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ACTIVI KOH-00308756 IP2-00056448 **NG**
Baby Of BALANNAGARI SOWMYA
02-06-2026 0 Y 0 M 0 D 1 H (F)
Dr. KADIRI BHANU VARUN KUMAR

Name: --  -----

UHID No : ----- IP NO. : ----- Consultant : ----- Dept : -----

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

Room / Bed No : ----- Ward : 4w Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/6/26	7:30pm	4w	Room (406)	<i>(M) Anju</i>
3/6/26	6:55pm	406.	NICU	Sushma.
4/6/26	10:30AM	NICU	406	<i>Sad Nagulkshori</i>

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
2/6/26	Blood grouping	26007633	} @maje
2/6/26	ABG	26007632	}
<p><i>(Cross check result) 2/6/26</i></p>			
3/6/26	Reticulocyte count	26007683	} A
	DCT; CBP; SBB		
3/6/26	SBR	26007695	}
4/6/26	SBR	26007708	} Spalvani
4/6/26	GRBS @ 6AM 92 mg/dl	26007709	} Spalvani
<p><i>c.c done by Samima 4/6/26 @ 10AM</i></p>			
5/6/26	CBP, SBR, NBS	26007740	} Anita
6/6/26	SBR	26007799	} Anita
<p><i>cross checked by Chandnani @ 10AM 6/6/26</i></p>			

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/6/26	DPV	}	}	}
	BCG			
	Hep. B			
3/10/26	IV cannulization	①	942893	R
c.c done by Samirna 4/6/26 @ 10AM				
5/6/26	O.A.E	①	943367	AK
USGS checked by Chandrani @ 10AM 8/6/28				

ANY OTHER INFORMATION

 Baby kit given

Date: 2/6/26

Time: 4pm

Prepared By: Tujasa

Staff Nurse Mangju	Shift / Ward 4/W ↓ Room (406) A/100	Billing Assistant	Billing Supervisor
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 Baby Of BALANNAGARI SOWMYA
 02-06-2026 0 Y 0 M 0 D 1 H (F)
 Dr. KADIRI BHANU VARUN KUMAR



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Ms. Sowmya B Age : Father's Name : Age :
 Date of Birth : Date of Admission : UHID No. :
 NICU Consultant : As per list 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 Sowmya Mother's Blood Group : B+
 Gender : M F Blood Group :
 Date of Birth : 2/6/26 Time of Birth : 4:00 pm Birth Weight (gms) : 3050 Length (cms) :
 Place of Birth : REM Bangalore OFC (cms) :
 Estimated Gesth Age : 39 w

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 30y Ht : Wt : BMI : Married Life : LMP : 24/5/25 EDD : 4/6/26

Conception : Spontaneous or with Rx :

Booked at what GA : AN Steroids Drugs / Doses :

Last Scans Details : 21/5/26 cephalic; BW = 3kg; 33%; AFI : 14.6 cm; Placenta - high; Doppler (+)
 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

(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: 1 L:

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
	<u>2020 (May)</u>	<u>misc</u>	<u>misc</u>	<u>misc</u>		

PERINATAL HISTORY

Treating Obstetrician : Hospital : 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 type="checkbox"/> Elective <input checked="" type="checkbox"/> Emergency Indication :</p> <p>Specify the reason : <u>M&L</u></p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL :</p> <p>Resuscitation : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cord ABG :</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :</p>
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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
	<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>2</u>	<u>2</u>	
TOTAL	<u>4</u>	<u>7</u>	

Resuscitation			
Minutes	1	5	10
Oxygen			
PPV / NCPAP			
ETT			
Chest Compressions			
Epinephrine			

Snapee II Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

KOH-00308756 IP2-00056448
Baby Of BALANNAGARI SOWMYA
02-06-2026 0 Y 0 M 2 D (F)
Dr. KADIRI BHANU VARUN KUMAR

Hist



Baby delivered by Sulec
↓
C/S
↓
dried, warm care
↓
well clamped & cut
↓
Vitamin

Investigation details in previous Hospital :

—

Feeding History :

—

Past History :

—

Family History :

—

Socio Economic History :

—

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : HR : RR : NIBP : CFT :

Color of the extremities :

Jaundice : Pallor : SpO2 :

Anthropometry : Birth Weight : Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

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

Facies :
(Any Facial
Dysmorphism)

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

EYES : Symmetry :
Red Reflex :
Discharge :

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

Patient Sticker

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

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

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

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

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

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 : Auscultation : *2.5. ⊕* Breath Sounds : *2.5. ⊕* Added Sounds :

Cardiovascular System :
HR : BP :
Femoral Pulses : *⊕ ⊕* Precordial Activity :
Other Peripheral Pulses : *⊕ ⊕* Murmurs :
Signs of Cardiac Failure : *-*

Abdomen :
Shape : *soft* Hernia orifice : *free*
Palpation : Anal Patency : *⊕*
Palpable masses : Umbilical Cord : *2A+IV*
Abdominal girth : First urine passed :
Meconium 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 :

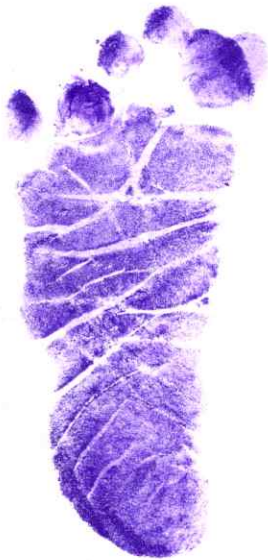
ATNR : Skull and Spine :

Any Congenital Anomalies :

Diagnosis :

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *[Handwritten Signature]*

Name :
[Handwritten Name]

Date & Time :

Consultant :

Signature : *[Handwritten Signature]*

Name :

Date & Time :

DISCHARGE PLAN

Information given by: Family Friend

Will patient require transportation arrangements to go home: Yes No NA

Will Physiotherapy require at home: Yes No NA

Is home medical equipment anticipated: Yes No NA

Is home oxygen therapy anticipated: Yes No NA

Breastfeeding Yes No NA

Formula Feed Yes No NA

Are dressing needs at home anticipated: Yes No NA

Any other needs anticipated: Yes No If Yes Specify

Feeding Plan at the time of shifting :
.....
.....
.....
.....
.....
.....
.....
.....

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Discharge Details:

Neonatal Condition at Discharge:

.....
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.....
.....
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F  sively Breastfeeding and Formula Feeding Formula Feeding

Vitamin K given: Yes No

Vaccinations given BCG Hepatitis B Others:

Neonatal Screen Taken: Yes No, parents advised to have Neonatal Screen at National screening program center on:/...../.....

Hearing Test: Yes No

Jaundice: NIL Slight Moderate

Passed Urine: Yes No

Passed Meconium: Yes No

Weight at discharge:

Appointment was given for follow-up at OPD: Yes No

Date of Discharge:/...../.....

Discharge to Home Other:

Against Medical Advice: Yes No

Referred to another hospital: Yes No

Discharge Medications: Yes No

Details:

Final Diagnosis:

*Imm / en USCS (near) | B-wt: 3.050 | AYA |
Female*

*warm care
- ORS 2 + long flb haps
- PRN NBS
- OAG, vaccination
- M. intake*

Doctor Signature: 

Doctor Name: *Dr. K. Bhanu Varun Kumar*

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6	w/B Dr. Varun	
	T 1 WU (MISL) 3000 g 1 AUA R OB setup	
	Baby well	
	Accepted feeds	
	cry	
0 hrs / 1 hr	tone good	
	activity	
UW	CU: 8, 15, 20	plan
✓	RI: BAE ✓	- maintain core
	PIA: soft	- feeds 2nd by plb
		bump
2 hrs		- OAE
1 hr		- vaccination
		- SBR, NBS @ 48 HOC
		TCB @ 4pm
	Noted by Srisha on 3/6/26 At: 10:30 AM	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6	4/3 hly 2 registers	
	Zwnt LSCS (MSR) 3.050 kg 44 A/P OB sitting	
07:00	Bare 4/5 2:30	
	propheic : wam	wam
		wam
		feeds 2nd hly f/b hly
		OAE, vaccination
		send SBR
		DCT
		Rhtc
5:30pm		cast
		-DSPT i eyes & genitals covered
		↓
		Repeat SBR after 6 hrs
		(@ 11pm)
		- Blood reserve
		(O-vp, cov O+vp)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		S/B <u>Dr. Pooja</u> :
5:00 pm	T8B, 12.3 neg/dl.	
	<u>o/e</u> :	
	Baby is Icteric.	Ⓡ ① Shift to NICU.
		T8PT - Now
		Repeat T8R @ 1 AM.
		- feed - 20-25ml - 2x/day - NP @ soc (by day)
		<i>[Signature]</i>
6 am	NP	
	↓ T8PT	Ad
	vital stable	- send T8R @ 7 am
		<i>[Signature]</i>
		Noted by Gurav 3/6/2026 11:30



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/26	S/B: Dr. Varun	
10am	NNT	
	↓ TSPT	
	Sethic warm	
	accepting feeds well	
	C/TA - good →	start feeds
	vital - stable	850 cal/24h
	HR - 131/m	
	RR - 42/m	SIBR - trace.
	spo ₂ - 98%	
	CUS	- The TSPT I change
	RS (M)	
	PIA	- Monitor vitals
		→ SSPT fill evening
		Rebound TSB } TM @
		CBP } 6AM.
		NBS
		noted by Titi 04/05/26 @ 10AM




PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 9:30	cls by Registrar	
	NNJ	
	child under SSP	R
	cls A: good puerperis: none	. DSB + PR (100) 2nd half flb Bunfy
	vitals: stable	. SSPT till evening
	Noted by - Sushma 4/6/26 @ 4pm	. TSB; CRP time back.
5/6/26 8AM		<u>S/B Dr. Varun:</u>
	TSB: 14.4	
	Baby icteric - upto legs } Satisfactory R Activity	
		DSPT - till 7pm
	Noted by Anitha 5/6/26 @ 8AM	bc



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6 10 AM	S/O Dr. Varun	
	T) US (MSL) 30SD R (AGA) NST - OB set up	
6-41 AM - Low	Baby under 107 Accepting feeds well	
	Cry tone good Alert	plan
	SRR: 10.4	- P/S.
	↓ D&PT	- 16 - Monday
		
	<hr/> Noted by Chandmani @ 10 AM 6/6/26	

RESULT SHEET

Patient Name

Age :

I.D. No. :

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INPR / 17



Date	3/06/26	3/6/16	4/5/20	5/6/26	6/6/26	
Time	2:4 pm	11:30 P	5A	@ 7AM	@ 7:40AM	
Hb	18.3			16.7		
PCV	51.0			40.1		
RBC	4.67			4.28		
WBC	15.91			19.63		
N/L						
Platelets	294			254		
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj	12.3 \rightarrow 0.1	13.7 \leftarrow 0.3	10.8 \leftarrow 0.2	14.4 \leftarrow 0.2	19.0 \leftarrow 0.1	
T.Protein	\rightarrow 12.2	13.2	10.6	14.2	11.9	
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein/Sugar						
Cells						
N/L						
Doctor's Signature						

Date	3/6/26					
Time	4 PM					
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
3/6/26 4 PM DCT →	Negative					
Reticulocyte →	4					
Doctor's Signature						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

Patient Sticker

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

Morning Shift

Clinical Diagnosis.....
Nursing Diagnosis.....
Plan of Care
Planned Investigations Procedures
Implementation

NIL

Handed Over by : Name & Signature

Received by : Name & Signature

Evening Shift

Clinical Diagnosis..... New Born
Nursing Diagnosis..... New Born Care
Plan of Care * Assess Condition of the Baby * Monitor
vitals * Warm Care * Cord Care
* DBF 2nd hourly * Maintain hand hygiene
Planned Investigations Procedures.....
Implementation * Assessed Baby's Condition * Monitored
vitals & recorded * Warm Care * provided
provided * Maintained hand hygiene * DBF 2nd hourly

Handed Over by: Maju 2/6/26 @ 8pm
Name & Signature

Received by: Sandhya @ 8pm
Name & Signature

Alia
2/6/26 @ 8pm

2/6/26

Night Shift

Clinical Diagnosis..... NCB
Nursing Diagnosis.....
Plan of Care → Assess the baby condition
→ Monitor vital
→ Encourage DM feeds → Encourage Burping
Planned Investigations Procedures
Implementation → Assessed the baby condition
→ Monitored vital
→ Encouraged DM feeds
→ Encouraged Burping

Handed Over by: Sandhya @ 8AM
Name & Signature
3/6/26

Received by: Shanika
Name & Signature
3/6/26 @ 8AM

12/6/26



VITALS CHART

Date →	Temp	HP	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am						DBM		✓		
8.00 am										
9.00 am						DBM				
10.00 am										
11.00 am						DBM		✓		
12.00 pm	97.7°	144	40	98%						
1.00 pm						DBM				
								U-2	M-0	V-0
2.00 pm										
3.00 pm						DBM				
4.00 pm						Nanexcelba - 30ml				
5.00 pm										
6.00 pm	98°	142	42	100%		DBM				
7.00 pm										
8.00 pm										
8.00 pm						DBM				
9.00 pm										
10.00 pm	98°	144	40	100%		DBM				
11.00 pm										
12.00 am										
1.00 am						DBM				
2.00 am										
3.00 am										
4.00 am										
4.00 am						DBM		✓		
5.00 am										
6.00 am	97.7°	147	42	100		DBM				
								U-2	M-0	V-0
						TOTAL		U-2	M-0	V-0

Temperature 97.5 to 99.5 F
HR 120 to 160 per minute
RR 30 to 60 per minute
SP02 93-100%

Feeding Plan..... DBM + nanexcelba

Morning Shift

Clinical Diagnosis..... N.B.
Nursing Diagnosis..... New born care

Plan of Care → Assess the baby condition.
→ Monitor vitals
→ maintain I/O chart encourage to feed 2-3rd try.

Planned Investigations Procedures

Implementation → Assessed the baby condition.
→ monitored vitals
→ maintained I/O chart
→ Encouraged feed 2-3rd only give burping.

Shanthy
Handed Over by : Name & Signature
3/6/26 @ 2pm

Sushma 108782
Received by : Name & Signature
3/6/26 @ 2pm

Evening Shift

Clinical Diagnosis..... N.B.
Nursing Diagnosis → Assess the baby condition. New born care
→ Check the vital

Plan of Care → Assess the baby condition.
→ Check the vital
→ maintain I/O chart.

Planned Investigations Procedures

Implementation → Assessed the baby condition.
→ Checked the vital
→ maintained I/O chart
→ provided warm care

Sushma @ 8pm
Handed Over by : Name & Signature
3/6/26

Navya @
Received by : Name & Signature

Night Shift

Clinical Diagnosis.....
Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

Handed Over by : Name & Signature

Received by : Name & Signature

5/6/26



VITALS CHART

Date →	Temp	HP	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am						DBM				
8.00 am						nanproexcel	30ml			
9.00 am	98°F	142	40	100%	9/10					
10.00 am						DBM				↓
11.00 am						Nanproexcel	30ml	✓	✓	
12.00 pm										
1.00 pm	96.5°F	144	42	99%		DBM		U-1	M-1	V-0
2.00 pm										
3.00 pm						DBM				
4.00 pm								✓	✓	↓
5.00 pm						Nanproexcel	30ml			
6.00 pm	98°F	148	45	100					✓	↓
7.00 pm										
								U-1	M-2	V-0
8.00 pm										
9.00 pm						DBM			✓	↓
10.00 pm	97°F	142	40	100%		NanproExcel	30ml	✓		
11.00 pm										
12.00 am						DBM nanproexcel	30ml	✓	✓	
1.00 am										
2.00 am						nanproExcel	30ml			
3.00 am										
4.00 am						DBM		✓		
5.00 am						nanproExcel	30ml		✓	
6.00 am	98°F	148	45	100						↓
								U-3	M-3	N-0
						TOTAL	210ml	U-5	M-6	V-0

Temperature 97.5 to 99.5 F
HR 120 to 160 per minute
RR 30 to 60 per minute
SP02 93-100%

Feeding Plan..... DBM

Morning Shift

Clinical Diagnosis..... ^{NNJ (NB)}

Nursing Diagnosis..... yellowish discoloration of the skin and eyes

Plan of Care..... Assess the Baby condition.

..... check the vital sign
..... maintain I/O chart

Planned Investigations Procedures

Implementation..... Assessed Baby condition.

..... checked vital sign
..... provided warm care

Handed Over by: Name & Signature
Sandhya
5/6/26 @ 2 PM

Received by: Name & Signature
Seema @ 2 PM
5/6/26

Evening Shift

Clinical Diagnosis..... ^{NNJ (NB)}

Nursing Diagnosis..... yellowish discoloration of the skin

Plan of Care * Assess the baby condition

* Check vital sign
* maintain I/O chart

Planned Investigations Procedures

Implementation * Assessed the baby condition

* checked vital sign
* maintained I/O chart
* encourage D.B.M. feed

Handed Over by: Name & Signature
Seema @ 8 PM
5/6/26

Received by: Name & Signature
Proje @ 8 PM
5/6/26

Night Shift

Clinical Diagnosis..... ^{NNJ}

Nursing Diagnosis..... yellowish discoloration of the skin

Plan of Care → Assess the baby condition

→ check the vitals
→ maintain I/O chart

Planned Investigations Procedures

Implementation → Assessed the baby condition

→ checked the vitals
→ maintained I/O chart

Handed Over by: Name & Signature
Proje @ 8 AM
5/6/26

Received by: Name & Signature
Seema @ 8 AM
5/6/26

KOH-00308756 IP2-00056448
 Baby Of BALANNAGARI SOWMYA
 02-06-2026 0 Y 0 M 2 D (F)
 Dr. KADIRI BHANU VARUN KUMAR



THE HUMPTY DUMPTY SCALE

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					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1	1	1	1	
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1	1	1	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	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			11	11	11	11	

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 :		Sandy		Poofy		
Signature :		S	S	S	S	
Date :		5/6/26	5/6	5/6	5/6/26	
Time :		2:20	2:00	2:00	2:00	

