

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176457 Admit Date : 16-Jul-2026 Admit Time : 11:04 AM UHID : BAH-00661804

Patient Details :

Patient Name	: Baby Of SEELAM MADHURI TWIN 1	Age	: 0 D
Guardian	: Mr V BHANU CHANDER	DOB	: 16-07-2026 09:59 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: H.NO-1-66 THIMMAI PALLI (V), KEESARA (M) Ghatkesar Hyderabad Telangana INDIA 501301	Phone No	: 9666808389/ 7799808389
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : NICU Bed No : NICU 250 Ward Name : 2F-NICU 1
 Room No : NICU 250 Admission Type : First Visit

Contact Details :

Name : Mr V BHANU CHANDER Relationship : Father
 Contact Address : H.NO-1-66 THIMMAI PALLI (V), KEESARA (M) Phone No : 9666808389 / 7799808389
 Ghatkesar Hyderabad Telangana INDIA 501301


 Signature

Doctor Details :

Doctor Name : Dr. NALINIKANTA PANIGRAHY Specialisation : NEONATAL INTENSIVE CARE
 Referral Doctor : SELF Phone No :
 Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
 Payor Name : ELECTRONIC CORPORATION OF INDIA

Date of Birth	:	
Time of Birth	:	
Mode of Delivery	:	
Birth Weight	:	
Head Circumference	:	22.5
Length	:	44
Red Reflex	:	

New Born Screening	:	
TFT	:	
OAE	:	
Mother's Blood Group	:	
Baby's Blood Group	:	
Anomaly Scan	:	
Vaccination	:	

Vaccination		
Given on 17/7/26 OPV, BCG, Hep-B SIS. <i>Valarun</i>		
Quantity	Temperature	Signature 17/7/26

Docu. No. : RCHBH /FRM / CLINICAL / 132

[illegible]

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 : Blo. seelam madhuri Twin 1 Mother's Blood Group : B positive
Gender : ☒ M ☐ F Blood Group : Birth Weight (gms) : 2997g Length (cms) : 44cm
Date of Birth : 16/7/26 Time of Birth : 9:59am OFC (cms) : 1+2.143g 22.5cm
Place of Birth : RCH, BH Estimated Gesth Age : 36 weeks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 25 yr Ht : Wt : BMI : Married Life : LMP : EDD :

Conception : Spontaneous or with Rx : Spontaneous

Booked at what GA : 27 weeks AN Steroids Drugs / Doses :

Last Scans Details : 7/7/26 → 34th week, cephalic, AFI 2.6 cm; FFW 1.95 kg

Doppler (N) TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : ☐ <18 yrs ☐ > 35yrs
Consanguinity : ☐ Yes ☒ No
If yes, degree of consanguinity : ☐ 1 ☐ 2 ☐ 3

H/o PIH (after 20 weeks) / PE

How many Drugs / Doses / Since how long :

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 : (N) 2.6 cm

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 ?

(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
G ₁	24 year	FT	2.6 kg	male	Oligohydramnios	LSCS
G ₂	Present pregnancy					

PERINATAL HISTORY

Treating Obstetrician: Dr. Shruthi Reddy / Dr. Lavanya Hospital: RCH, BH ☒ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS: ☒ Elective ☐ Emergency Indication:

Specify the reason: FGR with ↑ resistance in Doppler
⊕ F&C cerebral Redistribution

Augmentation of Labour: ☐ Induced ☐ Assisted Vaginal

CTG: ☐ Normal ☐ Suspicious ☐ Pathological

MSL:

Resuscitation: ☐ Yes ☐ No

Cord ABG: 7.23 / 5.15 / 3.4 / 5.4 / 17.7

Placenta: (weight, surface, No. of cotyledons, calcifications, malformations, clots etc:

NEONATAL RESCUSTITUTION 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
1	2	2
1	2	2
2	2	2
7/10	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)		0
Pao2 / Fio2 (mmHg%)	> 2.49 (0)	1-2.49 (5)	0.3-0.99 (15)	< 0.3 (28)	0
Lowest Serum PH	> 7.2 (0)	7.1-7.19 (7)	< 7.1 (16)		0
Multiple Seizures	No (0)	Yes (19)			0
U. Output (ml / kg / hr)	> 1 (0)	0.1-0.9 (5)	< 0.1 (18)		
Apgar Score	> 7 (0)	< 7 (18)			0
Birth Weight	> 1kg (0)	750 - 999 (10)	< 750 (17)		0
SGA	> 3rd percentile (0)	< 3rd (12)			0
Total					0

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints:



History of Present Illness:

Equipment checked
↓
Preheated warmer
↓
Delivered male baby through elective LSCS
↓
Cried immediately after birth
Delayed cord clamping done @ 60 seconds
↓
Cord cut
↓
Baby developed Respiratory distress in form
of ICR⁺, mild grunting
OR CPAP given for 10 minutes
↓
Respiratory distress settled
↓
I/v vitamin K 1mg 1m STAT
↓
Shift to NICU for further management

Investigation details in previous Hospital :

Feeding History :



Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5°C HR : RR : NIBP : CFT :

Color of the extremities :

Jaundice : Pallor : SpO2 :

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

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

HEAD :
Fontanelles : Af 2cm x 2cm
Sutures
Shape / Moulding : No moulding
Edema / Bruising :
Size - (H.C.) :

FACIES :
(Any Facial
Dysmorphism) No dysmorphism

**NECK and
CLAVICLES :**
Range of Motion :
Asymmetry : (N)
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 : (N)

**THORAX and
BREASTS :**
Shape of Thorax :
Position of Nipples and Number : (N)

**ABDOMEN and
UMBILICUS :**
Shape :
Organomegaly :
Bowel Sounds : (N)
Umbilical Stump :
Discharge :

GENITALIA :
Labia / Hymen :
Testicles/penis : (N)
Anus :

HERNIAL ORIFICES Free

TRUNK and SPINE : (N)

SKIN LESIONS : NO

EXTREMITIES :
Fingers / Toes : (N)
Deformities :
Hip Joint Examination :
Arms / Legs :
Mobility :

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: 100% T CPAP

Auscultation: mid grunting ⊕

Breath Sounds:

Added Sounds:

CARDIOVASCULAR SYSTEM:

HR: 161/min BP:

Femoral Pulses: well felt

Other Peripheral Pulses: palpable

Precordial Activity: no

Murmurs: no

Signs of Cardiac Failure: no

ABDOMEN:

Shape: (N)

Palpation: soft

Palpable masses: no

Abdominal girth:

Hernia orifice: free

Anal Patency: patent

Umbilical Cord: 2 Artery, 1 vein

First urine passed:

Meconium passed: not passed

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium):

State of wakefulness:

rechter Score: 1 (N)

irves:

TOR SYSTEM:

sive Tone:

ve Tone:

natal Reflexes:

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

DTR:

Skull and Spine:

Diagnosis : Late preterm / 36 week / CDDA Twin 2
male / CIAB Elective LSCS (fGR with abnormal Doppler in Twin 2)

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : [Signature]
Name : Cariteja
Date & Time : 16/7/26

Consultant :

Signature : [Signature]
Name : [Signature]
Date & Time : 17/7/26

PLEASE FILL UP THE FOLLOWING DETAILS

Name of the referring Doctor :
Name of the referring Hospital :

E-mail ID :

on whose name the patient is being referred.

BAH-00661804 IP5-00176457
Baby Of SEELAM MADHURI TWIN 1
18-07-2026 0 Y 0 M 0 D 6 H (M)
Dr. NALINIKANTA PANIGRAHY



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 :

1) Warm Care.

2) Low flow oxygen for
Target SpO_2 90-95%

3) IV: 60ml/kg/day = 11ml 2nd bsky
Full OG feeds - Start formula feed
Consent taken

Plan during ward follow up :

4) GRBS at 1HOL - Post feed.
2HOL, 6HOL, 12HOL, 24HOL,
36HOL, 48HOL - prefeed
Inform if < 50mg/dl

Feeding Plan at the time of shifting :

5) cuff - RD, tachypnea.

Screenings done during NICU Stay :

6) r/o chancing 6th bsky.

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

GRBS - NOW

GRBS = 59mg/dl at 12pm.

Doctor Signature (Handover Given):

Doctor Name:

Date & Time:

Doctor Signature (Handover Taken):

Doctor Name:

Date & Time:



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

	Problems		
	S.No.	Current	Past Problems
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment			
Medications Used			
Plan of Care:			

Doctor's Name (Hand over given):

Signature:

Date & Time:

Doctor's Name (Hand over taken):

Signature:

Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/26 8:45pm	US/B Resident	
	23HOL/Late Preterm/36w/DCDA twin 1/ELUSCS (FGR twin-1) mch/4AB/2143g	
		<u>Plan</u>
	Twt → 2040g.	
	M/BT B/OT	① TV = 60 cc/kg/day. 13ml B ₂ H DBF/EBM 2nd huly 13ml.
	Baby on room air Euthymic - Pink	
	GRBS → 100mg/dl @ 12HOL	② warm care ③ GRBS @ 24HOL 10am
	ref } good Tone } abmt }	④ Monitor vitals. 1/0 cheating Feed monitoring
	Peripheries warm sucking good	⑤ W/t RD/Desaturation ⑥ SBR } NBS } 48HOL TIm 10am OAC }
		<u>Soheli</u>
	15ml, 2nd huly EBM/Formula	
	Star Breast Feeding	Given on 17/7/26 Yadav vaccination today SBR, NBS, AAPR TIm
	17/7/26	R/v discharge TIm



DAILY ASSESSMENT AND HANDOVER SHEET OF NICU (NON-VENTILATED)

Day in NICU: Day of Life: PMA:

Term ☐ Preterm ☐ Gestation: Corrected Gestational Age: Today's Weight:

Problems	
S.No.	Current
1.	
2.	
3.	
4.	
5.	
6.	

Past Problems	

Overview	

Clinical Assessment	

Medications Used	

Plan of Care:	

Doctor's Name (Hand over given):

Signature:

Date & Time:

Doctor's Name (Hand over taken):

Signature:

Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Signature



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/26 8:15am	Morning Round.	
	47. W HCL / Late preterm / DCOA Twin 1	
	Baby is on RA. Hemodynamically stable.	Plan
M/B B/O	Time - 1928g (↓ 62g) Cumulative - 7.7-1	→ TV - 100cc/kg/day. 18ml/2nd hly OI/DBF
	Accepting paladay feed	
	P/A - Soft	→ Send SBR NBS } 10am
	U/S S/L	AAR AA
		→ Monitor vitals
	Vaccination done	
	<u>Dr. Popittha</u>	



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



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26. 7:50am	Morning Round.	
	95 HOL (DOL 4) 36wks RD NNT.	
	Baby is on room air Hemodynamically stable Accepting formula feed.	Plan - → Continue SSPT - eyes & genitals covered.
	TCBR at 80HOL - 14.7. (D4)	
	Started SSPT.	→ IV - 140cc/kg/day 25ml/2nd hly paladay feed.
	Vitals - stable.	
	P/A - soft a.u. 4 S/I	→ to to send SBR 5pm.
	T.Wt - 1969g (↑15g)	→ I/O charting 6th hly.
		→ Monitor vitals
		→ Temp. charting 4th hly
	Dr. Poopthe	Noted of Subhant Flu wednesday

07-2020
r. NALINIKANTA PANIGRAHI



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Your Right to a Safe Delivery

Date & Time	Progress Notes	Doctor's Order
20/7/26 4pm	<u>Afternoon rounds</u> 002-5/36 week Ro/mnjs on from air no Ro/ moderation Accepting feed well Euphoric Euglycemic CR 7.236 Vitals: Stable Passed urine & stool SBR -	<u>Plan</u> 1. BSP 7 with eye & genital care 2. SBR @ 5pm 2. If (N) plan (PIC) - fw on Wednesday 4. Vital monitoring 5. DBF 2nd wly, 2nd QH Sgt Jester



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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 9am	seen by Resident	
	DOL-6 Late pt 36 week MNT	
m/B ⁺ B/O ⁺	T. wt = 2 kg (931 gm)	Plan
	Baby on Room air Vitals: stable Accepting feeds well Lucky hood Cry Tone } Good Activity } Euthermic Euglycemic	1. Tx = 150 cc/kg/day 25ml O ₂ H 2. Temperature charting 3. DBF O ₂ H flh Burping 4. plan (pic) after rounds
		dry Saitog

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



It takes a lot to treat the little

BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RBS CHART

[illegible]

[illegible]

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward 3rd floor

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

VERIFIED BY : Name Signature

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				



REGULAR PRESCRIPTIONS

Weight. Ward. 2nd floor

DRUG : <u>NASOCLEAR DROPS</u>				Date Time	<u>19/7</u>	<u>20/7</u>														
Dose <u>2 drop</u>	Route <u>each</u> <u>nom</u>	Frequency <u>Q4H</u>	Start Date <u>19/7</u>	<u>12AM</u>	<u>X</u>	<u>all</u>														
Name & Signature of the Doctor Starting the Drugs: <u>Saibeg</u>				<u>4AM</u>	<u>X</u>	<u>all</u>														
				<u>1PM</u>	<u>X</u>	<u>all</u>														
				<u>4PM</u>	<u>X</u>	<u>all</u>														
				<u>8PM</u>	<u>X</u>	<u>all</u>														
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

Weight. Ward.

VARIABLE DOSE		Date Time							
				Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :			Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date		Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor			Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:			Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.

VARIABLE DOSE		Date Time							
			Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :			Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Start Date		Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Name & Signature of the Doctor			Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.
Additional Instructions:			Dose		Dose		Dose		Dose
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.

STAT / ONCE ONLY DRUGS

[illegible]

I.V. FLUIDS CHART

Weight. Ward.

[illegible]

BAH-00661804
Baby Of SEELAM MADHURI TWIN 1
16-07-2026
Dr. NALINIKANTA PANIGRAHY
IP5-00176457
YOMID (M)

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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It takes a lot to treat the little.

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Part - I
Patient's / Learner Language: Telegu 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		
16/7/20	11:40AM	1, 2	plan of care. Diagnosis is	Father	1	0	1	1	Good.	<i>[Signature]</i>

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 Differences	12. Impaired Vision/ or Hearing	

Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed

Mechanism/s to overcome barrier/s:

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
-----------------------------	-------------------------------	-----------------



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

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:
16/7/23	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	warmer care or need	provide warmer care providing low	warmer started low flow	<i>[Signature]</i>	☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



...RSING INITIAL ASSESSMENT FOR NICU

Date of Admission: 16/7/26

Source of Admission: ☐ OPD ☐ Ward ☒ Labor Ward ☐ Other:

Reason for Admission: Pre term, TTNB

Admission Diagnosis: TTNB

Accompanied By: ☒ Parent ☐ Guardian ☐ Other Name:

Primary Language: ☒ Telugu ☒ English ☐ Hindi ☐ Other Specify

Do you require an interpreter? ☐ Yes ☒ No

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:

If yes, identify

Source of Information: ☐ Family ☐ Others, Specify

Past Medical History	Past Surgical History	Last Hospital Admission
<u>Nil</u>	<u>Nil</u>	<u>Nil</u>

Significant History	Family History: <u>Nil</u>

Has the child or close family member had recent contact with a communicable disease? ☐ Yes ☒ No

If yes please list,

Was the child's birth normal? ☐ Yes ☒ No If No, please describe problems:

Are the child's immunization up to date? ☐ Yes ☒ No

Current Medications	Taking Medications? ☐ Yes ☐ No If yes, Fill the reconciliation form Medicine brought to the hospital? ☐ Yes ☐ No

Observations:

Birth Weight: 2.143 kgs Head Circumference: cm Length: cm

☐ Term ☒ Pre-Term ☐ Post-Term

Blood Group: Mother: B positive Baby:

Feeding: ☐ Breast Feeding ☒ Formula ☐ Both

Maternal Details: Age: 25 years, PARA: Gestation: 36 Weeks, Days

Risk Factors: ☐ PROM ☐ Fetal Distress ☐ Diabetes Mellitus / Gestational Diabetes

☐ PH / Pre Eclampsia ☐ Others, Specify:

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

Indication: LOWR

BAH-00661804
Baby Of SEELAM MADHURI TWIN 1
18-07-2026 0 Y 0 M 0 D 6 H (M)
Dr. NALINIKANTA PANIGRAHY

Joc. No. : RCH / 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:	11	12	2	4	6pm	10	2	6
Doctor/Nurse/Family Concern?						PM	AM	AM	
Temperature (F)	104								
	103								
	102								
	101								
	100	98.6	98.9	98.3	98.5				
	99				98.2°F	98.4°F	98.0°F	98.0°F	98.0°F
	98				*	*	*	*	*
	97								
	96								
	95								
	94								
Heart Rate (bpm)	190								
	180								
	170								
	160								
and	150								
	140								
Blood Pressure (mmHg) *	130								
	120								
	110								
	100								
	90								
Note:	80								
BP does not score	70								
in early	60								
warning scoring	50								
Heart Rate (Number)		153	149	148	145	140bpm	138bpm	132bpm	
Resp. Rate (bpm) (ver 1 Minute) *	70								
	60								
	50								
	40								
	30								
	20								
	10								
Resp Rate (Number)						140bpm	36bpm	35bpm	
Resp Distress	Mod/ Severe								
	None / Mild					N	N	N	
Receiving O ₂ (l/min)									
O ₂ Saturations (%)		98	95	93	95	100%	99%	99%	
Conscious Level	Normal					N	N	N	
	Altered								
GCS *		C	C	C	C	15/15	15/15	15/15	
TOTAL SCORE						0	0	0	
Number of shaded boxes						0	0	0	
Pain Score		0	0	0	0	0	0	0	
Observer's Initials									

ACTIONS

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- 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:

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- 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

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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)

ALY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	10 AM	2 PM	8 PM	10 PM	2 AM	6 AM	
Doctor/Nurse/Family Concern?								
Temperature (°F)	104							
	103							
	102							
	101							
	100							
	99	98.0 F	98.1 F	97.9 F	98.0 F	97.9 F	98.2 F	
	98	*	*	*	*	*	*	
	97							
	96							
	95							
Heart Rate (bpm)	190							
	180							
	170							
	160							
	150							
	140							
	130	*	*	*	*	*	*	
	120							
	110							
	100							
Blood Pressure (mmHg) *	140							
	130							
	120							
	110							
	100							
	90							
	80							
	70							
	60							
	50							
Note: BP does not score in early warning scoring								
Heart Rate (Number)		132b/m	138b/m	136b/m	136b/m	134b/m	130b/m	
Resp. Rate (bpm) over 1 Minute *	70							
	60							
	50							
	40							
	30							
	20							
	10							
	Resp Rate (Number)		36b/m	28b/m	35b	36b/m	34b/m	34b/m
	Resp Distress	Mod/ Severe None / Mild	N	N	N	N	N	N
	Receiving O ₂ (l/min)							
O ₂ Saturations (%)		100%	99%	99%	100%	99%	100%	
Conscious Level	Normal Altered	N	N	N	N	N	N	
GCS *		15/15	15/15	15/15	15/15	15/15	15/15	
TOTAL SCORE								
Number of shaded boxes		0	0	0	1	1	4	
Pain Score		0	0	0	0	0	0	
Observer's Initials		P	P	P	L	L	L	

NB: Scores 3 should be recorded overleaf

Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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3AH-00661804 IP5-00176457
Baby Of SEELAM MADHURI TWIN 1
16-07-2026 0 Y 0 M 1 D (M)
Dr. NALINIKANTA PANIGRAHY



No. : RCH / FRM / CLINICAL / 124

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

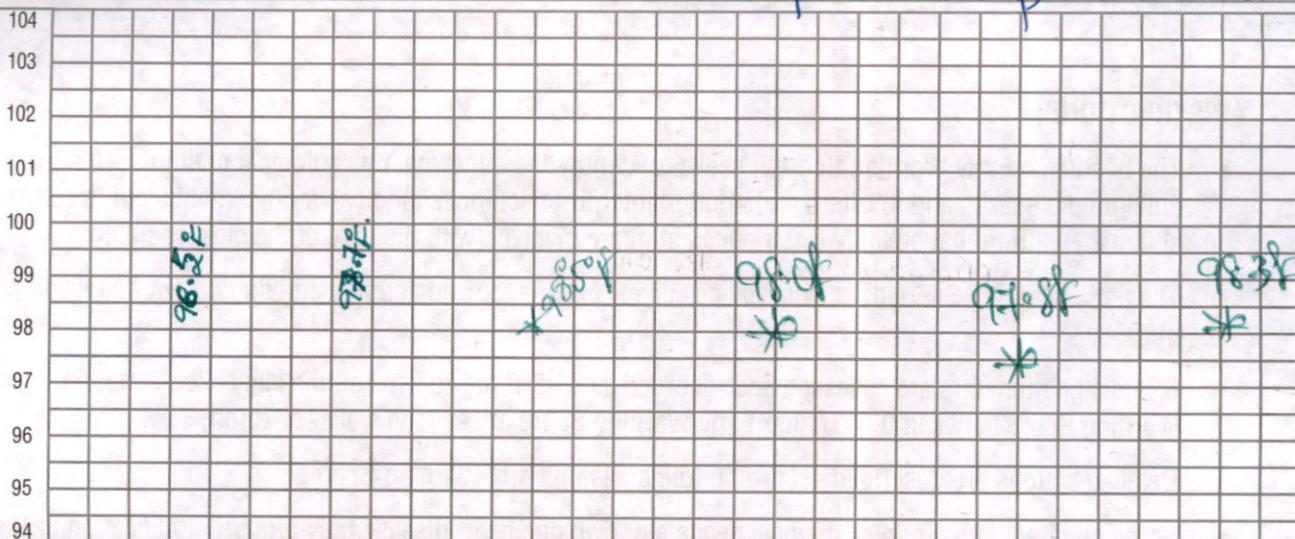
Pratiksha
**Rainbow
Children's
Hospital**
It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 18/7/26 Time: 10 am pm 6pm 10 pm 2 pm 6 am
Doctor/Nurse/Family Concern? am pm pm pm pm am

Temperature
(F)



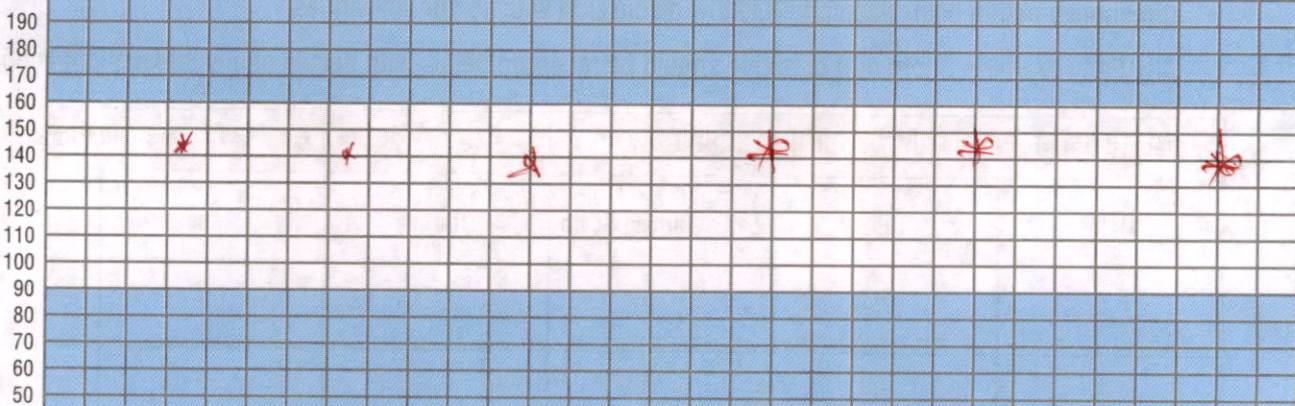
Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring



Heart Rate (Number)

142b/m 140b/m 140b/m 142b/m 140b/m 139b/m

Resp. Rate (bpm)
(Over 1 Minute) *



Resp Rate (Number)

32b/m 30b/m 38b/m 36b/m 34b/m 30b/m

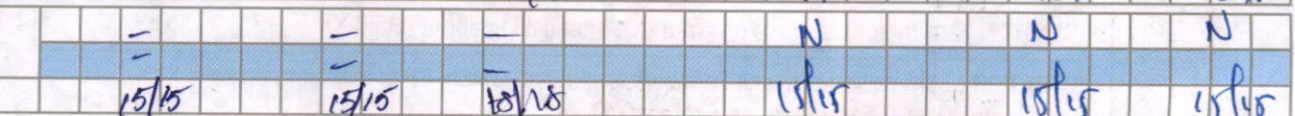
Resp Mod/ Severe
Distress None / Mild

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



Conscious Level
Normal Altered

GCS *



TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

TOTAL SCORE	10 am	pm	6pm	10 pm	2 pm	6 am
Number of shaded boxes	0	0	0	1	1	1
Pain Score	0	0	0	0	0	0
Observer's Initials	<u>A</u>	<u>A</u>	<u>A</u>	<u>A</u>	<u>A</u>	<u>A</u>

ACTIONS

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BAH-00661804
Baby Of SEELAM MADHURI TWIN 1
16-07-2026 0 Y 0 M 2 D (M)
Dr. NALINIKANTA PANIGRAHY

IP5-00175457

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

19/7/26

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	8	6	10	2	6
Doctor/Nurse/Family Concern?		am	pm	pm	pm	am	am
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99	97.8F	98.0F	97.8F	97.8F	98.2F	98.0F
	98	*	*	*	*	*	*
	97						
	96						
	95						
	94						
Heart Rate (bpm)	190						
	180						
	170						
	160						
and	150						
	140						
Blood Pressure (mmHg) *	130	*	*	*	*	*	*
	120						
	110						
	100						
	90						
	80						
	70						
	60						
	50						
Note: BP does not score in early warning scoring							
Heart Rate (Number)		132b/m	141	136b/m	130b/m	134b/m	140b/m
Resp. Rate (bpm) (Over 1 Minute) *	70						
	60						
	50						
	40	*	*	*	*	*	*
	30						
	20						
	10						
Resp Rate (Number)		37	40	36	34b/m	30b/m	34b/m
Resp Distress	Mod/ Severe						
	None / Mild	N	N	N	N	N	N
Receiving O ₂ (l/min)							
O ₂ Saturations (%)		99%	99%	99%	100%	98%	99%
Conscious Level	Normal	N	N	N	N	N	N
	Altered						
GCS *		15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE		0	0	0	1	1	1
Number of shaded boxes		0	0	0	1	1	1
Pain Score		0	0	0	0	0	0
Observer's Initials		N	N	N	N	N	N

ACTIONS

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INFANT (<1 year)

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Early Warning Scoring Chart

Pratiksha
Rainbow
Children's
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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

20/7/26.

Date:	Time:	10 am	1 pm	4 pm	10 pm	2 am	6 am
Doctor/Nurse/Family Concern?							
Temperature (F)	104						
	103						
	102						
	101						
	100						
	99	97.6 F	97.1 F	98.2 F	98.2 F	97.9 F	98.3 F
	98						
	97						
	96						
	95						
94							
Heart Rate (bpm)	190						
	180						
	170						
	160						
and	150	*	*	*	*	*	*
	140						
Blood Pressure (mmHg) *	130						
	120						
	110						
	100						
	90						
	80						
	70						
	60						
	50						
Note: BP does not score in early warning scoring							
Heart Rate (Number)		153b/m	143b/m	141b/m	138b/m	143b/m	140b/m
Resp. Rate (bpm) Over 1 Minute) *	70						
	60						
	50						
	40	*	*	*			
	30						
	20						
	10						
Resp Rate (Number)		32b/m	30b/m	31b/m	40b/m	42b/m	36b/m
Resp Distress	Mod/ Severe None / Mild				N	N	N
Receiving O ₂ (l/min) O ₂ Saturations (%)		100%	99%	99%	100%	99%	98%
Conscious Level	Normal Altered	-	-	-	N	N	N
GCS *		15/15	15/15	15/15	15/15	15/15	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		2	2	2	2	2	2

ACTIONS

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Dr. NALINIKANTA PANIGRAHI

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date: Time:

[illegible][illegible][illegible]

A blank coordinate grid with a vertical axis labeled 160, 170, 180, and 190, and a horizontal axis labeled 160, 170, 180, and 190. The grid is composed of 10x10 squares.

[illegible][illegible]

A blank coordinate grid for plotting. The vertical axis (y-axis) is labeled with values 50, 60, 70, 80, and 90. The horizontal axis (x-axis) is labeled with values 1 through 10. The grid consists of 10 columns and 4 rows of squares, with the bottom row corresponding to the 50 mark on the y-axis.

[illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible]

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)

FLUID CHART

Sheet No. :

16/7/26.

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						
	08:00 am										
	09:00 am										
	10:00 am										
	11:00 am	Nasogastric 10 ml									
	12:00 pm										
	01:00 pm	Nasogastric 10 ml									
Total Intake :					Total Output :						
	02:00 pm										
	03:00 pm	Nasogastric 10 ml							16 ml		
	04:00 pm										
	05:00 pm	Nasogastric 10 ml									
	06:00 pm	FF 15 ml									
	07:00 pm										
Total Intake :					Total Output : 0 - 2 m - 2						
	08:00 pm										
	09:00 pm	DBFT FF 15 ml									
	10:00 pm										
	11:00 pm										
	12:00 am	FF 15 ml									
	01:00 am										
Total Intake : 1 table					Total Output : N - 3 U - 2						
	02:00 am	FF 15 ml									
	03:00 am										
	04:00 am	FF 15 ml									
	05:00 am										
	06:00 am	DBFT FF 15 ml									
	07:00 am										
Total Intake : 1 table					Total Output : N - 2 U - 1						
Total 24 hrs. Intake			Total 24 hrs. Output								
1 table			N - 8 U - 6								

17/07/20

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.

Docu. No. : RCHBH/FRM/CLINICAL/092

FLUID CHART

Sheet No. :

18/7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
18/7	08:00 am	FF 5ml										NO IV Sushanta	
	09:00 am												
	10:00 am	DBF											
	11:00 am												
	12:00 pm	DBF											
	01:00 pm												
Total Intake : Taken						Total Output : m-Np-u-2							
	02:00 pm											NO IV Ashwinie	
	03:00 pm	DBF											
	04:00 pm												
	05:00 pm												
	06:00 pm	DBF											
	07:00 pm												
Total Intake :						Total Output : U-3 m-2							
	08:00 pm											NO IV Ashwinie	
	09:00 pm	DBF											
	10:00 pm												
	11:00 pm	DBF											
	12:00 am												
	01:00 am	EBM 10ml											
Total Intake : Taken						Total Output : M-1 U-3							
	02:00 am											NO IV Ashwinie	
	03:00 am	DBF											
	04:00 am												
	05:00 am												
	06:00 am	DOF											
	07:00 am	FF 15ml											
Total Intake : Taken						Total Output : M-0 U-2							

Total 24 hrs. Intake

Taken

Total 24 hrs. Output

M-3 U-10

19/7/26

FLUID CHART

Sheet No. : A

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 Thrombo-phlebitis Score	Sign. Nurse		
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine				
	08:00 am													
	09:00 am	DBF					✓			✓	NO			
	10:00 am										W			
	11:00 am	DBF								✓				
	12:00 pm													
	01:00 pm	BBF												
Total Intake :			Taken			Total Output :							U-2 M-1	
	02:00 pm						✓							
	03:00 pm	FF												
	04:00 pm						NP			✓	NO			
	05:00 pm	DBF												
	06:00 pm													
	07:00 pm	FF												
Total Intake :			Taken			Total Output :							U-1 M-0	
	08:00 pm						✓							
	09:00 pm	DBF												
	10:00 pm						NP				NO			
	11:00 pm	DBF									IV			
	12:00 am									✓				
	01:00 am	DBF												
Total Intake :			Taken			Total Output :							M-0 U-1	
	02:00 am						✓							
	03:00 am	DBF+FF 2ml												
	04:00 am													
	05:00 am	DBF					NP			NP	NO			
	06:00 am										IV			
	07:00 am													
Total Intake :			Taken			Total Output :							M-0 U-0	
Total 24 hrs. Intake			Taken			Total 24 hrs. Output			M-0 U-4					

FLUID CHART

Sheet No. :

20/7/26

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						
	08:00 am	DBF								✓	Sankarshi
	09:00 am										
	10:00 am	DBF					NP				Sankarshi
	11:00 am									✓	
	12:00 pm	FF 30ml									
	01:00 pm										

Total Intake : Taken

Total Output : m-NP, u-2

	02:00 pm	DBF									Sankarshi
	03:00 pm	DBF									
	04:00 pm	FF 30ml					NP			✓	Sankarshi
	05:00 pm	FF 30ml									
	06:00 pm	FF 30ml									
	07:00 pm										

Total Intake : Taken

Total Output : m-0, u-1

	08:00 pm										Kalki
	09:00 pm	DBF								✓	
	10:00 pm						NP				Kalki
	11:00 pm	FF									
	12:00 am	30ml									Kalki
	01:00 am									✓	

Total Intake :

Total Output : u-2 m-1

	02:00 am	DBF									Phatty
	03:00 am										
	04:00 am	FF 30ml					NP				Phatty
	05:00 am										
	06:00 am									✓	Phatty
	07:00 am	FF 30ml									

Total Intake :

Total Output : u-1 m-1

Total 24 hrs. Intake	Taken
----------------------	-------

Total 24 hrs. Output	u-6 m-0
----------------------	---------

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.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	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: 16/7/20

Assessment: Baby on 1/7 Chnged to R.D. maintaining on Room air

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
10:10 Am	monitor vitals	10:50 Am	monitoring vitals	Baby R
12Pm	maintain 210 chart	2Pm	maintaining 810 chart	stable
	continue feed;		continue feed	
3Pm	continue crib care	4Pm	continue crib care	
	shifting plan.	5:30 Pm	shifting to Room	
5Pm	shift to mother side		* Ensure safety	
7pm	* Ensure safety	7:10pm		

Re-Assessment:

Special Notes: RBS, monitoring

Nurse Signature: poaptha

Nurse Name: poaptha

Date & Time: 16/7/20 5:30 PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 16/7/26

Assessment: Baby is New Born for observation.

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 general condition of baby.	8:10pm	Assessed the general condition of baby.	Baby is stable and well.
10pm	Plan to establish feeds.	10:10pm	Established feeds.	
12am	DBF+HR and baby and bucpwell.	12:10am	PF and baby and bucpwell	
2am	Ensure warm care and	2:10am	Hot.	
4am	w/f hypothermia.	4:10am	Ensured warm care	
6am	maintain personal hygiene.	6:10am	w/f hypothermia	
8am	Ensure safety.	8:10am	Ensured safety.	

Re-Assessment: New Born for observation.

Special Notes: GBS monitoring.

Nurse Signature: *Sthe*

Nurse Name: *Sumetha*

Date & Time: 17/7/26 @ 8am

BAH-00661804 IP5-00176457
 Baby Of SEELAM MADHURI TWIN 1
 16-07-2026 0 Y 0 M 0 D 13 H (M)
 Dr. NALINIKANTA PANIGRAHY

NURSING CARE RECORD

Rainbow
Children's
Hospital
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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 17/07/26 @ 6am

Assessment: New born baby care

Goals

- | | | | | | |
|---|---|--|---|--|--|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☒ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☒ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8am	→ Assess the general condition of the baby and checking vitals.	8am	→ assessed the general condition of the baby and checked vitals.	Baby is stable
10am	→ Giving feeding and nappy and hygiene.	10am	→ Given feeding and nappy and hygiene.	
12pm	→ Giving warm care.	12pm	→ Given warm care.	
2pm	→ Providing safe care to the baby.	2pm	→ Care given	
4pm	→ Ensure safety	4:00pm	Ensured safety	
8pm	→ provide warm care	8pm	Provided warm care	

Re-Assessment:

Special Notes:

SBP, MBS, AFE at 48 Hrs

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 17/07/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 17/7/26

Assessment:

New Born Baby for observation.

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 general condition of baby.	8:10pm	Assess the general condition of baby.	
10pm	DBF 2nd baby and burped well.	10:10pm	DBF 2nd baby and burped well.	Baby is stable and well doing.
12am	Assess wound care	12:10am	Assess wound care	
2am	plan to do DBF & CBM	2:10am	plan to do samples @ 10am	
4am	f.f 1st	4:10am		
6am	Assess Safety	8:10am	Assess Safety	

Re-Assessment:

New Born doing good
 SBR | NBS | OAT @ 10am.

Special Notes:

Nurse Signature:

Shruti

Nurse Name:

Shruti

Date & Time:

18/7/26 @ 8am.

AH-00661804 IP5-00176457
Baby Of SEELAM MADHURI TWIN 1
5-07-2026 0 Y 0 M 1 D (M)
r. NALINIKANTA PANIGRAHY

NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 18/7/26 @ 8am

Assessment: New born care.

Goals

- | | | | | | |
|---|--|---|---|--|--|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess Baby's general condition.	8:10 am	Assessed Baby's general condition.	Baby is stable.
10 am	Ensure safety.	10:10 am	Provided cribcare.	
12pm	monitor vitals.	12:10 pm	monitored vitals.	
1pm	maintain good nutritional status.	1pm	wrapped the baby.	
2pm	Patient family education.	2:10 pm	did feeding assessment done.	
			educated patient about hospital procedure	

Re-Assessment: NA

Special Notes: NA

Nurse Signature: Sub

Nurse Name: Subhartha

Date & Time: 18/7/26 @



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 18/7/2026

Assessment: New born care

Goals

- | | | | | | |
|---|--|---|---|--|---|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the general Condition of the Baby	2:10pm	→ Assessed the general Condition of the Baby	Baby is stable
4pm	→ Monitor vital signs & Record	4:15pm	→ Monitored vital signs & Record	
5pm	→ Ensure safety	5:10pm	→ Ensured safety	
6pm	→ Maintain good nutritional status.	6:15pm	→ Maintained good nutritional status	
8pm	→ Educate family members.	8:10pm	→ Educated family members.	

Re-Assessment: N/A

Special Notes: N/A

Nurse Signature: Ashai

Nurse Name: Ashai

Date & Time: 18/7/26

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 18/7/26

Assessment: New Born Baby for observation.

- 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 Condition of baby.	8:10pm	Assessed the Condition of baby.	Baby is stable and well doing.
10pm	Monitor vitals and records.	10:10pm	Monitored vitals and recorded	
12am	DBF and hely and CBM to give Burp well.	12:10am	DBF and hely and CBM can also give burped well.	
2am	wf hypothermia and	2:10am	wf hypothermia not seen.	
4am	Ensure warm Care	4:10am	Ensured warm Care	
8am	Maintain Personal hygiene. Ensure Safety.	8:10am	Maintained Personal hygiene. Ensured Safety.	

Re-Assessment:

Baby doing good
 Baby Can D/C Tlw.

Special Notes:

Nurse Signature: Sreetha

Nurse Name: Sreetha

Date & Time: 19/7/26 @ 8am

BAH-00661804 IP5-00176457
 Baby Of SEELAM MADHURI TWIN 1
 16-07-2026 0 Y 0 M 2 D (M)
 Dr. NALINIKANTA PANIGRAHY


NURSING CARE RECORD


Rainbow Children's Hospital
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 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 19/7/26 @

Assessment: Ba new born baby

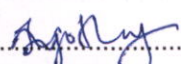
Goals

- | | | | | | |
|---|---|--|--|--|--|
| ☒ 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	Assess general condition of the patient	8am	Assessed general condition of the patient	Baby is Stable
10am	monitor vitals	10am	monitored vitals.	
12pm	maintain ilo chart	12pm	maintained ilo chart	
2pm	Ensure safety	2pm	Ensured safety	
4pm	Given feed 2nd hourly	4pm	Given feed 2nd hourly	
8pm	Provide warmth care	8pm	provide warmth care	

Re-Assessment: Re-assessment done

Special Notes: na

Nurse Signature: 

Nurse Name: Sydney

Date & Time: 19/7/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7/26

Assessment: Baby is in phototherapy.

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 general Condition of baby.	8:10pm	Assessed the general Condition of baby.	Is
10pm	DBF 2nd hely and topup	10:10pm	DBF + top up 2nd hely and burped Baby	
12am	also and burp well.	12:10am	well.	
2am	w/f hypothermia and recorded.	2:10am	Hypothermia and recorded.	
4am	plan to relieve nasal block.	4:10am	Nasal block relieved to baby.	
6am	Baby is SBR after rounds.	6:10am	SBR to do after rounds.	
8am	Ensure Safety.	8:10am	Ensured Safety.	

Re-Assessment:

Special Notes: Baby is in under SPT. SBR after R/V. baby was not comfortable from 2am to 6am to stay in SPT.

Nurse Signature: Sreetha Nurse Name: Sreetha Date & Time: 20/7/26 @ 8am.

BAH-00661804 IP5-00176457
 Baby Of SEELAM MADHURI TWIN 1
 16-07-2026 0 Y 0 M 4 D (M)
 Dr. NALINIKANTA PANIGRAHY



NURSING CARE RECORD

Rainbow Children's Hospital
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 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 20/7/26 @ 8am

Assessment: Baby on SSPT

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	Assess Baby's general condition.	8:10 am	Assessed Baby's general condition	
10 am	Ensure safety.	10:10 am	Provided subcutaneous.	Baby's stable
12pm	monitor vitals.		monitored vitals.	
	maintain good nutritional status.	12:10 pm	Feeding assessment to be.	
1pm	Warmth care		Baby on DBF + ERM.	
	Patient family education.	1:10 pm	Put on clothes.	
2pm		2:10 pm	educated patient about procedure related to hospitalization.	

Re-Assessment: NA

Special Notes: vaccination, today 2pm - 3pm - 4pm

Nurse Signature: zul

Nurse Name: Surharshi

Date & Time: 20/7/26 @

BAH-00661804
IP5-00176457
Baby Of SEELAM MADHURI TWIN 1
0 Y 0 M 4 D
16-07-2026
Dr. NALINIKANTA PANIGRAHY

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Night ☐ Afternoon ☐ Morning

Baby under observation

Date: 21/7/26

Goals

- ☒ Maintain Airway and Oxygenation
- ☒ Maintain Personal Hygiene
- ☐ Identify Potential Complications
- ☒ Relieve Pain & Discomfort
- ☒ Prevent Infection
- ☐ Any Others. Specify.....
- ☐ Maintain Fluid Balance
- ☐ Meet Elimination Needs
- ☒ Improve Activity Tolerance
- ☒ Ensure Safety
- ☐ Maintain Good Nutritional Status
- ☐ Early Ambulation Reduce Anxiety
- ☒ Maintain Skin Integrity
- ☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assesses the general condition	8:10pm	* Assessed the general condition	Baby is stable
10pm	* Monitor vitals and Record	10:10pm	* Monitored vitals and Recorded	
12am	* Maintain I/O chart	12:10am	* Maintained I/O chart	
2am	* Provide warm care	2:10am	* Provided warm care	
4am	* Feeding every 2nd	4:10am	* Giving every 2nd milk	
6am	* Insure safety	6:10am	* Insured safety	

Re-Assessment:

Baby taking feed well, sleeping calm and well

Special Notes:

Nurse Signature: *Kavita*

Nurse Name: *Kavita*

Date & Time: 21/7/26 @ 8pm

BAH-00661804

IP5-00176457

Baby Of SEELAM MADHURI TWIN 1

16-07-2026

Dr. NALINIKANTA PANIGRAHY

0 Y 0 M 4 D

(M)



NURSING CARE RECORD

Shift: ☐ Morning ☐ 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:

BAH-00861804 IP5-00176457
Baby Of SEELAM MADHURI TWIN 1
16-07-2026 0 Y 0 M 4 D (M)
Dr. NALINIKANTA PANIGRAHY



NURSING CARE RECORD



on ☐ 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:

Patient Sticker

NURSING CARE RECORD

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. Nalinikanta Department: 3rd floor Date of Admission: 16/7/26

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known					
		<u>SLP, DCOA.</u>		If Yes Specify:					
BACKGROUND	Area	Shift Time							
	Medical Condition (Any special condition to be noted):	<u>3rd floor 6:10 PM 9 PM</u>	<u>3rd floor 3:40 PM 8 PM</u>	<u>3rd floor 8 AM 9 PM</u>	<u>3rd floor 9 PM 2 PM</u>	<u>3rd floor 2 PM 5 PM</u>	<u>3rd floor 5 PM 8 PM</u>		
		<u>NA</u>	<u>NA</u>	<u>MB</u>	<u>MB</u>	<u>MB</u>	<u>MB</u>		
ASSESSMENT	Allergy:	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	
	Tubes/Drains/Catheter:	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	☒ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.1 F</u>	<u>98.0 F</u>	<u>98.2 F</u>	<u>97.9 F</u>	<u>98.1 F</u>	<u>98 F</u>	
		Res:	<u>14 bpm</u>	<u>38 bpm</u>	<u>38 bpm</u>	<u>37 bpm</u>	<u>34 bpm</u>	<u>32 bpm</u>	
		SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>	
		Pulse:	<u>148 bpm</u>	<u>142 bpm</u>	<u>140 bpm</u>	<u>141 bpm</u>	<u>140 bpm</u>	<u>142</u>	
		BP:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	
	Fall Risk Score:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>		
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>			
Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>			
Recommendations	Physiotherapy	☒ Yes ☒ No	☒ 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	☒ Yes ☒ No		
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>SBR 10 NBS an OAC</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>Lalitha</u>	<u>Sweettha</u>	<u>Priya</u>	<u>gyanya</u>	<u>Sweettha</u>	<u>subant</u>		
Signature :		<u>Lalitha</u>	<u>Sweettha</u>	<u>Priya</u>	<u>gyanya</u>	<u>Sweettha</u>	<u>subant</u>		
Date:		<u>16/7</u>	<u>17/7</u>	<u>17/7</u>	<u>17/7</u>	<u>18/7</u>	<u>18/7</u>		
Time:		<u>@ 8 PM</u>	<u>@ 8 AM</u>	<u>2 PM</u>	<u>@ 8 PM</u>	<u>@ 8 AM</u>	<u>@ 2 PM</u>		
Taken Over By Name :		<u>Sweettha</u>	<u>Priya</u>	<u>gyanya</u>	<u>Sweettha</u>	<u>subant</u>	<u>Ashwini</u>		
Signature :		<u>Sweettha</u>	<u>Priya</u>	<u>gyanya</u>	<u>Sweettha</u>	<u>subant</u>	<u>Ashwini</u>		
Date:		<u>16/7</u>	<u>17/7</u>	<u>17/7</u>	<u>17/7</u>	<u>18/7</u>	<u>18/7</u>		
Time:		<u>@ 8 PM</u>	<u>8 AM</u>	<u>@ 8 PM</u>	<u>@ 8 PM</u>	<u>@ 8 AM</u>	<u>@ 2 PM</u>		

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. N.K. Department: 3rd floor Date of Admission: 8/7/26

SITUATION		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area						
	Shift Time	<u>2nd floor 8pm-8am</u>	<u>3rd floor 8pm-8am</u>	<u>3rd floor 8am-8pm</u>	<u>3rd floor 8pm-8am</u>	<u>3rd floor 8am-8pm</u>	<u>3rd floor 8pm-8am</u>
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
RECOMMENDATIONS	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: <u>98.2°F</u>	Temp: <u>98.2°F</u>	Temp: <u>98.1°F</u>	Temp: <u>98.2°F</u>	Temp: <u>98°F</u>	Temp: <u>98.0°F</u>
	Res:	<u>40b/m</u>	<u>40b/m</u>	<u>36b/m</u>	<u>34b/m</u>	<u>32b/m</u>	<u>31b/m</u>
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>
	Pulse:	<u>140b/m</u>	<u>143b/m</u>	<u>138b/m</u>	<u>134b/m</u>	<u>132b/m</u>	<u>141b/m</u>
	BP:	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>
	Fall Risk Score:	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>	<u>—</u>
	Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>
Other Special Orders / Medications:	Safety Needs:	<u>ent case</u>	<u>ent case</u>	<u>ent case</u>	<u>ent case</u>	<u>ent case</u>	<u>ent case</u>
	Physiotherapy	☐ Yes ☒ No	☐ 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	☐ Yes ☒ No
	Other Special Orders / Medications:	<u>NA</u>	<u>DK T/c</u>	<u>DK T/c</u>	<u>SSPT going on</u>	<u>SSPT @ 2P</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>Aditi</u>	<u>Sneha</u>	<u>Sydney</u>	<u>Sneha</u>	<u>Sneha</u>	<u>Sydney</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>18/7/26</u>	<u>19/7/26</u>	<u>19/7/26</u>	<u>20/7/26</u>	<u>20/7/26</u>	<u>20/7/26</u>
Time:		<u>@ 8PM</u>	<u>@ 8am</u>	<u>@ 8pm</u>	<u>@ 8am</u>	<u>@ 2pm</u>	<u>@ 8pm</u>
Taken Over By Name :		<u>Sneha</u>	<u>Sydney</u>	<u>Sneha</u>	<u>Sneha</u>	<u>Sydney</u>	<u>Sydney</u>
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:		<u>18/7/26</u>	<u>19/7/26</u>	<u>19/7/26</u>	<u>20/7/26</u>	<u>20/7/26</u>	<u>20/7/26</u>
Time:		<u>@ 8pm</u>	<u>@ 8am</u>	<u>@ 8pm</u>	<u>@ 8am</u>	<u>@ 8pm</u>	<u>@ 8pm</u>



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. N. K. Department: 3rd floor. Date of Admission: 16/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>LP, DCDA</u>							
BACKGROUND	Area	Shift Time						
	Medical Condition (Any special condition to be noted):	<u>3rd floor 8 PM</u> <u>NA</u>						
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp: <u>98.2°F</u>						
	Res:	<u>20b/m</u>						
	SpO ₂ :	<u>100%</u>						
	Pulse:	<u>138b/m</u>						
	BP:	<u>-</u>						
	Fall Risk Score:	<u>-</u>						
Recommendations	Safety Needs:	<u>crib</u> <u>cool</u>						
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NA</u>						
	Special Diet:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>						
	Post Operative Procedure Special Orders:	<u>NA</u>						
Handed Over By Name :	<u>Kelita</u>							
Signature :	<u>Kelita</u>							
Date:	<u>21/7</u>							
Time:	<u>@ 8 AM</u>							
Taken Over By Name :	<u>Sush</u>							
Signature :	<u>Sush</u>							
Date:	<u>21/7/26</u>							
Time:	<u>@ 8 AM</u>							

Sticker

NURSING SHIFT HAND OVER FORM - WARD

Referring Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area							
	Shift Time							
BACKGROUND	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:						
	Res:							
	SpO ₂ :							
	Pulse:							
	BP:							
	Fall Risk Score:							
	Pain Score:							
Recommendations	Safety Needs:							
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:							
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:							
Post Operative Procedure Special Orders:								
Handed Over By Name :								
Signature :								
Date:								
Time:								
Taken Over By Name :								
Signature :								
Date:								
Time:								

BAH-00661804
 Baby Of SEELAM MADHURI TWIN 1
 18-07-2026
 Dr. NALINIKANTA PANIGRAHY
 IP5-00176457
 0 Y 0 M 0 D 6 H (M)

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA : 16/7/26		Diagnosis : MPT/ARDS		Surgery / Procedures : nil		
	Allergies :				Post OP Day : nil		
	Date :	16/7/26					
	Area	N2					
	Shift Time	8pm					
	Diet :	As per					
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)		RA				
	1.	} nil					
	2.						
	3.						
	4.						
	ASSESSMENT	Infusions / Transfusions		nil			
		PU Prophylaxis		nil			
		DVT Prophylaxis		nil			
		Vitals	BP	-			
			PR	152			
			RR	-			
			SpO ₂	98%			
Temp			36.7C				
Pain Score		3/10					
LOC (Alert, Conscious, Confusion, Unconscious)		Alert					
Skin Integrity (Intact / Bedsore / Any other condition)		Intact					
Restraints If any		Physical	nil				
	Chemical	nil					
Fall Risk (Vulnerable (Y/N) if yes score)		nil					
(Ambulation, walking, moving with assistance, bed ridden)		moving					
ADL (Dependent / Non-Dependent)		Depen					
Critical Lab Test / Values (if any)		nil					

Note : RA (Room Air, NP Nasal Prongs, NIV Non-Invasive Ventilation, VENTI Ventilator)

RECOMMENDATIONS	Investigations Procedures	Date :	16/12/20					
		Area	N1					
		Shift Time	8pm					
		Ordered / Planned	PBS					
			Need					
		Due	nil					
Reports Pending	nil							
Referrals (If any)	nil							
	Remarks (Special Interventions like, Drainage Tube flushing etc.)	Atk						
Handed Over By Name :		poor.th						
Signature :		poor.th						
Date :		16/12/20						
Time :		@ 8pm						
Taken Over By Name :		Latha						
Signature :		Latha						
Date :		16/12/20						
Time :		5:30 pm						



BRADEN 'Q' SCALE

					Date :	10/7	10/2	10/7
					Time :	8:45 AM	8:45 AM	1:00 PM
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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	2	2	2
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	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	2	2	2
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	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	3	3	3
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23								
Docu. No. : RCHBH /FRM / CLINICAL / 119								
TOTAL SCORE					28	18	18	18
Evaluator's Name					Sushil	Piyush	Sushil	Piyush

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BRADEN 'Q' SCALE

BAH-00661804 IP5-00176457
Baby Of SEELAM MADHURI TWIN 1
16-07-2026 0 Y 0 M 4 D (M)
Dr. NALINIKANTA PANIGRAHY



		Date : 19/7/26 20/7/26 21/7 20/7 Time : 8pm-8am 10am 8pm 8pm-8am							
	mobile: When 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 extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	2	3	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	1	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: Responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2	3	2	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	2	2	3	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."	3	3	3	3	
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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	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	18	18	18	18
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Dr. N. K. Panigrahy	Dr. N. K. Panigrahy	Dr. N. K. Panigrahy	Dr. N. K. Panigrahy

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
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Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BAH-00661804
 Baby Of SEELAM MADHURI TWIN 1
 16-07-2026 0 Y 0 M 0 D 7 H (M)
 Dr. NALINIKANTA PANIGRAHY

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

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	16/7	17/7	18/7	18/7	18/7
	3 to less than 7 years old	3	4	4	4	4	4
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3	3	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	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	1	1
TOTAL			18	18	18	18	18

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	yes	✓	✓	yes
Call device within reach		✓	yes	✓	✓	yes
Wheels Locked		✓	yes	✓	✓	yes
Room free of clutter		✓	yes	✓	✓	yes
Adequate Lighting		✓	yes	✓	✓	yes
Wheel Chair Support		x	no	x	x	no
Other Intervention(s) Specify		x	no	x	x	no
Nurse's Name :		Abhishek	Rishu	Suk	AD	Smith
Signature :		Abhishek	Rishu	Suk	AD	Smith
Date :		16/7	17/7	18/7	18/7	18/7
Time :		10:30 AM	8:30 AM	10:30 AM	10:30 PM	10 PM

BAH-00661804 IP5-00176457
Baby Of SEELAM MADHURI TWIN 1 (M)
16-07-2026 0 Y 0 M 4 D
Dr. NALINIKANTA PANIGRAHY

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THE HUMPTY DUMPTY SCALE 19/7 20/7 20/7 21/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	✓	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3	3	3	
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4	4	4	4	
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3	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	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	1	
TOTAL			18	18	18	18	

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	Yes	✓	✓	
Call device within reach	Yes	Yes	✓	✓	
Wheels Locked	Yes	Yes	✓	✓	
Room free of clutter	Yes	Yes	✓	✓	
Adequate Lighting	Yes	Yes	✓	✓	
Wheel Chair Support	No	No	X	X	
Other Intervention(s) Specify	No	No	X	X	
Nurse's Name :	Suetha	Rusha	Prithvi	Laksh	
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	
Date :	19/7	20/7	20/7	20/7	
Time :	@ 8pm	@ 2pm	@ 8pm	@ 8pm	

AM-00661804 IP5-00176457
by OI SEELAM MADHURI TWIN 1 (M)
-07-2026 0 Y 0 M 1 D
NALINIKANTA PANIGRAHY

CONSENT FOR FORMULA FEED

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Patient Name : B/O - Seelan madhuri T-I Age : Gender : ☐ Male ☐ Female

UHID No : Reg. No. : Department : Date :

I Mr / Mrs. : aged years, hereby declare that I have

admitted my ☐ son / ☐ daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on

I hereby give consent for formula feed for my child. Doctors have explained me
at the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : S. B. R. S. S. S.

Name : S. B. R. S. S. S.

Relationship with Patient : Grand mother

Date & Time : 16/7/26

Witness :

Signature : N. S. S. S.

Name : N. S. S. S.

Date & Time : 16/7/26 @ 12 PM

Doctor (who is taking the consent) :

Signature : P. S. S. S.

Name : P. S. S. S.

Date & Time : 16/7/26

డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

శిశు పేరు : వయస్సు లింగం పు స్త్రీ

యు. హెచ్.బి.డి. రిజిస్ట్రేషన్ నెం.: విభాగము

తేదీ

నేను శ్రీ / శ్రీమతి వయస్సు సంవత్సరాలు

నా కుమార్తె / కుమారుడు రెయిన్ఫో ఆసుపత్రిలో నవజాత శిశువుల ఇంటెన్సివ్ కేర్ లో అడ్మిట్ చేసినాము మరియు (ప్రార్థనా
ఫీల్డ్) డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుచున్నాను. డాక్టర్లు డబ్బా పాలు త్రాగించడం వల్ల కలుగు
ఉపయోగాలు, ప్రత్యామ్నాయాలు, మరియు నష్టాలు గురించి నాకు అర్థమైన భాషలో వివరించారు.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము