Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006412 **Admit Date** : 23-May-2026 **Admit Time** : 10:32 AM **UHID** : HNH-00015575

Patient Details :

Patient Name	: Baby Of CHANDANA GURAPPU	**Age**	: 0 D
Guardian	: Mr SRINANDAN MOTURI	**DOB**	: 23-05-2026 09:39 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: HIG,BLOCK-6,FLAT-15,Baghlingampally, HYDERABAD Bagh Lingampally Hyderabad Telangana INDIA 500044	**Phone No**	: 8367006955/ 8367006955
		E-mail	: srinandan594@gmail.com

Admission Details :

Bed Type : BASINET **Bed No** : CRDL-HNPDA-412-1 **Ward Name** : 4F -OT

Room No : CRDL-HNPDA-412-1 **Admission Type** : First Visit

Contact Details :

Name : Mr SRINANDAN MOTURI **Relationship** : Father

Contact Address : **Phone No** : 8367006955

Signature

Doctor Details :

Doctor Name : Dr. SPANDANA PASUPULETI **Specialisation** : NEONATOLOGY

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 10000.00

Payment Mode : DC/CC Card **Payor Name** : SELFPAY

HNH-00015575 IP26-00006412
Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 0 D 2 H (F)
Dr. SPANDANA PASUPULETI

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NEWBORN MONITORING FORM

Date of Birth	: 23/5/26	New Born Screening	:
Time of Birth	: 9:39AM	TFT	:
Mode of Delivery	: EL-LSCS	OAE	:
Birth Weight	: 2.640g	Mother's Blood Group	: O+ve
Head Circumference	: 33CM	Baby's Blood Group	:
Length	: 44CM	Anomaly Scan	:
Red Reflex	:	Vaccination	: BCG, OPV, HEP B given

Date	Weight	Type of Feed	Quantity	Temperature	Signature
23/5/26	2.640g	DBF	(1)	36.5	24/5/26
24/5/26	2.460kgs	DBF	(1)	36.5	
25/5/26	2.380kg	DBF	(1)	98.2°F	

Date	Time	Investigation	Result	Order No.	Signature
23/5/26	10:42AM	Blood grouping	-	8690	
23/5/26	10:55AM (1st)	GRBS	46mg/dl	8703	
23/5/26	—	ABG	-	8704	
23/5/26	12:40pm (3rd hour)	GRBS	48mg/dl	8713	
23/5/26	3:40pm (6th)	GRBS	63mg/dL	8721	
	9:40pm (12th)	GRBS	62mg/dl	8748	
23/5/26	6pm	CBP			
		CRP		8731	
		Blood c/s			
24/5/26	3 Am (15th)	GRBS	67mg/dl	8749	
24/5/26	9:40AM (24th)	GRBS.	64mg/dl	self	Needle
25/5/26	10AM	DSPT		2051	

CONSENT FOR FORMULA FEEDS

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Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 2 D (F)
Dr. SPANDANA PASUPULETI

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 : .....

Name : CHANDANA GURAPPU

Relationship with Patient: MOTHER

Date & Time : .....

Witness :

Signature : .....

Name : .....

Date & Time : 25/5/26 8AM

Doctor (who is taking the consent) :

Signature : .....

Name : ANVSHA

Date & Time : 25/5/26

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015575 IP26-00006412 Baby Of CHANDANA GURAPPU 23-05-2026 0Y0M0D2H (F) Dr. SPANDANA PASUPULETI	23/5/26 e	23/5/26 e.
	Transfer Ordered by Dr pranav.	Reason for Transfer obs
From Unit pre post	To Unit Room (213)	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 25	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Monika	Dr. Pranav.

Patient & Clinical Records Received by : Amrutha

Date & Time of Patient Received : 23/5/26 06m

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Chandana Gurappu Age : 29y.. Father's Name : ..... Age : .....

Date of Birth : ..... Date of Admission : ..... UHID No.: .....

NICU Consultant : ..... Referring Consultant : .....

Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward

Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : B/o Chandana Gurappu

Gender : ☐ M ☑ F Blood Group : .....

Date of Birth : 23/5/26 Time of Birth : 9:39am

Place of Birth : RCH - HNH

Mother's Blood Group : O Positive

Birth Weight (gms) : 2640g Length (cms) : 44CM

OFC (cms) : 32cm

Estimated Gesth Age : 35+1 wks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : ..... Ht : ..... Wt : ..... BMI : ..... Married Life : ..... LMP : 22/9 EDD : 29/6/26

Conception : Spontaneous or with Rx. : OI

Booked at what GA. : ..... AN Steroids Drugs / Doses : .....

Last Scans Details : 18/5 -> SLVF - 34+3 wks / EFW - 2.45 kg / AFI - 19cm / Doppler - (N)

..... TT Immunization and Iron / Folic Acid : .....

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs TIFFA - (N)

Consanguinity : ☐ Yes ☐ No NT - Low risk

If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long : .....

.....

H/o value of recent BP recording, proteinuria, edema,

oliguria, any investigations (LFT, platelet count) : .....

.....

IUGR - when detected : .....

Doppler (Increased Resistence / ADEF / REDF /

Redistrbution in MCA) / Ductus Venosus : .....

AFI : .....

H/o GDM/ pre GDM/ on diet or insulin Ctrl

Controlled or not, recent values, HbA1 values : .....

.....

Compliance with Rx : .....

Scans : LGA, TIFFA , Fetal Echo : .....

H/o Hypothyriodism : when diagnosed ? Medication?

.....

Any other Chronic Medical Problems, when detected

drugs ? .....

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

Infection : H/O, Fever

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

UTI : when : ..... Any culture : .....

PPROM : Duration : 8hrs ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results : .....

Medication during Pregnancy : ..... Duration : .....

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PAST OBSTETRIC HISTORY

G : 2 P : 0 A : 1 L :

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
1	2024				Brachial Plexus	
2		Present Preg				

PERINATAL HISTORY

Treating Obstetrician : Dr PADMAJA Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication : .....

Specify the reason : .....

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL : .....

Resuscitaion : ☐ Yes ☐ No

Cord ABG : .....

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

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : ..... Weeks : .....

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

1 Minute	5 Minutes	10 Minutes
8/10	9/10	

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

Equipment check done

↓

Girl baby delivered by Em. LSCS & forceps assisted

↓

CIAB

↓

Routine newborn care given

↓

Delayed cord clamp

↓

Inj Vitamin - K given

↓

Baby Vigilon

↓

Shift to mother side

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Baby Pink
Vigolous

VITALS : Temperature : 36.5°C HR : 172/m RR : 44/m NIBP : CFT :

Color of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 96%

Anthropometry : Birth Weight : 2640g Length : 44.0cm HC : 33cm Present Weight :

Ponderal Index : AGA : SGA : LGA :

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HEAD TO TOE EXAMINATION

HEAD :	Fontanelles :	(N)
	Sutures	
	Shape / Moulding :	
	Edema / Bruising :	
	Size - (H.C.) :	
Facies : (Any Facial Dysmorphism)		Small lacerations over (R) eye lateral canthus Forceps impression over forehead
NECK and CLAVICLES :	Range of Motion :	(N)
	Asymmetry :	
	Masses :	
EYES :	Symmetry :	
	Red Reflex :	To check
	Discharge :	
EARS, NOSE MOUTH and THROAT :	Ear set / Shape :	
	Periauricular Pits / Tags :	No cleft
	Nasal shape / Patency :	
	Palate :	(N)
	Gums :	
	Lips :	
	Tongue :	
THORAX and BREASTS :	Shape of Thorax :	(N)
	Position of Nipples and Number :	
ABDOMEN and UMBILICUS :	Shape :	
	Organomegaly :	(N)
	Bowel Sounds :	Soft
	Umbilical Stump :	2A+1V
	Discharge :	
GENITILIA :	Labia / Hymen :	Female
	Testicles/penis :	
	Anus :	patent
HERNIAL ORIFICES		
TRUNK and SPINE :		(N)
SKIN LESIONS :		
EXTREMETIES :	Fingers / Toes :	(N)
	Arms / Legs :	
	Deformities :	
	Mobility :	
	Hip Joint Examination :	

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SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☐ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress : RR : ..... SCR / ICR / See - Saw breating : .....

Scoring of respiratory distress if present (Silverman or Downe's) : .....

Mention if baby is on : ☐ Hood box ☐ CPAP ☐ Ventilator

Settings : .....

Spo2 : 98 % Auscultation : B/L AE Breath Sounds : ..... Added Sounds : .....

Cardiovascular System :

HR : 132/m BP : .....

Femoral Pulses : Felt

Other Peripheral Pulses : .....

Precordial Activity : .....

Murmurs : .....

Signs of Cardiac Failure : .....

Abdomen :

Shape : N

Palpation : Soft

Palpable masses : .....

Abdominal girth : .....

Hernia orifice : .....

Anal Patency : Patent

Umbilical Cord : 2A + 1V

First urine passed : X

Meconium passed : Passed

Nervous System : Higher intellectual functions (Sensorium) : .....

State of wakefulness : N

Prechtle Score : .....

Nerves :

N

.....

.....

.....

Motor System :

Passive Tone : +

Active Tone : +

Neonatal Reflexes : .....

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

Moro's : ..... DTR : .....

ATNR : ..... Skull and Spine : .....

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Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 0 D 2 H (F)
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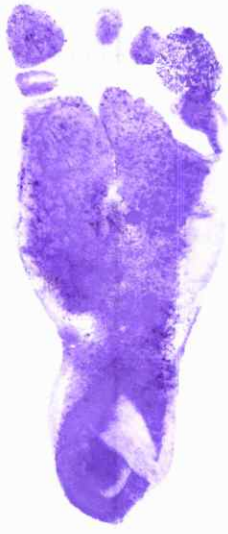
Forceps impression over forehead + small lacerations over ® lateral canthus
c forceps assist

Diagnosis : G2 P1 / 35+1 wk / Late PT / Emg LSCS (PPROM) / CHB3 / Cord / 2.64 kg AGA / Matured SGA

FOOT PRINTS

Left Side :

Right Side :



Resident Doctor :

Signature : SP

Name : Bramar

Date & Time : 23/5/26 at 10 am

Consultant :

Signature : .....

Name : .....

Date & Time : .....

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor : .....
2. Name of te 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 : ..... ☐ SPO2 : ..... Weight : .....

Any Oxygen requirement : .....

Systemic : .....

Medications : .....

Plan during ward follow up :

Plan

1) Warm care
2) DBF 1/6 burping Q2H
3) Send B/S/T
4) Vaccination - BCG, OPV, Hep B
5) SBR/NBS/OAE @ 48 HOL
6) GRBS Monitoring
1st HOL (Post fed), Later 3rd, 6th, 12th, 18th, 24th, 36th, 48 HOL (Pre fed)
7) Monitor Vitals
Inform SOS
8) CBP, CRP, Blood C/S at 6PM

Feeding Plan at the time of shifting : .....

Screenings done during NICU Stay :

NSG : .....

Hearing Screen : .....

ROP : .....

TFT : .....

NP2 : .....

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5 2:50 pm	C/S/B Dr Pranav	
	Late PT / 35+1 wk / LSCS / PROM - 9 hrs / C/AB / Girl / 2.64 kg / IDM / Minor laceration	
	Passed Urine & Stool	Plan
	GRBS 46 (1st post feed) / 48 (Pre feed)	1) DBF / f/b burping Q2H 2) Warm care 3) Vaccination today
	Baby Euthermic Accepted DBF	4) GRBS Monitoring 5) CBP, CRP, Blood c/s @ 6pm
		6) Monitor Vitals
		Pranav
23/5 3:30 pm	C/S/B Dr Spandana	
	Late PT / 35+1 wk / LSCS / PROM - 9 hrs / C/AB / Girl / 2.64 kg / IDM (R) Minor lateral canthus laceration	
	GRBS - 63 mg/dl Passed Urine & Stool	Plan 1) DBF f/b burping Q2H 2) Warm care
	Baby Euthermic Cry / Tone / Activity - Good	3) Vaccination T/m (BCG, OPV, HepB) 4) GRBS Monitoring 5) CBP, CRP, Blood c/s @ 6pm
	[signature]	6) Monitor Vitals 7) To check red reflex

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23-05-2026 0 Y 0 M 0 D 2 H (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/5/26 8am	U/B Dr. Sravani	
	- accepting feeds well	
	- urine ✓	
	- stools ✓	
		Plan
	T. wt: 6.8% loss.	1) Trace Blood c/s
		2) to check Red Reflex
	O/E: euthermic	3) vaccination today
	CT/A: good	4) warm care
	AF: flat	5) DBF every 2nd h
	moros (+)	6) SBK, NBS, OAE } @ 48 HOL
	vitals: stable	
		7) monitor vitals.
	(signature)	
24/5/26 11AM	c/s/by Dr Spandana	- Do TCB Inform
	Baby Euthermic / Active Pink	- Ⓣ B/c/s
	wt loss (+)	- to chk Red Reflex
	O/E NAD	- DBF + PF Only f/b supply
P.S (signature)	C/T/A Go.	- warm care.
		- Sample @ 48HOL
		- Monitor vit

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

HNH-00015575 IP26-00006412
Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 0 D 14 H (F)
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...GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	24/5/26	
	BCG, OPV, HepB given	
	c/s/b - Dr. Anusha / Dr Alekhya	
25/5/26 8am		2.380 kg.
	Baby Euthermic	80g ↓
	O/E -	9.8%
	Active; Alert	Advise:
		(i) Trace B/C.
	Cry, tone, Activity } good.	(ii) DBF / lb burping Q2H. 10AM Batch
		(iii) Samples at 48h - 930AM to check Red reflex.
		Give formula feed 25ml Q4hy
		NB Sum c 8hr

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NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5/26 9:30am	SR/B Dr. Spandana	
	- 9.8% wt loss.	
	- icteric	
	- accepting feeds ✓	
	urine ✓	
	stools ✓	
	O/E euthermic	
	AF/AT : good	Plan
	AF : flat	1) SBR] T/m
	Vitals : stable.	NBS] [illegible]
		OAE]
		2) warm care
	~~- TCB check now~~	3) DBF every 2nd h.
	→ if high	4) trace Blood c/s.
	start DSPT.	5) monitor urine.
		6) Red reflex to be checked.
	[signature]	

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/26, 2:15 PM	S/B Dr. Sreeghan	
	Δ Late preterm (35wk+(d)) / F / (IAB) / IDM / 2.66 kg / AGA / NNJ	
		Plan
	Baby euthermic	
		- DBF + Burping 2nd L
	CVS - S1 S2 (+)	
	RS - B/L AE (+)	- SBR / NBS } @ 6AM - T/M
	P/A - soft	
	CT A good	- Warm care
		- Trace Blood C/S
		- C/E DSPT
		- Red reflex to be checked
	Dr. [signature]	
		noted by Swapna @ 3pm

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/C. O. Tejasvi	
20/05/2[illegible] 4:30PM	Baby Cutharmi	
	passing urine/stools	
	Cry/Tone/Activity - good	
	Vitals: Stable	F/S Blood C/S
		- Negative
		(72hrs)
	S/B Sr- N/AD	
		Adv
		- DBF + burping [illegible]
		- STBR, MTSS, USG [illegible]
		- Cont. OSPT
		- Trace Blood C/S
		noted by Dr Tejasvi
		Supriya @ 4:30pm

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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NURSING DEPARTMENT
NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: chandana Mother's Name: Chandana

Date of Birth: 23/5/26 Time of Birth: 9:39 AM Gender: ☐ Male ☐ ~~Female~~

Birth Weight: 2.640g Kgs HC: ..... cm Lenght: ..... 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: 36.5 °C HR: 142 /Min RR: 44 /Min BP: ..... SpO_2: .....

Pain Score: ..... (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: Alen Signature: Alen Date &Time: 23/5/26 10:40

PATIENT STICKER

Bl. Chandana Gurappa

HNH-00015575 IP26-00006412
Baby Of CHANDANA GURAPPU
23-05-2026 0Y0M0D2H (F)
Dr. SPANDANA PASUPULETI

DATE : 23/5

NEWBORN OMOLY ASSESSMENT CHECKLIST

S.NO	ASSESSMENT PARAMETERS	CHECKED BY REGISTRAR	CHECKED BY CONSULTANT	REMARKS
1.	Palate	No cleft	No cleft	
2	Pre natal teeth	No	No	
3	Anal opening	Patent	Patent	
4	Genitalia	Female	Female genitalia	
5	Spine	(N)	(N)	
6	Red reflex	To check		
7	4 limb saturation (before discharge)	To check		

Small laceration over (R) eye. lateral canthus (Forceps)

Ped.Registrar signature

Ped.Consultant signature

HNH-00015575 IP26-00006412
Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 0 D 2 H (F)
Dr. SPANDANA PASUPULETI

213

Baby Blood group A +ve

RESULT SHEET

Rainbow® Children's Hospital
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Date	23/5/26					
Time						
Hb	16.1					
PCV	43.8					
RBC	4.34					
WBC	26.30					
N/L	67.0/23.2					
Platelets	281					
CRP	5					
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein/Sugar						
Cells						
N/L						

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 : 23/5/26 Blood C/S - 24 hrs no growth

.....

.....

.....

Radiology: USG : .....

X-Ray:.....

ECHO: .....

CT: .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

HNH-00015575 IP26-00006412
Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 0 D 2 H (F)
Dr. SPANDANA PASUPULETI

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

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 23/5/26 Time:	9pm	6pm	10	2	6
Doctor/Nurse/Family Concern?			PM	AM	AM

Temperature (°F)

104 103 102 101 100 99 98 97 96 95 94

38.5 101.1°F 98.8°F 97.8°F 98.6°F

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)	156bpm	149bpm	148bpm	138bpm	140bpm

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

70 60 50 40 30 20 10

Resp Rate (Number)	44bpm	42bpm	40bpm	30bpm	40bpm
Resp Distress (Mod/ Severe / None / Mild)					
Receiving O_2(l/min) O_2Saturations (%)	99%	99%	100%	99%	99%
Conscious Level (Normal / Altered)					
GCS *	15				
TOTAL SCORE Number of shaded boxes		0	0	0	0
Pain Score		0	0	0	0
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.

Patient Sticker

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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)

HNH-00015575 IP26-00006412
Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 1 D (F)
Dr. SPANDANA PASUPULETI

Patie: AL / 124

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 23/5 Time: 10 2 6 10 2 6 10 2 6

Doctor/Nurse/Family Concern? AM PM PM AM AM PM AM PM

Temperature (°F)

104 103 102 101 100 99 98 97 96 95 94

98.4°F 98.3 98.6°F 98.2°F 98.4°F 98.8°F 98.6°F 98.6°F 98.4°F

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) 140bpm 149bpm 136bpm 140bpm 147bpm 140bpm 141bpm 142bpm 143bpm

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

70 60 50 40 30 20 10

Resp Rate (Number) 40bpm 40bpm 48bpm 40bpm 42bpm 40bpm 42bpm 41bpm 42bpm

Resp Distress: Mod/ Severe / None / Mild									
Receiving O_2(l/min) O_2Saturations (%)	100%	100	100%	99%	98%	99%	99%	100%	100%
Conscious Level: Normal / Altered									
GCS *				14/15	14/15	14/15	14/15		
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0
Observer's Initials									

ACTIONS

NB: Scores 3 should be recorded overleaf

Score 1	:	Continue normal observation by staff nurse
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Patient Sticker

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Patient Sticker

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HNH-00015575 IP26-00006412
Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 2 D (F)
Dr. SPANDANA PASUPULETI

ANT (<1 year)

dren's Observation & y Warning Scoring Chart

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E: CHILDREN'S UNIT

Date: 23/5/26 Time: 10AM 2PM 6PM

Doctor/Nurse/Family Concern?

Temperature (°F)	104		
	103		
	102		
	101		
	100		
	99	97.5°F	97.3°F
	98	*	*
	97		
	96		
	95		
	94		
Heart Rate (bpm) and Blood Pressure (mmHg) *	190		
	180		
	170		
	160		
	150		
	140		
	130	*	*
	120		
	110		
	100		
Note: BP does not score in early warning scoring	90		
	80		
	70		
	60		
	50		
Heart Rate (Number)		138bpm	140bpm 140bpm
Resp. Rate (bpm) (Over 1 Minute) *	70		
	60		
	50		
	40		
	30		
	20		
	10		
Resp Rate (Number)		40bpm	40bpm 40bpm
Resp Distress: Mod/ Severe / None / Mild			
Receiving O_2 (l/min)			
O_2 Saturations (%)		99%	100% 100%
Conscious Level: Normal / Altered			
GCS *		-	-
TOTAL SCORE Number of shaded boxes		0	0 0
Pain Score		0	0 0
Observer's Initials			

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

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Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 0 D 2 H (F)
Dr. SPANDANA PASUPULETI

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
23/5/26	08:00 am											
	09:00 am		DBF					1	1			
	10:00 am				NA			0	0			
	11:00 am		DBF					1	1			
	12:00 pm											
	01:00 pm		DBF + EBM							✓		
Total Intake :		Taken(66)				**Total Output :**						
23/5/26	02:00 pm		DBF							✓	1	
	03:00 pm											
	04:00 pm		DBF		NA			NA		✓	0	
	05:00 pm									✓		
	06:00 pm		DBF								1	
	07:00 pm									✓		
Total Intake :						**Total Output :**				U-3 M-		
23/5/26	08:00 pm	1									1	
	09:00 pm		DBF									
	10:00 pm	0					✓	NA		✓	0	
	11:00 am		DBF		NA							
	12:00 am	1									1	
	01:00 pm		DBF									
Total Intake :		Taken				**Total Output :**				U-M-		
24/5/26	02:00 am										1	
	03:00 am	1	DBF									
	04:00 am						✓	NA		✓	0	
	05:00 am	0	DBF		NA							
	06:00 am										(	
	07:00 am	1	DBF									
Total Intake :		Taken				**Total Output :**				U-M-		

Total 24 hrs. Intake		Total 24 hrs. Output	

HNH-00015575 IP26-00006412
Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 0 D 2 H (F)
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FLUID CHART

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		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
24/5/26	08:00 am		DBf+ff									
	09:00 am									L		
	10:00 am		DBf+ff				L				0	
	11:00 am									L		
	12:00 pm		DBf+ff									
	01:00 pm											
Total Intake :								**Total Output :**		U-2	M-1	
24/5	02:00 pm	L										
	03:00 pm		DBf+ff									
	04:00 pm	0										
	05:00 pm		DBf+K								0	
	06:00 pm	J					L			L		
	07:00 pm		DBf+K								J	
Total Intake :		Tylcn						**Total Output :**		M-2	U-2	
24/5	08:00 pm		DBf+ff									
	09:00 pm						L					
	10:00 pm		DBf+ff							L		
	11:00 pm	0									a	
	12:00 am		DBf+ff							L		
	01:00 am											
Total Intake :								**Total Output :**		U-2 M-1		
25/5	02:00 am		DBf+ff									
	03:00 am											
	04:00 am	a	DBf+ff				L			L		
	05:00 am										6	
	06:00 am		DBf+ff									
	07:00 am											
Total Intake :								**Total Output :**		U-1 M-1		

Total 24 hrs. Intake		Total 24 hrs. Output	

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Patie Dr. SPANDANA PASUPULETI

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FLUID CHART

Sheet No. : .....

1. All measurements in ml.
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Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
23/5	08:00 am	~~DBF~~	DBF									
	09:00 am											
	10:00 am	~~DBF~~	FF									
	11:00 am				NA							
	12:00 pm	~~DBF~~	DBF									
	01:00 pm		FF									
Total Intake :						**Total Output :**						
23/5	02:00 pm		DBL									
	03:00 pm		THL									
	04:00 pm	D										
	05:00 pm		DBL		NA			NA				
	06:00 pm		THL									
	07:00 pm		DBL									
			THL									
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

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Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

HNH-00015575 IP26-00006412
Baby Of CHANDANA GURAPPU
23-05-2026 0Y0M0D2H (F)
Dr. SPANDANA PASUPULETI

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

Date: 23/5/26

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	Re-Assessment	Nurse Name & Signature
Morning	8AM 2pm	→ Assess the baby condition → plan for DBF → plan for vitals → plan for Blochart	8AM 2pm	→ Assessed the baby condition → DBF 2nd hourly → Maintained	→ Baby stable	→ Vitals	
Afternoon	2pm to 8pm	→ Assess the Baby condition → Monitor vitals → Maintain Blochart	2pm to 8pm	→ Assessed the pt condition → Monitor vitals → Maintain Blochart	New pt is stable	Re-check vitals	Moni
Night	8pm 8am	→ Assess the Baby condition → monitor vitals → Maintain Blochart → DBF every 2nd hourly → warm care	8pm 8am	→ Assessed the baby Condition → Monitored vitals recorded → Maintained Blochart → DBF every 2nd hourly	→ Baby is stable	→ Rechecked vitals	

HNH-00015575 IP26-00006412
Baby Of CHANDANA GURAPPU
23-05-2026 0Y0M0D2H (F)
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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

Date: 23/5/26

Goals

- ☐ Maintain Airway and Oxygenation
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- ☐ 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	Re-Assessment	Nurse Name & Signature
Morning	8Am to 2pm	→ Assess the Baby condition → Monitor vitals → Maintain I/o chart → Maintained I/o chart	8Am to 2pm	→ Assessed the Baby condition → Monitored vitals → Maintained I/o chart	Now pt is stable.	Re-check vitals	MOM
Afternoon	2pm | 8pm	→ Assess the pt condition → monitoring vitals checked and recorded → I/o chart maintained	2pm | 8pm	→ Assessed the pt condition → 2nd hourly feeding → I/o chart maintained → plan SBR, NBS, OAE	→ Pt is stable	→ Re-checked vitals	
Night	8pm to 8Am	Assess the baby/condition monitor vitals syncond. maintain I/o chart. Provide the comfortable position. give 2nd hourly feed.	8pm to 8Am	Assessed the baby/condition monitored vitals syncond maintained I/O chart. Provided the comfortable position. given 2nd hourly feed.	→ Pt is stable → monitor vitals. → vitals normal → maintain I/O chart.		Sneha

HNH-00015575 IP26-00006412
Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 1 D (F)
Dr. SPANDANA PASUPULETI

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

Date: 25/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am 2pm	- Assess the baby condition - Monitor vitals & records - Maintain I/o chart - DBF + FF 2nd hrly - DSPT started @ 10Am	8Am 2pm	- Assessed the baby condition - Monitored vitals & records - Maintained I/o chart - DBF + FF 2nd hrly - DSPT cont.	Baby is stable now	Re-checked vitals	
Afternoon	2pm 8pm	- Assess the Baby Condition - Monitor vitals & I/o - DBF + FF 2nd hourly - DSPT started today		-> Assessed the Baby Condition -> Monitored vitals & I/o Chart -> DBF + FF 2nd hourly given -> ct DSPT	-> Baby is stable	Rechecked vitals	
Night							

Patient Sticker

NURSING CARE RECORD

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

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- ☐ Meet Elimination Needs
- ☐ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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Goals

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- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

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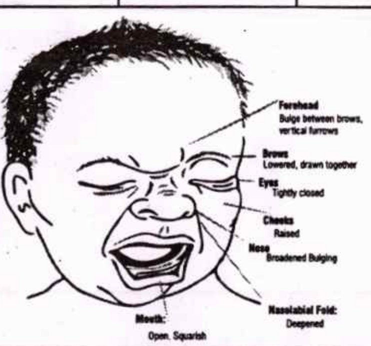
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	23/5	23/5	23/5/26	24/5	25/5	25/5			
						Time	Time	Time	Time	Time	Time	Time	Time	Time
						10AM	6P	10P	10pm	M6	6			
					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	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	NA	NA	NA	NA	NA			
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	NA	NA	NA	NA	NA			
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	NA	NA	NA	NA	NA			
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	NA	NA	NA	NA	NA			



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	37+	37+	37+	37+	37 wks	37 + wks			
Total Pain / Agitation Score	–	–	–	–	–	–			
Intervention	–	–	–	–	–	–			
Effectiveness	–	–	–	–	–	–			
Signature	[signature]	[signature]	[signature]	[signature]	[signature]	[signature]			

Docu.No: RCH' /FRM/CLINICAL/094 (P.T.O)

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.

HNH-00015575 IP26-00006412
Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 0 D 2 H (F)
Dr. SPANDANA PASUPULETI

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 : 23/5/26	23	23/5/26	24
					Time : 10AM	2PM	10PM	10PM
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	3	3	3	4
"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	4
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.	3	3	3	4
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.	4	3	3	4
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."	4	4	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 mean 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	21	23	24
					Evaluator's Name			

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

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

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Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 0 D 14 H (F)
Dr. SPANDANA PASUPULETI

BRADEN 'Q' SCALE

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

BirthRight BY RAINBOW HOSPITALS
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					Date : 24/4	25/4	26/5	
					Time : E	N	M	E
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"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.	4	3	4	3
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.	4	4	4	3
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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	28	27	28	23
				Evaluator's Name				

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

Docu. No. : RCH /FRM / CLINICAL / 119

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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23-05-2026 0 Y 0 M 0 D 2 H (F)
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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: Newborn baby

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

Surgery / Procedure:

Post OP Day:

BACKGROUND

Date / Shift	23/5/26 8AM	23/5 2pm	23/5/26 10PM	24/5/26 MG	24/5 AL	24/5 NJ
Medical Condition (Any special condition to be noted):	-	-	-	-	-	-
Diet:	DBF	DBF	DBF	DBF	DBF	-

ASSESSMENT

Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ventilation (RA, NP, NIV, VENTI):	RA	NP	NA	NA	RA	-
Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	36.5	36.5	98.2F	97.6	98.3F	98.2°F
Res:	43	43	40BPM	40BPM	40BPM	40BPM
SpO_2:	100%	100%	100%	100%	98%	98%
Pulse:	156bpm	150bpm	148bpm	140bpm	145bpm	142bpm
BP:	-	-	-	-	-	-
LOC:	LOC	-	-	-	-	-
Fall Risk Score:	-	-	-	-	-	-
Pain Score:	-	-	-	-	-	-
Skin Integrity	good	good	good	good	good	good

Recommendations

Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physiotherapy:	-	-	-	-	-	-
Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Special Diet:	DBF	-	-	-	-	-
Critical Lab Test / Values:	-	-	-	-	-	-
Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):	Yes	dependent	0	dependent	Dependent	-
Post Operative Procedure Special Orders:		NA		NA	NA	-
Handed Over By Name :	Abdul	Mouni	Divya	Mouni	Amruth	Sneha
Signature / ID :						
Date:	23/5/26	23/5	24/5/26	24/5/26	24/5	25/5
Time:		8pm	8PM	2pm	8pm	8AM
Taken Over By Name :		Di	Mouni	Amruth	Sneha	Priyanka
Signature / ID :						
Date:			24/5/26	24/5	24/5	25/5/26
Time:			8PM	2PM	8PM	8AM

HNH-00015575 IP26-00006412
Baby Of CHANDANA GURAPPU
23-05-2026 0 Y 0 M 2 D (F)
Dr. SPANDANA PASUPULETI

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: NB			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	25/5 M6	25/5/26 G2				
	Medical Condition (Any special condition to be noted):	–	–				
	Diet:	–	–				
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	–	–				
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97.8°F	98.1°F				
	Res:	20bh	21bh				
	SpO_2:	100%	99%				
	Pulse:	140bh	139bh				
	BP:	–	–				
	LOC:	–	–				
	Fall Risk Score:	–	–				
	Pain Score:	–	–				
	Skin Integrity	–	–				
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	–	–				
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	–	–				
	Critical Lab Test / Values:	–	–				
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	–	–				
Post Operative Procedure Special Orders:		–	–				
Handed Over By Name :		Priyanka	Supriya				
Signature / ID :							
Date:		25/5/26	25/5/26				
Time:		2pm	8pm				
Taken Over By Name :		Supriya					
Signature / ID :							
Date:		25/5/26					
Time:		2pm					