

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175824

Admit Date : 01-Jul-2026

Admit Time : 12:57 PM **UHID** : BAH-00660402

Patient Details :

Patient Name	: Baby Of ISPITA CHAMPATIRAY	Age	: 0 D
Guardian	: Mr PRITISH PATNAIK	DOB	: 01-07-2026 11:40 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H NO 301, VIDHATHA BILDUIING Thummaloor MAHESHWARAM Telangana INDIA 501359	Phone No	: 9573075202/ 9113995745
		E-mail	: na@gmail.com

Admission Details :
Bed Type : BASINET

Bed No : CRDL-MICU-427-1

Ward Name : 4F-BIRTHING CENTRE

Room No : CRDL-MICU-427-1

Admission Type : First Visit

Contact Details :

Name	: Mr PRITISH PATNAIK	Relationship	: Father
Contact Address	: H NO 301, VIDHATHA BILDUIING Thummaloor MAHESHWARAM Telangana INDIA 501359	Phone No	: 9573075202 / 9113995745

A. Isptia Champatiray
Signature

Doctor Details :

Doctor Name	: Dr. KAPIL BHAGWATRAO SACHANE	Specialisation	: NEONATOLOGY
Referral Doctor	: Self	Phone No	:
Co-Consultant	:		

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

(P.T.O)

[illegible]

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Ismithe chandhary Age : 34 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 : Ismithe chandhary Mother's Blood Group : AB +ve Positive
Gender : ☒ M ☐ F Blood Group : A+ Birth Weight (gms) : 2671 Length (cms) : 47
Date of Birth : 17/7/26 Time of Birth : 11:40am OFC (cms) : 34
Place of Birth : RCHBH Estimated Gesth Age : 36+5 wks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 34 Ht : Wt : BMI : Married Life : LMP : 14/10/25 EDD : 24/7/2026

Conception : Spontaneous or with Rx :

Booked at what GA : 19 wks

AN Steroids Drugs / Doses :

Last Scans Details : 20/6/26 : 36 wks / cephalic / CLIVF / 2481 / AC 18.4 / AFI 15 cms

(1) Dopplers / EF : 68%

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 : Fetal Echo : (1)

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

Controlled or not, recent values, HbA1 values :

Compliance with Rx :

Scans : LGA, TIFFA, Fetal Echo : (1)

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 ORSTETRIC HISTORY

P: A: L:

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

PERINATAL HISTORY

Treating Obstetrician : Dr. Annie Pooni Hospital : DCH: BH ☒ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☒ Elective ☐ Emergency Indication :

Specify the reason : Fibroids / Chr. Htn

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitaion : ☐ Yes ☐ No

Cord ABG :

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

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

1 Minute	5 Minutes	10 Minutes
1	1	
2	2	
2	2	
2	2	
1	2	
8	9	

TOTAL

Snapee II Score

Score

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)			
Brith Weight	> = 1kg (0)	750 - 999 (10)	< 750 (17)		
SGA	> 3rd percentile (0)	< 3rd (12)			
Total					

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



His

Equipment check done



Baby received in a prewarmed oven



Baby CIAB.



Dosed - warmed - Suction done



Injection vitamin K given IM.



Shifted to mother side.

Investigation details in previous Hospital :

Feeding History :

BAH-00660402 IP5-00175824
Baby Of ISPITA CHAMPATIRAY
01-07-2026 0 Y 0 M 0 D 2 H (M)
Dr. KAPIL BHAGWATRAO SACHANE

Past



Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Enteemic Acyanotic
clfa - good.
hemodynamic all stable

VITALS : Temperature : Enteemic HR : 144/min RR : 52/r NIBP : CFT : 13

Color of the extremities : Acyanotic

Jaundice : Pallor : SpO2 : 98% - 100%

ANTHROPOMETRY: Birth Weight : 2629 Length : HC : Present Weight :

Ponderal Index : AGA : ✓ SGA : LGA :

HEAD TO TOE EXAMINATION

HEAD :
Fontanelles :
Sutures :
Shape / Moulding :
Edema / Bruising :
Size - (H.C.) :

no caput

font open

FACIES :
(Any Facial
Dysmorphism)

no

**NECK and
CLAVICLES :**

Range of Motion :
Asymmetry :
Masses :

no

EYES :

Symmetry :
Red Reflex : to be checked
Discharge :

**EARS, NOSE
MOUTH and
THROAT :**

Ear set / Shape :
Periauricular Pits / Tags :
Nasal shape / Patency :
Palate :
Gums :
Lips :
Tongue :

no cleft lip / palate

**THORAX and
BREASTS :**

Shape of Thorax :
Position of Nipples and Number :

no

**ABDOMEN and
UMBILICUS :**

Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump : 2A + IV
Discharge :

GENITALIA :

Labia / Hymen :
Testicles/penis :
Anus :

no

HERNIAL ORIFICES

no

TRUNK and SPINE :

no

SKIN LESIONS :

no

EXTREMITIES :

Fingers / Toes :
Deformities :
Hip Joint Examination :

no

Arms / Legs :
Mobility :



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 32 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 : 94 Auscultation: BAE+ Breath Sounds: NIKS Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 149/min BP :

Femoral Pulses : all well felt

Other Peripheral Pulses :

Precordial Activity :

Murmurs :

Signs of Cardiac Failure :

ABDOMEN:

Shape :

Palpation :

Palpable masses : NI

Abdominal girth :

Hernia orifice :

Anal Patency : looks patent

Umbilical Cord : 24 + 10

First urine passed : ✓

Meconium passed : ✓

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves : NI

MOTOR SYSTEM:

Passive Tone : relaxed

Active Tone :

Neonatal Reflexes :

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

Moro's : all symmetrical DTR :

ATNR :

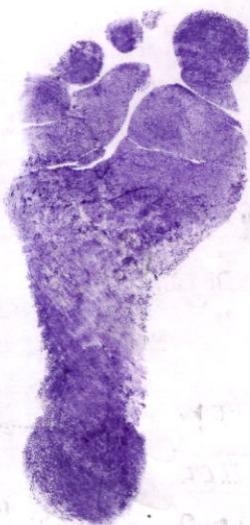
Skull and Spine :



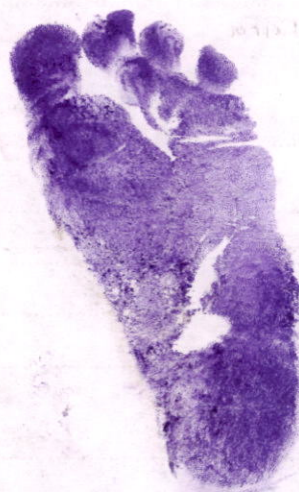
Diagnosis : BG+5 / GI-Pain / chronic hypertension / maternal asthma /
diAB / Maternal Fibroid / ASCS / Mch / 2621

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name : Dr. Vishth

Date & Time : 26/1/26

Consultant :

Signature :

Name : Dr. Kapil Bhagwat Rao Sachane

Date & Time : 02/08/2026

Dr. Kapil Bhagwat Rao Sachane
Reg. No. TSMC/FMR/19525

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.



HE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Neonatal condition at the time of Transfer:

Vital : HR : RR : BP : SP02 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

1. Send Cord Blood For
blood grouping

2. DRE/2H.

Plan during ward follow up :

3. Vaccines - OPV
BCG
Hep-B
Given on 17/26
SIS. Sachane

4. CRP/NBS/OAE @ 48HOL.

5. Warm care.

Feeding Plan at the time of shifting :

12 pm to 12:10 pm

6. W/F feed intolerance)
respiratory distress.

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:



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...PRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/7/26 APD PM	clsb <u>RESIDENT</u>	
	4HOL 36 + 5 Poin Chronic ten maternal asthma maternal fibroid LSC mch 26 21.	
		<u>Plan</u>
	AB ↑	1. DBF 24.
	AF.	2- warm care
	4 → m →	3- IF urine stool not passed by 11:00 am inform
	Enteric fine - warm peripheries. Good perfusion. cl/A: good.	4. w/F respiratory disease 5. RBC monitoring @ 3, 6, 12, 18, 24, 36, 48HOL inform if < 50mg/dl
	<u>Noted by Dr. [Signature]</u>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26 8Am	20Holl 36th / late pt elective Lsc / 2AS / Mch 2624 gm maternal Chronic HTN / Fibroids M/AB⁺ B wt → 2621 B/A⁺ 2466 S.G.I. Hemodynamically stable cry } Tone } Good Activity } Sucking = Good Drops of milk passed urine & stool CRT < 3 sec vaccination given 11/7/26 Euglycemic → last 61 mg/dl 12HOL	Plan 1. Df and hourly flb Burping 15-18ml measured feed 2. Warmth care 3. Lactation consult 4. RRS monitoring as advised 5. Clinical assessment every 4h 6. NBS } SBR } euglyc OAT } 7. Vital monitoring 3rd way
	Asst of 2624 Dr. Kapil Bhagwatrao Sachane Reg. No.: TSMC/FMR/19525 Kapil	Sai

BAH-00660402 IP5-00175824
 Baby Of ISBITA CHAMPATIRAY
 01-07-2026 0 Y 0 M 0 D 9 H (M)
 Dr. KAPIL BHAGWATRAO SACHANE

LESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26 10 AM	<u>Lactation care plan:</u> - well formed breast and nipples - colostrum good - latching good Adm: - Direct breast feeding - Aim for deep latch - Demand feeding not exceeding 2-2 1/2 hours - counselled about expressing milk	<i>[Signature]</i>
2/7/26 5 PM	4/18 Resident 30th of 36th / Elective LSC / mch / C&A chronic HTN Baby on Room air No cry/Tone Active } Good Sucking } Passed urine & stool Clinical assessment of grounds @ 24 hrs 6.5 mls Euphemie CR 7.11cc Last RBS: 66 mg/dl	<u>Plan</u> 1. DBF 2nd hour flb Burping 18-20ml measured feed 2. Warmth care 3. SBR NBS } @ 48 hrs Tim (11 AM) OAE } 4. RBS monitoring as advised <i>[Signature]</i>

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

CONSENT FOR FORMULA FEEDS

Patient Name : Age : Gender : ☐ Male ☐ Female
UHID No : Department : Date : 2h/2026
I Mr / Mrs. : aged years, hereby declare that I have
admitted my ☐ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on
..... I hereby give consent for formula feed for my child. Doctors have explained me
about the formula feeding benefits, risks, alternatives in the language I best understand.



Patient Attendant :

Signature : Prithvi Patnaik
Name : Prithvi Patnaik
Relationship with Patient : Father
Date & Time : 2/2 at 12:30pm

Witness :

Signature : [Signature]
Name : dalyani
Date & Time : 2h/26 at 12:30pm

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Sai
Date & Time : 2/7/26 at 12:30pm



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 16/20 Time: 12:00 PM

Doctor/Nurse/Family Concern?

Temperature
 (F)

Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

Note:

BP does not score
 in early
 warning scoring

Heart Rate (Number)

p. Rate (bpm)
 (over 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
 Distress None / Mild

Receiving O₂(l/min)
 O₂Saturations (%)

Conscious Normal
 Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
 recorded overleaf

Score 1 : Continue normal observation by staff nurse

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

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

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

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

BAH-00660402 IP5-00175824
Baby Of ISPIITA CHAMPATIRAY
01-07-2026 0 Y 0 M 0 D 9 H (M)
Dr. KAPIL BHAGWATRAO SACHANE



CHBH / FRM / CLINICAL / 124

21/7/26

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: 11am	5pm	10:30 PM	6PM		
Doctor/Nurse/Family Concern?						
Temperature (F)	104					
	103					
	102					
	101					
	100					
	99	97.9*	98.1*	98.8*	98.6*	
	98					
	97					
	96					
	95					
94						
Heart Rate (bpm) and Blood Pressure (mmHg) *	190					
	180					
	170					
	160					
	150					
	140	130				
	130					
	120		110			
	110					
	100					
Note: BP does not score in early warning scoring	90					
	80					
	70					
	60					
	50					
	Heart Rate (Number)					
		130b/m	110b/m	140b/m	135b/m	
	Resp. Rate (bpm) ver 1 Minute) *	70				
		60				
		50				
40						
30						
20						
10						
Resp Rate (Number)						
		40b/m	41	35b/m	40b/m	
Resp Distress		Mod/ Severe				
	None / Mild					
Receiving O ₂ (l/min)						
O ₂ Saturations (%)						
	99%	97%	99%	100%		
Conscious Level						
Normal / Altered						
GCS *						
	15/14	15/15	15/15	15/15		
TOTAL SCORE						
Number of shaded boxes						
	0	0	0	0		
Pain Score						
	0	0	0	0		
Observer's Initials						
ACTIONS						
Score 1 : Continue normal observation by staff nurse						
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01-07-2026
Dr. KAPIL BHAGWATRAO SACHANE

IP5-00175824

OYOMODH

(M)

RCHBH / FRM / CLINICAL / 124

3/7/26

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Pratiksha
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It takes a lot to treat the little.

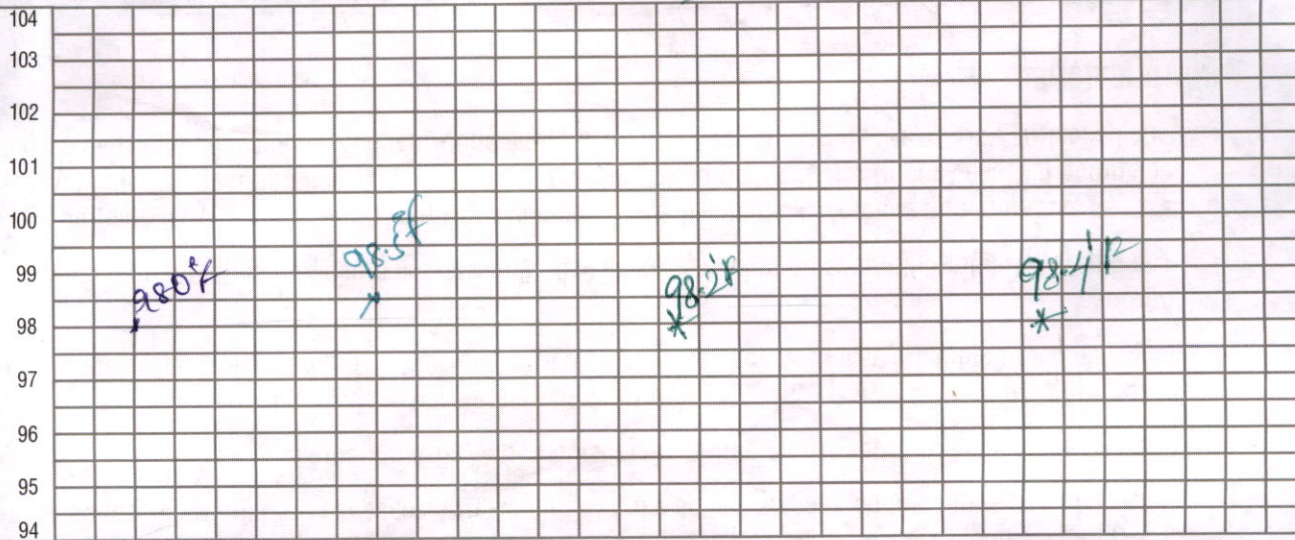
BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 12pm 5PM 10PM 6AM

Doctor/Nurse/Family Concern?

Temperature
(F)

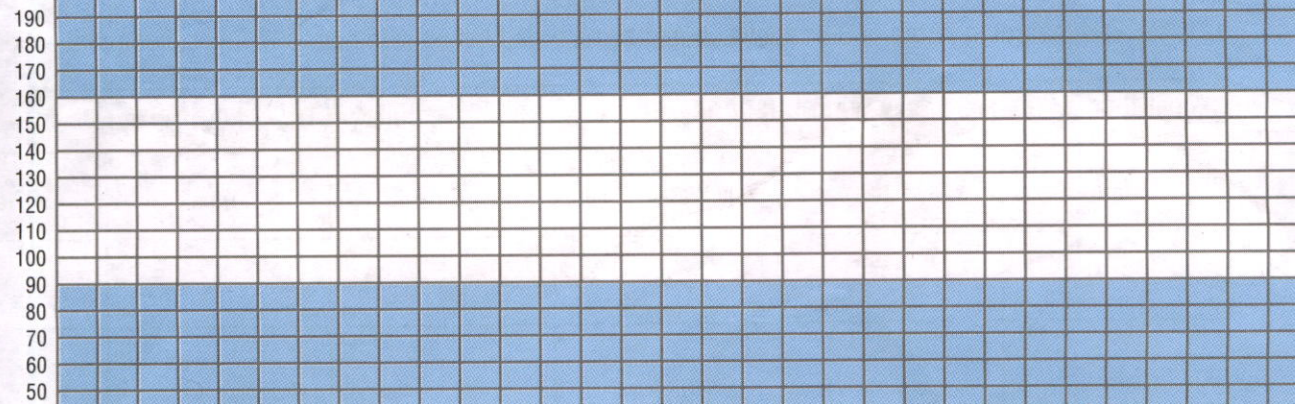


Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring



Heart Rate (Number)

145b/m 127 130b/m 135b/m

Resp. Rate (bpm)
ver 1 Minute) *



Resp Rate (Number)

42b/m 40 38b/m 42b/m

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

100% 97% 100% 100%

Conscious Level
Normal Altered

GCS *

15/15 15/15 15/15 15/15

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0 0 0 0
G G G G

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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)

BAH-00660402 IP5-00175824
Baby Of ISMITA CHAMPATIRAY
01-07-2026 0 Y 0 M 2 D (M)
Dr. KAPIL BHAGWATRAO SACHANE



4/12/26

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

Pratiksha
**Rainbow
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:

Doctor/Nurse/Family Concern?

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
per 1 Minute) *

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
- 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)

BAH-00660402
 Baby Of ISPITA CHAMPATIRAY
 01-07-2026 0 Y 0 M 0 D 2 H (M)
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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.

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	DBF											
	12:00 pm	DBF											
	01:00 pm												
Total Intake : 1200						Total Output : 0-0-0-0-0-0							
	02:00 pm	DBF											
	03:00 pm												
	04:00 pm	DBF											
	05:00 pm												
	06:00 pm	DBF											
	07:00 pm												
Total Intake : 1200						Total Output : 0-0-0-0-0-0							
	08:00 pm	DBF											
	09:00 pm												
	10:00 pm	DBF											
	11:00 pm												
	12:00 am	DBF											
	01:00 am												
Total Intake : 1200						Total Output : 0-0-0-0-0-0							
	02:00 am												
	03:00 am	DBF											
	04:00 am												
	05:00 am	DBF											
	06:00 am												
	07:00 am	DBF											
Total Intake : 1200						Total Output : 0-0-0-0-0-0							
Total 24 hrs. Intake													
Total 24 hrs. Output			M-30-4										

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							
21/7/26	08:00 am									✓		NA Seema
	09:00 am	DBF								✓		
	10:00 am					✓				✓		
	11:00 am											
	12:00 pm	DBF				✓				✓		
	01:00 pm	FF 20ml								✓		
Total Intake :					M-2 Total Output : U-4							
	02:00 pm											NA Seema
	03:00 pm	DBF										
	04:00 pm	FF 15ml				✓				✓		
	05:00 pm											
	06:00 pm											
	07:00 pm	DBF										
Total Intake :					Total Output : M-1 U-2							
	08:00 pm											NA Seema
	09:00 pm	DBF										
	10:00 pm	FF 25ml				✓				✓		
	11:00 pm											
	12:00 am	DBF										
	01:00 am	FF 20ml				✓				✓		
Total Intake :					Total Output : M-2 U-3							
	02:00 am	DBF										NA Seema
	03:00 am	FF 20ml										
	04:00 am					✓				✓		
	05:00 am											
	06:00 am	DBF				✓				✓		
	07:00 am											
Total Intake :					Total Output : M-2 U-2							
Total 24 hrs. Intake		F.F. 7100ml										
Total 24 hrs. Output		M-7 U-9										

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	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G							
3/7/26	08:00 am	DBP										NA Kalyan
	09:00 am	DBP								✓		
	10:00 am	DBP								✓		
	11:00 am	FF 20ml					NA			✓		
	12:00 pm											
	01:00 pm	DBP										
Total Intake :						M=0 Total Output : U=21						
	02:30 pm	FF 15ml										NA Soukhye
	03:00 pm						✓			✓		
	04:00 pm											
	05:00 pm	FF 30ml										
	06:00 pm						✓			✓		
	07:00 pm											
Total Intake :						Total Output : M=2 U=2						
	08:00 pm											NA Sema
	09:00 pm	DBP					✓			✓		
	10:00 pm	FF 30ml										
	11:00 pm											
	12:00 am	DBP										
	01:00 am						✓			✓		
Total Intake :						Total Output : M=2 U=2						
	02:00 am	DBP										NA Sema
	03:00 am											
	04:00 am	DBP										
	05:00 am						✓			✓		
	06:00 am	DBP										
	07:00 am											
Total Intake :						Total Output : M=1 U=1						
Total 24 hrs. Intake		FF- 100ml				Total 24 hrs. Output		M=5 U=6				

BAH-00660402 IP5-00175824
 Baby Of ISPITA CHAMPATIRAY
 01-07-2026 0 Y 0 M 0 D 9 H (M)
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FLUID CHART

Sheet No. :

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
4/7/26	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: 1/2/26

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
8:11:30 AM	Assessed to cardio	12 PM	Assessed to baby cardio	* baby is comfortable
12:30 PM	DIO Hand	1 PM	DIO Hand	
1:30 PM	DBF	2 PM	DBF	
2:30 PM	Warm care	2:40 PM	Warm care	
2:50 PM	breastfeed	3 PM	breastfeeding	

Re-Assessment: DBF and hand care

Special Notes: vaccination today

Nurse Signature: [Signature]

Nurse Name: Suvanda (606299)

Date & Time: 1/2/26 2 PM

BAH-00660402 IP5-00175824
 Baby Of ISPITA CHAMPATIRAY
 01-07-2026 0 Y 0 M 0 D 2 H (M)
 Dr. KAPIL BHAGWATRAO SACHANE



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 1/7/26

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 baby General	2:10pm	Assess the baby General	baby is fine.
3pm	Condition	3:30pm	Condition	
4pm	provide monite vitals	4:05pm	provided monite vitals	
5pm	provide D/O chart	5:10pm	provided D/O chart.	
6pm	provide warm care	6:10pm	provided warm care	
	provide DBF & Barfing		provided DBF & Barfing	
7pm	provide baby Safety	7:30pm	provided baby safety	

Re-Assessment: Re-Assessment is done

Special Notes:

AKBS monitoring as per advice

Nurse Signature: [Signature]

Nurse Name: Sushma

Date & Time: 1/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: newborn 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
8 pm	* Assess the baby condition	8:30 pm	* Assessed the baby condition	* Baby is stable.
10 pm	* plan to monitor vitals.	10:20 pm	* monitor vitals stable.	
12 Am	* plan to maintain I/O chart.	12:40 pm	* maintain I/O chart	
2 Am	* plan to warm care	2:30 Am	* provide warm care for baby.	
8 Am	* plan to feeding 2-3rd hourly.	8 Am	* Given feeding support 2-3rd hourly.	

Re-Assessment: provide warm care for baby

Special Notes: No

Nurse Signature: [Signature]

Nurse Name: Seema

Date & Time: 3/7/26 @ 8 Am

BAH-00660402 IP5-00175824
Baby Of ISPITA CHAMPATIRAY
01-07-2026 0 Y 0 M 2 D (M)
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NURSING CARE RECORD


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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:

Docu. No: RCHBH /FRM / CLINICAL / 148

SAH-00000402

IP5-00175824

Baby OFISPITA CHAMPATIRAY

01-07-2026 0 Y 0 M 2 D (M)

Dr. KAPIL BHAGWATRAO SACHANE



NURSING CARE RECORD

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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 KAPIL Department: DBS Date of Admission: 1/7/26

SITUATION	Diagnosis: <u>New born baby</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:					
	Area	Shift Time	<u>DBS</u> <u>2pm</u>	<u>DBS</u> <u>2pm</u>	<u>3rd Floor</u> <u>8am</u>	<u>3rd</u> <u>2pm</u>	<u>3rd Floor</u> <u>2pm</u>	<u>3rd Floor</u> <u>8am</u>
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>98.6°F</u>	Temp: <u>98.1°F</u>	Temp: <u>98.2°F</u>	Temp: <u>97.9°F</u>	Temp: <u>98.1°F</u>	Temp: <u>98.2°F</u>
	Res:		<u>40</u>	<u>56</u>	<u>35b/m</u>	<u>40b/m</u>	<u>41</u>	<u>42b/m</u>
	SpO ₂ :		<u>100</u>	<u>100</u>	<u>98%</u>	<u>99%</u>	<u>97</u>	<u>98%</u>
	Pulse:		<u>138</u>	<u>139</u>	<u>140b/m</u>	<u>130b/m</u>	<u>110</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>	
Recommendations	Safety Needs:		<u>Safe</u>	<u>Safe</u>	<u>Yes</u>	<u>Cns care</u>	<u>Yes</u>	<u>Yes</u>
	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>GRBS as per order</u>	<u>GRBS</u>	<u>HEBS 36HOL</u>	<u>GBR at 11AM 100/100</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>Swarna</u>	<u>Pushpale</u>	<u>Seema</u>	<u>Kalyani</u>	<u>Subhamni</u>	<u>Seema</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>1/7/26</u>	<u>1/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>3/7/26</u>	
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Pushpale</u>	<u>Seema</u>	<u>Kalyani</u>	<u>Subhamni</u>	<u>Seema</u>	<u>Kalyani</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>1/7/26</u>	<u>1/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>3/7/26</u>	
Time:		<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Kapil Department: PICU Date of Admission: 1/7/20

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known		
BACKGROUND		Area		If Yes Specify:		
BACKGROUND	Shift Time	3rd 2pm	3rd 8pm	3rd 8am		
	Medical Condition (Any special condition to be noted):	NB	NB	NB		
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	98.6	98.6	98.2	
		Res:	22b/m	40	38b/m	
		SpO ₂ :	100%	99	100%	
		Pulse:	175b/m	127	130b/m	
		BP:		NA	NA	
		Fall Risk Score:	16	16	16	
Pain Score:	0	0	0/10			
Recommendations	Safety Needs:	Crib care	yes	yes		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA		
Post Operative Procedure Special Orders:		NA	NA	NA		
Handed Over By Name :		Kalyani	Soubhagini	Lema		
Signature :						
Date:		3/7	3/7/26	4/7/20		
Time:		2pm	8pm	8am		
Taken Over By Name :		Soubhagini	Lema			
Signature :						
Date:		3/7/26	3/7/26			
Time:		2pm	8pm			

BAH-00660402
Baby OFISPITA CHAMPATIRAY
01-07-2026 0 Y 0 M 0 D 2 H (M)
Dr. KAPIL BHAGWATRAO SACHANE



Rainbow
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It takes a lot to treat the little.

BirthRight™
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Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	1/7/26	1/7/26	2/2/26	3/2	4/2
	3 to less than 7 years old	3	2PM	8PM			
	7 to less than 13 years old	2	4	4	4	4	4
	13 years old and above	1					
Gender	Male	2	2	2	2	2	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	1
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2	2	2			
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4		4	4	4	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3			3	3	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	1	1	1	1	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	16

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	yes	yes	NO	NO	NO
Call device within reach	yes	yes	NO	NO	NO
Wheels Locked	yes	yes	yes	yes	yes
Room free of clutter	NO	NO	yes	yes	yes
Adequate lighting	NO	NO	yes	yes	yes
Wheel chair support	NO	NO	NO	NO	NO
Other Intervention(s) Specify	yes	yes	NO	NO	NO
Nurse's Name:		Sumit Singh	Sumit Singh	Sumit Singh	Sumit Singh
Signature:		[Signature]	[Signature]	[Signature]	[Signature]
Date:		1/7/26	1/7/26	2/2/26	3/2
Time:		2PM	8PM	8AM	8AM

BAH-00660402 IP5-00175824
 Baby Of ISPIITA CHAMPATIRAY
 01-07-2026 0 Y 0 M 2 D (M)
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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	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					
	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					
TOTAL							

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

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

BRADEN 'Q' SCALE

					Date :	11/06/2026	2/7	3/7	
					Time :	2PM	8PM	8AM	2PM
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. 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.		2	2	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	3	3
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
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	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	18	18	20	20
					Evaluator's Name	Swarna	Swarna	Swarna	Swarna

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

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



BRADEN 'Q' SCALE

					Date: 8/7			
					Time: 12:00			
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: extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	3			
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			
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
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.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
					TOTAL SCORE	20		
					Evaluator's Name	S. S. S.		

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
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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



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
						12/07/2026	2/7	3/7	4/7				
						2 PM	8 PM	2 AM	8 AM	2 AM			
						NA	NA	NA	NA	NA			
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 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	36 wks	36 wks	36 wks	36 wks	36 wks		
	Total Pain / Agitation Score	0	0	0	0	0							
	Intervention	NA	NA	NA	NA	NA							
	Effectiveness	NA	NA	NA	NA	NA							
	Signature	Sachane	Sumith	Seema	Seema	Seema							

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.

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis.

New born baby

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:
1/7/26 12pm	☒ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	New born baby	→ To Encourage Breast feeding	→ Feeding 2-3rd hourly	Pushy	☒ 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:

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:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ 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

BAH-00660402 IP5-00175824
Baby Of ISPITA CHAMPATIRAY
01-07-2026 0 Y 0 M 0 D 2 H (M)
Dr. KAPIL BHAGWATRAO SACHANE

FAMILY EDUCATION RECORD

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Part - I,

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

Identified Education Needs :

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Terapy (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 Barries	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
17/08	12pm	7	Infection control Measures	PT BM	1	0	1	1	-	Becky

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 Barries 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 Barries 6. Desire / Motivate to Learn 9. Cultural Difference 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							

BAH-00660402
Baby OFISPIA CHAMPATIRAY
01-07-2026
Dr. KAPIL BHAGWATRAO SACHANE
IP5-00175824
0 Y 0 M 0 D 2 H (M)
0 Y 0 M 0 D 2 H (M)

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DISCHARGE PLANNING FORM

Nationality: India

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

1. Anticipated Date of Discharge: 31/7/26

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:

Remarks

☐ Medication

☐ Yes

☐ No

☐ Bathing

☐ Yes

☐ No

☐ Eating

☐ Yes

☐ No

☐ Walking

☐ Yes

☐ No

☐ Dressing

☐ Yes

☐ No

☐ Toileting

☐ Yes

☐ No

Need 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 Topic/s: personal hygiene

☐ Patient's Educational Topic/s discussed with the:

☒ Patient

☐ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Shard

Date and Time: 14/08/26 2PM

BAH-00660402 IPS-00175824
Baby Of ISPITA CHAMPATIRAY
01-07-2026 0 Y 0 M 0 D 2 H (M)
Dr. KAPIL BHAGWATRAO SACHANE

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NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name:

Mother's Name: M.M.

Date of Birth: 9/2/26

Time of Birth: 11:40 AM

Gender: ☐ Male ☒ Female

Birth Weight: 2.261 Kgs

HC: 34 cm

Length: 47 cm

Meconium in Liquor: ☒ Yes ☐ No

Cried at Birth: ☒ Yes ☐ No

Term / Pre-term / Post-term: Term

Resuscitated: ☐ Yes ☐ No

Blood Group: Mother: AB+ve Baby:

Feeding: ☒ Breast Feeding

☐ Formula

☐ Both

First Feed Time: 11:50 to 12 PM

AFFIX MOTHER'S
IDENTIFICATION LABEL

Mode of Delivery: ☒ Normal

☐ LSCS - Emergency/ Elective

☐ Instrumental

☐ AVD

Indication:

Physical Assessment of New Born:

Temp: 98.6 °C HR: 138 /Min RR: 20 /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: [Signature]

Signature: [Signature]

Date & Time: 17/2/26 2 PM

PATIENT TRANSFER FORM

Patient Name & IHD No BAH-00660402 IP5-00175824 Baby Of ISMITA CHAMPATIRAY 01-07-2026 0 Y 0 M 0 D 2 H (M) Dr. KAPIL BHAGWATRAO SACHANE 		Date & Time of Admission 11/12/26 @ 12:57 PM	Date & Time of Transfer Order 11/12/26 @ 7:00 PM
		Transfer Ordered by DR KAPIL	Reason for Transfer OBS
From Unit OBS	To Unit (A360)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 28	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 0			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Sis. Sushilpa		Name of Person Ordered Transfer DR KAPIL	
Patient & Clinical Records Received by : Ruchi			
Date & Time of Patient Received : 11/12/26 @ 2:30 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

BREASTFEEDING HISTORY FORM

Mother's Name: MRS. CHAMPATIRAY Baby's Name: B/o. CHAMPATIRAY Date of Birth: 17/1/28

Reason for consultation: Lactation counselling for mother.

1. Baby's feeding now Breastfeeds ye Day Night
(ask all these points) How often 2-2 1/2 hr

Length of breastfeeds 15-20 min

Longest time between feeds 2-2 1/2 hrs
(time mother away from baby)

One breast or both breasts Both

Complements (and water)

What given

When started

How much

How is it given

Pacifier (Yes / NO)

NO

2. Baby's health and behaviour Birth weight 2.621 kg Weight now 2.466 kg Growth
(ask all these points) Premature Term Twin

Urine output (more/less than 6 times per day)

Stools (soft and yellow/brown; or hard or green; frequency)

Feeding behaviour good

Illnesses

Abnormalities no

3. Pregnancy, birth, early feeds Antenatal care (attended/not) Delivery: Normal / C-section Rooming - in Yes / No Prelacteal feeds Yes / No (If Yes,) What given Breastfeeding discussed? Yes / No Early contact (First - 1 hour) Yes / No Time first breast feed (if not within 1st hour) ye

Formula samples given to the mother Yes / No

Postnatal help available for breastfeeding Yes / No

How given

4. Mother's condition and family planning Age 34 yrs Family planning method

Breast condition ye

Motivation to breastfeed ye

Alcohol, smoking, coffee, other drugs Yes / no

5. Previous infant feeding experience Number of previous babies } primi Experience good or bad Reasons

How many breastfeed

Any bottles used NO

6. Family and social situation Working / Home maker Father's attitude towards breastfeeding Other family members attitude towards breastfeeding Help with child care What others say about breastfeeding

Literacy status Educated

Positive

Counselled about DBF

Lactation Consultant:

Signature: [Signature] Name: Supriya Date & Time: 10/7

LACTATION ASSESSMENT FORM

Mother's details: MY. ISMITA CHAMPATIRAY

Baby details: B/O. ISMITA CHAMPATIRAY

Delivery: Vaginal ☐ Cesarean ☒ Vacuum ☐ Forceps ☐ Gravida ☐ GA ☒ 36 + 5 weeks

Reason for Visit: BF rounds ☒ Doctor Reference ☐ Patient Request ☐

BF previous baby: NO Previous BF difficulty: NO

Present Lactation:

Colostrum: Yes ☒ No ☐ Breast: Normal ☒ Engorged ☐ Soft ☐ Tender ☐

Nipples: Flat ☐ Inverted ☐ Everted ☒ Direct BF: Yes ☒ No ☐

Expressed / Pallada feeding: Yes ☐ No ☒

LATCH Assessment:

	0	1	2	SCORE					
				D-1	D-2	D-3	D-4	D-5	D-6
LATCH	Too sleepy not sustained LATCH / suck	Repeated attempts for suck / latch Hold nipple in mouth	Grasps breast tongue down lips flanged Rhythmic sucking	2	2				
AUDIBLE SWALLOWING	None	A few with stimulation	Spontaneous & Intermittent	2	2				
TYPE OF NIPPLE	Inverted	Flat	Everted (After stimulation)	2	2				
COMFORT	Engorged cracked Bleeding large Blisters bruises	Filling reddened small blisters / bruises	Soft Non tender	2	2				
HOLD	Full Assist	Minimal assist	No assist	0	1				
Total Score				8	9				

BABY WEIGHT CHART

Date	Weight	FIRST FEED					
		Breast Feed			Top Feed		
2/7/26	2.466kg						
3/7	2.434kg						

Teaching Instructions: deep latch

Discharge Instructions: urine output & weight monitor

Feed Frequency Duration: 2-2 1/2 hrs

Feeding techniques: cradle

Assessment of output: good

Sources of BF assistance at home: Handout

Next Follow up: 1 week

Lactation Consultant: Name: Surya Signature: [Signature] Date & Time: 2/7 12:2

Please tick ☒ for Yes, ☒ for No and leave ☐ blank for Not Applicable:

[illegible]

[illegible]