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

PATIENT DISCHARGE INTIMATION FROM NURSING STATION

CLEARANCE FOR DRUGS AND DISPOSABLES BILLING

GUC-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 2 D (F)
Dr. GIRIDHAR S

Name of the Patient: .

Date: 13/7/26

UHID No: .....

Ward: 6th Floor Gender: .....

Room No: 602

Certified that in respect of the above patient:

- ☐ a. There are no drugs for return
- ☐ b. Emergency cupboard issues have been replenished
- ☐ c. No pending indents are there against above patient
- ☐ d. Checked the bed side cupboard of the bed
- ☐ e. Checked by the patient's Mother / Father in the room

Patient Authorised Sign
Date: .....
Time: .....

Nurse Sign
Date: 13/7/26
Time: 6pm
Pheap

Pharmacy Sign
Date: 12/07/26
Time: 8.50pm

Docu. No. : RCH /FRM / GENERAL / 117

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

GUC-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 2 D (F)
Dr. GIRIDHAR S

UHID- FLOOR- NAME OF CONSULTANT

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing	(2) 7/26 6AM		Praveen 020PM				
Activity Sheet update by Pharmacy		7.50PM					

RCH No:- 133008338643

ACTIVITY RECORD FOR BILLING

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Name: B/O KANNAMMA

UHID No: 93673 IP No: ..... Consultant: Dr. Gowda Dept: Ldr

Date of Admission: ..... Time: ..... Date of Discharge: ..... Time: .....

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7/26	6pm	NICU	6th floor	Shalini Jyothi

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
10/7/26	Blood grouping ✓	2-6022138	
10/7/26	LFT, Retic count	26022149	
	RBS ✓	2-6022148	011/26
12/7/26	SBR, NBS	2-6022865	
13/7/26	SBR.	26022466	

M[illegible]CAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
12/7/26	BSPT	1pm	13/7/26 @ 10 Am	1726035	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
13/7/26	O.A.E	(1)	1726253	Sur ortho

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 12.7.26 Time: 6am Prepared By: Praveena

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Praveena Staff Nurse			

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DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

GUC:-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 0 D 13 H (F)
Dr. GIRIDHAR S

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement					
	INTIME	OUT TIME			
Arrangement of File by Nursing	13/7/26 @ 10.15 am	13/7/26 @ 10.30 am			
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

Wednesday review with BBR report:

wt - 2.845kg.

HC - 34 cm

L - 48cm.

T-wt - 2.849kg.

GUC-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 3 D (F)
Dr. GIRIDHAR S

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TELEPHONE / VERBAL ORDER AND CRITICAL RESULT REPORTING FORM

☐ Telephone Order ☐ Verbal Order ☑ Critical Result Reporting

Name of Reporter: Ms. Bhanu.

A. Order as per Medication Chart ☐ N/A	Route	Dose	Direction If Any

B. Critical Result Reporting (Lab/Radiology/others/ If Any)	☐ N/A ☐ Intervention for Critical Results?
SBR - 15. mg/dL	Continue breast feeding.

Order Recipient Response: **Please Tick**	Yes	No
Write Down by the receiver	✓	
Read Back by the recipient	✓	
Confirmed by the reporter	✓	

Receiving by: Praveena.	**Ordering Doctor Signature**
Name : Praveena.	Name :
Receiving Time : 7.30 Am Date: 12/07/2026.	Signature Time : Date: / /
Signature: PNW 12-07-26	

Notes for Telephone / Verbal order:

1. Verbal Order is for Emergency Situation only.
2. Doctor should sign the order ASAP but not later than 24 hours.
3. This form shall be placed in the Doctor Orders Part.

GUC-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 0 D 8 H (F)
Dr. GIRIDHAR S

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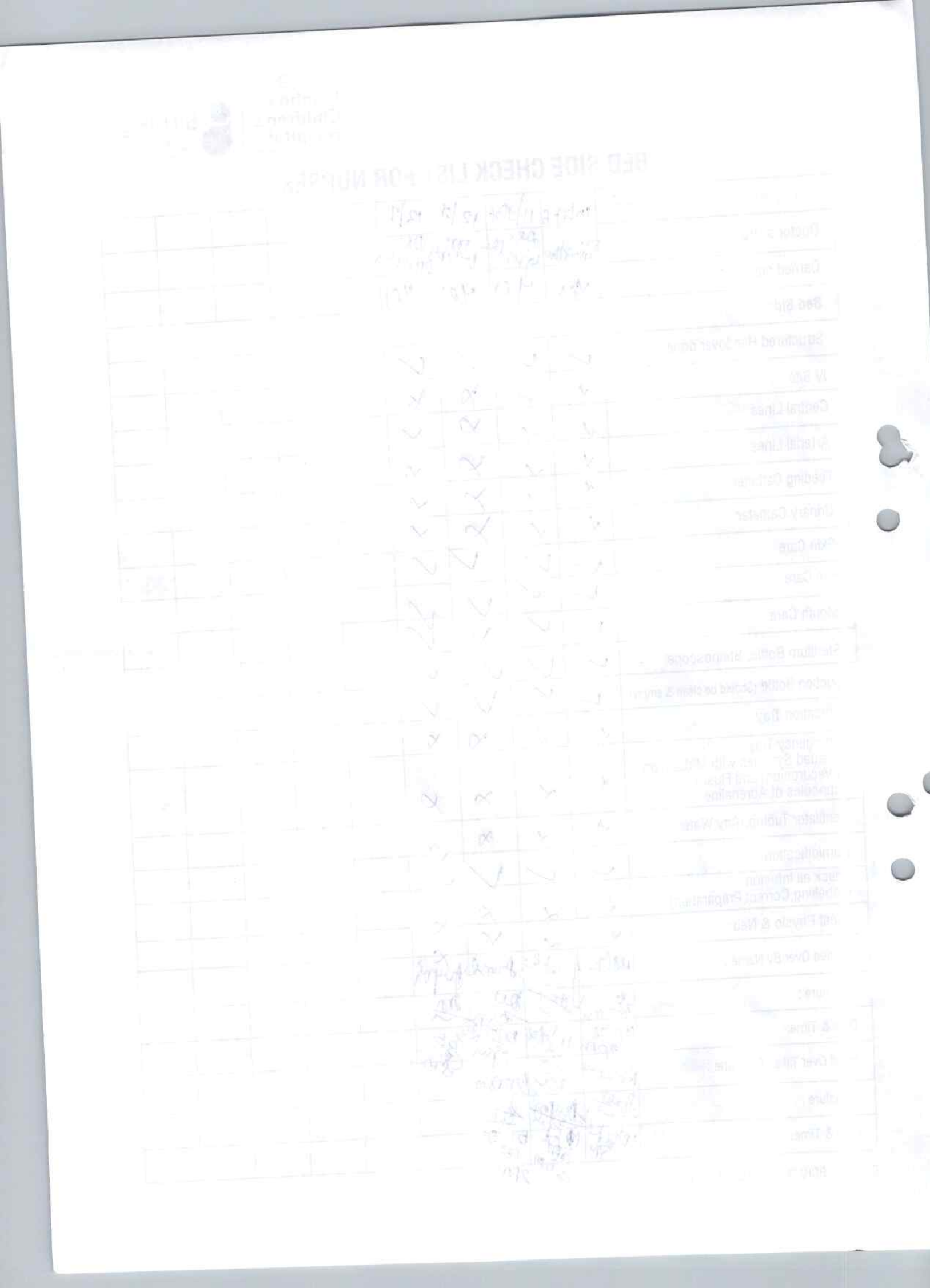
BED SIDE CHECK LIST FOR NURSES

Date:	10/7/26	11/7/26	12/7	13/7					
Doctor's Orders	Dr. Giridhar	Dr. Giridhar	Dr. Giridhar	Dr. Giridhar					
Carried out or not	Yes	Yes	Yes	Yes					
Bed Side									
Structured Handover done	✓	✓	✓	✓					
IV Site	X	X	X	X					
Central Lines	X	X	X	X					
Arterial Lines	X	X	X	X					
Feeding Catheter	X	✓	X	X					
Urinary Catheter	X	X	X	X					
Skin Care	✓	✓	✓	✓					
Eye Care	✓	✓	✓	✓					
Mouth Care	✓	✓	✓	✓					
Sterillum Bottle, Stethoscope	✓	✓	✓	✓					
Suction Bottle (Should be clean & empty)	✓	✓	✓	✓					
Intubation Tray	X	X	X	X					
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	X	X	X	X					
Ventilator Tubing,(Any Water, Blood)	X	X	X	X					
Humidification	✓	✓	✓	✓					
Check all Infusion (Labelling,Correct Preparation)	X	X	X	X					
Chest Physio & Neb	X	X	X	X					
Handed Over By Name :	Jeeva	Jeeva	Jeeva	Jeeva					
Signature :	Jeeva	Jeeva	Jeeva	Jeeva					
Date & Time:	10/7/26 @8pm	11/7/26 @ 8pm	12/7/26 @ 2pm	13/7 @ 8pm					
Hand Over Taken By Name :	Raveena	Jeeva	Sathya						
Signature :	Jeeva	Jeeva	Jeeva						
Date & Time:	10/7/26 8pm	11/7/26 8pm	12/7/26 2pm						



GUC-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. GIRIDHAR S

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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
10/7/26	1pm	52 mg/dl	Dr. Prasanna	[illegible]
			↓	
			Stop	

GUC-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. GIRIDHAR S

Patient Sticker

PIC No: 133008338643.

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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Mrs. Kannammai. Age : ..... Father's Name : ..... Age : .....

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

NICU Consultant : ..... Referring Consultant : .....

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

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

BIRTH INFORMATION

Name : B/o Kannammai.

Gender : ☐ M ☑ F Blood Group : .....

Date of Birth : 10/1/26. Time of Birth : 11:36AM

Place of Birth : RCH LDR.

Mother's Blood Group : O-ve.

Birth Weight (gms) : 3.046kg Length (cms) : .....

OFC (cms) : .....

Estimated Gesth Age : 38w+1D.

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 23y Ht : ..... Wt : ..... BMI : ..... Married Life : ..... LMP : 6/10/25 EDD : 13/7/26.

Conception : Spontaneous or with Rx. : .....

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

Last Scans Details : 1/1/26 – SUVG, cephalic, plaunta-posterior, Liquor - Normal, AFI - 14.7, EFW - 3145g ..... TT Immunization and Iron / Folic Acid : NCA PSV <1.5MOM, ICT-ve.

MATERNAL RISK FACTORS

Doppler – (N).

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 : 3 P : 1 A : 1 L : 1

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
G1	6yrs	41W	NVD,		Anti D given	
G2	8weeks	MTP	Medical management		? Anti D	
G3	PP	Spontaneous Conception				

PERINATAL HISTORY

Treating Obstetrician : Dr Mathangi Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig) KIV A/D.

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

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

APGAR SCORE

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
8/10	9/10	

TOTAL

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.
Pink ⊕, Activity, tone - good

HR : 156 bpm
SpO_2 : 97 %.
CRT < 3sec.

INJ VIT K 0.1ml given IM.
(Inj)

Investigation details in previous Hospital :

—

Feeding History :

—

Patient Sticker

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5°C HR : 156 bpm RR : 60 NIBP : ..... CFT : Slow

Color of the extremities : Pink

Jaundice : — Pallor : — SpO2 : 97%

Anthropometry : Birth Weight : 3.046 kg 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.) :
(N)

Facies : (Any Facial Dysmorphism)

NECK and CLAVICLES :
Range of Motion :
Asymmetry :
Masses :
(N)

EYES :
Symmetry :
Red Reflex :
Discharge :
(N)

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

THORAX and BREASTS :
Shape of Thorax :
Position of Nipples and Number :
(N)

ABDOMEN and UMBILICUS :
Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump : — 2 Art + 1 vein.
Discharge : — (N)

GENITILIA :
Labia / Hymen : (N)
~~Testicles/penis~~ :
Anus : — Patent

HERNIAL ORIFICES

TRUNK and SPINE :
(N)

SKIN LESIONS :

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

Patient Sticker

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☐ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress : RR : 60 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 : 99-1 Auscultation : B/L AE⊕ Breath Sounds : ..... Added Sounds : .....

Cardiovascular System :

HR : 156 bpm BP : .....

Femoral Pulses : +

Other Peripheral Pulses : +

Precordial Activity : –

Murmurs : –

Signs of Cardiac Failure : –

Abdomen :

Shape : N

Palpation : .....

Palpable masses : .....

Abdominal girth : .....

Hernia orifice : +

Anal Patency : N

Umbilical Cord : 2 art + 1 vein

First urine passed : .....

Meconium passed : .....

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

State of wakefulness : N

Prechtle Score : .....

Nerves : +

Motor System :

Passive Tone : +

Active Tone : .....

Neonatal Reflexes : .....

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

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

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

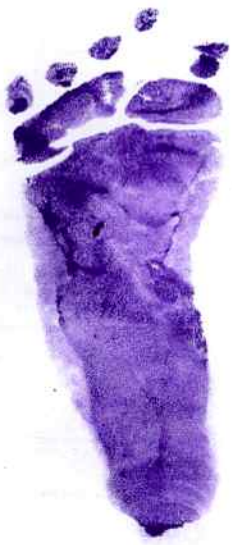
Patient Sticker

Any Congenital Anomalies : .....

Diagnosis : Term (38w + 1D) / Girl / AGA / Rh-ve mother / B.wt: 3.04 kg. (ICT-ve)

FOOT PRINTS

Left Side :



Right Side :

Resident Doctor :

Signature : .....

Name : Dr Prasanna.

Date & Time : 10/1/26

Consultant : for

Signature : .....

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 : Advice

.....

.....

- Provide warmth support
- To start Direct breast feeding exclusively.
- CBG monitoring 4 hrs.
- Birth vaccination < 24 Hrs.
- NBS, OAE @ 48 Hrs.
- TODO - DCT, Peripheral smear, Retic count.
- CBC, SBR @ 4 HR

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

.....

.....

Screenings done during NICU Stay :

NSG : .....

Hearing Screen : .....

ROP : .....

TFT : .....

NP2 : .....

13/12/23
Dr. Prashanth

Patient Sticker

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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: 3.04 kgs

Sheet No: .....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
10/7/26	11.40AM	INJ. VIT K	0.1ml (1mg)	IM		SP	SA
11/7/26	12pm	Inj Hep-B	0.5ml	IM			
11/7/26	12pm	Tab DCG	0.25ml	PO			
11/7/26	12pm	OP.V Drops	2drops	Oral			

Docu. No. : RCH /FRM / CLINICAL / 136

GUC-00093673
Baby B/O KANNAMMAI R N
IP18-00036404
10-07-2026
Dr. GIRIDHAR S
0 Y 0 M 0 D 1 H (F)

CLINICAL / 124

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

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WARNING SCORE: CHILDREN'S UNIT

Date: 10th Time: 11.38am 8pm 4pm 8pm 1.20am 4am

Doctor/Nurse/Family Concern?

Temperature (°F): 98F, 98.2, 98.6F, 97.8F, 97.4F, 97.8F

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

Note: BP does not score in early warning scoring

Heart Rate (Number): 142, 140, 140/M, 140bpm, 135bpm, 132bpm

Resp. Rate (bpm) (Over 1 Minute) *: 44

Resp Rate (Number): 40, 44, 46/M, 42bpm, 42bpm, 40bpm

Resp Distress (Mod/ Severe / None / Mild)	Mild	✓	↳	↳	↳	↳
Receiving O_2 (l/min) O_2 Saturations (%)	98%	98%	98%	99%	98%	99%
Conscious Level (Normal / Altered)	✓	✓	↳	↳	↳	↳
GCS *	15/15	Alert	Alert	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials						

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

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)

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Dr. GIRIDHAR S

Doc. No. : RCH/ FRM / CLINICAL / 124

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

Rainbow® Children's Hospital — It takes a lot to treat the little.
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 11/4/26 Time: 8pm 12pm. 4pm 8pm. 12Mn 4Mn.

Doctor/Nurse/Family Concern?

Temperature (°F): 96.8°F 97.6°F 97.4°F 98.6°F 97.4°F 96.8°F

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

Note: BP does not score in early warning scoring

Heart Rate (Number): 138bpm 130bpm 132bpm 135bpm 145bpm 132bpm

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

Resp Rate (Number): 40pm 40pm 38bpm 40bpm 40bpm

Resp Distress	Mod/ Severe					
	None / Mild	✓	✓	✓	✓	✓
Receiving O_2 (l/min)		RA	RA	RA		
O_2 Saturations (%)		97%	98%	99%	98%	99%
Conscious Level	Normal	✓	✓	✓	✓	✓
	Altered					
GCS *		Alert	Alert	Alert	Alert	Alert
TOTAL SCORE						
Number of shaded boxes		0	0	0	0	0
Pain Score		0	0	0	0	0
Observer's Initials		MM	DCC	[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.

Patient Sticker

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 0 D 8 H (F)
Dr. GIRIDHAR S

Doc. No. : RCH/ FRM / CLINICAL / 124

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

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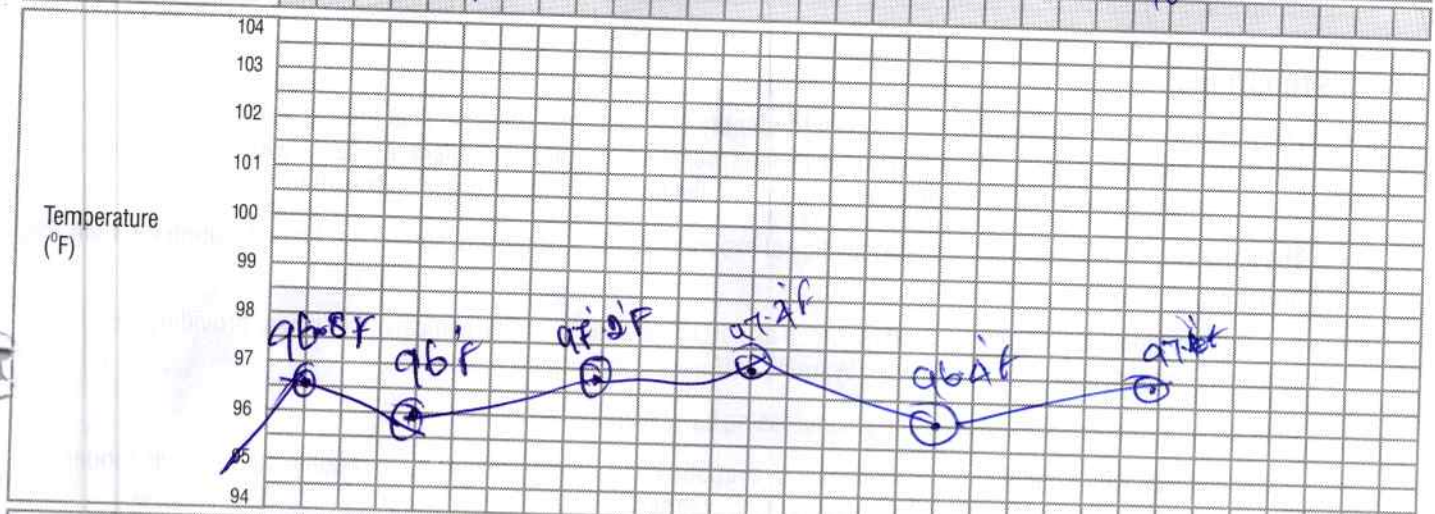
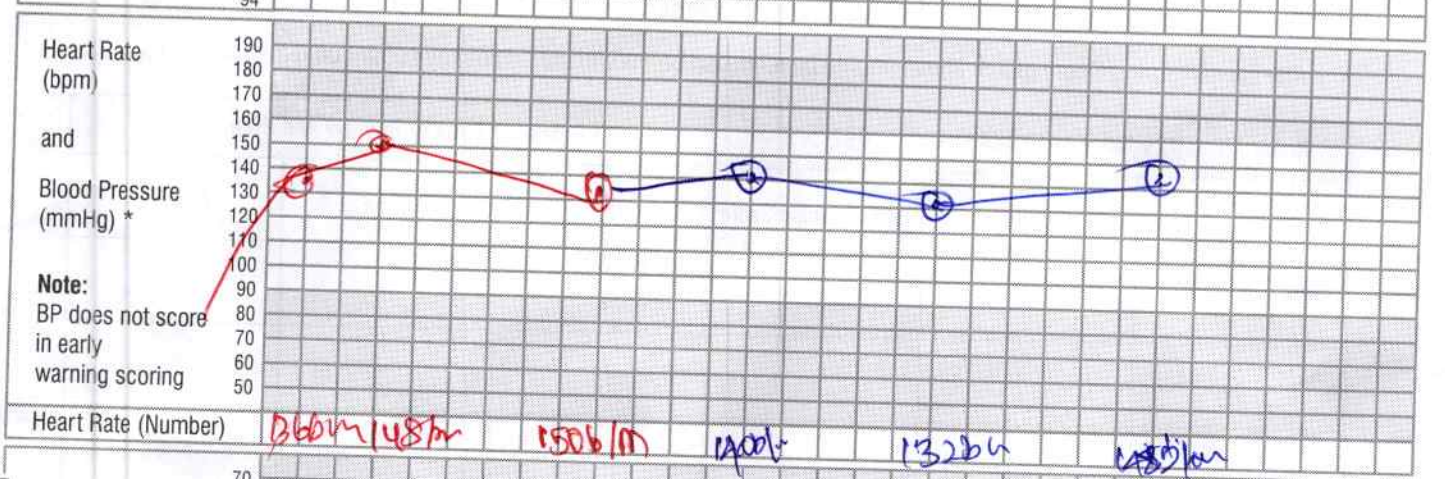
EARLY WARNING SCORE: CHILDREN'S UNIT

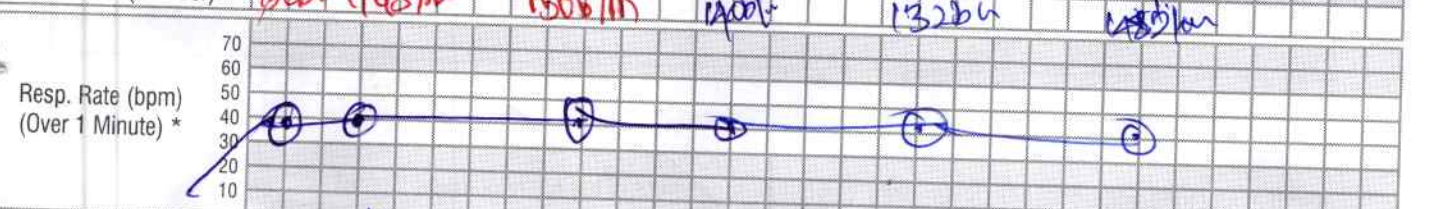
Date: 12/7/26 Time: 8am 12pm 4PM 8pm 12Am 4Am.

Doctor/Nurse/Family Concern?





Heart Rate (Number) 166bpm/148bpm 150b/m 140bpm 132bpm 138b/m



Resp Rate (Number) 46bpm 46b/m 48bpm 40bpm 42bpm 40bpm

Resp Distress	Mod/ Severe / None / Mild	✓	✓	✓	✓	✓	✓
Receiving O_2 (l/min)		RA	RA	RA	✓	✓	✓
O_2 Saturations (%)		99%	98%	99%	99%	99%	99%
Conscious Level	Normal / Altered	✓	✓	✓	✓	✓	✓
GCS *		15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE Number of shaded boxes		0	0	0	0	0	0
Pain Score		0	0	0	0	0	0
Observer's Initials							

ACTIONS

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Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. GIRIDHAR S

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FLUID CHART

Sheet No. : 1

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
10/7/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am	← on admission										
	12:00 pm											
	01:00 pm	DBF									No IV line	
Total Intake : Clinic						Total Output : U/m not passed.						
	02:00 pm											
	03:00 pm	DBF.									No Urim.	
	04:00 pm											
	05:00 pm	DBF										SP
	06:00 pm						✓				NO	SP
	07:00 pm										IV	
Total Intake : (2) DBF						Total Output : Nil.					line Sy/o DHF9.	
	08:00 pm	DBF										
	09:00 pm											
	10:00 pm	DBF.					✓				No	Ruth
	11:00 pm										IV	Ruth
	12:00 am	DBF									line	Ruth
	01:00 am											
Total Intake : (3) times DBF.						Total Output : Nil.						
	02:00 am											
	03:00 am	DBF.										Ruth
	04:00 am								✓		No	
	05:00 am	DBF							✓		IV	Ruth
	06:00 am											
	07:00 am	DBF					✓			✓	line	Ruth
Total Intake : (3) times DBF						Total Output : 3 times.						

Total 24 hrs. Intake	9 times DBF.

Total 24 hrs. Output	3 times.

GUC-0009367 3 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0Y0M0D8H (F)
Dr. GIRIDHAR S

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FLUID CHART

Sheet No. : (2)

T-cut -2-9/4.

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.

11-Th26

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Stool / Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am											
	09:00 am		DBF								NO	
	10:00 am											
	11:00 am		DBF				V			V	IV	
	12:00 pm										line	
	01:00 pm		DBF									
Total Intake : (3) DBF						Total Output : 1 time						
	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 - DBF						Total Output :						
	08:00 pm	Ophthal gold	15ml									
	09:00 pm						V			V	NO	
	10:00 pm		DBF									
	11:00 pm										IV	
	12:00 am		DBF								line	
	01:00 am											
Total Intake : 15ml + (2) times DBF.						Total Output : 1 time.						
	02:00 am											
	03:00 am		DBF.								No	
	04:00 am											
	05:00 am		DBF								IV	
	06:00 am	FF	80ml							L	line	
	07:00 am											
Total Intake : 2 times DBF + 80ml.						Total Output : 1 time.						

Total 24 hrs. Intake	10 times + 15ml	Total 24 hrs. Output	3 times.

GUC-0009367S IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0Y0M0D8H (F)
Dr. GIRIDHAR S

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

FLUID CHART

Sheet No. : (3)

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.

12/7/26.		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									
	09:00 am	FF	15ml							✓	NO	
	10:00 am											
	11:00 am		DBF								IV	
	12:00 pm	FF	25ml									
	01:00 pm									✓	Line	
Total Intake :		40 ml + (2) DBF				Total Output :		2 time				
	02:00 pm											
	03:00 pm		DBF				✓				NO	
	04:00 pm											
	05:00 pm										IV	
	06:00 pm		DBF								Line	
	07:00 pm											
Total Intake :		8 times DBF				Total Output :		Nil.				
	08:00 pm		DBF				✓			✓		
	09:00 pm										NO	Ryle
	10:00 pm		DBF									
	11:00 pm		DBF				✓			✓	IV	Ryle
	12:00 am											
	01:00 am		DBF								line	Ryle
Total Intake :		4 times DBF				Total Output :		2 times.				
	02:00 am									✓		
	03:00 am										NO	Ryle
	04:00 am		DBF									
	05:00 am										IV	Ryle
	06:00 am											
	07:00 am		DBF							✓	line	Ryle
Total Intake :		2 times DBF				Total Output :		2 times.				

Total 24 hrs. Intake	40mL + 8 times DBF	Total 24 hrs. Output	6 times.

GUC-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0Y0M0D8H (F)
Dr. GIRIDHAR S

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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: NB Norm

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

Surgery / Procedure:

Post OP Day: -

BACKGROUND

Date / Shift	10/7/26 morning	10/7/26 Evening	10/7 N	11/7 M	11/7 E	11/7 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):	RA	RA	RA.	RA	RA	RA.
Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	98°F	98.8	97.4°F	97.6°F	97.4°F	98.6°F
Res:	40	40	42brm	42brm	40 brm	42brm
SpO_2:	100%	100%	99%.	98%.	99%.	98%.
Pulse:	142	140	142bpm	142bpm	140bpm	145bpm
BP:	—	—	—	—	—	—
LOC:	Alert	Alert	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	Intact	Intact	Intact	Intact	Intact	Intact

Recommendations

Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physiotherapy:	—	—	—	—	—	—
Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Special Diet:	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:	—	—	—	—	—	—
Handed Over By Name :	Poorni	Devi	Praveena	Jeyantha	Praveena	Praveena
Signature / ID :						
Date:	10/7/26	10/7/26	11/7/26.	11/7/26	11/7/26	12/7/26
Time:	1.30pm	2pm	8pm	@ 2pm	@ 8pm	8am
Taken Over By Name :	Devi	Praveena	Jeyantha	Praveena	Praveena	Anupriya
Signature / ID :						
Date:	10/7/26	10/7/26	11/7/26	11/7/26	11/7/26	12/7/26
Time:	2pm	8pm	8am	@ 2pm	8pm.	8AM

GUC-00093673 IP18-000
Baby B/O KANNAMMAI R N
10-07-2026 0Y0M0D1H (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: 10/7/26

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	12pm	maintain good nutritional states	1pm	- monitor vital signs - To give DBF - keep baby warmth - maintain Dr advice	maintained Good nutritional status	Reassessment is done	Devi
Afternoon	4pm	Maintain good nutritional status	2:30pm	Monitor vital signs To give DBM assessment keep baby warmth. Maintain procha.	Maintained Good nutritional status	Reassessment done	Devi 5/10/60
Night		Promote. good Nutritional status.		To Assess the Feeding. maintained Intake	Maintained RC Chart	Reassessment done	Devi

GUC-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0Y0M0D8H (F)
Dr. GIRIDHAR S

NURSING CARE RECORD

Rainbow® Children's Hospital
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- ☐ Ensure Safety
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- ☐ Early Ambulation Reduce Anxiety
- ☐ Maintain Skin Integrity
- ☐ Patient & Family Education

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8 Am	⇒ Assess general condition ⇒ Monitor the vital Signs ⇒ Assess feeding pattern	9 Am	⇒ Assessed general condition ⇒ Monitored vital sign ⇒ Assessed and taught about EBF 2nd hrly	Following Breast feeding technique.	Re-assessment done	Jaq DUAD
Afternoon	2 Pm	Prevents falls and injury.	4 Pm	-> Keep the baby warm ⇒ Keep the bed in low lying position.	Baby was kept in cradle with wheels are locked.	Prevented falls.	Mythili Gotten.
Night	8Pm	Promote good Nutritional Status		To Assess the feeding Position.	To Encourage. Breast feeding Monitor f/o chart	Baby was. Clinically Normal	Rose Dev

GUC-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. GIRIDHAR S

Patient

(1)

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Your Right to a Safe Delivery

NURSES NOTES
(USE BALL POINT PEN ONLY)

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		On admission notes
10/7/26	11:36AM	B/o Kannammai GA - 38w+2d
		A single baby delivered via assisted
		vaginal delivery. Baby cried at birth
		delayed cord clamping done. Dr. Prasanna
		received the baby. kept in warmer
		cleaning done. vital signs checked &
		recorded. vitals are stable. NG tube
		passed mucus cleared. Inj. vit-K given.
		Baby urine, motion not passed at
		birth. vaccination not done. Baby is
		warmth, pinkish colour. [signature]
		Date - 10/07/2026
		Time - 11:36Am
		Sex - Girl
		weight - 3.076kgs. [signature]
	12:30pm	DBF given to baby sucking good.
		placed the baby on mother side.
		mother have good milk secretion.
		Humpty Dumpty, Braden Q, pain assessment
		done. [signature]
	1pm	CBG checked as per doctor order.
		52mg/dl informed to Dr. Prasanna
		advice to do DCT, Retic count, also
		carried out. cord blood sample collected

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0Y0M0D1H (F)
Dr. GIRIDHAR S

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NURSES NOTES

(USE BALL POINT PEN ONLY)

☐ No Known Drug Allergies

☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
10-7-26		blood grouping, DCT, Reticount sent to
continue		Lab as per doctor adv. — [signature]
	1.30pm	Baby care hand over given
		to evening duty staff — [signature]
	1.20pm	Evening duty report on 10-7-26
		Baby taken over from the morning
		duty staff Baby activity is good
		Crying is well, sucking is pink. Baby
		general condition is good. — [signature]
	2.00pm	Baby vital checked & recorded
		Baby DBF given sucking is good
		Baby general condition — [signature] 10-7-26
	4.00pm	Baby vital checked & recorded
		Baby not passed urine motion. Baby
		general condition is good. — [signature]
		Baby shifted to mother side order
		by Dr. Prasanna Sir. Baby condition
		over to 6th floor staff — [signature]
		Baby DCT - Negative informed Dr. Sivalakshmi
		PS, CBC, S.Bilirubin discuss after taken or not blood test
		informed
		I/O chart maintain
	6pm	Baby handing over given to 6th floor staff

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-0009367S IP16-0003640A
Baby B/O KANNAMMAI R N
10-07-2026 0Y0M0D8H (F)
Dr. GIRIDHAR S

(1)

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Your Right to a Safe Delivery

NURSES NOTES

(USE BALL POINT PEN ONLY)

☐ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
10/7/26		Receiving Notes.
	6:10pm	Baby was received From LDR to 6th Floor. Baby receiving weight checked Rwt - 2.977 kg. Id. band checked. Plan for vaccine tomorrow. CBC/SBR/PS after - 24 hours, Meconium passed. Urine not passed. → Nyffik 607481
	6:30pm	Maintained I/O chart for the baby
	7:30pm	Baby details are handing over given to Night duty staff → Nyffik 607481.
		Night duty Notes.
10/7/26	7:30pm	Baby details Hand over taken From Evening duty staff. Baby was Active and oriented → Praveen
	8pm	Baby Vitals Checked and Recorded. Vitals Normal → Praveen
	10pm	Baby taking feed No vomiting DBF 24 hrs.
		L - 2
		A - 2
		T - 2
		C - 2
		H - 1/2 (Head supervision)
		Plan for CBC, SBR, PS after 24 hr
		Dr. Srilakshmi mam phone call
		Advice to RT negative so no

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

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NURSES NOTES

(USE BALL POINT PEN ONLY)

☑ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
10/7/26		Need 24 hrs of life Sample. After 48 hrs of TO Ag, SBR, ABS, OAE, CBC, PS. → Praveen
11/7/26	12 Am	Baby Vitals checked and Recorded. Vitals Normal. → Praveen
		Maintained intake and output chart. Baby was → Praveen
		Sleeping well No complaints.
	4 Am.	Baby vitals checked and Recorded. Vitals Normal → Praveen
		Baby morning care given &
	6 Am	weight also checked and recorded → Praveen
		Maintained intake and
		output chart → Praveen
	7:30 Am	Hand over given from Morning
		duty staff. → Praveen
		Morning Duty Notes
11/7/26	7-30 am	Baby details hand over taken from night duty staff baby active and alert baby warmth and pink → Ars
	8 AM	→ Baby vital signs checked and record. are stable → Ars
	10 AM	→ Baby take feed. tolerated well. no vomitting sensation

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 0 D 8 H (F)
Dr. GIRIDHAR S

(3)

NURSES NOTES

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Your Right to a Safe Delivery

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
11/7/26		L -2	
		A -2	
		T -2	
		C -2	
		H -1	
		9 (need supervision)	Duty Nurse
	11AM	→ Dr. Giridhar sir come and seen the child. advised today vaccine and tommorow OAE / NBS / S. Bili at 6AM	Duty nurse
	12pm	→ Dr. Deepak sir vaccine given. and explained over parents. vaccine done. vital signs checked and record.	Duty
	1pm	→ Baby intake & out put chart maintained & record	Duty
	1:30pm	→ Baby detail hand over given to evening duty S/N	Duty
		Evening Duty Notes	
	1:30pm	→ Baby details are handing over taken from Morning duty staff vaccination Done. Tommorow SBR / OAE / NBS - Plan →	[illegible] 6007784
	3pm	Baby was initiated for DBF for every 2 hourly →	[illegible] 60774

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NURSES NOTES

☐ ~~No~~ Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
11-7-26.	4pm	Baby vitals are checked and recorded. Vitals are Stabled.	
		CP ++ / PP ++ / CRT <3sec →	Mythili Bottay
	5pm	Baby takes DBF. Baby sucks well.	
		L -2	
		A -2	
		T -2	
		C -2	
		H -1/9 needs supervision. →	Mythili Bottay
	6:30pm	Maintained I/O Chart for the baby. No other complaints. →	Mythili Bottay
	7:30pm	Baby details are handing over given to Night duty staff → Night duty notes.	Mythili Bottay
11-7-26	7:30pm	Baby details hand over taken from Evening duty staff. Baby was Active and alert →	Praveena 320826
	8pm	Baby vitals checked and Recorded. Vitals Normal. →	Praveena 320826
		Baby taking feed also vomiting DBF + Aptamil gets given by,	
		L -2	
		A - 2	
		T - 2	
		C - 2	
		H - 1/9 (Need Supervision) →	Praveena 320826

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GUC\00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0Y0M0D8H (F)
Dr. GIRIDHAR S

NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
12/7/26	12Am	Baby vitals checked and Recorded Vitals Normal →	Praveen Dsen
	2Am.	Maintained Intake and Output chart and Recorded. Baby was sleeping well No any other complaints. →	Praveen Dsen
	4Am.	Baby vitals checked and Recorded. Vitals Normal. →	Praveen Dsen
	6Am.	Baby Morning care given weight also checked and Recorded. Baby sample SBR, NBS sended to Lab →	Praveen Dsen
	7Am	Maintained Intake and output chart →	Praveen Dsen
	7.30Am	Heand over given from Morning duty Staff. →	Praveen Dsen
		Morning duty Notes	
12/7/26	7.30Am	→ Baby detail heand over taken from night duty S/N Baby warmth and active. Today NBS/S.Bili done. ® due	Dsen
	8Am	→ Baby vital signs checked and record. Vitals are Stable	Dsen
		→ Baby take feed. tolerated No vomiting sensation. Latching is good.	Dsen

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Patient Sticker

NURSES NOTES

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☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
12/7/96		L -2	
		A -2	
		T -2	
		C -2	
		H -1	
		9 hrs supervision	Dr Soon
	12pm	→ Baby vital signs checked and recorded. vitals are stable	Dr Soon
	1pm	→ Baby intake and output chart maintained & record. Dr. Bhisha mam come and seen the baby mam advised to start SSPT and tommorow to do repeat sample SBR.	Dr Soon
	1.30pm	→ Baby detail hand over given to evening duty SN evening duty notes.	Dr Soon
10/7/96	1.30AM	The Baby details is handing over taken from morning duty SN. NO IVline, PBF, SSPT ongoing, tomorrow 6AM to do SBR.	Dr
	2PM	Baby had mother mother feed	
		L - 2	
		A - 2	
		T - 2	
		C - 2	
		H - 1 need supervison	Dr

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE

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Patient Sticker

NURSES NOTES

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☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE

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Patient Sticker

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NURSES NOTES

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☐ Drug Allergies ....

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Patient Sticker

NURSES NOTES

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☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00093673 IP18-00038404
Baby B/O KANNAMMAI R N
10-07-2026 0Y0M0D1H (F)
Dr. GIRIDHAR S

Patient Sticker

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			10/7	10/7	10/7	10/7	10/7
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					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4	4	4	4	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	15	13	13	13

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		✗	✗	✗	✗	✗
	Other Intervention(s) Specify		✗	✗	✗	✗	✗
	Nurse's Name:		Sooji	Noori	Praveen	Jyothi	Praveen
	Signature:						
	Date:		10/7	10/7/26	10/26	11/7/26	11/7/26
	Time:		1.30pm	8pm	8pm	2pm	8pm

GUC-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 0 D 1 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
10/7/26	1pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
10/7/26	4pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	No pain	
10/7/26	10pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
11/7/26	4am	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
11/7/26	10am	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
11/7/26	4pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
12/7/26	10pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
12/7/26	4am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
12/7/26	8am	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
12/7/26	4PM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	

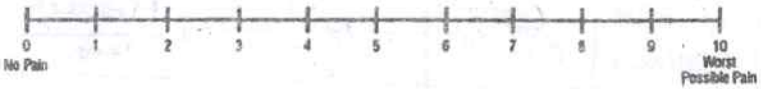
Re-assessment Frequency:

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 drawn 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

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BRADEN 'Q' SCALE

(for Paediatric use)

Patient Name : .....

Age..... Gender : ☐ M ☐ F

GUC-00093673 IP18-00035404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 0 D 8 H (F)
Dr. GIRIDHAR S

/04

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.	Date :	11/7	11/7	12/7	12/7
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		1	1	1	1
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	25	25	25	25
					Evaluator's Name				

Highest Risk : 7 | High Risk : 8-16 | Mild Risk : 17-21 | No Risk : 22-28

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BRADEN 'Q' SCALE

(for Paediatric use)

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

☐F IP No. : .....

					Date :	10/7	10/7/26	10.7	10.7
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.		1pm 4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		1	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	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	25	28	25	25
					Evaluator's Name				

Highest Risk : 7 | High Risk : 8-16 | Mild Risk : 17-21 | No Risk : 22-28

GUC-000936 IP18-00036404
Baby B/O KANNA...AI R N
10-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. GIRIDHAR S

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

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Your Right to a Safe Delivery

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 NB
2. Treatment and Care

Plan

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
12. Patient's / Family Rights
13. Risk / Safety

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		
10/7/26	1pm	Yes	Educate about fall risk safety needs (bed cradle)	mother	No learning barrier	oral	none	Yes	Good	[illegible]
11/7/26	2pm	Yes	Educated about the feeding technique for the mother to the baby	mother	Nil	oral	none	Yes	Good	[illegible]
12/7/26	2pm	Yes	EDUCATED ABOUT PERSONAL HYGIENE	Mother	Nil	verbal	Nil	Yes	-	[illegible]

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. Verbalises Understanding 2. Demonstrates Understanding 3. Needs Review

GUC-00093673 IP18-00036404
Baby B/O KANNAMMAI R N
10-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. GIRIDHAR S

Rainbow Children's Hospital — It takes a lot to treat the little.
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 kannammai Mother's Name: m/s: kannammal'

Date of Birth: 10/7/26 Time of Birth: 11:36 am

Birth Weight: 3.0 kg Kgs HC: 33 cm Gender: ☐ Male ☐ Female

Meconium in Liquor: ☐ Yes ☐ No Lenght: 48 cm

Term / Pre-term / Post-term: Term Cried at Birth: ☐ Yes ☐ No

Resuscitated: ☐ Yes ☐ No

Feeding: ☐ Breast Feeding ☐ Formula ☐ Both Blood Group: Mother: "O" negative Baby: 1

First Feed Time:

GUC-00088863 IP18-00036393
Mrs KANNAMMAI R N
26-09-1992 33 Y 9 M 13 D (F)
Dr. MATHANGI RAJAGOPALAN

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

Indication: Pre eclampsia

Physical Assessment of New Born:

Temp: 36.5 °C HR: 142 /Min RR: 40 /Min BP: — SpO_2: 100%

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☐ Yes ☐ No **Score:** 11 (Fill the Humpty Dumpty Sheet)

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

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

Findings:

General Appearance: Posture : ☐ Well-Flexed ☐ Asymmetry

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

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

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

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: ~~Yes~~ / No

Neonatal Screening Done: Yes / No

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

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

Newborn Screening Discussed: Yes / No

Nurse Name: Jaici Signature: Date &Time: 10/7/26 at 1130 pm

PATIENT TRANSFER FORM

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Your Right to a Safe Delivery

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
Bb. Kannammal	10/7/26 at	10/7/26 at 6pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Giridhar	Dr. Giridhar	further treatment
From Unit	**To Unit**	**Information to Attendant**
NICU	6th floor	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
op file (1)	–	Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Baby wipes	(1)
2.	Baby Pamper	(1)
3.	Baby Dress set	Female
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S. Shalini 8140th	Dr. Giridhar.

Patient & Clinical Records Received by : Mythili 607784

Date & Time of Patient Received : 10/7/26 @ 6:10 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