GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0 Y 0 M 2 D (F)
Dr. GIRIDHAR S

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

RID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIMATE	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		22/7/26 6 AM					
Activity Sheet update by Pharmacy							

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ACTIVITY RECORD FOR BILLING

Name: B/O VARSHITHAA

UHID No: 94070 IP No: 36533 Consultant: DR. GIRIDHAR Dept: LDR

Date of Admission: 20/7/26 Time: ..... Date of Discharge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7/26	1.05pm	LDR	7TH FLOOR	

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
20/7/26	Blood Grouping	26023304	
	RBS	26023308	
22/7/26	NBS, Qt bilu	26023525	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/7/21	ODE	(1)	1331097	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 22/7/21 Time: 6 AM Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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DISCHARGE TRACKING SHEET

UHID GUC-00094070 IP18-00036538 DR- NAME OF CONSULTANT-

Baby B/O VARSHITHAA S
20-07-2026 0 Y 0 M 2 D (F)
Dr. GIRIDHAR S

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	22/7/26 at 10AM				
	INTIME	OUT TIME			
Arrangement of File by Nursing		22/7/26 at 10AM	Sri 607373		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

22/7/26

T.wt - 2.376 K
H - 32 cm
L - 48 cm

Lactch Scan. 8

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Pat

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
20/7/26	11.30 Am	72mg/dl ✓ stop	Dr Srilakshmi	[illegible]

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Rainbow Children's Hospital - Guindy

Door No.157 to 160, Anna Salai, Guindy, Guindy ,Chennai ,Tamil Nadu, INDIA ,600015.
TEL NO :044-40122444
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP18-00036538 **Admit Date** : 20-Jul-2026 **Admit Time** : 08:40 AM **UHID** : GUC-00094070

Patient Details :

Patient Name	: Baby B/O VARSHITHAA S	**Age**	: 0 D
Guardian	: Mr SUMESH S	**DOB**	: 20-07-2026 07:35 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: NO 8 BASHYAM LAYOUT, GANESH NAGAR Adambakkam Chennai Tamil Nadu INDIA 110005	**Phone No**	: 8438957521
		E-mail	: varshitaa16@gmail.com

Admission Details :

Bed Type : BASINET **Bed No** : CRDL-PVT704-1 **Ward Name** : 7F-PVT/SUITE

Room No : CRDL-PVT704-1 **Admission Type** : First Visit

Contact Details :

Name : Mr SUMESH S **Relationship** : Father

Contact Address : NO 8 BASHYAM LAYOUT, GANESH NAGAR Adambakkam Chennai Tamil Nadu INDIA 110005 **Phone No** : 9600534238

Signature

Doctor Details :

Doctor Name : Dr. GIRIDHAR S **Specialisation** : NEONATOLOGY

Referral Doctor : Dr. Mathangi Rajagopalan **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : SELFPAY

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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby B/O VARSHITHAA S**	**Age :**	**0 Y 0 M 0 D 1 H**
IP No:	**IP18-00036538**	**Sex:**	**Female**
Consultant:	**Dr. GIRIDHAR S**	**Ward/Bed No:**	**7F-PVT/SUITE/CRDL-PVT704-1**

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: Mr. Sumesh
Relationship: father
Date: 20/07/26 Time: 05:40 Am
Wittness Name: A. Sivasankari
Wittness Signature: A.

Patient Address:
NO 8 BASHYAM LAYOUT, GANESH NAGAR Adambakkam Chennai Tamil Nadu INDIA 110005

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BILLING POLICY

- Billing Cycle: - Bed charges will be calculated based on 12PM to 12PM checkout. Settlement post 12PM, room rent will be charged for half day extra & post 6PM, it will be charged for full day. Less than 24 hours stay will be considered as one day.
- Room Rent inclusive of Bed, Nursing, Consultation Charges and all other charges, like Diet, Investigations, IP or OP Procedures, Equipment, Cross Consultations, Blood/ Blood Products, Implants, Ward Consumables, Infection Preventive Measure Charges, Pharmacy and Consumables will be charged extra.
- 5% GST Charges applicable on more than INR 5,000/- Bed Charges which was effective from 18.07.2022 as per the GST Council.
- As per the G.O.I. guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Credit Card/ Debit Card/ NEFT / RTGS / Demand Draft and Online Payment.
- In 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 / Corporate won't 9eapplicable.
- If the Surgery/ Procedures performed in emergency hours (8PM-6AM), Public Holiday and on Sunday will be charged 30% extra.
- Asst. Surgeon and Anesthetist Charges will be charged 30% on the Surgeon Charges.
- Admission will be done according to the ward category chosen by the patient; charges will be applicable as per the ward category. All charges vary as per Room category, except Pharmacy and consumables.
- Patient / Guardian Self Attested Government ID proof is mandatory to submit at the admission.
- TPA/Insurance Processing Fee applicable for all Insurance Cases.
- In our hospital there is "No Discounts Policy". Kindly co-operate.
- No Duplicate/ Second copy of OP or IP bill will be issued.
- In case the patient is shifted from lower category to higher category, all the charges like consultant visits, investigations, operations and procedures etc. from the date of admission will be charged according to the higher category.
- If the patient is shifted to the ICU, the attendant should vacate the room. If the attender occupies the room, it will be charged as per dual occupancy.
- Room eligibility is purely subject to TPA approval. Proportionate difference of the bill amount is applicable in case the patient opts for higher category higher than the TPA approved, which has to paid by the patient and may not be reimbursed by the TPA / Insurance Company at later stage.
- For Non - Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/ HbsAg, Medical Records, Insurance Processing Fee, Double Occupancy and Registration Charges, Etc., credit cannot be extended. These items are not payable to us as per insurance company norms (Depends on the TPA/Insurance Co. T&C).
- It takes time for cash discharge is a minimum 3-4hrs. and in the case of insurance, it will take a minimum 6-7hrs.
- Difference, if any between the final bill amount arid amount permitted / approved by the TPA or total bill amount in case of denial from TPA, has to be paid by the patient.
- Two attendants are permitted with patients in Deluxe, Private Rooms and only one is permitted in the rest of the categories of rooms. No attendant is permitted in ICU's.
- All the refunds more than Rs.5,000/- will be refunded through NEFT within 7 Bank working days.
- 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 enquire daily about the bill amount from billing section and pay the outstanding as on that day. You are requested to clear your outstanding amount on daily basis before 12 PM. **Patient bill outstanding should not be increase more than 10,000/-**

DECLARATION

I have attended the Financial Counselling desk & understood the expected costs & other conditions applicable. In this case, the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge. I promise to settle the claim with the hospital as per Hospital Cash Tariff.

Patient Name : B/o Varshitha	UHID Number : Guc-0009407o
Self/Attendant Name :	Relation : father
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor A. Ru

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Patient

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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : MRS. VARSHITHAA Age : 30y Father's Name : SUMESH Age : .....

Date of Birth : ..... Date of Admission : ..... UHID No.: .....

NICU Consultant : Dr GIRIDHAR Referring Consultant : .....

Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward

Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : B/O VARSHITHAA.

Gender : ☐ M ☒ F Blood Group : T.3 5 AM

Date of Birth : 20/7/26 Time of Birth : .....

Place of Birth : .....

Mother's Blood Group : O+ve.

Birth Weight (gms) : 2.541 kg. Length (cms) : .....

OFC (cms) : .....

Estimated Gesth Age : 38+5

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : ..... Ht : ..... Wt : ..... BMI : ..... Married Life : ..... LMP : 21/10/25 EDD : 28/7/26.

Conception : Spontaneous or with Rx. : Spontaneous.

Booked at what GA. : ..... AN Steroids Drugs / Doses : .....

Last Scans Details : 4/7/26 - 36+4, cephalic, Placenta-Posterior. SDP-4.8, EFW-2323g. Doppler - (N).

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 Resistence / ADEF / REDF / Redistrbution in MCA) / Ductus Venosus : .....

AFI : .....

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

Controlled or not, recent values, HbA1 values : .....

.....

Compliance with Rx : .....

Scans : LGA, TIFFA , Fetal Echo : .....

H/o Hypothyriodism : when diagnosed ? Medication?

.....

Any other Chronic Medical Problems, when detected drugs ? .....

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

Infection : H/O. Fever

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

UTI : when ..... Any culture : .....

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

Medication during Pregnancy : ..... Duration : .....

Patient Sticker

PAST OBSTETRIC HISTORY

G: 2 P: 1 A: L: 1

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
41	2023	37w		Kiwi	2-5kg Girl	
42	PP	Spontaneous Conception.				

PERINATAL HISTORY

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

Duration of Labour

First stage (> 18 hours sig) NVD.

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication : .....

Specify the reason : .....

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL : .....

Resuscitaion : ☐ Yes ☐ No

Cord ABG : .....

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

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : ..... Weeks : .....

SIGN	0	1	2
COLOUR	Blue or Pale	Acrocyanotic	Completely Pink
HEART RATE	Absent	< 100 Minutes	> Minutes
REFLEX IRRITABILITY	No Response	Grimace	Cry or Active Withdrawal
MUSCLE TONE	Limp	Some Flexion	Active Motion
RESPIRATION	Absent	Weak Cry; Hypoventilation	Good, Crying

1 Minute	5 Minutes	10 Minutes
TOTAL 8/10	9/10	

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

Patient Sticker

History of Present Illness:

Baby cried immediately after birth

Pulse Activity, tone - good

HR > 150 bpm

SpO_2 - 97%

CRT < 3sec

APGAR - 8/10 @ 1min
9/10 @ 5min

INJ. VITK 0.1ml (1mg) IM stat given

Investigation details in previous Hospital :

—

Feeding History :

—

Patient Sticker

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

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

Color of the extremities : .....

Jaundice : ..... Pallor : ..... SpO2 : .....

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

Ponderal Index : ..... AGA : ..... SGA : ..... LGA : .....

Patient Sticker

HEAD TO TOE EXAMINATION

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

Facies :
(Any Facial Dysmorphism)

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

EYES :
Symmetry :
Red Reflex :
Discharge :

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

THORAX and BREASTS :
Shape of Thorax :
Position of Nipples and Number :

ABDOMEN and UMBILICUS :
Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump :
Discharge :

GENITILIA :
Labia / Hymen :
Testicles/penis :
Anus :

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

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

Patient Sticker

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☐ Regular ☐ Periodic ☐ Shallow ☐ Gasping

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

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

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

Settings : RA

Spo2 : 98% Auscultation : ..... Breath Sounds : ..... Added Sounds : .....

Cardiovascular System :

HR : 150bpm BP : .....

Femoral Pulses : +

Other Peripheral Pulses : +

Precordial Activity : -

Murmurs : .....

Signs of Cardiac Failure : .....

Abdomen : N

Shape : .....

Palpation : .....

Palpable masses : .....

Abdominal girth : .....

Hernia orifice : .....

Anal Patency : .....

Umbilical Cord : .....

First urine passed : .....

Meconium passed : .....

Nervous System : Higher intellectual functions (Sensorium) : .....

State of wakefulness : N

Prechtle Score : .....

Nerves : N

.....

.....

.....

Motor System :

Passive Tone : N

Active Tone : .....

Neonatal Reflexes : .....

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

Moro's : ..... DTR : .....

ATNR : ..... Skull and Spine : .....

Patient Sticker

Any Congenital Anomalies : NO

Diagnosis : Term (38+5) / Girl / 2.54 kg / well baby

FOOT PRINTS

Left Side :

Right Side :

Resident Doctor :

Signature : 137223

Name : Dr Praveen

Date & Time :

Consultant :

Signature : For 137223

Name :

Date & Time :

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :
2. Name of te 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.

Patient Sticker

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 :

.....

.....

.....

.....

.....

.....

Feeding Plan at the time of shifting : .....

.....

.....

Screenings done during NICU Stay :

NSG : .....

Hearing Screen : .....

ROP : .....

TFT : .....

NP2 : .....

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Patient S

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient

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STAT / ONCE ONLY DRUGS

Name: .....

Weight: 2.541 kgs

Sheet No: 1

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
20/7/26	7:40 PM	INJ. VIT- K	1mg	I.M		SN	DS
21/7/26	11:00AM	Inj. Hep-B	0.5ml	IM		P.V	S.M
21/7/26	11:00AM	Inj. BCG	0.05ml	ID		P.V	S.M
21/7/26	11:00AM	OPV drops	2 drops	Oral		P.V	S.M

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Patient St... HOPE/ FRM / CLINICAL / 124

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/7/26 Time:	8AM	12pm	4PM	8pm	12AM	4AM
Doctor/Nurse/Family Concern?						
Temperature (°F)	98F	98.6F	98.0°F	97.8F	98F	98.F
Heart Rate (bpm) and Blood Pressure (mmHg) *	150	140				
Heart Rate (Number)	150bt/m	140bpm	150bt/m	146bm	150bm	146bm
Resp. Rate (bpm) (Over 1 Minute) *	50					
Resp Rate (Number)	50bt/m	50bpm	40bm	38bm	36bm	30m
Resp Distress: Mod/ Severe						
Resp Distress: None / Mild	–	–	✓	✓	✓	✓
Receiving O_2 (l/min)			RA			
O_2 Saturations (%)	96%	99	98%	99% (RA)	98% (RA)	99% (RA)
Conscious Level: Normal	✓	✓	✓	✓	✓	✓
Conscious Level: Altered						
GCS *	15/15	15/15	AVPU	AVPU	AVPU	AVPU
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

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.

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0 Y 0 M 0 D 13 H (F)
Dr. GIRIDHAR S

0. : RCH/ FRM / CLINICAL / 124

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/7/26 Time: 8AM 12P 4PM 8PM 12AM 4AM

Doctor/Nurse/Family Concern?

Temperature (°F): 97.5F, 97.8F, 97.5F, 97.4F, 98.4F, 97.6F

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

Note: BP does not score in early warning scoring

Heart Rate (Number): 136bpm, 130bpm, 140bpm, 134, 144, 118

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

Resp Rate (Number): 40pm, 30bpm, 40pm, 44pm, 50pm, 52pm

Resp Distress	Mod/ Severe / None / Mild	✓	✓	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)		99% RA	98% RA	99+ RA	99% RA	99% RA	99% RA
Conscious Level	Normal / Altered						
GCS *		Alert	Alert	Alert	Alert	Alert	Alert
TOTAL SCORE Number of shaded boxes		0	0	0	0	0	0
Pain Score		0	0	0	0	0	0
Observer's Initials			PB				

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.

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0 Y 0 M 0 D 2 H (F)
Dr. GIRIDHAR S

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FLUID CHART

Sheet No. : 1

Rht · 2.400kg

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.

20/7/26		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am	DBF					✓				NOIV	
	09:00 am											
	10:00 am	DBF									NO	
	11:00 am						✓					
	12:00 pm										NO IV	
	01:00 pm											
Total Intake : DBF 2 times						Total Output : NO CONTENT PUSHED						
	02:00 pm									✓	NO	
	03:00 pm	DBF					✓					
	04:00 pm										IV	
	05:00 pm	DBF								✓		
	06:00 pm										line	
	07:00 pm	DBF					✓					
Total Intake : DBF 3 time						Total Output : 2 time						
	08:00 pm											
	09:00 pm	DBF									No	
	10:00 pm						✓			30ml	IV	
	11:00 pm	DBF									line	
	12:00 am											
	01:00 am	DBF										
Total Intake : 2 time DBF						Total Output : 30ml						
	02:00 am											
	03:00 am	DBF									No	
	04:00 am										IV	
	05:00 am	DBF								30ml		
	06:00 am										line	
	07:00 am	DBF										
Total Intake : 2 time DBF						Total Output : 30ml						

Total 24 hrs. Intake	11. time DBF	Total 24 hrs. Output	Urine - 4 MOTION - 5

RH	LH
SpO_2 - 100%	SpO_2 - 100%
P - 136bmin	P - 136bmin
RL	LL
SpO_2 - 99%	SpO_2 - 100%
P - 136bmin	P - 136bmin

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Baby B/O VARSHITHAA S
20-07-2026 0 Y 0 M 0 D 13 H (F)
Dr. GIRIDHAR S

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FLUID CHART

T.wt - 2.424 kg

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	Intake: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
21/7/26												
	08:00 am											
	09:00 am	DBF									NO	
	10:00 am									30ml		
	11:00 am	DBF									IV	
	12:00 pm											
	01:00 pm	DBF								30ml	Line	
Total Intake : 3 time of DBF						Total Output : 60ml						
	02:00 pm											
	03:00 pm	DBF									NO	
	04:00 pm											
	05:00 pm	DBF					✓			✓	IV	
	06:00 pm										line	
	07:00 pm	DBF										
Total Intake : 3 time						Total Output : 1 time						
	08:00 pm	DBF									NO	
	09:00 pm										IV	
	10:00 pm	DBF								20ml		
	11:00 pm						✓				line	
	12:00 am	DBF									NO	
	01:00 am									20ml	IV	
Total Intake : 3 time DBF						Total Output : 40ml						
	02:00 am	DBF									NO	
	03:00 am										IV	
	04:00 am	DBF									line	
	05:00 am										NO	
	06:00 am	DBF								20ml	IV	
	07:00 am											
Total Intake : 3 time DBF						Total Output : 20ml						

Total 24 hrs. Intake	12 time DBF	Total 24 hrs. Output	V - 6 M - 2

Patient Sticker

GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0 Y 0 M 0 D 2 H (F)
Dr. GIRIDHAR S

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Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: Newborn / Term

Any Infection: ☐ Yes ☐ No ☑ Not Known
If Yes Specify: ......NIL......

Surgery / Procedure:

Post OP Day: —

BACKGROUND Date / Shift	20/7/26 M	20/7/26 E	21/7/26 N	21/7 M	21/7 E	21/7 N
Medical Condition (Any special condition to be noted):		—	—	—	—	—
Diet:	DBF	DBF	DBF	DBF	DBF	DBF
ASSESSMENT Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Ventilation (RA, NP, NIV, VENTI):	NA	NA	NA	NA	NA	NA
Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Vital Signs: Temp:	98F	98.0F	97.8F	98.0F	98.6F	98.2F
Res:	50b/m	60b/m	48bpm	56b/m	42b/m	44b/m
SpO_2:	99%	98%	99%(RA)	99%	99%	99%
Pulse:	150bt/m	140b/m	148bm	136b/m	141b/m	144b/m
BP:	—	—	—	—	—	—
LOC:	Conscious	Conscious	Alert	Alert	Alert	Alert
Fall Risk Score:	14	14	14	14	14	14
Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10
Skin Integrity	Normal	Normal	Healthy	Healthy	Healthy	Healthy
Recommendations Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☑ No	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No
Physiotherapy:	NA	NA	NA		NA	NA
Others Specify:	☐ Yes ☑ No	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
Special Diet:	DBF	DBF	DBF		DBF	DBF
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):	Dependent	Dependent	Dependent	Dependent	Dependent	Dependent
Post Operative Procedure Special Orders:		—	—	[illegible]	—	—
Handed Over By Name :	S.N.[illegible]	Pooja	E. Sowmiya	Sreelf	Hari	[illegible]
Signature / ID :	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Date:	20/7/26	20/7/26	21/7/26	21/7/26	21/7	21/7
Time:		7.30pm	7.30am	2pm	7.30pm	2pm
Taken Over By Name :	P. Kanna[illegible] / Pooja	E. Sowmiya	Sreelf	Hari	[illegible]	
Signature / ID :	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
Date:	20/7/26	20/7/26	21/7/26	21/7/26	21/7/26	
Time:	1-30pm	7.30pm	8am	2pm	8pm	

GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0 Y 0 M 0 D 2 H (F)
Dr. GIRIDHAR S

NURSING CARE RECORD

Rainbow® Children's Hospital
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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 20/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	7.30 AM	Promote adequate nutrition	1.00 PM	* Assess feeding * Monitor vitals * Monitor weight * provide DBF	Maintained Good nutritional status to some extend	Reassessment done	20/7/26
Afternoon	2pm	Assess the baby monitor vitals maintain I/O	7pm	Assessed the baby condition monitored vitals maintained I/O	Encourage DBF	Reassessment done	20/7/26
Night	7.30pm	- Assess the baby Genera condition - provide warmth Care to baby	10pm	- Assessed the baby Genra condition - provided warmth Care to baby	Provided warmth Care to baby	Baby temperature maintained	

GUC-00094070 IP18-00036538
Baby S/O VARSHITHAA S
20-07-2026 0 Y 0 M 0 D 13 H (F)
Dr. GIRIDHAR S

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: 21/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	Assess the Baby condition provide DBF Q2Hrs.	1pm	Assessed the Baby condition Provided DBF Q2Hrly.	Encouraged mother DBF Q2Hrs.	Done.	Sup bg383
Afternoon	2pm	Assess the baby feeding position.		Improved baby nutritional support.	Evaluate the baby weight checking.	Re-assessment is done.	Ahm bg495
Night	8pm	Assess the baby feeding position.	2am	Improved baby Nutritional support	Evaluate the baby weight check	Re-assessed is done	Sup

Patient Stic

GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0Y0M0D2H (F)
Dr. GIRIDHAR S

(1)

SES NOTES

Rainbow® Children's Hospital
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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

☐ No Known Drug Allergies
☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7/26	7.35AM	Admission Notes (20/7/26)	
		B/o. Varshithaa / Newborn / Girl	
		Baby delivered by mode of	
		Normal vaginal Delivery.	
		Baby care Hand over taken	
		by Dr. Prasanna. Resuitation	
		Done. Baby vitals Monitored	
		and Recorded. Maintained	
		RO. Cord clamping done by	
		Dr. Prasanna. Maintained RO.	
		Baby well and active. Baby	
		Motherside. Inj. Vit-K 0.1ml	
		Im given by Dr. prasanna.	
		Baby Details	
		B - New Girl Baby	
		A - 20/7/26 at 7.35AM	
		B - 2.5kg/kg	
		C - 3/10, 9/10	20/7/26
	8AM	Monitored Vitals and	
		Recorded. Maintained RO.	
		Baby Motherside. DBF given	
		No any other complaints	21/7/26
	9AM	Baby well and active.	
		Cord Not passed. Vaccine	
		Not Done. DBF given.	
		Baby Mother side	21/7/26
	10AM	Monitored vitals and Recorded	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

Rainbow® Children's Hospital
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BirthRight
BY RAINBOW HOSPITALS
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☐ No Known Drug Allergies
☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7/20		Baby Mother Side. Vaccine Not done	20/7/20
	12pm	Baby Meconium passed. RBS: at 11:30AM 72mg/dl. Baby Urine Not passed.	
		Vaccine Not Done.	21/7/20
	1.05pm	Baby Shifted from LDR To 7th Floor. Baby care Handing over given to 7th Floor Staff	21/7/20
		Receiving Notes	
	1.10pm	Baby details casefile handing over taken from the LDR to 7th floor staff. Baby Receiving weight checked and 2d band and Baby not passed U/m. Baby conscious.	Hari 21/7/20
	1.30pm	Baby feeding is good. baby RBS is last checked on 11.30am 72 mg/dl RBC is Stop the baby.	Hari
		I - 2	
		O - 1	
		T - 2	
		C - 1	
		H - 0	
		8	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0Y0M0D2H (F)
Dr. GIRIDHAR S

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NURSES NOTES

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

☐ No Known Drug Allergies
☑ Drug Allergies ..... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
	1.30pm	Baby details are file handing over given to the morning duty to evening duty staff!	Ha 60+918
		Evening duty	
20/7/26	1.30 pm	Baby details & handovers taken over from morning to duty. Baby urine & motion passed, Vaccine NOT done, NBS, SBR, O.A.E 48hrs	YP. Kaumo 607267
	2.00pm	patient feeds OBF, sucking is good.	
	4.00pm	Baby vitals checked and recorded. Dr. viridical sent for baby	YP. 607261
	7.00pm	Baby Intake/out put Maintained	YP. 607261
	7.30pm	Baby details handovers given to Night duty staff	YP. Kaur 607261
		Night duty on 20/7/26	
	9.30pm	Baby details handy over taken from Evening duty staff Baby active and good colour is pink and Normal. Baby urine and motion passed. Baby is On O2 at RA and taking well	dr.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

☐ No Known Drug Allergies
☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7/21	8pm	Vital Sign Checked and	
		Recorded. Vitals are Stable →	SL
	10pm.	Baby is on Q2H EBF.	
		feed taking well. No vomiting →	SL.
21/7/21	12mm	Vital Sign checked and	
		Recorded. Baby urine and motion	
		passed. Provided Warm Care →	SL.
	2mm.	Baby Sleeping well. No	
		Chief complaints →	SL
	4mm.	Maintain Intake and output	
		Chart. Vitals checked and Recorded →	SL
	6m	Morning care is given. weight	
		checked and Recorded →	SL
	7:30am	Baby details Hand over taken	
		On morning duty staff. →	SL
		Morning Duty	
21/7/21	7:30AM	Baby details, Hand over taken	
		from Night Duty Staff. Baby	
		active and alert, Baby vitals	
		are stable. Baby UIM/passed.	
		RBS stop, today Vaccine plan,	
		SBR/NBS/OAE after 48Hrs →	Sul 607383,
	8AM	Baby vital sign checked and	
		recorded. Vitals are stable.	
		Maintained I/O chart. →	Sul 607383.
	9 AM	Baby sucking is good	
		I/O Maintained	→ P.K 607261

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0 Y 0 M 0 D 13 H (F)
Dr. GIRIDHAR S

(2)

NURSES NOTES

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

☐ No Known Drug Allergies
☐ Drug Allergies ..... Nil.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
21/7/26	11.00am	Dr. Deepak sir come and see advised vaccine done Inj. BCG, Hep-B, oral polio 2 drops, Dr. Giridhar sir come and see advised tommorow WBS, SBR @ 6am	P. Kanimozhi 607261
	12.00pm	Baby vitals checked and recorded. Intake / output maintained	P. Kanimozhi 607261
	1.30pm	Baby details handover given to Evening duty staff	P. Kanimozhi 607261
		Evening Duty	
	2pm	Baby details case file handing over taken from the morning duty to evening duty staff. Baby vitals are monitoring and reported. Baby vitals are stable.	THari 607915
	3pm	Baby continues monitoring p/o chart. Baby feeding position is well and sucking and latching is well audible sound.	THari 607915
	4pm	Baby RBS Stop and Vaccine today done.	THari 607915
		I - 2	
		A - 1	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		T – 1	
21/7/26		C – 2	
		H – 1	
	6pm	Monitored input and output Chart and Recorded	
	7:30pm	Handover given Night Duty Staff	
		⇒ Night Duty ⇐	
21/7/26	7pm	Baby report heard other face from early duty staff. Baby is active cry is taken breathing is normal. ⇒	
	8pm	⇒ Baby is active baby feeds baby Pound crease is motion	
	9pm	⇒ Baby Pound uric is motion.	
	10pm	⇒ Baby feeds BBF is sleep well. no other complain ⇒	
	12AM	⇒ Baby sleep well sleep night no other complain ⇒ sleeping	
	2AM	Baby sleeping well. provided warmth care to baby ⟶	
	4AM	maintain intake and output Chart vital sign checked & Recorded	
	6AM	morning care is given weight checked and Recorded ⟶	
	7:30AM	Baby details handy over to (Nurse) duty staff	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0Y0M0D2H (F)
Dr. GIRIDHAR S

Patient S

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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING DEPARTMENT
NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/O. varshithaa.S. Mother's Name: Mrs. Varshithaa

Date of Birth: 20/7/26 Time of Birth: 7.35AM Gender: ☐ Male ☐ Female

Birth Weight: 2.54/kg Kgs HC: 32 cm Lenght: 48 cm

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

Term / Pre-term / Post-term: .....

Resuscitated: ☑ Yes ☐ No Blood Group: Mother: O positive Baby: Awaited

Feeding: ☑ Breast Feeding ☐ Formula ☐ Both First Feed Time: 8.33am

AFFIX MOTHER'S IDENTIFICATION LABEL

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

Indication: .....

Physical Assessment of New Born:

Temp: 98F °C HR: 150bt /Min RR: 50br /Min BP: 90 SpO_2: 99%

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☑ Yes ☐ No **Score:** 14 (Fill the Humpty Dumpty Sheet)

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

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

Findings:

General Appearance: Posture : ☑ Well-Flexed ☐ Asymmetry

Skin: ☑ Pink ☐ Meconium Stain ☐ Others, Specify: .....

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

Vitamin K 1 mg IM Administered: Yes / No

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No
2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No
3. Socio History: Siblings Yes / No

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

Newborn Screening Discussed: Yes / No

Nurse Name: S/N. Tamilselvi J Signature: 20/7/26 Date &Time: 20/7/26 at 8AM

GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0Y0M0D2H (F)
Dr. GIRIDHAR S

Patient Sticker

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THE HUMPTY DUMPTY SCALE

E N M E

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			20/7/17	20/7/17	20/7/17	21/7/17	21/7/17
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3	3	3	3	3	3
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3	3	3	3	3	3
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
	Total		14	14	14	14	14

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		✓	✓	✓	✓	✓
	Call device within reach		✓	✓	✓	✓	✓
	Wheels Locked		✓	✓	✓	✓	✓
	Room free of clutter		✓	✓	✓	✓	✓
	Adequate lighting		—	✓	✓	✓	✓
	Wheel chair support		—	✗	NA	✗	—
	Other Intervention(s) Specify		—	✗	NA	✗	—
	Nurse's Name:		Shirley	[illegible]	Esther	[illegible]	Hari
	Signature:		[signature]	[signature]	[signature]	[signature]	[signature]
	Date:		20/7/17	20/7/17	20/7/17	21/7/17	21/7/17
	Time:		2AM	2PM	8PM	8AM	2PM

GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0 Y 0 M 0 D 13 H (F)
Dr. GIRIDHAR S

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THE HUMPTY DUMPTY SCALE 21/7 22/7

PARAMETER	CRITERIA	SCORE	DATE N	DATE M	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4			
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1			
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not aware of Limitations	3	3	3			
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3	3	3			
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1			
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1			
	Total		14	14			

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		✓	✓		
	Call device within reach		✓	✓		
	Wheels Locked		✓	✓		
	Room free of clutter		X	✓		
	Adequate lighting		X	✓		
	Wheel chair support		✓	X		
	Other Intervention(s) Specify		—	X		
	Nurse's Name:		[illegible]	[illegible]		
	Signature:		[illegible]	[illegible]		
	Date:		21/7	22/7		
	Time:		8pm	8am		

GUC-00094070 IP18-0003[illegible]
Baby B/O VARSHITHAA S
20-07-2026 0 Y 0 M 0 D 2 H (F)
Dr. GIRIDHAR S

Ref. No.: F/HW/BRD-Q/NSG/04

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BRADEN 'Q' SCALE

(for Paediatric use)

..... Gender : ☐ M ☐ F IP No. : .....

				Date :	E	N	M
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 though 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 waking hours.	1	1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	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
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 lift 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 mean 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	25	25	25
				Evaluator's Name			

Highest Risk : 7 | High Risk : 8-16 | Mild Risk : 17-21 | No Risk : 22-23

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BRADEN 'Q' SCALE

(for Paediatric use)

Ref. No.: F/HW/BRD-Q/NSG/04

Patient Name: GUC-00094070 IP18-00036538 Baby B/O VARSHITHAA S 20-07-2026 0 Y 0 M 0 D 13 H (F) Dr. GIRIDHAR S

Age.........

	1	2	3	4	E	N	M	
				Date :	21/7	21/7	22/7	
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.	1	1	1	
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	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	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
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	25	25	25	
				Evaluator's Name	[illegible]	[illegible]	[illegible]	

Highest Risk : 7 | High Risk : 8-16 | Mild Risk : 17-21 | No Risk : 22-23

GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0 Y 0 M 0 D 2 H (F)
Dr. GIRIDHAR S

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PAIN ASSESSMENT FORM

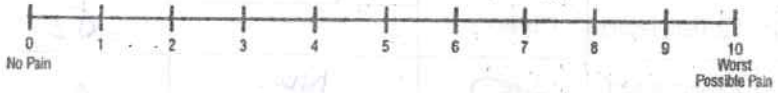
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7/26	8AM	9/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NIL	0/7/26
20/7/26	2pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	20/7/26
21/7/26	8pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	
21/7/26	2am	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	
21/7/26	8AM	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	6D
21/7/26	2pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	6D 22/7/26
21/7/26	8pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	
22/7/26	8AM	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	
22/7/26	6AM	10/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	
22/7/26	12pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NIL	6D

Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain relief intervention.

(P.T.O)

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0 Y 0 M 0 D 2 H (F)
Dr. GIRIDHAR S

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.
Patient's / Learner Language: Tamil Patient / Learner Literacy: ☐ Read ☑ Write ☐ Speak Willingness to Learn: Yes ☑ No ☐ Healthcare Literacy: Yes ☑ No ☐

Identified Education Needs:

1. Diagnosis: Newborn
2. Treatment and Care
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
20/7/26	8AM	Nutrition Diet	Educated to mother about need of EBF	Mother	NO	Oral	None	Verbal	Good	
21/7	8AM	Yes	Educated to mother about need EBF	Mother	NO	oral	None	Verbal	Good	
22/7	8AM	Yes	Educated about EBF · on Hrs	Mother	NO	Oral	None	Verbal	Good	

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify) .....

Learning Barriers:
1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:
1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

PATIENT TRANSFER FORM

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GUC-00094070 IP18-00036538
Baby B/O VARSHITHAA S
20-07-2026 0 Y 0 M 0 D 2 H (F)
Dr. GIRIDHAR S

	Date & Time of Admission	Date & Time of Transfer Order
	20/7/26 @ 8.40 Am	20/7/26 @ 1 PM
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr-Giridhar	Dr Giridhar	Shifted to ward for further care
From Unit	**To Unit**	**Information to Attendant**
LDR	7th floor	Yes ☐ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
DP files		Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Baby Pampers	0
2.	Baby cotpos	0
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Shr. Tamilselvi 20/7/26	Dr Giridhar

Patient & Clinical Records Received by : Hasini 8074918 20/7/26 1 pm

Date & Time of Patient Received : Hasini 8074918 20/7/26 1 pm

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