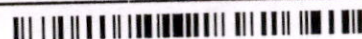


ADMISSION SHEET



Registration Details :

Admission No : IP5-00175871

Admit Date : 02-Jul-2026

Admit Time : 11:17 AM UHID : BAH-00660476

Patient Details :

Patient Name : Baby Of AMMREEN SYED

Age : 0 D

Guardian : Mr RIZWAN SHAIK

DOB : 02-07-2026 10:31 AM

Gender : Female

Religion :

Occupation :

Marital Status : Single

Address (H) : COLLECTOR CAMP OFFICE JOGULAMBA
Gadwal Telangana INDIA 509125

Phone No : 9701518689 / 9703978769

E-mail :
DRAMREENQHADRI786@GMAIL.COM

Admission Details :

Bed Type : BASINET

Bed No : CRDL-PRESIDENTIAL
SUITE422-1Ward Name : 4F-BIRTHRIGHT
PREMIUMRoom No : CRDL-PRESIDENTIAL
SUITE422-1

Admission Type : First Visit

Contact Details :

Name : Mr RIZWAN SHAIK

Relationship : Father

Contact Address : COLLECTOR CAMP OFFICE JOGULAMBA
Gadwal Telangana INDIA 509125

Phone No : 9701518689 / 9703978769

Signature

Doctor Details :

Doctor Name : Dr. NALINIKANTA PANIGRAHY

Specialisation : NEONATOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY



NEWBORN MONITORING FORM

Date of Birth : 2/7/26
Time of Birth : 10:31am
Mode of Delivery : SL-LSL
Birth Weight : 2.610
Head Circumference : 32cm
Length : 49cm
Red Reflex :

New Born Screening :
TFT :
OAE :
Mother's Blood Group : A+ve
Baby's Blood Group : B+ve
Anomaly Scan :
Vaccination : OPV, BCG, Hep-B

done on 27-2/7/26 By Sis. Kaveri

Date	Weight	Type of Feed	Quantity	Temperature	Signature
2/7/26	2.610	DBF	-	36.8°C	Dr. Y.
3/7/26	2.385 kg	DBF	Drops of Colostrum	97.9°F	Yamuna
4/7/26	2.330 kg	DBF	Drops of Colostrum	97.8°F	Yamuna
4/7/26	evening wt 2.308 kg	DBF	-	97.9°F	Anita
5/7/26	2.305 kg	DBF	50ml	98.0°F	Yamuna
5/7/26	2.315 kg (Evening wt)	DBF	-	97.4°F	Seelap
8/7/26	2.285 kg Recheck	DBF	-	98.3°F	Prasanna
6/7/26	2.307 kg				

Date	Time	Investigation	Result	Order No.	Signature
2/2/26		Blood group	B +ve	2606616/1	Dr. Jay
2/2/21	11:40 AM	R/R 1st	7 mg dl		Made
2/2/21	2:30 PM	R/R 3rd	5 mg dl	26066304/	Made
2/2/26	5:30 PM	R/R 6th	60 mg dl		
2/2/26	10:30 PM	R/R 12th	5 mg dl	260663687	Yamuna
3/2/26	5 AM	R/S 18th	80 mg dl	2606677/	Yamuna
3/2/26	10:30 PM	T/C R	6.5 mg dl	26067061/	Made
3/2/26	11 AM	R/R 24th	66 mg dl	26066779/	Made
3/2/26	5 PM	T/C R	6.4 mg dl	26067199/	Made
3/2/26	11 PM	R/R S	82 mg dl	26066780/	Yamuna
4/2/26	9:00 PM	T/C R	9.2	26067030/	Suanda
4/2/21	10:30 AM	SBR	9.0 < 8.9	26066941/	Made
4/2	10:50 PM	N/R	Spinal		Made
4/2	10:30 PM	R/R	89 mg dl	26067029/	Made
4/2	11 AM	OAE	Normal	9687511/	Made
5/2	9 AM	T/C R	11.2 mg dl	26067455	Made



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Amreen Syed. Age : 31. 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 Amreen Syed Mother's Blood Group : A+ve
Gender : ☐ M ☒ F Blood Group : B+ve Birth Weight (gms) : 2610 Length (cms) : 49cm
Date of Birth : 2/7/26 Time of Birth : 10:21am OFC (cms) : 32cm
Place of Birth : Delhi BH Estimated Gesth Age : 38+1

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 31. Ht : Wt : BMI : Married Life : LMP : 6/10/25 EDD : 15/1/26

Conception : Spontaneous or with Rx :

Booked at what GA : 16 weeks

Last Scans Details : 25/6/25 34+1 Cephalic 2.523 AC:26.4 AFI:18.4

Pl: LH 20/6/25 (N) TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs

Consanguinity : ☐ Yes ☐ No

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

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long :

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

IUGR - when detected :

Doppler (Increased Resistance / ADEF / REDF /

Redistribution in MCA) / Ductus Venosus :

AFI :

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

Controlled or not, recent values, HbA1 values :

Compliance with Rx :

Scans : LGA, TIFFA , Fetal Echo :

H/o Hypothyroidism : when diagnosed ? Medication?

Any other Chronic Medical Problems, when detected

drugs ?

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

Infection : H/O, Fever

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

UTI : when : Any culture :

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

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

P: 2 A: L: 1

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1.	2023-	FT.	3kg	m	Emergency LSCS	

PERINATAL HISTORY

Treating Obstetrician : Dr Shrutika Reddy Hospital : LCM : BM ☒ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☒ Elective ☐ Emergency Indication :

Specify the reason : Prev - LSCS -

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitaion : ☐ Yes ☐ No

Cord ABG :

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

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

1 Minute	5 Minutes	10 Minutes
1	1	
2	2	
2	2	
2	2	
1	2	
8	9	

TOTAL

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 :

History of Present Illness:

Equipment check done
↓
Baby was received in a prewarmed linen
↓
Dried / warmed / stimulated
↓
Cord cleaned / clamped / cut
↓
Vitamin K given 0.5ml IM
↓
Suctioning done in view of secretions
↓
Vitals checked
↓
Baby shifted to mother's side

Investigation details in previous Hospital :

Feeding History :



Family History :

Father is a k/c/o phlegmatic bulbar

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Euthermic Pink
cl/c/a's good
hemodynamics are stable

VITALS : Temperature : Euthermic HR : 149/min RR : 42/min NIBP : CFT : 23

Color of the extremities : Acrocyanotic

Jaundice : Pallor : SpO2 : 97%

ANTHROPOMETRY: Birth Weight : 2640 Length : HC : Present Weight :

Ponderal Index : AGA : ✓ SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :	Fontanelles : Sutures Shape / Moulding : <i>No caput</i> Edema / Bruising : Size - (H.C.) :
FACIES : (Any Facial Dysmorphism)	<i>— N —</i>
NECK and CLAVICLES :	Range of Motion : Asymmetry : <i>— N —</i> Masses :
EYES :	Symmetry : Red Reflex : <i>to be checked</i> Discharge :
EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Periauricular Pits / Tags : Nasal shape / Patency : Palate : <i>No cleft up/palate -</i> Gums : Lips : Tongue :
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number : <i>— N —</i>
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : <i>2A + 1V</i> Discharge :
GENITALIA :	Labia / Hymen : Testicles/penis : Anus :
HERNIAL ORIFICES	
TRUNK and SPINE :	<i>(N)</i>
SKIN LESIONS :	
EXTREMETIES :	Fingers / Toes : Deformities : Hip Joint Examination : Arms / Legs : Mobility :



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 39/min 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: 97% Auscultation: B4E ⊕ Breath Sounds: clear Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 149/min BP :

Femoral Pulses : B/L well felt

Other Peripheral Pulses :

Precordial Activity :

Murmurs :

Signs of Cardiac Failure :

ABDOMEN:

Shape :

Palpation :

Palpable masses :

Abdominal girth :

Hernia orifice :

Anal Patency : looks patent

Umbilical Cord : 2A + 1V

First urine passed : -

Meconium passed : -

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtl Score :

Nerves :

MOTOR SYSTEM:

Passive Tone :

Active Tone :

Neonatal Reflexes :

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

Moro's : B/L well felt DTR :

ATNR :

Skull and Spine :



Diagnosis :

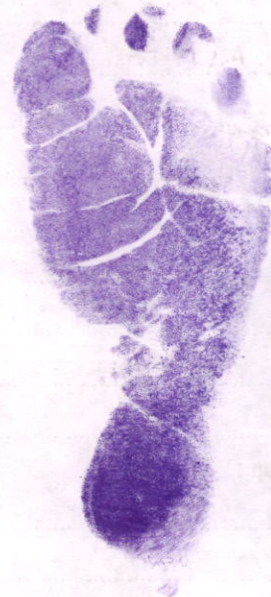
38+1 | G>P14 | EL-LSCC (Prev-LSCS) | CTAB | 2610 grams |
K1A | Fch.

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

Consultant :

Signature :

Name :

Date & Time :

PLEASE FILL UP THE FOLLOWING DETAILS

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

AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic :

Medications :

Plan

1. Send cord blood for blood grouping

2. DBP/2nd hourly

3. ORV/RCG/ACP-B today

4. SRA/NBS/OAE @ J&HOL

5. RBC monitoring 30 mins postfeed

Feeding Plan at the time of shifting :

and 3, 6, 12, 18, 24, 30, 45, 60

Postfeed

inform if 250mg/100ml

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

6. 2/4 eye examination

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7 2:00 AM	CSLB RESIDENT,	
	38+1 G2P1L1 EL-LSCS (Pren-LSCS) CIAB 2610 grams AGA Fch.	
	AT	Plan
	U → m →	1. DBF / 2nd hourly
	Eutocoid Fink	
	CT/D: good	2. BP ✓
	hemodynamically stable	✓ BCS ✓ today
	Good perfusion.	✓ Hep B ✓
		3. SBP / NBS / OAE @ 48HOL.
		4. Red reflex to check
		5. ct RBS monitoring as mentioned, inform if < 5mg/dl.
		<i>[Signature]</i>



PROGRESS NOTES AND DOCTOR'S ORDER

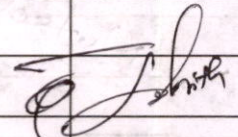
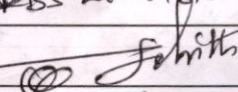
Date & Time	Progress Notes	Doctor's Order
3/7/26 @ 2nd	<u>Morning Rounds</u>	
	Term B.wt = 2.610 female Cl. LSCS CIAB (38+1wk) (Prev. LSCS)	
	No maternal Risk factors	
		<u>Plan</u>
	B.wt - 2.610	1) warm Care.
	Cur. wt = 2.885	
	wt loss - 8.6%	2) Breast feeding and baby flby formula feed.
	MBG A +ve	15-20ml as accepting
	BBG B +ve	flby Burping
	Baby started on formula accepting well	3) TcBR at 24HOL (10am) L 6.5
	No vomiting	
	Baby - Eutermic	4) NBS?
	Vitals: 140/min - HR	OAE } at 48HOL
	RR - 50/min	SBR }
	activity - Good.	
	Urine - } Passed	5) w/p - activity
	Stool - }	Temp monitoring } 3rd
		vital monitoring } 4th
	Vaccination - done	feeding } 6th
		- 36 hrs } GRBS monitor 2
		48 hrs } stop
		Incha
	RBS = 36hrs	
	4 hrs	
	TcB = 12hrs	12 July -> evening repeat

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 12:10 PM	S/B Ar. NK Sir	
	Plan	
		(1) continue breast + formula feed
		(2) G.RBS 36hrs 48hrs then stop
		(3) TCBR → 5:00 pm
		SBR } 100 NBS } 100 OAE } 100
		Noted by nurse



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7 4PM	C/CB <u>REGIDENT</u>	
	38+1 wk / 3010g / 1SCS / 2610 / C/AB.	
	A+ $\eta \sim$ B+ $m \sim$	Plan 1. GRS at 36 and 48 H.OI.
	Eutermic / Pink	2. DBF 2nd hourly.
	C/TA: good	3. CBR / NBS / OAE - E/M 10:00am
	hemodynamics are stable	4. TCB at 5pm
	Good perfusion.	
		
	Noted by S/S Anita	
4/7 2PM	C/CB <u>REGIDENT</u>	
	38+1 wk / 3010g / 1SCS / 2610 / C/AB.	
	T.Wt: 2320 (10.7+) (↓55g) Plan	
	A+ $\eta \rightarrow$ B+ $m \rightarrow 2$	1. SBR / NRS / O → 10:00am
	2) measured - DBF + PF	2. OAE today
	Eutermic / Pink	
	Engulceric	3. DBF 2nd hourly - express and look for the quantity
	icteric?	measured feed → 20-25ml / 2nd hourly
	C/TA: good	4. DBS at 48 H.OI and stop
	hemodynamics - stable	
	Good perfusion.	
		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		4/7/16 OAE New born hearing screening Bilateral responses are present Bilateral Pass Rajput 4/7/16
4/7/16	Participation Note Mother comfortable with feed. DBF DBF followed by EBM (hard expression) in view of SSPT. Shruti Dhabhi Noted by nurse	
4/7/16 8:30 PM	C/S/B <u>RESIDENT</u> SHTH/ SBH WLS/ ASLS/ 2610/ LAB Concerns: 10.7/-wt loss- c/cic: th chest R/L femorals well felt a/t/d: good Warm peripheries Good perfusion (u-2)	Plan 1. DBF/ind hourly. top up as demanded 2. Check evening weight 3. TCR - for 8am 4. Stop PBS monitoring Johns Noted by SS Anil

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26 5pm	Seen by Resident	
	Baby on Room air	Plan
	Evening weight: 2.315 (110gram) from morning weight	1. Continue measured feed Top up feed + DBF
	Euthermic	20-25 ml 2nd hourly
	Tolerating feeds well	
	Passed urine & stool	2. Plan discharge
	Cry } Tone } good Activity }	3. Warmth care
	Suckling = Good	4. vital monitoring 2hr
	CR-T = 31cc	
	Peripheries warm	by soni
	Noted by Dr. Sushruti	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 @ 8:30am	<u>Morning Rounds</u>	
	DOL-4 Term 2.61kg EL-LSCS CIAB (38+1wks)	
	B.wt = 2.61kg	<u>Plan</u>
	Cur.wt = 2.285kg.	
	(↓ 20g in 24hrs)	1) Continue measure feed
	(↓ 30g since evening)	DBF + Top up feed
	Last TCBR = 11.2	20-25mb 2nd hrly
	Not in phototherapy	
	↓ range.	2) Discharge today
	Accepting feeds well	
	Eutermic.	3) Warm Care
	Pink.	
	Active	4) Temp } 3rd hrly
	HR = 130/min	Vital monitoring
	RR = 40/min	
	SPO ₂ = 98%	Trace NBS
	RIS - BAE+ clear	Recheck wt.
	Urine - } Passed	<u>Snika</u>
	Stools - }	noted by <u>healyu</u>
	Rechecked wt	
	2307	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Mother's Name: Amreen
 Date of Birth: 2/7/26 Time of Birth: 10:31 AM Gender: ☐ Male ☒ Female
 Birth Weight: 2.610 Kgs HC: 32 cm Length: 49 cm
 Meconium in Liquor: ☐ Yes ☒ No Cried at Birth: ☒ Yes ☐ No
 Term / Pre-term / Post-term:
 Resuscitated: ☐ Yes ☒ No Blood Group: Mother: A+ Baby:
 Feeding: ☒ Breast Feeding ☐ Formula ☐ Both First Feed Time: 11:10 AM

AFFIX MOTHER'S
 IDENTIFICATION LABEL

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

Indication:

Physical Assessment of New Born:

Temp: 36.5 °C HR: 144 /Min RR: 42 /Min BP: SpO₂: 99
 Pain Score: 1.6 (Follow N Pass)

Fall Risk Assessment: ☒ Yes ☐ No Score: (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: Manika

Signature: [Signature]

Date & Time: 2/7/26 12

BAH-00660476 IP5-00175871
 Baby Of AMMREEN SYED
 02-07-2026 0 Y 0 M 0 D 8 H (F)
 Dr. NALINIKANTA PANIGRAHY



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

P:
Pat

..... 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		
2/7		2	Infection control measure	PT	1	D	1	1	1	<i>[Signature]</i>

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: <table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>										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	
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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: <table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td colspan="2">7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td colspan="2"></td> </tr> </table>										1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify		2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
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																								



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

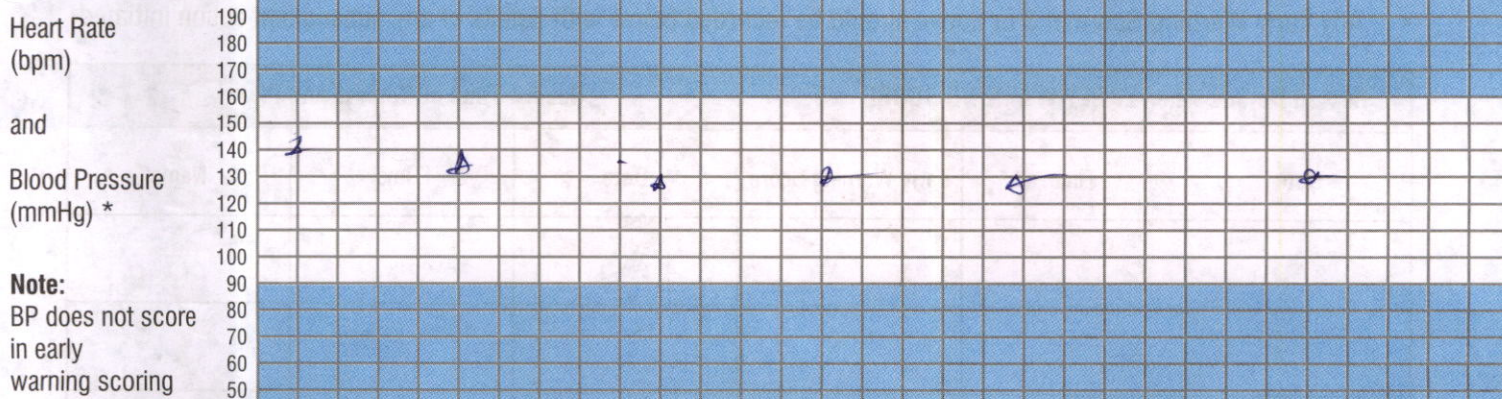
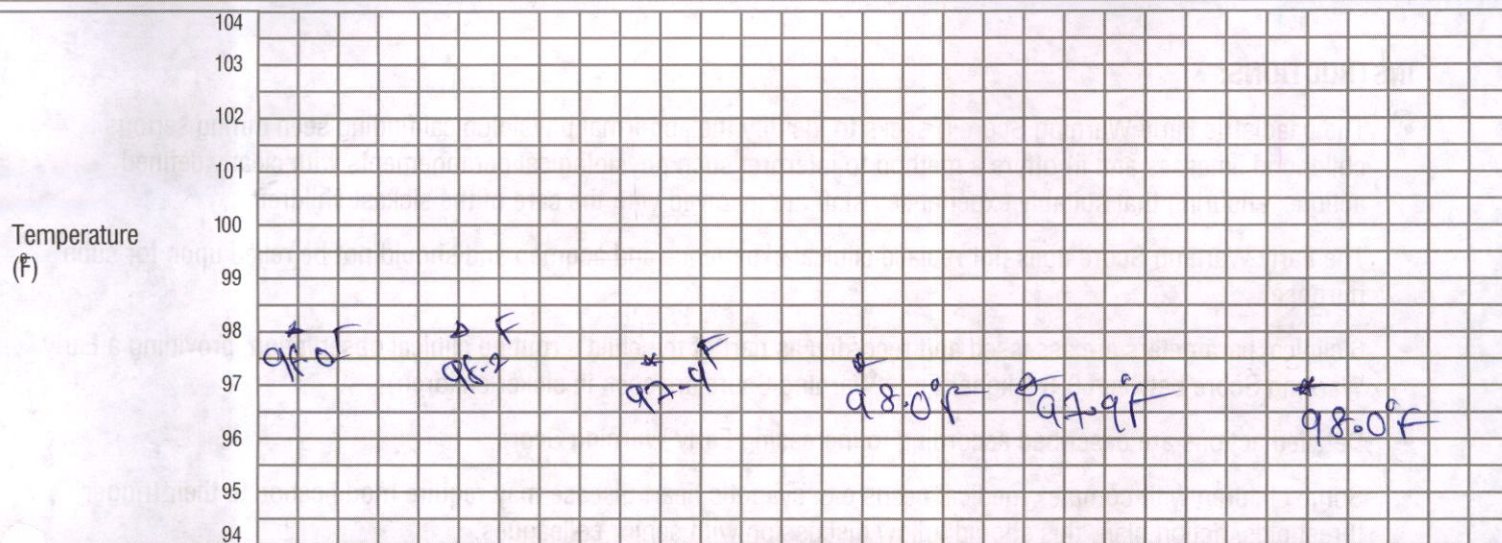
Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Nursing ☐ Others:
2/2	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Baby need warm care	→ provided warm care	→ plan for warm care	Amey	☐ 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:



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

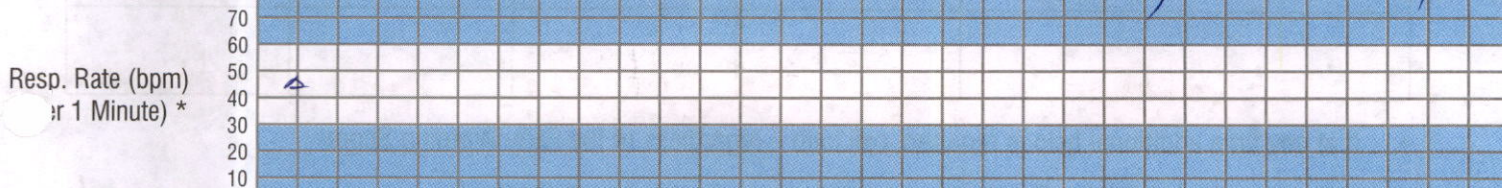
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 2/7/26 Time: 12M 4PM 2PM 11PM 3AM 7AM
 Doctor/Nurse/Family Concern?



Heart Rate (Number)

Time	Heart Rate (Number)
12M	142
4PM	149
2PM	139
11PM	140 bpm
3AM	138 bpm
7AM	140 bpm



Resp Rate (Number)

Time	Resp Rate (Number)
12M	44
4PM	42
2PM	35
11PM	35 bpm
3AM	40 bpm
7AM	38 bpm

Resp Mod/ Severe Distress None / Mild

Time	Resp Mod/ Severe Distress
12M	None
4PM	None
2PM	None
11PM	None
3AM	None
7AM	None

Receiving O₂(l/min)
 O₂Saturations (%)

Time	O ₂ Saturations (%)
12M	99%
4PM	100%
2PM	100%
11PM	100%
3AM	99%
7AM	98%

Conscious Level Normal / Altered

Time	Conscious Level
12M	Normal
4PM	Normal
2PM	Normal
11PM	Normal
3AM	Normal
7AM	Normal

GCS *

Time	GCS
12M	15
4PM	15
2PM	15
11PM	15
3AM	15
7AM	15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

Time	Number of shaded boxes	Pain Score	Observer's Initials
12M	0	0	PC
4PM	0	0	Q
2PM	0	0	X
11PM	0	0	Yay
3AM	0	0	Yay
7AM	0	0	Yay

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

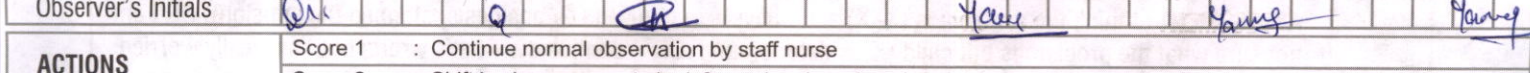
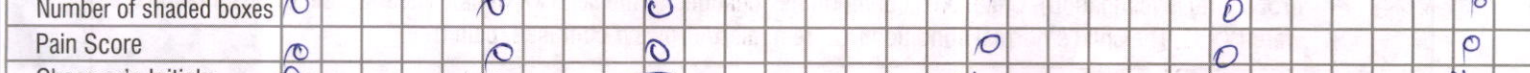
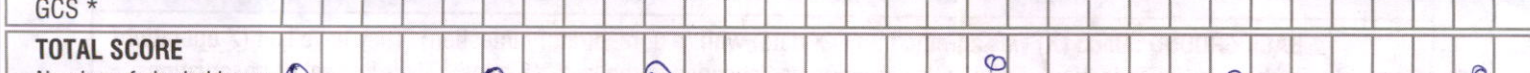
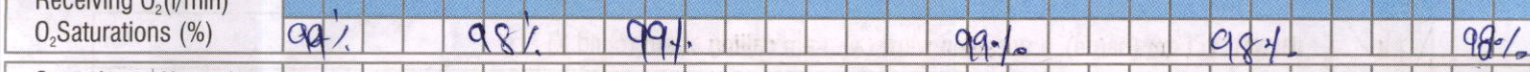
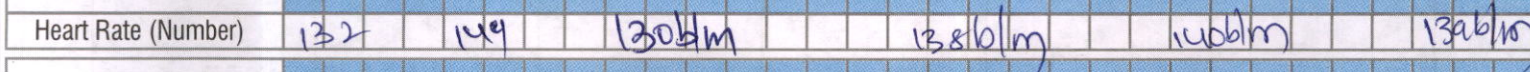
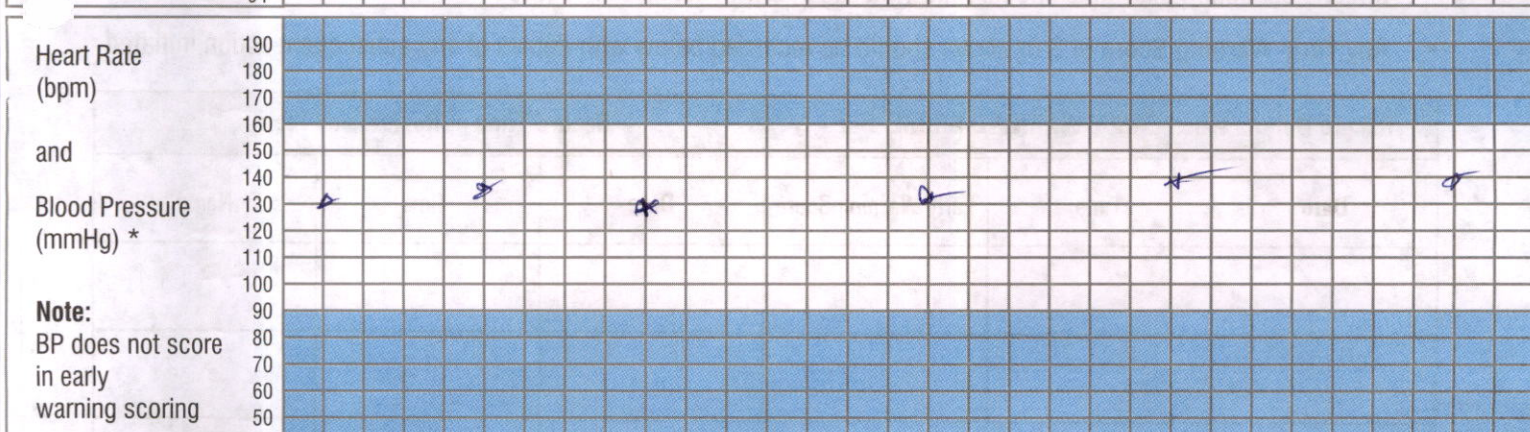
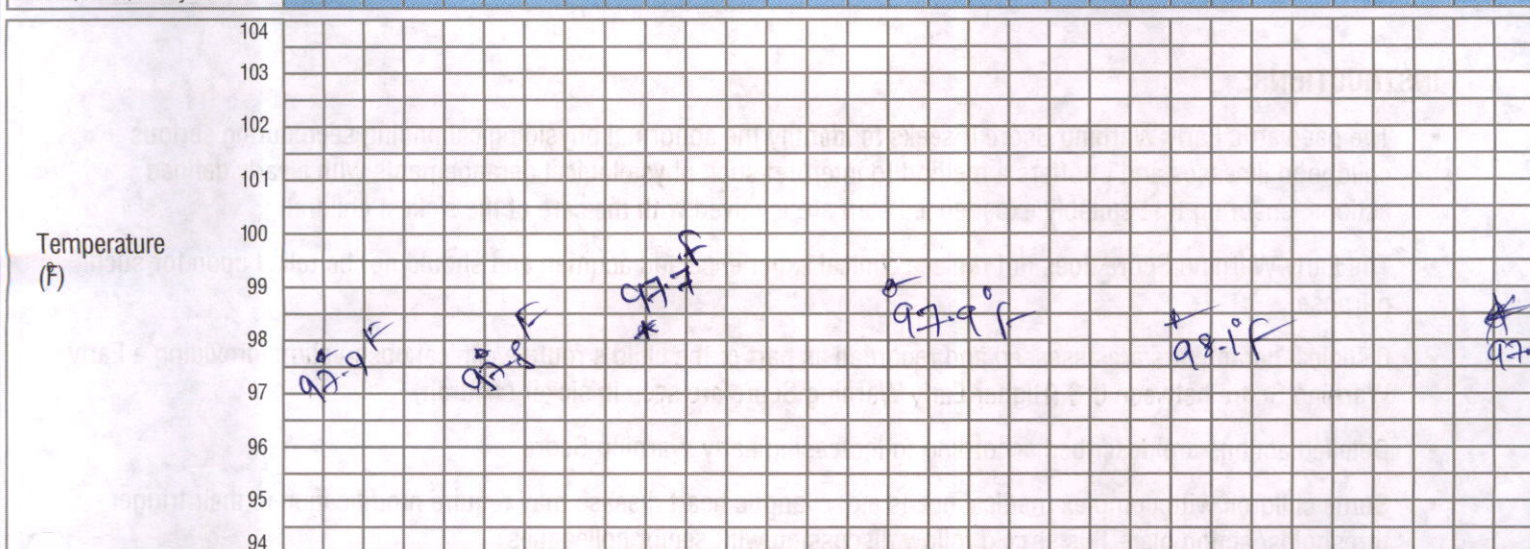
Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- 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)

Date: 3/2	Time: 9 AM	3 PM	5 PM	10 PM	3 AM	6 AM
Doctor/Nurse/Family Concern?						



NB: Scores 3 should be recorded overleaf	Score 2	: Shift in charge nurse to be informed and continue hourly observations
	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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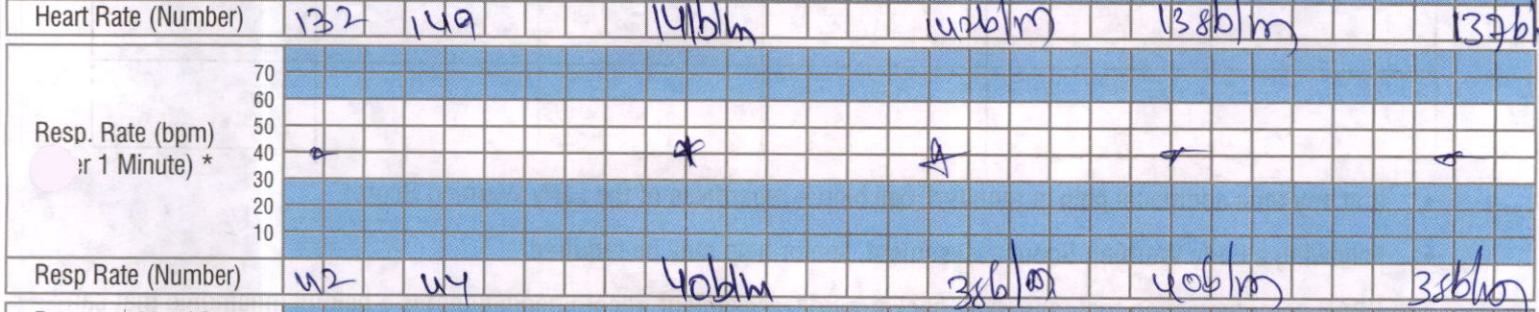
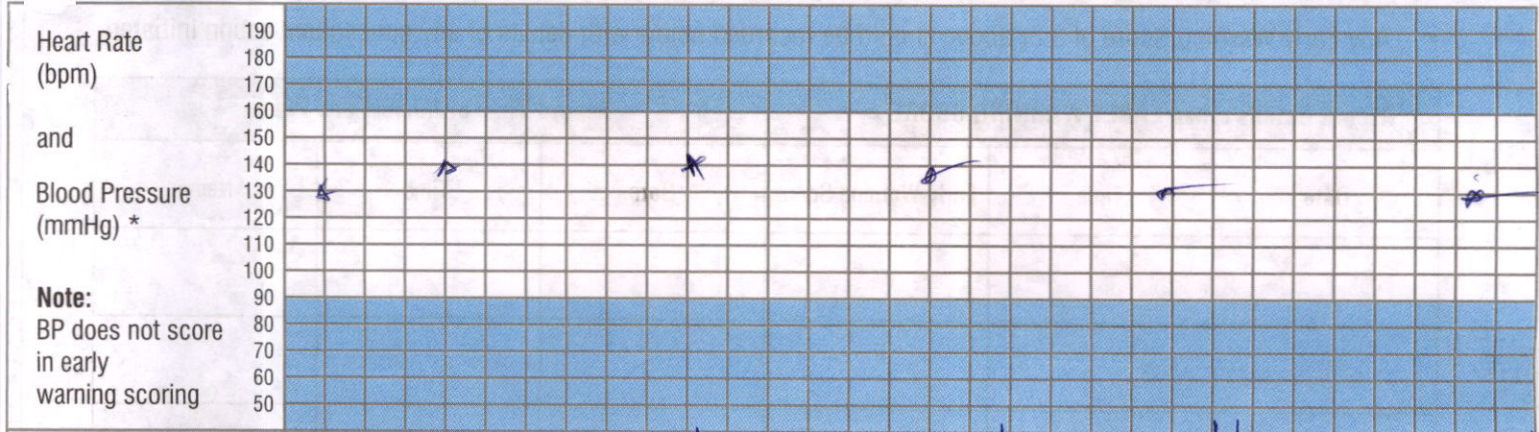
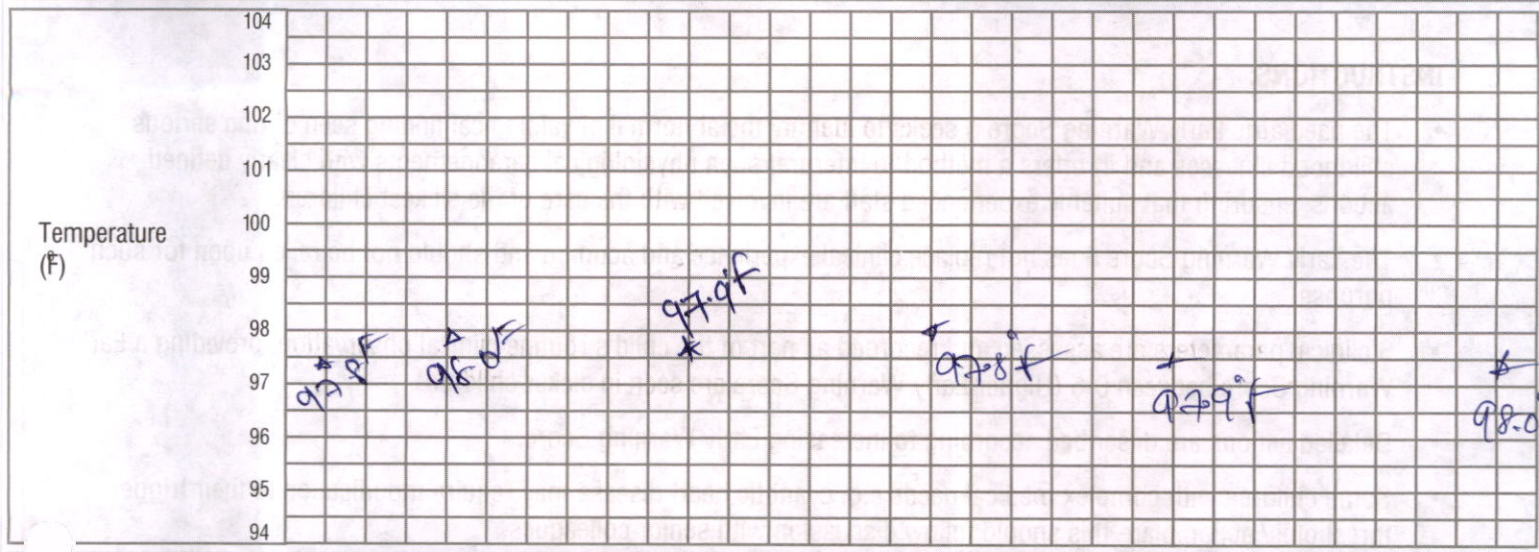
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INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 07/07/2026 Time: 8 AM 1 PM 5 PM 10 PM 3 AM 6 AM
Doctor/Nurse/Family Concern?



Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min)

O₂ Saturations (%)

Conscious Level Normal / Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be recorded overleaf

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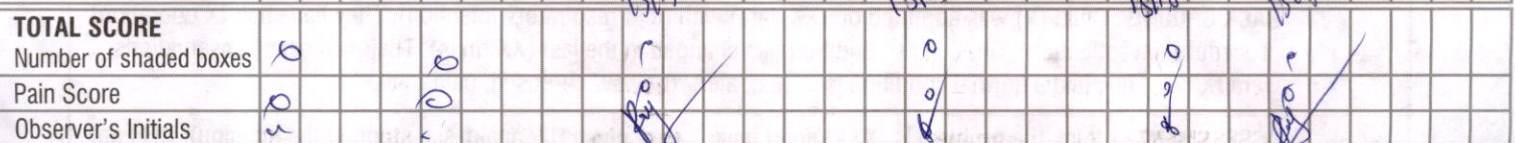
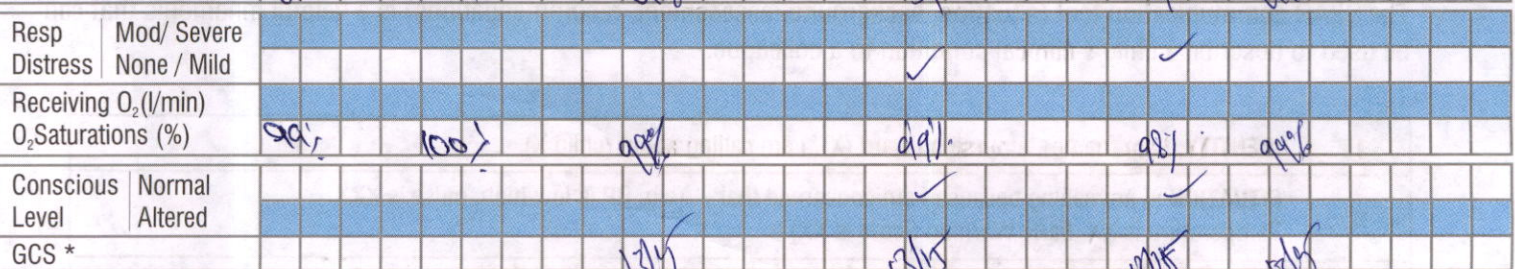
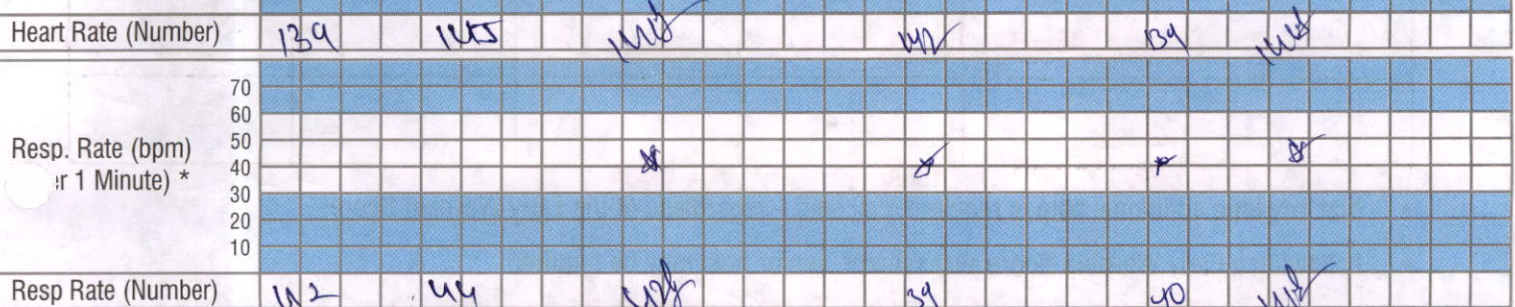
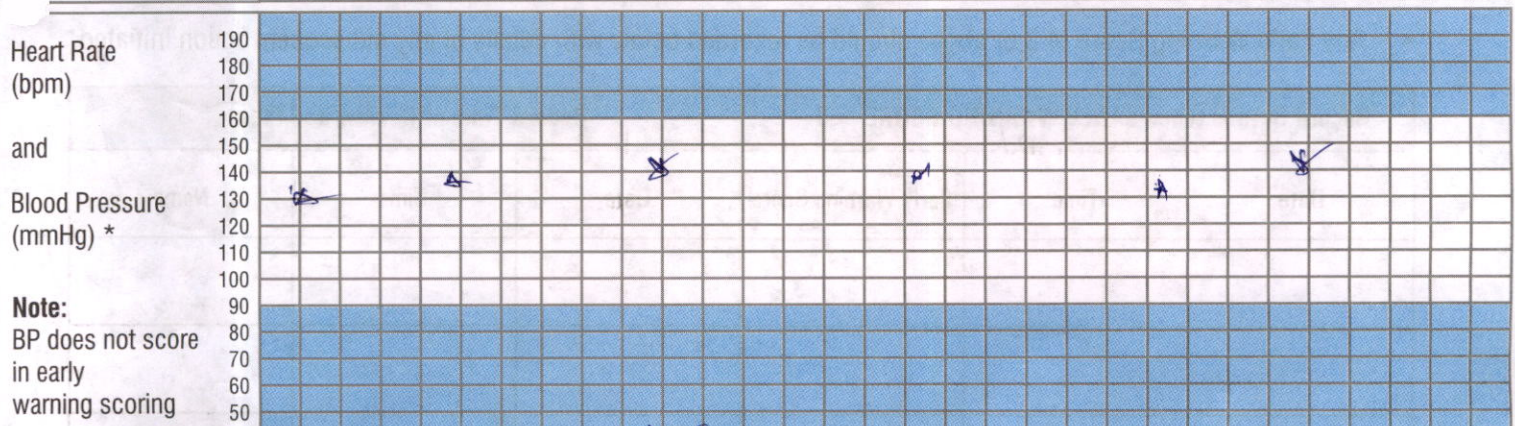
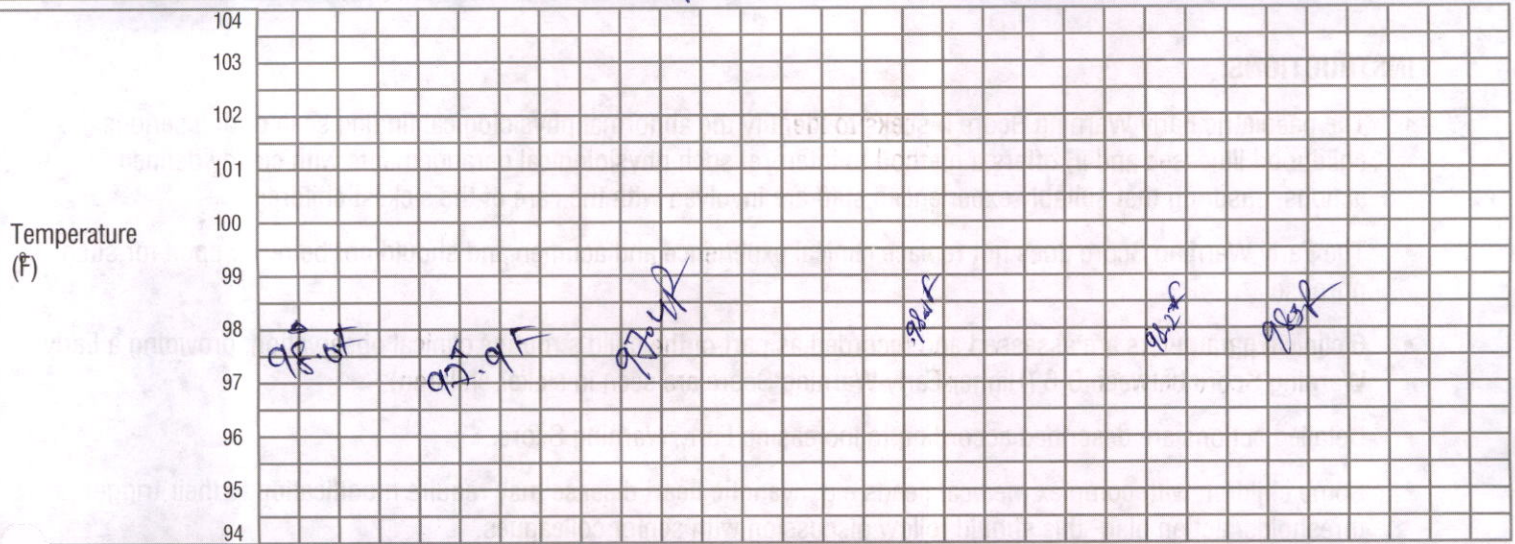
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INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 5/7/26 Time: 10 AM 12 PM 5 PM 11 PM 2 AM 9 AM
Doctor/Nurse/Family Concern?



ACTIONS

Score 1 : Continue normal observation by staff nurse

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

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Date	Time	Early Warning Score	Date	Time	Name

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FLUID CHART

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.

		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						NP			NP	No	
	11:00 am						/			/	To	write
	12:00 pm	DBF					/			/	Feet	write
	01:00 pm											write
Total Intake :						Total Output :						
	02:00 pm	DBF					/			/	/	write
	03:00 pm	DBF					/			/	/	write
	04:00 pm										No	write
	05:00 pm	DBF					NP				IV	write
	06:00 pm	DBF					/			/	Feet	write
	07:00 pm						/					write
Total Intake : Taken						Total Output : U-1-M-0						
	08:00 pm	DBF					✓			✓	/	Yamg
	09:00 pm										No	Yamg
	10:00 pm	DBF					✓			✓	IV	Yamg
	11:00 pm	DBF Int									cannula	Yamg
	12:00 am										/	Yamg
	01:00 am	DBF									/	Yamg
Total Intake :						Total Output : U-2-M-2						
	02:00 am	DBF					/			✓	/	Yamg
	03:00 am	ESM udops					/				/	Yamg
	04:00 am	DBF					NP				No	Yamg
	05:00 am										IV	Yamg
	06:00 am	DBF +					/			✓	cannula	Yamg
	07:00 am	FF 20ml					/				/	Yamg
Total Intake : Taken 20ml						Total Output : U-2-M-0						
Total 24 hrs. Intake			24ml			Total 24 hrs. Output			U-5-M-2			



FLUID CHART

Sheet No. : (2)

27/26

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	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score		
			Mouth	I.V	N.G							
	08:00 am								0			
	09:00 am	DBF							1		Am	
	10:00 am	FFlow							1		Am	
	11:00 am								1		Am	
	12:00 pm	DBF							1		Am	
	01:00 pm	FF15ml							1		Am	
Total Intake : Taken					Total Output : U-2ml-0							
	02:00 pm										Am	
	03:00 pm	DBF							✓		Am	
	04:00 pm	FF15ml							1		Am	
	05:00 pm										Am	
	06:00 pm	DBF							✓		Am	
	07:00 pm	FF10ml							1		Am	
Total Intake : Taken					Total Output : U-2ml-0							
	08:00 pm	DBF +									Am	
	09:00 pm	FF15ml									Am	
	10:00 pm										Am	
	11:00 pm	DBF +									Am	
	12:00 am	FF15ml							✓		Am	
	01:00 am										Am	
Total Intake :					Total Output : U-ml-							
	02:00 am	DBF +							✓		Am	
	03:00 am	FF20ml									Am	
	04:00 am										Am	
	05:00 am	DBF +									Am	
	06:00 am	FF15ml							✓		Am	
	07:00 am										Am	
Total Intake :					Total Output : U-2ml-1							
Total 24 hrs. Intake					Total 24 hrs. Output					U-7ml-2		

BAH-00660476 IP5-00175871
 Baby Of AMMREEN SYED
 02-07-2026 0 Y 0 M 1 D (F)
 Dr. NALINIKANTA PANIGRAHY



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. : (3)

04/7/26

- All measurements in ml.
- 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							
	08:00 am	DBF				✓			✓			
	09:00 am	FF 20ml				✓						
	10:00 am								✓			
	11:00 am	DBF										
	12:00 pm	BBM 20ml										
	01:00 pm											
Total Intake : Taken					Total Output : passed							
	02:00 pm											
	03:00 pm	DBF							✓			
	04:00 pm	DBF										
	05:00 pm											
	06:00 pm	DBF							✓			
	07:00 pm	EBM 10ml										
Total Intake : Taken					Total Output : Passed							
	08:00 pm											
	09:00 pm	DBF				✓			✓			
	10:00 pm	FF 20ml										
	11:00 pm	DBF										
	12:00 am								✓			
	01:00 am	BBM 15ml										
Total Intake : 35 ml					Total Output : 12-20-1							
	02:00 am											
	03:00 am	DBF				✓			✓			
	04:00 am	EBM 15ml										
	05:00 am	DBF										
	06:00 am	EBM 20ml							✓			
	07:00 am											
Total Intake : Taken 40ml					Total Output : 12-20-1							
Total 24 hrs. Intake		Taken 125ml			Total 24 hrs. Output		12-20-1					



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. : 4

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am	DBF					✓			✓		
	09:00 am	DBF										
	10:00 am						✓					
	11:00 am	DBF										
	12:00 pm	DBF										
	01:00 pm											
Total Intake : Taken						Total Output : passed						
	02:00 pm	DBF					✓					
	03:00 pm											
	04:00 pm											
	05:00 pm	DBF								✓		
	06:00 pm											
	07:00 pm											
Total Intake : Taken						Total Output : passed						
	08:00 pm	DBF										
	09:00 pm	DBF								✓		
	10:00 pm	DBF										
	11:00 pm	DBF					✓			✓		
	12:00 am											
	01:00 am	DBF					✓			✓		
Total Intake : Taken						Total Output : V-3 M-3						
	02:00 am	DBF					✓			✓		
	03:00 am											
	04:00 am	DBF										
	05:00 am	DBF					✓			✓		
	06:00 am											
	07:00 am	DBF								✓		
Total Intake : Taken						Total Output : V-4 M-2						
Total 24 hrs. Intake						Total 24 hrs. Output						

FLUID CHART

Sheet No. : 5

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		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
Time		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
6/7/26	08:00 am	DBP											
	09:00 am						✓			✓			
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake : 100ml						Total Output : 100ml							
	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											

FLUID CHART

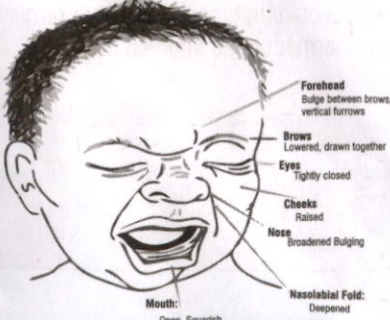
Sheet No. :

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse		
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine					
			Mouth	I.V	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									



NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

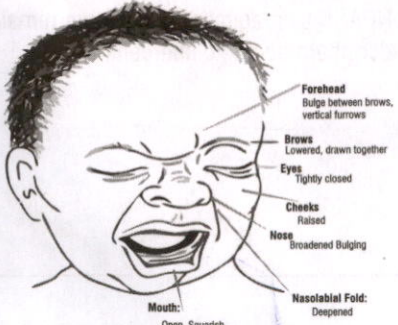
Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	Date	
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time	Time	
						2/7	2/7	3/7	3/7	3/7	4/7	4/7	4/7	5/7	
						8:50 AM	9:00 AM	9:20 AM	9:30 AM	9:40 AM	9:50 AM	10:00 AM	10:10 AM	10:20 AM	
						Procedure	CRBS	PRBS	RBS	RBS	PRBS	-	-		
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	0	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	0	0	0	0	0	
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0	0	0	0	0	0	0	
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0	0	0	0	0	0	
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0	0	0	0	0	0	
 Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention						Gestational Age / Corrected Age	38 ⁺ 1	38 ⁺ 1	38 ⁺ 1	38 ⁺ 1	38 ⁺ 1	38 ⁺ 1	38 ⁺ 1	38 ⁺ 1	38 ⁺ 1
						Total Pain / Agitation Score	0	0	0	0	0	0	0	0	
						Intervention	NA	NA	NA	NA	NA	NA	NA	NA	
						Effectiveness	NA	NA	NA	NA	NA	NA	NA	NA	
						Signature	Dr. Yashwanth	Anita Yashwanth	Anita Yashwanth	Anita Yashwanth	Anita Yashwanth	Anita Yashwanth	Anita Yashwanth	Anita Yashwanth	

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.

H-00660476 IP5-00175871
 by Of AMMREEN SYED
 07-2026 0 Y 0 M 0 D 19 H (F)
 NALINIKANTA PANIGRAHY

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Normal		Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
					Procedure →	5/11/2026	5/11/2026	5/11/2026					
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					
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					
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	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					
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					
 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	38w	38w	38w					
					Total Pain / Agitation Score	0	-	0					
					Intervention	Nil	Nil	Nil					
					Effectiveness	Nil	Nil	Nil					
					Signature	Amreen Syed	Amreen Syed	Amreen Syed					

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.

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					
	Female	1	1	1	1	1	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	3	3	3		
	Within 48 hours	2					
	More than 48 hours / None	1				1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
Total			16	16	16	15	15

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	x	x	x	x
Call device within reach		✓	x	x	x	x
Wheels Locked		x	✓	✓	✓	✓
Room free of clutter		x	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		✓	x	x	x	x
Other Intervention(s) Specify		✓	x	x	x	x
Nurse's Name:		Yamir	Yamir	Yamir	Anita	Yamir
Signature:		Yamir	Yamir	Yamir	Yamir	Yamir
Date:		2/6	2/6	3/6	3/6	3/2/26
Time:		11pm	11pm	11Am	8pm	11pm

H-00660476

IP5-00175871

by Of AMMREEN SYED

07-2026 0 Y 0 M 0 D 19 H (F)

NALINIKANTA PANIGRAHY



**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					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4	4	1	1	1	1
	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	1				
	History of Falls or Infant-Toddler Placed in Bed	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
	Patient Placed in Bed	2					
	Outpatient Area	1	1				
	Within 24 hours	3	3				
Response to Surgery / Sedation Anesthesia	Within 48 hours	2					
	More than 48 hours/ None	1		1	1	1	1
	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
Medication Usage	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	15	15	16	16

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		4	X	X	X	X
Call device within reach		4	X	X	X	X
Wheels Locked		4	✓	✓	✓	✓
Room free of clutter		4	✓	✓	✓	✓
Adequate lighting		4	✓	✓	✓	✓
Wheel chair support		1	X	X	X	X
Other Intervention(s) Specify		1	X	X	X	X
Nurse's Name:		Amrita	Amrita	Amrita	Amrita	Amrita
Signature:		Amrita	Amrita	Amrita	Amrita	Amrita
Date:		4/7	4/7	4/7	5/7	5/7
Time:		11:30	3pm	10pm	11:30	7pm



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1			
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1			
	History of Falls or Infant-Toddler Placed in Bed	4	4	4			
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3	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			
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
Other Medications / None		1	1	1			
Total			16	16			

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓			
Call device within reach		✓	✓			
Wheels Locked		✓	✓			
Room free of clutter		✓	✓			
Adequate lighting		✓	✓			
Wheel chair support		✓	✓			
Other Intervention(s) Specify		✓	✓			
Nurse's Name:		Rafael	Rafael			
Signature:		Rafael	Rafael			
Date:		5/7	6/7			
Time:		10PM	2PM			

BAH-00660476 IP5-00175871
 Baby Of AMMREEN SYED
 02-07-2026 0 Y 0 M 0 D 8 H (F)
 Dr. NALINIKANTA PANIGRAHY



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 :	2/7	2/7/26	2/7	2/7
					Time :	8:45pm	8:45pm	8:45	8:45pm
Mobility	Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	1	1	1	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	2	2	2	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	2	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3	3	3	3	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	3	3	2	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings 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	4	4	2	
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	16	18	18	15
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Dr. Nalinikanta Panigrahy	Mamta	new	Anita

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



BRADEN 'Q' SCALE

					Date :	3/7/26/2	4/7/26/2	4/7/26/2	4/7/26/2
					Time :	8pm	8pm	8pm	11pm
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:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	1	1	1	1	
"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	2	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3	3	3	3	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2	2	2	2	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings 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.	2	2	2	2	
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	15	15	15	15
Docu. No. : RCHRH / FRM / CLINICAL / 110					Evaluator's Name	V.	Devi	Anita	Yamini

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



BRADEN 'Q' SCALE

					Date :	5/7/26	5/7/26	5/7/26	6/7/26
					Time :	8 AM	2 PM	8 PM	8 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		1	1	1	1
"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	2	2	2	2
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2	2	2	2
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3	4	4	4	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."	2	4	4	4	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.	2	2	2	2	2
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	4
					TOTAL SCORE	15	19	19	19
					Evaluator's Name	Dr. Nalinkanta Panigrahy	Dr. Nalinkanta Panigrahy	Dr. Nalinkanta Panigrahy	Dr. Nalinkanta Panigrahy

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

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

Patient ID

BRADEN 'Q' SCALE

					Date :			
					Time :			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:tremitry position independently.	4. No limitations: Makes major and frequent changes in position without assistance.				
"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.				
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.				
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.				
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."				
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.				
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.				
					TOTAL SCORE			
					Evaluator's Name			

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
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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



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 2/7/26

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
12 M	Assess the Baby general condition	12:30 P	Assess the Baby general condition	Baby is stable
2 PM	Vital check.	2:40 PM	Vitals checked and monitoring	
3 PM	SpO2 check monitoring	3:10 P	SpO2 check monitoring	
4 PM	Warm care.	4:20 P	Warm care provided	
6 PM	DBF	6:40 PM	DBF are taken	
7 PM	Prevent Infection	7:10 P	Maintaining hand hygiene	
8 PM	Ensure Safety	8:10 PM	Ensure safety needs	

Re-Assessment: Baby well after taking feed

Special Notes: RDS, monitoring, SBR, NR, OAE ut hr

Nurse Signature: [Signature]

Nurse Name: Naithe

Date & Time: 2/7/26 8 PM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/7/26

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	→ Assess the general condition of the baby	10pm	→ Assessed general condition of the baby	→ Baby is calm and comfortable
10pm	→ DRF and Burping every 2nd hourly	12am	→ DRF and Burping done every 2nd hourly	
12am	→ Monitor I/O chart	2am	→ monitored I/O chart	
2am	→ monitor CRBS	4am	→ monitored CRBS it's maintaining	
4am	→ Warm care	6am	→ Warm care done by swaddling	
6am	→ Ensure safety	8am	→ Ensured safety by crib care	

Re-Assessment: Baby is latching and sucking well.

Special Notes: CRBS monitoring

Nurse Signature: Yami

Nurse Name: Yami

Date & Time: 3/2/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 3/2/26

Assessment: New Born Baby case

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	Assess The Baby general condition	8:15 AM	Assessed The Baby general condition	Baby is stable.
9 AM	Vital check.	9:20 AM	Vital checked and documented	
10 AM	DBF and Formula.	10:30 AM	DBF and Formula given	
11 AM	ILo clamp monitor	11:10 AM	ILo clamp monitoring	
12 PM	Swarm care.	12:20 PM	Swarm care provided	
1 PM	Prevent Infection	1:30 PM	Maintaining ILo clamp	
2 PM	Ensure safety	2 PM	Ensured safety needs	

Re-Assessment: Baby well after taking DBF

Special Notes: SBR, NRI, OAE, UR, HT

Nurse Signature: [Signature]

Nurse Name: Meenika

Date & Time: 3/2/26 @ 2 PM



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 2/2/26

Assessment: Baby on Room air

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the Baby condition	2:20 pm	→ Assessed the Baby general condition	→ Baby is fine
3pm	→ Monitor Vitals	3:30 pm	→ Checked Vitals & Recorded	
4pm	→ Feeding & burping	4:50 pm	→ Feeding & burping done	
5:20 pm	→ I/O chart	5:45 pm	→ I/O chart monitoring	
6pm	→ TCBR	6:10 pm	→ TCBR checked & inform	
6:20 pm	→ warm care	6:45 pm	→ to Dr. Lohith	
7pm	→ ensure safety	6:45 pm	→ Provided warm care	
		7:30 pm	→ Provided crib care	

Re-Assessment: Baby is sleeping

Special Notes: GRBS monitoring & SBR NBS t/m 10am

Nurse Signature: @

Nurse Name: S/s. Anita

Date & Time: 2/2/26, 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: Newborn 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	→ Assess the general condition of the baby.	10pm	→ Assessed general condition of the baby.	→ Baby is calm and comfortable.
10pm	→ monitor vitals.	12am	→ monitored vitals.	
12am	→ Df and formula feed followed by burping.	2am	→ Df and formula feed done by followed by burping.	
2am	→ monitor I/O chart	4am	→ monitored I/O chart.	
4am	→ Warm care	6am	→ Warm care done by swaddling	
6am	→ Ensure safety	8am	→ Ensured safety by crib care.	

Re-Assessment: Baby is latching and sucking well

Special Notes: GBR, NRS, OAE & vector

Nurse Signature: Yami

Nurse Name: Yami

Date & Time: 3/7/26 @ 2am

BAH-00660476 IP5-00175871

Baby Of AMMREEN SYED

02-07-2026 0 Y 0 M 2 D (F)

Dr. NALINIKANTA PANIGRAHY



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: 4/2/26

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
9 AM	Assess the patient general condition	9:30 AM	Assessed the patient general condition	Baby is stable
10:10 AM	Vital check.	10:20 AM	Vital checked and documented	
11 AM	Swarm care	11:20 AM	Swarm care provided	
12 PM	SI to chart monitoring	12:30 PM	SI to chart monitoring	
1 PM	DBF and formula	2 PM	DBF and formula given	
2 PM	EMSC safety.	2:20 PM	Ensured safety needs	

Re-Assessment: Baby well after feed

Special Notes: OAE today

Nurse Signature: [Signature]

Nurse Name: Meenu

Date & Time: 4/2/26 4 PM



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

Assessment: Baby on Room air

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the Baby general condition	2:30 pm	→ Assessed the Baby general condition	→ Baby is fine
3pm	→ Monitor vitals	3:30 pm	→ checked vitals & recorded	
4pm	→ Feeding & burping	4:50 pm	→ Feeding & burping	
5pm	→ I/O chart	5:30 pm	→ I/O chart monitoring	
6pm	→ warm care	6:30 pm	→ Provided warm care	
7pm	→ Ensure safety	7:30 pm	→ Provided crib care	

Re-Assessment: Baby is sleeping

Special Notes: No significant

Nurse Signature: @A

Nurse Name: Dis. Anita

Date & Time: 4/7/26 @ 8pm

BAH-00660476 IP5-00175871
 Baby Of AMMREEN SYED
 02-07-2026 0 Y 0 M 1 D (F)
 Dr. NALINIKANTA PANIGRAHY

NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: Newborn 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	→ Assess general condition of the baby and monitor vitals.	10pm	→ Assessed general condition of the baby and monitored vitals.	→ Baby is calm and comfortable.
10pm	→ Dsf and formula feed.	12am	→ Dsf and formula feed done.	
12am	→ monitor ilo chart	2am	→ Ilo chart monitoring done.	
2am	→ Warm care done.	4am	→ Warm care done by swaddling	
4am	→ Weight check	6am	→ weight checked and recorded	
6am	→ Ensure safety	8am	→ Ensured safety by crib care	

Re-Assessment: Baby is latching and sucking well.

Special Notes: TUBE tomorrow @ 8am.

Nurse Signature: [Signature] Nurse Name: Yamuna Date & Time: 4/7/26 @ 8am

Patient Sticker

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/9/26

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
8 AM	Assess The Baby general condition	8:10 AM	Assessed The Baby general condition	Baby is stable.
9 AM	vital check	9:20 AM	vital checked and documented	
10 AM	DBF + EBM	10:30 AM	EBM + DBF are given	
11 AM	SpO2 chart monitor.	11:30 AM	SpO2 chart monitoring	
12 PM	prevent infection	12:50 PM	maintaining hand hygiene	
1 PM	ensure safety	1:40 PM	ensure safety needs	

Re-Assessment:

Special Notes: N/A

Nurse Signature: [Signature]

Nurse Name: Nisha

Date & Time: 5/2/26 @ 2 PM

BAH-00660476

IP5-00175871

Baby Of AMMREEN SYED

02-07-2026 0 Y 0 M 1 D (F)

Dr. NALINIKANTA PANIGRAHY



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: 5/7/26

Assessment: new born baby for observation

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the baby condition	2:10pm	Assessed the baby condition	
3pm	Do chest	3:15pm	Do chest monitoring	Baby is well
5pm	Monitor vitals	5:05pm	Vitals checked & recorded	
6pm	warm care	6:10pm	warm care provided	
7pm	Safety	7:15pm	side rails provided	
8pm	DBT & Bumping	8:05pm	DBT & Bumping done	

Re-Assessment: new Baby is comfortable

Special Notes: Not Significant

Nurse Signature: [Signature]

Nurse Name: Anilpa

Date & Time: 5/7/26 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/8/24

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 condition	8:10pm	→ Assessed the baby condition	→ Baby is stable.
10pm	→ Monitor vitals	10:10pm	→ vitals checked and recorded.	
12AM	→ S/o chest	12:10AM	→ S/o chest maintained	
2AM	→ nasal care	2:10AM	→ nasal care provided	
4AM	→ umb care	4:10AM	→ umb care provided	
6AM	→ DBF	6:10AM	→ DBF (wedge) given	
8AM	→ Breeping	8:10AM	→ Breeping done.	

Re-Assessment: Vitals checked and recorded

Special Notes:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 5/8/24 @ 3AM



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

Assessment: New born baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	Assess the baby condition	8:15 AM	Assess the baby condition	Baby is well
9 AM	Do chest	9:15 AM	Do chest maintained	
10 AM	Monitor vitals	10:45 AM	Vitals checked & secured	
11 AM	Safety	11:15 AM	Baby born safely	
12 PM	warm care	11:30 AM	warm care provided	
1 PM	personal hygiene	12 PM	personal hygiene maintained	
2 PM	DBT & Burping	2 PM	DBT & Burping done	

Re-Assessment: now baby comfortable

Special Notes: Not Significant

Nurse Signature: [Signature]

Nurse Name: Poulpa

Date & Time: 6/7/26 2 PM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nalinikanta Panigrahy Department: BRP Date of Admission: 2/7/20

SITUATION	Diagnosis: <u>New Born Baby Case</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area	Shift Time	<u>BRP 8AM-12PM</u>	<u>BRP 12PM-2PM</u>	<u>BRP 2PM-4PM</u>	<u>BRP 4PM-6PM</u>	<u>BRP 6PM-8PM</u>	<u>BRP 8PM-12AM</u>
BACKGROUND	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>98.0°F</u>	<u>97.9°F</u>	<u>97.8°F</u>	<u>98.0°F</u>	<u>97.9°F</u>	<u>98.0°F</u>
		Res:	<u>44</u>	<u>42b/m</u>	<u>44</u>	<u>40b/m</u>	<u>42b/m</u>	<u>44</u>
		SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>98%</u>	<u>98%</u>	<u>99%</u>	<u>98%</u>
		Pulse:	<u>142</u>	<u>138b/m</u>	<u>149</u>	<u>130b/m</u>	<u>138b/m</u>	<u>149</u>
		BP:		<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Fall Risk Score:	<u>16</u>	<u>16</u>	<u>16</u>	<u>15</u>	<u>15</u>	<u>15</u>	
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>		
Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</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>BRP 8AM-12PM</u>	<u>BRP 12PM-2PM</u>	<u>BRP 2PM-4PM</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>BRP 12PM-2PM</u>	<u>BRP 2PM-4PM</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Namika</u>	<u>Yammy</u>	<u>Namika</u>	<u>Anita</u>	<u>Yammy</u>	<u>Namika</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>2/7/20</u>	<u>2/7/20</u>	<u>2/7</u>	<u>2/7/20</u>	<u>4/7/20</u>	<u>4/7</u>	
Time:		<u>8PM</u>	<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>	
Taken Over By Name :		<u>Yammy</u>	<u>Namika</u>	<u>Anita</u>	<u>Yammy</u>	<u>Namika</u>	<u>Anita</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>2/7/20</u>	<u>2/7/20</u>	<u>2/7/20</u>	<u>3/7/20</u>	<u>4/7</u>	<u>4/7/20</u>	
Time:		<u>8PM</u>	<u>8AM</u>	<u>3PM</u>	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nalinikanta Panigrahy Department: BPP Date of Admission: 4/7/26

SITUATION	Diagnosis: <u>New born baby</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area	<u>BPP</u>	<u>BPP</u>	<u>BPP</u>	<u>BPP</u>	<u>BPP</u>	
	Shift Time	<u>2pm-8pm</u>	<u>8pm-2am</u>	<u>2am-8am</u>	<u>8am-2pm</u>	<u>2pm-8pm</u>	
ASSESSMENT	Medical Condition (Any special condition to be noted):	<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	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>97.9°F</u>	<u>97.9°F</u>	<u>98.0°F</u>	<u>98.3°F</u>	<u>98.5°F</u>
		Res:	<u>40b/m</u>	<u>42b/m</u>	<u>44b/m</u>	<u>42b/m</u>	<u>41b/m</u>
		SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>
		Pulse:	<u>141b/m</u>	<u>142b/m</u>	<u>141b/m</u>	<u>141b/m</u>	<u>140b/m</u>
		BP:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Fall Risk Score:	<u>15</u>	<u>15</u>	<u>15</u>	<u>16</u>	<u>16</u>	
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
	Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		<u>NA</u>	<u>NA</u>	<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>	<u>NA</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>Anita</u>	<u>Yanning</u>	<u>Yanning</u>	<u>Yanning</u>	<u>Yanning</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	
Time:		<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>2pm</u>	
Taken Over By Name :		<u>Yanning</u>	<u>Yanning</u>	<u>Yanning</u>	<u>Yanning</u>	<u>Yanning</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	

BAH-00660476 IP5-00175871
Baby Of AMMREEN SYED
02-07-2026 0 Y 0 M 0 D 8 H (F)
Dr. NALINIKANTA PANIGRAHY



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: 8/7/26

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

Needed

.. 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: [Signature]

Nurse Name: Monika

Date and Time: 2/7/26 8pm

CONSENT FOR FORMULA FEEDS

H-00660476 IP5-00175871
by Of AMMREEN SYED
07-2026 0 Y 0 M 0 D 19 H (F)
NALINIKANTA PANIGRAHY



Patient Name : Age : Gender : ☐ Male ☐ Female

UHID No : Department : Date :

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

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

..... I hereby give consent for formula feed for my child. Doctors have explained me
about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : *P. Arshiga*

Name : Syed Arshiga

Relationship with Patient: Sister

Date & Time : 3/7/2026 2:30 AM

Witness :

Signature : *Yamuna*

Name : Yamuna

Date & Time : 3/7/2026 2:30 AM

Doctor (who is taking the consent) :

Signature : *Neethu*

Name : Neethu

Date & Time : 3/7/26 2:30 AM