

DISCHARGE SUMMARY

Name	Baby Of CHANDANA GURAPPU	UHID	HNH-00015575
Father/Guardian	Mr SRINANDAN MOTURI	Age/Gender	0 Y 0 M 6 D/ Female
Address	HIG,BLOCK-6,FLAT-15,Baghlingampally,HYDERABAD, Bagh Lingampally, Hyderabad, Telangana, INDIA, 500044		
IP No	IP26-00006444	Admission Date	28-05-2026
Ref Doctor	Self.		
Discharge Date	29.05.2026		

Consultant:

Dr. SPANDANA PASUPULETI
MBBS, MRCPCH
30925

DIAGNOSIS	ICD CODE
LPT(35+1 weeks)/AGA/ NEONATAL HYPERBILIRUBINEMIA	

History: Baby Of CHANDANA GURAPPU is a 0 Y 0 M 6 D old baby girl presented with history of yellowish discolouration of skin and eyes since 2 days prior to admission. For the above complaints, she was investigated on OPD basis (Transcutaneous bilirubin was 16.3 mg/dl). In view of hyperbilirubinemia, she was admitted to Rainbow Children's Hospital, Himayatnagar for further

Name	Baby Of CHANDANA GURAPPU	UHID	HNH-00015575
IP No	IP26-00006444	Admission Date	28-05-2026

management.

Birth history: Baby Of CHANDANA GURAPPU is a late preterm (35 weeks + 1 day) baby girl, delivered to a G2A1 mother by elective LSCS on 23.05.2026 at 09:39 am with birth weight of 2.640 kgs in Rainbow Children's Hospital, Himayatnagar Hyderabad. Baby cried immediately after birth. Apgar scores were 8/10 at 1 min, 9/10 at 5 min. Inj. Vitamin K 1mg IM was given after delivery. Delayed cord clamping done. Fetal presentation was Vertex.

Examination: She was euthermic, euvolemic & maintaining saturations at room air. Heart Rate- 132/min and Respiratory Rate - 38 /min. Icterus was present extending to B/L thighs. Chest was clear with normal heart sounds. Abdomen was soft without organomegaly. Cry, tone, activity and newborn reflexes were normal. There were no obvious external congenital anomalies.

Weight on admission : 2.33 kilo grams.

Weight at discharge : 2.340 kilo grams.

Investigations: Enclosed.

Initial hemogram showed Hemoglobin of 17 gm%, White Blood Cell count of 12900 cells/cumm, platelet count of 2.39 lakhs/cumm

Management: She was admitted in ward. Her transcutaneous bilirubin on admission at Day 5 of life (done on OP basis) was 16.3 mg/dl . She was started on double surface phototherapy. Baby was continued on demand breast feeds + measured feeds. Her last serum bilirubin on 6 days of life was 9.3 mg/dl with indirect fraction of 9.2 mg/dl. This does not come under phototherapy range, hence phototherapy stopped.

Name	Baby Of CHANDANA GURAPPU	UHID	HNH-00015575
IP No	IP26-00006444	Admission Date	28-05-2026

Baby remained hemodynamically stable and is being discharged with the following advice.

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

At the time of discharge : Baby was active, afebrile, hemodynamically stable, maintaining temperature, accepting & tolerating feeds well.

Advice:

- Keep the baby clean & warm
- Exclusive breast feeding
- Continue direct breast feeds + measured feeds as advised.
- Monitor urine output.
- Immunization as per schedule
- Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice.
- Nasoclear Nasal drops 2 drops in each nostril SOS for nose block.

Plan:

1. **TEOAE (Transient Evoked Otoacoustic Emissions): Hearing test:** To be done on follow up.
2. **Serum bilirubin to be done / decided on followup.**

Review consultation with Dr. SPANDANA PASUPULETI on Monday (01.06.2026) in OPD 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.

Name	Baby Of CHANDANA GURAPPU	UHID	HNH-00015575
IP No	IP26-00006444	Admission Date	28-05-2026

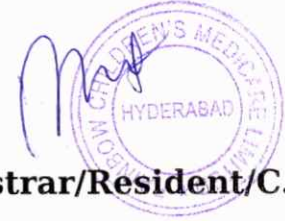
The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact number 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
30925

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006444 Admit Date : 28-May-2026 Admit Time : 12:58 PM UHID : HNH-00015575

Patient Details :

Patient Name : Baby Of CHANDANA GURAPPU Age : 0 Y 0 M 5 D
Guardian : Mr SRINANDAN MOTURI DOB : 23-05-2026 09:39 AM
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : HIG,BLOCK-6,FLAT-15,Baghlingampally,
HYDERABAD Bagh Lingampally Hyderabad
Telangana INDIA 500044 Phone No : 8367006955/ 8367006955
E-mail : srinandan594@gmail.com

Admission Details :

Bed Type : DAY CARE Bed No : ER01 Ward Name : GF -EMERGENCY
Room No : ER01 Admission Type : First Visit

Contact Details :

Name : Mr SRINANDAN MOTURI Relationship : Father
Contact Address : Phone No : 8367006955

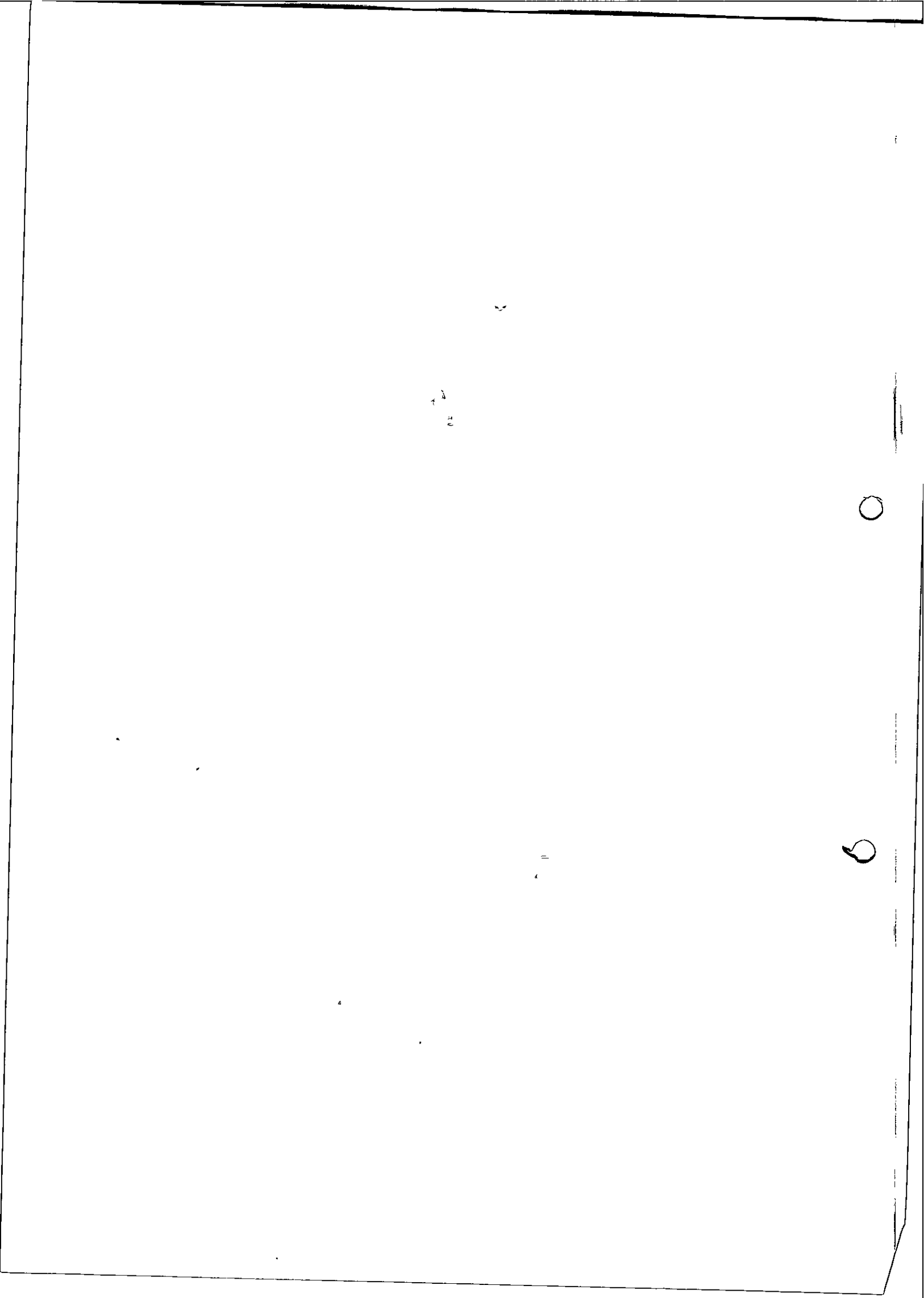

Signature

Doctor Details :


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

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 10000.00
Payor Name : VIDAL HEALTH INSURANCE TPA PVT LTD



ACTIVITY RECORD FOR BILLING

Name: --- HNH-00015575 IP26-00006444
 Baby Of CHANDANA GURAPPU
 UHID No: 23-05-2026 0 Y 0 M 5 D (F) ----- Consultant : ----- Dept : -----
 Dr. SPANDANA PASUPELETI
 Date of Adm:  e : ----- Date of Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/5/26	1:10 Pm	ER	305	A.R. 18 ✓

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
29/5	CBP, SBR. <	✓ 8982	[Signature]

Ref.No. F/IN/PR/10



**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

Patient Name : B/o Chandana

Patient ID# : HNH-00015575 IP26-00006444

Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 5 D (F)
Dr. SPANDANA PASUPULETI

Consultant : _____



Final Diagnosis : _____

Pediatric Multiorgan History & Physical Examination

Name : B/o Chandana Age/Sex sd / P

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

c/o Yellowish discoloration of eye & skin :: 2 days

History of present illness :

Baby brought with

c/o Yellowish discoloration of eyes & skin :: 2 days

Accepting feeds (DBK + FF)

Passing Urine & Stool

TcBil - 16.3 on DOL - 5

BT - WT - 2.64 kg

T - WT - 2.33 kg

WT loss - 11.7% :: birth

MBG / O+

BBG / A+

Pediatric Multiorgan History & Physical Examination

Anthropometry

Head Circum (cms) _____ (Centile _____) Height (cm) : _____ (Centile _____)

Weight (kgs) 2-33 kg (Centile _____)

On Examination :

Temperature : 98°1 Pulse Rate: 132/min Description _____

B.P. _____ SPO2 98% at _____

Resp. rate and type of breathing : _____

Rash _____ Itchy ⊕

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : _____ B/LA ⊕

Any addes sounds : _____

Relevant data from outside (Chest X-Ray, ABG, etc..) _____

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : _____ L, S, ⊕

Any murmur : _____

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc..) _____

Per Abdomen :

Inspection _____

Palpation : _____ soft

Ausculation : _____

Spine: _____ External Genitelia : _____

Relevant data from outside (CT, USG etc..) _____

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

Desired goals of the treatment :

Planned Labs :

Planned Management :

CBP } T/m 6Am
SBR }

NB JYU2'

→ PSPT E eyes & growth cones
→ DBF J/6 Burpin } 2p
+ F.F

→ Warm care
Mouth Vitah

→ CBP } T/m
SBR }

NB JYU2'

Please fill up the following details

1. Name of the Referring Doctor : _____
2. Name of the Referring Hospital : _____
(Including the name of City)
3. Contact number of the Referring Doctor : _____
(Preferring Mobile #)
4. Name of the doctor in Rainbow Team Dr. Spandan _____ on
whose name the patient is being referred

Doctor's Signature Name _____ Date 28/5 Time _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26	CLSB Dr. Varun / Dr. Bharav.	
2:30PM.	Dis - Late PT (35+1)	ASA / MNH.
	<ul style="list-style-type: none"> - Baby is eutermic. - G.D.P.P. - Cong - Tone - Activity 	Plan - Home care. - DSF + PF addis. Repeat - - CBP, SBR tomorrow @ 6am.
	Good.	
	S/E - vitals stable.	
	S/E - walk.	
		NB - Supriya 2:40 PM @ 28/5/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26 6:30pm	c/ly by Dr Tejawwi	
	Baby Seethi c on aspt	/ aspt aspt
	vital stable	/ DBP DBP only Ab bumping
	s/e NAD	/ (6Am) - CBP SBR
		/ with o/s
		Noted by Divya Dr Tejan 28/5/26 @ 6:30pm
	Dr. S. TEJASWI REDDY Registration No: 94068	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5 7:00 AM	<p>clsbs 100. Naipueya</p> <p>LPT AGA NNH</p>	<p>Dr. Alekya</p> <p>Plan</p>
	<p>on DSPT Euthemic. vitals - stable.</p> <p>R/S + NAID PLA</p>	<p>- Cont DSPT</p> <p>- (1) SBR, CBP.</p> <p>- DBF + FF @ 2H for bumping.</p> <p>- monitor vitals</p> <p><i>[Signature]</i></p>
29/5/26 11 AM	<p>S/B Dr. Tejaswi take pre-ANA/NNH</p> <p>Repeat SBR-9.3</p> <p>Euthemic</p> <p>CVT - S/S @</p> <p>M - BU - ACR @</p> <p>PLA take</p> <p>(Tejaswi)</p>	<p>Plan</p> <p>- Discharge</p> <p>- Fly on Monday</p> <p><i>[Signature]</i></p> <p>Dr. S. TEJASWI REDDY Registration No. 14068</p>

HNH-00015575 IP26-00008444
 Baby Of CHANDANA GURAPPU
 23-05-2026 0 Y 0 M 6 D (F)
 Dr. SPANDANA PASUPULETTI



DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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



REGULAR PRESCRIPTIONS

Weight. 2.3 kg Ward.

DRUG : VITAMIN - D3 Drop				Date																
				Time	08/5															
Dose	Route	Frequency	Start Date																	
0.5ml	PO	OD	28/5																	
Name & Signature of the Doctor Starting the Drugs: <i>Pranav</i>																				
Additional Instructions: <i>1ml = 800 IU</i>																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date																
				Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date																
				Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date																
				Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

305



RESULT SHEET



Date	29/5/26				
Time					
Hb	17.0				
PCV	46.4				
RBC	4.83				
WBC	12.90				
N/L	37.6/48.6				
Platelets	239				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein/Sugar					
Cells					
N/L					

MNH-00015575 IP26-00006444
 Baby Of CHANDANA GURAPPU
 23-05-2026 0 Y 0 M 5 D (F)
 Dr. SPANDANA PASUPULETI

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

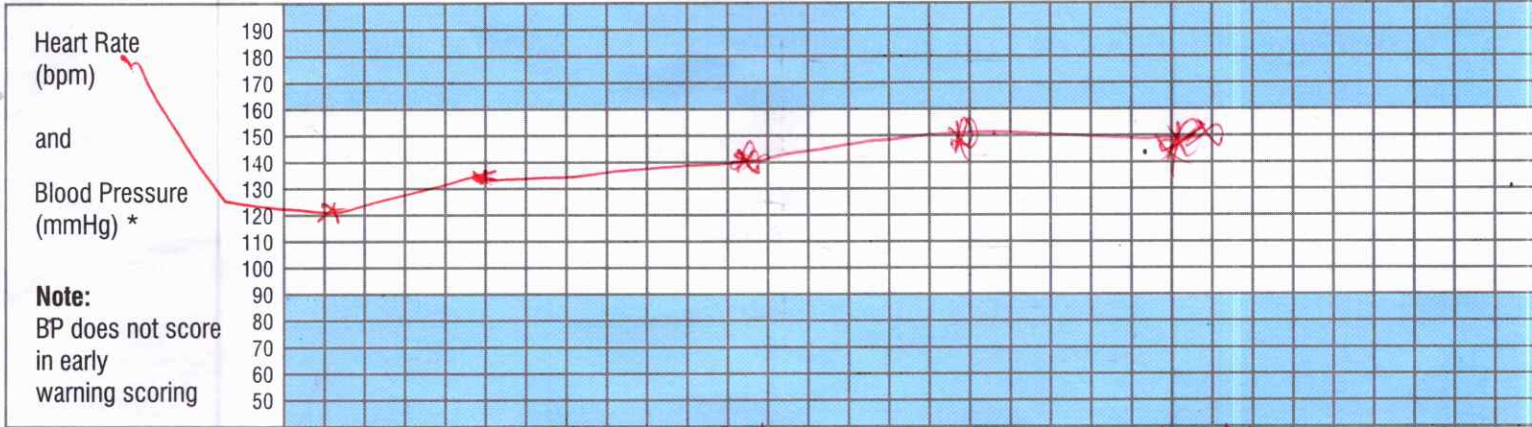
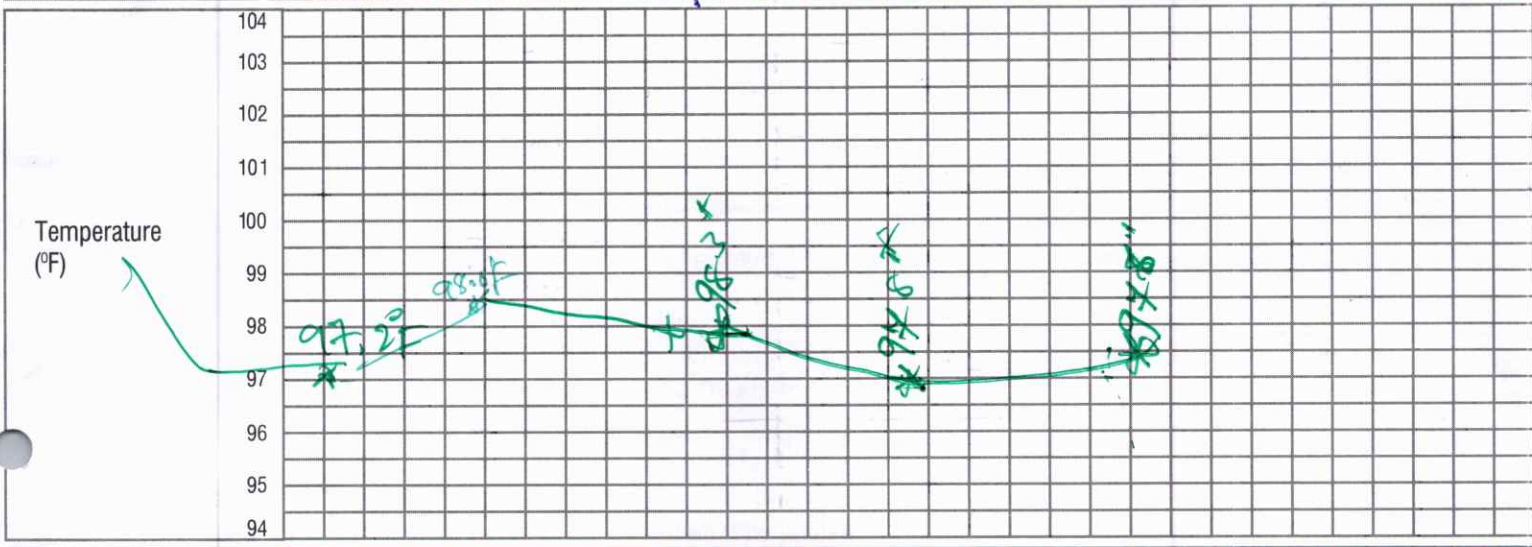


Patient Stick

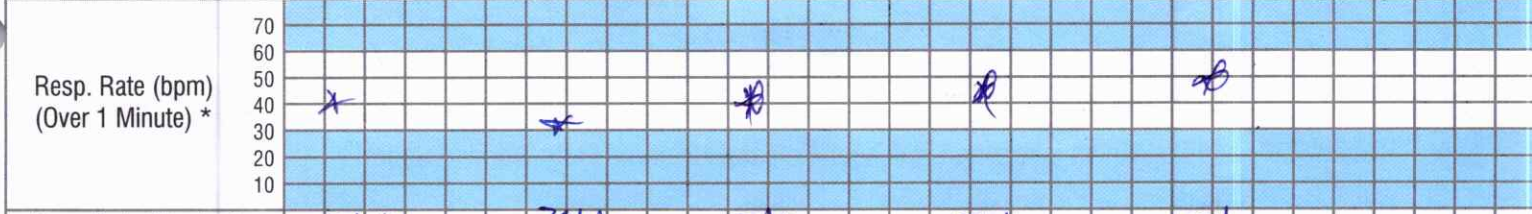


WARNING SCORE: CHILDREN'S UNIT

Date: Time: 1:30 PM 6 PM 10 PM 2 AM 6 AM
 Doctor/Nurse/Family Concern? PM PM AM AM



Heart Rate (Number) 121b/m 135b/m 145b/m 140b/m 139b/m



Resp Rate (Number) 38b/m 30b/m 30b/m 30b/m 30b/m

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 0.9% 100% 100% 100% 100%

Conscious Level Normal / Altered

GCS *

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

ACTIONS
 NB: Scores 3 should be recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

HNH-00015575 IP26-00006444
 Baby Of CHANDANA GURAPPU
 23-05-2026 0 Y 0 M 5 D (F)
 Dr. SPANDANA PASUPULETI

Patient Sticker



FLUID CHART

Sheet No. : 2.....

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
28/5/26	08:00 am											
	09:00 am											
	10:00 am	0										
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :						Total Output :					
28/5/26	02:00 pm											
	03:00 pm		DBF									
	04:00 pm									0	⊙	
	05:00 pm		DBF									
	06:00 pm											
	07:00 pm		DBF									
Total Intake :						Total Output :						
28/5/26	08:00 pm		DBF									
	09:00 pm		DBF									
	10:00 pm											
	11:00 pm											
	12:00 am		DBF									
	01:00 am											
Total Intake :						Total Output :						
29/5/26	02:00 am		DBF									
	03:00 am											
	04:00 am		DBF									
	05:00 am											
	06:00 am		DBF									
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00015575 IP28-0006444
 Baby Of CHANDANA GURAPPU
 23-05-2026 0 Y 0 M 5 D (F)
 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 :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00015575 IP26-00006444
 Baby Of CHANDANA GURAPPU
 23-05-2026 0 Y 0 M 5 D (F)
 Dr. SPANDANA PASUPULETI



NURSING CARE RECORD



Date: 28/5/20

- 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	1:30 pm to 2 pm	→ To assess the baby condition → To check the vitals → 2nd hourly DBF	1 pm to 2 pm	→ To assessed the condition → checked vitals → 2nd hourly DBF → I/O chart maintain	→ Baby is stable → Contd DSPT	→ Re-checked the vitals → I/O → T/M SBR, CBP	<i>[Signature]</i>
Afternoon	2 pm to 8 pm	→ To assess the baby condition → monitor vitals → maintain I/O chart → DBF + ff 2nd hourly → CT DSPT	2 pm to 8 pm	→ assessed the baby condition → monitored vitals → maintained I/O chart → DBF + ff 2nd hourly	→ baby is stable → continue DSPT → repeat CBP, SBR. → IM 6am	→ rechecked vitals	<i>[Signature]</i>
Night	2 pm to 8 pm	Assess the baby condition monitor vitals Maintain I/O chart DBF + ff 2nd hourly ct DSPT	2 pm to 8 pm	assessed the baby condition monitored vitals Maintained I/O chart DBF + ff 2nd hourly	→ baby is stable - continue DSPT	Re-checked vitals	<i>[Signature]</i>

IP28-00018575 IP28-00008444
 Baby Of CHANDANA GURAPPU
 23-06-2026 0 Y 0 M 6 D (F)
 Dr. SPANDANA PASUPULETI



NURSING CARE RECORD



Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: NNJ		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date	28/5/26 M6	28/5/26 E2	29/5/26 N1			
	Shift						
	Medical Condition (Any special condition to be noted):	-	-	-			
ASSESSMENT	Diet:	DBF+FF	DBF+FF	DBF+FF			
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	-	-	-			
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	98.1°F	97.9°F	98.3°		
		Res:	42	20b/m	40b/m		
		SpO ₂ :	99%	100%	100%		
		Pulse:	142b/m	138b/m	139b/m		
		BP:	-	-	-		
		LOC:	-	-	-		
Fall Risk Score:	-	-	-				
Pain Score:	"0"	"0"	0				
Skin Integrity	Good	good	good				
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-	-	-			
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	DBF-	DBF	DBF			
	Critical Lab Test / Values:	-	-	-			
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADL (Dependent / Non Dependent):	-	-	-				
Post Operative Procedure Special Orders:	T/M Cam SBR, LBP	T/M Cam SBR, LBP	T/M Cam SBR, LBP				
Handed Over By Name :	Sujaya	Divya	Madhuri				
Signature / ID :	[Signature]	[Signature]	[Signature]				
Date:	28/5/26	28/5/26					
Time:	2pm	8pm					
Taken Over By Name :	Divya	Madhuri					
Signature / ID :	[Signature]	[Signature]					
Date:	28/5/26	28/5/26					
Time:	2pm	8pm					

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date	Shift					
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:		Temp:				
			Res:				
			SpO ₂ :				
			Pulse:				
			BP:				
			LOC:				
			Fall Risk Score:				
		Pain Score:					
		Skin Integrity					
Recommendations	Safety Needs:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:						
	Others Specify:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
PU Prophylaxis:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:							

HNH-00015575 IP26-00006444
 Baby Of CHANDANA GURAPPU
 23-05-2026 0 Y 0 M 5 D (F)
 Dr. SPANDANA PASUPULETI



MEDICATION RECONCILIATION FORM

Drug Allergies: no Not known any Drug Allergies

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

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

Shifting From: ER Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Pranam


Date & Time : 28/5/26 @ 12:50 P.M.

Nurse Name & Signature: Amfiam

Date & Time : 28/5/26 @ 12:48 P.M.

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

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015575 IP26-00006444 Baby Of CHANDANA GURAPPU 23-05-2026 0 Y 0 M 5 D (F) Dr. SPANDANA PASUPULETI 		Date & Time of Admission 28/5/26 @	Date & Time of Transfer Order 28/5/26 @ 1:20 p
		Transfer Ordered by Dr. Prasar	Reason for Transfer Admission
From Unit ER	To Unit 305	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Anupam		Name of Person Ordered Transfer Dr Prasar	
Patient & Clinical Records Received by : Supriya			
Date & Time of Patient Received : 1:26pm @ 28/5/26			

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



wt - 2.33 kg



EMERGENCY ROOM TRIAGE FORM

Patient's Name : B.O Chandana Gurappu Age : 5 days Gender: Male Female

Date : 28/5/26 Time of Arrival : 12:50pm

Allergies: No Yes Food Medications Blood Transfusion Other (Specify): Not known

Source of Information : Parents Others (Specify)

Mode of Arrival : Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 98°F PR: 143b/m BP: RR: SpO₂: 100%

Chief Complaints: No yellow discoloration of skin

INITIAL PHYSIOLOGICAL CATEGORIZATION Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea		INITIAL PHYSIOLOGICAL STATUS <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life - Threatening
---	--	---	--	--

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient	<input type="checkbox"/> 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
 All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 12:50pm

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks Yes No
- Have you had cough or a rash in the past 2 weeks Yes No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks Yes No

PART B. For patients reporting fever and respiratory/rash symptoms: Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? Yes No
 If yes, State Location:
- Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? Yes No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- The patient should be given a surgical mask immediately, if not already wearing one.
- Both patient and triage staff should perform hand hygiene.
- The staff should use PPE (as appropriate).

Name of Triage Nurse : Amritha

Signature of Triage Nurse : [Signature]

Date & Time : 28/5/26 @ 1:00pm

1 2 3 4 5

6 7 8 9 10



11 12 13 14



15

16 17 18 19 20



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 28/5/26 Time of arrival : 12:50 PM

Chief Complaints: no yellow discoloration of skin RBS:

Height : Weight : 8.35kg BMI : Head Circumference (<2 years)

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes , identify

Pain Screening: Yes No If Yes, Pain Score: Pain Tool Used: N Pass FLACC Wong Baker

Character Location Frequency Duration

RISK FOR FALL:

If patient is < 6 years
 tick below fall risk intervention directly

If Patient is > 6 years
 Assess the below parameters

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

- Bedrest / immobile Yes No
- Weak Yes No
- Impaired Yes No

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- Escort while ambulating
- Assist Patient
- Educate patient and family on fall precautions/prevention

Functional Screening: No Abnormalities Detected

- Mobility Problem
- Walking Problem
- Developmental Delay
- Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

.....

.....

Nutritional Screening: No Abnormalities Detected

- Underweight
- Overweight
- Feeding Problem
- Special diet
- Special feeding method

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: (Date/Time):

Social History: Lives With family

Siblings in household Yes No (if yes How Many?)

Time of Initial assessment completed by ER Nurse : 1 Pm

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
	Assessed the patient condition vital checked.

Samples collected by:

Time:

Samples sent by:

Time:

N/A

N/A

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
	/				

Condition of patient at time of shift - out :	Details of Shift - out
HR: <u>146</u> BP: <u>-</u> CFT: <u>-</u> RR: <u>81</u> SPO ₂ : <u>100%</u> GCS: <u>-</u> Temperature: <u>98.3F</u> Pain Score: <u>0</u> Repeat RBS (if applicable):	Shift - out from ER to: Time of Shift - out: Handover given to: (Nurse's Name)

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):

N/A

Name of the Nurse : Ampin

Signature of the Nurse : A.K

Date & Time : 28/6/26 @ 1:pm