

[illegible]

ADMISSION SHEET



Registration Details :

Admission No : IP5-00175945 Admit Date : 03-Jul-2026 Admit Time : 11:07 PM UHID : BAH-00660641

Patient Details :

Patient Name : Baby Of TEJASWINI GANNAMANENI Age : 0 D
Guardian : Dr. SRUJITH NALLA DOB : 03-07-2026 10:25 PM
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : VILAA NO. 319,PALM MEADOWS Kompally
Hyderabad Telangana INDIA 500014 Phone No : 9966418666/ 7842952195
E-mail : NOMAIL@GMAIL.COM

Admission Details :

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

Contact Details :

Name : Dr. SRUJITH NALLA Relationship : Father
Contact Address : VILAA NO. 319,PALM MEADOWS Kompally
Hyderabad Telangana INDIA 500014 Phone No : 9966418666 / 9966418666

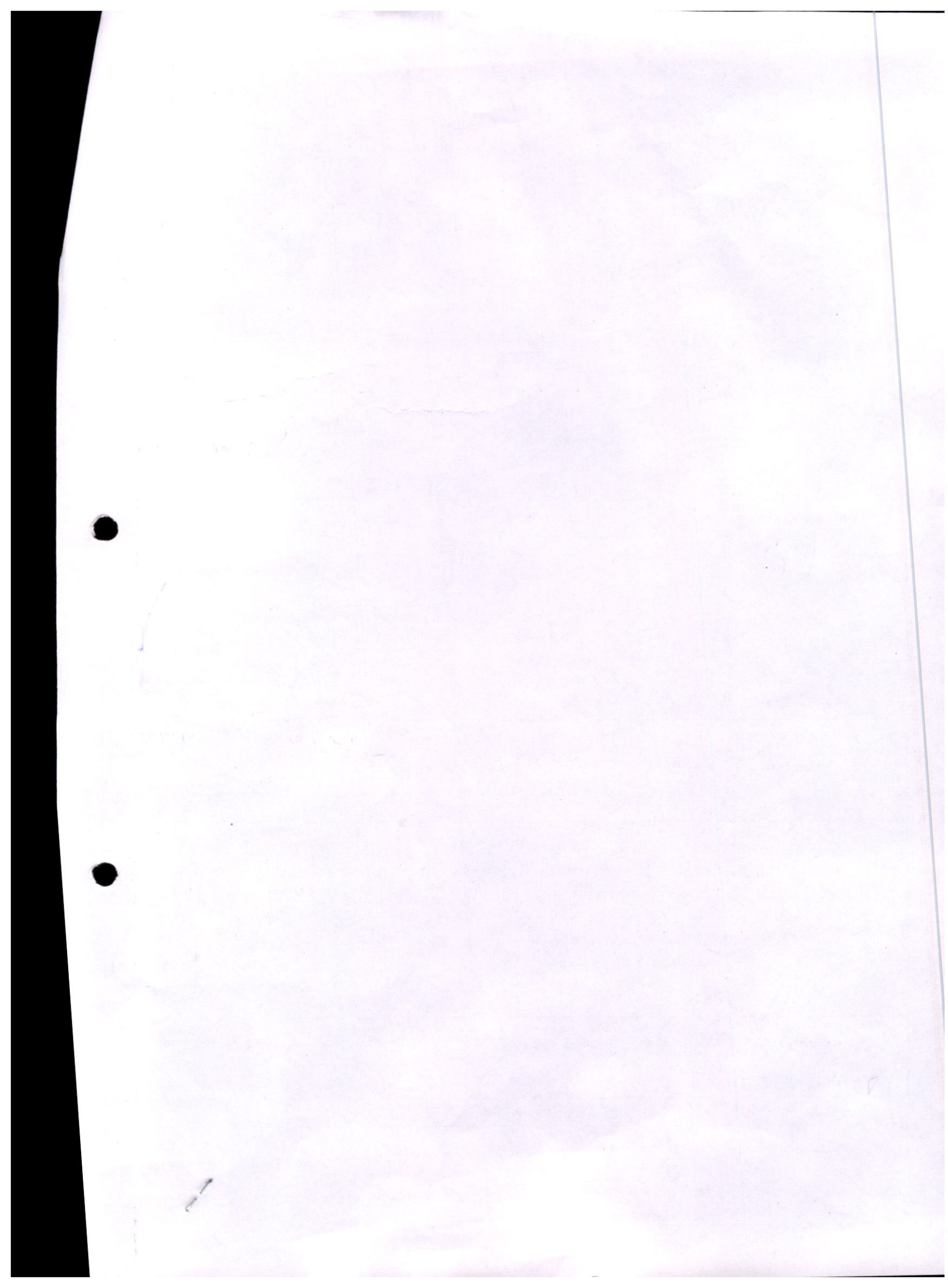
Signature

Doctor Details :

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

Payment Details :

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





NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

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

BIRTH INFORMATION

Name : B/o Tejaswini Mother's Blood Group : O positive
Gender : ☐ M ☒ F Blood Group : O+ Birth Weight (gms) : 3132g Length (cms) : 33cm
Date of Birth : 3/7/26 Time of Birth : 10:25pm OFC (cms) : 4.9cm
Place of Birth : RCH - Banjara Estimated Gesth Age : 38+1 wks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 35y Ht : Wt : BMI : Married Life : LMP : 4/10/25 EDD : 15/7/26

Conception : Spontaneous or with Rx :

Booked at what GA : IVF conception 2nd cycle Steroids Drugs / Doses :

Last Scans Details : 11/6/26 → 35+1 wks, cephalic, 2425g, AFI - 9.6cm.
Doppler - (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 : 9.6cm

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

Controlled or not, recent values, HbA1 values :

GDM on diet + insulin

Compliance with Rx :

Scans : LGA, TIFFA, Fetal Echo :

H/o Hypothyroidism : when diagnosed ? Medication?

H/o Hypothyroid : 4 yrs

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

G : 2 P : A : 1 L :

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1.	101	Conception, Spont.	expulsion, PROM, chorioamnionitis			
		↓ quadruplets → reduced	G at			
2.	PP.					

PERINATAL HISTORY

Treating Obstetrician : Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☒ Emergency Indication : NPL

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
8	10	10

TOTAL

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

Snapee II Score

Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



equipment check done.

↓
baby delivered via Em-LSCS.

↓
baby CABS

↓
Dried & secretions cleared

↓
Cord clamped & cut - 20A, 10V @.

↓
Suj. vit K inj IM given.

↓
Uneventful transition

↓
Shifted to mother's side.

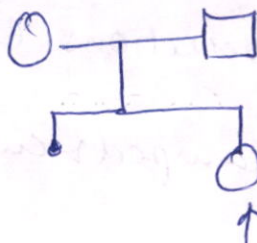
DCC @
30secs

Investigation details in previous Hospital :

Feeding History :



Family History :



Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Active

VITALS : Temperature : 36.5°C HR : 154 RR : 52 NIBP : CFT : <3 sec

Color of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 95%

ANTHROPOMETRY: Birth Weight : 3132g Length : HC : Present Weight :

Ponderal Index : AGA : V SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :
Fontanelles :
Sutures :
Shape / Moulding : caput Ⓢ
Edema / Bruising :
Size - (H.C.) :

FACIES :
(Any Facial
Dysmorphism)

Ⓝ

**NECK and
CLAVICLES :**

Range of Motion :
Asymmetry : } Ⓝ
Masses :

EYES :

Symmetry :
Red Reflex : TO be checked
Discharge :

**EARS, NOSE
MOUTH and
THROAT :**

Ear set / Shape :
Periauricular Pits / Tags :
Nasal shape / Patency :
Palate :
Gums :
Lips :
Tongue : } Ⓝ No cleft

**THORAX and
BREASTS :**

Shape of Thorax :
Position of Nipples and Number : Ⓝ

**ABDOMEN and
UMBILICUS :**

Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump : 2UA, 1VV Ⓢ
Discharge :

GENITALIA :

Labia / Hymen : Ⓝ female genitalia noted.
Testicles/penis :
Anus :

HERNIAL ORIFICES

free

TRUNK and SPINE :

Ⓝ

SKIN LESIONS :

No

EXTREMITIES :

Fingers / Toes :

Deformities :

Hip Joint Examination :

Arms / Legs :

Mobility :

Ⓝ



SYSTEMIC EXAMINATION

Breathing Pattern : ☐ Regular ☒ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 52 SCR / ICR / See - Saw breathing :

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

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

Settings :

SpO₂: 95.1 Auscultation: BAE ⊕ Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM:

HR : 152 BP :

Femoral Pulses : B/L equal.

Other Peripheral Pulses : ⊕

Precordial Activity : ⊕

Murmurs : No

Signs of Cardiac Failure : No

ABDOMEN:

Shape : ⊕

Palpation : Soft

Palpable masses : No

Abdominal girth :

Hernia orifice : free

Anal Patency : patent

Umbilical Cord : 2vA, 1v ⊕

First urine passed : No

Meconium passed :

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves : C/T/A - good.

MOTOR SYSTEM:

Passive Tone :

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR :

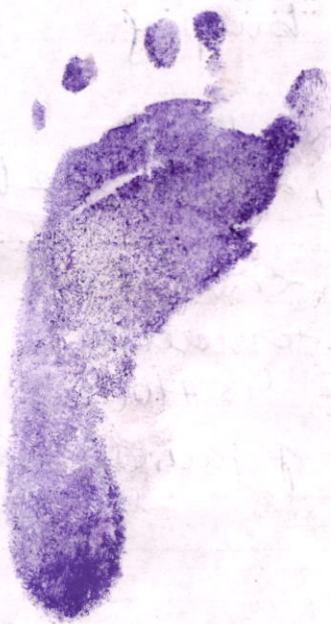
ATNR : Skull and Spine :



Diagnosis : Doc-1 / Term / AGA / Female / GDM / Hypothyroid
CIAB

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : [Signature]

Name : Dr. Poojitha

Date & Time : 3/7/26 10:36 pm

Consultant :

Signature : [Signature]

Name : Dr. VENKATALAKSHMI.A

Date & Time : Reg. No: 50115

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 : 1) DBF 2nd wely flb bumping

Medications : 2) keep baby warm

3) Send cord blood for BCIT
4) GLBS - 1, 3, 6, 12, 24, 48, 72h
post feed post feed

inform if $< 50 \text{ mg/dl}$

5) BCG, OPV, HepB tomorrow

6) SBR, NBS, OAE @ 48 HOC -

Plan during ward follow up : 7) Clinical assessment of jaundice @ 24 HOC

Feeding Plan at the time of shifting :

First feeding time : 10:40 to 10:55 pm

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:



Signature and Date :

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 9:00am	CSIB Resident	
	10HOL 38 ⁺ 1 LSCS IVF conception output + 1st Hypertension 3132g Fch 2nd c/de LSCS cephalic GDM on insulin	
	Baby on room air	Plan
		① DBF 2hly
		② Vaccination today Given BCG, OPV, Hep B, Hib
		③ Lactation review
		④ TCBR @ 10:20 ^{am} today
	Euthermic - Pink	
	Euglycemic - GRBS 63mg/dl	
	B wt: 3.132kg 3.1% ↓	⑤ SBR NBS OAT } TIm 10:30pm.
	Twt: 3.028kg	⑥ monitor GRBS 3hly.
	Tone } good	
	cy }	
	activity }	
	CRT < 2sec	
	no Resp distress	

Dr. VENKATALAKSHMI A
 Reg. No: 50175



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7 9:30am	<u>Lactation care plan:</u> - Lactating - Well formed breast and nipples - Colostrum seen - Suck good, but coming off the breast frequently. <u>Schmi:</u> - Direct breast feeding - Dem for deep latch as demonstrated - Make baby suck for 15-20 min on each side - Demand feeding not exceeding 2-2 1/2 hrs	
4/7/26 5:00pm	CS/B Resident 18 HOL/ 38⁺1 ^{Em} LSCS/IVF conception Baby on room air U/v Euthermic-Pink M/✓ Euglycemic Twl ! 3028 tone } cy- } good activity }	Caput/GDM on gest insulin/hypothyrin <u>Plan</u> ① DBF 2hly ② SBR NBS } T/M 10pm OAT } ③ warm care

PROGRESS NOTES AND DOCTOR'S ORDER

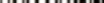
Date & Time	Progress Notes	Doctor's Order
5/7/26 4:30pm	Afternoon rounds	
	Baby on Room air cry Tone Activity } Good	plan
	Hemodynamically stable Sucking: Good CRT > 3 sec Passed urine & stool passed to	1. DBF 2nd hour fb sucking 2. Warmth care 3. vital monitoring 2nd hour 4. SBE NB } 2:10pm OAE }
		If mother discharging today then do the above test on followup. Clinical assessment of jaundice before discharge.
		Sy Sai

Date & Time	Progress Notes	Doctor's Order
5/7/26 9pm	Physical assessment of Jaundice @ 46 HCL 13.9mg/dL Wt loss → 8.1.	plan 1. Start SSP7 with eye and genital care 2. Measured feed 25 DRF / FF 25-30ml @ 2H 3. w/f urine output 4. vital monitoring 3rd hourly Noted by Dutta. <i>Sky</i> Sai



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 8:00am	S/B Resident	
	G A HOL 38 ⁺ Em IVP caput GDM 3132 g	
	Baby on room air	Plan
m/ot B/ot	U ✓ m ✓	① DBF 2huly + 25ml FF 2 nd huly
	Icterus ⊕	② SSPT to continue
	Twt → 2.864 kg (8.5% ↓)	E eye & genitals Concled
	GRBS → 93 mg/dl	③ warm care
	Cng } Tone } good actively }	④ SBR } NBS } today OAE } 8:00pm
	Peripheries warm	sohle
		/
		blake
		OAE - Newborn hearing Screening Bilateral responses are Present - Bilateral Pass



Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00660641 IP5-00175945
Baby Of TEJASWINI GANNAMANENI
03-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. VENKATA LAKSHMI A



C. 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

Date: 3/8/24 Time: 11pm

Doctor/Nurse/Family Concern?

Temperature
(F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



9/7/26

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

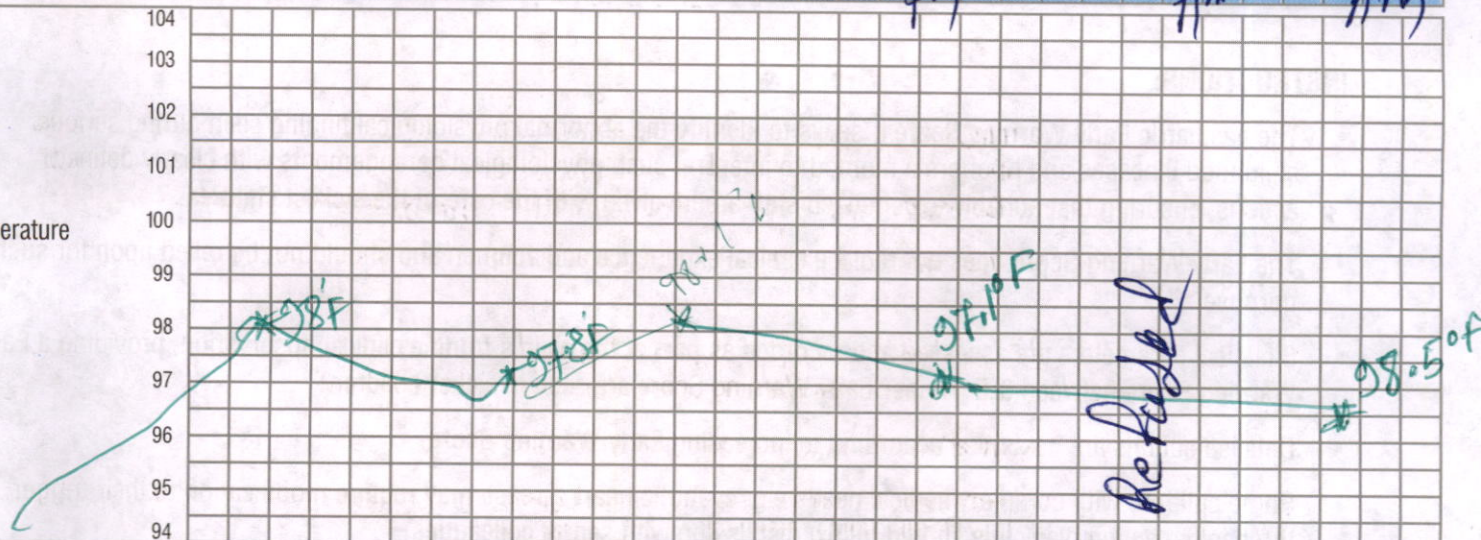
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 10AM 3PM 6PM 10 PM 2 AM 6 AM

Doctor/Nurse/Family Concern?

Temperature
 (F)

104
103
102
101
100
99
98
97
96
95
94



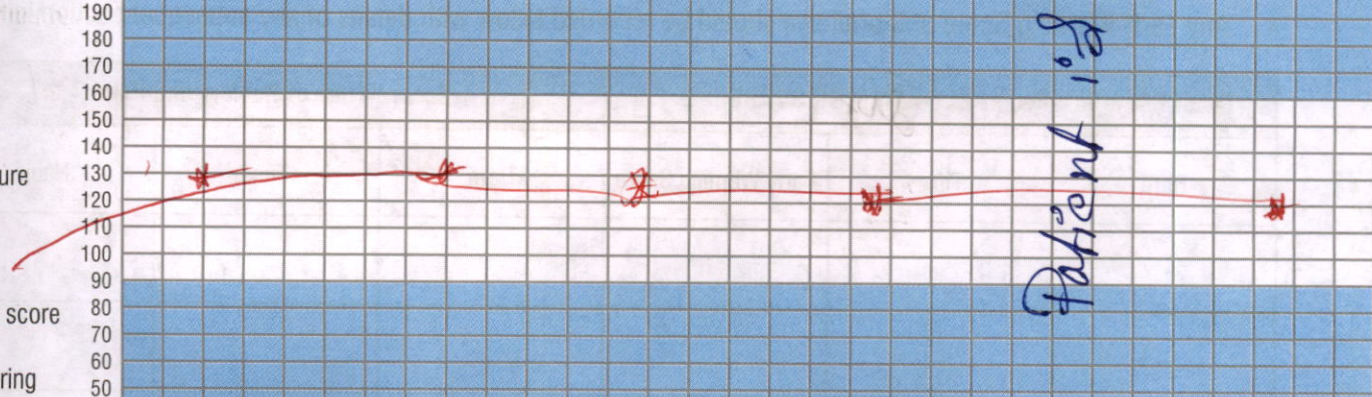
Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

Note:
 BP does not score
 in early
 warning scoring

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



Heart Rate (Number)

132 136 124 130 140

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

70
60
50
40
30
20
10

Resp Rate (Number)

34 36 36 38 40

Resp Mod/ Severe
 Distress None / Mild

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

99% 99% 98% 100% 100%

Conscious Level
 Normal Altered

GCS *

(15/15) (13/15) 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0 0 0
 4 4 4 4 4
 [Signature] [Signature] [Signature] [Signature] [Signature]

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5/7/26

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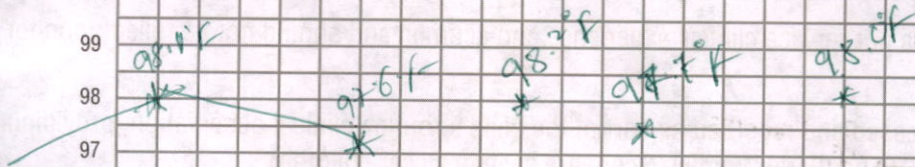
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Temperature
 (F)

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99
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97
96
95
94



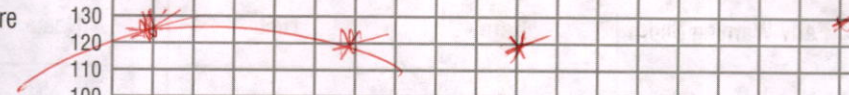
Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

Note:
 BP does not score
 in early
 warning scoring

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



Heart Rate (Number)

130b/m 125b/m 135b/m 142b/m

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

70
60
50
40
30
20
10



Resp Rate (Number)

30b/m 28b/m 38b/m 40b/m

Resp Mod/ Severe
 Distress None / Mild

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

0l/min 0l/min 0l/min 0l/min

Conscious Level
 Normal Altered

GCS *

(15/15) (15/15) (15/15) (15/15)

TOTAL SCORE

Number of shaded boxes

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Pain Score

0 0 0 0

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00660641 IP5-00175945
Baby Of TEJASWINI GANNAMANENI
03-07-2026 0 Y 0 M 2 D (F)
Dr. VENKATA LAKSHMI A

: RCH / FRM / CLINICAL / 124

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

Pratiksha
Rainbow
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Hospital
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 03/07/2026 Time: 6:12 AM

Doctor/Nurse/Family Concern?

Temperature
(F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

Rate (bpm)
(Over 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Level
Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

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 in charge and PICU /NICU fellow or PICU/NICU consultant to be informed

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.

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BAH-00660641 IP5-00175945
 Baby Of TEJASWINI GANNAMANENI
 03-07-2026 0 Y 0 M 0 D 1 H (F)
 Dr. VENKATA LAKSHMI A



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FLUID CHART

Sheet No. : 1

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

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



FLUID CHART

Sheet No. :

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.
3. 24 hrs. total to be entered in the kardex in RED.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am	DBF					✓			✓	no IV	R
	10:00 am										IV	R
	11:00 am	DBF									PMU	R
	12:00 pm											R
	01:00 pm	DBF										R

Total Intake :

Total Output : U - 2 M - 4

	02:00 pm											
	03:00 pm	DBF					✓				no IV	R
	04:00 pm										IV	R
	05:00 pm	DBF									PMU	R
	06:00 pm											R
	07:00 pm						✓					

Total Intake :

Total Output : U - 2 M - 2

	08:00 pm											
	09:00 pm	DBF					✓			✓	no IV	R
	10:00 pm										IV	R
	11:00 pm	DBF										R
	12:00 am											R
	01:00 am	DBF					✓					R

Total Intake :

Total Output : U - 2 M - 2

	02:00 am											
	03:00 am	DBF					✓			✓	no IV	R
	04:00 am										IV	R
	05:00 am	DBF										R
	06:00 am											R
	07:00 am	DBF								✓		R

Total Intake :

Total Output : U - 2 M - 1

Total 24 hrs. Intake	DBF
----------------------	-----

Total 24 hrs. Output	U - 7 M - 6
----------------------	-------------

FLUID CHART

Sheet No. : 3

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.

		Intake				Output					IV Site	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score		
			Mouth	I.V	N.G								
	08:00 am	RBF									↓	Wick	
	09:00 am										NO IV	Wick	
	10:00 am	RBF									cannula	Wick	
	11:00 am										↑	Wick	
	12:00 pm	RBF									↑	Wick	
	01:00 pm											Wick	
Total Intake :						Total Output : U: 2						M: 1	
	02:00 pm	RBF									↓	Wick	
	03:00 pm										↓	Wick	
	04:00 pm	RBF									NO IV	Wick	
	05:00 pm										cannula	Wick	
	06:00 pm	RBF									↑	Wick	
	07:00 pm											Wick	
Total Intake :						Total Output : U: 1						M: 1	
	08:00 pm	RBF									↓	Durga	
	09:00 pm										↓	Durga	
	10:00 pm	RBF									NO IV	Durga	
	11:00 pm										cannula	Durga	
	12:00 am	RBF									↓	Durga	
	01:00 am										↓	Durga	
Total Intake :						Total Output : U: 1						M: 2	
	02:00 am	RBF									↓	Durga	
	03:00 am										↓	Durga	
	04:00 am	RBF									NO IV	Durga	
	05:00 am										cannula	Durga	
	06:00 am	RBF									↓	Durga	
	07:00 am										↓	Durga	
Total Intake :						Total Output : U: 1						M: 1	
Total 24 hrs. Intake													
Total 24 hrs. Output		U-5 M-5											



FLUID CHART

Sheet No. : (A) 6/7/26

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am										✓	Sub	
	09:00 am	DBF+H										Sub	
	10:00 am						✓					Sub	
	11:00 am	DBF									✓	Sub	
	12:00 pm											Sub	
	01:00 pm	DBF+H										Sub	
Total Intake :						Total Output : M-1 a 2							
	02:00 pm											Sub	
	03:00 pm	DBF										Sub	
	04:00 pm											Sub	
	05:00 pm											Sub	
	06:00 pm											Sub	
	07:00 pm											Sub	
Total Intake :						Total Output : M-1 a 2							
	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													

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: new born baby.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
11 AM	Assess the baby condition	12 AM	Assess the baby condition	baby is stable.
1 PM	monitoring vitals.	2 PM	vital checks of overall	
4 PM	DRM	5 PM	DRM given.	
	burping		burping done.	
	burp sound come	7:30 AM	warm come done.	

Re-Assessment: Re Assessment 3rd hourly Feeding

Special Notes: GRBS monitoring / T/M vaccination

Nurse Signature: [Signature] Nurse Name: Rishi Date & Time: 4/7/26 2 PM

BAH-00660641 IP5-00175945
Baby Of TEJASWINI GANNAMANENI
03-07-2026 0 Y 0 M 0 D 7 H (F)
Dr. VENKATA LAKSHMI A



NURSING CARE RECORD

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

Assessment: New Born Baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	→ Assess the Baby condition.	8AM	→ Assessed the Baby condition	Baby is stable
11AM	→ vital chart maintain	11AM	→ vital chart maintained	
12PM	→ Ensure safety	12PM	→ Ensured safety	
3PM	→ 2nd round feeding	4PM	→ 2nd round feeding	
5PM	→ warm care	6PM	→ warm care	
7PM	→ Baby vaccination 1	8PM	→ vaccination done	

Re-Assessment: Baby is stable

Special Notes: vaccination today

Nurse Signature: Nurse Name: Alke Date & Time: 4/7/26



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: New born Baby.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general condition of the Baby.	8:30pm	Assessed the general condition of the Baby.	
10pm	vital the Monitoring.	10:30pm	vital Checked and recorded.	
12Am	Plan for warm care.	12:30pm	Provided the warm care.	
1Am	2nd - 3rd huly DBF.	1:30Am	Every 2nd - 3rd huly DBF given.	
7Am	Ensure the Safety.	7:30Am	Provided the warm care.	

Now is Baby feeding good.

Re-Assessment: Re-Assessment Done 4th huly vital

Special Notes: NBS SBR and OAE T/m 10pm

Nurse Signature:

Nurse Name: RN

Date & Time: 5/7/26



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: new born baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	→ Assess the Baby's condition.	8AM	→ Assessed the Baby's condition.	Baby's stable
11AM	→ vital chart maintain	11AM	→ vital chart maintained	
12PM	→ 2nd hourly feeding → warm care → crib care	12PM	→ Ensured safety → warm care → crib care	

Re-Assessment: Re assessment due

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Green

Date & Time: 5/7/26



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/6/26

Assessment: baby under SSPT

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the general condition of the baby	9pm	* Assessed the general condition of the baby	* Now baby is stable
10pm	* monitor the vital's	11pm	* monitored the vital's	
12Am	* Provide warm care	1Am	* Provided warm care	
2Am	* 2nd hourly feeding give	3Am	* 2nd hourly feeding given	
4Am	* prevent infection	5Am	* prevented infection	
6Am	* ensure safety	7Am	* ensured safety	

Re-Assessment: RC - Assessment done

Special Notes:

Nurse Signature:

Nurse Name: Durga (607539)

Date & Time: 6/7/26 @ 8Am



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 6/7/26

Assessment: Baby is under 88pt

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the baby condition and vitals check	8:30 am	* Assessed the baby condition and vitals	* noted baby condition is stable
10am	* every 2nd hourly DBF+ FF	10:30 am	* checked	
12pm	* provide warm care	12:30 pm	* every 2nd hourly and DBF+ FF	
3pm	* Continue 88pt eye and gentle area covered	3:30 pm	* provided warm care	
4pm	* Ensured Safety	4:30 pm	* Continued 88pt eye gentle area covered	
			* ensured Safety	

Re-Assessment: Assess the condition of the baby now it is stable

Special Notes: Nil

Nurse Signature: Sul

Nurse Name: Sulma 607635

Date & Time: 6/7/26 @ 8am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Venkata Lakshmi Department: BC Date of Admission: 3/7/20

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:					
	<u>newborn baby care</u>							
BACKGROUND	Area	Shift Time	<u>08:00-11:45 AM</u>	<u>11:45 AM-3:00 PM</u>	<u>3:00 PM-6:00 PM</u>	<u>6:00 PM-8:00 PM</u>	<u>8:00 PM-11:45 PM</u>	<u>11:45 PM-8:00 AM</u>
	Medical Condition (Any special condition to be noted):		<u>CRBS</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>97.5</u>	<u>98.1</u>	<u>97.1</u>	<u>98.1</u>	<u>98.2</u>	<u>97.6</u>
		Res:	<u>40/hr</u>	<u>38/hr</u>	<u>38b/m</u>	<u>38b/m</u>	<u>38b/m</u>	<u>40b/m</u>
		SpO ₂ :	<u>100%</u>	<u>99</u>	<u>100%</u>	<u>99%</u>	<u>98%</u>	<u>99%</u>
		Pulse:	<u>142/hr</u>	<u>138</u>	<u>140b/m</u>	<u>138b/m</u>	<u>135b/m</u>	<u>138b/m</u>
		BP:	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>
	Fall Risk Score:	<u>16</u>	<u>16</u>	<u>16</u>	<u>16</u>	<u>16</u>	<u>16</u>	
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>		
Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Rishi</u>	<u>A/keey</u>	<u>Rino</u>	<u>Citack</u>	<u>Durga</u>	<u>Sushu</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>4/7/20</u>	<u>4/7/20</u>	<u>5/7/20</u>	<u>5/7/20</u>	<u>6/7/20</u>	<u>6/7/20</u>	
Time:		<u>8am</u>	<u>8am</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	
Taken Over By Name :		<u>Ashu</u>	<u>Rino</u>	<u>hick</u>	<u>Durga</u>	<u>Sushu</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>4/7/20</u>	<u>4/7/20</u>	<u>5/7/20</u>	<u>5/7/20</u>	<u>6/7/20</u>		
Time:		<u>8am</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</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:						

BAH-00660641
Baby Of TEJASWINI GANNAMANENI
03-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. VENKATA LAKSHMI A



BRADEN 'Q' SCALE

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

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

					Date :	3/6/24	5/7	6/7
					Time :	10:00 AM	8:00 AM	8:00 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	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.	2	2	2	2
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2	2	2
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	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."	2	2	2	2
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23								
Docu. No. : RCHBH /FRM / CLINICAL / 119								
TOTAL SCORE					18	18	18	18
Evaluator's Name					S. Jeyaraj			

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

BRADEN 'Q' SCALE

					Date :				
					Time :				
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					TOTAL SCORE				
					Evaluator's Name				

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4	4	4	4	
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3	3	3	3	3	
	Patient Placed in Bed	2					
	Outpatient Area	1	1	1	1	1	
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1					
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	
TOTAL			15	15	15	15	

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓
Wheel Chair Support		x	x	x	x
Other Intervention(s) Specify		✓	✓	x	x
Nurse's Name :		Sangeetha	Rim	Durga	
Signature :		[Signature]	[Signature]	[Signature]	
Date :		8/7	5/7	6/7	
Time :		8 AM	6 AM	3 PM	

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	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					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
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	Forget Limitations	2					
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	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
TOTAL							

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position						
Call device within reach						
Wheels Locked						
Room free of clutter						
Adequate Lighting						
Wheel Chair Support						
Other Intervention(s) Specify						
Nurse's Name :						
Signature :						
Date :						
Time :						

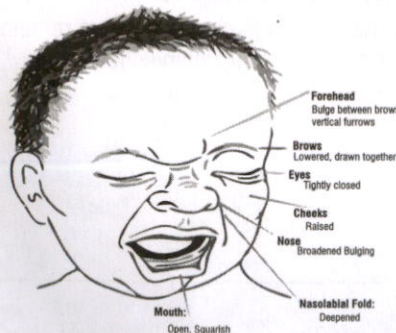
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

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	
						8/12/20	4/2	5/7/21						
						6:00	8:00	6:00 AM	8:00 AM					
						Procedure	GRB	GRB	GRB	GRB				
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0	0	0	0					
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0	0					
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0	0					
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0					
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0					
 Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention						Gestational Age / Corrected Age	38+1	38+1	38+1	38+1				
						Total Pain / Agitation Score	0	0	0	0				
						Intervention	0	0	0	0				
						Effectiveness	-	-	-	-				
						Signature	Sp	Alu	Rin	Surja				

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.

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
	Procedure →												
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								
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)								
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						Intervention							
						Effectiveness							
						Signature							

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
3/7/26	1pm	2	control infection	P. 19	1	0	1	1	-	Sarey

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									



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: new born baby case

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:
8/7/26 upm	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	→ plane for safety	→ keep comfortable	Baby is stable	Sandeep (016638)	☒ 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:



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Blo. Tejaswini Mother's Name: _____
Date of Birth: 10.07.2026 Time of Birth: 10:30pm Gender: ☐ Male ☒ Female
Birth Weight: 3.132 Kgs HC: 33 cm Length: 49 cm
Meconium in Liquor: ☐ Yes ☒ No Cried at Birth: ☒ Yes ☐ No
Term / Pre-term / Post-term: _____
Resuscitated: ☐ Yes ☒ No Blood Group: Mother: O+ Baby: _____
Feeding: ☒ Breast Feeding ☐ Formula ☐ Both First Feed Time: 11:00pm

AFFIX MOTHER'S
IDENTIFICATION LABEL

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

Physical Assessment of New Born:

Temp: 98.6 °C HR: 160 /Min RR: 46 /Min BP: _____ SpO₂: 100 %
Pain Score: 0 (Follow N Pass)

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

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

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

Findings:

General Appearance: Posture: ☒ Well-Flexed ☐ Asymmetry

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

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

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

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

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

Newborn Screening Discussed: Yes / No

Nurse Name: Sandeepa (016638) Signature: Sandeepa

Date & Time: 10.07.2026 14pm

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660641 IP5-00175945 Baby Of TEJASWINI GANNAMANENI 03-07-2026 0 Y 0 M 0 D 7 H (F) Dr. VENKATA LAKSHMI A 		Date & Time of Admission 3/7/26 @ 4:42 PM	Date & Time of Transfer Order 4/7/26 @ 5:50 PM
		Transfer Ordered by Dr. Poogishu	Reason for Transfer Observation.
From Unit OBS.	To Unit ROOM (315)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	Number of Imaging Films nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor: Yes ☒ No ☐			
Name & Signature of Person who is Transferring sis. Radler		Name of Person Ordered Transfer Dr. Poogishu.	
Patient & Clinical Records Received by : Rima 4/7/26 @ 5:50pm			
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



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 6/7/26

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

☒ Transfer
Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication ☐ Yes ☒ No

☐ Bathing ☐ Yes ☒ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☐ Yes ☒ No

☐ Dressing ☐ Yes ☒ No

☐ Toileting ☐ Yes ☒ No

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☒ Patient ☐ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☒ Patient ☐ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: hand hygiene

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

☒ Patient ☐ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Reddy

Date and Time: 3/7/26 01:00 pm

