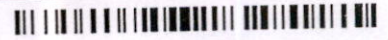


ADMISSION SHEET



Registration Details :

Admission No : IP5-00176589

Admit Date : 18-Jul-2026

Admit Time : 09:51 PM UHID : BAH-00662117

Patient Details :

Patient Name : Baby Of THARA

Age : 0 Y 0 M 4 D

Guardian : Mr R BHASKAR

DOB : 16-07-2026 01:00 AM

Gender : Male

Religion :

Occupation :

Marital Status : Single

Address (H) : #8-1-284/OU/468 OU COLONY SHAIKPET
Dargah Hussain Shah Wali Hyderabad
Telangana INDIA 500008

Phone No : 9052510320/ 8520052715

E-mail : nomailid@gmail.com

Admission Details :

Bed Type : NICU

Bed No : NICU 279

Ward Name : 2F-NICU 4

Room No : NICU 279

Admission Type : First Visit

Contact Details :

Name : Mr R BHASKAR

Relationship : Father

Contact Address : #8-1-284/OU/468 OU COLONY SHAIKPET
Dargah Hussain Shah Wali Hyderabad
Telangana INDIA 500008

Phone No : 9052510320 / 8520052715

Signature

Doctor Details :

Doctor Name : Dr. NITASHA BAGGA

Specialisation : NEONATAL INTENSIVE CARE

Referral Doctor : DR NILOFER HOSPITAL

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 33198.00

Payment Mode : DC/CC Card

Payor Name : SELFPAY



New Born Screening	: <u>done</u>
TFT	:
OAE	:
Mother's Blood Group	: <u>B +ve</u>
Baby's Blood Group	: <u>B +ve</u>
Anomaly Scan	:
Vaccination	:

parents are willing to
do it B) R-Bharat

[illegible]

BAH-00662117 IP5-00176589
Baby Of THARA
18-07-2026 0 Y 0 M 3 D (M)
Dr. MVB Pratyush



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ACTIVITY RECORD FOR BILLING

Name : B/O Thara

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
18/7/26	9:50 pm	ER	NECO	Pamadeen
22/7/26	4:10 pm	NICU	3rd floor	Positna

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : M. Thara Age : 30 Father's Name : Age :
Date of Birth : Date of Admission : UHID No.:
NICU Consultant : as per nola 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 Thara Mother's Blood Group : B+ve
Gender : ☒ M ☐ F Blood Group : B+ve
Date of Birth : 16/7/26 Time of Birth : 11:55 am
Place of Birth : Kondapur Govt. host. Estimated Gesth Age : 38+5 weeks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 30 Ht : Wt : BMI : Married Life : LMP : 28/10/25 EDD : 28/07/26
Conception : Spontaneous or with Rx. : Spontaneous

Booked at what GA : AN Steroids Drugs / Doses :

Last Scans Details : 38+5 → AFI - 11, EFW - 3670

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 : Gest
? Hypertension 3 days before delivery.

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

IUGR - when detected :

Doppler (Increased Resistance / ADEF / REDF / Normal

Redistribution in MCA) / Ductus Venosus :

AFI :

H/o GDM/ pre GDM/ on diet or insulin

Controlled or not, recent values, HbA1 values :

Compliance with Rx :

Scans : LGA, TIFFA, Fetal Echo :

H/o Hypothyroidism : when diagnosed ? Medication?

Gest hypothyroidism

Any other Chronic Medical Problems, when detected

drugs ?

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

Infection : H/O, Fever

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

UTI : when : Any culture :

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

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

P : A : L :

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

PERINATAL HISTORY

Treating Obstetrician : Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication :

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL : ☒

Resuscitation : ☐ Yes ☐ No

Cord ABG :

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

NEONATAL RESCUSTITATION 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
NA	NA	A

TOTAL

Snappee II Score

Score

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

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

History of Present Illness:
According to ~~mother~~ father

↓
Baby developed RD at birth
orangs @

↓
Baby developed RD at birth
↓
given O_2 by nasal prongs @ 2L/min
& started with I.V fluids.

↓
started to say Greenlandic

~~A~~ 8 HCL $\rightarrow$ Ref to Nilotfur hospital

Baby was continued O₂ by ~~bubble~~ by prongs,
~~CPAP~~ J.V.P., OI feeds - 10-15 ml - 2 hour
inj Piptas

Baby was initially fed ? Baffu lamilk
then was ^{X 1} fed
E donor breast
milk

☞ Donar brent
nüll

(P.T.O.)



Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : HR : RR : NIBP : CFT :

Color of the extremities :

Jaundice : Pallor : SpO2 :

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

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :

Fontanelles :

Sutures

Shape / Moulding :

Edema / Bruising :

Size - (H.C.) :

N

FACIES :

(Any Facial
Dysmorphism)

N

NECK and CLAVICLES :

Range of Motion :

Asymmetry :

Masses :

EYES :

Symmetry :

Red Reflex :

Discharge :

needs to be

EARS, NOSE MOUTH and THROAT :

Ear set / Shape :

Periauricular Pits / Tags :

Nasal shape / Patency :

Palate :

Gums :

Lips :

Tongue :

J

N

no cleft

THORAX and BREASTS :

Shape of Thorax :

Position of Nipples and Number :

1N

ABDOMEN and UMBILICUS :

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump :

Discharge :

2A 1V

2

GENITALIA :

Labia / Hymen :

Testicles/penis :

Anus :

N

testes 1/L
scrotum

HERNIAL ORIFICES

free

TRUNK and SPINE :

1N

SKIN LESIONS :

N

EXTREMITIES :

Fingers / Toes :

Deformities :

Hip Joint Examination :

Arms / Legs :

Mobility :

N

N



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☐ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: SCR / ICR / See - Saw breathing : *Baby is tachypneic*

Scoring of respiratory distress if present (Silverman or Downe's) : *RR = 70/min*

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

Settings : *B/L FAE*

SpO₂ : *94%* Auscultation: Breath Sounds: Added Sounds: *seen Moderate retraction*

CARDIOVASCULAR SYSTEM :

HR : *150* BP : Precordial Activity : *(N)*

Femoral Pulses : *(N)* Murmurs : *(N)*

Other Peripheral Pulses : Signs of Cardiac Failure :

ABDOMEN:

Shape : *(N)* Hernia orifice : *free*

Palpation : *(N)* Anal Patency : *patent*

Palpable masses : Umbilical Cord : *2 dried*

Abdominal girth : First urine passed : Meconium passed :

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : *Alert*

State of wakefulness :

Prechtlle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone : *good*

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR :

ATNR : Skull and Spine :



No gross congenital anomaly

Diagnosis : Term / AHA / male / suspected sepsis / RD
(MAS) malonut

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name : Rupnjal

Date & Time : 18/7/2026

Consultant :

Dr. NITASHA BAGGA
Reg. No: 66260

Signature :
Name : Dr. NITASHA BAGGA

Date & Time : 18/7/2026

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 during ward follow up :

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26 1:00 AM		Seen by Dr. Srinivas plans
		- TV - good lbs/day ↓ 12ml feed 2nd hely ↑ 5ml feed 4th hourly [TF = 24 ml]
		- Trace blood clots
		Check N/B Muteen 17
		→ Try weaning of O2
		→ Tena B/C/S
		→ CBP? + m [CRP]



2

[illegible]

19/7/26

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

Day in NICU: Day of Life: 70 HOL PMA:
Term ☒ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight: 2.978kg

		Problems	
Overview	S.No.	Current	Past Problems
	1.	term / AGA	
	2.	RD - low flow	
	3.	Suspected sepsis	
	4.		
	5.		
	6.		
Clinical Assessment	- on low flow, SpO₂ - 96%. PR - 106/min RR - 44/min. RBS - 87mg/dl urine - passed stool - passed		
Medications Used	Fej. PIPTAZ (0.1)		

Plan of Care: — Tv - 100 ml/kg/day — continue low flow
 ↓
 25ml feed 2nd half full of feed — wean off low flow as tolerated
 — RBS OD — Wt 11 distress
 — Trace blood clts — Rlv 2 Echo today,
 — Ilo. charting 6 to hourly.

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

Doctor's Name (Hand over taken):

Signature: Dr. Azeeb

Signature:

Date & Time: 19/7/26

Date & Time:

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
1.		
2.		
3.		
4.		
5.		
6.		

Overview	
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:



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/8/26 3:30pm	<u>Afternoon Round.</u> Baby is on low ^{mini} low flow hemodynamically stable. Intermittent tachypnea mild SCR (+)	<u>Plan.</u> → Continue low flow wean as tolerated
	<u>Vitals</u> HR - 151/min. RR - 42/min. SpO ₂ - 93% BP -	→ TV - 100cc/kg/day 25ml/2nd help. full OG feed.
	P/A - soft.	→ Send CBP } CRP } 11m CBG } 6am.
		→ RBS - OD
		→ Trace Blood c/s.
		→ Monitor vitals
	Dr. Pratyush	<u>Noted by</u> PO Kanya

BAH-00662117 IP5-00176589
Baby Of THARA
18-07-2026 0 Y 0 M 3 D (M)
Dr. MVB Pratyush



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26.		Seen by Dr. Nilesh
	Tachypnea (+) w/o MAS.	→ Continue minilow flow
	nasal flare (+)	→ Add Neb- Budecort.
		→ CBP } CRP } T/m bam CBG }



20/7/26

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

Day in NICU: Day of Life: Day 4 PMA:

Term ☒ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight: 2.970

(↓sgms)

Problems		
S.No.	Current	Past Problems
1.	Term / AGA	
2.	MSL → RD - low flow	
3.	Suspected sepsis	
4.		
5.		
6.		

Clinical Assessment
— on mini low flow (0.02lit/min) Issue: Intermittent Tachypnoea @ SpO₂ - 96% PR - 137/min RR - 45/min CRP - 18 - 320;

Medications Used
Inj. PIP TAZ (P3) neb. Budecort CRS - 1.7ml/kg/hr stool - passed RBS - 98mg/dl

Plan of Care:
→ TV - 120ml/kg/day ↓ 30ml 2nd hly full of feeds. — Trace blood clots & R/V to shift to NICO-3; — RBS - ON — wts ↑ distress. — continue mini low flow wean off as tolerated — 10. cholesty 6th hourly

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

Signature: Anusha

Date & Time: 20/7/26

Doctor's Name (Hand over taken):

Signature: /

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26		Seen by Dr. Nitasha
9:45 AM		Plan: - wear of low flow as directed. - continue Tr - 12 small sips ↓ full of feeds.
		- 2D Echo today - Trace blood clots - Rv shift to vilo-3.
		Dr. NITASHA BAGGA Reg. No: 66260
20/7/26	Afternoon rounds	Noted by Diphi
1:00 PM		017039 20/7/26 10 am
	on room air	Plan:

9



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

BAH-00662117

IP5-00176589

Baby Of THARA

18-07-2026

OYOM4D

(M)

NITASHA BAGGA



21/7/26

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

Day in NICU: Day of Life: D5 PMA:

Term ☒ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight: 2.768 (12gms)

		Problems		
		S.No.	Current	Past Problems
Overview	1.		Team / AGA.	
	2.		MSL- RD - BSA Flow.	
	3.		Suspected Sepsis.	
	4.			
	5.			
	6.			
Clinical Assessment	off low flow. NO RD/ apnea/ Brady/ desat RA: Soft/ distended - mild icterus (+) Tolerating paladai feeds well.			SpO2 92% HR: 135/min.
	Medications Used	Kleb- Budecort my. ppi 10mg Dy.		
Plan of Care:		1- TR 10ml/kg/day. 30-35ml/hr hourly full paladai Feeds 2. LBS -OD prefeed 3- Stop W abx after cfs. 4. crib care in evening. 5. Shift out of m		

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

Signature: [Signature]

Date & Time: 21/7/26

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

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

Signature: [Signature]

Date & Time: 21/7/26

Patient Sticker

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

Day in NICU: Day of Life: PMA:

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

	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:



(13)

Total by
21/11/26

IP5-00176589

QYOM3D

(M)

18-07-2026

Dr. MVB Pratyush



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BAH-00662117 IP5-00176589
Baby Of THARA
16-07-2026 0 Y 0 M 5 D (M)
Dr. NITASHA BAGGA



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

Day in NICU: Day of Life: 6 PMA:
Term ☐ Preterm ☐ Gestation: T Corrected Gestational Age: Today's Weight: 2.96 (42 gm)

	Problems		
	S.No.	Current	Past Problems
Overview	1.	Term / AUA	
	2.	MSL - RD	
	3.	Suspected sepsis	
	4.		
	5.		
	6.		
Clinical Assessment	self ventilating on RA Euthermic & crib care. tolerating paladay feeds PA - soft. HR - 134/min SpO ₂ - 99.1.		
Medications Used	Vit D ₃		
Plan of Care: ① TV = 140ml/kg/day = 30-35ml q4h full paladay ② RBBS OD ③ RD Shift out today Shift in room Vaccination Supplements ADAR.			

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

Signature: [Signature]

Date & Time: 22/7/20

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:

icker

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.	Past Problems
Overview	Current	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:

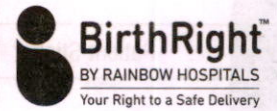
Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

~~Dr. Chung~~

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7 5:45 PM	CLSB RESIDENT.	
	DOL-6 38+5 WKS PDS MAS Suspected Sepsis NMJ maternal pre-eclampsia - Em-LSce.	
	BT 4 V B+ m V	Plan 1. Tr: 140ml/kg/day 30-35ml/2nd hourly.
	on Room air	A2A
	NO ED/apnea/desats	2. DBS - OD proceed
	Tolerating feeds well	3. Vitals c/v
	HA Soft distended	Ech
	icterus ⊖	Heb-B.
		4. S/Bs - t/m after rounds
		5. R/M d/c t/m
		noted by phys 8 PM



PROGRESS NOTES AND DOCTOR'S ORDER

(P.T.O)



00000000000000000000



(M)



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[illegible]

BAH-00662117

IP5-00176589

Baby Of THARA

16-07-2026

0Y0M5D

(M)

Dr. NITASHA BAGGA



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MEDICATION RECONCILIATION FORM

Drug Allergies: ☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: NICU Shifted to: 323-C

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	DROPS VITAMIN D ₃	0.5ml	PO	BD	21/7 6PM	☒ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Aishwarya
 Date & Time: 22/7/26

Nurse Name & Signature: Poojitha

Date & Time: 22/7/26 @ 4:20PM



RESULT SHEET

Date	18/07/26	20/7/26			
Time	10:40pm	6:29am			
Hb	19.8	19.1			
PCV	55.9	56.3			
RBC	5.50	5.31			
WBC	5.14	8.30			
N/L	61.9/13	38.8/30.0			
Platelets	323	302			
CRP	18	20			
ESR					
PCT					
RBS					
Na	140				
K	4.5				
Cl	107				
Ca/Mg	8.8				
Phosphate					
Urea	22				
Creatinine	0.8				
ALP					
SGPT					
SGOT					
T.Bill/Conj	9.1 / 0.1				
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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.,) :



DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 3.140 Ward.

DRUG : Inj Pipracillin + Fapacillin				Date Time	18/7	19/7	20/7	21/7													
Dose	Route	Frequency	Start Date																		
315mg	I.V	TID	18/7	10 AM	X	10 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	
Name & Signature of the Doctor Starting the Drugs:				Rupanjali																	
Additional Instructions:				100 mg / kg / dose 12 hr new																	
Daily Doctor's Endorsement by a Sign																					
DRUG : NEB. BUDEKORT				Date Time	19/7	20/7															
Dose	Route	Frequency	Start Date																		
1	Neb	Q12H	19/7	10 AM	X	10 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	11 AM	
Name & Signature of the Doctor Starting the Drugs:				Dr. Pratyush																	
Additional Instructions:				1/2 respule																	
Daily Doctor's Endorsement by a Sign																					
DRUG : Drops. VITAMIN D3				Date Time	21/7	22/7															
Dose	Route	Frequency	Start Date																		
0.5ml	PO	OD	21/7	6 PM	X	6 PM	6 PM	6 PM	6 PM	6 PM	6 PM	6 PM	6 PM	6 PM	6 PM	6 PM	6 PM	6 PM	6 PM	6 PM	
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:				1ml / 800 IU																	
Daily Doctor's Endorsement by a Sign																					
DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					



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

[illegible]

I.V. FLUIDS CHART

Weight. Ward.

[illegible]

BAH-00662117
Baby Of THARA
18-07-2026
Dr. MVB Pratyush
IP5-00176589
O Y O M 3 D
(M)



**Rainbow[®]
Children's
Hospital**
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I.V. FLUID CHART

[illegible]

Patient Sticker

I.V. FLUID CHART

[illegible]

INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: B+ve Baby's Blood Group: Sheet No: ①

Gest Age: 36 wks Birth Weight:

Date: <u>19/7/26</u>	Date: <u>20/7/26</u>	Date: <u>21/7/26</u>
DOL <u>2.978 kg</u>	DOL <u>D3</u> Weight <u>2.970 kg</u>	DOL <u>D4</u> Weight <u>2.968 gms</u> ↓ (2 gms)
Problems: <u>RDS</u>	Problems: <u>RDS / SEPSIS</u>	Problems: <u>RDS</u>
Rs. <u>Done</u> Exam <u>Done</u> Vent. Setting <u>NA</u> ABG <u>NA</u> CXR <u>NA</u>	Rs. <u>30-60 bpm</u> Exam <u>Done</u> Vent. Setting <u>HF</u> ABG <u>Done</u> CXR <u>NA</u>	Rs. <u>30-60 bpm</u> Exam <u>Done</u> Vent. Setting <u>RA</u> ABG <u>NA</u> CXR <u>NA</u>
CVS <u>normal</u> HR <u>140 bpm</u> BP <u>66/48 Map (51)</u> Cap Refil <u><2-3 sec</u>	CVS <u>normal</u> HR <u>140 bpm</u> BP <u>Map</u> Cap Refil <u><2-3 sec</u>	CVS <u>normal</u> HR <u>127 bpm</u> BP <u>Map</u> Cap Refil <u><2-3 sec</u>
F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>700 cc</u> T. Fluids <u>297 cc</u> CC/kg/day <u>25 cc</u> I/O/RBS: <u>98 cc</u> U Output: <u>1.8 cc</u> (CC/kg/hr) 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 T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam <u>Done</u> T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results <u>normal</u>	C/s Results <u>PENDING</u>	C/s Results
CRP <u>NA</u> Antibiotics <u>Piptaz</u>	CRP <u>18</u> Antibiotics <u>Piptaz</u>	CRP Antibiotics <u>Piptaz</u>
Med <u>Piptaz</u>	Med <u>NA</u>	Med
Neuro: <u>normal</u>	Neuro: <u>NORMAL</u>	Neuro: <u>normal</u>
Assessment <u>Done</u>	Assessment <u>Done</u>	Assessment <u>Done</u>
Plan	Plan <u>RDS - OP</u>	Plan <u>RBS - OD</u>

INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

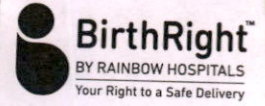
Maternal Blood Group: B+ve Baby's Blood Group: Sheet No: 2

Gest Age: Birth Weight:

Date: <u>22/7/26</u>	Date:	Date:
DOL <u>2</u> Weight <u>2.966</u> <u>↓ 2gms</u>	DOL Weight	DOL Weight
Problems: <u>PDS</u>	Problems:	Problems:
Rs. <u>630-60b/min</u> Exam <u>normal</u> Vent. Setting <u>RA</u> ABG <u>2</u> CXR <u>NA</u>	Rs. Exam Vent. Setting ABG CXR	Rs. Exam Vent. Setting ABG CXR
CVS <u>normal</u> HR <u>120-160b/min</u> BP <u>—</u> Map Cap Refil <u>(2-3s)</u>	CVS HR BP Map Cap Refil	CVS HR BP Map Cap Refil
F/E/N T. Fluids CC/kg/day <u>140cc/kg/day</u> I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion <u>NA</u>	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results CRP Antibiotics <u>NA</u>	C/s Results CRP Antibiotics	C/s Results CRP Antibiotics
Med Neuro: <u>vit D</u>	Med Neuro:	Med Neuro:
Assessment <u>normal</u>	Assessment	Assessment
Plan <u>RBS-OD</u>	Plan	Plan

BAH-00662117
Baby Of THARA
18-07-2026
Dr. MVB Pratyush
0 Y 0 M 2 D
(M)

C1



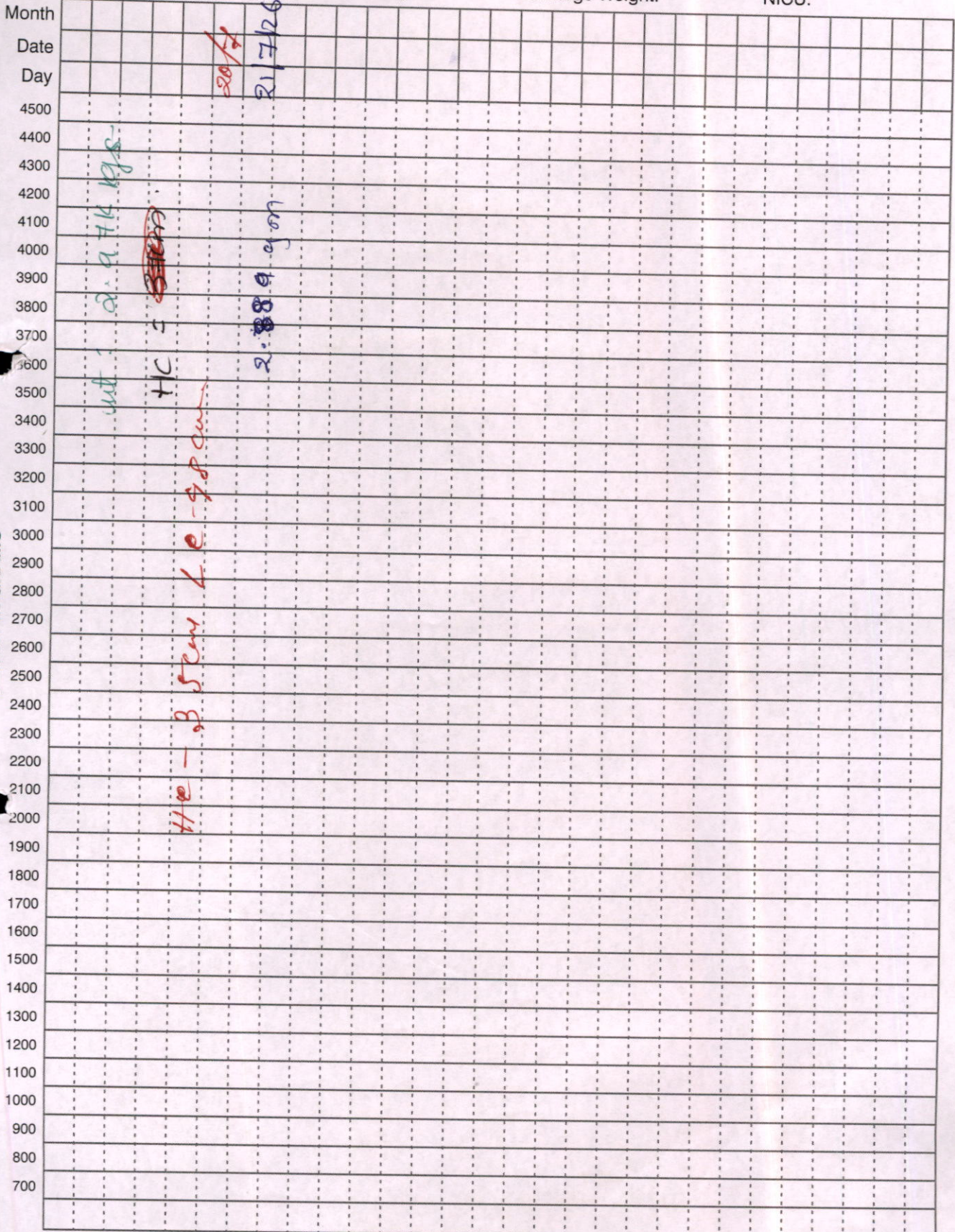
NEONATAL WEIGHT CHART

Birth Weight:

Admission Weight:

Discharge Weight:

NICU:





INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD


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Your Right to a Safe Delivery

Part - I.

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		

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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Your Right to a Safe Delivery

e Literacy: ☒ Yes ☐ No

Education / Coping Skills

Comments	Designation / Signature
cooperative	start nurse

e	Team Verification
	☒ Nursing ☐ Others:
	☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:

Date: Time: 10pm 12pm 2pm 4pm 6pm

[illegible]

Temperature (°F)

Time	Temperature (°F)
12:00	36.6
12:30	36.4
1:00	36.4
1:30	36.4
2:00	36.4
2:30	36.4
3:00	36.4

Heart Rate (bpm)	BP does not score in early warning scoring	Heart Rate (Number)
190		
180		
170		
160		
150		
140		
130		
120		
110		
100		
90		
80		
70		
60		
50		
		119 122 132 123 132

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

Observer's Initials M M AR M A

ACTIONS	Score 1 : Continue normal observation by staff nurse
---------	--

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

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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



INFANT (<1 year) (2)
Children's Observation &
Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	8 AM	10 AM	12 PM	2 PM	4 PM	6 PM	8 PM	10 PM	12 AM	2 AM	4 AM	6 AM	
Doctor/Nurse/Family Concern?														
Temperature (F)	104													
	103													
	102													
	101													
	100													
	99	36.6°C	36.6°C	36.6°C	36.5°C	36.6°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	
	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														
Note: BP does not score in early warning scoring														
Heart Rate (Number)		111	121	126	145	139	125	130	143	131	134	139	141	
sp. Rate (bpm) (over 1 Minute) *														
Resp Rate (Number)		30	39	40	37	50	45	50	55	42	65	34	50	
Resp Distress Mod/ Severe None / Mild														
Receiving O ₂ (l/min) O ₂ Saturations (%)		0.5L	100%	0.5L	0.8L	0.9L	100%	0.9L	0.9L	0.6L	0.4L	0.3L	0.4L	
Conscious Level Normal Altered		N	N	N	N	N	N	N	N	N	N	N	N	
GCS *		C	C	C	C	C	C	C	C	C	C	C	C	
TOTAL SCORE														
Number of shaded boxes		0	0	0	0	0	0	0	0	0	0	0	0	
Pain Score		1	1	1	1	1	1	1	1	1	1	1	1	
Observer's Initials														
ACTIONS		Score 1 : Continue normal observation by staff nurse												
		Score 2 : Shift in charge nurse to be informed and continue hourly observations												
		Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.												
		Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see												
		Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed												

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	8	10	12	2	4	6	8	10	12	2	4	6	8
Doctor/Nurse/Family Concern?		am	am	pm	pm	pm	pm	pm	pm	pm	am	am	am	am
Temperature (F)		36.6°C	36.6°C	36.6°C	36.6°C	36.6°C	36.5°C	36.4°C	36.5°C	36.4°C	36.5°C	36.4°C	36.4°C	36.4°C

Heart Rate (bpm)	and	Blood Pressure (mmHg) *	Note:									
190												
180												
170												
160												
150												
140												
130												
120												
110												
90												
80												
70												
60												
50												
Heart Rate (Number)	143	123	126	138	153	160	129	121	119	115	120	117

[illegible][illegible]

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

B/O Thara

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

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

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	8	10	12	2	4	6	8	10	12	2	4	6		
Doctor/Nurse/Family Concern?		Am	Am	Pm	Pm	Pm	Pm	Pm	Pm	Am	Am	Am	Pm		
Temperature (°F)	104														
	103														
	102														
	101														
	100														
	99														
	98														
	97														
	96														
	95														
	94														
Heart Rate (bpm)	190														
	180														
	170														
	160														
	150														
	140														
	130														
	120														
	110														
	100														
	90														
	80														
	70														
	60														
	50														
Note: BP does not score in early warning scoring															
Heart Rate (Number)		112	119	126	106	123	139	102	126	105	120	160	120		
Sp. Rate (bpm) (Over 1 Minute) *	70														
	60														
	50														
	40														
	30														
	20														
	10														
Resp Rate (Number)		51	60	33	26										
Resp Distress	Mod/ Severe														
	None / Mild														
Receiving O ₂ (l/min)															
O ₂ Saturations (%)		96	93	95	94	100	99	100	98	95	97	98			
Conscious Level	Normal	N	N	N	N	N	N								
	Altered														
GCS *		C	C	C	C	C	C	C	C	C	C	C			
TOTAL SCORE		1	1	1	1	1	1	1	1	1	1	1			
Number of shaded boxes		1	1	1	1	1	1	1	1	1	1	1			
Pain Score		0	0	0	0	0	0	0	0	0	0	0			
Observer's Initials		S	S	S	S	S	S	A	S	S	S	S			
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 I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00662117 IP5-00176589
Baby Of THARA
16-07-2026 0 Y 0 M 5 D (M)
Dr. NITASHA BAGGA



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

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

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 22/7/26	Time: 8	10	12	2	4	6	10	2	6
Doctor/Nurse/Family Concern?	Am	Am	Pm	Pm	Pm	Pm	Pm	Am	Am
Temperature (F)	98.6	98.6	98.6	98.6	98.6		98.0F	98.2F	98.3F
Heart Rate (bpm)	118	116	119	125			130b/m	132b/m	128b/m
Blood Pressure (mmHg) *	exib case						*	*	*
Resp. Rate (bpm) (Over 1 Minute) *	99	99	98	98			36b/m	34b/m	40b/m
Resp Distress							N	N	N
Receiving O ₂ (l/min)									
O ₂ Saturations (%)	99%	99%	98%	98%			99%	100%	99%
Conscious Level									N
GCS *	N	N	N	N			15/15	15/15	15/15
TOTAL SCORE	C	C	C	C			0	0	0
Number of shaded boxes									
Pain Score	1	1	1	1			0	0	0
Observer's Initials	g	g	g	g			a	a	a

ACTIONS

NB: Scores 3 should be recorded overleaf

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



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am	B.F		5.64								
	11:00 am			5.64								
	12:00 pm			5.64								
	01:00 pm	B.F		5.64								
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	B.F		5.64	12ml						0	
	11:00 pm			5.64			pu				0	
	12:00 am	B.F		5.64	12ml					20ml	0	
	01:00 am			5.64							0	
Total Intake :						Total Output :						
	02:00 am	B.F		2.7	12ml					12ml	0	
	03:00 am			2.7							0	
	04:00 am	B.F		2.7	17ml		pu				0	
	05:00 am			2.5							0	
	06:00 am	B.F		2.7	12ml					20ml	0	
	07:00 am			2.7							0	
Total Intake :						Total Output :						

Total 24 hrs. Intake

3.89cc/kg

Total 24 hrs. Output

55 cc/kg

FLUID CHART

Sheet No. : 2

TV - 90ml
BWT - 3.14
Tf - 281

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	O.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am	Preop 230ml		0.7ml	220ml		passed	-	-	120ml		
	09:00 am			0.7ml								
	10:00 am	Preop		0.7ml	250ml		-	-	-	100ml		
	11:00 am											
	12:00 pm	Nan pro			25ml		passed	-	-	15ml		
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm	Nan pro			25ml		passed	-	-	10ml		
	03:00 pm											
	04:00 pm	Nan pro			25ml		passed	-	-	12ml		
	05:00 pm											
	06:00 pm	NAN pro			25ml					13ml		
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm	NAN pro			25ml		passed			17ml		
	09:00 pm	ESMT			25ml							
	10:00 pm	NAN pro										
	11:00 pm											
	12:00 am	NA pro			25ml		passed			21ml		
	01:00 am											
Total Intake :						Total Output :						
	02:00 am	NAN pro			25ml		-					
	03:00 am											
	04:00 am	NAN pro			25ml		-			09ml		
	05:00 am											
	06:00 am	NAN pro			25ml		passed			11ml		
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						

BAH-00662117
Baby Of THARA
18-07-2026
Dr. MVB Pratyush

IP5-00176589
0Y0M3D (M)

20/7/22

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FLUID CHART

TV - 120cc/kg/day
Bwt - 3.1kg
TF - 30ml

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.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	O.G						0	}
	08:00 am										0	
	09:00 am	NanPro			30ml		Passed			18ml	0	
	10:00 am										0	
	11:00 am	NanPro			30ml		Passed				0	
	12:00 pm										0	
	01:00 pm	NanPro			30ml					20ml	0	
Total Intake :						Total Output :						
	02:00 pm											}
	03:00 pm	NanPro			30ml		—		—	14ml		
	04:00 pm											
	05:00 pm	NanPro			30ml		Passed	—	—	15ml		
	06:00 pm											
	07:00 pm	NanPro			30ml		Passed			14ml		
Total Intake :						Total Output :						
	08:00 pm											}
	09:00 pm	NanPro			30ml		Passed			10ml		
	10:00 pm						—					
	11:00 pm	NanPro			30ml		—			9ml		
	12:00 am											
	01:00 am	NanPro			30ml		passed			10ml		
Total Intake :						Total Output :						
	02:00 am											}
	03:00 am	NanPro			30ml		Passed			10ml		
	04:00 am						—					
	05:00 am	NanPro			30ml		passed			8ml		
	06:00 am						—					
	07:00 am	NanPro			30ml		—			12ml		
Total Intake : 360ml						Total Output : 140ml						

Total 24 hrs. Intake 120cc/kg/day

Total 24 hrs. Output 3.8 cc/kg/day



FLUID CHART

Sheet No. : 4

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am	nanpro	30ml				passed			10ml		
	10:00 am											
	11:00 am	nanpro	30ml							9ml		By
	12:00 pm											
	01:00 pm	nanpro	30ml							10ml		
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm	nanpro	30ml				passed			11ml		
	04:00 pm											
	05:00 pm	nanpro	30ml				passed			10ml		By
	06:00 pm											
	07:00 pm	nanpro	30ml							11ml		
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm	nanpro	30ml				passed			10ml		
	10:00 pm											
	11:00 pm	nanpro	30ml							8ml		
	12:00 am											
	01:00 am	nanpro	30ml				passed			10ml		
Total Intake :						Total Output :						
	02:00 am											
	03:00 am	EBM	30ml				passed			10ml		
	04:00 am											
	05:00 am	nanpro	30ml				passed			8ml		
	06:00 am											
	07:00 am	nanpro	30ml							10ml		
Total Intake :						Total Output :						
Total 24 hrs. Intake			120 cc by			Total 24 hrs. Output			117.4 cc			

BAH-00662117 IP5-00176589
 Baby Of THARA
 16-07-2026 0 Y 0 M 5 D (M)
 Dr. NITASHA BAGGA



FLUID CHART

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BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Sheet No. :

22/7/2026

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse		
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine					
			Mouth	I.V	N.G										
	08:00 am											1			
	09:00 am	Non P80	80ml				passed			10ml		0	PR		
	10:00 am											0			
	11:00 am	Non P80	30ml				-			8ml		1			
	12:00 pm											1			
	01:00 pm	Non P80	30ml				passed			12ml		1			
Total Intake :						Total Output :									
	02:00 pm											1			
	03:00 pm	Non P80	30ml							7ml		0	PR		
	04:00 pm											0	PR		
	05:00 pm						/					1	PR		
	06:00 pm	Non P80	30ml				/					1	PR		
	07:00 pm											1	PR		
Total Intake : 100						Total Output : M-2 U-2									
	08:00 pm											no	Puys		
	09:00 pm	Non P80	35ml									In	Puys		
	10:00 pm						/						Puys		
	11:00 pm	Non P80	35ml									can't	Puys		
	12:00 am												Puys		
	01:00 am	Non P80	35ml										Puys		
Total Intake :						Total Output : U=1 M=1									
	02:00 am	Non P80	35ml				/					no	Puys		
	03:00 am											In	Puys		
	04:00 am												Puys		
	05:00 am	Non P80	35ml									can't	Puys		
	06:00 am												Puys		
	07:00 am						/						Puys		
Total Intake :						Total Output : U=2 M=2									
Total 24 hrs. Intake						Total 24 hrs. Output								U=8	M=7

BAH-00662117 IP5-00176589
 Baby Of THARA
 16-07-2026 0 Y 0 M 6 D (M)
 Dr. NITASHA BAGGA



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.

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											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :					Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 18/7/26

Assessment: Baby on L/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
11PM	Assess the patients condition	11:10PM	Assessed the patients condition	Patient is stable now.
2AM	Monitor the patients vitals	2:20AM	Monitored the patients vitals	
3AM	check the patients urine out put	4AM	checked the patients urine out put.	
5AM	Monitor the patients respiratory distress.	6:10AM	Monitored the patients respiratory distress.	

Re-Assessment:

Re assessment done.

Special Notes:

NA

Nurse Signature: Mathew Nurse Name: Mathew Date & Time: 18/7/26 @ 9AM



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 19/7/26

Assessment: Baby on L/P

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

Time	Plan of Care	Time	Implementation	Evaluation
8Am →	Assess the general condition of the baby	9Am →	Assessed the general condition of the baby.	Baby on L/P and maintaining.
10Am →	provide feed as per the order	11Am →	provided feed and baby	
12pm →	provide comfortable position and w/o abnormalities	1pm →	provided feed and no abnormalities were present.	
1pm →	Administer medication as per the order.	2pm →	Administered medication as per the order.	

Re-Assessment: Re - Assessment Done

Special Notes:

Nurse Signature: @m Nurse Name: Abhirami Date & Time: 19/7/26

BAH-00662117

IP5-00176589

Baby Of THARA

18-07-2026

0 Y 0 M 3 D

(M)

Dr. MVB Pratyush



NURSING CARE RECORD

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

3
BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 19/7/26

Assessment: Baby on L/F

Goals

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

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

- ☒ Maintain Fluid Balance
☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
☒ Ensure Safety

- ☒ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess baby condition	2:15pm	→ Assessed baby condition.	Baby is now stable.
3pm	→ Monitor vital signs	3:15pm	→ Monitored vital signs	
4pm	→ Provide comfortable position	4:30pm	→ provided comfortable position	
5pm	→ Give feeds 2nd hourly.	5:10pm	→ Given feeds 2nd hourly	
6pm	→ Administer medications as per doctor's order.	6:30pm	→ Administered medications as per doctor's order.	

Re-Assessment: Re - Assessment done.

Special Notes: RBS - DD

Nurse Signature:

Nurse Name: Lokanya

Date & Time: 19/7/26 @ 2pm - 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7/26

Assessment: TERM / SUSPECTED SEPSIS

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	① Assess the general condition of the Baby	8 PM	① Assessed the general condition of the Baby	Baby is stable on the monitor for.
10 PM	① Administered medication to the Baby	10 PM	① Administered medication to the Baby	
12 AM	① Doing oral care & feeding to the Baby	12 AM	① Done oral care & feeding to the Baby	
2 AM	① Given feed to the Baby	12 AM	① Given feed to the Baby	
4 AM	① Maintained I/O count	2 AM	① Maintained I/O count	
6 AM	① Doing V/S & CRAB	4 AM	① Done V/S & CRAB	

Re-Assessment: Re-Assessment Done

Special Notes: RBS - 00

Nurse Signature: [Signature]

Nurse Name: Koushik

Date & Time: 19/7/26

4

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 20/7/26

Assessment: Brady desaturation full feed

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	To maintain I/o chart	8am	Maintained I/o chart	Baby is stable
10am	To monitor vital signs	10am	Monitored vital signs	
12pm	Leison feed up and hy	12pm	Leison feed up and hy	
2pm	Plan to give Neb	1pm	Given Nebulizer	
2pm	Administer medication as per doctor order	2pm	Administer medication as per doctor order	

Re-Assessment:

Special Notes: CPBSD

Nurse Signature: [Signature] Nurse Name: Diphi Date & Time: 20/7/26 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/7/26

Assessment: Baby is on R/A

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the Baby general condition.	2pm	Assessed the Baby general condition.	Baby is now stable.
4pm	Monitors vitals.	4pm	monitored vitals.	
5pm	give feed every 2nd Hourly	5pm	given feed every 2nd Hourly.	
6pm	Ensure safety.	6pm	Ensured safety.	
8pm	Provide Comfortable Position.	8pm	Provided Comfortable Position.	

Re-Assessment: Re-Assessment Done.

Special Notes: RBS- OD.

Nurse Signature: Ajay

Nurse Name: Ajay

Date & Time: 20/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/26

Assessment: Baby on Rht

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 General Condition of Patient Baby	8:30 pm	→ Assessed the General condition of baby.	Baby is stable
11pm	→ provide comfortable position	11:30 pm	→ Provided comfortable position.	
2 AM	→ Ensure safety	2:30 AM	→ Ensured Safety	
5am	→ maintain I/O chart	5:30 AM	→ maintained I/O chart	
7am	→ Give 2 nd hourly feed	7:AM	Given 2 nd hourly feed	

Re-Assessment: Re-assessment Done.

Special Notes: RBS - OD

Nurse Signature: *[Signature]*

Nurse Name: medhama

Date & Time: 21/7/26 @ 8pm

BAH-00662117 IP5-00176589
Baby Of THARA
18-07-2026 0 Y 0 M 3 D (M)
Dr. MVB Pratyush

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 21/7/26 @ 8 AM - 8 PM

Assessment: Baby is an RHA

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
8:00 AM	Assess the General condition of the baby	8:15 AM	Assessed the General condition of the baby	New baby is stable.
10:00 AM	Monitor the vital signs	10:30 AM	monitored the vital signs	
12:00 PM	Maintain ILO chart	12:15 PM	Maintained ILO chart	
2:00 PM	Given Feed and hourly	2:30 PM	Given Feed and hourly	
5:00 PM	Administer the medication As per doctor Advice	5:15 PM	Administered the medications As per doctor Advice	
7:00 PM	Ensure safety	7:30 PM	Ensured safety	

Re-Assessment:

Special Notes:

GABG-00

Nurse Signature:

[Signature]

Nurse Name:

Sritalika

Date & Time:

21/7/26 @ 8 AM - 8 PM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/7/26

Assessment: baby is on R/A

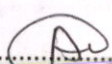
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the baby Condition	8pm	Assessed the baby Condition	Baby is on stable
10pm	monitor vitals	10pm	monitored vitals	
12AM	maintain I/O chart	12AM	monitored I/O Chart	
2AM	give feed 2nd hourly	2AM	given feed 2nd hourly	
4pm	provided comfortable position	4pm	provided comfortable position	
6pm	give medication	6pm	given medication	

Re-Assessment: Done

Special Notes: ABS

Nurse Signature: 

Nurse Name: Nitasha

Date & Time: 21/7/26

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: Baby is on Room air.

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	* Assess the general condition	8AM	* Assessed the general condition.	Now the Baby is stable.
10AM	* Monitor the vital signs	10AM	* monitored vital signs	
12PM	* maintain ilo chart.	12PM	* maintained ilo chart.	
2PM	* Giving the feeds orally	2PM	* Given feeds orally	
4PM	* administer medications as per doctors order.	4PM	* Administered medication as per doctor's order.	
6PM	* ensure safety.	6PM	* ensured safety	

Re-Assessment: Done.

Special Notes: RBS

Nurse Signature: pojitba

Nurse Name: pojitba

Date & Time: 22/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/07/2026 @ 8 PM

Assessment: Baby under observation

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 PM	→ assess the general condition of the baby and check vital.	8:00 PM	→ assessed the general condition of the baby and checked vital.	Baby is stable
10 PM	→ Giving feeding and nappy and burping.	10:00 PM	→ Given feeding and nappy and burped.	
12 AM	→ Giving warm bottle.	12:00 AM	→ Given warm bottle.	
6 AM	→ checking urine output.	6:00 AM	→ checked urine output.	
8 AM	→ Ensure safety.	8:00 AM	→ Ensured safety.	

Re-Assessment: Baby is stable (under observation)

Special Notes: Mastitis 6 AM

Nurse Signature: *Riya*

Nurse Name: Riya

Date & Time: 23/07/2026 @ 8 AM

NURSING CARE RECORD



Date:

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

Special Notes:

Nurse Signature: _____ Nurse Name: _____ Date & Time: _____

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nitasha Bagga Department: 300 floor Date of Admission: 18/7/26

SITUATION	Diagnosis: <u>Teen (38 wks + 5 days) / Male Baby / AGA</u> <u>Suspected Sepsis</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
	Area	Shift Time				
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</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>98.3°F</u>	<u>98.0°F</u>			
	Res:	<u>30b/m</u>	<u>36b/m</u>			
	SpO ₂ :	<u>99%</u>	<u>100%</u>			
	Pulse:	<u>104b/m</u>	<u>101b/m</u>			
	BP:	<u>-</u>	<u>-</u>			
	Fall Risk Score:	<u>17</u>	<u>17</u>			
Recommendations	Pain Score:	<u>112b/m</u>	<u>dfo</u>			
	Safety Needs:	<u>Cord Care</u>	<u>Chin Care</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>GRBS</u> <u>OD.</u>	<u>GRBS</u> <u>OD</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>Sunita</u>	<u>Rijs</u>			
Signature :		<u>Sunita</u>	<u>Rijs</u>			
Date:		<u>22/7/26</u>	<u>22/7</u>			
Time:		<u>@ 8pm</u>	<u>AM</u>			
Taken Over By Name :		<u>Rijs</u>	<u>Aslucii</u>			
Signature :		<u>Rijs</u>	<u>Aslucii</u>			
Date:		<u>22/7/26</u>	<u>22/7/26</u>			
Time:		<u>8PM</u>	<u>@ 8AM</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area						
	Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
	Res:						
	SpO ₂ :						
	Pulse:						
	BP:						
	Fall Risk Score:						
Pain Score:							
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							



NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 18/7/26		Diagnosis : Sepsis ERD		Surgery / Procedures : NO		
		Allergies : NOT KNOWN		Post OP Day : NO				
Date :		18/7/26	19/7/26	19/7/26	19/7/26	20/7	20/7/26	
Area		NA	NA	NA	NA	NA	NA	
Shift Time		8pm-8am	8am-2pm	2pm-8pm	8pm-7am	8am-2pm	2pm-8pm	
Diet :		FF	Preman	Nanpro	Nanpro	Nanpro	Nanpro	
Ventilation (RA, NP, NIV, VENTI)		RA	W/F	W/F	W/F	W/F	W/F	
INVASIVE LINES	1.	O-G	O-G-D	O-G-D	O-G-D	O-G-D	O-G-D	
	2.	IV	canula	IV-D	IV-D	IV-D	IV-D	
	3.							
	4.							
ASSESSMENT	Infusions / Transfusions		10% Isop	10%				
			Isop					
	PU Prophylaxis		NA	NA				
	DVT Prophylaxis		NA	NA				
	Vitals	BP	63/38 (47)	84/61	75/58 (60)	80/51/66	78/43 (59)	103/77 (86)
		PR	143b/m	148b/m	149b/m	120	140	119b/m
		RR	43b/m	36b/m	57b/m	41b/m	38	85b/m
		SpO ₂	96%	99%	96%	93%	97%	93%
		Temp	36.5°C	36.6°C	36.5°C	36.4°C	36.6°C	36.6°C
	Pain Score		+1/10	+1/10	1/10	2/10	+2	+2
	LOC (Alert, Conscious, Confusion, Unconscious)		Alert	Alert	Alert	Alert	Alert	Alert
Skin Integrity (Intact / Bedsore / Any other condition)		Intact	Intact	Intact	Intact	Intact	Intact	
Restraints If any		NA	NA	NA	NA	NA	NA	
Fall Risk (Vulnerable (Y/N) If yes score)		yes	yes	yes	yes	yes	yes	
(Ambulation, walking, moving with assistance, bed ridden)		moving	moving	moving	moving	bed ridden	Bed rid	
ADL (Dependent / Non-Dependent)		dependent	dependent	dependent	dependent	Dependent	Dependent	
Critical Lab Test/ Values (if any)		nil	nil	NA	NA	NA	NA	

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

RECOMMENDATIONS	Investigations Procedures	Date :	18/7/26	19/7/26	19/7/26	19/7/26	20/7/26	20/7/26
		Area	NY	NA	NA	NY	NY	NA
Shift Time		8pm-8am	8pm-8am	2pm-8am	8am-4pm	8am-4pm	8am-4pm	2pm-8pm
Ordered / Planned		GRBS-	GIRBS	RBS	RAE-OD	RBS	RBS	RBS
			-OD	OD		OD		-OD
Due		NA	NA	NA	NA	NA	NA	NA
Reports Pending		Blood	Blood		B/c			
		CIS &	cls &					
		Grouping	grouping					
Referrals (If any)		ND	NA	NA	NA			NA
Remarks (Special Interventions like, Drainage Tube flushing etc:)		NA	NA	NA	NA	NA	NA	NA
Handed Over By Name :		Madhew	Abhiram	Lokanjan	Koushik	Dipk	Ajay	Ajay
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		19/7/26	19/7/26	19/7/26	19/7/26	20/7/26	20/7/26	20/7/26
Time :		8pm	@2pm	8pm	8AM	@2pm	@2pm	@8pm
Taken Over By Name :		Abhiram	Lokanjan	Koushik	Dipk	Ajay	Ajay	Mukunda
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		19/7/26	19/7/26	19/7/26	19/7/26	20/7/26	20/7/26	20/7/26
Time :		@8pm	@2pm	8pm	@8am	@2pm	@2pm	@8pm



2

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA :		Diagnosis :		Surgery / Procedures :		
		Allergies :		Post OP Day :				
Date :		20/7/26		21/7/26		22/7		
Area		N3		N3		KMC		
Shift Time		8pm-8am		8am-8pm		8am-8pm		
Diet :		Nan pro		Nan pro		Nan pro		
Ventilation (RA, NP, NIV, VENTI)		P/A		P/A		P/A		
1.		O ₂ - ①		N/A - ①				
2.		IV - ①						
3.								
4.								
INFUSIONS / TRANSFUSIONS		NA		NA		NA		
PU Prophylaxis		NA		NA		NA		
DVT Prophylaxis		NA		NA		NA		
Vitals		BP	81/52/62		114/72		72/72	
		PR	117b/m		119b/m		114	
		RR	51b/m		78b/m		-	
		SpO ₂	96%		98%		95%	
		Temp	36.4°C		36.5°C		38.6°C	
Pain Score		2/10		2/10		1/10		
LOC (Alert, Conscious, Confusion, Unconscious)		Alert		Alert		Alert		
Skin Integrity (Intact / Bedsore / Any other condition)		Intact		Intact		Intact		
Restraints If any		NA		NA		NA		
Fall Risk (Vulnerable (Y/N) if yes score)		Yes		Yes		Yes		
(Ambulation, walking, moving with assistance, bed ridden)		moving		moving		moving		
ADL (Dependent / Non-Dependent)		Dependent		Dependent		Dependent		
Critical Lab Test / Values (if any)		NA		NA		NA		

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

RECOMMENDATIONS	Investigations Procedures	Date :	20/7/26	21/7/26	21/7/26	22/7		
		Area	N3	N3	KMC	KMC		
	Shift Time	8pm-8pm	8pm-8pm	8pm-8pm	8pm-8pm			
	Ordered / Planned	RIS-OD	RBS-OD	RBS-OD	RBS-OD			
	Due	NA	NA	NA	NA			
	Reports Pending	NA	NA	NA	NA			
	Referrals (If any)	NA	NA	NA	NA			
	Remarks (Special Interventions like, Drainage Tube flushing etc.)	NA	NA	NA	NA			
	Handed Over By Name :	Madhusu	Silbala	Agasti	Poojitha			
	Signature :	[Signature]	[Signature]	[Signature]	[Signature]			
	Date :	21/7/26	21/7/26	22/7/26	22/7			
	Time :	@ 8pm	@ 8pm	8pm	8pm			
	Taken Over By Name :	Silbala	Agasti	Poojitha				
	Signature :	[Signature]	[Signature]	[Signature]				
	Date :	21/7/26	21/7/26	22/7/26				
	Time :	@ 8pm	8pm	@ 8pm				



BRADEN 'Q' SCALE

					Date : 22/07			
					Time : 8:50			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	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			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	3			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	18		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Paje		

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



CHECKLIST FOR THROMBOPHLEBITIS

1

18/7

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			20/7 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			0	0	0	0	1	1	1	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			0	0	0	0	1	1	1	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			0	0	0	1	1	1	1	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			0	0	0	1	1	1	1	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			0	0	0	1	1	1	1	
Signature of the Nurse						Matthew @m							

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



CHECKLIST FOR THROMBOPHLEBITIS

22/7/26

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : SD. S. S. S. Name : Shivani

Signature : Name :



NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

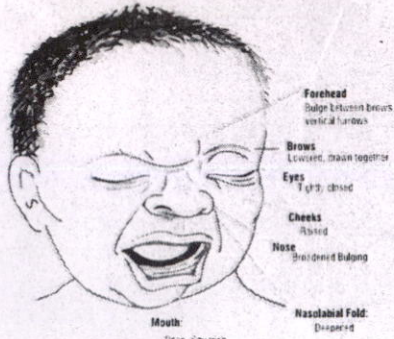
Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	Date	
	-2	-1	0	1	2	18/7	19/7	19/7	19/7	20/7	20/7	21/7	22/7	22/7	
						Time	Time	Time	Time	Time	Time	Time	Time	Time	
						11 PM	12 PM	6 PM	5 PM	4 PM	8 PM	6 AM		6 PM	
						Procedure → Cumulation + RBS									
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	1	1	1	1	1	1	1	1	1	
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	2	2	2	2	2	2	2	2	2	
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	1	1	1	1	1	1	1	1	1	
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0	0	0	0	0	0	
Vital Signs HR RR, BP, SaO ₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0	0	0	0	0	0	
Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 - No Intervention Pain Score greater than 3 - Intervention						Gestational Age / Corrected Age	43 weeks	43 wks	43 wks	43 wks	43 wks	43 wks	43 wks	43 wks	43 wks
						Total Pain / Agitation Score	4/10	2/10	2/10	2/10	1/10	1/10	1/10	1/10	1/10
						Intervention	OMC	OMC	OMC	OMC	OMC	OMC	OMC	OMC	OMC
						Effectiveness	Good	good	Good	Good	Good	Good	Good	Good	Good
						Signature	Mather	@m	BT	ec	BT	BT	BT	BT	BT

NPASS: Neonatal Pain, Agitation & Sedation Scale

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



NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
						22/07							
						RR							
						MA							
						Procedure →							
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0							
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							
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	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							
Vital Signs HR RR, BP, SaO ₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0							
 Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention						Gestational Age / Corrected Age	38+5						
						Total Pain / Agitation Score	WKS						
						Intervention	0/10						
						Effectiveness	-						
						Signature	-						

NPASS: Neonatal Pain, Agitation & Sedation Scale

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



1

THE HUMPTY DUMPTY SCALE

18/7 19/7 19/7 19/7 20/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3	3	3	3	3	3
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3	3	3	3	3	3
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			17	17	12	12	17

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		X	X	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓	✓
Wheel Chair Support		X	X	X	X	X
Other Intervention(s) Specify		X	X	X	X	X
Nurse's Name :		Mathen	Abhi	Lokesh	Amal	Rishi
Signature :		Mathen	Abhi	Lokesh	Amal	Rishi
Date :		18/7	19/7	19/7	19/7	20/7
Time :		12AM	12PM	6PM	5P	12PM

BAH-00662117
Baby Of THARA
16-07-2026
Dr. NITASHA BAGGA

IP5-00176589
OYOMSD (M)



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4		
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2		
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3	3		
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3	3	3	3		
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	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			17	17	17		

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		—	—	yes		
Call device within reach		—	—	yes		
Wheels Locked		—	—	yes		
Room free of clutter		—	—	yes		
Adequate Lighting		—	—	yes		
Wheel Chair Support		—	—	NA		
Other Intervention(s) Specify		—	—	NA		
Nurse's Name :		Raw	Pooja	Pooja		
Signature :		Raw	Pooja	Pooja		
Date :		22/7/2024	22/7/2024	22/7/2024		
Time :		6pm	6pm	6pm		

[illegible]

Blood Culture:

S.No	Date	DOL	Specimen	Findings	Antibiotics
	18/7/26		Blood cts		APTAS

Neurosonogram:

S.No	Date	DOL	Findings

ROP Screening:

S.No	Date	DOL	Findings

2D ECHO:

S.No	Date	DOL	Findings

Thyroid Function:

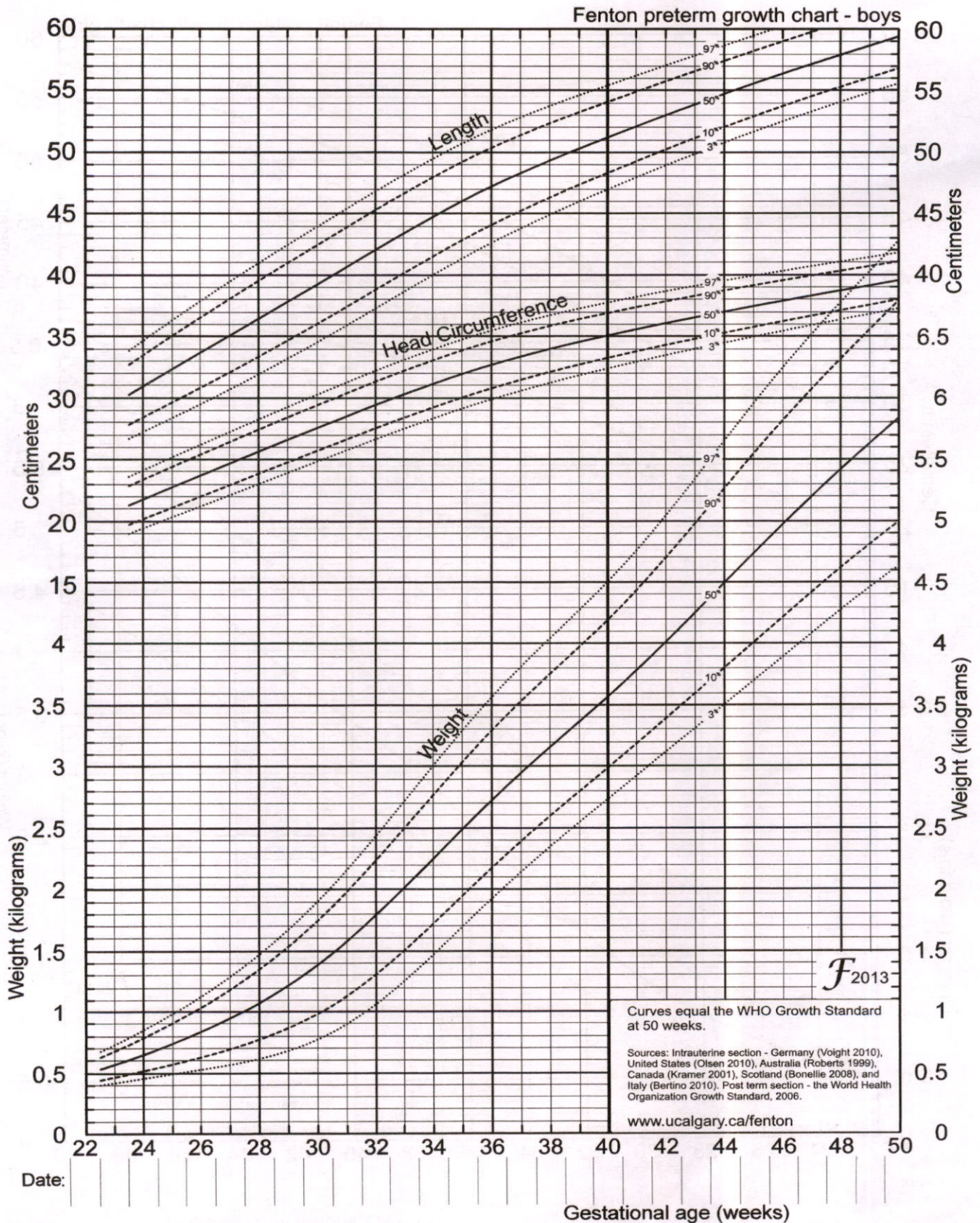
S.No	Date	DOL	Findings

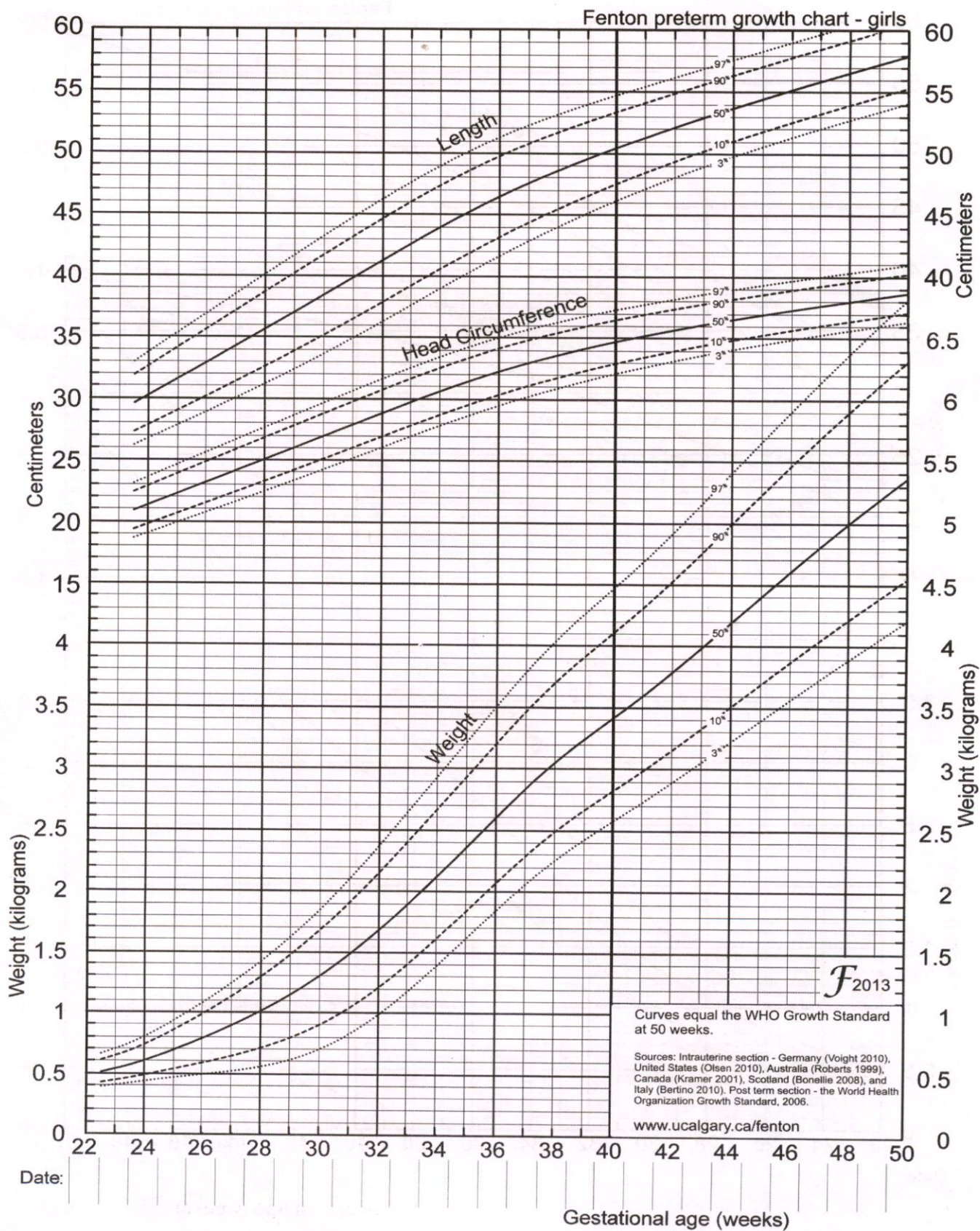
Hearing Screening: Date

Results:

Supplements:

1) Calcium	2) Multivitamins	3) HMF
4) Iron	5) Vitamin D	• 6) 3% NaCl
7) Vitamin A	8) Caffeine	9) Fluconazole Prophylaxis





PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
18/7 @ 11pm	left abd	left leg	supine	Given	Given	OD	NA	Given	Given	Mathur
18/7 @ 2am	lt abd	Rt leg	sup	given	given	OD	NA	given	given	Mathur
18/7 @ 6am	lt abd	Rt leg	sup	given	given	OD	NA	given	given	Mathur
18/7 @ 12pm	lt abd	Rt hand	sup	given	given	OD	NA	given	given	@ 12
19/7/26 6pm	lt abd	Rt hand	Supine	Given	Given	OD	NA	Given	Given	loke
19/7/26 @ 7pm	left abd	left hand	Supine	given	given	OD	NA	given	given	loti



PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
20/7/26 @ 11:00 AM	Left uff abd dom	Left hand	Sup	Given	Given	OD	Given	Given	Given	Q
20/7/26 2 PM	Right uff abd du	Right leg	Sup.	Given	Given	OD	Given	Given	Given	Q
20/7/26 @ 6 PM	Left up abd	Left legs	Supine	given	given	OD	given	given	given	Ajay
20/7/26 @ 8 PM	Left up abd	Left legs	Supine	given	given	OD	given	given	given	Ajay
20/7/26 @ 8 PM	Left Abdo	Left legs	Supine	given.	given	OD	given	given	given	A
21/7/26 @ 8 AM	Rt Abd	Rt hand	Supine	given	Given	OD Given	Given	Given	Given	Sh

BAH-00662117 IP5-00176589
 Baby Of THARA
 16-07-2026 0 Y 0 M 5 D (M)
 Dr. NITASHA BAGGA



PROBS AND POSITIONS CHART

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
21/7/26 @ 6 PM	Rt Abd	Rt leg	Supine	Given	Given	OD	NA Given	Given	Given	<i>[Signature]</i>
22/7/26 12 PM	Rt Abd	Rt leg	Supine	Given	Given	OD	NA	Given	Given	<i>[Signature]</i>
22/7/26 6 PM	Lt Abd	Rt leg	Supine	Given	Given	OD	NA	Given	Given	<i>[Signature]</i>

Patient Sticker

PROBS AND POSITIONS CHART



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: Expected date.

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

☒ Needs Assistance In:

Remarks

☐ Medication ☒ Yes ☐ No

☐ Bathing ☐ Yes ☐ No

☐ Eating ☒ Yes ☐ No

☐ Walking ☐ Yes ☐ No

☐ Dressing ☒ Yes ☐ No

☐ Toileting ☐ Yes ☐ No

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Explained about Care.

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 22/7/26 @ 4:50pm

PATIENT TRANSFER FORM

BAH-00662117 IP5-00176589
Baby Of THARA
18-07-2026 0 Y 0 M 6 D (M)
Dr. NITASHA BAGGA



Date & Time of Admission 18/7/26 at 9:51pm		Date & Time of Transfer Order 22/7/26 at 4:25pm
Treating Consultant Name Dr. Nitashabagga	Transfer Ordered by Dr. Nitashabagga	Reason for Transfer observation
From Unit NICU	To Unit 3rd floor zone-c	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File - 50 -	Number of Imaging Films x-ray chest - 1	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ? R. Bhaskar

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Shifting Summary	①
2.	VBG	③
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring Roojitha	Name of Person Ordered Transfer Dr. Namatha
--	--

Patient & Clinical Records Received by : *[Signature]*

Date & Time of Patient Received : 22/7/26 @ 4:48pm

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



NURSING INITIAL ASSESSMENT FOR NICU

Date of Admission: 18/7/26

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

Reason for Admission: Breathing difficulty & P

Admission Diagnosis: Term L.R.O.S

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: <u>Nil</u>
---------------------	----------------------------

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: Emergency LSCS

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: 3.1401 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: Gestation: 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:



FORM

Patient Name & UHID No. B/o Tara.		Date & Time of Admission 18/7/26 J	Date & Time of Transfer Order 18/7/26 J 9:50 pm
Treating Consultant Name		Transfer Ordered by Dr. Harika	Reason for Transfer Admission
From Unit CR	To Unit NICU	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 6	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films N/A			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.	MD		
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Ramadev P		Name of Person Ordered Transfer Dr. Harika.	
Patient & Clinical Records Received by : Mathew			
Date & Time of Patient Received : 18/7/26 @ 10 pm			

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

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

BAH-00662117 IP5-00176589
Baby Of THARA
18-07-2026 0 Y 0 M 3 D (M)
Dr. MVB Pratyush



C

ULA 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 : B/o Thara Age : 3yrs Gender : ☒ Male ☐ Female
UHID No : 662117 Reg. No. : 176589 Department : NSC Date : 18/07/26
I Mr / Mrs. : SHASHEER aged years, hereby declare that I have
admitted my ☒ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on
18/07/26 I hereby give consent for formula feed for my child. Doctors have explained me
a the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : R. Shaloor
Name : SHASHEER
Relationship with Patient : FATHER
Date & Time : 18/07/2026 2PM

Witness :

Signature : ANURAG
Name : Nargim Reddy
Date & Time : 18/07/26 2PM

Dr. (who is taking the consent) :

Signature : [Signature]
Name : Purnima
Date & Time : 18/07/2026 2PM

డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

కి 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

CONSENT
IN NEON

BAH-00662117

Baby Of THARA

18-07-2026

Dr. MVB Pratyush

IP5-00176589

0 Y 0 M 3 D

(M)

NIT

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: B/O Thara Age: 3 Days Gender: Male ☒ Female ☐

UHID.No: bb217 Date: 18/07/26

I BHASKAR S/o, D/o, W/o hereby
declare that our patient Mr. / Ms. B/O THARA who is related to me as Son is
getting admitted in the Neonatal Intensive Care Unit of Rainbow Children's Hospital on 18/07/26

The doctors have explained to me in a language understood by me that my child has following health related issues :

The doctors have clearly explained to me that my patient B/o THARA 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 THARA
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 : R. Bhaskar

Name : R. Bhaskar

Relationship with Patient: FATHER

Date & Time : 18/07/26 10PM

Witness :

Signature : Nargisum Reddy

Name : Nargisum Reddy

Date & Time : 18/07/26 10PM

Doctor (who is taking the consent) :

Signature : R. Bhaskar

Name : R. Bhaskar

Date & Time : 18/07/26 10PM

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



రోగి పేరు వయస్సు లింగం పు ☐ స్త్రీ ☐

యు.హెచ్.ఐ.డి బి

నేను నాడు పూర్తి సమ్మతితో చేర్చితిని. మా బాలుడి / బాలికలో. ఈ క్రింద

అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రేయిన్స్ బిల్డిన్ ఆసుపత్రి లోని నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్లో తేదీ తెలిపిన ఆరోగ్య సమస్యల గురించి వైద్య నిపుణుడు 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) డాక్టర్ 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, శ్వాసవరమైన 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