

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176049

Admit Date : 06-Jul-2026

Admit Time : 05:06 PM UHID : BAH-00660441

Patient Details :

Patient Name : Baby Of SANDHYA REDDY MALLADI TWIN 1 Age : 0 Y 0 M 5 D
Guardian : Mr SURESH REDDY MALLADI DOB : 01-07-2026 06:20 PM
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : H NO 3-182/1, PARIMALA COLONY Phone No : 9849680111/ 7337070207
Hanamkonda Warangal Telangana INDIA 506001 E-mail : SURESH.REDDY78@YAHOO.COM

Admission Details :

Bed Type : SEMI PRIVATE

Bed No : SPVT 335

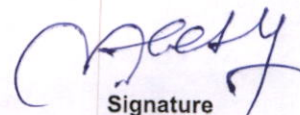
Ward Name : 3F-ZONE C

Room No : SPVT 335

Admission Type : First Visit

Contact Details :

Name : Mr SURESH REDDY MALLADI Relationship : Father
Contact Address : H NO 3-182/1, PARIMALA COLONY Phone No : 9849680111 /
Hanamkonda Warangal Telangana INDIA 506001


Signature

Doctor Details :

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

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAID

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

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

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

BAH-00660441 IP5-00176049
Baby Of SANDHYA REDDY MALLADI
01-07-2026 0 Y 0 M 6 D (F)
Dr. VIJAYANAND JAMALPURI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
06/07/26	5:40pm	ER	335	Keele

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

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.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

Date of Birth	01/02/2021	New Born Screening	:	
Time of Birth	6:20 pm	TFT	:	
Mode of Delivery	LSCS	OAE	:	
Birth Weight	2.804 kg	Mother's Blood Group	:	O +ve
Head Circumference	-	Baby's Blood Group	:	O +ve
Length	-	Anomaly Scan	:	
Red Reflex	-	Vaccination	:	Birth vaccine given

(P.T.O)

[illegible]



Rainbow[®] Children's Hospital

It takes a lot to treat the little.

PEDIATRIC IN-PATIENT MEDICAL RECORD

Patient Name: _____

UHID ID: _____

Department: _____

Consultant: _____

BAH-00660441 IP5-00176049
Baby Of SANDHYA REDDY MALLADI
01-07-2026 0 Y 0 M 6 D (F)
Dr. VIJAYANAND JAMALPURI





Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex _____

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Yellowish discoloration of skin & sclera since 1-2 days.

History of present illness :

~~Child~~

Mother details → 39 yrs

G2 P1L1 → L1 → F1 / Male / 3.7kg / 2018 / Healthy.
LSC in fetal distress

L2 → MCDA twins / twin 1 / female / 36wks Gd / Breech
presentation / RDS → DR CPAP.

Mother BG → 0 positive

Baby BG → 0 positive

6/8: SBR → 12-3 / 0-1 / 12-2

B-WT = 2.804 kg

T-WT = 2.63 kg (5% WT loss)



Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History:

Late preterm / 36wks Gd / AAA / Female / twin - 1.

□ TO

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

} upper middle class

Developmental History :

Ⓝ development

Immunization History :

Birth vaccine given



Pediatric Multiorgan History & Physical Examination

Anthropometry :

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

Weight (kgs)) 2.63 kg (Centile _____)

On Examination :

Temperature : 97.8°F Pulse Rate : 120/min B.P. _____ SPO2 98% on RA

Resp.rate and type of breathing : RR = 28/min

Rash 17

Lymphadenopathy _____

Oedema : Nil

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : B/L AEP

Any addes sounds : _____

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

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1S2 (+)

Any murmur : _____

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

Per Abdomen :

Inspection _____

Palpation : Soft, NT.

Ausculation : _____

Spine : _____ External Genitelia : _____

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

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

monetel jaundice → for DSPT.



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

SBR - TIM after rounds -

Planned Management

- DSPT with eyes & genitals covered
- Continue feeding (EBM)

Signature of the Doctor: Ramya

Name of the Doctor: Dr. RAMYA

Date & Time: 6/7/26, 5pm

Signature of the Consultant: [Signature]

Name of the Consultant: DR. VIJAYANAND JAMALPURI

Date & Time: _____

Registration No: 40526

[illegible]

28

Signature and Date

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



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26 8:00am	C/S IB Resident.	Delivered 8/2
	Δ: Neonatal	
	Terminide	
	6 th DOL Twin - 1 Breech LSCS Early Preterm 36 ^W 2804	
	M/O+ M/O+ B/O+ V/O+	Plan
		① DBF 2nd July
	Tw: 2.550 kg 9.1.↓	② warm care
	- on Exclusive breast feed	③ DSPT with eyes and genital covered
	- good Sucking & latching	
	Euthemic - Pink	
	Any Tone - } good activity	④ watch for mic output
	Reflexes - warm	⑤ Monitor vitals
	CRT 2 sec	⑥ SBR after voids.
		<u>Soluh</u>
7/7/26 9:00am	S/Br VJ Sir	Plan
	Baby doing well	① DBF 2nd July
		② SBR @ 4pm
		③ Procto guard T-out
		④ continue DSPT cycle

DR. VIJAYANAND JAMALPURI
Registration No. 40526

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00660441 IP5-00176049
 Baby Of SANDHYA REDDY MALLADI
 01-07-2026 0 Y 0 M 6 D (F)
 Dr. VIJAYANAND JAMALPURI



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	8/7/26					
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	17.3 < 0.1 17.2					
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.
Patient's / Learner Language: Telugu 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		
06/7	5pm	2	Treatment & care plan	F	1	1	1	0	—	Keetha

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							



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
06/7/26 5:30pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	NNJ	H ⁺ stability.	DSPT	Romya	☐ Nursing ☒ Others:
06/7/26 5:30pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	NNJ	H ⁺ stability	DSPT	Reethi	☒ 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:



MEDICATION RECONCILIATION FORM

Drug Allergies: NO ☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ER Shifted to: Ward

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ramee

Date & Time : 6/7/26; 5pm

Nurse Name & Signature: Kushi Vs

Date & Time : 06/07/26 5pm



REGULAR PRESCRIPTIONS

Weight. 2.63 kg, Ward.

DRUG : <u>VITAMIN D3 drops</u>				Date <u>6/7/26</u>															
Dose	Route	Frequency	Start Date	Time															
<u>0.5ml</u>	<u>PO</u>	<u>OD</u>	<u>6/7/26</u>																
Name & Signature of the Doctor Starting the Drugs: <u>D Remya</u>				<u>8:30 PM</u> <u>Prabha</u> <u>Shiva</u>															
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date															
Dose	Route	Frequency	Start Date	Time															
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date															
Dose	Route	Frequency	Start Date	Time															
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			
DRUG :				Date															
Dose	Route	Frequency	Start Date	Time															
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

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.	

VARIABLE DOSE		Date Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		DRUG :			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.	

STAT / ONCE ONLY DRUGS[illegible]



Weight. 2.634 Ward.

[illegible]



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Bto sandya Reddy Mother's Name: Mrs. Sandya Reddy
Date of Birth: 01/7/26 Time of Birth: 6:20 PM Gender: ☐ Male ☒ Female
Birth Weight: 2.804 Kgs HC: - cm Length: - cm
Meconium in Liquor: ☒ Yes ☐ No Cried at Birth: ☐ Yes ☐ No
Term / Pre-term / Post-term: -
Resuscitated: ☒ Yes ☐ No Blood Group: Mother: - Baby: -
Feeding: ☒ Breast Feeding ☐ Formula ☐ Both First Feed Time: -

AFFIX MOTHER'S
IDENTIFICATION LABEL

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

Indication: -

Physical Assessment of New Born:

Temp: 98.2 °C HR: 138 /Min RR: 36 /Min BP: - SpO₂: 99.1

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☐ Yes ☐ No Score: 13 (Fill the Humpty Dumpty Sheet)

Risk in Pressure Sore: ☒ Yes ☒ No (Braden Q Score) (Fill the Braden Q Sheet)

Behaviour Status on admission: ☒ Sleeping ☐ Crying ☐ Calm ☐ Drowsy

Findings:

General Appearance: Posture: ☒ Well-Flexed ☐ Asymmetry

Skin: ☒ Pink ☐ Meconium Stain ☐ Others, Specify: -

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

Vitamin K 1 mg I.M Administered: Yes / ~~No~~

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / ~~No~~

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

All information obtained from ☒ Mother ☐ Father ☐ Other Family Member

Newborn Screening Discussed: Yes / ~~No~~

Nurse Name: Syony

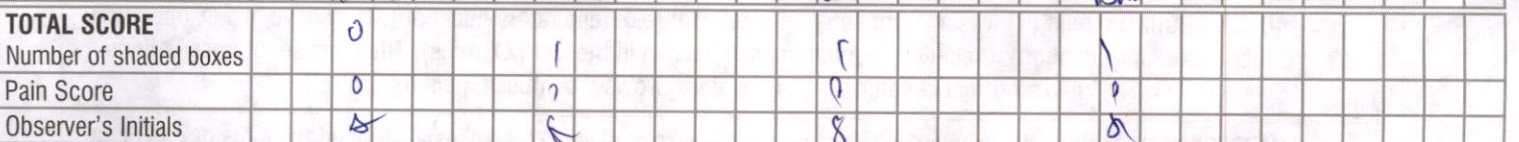
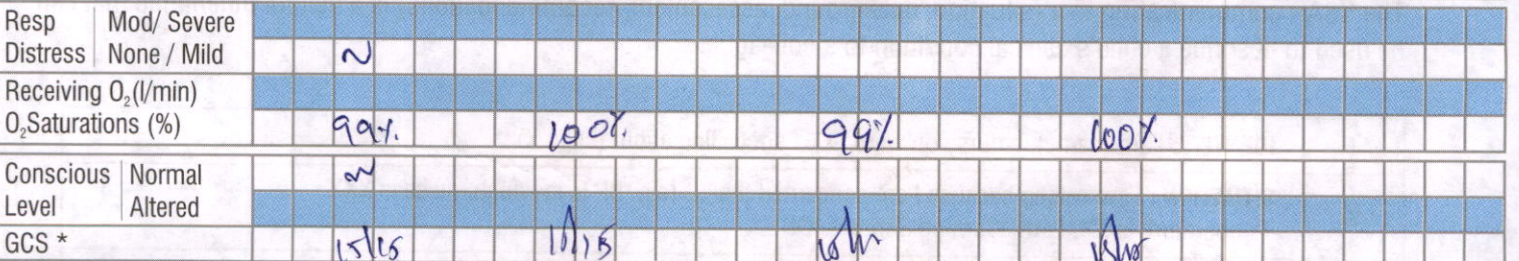
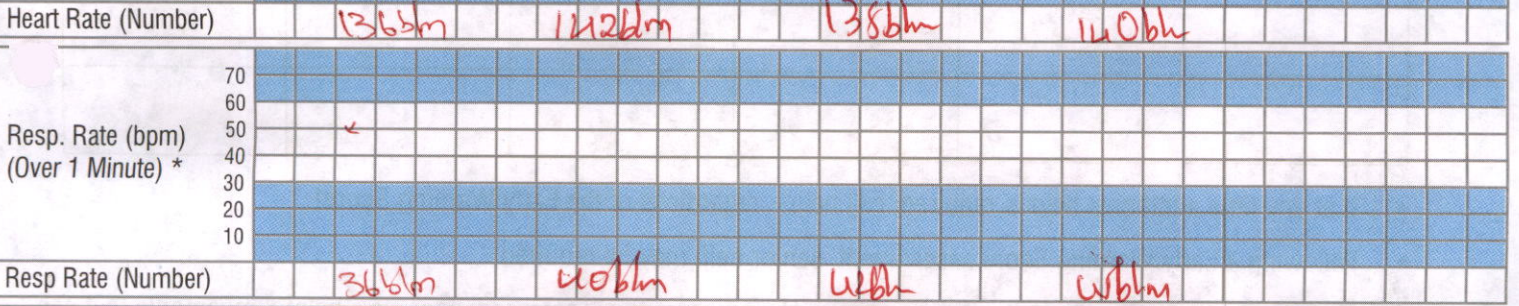
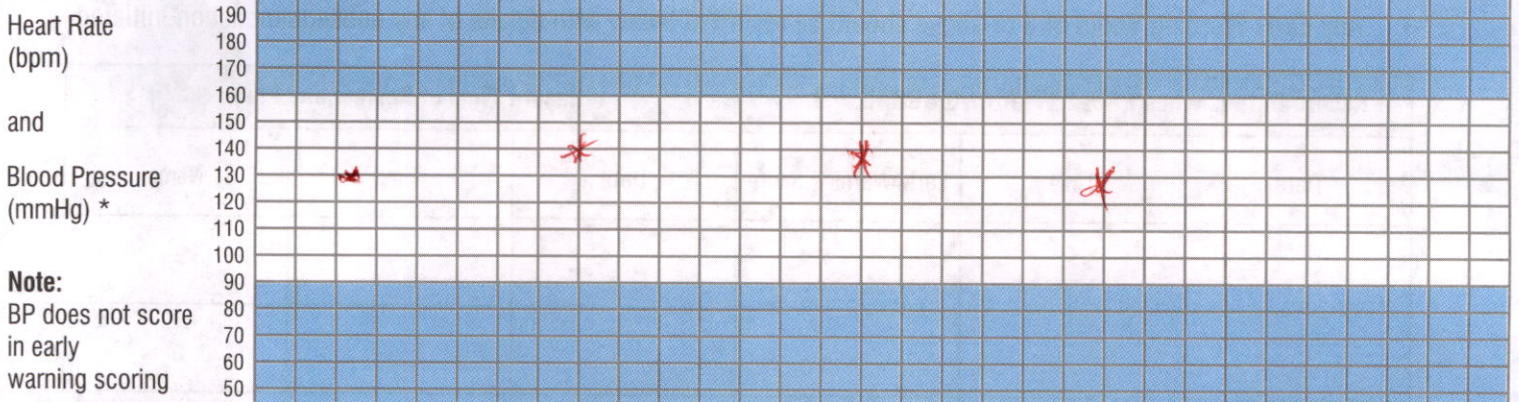
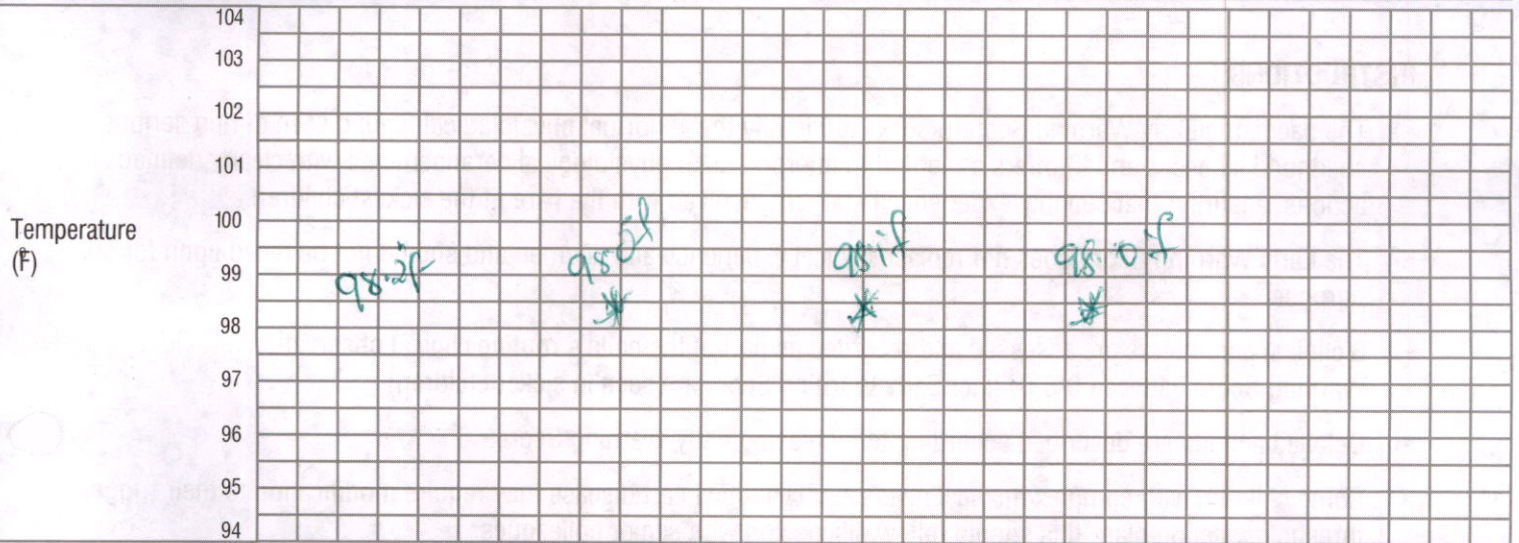
Signature: Syony

Date & Time: 6/7/26 @ 5 PM

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 5pm 10pm 2am 6am
Doctor/Nurse/Family Concern?



ACTIONS

Score 1 : Continue normal observation by staff nurse

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

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

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

Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00860441
Baby Of SANDHYA REDDY MALLADI
01-07-2026 0 Y 0 M 5 D
Dr. VIJAYANAND JAMALPURI (F)



7/7/26
FRM / CLINICAL / 124

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

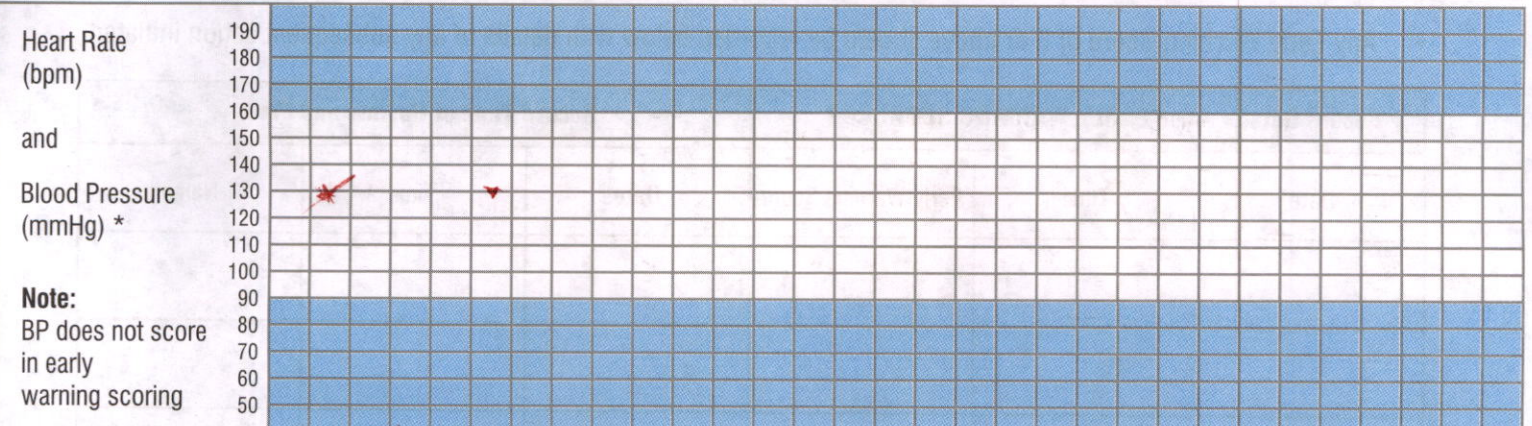
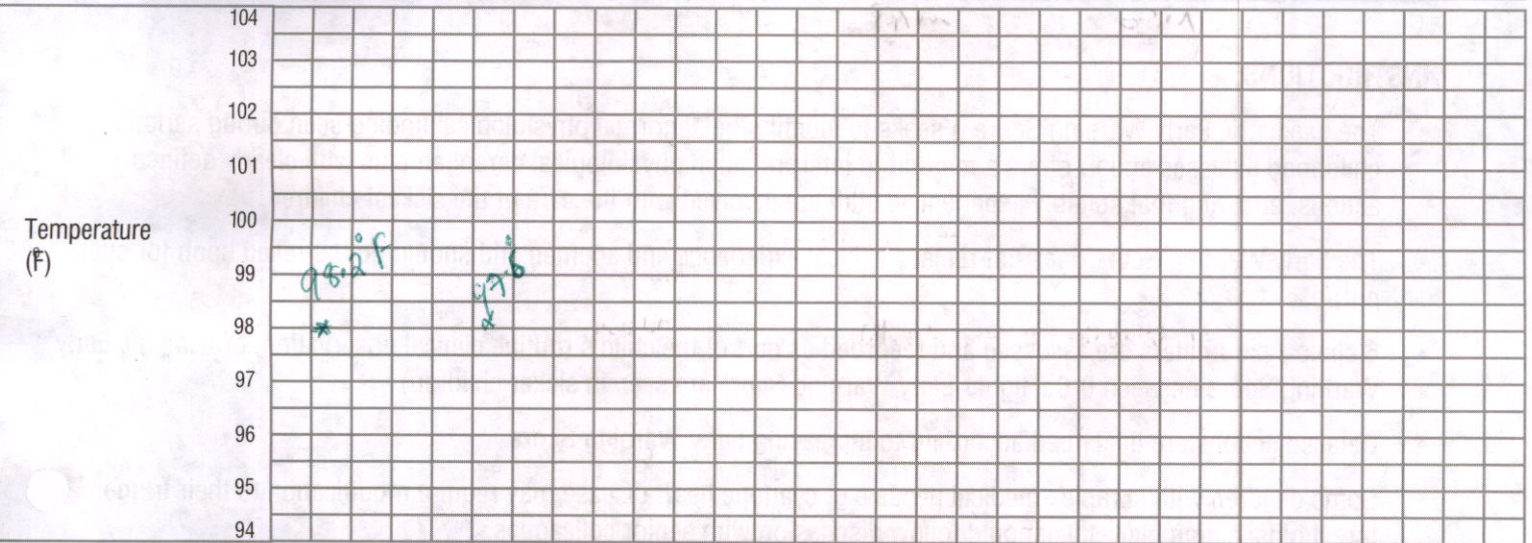
Pratiksha
**Rainbow
Children's
Hospital**
It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

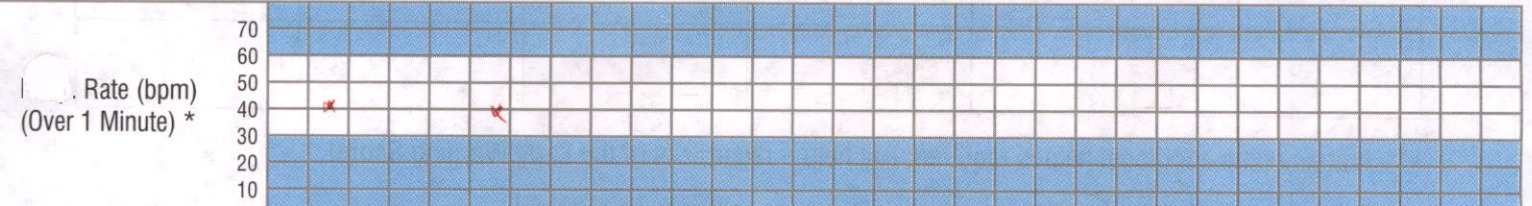
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 10 30

Doctor/Nurse/Family Concern? AM PM



Heart Rate (Number) 136 bpm 132 bpm



Resp Rate (Number) 37 bpm 40 bpm

Resp Distress Mod/ Severe None / Mild N N

Receiving O₂ (l/min) O₂ Saturations (%) 99% 99%

Conscious Level Normal Altered N N

GCS * 15/15 15/15

TOTAL SCORE

Number of shaded boxes 0 0

Pain Score 2 8

Observer's Initials E J

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

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

BAH-00650441
 Baby Of SANDHYA REDDY MALLADI
 01-07-2026 0 Y 0 M 5 D (F)
 Dr. VIJAYANAND JAMALPURI

6/9/26

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

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 Your Right to a Safe Delivery

FLUID CHART

Sheet No. : ①

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											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm	DBF										
	06:00 pm											
	07:00 pm	DBF										
Total Intake :			Taken			Total Output : u-1 m-1						
	08:00 pm											
	09:00 pm	DBF										
	10:00 pm											
	11:00 pm	DBF										
	12:00 am											
	01:00 am	DBF										
Total Intake :			Taken			Total Output : u-2 m-2						
	02:00 am											
	03:00 am	DBF										
	04:00 am											
	05:00 am	DBF										
	06:00 am											
	07:00 am	DBF										
Total Intake :			Taken			Total Output : u-3 m-2						
Total 24 hrs. Intake			Taken			Total 24 hrs. Output			u-6 m-4			



FLUID CHART

Sheet No. : 7/7/26 (2)

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

		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								
7/7/26	08:00 am												
	09:00 am	DBF					✓			✓	1		
	10:00 am						✓			✓	no		
	11:00 am	DBF					✓				iv		
	12:00 pm						✓			✓	1		
	01:00 pm	DBF					✓				1		
Total Intake : Taken						Total Output : 4-3m-5							
	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							