Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

GUC-00093931 IP18-00036491
Baby B/O VARSHA G
18-07-2026 0 Y 0 M 0 D 20 H (F)
Dr. PADMAPRIYA EKAMBARAM

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIMATE	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		12.15 pm					
Activity Sheet update by Pharmacy							

GUC-00093931 IP18-00036491
Baby B/O VARSHA G
16-07-2026 0Y0M0D1H (F)
Dr. PADMAPRIYA EKAMBARAM

RCH NO : -133011806
-174

ACTIVITY RECORD FOR BILLING

Name: B.O Varsha

UHID No: 93931 IP No: ..... Consultant: ..... 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
16/7/26	8.50 Am	NICU	7th Floor	Shalini 0140726

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
16/7/26	Blood grouping	26022838	Pool
16/7/26	FBS	26022855	Pool
16/7/26	RBS	26022886	
16/7/26	RBS	26022933	
17/7/26	RBS	26022944	
17/7/26	RBS	(26021002) 26022819	

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 17/7/26 Time: 4pm 12Δ0 Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Nurse			

Rainbow Children's Hospital | BirthRight

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	1.00pm				
	INTIME	OUT TIME			
Arrangement of File by Nursing		1.15pm	P.[illegible]60226'		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

T. Wt → 3.389kg
HC – 33cm
length – 46cm.

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0 Y 0 M 0 D 1 H (F)
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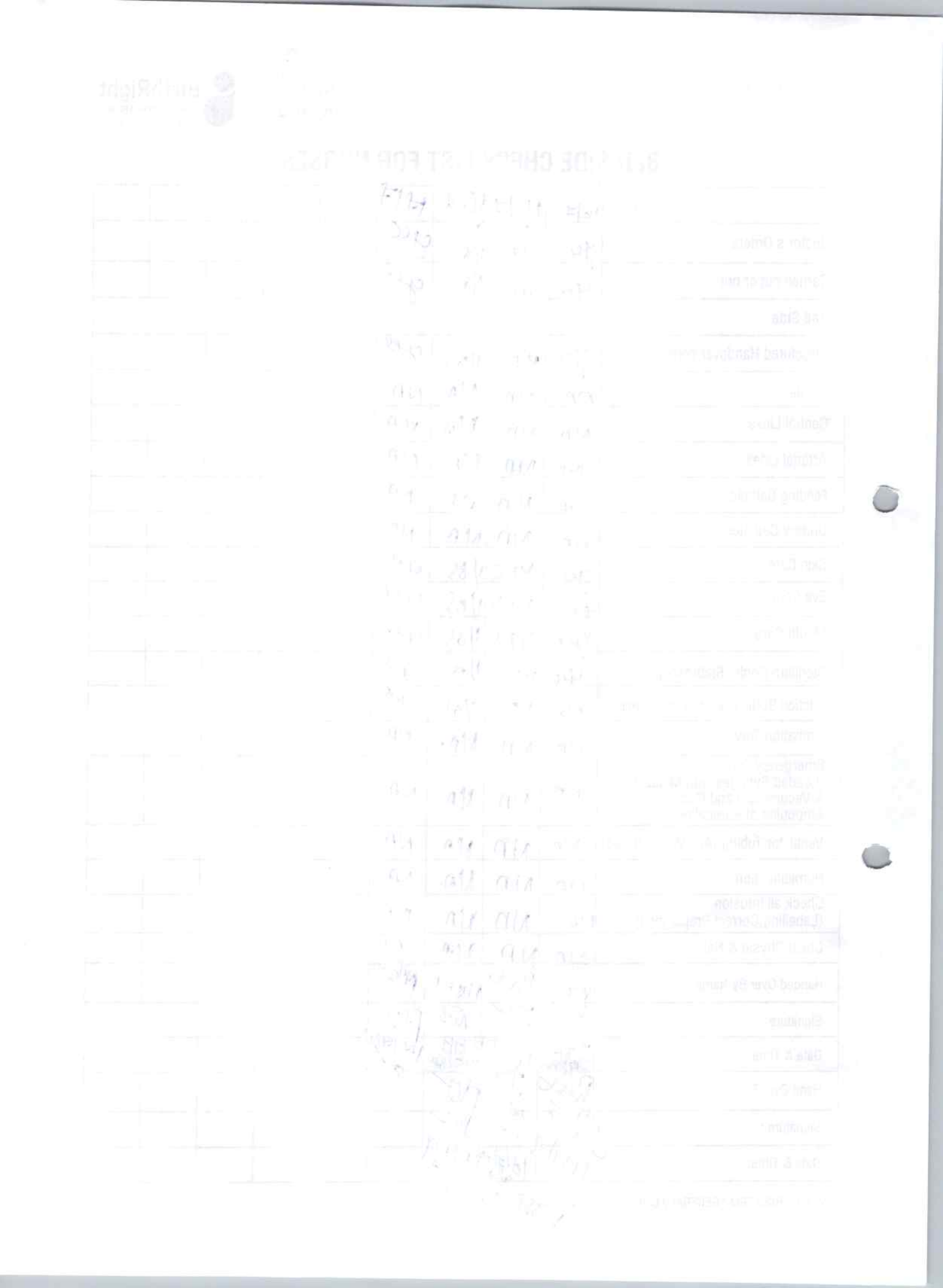
BED SIDE CHECK LIST FOR NURSES

Date:	16/7	16/7	16/7	16/7					
Doctor's Orders	Yes	E YES	N YES	yes					
Carried out or not	Yes	YES	YES	yes					
Bed Side									
Structured Handover done	Yes	YES	YES	yes					
IV Site	NA	NA	NA	NA					
Central Lines	NA	NA	NA	NA					
Arterial Lines	NA	NA	NA	NA					
Feeding Catheter	NA	NA	NA	NA					
Urinary Catheter	NA	NA	NA	NA					
Skin Care	Yes	YES	YES	yes					
Eye Care	Yes	YES	YES	yes					
Mouth Care	Yes	YES	YES	yes					
Sterillum Bottle, Stethoscope	Yes	YES	YES	yes					
Suction Bottle (Should be clean & empty)	NA	YES	YES	yes					
Intubation Tray	NA	NA	NA.	NA					
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA	NA	NA	NA					
Ventilator Tubing,(Any Water, Blood)	NA	NA	NA	NA					
Humidification	NA	NA	NA.	NA					
Check all Infusion (Labelling,Correct Preparation)	NA	NA	NA	NA					
Chest Physio & Neb	NA	NA	NA.	NA					
Handed Over By Name :	[illegible]	[illegible]	VARSHA	[illegible]					
Signature :	[illegible]	[illegible]	[illegible]	[illegible]					
Date & Time:	16/7/26	16/7/26 1:30 PM	16/7	16/7/26 8					
Hand Over Taken By Name :	[illegible]	[illegible]	[illegible]						
Signature :	[illegible]	[illegible]	[illegible]						
Date & Time:	16/7/26	16/7/26 1:30PM	16/7/26	16/7/26 8					

Doc. No. : RCH/ FRM / GENERAL / 088



Rainbow Children's Hospital

BirthRight by 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 : IP18-00036491 **Admit Date** : 16-Jul-2026 **Admit Time** : 05:36 AM **UHID** : GUC-00093931

Patient Details :

Patient Name	: Baby B/O VARSHA G	**Age**	: 0 D
Guardian	: NARESH A	**DOB**	: 16-07-2026 04:40 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: PT 24, RAMAKRSHNA NAGAR, ANANDA NAGAR, SANTHOSHPURAM Selaiyur Chennai Tamil Nadu INDIA 600073	**Phone No**	: 8925025861/ 9176336903
		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 : NARESH A **Relationship** : Father

Contact Address : PT 24, RAMAKRSHNA NAGAR, ANANDA NAGAR, SANTHOSHPURAM Selaiyur Chennai Tamil Nadu INDIA 600073 **Phone No** : 8925025861

Signature

Doctor Details :

Doctor Name : Dr. PADMAPRIYA EKAMBARAM **Specialisation** : GENERAL PEDIATRICS

Referral Doctor : Dr. Priyadharshini S M **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby B/O VARSHA G**	**Age :**	**0 Y 0 M 0 D 1 H**
IP No:	**IP18-00036491**	**Sex:**	**Female**
Consultant:	**Dr. PADMAPRIYA EKAMBARAM**	**Ward/Bed No:**	**7F-PVT/SUITE/CRDL-SUITE712-1**

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: > A. Nared.

Name: > A. Nared.
Relationship: > Father
Date: 16-07-2026 Time: 5:36
Witness Name: Irwin
Witness Signature:

Patient Address:
PT 24, RAMAKRSHNA NAGAR, ANANDA NAGAR, SANTHOSHPURAM Selaiyur Chennai Tamil Nadu INDIA 600073

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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 : > Baby of Varsha	UHID Number : 93931
Self/Attendant Name : > A. Naresh	Relation : > Father
Self/ Attendant Signature : > A. Naresh. Phone Number : > 9176336903	Name & Signature of Financial Counselor

GUC-00093931 IP18-00036491

Baby S/O VARSHA G

16-07-2026 0 Y 0 M 0 D 1 H (F)

Dr. PADMAPRIYA EKAMBARAM

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RBS CHART

6 hrly

Date	Time	RBS (mg/dl)	IVF %	Signature
16/7/26	5.40Am	76mg/dl.	Dr. Shilakshmi	SNICU
16/7/26	12PM	60mg/dl	6hrly	
16/7/26	6pm	90mg/dl	6Hrly	
17/7/26.	12Am	70mg/dl	6Hrly	
	~~6Am~~	stop	~~6Hrly~~	

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

IP18-00036491

Baby B/O VARSHA G
16-07-2025 0 Y 0 M 0 D 1 H (F)
Dr. PADMAPRIYA EKAMBARAM

Patient St

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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Mrs. Varsha. G. Age : 26yr Father's Name : ..... Age : .....

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

NICU Consultant : Dr. Padma Riya Referring Consultant : Dr. Priyadarshini

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

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

BIRTH INFORMATION

Name : B/o Varsha. G

Gender : ☐ M ☑ F Blood Group : .....

Date of Birth : 16/7/26 Time of Birth : 4:40Am

Place of Birth : RCH LDR

Mother's Blood Group : AB +ve.

Birth Weight (gms) : 2.494kg Length (cms) : .....

OFC (cms) : .....

Estimated Gesth Age : 37wk +4 days

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 26yr Ht : ..... Wt : ..... BMI : ..... Married Life : ..... LMP : 25/10/25 EDD : 1/8/26

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

Booked at what GA. : B & I AN Steroids Drugs / Doses : .....

Last Scans Details : 15/7/26 - SLIUA, cephalic, placenta posterior, liquor (N)
SDP - 5.4 . Doppler (N)

TT Immunization and Iron / Folic Acid : .....

EFW - 2415gm

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs NT - (N)

Consanguinity : ☐ Yes ☑ No FTS - low risk
Anomaly - (N)

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 / Redistribution 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: ..... P: ..... A: ..... L: .....

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

PRIMI

PERINATAL HISTORY

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

Duration of Labour

First stage (> 18 hours sig)

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
8	9	9

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:

A single live term GIRL baby delivered via NVD. Baby cried immediately after birth. Normal transition

HR- 168/min
SpO2 - 98% at RA
/at 10min

Investigation details in previous Hospital :

Feeding History :

Patient Sticker

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.4°C HR : 168/min RR : 54/min NIBP : ..... CFT : .....

Color of the extremities : Pink

Jaundice : - Pallor : - SpO2 : 96% on RA

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

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

Patient Sticker

HEAD TO TOE EXAMINATION

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

Facies : (Any Facial Dysmorphism)

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

EYES :
Symmetry :
Red Reflex :
Discharge :

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

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

ABDOMEN and UMBILICUS :
Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump : 2 + 1 V
Discharge :

GENITILIA :
Labia / Hymen :
Testicles/penis :
Anus : tip not sterical

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

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

Patient Sticker

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☐ Regular ☐ Periodic ☐ Shallow ☐ Gasping

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

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

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

Settings : .....

Spo2 : ..... Auscultation : ..... Breath Sounds : ..... Added Sounds : .....

Cardiovascular System :

HR : 164/m BP : .....

Femoral Pulses : ..... Precordial Activity : -

Other Peripheral Pulses : ..... Murmurs : -

Signs of Cardiac Failure : -

Abdomen :

Shape : ..... Hernia orifice : .....

Palpation : ..... Anal Patency : tip not stenal

Palpable masses : ..... Umbilical Cord : 2A+1V

Abdominal girth : ..... First urine passed : -

Meconium 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 : .....

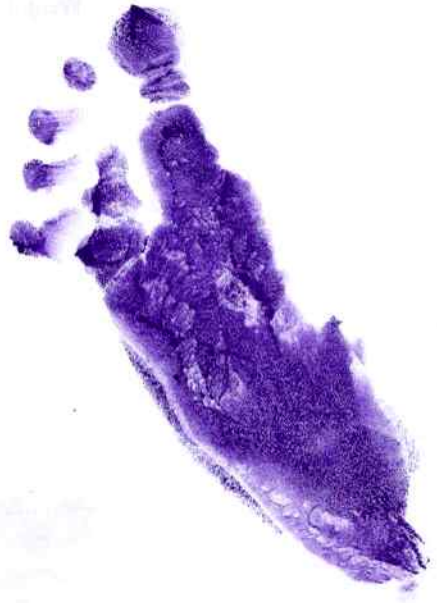
Patient Sticker

Any Congenital Anomalies : .....

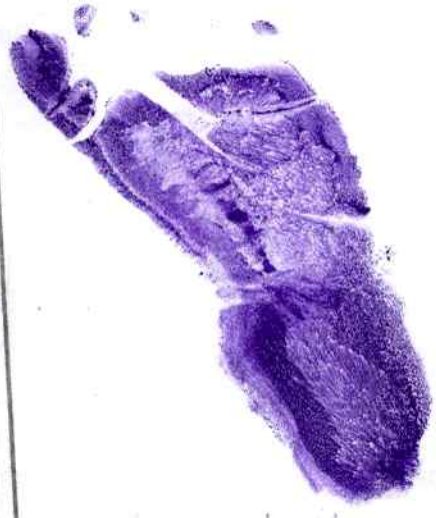
Diagnosis : Term 37 +4 wks | Cuil | 2.494 kg (14.1.1)
AGA | LBW

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : .....

Name : D. Sheikh

Date & Time : 16/7/26

Consultant :

Signature : .....

Name : D. Padma Priya

Date & Time : 16/7/26

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, F/b CBG monitory Q6H for 48 hours
3. Post ductal SPO2 at 24 hours of life
4. NBS, OAE, SBR at 48 HOL
5. Birth vaccination

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

.....

.....

Screenings done during NICU Stay :

NSG : .....

Hearing Screen : .....

ROP : .....

TFT : .....

NP2 : .....

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16-07-2026 0Y0M0D1H (F)
Dr. PADMAPRIYA EKAMBARAM

Patient S

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B. Dr. Lucky/Vignesh	
16/7/26 4.25 AM.	Δ: Term (37+4 weeks) / Male / 2.494 kg / AGA / LBW.	(Imm - NVD)
	Bwt 2.494 kg	M/ ABTve
	Twt: 2.459 kg	B/ BTve
	Δ: (physiological) / 35g (1.4%)	cries - heard
	↓ 1.4%	meconium - not passed
	Birth time: 16/7/26 4:30AM	
	Baby rained	
	pink in air	
	warm supplies	
	CRT 2 sec	
	RS: clear	CVS: (N) cy/tone / Acyan
	CVS: S1S2 (+) / No murm	PA: soft / NT / no masses
		Adv'c
		1) DBF - Qam / warm
		2) CBG - Q6A for 48hrs
	Lucky 10.31 PM	3) pre-ductal spO2 at 17/7/26 (5.00 AM).
		4) Vaccination (Today)
	E-Padmapriya	

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
17/11/16 10:40 AM	S/B. Ar LRLLEYNCINFECTN	
	Δ: Term (37+4) /Girl/ 2.494 kgs/ AGA/ LGW	
	Bwt: 2.494 kgs	M / ABthe
	TWT: 2.389 kgs	B / Bthe
	↓ 4.2 %	
	Δ: 105 g	
	vitals: stable	
	Baby remind	
	pallor in ant	
	warm limbs	
	RS: clear	CVS: S1S2+0 / No murmur
	PA: SOFT/NT / NO ORGS	CNS: NFND.
	L/ wise satisfac	Advice
	↓	1) OBF Orally / warm
		2) Cont nursing till 48 hrs
	Discharge today	3) NBS/OAE/SBR at review if
	E-Padmapriya.	mom discharge

GUC-00093931 IP18-00036491
Baby B/O VARSHA G
16-07-2026 0Y0M0D1H (F)
Dr. PADMAPRIYA EKAMBARAM

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STAT / ONCE ONLY DRUGS

Name: .....

Weight: 2.494 kgs

Sheet No: .....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
16/7	4:50 Am	INJ. VIT-K	1mg	I.M		SP	DS
16/7	5pm	INJ. BCG	0.1ml	ID		SM	KH
16/7	5pm	INJ HEPATITIS B	0.5ml	IM		SM	KH
16/7	5pm	OPV	2 DROPS	PO		SM	KH

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Dr. PADMAPRIYA EKAMBARAM

Patient Stick

/ CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 16/7/26 Time: A: 11:24pm

Doctor/Nurse/Family Concern?

Temperature (°F): 104 103 102 101 100 99 98 97 96 95 94

Heart Rate (bpm) and Blood Pressure (mmHg) *: 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

Note: BP does not score in early warning scoring

Heart Rate (Number) 142

Resp. Rate (bpm) (Over 1 Minute) *: 70 60 50 40 30 20 10

Resp Rate (Number) 40

Resp Distress	Mod/ Severe	
	None / Mild	
Receiving O_2 (l/min)		
O_2 Saturations (%)		
Conscious Level	Normal	✓
	Altered	
GCS *		15/15
TOTAL SCORE Number of shaded boxes		0
Pain Score		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. PADMAPRIYA EKAMBARAM

/ FRM / CLINICAL / 124

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 16/7/26 Time: 8Am | 12pm | 4pm | 8pm. | 12Am. | 4Am.

Doctor/Nurse/Family Concern?

Temperature (°F): 98.6F | 98.6F | 98.9F | 97.6F | 98.2F | 97.7F

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

Note: BP does not score in early warning scoring

Heart Rate (Number): 146bpm | 146bpm | 136bpm | 140bpm | 136bpm | 142bpm

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

Resp Rate (Number): 48bpm | 42bpm | 40bpm | 42bpm | 40bpm | 44bpm

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

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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* 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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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-00093931 IP18-00036491
Baby B/O VARSHA G
16-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. PADMAPRIYA EKAMBARAM

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FLUID CHART

Sheet No. : 1

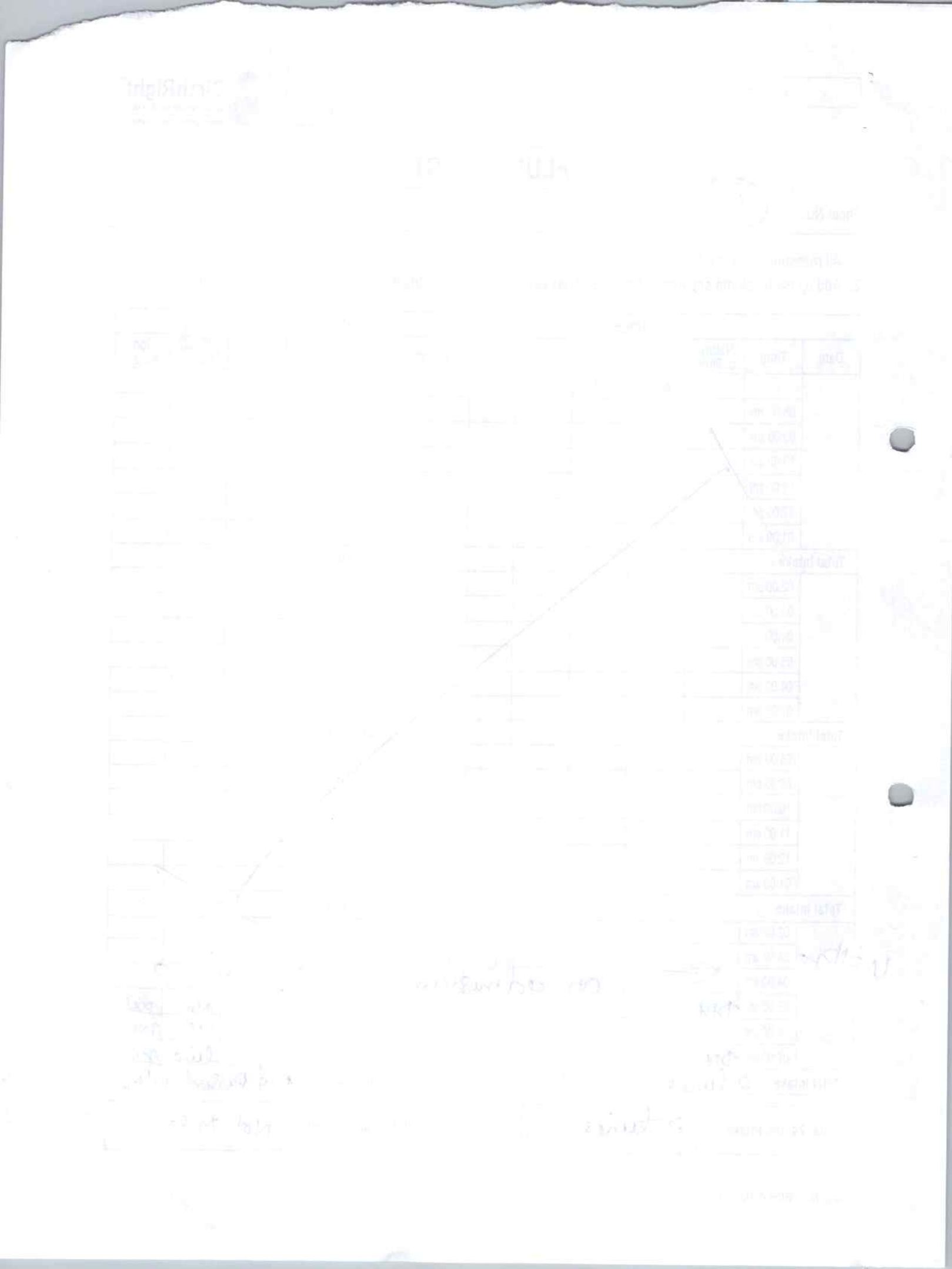
1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

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
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am	DBF										
	06:00 am											
	07:00 am	DBF										
Total Intake : 2 times						Total Output : Not passed U/M						

16 FEB ← on admission

NAD Post
UC Post
Line Post

Total 24 hrs. Intake	2 times	Total 24 hrs. Output	Not passed



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Baby B/O VARSHA G
16-07-2026 0Y0M0D1H (F)
Dr. PADMAPRIYA EKAMBARAM

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FLUID CHART

Sheet No. : (2)

R/W - 2.459/kg.

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.

16/7/26		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								No	SS
	09:00 am									30ml	IV	SS
	10:00 am	DBF									line	K·A
	11:00 am											K·A
	12:00 pm	DBF									No	V·A
	01:00 pm									30ml	IV	V·A
Total Intake : 3 time of DBF						Total Output : 60 ml					line	V·A
	02:00 pm											SS
	03:00 pm	DBF								diaper stool	No	Sm
	04:00 pm											Sm
	05:00 pm	DBF					✓			diaper stool	IV	Sm
	06:00 pm											Sm
	07:00 pm	DBF									line	Sm
Total Intake : 3 Time DBF						Total Output : U - 2					M - 1	
	08:00 pm											nsg
	09:00 pm	DBF									No	nsg
	10:00 pm											nsg
	11:00 pm	DBF								✓	IV	nsg
	12:00 am						✓					nsg
	01:00 am	DBF									line	nsg
Total Intake : 3 Time DBF						Total Output :						nsg
	02:00 am											nsg
	03:00 am	DBF									No	nsg
	04:00 am											nsg
	05:00 am	DBF									IV	nsg
	06:00 am									✓		nsg
	07:00 am	DBF									line	nsg
Total Intake : 3 Time DBF						Total Output :						nsg

Total 24 hrs. Intake	12 Time - DBF	Total 24 hrs. Output	Urine : 6 Time Motion : 2 Time

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NURSING CARE RECORD

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

Date: 16/7/26

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							
Night		maintain personal hygeene		- assess the baby condition - chang clothes regularly - keep baby warmth	maintained personal hygiene	reassessment is done	poo on

Docu. No: RCH /FRM / CLINICAL / 148

GUC-00093931 IP18-00036491
Baby B/O VARSHA G
16-07-2026 0 Y 0 M 0 D 13 H (F)
Dr. PADMAPRIYA EKAMBARAM

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BirthRight BY RAINBOW HOSPITALS
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NURSING CARE RECORD

Date: 16/7/26

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	6pm	Promote adequate Nutriti	8pm	→Asses the Baby Condition. →Monitor the chart →provide DSF Q2H →Monitor weight Daily	Maintain good Nutrition	Reassessment was done	Shal olyoth
Afternoon	1:30pm	Maintain the Provide the Adequate Nutritions	3PM	Assess the baby latch Condition and Encourage the feeding process	baby swalling is good 2nd hourly feeding teaching Done	Re Assessment Done.	
Night	8pm	TO prevent infection.	9pm	TO Assess the general condition. TO monitor vital signs. TO maintain hand hygie.	Infection will be prevented	Reassessment was done.	

GUC-00093931 IP18-00036491
Baby B/O VARSHA G
16-07-2026 0Y0M0D1H (F)
Dr. PADMAPRIYA EKAMBARAM

NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		K/C On admission notes	
16/7/26	4.40AM	B/O varsha GA-37w+4d A single baby delivered Normal Normal vaginal delivery Baby cried at birth. Delayed cord clamping done. Dr. Srilakshmi received the baby. kept in warmer cleaning done. vital signs checked & recorded. vital signs are stable, cleaning done. NG tube passed. mucus cleared. Inj. Vit-K given. cord blood collected for Blood grouping - send to lab as per doctor's advice. Baby is warm, pinkish colour.	
		Date - 16/07/2026	
		Time - 4:40AM	
		Sex - Girl	
		weight - 2.494 kgs.	
		APGAR - 8 to, 9 to.	Staff Nurse
	5AM	DBF given to baby sucking good. mothers had good milk secretion. Urine, motion not passed at birth.	Staff Nurse
	5.40AM	CBG checked as per doctor's advice 76mg/dl informed to	

Contd to next page.

6 Type ISO 11140 | STEAM | Green = Sterilized | Man.: 2025 - 06 Exp.: 2030 - 06 Ref.: 106.303.0500 Lot.: 14176 | SV: 121°C - 15 min. 134°C - 3,5 min. | Sterintech

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
16/7/26		Dr. Sri Lakshmi. Advice to continue 6th hrly phone. orders carried out. vaccination not done.	SM/Rooo
	6 AM	Baby is Stable. warmth. maintain Dro chart. Humpty, Dumpty, Braden q, pain assessment done.	SM/Rooo
	7 AM	Baby is stable warmth, pinkish colour. placed the baby on mother side.	Rooo
	7.30 AM	Baby care hand over given to morning duty staff	Rooo
		Morning duty on 16/7/26	
	7.30 AM	Report Received from Night Duty Staffs to Morning duty Staffs. Baby Activity are good No Irritation	
	8 AM	vital sign Checked & Recorded vital sign are stable.	Shalini ONOT
		Baby DBF taking well No vomiting.	
		Baby vaccination Not done.	
		Baby urine, Meconium Not passed Dro chart Maintain	
	8.30 AM	Baby Shifted 1st floor ward	Shalini ONOT

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00093931
Baby B/O VARSHA G IP18-00036491
16-07-2026 0 Y 0 M 0 D 13 H (F)
Dr. PADMAPRIYA EKAMBARAM

NURSES NOTES

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

☐ No Known Drug

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		RECEIVING NOTES	
	8:55 am	Baby received from LDR 6th floor. Baby was pink in colours. Active and cried * RBS done baby was monitored BT Q2H vaccine today	
	10:00am	Baby was bathed good no other complaints baby was sleepy	
	12:00pm	time for feeding. Baby latch well. baby on another side L - 2 A - 2 T - 2. C - 1 U - 1/8 cried to be Supervised is	
	1:00pm	maintained to chart and recorded no other complaints	
	1:30pm	Baby details handing over taken by evening duty staff	
	1:30PM	Evening duty ON 16/7/26. Baby Condition and details handing Over taken from Evening duty staff	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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Your Right to a Safe Delivery

NURSES NOTES

☐ ~~No Known~~ Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
16/7/26	2PM	CNS:- baby is Conscious & Oriented CRS EA VS ML.	
		CVS:- S1 and S2 heart Sounds are hearing good →	02187
		Res:- Bilateral breathing pattern	
		GIT:- Abdomen is las soft Bowel opend	
		GUV:- Suf voiding Fall Risk:- Low Risk	
		Diet:- DBF 2nd hourly Given	
	3PM	DBF will be Given baby Swalling is good →	02/1875
		L-2	
		A-2	
		T-2	
		CH-2	
		H-1 Total score 9	
	APM.	Vital singe. are Recorded and Monitored done H.D stable	
		CP PP CF+	
		++ ++ +++ →	Pound 02187
	5PM	Dr. Chandra Lekha mam Explain to parents today vaccine plan BCG 0.1ml ID, Hep-B 0.5ml IM, opv 2drops, plo Given as per order. →	02/2
	6pm	Baby vitals are stable. maintained bed dry. →	16/7

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00093931 IP18-00036491
Baby B/O VARSHA G
16-07-2026 0 Y 0 M 0 D 1 H (F)
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NURSING DEPARTMENT
NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/o varsha Mother's Name: Mrs. Varsha

Date of Birth: 16/7/26 Time of Birth: 2:40pm Gender: ☐ Male ☐ Female

Birth Weight: 2.49kg Kgs HC: 36 cm Lenght: 49 cm

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

Term / Pre-term / Post-term: Term

Resuscitated: ☐ Yes ☐ No Blood Group: Mother: AB +ve Baby: .....

Feeding: ☐ Breast Feeding ☐ Formula ☐ Both First Feed Time: 5pm

GUC-00092505 IP18-00036487
Mrs VARSHA G
05-08-1999 26 Y 11 M 11 D (F)
Dr. PRIYADHARSHINI S M

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

Indication: .....

Physical Assessment of New Born:

Temp: 36.5 °C HR: 140 /Min RR: 40 /Min BP: ~ SpO_2: 100%

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

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

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

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

Findings:

General Appearance: Posture : ☐ Well-flexed ☐ Asymmetry

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

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

Vitamin K 1 mg 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: ..... Signature: ..... Date &Time: .....

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE 16/7	DATE 16/7	DATE 16/7	DATE 16/7	DATE 17/7
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	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	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	14	14	14	14

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

Intervention:						
Bed in low position		✓	✓	—	✓	✓
Call device within reach		✓	✓	—	✓	✓
Wheels Locked		✓	✓	—	✓	✓
Room free of clutter		✓	✓	—	✓	✓
Adequate lighting		✓	✓	—	✓	✓
Wheel chair support		✗	—	—	NA	NA
Other Intervention(s) Specify		✗	—	—	NA.	NA
Nurse's Name:		Docy	Shalini		NISHA	Shalini
Signature:			Shalini			
Date:		16/7	16/7/26	16/7/26	16/7	17/7
Time:		7AM	8AM/3PM		8pm.	8am

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

Patient Sticker

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It takes a lot to treat the little.

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Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	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					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	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					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	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					
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					
	Total						

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:						
	Signature:						
	Date:						
	Time:						

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BRADEN 'Q' SCALE
(for Paediatric use)

GUC-00093931 IP18-00036491
Baby B/O VARSHA G
16-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. PADMAPRIYA EKAMBARAM

Gender : ☐ M ☐ F IP No. : .....

					Date :	16/7	16/7	16/7	16/7
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 though slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		8AM	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	25	25	25	25
					Evaluator's Name				

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

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BRADEN 'Q' SCALE

(for Paediatric use)

Patient Name : .....

Age..... Gender : ☐ M ☐ F IP No. : .....

				Date :	M F/F			
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			
"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 lift 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	07			
				Evaluator's Name	[signature]			

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

GUC-00093931 IP18-00036491
Baby B/O VARSHA G
16-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. PADMAPRIYA EKAMBARAM

Rainbow Children's Hospital
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PAIN ASSESSMENT FORM

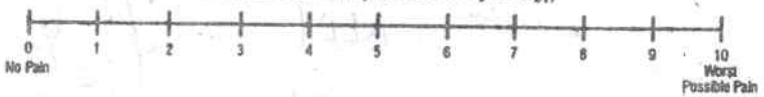
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
16/7/26	6AM	0/10	nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	nil	[illegible]
16/7/26	8AM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	No pain	Shalini 014072
16/7/26	2PM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[illegible] 02/875
16/7/26	8pm	0/10	Nil.	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	[illegible] 019801
17/7/26	4AM	0/10	Nil.	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Nil.	[illegible] 019801
17/7/26	10 am	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☑ No	Nil	[illegible] 609918
				☐ 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		

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

Patient Sticker

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It takes a lot to treat the little

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ 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		
				☐ 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		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

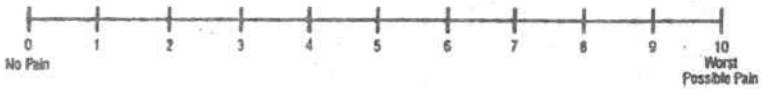
Re-assessment Frequency:

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

GUC-00093931 IP18-00036491
Baby B/O VARSHA G
16-07-2026 0 Y 0 M 0 D 1 H (F)
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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 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 Safety
12. Patient's / Family Rights
13. Risk / Safety

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
16/7/26	6pm	yes	Educate about fall risk safety needs (Pull sides)	mother	No learning barrier	Oral	None	Yes	Good	Done
17/7/26	8am	yes	Explain about feeding	mother	NO	oral	None	yes	Good	Done

Part - III: CODES

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

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

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

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

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

PATIENT TRANSFER FORM

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Your Right to a Safe Delivery

GUC-00093931 IP18-00036491
Baby B/O VARSHA G
16-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. PADMAPRIYA EKAMBARAM

	Date & Time of Admission	Date & Time of Transfer Order
	16/7/26 @	16/7/26 @ 8.40 Am
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Padmapriya	Dr. Sri Lakshmi	Baby Care
From Unit	**To Unit**	**Information to Attendant**
LDR	Job	Yes ☐ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
Baby DP file	—	Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Baby wipes	1
2.	Baby Pambes	1
3.	Baby Dress female	1 set
4.	Inj BCG	1
5.	Inj. Hep - B Peds	1

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

Dr. Sri Lakshmi

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S. Shalini 014072	Dr. Sri Lakshmi

Patient & Clinical Records Received by : P. Kanimozhi 607261

Date & Time of Patient Received : 16/7/26 @ 6.50 AM

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