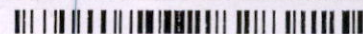


ADMISSION SHEET

Registration Details :


Admission No : IP5-00176084 Admit Date : 07-Jul-2026 Admit Time : 07:23 PM UHID : BAH-00660973

Patient Details :

Patient Name	: Baby Of CHANDANA VIJAYA ARUNADEVI	Age	: 0 D
Guardian	: Mr CHANDANA SATYAMURTHY	DOB	: 07-07-2026 06:11 PM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO 6-3-165/1/2, PREM NAGAR Khairatabad Hyderabad Telangana INDIA 500004	Phone No	: 6303933569/ 6302409298
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : BASINET Bed No : CRDL-SW-415-1 Ward Name : 4F-BIRTHING CENTRE
 Room No : CRDL-SW-415-1 Admission Type : First Visit

Contact Details :

Name : Mr CHANDANA SATYAMURTHY Relationship : Father
 Contact Address : H NO 6-3-165/1/2, PREM NAGAR Khairatabad Phone No : 6303933569 /
 Hyderabad Telangana INDIA 500004

Ch. S. Murthy.
 Signature

Doctor Details :

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

Payment Details :

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

BAH-00660973 IP5-00176084
 Baby Of CHANDANA VIJAYA
 07-07-2026 0 Y 0 M 0 D 1 H (M)
 Dr. ANNA POORNA TADAVARTHY



NEWBORN MONITORING FORM

willing (mother)

Date of Birth : 7/7/2026
 Time of Birth : 6:11pm
 Mode of Delivery : Em-LSC
 Birth Weight : 2.963 kg
 Head Circumference : 34 cm
 Length : 50 cm
 Red Reflex :

New Born Screening : ch-v-A Qnd.
 TFT :
 OAE :
 Mother's Blood Group : O+ve
 Baby's Blood Group : O+ve
 Anomaly Scan :
 Vaccination : R. C. C. P. W. H. A. B. S. on 8/7/26

Date	Weight	Type of Feed	Quantity	Temperature	Signature
7/7/26	2.963 kg	DBF	—	98.1 F	Swapne
7/7/26	2.849 kg	DBF	—	98.1	Shirish
8/7/26	2.871 kg	DBF	—	98.1	Shirish
9/7/26	2.800 kg	DBF + FF	—	98.2 F	Kalyani
10/7/26	2.756 kg	DBF + FF	—	98.2 F	Kalyani

[illegible]

BAH-00660973 IP5-00176084
Baby Of CHANDANA VIJAYA
07-07-2026 0 Y 0 M 0 D 1 H (M)
Dr. ANNAPOORNA TADAVARTHY



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

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

BIRTH INFORMATION

Name : B/o - Chandana Vijaya Arund Mother's Blood Group : O+ve
Gender : ☒ M ☐ F Blood Group : Birth Weight (gms) : 2963g Length (cms) : 50cm
Date of Birth : 7/7/26 Time of Birth : 6:11pm OFC (cms) : 8cm
Place of Birth : RCH, BH Estimated Gesth Age : 37⁺3

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : Ht : Wt : BMI : Married Life : LMP : 18/10/25 EDD : 25/7/26

Conception : Spontaneous or with Rx :

Booked at what GA : AN Steroids Drugs / Doses :

Last Scans Details : 24/6 - 35⁺ wks / cephalic / 2.82kg / AFI - 10.4
Dopplers (N) / TIFFA - (N) / NT - not done / quadrate test - low risk
TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs - 29 ys

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 : 1

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

IUGR - when detected :

Doppler (Increased Resistance / ADEF / REDF /

Redistribution in MCA) / Ductus Venosus :

AFI :

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

Controlled or not, recent values, HbA1 values : 1

Compliance with Rx :

Scans : LGA, TIFFA, Fetal Echo :

H/o Hypothyroidism : when diagnosed ? Medication?

Any other Chronic Medical Problems, when detected
drugs ? B Thal. trait, HbS

(Anemia, SLE, Jaundice, CHD, Heart Disease) - HPLC (N)

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

2 P: 1 A: 1 L: 1

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1	2020	FT	LSCS	♂	2.51kg	
2	P.P.					

PERINATAL HISTORY

Treating Obstetrician : Dr. K. R. Reddy Hospital : RCH, BH ☒ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☒ Emergency Indication *1st胎前置*

Specify the reason : *prev LCS in labor*

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 RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

1 Minute	5 Minutes	10 Minutes
1	2	1
2	2	
2	2	
2	2	
2	2	
9/10	6/10	

TOTAL

Snapee II Score

Score

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

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

42 P, L1 / 37th wk / prev. LCS in labor for emergency LCS.



preheated warmer
equipment check done
↓

male baby delivered
via - EMSCS. (presses is labor)

↓
CLAB
↓

delayed cord clamping
@ 60 sec of life

↓
routine care provided

↓
Hj Vitamin K 0.5ml given

↓
DR CPAP - was given
for 5min - 11V10-RD - 11poun of
grunk

↓
diapers settled

↓
shifted to mother side

Investigation details in previous Hospital :

Feeding History :



Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5°F HR : RR : NIBP : CFT : LBSEK

Color of the extremities : acrocyanosis → pink

Jaundice : Pallor : SpO2 :

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

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

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

1 (N)

FACIES :
(Any Facial
Dysmorphism)

**NECK and
CLAVICLES :**

Range of Motion :
Asymmetry :
Masses :

1 (N)

EYES :

Symmetry :
Red Reflex :
Discharge :

1 to be checked

**EARS, NOSE
MOUTH and
THROAT :**

Ear set / Shape :
Periauricular Pits / Tags :
Nasal shape / Patency :
Palate :
Gums :
Lips :
Tongue :

1 (N)

**THORAX and
BREASTS :**

Shape of Thorax :
Position of Nipples and Number :

1 (N)

**ABDOMEN and
UMBILICUS :**

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

1 (N)

GENITALIA :

Labia / Hymen :
Testicles/penis :
Anus :

1 (N)

male genitalia
Blk - testes palpable

HERNIAL ORIFICES

TRUNK and SPINE :

1 (N)

SKIN LESIONS :

EXTREMITIES :

Fingers / Toes :
Deformities :
Hip Joint Examination :

1 (N)

Arms / Legs :
Mobility :



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

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

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

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

Settings :

SpO₂: 92% Auscultation: Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 160/min BP :

Precordial Activity :

Femoral Pulses :

Murmurs : NAM

Other Peripheral Pulses :

Signs of Cardiac Failure :

ABDOMEN:

Shape : | (N)

Hernia orifice :

Palpation : | (N)

Anal Patency : - Freed

Palpable masses :

Umbilical Cord : 2A, 1V (N)

Abdominal girth :

First urine passed : not passed

Meconium passed : not passed

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : |

State of wakefulness : | CMA good

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone : ✓

Active Tone : ✓

Neonatal Reflexes :

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

Moro's : DTR :

ATNR : Skull and Spine :



Diagnosis :

32⁺ 3w.k / EMLSCS / Mch / 2.96 kg /

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *Pavane*

Name : *Pavane*

Date & Time : *7/7/26*

Consultant :

Signature : *[Signature]*

Name : *[Name]*

Date & Time : *8/7/26*

PLEASE FILL UP THE FOLLOWING DETAILS

- Name of the referring Doctor :
- Name of the referring Hospital :
Address :
Contact Numbers :
- Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
- 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 : SP02 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

Plan

- warm care

→ DBF - 2nd hly → burping

→ send BCG

→ BCG TOPU / HepB - 4th m.

Plan during ward follow up :

→ SBR / NBS / OAE @ 48 HOL

→ W/F - RD / quant in
monitor SpO₂

→ clinical assessment of
jaundice @ 24 Hrs

Feeding Plan at the time of shifting :

6:40 to 6:55 pm

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

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

Doctor Name: Pawan Doctor Name:

Date & Time: 7/7/26 Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 9:40am	C/S/B Resident	
	16 HOL 37+3 Term EM LSCS + B/L Tubal Ligam.	Mch 2960 ↓ Fetal movement
	Baby on room air	Plan
	M O+ue B O+ue	① DBF 2nd hwy.
	U/V M/V	② vaccination Today OPV BCG HepB
	T. wt → 2.87 Kg → 3% ↓ Euthermic - Pink Slightly cernic on breast feed good latching Tone cry. activity } good.	③ SBR } TIm 6:00 pm. NBS DAE
	Peripheries warm URT < 3 sec NO RD/gnawing	④ warm care ⑤ monitor vitals ⑥ clinical Jaundice assessment
		Soluble
10/7/26	P/S/B Dr. Annapurna.	P) vacin. today OATZ 10/7/26 Establish feeds measured feeds Dr. Tadavarthi Annapoorna Reg. No. 53054

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/26 10 AM	<u>Lactation notes</u> : - well formed breast and nipples - colostrum seen - suck not continues. <u>Advice</u> : - Direct breast feeding - Aim for deep latch - Demand feeding not exceeding 2-2 1/2 hours	
8/7/26 4:45 pm	<u>U/S/B Resident</u> 23 HOL / 37 +3 / Em LSCS / 2960 / Baby on room air V / ✓ M / ✓ hemodynamically stable Vitals - stable cy } good. tone } activity }	<u>Plan</u> : ① DBF 2nd hly ② warm care ③ OAE → TIm 8 am SBR / TIm 1:00 pm. NBS <u>sohik</u> Dr. Annapoorna Tadavarthi Reg. No: 53054
8/7/26 4:45 pm	U/S/B or Anapoor	Conti are



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/8/26 10am	<u>Lactation notes:</u> - Suck improved. - To feed in sitting position only. - Aim for deep latch as demonstrated in cradle hold. - Make baby suck for 15-20 mins on each side	Dr. [Signature] Super
9/7/26 9:30am	9/5/B Resident 40 HOL / 3 T + 3 / EM LSCS (L.F. movement) / 2960 / mch / 31L tubal ligation Baby on room air T. wt - 2.800kg m / ✓ u / ✓ B / 0+ue m / 0+ue feed well latch good Euthemic - Pink Euglycemic Cry Tone actively } good	Plan ① DBF 2nd July ② warm care ③ OAE - Today. ④ SBR } now @ 11am NBS } ⑤ monitor vitals SBR - 7.3 [Signature]

Date & Time	Progress Notes	Doctor's Order
1/7/26 10A	P/S/S Dr Annapur	P) LBR NBs OAE today.
		↓ A 7
	Dr. Tarlavarthy Annapoorna Reg. No: 53054	
9/7/26	OAE - results bilateral normal hearing. Suggestive of normal outer hair cells functioning	
	Dr. Isidori Oodli	
9/7/26	<u>US/B Resident</u>	
	Baby on room air Fed good DBF	(45HOL) Plan SBR - 73
	uy, Bone activity (+) hemodynamically stable Vitals - stable	① DBF and weeg ② warm care ③ Monitor vitals Solu



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



BirthRightTM
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00660973 IP5-00176084
Baby Of CHANDANA VIJAYA
07-07-2026 0 Y 0 M 0 D 1 H (M)
Dr. ANNA POORNA TADAVARTHY



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Blo Chandana Mother's Name: Mrs. Chandan
Date of Birth: 7/7/2026 Time of Birth: 6:11pm Gender: ☒ Male ☐ Female
Birth Weight: 2.963 Kgs HC: 34 cm Length: 50 cm
Meconium in Liquor: ☐ Yes ☒ No Cried at Birth: ☒ Yes ☐ No
Term / Pre-term / Post-term:
Resuscitated: ☐ Yes ☒ No Blood Group: Mother: O+ve Baby:
Feeding: ☒ Breast Feeding ☐ Formula ☐ Both First Feed Time: 6:40 to 6:51pm

AFFIX MOTHER'S
IDENTIFICATION LABEL

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

Physical Assessment of New Born:

Temp: 98.1F °C HR: 140 /Min RR: 40 /Min BP: NA SpO₂: 99%
Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☐ Yes ☒ No Score: 16 (Fill the Humpty Dumpty Sheet)

Risk in Pressure Sore: ☐ Yes ☒ No (Braden Q Score) (Fill the Braden Q Sheet)

Behaviour Status on admission: ☐ Sleeping ☒ Crying ☐ Calm ☐ Drowsy

Findings:

General Appearance: Posture: ☒ Well-Flexed ☐ Asymmetry

Skin: ☒ Pink ☐ Meconium Stain ☐ Others, Specify:

Nursing Management: (Please strike through If not applicable e.g. Yes / ~~No~~)

Vitamin K 1 mg I.M Administered: Yes / No

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / ~~No~~

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

All information obtained from ☒ Mother ☐ Father ☐ Other Family Member

Newborn Screening Discussed: Yes / No

Nurse Name: Shapna

Signature: Sh

Date & Time: 7/7/2026 8pm

BAH-00660973 IP5-00176084
 Baby Of CHANDANA VIJAYA
 07-07-2026 0 Y 0 M 0 D 1 H (M)
 Dr. ANNAPOORNA TADAVARTHY

MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Diagnosis:

newborn Baby Care

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:
7/5/26 SPM	☒ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	→ warm care	→ Provide warm care to Baby	→ To reduce Hyperthermia		☐ 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:

Patient Sticker

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD



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						

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 | 5. Medication / Terapy (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 Barries	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
7/1/20	8pm	7	Infection control measures	PT's	1	0	0	01	0	Self

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 Barries 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 Barries 6. Desire / Motivate to Learn 9. Cultural Difference 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									



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 07-07-2026	Time: 8pm	12pm	6pm	
Doctor/Nurse/Family Concern?				
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			
and Blood Pressure (mmHg) *	90			
	80			
	70			
	60			
	50			
	Note: BP does not score in early warning scoring			
	Heart Rate (Number)			
	140 bpm			
	130 bpm			
	140 bpm			
Resp. Rate (bpm) (Over 1 Minute) *	70			
	60			
	50			
	40			
	30			
	20			
	10			
	Resp Rate (Number)			
	40 bpm			
	40 bpm			
40 bpm				
Resp Distress	Mod/ Severe			
Receiving O ₂ (l/min)	None / Mild			
O ₂ Saturations (%)				
99%				
100%				
99%				
Conscious Level	Normal			
GCS *	Altered			
13/15				
14/15				
8/15				
TOTAL SCORE				
Number of shaded boxes				
Pain Score				
Observer's Initials				

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
Score 2 : Shift in charge nurse to be informed and continue hourly observations
Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and 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-00660973 IP5-00176084
Baby Of CHANDANA VIJAYA
07-07-2026 0 Y 0 M 0 D 5 H (M)
Dr. ANNAPOORNA TADAVARTHY



8/7/26
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

WARNING SCORE: CHILDREN'S UNIT

Date: Time: 12 pm 5:40 pm 10pm 2am 6am

Doctor/Nurse/Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

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

Heart Rate (Number)

142b/m 143b/m 136b/m 130b/m

Resp Rate (bpm)
(Over 1 Minute) *

70
60
50
40
30
20
10

Resp Rate (Number)

36b/m 38b/m 42b/m 40b/m

Resp Distress Mod/ Severe
None / Mild

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

97% 100% 99% 97%

Conscious Level Normal
Altered

GCS *

15/15 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0 0
0 0 0 0
K B B B

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



ICH / FRM / CLINICAL / 124

9/7/26

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

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:

11 am

6:40 PM

10 pm

2 am

6 am

Doctor/Nurse/Family Concern?

Temperature
 (F)

104
103
102
101
100
99
98
97
96
95
94

97.5°

98.5°

98.0°

98.2°

97.8°

Heart Rate
 (bpm)

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

and

Blood Pressure
 (mmHg) *

Note:
 BP does not score
 in early
 warning scoring

Heart Rate (Number)

111 bpm

136 bpm

128 bpm

130 bpm

Resp Rate (bpm)
 (1 Minute) *

70
60
50
40
30
20
10

Resp Rate (Number)

39 br/min

28 br/min

40 br/min

40 br/min

Resp Mod/ Severe
 Distress None / Mild

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

99%

100%

98%

98%

Conscious Level
 Normal Altered

GCS *

15/15

15/15

15/15

15/15

TOTAL SCORE

Number of shaded boxes

0

0

0

0

Pain Score

0

0

0

0

Observer's Initials

9/7/26

9/7/26

9/7/26

ACTIONS

NB: Scores 3 should be
 recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00660973
Baby Of CHANDANA VIJAYA
07-07-2026 0 Y 0 M 2 D
Dr. ANNAPOORNA TADAVARTHY

IP5-00176084

(M)

CH / 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

LY WARNING SCORE: CHILDREN'S UNIT

Date:

Doctor/Nurse/Family Concern?

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

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

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

70
60
50
40
30
20
10

Resp Rate (Number)

Resp Distress Mod/ Severe
None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Level Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

- Score 1 : Continue normal observation by staff nurse
Score 2 : Shift in charge nurse to be informed and continue hourly observations
Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half 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-00660973 IP5-00176084
 Baby Of CHANDANA VIJAYA
 07-07-2026 0 Y 0 M 0 D 1 H (M)
 Dr. ANNAPOORNA TADAVARTHY



FLUID CHART

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Sheet No. : ①

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 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	DBF										
	07:00 pm											
Total Intake :			Taken			Total Output :					Not pass	
	08:00 pm											
	09:00 pm	DBF										
	10:00 pm											
	11:00 pm	DBF										
	12:00 am											
	01:00 am	DBF										
Total Intake :			Taken			Total Output :					U-1 2M-1	
	02:00 am											
	03:00 am	DBF										
	04:00 am											
	05:00 am	DBF										
	06:00 am											
	07:00 am	DBF										
Total Intake :						Total Output :					M-1 U-1	
Total 24 hrs. Intake						Total 24 hrs. Output			M-2 U-2			

FLUID CHART

Sheet No. :

8/7/26

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

		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								
8/7	08:00 am												
	09:00 am	DBF											
	10:00 am												
	11:00 am	DBF											
	12:00 pm												
	01:00 pm	FF 20ml											
Total Intake :						Total Output : 021 ml							
8/7	02:00 pm	FF 20ml											
	03:00 pm												
	04:00 pm	DBF											
	05:00 pm												
	06:00 pm	FF 30ml											
	07:00 pm												
Total Intake :						Total Output : 100 ml							
8/7	08:00 pm												
	09:00 pm	DBF											
	10:00 pm	FF 15ml											
	11:00 pm												
	12:00 am	DBF											
	01:00 am												
Total Intake :						Total Output :							
8/7	02:00 am	DBF											
	03:00 am												
	04:00 am	DBF											
	05:00 am												
	06:00 am	DBF											
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

1021, 1024



FLUID CHART

Sheet No. :

9/7/26

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

		Intake				Output					IV Site 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	DBF											
	10:00 am												
	11:00 am												
	12:00 pm	DBF											
	01:00 pm						✓			✓			
Total Intake :						Total Output :						M-1	U-1
	02:00 pm	DBF											
	03:00 pm												
	04:00 pm	DBF											
	05:00 pm						✓			✓			
	06:00 pm	DBF											
	07:00 pm												
Total Intake :						Total Output :						M-10	U-1
	08:00 pm						✓			✓			
	09:00 pm	DBF											
	10:00 pm	FF (10ml)											
	11:00 pm												
	12:00 am	DBF					✓			✓			
	01:00 am												
Total Intake :						Total Output :						M-10	U-1
	02:00 am	DBF											
	03:00 am												
	04:00 am	DBF											
	05:00 am												
	06:00 am	DBF					✓			✓			
	07:00 am												
Total Intake :						Total Output :						M-10	U-1
Total 24 hrs. Intake													
Total 24 hrs. Output													

M = 5, U = 5

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												
	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													

BAH-00660973 IP5-00176084
 Baby Of CHANDANA VIJAYA
 07-07-2026 0 Y 0 M 0 D 1 H (M)
 Dr. ANNAPOORNA TADAVARTHY

NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 11/7/26

Assessment: new born Baby case

- 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
6:30pm	→ assessed the Baby condition	6:30pm	→ assessed the Baby condition	→ Baby stable
7pm	→ monitor vitals	7:30pm	→ monitored vitals	
7:30pm	→ DBF and Burping	7:40pm	→ DBF given	
8pm	→ warm care	8pm	→ warm care provided	

Re-Assessment: done Baby stable

Special Notes: SBR, NBE, OAE @ 48 Hrs. vaccination tomorrow

Nurse Signature: [Signature]

Nurse Name: Swapne

Date & Time: 11/7/2026 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26

Assessment: New born baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	⇒ Assess the baby	10pm	⇒ Assessed the baby vitals stable.	Baby is fine.
10pm	⇒ provide warm care	12Am	⇒ Baby well wrapped	
12Am	⇒ Ensure safety	2Am	⇒ Diaper care provided.	
2Am	⇒ prevent infection	4Am	⇒ Hand hygiene maintained.	
4Am	⇒ DBF + Burping	6Am	⇒ DBF + Burping given.	
6Am	⇒ U/O monitoring	8Am	⇒ U/O monitoring done.	

Re-Assessment: Baby taking well feed.

Special Notes: vaccination today. T/m

Nurse Signature: 

Nurse Name: T/m

Date & Time: 8/7/26 @

BAH-00660973 IP5-00176084
 Baby Of CHANDANA VIJAYA
 07-07-2026 0 Y 0 M 0 D 5 H (M)
 Dr. ANNAPOORNA TADAVARTHY



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/7/26

Assessment: newborn baby monitoring & routine Assessment

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the Baby general condition	8:30 am	→ Assessed the Baby general condition on the crib	Baby was active & good
10am	→ To monitor vitals	10:30 am	→ monitored vitals	
11am	→ To maintain ILO chart	11:30 am	→ maintained ILO chart	
12pm	→ To Give feed 2nd boly	12:30 pm	→ given feed 2nd boly	
1pm	→ To provide crib care	1:30 pm	→ provided crib care	

Re-Assessment:

Re assessment has done after 1 hour baby was stable now

Special Notes: vaccination today

TCBR @ 6pm, SBR, NBS, one @ 4pm

Nurse Signature:

Nurse Name: Raviath

Date & Time: 21/7/26 @ 2pm

BAH-00660973 IP5-00176084
 Baby Of CHANDANA VIJAYA
 07-07-2026 0 Y 0 M 0 D 5 H (M)
 Dr. ANNAPOORNA TADAVARTHY



NURSING CARE RECORD

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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 8/7/26

Assessment: newborn baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the baby condition	2:30 pm	* Assess the baby condition	* Baby is well
3pm	* plan to monitor vitals		baby is stable.	
4pm	* plan to maintain I/O chart.	3:10 pm	* monitor vitals stable.	
5pm	* plan to warm care	4:20 pm	* maintain I/O chart	
7pm	* plan to vaccination	5:30 pm	* provide warm care for baby.	
8pm	* plan to feeding 2-3ml hourly	7:20 pm	* vaccination today done.	
		8pm	* Given feeding support 2-3ml hourly.	

Re-Assessment:

Special Notes: provide warm care for baby

Nurse Signature: [Signature] Nurse Name: Seema Date & Time: 8/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 8/7/26

Assessment: New Born Baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ To assess the general condition of the baby	8:00pm	→ Assessed the general condition of the baby	Baby is stable Vitals normal
9pm	→ To monitor vital signs	11:30pm	→ Monitored vitals and recorded	
2am	→ To encourage oral intake	2:10am	→ DBF every 2 to 3rd hly	
5am	→ To maintain I/O chart	5:40am	→ Maintained I/O chart	
7am	→ To provide warm care	7:15am	→ Provided warm care	

Re-Assessment: After proper position, has good intake of direct feeding.

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Kalyani

Date & Time: 9/7/26 at 8am

BAH-00660973 IP5-00176084
 Baby Of CHANDANA VIJAYA
 07-07-2026 0 Y 0 M 1 D
 Dr. ANNAPOORNA TADAVARTHY

NURSING CARE RECORD



Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/7/26

Assessment: new born baby care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the baby general condition	8.10am	→ baby is stable	baby stable
9am	→ monitor vitals	9.10am	→ vitals stable	
10am	→ monitor I/O chart	10.10am	→ monitored I/O chart documented	
11am	→ to do sample SBR	11.10am	→ SBR done & signed	
12pm	→ to gradually encourage feeding and and 3rd hr	12.20pm	→ feeding provided	
1pm	→ to provide warm care	1.10pm	→ provided warm care	

Re-Assessment: Re-assessed after 2 hr baby stable

Special Notes: SBR done

Nurse Signature: Satya

Nurse Name: Satya

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

BAH-00660973
Baby Of CHANDANA VIJAYA
07-07-2026 0 Y 0 M 1 D
Dr. ANNAPOORNA TADAVARTHY

IP5-00176084

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment:

New born baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the baby	2:10pm	Assessed the general condition of the baby	Baby is stable
3pm	plan for vitals	3:15pm	checked vitals	
4pm	plan for ILO chart	4:20pm	Maintain ILO chart	
5pm	continue feeding every 2nd hly flb burping	5:30pm	continued feeding every 2nd hly flb burping	
6pm	Ensure safety	7pm	provide crib care	

Re-Assessment:

vitals checked & recorded

Special Notes:

Continue same, SBR, sendd

Nurse Signature: Seema

Nurse Name: Seema

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

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 9/7/26

Assessment: New Born Baby Care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ To assess the general condition of the baby	8:30pm	→ Assessed the general condition of the baby	Baby is stable Vitals normal
11pm	→ To monitor vital signs	11:10pm	→ Monitored vitals and recorded	
2am	→ To encourage oral intake	2:20 am	→ DBF and BF every 2 to 3rd hly.	
4am	→ To maintain S/O chart	4:40am	→ Maintained S/O chart	
7am	→ To provide warm care	7:10am	→ Provided warm care	

Re-Assessment: After proper position, has good latching & sucking

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Kalpani

Date & Time: 10/7 at 8am



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

Docu. No: RCHBH /FRM / CLINICAL / 148

Patient Sticker

NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

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

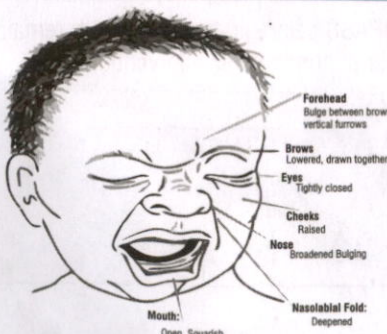
SITUATION	Diagnosis: <u>New born Baby Girl</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	<u>OB</u> <u>2pm-8pm</u>	<u>OB</u> <u>8pm-3am</u>	<u>3rd floor</u> <u>3pm-8am</u>	<u>3rd floor</u> <u>8am-2pm</u>	<u>3rd floor</u> <u>2pm-8pm</u>	<u>3rd floor</u> <u>8pm-3am</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
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: <u>98.1°F</u>	<u>98°F</u>	<u>98.0</u>	<u>99.0°F</u>	<u>98.5°F</u>	<u>98.0°F</u>
	Res:		<u>40b/m</u>	<u>42b/m</u>	<u>40</u>	<u>34b/m</u>	<u>35b/m</u>	<u>40b/m</u>
	SpO ₂ :		<u>98%</u>	<u>99%</u>	<u>98%</u>	<u>97%</u>	<u>100%</u>	<u>100%</u>
	Pulse:		<u>140</u>	<u>136b/m</u>	<u>140</u>	<u>142b/m</u>	<u>143b/m</u>	<u>138b/m</u>
	BP:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Fall Risk Score:		<u>16</u>	<u>16</u>	<u>16</u>	<u>16</u>	<u>16</u>	<u>16</u>
	Pain Score:		<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0/10</u>	<u>0</u>
	Recommendations	Safety Needs:		<u>no</u>	<u>yes</u>	<u>yes</u>	<u>no</u>	<u>yes</u>
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		<u>NA</u>	<u>NO</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NO</u>	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>SBR, 1/23 Tm 1pm</u>	<u>NA</u>	
Post Operative Procedure Special Orders:			<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :			<u>Swapna</u>	<u>Tunny</u>	<u>Shikha</u>	<u>Ravathi</u>	<u>Seema</u>	<u>Kalyani</u>
Signature :			<u>SV</u>	<u>TM</u>	<u>Shikha</u>	<u>Ravathi</u>	<u>Seema</u>	<u>Kalyani</u>
Date:			<u>7/7/26</u>	<u>7/7/26</u>	<u>8/7/26</u>	<u>8/7/26</u>	<u>8/7/26</u>	<u>8/7/26</u>
Time:			<u>8pm</u>	<u>10pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>
Taken Over By Name :			<u>Tunny</u>	<u>Shikha</u>	<u>Ravathi</u>	<u>Seema</u>	<u>Kalyani</u>	<u>Satyam</u>
Signature :			<u>TM</u>	<u>Shikha</u>	<u>Ravathi</u>	<u>Seema</u>	<u>Kalyani</u>	<u>Satyam</u>
Date:			<u>7/7/26</u>	<u>7/7/26</u>	<u>8/7/26</u>	<u>8/7/26</u>	<u>8/7/26</u>	<u>9/7/26</u>
Time:			<u>8pm</u>	<u>10pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Annapoorne Department: 3rd Floor Date of Admission: 8/7/26

SITUATION	Diagnosis: <u>NB</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
BACKGROUND	Area	Shift Time	<u>3rd Floor</u> <u>2pm</u>	<u>3rd Floor</u> <u>8pm</u>	<u>3rd Floor</u> <u>8am</u>	
	Medical Condition (Any special condition to be noted):		<u>NB</u>	<u>NB</u>	<u>NB</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>97.9°F</u>	<u>98.5°F</u>	<u>98.0°F</u>		
	Res:	<u>20 br/m</u>	<u>38 br/m</u>	<u>42 br/m</u>		
	SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>100%</u>		
	Pulse:	<u>141</u>	<u>130 br/m</u>	<u>132 br/m</u>		
	BP:	<u>-</u>	<u>-</u>	<u>-</u>		
	Fall Risk Score:	<u>-</u>	<u>1</u>	<u>16</u>		
Recommendations	Pain Score:	<u>-</u>	<u>0/10</u>	<u>0</u>		
	Safety Needs:	<u>(12)</u>	<u>yes</u>	<u>crib care</u>		
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Sathy</u>	<u>seema</u>	<u>kalyani</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>9/7/26</u>	<u>9/7/26</u>	<u>10/7</u>		
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>		
Taken Over By Name :		<u>seema</u>	<u>kalyani</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>9/7/26</u>	<u>9/7</u>			
Time:		<u>2pm</u>	<u>8pm</u>			

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
						8pm	10pm	6am	6am				
						NA	NA						
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not Irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0	0	0	0				
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0	0				
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0	0				
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				
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0				
	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 34+3 wks 34+3 wks 34+3 wks 34+3 wks							
						Total Pain / Agitation Score 0 0 0 0							
						Intervention - NA 0 0							
						Effectiveness - NA NA NA							
						Signature [Signature] [Signature] [Signature] [Signature]							

NPASS: Neonatal Pain, Agitation & Sedation Scale

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

BAH-00660973 IP5-00176084
Baby Of CHANDANA VIJAYA
07-07-2026 0 Y 0 M 0 D 1 H (M)
Dr. ANNAPOORNA TADAVARTHY



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

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

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		no	X	X	No	No
Call device within reach		no	X	X	yes	yes
Wheels Locked		yes	✓	✓	yes	yes
Room free of clutter		yes	✓	✓	yes	yes
Adequate lighting		yes	✓	✓	yes	yes
Wheel chair support		no	no	X	no	no
Other Intervention(s) Specify		no	no	X	no	no
Nurse's Name:		Suvar	Tanvi	Shit	Kalyani	Kalyani
Signature:		Se	TM	Shit	Q	Q
Date:		7/26	7/26	8/26	9/7	10/7
Time:		8:00	10:00	2:00	6:00	6:00

BAH-00660973
Baby Of CHANDANA VIJAYA
07-07-2026
Dr. ANNA POORNA TADAVARTHY
IPS-00176084
0 Y 0 M 0 D 1 H (M)
Barcode

BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	11/7	7/12/26	8/12/26	9/12/26
					Time :	8pm	8pm	8a	6am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:remity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	1	2	2	3	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1	1	1	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2	2	3	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	2	3	3	4	
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."	4	2	2	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings 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.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	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	18	18	23
					Evaluator's Name	SJ	Tunne	Shy	Shy

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

Patient ID

BRADEN 'Q' SCALE

					Date : 10/17			
					Time : 6am			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	3			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	3			
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.	4			
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."	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	23		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Kalyani		

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

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660973 IP5-00176084 Baby Of CHANDANA VIJAYA 07-07-2026 0 Y 0 M 0 D 1 H (M) Dr. ANNA POORNA TADAVARTHY 		Date & Time of Admission 7/7/26 @ 7:23 pm	Date & Time of Transfer Order 7/7/26 @ 11:15
		Transfer Ordered by Dr. parani	Reason for Transfer observation
From Unit OM	To Unit Room (318)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 30	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Sib Tunna		Name of Person Ordered Transfer Dr. parani.	
Patient & Clinical Records Received by :  Shweta 7/7/26 @ 11:30 pm			
Date & Time of Patient Received :			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

BREASTFEEDING HISTORY FORM

H-00660973 IP5-00176084
by Of CHANDANA VIJAYA
07-2026 0 Y 0 M 0 D 16 H (M)
ANNAPOORNA TADAVARTHY

Mother's Name:

y's Name: Date of Birth:

Reason for consultation:

- Baby's feeding now (ask all these points)**

Breastfeeds yes

How often 2-2½ hourly

Length of breastfeeds 15-20 mint

Longest time between feeds (time mother away from baby) 2-2½ hourly

One breast or both breasts Both

Complements (and water) No

What given No

When started No

How much No

How is it given No

Day

Night

Pacifier (Yes / NO) ✓
- Baby's health and behaviour (ask all these urine output (more/less than points))**

Birth weight

Premature Term

Urine output (more/less than 6 times per day)

Stools (soft and yellow/brown; or hard or green; frequency) ✓

Feeding behaviour Good

Illnesses ✓

Weight now

Twin

Growth

Abnormalities No
- Pregnancy, birth, early feeds**

Antenatal care (attended/not)

Delivery: Normal / C - section ✓

Rooming - in Yes / No ✓

Prelacteal feeds Yes / No (If Yes,) ✓

What given ✓

Formula samples given to the mother Yes / No ✓

Postnatal help available for breastfeeding Yes / No ✓

Breastfeeding discussed? Yes / No ✓

Early contact (First - 1 hour) Yes / No ✓

Time first breast feed (if not within 1st hour) yes

How given ✓
- Mother's condition and family planning**

Age

Family planning method Abol.

Breast condition yes

Motivation to breastfeed yes

Alcohol, smoking, coffee, other drugs Yes / no ✓
- Previous infant feeding experience**

Number of previous babies 3

How many breastfeed 3

Any bottles used No

Experience good or bad ✓

Reasons positive
- Family and social situation**

Working / Home maker

Father's attitude towards breastfeeding positive

Other family members attitude towards breastfeeding positive

Help with child care positive

What others say about breastfeeding positive

Literacy status Educated

counseled about DBF

Lactation Consultant:

Signature: Name: Date & Time: 8/7 9 AM

LACTATION ASSESSMENT FORM

Mother's details: Chandana vyasa

Baby details: also Chandana vyasa

Delivery: Vaginal ☐ Cesarean ☒ Vacuum ☐ Forceps ☐ Gravida ☐ GA ☐

Reason for Visit: BF rounds ☒ Doctor Reference ☐ Patient Request ☐

BF previous baby: yes Previous BF difficulty: No

Present Lactation:

Colostrum: Yes ☒ No ☐ Breast: Normal ☒ Engorged ☐ Soft ☐ Tender ☐

Nipples: Flat ☐ Inverted ☐ Everted ☒ Direct BF: Yes ☒ No ☐

Expressed / Pallada feeding: Yes ☐ No ☒

LATCH Assessment:

	0	1	2	SCORE					
				D-1	D-2	D-3	D-4	D-5	D-6
LATCH	Too sleepy not sustained LATCH / suck	Repeated attempts for suck / latch Hold nipple in mouth	Grasps breast tongue downlips flanged Rythmical sucking	1	2				
AUDIBLE SWALLOWING	None	A few with stimulation	Spontaneous & Intermittent	1	1				
TYPE OF NIPPLE	Inverted	Flat	Everted (After stimulation)	2	2				
COMFORT	Engorged cracked Bleeding large Blisters bruises	Filling reddened small blisters / bruises	Soft Non tender	2	2				
HOLD	Full Assist	Minimal assist	No assist	0	1				
Total Score				6	8				

BABY WEIGHT CHART

FIRST FEED

Date	8/12/20	9/1/20				Breast Feed	Top Feed
Weight	2.871	2.850					

Teaching Instructions: Deep latch

Discharge Instructions: Urine output & weight monitoring

Feed Frequency Duration: 2 - 2 1/2 hourly

Feeding techniques: cradle

Assessment of output: good

Sources of BF assistance at home: handout

Next Follow up: 1 week

Lactation Consultant: Name: Supriya Signature: [Signature] Date & Time: 8/17/20

H-00660973
 IP5-00176084
 by OF CHANDANA VIJAYA
 07-2026 0 Y 0 M 0 D 16 H (M)
 ANNAPOORNA TADAVARTHY


BREASTFEEDING OBSERVATION CHART

Please tick ☒ for Yes, ☒ for No and leave ☐ blank for Not Applicable:

Observation Parameters	Date & Time	No. of Feeds	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Body Position • Mother relaxed and comfortable • Shoulders tense, leans over baby • Baby's head and body in straight line • Baby's head and body is not straight line • Baby's body close to mother's • Baby's body not close to mother's • Baby's back • Only shoulder or head supported • Breast well supported (optional) • Breast supported in scissor hold or nipple being pushed in baby's mouth • Supine • Sitting			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
Responses • Baby roots for breast • No rooting observed • Baby explores breast with tongue • Baby not interested in breast • Baby calm and alert at breast • Baby restless or crying • Baby stays attached to breast • Baby slips off breast • Signs of milk ejection, (leaking, after - pain) • No signs of milk ejection			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	

[illegible]

BAH-00660973 IP5-00176084
Baby Of CHANDANA VIJAYA
07-07-2026 0 Y 0 M 0 D 1 H (M)
Dr. ANNAPOORNA TADAVARTHY



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 10/12/2026

2. Destination Post Discharge: ☒ Home
Family Members Notified (Person Contacted)

☐ Transfer
Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

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

need all assistance

4. Nutritional Plan:

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

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hand Hygiene

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: Cy

Nurse Name: Swapne

Date and Time: 10/12/26 4pm