

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174331      Admit Date : 26-May-2026      Admit Time : 08:42 AM      UHID : BAH-00657286

Patient Details :

Patient Name : Baby Of RAVALI REDDY S      Age : 0 D  
Guardian : Mr ADITHYA REDDY G      DOB : 26-05-2026 07:13 AM  
Gender : Male      Religion :  
Occupation :      Martial Status : Single  
Address (H) : VILLA NO 3, LUMBINI SPRING, PRESIDENTIAL      Phone No : 9063511111/ 9063511111  
VILLAS, Gachibowli Hyderabad Telangana      E-mail : adithyareddy\_gorupalli@yahoo.com  
INDIA 500032

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 : Mr ADITHYA REDDY G      Relationship : Father  
Contact Address :      Phone No : / 9063511111

*Adithyareddy*

Signature

Doctor Details :

Doctor Name : Dr. DINESH KUMAR CHIRLA      Specialisation : NEONATOLOGY  
Referral Doctor :      Phone No :  
Co-Consultant :

Payment Details :

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





BAH-00657286 IP5-00174331  
Baby Of RAVALI SUNKIREDDY  
28-05-2026 0 Y 0 M 1 D (M)  
Dr. DINESH KUMAR CHIRLA



### ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_

UHID No. : \_\_\_\_\_ IP No. : \_\_\_\_\_ Consultant: \_\_\_\_\_ Dept : \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Time : \_\_\_\_\_ Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

### WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

### Cross Consultation Visit

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









## NEONATAL IN-PATIENT MEDICAL RECORD

### ADMISSION INFORMATION

Mother's Name : Ravali Reddy 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 : 3/0 Ravali Reddy Mother's Blood Group : O+ve  
 Gender :  M  F Blood Group : O+ve Birth Weight (gms) 3.162kgs Length (cms) : .....  
 Date of Birth : 26/5/26 Time of Birth : 7:13AM OFC (cms) : .....  
 Place of Birth : RCH - B Estimated Gesth Age : 39 weeks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 31 Ht : ..... Wt : ..... BMI: ..... Married Life : ..... LMP : 19/8/25 EDD : 1/6/26

Conception : Spontaneous or with Rx. : .....

Booked at what GA : 3wks AN Steroids Drugs / Doses : .....

Last Scans Details : 17/5 - 35w, breech, 2.32kg, 14cm, Doppler

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 : (N)  
**H/o Hypothyroidism** : when diagnosed ? Medication?  
 Any other Chronic Medical Problems, when detected drugs ? Fibroid - intramural 4x8cm Ant wall  
 ( 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**

G: 1 P: 0 A: 0 L: 0

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
	<u>primi</u>					

**PERINATAL HISTORY**

Treating Obstetrician : Dr. Sruuti Hospital : Reth - B  Inborn  Outborn

<p><b>Duration of Labour</b></p> <p>First stage (&gt; 18 hours sig) <u>vacuum assisted</u></p> <p>Second stage (&gt; 2 hours after dilation) <u>Delivery</u></p> <p>LSCS : <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication : .....</p> <p>Specify the reason : .....</p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL : .....</p> <p>Resuscitaion : <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Fetal bradycardia (+)</u></p> <p>Cord ABG : .....</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc : .....</p>
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**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
	<u>1</u>	<u>2</u>	
	<u>2</u>	<u>2</u>	
	<u>2</u>	<u>2</u>	
	<u>2</u>	<u>2</u>	
<b>TOTAL</b>	<u>9</u>	<u>10</u>	

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

**Snapee II Score**

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

**POSTNATAL / HISTORY OF PRESENT ILLNESS**

Chief Complaints :



Equipment check done



Baby cried immediately  
delayed cord clamping done w/o s/c



Routine newborn care done  
by U/E K. O. S. M. J. M.



Reached target sats by 5 min



Developed distress of (O<sub>2</sub>)  
grunt (+) s/c (+) r/c (+)  
oral secretions (+)



suctioning done

Investigation details in previous Hospital :

DR CPAP given

cord gas →



shifted to NICU for

Feeding History :

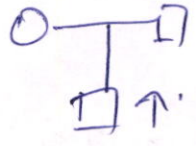
observation

BAH-00657286  
Baby Of RAVALI REDDY S  
28-05-2028  
Dr. DINESH KUMAR CHIRLA  
IP5-00174331  
O Y O M O D 3 H (M)



Past His

Family History :



Socio Economic History :

**GENERAL EXAMINATION ON ADMISSION**

General Disposition :

VITALS : Temperature : 36.4 HR : 138 RR : 68 NIBP : CFT : 32cl

Color of the extremities : pink

Jaundice : Pallor : SpO2 : 99% on CPAP

ANTHROPOMETRY: Birth Weight : 3.162 Length : HC : Present Weight :

Ponderal Index : (AGA) SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :

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

caput (+)

FACIES :

(Any Facial  
Dysmorphism)

(N)

NECK and  
CLAVICLES :

Range of Motion :  
Asymmetry :  
Masses :

(N)

EYES :

Symmetry :  
Red Reflex :  
Discharge :

(N) → to be checked

EARS, NOSE  
MOUTH and  
THROAT :

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

(N)

THORAX and  
BREASTS :

Shape of Thorax :  
Position of Nipples and Number :

(N)

ABDOMEN and  
UMBILICUS :

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

(N)  
2A + 2W

GENITILIA :

Labia / Hymen :  
Testicles/penis :  
Anus :

B/C descended

HERNIAL ORIFICES

TRUNK and SPINE :

(N)

SKIN LESIONS :

EXTREMITIES :

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: 68 SCR ICR See - Saw breathing: apunt (+)  
 Scoring of respiratory distress if present (Silverman or Downe's): 4.  
 Mention if baby is on:  Hood box  CPAP  Ventilator  
 Settings: DR CPAP PEEP 5cm  
 SpO<sub>2</sub>: ..... Auscultation: ..... Breath Sounds: ..... Added Sounds: .....

**CARDIOVASCULAR SYSTEM :**

HR : 148 BP : ..... Precordial Activity : .....  
 Femoral Pulses : (+) Murmurs : .....  
 Other Peripheral Pulses : ..... Signs of Cardiac Failure : .....

**ABDOMEN:**

Shape : (+) Hernia orifice : .....  
 Palpation : (+) Anal Patency : ~~+~~ (+)  
 Palpable masses : (+) Umbilical Cord : 2A + 3U  
 Abdominal girth : ..... First urine passed : ✓  
 Meconium passed : ✓

**NERVOUS SYSTEM:**

Higher intellectual functions (Sensorium) : .....  
 State of wakefulness : .....  
 Prechtle Score : .....  
 Nerves : very tone/activity good

**MOTOR SYSTEM:**

Passive Tone : .....  
 Active Tone : .....  
 Neonatal Reflexes : .....  
 Grasp :  Palmar  Plantar  Sucking  Rooting  Crossed adductor : .....  
 Moro's : ..... DTR : .....  
 ATNR : ..... Skull and Spine : .....



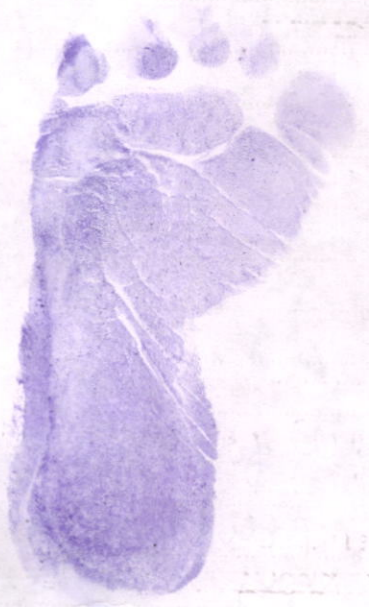
Patent sticker

Any Congenital Anomalies : .....

Diagnosis : Term / AUA / male / vacuum assisted <sup>vaginal</sup> ~~normal~~ delivery /  
Primi / WDM on diet / delayed transition

**FOOT PRINTS**

Left Side :



Right Side :



**Resident Doctor :**

Signature : *[Signature]*  
Name : Dr. Adhwanayya  
Date & Time : 26/5/26 8AM

**Consultant :**

Signature : *[Signature]*  
Name : Dr. DINESH KUMAR CHIRLA  
Reg. No. 66227  
Dr. Dinesh Chir -  
Date & Time : 26/5/26 9.30 a

**PLEASE FILL UP THE FOLLOWING DETAILS**

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

**AT THE TIME OF TRANSFER TO THE WARD**

Final Diagnosis : .....

Neonatal condition at the time of Transfer: .....

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

Any Oxygen requirement : .....

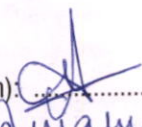
Systemic : .....

Medications : .....

Plan during ward follow up : Ran  
 ① Shift to NICU for observation  
 ② In case of T distress,  
 - chest xray  
 - CPAP  
 - on feeds

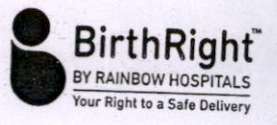
Feeding Plan at the time of shifting :  
 ③ If distress settles, give 2 paladey  
 & shift to mother's side

Screenings done during NICU Stay :  
 NSG : .....  
 Hearing Screen : .....  
 ROP : .....  
 TFT : .....  
 NP2 : .....  
 ④ Repeat gas @ 9AM + WRBS  
 ⑤ Full feed WRBS HOL 3, 6, 12,  
 24, 48.  
 ⑥ Clinical jaundice assessment  
 @ 24HOL  
 ⑦ 48HOL - SBR + NBS  
 - OAE

Doctor Signature (Handover Given):   
 Doctor Name: Dr. Adwainy  
 Date & Time: 26/5/20 8AM

Doctor Signature (Handover Taken): .....  
 Doctor Name: .....  
 Date & Time: .....

AH-00657286 IP J-00174331  
 SIBY OF RAVALI SUNKIREDDY  
 05-2026 0 Y 0 M 1 D  
 DINESH KUMAR CHIRLA



## NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Bh. Kavale Mother's Name: \_\_\_\_\_  
 Date of Birth: 26/5/26 Time of Birth: 7:18 AM Gender:  Male  Female  
 Birth Weight: 3.162 Kgs HC: 32 cm Length: 50 cm  
 Meconium in Liquor:  Yes  No Cried at Birth:  Yes  No  
 Term / Pre-term / Post-term: \_\_\_\_\_  
 Resuscitated:  Yes  No Blood Group: Mother: O+ve Baby: \_\_\_\_\_  
 Feeding:  Breast Feeding  Formula  Both First Feed Time: \_\_\_\_\_

AFFIX MOTHER'S IDENTIFICATION LABEL

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

**Physical Assessment of New Born:**

Temp: 38.0 °C HR: 148 /Min RR: 48 /Min BP: \_\_\_\_\_ SpO<sub>2</sub>: 100%  
 Pain Score: 0 (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: Srinivas

Signature: [Signature]

Date & Time: 26/5/26 @ 9 AM

BAH-00657286 IP5-00174331  
 Baby Of RAVALI REDDY S  
 28-05-2026 0 Y 0 M 0 D 3 H (M)  
 Dr. DINESH KUMAR CHIRLA

①



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
<u>26/5/26</u>	seen by Dr. Dinesh	<p>Plan</p> <ul style="list-style-type: none"> <li>① oral feeds</li> <li>② If worsening distress               <ul style="list-style-type: none"> <li>- xray</li> <li>- gas</li> </ul> </li> <li>③ IV = 60 ml/kg/day 16ml Q2H</li> </ul> <p>Noted by Vishnu Priga 019011</p>
<u>28/5/26</u> 1:30 PM		<p><del>chok or ok 26/5/26 @ 10 AM</del></p> <p><del>Send</del></p> <p><del>CBP ?</del></p> <p><del>CRP ?</del></p> <p><del>Noted by</del> <del>Vishnu Priga</del> <del>019011</del> <del>26/5/26 @ 1:10 PM</del></p>



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## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 2:15pm	Afternoon Round	
	FHOC   39 weeks   362g	
	on RA	
	tachypnea (+)	Plan
	PR - 146/min RR - 68/min SpO <sub>2</sub> - 96% CRT - < 3 sec	→ TV - 60 ckt/day 10ml 2nd half paladay feed
	P/A - soft	→ <del>Send</del> CBP, CRP, BGT do Trace
	passed urine Stool - not passed	→ w/f tachypnea inform if + work of breathing
		→ monitor vitals
	Poojithe	→ Noted by Ushnupriya 019011 26/5/26 @ 2:15pm



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26	14HOL / Term / CDM on diet	Plan
9pm.	wt. 3162 gms	1. Continue to 20 cals/kg/day 16ml @ 2H Palladay feeds
on loom cart	2. SpO <sub>2</sub> - 95% HR - 117/mg RR - 56/mg	3. Monitor vitals
Tachypnoea Reduced.	compared to afternoon.	4. w/f Respiratory distress
Vaccinations - not done	5. Trace baby blood group.	seen by Dr. N. Perthuisen N. Perthuisen
26/5/26	11:30pm	Plan: Breast the baby
	Note by Dr. Aswathy	26/5/26 @ 9pm



BAH-00657286 IP5-00174331  
 Baby Of RAVALI REDDY S  
 26-05-2026 0 Y 0 M 0 D 3 H (M)  
 Dr. DINESH KUMAR CHIRLA

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**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
27/5/26 9:30 AM	seen by Dr. Pradyumn	<p>Plan</p> <ol style="list-style-type: none"> <li>cont cub care</li> <li>URBS RD till 48 HZ</li> <li>shift to room once vitals are stable</li> <li>vaccination in room BCG, OPV, HepB</li> <li>48 HZ - SBR</li> </ol> <p>- NBS - OAE</p>
		<p>Note by Bushra 27/5/26 @ 9 AM Pradyumn</p> <p>Dr. Pradyumn</p>
27/5/26 9:50 AM	seen by Dr. Dinesh	<p>Plan</p> <ol style="list-style-type: none"> <li>Shift to room.</li> <li>trial of direct feeds</li> <li>7m - NBS + SBR</li> </ol> <p>- OAE</p> <p>4 vaccine <del>today</del> today</p>
		<p>Dr. Dinesh</p> <p>Dr. Dinesh</p> <p>Note by Bushra 27/5/26 @ 10 AM</p>

BAH-00657286 IP5-00174331  
 Baby Of RAVALI REDDY S  
 26-05-2026 0 Y 0 M 0 D 3 H (M)  
 Dr. DINESH KUMAR CHIRLA

(6)

Rainbow<sup>®</sup>  
 Children's  
 Hospital  
 It takes a lot to treat the little.

BirthRight<sup>™</sup>  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>27/5/26</del> 12pm	<del>Shifting Note</del>	
	on RA	
	hemodynamically stable	Plan
	periodic breathing	→ DBF 2nd hely
		→ 25 paladay juds
		→ 20-25 ml 2nd hely
		→ BCG, OPV, HepB today
		→ NBS
		SRE } 48hr
		OAE }
		→ monitor vitals
	A Poplite	
		note
		by
		Sis. Bashing 27/5/26 @ 12PM



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
28/5/26 9:15 AM	Seen by 50 HOL	DR. Dinesh
	<u>SBR-9.2 @ 48 HOL</u>	Plan:- - TCBR evening @ - OAE today.
		<del>NB. Dr. Suresh 28/5/26 @ 9:30 AM</del>
28/5/26	<u>Lactation notes.</u>	
	<p>37 Lactation counseling done.          position shown practically          Colostrum as seen Baby          is latching well. feed          advanced with deep          latch more than 20-25 in          each side. Adv. DRF          mother is having short nipple -          relation          (Achalani)</p>	<p><del>NB Dr. Suresh 28/5/26 @ 9:30 AM</del></p>



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 Baby Of RAVALI REDDY S  
 28-05-2026 0 Y 0 M 0 D 3 H (M)  
 Dr. DINESH KUMAR CHIRLA



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

# INFANT (<1 year)

## Children's Observation & Early Warning Scoring Chart

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

**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

### EARLY WARNING SCORE: CHILDREN'S UNIT

① 26/5/26

Date: ..... Time: 9 10 1 3 5 7 10 1 4 8

Doctor/Nurse/Family Concern? AM PM PM PM PM PM PM AM AM AM

Temperature (F)	104										
	103										
	102										
	101										
	100	36.6°C	36.6°C	36.6°C	36.6°C	36.6°C	36.5°C	36.6°C	36.5°C	36.4°C	
	99										
	98										
	97										
	96										
	95										
94											

Heart Rate (bpm)	190										
	180										
	170										
	160										
	150										
	140										
	130										
	120										
	110										
	100										
Blood Pressure (mmHg) *	130										
	120										
	110										
	100										
	90										
	80										
	70										
	60										
	50										

Exib. case

Sp. Rate (bpm) (Over 1 Minute) *	70										
	60										
	50										
	40										
	30										
	20										
	10										

Resp Distress	Mod/ Severe None / Mild										
---------------	-------------------------	--	--	--	--	--	--	--	--	--	--

Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)	99%	99%	98%	99%	100%	99%	98%	96%	99%	93%
----------------------------------	--------------------------------	-----	-----	-----	-----	------	-----	-----	-----	-----	-----

Conscious Level	Normal / Altered										
GCS *		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
-------------	------------------------	---	---	---	---	---	---	---	---	---	---

Pain Score		0	0	0	0	0	0	0	0	0	0
Observer's Initials		DS	DS	DS	DS	DS	DS	DS	DS	DS	DS

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

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

# CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

## INSTRUCTIONS:

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

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

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

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

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION:</b> 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>B</b>	<b>BACK GROUND:</b> 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)
<b>A</b>	<b>ASSESSMENT:</b> 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.
<b>R</b>	<b>RECOMMENDATION:</b> I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



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

**EARLY WARNING SCORE: CHILDREN'S UNIT**

28/5/21

Date: 28/5 Time: 8 AM 10 AM 12 PM 2 PM 4 PM 6 PM 8 PM

Doctor/Nurse/Family Concern? AY AY

Temperature (F)	104									
	103									
	102									
	101									
	100									
	99									
	98									
	97									
	96									
	95									
94										

Heart Rate (bpm) and Blood Pressure (mmHg) *	190									
	180									
	170									
	160									
	150									
	140									
	130									
	120									
	110									
	100									

Heart Rate (Number) 142 144 146 158

Resp. Rate (bpm) (Over 1 Minute) *	70									
	60									
	50									
	40									
	30									
	20									
	10									

Resp Rate (Number) 135 142 136 142 148 139 142 148

Resp Mod/ Severe Distress None / Mild

Receiving O<sub>2</sub>(l/min) O<sub>2</sub>Saturations (%) 99% 100% 99%

Conscious Level Normal / Altered

GCS \* 9/5 9/5 9/5 9/5 13/15 13/15 13/15 13/15

TOTAL SCORE Number of shaded boxes 0 0 0 0 0 0 0 0

Pain Score 1 1 1 1 1 1 1 1

Observer's Initials

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

\* 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.
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Date	Time	Early Warning Score	Date	Time	Name

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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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
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<b>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



# INFANT (<1 year)

## Children's Observation & Early Warning Scoring Chart



### EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 25/5/26 Time: 11AM 3PM

Doctor/Nurse/Family Concern? \_\_\_\_\_

Temperature (F)	104		
	103		
	102		
	101		
	100		
	99		
	98	<u>98.2</u>	<u>98.5</u>
	97		
	96		
	94		

Heart Rate (bpm) and Blood Pressure (mmHg) *	190		
	180		
	170		
	160		
	150		
	140	<u>140</u>	<u>140</u>
	130		
	120		
	110		
	90		

**Note:**  
BP does not score in early warning scoring

Heart Rate (Number) 140 140

Resp. Rate (bpm) Over 1 Minute *	70		
	60		
	50		
	40	<u>40</u>	
	30		
	20		
	10		

Resp Rate (Number) 40 40

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 100% 99%

Conscious Level Normal Altered

GCS \*

<b>TOTAL SCORE</b>		
Number of shaded boxes	<u>0</u>	<u>0</u>
Pain Score	<u>0</u>	<u>0</u>
Observer's Initials	<u>[Signature]</u>	<u>[Signature]</u>

<b>ACTIONS</b>	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:

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<b>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00657286 IP5-00174331  
 Baby Of RAVALI REDDY S  
 28-05-2026 0 Y 0 M 0 D 3 H (M)  
 Dr. DINESH KUMAR CHIRLA



①



# FLUID CHART

TV = 60 cc/kg/day  
 B.Wt = 3.4 kg  
 TF = 16 ml

Sheet No. : ①

28/5/26

- 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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am	Nanpro	16ml				-			9ml	0		
	11:00 am												
	12:00 pm	Nanpro	16ml				-			11ml			
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm	Nanpro	16ml				-			8ml			
	03:00 pm												
	04:00 pm	Nanpro	16ml				passed			9ml			
	05:00 pm												
	06:00 pm	Nanpro	16ml				-						
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm	Nanpro	16ml				Passed			10ml			
	10:00 pm												
	11:00 pm	Nanpro	16ml				Passed			8ml			
	12:00 am												
	01:00 am	Nanpro	16ml				-			11ml			
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am	Nanpro	16ml				-			10ml			
	04:00 am												
	05:00 am	Nanpro	16ml				-			9ml			
	06:00 am												
	07:00 am	Nanpro	16ml				-			11ml			
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake** 176ml = 56.7 cc/kg/day

**Total 24 hrs. Output** 96 = 29 cc/kg/day

27/5/26

**FLUID CHART**

Sheet No. : 2

TV = 80cc/kg/day  
 Bwt 3.1  
 TF = 22ml

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
27/5/26	08:00 am												
	09:00 am	NAN P80	20ml				passed			10ml			
	10:00 am						not passed						
	11:00 am	DBF + NAN P80	20ml										
	12:00 pm												
	01:00 pm		DBF										
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm		FF-25ml							✓			
	03:00 pm												
	04:00 pm												
	05:00 pm		DBF				✓						
	06:00 pm		FF-25ml										
	07:00 pm												
<b>Total Intake :</b>			Taken			<b>Total Output :</b>					Paused		
	08:00 pm												
	09:00 pm		DBF FF-25ml				✓			✓			
	10:00 pm												
	11:00 pm												
	12:00 am		DBF FF-25ml				✓						
	01:00 am												
<b>Total Intake :</b>			Taken			<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am		DBF FF-25ml				✓			✓			
	05:00 am												
	06:00 am												
	07:00 am		DBF				✓						
<b>Total Intake :</b>			Taken			<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>					U-4 M-6		

AH-00657286 IP5-00174331  
 S/o of RAVALI SUNKIREDDY  
 05-2026 0 Y O M 1 D M)  
 DINESH KUMAR CHIRLA



# FLUID CHART

Sheet No. : 3

- 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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
28/5	08:00 am	FF 25ml					✓				1		
	09:00 am								✓		NO		
	10:00 am										IV	Suresha	
	11:00 am	DBF									capule		
	12:00 pm	FF 25ml											
	01:00 pm												
Total Intake : 50						Total Output :							
	02:00 pm	DBF					✓				1		
	03:00 pm	FF 25ml					✓						
	04:00 pm										NO	Suresha	
	05:00 pm										IV		
	06:00 pm										capule		
	07:00 pm												
Total Intake : 100ml						Total Output : 100ml							
	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

Patient Sticker

# FLUID CHART



Sheet No. : .....

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
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												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

Patient Sticker

# FLUID CHART

Sheet No. : .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>						<b>Total 24 hrs. Output</b>							

Patient Sticker

# FLUID CHART



Sheet No. : .....

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