

DISCHARGE SUMMARY

Name	Baby Of T VARSHA RUDRANI	UHID	HNH-00016434
Father/Guardian	Mr T S RAHUL	Age/Gender	0 Y 0 M 3 D/ Male
Address	5-112 cplot no 55 shanthi nagar, AP Police Academy PO, Hyderabad, Telangana, INDIA, 500091		
IP No	IP26-00006784	Admission Date	08-07-2026
Ref Doctor	Self.		
Discharge Date	25.07.2026		

DR. S. TEJASWI REDDY
MBBS, MD (Paed) DM Neonatology
CONSULTANT PEDIATRICIAN AND
INTENSIVIST
APMC/FMR/94068

DR. SPANDANA PASUPULETI
MBBS, MRCPCH
CONSULTANT PEDIATRICIAN AND
INTENSIVIST
Reg No: 30925

**Diagnosis: MODERATE PRETERM (33 WEEKS + 6 DAYS)/ B. WT. 1.22KG/
VLBW/ SGA/ RH NEGATIVE PREGNANCY/ NNJ/ RDS/PROBABLE SEPSIS/
COAGULOPATHY**

History : Baby Of T VARSHA RUDRANI is a moderate preterm (33 weeks+ 6 days) male baby boy of birth weight 1.22 kgs, born to primi mother delivered by emergency LSCS (Indication: FGR with Oligohydramnios with Doppler changes) on 08.07.2026 at 12:04 pm. Baby cried immediately after birth. Apgar scores and resuscitation details were 4/10 at 1 min, 6/10 at 5 min. Baby developed respiratory distress after birth. In view of poor respiratory efforts and low saturations, Dr CPAP was given for 5-10 mins. Baby was intubated with 3.0 mm uncuffed ET and fixed at 8.5 cc. Baby was shifted to NICU - for further management.

Maternal History : Mrs. T VARSHA RUDRANI is a 27 years old primi mother . .
G1 : Present pregnancy, spontaneous conception. She had regular antenatal checkups and antenatal scans were done. Last scan done on 08/07/2026 suggestive of oligohydramnios and increased resistance in umbilical artery (abnormal doppler). History of UTI (proteus positive) on 29/06/2027. History of Hypothyroidism was present. There was history of oligohydramnios There was no history of Abortions/ Hydramnios/ PROM/ Diabetes/ Hypertension/ Cardiac/ Renal abnormalities/ PIH/ APH/ / Polyhydramnios / Fever. She received calcium,

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iron supplementation and TT prophylaxis.

Mother's blood group is A negative. Baby's blood group is A negative.

Examination: At the time of admission baby was euthermic and had low saturations at room air. His heart rate was 138/min, respiratory rate was 66/min (tachypnoea present) with poor respiratory efforts. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Abdomen was soft without organomegaly. There were no obvious external congenital anomalies.

Weight on Admission : 1.220 kgs

Weight on Discharge : 1.420 kgs

Investigations: Enclosed reports.

Date	On 08.07.2 026	On 09.07. 2026	On 10.07. 2026	On 11.07.2 026	On 12.07.2 026	On 13.07.2 026
TEST	Result	Result	Result	Result		
CBP: Hemogl obin	18.3 g/dl	17.7 g/dl	16.5 g/dl	16.2 g/dl	14.5 g/dl	14.2 g/dl
While blood cell	6730 cell/cm m	5690 cell/cm m	5260 cell/cm m	5470 cell/cmm	5910 cell/cmm	5810 cell/cmm
Platelet s	1.78 lakh/cm m	1.51 lakh/c mm	1.38 lakh/c mm	1.56 lakh/cm m	1.53 lakh/cm m	1.50 lakh/cm m
CRP	5 mg/L	14 mg/L	15 mg/L	21 mg/L	14 mg/L	11.0 mg/L
S.electr olytes: Natriu m (Na)		140 mmol/L				
Potassi um (K)		3.5 mmol/L				
Chlorid		114 mmol/L				

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e (Cl)						
Serum. CREATI NINE		0.7 mg/dl				
BLOOD UREA		17 mg/dl				
TOTAL BILIRUBI N		6.8 mg/dl				
UNCONJ UGATED BILIRUBI N		6.7 mg./dl				
CALCIU M		10.7 mg/dl				
PT/INR/ APTT		20/ 1.5 / 60	19/ 1.5 / 49	—		
BLOOD CULTUR E	Sterile					
BLOOD GROUP	A negative					

2d Echo shows

Situs Solitus Levocardia
Normal sized cardiac chambers
PFO with left to right shunt
Good biventricular function
Left arch, No COA
No PDA.

Name	Baby Of T VARSHA RUDRANI	UHID	HNH-00016434
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X-RAY CHEST AP VIEW	Feeding tube and ET tube insitu.
Done on 08.07.2026 at 17:25 X-RAY CHEST AP VIEW	ICU tubes insitu.
Done on 09.07.2026 X-RAY CHEST AP VIEW	Feeding tube and ET tube insitu.
Repeat done on 09.07.2026	ICU tubes insitu.

Management:

In view of Rh-negative pregnancy, baby was evaluated further. Cord blood bilirubin was 2.3 mg/dl with indirect fraction of 2.2 mg/dl. hemoglobin of 18.3 gm%, white blood cell count of 6730 cells/cumm, platelet count of 1.78 lakhs/cumm. Direct coombs test was negative. Reticulocyte count was 2%.

RDS/ HMD - Non-Invasive Ventilation: Baby was nursed in thermoneutral environment and started on NIPPV (FiO2 21%, PEEP 6, RR 60, PIP 15). Baby was nursed in thermoneutral environment and continued on invasive ventilation support. Initial chest X-ray was normal. Baby was loaded with Inj. Caffeine and continued on maintenance dose. UAC and UVC was fixed.

Gradually as baby's respiratory distress settled it was taken on NIV mode and the following day baby was weaned off to CPAP. Serial monitoring of chest x ray was done, which are normal. On day 3 of life baby was taken on CPAP and later to room air. Now baby is maintaining saturation at room air without any respiratory distress at room air.

Culture Negative Sepsis: Baby was nursed in thermoneutral environment. Baby was screened for sepsis and started on IV fluids and IV antibiotics (Inj. PIPTAZ) after sending blood culture. Baby's blood sugars were frequently monitored which remained stable. Baby initial hemogram and CRP was 5. Serum electrolytes and renal function tests were within normal limits. Serum calcium was normal and continued on maintenance dose. Repeat CRP done on 09/07/2026 was 14. Hence IV antibiotics were upgraded (Inj Meropenem) and started on antifungal (IV fluconazole). Serial monitoring of CRP was done which showed increasing trend (CRP on 11/07/2026 was 21). Last CRP done on 12/07/2026 was 14. Blood culture sent at the time of admission was sterile.

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Unconjugated Hyperbilirubinemia: Baby developed jaundice on day 2 of life. Baby was started on phototherapy. Baby maximum serum bilirubin was 6.7 mg/dl with indirect fraction of 6.8 mg/dl. Phototherapy was stopped after clinical improvement of jaundice.

CNS: Neurosonogram done on DOL 2 showed Tiny isolated linear echogenic foci in the right frontal subcortical white matter region noted, likely represents prominent medullary / cortical veins or tiny punctate white matter lesions. needed followup.

CVS: 2D Echo done on 09/07/2026 showed PFO with left to right shunt.

Coagulopathy: In view of deranged coagulation profile on DOL 2, 2 FFP transfusions were given and started on vitamin k injections, repeat coagulation profile was normal .

Feeding: Baby was initially kept NPO and started on IV fluids. On DOL 2, minimal OG feeds were started. On DOL 3, baby was started on TPN (Aminoven and Intralipid) . Gradual increase of OG feeds were done 1ml every 8th hourly with tapering IV fluids. DOL 4, TPN was stopped after reaching adequate OG feeds. Spoon feeds were introduced gradually. Baby is currently of full spoon feeds and tolerating well.

On DOL11 as baby maintaining saturations on room air , no distress , tolerating feedings well ,active , consecutive weight gain shifted to mother side for further weight gain and observation . Now baby active , on full feeds , with 3 days of consecutive weight gain (>1.4kg) hence being discharged with following advice .

Vaccination: Baby was given following vaccination:

Vaccine Name	Status	Date
BCG	Given	25.07.2026
OPV	Given	25.07.2026
HEPATITIS B	not Given	To be given after 2 weeks

SPO2 : 98% at room air

Red Reflex: Present & Symmetrical

Hip Examination was normal.

Baby tolerating feeds well, hemodynamically stable, passed urine and

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meconium, hence being discharged with the following advice.

Advice:

Keep the baby clean & warm
Regular breast feeding
continue measured feeds as advised.
Monitor urine output
Immunization as per schedule
Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice.
Nasoclear Nasal drops 2 drops in each nostril SOS for nose block.
Syrup Calcimax-p (5ml/150mg) 1.5 ml twice daily continue for 3 months.
MCT oil 1ml TID till further advice
HFM sachet (1 in 25ml EBM) with each feeds .

Plan:

1. **Newborn screening advanced : Report to be collected on followup.**
2. **Hearing test (TEOAE-Transient Evoked Otoacoustic Emissions) to be done on followup.**
3. **Serum Bilirubin to be done / decided on followup.**
4. **ROP screening to be done on 29.07.2026**
5. **Oral iron to be added on followup.**

Review consultation with Dr. SPANDANA PASUPULETI on (27.07.2026) Monday at Himayatnagar with prior appointment **(Review consultation will be charged).**

Review back to Hospital: If baby is not feeding continuously for > 6 hours, If breathing fast, Fever or poor activity or lethargy, Bluish discolouration of lips, Increase in jaundice, Abnormal movements occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Himayatnagar /**

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Banjara Hills / Rainbow Clinic Madhapur / Kukatpally / Vikramপুরi / LB Nagar dial just one toll free number **18002122**.

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**


Registrar/Resident/C.M.O

Dr. SPANDANA PASUPULETI
MBBS, MRCPCH
30925



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PAGE 1 OF 1 VAKSHI K/DAISI TO R/HW DUBLOVA L/HEB L/SCOW 2005 29 PM
RAINBOW CHILDREN'S HOSPITAL/CHIRIYATHI, NAGAR

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PACT OF THE ARABIA RAILROAD, LITH. IN THE DOUTCHER, LINES, AT THE LITH. D. ARABIA
RAILROAD, LITH. IN THE DOUTCHER, LINES, AT THE LITH. D. ARABIA

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RAJIBUDDHIN, THE DUTY OF HONORABLE SERVICE
AND THE DUTY OF HONORABLE SERVICE

HNH-00016434 IP26-00006784
Baby Of T VARSHA RUDRANI
08-07-2026 Y 0 M 0 D 22 H (M)
Dr. SPANDANA SUPULETI



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REPRODUCED FROM THE ORIGINAL MANUSCRIPT
BY THE NATIONAL ARCHIVES

ADMISSION SHEET


Registration Details :

Admission No : IP26-00006784 Admit Date : 08-Jul-2026 Admit Time : 01:17 PM UHID : HNH-00016434

Patient Details :

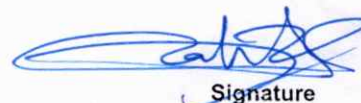
Patient Name	: Baby Of T VARSHA RUDRANI	Age	: 0 D
Guardian	: Mr T S RAHUL	DOB	: 08-07-2026 12:04 PM
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: 5-112 cplot no 55 shanthi nagar AP Police Academy PO Hyderabad Telangana INDIA 500091	Phone No	: 7799333738/ 7801028373
		E-mail	: tsrahul1819@gmail.com

Admission Details :

Bed Type : NICU Bed No : NICU1-402 Ward Name : 4F -NICU 1
Room No : NICU1-402 Admission Type : First Visit

Contact Details :

Name : Mr T S RAHUL Relationship : Father
Contact Address : 5-112 cplot no 55 shanthi nagar AP Police Academy PO Hyderabad Telangana INDIA 500091 Phone No : 7799333738



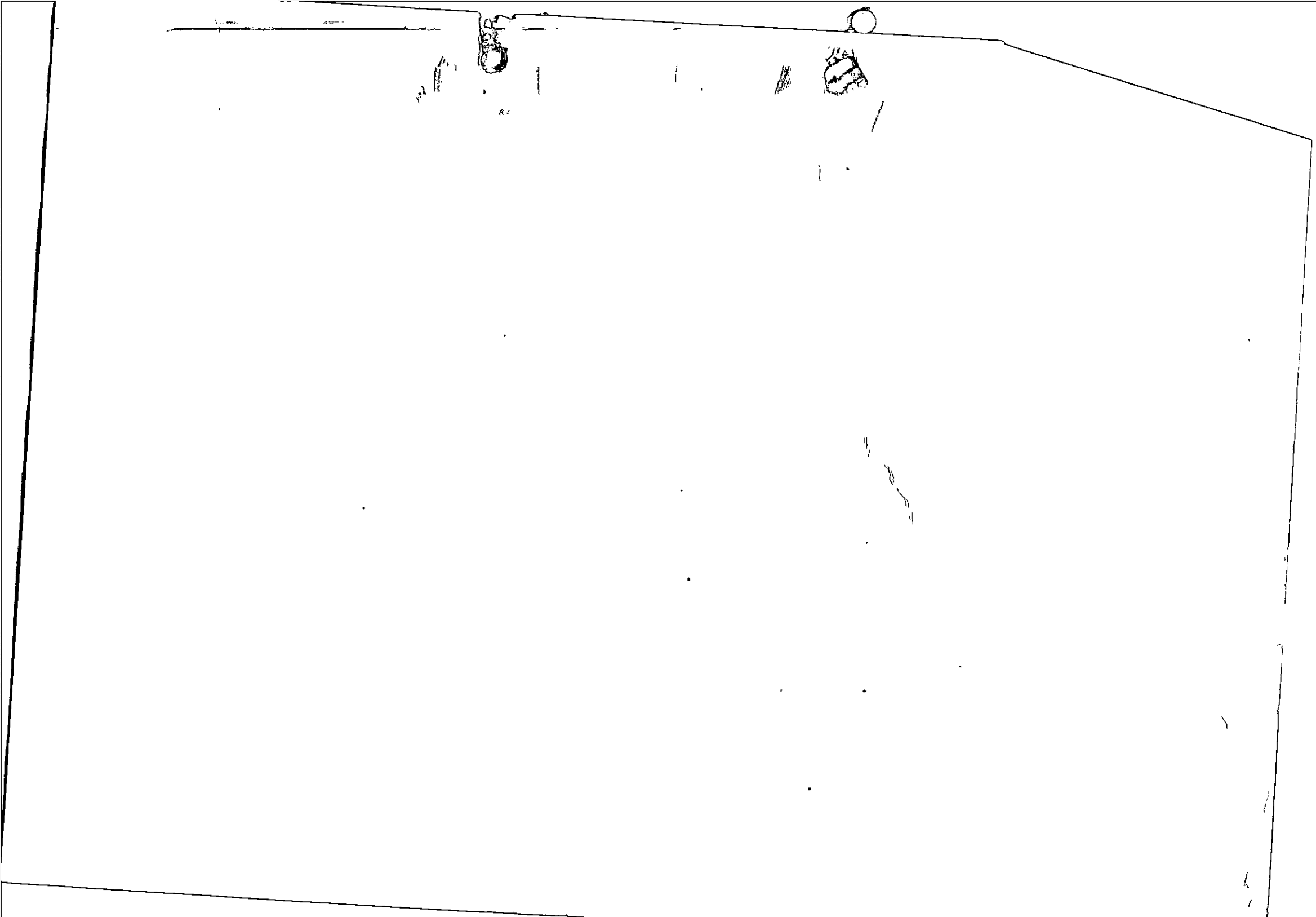
Signature

Doctor Details :

Doctor Name : Dr. SPANDANA PASUPULETI Specialisation : NEONATOLOGY
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

Deposit Amount : 60000.00
Payment Mode : DC/CC Card Payor Name : SELFPAY



HNH-00016434 IP26-00006784
 Baby Of T VARSHA RUDRANI
 08-07-2026 0 Y 0 M 0 D 22 H (M)
 Dr. SPANDANA PASUPULETI



Patient Name:

Age:

Dr.

B/o. Varsha Rudrani

UHID NO:

Date:

Done by:

9/7/26

PEDIATRIC ECHOCARDIOGRAM REPORT

Situs & Cardiac Looping	Situs, solitus, levocardia
Systemic Veins	RA
Pulmonary Veins	LA
Atrio ventricular connection	concordance
Ventricular arterial connection	concordance
Great artery relationship	NRGA
Right atrium	Normal
Left atrium	Normal
Inter atrial septum	PFO L→R shunt
Mitral Valve	Normal
Tricuspid Valve	Normal
Right ventricle	Normal
Left ventricle	Normal
Inter ventricular septum	Intact
Aorta and aortic arch	1 Arch, normal
Pulmonary artery and branch PA	Normal
Aortic Valve	Normal
Pulmonary valve	Normal
Coronaries	Normal
PDA	NO PDA
Pericardium	Nil
Others	Nil

DOPPLER / TISSUE Variables	Gradients	Regurgitation
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Mitral flow			
Tricuspid flow			
Aortic flow			
Pulmonary flow			
Mitral	E'	A'	S'
Medial LV	E'	A'	S'
Tricuspid	E'	A'	S'
Time intervals	IVRT	IVCT	DT
Others			

MEASUREMENTS:

PARAMETER	ABSOLUTE (cm)	Z score	PARAMETER	ABSOLUTE (cm)	Z score
AO	0.7		Tricuspid Annulus		
LA	0.6		Mitral Annulus		
IVSd	0.3		Aortic Annulus		
LVIDd	1.3		PA Annulus		
LVPWd	0.3		RPA		
IVSs	0.4		LPA		
IVIDS	0.8		MPA		
LVPWs	0.3		AO Isthmus		
EF	67 %		LV Mass		
FS	35 %		Others		

IMPRESSION:

= situs solitus, levocardia
 = normal sized cardiac chambers
 = PFO, L-R shunt
 - good RV function
 - 1st Arch, no COA
 - No PDA.

CONSULTANT: Performed By: *Handwritten signature*

PATIENT TRANSFER FORM

Patient Name & UHID No. HHM-00016434 IP26-00006784 Baby Of T VARSHA RUDEANI 08-07-2026 0 Y 0 M 11 D (M) Dr. SPANDANA PASUPULETI 		Date & Time of Admission 21/12/2020	Date & Time of Transfer Order 21/12/20 @ 1:20 PM
		Transfer Ordered by Dr. prashant..	Reason for Transfer stable
From Unit nllw	To Unit ward	Information to Attendant Yes ☐ No ☒	
Number of Sheets in Clinical File 2	Number of Imaging Films x-ray (4)	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	2 - x-ray clunk	(4)	
2.	also	(2)	
3.	2D Echo	(1)	
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dhayr		Name of Person Ordered Transfer	
Patient & Clinical Records Received by : madhulika 21/12/20 @ 1:30 PM			
Date & Time of Patient Received :			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

INVESTIGATIONS			
Date	Investigations	Order No.	Sign
14/7/26	RBS (67 mg/dl)	11690	SH
15/7/26	RBS (67 mg/dl)	11750	SH
15/7/26	NSG - 8	8559	SH
Cross checked by sr Shivedeek			
16/7/26	RBS (96 mg/dl)	11918	SH
17/7/26	RBS (76 mg/dl)	11917	SH
18/7/26	RBS (86 mg/dl)	12076	SH
19/7/26	RBS (102 mg/dl)	12076	SH
20/7/26	RBS (67 mg/dl)	2105	SH
21/7/26	RBS (72 mg/dl)	2176	SH
Cross checked done by Dhanya			21/7/26
9/7/26	RBS (69 mg/dl)	8335	SH (40 AM)
ABG - 11 RBS - 20 x-ray - 4 2D Echo - 1 NSG - 2			

ABG-11
RBS-20
x-ray-4
2D Echo-1
AsG-2

INVESTIGATIONS

Date	Investigations	Order No.	Sign
10/2/26	ABG, RBS (60mg/dl)	11380 ✓	DL
	Cross checked	done by Dhanya	10/2/26 @ 4pm.
10/2/26	CBP, CRP, PT / INR	11429 4 ✓	SL
10/2/26	ABG RBS (63mg/dl)	11423 ✓	SL
10/2/26	PT / INR	11430 ✓	SL
10/2/26	ABG	11452 ✓	SL
	Cross checked by pooja	11/2/26 at 1:30Am.	
11/2/26	CBP, CRP	11464 ✓	SL
11/2/26	ABG, RBS (62 mg/dl)	11474 ✓	SL
11/2/26	ABG	11521 ✓	SL
11/2/26	RBS (73mg/dl)	11522 ✓	SL
12/2/26	CBP, CRP, RBS x	11536	
12/2/26	RBS (61mg/dl)	11535 ✓	SL
	Cross checked by 17/2		
12/2/26	CBP, CRP x	11536 ✓	DL
13/2/26	RBS (60mg/dl)	11599 ✓	SL
13/2/26	CBP, CRP	11606 ✓	SL
	ABG - 11		
	RBS - 12		
	x - Ray - 4		
	USG - 1		
	2 decho - 1		
	checked by SD- Bhawan		
	13/2/26		

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
8/2/26	ET placement	1	11902	[Signature]
8/7/26	ET Intubation	1	2	[Signature]
8/7/26	UVC	1		
8/7/26	UAC	1	11830	
Cross checked done by Dhanya 9/7/26 @ 8am				

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

RBS - ①
X-ray - 4
NSG - 2
Dextro - 1

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
8/7	Ventilator		9/7/26 at 11:20 AM		
	Invasive Monitor		21/7/26 11 AM	11804	
	Oxygen (8v fluid)	1.17 PM	10/7/26 2 PM		
	Syringe pump		11/7/26 4 PM		
	Syringe pump (2 air - 1 heparin)	8/7/26 @ 8:30 PM	12/7/26 11 AM	11990	
Cross checked done by Dhanya a 12/6 @ 8 PM					
9/7/26	CPAP	11:20 AM	10/7/26 2 PM		
9/7/26	DSPT (Air Aminocou)	6 PM	10/7/26 2 PM		
9/7/26	Syringe pump	12:30 PM	12/7/26 8 AM	12209	
9/7/26	Syringe pump (2 air - 1 heparin)	1 PM	12/7/26 8 AM		
Cross checked by SO - Bharani 13/7/26					
25/7/26	NBS, OAE			12529	



INVESTIGATIONS

Date	Investigations	Order No.	Sign
8/7/26	X-Ray ①	8185	
	CBP, CRP, Blood group	11284	
	Blood culture, SBR, DLT		
	Reticulocyte count		
	RBS (6mg/dl), ABG ①	11299	
	ABG ②	11275	
8/7/26	RBS 128mg/dl	11256	
8/7/26	X-ray ②	8201	
8/7/26	ABG (RBS 65mg/dl) ③	11294	
8/7/26	ABG (RBS 10mg/dl) ④	11295	
Cross checked done by Dr. Shanya			
		821	8/7/26 @ 11:00 AM
9/7/26	Chest X-ray ③	8219	
9/7/26	PTAPTT INR	11336	
9/7/26	CBP, CRP, Electrolytes		
	Urea, Creatinine		
	SBR, Calcium	11335	
	ABG, RBS (78mg/dl) ⑤		
9/7/26	2D Echo	8226	
	NSG	8231	
9/7/26	Chest X-ray ④	8250	
9/7/26	ABG ⑥	11355	
	RBS ⑥ (76mg/dl)		

ACTIVITY RECORD FOR BILLING

Name: -----

UHID No : -----

Date of Admissi -----

Room / Bed No. -----

HNH-00016434 IP26-00006784
Baby Of T VARSHA RUDRANI
08-07-2026 0 Y 0 M 0 D 1 H (M)
Dr. SPANDANA PASUPULETI

----- Consultant : ----- Dept : -----

----- Date of Discharge : ----- Time: -----

----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/7/26	1pm	OT	NICU	Karuna / FP
21/7/26	1:20pm	NICU	Ward (3 rd floor)	Dr.

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Sweetha	9/7	3329	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Cross Checked done by Dr. Jayaraj 21/7/26

RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
8/7/26	1pm ①	61mg/dl	8 fluid	[Signature]
8/7/26	6pm ②	128mg/dl	IV fluids	[Signature]
8/7/26	11pm ③	65 mg/dl	2L fluid	[Signature]
9/7/26	5am ④	101mg/dl	2L fluid	[Signature]
9/7/26	2pm ⑤	98 mg/dl	IV fluids	[Signature]
9/7/26	8pm ⑥	96 mg/dl	w fluids	[Signature]
10/7/26	4am ⑦	60 mg/dl	2L fluid	[Signature]
Cross checked done by Dhanya 10/7/26 10am.				
10/7/26	3pm ⑧	63 mg/dl	8 fluid	[Signature]
11/7/26	6am ⑨	62 mg/dl	feeds	[Signature]
11/7/26	6pm ⑩	73 mg/dl	feeds	[Signature]
12/7/26	6am ⑪	61 mg/dl	11	[Signature]
13/7/26	6am ⑫	64 mg/dl	11	[Signature]
14/7/26	6am ⑬	67 mg/dl	11	[Signature]
15/7/26	6am ⑭	67 mg/dl	11	[Signature]
Cross checked by sr shreele				
16/7/26	6am ⑮	96 mg/dl	11	[Signature]
17/7/26	6am ⑯	76 mg/dl	11	[Signature]
18/7/26	6am ⑰	86 mg/dl	11	[Signature]
19/7/26	6am ⑱	102 mg/dl	11	[Signature]
20/7/26	6am ⑲	67 mg/dl	11	[Signature]
21/7/26	6am ⑳	72 mg/dl	11	[Signature]
21/7/26	6am ㉑	69 mg/dl	11	[Signature]
Cross checked done by Dhanya 21/7/26 @ 10pm				

4-14



Rh Negative

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : T. Varsha Rudrani Age : 27y Father's Name : Age :
 Date of Birth : Date of Admission : UHID No. :
 NICU Consultant : Referring Consultant :
 Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward
 Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : B/O - T. Varsha Rudrani Mother's Blood Group : A - Negative
 Gender : ☒ M ☐ F Blood Group : Birth Weight (gms) : 1.220kg Length (cms) :
 Date of Birth : 8/7/2026 Time of Birth : 12:04 pm OFC (cms) :
 Place of Birth : RCH - MMH Estimated Gesth Age : 33+6 wks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : Ht : Wt : BMI : Married Life : LMP : 13/11/25 EDD : 20/8/26
 Conception : Spontaneous or with Rx :

Booked at what GA : AN Steroids Drugs / Doses : 2 doses - 2 week ago + reg Dr
 Last Scans Details : 8/7 - 32w - 33+6w / Cephalic / AFI - 4.9 / Doppler - 1st resistance in
mild cardiomegaly noted : VAD @ FGA D.V. - 1st resistance
 TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ >35ys NT-
 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 : 4.9cm (Oligo)

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

Controlled or not, recent values, HbA1 values :

Compliance with Rx :

Scans : LGA, TIFFA , Fetal Echo :

H/o Hypothyroidism : when diagnosed ? Medication?

Any other Chronic Medical Problems, when detected

drugs ?

(Anemia, SLE, Jaundice, CHD, Heart Disease)

Infection : H/O, Fever

(☐ Malaria ☒ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)

UTI : when Prostus : 29/6 Any culture :

PPROM : Duration : ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results :

Medication during Pregnancy : Duration :

PAST OBSTETRIC HISTORY

G : P : A : L :

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

PERINATAL HISTORY

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

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☒ Emergency Indication : Ohja + Abnormal Doppler

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitaion : ☒ Yes ☐ No

Cord ABG : pH- 7.28 / pO₂-44.6 / pO₂-26 /

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

TOTAL

1 Minute	5 Minutes	10 Minutes
0	1	1
1	2	2
1	1	2
1	1	2
1	1	2
4/10	6/10	8/10

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



History of Present Illness:

Boy baby delivered by Em-LSCS

↓
C/AB

↓
Had poor respiratory effort

↓
DR-CPAP given for 5-10 min

↓
In view of poor efforts & not
improving saturation

↓
Baby was Intubated @ 3.0 mm uncuffed ET
& Fixed @ 8.5 cm

↓
Inj Vit - K given

↓
Baby shifted to NICU on starting
Bag & Tube Ventilation

Investigation details in previous Hospital :

Feeding History :

Patient Stic

HNH-00018434 IP26-00006784
Baby Of T VARSHA RUDRANI
08-07-2026 0 Y 0 M 0 D 22 H (M)
Dr. SPANDANA PASUPULETI



Past History :

Family History :



Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Baby Pink
Spontaneous movement (+)

VITALS : Temperature : 36.4°C HR : 138 bpm RR : 66 bpm NIBP : CFT :

Color of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 95% on MR

Anthropometry : Birth Weight : 1.22 kg Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :

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

AF 0m

Facies :

(Any Facial
Dysmorphism)

**NECK and
CLAVICLES :**

Range of Motion :
Asymmetry :
Masses :

10

EYES :

Symmetry :
Red Reflex :
Discharge :

To check

**EARS, NOSE
MOUTH and
THROAT :**

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

no cleft

**THORAX and
BREASTS :**

Shape of Thorax :
Position of Nipples and Number :

10

**ABDOMEN and
UMBILICUS :**

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

2++ IV

GENITILIA :

Labia / Hymen :
Testicles/penis :
Anus :

Male

HERNIAL ORIFICES**TRUNK and SPINE :****SKIN LESIONS :****EXTREMITIES :**

Fingers / Toes :
Arms / Legs :
Deformities :
Mobility :
Hip Joint Examination :

10



SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☐ Regular ☐ Periodic ☒ Shallow ☐ Gasping

SAS - 8/10

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 : SIPPV → PIP - 16cm / PEEP - 6cm / FiO₂ - 25%

Spo2 : Auscultation : B/L PRV Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 136/hr BP : Precordial Activity :

Femoral Pulses : Felt Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernia orifice :

Palpation : Anal Patency : Patent

Palpable masses : Umbilical Cord : 2A + 1V

Abdominal girth : First urine passed : X

Meconium passed : X

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 :

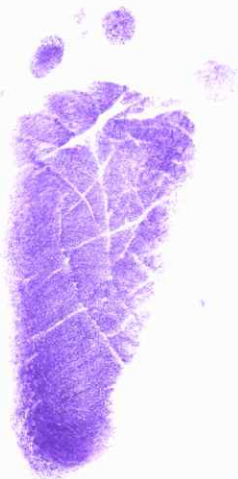


Any Congenital

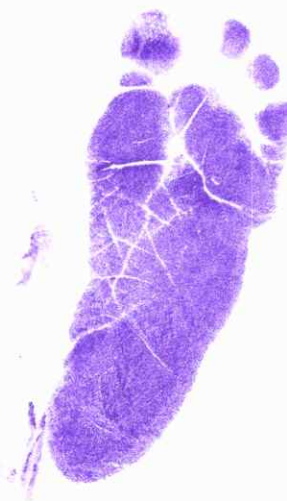
Diagnosis : *Primi / Med PT / 33⁺ w / Em LSCS (Oligo + Abnormal Doppler) / CIRS /*
RDS - MV / SGA / 1.22 kg / LBW / Boy *RH Negative / Mat - Hypothyroid / Gestational H/O*

FOOT PRINTS

Left Side :



Right Side :



Pratens - DTI
Klebsiella - LRTI *1 week ago*

Resident Doctor :

Signature : *[Signature]*

Name : *PRANAV*

Date & Time : *8/7/26 12:40pm*

Consultant :

Signature : *[Signature]*

Name : *Dr. Spandana*

Date & Time : *8/7/26 1pm*

Dr. Spandana Pasupuleti
Consultant Neonatologist and Pediatrician
Reg. No: 30925

PLEASE FILL UP THE FOLLOWING DETAILS

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



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

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

Any Oxygen requirement :

Systemic :

Medications :

→ Dig. PIPITAZ
→ Dig. Caffeine
→

Plan during ward follow up :

Send Cord (← B/L/T
DCT / Retic / SBR

→ Baby (← CBP / CRP / Blood C/S
C/S / GABs

- GABs monitoring - 4th hourly

- Chest X-ray

Feeding Plan at the time of shifting : → TV - 80 ml/kg . 10% D + Calcein glu!

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :



1

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7 2pm	B/o Varsha Baby boy 1.2 kg → Baby had respiratory distress & SpO ₂ - 50-60% @ birth & per efforts - Heena put on ventilator → Chest x-ray - appears - ok as per pernatality If screening USS chest also good - no need surfactant But if fluid in lung & abnormal - will need Surfactant. If needed - response noted in 6-8 hours. Based on how baby responds Ventilation 2-3 days SIPPV - will reduce pressure PIP - 15 - (13) Target } c SIMV mode PEEP - 6 - (5) Target } After ventilation (plan) → NIV - 2 pressure support ↓ step down CPAP - 1 pressure support MFNC → Low Flow → Rees Bi	
	Feeding → Possible for feed intolerance due to IVHR & abnormal dopph more concerned In utero will have differential blood supply to intestines Cx - Abdominal distension / Vomiting / Green aspirate ↓ if any NPO - 48 to 72 hrs Here will give via Umbilical line for TPN & Medication If not able to place line - then through peripheral port / line Today NPO - Will plan feed T/m of day after	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Infection - High probability, due to maternal history (High probability) of culture positive infection Will plan MSS (Brain scan) 2D echo (Heart scan) } needed in preterm babies otherwise currently maintaining vitals on ventilator support Stable for now. But complication risk present Preterm babies - have low bone marrow turnover If needed will plan blood transfusion Eyestest - after 3-4 weeks Hearing test at time of discharge D/C criteria -> 1.4 kg weight & hemodynamically stable with tolerating feed.	
	 Dr. S Tejaswi Reddy Consultant Neonatologist and Pediatrician Reg. No: 94063	



2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7 4pm	U/S D Tapam Mod Preterm (33⁺ wk) / En 1505 / CIAB / RDS-MV / VLBW 1.22 kg / Rh Negative / Vent-Hypoxia Baby on SIPPV PIP-15 / PEEP-6cm FiO₂ - 21% / Rate - 60 RD@ - SR @ / ICA@ VZJ HR - 144b SpO₂ - 98% RR - 56b BP - R/S - B/HR@ PA soft Patd Maccon & Vm	Plan 1) G-SIPPV 2) 2g PIP 502 8g Cuffi 3) Tran Lab 4) GRBS - 4th Lh TV - 8ml/kg/day 5) Plan vac & vvc 6) Monitor Vts 7) NPO - Today Bmr Noted by Saipriya 8/7/26 @upn



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery



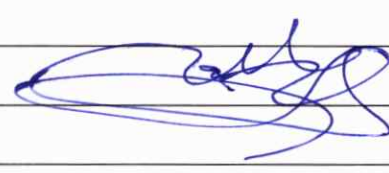
Date & Time	Progress Notes	Doctor's Order
8/7/26 12AM.	C/C bar. Varun Mod. PT/em. LSCC/ VLBW/ RDS/ PL - ve	
	On SIMV mode. 6 12 40 29.	
	O/E - vitals - HR - 125/min. RR - 40/min. SpO ₂ - 100% on SIMV.	
	S/E - <u>WNL.</u>	
		<u>Plan</u> - For reports - ↑ TR to 90ml/kg - 4RBS, ABG Q 6H.

Date & Time	Progress Notes	Doctor's Order
9/26 8 AM	CLC Dr. Venn Mod. PT / Br. LCS / VLBW / RDS / RA-V on SIMU mode. HR - 140/min. RR - 46/min. SpO₂ - 96% BP - 56/36(43). Q_R - 2/5 - BAC 0.	Plan - Extubate today. - 2 Bedch, Exray to report. - MDG Q6H.
		Noted by J. J. J. 9/2/26 @ 8 AM



(9)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7 10:15 AM	Counselling (Dr. Tejani) IS/O Varsha	
	Lungs: Baby stable on Ventilator → Plan to remove Ventilator Will taken on NIV and monitor CXR - lungs better	
	Feeding - Will start today → 0.3ml Try to get EBM - if not adequate today then may need protein formula - T/M Baby passed urine & stool Minor rash or possible issue with feed	
	Bloods - Will send for infection again after 24 HCL Next blood test - normal (No infection levels noted)	
	2D echo & USSG - Today	
	 Dr. Tejani	
	Dr. S Tejaswi Reddy Consultant Neonatologist and Pediatrician Reg. No: 94063	Noted by Spandana 9/7/26 @ 10:15 AM



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



5

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		<u>CLSB Dr. Tijasvi</u>
<u>9/7/26</u> <u>9 AM</u>	Mod. PT / Pm. 1 SLS / VLBW / RDS / RA - ve. <u>on SIMV mode:</u>	
	SE - HR - 130/min. RR - 40/min. SpO ₂ - 94%	
	SE - RIS - BAE A.	<u>Plan</u> - send PT/APTT/INR, NPI, ABG @ 12pm.
		- NSG, 2drugs, xray today.
		-
		- Start AminoVan 3g/kg/d. lipid - 2g/kg/d. Ca - 5ml/kg.
	- TP to make 100ml/kg/d.	- Plan extubation.
		- 0.3ml Q3H feeds.
		- Phenytoin to add.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7 12pm	<u>Extubation</u> not Baby was extubated to NIV mode of Ventilation PIP - 15 PEEP - 6 FiO ₂ 21% Rate - 50/min <u>Vital</u> HR - 132/min SpO ₂ - 98% RR - 55/min BP - 57/30/42 mmHg	<u>P2</u> 1) CT - NIV 2) Sent NP, PT/INR, VBS } @ 2pm 3) 4. PIPTAZ & Plavix 4) Check - NSG } Today 2 Decha 5) TV & blood by Intubated Arterial 6) Monitor Kt1
		Pun
	Noted by Jyotsna 9/7/26 @ 12pm.	

~~Noted by Jyoted~~
~~9/7/26 @ 1:40pm~~



Baby at risk

2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 17:36pm	Dr. Spandana	
	Morning Enteral	
	NTV - continue	
	Blood gases	
	homeless may rule on CPAP	
	HR/Sp - stable	
	Start feeds - 2mls	
	Formula feed	
	(NPI) - CRP - dual duration Abx	
	2 Echo - normal	
	NCG - normal	
	PS	
	Dr. Spandana Pasupuleti Consultant Neonatologist and Pediatrician Reg. No: 30925	
	Noted by Jyoreed 9/7/26 @ 5:36pm	

Date & Time	Progress Notes	Doctor's Order
9/2/20 7:40 PM	SIB Dr. Spandone PT - 20 APTT - 60 INR - 1.5 CRP-ly	- FFP Transfusion Send in 2 aliquots with a gap of 4 hrs - IV Fluid @ 2.5Lk
		M/Sep 1B
9/2/20 12:30 PM	FFP checked by Dr. Sneyden Blood group:- A Negative D.O.P:- 28/5/26 Blood bag No: 706 D.O.E:- 25/5/27	- FFP Transfusion 25cl over 1 hour
		H-Sr noted by Dhu 9/2/20 @ 11pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 11pm	WBS rx. Sneatha	
	HR: 134 bpm	
	RR: 43 bpm	
	SpO2: 95%	
	Bp: 59/30 (45)	
		Dr. Sneatha
		Dr. Dilnaaz Harooqui
		Consultant Pediatrician
		Reg. No: 27476
9/8/26 11:45 PM	Care drw Dr. Spandana	
	CRP - 14	- 1g. M. TROPENEM
		25g IV T70
		- 1g. vitamin K 2g IV on
		x3g
		ordered by Dr. Sneatha
		9/8/26
		@ 11pm



Date & Time	Progress Notes	Doctor's Order
10/2/16	SIB Dr-Singh Am Dot-3 / Mod Protein (GA → 34wH/d) [C IAD RDS - NIV - (PAP) mal / SAAT VLOW	
	Baby Fulltime	Plg
	Ht - 120/cm SpO ₂ - 94% Bt - 6.6/40 (48)	- CP IV Fluid, @ 2 Surfhz
	CNS - S, SIB (RT C3K R-BU-ALE @	- CP MEFOPENEM - FFP Transfusion @ 2:30 AM
		- CP VITAMIN K
		13:50 aloted by Dhruv 10/2/16
10/2/16 2:30 AM	FFP checked by Dr-Singh Blood group:- A Negative Blood Bcg:- 1322 D.O.P:- 20/6/16 D.O.E:- 20/6/27	Plg Transfused 25cc FFP o. Then aloted by Dhruv 10/2/16
		13:50



9

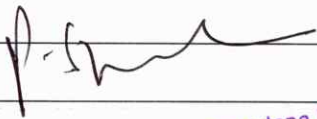
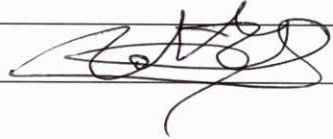
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 7:40 AM	S/B Dr. Sreejith DOL-3 / Mod. preterm (CGA → 34 weeks ftd) RDs - NIV - CPAP / Mech / SGA / VLBW / NMJ Coagulopathy Baby on CPAP HR - 130/min SpO ₂ - 95% CNS - S, S ₂ @ CRT = 3s PS - BIC - ALC @ Eggs PIA - SOL CNS - Spont. Activity @	Plm cf SSPT cf MEROPENEM cf VITAMIN K cf AMINOCAP @ 1.5ml Intralipid @ 0.5ml cf IV fluid @ 1.5ml Heplock @ 0.3ml
	2 FFP transfusion given - (50ml each)	cf OG feed 3 or 2ml ↑ Im 8ml
		Noted by Dr. Sreejith 10/7/26 @ 8 PM.

Date & Time	Progress Notes	Doctor's Order
10/7 10pm	U&B to Topsis DO2-3 / Mod PT / 33⁺ → 34⁺ / LSCS / CIAB / RDS - NIV-CIAB / Bay / SGA / 1.22 kg - VLBW / NNT / Congenitally On CPAP ← PEEP-6 cm FiO₂-21% Vital RR-144 / min SpO₂-95% RR-30 / min BP-55/44(44) mmHg Balances → +37 ml U.O - 4.4 ml/kg/h	1) CPAP - PEEP → 6 → 5 2) CPAP } CRP } down ABG } 3) Ig Meropenem Fluconazole Vit-K 4) TV - 120 ml/kg IOX-Iso-P Target-12w (ERPM) 5) Monitor Vital 6) Feed - 2ml/kg/h Dose 1ml/8th hourly
	Total by signing 10/7/20 @ 10pm	PA.



PROGRESS NOTES AND DOCTOR'S ORDER

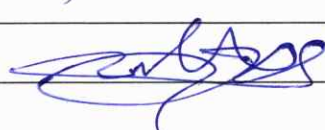
Date & Time	Progress Notes	Doctor's Order
10/7/26 8:30 PM	<u>COUNSELING</u>	
	- Baby in room air.	
	- Continuing IV Antibiotics - CRP-15	
		platelets ↓
	- Antifungal changed to sigmar	
	dox.	
	- Feeding started → plan to ↑ 1ml q 8h.	
	<u>1ml q 2h.</u>	
	- Repeat CRP, CRP tomorrow.	
	- Trea PT/INR → If abnormal	
		↓
		to give blood products.
		
	Dr. Spandana Pasupuleti Consultant Neonatologist and Pediatrician, Reg. No: 30925	
	Noted by Laxmiprasanna	
		10/7/26 @ 8:30 pm

Date & Time	Progress Notes	Doctor's Order
11/17/26 12 AM	C/L/B Dr. Vannu mod. PT / CCL / ROS / SG A / KWT. on room air. Tolerating feeds and O₂ feeds. TE - HR - 122 RR - 36 SpO₂ - 96% @ RA.	Plan ct. O₂ until Q2H. ↓ ↑ until Q8H. Repeat CBP, CRP, XBG / CBG @ 6 AM. <i>[Signature]</i>
	<i>[Signature]</i> Noted by Lanningsanna 11/17/26 @ 12 AM	



10

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7 11:40 AM	Counselling (Dr. Tejaswi) B/o Varsha	
	Baby is stable NIV → CPAP today ↓	
	→ If stable & tolerates well → Tlcr wean off phr Lungs appear OK on CXR	
	→ Will start Donor milk today as seen had issue arterially. But tolerated minimal feeds as of now	
	→ CRP - 14 - PCT - 1.5 LkH Will repeat blood test today so can u infection - on Antibiotics	
	→ Yesterday FFP given after derange PT/APTT	
	→ NSG & 2D echo done yesterday - @	
	→ Clinically baby stable	
	 Dr. Tejaswi Reddy	
	Dr. S Tejaswi Reddy Consultant Neonatologist and Pediatrician Reg. No: 94068	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7 3pm	CK/B Dr. Spandan on CPAP - 5cm FiO₂ - 21% Vit h HR - 122b Spo₂ - 99% RR - 36b R - S - B/2000 P/A - soft	Ph 1) End CPAP CRP PT, INR VBL 2) Feed - 4ml / 1st 7th 1st / 8th hly 3) TV - 110ml/kg 4) D₅ Mclapin Phlorazid Vit - K 5) Tem c/r 6) Cx - BP Noted by Sainiya 10/7/26 @ 3pm

Date & Time	Progress Notes	Doctor's Order
11/9/26 7 AM	C/S/B as. Exam DOL-4 / Mod. PT / 34+2 wks (CGA) / WLBW / NNT RDS / Coagulopathy on room air. O/E - HR - 133/min. RR - 56/min. SpO ₂ - 99% @ RA. BP - 60/42 (48). Balance - Uo-	Plan - Trace CBP, CRP. - Ct. Meropenem fluconazole vit-K ₁ - O ₂ feeds Tstl Q2 Target - 12ml ↓ ↑ 1ml Q8H - TF - 12ml/kg/d [Signature] Noted by Lashirrasanna 11/9/26 @ 7 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 10am		ch/b Dr. Tejaswi
		feeding
		→ 1ml every 4hrly
	- on Room air.	→ Total volume
	- currently on 9ml	↳ 130ml/kg/day
	(11/7/26).	↓
	- CRP: 15 → 21	Subtract feeds.
		→ Ammonium
		@ 3.5g/kg/day
		→ Lipid @ 2g/kg/day
		→ Ca glu → 5ml/kg/day.
		→ Meropenem to be continued
		fluconazole
		Trace CRP ✓
		→ ERM / donor milk.
		→ ABG evening 10pm.
		→ repeat CRP/CRP - Time 6am.
		Dr. Tejaswi

Dr. S Tejaswi Reddy
 Consultant Neonatologist and Pediatrician
 Reg. No: 94068



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Date & Time	Progress Notes	Doctor's Order
13/7/26 . 3:00 Am	<u>S/B Tegaswi</u>	Advice -
	on 15 cc/2 hourly .	• (T) CBP CRP (HMF sachets) • Start HMF sachets - 1/2 alt feed - - vit D3 drops
	ple vitally stable .	• Start Calcimax (1m) • Start Iron after 2 wks . • Ct flucon & meropenem . - Stop Antibiotics if CRP is downtrending . • Remove VAC line after stat Vancomycin dose
		Noted by <u>Laemprasanne</u> 13/7/26 @ 8:30 Am

15

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Dr. Spandana -
12/7/26	C/S/B - 7v Prashanti	
9am	A - mod PT 34+3 VLBW NNT RDS coagulopathy	
	on room air.	
	intermittent desat	Plan
8/E	HR - 174/min	Continue Antibiotics
	SpO2 95% on RA.	Continue Spoon feeds.
	BP - 55/40 mmHg	Trace CBP ^{feed} today
		CRP (14)
8/E	Cxg, tone, activity	Repeat CBP tomorrow
	Good	CRP morning.
	- urine ✓	check TCB.
	- stools ✓	
	CRP: 21 → (14).	Auth.
		Noted by
		shikha
		12/7/26
		@ 9am

HNH-00018434

1P26-00006784

HNH-00018434
Baby Of T VARSHA RUDRANI

08-07-2026

NY 9M5D

(M)

08-07-2026
DR. SPANDANA PASUPULETI



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Blo varsha (16)

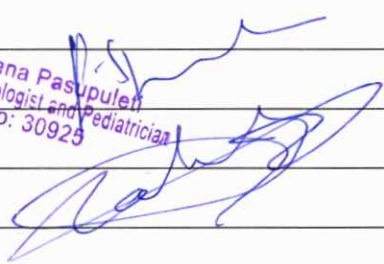
Date & Time	Progress Notes	Doctor's Order
2/7/26 2pm	SLB Dr. Spandana. [Counselling notes].	
	On Room Air. Feeds have been increased to full feeds. Tolerating upto 5cc spoon feeds. Antibiotics continued till sepsis. To continue increasing the spoon feeds gradually. Asked to get Expressed breast milk. Measured feeds requirement explained. Continuing to monitor for distress. Minimum 1.4 kgs weight at discharge.	
	P-Spandana Dr. Spandana Pasupuleti Consultant Neonatologist and Pediatrician Reg. No: 30925	

18

Date & Time	Progress Notes	Doctor's Order
02/26 2:30 PM	CL/15 - D. Luchan Being on Room air O₂ 15L and hourly ppx flow O/B: vitals HR: 120/min SpO₂ 99% @ RA RR: 56/min No RD	<u>As</u> - Ty Meyperson / Fluorocort - Trace CRP - Carb Spira feed - Monitor vitals and - Tapering SNG - HMF Budget (G. Sackel alt of - Sackel.
		Noted by Nikitha 13/7/26 @ 2:30 pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/7 8pm	Counselling (Dr. Spandana) <u>B/o Varsha</u>	
	- Baby is stable on Room Air - Tolerating spoon feeds - Once Matus trains in spoon feed, will D/C after 2 days - IV antibiotics will stop - t/m - Will start preterm formula	
		Dr. Spandana Pasupuleti Consultant Neonatologist and Pediatrician Reg. No: 30929 
		Noted by 13/7/26 @ 8pm



21

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/07/26 1 PM	Clk 15. Dr. Subhankar TS baby on room air Tolerating oral feeds well O/E: vitals: HR 125/min SpO₂ 97% @ RA RR 50/min S/E: DS: TS 44C PA: Soft	Acc - Spm feeds 2ml / 2h - RMP Sackel 1/2 sachet Als feeds - Monitor vitals and Temp Subhankar Sr
12/07/26 2 PM	Clk 15. Dr. Spandana TS baby on room air O/E: vitals: HR 123/min SpO₂ 97% @ RA RR 45/min S/E: NAO	Acc - Spm feeds 2ml / 2h - RMP Sackel 1/2 sachet - Alternate feeds - Monitor vitals and Temp Noted by Allitha 12/7/26 @ 1 PM
	- Vitamin D / Calceonax - Day 7 NSG (7/12)	

Date & Time	Progress Notes	Doctor's Order
15/07/2026 1 am	s/s Dr. Sreeghar / Dr. Naneen on room air HR - 142/min SpO₂ - 96% accepting feeds well	Plan ① ct spoon feeds + 1 sachet mmf ② ct supplants ③ Monitor vitals (^{slau} Dr. Naneen) noted by Lauren Masanna 15/7/26 @ 1 AM



Date & Time	Progress Notes	Doctor's Order
15/07/2026 7:30am	S/B Dr. Nameen / Dr. Sueghan D7 33 ⁺ → 34 ⁺ Mod PT LSCS VUBW - 1.22 kg / m RDS NNT Probable sepsis	
	Twt - 1.240 kgs ↓ 20 gms. on room air comfortable, no ED HR - 144 / min spo₂ - 95% @ RA urine ✓ stool ✓ accepting feeds well.	<u>Plan</u> ① ct spoon feeds 20ml Q2H + 1/2 sachet mmf ↑ feeds → 22ml Q2H ② ct supplements ③ NSG today ④ Monitor intake
		Dr. Nameen
	noted by Laxmiprasanna 15/7/26 @ 7:30 Am	



23

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7 2 PM	CL/B Dr. Prasad D ₇ / 33 → 34 w ^h / VL BW (1.22 kg) / NMT / RDS / Congenitally	
	Baby SV on RA Tolerating feed	Plan 1) Spaced feed - 23 ml / Q4h + HMF
	Vital HR - 130/min RR - 50/min SpO ₂ - 95%	2) C.A. Monitoring 3) Vit D ₃ drops 4) Monitor Vital
	Haemodynamically stable CL/B - Good	Plan
15/7 5 PM	CL/B Dr. Tejaswi SV on RA	Plan - SF 23 ml Q4h + HMF. - U. Vit. D ₃ drops.
	GE - HR - 130/min RR - 50/min SpO ₂ - 96%	
	GE - WNL	

Noted by
 15/7
 5 PM

GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26	d/s/B - Dr. Prashant Dr. Anusha	
8Am	A - D ₈ / 34+6 CGA GA 33w	SGA VLBW
	on Room air	Plan
	Tolerating feeds	- Spoon feed 23ml Q 2H E HMF to each feed
	Vitals stable	- ct. vit D3 drops
	SpO ₂ wnc	- monitor vitals Urine output
		Noted by subprip 16/7/26 3Am

Date & Time	Progress Notes	Doctor's Order
16/7/26	c/s/B	Dr. Prashant Dr. Anusha
8AM	moderate A- late Preterm GA → 34w CGA - 34+6	SGA VLBW RDS nng
	Bwt 1220 Twt 1280 Δ → ↑ 40g	mBG - A-ve BBG - A-ve
		plan
<u>O/E</u>		
feeds - ✓		- spoon feeds 23ml @ 2H. 2 tlmf to each feed.
Urine - ✓		
stool ✓		- ct vit D3 drops.
		- monitor vitals. Urine output
		initiated by supplier 16/7/26

Date & Time	Progress Notes	Doctor's Order
16/7 1pm	<u>Counselling</u> B/o <u>VARSHA</u> T.Wt - 1.28 (1kg) -) Baby stable Accepting feeds well Giving NMF in each feed -) If LT ≥ 1.35 kg - Room Shift -) If No LT gain - T/m then add MCT oil <u>Varsha</u> <u>Noted by Laxmiprasanna</u> 16/7/2020 @ 1pm	(D. Tejash)

Date & Time	Progress Notes	Doctor's Order
16/7 1:45pm	<u>C/S/B D₃ Phos</u> DOL - 8 / 33 → 34 ⁺ h / HCS / 1.22Kg VLBW / PDS / Congenitally / h SV on RA Tolerating Spoon feed <u>Vital</u> HR - 132/h SpO ₂ - 95% RR - 26/h R - S - B/LAB@ PIA - soft	<u>Pla</u> 1) Spoon feed - 23-25d/h PMF 2) Cf - Vd D ₃ calcium - P 3) Monitor Vital Infam SOS Raman
		Noted by nursing 26/4/26 ②



26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26 10 AM	S/O Dr. Sindhura Child stable Ht - 136 cm SpO ₂ - 98%	Plg - ce son Dr. Sindhura Munukuntla Consultant Pediatrician Reg. No: 66970
17/7/26 7:30 am	U/R Dr. Pravin Wt - 9.34 kg / 20 lb / 0.9 kg / 2.0 lb T. wt: 1.240. 1.40g.	Plg 17sf - 25 me / 2ml h + HMF 3) it. vit D ₃ drops calensiox - P 3) monitor vitals
	- feeds - urine - stools O/E vitals: HR: 132 bpm RR: 48 bpm SpO ₂ : 100% BP: 67/42(49) P/A - neg M: R/L C	Noted by Nikitha 17/7/26 @ 7:30 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26	CSB- Dr. Prashanti Dr. Anusha	
4pm		
	A-DOL-9 / 33 → 39+2 / VLBW / RDS LSCS W / mH	
	- on 2oom air	Plan
	- tolerating feeds.	
	- passing urine.	
	O/E	- ct spoonfeed 25 q 2H mt
	Vitals stable	- 1ml to each feed
	S/E	- dmcT oil 1ml TID
	color - pink	
	Cry	- Plan to shift if wt > 135 kg.
	Tone } Good	- 9 consecutive wt gain
	Activity }	for 3 days
		- ct vit D3 Prunthi
		calcimax
		- monitor
		Vitals
		Noted by laumiprasanna



28

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7 11:00 PM	CLINIC Dr. Naipunya / Dr. Archana LPT / VLBW / RDS / NNJ	Plan
	on Room Air.	
	Vitals - stable	Spoon feed 25ml / 2nd hours.
	RLs - BLAE @ PIA - soft, no distension	Cont MCT oil 1ml TID
		Cont Supplements
		Def
18/7/26 - 7 AM	S/B Dr. Archana / Dr. Naipunya Δ: DOL-10 / 33 → 39 ^{Wks} / VLBW / LSCS / RDS / NNH on Room Air Tolerating feeds t wt 7.280 kg i passed S	Advice. - Ct spoon feeds 25 cc 2 hourly - Ct MCT oil 1ml TID - Plan to shift if wt > 1.35 kgs & consecutive wt gain @ per 3 days - Ct rest as per chart
	ole c/LA - good .. vitality stable	
	ole wnt	
		Noted by Nikitha 18/7/26 @ 7 AM

HNH-00016434 IP26-00006784
 Baby Of T VARSHA RUDRANI
 08-07-2026 0 Y 0 M 7 D
 Dr. SPANDANA PASUPULETI (M)

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GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/2/21 1pm	c/s/hy. Dr. Anurag DOL-10 / 33-34+3 / VIBW / RDS / NNH	
	Baby on RA Euthic Pink	
	<u>Vital</u> HR=100/min SpO ₂ =94% HR	<u>Plan</u> - ct spoon feeds 25ml Qly.
	<u>Stc</u> c/T/A Good.	- Met Oil - ct HMF
		- Monitor vitals
19/2/2021 1am	AF 8/8 Dr. Sreegham / Dr. Nameer	
	on room air active HR-126/min SpO ₂ -100% accepting feeds well	<u>Plan</u> ① ct spoon feeds 25ml Qly + HMF sachets ② ct supplements ③ monitor vitals
		Noted by Nitishan 1pm

Date & Time	Progress Notes	Doctor's Order
19/02/2026 9:30 am	8/13 Dr. Sreegham / Dr. Nameen DOL-11 33 → 34 ⁺ hrs / VUSW / RDS / NNH13	
Today's wt - 1.3 kgs (↑ 20gms) on room air active Euthetic / pink HR - 138/min SpO ₂ - 96% accepting feeds well		Plan ① ct spoon feeds 25ml QH + HMP Sachets ② ct supplements ③ Monitor intals
Urine output - 6.25 ml/kg/hr Stools ✓		(Nameen)
		Noted by Nikitha 20/2/26 @ 9:30 am



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/07/26 10:30 AM	Dr. Tejinder Reddy/ O/C - D. Subbaraj	
	Therapy of women Tolmetrey feeds	
	O/C Subbaraj Vitals: HR = 140/min SpO ₂ = 99% @ RA BP = 80/80 mmHg	
	SpO ₂ NAD -	Adm - Ct. Spoon feeds - Ct. Supplements - Monitor vitals and Temp per Subbaraj



30

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/20	Counseling	
	Baby is feeding & growing	
	Wt → 1.2kg (↑ 20gm).	
	1.35kg	↑ 50gm
		↓
		Shift the baby to room side & mother.
	Discharge > 1.4kg	
	Dr. S Tejaswi Reddy Consultant Neonatologist and Pediatrician Reg. No: 94068	
	Dr. Tejas	
	21 days	

IP26-00006784

08-07-2026

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(M)

Dr. SPANDANA PASUPULETI



3)



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CONGRESS NOTES AND DOCTOR'S ORDER

PROGRESS NOTES AND DOCTOR'S ORDER		
Date & Time	Progress Notes	Doctor's Order
20/07/26 12 AM	Chk - D. Lumball / D. Vary Baby on room air Feeding goes well O/A vitals Gutheiser HRs - 130/min BP - 55/46 mm Hg RA - 32/min SpO2 96% @ RA	<u>Act</u> - Cont SpO2 feeds - Cont Supplement - Monitor vitals and - Inform SR <u>Scrub</u> acted by Dhanu 20/7/26 @ 8 AM

IP26-00006784

HNH-00016434
Baby Of T VARSHA RUDRANI
08-07-2026 0 Y 0 M 11 D (M)
Dr. SPANDANA PASUPULETI



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Date & Time	Progress Notes	Doctor's Order
10/2/26 8 AM	CPIS D. Tejovati Reddy/ D. Subudh / D. Yany DOL - 12 / 33 → 34 + 3 / VTSU / R01 / NNY Beddy on room air @ Spoon feedly - Tolerating (oral 2nd hourly) O/A vitals: Gutheerini HR - 150/min SpO₂ - 97% @ RA RR - 40/min	T. wt - 1320 (↑ 20g) <u>Atch</u> - Cont. Spoon feedly - Cont. Supplemently - Monitor vitals and Taper on Doc <u>Sunder</u> Noted by Dheeraj 20/10/26 @ 8 AM

Docu. No. : RCH / FRM / CLINICAL / 088



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7 1:30 pm	C/S/B Dr. Prannav / Dr. Seeghan D-12 / 33 → 34 ⁺⁵ wk / LSCS / 1.22 kg / VLOW / RDS / NNJ / Coagulopathy SV on RIA on spoon feed Vital HR - 138/min RR - 30/min SpO ₂ - 99% BP - RS - B/LAET P/A soft -	Plan 1) Spoon feed - 25ml/hr 2) CT - Supplement - Vit D Calcium MCT oil HMF sachet 3) Monitor Vitals
20/7 5:00 pm	C/S/B Dr. Spandana on RIA Vitals - HR - 144, RR - 32 SpO ₂ - 98% RS - B/LAET P/A - soft -	Plan - SF 25ml / Q2H for burping - Cont Supplements vit D3 Calcium MCT oil HMF sachet monitor vitals

Date & Time	Progress Notes	Doctor's Order
21/7/26 7:30am	DOLB re-examine DOL-13 33 → 34 ^{tw} 1.22kg RDS NNJ	
	- f.wt: 1.360kg ↑ 40g - on Room air - tolerating feeds well.	
	<u>O/E</u> vitals : HR : 130 bpm RR : 40 bpm spo ₂ : 99%.	<u>Plan</u> 1) U. spoonfeeds 2cm/ml max 2) Et syngutric care 3) monitor vials
	<u>hw</u>	
9:35 AM	C/S/B Dr Tgaswi shift to mother's side. Purts	

Docu. No. : RCH / FRM / CLINICAL / 088



Date & Time	Progress Notes	Doctor's Order
1/26	Today wt 1.36 Baby is ok, mother confident will shift. <i>Vandana</i> <i>Dr. Tejan</i> Dr. Tejaswi Reddy Consultant Neonatologist and Pediatrician Reg. No: 94068	

IP26-00006784

08-07-2026

0 Y 0 M 12 D

(M)

Dr. SPANDANA PASUPULETI



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~~21/7/26~~
~~5 PM~~

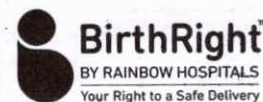
Date & Time	Progress Notes	Doctor's Order
26	CLB Dr. Tejaswi	
	DOL- 13 34+6 Wks POS NNH.	
	- Baby SV on RA.	<u>Plk</u>
	- Tolerating spoon feeds.	- Wkly cere.
	C T } <u>Good.</u> A }	- DBF @ 24H + PF
	Passing urine & stools.	- Vaccination 1
		- OAE tomorrow
		Dr. Tejaswi Reddy Consultant Neonatologist and Pediatrician Reg. No: 94068

Sheet No:

REGULAR PRESCRIPTIONS

Weight 1.22kg Ward

DRUG : <u>MMF sachets</u>				Date	Time
Dose	Route	Frequency	Start Dt.	13/7	14/7
<u>1/2 sachet</u>	<u>PO</u>	<u>every alt feed</u>	<u>13/7</u>		
Name & Signature of the Doctor Starting the Drugs:				10 AM	
				12 PM	
Additional Instructions:				2 PM	
				4 PM	
Daily Doctor's Endorsement by a Sign				6 PM	
				8 PM	
DRUG : <u>Syp Vit D3 drops</u>				Date	Time
Dose	Route	Frequency	Start Dt.	13/7	14/7
<u>0-5cc</u>	<u>PO</u>	<u>OD</u>	<u>13/7</u>		
Name & Signature of the Doctor Starting the Drugs:				10 AM	
				12 PM	
Additional Instructions:				2 PM	
				4 PM	
Daily Doctor's Endorsement by a Sign				6 PM	
				8 PM	
DRUG : <u>Syp. CALCEMAX - P</u>				Date	Time
Dose	Route	Frequency	Start Dt.	14/7	15/7
<u>1.5ml</u>	<u>PO</u>	<u>12H</u>	<u>14/7</u>		
Name & Signature of the Doctor Starting the Drugs:				10 AM	
				12 PM	
Additional Instructions:				2 PM	
				4 PM	
Daily Doctor's Endorsement by a Sign				6 PM	
				8 PM	
DRUG : <u>MMF SPCHET</u>				Date	Time
Dose	Route	Frequency	Start Dt.	15/7	16/7
<u>1 sach</u>	<u>PO</u>	<u>Each Feed</u>	<u>15/7</u>		
Name & Signature of the Doctor Starting the Drugs:				10 AM	
				12 PM	
Additional Instructions:				2 AM	
				4 AM	
Daily Doctor's Endorsement by a Sign				6 AM	
				8 AM	



REGULAR PRESCRIPTIONS

Weight

Ward

Docu. No. : RCH / FRM / CLINICAL / 108

(P.T.O.)

MEDICATION RECONCILIATION FORM

Drug Allergies:

☐ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From:

Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	mCT oil	1ml	PO	TID		☐ C ☐ DC
2	Amf Sachet	1sachet	PO	Each feed		☐ C ☐ DC
3	Syp Calcimax-P	1.5 ml	PO	Q12 h		☐ C ☐ DC
4	Syp VIT D3 drops	0.5 ml	PO	OD		☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Prashant

Date & Time: 21/7/26

Nurse Name & Signature:

Date & Time:

Docu. No. : RCH / FRM / GENERAL / 090

[illegible]

Date & Time	Progress Notes	Doctor's Order
25/2/22 9:40 AM	SIB Dn. Tejswi Modiprotein / SAA / 1.22g / RD T.wt 1.42g ↑ 20 gm	Plg OAG on Follow up
	CNS - S, S, B R1-BL - ACPB PLA 30L CTA 30L	SIF - 25-27w / 2nd EBM + HMP is not 1 packet is alternate feed - IF Supplements - Discharge - POP after 3 weeks of life
	✓ IB Singh for Dn. Tejswi	



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Date & Time	Progress Notes	Doctor's Order
4/7/26	CS/B Dr. Spandana	
4 PM	Δ - Mod. PT / SGA / 1.22 kgs / ROS / WBO	
	Pink, anthermic.	
	OE - vitals stable.	
	OE - WNL.	Plan
		SF 25ml Q4H.
		↓ Add HMF order to each feed.
		Worm Care.
		OAE Vaccination (OPV, BCG)] tomorrow
		Probable D/S tomorrow.
	N/B	Supurny 5 pm @ 24/26

HNH-00016434 IP26-00006784

Baby Of T VARSHA RUDRANI

08-07-2026 0 Y 0 M 15 D (M)

Dr. SPANDANA PASUPULETI



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7/26 3PM	S/D Dr. Sreehan Δ Mod preterm SGA/1.22kg/1ADJ / VLBW D/L	
	Euthermic	
	CVS - S/S: ⊕	- S/F - 2 Sw / 2 nd Lg
	M-BU - A/C ⊕	↓
	PA - 50k	Add HMF soaker in each Rect
	CTA good	
		+ no am con
		+ Monitor vitals
		+ Vaccination
		OPV, BCG - Tomorrow
		+ OAE - Tomorrow
		13-5/2 NIB-Moutushi @ 3PM.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/07/26	C/SB - Dr Tejaswi	
930 AM	A - moderate Preterm SGA	RDS
	Baby Euthermic, tolerating feeds	Plan
	Cor:	1) spoon feed 25/oznd me/hrly
	o/E	2) HMF sachet to E/F
	vitals stable	3) continue supplements
	S/E	4) monitor vitals & inform sos
	cry, Tone, Activity - Good	5) Tonn BCG, OPV
	P/A Tolerating feeds	HeP-B at 1m onlv of age
	soft	6) OAE - TOMMORROW
	NAD	
		Dr. Tejaswi
		Dr. S Tejaswi Reddy
		Consultant Neonatologist
		Reg. No: 54063
		Pediatrician

HNH-00016434

IP26-00006784

Baby Of T VARSHA RUDRANI

08-07-2026

0 Y 0 M 15 D

(M)

Dr. SPANDANA PASUPULETI



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/07/26 9 AM	C/SB: Dr. Sankar / Dr. Prem	
	Δ: Mod PT / Suck 1.22 kg / ROS	
	Baby Gethamir	Tests: 1.40 (Prog)
	Feeding well	
	Cry / Tone / Activity - good	
	passing urine / stool	
	O/G: vitals: stable	
	S/G: MOD	
		Adv.
		Spoon feed - 25ml / 2nd hourly
		- 1+MR for P every feed
		- Continue supplements
		- Monitor vitals and
		Inform Sg
	→ Vaccination (BCG, OPV)	
	→ OAB - Taken	Sushant



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PROGRESS NOTES AND DOCTOR'S ORDER	
Date & Time	Progress Notes
23/7/26 3:30pm	U/S by Dr. Spandana — feeds ✓ — urine ✓ — stools ✓ <u>o/e</u> U/A: good AF: flat mov ④ intest: stable P-17 Dr. Spandana Pasupuleti Consultant Neonatologist and Pediatrician Reg. No: 30925
	<u>plan</u> 1) ct S/F - 25 ml/2nd h 2) BMF for every feed 3) ct. supplements 4) monitor intest NB - Supriya 3:41pm @ 23/7/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7 11 AM	CLINIC Dr. Tejan	
	Baby SV on RA Tolerating Spoon feed	Ph D/W on can 2) Spoon feed - 20-25ml/hr
	Vitals Stable R/S - B/L ACP PIA - Soft	3) Vaccination - BCG OPV OAE Before OK
22/7 3:00 PM	CLINIC Dr. Spandana	Dr. S Tejaswini Reddy Consultant Neonatologist and Pediatrician Reg. No. 94068
	ON RA. Tolerating Spoon feed well	Plan Cont SF 20-25ml/24h
	Vitals - Stable R/S - B/L ACP PIA - Soft, NT	Vaccination BCG OPV OAE before discharge Before OK
		A/B Supp @3pm
	Dr. Spandana Pasupuleti Consultant Neonatologist and Pediatrician Reg. No: 30925	



I.V. FLUIDS CHART

Weight. 1-2m Ward.

VERIFIED BY: Name Signature

Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
8/7	1pm	TV-80ml/kg 10% D + 6ml CALCIUM GLUCONATE	IV	4ml/h	PP	Q			Q
8/7	11:45PM	TV-100ml		↓ 4.3ml		Q			Q
9/7	9AM	TV-100ml/kg d. 10% DX + 6ml Ca. Glucanate	4.7ml		L	Q			Q
		12-2ml				Q			Q
		2ml + 3% NS				Q			Q
		+ 1.2ml KCl							
9/7	10AM	9-12. INTRALIPID	12-2ml	0.3ml/h	L	Q			Q
9/7	10AM	9-12. AMINOVEN	3-6 3-6	1.5ml	L	Q			Q
9/8	8PM	IV.F D10% + 2ml 3% NS + 2ml KCl + 6ml Calcium glucanate	IV	2.5ml	K	Q	10/7	P	Q
10/8	2:45M	10% Dextrose + 2ml 3% NS + 3ml KCl + 6ml Calcium glucanate	IV	1.5ml	L	Q	10/7	P	Q



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
8/7	1pm	Inj CAFFEINE	25mg	IV	Pranav	Lewi
9/7	1:30 pm	FFP Transfusion	25u	IV		Shan
10/7	2:40 Am	FFP Transfusion	over 1hr 25u	IV		Pranav
			over 1hr			



REGULAR PRESCRIPTIONS

Weight. 1.22kg Ward.

Verified by Dr. Dhakshayani

DRUG: <i>PIPERRACILLIN + TAZOBACTAM</i>				Date: 8/6 Time: 9/6 AM
Dose	Route	Frequency	Start Date	
120mg	IV	BID	8/7	2 AM
Name & Signature of the Doctor Starting the Drugs: <i>Pranav</i>				<i>5 to 7 9/7</i>
Additional Instructions: 100mg/kg				2 large pm
Daily Doctor's Endorsement by a Sign				
DRUG: <i>CAFFEINE</i>				Date: 8/8 Time: 9/7 10/7 11/7 12/7 3/7
Dose	Route	Frequency	Start Date	
6.5mg	IV	once daily	8/7	6 AM
Name & Signature of the Doctor Starting the Drugs: <i>Pranav</i>				<i>stop 14/7</i>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG: <i>PLUGNAZOLE</i>				Date: 9/7 Time: 10/7 11/7
Dose	Route	Frequency	Start Date	
8mg	IV	Q4H	9/7	10 AM
Name & Signature of the Doctor Starting the Drugs:				CHANGE
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG: <i>MAROPENEM</i>				Date: 9/7 Time: 10/7
Dose	Route	Frequency	Start Date	
25mg	IV	TID	9/7	6 AM
Name & Signature of the Doctor Starting the Drugs: <i>B. Srinath</i>				2 PM 10 PM
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG CHART

Date of Admission: 8/7/26 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.

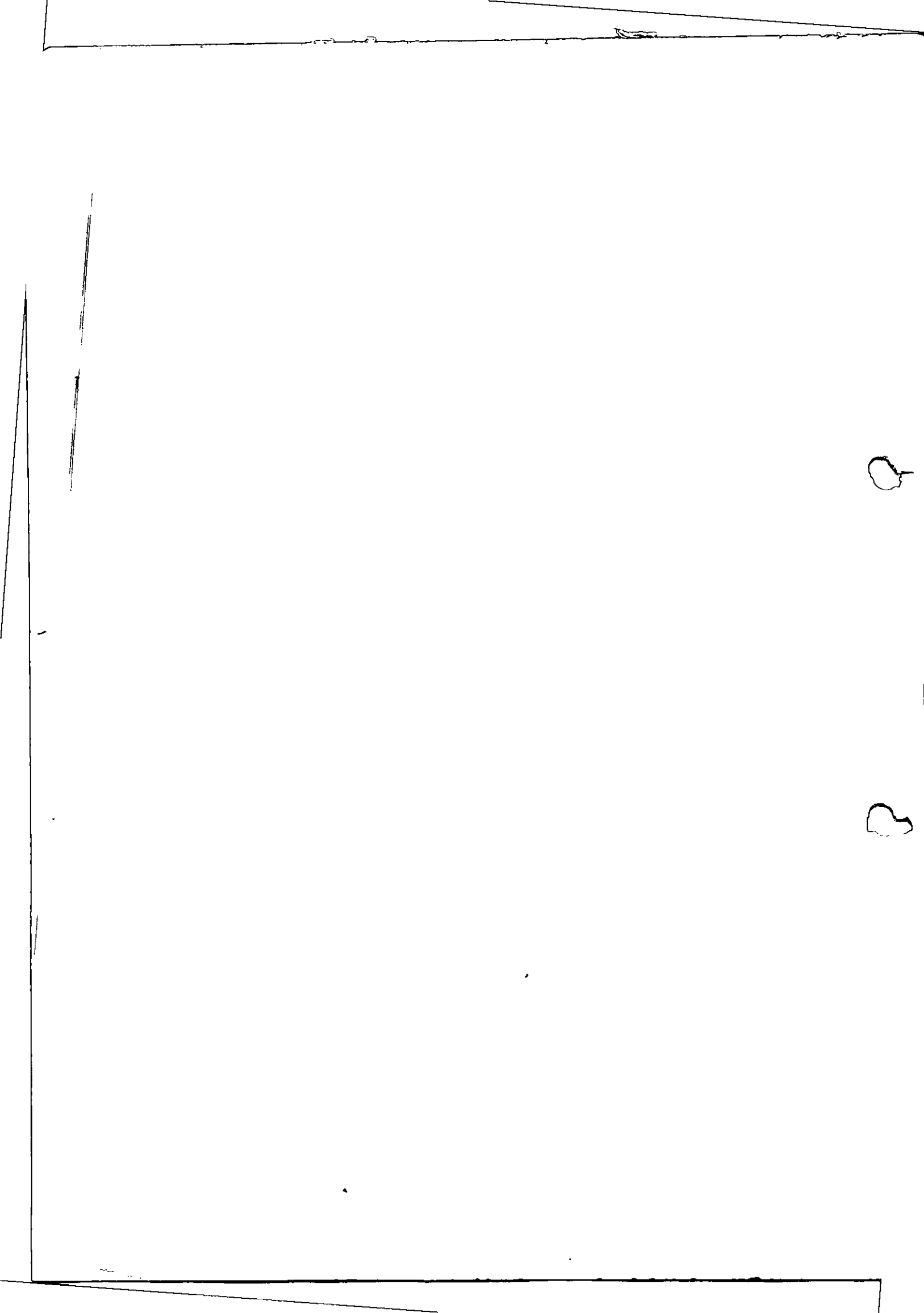
SOS / PRN (As Required Medication)

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 _____



Dr. SPANDANA PASUPULETI





Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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

Signature

VERIFIED BY Name

REGULAR PRESCRIPTIONS

Weight

Ward

Docu. No. : RCH / FRM / CLINICAL / 108

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date	Shift	21/7/26 N1	22/7/26 Mc	22/7/26 b	22/7/26 N1	23/7/26 Mc	
	Medical Condition (Any special condition to be noted):		RDS	RDS	RDS	RDS	RDS	
	Diet:		FF	FF	FF	FF	EBM+FF	
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	
	Ventilation (RA, NP, NIV, VENTI):		RA	-	-	-	-	
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	
	Vital Signs:		Temp: 98.4°F	98.1°F	98.1°F	98.6°F	98.1°F	
	Res:		38b/m	40b/h	40b/h	40b/m	40b/m	
	SpO ₂ :		99%	99%	99%	99%	99%	
	Pulse:		142b/m	140b/h	140b/h	140b/m	140b/m	
	BP:		-	-	-	-	-	
	LOC:		-	-	-	-	-	
	Fall Risk Score:		-	-	-	-	-	
	Pain Score:		0/10	1/1	1/1	-	0/1	
	Skin Integrity		Good	Yes	Yes	-	Yes Good	
Recommendations	Safety Needs:		☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	
	Physiotherapy:		-	-	-	-	-	
	Others Specify:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	
	Special Diet:		-	-	-	-	EBM+FF	
	Critical Lab Test / Values:		-	-	-	-	-	
	Other Special Orders / Medications:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	PU Prophylaxis:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	DVT Prophylaxis:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ADL (Dependent / Non Dependent):		-	-	-	-	-		
Post Operative Procedure Special Orders:								
Handed Over By Name :		Surpreya	Sumanda	Mastushi	Chir	Sumanda	Maheshwari	
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		21/7/26	22/7/26	22/7/26	22/7/26	23/7/26	23/7/26	
Time:		8pm	8am	2pm	8pm	8am	2pm	
Taken Over By Name :		Sumanda	Mastushi	Chir	Sumanda	Mahi	Surpreya	
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		21/7/26	22/7/26	22/7/26	22/7/26	23/7/26	23/7/26	
Time:		8pm	8am	9pm	8pm	8am	2pm	



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>Pre-term & RD</i>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date	<i>23/7/26</i>	<i>23/7</i>	<i>24/7</i>	<i>24/7/26</i>	<i>24/7</i>	
	Shift	<i>E2</i>	<i>N1</i>	<i>N6</i>	<i>E2</i>	<i>N1</i>	
	Medical Condition (Any special condition to be noted):	<i>-</i>	<i>-</i>	<i>-</i>	<i>RD</i>	<i>RD</i>	
	Diet:	<i>EBM+FF</i>	<i>EBM+FF</i>	<i>EBM+FF</i>	<i>EBM+FF</i>	<i>EBM+FF</i>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Ventilation (RA, NP, NIV, VENTI):	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<i>98.1°F</i>	<i>98.2°F</i>	<i>97.8°F</i>	<i>98.1°F</i>	<i>98.3°F</i>
		Res:	<i>42b/m</i>	<i>43b/m</i>	<i>40b/m</i>	<i>42b/m</i>	<i>43b/m</i>
		SpO ₂ :	<i>99%</i>	<i>99%</i>	<i>100%</i>	<i>99%</i>	<i>99%</i>
		Pulse:	<i>140b/m</i>	<i>142b/m</i>	<i>140b/m</i>	<i>143b/m</i>	<i>142b/m</i>
		BP:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>
		LOC:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>
	Fall Risk Score:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	Pain Score:	<i>"0"</i>	<i>"0"</i>	<i>"0"</i>	<i>"0"</i>	<i>"0"</i>	
	Skin Integrity	<i>Good</i>	<i>Good</i>	<i>Good</i>	<i>Good</i>	<i>Good</i>	
Recommendations	Safety Needs:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Physiotherapy:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Special Diet:	<i>EBM</i>	<i>EBM+FF</i>	<i>EBM+FF</i>	<i>EBM</i>	<i>EBM</i>	
	Critical Lab Test / Values:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ADL (Dependent / Non Dependent):	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>		
Post Operative Procedure Special Orders:		<i>-</i>	<i>-</i>	<i>OAC T/M</i>	<i>OAC T/M</i>		
Handed Over By Name :		<i>Supriya</i>	<i>Supriya</i>	<i>Supriya</i>	<i>Supriya</i>		
Signature / ID :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:		<i>23/7/26</i>	<i>24/7/26</i>	<i>24/7/26</i>	<i>25/7</i>		
Time:		<i>8pm</i>	<i>8am</i>	<i>2pm</i>	<i>8am</i>		
Taken Over By Name :		<i>Supriya</i>	<i>Supriya</i>	<i>Supriya</i>	<i>Supriya</i>		
Signature / ID :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:		<i>23/7</i>	<i>24/7/26</i>	<i>24/7/26</i>	<i>24/7</i>		
Time:		<i>8pm</i>	<i>8am</i>	<i>2pm</i>	<i>8pm</i>		

HNH-00016434
Baby Of T VARSHA RUDRANI
08-07-2026
Dr. SPANDANA PASUPULETI (M)

CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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	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			0	0						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			0	0						
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			0	0						
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			0	0						
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			0	0						
Signature of the Nurse						0	0						

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 : Supriya Name : Supriya

Signature of Ward In Charge :

Signature : Balan Name : Uthappa

HNH-00016434 IP26-00006784
Baby Of T VARSHA RUDRANI
08-07-2026 0 Y 0 M 0 D 10 H (M)
Dr. SPANDANA PASUPULETI

VENTILATOR CARE BUNDLE CHECK LIST

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date:

No of Days on Ventilation:

Date of Tracheostomy:

Parameters	Date	Shift Time						
Ready for Extubation today? (Discuss during the clinical round)	8/7/26		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Sedation holiday discussed? (Discuss during the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Ventilator Circuit visibly soiled? (If Yes - Please Change)			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Suction container visibly Soiled? (If Yes - Please Change)			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Inline Suction Used?			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is AMBU bag soiled? (If Yes - Please Change)			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check AMBU bag kept in a clean, Non-Sealed plastic bag? (If No - please change)			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there condensate in the ventilatory circuit? (If Yes - drain away from the patient)			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Head End elevated by 15°-30° (for neonates 10°-15°)? (If No - please change)			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Oral and Nasal Care every 4 Hrs			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Mouth Care with EBM (Only for Neonatal Patient)			☒ Yes ☐ No ☐ NA	☒ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA	☐ Yes ☐ No ☐ NA
Is ET / Oral Suction needed (2nd hrly)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sterile Suctioning Done			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse			SP	SP				
Signature of the Nurse								

HNH-00016434 IP26-00006784
 Baby Of T VARSHA RUDRANI
 08-07-2026 0 Y 0 M 0 D 10 H (M)
 Dr. SPANDANA PASUPULETI



2

ENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Type of Line: ☐ PICC Line ☒ UAC ☒ UVC ☐ Other Date of Initial Line Insertion: Duration of Central Line:

- Always perform hand hygiene before accessing central line
- Use Sterile gloves for handling central line
- Clean the hub with antiseptic solution every time before & after it is accessed
- Consider – antibiotic via central line before removal of the line
- Inspect Central line in each shift for the following

Parameters	Date	Shift Time	9/6/26	9/6/26	9/6/26	10/6/26	10/6/26		
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor))			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Central line changed on									
Name of the Nurse			Shr	Spandana	Shr	Shr	Nikitha		
Signature of the Nurse									





CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Type of Line: ☐ PICC Line ☒ UAC ☒ UVC ☐ Other Date of Initial Line Insertion: 8/7/26 Duration of Central Line:

- Always perform hand hygiene before accessing central line
- Use Sterile gloves for handling central line
- Clean the hub with antiseptic solution every time before & after it is accessed
- Consider – antibiotic via central line before removal of the line
- Inspect Central line in each shift for the following

Parameters	Date	Shift Time	11/7/26 NI	12/7/26 MS	12/7/26 NI				
Can we remove Central Line today (Discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Evidence of any inflammation at insertion site (Redness / Swelling (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Blood at insertion site (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any peeling of dressing? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Is dressing clean and dry? (If no inform the doctor)			☒ Yes ☐ No	☒ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any leakage at insertion site? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there any obstruction to the infusion flow? (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Central line changed on									
Name of the Nurse			prasanee	Nikita	prasanee				
Signature of the Nurse			Shy	Shy	Shy				



PATIENT TRANSFER FORM

Patient Name & UHID No. <i>140 varsha</i>	Date & Time of Admission <i>08/7/26</i>	Date & Time of Transfer Order <i>08/7/26 @ 1:00 PM</i>
Treating Consultant Name <i>Dr. Tejswini</i>	Transfer Ordered by <i>Dr. Pranav</i>	Reason for Transfer <i>OB</i> <i>Simu</i>
From Unit <i>OT</i>	To Unit <i>NICU</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐		
Name & Signature of Person who is Transferring <i>Karun</i>	Name of Person Ordered Transfer <i>Dr. Pranav</i>	
Patient & Clinical Records Received by : <i>--</i>		
Date & Time of Patient Received :		

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

Patient Sticker

HNH-00016434
Baby Of T VARSHA RUDRANI
08-07-2026 0 Y 0 M 0 D 22 H (M)
Dr. SPANDANA PASUPULETI

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CHECKLIST FOR MAINTAINING CPAP / HFNC / NIV

Date: 9/7/26

	CRITERIA MET / NOT MET ☐ Yes ☐ No			Comments by Duty Registrar
	Morning	Evening	Night	
CIRCUIT and BUBBLER:				
Blended Air / Oxygen Gas Supply		✓	✓	
Flow Between 5-7 Litres / Min		✓	✓	
Humidifier Temperature Correct (36.5-37.5°C)		✓	✓	
Humidifier Water Level Correct		✓	✓	
Proper Oxygen Tubing From Blender to Humidifier.		✓	✓	
Tubing Correctly Placed (Position & Leak)		✓	✓	
Excess Fainout (Afferent Tubing) Drained		✓	✓	
Excess Rainout (Efferent Tubing) Drained		✓	✓	
Temperature Probe away from Heat / Cover with Aluminium Foil		✓	✓	
Gas Bubbling Continuously		✓	✓	
Water Level at Desired Level in Bubble Chamber.		✓	✓	
INTERFACE:				
Nasal Prong / Mask Correct Size		✓	✓	
Nasal Prong/ Mask Correctly Placed		✓	✓	
Hat Fits Snugly		✓	✓	
Moustache Suitable and Effective		✓	✓	
Nasal Bridge Intact		✓	✓	
Septum Intact		✓	✓	
POSITION:				
Head Position Correct		✓	✓	
Head Roll - Correct Size and Position		✓	✓	
MONITORING/ SUCTIONING				
SpO ₂ Probe Monitoring		✓	✓	
Oro Nasal Suctioning Documentation		✓	✓	
OG Tube in SITU		✓	✓	
Baby Comfortable		✓	✓	
Chest Retractions		✓	✓	
Name of the Nurse:		✓	✓	
Signature of the Nurse:		✓	✓	
Date & Time:		9/7/26	9/7/26	

*If CPAP is being given through Dragger ventilator then make sure that: Flow to be set at 5 litres/min & PIP to be set between 12-15 cm.

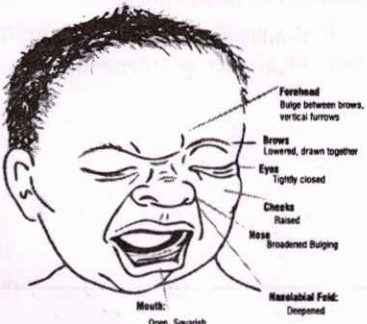
CHECKLIST FOR MAINTAINING CPAP / HFNC / NIV

Date:

	CRITERIA MET / NOT MET ☐ Yes ☐ No			Comments by Duty Registrar
	Morning	Evening	Night	
CIRCUIT and BUBBLER:				
Blended Air / Oxygen Gas Supply				
Flow Between 5-7 Litres / Min				
Humidifier Temperature Correct (36.5-37.5°C)				
Humidifier Water Level Correct				
Proper Oxygen Tubing From Blender to Humidifier.				
Tubing Correctly Placed (Position & Leak)				
Excess Fainout (Afferent Tubing) Drained				
Excess Rainout (Efferent Tubing) Drained				
Temperature Probe away from Heat / Cover with Aluminium Foil				
Gas Bubbling Continuously				
Water Level at Desired Level in Bubble Chamber.				
INTERFACE:				
Nasal Prong / Mask Correct Size				
Nasal Prong/ Mask Correctly Placed				
Hat Fits Snugly				
Moustache Suitable and Effective				
Nasal Bridge Intact				
Septum Intact				
POSITION:				
Head Position Correct				
Head Roll - Correct Size and Position				
MONITORING/ SUCTIONING				
SpO ₂ Probe Monitoring				
Oro Nasal Suctioning Documentation				
OG Tube in SITU				
Baby Comfortable				
Chest Retractions				
Name of the Nurse:				
Signature of the Nurse:				
Date & Time:				

*If CPAP is being given through Dragger ventilator then make sure that: Flow to be set at 5 litres/min & PIP to be set between 12-15 cm.

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
						18/7/2026	18/7/2026	19/7/2026	19/7/2026	19/7/2026	20/7/2026	20/7/2026	21/7/2026
						E2	NA	MB	E2	NA	MB	NA	MB
						Procedure							
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	NA	NA	NA	NA	NA	NA	NA	NA
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	NA	NA	NA	NA	NA	NA	NA	NA
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	NA	NA	NA	NA	NA	NA	NA	NA
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	NA	NA	NA	NA	NA	NA	NA	NA
Vital Signs HR RR, BP, SaO ₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	NA	NA	NA	NA	NA	NA	NA	NA
 Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 - No Intervention Pain Score greater than 3 - Intervention						Gestational Age / Corrected Age	34+ weeks	34+ weeks	34+ weeks	34+ weeks	34+ weeks	34+ weeks	34+ weeks
						Total Pain / Agitation Score							
						Intervention							
						Effectiveness							
						Signature							

NPASS: Neonatal Pain, Agitation & Sedation Scale

	Sedation	Pain / Agitation
How to use	- Observe the infant for a minute before selecting a score for each behavior. - Stimulate the infant and observe and select a score for each behavior. - Select only one numeric value (Highest) per behavior.	- Observe the infant for a minute before selecting a score for each behavior. - Select only one numeric value per behavior.
Scoring/ Documentation	- Sedation scores are negative scores only - Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age) - NPASS Sedation total score has a range from 0 to -10 possible. - Document total NPASS Sedation score in the medical record.	- Pain/Agitation scores are positive scores only - Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria. - Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score. - NPASS Pain/Agitation total score has a range from 0 to 13 possible. - Document the total NPASS Pain/Agitation score in the medical record
Interpretation	- Desired levels of sedation vary according to the situation. - Discuss and determine sedation goal with provider. "Deep sedation": goal score of -10 to -5 - Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea "Light sedation": goal score of -5 to -2 - Reassess patient per frequency in local sedation policy - A negative score without the administration of opioids/ sedatives may indicate: - The premature infant's response to prolonged or persistent pain/stress - Neurologic depression, sepsis, or other pathology	- Does not provide pain intensity rating. - Any score greater than 3 indicates the possibility of the presence of pain in the infant - Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological). - Reassess patient per frequency of local pain policy. - If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention.



CHECKLIST FOR THROMBOPHLEBITIS

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	0	0	0	0	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			0	0	0	0	0	0	0	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			0	0	0	0	0	0	0	
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			0	0	0	0	0	0	0	
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			0	0	0	0	0	0	0	
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			0	0	0	0	0	0	0	
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 : [Signature] Name : [Name]

Signature of Ward In Charge :

Signature : [Signature] Name : [Name]

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HNH-00016434
Baby Of T VARSHA RUDRANI
08-07-2026
Dr. SPANDANA PASUPULETI

CHECKLIST FOR THROMBOPHLEBITIS

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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	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0	0	0	0	0	0	0	0	0	
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	0	0	0	0	0	0	0	0	0	
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	0	0	0	0	0	0	0	0	0	
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	0	0	0	0	0	0	0	0	0	
Signature of the Nurse				0	0	0	0	0	0	0	0	0	

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 : [Signature] Name : [Name]

Signature of Ward In Charge :

Signature : [Signature] Name : [Name]

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CHECKLIST FOR THROMBOPHLEBITIS

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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	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0	0	0	0	0	0	0	0	0	
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	0	0	0	0	0	0	0	0	0	
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	0	0	0	0	0	0	0	0	0	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	0	0	0	0	0	0	0	0	0	
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 : M. Vignesh Name : M. Vignesh

Signature of Ward In Charge :

Signature : Sharan Name : Sharan

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HNH-00016434 IP26-00006784
Baby OFT VARSHA RUDRANI
08-07-2026 OYOMOD 10 H (M)
Dr. SPANDANA PASUPULETI

A standard 1D barcode is located at the bottom of the document, below the text 'Dr. SPANDANA PASUPULETI'. It consists of vertical black bars of varying widths on a white background.

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NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

[illegible]

NPASS: Neonatal Pain, Agitation & Sedation Scale

	Sedation	Pain / Agitation
How to use	- Observe the infant for a minute before selecting a score for each behavior. - Stimulate the infant and observe and select a score for each behavior. - Select only one numeric value (Highest) per behavior.	- Observe the infant for a minute before selecting a score for each behavior. - Select only one numeric value per behavior.
Scoring/ Documentation	- Sedation scores are negative scores only - Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age) - NPASS Sedation total score has a range from 0 to -10 possible. - Document total NPASS Sedation score in the medical record.	- Pain/Agitation scores are positive scores only - Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria. - Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score. - NPASS Pain/Agitation total score has a range from 0 to 13 possible. - Document the total NPASS Pain/Agitation score in the medical record
Interpretation	- Desired levels of sedation vary according to the situation. - Discuss and determine sedation goal with provider. "Deep sedation": goal score of -10 to -5 - Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea "Light sedation": goal score of -5 to -2 - Reassess patient per frequency in local sedation policy - A negative score without the administration of opioids/ sedatives may indicate: - The premature infant's response to prolonged or persistent pain/stress - Neurologic depression, sepsis, or other pathology	- Does not provide pain intensity rating. - Any score greater than 3 indicates the possibility of the presence of pain in the infant - Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological). - Reassess patient per frequency of local pain policy. - If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention.



NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
						14/7	14/7	15/7	15/7	16/7	16/7	17/7	17/7
						02	01	05	02	05	01	05	06
						Procedure →							
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	NA	NA	NA	NA	NA	NA	NA	NA
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	NA	NA	NA	NA	NA	NA	NA	NA
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	NA	NA	NA	NA	NA	NA	NA	NA
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	NA	NA	NA	NA	NA	NA	NA	NA
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	NA	NA	NA	NA	NA	NA	NA	NA
	Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 - No Intervention Pain Score greater than 3 - Intervention					Gestational Age / Corrected Age	34w	34w	34w	34w	34w	34w	34w
	Total Pain / Agitation Score	-	-	-	-	-	-	-	-	-	-	-	
	Intervention	-	-	-	-	-	-	-	-	-	-	-	
	Effectiveness	-	-	-	-	-	-	-	-	-	-	-	
	Signature	SP	SP	SP	SP	SP	SP	SP	SP	SP	SP	SP	

NPASS: Neonatal Pain, Agitation & Sedation Scale

	Sedation	Pain / Agitation
How to use	- Observe the infant for a minute before selecting a score for each behavior. - Stimulate the infant and observe and select a score for each behavior. - Select only one numeric value (Highest) per behavior.	- Observe the infant for a minute before selecting a score for each behavior. - Select only one numeric value per behavior.
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HNH-00016434

IP26-00006784

Baby Of T VARSHA RUDRANI

08-07-2026

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Dr. SPANDANA PASUPULETI



BRADEN 'Q' SCALE

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				Date :	21/7			
				Time :	me			
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.	4			
"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			
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			
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			
FRICITION-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			
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			
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			
TOTAL SCORE					28			
Evaluator's Name					CE			

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

Docu. No. : RCH /FRM / CLINICAL / 119

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

HNH-00016434 IP26-00006784
 Baby Of T VARSHA RUDEANI
 08-07-2026 0 Y 0 M 9 D (M)
 Dr. SPANDANA PASUPULETI



BRADEN 'Q' SCALE

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

BirthRight®
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

				Date :	17/7	18/7	18/7	18/7
				Time :	15	14	16	14
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.	4	4	4	4
"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	4	4	4
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	4	4	4
Molsture 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	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
TOTAL SCORE					28	28	28	28
Evaluator's Name					u	u	u	u

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)
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 :	19/7	19/7	20/7	20/7
					Time :	12	01	06	07
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.		4	4	4	2
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
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	4	4	4
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	4	4	4
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	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
TOTAL SCORE						20	20	20	28
Evaluator's Name						L	Q	R	JE

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

Docu. No. : RCH /FRM / CLINICAL / 119

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



BRADEN 'Q' SCALE

				Date :	14/7	14/7	14/7	15/7
				Time :	M6	E2	N1	M5
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.	4	4	4	4
"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	4	4	4
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	4	4	4
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	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
TOTAL SCORE					28	28	28	28
Evaluator's Name					[Signature]			

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

HNH-00016434

IP26-00006784

Baby Of T VARSHA RUDRANI

08-07-2026 0 Y 0 M 7 D (M)

Dr. SPANDANA PASUPULETI



BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

(9)

				Date :	12/7	12/6	12/5	12/4
				Time :	11:30	10:30	09:30	08:30
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.	4	4	4	4
"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	4	4	4
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	4	4	4
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	4	4	4
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	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
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TOTAL SCORE				28	28	28	28	
Evaluator's Name				SC	S	B	AA	

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

Docu. No. : RCH / FRM / CLINICAL / 119

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



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>33+6 weeks PT / PDS</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date	Shift	<u>8/7/26</u> <u>av</u>	<u>9/7/26</u> <u>ms</u>	<u>9/7/26</u> <u>av</u>	<u>10/7/26</u> <u>av</u>	<u>11/7/26</u> <u>ms</u>	<u>12/7/26</u> <u>av</u>
	Medical Condition (Any special condition to be noted):		<u>PDS</u>	<u>PDS</u>	<u>PDS</u>	<u>PDS</u>	<u>PDS</u>	<u>PDS</u>
	Diet:		<u>FF</u>	<u>NPO</u>	<u>FF</u>	<u>FF</u>		
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):		<u>Ventil</u>	<u>ventil</u>	<u>NIU</u>	<u>R/A</u>	<u>R/A</u>	<u>R/A</u>
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp:	<u>36.6°C</u>	<u>36.5°C</u>	<u>36.6°C</u>	<u>36.6°C</u>	<u>36.5°C</u>
	Res:		<u>40b/m</u>	<u>48 b/m</u>	<u>42b/m</u>	<u>42b/m</u>	<u>60b/m</u>	<u>42b/m</u>
	SpO ₂ :		<u>100%</u>	<u>98%</u>	<u>99%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>
	Pulse:		<u>140b/m</u>	<u>136b/m</u>	<u>138b/m</u>	<u>136b/m</u>	<u>132b/m</u>	<u>136b/m</u>
	BP:		<u>57/39</u>	<u>61/44/48</u>	<u>59/42</u>	<u>35/12</u>	<u>55/39</u>	<u>69/55(60)</u>
	LOC:		<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>
	Fall Risk Score:		<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>
Pain Score:		<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	
Skin Integrity		<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	
Recommendations	Safety Needs:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Physiotherapy:		<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>
	Others Specify:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Special Diet:		<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>
	Critical Lab Test / Values:		<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>
	Other Special Orders / Medications:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	PU Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	DVT Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
ADL (Dependent / Non Dependent):		<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	
Post Operative Procedure Special Orders:		<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	
Handed Over By Name :		<u>Prasanna</u>	<u>Jyothi</u>	<u>Prasanna</u>	<u>Prasanna</u>	<u>Nikitha</u>	<u>Prasanna</u>	
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>9/7/26</u>	<u>9/7/26</u>	<u>10/7</u>	<u>10/7</u>	<u>11/7/26</u>	<u>12/7/26</u>	
Time:		<u>8am</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Jyothi</u>	<u>Prasanna</u>	<u>Nikitha</u>	<u>Prasanna</u>	<u>Prasanna</u>	<u>Nikitha</u>	
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>9/7/26</u>	<u>9/7/26</u>	<u>10/7/26</u>	<u>10/7/26</u>	<u>11/7/26</u>	<u>12/7/26</u>	
Time:		<u>8am</u>	<u>8pm</u>	<u>8am</u>	<u>8am</u>	<u>8pm</u>	<u>8pm</u>	



NURSING SHIFT HAND OVER FORM

SITUATION		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date	12/7/26 MS	12/7/26 NI	13/7/26 M6	14/7/26 E2	15/7/26 NI	15/7/26 MS
	Shift						
	Medical Condition (Any special condition to be noted):	RDS	RDS	RDS	RDS	RDS	PD
Diet:							
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):	R/A	R/A	R/A	R/A	R/A	R/A
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: 36.6°C	36.5°C	36.5°C	36.5°C	36.5°C	36.6°C
	Res: 37 bpm	42 bpm	50 bpm	29 bpm	29 bpm	30 bpm	
	SpO ₂ : 100%	100%	96%	99%	100%	100%	
	Pulse: 142 bpm	146 bpm	133	157 bpm	120 bpm	135 bpm	
	BP: 54/29				54/29 (34)	52/29 (43)	
	LOC: —	—	—	—	—	—	
	Fall Risk Score: —	—	—	—	—	—	
Recommendations	Safety Needs:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Physiotherapy:	—	—	—	—	—	—
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Special Diet:	—	—	—	—	—	—
	Critical Lab Test / Values:	—	—	—	—	—	—
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	ADL (Dependent / Non Dependent):	—	—	—	—	—	—
	Post Operative Procedure Special Orders:	—	—	—	—	—	—
Handed Over By Name :		Nikitha	Prasanna	Nikitha	Saipriya	Prasanna	Saipriya
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		12/7/26	12/7/26	14/7/26	14/7/26	15/7/26	15/7/26
Time:		8 pm	8 am	8 pm	8 pm	8 am	8 pm
Taken Over By Name :		Prasanna	Nikitha	Saipriya	Prasanna	Saipriya	Saipriya
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		12/7/26	14/7/26	14/7/26	14/7/26	15/7/26	15/7/26
Time:		9 am	8 am	2 pm	8 pm	8 pm	8 pm

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date	16/7/26	16/7/26	16/7/26	17/7/26	17/7/26	18/7/26
	Shift	NI	MS	NI	MS	NI	MS
	Medical Condition (Any special condition to be noted):	RDS	RDS	RDS	RDS	RDS	RDS
	Diet:	-	-	-	-	-	-
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	RA	RA	RA
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: 36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C
	Res:	38 bpm	40 bpm	43 bpm	36 bpm	22 bpm	24 bpm
	SpO ₂ :	98.1%	96.1%	98.1%	100%	100%	100%
	Pulse:	144 bpm	139 bpm	145 bpm	125 bpm	132 bpm	130 bpm
	BP:	58/39/43	-	-	63/46/52	-	-
	LOC:	-	-	-	-	-	-
	Fall Risk Score:	-	-	-	-	-	-
Pain Score:	-	-	-	-	-	-	
Skin Integrity:	-	-	-	-	-	-	
Recommendations	Safety Needs:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
	Physiotherapy:	-	-	-	-	-	-
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Special Diet:	-	-	-	-	-	-
	Critical Lab Test / Values:	-	-	-	-	-	-
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ADL (Dependent / Non Dependent):	-	-	-	-	-	-	
Post Operative Procedure Special Orders:		-	-	-	-	-	-
Handed Over By Name :		Jyothi	Saipriya	Nikitha	Prasanna	Nikitha	Saisri
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		16/7/26	16/7/26	17/7/26	17/7/26	18/7/26	18/7/26
Time:		8 AM	8 PM	8 AM	8 PM	8 AM	8 PM
Taken Over By Name :		Saipriya	Nikitha	Prasanna	Nikitha	Saisri	Jyothi
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		16/7/26	16/7/26	17/7/26	17/7/26	18/7/26	18/7/26
Time:		8 AM	8 PM	8 AM	8 PM	8 AM	8 PM



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date	Shift	18/7/26 E2	18/7/26 N1	19/7/26 N2	19/7/26 E2	19/7/26 N1	20/7/26 N2
	Medical Condition (Any special condition to be noted):		RDS	RDS	RDS	RDS	RDS	RDS
	Diet:		—	—	—	—	—	—
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):		PIA	PIA	PIA	PIA	PIA	PIA
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp:	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C
	Res:		38b/m	40b/m	39b/m	40b/m	40b/m	48b/m
	SpO ₂ :		98%	96%	99%	100%	100%	99%
	Pulse:		155b/m	135b/m	125b/m	154b/m	154b/m	160
	BP:		58/38/46	—	58/38/42	60/50/33	62/50/47	52/38
	LOC:		—	—	—	—	—	—
	Fall Risk Score:		—	—	—	—	—	—
Pain Score:		—	—	—	—	—	—	
Skin Integrity		—	—	—	—	—	—	
Recommendations	Safety Needs:		☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
	Physiotherapy:		—	—	—	—	—	—
	Others Specify:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Special Diet:		—	—	—	—	—	—
	Critical Lab Test / Values:		—	—	—	—	—	—
	Other Special Orders / Medications:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	PU Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
DVT Prophylaxis:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ADL (Dependent / Non Dependent):		—	—	—	—	—	—	
Post Operative Procedure Special Orders:			—	—	—	—	—	
Handed Over By Name :			Jyothi	Nikitha	Saigini	Prasanna	Jyothi	Prasanna
Signature / ID :			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:			18/7/26	19/7/26	19/7/26	19/7/26	20/7/26	20/7/26
Time:			8pm	8am	8pm	8pm	8pm	8am
Taken Over By Name :			Nikitha	Saigini	Prasanna	Jyothi	Prasanna	Jyothi
Signature / ID :			[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:			18/7/26	19/7/26	19/7/26	19/7/26	20/7/26	20/7/26
Time:			8pm	8am	8pm	8pm	8pm	8pm

BRADEN 'Q' SCALE

					Date :	8/21/22	9/2	10/2
					Time :	12:15	10:00	12:00
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
"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	4	4	4
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	4	4	4
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	4	4	4
FRICITION-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	4	4	4
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.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
TOTAL SCORE					28	28	28	28
Evaluator's Name					SA	SA	SA	SA

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)
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

1NH-00016455

IP26-00006795

Baby Of SANNAMANDA KAMALA

18-07-2026

0 Y 0 M 2 D

(F)

Dr. SPANDANA PASUPULETI



BRADEN 'Q' SCALE

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	12/7	12/7	12/7	12/7
					Time :	11:30	11:30	11:30	11:30
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.		4	4	4	4
"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	4	4	4
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	4	4	4
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	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	Dr. SPANDANA PASUPULETI	Dr. SPANDANA PASUPULETI	Dr. SPANDANA PASUPULETI	Dr. SPANDANA PASUPULETI

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

Docu. No. : RCH /FRM / CLINICAL / 119

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

TOTAL PARENTERAL NUTRITION (TPN) CHART

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

4NH-00016455 IP26-00006795
Baby Of SANNAMANDA KAMALA
19-07-2026 0 Y 0 M 2 D (F)
Dr. SPANDANA PASUPULETI



Date : 11/7/20

D. NO:

Patient Name : Blo naesha

Current (Maximum) Weight : 1.30 kg (169 me)

Fluid : 130 ml / kg / day

Feed : ml / kg / day

Others : ml / kg / day

TPN Fluid :

feeds - 96 ml
anti : 10 ml

only 5ml remaining
e 0.2 ml/hr.

	Daily Requirement		Amount (ml)	Calories
	Per KG	Total		
Intra Lipid (20%) 1g = 5ml	2 g/kg	13	→ 0.5 ml/hr.	
Protein / Aminoventi 10, 1g=10ml	3.5 g/kg	45 ml	→ 1.9 ml/hr	
3% NaCl (1ml = 0.5 mEq)	mEq/kg			
KCL	mEq/kg			
POTPHOS (0.3 ml = 1.2 mEq K)	0.3 ml/kg			
Calcium Gluconate	ml/kg			
MVI	1 ml/kg			
CELECEL (Trace Elements)	1 ml/kg			
MgSo4	ml/kg			
Heplock (0.1 ml = 1 unit)	0.5 unit/ml of lipid			
5% Dextrose				
25% Dextrose				
TPN Fluid				
GIR				
NPC / Protein (gm)				

Total Calories:

Carbohydrates

Proteins

Fats

Name :

Signature : *[Signature]*

Date & Time : 11/7/20

2 4 1





BLOOD PRODUCTS TRANSFUSION MONITORING FORM

FFP Transfusion

Date: 9/7/26 Time: 10:30pm

Blood Group of the Patient: D-neg Blood Group on the Blood Bag: Angabine

Blood Bank Issue No: 706 Date of Collection: 26/5/26 Date of Expiry: 25/5/27

Date & Time of Starting Transfusion: 9/7/26 @ 10:30pm Planned duration of Transfusion: 1 hour

Check for Correct Unit: ☒ Correct Patient: ☐

Blood products cross checked by: Nurse 1: Dhanavel Nurse 2: Praveena

Before starting transfusion vitals: Temp: 36.6°C HR 128 RR: 35 BP: salu SpO₂ 97%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>9/7/26</u>	15 Min	<u>127</u>	<u>36.6°C</u>	<u>66/40</u>	<u>96%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	15 Min	<u>130</u>	<u>36.6°C</u>	<u>62/42</u>	<u>95%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	30 Min	<u>138</u>	<u>36.6°C</u>	<u>66/42</u>	<u>97%</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>Q</u>
	30 Min								
	30 Min								
	1 Hr								
	1 Hr								

Comments: No reactions

Name of the Incharge-Nurse: Praveena

Name of the Nurse: Dhanavel

Signature of the Incharge-Nurse: Praveena

Signature of the Nurse: Dhanavel

Date & Time: 9/7/26 @ 10:30pm

Date & Time: 9/7/26 @

Phone : 8790221175 , 8341711775

SURYA BLOOD CENTRE

(A unit of Telangana Development Committee)

#3-6-150, First Floor, Above Indian Bank, Main Road, Himayatnagar, Hyderabad-29.

Lic No. 111/HD/TS/2021/BC/G

FRESH FROZEN PLASMA BP 150-180 ML.

Prepared from Whole Human Blood Collected with
Anticoagulant : CPDA Solution U.S.P. 49 ml / 63 ml

Prepared from a VOLUNTARY DONOR / REPLACEMENT DONOR

Patient Name : *B/o Varsha* Age / Sex : *10/M*

Hospital Name : *Rainbow CH Hospital*

Blood Group : *A Neg* Blood Bag No. : *706*

Date of Preparation : *26/5/26* Tested Date : *26/5/26*

Expiry Date : *25/5/27* Volume : *50ml*

**Tested and Found Negative for HIV I & II antibodies,
HBsAg, HCV antibodies, VDRL & Malaria Parasites.**

INSTRUCTIONS: 1) Do not store Transfuse immediately.
2) Do not use if there is any visible evidence of deterioration 3) Check
blood group on label and recipients group before administration. 4)
Transfuse creteria 'ABO' Group Compatible. 5) Before Thawing Storage
Temperature - 30° C or below. 6) FFP must be thawed in a water bath
between 30°-37°C before Transfusion. 7) Use it Immediately after that
Discard. 8) Do not Refroze once FFP is Thawed. 9) Do not add any medicine
to the component. 10) Do not dispense without prescription 11) Transfuse
under medical supervision. 12) Use a fresh, clean sterile and pyrogen free
disposable transfusion set with filter.



CONSENT FOR SPECIAL PROCEDURES

Patient Name : B/o VARSHA Gender: ☒ Male ☐ Female

UHID No : HAH-00016434 Department : NICU Date : 8/7

I T.S. RAHUL S/D/W/O T. SRINIVAS RAO

Here by give consent for procedure of : Umbilical Catheter

For my patient, Named :

The doctors have clearly explained to me that the procedure has following possible complications:

Longline - Thrombosis / Bleeding / Infection

The doctor have explained to me about the alternatives, risks and benefits for this procedure that:

Intra BP monitoring / Sample line lastly 7-10 h

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. Tejaswini

Patient Attendant :

Signature : [Signature]

Name : T.S. RAHUL

Relationship with Patient: FATHER

Date & Time : 8/9/26 @ 12:40pm

Witness :

Signature : [Signature]

Name : [Name]

Date & Time : 8/9/26 @ 12:40pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : PRANAV

Date & Time : 8/7/26 @ 12:40pm

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CONSENT FOR SPECIAL PROCEDURES

Patient Name : B/o Varsha Gender: ☒ Male ☐ Female

UHID No : Gault-00016434 Department : NICU Date : 8/7/26

I T.S. RAHUL S/D/W/O T. SRINIVAS RAO

Here by give consent for procedure of : Intubation & Ventilation

For my patient, Named :

The doctors have clearly explained to me that the procedure has following possible complications:

Aspiration / Pneumothorax / Bradycardia / Arrest
Local laryngeal injury / Bleeding

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

Breathing support

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. T. Rajan

Patient Attendant :

Signature : [Signature]

Name : T.S. RAHUL

Relationship with Patient: FATHER

Date & Time : 8/2/26 1pm

Witness :

Signature : [Signature]

Name : POORVI

Date & Time : 8/2/26 1pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : P. R. ANAV

Date & Time : 8/7/26 @ 1pm

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CONSENT FOR SPECIAL PROCEDURES

Patient Name : S/o Varsha Gender: ☒ Male ☐ Female
UHID No : Catib-00016434 Department : NICU Date : 8/2/26

I T.S. RAHUL S/D/W/O T. SRINIVAS RAO

Here by give consent for procedure of : umbilical veinous line

For my patient, Named :

The doctors have clearly explained to me that the procedure has following possible complications:

Long line - Thrombus / Bleeding / Infection

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

IV medication / Parenteral nutrition lastng 5-7 days

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. Tejaswini

Patient Attendant :

Signature : [Signature]

Name : T.S. RAHUL

Relationship with Patient: Father

Date & Time : 8/2/26 1pm

Witness :

Signature : [Signature]

Name : POOJA

Date & Time : 8/2/26 1pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : PRANAV

Date & Time : 8/2/26 1pm

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CONSENT FOR ADMISSION IN NEONATAL INTENSIVE CARE UNIT

Name: B/o Varsha Age: 1d Gender: Male ☒ Female ☐

UHID.No: 6144-00016434 Date: 8/7/26

I T.S. Rahul S/o, B/o, W/o T. SRINIVAS RAO hereby
declare that our patient Mr. / Ms who is related to me as
..... is getting admitted in the Neonatal Intensive Care Unit of Rainbow Children's Hospital
on 8/7/26

The doctors have explained to me in a language understood by me that my child has following health related issues :

Med PT / 33+6 w / LSCS / IVSR - 1-2 kg / VLBW /
RDS - Mech Ventilation / Maternal Sepsis -> Risk of Sepsis in baby
Feed Issues

The doctors have clearly explained to me that my patient B/o during his / her stay
in the Neonatal Intensive Care Unit may undergo various medical and surgical procedures like airway management,
mechanical ventilation, Umbilical Artery Catheter, Umbilical Vein and Arterial Lines, Peripherally Inserted Central Catheter Line
and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this
procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed
consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Neonatal Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Neonatal Intensive Care Unit with multiple medical and surgical procedures
performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of
infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child B/o :
..... in the Neonatal Intensive Care Unit fully understanding the associated risk, benefits and
alternatives involved from various procedures, high risk medications and infections in the Neonatal Intensive Care Unit and
treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature : [Signature]

Name : T.S. Rahul

Relationship with Patient: FATHER

Date & Time : 8/7/26 @ 1pm

Witness :

Signature : [Signature]

Name : [Signature]

Date & Time : 8/7/26 at 1pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. PRANAV

Date & Time : 8/7/26 @ 1pm

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the 1990s, the number of people in the world who are under 15 years of age is expected to increase by 1.5 billion, from 1.1 billion in 1990 to 2.6 billion in 2010. The number of people aged 65 and over is expected to increase by 1 billion, from 350 million in 1990 to 1.4 billion in 2010. The number of people aged 15-64 is expected to increase by 1.5 billion, from 2.5 billion in 1990 to 4.0 billion in 2010. The number of people aged 65 and over is expected to increase by 1 billion, from 350 million in 1990 to 1.4 billion in 2010. The number of people aged 15-64 is expected to increase by 1.5 billion, from 2.5 billion in 1990 to 4.0 billion in 2010.

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$$v_1 = \frac{1}{2} \frac{v_1'}{v_1} = \frac{1}{2} \frac{v_1'}{v_1}$$

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HNH-00016434 IP26-00006784
Baby Of T VARSHA RUDRANI
08-07-2026 0 Y 0 M 0 D 1 H (M)
Dr. SPANDANA PASUPULETI



PATIENT STICKER

Bb Varsha

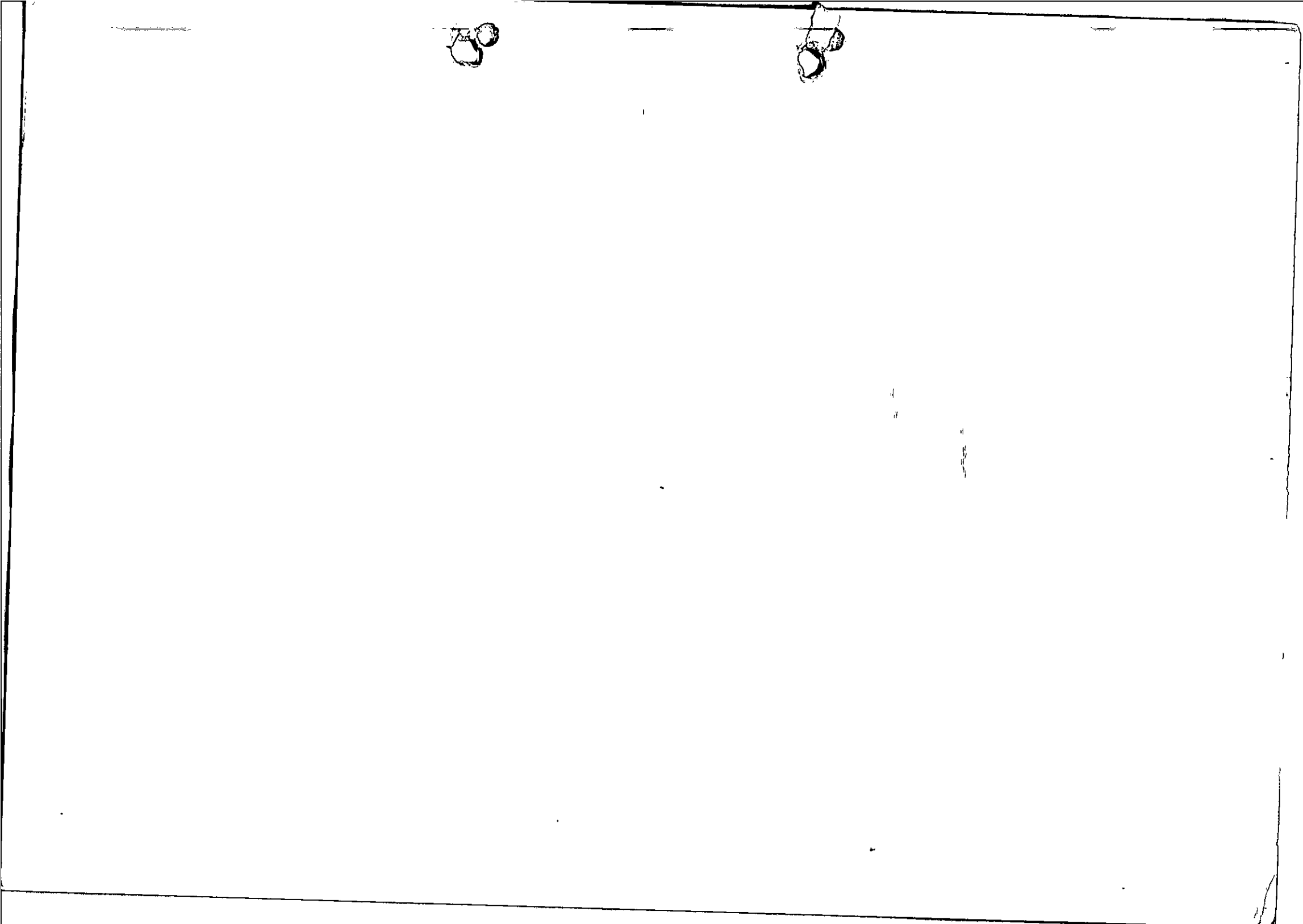
DATE : *8/7/21*

NEWBORN ANOMOLY ASSESSMENT CHECKLIST

| S.NO | ASSESSMENT PARAMETERS | CHECKED BY REGISTRAR | CHECKED BY CONSULTANT | REMARKS |
|------|--|----------------------|-----------------------|---------|
| 1. | Palate | <i>No cleft</i> | | |
| 2 | Pre natal teeth | <i>No</i> | | |
| 3 | Anal opening | <i>Patent</i> | | |
| 4 | Genitalia | <i>Male</i> | | |
| 5 | Spine | <i>Ⓢ</i> | | |
| 6 | Red reflex | <i>To check</i> | | |
| 7 | 4 limb saturation
(before discharge) | <i>To check</i> | | |

[Signature]
Ped.Registrar signature

Ped.Consultant signature





[FFP Transfusion]

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 10/7/26 Time: 2:45 pm

Blood Group of the Patient: A negative Blood Group on the Blood Bag: 1322 A negative

Blood Bank Issue No: 1322 Date of Collection: 2/16/26 Date of Expiry: 20/6/27

Date & Time of Starting Transfusion: 10/7/26 @ 2:45 pm Planned duration of Transfusion: 1 hour

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Dhanya Nurse 2: Praveen

Before starting transfusion vitals: Temp: 36.6°C HR: 132 RR: 40 BP: 66/40 SpO₂: 99%

PLEASE MONITOR THE FOLLOWING:

| Date | Time | HR | Temperature | Blood Pressure | SpO ₂ | Any Rash | Any Rigors | Any Breathlessness | Any Other Problem |
|---------|--------|-----|-------------|----------------|------------------|----------|------------|--------------------|-------------------|
| 10/7/26 | 15 Min | 136 | 36.6°C | 61/48 | 99% | — | — | — | — |
| | 15 Min | 140 | 36.5°C | 63/46 | 98% | — | — | — | — |
| | 30 Min | 142 | 36.5°C | 62/49 | 99% | — | — | — | — |
| | 30 Min | | | | | | | | |
| | 30 Min | | | | | | | | |
| | 1 Hr | | | | | | | | |
| | 1 Hr | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

Comments: No reaction

Name of the Incharge-Nurse: Bhavana

Name of the Nurse: Dhanya

Signature of the Incharge-Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 10/7/26 @ 2:45 pm

Date & Time: 10/7/26 @ 2:45 pm

Phone : 8790221175 , 8341711775

SURYA BLOOD CENTRE

(A unit of Telangana Development Committee)

#3-6-150, First Floor, Above Indian Bank, Main Road, Himayatnagar, Hyderabad-29.

Lic No. 111/HD/TS/2021/BC/G

FRESH FROZEN PLASMA BP 150-180 ML.

Prepared from Whole Human Blood Collected with
Anticoagulant : CPDA Solution U.S.P. 49 ml / 63 ml

Prepared from a **VOLUNTARY DONOR / REPLACEMENT DONOR**

Patient Name : **B/o Varsha** Age / Sex : **10/M**

Hospital Name : **Rainbow CH Hospital**

Blood Group : **A-Neg** Blood Bag No. : **1522**

Date of Preparation : **21/6/26** Tested Date : **21/6/26**

Expiry Date : **20/6/27** Volume : **30 ml.**

**Tested and Found Negative for HIV I & II antibodies,
HBsAg, HCV antibodies, VDRL & Malaria Parasites.**

INSTRUCTIONS : 1) Do not store Transfuse immediately.
2) Do not use if there is any visible evidence of deterioration 3) Check
blood group on label and recipients group before administration. 4)
Transfuse criteria 'ABO' Group Compatible. 5) Before Thawing Storage
Temperature - 30° C or below. 6) FFP must be thawed in a water bath
between 30°-37°C before Transfusion. 7) Use it Immediately after that
Discard. 8) Do not Refreeze once FFP is Thawed. 9) Do not add any medicine
to the component. 10) Do not dispense without prescription 11) Transfuse
under medical supervision. 12) Use a fresh, clean sterile and pyrogen free
disposable transfusion set with filter.

CONSENT FOR BLOOD TRANSFUSION

HNH-00016434 IP26-00006784
Name: Baby Of T VARSHA RUDRANI Age: 1.10 Gender: Male ☒ Female ☐
08-07-2026 0 Y 0 M 1 D (M)
Dr. SPANDANA PASUPULETI
UHID.No :  Date: 9/7/26

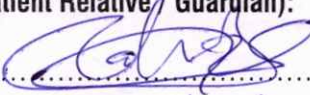
Type of Blood Product: ☒ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others

..... hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in the "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor has explained to me about the alternative for this procedure which is
..... Fresh Frozen plasma.

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: 
Name: T.S. Rahul
Date & Time

Doctor (Who is talking the consent)

Signature: 
Name: Dr. Spandana
Date & Time 9/7/26 10:30pm

Witness

Signature: 
Name: Dheya
Date & Time 9/7/26 @ 10:30pm





INTENSIVE CARE UNIT CAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: A-ve Baby's Blood Group: A-ve Sheet No: 2
 Gest Age: 33+6 wks Birth Weight: 1.220 kg

| | | |
|---|---|---|
| Date: <u>12/7/26</u> | Date: <u>13/7/26</u> | Date: <u>14/7/26</u> |
| DOL <u>D4</u>
Weight <u>1.280 kg ↓ 20 gm</u> | DOL <u>D5</u>
Weight <u>1.280 kg (S.Wt)</u> | DOL <u>D6</u>
Weight <u>1.260 kg ↓ 20 gm</u> |
| Problems: <u>PT/RDS</u> | Problems: <u>PT/RDS</u> | Problems: <u>PT/RDS</u> |
| Rs. <u>36-60 bpm</u>
Exam <u>Done</u>
Vent. Setting } <u>Sos</u>
ABG
CXR | Rs. <u>30-60 bpm</u>
Exam <u>Done</u>
Vent. Setting } <u>Sos</u>
ABG
CXR | Rs. <u>30-60 bpm</u>
Exam <u>Done</u>
Vent. Setting } <u>Sos</u>
ABG
CXR |
| CVS <u>Normal</u>
HR <u>130-160 bpm</u>
BP <u>41/51</u> Map <u>(57)</u>
Cap Refil <u><3 sec</u> | CVS <u>Normal</u>
HR <u>130-160 bpm</u>
BP Map
Cap Refil <u><3 sec</u> | CVS <u>Normal</u>
HR <u>130-160 bpm</u>
BP <u>48/32</u> Map <u>(38)</u>
Cap Refil <u><3 sec</u> |
| F/E/N
T. Fluids
CC/kg/day
I/O/RBS: <u>61 mg/dl</u>
U Output: (CC/kg/hr)
Exam - <u>Done</u>
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion } <u>Sos</u> | F/E/N
T. Fluids
CC/kg/day
I/O/RBS: <u>64 mg/dl</u>
U Output: (CC/kg/hr)
Exam - <u>Done</u>
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion } <u>Sos</u> | F/E/N
T. Fluids
CC/kg/day
I/O/RBS: <u>67 mg/dl</u>
U Output: (CC/kg/hr)
Exam - <u>Done</u>
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion } <u>Sos</u> |
| C/s Results
CRP
Antibiotics <u>inj. meropenem</u> | C/s Results
CRP
Antibiotics <u>inj. meropenem</u> | C/s Results
CRP
Antibiotics <u>inj. meropenem</u> |
| Med <u>inj. fluconazole</u> | Med <u>inj. fluconazole</u> | Med <u>inj. fluconazole</u> |
| Neuro: | Neuro: | Neuro: |
| Assessment <u>-Done</u> | Assessment <u>-Done</u> | Assessment <u>-Done</u> |
| Plan <u>CRBS-OD</u> | Plan <u>CRBS-OD</u> | Plan <u>CRBS-OD</u> |

DOCTOR

PHYSICIAN

1917

1917





INTENSIVE CARE UNIT STATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: A+ve Baby's Blood Group: A-ve Sheet No: 11
 Gest Age: 33+6wky Birth Weight: 1.220kg

| | | |
|--|--|--|
| Date: <u>9/7/26</u> | Date: <u>10/7/26</u> | Date: <u>11/7/26</u> |
| DOL <u>D1</u>
Weight <u>1.220kg</u> | DOL <u>D2</u>
Weight <u>1.240kg</u> ↑ <u>20g</u> | DOL <u>D3</u>
Weight <u>1.300kg</u> ↑ <u>60g</u> |
| Problems: <u>PT/RDS</u> | Problems: <u>PT/RDS</u> | Problems: <u>PT/RDS</u> |
| Rs. <u>30-60bpm</u>
Exam <u>done</u>
Vent. Setting } <u>sos</u>
ABG
CXR | Rs. <u>30-60bpm</u>
Exam <u>done</u>
Vent. Setting } <u>sos</u>
ABG
CXR | Rs. <u>30-60bpm</u>
Exam <u>Done</u>
Vent. Setting } <u>sos</u>
ABG
CXR |
| CVS <u>normal</u>
HR <u>120-160bpm</u>
BP <u>52/42</u> Map
Cap Refil | CVS <u>normal</u>
HR <u>120-160bpm</u>
BP <u>59/42</u> Map
Cap Refil | CVS <u>normal</u>
HR <u>120-160bpm</u>
BP <u>63/42</u> Map (ua)
Cap Refil <u><3sec</u> |
| F/E/N
T. Fluids
CC/kg/day
I/O/RBS: <u>[10mglday]</u>
U Output: (CC/kg/hr)
Exam <u>done</u>
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion | F/E/N
T. Fluids
CC/kg/day
I/O/RBS: <u>[60mglday]</u>
U Output: (CC/kg/hr)
Exam <u>done</u>
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion | F/E/N
T. Fluids
CC/kg/day
I/O/RBS: <u>62mglday</u>
U Output: (CC/kg/hr)
Exam
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion |
| C/s Results
CRP
Antibiotics <u>Inj. PIPITAZ</u> | C/s Results
CRP
Antibiotics <u>Inj. PIPITAZ</u> | C/s Results
CRP
Antibiotics <u>Inj. meropenem</u> |
| Med <u>Inj. Caffeine</u> | Med <u>Inj. Caffeine</u> | Med <u>Inj. Fluconazole</u> |
| Neuro: | Neuro: | Neuro: <u>Inj. caffeine</u> |
| Assessment <u>done</u> | Assessment <u>done</u> | Assessment <u>done</u> |
| Plan <u>GRBS 6th hour</u>
<u>ABG</u> | Plan <u>GRBS 6th hour</u>
<u>RRS</u> | Plan <u>GRBS - BD</u> |

Handwritten notes and a signature in the top right corner.





RESULT SHEET

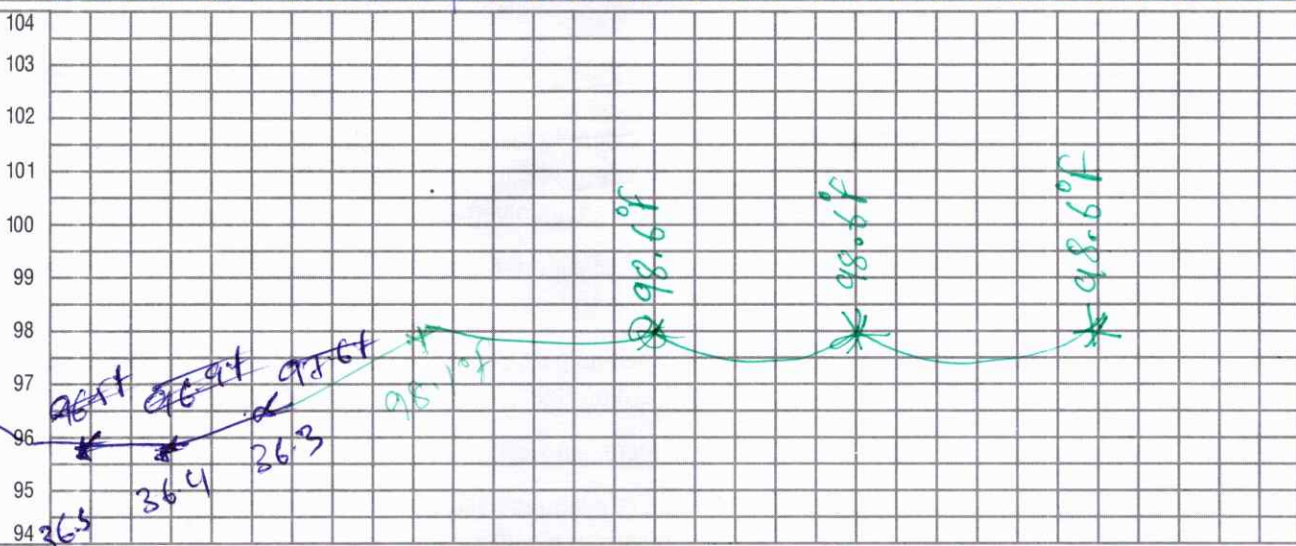
| Date | 8/7/26 | 9/7/26 | 10/7/26 | 11/7/26 | 12/7/26 |
|---------------------|------------|------------|---------|------------|------------|
| Time | | | | | |
| Hb | | | | | |
| PCV | 18.3 | 17.7 | 16.5 | 16.2 | 14.5 |
| RBC | 51.3 | 48.7 | 45.8 | 44.5 | 39.8 |
| WBC | 4.65 | 4.51 | 4.22 | 4.15 | 3.73 |
| N/L | 16.73 | 5.69 | 5.26 | 5.47 | 5.91 |
| Platelets | 25.8, 68.1 | 56.1, 35.4 | 69/30.3 | 32.0, 46.9 | 29.3, 54.1 |
| CRP | 128 | 151 | 138 | 156 | 153 |
| ESR | 5.0 | 14.0 | 15.0 | 21 | 14.0 |
| PCT | | | | | |
| RBS | | | | | |
| Na | | | | | |
| K | | 140 | | | |
| Cl | | 8.5 | | | |
| Ca/Mg | | 114 | | | |
| Phosphate | | 10.7 | | | |
| Urea | | | | | |
| Creatinine | | 1.7 | | | |
| ALP | | 0.7 | | | |
| SGPT | | | | | |
| SGOT | | | | | |
| T.Bill/Conj | | | | | |
| T.Protein | 2.3 | 6.8 | | | |
| S.Albumin | | | | | |
| S.Globulin | | | | | |
| A/G Ratio | | | | | |
| Uric Acid | | | | | |
| S.Amylase | | | | | |
| Sr.Lipase | | | | | |
| Blood Lactate | | | | | |
| S.Cholesterol | | | | | |
| PT/INR | | | | | |
| APTT | 20/1.5 | 20/1.5 | | | |
| CSF Protein / Sugar | 60 | 60 | 19/1.5 | | |
| Cells | | | 49 | | |
| N/L | | | | | |

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 21/7/26 Time: 8am 10am 12pm 6pm 10pm 2am 6am
 Doctor/Nurse/Family Concern?

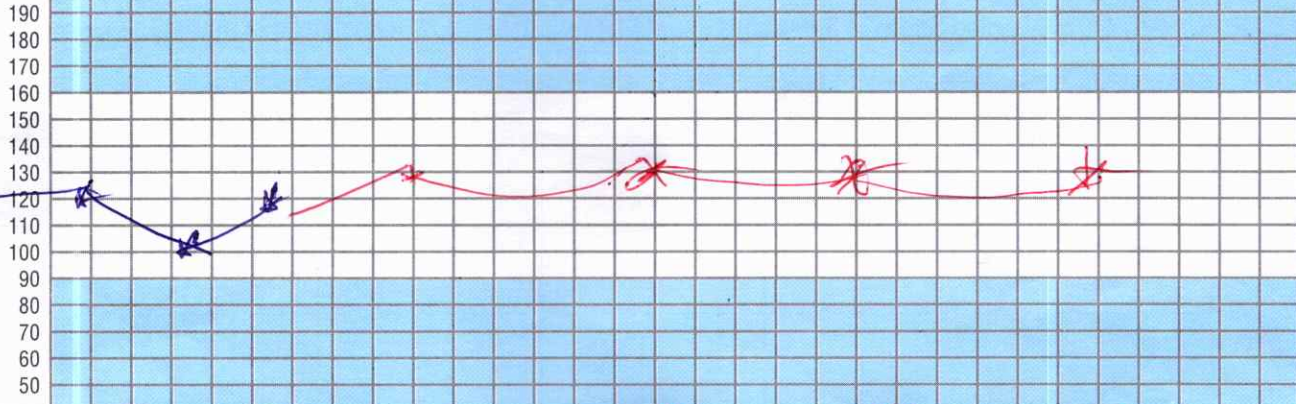
Temperature
 (°F)



Heart Rate
 (bpm)

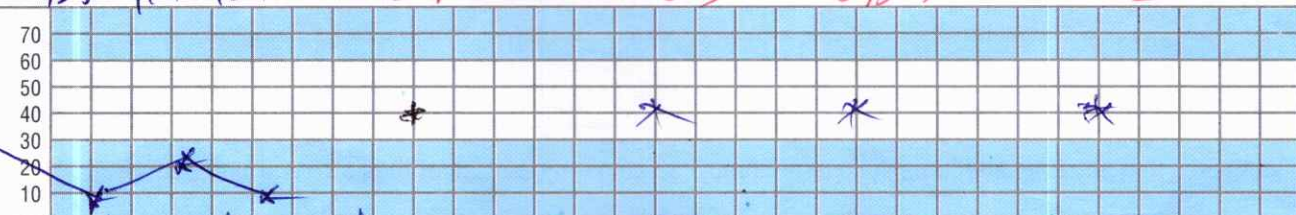
and
 Blood Pressure
 (mmHg)

Note:
 BP does not score
 in early
 warning scoring



Heart Rate (Number) 125 119 139 136bpm 140bpm 139bpm 140bpm

Resp. Rate (bpm)
 over 1 Minute *



Resp Rate (Number) 22bpm 28bpm 30bpm 40bpm 41bpm 42bpm

Resp Mod/ Severe
 Distress None / Mild

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

100% 100% 100% 99%

Conscious Level
 Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

2 6 6 0
 2 2 2 0
 6 2 2 0

ACTIONS

NB: Scores 3 should be
 recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

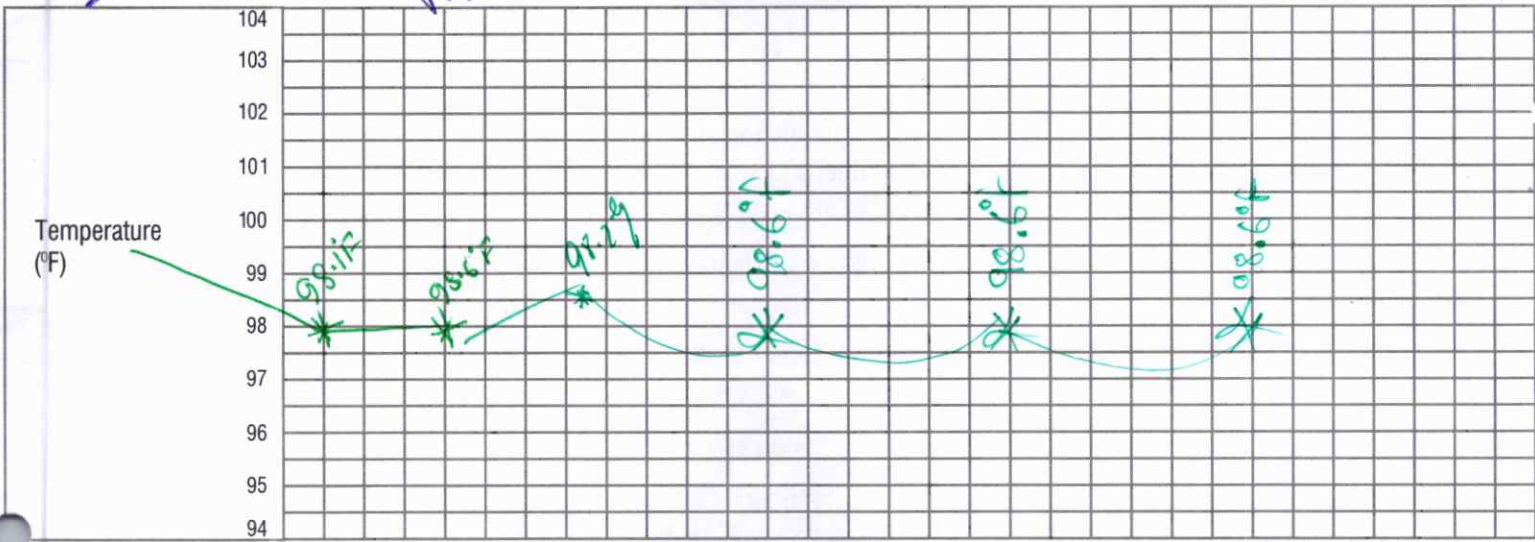
| | |
|----------|--|
| I | IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X) |
| S | SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX) |
| B | BACK GROUND : Child (X) was admitted on (XX date)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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 22/7/26 Time: 10 AM 9 PM 6 PM 10 PM 2 AM 6 AM
 Doctor/Nurse/Family Concern? AM PM PM PM AM AM



Heart Rate (bpm)
 and
 Blood Pressure (mmHg) *

Note:
 BP does not score
 in early
 warning scoring

| Time | Heart Rate (bpm) | Blood Pressure (mmHg) |
|-------|------------------|-----------------------|
| 10 AM | 136 | 130 |
| 9 PM | 140 | 130 |
| 6 PM | 140 | 130 |
| 10 PM | 140 | 130 |
| 2 AM | 143 | 130 |
| 6 AM | 142 | 130 |

Heart Rate (Number)

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

Resp Rate (Number)

| Time | Heart Rate (Number) | Resp Rate (bpm) | Resp Rate (Number) |
|-------|---------------------|-----------------|--------------------|
| 10 AM | 136 | 40 | 40 |
| 9 PM | 140 | 40 | 40 |
| 6 PM | 140 | 40 | 40 |
| 10 PM | 140 | 40 | 40 |
| 2 AM | 143 | 40 | 40 |
| 6 AM | 142 | 40 | 40 |

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

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

| Time | Receiving O ₂ (l/min) | O ₂ Saturations (%) |
|-------|----------------------------------|--------------------------------|
| 10 AM | 0 | 99 |
| 9 PM | 0 | 99 |
| 6 PM | 0 | 99 |
| 10 PM | 0 | 99 |
| 2 AM | 0 | 99 |
| 6 AM | 0 | 99 |

Conscious Level
 Normal
 Altered

| Time | Conscious Level |
|-------|-----------------|
| 10 AM | Normal |
| 9 PM | Normal |
| 6 PM | Normal |
| 10 PM | Normal |
| 2 AM | Normal |
| 6 AM | Normal |

GCS *

| Time | GCS |
|-------|-----|
| 10 AM | 10 |
| 9 PM | 10 |
| 6 PM | 10 |
| 10 PM | 10 |
| 2 AM | 10 |
| 6 AM | 10 |

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

| Time | Number of shaded boxes | Pain Score | Observer's Initials |
|-------|------------------------|------------|---------------------|
| 10 AM | 0 | 0 | SP |
| 9 PM | 0 | 0 | SP |
| 6 PM | 0 | 0 | SP |
| 10 PM | 0 | 0 | SP |
| 2 AM | 0 | 0 | SP |
| 6 AM | 0 | 0 | SP |

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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- 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) |

HNH-00016434 IP26-00006784
Baby Of T VARSHA RUDRANI
08-07-2026 0 Y 0 M 14 D (M)
Dr. SPANDANA PASUPULETI



INFANT (<1 year)

Observation &
Chart

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

| | | UNIT | | | | | |
|--|---|------|--|--|--|--|--|
| Date: 08/7/26 Time: 10Am 2P 6PM 10PM 2am 6am | | | | | | | |
| Doctor/Nurse/Family Concern? | | | | | | | |
| Temperature
(°F) | 104 | | | | | | |
| | 103 | | | | | | |
| | 102 | | | | | | |
| | 101 | | | | | | |
| | 100 | | | | | | |
| | 99 | | | | | | |
| | 98 | | | | | | |
| Heart Rate
(bpm)
and
Blood Pressure
(mmHg) * | 190 | | | | | | |
| | 180 | | | | | | |
| | 170 | | | | | | |
| | 160 | | | | | | |
| | 150 | | | | | | |
| | 140 | | | | | | |
| | 130 | | | | | | |
| Heart Rate (Number) | 140 | | | | | | |
| | 130 | | | | | | |
| | 120 | | | | | | |
| | 110 | | | | | | |
| | 100 | | | | | | |
| | 90 | | | | | | |
| | 80 | | | | | | |
| Resp. Rate (bpm)
(Over 1 Minute) * | 70 | | | | | | |
| | 60 | | | | | | |
| | 50 | | | | | | |
| | 40 | | | | | | |
| | 30 | | | | | | |
| | 20 | | | | | | |
| | 10 | | | | | | |
| Resp Rate (Number) | 40 | | | | | | |
| | 30 | | | | | | |
| | 20 | | | | | | |
| | 10 | | | | | | |
| | 0 | | | | | | |
| | 0 | | | | | | |
| | 0 | | | | | | |
| TOTAL SCORE | 0 | | | | | | |
| | 0 | | | | | | |
| | 0 | | | | | | |
| | 0 | | | | | | |
| | 0 | | | | | | |
| | 0 | | | | | | |
| | 0 | | | | | | |
| ACTIONS | Score 1 : Continue normal observation by staff nurse | | | | | | |
| | Score 2 : Shift in charge nurse to be informed and continue hourly observations | | | | | | |
| | Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue. | | | | | | |
| | Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see | | | | | | |
| | Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed | | | | | | |
| | NB: Scores 3 should be recorded overleaf | | | | | | |
| | | | | | | | |

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

CHILDREN'S OBSERVATION
and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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| Record Details when EARLY WARNING SCORE > 3 | | | Record Time of Review and Plan | | |
|---|------|---------------------|--------------------------------|------|------|
| Date | Time | Early Warning Score | Date | Time | Name |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

- 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) |



NICAL / 124

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

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

| | | | | | | |
|--|---|---------|---------|---------|---------|---------|
| Date: 24/7 | Time: 10 AM | 2 PM | 6 PM | 10 PM | 2 AM | 6 AM |
| Doctor/Nurse/Family Concern? | | | | | | |
| Temperature (°F) | 97.4°F | 98.4°F | 97.9°F | 98.6°F | 98.6°F | 98.6°F |
| Heart Rate (bpm) | 138 bpm | 146 bpm | 143 bpm | 148 bpm | 148 bpm | 140 bpm |
| Blood Pressure (mmHg) * | | | | | | |
| Resp. Rate (bpm) (Over 1 Minute) | 30 bpm | 36 bpm | 42 bpm | 42 bpm | 40 bpm | 42 bpm |
| Resp Mod/ Severe Distress None / Mild | | | | | | |
| Receiving O ₂ (l/min) | | | | | | |
| O ₂ Saturations (%) | 99% | 100% | 99% | 99% | 99% | 99% |
| Conscious Level Normal / Altered | | | | | | |
| GCS * | | | 15/15 | 15/15 | 15/15 | 15/15 |
| TOTAL SCORE | 0 | 0 | 0 | 0 | 0 | 0 |
| Number of shaded boxes | 0 | 0 | 0 | 0 | 0 | 0 |
| Pain Score | 0 | 0 | 0 | 0 | 0 | 0 |
| Observer's Initials | | | | | | |
| ACTIONS | Score 1 : Continue normal observation by staff nurse
Score 2 : Shift in charge nurse to be informed and continue hourly observations
Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed | | | | | |
| NB: Scores 3 should be recorded overleaf | | | | | | |

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

CHILDREN'S OBSERVATION
and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

HNH-00016434 IP26-00006784
 Baby Of T VARSHA RUDRANI
 08-07-2026 0 Y 0 M 14 D (M)
 Dr. SPANDANA PASUPULETI



FLUID CHART

Sheet No. :

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

| Date | Time | Nature of Fluid | Intake | | | Output | | | | | IV Site Thrombophlebitis Score | Sign. Nurse |
|----------------|----------|-----------------|--------|-----|-----|------------------------|-----------|-------|----------|-------|--------------------------------|-------------|
| | | | Mouth | I.V | N.G | NG | Diarrhoea | Vomit | Drainage | Urine | | |
| 29/7/26 | 08:00 am | | | | | | | | | | | |
| | 09:00 am | o | ABF+FF | | | | | | | ✓ | 0 | |
| | 10:00 am | | | | | | | | | | | |
| | 11:00 am | | ABF+FF | | | | | | | | | |
| | 12:00 pm | | | | | | | | | ✓ | | |
| | 01:00 pm | | ABF+FF | | | | | | | | | |
| Total Intake : | | | | | | Total Output : U - M - | | | | | | |
| 22/8/26 | 02:00 pm | | | | | | | | | | | |
| | 03:00 pm | o | EBM | | | | | | | ✓ | 0 | |
| | 04:00 pm | | | | | | | | | | | |
| | 05:00 pm | | EBM | | | | | | | | | |
| | 06:00 pm | | | | | | | | | ✓ | | |
| | 07:00 pm | | EBM | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | |
| 22/8/26 | 08:00 pm | | FF | | | | | | | | | |
| | 09:00 pm | | | | | | | | | ✓ | 0 | |
| | 10:00 pm | o | AB | | | | | | | | | |
| | 11:00 pm | | | | | | | | | | | |
| | 12:00 am | | AA | | | | | | | ✓ | | |
| | 01:00 am | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | |
| 23/8/26 | 02:00 am | | FF | | | | | | | | | |
| | 03:00 am | | | | | | | | | ✓ | 0 | |
| | 04:00 am | o | AB | | | | | | | | | |
| | 05:00 am | | | | | | | | | | | |
| | 06:00 am | | AA | | | | | | | ✓ | | |
| | 07:00 am | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | |

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. :

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

| | | 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 | | | | | | | | |
| 20/7/22 | 08:00 am | EBM+FF | | | | | | | | | | | |
| | 09:00 am | | | | | | | | | | | | |
| | 10:00 am | EBM+FF | | | | | | | | ✓ | | | |
| | 11:00 am | | | | | | | | | | | | |
| | 12:00 pm | EBM+FF | | | | | | | | | | | |
| | 01:00 pm | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| 23/7/26 | 02:00 pm | EBM | | | | | | | | | | | |
| | 03:00 pm | | | | | | | | | | | | |
| | 04:00 pm | EBM | | | | | | | | ✓ | | | |
| | 05:00 pm | | | | | | | | | | | | |
| | 06:00 pm | EBM | | | | | | | | | | | |
| | 07:00 pm | | | | | | | | | | | | |
| Total Intake : Taken | | | | | | Total Output : U- M- | | | | | | | |
| 28/7/26 | 08:00 pm | | | | | | | | | | | | |
| | 09:00 pm | EBM | | | | | | | | | | | |
| | 10:00 pm | | | | | | | | | ✓ | | | |
| | 11:00 pm | EBM | | | | | | | | | | | |
| | 12:00 am | | | | | | | | | | | | |
| | 01:00 am | EBM | | | | | | | | ✓ | | | |
| Total Intake : Taken | | | | | | Total Output : U-2 M-0 | | | | | | | |
| 24/8/26 | 02:00 am | | | | | | | | | | | | |
| | 03:00 am | EBM | | | | | | | | | | | |
| | 04:00 am | | | | | | | | | ✓ | | | |
| | 05:00 am | EBM | | | | | | | | | | | |
| | 06:00 am | | | | | | | | | | | | |
| | 07:00 am | EBM | | | | | | | | ✓ | | | |
| Total Intake : Taken | | | | | | Total Output : U-2 M-0 | | | | | | | |

| | |
|-----------------------------|--|
| Total 24 hrs. Intake | |
|-----------------------------|--|

| | |
|-----------------------------|--|
| Total 24 hrs. Output | |
|-----------------------------|--|

HNH-00016434 IP26-00006784
 Baby Of T VARSHA RUDRANI
 08-07-2026 0 Y 0 M 12 D (M)
 Dr. SPANDANA PASUPULETI

Patient Stic



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

JID CHART

Sheet No. :

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

| | | Intake | | | | Output | | | | | IV Site
Thrombo-
phlebitis
Score | Sign.
Nurse | |
|-----------------------|----------|--------------------|-------|-----|-----|-----------------------|-----------|-------|----------|-------|---|----------------|--|
| Date | Time | Nature
of Fluid | Route | | | NG | Diarrhoea | Vomit | Drainage | Urine | | | |
| 21/7/26 | | | Mouth | I.V | N.G | | | | | | | | |
| | 08:00 am | FF | 20ml | | | | | | | 20ml | | | |
| | 09:00 am | | | | | | | | | | | | |
| | 10:00 am | FF | 20ml | | | | | | | 20ml | | | |
| | 11:00 am | | | | | | | | | | | | |
| | 12:00 pm | FF | 20ml | | | | | | | 20ml | | | |
| 01:00 pm | | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| 21/7/26 | 02:00 pm | FF | 25ml | | | | | | | | 0 | | |
| | 03:00 pm | | | | | | | | | | 0 | | |
| | 04:00 pm | FF | 10ml | | | | | | | | 0 | | |
| | 05:00 pm | | | | | | | | | | 0 | | |
| | 06:00 pm | FF | 10ml | | | | | | | | 0 | | |
| | 07:00 pm | | | | | | | | | | 0 | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| 21/2/26 | 08:00 pm | FF | 20ml | | | | | | | | 1 | | |
| | 09:00 pm | | | | | | | | | | 1 | | |
| | 10:00 pm | FF | 20ml | | | | | | | | 0 | | |
| | 11:00 pm | | | | | | | | | | 1 | | |
| | 12:00 am | FF | 20ml | | | | | | | | 1 | | |
| | 01:00 am | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| 22/2/26 | 02:00 am | FF | 20ml | | | | | | | | 1 | | |
| | 03:00 am | | | | | | | | | | 1 | | |
| | 04:00 am | FF | 20ml | | | | | | | | 0 | | |
| | 05:00 am | | | | | | | | | | 1 | | |
| | 06:00 am | FF | 20ml | | | | | | | | 1 | | |
| | 07:00 am | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |

Total 24 hrs. Intake

Total 24 hrs. Output

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FLUID CHART

Sheet No. :

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

| Date | Time | Nature of Fluid | Intake | | | Output | | | | | IV Site Thrombo-phlebitis Score | Sign. Nurse |
|-----------------------|----------|-----------------|--------|-----|-----|------------------------------|-----------|-------|----------|-------|---------------------------------|-------------|
| | | | Mouth | I.V | N.G | NG | Diarrhoea | Vomit | Drainage | Urine | | |
| 24/7 | 08:00 am | | | | | | | | | | | |
| | 09:00 am | EBM | | | | | | | | | | |
| | 10:00 am | | | | | | ✓ | | | | | |
| | 11:00 am | EBM | | | | | | | | ✓ | | |
| | 12:00 pm | | | | | | | | | | | |
| | 01:00 pm | EBM | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : U- M-1 | | | | | | |
| 24/7/26 | 02:00 pm | | | | | | | | | | | |
| | 03:00 pm | EBM | | | | | | | | | | |
| | 04:00 pm | | | | | | | | | | | |
| | 05:00 pm | EBM | | | | | | | | | | |
| | 06:00 pm | | | | | | ✓ | | | ✓ | | |
| | 07:00 pm | EBM | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | |
| 24/7/28 | 08:00 pm | | | | | | | | | | | |
| | 09:00 pm | EBM | | | | | | | | | | |
| | 10:00 pm | | | | | | | | | | | |
| | 11:00 pm | EBM | | | | | | | | | | |
| | 12:00 am | | | | | | | | | | | |
| | 01:00 am | EBM | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | |
| 25/7/28 | 02:00 am | | | | | | | | | | | |
| | 03:00 am | EBM | | | | | | | | | | |
| | 04:00 am | | | | | | ✓ | | | | | |
| | 05:00 am | EBM | | | | | | | | | | |
| | 06:00 am | | | | | | | | | | | |
| | 07:00 am | EBM | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | |

Total 24 hrs. Intake

Total 24 hrs. Output

Handwritten notes in the top right corner, including a small diagram of a circle with internal lines and some illegible text.



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NURSING CARE RECORD

Date: 21/7/26

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 | Nurse Name & Signature |
|-----------|------|--|------|--|--|-----------------------------|------------------------|
| Morning | 8AM | → Assess the general condition of baby | 8AM | → Assess the general condition of baby | Baby is stable | Re-assess vitals | [Signature] |
| | 2pm | → Monitor vitals
→ Maintain I/O chart
→ Administer medication | 2pm | → Monitor vitals
→ Maintain I/O chart
→ Administer medication | | | |
| Afternoon | 2pm | → To assess the baby condition | 2pm | → To assess the baby condition | → Baby is stable
→ Vaccination to be done T/M | → Re-checked the vitals I/O | [Signature] |
| | 8pm | → To check the vitals & record
→ FF 2nd hourly
→ Contd. Supplement | 8pm | → To check the vitals & record
→ FF 2nd hourly
→ Contd. Supplement | | | |
| Night | 8pm | → Assess the Baby general condition | 8pm | → Assess the Baby general condition | Baby is stable | Re-checked vitals | [Signature] |
| | 8AM | → Check the vital sign
→ 2nd hourly FF
→ Maintain I/O | 8AM | → Check the vital sign
→ 2nd hourly FF
→ Maintain I/O | | | |

1-00016434
Baby OT VARSHA RUDRANI
08-07-2026
Dr. SPANDANA PASUPULETI
IP26-00006
0 Y 0 M 14 D
(M)

Patient Stn

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 22/7/26

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 | Nurse Name & Signature |
|-----------|------|--|------|--|--------------------|-------------------------|------------------------|
| Morning | 8AM | → Assess the general condition of pt.
→ Monitor vitals.
→ Maintain I/O chart.
→ drugs give as per drug chart. | 8AM | → Assessed the pt condition.
→ monitored the vitals.
→ maintained I/O chart.
→ drugs given as per drug chart. | → pt is stable now | → Reassessed the vitals | [Signature] |
| | 2PM | | 2PM | | | | |
| Afternoon | 2pm | → Assess the pt condition.
→ monitor vitals & I/O chart
→ drug as per chart
→ Spoon feeding | | → Assessed the pt condition.
→ monitored vitals & I/O chart
→ spoon feeding and hourly give | Baby is stable | Rechecked vitals | [Signature] |
| Night | 8pm | - Assess the Baby condition
- monitor vitals
- maintain I/O Chart
- Spoon feeding every 2nd H | 8pm | - Assessed the Baby condition
- monitored vitals
- maintained I/O Chart
- Spoon feeding every 2nd Hourly | Baby is stable | rechecked vitals | [Signature] |



NURSING CARE RECORD

Date: 23/7/26

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 | Nurse Name & Signature |
|-----------|------|---|------|---|--|----------------------------------|------------------------|
| Morning | 8Am | → Assess the baby condition.
→ monitor the vitals.
→ maintain I/O chart.
→ EBM+FF give every 2nd hourly given. | 8Am | → Assessed the baby condition
→ Monitored the vitals.
→ maintained I/O chart.
→ EBM+FF given every 2nd hourly given. | → Baby is stable Now. | → Reassessed the vitals. | |
| | 2pm | → To assess the baby condition
→ To check the vitals & record
→ 2nd hourly EBM + FF
→ Contd. Supplement | 2pm | → To assessed the baby condition
→ To checked the vitals & recorded
→ 2nd hourly EBM + FF
→ Contd. Supplement. | → Baby is stable
→ Before D/C BCG & OPV | → re-checked the vitals
→ I/O | |
| Afternoon | 8pm | → I/O chart maintain | 8pm | → I/O chart maintained | | | |
| | 10pm | → Assess the Pt condition
→ To check the v/s & Recorded
→ 2nd hourly EBM + FF
→ I/O charting | 10pm | → Assess the Pt condition
→ To check the v/s & Recorded
→ 2nd hourly EBM
→ I/O monitoring | → Baby is stable
→ Before D/C BCG, OPV, OAE | → Rechecked the v/s & I/O | |
| Night | 8am | | 8am | | | | |

HNH-00016434 IP26-00006784
 Baby Of T VARSHA RUDRANI
 08-07-2026 0 Y 0 M 15 D (M)
 Dr. SPANDANA PASUPULETI

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

NURSING CARE RECORD

Date: 24/7/26

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 | Re-Assessment | Nurse Name & Signature |
|-----------|------|--|------|--|----------------------|--|------------------------|
| Morning | 8AM | Assess the baby condition | 8AM | Assessed the baby condition | Baby is stable now | Re-checked vitals | R |
| | 1 | Monitor vitals & record
- Maintain I/O chart
- EBM + FF every 2nd hrly
- plan vaccination H/d | | Monitored vitals & record
- Maintained I/O chart
- EBM + FF 2nd hrly | | | |
| Afternoon | 2pm | To assess the baby condition | 2pm | To assessed the baby condition | Baby is stable | + re-checked the vitals
+ I/O
+ T/M vaccination & OAE plan | Supriya |
| | to | To check the vitals & record
→ 2nd hourly EBM + FF
→ I/O chart/maintain
8pm → Contd. Supplement | to | To checked the vitals & recorded
→ 2nd hourly EBM + FF
→ I/O chart/maintained
8pm → Contd. Supplement | | | |
| Night | 8pm | Assess the pt condition | 8pm | Assess the pt condition | - Now baby is stable | - Rechecked the v/s | Gy |
| | to | Monitor the v/s
- maintain the I/O
8am - EBM + FF 2nd hourly
- Contd. Supplement | to | Monitor the v/s
- maintain the I/O
8am - EBM + FF 2nd hourly | | | |



DEFICIENCY CHECK LIST OF CASE SHEET

| Sl.No. | List of Records | No. of Pages | Legibility | Completeness | Remarks |
|--------|--|--------------|------------|--------------|---------|
| 1 | Admission sheet | 1 | | | |
| 2 | Discharge Summary | 1 | | | |
| 3 | Nursing Initial assessment | 1 | | | |
| 4 | Patient Transfer form | 1 | | | |
| 5 | In-patient Medical record | 1 | | | |
| 6 | Doctors progress sheets | 39 | | | |
| 7 | Nursing plan of care and handover sheets | 3+2 | | | |
| 8 | Consultation sheet | | | | |
| 9 | General consent for treatment | 1 | | | |
| 10 | Consent for Surgery | | | | |
| 11 | Consent for blood transfusion | 1 | | | |
| 12 | Consent for chemotherapy | | | | |
| 13 | Consent for high risk | | | | |
| 14 | Consent for Restraint | | | | |
| 15 | LAMA consent | | | | |
| 16 | Consent for special procedure / Sedation | 2 | | | |
| 17 | Consent for Formula feed | 1 | | | |
| 18 | Consent for MTP | | | | |
| 19 | Consent for Radiological Investigations | 1 | | | |
| 20 | Consent for HIV test | | | | |
| 21 | Anaesthesia notes (Pre Anaesthesia & post) | | | | |
| 22 | Neonatal Admission/Delivery/Physical Exam | 1 | | | |
| 23 | Medication Reconciliation | 1 | | | |
| 24 | Emergency Triage record | | | | |
| 25 | Pre operative check list | | | | |
| 26 | Surgical safety checklist | | | | |
| 27 | Operation Theatre notes | | | | |
| 28 | Nurses clinical Presentation | | | | |
| 29 | TPR & BP chart | 4 | | | |
| 30 | Intake and Out take chart (fluid chart) | 3 | | | |
| 31 | Drug chart (Regular Prescription) | 1 | | | |
| 32 | Investigation Values (result sheet) | 1 | | | |
| 33 | Nebulization chart | | | | |
| 34 | Nutritional review chart | | | | |
| 35 | Intensive care unit (ICU Charts) ✓ | 5 | | | |
| 36 | Consent for Admission in PICU / NICU | 14 | | | |
| 37 | The Humpty dumpty scale | | | | |
| 38 | Braden Q Scale | 5+2 | | | |
| 39 | Bed side check list | | | | |
| 40 | PICU bed formula Dilution feeds | | | | |
| 41 | Gastro monitoring chart | | | | |
| 42 | Rch ED doctors note | | | | |
| 43 | BP Monitoring chart | | | | |
| 44 | RBS monitoring chart | | | | |
| | Billing | 1 | | | |
| | Others | 5 | | | |
| | Total No. of Pages | 98 | | | |

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

INTENSIVE CARE UNIT

CAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: A-ve Baby's Blood Group: A-ve Sheet No. 4

Gest Age: 33+6 weeks Birth Weight: 1.220 kg

| | | |
|--|--|--|
| Date: <u>21/7/26</u> | Date: <u>22/7/26</u> | Date: <u>23/7/26</u> |
| DOL <u>D13</u>
Weight <u>1.360 kg ↑ 40g</u> | DOL <u>D14</u>
Weight <u>1.360 kg</u> | DOL <u>D15</u>
Weight <u>1.380 kg ↑ 20g</u> |
| Problems: <u>PT/ARDS</u> | Problems: | Problems: |
| Rs. <u>30-60 bpm</u>
Exam <u>Done</u>
Vent. Setting <u>roomair</u>
ABG <u>sos</u>
CXR | Rs.
Exam
Vent. Setting
ABG
CXR | Rs.
Exam
Vent. Setting
ABG
CXR |
| CVS <u>Normal</u>
HR <u>140-160 bpm</u>
BP Map
Cap Refil <u>23 sec</u> | CVS
HR
BP Map
Cap Refil | CVS
HR
BP Map
Cap Refil |
| F/E/N
T. Fluids
CC/kg/day
I/O/RBS:
U Output: (CC/kg/hr)
Exam <u>Done</u>
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion | F/E/N
T. Fluids
CC/kg/day
I/O/RBS:
U Output: (CC/kg/hr)
Exam
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion | F/E/N
T. Fluids
CC/kg/day
I/O/RBS:
U Output: (CC/kg/hr)
Exam
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion |
| C/s Results
CRP
Antibiotics | C/s Results
CRP
Antibiotics | C/s Results
CRP
Antibiotics |
| Med <u>Wt D3 drops</u>
Neuro: | Med
Neuro: | Med
Neuro: |
| Assessment <u>Done</u> | Assessment | Assessment |
| Plan <u>GRRBS</u> | Plan | Plan |

D16 - 24/7/26 - 1.400 kg

25/7/26 - 1420 kg

HNH-00016434

IP26-00006784

Baby Of T VARSHA RUDRANI

05-07-2026 0Y0M5D

Dr. SPANDANA PASUPULETI

(M)

Dr

BY RAINBOW HC

Your Right in a Sa

INTENSIVE CARE UNIT

AL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: A - veBaby's Blood Group: A - veSheet No: 3Gest Age: 32+6 wksBirth Weight: 1.220 kg

| | | |
|---|---|---|
| Date: <u>15/7/26</u> | Date: <u>16/7/26</u> | Date: <u>17/7/26</u> |
| DOL <u>D2</u>
Weight <u>1.240 kg ↓ 20 gm</u> | DOL <u>D8</u>
Weight <u>1.280 kg ↑ 40 gm</u> | DOL <u>D9</u>
Weight <u>1.240 ↓ 40 gm</u> |
| Problems: <u>PT/RDS</u> | Problems: <u>PT/RDS</u> | Problems: <u>PT/RDS</u> |
| Rs. <u>30-60 bpm</u>
Exam <u>Done</u>
Vent. Setting
ABG
CXR } <u>SOS</u> | Rs. <u>30-60 bpm</u>
Exam <u>Done</u>
Vent. Setting
ABG
CXR } <u>SOS</u> | Rs. <u>30-60 bpm</u>
Exam <u>Done</u>
Vent. Setting <u>R/A</u>
ABG
CXR } <u>SOS</u> |
| CVS <u>Normal</u>
HR <u>120-160 bpm</u>
BP <u>60/50 Map (53)</u>
Cap Refil <u><3 sec</u> | CVS <u>Normal</u>
HR <u>120-160 bpm</u>
BP <u>50/30 Map (41)</u>
Cap Refil <u><3 sec</u> | CVS <u>Normal</u>
HR <u>120-160</u>
BP <u>60/50 Map 53</u>
Cap Refil |
| F/E/N
T. Fluids
CC/kg/day
I/O/RBS: <u>67 mg/dl</u>
U Output: (CC/kg/hr)
Exam <u>Done</u>
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion } <u>SOS</u> | F/E/N
T. Fluids
CC/kg/day
I/O/RBS: <u>96 mg/dl</u>
U Output: (CC/kg/hr)
Exam <u>Done</u>
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion } <u>SOS</u> | F/E/N
T. Fluids
CC/kg/day
I/O/RBS: <u>76 mg/dl</u>
U Output: (CC/kg/hr)
Exam
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion } <u>SOS</u> |
| C/s Results
CRP
Antibiotics | C/s Results
CRP
Antibiotics | C/s Results
CRP
Antibiotics |
| Med <u>Vit-D3 syrup</u>
Neuro: | Med <u>Vit D3 Syrup</u>
Neuro: | Med <u>Vit D3 Syrup</u>
Neuro: |
| Assessment <u>Done</u> | Assessment <u>Done</u> | Assessment <u>Done</u> |
| Plan <u>G RBS - OD</u> | Plan <u>G RBS - OD</u> | Plan <u>G RBS - OD</u> |

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INTENSIVE CARE UNIT

CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: A+VI Baby's Blood Group: A+VI Sheet No: 19

Gest Age: 33+6 weeks Birth Weight: 1.220 Kg

| | | |
|--|---|--|
| Date: <u>18/7/26</u> | Date: <u>19/7/26</u> | Date: <u>20/7/26</u> |
| DOL <u>Dio</u>
Weight <u>1.280 ↑ 40grm</u> | DOL <u>D11</u>
Weight <u>1.300 ↑ 20grms</u> | DOL <u>D12</u>
Weight <u>1.320 ↑ 20grms</u> |
| Problems: <u>PT/RDS</u> | Problems: <u>PT/RDS</u> | Problems: <u>PT/RDS</u> |
| Rs. <u>30-60bpm</u>
Exam <u>Done</u>
Vent. Setting <u>RIA</u>
ABG <u>psos</u>
CXR <u>psos</u> | Rs. <u>30-60bpm</u>
Exam <u>Done</u>
Vent. Setting <u>RIA</u>
ABG <u>psos</u>
CXR <u>psos</u> | Rs. <u>30-60bpm</u>
Exam <u>Done</u>
Vent. Setting <u>RIA</u>
ABG <u>psos</u>
CXR <u>psos</u> |
| CVS <u>Normal</u>
HR <u>120-160bpm</u>
BP <u>Map</u>
Cap Refil | CVS <u>Normal</u>
HR <u>120-160bpm</u>
BP <u>Map</u>
Cap Refil | CVS <u>Normal</u>
HR <u>120-160bpm</u>
BP <u>Map</u>
Cap Refil |
| F/E/N
T. Fluids
CC/kg/day
I/O/RBS: <u>86 mg/dl</u>
U Output: (CC/kg/hr)
Exam <u>Done</u>
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion | F/E/N
T. Fluids
CC/kg/day
I/O/RBS: <u>102 mg/dl</u>
U Output: (CC/kg/hr)
Exam
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion | F/E/N
T. Fluids
CC/kg/day
I/O/RBS: <u>82 mg/dl</u>
U Output: (CC/kg/hr)
Exam
T. Bil/D
Na HcO3
K BUN
Cl Crea
Hemat HB:
WCC
Plats
Transfusion |
| C/s Results

CRP
Antibiotics | C/s Results

CRP
Antibiotics | C/s Results

CRP
Antibiotics |
| Med <u>vit D3 Syrup</u>
Neuro: | Med <u>vit D3 Syrup</u>
Neuro: | Med <u>vit D3 Syrup</u>
Neuro: |
| Assessment <u>Done</u> | Assessment <u>Done</u> | Assessment <u>Done</u> |
| Plan <u>GRBS OD</u> | Plan <u>GRBS OD</u> | Plan <u>GRBS OD</u> |

HNH-00016434 IP26-00006784
Baby Of T VARSHA RUDRANI
08-07-2026 0 Y 0 M 0 D 21 H (M)
Dr. SPANDANA PASUPULETI



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



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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

I.V. FLUID CHART

[illegible]

1



CONSENT FOR BLOOD TRANSFUSION

HNH-00016434 IP26-00006784
Baby Of T VARSHA RUDRANI
Name: 08-07-2026 0 Y 0 M 1 D (M) Age: Gender: Male ☒ Female ☐
Dr. SPANDANA PASUPULETI
UHID.No:  Date: 9/2/26

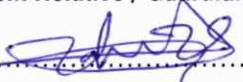
Type of Blood Product: ☒ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others

I hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in the "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor has explained to me about the alternative for this procedure which is 77P + new blood
Fresh Frozen plasma.

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

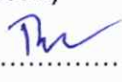
Patient (Or Patient Relative / Guardian):

Signature: 

Name: T.S. Rahu

Date & Time: 09/07/2026 8pm

Doctor (Who is talking the consent)

Signature: 

Name: B. S. Singh

Date & Time: 9/2/26 8pm

Witness

Signature: 

Name: Dhayabali

Date & Time: 9/2/26 @ 8pm

1
2 3 4

5 6 7 8

9
10 11 12
13 14



HNH-00016434 IP26-00006784
Baby Of T VARSHA RUDRANI
08-07-2026 0 Y 0 M 0 D 21 H (M)
Dr. SPANDANA PASUPULETI

CONSENT FOR DONOR BREAST MILK

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name : B/O VARSHA Age : 2d Gender : ☒ Male ☐ Female

UHID No : Department : NICU Date : 10/7/26

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 Donor Breast Milk for my child. Doctors have explained me
about the Donor Breast Milk feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : T.S. Rahul

Name : T.S. Rahul

Relationship with Patient : FATHER

Date & Time : 10/07/2026

Witness :

Signature : Sai Priya

Name : Sai Priya

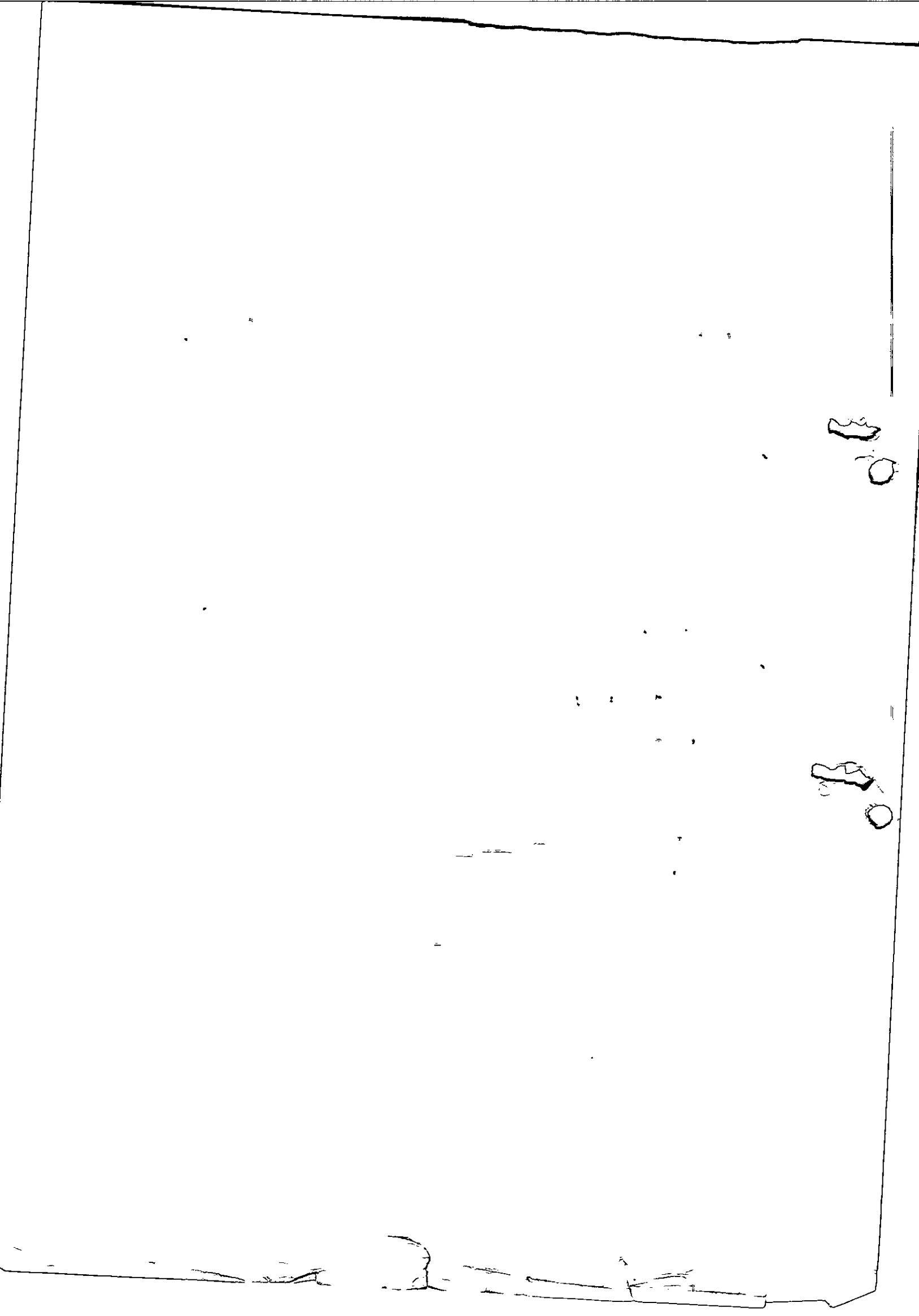
Date & Time : 10/7/26

Doctor (who is taking the consent) :

Signature : Dr. Praveen

Name : Dr. Praveen

Date & Time : 10/7/26





CONSENT FOR FORMULA FEEDS

Patient Name : B/o. Varsha Rudrani Age : Dr Gender : ☒ Male ☐ Female
UHID No : HNH-00016434 Department : Neuro Date : 9/7/26
I Mr / Mrs P. S. Rahul aged years, hereby declare that I have
admitted my ☐ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on
..... I hereby give consent for formula feed for my child. Doctors have explained me
about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : [Signature]
Name : T.S. Rahul
Relationship with Patient : FATHER
Date & Time : 9/7/26 @ 6pm

Witness :

Signature : [Signature]
Name : Syodhi
Date & Time : 9/7/26 @ 6pm

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Dr. Praveen
Date & Time : 9/7/26



... ..
... ..
... ..
... ..