

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176340 Admit Date : 13-Jul-2026 Admit Time : 02:16 PM UHID : BAH-00661508

Patient Details :

Patient Name	: Baby Of DOKKU DEEPTHI	Age	: 0 D
Guardian	: Mr D LEELA KRISHNA	DOB	: 13-07-2026 12:44 PM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO - 21-59-4, NEW HUDA COLONY , Hyderabad Airport 1 Hyderabad Telangana INDIA 501218	Phone No	: 8333838523/ 8897814103
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

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

Contact Details :

Name : Mr D LEELA KRISHNA Relationship : Father
Contact Address : H NO - 21-59-4, NEW HUDA COLONY ,
Hyderabad Airport 1 Hyderabad Telangana INDIA
501218 Phone No : 8333838523 / 8897814103


Signature

Doctor Details :

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

Payment Details :

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

Date of Birth	: 13/07/26	New Born Screening	:
Time of Birth	: 12:44pm	TFT	:
Mode of Delivery	: EM - LSCS	OAE	:
Birth Weight	: 1.990 kgs	Mother's Blood Group	: O+ve
Head Circumference	:	Baby's Blood Group	: O+ve
Length	:	Anomaly Scan	:
I Reflex	:	Vaccination	: OPV, BCG, Hep-B

[illegible]

[illegible]

BAH-00661508 IPS-00176340
 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 0 D 5 H (M)
 Dr. DINESH KUMAR CHIRLA



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

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 Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name : 1384800326

UHID No. : 88/15008 IP No. : 893893 Consultant: Dr. D. K. Chirala Dept : 00/15/1

Date of Admission: 19/7/26 Time : 9pm Date of Discharge : 19/7/26 Time: 10/15/1

Room / Bed No : 40005003 Ward : 302 Suggested Billable bed type : 89

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
19/7/26	9pm	Nicea	302	Agus

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
13/7/26	X-ray	265034851	
13/7/26	DCT, Blood group, CBP, SBR,	26070158	
	Reticount, RBS		
13/7/26	RBS, VBG	26070204	
13/7/26	GPBS		
14/7/26	RBS	26070487	
14/7/26	Npi		
15/7/26	RBS, RBS.	26070736	
15/7/26 ^{12am}	TCB		
17/7/26	RBS	26071568	
17/7	RBS	26071568	
18/7/26	SBR	26071949	
18/7/26	RBS	26071950	
18/7/26	RBS	26072248	
19/7	RBS	26012334	
19/7	SBR, RBS	26012297	
19/7	NBS	26012408	
20/7	2D Echo	036234	Jemie

[illegible]

[illegible]

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Dooku Deepthi Age : 24 Father's Name : Age :
Date of Birth : Date of Admission : UHID No. :
NICU Consultant : as per note 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 Deepthi Mother's Blood Group : * O - ve (Type - ve)
Gender : ☒ M ☐ F Blood Group : O negve
Date of Birth : 13/7/26 Time of Birth : 12:44pm Birth Weight (gms) : 1990 Length (cms) :
Place of Birth : REH Banjara OFC (cms) :
Estimated Gesth Age : 34 weeks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 24 Ht : Wt : BMI : Married Life : 2025 LMP : 18/11/25 EDD : 24/2/26

Conception : Spontaneous or with Rx : OT conception

Booked at what GA : AN Steroids Drugs / Doses : NOT GIVEN

Last Scans Details : 13/7/26 - AFI = 10.8 breech Mg 904 not given
DOPPLER - (B) EFW = 2208g TT Immunization and Iron / Folic Acid : uterine dapple

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 : (B)

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

Controlled or not, recent values, HbA1 values :
Compliance with Rx :
Scans : LGA, TIFFA, Fetal Echo :
H/o Hypothyroidism : when diagnosed ? Medication?
Any other Chronic Medical Problems, when detected
drugs ? Sx => H/O Mullerian anomaly
(Anemia, SLE, Jaundice, CHD, Heart Disease)
Infection : H/O, Fever
(☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)
UTI : when : Any culture :
uterine rupture @ 13 year case of uterine

PPROM: Duration : ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results :
Medication during Pregnancy : Duration : ovarian cystectomy +
hysterectomy +
anastomosis 2015
hymenoplasty - 2015
invo primary amenorrh



PAST OBSTETRIC HISTORY

P: A: L:

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

PERINATAL HISTORY

Treating Obstetrician : Dr. Shreekh Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication : onset of

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitaion : ☐ Yes ☐ No

Cord ABG : 7.23 / 53.7 / 13.2 / 3.5

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	
2	2	
9/10	9/10	

TOTAL

Snapee II Score

Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



History -

Baby had CTAB → acc card
clamping done - Baby received +
warmth → had developed RD →
given delivery room CPAP →
card continued → card-cut

- 2A 1V seen.

→ Baby shifted to N2O for
further ~~mx~~ mx

Investigation details in previous Hospital :

Feeding History :

BAH-00661508 IP5-00175340
Baby Of DOKKU DEEPTHI
13-07-2026 0 Y 0 M 0 D 5 H (M)
Dr. DINESH KUMAR CHIRLA



Pa:

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Alive

VITALS : Temperature : *36.7* HR : RR : NIBP : CFT :

Color of the extremities : *acrocyanosis*

Jaundice : Pallor : SpO2 : *92%*

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

Ponderal Index : AGA : SGA : LGA :

AT THE TIME OF TRANSFER TO THE WARD

Neonatal condition at the time of Transfer:

Vital : HR : RR : BP : SP02 : Weight :

Any Oxygen requirement : Plan

Systemic : - Shift to N2CU

Medications : - Low flow - O2

- TV - 60 cc / kg / day - 10ml 2nd hourly
full OG feeds (SBT + FBH)

Plan during ward follow up :

- SEND Cond blood
Blood group
SBR
DCT
Ref
CBP

Trace → Inform.

Feeding Plan at the time of shifting :

GRBS GRBS 6th hourly
pre feed.

Screenings done during NICU Stay :

NSG : Target SPO₂ = 90-95%

Hearing Screen : Review

ROP :

TFT :

NP2 :

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:



No gross congenital
anomaly seen

Diagnosis : 34 weeks (late PT) / 1.990 A GA / Pre term
onset of labour / CIAB / RD (PTNB) / maternal

FOOT PRINTS

Left Side :



Right Side :



(RM - ve pregnancy) (IC - ve) Ultero-cervical
anastomosis
done 2019

Resident Doctor :

Signature :

Name :

Date & Time : 13/7/26

Consultant :

Signature :
Dr. DINESH KUMAR CHIRLA
Reg. No: 66227

Name :

Date & Time : 13/7/26

PLEASE FILL UP THE FOLLOWING DETAILS

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



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☐ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 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 : Auscultation : Breath Sounds : Added Sounds :

B/T RD = 65

SCR = (-)

B/L FAE

Grunt occasional

CARDIOVASCULAR SYSTEM :

HR : BP :

Precordial Activity :

Femoral Pulses :

Murmurs :

Other Peripheral Pulses :

Signs of Cardiac Failure :

ABDOMEN:

Shape :

Hernia orifice :

Palpation :

Anal Patency :

Palpable masses :

Umbilical Cord :

Abdominal girth :

First urine passed :

Meconium passed :

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone :

Active Tone :

Neonatal Reflexes :

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

Moro's :

DTR :

ATNR :

Skull and Spine :



HEAD TO TOE EXAMINATION

HEAD :

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

N

FACIES :

(Any Facial
Dysmorphism)

1 N

NECK and CLAVICLES :

Range of Motion :
Asymmetry :
Masses :

N

EYES :

Symmetry :
Red Reflex :
Discharge :

- Needs to be seen.

EARS, NOSE MOUTH and THROAT :

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



N

No cleft.

THORAX and BREASTS :

Shape of Thorax :
Position of Nipples and Number :

1 N

ABDOMEN and UMBILICUS :

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

N

2A 1V

GENITALIA :

Labia / Hymen :
Testicles/penis :
Anus :

B/L. Testis at over inguinal
ex.

HERNIAL ORIFICES

1 N

TRUNK and SPINE :

N

SKIN LESIONS :

N

EXTREMITIES :

Fingers / Toes :
Deformities :
Hip Joint Examination :

1 N

Arms / Legs :
Mobility :

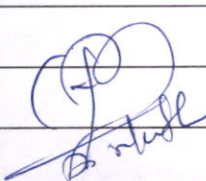
1 N

1

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/7/26 1:30pm	34wks. 1.9kg. Rh -ve preg. mild SCR ⊕	<u>Plan.</u> → Low flow (SOS) → TV - 60cc/kg/day 10ml/2nd hly full O2 feed. (DBM/EBM) Send → Test baby blood group Cord - Bilirubin; CBP, Retic count, DCT. → Wt + RD → CRBS - 6th hly. → Monitor vitals Seen. by by Dr. Nitesh mild SCR ⊕ tachypnea ⊕ → Chest X-Ray. now CBG now. → Check CRBS. noted by Belk 13/7/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 11:50am	<u>Night Rounds</u> Baby hemodynamically stable on O₂ @ 0.04 L/min resp respiratory distress → Mild tachypnea no retractions DCT - Negative Ref count - 5-5 SpO₂ - HR - 135/min SpO₂ - 94% RR - 42/min CRBS - 84 mg/dL	<u>Plan</u> 1) Off O₂ now O₂ only if SpO₂ < 95%. 2) continue feeds 10ml 2hly TV - 60cc/kg/day 3) CRBS 6hly (prn) 4) w/F Bradycardia/apnea/ Desaturations 

(3)

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

Day in NICU: Day of Life: 19HOL PMA:

Term ☐ Preterm ☐ Gestation: 34Wks Corrected Gestational Age: Today's Weight:

		Problems	
		S.No.	Past Problems
Overview	Current	1. Mod PT / LBW	
		2. Rh neg - preg.	
		3. RDS	
		4.	
		5.	
		6.	
Clinical Assessment	on mini low flow 0.02lit tachypnea (+) HR - 152/min RR - 62/min SpO2 - 94%		
	$\frac{M}{B} \frac{0}{0}$		
Medications Used			
Plan of Care: • IV - 60cc/kg/day → 10ml 2nd half full OG feed. • Continue minilow flow, wean as tolerated • Wt tachypnea, retractions • CRBS - 6th hely.			

Doctor's Name (Hand over given): Dr. Deepthi

Signature: [Signature]

Date & Time: 19/7/26

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:

BAH-00661508 IP5-00176340
Baby Of DOKKU DEEPTHI
13-07-2026 0 Y 0 M 0 D 5 H (M)
Dr. DINESH KUMAR CHIRLA



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

Day in NICU: Day of Life: PMA:

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

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

Doctor's Name (Hand over given):

Signature:

Date & Time:

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Send CBP? now.
		SPR.
		NP.
		Noted by Laxay
14/7/26	Afternoon rounds	
3pm	Baby on mini low flow 0.012 L/min No RR/No desaturation Intermittent tachypnea ⊕ (up to RR 71/min) No retractions SpO ₂ : 94% PR: 149/min RR: 49/min BP: 73/41 (51) mm Hg CRT < 3 sec Passed urine & stool	plan 1. Mini low flow; taper as tolerated 2. TV = 80 cc/kg/day ↓ 13ml O ₂ H full OG feed 3. Trace NP, report 4. GRBS 6th hourly 5. Wf Tachypnea, Retractions (Target SpO ₂ 90-95%) 6. vital monitoring
	NP → CBP 16.8/9630/409000 CRP 5 Creat 1.0; Urea 26	Noted by Laxay
		for Saiteja

6

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/8/26		Seen by Dr. Peatyush
	→	Stop low flow
	→	w/ tachypnea
	SBR - 5.4 (cutoff 6) →	TV - 80cc/kg/day. 13ml/2nd hly till 04 feed
	→	Clinical assessment of jaundice at 1AM today
		if ↑ trend. Start Phototherapy [cutoff - 8mg/dl] at 36 HOF
	Dr. Popli	Noted by Laxay
15/8/26		
12:30 AM	Tcbr - 8.5mg/dl	Plan:
		- Start SPT C eyes & genitalia covered.
		Sub



④

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

Day in NICU: Day of Life: 45 H 0 L PMA: 34+1 wks

Term ☐ Preterm ☒ Gestation: 34 wks Corrected Gestational Age: Today's Weight: 1.89 (694g)

		Problems		
		S.No.	Current	Past Problems
Overview	1.		mod pt / <u>LBW</u>	
	2.		<u>RDS</u>	
	3.		<u>NNJ</u>	
	4.			
	5.			
	6.			
Clinical Assessment	<u>M/O</u> <u>RDS</u> Baby <u>SSPT</u> (TCBR - @ 36 HOL - 8.5) = 145 mmol/L hemodynamically stable. PIA - soft Passing urine/stool Cutoff <u>140 mmol/L</u> HR - 137/min SPO₂ - 97%			
	Medications Used			
Plan of Care: <u>TU - 80 cal/kg/day - 13 ml/2nd hly</u> <u>- continue SSPT for 5 days & general care</u> <u>- RIV. SB on evening</u>				

Doctor's Name (Hand over given): Panar

Signature: Panar

Date & Time: 15/7/26

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:

Patient Sticker

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

Day in NICU: Day of Life: PMA:

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

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

Doctor's Name (Hand over given):

Signature:

Date & Time:

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:

BAH-00661508
 Baby Of DOKKU DEEPTHI
 13-07-2026
 Dr. DINESH KUMAR CHIRLA
 IPS-00175340
 0 Y 0 M 0 D 5 H (M)
 Barcode



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/07/26 9:15 am		
	<u>Morning Notes</u>	
	USHOL (34 wks). 1.99 kg / 6 ml SCS	
	Rh Negative	
	RDS	
	NWJ	<u>Seen by Dr. Dinesh.</u>
T-10-12 1-29 C-10-12	Baby ↓ SSPT CTCGR @ 36 HOL 8.5 mg/dl	1) T- 80 ml/kg/day 13 ml 2nd hrly Try 1-2 paladay feeds
	on room air	
	full OG feeds	2) Cont. SSPT for 24 hrs.
	<u>Vitals</u> HR = 139/min RR = 57/min	3) SBR - evening (5 pm)
		4) KMC to start
		5) Ilo charting 6th hr
	NBG - Normal	N: B Mathew TS 9:20 am
		<u>Sneha</u>

16/7

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

Day in NICU: Day of Life: D2 (68 Hrs) PMA: 34+3 Wks

Term ☐ Preterm ☒ Gestation: 34 Wk Corrected Gestational Age: Today's Weight: 1.841 kg
(65.5g)

Problems		
S.No.	Current	Past Problems
1.	moderate Perinatal RDS	
2.	NNJ	
3.		
4.		
5.		
6.		

Clinical Assessment
+CBR @ 36 Hrs. 8.5 → Baby ↓ SSPI → SBR @ 53 Hrs. 6.6 hemodynamically stable. ↓ phototherapy stopped HR - 144/min SpO₂ - 95% BP - 64/43 (50)mm - PIA - soft receives 2 palacodes yesterday - No vomiting - Passing urine/stool.

Medications Used
RIV. → TV - 100 cells/kg/day - 17ml/24hrs - stop 4th palacode → stop ILO cherting → CRBS - BD. → w/f - RD.

Plan of Care:
→ TV - 100 cells/kg/day - 17ml/24hrs - stop 4th palacode → stop ILO cherting → CRBS - BD. → w/f - RD.

Doctor's Name (Hand over given): Pavan

Signature: Pavan

Date & Time: 16/7/22

Doctor's Name (Hand over taken):

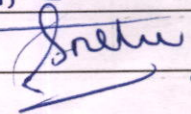
Signature:

Date & Time:

Date & Time	Progress Notes	Doctor's Order
16/7/2026 @ 10:10 am		Seen by Dr. Prathyush Spoon feeds. 1) Try Bottle feeds with preterm Nipple Try 3-4 Bottle feeds. 2) TV = 120ml/kg/day 19ml 3) Evening clinical assessment of Jaundice - 4) To review with feeding Specialist Dr. Vith if any difficulty with feed 5) Start RMC NNS Noted by AKanshu Sinha



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26 @ 3:45pm	Afternoon	Rounds
	Baby on Room air.	Plan
	Hemodynamically Stable. No Brady / desatur No Resp distress	1) TV = 120ml/kg/day 20ml 2nd hrly 3-4 paladay feeds Rest OG feeds
	<u>Vitals</u> HR = 129/min RR = 55/min SpO ₂ = 92% BP =	2) Clinical assessment of Saundice at 5pm.
	Peripheries warm, Pink.	3) KMC NNS } to Continue OMS
	Taken - 2 paladay feeds well.	4) Tlo charting 6th hrly 5) GIRBS - BD 6) w/f - RD, desaturat Vitals activity Noted by Akangsha 

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

Day in NICU: Day of Life: 24 PMA: 34⁺4 wks
 Term ☐ Preterm ☐ Gestation: 34 wks Corrected Gestational Age: Today's Weight: 1.881
CA 40g

Problems	
S.No.	Current
1.	Mod preterm 1 RDS
2.	
3.	
4.	
5.	
6.	

Clinical Assessment	
Baby - on room air. hemodynamically stable. - took took - 4 packets feeds well yesterday - No vomiting / spit out P/A - soft passing - urine / stool.	HR - 135/min SpO₂ - 96 RR - 40/min BP - 71/54 (63) TCB - 8.2 mmHg cut off - 11.6 CRBS - 90 mg/dL

Medications Used	
RIV.	

Plan of Care: TV - 140 cc/kg/day - 22ml/2hrs → to try 6 packets 600 feeds
 → continue KMC/NNLS 10M.S
 → CRBS - BD
 → I/O - charting 86th ly
 → W/P - RD / desaturation

Doctor's Name (Hand over given): D. Parani

Signature: Parani

Date & Time: 17/7/26

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

Doctor's Name (Hand over taken): D. Parani

Signature: Parani

Date & Time: 17/7/26

Patient Sticker

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

Day in NICU: Day of Life: PMA:

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

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

Doctor's Name (Hand over given):

Signature:

Date & Time:

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/26 11:00		Seen by Dr. Anush
		Try full paladay
		Dress the baby
	Noted by Dr. Anush at 11:00	
17/7/26 5:30 PM	afternoon note	Dr. Anush
		Plan
	Baby on room air hemodynamically stable C/A - good peripheries - warm passing urine/stool tolerating feeds well AA - soft	→ + V - 140 c/min / day 22mg / 2 nd hrs - - try full paladay → continue KMC / OMS / NMC.
	Paladay feeds taking well KMC - 1 hr NSG - (2)	→ GRBS - BD → I/O charting 6 th hrs → W/F - RD / observation - Dress the baby
	Noted by Dr. Anush at 5:30 PM	Paras



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/26 12:45	<u>Night Rounds</u>	Seen by Dr. N. Reddy
	Baby stable on RA	<u>Plan</u>
	1ctm (+)	
	TCBR - 13.1 (cut off 11.7)	1) Tr - 140 cc/kg/day
	Taken full palladay	22 ml 2hly full palladay feeds
	olerating well	2) Start SSPI
		3) SBR at 8 AM T/M
		4) I/O charting G/hy
		Dr. N. Reddy
		Noted by Nursing 02/07/26



(19)

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

Day in NICU: Day of Life: Day 5 PMA: 34+5 wk
 Term ☐ Preterm ☐ Gestation: 34 wks Corrected Gestational Age: Today's Weight: 1.885 kg

Overview	Problems	
	S.No.	Current
	1.	Moderate Preterm RDS
	2.	HNJ
	3.	
	4.	
	5.	
	6.	

Clinical Assessment
 Baby hemodynamically stable on RA.
 No apnea / bradycardia / desaturation
 TOBR (13.1) → @ 11 AM → started SSPT.
 Taken Palladai well over day & night.
 S/E - HR - 132/min
 RR - 42/min
 SPO₂ - 94%
 BP - 69/44

Medications Used
 SBR = 10.9

Plan of Care:

- 1) IV - 150 cal/kg/day - 25ml 2hly, full palladai feeds
- 2) continue SSPT → RL Trace SBR and R/V on SSPT
- 3) Continue KMC, OMS, NNS
- 4) No chesty Gbly
- 5) CRBS BD
- 6) W/F (RD) / apnea / Bradycardia / Desaturation

Doctor's Name (Hand over given): [Signature]

Signature: [Signature]

Date & Time: 18/7/20

Doctor's Name (Hand over taken): Paree

Signature: Paree

Date & Time: 18/7/20

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/26 @ 10am		Seen by Dr. Dinesh 1) ↑ TV = 150ml/kg/day 25ml/2nd hrs 2) Cont SSPT till evening 3) Plan shift to Room T/m noted by manjya Power
18/7/26	<u>Rounds</u> Baby on Room air Hemodynamically Stable full paladay No Resp. distress No Bradycard / desatur ongoing SSPT. <u>Vitals</u> : HR - 138/min RR - 30/min SPO ₂ - 92% Bp = 65/37(ub) P/A - soft Tolerating feeds well Stool - passed urine - Passed	Seen by Dr. 1) TV = 150ml/kg/day 25ml 2nd hrly mother to be involved in feeding 2) Cont. SSPT till 6pm. 3) Plan to shift T/m 4) monitor vitals 5) No charting 8th hrly 6) w/f - vitals Sneha



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

Day in NICU: Day of Life: 6 PMA: 34+6 wks

Term ☐ Preterm ☐ Gestation: 34 weeks Corrected Gestational Age: Today's Weight: 1.889
94g

Overview	Problems	
	S.No.	Current
	1.	Moderate Protein/RDS
	2.	NA
	3.	
	4.	
	5.	
	6.	

Clinical Assessment	Baby hemodynamically stable on air No apnoea/bradycardia/desaturations Tolerating feeds - full palledai 25 ml 2hrly for vomiting SpO₂ - 94+ RR - 42/hr HR - 120/hr
---------------------	--

Medications Used	SBR - 9.1
------------------	------------------

Plan of Care:	1) IV - 150 cc/day - 25 ml 2hrly, full palledai parents to be involved in feeds 2) Continue KMC, OMS, NNS 3) I/O charting 6hrly 4) ERBS BD (pre-feed) 5) shift to Room by evening 6) shift to Room by evening
---------------	--

Doctor's Name (Hand over given): Dr. Chirala

Doctor's Name (Hand over taken):

Signature: [Signature]

Signature:

Date & Time: 13/7/26

Date & Time:



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]

BAH-00661508 IP5-00176340
 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 2 D (M)
 Dr. DINESH KUMAR CHIRLA



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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/26 3:50 PM	Seen by Dr. PR.	Plan
	Noted by nariya at 3:15 PM	- T/m - SBR/NBS - @ 6 am
		Pain
19/7/26 9:30 AM		Seen by Dr. Densha
19/7/26 2 PM		Shift to Room today - by evening
	Afternoon Rounds	Plan
	Baby on room air	+ V-150cc/kg/day
	hemodynamically stable	25ml/24hrs - full pulse
	HR-129/min	Continue KMC/OMS/MMS
	SpO ₂ -95%	Vaccination BCG/OPV/Hep B
	- on crib care	to after shift out.
	- taking pulse/feels well	hearing assessed after shift out.
	- Passes urine/stool.	I/O Charting 6 hrs
	NBS - sent	CRBS - OD
		- WIF - T/WOB/apnea/cracks

Noted By Megha (P.T.D.)

22

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/7/26 8:00 AM	<u>Shifting Note</u>	
	Baby is on RA. Hemodynamically stable	<u>Plan</u>
		→ TV - 150cc/kg/day 2Tml 2nd hely paladay feed (EBM / FF)
		→ Vaccinations ABS } 1(m) AABR
		→ Temp. charting 3rd hely (Infant < 97.5°F)
	Noted by Dr. Pooja at 10:00 AM	→ RBS - OD.
		→ Monitor vitals
	Dr. Pooja	→ Trace NBS.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/8/26 8am	Morning Round.	
	DOL-7 PMA-35wks RDS NNT.	
	Baby is on RA.	Plan.
	Hemodynamically stable.	
	Maintaining temp.	1) Tr-180cc/kg/day.
		27ml/2nd hely.
		(EBM/FF)
	T.Wt-1816g. (47g).	full peraday feed.
NICU-1889g	y.w.w-1823g	
	Eutheuristic - 97.6°F.	
	peripheries warm.	2) BCG, OPV, Hep B - today.
	PLA-Soft.	3) AABR today.
	U ✓	
	m ✓	4) Trace NBS.
	RBS-78mg/dl.	
		5) Temp. charting 6th hely.
		(Inform if <97.5°F)
	Dr. Poopette	6) RBS-OD.
		7) I/O charting 6th hely.
		8) Monitor vitals

[illegible]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/7/26	<u>morning rounds</u>	
8:30 AM	34 week / Mod PT / 1.94kg / LBW / RR / NNG	
	Today wt: 1.814 (↑89gm)	<u>Plan</u>
	Baby on Room air Ongoing phototherapy Euthermic	1. Continue SPT with eye and genital care
	Accepting feeds well passed meconium stool Euglycemic CRT < 3 sec peripheries warm	2. TV = 160cc/kg/day 27ml/kg/h (6ml/kg/h)
	20 Echo → PFO with L→R shunt	3. GRRs OK 4. Temperature monitoring 5. (RIV) SBR @ 2pm
		<u>Seen by Dr. Aineesh</u>
	<u>Supplements:</u> Vit D3 drops - 0.5ml Syr. Ascorbic acid - 2ml / 8 hourly.	→ SBR now → Plan (RIV) → Pop @ 3 weeks → NB, NIG @ 40 weeks (FIV) Thursday

Patient Sticker

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]

Patient Sticker

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]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00661508 IP5-00176340
 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 0 D 3 H (M)
 Dr. DINESH KUMAR CHIRLA



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RESULT SHEET

Date	13/7/26	14/7/26	15/7/26	18/7/26	19/7/26	20/7	21/7
Time		1Pm	5pm				
Hb	12.8	16.8					
PCV	39.0	48.3					
RBC	3.78	4.93					
WBC	8.45	9630					
N/L	22.1/67.9	56/34					
Platelets	335	409000					
CRP		5					
ESR							
PCT							
RBS							
Na		134					
K		5.4					
Cl		109					
Ca/Mg		8.8					
Phosphate							
Urea		26					
Creatinine		1.0					
ALP							
SGPT							
SGOT							
T.Bill/Conj	2.1 < 2.0 ^{0.1}	5.04 < 5.3 ^{0.1}	6.3 < 6.2 ^{0.1}	10.9 < 10.0 ^{0.3}	9.1 < 9.0 ^{0.1}	12.8	7.6
T.Protein							
S.Albumin		8.5					
S.Globulin							
A/G Ratio							
Uric Acid							
S.Amylase							
Sr.Lipase							
Blood Lactate							
S.Cholesterol							
PT/INR							
APTT							
CSF Protein / Sugar							
Cells							
N/L							

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
DCT - Negative						
Ref count - 5-5						

Culture and Sensitivities :

.....

.....

.....

.....

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.) :

[illegible]

BAH-00661508 IP5-00175340
 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 0 D 3 H (M)
 Dr. DINESH KUMAR CHIRLA

DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : Vitamin-D3 drops				Date Time 2/7
0.5ml	PO	OD	2/7	
Name & Signature of the Doctor Starting the Drugs: Dr. Populthi				3PM 5/7/26
Additional Instructions: 1ml = 800IU				
Daily Doctor's Endorsement by a Sign				
DRUG : Syf. OSCOPAN-D				Date Time 2/7
2ml	PO	Q8H	2/7/26	4M X
Name & Signature of the Doctor Starting the Drugs: Dr. Populthi				2PM
Additional Instructions: 75mg/kg/day				10PM
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

[illegible]

I.V. FLUIDS CHART

Weight. Ward.

[illegible]

BAH-00661508 IP5-00175340
 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 0 D 5 H (M)
 Dr. DINESH KUMAR CHIRLA



Locu.No. : RCHBH/ FRM / CLINICAL / 127

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

Pratiksha
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 Hospital
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 12 PM 1 PM 2 PM 3 PM 4 PM 5 PM 6 PM 7 PM 8 PM
 Doctor / Nurse / Family Concern? PM PM PM PM PM PM PM PM PM

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																			
Heart Rate (Number)		139	140	135	129	132	136	146	134	136	143									

Resp. Rate (bpm)	70																			
	60																			
	50																			
	40																			
	30																			
	20																			
	10																			
Resp Rate (Number)																				

Resp Distress	Mod/ Severe																			
	None / Mild																			
Receiving O ₂ (l/min)																				
O ₂ Saturations (%)		99%	100%	98%	100%	97%	96%	97%	99%	99%	95%	96%								
Conscious Level	Normal	N	N	N	N	N	N	N	N	N	N	N								
	Altered																			
GCS *		C	C	C	C	C	C	C	C	C	C	C								

TOTAL SCORE																				
Number of shaded boxes		0	0	0	0	0	0	0	0	0	0	0								
Pain Score		0	0	0	0	0	0	0	0	0	0	0								
Observer's Initials		B	B	B	B	B	B	B	B	B	B	B								

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:

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

Receiving O ₂ (l/min)	O ₂ Saturations (%)
1	95
2	95
3	95
4	95
5	95
6	95
7	95
8	95
9	95
10	95
11	95
12	95
13	95
14	95
15	95
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86	95
87	95
88	95
89	95
90	95
91	95
92	95
93	95
94	95
95	95
96	95
97	95
98	95
99	95
100	95

Conscious Level	Normal Altered
-----------------	-------------------

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

JB: Scores 3 should be recorded overleaf

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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

Date: Time: 8am 10am 12pm 2pm 4pm 6pm 8pm 10pm 12am 2am 4am 6am

Doctor/Nurse/Family Concern?

104
103
102
101
100
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[illegible]

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

Blood Pressure
(mmHg) *

BP does not score
in early
warning scoring

Heart Rate (Number)

128 129 130 131 132 133 134 135 136 137 138

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

70
60
50
40
30
20
10

Resp Rate (Number)

Resp	Mod/ Severe
Distress	None / Mild

Receiving O ₂ (l/min)	O ₂ Saturations (%)
0.5	95.0
1.0	95.0
1.5	95.0
2.0	95.0
2.5	95.0
3.0	95.0
3.5	95.0
4.0	95.0
4.5	95.0
5.0	95.0
5.5	95.0
6.0	95.0
6.5	95.0
7.0	95.0
7.5	95.0
8.0	95.0
8.5	95.0
9.0	95.0
9.5	95.0
10.0	95.0
10.5	95.0
11.0	95.0
11.5	95.0
12.0	95.0
12.5	95.0
13.0	95.0
13.5	95.0
14.0	95.0
14.5	95.0
15.0	95.0
15.5	95.0
16.0	95.0
16.5	95.0
17.0	95.0
17.5	95.0
18.0	95.0
18.5	95.0
19.0	95.0
19.5	95.0
20.0	95.0
20.5	95.0
21.0	95.0
21.5	95.0
22.0	95.0
22.5	95.0
23.0	95.0
23.5	95.0
24.0	95.0
24.5	95.0
25.0	95.0
25.5	95.0
26.0	95.0
26.5	95.0
27.0	95.0
27.5	95.0
28.0	95.0
28.5	95.0
29.0	95.0
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68.0	95.0
68.5	95.0
69.0	95.0
69.5	95.0
70.0	95.0
70.5	95.0
71.0	95.0
71.5	95.0
72.0	95.0
72.5	95.0
73.0	95.0
73.5	95.0
74.0	95.0
74.5	95.0
75.0	95.0
75.	

100 100 100 100 100

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
---------	--

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

Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed. If the score is 5 or 6, irrespective of rest of the score, the Nurse MUST inform the PICU team.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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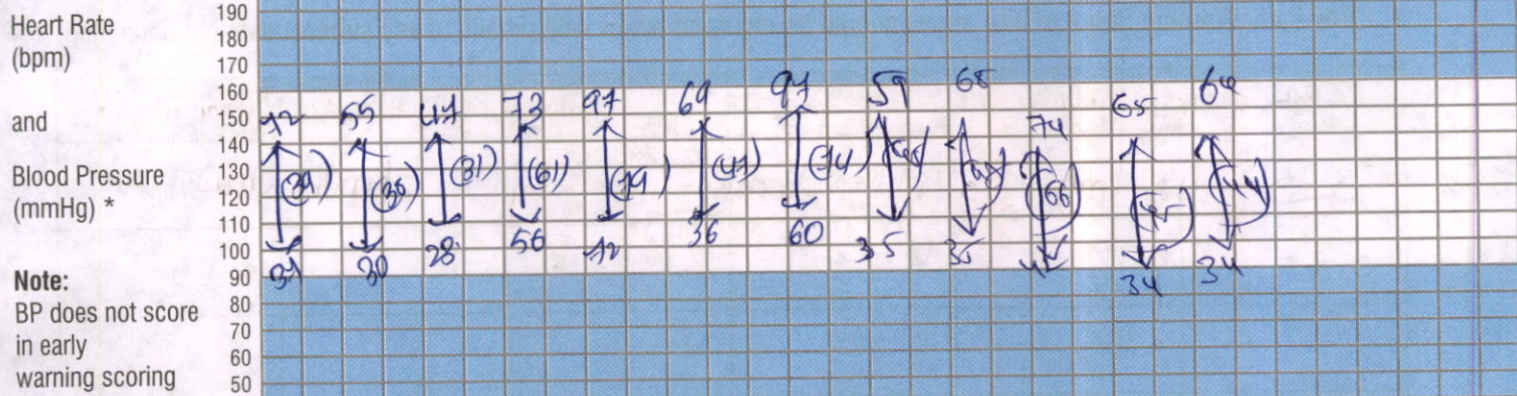
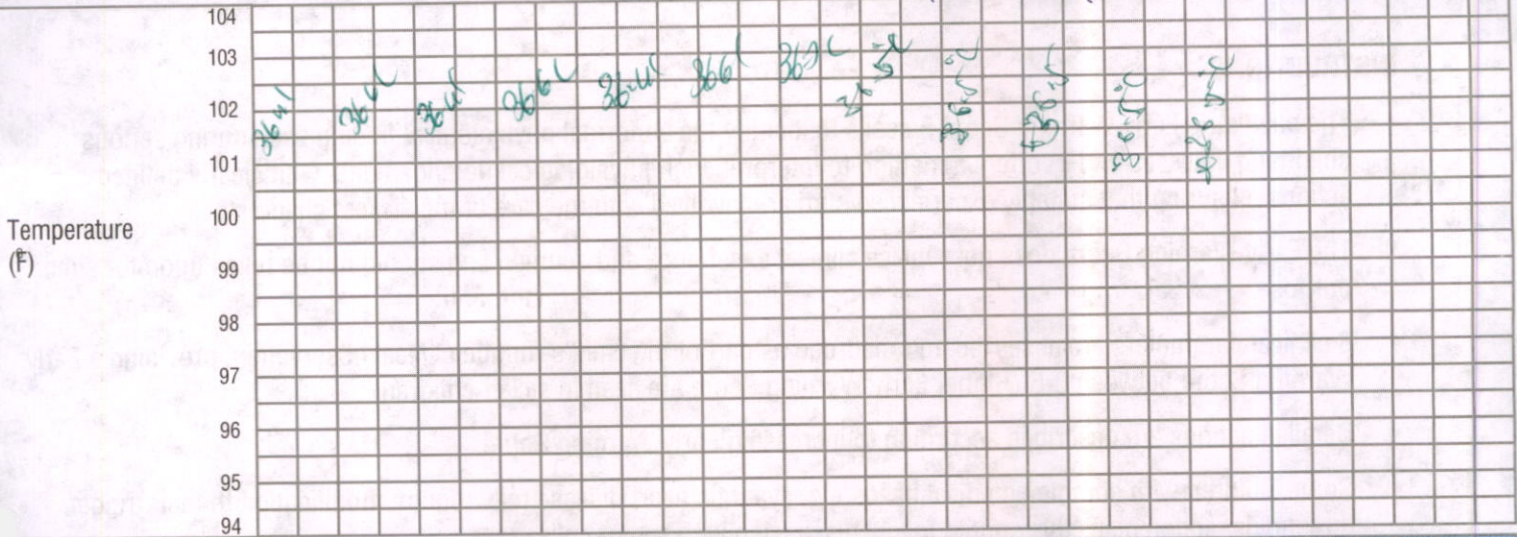


INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 13.07.2026 Time: 8AM 10AM 12PM 2PM 4PM 6PM 8PM 10 12 2 4 6

Doctor/Nurse/Family Concern?



Heart Rate (Number)

Resp. 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
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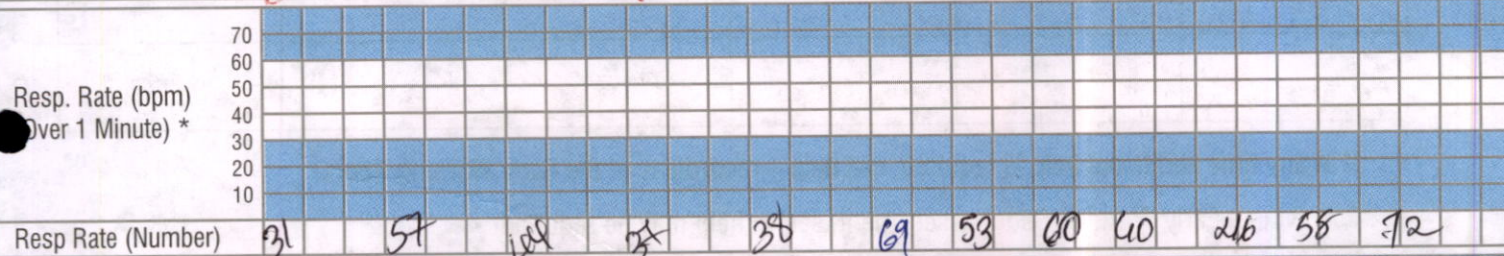
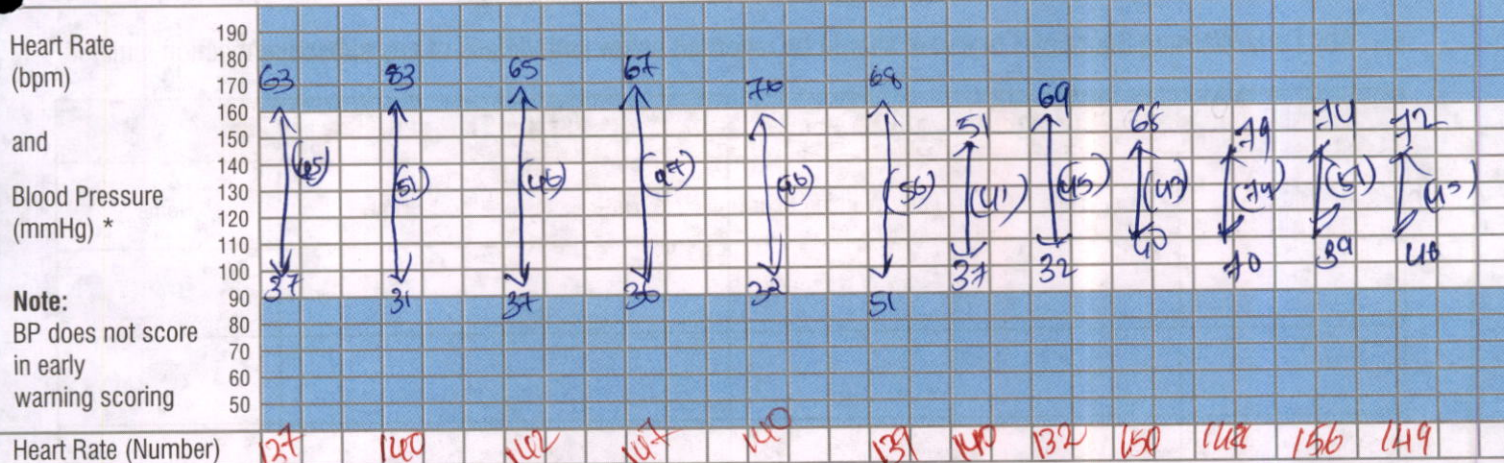
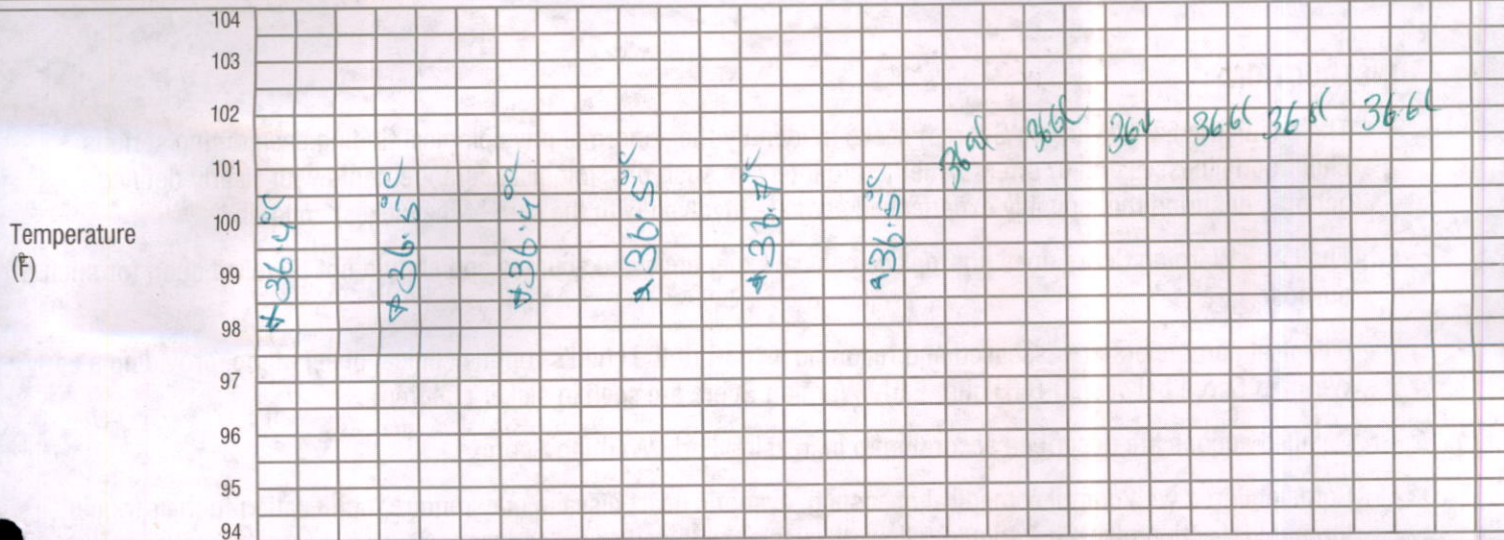


INFANT (<1 year)
**Children's Observation &
 Early Warning Scoring Chart**

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 8 10 12 2 4 6 8pm 10pm 12am 2am 4am 6am

Doctor/Nurse/Family Concern?



Resp Distress Mod/ Severe 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

Score 1 : Continue normal observation by staff nurse
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INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

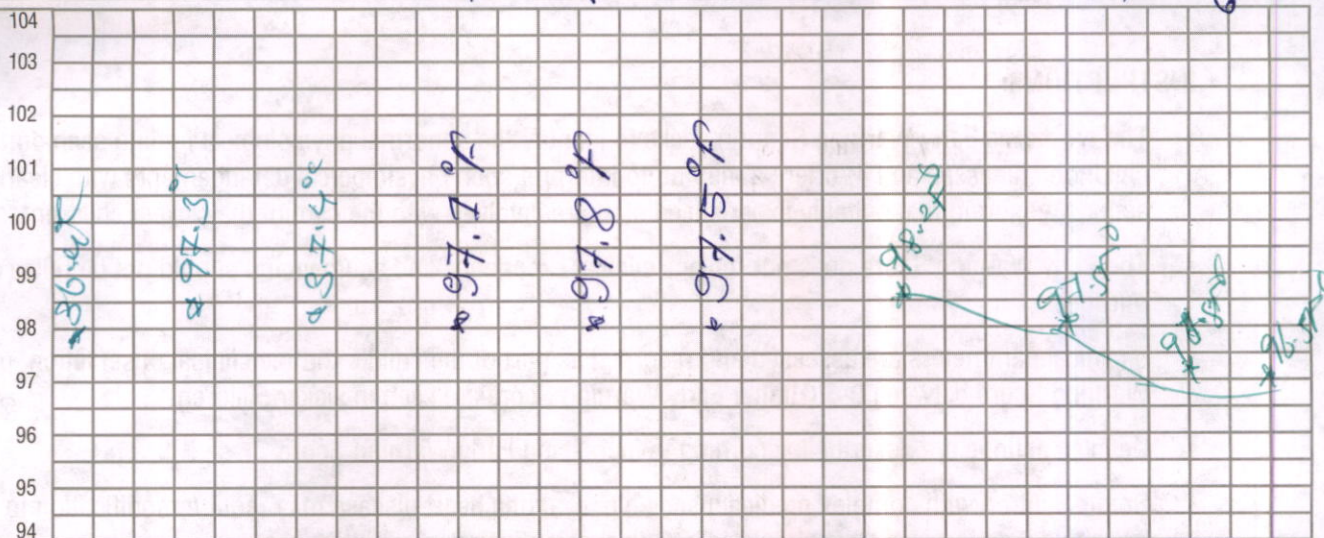
EARLY WARNING SCORE: CHILDREN'S UNIT

19/7/26

Date: Time: 8 10 12 2 4 6 8 10 12 PM 2 PM 4 PM 6 PM 8 PM 10 PM 12 PM 2 PM 4 PM 6 PM 8 PM

Doctor/Nurse/Family Concern?

Temperature (F)

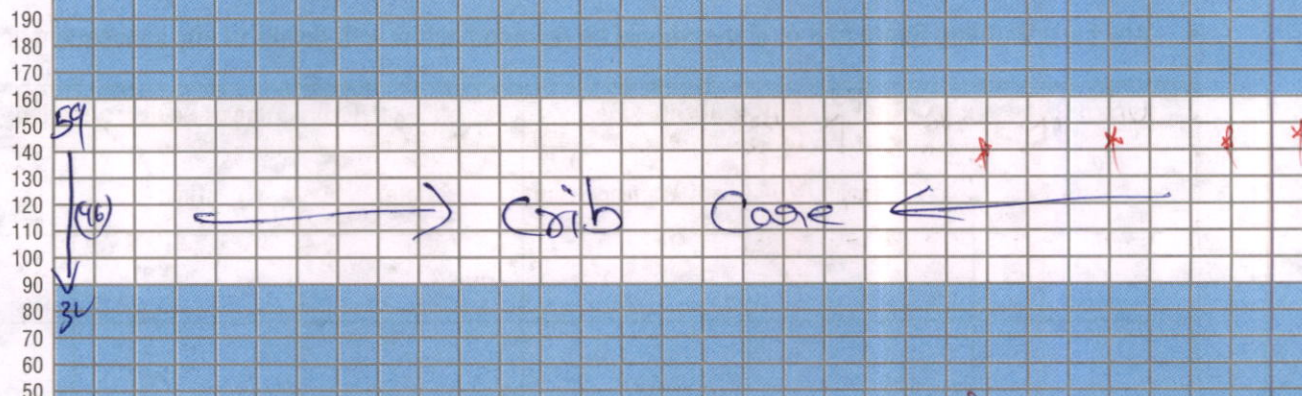


Heart Rate (bpm)

and

Blood Pressure (mmHg) *

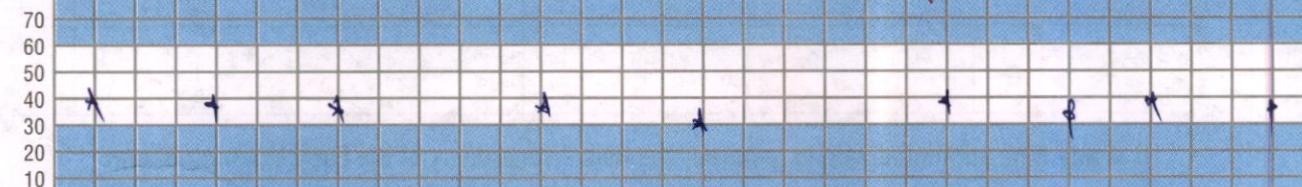
Note:
BP does not score in early warning scoring



Heart Rate (Number)

162 159 150 160 130 140 135 135 135 135 135 135 135 135 135

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



Resp Rate (Number)

39 36 34 34 34 34 34 34 34 34 34 34 34 34 34

Resp Mod/ Severe Distress None / Mild

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

99% 99% 100% 100% 100% 100% 99% 99% 99% 99% 99% 99% 99% 99% 99%

Conscious Level Normal Altered

GCS *

1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

TOTAL SCORE

Number of shaded boxes

1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

Pain Score

0 0 0 0 0 0 0 0 0 0 0 0 0 0 0

Observer's Initials

2 2 2 2 2 2 2 2 2 2 2 2 2 2 2

ACTIONS

Score 1 : Continue normal observation by staff nurse

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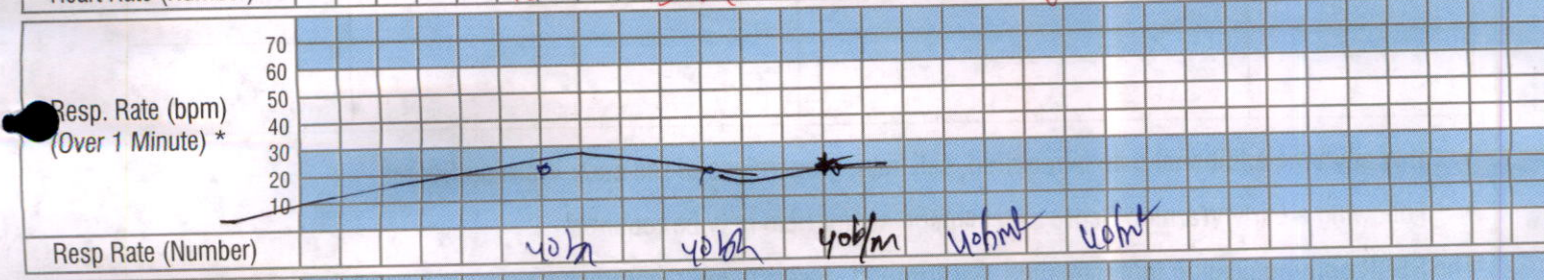
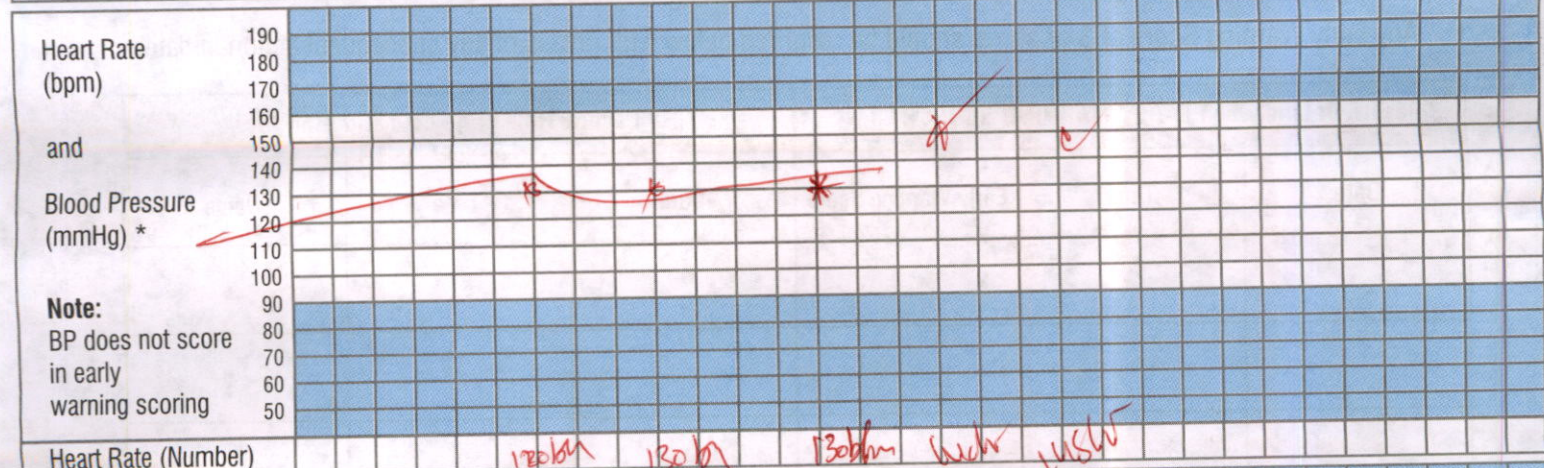
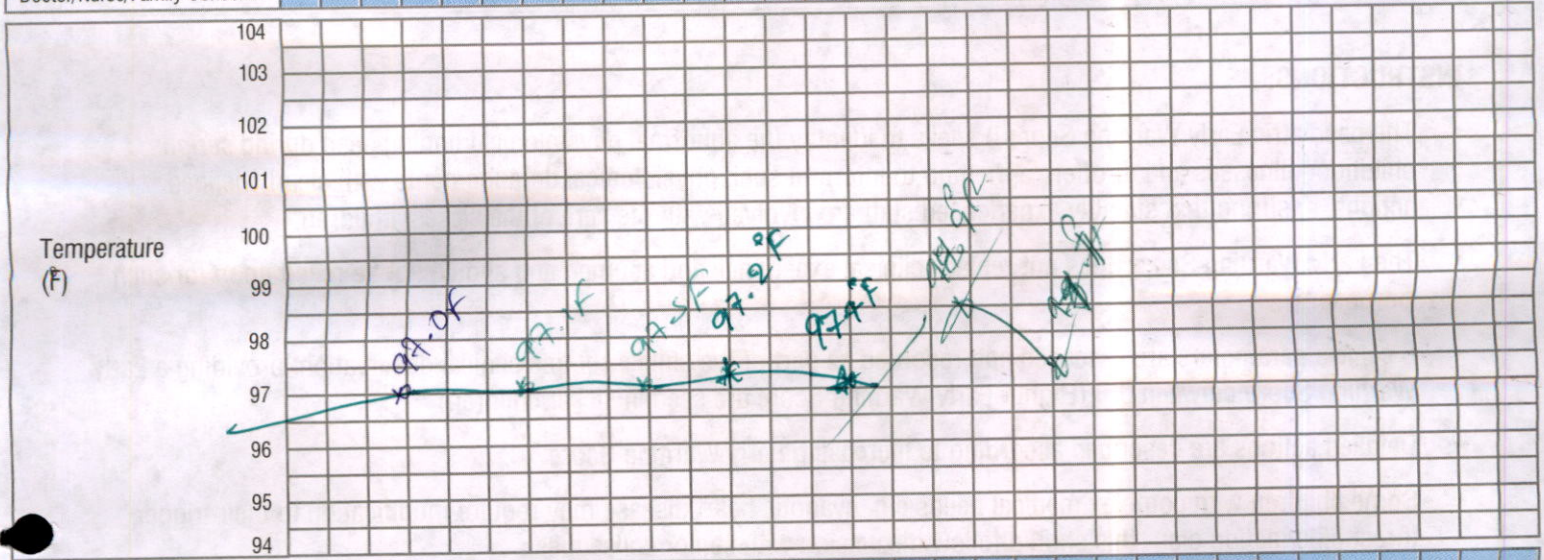
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/7/24 Time: 9 AM 11 AM 12 PM 9 PM 4:30 PM 10 PM 6 PM
 Doctor/Nurse/Family Concern? ☐ ☐ ☐ ☐ ☐ ☐ ☐



Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)		99%, 100%, 98%, 100%, 100%
Conscious Level	Normal / Altered	
GCS *		

TOTAL SCORE	
Number of shaded boxes	0, 0, 0, 0, 0
Pain Score	0, 0, 0, 0, 0
Observer's Initials	Dr, Dr, Dr, Dr, Dr

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- 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

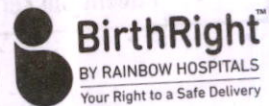
Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- 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)

H-00661508
 IP5-00176340
 by Of DOKKU DEEPTHI
 07-07-2026 0Y0M0D5H (M)
 r. DINESH KUMAR CHIRLA



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	O.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	DBM			10 ml					5 ml				
	03:00 pm													
	04:00 pm	DBM			10 ml					2 ml				
	05:00 pm													
	06:00 pm	DBM			10 ml					3 ml				
	07:00 pm													
Total Intake :		30 ml				Total Output : 0.8 ml cc/kg/hr								
	08:00 pm				10 ml									
	09:00 pm									15 ml				
	10:00 pm	DBM			10 ml									
	11:00 pm													
	12:00 am	DBM			10 ml									
	01:00 am													
Total Intake :						Total Output :								
	02:00 am	DBM			10 ml					10 ml				
	03:00 am													
	04:00 am	DBM			10 ml									
	05:00 am													
	06:00 am	DBM			10 ml									
	07:00 am													
Total Intake :		90 ml				Total Output : 55 ml = 1.6 ml/kg/hr								
Total 24 hrs. Intake												Total 24 hrs. Output		1.6 ml/kg/hr

FLUID CHART

Sheet No. : 16/07/26

T.F. 100 cc / kg / day

Baby weigh Today - 1.896 kg

- 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	NG						
	08:00 am										
	09:00 am	DBM 14ml		17ml		Passed			10ml		
	10:00 am										
	11:00 am	DBM 14ml		19ml		Passed			7ml		
	12:00 pm										
	01:00 pm	DBM 19ml				Passed			5ml		
Total Intake :					Total Output :						
	02:00 pm										
	03:00 pm	DBM 20ml				Passed			10ml		
	04:00 pm										
	05:00 pm	DBM 20ml				Passed			10ml		
	06:00 pm										
	07:00 pm	DBM 20ml				Passed			10ml		
Total Intake :					Total Output :						
	08:00 pm										
	09:00 pm	Ebm 20ml		20ml		passed			2ml		
	10:00 pm										
	11:00 pm	DBM 20ml		20ml					2ml		
	12:00 am										
	01:00 am	DBM 20ml		20ml		passed			2ml		
Total Intake :					Total Output :						
	02:00 am										
	03:00 am	DBM 20ml		20ml		passed			10ml		
	04:00 am										
	05:00 am	DBM 20ml		20ml					2ml		
	06:00 am										
	07:00 am	DBM 20ml		20ml		passed			11ml		
Total Intake :					Total Output :						

Total 24 hrs. Intake

122 cc/kg/day

Total 24 hrs. Output

22 cc/kg/day



17/7/26

(5)

FLUID CHART

TV:- 200cc/kg/day
 Sust:- 1-990kg
 TF:- 200ml

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am	BBM			200ml		passed			140ml	0	✓
	10:00 am											
	11:00 am	BBM	200ml							100ml	0	✓
	12:00 pm											
	01:00 pm	BBM	200ml				passed			90ml	0	✓
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm	BBM	200ml				-			140ml	0	✓
	04:00 pm											
	05:00 pm	BBM	200ml				-			80ml	0	✓
	06:00 pm											
	07:00 pm	BBM	200ml				passed			90ml	0	✓
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm	BBM	220ml				passed			100ml	0	✓
	10:00 pm											
	11:00 pm	BBM	220ml				-			90ml	0	✓
	12:00 am											
	01:00 am	BBM	220ml				passed			100ml	0	✓
Total Intake :						Total Output :						
	02:00 am											
	03:00 am	BBM	220ml				passed			110ml	0	✓
	04:00 am											
	05:00 am	BBM	220ml				-			110ml	0	✓
	06:00 am											
	07:00 am	BBM	220ml				passed			120ml	0	✓
Total Intake : 2580ml						Total Output : 1260ml						
Total 24 hrs. Intake		1370cc/kg/day										
Total 24 hrs. Output		2220cc/kg/day										



18/7/20

FLUID CHART

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TV:- 160cc/kg/day
 BW:- 1.99kg
 TF:- 25ml

Sheet No. : 6

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

		Intake			Output					IV Site	Sign.	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am	DBM	25ml				small passed.			9ml	0	MD
	10:00 am											
	11:00 am	EBM	25ml				passed			15ml	1	MD
	12:00 pm											
	01:00 pm	EBM	25ml							8ml		MD
Total Intake :						Total Output : 32						
	02:00 pm											
	03:00 pm	EBM	25ml				passed.			9ml	0	MD
	04:00 pm											
	05:00 pm	EBM	25ml				passed			7ml	1	MD
	06:00 pm											
	07:00 pm	EBM	25ml							9ml	1	MD
Total Intake :						Total Output : 25ml.						
	08:00 pm											
	09:00 pm	DBM	25ml				passed			15ml	0	MD
	10:00 pm											
	11:00 pm	DBM	25ml				-			8ml	0	MD
	12:00 am											
	01:00 am	DBM	25ml				-			6ml		MD
Total Intake :						Total Output :						
	02:00 am											
	03:00 am	DBM	25ml				-			11ml	0	MD
	04:00 am											
	05:00 am	DBM	25ml				passed			12ml	0	MD
	06:00 am											
	07:00 am	DBM	25ml				-			9ml	0	MD
Total Intake : 297ml						Total Output : 118ml						
Total 24 hrs. Intake			140cc/kg/day									
Total 24 hrs. Output			24cc/kg/day									

BAH-00661508 IP5-00175340
 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 1 D (M)
 Dr. DINESH KUMAR CHIRLA

19/7/26

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FLUID CHART

TV =
 But =
 IC =

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am										0	
	09:00 am	EBM 25ml								10ml	1	12
	10:00 am						Passed				1	12
	11:00 am	EBM 25ml								9ml	1	12
	12:00 pm											
	01:00 pm	EBM 25ml					Not passed			9ml		12
Total Intake :						Total Output : ✓ 28ml M-2						
	02:00 pm										1	
	03:00 pm	EBM 25ml					Passed			9ml	1	12
	04:00 pm										0	
	05:00 pm	PF 25ml					Not passed			7ml	1	12
	06:00 pm											
	07:00 pm	EB 25ml					-			6ml	1	12
Total Intake :						Total Output : ✓ 23ml M-2						
	08:00 pm											
	09:00 pm	FF 25ml					-			10ml	0	12
	10:00 pm										1	
	11:00 pm	FF 25ml					✓				1	Such
	12:00 am									✓	1	Such
	01:00 am	FF 25ml								✓	1	Such
Total Intake :						Total Output : M-1 U-2						
	02:00 am									✓	1	Such
	03:00 am	FF+EBM 25ml					1				1	Such
	04:00 am									✓	1	Such
	05:00 am	FF 25ml					NP			✓	1	Such
	06:00 am						1			✓	1	Such
	07:00 am	FF 25ml								✓	1	Such
Total Intake :						Total Output : M-0 U-3						

Total 24 hrs. Intake

Total-300ml/day

Total 24 hrs. Output

M-5 U-6ml



20/7/26

FLUID CHART

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Sheet No. : (3)

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	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											Jyothi
	09:00 am	milk	20ml									Jyothi
	10:00 am											Jyothi
	11:00 am	milk	20ml									Jyothi
	12:00 pm											Jyothi
	01:00 pm	milk	20ml									Jyothi
Total Intake : 60ml					Total Output : 0-3					m-0		
	02:00 pm											Jessie
	03:00 pm	Milk	20ml									Jessie
	04:00 pm											Jessie
	05:00 pm	Milk	20ml									Jessie
	06:00 pm											Jessie
	07:00 pm	Milk	20ml									Jessie
Total Intake : 60ml					Total Output : 0-4					m-2		
	08:00 pm											Sush
	09:00 pm	CBM	20ml									Sush
	10:00 pm											Sush
	11:00 pm	CBM	20ml									Sush
	12:00 am											Sush
	01:00 am	CBM	20ml									Sush
Total Intake : 40ml					Total Output : 0-3					m-2		
	02:00 am											Sush
	03:00 am	CBM	20ml									Sush
	04:00 am											Sush
	05:00 am	CBM	20ml									Sush
	06:00 am											Sush
	07:00 am	CBM	20ml									Sush
Total Intake : 40ml					Total Output : 0-2					m-1		
Total 24 hrs. Intake		CBM 20ml DBR			Total 24 hrs. Output		0-12			m-5		



FLUID CHART

Sheet No. : 21/7/26

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

		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

Patient Sticker

FLUID CHART

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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.

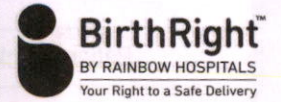
Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	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						

H-00661508 IP5-00176340
by Of DOKKU DEEPTHI
07-2026 0 Y 0 M 3 D (M)
DINESH KUMAR CHIRLA



NURSING CARE RECORD


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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date:

Assessment: baby on R/A

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	8pm	- Assess the baby General condition	baby on R/A
10am	- maintain I/O chart	10am	- maintain I/O chart	
12pm	- provide comfortable position	12pm	- provide comfortable position	
4pm	- Administer medication as per doctor advice.	4pm	- Administer medication as per doctor advice	
4pm	- ensure safety	4pm	- ensure safety.	
6pm	- feed given and hourly	6pm	- feed given and hourly	

Re-Assessment:

Special Notes: R/S - B/D

Nurse Signature: 

Nurse Name: Mariya

Date & Time: 18/7/26



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 17/11/2026 8pm

Assessment: Baby ill on PA

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the Baby condition	8pm	Assessed the Baby condition	- Now Baby is stable
10pm	Monitor vitals and recorded	10pm	monitored vitals and recorded	
12AM	Administer medication as per order	12AM	Administered medication as per order	
2AM	Monitor S/O chest	2AM	monitored S/O chest	
4AM	To give early feeds	4AM	To give and he feeds	
6AM	Provide comfortable position	6AM	provided comfortable position	

Re-Assessment: Done

Special Notes: Res - BD

Nurse Signature: [Signature]

Nurse Name: Shreya

Date & Time: 18/11/2026 @ 8AM

BAH-00661508 IP5-00175340
 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 0 D 3 H (M)
 Dr. DINESH KUMAR CHIRLA

NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 14/7/26

Assessment: Baby is on Lf

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
8 Am	Assess the baby condition	8 Am	Assessed the baby condition	Baby is stable
10 Am	monitor the vitals	10 Am	monitored the vitals	
11 Am	maintain I/O chart	11 Am	maintained I/O chart	
12 Pm	Given feed 2 nd hourly	12 Pm	Given feed 2 nd hourly	
1 Pm	provide comfortable position	1 Pm	provided comfortable position	

Re-Assessment: Re-Assessment done

Special Notes: PBS - 6th hourly

Nurse Signature: *[Signature]*

Nurse Name: Lavanya

Date & Time: 14/7/26 @ 8 Am - 8 Pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 13/7/26

Assessment: baby on P/A

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 <u>uay</u>	Assess the baby general condition provide comfortable position monitor vitals Sing. monitoring E/c chart. doctor. Advised to check GRBS 6th hourly baby with passed. O2 feeds 10ml 2nd hourly given on an O2 by low flow.		Assessed baby general condition provided comfortable position monitored vitals & recorded maintained E/c chart GRBS checked 6th hourly O2 feed 10ml 2nd hourly given DBM.	by doing above rall the pt condition slightly moored

Re-Assessment: monitored vitals 2nd hourly checked and GRBS 6th hourly)

Special Notes: doctor advised O2 low flow if baby noisy respiratory distress

Nurse Signature:

Nurse Name: Ignored

Date & Time: 13/7/26 6pm

BAH-00661508 IP5-00176340
 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 0 D 3 H (M)
 Dr. DINESH KUMAR CHIRLA

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 13/7/26 @ 2pm - 8pm

Assessment: Baby is on R/A

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
2 pm	Assess the general condition of baby	2:30pm	Assessed general condition of baby	Baby is stable
3 pm	Maintain s/o chart	3:15pm	Maintained s/o chart	
4 pm	Monitor vital signs	4:20pm	Monitored vital signs	
5 pm	Give feeds 2nd hourly	5:30pm	Given feeds 2nd hourly	
6 pm	Administer medication	6:40pm	Administered medication	

Re-Assessment: Reassessment done

Special Notes: RBS - 00

Nurse Signature: Bella

Nurse Name: Bella M

Date & Time: 13/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 13/07/26

Assessment: baby now in RLA

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the baby general condition	2:10pm	Assess baby general condition	By doing above all the care pt condition slightly normal
4pm	provide comfortable position.	4:10pm	provided comfortable position.	
	monitor vital signs.		monitored vitals & recorded.	
	maintain 1/6 chest.		maintained 1/6 chest	
6pm	doctor advised to check CRBS (6th hour)	6:10pm	Checked CRBS.	
8pm	Administered medications as per chart	8:10pm	Ensured safety.	
			Administered medications as per chart	

Re-Assessment: monitored vitals 2nd hour, checked CRBS (6th hour)

Special Notes: O₂ flow if baby having respiratory distress

Nurse Signature: *[Signature]*

Nurse Name: Beena

Date & Time: 13/07/26 (@ 8pm)



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 16/7/26

Assessment: Baby is on Loom Air.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8Am	Assess the Baby general condition.	8Am	Assessed the Baby General Condition.	Baby is now Stable.
10Am	Monitor vitals sigas.	10Am	Monitered vitals sigas.	
12pm	give the feeding 2 nd holly.	12pm	given the feeding 2 nd holly.	
2pm	Provide comfortable Position	2pm	Provided comfortable Position.	
8pm	Ensure Safety	8pm	Ensured safety	

Re-Assessment: Re-Assessment Due.

Special Notes: RBS - 6th Hourly.

Nurse Signature: Akash

Nurse Name: Akash

Date & Time: 16/7/26 @ 8pm

BAH-00661508 IP5-00176340
 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 1 D (M)
 Dr. DINESH KUMAR CHIRLA

NURSING CARE RECORD

Rainbow Children's Hospital
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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date:

Assessment: Baby - Having Bilirubin

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 Baby	10pm	(*) Assessed the Baby	Baby was stable.
12am	(*) Monitor the vital	12am	(*) Monitored the vital	
3Am	(*) Maintain I/O	3Am	(*) Maintained I/O Chart	
5Am	(*) Administer the medication As per Doctor Advice	5Am	(*) Administered the medication As per Doctor Advice	
8Am		8Am		

Re-Assessment: Done

Special Notes:

Nurse Signature: [Signature] Nurse Name: [Signature]

Date & Time: 12/07/2020 8Am

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 15/07/26

Assessment: RD

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
	* Assess the general condition of the baby * To check vitals 2nd hly * Give full OR feed DBM/BBM * To send blood samples as per doctor's order * To Encourage the KMC * To give phototherapy to patient		* Assessed the general condition of the baby * Checked vitals 2nd hly * Given full feed OR * Sample sended as per doctors order * KMC done by mother * Given 2hrs phototherapy	All plans are implemented

Re-Assessment: Done

Special Notes: W/F RD

Nurse Signature: [Signature] Nurse Name: Mathew T.J. Date & Time: 15/07/26 8pm

BAH-00661508
Baby Of DOKKU DEEPTHI
13-07-2026
Dr. DINESH KUMAR CHIRLA
IP5-00175340
0 Y 0 M 0 D 3 H (M)

NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☒ Night

Date: 12/7/26

Assessment: Baby is on L/F

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
- ☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the baby general condition.	8pm	Assess the baby general condition	the baby stable.
11pm	* baby on room air.		* baby on room air	
2AM	* 2nd 13ml DBM feed given		* 2nd DBM 06 13ml given	
4AM	em		* baby urine and stool passed.	
6AM	* baby urine and stool passed		* Spung bathing given.	
8AM	* 12 AM		at 5 AM,	
	* baby activity is good.		and medication given.	
	* Spunge bathing done.			

Re-Assessment: Re Assessment Done.

PBS - 6th checked

Special Notes:

Nurse Signature: 

Nurse Name: Jyothi

Date & Time: 12/7/26 8pm

BAH-00661508 IP5-00176340
 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 2 D
 Dr. DINESH KUMAR CHIRLA (M)

NURSING CARE RECORD

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BirthRight™
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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 17/1/26

Assessment: Baby is on room did

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 condition of baby	8am	Assessed the condition of baby	Baby is stable.
10am	maintain fluid balance.	10am	maintained fluid balance.	
1pm	maintain airway & oxygen.	1pm	maintained airway & oxygen.	
3pm	Prevent infection.	3pm	Prevented infection.	
5pm	maintain skin integrity	5pm	maintained skin integrity.	
8pm	ensure safety.	8pm	ensured safety.	

Re-Assessment: Done.

Special Notes: RBS - BD, Palladial feeds.

Nurse Signature: *Ab* Nurse Name: Agnes Date & Time: 17/1/26 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 16/7/26

Assessment: Baby R on RA 8pm

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the Baby condition	8pm	Assessed the Baby condition	Now Baby is stable
10pm	Monitor vitals and recorded	10pm	Monitored vitals and recorded	
12am	Administer medication as per order	12am	Administered medication as per order	
2am	to give and keep feeds	2am	to given early feeds	
4am	Monitor SpO2 chart	4am	Monitored SpO2 chart	
6am	provide comfortable position	6am	provided comfortable position	

Re-Assessment: done

Special Notes: PRS - BD

Nurse Signature: [Signature] Nurse Name: [Signature] Date & Time: 17/7/26 @ 8am



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 18/7/26

Assessment: Baby is on room air.

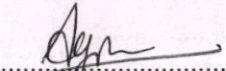
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Identify potential complications	8pm	Identified potential complications	Baby is stable.
10pm	maintain fluid balance	10pm	maintained fluid balance	
12:30am	maintain skin integrity	11pm	maintained skin integrity	
3am	maintain good nutrition	3am	maintain good nutritional status	
5am	Prevent infection	5am	Prevented infection	
7:30am	ensure safety	8am	Ensured safety	

Re-Assessment: Done.

Special Notes: PRS - B.D., SBR + NBS to send.

Nurse Signature:  Nurse Name: Dinesh Date & Time: 19/7/26 8 AM



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 19/7/26

Assessment: baby on R/A

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8Am	Assess the general condition to the Baby	8Am	Assessment the general condition to the Baby	Baby is on R/n
10Am	Monitor vitals	10Am	Monitored vitals	
12Pm	Monitor I/O chart	12Pm	Monitored I/O chart	
2Pm	Give feed to the	2Pm	Given feeding to the	
4Pm	25 ml 2nd Mother given	4Pm	25 ml 2nd Mother given	
6Pm	Crip care	6Pm	Crip care	

Re-Assessment: Re-Assessment

Special Notes: RBS-00 shift to room.

Nurse Signature: [Signature] Nurse Name: Megha Date & Time: 19/7/26 @ 8



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/07/26

Assessment: Baby is on Room air

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the baby Can diten and vitals	8:30 pm	* Assessed the baby Canditen and vitals	* now baby Can diten is stable
10pm	* monitor the ^{check} Ilo chart	10:30 pm	checked	
12AM	* every 2nd hourly EBMT FF (24ml)	12:30 AM	* monitored the Ilo chart	
3AM	* provide warm care	3:30 AM	* every 2nd hourly EBMT FF (24ml) gave	
6AM	* Ensure Safety	6:30 AM	* provided warm care	
			* Ensured Safety	

Re-Assessment: Assess the baby Canditen now # is stable

Special Notes: RBS - DD, AABR Vaccination Tomorrow

Nurse Signature: Suelw Nurse Name: Suelw - 607635 Date & Time: 19/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 20/7/26

Assessment: baby on room air

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	→ Assess the baby condition	8:10	→ Assesed the baby condition	now baby is stable
10AM	→ maintain vital sign	10:30	→ maintained vital sign	
11AM	→ warm care	11:30	→ provided warm care	
12pm	→ 2nd hourly feeding	12:20	→ provided 2nd hourly feeding	
1pm	→ ensure safety	1:30	→ provided ensure safety	

Re-Assessment: Re-assessment done

Special Notes:

Nurse Signature: A

Nurse Name: ANITHA CARLOS 321

Date & Time: 20/7/26 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/7/26

Assessment: Baby ~~breast~~ is under SSP

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the baby general Condition	2:30 pm	Assessed the baby General Condition	Baby is stable
3:30 pm	Assess the baby vitals	4pm	Assessed the baby vitals	
5:30 pm	Assess the baby under the SSP	6:30 pm	Assessed the baby under the SSP	
7pm	Assess the baby hygiene	7:15 pm	Assessed the baby hygiene	
7:30 pm	Assess the baby eyes cover	8pm	Assessed the baby eyes cover	

Re-Assessment: Baby is stable

Special Notes: GRBS - OD

Nurse Signature:

Nurse Name: jessie @ 9010577

Date & Time: 20/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/20

Assessment: Baby on room on

- 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 Baby	8:30pm	Assess the Baby	
10pm	Plan for 2nd hour	10:15pm	Plan for 2nd hour	Low Baby
12am	Plan for 1st hour	12:15am	Plan for 1st hour	Stable
3am	Plan for 1st hour	3:15am	Plan for 1st hour	
7am	Assess safety	7:15am	Assess safety	

Re-Assessment: Re-assessment done during 3rd hour

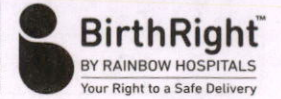
Special Notes: RBS - 00

Nurse Signature: [Signature]

Nurse Name: Sushu

Date & Time: 21/7/20 @ 5am

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Date:

Assessment:

☐ 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.....				

[illegible]

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

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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. Dinesh Kumar Chirila Department: 3rd floor Date of Admission: 13/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: <u>NA</u>				
	<u>New born baby on Room air</u>						
BACKGROUND	Area	Shift Time	<u>3rd floor 8pm-10pm</u>	<u>3rd floor 10pm-12pm</u>	<u>3rd floor 12pm-2pm</u>	<u>3rd floor 2pm-4pm</u>	
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>97.5°F</u>	<u>98.1°F</u>	<u>98.1°F</u>	<u>98.0°F</u>	
		Res:	<u>28b/m</u>	<u>30b/m</u>	<u>28b/m</u>	<u>40b/m</u>	
		SpO ₂ :	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>	
		Pulse:	<u>146b/m</u>	<u>140b/m</u>	<u>140b/m</u>	<u>147b/m</u>	
		BP:	<u>100/60</u>	<u>100/60</u>	<u>100/60</u>	<u>100/60</u>	
		Fall Risk Score:	<u>15</u>	<u>16</u>	<u>16</u>	<u>16</u>	
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>			
Recommendations	Safety Needs:	<u>care</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Sueho</u>	<u>Jyothi</u>	<u>Jessie</u>	<u>Sueho</u>		
Signature :		<u>Sueho</u>	<u>A</u>	<u>P</u>	<u>Sueho</u>		
Date:		<u>20/7/26</u>	<u>20/7</u>	<u>20/7</u>	<u>20/7</u>		
Time:		<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>		
Taken Over By Name :		<u>Jyothi</u>	<u>Jessie</u>	<u>Sueho</u>	<u>Jyothi</u>		
Signature :		<u>A</u>	<u>P</u>	<u>Sueho</u>	<u>A</u>		
Date:		<u>20/7/26</u>	<u>20/7</u>	<u>20/7/26</u>	<u>20/7</u>		
Time:		<u>8pm</u>	<u>8pm</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-00661508 IP5-00176340
Baby Of DOKKU DEEPTHI
13-07-2026 0 Y 0 M 2 D (M)
Dr. DINESH KUMAR CHIRLA



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	12/7	13/7	18/7	18/7	19/7
	3 to less than 7 years old	3	4	4	4	4	4
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3					
Diagnosis	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
	Not Aware of Limitations	3					
	Forget Limitations	2					
Cognitive Impairments	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4	4	4	4	4
	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
Environmental Factors	Outpatient Area	1					
	Within 24 hours	3					
	Within 48 hours	2					
Response to Surgery / Sedation Anesthesia	More than 48 hours / None	1	1	1	1	1	1
	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
Medication Usage	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
	TOTAL		15	15	15	15	16

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓	✓
Wheel Chair Support		✓	✓	✓	✓	✓
Other Intervention(s) Specify		✓	✓	✓	✓	✓
Nurse's Name :		Arce	Arce	Arce	Arce	Arce
Signature :		Arce	Arce	Arce	Arce	Arce
Date :		12/7	13/7	18/7	18/7	19/7
Time :		10am	10am	10am	10am	10am

JH-00661508 IP5-00176340
by Of DOKKU DEEPTHI
07-2026 0 Y 0 M 0 D 9 H (M)
DINESH KUMAR CHIRLA



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Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

13/7/26 14/7/26 15/7/26 16/7/26

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	—				
	13 years old and above	1					
Gender	Male	2	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	2	2	2	2	2
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	1	1
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	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		1			
	Other Medications / None	1	1		1	1	1
TOTAL			13	13	13	13	13

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	—	✓	✓	✓
Call device within reach	yes	yes	✓	✓	✓	✓
Wheels Locked	yes	yes	—	✓	✓	✓
Room free of clutter	yes	yes	—	✓	✓	✓
Adequate Lighting	yes	yes	—	✓	✓	✓
Wheel Chair Support	no	no	✓	x	x	x
Other Intervention(s) Specify	no	no	✓	x	x	x
Nurse's Name :		Jyothi	Jyothi	Leena	Jyothi	Jyothi
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		13/7/26	13/7/26	14/7/26	15/7/26	16/7/26
Time :		8pm	8pm	2:30pm	8pm	8pm

BAH-00661508 IP5-00176340
 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 6 D (M)
 Dr. DINESH KUMAR CHIRLA



THE HUMPTY DUMPTY SCALE 10/7 2/17

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2			
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2	2	2			
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1	1	1			
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2			
	Outpatient Area	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			
Total			13	13			

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	Yes	✓			
Call device within reach	Yes	Yes	✓			
Wheels Locked	Yes	Yes	✓			
Room free of clutter	Yes	Yes	✓			
Adequate lighting	Yes	Yes	✓			
Wheel chair support	No	No	✓			
Other Intervention(s) Specify	No	No	✓			
Nurse's Name:		Sush	Trath	Sush		
Signature:		Sush	Trath	Sush		
Date:		10/7	20/7	21/7		
Time:		8:30	8:30	8:30		

BRADEN 'Q' SCALE

					Date: 20/7/24		
					Time: 8:30 AM	2/2	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:tremitry position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	7	
"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.	4	7	
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.	4	7	
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.	4	7	
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."	4	7	
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	7	
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	7	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	27
					Evaluator's Name	Prabhu	6

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

Patient ID

BRADEN 'Q' SCALE

					Date :				
					Time :				
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.					
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.					
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.					
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.					
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."					
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.					
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.					
					TOTAL SCORE				
					Evaluator's Name				

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

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

CHECKLIST FOR THROMBOPHLEBITIS

15/07/26/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			1							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			1							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			1							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			1							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			1							
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: Telugu 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		
13/7/26	10PM	2	Baby condition, needs for 100 care, feeding,	Father	1	0	1	1	ok	Star

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

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 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 1 D (M)
 Dr. DINESH KUMAR CHIRLA



MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight
 BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Diag

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
13/7/26 SPM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Positionable Position	Proximal Comfort	Provided comfortable position		☒ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Blo. DOKKU DEEPTHI Mother's Name: MRS. DOKKU DEEPTHI
Date of Birth: 13/07/26 Time of Birth: 12:44PM Gender: ☒ Male ☐ Female
Birth Weight: 125.77 1.990 Kgs HC: — cm Length: — cm
Meconium in Liquor: ☒ Yes ☐ No Cried at Birth: ☐ Yes ☐ No
Term / Pre-term / Post-term: —
Resuscitated: ☒ Yes ☐ No Blood Group: Mother: 0-ve Baby: 0-ve
Feeding: ☐ Breast Feeding ☒ Formula ☐ Both First Feed Time: —

AFFIX MOTHER'S
IDENTIFICATION LABEL

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

Indication: —

Physical Assessment of New Born:

Temp: 97.6 °C HR: 148 /Min RR: 32 /Min BP: — SpO₂: 99.4
Pain Score: 0/6 (Follow N Pass)

Fall Risk Assessment: ☐ Yes ☒ No Score: 0/10 (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: NA

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: Suehi

Signature: Suehi

Date & Time: 19/7/26 @ 9pm



DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: As per doctor advice

2. Destination Post Discharge: ☐ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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

} need for assistance

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: personal Hygiene

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: Suchi

Nurse Name: Suchi

Date and Time: 19/07/26 @ 8pm

PATIENT TRANSFER FORM

BAH-00661508 Baby Of DOKKU DEEPTHI 13-07-2026 Dr. DINESH KUMAR CHIRLA IP5-00176340 (M) 		Date & Time of Admission 18/7/26 12:44pm	Date & Time of Transfer Order 19/7/26 9pm
Dr. DK		Transfer Ordered by Dr. pavani	Reason for Transfer Baby stable
From Unit NICU	To Unit 3rd floor 302	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File op file	Number of Imaging Films 1	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.	Prepar	(1)	
2.	feeding bottles	(2)	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Agnes		Name of Person Ordered Transfer Dr. pavani	
Patient & Clinical Records Received by : Sushu			
Date & Time of Patient Received : 19/7/26 @ 9:15pm			

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

BAH-00661508 IP5-00176340
Baby Of DOKKU DEEPTHI
13-07-2026 0 Y 0 M 6 D (M)
Dr. DINESH KUMAR CHIRLA



MULA FEEDS

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Patient Name : B/o Deepthi Age : Gender : ☐ Male ☐ Female

UHID No : Reg. 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
out the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : D. Leela Krishna

Name : D. Leela Krishna

Relationship with Patient : father

Date & Time : 19/7/26

Witness :

Signature : Megha

Name : Megha Roy

Date & Time : 19/7/26

Doctor (who is taking the consent) :

Signature : d

Name : D. Deepthi

Date & Time : 19/7/26

డబ్బా పాాలు పట్టించుటకు సమ్మతి పత్రం

శిగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.పాచ్ బడి. రిజిస్ట్రేషన్ నెం.: బిభాగము

తేది

నేను శ్రీ / శ్రీమతి వయస్సు సంవత్సరాలు

నా కుమార్తె / కుమారుడు రెయిన్ బి ఆసుపత్రిలో నవజాత శిశువుల ఇంటర్నిష్ కేర్ లో అడ్మిట్ చేసినాము మరియు (ఫార్ములా ఫీడ్) డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుచున్నాను. డాక్టర్లు డబ్బా పాలు త్రాగించడం వల్ల కలుగు ఉపయోగాలు, ప్రత్యామ్నాయాలు, మరియు నష్టాలు గురించి నాకు అర్థమైన భాషలో వివరించారు.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేది మరియు సమయము



TELEPHONE / VERBAL ORDER AND CRITICAL RESULT REPORTING FORM

☐ Telephone Order

☐ Verbal Order

☐ Critical Result Reporting

Name of Reporter:

A. Order as per Medication Chart	☐ N/A	Route	Dose	Direction If Any
B. Critical Result Reporting (Lab/Radiology/others/ If Any)	☐ N/A ☐ Intervention for Critical Results?			
Order Recipient Response: Please Tick		Yes	No	
Write Down by the receiver				
Read Back by the recipient				
Confirmed by the reporter				
Receiving by:		Ordering Doctor Signature		
Name :		Name :		
Receiving Time : Date: / /		Signature Time : Date: / /		
Signature:				

Notes for Telephone / Verbal order:

1. Verbal Order is for Emergency Situation only.
2. Doctor should sign the order ASAP but not later than 24 hours.
3. This form shall be placed in the Doctor Orders Part.

BAH-00661508 IP5-00176340
 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 0 D 5 H (M)
 Dr. DINESH KUMAR CHIRLA



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FLUID CHART

Sheet No. : (1)

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

Date	Time	Nature of Fluid	Intake			NG	Diarrhoea	Output			IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	O.G			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	DBM			10 ml					5 ml		DB
	03:00 pm											
	04:00 pm	DBM			10 ml					2 ml		DB
	05:00 pm											
	06:00 pm	DBM			10 ml					3 ml		DB
	07:00 pm											
Total Intake : 30 ml						Total Output : 0.8 ml cc/kg/hr						
	08:00 pm				10 ml							
	09:00 pm											
	10:00 pm	DBM			10 ml					15 ml		} 30 ml
	11:00 pm											
	12:00 am	DBM			10 ml							
	01:00 am											
Total Intake :						Total Output :						
	02:00 am	DBM			10 ml					10 ml		
	03:00 am											
	04:00 am	DBM			10 ml							} 30 ml
	05:00 am											
	06:00 am	DBM			10 ml					10 ml		
	07:00 am											
Total Intake : 90 ml						Total Output : 55 ml = 1.6 ml/kg/hr						

Total 24 hrs. Intake

Total 24 hrs. Output

1.6 ml/kg/hr



FLUID CHART

Sheet No. : 2

14/7/26

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 Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am	DBM			10ml		-			7ml	1		
	10:00 am										0		
	11:00 am	DBM			10ml		passed			8ml	1		
	12:00 pm										1		
	01:00 pm	DBM			10ml		-			7ml	1		
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm	DBM			13ml		-			7ml	1		
	04:00 pm												
	05:00 pm	DBM			13ml		passed			9ml	0		
	06:00 pm										1		
	07:00 pm	DBM			13ml		-			6ml	1		
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm	DBM			13ml		-			10ml	1		
	10:00 pm												
	11:00 pm	DBM			13ml		passed			8ml	1		
	12:00 am												
	01:00 am	DBM			13ml		passed			-	1		
Total Intake :						Total Output :							
	02:00 am												
	03:00 am	DBM			13ml		passed			20ml	1		
	04:00 am										0		
	05:00 am	DBM			13ml		-			15ml	1		
	06:00 am												
	07:00 am	DBM			13ml		passed			10ml	1		
Total Intake : 147ml = 73.8ml						Total Output : 100ml							
Total 24 hrs. Intake						Total 24 hrs. Output						2ml/kg/mtd.	

BAH-00661508 IP5-C0175340
 Baby Of DOKKU DEEPTHI
 13-07-2026 0 Y 0 M 1 D (M)
 Dr. DINESH KUMAR CHIRLA



FLUID CHART

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Sheet No. : 13

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

		Intake			Output					IV Site	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score		
			Mouth	I.V	O.G							
	08:00 am									0		
	09:00 am	DBM			13ml				8ml	0		
	10:00 am						normal stool			0		
	11:00 am	DBM			13ml					0		
	12:00 pm								12ml	0		
	01:00 pm	DBM	13ml				stool					
Total Intake :			49			Total Output :			20			
	02:00 pm								8ml	0		
	03:00 pm	DBM	17ml				stool			0		
	04:00 pm								10ml	0		
	05:00 pm	DBM			17ml					0		
	06:00 pm						stool			0		
	07:00 pm	DBM			17					8		
Total Intake :			51			Total Output :			18			
	08:00 pm									0		
	09:00 pm	DBM			17		passed		15	0		
	10:00 pm									0		
	11:00 pm	EBM + DBM			17					0		
	12:00 am									0		
	01:00 am	DBM			17		passed		18	0		
Total Intake :			51			Total Output :			33			
	02:00 am									0		
	03:00 am	DBM			17				15	0		
	04:00 am									0		
	05:00 am	DBM			17		passed		18	0		
	06:00 am									0		
	07:00 am	EBM			17		passed		8	0		
Total Intake :			51			Total Output :			41			
Total 24 hrs. Intake		209										
Total 24 hrs. Output		112										

Docu. No. : RCHBH/FRM/CLINICAL/092

106 cc/kg/day

= 2.46 cc/kg/hr

FLUID CHART

Sheet No. : 16/07/26

T.F. 100 cc / kg / day

Baby weigh Today - 1.896 kg.

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

		Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	OG						
	08:00 am										
	09:00 am	DBM 14ml		17ml		Passed			10ml		
	10:00 am										
	11:00 am	DBM 14ml		19ml		Passed			7ml		
	12:00 pm										
	01:00 pm	DBM 19ml				Passed			5ml		
Total Intake :					Total Output :						
	02:00 pm										
	03:00 pm	DBM 20ml				Passed			10ml		
	04:00 pm										
	05:00 pm	DBM 20ml				Passed			10ml		
	06:00 pm										
	07:00 pm	DBM 20ml				Passed			10ml		
Total Intake :					Total Output :						
	08:00 pm										
	09:00 pm	ECM 20ml		20ml		passed			2ml		
	10:00 pm										
	11:00 pm	DBM 20ml		20ml					2ml		
	12:00 am										
	01:00 am	DBM 20ml		20ml		passed			2ml		
Total Intake :					Total Output :						
	02:00 am										
	03:00 am	DBM 20ml		20ml		passed			10ml		
	04:00 am										
	05:00 am	DBM 20ml		20ml					2ml		
	06:00 am										
	07:00 am	DBM 20ml		20ml		passed			11ml		
Total Intake : 235ml					Total Output : 106ml						

Total 24 hrs. Intake : 120cc/kg/day

Total 24 hrs. Output : 23cc/kg/day