

HNH-00016240
Baby Of AREESA FATIMA
29-06-2026
Dr. S TEJASW REDDY

IP26-00006683
O Y O M O D 10 H (M)

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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	4			
6	Doctors progress sheets	3			
7	Nursing plan of care and handover sheets	3			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed	1			
18	Consent for MTP				
19	Consent for Radiological Investigations				
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	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
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)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale				
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			
	Extra	16			
	Total No. of Pages	29			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date: *[Signature]*
30/6/2026 (RT.O)

DISCHARGE AT REQUEST SUMMARY

Name	Baby Of AREEBA FATIMA	UHID	HNH-00016240
Father/Guardian	Mr MAHAMMED SAMAD	Age/Gender	0 Y 0 M 0 D 1 H/ Male
Address	10-2-510/1/a beside azra public school asif nagar, Gudimalkapur, Hyderabad, Telangana, INDIA, 500028		
IP No	IP26-00006683	Admission Date	29-06-2026
Ref Doctor	SELF		
Discharge Date	30.06.2026		

Consultant:

Dr. S TEJASWI REDDY

MBBS, MD Pediatrics, DM Neonatology

APMC/FMR/94068

DIAGNOSIS	ICD CODE
TERM (39 weeks + 3 days)/AGA/CIAB/BABY BOY/RIGHT UNDESCENDED TESTES	

History: Baby Of AREEBA FATIMA is a term (39 weeks + 3 days) baby boy, delivered to a G3P1A1L1 mother by normal vaginal delivery on 29.06.2026 at 10:48 am with birth weight of 2.820 kgs in Rainbow Children's Hospital, Himayathnagar, Hyderabad. Baby cried immediately after birth. Apgar scores

Name	Baby Of AREEBA FATIMA	UHID	HNH-00016240
IP No	IP26-00006683	Admission Date	29-06-2026

were 7/10 at 1 min, 9/10 at 5 min. Inj. Vitamin K 1mg IM was given after delivery. Delayed cord clamping done. Fetal presentation was Vertex.

Maternal History: Mrs. AREEBA FATIMA is a 26 years old G3P1A1L1 mother.

G1 -FT-NVD, Female, 2.6KG, H/O IUGR.

G2 - Spontaneous miscarriage at 5 weeks

G3- Present Pregnancy, Spontaneous conception, had regular Antenatal checkup's, received 2 doses of Injection. Tetanus Toxoid. Antenatal scans were normal. No history of Pregnancy Induced hypertension/ Urinary Tract Infection/ Antepartum Haemorrhage/ Hypothyroidism/ Gestational Diabetes Mellitus/ Oligohydramnios/ Polyhydramnios/ Prolonged Rupture Of Membranes/ Fever.

Mother's Blood group is AB positive.

Examination: Baby was euthermic (36.5°F), euvoletic and was maintaining saturations at room air. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Bilateral femoral pulses well felt. Abdomen was soft with no organomegaly. Cry and activity were good. Anterior fontanelle was at level. No obvious external congenital anomalies were noted clinically. All external orifices were patent and open. All neonatal reflexes were normal.

Anthropometry:

Weight at birth : 2.82 kgs.

Weight at discharge : 2.70 kgs.

Head Circumference : 32 cms.

Length : 47 cms.

Investigations: Enclosed reports.

Name	Baby Of AREEBA FATIMA	UHID	HNH-00016240
IP No	IP26-00006683	Admission Date	29-06-2026

Ultrasound scrotum shows

Findings in keeping with right undescended testis as described.

Management:

Course during hospital: On examination Right scrotal sac was empty and hence USG scrotum was done which showed right side undescended testes.

Feeding: Breast feeding was initiated (First feed was given within 30 minutes), measured feeds were started. Baby tolerated the feeds well.

Vaccination: Baby was given following vaccination:

Vaccine Name	Status	Date
BCG	Given	30.06.2026
OPV	Given	30.06.2026
HEPATITIS B	Given	30.06.2026

TEOAE (Transient Evoked Otoacoustic Emissions): Hearing test: To be done on follow up.

Newborn screening advanced / Newborn sreening-4 : To be done on follow up.

SPO2 : 98 % at room air

Red Reflex: Present & Symmetrical

Hip Examination was normal.

Parents were counselled about the need for further hospital stay. How ever

Name	Baby Of AREEBA FATIMA	UHID	HNH-00016240
IP No	IP26-00006683	Admission Date	29-06-2026

parents were unwilling for further management on personal grounds and requested the child to be discharged. Hence child is being Discharge on Request.

Condition at discharge: Baby is pink, warm, active and on direct breast feeds + measured feeds.

Advice:

Keep the baby clean & warm

Regular breast feeding

Continue direct breast feeds + measured feeds as advised.

Monitor urine output

Immunization as per schedule

Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice (after 5 days of life).

Nasoclear Nasal drops 2 drops in each nostril SOS for nose block.

Plan:

1. Newborn screening advanced / Newborn screening-4/ Thyroid function test to be done on followup.
2. Hearing test (TEOAE-Transient Evoked Otoacoustic Emissions) to be done on followup.
3. Serum Bilirubin to be done on followup.
4. Blood group to be done on follow up.

Review consultation with Dr. S TEJASWI REDDY on Wednesday(01.07.2026) at Himayatnagar with prior appointment (**Review consultation will be charged**).

Review back to Hospital: If baby is not feeding continuously for > 6 hours, If

Name	Baby Of AREEBA FATIMA	UHID	HNH-00016240
IP No	IP26-00006683	Admission Date	29-06-2026

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 **Himayalnagar / 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**

Tejaswi
Registrar/Resident/C.M.O

Dr. S TEJASWI REDDY
MBBS, MD Pediatrics, DM Neonatology
APMC/FMR/94068

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006683 **Admit Date** : 29-Jun-2026 **Admit Time** : 11:49 AM **UHID** : HNH-00016240

Patient Details :

Patient Name	: Baby Of AREEBA FATIMA	Age	: 0 D
Guardian	: Mr MAHAMMED SAMAD	DOB	: 29-06-2026 10:48 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: 10-2-510/1/a beside azra public school asif nagar Gudimalkapur Hyderabad Telangana INDIA 500028	Phone No	: 7680902074/ 8686876732
		E-mail	: areeba.fatima99@gmai.com

Admission Details :

Bed Type : BASINET **Bed No** : CRDL-HNPDA-415-1 **Ward Name** : 4F -OT
Room No : CRDL-HNPDA-415-1 **Admission Type** : First Visit

Contact Details :

Name : Mr MAHAMMED SAMAD **Relationship** : Father
Contact Address : 10-2-510/1/a beside azra public school asif
nagar Gudimalkapur Hyderabad Telangana
INDIA 500028 **Phone No** : 7680902074


Signature

Doctor Details :

Doctor Name : Dr. S TEJASWI REDDY **Specialisation** : NEONATOLOGY
Referral Doctor : SELF **Phone No** :
Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 10000.00
Payor Name : SELFPAY

HNH-00016240 IP26-00006683
Baby Of AREEBA FATIMA
29-08-2026 O Y O M O D 2 H (M)
Dr. S TEJASWI REDDY



NEWBORN MONITORING FORM

Date of Birth	29/01/20
Time of Birth	10:48 AM
Mode of Delivery	NVD
Birth Weight	2.820 kg
Head Circumference	32 cm
Length	47 cm
Red Reflex	

New Born Screening :
TFT :
OAE :
Mother's Blood Group :
Baby's Blood Group :
Anomaly Scan :
Vaccination 2016/26 BCG 2 give

[illegible]

[illegible]



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : AREEBA FATIMA Age : 26 yrs Father's Name : Age :
 Date of Birth : 03/7/1999 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 AREEBA Mother's Blood Group : AB +ve
 Gender : ☒ M ☐ F Blood Group : Birth Weight (gms) : 2820 gms Length (cms) : 49 cm
 Date of Birth : 29-6-26 Time of Birth : 10:48 AM OFC (cms) : 22 cm
 Place of Birth : RCH, Himachal Pradesh Estimated Gesth Age : 39+3

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 26 Ht : 156 Wt : 77.6 BMI : Married Life : LMP : 26/5/25 EDD : 3/7/2026
 Conception : Spontaneous or with Rx : Spontaneous
 Booked at what GA : AN Steroids Drugs / Doses :
 Last Scans Details : SLIUP 35+6 / Vx / AFI - 10.7 cm / EFV - 2.41 cm / RA
 TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs
 Consanguinity : ☐ Yes ☐ No
 If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long :

H/o value of recent BP recording, proteinuria, edema,
 oliguria, any investigations (LFT, platelet count) :

IUGR - when detected :

Doppler (Increased Resistance / ADEF / REDF /

Redistribution in MCA) / Ductus Venosus :

AFI :

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

Controlled or not, recent values, HbA1 values :

Compliance with Rx :

Scans : LGA, TIFFA, Fetal Echo : TIPPA - N

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 : Any culture :

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

Medication during Pregnancy : Iron / G4 Duration :



PAST OBSTETRIC HISTORY

G : 3 P : 1 A : 1 L : 1

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
1					M.D.	
2					Spont. Miscarriage @ 5 wks.	
3						

PERINATAL HISTORY

Treating Obstetrician : Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication :

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitation : ☐ Yes ☐ No

Cord ABG :

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

NEONATAL RESCUSTITATION 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
2	2	
2	2	
2	2	
2	2	
1	1	
7	9	

Resuscitation

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



SS:

Baby cried immediately after birth.



DCC done



~~Atta~~ good cry, tone, activity

↓ After 2 min

Weak cry, ~~SpO2~~, Tachypnea,
SpO2 - 88%.



DN CPAP for Swim.



cry improved, Tachypnea still
SpO2 - 96% @ NA.

Investigation details in previous Hospital :

Feeding History :



photo of mother taken prior to admission
Lab 010

Family History :

Grandmother, a diabetic, mother of father, died at age 70 years.
Father, a diabetic, died at age 65 years.
Grandfather, a diabetic, died at age 75 years.

Socio Economic History :

Family income is approximately Rs. 10,000 per month.
Family is from a rural area.
Family is a Hindu.

GENERAL EXAMINATION ON ADMISSION

General Disposition :

General Disposition : Good

VITALS : Temperature : *36.5°C* HR : *160/min* RR : *36/min* NIBP : *130/80* CFT : *23x23*

Color of the extremities : *Acrocyanosis (+)*

Jaundice : *-* Pallor : *-* SpO2 : *100% @ RA*

Anthropometry : Birth Weight : *2820 gms.* Length : *48 cm* HC : *34 cm* Present Weight : *2820 gms.*

Ponderal Index : *11.8 kg/m³* AGA : *-* SGA : *+* LGA : *-*



HEAD TO TOE EXAMINATION

HEAD :

Fontanelles : *AF - 2x2 cms, flat.*
Sutures
Shape / Moulding : *-*
Edema / Bruising : *-*
Size - (H.C.) : *-*

Facies :
(Any Facial
Dysmorphism)

(N)

NECK and
CLAVICLES :

Range of Motion :
Asymmetry : *(N)*
Masses :

EYES :

Symmetry : *→ Present*
Red Reflex :
Discharge :

EARS, NOSE
MOUTH and
THROAT :

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

*no cleft palate / lip / preauricular
skin tags.*

THORAX and
BREASTS :

Shape of Thorax :
Position of Nipples and Number :

(N)

ABDOMEN and
UMBILICUS :

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

(N)

GENITALIA :

Labia / Hymen :
Testicles/penis :
Anus :

*→ L testis descended. (R) Undescended
Tasty*
patent left

HERNIAL ORIFICES

free.

TRUNK and SPINE :

(N)

SKIN LESIONS :

EXTREMITIES :

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

(N)



SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

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

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

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

Settings : 5:217.

Spo2 : 100% Auscultation : Breath Sounds : BAC, WBS. Added Sounds :

Cardiovascular System :

HR : BP : Precordial Activity :

Femoral Pulses : Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernia orifice :

Palpation : Anal Patency :

Palpable masses : Umbilical Cord :

Abdominal girth : First urine passed : Passed.
Meconium passed :

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

Motor System :

Passive Tone : (N)

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR :

ATNR : Skull and Spine :



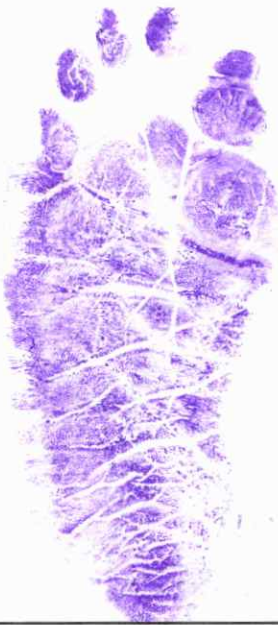
Any Congenital Anomalies :

Diagnosis :

Term (3A+3) / XGA / NVD / Male.

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time : 29/6/26 11:30 AM

Consultant :

Signature :

Name :

Date & Time :

PLEASE FILL UP THE FOLLOWING DETAILS

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



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

Vital : ☐ HR : ☐ RR : ☐ BP : ☐ SPO2 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

- Lkmm carry, DDF Q 2H.
- Vit. K, D5ml given.
- BCG, OPV, Hep B to be given.
- NAS / SBA / OAE @ 48 Hrs.

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6 3:15 PM	CL/B A. Spandana RT/39 th wh / NVD / Boy / 2.82 kg / (R) Side Undercand test Baby Externals Baby Exam B/L Red reflex (R) (R) Side Undercand test No cleft palate No Sacral dimple Passed Meconium Rest exams - (R)	Ph 1) War can 2) DBF 1/6 bulging 3) Vaccination (BCG, OPV, Hep B) 4) SBR NBS OPE } @ 48 hrs 5) Monitor VIT 6) USG Scrotum (1/1/2) Undercand test - T/M Morning
	fsh	

Dr. SPANDANA DASUBUDU
 REG. NO: 3552

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6 7am	Wt 2.7 (120g) (4.2%).	
	- feeds ✓ - urine ✓ - stools ✓	
	<u>OTE</u> : euthermic	<u>Plan</u>
	YTA : good	1) warm care
	BF : flat	2) DBF every 2nd h
	meets ⊕	3) SBR NBS } exotherm
	vitals : stable.	OTE
		4) hydration to be done food
		5) monitor vitals.
		6) USG Spleen - today.

Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

HNH-00016240 IP26-00006683
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29-06-2026 0 Y 0 M 0 D 2 H (M)
Dr. S TEJASWI REDDY



212


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


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

RESULT SHEET

Date					
Time					
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 29/6/26	3pm	6pm	10pm	2am	6am
Doctor/Nurse/Family Concern?					
Temperature (°F)	98.5	98.4	97.8	97.3	98.3
Heart Rate (bpm)					
Blood Pressure (mmHg) *					
Note: BP does not score in early warning scoring					
Heart Rate (Number)	160	136	138	140	148
Resp. Rate (bpm) (Over 1 Minute) *	56				
Resp Rate (Number)		46	30	40	40
Resp Mod/ Severe Distress None / Mild					
Receiving O ₂ (l/min) O ₂ Saturations (%)	100%	100%	99%	100%	99%
Conscious Level Normal Altered					
GCS *					
TOTAL SCORE	0	0	0	0	0
Number of shaded boxes	2	2	2	2	2
Pain Score					
Observer's Initials					

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN’S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



FLUID CHART

Sheet No. : 7

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
29/8/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm	DBF										
	01:00 pm											
	Total Intake : 2000			Total Output : Not noted								
29/8/26	02:00 pm											
	03:00 pm	DBF										
	04:00 pm											
	05:00 pm	DBF										
	06:00 pm											
	07:00 pm	DBF										
	Total Intake :			Total Output :								
29/8/26	08:00 pm											
	09:00 pm	DBF										
	10:00 pm											
	11:00 pm	DBF										
	12:00 am											
	01:00 am	DBF										
	Total Intake : 2000			Total Output : 2000								
30/8	02:00 am											
	03:00 am	DBF										
	04:00 am											
	05:00 am	DBF										
	06:00 am											
	07:00 am	DBF										
	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
			Mouth	I.V	N.G						
	08:00 am										
	09:00 am										
	10:00 am										
	11:00 am										
	12:00 pm										
	01:00 pm										
Total Intake :						Total Output :					
	02:00 pm										
	03:00 pm										
	04:00 pm										
	05:00 pm										
	06:00 pm										
	07:00 pm										
Total Intake :						Total Output :					
	08:00 pm										
	09:00 pm										
	10:00 pm										
	11:00 pm										
	12:00 am										
	01:00 am										
Total Intake :						Total Output :					
	02:00 am										
	03:00 am										
	04:00 am										
	05:00 am										
	06:00 am										
	07:00 am										
Total Intake :						Total Output :					

Total 24 hrs. Intake

Total 24 hrs. Output



NURSING CARE RECORD

Date: 29/6/26

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 stable - vital checked		
	2pm	- plan for vital & record - plan for DBT	2pm	- vital checked - DBT 2nd hourly			
Afternoon	2pm	- Assess the Baby Condition	2pm	- Assessed the Baby Condition	-> Baby stable	Rechecked vitals	
	8pm	- monitor vital & chart - DBT 2nd hourly give	8pm	- Monitored vital & chart - DBT 2nd hourly given			
Night	8pm	- Assess the baby	8pm	- Assessed the baby	- Baby warm	Reassess the baby warm	
	8pm	- Monitor the vitals admission vitals charting to chart.	8pm	- Monitor the vitals admission vitals charting to chart			



NURSING CARE RECORD



Date: 30/6/26

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 to 2pm	→ Assess Baby condition → monitor the vitals → maintain I/O chart → DBF every 2nd hly → vaccination today	8pm to 2pm	→ Assesed Baby conditi -on → monitored vitals → maintained I/O chart → DBF every 2nd hly → vaccination is due	Baby is stable	Re-checked vitals	Anuradha
Afternoon							
Night							



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known			
	Newborn Baby		If Yes Specify:			
BACKGROUND	Area	Shift Time	29/6/26 8AM-2PM	29/6/26 2PM-8PM	30/6/26 8AM-2PM	30/6/26 2PM-8PM
	Medical Condition (Any special condition to be noted):		-	-	NR	NR
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
	Vital Signs:	Temp:	26.6	38.2	38.5	37.8
	Res:	43	41b/h	41b/h	45b/h	
	SpO ₂ :	99	99	100	100	
	Pulse:	145	140	142	140	
	BP:	-	-	-	-	
	Fall Risk Score:	-	-	-	-	
	Pain Score:	0/10	0/10	-	-	
	Safety Needs:	Yes	Yes	-	-	
Recommendations	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
	Others Specify:	-	-	-	-	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No
	Other Special Orders / Medications:	-	-	-	-	
	Post Operative Procedure Special Orders:	-	-	-	-	
Handed Over By Name :		Ali		Anusha		
Signature :		Ali		Anusha		
Date:		29/6/26		30/6/26		
Time:		8PM		2PM		
Taken Over By Name :		Anusha		Anusha		
Signature :		Anusha		Anusha		
Date:		29/6/26		30/6/26		
Time:		8PM		8PM		

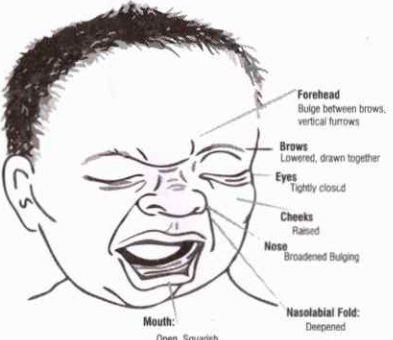
NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area: Shift Time:						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp: Res: SpO ₂ : Pulse: BP: Fall Risk Score: Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						



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
						29/6 11 AM	29/6 3 PM	30/6					
	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	0	0	0					
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0					
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0					
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0					
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0					
 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	34	34				
						Total Pain / Agitation Score	-	-	-				
						Intervention	-	-	-				
						Effectiveness	-	-	-				
						Signature	[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.

BRADEN 'Q' SCALE

					Date :	29/8/2026	29/8/2026	30/8/2026	
					Time :	11:45		16	
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.		3	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.		1	1	1	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		3	3	3	
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	
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	
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	
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	
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									
					TOTAL SCORE	23	23	23	
					Evaluator's Name	Dr. S. Tejaswi Reddy	Dr. S. Tejaswi Reddy	Dr. S. Tejaswi Reddy	

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-00016240 IP26-00006683
Baby Of AREEBA FATIMA
29-06-2026 0 Y 0 M 0 D 2 H (M)
Dr. S TEJASWI REDDY



PATIENT STICKER

DATE : 29/6/26

NEWBORN ANOMOLY ASSESSMENT CHECKLIST

S.NO	ASSESSMENT PARAMETERS	CHECKED BY REGISTRAR	CHECKED BY CONSULTANT	REMARKS
1.	Palate	(N)	(N)	
2	Pre natal teeth	Absent	NO	
3	Anal opening	Present	(N)	
4	Genitalia	(N)	(N) High Descend Right Vaginal Tr	
5	Spine	(N)	(N)	
6	Red reflex	To check	B/L Present	
7	4 limb saturation (before discharge)			

Ped.Registrar signature

Ped.Consultant signature

2 2 2 2

1

1

1

1





NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Areeba Fatima Mother's Name: Areeba Fatima

Date of Birth: 29/6/26 Time of Birth: 10:48 AM Gender: ☒ Male ☐ Female

Birth Weight: 2.820 gm Kgs HC: cm Length: cm

Meconium in Liquor: ☐ Yes ☒ No Cried at Birth: ☐ Yes ☒ No

Term / Pre-term / Post-term:

Resuscitated: ☐ Yes ☐ No Blood Group: Mother: Baby:

Feeding: ☒ Breast Feeding ☐ Formula ☐ Both First Feed Time:

AFFIX MOTHER'S
IDENTIFICATION LABEL

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

Indication:

Physical Assessment of New Born:

Temp: 36.5 °C HR: 156 /Min RR: 42 /Min BP: SpO₂: 99

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☐ Yes ☒ No Score: 0 (Fill the Humpty Dumpty Sheet)

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

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

Findings:

General Appearance: Posture: ☒ Well-Flexed ☐ Asymmetry

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

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

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

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

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

Newborn Screening Discussed: Yes / No

Nurse Name: Reddy

Signature: Reddy

Date & Time: 29/6/26
10:48 AM

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00016240 IP26-00006683 Baby Of AREEBA FATIMA 29-06-2026 0Y0M0D2H (M) Dr. S TEJASWI REDDY 		Date & Time of Admission 29/6/26 11:49 AM	Date & Time of Transfer Order 29/6/26 1:30 PM
		Transfer Ordered by DR Tejaswi Reddy	Reason for Transfer OBS
From Unit Pre-post	To Unit Room	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	Number of Imaging Films 2A	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.	Pl Sourd - ①		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring SPS Alankar		Name of Person Ordered Transfer DR Tejaswi Reddy	
Patient & Clinical Records Received by : Anirudh		29/6/26 @ 2:10 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

GENERAL CONSENT FOR TREATMENT

Patient Name: **Baby Of AREEBA FATIMA** Age : **0 Y 0 M 0 D 1 H**
IP No: **IP26-00006683** Sex: **Male**
Consultant: **Dr. S TEJASWI REDDY** Ward/Bed No: **4F -OT/CRDL-HNPDA-415-1**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:

1 We do not allow use of medication brought from outside by the patient.

2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

(Receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.

4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name:

SANAD

Relationship:

HUSBAND Father

Date:

Time:

Witness Name:

Sushu

Witness Signature:

Patient Address:

10-2-510/1/a beside azra public school
asif nagar Gudimalkapur Hyderabad
Telangana INDIA 500028

HNH-00016240
Baby Of AREEBA FATIMA
28-06-2026
Dr. S TEJASWI REDDY
IP26-00006683
0 Y 0 M 0 D 1 H (M)

BILLING POLICY

- From 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 6 pm will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
 - As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpain the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
 - If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
 - All charges vary as per Room category, except Pharmacy and consumables.
 - We follows a "No Discounts Policy" kindly cooperate.
 - No Duplicate/Second copy of OP OR IP bill is issued.
 - ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).
- Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.

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CIN: U85110 TG1998 PTC029914

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