

18019 IP28-00004510
DEEPA SEKAR
28 0 Y 0 M 3 D (F)
ESH KUMAR J



DISCHARGE TRACKING SHEET

UHID :

FLOOR:

CONSULTANT NAME: DR.

ACTIVITY	IN TIME	OUT TIME	REMARKS	<To be filled by Admin>
Activity Sheet updated by Nursing		5/6/26 at 9:15 pm		
Activity Sheet updated by Pharmacy	9:05	9:20	Jal Sekar	

ACTIVITY RECORD FOR BILLING



Na ANC-00016019 IP28-00004510
 Baby Of DEEPA SEKAR
 02-06-2026 0 Y 0 M 0 D 2 H (F)
 UHI Dr. THINESH KUMAR J



No: 28-4510 Consultant: Dr. Thinesh Dept: NICU

Date of Admission: 2/6/26 Time: Date of Discharge: Time:

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







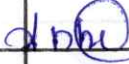

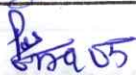
WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/6/26	8pm	RCH-OT	NICU	[Signature]

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
2/6/23	Blood Grouping	7478 ✓	
4	CBC	7479 ✓	
	Blood Culture	J	
3/6/23	RBS - ①	7485 ✓	
3/6/23	RBS	7486 ✓	
3/6/23 am	RBS	7488 ✓	
4/5/26	TCB ✓	7524 ✓	
4/5/26	OAE ✓	48573	
4/5/26	HBS	7539 ✓	
5/6/26	TCB (PoET)	7548 ✓	

ANC-00016019 IP28-0000451C
 Baby Of DEEPA SEKAR
 02-06-2026 0Y0M0D4H (1
 Dr. THINESH KUMAR J



1



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26	S/B Dr. Thinesh Kumar	
6:30pm		
	O ₂ @ 1L/min - taper & stop if no distress	
	Start paladai feeds	
	5ml 2nd hly - 2 feed	
	↓	
	8ml 2nd hly - 2 feed	
	↓	
	10ml 2nd hly.	
	CBC @ 6th hly	
	If distress persistent - XRay, Blood gases	
		②
		→ Continue feeds



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26 9pm	S/B Dr. Shobana To do	
	- CBC B/c/s. - oral feed 5ml / 2hrly	
2/6/26 8am	S/B Dr. Shobana	
	D. ketamine @ 2mg/kg/min Paladar 10ml 2nd hly IV - 60ml/kg/day + 4cot.	
2/6/26 10am	S/B Dr. Raghun	CR
	LPT (35 weeks) / Girl / AGA / NVD / B.wt = 2.04 kg. DOL = 16 hrs.	
	RS - pink, SAE ⊕, B/C ⊕, clear RR = 56/cin, SpO ₂ = 96% RA.	
	CVS - pink, pprof. @ volu, CRT ⊕ HR = 113/cin, BP = 59/37 (49) ulh on Dobutamine 2mcg/kg/cin	
	CNS: AF, c/STA = good, P/A - soft, no distention	
	meconium sticky. on 10ml Q2H feeds w 60cc/kg/day	

P.T.O



2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/26 10am	<p> $\text{Hb} = 11.0 = 1.25 \text{ ul/kg/hr}$ $\text{cu TUF to cck/deg} = 4 \text{ ca}$ Sepsis - NOT I $\text{TC} = 1160 \text{ NSB } 134$ Bld c/s -- also NO Abx </p>	<p> [Signature] 1/2CS. </p>
3/6/2026 7:30pm	<p> C/S/B Dr. Arishmeny Baby reviewed RA \rightarrow Maintaining $\text{SpO}_2 - 94\%$ LOOK @ BAB @ no added SO_2 CUS \rightarrow NOT ANIONOMY perfusion good PA \rightarrow on 15ml PR to C_1 well. cm: (n) HB - stable </p>	<p> Adv - To shift low water - To give MUST PR - To do vaccination Red reflex OAB, N.S. </p>



3

1

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/2026 7am	U/S/B Dr. Suenere	
	Baby renewed pink, euthermic erythematous / @ 7/10	icterus (+) fill Abdo
	vitals stable dorsalis - pulses - well felt	Adv
		- PF 15ml Q2H
		- NNS + P-F
		- vaccination - had reflex
		OAE, NBS, TCO



(h)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/26 9 AM	S/B Dr. Anesh	
	PRETERM (35WKS) AGA GIRL BABY NVD Bwt-2.04kg ~ 40 hrs of life RDS	
	(15ml) Paladai feeds + NNS - feeding well Passing urine & stools (M)	
	Cry } Tone } (N) Activity } pulses well felt CRT < 3s	Motherx Baby @ positive - Icterus (+) till abd.
	S/E CVS } PS } CNS } DAD P/A }	Bwt - 2.040 kg Twk - 1.940 kg ↓ 100g 4.9% wt loss
	Vaccination - Red reflex OAE, NBS, TCB	
		Anesh 163/65

ANC-00016019 IP28-00004510
 Baby Of DEEPA SEKAR
 02-06-2026 0Y0M1D (F)
 Dr. THINESH KUMAR J

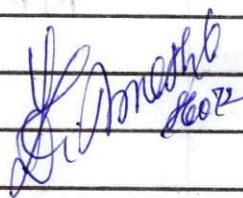


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/26	S/B Dr. Thinesh	
11:45 AM	well baby vitals stable M ^v / U ^v Toursat feeds well. Hetero ⊕	
	<u>Plan</u> Start phototherapy Vaccination + OAE today Admission in NICU SOS Repeat TCB tomorrow morning	
		<i>Dr. Thinesh</i>
4/6/26 3:40 PM	S/B Dr. Aneshu Baby on DSPT (~5hrs) Feeding well. Passing urine & stools ⊕ly Vitals stable. Tchuss ding S/E ⊕ NBS today.	
		<i>Aneshu</i> 163765



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/26	S/B Dr Sugima	
A:30pm		
	PRETERM (35wks) / AGA / Girl / NVD / d. Akg	
	DOL - HT hours	
	↓ 15ml pakdai feed + NNS.	
	<u>o/e</u> Baby pink	
	Alert, active,	Vitals
	Ⓜ Color, tone, activity	Stable
	↓ DSPT	
	Chest - N/AE ⊕	
	CUS - SIS2 ⊕	CRT < 3sec.
	PA - Soft, NT	
	passing urine & stool.	
	<u>Also</u>	
	- Monitor feeding	
	- Inform SOS	
	16:45.	
5/6/26	S/B Dr. Thinesh Kumar	
9 AM	well baby	
	<u>Plan</u>	
	Discharge today	
	Review on 8/6/2026	

ANC-00016019 IP28-00004510
 Baby Of DEEPA SEKAR (F)
 02-06-2026 0Y0M1D
 Dr. THINESH KUMAR J



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 9AM	S/B Dr. Aneesh	
	LT. PRETERM (35wks) AGA GIRL NVD 2.4kg But	RDS - RESOLVED.
	Day 3 of life.	
	- Feeding well passing urine & stools @ Day	
	- Tctw's bed. TCB - 7.7 - head	
	cyr } Tone } (N) Activity }	4.5 - chest BxM - 0 positive But - 2.040
	pulses well felt	1.960
	Normoothermic	↓ 80g
	S/E CWs } PS } NAD	~4% wt loss
	CWs } P/A }	Discharge today
		Aneesh 163765



STATE OF OHIO
DEPARTMENT OF REVENUE
DIVISION OF TAXATION

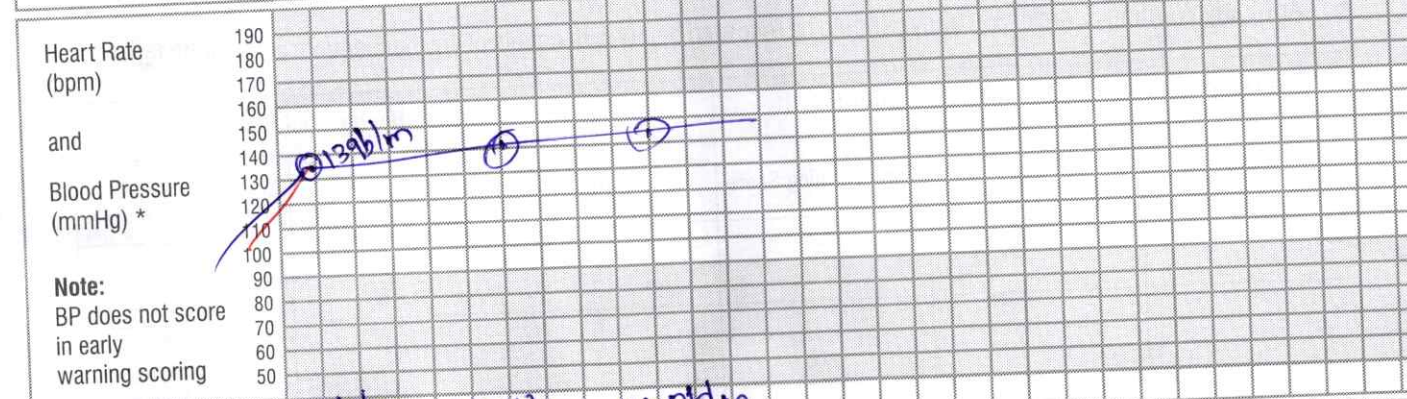
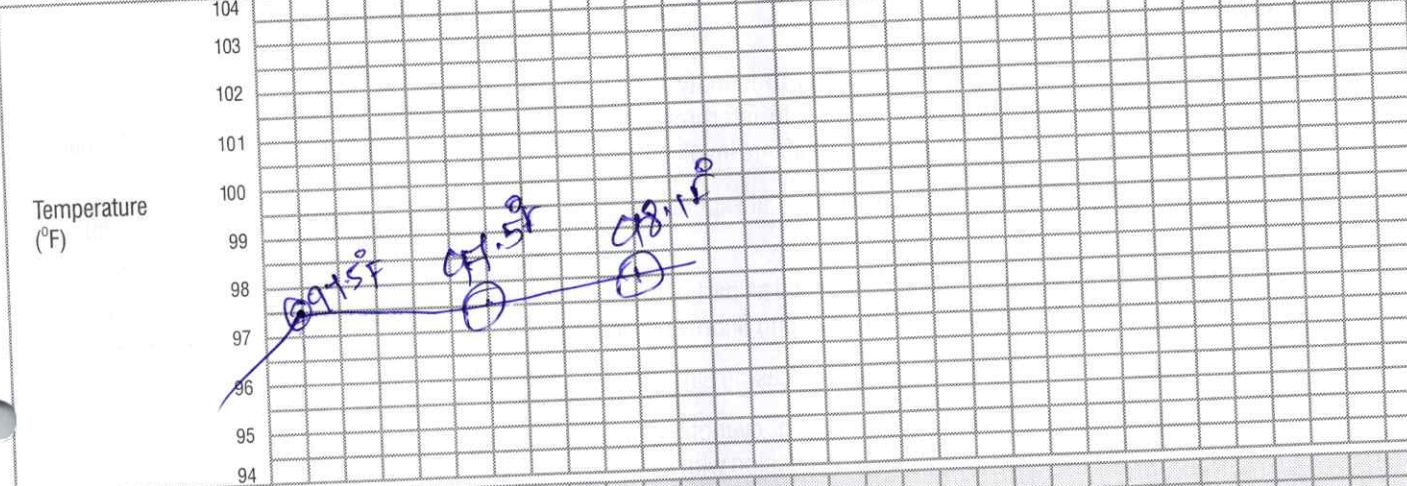
STATE OF OHIO

DATE: _____

DATE	DESCRIPTION	AMOUNT	TOTAL
10/1/00
10/2/00
10/3/00
10/4/00
10/5/00
10/6/00
10/7/00
10/8/00
10/9/00
10/10/00
10/11/00
10/12/00
10/13/00
10/14/00
10/15/00
10/16/00
10/17/00
10/18/00
10/19/00
10/20/00
10/21/00
10/22/00
10/23/00
10/24/00
10/25/00
10/26/00
10/27/00
10/28/00
10/29/00
10/30/00
10/31/00

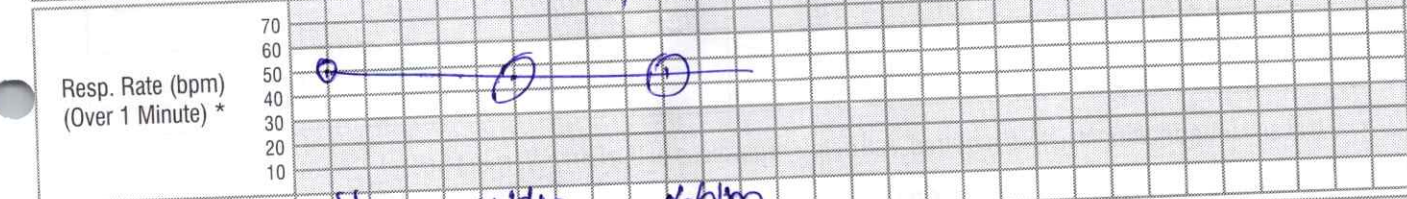
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 02/06/26 Time: 6pm 10pm 8pm



Note:
 BP does not score
 in early
 warning scoring

Heart Rate (Number) 136b/m 140b/m 142b/m



Resp Rate (Number) 50b/m 50b/m 50b/m

Resp Distress	Mod/ Severe / None / Mild	✓	✓	✓
Receiving O ₂ (l/min)	O ₂ Saturations (%)	99%	98%	99%
Conscious Level	Normal / Altered	✓	✓	✓
GCS *		01	15/15	15/15
TOTAL SCORE		01	01	01
Number of shaded boxes		0/10	0/10	0/10
Pain Score		0	0	0
Observer's Initials		AK	AK	AK

ACTIONS

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

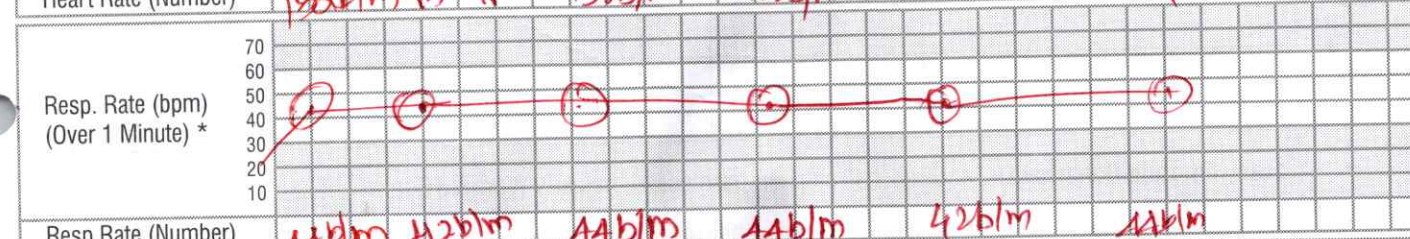
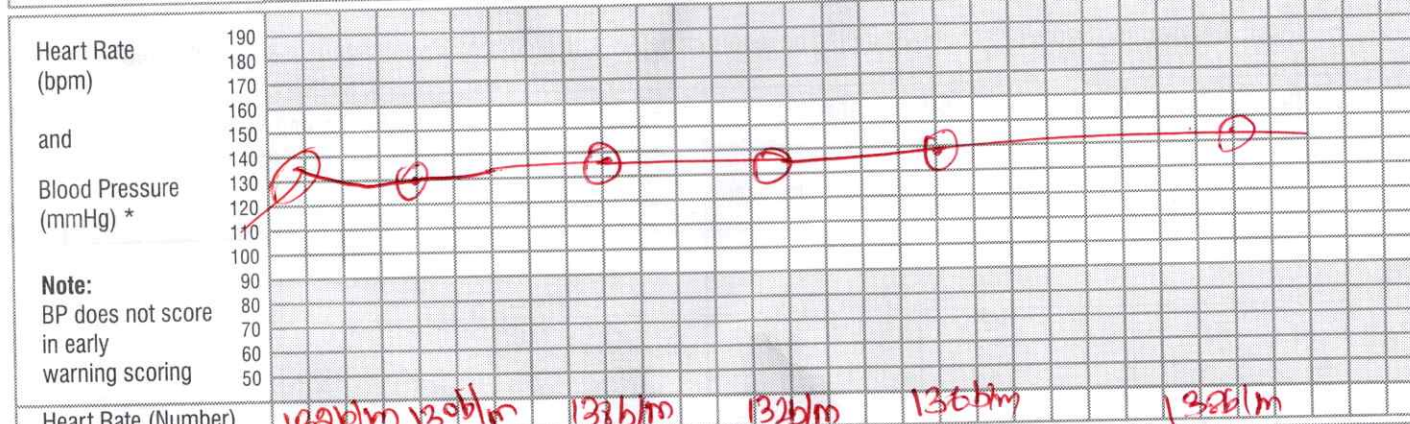
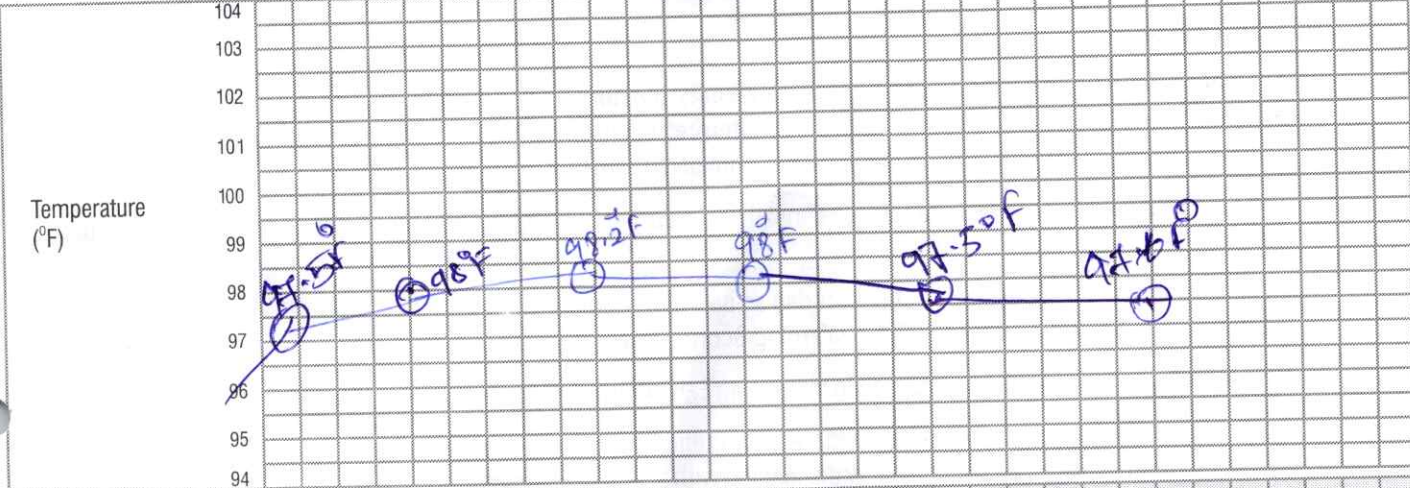


INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 4/6/26 Time: 8Am 12Pm 1Pm 7Pm 12Am 4Am
 Doctor/Nurse/Family Concern?



Heart Rate (Number)	138b/m	136b/m	138b/m	132b/m	136b/m	138b/m
Resp Rate (Number)	44b/m	42b/m	44b/m	44b/m	42b/m	44b/m
Resp Distress	None	None	None	None	None	None
Receiving O ₂ (l/min)	0	0	0	0	0	0
O ₂ Saturations (%)	98	100	99	100	99	98
Conscious Level	Normal	Normal	Normal	Normal	Normal	Normal
GCS *	15/15	15/15	15/15	15/15	15/15	15/15
TOTAL SCORE	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0/10	0/10	0/10	0/10	0/10	0/10
Observer's Initials	SS	SS	SS	SS	SS	SS

ACTIONS

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

NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- 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)



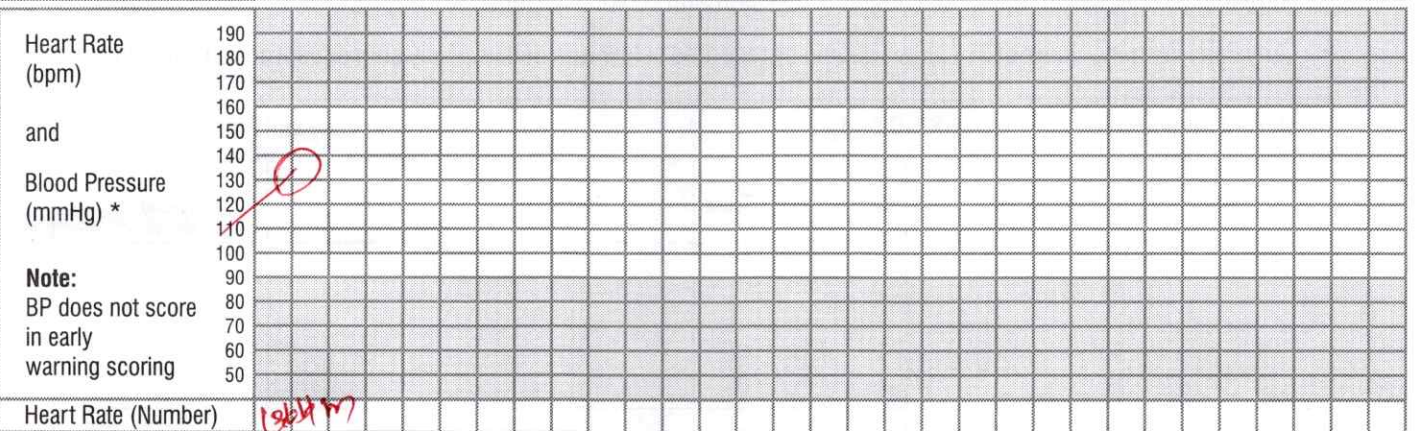
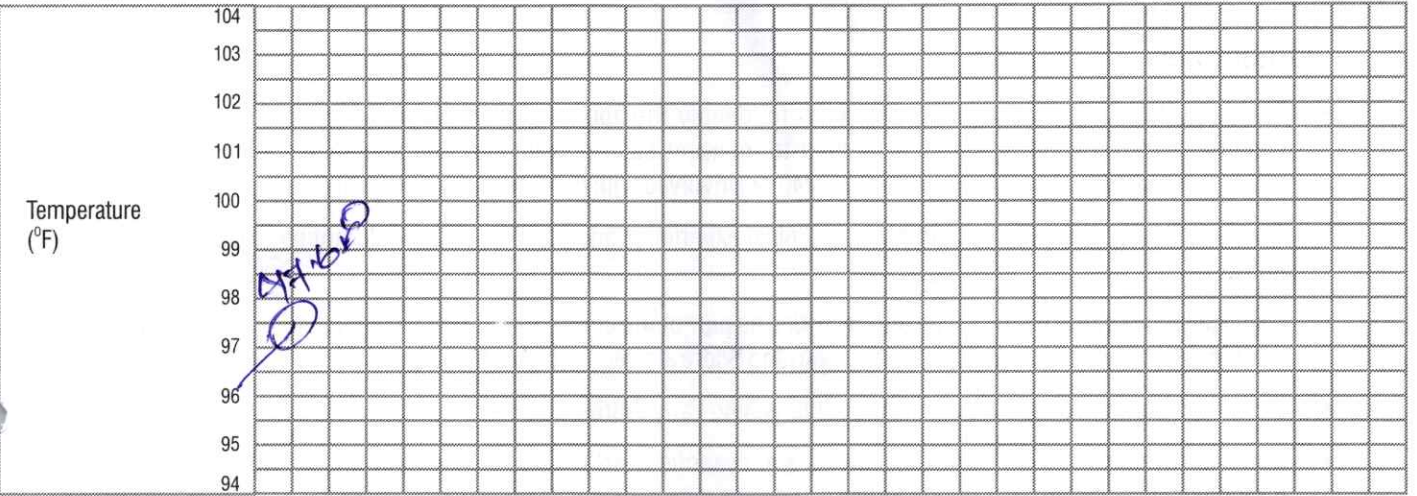
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



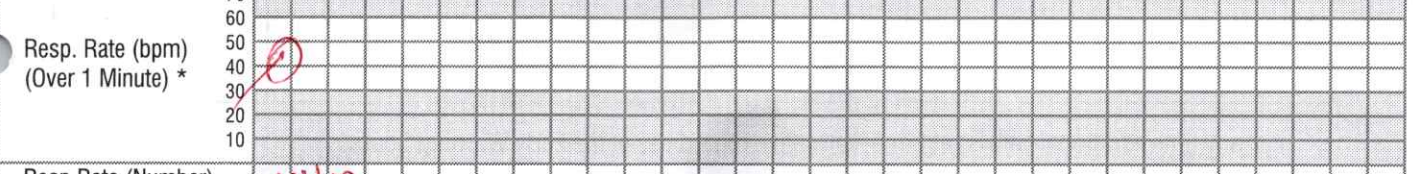
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 16/26 Time: 8:00 AM

Doctor/Nurse/Family Concern? ✓



Heart Rate (Number) 130/110



Resp Rate (Number) 40/40

Resp Distress Mod/ Severe None / Mild ✓

Receiving O₂ (l/min) 0
 O₂ Saturations (%) 98

Conscious Level Normal Altered ✓

GCS * 15/16

TOTAL SCORE
 Number of shaded boxes 0
 Pain Score 0/10
 Observer's Initials J

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- 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. : 11

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 Thrombophlebitis Score	Sign. Nurse	
			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	DF	15ml										
	11:00 pm												
	12:00 am	PF	15ml				✓		✓				
	01:00 am												
Total Intake : 30ml						Total Output : 0ml							
	02:00 am	PF	15ml						✓				
	03:00 am												
	04:00 am	PF	15ml										
	05:00 am												
	06:00 am	PF	15ml				✓		✓				
	07:00 am												
Total Intake : 45ml						Total Output : 0ml							
Total 24 hrs. Intake			75ml			Total 24 hrs. Output			0-3 ml-2				

ANC-00016019
 Baby Of DEEPA SEKAR
 02-06-2026 0 Y 0 M 1 D (F)
 Dr. THINESH KUMAR J



IP28-00004510



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
4/6/26													
	08:00 am	DBF	✓										
	09:00 am	FF	15ml										
	10:00 am												
	11:00 am	FF	15ml										
	12:00 pm	DBF	✓										
	01:00 pm	FF	15ml										
Total Intake :			DBF = 2 times FF = 45ml			m = 1 time			Total Output : U = 0				
	02:00 pm												SS
	03:00 pm	DBF	✓										01/24/26
	04:00 pm	FF	15ml										
	05:00 pm	DBF	✓										SS
	06:00 pm	FF	15ml										01/24/26
	07:00 pm	DBF	✓										
		FF	15ml										
Total Intake :			DBF = 3 times + FF = 45ml			m = 2			Total Output : U = 2 times				
	08:00 pm	DBF	✓										
	09:00 pm	DBF	✓										
	10:00 pm	15ml											
	11:00 pm												
	12:00 am	DBF	✓										01/24/26
	01:00 am	15ml											
Total Intake :			DBF 3 - 45ml			m = 1			Total Output : U = 2				
	02:00 am												
	03:00 am	FF	15ml										
	04:00 am												
	05:00 am	FF	15ml										
	06:00 am												
	07:00 am	FF	15ml										
Total Intake :			45ml						Total Output : U = 3				
Total 24 hrs. Intake		180ml DBF = 7 times											
Total 24 hrs. Output		U = 4 times m = 4 times											

2

NURSES NOTES
 (USE BALL POINT PEN ONLY)

- No Known Drug Allergies
- Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
2.6.26		Receiving Notes & Night Duty notes
	8pm	<ul style="list-style-type: none"> => Baby Received from RCH OT. Came with Room Air Support => Birth weight : 2.040 kg 35 weeks - crucial at Birth. CBG checked 80 mg/dl. => Baby now kept on under O2 Support & liters. => complaints Respiratory Distress
	9pm	<ul style="list-style-type: none"> => IV line Secured and IV fluids started 80 ml/kg 4 cal + D10 => And Dobutamine 30 mg in 24 ml D5 4 micks started. => Sample Send and Blood culture and CBC => Feed started. 5 ml Q 2 hourly pre Nan through paladai given. During Feed NO complaints.
	10pm	<ul style="list-style-type: none"> => Baby vitals are Monitoring and Recorded. => Baby urine passed Diaper changed.
	11pm	<ul style="list-style-type: none"> => Feed given 5 ml of pre Nan through paladai given. During Feed NO complaints. Baby sucking well.
	12am	<ul style="list-style-type: none"> => Baby Respirate Rate No little. O2 fapper 0.2 liters by Dr. Shobana Man

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

3

NURSES NOTES
 (USE BALL POINT PEN ONLY)

- No Known Drug Allergies
- Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
3.6.26	1am	=> Feed given 5 ml of prenan through paladai given. NO complaints. Baby taking Nicely. <i>[Signature]</i>
	2am	=> Baby urine passed so diaper changed. <i>[Signature]</i>
	3am	=> Feed given 5 ml of prenan through paladai given. During Feed NO complaints. <i>[Signature]</i>
	4am	=> Vitals are Monitoring and Record. -> vitals are stable. O2 Stopped.
	5am	=> Feed given 5 ml of prenan. through paladai given. During Feed NO complaints. <i>[Signature]</i>
	6am	=> Morning Routine Care given => Skin and Mouth Care given. => Sponge bath given. <i>[Signature]</i>
	7am	=> Feed given. 5 ml of prenan through paladai given. During Feed no complaints.
	8am	=> Baby details handing over given to Morning duty staffs. <i>[Signature]</i>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<u>Morning Duty Notes :- 3/6/26</u>
	8am	The Baby's Handover taken from Night duty staff, the Baby is on Room air and is kept under common. Trp is coming/day and Tr hrs is present.
		Feed is 10ml prn through paladi, no desaturation. → 8am
	9am	The Baby's feed is given through paladi; no desaturation. → 8am
	11am	The Baby's feed is given through paladi, no desaturation. → 8am
	12am	Dr Thinesh Come for Rounds and advised to stop desaturation. → 8am
	12am	Again desaturation started as per dr Thinesh because the baby having colour changes. → 8am
	1pm	The Baby's feed is given through paladi, no desaturation. → 8am
	2pm	The Baby's vital are stable and the Baby is handed over to the Evening duty staff. → 8am
		<u>Evening duty Notes:</u>
	2pm	→ Baby details handover taken from morning duty staff
		→ Baby is on room air support

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

(USE BALL POINT PEN ONLY)



No Known Drug Allergies

Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		=> Baby is under observation & vital sign stable. <u>to</u>
		=> Baby tone is Normal & skin pink colour activity good. vital sign stable. <u>to</u>
		=> IVF - 60cc/kg/hr (D10 + acal) going
		=> Inj: Drotidamine 0.2 ml/kg 2pm Now only stop. <u>to</u>
		=> Baby is no skin colour No change. baby vital sign stable. <u>to</u>
	8pm	=> Feed given 10ml breast - sals through paladai food During feed No complaints. <u>to</u>
	4pm	=> Inj: Drotidamine restart 0.2 ml/kg because pulse low <u>to</u>
	5pm	=> Baby IV line out & removed. IVF - stop & Inj: Drotidamine all so stop. <u>to</u>
		=> Baby urine & stool passed change diaper. <u>to</u>
		=> Feed ↑ 15ml breast. Ashirvacy man. I given 15ml breast - sals through paladai Feed During feed No vomit No desaturation vital sign stable. <u>to</u>
	6pm	=> Dr. Thinesh go baby side visit done advised shifted to room side. <u>to</u>
	7pm	=> Feed given 15ml breast - sals through given mother No During feed

NOTE: DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Complain & vital sign stable
	7:30pm	→ Baby shifted to N Floor @ 7:30pm No: 16. N/6. room side.
		RECEIVING NOTES
3/6/26	7:45 PM	Baby details received from NICU staff. Baby is stable and active. No IV line and baby pre-Nam 15 ml last feed given in NICU at 7pm.
	8pm	Baby details hand over given to Night duty staff.
		3/6/26 - Night duty.
	8pm	baby is hiccups occ, taken from evening dew, alert conscious and oriented.
	9pm	DBF given, formula feed given.
	10pm	To provide comfort care given. To provide comfort care
		care
	10pm	vital monitoring and recording.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

ANC-00016019 IP28-00004510
 Baby Of DEEPA SEKAR
 02-08-2026 0 Y 0 M 1 D (F)
 Dr. THINESH KUMAR J



NURSES NOTES

(USE BALL POINT PEN ONLY)

- No Known Drug Allergies
- Drug Allergies APPI

(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)		
DATE	TIME	
		BBF + formula feed given,
	2 AM	Formula feed given
	4 AM	Urine passed, formula feed given, baby is sleeping well,
	6 AM	TRUCK AND output monitoring.
	8 AM	morning care given. Handing over given to morning duty staff. * over
MORNING DUTY NOTES		
4/16/26	8:30 AM	Baby details hand over taken from Night duty staff. Baby is stable and active. Baby is on FF + NNS.
	9 AM	Assess the little FF
	11 AM	Baby slept well.
	11:30 AM	Phototherapy started. as per the doctor's Order.
	12 PM	Vitals checked documented in file
	1 PM	monitored D/o documented in file
	2 PM	Baby details hand over given to

NOTE: DO NOT WRITE OUTSIDE THE MARGINS

ANC-00018019 IP28-00004510
 Baby Of DEEPA SEKAR
 02-08-2026 0 Y 0 M 1 D (F)
 Dr. THINESH KUMAR J



NURSES NOTES

(USE BALL POINT PEN ONLY)

- No Known Drug Allergies
- Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Evening duty staff
		Evening duty
16/8/26	2pm	Baby hand over taken from morning duty staff Baby active alert awake baby stable baby on room air double surface phototherapy maintain
	3pm	DBF + formula feed pre nan 15ml paladai feed given no vomiting Baby passed urine and motion
	4pm	vitals stable room air saturation maintain Baby is slept
	5pm	NBS sample send to lab DBF + FF -> 15ml paladai feed given Baby is slept Baby on double surface phototherapy continue
	6pm	vitals stable room air saturation maintain DBF + FF -> 15 paladai feed given
	8pm	Baby hand over to next duty staff
		ST 21/5/23

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

(USE BALL POINT PEN ONLY)

- No Known Drug Allergies
- Drug Allergies

AP

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		16/06 - Night duty
	8pm	Baby is handing over taken from Evening duty
		stable conscious and oriented.
	9pm	Dr. Thirish Kumar seen the baby continue same treatment to be done tomorrow
		Morning TB, Double Sclerole phototherapy ongoing.
	10pm	DBF + formula feed
		15ml Green Eucy 2ml here
	12am	with monitoring and recording
	1am	baby is sleeping well, no complaint of baby.
	6am	Morning care given, intake and output monitoring.
		15ml formula to phototherapy
	8am	Handing over to Morning duty.
		MORNING DUTY NOTES
	8:30am	Baby details hand over taken from Night duty staff. Baby is stable and active.
	9am	Dr. Thirish Kumar came and saw

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

