BAH-00661561 IP5-00176721
Baby Of VIJAYA DURGA
13-07-2026 0 Y 0 M 6 D (M)
Dr. VIJAYANAND JAMALPURI

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NEWBORN MONITORING FORM

Date of Birth : .....
Time of Birth : .....
Mode of Delivery : .....
Birth Weight : .....
Head Circumference : .....
Length : .....
Red Reflex : .....

New Born Screening : .....
TFT : .....
OAE : .....
Mother's Blood Group : A positive
Baby's Blood Group : A positive
Anomaly Scan : .....
Vaccination : .....

Date	Weight	Type of Feed	Quantity	Temperature	Signature
21/7/26	3.007kg	EBM	—	98F	S
22/7/26	2.970kgs	EBM+FF	—	98.2F	Sangeetha

(P.T.O)

Date	Time	Investigation	Result	Order No.	Signature

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176721 **Admit Date** : 21-Jul-2026 **Admit Time** : 04:50 PM **UHID** : BAH-00661561

Patient Details :

Patient Name	: Baby Of VIJAYA DURGA PRABHAKARAN	**Age**	: 0 Y 0 M 8 D
Guardian	: Mr RAJASAGI AMAR VARMA	**DOB**	: 13-07-2026 04:17 PM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO 1503, BLOCK ASPEN, BRIGADE CITADEL APARTMENTS, Moti Nagar Hyderabad Telangana INDIA 500018	**Phone No**	: 8374004945/ 9629567885
		E-mail	: AMARPUNK@GMAIL.COM

Admission Details :

Bed Type : DELUXE ROOM **Bed No** : DLX 310 **Ward Name** : 3F-ZONE A

Room No : DLX 310 **Admission Type** : First Visit

Contact Details :

Name : Mr RAJASAGI AMAR VARMA **Relationship** : Father

Contact Address : FLAT NO 1503, BLOCK ASPEN, BRIGADE CITADEL APARTMENTS, Moti Nagar Hyderabad Telangana INDIA 500018 **Phone No** : 8374004945 / 9629567885

Signature

Doctor Details :

Doctor Name : Dr. VIJAYANAND JAMALPURI **Specialisation** : NEONATOLOGY

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

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Baby Of VIJAYA DURGA
13-07-2026 0 Y 0 M 8 D (M)
Dr. VIJAYANAND JAMALPURI

ACTIVITY RECORD FOR BILLING

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

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature

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 : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00661561 IP5-00176653
Baby Of VIJAYA DURGA
13-07-2026 0 Y 0 M 7 D (M)
Dr. VIJAYANAND JAMALPURI

Patient Name: R/o vijaya Durga prabhakaran

UHID ID:

Department:

Consultant:

BAH-00661561 IP5-00176653
Baby Of VIJAYA DURGA
13-07-2026 0 Y 0 M 7 D (M)
Dr. VIJAYANAND JAMALPURI

Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

c/o yellowish discolouration of eyes & skin since 1 day

History of present illness :

c/o yellowish discolouration of skin & sclera since 1 day

Baby OG	A positive
After OG	A positive

SBR → 16.1 / 0.1 → 16

Birth wt - 3.417 kg
Today wt - 3.08 kg ⇒

BAH-00661561 IP5-00176553
Baby Of VIJAYA DURGA
13-07-2026 0 Y 0 M 7 D (M)
Dr. VIJAYANAND JAMALPURI

Pediatric Multiorgan History & Physical Examination

Past History : (Including details of any previous investigation or treatment)

Birth & Neonatal History:

Term / NVD / CIAB / BW - 3. 4kg

Birth & Socio Economic History:

About Father :
About Mother :
Any additional Information :

middle class

Developmental History :

Immunization History :

Birth vaccine - given on 14/7/20

(P.T.O.)

BAH-00661661 IPS-00176653
Baby Of VIJAYA DURGA
13-07-2026 0 Y 0 M 7 D (M)
Dr. VIJAYANAND JAMALPURI

Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms)_____(Centile _____) Height (cms):_____(Centile)_____)

Weight (kgs)) 3.0 kg (Centile _____)

On Examination :

Temperature : 98°F Pulse Rate :_____ B.P. _____ SPO2 _____

Resp.rate and type of breathing : _____

Rash_____

Lymphadenopathy_____

Oedema :_____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : RAS (+)

Air entry & breath sounds : _____

Any addes sounds : _____

Relevant data from outside (Chest X-Ray, ABG,etc.,) _____

Cardiovascular System :

Inspection of procordium : S1S2 (+)

Heart Sounds :_____

Any murmur :_____

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection_____ Soft

Palpation :_____

Ausculation :_____

Spine :_____ External Genitelia : _____

Relevant data from outside (CT, USG etc.,) _____

BAH-00661561 IP5-00176653
Baby Of VIJAYA DURGA
13-07-2026 0 Y 0 M 7 D (M)
Dr. VIJAYANAND JAMALPURI

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

_____

_____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes : N

DTR **Superficials:**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

Neonatal jaundice

_____

_____

_____

_____

(P.T.O.)

BAH-00661561 IP5-00176653
Baby Of VIJAYA DURGA (M)
13-07-2026 0 Y 0 M 7 D
Dr. VIJAYANAND JAMALPURI

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: Kernicterus

Desired goals of the treatment : Resolution of Symptoms

Planned Labs:

~~CBC~~

Planned Management

1. DSPT c̄ eyes and genitals covered
2. continue DBF Q2-3hourly f/b burping
3. monitor vitals
4. temp. monitoring under light.

N/B
[illegible]
20/7/26

Signature of the Doctor: ....

Name of the Doctor: Dr. Balaji

Date & Time: 20/7/26, 2:00pm

Signature of the Consultant: ....

Name of the Consultant: ....

Date & Time: ....

DR. P V L N MURTHY
Registration No: 47264

Dr. VIJAYANAND JAMALPURI
Reg. No: 40526

BAH-00651561 IP5-00176653
Baby Of VIJAYA DURGA
13-07-2026 0Y0M7D (M)
Dr. VIJAYANAND JAMALPURI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 4:00pm	4S/B Resident	
	Δ Neonatal Jaundice	
	Term/NVD/C1AB / B wt → 3417g / NNJ / DOL-7	
	M/A+ B/A+ U/✓ M/✓	plan. SBR → 16.1 (0.1 / 16.0) D
		① DSPT with eyes & genitals covered.
	B wt → 3417g.	
	T wt → 3080g (9.8%↓)	
	yellowish discolouration of skin and eyes.	② DBF 45ml Q2H 60ml Q3H. Alb bumping
	hemodynamically stable	
	Cry, Tone, activity } good	③ SBR after rounds
	Euthermic	④ monitor vitals, feeds & U/O
	Euglycemic	
		Noted by Durgam / Sohele

BAH-00661561 IP5-00176721
Baby Of VIJAYA DURGA
13-07-2026 0 Y 0 M 8 D (M)
Dr. VIJAYANAND JAMALPURI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 8:00am	GS/B Resident S/B VJ sir	
	D: NNJ	Plan: Lactation Review
	M/A+ B/A+ U/✓ M/✓	① SBR, CBP, Retic count, DCT } 12pm
	Twt → 3007g	
	Bwt → 3417g (10% ↓)	
	hemodynamically stable	② DSPT with eyes & genitals covered
	euthermic	
	euglycemic	③ feeding assessment
	cry, tone, activity } good	④ DBF 45ml Q2H 60ml Q3H
		⑤ Monitor vitals, feed o/o
		[signature]

Dr. VIJAYANAND JAMALPURI
Reg. No: 40526

BAH-00661561 IP5-00176721
Baby Of VIJAYA DURGA
13-07-2026 0 Y 0 M 8 D (M)
Dr. VIJAYANAND JAMALPURI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 2:30pm	Seen by Resident	
	Term/AGA/NNJ	
	Baby on Room air Accepting feeds well m/A+/B A+ Cry Tone Activity — Good Euthermic CRT < 3sec passed urine & stool	Plan 1. DSPT with eye & genital care 2 - Trace SBR, Retic, DCT, CBP 3. (RW) discharge (TM) 4. EBF 40 ml 2H / 60 ml 3H
	DCT: Negative SBR → 13.3 < 13.0	Sri Sairaj
21/7/26 4pm	Seen by Dr. Vijayanand	
	SBR - 13.3 DCT: Negative Accepting feeds well	→ To continue DSPT tomorrow → Vital monitoring
		Sri Sairaj
		Notes by Durga

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Baby Of VIJAYA DURGA
13-07-2026 0 Y 0 M 8 D (M)
Dr. VIJAYANAND JAMALPURI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/1/26	CS/B Resident	
	D: NNJ	
	Term | AGA | 3417g | DOL-8 | NVD.	SBR-133 0·3 (C) 130 (VC)
	Twt → 2970g (13%.)	Plan
	3007 → 2970 (37g↓).	① DSPT with Eyes & genitals covered
	on phototherapy	② DBF HP Q2H / Q3H Hb bump 45ml Q2H or 60ml Q3H
	Cry, Tone, Activity } good	③ Monitor vitals
	DCT- negative	④ ~~SBR~~ SBR ~~after~~ on ~~records~~ FU
	RCT → 1'2	
	CBP →	Solved.
	Hb - 19·5	
	RBC - 5·48	
	PCV - 55·9	
	WBC - 12·29	
	Platelets - 2·34L	
	NIL - 22/66	

BAH-00661561 IP5-00176721
Patient Baby Of VIJAYA DURGA
13-07-2026 0 Y 0 M 8 D (M)
Dr. VIJAYANAND JAMALPURI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 8.50AM	S/B Dr. vijayanand	
		plan:
		1) continue DSPT
	↓RA	2) cont DBF/FF Q 2-3 hrly
	tolerating feeds	3) Discharge at 5pm
		4) Review on friday c̄ SBR
		5) no labs
		6) 60ml 3rd hourly
		R/V F/U
		SBR on
		Friday.
		DR. P V L N MURTHY. Registration No: 47267

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00661561 IP5-00176721
Baby Of VIJAYA DURGA
13-07-2026 0 Y 0 M 8 D (M)
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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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Baby Of VIJAYA DURGA
13-07-2026 0 Y 0 M 8 D (M)
Dr. VIJAYANAND JAMALPURI

21/7/26

: 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: ..... Time: 10pm 2am 6am

Doctor/Nurse/Family Concern?

Temperature (F)

104 103 102 101 100 99 98 97 96 95 94

98.7F 98.2F 98.7F

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) 132bpm 140bpm 136bpm

Rate (bpm) (Over 1 Minute) *

70 60 50 40 30 20 10

Resp Rate (Number) 40bpm 40bpm 42bpm

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

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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FLUID CHART

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Sheet No. : ..... (1)

29/7/26

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

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
			Mouth	I.V	N.G							
	08:00 am						✓			✓	1	Durga
	09:00 am		EBM								No IV	Durga
	10:00 am						✓			✓		Durga
	11:00 am		EBM								Cannula	Durga
	12:00 pm									✓	1	Durga
	01:00 pm		DBF									Durga
Total Intake :						Total Output : U-3 M-2						
	02:00 pm											Durga
	03:00 pm		DBF							✓	1	Durga
	04:00 pm						✓				No IV	Durga
	05:00 pm		DBF							✓		Durga
	06:00 pm									✓	Cannula	Durga
	07:00 pm		DBF								1	Durga
Total Intake :						Total Output : U-3 M-1						
21/7	08:00 pm										1	Sayee
	09:00 pm		DBF+FF									Sayee
	10:00 pm									✓	No IV	Sayee
	11:00 pm		DBF+FF				✓					Sayee
	12:00 am											Sayee
	01:00 am		DBF+FF								1	Sayee
Total Intake :						Total Output : U-1 m-1						
22/7	02:00 am										1	Sayee
	03:00 am		DBF+FF									Sayee
	04:00 am										No IV	Sayee
	05:00 am		DBF+FF				✓			✓		Sayee
	06:00 am										Cannula	Sayee
	07:00 am		DBF+FF								1	Sayee
Total Intake :						Total Output : U-1 m-1						

Total 24 hrs. Intake	mother given	Total 24 hrs. Output	U-8 m-4

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FLUID CHART

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.

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	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											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	