

BAH-00659928 IP5-00175616

Baby Of BHUPANI SHREEYA

20-06-2026

0 Y 0 M 6 D

Dr. NALINIKANTA PANIGRAHY

(M)

Rainbow Children's Hospital - Banjara Hills
20/103/1,2,3,4 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 : IP5-00175616

Admit Date : 25-Jun-2026

Admit Time : 08:08 PM UHID : BAH-00659928

Patient Details :

Patient Name : Baby Of BHUPANI SHREEYA

Age : 0 Y 0 M 5 D

Guardian : Mr MEENIGE SAIDUKUMAR

DOB : 20-06-2026 01:00 AM

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO 81, KOLLAPUR , KUDIKILLA Kollapur
Mahabubnagar Telangana INDIA 509102

Phone No : 7997144952/ 8142601906

E-mail : NOMAIL@GMAIL.COM

Admission Details :

Bed Type : NICU

Bed No : NICU 271

Ward Name : 2F-NICU 3

Room No : NICU 271

Admission Type : First Visit

Contact Details :

Name : Mr MEENIGE SAIDUKUMAR

Relationship : Father

Contact Address : H NO 81, KOLLAPUR , KUDIKILLA Kollapur
Mahabubnagar Telangana INDIA 509102

Phone No : 7997144952

Signature

Doctor Details :

Doctor Name : Dr. NALINIKANTA PANIGRAHY

Specialisation : NEONATAL INTENSIVE CARE

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY



(P.T.O)

[illegible]



ACTIVITY RECORD FOR BILLING

Name : Blo Bhupani Shreeya
 UHID No. : _____ IP No. : _____ Consultant: _____ Dept : _____
 Date of Admission: 25/6/26 Time : _____ Date of Discharge : _____ Time: _____
 Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/6/26		ER	ward	Abhishek
3/07/26	4:15pm	NICU	3rd floor	Yamuna

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
25/6/20	Np	26064081	Cous
	Blood c/s, Blood grouping		
	PT/INR		
	WBS, RBS	2604080	
	X-Ray	031740	Cous
26/6/20	NSG	R265-031820	Cous
"	CUE BP + Urine C/s	26064314	
26/6/20	RBS	26064486	Cous
27/6/20	RBS	26064486	
27/6/20	CBP, CRP, PT/INR	26064487	
28/6/20	CBP, CRP, Sr electrolyte	26064813	Cous
	RBS		
"	DCT	26064889	Cous
29/6/20	CBP, CRP, Dengue	26065028	Cous
29/6/20	RBC	26065040	
30/6/20	RBS	26065367	Cous
1/7/20	CBP, CRP	26065676	Cous
1/7/20	RBS	26065675	
1/7/20	CSF c/s and sensitivity	26065840	Cous
	CSF Analysis		
1/7/20	lumbar puncture	26065845	Cous
1/7/20	NSG	26065755	Cous
2/7/20	RBS	26066078	Cous

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
25/6	Intr. monitor Syringe pump (2) Oxygen	(25/6/26 @ 10 PM		9674981	[Signature]
25/6	Intr. monitor Syringe pump (2) oxygen	25/6/26 10 PM		9674981	[Signature]
25/6/26	Intr. monitor Syringe pump (2) oxygen	25/6/26 10 PM		9674981	[Signature]
29/6/26	Intr. Monitor Syringe Pump oxygen	29/6/26 10 PM		9674981	[Signature]
30/6	Intr. Monitor Syringe pump	29/6/26		9674981	[Signature]
1/7/26	Intr. monitor	25/6/26		9674981	[Signature]
2/7/26	Intr. monitor	25/6/26		9674981	[Signature]

PROCEDURE

[illegible]

ANY OTHER INFORMATION

Date : _____ Time : _____ Prepared By : _____

Date : _____ Time : _____ Prepared By : _____

Date : _____ Time : _____ Prepared By : _____

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



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 - Shreeya Mother's Blood Group : A+ve
Gender : ☒ M ☐ F Blood Group : O+ve Birth Weight (gms) : 2.5 kg Length (cms) :
Date of Birth : 20/6/26 Time of Birth : 4:40pm OFC (cms) :
Place of Birth : Sri Krupa hospital, Kollapur Estimated Gesth Age : term

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 23 yrs Ht : Wt : BMI : Married Life : LMP : EDD :

Conception : Spontaneous or with Rx :

Booked at what GA : AN Steroids Drugs / Doses :

Last Scans Details :

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?

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: 2 P: A: 1 L: 4

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
1.	26 weeks		1000			
2.	-					

PERINATAL HISTORY

Treating Obstetrician : Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation) Em LSCS

LSCS : ☐ Elective ☐ Emergency Indication : CO and arend

Specify the reason : neck one loop

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

TOTAL

1 Minute	5 Minutes	10 Minutes

8/10 10/10

Resuscitation

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

D60c / 20 mch / 2-37/9



3:

Clo: skull activity x 2 days
- ↓ cry.

D60L: PT | 2.5 Kg | EMLSCS | CIAB

- apparently well - till 23/6/26.

- on D40L - skull activity
poor cry

went to local hospital

23/6 → Vennela children hospital

CBP - ^{Hb} 15.5 | ^{Plt} 2.91 | ^{WBC} 10,200

CRP - 4.6

SBR - 11.2.

T₃ - 12.6 ng/dl

T₄ - 8.4 ng/dl

TSH - 4.95 μIU.

↓ induced phototherapy

↓ referred to higher cent.

24/6 → Rani children hospital (Mehab).

24/6 → 25/6

DSPT

- received - Phototherapy fold

IV meropenem (SBR - 17.3 → 10.8)

IV Amikacin

IV Taxim

IV Ampho - B

24/6

Hb - 17.1

PCV - 48

WBC - 4,200

Plt - 2.51 lakh

S. calcium - 11.8, CRP - 8

Na⁺ - 140

K⁺ - 4.1

Cl - 102

PT - 21.5

INR - 1.6

APTT - 139.4

Investigation details in previous Hospital:

23/6

Feeding History:



Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : HR : 172/min RR : 59/hr NIBP : CFT : 13cm

Color of the extremities : Purple

Jaundice : Pallor : SpO2 : 97%

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

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

Fontanelles :

Sutures

Shape / Moulding :

Edema / Bruising :

Size - (H.C.) :

} N

Facies :

(Any Facial
Dysmorphism)

NO

NECK and
CLAVICLES :

Range of Motion :

Asymmetry :

Masses :

} N

EYES :

Symmetry :

Red Reflex :

Discharge :

needs to be checked

EARS, NOSE
MOUTH and
THROAT :

Ear set / Shape :

Periauricular Pits / Tags :

Nasal shape / Patency :

Palate :

Gums :

Lips :

Tongue :

} N

THORAX and
BREASTS :

Shape of Thorax :

Position of Nipples and Number :

3 N

ABDOMEN and
UMBILICUS :

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump :

Discharge :

} N

GENITALIA :

Labia / Hymen :

Testicles/penis :

Anus :

B / descended testes

HERNIAL ORIFICES

Free

TRUNK and SPINE :

} N

SKIN LESIONS :

Mongolian spots (N)

EXTREMITIES :

Fingers / Toes :

Arms / Legs :

Deformities :

Mobility :

Hip Joint Examination :

} N



SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress : RR : 67/min 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 : 98% Auscultation : BAFD Breath Sounds : N Added Sounds :

Cardiovascular System :

HR : 176/min BP : Precordial Activity :

Femoral Pulses : Feet Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : N Hernia orifice : Pre

Palpation : Anal Patency : ✓

Palpable masses : Umbilical Cord : ✓

Abdominal girth : First urine passed : ✓

Meconium passed :

Nervous System : Higher intellectual functions (Sensorium) : } N

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 :

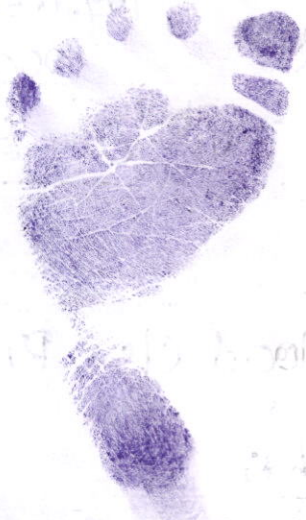


NO

Diagnosis : Teen Boy / Suspected Sepsis / SCA

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name : RAJ

Date & Time : 24/6/24

Consultant :

Signature :

Name : Dr. NALINI KANTA PANIGRAHY

Date & Time : 26/6/24

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :
2. Name of the 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.



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

Vital : ☐ HR : ☐ RR : ☐ BP : ☐ SP02 : Weight :

Any Oxygen requirement : do/w

Systemic : Dr. V.S. → TV → 140 cc/kg/day

Medications : Feeds - 120 cc/kg/day

→ CRBS openly 10% ISOP 20 cc/kg/day
→ 50 ml/2 hr

Do
Send

- NP, Blood Cts, PT/INR/APTT/CBG

Plan during ward follow up :

- CRBS
Antibiotics
q.i.v. Menoprenem

- q.i.v. Ampho-B

→ w/f ↑ WOB, brady, diarrhea

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/2026 10:30pm.	<u>NIGHT ROUNDS</u> On Room Air. SpO2 - Baby tachycardic. RR - 74/min. CRT 2 sec pelvis well felt Tachycardia B Vitals HR - 180/min RR - 74/min SpO2 - 98% BP - 51/25(35) GRBS - 10 cm/gldl.	<u>Seen by Dr. Vinub</u> → To start low flow O-5 L/min. → IV - 140cc/kg/day 10% Bsof + Ca3. → To start feeds Sml Dendhly EBM/Formula. → C-xray new. → Trace reports → Continue antibiotic → GRBS - 8th hourly. → w/f AWOB, dull activity, poor feeds Noted by G. Rashmedha 25/6/26

BAH-00659928 IP5-00175616
 Baby Of BHUPANI SHREEYA
 20-08-2026 0 Y 0 M 5 D
 Dr. NALINIKANTA PANIGRAHY (M)



9

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes				Doctor's Order
	20/08/2026 11:50 AM				
	BP centiles				
	5th	25th	50th	95th	
SBP	60	69	78	91	
DBP	30	37	44	60	
mean	40	48	55	70	
	Weight 10.5 kg				
	Height 100 cm				
	Head circumference 34 cm				
	Temperature 38.5				
	Heart rate 120				
	Respiratory rate 20				
	Oxygen saturation 98%				
	Finger pulse 2+				
	Chest clear				
	Abdomen soft				
	Genitals normal				
	Skin clear				
	Mucous membranes pink				
	Neck clear				
	No rashes				
	No swelling				
	No jaundice				
	No dehydration				
	No fever				
	No cough				
	No vomiting				
	No diarrhea				
	No blood in stool				
	No blood in urine				
	No hematuria				
	No proteinuria				
	No leukocyturia				
	No nitrites				
	No bacteria				
	No fungi				
	No parasites				
	No worms				
	No insects				
	No animals				
	No plants				
	No minerals				
	No vitamins				
	No nutrients				
	No toxins				
	No allergens				
	No irritants				
	No pollutants				
	No carcinogens				
	No mutagens				
	No teratogens				
	No embryotoxins				
	No fetotoxins				
	No neonatotoxins				
	No lactotoxins				
	No gametotoxins				
	No zygotoxins				
	No blastotoxins				
	No organotoxins				
	No somatotoxins				
	No gonadotoxins				
	No neurotoxins				
	No hepatotoxins				
	No nephrotoxins				
	No cardiotoxins				
	No pulmonotoxins				
	No dermatotoxins				
	No immunotoxins				
	No endocrinotoxins				
	No carcinogens				
	No mutagens				
	No teratogens				
	No embryotoxins				
	No fetotoxins				
	No neonatotoxins				
	No lactotoxins				
	No gametotoxins				
	No zygotoxins				
	No blastotoxins				
	No organotoxins				
	No somatotoxins				
	No gonadotoxins				
	No neurotoxins				
	No hepatotoxins				
	No nephrotoxins				
	No cardiotoxins				
	No pulmonotoxins				
	No dermatotoxins				
	No immunotoxins				
	No endocrinotoxins				

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: DB PMA:

Term ☐ Preterm ☐ Gestation: Term Corrected Gestational Age: Today's Weight:

Problems		
S.No.	Current	Past Problems
1.	Term/S&A/Boy	
2.	Suspected sepsis	
3.	Coagulopathy	
4.	Thrombocytopenia	
5.		
6.		

Clinical Assessment	
low flow on PR intermittent Tachypnea ⊕ o.2 PR tachypnea ⊕ 2 episodes of fever spikes 100°F one RDP given one AFP given Aspirate → Hmb Kept NP ⊕ Abdomen → soft stools → pink HR - 172/min RR - 51/min SpO2 - 94% WBC → 63/39/49 U.O →	

Medications Used	
1g meropenem 5g colistin 5g 100 mg phos-B.	

Plan of Care:	
→ TV - 140cc/kg/day 10% of O2 + Ca₂, 5ml 0.9% NaCl → CRBS 0.9% (afebrile) → Monitor for fever spikes, temperature 0.2h → Doxact 0.6h → Target mBP → 48-55mmHg U.O → 2-4 cc/kg/h SpO2 → 90-100% 16-20% = 21 90-95% 16-20% = 21%	→ Res blood clt. DBM (0.5) → RN for the Pad

Doctor's Name (Hand over given): RAC

Doctor's Name (Hand over taken): Dr. N. Kulk

Signature: [Signature]

Signature: [Signature]

Date & Time: 26/6/26

Date & Time: 26/6/26

Patient Sticker

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

	Problems		
	S.No.	Current	Past Problems
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Signature:

Date & Time:

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:



(3)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 12:15	Sepsis Encephalopathy. Thrombocytopenia Coagulopathy Pneumonitis	Plan 1) SGOT, SGPT from same sample ALP 2) HSG today Urea c/s to send Urine R/E. 3) CBP, CRP, PT-INR T/m 4) LP SOS 5) Feeding 5ml / 3rd hourly EBM / DBM to formula. 6) GRBS 8 hourly (prn). 7) vit K 1mg IV stat. 8) NBS sos after feeding
	Dr. NALINIKANTA PANIGRAHY Reg. No. 13405	Noted by DIP 17039 26/6/26 12:15pm D. Ashu

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/2026 @ 3:45pm	<u>Evening Rounds</u>	<u>Plan</u>
	Baby on Room air mild Tachypnea mild Intermittent ICR (+) No desaturations	1) SCS - low flow O ₂ 2) TV = 140 ml/kg/day 5ml 3rd hrly 10% F80 + 3ml/kg ca-gluc EBM/DBM
	No Fever Spikes <u>Vitals</u> HR = 155/min SPO ₂ = 92% RR = 57/min Intermittently RR upto 40/min	3) U/c/s } to trace B/c/s } 4) T/m = CBP CRP PT, INR, APTT
	P/A - Soft Started feeds 5ml 3rd hrly DBM Aspirates - Nil	5) GRBS 8th hrly (Pre-feed) 6) NBS (SOS) after reaching feeds
	GRBS - 110mg/dL @ 2pm	7) LP SOS
	VitK given, Inj. Varic added	9) Flocharting 6th hrly
	NSG - (N) RI 0.53	10) w/p - RD, desatur Abd. distension Fever Spikes

5

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 @ 9:15pm	<u>Night Rounds</u>	Plan:
	Baby on Room air.	
	No desaturations / Tachypnea.	1) $TU = 140 \text{ ml/kg/day}$ ↓ 5ml 3rd h x 4
	⊙ No fever spike.	Rest 10% Iso-P + 8ml/kg ca.
	last feed No aspirator	Rlv to ↑ feed T/m
	Temp = 98.4 °F. Rt axillary	2) Trace - u/s, B/s
		3) T/m = CBP CRP PT, INR, APTT
		4) NBS (803) after reaching Considerable feeds
		Sreha
		Noted by Dandamuk 26/6/26 10 PM



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



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



22/6/2026

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: 7 PMA:
Term ☐ Preterm ☐ Gestation: Term Corrected Gestational Age: Today's Weight: 1079g (2431kg) → Rechecked weight

Problems	
S.No.	Current
1.	Term AGA Male
2.	Late onset neonatal sepsis - culture reports awaited
3.	Encephalopathy
4.	Coagulopathy - resolved
5.	Thrombocytopenia
6.	Presumed AKI, Pneumonitis

Overview

Clinical Assessment

Baby hemodynamically stable on air.
No episodes of bradycardia/ desaturation overnight.
Tolerating feeds 5ml shyly, No vomiting. → NG aspirate 10ml overnight (last 24h (milky))
U.O - 1.85 c/kg/hr. GRBS - 92mg/dl.
Neurologically - activity better than yesterday, now crying for feed.

Medications Used

Blood cts - No growth after 24h
O/E - HR-143, RR-46, SPO₂-100
PT/INR-15/1.1
APTT-45
CRP ↑ 124
PLC (31)
NSG (N) - RI 0.53

Plan of Care:

1) TV - 140 c/kg/day - R/v to ↑ feeds & TV today
2) Trace Urine cts, Blood cts
3) GRBS 8th hly (Prefeed) → R/v to BD
4) NBS after reaching considerable feeds.
5) LP SOS.
6) Monitor vitals

Target

SPO₂ 90-100% hly FIO₂ 21-
90-95% hly FIO₂ 21-
MBP - 48-55 mmHg
GRBS - 60-150 mg/dl
U.O - 1-5 c/kg/hr

Doctor's Name (Hand over given): Dr. sneha

Signature: Dr. sneha

Date & Time: 21/6/26

Docu. No.: RCHB/ FRM/ CLINICAL/ 290

Doctor's Name (Hand over taken): Dr. Nalini

Signature: Dr. Nalini

Date & Time: 21/6/26

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

Overview	Problems		
	S.No.	Current	Past Problems
1.			
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Signature:

Date & Time:

Doctor's Name (Hand over taken):

Signature:

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/06/26 12pm		Seen by Dr. Nalinikanta
		- Feeds 3ml BD - DBM/EBM TV - 150 cc/kg/day.
		- CBP, CRP, s/E T/M.
	24 hr - Blood c/s - sterile.	- Trace urine c/s, Blood c/s.
		- Platelet once reaching 60,000. draw about LP
		- start low dose adrenaline (3mg/kg)
		- 2D Echo today
		- If persistent thrombocytopenia tomorrow, send DCT Tomorrow. (from same sample)
	Dr. Nalinikanta Panigrahy Reg. No. 03605	Noted by Dr. [Signature] 07/06/26 @ 12:15pm

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/06/26 3pm	Afternoon Rounds Baby hemodynamically stable on room air. No episodes of bradycardia/dysrhythmias. Tolerating feeds 8 ml shy, No vomiting. AK Aspirations - Nil SpO₂ HR - 151/min RR - 43/min SPa₂ - 97.1% BP - 58/35 (43) on Atracurium @ 0.1 mg/kg/hr. Urine cts 24 hr - sterile Blood cts Echo - 1.4 mm small PDA E L → R shunt. (Cir 35/15 mm) PFO E L → R shunt Dilated LA, LV Good Biventricular function EF 63%. No PAH LAA - 1.2	Plan 1) ↑ feeds 3ml BD DBM/EBM TV - 150 cc/kg/day (TF - 46 ml 3hrly) 2) CBP CRP C/E 3) R/v LP if Platelet > 60,000. 4) Trace Echo report 5) DCT to send T/m from Same sample y CBP report showing presence of thrombocytopenia Noted by Dr. P. P. S. 018039 27/6/26 @ 3:15 pm

Date & Time	Progress Notes	Doctor's Order
27/6/26 10pm	<u>night rounds</u> Baby on Room air No RR/desaturation No brady cardia Tolerating feeds well SpO₂: 99.1% PR: 138/min RR: 56/min BP: 62/44 (53) mmHg CRT < 3sec Ongoing adrenaline Temp: 36.5°C	<u>Plan</u> 1. TV = 150 cc/kg/day 11ml O₂ H₂O A feed <u>↑ 3ml 12th hourly</u> 2. CBP CRP Electrolytes } Tlm 3. Rlv lumbar puncture if platelet > 60,000 4. JF persistent thrombocytopenia send OCT from sample. 5. w/f fever RR/desaturation dated by <i>[Signature]</i> 02/02/22

10



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: 8 PMA:
 Term ☐ Preterm ☐ Gestation: Term Corrected Gestational Age: Today's Weight: 2.462 kg

	S.No.	Problems	
		Current	Past Problems
Overview	1.	Term AGA Male	
	2.	Late onset Neonatal Sepsis - final culture report pending.	
	3.	Exophthalmos	
	4.	Coagulopathy - resolved	
	5.	Thrombocytopenia	
	6.	Persistent ARI, Pneumonitis	
Clinical Assessment	Baby hemodynamically stable on air. No episodes of bradycardia/desaturation. Comfortable on prone position. Tolerating feeds 11 ml 3hrly, No vomiting, NG aspirate → 9 ml (last 24 hr) (3ml - light green X milky) U.O - Tone, activity - Better.		
Medications Used	Inj. Meropenem D4 Inj. Liposomal Amphotericin B-D4 Inj. Colistin D4 Inj. Vancomycin D3 On Adrenaline 0.1 mcg/kg/min Echo - small PDA PFO Dilated LA/LV Good perf. CRBS-99 8 - HR-149/min RR- 44/min SpO2 - 96% BP- 58/35/43		

Plan of Care:

- 1) Tr - 150 cc/kg/day - ↑ feeds 3ml BD DBM/EBM, TF 46 3hrly
- 2) Trace, CBP, CRP, SLE → If persistent thrombocytopenia, send DCM brain sample
- 3) Trace Blood & urine cts.
- 4) CRBS 8th day → R/L to BD
- 5) NBS after reaching considerable feeds
- 6) R/L LP if platelet > 60,000
- 7) Monitor vitals

Doctor's Name (Hand over given): P. Nishu

Signature: [Signature]

Date & Time: 28/6/26

Doctor's Name (Hand over taken): CRBS

Signature: [Signature]

Date & Time: 28/6/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/6/26 @.	- B/c/s - NG - 48hrs - U/c/s - NG - 24hrs	1) Ask for Send DCT in Same Sample 2) wear Adrenaline if MBP > 55mmHg as NIBP Target 48-55mmHg Saheha 3) feeds at 11ml ↑ 3ml / BD 4) R/v on antibiotics Saheha
	CBP, CRP - Th Dengue IgM 7th day all feed (6th) Trace DCT Reps Trace Urine Reps Trace Blood Reps Stop Colistin menoperan + Vancomycin to continue 3rd Day stop Amphotericin platelets > 60k 4 - 1m	



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date & Time	Progress Notes	Doctor's Order
2/6/22	<u>B/O Meye</u>	
	→ Cereb	
	→ Hablet	
	→ ↑ leads to Lolly	
	→ DPC to, LP Plan	
	→ Blood clots AG	
	→ vein clots Benig.	
	→ fugal stoppin	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

AH-00659928
 Baby Of BHUPANI SHREEYA
 3-06-2026
 R. NALINIKANTA PANIGRAHY (M)
 IP5-00175616
 0 Y 0 M 8 D

12



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/6/26		Afternoon rounds
4:40pm		Plan:
	- On room air	- IV - 150ml 1ks/day
		↓
	- DCT - Ove	14 ml 3rd hourly
		↑ feed 3ml 6th hourly
		- To stop after [TF = 46ml]
	Urine clt - 24 hours no growth	- Amphis - after
		72 hours clt.
	Pt count - 3,600 → 54,000	- CRP.
	CRP - 124 → 44	CRP.
		Dengue IgM
		- Target mwp - 48 to 55 mmHg.
		- R/LV UP if
		TLm Pt count > 60,000
		- Trace btrial clt report
		Noted by Dr. P. O. 18/06/26 @ 4:50pm

13



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: 9 PMA:

Term ☐ Preterm ☐ Gestation: Term Corrected Gestational Age: Today's Weight: 2.387 (276g)

Problems	
S.No.	Current
1.	Term/AGA/male
2.	Late onset Neonatal sepsis
3.	Coagulopathy - Resolved
4.	Thrombocytopenia
5.	Pre-renal AKI, Pneumonia
6.	Encephalopathy

Overview	Past Problems
1.	Coag
2.	
3.	
4.	
5.	
6.	

Clinical Assessment
Baby hemodynamically stable on room air No fever, no R/O, no dehydration Spontaneous cry, tone improving Tolerating feeds Passed urine & stool U/O: 2:1 cc/kg/hr RBC → 9/mg/dL Blood cl → 48 hrs sterile Urine cl → no growth OCT → negative CRT < 3 sec BP: 120/80 PR: 140/min RR: 52/min Bp: 56/38 (45) mmHg

Medications Used
1) Imipenem DS 2) Intraliposomal AmphoB DS 3) Imi. vancomycin DS Blood cl → 72 hrs no growth. (verbal report)

Plan of Care:
1. IV = 150 cc/kg/day 23ml @ 3h full OA feed 3ml 6th hourly (TF = 46 ml) <u>Target: SpO₂ + 90-100% CERA</u> 2. Send sepsis Igm 3. (Riv) Antibiotics 4. Riv Lp if platelet > 60,000 5. GRRS 8th hourly 6. NBS after reaching considerable feed 7. Vital monitoring 3rd hr MAP → 48-55 mmHg U/O → 2-4 cc/kg/hr

Doctor's Name (Hand over given): Rupanjali

Signature: [Signature]

Date & Time: 29/6/26

Doctor's Name (Hand over taken): Lai

Signature: [Signature]

Date & Time: 29/6/26

Date & Time	Progress Notes	Doctor's Order
6/26 3:30 AM		Seen by Dr. Nalinaksh
		1) Stop liposomal Amphotericin B
		2) Hcm LP, if PC > 60,000.
		3) ↑ feeds 3 ml alternate feeds
		4) RBS BD CBG SOS
		NP1 on Wednesday
		Noted by Sis. [Signature] 29/6/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/26 4pm	<u>Afternoon Rounds</u> Baby hemodynamically stable on air. Tachypnea & retractions ↑ while in supine position → changed to prone position Tolerating 26 ml of 3hly, No vomiting S/E - PR - 166/min RR - 56/min SpO₂ - 98% BP - 62/39(41)	<u>Plan</u> 1) TV - 150 cc/kg/day ↑ feeds 3 ml 6hly 2) W/F ↑ WOB, Tachypnea Retracting 3) Trace Dengue IgM 4) CRBS BD 5) ALP if PLC > 60,000 /- 6) NP₁ on Wednesday morning
29/6/26 4:30pm		Seen by Dr. Nalinikanta Panigrahy keep baby in supine position ↓ look for distress / oxygen requirements Noted by SIS Pradyumn 29/6/26

15



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

	Problems		
	S.No.	Current	Past Problems
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Doctor's Name (Hand over taken):

Signature:

Signature:

Date & Time:

Date & Time:

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: 10 PMA:

Term ☐ Preterm ☐ Gestation: Term Corrected Gestational Age: Today's Weight: 2.41 kg 28 gms

		Problems		
		S.No.	Current	Past Problems
Overview	1.		Term/AGA	
	2.		late onset sepsis	
	3.		Pneumonia	
	4.		Coagulopathy (Resolved)	
	5.		Prerenal AIC	
	6.		Encephalopathy	
Clinical Assessment	On PA, maintaining sat's tolerating feeds HR - 144/hr RR - 20/hr SpO2 98% PPI - 69/43/57			
Medications Used	zy meperiden P6			
Plan of Care: <u>full.</u> → IV - 150cl/hr/day <u>4ml/kg/day</u> Day Palady, <u>no</u> → Send NBS. → Rule LBP, CRP. → <u>no</u> case now → <u>no</u> BP (Rebel) → RW LP.				

Doctor's Name (Hand over given): San

Signature: y

Date & Time: 1/7/26

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:

Patient Sticker

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: PMA:

Term ☐ **Preterm** ☐ Gestation: Corrected Gestational Age:..... Today's Weight:

		Problems	
		S.No.	Past Problems
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Doctor's Name (Hand over taken):

Signature:

Signature:

Date & Time:

Date & Time:

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

	Problems		
	S.No.	Current	Past Problems
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Signature:

Date & Time:

Doctor's Name (Hand over taken):

Signature:

Date & Time:



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: 10 PMA:

Term ☐ Preterm ☐ Gestation: Term Corrected Gestational Age: Today's Weight: 2.389 (129g)

Problems	
S.No.	Current
1.	Term) AGA
2.	late onset Neonatal sepsis
3.	Pneumonitis
4.	Coagulopathy (Resolved), Thrombocytopenia
5.	PreRenal AKI
6.	Encephalopathy

Clinical Assessment	
Baby stable on Room air No R/o no desaturation Spontaneous cry @ Tolerating feeds Passed urine & stool	RR: 31/mph SpO ₂ : 94% PR: 148/min RR: 49/min BP: . Blood clt → 48 hrs. sterile Urine clt → 72 hrs sterile Dengue IgM → negative

Medications Used	
1) Inj. meropenem DS (4 doses)	
2) Inj. Vancomycin DS (4 doses)	

Plan of Care: 1) Tr = 150 cc/kg/day → 35 ml q3h (TF = 46 ml) ↑ 3ml 6th hrly
 2) plan LP if > 60,000
 3) NP₂ (T_{1m}) (NP₁)
 4) GRBS BD
 5) Supine position → look for R/o desaturation

Doctor's Name (Hand over given): Panigrahy

Signature: [Signature]

Date & Time: 30/6/26

Doctor's Name (Hand over taken): Choi

Signature: [Signature]

Date & Time: 30/6/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26 11:30 AM		Seen by Dr. Nalnikanta
		1) 3ml each feed Til (Tf=46ml)
		2) Start feeding
		3) ERP, CRP (Til)
		4) Erib care (Til)
		5) GRBC OD
		6) NBS to send
		7) Plan to shift after
		8) Kp if platelets > 60,000
		Noted by SD. Prayank 30/6/26

Dr. NALINIKANTA PANIGRAHY
 Reg. No: TSMC/FMR/036081
 30/6/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
30/6/26	<u>Afternoon rounds</u>	
	Baby on Room air no distress no dehydration Accepting feeds well No vomiting SpO ₂ : 98% PR: 151/min RR: 49/min CRT < 3 sec P/A: soft Tone: Improving	<u>Plan</u> 1. Stop vancomycin after tomorrow morning dose (1st dose complete) 2. Continue meropenam 3. TIV > 150cc/kg/day ↓ 46ml Q3H paladi feed 4. RRT OG feed 4. Crib care (Tm) 5. BP] (Tm) CRP] (Tm) 6. Send NBS With tomorrow sample 7. Plan LP if platelets > 60,000. 8. GRRs OD. 9. (RW) meropenam after LP
		Noted by Sris Tripathi 30/6/26

Sris
 Sen



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



18

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/26		Seen by Dr. Nalinikanta
		→ Antibiotics D7 to D10 depending on
		→ If today
		→ Press the baby
		→ crib care
		→ Shifting T/m
		→ CRBS DD. (Preferred)
		noted by Abh 1/7/26
	LP notes	
1/7/26 1 PM	Under sterile aseptic conditions LP done. Blood CRBS → 78 mg/dl. LP needle was inserted in L3 space. CSF fluid collected. Baby was stable throughout the procedure.	
	CSF sugar → 43 mg/dl	→ send for CSF Analysis picture → Store one container for single Gene Pathogen Rep.

19

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Afternoon Round</u>	
<u>11/7/26</u>	on RA, maintaining cabs	<u>Plan</u>
	taking Paladay feeds well	→ TV - 150cc/4/day with ongoing Paladay feed
	HR - 123/min RR - 31/min SpO ₂ - 92% BP - 69/43/53	→ Trace NBS → Crib care
	CP done	→ CRBS OD (Prefeed)
		→ Trace LP reports → Target CRBS 60-100/100 → Antibiotics D7-D10
		→ Dress the baby → CRBS OD (Prefeed)
		→ shift to Room → target SpO ₂ 90-100.
		→ (RARE)
		noted by Abhi 11/7/26

IP5-00175616

20-08-2026

0 Y 0 M 10 D

(M)

Dr. NALINIKANTA PANIGRAHY



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



BirthRight™

BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]



21



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: 11 PMA:

Term ☐ Preterm ☐ Gestation: Term Corrected Gestational Age: Today's Weight: 2.39 (1279g)

Problems	
S.No.	Current
1.	Term / AGA
2.	Late onset sepsis
3.	Pneumonitis
4.	Coagulopathy - Resolved
5.	Prerenal AKI
6.	Encephalopathy

Clinical Assessment	
Baby on room air hemodynamically - Stable - accepting feeds well.	HR - 130/min SpO₂ - 100% Chest - clear CVS - S₁ S₂ @ Peripheries - warm PIA - soft

Medications Used	
1x Meropenem - D.J.	CRBS - 89mg/d

Plan of Care:

- TV - Isoflurane day - 47ml - 32% w - full palatal
- Trace NB's, CSF - cultures
- Riv - antibiotics
- Riv - shift out
- CRBS - OD - prefeed
- PIV Antibiotics

Doctor's Name (Hand over given): Panigrahy

Signature: Panigrahy

Date & Time: 2/7/26

Docu. No.: RCHB / FRM / CLINICAL / 290

Doctor's Name (Hand over taken): Panigrahy

Signature: Panigrahy

Date & Time: 2/7/26

Patient Sticker

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

	Problems		
	S.No.	Current	Past Problems
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Signature:

Date & Time:

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:



22

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/5/26		Seen by Dr. Nalinikanta
		→ DBF / mother feeding is fed
		→ crib care
		→ shifting the by evening
		→ Stop ABx today
		→ Place NBS
2/5/26 2:20pm	Afternoon Dr. NALINIKANTA PANIGRAHY Reg. No. 15615616 / 0305	NO shifting today
		P/Len
	Baby on room air hemodynamically stable - accepting feeds well poor - urine/stool	→ +V - 150 ccl/kg/day - 47 ml @ 3rd hr
	HR - 132/min	→ EBM
	SpO ₂ - 98% p	→ encourage mother in feeding
		→ Stop by meropenem after afternoon dose
		→ Trace NBS / CSF - culture
		→ CRBS - OD - prefeed
		→ I/O - charting
		→ W/F - skull activity

Patient Sticker

23



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: 12 PMA:

Term ☐ Preterm ☐ Gestation: Term Corrected Gestational Age: Today's Weight: 2.431 (941 gm)

		Problems	
		S.No.	Current
Overview	1.	Term/A4A	coagulopathy (resolved)
	2.	Late onset of Neonatal sepsis	Encephalopathy
	3.	pneumonitis	
	4.	Acute Renal Axi	
	5.	Encephalopathy	
	6.		
Clinical Assessment	Baby on Room air Hemodynamically stable Accepting feeds well Passed urine & stool RBS: 82 mg/dL		SpO ₂ : 100% - CRT PR: 119/min RR: 43/min CRT < 3 sec Peripheries warm
	Medications Used		
Plan of Care: 1) Pre 150cc/kg/day → 47ml @ 3H 60ml / 0.8f 2) Encourage mother for feeding 3) Trace CSF clt 4) Elo charting 5) CRBS on (pre-feed) 6) (RW) shifting plan → shift to Rev			

Doctor's Name (Hand over given): neethu

Signature: [Signature]

Date & Time: 3/7/26

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken): San

Signature: [Signature]

Date & Time: 3/7/26

Patient Sticker

DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

	Problems		
	S.No.	Current	Past Problems
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Doctor's Name (Hand over taken):

Signature:

Signature:

Date & Time:

Date & Time:

Docu. No.: RCHBH / FRM / CLINICAL / 290

Date & Time	Progress Notes	Doctor's Order				
	<u>N/Cut Rounds</u>					
<u>3/2/24</u>		<u>Plan</u>				
8:30pm	on RA Talking Reels well CFT 3 sec <table border="1"> <tr> <td>lesome</td> <td>✓</td> </tr> <tr> <td>stool</td> <td>✓</td> </tr> </table> CFT/A Good Vaccination → Done NBS (N)	lesome	✓	stool	✓	→ Full Paley Reel 03hly → Buprop → ARBS (00) Refeed → AABR/Tm → vitals monitoring 02hly noted by Pijal 10pm H (PACU)
lesome	✓					
stool	✓					

(M)



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

[illegible]



RESULT SHEET

Date	25/6/26	27/6/26	28/6/26	29/6/26	1/7/26	17/7/26
Time	11:42pm	8:30am	9am	6am		
Hb	13.7	11.1	13.3	12.9	13.1	
PCV	37.7	32.3	38.4	38.1	38.9	
RBC	3.79	3.13	3.76	3.70	3.76	
WBC	29.45	38.21	29.13	9.97	15.78	
N/L	79.8/73	70.6/17.3	57.9/27.7	33/41	23.5	
Platelets	15	31	SDP 54	54	224	
CRP	85	124	44	21.2	9.0	
ESR						
PCT						
RBS						
Na	131		131			
K	5.5		4.5			
Cl	104		99			
Ca/Mg	8.7/1					
Phosphate						
Urea	54					
Creatinine	0.9					
ALP	97					
SGPT	15					
SGOT	52					
T.Bill/Conj	11.0	0.7				
T.Protein		10.3				
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR	29/2.3	15/1.1				
APTT	76	45				
CSF Protein / Sugar						
Cells						
N/L						

117/26

[illegible]

Culture and Sensitivities :

Radiology :

USG :

X-Ray :

ECHO :

CT :

MRI

Others (ECG, Contrast Studies etc.) :

BAH-00659928 IP5-00175616
Baby Of BHUPANI SHREEYA
20-06-2026 OYOMSD (M)
Dr. NALINIKANTA PANIGRAHY



DRUG CHART

Date of Admission: Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.

- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.

- Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.

- The date and time of stopping the drug along with the doctors name and sign must be mentioned.

- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

REGULAR PRESCRIPTIONS

Weight. 2.5 kg Ward. Ny

① 100mg
② 100mg
③ 100mg

INJ MEROPENEM.

Dose	Route	Frequency	Start Date	Date Time
100mg	IV	Q8H	25/6	6Am

Name & Signature of the Doctor Starting the Drugs: *Panigrahy*

Additional Instructions: 40mg/kg/8th hly

Daily Doctor's Endorsement by a Sign

DRUG : INJ AMPHOTERICIN B LIPOSOMAL

Dose	Route	Frequency	Start Date	Date Time
13mg	IV	OD	25/6	

Name & Signature of the Doctor Starting the Drugs: *Panigrahy*

Additional Instructions: 5mg/kg/dose. 1 vial (50mg) + 10ml = 5mg/ml → 2.6ml + 3ml 5% D - Over 1 hr

Daily Doctor's Endorsement by a Sign

DRUG : INJ COLISTIN

Dose	Route	Frequency	Start Date	Date Time
1,00,000 IU	IV	TD	25/6	6Am

Name & Signature of the Doctor Starting the Drugs: *Dr. Panigrahy*

Additional Instructions: 40,000 IU/kg/dose

Daily Doctor's Endorsement by a Sign

DRUG : INJ VANCOMYCIN

Dose	Route	Frequency	Start Date	Date Time
38mg	IV	8hly	26/6	6Am

Name & Signature of the Doctor Starting the Drugs: *Dr. Panigrahy*

Additional Instructions: 15mg/kg/dose

Daily Doctor's Endorsement by a Sign



Weight. 2.5kg Ward. Nly

		Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date	Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.

VARIABLE DOSE		Date Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date	Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:		Dose		Dose		Dose
		Dr. Sign.		Dr. Sign.		Dr. Sign.

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
26/6/26	1 AM	RDP	1ml/kg	Wax 30min	L	Rashmita
26/6/26	3 am	FFP	15ml/kg	over 30 min	Pu	Rashmita
28/6/26	12 pm	INJ. vit K	0.5mf	IV	(Signature)	Diphi
27/6/26	5 pm	SDP	15ml/kg	IV	(Signature)	Diphi



I.V. FLUIDS CHART

Weight. 2.5 kg Ward. 24

Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
25/6	10pm	TV-140cc/kg/day 10% ISOP: Ca ₂	IV	14.5ml	Panigrahy	Nurse Nurse	26/6		Nurse Nurse
25/6		5mg Adrenaline 3mg/kg in 50ml of S/D	IV	0.1	Dr.				
26/6									
27/6	1pm	IND. ADRENALINE 3mg/kg : 50ml S/D	IV	0.1	Dr.	Dr. Nurse	28/6		Dr.
28/6		TV-150ml/kg/day 10% Iso-p + Ca ₂	IV		Dr.	Nurse	28/6/26		Dr.

Signature

VERIFIED BY: Name

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

BAH-00659028
Baby Of BHUPANI SHREEYA
20-06-2026
Dr. NALINIKANTA PANIGRAHY
IP5-0011-
0 Y 0 M 5 D
(M)

Right™
OSPITALS
for Delivery

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 | 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		
25/6/2	11pm	1, 2	- About school care - Diagnosis	F	Ⓢ	1	1	1	Ala	Das

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					



NURSING INITIAL ASSESSMENT FOR NICU

Date of Admission: 23/6/26

Source of Admission: ☐ OPD ☐ Ward ☐ Labor Ward ☐ Other: ER

Reason for Admission: sepsis, Thrombocytopenia

Admission Diagnosis: sepsis, Thrombocytopenia

Accompanied By: ☒ Parent ☐ Guardian ☐ Other Name:

Primary Language: ☒ Telugu ☒ English ☐ Hindi ☐ Other Specify

Do you require an interpreter? ☐ Yes ☐ No

Allergies: ☐ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:

If yes, identify

Source of Information: ☐ Family ☐ Others, Specify

Past Medical History	Past Surgical History	Last Hospital Admission
no past history	no surg's GI history	-

Significant History

Family History:

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☐ No

If yes please list,

Was the child's birth normal? ☐ Yes ☐ No If No, please describe problems:

Are the child's immunization up to date? ☐ Yes ☐ No

Current Medications

Taking Medications? ☐ Yes ☐ No

If yes, Fill the reconciliation form

Medicine brought to the hospital? ☐ Yes ☐ No

Observations:

Birth Weight: 2.5 kg Head Circumference: cm Length: cm

☒ Term

☐ Pre-Term

☐ Post-Term

Blood Group:

Mother: A+

Baby: (+ve)

Feeding:

☐ Breast Feeding

☒ Formula

☐ Both

Maternal Details:

Age: 23 years,

PARA:

Gestation: Weeks, Days

Risk Factors:

☐ PROM

☐ Fetal Distress

☐ Diabetes Mellitus / Gestational Diabetes

☐ PH / Pre Eclampsia

☐ Others, Specify:

Mode of Delivery:

☒ Normal

☐ LSCS - Emergency / Elective

☐ Instrumental

☐ AVD

Indication:

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)

EARLY WARNING SCORE: CHILDREN'S UNIT

[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.

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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



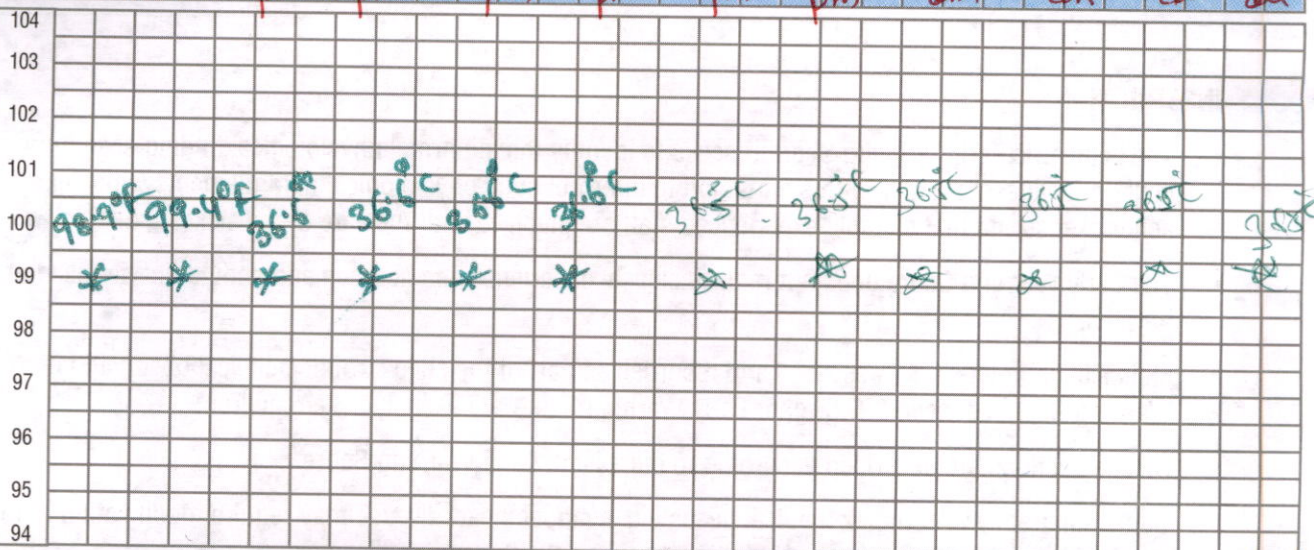
27/6/26

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 8 10 12 2 4 6 8 10 12 2 4 6
Doctor/Nurse/Family Concern? am ar pr pr pm pr pm pm am am am am

Temperature
(F)

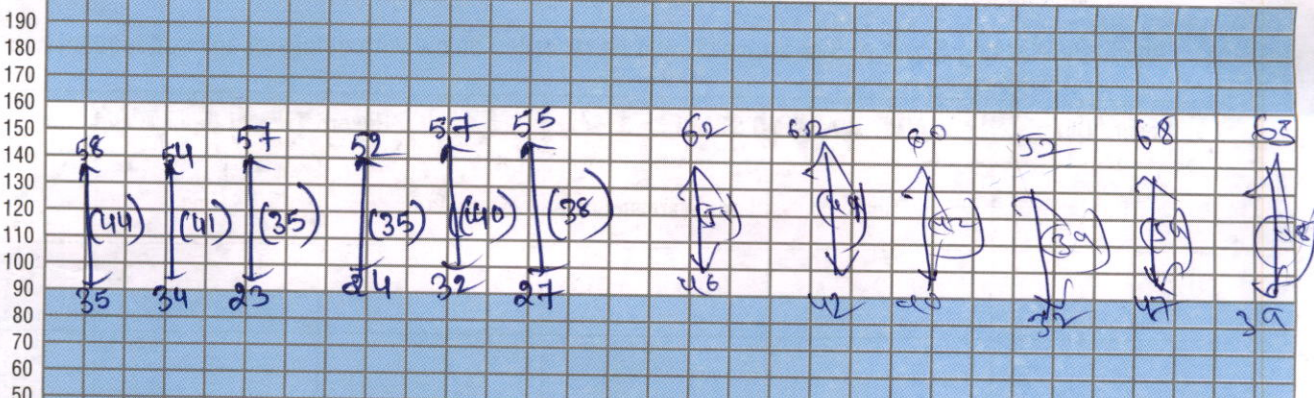


Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring



Heart Rate (Number) 148 156 167 162 132 142 131 133 130 139 138 155

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



Resp Rate (Number) 35 51 48 46 50 64 43 46 35 42 54 53

Resp Mod/ Severe
Distress None / Mild

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

Conscious
Level Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

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)



28/6/26

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time: 8	10	12	2	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?	am	am	pm	pm	pm	pm	pm	p	am	am	am	am

Temperature (°F)	104											
	103											
	102											
	101	98.5° F	98.7° F	98.8° F	98.5° F	98.6° C	98.6° C					
	100	*	*	*	*	*	*	*	*			
	99											
	98											
	97											
	96											
	95											
	94											

Heart Rate (bpm) and Blood Pressure (mmHg) * Note: BP does not score in early warning scoring	190											
	180											
	170											
	160											
	150											
	140	59	57	59	61	55	55					
	130	(49)	(52)	(48)	(48)	(43)	(44)					
	120											
	110											
	100											
	90	43	46	43	39	37	37					
	80											
	70											
60												
50												
Heart Rate (Number)	149	138	158	152	142	138	128	125	128	129	129	129

Resp. Rate (bpm) (Over 1 Minute) *	70																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																								
---------------------------------------	----	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Resp Distress	Mod/ Severe											
	None / Mild											
Receiving O ₂ (l/min)		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
O ₂ Saturations (%)		94%	93%	98%	98%	99%	96%	98	98	99	99	98
Conscious Level	Normal											
	Altered											
GCS *		C	C									
TOTAL SCORE		1	1									
Number of shaded boxes		1	1									
Pain Score		0	0									
Observer's Initials		P	P									

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: Scores 3 should be recorded overleaf		

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)



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

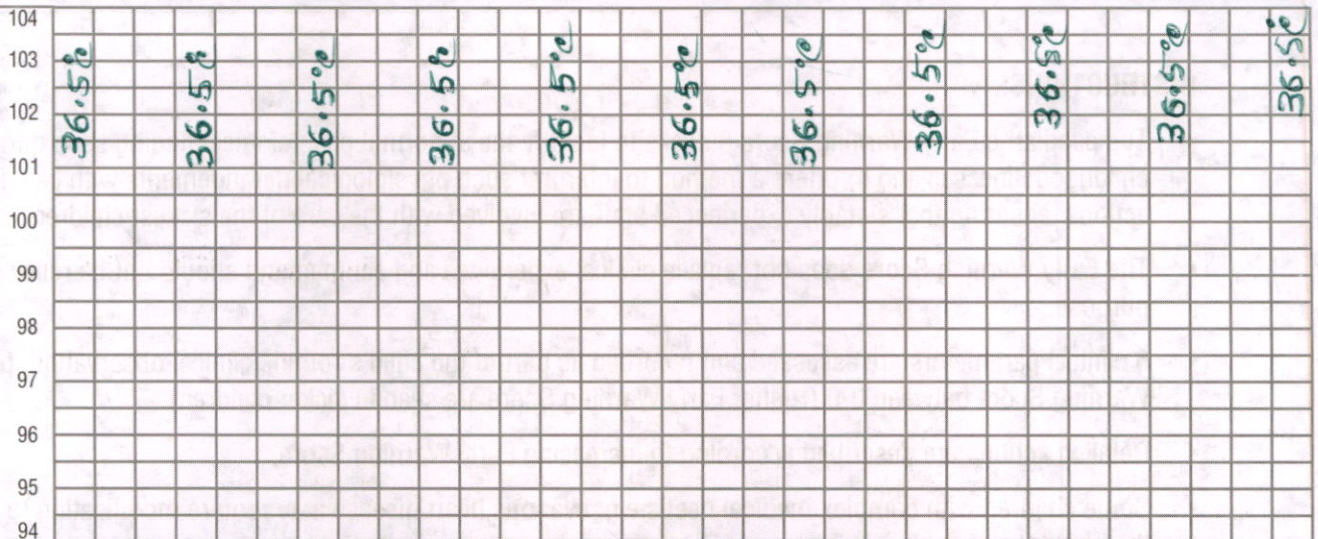
28/6 - 29/6

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 9 AM 10 AM 11 AM 12 AM 13 AM 2 AM 3 AM 4 AM 5 AM 6 AM 7 AM

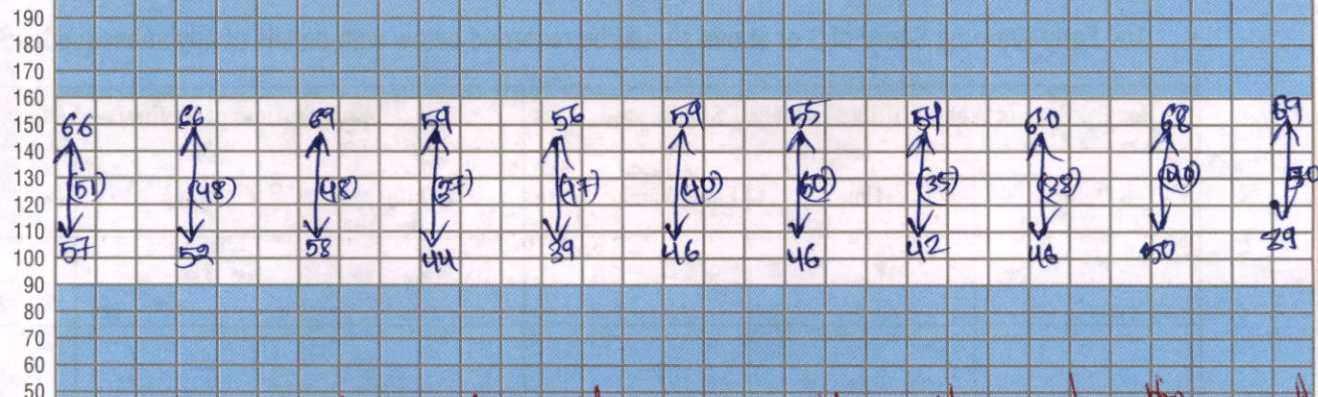
Doctor/Nurse/Family Concern?

Temperature
(F)



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

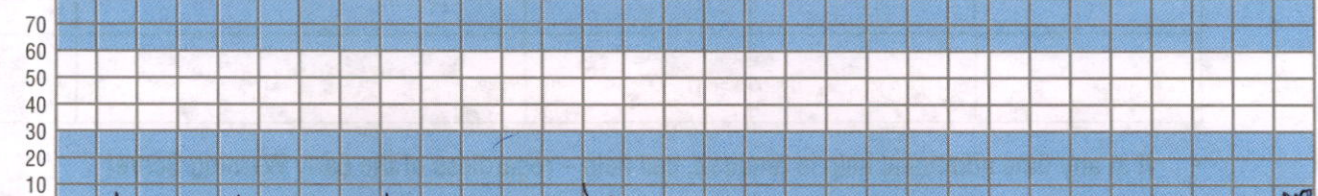
Note:
BP does not score
in early
warning scoring



Heart Rate (Number)

131 bpm 153 bpm 112 bpm 138 bpm 129 bpm 118 bpm 124 bpm 132 bpm 132 bpm 130 bpm 130 bpm

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



Resp Rate (Number)

38 bpm 40 bpm 32 bpm 36 bpm 36 bpm 44 bpm 40 bpm 46 bpm 48 bpm 50 bpm 48 bpm

Resp Mod/ Severe
Distress None / Mild

None / Mild

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

RA 98% RA 96% RA 98% RA 97% RA 95% RA 95% RA 96% RA 91% RA 94% RA 87% RA 80%

Conscious Level
Normal Altered

Normal

GCS *

15 15 15 15 15 15 15 15 15 15 15 15

TOTAL SCORE

Number of shaded boxes

1 1 1 1 1 1 1 1 1 1 1 1

Pain Score

0 0 0 0 0 0 0 0 0 0 0 0

Observer's Initials

Signature Signature Signature Signature Signature Signature Signature Signature Signature Signature Signature

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.

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)



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

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

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	8	10	12	2	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?		Am	Am	Pm	Pm	Pm	Pm	Pm	Pm	am	am	am	am
Temperature (F)		98.4	98.6	98.8	98.9	98.7	98.6	98.6	98.6	36.5°C	36.5°C	36.5°C	36.5°C
Heart Rate (bpm)		57	62	61	58	64	56	56	63	59	53	51	
Blood Pressure (mmHg) *		115/38	42/42	47/39	44/37	47/40	(110)/40	(46)/40	(48)/38	(46)/40	(69)/31	(41)/35	
Note: BP does not score in early warning scoring													
Heart Rate (Number)		133	138	137	142	149	159	136	133	140	133	135	
Resp. Rate (bpm) (Over 1 Minute) *													
Resp Rate (Number)		56	35	30	34	45	38	31	46	44	40	46	
Resp Distress	Mod/ Severe	None	None	None	None	None	None	None	None	None	None	None	
Receiving O ₂ (l/min)		0	0	0	0	0	0	0	0	0	0	0	
O ₂ Saturations (%)		93%	96%	88%	97%	97%	97%	99%	99%	97%	95%	96%	98%
Conscious Level	Normal	Altered											
GCS *		C	C	C	C	C	C	C	C	C	C	C	
TOTAL SCORE		1	1	1	1	1	1	1	1	1	1	1	
Number of shaded boxes		0	0	0	0	0	0	0	0	0	0	0	
Pain Score		P	P	P	P	P	P	P	P	P	P	P	
Observer's Initials		P	P	P	P	P	P	P	P	P	P	P	
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: Scores 3 should be recorded overleaf													

* 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)



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	8	10	12	2	4	6	8	10	12	2	4	6				
Doctor/Nurse/Family Concern?		am	am	pm	pm	pm	pm	pm	pm	pm	pm	pm	pm				
Temperature (F)	104																
	103																
	102																
	101																
	100																
	99																
	98																
	97																
	96																
	95																
	94																
Heart Rate (bpm)	190																
	180																
	170																
	160																
	150																
	140																
	130																
	120																
	110																
	100																
	90																
	80																
	70																
	60																
	50																
Blood Pressure (mmHg) *	140																
	130																
	120																
	110																
	100																
	90																
	80																
	70																
	60																
	50																
Note:																	
BP does not score in early warning scoring																	
Heart Rate (Number)		132	133	129	164	132	148	194	132	145	145	145	139				
Sp. Rate (bpm) * Vcr 1 Minute *	70																
	60																
	50																
	40																
	30																
	20																
	10																
Resp Rate (Number)		32	41	44	33	28	29	30	22	52	44	42	48				
Resp Distress	Mod/ Severe																
	None / Mild	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A	R/A				
Receiving O ₂ (l/min)																	
O ₂ Saturations (%)		95	96	95	99	98	96	99	99	100	99	93	89				
Conscious Level	Normal																
	Altered																
GCS *		C	C	C	C	C	C	C	C	C	C	C	C				
TOTAL SCORE																	
Number of shaded boxes		1	1	1	1	1	1	6	6	0	0	0	0				
Pain Score		0	0	0	0	0	0	6	6	0	0	0	0				
Observer's Initials		P	P	P	P	P	P	P	P	P	P	P	P				

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.

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)

BAH-00659928 IP5-00175616

Baby Of BHUPANI SHREEYA
20-08-2026 0 Y 0 M 10 D (M)
Dr. NALINIKANTA PANIGRAHY



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

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

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 11-7-26	Time: 8am	10am	12pm	2pm	4pm	6pm	8pm	10pm	12am	2am	4am	6am
Doctor/Nurse/Family Concern?							PR	M	AN	A	P	R
Temperature (°F)	36.6°C	36.6°C	36.6°C	36.6°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C	36.5°C
Heart Rate (bpm)	158	132	127	140	149	164	164	130	145	160	135	
Blood Pressure (mmHg) *	100/50	100/41	100/45	100/49	100/50	100/35	100/40	100/40	100/40	100/40	100/40	100/40
Resp. Rate (bpm) (Over 1 Minute) *	18	25	24	22	21	33	22	29				
Resp Distress	None	None	None	None	None	None	None	None	None	None	None	None
Receiving O ₂ (l/min)	0	0	0	0	0	0	0	0	0	0	0	0
O ₂ Saturations (%)	94%	98%	100%	99%	99%	98%	100%	96%	99%	100%	98%	100%
Conscious Level	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal
GCS *	15	15	15	15	15	15	15	15	15	15	15	15
TOTAL SCORE	0	0	0	0	0	0	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	@	@	@	@	@	@	@	@	@	@	@	@
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)

* 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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 3/7/26	Time: 8	10	12	2	4	6	8	10	12	2	4
Doctor/Nurse/Family Concern?	Am	Am	Pm	Pm	Pm	Pm	Pm	Pm	Am	Am	Am
Temperature (F)	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6
Heart Rate (bpm)	130	140	140	142	136	139	132	130	140	140	140
Blood Pressure (mmHg) *											
Resp. Rate (bpm) Over 1 Minute *											
Resp Rate (Number)	38	40	38	40	38	40	38	40	38	40	40
Resp Mod/ Severe Distress None / Mild											
Receiving O ₂ (l/min)											
O ₂ Saturations (%)	98	98	98	98	98	98	98	98	98	98	98
Conscious Level Normal Altered	C	C	C	C	C	C	C	C	C	C	C
GCS *	1	1	1	1	1	1	1	1	1	1	1
TOTAL SCORE	0	0	0	0	0	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	YJ	YJ	YJ	YJ	YJ	YJ	YJ	YJ	YJ	YJ	YJ

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.

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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:		Time:	
Doctor/Nurse/Family Concern?		6 AM	10 AM
Temperature (F)	104		
	103		
	102		
	101		
	100		
	99	98.2 F	
	98		97.7 F
	97		
	96		
	95		
94			
Heart Rate (bpm)	190		
	180		
	170		
	160		
	150		
	140		
	130	125 bpm	139 bpm
	120		
	110		
	100		
and Blood Pressure (mmHg) *	150		
	140		
	130		
	120		
	110		
	100		
	90		
	80		
	70		
	60		
Note: BP does not score in early warning scoring	50		
Rate (Number)		125 bpm	139 bpm
Resp. Rate (bpm) (Over 1 Minute) *	70		
	60		
	50		
	40	40 bpm	20 bpm
	30		
	20		
	10		
Resp Rate (Number)		40 bpm	20 bpm
Resp Distress	Mod/ Severe		
	None / Mild	N	N
Receiving O ₂ (l/min)			
O ₂ Saturations (%)		100%	98%
Conscious Level	Normal	N	N
	Altered		
GCS *		15/15	15/15
TOTAL SCORE			
Number of shaded boxes		0	0
Pain Score		0	0
Observer's Initials		ph	ph

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.

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)

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:

Doctor/Nurse/Family Concern?

Temperature
 (°F)

104
 103
 102
 101
 100
 99
 98
 97
 96
 95
 94

Heart Rate
 (bpm)

190
 180
 170
 160

and

Blood Pressure
 (mmHg) *

150
 140
 130
 120
 110
 100

Note:

BP does not score
 in early
 warning scoring

90
 80
 70
 60
 50

Rate (Number)

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

70
 60
 50
 40
 30
 20
 10

Resp Rate (Number)

Resp Distress Mod/ Severe
 None / Mild

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

Conscious Level Normal
 Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
 recorded overleaf

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

Score 5 & 6 : Shift in charge 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)

Medication - 10 ml

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. : 1

to :- 140cc/kg
 Bwt :- 25kg

To F :- 29 ml

- 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 Thrombophlebitis 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			14.1 ml						25 ml	0	
	11:00 pm			14.1 ml							0	
	12:00 am			14.1 ml							0	
	01:00 am			14.1 ml						10 ml	0	
Total Intake :						Total Output :						
	02:00 am			13 ml							0	
	03:00 am			13 ml						23 ml	0	
	04:00 am			11 ml							0	
	05:00 am			11 ml							0	
	06:00 am			11 ml							0	
	07:00 am			11 ml						18 ml	0	
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						



FLUID CHART

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. : 2

Medication 100
 TV - 140 cc/kg/day
 Bwt - 2.5
 TF - 29ml

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 Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	NG	Diarrhoea	Vomit	Drainage	Urine			
				104.5ml	0.6							
	08:00 am			14.1ml								
	09:00 am	NPO	NPO	14.1ml		Not passed			13ml			
	10:00 am			14.1ml								
	11:00 am	NPO	NPO	14.1ml								
	12:00 pm			14.1ml								
	01:00 pm	DBM		12.5ml	5ml	Nil	Paused		18ml			
Total Intake :					Total Output :							
	02:00 pm			12.5ml								
	03:00 pm			12.5ml								
	04:00 pm	DBM		12.5ml	5ml	3ml	Paused		20ml			
	05:00 pm			12.5ml								
	06:00 pm			12.5ml								
	07:00 pm	DBM		12.5ml	5ml	Nil	Not fed		10ml			
Total Intake :					Total Output :							
	08:00 pm			12.5ml								
	09:00 pm			12.5ml		light yellow						
	10:00 pm	DBM		12.5ml	5ml	4ml	Paused		21ml			
	11:00 pm			12.5ml								
	12:00 am			12.5ml								
	01:00 am	DBM		12.5ml	5ml	Nil	Paused		10ml			
Total Intake :					Total Output :							
	02:00 am			12.5ml								
	03:00 am			12.5ml		Milky						
	04:00 am	DBM		12.5ml	5ml	2ml	Paused		19ml			
	05:00 am			12.5ml								
	06:00 am			12.5ml								
	07:00 am	DBM		12.5ml	5ml							
Total Intake :					Total Output :							
Total Intake : 342.5ml					Total Output : 111ml							

Total 24 hrs. Intake

137cc/kg/day

Total 24 hrs. Output

1.85cc/kg

BAH-00659928 IP5-00175616
 Baby Of BHUPANI SHREEYA
 20-08-2026 0 Y 0 M 6 D (M)
 Dr. NALINIKANTA PANIGRAHY

27/6/2026
 ③

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. : ③

of calculation 10ml
 TR:- 150cc/kg/day
 B.Wt:- 2.5 kg
 47ml
 TR:- 47ml (80H)

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					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	OG						
	08:00 am			12.5ml					18ml	0	}
	09:00 am	DBM		12.5ml						0	
	10:00 am	DBM		12.5ml	5ml	Nil	Passed			0	
	11:00 am			12.5ml						0	
	12:00 pm			12.5ml						0	
	01:00 pm	DBM	0.1ml	12.5ml	18ml		not passed		13ml	0	}
Total Intake :		150cc/kg/day			Total Output :						
	02:00 pm		0.1ml	12.4ml						0	}
	03:00 pm		0.1ml	12.4ml	milky	Not passed			16ml	0	
	04:00 pm	EBM	0.1ml	12.4ml	8ml	2ml				0	
	05:00 pm	BS	0.1ml	10.7ml						0	
	06:00 pm		0.1ml	10.7ml						0	
	07:00 pm	EBM	0.1ml	10.7ml	8ml	Nil	Passed		15ml	0	}
Total Intake :					Total Output :						
	08:00 pm		0.1ml	10.2ml						1	}
	09:00 pm		0.1ml	11.2ml	3ml	light green			10ml	1	
	10:00 pm	EBM	0.1ml	11.2ml	8ml		not passed			0	
	11:00 pm		0.1ml	11.2ml						1	
	12:00 am		0.1ml	10.2ml					25ml	1	
	01:00 am	EBM	0.1ml	9.7ml	11ml	2ml	Milk			1	}
Total Intake :					Total Output :						
	02:00 am		0.1ml	9.7ml						1	}
	03:00 am		0.1ml	9.7ml					6ml	1	
	04:00 am	EBM	0.1ml	9.2ml	11ml	2ml	Milk	passed		0	
	05:00 am		0.1ml	9.7ml					10ml	1	
	06:00 am		0.1ml	9.7ml						1	
	07:00 am	EBM	0.1ml	9.7ml	11ml				8ml	1	}
Total Intake :		269.7ml			Total Output :					122ml	
Total 24 hrs. Intake		107cc/kg/day			Total 24 hrs. Output					21cc/kg/day	



FLUID CHART

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. : 4

TF - 150cc/kg/day
8 wt 2.5kg

TF - 47ml

Medication - 10

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.

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route	NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth ^{3mg/kg Adrenaline} IV ^{10.4ml} IG								
	08:00 am		0.1ml 10.4ml								
	09:00 am		0.1ml 10.4ml					16ml			
	10:00 am	EBM	0.1ml 10.4ml 11ml Nil Not passed								
	11:00 am		0.1ml 10.4ml								
	12:00 pm		0.1ml 10.4ml								
	01:00 pm	EBM	0.1ml 10.4ml 11.4ml Not passed					18ml			
Total Intake :				Total Output :							
	02:00 pm		0.1ml 10.4ml								
	03:00 pm		0.1ml 10.4ml								
	04:00 pm	EBM	0.1ml 10.4ml 14ml Passed					20ml			
	05:00 pm		0.1ml 10.4ml								
	06:00 pm		0.1ml 10.4ml								
	07:00 pm	EBM	0.1ml 9.4ml 17ml Not passed					17ml			
Total Intake :				Total Output :							
	08:00 pm		6.2ml								
	09:00 pm		6.2ml								
	10:00 pm	EBM	6.2ml 17ml Passed					15ml			
	11:00 pm		6.2ml								
	12:00 am		6.2ml								
	01:00 am	EBM	4.7ml 20ml N-passed					18ml			
Total Intake :				Total Output :							
	02:00 am		4.7ml								
	03:00 am		4.7ml								
	04:00 am	EBM	4.7ml 20ml Small					15ml			
	05:00 am		4.7ml								
	06:00 am		4.7ml								
	07:00 am	EBM	7.9 23ml					12ml			
Total Intake : 365.559ml				Total Output : 131ml							

Total 24 hrs. Intake

146cc/kg/day

Total 24 hrs. Output

2.1ml/kg=

29/06/26

FLUID CHART

Sheet No. : 5

TV - 1500cc/kg/day
 3wt - 2.5kg
 TP = 47ml
 Medication 29

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

		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		6.9ml								
	09:00 am		6.9ml								
	10:00 am	DBM	6.9ml	23ml	Passed			20ml			
	11:00 am		6.9ml								
	12:00 pm		6.9ml								
	01:00 pm	EBM	5.9ml	26ml	Passed			21ml			
Total Intake :					Total Output :						
	02:00 pm		5.9ml								
	03:00 pm		5.9ml								
	04:00 pm	EBM	5.9ml	26ml	Passed			23ml			
	05:00 pm		5.9ml								
	06:00 pm		5.9ml								
	07:00 pm	EBM	4.9ml	29ml	Passed			29ml			
Total Intake :					Total Output :						
	08:00 pm		4.9ml								
	09:00 pm		4.9ml								
	10:00 pm	EBM	4.9ml	29ml	passed			16ml			
	11:00 pm		4.9ml								
	12:00 am		4.9ml								
	01:00 am	EBM	3.9ml	32ml	passed			10ml			
Total Intake :					Total Output :						
	02:00 am		3.9ml								
	03:00 am		3.9ml								
	04:00 am	DBM	3.9ml	32ml	Passed			12ml			
	05:00 am		3.9ml								
	06:00 am		3.9ml								
	07:00 am	EBM	2.9ml	35ml	passed			16ml			
Total Intake : 357.6ml					Total Output : 147ml						

Total 24 hrs. Intake

143cc/kg/day

Total 24 hrs. Output

2.4cc/kg/day



FLUID CHART

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

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.

TV - 1500cc/day
 Bwt - 2.5
 TP - 47
 Medication - 24hr

Date		Time	Nature of Fluid	Route	Intake	NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
30/6/26				Mouth	I.V	NG						
	08:00 am				2.9ml							
	09:00 am				2.9ml							
	10:00 am	EBM			2.9ml	35ml	Passed			30ml		P.
	11:00 am				2.9ml							
	12:00 pm				2.9							
	01:00 pm	EBM			38ml	1.9ml	Passed			32ml		P
Total Intake :						Total Output : 62ml						
	02:00 pm				1.9ml							
	03:00 pm				1.9ml							
	04:00 pm	EBM			41ml	0.9ml	Passed			32ml		P
	05:00 pm				0.9ml							
	06:00 pm				0.9ml							
	07:00 pm	EBM			44ml	Stop	Pause			29ml		
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm									15ml		
	10:00 pm	EBM			47ml		Passed					
	11:00 pm											
	12:00 am									12ml		
	01:00 am	EBM			49ml							
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am	EBM			49ml					11ml		
	05:00 am											
	06:00 am											
	07:00 am	EBM			47ml					10ml		
Total Intake : 338.9						Total Output : 72						
Total 24 hrs. Intake			1400ml/kg/day			Total 24 hrs. Output			2.8 ccl/kg/day			

FLUID CHART

Sheet No. : 2

Td - 150cc/kg/day
 B.Wt - 2.5 kg -
 TF - 47ml

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					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										}	@m			
	09:00 am	EBM	47ml				passed	-	-	20ml					
	10:00 am	EBM	47ml												
	11:00 am	EBM	47ml				passed	-	-	19ml					
	12:00 pm														
	01:00 pm	EBM	47ml				-	-	-	20ml					
Total Intake : 94ml						Total Output : 59ml									
	02:00 pm										}	A			
	03:00 pm														
	04:00 pm	EBM	47ml				Passed			20ml					
	05:00 pm														
	06:00 pm	EBM	47ml												
	07:00 pm	EBM	47ml				Passed			18ml					
Total Intake :						Total Output : 38ml									
	08:00 pm										}	A			
	09:00 pm	EBM	47ml				passed			19ml					
	10:00 pm						-								
	11:00 pm						-								
	12:00 am	EBM	47ml				passed			10ml					
	01:00 am														
Total Intake :						Total Output : 29ml									
	02:00 am										}	A			
	03:00 am	EBM	47ml				Passed			15ml					
	04:00 am														
	05:00 am						-								
	06:00 am	EBM	47ml				-			10ml					
	07:00 am														
Total Intake : 376 ml						Total Output : 151 ml									
Intake		150 cc / kg / day										Total 24 hrs. Output		42.5 cc / kg / day	



FLUID CHART

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. : 3

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			
	08:00 am			1	1								
	09:00 am	EBM	47ml	0	0		passed	-	-	10ml	0		
	10:00 am			1	1								
	11:00 am												
	12:00 pm	EBM	47ml	-	-					15ml			
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm	EBM	47ml	-	-		passed	-	-	10ml	0		
	04:00 pm												
	05:00 pm												
	06:00 pm	EBM	47ml							17ml			
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm	EBM	47ml							10ml			
	10:00 pm												
	11:00 pm												
	12:00 am	EBM	47ml							15ml			
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am	EBM	47ml				passed			15ml			
	04:00 am												
	05:00 am												
	06:00 am	EBM	47ml							16ml			
	07:00 am												
Total Intake : 376ml						Total Output : 124ml							
Total 24 hrs. Intake			3500cc/kg/day										
Total 24 hrs. Output			12.5cc/kg/day										

3/7/26

FLUID CHART

Sheet No. : (4)

TV = 150cc/kg/day
Baby wt : 2.5 Kg
TF : 47 ml

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

		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												
	09:00 am	EBM	47ml				-			10ml			
	10:00 am												
	11:00 am	DBF	-				PAUSE			8ml			
	12:00 pm												
	01:00 pm	DBF					-			16ml			
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm	DBF					PAUSED			8ml			
	04:00 pm	DBF											
	05:00 pm	DBF-EBM	47ml				-			PAUSE			
	06:00 pm												
	07:00 pm						✓			✓			
Total Intake :						Total Output : M = 2 U = 2							
	08:00 pm	EBM	47ml							✓			
	09:00 pm												
	10:00 pm	EBM	47ml										
	11:00 pm												
	12:00 am												
	01:00 am						✓			✓			
Total Intake :						Total Output : U = 2 M = 1							
	02:00 am	EBM	47ml										
	03:00 am												
	04:00 am												
	05:00 am	EBM	47ml										
	06:00 am												
	07:00 am						✓			✓			
Total Intake :						Total Output : U = 1 M = 1							

Total 24 hrs. Intake	
----------------------	--

Total 24 hrs. Output	U = 8 M = 5
----------------------	-------------

FLUID CHART

Sheet No. :

4/7/26

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.

		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							
4/7/26	08:00 am										0	J. S. [Signature]
	09:00 am	DBF									2	
	10:00 am										2	
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :						Total Output :					
4/7/26	02:00 pm											[Signature]
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
4/7/26	08:00 pm											[Signature]
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
4/7/26	02:00 am											[Signature]
	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

①

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 25/6/26

Assessment: Baby is on Low Flow / tachycardia.

Goals

- ☐ Maintain Airway and Oxygenation ☐ Relieve Pain & Discomfort ☐ Maintain Fluid Balance ☐ Improve Activity Tolerance ☐ Maintain Good Nutritional Status ☐ Maintain Skin Integrity
☒ Maintain Personal Hygiene ☒ Prevent Infection ☒ Meet Elimination Needs ☒ Ensure Safety ☒ Early Ambulation Reduce Anxiety ☒ Patient & Family Education
☐ Identify Potential Complications ☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
10:00	Assess baby general condition	10:10	Assessed baby's general condition	Baby is on L/R (0.5ml)
11:00	Monitor vitals & record	11:15	Monitored vitals & recorded	
12:00	Maintain Ilo chest	12:20	Maintained Ilo chest	
1:00	Provide Comfortable position	1:15	Provided Comfortable position	
2:00	Keep Plan for NPO	2:20	Baby is on NPO	
6:00	check weight	6:30	Weight checking done	
8:00	Ensure safety	8:00	Ensured Safety	

Re-Assessment: Re-assessment done.

Special Notes: RBS 8th hourly.

Nurse Signature: 

Nurse Name: Rashmi Thakur

Date & Time: 26/6/26 08 am

BAH-00659928

IP5-00175616

Baby Of BHUPANI SHREEYA

20-08-2026

0 Y 0 M 5 D

(M)

Dr. NALINIKANTA PANIGRAHY



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 26/6/26

Assessment: Brady, dehydration, Apnea, Oxygen Support

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
8am	To maintain I/O chart	8am	Maintained I/O chart	Baby is stable
10am	To monitor vital signs	10am	Monitored vital signs	
12pm	Give feed every 3rd hly	12pm	Given feed every 3rd hly	
2pm	ET & Oral suction	2pm	ET & Oral suction done	
4pm	Plan to send CUE & Urine q/s	4pm	CUE & Urine q/s	
6pm	Administer medication as per doctor order	6pm	Administered medication as per doctor order	

Re-Assessment:

Special Notes: Gases Bth Gas SO2

Nurse Signature: [Signature] Nurse Name: Dipti Date & Time: 26/6/26 2pm

3

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 26/6/2026

Assessment:

- Goals:
- ☒ Maintain Airway and Oxygenation
 - ☒ Relieve Pain & Discomfort
 - ☒ Maintain Fluid Balance
 - ☒ Improve Activity Tolerance
 - ☒ Maintain Good Nutritional Status
 - ☒ Maintain Skin Integrity
 - ☒ Maintain Personal Hygiene
 - ☒ Prevent Infection
 - ☒ Meet Elimination Needs
 - ☒ Ensure Safety
 - ☒ Early Ambulation Reduce Anxiety
 - ☒ Patient & Family Education
 - ☐ Identify Potential Complications
 - ☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
8pm	plan to monitor vitals and 2 to club 6 QH	8pm	Monitored vitals and 2 to club 6 QH	feeds, stable
10pm	Administer Meclizine as per doctor order	10pm	Administer Meclizine as per doctor order	stable on R/A
12Am	feed 20ml	12Am	feed 20ml	
2Am	provide cluster care	2Am	provided cluster care	
4Am	provide comfort position	4Am	provided comfort position	
6Am	plan to aspirate NG	6Am	Aspirated NG per 6 QH	

Re-Assessment:

h/t Hypertension, Dehydration, Hypohydrate (st) Intake out

Special Notes:

RM-TO, 20

Nurse Signature:

Nurse Name: Dandana

Date & Time: 27/6/2 8Am

BAH-00659928 IP5-00175616
 Baby Of BHUPANI SHREEYA
 20-06-2026 0 Y 0 M 6 D (M)
 Dr. NALINIKANTA PANIGRAHY



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 27/6/26

Assessment: Brady desaturation 4ma feeding R/A

Goals

- ☒ Maintain Airway and Oxygenation
☒ Relieve Pain & Discomfort
☒ Maintain Fluid Balance
☒ Improve Activity Tolerance
☒ Maintain Good Nutritional Status
☒ Maintain Skin Integrity
☒ Maintain Personal Hygiene
☒ Prevent Infection
☒ Meet Elimination Needs
☒ Ensure Safety
☒ Early Ambulation Reduce Anxiety
☒ Patient & Family Education
☒ Identify Potential Complications
☒ Any Others. Specify

Time	Plan of Care	Time	Implementation	Evaluation
8am	TV - 140 cc/kg/day Increase 150 cc/kg/day	8am	TV - 140 cc/kg/day Increased 150 cc/kg/day	
10am	Maintain I/O chart	10am	Maintained I/O chart	
12pm	Monitor vital signs	12pm	Monitored vital signs	
2pm	Continue feed every 3rd hly + 3rd BD	2pm	Continue feeding 3rd hly + 3rd BD	
4pm	Plan to give SDP	4pm	Continue SDP	
6pm	Administer medication as per doctor order	6pm	Administered medication as per doctor order	Baby is stable

Re-Assessment:

Special Notes: GPRS stg Baby had hypotension / start Adrenaline 3mg/kg

CBP, CRP, S.E T/m 2D echo done

Nurse Signature: [Signature]

Nurse Name: Diphi

Date & Time: 27/6/26 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 27/6/28

Assessment: Baby is on R/A 8PM

- Goals
- ☒ Maintain Airway and Oxygenation
 - ☒ Relieve Pain & Discomfort
 - ☒ Maintain Fluid Balance
 - ☒ Improve Activity Tolerance
 - ☐ Maintain Good Nutritional Status
 - ☐ Maintain Skin Integrity
 - ☐ Maintain Personal Hygiene
 - ☒ Prevent Infection
 - ☒ Meet Elimination Needs
 - ☐ Ensure Safety
 - ☐ Early Ambulation Reduce Anxiety
 - ☐ Patient & Family Education
 - ☐ Identify Potential Complications
 - ☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
8PM	Assess the Baby condition	8PM	Assessed the Baby condition	New Baby
10PM	monitor vitals and recorded	10PM	monitored vitals and recorded	is stable
12AM	Administer medication as per order	12AM	Administered medication as per order	
2AM	monitor SpO2 chart	2AM	monitored SpO2 chart	
4AM	To give end key feed	4AM	To given end key feed	
6AM	provide comfortable position	6AM	provided comfortable position	

Re-Assessment: Done

Special Notes: Vitals stable

Nurse Signature: [Signature] Nurse Name: Shweta Date & Time: 28/6/28 @ 8AM

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 28/6/22

Assessment: Brady desaturation Apnea feeding Oxygen support

Goals

- ☒ Maintain Airway and Oxygenation ☒ Relieve Pain & Discomfort ☒ Maintain Fluid Balance ☒ Improve Activity Tolerance ☐ Maintain Good Nutritional Status ☐ Maintain Skin Integrity
☒ Maintain Personal Hygiene ☒ Prevent Infection ☒ Meet Elimination Needs ☒ Ensure Safety ☐ Early Ambulation Reduce Anxiety ☐ Patient & Family Education
☒ Identify Potential Complications ☐ Any Others. Specify

Time	Plan of Care	Time	Implementation	Evaluation
8am	To maintain I/o chart	8am	Maintained I/o chart	Baby is stable
10am	To monitor vital signs	10am	Monitored vital signs	
12pm	Given feed every 2nd hly	12pm	Given feed every 2nd hly	
2pm	Given comfortable position	2pm	Given comfortable position	
4pm	Plan to increase feed 3rd 6hly	4pm	Increased feed 3rd 6hly	
6pm	Administer medication as per doctor order	6pm	Administered medication as per doctor order	

Re-Assessment:

Special Notes: GRABs 8th Gm SOS T/m CBP, CRP, Dengue

Nurse Signature: [Signature]

Nurse Name: Dipk

Date & Time: 28/6/22 08pm

2

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 28/6 - 29/06

Assessment:

Baby is suspected sepsis

- Goals
- ☒ Maintain Airway and Oxygenation
 - ☒ Relieve Pain & Discomfort
 - ☒ Maintain Fluid Balance
 - ☒ Improve Activity Tolerance
 - ☒ Maintain Good Nutritional Status
 - ☒ Maintain Skin Integrity
 - ☒ Maintain Personal Hygiene
 - ☒ Prevent Infection
 - ☐ Meet Elimination Needs
 - ☒ Ensure Safety
 - ☐ Early Ambulation Reduce Anxiety
 - ☒ Patient & Family Education
 - ☒ Identify Potential Complications
 - ☐ Any Others. Specify

Time	Plan of Care	Time	Implementation	Evaluation
8Am	Assess the General condition	8Am	Assess the General	Baby is well now
10Am	of the baby.	10Am	condition of the baby	
12Am	Maintain vital signs of	12Am	Maintained vital signs	
2Am	the baby		of the baby	
4Am	Maintain I/O chart	4Am	Maintain I/O chart	
6Am	All medication administered	6Am	All medication ad-	
7Am	Maintain personal hygiene	7Am	ministrated	
			Maintained personal hygiene	

Re-Assessment:

Baby is suspected sepsis

Special Notes:

Nurse Signature: 

Nurse Name: Dipa

Date & Time: 28/06/26

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 29/6/26

Assessment: Baby on Room air / Fed intolerance / Sepsis

Goals

- ☒ Maintain Airway and Oxygenation
- ☒ Relieve Pain & Discomfort
- ☒ Maintain Fluid Balance
- ☒ Improve Activity Tolerance
- ☒ Maintain Good Nutritional Status
- ☒ Maintain Skin Integrity
- ☒ Maintain Personal Hygiene
- ☒ Prevent Infection
- ☒ Meet Elimination Needs
- ☒ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☒ Patient & Family Education
- ☒ Identify Potential Complications
- ☐ Any Others. Specify

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	Assess the baby condition	9 AM	Assessed the baby condition	Now baby is maintaining Saturation in Room air
10 AM	Monitor vitals	11 AM	Monitored vitals	
12 PM	Maintain I/O chart	1 PM	Maintained I/O chart	
2 PM	To give medication	3 PM	Medication given as per doctors order	
4 PM	To give Fed	5 PM	Feed given 3rd hourly	
6 PM	RBS	7 PM	RBS done	

Re-Assessment: Reassessment done

Special Notes: RBS BD

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 29/6/26 08 PM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 29/6/26

Assessment: Baby is on R/L

Goals

- | | | | | | |
|---|---|--|---|--|--|
| ☒ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☐ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ To Assess the Baby's general Condition	8pm	→ Assessed the Baby's general Condition	Baby is stable & Maintaining
10pm	→ To Maintain Airway & Oxygenation	10pm	→ Maintained Airway & Oxygenation	
12am	→ To Maintain Personal Hygiene	12am	→ Maintained Personal Hygiene	
2am	→ To Maintain Fluid Balance	2am	→ Maintained Fluid Balance	
4am	→ To Maintain Good Nutrition	4am	→ Maintained Good Nutritional Balance	
6pm	→ To Administer the medications as per the chart	6pm	→ Administered the medication as per the chart	

Re-Assessment: Done

Special Notes: RBS - O.D.

Nurse Signature: K. Berry

Nurse Name: K. Berry

Date & Time: 30/6/26 @ 8pm



NURSING CARE RECORD

10

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 30/6/26

Assessment: Baby is an R/A

- | | | | | | | |
|-------|--|---|--|---|--|--|
| Goals | ☐ Maintain Airway and Oxygenation | ☒ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☒ Maintain Skin Integrity |
| | ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| | ☒ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
@ 8am	Assess the patient condition	@ 8am	Assess the patient condition	Now baby is stable on R/A
@ 12pm	Monitoring the vital sings	@ 12pm	Monitoring the vital sings	
@ 2pm	Provide comfortable posi-tion	@ 2pm	Provide comfortable position	
@ 6pm	Given feeding every 3 hours	@ 6pm	Given feeding every 3 hours	
@ 8pm	Administered medication as per doctor order	@ 8pm	Administered medication as per doctor order.	

Re-Assessment: Done

Special Notes: Palada feed 30cc 3 spoon pad given today baby taken well

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 30/6/26 @ 8 am

W

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 11/7/2026

Assessment: Baby on R/LA

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
8am →	Assess the general condition of the baby.	9am →	Assessed the general condition of the baby.	Baby on R/LA and maintaining.
10am →	Plan to do I/P and monitor the vitals.	11am →	I/P done and test send.	
12pm →	Maintain the I/O chart and provide feeding and urly.	1pm →	Maintained the I/O chart and provided feed and urly.	
1pm →	Administer medication as per the drug chart.	2pm →	Administered medication as per the drug chart.	

Re-Assessment: Re - Assessment Done

Special Notes:

Nurse Signature:

Abhis

Nurse Name:

Abhisamr

Date & Time:

11/7/26



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 1/7/26

Assessment:

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
2pm	Assess the patient Condition	2pm	pt. Conditions are assessed.	Now pt is good.
4pm	Provide comfortable position of the patient.	4pm	comfortable positions provided.	
6pm	Given 3 rd hourly feeding Monitor vitals.	6pm	3 rd hourly feeding given vitals Monitored.	
8pm	Maintain I/O chart.	8pm	I/O chart Maintained	

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name: Akansha

Date & Time: 1/7/26 @ 8pm



13

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 1/7/26

Assessment: Baby on R/A

Goals

- | | | | | | |
|--|---|--|--|--|--|
| ☒ Maintain Airway and Oxygenation | ☒ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☒ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☒ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☒ Meet Elimination Needs | ☒ Ensure Safety | ☒ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☒ Identify Potential Complications | ☒ Any Others. Specify | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8:pm	→ Assess the General condition of baby	8:30pm	→ Assessed General condition of baby.	Baby is stable
10:pm	→ monitor vitals & Record	10:30pm	→ Monitored vitals & recorded.	
12:pm	→ maintain I/o chart	12:10pm	→ Maintained I/o chart	
2:pm	→ Provide comfortable position	2:30pm	→ Provided comfortable position.	
4:Am	→ Ensure safety	4:30pm	→ Ensured safety.	
6:Am	→ check weight	6:Am	→ Checked weight done	

Re-Assessment: Re Assessment done.

Special Notes: RBS and Done.

Nurse Signature:

Nurse Name: Madhama

Date & Time: 1/7/26

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 2/7/26

Assessment: Baby is on R/A

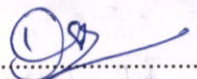
Goals

- | | | | | | |
|---|---|--|--|---|--|
| ☒ Maintain Airway and Oxygenation | ☒ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☒ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	Assess the baby general condition.	8 AM	Assess the baby general condition.	Baby is Stable
10 AM	monitors vitals.	10 AM	monitored vitals.	
12 pm	To give the feeding 2 nd hly	12 pm	To give the feeding 2 nd hly.	
2 pm	antibiotics stop	2 pm	antibiotics stop.	
4 pm	provide comfortable position.	4 pm	Provide comfortable position.	
6 pm	plan to direct Breastfeed	6 pm	given direct Breastfeed.	

Re-Assessment: Re-Assessment Done.

Special Notes:

Nurse Signature: 

Nurse Name: Dandank

Date & Time: 2/7/26 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/7/26

Assessment: ashy as om R/A

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
8pm	Assess the baby condition	8pm	Assessed the baby condition	Baby is stable
10pm	monitor vitals	10pm	monitored vitals	
12pm	maintain I/O Chart	12pm	maintained I/O Chart	
2pm	give 3rd med early	2pm	give 3rd med early	
4pm	provided comfortable position	4pm	provided comfortable position	
6pm	give medication	6pm	give medication	

Re-Assessment: Done

Special Notes: RBS OP

Nurse Signature: [Signature]

Nurse Name: Depa Sr

Date & Time: 2/7/26 8pm



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment:

Baby is on RA

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

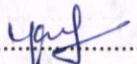
Time	Plan of Care	Time	Implementation	Evaluation
8Am	* Assess the General Condition of the baby	8Am	* Assessed the General Condition of the baby	Baby is now stable
12Am	* monitor vital signs	10Am	* monitored vital signs	
12pm	* provide Comfortable position to the baby	12pm	* provided Comfortable position to the baby	
1pm	* Given feeding as hourly	1pm	* Given feeding as hourly	
	* monitor S/O chart		* monitored S/O chart	
8:00pm	* Ensured safety	8:00pm	* Ensured safety	

Re-Assessment:

Done

Special Notes:

RBS - OD

Nurse Signature: 

Nurse Name: Yamuna

Date & Time: 3/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26 @ 8 PM

Assessment: Baby under observation

Goals

- ☐ Maintain Airway and Oxygenation ☐ Relieve Pain & Discomfort ☐ Maintain Fluid Balance ☒ Improve Activity Tolerance ☐ Maintain Good Nutritional Status ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene ☒ Prevent Infection ☒ Meet Elimination Needs ☐ Ensure Safety ☒ Early Ambulation Reduce Anxiety ☒ Patient & Family Education
- ☐ Identify Potential Complications ☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	→ assess the general condition of the baby and check vital.	8:00 AM	→ assessed the general condition of the baby and checked vital.	Baby is stable
10 AM	→ Giving feeding and hourly D&F and 63ml urine	10:00 AM	→ Given feeding and hourly D&F and 63ml urine.	
12 AM	→ checking urine output.	12:00 AM	→ checked urine output.	
4 AM	→ Giving warm care.	4:00 AM	→ Given warm care.	
6 AM	→ checking urine output.	6:00 AM	→ checked urine output.	
8 AM	→ Ensure safety.	8:00 AM	→ Ensured safety.	

Re-Assessment:

Special Notes: NA

Nurse Signature: Rina

Nurse Name: Rina

Date & Time: 4/7/26 @ 8 AM

BAH-00659928 IP5-00175616
Baby Of BHUPANI SHREEYA
20-06-2026 0 Y 0 M 13 D (M)
Dr. NALINIKANTA PANIGRAHY



NURSING CARE RECORD


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


BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

- | | | | | | |
|---|--|---|---|---|---|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☐ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

BAH-00659928 IP5-00175616
Baby Of BHUPANI SHREEYA
20-06-2026 0 Y 0 M 14 D (M)
Dr. NALINIKANTA PANIGRAHY



SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. NIK Department: 3rd Floor Date of Admission: 25/6/26

SITUATION	Diagnosis: <u>suspected sepsis</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known			
			If Yes Specify:			
BACKGROUND	Area	<u>3rd Floor</u>				
	Shift Time	<u>4:30 PM - 8:30 PM</u>	<u>8:30 AM - 12:30 PM</u>			
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>98.04°</u>	<u>98.26</u>			
	Res:	<u>38b/m</u>	<u>40b/m</u>			
	SpO ₂ :	<u>99.1</u>	<u>100.1</u>			
	Pulse:	<u>140b/m</u>	<u>135b/m</u>			
	BP:	<u>-</u>	<u>-</u>			
	Fall Risk Score:	<u>0/10</u>	<u>0/10</u>			
Recommendations	Pain Score:	<u>0</u>	<u>-</u>			
	Safety Needs:	<u>CRIB</u>	<u>CRIB</u>			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>NA</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	<u>NA</u>	<u>CRIBS</u> <u>OD</u>			
	Post Operative Procedure Special Orders:	<u>NA</u>	<u>NA</u>			
	Handed Over By Name :	<u>Paula</u>	<u>Pijs</u>			
	Signature :	<u>Paula</u>	<u>Pijs</u>			
	Date:	<u>27</u>	<u>27/6/26</u>			
	Time:	<u>8 PM</u>	<u>8 AM</u>			
	Taken Over By Name :	<u>Pijs</u>	<u>Daltg</u>			
	Signature :	<u>Pijs</u>	<u>Daltg</u>			
	Date:	<u>27/6/26</u>	<u>27</u>			
	Time:	<u>8 AM</u>	<u>8 AM</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area							
	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
		Fall Risk Score:						
	Pain Score:							
	Recommendations	Safety Needs:						
Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Others Specify:								
Special Diet:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Other Special Orders / Medications:								
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								



BRADEN 'Q' SCALE

					Date :	25/6/26	26/6/26	26/6/26	27/6/26
					Time :	8pm-8am	2pm	9pm	2pm
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.	3	2	2	2	
"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.	2	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.	2	2	2	2	
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.	2	2	2	2	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	3	3	3	
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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	2	3	3	3	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	2	4	4	4	
TOTAL SCORE					13	17	17	17	
Evaluator's Name					key	0	085	0	

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

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



BRADEN 'Q' SCALE

					Date :	28/6/26	28/6/26	29/6/26	29/6/26
					Time :	2 PM	2 PM	8 AM	2 PM
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.	2	2	2	2	
"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.	2	2	2	2	
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.	2	2	2	2	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	3	3	3	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	3	3	3	3	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
TOTAL SCORE					15	15	19	19	
Evaluator's Name					[Signature]				

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

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

BRADEN 'Q' SCALE

					Date :	30/6	17	17	2/8
					Time :	10 ^u	2pm	8pm	8a
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 e:remity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		2	2	2	2
"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.		2	2	2	2
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.		2	2	2	2
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		2	2	2	2
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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.		2	2	2	2
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
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	15	15	15	15
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	KE	@m	AT	15

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

BRADEN 'Q' SCALE

					Date :	Time :			
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 e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2/7	8m	2		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.			1		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.			2		
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.			2		
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."			3		
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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.			4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.			4		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23									
Docu. No. : RCHBH /FRM / CLINICAL / 119									
					TOTAL SCORE		18		
					Evaluator's Name		Piya		

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

BAH-00659028 IP5-00175616
 Baby Of BHUPANI SHREEYA
 20-06-2026 0 Y 0 M 5 D (M)
 Dr. NALINIKANTA PANIGRAHY



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

25/6/26 26/6/26 26/6 27/6 28/6

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3	3	3	3	3	3
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
TOTAL			16	16	16	16	16

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓	✓
Wheel Chair Support		✗	✗	✗	✗	✗
Other Intervention(s) Specify		✗	✗	✗	✗	✗
Nurse's Name :		Rashmi	hine	Dual	Dip	feru
Signature :		Rat	Q	Q	Q	Q
Date :		25/6	26/6	26/6	27/6	28/6
Time :		11pm	10pm	9pm	4pm	8pm



THE HUMPTY DUMPTY SCALE 28/6 29/6 29/6 30/6 30/6

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2		2			
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4		4	4	4
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3	3				
	Patient Placed in Bed	2		2	2	2	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			16	13	15	15	15

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

Bed in low position	✓	✓	✓	✓	✓
Call device within reach	✓	✓	✓	✓	✓
Wheels Locked	✓	✓	✓	✓	✓
Room free of clutter	✓	✓	✓	✓	✓
Adequate Lighting	✓	✓	✓	✓	✓
Wheel Chair Support	4	X	X	X	X
Other Intervention(s) Specify	X	X	X	X	X
Nurse's Name :		Dipa	Pooja	Shruti	Shruti
Signature :		[Signature]	[Signature]	[Signature]	[Signature]
Date :		28/6	29/6	29/6	30/6
Time :		10:00 am	5:00 pm	10:00 am	10:00 am



THE HUMPTY DUMPTY SCALE 1/7 1/8 1/8 2/2 3/2

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

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		X	X	X	X	X
Other Intervention(s) Specify						
Nurse's Name :		AK	AK	AK	AK	AK
Signature :		AK	AK	AK	AK	AK
Date :		1/7/26	1/7/26	1/7/26	1/7/26	1/7/26
Time :		8 pm	8 pm	8 pm	8 pm	8 pm



THE HUMPTY DUMPTY SCALE

3/7/26

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4				
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3				
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4	4				
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3	3				
	Patient Placed in Bed	2					
	Outpatient Area	1	1				
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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				
TOTAL			18				

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes					
Call device within reach	Yes					
Wheels Locked	Yes					
Room free of clutter	Yes					
Adequate Lighting	Yes					
Wheel Chair Support	No					
Other Intervention(s) Specify	NA					
Nurse's Name :	Rup					
Signature :	Rup					
Date :	3/7					
Time :	8:00					



NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date		
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time		
						20/6	21/6	28/6	29/6	29/6	30/6	1/7/26	1/7/26		
						3am	10am	8AM	8AM	2PM	8am	2pm	8pm		
						Procedure → RBS	Con	RBS	RBS	RBS		RBS	RBS		
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	0	+1	+1	+1	1	1	1	1		
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)	0	0	0	0	1	1	1	1		
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	1	+1	+1	+1	1	1	1	1		
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	0	0	0	0	1	1	1	1		
Vital Signs HR, RR, BP, SaO₂	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	0	+1	+1	+1	1	1	1	1		
	Premature Pain Assessment: Scoring					Gestational Age / Corrected Age	38 wks	+1	+1	+1	+1	+1	+1	+1	
	+3 if less than 28 weeks gestation age / Corrected Age					Total Pain / Agitation Score	1/10	+4	+4	+4	4/10	1/10	1/10	1/10	1/10
	+2 if 28 - 31 weeks gestation age / Corrected Age					Intervention	-	EBM	EBM	EBM	EBM	EBM	EBM	EBM	
	+1 if 32 - 35 weeks gestation age / Corrected Age					Effectiveness	-	1/9	1/9	1/9	yes	yes	yes	yes	
	Intervention					Signature	Ra	Ra	Ra	Ra	(M)	@m	Ra	Ra	
Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention															

NPASS: Neonatal Pain, Agitation & Sedation Scale

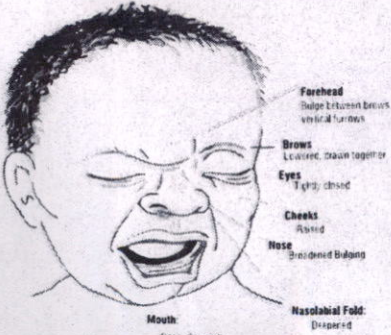
	Sedation	Pain / Agitation
How to use	- Observe the infant for a minute before selecting a score for each behavior. - Stimulate the infant and observe and select a score for each behavior. - Select only one numeric value (Highest) per behavior.	- Observe the infant for a minute before selecting a score for each behavior. - Select only one numeric value per behavior.
Scoring/ Documentation	- Sedation scores are negative scores only - Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age) - NPASS Sedation total score has a range from 0 to -10 possible. - Document total NPASS Sedation score in the medical record.	- Pain/Agitation scores are positive scores only - Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria. - Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score. - NPASS Pain/Agitation total score has a range from 0 to 13 possible. - Document the total NPASS Pain/Agitation score in the medical record
Interpretation	- Desired levels of sedation vary according to the situation. - Discuss and determine sedation goal with provider. "Deep sedation": goal score of -10 to -5 - Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea "Light sedation": goal score of -5 to -2 - Reassess patient per frequency in local sedation policy - A negative score without the administration of opioids/ sedatives may indicate: - The premature infant's response to prolonged or persistent pain/stress - Neurologic depression, sepsis, or other pathology	- Does not provide pain intensity rating. - Any score greater than 3 indicates the possibility of the presence of pain in the infant - Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological). - Reassess patient per frequency of local pain policy. - If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention.

AH-00659928
 sdy Of BHUPANI SHREEYA
 0-06-2026
 0 Y 0 M 8 D
 r. NALINIKANTA PANIGRAHY (M)

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
						27/06/24	8:30 AM	8:30 AM					
						Procedure	RBS	MD					
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	1	0						
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)	1	0						
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	1	0						
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	1	0						
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	1	0						
 Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention						Gestational Age / Corrected Age	38w	38 wky					
						Total Pain / Agitation Score	4/10	0/10					
						Intervention	RBM	ERM					
						Effectiveness	yes	yes					
						Signature	[Signature]	[Signature]					

NPASS: Neonatal Pain, Agitation & Sedation Scale

	Sedation	Pain / Agitation
How to use	- Observe the infant for a minute before selecting a score for each behavior. - Stimulate the infant and observe and select a score for each behavior. - Select only one numeric value (Highest) per behavior.	- Observe the infant for a minute before selecting a score for each behavior. - Select only one numeric value per behavior.
Scoring/ Documentation	- Sedation scores are negative scores only - Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age) - NPASS Sedation total score has a range from 0 to -10 possible. - Document total NPASS Sedation score in the medical record.	- Pain/Agitation scores are positive scores only - Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria. - Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score. - NPASS Pain/Agitation total score has a range from 0 to 13 possible. - Document the total NPASS Pain/Agitation score in the medical record
Interpretation	- Desired levels of sedation vary according to the situation. - Discuss and determine sedation goal with provider. "Deep sedation": goal score of -10 to -5 - Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea "Light sedation": goal score of -5 to -2 - Reassess patient per frequency in local sedation policy - A negative score without the administration of opioids/ sedatives may indicate: - The premature infant's response to prolonged or persistent pain/stress - Neurologic depression, sepsis, or other pathology	- Does not provide pain intensity rating. - Any score greater than 3 indicates the possibility of the presence of pain in the infant - Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological). - Reassess patient per frequency of local pain policy. - If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention.



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	0	-	-	-	-	-	-	9		
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-		-	-	-	-	-	2		
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-		-	-	-	-	-	2		
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-		-	-	-	-	-	2		
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-		-	-	-	-	-	2		
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
27/6/26 10PM	Back side	Rt hand	Prone	Given	Given	OD	NA	Given	Given	[Signature]
28/6/26 6AM	Back side	Lt hand	Prone	Given	Given	OD	NA	Given	Given	[Signature]
28/6/26 @ 11am	Back side	Left hand	Prone	Given	Given	OP	NA	Given	Given	[Signature]
28/6/26 @ 6pm	Back side	Right leg	Prone	Given	Given	OD	NA	Given	Given	[Signature]
28/06/26 10PM	Back side	Right- hand	Supine	Given	Given	OD	NA	Given	Given	[Signature]
29/06/26 2AM	Back side	Left hand	Prone	Given	Given	OD	NA	Given	Given	[Signature]

BAH-00659928

IP5-00175616

Baby Of BHUPANI SHREEYA

20-06-2026 0 Y 0 M 6 D

(M)

Dr. NALINIKANTA PANIGRAHY



PROBS AND POSITIONS CHART

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
26/6/26	Right Abdomen	Right hand	prone	Given	Given	TID	NA	Given	Given	Des
27/6/26	Back of the Abdomen	Left hand	prone	Given	Given	TID	NA	Given	Given	Des
27/6/26	Back of the Abdomen	Right hand	prone	Given	Given	TID	NA	Given	Given	Des
27/6/26 @ 11am	Back side	Right leg	Prone	Given	Given	TID	NA	Given	Given	Des
27/6/26 2pm	Back side	Left leg	Prone	Given	Given	TID	NA	Given	Given	Des
27/6/26 6pm	Back side	Right hand	Prone	Given	Given	TID	NA	Given	Given	Des

PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
30/6/26 @ 2pm	rt abdomen	left hand	Supine	Given	Given	OD	-	Given	Given	(M)
30/6/26 @ 6pm	Rt abdomen	left hand	Supine	Given	Given	OD	-	Given	Given	(P)
30/6/26 10pm	Rt abd	Rt leg	supine	Given	Given	OD	-	Given	Given	(B)
1/7/26 9am	Rt Abd	Lt hand	supine	Given	Given	OD	-	Given	-	(B)
1/7/26 6am	Rt abd	Rt hand	supine	Given	Given	OD	-	Given	Given	(B)
1/7/26 10Am	Rt abd	Rt hand	supine	Given	Given	OD	-	Given	Given	(B)



3

PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
29/06/26 6 Am	Right side	Right hand	Prone	Given	Given	OD	Given	Given	Given	Am
29/6/26 11 Am	Right Abdomen	Right leg	Prone	Given	Given	Once 8th hourly	NA	Given	Given	Am
29/6/26 5 PM	Left Abdomen	Left hand	Supine	Given	Given	8th hourly	NA	Given	Given	Am
29/6/26 @10pm	Right Abdomen	Right hand	Supine	Given	Given	OD	NA	Given	Given	Am
30/6/26 @ 6 AM	Right Abdomen	Left hand	Supine	Given	Given	OD	NA	Given	Given	Am
30/6/26 @ 10 am	RT abdomen	left hand	Supine	Given	Given	OD	NA	Given	Given	Am



(K)

PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
1/7/26 10pm	Rt abd	Lt hand	supine	given	given	OD	-	given	given	Ahs
1/7/26 2pm	Rt abd	Rt hand	supine	given	given	OD	-	given	given	Ahs
1/7/26 8pm	Rt Abd	Left hand	supine	Given	Given	OD	-	Given	Given	AD
1/7/26 10pm	Rt Abd	Rt hand	Supine	Given	Given	OD	-	Given	Given	AD
2/7/26 10pm	Crib care	Left hand	Sup	Given	Given	on	-	Given	Given	OS
2/7/26	Crib care	Right hand	Sup	Given	Given	on	-	Given	Given	A

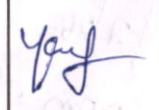
Patient Sticker

6

PROBS AND POSITIONS CHART

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
2/7/26 @ 2pm	Right abd	left hand	Supine	given	given	OD	NA	given	given	
2/7/26 @ 6pm	Right abd	left hand	Supine	given	given	OD	NA	given	given	
2/7/26 @ 8pm	NA	left hand	Supine	given	given	OD	NA	given	given	
3/7/26 8Am	NA	left hand	Supine	given	given	OD	NA	given	NA	
3/7/26 10Am	NA	left hand	Supine	given	given	OD	NA	given	NA	



10

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 25/6/26		Diagnosis : Suspected sepsis		Surgery / Procedures :		
		Allergies :		Post OP Day :				
Date :		25/6/26	26/6/26	26/6/26	27/6/26	28/6/26	28/6/26	
Area		N4	N4	N4	N4	N4	N4	
Shift Time		80pm-10am	8pm-8pm	8pm-8pm	8pm-8pm	8pm-8pm	8pm-8pm	
Diet :		NPO	DBM	DBM	DBM-EBM	DBM-EBM	DBM-EBM	
Ventilation (RA, NP, NIV, VENTI)			RA	RA	RA	RA	RA	
INVASIVE LINES	1. Central	In line	W line	In line	In line	In line	In line	
	2.							
	3.							
	4.							
ASSESSMENT		Infusions / Transfusions		10% Isop	10% Isop	10% Isop	10% Isop	
		PU Prophylaxis		NA	NA	NA	NA	
		DVT Prophylaxis		NA	NA	NA	NA	
		Vitals		BP 61/46(51)	72/38(55)	86/33(41)	58/30(38)	60/40(52)
				PR 182b/m	166b/m	168b/m	173	180b/m
				RR 25b/m	53b/m	30bpm	42	50b/m
				SpO ₂ 90%	98%	98%	98%	99%
				Temp 36.5°C	36.6°C	36.6°C	36.6°C	36.5°C
				Pain Score 2/10	+2	+2/10	+2	+2
				LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert
Skin Integrity (Intact / Bedsores / Any other condition)		Intact	Intact	Intact	Intact	Intact		
Restraints If any		NA	NA	NA	NA	NA		
Fall Risk (Vulnerable (Y/N) if yes score)		NO	Yes	Yes	Yes	Yes		
(Ambulation, walking, moving with assistance, bed ridden)		Moving	Bedridden	Bedridden	Bedridden	Bedridden		
ADL (Dependent / Non-Dependent)		Depend	Depend	Depend	Depend	Depend		
Critical Lab Test / Values (if any)		NA	NA	NA	NA	NA		

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS

Investigations Procedures

Date : 25/6/26	26/6/26	26/6/26	26/6/26	27/6/26	28/6/26	28/6/26
Area	NA	NA	NA	NA	NA	NA
Shift Time	19pm-8am	14-8am	8pm-2am	8am-2pm	8pm-2am	8pm-2am
Ordered / Planned	RBS 8th Hx	RBS 8th	RBS 8th	RBS 8th	RBS 8th	RBS 8th
Due	NA	NA	NA	NA	NA	NA
Reports Pending	Blood cls	Blood cls	Blood cls	Blood cls	Blood cls	Blood cls
Referrals (If any)	NA	NA	NA	NA	NA	NA
Remarks (Special Interventions like, Drainage Tube flushing etc.)	NA	NA	NA	NA	NA	NA
Handed Over By Name :	Reshmita	Diff.	Dumlaht	Diff	Judith	Diff
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	26/6/26	26/6/26	27/6/26	27/6/26	28/6/26	28/6/26
Time :	8am	8pm	8pm	8pm	8am	8pm
Taken Over By Name :	Diff	Dumlaht	Diff	Judith	Diff	Diff
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	26/6/26	26/6/26	27/6/26	27/6/26	28/6/26	28/6/26
Time :	8am	8pm	8pm	8pm	8am	8pm

2

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 25.06.26		Diagnosis : Suspected Sepsis		Surgery / Procedures :		
		Allergies :		Post OP Day :				
SITUATION & BACKGROUND	Date :	28.06.26	29/6/26	29/6/26	30/6/26	30/6/26	1/7/26	
	Area	NA4	NICU4	N4	N4	N3	N3	
	Shift Time	8pm-8am	8am-8pm	8pm-8am	8am-8pm	8pm-8am	8am-2pm	
	Diet :	EBM+DBM	EBM/DBM	EBM/DBM	EBM/DBM	EBM/DBM	EBM/DBM	
	Ventilation (RA, NP, NIV, VENTI)	RA	R/A	R/A	R/A	RA	R/A	
INVASIVE LINES	1. <u>Cannula</u>	IV Line	IV line	IV - (1)	IV - (1)	IV line	IV - (1)	
	2.		OG	OG - (1)	OG - (1)	OG	-	
	3.							
	4.							
ASSESSMENT	Infusions / Transfusions	10% ISOP	10%	10% ISOP	10%	NA	NA	
			ISOP					
		NA						
		NA						
	PU Prophylaxis	NA	NA	NA	NA	NA	NA	
	DVT Prophylaxis	NA	NA	NA	NA	NA	NA	
	Vitals	BP	67/48(53)	58/35(40)	58/34(42)		67/42(55)	71/41(54)
		PR	122b/m	133b/m	148b/m	139b/m	141b/m	141b/m
		RR	62b/m	42b/m	58b/m	21b/m	38	41b/m
		SpO ₂	98%	94%	100%	93%	96%	98%
		Temp	36.6	36.9°C	36.6°C	36.5°C	36.6°C	36.6°C
	Pain Score	+2	2/10	2/10	2/10	2	2/10	
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	conscious	Alert	Alert	Alert	Alert	
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact	Intact	Intact	
	Restraints If any	Physical	NA	NA	NA	NA	NA	
Chemical	NA	NA	NA	NA	NA	NA		
Fall Risk (Vulnerable (Y/N) if yes score)	yes	yes	yes	yes	yes	yes		
(Ambulation, walking, moving with assistance, bed ridden)	Moving	Bed ridden	Moving	Moving	Bed ridden	Moving		
ADL (Dependent / Non-Dependent)	Dependent	Dependent	Dependent	Dependent	Dependent	Dependent		
Critical Lab Test / Values (if any)	NA	NA	NA	NA	NA	NA		

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS

Investigations Procedures

Date :	28/06/26	29/6/26	29/6/26	30/6/26	30/6	1/7/26
Area	N4	NICU	N4	N4	N3	N3
Shift Time	8Am-8Am	8Am-8pm	8pm-8am	8am-8pm	8pm-8am	8am-2pm
Ordered / Planned	RBS 6th hourly	RBS 8th hourly	RBS-BD 6	RBS-BD	150cc RBS by	RBS-OB
Due	NA	NA	NA	NA	NA	NA
Reports Pending		NA			NA	NA
Referrals (If any)	NA	NA	NA	NA	NA	NA
Remarks (Special Interventions like, Drainage Tube flushing etc.)		NA	NA	NA	NA	NA
Handed Over By Name :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>
Signature :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>
Date :	29/06/26	29/6/26	30/6/26	30/6/26	1/7/26	1/7/26
Time :	8Am	8pm	8pm	8pm	8Am	2pm
Taken Over By Name :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>
Signature :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>
Date :	29/6/26	29/6/26	30/6/26	29/6/26	1/7/26	1/7/26
Time :	8pm	8pm	8Am	8pm	2pm	2pm

3

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA : 20/06/2026	Diagnosis : Suspected Sepsis			Surgery / Procedures :	
	Allergies :				Post OP Day :	
	Date : 1/7/26				2/7/26	3/7/26
	Area	N3 2pm-8pm	N3 8pm-8am	N3 8am-9A	N3 8am-8pm	N3 8pm to 8am
INVASIVE LINES	Shift Time					
	Diet :	EBM+DBM	EBM+DBM	EBM+DBM	EBM	EBM
	Ventilation (RA, NP, NIV, VENTI)	RA	RA	RA	RA	RA
	1.	IV-①	IV-①	IV-①	IV-①	IV-①
ASSESSMENT	2.					
	3.					
	4.					
	Infusions / Transfusions	NA	NA	NA	NA	NA
	PU Prophylaxis	NA	NA	NA	NA	NA
	DVT Prophylaxis	NA	NA	NA	NA	NA
	Vitals	BP	60/43 (51)	62/46 (50)	-	-
		PR	134	144	129	139
		RR	46 b/m	36 b/m	-	-
		SpO ₂	93%	98%	99%	99%
		Temp	36.4c	36.5c	98.8c	98.6c
	Pain Score	1/10	1/10	1/10	1/10	1/10
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert	Alert
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact	Intact
	Restraints If any	NA	NA	NA	NA	NA
	Fall Risk (Vulnerable (Y/N) if yes score)	yes	yes	yes	yes	yes
	(Ambulation, walking, moving with assistance, bed ridden)	moving	moving	moving	moving	moving
	ADL (Dependent / Non-Dependent)	Dependent	Dependent	Dependent	Dependent	Dependent
	Critical Lab Test / Values (if any)	NA	NA	NA	NA	NA

		Date : 1/7/26					
		N3 2pm-8pm		N3 8pm-8am		N3 8pm-8am	
Area		N3 2pm-8pm		N3 8pm-8am		N3 8pm-8am	
Shift Time		N3 2pm-8pm		N3 8pm-8am		N3 8pm-8am	
RECOMMENDATIONS	Investigations Procedures	Ordered / Planned	NA	NA	NA		RBS OD
		Due		NA	NA	NA	NA
		Reports Pending	CSF cls, CSF Analysis N3G	NA	NA	NA	NA
		Referrals (If any)	NA	NA	NA	NA	
		Remarks (Special Interventions like, Drainage Tube flushing etc.)			NA	NA	
	Handed Over By Name :		Akansha	Madhura	Deved	Agasthi	Yamun
	Signature :						
	Date :		1/7/26	2/7/26	2/7/26	3/7/26	3/7/26
	Time :		@ 8pm	@ 8am	8pm	8 AM	8pm
	Taken Over By Name :		Madhura	Deved	Agasthi	Yamun	
Signature :							
Date :		1/7/26	2/7/26	2/7/26	3/7/26		
Time :		@ 8pm	8pm	8pm	8pm		

BED SIDE CHECK LIST FOR NURSES

Date:	25/6	28/06/26	29/6/26	29/6	30/6	30/6	2/7		
Doctor's Orders	yes	yes	yes	followed	yes	yes	yes		
Carried out or not	yes	yes	yes	yes	yes	yes	yes		
Bed Side									
Structured Handover done	yes	yes	yes	Done	Done	Done	Done		
IV Site	yes	yes	yes	yes	yes	yes	yes		
Central Lines	NA	NA	NA	No	NO	NO	NO		
Arterial Lines	NA	NA	NA	No	NO	NO	NO		
Feeding Catheter	yes	yes	NA	yes	yes	yes	yes		
Urinary Catheter	NA	NA	NA	No	NO	NO	NO		
Skin Care	yes	yes	yes	Given	Given	Given	Given		
Eye Care	yes	yes	yes	Given	Given	Given	Given		
Mouth Care	yes	yes	yes	Given	Given	Given	Given		
Sterillum Bottle, Stethoscope	yes	yes	yes	yes	yes	yes	yes		
Suction Bottle (Should be clean & empty)	yes	yes	yes	yes	yes	yes	yes		
Intubation Tray	NA	NA	NA	NO	NA	NA	NA		
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	NA	NA	NA	NO	NA	NA	NA		
Ventilator Tubing, (Any Water, Blood)	NA	NA	NA	NO	NO	NO	NO		
Humidification	NA	NA	NA	NO	NO	NO	NO		
Check all Infusion (Labelling, Correct Preparation)	yes	yes	yes	yes	yes	yes	yes		
Chest Physio & Neb	NA	NA	NA	NA	NA	NA	NA		
Handed Over By Name :	Shweta	Shweta	Pragya	Shweta	Pragya	Shweta	Shweta		

Checked & Handover given by

Name of the Nurse : Shweta

Signature : [Signature]

Date & Time : 27/6/26 8 PM

Checked & Handover taken by

Name of the Nurse : Shweta

Signature : [Signature]

Date & Time : 28/6/26 8 PM



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

8月1日

NICU:

WEIGHT IN GRAMS

421.0 + 98.19
451.95 (average) 182.06

INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: A+ve Baby's Blood Group: o+ve Sheet No: 1
 Gest Age: Term Birth Weight: 2.5 kg

Date: <u>26/6/26</u>	Date: <u>27/6/26</u>	Date: <u>28/6/26</u>
DOL <u>D5</u> Weight <u>→ 2.538 kg</u>	DOL <u>D6</u> <u>2.460 Recheck</u> Weight <u>→ 2.431 gm</u>	DOL <u>D7</u> Weight <u>2.463 ↑ 30 gm</u>
Problems: <u>→ Term / RDS</u>	Problems: <u>→ Term / RDS</u>	Problems: <u>Term / RDS</u>
Rs. <u>→ 30-60 bl/min</u> Exam <u>→ Done</u> Vent. Setting <u>low flow</u> ABG <u>→ Done</u> CXR <u>→ Done</u>	Rs. <u>→ 30-60 bpm</u> Exam <u>→ Done</u> Vent. Setting <u>→ RFA</u> ABG <u>→ done</u> CXR <u>→ done</u>	Rs. <u>30-60 bl/min</u> Exam <u>done</u> Vent. Setting <u>RFA</u> ABG <u>done</u> CXR <u>done</u>
CVS <u>→ normal</u> HR <u>→ 120-160 bl/min</u> BP <u>→ Map</u> Cap Refil <u>→ 2-3 sec</u>	CVS <u>→ Normal</u> HR <u>→ 120-160 bpm</u> BP <u>→ Map</u> Cap Refil <u>→ 2-3 sec</u>	CVS <u>normal</u> HR <u>120-160 bl/min</u> BP <u>60/40 Map</u> Cap Refil <u>2-3 sec</u>
F/E/N <u>→ 140 cc/kg/day</u> T. Fluids <u>→ 126.4 ml/kg/day</u> CC/kg/day <u>→ 50.5 cc/kg/day</u> I/O/RBS: <u>→</u> U Output: (CC/kg/hr) <u>3 cc</u> Exam <u>→</u> T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>→ 140 cc/kg/day</u> T. Fluids <u>→ 342.5 ml</u> CC/kg/day <u>→ 137 cc/kg/day</u> I/O/RBS: <u>→ 92 ml/kg</u> U Output: <u>111</u> (CC/kg/hr) <u>→ 1.8 cc</u> Exam T. Bil/D <u>11.0 - 0.2</u> Na <u>131</u> <u>10.3</u> K <u>BUN</u> <u>5.5</u> Cl <u>Crea</u> <u>104</u> Hemat HB: <u>15.2</u> WCC <u>29.4</u> Plats <u>15</u> Transfusion <u>→ 25/6/26 (PRP)</u>	F/E/N <u>150 cc/kg/day</u> T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results <u>→</u> CRP <u>→</u> Antibiotics <u>→ Inj. meropenem</u>	C/s Results <u>→ NA</u> CRP <u>→ 85</u> <u>25/6/26</u> Antibiotics <u>→ Inj. Meropenem</u>	C/s Results <u>NA</u> CRP <u>85</u> <u>25/6/26</u> Antibiotics <u>Inj. meropenem</u>
Med <u>→ Inj. liposomal Amph-B</u> Neuro: <u>→ Done</u>	Med <u>→ Inj. liposomal</u> <u>ns. colistin</u> Neuro: <u>→ nil - vancomycin</u>	Med <u>Inj. liposomal</u> <u>Inj. vancomycin</u> Neuro: <u>Inj. vancomycin</u>
Assessment <u>→ Done</u>	Assessment <u>→ Done</u>	Assessment <u>done</u>
Plan <u>→ normal</u>	Plan <u>→ Normal</u>	Plan <u>normal</u>



INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: A+ve Baby's Blood Group: O+ve Sheet No: 2
Gest Age: Term Birth Weight: 2.5 kg

Date: <u>29/06/26</u>	Date: <u>30/6/26</u>	Date: <u>1/7/26</u>
DOL <u>D8</u> Weight <u>2.387 (↓ 76 gms)</u>	DOL <u>D9</u> Weight <u>2.389 (↑ 2 gms)</u>	DOL <u>+</u> <u>D10</u> Weight <u>+</u> <u>2.417 (↑ 28 gms)</u>
Problems: <u>Term / RDS</u>	Problems: <u>Term / RDS</u>	Problems: <u>+</u> <u>Term / RDS</u>
Rs. <u>30-60 bpm</u> Exam <u>done</u> Vent. Setting <u>RIA</u> ABG <u>done</u> CXR <u>done</u>	Rs. <u>30-60 bpm</u> Exam <u>Done</u> Vent. Setting <u>RIA</u> ABG <u>4 mA</u> CXR <u>4 mA</u>	Rs. <u>+</u> <u>30-60 bpm</u> Exam <u>+</u> <u>Done</u> Vent. Setting <u>+</u> <u>RIA</u> ABG <u>+</u> CXR <u>+</u>
CVS <u>Normal</u> HR <u>128 bpm</u> BP <u>66/51</u> Map <u>(12)</u> Cap Refil <u>(2-3 sec)</u>	CVS <u>Normal</u> HR <u>120-160 bpm</u> BP <u>57/36</u> Map <u>(48)</u> Cap Refil <u>< 2-3 sec</u>	CVS <u>+</u> <u>Normal</u> HR <u>+</u> <u>120-160 bpm</u> BP <u>+</u> Map <u>+</u> Cap Refil <u>+</u> <u>< 2-3 sec</u>
F/E/N <u>150 cc/kg/day</u> T. Fluids <u>365 ml</u> CC/kg/day <u>146</u> (cc/kg/day) I/O/RBS: <u>91 mg/dl</u> U Output: <u>131</u> (CC/kg/hr) <u>2.1</u> cc/kg/day Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>150 cc/kg/day</u> T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>+</u> <u>150 cc/kg/day</u> T. Fluids <u>+</u> <u>333.9 ml</u> CC/kg/day <u>+</u> <u>140</u> (cc/kg/day) I/O/RBS: <u>+</u> <u>71 mg/dl</u> U Output: <u>+</u> <u>171</u> (CC/kg/hr) <u>+</u> <u>2.8</u> cc/kg/day Exam <u>+</u> <u>Done</u> T. Bil/D Na <u>+</u> <u>13</u> HcO3 K <u>+</u> <u>4.5</u> BUN Cl <u>+</u> <u>92</u> Crea Hemat HB: <u>+</u> <u>12.9</u> WCC <u>+</u> <u>9.92</u> Plats <u>+</u> <u>54</u> Transfusion
C/s Results <u>NA</u> CRP <u>85</u> (26/06/26) Antibiotics <u>Inj Meropenem</u>	C/s Results <u>NA</u> CRP Antibiotics <u>Inj Meropenem</u>	C/s Results CRP <u>+</u> <u>21.2</u> - <u>29/6</u> Antibiotics <u>+</u> <u>Inj Meropenem</u>
Med <u>Inj Liposomal</u> Neuro: <u>Inj Vancomycin</u>	Med <u>Inj Amphot. B</u> <u>Inj Vancomycin</u> Neuro: <u>NA</u>	Med <u>+</u> Neuro: <u>+</u>
Assessment <u>done</u>	Assessment <u>Done</u>	Assessment <u>+</u> <u>done</u>
Plan <u>Normal</u>	Plan <u>RBS, OD</u>	Plan <u>+</u> <u>RBS</u>

INTENSIVE CARE UNIT

CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: Atve Baby's Blood Group: 0 +ve Sheet No: 3
 Gest Age: Term Birth Weight: 2.5 kg

Date: <u>2/7/26</u>	Date: <u>3/7/26</u>	Date:
DOL <u>D11</u> Weight <u>2.390 gm</u>	DOL <u>D12</u> Weight <u>2.431 gm</u>	DOL Weight
Problems: <u>Term / RDS</u>	Problems: <u>Term / RDS</u>	Problems:
Rs. <u>30-60 b/m</u> Exam <u>Done</u> Vent. Setting <u>RA</u> ABG CXR <u>NA</u>	Rs. <u>30-60 b/m</u> Exam <u>Done</u> Vent. Setting <u>RA</u> ABG CXR	Rs. Exam Vent. Setting ABG CXR
CVS <u>normal</u> HR <u>120-160 b/m</u> BP Map Cap Refil <u>(2-3 sec)</u>	CVS <u>Normal</u> HR <u>120-160</u> BP Map Cap Refil <u>(2-3 sec)</u>	CVS HR BP Map Cap Refil
F/E/N T. Fluids <u>150 cc/kg/day</u> CC/kg/day <u>150 cc</u> I/O/RBS: <u>89 mg/dl</u> U Output: <u>151 (CC/kg/hr)</u> <u>2.5 cc</u> Exam T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day <u>150 cc/kg/day</u> I/O/RBS: <u>82 mg/dl</u> U Output: <u>(CC/kg/hr)</u> Exam <u>Done</u> T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results CRP <u>21.2</u> Antibiotics <u>Meropenem</u>	C/s Results CRP Antibiotics	C/s Results CRP Antibiotics
Med Neuro:	Med Neuro:	Med Neuro:
Assessment <u>Done</u>	Assessment <u>Done</u>	Assessment
Plan <u>RBS</u>	Plan <u>RBS</u>	Plan



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

S.No	Date	DOL	Specimen	Findings	Antibiotics

S.No	Date	DOL	Findings
	26/5	6	NSG-Normal.

S.No	Date	DOL	Findings

S.No	Date	DOL	Findings
1	27/06	7	Small PDA - L→R shunt - 1.4mm PDA PFO - L→R shunt, Dilated LA, LV, Good biventricular function. EF - 63%, LA/Ao - 1.2

S.No	Date	DOL	Findings

Results:

9) Fluconazole Prophylaxis

Dr. NAUNIKANTA PANIGRAHI

(M)

[illegible]

BAH-00659928 IP5-00175616
Baby Of BHUPANI SHREEYA
20-06-2026 0 Y 0 M 7 D (M)
Dr. NALINIKANTA PANIGRAHY




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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission 25/6/26 at	Date & Time of Transfer Order 25/6/26 at		
Treating Consultant Name	Transfer Ordered by Dr. Ayushman	Reason for Transfer Admission		
From Unit ER	To Unit ICU	Information to Attendant Yes ☒ No ☐		
Number of Sheets in Clinical File 2	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant 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 ☐				
Name & Signature of Person who is Transferring Anand	Name of Person Ordered Transfer Dr. Ayushman			
Patient & Clinical Records Received by : Yamuna				
Date & Time of Patient Received : 28/6/26				

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



CONSENT FOR ADMISSION IN NEONATAL INTENSIVE CARE UNIT

Name: B/o - B. Shreeya Age: 6 Gender: Male ☒ Female ☐

UHID.No: BAH-659928 Date: 25/06/26

I Dr. Nalinikanta Panigrahy S/o, D/o, W/o hereby
declare that our patient Mr. / Ms. B/o Shreeya who is related to me as son is
getting admitted in the Neonatal Intensive Care Unit of Rainbow Children's Hospital on 25/06/2026

The doctors have explained to me in a language understood by me that my child has following health related issues :

Recess

The doctors have clearly explained to me that my patient B/o Shreeya during his / her stay
in the Neonatal Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical
ventilation, Umbilical Artery Catheter, Umbilical Vein and Arterial Lines, Peripherally Inserted Central Catheter Line and arterial line
placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure
shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is
implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Neonatal Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Neonatal Intensive Care Unit with multiple medical and surgical procedures
performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of
infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child B/o B/o - B. Shreeya
in the Neonatal Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various
procedures, high risk medications and infections in the Neonatal Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature : [Signature]

Name : Dr. Nalinikanta Panigrahy

Relationship with Patient: Parent

Date & Time : 25/6/26 @ 10 PM

Witness :

Signature : [Signature]

Name : [Name]

Date & Time : 25/6/26 @ 10 PM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Pawan

Date & Time : 25/6/26 10 PM

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యు) సమ్మతి పత్రం

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

 **BirthRight**
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

రోగి పేరు వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి బి తేదీ

నేను నివాసం

అనే బాలుడు / బాలిక యొక్క బికిట్స్ వేరకు రేయిన్స్ బిల్డ్ ఆసుపత్రిలోని నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్లో తేదీ

..... నాడు పూర్తి సమ్మతితో చేర్చబడింది. మా బాలుడి / బాలికలో. ఈ క్రింద

తెలిపిన ఆరోగ్య సమస్యల గురించి వైద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించింది.

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ లో మా పాప / బాబుకు వైద్య పరంగా అవసరమగు అన్ని రకాల బికిట్స్ విధానాలకు మరియు ప్రక్రియలను (ఉదా కృత్రిమ శ్వాస వెంటిలేటర్, ధమని మార్గం, సింట్రిల్ ట్రైన్ చెస్ట్ డ్రైయింగ్, పెరిటోనియల్ డ్రైయింగ్ ఇంసర్షన్ వంటి ప్రక్రియలను డాక్టరు గారు నాకు అర్థమగు భాషలో వివరించారు.

ఆటవంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైనప్పటికీ, పైన తెలుపబడిన శస్త్ర ప్రక్రియలు చేసేమందు సమ్మతి తీసుకునే వీలు లేని చో ఏదైనా ప్రాణాంతక అత్యవసర పరిస్థితులు ఏర్పడినప్పుడు మా బాలుడు / బాలికను కాపాడుటకు అవసరమైన వైద్య శస్త్ర ప్రక్రియలు మా సమ్మతి లేకుండానే చేయవచ్చని నేను సమ్మతిస్తున్నాను.

ఆరోగ్య సమస్యలతో బాధపడుతున్న మా బాలుడికి / బాలికకు రుగ్మతలచే ప్రాణహాని కలుగవచ్చిన నాకు వైద్యుడు అర్థమగు భాషలో వివరించింది

మా బాలుడు / బాలిక నవజాత శిశువు ఇంటెన్సివ్ కేర్ యూనిట్ లో ఉన్నప్పుడు ఎన్నో విధాల వైద్య మరియు శస్త్ర ప్రక్రియలు ఇంకా వివిధ బికిట్స్ విధానాలు అవసరం పడతాయని మరియు వాటివల్ల దుష్పరిణామాలు కలగవచ్చని అర్థం చేసుకున్నాను. ఆ పరిణామాలు ఎటువంటివి అనగా నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన సమస్యలు, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు.

మా బాలుడిని/బాలికను అడ్మిట్ చేయుటకు మరియు ఎన్.ఐ.సి.యు. లో ఉన్నప్పుడు జరుగు బికిట్స్ విధానాలు మరియు శస్త్ర ప్రక్రియలు వలన కలిగే అపాయాలను నేను అంగీకరిస్తున్నాను. మా పేషెంట్ ను తగిన విధంగా బికిట్స్ చేయడానికి వైద్యునికి నా పూర్తి అంగీకారం తెలియజేస్తున్నాను. వైద్యుడు నాకు అర్థమగు భాషలో అంతా వివరించారు.

మా బాలుడు / బాలిక ను ఇన్ టెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు

CONSENT FOR BLOOD TRANSFUSION

Name: B/o - B. Shreeya Age: DG Gender: Male ☒ Female ☐
UHID.No : BAH - 059928 Date: 26/06/26

Type of Blood Product: ☒ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☒ Random Donor Platelets
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others

I, M. SARDUKHAR hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: [Signature]

Name: M. SARDUKHAR

Date & Time: 26/06/26

Doctor (Who is talking the consent)

Signature: [Signature]

Name: Paw

Date & Time: 26/6/26

Witness

Signature: [Signature]

Name: Karoj

Date & Time: 26/06/26

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

- | | |
|---|--|
| ☐ తాజా ఘనీభవించిన ప్లాస్మా | ☐ ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు Random Donor Platelets |
| ☐ క్రయోప్రెసిపిటేట్ | ☐ ఒకే ధాత ఫ్లేటిలాట్స్ |
| ☐ మొత్తం రక్తం | ☐ ఎర్ర రక్త కణం |
| | ☐ ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడి/రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. ధాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడీస్, హైపటేబీస్ జి సర్వేస్ యాంటీజెన్, హైపటేబీస్ యాంటీబడీస్, మలేరియా మరియు సిప్టిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణీత కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్ల సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రక్తముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్యాక్ చేయబడి ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ఫ్రెష్ ఫ్రోజెన్ ప్లాస్మా, క్రయోప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెన్డెంట్)

సాక్షి

సంతకము

సంతకం

పేరు

పేరు

తేదీ మరియు సమయము

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

BAH-00659928 IP5-00175616
 Baby Of BHUPANI SHREEYA
 20-06-2026 0 Y 0 M 5 D (M)
 Dr. NALINIKANTA PANIGRAHY



hRight™
 LOW HOSPITALS
 to a Safe Delivery

CONSENT FOR FORMULA FEEDS

Patient Name : B/o - B. Shreeya Age : 05 Gender : ☐ Male ☒ Female

UHID No : BAH-659928 Reg. No. : 175610 Department : NICU Date : 25/06/26

I Mr / Mrs. : Dr. Sankar Kumar aged years, hereby declare that I have

admitted my ☒ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on

25/06/26 I hereby give consent for formula feed for my child. Doctors have explained me

about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : [Signature]

Name : Sankar Kumar

Relationship with Patient : FATHER

Date & Time : 25/06/26 @ 10 PM

Witness :

Signature : [Signature]

Name : Rashmi

Date & Time : 25/6/26

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. N. K. Panigrahy

Date & Time : 25/06/26 @ 10 PM

డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. రిజిస్ట్రేషన్ నెం.: విభాగము

తేదీ

నేను శ్రీ / శ్రీమతి వయస్సు సంవత్సరాలు

నా కుమార్తె / కుమారుడు రెయిన్ఫో ఆసుపత్రిలో నవజాత శిశువుల ఇంటెన్సివ్ కేర్ లో అడ్మిట్ చేసినాము మరియు (ఫార్ములా

ఫీడ్) డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుచున్నాను. డాక్టర్లు డబ్బా పాలు త్రాగించడం వల్ల కలుగు

ఉపయోగాలు, ప్రత్యామ్నాయాలు, మరియు నష్టాలు గురించి నాకు అర్థమైన భాషలో వివరించారు.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

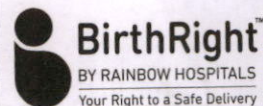
సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

CONSENT FOR SPECIAL PROCEDURES



BAH-00659928 IP5-00175616
 Baby Of BHUPANI SHREEYA
 20-06-2026 0 Y 0 M 10 D (M)
 Dr. NALINIKANTA PANIGRAHY



Patient Name : B/O Smey

Gender: ☒ Male ☐ Female

UHID No : 659928 Department :

Date : 01/07/2026

I M. SARDUKHAR S/D/W/O

Here by give consent for procedure of : Lampal Puncture

For my patient, Named : B/O SHREEYA

The doctors have clearly explained to me that the procedure has following possible complications:

bleeding, infection

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure:

Patient Attendant :

Signature : B. Shreeya

Name : B. Shreeya

Relationship with Patient: Mother

Date & Time : 1/7/26 12:30pm

Witness :

Signature : Abhinav

Name : Abhinav

Date & Time : 1/7/26 @ 12:30pm

Doctor (who is taking the consent) :

Signature : BAU

Name : BAU

Date & Time : 1/7/26 12:30pm

ప్రత్యేక విధానాలకు సమ్మతి



Rainbow
Children's
Hospital
It takes a lot to treat a

రోగి పేరు లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.పొ.బి.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 26/6/26 Time: 1:40 PM

Blood Group of the Patient: O+ve Blood Group on the Blood Bag: O+ve

Blood Bank Issue No: BAH26-01500 Date of Collection: 23/6/26 Date of Expiry: 28/6/26

Date & Time of Starting Transfusion: 26/6/26 Planned duration of Transfusion:

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Laxmi Nurse 2: Devadamma

Before starting transfusion vitals: Temp: 36.7°C HR: 171 RR: 20 BP: 50/1 SpO₂: 91%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
26/6/26	15 Min	170	36.7°C	S-65 D-44 M-51	99%	No	No	No	No
	15 Min	203	36.5°C	S-53 D-40 M-43	99%	No	No	No	No
	30 Min								
	30 Min								
	30 Min								
	1 Hr								
	1 Hr								

Comments:

No complications during and after transfusion

Name of the Incharge-Nurse: Laxmi

Name of the Nurse: G. Rashmi

Signature of the Incharge-Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 26/06/26 @ 1:45 AM

Date & Time: 26/6/26 @ 1:40 AM

BAH26-01500

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

PLATELET CONCENTRATE I.P.

Qty. 55 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D./
SAGM Solution.

O

HIV I & II/ HBsAG/ HCV - Non
reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non
reactive

Unit No.: BAH26-01500
Blood Group: O Rh Positive
Collection Date: 23/Jun/2026
Expiry Date: 28/Jun/2026

1. Do Not Dispense Without Prescription. 2. Check Blood Group On
Label & Recipient's Group And Name Before Administration. 3. Shake
Gently Before Use. 4. Do Not Add Any Medication. 5. Use Immediately
After Issuc. 6. Use Sterile Transfusion Set With Filter. 7. Do Not Use If
There Is Any Visible Evidence Of Deterioration Like Haemolysis
Clotting Or Discoloration. 8. Store Cont... 22° C - 24° C With
Gentle Agitation. 9. Adm...

Issue Label / CrossMatching Report

Patient : B/O BHUPANI SHREEYA
Patient's Blood Group : O Rh Positive
Hosp/Dr : Rainbow Childrens Hospital, Dr. Nahnikanth
UHID No.: BAH-00659928 Wd-Bed No.:
Product : RDP
Blood Group : O Rh Positive
Unit No.: BAH26-01500
XMatching Report: Group Specific
X-matched by: K. Alok

Issue Dt : 26/Jun/2026
Colln. Dt : 23/Jun/2026
Exp. Dt : 28/Jun/2026
Issued By : K. Alok

**Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital**

D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic No. 46/HD/TS/2018/BB/G



BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 26/6/26 Time: 4:00 am

Blood Group of the Patient: otve Blood Group on the Blood Bag: otve

Blood Bank Issue No: BAH260352 Date of Collection: 26/6/26 Date of Expiry: 6/6/27

Date & Time of Starting Transfusion: 26/6/26 Planned duration of Transfusion: 8:00 am

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Nurse 2:

Before starting transfusion vitals: Temp: 99.5°C HR 176 RR: 69 BP: 50/4 SpO₂ 90%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
<u>26/6/26</u>	<u>15 Min</u>	<u>176</u>	<u>99°F</u>	<u>59/31/41</u>	<u>90%</u>	<u>NO</u>	<u>NO</u>	<u>NO</u>	<u>NO</u>
	<u>15 Min</u>	<u>168</u>	<u>99°F</u>	<u>65/40/50</u>	<u>92%</u>	<u>NO</u>	<u>NO</u>	<u>NO</u>	<u>NO</u>
	<u>30 Min</u>								
	<u>30 Min</u>								
	<u>30 Min</u>								
	<u>1 Hr</u>								
	<u>1 Hr</u>								

Comments:

NO issue

Name of the Incharge-Nurse: S. S. S. S.

Signature of the Incharge-Nurse: [Signature]

Date & Time: 26/06/26

Name of the Nurse: Rat

Signature of the Nurse: G. Roshni

Date & Time: 26/6/26

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

FRESH FROZEN PLASMA B.P (I)

Qty. 50

O

HIV I & II/ HBsAG/ HCV - Non
reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non
reactive

Unit No.: BAH26-01352
Blood Group: O Rh Positive
Collection Date: 06/Jun/2026
Expiry Date: 06/Jun/2027

1)administer Without Warming. 2)shake Gently Before Use.3)do Not
Add Any Medication. 4)check Blood Group on Label & Recipient's
Group and Name Before Administration. 5)use Sterile Transfusion Set
With Filter. 6)do Not Dispense Without Prescription. 7)do Not Use if
Turbid Evidence. 8)store Between -30° C or Below.

Issue Label / CrossMatching Report

Patient : B/O BHUPANI SHREEYA
Patient's Blood Group : O Rh Positive
Hosp/Dr : Rainbow Childrens Hospital, Dr. Nalinikanth
UHID No.: BAH-00659928 Wd-Bed No.:

Product : FFP-I

Blood Group : O Rh Positive

Unit No.: BAH26-01352

XMatching Report: ABO Compatible

X-matched by: K. Alok

Issue Dt : 26/Jun/2026

Colln. Dt : 06/Jun/2026

Exp. Dt : 06/Jun/2027

Issued By : K. Alok

**Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital**

D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic No. 46/HD/TS/2018/BB/G

Residual
Water Bath

Oral conf taken by Dr Neethu

CONSENT FOR BLOOD TRANSFUSION

Name: B/o Shreeya Age: D 7 Gender: Male ☒ Female ☐
UHID.No: BAH-00659928 Date: 27/6/26

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets
☐ Cryoprecipitate ☒ Single Donor Platelet ☐ Whole Blood
☐ Albumin ☐ Red Blood Cell ☐ Others

I hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Doctor (Who is talking the consent)

Signature: Signature:

Name: Name:

Date & Time Date & Time

Witness

Signature:
↓

Name: Dr. P.

Date & Time 27/6/26

రోగి పేరు: వయస్సు: లింగము ☐ పురుషుడు ☐ స్త్రీ
UHID. సంఖ్య: తేదీ:

రక్త ఉత్పత్తి రకాలు:

☐ తాజా ఘనీభవించిన ప్లాస్మా	☐ ప్లాక్ చేయబడిన ఎర్ర రక్త కణాలు	Random Donor Platelets
☐ క్రయో ప్రెసిపిటేట్	☐ ఒకే ధాత ప్లేటిలెట్స్	☐ Whole Blood
☐ మొత్తం రక్తం	☐ ఎర్ర రక్త కణం	☐ ఇతరులు.....

నేను
ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా
దాత రక్తాన్ని హెచ్ఐవి మరియు
లక్షణాలు లేవని పరీక్షించి బడి
ఇతర ఇన్ఫెక్షన్ దానానికి అనుకూలంగా
ప్రతిచర్యలు సోకే
చేసుకున్నాను.
ఈ ప్రక్రియకు ప్రతిబంధం లేదు.

పైన పేర్కొన్న అన్ని
వివరించబడ్డాయి
ఎర్ర రక్త కణాలు, ప్లాస్మా
నాకు పూర్తిగా అర్థం.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

PLATELETAPHERESIS SDP-1
Qty. 45 ml. Prepared from 1 Human Whole Blood by Apheresis using Cell Separator
Qty. 250 ml ± 20 ml.)

O

HIV 1 & II/ HBsAG/ HCV - Non reactive
VDRL - Non reactive
MP - Negative

Donor Type: Replacement
Unit No.: BAH26-P0151
Blood Group: O Rh Positive
Collection Date: 27/Jun/2026
Expiry Date: 02/Jul/2026

1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not Add Any Medication. 4) Check Blood Group on Label & Recipient's Group and Name Before Administration. 5) Use Sterile Transfusion Set With Filter. 6) Do Not Dispense Without Prescription. 7) Do Not Use if There is Any Visible Evidence. 8) Store Between 2° C to 6° C 9) Appropriate Compatible Cross Matched Blood Without Atypical Antibodies in Recipient Should Be Used.

Issue Label / Cross Matching Report

Patient : B/O BHUPANI SHREEYA
Patient's Blood Group : O Rh Positive
Hosp/Dr : Rainbow Childrens Hospital, Dr. Nalinikanth
UHID No.: BAH-00659928 Wd-Bed No.:
Product : SDP-1
Blood Group : O Rh Positive
Unit No.: BAH26-P0151
X-Matching Report: ABO Compatible
X-matched by: MONOJ
Issue Dt : 27/Jun/2026
Colln. Dt : 27/Jun/2026
Exp. Dt : 02/Jul/2026
Issued By : MONOJ

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2, Banjara Hills, Hyderabad, Telangana State
Lic No. 46/HD/TS/2018/BB/G

ఆసుపత్రిలో అడ్మిట్ అయి
ఓకీ అంగీకారం తెలుపుతున్నాను.
మలేరియా మరియు సిఫ్లిస్
రీకి పరీక్షలో కనబడని అనేక
తృప్తుల మార్పిడికి సంబంధించిన
మరింత వివరాలు అని నేను అర్థం

డాక్టర్ ద్వారా నాకు
ఓత్పత్తులు ప్లాక్ చేయబడిన
రక్తం తెలుపుతున్నాను.

నేను

సమయము

BAH-00650928
Baby Of BHUPANI SHREEYA
20-08-2026
Dr. NALINIKANTA PANIGRAHY
IP5-00175616
O Y O M 7 D
(M)

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 27/6/26 Time: 5pm

Blood Group of the Patient: O+ve Blood Group on the Blood Bag: O+ve

Blood Bank Issue No: BAH26-P0151 Date of Collection: 27/6/26 Date of Expiry: 2/7/26

Date & Time of Starting Transfusion: 22/6/26 Planned duration of Transfusion: 30 mins

Check for Correct Unit: ☐ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Dr - Faiz Nurse 2: Sh - Dipp

Before starting transfusion vitals: Temp: 98.6°F HR: 145 RR: 37 BP: 59/39(47) SpO₂: 98%.

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
27/6/26	15 Min	162	98.6°F	54/32(40)	96%.				
11	15 Min	134	98.7°F	55/27(38)	97%.				
12	30 Min	142	98.6°F	65/39(48)	96%.				
	30 Min								
	30 Min								
	1 Hr								
	1 Hr								

Comments: No any complications during transfusion

Name of the Incharge-Nurse: Shilpa

Name of the Nurse: Dipp

Signature of the Incharge-Nurse: [Signature]

Signature of the Nurse: [Signature]

Date & Time: 27/6/26 5pm

Date & Time: 27/6/26 5pm

BAH-00559928
Baby Of BHUPANI SHREEYA
20-06-2026 0 Y 0 M 6 D (M)
Dr. NALINIKANTA PANIGRAHY

CONSENT FOR DONOR BREAST MILK

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name : B/o Bhupani Shreeya Age : 6 days Gender : ☒ Male ☐ Female
UHID No : 659928 Department : NICU 4 Date : 26/06/2026
I Mr / Mrs : Sridhara . aged years, hereby declare that I have
admitted my ☒ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on
25/6/26 I hereby give consent for Donor Breast Milk for my child. Doctors have explained me
about the Donor Breast Milk feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : [Signature]
Name : M. Sridhara
Relationship with Patient : Father
Date & Time : 26/6/26

Witness :

Signature : [Signature]
Name : Diphu
Date & Time : 26/6/26

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Dr. Nalinikanta Panigrahy
Date & Time : 26/6/26