer doctors Advice
From Unit Nicu - 2	To Unit 3rd floor (B-zone)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 1	Number of Imaging Films 4	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 Nayya. 		Name of Person Ordered Transfer Dr. Sowmya 	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 4:30pm 5/7/26			

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-00660538 IP5-00175893
Baby Of SATYA YAMINI PEMMARAJU
12-07-2026 0 Y 0 M 2 D (M)
Dr. VIJAYANAND JAMALPURI



DISCHARGE PLANNING FORM

Nationality: Indians

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

1. Anticipated Date of Discharge: As per doctors advice

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☒ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☒ Medication	☒ Yes	☐ No
☒ Bathing	☒ Yes	☐ No
☒ Eating	☒ Yes	☐ No
☒ Walking	☒ Yes	☐ No
☒ Dressing	☒ Yes	☐ No
☒ Toileting	☒ Yes	☐ No

Need 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:

Regarding feeding

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Shrisha

Date and Time: 5/7/26, 4:30 pm

NURSE HAND OFF COMMUNICATION - ICU.

SITUATION & BACKGROUND	DOA :	Diagnosis :		Surgery / Procedures :			
	Allergies :			Post OP Day :			
	Date :	4/7	4/7	4/7	4/7/26	5/2/26	
	Area	N2	N2	N2	N2	N2	
	Shift Time	8pm-8pm	8pm-8pm	8pm-8pm	8pm-8pm	8pm-8pm	
Diet :		Naupro	Naupro	Naupro	Naupro		
Ventilation (RA, NP, NIV, VENTI)	4/50	RA	RA	RA	RA		
INES	1.						
	2.	OG - ①	OG - ①				
	3.						
	4.						
ASSESSMENT	Infusions / Transfusions	BP	na	na	na	na	
		PR	150/61mm	130/61mm	111/61mm	150/61mm	130/61mm
		RR					
	PU Prophylaxis	BP	na	na	na	na	na
		PR	150/61mm	130/61mm	111/61mm	150/61mm	130/61mm
		RR					
	DVT Prophylaxis	BP	na	na	na	na	na
		PR	150/61mm	130/61mm	111/61mm	150/61mm	130/61mm
		RR					
	Vitals	SpO ₂	96%	99%	99%	98%	93%
		Temp	36.5°C	36.6°C	36.6°C	36.5°C	36.5°C
		Pain Score	1/10	1/10	1/10	1/10	1/10
LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert	Alert		
Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact	Intact		
Restraints If any	Physical	na	na	na	na	na	
Fall Risk (Vulnerable (Y/N) if yes score)	Physical	na	na	na	na	na	
(Ambulation, walking, moving with assistance, bed ridden)	Chemical	na	na	na	na	na	
ADL (Dependent / Non-Dependent)		moving	moving	moving	moving	moving	
Critical Lab Test / Values (if any)		dependent	dependent	dependent	dependent	dependent	

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

RECOMMENDATIONS	Investigations Procedures	Date :	3/7/26	4/8/26	4/8/26	4/7/26	5/8/26	
		Area	N2	N2	N2	N2	N2	
		Shift Time	8pm-8am	8pm-2pm	8pm-8am	8pm-8am	8pm-8am	
		Ordered / Planned	RBS to 100% by 4/8/26	RBS-BD	RBS-BD	RBS-BD	RBS-BD	
		Due	NA	NA	NA	NA	NA	
		Reports Pending	NA	NA	NA	NA	NA	
		Referrals (If any)	NA	NA	NA	NA	NA	
		Remarks (Special Interventions like, Drainage Tube flushing etc.)	NA	NA	NA	NA	NA	
		Handed Over By Name :	Sevanan	Daey	Sevan	Sevanan	Daey	
		Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
		Date :	3/7/26	4/8/26	4/8/26	5/7/26	5/8/26	
		Time :	@ 8pm	@ 8pm	@ 8pm	@ 8pm	@ 8pm	
		Taken Over By Name :	Daey	Sevan	Sevanan	Daey	Shirisho	
		Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
		Date :	4/8/26	4/8/26	4/7/26	5/7/26	5/7/26	
		Time :	@ 8pm	@ 8pm	@ 8pm	@ 8pm	@ 8pm	

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IP5-00175893

Baby Of SATYA YAMINI PEMMARAJU

02-07-2026 0 Y 0 M 0 D 13 H (M)

Dr. VIJAYANAND JAMALPURI

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA :		Diagnosis :			Surgery / Procedures :			
	Allergies :					Post OP Day :			
	Date :								
	Area								
	Shift Time								
	Diet :								
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)								
	1.								
	2.								
	3.								
	4.								
ASSESSMENT	Infusions / Transfusions								
	PU Prophylaxis								
	DVT Prophylaxis								
	Vitals	BP							
		PR							
		RR							
		SpO ₂							
		Temp							
	Pain Score								
	LOC (Alert, Conscious, Confusion, Unconscious)								
	Skin Integrity (Intact / Bedsores / Any other condition)								
	Restraints If any	Physical							
		Chemical							
Fall Risk (Vulnerable (Y/N) if yes score)									
(Ambulation, walking, moving with assistance, bed ridden)									
ADL (Dependent / Non-Dependent)									
Critical Lab Test / Values (if any)									

RECOMMENDATIONS	Investigations Procedures	Date :						
		Area						
			Shift Time					
		Ordered / Planned						
		Due						
		Reports Pending						
		Referrals (If any)						
	Remarks (Special Interventions like, Drainage Tube flushing etc.)							
Handed Over By Name :								
Signature :								
Date :								
Time :								
Taken Over By Name :								
Signature :								
Date :								
Time :								

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA :	Diagnosis :			Surgery / Procedures :		
	Allergies :				Post OP Day :		
	Date :						
	Area						
	Shift Time						
	Diet :						
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)						
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	LOC (Alert, Conscious, Confusion, Unconscious)						
	Skin Integrity (Intact / Bedsore / Any other condition)						
	Restrains If any	Physical					
		Chemical					
	Fall Risk (Vulnerable (Y/N) if yes score)						
	(Ambulation, walking, moving with assistance, bed ridden)						
ADL (Dependent / Non-Dependent)							
Critical Lab Test / Values (if any)							

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

RECOMMENDATIONS	Investigations Procedures	Date :						
		Area						
		Shift Time						
		Ordered / Planned						
		Due						
		Reports Pending						
		Referrals (If any)						
	Remarks (Special Interventions like, Drainage Tube flushing etc.)							
Handed Over By Name :								
Signature :								
Date :								
Time :								
Taken Over By Name :								
Signature :								
Date :								
Time :								



INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: B+ve Baby's Blood Group: Sheet No: ①
Gest Age: 38+4 Birth Weight: 3.188

Date: <u>03/07/26</u>	Date: <u>04/7/26</u>	Date: <u>5/7/26</u>
DOL <u>D1</u> Weight <u>NOT CHECKED</u>	DOL <u>D2</u> Weight <u>3.224 (grms)</u>	DOL <u>D3</u> Weight <u>3.220 (↓ 20grms)</u>
Problems: <u>RDS / Retractions</u>	Problems: <u>RDS / Retractions</u>	Problems: <u>RDS.</u>
Rs. <u>30-60b/m</u> Exam <u>DONE</u> Vent. Setting <u>RA</u> ABG <u>NA</u> CXR <u>DONE</u>	Rs. <u>30-60b/m</u> Exam <u>DONE</u> Vent. Setting <u>R/A</u> ABG <u>NA</u> CXR <u>NA</u>	Rs. <u>30-60b/m</u> Exam <u>DONE</u> Vent. Setting <u>2/F</u> ABG <u>NA</u> CXR <u>NA</u>
CVS <u>NORMAL</u> HR <u>120-160b/m</u> BP <u>Map</u> Cap Refil <u>22-30</u>	CVS <u>Normal</u> HR <u>120-160b/m</u> BP <u>Map</u> Cap Refil <u>22-35</u>	CVS <u>normal</u> HR <u>120-160b/m</u> BP <u>Map</u> Cap Refil <u>22-35</u>
F/E/N <u>60cc</u> T. Fluids <u>NA</u> CC/kg/day <u>NA</u> I/O/RBS: <u>NA</u> U Output: (CC/kg/hr) <u>NA</u> Exam <u>DONE</u> T. Bil/D <u>NA</u> Na HcO3 <u>NA</u> K BUN <u>NA</u> Cl Crea <u>NA</u> Hemat HB: <u>NA</u> WCC <u>NA</u> Plats <u>NA</u> Transfusion <u>NA</u>	F/E/N <u>60cc/kg/day</u> T. Fluids <u>NA</u> CC/kg/day <u>NA</u> I/O/RBS: <u>NA</u> U Output: (CC/kg/hr) <u>NA</u> Exam <u>DONE</u> T. Bil/D <u>NA</u> Na HcO3 <u>NA</u> K BUN <u>NA</u> Cl Crea <u>NA</u> Hemat HB: <u>NA</u> WCC <u>NA</u> Plats <u>NA</u> Transfusion <u>NA</u>	F/E/N <u>80cc/kg/day</u> T. Fluids <u>NA</u> CC/kg/day <u>NA</u> I/O/RBS: <u>NA</u> U Output: (CC/kg/hr) <u>NA</u> Exam <u>DONE</u> T. Bil/D <u>NA</u> Na HcO3 <u>NA</u> K BUN <u>NA</u> Cl Crea <u>NA</u> Hemat HB: <u>NA</u> WCC <u>NA</u> Plats <u>NA</u> Transfusion <u>NA</u>
C/s Results <u>NA</u> CRP <u>NA</u> Antibiotics <u>NA</u>	C/s Results <u>NA</u> CRP <u>NA</u> Antibiotics <u>NA</u>	C/s Results <u>NA</u> CRP <u>NA</u> Antibiotics <u>NA</u>
Med <u>NA</u> Neuro: <u>NORMAL</u>	Med <u>NA</u> Neuro: <u>Normal</u>	Med <u>NA</u> Neuro: <u>normal</u>
Assessment <u>DONE</u>	Assessment <u>DONE</u>	Assessment <u>DONE</u>
Plan <u>RBS-60</u>	Plan <u>RBS-6th hourly</u>	Plan <u>RBS-60.</u>

SION
VE CARE UNIT

Name: B/o Satya Yamini Age: 1 M Gender: Male ☒ Female ☐
UHID.No: 660538 Date: 2/7/26
I LAKSHMAN TBOA S/o, D/o, W/o hereby
declare that our patient Mr. / Ms. B/o SATYA YAMINI who is related to me as son is
getting admitted in the Neonatal Intensive Care Unit of Rainbow Children's Hospital on 03/07/2026
The doctors have explained to me in a language understood by me that my child has following health related issues :

Observation

The doctors have clearly explained to me that my patient B/o SATYA YAMINI during his / her stay
in the Neonatal Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical
ventilation, Umbilical Artery Catheter, Umbilical Vein and Arterial Lines, Peripherally Inserted Central Catheter Line and arterial line
placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure
shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is
implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Neonatal Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Neonatal Intensive Care Unit with multiple medical and surgical procedures
performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of
infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child B/o SATYA YAMINI
in the Neonatal Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various
procedures, high risk medications and infections in the Neonatal Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature :
Name : LAKSHMAN TBOA
Relationship with Patient: FATHER
Date & Time : 03/07/2026 8pm

Witness :

Signature : Nayee S
Name : N
Date & Time : 3/7/26 @ 8pm

Doctor (who is taking the consent) :

Signature : P
Name : P
Date & Time : 3/7 8pm

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యు) సమ్మతి పత్రం



రోగి పేరు వయస్సు లింగం పు స్త్రీ
యు.హెచ్.ఐ.డి
నేను బి
అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రేయిన్స్ బిల్డింగ్ ఆసుపత్రి లోని నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్లో తేదీ
..... నాడు పూర్తి సమ్మతితో చేర్చితిని. మా బాలుడి / బాలికలో. ఈ క్రింద
తెలిపిన ఆరోగ్య సమస్యల గురించి వైద్య నిపు ణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ లో మా పాప /బాబుకు వైద్య పరంగా అవసరమగు అన్ని రకాల చికిత్స విధానాలకు మరియు ప్రక్రియలను (ఉదా కృత్రిమ శ్వాస వెంటిలేటర్, ధమని మార్గం, సింట్రిల్ లైన్ చెస్ట్ డ్రైయిన్, పెరిటోనియల్ డ్రైయిన్ ఇంనర్వేన్ వంటి ప్రక్రియలను డాక్టరు గారు నాకు అర్థమగు భాషలో వివరించారు.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైనప్పటికీ, పైన తెలుపబడిన శస్త్ర ప్రక్రియలు చేసేముందు సమ్మతి తీసుకునే వీలు లేని చో ఏదైనా ప్రాణాంతక అత్యవసర పరిస్థితులు ఏర్పడినప్పుడు మా బాలుడు / బాలికను కాపాడుటకు అవసరమైన వైద్య శస్త్ర ప్రక్రియలు మా సమ్మతి లేకుండానే చేయవచ్చని నేను సమ్మతిస్తున్నాను.

ఆరోగ్య సమస్యలతో బాధపడుతున్న మా బాలుడికి / బాలికకు రుగ్మతలచే ప్రాణహాని కలుగవచ్చిన నాకు వైద్యుడు అర్థమగు భాషలో వివరించితిరి

మా బాలుడు / బాలిక నవజాత శిశువు ఇంటెన్సివ్ కేర్ యూనిట్ లో ఉన్నప్పుడు ఎన్నో విధాల వైద్య మరియు శస్త్ర ప్రక్రియలు ఇంకా వివిధ చికిత్స విధానాలు అవసరం పడతాయని మరియు వాటివల్ల దుష్పరిణామాలు కలగవచ్చని అర్థం చేసుకున్నాను. ఆ పరిణామాలు ఎటువంటివి అనగా నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన సమస్యలు, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు.

మా బాలుడిని/బాలికను అడ్మిట్ చేయుటకు మరియు ఎన్.ఐ.సి.యు. లో ఉన్నప్పుడు జరుగు చికిత్స విధానాలు మరియు శస్త్ర ప్రక్రియలు వలన కలిగే అపాయాలను నేను అంగీకరిస్తున్నాను. మా పేషంట్ ను తగిన విధంగా చికిత్స చేయడానికి వైద్యునికి నాపూర్తి అంగీకారం తెలియజేస్తున్నాను. వైద్యుడు నాకు అర్థమగు భాషలో అంతా వివరించారు.

మా బాలుడు / బాలిక ను ఇన్టెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

BAH-00660538 IP5-00175893
Baby Of SATYA YAMINI PEMMARAJU
02-07-2026 0 Y 0 M 0 D 2 H (M)
Dr. VIJAYANAND JAMALPURI



FORMULA FEEDS


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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name : BLO SATYA YAMINI Age : 2/10 Gender : ☒ Male ☐ Female

UHID No : 660528 Reg. No. : 175893 Department : NEON Date : 03/07/2026

I Mr / Mrs. : LAKSHMAN TESA L aged years, hereby declare that I have

admitted my ☒ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on

03/07/2026 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 : Lakshman

Name : LAKSHMAN TESA L

Relationship with Patient : FATHER

Date & Time : 03/07/2026 at 12am

Witness :

Signature : [Signature]

Name :

Date & Time : 03/07/2026 at 12am

Doctor (who is taking the consent) :

Signature : Pur

Name : Pur

Date & Time : 3/7/2026 at 12am

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

RSING INITIAL ASSESSMENT FOR NICU

Date of Admission: 02/7/26

Source of Admission: ☐ OPD ☐ Ward ☒ Labor Ward ☐ Other:

Reason for Admission: ADS, TERM

Admission Diagnosis: RDS, TERM

Accompanied By: ☒ Parent ☐ Guardian ☐ Other Name:

Primary Language: ☐ Telugu ☒ English ☐ Hindi ☐ Other Specify:

Do you require an interpreter? ☐ Yes ☒ No

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:

If yes, identify:

Source of Information: ☒ Family ☐ Others, Specify:

Past Medical History	Past Surgical History	Last Hospital Admission
<u>nil</u>	<u>nil</u>	<u>nil</u>

Significant History	Family History:
---------------------	-----------------------

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No

If yes please list:

Was the child's birth normal? ☐ Yes ☒ No If No, please describe problems:

Are the child's immunization up to date? ☐ Yes ☒ No

Current Medications	Taking Medications? ☐ Yes ☐ No If yes, Fill the reconciliation form Medicine brought to the hospital? ☐ Yes ☐ No
---------------------	--

Observations:

Birth Weight: 2.1 kgs Head Circumference: cm Length: cm

☐ Term ☐ Pre-Term ☐ Post-Term

Blood Group: Mother: B+ve Baby:

Feeding: ☐ Breast Feeding ☒ Formula ☐ Both

Maternal Details: Age: 30 years, PARA: G5P4 Gestation: 38w4d Weeks, Days

Risk Factors: ☐ PROM ☐ Fetal Distress ☐ Diabetes Mellitus / Gestational Diabetes

☐ PH/Pre Eclampsia ☐ Others, Specify:

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

Indication:

