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 : IP26-00006431 **Admit Date** : 26-May-2026 **Admit Time** : 06:55 AM **UHID** : HNH-00015621

Patient Details :

Patient Name	: Baby Of CHITTIMALLI SUSMITHA	**Age**	: 0 D
Guardian	: Mr SRIVATSAVA	**DOB**	: 26-05-2026 06:02 AM
Gender	: Male	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 3-2-121,FLAT NO 304,KALYANI RESIDENCY APARTMENT Kachiguda Hyderabad Telangana INDIA 500027	**Phone No**	: 8919274597/ 7842110885
		E-mail	: SRI.VATSAVA99@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 SRIVATSAVA	**Relationship**	: Father
Contact Address	: 3-2-121,FLAT NO 304,KALYANI RESIDENCY APARTMENT Kachiguda Hyderabad Telangana INDIA 500027	**Phone No**	: 8919274597

Ch. Ayanch.

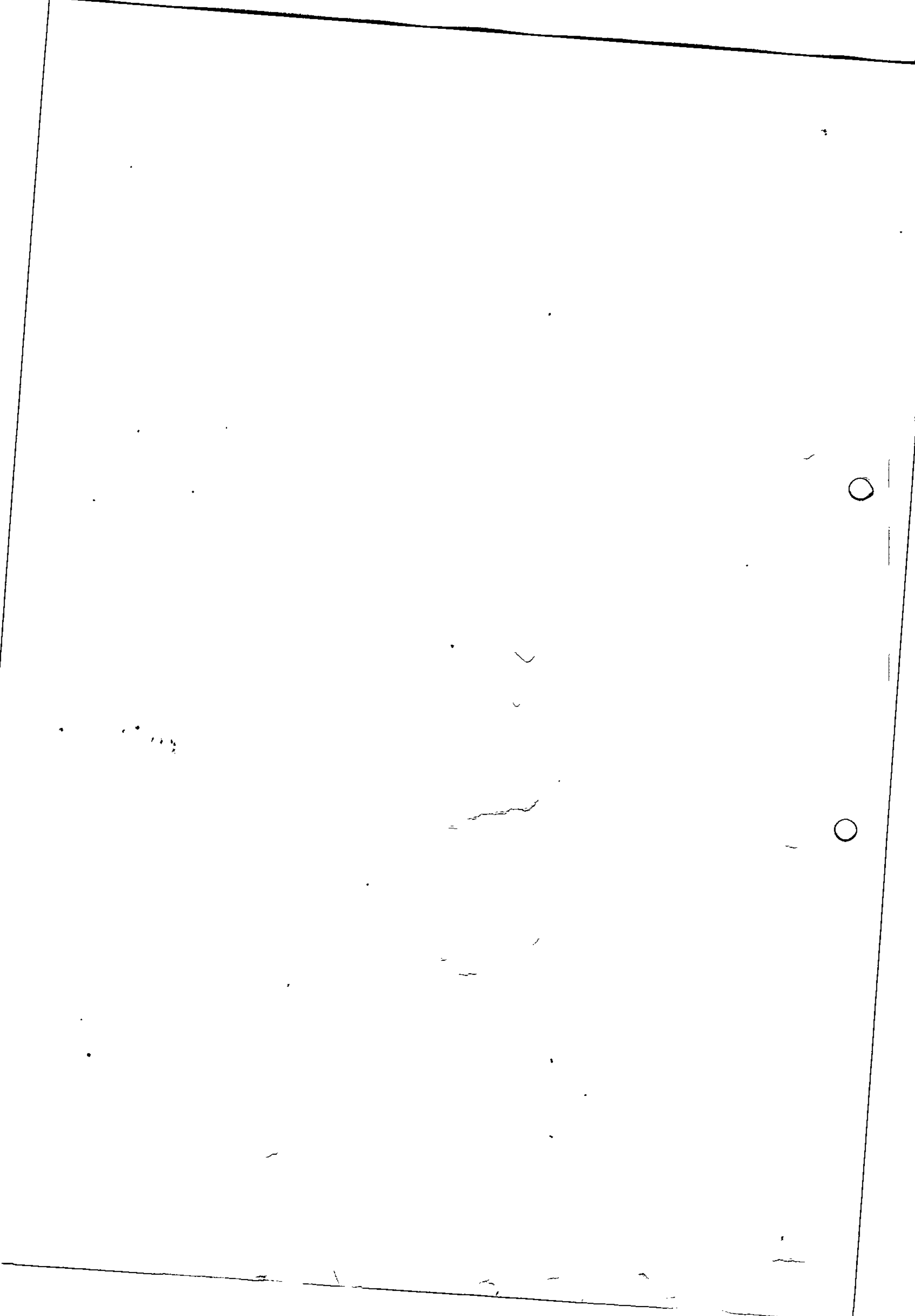
Signature

Doctor Details :

Doctor Name	: Dr. SANJAY SRIRAMPUR	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	:	**Phone No**	:
Co-Consultant	: Dr. PRITESH NAGAR		

Payment Details :

		Deposit Amount	: 10000.00
Payment Mode	: Cash	**Payor Name**	: SELFPAY



CONSENT FOR FORMULA FEEDS

Patient Name : HNH-00015621 IP26-00006431 Baby Of CHITTIMALLI SUSMITHA 26-05-2026 0 Y 0 M 1 D (M) Dr. SANJAY SRIRAMPUR .... Age : .... Gender : ☐ Male ☐ Female

UHID No : ...... 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 : Ch. Susmitha

Name : Ch. Susmitha

Relationship with Patient: Mother

Date & Time : 11pm @ 26/5/26

Witness :

Signature : Madhuri

Name : Madhuri

Date & Time : 11:pm. 26/05/26

Doctor (who is taking the consent) :

Signature : Dr. Sushanth

Name : Sushanth

Date & Time : 26/05/26

Ref. : F/NICU/FD/02

డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

రోగి పేరు : .... వయస్సు .... లింగం పు ☐ స్త్రీ ☐

యు.హెచ్.ఐ.డి. .... రిజిస్ట్రేషన్ నెం.: .... విభాగము ....

తేదీ ....

నేను శ్రీ / శ్రీమతి .... వయస్సు .... సంవత్సరాలు

నా కుమార్తె / కుమారుడు రెయిన్బో ఆసుపత్రిలో నవజాత శిశువుల ఇంటెన్సివ్ కేర్ లో అడ్మిట్ చేసినాము మరియు (ఫార్ములా ఫీడ్) డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుచున్నాను. డాక్టర్లు డబ్బా పాలు త్రాగించడం వల్ల కలుగు ఉపయోగాలు, ప్రత్యామ్నాయాలు, మరియు నష్టాలు గురించి నాకు అర్ధమైన భాషలో వివరించారు.

సహాయకుడు(అటెండెంట్)

సంతకము ....

పేరు ....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము ....

పేరు ....

సాక్షి

సంతకము ....

పేరు..

తేదీ మరియు సమయము ....

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Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0Y0M0D1H (M)
Dr. SANJAY SRIRAMPUR

CROSS CONSULTATION FORM

Doctor Name: Dr. Leena Priyambada Date: 26/5/26 Time: 3pm

Diagnosis: ? Micropenis

Hospital: RCH-GMNR

Referred for: ☑ Opinion ☐ Co-Management ☐ Transfer of care

Type of Referral:
☐ Emergency
☐ Urgent
☑ Non Urgent

Reason for Referral: If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations: Stretched penile length - 2.5cm

- NC
- fam H - (-ve)

Base of penis - attached anterior to scrotum
Scrotal rugae (+)
Scrotum - well formed
Both testes palpable
(N) consistency
Width of penis - normal

Plan
- USG Scrotum
- USG Abdomen to rule out Mullerian structure & pelvis

Late preterm (36wk+3d) / 3.05kg / AGA / CIAB
Male / Non consanguineous marriage / First baby

Likely Buried Penis.
- Baseline Scrotum USG - for B/L testis consistency.
USG Abd - r/o Mullerian str.
- R/v in OPD after 1 month.

Consultant:
Name: Dr. Leena Priyambadi Signature: [signature] Date & Time: 26/5/26 3pm

Doc. No.: RCH / FRM / CLINICAL / 049

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015621 IP26-00006431 Baby Of CHITTIMALLI SUSMITHA 26-05-2026 0Y0M0D1H (M) Dr. SANJAY SRIRAMPUR	26/5/26 @ 6:55 Am	26/5/26 @ 9:35 AM
	Transfer Ordered by	**Reason for Transfer**
	Dr. Pranavi	observation
From Unit	**To Unit**	**Information to Attendant**
MICU	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
20	—	Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sujatha (signature)	Dr. Pranavi

Patient & Clinical Records Received by : Swetha

Date & Time of Patient Received : 26/5/26 @ 9:35 AM

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

Docu. No. : RCH /FRM / CLINICAL / 102

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26-05-2026 0Y0M0D1H (M)
Dr. SANJAY SRIRAMPUR

NEWBORN MONITORING FORM

Date of Birth	: 26/5/26	New Born Screening	: willing
Time of Birth	: 6:02 AM	TFT SBR	: willing
Mode of Delivery	: EL-LSCS	OAE	: willing
Birth Weight	: 3.06 kg	Mother's Blood Group	: O Negative
Head Circumference	: 35 cm	Baby's Blood Group	: B Negative
Length	: 47 CM	Anomaly Scan	:
Red Reflex	:	Vaccination 27/5/26	: BCG, OPV, Hep-B } given

Date	Weight	Type of Feed	Quantity	Temperature	Signature
26/5/26	3.06 kg	DBF	(1)	36 °C	[signature]
27/5/26	2.920	DBF	(2)	36 C	[signature]
28/5/26	2.880	DBF	(3)	36 °C	[signature]
Night 28/5/26	2.860	DBF	(4)	36 °C	[signature]
29/5/26	2.860	DBF + ff	(5)	36 C	[signature]

Date	Time	Investigation	Result	Order No.	Signature
26/5/26	7:15Am	Blood group		8849	
,,		CBP, SBR		8849	[illegible]
,,		DCT, Reticulocyte,		8849	
,,		Count		8849	
26/5/26	3:00pm	Endocrinologist (Dr. Reena)		8248	[illegible]
26/5/26	6:pm	USG Abdomen			
		c̄ pelvis		06378	Sandhya.
		USG scrotum			
26/5/26	6pm.	GRBS	49mg/dl	08882	[illegible]
27/5/26.	6Am.	GRBS	75 mg/dl	8893	[illegible]
27/5/26	6pm	GRBS			
28/5/26	6Am	SBR		8925	Madhuri
		NBS			
28/5/26	6Am	GRBS	73	8929	Madh
28/5/26	11AM	DSP T	29/5/26 @10am	2587	[illegible]
29/5/26	6Am	SBR.		8980	[illegible]

Cross checked by Saranda

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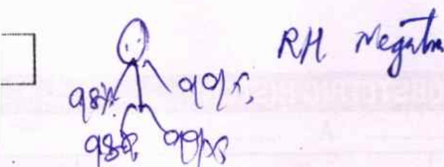

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : SUSHMITHA Age : 25y 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 Sushmitha

Gender : ☑ M ☐ F Blood Group : ....

Date of Birth : 26/5/2026 Time of Birth : 6:02 AM

Place of Birth : RCH - HNH

Mother's Blood Group : O Negative

Birth Weight (gms) : 3.06 kg Length (cms) : 47cm

OFC (cms) : 35cm.

Estimated Gesth Age : 36+6 wks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : .... Ht : .... Wt : .... BMI : .... Married Life : .... LMP : 1o/9/25 EDD : 17/7/...

Conception : (Spontaneous) or with Rx. : ....

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

Last Scans Details : 1/5/26 → SLVF / 33+2 wk / Breech / EFW - 2123g / AFI - 8cm

Doppler - (N) .... TT Immunization and Iron / Folic Acid : ....

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs TIFFA - (N)

Consanguinity : ☐ Yes ☐ No

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

H/o PIH (after 20 weeks) / PE

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

H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : ....

IUGR - when detected : ....

Doppler (Increased Resistence / ADEF / REDF / Redistrbution in MCA) / Ductus Venosus : ....

AFI : ..OL-4.0..

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

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

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Dr. SANJAY SRIRAMPUR

PAST OBSTETRIC HISTORY

G : .... P : .... A : .... L : ....

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
	PRIMI					

PERINATAL HISTORY

Treating Obstetrician : D. SUCHITHRA .... 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

	1 Minute	5 Minutes	10 Minutes
COLOUR			
HEART RATE			
REFLEX IRRITABILITY			
MUSCLE TONE			
RESPIRATION			
TOTAL	8/10	9/10	

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

:

Boy Baby delivered by El. LSCS
↓
CIAB
↓
Routine newborn care given
↓
Delayed cord clamping done
↓
Inj Vit - K given in (L) AL Thigh
↓
Baby Vigorous

Investigation details in previous Hospital :

Feeding History :

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26-05-2026 0 Y 0 M 0 D 1 H (M)
Dr. SANJAY SRIRAMPUR

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Baby Pink
Vigorous

VITALS : Temperature : 36.5°c HR : 156/min RR : 42/min NIBP : .... CFT : ....

Color of the extremities : Acrocyanosis

Jaundice : .... Pallor : .... SpO2 : 97%

Anthropometry : Birth Weight : 3060 g Length : .... HC : .... Present Weight : ....

Ponderal Index : .... (AGA) .... SGA : .... LGA : ....

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HEAD TO TOE EXAMINATION

HEAD :	Fontanelles : Sutures Shape / Moulding : Edema / Bruising : Size - (H.C.) :	AF - Opn
Facies : (Any Facial Dysmorphism)		
NECK and CLAVICLES :	Range of Motion : Asymmetry : Masses :	(N)
EYES :	Symmetry : Red Reflex : Discharge :	To check
EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Periauricular Pits / Tags : Nasal shape / Patency : Palate : Gums : Lips : Tongue :	(N)
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number :	
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : Discharge :	2A+1V
GENITILIA :	Labia / Hymen : Testicles/penis : Anus : Patent	Male B/L Testis descended ? (To R/o Micropenis)
HERNIAL ORIFICES		
TRUNK and SPINE :		(N)
SKIN LESIONS :		Hyperpigmented lesion over (L) leg
EXTREMETIES :	Fingers / Toes : Arms / Legs : Deformities : Mobility : Hip Joint Examination :	(N)

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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 : 96% Auscultation : .... Breath Sounds : .... Added Sounds : ....

Cardiovascular System :

HR : .... BP : .... Precordial Activity : ....

Femoral Pulses : Felt Murmurs : No

Other Peripheral Pulses : .... Signs of Cardiac Failure : ....

Abdomen : Hernia orifice : ....

Shape : .... Anal Patency : Patent

Palpation : Soft Umbilical Cord : 2A + 1V

Palpable masses : .... First urine passed : Passed

Abdominal girth : .... Meconium passed : ×

Nervous System : Higher intellectual functions (Sensorium) : C

State of wakefulness : T } Good

Prechtle Score : A

Nerves :

....

....

....

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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...ies : To rule out micropenis

Diagnosis : Primi / late PT / 36+6 wk / El-LSCS (oligo) / C(AB) / Boy / 3.06 kg / AGA
RH Negative Pregnancy

FOOT PRINTS

Left Side :	Right Side :

Resident Doctor :

Signature : [signature]

Name : Dr. PRANAV

Date & Time : 26/5/26

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.

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AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

Vital : ☐ HR : ☐ RR : ☐ BP : ☐ SPO2 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

Plan

1) Send cord sample
CBP, Blood group, SBR, DCT, Retic Count

(R/V) 2) To check Penile length

3) Warm care

Plan during ward follow up :

4) DBF 1/2 burping Q_2H
5) Vaccination Today (BCG, OPV, Hep B)
6) SBR/NBS/OAE @ 48 HOL
7) Monitor Vitals
8) Check 4 limbs SpO_2 & Red reflex
9) Nasoclear Saline nasal drops - 2 drops each Nostril.

Feeding Plan at the time of shifting :
6:32 to 6:38 am.

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
26/5 9:30Am	C/S/B Dr Pritesh Sir	
	Late Pre Term / 36+6 wk / Rh Negative Preg / 3.04 kg / Boy.	
		Plan
	Peaks over palate	1) Check stretched penile length (2.5cm)
	Baby Activity - Good, Moving all limbs	2) Trace labs of Rh Neg
		3) Vaccination Today, due
	Accepted DBF	4) DBF / 1h burping Q2h
	Passed Urine & Meconium	5) Check Red reflex, 4 limb SpO2
	Rest examination - (N) -) Penile length <2.5cm	6) Monitor Vitals, Inform SOS
		7)
26/5 12:45PM	S/B Dr. Sanjay Sir, Term AGA, ? Micropenis, Stretched penile length - 2.5cm	CST - Endocrinologist opinion

Dr. SANJAY SRIRAMPUR Reg. No: HN09465

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 4pm	S/B Dr. Pritesh	
	Left preterm (36wk+6d)	
	AGA/M/C/IAB	
	Rh-ve mother	
	Baby B Negative	Plan
	DCT - Negative	
	Baby euthermic	- DBF + Burping 2nd h
	pelvic count - (N)	
	CVS - S1, S2 (N)	
	RS - B/L AE (N)	Warm care
	P/A - soft	- USG Scrotum] NOD
	CT <3 sec	USG Abdo pelvis
	Red reflex - B/L - present	
		- SBR NBS @ 48 HOL
	Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184	
26/5/26 7pm.	S/B. Dr. Prabhath.	
	LPT/AGA/M/CIAB/Rh (-)	
	Baby stable	Adv
	accepts feed	
	Passed S/U	(1) GRBS BD
		(2) CT. Rest
		NB duty

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Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0 Y 0 M 0 D 17 H (M)
Dr. SANJAY SRIRAMPUR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/05/26 8 Am	S/B Dr Prabhath	Dr Sushanth
	LPT (36wk+6d) | AGA | M | C/AB | Rh ⊖	
		Bi. wt: 3060 gm
	Baby B ⊖. Baby euthermic.	T. wt: 2920 gm
	DCT - Negative. accepting feed	(4.5% wt loss)
	Retic count (N) passing u/s	Adv
	O/E Vitals stable.	→ DBF + Burping Q2H + FF
	AF OSF.	→ Warm. Care.
	S/E CVS S_1S_2+	→ ~~ALSG, SG~~
	CNS CTA good	SBR } 48 HOL
	RS: BAE +	NBS }
	PA soft.	
		Sushanth
		NB - Madhuri

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Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0 Y 0 M 0 D 17 H (M)
Dr. SANJAY SRIRAMPUR

GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5/26 11Am	Lactation care plan	
	- well formed breast & Nipple's	
	- colostrum scan	
	- primi	
	- baby suck & latch observed	
	- baby is not sucking continuously, started Suck with strong Stimulation.	
	Adv:-	
	- Direct breast feeding	
	- Aim for deep latch as demonstrated in cross cradle / cradle hold position.	
	- make baby 15-20 mints on each side	
	- make baby suck continuously & stimulate	
	- Demand feeding not exceeding 2½ hours as per early hunger cues.	
	- Adv To start galat & Lactare.	
	Sathwika. G, Dietitian & Lactation. 11:5 Am	
27/5/26	BCG, OPV, Hep-B given	

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

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Baby Of CHITTIMALLI SUSMITHA
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Dr. SANJAY SRIRAMPUR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/3 12 pm	C/B/B Dr. PRITESH Sir	
	LPT (36+6 wk) / LSCS / CIAD / 3.06 kg	(Rh Negative Pregnancy)
	T. Wt - 2.92 kg	
	Wt loss - 4.5% ↓ birth	
	Baby on DBF + FF	Ph
		1) DBF / 1/6 burping q2h
	Euthermic	2) SBR
	Cry	NBS / T/M 6AM
	Tone / Good	OAE
	Activity	3) Warm care
		4) Monitor Vitals
	Passing Urine & Stools	
	Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184	[signature]
		NB - Supervising
		12:45pm @ 27/3

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0 Y 0 M 0 D 17 H (M)
Dr. SANJAY SRIRAMPUR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/b Dr. [illegible] / Dr. Pranav.	
27/5/26 2 PM	LPT (36+6 wks) / EL. LSCS / AGA / RA -ve pregnancy.	
	- Baby is euthermic.	DAT - -ve.
	- Cry, Tone, Activity } Good.	Plan - Warm care.
		- DBF + FF ad lib.
		- SBR, NBS, OAE } tmrw @ 6cm.
	P/E - Vitals stable.	- Monitor vitals.
	S/E - WNL.	
	Last GRBS - (N).	
	noted by sr. sandhya. 27/5/26 2 pm	

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

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
25-05-2026 0 Y 0 M 0 D 17 H (M)
Dr. SANJAY SRIRAMPUR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26		
8am	C/W/B Re. Marni	
		Rh – ve pregnancy.
	- accepting feeds well	T. wt : 2.880 kg
	- passing urine –	↓ 140 g
	stools –	wt loss : 5.8%
	O/E	
	euthermic	
	AF/A - good	Plan
	AF : flat	1) warm care
	murmur (+)	2) DBF every 2nd hr
	vitals : stable	3) feare SBR
	S/t – (N)	NBS
		4) OAE to be done
		5) monitor vitals
28/5/26	C/S/b Dr. Sanjay	
10 AM.	- Accepting feeds well.	Plan – warm care
	- Passing urine	D/S today after SBR - 13.8
	Stool –	– OAE to be done.
	O/E – vitals stable.	– ~~R/V tomorrow at~~
	O/E – WNL.	8am place.
		– Start DSPT now.

Dr. SANJAY SRIRAMPUR
Reg. No. ...

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0 Y 0 M 0 D 17 H (M)
Dr. SANJAY SRIRAMPUR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/s/b Dr. Venu /	Dr. Pranav.
28/5/26 2:30 PM.	Asis - LPT (36+6wks) /	Ct. LSCS / AGA / Rh-ve Pregnancy.
	- Baby is euthermic.	
	- ↓ DS PT.	
	- Cry, Tone, Activity } Good.	Plan - Warm care.
		- DBF + PF cdl's.
		- OAE to be done.
		- Rpt. SBR tomorrow
	- P/E - vitals stable.	after discussing c sir.
	S/E - WNL.	- Monitor vitals.
	Repeat SBR tomorrow at 6:00 Am.	
		NB - Supriya 2:50 pm @ 28/5

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

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0 Y 0 M 2 D (M)
Dr. SANJAY SRIRAMPUR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26 8pm	c/e/b - Dr. Shruthi	
	Late Preterm (36W+6d)	EM.LSCS | AGA | Rh -ve Pkg
	O -ve	Advice:
	B -ve	i) Recheck wt now.
	Rchy Eutheric	ii) DBF + FF Q2H.
	On DSPT.	iii) Repeat SBR tomorrow morning 6 am
	O/E - Cry, tone, Activity } good.	iv) Monitor vitals.
		v) OAE tomorrow.
		vi) Continue DSPT.
		Noted by madley

Patient Sticker

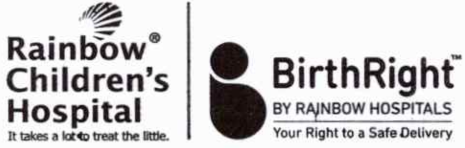
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Naipriya	Dr. Akhya
29/5 7:00 Am	LPT (36+6) / AGA / M /	Em. LSCS /
	Rh Negative pregnancy /	NNJ
	~~fever~~ on DSPT	plan
	Asthenic	
	C/T/A - Good	- DBF + FF 2nd hourly
	Vitals - Stable	
	R/S / P/A / NAD	- ⓣ SBR
		- OAC today
	T. wt - 2.860 kg	- Cont DSPT
		- Monitor vitals
		[signature]

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

(P.T.O)

Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. pritesh	
29/5 9:00AM	LPT / AGA / M / NNJ / Rh -ve pregnancy	
	on DSPT	Plan
	Euthemic	
	C/T/A - Good	- DBF + FF 2nd hourly
	vitals - Stable.	
	R/S / NAD	- (T) SBR
	P/A	- OAE today
		- cont DSPT
		- Warmth care
	Dr. Pritesh Nagar Consultant Pediatrician & Intensivist Reg. No: 47184	[signature]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/by Dr Sruthi	
29/5/26		
10 30AM	NNJ.	
	SBR - (n)	
		- Enhance orally
	c/T/A Good	DBF + FF Oil [illegible]
	vital stable	- Kan Care.
		- ODF
		- Iyom SOS
		- d/s today.
		- T Bact Ointmt
		L/A TID

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0 Y 0 M 0 D 1 H (M)
Dr. SANJAY SRIRAMPUR

Blood Group → B -ve

306 100% 100% 100% 100%

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

RESULT SHEET

Date	26/5					
Time						
Hb	16.2					
PCV	44.8					
RBC	4.61					
WBC	11.79					
N/L	45.4/45.6					
Platelets	209					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj 2.5 < C-0.1 U-2.4						
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~~ DCT	Negative					
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 : ....

....

....

....

Radiology : USG : ....

X-Ray : ....

ECHO : ....

CT : ....

MRI ....

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

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0 Y 0 M 0 D 1 H (M)
Dr. SANJAY SRIRAMPUR

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 26/5 Time:	6AM	10AM	2pm	6pm	10pm	2Am	6Am
Doctor/Nurse/Family Concern?							
Temperature (°F)	36.5	36.5°C	37.1	37.5	98.7	97.8	98.6
Heart Rate (bpm) and Blood Pressure (mmHg) *							
Heart Rate (Number)	156bpm	148b/m	[illegible]	149b/m	140	142	140
Resp. Rate (bpm) (Over 1 Minute) *							
Resp Rate (Number)	42b/m	40b/m	45b/m	46b/m	40bm	40bm	40bm
Resp Distress: Mod/ Severe / None / Mild							
Receiving O_2(l/min) / O_2 Saturations (%)	94%	98%	98%	99%	99%	99%	100%
Conscious Level: Normal / Altered	0						
GCS *	0	0	0	0			
TOTAL SCORE Number of shaded boxes		0		0	0	0	0
Pain Score	[illegible]	[illegible]	[illegible]	[illegible]	0	0	0
Observer's Initials					[illegible]	[illegible]	[illegible]

Note: BP does not score in early warning scoring

Temperature scale: 104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94
Heart rate / BP scale: 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50
Resp. rate scale: 70, 60, 50, 40, 30, 20, 10

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

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-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0 Y 0 M 0 D 17 H (M)
Dr. SANJAY SRIRAMPUR

H / FRM / CLINICAL / 124

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

...LY WARNING SCORE: CHILDREN'S UNIT

Date: 27/5/26

Time:	10 AM	2 PM	6 PM	10 pm	2 Am	6 Am
Doctor/Nurse/Family Concern?						
Temperature (°F)	98.1°F	97.6°F	97.8°F	98.3°F	97.8°F	97.8°F
Heart Rate (bpm) and Blood Pressure (mmHg) *						
Heart Rate (Number)	143b/m	140b/m	145b/m	140bm	142bm	142bm
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	43b/m	42b/m	45b/M	42bm	40bm	40bm
Resp Distress Mod/ Severe / None / Mild						
Receiving O_2(l/min) / O_2Saturations (%)	99%	99%	99%	99%	99%	99
Conscious Level Normal / Altered						
GCS *	15/15	15/15	15/15			
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Temperature scale: 104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94

Heart Rate / Blood Pressure scale: 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50

Note: BP does not score in early warning scoring

Resp. Rate scale: 70, 60, 50, 40, 30, 20, 10

ACTIONS		
NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
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Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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

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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-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0 Y 0 M 0 D 17 H (M)
Dr. SANJAY SRIRAMPUR

/ FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

LY WARNING SCORE: CHILDREN'S UNIT

Date: 28/5

Time:	10Am	2pm	6 PM	10 PM	2Am	6Am
Doctor/Nurse/Family Concern?						
Temperature (°F)	98.3°F	98.5°F	97.3°F	98.0°F	98.3°F	98.5°F
Heart Rate (bpm) and Blood Pressure (mmHg) *						
Heart Rate (Number)	138b/m	142b/m	140b/m	143b/m	146b/m	140b/m
Resp. Rate (bpm) (Over 1 Minute) *						
Resp Rate (Number)	33b/m	38b/m	40b/m	41b/m	49b/m	43b/m
Resp Distress: Mod/ Severe / None / Mild						
Receiving O_2 (l/min) / O_2 Saturations (%)	99%	99%	100%	99%	98%	100%
Conscious Level: Normal / Altered						
GCS *						
TOTAL SCORE Number of shaded boxes	0	0	0	-	-	0
Pain Score	0	0	0	0	0	0
Observer's Initials	4	4	8	9	e	10

Temperature scale: 104, 103, 102, 101, 100, 99, 98, 97, 96, 95, 94

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

Note: BP does not score in early warning scoring

Resp. Rate (bpm) scale: 70, 60, 50, 40, 30, 20, 10

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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* 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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Date	Time	Early Warning Score	Date	Time	Name

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

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0 Y 0 M 0 D 1 H (M)
Dr. SANJAY SRIRAMPUR

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							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm						NA					
	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					NA						
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
26/12	04:00 am					NA		0				
	05:00 am								0		0	
	06:00 am		DBF C07									
	07:00 am		DBF									
Total Intake : Taken						Total Output : Not passed.						

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
28-05-2026 0 Y 0 M 0 D 1 H (M)
Dr. SANJAY SRIRAMPUR

FLUID CHART

Sheet No. : ....

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

Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
26/5/26	08:00 am		[illegible]									
	09:00 am		DBF									
	10:00 am											
	11:00 am		DBF				✓			✓		[signature]
	12:00 pm											
	01:00 pm											
Total Intake : taken						**Total Output :** passed						
26/5/26	02:00 pm											
	03:00 pm		DBF									
	04:00 pm						✓			✓		
	05:00 pm	0	DBF	NA								[signature]
	06:00 pm									✓		
	07:00 pm		DBF									
Total Intake :						**Total Output :**						
26/5/26	08:00 pm		DBF									
	09:00 pm						✓			✓		
	10:00 pm	0	DBF					NA				[signature]
	11:00 pm			NA								
	12:00 am		DBF				✓			✓		
	01:00 am											
Total Intake :						**Total Output :** U-2 M-2						
26/5/26	02:00 am		DBF									
	03:00 am											
	04:00 am	0	DBF	NA			✓	NA		✓		[signature]
	05:00 am											
	06:00 am		DBF				✓					
	07:00 am											
Total Intake :						**Total Output :** U-2 M-1						

Total 24 hrs. Intake	

Total 24 hrs. Output	

FLUID CHART

Sheet No. : ....

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

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
27/5/26	08:00 am	|	DBF + FF				✓		/	✓	0	
	09:00 am	|				/					0	
	10:00 am	0	DBF + FF		NA						0	[illegible]
	11:00 am	|						NA			0	
	12:00 pm	|	DBF + FF		/			/		✓	0	
	01:00 pm										0	
Total Intake :						Total Output : U – 2					M – 1	
27/5/26	02:00 pm	|	DBF + FF								|	
	03:00 pm	|								✓		
	04:00 pm	0	DBF + FF								0	
	05:00 pm	|					✓				|	[illegible]
	06:00 pm	|	DBF + FF					NA		✓	|	
	07:00 pm			NA								
Total Intake :						Total Output : U – 2					M – 1	
27/5/26	08:00 pm	|	DBF + F								|	
	09:00 pm	|								✓	|	
	10:00 pm	0	DBF + F				✓				0	[illegible]
	11:00 pm	|		NA				NA			|	
	12:00 am	|	DBF + F							✓	|	
	01:00 am	|									|	
Total Intake :						Total Output : U – 2					M – 1	
28/5/26	02:00 am	|	DBF + FF								|	
	03:00 am	|								✓	|	
	04:00 am	0	DBF + FF				✓				0	[illegible]
	05:00 am	|		NA				NA			|	
	06:00 am	|	DBF + FF							✓	|	
	07:00 am										|	
Total Intake :						Total Output : U – 2					M – 1	

Total 24 hrs. Intake		Total 24 hrs. Output	

FLUID CHART

Sheet No. : ....

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

Date	Time	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
28/5/26	08:00 am											
	09:00 am		DBF							✓		
	10:00 am	0	FF		NA		✓	NA			0	[illegible]
	11:00 am											
	12:00 pm		DBF							✓		
	01:00 pm		FF									
Total Intake : Talken						**Total Output :**				U —	M —	
28/5/26	02:00 pm											
	03:00 pm		DBFFF									
	04:00 pm	0								✓		Ⓓ
	05:00 pm		DBFFF		NA		0	NA			0	
	06:00 pm									✓		
	07:00 pm		DBFFF									
Total Intake : Taken						**Total Output :**				U —	M —	
28/5/26	08:00 pm											
	09:00 pm		DBF									
	10:00 pm				NA		✓	NA		Done		Madhu
	11:00 pm	0	DBF								0	
	12:00 am											
	01:00 am		DBF				✓					
Total Intake :						**Total Output :**						
29/5/26	02:00 am											
	03:00 am		DBF								0	
	04:00 am							NA		✓		Madhu
	05:00 am	0	DBF		NA						0	
	06:00 am											
	07:00 am		DBF									
Total Intake :						**Total Output :**						

Total 24 hrs. Intake	

Total 24 hrs. Output	

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA (M)
28-05-2026 0 Y 0 M 1 D
Dr. SANJAY SRIRAMPUR

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							
29/5/26	08:00 am											
	09:00 am		DBF									
	10:00 am	0			NA				NA		0	[signature]
	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	

Docu. No. : RCH /FRM / CLINICAL / 092

Patient Sticker

FLUID CHART

Sheet No. : ....

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

		Intake				Output					IV Site Thrombo-phlebitis Score	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		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	

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0 Y 0 M 0 D 1 H (M)
Dr. SANJAY SRIRAMPUR

NURSING CARE RECORD

Date: 25/5

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		N-A					
Afternoon							
Night	8pm to 8Am	→ Assess the baby condition → monitor vitals → give every 2nd hrly feeding	8pm to 8Am	→ assessed the pt condition → monitor vitals → maintained 86 chart	Now pt is stable	Re-check vitals	Mouni

Docu. No: RCH /FRM / CLINICAL / 148

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0 Y 0 M 0 D 1 H (M)
Dr. SANJAY SRIRAMPUR

NURSING CARE RECORD

Date: 26/5/26

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 → monitor the vitals & record → DBF 2nd hrly & burping → maintain I/O chart & record	8Am – 2Pm	→ Assessed the baby condition → monitored the vitals & recorded → DBF 2nd hrly & burping → maintained I/O chart & record	Baby is stable	maintain the chart [illegible]	Akhila
Afternoon	2pm to 8pm	→ Assess the pt condition → monitor vitals & record → Maintain I/O chart → DBF 2nd hrly	2pm to 8pm	→ Assessed the baby condition → monitored vitals & record → maintained I/O chart → DBF 2nd hrly	Baby is stable	Rechecking vitals	[illegible]
Night	8pm to 8AM	→ Assess the pt condition → Maintain I/O chart → DBF + 2nd hourly	8pm to 8AM	→ Assess the Baby condition → monitored vitals → DBF + 2nd hourly	Baby is a stable	re-checked vitals	[illegible]

NURSING CARE RECORD

Date: 27/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM to 2PM	→ To assess the baby condition → To check the vitals & record → 2nd hourly DBF + FF → I/O chart maintain	8AM to 2PM	→ To assessed the baby condition → To checked the vitals & recorded → 2nd hourly DBF + FF → I/O chart maintained → GRBS monitoring	→ Baby is stable NOW → GRBS monitoring - BD	→ Re-checked the vitals → I/O → Today vaccination to be done	Supriya
Afternoon	2PM to 8PM	→ Assess the baby general condition → Monitor vitals → DBF + FF every 2nd hrly → Maintain I/O chart	2PM to 8PM	→ Assessed the baby general condition → monitored vitals → maintained I/O chart	→ Baby is stable. → GRBS monito-ring,	→ Rechecked vitals	[signature]
Night	8pm to 8AM	→ Assess the Baby condition → monitored vitals → maintained I/O chart → DBF + FF 2nd hr	8pm to 8Am	→ Assess the baby general condition → monitored vitals. → maintained I/O chart DBF + FF 2nd hourl	Baby is stable	Re-checked vitals	[signature]

NH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
28-05-2026 0 Y 0 M 0 D 17 H (M)
Dr. SANJAY SRIRAMPUR

NURSING CARE RECORD

Date: 28/5/26

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 to 2pm	→ Assess the baby condition → Monitor the vitals → Maintaine I/o chart → DBF + FF every 2nd hourly	8Am to 2pm	→ Assessed Baby condition → monitored vitals → maintained I/o chart → DBF + FF - every 2nd hourly → DSPT continue	Baby is stable	Re-checked vitals	[signature]
Afternoon		Assess the baby condition; monitor vitals; Maintaine I/o chart; DBF + ff every 2nd hourly		→ Assessed baby condition → Monitored vitals & recorded → Maintained I/o chart; DBf + f f every 2nd hourly	→ baby is stable	→ rechecked vitals	[signature]
Night	8pm to 8Am	- Assess the Baby condition - Monitor the vitals - maintain I/o charts - DBF + FF every 2nd hourly - Repeat Trace SBR	8Pm to 8A	- Assess the Baby condition - monitor the vitals - maintain I/o charts - DBF + FF every 2nd hourly - Repeat SBR Trace	- Baby is Hemo stable	- Re-Assessment done	[signature]

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
28-05-2026 0 Y 0 M 1 D (M)
Dr. SANJAY SRIRAMPUR

NURSING CARE RECORD

Date: 29/5/26

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 to 2PM	-> Assess Baby condition -> monitor the vitals -> Maintain I/O chart -> Trace reports -> DBF+FF every 2nd hrly	8AM to 2PM	-> Assessed baby condition -> monitored vitals -> maintained I/O chart -> DBF+FF every 2nd hrly -> Traice reports -> DSPT continue	Baby is stable	Re-checked vitals	[illegible]
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

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							

Docu. No: RCH /FRM / CLINICAL / 148

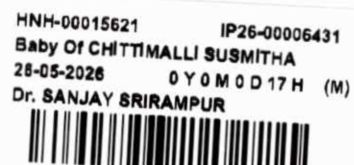
HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0Y0M0D1H (M)
Dr. SANJAY SRIRAMPUR

NURSING SHIFT HAND OVER FORM

SITUATION		
	Diagnosis: New born baby	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify: ....
	Surgery / Procedure:	Post OP Day:

	Date / Shift	25/5 N1	26/5/26 M6	26/5 E	28/5 N	27/5/26 M6	27/5/26 Evng
BACKGROUND	Medical Condition (Any special condition to be noted):	–	–	–	–	–	–
	Diet:	DBF	DBF	DBF	DBF	DBF + FF	DBF + FF
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	98°F	98°F	98.3	98.1°F	98.3°F
	Res:	32	50 b/mt	48 b/m	40 b	42 b/m	40 b/m
	SpO_2:	99	99%	98%	99%	99%	99%
	Pulse:	132	145 b/m	145 b/m	145 b/m	143 b/m	145 b/m
	BP:	.	–	–	–	–	–
	LOC:	–	–	–	–	–	–
	Fall Risk Score:	–	–	–	–	–	–
	Pain Score:	–	–	–	–	"0"	–
	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 + FF	DBF + FF
	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):	dependent	NA	–	–	–	–
Post Operative Procedure Special Orders:		NA	NA	–	–	–	–
Handed Over By Name :		Mooni	Akhila	Swetha	Neela	Supriya	Sandhya
Signature / ID :		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Date:		26/5	26/5/26	26/5	27/5	27/5	27/5/26
Time:		8 Am	8 pm	8 P	8 Am	2 pm	8 pm
Taken Over By Name :		Akhila	Swetha	Neela	Supriya	Sandhya	Neela
Signature / ID :		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Date:		26/5/26	26/5/26	26/5	27/5/26	27/5/26	27/5/26
Time:		8 Am	8 pm	8 PM	8 AM	2 pm	8 PM

Docu. No. : RCH /FRM / CLINICAL / 097


HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
28-05-2026 0 Y 0 M 0 D 17 H (M)
Dr. SANJAY SRIRAMPUR

NURSING SHIFT HAND OVER FORM

SITUATION		
Diagnosis: NB		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify: ....
Surgery / Procedure:		Post OP Day:

Section	Item	28/5/26	28/5 M6	28/5 E2	28/5/26 N1	29/5 M6	
BACKGROUND	Date / Shift	28/5/26	28/5 M6	28/5 E2	28/5/26 N1	29/5 M6	
	Medical Condition (Any special condition to be noted):	—	—	—	—	—	
	Diet:	DDF+FF	DBF+FF	DBF+FF	DBF+FF	DBF+FF	
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:	98.5	98.0°F	98.5°F	98.6°F	98.2°F	
	Res:	40	40b/m	42b/m	40b/m	40b/m	
	SpO_2:	100	100%	100%	99%	99%	
	Pulse:	143	140b/m	140b/m	145b/m	140b/m	
	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:	NA	—	—	—	—	
	Handed Over By Name :	Madhu	Anusha	Divya	Neha	Anusha	
	Signature / ID :	[signature]	[signature]	[signature]	[signature]	[signature]	
	Date:	28/05/2	28/5/26	28/5	29/5/26	29/5/26	
	Time:	8AM	2pm	8PM	8Am	2PM	
	Taken Over By Name :	Anusha	Divya	Neha	Anusha		
	Signature / ID :	[signature]	[signature]	[signature]	[signature]		
	Date:	28/5/26	28/5	28/5/26	29/5/26		
	Time:	8AM	2PM	8Pm	8AM		

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0 Y 0 M 0 D 1 H (M)
Dr. SANJAY SRIRAMPUR

BRADEN 'Q' SCALE

				Date :	25/5	25/5	26/5	26/5
				Time :	N1	M6	E	N1
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	[illegible]	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.	4	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	3	3	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	3	3	4
				TOTAL SCORE	28	25	29	[illegible]
				Evaluator's Name	[illegible]	[illegible]	[illegible]	[illegible]

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
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

HNH-00015621 IP26-00006431
Baby Of CHITTIMALLI SUSMITHA
26-05-2026 0Y0M0D1H (M)
Dr. SANJAY SRIRAMPUR

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date 25/5	Date 25/5	Date 26/5	Date 27/5	Date 28/5	Date 28/5	Date 28/5	Date 29/5	Date
	-2	-1	0	1	2	Time N1	Time M6	Time S2	Time M6	Time M6	Time S2	Time N1	Time M6	Time
					Procedure ➡	0	0	0	0	0	0	0	0	
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	NR	–	–	–	–	–	–	–	
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)	NR	–	–	.	–	–	–	–	
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	NR	–	–	–	–	–	–	–	
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	NR	–	–	.	–	–	–	–	
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	NR	–	–	–	–	–	–	–	
					Gestational Age / Corrected Age	3	37wk	37w	37wk	37 wks	37+ weeks	37/ wks	37+ wks	
					Total Pain / Agitation Score	–	–	–	–	–	–	–	–	
					Intervention	–	–	–	–	–	–	–	–	
					Effectiveness	–	–	–	–	–	–	–	–	
					Signature	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

Forehead: Bulge between brows, vertical furrows
Brows: Lowered, drawn together
Eyes: Tightly closed
Cheeks: Raised
Nose: Broadened Bulging
Nasolabial Fold: Deepened
Mouth: Open, Squarish

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

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.

MC-7373

Laboratory Report

Baby Of CHITTIMALLI SUSMITHA	8919274597
0 Y 0 M 2 D	HN26008925
Male	28-05-2026 06:11 AM
IP26-00006431	28-05-2026 06:23 AM
HNH-00015621	28-05-2026 10:11 AM
Dr. SANJAY SRIRAMPUR	3F -PRIVATE ROOM / CRDL-HNPVT-306-1

Investigation	Result	Unit		Biological Reference Interval
BILIRUBIN (INDIRECT / DIRECT) (Specimen : SERUM)		**TEST RESULT STATUS : REPORT AUTHORISED**		
TOTAL BILIRUBIN (Azobilirubin)	**13.8**	**mg/dl**	H	<8.2
CONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl		<0.6
UNCONJUGATED BILIRUBIN (Spectrophotometric)	**13.7**	**mg/dl**	H	0.6 - 7.6

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