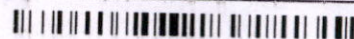


ADMISSION SHEET

Registration Details :



Admission No : IP5-00175875

Admit Date : 02-Jul-2026

Admit Time : 12:51 PM UHID : BAH-00660503

Patient Details :

Patient Name : Baby Of SRI VAISHNAVI RENUKUNTLA

Age : 0 D

Guardian : DR SAI CHANDRA HAKEEM

DOB : 02-07-2026 11:53 AM

Gender : Female

Religion :

Occupation :

Martial Status : Single

Address (H) : C-604, PRANAVA ONE, ADJ TO ERRAMANZIL
METRO STATION, Erramanzil Hyderabad
Telangana INDIA 500082

Phone No : 9849039577

E-mail : srivaishnavirenukuntla@gmail.com

Admission Details :

Bed Type : BASINET

Bed No : CRDL-SUITE424-1

Ward Name : 4F-BIRTHRIGHT
PREMIUM

Room No : CRDL-SUITE424-1

Admission Type : First Visit

Contact Details :

Name : DR SAI CHANDRA HAKEEM

Relationship : Father

Contact Address : C-604, PRANAVA ONE, ADJ TO
ERRAMANZIL METRO STATION, Erramanzil
Hyderabad Telangana INDIA 500082

Phone No : / 9849039577

Signature

Doctor Details :

Doctor Name : Dr. NALINIKANTA PANIGRAHY

Specialisation : NEONATOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY



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Date of Birth	: 26/12/26	New Born Screening	:
Time of Birth	: 11:53 AM	TFT	:
Mode of Delivery	: FL - LSCS	OAE	: (otve)
Birth Weight	: 2.820kg	Mother's Blood Group	: (otve)
Head Circumference	: 35CM	Baby's Blood Group	: (otve)
Length	: 50CM	Anomaly Scan	:
Red Reflex	:	Vaccination	: BCG, OPV, Hep B Given on 21/12/26 Kaveri 12/12/26

Docu. No. : RCHBH /FRM / CLINICAL / 132

Date	Time	Investigation	Result	Order No.	Signature
✓ 2/2/26	1:00 PM	Blood grouping	O ⁺ ve	26066209	Sunanda
✓ 2/7/26	1:20 PM	GPBS	73mg/dl	26066472	Sunanda
✓ 2/7/26	5:00 PM	GPBS	87mg/dl	26066472	Sunanda
✓ 3/2/26	11 AM	GRBS	61mg/dl	26066472	Ashwini
✓ 3/2/26	5 AM	GRBS	76mg/dl	26066472	Ashwini
✓ 3/7	12:00 PM	TCBR	8.7	26066562	Sunanda
✓ 3/7	4:40 PM	TCBR	9.2	26066691	Sonax
✓ 3/7	7 PM	GRBS	84mg/dl	26066794	Sonax
4/2/26	7 AM	GRBS	85mg/dl	26066691	Sonax
✓ 4/7/26	9:00 AM	TCBR	13.5	26067115	Sunanda
4/7/26	12 PM	OAE	done	4687777	Sunanda
4/7/26	10:40 AM	SSPT	stop 5/7/26	4687777	Sunanda
✓ 5/7/26	8:10 AM	SBR	11.8 < 11.2	26067240	Anita
✓ 5/7/26	8:10 AM	NBS	sent	26067306	Anita
✓ 5/7/26	9:30 AM	RBS	86mg/dl	26067306	Anita
cross					
3/7/26	4:40 PM	TCBR	9.2	26067360	Sonax
6/7/26	8:30 AM	TCBR	12.5mg/dl	26067458	Anita



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Sri Vaishnavi Age : Father's Name : Age :
Date of Birth : Date of Admission : UHID No.:
NICU Consultant : Referring Consultant :
Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward
Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : Sri Vaishnavi Mother's Blood Group : O positive
Gender : ☐ M ☒ F Blood Group : Birth Weight (gms) : 3.220kg Length (cms) : 50cm
Date of Birth : 2/7/26 Time of Birth : 11:52am OFC (cms) : 35cm
Place of Birth : RCH:RH Estimated Gesth Age : 38+2

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 29 Ht : Wt : BMI : Married Life : LMP : 11/10/25 EDD : 18/9/26
Conception : ☒ Spontaneous or with Rx : Intrauterine insemination
Booked at what GA : 5+1 AN Steroids Drugs / Doses :
Last Scans Details : 25/6 : 32+1 / cephalic / 3.2kg / AC: 80- / AF: 18- / Placenta anterior
NI Doppler TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs Progressive myopia
Consanguinity : ☐ Yes ☐ No Compound astigmatism
If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3 Retinal detachment
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?

Just hypothyroid

Any other Chronic Medical Problems, when detected drugs ? T. Thyroxine 50mcg

(Anemia, SLE, Jaundice, CHD, Heart Disease)

Infection : H/O, Fever

(☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)

UTI : when : Any culture :

PPROM : Duration : ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results :

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

P: A: L:

Sl. No.	Wks	B. W	Gender	Significant	Details
		Posm			

PERINATAL HISTORY

Treating Obstetrician : Dr. Pranathi Reddy Hospital : ECM:BN ☒ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☒ Elective ☐ Emergency Indication :

Specify the reason : IVF

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitaion : ☐ Yes ☐ No

Cord ABG :

Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

SIGN	0	1	2
COLOUR	Blue or Pale	Acrocyanotic	Completely Pink
HEART RATE	Absent	< 100 Minutes	> Minutes
REFLEX IRRITABILITY	No Response	Grimace	Cry or Active Withdrawal
MUSCLE TONE	Limp	Some Flexion	Active Motion
RESPIRATION	Absent	Weak Cry; Hypoventilation	Good, Crying

TOTAL

1 Minute	5 Minutes	10 Minutes
1	1	
2	2	
2	2	
2	2	
1	2	
8	9	

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



Gripment check done



Baby received in a prewarmed linen



Dried / cleaned / stimulated



Cord cleaned / clamped / cut



W. vitamin K D. sul. 1.m. given



vitals checked



Shifted to mother's side

Investigation details in previous Hospital :

Feeding History :

Pati

Past History :



Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Euthermic Pink
C/T/A : good
Hemodynamically stable

VITALS : Temperature : euthermic HR : 149/min RR : 24/min NIBP : ✓ CFT : 135

Color of the extremities : Acrocyanotic

Jaundice : Pallor : SpO2 : 97%

Anthropometry : Birth Weight : 3820 Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA : ✓



HEAD TO TOE EXAMINATION

HEAD : Fontanelles :
 Sutures
 Shape / Moulding : *no caput*
 Edema / Bruising :
 Size - (H.C.) :

Facies :
 (Any Facial
 Dysmorphism) *— N —*

**NECK and
 CLAVICLES :** Range of Motion :
 Asymmetry : *N —*
 Masses :

EYES : Symmetry :
 Red Reflex : *to be checked*
 Discharge :

**EARS, NOSE
 MOUTH and
 THROAT :** Ear set / Shape :
 Periauricular Pits / Tags :
 Nasal shape / Patency :
 Palate :
 Gums : *no cleft lip / palate*
 Lips :
 Tongue :

**THORAX and
 BREASTS :** Shape of Thorax : *N*
 Position of Nipples and Number :

**ABDOMEN and
 UMBILICUS :** Shape :
 Organomegaly :
 Bowel Sounds :
 Umbilical Stump : *QA + W*
 Discharge :

GENITILIA : Labia / Hymen : *21*
 Testicles/penis :
 Anus :

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

EXTREMITIES : Fingers / Toes :
 Arms / Legs : *21*
 Deformities :
 Mobility :
 Hip Joint Examination :



SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress : RR : 49/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 : 97 - Auscultation : R+E (+) Breath Sounds : NVBS (+) Added Sounds :

Cardiovascular System :

HR : 149/min BP : Precordial Activity :

Femoral Pulses : R/L well felt Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure : NI

Abdomen :

Shape : Hernia orifice :

Palpation : Anal Patency : looks patent

Palpable masses : Umbilical Cord : 2A + IV

Abdominal girth : First urine passed : 5

Meconium passed : -

Nervous System : Higher intellectual functions (Sensorium) : As

State of wakefulness :

Prechtle Score :

Nerves :

Motor System :

Passive Tone : d/t as good

Active Tone :

Neonatal Reflexes :

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

Moro's : R/L Symmetrical DTR : As

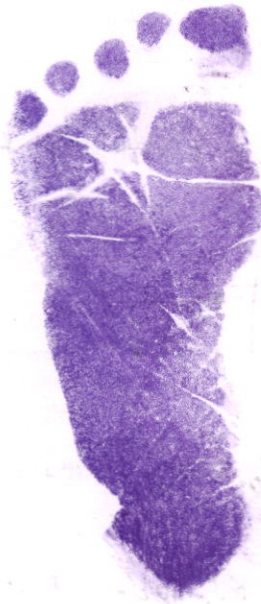
ATNR : Skull and Spine :



Diagnosis : Premi | 38+2 | FL-LSCS | 101 | CIAB | 3820 gram | 244 |
Gestational hypothyroid

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : [Signature]

Name : Dr. Lohith

Date & Time : 2/7/26

Consultant :

Signature : [Signature]

Name : [Signature]

Date & Time : 2/7/26

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.

AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

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

Any Oxygen requirement :

Systemic : Plan

Medications :

1. Send cord blood for blood grouping.

2. OPV
ECG
Hep. B | today

Plan during ward follow up :

3. SRE/NBS/OAE @ 48 Hrs.

4. RBS RT HOL - Post feed
GM HOL - Post feed
inform if < 50mg/dl.

Feeding Plan at the time of shifting :

12:00 PM to 12:20 PM

IF mother not confident on feeding,
low engage then every 4H post feed
RBS monitoring

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :



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Hospital**
It takes a lot to treat the little.

PROGRESS NOTES AND DOCTOR'S ORDER

Docu. No. : RCHBH /FRM / CLINICAL / 088



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7 4 PM	CLCB RESIDENCE	
	28 Wk 38+2 Wks Gest-Hypothyroid / CLAB	
	OT	Plan
	OT	1. Measured Feeds
	Excessive weight loss. on measured feedings	AS top-up + DBF 12-15ml/2nd hourly.
	Enteric milk	2. SBE/NBS/OAE @
	at/A: good	18HOL - 6 PM 12:00 PM
	hemodynamic - stable	
	icteric on face	3. TBL at 18HOL 11:30 PM
	NB - Sr-Sona	



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		4/7/26 OAE - New born hearing screen Bilateral responses are present Bilateral Pass
	Labelation notes Labelled 00-00-00, Demand Pumping in after DBF in view of SSPT and big baby. <u>Shruya Prod/Lin</u>	
4/7 5:20 PM	cl/B <u>RESIDENT</u> 50Kw/ 28+2 Gestational hypothyroid/ 194/ 3820/ CIAB.	
OT OT	$\begin{array}{r} 4 \rightarrow 3 \\ m \rightarrow 3 \end{array}$ Br Reflexes: not symmetrical Br femorals 1+ cl/as good Autonomic fine ↓ SSPT. Good perfusion.	Plan 1. DBF and house + top up as advised. 2. SBR/NBS tpm 8am 3. Temp. monitoring with house. 4. Wt at SSPT.

Date & Time	Progress Notes	Doctor's Order
5/7/26 4pm	<u>Seen by Resident</u> Baby on room air Accepting feeds well Cry } Tone } Good Activity } Sucking: Good Hemodynamically stable CRT 23sec passed urine & stool Euthermic <u>Heart rate normal</u>	<u>plan</u> 1. DRF 2nd hourly followed by burping Topup as advised 2. Trace NBS 3. Temperature Charting 4th hourly 4. Plan (OII) Tomorrow Suf sai
Noted by Sis. Anita		

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00660503 IP5-00175875
Baby Of SRI VAISHNAVI
02-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. NALINIKANTA PANIGRAHY



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NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B10 vaishnavi Mother's Name: Mrs. vaishnavi

Date of Birth: 2/2/26 Time of Birth: 11:53 AM Gender: ☐ Male ☒ Female

Birth Weight: 3.820 Kgs HC: 35cm cm Length: 50cm cm

Meconium in Liquor: ☒ Yes ☐ No Cried at Birth: ☒ Yes ☐ No

Term / Pre-term / Post-term:

Resuscitated: ☒ Yes ☐ No

Blood Group: Mother: (O+ve) Baby:

Feeding: ☒ Breast Feeding ☐ Formula ☐ Both

First Feed Time: 12:00 PM to 12:20 PM

BAH-00640436 IP5-00175863
Dr. SRI VAISHNAVI RENUKUNTLA
14-03-1997 29 Y 3 M 21 D (F)
Dr. PRANATHI REDDY A



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

Indication:

Physical Assessment of New Born:

Temp: 98.6 °C HR: 140 /Min RR: 40 /Min BP: SpO₂: 100 %

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☐ Yes ☐ No Score: (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: Sundar

Signature: [Signature]

Date & Time: 2/2/26 12:14 PM

MULTI-DISCIPLINARY PLAN OF CARE FORM

new born baby.

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Nursing ☐ Others:
2/7/26	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	+ DBF 8/1 burping	* burping after feed.	* provided to saide saile provided	Sunanda	☐ 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:



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: English 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		
2/7/26										
2/7/26			Infection control measures	M/F	1	0	1	1	—	Sunanda

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							

BAH-00660503 IP5-00175875

Baby Of SRI VAISHNAVI

02-07-2026

0 Y 0 M 0 D 1 H (F)

Dr. NAJNIKANTA PANIGRAHY

INITIAL / 124



INFANT (<1 year)

Children's Observation &
Early Warning Scoring Chart
 Pratiksha
Rainbow
Children's
Hospital
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Patient S

WARNING SCORE: CHILDREN'S UNIT

Date: 2/7/26 Time: 12 PM 4 PM 8 PM 2 AM 7 AM

Doctor/Nurse/Family Concern?

Temperature
(°F)Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
per 1 Minute *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / MildReceiving O₂ (l/min)
O₂ Saturations (%)Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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

Score 5 & 6 : Shift 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-00660503
Baby Of SRI VAISHNAVI
02-07-2026
Dr. NAUNIKANTA PANIGRAHY
0 Y 0 M 0 D 1 H
IP5-00175875
(F) / FRM / CLINICAL / 124

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

Pratiksha
**Rainbow
Children's
Hospital**
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Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 3/7/26 Time: 8PM 11:30 PM 1PM 6PM 10PM 2AM 6AM

Doctor/Nurse/Family Concern?

Temperature
(°F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
per 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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- 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.
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- 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)



RM / 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: 07/07/26 Time: 8 AM 11 AM 5 PM 10 PM 3 AM 8 AM
Doctor/Nurse/Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

Heart Rate (Number)

Resp. Rate (bpm)
per 1 Minute) *

70
60
50
40
30
20
10

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Level
Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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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)

* 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.

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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)

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	DBF					N				N	NO	Sundar	
	01:00 pm						P.				P	IV		
Total Intake :			Taken			Total Output :								
	02:00 pm	DBF										N	NO	Sundar
	03:00 pm											P	IV	
	04:00 pm											NO		
	05:00 pm	DBF					✓				I	IV		
	06:00 pm										N	NO		
	07:00 pm	DBF									P	IV		
Total Intake :			Taken			Total Output :								passed
	08:00 pm	DBF					✓						I	Ashwita
	09:00 pm						✓							
	10:00 pm													
	11:00 pm	DBF										NO		
	12:00 am	DBF										IV		
	01:00 am													
Total Intake :			Taken			Total Output :								Passed
	02:00 am	DBF					✓						I	Ashwita
	03:00 am	DBF												
	04:00 am													
	05:00 am	DBF										NO		
	06:00 am	DBF										IV		
	07:00 am						✓							
Total Intake :			Taken			Total Output :								Passed

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. : 7

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							
3/7/26	08:00 am	DBF				✓			✓			Sumande
	09:00 am					✓			✓			
	10:00 am					✓			✓			
	11:00 am	DBF				✓			✓			
	12:00 pm								✓			
	01:00 pm	DBF							✓			
Total Intake : taken					Total Output : passed 23 ml							
3/7	02:00 pm											f
	03:00 pm	DBF										
	04:00 pm	DBF										
	05:00 pm	DBF										
	06:00 pm								✓			
	07:00 pm	DBF				✓						
Total Intake : Taken					Total Output : U-1 M-1 passed							
	08:00 pm											no
	09:00 pm	DBF				✓			✓			
	10:00 pm	EBM 6ml										
	11:00 pm	FF 10ml										
	12:00 am								✓			
	01:00 am	DBF+EBM 3ml										
Total Intake : Taken					Total Output : U-1 ml							
4/7	02:00 am	FF 6ml							✓			no
	03:00 am											
	04:00 am	DBF+EBM 3ml							✓			
	05:00 am	FF 20ml										
	06:00 am											
	07:00 am	DBF+EBM 2ml				✓			✓			
Total Intake : Taken					Total Output : Passed							
Total 24 hrs. Intake					Total 24 hrs. Output							
					U 8 ml - 6							

BAH-00660503
Baby Of SRI VAISHNAVI
02-07-2026
Dr. NALINIKANTA PANIGRAHY
IP5-00175875
(F)

Patient

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. : 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.

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	10ml LF					✓			✓	2	Suranda	
	09:00 am									0			
	10:00 am									1			
	11:00 am	DBF								✓			
	12:00 pm	13ml LF					✓			✓	NO		
	01:00 pm	DBF					✓			✓	NO		
Total Intake :			Taken			Total Output : V=3, M=3 passed							
	02:00 pm	10ml								✓	1	Suranda	
	03:00 pm												
	04:00 pm						✓			✓	no		
	05:00 pm	DBF								✓	1		
	06:00 pm	ff-10ml								✓	1		
	07:00 pm						✓			✓	1		
Total Intake :			Taken			Total Output : V=2, M=2							
	08:00 pm	DBF					✓			✓	1	Suranda	
	09:00 pm	ff-15ml								✓	1		
	10:00 pm	DBF								✓	1		
	11:00 pm	ff-15ml								✓	1		
	12:00 am									✓	1		
	01:00 am	DBF					✓			✓	1		
Total Intake :			Taken			Total Output : Passed V=5, M=2							
	02:00 am	ff-15ml					✓				1	Suranda	
	03:00 am												
	04:00 am										NO		
	05:00 am	DBF					✓			✓	1		
	06:00 am	ff-10ml								✓	1		
	07:00 am									✓	1		
Total Intake :			Taken			Total Output : Passed M=9, V=13							
Total 24 hrs. Intake						Total 24 hrs. Output							

FLUID CHART

Sheet No. : (4)

5/7/26

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	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	DBF					✓						Anita
	09:00 am												
	10:00 am	DBF EBM 2ml								✓	No IV		Anita
	11:00 am	FF 20ml											
	12:00 pm												Anita
	01:00 pm	DBF					✓			✓			
Total Intake :			Taken			Total Output :			U-2m-2				
	02:00 pm	EBM 3ml								✓			Anita
	03:00 pm	FF 20ml								✓			
	04:00 pm										No IV		Anita
	05:00 pm	DBF											
	06:00 pm	DBF					✓			✓			Anita
	07:00 pm	EBM 3ml FF 20ml								✓			
Total Intake :			Taken			Total Output :			U-4m-1				
5/7/26	08:00 pm						✓			✓	No IV		Surand
	09:00 pm												
	10:00 pm	DBF								✓	No IV		
	11:00 pm	EBM 3ml FF 20ml					✓				No IV		
	12:00 am												
	01:00 am										No IV		
Total Intake :			taken			Total Output :			passed				
6/7/26	02:00 am										No IV		Surand
	03:00 am	DBF EBM 3ml											
	04:00 am	20ml					✓			✓			
	05:00 am												
	06:00 am	DBF EBM 3ml									No IV		
	07:00 am	FF 20ml					✓			✓			
Total Intake :			taken			Total Output :			passed				
Total 24 hrs. Intake													
Total 24 hrs. Output													



NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time	
						2/2/26	2/2/26	2/2/26	2/2/26	2/2/26	2/2/26	2/2/26	2/2/26	
						8:30 PM	8:30 PM	8:30 PM	8:30 PM	8:30 PM	8:30 PM	8:30 PM	8:30 PM	
						NA	NA	NA	NA	NA	NA	NA	NA	
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0	0	0	0	0	0	0	0	
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0	0	0	0	0	0	
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0	0	0	0	0	0	
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0	0	0	0	0	
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0	0	0	0	0	
Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention					Gestational Age / Corrected Age	28 wks	28 wks	30 wks	30 wks	30 wks	30 wks	30 wks	30 wks	
					Total Pain / Agitation Score	0/10	0/10	0/10	0/10	0	0	0	0	0
					Intervention	NA	NA	NA	NA	0	0	0	0	0
					Effectiveness	NA	NA	NA	NA	NA	NA	NA	NA	NA
					Signature	Sirad	Ashwin	Sirad	Sirad	Sirad	Sirad	Sirad	Sirad	Sirad

NPASS: Neonatal Pain, Agitation & Sedation Scale

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

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
						5/7							
						8:00 AM							
						Procedure							
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0							
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0							
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0							
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0							
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0							
 Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention						Gestational Age / Corrected Age	38-26/29						
						Total Pain / Agitation Score	0						
						Intervention	Nb						
						Effectiveness	Nb						
						Signature	Swanda						

NPASS: Neonatal Pain, Agitation & Sedation Scale

	Sedation	Pain / Agitation
How to use	- Observe the infant for a minute before selecting a score for each behavior. - Stimulate the infant and observe and select a score for each behavior. - Select only one numeric value (Highest) per behavior.	- Observe the infant for a minute before selecting a score for each behavior. - Select only one numeric value per behavior.
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BAH-00660503
 Baby Of SRI VAISHNAVI
 02-07-2026
 Dr. NALINIKANTA PANIGRAHY

IP5-00175875

0 Y 0 M 0 D 1 H (F)



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

BirthRight™
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 Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	2/7/26	2/7/26	3/7/26	3/7/26	3/7
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2				
	Female	1	1	1	1	1	
Diagnosis	Neurological Diagnosis	4			1	1	
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3		3	3	
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1		1			1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2		2	2	
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4		2			4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					3
	Patient Placed in Bed	2	2	2	2	2	
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
Total			16	16	16	16	15

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	YES	✓	✓	✓	✓	✓
Call device within reach	YES	✓	✓	✓	✓	✓
Wheels Locked	YES	✓	✓	✓	✓	✓
Room free of clutter	NO	✓	NO	NO	NO	✓
Adequate lighting	NO	✓	NO	NO	NO	✓
Wheel chair support	NO	✓	NO	NO	NO	✓
Other Intervention(s) Specify	NO	✓	YES	✓	✓	✓
Nurse's Name:		Susma	Ashita	Susma	Far	Set
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		2/7/26	3/7/26	3/7/26	3/7/26	3/7
Time:		8PM	12PM	2PM	3PM	10PM



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4/7/2024	4/7	4/7	4/7	4/7
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2	2	2	2	2	2
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3	3	3	3		
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4				4	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3	3	3	3	3	3
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1	1	1	1	1
Total			16	16	16	16	16

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	yes	x	x
Call device within reach	yes	yes	yes	x	x
Wheels Locked	yes	yes	yes	✓	✓
Room free of clutter	yes	yes	yes	✓	✓
Adequate lighting	no	no	no	✓	✓
Wheel chair support	no	no	no	x	x
Other Intervention(s) Specify	no	no	no	x	x
Nurse's Name:		Suvarna	Shree	ashoka	Anita
Signature:		[Signature]	[Signature]	[Signature]	[Signature]
Date:		4/7/2024	4/7	5/7	5/7
Time:		8pm	5pm	8pm	8pm

BAH-00660503 IP5-00175875
 Baby Of SRI VAISHNAVI
 02-07-2026 0 Y 0 M 0 D 1 H (F)
 Dr. NALINIKANTA PANIGRAHY



BRADEN 'Q' SCALE

		Date : 26/7/26 3/1/26 20/8/26 20/8/26			
		Time : 8:30 AM 8:30 AM 8:30 AM 8:30 AM			
Mobility	Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2 2 2 2
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	2 2 2 2
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation. OR, limited ability to feel pain over most of the body surface.	2. Very limited: Responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2 2 2 2
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	2 2 2 2
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2 2 2 2
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4 4 4 2
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4 4 4 2
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23				TOTAL SCORE	18 18 18 18
Docu. No: RCHBH /FRM / CLINICAL / 119				Evaluator's Name	Sunanda Kishor Sunanda Kishor

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

BAH-00660503 IP5-00175875
 Baby Of SRI VAISHNAVI
 02-07-2026 0 Y 0 M 0 D 1 H (F)
 Dr. NALINIKANTA PANIGRAHY



BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	24/26/2026			
					Time :	8:30 AM			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:tremitry position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		1	1	1	1
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		1	1	1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		2	2	2	2
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		2	2	2	2
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	2	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
TOTAL SCORE						18	18	18	18
Evaluator's Name						Sangeeta			

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
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BAH-00660503
Baby Of SRI VAISHNAVI
02-07-2026
Dr. NALINIKANTA PANIGRAHY
IP5-00175875
O Y O M 2 D
(F)

BRADEN 'Q' SCALE

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

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

					Date :	5/7	5/7		
					Time :	6 PM	8 AM		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	1	1			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2			
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Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23									
Docu. No. : RCHBH /FRM / CLINICAL / 119									
					TOTAL SCORE				
					Evaluator's Name				
					15 15 Hrita Suresh				

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
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BAH-00660503 IP5-00175875
 Baby Of SRI VAISHNAVI
 02-07-2026 0 Y 0 M 0 D 1 H (F)
 Dr. NALINIKANTA PANIGRAHY



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 26/26

Assessment: New born baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
12PM	Assessed to the condition	4PM	Assessed to baby condition	pt is comfortable
2PM	DIO Hand	2:30 PM	DIO Hand Moulding done	stable
3PM	DBF	4PM	DBF Hand hardly done	
4:50 PM	Warm care	5PM	Warm care done	
5:30	hooping	6PM	hooping after feed done	
6:30 PM	GRBS.	7PM	PBS. checked done	
8PM	safety	8:30 PM	saidle rails provided	

Re-Assessment: Re-assessed 2nd hourly done

Special Notes: GRBS / SBR / NBS / OAE 48HOL / GRBS. 12 hourly / TCBP 4:30 PM today Evening

Nurse Signature: [Signature]

Nurse Name: Sruard (606299)

Date & Time: 26/26 8PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/8/26

Assessment: Newborn baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8:00pm	Assess the general condition	8:10pm	Assessed the general condition	Baby is Stable
10:00pm	monitor vitals	10:10pm	Vitals checked Pulse, SpO2, Resp	
12:00am	monitor Ilochart	12:10am	Ilochart monitored	
2:00am	GRBS monitoring	2:10am	GRBS monitoring done	
4:00am	DBF every 2-3 hourly	4:10am	DBF given every 2-3 hourly	
6:00am	Ensure safety	6:10am	Cribcase provided.	

Re-Assessment:

Special Notes: GRBS monitoring.

Nurse Signature: [Signature]

Nurse Name: Ashwita

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



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 3/7/26

Assessment: New born baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	* Assess to baby condition.	9 AM	* assessed to baby condition	* pt is
10 AM	* DIO Hand	10:30 AM	* DIO Hand monitoring	comfortable
11 AM	* DBF	11:30 AM	* DBF and hourly care	
12 PM	* burping	12:30 PM	* burping after feed	
1 PM	* warm care	1:30 PM	* warm care	
2 PM	* safety	2:30 PM	* side rails provided	

Re-Assessment: DBF and hourly care

Special Notes: SBR NBS QAE / 4840L

Nurse Signature:

[Signature]

Nurse Name:

Sanade (606299)

Date & Time:

3/7/26 8 PM

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 27/7/26

Assessment: New Born Baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ plan for vitals	2:10 pm	→ vitals checked and Ruled	
3pm	→ I/O chart	3:10 pm	→ I/O Charting maintained	→ B-Saf
4pm	→ wound care	4:10 pm	→ wound care provided	shd
5pm	→ vitals care	5:10 pm	→ vitals are provided	
6pm	→ DBF feeding	6:10 pm	→ DBF feeding Given	
7pm	→ Baby	7:10 pm	→ Ensured Safety	
8pm	→ Burping	8:10 pm	→ Burping done	

Re-Assessment: vitals checked and Ruled.

Special Notes:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 27/7/26

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/12/26

Assessment: new born Baby care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ assess the Baby condition	8:30pm	→ assessed the Baby condition	→ Patient stable
10pm	→ monitor vitals	10:30pm	→ monitor vitals	
11pm	→ Ensure Safety.	11:20pm	→ Provided crib care	
1Am	→ DBF and Burping	1:30Am	→ DBF given & Burping done	
3Am	→ Warm care	4Am	→ warm care Provided	
5Am	→ Ifo chart monitoring.	6Am	→ Ifo chart monitored	
8Am	→ RBS monitoring	8Am	→ RBS monitored.	

Re-Assessment: done Baby Stable

Special Notes: RBS 12 hours Pre-feed SBR. NBS OAE @ postnatal

Nurse Signature: Sel

Nurse Name: Swapna

Date & Time: 4/12/2026 @ 8Am.

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/12/26

Assessment: New Born Baby Care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Asses the Baby condition monitor vitals	8:30pm	→ TO Asses the Baby condition	Baby is stable
10pm	⇒ Monitor vitals	10:30pm	→ Vitals checked & Recorded	
12Am	⇒ Norm care	12:30Am	→ provided Norm Care	
2Am	⇒ Baby is on SSPT	2:30Am	⇒ Continue SSPT	
4Am	→ DBF Every 2nd hourly	4:30Am	→ DBF given orally & Burping	
7Am	⇒ ensure safety	7:30Am	⇒ ensured safety	

Re-Assessment:

Re-Assmt done

Special Notes:

Baby is on SSPT, SBR, NBS to be

Nurse Signature:

Nurse Name:

Date & Time:

BAH-00660503 IPS-00175875
 Baby Of SRI VAISHNAVI
 02-07-2026 0 Y 0 M 2 D (F)
 Dr. NALINIKANTA PANIGRAHY

NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Baby on Room air

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the Baby general condition	8:20 am	→ Assessed the Baby general condition	→ Baby is fine
9am	→ Monitor vitals	9:20 am	→ Checked Vitals & Recorded	
10am	→ SBR & NBS	10:20 am	→ SBR & NBS sent	
12Pm	→ Feeding & burping	12:20 pm	→ Feeding & burping done	
2pm	→ Sponge bath	2:20 pm	→ Sponge bath given	
4pm	→ Ilo chart	4:20 pm	→ Ilo chart monitoring	
6pm	→ warm care	6:20 pm	→ Provided warm care	
7pm	→ Ensure safety	7:20 pm	→ Provided cribe care	

Re-Assessment:

Baby is sleeping

Special Notes:

feeding and hourly

Nurse Signature:

(Signature)

Nurse Name:

Sis. Anita

Date & Time:

5/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment:

New born baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8PM	* Assess to baby condition	9PM	* assessed to baby condition	* baby is comfortable
10PM	* I/O Hard	11PM	* I/O Hard monitoring	
12PM	* DBF	2PM	* DBF IIIrd hourly	
3PM	* Warm Care	4PM	* Warm care doe	
5PM	* burping	6PM	* burping after feed	
7PM	* safety	8PM	* sickle rails provided	

Re-Assessment: Re-assessment DBF 2nd hourly doe

Special Notes:

Nurse Signature: 

Nurse Name: Sunanda (606299)

Date & Time: 6/1/26 8AM



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. NALINIKANTA Department: Suite-4 Date of Admission: 2/7/26

SITUATION		Diagnosis: <u>New born baby</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known		If Yes Specify:		
BACKGROUND	Area	<u>Suite-4</u>	<u>Suite-4</u>	<u>Suite-4</u>	<u>Suite-4</u>	<u>Suite-4</u>	<u>Suite-4</u>	
	Shift Time	<u>8PM</u>	<u>8PM-8AM</u>	<u>8PM-5PM</u>	<u>5PM-8PM</u>	<u>8PM-8AM</u>	<u>8PM-8AM</u>	
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>GPPBS.</u>	<u>GPPBS</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.6°F</u>	<u>98.4°F</u>	<u>98.6°F</u>	<u>98.5°F</u>	<u>98.1°F</u>	<u>98.6°F</u>
		Res:	<u>40</u>	<u>42</u>	<u>42</u>	<u>40</u>	<u>40</u>	<u>40</u>
		SpO ₂ :	<u>100</u>	<u>100</u>	<u>100</u>	<u>99</u>	<u>98</u>	<u>99</u>
		Pulse:	<u>128</u>	<u>140</u>	<u>142</u>	<u>140</u>	<u>140</u>	<u>128</u>
		BP:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
		Fall Risk Score:	<u>16</u>	<u>16</u>	<u>16</u>	<u>16</u>	<u>15</u>	<u>16</u>
	Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0</u>	<u>0</u>	
Safety Needs:	<u>Safer</u>	<u>Safer</u>	<u>Safer</u>	<u>Safer</u>	<u>Safer</u>	<u>Safer</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :	<u>Suanda</u>	<u>Suanda</u>	<u>Suanda</u>	<u>Suanda</u>	<u>Suanda</u>	<u>Suanda</u>		
Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>		
Time:	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>		
Taken Over By Name :	<u>Suanda</u>	<u>Suanda</u>	<u>Suanda</u>	<u>Suanda</u>	<u>Suanda</u>	<u>Suanda</u>		
Signature :	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>		
Time:	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>	<u>8PM</u>	<u>8AM</u>	<u>2PM</u>		

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nalinikanta Department: BPP Date of Admission: 4/7/26

SITUATION	Diagnosis: <u>New Born Baby</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:			
	Area	Shift Time	<u>BPP</u> <u>7m-4pm</u>	<u>BPP</u> <u>8pm-5am</u>	<u>BPP</u> <u>8am-8pm</u>	<u>BPP</u> <u>8pm-8am</u>
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.5°F</u>	<u>98.4°F</u>	<u>97.9°F</u>	<u>98.3°F</u>
		Res:	<u>40b/m</u>	<u>40b/m</u>	<u>40b/m</u>	<u>40b/m</u>
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>98.5%</u>	<u>99.1%</u>
		Pulse:	<u>140b/m</u>	<u>140b/m</u>	<u>145b/m</u>	<u>138</u>
		BP:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Fall Risk Score:	<u>15</u>	<u>15</u>	<u>15</u>	<u>16</u>	
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>		
Recommendations	Safety Needs:	<u>with care</u>	<u>with care</u>	<u>yes</u>	<u>safer</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Swade</u>	<u>Ashwita</u>	<u>Anita</u>	<u>Swade</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>4/7</u>	<u>5/7</u>	<u>5/7</u>	<u>6/7/26</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Ashwita</u>	<u>Anita</u>	<u>Swade</u>	<u>Anita</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>4/7/26</u>	<u>5/7/26</u>	<u>5/7/26</u>	<u>6/7/26</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8am</u>	

BAH-00660503 IP5-00175875
Baby Of SRI VAISHNAVI
02-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. NALINIKANTA PANIGRAHY



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Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: India

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: 12/12/26

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☒ Self Care ☐ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication	☐ Yes	☐ No
☐ Bathing	☐ Yes	☐ No
☐ Eating	☐ Yes	☐ No
☐ Walking	☐ Yes	☐ No
☐ Dressing	☐ Yes	☐ No
☐ Toileting	☐ Yes	☐ No

need assist tencels

Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☒ Patient ☐ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☒ Patient ☐ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☒ Educational Topic/s: personal hygiene

☐ Patient's Educational Topic/s discussed with the:

☒ Patient ☐ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Suranda

Date and Time: 12/12/26 2PM

CONSENT FOR FORMULA FEEDS

BAH-00660503 IP5-00175875
Baby Of SRI VAISHNAVI
02-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. NALINIKANTA PANIGRAHY

Patient Name : Age : Gender : ☐ Male ☒ Female

UHID No : Department : Date :

I Mr / Mrs. : aged years, hereby declare that I have
admitted my ☐ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on
..... I hereby give consent for formula feed for my child. Doctors have explained me
about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : H Sai chandra
Name : Dr Hakeem Sai Chandra
Relationship with Patient : Father
Date & Time : 3/7/26 12:30 pm

Witness :

Signature : [Signature]
Name : Suand
Date & Time : 3/7/26 2 PM

Doctor (who is taking the consent) :

Signature : Sohel
Name : Dr. Sohel
Date & Time : 3/07/26 12:20 pm