

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175972 Admit Date : 04-Jul-2026 Admit Time : 02:41 PM UHID : BAH-00660711

Patient Details :

Patient Name	: Baby Of ANANYA NIMMAGADDA	Age	: 0 D
Guardian	: Mr N V ANIRUDH	DOB	: 04-07-2026 01:07 PM
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO. 8-2-293/82/A/856/1, ROAD NO. 44 Jubilee Hills Hyderabad Telangana INDIA 500033	Phone No	: 9000703243
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : BASINET Bed No : CRDL-SUITE 1 (311)-1 Ward Name : 3F-ZONE A
Room No : CRDL-SUITE 1 (311)-1 Admission Type : First Visit

Contact Details :

Name : Mr N V ANIRUDH Relationship : Father
Contact Address : H NO. 8-2-293/82/A/856/1, ROAD NO. 44 Phone No : 9000703243
Jubilee Hills Hyderabad Telangana INDIA 500033


Signature

Doctor Details :

Doctor Name : Dr. DINESH KUMAR CHIRLA Specialisation : NEONATOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : SELFPAID

Date	Time	Investigation	Result	Order No.	Signature
21/7/26	3pm	Blood grouping	1	2606707	Sueally
4/7/26	3:44pm	CBP, Reticulocyte count		2606707	Becken
		DCT, Bilirubin			
5/7/26	2am	TCBR	A-5mg/dl	26067162	Suzelle
5/7/26	1:30pm	TCBR	7.5mg/dl	26067162	Smiths
6/7/26	12AM	TCBR	9.6	2607448	Freemore
7/7/26	11AM	OAE	Normal	09689930	Suzelle
7/7/26	2am	SBR + NBS	10.5 10.7	26067609	Suzelle
7/7/26	9AM	TCBR	26067897	12.7mg/dl	He



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

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

BIRTH INFORMATION

Name : B/o Ananya Nimmagadda Mother's Blood Group : O Negative
Gender : ☐ M ☒ F Blood Group :
Date of Birth : 4/7/2026 Time of Birth : 1:07pm Birth Weight (gms) : 2.685kg Length (cms) :
Place of Birth : RCH, Banjara OFC (cms) :
Estimated Gesth Age : 38+1

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 35yrs Ht : 162cm Wt : 70.6 BMI : Married Life : LMP : 10/10/25 EDD : 17/7/25

Conception : Spontaneous or with Rx :

Booked at what GA : 6wks AN Steroids Drugs / Doses :

Last Scans Details : 1/7/26 - 37+5wks Cephalic, AFI-13.6cm, EFW-2504(6.1)
Ac-2.1 Dopplers -N TT Immunization and Iron / Folic Acid : ?

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs 29+8 GMA
Consanguinity : ☐ Yes ☐ No (EFW - 10%)
If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3
H/o PIH (after 20 weeks) / PE Anti-D-Given
How many Drugs / Doses / Since how long : Crd 5/26
H/o value of recent BP recording, proteinuria, edema,
oliguria, any investigations (LFT, platelet count) :
IUGR - when detected :
Doppler (Increased Resistance / ADEF / REDF /
Redistribution in MCA) / Ductus Venosus :
AFI :

H/o GDM/ pre GDM/ on diet or insulin
Controlled or not, recent values, HbA1 values :
Compliance with Rx : /
Scans : LGA, TIFFA, Fetal Echo :
H/o Hypothyroidism : when diagnosed ? Medication?
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 :



PAST OBSTETRIC HISTORY

5 P: 2 A: 2 L: 2

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
G1	2021	FT	AVD (forcep)	male	2.9	(Rh neg)
G2	2023	8+2	missed mscm			
G3	2024	FT	SVD	male	2.5kg	(Rh neg)

PERINATAL HISTORY

G11 - 2025 - 5+3 - TOP - HERPC

Treating Obstetrician : 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 :

Resuscitation : ☐ 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
1	1	1
2	2	2
2	2	2
2	2	2
2	2	2
2	2	2
9/10	9/10	9/10

TOTAL

Snapee II Score

Score

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

Mean BP (mmHg)	> 30 (0)	20-29 (9)	< 20 (19)		
Lowest Temp (oF)	> 96 (0)	96-95 (8)	< 95 (15)		
Pao2 / Fio2 (mmHg%)	> 2.49 (0)	1-2.49 (5)	0.3-0.99 (15)	< 0.3 (28)	
Lowest Serum PH	> = 7.2 (0)	7.1-7.19 (7)	< 7.1 (16)		
Multiple Seizures	No (0)	Yes (19)			
U. Output (ml / kg / hr)	> = 1 (0)	0.1-0.9 (5)	< 0.1 (18)		
Apgar Score	> = 7 (0)	< 7 (18)			
Birth Weight	> = 1kg (0)	750 - 999 (10)	< 750 (17)		
SGA	> 3rd percentile (0)	< 3rd (12)			
Total					

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



History of Present Illness:

- ✓ Ketelway equipment check done
- Baby delivered by NVD
- Cried immediately after birth.
- Delayed Cord clamping done at 60 sec
↓
- Baby taken under warm.
- Oral Secretions - wiped ,
- Umbilical Cord - clamped cut
2A + 1V (+) ,
- Inf. vitamin K given ;
- ↓
- Vitals Stable
- Shifted to mother Side.
- Attended by Dr. Dinesh Sir .

Investigation details in previous Hospital :

Feeding History :

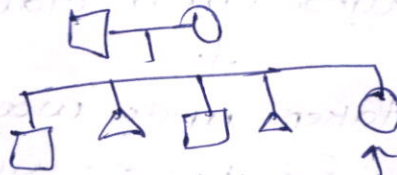
Patient S

BAH-00660711 IP5-00175972
Baby Of ANANYA NIMMAGADDA
04-07-2026 0 Y 0 M 0 D 4 H (F)
Dr. DINESH KUMAR CHIRLA



Past History :

Family History :



Socio Economic History :

Upper class

GENERAL EXAMINATION ON ADMISSION

General Disposition :

awake active

VITALS : Temperature : 36.7 HR : 150/min RR : 45/min NIBP : CFT : <38cc

Color of the extremities : Acrocyanosis

Jaundice : - Pallor : - SpO2 : 96%

ANTHROPOMETRY: Birth Weight : 2.685kg Length : HC : Present Weight :

Ponderal Index : AGA : ✓ SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :

Fontanelles :

Sutures

Shape / Moulding :

Edema / Bruising :

Size - (H.C.) :

AF open, flat

FACIES :

(Any Facial
Dysmorphism)

No dysmorphism

NECK and CLAVICLES :

Range of Motion :

Asymmetry :

Masses :

(N)

EYES :

Symmetry :

Red Reflex :

Discharge :

- Need to be assessed

EARS, NOSE MOUTH and THROAT :

Ear set / Shape :

Periauricular Pits / Tags :

Nasal shape / Patency :

Palate :

Gums :

Lips :

Tongue :

No cleft palate

THORAX and BREASTS :

Shape of Thorax :

Position of Nipples and Number :

(N)

ABDOMEN and UMBILICUS :

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump :- 2A + 1 V

Discharge :

(N)

GENITILIA :

Labia / Hymen :

Testicles/penis :

Anus :

Anab patency + female genitalia (N)

HERNIAL ORIFICES

free

TRUNK and SPINE :

(N)

SKIN LESIONS :

(N)

EXTREMITIES :

Fingers / Toes :

Deformities :

Hip Joint Examination :

(N)

Arms / Legs :

Mobility :

(N)



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 45/min SCR / ICR / See - Saw breathing :

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

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

Settings : Room air

SpO₂ : Auscultation: BAC (+) Breath Sounds: clear Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 145/min BP :

Precordial Activity : (+)

Femoral Pulses : well felt

Murmurs : NO

Other Peripheral Pulses :

Signs of Cardiac Failure : NO

ABDOMEN:

Shape : (+)

Hernia orifice : Free (+)

Palpation :

Anal Patency :

Palpable masses :

Umbilical Cord : A+IV

Abdominal girth :

First urine passed : Not passed

Meconium passed :

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : Awake

State of wakefulness : active

Prechtle Score : Stage - IIR

Nerves :

MOTOR SYSTEM:

Passive Tone : (+)

Active Tone :

Neonatal Reflexes :

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

Moro's : complete DTR :

ATNR :

Skull and Spine : (+)



Any Congenital Anomalies :

Diagnosis :

Term 1 AGA 1 female / CIAB / NVD / Rh. Neg. pregnancy
(38+1wks (2.685))

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

Sneha

Y. Sneha

4/7/26

Consultant :

Signature :

Name :

Date & Time :

[Signature]
Dr. Dinesh Kumar

4/7/26

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :

2. Name of the referring Hospital :

Address :

Contact Numbers :

3. Contact Details of the referring Doctor :

Mobile No. :

E-mail ID :

4. Name of the Doctor in Rainbow Team :

..... on whose name the patient is being referred.



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic : Plan

Medications :

1) warm care.

2) Direct Breast feeding 2nd hrly
flby Buping

3) Send - Cord Blood for
Blood grouping & typing
DCT, Retic Count, SBR

Plan during ward follow up :

4) Vaccination

BcG

OPV

Hep B

Today

Given on.

4/7/26

Sis. Yashwanth
4/7/26

Feeding Plan at the time of shifting :

1:40 pm to 2pm.

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

5) OAE }
NBS } at HBHOL
SBR }

6) w/f - feeding, activity
Intake, Respiration,
vitals

Doctor Signature (Handover Given): Doctor Signature (Handover Taken):

Doctor Name: Doctor Name:

Date & Time: Date & Time:

BAH-00660711 IP5-00175972
Baby Of ANANYA NIMMAGADDA
04-07-2026 0 Y 0 M 0 D 4 H (F)
Dr. DINESH KUMAR CHIRLA



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name:

Mother's Name: Ananya Nammagadda

Date of Birth: 4/07/26

Time of Birth: 1:07 pm

Gender: ☐ Male ☒ Female

Birth Weight: 2.685 Kgs

HC: 34 cm

Length: 48 cm

Meconium in Liquor: ☐ Yes ☒ No

Cried at Birth: ☒ Yes ☐ No

Term / Pre-term / Post-term: Term

Resuscitated: ☐ Yes ☒ No

Blood Group: Mother: O Negative Baby:

Feeding: ☒ Breast Feeding

☐ Formula

☐ Both

First Feed Time: 1:40 pm to 2 pm

AFFIX MOTHER'S
IDENTIFICATION LABEL

Mode of Delivery: ☒ Normal

☐ LSCS - Emergency/ Elective

☐ Instrumental

☐ AVD

Indication:

Physical Assessment of New Born:

Temp: 98.1 °C HR: 147 /Min RR: 42 /Min BP: SpO₂: 100%

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: Suritha

Signature: [Signature]

Date & Time: 4/7/26 2:30 pm

BAH-00660711 IP5-00175972
Baby Of ANANYA NIMMAGADDA
04-07-2026 0 Y 0 M 0 D 4 H (F)
Dr. DINESH KUMAR CHIRLA




**Rainbow[®]
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It takes a lot to treat the little.


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RESULT SHEET

Date	4/7/26					
Time						
Hb	12.6					
PCV	38.4					
RBC	3.71					
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

B+ positive
baby Blood
Group

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc.) :



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 5:00 PM	CL/B RESIDENT.	
	28+1 / 95 P ₂ L ₂ / A44 / 2.681 kg / NVD / RH - ve pregnancy.	
4/7/26 M	CL/B - 0 - Euthermic / Pink CL/TAs good Good perfusion warm peripheries.	Plan 1. DBP / 2nd hourly. 2. TCB @ 11:00 am. ↓ inform NW. 3. trace blood group, CBP, SBR and Letic. send and inform 4. warm care
		<i>[Signature]</i>
5/7/26 4 am.	CL/B - Recurrent	
5/7/26 M/B +ve.	15HOL / 2.68 kg / 38+1 WK / NVD / RH - ve preg - Baby Euthermic CL/TAs - good - peripheries - warm - passed - urine / stool TCBR - 4.5 @ 12HOL cut (8.5)	Plan - measured feeds: - TV - 60cc/kg/day = 14 ml / 2 nd hrs DBP + PF - warm care - TCB @ 24 h 3 ch
	DCT - Neg	<i>[Signature]</i>

Date & Time	Progress Notes	Doctor's Order
5/7/26 8:30am	C/S/B Resident	
	19HOL/38+1 AGA NVD Rh -ve	2681g
	Baby on room air	Plan TCBR - 4.5mg/dl (12HOL)
	<u>V</u> <u>✓</u> <u>m</u> <u>✓</u> <u>m</u> <u>O-ue</u> <u>B</u> <u>B+ue</u>	① TCBR @ 24hr → 1pm @ 36hr → 12am
	Eutheemic - Pink	
	Sugly cemic	② DBF 2nd huly
	Tnet - 2.542 5'1.↓	Restrict formula feed to give in case of excessive cny.
	DCT → negative	measured Feeds 60ml/kg 2huly
		③ warm care
		<u>Soheli</u>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/07/2026	lactation notes	
4pm	mother motivated to feed, shy breast seen, demonstrated recommended (slyly agree). FF started in view of low urine output. and Demand Pumping to stimulate for from 6/07 12pm	
	Shreya Prodduturi	
6/7/26 @ 8:30am	Morning Rounds	
	HE-HOC Term Rh neg Preg G5P2L0A2 (38+1)	
	B.wt = 2.685kg	Plan
	T.dy wt - 2.472	
	wt loss - 7.9%.	1) DBF and hourly + measured Top up
	BBG ONeg MBG ONeg + measured Top up	
	MBG B+ BBG B+ve feeds	
	Eutheemic	2) NBS } @ 1pm
	Pink, Tcterus+	SBR } OAC - Today
	TCBR 9.4mg/dL	
	Vitals Stable	3) Warm care

Date & Time	Progress Notes	Doctor's Order
7/1 8:20 AM	CLB RESIDENT GRHL 28+1 SVD CLAB Rh-ve pregnancy G5P2L2A2	
	TWT: U-G O- M-3 RT	Plan 1. DBF 2nd hourly.
	on DBF + top up as needed intake: enthusiastic pink cl/A: good warm peripheries Good perfusion hemodynamics are stable Red better: (+)	2. warm care 3. check weight
	DOL - 70HOL B.wt: 2.685 T.d.wt: 2.500kg (↑28g)	<i>[Signature]</i>
	on DBF + top up TCBR = 12.9	<u>Luha</u> ⇒ f/up on 2 days



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Nursing ☐ Others:
4/7/26 Cpm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	* DBF	* Bussing	* TO provide warm care	[Signature]	☒ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☒ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
4/11/26 6:20pm	6:20pm	7	Infection control measures	pt	4	D	1	1	NA	By

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: <table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>										1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)	3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	
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Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed																								
Mechanism/s to overcome barrier/s: <table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>										1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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THE HUMPTY DUMPTY SCALE

4/7 4/7 5/7 26 5/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4/07		8am 8pm	8pm	2p
	3 to less than 7 years old	3	4	4	4	4	4
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope/ Dizziness, etc.	3					
	Psych/ Behavioral Disorders	2					
	Other Diagnosis	1	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	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3	3	3	3	3	3
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2	2	2	2	2	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	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	Y	X	X	X
Call device within reach		X	Y	X	Y	X
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		X	Y	X	X	X
Other Intervention(s) Specify		X	Y	X	Y	X
Nurse's Name:		Suritha	Suritha	Suritha	Pray	Suritha
Signature:		Suritha	Suritha	Suritha	Pray	Suritha
Date:		4/7	4/7	5/7 26	5/7	5/7
Time:		7pm	5pm	8pm	8pm	2p



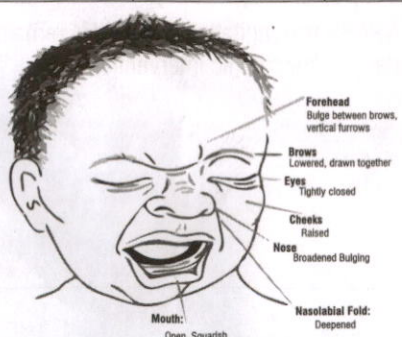
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

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	
						4/7	4/7	5/7	5/7	6/7	6/7			
						2pm	8pm	8pm	8pm	9pm	2pm	8pm		
						Procedure →								
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0	0	0	0	0				
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0	0	0				
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0	0	0				
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0	0				
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0	0				
	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					Gestational Age / Corrected Age	38+1 wks	38+1 wks	38+1 wks	38+1 wks	38+1 wks			
						Total Pain / Agitation Score	0	0	0	0	0			
						Intervention	NA	NA	NA	NA	NA			
						Effectiveness	NA	NA	NA	NA	NA			
						Signature	Sumit	Sumit	Sumit	Sumit	Sumit			

NPASS: Neonatal Pain, Agitation & Sedation Scale

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

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
Procedure →													
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable								
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)								
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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								
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator								
 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							
						Total Pain / Agitation Score							
						Intervention							
						Effectiveness							
						Signature							

NPASS: Neonatal Pain, Agitation & Sedation Scale

	Sedation	Pain / Agitation
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BRADEN 'Q' SCALE

					Date :	4/7	4/7	5/7	5/7
					Time :	2pm	8pm	8am-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.	2	2	2	2	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1	1	1	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2	2	2	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	2	2	2	2	
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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	3	3	3	3	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	16	16	16	16
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Dr. S. S.	Dr. S. S.	Dr. S. S.	Dr. S. S.

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

					Date :	Time :		
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"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.			1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.			2	2
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Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE		16	16
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name		Shruti	Shruti

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BAH-00660711 IP5-00175972
 Baby Of ANANYA NIMMAGADDA
 04-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. DINESH KUMAR CHIRLA



BRADEN 'Q' SCALE

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

					Date :				
					Time :				
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.					
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					TOTAL SCORE				
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INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart

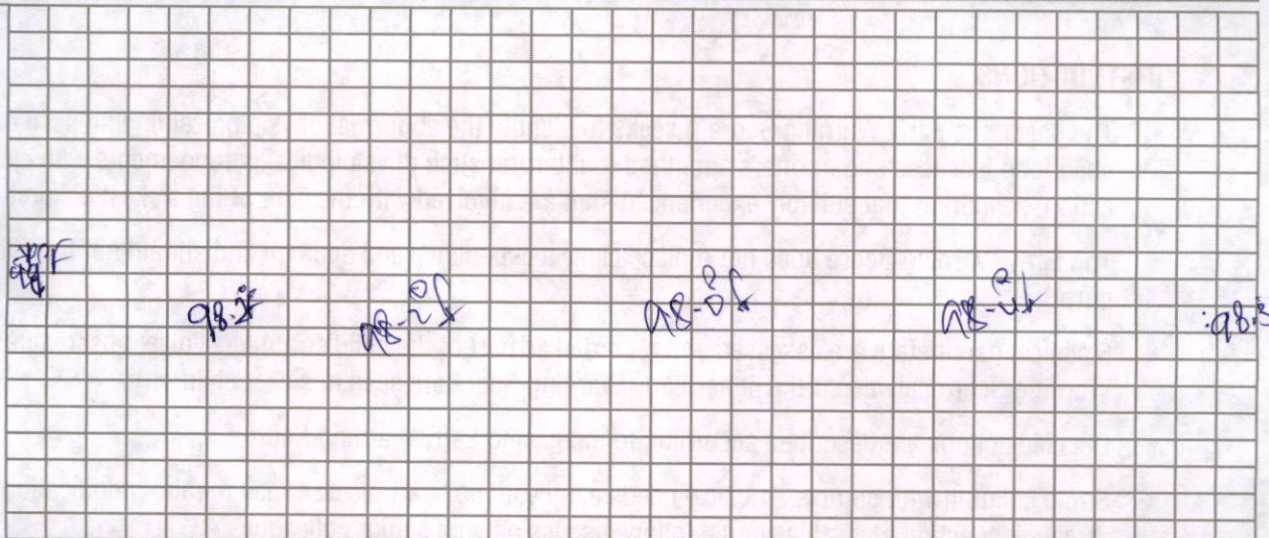
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 4/7/26 Time: 2pm 6pm 10pm 2am 6am 9am

Doctor/Nurse/Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94



Heart Rate
(bpm)

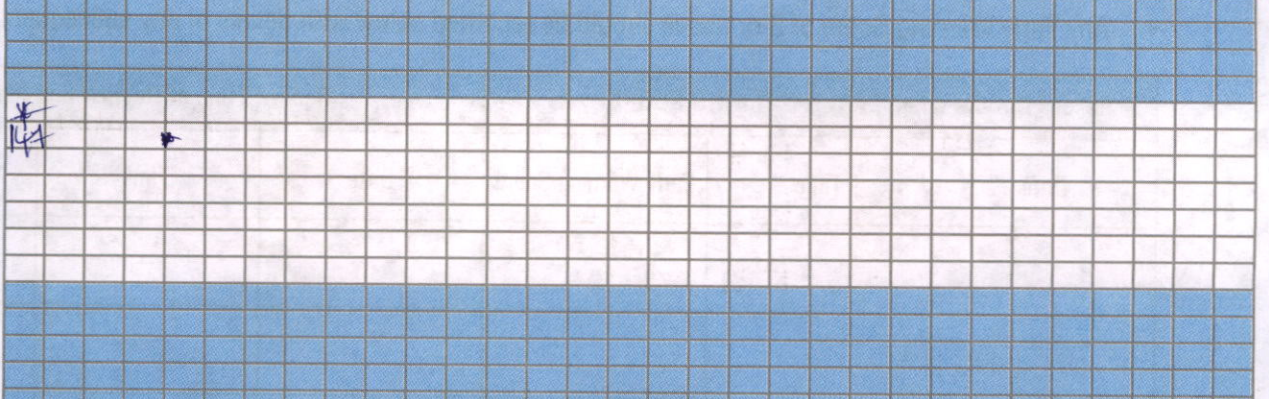
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring



Heart Rate (Number)

144 142 142 142 142 145

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

70
60
50
40
30
20
10



Rate (Number)

42 48 48 48 38 42

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

100% 100 100% 99% 100% 99%

Conscious Level Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

8 8 8 8 8 8

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



No. : RCH / FRM / CLINICAL / 124

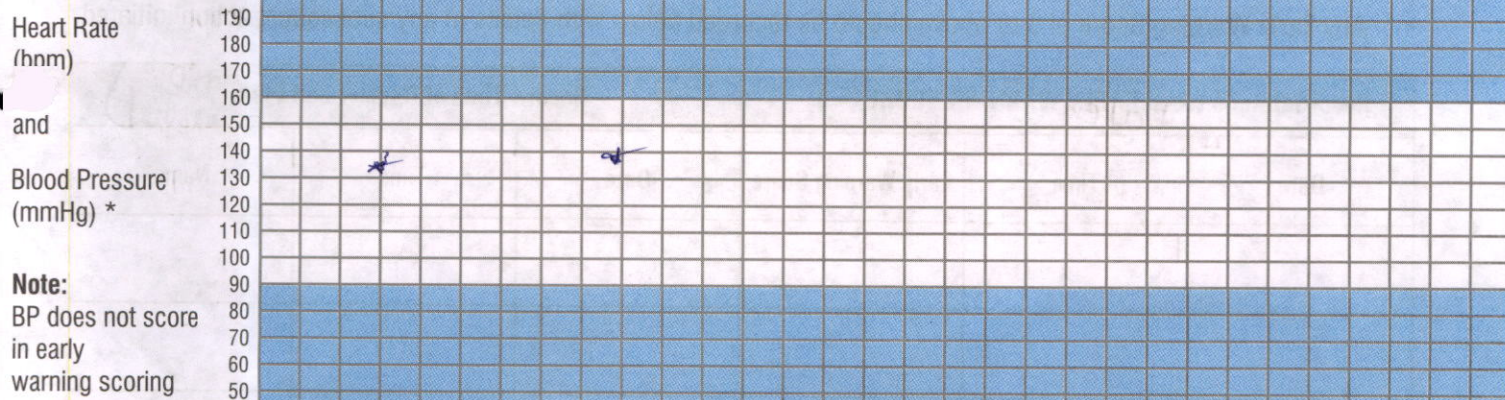
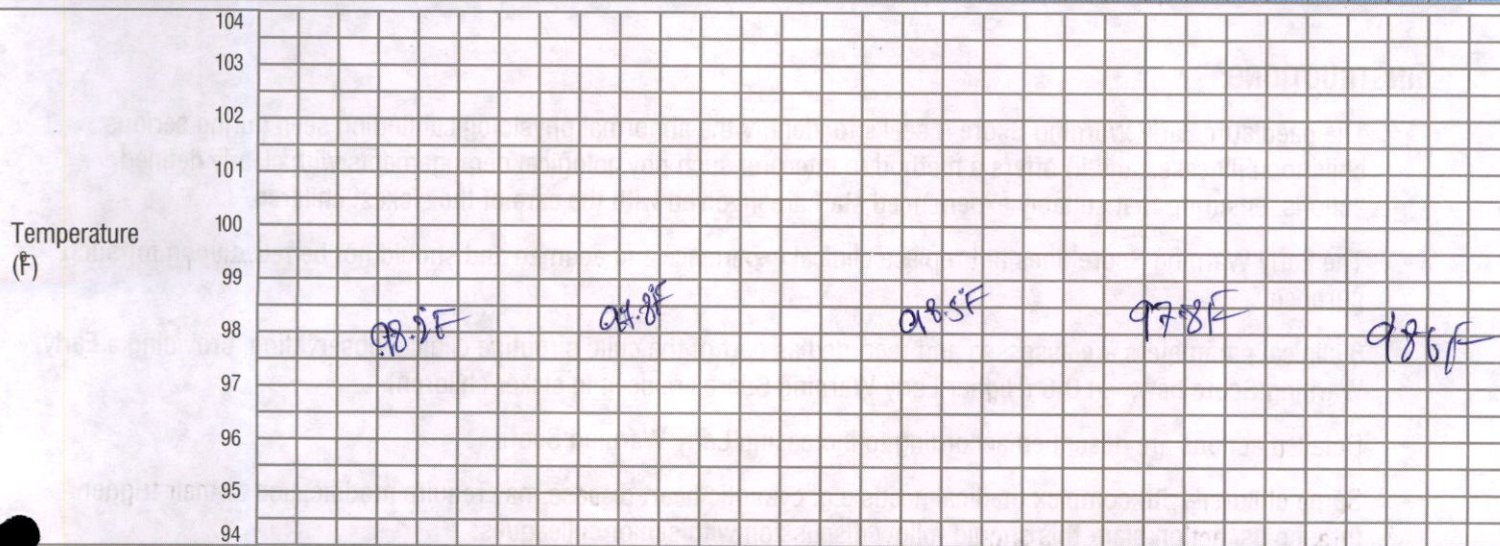
INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart

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

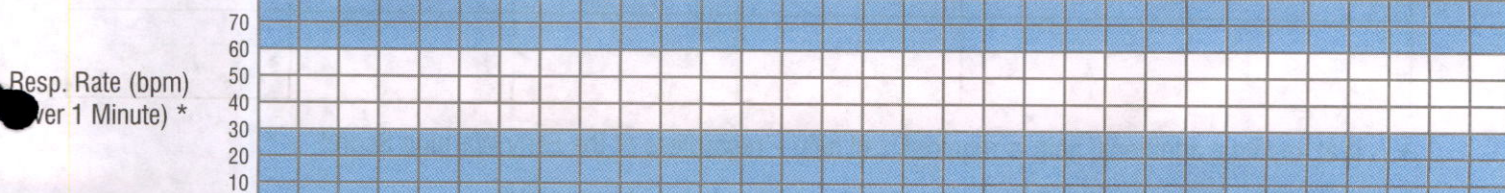
BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 04/07/2026	Time: 11pm	4pm	7pm	9:30AM	6AM
Doctor/Nurse/Family Concern?					



Heart Rate (Number)	135b/m	145b/m	142b/m	144	144
---------------------	--------	--------	--------	-----	-----



Rate (Number)	144b/m	150b/m	148b/m	144	144
---------------	--------	--------	--------	-----	-----

Resp Distress	Mod/ Severe	None / Mild			
---------------	-------------	-------------	--	--	--

Receiving O ₂ (l/min)					
O ₂ Saturations (%)	100%	99%	99%	98%	98%

Conscious Level	Normal	Altered			
-----------------	--------	---------	--	--	--

GCS *					
-------	--	--	--	--	--

TOTAL SCORE					
-------------	--	--	--	--	--

Number of shaded boxes					
------------------------	--	--	--	--	--

Pain Score					
------------	--	--	--	--	--

Observer's Initials	SP	SP	SP	i	j
---------------------	----	----	----	---	---

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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)

190
180
170
160
150
140
130
120
110
100
90

and

Blood Pressure
(mmHg) *

130
120
110
100
90

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

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

70
60
50
40
30
20
10

Resp Rate (Number)

Resp Distress | Mod/ Severe
None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

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

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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



FLUID CHART

Sheet No. : ①

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

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

Total 24 hrs. Intake

Total 24 hrs. Output

M - 4
 U - 3



FLUID CHART

Sheet No. : 2

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

		Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
5/7	08:30 am	DBF					✓			✓		Sumitha
	09:00 am	FF-15ml										Sumitha
	10:30 am									✓		Sumitha
	11:00 am						✓			✓		Sumitha
	12:00 pm	DBF										Sumitha
	01:00 pm	DBF										Sumitha
Total Intake : taken					Total Output : pass-U							
5/7	02:00 pm	DBF										Sumitha
	03:00 pm											Sumitha
	04:00 pm											Sumitha
	05:00 pm	DBF										Sumitha
	06:00 pm	FF-17ml					✓			✓		Sumitha
	07:00 pm											Sumitha
Total Intake :					Total Output : U-1, m-1							
5/7	08:00 pm											
	09:00 pm	DBF					✓			✓		
	10:00 pm	DBF										
	11:00 pm											
	12:00 am											
	01:00 am	DBF										
Total Intake :					Total Output : U-1 m-1							
5/7	02:00 am	FF-25ml					✓			✓		
	03:00 am											
	04:00 am											
	05:00 am									✓		
	06:00 am	DBF								✓		
	07:00 am	DBF										
Total Intake :					Total Output : U-2 m-1							
Total 24 hrs. Intake												
Total 24 hrs. Output		U-3 m-5										

FLUID CHART

Sheet No. : 3

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am	FF-15ml								✓	1	Suretha
	09:00 am										00	Suretha
	10:00 am	DBF									P	Suretha
	11:00 am									✓	F	Suretha
	12:00 pm	DBF					✓					Suretha
	01:00 pm	FF 9ml										Suretha
Total Intake :			Total Output :									
	02:00 pm						1			1	1	Suretha
	03:00 pm						1			1	1	Suretha
	04:00 pm	DBP					NP			NP	00	Suretha
	05:00 pm	DBF									10	Suretha
	06:00 pm						1			✓	1	Suretha
	07:00 pm											Suretha
Total Intake : Taken			Total Output : Passed U-1									
	08:00 pm											
	09:00 pm	DBF								✓	No	
	10:00 pm	DBF					✓				W	
	11:00 pm											
	12:00 am									✓		
	01:00 am	DBF										
Total Intake :			Total Output : U-2 M-1									
	02:00 am	DBF					✓					
	03:00 am											
	04:00 am										No	
	05:00 am	DBF									W	
	06:00 am	DBF								✓		
	07:00 am											
Total Intake :			Total Output : ml U-1									
Total 24 hrs. Intake			Total 24 hrs. Output U-6 M-3									

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.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	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						

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

Assessment: New Born Baby for observation

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
2pm	* Assess the general condition of the Baby	2:30pm	* Assessed the general condition of the Baby	* Baby is stable
3pm	* monitor vitals	3:30pm	* monitored vitals	
4pm	* DBF & Burping	4:30pm	* DBF Burping 2nd hourly Done	
5pm	* Vaccination	5:30pm	* Vaccination Done	
6pm	* Warm care	6:30pm	* Warm care provided	
7pm	* Safety	8:00pm	* Ensure safety provided	

Re-Assessment: Baby comfortable

Special Notes: vaccination T/M

Nurse Signature: [Signature]

Nurse Name: Smitha

Date & Time: 4/7/26 2pm

BAH-00660711 IP5-00175972

Baby Of ANANYA NIMMAGADDA

04-07-2026 0 Y 0 M 0 D 4 H (F)

Dr. DINESH KUMAR CHIRLA



NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26

Assessment: New Born Baby Case

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	→ TO Assess the Baby Condition	8:30pm	→ TO Assess the Baby Condition	Baby is stable
10pm	→ Monitor vitals	10:30pm	→ Vitals checked & Recorded	
12Am	→ DBF Every 2nd hourly followed By Burping	12:30Am	→ DBF 2nd hourly given & Burping	
2Am	→ Warm care	2:30Am	→ provided Warm care	
4Am	→ Maintain xlo chart	4:30Am	→ maintained xlo charting	
7Am	→ Ensure safety	7:30Am	→ provided cribe care	

Re-Assessment: Re-Assessment done

Special Notes: SBR, NBS, one 4.5 hours

Nurse Signature: [Signature]

Nurse Name: priya

Date & Time: 5/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 05/07/2026

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
8am	* Assess the baby General Condition	8:10 AM	* Assessed the baby General condition.	baby is stable
10am	* provide monitor vitals	10:5 AM	* provided monitor vitals	
1pm	* DBF Every 2nd hourly and Barfing	1:10 pm	* DBF Every 2nd hourly and Barfing	
5pm	* provide warm care	5:15 pm	* provided warm care	
7pm	* provide D10 chart	7:5pm	* provided D10 chart	
8pm	* baby safety and care	8:1	* baby safety and care	

Re-Assessment: Re-Assessment is done, baby vital is good.

Special Notes:

Nurse Signature: 

Nurse Name: Sunitha

Date & Time: 5/7/2026 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6-5-26

Assessment: New born 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	Monitor vitals and Recorded	8:10PM	Monitoring vitals and Recorded	Baby is well
9PM	Plan for warm care	10PM	Given warm care	
11PM	Plan for DBF & Burping	12AM	Done DBF & Burping	
1AM	Plan for Crib Care	2AM	Given Crib Care	
4AM	Plan for Diaper Changing	5AM	Done Diaper Changing	
6AM		7AM		

Re-Assessment: reassessed done

Special Notes: SBR NBS OAF after 48 hrs

Nurse Signature: [Signature]

Nurse Name: Preema

Date & Time: 6-5-26

BAH-00660711
Baby Of ANANYA NIMMAGADDA
04-07-2026
Dr. DINESH KUMAR CHIRLA

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 6/7/26

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
8 AM	Assess the baby General Condition	8:5 AM	Assess the baby General condition	baby is stable
11 AM	provide I/O chart	11:15 PM	provided I/O chart	
12 PM	provide DBF	12:10 PM	provided DBF	
1 PM	provide warm care	1:5 PM	provided warm care	
2 PM	provide baby safety	2:10 PM	provided baby safety	

Re-Assessment: RC - Assessment is done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Sunita

Date & Time: 6/7/26 @ 2 PM

BAH-00660711 IP5-00175972
 Baby Of ANANYA NIMMAGADDA
 04-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. DINESH KUMAR CHIRLA



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 6/7/26

Assessment: New born baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the baby.	10 am	Assessed the general condition of the baby.	Baby is stable.
3pm	Monitor care.	10 30 am	Provided warm care.	
4pm	VO chart.	11 am	Maintained VO chart.	
6pm	Prevent infection	11 30 am	Preventing infection by using hand gels.	
7pm	DBF & burping.	12 pm	DBF given Every 2-3rd	

Re-Assessment: Baby is comfortable

Special Notes: Nil Significant

Nurse Signature: [Signature] Nurse Name: Suresh Date & Time: 6/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/16/26

Assessment: New born 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	Monitor vitals and recorded	9pm	Monitor vitals and recorded	Baby is well
10pm	Plan for warm care	11pm	Given warm care	
12pm	Plan for crib care	1pm	Given crib care	
3pm	Plan for DBF - E Burp	4pm	Done DBF - Burping	
5pm	Plan for weight check	8pm	Done weight check	

Re-Assessment: Reassess care

Special Notes: STCP - EBM

Nurse Signature: [Signature] Nurse Name: Paeem

Date & Time: 7-6-26 28PM

Patient Sticker

NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

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:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Dinesh Kumar Department: BRP Date of Admission: 4/7/26

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:						
Diagnosis: <u>New born baby for observation</u>								
BACKGROUND	Area	<u>BRP 8pm to 8pm</u>	<u>BRP 8pm to 8pm</u>	<u>BRP 8pm to 8pm</u>	<u>BRP 8pm to 8pm</u>	<u>BRP 8pm to 8pm</u>	<u>BRP 8pm to 8pm</u>	
	Shift Time							
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
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:	<u>98.3F</u>	<u>98.3F</u>	<u>98.5F</u>	<u>98.5F</u>	<u>98.5F</u>	<u>98-2F</u>
		Res:	<u>11b/m</u>	<u>40b/m</u>	<u>42b/m</u>	<u>11b/m</u>	<u>11b/m</u>	<u>40b/m</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>100%</u>
		Pulse:	<u>142b/m</u>	<u>145b/m</u>	<u>139b/m</u>	<u>142b/m</u>	<u>142b/m</u>	<u>140b/m</u>
		BP:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Fall Risk Score:	<u>16</u>	<u>16</u>	<u>16</u>	<u>16</u>	<u>16</u>	<u>16</u>	
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>		
Safety Needs:	<u>side rails</u>	<u>side rails</u>	<u>side rails</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>		
Recommendations	Physiotherapy	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	☒ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Puelipa</u>	<u>Surecha</u>	<u>Sunitha</u>	<u>Pael</u>	<u>Sunitha</u>	<u>Surecha</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>4/7</u>	<u>5/7/26</u>	<u>5/7/26</u>	<u>6/7</u>	<u>6/7</u>	<u>6/7/26</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>8pm</u>	<u>2pm</u>	<u>8pm</u>	
Taken Over By Name :		<u>Surecha</u>	<u>Sunitha</u>	<u>Pael</u>	<u>Sunitha</u>	<u>Surecha</u>	<u>Pael</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>4/7/26</u>	<u>5/7/26</u>	<u>5/7</u>	<u>6/7</u>	<u>6/7/26</u>	<u>6/7</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. D. U. Department: BLP Date of Admission: 4-7-26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	<u>New born Care</u>							
BACKGROUND	Area	<u>BLP</u>						
	Shift Time	<u>2pm-8pm</u>						
ASSESSMENT	Medical Condition (Any special condition to be noted):		<u>NA</u>					
	Allergy:	☐ Yes ☒ No	☐ 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	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.6</u>					
		Res:	<u>24</u>					
		SpO ₂ :	<u>100%</u>					
		Pulse:	<u>124</u>					
		BP:						
	Fall Risk Score:	<u>-</u>						
	Pain Score:	<u>-</u>						
Recommendations	Safety Needs:	<u>NA</u>						
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>						
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>						
Post Operative Procedure Special Orders:		<u>NA</u>						
Handed Over By Name :		<u>Pras</u>						
Signature :		<u>[Signature]</u>						
Date:		<u>7-8-26</u>						
Time:		<u>8AM</u>						
Taken Over By Name :								
Signature :								
Date:								
Time:								