

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175884

Admit Date : 02-Jul-2026

Admit Time : 01:54 PM UHID : BAH-00660510

Patient Details :

Patient Name : Baby Of PRANAVI BOMMIREDDY

Age : 0 D

Guardian : MR RAJESH REDDY PALETI

DOB : 02-07-2026 12:13 PM

Gender : Female

Religion :

Occupation :

Martial Status : Single

Address (H) : PLOT NO. 792,VIVEKANANADA COLONY
Kukatpally Hyderabad Telangana INDIA
500072

Phone No : 9985696633/ 9000770005

E-mail : nomailid@gmail.com

Admission Details :

Bed Type : BASINET

Bed No : CRDL-SUITE421-1

Ward Name : 4F-BIRTHRIGHT
PREMIUM

Room No : CRDL-SUITE421-1

Admission Type : First Visit

Contact Details :

Name : MR RAJESH REDDY PALETI

Relationship : Father

Contact Address : PLOT NO. 792,VIVEKANANADA COLONY
Kukatpally Hyderabad Telangana INDIA 500072

Phone No : / 9985696633

Signature

Doctor Details :

Doctor Name : Dr. DINESH KUMAR CHIRLA

Specialisation : NEONATOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

BAH-00660510 IP5-00175884
 Baby Of PRANAVI BOMMIREDDY
 02-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. DINESH KUMAR CHIRLA



NEWBORN MONITORING FORM

Date of Birth : 2/7/26
 Time of Birth : 12:13 PM
 Mode of Delivery : VBAC
 Birth Weight : 3.84 kg
 Head Circumference : 35 cm
 Length : 50 cm
 Red Reflex :

New Born Screening :
 TFT :
 OAE :
 Mother's Blood Group : A+ve
 Baby's Blood Group : A+ve
 Anomaly Scan :
 Vaccination : OPV, DCC, Hep B given on 3/7/26 NDMCH

Date	Weight	Type of Feed	Quantity	Temperature	Signature
2/7/26	3.442 kg	DBF	—	98.3 F	Swarna
	ward weight 3.380 kgs				
3/7/26	3.289 kg	DBF	—	98.3 F	Swarna
4/7/26	3.169 kgs	DBF	—	98.3 F	Ashwita

[illegible]

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

Docu. No. : RCHBH /FRM / CLINICAL / 185

Patient Sticker

RBS CHART

[illegible]

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Doanari Bommireddy 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 Pranavi Bommireddy Mother's Blood Group : A POSITIVE
Gender : ☒ M ☐ F Blood Group : A + ve Birth Weight (gms) : 3.442 Length (cms) : 50cm
Date of Birth : 21/7/2026 Time of Birth : 12:13pm OFC (cms) : 35cm
Place of Birth : RCH, Banjara Estimated Gesth Age : 37+1wks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 33y Ht : Wt : 75kg BMI : Married Life : 8yrs LMP : 15/10/25 EDD : 22/7/26

Conception : Spontaneous or with Rx : 22+6w

Booked at what GA : 22+6wks

Last Scans Details : SUVF 34+5wks Cephalic : AFI = 12.5cm

EFW = 3041g (93%) 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 :

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

Controlled or not, recent values, HbA1 values :

GDM on OHA : 30wks

Compliance with Rx : Diet : 28wks

Scans : LGA, TIFFA , Fetal Echo :

H/o Hypothyroidism : when diagnosed ? Medication?

Any other Chronic Medical Problems, when detected

drugs ?

(Anemia, SLE, Jaundice, CHD, Heart Disease)

Infection : H/O, Fever

(☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)

UTI : when : Any culture :

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

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

.....3..... P:.....2..... A:..... L:.....1..... D1

Sl. NO.	Age	GA wks	B.W	Gender	Significant	Details
G ₁	2020	Em-18cs	(Preterm @ 32wks, 18L, Still birth 2-1kg 0.7)			
G ₂	2021	El-18cs (34wks)	3.1kg		H/o Scar dehiscence GDM on OHA.	
G ₂	2026	Sp-Conception				

PERINATAL HISTORY

Treating Obstetrician : Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig) Elec-18cs

Second stage (> 2 hours after dilation)

LSCS : ☒ Elective ☐ Emergency Indication :

Specify the reason : Scar dehiscence

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL :

Resuscitaion : ☐ Yes ☐ No

Cord ABG :

Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc : 100g/10cm

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

1 Minute	5 Minutes	10 Minutes
1	1	
2	2	
2	2	
2	2	
1	1	
8	8	

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 :



Equipment check done



Baby has received in a pre warmed linen



Dried / cleaned / Stimulated



Cord cleaned / clamped / cut



mg. vitamin K 0.5ml 1.m given



Noted to have RD

→ SCB

→ audible grunt

→ Nasal Flaring

DR CPAP



Downes: 4.

Shifted to
NIV

Investigation details in previous Hospital :

Feeding History :

BAH-00660510

IP5-00175884

Baby Of PRANAVI BOMMIREDDY

02-07-2026 0 Y 0 M 0 D 5 H (F)

PcDr. DINESH KUMAR CHIRLA



not visible - this morning

not visible - this morning

Family History :

no chronic / acute / systemic diseases
 → / no chronic / acute / systemic diseases

Socio Economic History :

Family history of chronic / acute / systemic diseases
 no chronic / acute / systemic diseases
 no chronic / acute / systemic diseases

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Euthermic pink
 CRT/As good
 hemodynamics stable

VITALS : Temperature : Euthermic HR : 149/min RR : 29/min NIBP : CFT : 23

Color of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 97%

ANTHROPOMETRY: Birth Weight : 3440 Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

BAH-00660510

IP5-00175884

Baby Of PRANAVI BOMMIREDDY

02-07-2026

0 Y 0 M 0 D 5 H (F)

Dr. DINESH KUMAR CHIRLA



HEAD TO TOE EXAMINATION

HE

Fontanelles :

Sutures

Shape / Moulding :

Edema / Bruising :

Size - (H.C.) :

AF: open

FACIES :

(Any Facial

Dysmorphism)

— x —

NECK and
CLAVICLES :

Range of Motion :

Asymmetry :

Masses :

— x —

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 :

no cleft lip/palate

THORAX and
BREASTS :

Shape of Thorax :

Position of Nipples and Number :

— x —

ABDOMEN and
UMBILICUS :

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump : 2A + 1V

Discharge :

GENITALIA :

Labia / Hymen :

Testicles/penis :

Anus :

no

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

EXTREMITIES :

Fingers / Toes :

Deformities :

Hip Joint Examination :

Arms / Legs :

Mobility :

no



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern: ☒ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress: RR: 69/min SCR ICR / See - Saw breathing:

Scoring of respiratory distress if present (Silverman or Downe's): 4

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

Settings:

SpO₂: 97% Auscultation: BAE(+) Breath Sounds: ANBS+ Added Sounds:

CARDIOVASCULAR SYSTEM:

HR: 149/min BP:

Precordial Activity:

Femoral Pulses: 2/2 well felt

Murmurs:

Other Peripheral Pulses:

Signs of Cardiac Failure:

ABDOMEN:

Shape:

Hernia orifice:

Palpation:

Anal Patency: looks patent

Palpable masses:

Umbilical Cord: 24 cm

Abdominal girth:

First urine passed:

Meconium passed:

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium):

State of wakefulness:

Prechtl Score:

Nerves:

MOTOR SYSTEM:

Passive Tone:

Active Tone: 2/2 good

Neonatal Reflexes:

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

Moro's: 2/2 symmetrical DTR:

ATNR:

Skull and Spine: 1/1

Any C



Diagnosis :

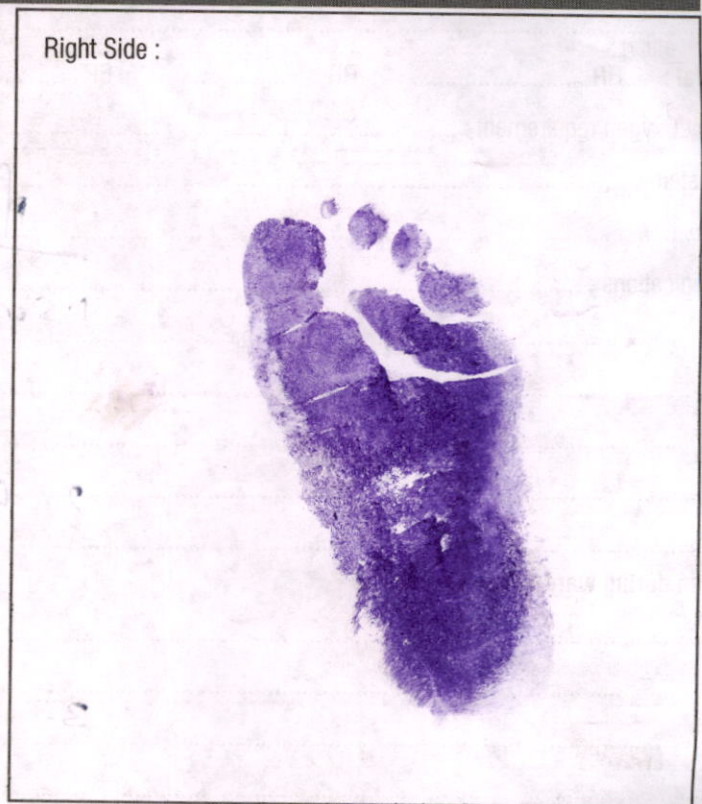
S7+1 / S2P1UD1 / EL-LSC - Scal dehiscence / GDM /
CIAB / 3442 grams / Fch.

FOOT PRINTS

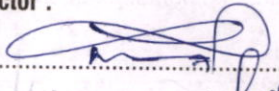
Left Side :



Right Side :



Resident Doctor :

Signature : 

Name : Dr. Lohith

Date & Time : 2/7/26

Consultant :

Signature :

Name :

Date & Time :

PLEASE FILL UP THE FOLLOWING DETAILS

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

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

AT THE TIME OF TRANSFER TO THE WARD

Neonatal condition at the time of Transfer:

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

Any Oxygen requirement :

Systemic :

Medications :

Plan
1. Send cord blood for
blood grouping / ABG.

2. OG tube placement
- 60ml/kg/day.
- 2nd hourly feed

Plan during ward follow up :

3. ABG monitoring 30mins post feed
3, 6, 12, 18, 24, 36, 48 hrs post feed.

Feeding Plan at the time of shifting :

4. low flow O₂ @ 2 lit/min.

Screenings done during NICU Stay :

5. IF ↑ed LD then repeat gas
and chest x ray.

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:

BAH-00660510 IP5-00175884
Baby Of PRANAVI BOMMIREDDY
02-07-2026 0 Y 0 M 0 D 4 H (F)
Dr. DINESH KUMAR CHIRLA



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name:

Mother's Name: Mrs. Pranavi

Date of Birth: 02/07/2026

Time of Birth: 12:13 PM

Gender: ☐ Male ☒ Female

Birth Weight: 3.442 Kgs

HC: 35 cm

Length: 50 cm

Meconium in Liquor: ☐ Yes ☒ No

Cried at Birth: ☒ Yes ☐ No

Term / Pre-term / Post-term: Term

Resuscitated: ☐ Yes ☒ No

Blood Group: Mother: A+

Baby: A+

Feeding: ☒ Breast Feeding

☐ Formula

☐ Both

First Feed Time:

AFFIX MOTHER'S
IDENTIFICATION LABEL

Mode of Delivery: ☐ Normal

☒ LSCS - Emergency/ Elective

☐ Instrumental

☐ AVD

Indication:

Physical Assessment of New Born:

Temp: 98.5 °C HR: 141 /Min RR: 41 /Min BP: — SpO₂: 100%

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: ☒ Yes ☐ No

Score: 16 (Fill the Humpty Dumpty Sheet)

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

Behaviour Status on admission: ☐ Sleeping ☐ Crying ☐ Calm ☐ Drowsy

Findings:

General Appearance:

Posture:

☐ Well-Flexed

☐ Asymmetry

Skin:

☒ Pink

☐ Meconium Stain

☐ Others, Specify:

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

Vitamin K 1 mg

I.M. Administered: Yes / No

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

All information obtained from ☒ Mother ☐ Father ☐ Other Family Member

Newborn Screening Discussed: Yes / No

Nurse Name: Surekha

Signature: [Signature]

Date & Time: 02/07/2026 12:30 PM

Date & Time	Progress Notes	Doctor's Order
02/07	lactation Notes mother motivated to feed. nipple well formed with colostrum seen. DBF every 2-5 hours. monitor urine output <u>Shreya Moddali</u>	0300 - provide 0600 - provide 0900 - provide 1200 - provide 1500 - provide 1800 - provide 2100 - provide
3/7/26 @ 8:15am	<u>Morning Rounds</u> 20 HOL / 37+1wks / mother - GDM on OHA. RD - TTNB. B.wt = 3.442 - 3.380. Tdy.wt = 3.289. wt. loss = 1.8%. MBG - A+ve. BBG - A+ve. last GIRBS 70 > 61 > 65 Vitals : HR = 142/min RR = 40/min SpO₂ = 99%. P/A - Soft.	Plan 1) Continue Direct Breast feeding 2nd hourly play Burping 2) TCBR at 24 HOL - 6.0 (12pm) 3) OAE / SBR / NBS at 48 HOL 4) vaccination OPV, Hep B, BBG - Today



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	latching well Receiving feeds well	5) Continue GRBS monitoring 24 HOL, 36#OL, 48HOL.
	Stool - passed Urine - passed.	↓ Prefeed Inform if <50 mg/dl
		6) w/ feeding, activity
		<u>Sruha</u>
30/7/26 4pm	CLB RESIDENT	
	27#OL 37#H WKS / Gen on OHA	RD-TTNB
	A+ M A+ MV	Plan
	Euthermic Pink	1. ct RES monitoring
	ct/Ar good	2. DBF/2nd week,
	Warm peripheries.	
	Good perfusion.	3. OAE/GRB/WBS at 12pm t/m.
		4. Warm care
		5. vaccines - OPV/BCG/Hep-B
		shots
		<u>WB by Ashwika</u>

BAH-00660510

IP5-00175884

BAH-00660510
Baby Of PRANAVI BOMMIREDDY
X O M 1 D

Baby Of PR
02-07-2026

0Y0M1D

(F)

02-07-2026
Dr. DINESH KUMAR CHIRLA



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

It takes a lot to treat the little



BirthRight™

BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]



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	↓ ROS	To Reduce RDS. To give feed	Feed given infection to control hand hygiene	<i>[Signature]</i>	☒ Nursing ☐ Others:
3/7/26 8pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	DBF BURPING	BURPING after feed	Provide care	<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:



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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		
2/7/26	2pm	1/7/9	Nutrition & Diagnosis	M/P	9	0	1	9	good	J
3/7/26	8pm	7	Infection control Measures	M/P	1	0	1	1	-	Abhis

Part - III: CODES

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

BAH-00660510 IP5-00175884
Baby Of PRANAVI BOMMIREDDY
02-07-2026 0 Y 0 M 0 D 5 H (F)
Dr. DINESH KUMAR CHIRLA



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

THE HUMPTY DUMPTY SCALE 2/2 2/2 3/2 2/2 3/2

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	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					
	Female	1	1	1	1	1	1
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3				
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1		1	1	1	1
Cognitive Impairments	Not Aware of Limitations	3	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	2				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			15	15	15	15	15

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	x	x	x	x
Call device within reach		✓	x	x	x	x
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓	✓
Wheel Chair Support		x	x	x	x	x
Other Intervention(s) Specify		x	x	x	x	x
Nurse's Name :		Key Sampath				
Signature :		[Signature]				
Date :		2/2 2/2 3/2 2/2 3/2				
Time :		10pm 8pm 8pm 8pm 8pm				

BAH-00660510 IP5-00175884
 Baby Of PRANAVI BOMMIREDDY
 02-07-2026 0 Y 0 M 0 D 5 H (F)
 Dr. DINESH KUMAR CHIRLA



NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

Assessment Criteria	Sedation		Normal	Pain / Agitation		Date	Date	Date	Date	Date	Date	Date	Date
	-2	-1	0	1	2	Time	Time	Time	Time	Time	Time	Time	Time
						2/7	2/7	3/7	3/7	4/7			
						2m	10pm	2am	2pm	8pm			
						Procedure	RBS	RBS	RBS	RBS	RBS		
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0	0	0	0	0			
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)	0	0	0	0	0			
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	1	0	0	0	0			
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense	0	0	0	0	0			
Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	0	0	0	0	0			
	Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age					Gestational Age / Corrected Age 34w 3d 3h 3m 3s / 34w 3d 3h 3m 3s		Total Pain / Agitation Score 1/10 0 0 0 0					
	Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 - No Intervention Pain Score greater than 3 - Intervention					Intervention Dme NA NA NA NA		Effectiveness gms NA NA NA NA					
						Signature [Signature]							

NPASS: Neonatal Pain, Agitation & Sedation Scale

	Sedation	Pain / Agitation
How to use	- Observe the infant for a minute before selecting a score for each behavior. - Stimulate the infant and observe and select a score for each behavior. - Select only one numeric value (Highest) per behavior.	- Observe the infant for a minute before selecting a score for each behavior. - Select only one numeric value per behavior.
Scoring/ Documentation	- Sedation scores are negative scores only - Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age) - NPASS Sedation total score has a range from 0 to -10 possible. - Document total NPASS Sedation score in the medical record.	- Pain/Agitation scores are positive scores only - Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria. - Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score. - NPASS Pain/Agitation total score has a range from 0 to 13 possible. - Document the total NPASS Pain/Agitation score in the medical record
Interpretation	- Desired levels of sedation vary according to the situation. - Discuss and determine sedation goal with provider. "Deep sedation": goal score of -10 to -5 - Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea "Light sedation": goal score of -5 to -2 - Reassess patient per frequency in local sedation policy - A negative score without the administration of opioids/ sedatives may indicate: - The premature infant's response to prolonged or persistent pain/stress - Neurologic depression, sepsis, or other pathology	- Does not provide pain intensity rating. - Any score greater than 3 indicates the possibility of the presence of pain in the infant - Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological). - Reassess patient per frequency of local pain policy. - If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention.

BAH-00660510 IP5-00175884
 Baby Of PRANAVI BOMMIREDDY
 02-07-2026 0 Y 0 M 0 D 5 H (F)
 Dr. DINESH KUMAR CHIRLA



BRADEN 'Q' SCALE

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

BirthRight[™]
 BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	2/7	3/7	3/7/26	
					Time :	2 pm	8 am	8 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 e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	L	2		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1	1		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	3	3	3		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3	3	3		
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	3	3	3		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	3	3	3		
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				
					19 18 18				
					Evaluator's Name				
					[Signature] [Signature] [Signature]				

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



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time: 12	2	4	7:15	11 PM	3 AM	7 AM
Doctor/Nurse/Family Concern?	pm	p	pm	7:15	11 PM	3 AM	7 AM
Temperature (°F)	36.5°C	36.5°C	36.6°C	98.5	98.5	98.5	98.5
Heart Rate (bpm)	53	55	56	144	140	142	142
Blood Pressure (mmHg) *	40/30	45/33	45/36				
Resp. Rate (bpm) (Over 1 Minute) *	30	40	42	30	40	42	40
Resp Rate (Number)							
Receiving O ₂ (l/min)	0	0	0	0	0	0	0
O ₂ Saturations (%)	96%	98%	96%	98%	98%	98%	98%
Conscious Level	1/15	2/10	2/10	13/15	13/15	14/15	13/15
GCS *	2	2	2	13	13	14	13
TOTAL SCORE	1	1	1	0	0	0	0
Number of shaded boxes							
Pain Score							
Observer's Initials							

ACTIONS

NB: Scores 3 should be recorded overleaf

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

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

BAH-00660510 IP5-00175884
Baby Of PRANAVI BOMMIREDDY
02-07-2026 0 Y 0 M 0 D 4 H (F)
Dr. DINESH KUMAR CHIRLA



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

.....Y WARNING SCORE: CHILDREN'S UNIT

Date: 3/7/26 Time: 10pm 1pm 4pm 8pm 11pm 3am 7am
Doctor/Nurse/Family Concern?

Temperature
(F)

104							
103							
102							
101							
100							
99							
98	<u>98.1</u>	<u>98.2</u>	<u>98.3</u>	<u>98.4</u>	<u>98.5</u>	<u>98.6</u>	<u>98.7</u>
97							
96							
95							
94							

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

190							
180							
170							
160							
150							
140	<u>141</u>	<u>142</u>	<u>143</u>	<u>144</u>	<u>145</u>	<u>146</u>	<u>147</u>
130							
120							
110							
100							
90							
80							
70							
60							
50							
Heart Rate (Number)	<u>141bpm</u>	<u>142bpm</u>	<u>143bpm</u>	<u>144bpm</u>	<u>145bpm</u>	<u>146bpm</u>	<u>147bpm</u>

Resp. Rate (bpm)
per 1 Minute) *

70							
60							
50							
40	<u>41</u>	<u>42</u>	<u>43</u>	<u>44</u>	<u>45</u>	<u>46</u>	<u>47</u>
30							
20							
10							
Resp Rate (Number)	<u>38bpm</u>	<u>40bpm</u>	<u>42bpm</u>	<u>44bpm</u>	<u>46bpm</u>	<u>48bpm</u>	<u>49bpm</u>

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>100%</u>	<u>99%</u>	<u>100%</u>

Conscious Normal
Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

0		0		0		0		0
0		0		0		0		0
<u>8</u>		<u>9</u>		<u>8</u>		<u>9</u>		<u>8</u>

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 02/07/2026 Time: 10:47 AM

Doctor/Nurse/Family Concern?

Temperature
(F)

Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

Resp. Rate (bpm)
ver 1 Minute) *

Resp Rate (Number)

Resp Distress Mod/ Severe
None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

Conscious Level Normal
Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
recorded overleaf

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

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- 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)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time:																			
Doctor/Nurse/Family Concern?																			
Temperature (°F)	104																		
	103																		
	102																		
	101																		
	100																		
	99																		
	98																		
	97																		
	96																		
	95																		
	94																		
Heart Rate (bpm)	190																		
	180																		
	170																		
	160																		
	150																		
	140																		
	130																		
	120																		
	110																		
	100																		
	90																		
and Blood Pressure (mmHg) *	80																		
	70																		
	60																		
	50																		
	40																		
Note: BP does not score in early warning scoring																			
Heart Rate (Number)																			
Resp. Rate (bpm) ver 1 Minute) *	70																		
	60																		
	50																		
	40																		
	30																		
	20																		
	10																		
	0																		
Resp Rate (Number)																			
Resp Distress	Mod/ Severe None / Mild																		
Receiving O ₂ (l/min) O ₂ Saturations (%)																			
Conscious Level	Normal Altered																		
GCS *																			
TOTAL SCORE																			
Number of shaded boxes																			
Pain Score																			
Observer's Initials																			
ACTIONS NB: Scores 3 should be recorded overleaf		Score 1 : Continue normal observation by staff nurse																	
		Score 2 : Shift in charge nurse to be informed and continue hourly observations																	
		Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.																	
		Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see																	
		Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed																	

* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- 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. : 1

Bwt - 3.4 kgs

Tv - 60 celly/ly

TP - 12m

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

		Intake				Output						IV Site	Sign.
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	Nurse		
			Mouth	I.V	NG								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm	Nan			12m	-			5ml	1			
Total Intake :					Total Output :								
	02:00 pm												
	03:00 pm	Nan			12ml	-			10ml	1			
	04:00 pm												
	05:00 pm	Nan			12ml	-				2			
	06:00 pm					✓				1			
	07:00 pm												
Total Intake :					Total Output :								
	08:00 pm	DBF				✓			✓				
	09:00 pm	DBF				✓							
	10:00 pm												
	11:00 pm												
	12:00 am	DBF				✓			✓				
	01:00 am												
Total Intake :					Total Output :								
	02:00 am	DBF											
	03:00 am	DBF				✓			✓				
	04:00 am												
	05:00 am	DBF				✓							
	06:00 am	FF20ml											
	07:00 am												
Total Intake :					Total Output :								
Total 24 hrs. Intake		Total 24 hrs. Output											

BAH-00660510 IP5-00175884
 Baby Of PRANAVI BOMMIREDDY
 02-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. DINESH KUMAR CHIRLA



FLUID CHART

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Sheet No. : 2

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

		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							
03/7/26	08:00 am										no IV sandhya	sandhya
	09:00 am	DBM							✓			
	10:00 am					✓						
	11:00 am	DBM										
	12:00 pm											
	01:00 pm	DBM							✓			
Total Intake : taken					Total Output : passed							
03/7/26	02:00 pm										no IV sandhya	sandhya
	03:00 pm	DBM				✓			✓			
	04:00 pm											
	05:00 pm	DBM										
	06:00 pm								✓			
	07:00 pm	DBM				✓						
Total Intake : taken					Total Output : passed							
3/7/26	08:00 pm	DBM									no IV ashwita	ashwita
	09:00 pm	-										
	10:00 pm	DBM				✓			✓			
	11:00 pm	DBM										
	12:00 am											
	01:00 am	-										
Total Intake : Taken					Total Output : Passed							
4/7/26	02:00 am	DBM							✓		no IV ashwita	ashwita
	03:00 am	DBM										
	04:00 am											
	05:00 am	DBM										
	06:00 am											
	07:00 am	DBM				✓			✓			
Total Intake : Taken DBM					Total Output : Passed U=8, M=4							
Total 24 hrs. Intake												
Total 24 hrs. Output												

BAH-00660510 IP5-00175884
 Baby Of PRANAVI BOMMIREDDY
 02-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. DINESH KUMAR CHIRLA



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

FLUID CHART

Sheet No. : 3

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								
7/7/26	08:00 am									✓	NO	Seethu	
	09:00 am	DBM					✓				IV	Seethu	
	10:00 am											Seethu	
	11:00 am												
	12:00 pm	DBP											
	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							



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						



①

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 2/2/26

Assessment: New born baby to observatory

- 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
12pm	To monitor the vitals	12pm	monitored the vitals	⇒ Baby is stable
	To Maintain 2to chesty		maintained 2to chesty	⇒ to chesty feeds.
2pm	To give feeding	2pm	1st feeding given	
	To check RBS		every 2nd hourly	
4pm	To provide position	4pm	RBS checked as advised.	
6pm		6pm	provided comfortable position and warm care.	

Re-Assessment: Re-assessment done

Special Notes: RBS -

Nurse Signature:

Nurse Name: Kanya

Date & Time: 2/2/26 8pm

BAH-00660510 IP5-00175884
 Baby Of PRANAVI BOMMIREDDY
 02-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. DINESH KUMAR CHIRLA



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: 21/7/2026

Assessment: new born Baby Clee

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ assess the Baby condition	8:30pm	→ assessed the Baby condition	→ Baby stable
10pm	→ monitor vitals	10:30pm	→ monitor vitals	
12am	→ Ifo chart monitoring	12:30am	→ Ifo chart monitored	
2am	→ warm care	2am	→ warm care Provided	
5am	→ RBS monitoring	6am	→ RBS monitored as per order	
7am	→ DBF and Burping	8am	→ DBF and Burping done	

Re-Assessment: done Baby stable

Special Notes: RBS monitoring SBR, NBS OAE @ 48 Hrs.

Nurse Signature:

Nurse Name: Swapna

Date & Time: 31/7/2026 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 03/07/2026

Assessment: New born baby case

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
8 AM	⇒ Assess the baby condition	8:30 AM	⇒ Assessed the baby condition	⇒ Baby is stable.
9 AM	⇒ monitor the vitals	9:30 AM	⇒ monitoring the vitals checked and recorded	
10 AM	⇒ DBM and burping 2nd hourly	10:30 AM	⇒ DBM and burping done 2nd hourly.	
11 AM	⇒ warm care	11:30 AM	⇒ warm care given	
12 PM	⇒ maintain I/O chart	12:30 PM	⇒ maintaining I/O chart	
1 PM	⇒ ensure safety needs	1:30 PM	⇒ ensured safety needs	

Re-Assessment: Re-Assessment done

Special Notes: vaccination today

Nurse Signature:

Nurse Name: Saneliya

Date & Time: 03/07/26 @ 2 PM

BAH-00660510 IP5-00175884
 Baby Of PRANAVI BOMMIREDDY
 02-07-2026 0 Y 0 M 0 D 4 H (F)
 Dr. DINESH KUMAR CHIRLA



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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 03/07/2026

Assessment: New born baby case

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	⇒ Assess the baby condition	2:30pm	⇒ Assessed the baby condition	⇒ Baby is stable.
3pm	⇒ monitor the vitals	3:30pm	⇒ monitoring the vitals checked and recorded	
4pm	⇒ DBM and burping 2nd hourly	4:30pm	⇒ DBM and burping done 2nd hourly	
5pm	⇒ warm care	5:30pm	⇒ warm care given	
6pm	⇒ vaccination done	6:30pm	⇒ vaccination done. BCG, OPV, Hep B	
7pm	⇒ ensure safety needs	7:30pm	⇒ ensured safety needs	

Re-Assessment: Re-Assessment done

Special Notes: monitoring vitals

Nurse Signature:

Nurse Name: sandhya

Date & Time: 03/07/2026 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: New born baby care

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8:00pm	Assess the general Condition	8:10pm	Assessed the general Condition of baby	Baby is stable
10:00pm	monitor vitals	10:10pm	Vitals checked pulse, spO2, Resp	
12:00am	monitor Ilo chart	12:10am	Ilo chart monitored	
2:00am	DBF every 2nd hourly	2:10am	DBF given every 2nd hourly	
4:00am	CRBS monitoring	4:10am	CRBS monitoring done	
6:00am	provide crib care	6:10am	crib care provided.	
8:00am	Ensure Safety	8:10am	Safety provide	

Re-Assessment:

Re-Assessment done

Special Notes:

CRBS monitoring

Nurse Signature:

Alexandra

Nurse Name:

Ashwitha

Date & Time:

4/7/26 @ 8am

BAH-00660510 IP5-00175884
Baby Of PRANAVI BOMMIREDDY
02-07-2026 0 Y 0 M 1 D (F)
Dr. DINESH KUMAR CHIRLA

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:

①

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA : 2/7/26	Diagnosis : ROS	Surgery / Procedures :				
	Allergies :		Post OP Day :				
	Date :	2/7/26					
	Area	N2					
	Shift Time	8 AM - 3 PM					
	Diet :	Naspr					
INVASIVE LINES	Ventilation (RA, NP, NIV, VENTI)	RA					
	1.	OG - ①					
	2.						
	3.						
	4.						
ASSESSMENT	Infusions / Transfusions						
	PU Prophylaxis						
	DVT Prophylaxis						
	Vitals	BP					
		PR	152 bpm				
		RR	-				
		SpO ₂	96%				
		Temp	98.6 F				
	Pain Score		0/10				
	LOC (Alert, Conscious, Confusion, Unconscious)		Alert				
	Skin Integrity (Intact / Bedsore / Any other condition)		Intact				
	Restraints If any	Physical	NR				
		Chemical	NR				
	Fall Risk (Vulnerable (Y/N) if yes score)		yes				
	(Ambulation, walking, moving with assistance, bed ridden)		moving				
ADL (Dependent / Non-Dependent)		Dependent					
Critical Lab Test / Values (if any)		NR					

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

RECOMMENDATIONS	Investigations Procedures	Date :	2/7/20						
		Area							
		Shift Time	N2 8am-4pm						
		Ordered / Planned	TU 1:50 PDS						
		Due							
		Reports Pending							
		Referrals (If any)							
		Remarks (Special Interventions like, Drainage Tube flushing etc.)							
		Handed Over By Name :							
		Signature :							
Date :									
Time :									
Taken Over By Name :									
Signature :									
Date :									
Time :									

BAH-00660510 IP5-00175884
Baby Of PRANAVI BOMMIREDDY
02-07-2026 0 Y 0 M 0 D 4 H (F)
Dr. DINESH KUMAR CHIRLA



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Dinesh Kumar Department: BP Date of Admission: 2/7/26

SITUATION	Diagnosis: <u>New born baby for observation</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known			
			If Yes Specify:			
BACKGROUND	Area	<u>BP</u>	<u>BP</u>	<u>BP</u>	<u>BP</u>	
	Shift Time	<u>7pm-8pm</u>	<u>8pm-9pm</u>	<u>9pm-10pm</u>	<u>10pm-11pm</u>	
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NH</u>	<u>NA</u>	<u>NA</u>	<u>NH</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.2°</u>	<u>98.1°</u>	<u>98.1°</u>	<u>98.2°</u>
		Res:	<u>40b/m</u>	<u>40b/m</u>	<u>40b/m</u>	<u>40b/m</u>
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>
		Pulse:	<u>140</u>	<u>140b/m</u>	<u>140b/m</u>	<u>140b/m</u>
		BP:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
	Fall Risk Score:	<u>16</u>	<u>16</u>	<u>15</u>	<u>16</u>	
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	
	Recommendations	Safety Needs:	<u>Side rail</u>	<u>Side rail</u>	<u>Side rail</u>	<u>Crib rail</u>
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		<u>NH</u>	<u>NA</u>	<u>NA</u>	<u>NH</u>	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		<u>NH</u>	<u>NA</u>	<u>NA</u>	<u>NH</u>	
Post Operative Procedure Special Orders:		<u>GAB</u>	<u>NA</u>	<u>NA</u>	<u>NH</u>	
Handed Over By Name :		<u>Deepa</u>	<u>Swapne</u>	<u>Sandhya</u>	<u>Ashwita</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>2/7</u>	<u>3/7/26</u>	<u>3/7/26</u>	<u>4/7</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>8pm</u>	<u>2pm</u>	
Taken Over By Name :		<u>Swapne</u>	<u>Sandhya</u>	<u>Ashwita</u>	<u>Deepa</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>2/7/26</u>	<u>3/7/26</u>	<u>3/7/26</u>	<u>4/7</u>	
Time:		<u>8pm</u>	<u>8am-2pm</u>	<u>8pm</u>	<u>8am</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area						
	Shift Time						
	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:							