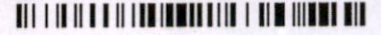






ADMISSION SHEET

Registration Details :



Admission No : IP5-00174610 Admit Date : 01-Jun-2026 Admit Time : 04:47 PM UHID : BAH-00657362

Patient Details :

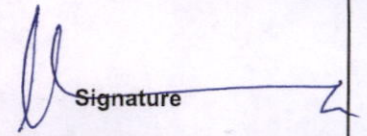
Patient Name : Baby Of SHARANYA A. Age : 0 Y 0 M 5 D  
Guardian : Mr YEMMANURU VENKATA SAI CHAITANYA DOB : 27-05-2026 08:34 AM  
Gender : Male Religion :  
Occupation : Martial Status : Single  
Address (H) : F NO - E-307, VISTA HOMES , VASAVI SIVA Phone No : 9901478399/ 9840039705  
SAI NAGAR ROAD , KUSHAIGUDA , Kapra E-mail : NOMAIL@GMAIL.COM  
Hyderabad Telangana INDIA 500062

Admission Details :

Bed Type : SEMI PRIVATE Bed No : TEMP SPVT 307 B Ward Name : 3F-ZONE A  
Room No : TEMP SPVT 307 B Admission Type : First Visit

Contact Details :

Name : Mr YEMMANURU VENKATA SAI Relationship : Father  
Contact Address : F NO - E-307, VISTA HOMES , VASAVI SIVA Phone No : 9901478399 / 9840039705  
SAI NAGAR ROAD , KUSHAIGUDA , Kapra  
Hyderabad Telangana INDIA 500062

  
Signature

Doctor Details :

Doctor Name : Dr. VIJAYANAND JAMALPURI Specialisation : NEONATAL INTENSIVE CARE  
Referral Doctor : Self Phone No :  
Co-Consultant :

Payment Details :

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

BAH-00657362 IP5-00174610  
Baby Of SHARANYA A.  
27-05-2026 0 Y 0 M 5 D (M)  
Dr. VIJAYANAND JAMALPURI



### ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_

UHID No. : \_\_\_\_\_ IP No : \_\_\_\_\_ Consultant: \_\_\_\_\_ Dept : \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Time : \_\_\_\_\_ Date of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

### WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
1/6/20	5:20 p	ER	ward 307B	B

### Cross Consultation Visit

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









**Rainbow<sup>®</sup>  
Children's  
Hospital**  
It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

BAH-00657362      IP5-00174610  
Baby Of SHARANYA A.  
27-05-2028      0 Y 0 M 6 D      (M)  
Dr. VIJAYANAND JAMALPURI



Patient Name:

*BAH*

*kaikanga*

*B/o Sharanya*

UHID ID:

Department:

Consultant:



### Pediatric Multiorgan History & Physical Examination

Name : \_\_\_\_\_ Age/Sex \_\_\_\_\_

Information given by: \_\_\_\_\_ Relationship \_\_\_\_\_

#### Chief Presenting Complaints & Duration (Chronologically)

Yellowish discoloration of skin & sclera since 2 days.

#### History of present illness :

DOB : 27/5/26

TOB : 8:34am.

Mother details: G2A1 / 3kays

no risk factors.

Mother + A positive

Baby + A positive.

by assisted vaginal delivery.

Baby delivered @ our hospital, had Unconjugated Hyperbilirubinemia  
since phototherapy (DSPT), discharged later on 30/5/26.

Assisted vaginal delivery no cord around neck & one hand  $\bar{c}$   
bradycardic on each contraction.

2/6/26 → SBR → 16.6 / 0.2 / 16.4.



## Pediatric Multiorgan History & Physical Examination

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

---

---

---

---

---

---

---

---

---

---

**Birth & Neonatal History:**

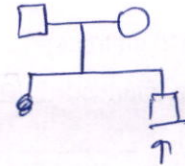
f

---

---

---

---



**Birth & Socio Economic History:**

About Father : \_\_\_\_\_  
About Mother : \_\_\_\_\_ } upper middle class  
Any additional Information : \_\_\_\_\_  
\_\_\_\_\_

**Developmental History :**

---

---

---

**Immunization History :**

Birth vaccine given

---

---

---



### Pediatric Multiorgan History & Physical Examination

#### Anthropometry :

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_) Height (cms): \_\_\_\_\_ (Centile \_\_\_\_\_)  
Weight (kgs) ) 2.56kg . (Centile \_\_\_\_\_)

#### On Examination :

Temperature : 97.2°F Pulse Rate : 152/min . B.P. \_\_\_\_\_ SPO2 98% on RA

Resp. rate and type of breathing : \_\_\_\_\_

Rash \_\_\_\_\_ } Yellowish discoloration of skin & sclera  
Lymphadenopathy \_\_\_\_\_ }  
Oedema : \_\_\_\_\_ }  
Allergies (if any): \_\_\_\_\_

#### Respiratory System :

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : BILAE (+)

Any addes sounds : \_\_\_\_\_

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

#### Cardiovascular System :

Inspection of precordium : \_\_\_\_\_

Heart Sounds : S1S2 (+)

Any murmur : \_\_\_\_\_

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

#### Per Abdomen :

Inspection \_\_\_\_\_

Palpation : Soft INT.

Ausculation : \_\_\_\_\_

Spine : \_\_\_\_\_ External Genitalia : \_\_\_\_\_

Relevant data from outside (CT, USG etc..) \_\_\_\_\_



### Pediatric Multiorgan History & Physical Examination

#### Central Nervous System :

Level of Consciousness : AVPU/GCS score : \_\_\_\_\_

Cranial Nerves : \_\_\_\_\_

#### Motor System:

Nutriton : \_\_\_\_\_

Tone: \_\_\_\_\_ Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_

Involuntary Movements : \_\_\_\_\_

#### Reflexes :

##### DTR

Plantars \_\_\_\_\_

##### Superficials:

#### Sensory System :

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Bladder / Bowel : \_\_\_\_\_

#### Clinical Summary & Diagnostic:

Neonatal hyperbilirubinemia  
Came for phototherapy.



### Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: \_\_\_\_\_

Desired goals of the treatment : \_\_\_\_\_

**Planned Labs:**

SBR done on OPD basis  
NS  
Shawar  
1/6/26

**Planned Management**

- DSP-1 with eyes & genital covered.
- Vitamin D3 drops - OD
- Colvicaid drops } SOS
- Crocin drops.

Signature of the Doctor: Ramy

Name of the Doctor: Dr. RAMYA

Date & Time: 1/6/26; 4:30pm

Signature of the Consultant: [Signature]

Name of the Consultant: \_\_\_\_\_

Date & Time: 02/06/26 9am

Dr. VIJAYANAND JAMALPURI  
Reg. No. 8852

BAH-00657362 IP5-00174610  
 Baby Of SHARANYA A.  
 27-05-2026 0 Y 0 M 6 D (M)  
 Dr. VIJAYANAND JAMALPURI



## DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet				
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet				
9	General consent for treatment				
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				
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				
29	TPR & BP chart				
30	Intake and Out take chart (fluid chart)				
31	Drug chart (Regular Prescription)				
32	Investigation Values (result sheet)				
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
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				
	Billing				
<b>Total No. of Pages</b>		12			

## 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



*range*

## DRUG CHART

Date of Admission: 11/6/26 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)

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

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

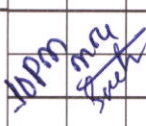
<b>DRUG :</b>				Date Time																	
Dose	Route	Frequency	Start Date																		
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:																					

VERIFIED BY: Name ..... Signature .....



REGULAR PRESCRIPTIONS

Weight. .... Ward. ....

DRUG : VITAMIN - D3 drops				Date Time	11/6																		
Dose	Route	Frequency	Start Date																				
0.5ml	PO	Q24H	1/6/26																				
Name & Signature of the Doctor Starting the Drugs: Dr Ramya																							
Additional Instructions: (1ml = 800 IU)																							
Daily Doctor's Endorsement by a Sign																							
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																							
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																							
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																							





BAH-00857362 IP5-00174610  
 Baby Of SHARANYA A.  
 27-05-2026 0 Y 0 M 5 D (M)  
 Dr. VIJAYANAND JAMALPURI



## RESULT SHEET

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



BAH-00657362  
 Baby Of SHARANYA A. IPS-00174610  
 27-05-2026 0 Y 0 M 6 D  
 Dr. VIJAYANAND JAMALPURI (M)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>25/5/20            9 AM</p>	<p>seen by Dr. vijayanand</p>	<p>Plan            ① cont DSPT            ② SBR @ 3 PM            ③ regular feeding.</p> <p>noted by Sanghvi</p>
<p>28/6/20            3 PM</p>	<p>Afternoon Note            DOL - 6 / NVD / 2-50.            ↓ DSPT.            taking BF well            S / ✓            PA soft            guttural            Erythema            vitally stable</p>	<p>Plan            ① cont DSPT            ② trace SBR.            ③ cont DBF &amp; / b            burping</p>

Dr. VIJAYANAND JAMALPURI  
 Reg. No: 40526

Dr. Sanghvi

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>2/5/26</del> 5 pm	Seen by Dr. Vijayanand  D/c looks well No resusc Chest clear	
	<del>SDR 133</del> Soft, firm swelling →	Plan <ul style="list-style-type: none"> <li>Cont. Budecort Neb<sup>b</sup></li> <li>Review discharge T/x</li> <li>Amoxycillin - <del>Carand</del> 1 drop BD</li> </ul>
<del>Wrong entry</del>	<del>SD</del> <del>5 pm (2/5/26)</del>	
<del>2/6/26</del> 5 pm	Seen by Dr. Vijayanand	
	Dr. VIJAYANAND JAMALPURI Reg. No: 4526	Plan <ul style="list-style-type: none"> <li>Cont. DSP1</li> <li>Review D/c → Tomorrow</li> <li>Regular feeding</li> <li>Monitor vitals</li> </ul> (Ayashman)



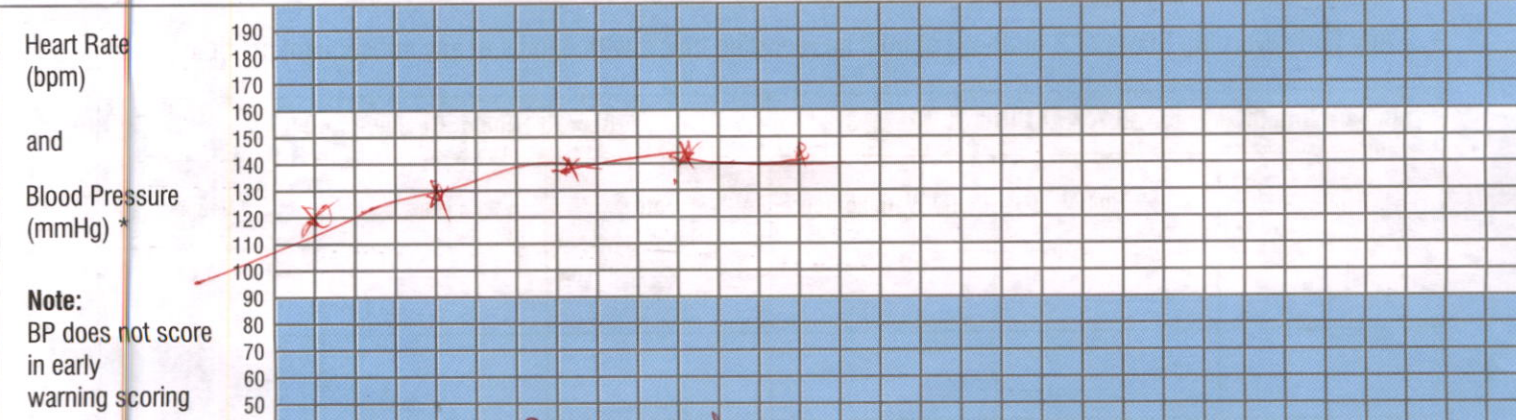
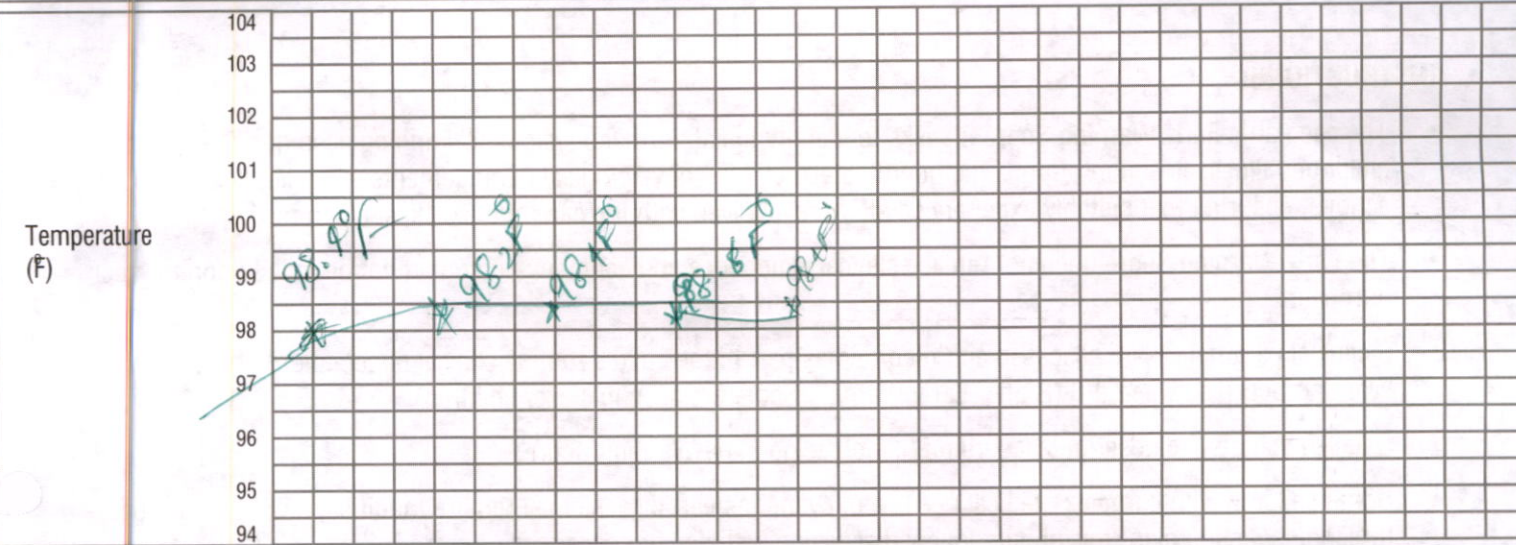




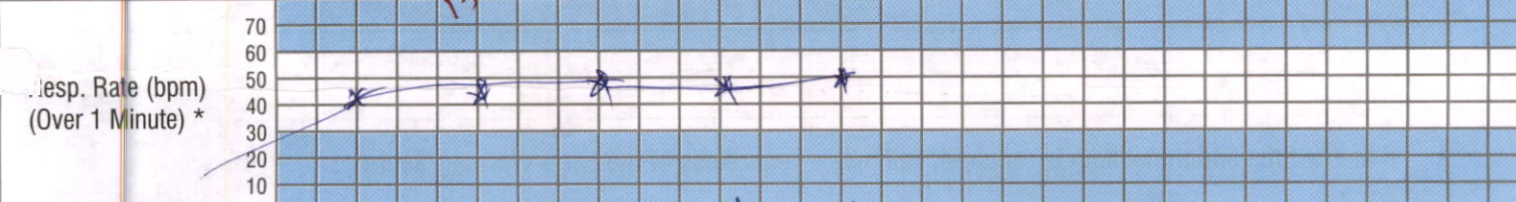
**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: ..... Time: 1/6/26 6PM 9PM 12AM 3AM 6AM 10.

Doctor/Nurse/Family Concern? .....



Heart Rate (Number) 127bpm 132bpm 140bpm 145bpm 146bpm



Resp Rate (Number) 38bpm 44bpm 46bpm 46bpm 46bpm

Resp Mod/ Severe Distress None / Mild

Receiving O<sub>2</sub>(l/min) O<sub>2</sub>Saturations (%) 99% 98% 98% 98% 98%

Conscious Level Normal / Altered

GCS \* (15/15) (15/15) (15/15) (15/15) (15/15)

**TOTAL SCORE**  
 Number of shaded boxes 0 0 0 0 0  
 Pain Score 0 0 0 0 0  
 Observer's Initials [Signature]

**ACTIONS**

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

NB: Scores 3 should be recorded overleaf

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

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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

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

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

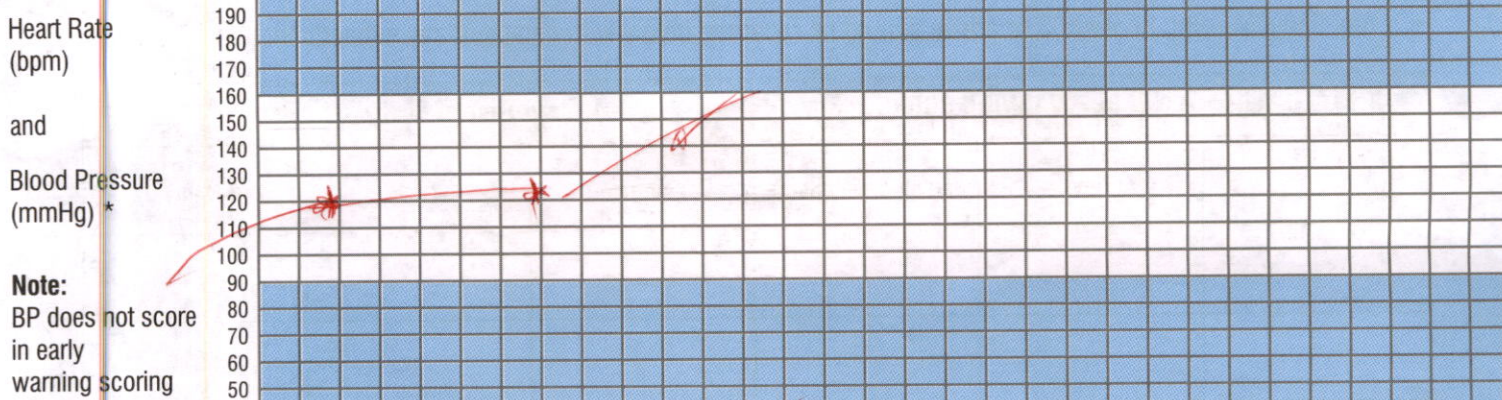
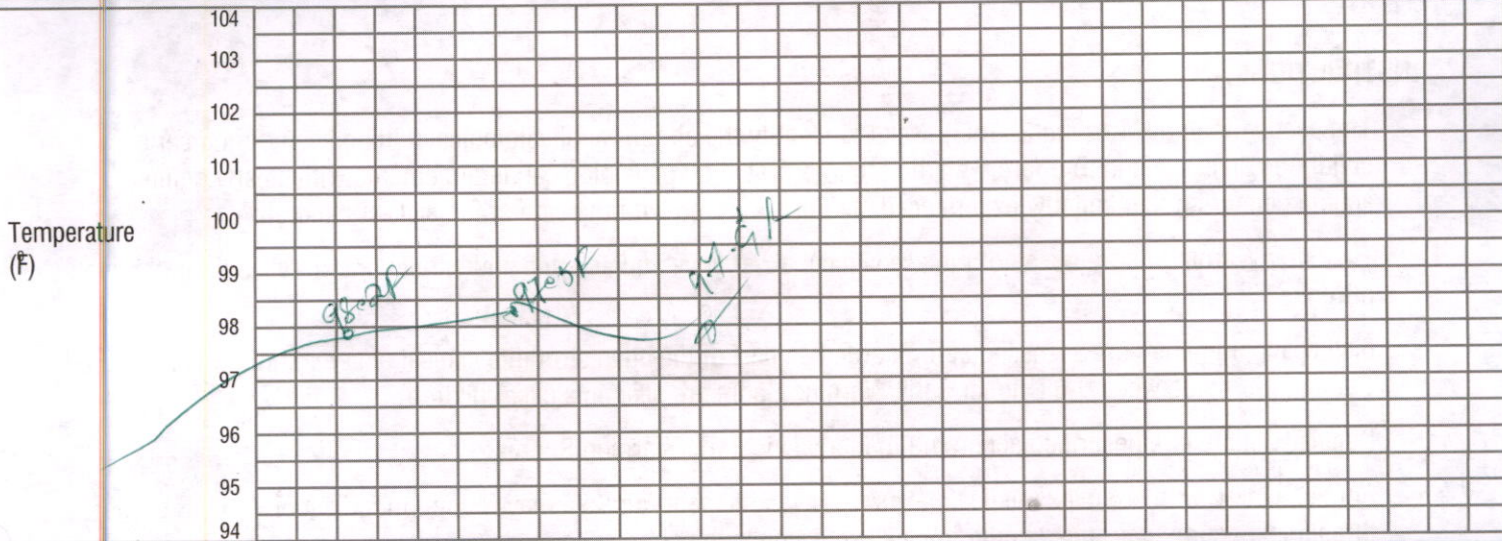
The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: ..... Time: 5 AM 12 PM 6 PM

Doctor/Nurse/Family Concern? \_\_\_\_\_



Heart Rate (Number) 120 125 140



Resp Rate (Number) 30 35 40

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub>(l/min) O<sub>2</sub>Saturations (%) 99% 99% 100%

Conscious Level Normal Altered

GCS \* (15/15) (15/15) (16/16)

**TOTAL SCORE** Number of shaded boxes 0 0 0

Pain Score 0 0 0

Observer's Initials Gy Gy V

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

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

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

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

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

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

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

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> 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-00657362 IP5-00174610  
 Baby Of SHARANYA A.  
 27-05-2026 0 Y 0 M 6 D (M)  
 Dr. VIJAYANAND JAMALPURI



# FLUID CHART

Sheet No. : .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm	DBF EBM FF					✓		✓	0	0	Diags
	07:00 pm		35ml							0	0	Diags
<b>Total Intake :</b>						<b>Total Output :</b> U-1 M-1						
	08:00 pm											
	09:00 pm	DBF EBM		35ml			✓		✓	0	0	Suck
	10:00 pm									No	U	Suck
	11:00 pm	DBF EBM		35ml					✓	U	U	Suck
	12:00 am								✓	U	U	Suck
	01:00 am									U	U	Suck
<b>Total Intake :</b>						<b>Total Output :</b> U-2 M-1						
	02:00 am	DBF EBM		35ml						U	U	Suck
	03:00 am									No	U	Suck
	04:00 am								✓	U	U	Suck
	05:00 am	DBF EBM		35ml			✓			U	U	Suck
	06:00 am								✓	U	U	Suck
	07:00 am	DBF EBM		35ml						U	U	Suck
<b>Total Intake :</b>						<b>Total Output :</b> U-2 M-1						
<b>Total 24 hrs. Intake</b>		210 ml today										
<b>Total 24 hrs. Output</b>		U-5 M-3										

BAH-00657362 IP5-00174610  
 Baby Of SHARANYA A.  
 27-05-2026 0 Y 0 M 5 D (M)  
 Dr. VIJAYANAND JAMALPURI

# 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.
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		
2/5/26	08:00 am	DBF 35ml					✓				1	Sagee
	09:00 am	DBF 35ml					✓				1	Sagee
	10:00 am	ERM							✓		1	Sagee
	11:00 am	DBF 35ml							✓		1	Sagee
	12:00 pm	DBF 35ml					✓		✓		1	Sagee
	01:00 pm	DBF 35ml							✓		1	Sagee
	<b>Total Intake :</b> taken			<b>Total Output :</b> 1-2 m-2								
	02:00 pm										1	Yan
	03:00 pm	DBF 35ml									1	Yan
	04:00 pm						✓		✓		1	Yan
	05:00 pm	ERM 35ml					✓		✓		1	Yan
	06:00 pm										1	Yan
	07:00 pm	ERM 35ml					✓				1	Yan
<b>Total Intake :</b>			<b>Total Output :</b> 3 m-3									
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
<b>Total Intake :</b>			<b>Total Output :</b>									
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
<b>Total Intake :</b>			<b>Total Output :</b>									

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

Patient Sticker



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

Patient Sticker

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