

[illegible]

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : 3AH-00660770 IP5-00175998
Baby Of RACHURI SOUMYA
15-07-2026 0 Y 0 M 0 D 13 H (M)
Dr. NITASHA BAGGA

Date of Admis _____ Date of Discharge : _____ Time: _____

Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/7/26	5 PM	NICU	3 rd Floor (306)	<i>[Signature]</i>

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible][illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

ADMISSION SHEET



Registration Details :

Admission No : IP5-00175998 Admit Date : 06-Jul-2026 Admit Time : 12:14 AM UHID : BAH-00660770

Patient Details :

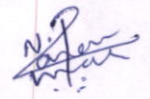
Patient Name	: Baby Of RACHURI SOUMYA	Age	: 0 D
Guardian	: Mr NADIMINTI PAVAN KUMAR	DOB	: 05-07-2026 11:02 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: #FLAT 301 LEGEND VASUDEVA , GAGAN MAHAL STREET NO 7 Domalguda Hyderabad Telangana INDIA 500029	Phone No	: 9000830220/ 8297441169
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type	: NICU	Bed No	: NICU 256	Ward Name	: 2F-NICU 2
Room No	: NICU 256	Admission Type	: First Visit		

Contact Details :

Name	: Mr NADIMINTI PAVAN KUMAR	Relationship	: Father
Contact Address	: #FLAT 301 LEGEND VASUDEVA , GAGAN MAHAL STREET NO 7 Domalguda Hyderabad Telangana INDIA 500029	Phone No	: 9000830220 / 8297441169


Signature

Doctor Details :

Doctor Name	: Dr. NITASHA BAGGA	Specialisation	: NEONATAL INTENSIVE CARE
Referral Doctor	: SELF	Phone No	:
Co-Consultant	:		

Payment Details :

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

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 Soumya Mother's Blood Group : B NEGATIVE
 Gender : ☒ M ☐ F Blood Group : B NEGATIVE Birth Weight (gms) : 2935gm Length (cms) :
 Date of Birth : 5/7/26 Time of Birth : 11:02pm OFC (cms) :
 Place of Birth : RCH, B.H Estimated Gesth Age : 39+6

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 33y 9 months Ht : 159 Wt : 74.9 BMI : Married Life : 4 years LMP : 6/10/25 EDD : 15/7/26

Conception : Spontaneous or with Rx : Spontaneous

Booked at what GA : 14+2 AN Steroids Drugs / Doses :

Last Scans Details : 16/6/26 - 36+1 week, FFW 2670gm, AFI 17.6cm, TFF

oxygen (N)

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

IUGR - when detected :

Doppler (Increased Resistance / ADEF / REDF /

Redistribution in MCA) / Ductus Venosus :

AFI : 17.6cm

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

Controlled or not, recent values, HbA1 values :

Compliance with Rx :

Scans : LGA, TIFFA, Fetal Echo : TFFA (N)

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

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

..... P: A: L:

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

PERINATAL HISTORY

Treating Obstetrician : Dr. Pratyushreddy Hospital : RCH, BH ☒ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication :

Specify the reason : SVD

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitaion : ☐ Yes ☐ No

Cord ABG : 7.250 / 49.1 / 5.6 / -4.8 / 10.2

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
1	2	2
1	1	2
2	2	2
7/10	8/10	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:

Equipment checked

↓

Preheated warmer

↓

delivered male baby through sup

cried after tactile stimulation

↓

secretions cleared

↓

delayed cord clamping done

↓

1mg vitamin K 1mg 1m given

↓

Baby developed Respiratory distress
in form of Grunting, SCR(+), tachypnea
PRCPAP started
given for 10 minutes

↓

RO persisted

↓ cord gas sent

NR: non reactive
4 loops of cord
around neck

Investigation details in previous Hospital :

↓ counselled father and
shifted to NICU
baby

Feeding History :



Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5°C HR : 156/min RR : 48/min NIBP : CFT : < 35 sec

Color of the extremities : Acrocyanotic → pink

Jaundice : Pallor : SpO2 :

ANTHROPOMETRY: Birth Weight : Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :	Fontanelles : Af 2cm x 2cm Sutures : Shape / Moulding : mouldy Edema / Bruising : Caput Size - (H.C.) :	
FACIES : (Any Facial Dysmorphism)	no dysmorphism	
NECK and CLAVICLES :	Range of Motion : Asymmetry : 1 (N) Masses :	
EYES :	Symmetry : Red Reflex : 1 To be checked Discharge :	
EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Periauricular Pits / Tags : Nasal shape / Patency : 1 (N) Palate : Gums : Lips : Tongue :	
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number : 1 (N)	
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : 1 (N) Umbilical Stump : Discharge :	
GENITALIA :	Labia / Hymen : Testicles/penis : 1 (N) External male genitalia Anus :	
HERNIAL ORIFICES	free	
TRUNK and SPINE :	N	
SKIN LESIONS :	NO	
EXTREMITIES :	Fingers / Toes : Deformities : 1 (N) Hip Joint Examination :	Arms / Legs : Mobility :



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 48/min SCR / ICR / See - Saw breathing :

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

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

Settings :

SpO₂ : 96.1, 98.1 Auscultation: Ba & C clear Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 156 bpm BP : Precordial Activity : no

Femoral Pulses : well felt Murmurs : no

Other Peripheral Pulses : paleable Signs of Cardiac Failure : no

ABDOMEN:

Shape : (N) Hernia orifice : Free

Palpation : soft Anal Patency : patent

Palpable masses : no Umbilical Cord : L artery, 1 vein

Abdominal girth : First urine passed : not passed

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score : 2

Nerves : (N)

MOTOR SYSTEM:

Passive Tone :

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR :

ATNR : Skull and Spine :

Diagnosis : Term 39^W / AGA / SVD / delayed transition / CIAS /
perom 18 hours

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *[Signature]*

Name : *Saitya*

Date & Time : *6/7/26*

Consultant :

Signature : *[Signature]* NITASHA BAGGA

Name : *Dr. Nitasha Bagga*

Date & Time : *6/7/26*

PLEASE FILL UP THE FOLLOWING DETAILS

- Name of the referring Doctor :
- Name of the referring Hospital :
Address :
Contact Numbers :
- Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
- 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 : 1. 1000 (maternal) 1000 (fetal) 1000 (placental) 1000 (umbilical)

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic :

Medications : Plan

- 1. shift to NRU
- 2. start low flow
of Re persity → CPAP sor

Plan during ward follow up : 3. Tr = 60 cc/kg/day
↓
Half-feed
Half fluid

4. Repeat CRG

Feeding Plan at the time of shifting : 5. collect Blood culture
and start 2g. piphz

Screenings done during NICU Stay : 6. send cord blood for

NSG : Blood grouping

Hearing Screen : Det, Retie, SRR, Hb, peripheral smear

ROP :

TFT :

NP2 : def
ser

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:

AH-00660770 IP5-00175998
 Baby of RACHURI SOUMYA
 5-07-2026 0 Y 0 M 0 D 13 H (M)
 r. NITASHA BAGGA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 12:30am	seen by Dr. Soumya	
		plan
	Baby on low flow	
	Nasal flanny settled	1. TV=60cc/1hr/day
	Retractions settled	15ml O_2 H ⁰⁹ feeding
	SpO ₂ = 96%	
	PR: 151b/min	2. low flow 0.5l/min
	RR: 48b/min	
	ERT < 4sec	3. CRP, CRP @ 12 Hrs
	G, S (+)	
	BAT (+), clear	4. w/f R/O dehydration
	P/A: soft	
	Repeat Gas: 7.332/42.4/6.3/3.2 21.2	
	Noted by Jeyanani 6/7/26 @ 12AM	

Shy
Kai

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: 9HOL PMA:

Term ☐ Preterm ☐ Gestation: 39+6 Corrected Gestational Age: Today's Weight:

		Problems	
		Current	Past Problems
Overview	S.No.		
	1.	Term / Apgar	
	2.	Delayed transition / RD → low flow	
	3.	Rh-negative pregnancy	
	4.	Non-reactive NST & loops of	
	5.	Cord around neck	
Clinical Assessment	6.	Leaking PV - 18 hrs	
	Baby was on low flow O ₂ for 1 hr ⇒ RA. Currently on RA, no RD. HR - 120/min. RR - 51/min. SpO ₂ - 100%.		
Medications Used	Drug. DCT neg.		
Plan of Care: TV - 60cc/kg/day ⇒ 15ml/2nd hely full paladay feed. Trace DCT, R _c , Baby blood group. R/v to send NP _i @ 24HOL @1 CBP @ 12HOL CURBS - OD			

Doctor's Name (Hand over given): Dr. Poojithe

Signature: [Signature]

Date & Time: 6/7/26

Doctor's Name (Hand over taken): Dr. Adhwaney

Signature: [Signature]

Date & Time: 6/7/26





PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
07/12/26	<u>Lactation notes</u>	
	Lactation Counseling done. position shows perfectly Colostrum as seen baby is latching well. feed and hold with deep latch note than 15-20ml each side. (Adv) DBF	
	<u>labour</u>	
7/17/26 @ 2:00pm	<u>Afternoon Rounds</u>	
	39 HOL 39+6 2935 Baby on Room air. No Resp. distress No Tachypnea Auscultation - Air entry equal clear. Euthermic Vitals - HR = 145/min SpO ₂ - 96% P/A - Soft Accepting feeds well. Urine, Stool - passed	Rh neg preg PROM - 18 hours Primie <u>Plan</u> 1) DBF 2nd try to capture + Top up feed with formula if need. 2) Vaccination - Now BCG, OPV, Hep B - done on 7/17/26 3) NBS } today at 9pm SBR } 4) OAC Tomorrow 5) w/f - RD, feeding

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7 @ 8:15 am		S/B D & NBS
		1) Plan discharge today
		2) Flup on Friday
		3) Trace NBS
		4) Regular feeding
		5) OAC - Today
		6) Nasogastric drops
		308

Dr. NITASHA BAGGA
 Reg. No. 65260

AH-00660770 IP5-00175998
 aby Of RACHURI SOUMYA
 5-07-2026 0 Y 0 M 0 D 13 H (M)
 r. NITASHA BAGGA



RESULT SHEET

Date	6/7/26	6/7/26	7/7/26			
Time	12:30pm	12pm	10pm			
Hb	12.8	14.2				
PCV		41.6				
RBC		3.97				
WBC		18.62				
N/L		68/22				
Platelets		208				
CRP		12				
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj	1.8 10.1 1.7		6.2 10.1 6.1			
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	RL 1.2					

[illegible]



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Docu. No. : RCHBH /FRM / CLINICAL / 185

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)

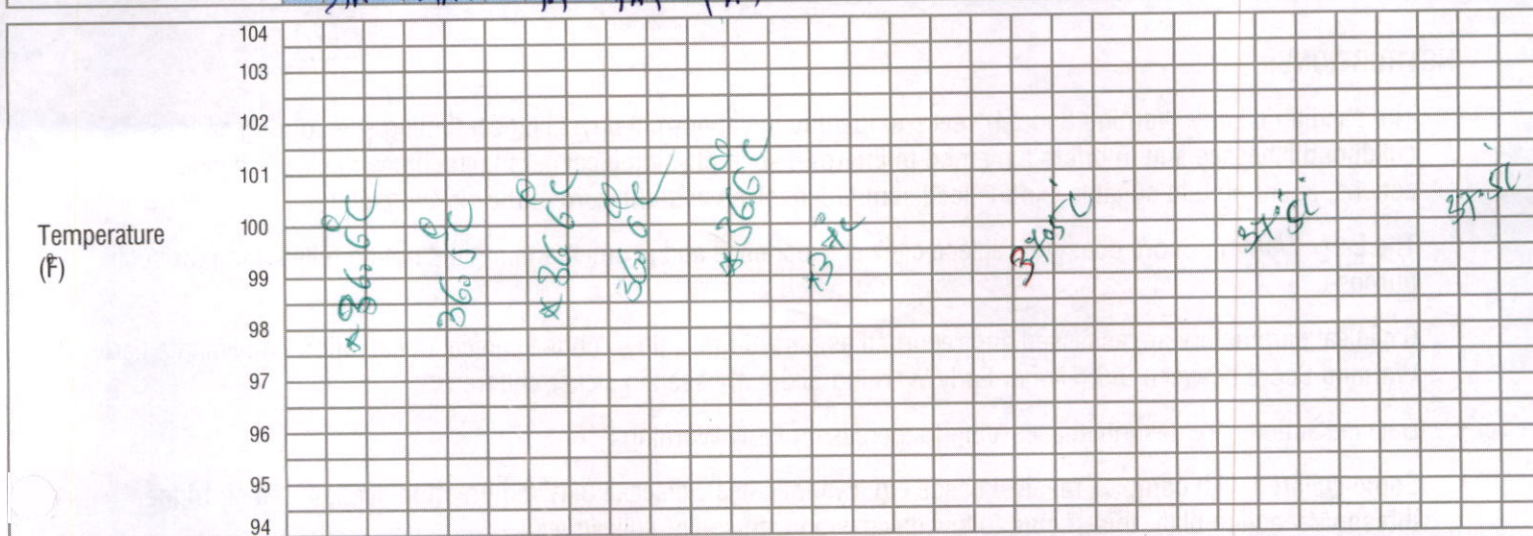


TEENAGE (12 + years)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date : Time: 8 10 12 2 4 6pm 10pm 2am 6am
Doctor / Nurse / Family Concern? Am Am In Pm Pm 6pm 10pm 2am 6am



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)	136b/m	140b/m	138b/m	140b/m	140b/m	138b/m	136b/m	136b/m	136b/m	136b/m	136b/m	136b/m	136b/m	136b/m	136b/m

Resp. Rate (bpm) (Over 1 Minute)	70	60	50	40	30	20	10								
Resp Rate (Number)	31														

Resp Distress	Mod/ Severe	None / Mild													
Receiving O ₂ (l/min)															
O ₂ Saturations (%)	100	99	99	99	99	99	99	99	99	99	99	99	99	99	99
Conscious Level	Normal	Altered													
GCS *	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15

TOTAL SCORE															
Number of shaded boxes	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Pain Score	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials															

ACTIONS	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 in charge AND PICU fellow or PICU 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.

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BAH-00660770 IP5-00175998
Baby Of RACHURI SOUMYA
05-07-2026 0 Y 0 M 1 D (M)

Dr. NITASHA BAGGA



CLINICAL / 124

7/7/26

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: Time: 7/7/26

Doctor/Nurse/Family Concern?

Temperature
(°F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

Conscious Level
Normal Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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- 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)

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
80
70
60
50

and

Blood Pressure
(mmHg) *

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 Mod/ Severe
Distress None / Mild

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

Conscious Level
Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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

Score 5 & 6 : Shift in charge 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

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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)



5/7/26

FLUID CHART

Tr. 60 ccl/kg/day

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.

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	NG							
	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	DBM		15ml			-				9	
	01:00 am											Peri
Total Intake :						Total Output :						
	02:00 am	DBM		15ml								
	03:00 am					passed						
	04:00 am	DBM		15cm								Peri
	05:00 am											
	06:00 am	DBM		15ml								
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake												
Total 24 hrs. Output												

FLUID CHART

Sheet No. : 12

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am	DBM 15ml					passed			10ml		
	10:00 am											
	11:00 am	DBM 15ml					-			12ml		
	12:00 pm											
	01:00 pm	DBM 15ml					-			8ml		
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm	DBM 15ml					-			9ml		
	04:00 pm											
	05:00 pm	DBF 15ml										
	06:00 pm											
	07:00 pm	DBF 15ml										
Total Intake :						Total Output : m-r 0-2						
	08:00 pm											
	09:00 pm	DBF 15ml										
	10:00 pm											
	11:00 pm	DBF 15ml										
	12:00 am											
	01:00 am	DBFFF 15ml										
Total Intake :						Total Output : u-1 m-1						
	02:00 am											
	03:00 am	DBFFF 15ml										
	04:00 am											
	05:00 am	DBFFF 15ml										
	06:00 am											
	07:00 am	DBFFF 15ml										
Total Intake :						Total Output : u-2 m-0						
Total 24 hrs. Intake			Total 24 hrs. Output									

Patient Stic



FLUID CHART

Sheet No. :

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

Date	Time	Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											Supra
	09:00 am	DBM	DBM	15ml		✓			✓			Supra
	10:00 am											Supra
	11:00 am	DBM	DBM	15ml					✓			Supra
	12:00 pm											Supra
	01:00 pm	DBM	DBM	15ml								Supra
Total Intake :					Total Output :							
	02:00 pm											Supra
	03:00 pm	DBM	DBM	15ml					✓			Supra
	04:00 pm					✓						Supra
	05:00 pm	DBM	DBM	15ml					✓			Supra
	06:00 pm					✓						Supra
	07:00 pm	DBM	DBM	15ml								Supra
Total Intake :					Total Output :							
	08:00 pm											Alekya
	09:00 pm	DBM	DBM	15ml					✓			Alekya
	10:00 pm											Alekya
	11:00 pm					✓						Alekya
	12:00 am	DBM	DBM						✓			Alekya
	01:00 am											Alekya
Total Intake :					Total Output :							
	02:00 am											Alekya
	03:00 am	ff	ff	15ml								Alekya
	04:00 am											Alekya
	05:00 am	DBM	DBM									Alekya
	06:00 am					✓						Alekya
	07:00 am	ff	ff	15ml								Alekya
Total Intake :					Total Output :							
Total 24 hrs. Intake		total = 135			Total 24 hrs. Output		U-8 M-5					

BAH-00660770 IP5-00175998
 Baby Of RACHURI SOUMYA
 05-07-2026 0 Y 0 M 2 D (M)
 Dr. NITASHA BAGGA



FLUID CHART

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

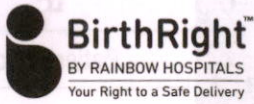
Sheet No. : 14

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: 5/7/26 @ 8pm

Assessment: Baby is on Lf

- 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
12am	To Assess the baby general condition.	12am	Assessed baby general condition. si stoped O2 24hr	Baby is stable on Rf.
2am	to monitor vitals & maintain Ilo chart	2am	monitored vitals & maintain Ilo chart	
4am	To Give 2nd Hourly feed	4am	Given 2nd Hourly feed	
6am	to provide comfortable position.	6am	provided comfortable position	
7am	to w/f brady desats	7am	no brady desaturators	
8am	ensure safety.	8am	Ensured safety.	

Re-Assessment: Done

Special Notes: CBP, CRP 12 Hrs

Nurse Signature: [Signature] Nurse Name: Jeevanani

Date & Time: 6/7/26 @ 8am

AH-00660770 IP5-00175998
Baby Of RACHURI SOUNYA
5-07-2026 0 Y 0 M 0 D 23 H (M)
r. NITASHA BAGGA



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: Baby is R/A

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 am	Assess the baby general condition.	8 am	Assessed the baby general condition.	Baby is Stable Now
10 am	monitor the vitals signs	10 am	monitor the vitals signs.	
12 pm	Provide comfortable position	12 pm	provided comfortable position.	
2 pm	give the feed 2 nd haly	2 pm	given the feed 2 nd haly.	
4 pm	Ensure Safety	4 pm	Ensured Safety	

Re-Assessment: Done.

Special Notes:

Nurse Signature: Malleswari

Nurse Name: Malleswari

Date & Time: 6/07/26 @ 8pm.



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/26

Assessment: New Born Baby

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the baby general condition.	8:20pm	Assessed the baby general condition	Baby is stable
10pm	monitor vitals	10:20pm	monitored vitals.	
12pm	DBF & smiting and baby	12:20pm	DBF & Burping liver	
3pm	maintain the clot	3:20pm	maintained clot	
6pm	warm care	6:50 pm	warm care liver	

Re-Assessment:

Special Notes: Baby is stable

Nurse Signature: [Signature] Nurse Name: Sangeetha C Gouda Date & Time: 6/26 @ 8:45



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 07/7/26

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
8am	* Assess the baby condition of the chest	8:30 AM	* Assessed the baby condition and vitals checked	* New baby condition is stable
10am	* monitor the Ilo chart	10:30 AM	* monitored the Ilo chart	
12pm	* provide warm care	12:30 PM	* provided warm care	
3pm	* DBF + TF every 2nd hourly	3:30 PM	* DBF + TF every 2nd hourly gives	
6pm	* vaccination done	6:30 PM	* vaccination given	
7pm	* ensure safety	7:30 PM	* ensured safety	

Re-Assessment: Assess the condition of the baby, now it is stable

Special Notes: SBR, MBS, today @ 9pm, OAE tomorrow

Nurse Signature: Sneh

Nurse Name: Sneh - 607635

Date & Time: 07/7/26 @ 8pm

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 7/7/26

Assessment: Baby having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Baby is having	8:30 pm	→ Assessed the baby	Baby is stable now
10:30 pm	→ Assess the baby general condition	12 AM	→ Assessed the baby	
2 AM	→ Assess the baby vitals	2:30 AM	→ Assessed the baby in	
4:30 am	→ Assess the baby in a comfortable position	6 AM	→ Assessed the baby	
6:30 am	→ Assess the Baby hygiene	7:30 am	→ Assessed the Baby hygiene	

Re-Assessment: Baby is stable now

Special Notes: NA one time

Nurse Signature: 

Nurse Name: Alekya @ 6068 20

Date & Time: 8/7/26 @ 8am

Patient Sticker

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:

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:



①

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nitasha Department: 3rd floor Date of Admission: 8/7/26

SITUATION	Diagnosis: <u>NIS</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area	Shift Time	<u>8:30 AM - 12:30 PM</u>	<u>12:30 PM - 3:30 PM</u>	<u>3:30 PM - 8:30 PM</u>	
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:		☒ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Not Known
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Not Known
	Vital Signs:	Temp:	<u>97.5F</u>	<u>97.8F</u>	<u>98.0F</u>	
		Res:	<u>18</u>	<u>18</u>	<u>18</u>	
		SpO ₂ :	<u>98%</u>	<u>96%</u>	<u>99%</u>	
		Pulse:	<u>132</u>	<u>136</u>	<u>132</u>	
		BP:	<u>110/70</u>	<u>110/70</u>	<u>110/70</u>	
	Fall Risk Score:	<u>0</u>	<u>0</u>	<u>0</u>		
Pain Score:	<u>Nil</u>	<u>Nil</u>	<u>Nil</u>			
Recommendations	Safety Needs:	<u>side rail</u>	<u>side rail</u>	<u>side rail</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Not Known	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No ☐ Not Known	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Sangeetha</u>	<u>Subh</u>	<u>Alekya</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>8/7/26</u>	<u>8/7/26</u>	<u>8/7/26</u>		
Time:		<u>8:30 AM</u>	<u>3:30 PM</u>	<u>8:30 PM</u>		
Taken Over By Name :		<u>Subh</u>	<u>Alekya</u>	<u>Timor</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>8/7/26</u>	<u>8/7/26</u>	<u>8/7/26</u>		
Time:		<u>8:30 AM</u>	<u>3:30 PM</u>	<u>8:30 AM</u>		

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
	Tubes/Drains/Catheter:		☐ 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:							



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	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	1	1			
Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3			
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1			
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2	2	2			
	Oriented to own Ability	1	1	1			
	History of Falls or Infant - Toddler Placed in Bed	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			
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	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			
TOTAL			15	15			

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		4	4			
Call device within reach		1	1			
Wheels Locked		1	1			
Room free of clutter		1	1			
Adequate Lighting		1	1			
Wheel Chair Support		1	1			
Other Intervention(s) Specify		1	1			
Nurse's Name :		malvi	Sage			
Signature :		AP	SH			
Date :		5/7	2/7			
Time :		2PM	8AM			

AH-00660770 IP5-00175998
 aby Of RACHURI SOUMYA
 5-07-2026 0 Y 0 M 0 D 23 H (M)
 r. NITASHA BAQGA



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 :	6/7/26	7/7	8/7	
					Time :	2 PM	5:45	8 AM	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:tremitry position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	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		
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.	3	3	3		
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2	2	2		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	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.	2	2	2		
TOTAL SCORE					18	18	18		
Evaluator's Name					Nf Bay				

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

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

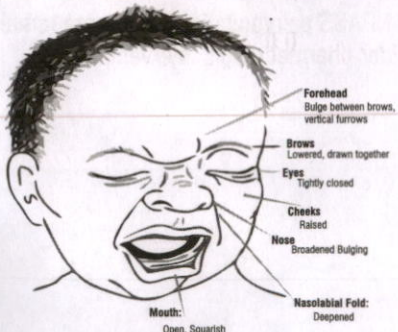
Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution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

AH-00660770
 sdy Of RACHURI SOUMYA
 5-07-2026 0 Y 0 M 0 D 23 H (M)
 r. NITASHA BAGGA

IP5-00175998



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
						6/7/26	8/7	8/7					
						8:10	8:10	8:10					
						6	0	0					
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	-	-	-					
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)	-	-	-					
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	-	-	-					
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	0/10	0/10	0/10				
						Intervention	NA	NA	NA				
						Effectiveness	NA	NA	NA				
						Signature	Sushu	Sushu	Alek				

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.

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
5/2/26	11:02 AM	DBF	Feeding	M	5	0	4	1	-	June

Part - III: CODES

Who was taught:	PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)
Learning Barriers:								
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations		10. Financial Difficulties		13. Cultural/Religion Practice		
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home		11. Beliefs and Values		14. Others (Specify)		
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences		12. Impaired Vision/ or Hearing				
Teaching Tools Used:								
A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed				
Mechanism/s to overcome barrier/s:								
1. None	3. Reassurance & Support	5. Respect values & beliefs		7. Other, Specify				
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference						
Understanding:								
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review						

NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Bb Rachuri Soumya Mother's Name: _____
 Date of Birth: 5/7/26 Time of Birth: 4:02pm Gender: ☒ Male ☐ Female
 Birth Weight: 2.935 Kgs HC: _____ cm Length: _____ cm
 Meconium in Liquor: ☒ Yes ☐ No Cried at Birth: ☐ Yes ☐ No
 Term / Pre-term / Post-term: _____
 Resuscitated: ☒ Yes ☐ No Blood Group: Mother: B-ve Baby: B-ve
 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 F °C HR: 144 /Min RR: 26 /Min BP: 10/6 SpO₂: 99.1
 Pain Score: 0/10 (Follow N Pass)

Fall Risk Assessment: ☐ Yes ☒ No Score: 0/10 (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

- Nutritional Screening: Feeding Problem Yes / No
 - Functional Screening: Musculoskeletal Congenital Abnormality Yes / No
 - Socio History: Siblings Yes / No
- All information obtained from ☐ Mother ☒ Father ☐ Other Family Member

Newborn Screening Discussed: Yes / No

Nurse Name: Sueha Signature: Sueha

Date & Time: 6/7/26 @ 8pm



DISCHARGE PLANNING FORM

Nationality : Indian

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

1. Anticipated Date of Discharge : As per doctor advice

2. Destination Post Discharge : ☐ Home
Family Members Notified (Person Contacted)

☐ Transfer
Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In :

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

Remarks

need for assistance

4. Nutritional Plan :
☐ Dietary Instruction Discussed with the :
☐ Patient ☒ Family Member

☐ Others :

5. Discharge Planning Discussed with the :
☐ Patient ☒ Family Member

☐ Others :

6. Patient / Family Educational Plan :
☐ Educational Topics/s : personal hygiene

Patient's Educational Topic/s discussed with the :
☐ Patient ☒ Family Member

☐ Others :

Nurse Signature : Sushma

Nurse Name : Sushma

Date and Time : 6/7/26 @ 8pm

Docu. No. : RCHBH / FRM / CLINICAL / 191

PATIENT TRANSFER FORM

AH-00660770 IP5-00175998
Baby Of RACHURI SOUMYA
P-07-2026 0 Y 0 M 0 D 23 H (M)
r. NITASHA BAGGA



Date & Time of Admission 5/6/26		Date & Time of Transfer Order 6/7/26 @ 4:55 PM
Treating Consultant Name DR. N.B.	Transfer Ordered by DR. Nitasha mam	Reason for Transfer stable
From Unit NICU	To Unit 3rd floor (306)	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films		

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Diapers	①
2.	wipes	①
3.	feeding bottles	②
4.		

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

Name & Signature of Person who is Transferring Nalini	Name of Person Ordered Transfer
Patient & Clinical Records Received by : Suh	
Date & Time of Patient Received : 6/7/26 @ 5:00 PM	

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

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

CONSENT FOR FORMULA FEEDS

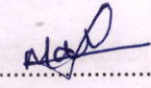
Patient Name : **BAH-00660755 IP5-00175976**
Baby Of CHARLAPALLY AKHILA Age : 2 day Gender : ☒ Male ☐ Female
04-07-2026 0 Y 0 M 2 D (M)
Dr. VENKATA LAKSHMI A
UHID No :  Department : NICU Date : 6/7/26

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
6/7/26 I hereby give consent for formula feed for my child. Doctors have explained me
about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : 
Name : NADIMINTI PAVAN KUMAR
Relationship with Patient : FATHER
Date & Time : 6/7/26 2PM

Witness :

Signature : 
Name : NADIMINTI PAVAN KUMAR
Date & Time : 6/7/26 @ 2PM

Doctor (who is taking the consent) :

Signature : 
Name : Dr. Venkata Lakshmi A
Date & Time : 6/7/26 2PM

డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

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

తేదీ

నేను శ్రీ / శ్రీమతి వయస్సు సంవత్సరాలు

నా కుమార్తె / కుమారుడు రెయిన్ఫో ఆసుపత్రిలో నవజాత శిశువుల ఇంటెన్సివ్ కేర్ లో అడ్మిట్ చేసినాము మరియు (ఫార్ములా

ఫీడ్) డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుచున్నాను. డాక్టర్లు డబ్బా పాలు త్రాగించడం వల్ల కలుగు

ఉపయోగాలు, ప్రత్యామ్నాయాలు, మరియు నష్టాలు గురించి నాకు అర్థమైన భాషలో వివరించారు.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

**CONSENT FOR ADMISSION
IN NEONATAL INTENSIVE CARE UNIT**

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: B/o R. Soumya Age: NR Gender: Male ☒ Female ☐
UHID.No : 660770 Date: 6/7/26

I Pavan kumar S/o, D/o, W/o hereby
declare that our patient Mr. / Ms. B/o Soumya who is related to me as son is
getting admitted in the Neonatal Intensive Care Unit of Rainbow Children's Hospital on 6/7/26

The doctors have explained to me in a language understood by me that my child has following health related issues :

The doctors have clearly explained to me that my patient B/o Soumya during his / her stay
in the Neonatal Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical
ventilation, Umbilical Artery Catheter, Umbilical Vein and Arterial Lines, Peripherally Inserted Central Catheter Line and arterial line
placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure
shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is
implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Neonatal Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Neonatal Intensive Care Unit with multiple medical and surgical procedures
performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of
infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child B/o Soumya
in the Neonatal Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various
procedures, high risk medications and infections in the Neonatal Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature : Nadiminti Pavan Kumar
Name : NADIMINTI PAVAN KUMAR
Relationship with Patient: FATHER
Date & Time : 6/7/26 @ 12:15 PM

Witness :

Signature : Mallikarjuna
Name : Mallikarjuna
Date & Time : 6/7/26 @ 12:15 PM

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Dr. Poojitha
Date & Time : 6/7/26 @ 12:15 PM

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యు) సమ్మతి పత్రం



రోగి పేరు వయస్సు లింగం పు ☐ స్త్రీ ☐

యు.హెచ్.ఐ.డి
నేను బి

అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రేయిన్స్ బిల్డిన్ ఆసుపత్రి లోని నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్లో తేదీ
నాడు పూర్తి సమ్మతితో చేర్చితిని. మా బాలుడి / బాలికలో. ఈ క్రింద తెలిపిన ఆరోగ్య సమస్యల గురించి వైద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ లో మా పాప /బాబుకు వైద్య పరంగా అవసరమగు అన్ని రకాల చికిత్స విధానాలకు మరియు ప్రక్రియలను (ఉదా కృత్రిమ శ్వాస వెంటిలేటర్, ధమని మార్గం, సింట్రిల్ లైన్ చెస్ట్ డ్రైయిన్, పెరిటోనియల్ డ్రైయిన్ ఇంనర్వేన్ వంటి ప్రక్రియలను డాక్టరు గారు నాకు అర్థమగు భాషలో వివరించారు.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు.
ఏదేమైనప్పటికీ, పైన తెలుపబడిన శస్త్ర ప్రక్రియలు చేసేముందు సమ్మతి తీసుకునే వీలు లేని చో ఏదైనా ప్రాణాంతక అత్యవసర పరిస్థితులు ఏర్పడినప్పుడు మా బాలుడు / బాలికను కాపాడుటకు అవసరమైన వైద్య శస్త్ర ప్రక్రియలు మా సమ్మతి లేకుండానే చేయవచ్చని నేను సమ్మతిస్తున్నాను.

ఆరోగ్య సమస్యలతో బాధపడుతున్న మా బాలుడికి / బాలికకు రుగ్మతలచే ప్రాణహాని కలుగవచ్చిన నాకు వైద్యుడు అర్థమగు భాషలో వివరించితిరి

మా బాలుడు / బాలిక నవజాత శిశువు ఇంటెన్సివ్ కేర్ యూనిట్ లో ఉన్నప్పుడు ఎన్నో విధాల వైద్య మరియు శస్త్ర ప్రక్రియలు ఇంకా వివిధ చికిత్స విధానాలు అవసరం పడతాయని మరియు వాటివల్ల దుష్పరిణామాలు కలగవచ్చని అర్థం చేసుకున్నాను. ఆ పరిణామాలు ఎటువంటివి అనగా నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన సమస్యలు, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు.

మా బాలుడిని/బాలికను అడ్మిట్ చేయుటకు మరియు ఎన్. ఐ. సి.యు. లో ఉన్నప్పుడు జరుగు చికిత్స విధానాలు మరియు శస్త్ర ప్రక్రియలు వలన కలిగే అపాయాలను నేను అంగీకరిస్తున్నాను. మా పేషంట్ ను తగిన విధంగా చికిత్స చేయడానికి వైద్యునికి నాపూర్తి అంగీకారం తెలియజేస్తున్నాను. వైద్యుడు నాకు అర్థమగు భాషలో అంతా వివరించారు.

మా బాలుడు / బాలిక ను ఇన్ఫెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండెంట్)	సాక్షి
సంతకము	సంతకము
పేరు	పేరు
వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)	తేదీ మరియు సమయము
సంతకము	
పేరు	