

DISCHARGE SUMMARY

Name	Baby Of SINDHUJA M	UHID	HNH-00016698
Father/Guardian	Mr P PRADEEP	Age/Gender	0 Y 0 M 4 D/ Male
Address	RTC x roads, RTC X Road, Hyderabad, Telangana, INDIA, 500020		
IP No	IP26-00006896	Admission Date	20-07-2026
Ref Doctor			
Discharge Date	28.07.2026		

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

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

Diagnosis: VERY PRETERM (31W+2D)/ EM.LSCS/ CIAB/ MALE/ 1.78KG/ LBW/ RDS/ NNHB

History : Baby Of SINDHUJA M is a Very preterm (31 weeks + 2 days) / baby boy of birth weight 1.78 kgs, born to primi mother delivered by emergency LSCS (Indication: Severe oligo hydramnios) on 20.07.2026 at 11:57 am. Baby cried immediately after birth. Apgar scores and resuscitation details were were 8/10 at 1 min, 9/10 at 5 min. Baby developed respiratory distress after birth for which baby was shifted to NICU- for further management.

Maternal History : Mrs. SINDHUJA M is a 35 years old primi mother . G1 - Present pregnancy, ICSI - Donor conception.. She had regular antenatal checkups and antenatal scans were normal. There was no history of UTI/

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Abortions/ Hydramnios/ PROM/ Diabetes/ Hypothyroidism/ Hypertension/ Cardiac/ Renal abnormalities/ PIH/ APH/ Oligohydramnios/ Polyhydramnios / Fever. She received calcium, iron supplementation and TT prophylaxis.

Mother's blood group is AB positive. Baby's blood group is B positive.

Examination: At the time of admission baby was euthermic and having respiratory distress & tachypnea at room air, taken on DR-CPAP. His heart rate was 146/min, respiratory rate was 65/min. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Abdomen was soft without organomegaly. Cry, tone, activity and newborn reflexes were appropriate for GA. There were no obvious external congenital anomalies.

Weight on Admission : 1.78 kgs
Weight on Discharge : 1.68 kgs
Head circumference : 33 cms
Length : 40 cms.

Investigations: Enclosed reports.

Date	On 20.07.2026	On 21.07.2026	On 22.07.2026
TEST	Result	Result	Result
CBP: Hemoglobin	14.9 g/dl	15.4 g/dl	13.4 g/dl
While blood cell	9610 cell/cmm	10360 cell/cmm	9120 cell/cmm

Name	Baby Of SINDHUJA M	UHID	HNH-00016698
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Platelets	3.17 lakh/cmm	3.06 lakh/cmm	3.27 lakh/cmm
CRP	5 mg/L	5 mg/L	6 mg/L
S.electrolytes: Natrium (Na)	-	137 mmol/L	-
Potassium (K)	-	5.6 mmol/L	-
Chloride (Cl)	-	107 mmol/L	-
Serum.CREATININE	-	0.7 mg/dl	-
CALCIUM	-	8.9 mg/dl	-
TOTAL BILIRUBIN	-	6.1 mg/dl	-
UNCONJUGATED BILIRUBIN	-	6.0 mg/dl	-
BLOOD CULTURE	Sterile	-	-
BLOOD GROUP	B positive	-	-

Chest X ray done on 20.07.2026 at 10pm shows Feeding tube insitu.

Chest X ray done on 20.07.2026 Rotation noted to right side.

Name	Baby Of SINDHUJA M	UHID	HNH-00016698
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Feeding tube insitu.

NEUROSONOGRAM shows
no significant abnormality detected.

2d Echo shows
Situs Solitus Levocardia
Normal sized cardiac chambers
Small PDA with left to right shunt.
PFO with left to right shunt
Good biventricular function
Left arch, No COA.

Chest X ray shows Feeding tube insitu.

NEUROSONOGRAM shows
No significant abnormality detected.

Management:

RDS : In view of respiratory distress, the baby was shifted to NICU and started on NIPPV. (PEEP: 7, PIP:18, FiO2: 21%). Baby was nursed in thermoneutral environment and continued on non invasive ventilation support. Cord ABG showed pH of 7.18, pCO2 of 62.8 mmHg, pO2 of 51 mmHg, HCO3 of 19.7 mmol/L and BE of -4.9mmol/L. Inj. Caffeine loading dose was given followed by maintenance dose. As the respiratory distress gradually settled baby was weaned off to CPAP after 2 days and later to HFNC the next day and off oxygen support by DOL-4. Now baby is maintaining saturation at room air without any respiratory distress.

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Culture Negative Sepsis: Baby was nursed in thermoneutral environment. Baby was screened for sepsis and started on IV fluids and IV antibiotics after sending blood culture. Baby's blood sugars were frequently monitored which remained stable. Baby initial hemogram and CRP were normal. Serum electrolytes and renal function tests were within normal limits. Blood culture sent at the time of admission was sterile and IV antibiotics were stopped after 3 days.

Unconjugated Hyperbilirubinemia: Baby was noted to have yellowish discoloration of skin on day 1 of life. Serum bilirubin at 24 hours of life was 6.1 mg/dl with indirect fraction of 6.0mg/dl and hence baby was started on double surface phototherapy for 24 hours and stopped

Feeding: Once hemodynamically stable, he was started on OG feeds, which he accepted and tolerated well. Once off oxygen, spoon feeds were introduced, which baby tolerated well. As the baby is accepting spoon feeds.

Vaccination: Baby was given following vaccination:

Vaccine Name	Status	Date
BCG	Given	27/7/2026
OPV	Given	27/7/2026
HEPATITIS B	Given	27/7/2026

Advice:

Name	Baby Of SINDHUJA M	UHID	HNH-00016698
IP No	IP26-00006896	Admission Date	20-07-2026

Keep baby clean and warm.

Continue kangaroo mother care.

Continue demand paladay feeding as advised.

Immunization as per schedule.

Syp. Calcimax 2ml orally twice daily till 3kg.

HMf sachet- half sachet(in EBM) with alternate feed

Vitamin D drops(800IU/ml) 0.5ml per oral once daily till further advice.

Plan:

1. **Newborn screening advanced : 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. SPANDANA PASUPULETI on Friday (31.07.2026) at Himayatnagar with prior appointment **(Review consultation will be charged).**

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

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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 / Vikrampuri / LB Nagar** dial just one toll free number **18002122**.

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


Registrar/Resident/C.M.O

DR. SPANDANA PASUPULETI

MBBS, MRCPCH

CONSULTANT PEDIATRICIAN AND INTENSIVIST

Reg No: 30925

DR. S. TEJASWI REDDY

MBBS, MD (Paed) DM Neonatology

CONSULTANT PEDIATRICIAN AND INTENSIVIST

APMC/FMR/94068

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	24			
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	1			
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia & post)				
22	Neonatal Admission/Delivery/Physical Exam				
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				
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	8			
37	The Humpty dumpty scale				
38	Braden Q Scale	2			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing Others	16			
	Total No. of Pages	57			

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

HNH-00016698 IP26-00006896
 Baby Of SINDHUJA M
 20-07-2026 0 Y 0 M 4 D (M)
 Dr. SPANDANA PASUPULETI



Patient Name:
 Age:
 Dr.

UHID NO:

Date:

Done by:

21/7/26

PEDIATRIC ECHOCARDIOGRAM REPORT

Situs & Cardiac Looping	S. S. L
Systemic Veins	RA
Pulmonary Veins	LA
Atrio ventricular connection	concordance
Ventricular arterial connection	concordance
Great artery relationship	NRGA
Right atrium	@
Left atrium	@
Inter atrial septum	PFO L→R shunt
Mitral Valve	@
Tricuspid Valve	@ mild TR, RVsp: 28mmHg
Right ventricle	@
Left ventricle	@
Inter ventricular septum	Intact
Aorta and aortic arch	lt Arch, NO COA
Pulmonary artery and branch PA	confluent Branch PA's
Aortic Valve	@
Pulmonary valve	@
Coronaries	@
PDA	Small PDA ~ L→R shunt
Pericardium	Nil
Others	Nil

DOPPLER / TISSUE Variables

Gradients

Regurgitation

B/o Sindhuja.

Mitral flow			
Tricuspid flow			
Aortic flow		0.6	
Pulmonary flow			
Mitral	E'	A'	S'
Medial LV	E'	A'	S'
Tricuspid	E'	A'	S'
Time intervals	IVRT	IVCT	DT
Others			

MEASUREMENTS:

PARAMETER	ABSOLUTE (cm)	Z score	PARAMETER	ABSOLUTE (cm)	Z score
AO	0.6		Tricuspid Annulus		
LA	0.68		Mitral Annulus		
IVSd	0.3		Aortic Annulus		
LVIDd	1.2		PA Annulus		
LVPWd	0.4		RPA		
IVSs	0.3		LPA		
IVIDS	0.7		MPA		
LVPWs	0.3		AO Isthmus		
EF	71 %		LV Mass		
FS	36 %		Others		

IMPRESSION:

- situs solitus, levocardia
- Normal sized cardiac chambers
- small PDA & L→R shunt
- PFO L→R shunt
- good BLV function
- 1st Arch, no con

CONSULTANT: Performed By: Ganesh

S.B:- 11:57 AM
Sinhwt:- 1.780 kg
LMP:- 9/12/2022

HNH-00016698
Baby Of SINDHUJA M
20-07-2026

IP26-00006896

0 Y 0 M 0 D 1 H (M)
Dr. SPANDANA PASUPULETI



nRight™
QW.HOSPITALS
to a Safe Delivery

ADMISSION INTIMATION

Date: 20/7/26

Name of the Patient: B/o Sindhuja

UHID No: HNH-00016698

Gender: ☒ Male ☐ Female

Admitting Doctor: Dr. Spandana

Department: NICU.

Referred by Doctor:

Admit in : ☒ NICU ☐ PICU ☐ Ward ☐ OT
☐ Oncology ☐ Day Care ☐ Birthing Centre

Admission Type : ☐ OPD ☐ Emergency ☐ Referral
☐ Transport ☐ New Born ☒ Labour Ward

Category : ☒ Medical ☐ Surgical ☐ Ventilation
☐ Phototherapy ☐ Cradle

Plan of Treatment : IV fluids & Lab, IV Antibiotics

Duration of Hospitalization : 2 weeks

Doctor Signature : [Signature]

Type of Payment :

Package Opted: Room Eligibility:

Name & Relationship: P. Pradeep (father) Admitting Executive: Monalisa

Signature: [Signature] Signature: [Signature]

Date & Time: Date & Time: 20/7/26 @ 13:04

2000-11-11
1080-1 1000-1
1000-1 1000-1

2000-11-11

1000-1 1000-1

1000-1 1000-1

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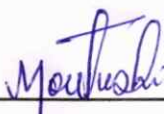
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PATIENT TRANSFER FORM

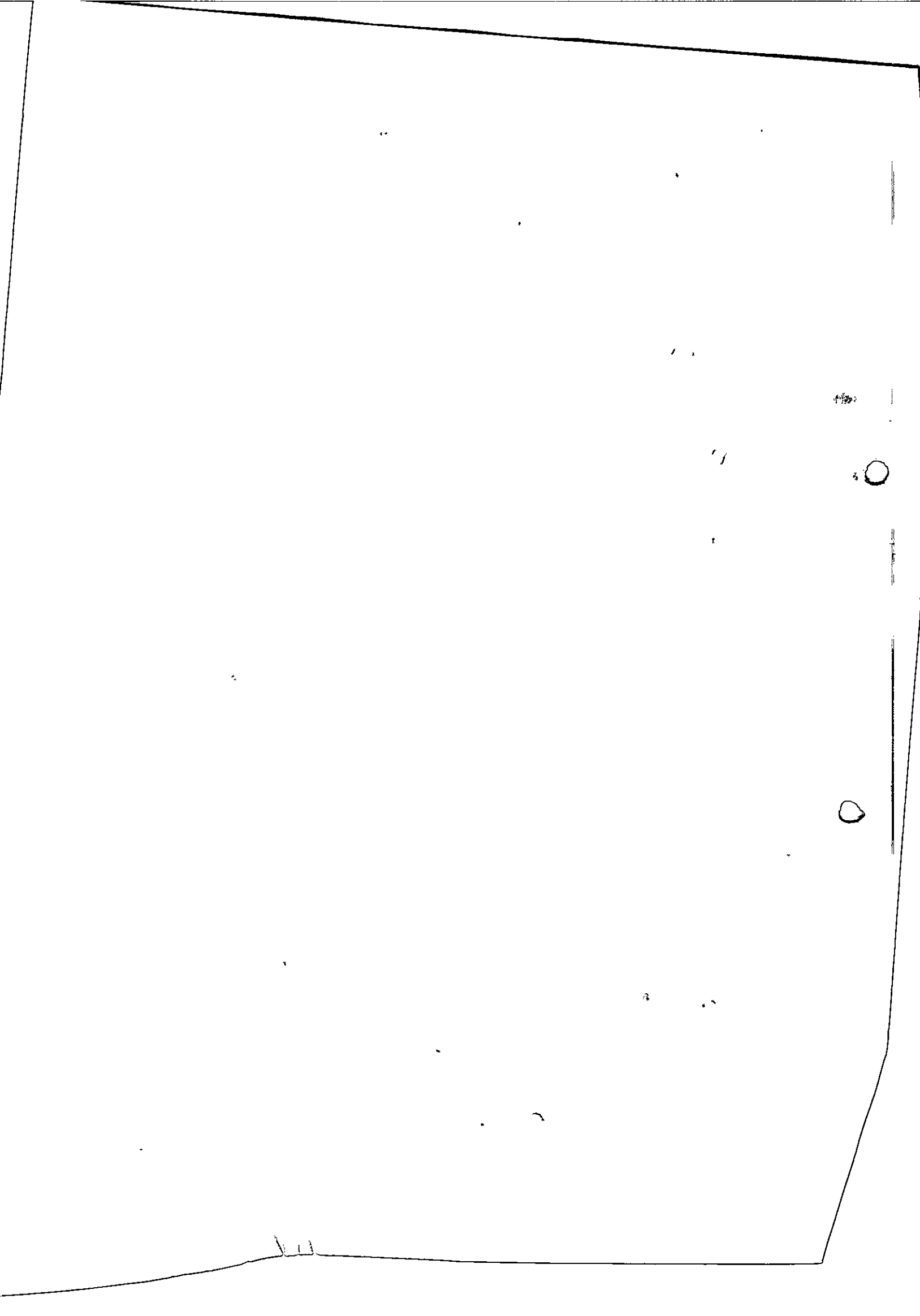
HN-00016598 IP26-00006896 Baby Of SINDHUJA M 20-07-2026 0 Y 0 M 6 D (M) Dr. SPANDANA PASUPULETI 		Date & Time of Admission 20/7/26 @ 12:42 pm	Date & Time of Transfer Order
Treating Consultant Name Dr. Spandana	Transfer Ordered by Dr. Anusha	Reason for Transfer stable	
From Unit NICU	To Unit	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 21	Number of Imaging Films 3	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 sis Nikitha		Name of Person Ordered Transfer Dr. Anusha	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : @ 12:45 PM, 27/7/26			

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



premi**cath**

REF. / Art.-Nr. / Code

1261.203

Size / Taille / Tamanho / Größe / Misura /
Gröötte / Tamañho / Storlek **28 G (1Fr)** Ø 0.17 x 0.35 mm

Length / Longueur / Longitud / Länge / 20 cm
Lunghezza / Lengte / Comprimento / Längd



REF 1261.203

VYCON

2031-03-23

LOT 230326GS

2026-03-23

Insertion Date

CAUTION - do not expose the catheter to alcohol-based solutions

REF 1261.203

VYCON

2031-03-23

LOT 230326GS

2026-03-23

Insertion Date

CAUTION - do not expose the catheter to alcohol-based solutions



(01)03660812138710(17)310323(30)1(10)230326GS

CE 0481

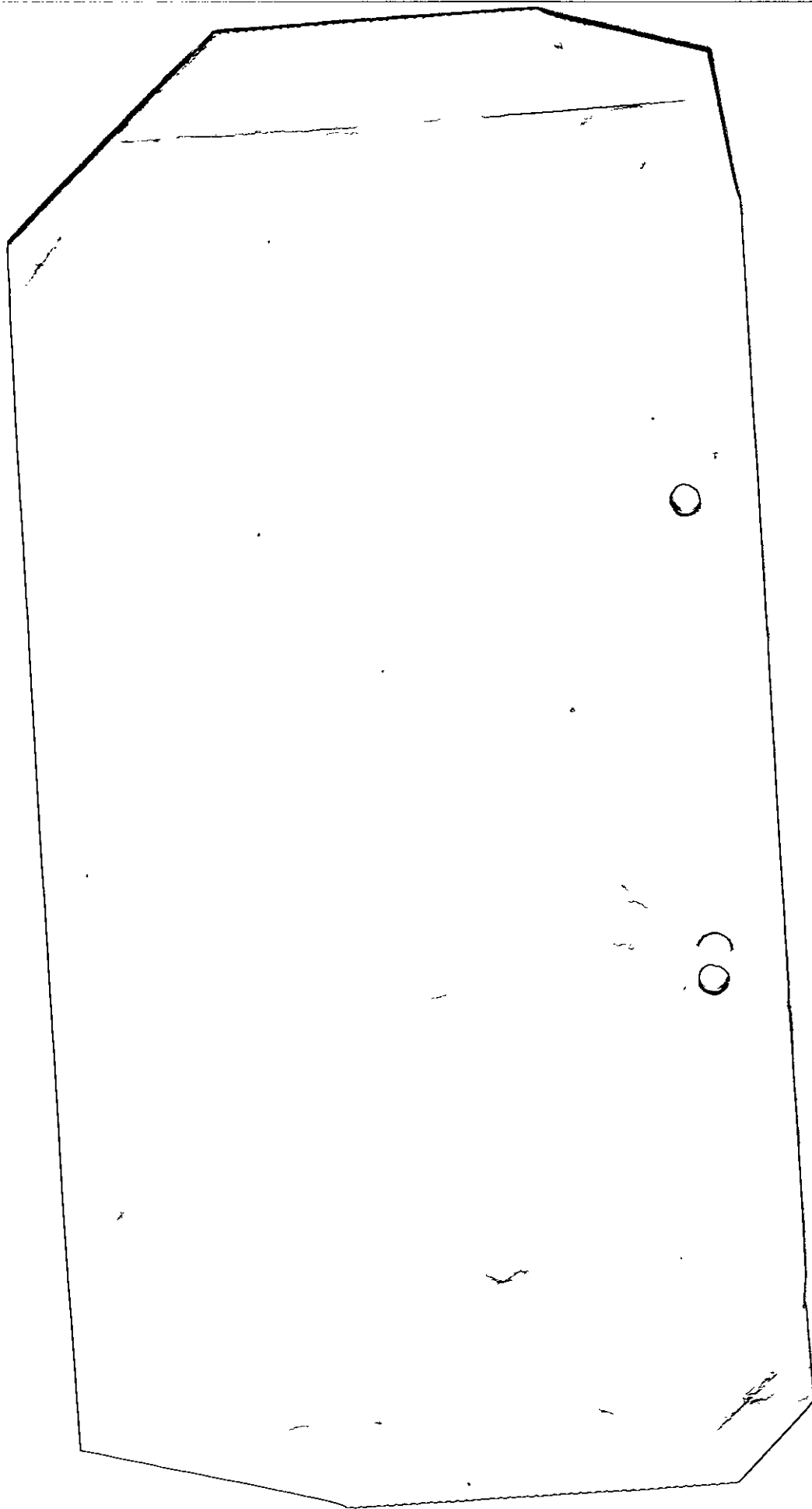
Symbole/Symbols ISO 7000 / ISO 15223



Made in Germany

28G/1Fr 20

premiath





Rainbow Childrens Hospital-Himayatnagar
Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing
Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : <https://rainbowhospitals.in>

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006896 Admit Date : 20-Jul-2026 Admit Time : 12:42 PM UHID : HNH-00016698

Patient Details :

Patient Name	: Baby Of SINDHUJA M	Age	: 0 D
Guardian	: Mr P PRADEEP	DOB	: 20-07-2026 11:57 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: RTC x roads RTC X Road Hyderabad Telangana INDIA 500020	Phone No	: 8886118808/ 8555847671
		E-mail	: sindhuja.ms2017@gmail.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 P PRADEEP	Relationship	: Father
Contact Address	: RTC x roads RTC X Road Hyderabad Telangana INDIA 500020	Phone No	: 8886118808

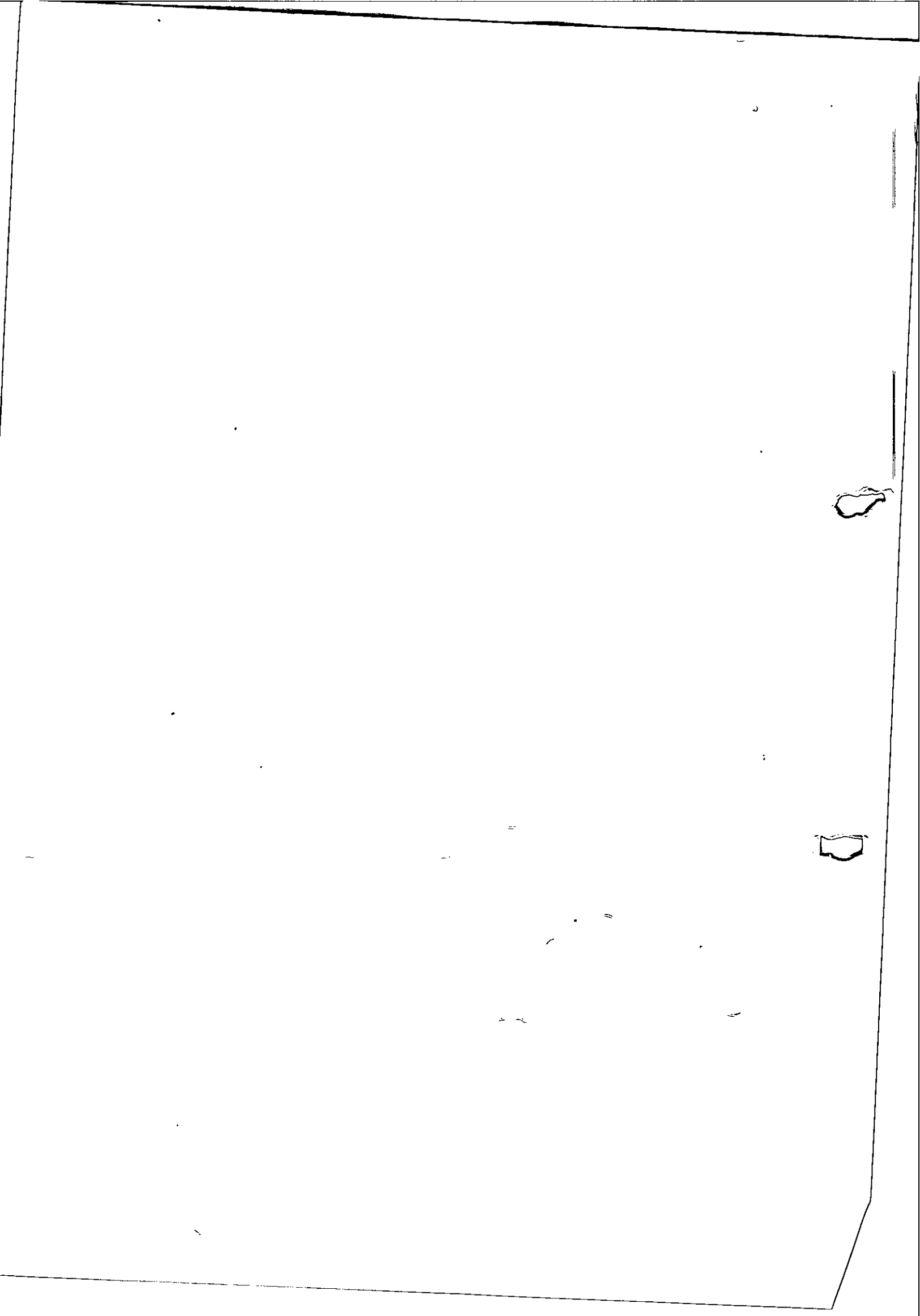
Signature

Doctor Details :

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

Payment Details :

Payment Mode	: DC/CC Card	Deposit Amount	: 15000.00
		Payor Name	: SELF PAY



ACTIVITY RECORD FOR BILLING

HNH-00016698 IP26-00006896
Baby Of SINDHUJA M
20-07-2026 0 Y 0 M 0 D 2 H (M)
Dr. SPANDANA PASUPULETI

Name: _____ nt: Dr. Spandana Dept: NICU
UHID No: HNH-00016698



Date of Admission: 20/7/26 Time: 2:42 pm Date of Discharge: _____ Time: _____

Room / Bed No: 406 Ward: NICU Suggested Billable bed type: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7/26	12:40 pm	OT	NICU	poja
21/7/26	12:45 pm	NICU	2nd floor	Nikitha

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	DR. Sweetha	21/7/26	5653 ✓	Be
2.	Cross checked by Nirmala's on 24/07/26 at 5:15 Am			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				



Date	Investigations	Order No.	Sign
20/7/26	CBP, CRP, Blood group	12135 ✓	}
20/7/26	Blood culture		
20/7/26	RBS (1) 77mg/dl, ABG (1)	12134 ✓	}
20/7/26	X-ray (1)	8817 ✓	
20/7/26	X-ray (2)	8853 ✓	}
21/7/20	ABG (2) RBS (2) (107mg/dl)	12170 ✓	
	ABG (3) RBS (3) (80mg/dl)		
	Cross checked by sis Laxmi 21/7/26 5:30pm		
21/7	MSG	8868	}
	2D-echo	8868	
20/7	ABG (4) RBS (4) (125mg/dl)	2205 ✓	}
21/7	ABG (5) RBS (5) (148mg/dl)		
	Cross checked by Dr. Sharmi 21/7/26		
22/7/26	ABG (6) RBS (6) (123mg/dl)	2248 ✓	}
22/7/26	CBP, CRP, SBR	2216 ✓	
	Urea, Creatinine, Electrolytes, Calcium		
22/7/26	ABG (7) RBS (7) (140mg/dl)	12281 ✓	}
22/7/26	CBP, CRP	12291 ✓	
22/7/26	X-ray (8)	8962 ✓	}
22/7/26	ABG (9)	12314 ✓	
23/7/26	ABG (10) RBS (10)	2349 ✓	}
23/7/26	MSG	8974 ✓	
24/7/26	Cross checked by Normalan sis on 24/07/26 at 5:15 Am		



INVESTIGATIONS

Date	Investigations	Order No.	Sign
24/7/26	ABG ⁽¹⁰⁾ RBS ⁽⁹⁾ (101 mg/dl)	12424 ✓	SJ
24/7/26	RBS ⁽¹¹⁾ RBS ⁽¹⁶⁾ [87 mg/dl]	2473 ✓	Shivuloch
25/7/26	RBS ⁽¹¹⁾ (81 mg/dl)	2520 ✓	SJ
26/7/26	RBS ⁽¹²⁾ (82 mg/dl)	2616 ✓	SJ
Cross Checked by Nanya 26/7/26 at 7 am.			
27/7/26	RBS ⁽¹³⁾ [87 mg/dl]	12682 ✓	Logg
28/7/26	NBS	2777	SJ
	ABG - 10		
	VBG - 1		
	RBS - 13		
	X-Ray - 3		
	USG - 2		
	2 echo - 1		
checked by Bhawni 27/7/26 11 AM			

IP26-00006896

20-07-2026

0YOM4D

(M)

Dr. SPANDANA PASUPULETI

[illegible]

Date _____

Investigations

Order No.

Sign



ENT (WARD & ICU)

[illegible]

[illegible]

IP26-00006896

HNH-00016698
Baby Of SINDHUJA M
0 Y

20-07-2026

AM
OYOMOD6H

(M)

20-07-2026
Dr. SPANDANA PASUPULETI



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
20/7/26	1pm (1)	77mg/dl	IVF	Ar
20/7/26	10pm (2)	105mg/dl	Iv Plus	Ar
21/7/26	3AM (3)	80mg/dl	"	Ar
21/7/26	2pm (4)	125mg/dl	"	Ar
22/7/26	6am (5)	148mg/dl	"	Ar
23/7/26	6am (6)	86mg/dl	"	Ar
24/7/26	10pm (7)	123mg/dl	"	Ar
24/7/26	6AM (8)	101mg/dl	"	Ar
24/7/26	12pm (9)	87mg/dl	"	Ar
25/7/26	6 AM (10)	81mg/dl	Feeds	Ar
26/7/26	6 AM (11)	8.2mg/dl	Feeds	Ar
27/7/26	6 AM	101mg/dl	"	Ar
27/7/26	6 AM (12)	87mg/dl	Feeds	Ar
27/7	Cross checked by poors 6AM	82mg/dl	27/7/26 at 3AM	Ar

CONSENT FOR ADMISSION IN NEONATAL INTENSIVE CARE UNIT



HNH-00016698 IP26-00006896
Baby Of SINDHUJA M
20-07-2026 0 Y 0 M 0 D 10 H (M)
Dr. SPANDANA PASUPULETI

Name:

Age: 07 Gender: Male ☒ Female ☐

UHID.Nc



Date: 20/7/26

I H pradeep S/o, D/o, W/o B/o Sindhuja hereby declare that our patient Mr. / Ms B/o Sindhuja who is related to me as is getting admitted in the Neonatal Intensive Care Unit of Rainbow Children's Hospital on 20/7/26

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

Respiratory distress
pre term
low birth weight

The doctors have clearly explained to me that my patient B/o B/o Sindhuja 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 Sindhuja in the Neonatal Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Neonatal Intensive Care Unit and treat him/her with all necessary means.

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

Patient Attendant :

Signature : [Signature]

Name : pradeep

Relationship with Patient: father

Date & Time : 21/7/26 at 10am

Witness :

Signature : [Signature]

Name : [Name]

Date & Time : 21/7/26 at 10am

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Prashanth

Date & Time : 20/7/26 at 10am

CONSENT FOR SPECIAL PROCEDURES

HNH-00016698 IP26-00006896
Baby Of SINDHUJA M
20-07-2026 0 Y 0 M 0 D 10 H (M)
Dr. SPANDANA PASUPULETI

UHID No :



Gender: ☒ Male ☐ Female

Department : NICU Date : 21/7/26

I pradeep S/D/W/O Bl. sindhuja

Here by give consent for procedure of : NIV

For my patient, Named : Bl. sindhuja

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

Respiratory distress
Pneumonia, Sepsis

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

ventilation (non-invasive)
pressure support

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

Name of the Doctor performing the procedure: Dr. Prashanth

Patient Attendant : [Signature]

Signature :

Name : pradeep

Relationship with Patient: father

Date & Time : 21/7/26 at 10 AM

Witness :

Signature : [Signature]

Name : Sunitha

Date & Time : 21/7/26 at 11 AM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Prashanth

Date & Time : 20/7/26 at 11 AM

CONSENT FOR SPECIAL PROCEDURES

HNH-00016698 IP26-00006896
Baby Of SINDHUJA M
20-07-2026 0 Y 0 M 0 D 10 H (M)
Dr. SPANDANA PASUPULETI

Patient Name

Gender: ☒ Male ☐ Female

UHID No :

Department :

Date : 21/7/26.

I pradeep S/D/W/O Blo sindhya

Here by give consent for procedure of : Pic line

For my patient, Named : Blo sindhya

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

Pic line bleed
Pic line block

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

Invasive line
IV line (peripheral), IV fluids

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

Name of the Doctor performing the procedure: Dr. Prashanth

Patient Attendant :

Signature : [Signature]

Name : pradeep

Relationship with Patient: father

Date & Time : 21/7/26 at 11 AM

Witness :

Signature : [Signature]

Name : Santhya (RHH)

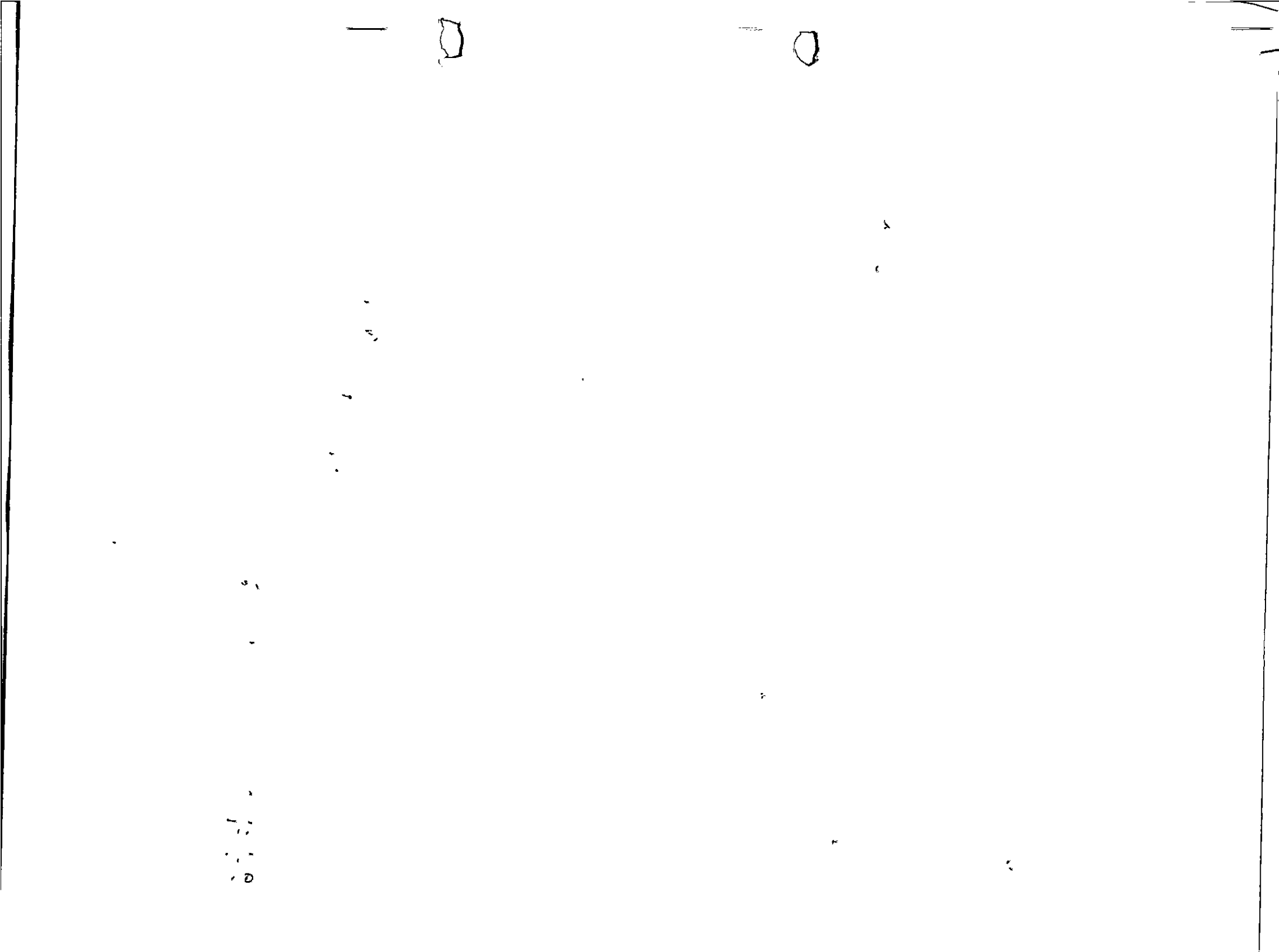
Date & Time : 21/7/26 at 10 AM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Prashanth

Date & Time : 20/7/26 at 10 AM



HNH-00016698 IP26-00006896
Baby Of SINDHUJA M
20-07-2026 0 Y 0 M 0 D 9 H (M)
Dr. SPANDANA PASUPULETI

DATE: 20/7/26

NEWBORN ANOMOLY ASSESSMENT CHECKLIST

S.NO	ASSESSMENT PARAMETERS	CHECKED BY REGISTRAR	CHECKED BY CONSULTANT	REMARKS
1.	Palate	No cleft		
2	Pre natal teeth	N7		
3	Anal opening	Patent		
4	Genitalia	Male		
5	Spine	C6		
6	Red reflex	Tachich		
7	4 limb saturation (before discharge)	To check		


Ped.Registrar signature

Dr. S. TEJASWI REDDY
Registration No: 94063
Ped.Consultant signature

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 12:50 PM	cl/hy Dr. Anusha / Dr. Tejaswi Early PT (31w+5d) / AGA / 1.780kg / Male / CIAR / 2 RDS - NIV Baby on NIV - PIP 20 resp at fior 21%. spo₂ = 95%. HR = 158/min Bp = 59/33 (u2) RR = 54/min. USG chub screen (Beck'sick) ↓ fluid (+) posterior field cong. ↓ N/H CXR AP THU.	- (T) CXR. - ct NIV. - ct IV fluid - ct Ampic PIP TAB. AMIKACIN 17' CAFFEINE. - GRBS QID - Surfactant (so). - LBP, BGT, VBS, B/c/p. - Norm son

[illegible]



2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 2:30 PM	S/D Dr. Spandana Δ Very preterm (31wk+5d) / AGA / Male / C IAB 1.780 kg / 2 BW / MDS - MIV	PG
	Baby Euthermic HR - 152/min SpO ₂ - 98% BP - 45/35 (38)	- CT IVF 10% Dextrose @ 6 mL
	CVS - S ₄ S ₂ @ CRT - 3 sec P ₁ - BIC - ACF @ Equal.	- CP PIPTA 2 - Trace reponb - GMBs monitoring 6 th h
	PIA - 50 cc CMI - Spont Activity	- Plan for PICC line insertion - Monitor vitals - w/resp distress
		- CT Caffeine



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 12am	MLB re-spondana - on NIV FiO₂: 21 PEEP: 6.5 L PIP: 20 <u>meals</u> HR: 190 bpm RR: 50 bpm SpO₂: 99% Bp: 66/39 (44) <u>Am'</u>	Plan 1) VBY at 4am 2) it- caffeine Replaz IVF 3) it- 4KBS monitoring 4) trace closed cl 5) Pert it- as per ex chart 6) 2D-ECHO, NSG → coming morning
		Noted by 3rd (amr) 21/7/26 12am



80/7/26

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : PMA:

Term ☐ Preterm ☐ Gestation : Corrected Gestational Age:

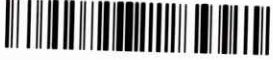
OVERVIEW	Problems :		
	S.No.	Current	Past Problems
	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Today's Weight :			
RESPIRATORY SYSTEM	Ventilatory Support : ☐ Yes ☐ No - Day # of Vent :		
	Mode of Ventilation : HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ iNO ☐ PPM ☐		
	Ventilator Settings : PIP.....PEEP.....VG.....Rate.....Fio ₂Oxygen :L/min		
	Last CXR :Spo ₂ :.....		
	ET Secretions : Clear ☐ Thick ☐ Yellow ☐ Last ABG:		
	Change over the Last 24 Hours.....		
			
			
CARDIO VASCULAR SYSTEM	Plan of Care :		
CNS	Neurological Examination :		
	Sedation.....		
	Last Neurosonogram :Any Seizures.....		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26	C/S/B - Dr. Tejaswi	
11AM	Δ - V97/31+5 1.78 kg RDS-NIV TWt - 1740g	BBG - BL mBG - ABT
	<u>On NIV</u>	<u>plan</u>
	PIP - 20	- IVF 80/kg → 90 ml/kg → ml/kg
	Peep - 6.5	
	Fio ₂ - 21%	- ct Piptaz Coffeine
	O/E	- 2 DE cho / today WSR
	HR - 147/min	
	RR - 60/min	
	SpO ₂ - 100% on RA	- RBS / CBG Q6h
	BP -	- Blood c/s trace
	Picc line insitu	- Feeds ⇒ and 0.5ml
	O/E	Noted by Swathi
	Cry Tone activity Good.	

Date & Time	Progress Notes	Doctor's Order
	Counselling notes	
21/7/26	Baby requires high pressures.	
45 m'	→ Had higher pressures respiratory distress; but not ventilated, which is good	
	→ Baby better on NIV	
	→ kept PICC line	
	→ Baby can be given formula feeds	
	→ 24 hrs later birth, infection test to repeat.	
	→ upto 34 weeks / 1.4 kg ^{NICU} discharge criteria.	
	→ on caffeine breathing better - upto 34 weeks	
	Dr. S. Tejaswini Reddy	Doctor



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>C/S/B - Dr. Prashanthi</u>	
21/7/26 8pm	A - Early preterm / AGA / RDS 31+5	
	GA-31+5 CGA-31+6	BBG-Bt mBG-ABt
	But 1780g Tw 1740g	
	On NIV ⁶⁻⁶ 21- 20	<u>Plan</u>
	maintaining Saturation	1) Ct NIV
	O/E	2) IVF 90ml/kg
	HR-158/min	3) feeds - 1ml Q2h
	RR-48/min	4) Ct Ripta2
	SpO2-100% on NIV	Caffeine
	BP-	5) Trace Blood c/s
	H/E Euthemic, Pink	6) CBG Q 2h
	RS-clear	RBS
	CVS-S1S2+, NO MURMUR	7) sent NP,
	CNS-WNL	
	PA-Soft	
	<u>V/K</u> M	

Noted by
21/7/26
3pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/2 Spm	CH/B Dr. Tejastini VPT / 31th → 31th h / LSCS / Mch / 1.78 kg / ASA / LBU / RDS ~ NIV on NIV T PIP - 20 PEEP - 6.5 RD - Better Maintaining Sats Vital HR - 162 h SpO₂ - 98 % RR - 46 BP - 56/31 (39) CIT(A) - Good Movement - (a) Pressed Vwir & stool	Pl 1) Cont NIV 2) TV - 90 ml/kg 3) Feed - 1ml/kg Tsc. 1ml / 6th hourly 4) In PIP T A 2 CAFFEINE 5) Thas NPI 6) CBG - 8th hly anBS 7) Monitor Vital
		Noted by Pm 21/2/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 12 AM	c/s/hy Dr Anu Early PT / AGA / RDS / 1.78kg (31+5) (CGA - 31+6wk) on NIV PIP 20 → 18. PEEP - 6 cmH₂O. FiO₂ 21%. Bp 55/32 (ul) HR 145/min RR = 48/min Spo₂ 99% on NIV.	Plan → VBG C Trm my 2AM → 1ml Oxy (1ml Q4hly) → 17' PIP 20 CAFFEINE → CBG Q4hly GRBS. → Monit vitals
	AP 12 AM	
		Noted by Sai Prasad 22/7/26 12 AM

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day 2 Day of Life : 2 PMA:

Term ☐ Preterm ☒ Gestation : 31+5 Corrected Gestational Age: 31+6 wk

Problems :		
S.No.	Current	Past Problems
1.	<u>RDS on NIV.</u>	
2.		
3.		
4.		
5.		
6.		

Today's Weight :

OVERVIEW	
Ventilatory Support : ☒ Yes ☐ No - Day # of Vent :	
Mode of Ventilation : HFNC ☐ CPAP ☒ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ iNO ☐ PPM ☐	
Ventilator Settings : PIP <u>18</u> PEEP <u>6</u> VG Rate FiO ₂ <u>21</u> Oxygen : L/min	
Last CXR : <u>Impending</u> Spo ₂ : <u>95%</u>	
ET Secretions : Clear ☐ Thick ☐ Yellow ☒ Last ABG : <u>Impending</u>	
Change over the Last 24 Hours : <u>Nil</u>	

RESPIRATORY SYSTEM	
Plan of Care : <u>N</u>	

CARDIO VASCULAR SYSTEM	
Neurological Examination : <u>N</u>	
Sedation : <u>No</u>	
Last Neurosonogram : Any Seizures : <u>No</u>	

CNS	

FLUIDS STATUS NUTRITION	☐ NPO ☒ NG Feeds Wt. Gain: Head Circumference: Input : / (+/-) Output : ml/k/d Urine Output : ml/kg/hr Stools : IV Fluids - Type of IVF : <u>Isop 10%</u> @ ml / hr Feeding: EBM ☒ Formula ☐ Donor BM ☐ Volume: Frequency: <u>1ml only</u> TPN : ☐ Yes ☒ No - If yes, details : Calories: Abdominal Examination: <u>no distension</u>			
	Other Systems : Haematology / Nephrology / Metabolic / Endo / NNJ - PT / OPTH / RICKETS			
	Risk of Sepsis / <u>Suspected Sepsis</u> / Proven Sepsis : Sepsis screen: <u>Negative</u> Blood culture ☐ Urine culture ☐ ET culture ☐ Fungal Culture ☐ LP ☐ CSF :			
INFECTION	Antibiotic	Sl.No.	Drugs	Days
	1.		<u>Hy PIPID3</u>	
	2.			
	3.			
Plan of Treatment : <u>- cl NIV</u> <u>- cl Antibiotic</u> <u>- pla to taper NIV support</u> <u>- ↑ 1ml Only NG feeds</u> <u>- hyform so s</u>				

 Doctor's Name (Handover given) : Al

 Signature : Anu

 Date & Time : 22/1/26

 Doctor's Name (Handover taken) : Thonus

 Signature : Thonus

 Date & Time : 22/1/26

HNH-00016698

IP26-00006896

Baby Of SINDHUJA M

20-07-2026

0Y0M1D

(M)

Dr. SPANDANA PASUPULETI

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Children's
Hospital

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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



2217126

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : PMA:

Term ☐ Preterm ☐ Gestation : Corrected Gestational Age:

OVERVIEW	Problems :		
	S.No.	Current	Past Problems
	1.		
	2.		
	3.		
	4.		
	5.		
6.			

Today's Weight :

RESPIRATORY SYSTEM	Ventilatory Support : ☐ Yes ☐ No - Day # of Vent :
	Mode of Ventilation : HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ iNO ☐ PPM ☐
	Ventilator Settings : PIP.....PEEP.....VG.....Rate.....Fio ₂Oxygen :L/min
	Last CXR :Spo ₂ :
	ET Secretions : Clear ☐ Thick ☐ Yellow ☐ Last ABG:
	Change over the Last 24 Hours.....
	

CARDIO VASCULAR SYSTEM	Plan of Care :

CNS	Neurological Examination :
	Sedation.....
Last Neurosonogram :Any Seizures.....	

FLUIDS STATUS NUTRITION	☐ NPO ☐ NG Feeds Wt. Gain: Head Circumference: Input : / (+/-) Output : ml/k/d Urine Output : ml/kg/hr Stools : IV Fluids - Type of IVF : @ ml / hr Feeding: EBM ☐ Formula ☐ Donor BM ☐ Volume: Frequency: TPN : ☐ Yes ☐ No - If yes, details : Calories: Abdominal Examination:			
	Other Systems : Haematology / Nephrology / Metabolic / Endo / NNJ - PT / OPTH / RICKETS			
INFECTION	Risk of Sepsis / Suspected Sepsis / Proven Sepsis : Sepsis screen: Blood culture ☐ Urine culture ☐ ET culture ☐ Fungal Culture ☐ LP ☐ CSF :			
Antibiotic	Sl.No.	Drugs	Days	
	1.			
	2.			
	3.			
Plan of Treatment :				

Doctor's Name (Handover given) :

Signature :

Date & Time:

Doctor's Name (Handover taken) :

Signature :

Date & Time:



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 9:30 AM	cl/hy Dr. Anurag Early PT / AGA / Male / 1-78ly / RDS - NIV CGA 32 weeks / Day 2. Baby on NIV - PIP 18 PEEP 6 FiO₂ 21%. HR = 143/min SpO₂ = 99% BP 65/48 (54) (R/S) Bil AC (+) NIVBS (+) AF 11/20/21	I/o = T.Wt = 1.740 = (same wt) plan — iv fluids — slow 4ml Orally → iv fluid 4.5ml/L. (1ml Orally) — ct Antibiotic CAPRENE — CBG, GRBS Orally. — Monitor vitals checked by <i>[signature]</i> 22/7/26 8:30 AM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 10:30am	B/o sindhuja	
	— A/V → c/p today.	
	— will repeat KBY 12pm	
	↳ if (N) or → HFNC.	
	↓	
	will change to room air.	
	— Baby accepting 4ml feed.	
	will ↑ 1ml every 4 th hourly.	
	— Kp: 05 [negative].	
	— will have blood clots & stop analgesic.	
	Dr. Tejan	
	Dr. S. TEJASWI REDDY Registration No: 94068	
	Admitted by Dhanya 22/7/26 @ 10:31am.	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 3pm	MR R. Sharma	
	on pop: FiO_2 : 21% keep: 6	
	intals ; HR: 156 bpm RR: 56 bpm SpO ₂ : 100% As: BRE ⊕ moderate SER ⊕ HA - rose	plan 1) ut. caffeine nifed dosmtal glycerin 2) ut. smc feeds, ↑ 1ml every 4th h 3) VBY at 6pm 4) leave blood ils 5) Rnt ut. as per RX chart 6) monitor intals - 7) send { UBP URP. chest x Ray 8) DSPT.
	- <u>icteric</u> - TCB check. - start DSPT.	
		Abol by Kesthi 22/7/26 3pm

Date & Time	Progress Notes	Doctor's Order
22/7 4m	<u>C/S/B Dr Spandam</u>	
	on CPAP $\rightarrow$ 6m PEEP 24% F _{IO2}	<u>Plan</u> 1) Gs - 8 th hly 2) CPAP - Cn 3) HSC - T/h 4) Check Taurdin 4 hr 5) CBP CRP CXR } C Nov 6) Tsm blood CU 7) Ct - PIP/A2 Caffeine 8) Feed - 5ml B24 Tm 1ml/6 th hly 9) TV - 120ml/hy
	<u>V.H</u> NR - 149/in SpO ₂ - 99% BP - 55/37 (45) RR - 28/h	
	Tolerating feed	
	<u>Super</u>	
		<u>total by hanni</u> 22/7/20 Pm

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Date & Time	Progress Notes	Doctor's Order
07/26 39pm	Dr. Chandana	
	[CPAP] NIV - off	
	Rpt HR - stable.	
	Cep1 cep- Blood ktz	
	Continue Abx	
	-> Feeds increasing ↑ 1ml - every 6m hour	
	-> tomorrow - NLA Brain	
	D ₁ - D ₃ - D ₇ - D ₁₄ - D ₂₁	
		Dr. Spandana Pasupuleti Consultant Neonatologist and Pediatrician Reg. No: 30925

(P.T.O)

Date & Time	Progress Notes	Doctor's Order
23/7/26 20 Am	<u>C/S/B - Dr. Prashanti / Dr. Sreehan</u>	
	<u>Δ - Early Preterm / AGA / ROS / nnJ</u>	
	on CPAP < 21 / G on SSP1	<u>Plan</u> 1) check NSG Brain today 2) ↑ feeds 1ml @ 6th hly 3) Continue CPAP 4) Trace blood c/s A. PipTaz Caffeine 5) TV - 120ml/kg 6) monitor vitals Urine output
	<u>O/E</u> RR - 164/min RR - 38/min SpO ₂ - 100% on nCPAP	
	<u>S/E</u> RS - NUBST, 3 LAET CVS - S, S ₂ + CNS - wnl P/A - soft	<u>Prnti</u> Coded by Supriya 23/7/26



23/7/26

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : PMA:

Term ☐ Preterm ☐ Gestation : Corrected Gestational Age:

OVERVIEW	Problems :		
	S.No.	Current	Past Problems
	1.		
	2.		
	3.		
	4.		
	5.		
RESPIRATORY SYSTEM	Today's Weight :		
	Ventilatory Support : ☐ Yes ☐ No - Day # of Vent :		
	Mode of Ventilation : HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ iNO ☐ PPM ☐		
	Ventilator Settings : PIP.....PEEP.....VG.....Rate.....FiO ₂Oxygen :L/min		
	Last CXR : Spo ₂ :		
	ET Secretions : Clear ☐ Thick ☐ Yellow ☐ Last ABG:		
	Change over the Last 24 Hours.....		
			
			
			
CARDIO VASCULAR SYSTEM	Plan of Care :		
CNS	Neurological Examination :		
	Sedation.....		
Last Neurosonogram :Any Seizures.....			



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/07/2026	C/S/B- Dr. Prashanti Dr. Sreegham	
8:00 Am	Δ - Early preterm GA - 34⁵ - 92 Hb CGA - 32⁴ for 1 weeks BW - 1780 TW - 1700 Δ - 4.4% ↓ 40 gm: 48% loss on NCPAP, BspT tolerating feeds Urine ✓ stool ✓	RDS / nnJ MBG AB+ve B BG B+ve <u>Plan</u> 1) Continue NCPAP 2) ↑ feeds Int & Gelly 3) CBG & 12th hly 4) ct Piptaz Caffeine 5) NSG today.
O/E	HR - 160/min RR - 82/min SpO₂ - 96% on NCPAP BP - 63/45(SI)	
C/E	RS - NUBST, B/LAET, No added sounds CVS - S₁S₂+ CNS - wnl P/A - soft	auth. Noted by Shivalika 8 AM 23/7/26

Date & Time	Progress Notes	Doctor's Order
28/7/26 11AM	C/8/13 - Dr. Tegabani A - Early preterm / AGA / NNT	
	on NCPAP	plan 1) HFNC 4L/min
	Gas ok	2) Piptaz Caffeine
	o/e vitals stable	3) Prone position
		4) CBG - Q12h
		5) NSG today
		6) TV - 120 ml/kg
		Noted by Shivali 28/7/26 21AM



Pr

Date & Time	Progress Notes	Doctor's Order
28/7/26	<u>CO unSelling note</u>	
10:30am	will taper from CPAP → HFNC Cht fm. will keep in prone position	
RP	from 5 → 6	
10T	will give only small quantity feeds	
		
	 Dr. S. TEJASWI REDDY Registration No: 94068 Dr. Tejan	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7/26	C/S/b Dr. Spandana D- Early PT / AGP / RDS / N/AH 3.0 OPH HFNC on CPAP 21 5 O/E - RR - 30/min. SpO ₂ - 97% @ RA.	<u>Plan</u> - Ct. SLEPT for 24 hrs - 9ml O ₂ feeds ↑ 1ml Q 4H. - Stop Antibiotics.
		acted by Dhanya 23/7/26 @ 8pm





PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (VENTILATED PATIENT)

Day in NICU : Day of Life : PMA:

Term ☐ Preterm ☐ Gestation : Corrected Gestational Age:

OVERVIEW	Problems :		
	S.No.	Current	Past Problems
	1.		
	2.		
	3.		
	4.		
	5.		
	6.		

Today's Weight :

RESPIRATORY SYSTEM	Ventilatory Support : ☐ Yes ☐ No - Day # of Vent :
	Mode of Ventilation : HFNC ☐ CPAP ☐ Conventional Ventilation : SIMV ☐ A/C ☐ VG ☐ HFOV ☐ iNO ☐ PPM ☐
	Ventilator Settings : PIP.....PEEP.....VG.....Rate.....Fio ₂Oxygen :L/min
	Last CXR :Spo ₂
	ET Secretions : Clear ☐ Thick ☐ Yellow ☐ Last ABG:
	Change over the Last 24 Hours.....
	
	

CARDIO VASCULAR SYSTEM	Plan of Care :

CNS	Neurological Examination :
	Sedation.....
	Last Neurosonogram :Any Seizures.....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7 7AM	48/15 DA. Pranam / DA. Subhank Die / VPT (31⁺5 → 32⁺2 min) / LSCS / 1.78kg / LSW / ASA / RDS - NIV - HFNC / NNT T-Wt → 1.740 kg (740g) on HFNC T 2 Ltr 21% FiO₂ No RD Tolerating feed - 13 ml Vital HR - 148/min SpO₂ - 96% RR - 48/min R-S - B/LAB @ PIA - Soft - Baboon → 472ml VO → 3-5ml/kg/h	PL 1) HFNC - turn off 2) Feed - 13 ml (9.4 1st 1ml / 4th Ltr Target - 20 ml 3) TV - 130 ml/kg/h 10V-280-P - 2-6 ml/h 4) Dig Caffeine Dantrol Glycolis 5) Monitor vitals Prescribed Noted by <i>[Signature]</i> 24/7/26 @ 7AM

[illegible]



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Date & Time	Progress Notes	Doctor's Order
24/7 9:00 AM.	<u>Counseling notes</u> - Baby on room Air, plan to observe for 24 hours, VBG after 4 hours - Plan to continue OG feeds 14ml/hr, 1ml/4th hourly - Urine, stool passed. - plan to continue NICE stay	
	Dr. S. TEJASWI REDDY Registration No: 94068	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7 2:00pm	Chloro Dox - Naipura on Room Air. Vitals - HR - 162 RR - 62 SpO₂ - 98% RLS - BILACED PLA - Soft no distension Tolerating feeds well	Plan - OA feeds 1ml/2nd hourly ↑ 1ml/4th hourly - TV - 130ml/1g/ds - Cont Zyr' Caffeine - Cont Domstead suspension - Monitor vitals
24/7/26 5:55pm	cl/s/hy Responder 29 - on RA - HR = 162/min - SpO₂ = 99% - BP = 62/42/40	- Queth 1ml - Now on 1um/Only - ct 1/2 caffeine - Domstead - Monitor vitals

Dr. Spandana Pasupuleti
 Physician

Noted by Dr. Pasupuleti
 24/7/26
 2pm

Date & Time	Progress Notes	Doctor's Order
	<u>counselled</u>	
	<u>Baby on RA</u>	
	- Tolerating feed well, we are @ feed gradually. ↓ once full feeds OGT ↓ Try spoon feeds.	
	- No other current issues / new issues.	
		
		Dr. Spandana Pasupuleti Consultant Neonatologist and Pediatrician Reg. No: 30925

[illegible]

V8

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/7 9:15 AM	C/S/B D. Tejani D. S / SVPT (31 st → 32 nd wk) / LSCS / AGA / 1.78 kg / 12 BW / ROS / Int SV on RA Tolerating feed D/E Baby Bethlehem C/T / A - Good Vital: HR - 180/min SpO ₂ - 100% BP - 53/45 (47) RR - 32/min	Phs 1) TK - 140 ml/kg Target - 20nd / Q4 2) Ct - Dorstal Glycine Caffeine 3) Try span feeds 4) Monitor vitals
25/7 1:30 PM	C/S/B Dr. Prasad Baby SV on RA Tolerating 19ml feed Vital: HR - 166/min SpO ₂ 99% RR - 52/min BP - 68/38 C/T / A - Good	Phs 1) Feed - 19ml / Q4 Next feed - 20ml (Target) 2) Ct - Dorstal / Glycine Caffeine 3) span feeds 4) Monitor Vitals



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/2/26 5:45 PM	S/B Dr. Spandana Δ Very packed 31 wk + 5d → 32 wk + 4d Maternal 1.880g / 23w / 12D	
	Futheer	Plg
	HR - 160/min SpO ₂ - 60%	- Give VANCOMYCIN ↳ remove PICC Line Tomorrow
	CNS - S ₄ S ₁₀ CATE 3L	- S/E - 20u / 2wk
	PR - BU - AIC ①	- Monitor vitals
	CNS Spont. movements ①	
	e	
	<u>Singh</u>	
		Noted by Dr. Singh 25/2/26 5:45 PM

19



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



51
Bakya of Sindhya

Date & Time	Progress Notes	Doctor's Order
26/7/25	<u>Counselling Notes</u>	
11 AM	Baby better will remove Pico line mother - direct breast feeds.	Dr. Spandana Pasupuleti Consultant Neonatologist and Pediatrician Reg. No: 30925





PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/7/26	e/s/B-Dr Prashant	
5:45 pm	A -	
	Extreme PT CGA 32+5 w LBN	
	31+5 RDS Day 6	
	Baby on RA	Plan
0/E	vitals stable	1) Picc line to be removed
		2) Continue Direct Breast feeds
8/E		3) Spoon feed 25 ml
	Re-assess Bst, Bf later	
	No added sounds	
27/7/26	on RA	
1 AM	Picc line removed	
	Stable	
	Continue feeds	

Noted by
 Nikitha
 26/7/26
 @ 5:45 pm



21

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		C/S/B Dr. Prashanti / Dr. Naipanya
27/7/26		
7.15 Am	Δ Ext. PT GA 31+5 CGA 32+6	LBW RDS DoL- 7
	Bwt - 1780 Twt - 1720	m BG AB+
	↓ Gog Δ -	BBG B+
		<u>plan</u>
	PICC line removed. LV canular insitu (R) hand	1) continue DBF warm care
	<u>O/E</u> HR - 150/mi RR - 38/mi SpO ₂ - 98% RA BP - 53/25 (35)	2) Spoonfeed 25ml Q2h.
		3) monitor vitals U.O
	<u>S/E</u> Pink Cry Tone Activity } Good	

Noted by poof
27/7/26
7:15 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/7/26 11:30 AM	<u>Shifting Note</u> EPT / 31+5 / CGA 32+6 / Dg 7 / Mole / 1780g	
	<u>Twt</u> 1.720 kg	
	vital stable	<u>Plcn</u>
	No diet	- shift to Room
	on full feed - to kit	- Train moth spoon feed
		SF + (DBF)
		- vit D
		Calumox P
		- Coughin
		- Hormos
		- vaccination today (BCG, OPV, Hep. B)
27/7/26	BCG OPV Hep B } given	

Date & Time	Progress Notes	Doctor's Order
27/7 8:45p	CB/B <u>Dr. Spandana</u> D₁ / VPT / 37⁺ hr $\rightarrow$ 32⁺ hr / WSCS / ASA / Bay / AOS T-N+ - 1.72 hr Baby Swan RA Tolerating feed Vital stable R-S-B/LPSE PIA - Sep	<u>PR</u> 1) Feed - 25ml/2h at Supplement 2) Vaccination <u>Ph.D.</u> (BCG, OPV, Hib) 3) Monitor Vitals
	<u>Dr. Spandana Pasupuleti</u> Consultant Neonatologist and Pediatrician Reg. No: 30925 <u>Dr. S. TEJASWI</u> Registration No: 94008	

IP26-00006896

20-07-2026

0Y0M7D

(M)

Dr. SPANDANA PASUPULETI



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Date & Time	Progress Notes	Doctor's Order
	45/6 - O. Subhenth / O. Phanas	
28/07/26 8 AM	O ₂ / VPT (31 ⁺ 5 → 33 /	LSA / AGA / PDS
	T Baly on remain Toluenhy Feds	
	O/E: vitals - stable Gy / Tou / Activity - good	
	ster NAD	
	Wt → 1.680 kg (↓ 40 g)	
		<u>Ado</u> - Feeds 25 ml 2nd hourly - <u>Observation</u> - (TSCA, OPR, Hcp <u>ESP</u>) - Monitor vitals and - Tybam SOS → <u>Sumble</u> noted by sr. sandhya 27/6/26

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Sindhya Age : 35y Father's Name : _____ Age : _____
 Date of Birth : _____ Date of Admission : _____ UHID No. : _____
 NICU Consultant : _____ Referring Consultant : _____
 Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward
 Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : B/S Sindhya Mother's Blood Group : AB positive
 Gender : ☒ M ☐ F Blood Group : B Positive Birth Weight (gms) : 1.780 Length (cms) : _____
 Date of Birth : 20/7/26 Time of Birth : 11:45 AM OFC (cms) : _____
 Place of Birth : ACH-HMNR Estimated Gesth Age : 31 wks + 3d.

Current Obstetric History : (Booked / Unbooked Case) 35y + 35y
 Maternal Age : _____ Ht : 151cm Wt : 20y BMI : _____ Married Life : _____ LMP : 9/12/2026 EDD : 16/9/26
 Conception : Spontaneous or with Rx. : IVF
 Booked at what GA : _____ AN Steroids Drugs / Doses : _____
 Last Scans Details : 2/7/26 - SL IUG, AFI-15.80 / Breech, Fetal Gb-Ⓜ
FEW-1.4y 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 : 2cm

H/o GDM/ pre GDM/ on diet or insulin
 Controlled or not, recent values, HbA1 values : _____
 Compliance with Rx : _____
 Scans : LGA, TIFFA , Fetal Echo : _____
H/o Hypothyroidism : when diagnosed ? Medication?
 Any other Chronic Medical Problems, when detected
 drugs ? _____
 (Anemia, SLE, Jaundice, CHD, Heart Disease)
 Infection : H/O, Fever 12y
 (☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)
 UTI : when : _____ Any culture : _____

PPROM : Duration : 3 days ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results : _____
 Medication during Pregnancy : _____ Duration : _____



PAST OBSTETRIC HISTORY

G: P: A: L:

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

PERINATAL HISTORY

Treating Obstetrician : Dr. Swaguna Hospital : PCH - HANNA ☒ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☒ Elective ☐ Emergency Indication : Oligohydramnios

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☒ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitation : ☒ Yes ☐ No

Cord ABG : DN-C PAP.

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	
2	2	
1	2	
2	2	
8/12	9/12	

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

Prem (31 wks 4 d) / AHA / Placenta LSCS
 C EAB / 1.280 kg / Male baby



Baby cried Immediately after birth



HR 100/min, Tone in b/w

Auscultation



Oro nasal suction done
liquor-clear

Cord clamped & cut < 2A
12

Baby had resp. distress



DR-CPAP started



Shifted to NICO

Birth weight 3.2 kg
Birth length 48 cm

Investigation details in previous Hospital :

Feeding History :



Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Acrocyanosis
HR 100/min
Tone in 5/5

VITALS : Temperature : HR : 146/min RR : 54/min NIBP : CFT : C3x

Color of the extremities :

Jaundice : Pallor : SpO2 : 96% on DR-CAP

Anthropometry : Birth Weight : 1780g Length : HC : Present Weight :

Ponderal Index : AGA : ✓ SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD : Fontanelles : *AT at 6m*
 Sutures
 Shape / Moulding :
 Edema / Bruising :
 Size - (H.C.) :

Facies :
 (Any Facial
 Dysmorphism)

**NECK and
 CLAVICLES :** Range of Motion :
 Asymmetry :
 Masses :

EYES : Symmetry :
 Red Reflex : *→ to be checked*
 Discharge :

**EARS, NOSE
 MOUTH and
 THROAT :** Ear set / Shape :
 Periauricular Pits / Tags :
 Nasal shape / Patency :
 Palate :
 Gums :
 Lips :
 Tongue :

**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 : *male extend gen: 6/2*
 Anus : *pos*

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

EXTREMITIES : 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 : 54/m 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 : 96% on CPAP Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 145/m BP : Precordial Activity :

Femoral Pulses : 6+ Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernia orifice :

Palpation : Anal Patency : patent

Palpable masses : Umbilical Cord : 2A 1V

Abdominal girth : First urine passed : 7 hours

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR :

ATNR : Skull and Spine :



Any Congenital Anomalies :

Diagnosis : Pink (31 weeks) / AWA 10 1.7804 / Male / CIAD
..... RDS / LBW

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : [Signature]

Name : B. Suresh

Date & Time : 20/7/26 12:30 PM

Consultant :

Signature : [Signature]

Name : Dr. Tejaswini

Date & Time : 20/7/26 + 12:30 PM

Dr. S. TEJASWI REDDY
Registration No: 94068

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 :

- Shift to NICU
- I/V D10W @ 6ml/L + 8.5ml calcium gluconate
- 1g vit K 1g IM stat
- Send CB, Blood group, Blood CS
- O/C Insulin
- Chest X-ray

Feeding Plan at the time of shifting :

- NIV Support - PEEP 6 Rmk-60
FiO2 1.0
Freq-30x
- Warm on

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Noted by
SD Sharma
20/7/26
gm

Sy

DRUG CHART

Date of Admission: 20/7/26 Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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



REGULAR PRESCRIPTIONS

Weight. 1.780 kg Ward.

DRUG : <u>1. PIPITAL</u>				Date 20/7 21/7 22/7 23/7	
Dose	Route	Frequency	Start Date		
180g	IV	BD	20/7		
Name & Signature of the Doctor Starting the Drugs: <u>B. Sangeetha</u>				20/7 21/7 22/7 23/7 2pm X 10am 5pm 2pm	
Additional Instructions:				STOP 23/7/26 @ 2pm	
Daily Doctor's Endorsement by a Sign				[Signature]	

DRUG : <u>1. CAFFEINE</u>				Date 21/7 22/7 23/7 24/7 25/7 26/7 27/7	
Dose	Route	Frequency	Start Date		
100g	IV	OD	21/7		
Name & Signature of the Doctor Starting the Drugs: <u>B. Sangeetha</u>				6 AM 10 AM 2 PM 5 PM 8 PM 11 PM	
Additional Instructions:				c/c	
Daily Doctor's Endorsement by a Sign				[Signature]	

DRUG : <u>Glycerin supp</u>				Date 22/7 23/7 24/7 25/7 26/7 27/7 28/7	
Dose	Route	Frequency	Start Date		
1cc	PR	BD	22/7		
Name & Signature of the Doctor Starting the Drugs: <u>AL</u>				6 PM 9 PM 12 PM 3 PM 6 PM 9 PM	
Additional Instructions:				Stop 28/7	
Daily Doctor's Endorsement by a Sign				[Signature]	

DRUG : <u>DOMITAL drops</u>				Date 22/7 23/7 24/7 25/7 26/7 27/7 28/7	
Dose	Route	Frequency	Start Date		
cc	PO	TID	22/7		
Name & Signature of the Doctor Starting the Drugs: <u>AL</u>				6 AM 9 AM 12 PM 3 PM 6 PM 9 PM	
Additional Instructions:				10 PM 12 PM 2 PM 5 PM 8 PM 11 PM	
Daily Doctor's Endorsement by a Sign				[Signature]	

Sheet No:

REGULAR PRESCRIPTIONS

Weight 1.78 kg Ward

DRUG : Calcimax-P				Date/Time	21/7/2026
Dose	Route	Frequency	Start Dt.		
2ml	PO	BD	27/7		
Name & Signature of the Doctor Starting the Drugs:				[Signature]	
Additional Instructions:				(300mg/10ml)	
Daily Doctor's Endorsement by a Sign				[Signature]	
DRUG : Vit D3 dr				Date/Time	21/7
Dose	Route	Frequency	Start Dt.		
0.5ml	PO	OD	27/7		
Name & Signature of the Doctor Starting the Drugs:				[Signature]	
Additional Instructions:				(800IU/1ml)	
Daily Doctor's Endorsement by a Sign					
DRUG : Caffeine dr				Date/Time	21/7
Dose	Route	Frequency	Start Dt.		
0.5ml	PO	OD	27/7		
Name & Signature of the Doctor Starting the Drugs:				[Signature]	
Additional Instructions:				(20mg/1ml) (CAFFEINE)	
Daily Doctor's Endorsement by a Sign					
DRUG :				Date/Time	
Dose	Route	Frequency	Start Dt.		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Verified by
 Dr. Dhakshayani

Verified by
 Dr. Dhakshayani

Verified by
 Dr. Dhakshayani

Signature

VERIFIED BY : Name

HNH-00016698 IP26-00006896
 Baby Of SINDHUJA M
 20-07-2025 0 Y 0 M 7 D (M)
 Dr. SPANDANA PASUPULETI

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Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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



Weight. 1.780 kg Ward.

Dr. SPANDANA PASUPULETI



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

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

[illegible]



I.V. FLUIDS CHART

Weight. 1.78kg Ward.

Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
20/7 12:40 PM	Dextrose 10% + 8.5ml Colcing gluconet	IV	6 ml		TP	21/7/26		Boof Sweeten
20/7 12:40 PM	INJ. HEPLOCK.	IV	0.3ml/min.	Boof	Shel	21/7/26 3pm		Nikita
21/7 11:20 AM	IVF 10% Dextrose + 9ml calcium Gluconate	IV	6.5 ml/hr	Pult	Sweeten	22/7/26		Boof
22/7 4:30 PM	TV - 120ml/kg 10% ISO - P	IV	6.5	TP	Kenn	23/7/26		Boof
22/7 8 AM	Change	IV	4.5 ml/hr		Boof			
23/7 6 PM	TV - 120 ml/kg 10% ISO - P	IV	3 ml/h	TP	Boof	24/7/26		Boof
24/7 6 AM	TV - 130 ml/kg 10% ISO - P	IV	2.6 ml/h	TP	Boof	25/7/26		Boof
20								

Dr. Dhakshayani



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INTENSIVE CARE UNIT

CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: AB +ve Baby's Blood Group: B +ve Sheet No: (2)
 Gest Age: 32 + 2 weeks Birth Weight: 1.780 kg

Date: <u>24/7/26</u>	Date: <u>25/7/26</u>	Date: <u>26/7/26</u>
DOL <u>D4</u> Weight <u>1.740</u>	DOL <u>D5</u> Weight <u>1.740 (CS.Wt)</u>	DOL <u>D6</u> Weight <u>1.720 ↓ 20gm</u>
Problems: <u>PT/RDS</u>	Problems: <u>PT/RDS</u>	Problems: <u>PT/RDS</u>
Rs. <u>30-60 blw</u> Exam <u>Done</u> Vent. Setting <u>HFNC</u> ABG <u>3 sos</u> CXR <u>3 sos</u>	Rs. <u>30-60 bpm</u> Exam <u>Done</u> Vent. Setting <u>Room Air</u> ABG <u>3 sos</u> CXR <u>3 sos</u>	Rs. <u>30-60 bpm</u> Exam <u>Done</u> Vent. Setting <u>Room Air</u> ABG <u>3 sos</u> CXR <u>3 sos</u>
CVS <u>Normal</u> HR <u>120-160 bpm</u> BP <u>65/45</u> Map <u>(52)</u> Cap Refil <u>2 sec</u>	CVS <u>Normal</u> HR <u>120-160 bpm</u> BP <u>71/49</u> Map <u>(56)</u> Cap Refil <u>2 sec</u>	CVS <u>Normal</u> HR <u>120-160 bpm</u> BP <u>59/49</u> Map <u>(39)</u> Cap Refil <u>2 sec</u>
F/E/N T. Fluids CC/kg/day I/O/RBS: <u>(10mg/dl)</u> U Output: <u>(CC/kg/hr)</u> Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: <u>(81mg/dl)</u> U Output: <u>(CC/kg/hr)</u> Exam <u>Done</u> T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: <u>(82mg/dl)</u> U Output: <u>(CC/kg/hr)</u> Exam <u>Done</u> T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results CRP Antibiotics <u>STOP</u>	C/s Results CRP Antibiotics <u>STOP</u>	C/s Results CRP Antibiotics <u>STOP</u>
Med Neuro:	Med Neuro:	Med Neuro:
Assessment <u>Done</u>	Assessment <u>Done</u>	Assessment <u>Done</u>
Plan <u>GRBS - OD</u>	Plan <u>GRBS - OD</u>	Plan <u>GRBS - OD</u>

INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: AB+ve Baby's Blood Group: B+ve Sheet No:

Gest Age: 31+5 weeks Birth Weight:

Date: <u>27/7/26</u>	Date: <u>28/7/26</u>	Date:
DOL Weight <u>1.720</u>	DOL Weight <u>1.680 kg</u>	DOL Weight
Problems: <u>PT/RBS</u>	Problems:	Problems:
Rs. <u>20-60b/min</u> Exam <u>done</u> Vent. Setting <u>none</u> ABG <u>801</u> CXR <u>801</u>	Rs. Exam Vent. Setting ABG CXR	Rs. Exam Vent. Setting ABG CXR
CVS <u>Normal</u> HR <u>120-160b/min</u> BP <u>Map (42)</u> Cap Refill <u>2 sec</u>	CVS HR BP <u>Map</u> Cap Refill	CVS HR BP <u>Map</u> Cap Refill
F/E/N T. Fluids CC/kg/day I/O/RBS: <u>(87 mg/dl)</u> U Output: <u>(CC/kg/hr)</u> Exam <u>done</u> T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: <u>(CC/kg/hr)</u> Exam T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: <u>(CC/kg/hr)</u> Exam T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results CRP <u>2.1 stop</u> Antibiotics	C/s Results CRP Antibiotics	C/s Results CRP Antibiotics
Med Neuro:	Med Neuro:	Med Neuro:
Assessment <u>Done</u>	Assessment	Assessment
Plan <u>Gabi DD</u>	Plan	Plan

HNH-00016698

IP26-00006896

Baby Of SINDHUJA M

20-07-2026 0 Y 0 M 0 D 6 H (M)

Dr. SPANDANA PASUPULETI



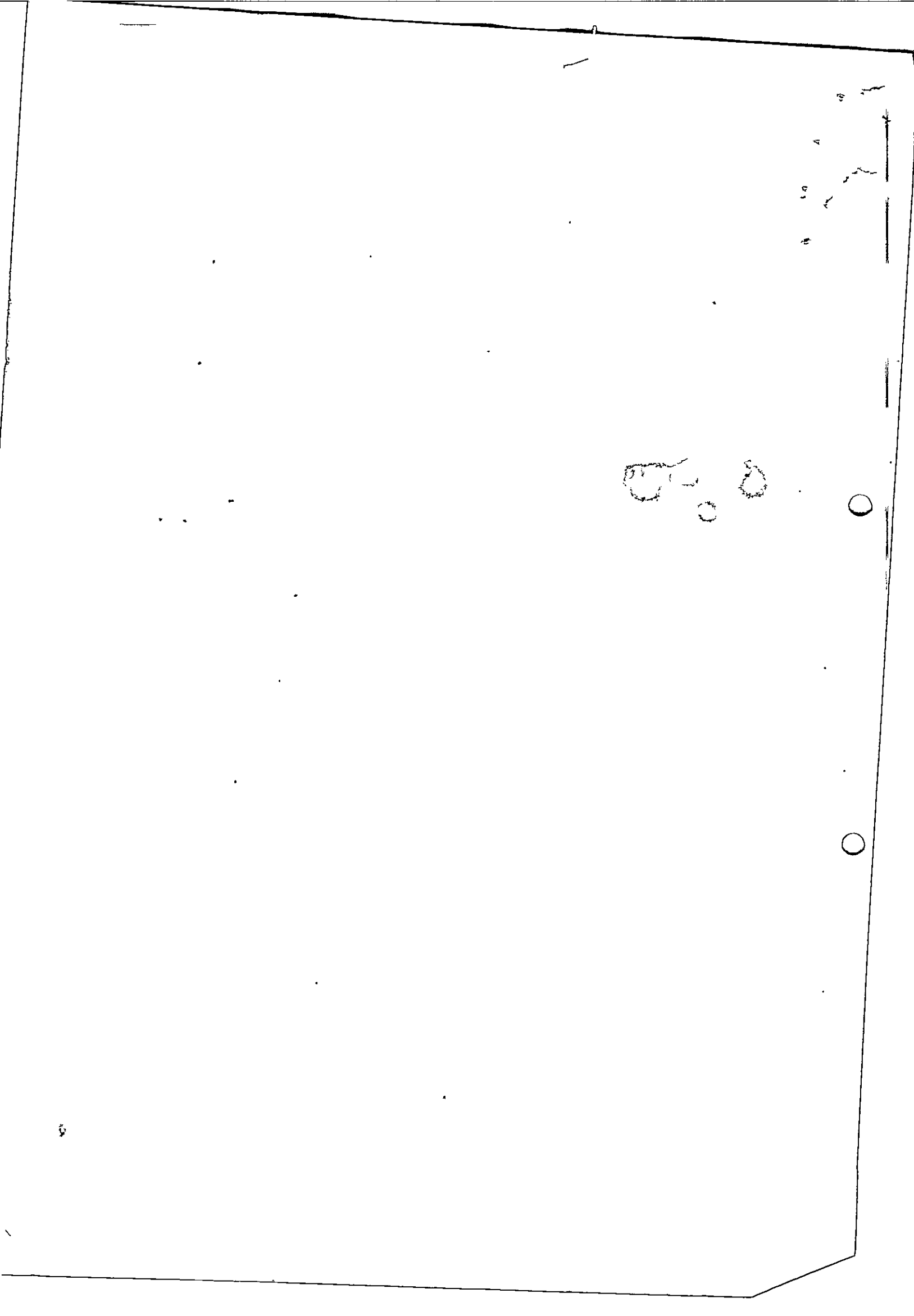
INTENSIVE CARE UNIT

CAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

 Chest - 11.0
 Head 9.4

 Maternal Blood Group: A B +ve Baby's Blood Group: B +ve Sheet No: ①
 Gest Age: 31 + 5 weeks Birth Weight: 1.780 kg

Date: <u>21/7/26</u>	Date: <u>22/7/26</u>	Date: <u>23/7/26</u>
DOL <u>D1</u> Weight <u>1.740 ↓ 40gms</u>	DOL <u>D2</u> Weight <u>1.740 (s.wt)</u>	DOL <u>D3</u> Weight <u>1.700 ↓ 40gm</u>
Problems: <u>PT / RDS</u>	Problems: <u>PT / RDS</u>	Problems: <u>PT / RDS</u>
Rs. <u>30-60b/m</u> Exam <u>Done</u> Vent. Setting <u>NIV</u> ABG <u>§ SOS</u> CXR <u>§ SOS</u>	Rs. <u>30-60 b/m</u> Exam <u>Done</u> Vent. Setting <u>NIV</u> ABG <u>§ Done</u> CXR <u>§ Done</u>	Rs. <u>30-60 b/m</u> Exam <u>Done</u> Vent. Setting <u>C-PAP</u> ABG <u>§ Done</u> CXR <u>§ Done</u>
CVS <u>Normal</u> HR <u>120-160b/m</u> BP <u>61/41</u> Map <u>(47)</u> Cap Refil <u>< 2sec</u>	CVS <u>Normal</u> HR <u>120-160 b/m</u> BP <u>55/32</u> Map <u>(41)</u> Cap Refil <u>< 2sec</u>	CVS <u>Normal</u> HR <u>120-160 b/m</u> BP <u>54/36</u> Map <u>(42)</u> Cap Refil <u>12 sec</u>
F / E / N T. Fluids CC / kg / day I / O / RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F / E / N T. Fluids CC / kg / day I / O / RBS: <u>(148 mg/dl)</u> U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F / E / N T. Fluids CC / kg / day I / O / RBS: <u>(86 mg/dl)</u> U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results CRP <u>Inj piptaz</u> Antibiotics	C/s Results CRP <u>Inj piptaz</u> Antibiotics	C/s Results CRP <u>Inj piptaz</u> Antibiotics
Med Neuro:	Med Neuro:	Med Neuro:
Assessment <u>- Done</u>	Assessment <u>- Done</u>	Assessment <u>Done</u>
Plan <u>ABG - QID</u> <u>RBS QID</u>	Plan <u>ABG & QID</u> <u>CRS & QID</u>	Plan <u>ABG & QID</u> <u>CRS</u>





B+ve

RESULT SHEET

Date	20/7/26	22/7/26	21/7/26			
Time						
Hb	14.9	13.4	15.4			
PCV	42.8	37.4	43.1			
RBC	4.17	3.76	4.28			
WBC	9.61	9.12	10.26			
N/L	24.7/66.4	46/41	43, 46			
Platelets	317	327	306			
CRP	5	6	5.0			
ESR						
PCT						
RBS						
Na			132			
K			5.6			
Cl			107			
Ca/Mg			8.9			
Phosphate						
Urea			17			
Creatinine			0.7			
ALP						
SGPT						
SGOT						
T.Bill/Conj			6.1			
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						

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

Rainbow
Children's
Hospital
It takes a lot to be a child

Patient Sticker

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/07/2025 Time: 6am

Doctor/Nurse/Family Concern?

Temperature
(°F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
over 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Level Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift in charge and PICU /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)



NURSING CARE RECORD

Date: 27/7

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 to 8pm	⇒ Assess the pt condition ⇒ Monitor vitals & record ⇒ Maintain I/O chart ⇒ Administer medication on as per drug chart	8pm	⇒ Assessed the baby condition ⇒ Monitored vitals & recorded ⇒ Maintained I/O chart ⇒ Administered medication as per drug chart	Baby is stable	⇒ Rechecked vitals	
Night	8pm to 8am	⇒ Assess the patient general condition ⇒ monitor vitals ⇒ DBF + SF 2nd hourly ⇒ maintain I/O	8pm to 8am	⇒ Assessed the baby condition ⇒ monitored vitals ⇒ maintained I/O ⇒ DBF + SF 2nd hourly	Baby is stable.	Rechecked vitals	

Patient Sticker

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:

- 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							

HNH-00016698 IP26-00006896
 Baby Of SINDHUJA M
 20-07-2026 0 Y 0 M 7 D (M)
 Dr. SPANDANA PASUPULETI



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site 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 :						
21/7/26	02:00 pm	1										
	03:00 pm	1	DBF 25ml									
	04:00 pm	1										
	05:00 pm	1										
	06:00 pm	1										
	07:00 pm	1										
Total Intake : oral						Total Output : 0 m						
	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 SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Spandana Department: NICU - II Date of Admission: 20/7/26

SITUATION		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area	20/7/26 NI	21/7 M6	21/7/26 NI	22/7/26 M6	22/7/26 G2	23/7/26 NI
	Medical Condition (Any special condition to be noted):	PT/RDS	PT/RDS	PT/RDS	PT/RDS	PT/RDS	PT/RDS
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:	36.5	36.4°C	36.5°C	36.5°C	36.4°C	36.5°C
	Res:	46b/m	52b/m	40b/m	30b/m	30b/m	36b/m
	SpO ₂ :	100%	100%	98%	98%	100%	98%
	Pulse:	149b/m	143b/m	150b/m	139b/m	140	139b/m
	BP:	66/39(mm)	58/28	55/32(mm)	60/36	56/34	50/36(42)
Fall Risk Score:	-	-	-	-	-	-	
Pain Score:	-	-	-	-	-	-	
Recommendations	Safety Needs:	yes	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:	-	NA	NA	NA	NA	NA
Post Operative Procedure Special Orders:		-	NA	NA	NA	NA	NA
Handed Over By Name :		Lami	Prasanna	Saipriya	Uday	Ramya	Saipriya
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		21/7/26	21/7	22/7/26	22/7/26	22/7/26	23/7/26
Time:		8AM	2pm	8AM	2pm	2pm	8AM
Taken Over By Name :		Lami	Saipriya	Uday	Ramya	Saipriya	Nikitha
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		21/7	21/7	22/7/26	22/7/26	22/7/26	23/7/26
Time:		8AM	8pm	8AM	2pm	8pm	8AM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Spandana Department: NICU - 2 Date of Admission: 20/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known					
	PT / RDS 32 + 2 weeks		If Yes Specify:					
BACKGROUND	Area	Shift Time	23/7/26 M6	23/7 m6	23/7/26 m1	24/7/26 M6	24/7 G2	24/7/26 m1
	Medical Condition (Any special condition to be noted):		PT/RDS	PT/RDS	PT/RDS	PT/RDS	PT/RDS	PT/RDS
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: 36.6°C	36.6°C	36.6°C	36.4°C	36.4°C	36.5°C
	Res:		25 b/m	28 b/m	30 b/m	39 b/m	40 b/m	50 b/m
	SpO ₂ :		100%	100%	99%	98%	99%	98%
	Pulse:		151 b/m	100 b/m	150 b/m	153 b/m	150 b/m	145 b/m
	BP:		79/41	80/51	65/45	61/43	58/62	62/36
	Fall Risk Score:		—	—	—	—	—	—
Recommendations	Safety Needs:		yes	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 :			Airitha	Dheer	Saipriya	Shivakala	Dheer	Saipriya
Signature :			(Signature)	(Signature)	(Signature)	(Signature)	(Signature)	(Signature)
Date:			23/7/26	23/7	24/7/26	24/7/26	24/7	24/7/26
Time:			2pm	8pm	8pm	2pm	8pm	8pm
Taken Over By Name :			Dheer	Saipriya	Shivakala	Dheer	Saipriya	Dheer
Signature :			(Signature)	(Signature)	(Signature)	(Signature)	(Signature)	(Signature)
Date:			23/7	23/7/26	24/7/26	24/7	24/7/26	24/7
Time:			2pm	8pm	8pm	2pm	8pm	8pm



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>PT/RDS 32+2 weeks</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known			
	Surgery / Procedure:		If Yes Specify: Post OP Day:			
BACKGROUND	Date	<u>25/7</u>	<u>25/7/26</u>	<u>25/7/26</u>	<u>26/7/26</u>	<u>26/7/26</u>
	Shift	<u>m6</u>	<u>E2</u>	<u>m1</u>	<u>M5</u>	<u>nee</u>
	Medical Condition (Any special condition to be noted):	<u>PT/RDS</u>	<u>PT/RDS</u>	<u>PT/RDS</u>	<u>PT/RDS</u>	<u>PT/RDS</u>
	Diet:	<u>GBM</u>	<u>EBM</u>	<u>EBM</u>	<u>EBM</u>	<u>EBM</u>
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Ventilation (RA, NP, NIV, VENTI):	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>	<u>RA</u>
	Tubes/Drains/Catheter:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
	Vital Signs:	Temp: <u>36.6°C</u>	Temp: <u>36.6°C</u>	Temp: <u>36.5°C</u>	Temp: <u>36.6°C</u>	Temp: <u>36.5</u>
	Res:	<u>40b/m</u>	<u>30b/m</u>	<u>30b/m</u>	<u>43b/m</u>	<u>43b/m</u>
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>100%</u>
	Pulse:	<u>140b/m</u>	<u>142b/m</u>	<u>150b/m</u>	<u>144b/m</u>	<u>153b/m</u>
	BP:	<u>55/46</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	LOC:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Fall Risk Score:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Recommendations	Pain Score:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Skin Integrity	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Safety Needs:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Physiotherapy:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Others Specify:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Special Diet:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Critical Lab Test / Values:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Other Special Orders / Medications:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
PU Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
DVT Prophylaxis:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ADL (Dependent / Non Dependent):	<u>Dependent</u>	<u>dependent</u>	<u>dependent</u>	<u>dependent</u>	<u>Depend</u>	
Post Operative Procedure Special Orders:		<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Handed Over By Name :		<u>Shrey</u>	<u>Vaishnavi</u>	<u>Shrey</u>	<u>Nikitha</u>	<u>Shrey</u>
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>25/7</u>	<u>25/7/26</u>	<u>26/7/26</u>	<u>26/7/26</u>	<u>26/7/26</u>
Time:		<u>8pm</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8pm</u>
Taken Over By Name :		<u>Vaishnavi</u>	<u>Shrey</u>	<u>Nikitha</u>	<u>Vaishnavi</u>	<u>Shrey</u>
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>25/7/26</u>	<u>25/7/26</u>	<u>26/7/26</u>	<u>26/7/26</u>	<u>26/7/26</u>
Time:		<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date						
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:						
	Temp:						
	Res:						
	SpO ₂ :						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
Skin Integrity							
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):							
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							



BRADEN 'Q' SCALE

					Date :	20/7/26	20/7/26	21/7/26	21/7/26
					Time :	6:2	11:00	17:5	17:1
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	3	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.	2	2	3	3	
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	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.	3	3	3	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	3	3	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	3	3	3	3	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	3	3	3	3	
TOTAL SCORE					21	21	21	21	
Evaluator's Name					[Signature]	[Signature]	[Signature]	[Signature]	

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

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

2

				Date :	22/7	22/7	22/7	23/7
				Time :	16	12	11	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.	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.	3	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.	3	3	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.	3	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	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.	3	3	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.	3	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								
Docu. No. : RCH /FRM / CLINICAL / 119								
TOTAL SCORE					24	24	24	28
Evaluator's Name					GA	GA	GA	GA

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

3

				Date :	20/7/2026	20/7/2026	20/7/2026	20/7/2026
				Time :	12	12	12	12
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: Responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	25	27	28	28
				Evaluator's Name	Dr. SPANDANA PASUPULETI	Dr. SPANDANA PASUPULETI	Dr. SPANDANA PASUPULETI	Dr. SPANDANA PASUPULETI

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

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

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

Patient ID

BRADEN 'Q' SCALE

				Date :	26/7	26/7	26/7	
				Time :	21	215	212	
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	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	
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	
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	
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
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	
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	
				TOTAL SCORE	40	24	24	
				Evaluator's Name	22	22	22	

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

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

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

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	0	0	0	0	0	0	0	0	0	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0	0	0	0	0	0	0	0	0	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	0	0	0	0	0	0	0	0	0	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	0	0	0	0	0	0	0	0	0	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	0	0	0	0	0	0	0	0	0	
Signature of the Nurse				8/2	8/2	8/2	8/2	8/2	8/2	8/2	8/2	8/2	

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 : Nirmala Name : Nirmala

Signature of Ward In Charge :

Signature : B Name : Bharani



CHECKLIST FOR THROMBOPHLEBITIS

23/4/26

24/7/26

25/7/26

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	0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	0	0	0	0	0	0	0	0	0	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0	0	0	0	0	0	0	0	0	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	0	0	0	0	0	0	0	0	0	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	0	0	0	0	0	0	0	0	0	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	0	0	0	0	0	0	0	0	0	
Signature of the Nurse				87	21	34	1	21	34	0	0	0	

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

Signature of Shift In Charge :

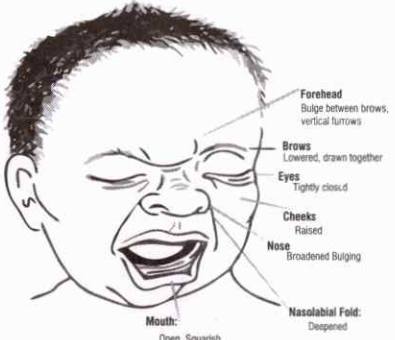
Signature : Laxmi Name : Laxmi

Signature of Ward In Charge :

Signature : Shruti Name : B



NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

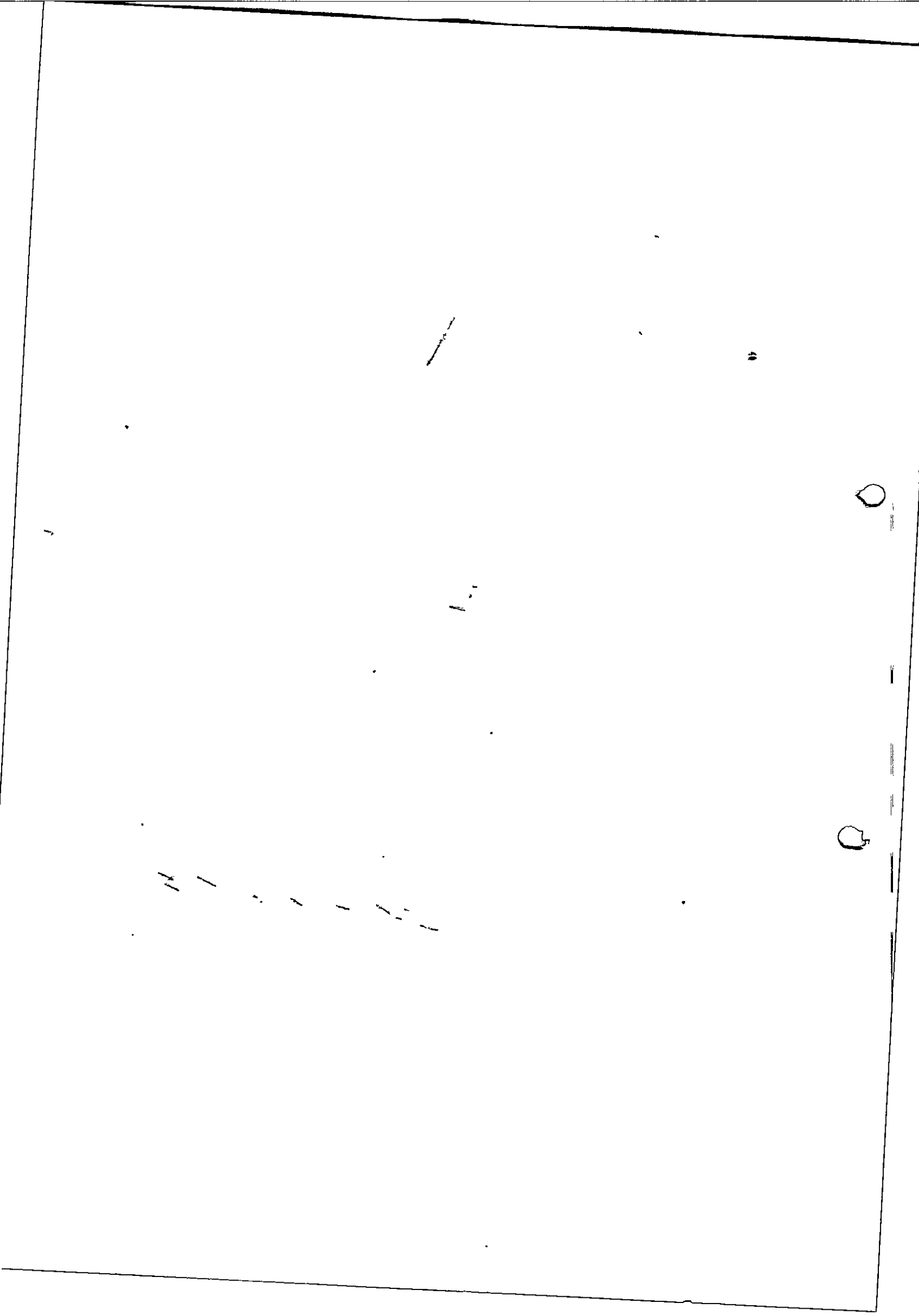
Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
						25/7/26	26/7/26	26/7/26	26/7/26				
						ms	NI	MS	ale				
						Procedure →							
Crying Irritability	No Cry with painful stimuli.	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0	0	0	0				
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0	0				
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0	0				
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0				
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	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	32+2 wks	32+2 wks	32+2 wks	32+2 wks			
						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.



Parameters	Date	Shift Time	22/7 N1	23/7 m6	23/7 e2	23/7 n1	24/7 62	24/7 n1	25/7 m5
we remove Central Line today (discuss in the clinical round)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
presence of any inflammation at insertion site redness / Swelling (If yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
blood at insertion site (yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
any peeling of dressing? (yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
dressing clean and dry? (no inform the doctor)			☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☒ No	☒ Yes ☐ No	☒ Yes ☐ No
any leakage at insertion site? (yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
is there any obstruction to the infusion flow? (yes inform the doctor)			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
dressing intact and labelled properly			☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No
			SL	SL	SL	SL	SL	SL	SL



HNH-00016698 IP26-00006896

Baby Of SINDHUJA M
20-07-2026 0 Y O M 4 D (M)
Dr. SPANDANA PASUPULETI



Pati



CENTRAL LINE MAINTENANCE CARE BUNDLE CHECK LIST

Line: ☒ PICC Line ☐ UAC ☐ UVC ☐ Other Date of Initial Line Insertion: 20/7/26 Duration of Central Line: 30 weeks

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

Parameters	Date	Shift Time	☒ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do we remove Central Line today (discuss in the clinical round)	25/7/26	NI	☒ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there any inflammation at insertion site (redness / Swelling (if yes inform the doctor))			☒ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there any leakage at insertion site? (if yes inform the doctor)			☒ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there any obstruction to the infusion flow? (if yes inform the doctor)			☒ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Dressing intact and labelled properly			☒ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

87



CHECKLIST FOR MAINTAINING CPAP / HFNC / NIV

Date:

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

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



CHECKLIST FOR MAINTAINING CPAP / HFNC / NIV

Date: 21/7

	CRITERIA MET / NOT MET ☐ Yes ☐ No			Comments by Duty Registrar
	Morning	Evening	Night	
CIRCUIT and BUBBLER:				
Blended Air / Oxygen Gas Supply	✓	✓	✓	
Flow Between 5-7 Litres / Min	✓	✓	✓	
Humidifier Temperature Correct (36.5-37.5°C)	✓	✓	✓	
Humidifier Water Level Correct	✓	✓	✓	
Proper Oxygen Tubing From Blender to Humidifier.	✓	✓	✓	
Tubing Correctly Placed (Position & Leak)	✓	✓	✓	
Excess Fainout (Afferent Tubing) Drained	✗	✗	✗	
Excess Rainout (Efferent Tubing) Drained	✗	✗	✗	
Temperature Probe away from Heat / Cover with Aluminium Foil	✗	✗	✗	
Gas Bubbling Continuously	✓	✓	✓	
Water Level at Desired Level in Bubble Chamber.	✓	✓	✓	
INTERFACE:				
Nasal Prong / Mask Correct Size	✓	✓	✓	
Nasal Prong/ Mask Correctly Placed	✓	✓	✓	
Hat Fits Snugly	✓	✓	✓	
Moustache Suitable and Effective	✓	✓	✓	
Nasal Bridge Intact	✓	✓	✓	
Septum Intact	✓	✓	✓	
POSITION:				
Head Position Correct	✓	✓	✓	
Head Roll - Correct Size and Position	✓	✓	✓	
MONITORING/ SUCTIONING				
SpO ₂ Probe Monitoring	✓	✓	✓	
Oro Nasal Suctioning Documentation	✓	✓	✓	
OG Tube in SITU	✓	✓	✓	
Baby Comfortable	✓	✓	✓	
Chest Retractions	✓	✓	✓	
Name of the Nurse:	Prasanna	Divya	Sangeetha	
Signature of the Nurse:	[Signature]	[Signature]	[Signature]	
Date & Time:	21/7	21/7/26	21/7/26	

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



2

CHECKLIST FOR MAINTAINING CPAP / HFNC / NIV

Date: 22/4/26

	CRITERIA MET / NOT MET ☐ Yes ☐ No			Comments by Duty Registrar
	Morning	Evening	Night	
CIRCUIT and BUBBLER:				
Blended Air / Oxygen Gas Supply	✓	✓	✓	
Flow Between 5-7 Litres / Min	✓	✓	✓	
Humidifier Temperature Correct (36.5-37.5°C)	✓	✓	✓	
Humidifier Water Level Correct	✓	✓	✓	
Proper Oxygen Tubing From Blender to Humidifier.	✓	✓	✓	
Tubing Correctly Placed (Position & Leak)	✗	✓	✓	
Excess Fainout (Afferent Tubing) Drained	✗	✗	✗	
Excess Rainout (Efferent Tubing) Drained	✗	✗	✗	
Temperature Probe away from Heat / Cover with Aluminium Foil	✓	✗	✗	
Gas Bubbling Continuously	✗	✓	✓	
Water Level at Desired Level in Bubble Chamber.	✓	✓	✓	
INTERFACE:				
Nasal Prong / Mask Correct Size	✓	✓	✓	
Nasal Prong/ Mask Correctly Placed	✓	✓	✓	
Hat Fits Snugly	✓	✓	✓	
Moustache Suitable and Effective	✓	✓	✓	
Nasal Bridge Intact	✓	✓	✓	
Septum Intact	✓	✓	✓	
POSITION:				
Head Position Correct	✓	✓	✓	
Head Roll - Correct Size and Position	✓	✓	✓	
MONITORING/ SUCTIONING				
SpO ₂ Probe Monitoring	✓	✓	✓	
Oro Nasal Suctioning Documentation	✓	✓	✓	
OG Tube in SITU	✓	✓	✓	
Baby Comfortable	✓	✓	✓	
Chest Retractions	✓	✓	✓	
Name of the Nurse:	Shweta	Shweta	Shweta	
Signature of the Nurse:	[Signature]	[Signature]	[Signature]	
Date & Time:	22/4/26	22/4/26	22/4/26	

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



CHECKLIST FOR MAINTAINING CPAP / HFNC / NIV

Date: 23/7/26

	CRITERIA MET / NOT MET ☐ Yes ☐ No			Comments by Duty Registrar
	Morning	Evening	Night	
CIRCUIT and BUBBLER:				
Blended Air / Oxygen Gas Supply	✓	✓	✓	
Flow Between 5-7 Litres / Min	✓	✓	✓	
Humidifier Temperature Correct (36.5-37.5°C)	✓	✓	✓	
Humidifier Water Level Correct	✓	✓	✓	
Proper Oxygen Tubing From Blender to Humidifier.	✓	✓	✓	
Tubing Correctly Placed (Position & Leak)	✗	✓	✓	
Excess Fainout (Afferent Tubing) Drained	✗	✗	✗	
Excess Rainout (Efferent Tubing) Drained	✗	✗	✗	
Temperature Probe away from Heat / Cover with Aluminium Foil	✓	✗	✗	
Gas Bubbling Continuously	✗	✓	✓	
Water Level at Desired Level in Bubble Chamber.	✓	✓	✓	
INTERFACE:				
Nasal Prong / Mask Correct Size	✓	✓	✓	
Nasal Prong/ Mask Correctly Placed	✓	✓	✓	
Hat Fits Snugly	✓	✓	✓	
Moustache Suitable and Effective	✓	✓	✓	
Nasal Bridge Intact	✓	✓	✓	
Septum Intact	✓	✓	✓	
POSITION:				
Head Position Correct	✓	✓	✓	
Head Roll - Correct Size and Position	✓	✓	✓	
MONITORING/ SUCTIONING				
SpO ₂ Probe Monitoring	✓	✓	✓	
Oro Nasal Suctioning Documentation	✓	✓	✓	
OG Tube in SITU	✓	✓	✓	
Baby Comfortable	✓	✓	✓	
Chest Retractions	✓	✓	✓	
Name of the Nurse:	Anuradha	Dhanu	Sapna	
Signature of the Nurse:	[Signature]	[Signature]	[Signature]	
Date & Time:	24/7/26	24/7/26	24/7/26	

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

HNH-00016698 IP26-00006896
Baby Of SINDHUJA M
20-07-2026 0 Y 0 M 4 D (M)
Dr. SPANDANA PASUPULETI



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

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

PATIENT TRANSFER FORM

Patient Name & UHID No. B/o Sindhuja	20/7/26 @ 12:42 pm	Date & Time of Transfer Order 20/7/26 @ 12:42 pm
Treating Consultant Name Dr. Spandana	Transfer Ordered by Dr. Sreeghan	Reason for Transfer ① NIV
From Unit OT	To Unit NICU	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File ②	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 Karuna	Name of Person Ordered Transfer Dr. Sreeghan	
Patient & Clinical Records Received by : pooja 20/7/26 @ 12:40 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

HNH-00016698 IP26-00006896
Baby Of SINDHUJA M
20-07-2026 0 Y 0 M 0 D 1 H (M)
Dr. SPANDANA PASUPULETI



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.

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

CIN: U85110 TG1998 PTC029914

email : info@rainbowhospitals.in

www.rainbowhospitals.in



GENERAL CONSENT FOR TREATMENT

Patient Name: Baby Of SINDHUJA M Age : 0 Y 0 M 0 D 0 H
IP No: IP26-00006896 Sex: Male
Consultant: Dr. SPANDANA PASUPULETI 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 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:

Name: P. Pradeep

Relationship: father

Date: 20/7/26

Witness Name: monalisa

Witness Signature:

Time: 13:05

Patient Address:

RTC x roads RTC X Road Hyderabad
Telangana INDIA 500020