



Rainbow Children's Hospitals - Visakhapatnam

Plot No.15, Health City layout, Sy. No. 21 & 27, Part of Chinagadili, GVMC Limits. Govt General Hospital Kda
Vishakhapatnam, Andhra Pradesh, INDIA, 530040.
TEL NO :891-3501601
WEB : <https://rainbowhospitals.in>

ADMISSION SHEET

Registration Details :



Admission No : IP22-00023309 Admit Date : 18-Jun-2026 Admit Time : 11:15 AM UHID : HCV-00040876

Patient Details :

Patient Name	: Baby B/O P MANISHA SRI LAKSHMI	Age	: 0 D
Guardian	: Mr HEMANTH	DOB	: 18-06-2026 09:19 AM
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: Govt Diary Farm Vishakhapatnam Andhra Pradesh INDIA 530040	Phone No	: 7730038688/
		E-mail	: no@gmail.com

Admission Details :

Bed Type : NICU Bed No : NICU 115 Ward Name : 1F-FIRST FLOOR-NICU
Room No : NICU 115 Admission Type : First Visit

Contact Details :

Name : Mr HEMANTH Relationship : Baby/O
Contact Address : Govt Diary Farm Vishakhapatnam Andhra Pradesh INDIA 530040 Phone No :

Signature

Doctor Details :

Doctor Name : Dr. TIRUMALASETTY PARAMESH Specialisation : GENERAL PEDIATRICS
Referral Doctor : SELF Phone No :
Co-Consultant :

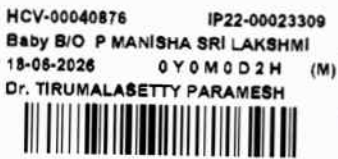
Payment Details :

Deposit Amount : 20000.00
Payment Mode : DC/CC Card Payor Name : SELFPAY

OPV done - 19/6/26
BCG, Hepatitis done - 19/6/26
Red reflex done - 19/6/26

ACTIVITY RECORD FOR BILLING

Name:----- HCV-00040876 IP22-00023309
Baby B/O P MANISHA SRI LAKSHMI
18-06-2026 0 Y 0 M 0 D 2 H (M)
UHID No :----- Dr. TIRUMALASETTY PARAMESH
Date of Admission :----- Date of Discharge:----- Time:-----
Room / Bed No :----- Ward :----- Suggested Billable bed type:-----



Consultant :----- Dept: **NICU**

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/6/26	9:30 am	LDR	NICU	Sandhya / Chaya
18/6/26	10 pm	NICU	5 th floor	neena / shun

Cross Consultation Visit

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



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Manisha Sr. Age : 29 Father's Name : Age :
 Date of Birth : Date of Admission : I.P. No.:
 NICU Consultant : Dr. Hariharan Referring Consultant : Dr. Shrilalaj
 Transferring Unit : OT Labour Room ER Ward
 Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : B/o Manisha Mother's Blood Group : A +ve
 Gender : M F Blood Group : O +ve Birth Weight (gms) : 2.642 kgs Length (cms) :
 Date of Birth : 18/6/26 Time of Birth : 9:19 AM OFC (cms) :
 Place of Birth : RCH, Vizag Estimated Gesth Age : 37 + 3 days

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 29 Ht : Wt : BMI : Married Life : 3 yrs LMP : 24/9/25 EDD : 5/8/26
 Conception : Spontaneous or with Rx : I.V.F. conception
 Booked at what GA : AN Steroids Drugs / Doses :
 Last Scans Details : SLUG, cephalic, AFI - 18.5cm, EFW - 2.326 kgs - 6/6/26
Doppler - (N), Two loop of cord, avoid neck persistent LCRG - anomaly scan (7/2/26)
 TT Immunization and Iron / Folic Acid : immunized

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 / RDDF / Redistribution in MCA) / Ductus Venosus :
 AFI :

H/o GDM/ pre GDM/ on diet or insulin
 Controlled or not, recent values, HbA1 values :
GDM on OHA :: 1 month
 Compliance with Rx :
 Scans : LGA, TIFFA, Fetal Echo : 250mg - (M)
100mg - (N)
H/o Hypothyroidism : when diagnosed ? Medication?
 Any other Chronic Medical Problems, when detected drugs ?
 (Anemia, SLE, Jaundice, CHD, Heart Disease)
 Infection : H/O, Fever
 (Malaria UTI TORCH TB HIV HBV)
 UTI : when : Any culture :

PPROM : Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :

PAST OBSTETRIC HISTORY

G: 2 P: A: E: 1

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
<u>G1</u>	<u>Ectopic pregnancy</u>				<u>med MTP - 2022</u>	
<u>GII</u>	<u>IVF</u>	<u>conception</u>			<u>present pregnancy</u>	

PERINATAL HISTORY

Treating Obstetrician : Dr. Shaikjav Hospital : RCH, Vizag Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig)</p> <p>Second stage (> 2 hours after dilation)</p> <p>LSCS : <input checked="" type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</p> <p>Specify the reason : <u>maternal request</u></p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL : <u>-</u></p> <p>Resuscitation : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cord ABG : <u>-</u></p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :</p>
---	--

NEONATAL RESUSCITATION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

TOTAL

	1 Minute	5 Minutes	10 Minutes
	<u>0</u>	<u>1</u>	<u>1</u>
	<u>2</u>	<u>2</u>	<u>2</u>
	<u>2</u>	<u>2</u>	<u>2</u>
	<u>1</u>	<u>1</u>	<u>2</u>
	<u>1</u>	<u>2</u>	<u>2</u>
	<u>5</u>	<u>7</u>	<u>9</u>

Resuscitation			
Minutes	1	5	0
Oxygen			
PPV / NCPAP			
ETT			
Chest Compressions			
Epinephrine			

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

HOP1:

A single live male baby is delivered via F.L. LSCS

↓

Baby cried immediately

↓

Delayed cord clamping done, shift to warmer

↓

Weak cry, cyanosed, ^{limp} even on stimulation
suctioning

↓

Saturations @ 60% \downarrow RA

↓

Delivery room CPAP was started \bar{c}
PEEP-5 FIO_2 -30%

↓

Colour & tone improved

↓

Saturation @ 92% \downarrow RA

↓

Antibiotic newborn care given

↓

Investigation details in previous Hospital:

umbilical cord clamped & cut

↓

2nj. Vit K 1mg IM given

↓

Saturation @ 88%, with nasal flange
tachypnea

↓

Feeding History:

Shift to NICU

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Description :

cry (time) activity - good

VITALS : Temperature : 36.5°C HR : 154 bpm RR : NIBP : CFT :

Colour of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 90% @ 10min

Anthropometry : Birth Weight : 2.642kg Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

HEAD : Fontanelles :
Sutures :
Shape / Moulding :
Edema / Bruising :
Size - (H.C.) :

} open & at level

Facies :
(Any Facial Dysmorphism)

(N)

NECK and CLAVICLES : Range of Motion :
Asymmetry :
Masses :

} (N)

EYES : Symmetry :
Red Reflex : → TO be checked
Discharge :

EARS, NOSE MOUTH and THROAT : Ear set / Shape :
Preauricular Pits / Tags :
Nasal shape / Patency :
Palate :
Gums :
Lips :
Tongue :

} (N)

THORAX and BREASTS : Shape of Thorax :
Position of Nipples and Number :

(N)

ABDOMEN and UMBILICUS : Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump : → 2A + IV
Discharge :

GENITILIA : Labia / Hymen :
Testicles/penis :
Anus :

male external genitalia

HERNIAL ORIFICES

(N)

TRUNK and SPINE :

(N)

SKIN LESIONS :

(N)

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

} (N)

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

Mention if baby has Respiratory distress : RR : 64/min SCR / ICR / See - Saw breathing : - nasal flare (N)

Scoring of respiratory distress if present (Silverman or Downe's) : 1
1+0+0+0+0

Mention if baby is on : Hood box CPAP Ventilator

Settings :

Spo2 : Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 156 bpm BP : Precordial Activity :

Femoral Pulses : felt Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernial orifice :

Palpation : soft Anal Patency : patent

Palpable masses : Umbilical Cord : 2A+1V

Abdominal girth : First urine passed : not passed
Meconium passed : not passed

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness : (N)

Prechtle Score :

Cranial Nerves :

.....
..... (N)
.....

Motor System :

Passive Tone :

Active Tone : (N)

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

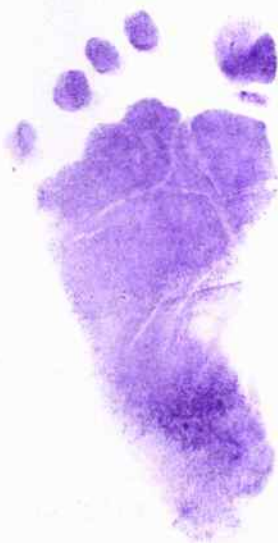
ATNR : Skull and Spine :

Any Congenital Anomalies :

Diagnosis : Term | AGA | E-LSCS | 2.6 kgs | TTVB | IDM | persistent (+) SVC

FOOT PRINTS

Left Side :



Right Side :



Noted by
Sanyam (SPW)

Resident Doctor :

Signature : G. Suminaa

Name : G. Suminaa

Date & Time : 18/6/26

Consultant :

Signature : R. Hanhan

Name : R. Hanhan

Date & Time : 20/6/26

PLEASE FILL UP THE FOLLOWING DETAILS

- Name of the referring Doctor :
- Name of the referring Hospital :
Address :
Contact Numbers :
- Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
- Name of the Doctor in Rainbow Team :
..... on whose name the patients is being referred.

AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

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

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

Adv

- 1. Shift to NICU
- 2. GRBS monitoring 2, 6, 12, 24, 48 hrs
- 3. Red reflex & birth vaccination to be done

Feeding Plan at the time of shifting :

- 4. CCHD screening @ 24 hrs
- 5. TSBX adv NBS @ 48 hrs
- 6. cord blood BUT, TSH, T4

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Smearies

NOTED BY
XXXXXXXXXX

Pulse Oxymetry Screen : RH-987, RL-987, LH-987, LL-987 -

New Born Screening :

18/6/26
5PM

CLB Dr. Hanhanan | Dr. Suminaa

Team (AGA) 10M | TTNB | peristalt (A) SVC

Baby is self ventilating on room air

No episodes of apnea, desaturation

No signs of ~~signs~~ distress

colour & perfusion - good

urine } paired
stool }

On 12 ml 2nd hly OG feeds

Tolerating well.

ota vitals

HR - 134 bpm

SpO₂ - 97%

Temp - 36.5°C

Adv

- 1. Try spoon feeds after
& OG feeds & 2D Echo
- 2. w/t distress

h
Suminaa

revised by Suminaa
01/07/26

PROGRESS NOTES
(USE BALL POINT PEN ONLY)

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
19/6/26	8 AM	cls/B Dr. TP/ Dr. Balaji
		23hr of life
		Birth wt → 2.642kg
		C. wt → 2.625kg
		[Wt loss → 0.6%]
		• Baby Self Ventilatory on Svc. Room air
		• NO Apnea, desaturations
		• hemodynamically stable
		Color & perfusion - good.
		• urine } passed.
		• stool } passed.
		Advice:
		• cont. Spoon feeds 12ml/2hrly
		• CcTD screening → today
		TSB } @ 9 AM + Tlm
		NBS }
		Dr. Balaji
		N.B. Santhosh

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

19/6/28
5pm


cls/B Dr. Praveen/ Dr. Balaji

Dts: TERM/AGA/TTNB/BDM/peristaltic
(U) sue

- clylonel activity - good
- urine } paired
 stool }
- Feeding → DRF + spoon feed.

Advice

- DRF every 2nd hrly AB
 burp
- TSB } T/m @ 9 AM
 NBS }


Balaji

Noted by Pinky
19/6/28



PATIENT TRANSFER FORM

<p>HCV-00040876 IP22-00023309 ILS Baby B/O P MANISHA SRI LAKSHMI 18-06-2026 0 Y 0 M 0 D 2 H (M) Dr. TIRUMALABETTY PARAMESH</p> <p>B</p>	<p>Date & Time of Admission 18/6/26 at:</p>	<p>Date & Time of Transfer Order 18/6/26 at: 9:10^{AM}</p>																		
<p>Treating Consultant DR. Paramesh</p>	<p>Transfer ordered by Dr. Jayaraja</p>	<p>Reason for Transfer Mother side</p>																		
<p>From Bed / Ward / Hospital MICU</p>	<p>To Bed / Ward / Hospital 102</p>	<p>Information to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>																		
<p>Number of Sheets in clinical file 13</p>	<p>Number of Imaging films -</p>	<p>Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, What ?</p>																		
<p>Medications / Consumables / Surgicals / Hand over</p>																				
<table border="1"> <thead> <tr> <th>Sl.No.</th> <th>Item Name</th> <th>Quantity</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td>Baby Diaper</td> <td>- 1</td> </tr> <tr> <td>2.</td> <td></td> <td></td> </tr> <tr> <td>3.</td> <td></td> <td></td> </tr> <tr> <td>4.</td> <td></td> <td></td> </tr> <tr> <td>5.</td> <td></td> <td></td> </tr> </tbody> </table>			Sl.No.	Item Name	Quantity	1.	Baby Diaper	- 1	2.			3.			4.			5.		
Sl.No.	Item Name	Quantity																		
1.	Baby Diaper	- 1																		
2.																				
3.																				
4.																				
5.																				
<p>Shifting Summary / Notes written by Doctor: Dr.</p>																				
<p>Name and Signature of Person filling this part Sandhya</p>	<p>Name of person ordering transfer Jaya Dr. Surya</p>	<p>Name & Signature of Nurse Supervisor Malathi</p>	<p>Referral note & referral Doctor Name:</p>																	
<p>Patient & Clinical records received by:</p>																				
<p>Signature with Date & Time B. Chaudhary 020245 18/09/26 @ 10:14 AM.</p>																				

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