

ADMISSION SHEET

Registration Details :


Admission No : IP5-00176620 Admit Date : 20-Jul-2026 Admit Time : 01:34 AM UHID : BAH-00661624

Patient Details :

Patient Name	: Baby Of PONDUGULA NANDITHA	Age	: 0 Y 0 M 6 D
Guardian	: Mr SAI KIRAN MAGULURI	DOB	: 14-07-2026 11:54 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: EDENC 112, LODHA CASA PARADISO. Sanathnagar Hyderabad Telangana INDIA 500018	Phone No	: 7204899289/ 9908423355
		E-mail	: SAIKIRAN.MAGULURI@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD Bed No : SW 323 C Ward Name : 3F-ZONE C
 Room No : SW 323 C Admission Type : First Visit

Contact Details :

Name	: Mr SAI KIRAN MAGULURI	Relationship	: Father
Contact Address	: EDENC 112, LODHA CASA PARADISO. Sanathnagar Hyderabad Telangana INDIA 500018	Phone No	: 7204899289


 Signature

Doctor Details :

Doctor Name	: Dr. NALINIKANTA PANIGRAHY	Specialisation	: NEONATOLOGY
Referral Doctor	: SELF	Phone No	:
Co-Consultant	:		

Payment Details :

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

BAH-00661624 IP5-00176620
 Baby Of PONDUGULA NANDITHA
 14-07-2026 0 Y 0 M 6 D (M)
 Dr. NALINIKANTA PANIGRAHY



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ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____ Date of Discharge : _____ Time: _____

Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7/26	2:05 PM	ER	523 L	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

21/7/26

SBP.

Sent

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



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

Vaccination : opv, BCG, Hep-B
done on 21-20/07/26 by sis. Prithi

(P.T.O)

[illegible]



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PEDIATRIC IN-PATIENT MEDICAL RECORD

BAH-00661624 IPS-00176620
Baby Of PONDUGULA NANDITHA
14-07-2026 0 Y 0 M 6 D (M)
Dr. NALINIKANTA PANIGRAHY



Patient Name:

B/o Nanditha

UHID ID:

Department:

Consultant:



Pediatric Multiorgan History & Physical Examination

Name : _____ Age/Sex 5 days / m

Information given by: _____ Relationship _____

Chief Presenting Complaints & Duration (Chronologically)

Yellowish discoloration (jaundice)

History of present illness :

- Yellowish discoloration till legs

M / B⁺
B / B⁺

Day of life 5

B.Wt - 2.157 kg

Birth Discharge - wt $\rightarrow$ 2.091 kg

T.Wt - 2.12 kg

NBS awaited.

ADBR - $\checkmark$

NSG - (N)

Serum TBLR - 15.1 mg/dl

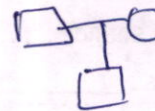


Pediatric Multiorgan History & Physical Examination

Past History : (Including details of any previous investigation or treatment)

Birth & Neonatal History:

Used open stimulation
Term (38+5) / ~~MAVD~~ / ~~GBS~~ / Bwt - 2.57kg
NICU stay - d/t - RDS - DR CPAP.



Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Immunization History :

~~Both vaccines~~

Both vaccination not done



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____)

Weight (kgs)) 2.1576g (Centile _____)

On Examination :

Temperature : 98.2°F Pulse Rate : 139/min B.P. _____ SP02 97% on RA

Resp.rate and type of breathing : 52/min

Rash _____

Lymphadenopathy _____

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : _____

Air entry & breath sounds : Bare in clear

Any addes sounds : _____

Relevant data from outside (Chest X-Ray, ABG, etc.,) _____

Cardiovascular System :

Inspection of procordium : _____

Heart Sounds : S1 S2 (+)

Any murmur : _____

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection _____

Palpation : (+)

Ausculation : _____

Spine : _____ External Genitalia : _____

Relevant data from outside (CT, USG etc.,) _____



Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR

Plantars _____

Superficials:

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

NNG



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

dehydration, ↓ urine output, Hypotension

Desired goals of the treatment: _____

Hemodynamic stability

Planned Labs:

RBS - 70mg/dL

Bhava
20/7/26

Planned Management

- Sept E eyes and
genitals covered

- IV - 140ml/kg/day
25-30ml/kg/day E
Pedsday (or) DNR

- All SBR after round
the

Signature of the Doctor: _____

Name of the Doctor: Dr. Nalinikanta Panigrahy

Date & Time: 20/7/26

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: 20/7/26

Dr. NALINIKANTA PANIGRAHY
Reg. No.: TSMC/FMR/03605

BAH-00661624 IP5-00176620
Baby Of PONDUGULA NANDITHA
14-07-2026 0 Y 0 M 7 D (M)
Dr. NALINIKANTA PANIGRAHY



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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary				
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	3			
7	Nursing plan of care and handover sheets	3			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation				
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Total No. of Pages	22			

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

Date & Time	Progress Notes	Doctor's Order
20/7/26 1:20am	DOL-5. T.Wt - 2.12kg B.Wt - 2.15kg. Q/E - Icterus @ legs. C/T/A - good. RBS - 7oml/de. HR - 156/min RR - 49/mic. <i>[Signature]</i> Dr. Porjittu.	<u>Plan.</u> → Admit in ward → Start SSPT E eyes & genitals covered. → TV - 140cc/kg/day 25-30ml 2nd hily paladay feed ① DBF → R/V SBR after loads - 11m. noted by martha 2/15Am

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 8:10 am	Morning Round. DOL-6 / Term / A/GA / NNTJ - 2157g. on RA. Hemodynamically stable TCBR at on DOL-5 - TCBR-15-1 started SSPT at 2AM.	Dr. LBW, 2kg baby hence needed Plan SSPT @ 15mg/dl SBR → Continue SSPT & eyes & genitals covered
M/BT B/BT	T.Wt - 2.078kg 3.6 l. P/A - soft U/I S/I	→ IV - 160cc/kg/day 30ml/2nd half full paladay on DOR. → Lactation assessment
	breast feed 63m = 45/100 Colostrum 400g/Regime eye swabs Dr. Poopilla	→ to to send SBR after sounds 3pm If < 12 mg/dl → D/C → Temp. monitoring 4th half (Conform if < 97.5°F) → Monitor vitals ✓ BCG, OPV, Hep B today. Noted by Sakshita

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order										
20/7/26 4:30pm	CS/B Resolint											
	DOL-6 / Term / AGA / NNT / 257g. Plan SBR-14.2	0.1 14.1										
	low birth wt. 2.1kg. baby now with neonatal jaundice	① SSPT with eyes & genital covered.										
	<table><tr><td>M</td><td>B⁺</td><td>U</td><td>✓</td><td>4</td></tr><tr><td>B</td><td>B⁺</td><td>m</td><td>✓</td><td>4</td></tr></table>	M	B ⁺	U	✓	4	B	B ⁺	m	✓	4	② TV 180cc/kg/day 45-50ml Q.4 full paladai (or) DBF
M	B ⁺	U	✓	4								
B	B ⁺	m	✓	4								
	On phototherapy. very low activity } good vitals stable	③ SBR - trace 14.2. Riv dic of SBR < 12mg/dl										
		④ Monitor vitals, O/P, feeds										
		⑤ continue Solich phototherapy.										
20/7/26 5:20pm	Discussed with Dr. Nalinikanta SBR → 14.2											
	→ continue SSPT with eye & genital care → SBR (T/m) 10 Am → Temperature monitoring											
	noted by Rign SRM	SRM Scuteja										

BAH-00661624 IP5-00176620
Baby Of PONDUGULA NANDITHA
14-07-2026 0 Y 0 M 6 D (M)
Dr. NALINKANTA PANIGRAHY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 9:00am	QSB Dr. Sohela (Resident)	
	DOL-7 Term/2157/LBW/NNJ	
	D: Neonatal Jaundice.	
	on SSPT	Plan
	m/B ⁺ u/B ⁻ B/B ⁺ m/B ⁻	① SSPT with eyes & genitals covered
	Baby on room air	② TV 180 cc/kg/day 45-50 ml Q, H
	DOL-5 TCBR-15.1mg(OD)	full Paladai or DBF
	DOL-6 SBR-14.25 ^{0.1} 14.1 (78g↑)	
	T wt → 2156g (static ~Birth wt).	③ SBR @ 10:30am
	ey } Euthemic Tone } good Euglycemic	seconds
	activity } good	④ Monitor vitals
	CRT < 3sec.	Temp, Feeds, u/o
		⑤ SBR @ report o/c.
		when
		→ SBR @ 10am
		Noted by Suraksha

BAH-00661624 IP5-00176620
Baby Of PONDUGULA NANDITHA (M)
14-07-2026 OYOM 6 D
Dr. NALINIKANTA PANIGRAHY



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[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00661624 IPS-00176620
 Baby Of PONDUGULA NANDITHA
 14-07-2026 0 Y 0 M 6 D (M)
 Dr. NALINIKANTA PANIGRAHY



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RESULT SHEET

Date	20/7/26				
Time					
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj	14.2 < 0.1 14.1				
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :



MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: *ICU*

Shifted to: *ward*

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : *Rambh*

Date & Time : *20/7 2 pm*

Nurse Name & Signature: *Bhavan*

Date & Time : *20/7/2020 am*



DRUG CHART

Date of Admission: 20/8 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
- 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature				Valid Period
Pharm.				
Additional Instructions:				

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature				Valid Period
Pharm.				
Additional Instructions:				

DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Doctor's Signature				Valid Period
Pharm.				
Additional Instructions:				



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG : <i>Drop Vit D3</i>				Date Time	<i>20/7</i>															
Dose <i>0.5ml</i>	Route <i>PO</i>	Frequency <i>OD</i>	Start Date <i>20/7</i>																	
Name & Signature of the Doctor Starting the Drugs: <i>[Signature]</i>				<i>[Signature]</i>																
Additional Instructions: <i>Int - 800 RM</i>																				
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																				

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.		

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]

Weight. Ward.

[illegible]

Signature

VERIFIED BY : Name



661604

EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/o. pondugula nanditha Age : 5 Days Gender: ☒ Male ☐ Female

Date : 20/07/26 Time of Arrival : 12:07 AM Triage Completion Time : 12:09 AM

Allergies: ☒ No ☐ Yes ☐ Food ☐ Medications ☐ Other (Specify): ☒ Not known any drug Allergies

Source of Information : ☒ Parents ☐ Others (Specify)

Mode of Arrival : ☒ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Ambulance

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance

☒ Normal

☐ Sick Looking

Circulation / Colour

☒ Normal

☒ Abnormal

☐ Bleeding

Work of Breathing

☒ Normal

☐ Decreased

☐ Increased

☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS

☒ Stable

☐ Unstable :

☐ Not - Life - Threatening

☐ Life -Threatening

Initial Vital Signs: Temp: 98.2F PR: 139b/m BP: 76/67 RR: 30b/m SpO₂: 97%

Chief Complaints: Yellowish Discoloration of the skin yesterday.

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☒ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☒ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON - URGENT : May receive care when convenient	☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.

All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☒ No
- Have you had cough or a rash in the past 2 weeks ☐ Yes ☒ No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☒ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☒ No
If yes, State Location:
- Are your parents / close contacts at home healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☒ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- ☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- ☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- ☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- ☐ The patient should be given a surgical mask immediately, if not already wearing one.
- ☐ Both patient and triage staff should perform hand hygiene.
- ☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Javange

Signature of Triage Nurse : Javange

Date & Time : 20/07/26 @ 12:09 AM

NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 20/7/26 Time of arrival : 12:10 AM skin x yesterday
Chief Complaints: c/o yellowish discoloration of the RBS: 70 mg/dl
Height : Weight : 8.10kg BMI : NA Head Circumference (<2 years)
Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:
If yes, identify
Pain Screening: ☒ Yes ☐ No If Yes, Pain Score: 0/10 Pain Tool Used: ☒ N Pass ☐ FLACC ☐ Wong Baker
☐ Character NA ☐ Location NA ☐ Frequency NA ☐ Duration NA

RISK FOR FALL:

☒ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years

Assess the below parameters

History of Falling: within past 3 months

☐ Yes ☒ No

Ambulatory Aids:

• Wheelchair

☐ Yes ☒ No

• Uses furniture for support

☐ Yes ☒ No

Gait/Transferring:

• Bedrest / immobile

☐ Yes ☒ No

• Weak

☐ Yes ☒ No

• Impaired

☐ Yes ☒ No

Mental Status: Forgets limitations

☐ Yes ☒ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

☐ Escort while ambulating

☐ Assist Patient

☐ Educate patient and family on fall precautions/prevention

Functional Screening: ☒ No Abnormalities Detected

☐ Mobility Problem

☐ Walking Problem

☐ Developmental Delay

☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: ☒ No Abnormalities Detected

☐ Underweight

☐ Overweight

☐ Feeding Problem

☐ Special diet

☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☒ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☒ No

If Yes Consultant Notified: NA (Date/Time): NA

Social History: Lives With Family

Siblings in household ☐ Yes ☒ No (if yes How Many?) NA

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify NA Inform consultant for positive criteria.

Time of Initial assessment completed by ER Nurse : 12:12 AM

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
	15. fore head]
	15.1 chest
	- Assessed the pt condition
	- monitor the vitals
	- shifted to ward

Samples collected by: / NA

Samples sent by : / NA

Time: / NA

Time: / NA

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: 142 bpm BP: CFT: 22 sec RR: 30.6 bpm SPO ₂ : 100% GCS: 15/15 Temperature: 98.2°F Pain Score: 0/10 Repeat RBS (if applicable): NA	Shift - out from ER to: ward Time of Shift - out: 2:05 PM Handover given to: (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Name of the Nurse : Bhavai

Signature of the Nurse : B

Date & Time : 20/9/20 12:45 PM

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
20/7	1 AM	7	Infection control measures	M	1	0	1	1	-	Shavani

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
20/7 1 AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	SSPT	stability	phototherapy	Ran	☐ Nursing ☒ Others:
20/7/26 1 AM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	SSPT	hemodynamic stability	phototherapy	Bharani	☐ 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:

BAH-00661624 IP5-00176620

Baby Of PONDUGULA NANDITHA

14-07-2026 0 Y 0 M 6 D (M)

Dr. NALINKANTA PANIGRAHY



: RCH / FRM / CLINICAL / 124

20/7/26

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:

Doctor/Nurse/Family Concern?

6 AM

10 am

1 pm

7 pm

10 pm

9 AM

6 AM

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

feeding

97.6 F

97.5 F

R

E

E

B

E

E

B

E

E

98.6 F

#

Heart Rate
(bpm)190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

and

Blood Pressure
(mmHg) *

Note:

BP does not score
in early
warning scoring

Heart Rate (Number)

135b/m

148b/m

148b/m

146b/m

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

Resp Rate (Number)

31b/m

32b/m

30b/m

38b/m

Resp Mod/ Severe
Distress None / MildReceiving O₂ (l/min)
O₂ Saturations (%)

98%

100%

99%

99%

Conscious Level
Normal
Altered

GCS *

15/15

15/15

15/15

15/15

TOTAL SCORE

Number of shaded boxes

0

0

0

0

Pain Score

0

0

0

0

Observer's Initials

P

P

P

P

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 in charge and PICU / NICU fellow or PICU / NICU consultant to be informed

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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



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

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)

and

Blood Pressure
 (mmHg) *

Note:

BP does not score
 in early
 warning scoring

190
180
170
160
150
140
130
120
110
100
90
80
70
60
50

Heart Rate (Number)

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

70
60
50
40
30
20
10

Resp Rate (Number)

Resp Mod/ Severe
 Distress None / Mild

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

Conscious Normal
 Level Altered

GCS *

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

ACTIONS

NB: Scores 3 should be
 recorded overleaf

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

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

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A	ASSESSMENT : I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
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-00861624 IP5-00176620
 Baby Of PONDUGULA NANDITHA
 14-07-2026 0 Y 0 M 6 D (M)
 Dr. NALINIKANTA PANIGRAHY



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. :

20/07/26

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		
	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	EBH 50ml										
	04:00 am											
	05:00 am											
	06:00 am	EBH 30ml										
	07:00 am											
Total Intake :						Total Output : $\sqrt{2}$ 1 M2 1						
Total 24 hrs. Intake			faken									
Total 24 hrs. Output			$\sqrt{2}$ 1 M2 1									

FLUID CHART

Sheet No. :

20/7/2026.

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
20/7												
	08:00 am	50ml EBM					✓			✓	1	} Sign. Nurse
	09:00 am									NO		
	10:00 am	50ml EBM					✓			IV		
	11:00 am								✓	1		
	12:00 pm	DBF					✓			1		
01:00 pm						✓			1			
Total Intake : Taken						Total Output : m-4, u-2						
	02:00 pm	DBF									1	} Sign. Nurse
	03:00 pm	R									1	
	04:00 pm	50ml EBM							✓	NO		
	05:00 pm						✓			1		
	06:00 pm	DBF								1		
	07:00 pm											
Total Intake : Taken						Total Output : M-1 U-?						
20/7	08:00 pm											} Sign. Nurse
	09:00 pm	EBM 40ml									NO	
	10:00 pm						✓		✓	IN		
	11:00 pm	EBM 40ml								IN		
	12:00 am									IN		
	01:00 am	EBM 40ml								IN		
Total Intake :						Total Output : ✓ 2 m-1						
21/7	02:00 am						✓					} Sign. Nurse
	03:00 am	EBM 40ml							✓	NO		
	04:00 am									IN		
	05:00 am	EBM 40ml								IN		
	06:00 am						✓			IN		
	07:00 am	EBM 40ml							✓	IN		
Total Intake :						Total Output : ✓ 2 m-2						
Total 24 hrs. Intake		Taken										
Total 24 hrs. Output		✓ 6 m-8										

BAH-00661624
Baby Of PONDUGULA NANDITHA
14-07-2026
Dr. NALINKANTA PANIGRAHY
IP5-00176620
O Y O M 6 D (M)

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	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							

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: 20/7/26 @ 2 AM

Assessment: Baby under 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
2 AM	→ advised the general condition of the baby and checked vitals	2:10 AM	→ checked the general condition of the baby and checked vitals	Baby is Stable
3 AM	→ Given Feeding and nappy and burping.	3:10 PM	→ Given Feeding and nappy and burped.	
4 AM	→ Continue phototherapy as advised.	4:10 AM	→ Continued phototherapy as advised.	
6 AM	→ Checked urine output.	6:10 AM	→ checked urine output.	
8 AM	→ Ensure safety.	8:10 AM	→ Ensured safety.	

Re-Assessment: Baby under phototherapy

Special Notes: SRE after Rounds

Nurse Signature: Marthen

Nurse Name: Marthen

Date & Time: 20/7/26 @ 8 AM

BAH-00661624 IP5-00176620
 Baby Of PONDUGULA NANDITHA
 14-07-2026 0 Y 0 M 6 D (M)
 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: ☒ Morning ☐ Afternoon ☐ Night

Date: 20/7/26 @ 9am

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.	Baby is Stable.
10am	Ensure safety.	10:10 am	Provided cribcare.	
12pm	warmth care	12:10 pm	Put on cloths top to maintain temp.	
1pm	monitor vitals.	1:10 pm	monitored vitals.	
1pm	maintain good nutritional status.	1:10 pm	Feeding assessment	
2pm	vacination done	2:10 pm	cbm 4 DRF.	
2pm	Patient family education		educated patient's family.	

Re-Assessment:

Special Notes:

SSR @ 3pm.

Nurse Signature:

[Signature]

Nurse Name:

Sushantha

Date & Time:

20/7/26 @ 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/7

Assessment:

Baby having hyperbilirubinemia

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
2 PM	* Assess the general condition of baby.	2:10 PM	* Assessed the baby condition.	Baby is stable now.
4 PM	* Monitor vital signs	4:10 PM	* vitals checked & documented	
6 PM	* maintain I/O chart	6:15 PM	* I/O chart maintained	
	* DBF + FF 2nd hly & burping well.		* DBF + FF 2nd hly & burping well.	
8 PM	* ensure safety.	8 PM	* ensured safety.	

Re-Assessment:

Baby is doing well

Special Notes:

Nurse Signature: 

Nurse Name: Jyothi

Date & Time: 20/7 @ 8 PM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/26 6 PM

Assessment: Baby under 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
8 AM	→ Assess the general condition of the baby and increase vitals.	8:00 AM	→ Assessed the general condition of the baby and increased vitals.	Baby is stable
10 AM	→ Giving feeding and hourly DSF or EBM.	10:00 AM	→ Given feeding and hourly DSF or EBM.	
2 PM	→ Continue phototherapy as advised.	2:00 PM	→ Continued phototherapy as advised.	
6 AM	→ Increased urine output.	6:00 AM	→ Increased urine output.	
8 AM	→ Ensure safety.	8:00 AM	→ Ensured safety.	

Re-Assessment: Baby under observation

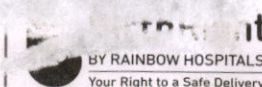
Special Notes: SBR 11 AM 10 AM

Nurse Signature: *Piyu*

Nurse Name: *Piyu*

Date & Time: 21/7/26 6 AM

NURSING CARE RECORD



Date:

Assessment:

☐ 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.....				

[illegible]

Re-Assessment:

Special Notes:

Nurse Signature: _____ Nurse Name: _____ Date & Time: _____

Patient Sticker

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:

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: Nalinikanta Panigrahy Department: CR Date of Admission: 20/2/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>N/A</u>							
BACKGROUND	Area	Shift Time	<u>CR</u> <u>2:05A</u>	<u>3rd Floor</u> <u>2:05 8AM</u>	<u>3rd Floor</u> <u>8AM 2PM</u>	<u>3rd Floor</u> <u>2PM 8PM</u>	<u>3rd Floor</u> <u>8PM 1AM</u>	
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</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>	<u>98.0°F</u>	<u>98°F</u>	<u>98.0°F</u>	<u>98.2°F</u>	
		Res:	<u>32 b/m</u>	<u>36 b/m</u>	<u>32 b/m</u>	<u>36 b/m</u>	<u>38 b/m</u>	
		SpO ₂ :	<u>97%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	
		Pulse:	<u>139 b/m</u>	<u>140 b/m</u>	<u>134 b/m</u>	<u>135 b/m</u>	<u>142 b/m</u>	
		BP:						
Fall Risk Score:	<u>13</u>	<u>13</u>	<u>15</u>	<u>15</u>	<u>15</u>			
Pain Score:	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0/10</u>			
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>yes</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>Sgt + 1M 10AM</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Shavani</u>	<u>Martha</u>	<u>Sushanti</u>	<u>Jyoti</u>	<u>Priya</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>20/2</u>	<u>20/2/26</u>	<u>20/2</u>	<u>20/2</u>	<u>21/2</u>		
Time:		<u>2:05A</u>	<u>8AM</u>	<u>@2pm</u>	<u>@8pm</u>	<u>8AM</u>		
Taken Over By Name :		<u>Martha</u>	<u>Sushanti</u>	<u>Jyoti</u>	<u>Priya</u>	<u>Sushanti</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>20/2/26</u>	<u>20/2/26</u>	<u>20/2</u>	<u>20/2</u>	<u>21/2</u>		
Time:		<u>2:05AM</u>	<u>@ 8am</u>	<u>@2PM</u>	<u>8PM</u>	<u>@ 8am</u>		

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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:						

BAH-00661624 IP5-00175620
 Baby Of PONDUGULA NANDITHA (M)
 14-07-2026 0 Y 0 M 6 D
 Dr. NALINIKANTA PANIGRAHY

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 : 20/7/2017	20/7/2017	20/7/2017	20/7/2017
					Time : 1 AM	8 AM	2 PM	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.tremity 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	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	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
TOTAL SCORE					28	19	19	19
Evaluator's Name					Shavani	Madan	Hota	Phys

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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

BAH-00661624 IP5-00176620
 Baby Of PONDUGULA NANDITHA
 14-07-2026 0 Y 0 M 6 D (M)
 Dr. NALINIKANTA PANIGRAHY



BRADEN 'Q' SCALE

					Date :				
					Time :				
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					TOTAL SCORE				
					Evaluator's Name				

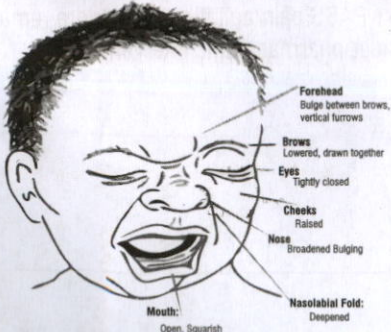
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 Baby Of PONDUGULA NANDITHA
 14-07-2026 0 Y 0 M 6 D (M)
 Dr. NALINIKANTA PANIGRAHY



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	
						20/7 2 PM	20/7 10 AM	20/7 2 PM	20/7 8 PM					
						Procedure →								
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					
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					
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	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					
Vital Signs HR RR, BP, SaO ₂	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					
 Premature Pain Assessment: Scoring +3 if less than 28 weeks gestation age / Corrected Age +2 if 28 - 31 weeks gestation age / Corrected Age +1 if 32 - 35 weeks gestation age / Corrected Age Intervention Deep Sedation: Score = -10 to -5 Light Sedation: Score = -5 to -2 Pain Score less than or equal to 3 – No Intervention Pain Score greater than 3 – Intervention						Gestational Age / Corrected Age	38+5 WKS	38+5 WKS	38+5 WKS	38+5 WKS				
						Total Pain / Agitation Score	0/10	0/10	0/10	0/10				
						Intervention	-	-	-	-				
						Effectiveness	-	-	-	-				
						Signature	Margh	sw	Gyoti	Peg				

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.



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	2017	2017	2017	2017	
	3 to less than 7 years old	3	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	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2	2	2	2	2	
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	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	
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			13	13	13	13	

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	Yes	Yes	✓	Yes
Call device within reach	Yes	Yes	✓	Yes
Wheels Locked	Yes	Yes	✓	Yes
Room free of clutter	Yes	Yes	✓	Yes
Adequate Lighting	Yes	Yes	✓	Yes
Wheel Chair Support	No	No	x	No
Other Intervention(s) Specify	No	No	x	No
Nurse's Name :	Shan	Sushma	Jyoti	Priya
Signature :	[Signature]	[Signature]	[Signature]	[Signature]
Date :	20/7	20/7	20/7	21/7
Time :	1:30 PM	2:30 PM	3:30 PM	4:30 PM

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PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
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TOTAL							

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Bed in low position						
Call device within reach						
Wheels Locked						
Room free of clutter						
Adequate Lighting						
Wheel Chair Support						
Other Intervention(s) Specify						
Nurse's Name :						
Signature :						
Date :						
Time :						

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00661624 IP5-00176620 Baby Of PONDUGULA NANDITHA 14-07-2026 0 Y 0 M 6 D (M) Dr. NALINIKANTA PANIGRAHY 		Date & Time of Admission 20/7/26 @ 1:54 AM	Date & Time of Transfer Order 20/7/26 @ 2:05 AM
		Transfer Ordered by Dr. Ramakrishna	Reason for Transfer Admission
From Unit ER	To Unit 323 C	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 4	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what? ... of file	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films No			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring NR. Bhavana		Name of Person Ordered Transfer Dr. Ramakrishna	
Patient & Clinical Records Received by : Martha 20/7/26 @ 2:15 AM			
Date & Time of Patient Received :			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- ☐ Unavailable Bed
 ☐ Nurse not Available
 ☐ Available Bed not ready