

ADMISSION SHEET
Registration Details :

Admission No : IP5-00175520 **Admit Date** : 23-Jun-2026 **Admit Time** : 10:39 PM **UHID** : BAH-00656409

Patient Details :

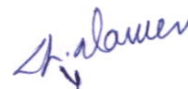
Patient Name :	Baby Of MUTTAMPETH LIKITHA TWIN-I	Age :	0 Y 1 M 7 D
Guardian :	Mr CHITELLI NAVEEN	DOB :	16-05-2026 01:00 AM
Gender :	Male	Religion :	
Occupation :		Marital Status :	Single
Address (H) :	#FLAT NO SFD 3RD FLOOR SANTHI SAGAR APTS MAYURI MARG Begumpet Hyderabad Telangana INDIA 500016	Phone No :	8121861614/ 8686090724
		E-mail :	nomailid@gmail.com

Admission Details :

Bed Type :	NICU	Bed No :	NICU 252	Ward Name :	2F-NICU 2
Room No :	NICU 252	Admission Type :	First Visit		

Contact Details :

Name :	Mr CHITELLI NAVEEN	Relationship :	Father
Contact Address :	#FLAT NO SFD 3RD FLOOR SANTHI SAGAR APTS MAYURI MARG Begumpet Hyderabad Telangana INDIA 500016	Phone No :	8121861614 / 8686090724


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 :	SELPAY

JOHNSON & GRAY, FIDELITY & DRYDEN

This image shows a blank sheet of white paper designed for handwriting practice. It features five identical rows of horizontal dashed lines, each row consisting of two parallel dashed lines. The rows are evenly spaced across the page, providing a guide for letter height and placement. There is no text or other markings on the paper.

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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[illegible]

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : B/o Likitha R 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 Likitha C Twin 1 Mother's Blood Group : B +ve
Gender : ☒ M ☐ F Blood Group : O positive Birth Weight (gms) : 1.3 kg Length (cms) :
Date of Birth : 16/5/26 Time of Birth : 12:38 AM OFC (cms) :
Place of Birth : Koi Hospital Estimated Gesth Age : 28⁺6 weeks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 26 yrs Ht : Wt : BMI : Married Life : LMP : 25/10/25 EDD : 02/08/26
Conception : Spontaneous or with Rx : Ovulation Induction MgSO₄ - Not given
Booked at what GA : AN Steroids Drugs / Doses : one dose of Betamethasone
Last Scans Details : 14/05 → 28⁺5 wks → 2 doses of Betamethasone given 32 hrs prior to delivery
Twin 1 → 1197, Twin 2 1132 given 10 days back
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 :

Compliance with Rx :

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 Short Cervix & Cervical intra
(☐ Malaria ☐ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV) infection

UTI : when : Any culture :

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

Medication during Pregnancy : No Leaking PV Duration :



PAST OBSTETRIC HISTORY

G : P : A : L :

Sl. No.	Age	GA wks	B.W	Gender	Significant	Details
Prim						

PERINATAL HISTORY

Treating Obstetrician : Hospital : ☐ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation) Em. LSH

LSCS : ☐ Elective ☒ Emergency Indication :

Specify the reason : Preterm onset of labour

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 :

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	
2	2	
9/10	9/10	

TOTAL

Snapee II Score

Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

Patient Sticker

Baby Of MUTTAMPETH LIKITHA

6-05-2026

0 Y 1 M 9 D

(M)

Dr. NALINIKANTA PANIGRAHY



History of Present Illness:

Delivered by Em. LSCs 10/10 preterm onset labour

↓

Cried immediately after birth

↓

1/10 Respiratory distress and
grunting, started on DR-CPAP

↓

Cord clamping done

1st vit K given

↓

Shifted to RCH Bangalore for further
management

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5°C HR : 155/min RR : 55/min NIBP : CFT : 3 sec

Color of the extremities : Acrocyanosis → pink

Jaundice : Pallor : SpO2 : 96% on DR-CPAP

ANTHROPOMETRY: Birth Weight : 1.3 kg Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

HEAD :

Fontanelles :

Sutures

Shape / Moulding :

Edema / Bruising :

Size - (H.C.) :

Ⓢ Open @ level

FACIES :

(Any Facial
Dysmorphism)

No dysmorphism

NECK and
CLAVICLES :

Range of Motion :

Asymmetry :

Masses :

Ⓢ

EYES :

Symmetry :

Red Reflex :

Discharge :

To be checked

EARS, NOSE
MOUTH and
THROAT :

Ear set / Shape :

Periauricular Pits / Tags :

Nasal shape / Patency :

Palate :

Gums :

Lips :

Tongue :

Ⓢ

THORAX and
BREASTS :

Shape of Thorax :

Position of Nipples and Number :

Ⓢ

ABDOMEN and
UMBILICUS :

Shape :

Organomegaly :

Bowel Sounds :

Umbilical Stump :

Discharge :

2A+1 vein

GENITALIA :

Labia / Hymen :

Testicles/penis :

Anus :

Ⓢ

HERNIAL ORIFICES

Free

TRUNK and SPINE :

SKIN LESIONS :

EXTREMITIES :

Fingers / Toes :

Deformities :

Hip Joint Examination :

Arms / Legs :

Mobility :

Ⓢ



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

Breathing Pattern : ☐ Regular ☐ Periodic ☐ Shallow ☐ Gasping

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

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

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

Settings :

SpO₂: 96% CPAP Auscultation: Breath Sounds: Added Sounds:

CARDIOVASCULAR SYSTEM :

HR : BP : Precordial Activity :

Femoral Pulses : Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

ABDOMEN:

Shape : Hernia orifice :

Palpation : Anal Patency : Present

Palpable masses : Umbilical Cord :

Abdominal girth : First urine passed : Passed
Meconium passed : Not passed

NERVOUS SYSTEM:

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

MOTOR SYSTEM:

Passive Tone :

Active Tone :

Neonatal Reflexes :

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

Moro's : DTR :

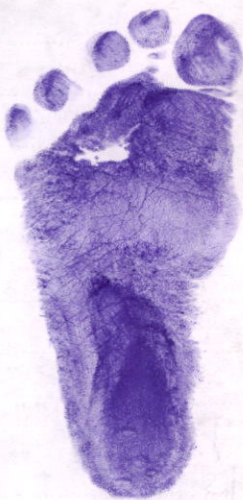
ATNR : Skull and Spine :



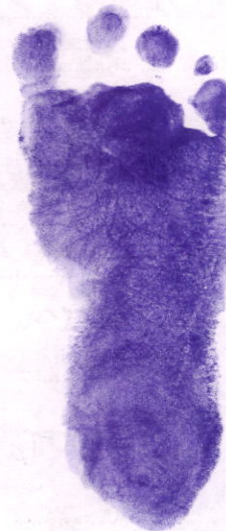
Diagnosis : Very Preterm / VLBW / RDS / DCDA Twin 1 / MCL
(28TG) (1.34)

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : Dr. Anushe

Name : Dr. Anushe

Date & Time : 16/5/26 @ 1 AM

Consultant :

Signature : Dr. NALINIKANTA PANIGRAHY

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

Date & Time : 16/5/26

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

Final Diagnosis :

Neonatal condition at the time of Transfer:

Vital : HR : RR : BP : SP02 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

Plan

seen by Dr. Nalinikanta

Plan during ward follow up :

1) to send - CBP, Blood grouping
Blood c/s

2) Start Piptaz

3) Start caffeine

4) TV - 60cc/kg/day

Feeding Plan at the time of shifting :

10:1 D + 3ml/kg calcium gluconate

Screenings done during NICU Stay :

5) feeds 1ml 2hly to start
(CBM)

NSG :

Hearing Screen :

6) GRBS only

ROP : (BCA BD)

TFT :

NP2 :

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

Doctor Name: Doctor Name:

Date & Time: Date & Time:

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/10/16	<u>Colic</u> → off oxygen → Bottle feeding today → will be shifting in next feeds	<u>10</u> → tapering oxygen → 0mg/ml



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5/26 10:30am		Seen by Dr. Nalinikanta
		TV = 160 cc / kpl day
		3 peradi feeds / today (bottle feeds) (senior sister)
		Rest on feeds
		W/L
		GRBS OP
		OMI] to continue
		NVS]
		kmc
		Noted by
		Lokanga
		22/5/26 @ 11:00 am

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Afternoon Rounds</u>	
22/05/25 4 PM	Baby hemodynamically stable on air. Two times bradycardia - self pickup. No desaturation Tolerating feeds ²⁹ ml 2hrly Took 3 pallidai feeds each = 20-30ml	Plan 1) TV - 160 cc/kg/day 29 ml 2hrly + KMF 2) KMC minimum 6-8hr 3) OMS, NTS to continue 4) GRBS OD 5) W/F ↑ WOB, Bradycardia Desaturation
	$\frac{8}{8}$ - HR - 148/min RR - 42/min SPO ₂ - 96% BP - 70/36 (4+)	(10) D. Suthan noted by Jeevanani

Date & Time	Progress Notes	Doctor's Order
9/6/26 @ 11:45pm	Night Rounds Baby on Room air No Bradycardia No Desatn Took - 3 paladay with desatn upto 85% Last Paladay with Spelling	Juan

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

Day in NICU: Day of Life: PMA:

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

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

Doctor's Name (Hand over given):

Doctor's Name (Hand over taken):

Signature:

Signature:

Date & Time:

Date & Time:

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6/26 10:45 AM		seen by Dr. Nalinikanta
		Adv
		① down flow (non-vent) to Calm
		② O ₂ feed only x 24 hr
		③ give one stat dose of caffeine for 10mg/kg PO
		④ CRP NP ₂ today
		⑤ keep Numb Sp ₂ , RR (Apnea) & Bradycardia
		(16) Furosemide
	Dr. NALINIKANTA PANIGRAHY Reg. No. 10111/2015/03605	noted by Lokanayana 24/6/26 @ 10:45 AM



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

Day in NICU: Day of Life: PMA:

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

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

Doctor's Name (Hand over given):

Signature:

Date & Time:

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 11:20 AM		S/S Dr. Nalinikanta Adv
	Prone nursing - TV - 160cc/kg/day - 43ml EBM 3RD hourly + 2.5ml 3% NaCl + HMF (Mix 2 HMF in 50ml feeds)	charge caffeine to 7.5mg/kg/day as per current wt.
		→ Complete O₂ feed
		→ Off O₂ ↓ Keep strict monitoring
		Keep target of 90-100% in case of $fiO_2 = 21\%$ (R/A)
		if needing O₂ keep SpO₂ - 90-95%
		→ RBS - OD - T/M - S/E
	Dr. NALINIKANTA PANIGRAHY Reg. No. TSMC/FMR/03605	Noted by Lokanay 26/6/26 @ 11:20 AM

IAH-00656409 IP5-00175520
 Baby Of MUTTAMPETH LIKITHA
 8-05-2026 0 Y 1 M 9 D (M)
 Dr. NALINIKANTA PANIGRAHY



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

Day in NICU: Day of Life: 42 PMA: 34⁺6
 Term ☐ Preterm ☐ Gestation: 28⁺6 Corrected Gestational Age: Today's Weight: 2.243 (193gm)

Problems		
S.No.	Current	Past Problems
1.	Very PT / VLBW / OCPA Twins	NNJ
2.	ROS CRAP → Hfvc → low flow → RA	Suspected sepsis
3.	Anemia of prematurity	
4.	Anemia of prematurity	
5.	osteopenia of prematurity	
6.	Hyponatremia of prematurity	

Clinical Assessment
Baby on Room air Hemodynamically stable NO RD / no desaturation no bradycardia tolerating feeds well Passed urine & stool KMC: 5 hr 18 min Gress: 80 mg/dl SpO ₂ : 98% PR: 154/min RR: 49/min BP: 73/51 (56) mmHg CRT < 3 sec

Medications Used
SyP. Caffeine (7.5 mg/kg) SyP. Olanopar → 3.1. NaCl each feed (2.5 ml) Supraped drop (OD) 0.5 mg/kg (OD) Orofer XT Budecort neb Hmf sachet

Plan of Care:
1) T _{IV} = 160 cc/kg/day → 43 ml @ 3H + 2 Hmf in 50ml and give 43ml 2) prone nursing 3) GRBS OD 4) Trace serum electrolytes 5) KMC minimum 6 hours Target SpO ₂ 90-100% MBP 40-50 mmHg U/O 2-4 cc/kg/hr

Doctor's Name (Hand over given): Sai

Signature: [Signature]

Date & Time: 26/6/26

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken): [Signature]

Signature:

Date & Time:

3AH-00656409 IP5-00175520
 Baby Of MUTTAMPETH LIKITHA
 16-05-2026 0 Y 1 M 9 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

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

Day in NICU: Day of Life: PMA:

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

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

Doctor's Name (Hand over given):

Signature:

Date & Time:

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:

[illegible]

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

Day in NICU: Day of Life: 43 PMA: 35 week
 Term ☐ Preterm ☐ Gestation: 28⁴⁶ week Corrected Gestational Age: Today's Weight: 2.288 kg (145)

Problems		
S.No.	Current	Past Problems
1.	VERY PT / VLBW / DCDA Twin I	NNT
2.	RDS: CPAP → HFV → low flow → RA → Mini low flow	Expected sepsis
3.	Apnea of prematurity	
4.	Anemia of prematurity	
5.	Osteopenia of prematurity	
6.	Hypонатremia of prematurity	
Clinical Assessment	Baby on minilow flow 0.014/min In last 24 hours → baby had tachypnea with retractions Lvs → 7-8 with Right & left sup lobe with fluid 1 stat dose larix given → Tachypnea settled Now baby on minilow flow, NO RR/No desaturation u/o in 24hrs = 1.4 ccl/kg/hr SpO₂: 99% PR: 153/min RR: 53/min CRT < 3 sec BP: 67/36 (64) mmHg	
Medications Used	1) Hmf 2) Furosed drop (2.5mg/day) 3) Sup. caffeine (7.5mg/kg/day) 4) 3.1. Nacl each feed (5mcg/kg) 5) Sup. ossopan-D 6) Budecort nebr	
Plan of Care:	1) Tr = 150 ccl/kg/day → 40 ml @ 3H full OA feed 2) Head end elevation 3) Prone nursing 4) Kmc minimum 6-8 hours 5) Rlv CBP, CRP, etc Target SpO₂: 90-95% minilow flow 90-100% eRA MBP 40-50 mmHg Uo 2-4 ccl/kg/hr	

Doctor's Name (Hand over given): Sneha

Signature: [Signature]

Date & Time: 27/6

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken): [Signature]

Signature: [Signature]

Date & Time: 27/6/26

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

Day in NICU: Day of Life: PMA:

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

	Problems		
	S.No.	Current	Past Problems
Overview	1.		
	2.		
	3.		
	4.		
	5.		
	6.		
Clinical Assessment	Handwritten clinical assessment notes in the Clinical Assessment section.		
Medications Used	Handwritten medication notes in the Medications Used section.		
Plan of Care: Handwritten plan of care notes.			

Doctor's Name (Hand over given):

Doctor's Name (Hand over taken):

Signature:

Signature:

Date & Time:

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26 10:45 AM		Seen by Dr Nalinikanta
		<u>P/m</u>
		1) Furosed drops 8 th hly 0.5 x 1g/dose (ing TID)
		2) 2D Echo today
		3) TV - 150 cc/kg/day - 40ml Q3H full or feed
		4) 1/2 further weight gain Plan for → LFT Urea, Cr Electrolytes } T/n
		5) CRBS OD

Dr. NALINIKANTA PANIGRAHY
Reg. No. / TSMC / FMR / 03605
27/6/26

Noted by
Jenamani
27/6/26
@ 10:46 pm.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26 2:40 PM	<u>Afternoon Rounds</u> Baby on minimal flow @ 0.01 L/min Intermittent Tachypnoea (+) mild Retractions (+) Tolerating feeds 40 ml shy No vomiting SpE - HR - 162/min RR - 62/min SpO₂ - 98% BP - 64/40 (48) U.O → 1.5 cc/kg/hr Echo (N)	g/m 1) Taper gtt O₂ if SpO₂ > 95% SpO₂ target - 90-95% if PreO₂ > 21% 90-100% if PreO₂ 21%. 2) TV - 150 cc/kg/day 40 ml shy on feeds 3) I/O checking QID 4) 2D Echo today 5) LFT Urea, Cr T/m S/E 6) Prone nursing, Head cool down 7) KMC nursing 6-8 hrs ONS, NNS to continue. 8) ERBS OD 9) W/F ↑ WOB, Desaturation apnea & Bradycardia
	Noted by Jeervaneni	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26	mini @ 1:15 am Baby on low flow oxygen at 0.02l/min ↓ on Prone nursing ↓ Has tachypnea ↓ O/c in Supine position Tachypnea (+) RR = 85/min SPO₂ = 96% HR = 182/min with SCR (+), TCR (+) ↓ chest x-ray taken B/L haziness (+) LUS - 7-8 Score with coalescent B-lines in (Rt) UL, (Lt) UL B-lines with A-lines (Lt) Side (Rt) lateral	1) Plan for CPAP with Rams Cannula. 2) CBG. 3) CBP } R/V CRP } 4) 1st dose of furosemide

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



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

Day in NICU: Day of Life: 44 PMA: 35⁺
 Term ☐ Preterm ☐ Gestation: 28⁺ Corrected Gestational Age: Today's Weight: 2.301

Problems	
S.No.	Current
1.	Very pt / VLBW / BCPA Twin I
2.	RDS CPAP → HFNC → low flow → RA → low flow
3.	Apnea of prematurity
4.	Anemia of prematurity
5.	Osteopenia of prematurity
6.	Hyponatremia of prematurity

Clinical Assessment	
Baby on Room air	SpO ₂ = 99%
no RPI / No dehydration	PR: 151w
No vomiting	RR: 49w
Tolerating OG feeds	BP: 64/37 (48) mmHg
Paissed urine & stool	

Medications Used	
Hmf	Budecort nebs
Forced drop @ 1.5mg/kg/day	
Syr. Caffeine @ 7.5mg/kg/day	
3.1 NaCl each feed	
Syr. Olanopran D	

Plan of Care:

- 1) Tr = 150cc/kg/day → 40ml @ 3H full OG feeds + Hmf (2Hmf in 50ml then give 40ml)
- 2) Minilow flow SOT with target SpO₂ 90-100% (90-100)
- 3) LFT, s. urea, creatinine, serum Electrolytes (Tham) daily
- 4) W/F RPI dehydration
- 5) GRBS on
- 6) Iemc maximum 6-8h

Doctor's Name (Hand over given): Sai

Signature: [Signature]

Date & Time: 28/6/26

Doctor's Name (Hand over taken):

Signature:

Date & Time:

Date & Time	Progress Notes	Doctor's Order
28/6/21 1:30am		S/B - Dr Nalinika
		Trace ALP in LFT
		Keep in prone nursing.
		Noted by Sitalika 28/6/20
28/06/21 1:30am	Afternoon	Plan
	- Baby on room air	- cont in R/A
	- Maintaining SpO2 90-100%	- W/F any distress , desaturation
	- Comfortable in prone position	- TV - 150cc/kg/day
	- No ↑ NOB	- 4ml - 3 hourly feeds -
	- Feeds tolerated	- Continue prone nursing
		- KMC, NNS, OMS
		- ARBS - OD



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

ight[™]
SPITALS
Delivery

Day in NICU: Day of Life: 45 PMA: 35+2
Term ☐ Preterm ☐ Gestation: 28+6 Corrected Gestational Age: Today's Weight: 2.326
(125g)

Overview	Problems	
	S.No.	Current
	1.	Very PT / ULBBW / 2 EDA Twin - 1
	2.	Apnea of prematurity Pneumonia of prematurity
	3.	Osteopenia of prematurity
	4.	Hypocalcaemia of prematurity
	5.	Issues of Excessive wt gain
	6.	

Past Problems MC = 32.5
cm.

Clinical Assessment

- On room air O₂
- accepted full ~~palatal~~ feeds. GRBS - 89 ml/de
=
NO - 2.4 ml/kg/hr
- ~~has~~ passed stools since urine.
- No other concerns.

Medications Used

- On HMF
- Furapred - 10.5 mg / kg / day
- Drap
- SYP Caffeine @ 7.5 mg / kg / day.
- 3-1. NaCl - each feed
- SYP Ossapan - D.

Profer
Budest

Plan of Care:

- Plan
- 150 cc / kg / day - 40 ml - 3 hourly - full O₂ feeds
(with ↑ wt val 4.4 ml)
- R/V palatal / bottle, prone nursing
- GRBS OD
- W/F 9 NOB, desat
- Nutritional calculation.

Doctor's Name (Hand over given): Ranjit

Signature: Ranjit

Date & Time: 29/06/20

Doctor's Name (Hand over taken): Ranjit

Signature: Ranjit

Date & Time: 29/6/20

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

Day in NICU: Day of Life: 49. PMA: 35+6 wks

Term ☐ Preterm ☐ Gestation: 28+6 wks Corrected Gestational Age: Today's Weight: 2510g (+111g)

		Problems	
		S.No. Current	Past Problems
Overview	1.	VPT/VUBW/DCDA twin 1	RDS-1°S → MV → CPAP-CP
	2.	Apnea of prematurity	
	3.	Anemia of prematurity	
	4.	Hyponatremia of prematurity	
	5.	Osteopenia of prematurity	
	6.		
Clinical Assessment	Baby is on room air Hemodynamically stable. Looks edematous. Accepted full paladay feed yesterday. KMC given for 5 hrs HR-132/min SpO₂-97% U/O-1.5cc/kg/hr Stool-passed. RBS-91mg/dl Excessive wt. gain		
	Medications Used Syp. Caffeine (7.5mg/kg/day) Furosemide drops (1.5mg/kg/day) 3% NaCl (5meq/kg/day) Syp. Osipam D oxygen xT Neb. Budecort Zincovit Vit D3 drops.		
Plan of Care: • TV-150cc/kg/day → 45ml/3rd hly. + 3% NaCl full paladay 2.5ml • Crib care. • R/v shift out • R/v to stop Caffeine.			

Doctor's Name (Hand over given): Dr. Bojake

Signature: [Signature]

Date & Time: 2/2/26.

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:

Patient Sticker

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

Day in NICU: Day of Life: PMA:

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

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

Doctor's Name (Hand over given):

Signature:

Date & Time:

Docu. No.: RCHBH / FRM / CLINICAL / 290

Doctor's Name (Hand over taken):

Signature:

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/2/26 11am.	Seen by Dr. NK	
		Plan.
		→ Shift to room.
		→ TV-150cc/kg/day
		→ US a.s. abdomen - today & then shift out.
		→ Stop Budecort.
	Dr. NALINIKANTA PANIGRAHY Reg. No: TSMC/FMR/02605	
	<u>SHIFTING NOTES</u>	
3/2/26 4pm	Baby on room air hemodynamically stable - HR-150/min - SpO ₂ -100% - accepting feeds well USG ÷ B/L - mild hydrocoele - Left inguinal hernia (bowel).	Plan. → Shift to room - TV-150cc/kg/day - 47ml @ 3rd hrs + 3% NaCl (2.5ml - each feed) - full paladai - GBM.

BAH-00656409 IP5-00175520

Baby Of MUTTAMPETH LIKITHA

16-05-2026

0 Y 1 M 17 D

(M)

Dr. NALINIKANTA PANIGRAHY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		→ ROP after 2 wks
		→ cont. Supplements as advised
		- RIV - vaccination (AABR) NBS after shift out
		→ Pediatric Sur
		Noted by Sonu 3/8/26 Parson
3/8/26 8:30 PM	NIGHT Afternoon Rounds on RA, mainting sets.	Plan
	Taking Red Shell CFR3sees	→ 45ml Bzshy + 2.5ml 30% meal each feed
	Urine ✓ Stools ✓	→ BCh, Rotavax, RSV Hexaxim Penner
	Haemodynamically stable	→ AABR T/m
		→ RIV NBS
		→ w/R ROP, dull ceforty H (Haw)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/5 9:30 AM	CLB RESIDENT VPT / VLBW / DCDA twin / Apnea of Prematurity Anemia of Prematurity Osteopenia of Prematurity	Play 1. RLV vaccinations. - (BCG, Rota, Hexaxim) today 2. AABR today. Preverax T/m
	last NB2: 28/6. 2u/6 Hb: 9.4. Enterocolic Pink TWT: 2-HB1 (↓29grams) urine: V stools: V Hx: soft distended. Good perfusion. hemodynamics are stable.	3. TW: 150ml/kg/day. - 45 ml/3rd hourly + 2.5ml 3t Nacl each feed. 4. RLV sending NBS. 5. ROP after 2 wks. 6. RLV on Caffeine. Stopping
	Zincovit / Crofer XT / Vitamin D / Furosemide / Caffeine / 3t Nacl. (TID)	② Schitts NOTED BY Latta @ 9:30am
	on Room air Since 7 days.	
	Discharge the 24 BL Straw	4/7/26 AABR - Hearing Assessment Bilateral responses are present Bilateral Normal ② Schitts
	Preverax Hexaxim Rota BCG	2.5v m/s

BAH-00656409

IP5-00175520

Baby Of MUTTAMPETH LIKITHA

16-05-2026

0 Y 1 M 17 D

(M)

Dr. NALINIKANTA PANIGRAHY

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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



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[illegible]

3AH-00656409 IP5-00175520
Baby Of MUTTAMPETH LIKITHA
18-05-2026 0 Y 1 M 14 D (M)
Dr. NAUNIKANTA PANIGRAHY



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26	Jenitha T-2	
	- Gib care	
	- full feeds	
	- if taking well shift to Room 1/m	
	Jikitha - T-1.	
	- Cont O2-feed	Jikitha
	- weight gain is more.	
	- we are decreasing feed volume.	
	- we are starting minimal oxygen.	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26	<u>B/p stops</u> <u>Wlante - 5</u> → R00 → 6xix ⊕ 1 dose → or feed. → we might return 2-3 days. → 2 Decha today → 450, RFT.	<u>II</u> → shifting baby two → R00 → variation

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



REFERRAL FORM

Doctor Name : Dr. Nabeel Date : 3/7/26 Time : 3:30pm

Diagnosis : (L) inguinal hernia

Hospital : Rainbow Children's Hospital
Parana Hill

Type of Referral :

☐ Emergency

☐ Urgent

☒ Non Urgent

Referred for: ☐ Opinion ☐ Co-Management ☐ Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

(case discussed to Dr. Nabeel)

Thank for the referral
History noted.

48 DOc male child very preterm (28wks + 6D)
Emergency LSCs (preterm onset of labor) / CIAB
developed respiratory distress → CPAP
child improved - weaned off CPAP.

40 swelling in left inguinal region.
Not a/w feed intolerance, abd. distension
as obstipation as fewer stools
o/e - child sleeping

Vitals - HR - 136 bpm

SpO₂ - 99% RA

S/E - P/A - soft

4E - left scrotal swelling present
manual reduction possible

B/L Testes descended.

Adv

① plan - open B/L herniotomy
(2 days before planned d/c)

② PAC

③ Financial counselling

Imp - (L) inguinal hernia

Dr. Nabeel
3/7/26
3:30pm

Consultant :

Name : Dr. Nabeel Signature : [Signature] Date & Time : 3/7/26
3:30pm

BAH-00656409 IP5-00173894
 Baby Of MUTTAMPETH LIKITHA
 16-05-2025 0 Y 1 M 6 D (M)
 Dr. NALINIKANTA PANIGRAHY



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RESULT SHEET

Date	24/6	26/6	28/6			
Time						
Hb	9.4					
PCV	27.9					
RBC	3.00					
WBC	8.24					
N/L	22/65					
Platelets	378					
CRP	5.0					
ESR						
PCT						
RBS						
Na	130	132	132			
K	3.5	4.7	4.7			
Cl		101	99			
Ca/Mg	10.7	7				
Phosphate						
Urea			11			
Creatinine			0.3			
ALP			576			
SGPT			13			
SGOT			35			
T.Bill/Conj			4.5 < 0.3 4.2			
T.Protein			4.8			
S.Albumin			3.1			
S.Globulin			1.7			
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

B10-likilina 7-I

Patient Sticker

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:

Shifted to:

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	Syp OSSOPAN-D	2ml	PO	TID	3/7	☒ C ☐ DC
2	FUROFED drops	0.1ml	PO	24H TID	3/7	☒ C ☐ DC
3	3% NaCl	2.5ml	PO	each feed	3/7	☒ C ☐ DC
4	Syp CAFFEINE	0.8ml	PO	24H	3/7	☒ C ☐ DC
5	Zincovit drops	0.5ml	PO	OD	3/7	☒ C ☐ DC
6	MORFGR XT drops	0.5ml	PO	OD	3/7	☒ C ☐ DC
7	Vitamin D3 drops	0.5ml	PO	OD	3/7	☒ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

MEDICATION HISTORY RECORDED / VERIFIED BY

* C- Continue, DC - Discontinue

Doctor Name & Signature : PawanDate & Time : 3/7/20

Nurse Name & Signature:

Date & Time :

Docu. No. : RCHBH / FRM / GENERAL / 090

DATE OF BIRTH: 1944

DATE OF DEATH:

DATE OF BURIAL:

DATE OF CREMATION:

3/2/50
Loman

DATE OF INTERMENT:

DATE OF INTERMENT:

DATE OF INTERMENT:

1/14/1944	08	02	00	00	00	00
01/14/1944	08	02	00	00	00	00
02/14/1944	08	02	00	00	00	00
03/14/1944	08	02	00	00	00	00
04/14/1944	08	02	00	00	00	00
05/14/1944	08	02	00	00	00	00
06/14/1944	08	02	00	00	00	00
07/14/1944	08	02	00	00	00	00
08/14/1944	08	02	00	00	00	00
09/14/1944	08	02	00	00	00	00
10/14/1944	08	02	00	00	00	00
11/14/1944	08	02	00	00	00	00
12/14/1944	08	02	00	00	00	00

RECEIVED BY: [Signature]

DATE: [Date]

TIME: [Time]

LOCATION: [Location]

REMARKS: [Remarks]

RECEIVED BY: [Signature]

DATE: [Date]

TIME: [Time]

LOCATION: [Location]

REMARKS: [Remarks]



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : BUDELORT NEB				Date Time	
Dose	Route	Frequency	Start Dt.	23/6	24/6
	Neb	BD	20/6	25/6	26/6
Name & Signature of the Doctor				27/6	28/6
Starting the Drugs:				29/6	30/6
Additional Instructions:				1/7	2/7
1/2 nebulizer (2 times)				3/7	4/7
Daily Doctor's Endorsement by a Sign				5/7	6/7

DRUG : DROPEROT DROPS				Date Time	
Dose	Route	Frequency	Start Dt.	23/6	24/6
	PO	OD	21/6	25/6	26/6
Name & Signature of the Doctor				27/6	28/6
Starting the Drugs:				29/6	30/6
Additional Instructions:				1/7	2/7
3mg/1/2 day (ml = 10mg)				3/7	4/7
Daily Doctor's Endorsement by a Sign				5/7	6/7

DRUG : NALIN				Date Time	
Dose	Route	Frequency	Start Dt.	23/6	24/6
			23/06	25/6	26/6
Name & Signature of the Doctor				27/6	28/6
Starting the Drugs:				29/6	30/6
Additional Instructions:				1/7	2/7
Daily Doctor's Endorsement by a Sign				3/7	4/7

DRUG : NALIN				Date Time	
Dose	Route	Frequency	Start Dt.	23/6	24/6
			23/06	25/6	26/6
Name & Signature of the Doctor				27/6	28/6
Starting the Drugs:				29/6	30/6
Additional Instructions:				1/7	2/7
Daily Doctor's Endorsement by a Sign				3/7	4/7

DRUG : NALIN				Date Time	
Dose	Route	Frequency	Start Dt.	23/6	24/6
			23/06	25/6	26/6
Name & Signature of the Doctor				27/6	28/6
Starting the Drugs:				29/6	30/6
Additional Instructions:				1/7	2/7
Daily Doctor's Endorsement by a Sign				3/7	4/7

(P.T.O)

BAH-00656409 IP5-00173894
Baby Of MUTTAMPETH LIKITHA
16-05-2025 0 Y 1 M 7 D (M)
Dr. NALINIKANTA PANIGRAHY



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REGULAR PRESCRIPTIONS

Weight 2 kg

Ward

Dose Route Frequency Start Dt. Date Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: FUROSED DROPS

Dose Route Frequency Start Dt. Date Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: 3% NaCl

Dose Route Frequency Start Dt. Date Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: 3% NaCl

Dose Route Frequency Start Dt. Date Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Docu. No.: RCHP

3AH-00656409 IP5-00175520
Baby Of MUTTAMPETH LIKITHA
16-05-2025 0 Y 1 M 14 D (M)
Dr. NALINIKANTA PANIGRAHY

Sheet No.

DRUG: ZINCovit DROPS

Dose Route Frequency Start Dt. Date Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: OROTEXT DROPS

Dose Route Frequency Start Dt. Date Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: VITAMIN D3 drops

Dose Route Frequency Start Dt. Date Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:



DRUG CHART

Date of Admission: 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:																			

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG : SUP AFFIENE				Date Time	23/6	24/6	25/6													
Dose	Route	Frequency	Start Date																	
0.5ml	PO	OD	30/5																	
Name & Signature of the Doctor Starting the Drugs: Dr. Ashwarys				6AM Change dose 25/6																
Additional Instructions: + 5mg/kg/day 1ml = 20mg																				
Daily Doctor's Endorsement by a Sign																				
DRUG : SUP OSSOPAN-A				Date Time	23/6	24/6	25/6	26/6	27/6	28/6	29/6	30/6	1/7	2/7	3/7	4/7				
Dose	Route	Frequency	Start Date																	
2ml	PO	TDS	16/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Ashwarys				6AM 2PM 10PM Change 25/6 26/6 27/6 28/6 29/6 30/6 1/7 2/7 3/7 4/7																
Additional Instructions: 75mg/kg/day 5ml = 120mg																				
Daily Doctor's Endorsement by a Sign																				
DRUG : IMF SACET				Date Time	23/6	24/6	25/6	26/6												
Dose	Route	Frequency	Start Date																	
	PO	each feed	17/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Ashwarys				changed by																
Additional Instructions: teachet each feed																				
Daily Doctor's Endorsement by a Sign																				
DRUG : EUROPE DROPS				Date Time	23/6															
Dose	Route	Frequency	Start Date																	
0.1ml	PO	Q2H	20/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Ashwarys				6PM 25/6																
Additional Instructions: 0.5mg/kg/day																				
Daily Doctor's Endorsement by a Sign																				

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
24/6/20	9 PM	CAFFEINE CITRATE	1mg/kg	ORAL	Dr. Nalinikanta Panigrahy	Dr. Nalinikanta Panigrahy
25/6/20						
27/6/20	2 AM	DROPS-FURDOBENIDE	0.5mg/kg	PO	Sneha	Karaj
			1mg			

Patient Sticker

I.V. FLUIDS CHART

Weight. Ward.

[illegible]

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175520 Admit Date : 23-Jun-2026 Admit Time : 10:39 PM UHID : BAH-00656409

Patient Details :

Patient Name	: Baby Of MUTTAMPETH LIKITHA TWIN-I	Age	: 0 Y 1 M 7 D
Guardian	: Mr CHITELLI NAVEEN	DOB	: 16-05-2026 01:00 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: #FLAT NO SFD 3RD FLOOR SANTHI SAGAR APTS MAYURI MARG Begumpet Hyderabad Telangana INDIA 500016	Phone No	: 8121861614/ 8686090724
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : NICU Bed No : NICU 252 Ward Name : 2F-NICU 2
Room No : NICU 252 Admission Type : First Visit

Contact Details :

Name : Mr CHITELLI NAVEEN Relationship : Father
Contact Address : #FLAT NO SFD 3RD FLOOR SANTHI SAGAR Phone No : 8121861614 / 8686090724
APTS MAYURI MARG Begumpet Hyderabad
Telangana INDIA 500016

Signature
Signature

Doctor Details :

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

Payment Details :

Deposit Amount : 0.00
Payment Mode : Cash Payor Name : SELF PAY

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

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

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

BAH-00656409 IP5-00173894
Baby Of MUTTAMPETH LIKITHA
16-05-2026 0 Y 1 M 6 D (M)
Dr. NALINIKANTA PANIGRAHY



Consultant: _____ Dept : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/2/26	5:30 PM	PICU	3B 1B	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	L. V prasad	21/1/2026	9684140.	rooja.K
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible][illegible]

[illegible]

[illegible]

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

[illegible]



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EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time:	2	4	6	8	10	12	2	4	6	8	10
Doctor/Nurse/Family Concern?		pm	pm	pm	pm	pm	Am	Am	Am	Am	Am	Am
Temperature (°F)		36.5°C	36.5°C	36.6°C	36.5°C	36.7°C	36.6°C	36.5°C	36.6°C	36.5°C	36.5°C	36.5°C
Heart Rate (bpm)		163	172	170	154	162	175	172	173	171		
Blood Pressure (mmHg) *		(41)	(44)	(47)	(45)	(51)	(55)	(53)	(53)	(42)		
Note: BP does not score in early warning scoring		28	28	36	41	46	44	44	44	27		
Heart Rate (Number)		186	156	163	164	169	161	154	154	154	170	
Resp. Rate (bpm) (Over 1 Minute) *		70	44	48	45	48	47	49	51	47		
Resp Mod/ Severe Distress None / Mild												
Receiving O ₂ (l/min) O ₂ Saturations (%)		97%	97%	98%	99%	99%	93%	99%	98%	96%		
Conscious Level Normal Altered		N	N	N	N	N	N	N	N	N		
GCS *		1	1	1	1	1	1	1	1	1		
TOTAL SCORE		0	0	0	0	0	0	0	0	0		
Number of shaded boxes		0	0	0	0	0	0	0	0	0		
Pain Score		1	1	1	1	1	1	1	1	1		
Observer's Initials												

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)



23/6/26

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

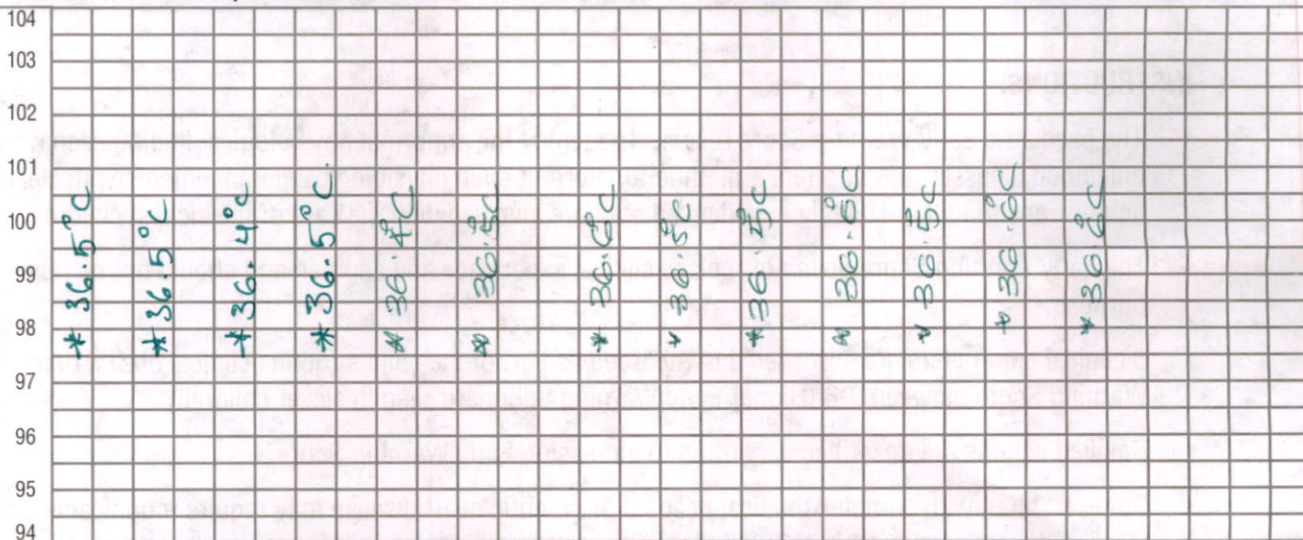
EARLY WARNING SCORE: CHILDREN'S UNIT

2

Date: 23/6/26 Time: 8 10 12 2 4pm 6pm 8 10 12 2 4 6 8 10

Doctor/Nurse/Family Concern? Am Am pm pm

Temperature
(F)



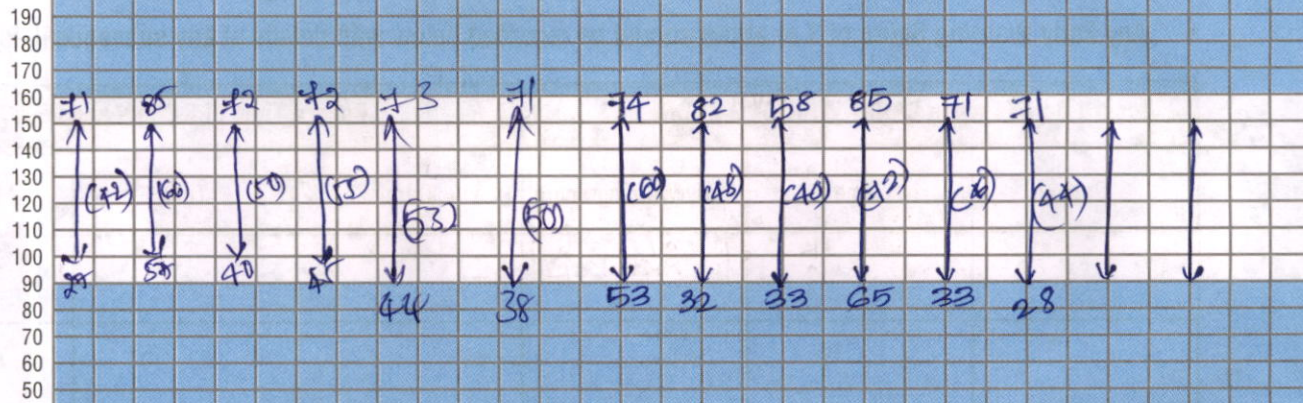
Heart Rate
(bpm)

and

Blood Pressure
(mmHg) *

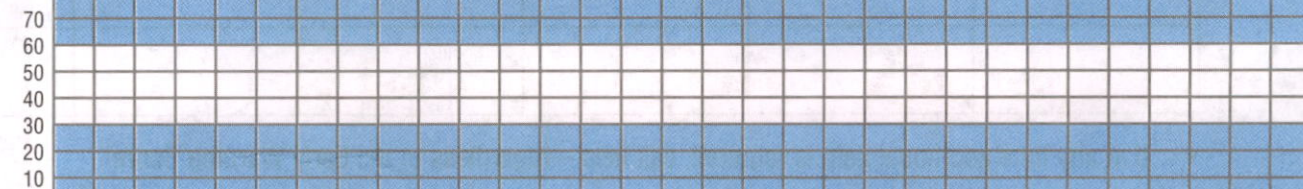
Note:

BP does not score
in early
warning scoring



Heart Rate (Number) 139 148 163 170 152 150 184 160 163 162 159 53

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



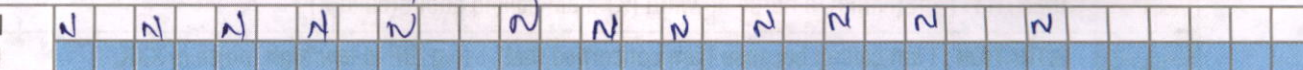
Resp Rate (Number) 42 38 57 54 43 46 31 60 65 53 57 60

Resp Mod/ Severe
Distress None / Mild

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



Conscious Level
Normal Altered



GCS * C C C C C C C C C C C C C

TOTAL SCORE

Number of shaded boxes 0 0 0 0 1 1 1 1 1 1 1 1

Pain Score 1 1 1 1 0 0 0 0 0 0 0 0

Observer's Initials [Signature] [Signature] [Signature] [Signature] [Signature] [Signature] [Signature] [Signature] [Signature] [Signature] [Signature] [Signature]

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.



RVATION 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)

Date: 24/6/98 Time: 2 10 12 2 4 6 8 10 12 2 4 6 8 11:00 AM 12 AM

Doctor/Nurse/Family Concern?	Am	Am	Pm	Pm	pm	Pm	Pm	Pm	AM	AM	AM	AM	AM
------------------------------	----	----	----	----	----	----	----	----	----	----	----	----	----

Temperature
(°F)Heart Rate
(bpm)

Blood Pressure
(mmHg) *

Note:
BP does not score
in early
warning scoring

Heart Rate (Number)

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

Resp Rate (Number)

Resp	Mod/ Severe
Distress	None / Mild

Receiving O ₂ (l/min)	O ₂ Saturations (%)
0	95.0
1	95.0
2	95.0
3	95.0
4	95.0
5	95.0
6	95.0
7	95.0
8	95.0
9	95.0
10	95.0
11	95.0
12	95.0
13	95.0
14	95.0
15	95.0
16	95.0
17	95.0
18	95.0
19	95.0
20	95.0
21	95.0
22	95.0
23	95.0
24	95.0
25	95.0
26	95.0
27	95.0
28	95.0
29	95.0
30	95.0
31	95.0
32	95.0
33	95.0
34	95.0
35	95.0
36	95.0
37	95.0
38	95.0
39	95.0
40	95.0
41	95.0
42	95.0
43	95.0
44	95.0
45	95.0
46	95.0
47	95.0
48	95.0
49	95.0
50	95.0
51	95.0
52	95.0
53	95.0
54	95.0
55	95.0
56	95.0
57	95.0
58	95.0
59	95.0
60	95.0
61	95.0
62	95.0
63	95.0
64	95.0
65	95.0
66	95.0
67	95.0
68	95.0
69	95.0
70	95.0
71	95.0
72	95.0
73	95.0
74	95.0
75	95.0
76	95.0
77	95.0
78	95.0
79	95.0
80	95.0
81	95.0
82	95.0
83	95.0
84	95.0
85	95.0
86	95.0
87	95.0
88	95.0
89	95.0
90	95.0
91	95.0
92	95.0
93	95.0
94	95.0
95	95.0
96	95.0
97	95.0
98	95.0
99	95.0
100	95.0

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!
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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)

25/6/26
 Doc. No.: RCH / FRM / CLINICAL / 124

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

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 25/6/26	Time:	8	10	12	2pm	4pm	6pm	8pm	10pm	12am	2am	4am	6am
Doctor/Nurse/Family Concern?													
Temperature (F)	104												
	103												
	102												
	101												
	100												
	99												
	98												
	97												
	96												
	95												
	94												
Heart Rate (bpm) and Blood Pressure (mmHg) *	190												
	180												
	170												
	160												
	150												
	140												
	130												
	120												
	110												
	100												
	90												
	80												
	70												
	60												
50													
Note: BP does not score in early warning scoring													
Heart Rate (Number)		170	155	154	166	157	162	147	162	188	162	150	148
Resp Rate (Number)	70												
	60												
	50												
	40												
	30												
	20												
	10												
Resp	Mod/ Severe												
Distress	None / Mild												
Receiving O ₂ (l/min)													
O ₂ Saturations (%)													
Conscious	Normal												
Level	Altered												
GCS *													
TOTAL SCORE													
Number of shaded boxes													
Pain Score													
Observer's Initials													
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.
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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!
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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:	26/6/26	Time:	8am	10am	12pm	2pm	4pm	6pm	8pm	10	12	2	4	6	
Doctor/Nurse/Family Concern?															
Temperature (F)	104														
	103														
	102														
	101														
	100														
	99														
	98														
	97														
	96														
	95														
	94														
	Heart Rate (bpm) and Blood Pressure (mmHg) *	190													
		180													
		170													
		160													
150															
140															
130															
120															
110															
100															
90															
80															
70															
60															
50															
Heart Rate (Number)		149	141	140	159	171	160	161	163	168	159	173	165		
Resp. Rate (bpm) (Over 1 Minute) *	70														
	60														
	50														
	40														
	30														
	20														
	10														
	Resp Rate (Number)		50	48	54	56	39	59	49	59	55	49	42	53	
	Resp Distress	Mod/ Severe													
	None / Mild														
	Receiving O ₂ (l/min)														
	O ₂ Saturations (%)		94%	96%	99%	99%	98%	98%	99%	99%	100%	99%	100%		
	Conscious Level	Normal	N	N	N	N	N	N	N	N	N	N	N		
		Altered													
	GCS *		C	C	C	C	C	C	C	C	C	C	C		
TOTAL SCORE															
Number of shaded boxes		0	0	10	0	1	1	0	0	0	0	0			
Pain Score		0	1	1	1	0	0	0	0	1	1	1			
Observer's Initials		A	B	A	B	B	B	B	B	B	B	B			

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:

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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!
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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)

30/6/26

No. : RCH / FRM / CLINICAL / 124

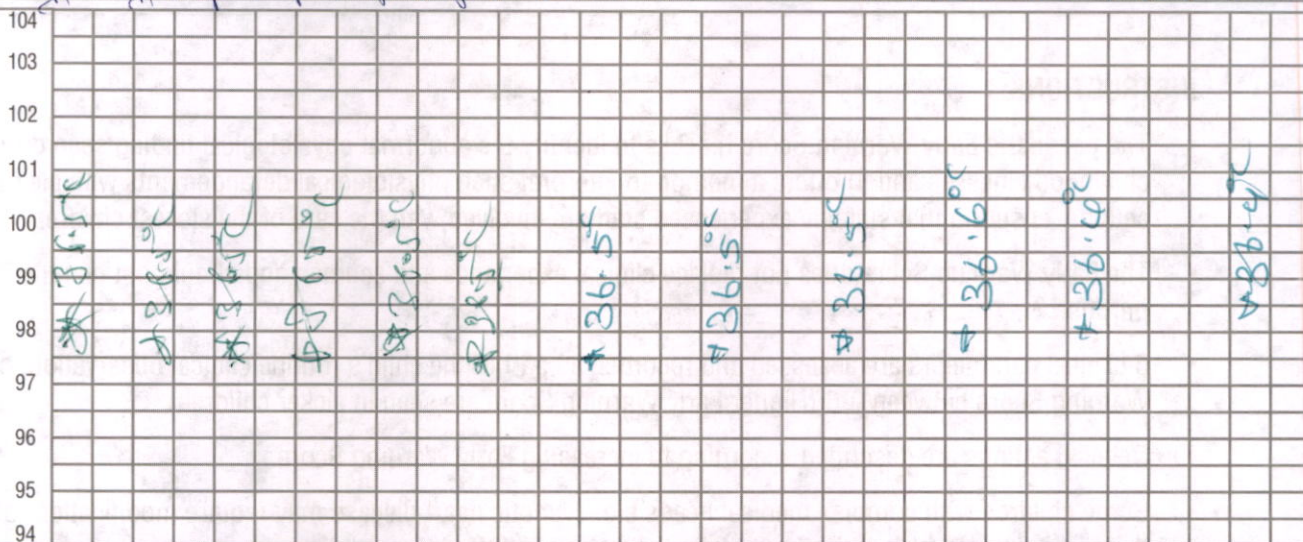
INFANT (<1 year) Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 30/6/26 Time: 8 10 12 2 4 6 8 10 12 2 4 6

Doctor/Nurse/Family Concern? Au Au pu pu pu pu

Temperature
 (F)

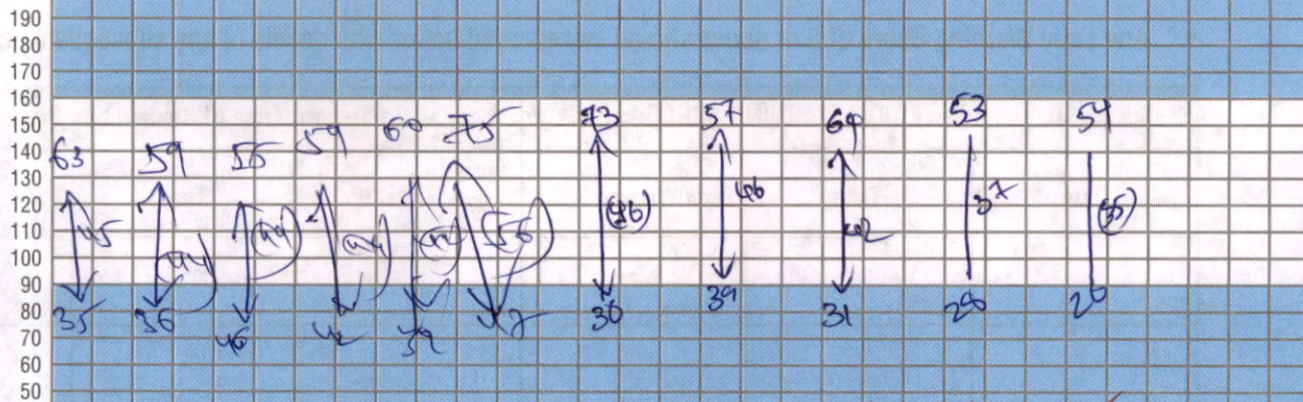


Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

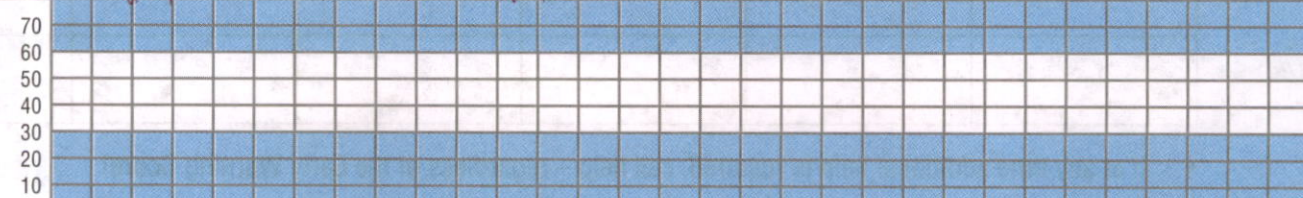
Note:
 BP does not score
 in early
 warning scoring



Heart Rate (Number)

153 149 155 165 153 145 150 162 156 148 155

Resp. Rate (bpm)
 per 1 Minute *



Resp Rate (Number)

42 40 49 50 48 47 51 45 32 40 54

Resp Mod/ Severe
 Distress None / Mild

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

99% 98% 99% 98% 99% 100% 99% 100% 98% 100% 99%

Conscious Level
 Normal Altered

N N N N N N N N N N N

GCS *

C C C C C C C C C C C

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

1 1 1 1 1 1 1 1 1 1 1
 0 0 0 0 0 0 0 0 0 0 0
 [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.
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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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27/6/26

INFANT (<1 year)

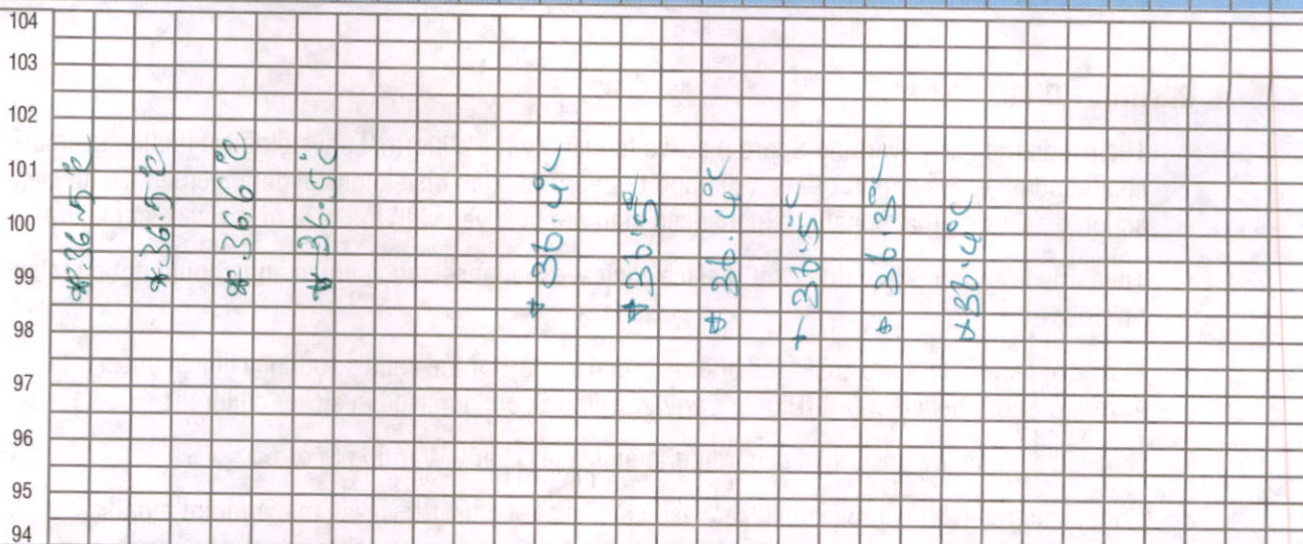
Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 27/6/26 Time: 8 10 12 2 4 6 8 10 12 2 4 6 8 10

Doctor/Nurse/Family Concern?

Temperature
 (°F)



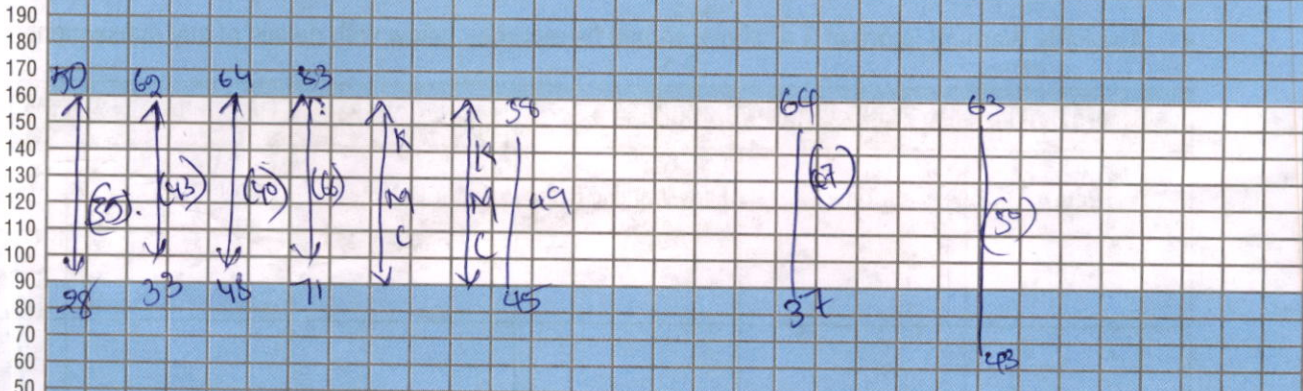
Heart Rate
 (bpm)

and

Blood Pressure
 (mmHg) *

Note:

BP does not score
 in early
 warning scoring



Heart Rate (Number)

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

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

* 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

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28/6/26

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date:	Time: 10	12	2	4	6	8	10	12	2	4	6
Doctor/Nurse/Family Concern?	PM	PM	PM	PM	PM	PM					
Temperature (°F)	36.4°C	36.5°C	36.4°C	36.4°C	36.5°C	36.4°C	36.6°C	36.5°C			
Heart Rate (bpm)	153	156	152	159	155	153	162	162	155		
Blood Pressure (mmHg) *	100/40	100/54	100/41	100/41	100/49	100/44	100/34	100/34			
Resp. Rate (bpm) (Over 1 Minute) *	65	45	59	49	51	40	43	56	13		
Resp Mod/ Severe Distress None / Mild											
Receiving O ₂ (l/min) O ₂ Saturations (%)	44%	95%	100%	98%	98%	96%	96%	96%	97%		
Conscious Level Normal / Altered	N	N	N	N	N	N	N	N	N		
GCS *	C	C	C	C	C	C	C	C	C		
TOTAL SCORE Number of shaded boxes	1	1	1	1	1	1	1	1	1		
Pain Score	0	0	0	0	0	0	0	0	0		
Observer's Initials	S	S	S	S	S	S	S	S	S		

ACTIONS

NB: Scores 3 should be recorded overleaf

- Score 1 : Continue normal observation by staff nurse
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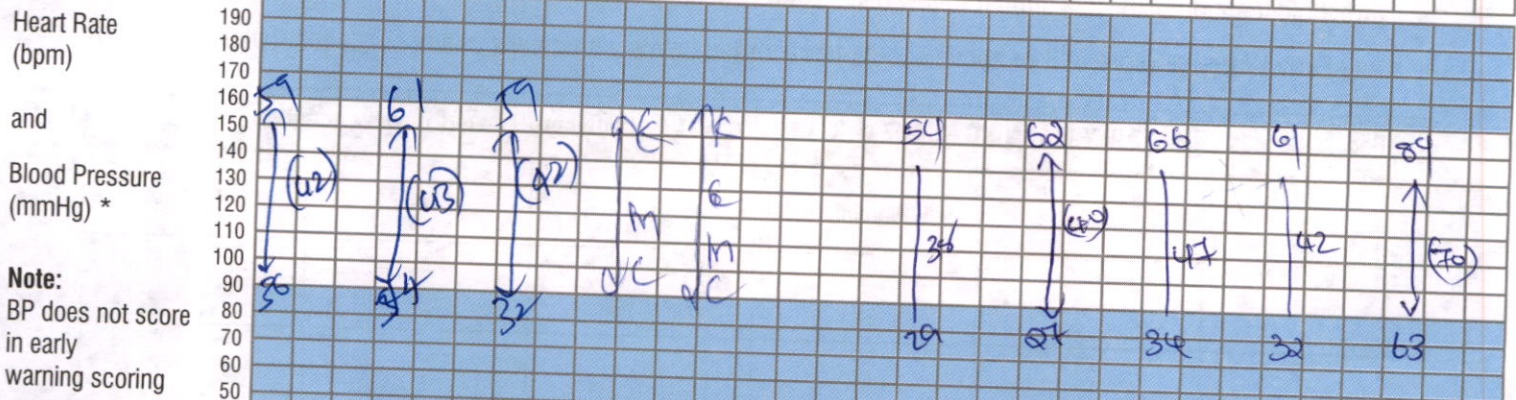
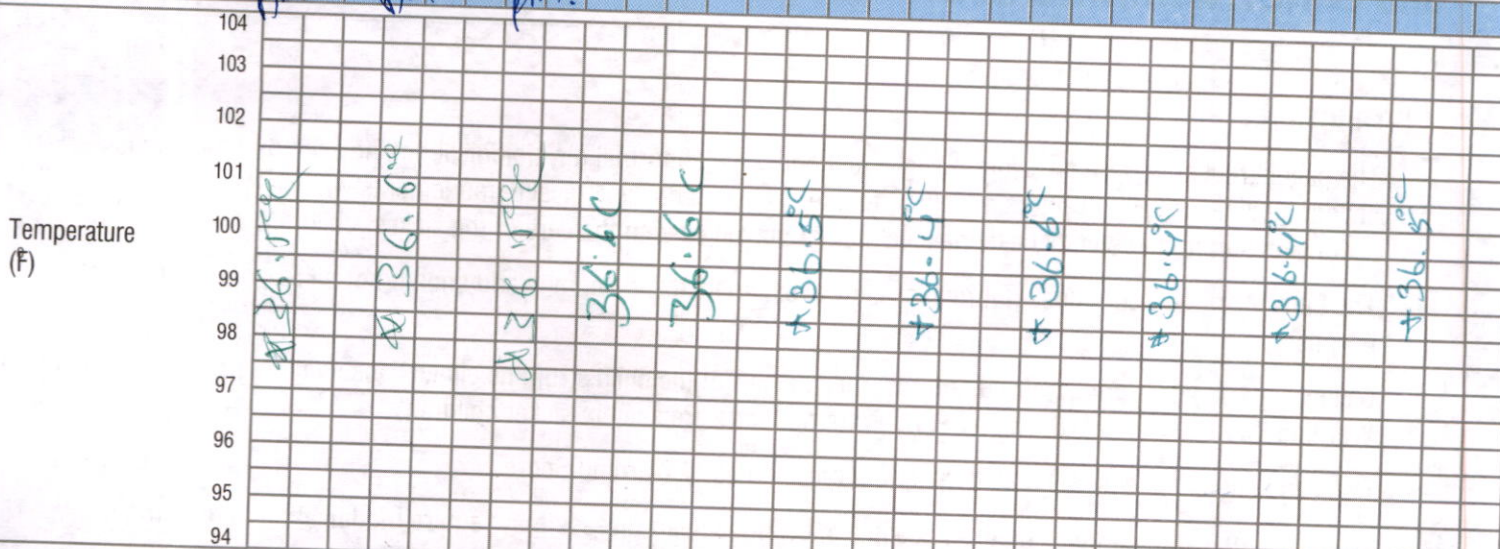


29/6/26

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 9 11 2 4 6 8 10 12 2 4 6
 Doctor/Nurse/Family Concern? pm pm pm.



Heart Rate (Number) 157 160 157 160 160 157 160 157 160 157 160 157 160 157

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

70														
60														
50														
40														
30														
20														
10														

Resp Rate (Number) 63 55 60 50 48 54 60 61 56 59 58

Resp Mod/ Severe Distress None / Mild

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

Receiving O₂ (l/min) O₂ Saturations (%) 98% 98% 95% 95% 100% 98% 97% 98% 95% 96% 100%

Conscious Level Normal Altered

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

GCS * C C C C C C C C C C C C C C

TOTAL SCORE Number of shaded boxes 1 1 1 1 1 1 1 1 1 1 1 1 1 1

Pain Score 1 1 1 1 1 1 1 1 1 1 1 1 1 1

Observer's Initials [Signatures]

ACTIONS

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AH-00656409 IP5-00175520
sdy Of MUTTAMPETH LIKITHA (M)
3-05-2026 0 Y 1 M 12 D
r. NALINIKANTA PANIGRAHY



1/7/26
D. : RCHBH / FRM / CLINICAL / 124

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

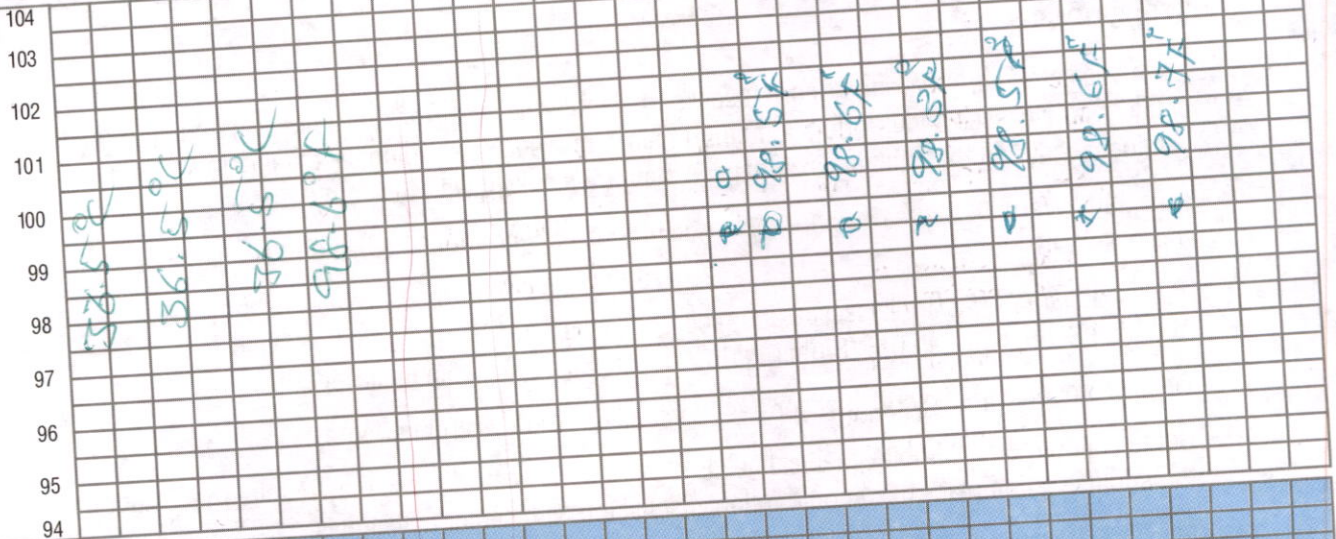
Pratiksha
Rainbow
Children's
Hospital
It takes a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 1/7/26 Time: 8 10 12 2 4 6 8 10 12 2 4 6
Doctor/Nurse/Family Concern? Am Am Am Am Am Am Am Am Am Am Am Am

Temperature
(F)



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

80 98 61
(64) 92 (45) (core)
58 89 37

Heart Rate (Number)

164 171 148 150 161 151 146 146 171 155 164 155

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

70
60
50
40
30
20
10

Resp Rate (Number)

53 87 146

Resp Mod/ Severe
Distress None / Mild

Receiving O₂(l/min)
O₂Saturations (%)

99% 100% 99% 99% 99% 99% 99 100 97 100 99 100

Conscious Normal
Level Altered

C C C C C C C C C C C C

GCS *

N N N N N N N N N N N N

TOTAL SCORE

Number of shaded boxes

Pain Score

Observer's Initials

1 1 1 1 1 1 1 1 1 1 1 1
0 0 0 0 0 0 0 0 0 0 0 0
4 4 4 4 4 4 4 4 4 4 4 4

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 8 10 12 2 4 6 8

Doctor/Nurse/Family Concern?

pm pm pm pm

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

36.5°C
36.5°C
36.5°C
36.5°C

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
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Resp. Rate (bpm)
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70
60
50
40
30
20
10

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Resp Mod/ Severe
Distress None / Mild

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

100% 98% 96% 94%

Conscious Level
Normal Altered

C C C C

GCS *

N N N N

TOTAL SCORE

Number of shaded boxes

0 0 0 0

Pain Score

0 0 0 0

Observer's Initials

* * * *

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Date:	Time: 8	10	12	2	4	6	8	10	12	2	4	6	
Doctor/Nurse/Family Concern?	pm	pm	pm	pm	pm	pm	pm	pm	pm	am	am	am	
Temperature (°F)	104												
	103												
	102												
	101	98.7											
	100		98.6										
	99			98.8									
	98				98.5								
	97					98.6							
	96						98.6						
	95							98.6					
	94								98.6				
	Heart Rate (bpm)	190											
180													
and Blood Pressure (mmHg) *	170												
	160												
Note: BP does not score in early warning scoring	150												
	140												
	130												
	120												
	110												
	100												
	90												
	80												
	70												
	60												
	50												
	Heart Rate (Number)	125	135	131	150	144	139	159	134	145	151	160	152
Resp. Rate (bpm) (Over 1 Minute) *	70												
	60												
Resp Rate (Number)	50												
	40												
Resp Distress	30												
	20												
Mod/ Severe Distress	10												
	None / Mild	N	N	N	N	N	N	N	N	N	N	N	
Receiving O ₂ (l/min)													
	O ₂ Saturations (%)	97%	97%	100%	100%	100%	98%	97%	98%	98%	100%	97%	97%
Conscious Level													
	Normal / Altered												
GCS *													
		C	C	C	C	C	C	C	C	C	C	C	
TOTAL SCORE													
	Number of shaded boxes	1	7	11	1	1	1	1	1	1	1	1	
Pain Score													
		1	1	1	1	1	1	1	1	1	1	1	
Observer's Initials													
		AD	AD	AD	AD	AD	AD	AD	AD	AD	AD	AD	
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318/26

Children's Observation & Early Warning Scoring Chart



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

[illegible]

18.6 case

134	143	132	144	138	138b	143b	150b	138b
-----	-----	-----	-----	-----	------	------	------	------

A grid with 10 rows and 20 columns. The grid is colored in alternating blue and white horizontal bands. The rows are numbered 10 to 70 on the left side. There are three red 'X' marks on the grid: one at row 30, column 15; one at row 40, column 18; and one at row 30, column 20.

3861s 30bm 41bm 3862s

[illegible]

98%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
98%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%

(16)	97%	98%	97%	97%	99%	98%	99%	98%
N	N	N	N	N	N	N	N	N

1	1	1	1	1	15/15	15/15	15/15	15/15
---	---	---	---	---	-------	-------	-------	-------

[illegible]

0	0	0	0	0	0	0	0	0	0
1	2	1	2	1	2	1	2	1	2

[illegible]

Score 1 : Continue normal observation by staff nurse

Score 2 : Shift in charge nurse to be informed and continue hourly observations

Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.

Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see

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

NB: 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)

BAH-00656409 IP5-00175520
Baby Of MUTTAMPETH LIKITHA
16-05-2026 0 Y 1 M 17 D (M)
Dr. NALINIKANTA PANIGRAHY



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

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

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.

Doctor/Nurse/Family Concern?

10 am

Temperature
(F)

104
103
102
101
100
99
98
97
96
95
94

98.1 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

166/10

Heart Rate (Number)

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

70
60
50
40
30
20
10

32 bpm

Resp Rate (Number)

Resp Mod/ Severe
Distress None / Mild

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

100%

Conscious Level
Normal
Altered

GCS *

16/15

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

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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

22/6/26

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

		Intake			Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	NG						
	08:00 am										
	09:00 am	EBM		25ml		passed			8ml		
	10:00 am									0	Epura
	11:00 am	EBM	29ml			—			10ml		
	12:00 pm										
	01:00 pm	EBM	29ml			—			11ml		
Total Intake :					Total Output :						
	02:00 pm										
	03:00 pm	EBM	29ml			passed			8ml		
	04:00 pm										
	05:00 pm	EBM		29ml		—			9ml	0	Epura
	06:00 pm										
	07:00 pm	EBM		29ml		—			6ml		
Total Intake :					Total Output :						
	08:00 pm										
	09:00 pm	EBM		29ml		—			7ml		
	10:00 pm									0	Epura
	11:00 pm	EBM		29ml		—			8ml		
	12:00 am										
	01:00 am	EBM		29ml		passed			10ml		
Total Intake :					Total Output :						
	02:00 am										
	03:00 am	EBM		29ml		—			7ml		
	04:00 am									0	Epura
	05:00 am	EBM		29ml		passed			9ml		
	06:00 am										
	07:00 am	EBM		29ml		—			10ml		
Total Intake : 364ml					Total Output : 103ml						
Total 24 hrs. Intake			160cc/kg/day								
Total 24 hrs. Output			1.9 cc/kg/day								



FLUID CHART

Sheet No. : ②

23/6/26.

B.W. 1.3 kg
TV: 160 cc/day
TK: 29 ml.

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	O.G							
	08:00 am											
	09:00 am	EBM			29ml	-			8ml			
	10:00 am											
	11:00 am	EBM			29ml	passed			10ml			
	12:00 pm		palada									
	01:00 pm	EBM			29ml	passed			8 ml.			
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm	EBM	29ml			-			8ml			
	04:00 pm											
	05:00 pm	EBM	29ml			passed			9 ml			
	06:00 pm											
	07:00 pm	EBM	29ml		29ml	-			8ml			
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm	EBM	29ml						10ml			
	10:00 pm											
	11:00 pm	EBM	29ml						8ml			
	12:00 am											
	01:00 am	EBM	29ml			passed			8ml			
Total Intake :					Total Output :							
	02:00 am											
	03:00 am	EBM	29ml						10ml			
	04:00 am											
	05:00 am	EBM	29ml						8ml			
	06:00 am											
	07:00 am	EBM	29ml						8ml			
Total Intake : 348 ml					Total Output : 103 ml							

Total 24 hrs. Intake

267.6 cc/day

Total 24 hrs. Output

3.30 cc/day

FLUID CHART

Sheet No. : ③

24/6/26

B. w → 2.250 kg

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	0.G							
	08:00 am											
	09:00 am	CBM			29ml		passed			8ml		
	10:00 am											
	11:00 am	CBM			29ml					5ml		
	12:00 pm											
	01:00 pm	CBM			29ml		passed			8ml		
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm	CBM			29ml		—			10ml		
	04:00 pm											
	05:00 pm	CBM			29ml		—			5ml		
	06:00 pm											
	07:00 pm	CBM			29ml		—			16ml		
Total Intake :					Total Output :							
	08:00 pm	EBM										
	09:00 pm	EBM			29ml		passed			8ml		
	10:00 pm	EBM										
	11:00 pm	EBM			29ml					5ml		
	12:00 am											
	01:00 am	EBM			29ml		passed			10ml		
Total Intake :					Total Output :							
	02:00 am											
	03:00 am	EBM			29ml		passed			5ml		
	04:00 am											
	05:00 am	EBM			29ml		passed			8ml		
	06:00 am											
	07:00 am	EBM			29ml		passed			6ml		
Total Intake : 348 ml					Total Output : 88 ml							
Total 24 hrs. Intake		161 cc/kg/day										
Total 24 hrs. Output		1.70 cc/day										



6/26

FLUID CHART

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BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Sheet No. :

25/6/26

25/6/26
 B.W → 2.245
 TP-43ml

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	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score		
			Mouth	I.V	O.G							
	08:00 am											
	09:00 am	EBM			43ml		-			9ml		
	10:00 am											
	11:00 am											
	12:00 pm	EBM			43ml		-			10ml		
	01:00 pm						passed					
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm	EBM			43ml		-			8ml		
	04:00 pm											
	05:00 pm						passed			6ml		
	06:00 pm	EBM			43ml		-					
	07:00 pm						-			5ml		
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm	EBM			43ml		passed			10 ml		
	10:00 pm											
	11:00 pm											
	12:00 am	EBM			43ml		Passed			5ml		
	01:00 am											
Total Intake :					Total Output :							
	02:00 am											
	03:00 am	EBM			43ml		-			10ml		
	04:00 am											
	05:00 am											
	06:00 am	EBM			43ml		Passed			6ml		
	07:00 am											
Total Intake :					Total Output :							
Total Intake : 330 CC/ Kg/day					Total Output : 269							
Total 24 hrs. Intake		116.7										
Total 24 hrs. Output		24.4										



26/6/26

FLUID CHART

TV: 160 cc/kg/day
 B.W: 1.3 kg
 TF: 40 ml

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	O.G						
	08:00 am									1	
	09:00 am					passed				1	
	10:00 am	EBM+2		45ml					8ml	0	Obj
	11:00 am	HMF 30 ml				-				1	
	12:00 pm										
	01:00 pm	EBM+2		40ml		-			8ml		
Total Intake :					Total Output :						
	02:00 pm										
	03:00 pm					passed			9ml	1	
	04:00 pm	EBM+2		40ml							Obj
	05:00 pm	HMF + 30 ml				-			6ml	0	
	06:00 pm									1	
	07:00 pm	EBM+2		40ml							
Total Intake :					Total Output :						
	08:00 pm										
	09:00 pm									1	
	10:00 pm	EBM+2		40ml		-			10ml	1	Obj
	11:00 pm	HMF								0	
	12:00 am									1	
	01:00 am	EBM		40 ml		-			10ml	1	
Total Intake :					Total Output :						
	02:00 am										
	03:00 am									1	
	04:00 am	EBM		40ml		passed			9ml	0	Obj
	05:00 am									1	
	06:00 am										
	07:00 am	EBM		40ml		-			10ml	1	
Total Intake :					Total Output :						

Total Intake : 325 cc/kg/day

Total Output : 71 ml

Total 24 hrs. Intake

150 cc/kg/day

Total 24 hrs. Output

6.76 cc/kg/day



FLUID CHART

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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. :

27/6/26

TW: 1600g
B.W: 1.3 kg
TF: 40ml

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	OG						
	08:00 am										
	09:00 am										
	10:00 am	EBM			40ml		passed		8ml		
	11:00 am										
	12:00 pm										
	01:00 pm	EBM			40ml		-		11ml		
Total Intake :					Total Output : 19ml						
	02:00 pm										
	03:00 pm										
	04:00 pm	EBM			40ml		-		10ml		
	05:00 pm										
	06:00 pm										
	07:00 pm	EBM			40ml		passed		11ml		
Total Intake :					Total Output : 21						
	08:00 pm										
	09:00 pm										
	10:00 pm	EBM			40ml		-		10ml		
	11:00 pm										
	12:00 am										
	01:00 am	EBM			40ml		passed		10ml		
Total Intake :					Total Output : 22						
	02:00 am										
	03:00 am	EBM									
	04:00 am	EBM			40ml		passed		12ml		
	05:00 am										
	06:00 am	EBM									
	07:00 am	EBM			40ml		-		10ml		
Total Intake :					Total Output :						
Total 24 hrs. Intake		4.3 ccl/kg/day.									
Total 24 hrs. Output		3.0 ccl/kg/day									



28/6/26

FLUID CHART

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Sheet No. :

TV - 160 cc / kg / day
 B.wt - 1.3 kg
 TF - 40 ml

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	EBMT 2 4ml F13 3-1 ml		40ml		passed			10ml			
	11:00 am											
	12:00 pm											
	01:00 pm	EBMT 2 4ml F13 3-1 ml		40ml		-			11ml			
Total Intake :					Total Output :							
	02:00 pm											
	03:00 pm											
	04:00 pm	EBMT 2 4ml F13 3-1 ml		40ml		-			9ml			
	05:00 pm											
	06:00 pm											
	07:00 pm	EBMT 2 4ml F13 3-1 ml		40ml		-			12ml			
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm											
	10:00 pm	EBMT 2 4ml F13 3-1 ml		40ml					12ml			
	11:00 pm											
	12:00 am											
	01:00 am	EBMT 2 4ml F13 3-1 ml		40ml					12ml			
Total Intake :					Total Output :							
	02:00 am											
	03:00 am											
	04:00 am	EBMT 2 4ml F13 3-1 ml		40ml		passed			9ml			
	05:00 am											
	06:00 am											
	07:00 am	EBMT 2 4ml F13 3-1 ml		40ml		-			10ml			
Total Intake :					Total Output :							

Total 24 hrs. Intake

246 cc / kg / day

Total 24 hrs. Output

2.7 cc / kg / day

29/6/26

FLUID CHART

TV -
 B.Wt - 2.3
 TF -

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	O.G							
	08:00 am											
	09:00 am											
	10:00 am	EBM	4		40ml	passed			15ml	0	2	
	11:00 am											
	12:00 pm											
	01:00 pm	EBM	40ml			passed			13ml	1		
Total Intake :					80	Total Output :					28	
	02:00 pm											
	03:00 pm											
	04:00 pm	EBM	40ml			passed			15ml			
	05:00 pm											
	06:00 pm											
	07:00 pm	EBM	40ml						10ml			
Total Intake :					80	Total Output :					25	
	08:00 pm											
	09:00 pm											
	10:00 pm	EBM	4		40ml	passed			12ml	0	2	
	11:00 pm	+ NS + HMC										
	12:00 am											
	01:00 am	EBM			40ml	-			15ml	1	2	
Total Intake :					80	Total Output :					27 ml	
	02:00 am											
	03:00 am											
	04:00 am	EBM			40ml				12ml	0	2	
	05:00 am	+ NS + HMC										
	06:00 am											
	07:00 am	EBM			40ml				10ml	1	2	
Total Intake :					80	Total Output :						
Total 24 hrs. Intake		139.1 cc / 1 g bday										
Total 24 hrs. Output		1.8 cc / 1 g bday										



30/6/26

FLUID CHART

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 Your Right to a Safe Delivery

Sheet No. :

JV - 15 cc/kg/day
 Bwt - 1.3 kg
 TF - 100ml

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	OG							
	08:00 am											
	09:00 am											
	10:00 am	EBM + HMF + 3% NS	40ml							10ml		
	11:00 am											
	12:00 pm											
	01:00 pm	EBM + HMF + 3% NS	40ml				Small passed			9ml		
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm	EBM + HMF + 3% NS	40ml				Passed			8ml		
	05:00 pm									5ml		
	06:00 pm											
	07:00 pm	EBM + HMF + 3% NS	40ml				also passed			12ml		
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm	EBM + HMF + 3% NS	40ml				Small passed			11ml		
	11:00 pm											
	12:00 am											
	01:00 am	EBM + HMF + 3% NS	40ml							9ml		
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am	EBM + HMF + 3% NS	40ml							10ml		
	05:00 am											
	06:00 am											
	07:00 am	EBM + HMF + 3% NS	40ml							10ml		
Total Intake :						Total Output :						

Total 24 hrs. Intake

133 cc/kg/day.

Total 24 hrs. Output

1.5 cc/kg/day.
~~37~~ cc/kg/day.

1/7/26

FLUID CHART

B.Wt - 2.913
 TV - 150 cc/kg/day
 TF - 45 ml

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	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombophlebitis Score	
			Mouth	I.V	N.G						
	08:00 am										
	09:00 am	EBM + 3% NS				Passed			10ml		
	10:00 am										
	11:00 am								8ml		
	12:00 pm										
	01:00 pm	EBM + 3% NS				passed			12ml		
Total Intake :					Total Output :						
	02:00 pm									1	
	03:00 pm	EBM + 3% NS									
	04:00 pm	EBM + 3% NS				Passed			10 ml		
	05:00 pm	EBM + 3% NS									
	06:00 pm										
	07:00 pm	EBM + 3% NS				Passed			12ml		
Total Intake :					Total Output :						
	08:00 pm										
	09:00 pm										
	10:00 pm	EBM + 3% NS							15ml		
	11:00 pm										
	12:00 am										
	01:00 am	EBM + 3% NS							18ml		
Total Intake :					Total Output :						
	02:00 am								15ml		
	03:00 am										
	04:00 am	EBM + 3% NS				passed			13ml		
	05:00 am										
	06:00 am										
	07:00 am	EBM + 3% NS							15ml		
Total Intake : 360 ml					Total Output : 124ml						
Total 24 hrs. Intake		156.5 cc/kg/day									
Total 24 hrs. Output		2.2 cc/kg/hr									



FLUID CHART

Sheet No. :

2/7/26

TV = 150 cc
 B.Wt = 1.3 kg.
 TF = 45 ml.

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	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G						
	08:00 am										
	09:00 am										
	10:00 am	EBM 45ml				passed			15ml	0	
	11:00 am										
	12:00 pm										
	01:00 pm	EBM NS 45ml							10ml	1	
Total Intake :					Total Output :						
	02:00 pm										
	03:00 pm										
	04:00 pm	EBM NS 45ml				passed			5ml	0	
	05:00 pm										
	06:00 pm										
	07:00 pm	EBM 45ml							10ml	1	
Total Intake :					Total Output :						
	08:00 pm										
	09:00 pm										
	10:00 pm	EBM 45ml				passed			15ml		
	11:00 pm										
	12:00 am										
	01:00 am	EBM 45ml				passed			10ml		
Total Intake :					Total Output :						
	02:00 am										
	03:00 am								10ml		
	04:00 am	EBM 45ml				passed					
	05:00 am								15ml		
	06:00 am										
	07:00 am	EBM 45ml				passed			5ml		
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.

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	EBMT 3% NS 45ml					Small Passed			10ml		
	11:00 am											
	12:00 pm											
	01:00 pm	EBMT 3% NS 45ml					Passed			15ml		
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm	EBMT 3% NS 45ml					-			12ml		
	05:00 pm											
	06:00 pm											
	07:00 pm	EBMT 3% NS 45ml					✓			✓		
Total Intake :						Total Output : M-2U-2						
	08:00 pm						↑					
	09:00 pm											
	10:00 pm	EBMT 3% NS 45ml					NP			✓		
	11:00 pm									✓		
	12:00 am						↑					
	01:00 am	EBMT 45ml										
Total Intake :						Total Output : M-0U-2						
	02:00 am											
	03:00 am											
	04:00 am	EBMT 40ml										
	05:00 am											
	06:00 am						✓			✓		
	07:00 am	EBMT 40ml										
Total Intake :						Total Output : M-1U-1						
Total 24 hrs. Intake			taken									
Total 24 hrs. Output			M-5U-6									



FLUID CHART

Sheet No. :

4/7/26

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am											1	Latta
	09:00 am	EBM 40ml										No	
	10:00 am											IV	
	11:00 am	EBM 40ml											
	12:00 pm												
	01:00 pm											1	
Total Intake :						Total Output :						V	u
	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

Patient Sticker

FLUID CHART

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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: 22/6/24

Assessment: Baby is an R/A

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 general condition	2pm	Assess the baby general condition	Baby is Stable on R/A
4pm	Monitor the vital sings	4pm	Monitor the vital sings	
6pm	Given feeding	6pm	Given feeding every 2 hourly.	

Re-Assessment: Done.

Special Notes: RBS op

Nurse Signature: [Signature] Nurse Name: Gauri Date & Time: 22/6/24 @ 3pm

BAH-00656409 IP5-00173894

Baby Of MUTTAMPETH LIKITHA

16-05-2026 0 Y 1 M 6 D (M)

Dr. NALINI KANTA PANIGRAHY



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/6/26

Assessment: Baby is on RLA

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 pm	Assess the baby condition	8 pm	Assessed the baby condition	Baby is stable
10 pm	Monitor the vitals	10 pm	monitored the vitals	
12 Am	Maintain I/o chart	12 Am	Maintained I/o chart	
2 Am	Given feed 2nd hourly	2 Am	Given feed 2nd hourly	
4 Am	Ensure Safety	4 Am	Ensured Safety	
6 Am	Administer medication as per doctor's order.	6 Am	Administered medication as per doctor's order.	

Re-Assessment: Re-Assessment done

Special Notes: RBS - OD

Nurse Signature: [Signature]

Nurse Name: Lavanya

Date & Time: 22/6/26 @ 8 pm - 8 AM

BAH-00656409 IP5-00173894
 Baby Of MUTTAMPETH LIKITHA
 16-05-2026 0 Y 1 M 7 D (M)
 Dr. NALINIKANTA PANIGRAHY

2

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 23/6/26 @ 2pm

Assessment: Baby is on R/A

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	to assess the baby general condition.	2pm	Assessed baby general condition	Baby is stable on R/A
4pm	to monitor vitals & maintain I/O chart	4pm	monitor vitals & maintain I/O chart	
5pm	to give 2nd hourly feed	5pm	Given 2nd hourly feed	
6pm	to provide comfortable position	6pm	provided comfortable position	
7pm	to administer medications As per Doctor's order	7pm	Administered medications As per Doctor's order	

Re-Assessment: Done

Special Notes: RBS - on

Nurse Signature: [Signature]

Nurse Name: Jeyaraman

Date & Time: 23/6/26 @ 8pm

1

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 23/6/26

Assessment: Baby is on R/A.

- 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.	8:15 Am	Assessed the baby condition.	Baby is now stable.
9:00 Am	Monitor vital signs.	9:30 Am	Monitored vital signs	
11:15 Am	Maintain I/O chart.	11:30 Am	Maintained I/O chart.	
12:00 pm	provide comfortable position.	12:15 pm	provided comfortable position.	
12:45 pm	Given feed 2 nd hourly	1:00 pm	Given feed 2 nd hourly	
1:30 pm	Administer medication as per doctor order.	2:00 pm	Administered medication as per doctor order.	

Re-Assessment: Re - Assessment done

Special Notes: RBS - DD

Nurse Signature: bt Nurse Name: Lokanya Date & Time: 23/6/26 @ 8 Am - 2 pm

3

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 24/6/26

Assessment: Baby is on R/A

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 →	check the general condition of the baby	9pm →	checked the general condition. baby is on R/A.	Baby is on R/A and maintaining.
11pm →	provide feeding and burp and position change.	12am →	provided feeding and position change.	
2am →	check for discolorization and desaturation.	3am →	checked for abnormalities	
3am →	provide nebulizer.	4am →	provided nebulizer	
6am →	administered medications as per the drug chart.	7am →	administered medications as per the drug chart	

Re-Assessment:

Re-Assessment Done.

Special Notes:

Nurse Signature:



Nurse Name:

Abhisami

Date & Time:

24/6/26



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 24/6/2026

Assessment: Baby on L/P

- | | | | | | | |
|--------------|---|---|--|---|--|--|
| 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 | | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8 Am	→ Assess the baby condition.	8:15 Am	→ Assessed the baby condition	Baby is now stable.
9 Am	→ Monitor vital signs	9:30 Am	→ monitored vital signs.	
10 Am	→ provide comfortable position	10:30 Am	→ provided comfortable position	
11 Am	→ Give feeds OGI.	11:30 Am	→ Given feeds OGI.	
12 pm	→ Connect L/P	12:15 pm	→ connected L/P	
4 pm	→ Administer medication as per doctor's order.	1:30 pm	→ Administered medication as per doctor's order.	

Re-Assessment: Re - Assessment done, watching for brady and desaturation.

Special Notes: RBS - OD, NP2 done.

Nurse Signature: [Signature]

Nurse Name: Lakanya

Date & Time: 24/6/26 @ 8am-2pm

5

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 25.6.26

Assessment: Patient is on L/F

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 pt. Condition	8pm	Assessed the pt. Condition	Now pt is stable
10pm	Provide Com-fortable positions of the patient	10pm	com-fortable position provided.	
12AM	Given 2 nd Hourly Feeding	12AM	2 nd Hourly Feeding given	
2 AM	Monitored vital signs.	2 AM	Monitored vital signs	
4 AM	Maintained I/O chart.	4 AM	Maintained I/O chart.	
6 AM	Given all medications, Syrup as doctor's orders	6 AM	All medications, Syrup was given	

Re-Assessment:

Special Notes: CRBS O.D

Nurse Signature: [Signature]

Nurse Name: Akansha

Date & Time: 25/6/26 @ 8AM

6

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 25/6/26

Assessment: Baby on R/A

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
8 Am	* Assess the baby condition.	8:45 Am	=> Assessed the baby condition.	Baby is now Stable.
9 Am	* Monitor vital signs.	9:30 Am	=> Monitored vital signs.	
10 Am	* Provide comfortable position.	10:30 Am	=> provided comfortable position.	
11 Am	* Give OG feeds 3 rd hourly	11:30 Am	=> Given OG feeds 3 rd hourly	
12 pm	* Administer medication as per doctor's order.	12:30 pm	=> Administered medication as per doctor's order.	

Re-Assessment: Re - Assessment done

Special Notes: RBS - OD

Nurse Signature: Lokanya

Nurse Name: Lokanya

Date & Time: 25/6/26 @ 8 am - 2 pm

IAH-00656409 IP5-00175520
Baby Of MUTTAMPETH LIKITHA (M)
6-05-2026 0 Y 1 M 8 D
Jr. NALINIKANTA PANIGRAHY



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 25/6/26 @ 2pm

Assessment: Baby is on R/A

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
2pm	TO Assess the baby general condition.	2pm	Assessed the baby general condition	Baby is stable.
4pm	TO monitor vitals & maintain I/O chart	4pm	monitored vitals & maintain I/O chart	
6pm	TO provide prone nursing.	6pm	Provided prone nursing	
7pm	TO Give 3rd Hourly feed	7pm	Given 3rd Hourly feed + HMR	
7:30pm	TO Administer medications As per Dr order.	7:30pm	Administered medications as per Dr Order.	

Re-Assessment: Done

Special Notes: RBS on S/E TM

Nurse Signature: [Signature]

Nurse Name: Jeevanani

Date & Time: 25/6/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

(8)

Date: 26/6/26

Assessment: pt is on R/A

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 pt Condition	8pm	Assessed the pt Condition	Now pt is Stable.
10pm	provide Prone position of the Patient.	10pm	provided Prone position	
12 Am	Monitor vital Signs	12am	vital Signs Monitored	
2Am	Maintain I/O chart	2am	I/O chart Maintained	
4Am	Given feed 3 rd hourly	4am	3 rd hourly feed given	
6 Am	Given medications for docb	6 am	Medications given	

Re-Assessment:

Special Notes:

RBS OP, S/E T/m (26/6/26)

Nurse Signature: 

Nurse Name: Akansha

Date & Time: 26/6/26 @ 8am

AH-00656409
 Baby Of MUTTAMPETH LIKITHA
 8-05-2026
 R. NALINIKANTA PANIGRAHY (M)
 0 Y 1 M 10 D

NURSING CARE RECORD

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 26/6/26 @ 11am

Assessment: Baby is on Rtn

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	To Assess the baby general condition.	8am	Assess the baby general condition.	Baby is
10am	To monitor vitals & maintain	10am	monitored vitals & maintain	
12pm	Do chart	12pm	Do chart	
2pm	To Give 3rd Hourly feed	2pm	Given 3rd Hourly feed	
4pm	To provide prone nursing	4pm	provided prone nursing.	
6pm	To Give nebulizations.	6pm	Given nebulization.	
7pm	To Administer medications	7pm	Administered medications	

Re-Assessment: Done Wt 6.25kg, sat.

Special Notes: RBS - on

Nurse Signature: [Signature]

Nurse Name: Jeevanani

Date & Time: 26/6/26 @ 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 26/6/26

Assessment: Baby on L/F

Goals

- ☐
- Maintain Airway and Oxygenation
-
- ☒
- Maintain Personal Hygiene
-
- ☐
- Identify Potential Complications

- ☒
- Relieve Pain & Discomfort
-
- ☒
- Prevent Infection
-
- ☐
- Any Others. Specify.....

- ☒
- Maintain Fluid Balance
-
- ☐
- Meet Elimination Needs

- ☐
- Improve Activity Tolerance
-
- ☒
- Ensure Safety

- ☒
- Maintain Good Nutritional Status
-
- ☐
- Early Ambulation Reduce Anxiety

- ☐
- Maintain Skin Integrity
-
- ☒
- Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the baby condition	8:30 pm	⇒ Assessed baby condition.	Baby is now stable.
10pm	→ Monitor vital signs.	10:30pm	⇒ Monitored vital signs.	
12Am	→ provide comfortable position.	12:30 Am	⇒ provided comfortable position.	
2pm	→ Give feeds 3rd hourly.	2:30 Am	⇒ Given feeds 3rd hourly	
4Am	→ Maintain I/O chart.	4:30 Am	⇒ Maintained I/O chart	
6Am	→ Administer medication as per doctor's order.	6:30 Am	⇒ Administered medication as per doctor's order.	

Re-Assessment: Re-assessment done.

Special Notes: RBS - A.D

Nurse Signature:

Nurse Name: Lakanya

Date & Time: 26/6/26 @ 8pm-8Am

AH-00656409 IP5-00175520
 Sdy Of MUTTAMPETH LIKITHA
 3-05-2026 0 Y 1 M 10 D (M)
 r. NALINIKANTA PANIGRAHY

NURSING CARE RECORD

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 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 27/6/26

Assessment: Baby is on L/F

- | | | | | | | |
|-------|---|---|--|---|--|--|
| 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	2pm	Assessed the baby condition	Baby is stable
3pm	Monitor the vitals	3pm	Monitored the vitals	
5pm	Maintain I/O chart	5pm	Maintained I/O chart	
6pm	Given feed 2nd hourly	6pm	Given feed 2nd hourly	
8pm	Administer medication as per doctor order.	8pm	Administered medication as per doctor order.	

Re-Assessment: Re-Assessment done

Special Notes: RBS - OP, LFT, co, usia, S/E - T/M

Nurse Signature: Rajp

Nurse Name: Ravanya

Date & Time: 27/6/26 @ 2pm - 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 27/6/26

Assessment: baby on 12/A

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 General Condition	8pm	- Assess the baby General Condition	Now the baby on A/A
10pm	- baby - Administer medication as per doctor advice.		- Administer medication as per doctor advice.	
12am	- provide comfortable position		- provide comfortable position	
2 AM	- maintain I/O chart.		- maintain I/O chart.	
4 AM	- monitor vitals		- monitor vitals	
6 AM	- ensure safety		- ensure safety.	

Re-Assessment: Re-Assessment done.

Special Notes:

Nurse Signature: Maya

Nurse Name: Maya

Date & Time: 28/6/26 @ 8 AM



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 28/6/2026 8 AM - 4 PM

Assessment: Baby is an RLB

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
8:00 AM	⇒ Assess the General condition of the baby	8:15 AM	⇒ Assessed the General condition of the baby	⇒ Now Baby is stable
10:00 AM	⇒ monitor the vital signs	10:30 AM	⇒ monitored the vital signs	
12:00 PM	⇒ maintain I/O chart	12:15 PM	⇒ maintained I/O chart	
2:00 PM	⇒ Given feed 3rd hourly	2:30 PM	⇒ Given feed 3rd hourly	
5:00 PM	⇒ Administer the medications As per doctor Advice	5:15 PM	⇒ Administered the medications - as per	
7:00 PM	⇒ Ensure safety	7:20 PM	⇒ Ensured safety	

Re-Assessment:

Special Notes: GRBS - 00

Nurse Signature:

Nurse Name: Sritella

Date & Time: 28/6/2026 8 AM - 4 PM



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 28/6/26

Assessment: baby on R/A

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the baby Condition	8pm	Assess the baby condition	baby on R/A
10pm	maintain I/o chart	10pm	maintain I/o chart	
12AM	Provide comfortable position	12AM	provide comfortable position	
2AM	feed given 3rd hourly	2AM	feed given 3rd hourly	
4AM	monitor vitals	4AM	monitor vitals	
6AM	Administer medication as per doctor advice	6AM	Administer medication as per doctor advice	

Re-Assessment: Re-Assessment done.

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Marya

Date & Time: 29/6/26 @ 6AM



NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 29/6/26

Assessment: Baby is m.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the baby's condition.	9am	Assessed baby's condition.	Baby is stable
9am	monitored the vitals.	9:30am	monitored the vitals.	
10am	maintain I6 chelt	10:30 am	maintained I6 chelt	
12pm	give Feed 2ml hourly	12:30 pm	given Feed and hourly	
1pm	Administer medication and Ncb as per orders	1:30 pm	Administered medication as per doctors orders.	

Re-Assessment: One

Special Notes: RBS -00, as per

Nurse Signature: [Signature]

Nurse Name: Nays. G

Date & Time: 29/6/26 @ 2pm

AH-00656409
 Baby of MUTTAMPETH LIKITHA
 0 Y 1 M 12 D (M)
 3-05-2026
 r. NALINIKANTA PANIGRAHY

NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 29/6/26

Assessment: baby on R/A

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
8 pm	Assess the baby	8 pm	Assess the baby	baby on R/A
	General condition		General condition	
10 pm	maintain I/O chart	10 pm	maintain I/O chart	
12 AM	provide comfortable position	12 AM	provide comfortable position	
2 AM	monitor vital signs.	2 AM	monitor vital signs	
4 AM	Administer medication as per doctor advice.	4 AM	Administer medication as per doctor advice	
6 AM	Ensure safety	6 AM	ensure safety.	

Re-Assessment: Re-Assessment done

Special Notes: R/S - OP

Nurse Signature:

Nurse Name:

Date & Time:

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 30/6/2026

Assessment: Baby is on RA

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
8am	Assess the Baby condition	8am	Assessed the Baby condition	New Baby is stable
10am	Monitor vitals and recorded	10am	Monitored vitals and recorded	
12pm	Administer medication as per order	12pm	Administered medicine as per order	
2pm	Monitor the chart	2pm	Monitored the chart	
4pm	To give 3rd baby feeds	4pm	To give 3rd baby feeds	
6pm	provide comfortable position	6pm	provided comfortable position	

Re-Assessment: done

Special Notes: RBS - 10 & gal flow

Nurse Signature: [Signature]

Nurse Name: Shweta

Date & Time: 30/6/2026 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 01/07/26

Assessment: Baby Is In Room Asst

- 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 General Condition	2pm	⇒ Assessed the baby General Condition	Baby Is Stable
	⇒ Monitor vital chart		⇒ Monitored vital chart	
4pm	⇒ Maintained I/O chart	4pm	⇒ Maintained I/O chart	
	⇒ Give feed every 3 rd hourly		⇒ Given feed every 3 rd hourly	
6pm	⇒ Crib Care	6pm	⇒ Crib Care	
8pm	⇒ Give medication as Per doctor's	8pm	⇒ Given medication as Per doctor's	

Re-Assessment: Re-Assessment Done

Special Notes: GRBS - OD

Nurse Signature: 

Nurse Name: Nagalaxmi

Date & Time: 1/07/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 1/7/26

Assessment: Baby on Room Air

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	⇒ Assess the baby condition.	9pm	⇒ Assessed the baby condition.	Baby is stable.
10pm	⇒ Monitor the vitals.	11pm	⇒ Monitored the vitals.	
12AM	⇒ Baby on crib care.	1AM	⇒ Baby on crib care.	
2AM	⇒ Maintain skin integrity.	3AM	⇒ Maintained skin integrity.	
4AM	⇒ Ensure safety.	5AM	⇒ Ensure safety.	
6AM	⇒ provide comfortable position.	7AM	⇒ provided comfortable	

Re-Assessment: Re-assessment done

Special Notes: GRBS-00

Nurse Signature: [Signature]

Nurse Name: Nalinikanta

Date & Time: 1/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 26/2/26

Assessment: Baby is on R/L

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
5.	Assess the baby's condition. monitor the vitals. maintain Ilo Chest give 3rd hourly hourly. Administer medication as per doctor orders. Ensure Safety.		Assess of baby's condition. monitored the vitals. maintained Ilo chest given feed 3rd hourly. Administered medication as per doctor order Ensured Safety.	Baby is stable in R/L

Re-Assessment: Once

Special Notes: R/S - OD.

Nurse Signature: [Signature]

Nurse Name: Naveen - G

Date & Time: 26/2/26 @ 6 PM

3AH-00656409 IP5-00175520
Baby Of MUTTAMPETH LIKITHA
18-05-2026 0 Y 1 M 14 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: 2/7/26

Assessment: Baby no R/A

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 baby condition.	2:15	→ Assessed baby condition	baby stable now
4pm	→ Monitor vital signs.	4:30	→ Monitored vital signs	
6pm	→ provide comfortable position.	6:30	→ provided comfortable position.	
7pm	→ Give feeds 3rd hourly	7:30	→ Given feeds 3rd hourly	
8pm	→ Ensure safety	8:15	→ Ensure safety.	

Re-Assessment: Done

Special Notes: RBS - OD.

Nurse Signature: [Signature] Nurse Name: Lokanjan Date & Time: 2/7/26 @ 2pm - 8am

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/7/26

Assessment: Baby is on R/A

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the General condition of the baby	8:30pm	→ Assessed the General condition of baby.	Baby is Stable.
10pm	→ maintain I/o chart	10:30pm	→ Maintained I/o chart	
12pm	→ Give 3rd hourly feed	12pm	→ Given 3rd hourly feed	
4pm	→ Administer the Medication as doctors order	4pm	→ Administered the medication as doctors order	
6pm	→ Ensure Safety	6pm	→ Ensured safety	

Re-Assessment: Re-assessment Done.

Special Notes: RBS -OD

Nurse Signature: *[Signature]*

Nurse Name: Madhama

Date & Time: 3/7/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment: Baby is on R/O

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
8 AM	Assess the baby general condition	8 AM	Assessed the baby general condition	Baby is stable.
10 AM	monitor vital	10 AM	monitored vital	
12 PM	maintain Diapers	12 PM	maintained Diapers	
2 PM	Feed give every 2nd hour	2 PM	Feed given every 2nd hour	
4 PM	Administer medication As Per the doctor's order.	4 PM	Administered medication As Per the doctor's order.	
6 PM	Ensured safety			

Re-Assessment: R - Assessment Done

Special Notes: RBS - 01

Nurse Signature: [Signature] Nurse Name: Sonu Date & Time: 3/7/26 @ 8 AM - 8 PM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment: baby under observation

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2PM →	Assess the general condition of baby	4PM →	Activity good	feeds were
4PM →	with distress	11PM →	baby was comfortable	
1AM →	Plan for medication	1AM →	oral medication given as per orders	
4AM →	EBM + 3% NaCl 3ml hourly	4am →	Educate about feeds the mother	
6am →	Plan for vaccination time	6am →	vaccination NBS R/v	

Re-Assessment:

Special Notes: RBS - OD vaccination time

Nurse Signature: Maitha

Nurse Name: Maitha

Date & Time: 4/7/26 @ 8am

BAH-00656409 IP5-00175520
 Baby Of MUTTAMPETH LIKITHA
 16-05-2026 0 Y 1 M 17 D (M)
 Dr. NALINIKANTA PANIGRAHY



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:

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature: Nurse Name: Date & Time:

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature: Nurse Name: Date & Time:

Patient Sticker

NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. NIK Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area	Shift Time	3rd Floor 5:30 PM - 8 PM	2nd Floor 8 PM - 11:30 AM		
	Medical Condition (Any special condition to be noted):		NA	NA		
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: 98.1 F	98.0 F			
	Res:	38 bpm	31 bpm			
	SpO ₂ :	99.1%	98%			
	Pulse:	142 bpm	133 bpm			
	BP:	-	-			
	Fall Risk Score:	0/10	0/10			
Recommendations	Safety Needs:	Crib Care	Crib Care			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	NA	NA			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	NA	Vaccination tm			
Post Operative Procedure Special Orders:		NA	NA			
Handed Over By Name :		Sushma		maurhe		
Signature :		Sushma		maurhe		
Date:		3/7		4/7/26		
Time:		@ 8 PM		@ 8 AM		
Taken Over By Name :		maurhe		katta		
Signature :		maurhe		katta		
Date:		3/7		4/7		
Time:		@ 8 PM		@ 8 AM		

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
	Tubes/Drains/Catheter:	☐ 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
Others Specify:						
Special Diet:		☐ 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:						



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	27/6	27/6	28/6	29/6	29/6
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	2				
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3		3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1		1		
Cognitive Impairments	Not Aware of Limitations	3	3		3	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					
	Patient Placed in Bed	2	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					
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			14	16	16	16	16

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

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 :		Jeeva	Lavanya	Madh	Madh	Madh
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		27/6	27/6	28/6	29/6	29/6
Time :		@	@2pm	@1pm	@1pm	@1pm



THE HUMPTY DUMPTY SCALE 22/6 23/6 24/6 24/6 24/6

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	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	1
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4	4	4	4	4
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	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					
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	2				
	Other Medications / None	1		1	2	1	1
TOTAL			15	14	14	14	14

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position	✓	✓	✓	✓	✓
Call device within reach	✓	✓	✓	✓	✓
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 :		Ranaya	Kohya	Ali	Kohya
Signature :		Ranaya	Kohya	Ali	Kohya
Date :		23/6	23/6	24/6	24/6
Time :		6 AM	2 PM	6 AM	2 PM

AH-00656409 IP5-00175520
 Baby Of MUTTAMPETH LIKITHA
 6-05-2026 0 Y 1 M 8 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

THE HUMPTY DUMPTY SCALE 25/6/25 16 26/6 26/6 27/6

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	2	2	2	2	2
	Female	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	1
Cognitive Impairments	Not Aware of Limitations	3	3	3	3	3	3
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4					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	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	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			13	13	13	13	16

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

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 :		Akash	Akash	Akash	Akash	Akash
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		25/6/25	25/6/25	26/6/25	26/6/25	27/6/25
Time :		8 AM	2 PM	8 PM	10 PM	8 AM

THE HUMPTY DUMPTY SCALE

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	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3	3	3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3	3	3	3	4	4
	Forget Limitations	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	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			16	16	16	16	16

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓	✓
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 :		Kung	Moog	Yam	Wagham	alukto
Signature :		SP	MS	Yam	Wagham	alukto
Date :		20/6/26	30/6	1/07	1/07	2/7
Time :		2 AM @ 6 PM	@ 6 PM	@ 2 PM	@ 6 AM	@ 6 AM



THE HUMPTY DUMPTY SCALE

20/20 2/7/25/7

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.)	3	3	3	3	3	
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4	4	4	4	4	
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	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			12	12	12	12	

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓
Call device within reach		✓	✓	✓	✓
Wheels Locked		✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓
Adequate Lighting		✓	✓	✓	✓
Wheel Chair Support		X	X	X	X
Other Intervention(s) Specify		X	X	X	X
Nurse's Name :		Lokesh Reddy Sang maita			
Signature :		[Signatures]			
Date :		2/7 2/7 3/7 3/7			
Time :		6pm 10pm 8am 10pm			

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	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					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1					
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1					
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					
TOTAL							

Intervention :

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

High Risk Humpty Dumpty Score = 12 or above

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 :							

BAH-00656409 IP5-00173894
 Baby Of MUTTAMPETH LIKITHA
 16-05-2026 0 Y 1 M 6 D (M)
 Dr. NALINI KANTA PANIGRAHY



BRADEN 'Q' SCALE

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

					Date :	22/6	23/6	24/6	24/6
					Time :	6 AM	10 AM	6 PM	2 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		2	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.		1	1	1	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		2	2	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.		2	2	2	2
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		3	3	3	3
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings 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	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	3
TOTAL SCORE						16	16	16	16
Evaluator's Name						Roy	BT	Qhi	7

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

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



BRADEN 'Q' SCALE

					Date :	25/6/25	27/6/25	28/6/25	29/6/25
					Time :	06AM	02PM	06AM	02PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	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.	1	1	1	1	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	2	2	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.	2	2	2	2	
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	3	3	3	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings 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.	3	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	3	
TOTAL SCORE					16	16	16	16	
Evaluator's Name					DA	DA	DA	DA	

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



BRADEN 'Q' SCALE

					Date :	28/6	29/6	29/6	30/6
					Time :	8 AM	7 AM	@ 10 PM	5 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	3	3	3	3	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	1	1	1	1	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	3	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	3	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	3	3	3	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	3	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	3	
TOTAL SCORE					19	19	19	19	
Evaluator's Name					SK	SK	N Deery	SK	

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



BRADEN 'Q' SCALE

(4)

					Date :	30/6	30/7	7/7	9/7
					Time :	10pm	8am		6am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	3	5	3	3	
"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	2	2	
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	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	3	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	3	2	2	
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.	3	3	1	1	
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	1	1	
TOTAL SCORE					19	19	13	17	
Evaluator's Name					ms	yaf	d	de	

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

3AH-00656409 IP5-00175520
 Baby Of MUTTAMPETH LIKITHA
 18-05-2026 0 Y 1 M 14 D (M)
 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 :	21/7/20	21/7/20	3/7	3/7
					Time :	6pm	8pm	8:30pm	10pm
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.	3	3	3	3	
"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.	2	2	2	2	
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	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	3	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	2	2	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.	1	1	1	1	
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.	1	1	1	1	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	15	15	15	15
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	hij	hij	hij	marile

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

BAH-00856409 IP5-00175520
 Baby Of MUTTAMPETH LIKITHA
 16-05-2026 0 Y 1 M 18 D (M)
 Dr. NALINIKANTA PANIGRAHY



BRADEN 'Q' SCALE

					Date :				
					Time :				
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:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.					
"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.					
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.					
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.					
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."					
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.					
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.					
					TOTAL SCORE				
					Evaluator's Name				

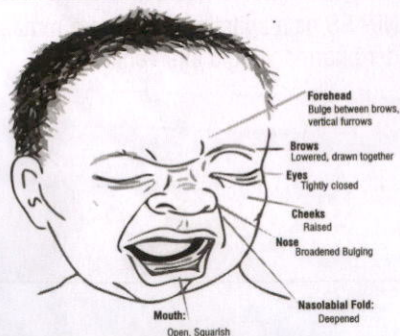
Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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
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1

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	23/6 Time	23/6 Time	24/6 Time	24/6 Time	25/6 Time	26/6 Time	27/6 Time	27/6 Time
						6AM	2pm	6AM	2pm	8am	8am	6AM	@2pm
	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	1	0	0	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	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	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	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	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

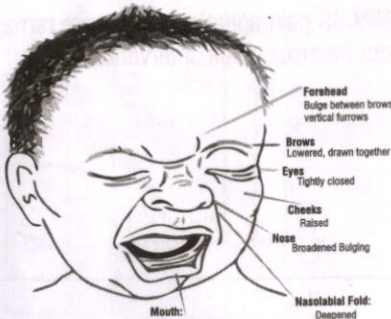
Gestational Age / Corrected Age	28+2	28+2	28+2	28+2	28+2	28+2	28+2	28+2	28+2
Total Pain / Agitation Score	4/10	0/10	0/10	0/10	0/10	0/10	0/10	1/10	1/10
Intervention	EBM	EBM	EBM	EBM	EBM	EBM	EBM	EBM	EBM
Effectiveness	Good	Good	Good	Good	Good	Good	Good	Good	Good
Signature	Loys	At	Alvi	At	At	At	At	At	At

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.

2

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	
						30/6	1/7	1/7	2/7	2/7	2/7	2/7	2/7	
						8am	8am	2pm	6am	6pm	8pm	6pm		
						RBS	RBS	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	-1	-1	-1	-1	-1	-1	-1		
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)	-1	-1	-1	-1	-1	-1	-1		
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	1	1	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	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	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	+2	+2	+2	28+2 weeks	28+2 weeks	28+2 weeks	28+2 weeks	
	Total Pain / Agitation Score	2/10	2/10	2/10	1/10	1/10	1/10	1/10						
	Intervention	EBM	EBM	EBM	EBM	EBM	EBM	EBM						
	Effectiveness	Good	Good	Good	Good	Good	Good	Good						
	Signature	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]						

RECOMMENDATIONS	Investigations Procedures	Date : 25/6/26	25/6	25/6	25/6	26/6	26/6/26	26/6/26
		Area	N2 8pm-8am	N2 8am-2pm	N2 2pm-8pm	N2 8pm-8am	N2 8am-8pm	N2 8pm-8am
		Shift Time						
	Ordered / Planned		NA	NA	NA	NA	NA	NA
	Due		NA	NA	NA	NA	NA	NA
	Reports Pending		NA	NA	NA	NA	NA	NA
	Referrals (If any)		NA	NA	NA	NA	NA	NA
Remarks (Special Interventions like, Drainage Tube flushing etc.)		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Akash	Lokesh	Tejash	Akash	Tejash	Lokesh	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date :		25.6.26	25/6/26	25/6/26	26/6/26	26/6/26	27/6/26	
Time :		@ 8am	@ 2pm	@ 8pm	@ 8am	@ 8pm	@ 8am	
Taken Over By Name :		Lokesh	Tejash	Akash	Tejash	Lokesh	Tejash	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date :		25/6/26	25/6/26	25/6/26	26/6/26	26/6/26	26/6/26	
Time :		@ 8am	@ 2pm	@ 8pm	@ 8pm	@ 8pm	@ 8pm	

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 16/5/26		Diagnosis : PT / LBW / RDS		Surgery / Procedures : —		
		Allergies :		Post OP Day : —				
Date :		27/6/26	27/6	28/6	28/6	29/6/26	29/6/26	
	Area	N2 2pm-8pm	N2 8pm-8am	N2 2pm-8pm	N2 8pm-8am	N2 8am-2pm	N2 8pm-8am	
Shift Time								
Diet :		EBM	EBM	EBM	EBM	EBM	EBM	
Ventilation (RA, NP, NIV, VENTI)		L/F	L/F(SOS)	L/F(SOS)	R/A	R/A	R/A	
INVASIVE	1.	OG-①	OG-①	OG-①	OG-①	OG-①	OG-①	
	2.							
	3.							
	4.							
ASSESSMENT	Infusions / Transfusions	NA	NA	NA	NA	NA	NA	
	PU Prophylaxis	NA	NA	NA	NA	NA	NA	
	DVT Prophylaxis	NA	NA	NA	NA	NA	NA	
	Vitals	BP	62/33(43)	64/45(45)	64/35(44)	69/34(43)	69/80(85)	60/34(43)
		PR	161 blm	159 blm	131 blm	159 blm		150 blm
		RR	40 blm	55 blm	36 blm	35 blm		49 blm
		SpO ₂	98%	97%	95%	99%		98%
		Temp	36.6°C	36.5°C	36.4°C	36.4°C		36.4°C
	Pain Score	1/10	1/10	1/10	1/10	1/10	1/10	
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert	Alert	Alert	
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact	Intact	Intact	
	Restraints If any	NA	NA	NA	NA	NA	NA	
Fall Risk (Vulnerable (Y/N) if yes score)	Yes	Yes	Yes	Yes	Yes	Yes		
(Ambulation, walking, moving with assistance, bed ridden)	Moving	Moving	Moving	Moving	Moving	Moving		
ADL (Dependent / Non-Dependent)	Dependent	Dependent	Dependent	Dependent	Dependent	Dependent		
Critical Lab Test / Values (if any)	NA	NA	NA	NA	NA	NA		

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

RECOMMENDATIONS		Investigations Procedures					
		Date :	27/6/26	27/6	28/6	28/6	29/6
Area	Shift Time	N2	N2	N2	N2	N2	N2
		8pm-8pm	8pm-8pm	8pm-8pm	8pm-8pm	8pm-8pm	8pm-8pm
Ordered / Planned		RBS-OD 4T/area 4T/sk Tm	RBS-OD 4T/area 4T/sk Tm	RBS-OD	RBS OD NBS skt.	RBS-OD 4T/sk Tm	RBS-OD 4T/sk Tm
Due		NA	NA	NA	NA	NA	NA
Reports Pending		NA	NA	NA	NA	NA	NA
Referrals (If any)		NA	NA	NA	NA	NA	NA
Remarks (Special Interventions like, Drainage Tube flushing etc.)		NA	NA	NA	NA	NA	NA
Handed Over By Name :		Lucy	Lucy	Lucy	Lucy	Lucy	Lucy
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		27/6/26	28/6	28/6	29/6	29/6	30/6
Time :		@8pm	@8pm	@8pm	@8pm	@8pm	@8pm
Taken Over By Name :		Lucy	Lucy	Lucy	Lucy	Lucy	Lucy
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :		27/6/26	28/6/26	28/6/26	29/6/26	29/6	30/6/26
Time :		@8pm	@8pm	@8pm	@8pm	@8pm	@8pm



NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND	DOA :	16/5/26		Diagnosis :	PT / RDS / LBW		Surgery / Procedures :		
	Allergies :					Post OP Day :			
	Date :	22/6/26	23/6/26	23/6/26	24/6/26	24/6/26	24/6/26	24/6/26	
	Area	N2 8pm-8am	N2 8am-2pm	N2 2pm-8pm	N2 8pm-8am	N2 8pm-2pm	N2 8pm-8am		
	Shift Time								
INVASIVE LINES	Diet :	EBM	EBM	EBM	EBM	EBM	EBM	EBM	
	Ventilation (RA, NP, NIV, VENTI)	R/A	R/A	R/A	R/A	R/A	R/A	R/A	
	1.	OG-①		OG-①	OG-①	OG-①	OG-①	OG-①	
	2.								
ASSESSMENT	3.								
	4.								
	Infusions / Transfusions	NA	NA	NA	NA	NA	NA	NA	
	PU Prophylaxis	NA	NA	NA	NA	NA	NA	NA	
	DVT Prophylaxis	NA	NA	NA	NA	NA	NA	NA	
	Vitals	BP	53/45 (48)	98/36 (61)	71/38 (58)	74/53 (66)	95/81 (88)	74/35 (49)	
		PR	151 b/m	140 b/m	150 b/m	166 b/m	164 b/m	167 b/m	
		RR	51 b/m	46 b/m	48 b/m	57 b/m	48 b/m	67 b/m	
		SpO ₂	97%	97%	98%	96%	98%	99%	
		Temp	36.5°C	36.5°C	36.6°C	36.6°C	36.5°C	36.5°C	
	Pain Score	1/10	1/10	1/10	1/10	1/10	1/10		
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert	Alert	Alert	Alert	Alert	Alert		
	Skin Integrity (Intact / Bedsore / Any other condition)	Intact	Intact	Intact	Intact	Intact	Intact		
	Restraints If any	Intact	Intact	Intact	Intact	Intact	Intact		
	Fall Risk (Vulnerable (Y/N) if yes score)	No	No	No	No	No	No		
(Ambulation, walking, moving with assistance, bed ridden)	Moving	Moving	Moving	Moving	Moving	Moving			
ADL (Dependent / Non-Dependent)	Dependent	Dependent	Dependent	Dependent	Dependent	Dependent			
Critical Lab Test / Values (if any)	NA	NA	NA	NA	NA	NA			

RECOMMENDATIONS	Investigations Procedures	Date :	22/6/26	23/6	23/6	24/6	24/6	24/26	
		Area	N2	N2	N2	N2	N2	N2	
		Shift Time	8pm-8Am	8pm-8Am	2pm-8pm	8pm-8am	8am-2pm	8pm-8Am	
		Ordered / Planned	RBS - OD						RBS
					RBS	RBS	RBS	RBS	OO
					OD	OD	- OD	OD	
		Due							
Reports Pending									
Referrals (If any)									
Remarks (Special Interventions like, Drainage Tube flushing etc.)		NA	NA	NA	NA	NA	NA		
Handed Over By Name :		Lokanyu	Lokanyu	Jeenuwan	Abhirami	Lokanyu	Agasthi		
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date :		23/6/26	23/6/26	23/6/26	24/6/26	24/6/26	24/6		
Time :		@ 8Am	@ 2pm	@ 8pm	@ 8am	@ 2pm	8 pm		
Taken Over By Name :		Lokanyu	Jeenuwan	Abhirami	Lokanyu	Agasthi	Akansha		
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date :		23/6/26	23/6/26	24/6/26	24/6/26	24/6/26	24/6/26		
Time :		@ 8Am	@ 2pm	@ 8pm	@ 8am	8 pm	8pm		

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 10/5/26		Diagnosis : FLOW / RAS		Surgery / Procedures : —		
		Allergies : —		Post OP Day : —				
Date : 30/6/26		Area : N2		1/7/26		1/7/26		
Shift Time : 8AM-5PM		Area : N2		1/7/26		1/7/26		
Diet : EBM		Area : N2		1/7/26		1/7/26		
Ventilation (RA, NP, NIV, VENTI)		Area : N2		1/7/26		1/7/26		
INVASIVE LINES	1.	RA		RA		RA		
	2.	RA		RA		RA		
	3.	RA		RA		RA		
	4.	RA		RA		RA		
ASSESSMENT	Infusions / Transfusions	RA		RA		RA		
	PU Prophylaxis	RA		RA		RA		
	DVT Prophylaxis	RA		RA		RA		
	Vitals	BP	60/40		60/40		60/40	
		PR	110bpm		110bpm		110bpm	
		RR	20bpm		20bpm		20bpm	
		SpO ₂	99%		99%		99%	
		Temp	36.5°C		36.5°C		36.5°C	
	Pain Score	1/10		1/10		1/10		
	LOC (Alert, Conscious, Confusion, Unconscious)	Alert		Alert		Alert		
Skin Integrity (Intact / Bedsore / Any other condition)	Intact		Intact		Intact			
Restraints If any	No		No		No			
Fall Risk (Vulnerable (Y/N) if yes score)	Yes		Yes		Yes			
(Ambulation, walking, moving with assistance, bed ridden)	moving		moving		moving			
ADL (Dependent / Non-Dependent)	Dependent		Dependent		Dependent			
Critical Lab Test / Values (if any)	NA		NA		NA			

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

RECOMMENDATIONS	Investigations Procedures	Date :	30/6/26	30/6	1/07	1/07/26	1/7/26	2/7/26
		Area	N2	N2	N2	N2	N2	N2
		Shift Time	2Am-8Pm	3pm-8pm	8Am-2pm	2Pm-8Pm	8Pm-8Am	8Pm
		Ordered / Planned	RBS-OD gas T/w	RBS OD gas T/w	RBS OD gas T/w	RBS OD Gas T/w	RBS-OD gas-T/w	RBS-OD
		Due	NA	NA	NA	NA	NA	NA
		Reports Pending	NA	NA	NA	NA	NA	NA
		Referrals (If any)	NA	NA	NA	NA	NA	NA
		Remarks (Special Interventions like, Drainage Tube flushing etc.)	NA	NA	NA	NA	NA	NA
		Handed Over By Name :	Robyng	Mooring	Yamuna	Nagalaxmi	Naravetha	Deep
		Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date :	30/6/26	1/7/26	1/7/26	1/07/26	2/7/26	2/7/26		
Time :	8Pm	@8pm	2pm	@8Pm	@8Am			
Taken Over By Name :	Mooring	Yamuna	Nagalaxmi	Naravetha	Deep	Robyng		
Signature :	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]		
Date :	30/6/26	1/07/26	1/07/26	1/7/26	2/7/26	2/7/26		
Time :	@8pm	8Am	@8Pm	@8pm	@8pm	@2pm		

NURSE HAND OFF COMMUNICATION - ICU

SITUATION & BACKGROUND		DOA : 16/5/26		Diagnosis : ELBW / RDS		Surgery / Procedures :	
		Allergies :		Post OP Day :			
Date :		2/7/26	2/7/26	3/7/26			
	Area						
Shift Time		N2 8pm-8pm	N2 8pm-8am	N2 8A m-8pm			
	Diet :	EBM	EBM	EBM			
Ventilation (RA, NP, NIV, VENTI)		R/A	R/A	R/A			
INVASI INES	1.						
	2.						
	3.						
	4.						
ASSESSMENT	Infusions / Transfusions		NA	NA	NA		
	PU Prophylaxis		NA	NA	NA		
	DVT Prophylaxis		NA	NA	NA		
	Vitals	BP	-	150/61mm	-		
		PR	150b/m	150b/m	136b/m		
		RR	-	-	-		
		SpO ₂	98%	98%	96%		
	Temp	36.5°C	36.5°C	36.5°C			
		Pain Score	1/10	1/10	1/10		
	LOC (Alert, Conscious, Confusion, Unconscious)		Alert	Alert	Alert		
	Skin Integrity (Intact / Bedsore / Any other condition)		Intact	Intact	Intact		
	Restrains If any	Physical	NA	NA	NA		
		Chemical	NA	NA	NA		
	Fall Risk (Vulnerable (Y/N) if yes score)		Yes	Yes	Yes		
(Ambulation, walking, moving with assistance, bed ridden)		Moving	Moving	Moving			
ADL (Dependent / Non-Dependent)		Dependent	Dependent	Dependent			
Critical Lab Test / Values (if any)		NA	NA	NA			

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

RECOMMENDATIONS	Investigations Procedures	Date :	2/7/26	2/7/26	3/7/26			
		Area	N2	N2	N2			
		Shift Time	8pm-8am	8pm-8am	8AM-8PM			
		Ordered / Planned	RBS-00	RBS-00	RBS-00			
		Due	NA	NA	NA			
		Reports Pending	NA	NA	NA			
		Referrals (If any)	NA	NA	NA			
		Remarks (Special Interventions like, Drainage Tube flushing etc.)	NA	NA	NA			
		Handed Over By Name :	Kokang	Modang	Song			
		Signature :	[Signature]	[Signature]	[Signature]			
Date :	2/7/26	3/7/26	3/7/26					
Time :	8pm	8AM	8PM					
Taken Over By Name :	Modang	Song						
Signature :	[Signature]	[Signature]						
Date :	2/7/26	3/7/26						
Time :	8pm	8AM						

BAH-00656409 IP5-00173894
 Baby Of MUTTAMPETH LIKITHA
 16-05-2026 0 Y 1 M 6 D (M)
 Dr. NALINIKANTA PANIGRAHY



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Date	Temp	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
		6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
22/6/26 @ 2pm	Back side	Right hand	prone	Given	Given	OD	Given	Given	Given	Lokayya
22/6/26 @ 4pm	Back side	Rt hand	Prone	Given	Given	OD	Given	Given	Given	(G)
22/6/26 @ 6pm	Back side	Rt hand	Prone	Given	Given	OD	Given	Given	Given	(G)
23/6/26 @ 12AM	Back side	Rt hand	Prone	Given	Given	OD	Given	Given	Given	Payo
23/6/26 @ 6AM	Back side	Rt hand	Prone	Given	Given	OD	Given	Given	Given	Payo
23/6/26 @ 10AM	Back side.	Rt hand	prone	Given	Given	OD	Given	Given	Given	Lokayya

BAH-00656409
 Baby Of MUTTAMPETH LIKITHA
 16-05-2025 0 Y 1 M 6 D (M)
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Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
23/6/26 @ 2pm	Rt Abd	Rt Hand	Supine	Given	Given	OD	Given	Given	Given	Lokya
22/6/26 4pm	Rt Abd	Rt leg	Supine	Given	Given	OD	Given	Given	Given	Ch
23/6/26 8pm	Rt abd	Rt hand	supine	Given	Given	OD	Given	Given	Given	Ch
23/6 11pm	Rt abd	Lt hand	supine	Given	Given	OD	Given	Given	Given	Ch
24/6 2am	Rt abd	Rt hand	supine	Given	Given	OD	Given	Given	Given	Ch
24/6 6am	Rt abd	Lt hand	supine	Given	Given	OD	Given	Given	Given	Ch

AH-00656409 IP5-00175520
 aby Of MUTTAMPETH LIKITHA
 3-05-2026 0 Y 1 M 11 D (M)
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Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
28/6/26 @ 8pm	Rt Abd	Rt hand	Supine	Given	Given	OD	Given	Given	Given	
28/6/26 @ 4pm	Rt Abd	Lt hand	Supine	Given	Given	OD	Given	Given	Given	
28/6 @ 10pm	Rt Abd	Lt hand	prone	given	given	OD	given	given	given	
29/6 10am	Back Side	Rt leg	prone	given	given	OD	given	given	given	

3AH-00656409

IP5-00175520

Baby Of MUTTAMPETH LIKITHA

8-05-2026

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(M)

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Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
26/6/26 @ 7pm	back side	Rt leg	prone	Given	Given	OD	Given	Given	Given	Bi
27/6/26 @ 12Am	Back side	Left leg	prone	Given	Given	OD	Given	Given	Given	huy
27/6/26 @ 6Am	Back side	Right hand	prone	Given	Given	OD	Given	Given	Given	hy
27/6/26 @ 12pm	Back side	Right hand	prone	Given	Given	OD	Given	Given	Given	Jeevanani
27/6/26 @ 2pm	Back side	lt hand	prone	Given	Given	OD	Given	Given	Given	Roy
27/6 @ 10Am	back side	lt hand	prone	given	given	OD	given	given	given	me



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PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
24/6/26 @ 10am	Rt Abd	Rt leg	Supine	Given	Given	OD	Given	Given	Given	Lokya
24/6/26 @ 2pm	Rt Abd	Rt leg	Supine	Given	Given	OD	Given	Given	Given	Lokya
24/6/26 @ 8pm	Rt Abd	Rt leg	Supine	Given	Given	OD	Given	Given	Given	Akash
25/6/26 @ 2AM	Rt Abd	Rt hand	supine	Given	Given	OD	Given	Given	Given	Akash
25/6/26 @ 8AM	Rt Abd	Rt leg	Supine	Given	Given	OD	Given	Given	Given	Akash
24/6/26 @ 10am	Rt Abd	Rt leg	Supine	Given	Given	OD	Given	Given	Given	Lokya



PROBS AND POSITIONS CHART

Date	Temp. Probe	SpO ₂ Probe	Positioning	Mouth Care	Eye Care	RBS	Nebulization	Feeding	Medication	Nurse sign
	6th Hourly	6th Hourly	3rd Hourly	3rd Hourly	3rd Hourly					
25/6/26 @ 2pm	Back Side	Rt leg	prone	Given	Given	OD	Given	Given	Given	<u>lokya</u>
25/6/26 @ 4pm	Rt Abd	Rt Hand	prone	Given	Given	OD	Given	Given	Given	<u>Ar</u>
25/6/26 @ 10pm	Rt Abd	Rt hand	prone	Given	Given	OD	Given	Given	Given	<u>Ar</u>
26/6/26 @ 4am	Rt Abd	Rt hand	prone	Given	Given	OD	Given	Given	Given	<u>Arsh</u>
26/6/26 @ 10am	Rt Abd	Rt leg	Prone	Given	Given	OD	Given	Given	Given	<u>Arsh</u>
26/6/26 3pm	Rt Back side	Rt Hand	prone	Given	Given	OD	Given	Given	Given	<u>Ar</u>



INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: B+ve Baby's Blood Group: O+ve Sheet No: 4
 Gest Age: 28+2 wks Birth Weight: 1.3 kg

Date: <u>2/7/26</u>	Date: <u>31/7/26</u>	Date:
DOL <u>Dug</u> Weight <u>2.399 (↑26gms)</u>	DOL <u>49</u> Weight <u>2.510 (↑1119gms)</u>	DOL Weight
Problems: <u>PT/RDS</u>	Problems: <u>PT/RDS</u>	Problems:
Rs. <u>30-60 b/min</u> Exam <u>Done</u> Vent. Setting <u>R/A</u> ABG <u>Nil</u> CXR <u>Nil</u>	Rs. <u>30-60 b/min</u> Exam <u>Done</u> Vent. Setting <u>R/A</u> ABG <u>Nil</u> CXR <u>Nil</u>	Rs. Exam Vent. Setting ABG CXR
CVS <u>Normal</u> HR <u>120-160 b/min</u> BP <u>Map</u> Cap Refil <u><2-3 seconds</u>	CVS <u>Normal</u> HR <u>120-160 b/min</u> BP <u>Map</u> Cap Refil <u><2-3 seconds</u>	CVS HR BP <u>Map</u> Cap Refil
F/E/N <u>150cc/kg/day</u> T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam <u>Done</u> T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>150cc/kg/day</u> T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam <u>Done</u> T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results <u>Nil</u> CRP Antibiotics	C/s Results <u>Nil</u> CRP Antibiotics	C/s Results CRP Antibiotics
Med <u>Syp: caffeine</u> Neuro: <u>Syp: ossopan-D</u> <u>NA</u>	Med <u>Syp: caffeine</u> Neuro: <u>Syp: ossopan-D</u> <u>NA</u>	Med Neuro:
Assessment <u>Done</u>	Assessment <u>Done</u>	Assessment
Plan <u>GRBS-OD</u>	Plan <u>GRBS-OD</u>	Plan

INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: B⁺ve Baby's Blood Group: O⁺ve Sheet No: (2)
 Gest Age: 28⁺2 Birth Weight: 1.3 kg's

Date: <u>26/6/26</u>	Date: <u>26/6/26</u>	Date: <u>26/6/26</u>
DOL <u>D42</u> Weight <u>2.243 (↑ 139g)</u>	DOL <u>D43</u> Weight <u>2.288 (↑ 45gms)</u>	DOL <u>D44</u> Weight <u>2.301 (↑ 13gms)</u>
Problems: <u>PT/RDS</u>	Problems: <u>PT/RDS</u>	Problems: <u>PT/RDS</u>
Rs. Exam <u>Done</u> Vent. Setting <u>RIA</u> ABG CXR	Rs. <u>30-60 b/min</u> Exam <u>Done</u> Vent. Setting <u>RIA</u> ABG <u>NA</u> CXR <u>NA</u>	Rs. <u>30-60 b/min</u> Exam <u>Done</u> Vent. Setting <u>RIA</u> ABG <u>NA</u> CXR <u>NA</u>
CVS HR <u>120-160 b/min</u> BP <u>Map</u> Cap Refil <u>(2-3 sec)</u>	CVS <u>Normal</u> HR <u>120-160 b/min</u> BP <u>Map</u> Cap Refil <u><2-3 sec.</u>	CVS <u>Normal</u> HR <u>120-160 b/min</u> BP <u>Map</u> Cap Refil <u><2-3 sec.</u>
F/E/N <u>160cc/kg</u> T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam <u>Done</u> T. Bil/D Na HcO3 <u>130</u> K BUN <u>3.5</u> Cl Crea Hemat HB: WCC Plats <u>378</u> Transfusion	F/E/N <u>160cc/kg/day</u> T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam <u>Done</u> T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>160cc/kg/day</u> T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam <u>Done</u> T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results CRP Antibiotics	C/s Results CRP Antibiotics	C/s Results CRP Antibiotics
Med <u>Syp Ossopan-D</u> <u>Syp Caffeine</u> Neuro: <u>Furosemide drops</u>	Med <u>Syp: ossopan-D</u> <u>Syp: Caffeine</u> Neuro: <u>NA</u>	Med <u>syp. ossopan-D</u> <u>syp. caffeine</u> Neuro: <u>syp. caffeine</u>
Assessment <u>Done</u>	Assessment <u>Done</u>	Assessment <u>Done</u>
Plan <u>RBS OD</u>	Plan <u>RBS-OD</u>	Plan <u>RBS-OD</u>

INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: B⁺ Baby's Blood Group: O⁺ Sheet No: 3
 Gest Age: 28² Birth Weight: 1.3 kgs

Date: <u>29/6/26</u>	Date: <u>30/6/26</u>	Date: <u>1/7/26</u>
DOL <u>D45</u> Weight <u>2.326 (25gms)</u>	DOL <u>D46</u> Weight <u>2.348 (22gms)</u>	DOL <u>D47</u> Weight <u>2.373 (25gms)</u>
Problems: <u>PT / RDS</u>	Problems: <u>PT / RDS</u>	Problems: <u>PT / RDS</u>
Rs. <u>30-60 blm</u> Exam <u>Done.</u> Vent. Setting <u>RIA</u> ABG <u>} NA</u> CXR <u>} NA</u>	Rs. <u>30-60 blm</u> Exam <u>Done</u> Vent. Setting <u>RIA</u> ABG <u>} 27/6/26</u> CXR <u>} 27/6/26</u>	Rs. <u>30-60 blm</u> Exam <u>Done</u> Vent. Setting <u>RIA</u> ABG <u>} 27/6/26</u> CXR <u>} 27/6/26</u>
CVS <u>Normal</u> HR <u>120-160 blm</u> BP <u>66/46</u> Map <u>52</u> Cap Refil <u>< 2-3 sec.</u>	CVS <u>Normal</u> HR <u>120-160 blm</u> BP <u>60/34</u> Map <u>43</u> Cap Refil <u>< 2-3 sec</u>	CVS <u>Normal</u> HR <u>120-160 blm</u> BP <u>57/28</u> Map <u>38</u> Cap Refil <u>< 2-3 sec.</u>
F/E/N <u>160 cc/kg/day</u> T. Fluids CC /kg /day I/O / RBS: U Output: (CC/kg/hr) Exam <u>Done.</u> T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>150 cc/kg/day</u> T. Fluids CC /kg /day I/O / RBS: U Output: (CC/kg/hr) Exam <u>Done.</u> T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion	F/E/N <u>150 cc/kg/day</u> T. Fluids CC /kg /day I/O / RBS: U Output: (CC/kg/hr) Exam <u>Done.</u> T. Bil/D Na Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results CRP Antibiotics	C/s Results CRP Antibiotics	C/s Results CRP Antibiotics
Med <u>syp. ossopan-D</u> <u>syp. caffeine.</u> Neuro:	Med <u>syp. ossopan-D</u> <u>syp. caffeine.</u> Neuro:	Med <u>syp. ossopan cl.</u> <u>syp. caffeine.</u> Neuro:
Assessment <u>Done.</u>	Assessment <u>Done.</u>	Assessment <u>Done.</u>
Plan <u>RBS - OD</u>	Plan <u>RBS - OD</u>	Plan <u>OD</u>



BED SIDE CHECK LIST FOR NURSES

Date:	23/6	23/6	24/6	24/6	25/6	25/6	26/6	27/6	27/6
Doctor's Orders	✓	✓	✓	✓	✓	✓	✓	✓	✓
Carried out or not	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bed Side									
Structured Handover done	✓	✓	✓	✓	✓	✓	✓	✓	✓
IV Site	x	x	x	x	x	x	x	x	x
Central Lines	x	x	x	x	x	x	x	x	x
Arterial Lines	x	x	x	x	x	x	x	x	x
Feeding Catheter	✓	✓	✓	✓	✓	✓	✓	✓	✓
Urinary Catheter	x	x	x	x	x	x	x	x	x
Skin Care	✓	✓	✓	✓	✓	✓	✓	✓	✓
Eye Care	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mouth Care	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sterillum Bottle, Stethoscope	✓	✓	✓	✓	✓	✓	✓	✓	✓
Suction Bottle (Should be clean & empty)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Intubation Tray	x	x	x	x	x	x	x	x	x
Emergency Tray (Loaded Syringes with Midazolam & Vecuronium and Flush) Ampoules of Adrenaline	Ambu O mask	Ambu O mask	Ambu O mask	Ambu O mask	Ambu O mask	Ambu O mask	Ambu O mask	Ambu O mask	Ambu O mask
Ventilator Tubing, (Any Water, Blood)	x	x	x	x	x	x	x	x	x
Humidification	x	x	x	x	x	x	x	x	x
Check all Infusion (Labelling, Correct Preparation)	x	x	x	x	x	x	x	x	x
Chest Physio & Neb	x	x	x	x	x	x	x	x	x

Checked & Handover given by

Name of the Nurse : Laxanya

Signature : [Signature]

Date & Time : 23/6/23 @ 6 AM

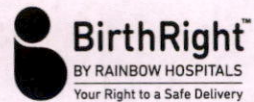
Checked & Handover taken by

Name of the Nurse : Akash

Signature : [Signature]

Date & Time : 24/6/23

BAH-00656409 IP5-00173894
 Baby Of MUTTAMPETH LIKITHA
 16-05-2026 0 Y 1 M 6 D (M)
 Dr. NALINIKANTA PANIGRAHY



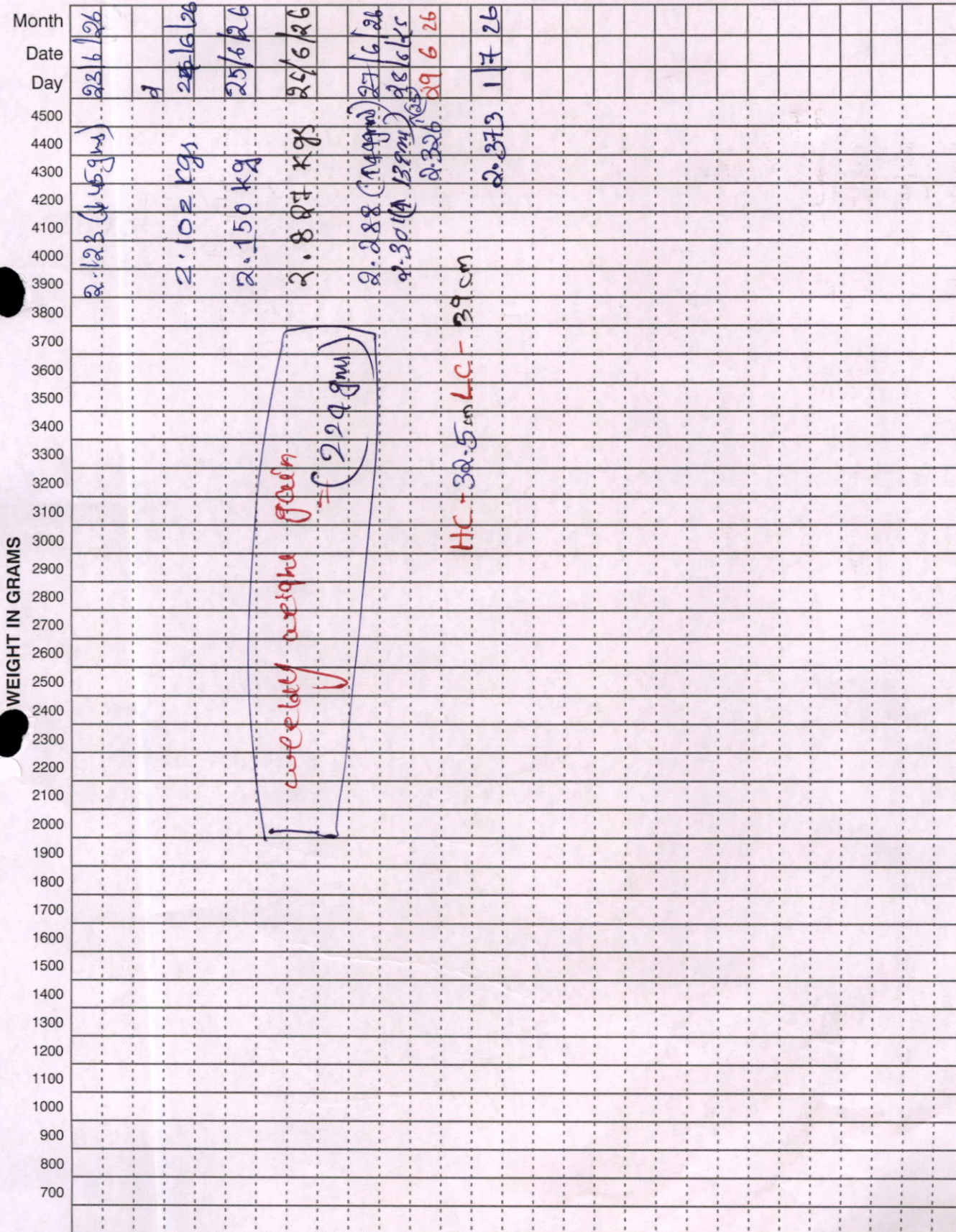
NEONATAL WEIGHT CHART

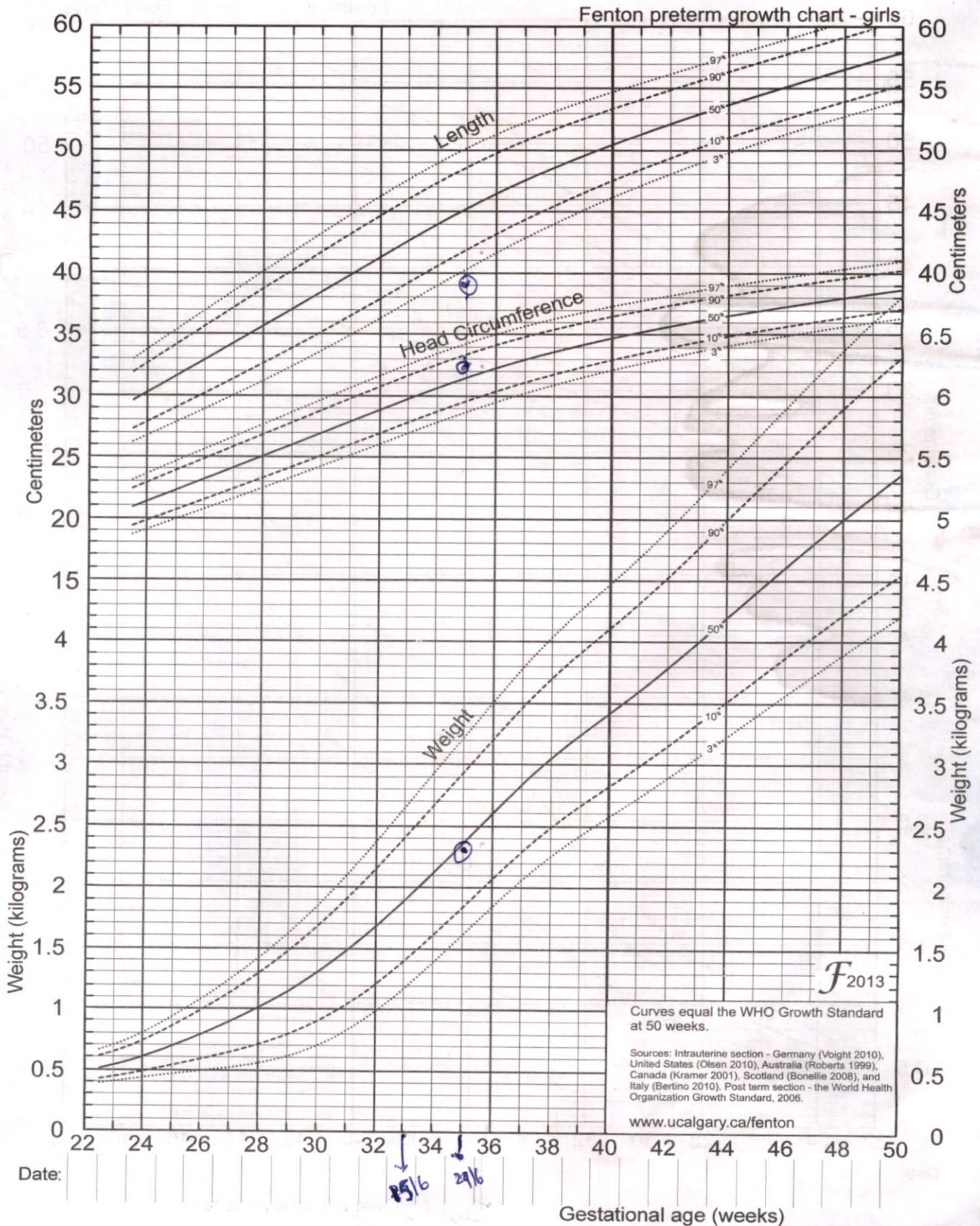
Birth Weight:

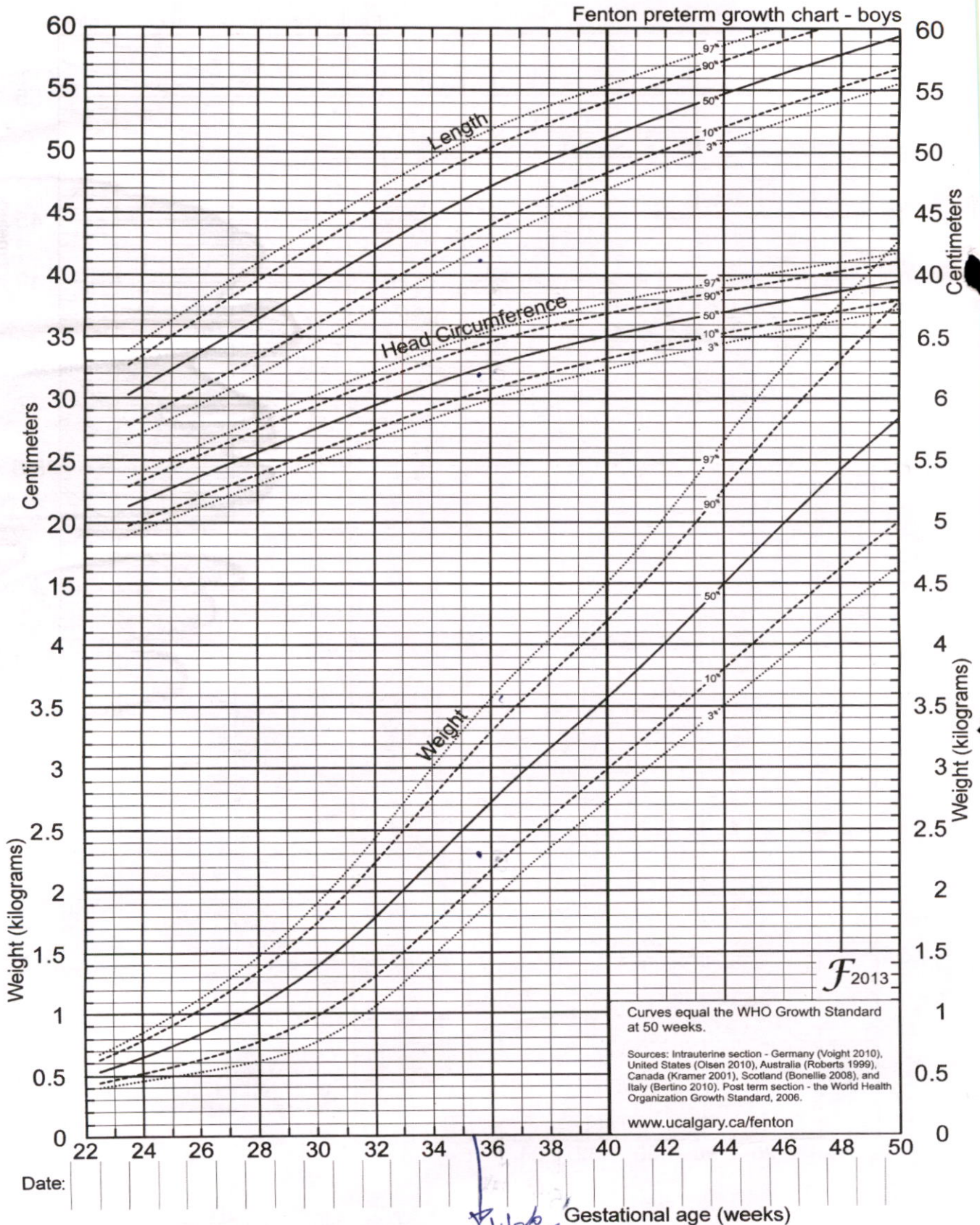
Admission Weight:

Discharge Weight:

NICU:







AH-00656409 IP5-00175520
aby Of MUTTAMPETH LIKITHA
1-05-2026 0 Y 1 M 12 D (M)
NALINIKANTA PANIGRAHY

[illegible]

RAINBOW HOSPITAL NICU HIC CHECK LIST

[illegible]



①



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Gestational Age:

Birth Weight:

[illegible]

Blood Culture:

S.No	Date	DOL	Specimen	Findings	Antibiotics

Neurosonogram:

S.No	Date	DOL	Findings

ROP Screening:

S.No	Date	DOL	Findings
	21/7/16		zone 2A-3 → RE - no stage plus, LE → stage I plus no plus.

2D ECHO:

S.No	Date	DOL	Findings
1	22/7/16	43	PFO ± L→R shunt, Good biventricular fm EF - GT1.

Thyroid Function:

S.No	Date	DOL	Findings

Hearing Screening: Date

Results:

Supplements:

1) Calcium

2) Multivitamins

3) HMF

4) Iron

5) Vitamin D

6) 3% NaCl

7) Vitamin A

8) Caffeine

9) Fluconazole Prophylaxis

IP5-00173894

16-05-2026

0Y1M6D

(M)

Dr. NALINIKANTA PANIGRAHY



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[illegible]



①

KANGAROO MOTHER CARE CHART

Gestational Age:					Birth Weight:		
S.No	Date	Time-In	Time-Out	Total Hours	Weight of Baby	Parents Sign	Nurse Sign
1	22/6/26	2:30pm	3:30pm	1 hrs	2.1kgs	Nandu	G
2	22/6/26	6:30pm	8:30	2 hrs	2.1kgs	Nandu	G
3	22/6/26	9pm	10pm	1 hr	2.2 kgs	Nandu	Roy
4	22/6/26	10:PM	10:30pm	30min	2.1kgs	Nandu	
5	23/6/26.	7:50Am	11:30	3hrs, 40min	2.1kgs	Nandu	Lokya
6	23/6/26	8:30pm	9:30pm	1hr	2.1kgs	Nandu	Nandu
7	24/6/26	2:30pm	3:30pm	1 hr	2.1 kg	Nandu	G
8	24/6	7:10pm	8:00	1 hr	2.1 kg	Nandu	Nandu
9	24/6/26	8:45	10:00	1hr 15min	2.1 kg	Nandu	Nandu
10	25/6/26	2:15pm	5:15pm	3hr 15min	2.15 kg	Nandu	Nandu
11	25/6/26	8:00pm	10:00pm	2hr	2.1 kg	Nandu	Nandu
12	26/6/26	3:00pm	4:30pm	1hr 30min	2.1 kg	Nandu	Nandu
13	26/6/26	6:pm	8:50pm	2:50min	2.1kg.	Nandu	Nandu
14	26/6/26	9:00pm	10:00pm	1hr	2.1 kg.	Nandu	Nandu
15	27/6/26	2:45pm	7:40pm	5hr	2.288 kgs	Nandu	Roy
16	27/6/26	7:48pm	8:48pm	1hr		Nandu	Nandu
17	28/6/26	10:00AM	12:15PM	2:15min	2.301kgs	Nandu	Nandu
18	28/6/26	2:45PM	5:30PM	2:45min	2.301kgs	Nandu	Nandu
19	29/6/26	3:30pm	4:pm	1 hr		Nandu	
		5:PM	7:10pm	2 hr		Nandu	
20	30/6/26	10AM	1PM	3hr	2-301kgs	Nandu	Roy

Total KMC Hours:

Gestational Age:

Birth Weight:

Total KMC Hours:

BAH-00656409 IP5-00173894
 Baby Of MUTTAMPETH LIKITHA
 16-05-2026 0 Y 1 M 6 D (M)
 Dr. NALINIKANTA PANIGRAHY

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ADMISSION CRITERIA – NICU

Admission / Transfer from:

☐ Emergency ☐ Outpatient (OPD) ☒ Ward ☐ Operation Theater ☐ Others:

Tick (✓) any of the following criteria requiring admission / transfer to NICU

Prematurity and Low Birth Weight Babies:

- ☒ Respiratory Distress
- ☐ Congenital Heart Disease
- ☐ Suspected or CONFIRMED SEPTICAEMIA
- ☐ Suspected or Diagnosed Meningitis
- ☐ UTI
- ☐ Septic Arthritis or Osteomyelitis
- ☐ Congenital Infections (Varicella, Pneumonia)
- ☐ Acquired Viral Illness
- ☐ Hyperbilirubinemia
- ☐ Severe Dehydration
- ☐ Bleeding Manifestations
- ☐ Neonatal Seizures
- ☐ Birth Asphyxia
- ☐ Surgical Problems
- ☐ Suspected Metabolic Disorders
- ☐ Dysmorphic Features
- ☐ Congenital Serious Cutaneous Disorder

Major Surgical Problems:

- ☐ Congenital Hydrocephalus
- ☐ Neural Tube Defects
- ☐ Choanal Atresia
- ☐ Trachea- Esophageal Fistula
- ☐ Esophageal Atresia
- ☐ Congenital Diaphragmatic Hernias
- ☐ Eventration of Diaphragm
- ☐ Congenital Cystic Adenomatoid Malformation
- ☐ Intestinal Atresias
- ☐ Gastric Volvulus
- ☐ Cleft lip or Cleft Palate
- ☐ Omphalocele / Gastroschisis
- ☐ Anorectal Malformations
- ☐ Gross Hydronephrosis
- ☐ Posterior Urethral Valves
- ☐ Congenital Tumors
- ☐ Cystic Hygromas

Criteria for shifting inborn babies from wards to NICU:

- ☐ Any Baby with Lethargy, Poor Feeding, Gross Weight Loss and Dehydration
- ☐ Any Baby with Severe Jaundice Requiring Exchange Transfusion
- ☐ Any Baby with Blood Sugar Abnormalities (Hypo or Hyperglycaemia)
- ☐ Any Baby with Temperature Instability
- ☐ Any Baby with Signs of Sepsis
- ☐ Any Baby with Seizures
- ☐ Out Born Babies: (Including Walk in Patients to the Emergency Room / Neonatal Transports)

Signature of the Doctor:

Name of the Doctor:

Date & Time:

Patient Sticker

DISCHARGE CRITERIA – NICU

Discharge to:

- ☐ HDU / Step down ICU ☐ Ward ☐ Outside Facility ☐ Others:

Tick (✓) any of the following criteria requiring discharge / transfer from NICU

- ☐ The clinical status of the patient no longer warrants constant medical and nursing monitoring or specialized services originally required.
- ☐ Preterm baby once attained weight of >1.5kgs and crossing the PMA of >35 weeks of gestation.
- ☐ Preterm babies maintaining normal temperatures (36.5-37.5°C) in room temperature.
- ☐ All preterm, low birth weight babies and babies who had critical course in the NICU

Signature of the Doctor:

Name of the Doctor :

Date & Time:

CONSENT FOR ADMISSION IN NEONATAL INTENSIVE CARE UNIT

AN-00036403 1F3-001/3320
Baby Of MUTTAMPETH LIKITHA
6-05-2026 0 Y 1 M 9 D (M)
Dr. NALINIKANTA PANIGRAHY



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Name: B/o M. Likitha Twin I Age: 1 month 9 days Gender: Male ☒ Female ☐

UHID.No : 656409 Date: 22/6/26

I C. NAREEN S/o, D/o, W/o _____ hereby
declare that our patient Mr. / Ms. B/o LIKITHA - I who is related to me as SON is
getting admitted in the Neonatal Intensive Care Unit of Rainbow Children's Hospital on 22/6/2026

The doctors have explained to me in a language understood by me that my child has following health related issues :

Extreme prematurity P.D, feed intolerance Apnea
of prematurity, Anemia of prematurity

The doctors have clearly explained to me that my patient B/o Likitha Twin I during his / her stay
in the Neonatal Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical
ventilation, Umbilical Artery Catheter, Umbilical Vein and Arterial Lines, Peripherally Inserted Central Catheter Line and arterial line
placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure
shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is
implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Neonatal Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Neonatal Intensive Care Unit with multiple medical and surgical procedures
performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of
infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child B/o B/o LIKITHA TWIN - I
in the Neonatal Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various
procedures, high risk medications and infections in the Neonatal Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature : M. Likitha

Name : M. Likitha

Relationship with Patient: Mother

Date & Time : 22/6/26

Doctor (who is taking the consent) :

Signature : Sai Suraj

Name : Saiteja

Date & Time : 22/6/26

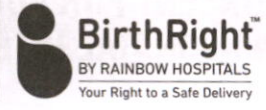
Witness :

Signature : Lokanay

Name : Lokanay

Date & Time : 22/6/26

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యు) సమ్మతి పత్రం



రోగి పేరు వయస్సు లింగం పు స్త్రీ
యు.హెచ్.ఐ.డి
నేను బి
అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రేయిన్ఫీ బిల్డ్ ఆసుపత్రి లోని నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్లో తేదీ
..... నాడు పూర్తి సమ్మతితో చేర్చితిని. మా బాలుడి / బాలికలో. ఈ క్రింద
తెలిపిన ఆరోగ్య సమస్యల గురించి వైద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ లో మా పాప /బాబుకు వైద్య పరంగా అవసరమగు అన్ని రకాల చికిత్స విధానాలకు మరియు ప్రక్రియలను (ఉదా కృత్రిమ శ్వాస వెంటిలేటర్, ధమని మార్గం, సింట్రిల్ లైన్ చెస్ట్ డ్రైయిన్, పెరిటోనియల్ డ్రైయిన్ ఇంసర్జన్ వంటి ప్రక్రియలను డాక్టరు గారు నాకు అర్థమగు భాషలో వివరించారు.

అటువంటి ప్రక్రియలు చేస్తున్నప్పుడు నాకు సమాచారం ఇవ్వబడుతుందని మరియు దీనికి ప్రత్యేక సమ్మతి ఉంటుందని వైద్యులు నాకు చెప్పారు. ఏదేమైనప్పటికీ, పైన తెలుపబడిన శస్త్ర ప్రక్రియలు చేసేముందు సమ్మతి తీసుకునే వీలు లేని చో ఏదైనా ప్రాణాంతక అత్యవసర పరిస్థితులు ఏర్పడినప్పుడు మా బాలుడు / బాలికను కాపాడుటకు అవసరమైన వైద్య శస్త్ర ప్రక్రియలు మా సమ్మతి లేకుండానే చేయవచ్చని నేను సమ్మతిస్తున్నాను.

ఆరోగ్య సమస్యలతో బాధపడుతున్న మా బాలుడికి / బాలికకు రుగ్మతలచే ప్రాణహాని కలుగవచ్చిన నాకు వైద్యుడు అర్థమగు భాషలో వివరించితిరి

మా బాలుడు / బాలిక నవజాత శిశువు ఇంటెన్సివ్ కేర్ యూనిట్ లో ఉన్నప్పుడు ఎన్నో విధాల వైద్య మరియు శస్త్ర ప్రక్రియలు ఇంకా వివిధ చికిత్స విధానాలు అవసరం పడతాయని మరియు వాటివల్ల దుష్పరిణామాలు కలగవచ్చని అర్థం చేసుకున్నాను. ఆ పరిణామాలు ఎటువంటివి అనగా నష్టాలు మరియు అధిక ప్రమాదకరమైన మందుల రూపంలో అంటువ్యాధులు, రక్తస్రావం, శ్వాసపరమైన సమస్యలు, చర్మం మరియు ఇతర కణజాల నష్టం మొదలైనవి కలగవచ్చు.

మా బాలుడిని/బాలికను అడ్మిట్ చేయుటకు మరియు ఎన్. ఐ. సి.యు. లో ఉన్నప్పుడు జరుగు చికిత్స విధానాలు మరియు శస్త్ర ప్రక్రియలు వలన కలిగే అపాయాలను నేను అంగీకరిస్తున్నాను. మా పేషంట్ ను తగిన విధంగా చికిత్స చేయడానికి వైద్యునికి నాపూర్తి అంగీకారం తెలియజేస్తున్నాను. వైద్యుడు నాకు అర్థమగు భాషలో అంతా వివరించారు.

మా బాలుడు / బాలిక ను ఇన్టెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు(అటెండెంట్)
సంతకము
పేరు
వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)
సంతకము
పేరు

సాక్షి
సంతకము
పేరు
తేదీ మరియు సమయము



PATIENT TRANSFER FOR...

Patient Name & UHID No. <i>B/o Irikitha. 656409.</i>	Date & Time of Admission <i>23-6-2026.</i>	Date & Time of Transfer Order <i>3-7-26</i>
Treating Consultant Name <i>Dr. N.K sir</i>	Transfer Ordered by <i>Dr. N.K sir</i>	Reason for Transfer <i>baby stable.</i>
From Unit <i>NICU</i>	To Unit <i>3rd floor</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>yellow file - (1)</i>	Number of Imaging Films <i>Xray - 3</i>	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	<i>wipes</i>	<i>1</i>
2.	<i>bottle</i>	<i>7</i>
3.	<i>Thermometer</i>	<i>1</i>
4.		
5.		

Sniffing Summary / Notes Written by Doctor : Yes ☒ No ☐

Name & Signature of Person who is Transferring <i>Sona.</i>	Name of Person Ordered Transfer <i>Dr. Nalinkantha sir.</i>
Patient & Clinical Records Received by : <i>Sis. Sanya.</i>	
Date & Time of Patient Received : <i>3/7/26 @ 6:10pm</i>	

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