GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN (F)
20-07-2026 CYCM2C
Dr. GIRIDHAR S

Rainbow Children's Hospital

DISCHARGE TRACKING SHEET

RID- FLOOR- NAME OF CONSULTANT-

ACTIVITY	INTIME	OUT TIME	NAME & SIGNATURE	REMARKS	<To be filled by Admin>		
Activity Sheet update by Nursing		21/7/26 6 AM					
Activity Sheet update by Pharmacy							

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANCHARAN
20-07-2026 0 Y 0 M 0 D 5 H (F)
Dr. GIRIDHAR S

ACTIVITY RECORD FOR BILLING

BirthRight™ BY RAINBOW HOSPITALS
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Name: .....

UHID No: ..... 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
20/7/26	1.45pm	UIR	ICU	S/NPOO 04

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	26023326	[illegible]
20/7/26	RBS	26023361	[illegible]
21/7/26	RBS	26023448	[illegible]
22/7/26	NBS, S. bili	26023529	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/7/26	OAF	(1)	1731094	

ANY OTHER INFORMATION:

.....

.....

.....

.....

.....

.....

Date: 22/7/26 Time: 6AM Prepared By: .....

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Children's Hospital | Birthright

DISCHARGE TRACKING SHEET

UHID- FLOOR- NAME OF CONSULTANT-

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0 Y 0 M 2 D (F)
Dr. GIRIDHAR S

ACTIVITY	TIME		NAME & SIGNATURE	REMARKS	<To be filled by Admin>
Discharge Announcement	22/7/26 at 10AM				
	INTIME	OUT TIME			
Arrangement of File by Nursing		22/7 at 10pm	Suraj E074363		
Preparation of Discharge Summary					
Finalization of discharge summary					
Transfer of file from Ward to Billing Dept					
Bill Processing					
Audit Clearance					
Billing Clearance					
Physical Clearance					

21/7/26

Twt - 2.459 kg

H - 33 cm

L - 49 cm

Ratch Fwd : 8

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20-07-2026 0 Y 0 M 0 D 5 H (F)
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RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
20/7/26	10:30Am	61mg/dl	Dr. Srilakshmi	[illegible]
		Stop		
21/7/26	11:20Am	60mg/dl	Stat° Dr. Giridhar	602228

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

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 : IP18-00036542 **Admit Date** : 20-Jul-2026 **Admit Time** : 10:49 AM **UHID** : GUC-00094073

Patient Details :

Patient Name : Baby B/O VAISHNAVI MANOHARAN
Guardian : Mr BHARATH CHAKKARAVARTHY D
Gender : Female
Occupation :
Address (H) : NO 2/33, SINGARAVELAN ST, KASTHURIBAI NAGAR , WEST TAMBARAM Tambaram West Kancheepuram Tamil Nadu INDIA

Age : 0 D
DOB : 20-07-2026 09:36 AM
Religion :
Martial Status :
Phone No : 7418333902/ 9789240027
E-mail : vaishuvm1@gmail.com

Admission Details :

Bed Type : BASINET **Bed No** : CRDL-SUITE711-1 **Ward Name** : 7F-PVT/SUITE
Room No : CRDL-SUITE711-1 **Admission Type** : First Visit

Contact Details :

Name : Mr BHARATH CHAKKARAVARTHY D **Relationship** : Father
Contact Address : NO 2/33, SINGARAVELAN ST, KASTHURIBAI NAGAR , WEST TAMBARAM Tambaram West Kancheepuram Tamil Nadu INDIA **Phone No** : 7418333902

Signature

Doctor Details :

Doctor Name : Dr. GIRIDHAR S **Specialisation** : NEONATOLOGY
Referral Doctor : Dr. Mathangi Rajagopalan **Phone No** :
Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00
Payor Name : SELFPAY

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GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby B/O VAISHNAVI MANOHARAN**	**Age :**	**0 Y 0 M 0 D 9 H**
IP No:	**IP18-00036542**	**Sex:**	**Female**
Consultant:	**Dr. GIRIDHAR S**	**Ward/Bed No:**	**7F-PVT/SUITE/CRDL-SUITE711-1**

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 c 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: Bharath Chakkaravathy

Relationship: Father

Date: 20/07/2026 Time: 10.49

Witness Name: Jeevitha

Witness Signature:

Patient Address:

NO 2/33, SINGARAVELAN ST,
KASTHURIBAI NAGAR , WEST
TAMBARAM Tambaram West
Kancheepuram Tamil Nadu INDIA

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 : Mo. vaishnavi Manohara	UHID Number : Cuc -00094073
Self/Attendant Name : Bharath Chakravarthy	Relation : Father
Self/ Attendant Signature : Phone Number :	Name & Signature of Financial Counselor

Patient Sticker

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Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0 Y 0 M 0 D 5 H (F)
Dr. GIRIDHAR S

RCH IN NO - 133008812163.

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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Mrs. Vaishnavi Manohara Age : 32y Father's Name : Bharath Chakaravarthy Age : .....

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

NICU Consultant : Dr. Ciruelha Referring Consultant : Dr. - Mathapi

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

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

BIRTH INFORMATION

Name : B/o Vaishnavi Manoharan

Gender : ☐ M ☐ F Blood Group : .....

Date of Birth : 20/7/26 Time of Birth : 9:36 Am

Place of Birth : Rch OT LOR

Mother's Blood Group : 'A' POSITIVE

Birth Weight (gms) : 2.655 kg Length (cms) : .....

OFC (cms) : .....

Estimated Gesth Age : 38 wk + 3 days

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 32y Ht : ..... Wt : ..... BMI : ..... Married Life : 7y LMP : 18/10/25 EDD : 25/7/26.

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

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

Last Scans Details : 3/7/26 - 36wk + 1 day, SLIUA, cephalic, placenta posterior, Liquor (N), SDP - 5.4, EFW - 2572 gr, Doppler (N) TT Immunization and Iron / Folic Acid : .....

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs NT - 1.7mm

Consanguinity : ☐ Yes ☑ No Anomalies R/o

If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3 FTS - low risk - Toxic PE

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long : —

H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : —

IUGR - when detected : .....

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

AFI : —

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

Controlled or not, recent values, HbA1 values : —

Compliance with Rx : .....

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

H/o Hypothyriodism : when diagnosed ? Medication? Hypothyroidism

Any other Chronic Medical Problems, when detected drugs ? Asthma (Occasional wheeze)

(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
G1	4yr	SVD	2.36kg	Girl	FGR, PUT antly dopplr.	
G2	PP					

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	8	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.

HR - 168/min
SpO2 - 98%. | at 10 min

Baby has SCR, ICR (+)

Investigation details in previous Hospital :

-

Feeding History :

-

Patient Sticker

Past History :

–

Family History :

–

Socio Economic History :

–

GENERAL EXAMINATION ON ADMISSION

General Disposition :

–

VITALS : Temperature : 36.5°C HR : 168/N RR : ..... NIBP : ..... CFT : .....

Color of the extremities : Acrocyanosed

Jaundice : ..... Pallor : ..... SpO2 : 98% .

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+1V
Discharge :

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

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

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

Patient Sticker

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☐ Regular ☐ Periodic ☐ Shallow ☐ Gasping

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

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

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

Settings : RA

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

Cardiovascular System :

HR : 168/m BP : ..... Precordial Activity : -

Femoral Pulses : ..... Murmurs : -

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

Abdomen :

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

Palpation : ..... Anal Patency : .....

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 : .....

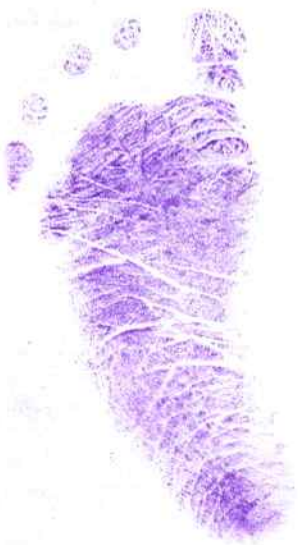
Patient Sticker

Any Congenital Anomalies : .....

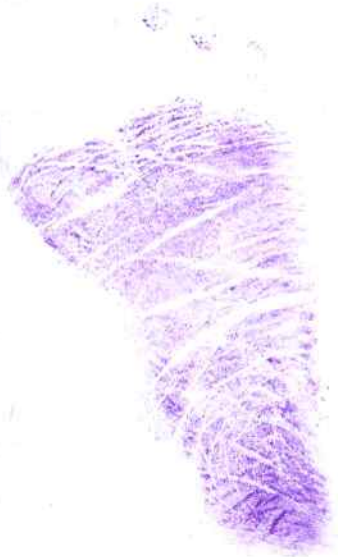
Diagnosis : Term 38+3 wks | Girl | 2.665 kg | AGA (15%)

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : .....

Name : Dr. Shilathai

Date & Time : 20/7/26

Consultant :

Signature : for .....

Name : Dr. Sindhia

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
3. Post ductal SpO_2 at 24 HOL
4. SB, OAE, NBS at 48 HOL
5. Birth vaccination.
6. Monitor RR, HR, SpO_2 for 1 hour.

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

.....

.....

Screenings done during NICU Stay :

NSG : .....

Hearing Screen : .....

ROP : .....

TFT : .....

NP2 : .....

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Patie

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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Pat

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STAT / ONCE ONLY DRUGS

Name: .....

Weight: 2.6 kgs

Sheet No: .....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
20/7	9:50 AM	INJ. VITAMIN K	1mg	I.M	[illegible]	SP	SA
21/7/26	11:05AM	Inj. HEP B	0.5ml	IM	[illegible]	P.D	S.M
21/7/26	11:05AM	Inj BCG	0.05ml	ID	[illegible]	P.D	S.M
21/7/26	11:05AM	OPV DROPS	2drops	Oral	[illegible]	P.D	S.M

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

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Baby B/O VAISHNAVI MANOHARAN
20-07-2025 0 Y 0 M 0 D 5 H (F)
Dr. GIRIDHAR S

LINICAL / 124

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/7/25 Time:	9.37AM	12PM	4PM	8PM	12AM	4AM
Doctor/Nurse/Family Concern?						
Temperature (°F)	98F	98F	97.8°F	98.6F	98F	97.6F
Heart Rate (bpm) and Blood Pressure (mmHg) *						
Note: BP does not score in early warning scoring						
Heart Rate (Number)	142	140	132bpm	128bpm	130bpm	132bpm
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	40	42	40bpm	42bpm	40bpm	44bpm
Resp Distress: Mod/ Severe / None / Mild	Mild	Mild				
Receiving O_2 (l/min) O_2 Saturations (%)	RA	RA	RA 100%	99% (RA)	98% (RA)	99% RA
Conscious Level: Normal / Altered	✓	✓				
GCS *	15	15	15	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	SP	SP	PB	[illegible]	[illegible]	[illegible]

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

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

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0 Y 0 M 0 D 12 H (F)
Dr. GIRIDHAR S

(2)

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

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

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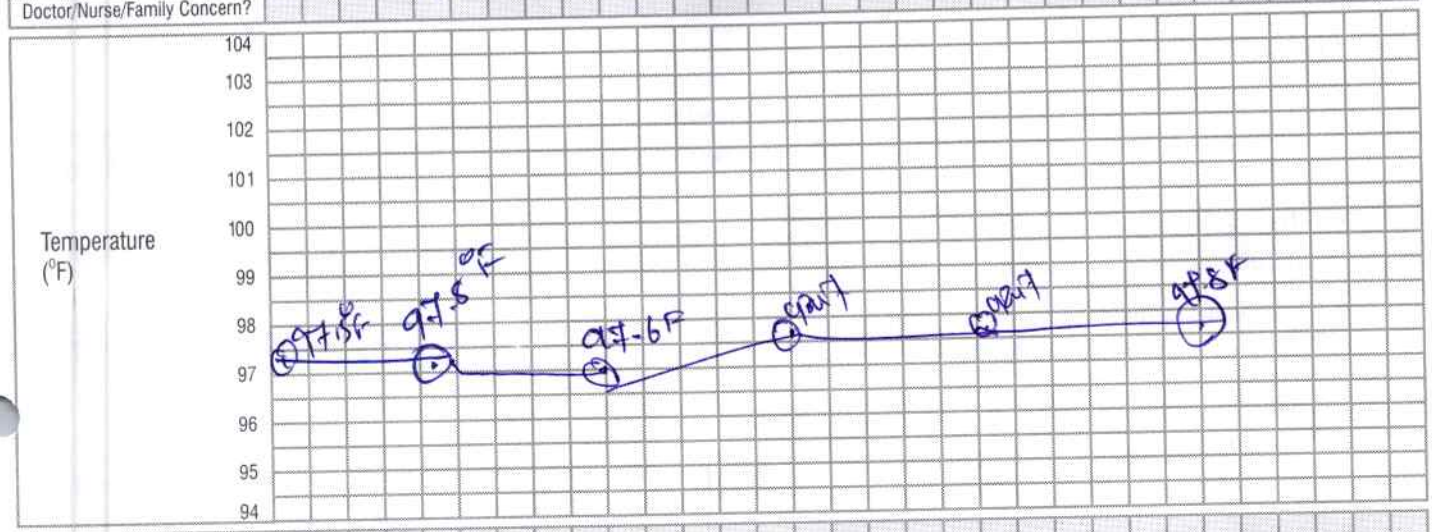
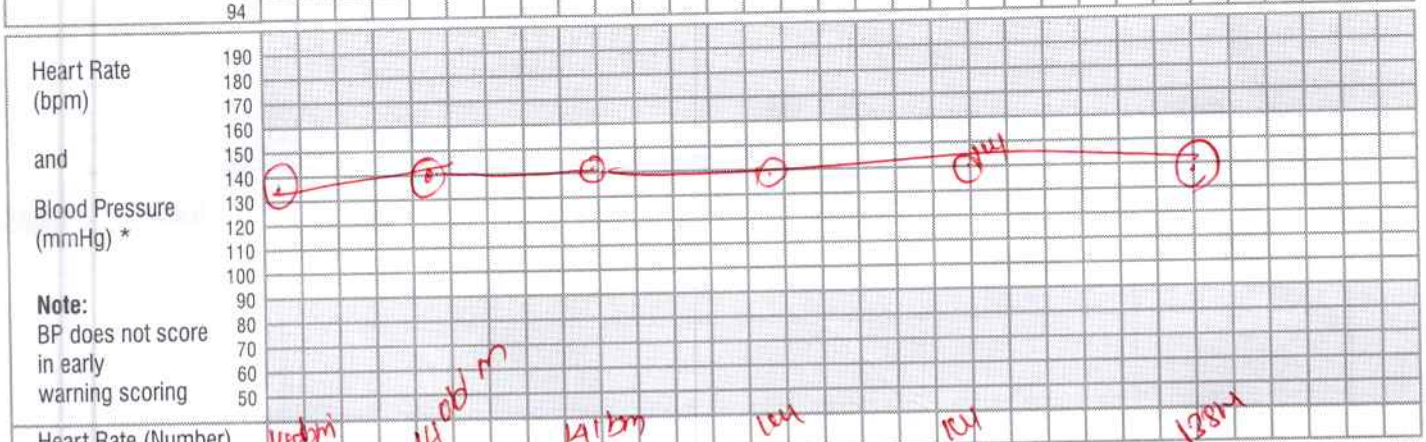
EARLY WARNING SCORE: CHILDREN'S UNIT

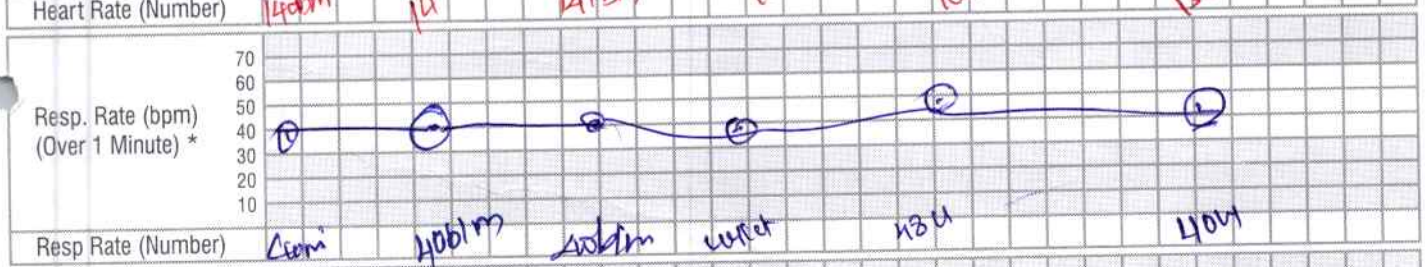
Date: 21/7/26 Time: 8am 12pm 4pm 8pm 12am 4am

Doctor/Nurse/Family Concern?





Heart Rate (Number) 144bpm 140bpm 141bpm 144 [illegible] 138bpm



Resp Rate (Number) 42bpm 40bpm 40bpm [illegible] 43bpm 40bpm

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

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

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

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.
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- 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-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0Y0M0D5H (F)
Dr. GIRIDHAR S

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FLUID CHART

Sheet No.: 1

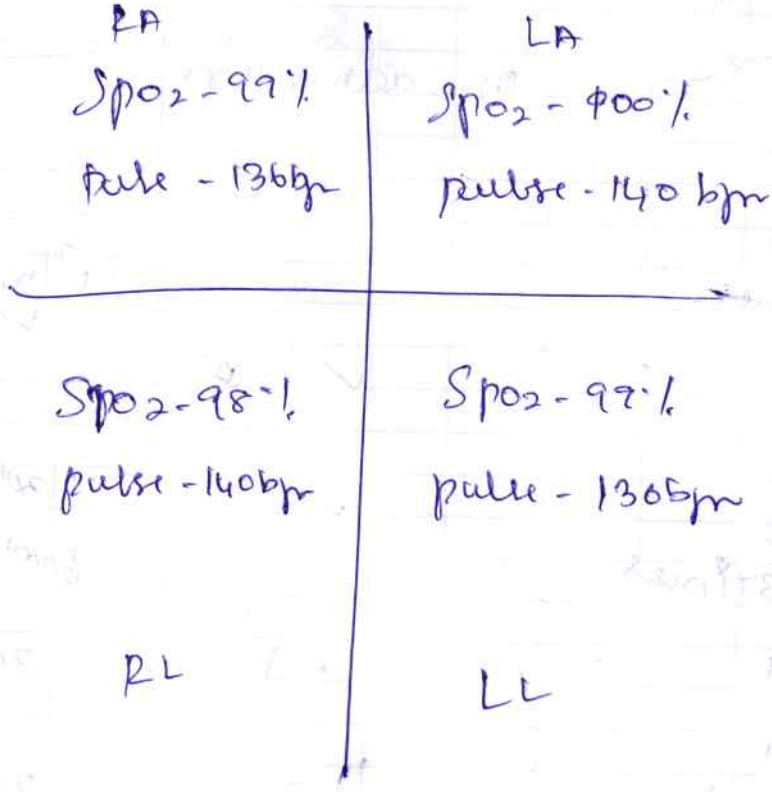
R.Wt → 2.608Kg

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

Date	Time	Nature of Fluid	Intake Route: Mouth	I.V	N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
20/7/26	08:00 am											
	09:00 am				On	admission						
	10:00 am											
	11:00 am	DBF										
	12:00 pm											
	01:00 pm	DBF										
Total Intake: 2 times						Total Output: U/m not passed						
	02:00 pm									✓	NO	P.G
	03:00 pm	DBF					✓					P.G
	04:00 pm										IV	P.G
	05:00 pm	DBF								30ml	line	P.G
	06:00 pm						✓					P.G
	07:00 pm	DBF										P.G
Total Intake: DBF 3 times						Total Output: 60ml						
	08:00 pm										No	
	09:00 pm	DBF					✓			30ml	IV	
	10:00 pm										line	
	11:00 pm	DBF									No	
	12:00 am						✓			30ml		
	01:00 am	DBF										
Total Intake: 3 time DBF						Total Output: 60ml						
	02:00 am										No	
	03:00 am	DBF	25ml								IV	
	04:00 am										line	
	05:00 am	DBF								30ml	No	
	06:00 am											
	07:00 am	DBF										
Total Intake: 3 hr DBF						Total Output: 30ml						

Total 24 hrs. Intake	11 Time DBF + 15ml	Total 24 hrs. Output	Urine - 5 Motion - 4

Docu. No. : RCH /FRM / CLINICAL / 092


RA
SpO2 - 99%
Pulse - 136bpm
LA
SpO2 - 100%
Pulse - 140 bpm
SpO2 - 98%
pulse - 140bpm
RL
SpO2 - 99%
pulse - 130bpm
LL

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0 Y 0 M 0 D 12 H (F)
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FLUID CHART

T.wt - 2.530 kg

Sheet No. : .....

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

21/7/26		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										NO	SH
	09:00 am	DBF										SH
	10:00 am									30 ml	IV	SH
	11:00 am	DBF									Line	SH
	12:00 pm										NO	SH
	01:00 pm	DBF								30ml	Fine	SH
Total Intake : 3 times DBF						Total Output : 60ml						
	02:00 pm										NO	SH
	03:00 pm	DBF								✓		SH
	04:00 pm											SH
	05:00 pm	DBF					✓			✓	IV	SH
	06:00 pm										Line	SH
	07:00 pm	DBF					✓			✓		SH
Total Intake :						Total Output : U - 3 M - 2						
	08:00 pm	DBF									NO	SH
	09:00 pm									40ml		SH
	10:00 pm	DBF									IV	SH
	11:00 pm											SH
	12:00 am	DBF								30ml	NO	SH
	01:00 am										IV	SH
Total Intake : 3 ml DBF						Total Output : 50ml						
	02:00 am	DBF									NO	SH
	03:00 am									20ml	IV	SH
	04:00 am	DBF									IV	SH
	05:00 am										NO	SH
	06:00 am	DBF								20ml	IV	SH
	07:00 am										IV	SH
Total Intake : 3 ml DBF						Total Output : 40 ml						

Total 24 hrs. Intake	12 ml DBF	Total 24 hrs. Output	U - 9 M - 2

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Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0Y0M0D5H (F)
Dr. GIRIDHAR S

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NURSING CARE RECORD

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	8AM	Promote good nutritional status	12pm	Assess the baby condition. TO give DBF 2nd hrly. Keep baby warmth	Baby is warmth	Reassessment is done	Shalini
Afternoon	9pm	Assess the baby condition Monitor Vitals	9pm	Assessed the baby condition Monitored Vitals Encourage DBF	Warmth Maintain	Reassessment done	P.Pe 20726
Night	7:30pm	- Assess the baby warm condition - Provide warmth care to baby	10pm	- Assessed the baby warm condition. - Provided warmth care to baby	Provided warmth care to baby	Baby temperature maintain	Sh.

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0 Y 0 M 0 D 12 H (F)
Dr. GIRIDHAR S

NURSING CARE RECORD

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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: 21/7/26

Goals

- ☐ Maintain Airway and Oxygenation
- ☐ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☐ Relieve Pain & Discomfort
- ☐ Prevent Infection
- ☐ Any Others. Specify.....N.N.
- ☐ 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.	17PM	Assessed the Baby condition provided DBF Q2Hrly.	Encouraged mother DBF Q2Hrs.	Done.	Sruti 67363
Afternoon	2pm	Assess the baby feeding and intake position.		Improve the baby Nutritional Support.	Evaluate the baby weight check.	Re-assessment is done.	Hari 607918
Night	2pm	Assess the baby Feeding Intake Positn	8pm	Improve the baby nutritional Support	Evaluate the baby weight chec	Re-assess ed	

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0Y0M0D5H (F)
Dr. GIRIDHAR S

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NURSES NOTES

☑ No Known Drug Allergies

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		✓ On admission notes	
20/7/26	9.36am	B/o vaishnavi GA - 38+3d	
		A single baby delivered Normal	
		vaginal delivery. Baby	
		cried at birth. Delayed cord	
		clamping done. Dr. Sri Lakshmi	
		received the baby. kept in	
		warmer cleaning done. vital	
		signs checked & recorded.	
		PR-142 RR-60bm SPO2-100%	
		NG tube passed mucus cleared.	
		Re. vit K given. Baby have	
		mild tachypnea. cord blood	
		collected for blood grouping	
		sent to lab as per doctor order.	Staff Nurse
		Date - 20/07/2026	
		Time - 9:26am	
		Sex - Girl	
		weight - 2.655 kgs	
		APGAR - 8to 8to	
	10.30am	CBG checked as per doctor	
		order 61mg/dl. PR-142bm RR-40bm	
		SPO2-100% Informed to Dr. Sri Lakshmi	
		advised to give DBF. Stop CBG	
		order could be out.	Staff Nurse.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0Y0M0D5H (F)
Dr. GIRIDHAR S

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7/26	11 Am	Tab given to baby sucking good. vaccination not done. Urine, stool not passed.	
	12 pm	Baby vital signs checked & recorded. Baby is in table warmth.	
	1 pm	Baby is in table warmth. placed the baby on mother side.	
	1.40 pm	Baby shifted to ward as per doctor order. Baby care hand over given to 7th floor staff. Baby passed urine	
		Evening duty	
20/7/26	2.00 pm	Baby details & randomly taken over from LDR staff to 7th floor. Baby is NVD, EBF, Day 1 vitK given urine passed, RBS 01 stop vaccine due, NBS, SBR 48hrs	
	4.00 pm	Baby vitals checked and recorded. Dr. Viridhas sir come and see advised, NBS, SBR 48hrs	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0 Y 0 M 0 D 12 H (F)
Dr. GIRIDHAR S

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NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7/26	7.00pm	Baby Intake/output chart Maintained	P. Kaviraj 607261
	7.30pm	Baby details handover given to night duty staff	P. Kaviraj 607261
		Night duty On 20/7/26	
	12.30pm	Baby details Handy Over taken from Evening duty staff. Baby active and good colour is pink and normal. Baby urine and motion passed. Baby is On OBH IDBF. feed taking well. No vomiting →	
	8pm	Vital Signs checked and Recorded. →	
	10pm	Baby is On OBH IDBF. feed taking well. sucking is good →	
21/7/26	12am	vital Signs checked and Recd. Baby urine and motion passed	
	2am	Baby sleeping well provided warm cover to baby →	
	4am	maintain Intake and output chart. vital Signs checked and Recorded →	
	6am	nursing care is given. Vitals checked and Recorded →	
		(P1)	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

NURSES NOTES

Rainbow® Children's Hospital
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☑ No Known Drug Allergies
☐ Drug Allergies ..... Nil.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
20/7/22	7.30pm	Baby details handing over taken on morning duty staff → morning duty	
21/7/22	7:30am	Baby details Handover taken from Night Duty Staff. Baby active and alert, Vitals are stable. Baby u/m passed, SBR/ NBS/OAE done 48Hrs. today vaccine plan: RBS stop. →	Sri 607353.
	8am	Baby vital signs checked and recorded, Vitals are stable. Maintained flo chart. U/m passed, Baby sucking well, feeding well. →	Sri 607353
	9.00am	Baby taking OBF, Intake output chart Maintained →	P. Kanimozhi 607261
	11.00am	Dr. Viridhas Sir came and see advised RBS Stat one checked completed, Informed Dr. Viridhas NBS, SBR Tomorrow 6AM vaccine done by Dr. Deepak Sir Inj. BCG, Hep-B, oral polio - 2 drops given and Recorded →	P. Kanimozhi. 607261
	12pm	Baby Vitals are stable, maintained flo chart. Baby sucking well, Feeding well. →	S. Nandhini 607362

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0Y0M0D12H (F)
Dr. GIRIDHAR S

(2)

NURSES NOTES

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
21/7/26	1:30pm	Baby details Hand over given to Evening duty staff. → Evening Duty	Sinuaf 607353.
21/7/26	2pm	Baby details carefile handing over taken from the morning duty to evening duty staff. Baby vitals are monitoring and reported and vitals are stable.	Hari 607918
	3pm	Baby today RBS Stop and today examination is done. Sepsis Protocol is maintain continued.	Hari 607918
	4pm	Baby latching is well and audible sound of latch baby feeding position is good.	Hari 607918
	5pm	J - 2 P - 1 T - 1 C - 2 H - 1 T	Hari 607918
	6:30pm	Baby continues intake of BF only and baby continues monitoring Protocol.	Hari 607918
	7pm	Baby tomorrow 6 am N/BS, SBR level Plan.	Hari 607918

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

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
21/7/66	7.30pm	Baby details carefile handing over given to the evening duty to night duty staffs → THR	
		⇒ Afebrile Day 1	
21/7/66	7.30pm	Baby is active cry ++ colour breathing is normal Baby Vital Signs Stable.	
	8pm	General condition Fair ⇒ Baby Temp 98.7 ++ Baby well no other complaints	
	9pm	⇒ Baby Passed urine ++ motion no other complaints	
	10pm	⇒ Baby Sleep + well duty nurse no other complaints	
22/7/66	12am	⇒ Vital Signs checked and Recorded.	
	2am.	Baby sleeping well. provided warmth care baby	
	4am	maintain Intake and output Chart.	
	6am.	morning care is given. weight checked & Recorded. Sr. bili. RBS sample sended to Lab	
	7.30am	Baby delivered handing over to duty staff	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0 Y 0 M 0 D 5 H (F)
Dr. GIRIDHAR S

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NURSING DEPARTMENT
NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/o vaishnavi Mother's Name: Mrs. Vaishnavi

Date of Birth: 20/07/2026 Time of Birth: 9:36am Gender: ☐ Male ☑ Female

Birth Weight: 2.655 Kgs HC: 36 cm Lenght: 48 cm

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

Term / Pre-term / Post-term: Term

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

Feeding: ☑ Breast Feeding ☐ Formula ☐ Both First Feed Time: 11.00am

GUC-00013971 IP18-00036532
Mrs VAISHNAVI MANOHARAN
01-01-1994 32 Y 6 M 19 D (F)
Dr. MATHANGI RAJAGOPALAN

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

Indication:

Physical Assessment of New Born:

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

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☐ Yes ☐ No **Score:** 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: Jaya Signature: Date &Time: 20/7/26

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0Y0M0D5H (F)
Dr. GIRIDHAR S

Patient Si

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			20/7	20/7	21/7	21/7	22/7
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3	3	3	3	3	3
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
	Total		14	14	14	14	14

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

	Bed in low position		✓	—	✓	✓	✓
	Call device within reach		✓	—	✓	✓	✓
	Wheels Locked		✓	—	—	—	—
	Room free of clutter		✓	—	✓	—	—
	Adequate lighting		✓	—	✓		
	Wheel chair support		✗	NA	✗	✗	✗
	Other Intervention(s) Specify		✗	NA	✗	✓	✗
	Nurse's Name:		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Signature:		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	Date:		20/7	20/7/24	21/7	21/7	22/7
	Time:		11AM	8PM	8AM	8PM	8AM

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0Y0M0D5H (F)
Dr. GIRIDHAR S

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

BRADEN 'Q' SCALE

(for Paediatric use)

Patient Name : .....

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

				Date :	E 20/7	N 20/7	M 21/7
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.	10am 4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1	1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	24	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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BRADEN 'Q' SCALE

(for Paediatric use)

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0 Y 0 M 0 D 12 H (F)
Dr. GIRIDHAR S

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

Patient Name : .....

Age..... G

				Date :	E 21/7	22/7	M 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 though slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during 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 lift up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
				TOTAL SCORE	25	24	29	
				Evaluator's Name	Hai			

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

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0Y0M0D5H (F)
Dr. GIRIDHAR S

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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PAIN ASSESSMENT FORM

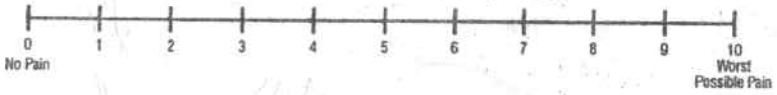
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7/26	10AM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	Sanjeev
20/7/26	4pm	0/10	NC	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NIL	Priya 607-61
20/7/26	8pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NIL	
21/7/26	2AM	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NIL	
21/7	5AM	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	S.Nagaraj 609303
21/7/26	2pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☑ No	Nil	Hai 607913
21/7/26	8pm	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NIL	Sanj
21/7/26	12AM	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NIL	Sanj
21/7/26	6AM	0/10	NIL	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	NIL	Sanj
22/7	12pm	0/10	Nil	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☑ Yes ☐ No	Nil	Gow

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-000[illegible]3 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0 Y 0 M 0 D 5 H (F)
Dr. GIRIDHAR S

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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
20/7/26	10AM	Yes	Educate about fall risk safety needs (Pull cradle)	mother	No learning barriers	oral	None	Yes	Good	[illegible]
21/7	8AM	Yes	Educated about DBF Q 2 Hrly.	Mother	No	Oral	None	Yes	Good	[illegible]
22/7	8AM	Yes	Educated about DBF Q 2 Hrly.	Mother	No	Oral	None	Yes	Good	[illegible]

Part - III: CODES

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

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

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

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

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

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Your Right to a Safe Delivery

PATIENT TRANSFER FORM

GUC-00094073 IP18-00036542
Baby B/O VAISHNAVI MANOHARAN
20-07-2026 0 Y 0 M 0 D 5 H (F)
Dr. GIRIDHAR S

Date & Time of Admission	Date & Time of Transfer Order
20/7/26	20/7/26 1.45pm

Treating Consultant Name	Transfer Ordered by	Reason for Transfer
Dr. Giridhar	Dr. Srilakshmi	Baby care

From Unit	To Unit	Information to Attendant
CPR	To T	Yes ☒ No ☐

Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
Baby's 20 file	-	Yes ☐ No ☒ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐
Dr. Srilakshmi

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S. Pooja	Dr. Srilakshmi

Patient & Clinical Records Received by : P. Kavya 80-7361

Date & Time of Patient Received : P. Kavya 80-7361 20/7/26 @ 2:00pm

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