

**DISCHARGE TRACKING SHEET**

ANC-00015892 IP28-00004478  
Baby Of M SANGEETHAPRIYA TWIN  
28-05-2026 0 Y 0 M 2 D (M)  
Dr. EZHILARASI



UHID :                      FLOOR:                      CONSULTANT NAME: DR.


ACTIVITY	IN TIME	OUT TIME	REMARKS	<To be filled by Admin>
Activity Sheet updated by Nursing		30/5/26 at PP H OUT		
Activity Sheet updated by Pharmacy		1:16 pm	PP	

# ACTIVITY RECORD FOR BILLING



Name: BABY OF SANGEETHA TWIN - II

UHID No: ANC-00015892 IP28-00004478  
Baby Of M SANGEETHAPRIYA TWIN II  
28-05-2026 0 Y 0 M 0 D 2 H (M)  
Dr. EZHILARASI

Date of Admissior:  Consultant: \_\_\_\_\_ Dept: \_\_\_\_\_

Room / Bed No: \_\_\_\_\_ Ward: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_ Time: \_\_\_\_\_

Suggested Billable bed type: \_\_\_\_\_

## WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/5/26	12:40 pm	OT - II	post up	S. D. [Signature]
28/5/26	1:00 pm	post-op	3rd Floor	[Signature]

## CROSS CONSULTATION VISIT

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











PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26	Baby s/a Dr. Ezhilarasi	
4:00pm	Cry & rest only good	
	Pink	
	Coe: S.S.P	
	Lungs B.I are entry good	
Ux	Abd. soft	
Mx.	AE →	
	Tone (2)	
		Breast Feed
		S.I
28/5/26	S/B Dr Malini	
8:15pm	Sgae - 64 → 57	MBC → 0-ve
	Called for tachypnoea	MBC → Btle
	O/E Baby pink	
	periphery - cold + dusky	
	Cord Bc - 1.6	pulse volume good
	C - 0	CRT = 4 sec
	Hb - 13.1	RR - 60/min
		SpO <sub>2</sub> - 97%
		mild str +, nasal flaring
		HR - 142/min
	Urine once passed	



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	D/w <u>E</u> <u>Do</u> <u>Ezhilacani</u>	
	→ Nasal saline drops	
	→ Warmth	
	↓	
	Reassess & inform	
	Trace remaining report	
		<i>[Signature]</i> 11/28/25
28/5/25 9:30p	↓ after nasal saline drops Warmth	
	↓ periphery - pink warm	
	HR - 42/mi	
	SpO <sub>2</sub> - 97%	
	WOB (A)	
	no nasal drops	
	To put nasal saline drops 2-3 drops before every feed	
		<i>[Signature]</i> 11/28/25



## PROGRESS NOTES AND DOCTOR'S ORDER

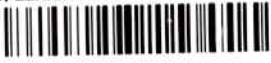
Date & Time	Progress Notes	Doctor's Order
29/5/26	S/B Dr. Mithun	
9 AM		
	A: Late Pt-Twin / DCDA Twin 2 / CSIS / Boy / AOA / Boy (36+3)	
	B.Wt: 2.58 kgs. F.Wt: 2.540 kgs. (140g)	M / O - W B / B tw
	On DBF + FF - following will U/o: Round (25-30 ml) since birth Mentum:	
	O/S: Gyr + Activity (N) Normothen PPWF	Vaccination ✓ Red Reflex ✓
	Icterus (+) - face. S/S: CS: SIS (+) RE: B/A (+) PIA: soft.	
	Plan: ① T/c DBF + FF ② To vaccinate today, check Red Reflex. ③ If no do T/c.	

*Dr. Mithun*



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/26 10.15am	s/o Dr. Ezhilarasi Cx & activity good Pink Cos. S, S, + lungs. Bil. cre entry good Abol: soft AF → Tow (w)	
✓ ✓		- DBF / formula - Vaccination / Red reflex / OAS
29/5/26	SIBDA: Mithuna	
3:10pm	Baby Pnd On DBF + FF (20 ml) - 2 1/2 bag by palatali feeds. U/o: <del>There</del> since morning Mucous: Twice since morning o/e: Cx + Activity (w) PPWF Pink s/o: Cx: S, S, (+) R: B, A, C (+) P/A: soft Plan: watch for icterus	✓ Vaccinate ✓ Red reflex ✓ OAS - Bilious. DCI - 2 (+)



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/26	SIB Dr. Divya Sri	
7:30 pm	Balay received	
	Pink / Ecthyma	
	T/P - (A)	
	e/T/A - good	
	Meconium - ✓	<u>Adv</u>
	urine output ✓	
	O/E Vitals stable	1) Normal rate
		2) DBF + FF on demand
		3) to do TCB tomorrow at 6am
	RS J NAP	Plan NBS.
	C/S J	
	P/A - soft	<u>CR</u>
	ENS - AF (-)	14/119.
<del>30/5/26</del>	<del>SIB Dr. Mithuna</del>	
<del>9:10 AM</del>	<del>A. Late Pre-Term / Twin-2 / Boy / ACH.</del>	
	<del>(36+4)</del>	
	B.Wt: 2.580 kg	M / 0.4
	F.Wt: 2.520 kg	B / Btw
	(2.34.kg)	
		TCB: H - 7.9
		C - 7.4.

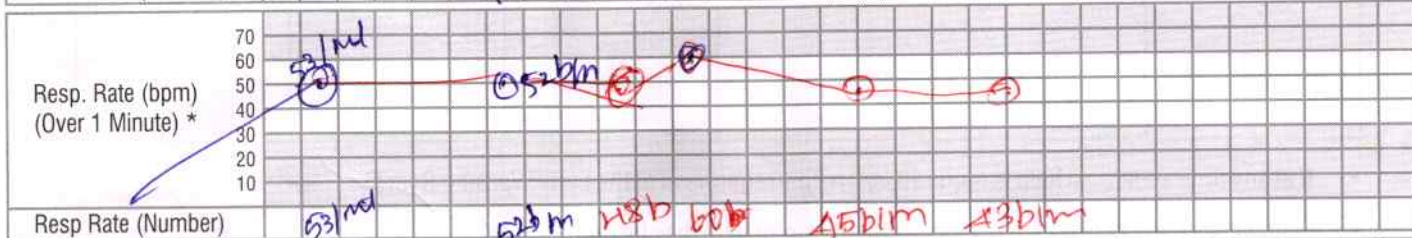
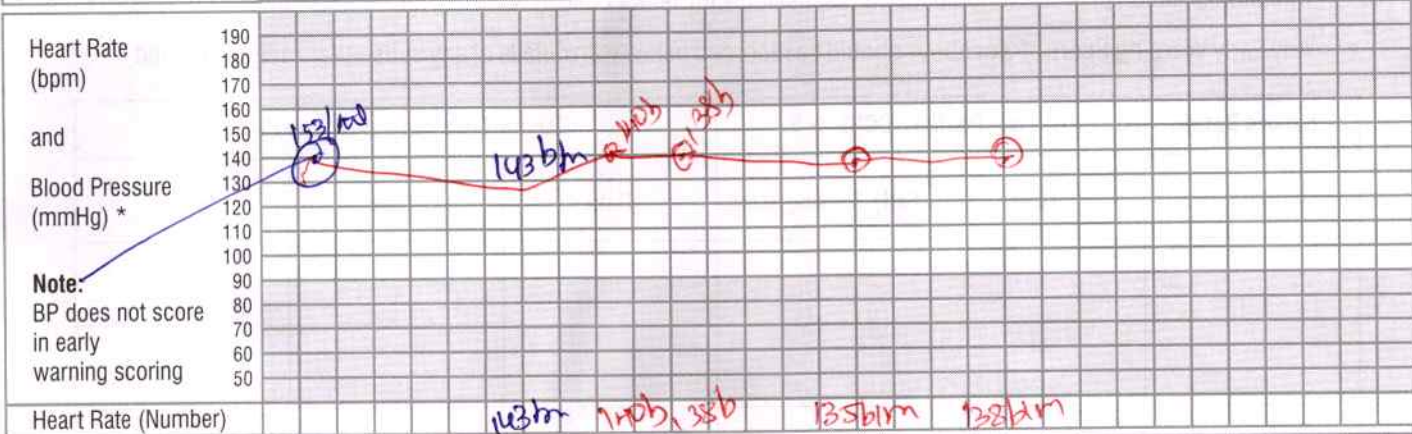
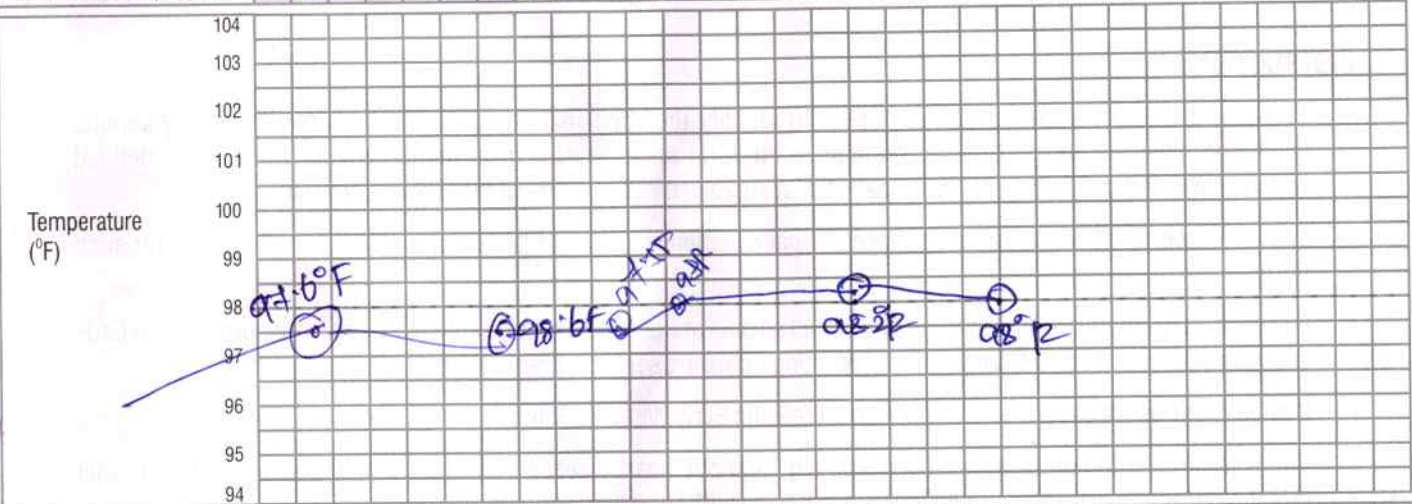




**INFANT (<1 year)**  
**Children's Observation & Early Warning Scoring Chart**

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

Date: 22/5/26	Time: 12pm	4pm	8pm	12am	4am
Doctor/Nurse/Family Concern?	✓	✓	✓	✓	✓



Resp Mod/ Severe Distress None / Mild	✓	✓	✓	✓	✓
Receiving O <sub>2</sub> (l/min) O <sub>2</sub> Saturations (%)	0.2L	0.2L	0.2L	0.2L	0.2L
O <sub>2</sub> Saturations (%)	97	97	97	97	98
Conscious Level Normal Altered	✓	✓	✓	✓	✓
GCS *	15/15	15/15	15/15	15/15	15/15
<b>TOTAL SCORE</b>	01	01	02	01	01
Number of shaded boxes	0/10	0/10	0/10	0/10	0/10
Pain Score	0	0	0	0	0
Observer's Initials	E	E	E	E	E

<b>ACTIONS</b>	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.

<b>I</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S</b>	<b>SITUATION :</b> 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>B</b>	<b>BACK GROUND :</b> 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)
<b>A</b>	<b>ASSESSMENT :</b> 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.
<b>R</b>	<b>RECOMMENDATION :</b> 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)

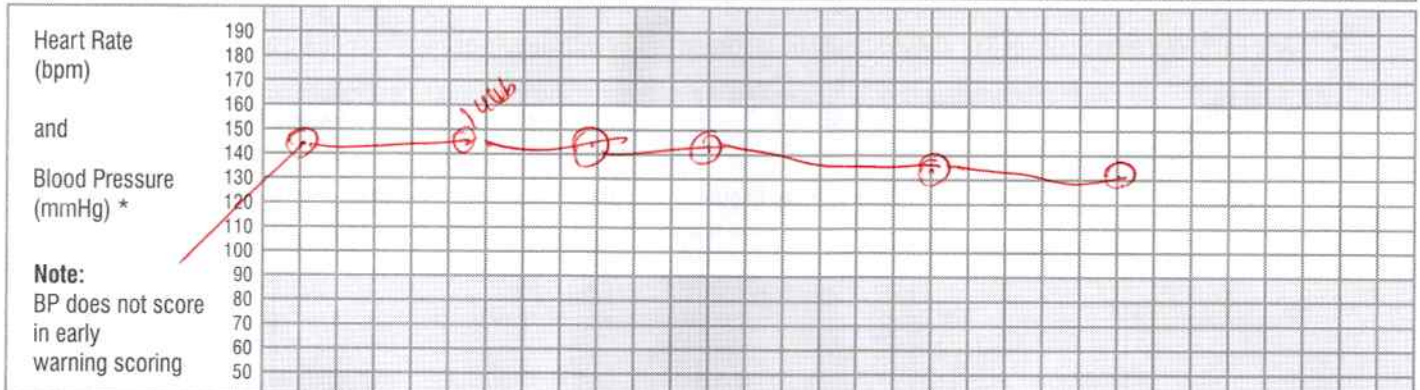
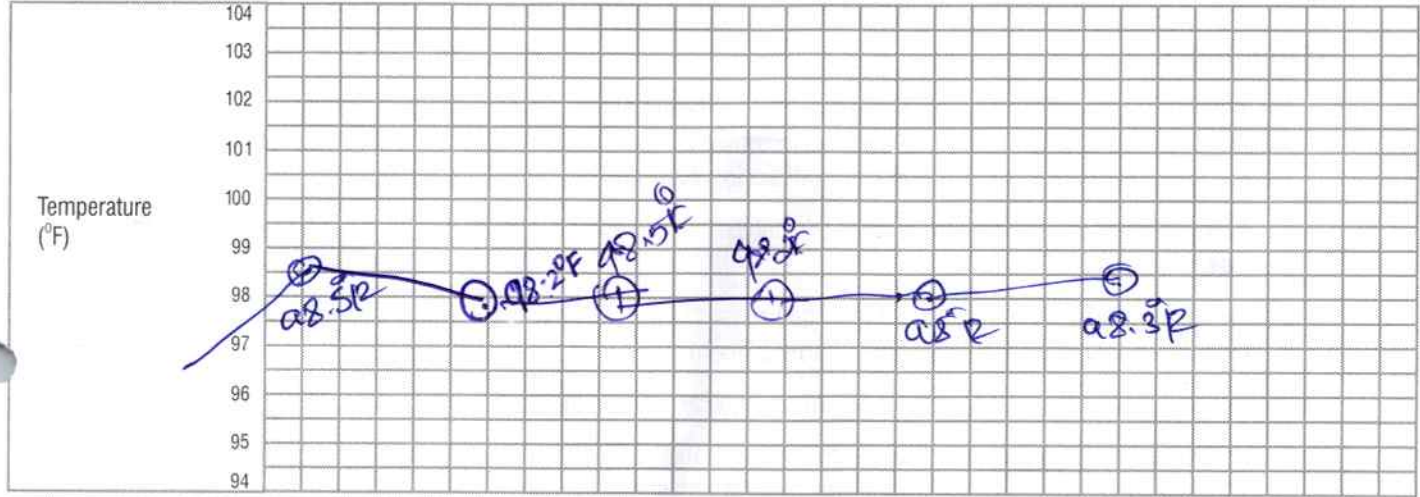


**INFANT (<1 year)**  
**Children's Observation & Early Warning Scoring Chart**



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

Date: 28/5/26	Time: 2am	12pm	4pm	8pm	12am	4a
Doctor/Nurse/Family Concern?	✓	✓	✓	✓	✓	✓



Note: BP does not score in early warning scoring



Heart Rate (Number) 142bpm 144b 141bpm 140bpm 135bpm 130bpm

Resp Distress	Mod/ Severe None / Mild	✓	✓	✓	✓	✓
Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)	98%	98%	98%	98%	98%
Conscious Level	Normal / Altered	✓	✓	✓	✓	✓
GCS *		15/15	15/15	15/15	15/15	15/15
<b>TOTAL SCORE</b>	Number of shaded boxes	0/1	0/1	0/1	0/1	0/1
Pain Score		0/10	0/10	0/10	0/10	0/10
Observer's Initials		ES	ES	ES	ES	ES

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



**FLUID CHART**

Sheet No. : ..... *(Handwritten circled number)*

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

28/5/26		Intake			Output					IV Site Thrombophlebitis 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	DBF ✓										<i>(Signature)</i>
<b>Total Intake :</b>		DBF			M-O		<b>Total Output :</b>		U-O			
	02:00 pm											
	03:00 pm	DBF ✓										<i>(Signature)</i>
	04:00 pm											
	05:00 pm	DBF ✓							✓			<i>(Signature)</i>
	06:00 pm											
	07:00 pm	DBF										<i>(Signature)</i>
<b>Total Intake :</b>		DBF			M-O		<b>Total Output :</b>		U-1			
	08:00 pm											
	09:00 pm	name										
	10:00 pm	FR 25ml										<i>(Signature)</i>
	11:00 pm						✓					
	12:00 am											
	01:00 am	DBF ✓										
<b>Total Intake :</b>		FR 25ml + DBF			M-O		<b>Total Output :</b>		U-O			
	02:00 am	FR 20ml										
	03:00 am											
	04:00 am											
	05:00 am	DBF ✓										
	06:00 am	FR 30ml										<i>(Signature)</i>
	07:00 am											
<b>Total Intake :</b>		FR 50ml + DBF			M-O		<b>Total Output :</b>		U-O			

**Total 24 hrs. Intake**  
 FR - 75ml  
 DBF - 6 times

**Total 24 hrs. Output**  
 U - 1 time  
 M - 0





**FLUID CHART**

Sheet No. : 02

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

29/5/26		Intake				Output					IV Site Thrombophlebitis 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	FF 20ml								✓		
	11:00 am											
	12:00 pm	FF 20ml										
	01:00 pm											
<b>Total Intake :</b>		40ml				<b>Total Output :</b> 0-2						
	02:00 pm	DBP ✓									↓	
	03:00 pm						✓			✓		
	04:00 pm	Faramin 20ml								✓		
	05:00 pm	Faramin 20ml					✓			✓		
	06:00 pm	Faramin 20ml					✓			✓		
	07:00 pm											
<b>Total Intake :</b>		55ml				<b>Total Output :</b> 0-4						
	08:00 pm										↓	
	09:00 pm	FF 20ml										
	10:00 pm											
	11:00 pm									✓		
	12:00 am	FF 20ml					✓					
	01:00 am											
<b>Total Intake :</b>		40ml				<b>Total Output :</b> 0-4						
	02:00 am										↓	
	03:00 am	FF 20ml										
	04:00 am											
	05:00 am											
	06:00 am	FF 20ml								✓		
	07:00 am											
<b>Total Intake :</b>		40ml				<b>Total Output :</b> 0-4						
<b>Total 24 hrs. Intake</b>		135ml										
<b>Total 24 hrs. Output</b>		U-8 times M-4 times.										



5892 IP28-00004478  
 1 SANGEETHAPRIYA TWIN  
 8 0 YOM 2 D (M)  
 ARASI



Sheet No. : 03

# FLUID CHART

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>													
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>													
	08:00 pm												
	09:00 pm												
	10:00 pm												
	1:00 pm												
	00 am												
	am												
<b>Total Intake :</b>													
<b>Total Output :</b>													
<b>Total Output :</b>													
<b>Total Output :</b>													
<b>Total Output :</b>													
<b>Total 24 hrs. Output</b>													

8015126



Patient Sticker



# FLUID CHART

Sheet No. : .....

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

Date	Time	Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse
		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											
<b>Total Intake :</b>												
		<b>Total Output :</b>										
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
<b>Total Intake :</b>												
		<b>Total Output :</b>										
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
<b>Total Intake :</b>												
		<b>Total Output :</b>										
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
<b>Total Intake :</b>												
		<b>Total Output :</b>										
<b>Total 24 hrs. Intake</b>												
		<b>Total 24 hrs. Output</b>										





# NURSES NOTES

- No Known Drug Allergies
- Drug Allergies ..... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		<u>OT Notes</u>	
28/5/26	10pm	⇒ An alin team Baby Elective L&S done Boy Baby ⇒ Baby suction care done ⇒ Vitals are checked and secured. ⇒ Nasal & suction done oral done ⇒ Anal patency checked. <del>and care</del> ⇒ Inj. vit K Im given ⇒ cord clamp & cut done ⇒ Baby vitals checked and secured. ⇒ Blood Sample Sent to Lab B - 28/5/26 @ 11:41 AM A - 2.58 Kg B - BOY Y - 7/10, 8/10.	 620115
		⇒ Baby shifted to Mother's side.	
	12-30pm	CBH - by mgd informed to Dr. Malini	 02/16/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



# NURSES NOTES

No Known Drug Allergies

Drug Allergies ..... *Nil*

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		<i>Receiving Note</i>	
28/5/26	2:20pm	Baby delivered handing over by morning duty staff	
		Baby vital are stable	
		Baby urine and motion is not passed.	
	3pm	DBF is given and good. CBG @ 6pm	<i>[Signature]</i>
		<i>todo.</i>	
	6:30pm	Baby shifted to 3rd floor	<i>[Signature]</i>
		<i>Receiving notes</i>	
28/5/26	5:30pm	Baby received from post-anest	
		Baby looks pink in colour crying well, not passed urine & meconium	
	6pm	CRG checked CRG - 57 mg/dl - informed to Dr. Malini advised to give - naspro - paracetamol feed. Tomoxon vaccine and reflexes	
	7pm	Baby passed urine formula feed - naspro - oil given	
		Dr. F. Baby has nasal	
	8:20pm	Baby hand over given to night shift staff	<i>[Signature]</i>
		Baby had nasal foreign body removed to Dr. Malini, she assessed, advised to give nasal drops	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



# NURSES NOTES

(USE BALL POINT PEN ONLY)

- No Known Drug Allergies  
 Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<i>Night duty notes</i>
28/5/26	8:20pm	Baby handover taken from evening duty staff.
		→ baby is active and alert
		→ baby warmth and pink
		→ baby present mild retraction
		→ now baby stable.
		→ baby not passed motion urine passed. 1 time.
	10pm	PR 25ml given to the baby.
	11pm	→ baby has vomiting 2 times.
28/5/26	12am	Baby vitals checked and recorded vitals stable no retraction
	2am	Baby sleep well no other complaints.
	4am	Baby vitals checked and recorded vitals stable.
	6am	Morning care given to the baby baby weight checked and recorded.
		→ baby vitals checked and recorded vitals stable.
	8am	→ baby not passed urine and motion in overnight
	8am	Baby handover given to morning duty staff.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



# NURSES NOTES

(USE BALL POINT PEN ONLY)

- No Known Drug Allergies
- Drug Allergies .....

AI

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
29/5/26		morning shift
	8:30am	Baby taken over from night shift staff & N. Srinathu
		Baby looks alert and active. on DBP+FF
	10am	Vaccination given by Dr. Mithuna mam
	11am	Baby's FF 15ml given baby no vomiting
	12pm	Baby vitals checked and recorded vitals are stable
	1pm	Baby sleeping well No other complaints
	2pm	Baby details handing over going to Evening duty staff
		29/5/26 - Evening duty May
	2pm	Baby is handing over taken from morning duty staff conscious and oriented.
	3pm	DBF given formula feed given.
		To provide accurate care
	4pm	Vital Monitoring and Recording.
		No complaint of baby.
		Intake and output Monitoring.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



# NURSES NOTES

(USE BALL POINT PEN ONLY)

Known Drug Allergies

Drug Allergies

AP /

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
	6pm	deeply asleep seen too
	8pm	baby continues same treatment moving over green to night duty
		Night duty notes
27/5/26	2:30am	baby handover taken from evening duty staff → baby is active and alert → baby warm and pink. <span style="float: right;">→ JPS 6/21</span>
	10pm	baby is on DR 2 and RR 23 being given to the baby. <span style="float: right;">→ JPS 6/21</span>
28/5/26	2am	baby vitals checked and recorded Vitals stable. <span style="float: right;">→ JPS 6/21</span>
	2am	baby sleep well no other complaints <span style="float: right;">→ JPS 6/21</span>
	3am	baby passed urine and motion no other complaints. <span style="float: right;">→ JPS 6/21</span>
	6am	morning care given to the baby <span style="float: right;">→ JPS 6/21</span>
		baby weight checked and recorded → baby vitals checked and recorded Vitals stable. <span style="float: right;">→ JPS 6/21</span>
		→ baby handover given to morning duty staff. <span style="float: right;">→ JPS 6/21</span>

NOTE: DO NOT WRITE OUTSIDE THE MARGINS

