

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175964 Admit Date : 04-Jul-2026 Admit Time : 10:34 AM UHID : BAH-00660654

Patient Details :

Patient Name : Baby Of KAWSAR JAMA MOHAMED Age : 0 D
Guardian : Mrs MARYAN SALAAD DOB : 04-07-2026 09:20 AM
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : Alhasanath colony Tolichowki Hyderabad Phone No : 7569371607/ 7569371607
Telangana INDIA 500008 E-mail : asaliye24@gmail.com

Admission Details :

Bed Type : NICU Bed No : NICU 244 Ward Name : 2F-NICU 1
Room No : NICU 244 Admission Type : First Visit

Contact Details :

Name : Mrs MARYAN SALAAD Relationship : Father
Contact Address : Alhasanath colony Tolichowki Hyderabad Phone No : / 7569371607
Telangana INDIA 500008


Signature

Doctor Details :

Doctor Name : Dr. VENKATA LAKSHMI A Specialisation : NEONATOLOGY
Referral Doctor : Phone No :
Co-Consultant :

Payment Details :

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



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



BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date of Birth : 04/07/2026
Time of Birth : 9:20 AM
Mode of Delivery : EL-LSCS
Birth Weight : 3.08 Kg
Head Circumference :
Length :
Red Reflex :

New Born Screening	:	
TFT	:	
OAE	:	
Mother's Blood Group	:	
Baby's Blood Group	:	
Anomaly Scan	:	
Vaccination	:	given - 6.12

given - 6/7/26-Dura
(BCG, OPV, Hep-B)

: RCHBH / FRM / CLINICAL / 132

[illegible]

ACTIVITY RECORD FOR BILLING

Name : _____
 BAH-00660654 IP5-00175964
 Baby Of KAWSAR JAMA MOHAMED
 UHID No. : 04-07-2026 0 Y 0 M 0 D 9 H (F) _____ Consultant: _____ Dept : _____
 Dr. VENKATA LAKSHMI A
 Date of Adm _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/7/26	@ 8:40pm	Nicee	-k-l-a-r-d	(Signature)

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Age : Father's Name : Age :

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

NICU Consultant : Referring Consultant :

Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward

Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : Baby of Kawsar Jama Mohamed Mother's Blood Group : A+ve.

Gender : ☐ M ☒ F Blood Group : A+ve - Birth Weight (gms) : 3.086 kg length (cms) :

Date of Birth : 4/7/2026 Time of Birth : 9:20 AM OFC (cms) :

Place of Birth : RCH, Banjara Estimated Gesth Age : 38+3 wks.

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 27y Ht : 151cm Wt : 70 BMI : Married Life : 10yrs LMP 27/10/25 EDD : 15/7/2026

Conception : Spontaneous or with Rx : 6 Cycles of IVF.

Booked at what GA : 13wks AN Steroids Drugs / Doses :

Last Scans Details : 34+4 - Cephalic 248.6 (41%), AC-17%, AFI-12.6cm,

Doppler - Normal. m. echo - (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

A P : A : L :

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

PERINATAL HISTORY

Treating Obstetrician : Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Elec. 18cs

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication :

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitaion : ☐ Yes ☐ No

Cord ABG :

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

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

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

TOTAL

Snapee II Score

Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



delivery equipment check done..

↓
Baby delivered by C.S. 1808

Cried immediately after birth

↓
~~Not~~ Delayed Cord clamping done at 60 sec

↓
Taken under warmer

Nasal Oral Secretions Cleared

1 Small vomiting - clear amniotic fluid (+)

↓
Umbilical cord-clamped cut

2A + 1U (+)
Vitamin K Inj. given

↓
Intermittent desaturations
upto 80% - requiring
Oxygen (+)

↓
Shifting to NICU for observation

Investigation details in previous Hospital :

Feeding History :



Family History :



Socio Economic History :

upper middle

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.8°f HR : 163/min RR : 55/min NIBP : CFT : <3 sec

Color of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 94%

ANTHROPOMETRY: Birth Weight : 3.086 Length : HC : Present Weight :

Ponderal Index : AGA : ✓ SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :

Fontanelles :

Sutures

Shape / Moulding :

Edema / Bruising :

Size - (H.C.) :

(N)

AF-open

FACIES :

(Any Facial
Dysmorphism)

No dysmorphism

NECK and
CLAVICLES :

Range of Motion :

Asymmetry :

Masses :

(N)

EYES :

Symmetry :

Red Reflex : - Need to be assessed

Discharge :

EARS, NOSE
MOUTH and
THROAT :

Ear set / Shape :

Periauricular Pits / Tags :

Nasal shape / Patency :

Palate :

Gums :

Lips :

Tongue :

No cleft palate

THORAX and
BREASTS :

Shape of Thorax :

Position of Nipples and Number :

Small Bruise over chest.

ABDOMEN and
UMBILICUS :

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump : - 2A + 1U, present

Discharge :

Abdomen - full

GENITALIA :

Labia / Hymen :

Testicles/penis :

Anus :

Female genitalia (+)

HERNIAL ORIFICES

free

TRUNK and SPINE :

(N)

SKIN LESIONS :

NO

EXTREMITIES :

Fingers / Toes :

Deformities :

Hip Joint Examination :

(N)

Arms / Legs :

Mobility :

(N)



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 55/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 : on low flow O₂

SpO₂ : Auscultation: BAC (+) Breath Sounds: clear Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 154/min BP :

Precordial Activity : (N)

Femoral Pulses : well felt

Murmurs : NO

Other Peripheral Pulses :

Signs of Cardiac Failure : NO

ABDOMEN:

Shape : distended

Hernia orifice : free

Palpation :

Anal Patency :

Palpable masses :

Umbilical Cord : 2A+1V

Abdominal girth :

First urine passed : Passed

Meconium passed : Not passed

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness : awake, active

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone : (N)

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR :

ATNR : Skull and Spine : (N)



Congenital Anomalies :

Diagnosis :

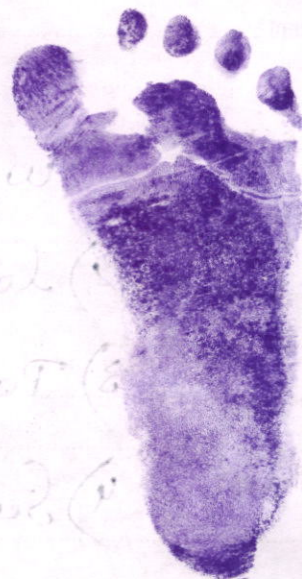
Term / AGA / female / mother / Intermittent desaturation
(38+3 wks) (3.086) / Thrombophilia / vomiting
Prot-C, AT-III deficiency

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

Sneha

Y. Sneha

48/7/26

Consultant :

Signature :

Name :

Date & Time :

Dr. MVB PRATHYUSH

Registration No.: TSMC/FMR/30369

Dr. MVB Prathyush

04/07/26

PLEASE FILL UP THE FOLLOWING DETAILS

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



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 : Plan

Systemic :

Medications : 1) Warm care

..... 2) low flow oxygen

..... 3) Paladary feeds observe for desaturations

Plan during ward follow up :

..... 4) Send - Cord Blood for < CBP

..... 5) Send PT, aPTT, INR at 12HOL

..... 6) monitor for RO

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 10:30am	CLS/IB - Resident	
	IHOL / 38 ^{Wk} / EL. LSCS / 3.08 kg	
	- H10 - 6 cycles of IVF.	
	H10 - maternal - thrombophilia	
	Protein S / AT-III deficiency	
	ANA - negative	
	- on T. Eco sprin / HCG / clexane.	
	H10 - 2 episodes of - clear amniotic fluid in Delux room	
	- intermittent desaturations - upto - 80%.	
	↓ requiring O ₂	
	Shifted to NICU	
	OIEs. SpO ₂ - 85% in Room air	
	- Small urine over chest	
	CUS - S ₁ S ₂ ⊕	
	PIA - full.	
	Plan	
	→ low flow - 0.5 L/min	
	→ TV - 60 cels / day - 15 ml / 2 nd / 4 th	
	Formula / paladai	
	→ Tissue CBP / Blood count	
	→ PT / APTT / INR - @ 9:30 pm	
	→ monitor SpO ₂	
	→ Check CRBS - 1 hr - post feed.	
	Ramon	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		cls/B- Dr. Nilesh
	SpO ₂ - 92% C/A	<u>Plan</u>
		→ SOA - feeds
		→ low flow - 0.5 L/min
		→ chest & stony now
		→ CBA - now
		→ send - PT / APTT / INR / CBR
		@ 9:30pm
		<u>Plan</u>
		→ <u>2DECHO</u>
4/7/26 3pm	Afternoon Rounds	<u>Plan</u>
M/A +ve B	Baby on low flow O ₂ SpO ₂ - 94% I+R - 48/min Passed - urine / stool PIA - soft.	→ continue low flow → TV - 60cc / 30cc 15ml / 2nd hr / 04 / 10pm
	~ 1 episode of vomiting (undigested milk)	→ PT / APTT / INR / CBR - @ 9:30p
	- around 3 ml	- URBS - BD.
		→ Monitor SpO ₂
		- w / r cyanosis
		<u>Plan</u>
		noted by K. K. Arany



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/10/26	S/B - Dr. PP	Plan → Admit → Continue low flow - 0.05 L/min 15ml/2nd hrs - Formula 5 TV - 60 cc/kg/day - O2 feed → O2 feeds - till dietary settle → PT/APTT/INR/CBP - @ (9:30pm) 12 HCL - CRBS - BD → noted by Lokanagar. Pavan
4/10/26 9:20pm	c/s /B - Dr. Nilach Night Rounds Baby on low flow hemodynamically - Stable. - No further vomiting - tolerating feeds well	Plan - continue low flow 5 TV - 60 cc/kg/day - full O2 feed → at 9:30pm - send PT/APTT/INR/CBP/CRR → CRBS - BD → trial of room air 6 hrs Target SpO ₂ - 92% P.T.O.

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

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

Day in NICU: 1 Day of Life: 1 PMA: 38⁺4 wks

Term ☒ Preterm ☐ Gestation: 38⁺3 wks Corrected Gestational Age: Today's Weight: 2.921 kg (3116g)

Problems	
S.No.	Current
1.	Term / NGA /
2.	→ Maternal H/O - thrombophilia
3.	→ 1
4.	
5.	
6.	

Clinical Assessment
Baby on low flow: - hemodynamically stable - on full OA feeds. - no further vomitings HR - 120 / min. BP SpO₂ - 96% GRBS - 85 mg/dl.

Medications Used
CRP - 12 WBC - 23,180 2 DEcho - (verbally) - large PDA - 4.1 mm

Plan of Care:
→ Taper Oxygen as possible - Target SpO₂ - > 92% TV - 60 c/min/day - full OA feeds - 15 ml/2 hrs - GRBS - BD.

Doctor's Name (Hand over given): Panku

Signature: Panku

Date & Time: 5/12/20

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

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

Signature: [Signature]

Date & Time: 5/12/20

Patient Sticker

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

Day in NICU: Day of Life: PMA:

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

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

Doctor's Name (Hand over given):

Signature:

Date & Time:

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/1/20	Plan	Seen by Dr. Pratyush.
		① CRP to be done + SBR + NBS 7m
		② If CRP still high, then take c/s & start antibiotics
		③ Paladacy trial.
		④ 7m @ 20 ECHO screening
		⑤ 7m - CRP - CRP - NBS - SBR. } 6 am.
		⑥ If taken paladacy well, full paladacy
		⑦ Evening crib care
		⑧ ⑨ Shift out from in evening
		⑩ Put ECG leads. & BP cuff.
		⑪ tapes O ₂ as tolerated. Noted by Akansha

Date & Time	Progress Notes	Doctor's Order
5/7/26	<u>Afternoon rounds</u>	
3pm	Baby on Room air Tolerated 2 paladi feeds well no R/O no desaturation No vomiting SpO ₂ : 98% PR: 146b/min RR: 43b/min BP: periphery: Pink, warm CRT = 3sec passed urine & stool	<u>Plan</u> 1. IVz Bocel/Kildan ↓ 20ml O ₂ H full paladey feed 2. CRP } CRP } SBR } (11m) NBS } 3. Crib Care now 4. If CRP high (>20) take blood clt and start Antibiotic 5. Wif R/O desaturation 6. (11) shifting to Room
	Noted by Yamuna @ 5/7/26 @ 3pm	Suy Sai
	Dr. MVB PRATHYUSH Registration No: TSMG/FMR/30369	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26 6:30 pm	<u>Shyby Note</u> Baby hemodynamically stable on air Tolerating pallidair feeds well No bradycardia/desaturation On crib care. o/c - HR - 154/min RR - 36/min SpO ₂ - 96% BP - 75/58 (62)	<u>Plan</u> 1) Shift to Room 2) CBP SBR CRP WBS T/m Gam 3) Vaccination, AABR t/m 4) If CRP high (>20) - take blood cts and start antibiotics 5) w/ - TV - 80 cc/kg/day 2ml 2hly full pallidair 6) w/F Bradycardia/desaturation 7) 2D Echo T/m
	Dr. MVB PRATHYUSH - JMD Registration No: TSMC/FMR/30369	noted by MATHEA [Signature]

BAH-00660654 IP5-00175964
Baby Of KAWSAR JAMA MOHAMED
04-07-2026 0 Y 0 M 1 D (F)
Dr. VENKATA LAKSHMI A



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Bla Kawsar Mother's Name: Mu Kawsar

Date of Birth: 4/7/26 Time of Birth: 9:20 am Gender: ☐ Male ☒ Female

Birth Weight: 3.086 Kgs HC: cm Length: cm

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

Term / Pre-term / Post-term:

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

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

AFFIX MOTHER'S
IDENTIFICATION LABEL

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

Indication:

Physical Assessment of New Born:

Temp: 97.9 °C HR: 31 /Min RR: 13.1 /Min BP: SpO₂: 98.5

Pain Score: (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: Maithu

Signature: (Signature)

Date & Time: 5/7/26

BAH-00660654 IP5-00175964
Baby Of KAWSAR JAMA MOHAMED
04-07-2026 0 Y 0 M 0 D 4 H (F)
Dr. VENKATA LAKSHMI A




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

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

RESULT SHEET

Date	4/7	5/7				
Time	9:50pm					
Hb	18.4					
PCV	55.5					
RBC	4.95					
WBC	23.18					
N/L	67.4/21.4					
Platelets	257					
CRP	12.0	12.0				
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR	14.1.0					
APTT	→ 34 28.5 35.1 sec					
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.,) :

BAH-00660654 IP5-00175964
 Baby Of KAWSAR JAMA MOHAMED
 04-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. VENKATA LAKSHMI A



DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY: Name _____, Sign _____



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				



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

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

STAT / ONCE ONLY DRUGS[illegible]

3AH-00660854 IP5-00175964
 Baby Of KAWSAR JAMA MOHAMED
 14-07-2026 0Y0M0D9H (F)
 Dr. VENKATA LAKSHMI A



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

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C Caregiver O: Other (Specify)									
Learning Barriers:									
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice					
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)					
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing						
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s:									
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify						
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding:									
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review							

Patient Sticker

MULTI-DISCIPLINARY PLAN OF CARE FORM

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

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

Diagnosis: _____

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:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



Patient Sticker

RBS CHART

[illegible]



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	8Am	10Am	12Am	2Pm	4Pm	6Pm	8Pm	10Pm	12Pm	2Am	4Am	6Am	8Am	
Doctor/Nurse/Family Concern?															
Temperature (F)	104														
	103														
	102														
	101														
	100														
	99														
	98														
	97														
	96														
	95														
	94														
	Heart Rate (bpm)	190													
		180													
		170													
		160													
	and	150													
		140													
Blood Pressure (mmHg) *	130														
	120														
	110														
	100														
	90														
	80														
	70														
	60														
	50														
Note: BP does not score in early warning scoring															
Heart Rate (Number)				145	139	141	150	157	151	157	160	159	160		
Resp. Rate (bpm) per 1 Minute) *	70														
	60														
	50														
	40														
	30														
	20														
	10														
Resp Rate (Number)				42	50	42		40	41	42	43	44	45		
Resp Distress	Mod/ Severe None / Mild														
Receiving O ₂ (l/min)															
O ₂ Saturations (%)				95			97	98	99	100	99	99			
Conscious Level	Normal Altered														
GCS *															
TOTAL SCORE				1	1	1	1	1	1	1	1	1	1		
Number of shaded boxes				1	1	1	1	1	1	1	1	1	1		
Pain Score				0	0	0	0	0	0	0	0	0	0		
Observer's Initials				AS	AS	AS	AS	AS	AS	AS	AS	AS	AS		
ACTIONS	Score 1	: Continue normal observation by staff nurse													
	Score 2	: Shift in charge nurse to be informed and continue hourly observations													
	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.													
	Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see													
	Score 5 & 6	: Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed													
NB: Scores 3 should be recorded overleaf															

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



5/7/26

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 5/7/26	Time:	8	10	12	2	4	6	10	12	2	4	6	8pm	
Doctor/Nurse/Family Concern?		Am	Am	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm	
Temperature (F)	104													
	103													
	102													
	101													
	100	98.6°C	98.7°C	98.7°C	98.6°C	98.5°C	98.6°C	98.7°C	98.6°C	98.7°C				
	99													
	98													
	97													
	96													
	95													
	94													
	Heart Rate (bpm)	190												
	180													
170														
160														
150														
140														
130														
120														
110														
100														
90														
80														
70														
60														
50														
Blood Pressure (mmHg) *														
Note: BP does not score in early warning scoring														
Heart Rate (Number)		—	144	153	141	150	125	145	152	126	162	170	180	
Resp. Rate (bpm) (Over 1 Minute) *	70													
60														
50														
40														
30														
20														
10														
Resp Rate (Number)		32	32	40	40	45	60	45	32	46	52	39	39	
Resp Distress	Mod/ Severe None / Mild													
Receiving O ₂ (l/min)														
O ₂ Saturations (%)		93%	92%	93%	96%	95%	96%	98%	98%	99%	99%	98%	96%	
Conscious Level	Normal Altered													
GCS *		C	C	C	C	C	C	C	C	C	C	C	C	
TOTAL SCORE														
Number of shaded boxes		1	1	1	1	1	1	1	1	1	1	1	1	
Pain Score		0	0	0	0	0	0	0	0	0	0	0	0	
Observer's Initials		A	A	A	A	A	A	A	A	A	A	A	A	
ACTIONS		Score 1 : Continue normal observation by staff nurse												
		Score 2 : Shift in charge nurse to be informed and continue hourly observations												
		Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.												
		Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see												
		Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed												
NB: Scores 3 should be recorded overleaf														

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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

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A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

5/7/26

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	2	6
Doctor/Nurse/Family Concern?	10PM	AM	AM
Temperature (°F)	97.9	98.1	97.6
Heart Rate (bpm)	130bpm	150bpm	148bpm
Blood Pressure (mmHg) *	130	140	140
Resp Rate (bpm)	31bpm	38bpm	46bpm
Resp Mod/ Severe Distress	N	N	N
Receiving O ₂ (l/min)	0	0	0
O ₂ Saturations (%)	98%	100%	98%
Conscious Level	Normal	Normal	Normal
GCS *	15/15	15/15	15/15
TOTAL SCORE	0	0	0
Number of shaded boxes	0	0	0
Pain Score	0	0	0
Observer's Initials	2	2	2

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

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

Patient Sticker

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

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

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time: 10am	2pm	6pm		
Doctor/Nurse/Family Concern?					
Temperature (°F)	104				
	103				
	102				
	101				
	100				
	99	98.2°F	98.5°F	98.3°F	
	98	*	*	*	
	97				
	96				
	95				
94					
Heart Rate (bpm)	190				
	180				
	170				
	160				
	150				
	140	*	*	*	
	130				
	120				
	110				
	100				
and Blood Pressure (mmHg) *	90				
	80				
	70				
	60				
	50				
	Note: BP does not score in early warning scoring				
	Heart Rate (Number)	137bpm	140bpm	140bpm	
	Resp. Rate (bpm) (1 Minute) *	70			
		60			
		50			
40		*			
30					
20					
10					
Resp Rate (Number)		40bpm	42bpm	38bpm	
Resp Distress		Mod/ Severe			
		None / Mild	N	N	N
Receiving O ₂ (l/min)					
	O ₂ Saturations (%)	100%	99%	99%	
Conscious Level	Normal	N	N	N	
	Altered				
GCS *		15/15	15/15	15/15	
TOTAL SCORE		0	0	0	
Number of shaded boxes		0	0	0	
Pain Score		0	0	0	
Observer's Initials		JA	JA	JA	

ACTIONS

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
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NB: Scores 3 should be
 recorded overleaf

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

3AH-00660554 IP5-00175964
 Baby Of KAWSAR JAMA MOHAMED
 04-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. VENKATA LAKSHMI A

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. : ①

4/7/26.

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	O.G						
	08:00 am										
	09:00 am										
	10:00 am										
	11:00 am										
	12:00 pm										
	01:00 pm	Nanpro	15ml						8ml		

Total Intake :

Total Output : u-8ml m-Np.

	02:00 pm										
	03:00 pm	Nanpro		15ml		passed			10ml		
	04:00 pm										
	05:00 pm	Nanpro		15ml		passed			5ml		
	06:00 pm										
	07:00 pm	Nanpro		15ml					8ml		

Total Intake :

Total Output : m-2 u-23ml

	08:00 pm										
	09:00 pm	Nanpro		15ml		passed			8ml		
	10:00 pm										
	11:00 pm	Nanpro		15ml		passed			10ml		
	12:00 am										
	01:00 am	Nanpro		15ml					8ml		

Total Intake :

Total Output : m-2 u-26ml

	02:00 am										
	03:00 am	Nanpro		15ml					10ml		
	04:00 am										
	05:00 am	Nanpro		15ml		passed			7ml		
	06:00 am										
	07:00 am	Nanpro		15ml							

Total Intake :

Total Output : u-12ml m-1.

Total 24 hrs. Intake

7ml

Total 24 hrs. Output

u-9 m-1



5/7/26

FLUID CHART



Sheet No. :

5/7/26

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

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
5/7/26	08:00 am											
	09:00 am	Nanpro 15ml					Passed			10ml		A M
	10:00 am											
	11:00 am	Nanpro 15ml					Passed			9ml		
	12:00 pm											
	01:00 pm	Nanpro 15ml										
Total Intake :						Total Output :						
5/7/26	02:00 pm	Nanpro 15ml					passed			12ml		A M
	03:00 pm	Nanpro 20ml					passed			12ml		
	04:00 pm											
	05:00 pm	Nanpro 20ml								8ml		
	06:00 pm											
	07:00 pm	Nanpro 20ml					passed			9ml		
Total Intake :						Total Output : motion 3 times U/G						
5/7/26	08:00 pm											A M
	09:00 pm	Nanpro 20ml								12ml		
	10:00 pm											
	11:00 pm	DBF + FF										
	12:00 am											
	01:00 am	DBF										
Total Intake :						Total Output : V 2 2 m2						
6/7/26	02:00 am											A M
	03:00 am	Nan 25me										
	04:00 am											
	05:00 am	Nan 20me										
	06:00 am											
	07:00 am	DBF										
Total Intake :						Total Output : V 2 1 m = 1						
Total 24 hrs. Intake		Total 24 hrs. Output										
taken		V 2 9 m = 7										

BAH-00660654 IP5-00175964
 Baby Of KAWSAR JAMA MOHAMED
 04-07-2026 0 Y 0 M 1 D (F)
 Dr. VENKATA LAKSHMI A



FLUID CHART

6/7/26

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am	DBF								✓	1	Latha	
	09:00 am	FF 25ml					✓				NO		
	10:00 am										IV	Latha	
	11:00 am	DBF								✓	1	Latha	
	12:00 pm	FF 20ml					✓						
	01:00 pm												
Total Intake :			taken			Total Output :						U - 2 M - 2	
	02:00 pm	DBF								✓	1	Latha	
	03:00 pm	FF 25ml											
	04:00 pm											Latha	
	05:00 pm	DBF					✓				NO		
	06:00 pm	FF								✓	IV	Latha	
	07:00 pm	30ml									1	Latha	
Total Intake :			taken			Total Output :						U - 2 M - 1	
	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

BAH-00660654 IP5-00175964
 Baby Of KAWSAR JAMA MOHAMED
 04-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. VENKATA LAKSHMI A



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: 4/7/26

Assessment: Baby on LP

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	2:15pm	→ Assessed the baby condition.	Baby is now stable.
4pm	→ Monitor the vital signs	4:30pm	→ Monitored the vital signs.	
6pm	→ Provide comfortable position	6:30pm	→ provided comfortable position.	
7pm	→ Administered medicine - Ensure safety	7pm	→ Ensure safety.	

Re-Assessment: Re-Assessment done.

Special Notes: RBS - BD

Nurse Signature: *[Signature]*

Nurse Name: Lokanya

Date & Time: 4/7/26 @ 2pm-8pm

Patient Sticker

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: 4/7/26

Assessment: Baby on LIF

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 at baby	8:30pm	→ Assessed the General condition at baby.	Baby is stable
12:-	→ provide comfortable position	12:30pm	→ Provided comfortable position.	
3:Am	→ Give 2 nd hourly feed	3:30Am	→ Given 2 nd hourly feed	
6:Am	→ Ensure safety	6:30Am	→ Ensured safety	
8Am	→ maintain I/O chart	8:30Am	→ maintained I/O chart	

Re-Assessment: Done.

Special Notes: PT, ApTT, INR, CBP, CRP Done, 4RBS -BD

Nurse Signature: *[Signature]*

Nurse Name: maddhura

Date & Time: 4/7/26 8am

BAH-00660654 IP5-00175964
Baby Of KAWSAR JAMA MOHAMED
04-07-2026 0 Y 0 M 0 D 23 H (F)
Dr. VENKATA LAKSHMI A



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:

Assessment: Baby is on L/P.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 Am	Assess the baby general condition.	8 Am.	Assessed the baby general condition.	
10 Am	monitors vitals signs.	10 Am	monitored vitals signs	Baby is stable on low flow
12 pm	Provide Comfortable position.	12 pm	provided comfortable position.	
2 pm	give the feeding 2 nd holly	2 pm	given the feeding 2 nd holly	

Re-Assessment:

Re-Assessment Done.

Special Notes:

RBS-OD

Nurse Signature: Akasha

Nurse Name: Akasha

Date & Time: 5/7/26 @ 2 pm.

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/07/2026

Assessment: Baby is on RAO

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the General Condition of the baby * Monitor vital signs * provide Comfortable position to the baby * maintain Ilo chart * Give 2nd hourly feed * Ensure safety	2pm	* assessed the General Condition of the baby * monitored vital signs * provided Comfortable position to the baby * maintained Ilo chart * Given 2nd hourly feeding * Ensured safety	Now baby is stable.

Re-Assessment:

Done

Special Notes:

RBS - (BD)

Nurse Signature:

yana

Nurse Name:

yamuna

Date & Time:

5/07/26 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 07/07/25 @ 8 PM

Assessment: Baby under observation (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
8 PM	→ Assess the general condition of the baby and check vital.	8:10 PM	→ assessed the general condition of the baby and checked vital.	Baby is stable
10 PM	→ Giving feeding and nappy and burping.	10:10 PM	→ Given feeding and nappy and burped.	
12 AM	→ plan for giving warm care.	12:10 AM	→ Given warm care.	
4 AM	→ Maintaining personal hygiene.	4:10 AM	→ maintained personal hygiene.	
6 AM	→ checking urine output.	6:10 AM	→ checked urine output.	
8 AM	→ Ensure safety.	8:10 AM	→ Ensured safety	

Re-Assessment:

Special Notes:

2D Echo 12m

Nurse Signature: Marthen

Nurse Name: Marthen

Date & Time: 06/7/25 @ 8 AM

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

Assessment: New born baby under observation

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the general condition	8:10AM	* Assessed the general condition	Baby is stable
10am	* monitor vitals and Record	10:10am	* monitored vitals and Recorded	
12pm	* maintain I/O chart	12:10pm	* maintained I/O chart	
2pm	* provide warm care	2:10pm	* provided warm care	
4pm	* TO do today 20 Echo HO	4:10pm	* today 20 Echo done	
6pm	* Ensure safety	6:10pm	* Ensured safety	

Re-Assessment: Re-assessment done by checking vitals

Special Notes:

Nurse Signature: Latha

Nurse Name: Latha

Date & Time: 6/7/26 @ 2pm



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Venkata Lakshmi A Department: 3rd Floor Date of Admission: 04/07/26

SITUATION	Diagnosis: <u>Thrombophilia</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area	Shift Time						
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>					
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>97.8°F</u>	<u>98.1°F</u>				
		Res:	<u>38b/m</u>	<u>40b/m</u>				
		SpO ₂ :	<u>99%</u>	<u>100%</u>				
		Pulse:	<u>140b/m</u>	<u>137b/m</u>				
		BP:	<u>-</u>	<u>-</u>				
	Fall Risk Score:	<u>-</u>	<u>-</u>					
Pain Score:	<u>-</u>	<u>0/10</u>						
Recommendations	Safety Needs:	<u>Sub WIP</u>	<u>crib</u>					
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NA</u>	<u>NA</u>					
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>					
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>					
Handed Over By Name :		<u>Martina</u>	<u>Lakshya</u>					
Signature :		<u>Martina</u>	<u>Lakshya</u>					
Date:		<u>6/7/26</u>	<u>6/7</u>					
Time:		<u>PM</u>	<u>@ 8pm</u>					
Taken Over By Name :		<u>Lakshya</u>	<u>Sushanta</u>					
Signature :		<u>Lakshya</u>	<u>sen</u>					
Date:		<u>6/7</u>	<u>6/7/26</u>					
Time:		<u>@ 8pm</u>	<u>@ 8pm</u>					

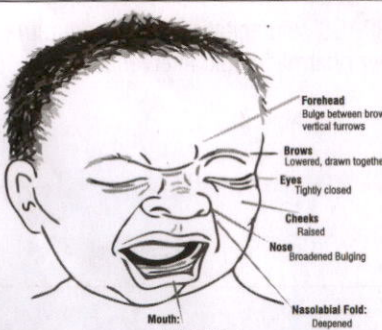
NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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



NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time	
						4/7/26 8pm	5/7/26 8am	5/7/26 2pm	5/7/26 6pm	6/7/26 10am	6/7/26 4pm			
						Procedure → RBS RBS RBS NA NA								
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	1	1	1	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			
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	1	1	1	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			
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			
 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	2	2	2	38 wks	38w 1d	38w 2d		
						Total Pain / Agitation Score	3/10	1/10	1/10	0/10	0/10	0/10		
						Intervention	FBM PRO	MAN PRO	MAN PRO	-	-	-		
						Effectiveness	Good	good	good	-	-	-		
						Signature	AT	AK	YGL	Manu Lakshy	Sw			

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.

BRADEN 'Q' SCALE

					Date :	05/7	6/7	6/2	
					Time :	8:00	10:00	8:00	
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.	2	2	2		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	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		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	2	2	2		
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		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4		
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		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	18	18	18	
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Pujy	1.000	800	

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

BAH-00650654 IP5-00175964
 Baby Of KAWSAR JAMA MOHAMED
 04-07-2026 0 Y 0 M 1 D (F)
 Dr. VENKATA LAKSHMI A



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					
	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			15	15			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	Yes			
Call device within reach	Yes	Yes			
Wheels Locked	Yes	Yes			
Room free of clutter	Yes	Yes			
Adequate Lighting	Yes	Yes			
Wheel Chair Support	NA	NA			
Other Intervention(s) Specify	NA	NA			
Nurse's Name :	Piyu	Laksh			
Signature :	Piyu	Laksh			
Date :	5/7	6/7			
Time :	8PM	8PM			



INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

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

Gest Age: Term Birth Weight: 3.082gm

Date: <u>5/7/26</u>	Date:	Date:
DOL Weight <u>2.977 kgm</u>	DOL Weight	DOL Weight
Problems: <u>Term/RDS</u>	Problems:	Problems:
Rs. Exam <u>Done</u> Vent. Setting ABG CXR	Rs. Exam Vent. Setting ABG CXR	Rs. Exam Vent. Setting ABG CXR
CVS <u>normal</u> HR <u>140bpm</u> BP <u>Map</u> Cap Refil <u>2-3 sec</u>	CVS HR BP <u>Map</u> Cap Refil	CVS HR BP <u>Map</u> Cap Refil
F/E/N <u>Good 1 day</u> T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam <u>Done</u> T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results CRP Antibiotics <u>will</u>	C/s Results CRP Antibiotics	C/s Results CRP Antibiotics
Med <u>will</u> Neuro:	Med Neuro:	Med Neuro:
Assessment <u>Done</u>	Assessment	Assessment
Plan <u>GRBS-BD</u>	Plan	Plan

BAH-00660654 IP5-00175964
Baby Of KAWSAR JAMA MOHAMED
04-07-2026 0 Y 0 M 2 D (F)
Dr. MVB Pratyush


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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CONSENT FOR FORMULA FE

Patient Name : B/O Kawsar Jama Age : 2/3 Gender : ☐ Male ☒ Female

UHID No : 66654 Reg. No. : 175964 Department : NICU Date : 01/07/2026

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

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

01/07/2026 I hereby give consent for formula feed for my child. Doctors have explained me

about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : AS

Name : MARIAM SALAM

Relationship with Patient : FATHER

Date & Time : 01/07/2026

Witness :

Signature : Abhizami

Name : Abhizami

Date & Time : 4/7/26

Doctor (who is taking the consent) :

Signature : Sneha

Name : Y. Sneha

Date & Time :

డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. రిజిస్ట్రేషన్ నెం.: విభాగము

తేదీ

నేను శ్రీ / శ్రీమతి వయస్సు సంవత్సరాలు

నా కుమార్తె / కుమారుడు రెయిన్ఫో ఆసుపత్రిలో నవజాత శిశువుల ఇంటెన్సివ్ కేర్ లో అడ్మిట్ చేసినాము మరియు (ఫార్ములా

ఫీడ్) డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుచున్నాను. డాక్టర్లు డబ్బా పాలు త్రాగించడం వల్ల కలుగు

ఉపయోగాలు, ప్రత్యామ్నాయాలు, మరియు నష్టాలు గురించి నాకు అర్థమైన భాషలో వివరించారు.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA :	4/7/26		Diagnosis :			Surgery / Procedures :			
	Allergies :					Post OP Day :				
	Date :	4/7/26	4/7/26	5/7/26	5/7/26					
	Area	N2	N2	N2	N2					
	Shift Time	2pm-8pm	8pm-8am	8 Am-2p	2pm to 8pm					
Diet :	Neo cate		Neo cate		NeoCate		Neo PPO			
Ventilation (RA, NP, NIV, VENTI)	L/F		L/F		L/F		RA			
INVASIVE LINES	1.	06-①		04-①		06-①				
	2.									
	3.							NA		
	4.									
ASSESSMENT	Infusions / Transfusions	NA		NA		NA		NA		
	PU Prophylaxis	NA		NA		NA		NA		
	DVT Prophylaxis	NA		NA		NA		NA		
	Vitals	BP								
		PR	159b/m		150b/m		175b/m		136b/m	
		RR					37b/m		36b/m	
		SpO ₂	100%		100%		98%		98%	
		Temp	36.5°C		36.5°C		36.5°C		36.5°C	
	Pain Score	1/10		2/10		1/10		1/10		
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert		Alert		Alert		Alert		
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact		Intact		Intact		Intact		
	Restraints If any	NA		NA		NA		NA		
	Fall Risk (Vulnerable (Y/N) if yes score)	yes		yes		yes		yes		
		Moving		moving		moving		moving		
ADL (Dependent / Non-Dependent)	dependent		dependent		dependent		dependent			
Critical Lab Test / Values (if any)	NA		NA		NA		NA			

RECOMMENDATIONS	Investigations Procedures	Date :	4/7/26	4/7/26	5/7/26	5/7/26		
		Area	N2	N2	N2	N2		
		Shift Time	2pm-8pm	8pm-2am	8AM-2P	2pm-8pm		
		Ordered / Planned	RBS	RBS	RBS	RBS		
			BD	BD	BD	BD		
		Due	{ NA }	NA	{ NA }	{ NA }		
		Reports Pending	{ NA }	NA	{ NA }	{ NA }		
		Referrals (If any)	{ NA }	NA	{ NA }	{ NA }		
Remarks (Special Interventions like, Drainage Tube flushing etc.)	NA	NA	NA	NA				
Handed Over By Name :	Lokesh	Madhane	Akanksha	Yamuna				
Signature :	[Signature]	[Signature]	[Signature]	[Signature]				
Date :	4/7/26	5/7/26	5/7/26	5/7/26				
Time :	@ 8pm	8am	@ 2pm	8pm				
Taken Over By Name :	Madhane	Akanksha	Yamuna					
Signature :	[Signature]	[Signature]	[Signature]					
Date :	4/7/26	5/7/26	5/7/26					
Time :	9pm	@ 8AM	@ 2pm					

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660654 IP5-00175964 Baby Of KAWSAR JAMA MOHAMED 04-07-2026 0 Y 0 M 0 D 23 H (F) Dr. VENKATA LAKSHMI A 		Date & Time of Admission 4/7/26 @ 10:30 am	Date & Time of Transfer Order 5/7/26 @ 8:40 pm
		Transfer Ordered by Dr. prathyesh	Reason for Transfer observation.
From Unit NICE	To Unit WARD	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 45	Number of Imaging Films 01	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Diapers	→ 1 pack	
2.	Wipes	→ 1 pack	
3.	Dwater 10ml	→ 35	
4.	Feeding bottle	→ 2	
5.	Nan pro	→ 1	
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐ 2D Echo pending system wise			
Name & Signature of Person who is Transferring Madamma		Name of Person Ordered Transfer Dr. Neethu.	
Patient & Clinical Records Received by : Neethu 5/7/26 @ 10pm			
Date & Time of Patient Received :			

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

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

WBG- (2)
2D Eno- (1)
x-ray (1)