

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175839

Admit Date : 01-Jul-2026

Admit Time : 07:42 PM **UHID** : BAH-00660441

Patient Details :
Patient Name : Baby Of SANDHYA REDDY MALLADI TWIN 1

Age : 0 D

Guardian : Mr SURESH REDDY MALLADI

DOB : 01-07-2026 06:20 PM

Gender : Female

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO 3-182/1, PARIMALA COLONY
 Hanamkonda Warangal Telangana INDIA
 506001

Phone No : 9849680111/ 7337070207

E-mail : REDVANI@YAHOO.COM

Admission Details :
Bed Type : BASINET

Bed No : CRDL-SW-414-1

Ward Name : 4F-BIRTHING CENTRE

Room No : CRDL-SW-414-1

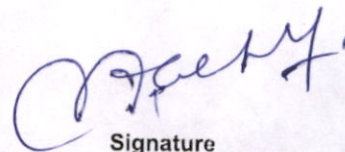
Admission Type : First Visit

Contact Details :
Name : Mr SURESH REDDY MALLADI

Relationship : Father

Contact Address : H NO 3-182/1, PARIMALA COLONY
 Hanamkonda Warangal Telangana INDIA 506001

Phone No : 9849680111 /


Signature
Doctor Details :
Doctor Name : Dr. VIJAYANAND JAMALPURI

Specialisation : NEONATOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

New Born Screening	: Anitha (Sis)
TFT	:
OAE	:
Mother's Blood Group	: O+ve
Baby's Blood Group	: O +ve
Anomaly Scan	:
Vaccination	BCG, OPV, Hep-B Given on 21/7/26 Kaveri/21/7/26

[illegible]

[illegible]

BAH-00660441
Baby Of SANDHYA REDDY MALLADI
01-07-2026
Dr. VIJAYANAND JAMALPURI
IP5-00175839
0 Y 0 M 0 D 5 H (F)

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Sandhya Reddy Age : 39 Father's Name : Age :

Date of Birth : Date of Admission : UHID No. :

NICU Consultant : Referring Consultant :

Transferring Unit : ☐ OT ☐ Labour Room ☐ ER ☐ Ward

Transported ? ☐ Yes ☐ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : B/o Sandhya, twin I Mother's Blood Group : O Positive
Gender : ☐ M ☒ F Blood Group : O+ve Birth Weight (gms) : 2.804 kgs Length (cms) : 48 cms
Date of Birth : 17/26 Time of Birth : 6:20 pm OFC (cms) : 34 cm
Place of Birth : RM: BH. Estimated Gesth Age : 36+6

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 39 Ht : Wt : BMI : Married Life : LMP : 14/10/25 EDD : 23/1/26

Conception : Spontaneous or with Rx :

Booked at what GA : 12+2 AN Steroids Drugs / Doses :

Last Scans Details : 10/6 : Twin I : 2020 grams / AC: 10; Dopplers: (N) / TIFFA: (N) / aplanic
(1st) AT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ < 18 yrs ☐ > 35 yrs

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 :

Gestational Hypertension.

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: (N))

H/o Hypothyroidism : when diagnosed ? Medication?

Any other Chronic Medical Problems, when detected
drugs ? T. Levetiracetam 100mg BD.

(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: L: 1

Sl. NO.	Age	GA wks	B. W	Gender	Significant	Details
1	2018		3.7kg	(m)	Em-LSCS	

PERINATAL HISTORY

Treating Obstetrician : Dr. Parthivisha Reddy Hospital : PCHRN ☒ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☒ Elective ☐ Emergency Indication :

Specify the reason : Prev-LSCS mCDA going

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL : (+)

Resuscitation : ☐ Yes ☐ No

Cord ABG : 7.283 / PO2 39 / R-E 7.6 / Bicarb 16.8

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	
2	2	
1	1	
8	8	

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



Equipment check done



Baby was received in a prewarmed linen



Dried / warmed / cleaned



cord cleaned / clamped and cut



Baby was noted to have R-D 1/F/O

Fast breathing / $\text{SpO}_2 \oplus$ / $\text{HR} \oplus$ → DR-CAP given for 10 mins



Im-vitamin K given 0.5ml IM



Baby was noted to have

2nd limbs decreased perfusion. } settled after warming

Investigation details in previous Hospital :

Feeding History :

BAH-00660441

IP5-00175839

Baby Of SANDHYA REDDY MALLADI

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

Dr. VIJAYANAND JAMALPURI



Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Euthermic Acrocyanotic

cl/ax good

hemodynamics are stable

VITALS : Temperature : Euthermic HR : 170/min RR : 52/n NIBP : CFT : 13

Color of the extremities : Acrocyanotic

Jaundice : Pallor : SpO2 : 96f

Anthropometry : Birth Weight : 2804 Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :

Fontanelles :

Sutures

Shape / Moulding :

Edema / Bruising :

Size - (H.C.) :

AT open

Facies :

(Any Facial
Dysmorphism)

— N —

NECK and

CLAVICLES :

Range of Motion :

Asymmetry :

Masses :

Nil

EYES :

Symmetry :

Red Reflex :

Discharge :

to be checked

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 :

— N —

ABDOMEN and

UMBILICUS :

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump :

Discharge :

2A + IV

GENITALIA :

Labia / Hymen :

Testicles/penis :

Anus :

N

HERNIAL ORIFICES

TRUNK and SPINE :

N

SKIN LESIONS :

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 : 44/min SCR / ICR / See - Saw breathing :

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

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

Settings :

Spo2 : 97 Auscultation : BATE+ Breath Sounds : NI Added Sounds :

Cardiovascular System :

HR : 170/min BP : Precordial Activity :

Femoral Pulses : all well felt Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernia orifice :

Palpation : Anal Patency : looks patent

Palpable masses : NI Umbilical Cord : 2A + 1V

Abdominal girth : First urine passed : ✓

Meconium passed : ✓

Nervous System : Higher intellectual functions (Sensorium) : NI

State of wakefulness : NI

Prechtle Score :

Nerves :

.....

.....

.....

Motor System :

Passive Tone : all relaxed

Active Tone : all relaxed

Neonatal Reflexes :

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

Moro's : Bilateral Symmetric DTR : NI

ATNR : NI Skull and Spine : NI



Diagnosis : SGTG / GPP1 / mCPA twin 1 / Breech / OIAB / Gestational hypertension /
Prev-LSCS - LSCS / 2804 grams.

FOOT PRINTS

Left Side :



Right Side :



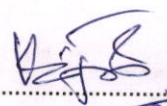
Resident Doctor :

Signature : 

Name : Dr. Venkatesh

Date & Time : 1/7/26

Consultant :

Signature : 

Name : Dr. Vijayanand Jamalpur

Date & Time : 1/7/26

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 :

1. Warm care

2. Cord Blood For — ABA /
Blood grouping

3. Vaccines $\frac{OPV}{BCG}$ / today,
Hep-B

Plan during ward follow up :

4. GBR / USS / D/E @ 18 hr

5. USG hip at end of life

6. monitor for ROP / feed
intolerance

Feeding Plan at the time of shifting :

6:55 to 7:05pm

7. LBS monitoring 30 mins post feed

1, 3, 6, 12, 24, 48, 72

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

8. To assess perfusion of
upper limb at night

BAH-00660441

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Baby Of SANDHYA REDDY MALLADI

01-07-2026

0 Y 0 M 0 D 5 H (F)

Dr. VIJAYANAND JAMALPURI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26	Seen by Resident	
	Late pt / 36 th / G2P1 / MCA Twin 1 / breech / GHW / 2804 gm 13 HOL	
	Wt → 2804 → 2698 106 gm → 3.7%.	Plan
	Baby on Room air	1. DBF every 2nd hourly flb Burping
	Hemodynamically stable	2. Trace baby blood group
	Cry } Good	3. GRRS monitoring as advised 24 HOL, 48 HOL
	Tone } Good	4. ☒ Vaccination BCG, OPV, Hepatitis B today
	Activity } Good	5. clinical assessment of jaundice @ 24 HOL
	Sucking: good	
	Euglycemic	
	Euthermic (last RBS → 59 mg/dL)	
	Peripheries: warm	6. NBS } SBR } @ 48 HOL OAC }
	passed urine & stool	
		7. USG hip @ 6 weeks of life
2/7/26	Seen by Dr. vijayanand	plan
10 AM		
	Hemodynamically stable	1. Regular feeding
	Euthermic	2. GRRS monitoring as planned by Sai
		3. Vaccination today
		4. USG hips @ 48 HOL



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/26 10:30am	<u>Lactation care plan:</u> - Well formed breast and nipples - areola seen - Suck good. <u>Advice:</u> - Direct breast feeding - Aim for deep latch as demonstrated. - Make baby back for 20-25 min. - Demand feeding not exceeding 2-2 1/2 hours	
2/7/26 4pm	2240L / 36 th / Late preterm Elective Uterine MCDA Tummy Baby on Room air vitals: stable Cry Tone } Good Activity } Sucking: Good CST: free Passed urine & stool Vaccine: done	<u>plan</u> 1. DRF 2nd hour 2. Warmth care 3. USG hip @ 6 weeks of life 4. Clinical Jaundice @ 4th hr 5. RRT monitoring as planned N/B sonication Sry Sai

Date & Time	Progress Notes	Doctor's Order
3/1/26 8:00am	CLB/B Resident.	Bwt : 2.80 kg . Today wt : 2.577kg. 8% wt loss
	38 HOL/36 ⁺⁶ Female) Breech Late PT/elective LSCS /mcDA twins .	
	Baby on room air - taking /latching properly. - feed adequate - stools & urine passed - Hemodynamically stable.	Plan ①-DBF 2hly ② warm care . ③ USG both hip @ 6 wks of life
	Euglycemic : GRBS @ 7:40am 50mg/dl .	(4) SBR } TBS } 4thrs of OAE } life (6pm .
	Euthermic: OIE	
	baby is alert & active vitals : Stable sucking : good CRT I < 3sec Passed stools & urine vaccine : done.	⑤ GRBS monitoring . <u>Sole</u>
		'DR. VIJAYANAND JAMALPURI' Registration No: 40526
		Noted by sis-kalyani 01634 at 2pm

Date & Time	Progress Notes	Doctor's Order
3/7 9Am	lactation care plan: - Suck good. - colostrum good. - counselled about importance of deep latch - counselled about expressing milk if required	
		<i>[Signature]</i> <u>Supervising</u>
3/7/26 2:30pm	<u>US/B Resident</u> 44 HOL/36 ⁺ / Late Preterm / LSCs / Fch / MCDA twins / breech Baby on room air - Taking breast milk GRBS → 49mg/dl	<u>Plan</u> ① DFF + Formula feed (20-25ml / Feed) ② warm case ③ USG both hips @ 6 weeks. ④ GRBS monitoring @ 5pm SBR } 6pm NBS } DAE → T/M
	V/V ✓ M/V ✓ D/E ✓ Activity } good cry } tone } Sucking clone	

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0 Y 0 M 0 D 5 H (F)



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 3:00pm	S/B Vijayanand	Plan.
4/7/26 7:30am	qs/B Resident S/B <u>Vjsir</u>	
	61 HOL 36+6 Late Preterm breech Fch USG MCDA twins	
	Baby on room air on breast milk + formula feed	Plan. SBR - 10.3 TCBR - 7.5
	B.Wt → 2.80kg T.Wt → 2.54kg GRBS - Singl dl Ga'm	① DBF to continue 2hly + 20ml Formula feed + 9% wt loss
	U/V M/V	② warm care ③ USG both hips @ Gwerles.
	M/O+ B/O+	④ OAE Today.
	Eutheemic - Pink Euglycemic	⑤ GRBS monitoring discharge today
	Activity } cry } good tone }	⑥ TUBR before soluh. NIC
	vitals Stable	PIU monday.
		DR. VIJAYANAND JAMALPURI Registration No: 40526

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[illegible]

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Doc. No. : RCH / FRM / CLINICAL / 124

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 1/7/25 Time: 7pm 10pm 6pm

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)

Sp. Rate (bpm)
per 1 Minute) *

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

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)

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Baby Of SANDHYA REDDY MALLADI
01-07-2026 0 Y 0 M 0 D 5 H (F)
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2/7/26
RCH / FRM / CLINICAL / 124

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

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EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time: 11am	5:30 PM	10:20 PM	6:00 AM	
Doctor/Nurse/Family Concern?					
Temperature (°F)	104				
	103				
	102				
	101				
	100				
	99	98.0°F			
	98		98.3°F		98.4°F
	97				
	96				
	95				
94					
Heart Rate (bpm)	190				
	180				
	170				
	160				
	150	146			
	140		140		
	130				
	120				
	110				
	100				
Resp. Rate (bpm) (Over 1 Minute) *	70				
	60				
	50				
	40				
	30				
	20				
	10				
	Resp Rate (Number)				
	42b/m				
	40				
32b/m					
38b/m					
Resp Mod/ Severe Distress None / Mild					
Receiving O ₂ (l/min)					
O ₂ Saturations (%)					
98%					
98%					
100%					
98%					
Conscious Level Normal / Altered					
GCS *					
15/15					
15/15					
15/15					
15/15					
TOTAL SCORE					
Number of shaded boxes					
Pain Score					
Observer's Initials					

ACTIONS NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
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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.
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3/7/26
RM / CLINICAL / 124

INFANT (<1 year)

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WARNING SCORE: CHILDREN'S UNIT

Date: Time: 12pm

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)
er 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-00660441 IP5-00175839
 Baby Of SANDHYA REDDY MALLADI
 01-07-2026 0 Y 0 M 0 D 5 H (F)
 Dr. VIJAYANAND JAMALPURI



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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.

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

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FLUID CHART

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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							
27/7/26	08:00 am											}
	09:00 am	DBF										
	10:00 am						NP			✓	NP	
	11:00 am									✓		
	12:00 pm	DBF								✓		
	01:00 pm											
Total Intake :						M 20 Total Output : 20 22						
	02:00 pm	DBF								✓		}
	03:00 pm									✓		
	04:00 pm										nm	
	05:00 pm	DBF					✓			✓		
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output : M - 10 - 2						
	08:00 pm	DBF										}
	09:00 pm									✓	NP	
	10:00 pm	DBF								✓	NP	
	11:00 pm						NP				NP	
	12:00 am	DBF								✓		
	01:00 am									✓		
Total Intake :						Total Output : M - 0 - 2						
	02:00 am											}
	03:00 am	DBF										
	04:00 am										NP	
	05:00 am	DBF					NP			✓	NP	
	06:00 am									✓		
	07:00 am	DBF										
Total Intake :						Total Output : M - 0 - 2						
Total 24 hrs. Intake												
Total 24 hrs. Output		M - 1 0 - 8										

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 01-07-2026 0 Y 0 M 0 D 5 H (F)
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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								
2/7/26	08:00 am											Kalyani	
	09:00 am	DBF							✓				
	10:00 am												
	11:00 am	DBF				NP			✓				
	12:00 pm								✓				
	01:00 pm	DBF											
Total Intake :					M=0 Total Output : U=2								
	02:00 pm	DBF										Soubha	
	03:00 pm	FF 12ml							✓				
	04:00 pm												
	05:00 pm	DBF				NP							
	06:00 pm	DBF							✓				
	07:00 pm	FF 15ml							✓				
Total Intake :					Total Output : M=0 U=2								
	08:00 pm											Soma	
	09:00 pm	DBF											
	10:00 pm	f.f. 15ml							✓				
	11:00 pm					NP							
	12:00 am	DBF f.f.							✓				
	01:00 am	15ml							✓				
Total Intake :					Total Output : M=0 U=2								
	02:00 am											Soma	
	03:00 am	DBF f.f. 15ml							✓				
	04:00 am												
	05:00 am	DBF											
	06:00 am								✓				
	07:00 am	f.f. 20ml							✓				
Total Intake :					Total Output : M=1 U=2								

Total 24 hrs. Intake

DBF f.f. 92ml

Total 24 hrs. Output

M=1 U=8

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Sheet No. :

1. All measurements in ml.
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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

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 1/7/26

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
7pm	→ Assess the general condition of the baby	9pm	→ Assessed general condition of the baby	→ Baby is calm and comfortable
8pm	→ monitor vitals	12am	→ monitored vitals and recorded.	
12am	→ DBF and Burping	2am	→ DBF and Burping done	
2am	→ CRBS monitoring	4am	→ CRBS monitoring done	
4am	→ Warm care	6am	→ Warm care done by swaddling	
6am	→ Ensure safety	8am	→ Ensured safety.	

Re-Assessment: Baby is latching and sucking well.

Special Notes: CRBS monitoring, vaccination

Nurse Signature: [Signature]

Nurse Name: Yamini

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

NURSING CARE RECORD

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

Re-Assessment:

After proper position, has good latching → sucking

Special Notes:

Vaccination today

Nurse Signature: [Signature]

Nurse Name: Kalpani

Date & Time: 2/7 4:30pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date:

Assessment: Newborn baby (Risk for hypoglycemia related to insufficient of feed)

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 patient condition	2pm	Assessed to the baby on sleep.	Baby well & active
2pm	Takeen teen 1/0 chart.	3:30 PM	Maintained. 1/0 chart.	
4pm	To monitor vitals.		Monitored vitals.	
5pm	Plan to give vaccination today	7:20 PM	Vaccination done today.	
6pm	Plan to keep warm.	5:18pm	Covered by 2 clothes for giving warm care.	
7pm	Dorm + Burping every 2 to 3rd hly	6:58pm	provided feeding every 2 to 3rd hly	
		7:38pm	Dorm + Burping	

Re-Assessment:

Special Notes: Reassessment after 2 hrs baby feeding well

.....

Nurse Signature: Nurse Name: Date & Time: 02/07/26 @ 8pm



NURSING CARE RECORD

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
8pm	* Assess the baby condition	8:30 pm	* Assessed the baby condition	* Baby is stable.
10pm	* plan to monitor vitals			
11pm	* plan to maintain	10:20 pm	* monitor vitals stable.	
	to chart.	11:40 pm	* maintain to chart	
6am	* plan to warm care	6:30 am	* provide warm care for baby.	
7am	* plan to GRBS	7:20 am	* D. checked GRBS as per doctor orders.	
8am	* plan to feeding 2-3rd hourly.	8am	* Given feeding support 2-3rd hourly	

Re-Assessment:

provide warm care for baby.

Special Notes:

GRBS as per orders.

Nurse Signature:

Nurse Name: Seema

Date & Time: 21/7/26 @ 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	10:30 pm	* monitor vitals stable.	
12Am	* plan to maintain I/O chart	12:40 Am	* maintain I/O chart	
6Am	* plan to GRBS	6:30 Am	* I checked GRBS as per doctor orders.	
2Am	* plan to warm care	7:20 Am	* provide warm care for baby.	
8Am	* plan to Feeding 2-3ml hourly.	8Am	* Given Feeding support 2-3ml hourly.	

Re-Assessment: provide warm care for baby.

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: Samra

Date & Time: 4/7/26 @ 2Am

BAH-00660441 IP5-00175839
Baby Of SANDHYA REDDY MALLADI
01-07-2026 0 Y 0 M 2 D (F)
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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:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. vijayanand Department: OBG Date of Admission: 1/7/26

SITUATION	Diagnosis: <u>Newborn baby</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area	Shift Time	08:00-12:00 <u>08:00-12:00</u>	12:00-02:00 <u>12:00-02:00</u>	02:00-04:00 <u>02:00-04:00</u>	04:00-08:00 <u>04:00-08:00</u>	08:00-12:00 <u>08:00-12:00</u>	
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NB</u>	<u>NB</u>	<u>NB</u>	<u>NB</u>	
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.0°F</u>	<u>98.2°F</u>	<u>98.0°F</u>	<u>98.5°F</u>	<u>98.2°F</u>	<u>98°F</u>
		Res:	<u>40b/m</u>	<u>37b/m</u>	<u>42b/m</u>	<u>40</u>	<u>35b/m</u>	<u>40b/m</u>
		SpO ₂ :	<u>100%</u>	<u>98%</u>	<u>98%</u>	<u>98%</u>	<u>100%</u>	<u>100%</u>
		Pulse:	<u>138b/m</u>	<u>132b/m</u>	<u>146b/m</u>	<u>140</u>	<u>138b/m</u>	<u>131b/m</u>
		BP:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Fall Risk Score:	<u>15</u>	<u>16</u>	<u>18</u>	<u>16</u>	<u>16</u>	<u>16</u>	
Pain Score:	<u>0</u>	<u>0/10</u>	<u>0</u>	<u>0</u>	<u>0/10</u>	<u>0</u>		
Recommendations	Safety Needs:	<u>side rail</u>	<u>yes</u>	<u>Cost case</u>	<u>yes</u>	<u>yes</u>	<u>Cost case</u>	
	Physiotherapy		☐ 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	
	Other Special Orders / Medications:	<u>CRBS monitoring</u>	<u>CRBS monitoring</u>	<u>CRBS</u>	<u>CRBS</u>	<u>CRBS</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Radha</u>	<u>Seema</u>	<u>Kalyani</u>	<u>Soubhami</u>	<u>Seema</u>	<u>Kalyani</u>	
Signature :		<u>Radha</u>	<u>Seema</u>	<u>Kalyani</u>	<u>Soubhami</u>	<u>Seema</u>	<u>Kalyani</u>	
Date:		<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7</u>	
Time:		<u>2pm</u>	<u>8am</u>	<u>3pm</u>	<u>8pm</u>	<u>8am</u>	<u>3pm</u>	
Taken Over By Name :		<u>Seema</u>	<u>Kalyani</u>	<u>Soubhami</u>	<u>Seema</u>	<u>Kalyani</u>	<u>Soubhami</u>	
Signature :		<u>Seema</u>	<u>Kalyani</u>	<u>Soubhami</u>	<u>Seema</u>	<u>Kalyani</u>	<u>Soubhami</u>	
Date:		<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7/26</u>	<u>2/7</u>	<u>2/7/26</u>	
Time:		<u>2:30 am</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	



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					
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>3rd Floor 8pm</u> <u>NB</u>	<u>3rd Floor 8am</u> <u>NB</u>				
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98°F</u>	<u>98.2°F</u>			
		Res:	<u>39</u>	<u>40b/m</u>			
		SpO ₂ :	<u>98</u>	<u>100%</u>			
		Pulse:	<u>110</u>	<u>130b/m</u>			
		BP:	<u>NA</u>	<u>NA</u>			
		Fall Risk Score:	<u>16</u>	<u>16</u>			
	Pain Score:	<u>0</u>	<u>0/10</u>				
	Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>			
Physiotherapy		☐ Yes ☒ No	☐ 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	☐ 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>Soubhasini</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>Blush</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>				

THE HUMPTY DUMPTY SCALE ^{2/26 3/2 4/2}

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4 pm				
	3 to less than 7 years old	3	4	4	4		
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	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	1	1	1		
Cognitive Impairments	Not aware of Limitations	3	1	1	1		
	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	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	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			16	16	16		

Intervention:

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		X	No	No		
Call device within reach		X	No	No		
Wheels Locked		✓	Yes	Yes		
Room free of clutter		✓	Yes	Yes		
Adequate lighting		✓	Yes	Yes		
Wheel chair support		X	No	No		
Other Intervention(s) Specify		X	No	No		
Nurse's Name:		Jasmine Viret Coomes				
Signature:		[Signature]				
Date:		2/7/26 3/2/26 4/2				
Time:		8 pm 8 am 8 am				

BAH-00660441 IP5-00175839
Baby Of SANDHYA REDDY MALLADI
01-07-2026 0 Y 0 M 0 D 5 H (F)
Dr. VIJAYANAND JAMALPURI



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
						21/7/26	3/7	1/7					
						8pm	8pm	8am					
						Procedure → 4RR (GRS) -							
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	36 ⁺ 6 wks	36 ¹ 6 weeks	36 ¹ 6 weeks				
	Total Pain / Agitation Score	0	0	0									
	Intervention	0	0	0									
	Effectiveness	NA	NA	NA									
	Signature	Yannu Selma Selma											

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.



BRADEN 'Q' SCALE

					Date :	21/7/20	21/7/20	9/7	
					Time :	8pm	10am	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.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	1	2	2		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1	1		
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.	4	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.	4	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."	4	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.	3	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.	3	4	4		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23									
					TOTAL SCORE	20	20	20	
					Evaluator's Name	Name of the evaluator			

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
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Patient ID

BRADEN 'Q' SCALE

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					Time :				
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Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name				

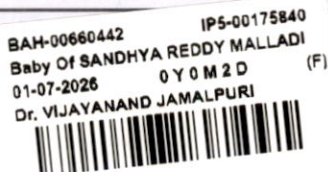
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CONSENT FOR FORMULA FEEDS

Patient Name :

UHID No :

I Mr / Mrs. :



Age : Gender : ☐ Male ☐ Female

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 :

Relationship with Patient :

Date & Time :

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature :

Name :

Date & Time :

BAH-00660441 IP5-00175839
 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 ~~cases~~

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:
1/2/26 @ 9pm	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	→ Warm Care → direct breast feed.	→ To reduce hypothermia	→ DBF and Burping done → swaddling done	Yamini	☐ 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:
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BAH-00660441 IP5-00175839
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

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
1/7/26	9pm	10	fall risk education	M	1	0	1	1	-	Radha

Part - III: CODES

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

Nationality: INDIAN

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

1. Anticipated Date of Discharge: 4/7/26

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

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:

Hand hygiene

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

☐ Patient

☒ Family Member

☐ Others:

Nurse Signature: Radhya

Nurse Name: Radhya

Date and Time: 4/7/26 @ 9pm

NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/g: Sandhya Reddy Mother's Name: Mrs. Sandhya Reddy
Date of Birth: 17/25 Time of Birth: 6:20pm Gender: ☐ Male ☒ Female
Birth Weight: 2.804 Kgs HC: 34 cm Length: 48 cm
Meconium in Liquor: ☐ Yes ☒ No Cried at Birth: ☒ Yes ☐ No
Term / Pre-term / Post-term: Preterm
Resuscitated: ☐ Yes ☒ No Blood Group: Mother: Baby:
Feeding: ☒ Breast Feeding ☐ Formula ☐ Both First Feed Time:

AFFIX MOTHER'S
IDENTIFICATION LABEL

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

Indication:

Physical Assessment of New Born:

Temp: 97.9 °C HR: 140 /Min RR: 40 /Min BP: SpO₂: 100 %
Pain Score: 15 (Follow N Pass)

Fall Risk Assessment: ☒ Yes ☐ No Score: 15 (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

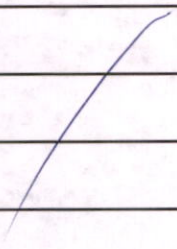
Newborn Screening Discussed: Yes / No

Nurse Name: Radhika

Signature: Radhika

Date & Time: 17/26 @ 9pm

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00660441 IP5-00175839 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 @ 7:14 PM	Date & Time of Transfer Order 2/7/26 @ 2:30 PM
		Transfer Ordered by Dr. Rajanjali	Reason for Transfer Observation
From Unit OBS	To Unit Room (337)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?	
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. Radhu		Name of Person Ordered Transfer Dr. Rajanjali	
Patient & Clinical Records Received by :		Seema 2/7/26 @ 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