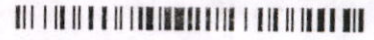


ADMISSION SHEET

Registration Details :



Admission No : IP5-00174408 Admit Date : 27-May-2026 Admit Time : 11:23 PM UHID : BAH-00657440

Patient Details :

Patient Name : Baby Of POOJA TEJAWATH Age : 0 D
Guardian : Mr RAVINDER K DOB : 27-05-2026 10:27 PM
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : HNO 8-2-293/65/9,SV NAGAR,ROAD NO 14,
Banjara Hills Hyderabad Telangana INDIA 500034 Phone No : 8978157143/ 9177620547
E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : BASINET Bed No : CRDL-MICU-426-1 Ward Name : 4F-BIRTHING CENTRE
Room No : CRDL-MICU-426-1 Admission Type : First Visit

Contact Details :

Name : Mr RAVINDER K Relationship : Father
Contact Address : HNO 8-2-293/65/9,SV NAGAR,ROAD NO 14,
Banjara Hills Hyderabad Telangana INDIA 500034 Phone No : 8464088626 / 8978157143


Signature

Doctor Details :

Doctor Name : Dr. VIJAYANAND JAMALPURI Specialisation : NEONATOLOGY
Referral Doctor : SELF Phone No :
Co-Consultant :

Payment Details :

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

BAH-00657440 IP5-00174408
 Baby Of POOJA TEJAWATH
 27-05-2026 0Y0M0D1H (F)
 Dr. VIJAYANAND JAMALPURI



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Age : Father's Name : Age :
 Date of Birth : Date of Admission : UHID No.:
 NICU Consultant : Referring Consultant :
Transferring Unit : OT Labour Room ER Ward
Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : B/o. Pooja Tejawath Mother's Blood Group : O positive
 Gender : M F Blood Group : Birth Weight (gms) : 2629g Length (cms) :
 Date of Birth : 27/5/26 Time of Birth : 10:27pm OFC (cms) :
 Place of Birth : RCH-B Estimated Gesth Age : 37+5 wks.

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 32y Ht : 149 Wt : 87g BMI: Married Life : LMP : 2/9/25 EDD : 9/6/26
 Conception : Spontaneous or with Rx : spontaneous
 Booked at what GA : 9+4 wks AN Steroids Drugs / Doses :
 Last Scans Details : 13/5/26 - 35+5 wks / cephalic / AFI-11cm / EFW-2407g
Doppler (+), mca redistribution (+) TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : <18 yrs > 35yrs
 Consanguinity : Yes No
 If yes, degree of consanguinity : 1 2 3
H/o PIH (after 20 weeks) / PE
 How many Drugs / Doses / Since how long :
 H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) :
 IUGR - when detected :
 Doppler (Increased Resistance / 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 Hypothyroidism : when diagnosed ? Medication?
K/O Hypothyroid on Thyrox
 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 :



PAST OBSTETRIC HISTORY

G : 3 P : 2 A : L : 1 D

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
1.	24	14		Female	miscarriage	
2.	24			Female	miscarriage	
3.					miscarriage	

PERINATAL HISTORY

Treating Obstetrician : Hospital : Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig)</p> <p>Second stage (> 2 hours after dilation) NVD</p> <p>LSCS : <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</p> <p>Specify the reason :</p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL :</p> <p>Resuscitation : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Cord ABG :</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :</p>
---	--

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	10	10

TOTAL

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

Snapee II Score

Score

Parameter	> 30 (0)	20-29 (9)	< 20 (19)		
Mean BP (mmHg)	> 30 (0)	20-29 (9)	< 20 (19)		
Lowest Temp (oF)	> 96 (0)	96-95 (8)	< 95 (15)		
Pao2 / Fio2 (mmHg%)	> 2.49 (0)	1-2.49 (5)	0.3-0.99 (15)	< 0.3 (28)	
Lowest Serum PH	> = 7.2 (0)	7.1-7.19 (7)	< 7.1 (16)		
Multiple Seizures	No (0)	Yes (19)			
U. Output (ml / kg / hr)	> = 1 (0)	0.1-0.9 (5)	< 0.1 (18)		
Apgar Score	> = 7 (0)	< 7 (18)			
Birth Weight	> = 1kg (0)	750 - 999 (10)	< 750 (17)		
SGA	> 3rd percentile (0)	< 3rd (12)			
Total					

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



SS:

Equipment check done



Baby delivered via NVD



Deidx scalions cleared



Cord clamped & cut 20A, 10V ⊕



Saj. let & mg IM given



Uneventful transition.



Baby shifted to mother's side.

Investigation details in previous Hospital :

Feeding History :

Patie



Past History :

to be done - emergency

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Active

VITALS : Temperature : *36.5* HR : *156* RR : *52* NIBP : CFT : *53ml*

Color of the extremities : *acrocyanosis → pink*

Jaundice : Pallor : SpO2 : *96%*

ANTHROPOMETRY: Birth Weight : *2629g* Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

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

FACIES :
(Any Facial
Dysmorphism) flat nasal bridge.

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

EYES :
Symmetry :
Red Reflex : TO be checked
Discharge :

**EARS, NOSE
MOUTH and
THROAT :**
Ear set / Shape :
Periauricular Pits / Tags :
Nasal shape / Patency :
Palate :
Gums :
Lips :
Tongue :
} ⊕
no deft

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

**ABDOMEN and
UMBILICUS :**
Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump :
Discharge :
} ⊕
20A, 10V ⊕

GENITALIA :
Labia / Hymen : ⊕ female genitalia.
Testicles/penis :
Anus :

HERNIAL ORIFICES free

TRUNK and SPINE : ⊕

SKIN LESIONS : No

EXTREMITIES :
Fingers / Toes : ⊕ Arms / Legs :
Deformities : Mobility :
Hip Joint Examination :



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : Regular Periodic Shallow Gasping

Mention If baby has Respiratory distress: RR: 54 SCR / ICR / See - Saw breathing :

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

Mention if baby is on : Hood box CPAP Ventilator

Settings :

SpO₂: 96% Auscultation: BAE (G) Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 154 BP :

Precordial Activity : (N)

Femoral Pulses : B/c equally felt

Murmurs : No

Other Peripheral Pulses : palpable

Signs of Cardiac Failure : No

ABDOMEN:

Shape : (N)

Hernia orifice : free

Palpation : Soft

Anal Patency : patent

Palpable masses : No

Umbilical Cord : 2VA, (N)

Abdominal girth :

First urine passed : 2 No.

Meconium passed :

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score : e/T/A - good.

Nerves :

MOTOR SYSTEM:

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

ATNR : Skull and Spine :



No

Diagnosis : DOL-1 / Term / AGA / Female / 2.6kg

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *[Signature]*

Name : Poojithe

Date & Time : 24/5/26 10:43pm

Consultant :

Signature : *[Signature]*

Name : DR. VIJAYANAND JAMALPURI

Date & Time : Registration No: 40526

PLEASE FILL UP THE FOLLOWING DETAILS

- Name of the referring Doctor :
- Name of the referring Hospital :
Address :
Contact Numbers :
- Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
- Name of the Doctor in Rainbow Team :
..... on whose name the patient is being referred.



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

Vital : HR : RR : BP : SPO2 : Weight :

Any Oxygen requirement : Plan

Systemic :

Medications :

- 1) DDAF and hely Alb bueping
- 2) Keep baby warm
- 3) Send cord blood for BCT
- 4) BCG, OPV, Hep B tomorrow
- 5) Monitor vitals

noted by
Aswini

Plan during ward follow up :

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Doctor Signature (Handover Given): Doctor Signature (Handover Taken):

Doctor Name: Doctor Name:

Date & Time: Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26 8:30AM	Seen by Dr. Vijayanand	Plan:-
	10 Hrs 2.629 kg NVD.	- Regular feeding - Feeding assessment
	urine & motion } passed	- Sugar monitoring 6th hourly. - Clinical assessment of
		Jaundice @ 24 Hrs (10:30PM)
		- BCG, OPV Hep B } Today
		- Trace baby blood group
		Noted by Suresha 28/5/26 @ 9:30AM
		DR. VIJAYANAND JAMALPURI Registration No: 40526
28/5/26 3:12PM	Seen by Dr. Bharath (Resident)	
	17 Hrs 2.629 kg 37 +5 NVD maternal hypothyroidism	Plan:-
M/O+ B/O+	Bt. wt - 2.629 kg	- Continue DBF flb burping @ 2-3hrly - Sugar monitoring 6th hourly
	urine & motion } passed.	- clinical assessment of Jaundice @ 24 Hrs [10:30PM]
		- BCG, OPV, Hep-B -> Today - Feeding assessment - Monitor vitals & Inform SOS
		Bharath

BAH-00657440 IP5-00174408
 Baby Of POOJA TEJAWATH
 27-05-2026 0 Y 0 M 0 D 1 H (F)
 Dr. VIJAYANAND JAMALPURI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26	Seen by Dr. Bhaerath	
5:30 pm	D/w Dr. Vijayanand	Plan-
		- Discharge at parent request
		- FW Tomorrow
		Bhaerath



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Pooja Tejawath Mother's Name: Pooja
Date of Birth: 27/5/26 Time of Birth: 10:27 pm Gender: Male Female
Birth Weight: 2.629 Kgs HC: 30 cm Length: 49 cm
Meconium in Liquor: Yes No Cried at Birth: Yes No
Term / Pre-term / Post-term:
Resuscitated: Yes No Blood Group: Mother: O+ve Baby:
Feeding: Breast Feeding Formula Both First Feed Time: 11.30

AFFIX MOTHER'S IDENTIFICATION LABEL

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

Physical Assessment of New Born:

Temp: 97.2 °C HR: 112 /Min RR: 48 /Min BP: - SpO₂: 100%
Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: Yes No Score: 16 (Fill the Humpty Dumpty Sheet)
Risk in Pressure Sore: Yes No (Braden Q Score) (Fill the Braden Q Sheet)
Behaviour Status on admission: Sleeping Crying Calm Drowsy

Findings:

General Appearance: Posture: Well-Flexed Asymmetry
Skin: Pink Meconium Stain Others, Specify:

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

Vitamin K 1 mg IM Administered: Yes / No
Routine Care Provided: Yes / No
Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / ~~No~~
1. Nutritional Screening: Feeding Problem Yes / ~~No~~
2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / ~~No~~
3. Socio History: Siblings Yes / ~~No~~
All information obtained from Mother Father Other Family Member

Newborn Screening Discussed: Yes / ~~No~~

Nurse Name: Radhika Signature: [Signature] Date & Time: 27/5/26

1
Bureau of
Census
Washington, D.C.

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

1910
No. 1000
10/10/10

1910
No. 1000

1910
No. 1000

1910
No. 1000

1910
No. 1000

1910
No. 1000



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: slow born baby case

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	Direct breast feeding warmth care vaccination GRBS monitoring	Hemodynamic stability Maintenance of Temp. Sugars	Warm care Regular feeding	Bhaerath	<input type="checkbox"/> Nursing <input type="checkbox"/> Others:
27/5/26 11 pm	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op	DBM	breathing	Warm care	[Signature]	<input type="checkbox"/> Medical <input type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:
	<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:	<input type="checkbox"/> Initial <input type="checkbox"/> Modified <input type="checkbox"/> Per-Op <input type="checkbox"/> Post Op					<input type="checkbox"/> Medical <input type="checkbox"/> Nursing <input type="checkbox"/> Others:

Patient Sticker

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD



Part - I.

Patient's / Learner Language: Patient / Learner Literacy: Read Write Speak Willingness to Learn: Yes No Healthcare Literacy: Yes No

Identified Education Needs:

- | | | |
|----------------------------|--|--|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights |
| | | 13. Risk / Safety |
| | | 14. Activity / Exercise |
| | | 15. Social & Rehabilitation Needs |
| | | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | 17. Others |

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		

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	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
	3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing						
Teaching Tools Used:	A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed					
Mechanism/s to overcome barrier/s:	1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify						
	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference							
Understanding:	1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review							

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

BAH-00657440 IP5-00174408
 Baby Of POOJA TEJAWATH
 27-05-2026 0 Y 0 M 0 D 1 H (F)
 Dr. VIJAYANAND JAMALPURI



Part - I.

Patient's / Learner Language: Theliga/Sabit Patient / Learner Literacy: Read Write Speak Willingness to Learn: Yes No Healthcare Literacy: Yes No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain-Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

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		
22/5/26	4 PM	4	Informed Consent	PT (M)	0	1	01	1	-	Radhya

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	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	

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

Mechanism/s to overcome barrier/s:

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

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 27/5/2026 Time: 11 AM 1:20 PM 5 AM

Doctor/Nurse/Family Concern?

Temperature (F)	104			
	103			
	102			
	101			
	100			
	99			
	98		98.0°F	98.5°F
	97	97.3		
	96			
	94			

Heart Rate (bpm) and Blood Pressure (mmHg) *	190			
	180			
	170			
	160			
	150			
	140	142	*	*
	130			
	120			
	110			
	100			

Heart Rate (Number) 142 140bpm 140bpm

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

Resp Rate (Number) 40 40bpm 38bpm

Resp Mod/ Severe Distress None / Mild N N

Receiving O₂ (l/min) O₂ Saturations (%) 100% 100% 100%

Conscious Level Normal / Altered N

GCS * 14/15 15/15 15/15

TOTAL SCORE Number of shaded boxes 0 0 0

Pain Score 0 0 0

Observer's Initials S A A

ACTIONS	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.

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)

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.
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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)

BAH-00657440 IP5-00174408
 Baby Of POOJA TEJAWATH
 27-05-2026 0 Y 0 M 0 D 2 H (F)
 Dr. VIJAYANAND JAMALPURI



FLUID CHART

Sheet No. : 27/5/26

- All measurements in ml.
- 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			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	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	DBH										
	12:00 am											
	01:00 am	DBH										
Total Intake :						Total Output :						
	02:00 am											
	03:00 am	DBF										
	04:00 am											
	05:00 am	DBF										
	06:00 am											
	07:00 am	DBF										
Total Intake :						Total Output :						
Total 24 hrs. Intake		Taken										
Total 24 hrs. Output		M-2 U-4										



FLUID CHART



Sheet No. : 2

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
28/5/26	08:00 am											
	09:00 am	DRF										
	10:00 am											
	11:00 am	DRF					✓		✓	✓		
	12:00 pm								✓	✓		
	01:00 pm	DRF							✓	✓		
Total Intake : <u>DRF</u>						Total Output : <u>M-01 U-2</u>						
28/5/26	02:00 pm											
	03:00 pm	DRF					✓			✓		
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output : <u>M- U-</u>						
28/5/26	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
28/5/26	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output