



Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5, Road No: 2, Banjara Hills, Telangana, Hyderabad,
Telangana, India, 500034.
TEL NO : +91-40-4466 5555
WEB : <https://rainbowhospitals.in>

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175922 Admit Date : 03-Jul-2026 Admit Time : 01:07 PM UHID : BAH-00660586

Patient Details :

Patient Name : Baby Of NABEELA SHEERIN TWIN 2 Age : 0 D
Guardian : Mr SYED SALMAN DOB : 03-07-2026 12:24 PM
Gender : Male Religion :
Occupation : Martial Status : Single
Address (H) : H NO: 17-1-182/S/76, SALAHUDDIN NAGAR,
SANTOSH NAGAR Saidabad Hyderabad
Telangana INDIA 500059 Phone No : 8121553360
E-mail : nabeelasheerin23@gmail.com

Admission Details :

Bed Type : BASINET Bed No : CRDL-MICU-427-2 Ward Name : 4F-BIRTHING CENTRE
Room No : CRDL-MICU-427-2 Admission Type : First Visit

Contact Details :

Name : Mr SYED SALMAN Relationship : Father
Contact Address : H NO: 17-1-182/S/76, SALAHUDDIN
NAGAR, SANTOSH NAGAR Saidabad
Hyderabad Telangana INDIA 500059 Phone No : 8501054928 / 8121553360

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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

willing

New Born Screening : Negative

TFT :

OAE :

Mother's Blood Group : ~~B+~~ B +ve

Baby's Blood Group :

Anomaly Scan :

Vaccination OPV, DCA, Hep-B given
on 3/7/20 Nanzy

Docu. No. : RCHBH /FRM / CLINICAL / 132

[illegible]

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rainbow
children's
hospital
a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Nabeela Sheerin Age : 28 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 Nabeela Sheerin twin 11. Mother's Blood Group : B+
Gender : ☒ M ☐ F Blood Group : B+ Birth Weight (gms) : 2319 Length (cms) : 48
Date of Birth : 3/7/2026 Time of Birth : 12:24pm OFC (cms) : 35
Place of Birth : RCHBH Estimated Gesth Age : 36+1

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 28 Ht : Wt : BMI : Married Life : LMP : 23/10/25 EDD : 30/7/26

Conception : Spontaneous or with Rx :

Booked at what GA : AN Steroids Drugs / Doses :

Last Scans Details : 28/6 : twin I : Breech / AFI: 11.7cm / 9ed umbilical / A resistance / A Doppler
twin 2 / cephalic / AFI: 2.7cm / A Doppler → 14 BFP twin 1 : 1809 twin 11 : 2061
TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ < 18 yrs ☐ > 35yrs 1/0 obstructive
Consanguinity : ☐ Yes ☐ No Compulsive disorder
If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3 on Fluoxetine

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 : MCA shows redistria
Doppler (Increased Resistance / ADEF / REDF / reduction of
Redistribution in MCA) / Ductus Venosus : Blood flow

AFI : Dumoid cyst

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

Controlled or not, recent values, HbA1 values :

Compliance with Rx :

Scans : LGA, TIFFA , Fetal Echo :

H/o Hypothyroidism : when diagnosed ? Medication?

hypothyroid on T-Thyronorm 75mg

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

..... 2 P: 1 A: L: 1

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1.	2024	FT	LSCS	(M)	2.5 kg low AFI	FGR.

PERINATAL HISTORY

Treating Obstetrician : Dr. Sarikala. Hospital : RUP. ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☒ Elective ☐ Emergency Indication :

Specify the reason : DCDP twins.

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitation : ☐ Yes ☐ No

Cord ABG :

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

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

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

TOTAL

Snapee II Score

Score

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

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



History

equipment check done



Baby was received in a prewarmed linen



Dioid / Stimulated / warms



Cord cleaned / clamped / cut



oxy. vitamin K given 1.m. 0.5ml



Shifted to mother side

Investigation details in previous Hospital :

Feeding History :

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Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Euthermic skin
clt/ds good
hemodynamics are stable

VITALS : Temperature : Euthermic HR : 139/min RR : 39/min NIBP : CFT : 135

Color of the extremities : Acrocyanotic

Jaundice : Pallor : SpO2 : 92%

ANTHROPOMETRY: Birth Weight : 231g Length : HC : Present Weight :

Ponderal Index : AGA : SGA : ✓ LGA :



HEAD TO TOE EXAMINATION



HEAD :
Fontanelles :
Sutures
Shape / Moulding : *AF 20pen*
Edema / Bruising :
Size - (H.C.) :

FACIES :
(Any Facial
Dysmorphism)

— x/ —

**NECK and
CLAVICLES :**

Range of Motion :
Asymmetry : *— x/ —*
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 : *no defect up/palate*
Lips :
Tongue :

**THORAX and
BREASTS :**

Shape of Thorax :
Position of Nipples and Number : *— x/ —*

**ABDOMEN and
UMBILICUS :**

Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump : *24 + IV .*
Discharge :

GENITILIA :

Labia / Hymen :
Testicles/penis : *↑ x/*
Anus :

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

x/

EXTREMETIES :

Fingers / Toes :

Deformities :

Hip Joint Examination :

Arms / Legs :

Mobility :

↑ x/



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern: ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 84/min SCR / ICR / See - Saw breathing :

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

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

Settings :

SpO₂: 97% Auscultation: BAE (+) Breath Sounds: IVBS (+) Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 129/min BP :

Femoral Pulses : B/E well felt

Other Peripheral Pulses :

Precordial Activity :

Murmurs :

Signs of Cardiac Failure : RP

ABDOMEN:

Shape :

Palpation : RP

Palpable masses :

Abdominal girth :

Hernia orifice :

Anal Patency : looks patent

Umbilical Cord : 2A HV

First urine passed : ✓

Meconium passed : —

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : FM

State of wakefulness :

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone : cl/f as good

Active Tone :

Neonatal Reflexes :

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

Moro's : B/E well felt DTR :

ATNR :

Skull and Spine :

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Any Comments

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Diagnosis :

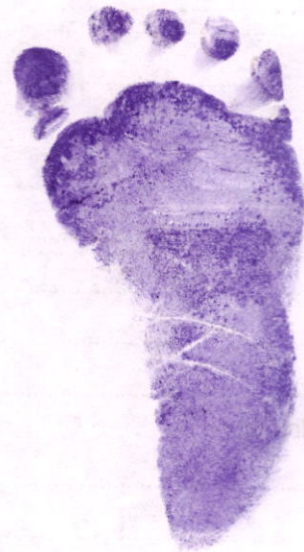
SGT / ASD / DCD / ADHD / OAB / Gest. Hypothyroid / LCC /
23 / 10 / 2026 / LSW.

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name : Dr. Lakshmi

Date & Time : 3/7/26

Consultant :

Signature :

Name : Dr. Venkata Lakshmi A

Date & Time : 3/7/26

DR. VENKATA LAKSHMI A
Registration 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.

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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 :

1. Send cord blood for blood group

2. Vaccines OPV
BCG today
Hep-B

Plan during ward follow up :

3. RBC monitoring 30 mins post feed,
1, 3, 6, 12, 18, 24, 36, 48 hrs
post feed.
Inform if < 50mg/dl.

Feeding Plan at the time of shifting :

4. SBR/NBC/OAE @ 48 Hrs.

5. USG hip at 6 wks of life

12:40 to 12:50 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:

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OYOMOD3H (M)

VENKATA LAKSHMI A



Date & Time	Progress Notes	Doctor's Order
3/7 4PM	ds/B <u>RECIDENT</u> 36+1 DCD A to 111 CRAB Get hypothyroid 2319 1042 LBW.	
	Bt $\frac{u}{m}$ Enteric Pink dr/A: good Euglycemic. hemodynamics are stable	<u>Plan</u> 1. trace blood group. 2. vaccines OPV BCG Hep-B today 3. RBS monitoring to continue. 4. DBF/2nd. Hourly. 80s formula feeds
		<i>[Signature]</i>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26	lactation care plan: - suck good - colostrum seen - Mother is not letting to latch the baby, complementing of breasts given	
4/7/26 3:30pm	C/S/B Resident	
	26 HOL / 36 ⁺ / cephalic / 10GR / LBW / 2314 / GDM mother diet bromium	
U/V m/V	Twt - 2.196kg	Plan
	GRBS @ 24HOL 7mg/dl	① DBF 2hly + Formula 10-15ml 2hly
	Euthermic - Pink Euglycemic	② GRBS @ 36 HOL @ 1:30am (5/7/26)
	Tone } cry } good activity } peripheries warm	③ monitor feeds ④ warm care ⑤ NBS } SBR } @ 12:30pm T/m OAE }
		A+B euthermic Solich

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26		
5pm	<u>Afternoon rounds</u> S2 H01 Baby on room air No RD / no desaturation Accepting feeds well Euthermic Euglycemic Hemodynamically stable CR743rel Peripheries: warm passed urine & stool	plan 1. DSF 2nd hourly thb . 20ml ff Q24 2. NBS SBR } (TIm) IAM OAT 3. Warmth care 4. vital monitoring by Sai NB Sema



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 8:40am	S/B Resident	
	68104 36 th Preterm cephalic LBW Twin II 2314g	DCPA
	m B ⁺ U ✓ B B ⁺ m ✓	Plan
		① DBF 2 nd July +
	Baby Euglycemic	18-20ml FF
	Twt J 2.144kg 7.3:1.↓	② OAE today
	Feed well on formula	③ Warm Care
	Feed	
	cry tone activity } good	④ trace SBR - 8-3
	discharge today	Solids
	Flu Wednesday.	
		Shhs
		OAE - New born hearing screening. Bilateral responses are present Bilateral Pass



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

4



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

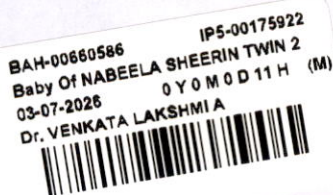
Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

CONSENT FOR FORMULA FEEDS

Patient Name : Age : Gender : ☐ Male ☐ Female
UHID No : Department : Date :
I Mr / Mrs. : aged years, hereby declare that I have
admitted my ☐ son ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on
..... I hereby give consent for formula feed for my child. Doctors have explained me
about the formula feeding benefits, risks, alternatives in the language I best understand.



Patient Attendant :

Signature :
Name : SYED SAJJAD
Relationship with Patient: FATHER
Date & Time : 10:00 PM

Witness :

Signature :
Name :
Date & Time :

Doctor (who is taking the consent) :

Signature :
Name : Dr. Soheli
Date & Time : 04/07/26

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NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name:

Mother's Name: Mr. Nabeela

Date of Birth: 31/7/26

Time of Birth: 12:24 pm

Gender: ☒ Male ☐ Female

Birth Weight: 2.3 kg Kgs

HC: 35 cm

Length: 48 cm

Meconium in Liquor: ☐ Yes ☐ No

Cried at Birth: ☐ Yes ☐ No

Term / Pre-term / Post-term: Term

Resuscitated: ☐ Yes ☒ No

Blood Group: Mother: B+ Baby:

Feeding: ☒ Breast Feeding

☐ Formula

☐ Both

First Feed Time: 12:40 pm to 12:50 pm

AFFIX MOTHER'S
IDENTIFICATION LABEL

Mode of Delivery: ☐ Normal ☐ LSCS - Emergency/ Elective

☐ Instrumental

☐ AVD

Indication:

Physical Assessment of New Born:

Temp: 38.2 °C HR: 142 /Min RR: 41 /Min BP: - SpO₂: 100%

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☒ Yes ☐ No Score: 17 (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: Leulyn

Signature: [Signature]

Date & Time: 31/7/26 1 pm

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ARY PATIENT / FAMILY EDUCATION RECORD



.....Patient / Learner Literacy : ☐ Read ☐ Write ☐ Speak Willingness to Learn : ☐ Yes ☐ No Healthcare Literacy : ☐ Yes ☐ No

Identified Education Needs :

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barries	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
			7 Infection control Measures PT BM		1	0	1	7	-	Subdy

Part - III : CODES

Who was taught : PT : Patient F : Father M : Mother S : Spouse Sn : Son D : Daughter C : Caregiver O : Other (Specify).....

Learning Barriers :

1. No Learning Barries	4. Language Barrier	7. Impaired Thought Process / Cognitive limitations	10. Financial Difficulties	13. Cultural / Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barries	6. Desire / Motivate to Learn	9. Cultural Difference	12. Impaired Vision / or Hearing	

Teaching Tools Used : A : Audio D : Demonstration V : Video O : Oral P : Printed

Mechanism/s to overcome barrier/s :

1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify.....
2. Obtain translator	4. Teach Family / others	6. Respect Cultural / Religion Preference	

Understanding :

1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review
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Baby Of NABEELA SHEERIN TWIN 2
03-07-2026 0 Y 0 M 0 D 8 H (M) : RCH / FRM / CLINICAL / 124
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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: 2/8/24 Time: 12:30 PM 5 PM 9 PM 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)

p. Rate (bpm)
(over 1 Minute) *

70
60
50
40
30
20
10

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

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)

BAH-00660586 IP5-00175922
Baby Of NABEELA SHEERIN TWIN 2
03-07-2026 0 Y 0 M 0 D 11 H (M)
Dr. VENKATA LAKSHMIA



No. : RCH / FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

Pratiksha
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Children's
Hospital
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Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 03/07/2026 Time: 11 AM 5 PM 10 PM 6 PM

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)
per 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 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)
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Baby Of NABEELA SHEERIN TWIN 2
03-07-2026 0 Y 0 M 2 D (M)
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INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 11:00 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)

p. Rate (bpm)
(over 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

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BAH-00660586
Baby Of NABEELA SHEERIN TWIN 2
03-07-2026
Dr. VENKATA LAKSHMI A
IP5-00175922
0 Y 0 M 2 D
(M)

RM / CLINICAL / 124

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

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Y WARNING SCORE: CHILDREN'S UNIT

Date: Time:

Doctor/Nurse/Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

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

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

p. Rate (bpm)
over 1 Minute *

70
60
50
40
30
20
10

Resp Rate (Number)

Resp Distress

Mod/ Severe
None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Level

Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
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BAH-00660586 IP5-00175922
 Baby Of NABEELA SHEERIN TWIN 2
 03-07-2026 0 Y 0 M 0 D 8 H (M)
 Dr. VENKATA LAKSHMI A



FLUID CHART

Sheet No. : ①

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

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	DBP											
	01:00 pm												
Total Intake : 2/8						Total Output : U-ND M-ND							
	02:00 pm												
	03:00 pm	DBP											
	04:00 pm												
	05:00 pm	DBP											
	06:00 pm												
	07:00 pm	DBP											
Total Intake : 2/8						Total Output : U-1 M-1							
	08:00 pm												
	09:00 pm	DBP											
	10:00 pm	DBP											
	11:00 pm												
	12:00 am	DBP											
	01:00 am												
Total Intake : 2/8						Total Output : m-1 u-1							
	02:00 am												
	03:00 am	DBP											
	04:00 am												
	05:00 am												
	06:00 am	DBP											
	07:00 am												
Total Intake : 2/8						Total Output : m-1 u-1							
Total 24 hrs. Intake						Total 24 hrs. Output			m-3 u-2				



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								
4/7/26	08:00 am	DBF										NA Shahar Shahar	
	09:00 am									✓			
	10:00 am	DBF					✓						
	11:00 am												
	12:00 pm	DBF											
	01:00 pm												
Total Intake :						Total Output : m-10-1							
4/7	02:00 pm											NA Shahar Shahar	
	03:00 pm	FF 15ml					✓			✓			
	04:00 pm												
	05:00 pm	FF 20ml					✓			✓			
	06:00 pm									✓			
	07:00 pm												
Total Intake :						Total Output : m-20-2							
4/7	08:00 pm	FF 20ml										NA Shahar Shahar	
	09:00 pm												
	10:00 pm	FF 30ml					✓			✓			
	11:00 pm												
	12:00 am						✓						
	01:00 am	FF 20ml											
Total Intake :						Total Output : m-20-2							
5/7	02:00 am											NA Shahar Shahar	
	03:00 am												
	04:00 am	FF 30ml					✓			✓			
	05:00 am												
	06:00 am	FF 20ml					✓			✓			
	07:00 am												
Total Intake :						Total Output : m-20-2							
Total 24 hrs. Intake		155 ml											
Total 24 hrs. Output		m-20-2 u-6											



5/2/26

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
5/2	08:00 am	f-t 20ml					✓			✓	NA } Southair	
	09:00 am											
	10:00 am	f-t 28ml										
	11:00 am						✓			✓		
	12:00 pm									✓		
	01:00 pm	f-t 28ml								✓		
Total Intake :						Total Output : m-2 u-3						
5/2	02:00 pm										NA } Scema	
	03:00 pm											
	04:00 pm	f.f. 25ml					✓			✓		
	05:00 pm											
	06:00 pm											
	07:00 pm	f.f. 25ml										
Total Intake :						Total Output : m-1 u-1						
5/2	08:00 pm										NA } Ringg	
	09:00 pm	ff 30ml					✓			✓		
	10:00 pm											
	11:00 pm											
	12:00 am	ff 20ml					✓					
	01:00 am											
Total Intake :						Total Output : m-2 u-1						
6/2	02:00 am										NA } Ringg	
	03:00 am									✓		
	04:00 am	ff DBF					✓					
	05:00 am											
	06:00 am						✓			✓		
	07:00 am	ff 30ml										
Total Intake :						Total Output : m-2 u-2						
Total 24 hrs. Intake		Total 24 hrs. Output										
		m-7 u-7										

BAH-00660586 IP5-00175922
 Baby Of NABEELA SHEERIN TWIN 2 (M)
 03-07-2026 0 Y 0 M 2 D
 Dr. VENKATA LAKSHMI A

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FLUID CHART

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

BAH-00660586 IP5-00175922
 Baby Of NABEELA SHEERIN TWIN 2
 03-07-2026 0 Y 0 M 2 D (M)
 Dr. VENKATA LAKSHMI A

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Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
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	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												

Patient Sticker

FLUID CHART

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			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
	Total Intake :						Total Output :						
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
	Total Intake :						Total Output :						
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
	Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output							

BAH-00660586 IP5-00175922
 Baby Of NABEELA SHEERIN TWIN 2
 03-07-2026 0 Y 0 M 2 D (M)
 Dr. VENKATA LAKSHMI A



BAH-00660586 IP5-00175922
 Baby Of NABEELA SHEERIN TWIN 2
 03-07-2026 0 Y 0 M 0 D 3 H (M)
 Dr. VENKATA LAKSHMI A



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NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 31/7/24

Assessment: New baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess pt general condition	2:10 PM	Assessed pt general condition	Baby is Stable
3pm	monitor vital	3:10 PM	Bp Spox pulse checked & recorded	
4pm	DBF & Burping	4:10 PM	DBF Burping done	
5pm	Warm care	5:10 PM	Warm provided	

Re-Assessment: R Assessment sent floor

Special Notes:

Nurse Signature: *[Signature]*

Nurse Name: Shobue

Date & Time: 31/7/24

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 31/7/26

Assessment: pa. plus born baby care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
10pm	Assess the pt condition	10:30 pm	Assessed pt condition	Baby is stable now & baby sleeping well
11pm	monitor vital	11:30 pm	monitored vital	
12am	flb chart	12:30 am	maintained flb chart	
4am	ARBS monitored	4:30 am	monitored ARBS	
6am	shift to room	6:30 am	shifted to room	
7am	→ To provide crib care to the Baby	7:30 am	→ provided crib care to the Baby	

Re-Assessment: done after 2nd hourly pt is stable

Special Notes: ARBS monitored ARBS
SBK, UB, inc @ 11:30 and TCBK @ 2:30

Nurse Signature: Sandhya Nurse Name: Sandhya (016625) Date & Time: 4/7/26 2 pm



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

Assessment: new born baby care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	Assess the patient.	8:05 PM	Assessed the patient.	Baby is stable
10 AM	General condition	10:05 AM	General condition	
12 PM	Monitor the vitals.	12:05 PM	monitored the vitals.	
2 PM	Maintain Ilo chart.	2:05 PM	Maintained Ilo chart.	
4 PM	provide comfortable position to Baby.	4:05 PM	provided comfortable position to Baby.	
7 PM	provide 2nd hourly feeding and Burping.	7:05 PM	provided 2nd hourly feeding and Burping.	
	provide warm care.		provide warm care to Baby.	

Re-Assessment:

Special Notes: GRBS monitoring TCBR checked.

Nurse Signature: [Signature]

Nurse Name: Shrinika

Date & Time: 4/7/26

BAH-00660586 IP5-00175922
 Baby Of NABEELA SHEERIN TWIN 2
 03-07-2026 0 Y 0 M 2 D (M)
 Dr. VENKATA LAKSHMI A



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26

Assessment: Newborn Baby care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the Baby General Condition	8:10 PM	→ Assessed the Baby General condition	Baby is stable
10pm	→ Assess the Baby vitals	10:20 PM	→ Assessed the Baby vitals	
12AM	→ To maintain I/O chart	12:10 PM	→ maintained I/O chart	
2AM	→ To encourage for feeds	2:20 AM	→ Established for feeds	
4AM	→ To GRRS monitoring	4:15 AM	→ GRRS monitored	
6AM	→ Ensure safety	6:10 AM	→ Ensure safety	

Re-Assessment: Baby is Good

Special Notes: GRRS monitoring SBR, NRS, OAR 12:30pm T/m

Nurse Signature: *Reip*

Nurse Name: *Reip*

Date & Time: 05/7/26 @ 8AM

BAH-00660586 IP5-00175922
 Baby Of NABEELA SHEERIN TWIN 2
 03-07-2026 0 Y 0 M 2 D (M)
 Dr. VENKATA LAKSHMIA



NURSING CARE RECORD

Rainbow
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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning

on ☐ Night

Date: 5/7/26

Assessment: New born Baby care

Goals

- ☐ Maintain Airway and Oxygenation
☒ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☐ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify

- ☐ Maintain Fluid Balance
☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
☒ Ensure Safety

- ☐ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the Baby General condition	8:30 am	Assessed the Baby General condition on bed	patient is stable
9am	To monitor vitals	9:15 am	monitored Baby vitals	
10am	To monitor I/O chart	10:20 am	monitored Baby I/O chart	
11am	To provide cribe care	11:15 am	provided cribe care	
12pm	To plan for feed	12:20 pm	every 2nd hourly feeding burping	
1pm	To plan ensure safety	1pm	given Baby ensure safety	

Re-Assessment: Provide cribe care Baby was sleeping

Special Notes: NA

Nurse Signature: Subhashini

Nurse Name: Subhashini

Date & Time: 5/7/26 2pm

BAH-00660586 IP5-00175922
 Baby Of NABEELA SHEERIN TWIN 2
 03-07-2026 0 Y 0 M 2 D (M)
 Dr. VENKATA LAKSHMIA



NURSING CARE RECORD

Rainbow Children's Hospital
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BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Unit: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: newborn baby

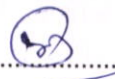
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the baby condition	2:30 pm	* Assessed the baby condition	* baby is stable
3pm	* plan to monitor vitals		baby is stable.	
4pm	* plan to maintain I/O	3:10 pm	* monitor vitals stable.	
	chart.		* maintenance I/O chart	
5pm	* plan to CRBS	4:20 pm	* I checked CRBS cos	
			per doctor orders.	
7pm	* plan to warm care	5:30 pm		
		7:20 pm	* provide warm care	
8pm	* plan to feeding		for baby.	
	2-3rd hourly.	8pm	* Given feeding support	
			2-3rd hourly.	

Re-Assessment:

Special Notes: provide warm care for baby

Nurse Signature:  Nurse Name: Sema

Date & Time: 5/7/26 @ 8am

BAH-00660586 IP5-00175922
 Baby Of NABEELA SHEERIN TWIN 2
 03-07-2026 0 Y 0 M 0 D 11 H (M)
 Dr. VENKATA LAKSHMIA



NURSING CARE RECORD

Rainbow
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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 05/7/26

Assessment: New born Baby Care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	⇒ Assess the Baby General Condition	8:10 pm	⇒ Assessed the Baby General Condition	Baby is stable
10pm	⇒ Assess the Baby vitals	10:20 pm	⇒ Assessed the Baby vitals	
12am	⇒ To maintain ILO chart	12:10 am	⇒ maintain ILO chart	
4pm	⇒ To establish feeds	4:10 am	⇒ established feeds	
6am	⇒ To provide warmth Care	6:10 am	⇒ provided warmth care	

Re-Assessment:

Baby activity is Good

Special Notes:

SPRINKLS, Done OAC TLM

Nurse Signature:

[Signature]

Nurse Name:

[Signature]

Date & Time:

06/7/26 @ 8pm

BAH-00660586 IP5-00175922
Baby Of NABEELA SHEERIN TWIN 2
03-07-2026 0 Y 0 M 0 D 11 H (M)
Dr. VENKATA LAKSHMIA



NURSING CARE RECORD


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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature: Nurse Name: Date & Time:

Patient Sticker

NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Venkatesh Lakshmi Department: Ble Date of Admission: 3/7/26

SITUATION		Diagnosis: <u>New born Baby</u>						
		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:						
BACKGROUND	Area	<u>OBG 2nd floor</u>	<u>OBG 2nd floor</u>	<u>3rd floor 10:30pm</u>	<u>3rd floor 8pm</u>	<u>3rd floor 8 AM</u>	<u>3rd floor 2pm</u>	
	Shift Time	<u>2:30-8:30</u>	<u>8:30-1:30</u>	<u>1:30-6:30</u>	<u>6:30-10:30</u>	<u>10:30-2:30</u>	<u>2:30-6:30</u>	
Medical Condition (Any special condition to be noted):		<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.32</u>	<u>98.61</u>	<u>98.1</u>	<u>98.5F</u>	<u>98.9F</u>	<u>98.14</u>
		Res:	<u>41</u>	<u>46</u>	<u>44</u>	<u>40</u>	<u>40</u>	<u>40</u>
		SpO ₂ :	<u>106%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>100%</u>
		Pulse:	<u>141</u>	<u>146</u>	<u>140</u>	<u>145</u>	<u>130</u>	<u>140</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>NR</u>	<u>NR</u>	<u>CRIB CARE</u>	<u>CRIB CARE</u>	<u>YES</u>	<u>YES</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	<u>NR</u>	
Post Operative Procedure Special Orders:		<u>CRIBS</u>	<u>CRIBS</u>	<u>CRIBS</u>	<u>CRIBS</u>	<u>CRIBS</u>	<u>CRIBS</u>	
Handed Over By Name :		<u>Shobha</u>	<u>Sandhya</u>	<u>Divya</u>	<u>Shrisha</u>	<u>Divya</u>	<u>Sandhya</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>3/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>5/7</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>10am</u>	<u>8pm</u>	<u>8am</u>	<u>3pm</u>	
Taken Over By Name :		<u>Pooja</u>	<u>Divya</u>	<u>Shrisha</u>	<u>Divya</u>	<u>Sandhya</u>	<u>Divya</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>3/7/26</u>	<u>3/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>5/7/26</u>	<u>5/7</u>	
Time:		<u>8pm</u>	<u>2:30pm</u>	<u>9:30am</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. V.L Department: 3rd Floor Date of Admission: 3/7/26

SITUATION	Diagnosis: <u>Newborn baby</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	<u>2nd Floor</u>	<u>3rd Floor</u>				
	Shift Time	<u>8pm</u>	<u>8am</u>				
	Medical Condition (Any special condition to be noted):	<u>NB</u>	<u>NB</u>				
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>98.2°F</u>	<u>98.1°F</u>				
	Res:	<u>40b/m</u>	<u>40b/m</u>				
	SpO ₂ :	<u>98%</u>	<u>99%</u>				
	Pulse:	<u>138b/m</u>	<u>130b/m</u>				
	BP:	<u>—</u>	<u>—</u>				
	Fall Risk Score:	<u>16</u>	<u>16</u>				
	Pain Score:	<u>0/10</u>	<u>0/10</u>				
	Recommendations	Safety Needs:	<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>				
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:		<u>SBP, NB</u> <u>7/10</u> <u>8am</u>	<u>NA</u>				
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>				
Handed Over By Name :		<u>Seema</u>	<u>Princy</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>3/7/26</u>	<u>6/7/26</u>				
Time:		<u>8pm</u>	<u>8am</u>				
Taken Over By Name :		<u>Princy</u>	<u>Seeshabini</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>5/7/26</u>	<u>6/7/26</u>				
Time:		<u>8pm</u>	<u>8am</u>				

BAH-00660586 IP5-00175922
Baby Of NABEELA SHEERIN TWIN 2
03-07-2026 0 Y 0 M 0 D 3 H (M)
Dr. VENKATA LAKSHMI A



BRADEN 'Q' SCALE

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					Date : 3/7/24	3/7/24	4/7/24	5/7/24
					Time : 2pm	8pm	8am	7am
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	1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2	2	2
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	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	3	3
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	3	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 28 Evaluator's Name 			

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03-07-2026 0 Y 0 M 0 D 3 H (M)
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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

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Baby Of NABEELA SHEERIN TWIN 2
03-07-2026 0 Y 0 M 0 D 11 H (M)
Dr. VENKATA LAKSHMI A



BRADEN 'Q' SCALE

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

					Date : 6/7			
					Time : 3:27			
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			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	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			
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3			
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.	3			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	17		
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Dr. Venkata Lakshmi A		

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

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 Baby OF NABEELA SHEERIN TWIN 2
 03-07-2026 0 Y 0 M 0 D 3 H (M)
 Dr. VENKATA LAKSHMI A

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
						3/7/24	3/7/24	4/7/24	5/7/24	6/7/24			
						2pm	5pm	8am	8AM	8AM			
						Procedure	GIRBS	GIRBS	GIRBS	GIRBS	GIRBS		
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0	0	0	0	0			
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0	0	0			
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0	0	0			
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0	0			
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	6	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	36w	36 ⁺	36 ⁺ weeks	36 ⁺ weeks	38 ⁺ weeks		
	Total Pain / Agitation Score	0	0	0	0	0							
	Intervention	NA	NA	NA	NA	NA							
	Effectiveness	NA	NA	NA	NA	NA							
	Signature	Shobha	Shobha	Shobha	Shobha	Shobha							

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.

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Rainbow
Children's
Hospital

It takes a lot to treat the little. | Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

3/7/26 3/7/26 3/7/26 3/7/26 3/7/26

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	3/7/26	3/7/26	3/7/26	3/7/26	3/7/26
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3		3	3	3	3
	Patient Placed in Bed	2	2		2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3	3				
	Within 48 hours	2	2				
	More than 48 hours / None	1		1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
TOTAL			17	16	16	16	16

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		X	X	X	X	X
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓	✓
Wheel Chair Support		+	+	+	+	+
Other Intervention(s) Specify		✓	✓	✓	✓	✓
Nurse's Name :		Sush Sanyal	Rajy	Rajy	Rajy	Rajy
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		3/7/26	3/7/26	3/7/26	3/7/26	3/7/26
Time :		7:00 AM	8:00 AM	9:00 AM	10:00 AM	11:00 AM