

well ing

New Born Screening	: Anitha CSIS/ur
TFT	:
OAE	:
Mother's Blood Group	: O+ve.
Baby's Blood Group	: O+ve
Anomaly Scan	:
Vaccination	: BCG, opv, Hep-B Given on 2/7/26 Kaveri/2/7/26

CHBH / FRM / CLINICAL / 132

[illegible]



Twins-II

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Sandhya Reddy Age : 39y Father's Name : Age :
Date of Birth : Date of Admission : UHID No. :
NICU Consultant : as per rota 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 Sandhya Reddy Mother's Blood Group : O+ve
Gender : ☐ M ☒ F Blood Group : O+ve Birth Weight (gms) : 2.5kg Length (cms) : 49cm
Date of Birth : 11/7/26 Time of Birth : 6:21pm OFC (cms) : 34cm
Place of Birth : RCH Bangalore Estimated Gesth Age : 36+6

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : Ht : Wt : BMI : Married Life : LMP : EDD :
Conception : Spontaneous or with Rx : spontaneous conception, MCDA - Twins
Booked at what GA : Booked @ 16 weeks AN Steroids Drugs / Doses :
Last Scans Details : 2016/26 - 35+ Twins-II 2355 Doppler @
..... TT Immunization and Iron / Folic Acid : breast

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 : Chest NTN
H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) :
IUGR - when detected :
Doppler (Increased Resistance / ADEF / REDF /
Redistribution in MCA) / Ductus Venosus :
AFI :

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

Controlled or not, recent values, HbA1 values :
Compliance with Rx :
Scans : LGA, TIFFA , Fetal Echo :
H/o Hypothyroidism : when diagnosed ? Medication?
Any other Chronic Medical Problems, when detected
drugs ?
(Anemia, SLE, Jaundice, CHD, Heart Disease)
Infection : H/O, Fever
(☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)
UTI : when : Any culture :

PPROM : Duration : ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results :

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

G: 2 P: 1 A: 0 L: 1

Gr. No.	Age	GA wks	B. W	Gender	Significant	Details
01	- 2018 -	Emg - LSCS				male 3.7 kg A 8 H

PERINATAL HISTORY

Treating Obstetrician : Dr. Pratyusha Hospital : RML bangalore ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☐ Emergency Indication :

Specify the reason :

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitation : ☐ Yes ☐ No

Cord ABG : 7.26 / 99-8 / 2.5 / -4.1 / 18.5

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

TOTAL

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

Resuscitation

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



MEDA twins - Baby delivered by heels
- by breech presentation → was
limp at birth → Immediately
cord clamped → received + warmed
→ drying & stimulation baby cried
Tons, HR, colour improved - sterile card
cut → inj vit - K 1mg T.M
given → sent to mother side
for breast feeding.

Investigation details in previous Hospital :

Feeding History :



Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.7 HR : RR : NIBP : CFT :

Color of the extremities :

Jaundice : Pallor : SpO2 :

Anthropometry : Birth Weight : 2500 Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :

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

(N)

Facies :

(Any Facial
Dysmorphism)

(NO)

NECK and CLAVICLES :

Range of Motion :
Asymmetry :
Masses :

(Normal)

EYES :

Symmetry :
Red Reflex :
Discharge :

— needs to be checked

EARS, NOSE MOUTH and THROAT :

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

(N)

No cleft

THORAX and BREASTS :

Shape of Thorax :
Position of Nipples and Number :

(N)

ABDOMEN and UMBILICUS :

Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump :
Discharge :

(N)

2 A 1 V

GENITALIA :

Labia / Hymen :
Testicles/penis :
Anus :

(N)

female

HERNIAL ORIFICES

free

TRUNK and SPINE :

(N)

SKIN LESIONS :

(N)

EXTREMITIES :

Fingers / Toes :
Arms / Legs :
Deformities :
Mobility :
Hip Joint Examination :

(N)



SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress : RR : SCR / ICR / See - Saw breathing : (N)

Scoring of respiratory distress if present (Silverman or Downe's) : B/L EAF

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

Settings : No other

Spo2 : 94.1 Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 150 BP : Precordial Activity : (N)

Femoral Pulses : Murmurs : (N)

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernia orifice : free

Palpation : Anal Patency : patine

Palpable masses : Umbilical Cord : 2A 1V

Abdominal girth : First urine passed : not yet

Meconium passed :

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness : alert

Prechtle Score :

Nerves :

No focal Neuromuscular deficit

Motor System :

Passive Tone : (N)

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR : (N)

ATNR : Skull and Spine :



No gross congenital anomaly.

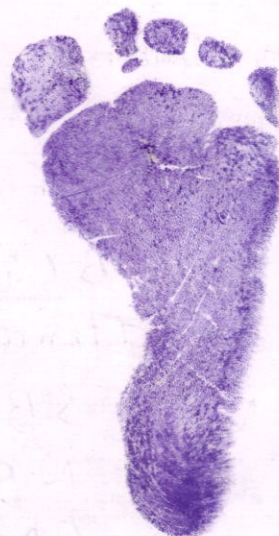
Diagnosis : Late pre-term / MLEA / Female / 2.5 kg
Apgar / Breech / cried & stimulation.

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : _____

Name : _____

Date & Time : _____

Consultant :

Signature : _____

Name : _____

Date & Time : _____

DR. VIJAYANAND JAMALPURI
Registration No: 40526

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor : _____
2. Name of the referring Hospital : _____
Address : _____
Contact Numbers : _____
3. Contact Details of the referring Doctor : _____
Mobile No. : _____ E-mail ID : _____
4. Name of the Doctor in Rainbow Team : _____

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



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

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

Any Oxygen requirement :

Systemic :

Medications :

Plan
✓ BCF fib burping - 2 hourly
✓ BCG, OPV, Hep-B T/M
✓ Clinical jaundice @ 24 hours
✓ SBR
NSG / ~~TFT~~ @ 48 hours
OAE

Plan during ward follow up :

W/E vitals & infant sat
GRSS - 1 hour post
- 3h, 12h, 36h
- 6h, 24h, 42h } preferred
infant if GRSS less than 50 mg/dl.
Rmrajul

Feeding Plan at the time of shifting :

6:45 to 6:55 pm

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26 8 AM	seen by Resident 13 H of late preterm 36¹⁶ / Elective LSCS / MCDA Twin II / Fch / 2.5 kg Breech / delayed M₁ & O⁺ cried on stimulation Hemodynamically stable on Room air Euthermic Euglycemic last GBS (53 mg/dL) B Wt → 2500 → 2438 62 gm (2.4.1.) Cry } Tone } Good Activity } Passed urine & stool	plan 1. DBF followed by Burp 2. Warmth care 3. Vaccination BCG, OPV, Hepatitis today 4. clinical assessment of jaundice @ 24 H of 5. Trace baby blood group 6. USG hip @ 6 weeks of life 7. RBS monitoring as planned
2/7/26 10 AM	seen by Dr. vijayanand Hipt examination @ Hemodynamically stable	plan 1. DBF 2nd hourly 2. B, RBS monitoring as planned 3. USG hip @ 6 weeks of life 4. clinical assessment @ 24 H of

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Baby Of SANDHYA REDDY MALLADI
01-07-2026
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IP5-00175840

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7 10:30 AM	<u>Lactation care plan:</u> - well formed breast and nipples - colostrum seen - Suck not continuous, sleeping at the breast <u>Advice</u> Direct Breast feeding - Arm for deep latch as demonstrated. - Male baby suck for 15-20 min - Demand feeding not exceeding 2-2 1/2 hours	
2/7/26 4pm	22H01 (latept 36th) MCDA / ^{twice} Baby on Room air vitals: stable cry } good Tone } Activity } Sucking - good CRT - green Peripheries: warm Euglycemic Vaccines - done	<u>Plan</u> 1. Regular feeding flb Burping 2. RBS monitoring as planned 3. Warmth care w/ vsc hip & back of life 5. clinical assessment of Jaundice <i>by</i> <i>Dr</i>



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7 9am	<u>lactation care plan:</u> - Suck improved - Bolus seem good - counselled about importance of direct breast feeding and deep latch - counselled about expressing milk if required after direct feeding	
3/7/26 2:30pm	CS/B Resident 44 HOU late Preterm/36⁺6 / MCDA Twin II Fch 2.50kg breech <u>Plan</u> Baby on room air U ✓ M ✓ Euglycemic → 55g/ml Euthermic Pink Sucking - good Baby active Tone } cry } good. activity }	(1) DBF + Formula Fed. (20-25ml) Per feed 2hly (2) GRBS regular monitoring 3hly (3) warm care (4) USG both hips @ 6 weeks. (5) SBR } 6p.m NBS } (6) OAE - T/m <u>Solu</u>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 7:30pm	CLB Resident	S/B
	61 HCL / late Preterm / breech / FCH / 36 ⁺ / MCDA twin II / 2.5kg	
	Baby on room air	Plan SBR-9.1
		TCBR- 9.1 11.4
U/V m/✓	m/ O+ B/ O+	① DBF ⊕ + Formula feed 2hly 30ml.
	Bwt - 2.50kg	② GRBS monitoring shly.
	T.Wt + 2.29kg → 8.4% ↓	③ warm cage
	GRBS - 52mg/dl	④ USG both hips @ 6 weeks
	Eutheemic - Pink	⑤ OAE - Today
	Euglycemic	
	Sucking - good.	
	on breast + Formula feed	Solub
	activity } Tone } good. cry }	discharge today.
		Flu Monday.
		TCBR before d/c.

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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 1/2/26 Time: 8 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)

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.

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!
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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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

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Baby Of SANDHYA REDDY MALLADI
01-07-2026
Dr. VIJAYANAND JAMALPURI

IP5-00175840

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: ...2/7/26	Time: 11am	5:30 PM	10:20 PM	6AM
Doctor/Nurse/Family Concern?				
Temperature (°F)	98.0°	98.4°	98.5°	98.3°
Heart Rate (bpm)	140b/m	130b/m	140b/m	145b/m
Blood Pressure (mmHg) *				
Resp. Rate (bpm) (Over 1 Minute) *	42b/m	40b/m	35b/m	31b/m
Resp Distress				
Receiving O ₂ (l/min)	98%	97%	100%	99%
O ₂ Saturations (%)				
Conscious Level	15/15	15/15	15/15	15/15
GCS *				
TOTAL SCORE	0	0	0	0
Number of shaded boxes				
Pain Score	0	2	0	0
Observer's Initials	AB	2	AB	AB

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INFANT (<1 year)

Children's Observation &
Early Warning Scoring ChartPratiksha
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 12pm 6:00 10:30 4:00

Doctor/Nurse/Family Concern?

Temperature
(F)104
103
102
101
100
99
98
97
96
95
94Heart 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 / MildReceiving O₂(l/min)
O₂Saturations (%)Conscious Normal
Level Altered

GCS *

TOTAL SCORE

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FLUID CHART

Sheet No. : 1

- All measurements in ml.
- 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										
	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	DBM									
	07:00 pm										
Total Intake :					Total Output :						
	08:00 pm										
	09:00 pm										
	10:00 pm	DBM									
	11:00 pm										
	12:00 am										
	01:00 am	DBM									
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	03:00 am	DBM									
	04:00 am										
	05:00 am	DBM									
	06:00 am										
	07:00 am	DBM									
Total Intake :					Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

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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							
2/7	08:00 am											
	09:00 am	DBF					✓					
	10:00 am											
	11:00 am											
	12:00 pm	DBF					✓			✓		
	01:00 pm											
Total Intake :						m-2 Total Output : 1212						
	02:00 pm											
	03:00 pm	DBF										
	04:00 pm									✓		
	05:00 pm	DBF										
	06:00 pm									✓		
	07:00 pm											
Total Intake :						Total Output : m-10-2						
	08:00 pm	DBF										
	09:00 pm											
	10:00 pm	DBF								✓		
	11:00 pm											
	12:00 am	DBF										
	01:00 am											
Total Intake :						Total Output : m-0 12						
	02:00 am											
	03:00 am	DBF										
	04:00 am											
	05:00 am	DBF										
	06:00 am									✓		
	07:00 am	DBF										
Total Intake :						Total Output : m-0 12						
Total 24 hrs. Intake												
Total 24 hrs. Output		m-3 16										

BAH-00660442 IP5-00175840
 Baby Of SANDHYA REDDY MALLADI
 01-07-2026 0 Y 0 M 0 D 5 H (F)
 Dr. VIJAYANAND JAMALPURI



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						
27/02/26	08:00 am									1	NA Seetharam
	09:00 am	DBF							✓	1	
	10:00 am					✓			✓	1	
	11:00 am	DBF								1	
	12:00 pm								✓	1	
	01:00 pm	DBF								1	
Total Intake :					Total Output : M=1 U=2						
	02:00 pm									1	NA Soubha
	03:00 pm	DBF							✓	1	
	04:00 pm					NA				1	
	05:00 pm									1	
	06:00 pm	DBF							✓	1	
	07:00 pm	FF 15ml								1	
Total Intake :					Total Output : M=0 U=2						
	08:00 pm									1	NA Seema
	09:00 pm	DBF								1	
	10:00 pm	f.f. 15ml							✓	1	
	11:00 pm					NA				1	
	12:00 am	f.f. 15ml								1	
	01:00 am								✓	1	
Total Intake :					Total Output : M=0 U=2						
	02:00 am	DBF								1	NA Seema
	03:00 am	f.f. 15ml				✓			✓	1	
	04:00 am									1	
	05:00 am	DBF								1	
	06:00 am								✓	1	
	07:00 am	f.f. 30ml								1	
Total Intake :					Total Output : M=1 U=2						
Total 24 hrs. Intake		f.f. - 90ml			Total 24 hrs. Output		M=2 U=8				

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 Baby Of SANDHYA REDDY MALLADI
 01-07-2026 0 Y 0 M 1 D (F)
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FLUID CHART

Rainbow®
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BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

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								
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							

BAH-00660442 IP5-00175840
 Baby Of SANDHYA REDDY MALLADI
 01-07-2026 0 Y 0 M 0 D 5 H (F)
 Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

Rainbow Children's Hospital
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BirthRight
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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 1/7/26

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
	9 am Assess the baby condition 1 pm monitor vitals 4 pm DBM wraping done warm care GRBS monitoring.		9 am Assess the baby condition 4 pm vitals checked & record. 4 pm DBM given. 5 am wraping done. warm care done 7:30 GRBS monitoring done	baby is stable

Re-Assessment: Re-assessment 3rd hour/2

Special Notes: GRBS monitoring, vaccination today

Nurse Signature: [Signature] Nurse Name: Reddy Date & Time: 2/7/26 [Signature]

BAH-00660442 IP5-00175840
Baby Of SANDHYA REDDY MALLADI
01-07-2026 0 Y 0 M 0 D 5 H (F)
Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD


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BirthRight
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Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 2/7/26

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
8am	→ To assess the general condition of the baby	8:10am	→ Assessed the general condition of the baby	Baby is stable Vitals normal
10am	→ To monitor vital signs	10:20 am	→ Monitored vitals and recorded	
11am	→ To encourage oral intake	11:15 am	→ DBF every 2to 3rd hrly	
12pm	→ To maintain I/O chart	12:30pm	→ Maintained I/O chart	
1pm	→ To provide warm care	1:10pm	→ Provided warm care	

Re-Assessment:

After proper position, has good latching + sucking

Special Notes:

Vaccination Today

Nurse Signature: 

Nurse Name: Kalyani

Date & Time: 2/7 at 3pm

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Baby Of SANDHYA REDDY MALLADI
01-07-2026
Dr. VIJAYANAND JAMALPURI

IP5-00175840
0 Y 0 M 0 D 5 H (F)

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 27/7/26

Assessment: Newborn baby (Risk for hypoglycemia related poor feeding)

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 to the baby condition	2.15pm	Assessed to the baby on sleep	Baby well & active.
3pm	to maintain y/o chart.	3.30pm	maintained y/o chart.	
4pm	to monitor vitals	4.10pm	monitored vitals	
5pm	plan to keep warm	5.20pm	provided warm care by covering 2 clothes.	
6pm	vaccination today.	6.20pm	vaccination done today.	
7pm	DBM + Burping every 203rd hly.	7.30pm	provided DBM + Burping every 203rd hly.	

Re-Assessment:

Special Notes:

Reassessment after 2 hr baby feeding well
as per orders.

Nurse Signature:

Nurse Name:

Soubharni

Date & Time:

27/7/26 @ 8pm

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Baby Of SANDHYA REDDY MALLADI
01-07-2026 0 Y 0 M 0 D 5 H (F)
Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 21/7/26

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
2pm	* Assess the baby condition	2:30 pm	* Assess the baby condition	* Baby is stable.
10pm	* plan to monitor vitals	10:20 pm	* monitor vitals stable.	
11pm	* plan to maintain I/O Chart.	11:30 pm	* maintain I/O chart	
6Am	* plan to warm care	6:40 Am	* provide warm care for baby.	
7Am	* plan to GRBS	7:20 Am	* I checked GRBS as per orders.	
8Am	* plan to feeding 2-3ml hourly.	8Am	* Given medication as per doctor orders.	

Re-Assessment:

provide warm for baby

Special Notes:

GRBS as per orders.

Nurse Signature:

Nurse Name: Seema

Date & Time: 31/7/26 @ 8Am

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
8pm	* Assess the baby condition	8:30 pm	* Assessed the baby condition, baby is stable.	* Baby is stable.
10pm	* plan to monitor vitals	10:20 pm	* monitor vitals stable.	
12Am	* plan to maintain I/O Chart.	12:30 Am	* maintain I/O Chart	
1Am	* plan to GRBS	1:40 Am	* I checked GRBS as per doctor order.	
2Am	* plan to warm care	2:20 Am	* provide warm care for baby.	
3Am	* plan to feeding 2-3ml hourly.	3Am	* Given feeding support 2-3ml hourly.	

Re-Assessment: provide warm care for baby.

Special Notes: NA

Nurse Signature: 

Nurse Name: Sierra

Date & Time: 4/7/26 @ 8Am

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Baby Of SANDHYA REDDY MALLADI
01-07-2026 0 Y 0 M 2 D (F)
Dr. VIJAYANAND JAMALPURI



NURSING CARE RECORD


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BirthRight
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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. Vijayanand Department: BC Date of Admission: 2/7/26

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known		If Yes Specify:		
BACKGROUND	Area							
	Shift Time	08:00 AM - 12:00 PM	12:00 PM - 02:00 PM	02:00 PM - 04:00 PM	04:00 PM - 08:00 PM	08:00 PM - 12:00 AM	12:00 AM - 02:00 AM	
ASSESSMENT	Medical Condition (Any special condition to be noted):							
		CRBS	NB	NB	NB	NB	NB	
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:	97.5°F	98.8°F	98°F	98.6°F	98.8°F	98°F
		Res:	40b/m	35b/m	40b/m	40	35b/m	40b/m
		SpO ₂ :	100%	100%	100%	97	100%	100%
		Pulse:	142	132b/m	131b/m	140	142b/m	130b/m
		BP:	-	-	-	-	-	-
	Fall Risk Score:	16	16	16	16	16	16	
Pain Score:	0	0	0	0	0/10	0		
Recommendations	Safety Needs:	Call m	yes	Call m	yes	yes	Crib care	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	CRBS monitoring	CRBS	CRBS	CRBS	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Pulley	Seema	Kalyani	Soubhami	Seema	Kalyani	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		2/7/26	2/7/26	2/7	2/7/26	3/7/26	3/7	
Time:		2pm	8am	2pm	8pm	8am	2pm	
Taken Over By Name :		Seema	Kalyani	Soubhami	Seema	Kalyani	Soubhami	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		2/7/26	2/7	2/7/26	2/7/26	2/7	3/7/26	
Time:		2:30 pm	8am	8pm	8am	8am	8pm	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. V.J Department: 3rd floor Date of Admission: 1/7/26

SITUATION	Diagnosis: <u>Newborn baby</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
	Area	Shift Time	<u>3rd floor 8AM</u>	<u>3rd floor 8AM</u>		
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NO</u>	<u>NK</u>		
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.8°F</u>	<u>98.2°F</u>		
		Res:	<u>39</u>	<u>40 bpm</u>		
		SpO ₂ :	<u>98%</u>	<u>100%</u>		
		Pulse:	<u>140</u>	<u>145 bpm</u>		
		BP:	<u>MA</u>	<u>NA</u>		
		Fall Risk Score:	<u>16</u>	<u>16</u>		
	Pain Score:		<u>0/10</u>	<u>0/10</u>		
	Recommendations	Safety Needs:		<u>yes</u>	<u>yes</u>	
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		<u>NA</u>	<u>NA</u>			
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>Saibhaskar</u>	<u>Seema</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>3/7/26</u>	<u>4/7/26</u>			
Time:		<u>8pm</u>	<u>8AM</u>			
Taken Over By Name :		<u>Seema</u>	<u>[Signature]</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>3/7/26</u>	<u>4/7</u>			
Time:		<u>8pm</u>	<u>20</u>			

BAH-00660442 IP5-00175840
 Baby Of SANDHYA REDDY MALLADI
 01-07-2026 0 Y 0 M 0 D 5 H (F)
 Dr. VIJAYANAND JAMALPURI



THE HUMPTY DUMPTY SCALE 2/7/24 4/2

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4		
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1	1	1		
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1		
Cognitive Impairments	Not aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4	4	4		
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3		3	3		
	Patient Placed in Bed	2					
	Outpatient Area	1	1				
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	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		
Total			13	15	15		

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		NO	NO	NO		
Call device within reach		NO	NO	NO		
Wheels Locked		YES	YES	YES		
Room free of clutter		YES	YES	YES		
Adequate lighting		YES	YES	YES		
Wheel chair support		NO	NO	NO		
Other Intervention(s) Specify		NO	NO	NO		
Nurse's Name:		Pdhu	Scmg	Scmg		
Signature:		[Signature]	[Signature]	[Signature]		
Date:		2/7/24	3/2	4/2		
Time:		8 AM	8 AM	8 AM		

BAH-00660442

IP5-00175840

Baby Of SANDHYA REDDY MALLADI

01-07-2026 0 Y 0 M 0 D 5 H (F)

Dr. VIJAYANAND JAMALPURI



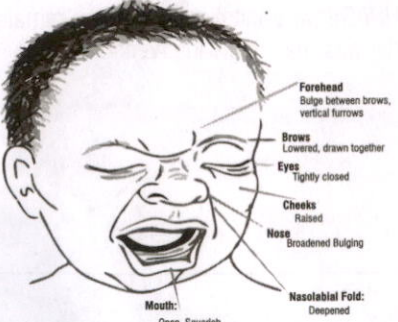
BRADEN 'Q' SCALE

					Date : 2/7/2026	Time : 8:00 AM	2/7/2026	8:00 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: extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	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	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	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	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2	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	
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	
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								
TOTAL SCORE					28	20	20	
Evaluator's Name					E	Suma	Suma	

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



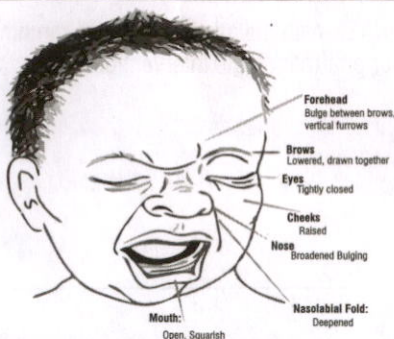
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

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	
						26/7/24	31/7	4/2						
						8 AM	8 AM	8 AM						
						NA	GRBS	GRBS						
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0	0	0						
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0						
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	0	0	0						
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0						
Vital Signs HR RR, BP, 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						
 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	36w	36w	36w					
						Total Pain / Agitation Score	0	0	0					
						Intervention	NA	NA	NA					
						Effectiveness	NA	NA	NA					
						Signature	Dede	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.

NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
						Procedure →							
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable								
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						Intervention							
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						Signature							

NPASS: Neonatal Pain, Agitation & Sedation Scale

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CONSENT FOR FORMULA FEEDS

Patient Name : Age : Gender : ☐ Male ☐ Female
UHID No : Department : Date :


I Mr / Mrs. : aged years, hereby declare that I have
admitted my ☐ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on
..... I hereby give consent for formula feed for my child. Doctors have explained me
about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature :
Name : Surekha Reddy
Relationship with Patient : husband
Date & Time : 3/7/26 @ 7:50pm

Witness :

Signature :
Name : Soubhagini
Date & Time : 3/7/26 @ 7:50pm

Doctor (who is taking the consent) :

Signature :
Name : DR. Sobila
Date & Time : 3/7/26 @ 7:50pm

BAH-00660442 IP5-00175840
 Baby Of SANDHYA REDDY MALLADI
 01-07-2026 0 Y 0 M 0 D 5 H (F)
 Dr. VIJAYANAND JAMALPURI



MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

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:
<i>16/7/20</i> <i>8 PM</i>	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<i>DBM</i>	<i>breathing</i>	<i>warm cover</i>	<i>[Signature]</i>	☐ 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:

BAH-00660442 IP5-00175840
Baby Of SANDHYA REDDY MALLADI
01-07-2026 0 Y 0 M 0 D 5 H (F)
Dr. VIJAYANAND JAMALPURI



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Patient's / Learner Language: 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		
17/7/20	8 pm	7	Infection Control measures	PT's	☒	1	1	—	0	e

Part - III: CODES

Who was taught:	PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)															
Learning Barriers:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)	3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	
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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:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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Understanding:	<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
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BAH-00660442 IP5-00175840
Baby Of SANDHYA REDDY MALLADI
01-07-2026 O Y O M O D S H (F)
Dr. VIJAYANAND JAMALPURI

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 11/7/20

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

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: Hand Hygiene

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

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 11/7/20 09:00

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NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Mother's Name:
Date of Birth: 1/7/26 Time of Birth: 6:21pm Gender: ☐ Male ☒ Female
Birth Weight: 2.05 kg Kgs HC: 33 cm Length: 49 cm
Meconium in Liquor: ☐ Yes ☒ No Cried at Birth: ☒ Yes ☐ No
Term / Pre-term / Post-term:
Resuscitated: ☐ Yes ☒ No Blood Group: Mother: O+ve Baby:
Feeding: ☒ Breast Feeding ☐ Formula ☐ Both First Feed Time: 6:45 PM

AFFIX MOTHER'S
IDENTIFICATION LABEL

Mode of Delivery: ☐ Normal ☒ LSCS - Emergency/ Elective ☐ Instrumental ☐ AVD
Indication:

Physical Assessment of New Born:

Temp: 36.5 °C HR: 142 /Min RR: 40 /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: Rudra

Signature: [Signature]

Date & Time: 1/7/26

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660442 IP5-00175840 Baby Of SANDHYA REDDY MALLADI 01-07-2026 0 Y 0 M 0 D 5 H (F) Dr. VIJAYANAND JAMALPURI 		Date & Time of Admission 1/7/26 @ 7:15 AM	Date & Time of Transfer Order 1/7/26 @ 2:00 PM
		Transfer Ordered by Dr. Rupanjali	Reason for Transfer Observation.
From Unit OB/S	To Unit ROOM (337)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	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 N/A			
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. Reddy		Name of Person Ordered Transfer Dr. Rupanjali	
Patient & Clinical Records Received by : Seema 1/7/26 @ 2:30 PM			
Date & Time of Patient Received :			

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. SANDHYA Baby's Name: Bla. SANDHYA Date of Birth: 11/7/26

Reason for consultation: Lactation counselling for mother

- 1. Baby's feeding now (ask all these points)**

Breastfeeds Yes Day Night

How often 2-2½ hr

Length of breastfeeds 15-20 min

Longest time between feeds 2-2½ hr (time mother away from baby)

One breast or both breasts Both

Complements (and water) } NO

What given

When started

How much

How is it given

Pacifier (Yes / NO) NO
- 2. Baby's health and behaviour (ask all these urine output (more/less than points))**

Birth weight 2.50 kg Weight now 2.438 kg Growth Twin

Premature Term

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

Formula samples given to the mother Yes / No

Postnatal help available for breastfeeding Yes / No

Breastfeeding discussed? Yes / No

Early contact (First - 1 hour) Yes / No

Time first breast feed (if not within 1st hour) Yes

How given
- 4. Mother's condition and family planning**

Age

Family planning method

Breast condition Normal

Motivation to breastfeed Yes

Alcohol, smoking, coffee, other drugs Yes / no
- 5. Previous infant feeding experience**

Number of previous babies

How many breastfeed

Any bottles used NO } G2

Experience good or bad

Reasons
- 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: Supreet Date & Time: 2/7/26

LACTATION ASSESSMENT FORM

Mother's details: Mrs. SANDHYA

Baby details: Mrs. SANDHYA

Delivery: Vaginal ☐ Cesarean ☒ Vacuum ☐ Forceps ☐ Gravida ☒ GA 36+6 weeks

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

BF previous baby: yes 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 / latchHold nipple in mouth	Grasps breast tongue downlips flanged Rythmical sucking	1					
AUDIBLE SWALLOWING	None	A few with stimulation	Spontaneous & Intermittent	1					
TYPE OF NIPPLE	Inverted	Flat	Everted (After stimulation)	2					
COMFORT	Engorged cracked Bleeding large Blisters bruises	Filling reddened small blisters / bruises	Soft Non tender	2					
HOLD	Full Assist	Minimal assist	No assist	0					
Total Score				6					
BABY WEIGHT CHART				FIRST FEED					
Date	<u>2/7/26</u>						Breast Feed	Top Feed	
Weight	<u>2.438kg</u>								

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: Supriya Signature: [Signature] Date & Time: 2/7/26 10:26

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

[illegible]

[illegible]