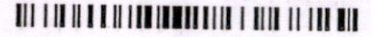


ADMISSION SHEET

Registration Details :



Admission No : IP5-00174376 Admit Date : 27-May-2026 Admit Time : 10:29 AM UHID : BAH-00657370

Patient Details :

Patient Name : Baby Of KHANSA AIMAN Age : 0 D
Guardian : Mr MOHAMMED NAYEEMUL HASSAN DOB : 27-05-2026 10:00 AM
Gender : Female Religion :
Occupation : Martial Status : Single
Address (H) : H NO 11-3-577 Mallepally Hyderabad Phone No : 9550128974/ 9493215010
Telangana INDIA 500001 E-mail : AIMANMJCET@GMAIL.COM

Admission Details :

Bed Type : BASINET Bed No : CRDL-SW-417-1 Ward Name : 4F-BIRTHING CENTRE
Room No : CRDL-SW-417-1 Admission Type : First Visit

Contact Details :

Name : Mr MOHAMMED NAYEEMUL HASSAN Relationship : Father
Contact Address : H NO 11-3-577 Mallepally Hyderabad Phone No : 9550128974 / 9493215010
Telangana INDIA 500001

Signature

Doctor Details :

Doctor Name : Dr. VIJAYANAND JAMALPURI Specialisation : NEONATOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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

BAH-00657370 IP5-00174376
 Baby Of KHANSA AIMAN
 27-05-2026 0 Y 0 M 0 D 1 H (F)
 Dr. V. JAYANAND JAMALPURI



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : KHANSA AIMAN 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 Khansa Aiman Mother's Blood Group : B positive
 Gender : M F Blood Group : Birth Weight (gms) : 2489 Length (cms) : 43cm
 Date of Birth : 27/05/26 Time of Birth : 10 AM OFC (cms) : 35cm
 Place of Birth : Rw. Baujara Estimated Gesth Age : 36 +6 → 37 weeks
 Current Obstetric History : (Booked / Unbooked Case) 14/9/25 17/6/26
 Maternal Age : 29y Ht : Wt : BMI : Married Life : LMP : EDD :
 Conception : Spontaneous or with Rx : 1UI Conception
 Booked at what GA : 8 +4 weeks AN Steroids Drugs / Doses :
 Last Scans Details : 26/5/26, 36 weeks, cephalic - placenta - Ant, right lateral with Doppler
AFI - 11.4, EFW - 2448 (16.1) TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

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 :	H/o GDM/ pre GDM/ on diet or insulin Controlled or not, recent values, HbA1 values : <u>TIFFA - Mild RR</u> Compliance with Rx : <u>[213/26]</u> Scans : LGA, TIFFA <u>Fetal Echo</u> <u>Normal</u> 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 :
--	---

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
				primi		

PERINATAL HISTORY

Treating Obstetrician : Hospital : Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig) <i>Early labour</i></p> <p>Second stage (> 2 hours after dilation)</p> <p>LSCS : <input 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>Resuscitaion : <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>
--	--

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
8/10	9/10	10/10

TOTAL

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

Snapee II Score

Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

primi / 37 weeks / early labour



History of

Equipment check done
↓
Baby delivered by NVD.
↓
cried immediately after birth
↓
Received into preheated radiant warmer
↓
maternal nasal flexion seen
Ajit-k long intub
↓ delayed cord clamping done
Baby stable
↓
settling to mother's side.

Investigation details in previous Hospital :

Feeding History :

Breast feeding given within 30 mins of life

Pa

BAH-00657370 IP5-00174376
Baby Of KHANSA AIMAN
27-05-2026 0Y0M0D1H (F)
Dr. VIJAYANAND JAMALPURI



Past History :

Family History :

□ TO

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

CTA good

VITALS : Temperature : 36.4°C HR : 120/min RR : 46/min NIBP : CFT : ← 2pc

Color of the extremities : Acrocyanosis - pink

Jaundice : Pallor : SpO2 : 98% on O2

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

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD : Fontanelles : Caput ⊕
Sutures :
Shape / Moulding : Af ⊕, cat level
Edema / Bruising :
Size - (H.C.) :

FACIES :
(Any Facial Dysmorphism) — No facial dysmorphism

NECK and CLAVICLES : Range of Motion : —
Asymmetry :
Masses :

EYES : Symmetry :
Red Reflex : — To be checked,
Discharge :

EARS, NOSE MOUTH and THROAT : Ear set / Shape :
Periauricular Pits / Tags :
Nasal shape / Patency : ⊕
Palate :
Gums :
Lips :
Tongue :

THORAX and BREASTS : Shape of Thorax : | ⊕
Position of Nipples and Number :

ABDOMEN and UMBILICUS : Shape :
Organomegaly :
Bowel Sounds : — 20 A + 20 V ⊕
Umbilical Stump :
Discharge :

GENITALIA : Labia / Hymen : ⊕ Level External genitalia present
Testicles/penis :
Anus : — Patent

HERNIAL ORIFICES — free

TRUNK and SPINE : — ⊕

SKIN LESIONS :

EXTREMITIES : Fingers / Toes : 5 fingers ⊕ Arms / Legs :
Deformities : 5 toes ⊕ Mobility :
Hip Joint Examination :



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: Auscultation: Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : 146/min BP :

Precordial Activity : (D)

Femoral Pulses : 2/4

Murmurs :

Other Peripheral Pulses :

Signs of Cardiac Failure :

ABDOMEN:

Shape :

Hernia orifice : See

Palpation :

Anal Patency : patent

Palpable masses : (N)

Umbilical Cord : 2v+2a+2v+

Abdominal girth :

First urine passed : not passed

Meconium passed :

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

ATNR : Skull and Spine :

IP5-00174376
27-05-2026
DR. VIJAYANAND JAMALPURI (F)

Patient Sticker

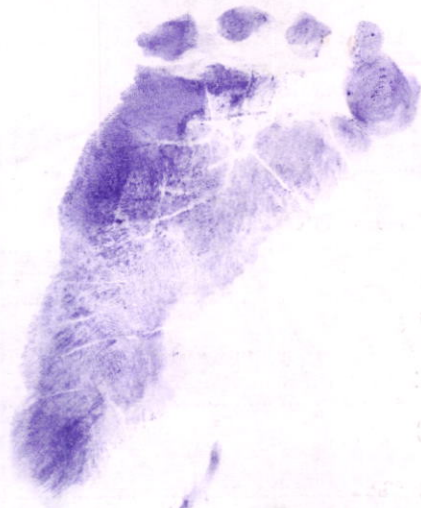
Any Congenital Anomalies :

Diagnosis :

Ternon / Polmal / Early lesion / SCA

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : N Peethu

Name : Dr. N. Peethu

Date & Time : 27/05/26 at 10am

Consultant :

Signature : Vijay

Name : Dr. Vijaynand

Date & Time : 27/5/26 at 3:20pm

PLEASE FILL UP THE FOLLOWING DETAILS

- Name of the referring Doctor :
- Name of the referring Hospital :
Address :
Contact Numbers :
- Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
- 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. warm case

2. DBF 2-3 hourly for burping for 30 mins

3. BCG, OPV, Hep-B today

4. SBR, NBS, DAF at 48 Hrs

Feeding Plan at the time of shifting :

5. clinical assessment of jaundice at 24 Hrs

Screenings done during NICU Stay : 6. CRBS monitoring at 1, 3, 6, 12, 18, 24, (pre-bleed) ✓ ✓

NSG : 48 Hrs tuberc 16 x 5 mg/dl

Hearing Screen :

ROP :

TFT : 7 w/f anaemia, hypothyroidism

NP2 : 8 send cord blood for blood group & Rh

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:

BAH-00657370 IP5-00174376
 Baby Of KHANSA AIMAN
 27-05-2026 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
27/5/26 3:15 pm	Seen by Dr. Vijayanand	Plan:- - Feeding assessment - Regular feeding - Sugar monitoring - BCG ✓ OPV ✓ Today Hep B ✓
noted by Sulekha 27/5/26 @ 3:30 pm (020806)		
28/5/26 7:40 AM	Seen by Dr. Bharath (Resident) 22 Hoz 37 wks 2489gms SGA Primi CIAB NVD Fch	Plan:- - Continue direct breast feeding followed by burping every 2-3 hourly - warmth care - Clinical assessment of jaundice @ 24 Hoz (10 AM) - GRBS monitoring as advised (24, 36, 48 Hoz. inform if <50) - watch for feeding difficulties - Monitor vitals & Inform SOS.
M/B+ B/B+	Bt. wt - 2489 gm (2432) ^{ww} Today wt - 2391 gm 92 gm (3.6%)	
	urine - 3 times stools - 2 times GRBS - 55, 56, 63, 84, 103, 103.	
		Bharath

BAH-00657370 IP5-00174376
 Baby Of KHANSA AIMAN
 27-05-2026 0 Y 0 M 0 D 1 H (F)
 Dr. VIJAYANAND JAMALPURI




PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26		<u>Plan-</u> - Regular feeding
5:23 AM		cont. - Sugar monitoring
		- clinical assessment @ 24 h of of jaundice (10 AM)
		- Feeding assessment

CONSENT FOR FORMULA FEEDS

BAH-00657370 IP5-00174376
Baby Of KHANSA AIMAN
27-05-2026 0 Y 0 M 0 D 1 H (F)
Dr. VIJAYANAND JAMALPURI

Patient No: Age: Gender: Male Female
UHID No:  Reg. No.: Department: BCU Date: 27/5/26

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 : [Signature]
Name : Mohammed Nayeem ul Hassan
Relationship with Patient: Husband
Date & Time : 27/5/26 12:25 PM

Witness :

Signature : [Signature]
Name : Sibtey
Date & Time : 27/5/26 12:20 PM

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Poojitha
Date & Time : 27/5/26 1:30 PM

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)

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-00657370 IP5-00174376
 Baby Of KHANSA AIMAN
 27-05-2026 0 Y 0 M 0 D 1 H (F)
 Dr. VIJAYANAND JAMALPURI



FLUID CHART

Sheet No. : 1

27/5/26

- 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												Sulbut 27/5/26 R 1 pm
	09:00 am												
27/5	10:00 am												
	11:00 am	DBM											
	12:00 pm												
	01:00 pm	DBM											
Total Intake :			DBM - 2			Total Output :					0 - nil m - nil		
	02:00 pm												Kalyani
	03:00 pm												
27/5	04:00 pm	DBF											
	05:00 pm												
	06:00 pm	DBF											
	07:00 pm	DBF											
Total Intake :						Total Output :					U = 1 m = 2		
	08:00 pm												Pravathi
	09:00 pm	DBP											
27/5	10:00 pm												
	11:00 pm	FP 17ml DBP											
	12:00 am												
	01:00 am	DBP											
Total Intake :						Total Output :							
	02:00 am												Pravathi
27/5	03:00 am	FP DBP											
	04:00 am												
	05:00 am	DBP											
	06:00 am												
	07:00 am	DBP											
Total Intake :						Total Output :							
Total 24 hrs. Intake		orally taken											
Total 24 hrs. Output		U = 3 m = 2											



FLUID CHART



Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
28/5/26	08:00 am	DBF											
	09:00 am					✓							
	10:00 am	DBF											
	11:00 am												
	12:00 pm	DBF											
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm	DBF				✓				✓			
	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							