

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176046

Admit Date : 06-Jul-2026

Admit Time : 04:11 PM **UHID** : BAH-00660870

Patient Details :
Patient Name : Baby Of YANAMALA RAJANI TWIN 1

Age : 0 D

Guardian : Mr OBULAM SUDHEER REDDY

DOB : 06-07-2026 01:00 AM

Gender : Male

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO 21/470, TERU ROAD, 1ST LINE
 Jammalamudugu North Cuddapah Andhra
 Pradesh INDIA 516434

Phone No : 7093381580/ 9959557783

E-mail : RAJANI.YANAMALA@GMAIL.COM

Admission Details :
Bed Type : NICU

Bed No : NICU 279

Ward Name : 2F-NICU 4

Room No : NICU 279

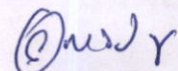
Admission Type : First Visit

Contact Details :
Name : Mr OBULAM SUDHEER REDDY

Relationship : Father

Contact Address : H NO 21/470, TERU ROAD, 1ST LINE
 Jammalamudugu North Cuddapah Andhra
 Pradesh INDIA 516434

Phone No : 7093381580


 Signature

Doctor Details :
Doctor Name : Dr. DINESH KUMAR CHIRLA

Specialisation : NEONATAL INTENSIVE CARE

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

AH-00660870 IP5-00176046
Baby of YANAMALA RAJANI TWIN 1
0-07-2026 0 Y 0 M 0 D 15 H (M)
r. DINESH KUMAR CHIRLA



RECORD FOR BILLING

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Name : Bb. Rajani Twin - (1)

UHID No. : _____ IP No. : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____ Date of Discharge : _____ Time: _____

Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

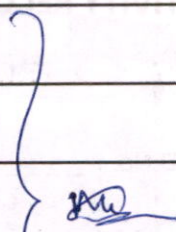
WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
16/7/26	6pm	NICU	326	Mish
21/7/26	7:35pm	NICU	330	df

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
6/7/26	VBG / RBS	26067701	
"	Blood Culture / sensitivity	26067702	
"	Blood Grouping	26067705	
"	x-ray	033611	
8/7/26	RBS	26068765	①
8/7/26	NBS	26068419	①
9/7/26	RBS	26068498	①
11/7/26	RBS	26069276	
12/7/26	GRBS		①
13/7/26	RBS	26069943	①
13/7/26	Np1	26070143	①
14/7/26	RBS	26070413	①
16/7/26	RBS	26071146	①
17/7/26	NBS 2D echo	035706	①
17/7/26	RBS (88mg/dl) 7.15pm		manu
18/7/26	RBS	26071966	①
18/7/26	CRP, CBP	26071973	①
19/7/26	RBS	26072376	①
20/7/26	RBS, NP2	260725820004	①
21/7/26	RBS	26073030	①

[illegible]

[illegible]

Prepared By :

Billing Supervisor

[illegible]

AH-00660870 IP5-00176046
Baby of YANAMALA RAJANI TWIN 1
8-07-2026 0 Y 0 M 0 D 15 H (M)
r. DINESH KUMAR CHIRLA

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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Blo. Rajani T-2 Age : Father's Name : Age :
Date of Birth : 06/07/26 Date of Admission : 06/07/26 UHID No. : 660890
NICU Consultant : Dr. D. K. Sr. Referring Consultant :
Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward
Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : Blo. Y. Rajani Twin-1 Mother's Blood Group : B
Gender : ☒ M ☐ F Blood Group : Birth Weight (gms) : 1.87kg Length (cms) :
Date of Birth : 6/7/2026 Time of Birth : 2:46pm OFC (cms) :
Place of Birth : Saikhon Hosp, Lakshitapool Estimated Gesth Age : 33+2wks

Current Obstetric History : (Booked / Unbooked Case) LMP : EDD :

Maternal Age : 39yrs Ht : Wt : BMI : Married Life :
Conception : Spontaneous or with Rx. : Surrogacy AN Steroids Drugs / Doses : 2 doses Steroid - last dose
Booked at what GA : TT Immunization and Iron / Folic Acid :
Last Scans Details : AFI - Oligo, EFW = 1887g $\pm$ 256g, Cephalic, 10cm
MEDA twins 06/7/26

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 : 24hrs ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results :
Medication during Pregnancy : Duration :

Docu. No. : RCHBH / FRM / CLINICAL / 129(26)

Page: 1/8

(P.T.O.)



PAST OBSTETRIC HISTORY



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 65/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 : Auscultation: Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : BP : Precordial Activity :

Femoral Pulses : Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

ABDOMEN:

Shape : Hernia orifice :

Palpation : Anal Patency : ☒

Palpable masses : Umbilical Cord :

Abdominal girth : First urine passed : Perine not passed

Meconium passed : not passed

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness : CTHA - good!

Prechtle Score :

Nerves : Dilatation of pupil

MOTOR SYSTEM:

Passive Tone : ☒

Active Tone :

Neonatal Reflexes :

Grasp : ☐ Palmar ☐ Plantar ☐ Sucking ☐ Rooting ☐ Crossed adductor :

Moro's : DTR :

ATNR : Skull and Spine :



Diagnosis :

Moderate preterm [AIA] PPRG (m LCC),
mch [1.82kg], mltz H/O- PPRGM-24 hrs/. RD

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

Pawan
Pawan

7/7/26

Consultant :

Signature :

Name :

Date & Time :

Dr. DINESH KUMAR CHIRLA
Reg. No: 66227

Dr. Dinesh
7/7/26

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.

AH-00660870

IP5-00176046

Baby Of YANAMALA RAJANI TWIN 1

8-07-2026

0 Y 0 M 0 D 15 H (M)

r. DINESH KUMAR CHIRLA



THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:

B204. Rakni Train-I
 Patient's Sister
 330
 BAH-10660870

DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	2			
5	In-patient Medical record	1			
6	Doctors progress sheets	3			
7	Nursing plan of care and handover sheets	16			
8	Consultation sheet	6			
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed	1			
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation				
24	Emergency Triage record				
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation	18			
29	TPR & BP chart	2			
30	Intake and Out take chart (fluid chart)	8			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	7			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU	1			
37	The Humpty dumpty scale				
38	Braden Q Scale				
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
Total No. of Pages		101			

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /

2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

1. Rajani Twin 1.
 AH-00660870 IP5-00176046
 Baby Of YANAMALA RAJANI TWIN 1
 8-07-2026 0 Y 0 M 0 D 15 H (M)
 R. DINESH KUMAR CHIRLA

①



GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26		Plan,
	→	CPAP - SOS.
	→	TV - 60cc/kg/day. Full OG feed. (after DBM consent) 10ml/2nd hly.
	LUS - 5/10. RBS - 108mg/dl.	→ CBG / RBS - now.
	→	CBP } new Blood cts }
	→	Start PIPTAZ
	→	Chest X-Ray if RDE.
	→	RBS - 6th hly.
	RT Lt	Noted by Sr. 2 @ 8 AM 05/08/26
	LUS ' 4-5 mg/dl	



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H/H/26

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

Day in NICU: Day of Life: 18.HOL PMA:

Term ☐ Preterm ☒ Gestation: 33^{1/2} wks Corrected Gestational Age: Today's Weight: 1.81 kg
(4270g)

Problems		
S.No.	Current	Past Problems
1.	Mod. preterm (AUA), MCDA T1	
2.	H/O-PPROM-24hrs	
3.	Suspected Sepsis (oligo)	
4.		
5.		
6.		

Clinical Assessment	Baby is on RA. Hemodynamically stable. On full O4 feeds. Passed urine, meconium. RBS - 80mg/dl. HR - 119/min. RR - 42/min. SpO₂ - 98%. BP - 58/43 (46)
Medications Used	Swi-PIPTAZ-D₂

Plan of Care:

- TV - 60cc/kg/day → 10ml/2nd hly. full O4 feed. (EBM/DBM).
- NP₁ @ 24HOL.
- Trace blood clts and R/v antibiotic.
- RBS - 6th hly.

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

Signature: [Signature]

Date & Time: 7/7/26 9am.

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:

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
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:

AH-00660870 IP5-00176046
 Baby Of YANAMALA RAJANI TWIN 1
 3-07-2026 0 Y 0 M 0 D 15 H (M)
 Dr. DINESH KUMAR CHIRLA



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 1pm	NO Afternoon Round.	
	Baby is on RA. No desat (beady)	
	Vitals	Plan.
	HR - 120/min.	
	RR - 42/min.	→ TV - 80cc/kg/day.
	SpO ₂ - 96%.	12ml/2nd hly
	BD - 69/53 (sb)	full O ₂ feed.
	GRBS - 86 mg/dl.	
	U/O -	→ NSC today
	P/A - soft,	→ Send NPi @ 3pm.
	tolerating feed.	→ Trace blood c/s.
		→ RBS - 6th hly.
		→ w/A beady / desat
		→ Give KMC.
		→ Monitor vitals
		→ E/o chattering 6th hly
	Dr. Deepthi	
		NiO Nucleus 1pm





8/7/26.

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

Day in NICU: Day of Life: 42 H 0 L PMA: 33 wks

Term ☐ Preterm ☐ Gestation: 33 wks Corrected Gestational Age: Today's Weight: 1827g

Overview	Problems	
	S.No.	Current
Overview	1.	Mod preterm / PCAA / MCDA Twin 1
	2.	Suspected sepsis
	3.	NNJ
	4.	
	5.	
	6.	

Clinical Assessment
Baby is on RA SBR at 24 H 0 L → 7.6 (PT-5.8) on DSPT. HR-131/min RBS-88mg/kg RR-42/min SpO₂-100% U/O - 1.7cc/kg/hr Stools - passed

Medications Used
• Inj-PIPTAZ-D3

Plan of Care:
• Continue DSPT till 3pm.; TR-100cc/kg/day • R/V SBR, NBS @ 48 H 0 L. 15ml/2 hourly • Trace blood c/s & review antibiotics • R/V KMC after stopping phototherapy • Monitor vitals • R/V RBS - 8th hly.

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

Signature: [Signature]

Date & Time: 8/7/26

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

Signature: [Signature]

Date & Time: 8/7/2026



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/2/26 10:30		Seen by Dr. Dinesh Ch
		→ Continue DSPT
		→ SBR, NBS at 3pm.
		→ w/f - RD
		Try 1 Paladay feed
		1 hour KMC <i>frank</i>
8/2/26 @ 2:10pm	<u>Afternoon Rounds</u>	
	⊙ Baby on Room air.	Plan.
	No desaturation.	
	→ Took 1 paladay feed	1) TV = 100mb/kg/day
	well with minimal	15mb 2nd half
	spilling	full OG feed.
		Try - another Paladay
		2) Trace - B/C/S
	⊙ vitals: RR = 114/min	
	RR = 39/min	3) SBR, NBS at 3pm
	SpO ₂ = 98%	
	BP = 51/29 (36)	4) RLV on phototherapy
		after SBR.
	1 hour KMC - done 1 hour.	
		5) w/f - RD.

AH-00660870 IP5-00176046
 Baby Of YANAMALA RAJANI TWIN 1
 3-07-2026 0 Y 0 M 3 D (M)
 r. DINESH KUMAR CHIRLA



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

Day in NICU: Day of Life: 67 PMA: 33+4 wks
 Term ☐ Preterm ☐ Gestation: 33+2 wks Corrected Gestational Age: Today's Weight: 1.804 (1.33)

Problems		
S.No.	Current	Past Problems
1.	Mod Preterm / AGIA / MODATWIN 1	
2.	Suspected Sepsis	
3.	NNJ	
4.		
5.		
6.		

Clinical Assessment	Baby is on RA. SBR - 7-2 DSPT > SSPT Accepted 2 paladay - well 1 paladay - slowly spilling. Erythematous-macular rash
Medications Used	Inj - Piptaz (D3)

Plan of Care:	1) TV = 120ml/kg/day - 18ml 2 paladay Rest on feeds. 2) Trace - NBS 3) Stop SSPT at 12pm 4) w/f - RD, abdominal distension Trace - B/c/s KMC to Continue OMS.
---------------	--

Doctor's Name (Hand over given): Y. Sneha
 Signature: Sneha
 Date & Time: 9/7/26
 Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):
 Signature:
 Date & Time:

AH-00660870
aby OYANAMALA RAJANI TWIN 1
3-07-2026 0 Y 0 M 3 D
r. DINESH KUMAR CHIRLA (M)



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:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 @ 9:50 PM		Seen by Dr. Dinesh S.
		1) Stop phototherapy
		2) After Bld's - Sterile Stop antibiotic.
		3) Try paladay feeds.
		4) KMC.
		5) Trace NBS.
9/7/26 2 PM	Afternoon Round.	Plan.
	Baby is on RA. Hemodynamically stable. Accepted 2 paladay feeds over 30 mins, but significant spillage.	TV - 120 cc/kg/day. 18 ml/2nd hly full. O4 feed.
	Vitals - stable.	→ Continue KMC, OMS.
	P/A - soft.	→ Trace NBS.
		→ GRBS - 12 th hly.
		→ Monitor vitals.
	Dr. Proople	Noted By Megha



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

Day in NICU: Day of Life: 4 PMA: 38 + 6 wks
Term ☐ Preterm ☒ Gestation: 33 + 2 wks Corrected Gestational Age: Today's Weight: 1.785 (1250g)

		Problems		
		S.No.	Current	Past Problems
Overview	1.		Mod Preterm / AGA / MODA Twin 1	
	2.		Suspec. Sepsis	
	3.		NNS	
	4.			
	5.			
	6.			
Clinical Assessment	Baby on Room air. No Resp. distress. 3 paladay feeds - taken well. Icteric (+) No vomit RR = 129/min RR = 50/min SpO₂ = 93%.			
	Medications Used	Stopped antibiotic.		
Plan of Care: 1) TV = 140 cc/kg/day = 21ml 2nd hrly Try 5-6 paladay feeds Rest (OG). 2) clinical assessment of Jaundice Trace - NBS KMC ONS to Continue				

Doctor's Name (Hand over given): T. Sneha

Signature: Sneha

Date & Time: 10/7/26

Doctor's Name (Hand over taken): D. Sreelakshmi

Signature: [Signature]

Date & Time: 10/7/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26		Discharge TBR To give 5-6 PR KMC OMS NNS Dr. MVB PRATHYUSH Registration No. TSMC/FMR/30300
16/7/26	Afternoon Rounds Baby hemodynamically stable on air. tolerated feeds 18ml 2hrly no vomit SpO₂ - HR - 125/min RR - 30/min SpO₂ - 95%. Taken 2 packets well each - 20-30mls	Plan 1) TV - 140 ccl/kg/day 2) 2130ml 2hrly, total 5-6 packets today 2) Continue KMC, OMS, NNS 3) Terece NBS 4) w/F. Bradycardia / apnea / desaturation / non



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

Day in NICU: Day of Life: 5 PMA: 34 wks.

Term ☐ Preterm ☐ Gestation: 33+2 wks Corrected Gestational Age: Today's Weight: 1758g (↓29g)

		Problems	
	S.No.	Current	Past Problems
Overview	1.	Mod PT / ACIA / MCDA-Twin 1	Suspected sepsis
	2.		NNJ
	3.		
	4.		
	5.		
	6.		
Clinical Assessment	Baby is on RA. Hemodynamically stable. Acceptable. 6 paladay feed over 20-25ml/h. No vomitings HR-121/min. RR-49/min. SpO₂-96/ BP-58/37(42)		
	Medications Used		
Plan of Care: - TV- 160cc/kg/day → 25ml/2nd hely. 6 paladay feed - RIV of paladay feed - kmc oms } to continue NNS - Trace NBS 5) w/f bradycardia/desaturation			

Doctor's Name (Hand over given): Dr. Dinesh Kumar Chirala

Signature: [Signature]

Date & Time: 11/7/26

Doctor's Name (Hand over taken): Dr. [Signature]

Signature: [Signature]

Date & Time: 11/7/26

12/07/26

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

Day in NICU: Day of Life: 6 PMA: 34⁺
 Term ☐ Preterm ☐ Gestation: 33⁺2 Corrected Gestational Age: Today's Weight:

Problems	
S.No.	Current
1.	Moderate PT / AGA / LRW
2.	MCDA Twin 1
3.	
4.	
5.	
6.	

Past Problems	
suspected sepsis	
NNJ	

Overview	

Clinical Assessment	
	Baby on Room air NO RO / NO desaturation Tolerated full paladi feeds Each feed 15-20 minutes NO desaturation while feeding Paired urine & stool
	SpO ₂ : 96% PR: 136/min RR: 46/min BP: 64/31 (39) mmHg CRT < 3 sec

Medications Used	

Plan of Care:	
1) TV = 160 cc/kg/day → 25ml Q2H · full paladi feeding	
2) kmc oms NNS	to continue
3) w/f vomiting / RO / desaturation	
4) NSG 2D Echo	before discharge

Doctor's Name (Hand over given): Saiteja
 Signature: [Signature]
 Date & Time: 12/7/26
 Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken): Dr. Ashwanga
 Signature: [Signature]
 Date & Time: 12/7/26

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:

AH-00660870 IP5-00176046
 Baby Of YANAMALA RAJANI TWIN 1
 8-07-2026 0 Y 0 M 0 D 15 H (M)
 R. DINESH KUMAR CHIRLA



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 Hospital
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/7/26		Seen by Dr. Dinesh Sir
		→ Dress baby.
	wt-loss 25%.	→ TV-180cc/kg/day.
		↓
		28ml Q2H
		full paladi feeding
		noted by submit 12/7/26 @
12/7/26 7PM	evening notes.	
	Self ventilating on RA.	Plan
	KMC ongoing	① cont RA
	HR-127/min	② TV=180 ml/kg/day
	RR-32/min	28ml Q2H full
	SpO ₂ -94%.	paladay
	taken paladay well	③ NSH before ①
	RA soft	20cc/kg
	Passing stools	④ cont KMC
		noted by submit 12/7/26 @

[Signature]

⑧



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BAH-00660870 IP5-00176046
 Baby Of YANAMALA RAJANI TWIN 1
 08-07-2026 0 Y 0 M 6 D (M)
 Dr. DINESH KUMAR CHIRLA

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

Day in NICU: Day of Life: 7 PMA: 34+2

Term ☐ Preterm ☐ Gestation: 33+2 Corrected Gestational Age: Today's Weight: 1735 (969)

S.No.	Problems	
	Current	Past Problems
1.	Mom PT / AGA / LBW.	Suspected sepsis
2.	MCDA Twin - 1	NNS
3.		
4.		
5.		
6.		

weekly - $\downarrow 135g \Rightarrow 7.2\%$

Overview	Clinical Assessment	Medications Used
	Accepting full paladay feed. HR - 125/min. RR - 40/min. SpO ₂ - 95%. BP - 61/50(52)	
Plan of Care: • TV - 180cc/kg/day $\Rightarrow$ 28ml/2nd hly R/v to add fortification. • Continue kmc. • Monitor vitals.		

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

Signature: [Signature]

Date & Time: 13/7/26

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:

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:

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

Doctor's Name (Hand over taken):

Signature:

Date & Time:



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Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



(a)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		→ Send NP ₁ today now
		→ Add fortification today
		date/box Navy. S 13/7/28
13/7/26 5pm.	Afternoon Round.	
	Baby is on RA. Hemodynamically stable. Accepting paladay feeds well.	Plan: TV - 180cc/kg/day 28ml/2nd help + Hm R
	Vitals HR - 137/min. RR - 38/min. SpO ₂ - 97%. BP - 58/41 (46)	full paladay feed.
	P/A - soft, non distended	✓ Trace NP ₁ report ✓ Continue KMC. OMS.
		✓ Monitor vitals
	Dr. Populhe	noted By #/Julya



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

Day in NICU: Day of Life: 8 PMA: 34⁺3
 Term ☐ Preterm ☒ Gestation: 33⁺2 Corrected Gestational Age: Today's Weight: 1.727 (↓ 8g)

Problems	
S.No.	Current
1.	mod PT / AEA / CBW
2.	NNT
3.	
4.	
5.	
6.	

Overview	Past Problems
	respected sepsis

Clinical Assessment
Baby on Room air Hemodynamically stable Tolerating full orally with fortification

Medications Used
SPO ₂ : 96-1. PR: 145/min RR: 47/min BP: 68/47 (55/min Hg)

Plan of Care:
1) TV = 180 cc/kg/day → 28ml O ₂ H + 11ml each feed 2) continue SSPT with eye and genital care 3) continue KMC, OM 4) vital monitoring 2nd hourly. 5) R/W SBR

Doctor's Name (Hand over given): Neethu

Signature: [Signature]

Date & Time: 14/7/26

Doctor's Name (Hand over taken): Sarthy

Signature: [Signature]

Date & Time: 14/7/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Seen by Dr. Dinesh sir
		→ Tr = 190 c/kg/day 30ml O ₂ H palady feed
		→ Involve mother in feeding
		→ Stop SSPT by night 8pm
	Noted by Nithu	
14/7/26 3pm	After noon rounds	Plan
	Baby on room air No RPI no desaturation Accepting full palady feeds	1. Tr = 190 c/kg/day 30ml O ₂ H palady feed
	ongoing phototherapy SpO ₂ : 99.1 PR: 146/min RR: 46/min Bp: 67/48 (54) mmHg CRT < 3 sec	2. SSPT with eye and genital cone till 8pm 4pm 3. Involve mother in feeding 4. continue - KMC - Oms before each feed
	mother given 2 feeds Desaturation upto 84.1.	5. vital monitoring @ 4pm 6. wif RPI desaturation

Dr. Saiteja



7. DINESH KUMAR CHIRLA



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



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Date & Time	Progress Notes	Doctor's Order
11/7/26.	B/o <u>Rajani</u> Twins	
	→ Stable on RA	
	→ Tolerating feeds.	
	→ Minimal wt. loss.	
	→ To get involved in feeding.	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/8/26	Bo <u>Ragani</u> twins Twin 1 Accepting full paladay. feed. Stable.	Twin 2 Difficulty feeding paladay. to continue OG feed til 1.5kg

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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

Day in NICU: Day of Life: 9 PMA: 34+4

Term ☐ Preterm ☒ Gestation: 33+2 Corrected Gestational Age: Today's Weight: 1.746 (195)

Problems		
S.No.	Current	Past Problems
1.	Mod PT / AGIA / LBW	Suspected Seps 4
2.	NNJ	
3.		
4.		
5.		
6.		

Clinical Assessment
Baby on room air hemodynamically stable - accepting full paladay feeds Passing urine/stool P/A - Soft

Medications Used

Plan of Care:
1) TV = 190ml/kg/day 30ml 2nd hly + 1 HMF. Paladay feed 2) SSPT with eyes & genital Coib care. 3) RU on formula feed. OMB to continue,

Doctor's Name (Hand over given): Pooja Sreha

Signature: Sreha

Date & Time: 15/11/26

Doctor's Name (Hand over taken):

Signature:

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Formula feeds
		Shift to room
		<u>Snack</u>
15/7/26 1:40pm	Afternoon Round	
		<u>Plan</u>
	Baby on room as hemodynamically stable	→ TV-190 cells/day 30ml/2 nd half + 1HMF each feed.
	HR - 136/min. SpO ₂ - 100%	- full palpable
	→ 1 episode of vomiting post feed (milk) c-formula	→ continue KMC/oms before/with
	- P/A - soft	- monitor vitals
	→ passing urine/stool	- I/O charting
	GRBS - 102mg/dL	→ GRBS - DD
		→ 2D Echo and USG-abdomen before scan
		Parent

noted by
poor



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

Day in NICU: Day of Life: 10 PMA: 34+4
 Term ☐ Preterm ☐ Gestation: 33+2 Corrected Gestational Age: Today's Weight: 1.753 (779g)

Overview	Problems	
	S.No.	Current
1.	Mod PT / AGA / LBW	Suspected Sepsis
2.	NNS	
3.		
4.		
5.		
6.		

Clinical Assessment
Baby under warmer care. No tachycardia HR = 147/min NO Resp. distress SpO ₂ - 95% BP

Medications Used
Nutritional Calculation Today & add Supplements

Plan of Care:
1) T _v = 190ml/kg/day - 30ml 2nd hrly formula feed 2) Today USG-abdomen, 20echo, full paladay / Bottle feeds 3) Gib care. Now. 4) Rlv shifting to Room I/O charting 5) ROP on DOL-21 - KMC, OMS. GIRBS - O.D.

Doctor's Name (Hand over given): Y. Sneha

Signature: Sneha

Date & Time: 16/7/26

Doctor's Name (Hand over taken):

Signature:

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/26 @ 10:13		Seen by Dr. Pathyush
		1) Grib care.
		2) Cont KMC.
		3) f Do-USG- abd 2D echo
		4) Plan shifting in evening
		Dr. Pathyush
		noted by Dr. Pathyush 16/7/26 @ 10:13 AM
16/7/26 5:30 PM	<u>SHIFTING NOTES</u>	<u>Plan</u>
	PHOC, 37 th wks, 1.87 kg → TV - 190 cel/kg/day → 1 HMA	
	mod PT / A 4 A / 4 BW	30 ml / 24 hrs - full paleo diet
	Baby on room air	→ continue KMC / OMS
	hemodynamically stable	→ 2D Echo - TM / today
	tolerating feeds well	→ CRBS-OD
	PIA - soft	→ I/O charting @ 6 th hrs
	passing urine / stool	→ Vaccination
	USG- abd - (N)	BCG / OPV / HepB after
	NBS - ✓	→ AABR - after shift out
		→ monitor temperature /
		@ 4 th hrs
		→ Inform @ temp < 97.5

3AH-00660870 IP5-00176046
 Baby Of YANAMALA RAJANI TWIN 1
 18-07-2026 0 Y 0 M 6 D (M)
 Dr. DINESH KUMAR CHIRLA



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Scan by Dr. Soumya
		Plan
1st shift 9:50 PM	Temp → 36.35.6°C Cold Peripheries	→ Remove from crib Case
	HR - 138/min SpO2 98%	→ Keep baby under warmer
	Activity - Good Peygusion - Good	→ Give now ^{102mg} 102mg DL
	↓	→ Plv case 7m after Ponds.
	Temp @ 11 PM 98.8°F	→ Check temp after half hour
		Noted in skin @ 10 PM 15th

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/26 8:40Am	Seen by Resident DOL-11 / 33 ⁺ 2 / mod pt / AGA / LBW / 1.794 (920 gm) 6 Am Temp → 96.6°F → KMC given Baby on Room air Hemodynamically stable NO ROL / NO desaturation Accepting feed well NO Vomiting Euthermic Euglycemic Vitals: stable GRBS → 92 mg/dl CRT < 3 sec peripheries: warm Passed urine & stool	Plan 1. Tr = 190 cc/kg/day ↓ 30ml O ₂ H + 1Hmf each feed full paladi 2. BCG, Dpr, Hepatitis B today Given on 17/7/26 Yadav 3. GRBS OD 4. AABR today 5. 2D Echo today 6. I/O Charting Q6H 7. Temperature Charting 8. w/f ROL Hypothermia 9. KMC to continue
	Seen by Dr pines h	Shy Sairajen
		→ Temp. charting & Temp care → wrap baby



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		17/7/26
		AABR- Hearing Assessment
		Bilateral responses are present
		Bilateral Normal
		pinku.
17/7/26 4pm	Seen by Resident	
	Baby on Room air	plan
	Hemodynamically stable	
	Documented temperature	1. T _{re} 190 cc/kg/day
	@ 3pm → 96.8°F	↓
	↓	30ml O ₂ H + 10mlf each feed
	Kmc given	full pabadi
	Now Temperature 97.9°F	
	Peripheries warm	3. GRBS OD
	Pink	3. 2D Echo to be done today
	CR7 < 3 sec	4. Temperature charting
	Accepting feeds well	5. warmth care
	Last feed finished within 10-15 min	- 3 layered baby wrapping
	SpO ₂ : 98%	- (Kodlen cloth)
	PR: 139/min	6. Kmc to continue
	RR: 49/min	7. Wt Hypothermia
	CRT < 2 sec	⊕ Urine output
	Passed urine & stool	
	Vaccination done	Saiteja
	AABR	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/26 5pm	seen by Dr. Dinesh	→ DBF/Ht 45ml 3H → If any further Hypothermia Repeat RBS Shift to NICU LOS in night
18/7/26 12AM	<u>Night Rounds</u> Baby stable on warmer Taking palladan 45ml 3hly No vomity	Seen by Dr. A. Lesh - Continue nursing on warmer crib came from GAM T10 ↓ In crib care temperature yearly ably during feeding time - If any episode of hypothermia check RBS, CBP, CRP - GRBS ON - Monitor vitals Noted by Ajay 18/7/26



BAH-00666870
Baby Of YANAMALA RAJANI TWIN 1
06-07-2026 0 Y 0 M 6 D (M)
Dr. DINESH KUMAR CHIRLA



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[illegible]



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[illegible]

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

Day in NICU: Day of Life: 12 (12) PMA: 34+6 weeks
 Term ☐ Preterm ☐ Gestation: 33+2 Corrected Gestational Age: Today's Weight: 1.824 (130g)

	Problems		
	S.No.	Current	Past Problems
Overview	1.	Mod. Preterm / AGA / LBW	
	2.	NNS	
	3.	Cold stress	
	4.	Suspected Sepsis	
	5.		
	6.		
Clinical Assessment	Baby on Room air . Peri-warm, Pink . HR = 131/min SpO₂ - 92% Temp - 98.8°F . RBS 89mg/dl Vaccination - done ABBR - Normal .		
Medications Used			
Plan of Care: 1) Tn = 190mc/kg/day - 3omb 2nd brly + 1HMF . 2) Cont. KMC, OMS . 3) Trace- CBP, CRP 4) Warm care . 5) wif - Hypothermia Full paladay No charting activity, distress			

Doctor's Name (Hand over given): Y. Socha

Signature: Socha

Date & Time: 18/7/26

Doctor's Name (Hand over taken): Neelam

Signature: Neelam

Date & Time: 18/7/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/26 9:45 AM	Seen by Dr. Pachyush Baby had hypothermic dry care CBP, CRP (N)	Dr. Pachyush start on care proper socks, mittens, headcap ↓ HOLD
18/7/26 10 AM	Noted by Poojitha 18/7/26	Seen by Dr. Dinesh Fix the nesting Continue warmer care
18/7/26	Afternoon rounds	Plan
	Baby on room air Temp - 36.3°C HR - 140/min SpO ₂ - 91% - taking paladai for No vomitings / spit out PIA - soft Passing urine / stool	Cont TV - 140 cal/kg/day 30ml/2nd hrs + 1g NISOLIN each feed - full palate CARBS - ON cont Kmc/ONS I/O charting as 6th W/R - RD / apnea / brachy

VENKAT KUMAR CHIRLA

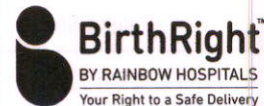
IP5-00176046

Baby Of YANAMALA RAJANI TWIN 1
06-07-2026

06-07-2026

0Y0M9D

(M)



—

9/7/26
9. 2003

noted by
Pujitha
18/7/22

Seen by Dr. Dinesh Kumar

Send NP2 - Tim Baum

Grip care afternoon

Noted by
Pugilth
19/7/26
@ 9:30am



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



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BAH-00660870 IP5-00176046
 Baby Of YANAMALA RAJANI TWIN 1 (M)
 06-07-2026 0 Y 0 M 11 D
 Dr. DINESH KUMAR CHIRLA

ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: 13 PMA: 35 wks
 Term ☐ Preterm ☐ Gestation: 33+2 Corrected Gestational Age: Today's Weight: 1.887 (163g)

Overview	Problems		
	S.No.	Current	Past Problems
	1.	Mod. Preterm / AGA / LBW	
	2.	NNI	
	3.	Cold stream	
	4.	Suspected sepsis	
	5.		
	6.		

Clinical Assessment	Baby stable on room air Marking temperature under warmer care. Potentially feeds <u>45</u> ml 3hrly, no vomiting No bradycardia / desaturations / apnea. S/E - RR - 135/min HR - 42/min SpO₂ - 94%.
---------------------	---

Medications Used	Vit D₃ drops LRBS - 73 ml
------------------	--

Plan of Care:

- 1) TV - 190 cal/kg/day - 45 ml 3hrly full preterm feeds
- 2) Continue KMC - oms
- 3) Crib care in the afternoon
- 4) NP2 TLM
- 5) CRBS OD
- 6) w/f hypothermia / apnea / Bradycardia / desat

Doctor's Name (Hand over given): D. Sathya

Signature: [Signature]

Date & Time: 19/7/26

Doctor's Name (Hand over taken): Sathya

Signature: [Signature]

Date & Time: 19/7/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/7/26 2:30pm	Afternoon rounds	Plan
	Baby on room air	
	hemodynamically stable	TV - 190 c/min/day
	- maintaining	45 ml/3 rd hrs
	temp - 36.4° C	full palatal feed
	HR - 136/min	
	SpO ₂ - 95%	- continue KMC/oms
	- taking palatal	> NP ₂ - TLM
	well.	
	- passing urine/stool	> CRBS - ON
	PIA - soft	
		> crib care NOW
		- WIA - hypothermia/
		apnea / bradycardia / bleed
	noted by	
	Pujatha	
	19/7/26	
	@ 2:30pm	
		Pamer



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

Day in NICU: Day of Life: 14 PMA: 35¹/₂ wks

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight: 1.970

(183g)

Overview	Problems	
	S.No.	Current
	1.	mod. preterm / AHA / LOW
	2.	NNJ
	3.	Cold Stress
	4.	Suspected Sepsis
	5.	
	6.	

Clinical Assessment	Baby on room air maintaining temperature - $>97^{\circ}\text{F}$. $\downarrow$ crib cover tolerating feeds well. no vomiting / bradycardia / apnea.
---------------------	---

HR - 140/min
 SpO₂ - 94%

Medications Used	<u>VitD₃</u>
------------------	-------------------------

CRBS: Hmgid
 Temp = 97.6°F

Plan of Care:	TV = 140 cal/kg/day - 47ml / 3 rd hly - full paladai/feeds - continue KMC/oms - Crib Cover - Trace NP ₂ - w/r - hypothermia / apnea / brady / desat
---------------	---

Doctor's Name (Hand over given): Pavani

Signature: Pavani

Date & Time: 20/7/26

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

Doctor's Name (Hand over taken): Y. Sneha

Signature: Sneha

Date & Time: 20/7/26

BAH-00660570 IP5-00176046
Baby Of YANAMALA RAJANI TWIN 1
08-07-2026 0 Y 0 M 13 D (M)
Dr. DINESH KUMAR CHIRLA



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:



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 10 AM		Seen by Dr. Pradyumn
		- Cnb care
		- Monitor temperature till today evening every 2 hrs
		- Plan to shift to room in the evening
		- Rop - Day 2 of life 21
		- KMC, NNS
		OMS
	Nutrition Calculation	Noted by Dr. Pradyumn
		Wt = 1.97 kg
	Kcal Pro Ca P Fe vit D	
FF (376ml)	300.8 10.4	376 188 5.26 360.96
80/2.7/100.1/50/		
1.4/96		
VIT D		400
	300.8 10.4	376 188 5.26 360.96
		287.7
Per kg	152.6 5.27	190.8 95.4 2.67 386.27



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 @ 2pm	Afternoon Rounds	Plan
	Baby on Room air No Brady cardia No desaturation ↓	1) GTU = 190 ml/kg/day 47ml 3rd hrly Full paladay Bottle feeds
	Under crib care Axillary Temp - 97.8°F Baby - active	2) wlf apnea, Brady, dg
	<u>Vitals</u> HR - 143/min SpO ₂ - 94%	3) ROP next Thursday (or on DOL-2)
	Accepting & tolerating feeds well P/A - Soft	4) check Axillary temp uthrly & document
	Stool, urine passed	5) monitor vitals wlf - apnea, Brady, desaturation
	Noted by <i>Yamuna</i> 20/7/26 @ 2pm	<i>Sneha</i>
		Noted by <i>Dypt</i>
		Give 2nd hrly feeds.

21/7/26

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

Day in NICU: Day of Life: 15 PMA: 35⁺3 wks
 Term ☐ Preterm ☐ Gestation: 33⁺2 wks Corrected Gestational Age: Today's Weight: 1.0990C120g

S.No.	Problems	
	Current	Past Problems
1.	mod. preterm / AGA / LBW	
2.	NNJ	
3.	cold stress	
4.	superficial sepsis	
5.		
6.		

Clinical Assessment	Baby on room air / crib care maintained temperature over night - taking paladai feeds well. - No vomitings / brady / desaturations	Temp - <u>36.4°C</u> HR - <u>145/min</u> SpO ₂ - <u>93%</u>
---------------------	---	--

Medications Used	Vitamin D ₃ - 1ml @ (800 IU) ARBS - 96mg/dy 12 MC: 1 hr.
------------------	---

Plan of Care: +V - 190 cal/kg/day - 42ml / 3rd half - full paladai feeds
 - continue KMC/MS/MS (Prevention)
 - ROP - ON OOL-21 C30/7/26
 - Monitor temperature @ 4th half & document
 - W/R - cyanosis / brady / desaturations

Doctor's Name (Hand over given): Panwar

Signature: Panwar

Date & Time: 21/7/26

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

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

Signature: [Signature]

Date & Time: 21/7/26

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:

BAH-00660870 IP5-00176046
 Baby Of YANAMALA RAJANI TWIN 1
 08-07-2026 0 Y 0 M 13 D (M)
 Dr. DINESH KUMAR CHIRLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26	SHIFTING NOISES	
		Plan
	Baby on room air	3TV - 190 cel/kg 1 July
	hemodynamically stable	47 ml / 23 rd haly
	maintaining temperature	full paladar
	↓ crib care	
	HR - 152/min	- continue KM (10ms)
	SpO ₂ - 91%	- ARBS - ON
	taking paladar feeds well	
	PIA - soft	- monitor temperature
	Pneum - urine/stool!	2 nd haly.
	Temp - 36.7°C	inform - 297°F
	USG - abdomen ✓	- ROP - on - 30/7/26
	2D echo ✓	- I/O charting 26 th haly
	- NBS ✓	- monitor vitals
	Bcu/OPU/HpB - ✓	- W/F - apnea / brady / desaturation
	- AABR - ✓	
		Noted by
		Lokaraja
		Dr. Chirala

BAH-00660870 IP5-00176046
 Baby Of YANAMALA RAJANI TWIN 1
 16-07-2026 0 Y 0 M 16 D (M)
 Dr. DINESH KUMAR CHIRLA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26	<u>Morning rounds</u>	
8:00 AM	Moderate prem / LBW / MCDA [TWIN-1] NOT / Suspected sepsis (1.87kg) DOC-16	
	33+2 → 35+4 Today wt - 2.043kg (↓ 25gms)	<u>Plan:-</u>
	Temp - 98.6°F - SpO ₂ - 96% PR - 140/min RR - 45/min	- Crib care - TV - 190ml/kg/day ↓ - 50ml 50ml 4th 3rd hourly full paladai feeds.
	Urine - passed Stool - passed	- Continue RMC, OMS, NRS - - RBS OD
	- Vaccination ✓ - AABR ✓ - NCG (N) (Day 2) - 2DEcho (N) (D11) - USG - (N) (D10)	- Temperature monitoring 2nd & 3rd hourly (Inform if < 97.5°F)



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Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

①

RBS CHART

Date	Time	RBS (mg/dl)	IVF %	Signature
6/7/26	4:00 PM	78 mg/dl	feed	<i>[Signature]</i>
6/6/26	10:00 PM	90 mg/dl	10% dextrose	<i>[Signature]</i>
2/2/26	4 AM	80 mg/dl	—	<i>[Signature]</i>
7/7/26	10 AM	86 mg/dl	—	<i>[Signature]</i>
7/7/26	4 PM	80 mg/dl	—	<i>[Signature]</i>
8/7/26	5 PM	88 mg/dl	full feed	<i>[Signature]</i>
8/7/26	11 AM	99 mg/dl	full feed	<i>[Signature]</i>
8/7/26	5 PM	96 mg/dl	full feed	<i>[Signature]</i>
9/7/26	5 PM	113 mg/dl	full feed	<i>[Signature]</i>
10/7/26	6 PM	128 mg/dl	full feed	<i>[Signature]</i>
11/7/26	6 PM	90 mg/dl	full feed	<i>[Signature]</i>
11/7/26	6 PM	98 mg/dl	full feed	<i>[Signature]</i>
12/7/26	6 AM	108 mg/dl	full feed	<i>[Signature]</i>
13/7/26	6 AM	98 mg/dl	full feed	<i>[Signature]</i>
14/7/26	6 AM	92 mg/dl	full feeds	<i>[Signature]</i>
15/7/26	6 AM	102 mg/dl	full feeds	<i>[Signature]</i>
16/7/26	6 AM	105 mg/dl	full feed	<i>[Signature]</i>
17/7/26	6 AM	92 mg/dl	full feeds	<i>[Signature]</i>
18/7/26	6 AM	89 mg/dl	full feeds	<i>[Signature]</i>
19/7/26	6 AM	73 mg/dl	full feed	<i>[Signature]</i>
20/7/26	6 AM	71 mg/dl	full feed	<i>[Signature]</i>
21/7/26	6 AM	96 mg/dl	full feed	<i>[Signature]</i>
22/7/26	6 AM	98 mg/dl	full feed	<i>[Signature]</i>
23/7/26				

[illegible]

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RESULT SHEET

Date	06/07/26	7/7/26	8/7/26	13/7/26	18/7	20/7
Time	6:30pm			4pm		
Hb	18.3	17.5		17.1	15.6	15.3
PCV	54.7	51.7		47.5	45.5	45.4
RBC	5.23	4.99		4.92	4.63	4.53
WBC	6.51	7.64		8.92	11.13	12.890
N/L	60.8/27.5	35		31.7/51.6	51/39	28/49.
Platelets	421	353		318	354	3.79 (10 ⁹ /L)
CRP		5.0		5.0	5	
ESR		.		.		
PCT						
RBS						
Na		137		134		134
K		4.3		4.5		5.5
Cl		110		105		106
Ca/Mg		94		10.9		10.6
Phosphate						7
Urea				4.		
Creatinine		0.9		0.5		
ALP						163
SGPT						
SGOT						
T.Bill/Conj		7.6 ^{0.1} 7.5	7.1 ^{0.1} 7.0	11.7 ^{0.1} 11.6		
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						



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:																			

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. 1.8..... Ward. 2160

* Sweetha
 ①

VERIFIED
 ② Sangeetha

* Sweetha
 ③

DRUG : <u>94 PIPERACILLIN TAZOBACTAM</u>				Date Time	<u>6/7</u> <u>8/7</u> <u>9/7</u>
Dose	Route	Frequency	Start Date		
<u>187mg</u>	<u>IV</u>	<u>Q12H</u>	<u>6/7/26</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Porpille</u>				<u>10 AM</u> <u>8/7</u>	<u>STOP</u> <u>Sneha</u> <u>9/7/26</u>
Additional Instructions: <u>100 mg/kg/dose</u>				<u>10 AM</u> <u>8/7</u> <u>9/7</u>	
Daily Doctor's Endorsement by a Sign				<u>Dr. Porpille</u>	
DRUG : <u>TIME</u>				Date Time	<u>13/7</u> <u>14/7</u> <u>15/7</u> <u>16/7</u> <u>17/7</u>
Dose	Route	Frequency	Start Date		
	<u>PO</u>	<u>each feed</u>	<u>13/7/26</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Porpille</u>				<u>✓</u> <u>✓</u> <u>✓</u> <u>✓</u> <u>✓</u>	<u>STOP</u> <u>2/7/26</u> <u>P. Sangeetha</u>
Additional Instructions: <u>1 sachet in 25ml EBM</u>				<u>✓</u> <u>✓</u> <u>✓</u>	
Daily Doctor's Endorsement by a Sign				<u>Dr. Sangeetha</u>	
DRUG : <u>VITAMIN D3</u>				Date Time	<u>20/7/26</u> <u>21/7/26</u>
Dose	Route	Frequency	Start Date		
<u>1mb</u>	<u>PO</u>	<u>OD</u>	<u>20/7</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Sneha</u>				<u>6 PM</u> <u>20/7</u>	
Additional Instructions: <u>1mb = 800 IU</u>					
Daily Doctor's Endorsement by a Sign				<u>Sneha</u>	
DRUG :				Date Time	
Dose	Route	Frequency	Start Date		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

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Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : VITAMIN D3 drops				Date Time	16/7	17/7	18/7	19/7												
Dose	Route	Frequency	Start Dt.																	
0.5ml	PO	OD	15/7																	
Name & Signature of the Doctor Starting the Drugs: Pawar				6PM 12PM 6PM 12PM me.																
Additional Instructions: 1ml-800IU				change of dose - Sneha 20/7/26.																
Daily Doctor's Endorsement by a Sign				[Signature]																
DRUG : CROFER XT drops				Date Time	21/7	22/7														
Dose	Route	Frequency	Start Dt.																	
0.4ml	PO	OD	21/7																	
Name & Signature of the Doctor Starting the Drugs: Pawar																				
Additional Instructions: 2mg/kg/day																				
Daily Doctor's Endorsement by a Sign				[Signature]																
DRUG : VITAMIN D3 drops				Date Time																
Dose	Route	Frequency	Start Dt.																	
1ml	PO	OD	21/7																	
Name & Signature of the Doctor Starting the Drugs: Pawar																				
Additional Instructions: 1ml-800IU																				
Daily Doctor's Endorsement by a Sign																				
DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

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Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

DRUG :				Date Time															
Dose	Route	Frequency	Start Dt.																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

VERIFIED BY : Name Signature

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

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I.V. FLUIDS CHART

Weight. Ward.



on of I.V. Fluid
nl/hr = Mcg/kg/min. etc)

Route

Flow Rate
ml/hr

Doctor
Sign

Nurse
Sign

Date of
Stopping

Doctor
Sign

Nurse
Sign

Signature

VERIFIED BY : Name

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

Patient's / Learner Language: Telegu 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		
6/2/26	10am	2/9	Nutrition diet hand hygiene	m/p	4	0	1	1	good	

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							

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 08-07-2026 0 Y 0 M 6 D
 Dr. DINESH KUMAR CHIRLA (M)



MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☒ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Hygiene RDS LBW	To ↓ RDS to ↑ weight of the Baby	given oxygen Support given feeding		☒ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



NURSING INITIAL ASSESSMENT FOR NICU

Date of Admission: 6/7/26

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

Reason for Admission:

Admission Diagnosis:

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

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: 1.870 kgs Head Circumference: cm Length: cm

☐ Term ☐ Pre-Term ☐ Post-Term

Blood Group: Mother: Baby:

Feeding: ☐ Breast Feeding ☒ Formula ☒ Both

Maternal Details: Age: years, PARA: Gestation: 33 Weeks, 2 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:

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time :	4	6	8	10	12	2	4	6
Doctor / Nurse / Family Concern?		PM	PM	PM	PM	PM	PM	PM	PM
Temperature (°F)		98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6
Heart Rate (bpm)									
Blood Pressure (mmHg) *									
Heart Rate (Number)		136bpm	136bpm	146bpm	150	145	152	150	
Resp. Rate (bpm)									
Resp Rate (Number)		36bpm	47bpm	51bpm	45	38	42	50	
Resp Distress									
Receiving O ₂ (l/min)									
O ₂ Saturations (%)		100%	99%	98%	98%	99%	98%	98%	
Conscious Level		N	N	N	N	N	N	N	
GCS *		1	1	1	1	1	1	1	
TOTAL SCORE		1	1	1	1	1	1	1	
Number of shaded boxes		0	0	0	0	0	0	0	
Pain Score		0	0	0	0	0	0	0	
Observer's Initials		8	8	8	8	8	8	8	

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 fellow or PICU 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)

TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :		Time: 8 AM		9 AM	12 PM	2 PM	4 PM	6 PM	8 PM	10 PM	12 PM	2 PM	4 PM	6 PM		
Doctor / Nurse / Family Concern?																
Temperature (F)	104															
	103															
	102															
	101															
	100															
	99															
	98															
	97															
	96															
	95															
	94															
	Heart Rate (bpm) and Blood Pressure (mmHg) *	190														
		180														
170																
160																
150																
140																
130																
120																
110																
100																
90																
80																
70																
60																
50																
Note: BP does not score in early warning scoring																
Heart Rate (Number)		108	112	119	126	130	136	144	130	139	135	126	132			
esp. Rate (bpm) (Over 1 Minute)																
Resp Rate (Number)		24	27	22	30	32	41	44	35	35	35	36	48			
Resp Distress	Mod/ Severe None / Mild															
Receiving O ₂ (l/min) O ₂ Saturations (%)		98%	98%	98%	98%	98%	98%	98%	95%	95%	96%	96%	95%			
Conscious Level	Normal Altered	C	C	C	C	C	C	C	C	C	C	C	C			
GCS *																
TOTAL SCORE																
Number of shaded boxes																
Pain Score		0	0	0	0	0	0	0	1	1	1	1	1			
Observer's Initials		V	I	I	I	I	I	I	B	B	B	B	B			
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 in charge AND PICU fellow or PICU consultant to be informed.														

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

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

TEENAGE (12 + years) 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) and Blood Pressure (mmHg) *	190															
	180															
	170															
	160															
	150															
	140															
	130															
	120															
	110															
	100															
90																
80																
70																
60																
50																
Note: BP does not score in early warning scoring																
Heart Rate (Number)		120	130	130	139	147	125	138	132	155	141	130	125			
Resp. Rate (bpm) (Over 1 Minute)	70															
	60															
	50															
	40															
	30															
	20															
	10															
Resp Rate (Number)		34	36	45	49	45	45	35	41	33	57	36				
Resp																
Mod/ Severe Distress																
Receiving O ₂ (l/min)																
O ₂ Saturations (%)		96%	99%	99%	95%	95%	99%	98%	93%	95%	92%	93%				
Conscious Level																
Normal / Altered																
GCS *		C	C	C	C	C	C	C	C	C	C	C				
TOTAL SCORE																
Number of shaded boxes		1	1	1	1	1	1	1	1	1	1	1				
Pain Score		0	0	0	0	0	0	1	1	1	1	1				
Observer's Initials		HA	HA	HA	HA	HA	HA	HA	HA	HA	HA	HA				
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 in charge AND PICU fellow or PICU consultant to be informed.														

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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TEENAGE (12 + years) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :	Time:	9	10	12	2	4	6	8	10	12	2	4	6
Doctor / Nurse / Family Concern?		A	A	P	P	P	P	pm	pm	pm	pm	pm	pm
Temperature (F)	104												
	103												
	102												
	101	36.5	36.5	36.5	36.5	36.5	36.6	36.6	36.6	36.6	36.6	36.6	36.6
	100												
	99												
	98												
	97												
	96												
	95												
94													
Heart Rate (bpm)	190												
	180												
and Blood Pressure (mmHg) *	150												
	140												
Note: BP does not score in early warning scoring	130												
	120												
Heart Rate (Number)	110												
	100												
Resp. Rate (bpm) (Over 1 Minute)	90												
	80												
Resp Rate (Number)	70												
	60												
Resp	50												
	40												
Mod/ Severe Distress	30												
	20												
Receiving O ₂ (l/min) O ₂ Saturations (%)	10												
Conscious Level													
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.
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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)		101.5	101.5	101.5	101.5	101.5	101.5	101.5	101.5	101.5	101.5	101.5	101.5
Heart Rate (bpm)		127	129	131	134	132	131	132	134	136	137	123	128
Blood Pressure (mmHg) *		135/84	135/84	135/84	135/84	135/84	135/84	135/84	135/84	135/84	135/84	135/84	135/84
Resp. Rate (bpm)		48	36	32	41	43	34	42	38	28	32	36	36
Conscious Level		N	N	N	N	N	N	N	N	N	N	N	N
GCS *		C	C	C	C	C	C	C	C	C	C	C	C
TOTAL SCORE		1	1	1	1	1	1	1	1	1	1	1	1
Observer's Initials		C	C	C	C	C	C	C	C	C	C	C	C

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.
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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?		pm	pm	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) and Blood Pressure (mmHg) *	190												
		180												
		170												
160														
150														
140														
130														
120														
110														
100														
90														
80														
70														
60														
50														
Heart Rate (Number)		151	120	127	134	145	132	128	124	164	137	131		
Resp. Rate (bpm) (Over 1 Minute) *	70													
	60													
	50													
	40													
	30													
	20													
	10													
	Resp Rate (Number)		44	36	42	31	30	37	32	25	35	39	25	
	Resp Distress		Mod/ Severe	None / Mild										
	Receiving O ₂ (l/min)													
	O ₂ Saturations (%)		97%	95%	96%	97%	96%	94%	94%	97%	94%	93%	95%	
	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		1	1	1	1	1	1	1	1	1	1	1		
Pain Score		1	1	1	1	1	1	1	1	1	1	1		
Observer's Initials		D	D	D	D	D	D	D	D	D	D	D		

ACTIONS

NB: Scores 3 should be recorded overleaf

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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TEENAGE (12 + years)
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								

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

36.4°C

36.3°C

36.2°C

36.3°C

99.4°C

97.6°F

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

Note:
BP does not score
in early
warning scoring

159 142 139 144 152 155 121 131 136 122 132

175 56 68 63
61 40 44 44
56 31 33 34

CRIB Case

Heart Rate (Number)	159	142	139	144	152	155	121	131	240	136	102	132	
Resp. Rate (bpm) (Over 1 Minute)													
Resp Rate (Number)	40	36	33	44									

Resp Distress	Mod/ Severe	None / Mild											
Receiving O ₂ (l/min)													
O ₂ Saturations (%)	93	92	93	92	96%	96%	98%	99%	98%	99%	98%	100%	
Conscious Level	RIA	RIA	RIA	RIA	RIA	RIA	RIA	RIA	RIA	RIA	RIA	RIA	
GCS *	N	N	N	N	N	N	N	N	N	N	N	N	
TOTAL SCORE	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	M	M	M	M	S	S	R	R	R	R	R	R	

ACTIONS	Score 1	: Continue normal observation by staff nurse
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* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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15/7/26

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	PM	Am	Am	Am	Am
Temperature (°F)		98.4°F	98.3°F	98.4°F	98.3°F	98.2°F	98.4°F	98.5°F	98.6°F	98.5°F	98.5°F	98.6°F	98.4°F
Heart Rate (bpm)													
Blood Pressure (mmHg) *													
Note: BP does not score in early warning scoring													
Heart Rate (Number)													
Resp. Rate (bpm) (Over 1 Minute) *													
Resp Rate (Number)		168	136	139	140	139	136	142	137	144	141	144	138
Resp Mod/ Severe Distress None / Mild													
Receiving O ₂ (l/min) O ₂ Saturations (%)		96%	95%	99%	98%	96%	99%	94%	98%	94%	94%	92%	93%
Conscious Level Normal / Altered		N	N	N	N	N	N	N	N	N	N	N	N
GCS *		C	C	C	C	C	C	C	C	C	C	C	C
TOTAL SCORE		1	1	1	1	1	1	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0	1	1	1	1	1	1
Observer's Initials		PH	PH	PH	PH	PH	PH	Q	Q	Q	Q	Q	Q
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											
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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-00660870 IP5-00175046
Baby Of YANAMALA RAJANI TWIN 1
06-07-2026 0 Y 0 M 9 D (M)
Dr. DINESH KUMAR CHIRLA



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

16/7/26

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	10	2	6
Doctor/Nurse/Family Concern?		am	am	pm	pm	pm	pm	pm	pm	am
Temperature (F)	104									
	103									
	102									
	101									
	100	98.5F	98.3F	98.0F	98.2F	98.4F	97.9F	96.8F	97.9F	(KMC) 96.0F
	99	*	*	*	*	*	*	*	*	*
	98									*
	97									
	96									
	95									
	94									
Heart Rate (bpm)	190									
	180									
	170									
	160									
and	150									
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)		133	140	126	127	136	142b/m	138b/m	136b/m	140b/m
Resp. Rate (bpm) (Over 1 Minute) *	70									
	60									
	50									
	40									
	30									
	20									
	10									
Resp Rate (Number)							38b/m	36b/m	40b/m	38b/m
Resp Distress	Mod/ Severe						N	N	N	N
	None / Mild									
Receiving O ₂ (l/min)										
O ₂ Saturations (%)		96%	98%	97%	98%	97%	99%	100%	98%	97%
Conscious Level	Normal	N	N	N	N	N	N	N	N	N
	Altered									
GCS *		C	C	C	C	C	15/15	15/15	15/15	15/15
TOTAL SCORE										
Number of shaded boxes		1	1	1	1	1	0	1	0	0
Pain Score		0	0	0	0	0	0	0	0	0
Observer's Initials		PL	PL	PL	PL	PL	PL	PL	PL	PL

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:

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- 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!
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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)
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B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
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Doc. No. : RCH/ FRM / CLINICAL / 127

17/7/20

infant

TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart



**Rainbow®
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It takes a lot to treat the little ones.



BirthRight
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Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date :		Time:					
Doctor / Nurse / Family Concern?		9AM	11AM	1PM	3PM	4-8PM	6PM
Temperature (°F)	104						
	103						
	102						
	101						
	100						
	99						
	98						
	97	97.5F	97.1F	96.5F	96.8F	97.0F	96.0F
	96						
	95						
Heart Rate (bpm)	190						
	180						
	170						
	160						
	150						
	140						
	130						
	120						
	110						
	100						
and Blood Pressure (mmHg) *	90						
	80						
	70						
	60						
	50						
	130						
	120						
	110						
	100						
	90						
Note: BP does not score in early warning scoring	80						
	70						
	60						
	50						
	130						
	120						
	110						
	100						
	90						
	80						
Heart Rate (Number)	130bpm						
	143bpm						
	152bpm						
Resp. Rate (bpm) (Over 1 Minute)	70						
	60						
	50						
	40						
	30						
	20						
	10						
	30bpm						
	35bpm						
	38bpm						
Resp Rate (Number)	41bpm						
Respiratory Distress	Mod/ Severe						
	None / Mild						
Receiving O ₂ (l/min) O ₂ Saturations (%)	98%						
	100%						
	98%						

* 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

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IAH-00660870 IP5-00175046
Baby Of YANAMALA RAJANI TWIN 1
16-07-2026 0 Y 0 M 11 D (M)
Dr. DINESH KUMAR CHIRLA



C. No. : BCH TERM / CLINICAL / 124

18/7/26

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:	12	2	4	6	8
Doctor/Nurse/Family Concern?	8pm	10pm	Am	Am	Am	Am
Temperature (F)	95.4	96.9	98.3	98.8	98.3	98.8
Heart Rate (bpm)	150	150	150	145	145	145
Blood Pressure (mmHg) *				135/85	135/85	135/85
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)						
Resp Distress						
Receiving O ₂ (l/min)						
O ₂ Saturations (%)	95%	95%	95%	95%	95%	95%
Conscious Level						
GCS *	15/5	15/5	15/5	15/5	15/5	15/5
TOTAL SCORE	1	1	1	1	1	1
Number of shaded boxes	0	0	0	0	0	0
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
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18/7/26

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	pm	am	am	am	am

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

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

Note: BP does not score in early warning scoring													
---	--	--	--	--	--	--	--	--	--	--	--	--	--

Heart Rate (Number)	153	151	168	139	140	144	142	146	152	148	156	134
---------------------	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

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

Resp	Mod/ Severe	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
Distress	None / Mild											

Receiving O ₂ (l/min)												
O ₂ Saturations (%)	94%	92%	94%	93%	96%	95%	96%	97%	95%	96%	97%	97%

Conscious	Normal	N	N	N	N	N	N	N	N	N	N	N
Level	Altered											

GCS *												
-------	--	--	--	--	--	--	--	--	--	--	--	--

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	FF	FF	FF	FF	FF	FF	FF	FF	FF	FF	FF	FF

ACTIONS	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
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BAH-00660870 IP5-00176046
Baby Of YANAMALA RAJANI TWIN 1
08-07-2026 0 Y 0 M 11 D (M)
Dr. DINESH KUMAR CHIRLA



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

19/12/26
INFANT (<1 year)
**Children's Observation &
Early Warning Scoring Chart**

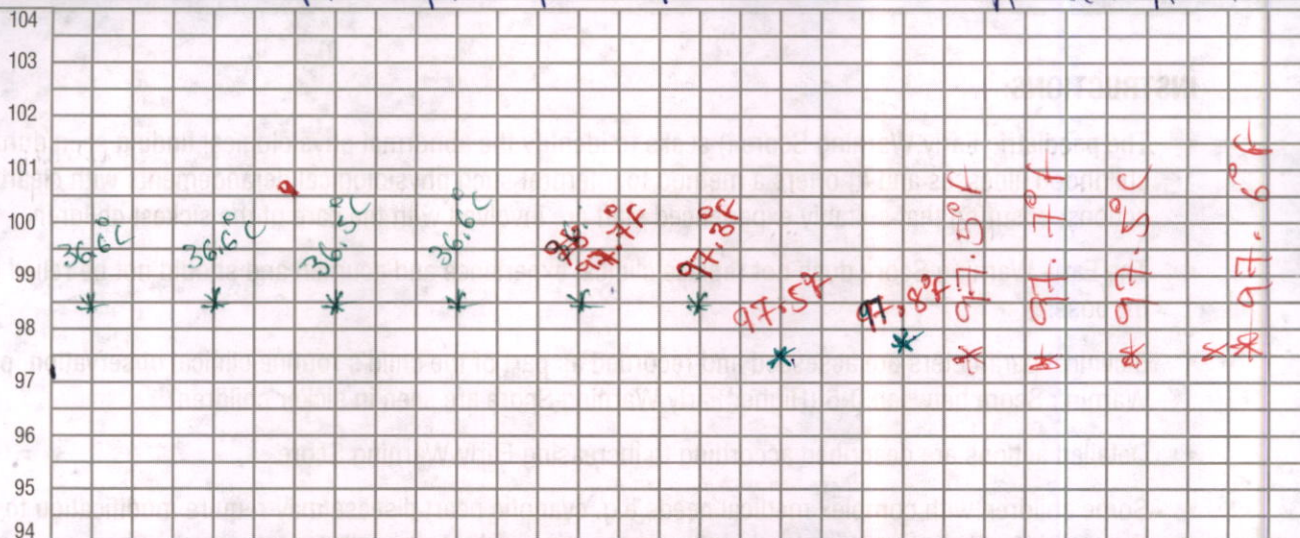
Pratiksha
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It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

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

Temperature
(°F)

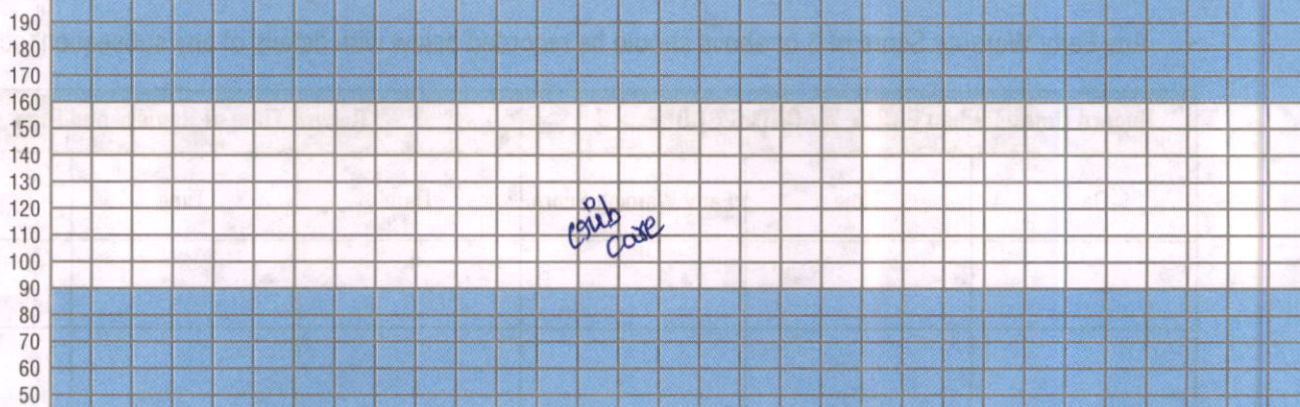


Heart Rate
(bpm)

and

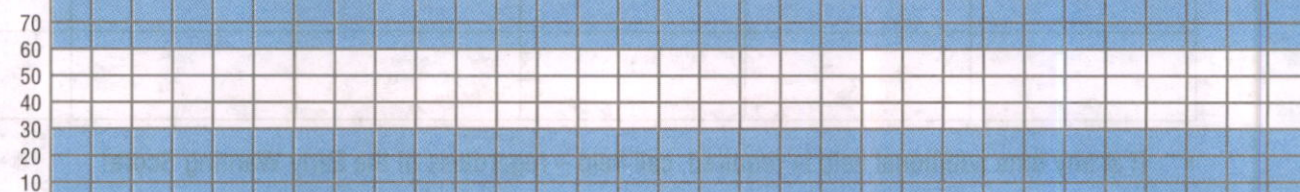
Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring



Heart Rate (Number) 137 138 140 134 133 142 149 150 133 137 150 146

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



Resp Rate (Number)

Resp Mod/ Severe Distress 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 O₂ (l/min) O₂ Saturations (%) 95% 97% 98% 97% 96% 95% 96% 96% 95% 97% 98% 98%

Conscious Level Normal Altered N N N N N N N N N N N N

GCS * C C C C C C C C C C C C

TOTAL SCORE 1 1 1 1 1 1 1 1 1 1 1 1

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 [Signatures]

ACTIONS
Score 1 : Continue normal observation by staff nurse
Score 2 : Shift in charge nurse to be informed and continue hourly observations
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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	Am	Pm	Pm	Pm	Am	Am	Am	Am	
Temperature (F)	104													
	103													
	102													
	101													
	100													
	99													
	98													
	97													
	96													
	95													
	94													
	Heart Rate (bpm)	190												
		180												
	170													
	160													
and	150													
	140													
Blood Pressure (mmHg) *	130													
	120													
	110													
	100													
Note:	90													
BP does not score	80													
in early	70													
warning scoring	60													
	50													
Heart Rate (Number)		120	145	156	145	148	150	160	155	136	140	126	154	
Resp. Rate (bpm) (Over 1 Minute) *	70													
	60													
	50													
	40													
	30													
	20													
	10													
Resp Rate (Number)		30	45	59	50	45	48	50	.					
Resp Distress	Mod/ Severe													
	None / Mild													
Receiving O ₂ (l/min)														
O ₂ Saturations (%)		95%	93%	99%	98%	96%	94%	96%	96%	95%	98%	98%	98%	
Conscious Level	Normal	N	N	N										
	Altered													
GCS *		C	C	C	C	C	C	C	C	C	C	C	C	
TOTAL SCORE														
Number of shaded boxes		0	0	0	0	0	0	0	0	1	1	1	1	
Pain Score		1	1	1	1	1	1	1	1	0	0	0	0	
Observer's Initials		Dr	Dr	Dr	Dr	Dr	Dr	Dr	Dr	Dr	Dr	Dr	Dr	

ACTIONS

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recorded overleaf

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- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

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



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	10pm	12am	2am	6am	
Doctor/Nurse/Family Concern?		Am	Am	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												
and Blood Pressure (mmHg) *	90												
	80												
	70												
	60												
	50												
	Note: BP does not score in early warning scoring	130											
		139											
		148											
		150											
		157											
150													
119b/m													
138b/m													
140b/m													
Heart Rate (Number)		70											
	60												
	50												
	40												
	30												
	20												
	10												
	Resp. Rate (bpm) (Over 1 Minute) *	33											
		38b/m											
		39b/m											
41b/m													
Resp Rate (Number)		70											
		60											
		50											
		40											
		30											
		20											
	10												
	Resp Mod/ Severe Distress None / Mild	N											
		N											
		N											
N													
N													
N													
N													
N													
N													
N													
Receiving O ₂ (l/min) O ₂ Saturations (%)	95%												
	93%												
	99%												
	100%												
	96%												
	99%												
	100%												
	99%												
	98%												
	98%												
Conscious Level	N												
	N												
	N												
	N												
	N												
	N												
	N												
	N												
	N												
	N												
GCS *	C												
	C												
	C												
	C												
	C												
	C												
	C												
	C												
	C												
	C												
TOTAL SCORE	0												
	0												
	0												
	0												
	0												
	0												
	0												
	0												
	0												
	0												
Pain Score	1												
	1												
	1												
	1												
	1												
	1												
	1												
	1												
	1												
	1												
Observer's Initials	to												
	to												
	to												
	to												
	to												
	to												
	to												
	to												
	to												
	to												

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

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:

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ESTH KUMAR CHIRLA

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

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



Date:

[illegible]

Heart Rate	190
(bpm)	180
	170
	160
and	150
	140
Blood Pressure	130
(mmHg) *	120
	110
	100
Note:	90
BP does not score	80
in early	70
warning scoring	60
	50

[illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible]

ACTIONS	Score 1	Continue normal observation by staff nurse
	Score 2	Shift in charge nurse to be informed and continue hourly observations

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

recorded overleaf	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	
---	--

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:

[illegible][illegible]

	Heart Rate	(bpm)	and	Blood Pressure	(mmHg) *	Note:	BP does not score in early warning scoring
190							
180							
170							
160							
150							
140							
130							
120							
110							
100							
90							
80							
70							
60							
50							

[illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible]

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FLUID CHART

Sheet No. : ①

No - 60cl/kg
 Built - 1.08 kg
 TF - 10uf.

- 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	NG						
	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	DBM	5.0	10uf					9uf		yo
	06:00 pm		5.0								
	07:00 pm	DBM	5.0	10uf		poor			10uf		yo
Total Intake :					Total Output :						
	08:00 pm										
	09:00 pm	DBM		10uf							
	10:00 pm										
	11:00 pm	DBM		10uf		poor			10uf		
	12:00 am										
	01:00 am	DBM		10uf							
Total Intake :					Total Output :						
	02:00 am										
	03:00 am	DBM		10uf		poor			10uf		
	04:00 am										
	05:00 am	DBM		10uf							
	06:00 am										
	07:00 am	DBM		10uf					10uf		
Total Intake : 95uf					Total Output : 51uf						
Total 24 hrs. Intake			52cl/kg/day								
Total 24 hrs. Output			11cl/kg/day								



FLUID CHART

TV: - 60 ccl/kg
 Buft: - 1.8 kys
 TF: 10 ml

Sheet No. : 4

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	OG	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am				OG						0	
	09:00 am	DBM	-	-	10ml						0	
	10:00 am			Pinkish 10ml			Small stool passed			15ml	0	
	11:00 am	DBM	-	-	10ml						0	
	12:00 pm										0	
	01:00 pm	DBM	-	-	10ml					10ml	0	

Total Intake : 3.24 ccl/kg

Total Output : 2.3 ccl/kg

	02:00 pm			-							0	
	03:00 pm	DBM	-	-	12ml					10ml	0	
	04:00 pm			-			Small stool passed				0	
	05:00 pm	DBM	-	-	12ml						0	
	06:00 pm			-						12ml	0	
	07:00 pm	DBM	-	-	12		passed				0	

Total Intake : 3.33 ccl/kg

Total Output : 2.03 ccl/kg

	08:00 pm											
	09:00 pm	DBM			14ml		Small passed			6ml	1	
	10:00 pm										0	
	11:00 pm	DBM			14ml						0	
	12:00 am						Not passed			9ml	1	
	01:00 am	DBM			14ml						1	

Total Intake :

Total Output :

	02:00 am											
	03:00 am	DBM			14ml		-			7ml	1	
	04:00 am											
	05:00 am	DBM			14ml		passed				0	
	06:00 am									8ml	1	
	07:00 am	DBM			14ml						1	

Total Intake :

Total Output :

Total 24 hrs. Intake

100 ccl/kg/day

Total 24 hrs. Output

1.7 ccl/kg/day

8/7/26

FLUID CHART

Sheet No. : 3

TV -
 TF -
 B.Wt -

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	NG							
	08:00 am								10			
	09:00 am	DBM		1um		passed			10ml			
	10:00 am					-						
	11:00 am	DBM		1um		-			5ml			
	12:00 pm					-						
	01:00 pm	DBM		1um		passed			7ml			
Total Intake :					Total Output :							
	02:00 pm					-			7ml			
	03:00 pm	DBM		1um		-						
	04:00 pm											
	05:00 pm	DBM		15ml		passed			9ml			
	06:00 pm					-						
	07:00 pm	DBM		15ml		-			10ml			
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm	DBM		10ml		not passed			5ml			
	10:00 pm											
	11:00 pm	DBM		10ml					0			
	12:00 am											
	01:00 am	DBM		10ml		passed			12ml			
Total Intake :					Total Output :							
	02:00 am											
	03:00 am	DBM		15ml					15ml			
	04:00 am											
	05:00 am	DBM		15ml		passed little			0			
	06:00 am											
	07:00 am	DBM		10ml					10ml			
Total Intake :					Total Output :							
Total 24 hrs. Intake		93cc/kg/day										
Total 24 hrs. Output		2.4cc/kg/day										



FLUID CHART

Sheet No. :

9/7/26

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	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	O.G						
	08:00 am									1	
	09:00 am	DBM			15ml		Passed		7ml	0	R
	10:00 am									1	
	11:00 am	DBM	15ml				not Passed		10ml		R
	12:00 pm		0ml								
	01:00 pm	DBM	18ml				Passed		9ml	1	e
Total Intake :					Total Output :						
	02:00 pm									1	
	03:00 pm	DBM	18ml				not Passed		10ml		R
	04:00 pm									0	
	05:00 pm	DBM			18ml		Not Passed		7ml	1	e
	06:00 pm										
	07:00 pm	DBM			18ml					1	
Total Intake :					Total Output :						
	08:00 pm										
	09:00 pm	DBM			18ml		little passed		6ml	1	
	10:00 pm										
	11:00 pm	DBM			18ml					0	R
	12:00 am									1	
	01:00 am	DBM			18ml		passed		10ml	1	
Total Intake :					Total Output :						
	02:00 am									1	
	03:00 am	DBM			18ml				8ml	1	
	04:00 am										
	05:00 am	DBM			18ml		passed			0	R
	06:00 am									1	
	07:00 am	DBM			18ml				12ml	1	
Total Intake : 215ml					Total Output :						
Total 24 hrs. Intake		116 c.c/24hrs									
Total 24 hrs. Output		118 c.c/24hrs									



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am	DBM	18ml				Passed			10 ml		
	10:00 am											
	11:00 am	DBM	18ml				Not passed			7 ~ 1		
	12:00 pm											
	01:00 pm	DBM	18ml									
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm	DBM	20ml				Passed			7ml		
	04:00 pm						-					
	05:00 pm	DBM	21ml				-			10ml		
	06:00 pm						-					
	07:00 pm	DBM	21ml				passed			9ml		
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm	DBM	21ml		21ml		passed			21ml		
	10:00 pm											
	11:00 pm	DBM	21ml		21ml		-			21ml		
	12:00 am											
	01:00 am	DBM	21ml		21ml					9ml		
Total Intake :						Total Output :						
	02:00 am											
	03:00 am	DBM			21ml		passed			8ml		
	04:00 am											
	05:00 am	DBM			21ml		Passed			5ml		
	06:00 am											
	07:00 am	DBM			21ml					7ml		
Total Intake : 242ml						Total Output :						
Total 24 hrs. Intake			134.46 ccl/kg/day									
Total 24 hrs. Output			1.9 ccl/kg/day									

FLUID CHART

Sheet No. :

BW = 1.758 kg
 TV = 160 cc/kg/day
 TF = 25 ml/2 hrs

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						
	08:00 am										
	09:00 am	DBM		25ml			Not passed			2ml	
	10:00 am										
	11:00 am	DBM	25ml				Passed			6ml	
	12:00 pm										
	01:00 pm	DBM	25ml				Not passed			7ml	
Total Intake :						Total Output :					
	02:00 pm										
	03:00 pm	DBM	25ml				Not passed			9ml	
	04:00 pm										
	05:00 pm	DBM	25ml				passed			20ml	
	06:00 pm										
	07:00 pm	DBM	25ml				-			11ml	
Total Intake :						Total Output :					
	08:00 pm										
	09:00 pm	DBM	25ml				Passed			8ml	
	10:00 pm										
	11:00 pm	DBM	25ml				-			10ml	
	12:00 am										
	01:00 am	DBM	25ml				Passed			6ml	
Total Intake :						Total Output :					
	02:00 am										
	03:00 am	DBM	25ml				-			12ml	
	04:00 am										
	05:00 am	DBM	25ml				Passed			8ml	
	06:00 am										
	07:00 am	DBM	25ml				Passed			10ml	
Total Intake :						Total Output :					

Total 24 hrs. Intake

168
~~560~~ cc/kg/day

Total 24 hrs. Output

2.5 cc/kg/day



12/07/26

FLUID CHART

IV = 180 cc/kg/day
 TK = 1.785 gm.
 B.Wt = 28mg 1200ml
 2026

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.

		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										1	6
	09:00 am	DBM	28ml				passed			16ml	1	
	10:00 am										0	
	11:00 am	DBM	28ml				NOT passed.				1	
	12:00 pm									18ml	1	
	01:00 pm	DBM	28ml								1	

Total Intake :

Total Output :

	02:00 pm						passed					
	03:00 pm	DBM	28ml							14ml		
	04:00 pm											
	05:00 pm	DBM	28ml				NOT passed					
	06:00 pm									15ml		
	07:00 pm	DBM	28ml									

Total Intake :

Total Output :

	08:00 pm											
	09:00 pm	DBM	28ml							12ml		
	10:00 pm											
	11:00 pm	DBM	28ml				passed			12ml		
	12:00 am											
	01:00 am	DBM	28ml							9ml		

Total Intake :

Total Output :

	02:00 am											
	03:00 am	DBM	28ml							10ml		
	04:00 am											
	05:00 am	DBM	28ml				passed					
	06:00 am									11ml		
	07:00 am	DBM	28ml									

Total Intake : 336ml

Total Output : 105ml

Total 24 hrs. Intake 197.6 cc/kg/day

Total 24 hrs. Output 2.5 cc/kg/day



13/2/26

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Sheet No. : (4)

TW ✓
Bwt ✓
TFL

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							
	08:00 am											
	09:00 am	DBM 28ml					-	-		8ml		
	10:00 am											
	11:00 am	DBM 28ml					-			8ml		
	12:00 pm											
	01:00 pm	DBM 28ml					passed			6ml		
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm	DBM 28ml					-			9ml		
	04:00 pm											
	05:00 pm	DBM 28ml										
	06:00 pm											
	07:00 pm	DBM 28ml					-			8ml		
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm	DBM 28ml					passed			8ml		
	10:00 pm											
	11:00 pm	DBM 28ml								9ml		
	12:00 am						Not passed					
	01:00 am	DBM 28ml								6ml		
Total Intake :						Total Output :						
	02:00 am											
	03:00 am	DBM 28ml					passed			4ml		
	04:00 am											
	05:00 am	DBM 28ml								12ml		
	06:00 am											
	07:00 am	DBM 28ml					passed			6ml		
Total Intake :						Total Output :						
Total Intake : 336 ml						Total Output : 83 ml						

Total 24 hrs. Intake

197ml/kg/day.

Total 24 hrs. Output

2.0cc/kg/day



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Sheet No.: 5

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							
	08:00 am											
	09:00 am	DBM	28ml				Small amount			10ml		
	10:00 am											
	11:00 am	DBM	28ml				Passed			10ml		
	12:00 pm											
	01:00 pm	PBM	28ml							10ml		
Total Intake :						Total Output : 30						
	02:00 pm											
	03:00 pm	DBM	28ml							12ml		
	04:00 pm											
	05:00 pm	DBM	28ml				Passed			8ml		
	06:00 pm											
	07:00 pm	DBM	28ml							15ml		
Total Intake :						Total Output : 35						
	08:00 pm											
	09:00 pm	DBM	30ml							9ml		
	10:00 pm											
	11:00 pm	DBM	30ml				Passed			5ml		
	12:00 am											
	01:00 am	DBM	30ml							9ml		
Total Intake :						Total Output : 25ml						
	02:00 am											
	03:00 am	DBM	30ml							9ml		
	04:00 am											
	05:00 am	DBM	30ml				Passed			10ml		
	06:00 am											
	07:00 am	DBM	30ml							10ml		
Total Intake :						Total Output : 29						
Total 24 hrs. Intake		204. cc/kg/day										
Total 24 hrs. Output		2.9 cc/kg/day										

15/7/26

FLUID CHART

Sheet No. : (6)

B.Wt - 1.8 kg
 TV - 190cc/kg/day
 TF - 30 ml

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
Mother given	08:00 am											
	09:00 am	DRH+ HMF	30 ml				Passed			10 ml		
	10:00 am										0	
	11:00 am	Pre nan	30 ml				-	Vomit Medium		12 ml		
	12:00 pm											
	01:00 pm	Pre nan	30 ml				not passed			-		
Total Intake :			Total Output :									
Mother given	02:00 pm											
	03:00 pm	Pre nan	30 ml				Passed			14 ml		
	04:00 pm											
	05:00 pm	Pre nan	30 ml				Passed				0	
	06:00 pm									9 ml		
	07:00 pm	Pre nan	30 ml				-					
Total Intake :			Total Output :									
	08:00 pm											
	09:00 pm	Pre nan	30 ml (20 min)				not passed			10 ml		
	10:00 pm										NA	
	11:00 pm	Pre nan	30 ml				-			-		
	12:00 am											
	01:00 am	Pre nan	30 ml				passed			ane		
Total Intake :			Total Output :									
	02:00 am											
	03:00 am	Pre nan	30 ml				passed			11 ml		
	04:00 am										NA	
	05:00 am	Pre nan	30 ml				not passed			ane		
	06:00 am						passed					
	07:00 am	Pre nan	30 ml				-			-		
Total Intake : 360 ml			Total Output : 80 ml									
Total 24 hrs. Intake		200 cc/kg/day										
Total 24 hrs. Output		1.1 cc/kg/day										



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Sheet No. : (7)

18/07/26

TN - 190 cc/kg/day
 Bwt - 1.8 kg
 TR - 30 ml

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							
	08:00 am											
	09:00 am	Pne nan	30 ml				Parsed		14 ml			
	10:00 am											
	11:00 am	Pne nan	30 ml				Parsed					
	12:00 pm								12 ml			
1:40 pm	01:00 pm	Pne nan	30 ml				Parsed					
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm								10 ml			
4:30 pm	04:00 pm	Pne nan	30 ml				Parsed					
	05:00 pm											
	06:00 pm											
	07:00 pm	Pne nan	30 ml					(3 ml)				
Total Intake :					Total Output : if 1, M=01							
	08:00 pm											
	09:00 pm	Pne nan	30 ml									
	10:00 pm											
	11:00 pm	F.F	30 ml									
	12:00 am											
	01:00 am	F.F	30 ml									
Total Intake : Taken					Total Output : M-2 U-1 V-2							
	02:00 am											
	03:00 am	F.F	30 ml									
	04:00 am											
	05:00 am	F.F	30 ml									
	06:00 am											
	07:00 am	F.F	30 ml									
Total Intake : Taken					Total Output : M-1 U-1							
Total 24 hrs. Intake			Taken									
Total 24 hrs. Output			M-1 U-5 V-3									



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Sheet No. :

21/7/26.

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route	NG	Diarrhoea	Vomit	Drainage	Urine				
21/2			Mouth	I.V	N.G							
	08:00 am											
	09:00 am	pre nan	45ml			passed			15ml			
	10:00 am											
	11:00 am											
	12:00 pm	pre nan	45ml			passed			8ml.			
01:00 pm												
Total Intake :					Total Output : m - 2 U - 2							
21/2	02:00 pm											
	03:00 pm	pre nan	45ml						10ml.			
	04:00 pm											
	05:00 pm											
	06:00 pm	pre nan	45ml						10ml			
	07:00 pm											
Total Intake : 0ah					Total Output : M - 0 U - 2							
21/2	08:00 pm											
	09:00 pm	pre nan	47ml									
	10:00 pm											
	11:00 pm											
	12:00 am	pre nan	47ml									
	01:00 am											
Total Intake :					Total Output : U - 2 m - 1							
21/2	02:00 am											
	03:00 am	pre nan	47ml									
	04:00 am											
	05:00 am											
	06:00 am	pre nan	47ml									
	07:00 am											
Total Intake :					Total Output : U - 2 m - 2							
Total 24 hrs. Intake		taken										
Total 24 hrs. Output		U - 8 m - 5										

BAH-00660870 IP5-00176046
 Baby Of YANAMALA RAJANI TWIN 1
 06-07-2026 0 Y 0 M 16 D (M)
 Dr. DINESH KUMAR CHIRLA



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Sheet No. :

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

		Intake				Output						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													
	10:00 am													
	11:00 am													
	12:00 pm													
	01:00 pm													
Total Intake :						Total Output :								
	02:00 pm													
	03:00 pm													
	04:00 pm													
	05:00 pm													
	06:00 pm													
	07:00 pm													
Total Intake :						Total Output :								
	08:00 pm													
	09:00 pm													
	10:00 pm													
	11:00 pm													
	12:00 am													
	01:00 am													
Total Intake :						Total Output :								
	02:00 am													
	03:00 am													
	04:00 am													
	05:00 am													
	06:00 am													
	07:00 am													
Total Intake :						Total Output :								
Total 24 hrs. Intake						Total 24 hrs. Output								

Patient Sticker

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Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
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	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
	Total Intake :						Total Output :					
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
	Total Intake :						Total Output :					
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
	Total Intake :						Total Output :					
Total 24 hrs. Intake						Total 24 hrs. Output						