BAH-00660453 IP5-00175862
Baby Of BHOOMIKA GAJPAL
02-07-2026 0Y0M0D1H (F)
Dr. KAPIL BHAGWATRAO SACHANE

Rainbow® Children's Hospital
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NEWBORN MONITORING FORM

Date of Birth : 2/7/2026
Time of Birth : 8:46 AM
Mode of Delivery : LSCS
Birth Weight : 3.610
Head Circumference : 34 cm
Length : 50 cm
Red Reflex :

New Born Screening : Done [father]
TFT :
OAE :
Mother's Blood Group : O+ve
Baby's Blood Group : A+ve
Anomaly Scan :
Vaccination : OPV, BCG, Hep-B done on 2/7/26 by Sis. Kaveri

Date	Weight	Type of Feed	Quantity	Temperature	Signature
2/7	3.610	DBF	1	97.4 F	Sunitha
2/7/26 D.O.L	3.554 kg	DBF	1	97.7 F	Akshaya
3/7/26	3.76 kgs	DBF	1	97.8 F	Sneha
4/7/26	3.440 kg	DBF	—	97.9 F	Rino

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

(P.T.O)

Date	Time	Investigation	Result	Order No.	Signature
2/7/26	10:00AM	Blood grouping		26066126	Shoby
2/7/26	10:30AM	1st GRBS	36	26066274	Sunitha
2/7/26	11:20AM	2nd GRBS	53	26066275	Sunitha
2/7/26	2:46pm	6th GRBS	67	26060277	Shoby
2/7/26	8:46pm	12 GRBS	66mg/dl	26066684	Sneha
3/7/26	3:30AM	18 GRBS	62 mg/dl	2606682	[illegible]
3/7/26	8:46AM	24 GRBS	90 mg/dl	2606683	[illegible]
3/7/26	9 PM	36 " GRBS	80 mg/dl	2606685	[illegible]
4/7/26	9AM	GRBS 98mg/dl	98 mg/dl	26066247884	[illegible]

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175862 **Admit Date** : 02-Jul-2026 **Admit Time** : 09:37 AM **UHID** : BAH-00660453

Patient Details :

Patient Name	: Baby Of BHOOMIKA GAJPAL	**Age**	: 0 D
Guardian	: Mr KSHITIJ CHOUDHARY	**DOB**	: 02-07-2026 08:46 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Single
Address (H)	: FLAT NO-1803 TOWER 7NCC URBAN ONE, Narsingi Hyderabad Telangana INDIA 500075	**Phone No**	: 9717131905/ 9399743741
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : BASINET **Bed No** : CRDL-SW-416-1 **Ward Name** : 4F-BIRTHING CENTRE

Room No : CRDL-SW-416-1 **Admission Type** : First Visit

Contact Details :

Name : Mr KSHITIJ CHOUDHARY **Relationship** : Father

Contact Address : FLAT NO-1803 TOWER 7NCC URBAN ONE, Narsingi Hyderabad Telangana INDIA 500075 **Phone No** : 9717131905 / 9399743741

Signature

Doctor Details :

Doctor Name : Dr. KAPIL BHAGWATRAO SACHANE **Specialisation** : NEONATOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

Equipment check done

↓

Baby received in a prewarmed linen

↓ loops of 2 cord around the neck

Dried/ stimulated / cleaned

↓

Cord cleaned/ clamped / cut

↓

Inj. vitamin K 0.5ml I.M. given

↓

Vitals were checked

↓

Baby was shifted to mother side

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Bhoomika Gajpal. Age : 29. 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 Bhoomika Gajpal.

Gender : ☐ M ☐ F Blood Group : A+

Date of Birth : 2/7/2026. Time of Birth : 8:48am

Place of Birth : RCH : BH.

Mother's Blood Group : O positive.

Birth Weight (gms) : 3.610 Length (cms) : .....

OFC (cms) : .....

Estimated Gesth Age : 38+6.

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 29. Ht : ..... Wt : ..... BMI : ..... Married Life : ..... LMP : 11/10/25 EDD : 9/7/26

Conception : Spontaneous or with Rx. : .....

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

Last Scans Details : 6/6/26: 35+2/ 2kg (SRF) / AFI 19.7 / Placenta : Anterior/ (N) dopplers.

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

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs

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,

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?

Gest. hypothyroid .....

Other Chronic Medical Problems, when detected

BAH-00660453 IP5-00175862
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—

Family History :

—

Socio Economic History :

—

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Euthermic Pink.

cl/c/a : good.

Hemodynamically stable

VITALS : Temperature : Euthermic HR : 159/min RR : 49/- NIBP : ..... CFT : 2 3

Color of the extremities : Acrocyanosis

Jaundice : ..... Pallor : ..... SpO2 : 97 - bra.

Anthropometry : Birth Weight : 3601 Length : ..... HC : ..... Present Weight : .....

Ponderal Index : ..... AGA : ✓ SGA : ..... LGA : .....

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
1	1	
2	2	
2	2	
2	2	
1	2	
8	9.	

TOTAL

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

Comments :

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HEAD TO TOE EXAMINATION

HEAD :	Fontanelles :	
	Sutures	AF 2 open
	Shape / Moulding :	
	Edema / Bruising :	-
	Size - (H.C.) :	
Facies : (Any Facial Dysmorphism)		—ali—
NECK and CLAVICLES :	Range of Motion :	— N —
	Asymmetry :	
	Masses :	
EYES :	Symmetry :	
	Red Reflex :	to be checked
	Discharge :	
EARS, NOSE MOUTH and THROAT :	Ear set / Shape :	
	Periauricular Pits / Tags :	
	Nasal shape / Patency :	
	Palate :	
	Gums :	NO cleft lip/ palate
	Lips :	
	Tongue :	
THORAX and BREASTS :	Shape of Thorax :	
	Position of Nipples and Number :	—N—
ABDOMEN and UMBILICUS :	Shape :	
	Organomegaly :	
	Bowel Sounds :	
	Umbilical Stump :	DA + IV.
	Discharge :	
GENITILIA :	Labia / Hymen :	
	Testicles/penis :	—N—
	Anus :	
HERNIAL ORIFICES		
TRUNK and SPINE :		
SKIN LESIONS :		N
EXTREMETIES :	Fingers / Toes :	
	Arms / Legs :	
	Deformities :	N
	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 : 49/min : 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 : 97% Auscultation : RAE (+) Breath Sounds : NVBS (+) Added Sounds : .....

Cardiovascular System :

HR : 149/min BP : ..... Precordial Activity : .....

Femoral Pulses : B/L well Felt Murmurs : .....

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

Abdomen :

Shape : ..... Hernia orifice : .....

Palpation : ..... Anal Patency : Both patent

Palpable masses : Nil Umbilical Cord : 2A 1V

Abdominal girth : ..... First urine passed : —

Meconium passed : passed

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

State of wakefulness : ..... Nil

Prechtle Score : .....

Nerves :

.....

.....

.....

Nil

Motor System :

Passive Tone : .....

Active Tone : ..... C/T/A: good

Neonatal Reflexes : .....

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

Moro's : B/L Symmetrical DTR : .....

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

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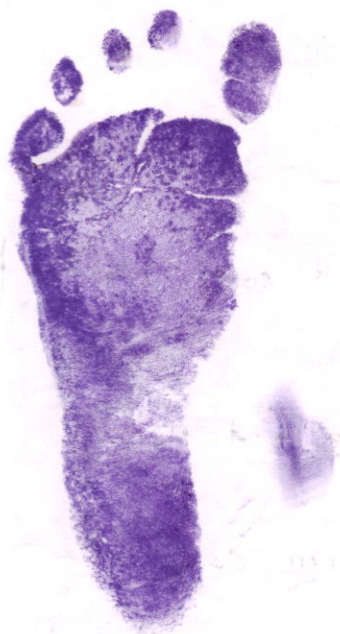
Any Congenital Anomalies : .....

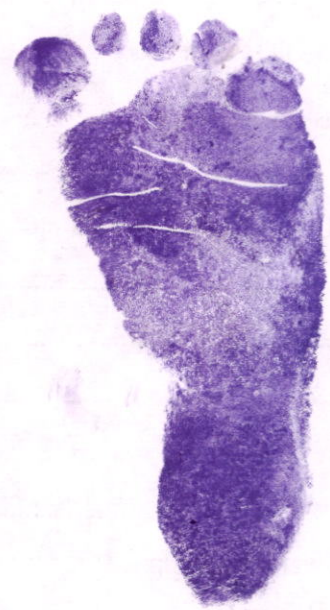
Diagnosis : 38+6/ Primi/ EM-LSCS – FHR variabilities/ CIAB/ 3.601kg/ Fch

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : .....

Name : Dr. Lohith

Date & Time : 2/7/26

Consultant :

Signature : .....

Name : .....

Date & Time : .....

DR. KAPIL BHAGWATRAO SACHANE
Registration No. 2002/06/1356

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 : Nil

Medications : 1. Send cord blood for Blood grouping.

2. DBF/2nd monthly

3. warm care

Plan during ward follow up :

4. Vaccine OPV / BCG / Hep B / today

5. BBS monitoring 30 mins' post feed 3, 6, 12, 18, 24, 30, 48 Pre feed AEL.

Feeding Plan at the time of shifting : first feeding time. 9:10 Am to 9:20 Am.

6. CBC/NBS/OAE @ discharge

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
2/7 3:00 pm	c/c/B RESIDENT.	
	38+6 | Primi | LSCS | c/AB | 3.60 grams | Fch.	
	8+ / A+ 4 / m.	Plan
	Euthermic | Pink	1. DBF | 2nd hourly
	c/T/A: good	2 - warmth care
	Warm peripheries	3 OPV | BCG | Hep-B → today
	hemodynamics are stable.	4. ct RBS monitoring, inform if < 50mg/dl
	Euglycemic so far.	
	GRBS last 67	5. SBR | NBS | DAE @ HBTOT.
		Trace - Blood group
		Noted by Ishaan

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 8:00 am	C/S/B Resident.	
	23 HOL/38th Term/Primi/C/AB/LSCS/Female child	
	B.wt → 3.610 kg +today's wt → 3.76 kg 4% ↑ in Bwt	Plan
		① DBF 2nd day + Formula feed (10-15ml)
	Euthermic - Pink Euglycemic - 62 mg/dl (GRBS)	② warm care
	feed well	③ vaccines given
	M/O+ U/✓ B/A+ S/✓	④ Lactation review
	O/E Baby is active. CRT < 3sec Cry / Tone } good. feed well on formula	⑤ SBR / NBS / OAE } @ 48hrs 7am 9a.m ⑥ GRBS monitoring
		Soluble

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Registration No: 2002/03/1356

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7 10 AM	Lactation care plan : - Primi - Well formed breast and nipples - colostrum richly seen. - Suck not active, sleepy at breast even after continuous stimulation. Advice : - Direct breast feeding. - Seen for deep latch as demonstrated. - Always get baby to the breast first - Demand feeding not exceeding 2-2½ hours	
3/7/26 3:00 pm	CS IB Resident 29+1 OL / 38+6 / Primi / Fch / LSCS Bwt : 3.610 kg Twt : 3.76 kg GRBS 90 mg/dl Euthermic - Pink Euglycemic Cry Tone activity } good.	Plan ① DBF 2hrly ② TCBR - now - 7.3 ③ Warm Care ④ Lactation review ⑤ GRBS monitoring SBR & TSH 9a.m NBS OAE

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 9:15am	CIS/B Resident.	
	48 HOL | 38+6 | Primi | CIAB | LSCS | FCH | 3610g.	
	Baby on room air	
		Plan
	M | O+ U | ✓ B | A+ M | ✓	
		① DBF 2 hrly + 24 ml formula feed.
	feeding well	
		② warm care
	Euthermic - Pink	③ SBR, NBS, OAE } Today 9:00am
	Euglycemic - 98 mg/dl	
	Bwt → 3.610 kg.	
	Twt → (3.44) kg 3.44 4.7% ↓	④ Stop GRBS monitor
		⑤ lactation review
	Tone, cry, activity } good.	Soluble

DR. KAPIL BHAGWATH RAO SACHANE
Registration No: 2002/05/1356

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		4/7/26
		OAE - Newborn hearing screening
		Bilateral responses are present
		Bilateral Pass
		4/7/26.
4/7/26 10am	Lactation note:	
	- Baby is still not sucking (latching).	
	- To try feeding with nipple shield	
	- Always direct breast feeding 1st	

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Date & Time	Progress Notes	Doctor's Order

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

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

Pratiksha Rainbow Children's Hospital
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 2/7/26 Time:	10am			12pm			8pm			9pm		12am			3am			6am					
Doctor/Nurse/Family Concern?																								
Temperature (F) 104 103 102 101 100 99 98 97 96 95 94	98.2F			98.2F			98.4F			97.5F		98.2F			98.4F			98.8F					
Heart Rate (bpm) and Blood Pressure (mmHg) * 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50																								
Note: BP does not score in early warning scoring																								
Heart Rate (Number)	150 b/m			140 b/m			136 b/m			134 bpm		142 bpm			136 bpm			142 bpm					
Resp. Rate (bpm) (over 1 Minute) * 70 60 50 40 30 20 10																								
Resp Rate (Number)	40 b/m			44			38 bpm			42 bpm		44 bpm			46 bpm			48 bpm					
Resp Distress: Mod/ Severe / None / Mild																								
Receiving O_2 (l/min) O_2 Saturations (%)	99%			100			100			99%		97%			98%			99%					
Conscious Level: Normal / Altered																								
GCS *	-			-																				
TOTAL SCORE Number of shaded boxes	0			0			0			0		0			0			0					
Pain Score	0			0			0			0		0			0			0					
Observer's Initials	[illegible]			[illegible]			[illegible]			[illegible]		[illegible]			[illegible]			[illegible]					

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)

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3/7/26

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

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

Pratiksha Rainbow Children's Hospital
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: ..... Time:	10AM	2PM	6PM	10 PM	2 AM	6 AM
Doctor/Nurse/Family Concern?						
Temperature (F)	98°F	97.8°F	98°F	97.1°F	98.0°F	97.3°F
Heart Rate (bpm) and Blood Pressure (mmHg) *						
Heart Rate (Number)	136	134	132	115 b/m	125 b/m	131 b/m
Resp. Rate (bpm) (over 1 Minute) *						
Resp Rate (Number)	36	32	34	38 b/m	38 b/m	38 b/m
Resp Distress: Mod/ Severe / None / Mild						
Receiving O_2(l/min) O_2Saturations (%)	92%	92%	99%	99%	99%	98%
Conscious Level: Normal / Altered	—	—	—			
GCS *	(14/15)	(14/15)	(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						

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

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BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00660453 IP5-00175862
Baby Of BHOOMIKA GAJPAL
02-07-2026 0 Y 0 M 0 D 16 H (F)
Dr. KAPIL BHAGWATRAO SACHANE

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: .... Time:	
Doctor/Nurse/Family Concern?	
Temperature (F)	104
	103
	102
	101
	100
	99
	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)	
Resp. Rate (bpm) (per 1 Minute) *	70
	60
	50
	40
	30
	20
	10
Resp Rate (Number)	
Resp Distress	Mod/ Severe
	None / Mild
Receiving O_2 (l/min)	
O_2 Saturations (%)	
Conscious Level	Normal
	Altered
GCS *	
TOTAL SCORE Number of shaded boxes	
Pain Score	
Observer's Initials	

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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)

BAH-00660453 IP5-00175862
Baby Of BHOOMIKA GAJPAL
02-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. KAPIL BHAGWATRAO SACHANE

FLUID CHART

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Sheet No. : C1

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

		Intake				Output						
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		DBF				Mp			VP	NO	Sunitha
	10:00 am		DBF									Sunitha
	11:00 am											
	12:00 pm											
	01:00 pm		DBF									
Total Intake :						Total Output :						
	02:00 pm											Shobha
	03:00 pm		DBF								NO	
	04:00 pm						Mp					Shobha
	05:00 pm									VP		
	06:00 pm		DBF									Shobha
	07:00 pm											Shobha
Total Intake :						Total Output : M-1 U-0						
	08:00 pm											Sneh
	09:00 pm		DBF				✓			✓		
	10:00 pm										NO	Sneh
	11:00 pm		DBF							✓	W Canula	Sneh
	12:00 am						✓					
	01:00 am		FF	15ml								Sneh
Total Intake :						Total Output : U-2 M-2						
	02:00 am											Sneh
	03:00 am		DBF FF	15 ml			✓				NO	
	04:00 am									✓		Sneh
	05:00 am		FF	15ml							W Canula	Sneh
	06:00 am											
	07:00 am		FF	15ml			✓			✓		Sneh
Total Intake :						Total Output : U-2 M-2						

Total 24 hrs. Intake		Total 24 hrs. Output	M-5 U-4

BAH-00660453 IP5-00175862
Baby Of BHOOMIKA GAJPAL
02-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. KAPIL BHAGWATRAO SACHANE

3/7/26

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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.

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
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am		DBF									
	10:00 am											
	11:00 am		DBF									
	12:00 pm											
	01:00 pm		FF									
Total Intake :							**Total Output :**					
	02:00 pm											
	03:00 pm		DBF									
	04:00 pm											
	05:00 pm		DBF									
	06:00 pm											
	07:00 pm		DBF									
Total Intake :							**Total Output :**					
	08:00 pm											
	09:00 pm		DBF									
	10:00 pm											
	11:00 pm		DBF									
	12:00 am											
	01:00 am		DBF									
Total Intake :							**Total Output :**					
	02:00 am											
	03:00 am		DBF									
	04:00 am											
	05:00 am		DBF									
	06:00 am											
	07:00 am		DBF									
Total Intake :							**Total Output :**					

Total 24 hrs. Intake	taken	Total 24 hrs. Output	

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

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Baby Of BHOOMIKA GAJPAL
02-07-2026 0 Y 0 M 0 D 16 H (F)
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			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											
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	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

FLUID CHART

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	06:00 pm											
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Total Intake :						**Total Output :**						
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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**	

BAH-00660453 IP5-00175862
Baby Of BHOOMIKA GAJPAL
02-07-2026 0 Y 0 M 0 D 1 H (F)
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NURSING CARE RECORD

Shift: ☑ Morning ☐ Afternoon ☐ Night

Date: 2/7/26

Assessment: Newborn baby.

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

Time	Plan of Care	Time	Implementation	Evaluation
9 AM	✱ Assess the baby General condition	9:10 AM	✱ Assessed baby General condition	baby is Stable.
10 AM	✱ provide moniter vitals.	10:5 AM	✱ provied moniter vitals	
11 AM	✱ provide I/O Monitering.	11:10 AM	✱ provied I/O monitering	
	✱ provide GRBS	12:5 PM	✱ provied GRBS	
12pm	✱ provide DBF and Barfing	1:10 pm	✱ provied DBF & Barfing	
1pm	✱ provide warm care		✱ provied warm care	
2pm	✱ provide baby Safety	2:10 pm	✱ provied baby Safety	

Re-Assessment: Re-Assessment is done.

Special Notes: GRBS.

Nurse Signature: Sf Nurse Name: Sunitha Date & Time: 2/7/26 @ 2pm

BAH-00660453 IP5-00175862
Baby Of BHOOMIKA GAJPAL
02-07-2026 0Y0M0D1H (F)
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NURSING CARE RECORD

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Your Right to a Safe Delivery

Shift: ☐ Morning ☑ Afternoon ☐ Night

Date: 2/7/26

Assessment: Newborn Care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess baby general condition	2:10 pm	Assessed baby general condition	Baby is stable
3pm	monitor vital	3:10 pm	Bp spo2 pluse checked recorded	
4pm	DBF + Burping	4:10 pm	DBF + Burping done	
5pm	Warm Care	5:10 pm	Warm Care provided	
7pm	Ensure provided	7:30 pm	Ensure Safety provided	

Re-Assessment: Re Assessment 2nd hourly done

Special Notes:

Nurse Signature: S Nurse Name: Shobha Date & Time: 2/7/26 6pm

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02-07-2026 0 Y 0 M 0 D 1 H (F)
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NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☑ Night Date: 2/7/26

Assessment: New born baby care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the baby condition and vitals check	8:30 pm	* Assessed the baby condition and vitals checked	* now baby condition is stable
10pm	* monitor the I/O chart	10:30 pm	* monitored the I/O chart	
12Am	* DBF every 2nd hourly and Burping	12:30 Am	* DBF every 2nd hourly and burping given	
3Am	* provide warm care	3:30 Am	* provided warm care	
6Am	* Ensure safety	6:30 Am	* Ensured safety	

Re-Assessment: Assess the baby condition now this stable

Special Notes: Nil

Nurse Signature: [signature] Nurse Name: Sneha 607635 Date & Time: 2/7/26 @ 8pm

Docu. No: RCHBH /FRM / CLINICAL / 148

BAH-00660453 IP5-00175862
Baby Of BHOOMIKA GAJPAL
02-07-2026 0Y0M0D1H (F)
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NURSING CARE RECORD

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Shift: ☑ Morning ☐ Afternoon ☐ Night

Date: 3/7/26

Assessment: Baby having hypothermia

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
8AM	→ ASSESS the Baby condition.	8AM	→ ASSESSED the Baby condition.	Baby is stable
11AM	→ vital chart Maintain	11AM	→ vital chart maintained	
12PM	→ Ensure safety	12PM	→ Ensured safety	
4PM	→ 2hr hourly feeding	4PM	→ 2hr hourly feeding	
8PM	→ warm care	8PM		

Re-Assessment: Baby is stable

Special Notes: NVBS, SBR, OAE T/W

Nurse Signature: S Nurse Name: Sumana Date & Time: 3/7/26 @ 8P

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NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☑ Night

Date: 3/7/26

Assessment: New born baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
10PM →	Assess the general condition of baby	10pm →	Assess condition & checked the vitals	feeds well
12AM →	Educate the mother about feeding	12AM →	Mother was confident about feeding	
2AM →	DBF and hourly	2AM →	DBF f/b burping	
4AM →	W/f due activity	4AM →	baby was active	
6AM →	Warm Cure	6AM →	Swadle the baby & kept bed side	

Re-Assessment: baby was active taking feeds well

Special Notes: SBR. NBS. 9AM Tim

Nurse Signature: R Nurse Name: Reena Date & Time: 4/7/26 @ 8am

BAH-00660453 IP5-00175862
Baby Of BHOOMIKA GAJPAL
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NURSING CARE RECORD

Rainbow® Children's Hospital
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BirthRight™
BY RAINBOW HOSPITALS
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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: .....

Assessment: .....

.....

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: .....

.....

Special Notes: .....

.....

Nurse Signature: ..... Nurse Name: ..... Date & Time: .....

BAH-00660453 IP5-00175862
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02-07-2026 0 Y 0 M 0 D 1 H (F)
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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: - Department: OBS Date of Admission: 2/7/26 @

SITUATION

Diagnosis: Newborn baby.

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

BACKGROUND

Area / Shift Time	OBS 8AM-2PM	OBS 2PM-8PM	3rd floor 8PM-8AM	3rd Floor 8PM-8AM	
Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	

ASSESSMENT

Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
Vital Signs: Temp:	98.2 F	98 F	97 F	98 F	97.9 F	
Res:	49 b/m	40 b/m	42 b/m	36 b/m	31 b/m	
SpO_2:	99%	99	99%	99%	98%	
Pulse:	154 b/m	153 b/m	146 b/m	136 b/m	135 b/m	
BP:	—	—	—	—	—	
Fall Risk Score:	16	16	16	16	16	
Pain Score:	0	0	0	0	0	

Recommendations

Safety Needs:	Yes	Yes	Yes	Yes	Cuib Cuve	
Physiotherapy	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
Others Specify:	NO	NO	NA	NA	NA	
Special Diet:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
Other Special Orders / Medications:	NA	NA	NA	NA	SBR +IM	
Post Operative Procedure Special Orders:	NA	NA	NA	NA	NA	
Handed Over By Name :	Sunitha	Shoba	Suchi	Sumana	Rima	
Signature :						
Date:	2/7/26	2/7/26	3/7/26	3/7/26	4/7/26	
Time:	2pm	5:40	8AM	8 PM	@8pm	
Taken Over By Name :	2/7/26	Shoba	Sumana	Rima		
Signature :	2pm					
Date:	5	2/7/26	3/7/26	31/7/26		
Time:		8pm	8AM	@8pm		

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Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

BAH-00660453 IP5-00175862
Baby Of BHOOMIKA GAJPAL
02-07-2026 0 Y 0 M 0 D 1 H (F)
Dr. KAPIL BHAGWATRAO SACHANE

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

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

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

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position		X	X	X	X
	Call device within reach		X	X	X	✓
	Wheels Locked		X	X	X	✓
	Room free of clutter		✓	✓	✓	✓
	Adequate lighting		✓	✓	✓	✓
	Wheel chair support		X	X	X	X
	Other Intervention(s) Specify		X	X	X	X
	Nurse's Name:		Sonali	Shobha	Rima	
	Signature:					
	Date:		2/7	2/7	3/7	3/7
	Time:		2 pm	8 pm		10 pm

Docu. No. : RCHBH /FRM / CLINICAL / 005

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PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
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	7 to less than 13 years old	2					
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Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
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	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
	Total						

Intervention: -Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

	Bed in low position						
	Call device within reach						
	Wheels Locked						
	Room free of clutter						
	Adequate lighting						
	Wheel chair support						
	Other Intervention(s) Specify						
	Nurse's Name:						
	Signature:						
	Date:						
	Time:						

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BRADEN 'Q' SCALE

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					Date : 2/7	2/7	3/7	3/7
					Time : ~~8am~~ ~~2pm~~	~~8pm~~ 8pm	8pm	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.	4	2	2	2
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	2	2	2	2
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2	2	2
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	2	2	2	2
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2	2	2	2
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	2	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	04
				TOTAL SCORE	18	18	18	18
				Evaluator's Name	Reethu	Shobha	Sneha	Ra

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
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BRADEN 'Q' SCALE

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				Date : / Time :				
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				TOTAL SCORE				
				Evaluator's Name				

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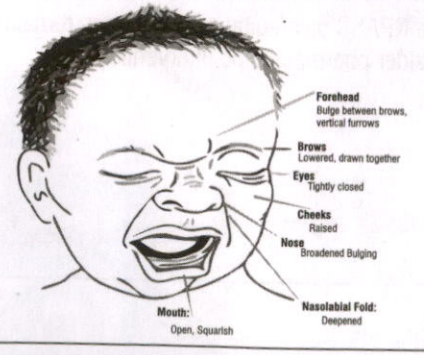
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
						8pm	2pm	8pm	8pm				
					Procedure →	ExPRS	bPRS	Gavage					
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					
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0					
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0					
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0					
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	0	0					



Premature Pain Assessment: Scoring

+3 if less than 28 weeks gestation age / Corrected Age
+2 if 28 - 31 weeks gestation age / Corrected Age
+1 if 32 - 35 weeks gestation age / Corrected Age

Intervention

Deep Sedation: Score = -10 to -5
Light Sedation: Score = -5 to -2
Pain Score less than or equal to 3 – No Intervention
Pain Score greater than 3 – Intervention

Gestational Age / Corrected Age	38+6 wks	38+6 wks	38+6 wks										
Total Pain / Agitation Score	0	0	0										
Intervention	NA	NA	NA										
Effectiveness	NA	NA	NA										
Signature	Sudha	Shaj	Shaj										

Docu.No: RCHBH/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.

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CONSENT FOR FORMULA FEEDS

Patient Name : ..... Age : ..... Gender : ☐ Male ☐ Female

UHID No : ..... Reg. 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 : Bhoomika

Name : Bhoomika Gajpal

Relationship with Patient: Self

Date & Time : .....

Witness :

Signature : Sneha

Name : Sneha

Date & Time : 3/7/26 @ 1AM

Doctor (who is taking the consent) :

Signature : Soheb

Name : Dr. Soheb

Date & Time : 3/7/26 @ 1 am

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NURSING DEPARTMENT
NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/O. Bhoomika Gajpal Mother's Name: Mrs. Bhoomika Gajpal

Date of Birth: 2/7/26 Time of Birth: 8:46am Gender: ☑ Male ☑ Female

Birth Weight: 3.610 Kgs HC: 34cm cm Lenght: 50cm cm

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

Term / Pre-term / Post-term: Term

Resuscitated: ☐ Yes ☐ No Blood Group: Mother: O+ve 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: 97.6 ℃ HR: 146 /Min RR: 49 /Min BP: — SpO_2: 99

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☑ Yes ☐ No **Score:** 16 (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: Sunitha Signature: Date &Time: 2/7/26 @ 10pm

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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
2/7/26 @ 10am	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Baby care	H- Stability DBF	safety & treatment & monitoring	So Leh	☑ Nursing ☐ Others: Doctor
2/7/26 @ 10AM	☐ Medical ☑ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	provide baby wrom care.	provided DBF and Barfing	baby is ~~wrom~~ Safety. and care.	Smitha	☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

Patient Sticker

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Part - I.

Patient's / Learner Language: ..... Patient / Learner Literacy: ☐ Read ☐ Write ☐ Speak Willingness to Learn: ☐ Yes ☐ No Healthcare Literacy: ☐ Yes ☐ No

Identified Education Needs:

1. Diagnosis
2. Treatment and Care Plan
3. Pain Management
4. Informed Consent
5. Medication / Therapy (safety, effects/ side effect, interactions)
6. Discharge Medication
7. Infection Control Measures
8. Diagnostic Test / Procedures
9. Nutrition / Diet
10. Fall Risk Education
11. Safe use of Medical Equipment / Implantable Devices Safety
12. Patient's / Family Rights
13. Risk / Safety
14. Activity / Exercise
15. Social & Rehabilitation Needs
16. Special Discharge / Follow-up Education / Coping Skills
17. Others .....

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
2/7	10AM	7	Infection control measures	P.T.s	1	1	0	1	+	Smith

Part - III: CODES

Who was taught: **PT:** Patient **F:** Father **M:** Mother **S:** Spouse **Sn:** Son **D:** Daughter **C** Caregiver **O:** Other (Specify) .....

Learning Barriers:

1. No Learning Barriers
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

Teaching Tools Used: **A:** Audio **D:** Demonstration **V:** Video **O:** Oral **P:** Printed

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review