Rainbow Children's Hospital | BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00174568 **Admit Date** : 31-May-2026 **Admit Time** : 02:36 PM **UHID** : BAH-00657716

Patient Details :

Patient Name : Baby Of YETURU ANVITHA REDDY
Age : 0 D
Guardian : Mr VIKRAM REDDY BACHALI
DOB : 31-05-2026 12:59 PM
Gender : Male
Religion :
Occupation :
Martial Status : Single
Address (H) : VILLA- 302, NAMBAIR BELLEZEA , CHANDAPUR , Muthanallur Bangalore Karnataka INDIA 560099
Phone No : 9900943298/ 8008766771
E-mail : NOAMAIL@GMAIL.COM

Admission Details :

Bed Type : BASINET **Bed No** : CRDL-SW-414-1 **Ward Name** : 4F-BIRTHING CENTRE
Room No : CRDL-SW-414-1 **Admission Type** : First Visit

Contact Details :

Name : Mr VIKRAM REDDY BACHALI
Relationship : Father
Contact Address : VILLA- 302, NAMBAIR BELLEZEA , CHANDAPUR , Muthanallur Bangalore Karnataka INDIA 560099
Phone No : 9900943298 / 8008766771

Signature

Doctor Details :

Doctor Name : Dr. MVB Pratyush
Specialisation : NEONATOLOGY
Referral Doctor : SELF
Phone No :
Co-Consultant :

Payment Details :

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

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0Y0M0D2H (M)
Dr. MVB Pratyush

NEWBORN MONITORING FORM

Date of Birth	: 31/5/26	New Born Screening	: (father willing) Vikram Reddy B
Time of Birth	: 12.59pm	TFT	:
Mode of Delivery	: EL-LSCS	OAE	:
Birth Weight	: 2.644kgs	Mother's Blood Group	: B+ve
Head Circumference	: 34cms	Baby's Blood Group	:
Length	: 49cms	Anomaly Scan	:
Red Reflex	:	Vaccination	: OPV, BCG, Hep-B Given on 31/5/26. Sis. Yadamma 31/5/26

Date	Weight	Type of Feed	Quantity	Temperature	Signature
31/5/26	2.644kgs	DBF	—	98°f	Ashwitha
31/5/26	2.576kg - warmer cot				
01/6/26	2.511kg	DBF	—	98.0°f	Divya
02/6/26	2.427kg	DBF	—	97.2°F	Divya

Date	Time	Investigation	Result	Order No.	Signature
31/5/26	2:00pm	Bloodgrouping	O +ve.	26055331	Ashwitha
31/5/26	1st 2:15	GRBS	51mg/dl	26055357	Ashwitha
31/5/26	3rd 4:00pm	GRBS	62 mg/dl	26055358	Ashwitha
31/5/26	6th 7:00pm	GRBS	71 mg/dl	26055371	Ashwitha.
01/5/26	12th 1:Am	GRBS	66 mg/dL	26055424	[illegible]
01/6/26	24th 1pm	GRBS	83mg/dl	26055645	Soukhami
02/6/26	1am	GRBS	79 mg/dL	26055809	[illegible]
2/6/26	1:52pm	NBS		26056036	Annamma
2/6/26	2:45pm	SBR	~~SBR~~	26056001	Annamma

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0Y0M0D2H (M)
Dr. MVB Pratyush

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Mrs Anvitha Age : 31 Father's Name : .... Age : 32

Date of Birth : .... Date of Admission : .... UHID No.: 00657704

NICU Consultant : as per rota 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 Anvitha

Mother's Blood Group : B+ve

Gender : ☑M ☐F Blood Group : O+ve

Birth Weight (gms) : 2.644 Length (cms) : 49 cm

Date of Birth : 31/05/26 Time of Birth : 12:59pm

OFC (cms) : 35 cm

Place of Birth : RCH Banjara

Estimated Gesth Age : 38+5

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 31 Ht : .... Wt : .... BMI: .... Married Life : .... LMP : 1/9/2025 EDD : 8/06/2026

Conception : Spontaneous or with Rx. : spontaneous conception

Booked at what GA. : Booked elsewhere AN Steroids Drugs / Doses : ....

Last Scans Details : 36+6, EFW - 2969, Doppler - NAD

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

MATERNAL RISK FACTORS

Age : ☐<18 yrs ☐ > 35yrs 31 year.

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 : X

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

IUGR - when detected : ....

Doppler (Increased Resistence / ADEF / REDF / Redistrbution in MCA) / Ductus Venosus : X

AFI : ....

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

Controlled or not, recent values, HbA1 values : X

Compliance with Rx : ....

Scans : LGA, TIFFA, (Fetal Echo) : Normal study

H/o Hypothyriodism : when diagnosed ? Medication? X

Any other Chronic Medical Problems, when detected drugs ? ....

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

Infection : H/O, Fever X

(☐ 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 : ....

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0 Y 0 M 0 D 2 H (M)
Dr. MVB Pratyush

PAST OBSTETRIC HISTORY

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

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

PERINATAL HISTORY

Treating Obstetrician : Dr Sarada Reddy Hospital : Rainbow Banjara ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig) Elective LSCS

Second stage (> 2 hours after dilation) Emg LSCS

LSCS : ☐ Elective ☐ Emergency Indication : INVO NPOL

Specify the reason : Maternal + family request

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL : ....

Resuscitaion : ☐ Yes ☐ No

Cord ABG : ....

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

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : .... Weeks : ....

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

	1 Minute	5 Minutes	10 Minutes
	1	1	
	2	2	
	2	2	
	2	2	
	2	2	
	9/10	9/10	
TOTAL			

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

Snapee II Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0 Y 0 M 0 D 2 H (M)
Dr. MVB Pratyush

History of Present Illness:

Delivered by LSCS
↓
CIAB
↓
DCC done
↓
Recieved & warmer
↓
Routine new born care
- Inj Vit - K 1mg I.M given
↓
Shifted to Mother Side

Investigation details in previous Hospital :

—

Feeding History :

—

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0 Y 0 M 0 D 2 H (M)
Dr. MVB Pratyush

Past History :

—

Family History :

—

Socio Economic History :

—

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Alert, active.

VITALS : Temperature : 36.5 HR : 150 RR : 50 NIBP : .... CFT : < 3 sec

Color of the extremities : Acrocyanosis — pink

Jaundice : .... Pallor : .... SpO2 : 95% pre-ductal

ANTHROPOMETRY: Birth Weight : 2644 Length : .... HC : .... Present Weight : ....

Ponderal Index : .... AGA : .... SGA : 10th centile LGA : ....

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0 Y 0 M 0 D 2 H (M)
Dr. MVB Pratyush

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 :	(N)
EYES :	Symmetry : Red Reflex : Discharge :	— Needs to be checked
EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Periauricular Pits / Tags : Nasal shape / Patency : Palate : Gums : Lips : Tongue :	Normal No cleft
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number :	(N)ormal
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : Discharge :	(N) 2A 1V
GENITILIA :	Labia / Hymen : Testicles/penis : Anus :	(N) male genitalia B/L testis descended
HERNIAL ORIFICES		free
TRUNK and SPINE :		(N)
SKIN LESIONS :		(N)
EXTREMETIES :	Fingers / Toes : Deformities : Hip Joint Examination :	(N)
	Arms / Legs : Mobility :	(N)

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0Y0M0D2H (M)
Dr. MVB Pratyush

SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☑ Regular ☐ Periodic ☐ Shallow ☐ Gasping

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

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

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

Settings : ....

SpO2: 95% preductal Auscultation: B/L EAE Breath Sounds: NVS Added Sounds: No

CARDIOVASCULAR SYSTEM :

HR : 150 BP : -

Femoral Pulses : (N)

Other Peripheral Pulses : (N)

Precordial Activity : Normal

Murmurs : (N)

Signs of Cardiac Failure : (N)

ABDOMEN:

Shape : (N)

Palpation : (N)

Palpable masses : (N)

Abdominal girth : ....

Hernia orifice : free

Anal Patency : patent

Umbilical Cord : 2A 1V

First urine passed : Not yet

Meconium passed : Not yet

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : alert active

State of wakefulness : alert

Prechtle Score : ....

Nerves : No focal neurological deficit

....

MOTOR SYSTEM:

Passive Tone : good

Active Tone : good

Neonatal Reflexes : ....

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

Moro's : B/L complete DTR : (N)

ATNR : .... Skull and Spine : (N)

31-05-2026 ...AVITHA REDDY 0Y0M0D2H (M)
Dr. MVB Pratyush

Any Congenital Anomalies : No gross congenital anomaly

Diagnosis : Term | Borderline SGA (10th centile) | 2.641 kg | Male | CTAB — Normal transition

FOOT PRINTS

Left Side :

Right Side :

Resident Doctor :

Signature : [signature]

Name : Rupanjali

Date & Time : 31/05/26

Consultant :

Signature : [signature]

Name : Pratyush

Date & Time : 1/6/26

PLEASE FILL UP THE FOLLOWING DETAILS

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

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0Y0M0D2H (M)
Dr. MVB Pratyush

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
- DBF q1b burping - 2 hourly
- BCG, OPV, Hep B today
- Clinical jaundice @ 24 h
- Trace baby blood group
- GRBS - post feed 1h of life 3, 6, 12h, 24, 36, 48h
Target > 50 mg
If less than ↑ Inform

Plan during ward follow up :

- Warmth & care
- W/f vitals
W/f lethargy, feeding dullness
Inform SOS

Feeding Plan at the time of shifting :

First feeding time: 1pm to 1:15pm

SBR / OAE / NBS | Routinely as planned @ 48 HOL

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:

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0 Y 0 M 0 D 5 H (M)
Dr. MVB Pratyush

DEFICIENCY CHECK LIST OF CASE SHEET

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

Signature and Date : 3/6/26

Doc. No. : RCHBH/ FRM / GENERAL / 126

(P.T.O)

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0Y0M0D2H (M)
Dr. MVB Pratyush

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/26 9am	C/4B Resident Dr Ayushma	
	20 HOL / 38+5 / 2644 gm / El. LSCS / SGA	
	2.644 → 2.511 ↓133 gm (5%)	
	Bt wt - 2644 gm.	
M ? Bt / B OT	GRBS	Plan
	1st hourly - 51 mg	
	3rd 62	• GRBS monitoring to cont
	6h 71	24, 48 HOL
	12h 66	if any of < 50 mg/dl
	18th	• BCG, OPV, HepB → Taken
	Stools - 2 times	• warmth care
	Urine - 4 time	• Cont. DBF f/b burping every 2-3 hourly
	o/e	
	Euthermic, pink,	• clinical assessment of
	C/T/A - Good	Jaundice @ 24 HOL (Today 12pm)
	Hemodynamically stable	
	Peripheral warm	• SBR
	AF - at level	UAE] 48 HOL
	No distension	NBS
	2-3 s/o sucking (+)	s/o of feeding difficult distress, dull activity
		• Monitor vitals
		Ayushma

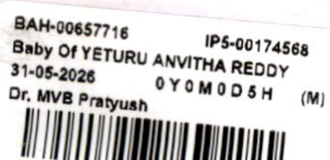
Docu. No. : RCHBH /FRM / CLINICAL / 088

N.B soushann

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0Y0M0D5H (M)
Dr. MVB Pratyush

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6 10:30Am	Lactation care plan:	
	→ Primi	
	- well formed breast and nipples	
	- colostrum seen	
	- Baby is sucking for 2-3 times & coming off the breast and again searching	
	- unable to sustain the latch.	
	Advice	
	- Direct breast feeding.	
	- To feed in sitting position only.	
	- Aim for deep latch as demonstrated in cross cradle hold	
	- Support the breast while latching the baby as demonstrated.	
	- Make baby suck for 15-20min on each side every 2-2½ hours	
	[signature] Supriya	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/26 3PM	Afternoon Notes	
	taken DBF well	Plan
	Active	(1) cont DBF c/b burping
	Pink	(2) 48HOL - SBR
	Euthermic	- NBS
	vitally stable	- OAE
	✓ | ✓	(3) GRBS monitoring as
	S | ✓	planned.
	PA - soft.	
	Dr Abhinya.	NB Seema
2/6/26 9AM	Morning Rounds	
	44HOL / Term / SGA / EL-LSCS.	
	2.644 → 2.427 (8.2% ↓)	
	↓84 gm x yest.	
	Euthermic	Plan
	Euglycemic - 66-83-79.	(1) cont DBF + FF.
	on DBF + FF (maternal request).	upto 22ml Q2H.
	Pink	(TV=100ml/kg/day).
	vitally stable.	(2) 48HOL @ 1PM
	✓ | ✓	SBR + NBS
	S | ✓	(3) OAE today
	PA - soft.	(4) Stop GRBS monitoring
	Dr Abhinya.	NB Seema

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6. 9am	Lactation care plan:	
	- Suck improved.	
	- Continue c̄ cross cradle hold as demonstrated.	
	- Do not give long gap between the feeds	
		[signature]
2/6/25 3.30pm	Seen by Resident Dr. Ayushman	
	50 HOL/ Term/ S4A/ El.LSCS	
	@	
		Plan
M/B | B↑/O↑	SBR – 5.5	◦ Cont DBF + FP (upto 22ml Q2h) TV-120ml/kg/day
S/V ✓/✓		◦ Stop GRBS monitoring
	Euthermic	◦ OAE on follow up
	Pink	
	Vitals stable	
	Peripheries warm	
	P/A – Soft	[signature]
	Vaccines done	

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0 Y 0 M 0 D 5 H (M)
Dr. MVB Pratyush

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0 Y 0 M 0 D 5 H (M)
Dr. MVB Pratyush

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0 Y 0 M 0 D 2 H (M)
Dr. MVB Pratyush

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: New born baby

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Nursing ☐ Others:
31/5/26 2:00pm	☐ Medical ~~☐ Nursing~~ ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Baby is crying	DBF given every 2-3 hourly	warm care Provided.	Ashwitha	☐ Medical ~~☐~~ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0 Y 0 M 0 D 5 H (M)
Dr. MVB Pratyush

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social & Rehabilitation Needs
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		
31/5/26	2pm	7	Infection control Measures	M, F	1	O	1	1	A	Ashwitha

Part - III: CODES

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

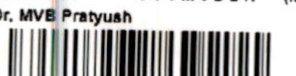
Learning Barriers:
1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and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

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

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

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

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0Y0M0D2H (M)
Dr. MVB Pratyush



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

31/5/26

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: .... Time:	2 pm	7 pm	10pm	6am
Doctor/Nurse/Family Concern?				
Temperature (F) (scale 94–104)	98°F	98.2°F	97.4°F	98.8°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)	142	140b/m		
Heart Rate (Number)	142b/m	140b/m	135b/m	120b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)				
Resp Rate (Number)	42	40b/m	40b/m	40b/m
Resp Distress — Mod/ Severe				
Resp Distress — None / Mild				
Receiving O_2 (l/min)				
O_2 Saturations (%)	100%	99%	100%	100%
Conscious Level — Normal				
Conscious Level — Altered				
GCS *			15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	[signature]	[signature]	[signature]	[signature]

Note: BP does not score in early warning scoring

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

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

Patient Sticker

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-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0Y0M0D5H (M)
Dr. MVB Pratyush

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

1/6/26

Parameter				
Date: .... Time:	11AM	5pm	10pm	6am
Doctor/Nurse/Family Concern?				
Temperature (F) (scale 94–104)	97.9F	98.2F	97.2F	97.2F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)	120			
Heart Rate (Number)	120 bpm	130 bpm	125 bpm	120 bpm
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)				
Resp Rate (Number)	30 bpm	35 bpm	40 bpm	40 bpm
Resp Distress: Mod/ Severe				
Resp Distress: None / Mild				
Receiving O_2 (l/min)				
O_2 Saturations (%)	97%	100%	100%	100%
Conscious Level: Normal				
Conscious Level: Altered				
GCS *	15	14	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

ACTIONS

NB: Scores 3 should be recorded overleaf

Score	Action
Score 1	Continue normal observation by staff nurse
Score 2	Shift in charge nurse to be informed and continue hourly observations
Score 3	Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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.

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

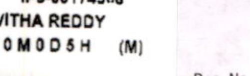
- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of 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

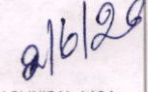
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0 Y 0 M 0 D 5 H (M)
Dr. MVB Pratyush



2/6/26

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Parameter	Observation 1	Observation 2
Date: .... Time:	11 AM	6 pm
Doctor/Nurse/Family Concern?		
Temperature (°F) (scale 104 – 94)	98.0°F	98.7°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 190 – 50)		
Heart Rate (Number)	134 b/m	145 b/m
Resp. Rate (bpm) (Over 1 Minute) * (scale 70 – 10)		
Resp Rate (Number)	38 b/m	40 b/m
Resp Distress – Mod/ Severe		
Resp Distress – None / Mild		
Receiving O_2 (l/min)		
O_2 Saturations (%)	100%	100%
Conscious Level – Normal		
Conscious Level – Altered		
GCS *	14	15/15
TOTAL SCORE Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials	[illegible]	[illegible]

Note: BP does not score in early warning scoring

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

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

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

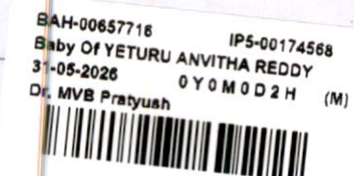
- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of 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)



FLUID CHART

Sheet No. : ....

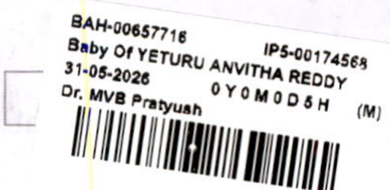
31/5/26

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

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm		DBF				NP			NP		Ashwitha
Total Intake : Taken						**Total Output :** Passed						
	02:00 pm											
	03:00 pm											
31/5/26	04:00 pm 4'45		DBF							✓	NO IV	Ashwitha
	05:00 pm 5		DBF				NP					
	06:00 pm									✓		
	07:00 pm											
Total Intake :						**Total Output :** M-0 U-2						
	08:00 pm		DBF									
	09:00 pm									✓		
	10:00 pm		DBF				✓				NA	Divya
	11:00 pm											
	12:00 am											
	01:00 am		DBF									
Total Intake :						**Total Output :** M-10 U-1						
	02:00 am											
	03:00 am						✓					
	04:00 am		DBF									
	05:00 am										NA	Divya
	06:00 am		DBF									
	07:00 am											
Total Intake :						**Total Output :** M-1 U-1						

Total 24 hrs. Intake		**Total 24 hrs. Output**	M-2 U-4

Docu. No. : RCHBH/FRM/CLINICAL/092



FLUID CHART

Sheet No. : ....

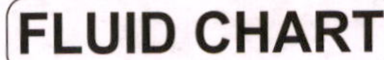
1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
01/6/26	08:00 am											
	09:00 am		DBM									
	10:00 am									✓		
	11:00 am										NA	Sasha
	12:00 pm		DBM									
	01:00 pm						✓					
Total Intake :						Total Output : M-1 U-1						
01/6	02:00 pm		DBF									
	03:00 pm											
	04:00 pm		DBF									Seema
	05:00 pm						passed			✓	NA	
	06:00 pm		DBF									
	07:00 pm	f.f.	10ml				✓					
Total Intake :						Total Output : M-0 U-1						
01/6	08:00 pm											
	09:00 pm		DBF				✓			✓		
	10:00 pm	ff	10ml									
	11:00 pm										NA	Divya
	12:00 am									✓		
	01:00 am											
Total Intake :						Total Output : M-1 U-2						
2/6	02:00 am											
	03:00 am		DBF				✓					
	04:00 am	ff	15ml							✓		
	05:00 am										NA	Divya
	06:00 am		DBF									
	07:00 am											
Total Intake :						Total Output : M-1 U-1						

Total 24 hrs. Intake	35ml

Total 24 hrs. Output	M-4 U-5

BAH-00657716 IP5-00174568
Baby Of YETURU ANVITHA REDDY
31-05-2026 0Y0M0D5H (M)
Dr. MVB Pratyush



FLUID CHART

Sheet No. : ....

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

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
2/6/26	08:00 am									✓		
	09:00 am		DBF									
	10:00 am	P.F.	10ml								NA	Soma
	11:00 am		DBF				✓			✓		
	12:00 pm	F.F.	10ml									
	01:00 pm											
Total Intake :							M-1	Total Output :		U-2	C	
	02:00 pm		DBF									
	03:00 pm						✓			✓		
	04:00 pm		DBF								NA	Annam
	05:00 pm	F.F	10ml							✓		
	06:00 pm						✓					
	07:00 pm									4		
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	

Docu. No. : RCHBH/FRM/CLINICAL/092

Patient Sticker

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

Docu. No. : RCHBH /FRM / CLINICAL / 092