

DISCHARGE SUMMARY

Name	Baby Of VOONNA SHALINI	UHID	HNH-00016340
Father/Guardian	Mr V GOWTHAM KRISHNA	Age/Gender	0 Y 0 M 0 D 18 H/ Female
Address	SESHADRI TOWERS, 1ST FLOOR, MADHURA NAGAR, Yousufguda, Hyderabad, Telangana, INDIA, 500045		
IP No	IP26-00006734	Admission Date	04-07-2026
Ref Doctor	Self.		
Discharge Date	06.07.2026		

Consultant:

Dr. SINDHURA MUNUKUNTLA

MBBS, DCH, DNB PEDIATRICS

66970

DIAGNOSIS	ICD CODE
TERM (38 weeks + 1 day)/SGA/BABY GIRL/NVD/NEONATAL HYPERBILIRUBENIMIA	

History: Baby Of VOONNA SHALINI is a term (38 weeks + 1 day) baby girl, delivered to a G2A1 mother by Induced vaginal delivery on 04.07.2026 at 11:20pm with birth weight of 2.4 kgs in Rainbow Children's Hospital, Himayatnagar Hyderabad. Baby cried immediately after birth. Apgar scores were 6/10 at 1 min, 8/10 at 5 min. Inj. Vitamin K 1mg IM was given after delivery. Delayed cord clamping done. Fetal presentation was Vertex.

Name	Baby Of VOONNA SHALINI	UHID	HNH-00016340
IP No	IP26-00006734	Admission Date	04-07-2026

Maternal History: Mrs. VOONNA SHALINI is a 32 years old G2A1 mother. G1 - 2021- Spontaneous conception, Complete miscarriage at 7-8weeks, D&C done.

G2 - 2025 - 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 O positive. Baby's blood group is O positive.

Examination: Baby was euthermic (36.5 *C), euvolemic 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 : 2.4 kgs.
Weight at discharge : 2.240 kgs.
Head Circumference : 30 cms.
Length : 40 cms.

Investigations: Enclosed reports.

Management:

Course during hospital:

Name	Baby Of VOONNA SHALINI	UHID	HNH-00016340
IP No	IP26-00006734	Admission Date	04-07-2026

In view of small for gestational age, baby's blood sugar levels were serially monitored which remained stable.

As baby was clinically icteric at 36 hours of life TCB was done , 16.7mg/dl which is more than phototherapy range , hence was shifted to NICU and started TSPT along with measured feeds and iv fluids . SBR was repeated 48 hours, value was 12.2, therefore patient was shifted to DSPT, monitored overnight and then shifted to ward. Baby responded well to phototherapy and bilirubin values have reduced to below phototherapy, hence feeding counseling was given and baby was discharged.

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

Vaccination: Baby was given following vaccination:

Vaccine Name	Status	Date
BCG	Given	04.07.2026
OPV	Given	04.07.2026
HEPATITIS B	Given	04.07.2026

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

Newborn screening advanced / Newborn screening-4: Sent report to collect on follow up.

SPO2 : 99% at room air

Name	Baby OF VOONNA SHALINI	UHID	HNH-00016340
IP No	IP26-00006734	Admission Date	04-07-2026

**Red Reflex: Present & Symmetrical
Hip Examination was normal.**

Baby tolerating feeds well, hemodynamically stable, passed urine and meconium, hence being discharged with the following advice.

Condition at discharge: Baby is Icteric, warm, active and on direct breast feeds.

Advice:

Keep the baby clean & warm

Regular breast feeding

Continue direct breast feeds.

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 report to collect on followup.**
2. **Hearing test (TEOAE-Transient Evoked Otoacoustic Emissions) to be done on followup.**
3. **Serum Bilirubin to be done / decided on followup.**

Review consultation with Dr. SINDHURA MUNUKUNTLA on (08.07.2026) Wednesday at Himayatnagar with prior appointment (**Review consultation will be charged**).

Name	Baby Of VOONNA SHALINI	UHID	HNH-00016340
IP No	IP26-00006734	Admission Date	04-07-2026

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

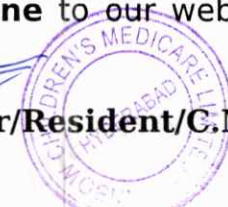
In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Himayatnagar / 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. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970





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	5			
7	Nursing plan of care and handover sheets	2			
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				
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	1			
	Billing	1			
	Extra	6			
	Total No. of Pages	38			

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006734 **Admit Date** : 04-Jul-2026 **Admit Time** : 12:12 AM **UHID** : HNH-00016340

Patient Details :

Patient Name	: Baby Of VOONNA SHALINI	Age	: 0 D
Guardian	: Mr V GOWTHAM KRISHNA	DOB	: 03-07-2026 11:20 PM
Gender	: Female	Religion	:
Occupation	:	Martial Status	:
Address (H)	: SESHADRI TOWERS,1ST FLOOR ,MADHURA NAGAR Yousufguda Hyderabad Telangana INDIA 500045	Phone No	: 8341139510
		E-mail	: gudlashalini2010@gmail.com

Admission Details :

Bed Type : BASINET **Bed No** : CRDL-HNPDA-412-1 **Ward Name** : 4F -OT
Room No : CRDL-HNPDA-412-1 **Admission Type** : First Visit

Contact Details :

Name : Mr V GOWTHAM KRISHNA **Relationship** : Father
Contact Address : SESHADRI TOWERS,1ST FLOOR ,MADHURA NAGAR Yousufguda Hyderabad Telangana INDIA 500045
Phone No : 8341139510

T. D. Diga
Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTALA **Specialisation** : GENERAL PEDIATRICS
Referral Doctor : Self. **Phone No** :
Co-Consultant :

Payment Details :

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

CONSENT FOR ADMISSION IN NEONATAL INTENSIVE CARE UNIT

Name: INH-00016340 IP26-00006734 Age: Gender: Male ☐ Female ☐
Baby Of VOONNA SHALINI
3-07-2026 0 Y 0 M 2 D (F)
UHID.No : Dr. SINDHURA MUNUKUNTLA Date:


I D/o, W/o 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

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

*Neonatal hyperbilirubinaemia
for Triple surface phototherapy*

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 : *Sateesh Kumar*
Name : *Sateesh Kumar*
Relationship with Patient :
Date & Time : *5/8/26 @ 3pm*

Witness :

Signature : *G. Rosamani*
Name : *Rosa Rosamani*
Date & Time : *5/8/26 @ 3pm*

Doctor (who is taking the consent) :

Signature : *A. Jameen Bai*
Name : *A. Jameen Bai*
Date & Time : *5/8/26 @ 3pm*



CONSENT FOR FORMULA FEEDS

Patient Name: HNH-00016340 IP26-00006734
Baby Of VOONNA SHALINI
03-07-2026 0 Y 0 M 2 D (F) Age: 20, Gender: ☐ Male ☐ Female
UHID No: Dr. SINDHURA MUNUKUNTLA
Department: Accu Date: 5/2/26
I Mr / Mrs. Gowtham Krishnaged 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: V. G. Krishn
Name: V. Gowtham Krishn
Relationship with Patient: Father
Date & Time: 5/2/26

Witness :

Signature: Laxmi Prasanna
Name: L.
Date & Time: 5/2/26

Doctor (who is taking the consent) :

Signature: Nam
Name: DR. NARMEEN BANU
Date & Time: 5/2/2026

HNH-00016340 IP26-00006734
Baby Of VOONNA SHALINI
03-07-2026 0 Y 0 M 2 D (F)
Dr. SINDHURA MUNUKUNTALA



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

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

ACTIVITY RECORD FOR BILLING

Name: B/o Voonna Shalini

UHID No : _____ IP No : _____ Consultant : _____ Dept : _____

Date of Admission : _____ Time : _____ Date of Discharge : _____ Time : _____

Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/2/26	at 3:40	2nd floor	NICU	Mowika / Japh

Cross Consultation Visit

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

[illegible]

Cross checked done by Dhanya
6/12/20 @ 12pm

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

Date	Procedure	Quantity	Order No.	Signature
5/2/26	E.v placement	1	10964	Pooja
Cross checked done by Dhanya 6/2/26 @ 12pm				
ANY OTHER INFORMATION ----- ----- ----- ----- ----- -----				
Date :		Time :		Prepared By :
Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor	

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]

Date	Time	Investigation	Result	Order No.	Signature
13/7/26	1Am	Blood group		✓ 10895	} <i>Amari</i>
4/7/26	11:20pm	-ABG		✓ 10897	
4/7/26	1:50Am	VBG		✓ 10898	
4/7/26	1:20Am ²⁾	GRBS ^{and}	97mg/dL	✓ 10896	
4/7/26	3:20Am ⁴	GRBS	90mg/dL	✓ 10902	
4/7/26	5:20Am ^{6th}	GRBS	67mg/dL	✓ 10903	<i>my inter</i>
4/7/26	11:20Am	GRBS			
	5:20pm	GRBS			
4/7/26	11:30Am ^{12th}	GRBS - sample	87mg/dL	✓ 0979	<i>De</i>
4/7/26	5:20pm ¹⁰	GRBS	91mg/dL	✓ 0980	<i>AD</i>
4/7/26	11:30pm ^{24th}	GRBS	85mg/dL	✓ 0981	<i>P</i>
5/7/26	11:30am ^{36th}	GRBS			
<i>Cross checked done by Sunanda</i>					
5/7/26	11:30pm	GRBS		0989	<i>De</i>
	BS SBR				
6/7/26	NBS			11073	<i>AD</i>
6/7/26	TCBR				

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : TS6 Vonnathalini Age : 32y Father's Name : Age :
 Date of Birth : 03/07/26 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 : TS6 Vonna Shalini Mother's Blood Group : O+
 Gender : ☐ M ☒ F Blood Group : O+ Birth Weight (gms) : 2940gm Length (cms) :
 Date of Birth : 03/07/26 Time of Birth : 11:20 PM OFC (cms) :
 Place of Birth : Estimated Gesth Age : 38 w + 1 d

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : Ht : Wt : BMI : Married Life : LMP : EDD :
 Conception : Spontaneous or with Rx : Spontaneous
 Booked at what GA : 38 w + 1 d AN Steroids Drugs / Doses :
 Last Scans Details : 19/06/26 ~
 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 /
 Redistrbution 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, TFFA , 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 : Any culture :

PPROM : Duration : 11 min ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results :

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

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

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
(2021)					Spontaneous conception → Complete miscarriage (D&C)	
PR			2940g	female	(SGA)	

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 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
1	1	
2	2	
1	2	
1	2	
1	2	
6/10	8/10	

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

Tam (38 w + 1 d) / Female / TB. wt. 2940gm / SGA /
 CIAR / NVD /



Female baby born by NVD @ 03/07/26 11:20 PM

↓
craze cry after birth

↓
Grooel cry after dry and stimulation

↓
Reuben Newborn care given

↓
Try Vit - a ~~and~~ ~~care~~ given

↓
Shift to mother side

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : HR : RR : NIBP : CFT :

Color of the extremities :

Jaundice : Pallor : SpO2 :

Anthropometry : Birth Weight : Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :	Fontanelles : Sutures Shape / Moulding : Edema / Bruising : Size - (H.C.) :	<i>Cagat Kundrum</i>
Facies : (Any Facial Dysmorphism)		
NECK and CLAVICLES :	Range of Motion : Asymmetry : Masses :	
EYES :	Symmetry : Red Reflex : Discharge :	
EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Periauricular Pits / Tags : Nasal shape / Patency : Palate : Gums : Lips : Tongue :	<i>2</i>
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number :	
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : Discharge :	
GENITALIA :	Labia / Hymen : Testicles/penis : Anus :	
HERNIAL ORIFICES		
TRUNK and SPINE :		
SKIN LESIONS :		
EXTREMETIES :	Fingers / Toes : Arms / Legs : Deformities : Mobility : Hip Joint Examination :	



SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress : RR : 57/minute SCR / ICR / See - Saw breathing :

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

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

Settings :

Spo2 : Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 160/minute BP : Precordial Activity :

Femoral Pulses : 7/6 left Murmurs : 1/0

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernia orifice :

Palpation : 1/0 Anal Patency : Umbilical Cord : 207 + 10.2

Palpable masses : First urine passed :

Abdominal girth : Meconium passed :

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

.....

.....

Motor System :

Passive Tone : 1/0

Active Tone : 1/0

Neonatal Reflexes :

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

Moro's : DTR :

ATNR : Skull and Spine :

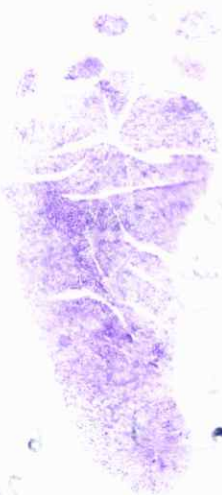


N6

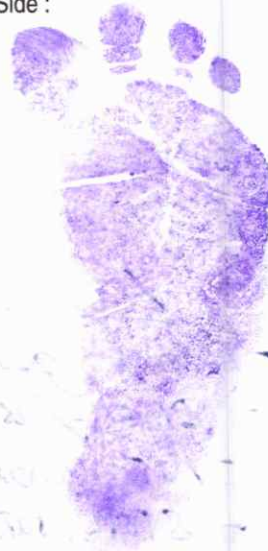
Diagnosis : Term (38w+1d) / female / NV2 / B.Wt = 2490gm /
CIAB / SGA / Apgar ①

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *[Signature]*

Name : *U. Sankar*

Date & Time : 02/07/26 11:20 PM

Consultant :

Dr. Sindhura Munukuntla
Consultant Pediatrician
Reg. No: 66970

Signature : *[Signature]*

Name : Dr. Sindhura

Date & Time : 03/7/26 @ 11:20 PM

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 : ☐ SP02 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

- Adm
- T. Blood gas @ 12 AM (04/07/26)
 - DBF / Is bumping over hourly
 - NIB - 100% O₂
 - SIBP, NIBP, OAG @ 98% O₂
 - C. NBS monitoring (1, 2, 4, 6, 12, 18, 24, 36, 98% O₂)

Plan during ward follow up :

- Ventilation to be done
- Shift to mother side

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Voonna Shalini

DATE: 15/07/26
 11:20 AM

NEWBORN ANOMOLY ASSESSMENT CHECKLIST

S.NO	ASSESSMENT PARAMETERS	CHECKED BY REGISTRAR	CHECKED BY CONSULTANT	REMARKS
1.	Palate	Normal		
2	Pre natal teeth	No		
3	Anal opening	+		
4	Genitalia	Normal female genitalia		
5	Spine	Normal sacral hair	+	
6	Red reflex		+	
7	4 limb saturation (before discharge)	Left foot checked	+	

Sindhura

Ped.Registrar signature

Sindhura

Ped.Consultant signature

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26	Term / MVD / SGA / LBS / Female.	
7/7/26	Birthweight: 2380gms (60L) B.W - 2440gms	
	Cry Tone Activity } Normal.	Plan
	GE - vitals stable.	Vaccination today
	Passed meconium stool.	- Warm care
		• DBF 12H.
		SDR, MBS, SAE @ 9 AM.
		9 MBS monitoring
4/7/26	B CG OPV Hep-B. } given 8/8	N.B. Maheshwari @ 2pm

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/7 12:20pm	cl/ty. Dis. Sindhu M. T NVD SGA	
	Eutermic	Plan
	C/T/A - Good	✓ Vaccination today
	B/L Red reflex - (N)	✓ SBR
	Caput (+)	NBS
	oral cavity - (N)	OAE
	chest (N)	✓ 4 limb saturation
	(N) female genitalia	
	stool, urine - passed.	
	Spine - (N)	
		Dr. Sindhura Munukunta Consultant Pediatrician Reg. no. 00370
		N.B. maheshwari



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7 2:00pm	C/S/RB Dr. Naipunya T SGA NVD F CIAB	
	Eutheonic. CTIA - Good. Vitals - Stable R/S - NAI PIA	Plan - DBF 2nd hourly for bumping - SBR NBS OAE } 48 H.O.L. - GRBS monitoring - Warmth care
4/7/26 6pm	Dr. Sindhura Term SGA NVD F CIAB	Plan 1) Warmth care 2) DBF every 2nd h 3) SBR NBS OAE } 48 H.O.L. Tomorrow 11pm 4) GRBS monitoring 5) monitor vitals 6) TM discharge 7) nasoclear saline drops
	feeds urine stools CTE eutheonic CTIA: head BF start miles @ sk Dr. Sindhura Munukuntala Consultant Pediatrician Reg. No. 66874 <i>Sindhura</i>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7 7am	CLB Dr. Praveen / Dr. Thanni FT / 38⁺ W / NVD / CABS / 2.44 kg / LSW T-WT → 2.240 kg (↓ 140g) WT loss → (8) % Baby on DBF Baby Enteral Cry } Good Tone } Activity } Passing Urine & Meconium	M / O + B / O + Ph 1) DBF Jlt burping Qrt 2) Wm cm 3) DIC Today & Flup T/m - SBR NBS
5/7 10am	CLB Dr. Spandana Baby on DBF WT loss - 8 % Baby Enteral Dr. Spandana Paediatric and Neonatologist Reg. No. 30925 T } Good A } Passing Urine & Meconium Stercile (CLB) (1)	Ph 1) DBF Jlt burping Qrt + Kumbh 2) DIC Today & Flup - T/m (D/W Dr. Sridhar) 3) SBR/NBS & Npm 4) check TCBs & Nbs 5) start p/spt

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26 11 AM.	c/s/by Dr Anusha	
	11/6 TCB = 16.7 (> photothy range) 1cke ⊕	
	↓	
	1formed to Dr Sindhur	- start TSPT E.
		- shift to NICU
		- Exchange. Transf (sos)
		- send VB4, SBR after shifting to NICU
	AP 1 nurse	- line DBF + FF 16ml - 20ml Q2H
		- sos IV fluids based on VB4
	As father is not with for further stay & photothy Baby is closely against medical advice.	Dr. Anusha
		checked by

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/1/20 6 pm	Dr. Sundhar M NNS Baby alert accepting feed BIND 0²	Adv center TSP
5/1/20 10:40 pm	Dr. Sundhar M Baby alert w/ing vitals stable HR - 120 bpm accepting 2nd feeding BIND	Adv - check to DSP - SBR at 12 pm NBS [TET] OAE - Slight act in morning

Dr. Sundhar Munukunta
 Consultant Pediatrician
 Reg. No: 66970

Dr. Sundhar Munukunta
 Consultant Pediatrician
 Reg. No: 66970



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/2/26	e/s/by Dr Anush T/AGA/NMIS.	
	Baby active	T. 2.200
	c/t/a good	wt low - 400g (9.8%) wt low.
	vital stable	Plan
	S/E	✓ CB nspT
	Bl AC (+) NB (+)	✓ SBR e (2pm) 6/2/26 NB/TFT OAE
		✓ ct EBM + DF only DBF. flb bur
		✓ Norm SOS
	Al	NB Sunanda
	Noted by Sripa 6/4/26	

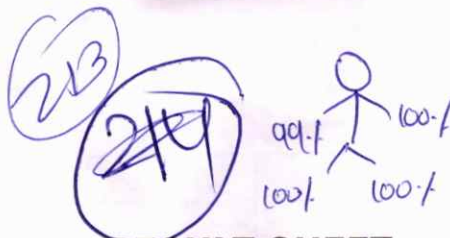
Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

HNH-00016340 IP26-00006734
 Baby Of VOONNA SHALINI
 03-07-2026 0 Y 0 M 0 D 1 H (F)
 Dr. SINDHURA MUNUKUNTLA



**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	20.4	12.2	12.1			
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						

Patient Stick



AL / 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

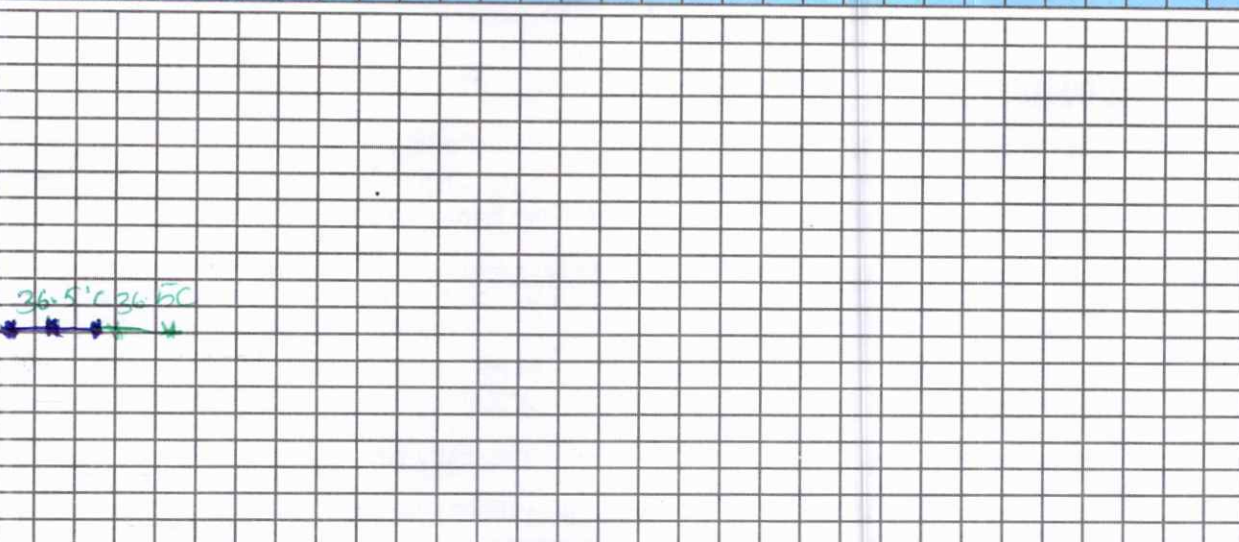
Date: 5/7/26... Time: 4PM 6p 7p 8p

Doctor/Nurse/Family Concern?

Temperature
(°F)

Temp

104
103
102
101
100
99
98
97
96
95
94



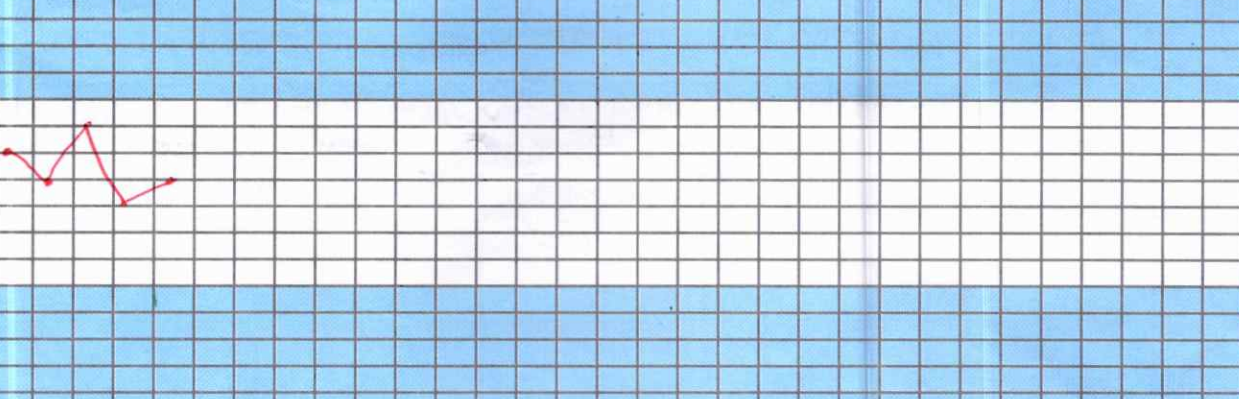
Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

HR

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



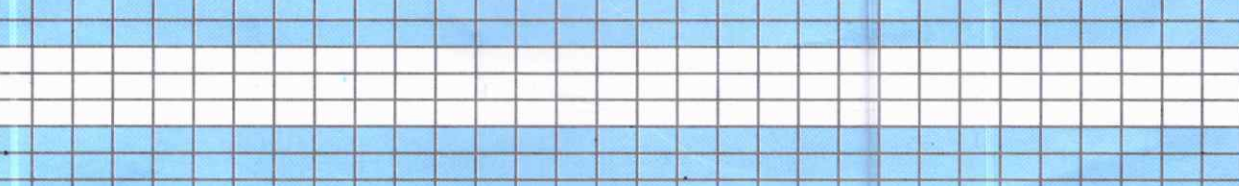
Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

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

RR

70
60
50
40
30
20
10



Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

100% 95% 100% 100% 95%

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

HNH-00018340 IP26-00006734
Baby Of VOONNA SHALINI
03-07-2026 0 Y 0 M 2 D (F)
Dr. SINDHURA MUNUKUNTLA



1/ CLINICAL / 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

WARNING SCORE: CHILDREN'S UNIT

Date: Time:

Doctor/Nurse/Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

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

Heart Rate (Number)

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

70
60
50
40
30
20
10

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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							
	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										1	
	03:00 pm											
	04:00 pm	Naspro 25		NA						20ml	0	SA
	05:00 pm											
	06:00 pm	Naspro 25		NA						20ml	1	Q
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm	Naspro 25		NA						20ml		Q
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake												
Total 24 hrs. Output												



FLUID CHART

Sheet No. :

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

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

Patient Sticker

NURSING CARE RECORD

Date: 5/7/26

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							
Afternoon	2pm 7:00 8pm	+ Assess Baby general condition + Baby on Room Air + monitor vital signs & record + maintain I/O chart & record + TSPT continue + 1 spoon feeds 20-25ml/2nd half	2pm 7:00 8pm	+ Assessed Baby general condition + Baby on Room Air + Continued spoon feeds 20-25ml/2nd half + continued TSPT + Trace SBR Reports	Stable	Rechecked vital signs	
Night							

INH-00018340 IP26-00006734
 Baby Of VOONNA SHALINI
 13-07-2026 0 Y 0 M 0 D 23 H (F)
 Mr. SINDHURA MUNUKUNTALA

NURSING CARE RECORD



Date:

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							
Afternoon							
Night							

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area	3/7/26 N1	4/7/26 N6	4/7/26 N2	5/7/26 N1	5/7/26 N2	5/7/26 N1
	Shift Time						
BACKGROUND	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:	97.2	97.1F	98.3	98.20C	36.5C	36.4C
	Res:	26	40b/m	40b/m	41b/m	32bpm	30bpm
	SpO ₂ :	99	99%	99%	100%	100%	99%
	Pulse:	102	141b/m	102	141b/m	136bpm	130bpm
	BP:						
Fall Risk Score:							
Pain Score:		10					
Recommendations	Safety Needs:		Yes	Yes	Yes	Yes	Yes
	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 :		Nouin	Maheshwari	Madhani	Shinde	Prasanna	Singh
Signature :							
Date:		6/7/26	4/7/26	4/7/26	5/7/26	5/7/26	6/7/26
Time:		8hr	8pm	8pm	8pm	8pm	8pm
Taken Over By Name :		mahi	Madhani	Shinde	Prasanna	Singh	Singh
Signature :							
Date:		4/7/26	4/7/26	4/7/26	5/7/26	5/7/26	5/7/26
Time:		8Am	8pm	8pm	3pm	8pm	8pm

Treating Doctor: Department: Date of Admission:

BRADEN 'Q' SCALE

					Date :	3/7	U/7	4/7	13/7
					Time :	N1	M6	E2	B3
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	3	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	3	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23									
					TOTAL SCORE				
					28 26 28 28				
					Evaluator's Name				
					[Signature] [Signature] [Signature] [Signature]				

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

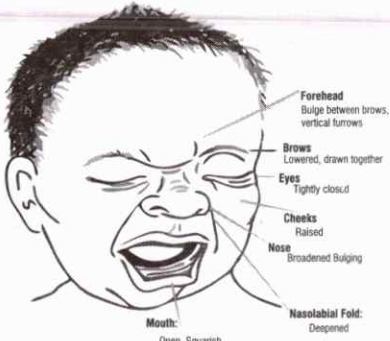
BRADEN 'Q' SCALE

					Date :	5/2/26	5/6/2		
					Time :	62	21		
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			
"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			
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			
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			
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			
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			
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			
TOTAL SCORE					28	28			
Evaluator's Name					L	2			

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

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
						3/2	4/2	4/7	5/2	5/7			
						Time	Time	Time	Time	Time	Time	Time	Time
						NA	MC	NI	E2	NI			
						Procedure							
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable								
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)								
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual								
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								
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								
 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							
						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.

HNH-00016340 IP26-00006734
 Baby Of VOONNA SHALINI
 03-07-2026 0 Y 0 M 2 D (F)
 Dr. SINDHURA MUNUKUNTALA

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

5/7/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	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 : B Name : Bharani

Signature of Ward In Charge :

Signature : B Name : Bharani

GENERAL CONSENT FOR TREATMENT

Patient Name:	Baby Of VOONNA SHALINI	Age :	0 Y 0 M 0 D 0 H
IP No:	IP26-00006734	Sex:	Female
Consultant:	Dr. SINDHURA MUNUKUNTLA	Ward/Bed No:	4F -OT/CRDL-HNPDA-412-1

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 also 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: *T. Divya*

Name: *T. Divya*

Relationship: *Sister in law*

Date: *04/07/2026*

Time: *12:12 PM*

Witness Name: *Yaseen ali Khan*

Witness Signature: *Yaseen*

Patient Address:

SESHADRI TOWERS, 1ST FLOOR,
MADHURA NAGAR Yousufguda
Hyderabad Telangana INDIA 500045



BILLING POLICY

- **Billing cycle:** - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent 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.

T. Divya

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.

Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.

Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR
- T: 6464 2020 | KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80
7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

HNH-00016340 IP26-00006734
Baby Of VOONNA SHALINI
03-07-2026 0 Y 0 M 0 D 0 H (F)
Dr. SINDHURA MUNUKUNTLA

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

25
of being the guiding light
Birthright Babies, Shining Bright

UNDERTAKING FOR BALANCE DEPOSIT

To
The Management,
Rainbow Children's Hospital, Himayatnagar
Hyderabad-500029

Sub:- Undertaking Balance Deposit

I Mr./Mrs./Ms. T. Divya (Father/
Mother/ Other _____) of Master/ Baby/ Baby of/
Mrs./ Ms. B/o Vonna Shalini was
bought to your hospital on 04/07/2026 at 12:12 AM.
Admitted in ward. Approximate charges deposit details
were explained by the Front office/ Billing executive on duty.
I have to pay the amount of 10k as a caution deposit but for
now I'm depositing 0. The remaining amount 10k I'll
deposit on 04/07/2026 at 2 PM.

Thanking You

T. Divya
Signature

Name:- T. Divya
Ph. No.:- 9133775599

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00016340 IP26-00006734 Baby Of VOONNA SHALINI 03-07-2026 0 Y 0 M 0 D 1 H (F) Dr. SINDHURA MUNUKUNTLA 		Date & Time of Admission 3/4/26	Date & Time of Transfer Order 4/4/26 5:40am
		Transfer Ordered by Dr. Sushanth	Reason for Transfer observation
From Unit LOR	To Unit Room	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	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 Srs. Mounika.		Name of Person Ordered Transfer Dr. Sushanth.	
Patient & Clinical Records Received by : Sunanda @ 6am			
Date & Time of Patient Received : 4/7/26			

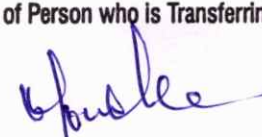
If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No. IPNH-00015299 Mrs VOONNA SHALINI IP26-00006731 11-05-1994 32 Y 1 M 14 D (F) Dr. KADIYALA RAMYA THEJA 		Date & Time of Admission 4/7/26 @ 12:12 PM	Date & Time of Transfer Order 5/7/26 @ 3pm
		Transfer Ordered by DR. Anusha	Reason for Transfer 2nd floor
From Unit 2nd floor	To Unit NICU	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 32	Number of Imaging Films 1 (VSA)	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 		Name of Person Ordered Transfer DR. Anusha	
Patient & Clinical Records Received by :			
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





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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 4/7	Time: 12 AM	3
Doctor/Nurse/Family Concern?		
Temperature (°F)	104	
	103	
	102	
	101	
	100	
	99	
	98	
	97	
	96	
	95	
	94	
Heart Rate (bpm)	190	
	180	
	170	
	160	
and	150	
	140	
Blood Pressure (mmHg) *	130	
	120	
	110	
	100	
Note:	90	
BP does not score	80	
in early	70	
warning scoring	60	
	50	
Heart Rate (Number)	130	130
Resp. Rate (bpm)	70	
(Over 1 Minute) *	60	
	50	
	40	
	30	
	20	
	10	
Resp Rate (Number)	30	30
Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O ₂ (l/min)		
O ₂ Saturations (%)	99	99
Conscious Level	Normal	
	Altered	
GCS *		
TOTAL SCORE		
Number of shaded boxes	0	0
Pain Score	0	5
Observer's Initials	se	

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)

HNH-00016340 IP26-00006734
Baby Of YOONNA SHALINI

03-07-2026 0 Y 0 M 0 D 2 H (F)
Dr. SINDHURA MUNUKUNTLA

3M / CLINICAL / 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

WARNING SCORE: CHILDREN'S UNIT

Date: 4/7/26 Time: 11Am 2pm

Doctor/Nurse/Family Concern?

6 10 2 6
pm pm Am Am

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

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

Heart Rate (Number)

136b/m 137b/m 140b, 146b 140b/m 142b/m

Resp. Rate (bpm)
(Over 1 Minute)

70
60
50
40
30
20
10

Resp Rate (Number)

40b/m 40b/m 40b/m 40b/m 40b/m 42b/m

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

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

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0 0 0 0
0 0 0 0 0 0
AS AS AS AS AS AS

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)

INH-00016340 IP26-00006734
 Baby Of VOONNA SHALINI
 13-07-2028 0 Y 0 M 0 D 12 H (F)
 Mr. SINDHURA MUNUKUNTALA



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: 9/8/21

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	6am	Assess the general condition	6am	Assessed the general condition	Stable	Rechecked vital	SP
	2pm	checked vital & recorded also chart maintain Administered medication as per doctor advice	2pm	checked vital & recorded also chart maintain Administered medication as per doctor advice			
Afternoon	2pm	⇒ Assess the pt condition	2pm	⇒ Assess the pt condition	Stable	Re-check vitals	SP
	to	⇒ Check the vitals ⇒ DBF + FF 2nd hourly	to	⇒ checked vitals re cords ⇒ Administration as per chart order			
Night	8pm	⇒ Assess the pt condition	8pm	⇒ Assess the general condition	Stable	Re-check the vitals	SP
	to	⇒ checked the v/s ⇒ DBF + FF 2nd hourly	to	⇒ checked the v/s 2 record ⇒ DBF + FF 2nd hourly			

NURSING CARE RECORD

Date:

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							
Afternoon							
Night	8pm	Assess the baby condition monitor vital maintain blood	8pm	Assessed the baby condition monitor	Now baby is stable	Re-check vitals	need ✓



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		
	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 :					
3/7/26	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am	DBF										
	01:00 am											
	Total Intake :						Total Output :					
4/2/26	02:00 am		DBF									
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
	Total Intake :						Total Output :					
Total 24 hrs. Intake						Total 24 hrs. Output						

FLUID CHART

Sheet No. :

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 Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am		DBF										
	10:00 am												
	11:00 am		DBF										
	12:00 pm												
	01:00 pm		DBF										
Total Intake :						Total Output :							
4/8/26	02:00 pm		DBF										
	03:00 pm												
	04:00 pm		DBF										
	05:00 pm												
	06:00 pm		DBF										
	07:00 pm												
Total Intake :						Total Output :							
4/7/26	08:00 pm		DBF										
	09:00 pm												
	10:00 pm		DBF										
	11:00 pm												
	12:00 am		DBF										
	01:00 am												
Total Intake :						Total Output :							
5/7/26	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							

NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Mother's Name: B/o. Shalini

Date of Birth: 3/2/26 Time of Birth: 11:20pm Gender: ☐ Male ☒ Female

Birth Weight: 2.4000 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: 97.2 °C HR: 130 /Min RR: /Min BP: SpO₂: 94

Pain Score: (Follow N Pass)

Fall Risk Assessment: ☐ Yes ☒ No Score: (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: Mounika

Signature: [Signature]

Date & Time: 3/2/26

INH-00016340 IP26-00006734
Baby Of VOONNA SHALINI
13-07-2026 0 Y 0 M 0 D 23 H (F)
Dr. SINDHURA MUNUKUNTALA



Rainbow®
Children's
Hospital
It takes a bit 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	1			
6	Doctors progress sheets	2			
7	Nursing plan of care and handover sheets	2			
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				
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				
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	2			
30	Intake and Out take chart (fluid chart)	2			
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	1			
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	1			
	<i>Billing sheet</i>	6			
	Total No. of Pages	25			

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

Signature and Date :

M. Dais (P.T.O)
5/7/26