

ADMISSION SHEET

Registration Details :



Admission No : IP5-00173594 Admit Date : 09-May-2026 Admit Time : 09:37 AM UHID : BAH-00655840

Patient Details :

Patient Name	: Baby Of SHREYA REDDY	Age	: 0 D
Guardian	: Mr MAHENDRA REDDY	DOB	: 09-05-2026 09:35 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: Eternal songs of earth Jubilee Hills Hyderabad Jubilee Hills Hyderabad Telangana INDIA 500033	Phone No	: 9010432686/
		E-mail	: dr.shreyareddy@gmail.com

Admission Details :

Bed Type	: BASINET	Bed No	: CRDL-SUITE424-1	Ward Name	: 4F-BIRTHRIGHT PREMIUM
Room No	: CRDL-SUITE424-1	Admission Type	: First Visit		

Contact Details :

Name	: Mr MAHENDRA REDDY	Relationship	: Father
Contact Address	: Eternal songs of earth Jubilee Hills Hyderabad Jubilee Hills Hyderabad Telangana INDIA 500033	Phone No	: 9010432686

Signature

Doctor Details :

Doctor Name	: Dr. DINESH KUMAR CHIRLA	Specialisation	: NEONATOLOGY
Referral Doctor	: SELF	Phone No	:
Co-Consultant	:		

Payment Details :

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

3AH-00655840 IP5-00173594
 3aby Of SHREYA REDDY
 19-05-2026 OYOMODOH (M)
 Jr. DINESH KUMAR CHIRLA

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Age : Father's Name : Age :
 Date of Birth : Date of Admission : UHID No. :
 NICU Consultant : Referring Consultant :
 Transferring Unit : OT Labour Room ER Ward
 Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : B/O Shreya Reddy Mother's Blood Group : A - negative
 Gender : M F Blood Group : Birth Weight (gms) : 3.419 Length (cms) : 50cm
 Date of Birth : 9/5/26 Time of Birth : 8:33 AM OFC (cms) : 3Hcm
 Place of Birth : Rel-B Estimated Gesth Age : 39+4w

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 31yrs Ht : Wt : BMI : Married Life : LMP : EDD :
 Conception : Spontaneous or with Rx : IUI Conception
 Booked at what GA : @ 11+6w AN Steroids Drugs / Doses :
 Last Scans Details : 37+4 [cephalic] 3145 (SD :) AL - 59 / Doppler - (N)
 TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

<p>Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs Consanguinity : <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 H/o PIH (after 20 weeks) / PE How many Drugs / Doses / Since how long : H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : IUGR - when detected : Doppler (Increased Resistance / ADEF / REDF / Redistribution in MCA) / Ductus Venosus : AFI : <u>17.9cm</u></p>	<p>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 (<input type="checkbox"/> Malaria <input type="checkbox"/> UTI <input type="checkbox"/> TORCH <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> HBV) UTI : when : Any culture : <u>multitype</u> <u>phospho</u></p>
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PPROM: Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

P: A: L:

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

PERINATAL HISTORY

Treating Obstetrician : Dr. Pranathi Reddy Hospital : SKH-B Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig)</p> <p>Second stage (> 2 hours after dilation)</p> <p>LSCS : <input checked="" type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</p> <p>Specify the reason :</p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL :</p> <p>Resuscitation : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cord ABG :</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :</p>
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NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

1 Minute	5 Minutes	10 Minutes
1	1	
2	2	
2	2	
2	2	
2	2	
<u>9/10</u>	<u>9/10</u>	

TOTAL

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

Snapee II Score

	> 30 (0)	20-29 (9)	< 20 (19)	Score
Mean BP (mmHg)	> 30 (0)	20-29 (9)	< 20 (19)	
Lowest Temp (oF)	> 96 (0)	96-95 (8)	< 95 (15)	
Pao2 / Fio2 (mmHg%)	> 2.49 (0)	1-2.49 (5)	0.3-0.99 (15)	< 0.3 (28)
Lowest Serum PH	> = 7.2 (0)	7.1-7.19 (7)	< 7.1 (16)	
Multiple Seizures	No (0)	Yes (19)		
U. Output (ml / kg / hr)	> = 1 (0)	0.1-0.9 (5)	< 0.1 (18)	
Apgar Score	> = 7 (0)	< 7 (18)		
Birth Weight	> = 1kg (0)	750 - 999 (10)	< 750 (17)	
SGA	> 3rd percentile (0)	< 3rd (12)		
Total				

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints : ...



Telur
toce - (N)
cying



initial steps done
ing vit k gives



HR - 140 bpm

SpO₂ - 99.1%

respiration - regular



shift to another side

Investigation details in previous Hospital :

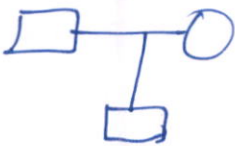
- nil -

Feeding History :

- nil -

-w1-

Family History :



Socio Economic History :

upper-class

GENERAL EXAMINATION ON ADMISSION

General Disposition :

vigorous

VITALS : Temperature : 36.5°F HR : 140 bpm RR : NIBP : CFT :
 Color of the extremities : acrocyanosis
 Jaundice : nr Pallor : nil SpO2 : 98%

ANTHROPOMETRY: Birth Weight : 3.419 Length : HC : Present Weight :
 Ponderal Index : AGA : SGA : LGA :



①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/5/26	Seen by Dr. Dinesh Sir.	
10:40 AM	2 H02 39+4 Rh negative preg EL-25CS 3-419Kg (AGA) GDM (Ipm) on diet	Plani-
		- Continue direct breast feeding
	Bt. wt - 3.419Kg	flb burping every 2-3hrly
M/A ^{-ve}		- Warmth care
B/		- GRBS monitoring 0, 3, 6, 9, 12, 24, 48 H0L.
O/EI-	Baby - eutermic pink	- Trace blood group, DCT, Retic
	C/T/A - good	Count, Cord Hb, cord bilirubin
	Hemodynamically stable	Peripheral smear.
	Peripherals warm	- BCG ?
	AF - at level.	Opv HepB } Today
		- SBR ?
		NBS } 48 H0L
		OATC }
		- Clinical assessment of Jaundice
		@ 12 H0L, 24 H0L.
		- Monitor for distress, feeding
		difficulties
		- Monitor vitals and Inform sos.
		Bhalerao
		NB Suresh



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/5/26	Seen by Resident	
3:45 PM	7 HOL / 39+4 / Rh neg. pregnancy / el. LSCS / 3.419 Kg (AGA) /	GDM on diet (Iam)
	Bt. wt - 3.419 Kg	Plan -
		- Continue DBF HB
M	A	burping every 2-3 hrsly
B	O+	- wear mth care
	cord bilirubin - 1.6 ^{0.1} / 1.5	- GRBS monitoring 9, 12, 24, 36, 48 HOL.
	cord CBPI -	- Trace DLT, baby blood group.
	Hb - 15.6	- BCG
	PCV - 47.5	- OPV
	PLT - 320	- Hep B } Today
	DCT - negative	- Clinical assessment
	OLET	- of Jaundice @ 12, 24 HOL
	Baby - euthermic, pink	- Monitor for distress,
	CLTA - Good	feeding difficulties
	Hemodynamically stable	- Monitor & Inform SAs.
	Peripheries - warm	
9/5/26	Lentation note	Shreya
9/5/26	mother motivated to feed,	
9/5/26	but uncomfortable with pain.	
9/5/26	DBF suggested by Dr. Shan.	
9/5/26	monthly urine output	
9/5/26	of the baby.	
9/5/26	Shreya Prabh	

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 Baby Of SHREYA REDDY
 19-05-2026 0 Y 0 M 0 D 15 H (M)
 Jr. DINESH KUMAR CHIRLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/5/26	Seen by Resident	
8:20 AM	24 HOL 39+4 Rh neg pregnancy EL-LSIS 3.419 kg (AGA)	GDM on diet
		Plan:
	Bt. wt - 3.419 kg	
M/A B/O+	Today, wt - 3.315 kg 104g (↓ 3%)	- Continue DBF f/b burping every 2-3 hourly
	urine - 4 times	- GRBS monitoring 24, 36, 48 HOL
	motion - 4 times	- Clinical assessment of jaundice @ 24 HOL
		- Monitor for distress, feeding difficulties
		- Monitor & Inform SOS
		- SBR } NBS } @ 48 HOL. OAE }
10/5/26		<u>Breath</u>
9:35 AM	Seen by Dr. Dinesh	
		- TCBR @ 36 HOL
		- SBR } NBS } 48 HOL OAE }
	not by resident	
11/5/26	Seen by Resident	
1 AM	TCBR - 10.5 @ 36 HOL	- Start SSPT eyes and genitalia covered
		- measured feeds as advised.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/5/26	Seen by Resident	
8:00 AM	47 HOL/39+4 Rh neg pregnancy ELUSLS 3.419 kg (AUA)	GDM on diet
	Bt.wt - 3.419 kg	Plan -
	Today.wt - 3.195 kg	- Continue SSPT & eyes
	224 (↓6.5%)	and genitalia covered.
M/A	urine	- GRBS monitoring 48 HOL
B/O	motion } Passed.	- Measured feeds (EBM+FF)
	↓ SSPT since 1 AM	30ml q 2hrly (CO)
		45-50 ml q 3hrly.
		- R/N SBR
		NBS
		OAE
		- check Today's weight
		Shreya
	Seen by Dr Dinesh	
11/5/26		- SBR
9:30 am		NBS } today
		OAE }
		Trace - (R)
		- R/O / discharge after staples.
		- Continue photokere
		- No more sugar pg
		monitoring

Noted by *Srinavare*

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 Baby Of SHREYA REDDY
 19-05-2026 0 Y 0 M 1 D (M)
 Jr. DINESH KUMAR CHIRLA



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		11/5/26
		OAE - New born hearing screening Bilateral responses are present Bilateral Pass
		<i>[Signature]</i> 11/5/26
		Afternoon Rounds
11/5/26	Seen by Resident	
2:30 PM	54 HOL 39+4 Rh. neg prog. E.L.SCS 3-4 9 Kg (AGA) GDM on diet	
		Plan:-
	SBR @ 52 HOL - 9-1	- Continue SSPT in eyes and genitalia covered.
	2 SSPT since 1 AM	- Measured feeds (EBM + FF)
M A ⁻	Urine } passed. Stools }	30 ml 9 2hrly (ox)
B O ⁺		45-50ml 2 3hrly
		- Monitor vitals & Inform SOS
		<i>[Signature]</i>
11/5/26		Evening rounds
4:10 PM		Plan:-
		- Stop SSPT
	SBR @ 52 HOL - 9-1	- Continue regular feeding
M A ⁻		- Monitor vitals & Inform
B O ⁺		SOS.
		<i>[Signature]</i>

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 Baby of SHREYA REDDY
 19-05-2026 0 Y 0 M 1 D (M)
 Dr. DINESH KUMAR CHIRLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/05/26 8pm	Lactation advice mother motivated to feed, DF every 2 hours. Adrenaline between hand expression and DF in use of coated nipple and mother in pain. Nipple shield suggested. <u>Shreya Prosthesis</u>	
11/05/26 11:00pm		<u>Adv</u>
	<ul style="list-style-type: none"> - Baby is sleeping comfortably - Feeding well - Eutermic 	<ul style="list-style-type: none"> - continue DF feeding as advised - w/f vitals & infant soS
		Ratju

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 Baby Of SHREYA REDDY
 19-05-2026 0 Y 0 M 1 D (M)
 Jr. DINESH KUMAR CHIRLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/5/26	Seen by Resident	
7:55 AM	72 HOL / 39+4 / Rh. negative pregnancy / EL. LSCS / 3-419 kg (ANA)	60M on diet
	Bt. wt - 3419 g	Plan -
	Today. wt - 3-206 kg	- Continue direct breast feeding
	Yest. wt - 3-195 kg } ↑ 11gms	flb adequate burping
MA-		every 2-3 hly. + SOS FF.
B/O+	Urine - 7 times	- Warmth care
	Stools - 5 times	- Monitor vitals and
		Inform SOS.
		Bharath
12/5/26.	<u>Lactation notes</u>	
12/5/26	Lactation Counseling done	
	position shown practically	
	Cohesion as seen	
	Baby is latching well.	
	feed adequate with	
	deeps later more	
	shall 25-min each	
	side (Adv) 100%	

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 Baby Of SHREYA REDDY
 19-05-2026 0 Y 0 M 1 D (M)
 Dr. DINESH KUMAR CHIRLA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		Seen by <u>Dr. Peatyun</u>
		→ Discharge today Thu Thursday
		- <u>Propitil</u>
12/5/26	Seen by Resident	
2:45PM	78 H/L 39+4 Rh negative E-LSIS 3.419 kg (AGA) GDM on diet	
		Plan:-
M/A ⁻	Urine ?	- Continue DBF #1b
B/O ⁺	Stools } Passed	adequate burping every 2-3 hrsly
	Euthermic, pink	- Warmth care
	Hemodynamically stable	- Monitor vitals and Inform SOS.
	C/T/A - Good.	
		<u>Bhelath</u>

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 baby Of SHREYA REDDY
 19-05-2026 0 Y 0 M 0 D 15 H (M)
 Dr. DINESH KUMAR CHIRLA



RESULT SHEET

Date	9/5/26	11/5/26			
Time	10:01AM				
Hb	15.6				
PCV	47.5				
RBC	4.51				
WBC	11.72				
N/L	59/31				
Platelets	320				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj	1.6	<0.1 1.5	9.15	<0.1 9.0	
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones				2		
CUE - PUS Cells				2/1		
CUE - RBC Cells				0		
CUE						
				1		
				5		
				11		
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
DCT	Negative					
Reticulocyte count	3.6					

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :

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Baby Of SHREYA REDDY
19-05-2026 0 Y 0 M 0 D 0 H (M)
Jr. DINESH KUMAR CHIRLA



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name:

Mother's Name: B/o. Shreya Reddy

Date of Birth: 9/5/26

Time of Birth: 8:33 AM

Gender: Male Female

Birth Weight: 3.419 Kgs

HC: 34 cm

Length: 50 cm

Meconium in Liquor: Yes No

Cried at Birth: Yes No

Term / Pre-term / Post-term:

Resuscitated: Yes No

Blood Group: Mother: A - ve Baby:

Feeding: Breast Feeding Formula Both

First Feed Time:

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Jr. SHREYA REDDY
17-10-1994 31 Y 6 M 13 D (F)
Jr. PRANATHI REDDY A



Mode of Delivery: Normal LSCS - Emergency/ Elective Instru..... AVD

Indication: NA

Physical Assessment of New Born:

Temp: 98.0 °C HR: 140 /Min RR: 44 /Min BP: - SpO₂: 100%

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: Yes No Score: 16 (Fill the Humpty Dumpty Sheet)

Risk in Pressure Sore: Yes No (Braden Q Score) (Fill the Braden Q Sheet)

Behaviour Status on admission: Sleeping Crying Calm Drowsy

Findings:

General Appearance: Posture: Well-Flexed Asymmetry

Skin: Pink Meconium Stain Others, Specify:

Nursing Management: (Please strike through if not applicable e.g. Yes / ~~No~~)

Vitamin K 1 mg I.M. Administered: Yes / No

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

All information obtained from Mother Father Other Family Member

Newborn Screening Discussed: Yes / No

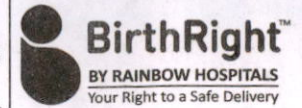
Nurse Name: [Signature]

Signature: [Signature]

Date & Time: 9/5/26 @ 10:00

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

IAH-00655840 IP5-00173594
 Dr. SHREYA REDDY
 19 26 0 Y 0 M 0 D 0 H (M)
 Dr. DINESH KUMAR CHIRLA



Part - I,

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		
9/5/20	9AM	7	Infection Control Measures	M, F	1	0	1	1	-	Ⓢ

Part - III : CODES

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 9/5/26 Time: 10pm 2pm 6pm 10pm 2Am 6am

Doctor/Nurse/Family Concern?

Temperature (F)	104								
	103								
	102								
	101								
	100								
	99								
	98								
	97								
	96								
	95								
94									

Heart Rate (bpm) and Blood Pressure (mmHg) *	190								
	180								
	170								
	160								
	150								
	140								
	130								
	120								
	110								
	100								

Heart Rate (Number) 142bpm 140bpm 144bpm 140bpm 138bpm 149bpm

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

Resp Rate (Number) 44bpm 40bpm 40bpm 42bpm 40bpm 45bpm

Resp Mod/ Severe Distress None / Mild

Receiving O₂(l/min) O₂Saturations (%) 100% 100% 99% 98% 100% 99%

Conscious Level Normal / Altered

GCS * 14/15 15 14/15 15/15 14/15 15/15

TOTAL SCORE						
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	<u>DC</u>	<u>DC</u>	<u>DC</u>	<u>DC</u>	<u>DC</u>	<u>DC</u>

ACTIONS
 Score 1 : Continue normal observation by staff nurse
 Score 2 : Shift in charge nurse to be informed and continue hourly observations
 Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
 Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
 Score 5 & 6 : Shift 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 is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

IAH-00655840 IP5-00173594
 Baby Of SHREYA REDDY
 19-05-2026 0 Y 0 M 0 D 15 H (M)
 Jr. DINESH KUMAR CHIRLA



JHBH / FRM / CLINICAL / 124

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

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	10	2	6	12on	6on	
Doctor/Nurse/Family Concern?		Am	pm	pm			
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99						
	98						
	97	97.3	97.5	97.6	97.2	97.6	
	96						
	95						
	94						
Heart Rate (bpm) and Blood Pressure (mmHg) *	190						
	180						
	170						
	160						
	150						
	140		*				
	130	*		*	135	140	
	120						
	110						
	100						
	90						
80							
70							
60							
50							
Note: BP does not score in early warning scoring							
Heart Rate (Number)		130mt	140mt	135mt	135	140	
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40	*	*	*	37	40	
	30						
	20						
	10						
	Resp Rate (Number)		40	41	40	37	40
	Resp Distress	Mod/ Severe None / Mild	✓	✓	✓		
	Receiving O ₂ (l/min)						
	O ₂ Saturations (%)		100%	98%	100%	99%	99%
Conscious Level	Normal / Altered	✓	✓	✓			
GCS *		15/15	15/15	15/15			
TOTAL SCORE							
Number of shaded boxes		0	0	0	0	0	
Pain Score		0	0	0	0	0	
Observer's Initials		msw	msw	msw	msw	msw	

ACTIONS

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
- Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

NB: Scores 3 should be recorded overleaf

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

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 11/5/26 Time: 10am 2pm 6pm 6am
 Doctor/Nurse/Family Concern? _____

Temperature (F)	104			
	103			
	102			
	101			
	100			
	99			
	98	<u>97.8</u>	<u>98.0</u>	<u>98</u>
	97			
	96			
	94			

Heart Rate (bpm)	190			
	180			
	170			
	160			
	150			
	140			
	130	<u>139</u>		
	120			
	110			
	100			

Heart Rate (Number) 140b/m 140b/m 140b/m 139

Resp. Rate (bpm) (Over 1 Minute) *	70			
	60			
	50			
	40	<u>40</u>	<u>40</u>	
	30			
	20			
	10			

Resp Rate (Number) 40b/m 40b/m 40b/m 42

Resp Distress	Mod/ Severe None / Mild	<u>N</u>	<u>N</u>	<u>N</u>
Receiving O ₂ (l/min)	O ₂ Saturations (%)	<u>100%</u>	<u>99%</u>	<u>100%</u>

Conscious Level	Normal / Altered	<u>13/15</u>	<u>13/15</u>	<u>13/15</u>
-----------------	------------------	--------------	--------------	--------------

TOTAL SCORE				
Number of shaded boxes	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Pain Score	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Observer's Initials	<u>A</u>	<u>A</u>	<u>A</u>	<u>A</u>

ACTIONS	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
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3AH-00655840 IP5-00173594
 Baby Of SHREYA REDDY
 19-05-2026 0 Y 0 M 1 D (M)
 Dr. DINESH KUMAR CHIRLA



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

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

Pratiksha
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 It takes a lot to treat the little.

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 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 12/5 Time: 10am 2 6 Day

Doctor/Nurse/Family Concern? PM PM PM

Temperature (°F)	104				
	103				
	102				
	101				
	100				
	99	<u>98.5</u>			
	98		<u>98.5</u>	<u>98.5</u>	<u>99.2</u>
	97				
	96				
	95				
	94				

Heart Rate (bpm) and Blood Pressure (mmHg) *	190				
	180				
	170				
	160				
	150				
	140	<u>*</u>			
	130				<u>130</u>
	120				
	110				
	100				
	90				

Heart Rate (Number) 141bpm 142bpm 140bpm 130

Resp. Rate (bpm) (Over 1 Minute) *	70				
	60				
	50				
	40	<u>*</u>			<u>30</u>
	30				
	20				
	10				
	Resp Rate (Number)	<u>40bpm</u>	<u>42bpm</u>	<u>40bpm</u>	<u>30</u>

Resp Mod/ Severe Distress None / Mild

Receiving O₂(l/min) O₂Saturations (%) 98% 100% 99% 99%

Conscious Level Normal / Altered

GCS * 13/15 14/15 15/15 14/15

TOTAL SCORE				
Number of shaded boxes				
Pain Score	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Observer's Initials	<u>CA</u>	<u>A</u>	<u>A</u>	<u>A</u>

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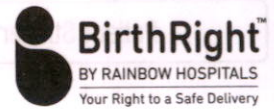
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3AH-00655840 IP5-00173594
 Baby Of SHREYA REDDY
 19-05-2026 0 Y 0 M 0 D 0 H (M)
 Dr. DINESH KUMAR CHIRLA



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 Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
9/5	08:00 am												
	09:00 am	DBF										No IV	Surtho
	10:00 am						NP						
	11:00 am	DBF								✓			
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm	DBF								✓			
	03:00 pm	DBF											
	04:00 pm											No IV	Surtho
	05:00 pm												
	06:00 pm	DBF					✓						
	07:00 pm	DBF											
Total Intake : Taken						Total Output : Passed							
	08:00 pm												
	09:00 pm	DBF											No diet
	10:00 pm						✓						
	11:00 pm	DBF								✓		IV	diet
	12:00 am												diet
	01:00 am												diet
Total Intake : Taken						Total Output : U-1 M-1							
	02:00 am	DBF					✓						diet
	03:00 am	DBF											diet
	04:00 am											No	diet
	05:00 am											IV	diet
	06:00 am	DBF					✓			✓			diet
	07:00 am												diet
Total Intake : Taken						Total Output : U-1 M-2							
Total 24 hrs. Intake			Taken			Total 24 hrs. Output			U-4 M-4				



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
10/5/26	08:00 am						✓					Ashwin
	09:00 am											
	10:00 am	DBF					✓		✓	NO IV		
	11:00 am	DBF										
	12:00 pm											
	01:00 pm											
	Total Intake :						Total Output :					
10/5/26	02:00 pm											Ashwin
	03:00 pm	DBF										
	04:00 pm											
	05:00 pm											
	06:00 pm	DBF					✓		✓			
	07:00 pm											
	Total Intake : Taken						Total Output : Passed					
10/5/26	08:00 pm	DBF										Ashwin
	09:00 pm											
	10:00 pm											
	11:00 pm	DBM							✓	NO IV		
	12:00 am											
	01:00 am											
	Total Intake : Taken						Total Output : 0-1 M-0					
10/5/26	02:00 am						✓		✓			Ashwin
	03:00 am											
	04:00 am	DBF										
	05:00 am	DBM					✓		✓	NO IV		
	06:00 am											
	07:00 am											
	Total Intake : Taken						Total Output : 0-2 M-2					
Total 24 hrs. Intake						Total 24 hrs. Output						

3AH-00655840 IP5-00173594
 Baby Of SHREYA REDDY
 19-05-2026 0 Y 0 M 1 D (M)
 Jr. DINESH KUMAR CHIRLA



FLUID CHART

Sheet No. : ③

- 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							
11/5/26	08:00 am									NO IV	Yamuna	
	09:00 am	DBF+							✓	NO IV	Yamung	
	10:00 am	FF 30ml								NO IV	Yamung	
	11:00 am									NO IV	Yamung	
	12:00 pm									NO IV	Yamung	
	01:00 pm	DBF+								NO IV	Yamuna	
Total Intake :					Total Output :					Passed U - 1 m -		
11/5/26	02:00 pm	FF				✓						
	03:00 pm	#										
	04:00 pm									NO IV	Yamuna	
	05:00 pm											
	06:00 pm	DBM				✓				Completed		
	07:00 pm											
Total Intake :					Total Output :					U - 1 - M - 1		
	08:00 pm											
	09:00 pm											
	10:00 pm					✓						
	11:00 pm	DBM								NO IV	Reddy	
	12:00 am											
	01:00 am									Completed	Reddy	
Total Intake :					Total Output :					U - 1 - M - 1		
	02:00 am											
	03:00 am	DBM				✓						
	04:00 am											
	05:00 am											
	06:00 am	DBM				✓						
	07:00 am	DBM										
Total Intake :					Total Output :					U - 3 - M - 2		
Total 24 hrs. Intake					Total 24 hrs. Output							

3AH-00655840 IP5-00173594
 Baby Of SHREYA REDDY
 19-05-2026 0 Y 0 M 1 D (M)
 Dr. DINESH KUMAR CHIRLA

FLUID CHART



Sheet No. : **4**

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
12/5/26	08:00 am											
	09:00 am	DBF							✓			
	10:00 am	DBF				✓						
	11:00 am											
	12:00 pm											
	01:00 pm	DBF					✓					
Total Intake : Taken					Total Output : U-1 M-2							
12/5/26	02:00 pm					✓			✓			
	03:00 pm											
	04:00 pm	DBF										
	05:00 pm	DBF				✓			✓			
	06:00 pm											
	07:00 pm	DBM										
Total Intake : Taken					Total Output : Passed U=2, M=2							
	08:00 pm											
	09:00 pm	DBM										
	10:00 pm											
	11:00 pm											
	12:00 am	DBM				✓						
	01:00 am											
Total Intake : Taken					Total Output : Passed U=1 M=1							
	02:00 am											
	03:00 am	DBM				✓						
	04:00 am											
	05:00 am	DBM										
	06:00 am					✓						
	07:00 am											
Total Intake : Taken					Total Output : U=3 M=2							
Total 24 hrs. Intake												
Total 24 hrs. Output												



HEAD TO TOE EXAMINATION

HEAD :	Fontanelles : Sutures Shape / Moulding : Edema / Bruising : Size - (H.C.) :	} (N)
FACIES : (Any Facial Dymorphism)		- NO dysmorphism
NECK and CLAVICLES :	Range of Motion : Asymmetry : Masses :	} (N)
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 :	} (N)
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number :	} (N)
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : Discharge :	- 24710
GENITILIA :	Labia / Hymen : Testicles/penis : Anus :	
HERNIAL ORIFICES		- Intact
TRUNK and SPINE :		(N)
SKIN LESIONS :		- NO
EXTREMETIES :	Fingers / Toes : Deformities : Hip Joint Examination :	} (N)
	Arms / Legs : Mobility :	} (N)



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern: Regular Periodic Shallow Gasping

Mention If baby has Respiratory distress: RR: 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: 98% Auscultation: Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 140 bpm BP : Precordial Activity : (N)

Femoral Pulses : R/L well felt Murmurs : nil

Other Peripheral Pulses : well felt Signs of Cardiac Failure : NO

ABDOMEN:

Shape : (N) Hernia orifice : intact

Palpation : Anal Patency : Patent

Palpable masses : Umbilical Cord : 2/1/1

Abdominal girth : First urine passed : -

..... Meconium passed : -

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) : (N)

State of wakefulness : (N)

Prechtle Score : (N)

Nerves : (N)

MOTOR SYSTEM:

Passive Tone : (N)

Active Tone : (N)

Neonatal Reflexes : (N)

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

ATNR : Skull and Spine :

ies : - NO

Diagnosis : Term / AGAL male / used Rh-negative pregnancy

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : [Signature]
Name : Dr. Manjha
Date & Time : 9/5/26

Consultant :

Signature : [Signature]
Name : Dr. Piner Chak
Date & Time : 9/7/26

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 :

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

① Keep baby warm

② Breast feed on demand

③ send cord HG, DCL
seric count
blood grouping
peripheral smear

④ monitor vitals

Feeding Plan at the time of shifting :

8:50 to 9:18 AM

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

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

Doctor Name: Doctor Name:

Date & Time: Date & Time: