GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0 Y 0 M 0 D 4 H (M)
Dr. GIRIDHAR S

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

HID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	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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GUC-94110

ACTIVITY RECORD FOR BILLING

Name: B/o. Stella Mary

UHID No: 94110 IP No: 36546 Consultant: Dr. Giridhar Dept:

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7/26	7.30pm	JDR	4th 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	26023378	
20/7/26	RBS	26023374	
20/7/21	RBS	26023386	
20/7/2	RBS	21023381	
21/7/26	RBS	26023461	
21/7/26	RBS	26023508	
22/7/26	NBS, S1. bw	26023527	
22/7/26	RBS	26023528	
22/7/26	Sa. bilirubin	26023634	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
	SSPT	22/5/26 @ 12pm		1731277	[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/7/24	ODE	1	1731028	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 22/7/24 Time: 6 PM Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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DISCHARGE TRACKING SHEET

R- NAME OF CONSULTANT-

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

23/7/26
TWt: 2.955 kg

22/7/26
T.Wt - 2877
H - 33cm
L - 49cm
Rabeh Sun - 8
23/7 T.Wt. 2.955 K

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RBS CHART

(6th hourly)

Date	Time	RBS (mg/dl)	IVF %	Signature
20/7/26	5pm	9/mg/dl/	Dr.poojitha	S/N
20/7/26	11 pm	63 mg/dl.	Q6H	
21/7/26	5am	98 mg/dl.	Q6H	
21/7/26	11 AM	64 mg/dl	Q6Hrly.	
21/7/26	7pm	92 mg/dl	Q 6th hourly	
22/7/26	2am	63 mg/dl	Q6H	
		STOP.		

Docu. No. : RCH /FRM / CLINICAL / 185

ELJAY
PROFESSIONALS IN HEARING CARE
SINCE 1976

NEWBORN HEARING SCREENING

1st Screening / 2nd Screening

Name: Baby of Stella Mary **Date:** 22/7/26

Age/Sex: 2D/M **D.O.B:** 20/7/26

OP/IP No: 94110 / 36545

Hospital: Rainbow Children's Hospital

High Risk Registers (if any):

Test Done: DP-OAE

Results:

Right Ear: } Pass (5/5) Frequencies Present at 6 dB SNR

Left Ear: Frequencies Present at 6 dB SNR

Clap Screening: PASS/FAIL

Plan:

☑ Counseled regarding Normal Auditory and Language Development.

☐ Follow up for 2nd Screening after 2 weeks, Date: Time:
For Appointment Contact +91-

☐ Detailed Audiological Evaluation at 2 months of Age.

☑ Review with Pediatrician.

(Audiologist and Speech Language Pathologist)

Head Office.: #A1, 1st Floor, Garden Apartments, No.68, Purasawalkam High Road, Purasawalkam, Chennai - 07. T : 2641 1095 / 2640 0578 E : sales@eljayhearing.com

Branch.: Door No. New 26 Old 15, North Vijaya Nagar, 100 Feet Bypass Road, Velachery, Chennai - 600 042. T : 4720 3644 M : 89397 20006 E : eljay.velachery@eljayhearing.com

www.eljayhearing.com

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Rainbow Children's Hospital

BirthRight Rainbow

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 : IP18-00036545 **Admit Date** : 20-Jul-2026 **Admit Time** : 02:57 PM **UHID** : GUC-00094110

Patient Details :

Patient Name	: Baby B/O STELLA MARY .J	**Age**	: 0 D
Guardian	: Mr DHARMAR .M	**DOB**	: 20-07-2026 12:28 PM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 2/188 ragavendva nagar ckikaya puram kovil eb Kunnathur Kunnathur Kanchipuram Chennai Tamil Nadu INDIA 600069	**Phone No**	: 9790449822/ 6380043995
		E-mail	: no@gmail.com

Admission Details :

Bed Type : BASINET **Bed No** : CRDL-SUITE712-1 **Ward Name** : 7F-PVT/SUITE

Room No : CRDL-SUITE712-1 **Admission Type** : First Visit

Contact Details :

Name : Mr DHARMAR .M **Relationship** : Father

Contact Address : 2/188 ragavendva nagar ckikaya puram kovil eb Kunnathur Kunnathur Kanchipuram Chennai Tamil Nadu INDIA 600069 **Phone No** : 9790449822

Signature

Doctor Details :

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

Referral Doctor : self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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Rainbow Children's Hospital - Guindy

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TEL NO :044-40122444
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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby B/O STELLA MARY .J**	**Age :**	**0 Y 0 M 0 D 2 H**
IP No:	**IP18-00036545**	**Sex:**	**Male**
Consultant:	**Dr. GIRIDHAR S**	**Ward/Bed No:**	**6F-PRIVATE/CRDL-PVT605-1**

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: ∝

Relationship: ∝

Date: 20/7/26 Time: 3:04 pm

Wittness Name: V-Naveen Antony

Wittness Signature:

Patient Address:

2/188 ragavendva nagar ckikaya puram kovil eb Kunnathur Kunnathur Kanchipuram Chennai Tamil Nadu INDIA 600069

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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 Stella Mary. J	UHID Number : 94110
Self/Attendant Name : ✓	Relation : ✓
Self/ Attendant Signature : ✓ Phone Number : ✓	Name & Signature of Financial Counselor

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Patient Sticke

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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Mrs. Stella Mary. J Age : 28yr Father's Name : ..... Age : .....

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

NICU Consultant : Dr. Cuddan Referring Consultant : D- Sheela.

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

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

BIRTH INFORMATION

Name : B/- Stella Mary- J.

Gender : ☑ M ☐ F Blood Group : .....

Date of Birth : 20/7/26 Time of Birth : 12:28pm

Place of Birth : Rch Cuddy

Mother's Blood Group : 'A' Positive

Birth Weight (gms) : 3.084kg Length (cms) : .....

OFC (cms) : .....

Estimated Gesth Age : 37wk + 4days

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 38yr Ht : ..... Wt : ..... BMI : ..... Married Life : 10yr LMP : 29/10/25 EDD : 5/8/26.

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

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

Last Scans Details : 11/7/26 - SLIUA 36 + 3 wks, Cephalic, placenta Antua, SDP - 6, Liquor (N) TT Immunization and Iron / Folic Acid : .....

Doppler (N) - EFW - 2870gm

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs NT Scan - WNL

Consanguinity : ☐ Yes ☑ No FTS - low risk

If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3 Anomaly - (N)

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long : .....

Chr- HTN on labetalol

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 : .....

GDM on OHA.

Compliance with Rx : .....

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

H/o Hypothyriodism : when diagnosed ? Medication?

IC/C/O Hypothyroidism.

Any other Chronic Medical Problems, when detected drugs ? Anxiety disorder on T-Sertraline 50mg.

(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
I	5.5yr		2.9kg	Girl	FTNVD	PIH, Hypothyroidism
II	Spontaneous Conceptions.					

PERINATAL HISTORY

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

Duration of Labour

First stage (> 18 hours sig) Chronic MSL Grade II

Second stage (> 2 hours after dilation) NVD

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	9	9

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:

A Single live term Boy baby delivered via NVD. Grade II MSL Baby cried immediately after birth

HR - 164/m' / at 10 min
SpO_2 - 98%.

Investigation details in previous Hospital :

Feeding History :

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 : .....

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

Cardiovascular System :

HR : 164/m BP : ..... Precordial Activity : .....

Femoral Pulses : ..... Murmurs : .....

Other Peripheral Pulses : ..... Signs of Cardiac Failure : .....

Abdomen : Hernia orifice : .....

Shape : ..... Anal Patency : Patent

Palpation : ..... Umbilical Cord : 2 A + 1 V

Palpable masses : ..... First urine passed : Passed

Abdominal girth : ..... Meconium passed : Passed

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

State of wakefulness : .....

Prechtle Score : .....

Nerves :

.....

.....

.....

Motor System :

Passive Tone : .....

Active Tone : .....

Neonatal Reflexes : .....

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

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

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

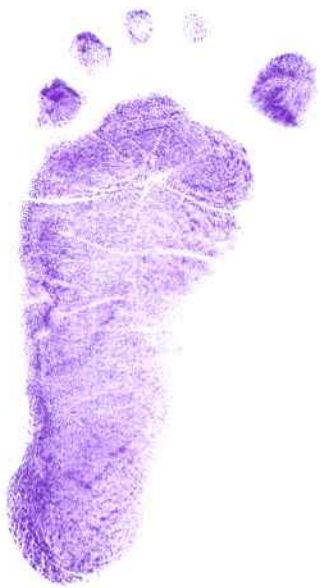
Patient Sticker

Any Congenital Anomalies : .....

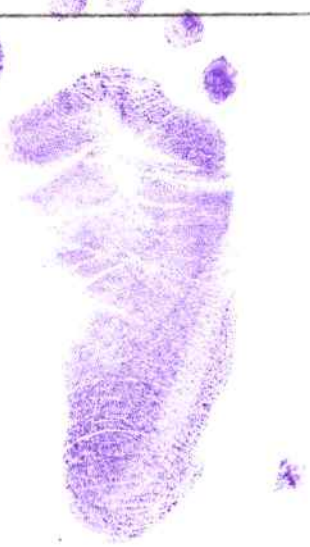
Diagnosis : Term 37wk + 4 days / Boy / 3.084 kg / AGA / MSL Grade II / Vigorous baby / IDM

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : .....

Name : Dr. Sruthi

Date & Time : 20/7/26

Consultant :

Signature : for .....

Name : Dr. Cruddha

Date & Time : 20/7/26.

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 :

1. DBF / warmth
2. CBG at 1 hour of life, FIG
CBG monitoring Q6H for 48 hrs.
3. Post ductal SPO_2 at 24 HOL
4. NBS, OAE, SBR at 48 HOL
5. Bulb vaccination
6. Observation for 1 hr. HR, SPO_2, RR

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

.....

.....

Screenings done during NICU Stay :

NSG : .....

Hearing Screen : .....

ROP : .....

TFT : .....

NP2 : .....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Dr Lovely Vignesh	
23/7/26 9:30AM	Δ: Term (37w+4d) / Boy / 3.084 kgs / AGA / MSL-II / Infant of diabetic mother / IDM	
		BWt: 3084 kgs
M/ Active B/ Active	Baby examined	TWt: 2955 kgs
	Normal C/T/A	% : 4.1%
	Pink in air	Δ: 129 grams
	Warm peripheries	
urine ✓	CRT <3 sec	
meconium ✓		
	RS: clear	PA: soft NT
	CVS: S1 S2 ⊕ / No murmur	CNS: (N) T/C/A.
	OAE - B/L pass	Adv
	NBS Done	1.) DBF Q2H / warmth
	SBr ↓	2) on SSPT
	22/7	Continue SSPT.
	SBr. 12.4 mg/dl	3) To decide on discharge
	↓ SSPT	after consultant rounds.
	23/7 → 10.9 mg/dl	
	Not in range for phototherapy	
	Lovely Vignesh	
	203377	

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

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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STAT / ONCE ONLY DRUGS

Name: ....

Weight: 3.084 kgs

Sheet No: (1)

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
20/7	12:40 pm	INJ-VIT-K	1mg	I.M	11333	MD	TJ
21/7/26	11:10AM	Inj HEP-B	0.5ml	IM	[illegible]	SM	PK
21/7/26	11:10AM	Inj BCG	0.05ml	ID	[illegible]	SM	PK
21/7/26	11:10AM	OPV drops	2drops	Oral	[illegible]	[illegible]	PK

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Patient Sticker

(1)

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:	12.35pm	4pm	8pm	12am	4am
Doctor/Nurse/Family Concern?					
Temperature (°F)	98F	98F	97.8F	98F	97.2F
Heart Rate (bpm) and Blood Pressure (mmHg) *	153	154			
Note: BP does not score in early warning scoring	on admission				
Heart Rate (Number)	153	154	148bpm	140bpm	124bpm
Resp. Rate (bpm) (Over 1 Minute) *	54	50			
Resp Rate (Number)	54	50	48rpm	46rpm	42rpm
Resp Distress: Mod/ Severe / None / Mild	-	-	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	99% Afebrile	99% Afebrile	99% (RA)	99% (RA)	98% (RA)
Conscious Level: Normal / Altered					
GCS *	15/15	15/15	AVPU	AVPU	AVPU
TOTAL SCORE Number of shaded boxes	0	0	0	0	0
Pain Score	0	0	0	0	0
Observer's Initials	TW	TW	N	N	N

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-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0 Y 0 M 0 D 4 H (M)
Dr. GIRIDHAR S

2

C. 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: 21/7/26 Time: 8AM 12PM 4PM 8PM 12AM 4AM

Doctor/Nurse/Family Concern?

Temperature (°F): 97.5F | 97.8F | 98F | 98.4F | 97.4F | 98.1F

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

Note: BP does not score in early warning scoring

Heart Rate (Number): 136 | 136 | 134 | 144 | 140 | 140

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

Resp Rate (Number): 40 | 40 | 42 | 42 | 45 | 40

Resp Distress	Mod/ Severe					
	None / Mild	✓	✓	✓	✓	✓
Receiving O_2 (l/min)		RA	RA	RA	RA	RA
O_2 Saturations (%)		99%	99%	98%	99%	98%
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						

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.
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Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0 Y 0 M 0 D 4 H (M)
Dr. GIRIDHAR S

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: 22/7/26 Time:	8AM	12PM	4PM	8PM	12AM	4AM
Doctor/Nurse/Family Concern?						
Temperature (°F)	98.6°F	98.6°F	98.2°F	98.1°F	98.1°F	98.3°F
Heart Rate (bpm) and Blood Pressure (mmHg) *	136 bpm	136 bpm	140 bpm	144 bpm	152 bpm	148 bpm
Resp. Rate (bpm) (Over 1 Minute) *	40 rpm	40 rpm	48 rpm	40 rpm	48 rpm	46 rpm
Resp Distress: Mod/ Severe / None / Mild	✓	✓	✓	✓	✓	✓
Receiving O_2 (l/min) O_2 Saturations (%)	98% RA	99% RA	99% RA	97% RA	97% RA	95% RA
Conscious Level: Normal / Altered	Alert	Alert	Alert	Alert	Alert	Alert
GCS *						
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Doctor's Initials				NB		

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.
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hould be

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Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Patient Stick

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0 Y 0 M 0 D 4 H (M)
Dr. GIRIDHAR S

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FLUID CHART

Sheet No. : 1

R. WT : 3.036kg

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
20/7/26												
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm		←			On Admission				→		
	01:00 pm	DBF				✓				✓	NO IV	
Total Intake : DBF 1time						Total Output :						
	02:00 pm										NO IV	
	03:00 pm	DBF					✓			✓	Line	
	04:00 pm										NO IV	
	05:00 pm	DBF									Line	
	06:00 pm	DBF									NO IV	
	07:00 pm										Line	
Total Intake : DBF 3times						Total Output : Urine / meconium passed						
	08:00 pm											
	09:00 pm	DBF									NO IV	
	10:00 pm											
	11:00 pm	DBF					✓			30ml	NO IV	
	12:00 am											
	01:00 am	DBF									IV	
Total Intake : 30ml DBF						Total Output : 30ml						
	02:00 am											
	03:00 am	DBF									NO IV	
	04:00 am	DBF										
	05:00 am										NO IV	
	06:00 am						✓			30ml	IV	
	07:00 am	DBF										
Total Intake : 30ml DBF						Total Output : 30ml						

Total 24 hrs. Intake	1otime DBF	Total 24 hrs. Output	Motion - 3 Urine - 4

RA	LA
SpO_2 - 99%	SpO_2 - 99%
pulse - 136 bpm	pulse - 140 bpm
SpO_2 - 99%	SpO_2 - 99%
pulse - 130 bpm	pulse - 140 bpm
RL	LL

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0Y0M0D4H (M)
Dr. GIRIDHAR S

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FLUID CHART

T.wt - 2.994 kg

Sheet No. : 2

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.

21/7/26		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am	DBF								30ml	NO	
	10:00 am											
	11:00 am	DBF					✓			30ml	IV	
	12:00 pm											
	01:00 pm	DBF									line	
Total Intake : DBF 3 Times.						Total Output : 60ml						
	02:00 pm	DBF								✓		
	03:00 pm						✓				NO	
	04:00 pm	DBF								✓	IV	
	05:00 pm						✓					
	06:00 pm	DBF								✓	line	
	07:00 pm											
Total Intake : DBF (3)						Total Output : 3 times.						
	08:00 pm	DBF									NO	
	09:00 pm									20ml	IV	
	10:00 pm	DBF									line	
	11:00 pm										NO	
	12:00 am	DBF								20ml	IV	
	01:00 am										line	
Total Intake : (3) hr × DBF						Total Output : 40ml						
	02:00 am	DBF									NO	
	03:00 am									20ml	IV	
	04:00 am	DBF									line	
	05:00 am										NO	
	06:00 am	DBF								30ml	IV	
	07:00 am										line	
Total Intake : 3 hr DBF						Total Output : 50ml						

Total 24 hrs. Intake	12 hr DBF	Total 24 hrs. Output	U-9 M-3

Patient Sti

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0Y0M0D8H (M)
Dr. GIRIDHAR S

Rainbow Children's Hospital
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FLUID CHART

T:W1 - 2.8774

Sheet No. : .....

22/7/26

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
	08:00 am											
	09:00 am	DBF									NO	
	10:00 am											
	11:00 am	DBF					✓			30	IV	
	12:00 pm											
	01:00 pm	DBF									line	
Total Intake : 3 times DBF								Total Output : 30ml				
	02:00 pm											
	03:00 pm	DBF					✓				NO	AA
	04:00 pm											AA
	05:00 pm	DBF									IV	AA
	06:00 pm											AA
	07:00 pm	DBF					✓			✓	line	AA
Total Intake :								Total Output :	Vomit - 1 Urine - 1			AA
	08:00 pm										0	EP
	09:00 pm	DBF								2ml	NO	EP
	10:00 pm						✓				NO	EP
	11:00 pm	DBF									NO	EP
	12:00 am										NO	EP
	01:00 am	DBF					✓			30ml	GNO	EP
Total Intake :		3 ml DBF						Total Output :	50ml			EP
	02:00 am										0	EP
	03:00 am	DBF								20ml	NO	EP
	04:00 am										NO	EP
	05:00 am	DBF									NO	EP
	06:00 am						✓			20ml	NO	EP
	07:00 am	DBF									NO	EP
Total Intake :		3 ml DBF						Total Output :	40ml			

Total 24 hrs. Intake	12 ml DBF	Total 24 hrs. Output	U-b M-b

Patient Stic

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0Y0M0D4H (M)
Dr. GIRIDHAR S

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: Newborn / Term			Any Infection: ☐ Yes ☐ No ☑ Not Known If Yes Specify: –			
	Surgery / Procedure:			Post OP Day: –			
BACKGROUND	Date / Shift	20/7/26 E	20/7/26 N	21/7/26 M	21/7/26 E	21/7/26 N	22/7 M
	Medical Condition (Any special condition to be noted):	DBF	–	–	–	–	–
	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:	98F	97.8F	98.6F		97.4	98.6°F
	Res:	52b/m	46 bm	46bm		44	40bm
	SpO_2:	99%	99%	99%		99%	99%
	Pulse:	158b/m	148 bm	140bm		144	140bm
	BP:	–	–	–	–	–	–
	LOC:	Conscious	Alert	Alert	Alert	Alert	Alert
	Fall Risk Score:	15	15	15	15	15	15
	Pain Score:	0/10	0/10	0/10	0/10	0/10	0/10
	Skin Integrity	Normal	Normal	Normal	normal	NA	NA
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No
	Physiotherapy:	NA	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	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 :		[illegible]	F [illegible]	S. meeli	Hasini	[illegible]	[illegible]
Signature / ID :		[illegible] 6120	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Date:		20/7/26	21/7/26	21/7/26	21/7/26	21/7	22/7
Time:		7.30pm	S. meeli	2pm	7.30pm	8pm	2pm
Taken Over By Name :		F [illegible]	[illegible]	Hasini	[illegible]	[illegible]	[illegible]
Signature / ID :		[illegible]	S. meeli	[illegible]	[illegible]	[illegible]	[illegible]
Date:		21/7/26	21/7/26	21/7/26	21/7/26	22/7	22/7/26
Time:		7.30pm	8am	2pm	8pm	8am	2pm

Docu. No. : RCH /FRM / CLINICAL / 097

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0Y0M0D4H (M)
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: 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							
Afternoon	1.30 pm	Promote adequate nutrition	2PM	* Assisst feeding * Monitor I/o * Monitor weight	Maintained good nutritional status to some extend	Reassessment done	
Night	7pm	- Assess the Baby Gerni condition - Provide warmth care to baby	10pm	- Assessed the Baby General Condition. - Provide warmth care to baby	Provided warmth care to baby	Baby temperature maintained	

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0Y0M0D8H (M)
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 CARE RECORD

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 Q2Hrly.	12pm	Assessed the Baby condition. Provided DBF Q2Hrly	Encouraged mother DBF	Done	Simeep [illegible]
Afternoon	2pm	Assess the baby feeding position.		Improve the baby nutritional support.	Evaluate the baby weight checking.	Re-assessment is done.	[signature] [illegible]
Night	8pm	Assess the baby Feeding Position	8.30 pm	Improve the baby Nutional Support	Encourage the baby weight chart	Re-assessment is done	[signature]

Docu. No: RCH /FRM / CLINICAL / 148

Patient St

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0Y0M0D4H (M)
Dr. GIRIDHAR S

(1)

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
20/7/26	12.22pm	Admission Notes (20/7/26)	
		B/o. Stella mary / Newborn /	
		Boy Baby delivered by mode	
		of Normal vaginal delivery.	
		Baby Resuscitation done by	
		Dr. Srilakshmi. Baby Vitals	
		and Recorded. Maintained I/O,	
		Baby Urine / Meconium passed	
		at birth. Vaccination not	
		done. Inj. vit-K o. Inj Imgion.	
		cord clamped. Baby well	
		and active	
		Baby Details	
		B - Alive Boy Baby	
		A - 20/7/26 at 12.22pm	
		B - 3.034/kg	
		y - 8/10, 9/10,	
	1.30pm	Baby well and active. Urine	
		Meconium passed. Vaccination	
		Not Done. DBF given.	
		Baby Mother side. Urine passed	
	2pm	Monitored Vitals and Record	
		Maintained I/O. Urine / Meconium	
		passed. DBF given. No any	
		other complaints	
	4pm	Monitored Vitals and Recorded.	
		Maintained I/O. Baby well	

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
20/7/26		and active. Vaccination Not Done	[signature] 01/670
	5pm	RBS Monitored 91mg/dl Informed to Continue DBF and RBS 6th hourly. DBF given. Vaccination Not Done.	[signature] 01/670
	6pm	Monitored vitals and Recorded. maintained I/O. DBF given. Baby Mother side	[signature] 01/670
	7.30pm	Baby Shifted to mother side Baby handling over to 4th floor staff to be followed duties and	[signature]
		Night duty on 20/7/26	
	7.30pm	Baby details handy over taken details handover g/n tamil Baby received from LDR to 4th floor. Baby active and good colour is pink and normal Baby urine and motion passed vaccine due to do ga. bilirubin, NBS @ 48 hours	[signature]
	8pm.	vital sign checked and Recorded. vitals are stable	[signature]
	10pm.	Baby is on Q2H DBF. feed taking well. Sucking is good. mother's milk secretion good (PT)	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Docu. No. : RCH /FRM / CLINICAL / 089

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0Y0M0D4H (M)
Dr. GIRIDHAR S

(2)

NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7/26	12 Am	Vital sign checked and Recorded Baby urine and motion passed	
	2 am.	Baby sleeping well. provided warmth care to baby →	
	4 am.	Maintain intake and output chart. Vital sign checked & Recorded	
	6 am.	Morning care is given. Weight Checked and Recorded. CBG Checked and Recorded →	
	7:00 am	Baby details handy over to Morning duty staff →	
		Morning duty	
21/7/26	7:30 Am	Baby details = Hand over taken from Night Duty staff. Baby active and alert, Baby ✓ Vitals are stable. Baby U/M passed, today vaccine plan - SBR/NBS/OAE after 48 HRS, RBS 6 HRly. →	607383.
	8 am	Baby Vital sign checked and recorded. vitals are stable. Maintained Ho chart. U/M passed, Baby sucking well & feeding well. →	607383.
	10 Am	Baby wo other complaints, sucking is good, Maintained Ho chart. →	607353.
	11 Am	Baby today vaccine explain to parents for Dr. Deepak sir BCG O.M.D	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

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

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☐ No Known Drug Allergies

☐ Drug Allergies ....Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
21/7/26	11AM	Hep-B 0.5ml IM, OPV 2 drops P/O	
		given as per order. →	Suf 607373
	11:30PM	Dr. Giridhar sir came and seen	
		assessed the baby condition,	
		Vaccine done, SBR/NBS 1OAF. at 6AM	
		22/7/26. RBS Q6Hrly. →	Suf 607373
	12pm	Baby vitals are stable RBS	
		checked and recorded. RBS 64mg/dl.	
		Maintained flowchart. →	Sindhu 64355
	1:30pm	Baby details Hand over given to	
		Evening Duty staff. →	Suf 607373
		Evening Duty	
	2pm	~~Baby vitals are~~	
		Baby details casefile handing	
		over taken from the morning	
		duty to evening duty staff.	
		Baby vitals are monitoring	
		and reported vitals are stable. →	Hari 607915
	3pm	Baby is activity well	
		and general condition is assisted	
		and baby continues monitoring	
		I/O chart and continuous of	
		intake DBF is advised to the	
		baby mother.	Hari 607915
	4pm	Latching is well audiable	
		sound and sucking well	
		good. Baby RBS level is Q 6th hourly checked	Hari

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0 Y 0 M 0 D 8 H (M)
Dr. GIRIDHAR S

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NURSES NOTES

Rainbow Children's Hospital
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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
2	6.pm	monitored input and output chart and Recorded.	
	7.30pm	Handover given to night Duty staff	[signature]
		⇒ NIGHT DUTY ⇐	
21/7/26	7.30pm	Baby report hand over taken from evening duty staff. baby is active cry & colour breathing is Normal	
	8pm	⇒ Baby vital signs checked & recorded, General condition fair	⇒ [signature]
	9pm	⇒ Baby temp 20B7 & sucking well. No other complaints	⇒ [signature]
	10pm	⇒ Baby passed urine & motion no other complaint	⇒ [signature]
22/7/26	12mn	vital signs checked and Recorded, vitals are stable	⇒ [signature]
	2am.	Baby sleeping well. provided warmth care to baby	[signature]
	4am	maintain intake and output chart.	[signature]
	6am	Morning care is given. Sr.bili, NBS sample collected & sent to lab	[signature]
	7.30am	Baby details handing over (N) duty	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Docu. No. : RCH / FRM / CLINICAL / 089

Patient Sticker

NURSES NOTES

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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
		Morning duty	
22/7	7:30pm	Baby details Hand over taken from Night duty staff. Baby vitals are stable. Maintained I/O chart, today DISP Lin, SBR/ NBS/ CPE today, U/M passed, DBF only.	Sd 607353
	8AM	Baby vital signs checked and recorded. vitals are stable. U/M passed.	Sd 6073
	6pm	Baby SBR-12.4 Inform to Dr. Giridhar sir D/b come and seen assessed the Baby condition, DBF Q2Hrly, SSPT start, repeat SBR at 6AM	Sd 607353
	12pm	Baby no other complaints maintained I/O chart.	Sd
	1-30pm	Baby details Hand over given to Evening duty staff	Sd 6073
		Evening duty Note	
22/7/26	1·30pm.	Baby details handing Over taken from Morning duty Staff. Baby Bed Side Assessment done.	Sd
		Conscious & Oriented. Urine & Motion passed. active & Alert. Baby Breast feeding Sucking good.	Sd

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Docu. No. : RCH /FRM / CLINICAL / 089

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0 Y 0 M 0 D 4 H (M)
Dr. GIRIDHAR S

Patient St

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NURSING DEPARTMENT
NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/o. Stella Mary Mother's Name: Mrs: Stella

Date of Birth: 20/7/26 Time of Birth: 12.23pm Gender: ☑ Male ☐ Female

Birth Weight: 3.034 Kgs HC: 34 cm Lenght: 44 cm

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

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

Resuscitated: ☑ Yes ☐ No Blood Group: Mother: A+ve Baby: Awaited

Feeding: ☑ Breast Feeding ☐ Formula ☐ Both First Feed Tim 9 min

GUC-00091442 IP18-00036534
Mrs STELLA MARY .J
05-02-1988 38 Y 5 M 15 D (F)
Dr. SHEELA M

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

Indication: Poor maternal effort

Physical Assessment of New Born:

Temp: 98F °C HR: 158bt/Min RR: 50br /Min BP: — SpO_2: 99%

Pain Score: ..... (Follow N Pass)

Fall Risk Assessment: ☑ Yes ☐ No **Score:** 15 (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: S/N: Tamilselvi Signature: Date &Time: 20/7/26 at 1pm

Patient Sticker

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0 Y 0 M 0 D 4 H (M)
Dr. GIRIDHAR S

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE E 20/7/20	DATE N 20/7	DATE M 21/7	DATE E 21/7	DATE N 21/7
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	1					
	Female	2	2	2	2	2	2
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					
Environmental Factors	History of Falls or Infant-Toddler Placed in Bed	4					
	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		15	15	15	15	[illegible]

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	—	NR	X	X	X
	—	NR	X	X	X
Nurse's Name:	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Signature:	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Date:	20/7/20	20/7	21/7	21/7	21/7
Time:	1pm	8pm	8AM	8pm	8pm

Docu. No. : RCH /FRM / CLINICAL / 005

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0Y0M0D8H (M)
Dr. GIRIDHAR S

Patient Sti

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THE HUMPTY DUMPTY SCALE

M F N M

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			22/7	22/7	22/7	23/7	
Age	Less than 3 years old	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	2	2	2	2	
	Female	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	
Cognitive Impairments	Not aware of Limitations	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	
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3	1	1	1	1	
	Within 48 hours	2					
	More than 48 hours/ None	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	
	Total		15	15	15	15	

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		x	x	x	x	
Nurse's Name:		SD	[illegible]	Vdk	SD	
Signature:		SD	[illegible]	Vdk	SD	
Date:		22/7	22/7	22/7	22/7	
Time:		8AM	8PM	8PM	8AM	

Docu. No. : RCH /FRM / CLINICAL / 005

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GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0 Y 0 M 0 D 4 H (M)
Dr. GIRIDHAR S

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

BRADEN 'Q' SCALE

(for Paediatric use)

Gender : ☐ M ☐ F IP No. : .....

					Date :	20/7/26	21/7 M	21/7 B
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.		3	3	3
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4
					TOTAL SCORE	24	24	24
					Evaluator's Name			

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

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GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0 Y 0 M 0 D 4 H (M)
Dr. GIRIDHAR S

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

BRADEN 'Q' SCALE

(for Paediatric use)

Patient Name : .....

Age.....

					M	B	N
Date :					21/7	22/7	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	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 life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of 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	24	27	27	27
				Evaluator's Name				

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

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0 Y 0 M 2 D (M)
Dr. GIRIDHAR S

(3)

BRADEN 'Q' SCALE

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

BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

					Date : 23/7			
					Time : M			
Mobility	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			
"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			
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			
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			
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			
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			
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			
				TOTAL SCORE	24			
				Evaluator's Name	SP			

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

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

GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0 Y 0 M 0 D 4 H (M)
Jr. GIRIDHAR S

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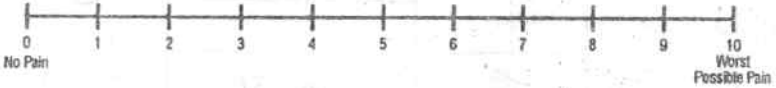
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7/26	2pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NIL	0/07/26
21/7/26	8pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
21/7/26	2pm	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	607383
21/7/26	8pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
21/7/26	8pm	0/10	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	
22/7/26	6pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
22/7	12pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil	
22/7	6pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	02/7/26

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.

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

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Dr. GIRIDHAR S (M)

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PAIN ASSESSMENT FORM

Date	[illegible]	...re (...)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
23/7	3AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[signature] 021864
23/7	9AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
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Docu.No: RCH /FRM / CLINICAL / 152

(P.T.O)

PAIN ASSESSMENT TOOLS

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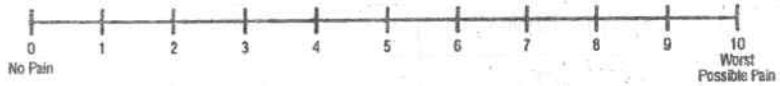

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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 / Term
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 (circled)
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	Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding	Comments	Designation / Signature
				Use codes from the list in part III						
20/7/26	2pm	Nutrition Diet	Educated to Mother about DBF	Mother	No	oral	None	verbal	Good	[signature] 610726
21/7/26	8Am	yes	Educated to mother about DBF	mother	NO	oral	None	verbal	Good	[signature] 60738
22/7	8Am	yes	Educated to mother about DBF	Mother	NO	oral	None	verbal	Good	[signature]
23/7	8Am	yes	Educated about DBF Q2Hrly	mother	NO	oral	none	verbal	Good	[signature]

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

Doc No. : RCH / FRM / CLINICAL / 187

PATIENT TRANSFER FORM

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GUC-00094110 IP18-00036545
Baby B/O STELLA MARY .J
20-07-2026 0 Y 0 M 0 D 4 H (M)
Dr. GIRIDHAR S

	Date & Time of Admission	Date & Time of Transfer Order
	20/7/26 at 2.57pm	20/7/26 at 7.30pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Giridhar	Dr. poojitha	Shifted to ward
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**
DPF(10)		Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Baby pampers	1
2.	Baby wipes	1
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S/N. Pavithra 20/7/26	Dr. poojitha

Patient & Clinical Records Received by : [signature]

Date & Time of Patient Received : 20/7/26 @ 7.50pm

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

Docu. No. : RCH /FRM / CLINICAL / 102