

HNH-00016046 IP26-00006609
 Baby Of PAMMI UJWALA
 19-06-2026 0 Y 0 M 2 D
 Dr. SPANDANA PASUPULETI (M)



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
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21	Anaesthesia notes (Pre Anaesthesia & post)				
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29	TPR & BP chart	1			
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ADMISSION SHEET

Registration Details :



Admission No : IP26-00006609 Admit Date : 19-Jun-2026 Admit Time : 10:29 AM UHID : HNH-00016046

Patient Details :

Patient Name : Baby Of PAMMI UJWALA Age : 0 D
Guardian : Mr NAGA PRASAD DOB : 19-06-2026 10:01 AM
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : RTC X Road Hyderabad Telangana INDIA Phone No : 6304330037/
500020 E-mail : PRASORE3@gmail.com

Admission Details :

Bed Type : BASINET Bed No : CRDL-HNPDA-415-1 Ward Name : 4F -OT
Room No : CRDL-HNPDA-415-1 Admission Type : First Visit

Contact Details :

Name : Mr NAGA PRASAD Relationship : Father
Contact Address : RTC X Road Hyderabad Telangana INDIA Phone No : 6304330037
500020


Signature

Doctor Details :

Doctor Name : Dr. SPANDANA PASUPULETI Specialisation : NEONATOLOGY
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

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

FC

DISCHARGE SUMMARY

Name	Baby Of PAMMI UJWALA	UHID	HNH-00016046
Father/Guardian	Mr NAGA PRASAD	Age/Gender	0 Y 0 M 3 D/ Male
Address	RTC X Road, Hyderabad, Telangana, INDIA, 500020		
IP No	IP26-00006609	Admission Date	19-06-2026
Ref Doctor	Self.		
Discharge Date	22.06.2026		

Consultant:

Dr. SPANDANA PASUPULETI
MBBS, MRCPCH
30925

DIAGNOSIS	ICD CODE
TERM (37 weeks)/LGA/INFANT OF DIABETIC MOTHER/NEONATAL HYPERBILIRUBINEMIA/BABY BOY	

History: Baby Of PAMMI UJWALA is a term (37 weeks) baby boy, delivered to a G2P1L1 mother by elective LSCS on 19.06.2026 at 10:01 am with birth weight of 4.18 kgs in Rainbow Children's Hospital, Himayatnagar, Hyderabad. Baby cried immediately after birth. Apgar scores were 8 /10 at 1 min, 9/10 at 5 min. Inj. Vitamin K 1mg IM was given after delivery. Delayed cord clamping done . Fetal presentation was Vertex.

Maternal History: Mrs. PAMMI UJWALA is a 34 years old G2P1L1 mother. G1 - 2023, FT LSCS (ind:- GDM on insulin), Boy, 3kg: A&H

Name	Baby Of PAMMI UJWALA	UHID	HNH-00016046
IP No	IP26-00006609	Admission Date	19-06-2026

G2 - Present pregnancy, Spontaneous conception, had regular Antenatal checkups, received 2 doses of Injection. Tetanus Toxoid. Antenatal scans were normal. No history of Pregnancy Induced hypertension/ Urinary Tract Infection/ Antepartum Haemorrhage/ Hypothyroidism/ Gestational Diabetes Mellitus/ Oligohydramnios/ Polyhydramnios/ Prolonged Rupture Of Membranes/ Fever.

Mother's Blood group is O positive. Baby's blood group is O positive.

Examination: Baby was eutermic (36.5°F), euvolemic and was maintaining saturations at room air. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Bilateral femoral pulses well felt. Abdomen was soft with no organomegaly. Cry and activity were good. Anterior fontanelle was at level. No obvious external congenital anomalies were noted clinically. All external orifices were patent and open. All neonatal reflexes were normal.

Anthropometry:

Weight at birth : 4.18 kgs.
Weight at discharge : 3.96 kgs.
Head Circumference : 40 cms.
Length : 49 cms.

Investigations: Enclosed reports.

2d Echo done report was pending.

Management:

Course during hospital:

In view of gestational diabetes mellitus on oral hypoglycemic, baby's blood

Name	Baby Of PAMMI UJWALA	UHID	HNH-00016046
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sugar levels were serially monitored which remained stable.

Unconjugated Hyperbilirubinemia: Baby was noted to have yellowish discoloration of skin on day 2 of life. Serum bilirubin at 48 hours of life was 12.7 mg/dl with indirect fraction of 12.6 mg/dl. Baby was started on double surface phototherapy and continued on direct breast feeds + measured feeds. Repeat serum bilirubin at 3 days of life was 11.3 mg/dl with indirect fraction of 11.2 mg/dl. This doesn't fall in phototherapy range. Hence phototherapy was stopped.

Feeding: Breast feeding was initiated (First feed was given within 30 minutes), but in view of insufficient mother milk and Large for gestational age, measured feeds were started. Baby tolerated the feeds well.

Vaccination: Baby was given following vaccination:

Vaccine Name	Status	Date
BCG	Given	20.06.2026
OPV	Given	20.06.2026
HEPATITIS B	Given	20.06.2026

TEOAE (Transient Evoked Otoacoustic Emissions): Hearing test: Done on 22.06.2026 showed Bilateral normal outer hair cells functioning.

Newborn screening advanced / Newborn screening-4 : Sent on 21.06.2026, report awaited.

SPO2 : 99% at room air

Name	Baby Of PAMMI UJWALA	UHID	HHH-00016046
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**Red Reflex: Present & Symmetrical
Hip Examination was normal.**

Baby tolerating feeds well, hemodynamically stable, passed urine and meconium, hence being discharged with the following advice.

Condition at discharge: Baby is pink, warm, active and on direct breast feeds + measured feeds.

Advice:

Keep the baby clean & warm

Regular breast feeding

Continue direct breast feeds + measured feeds as advised.

Monitor urine output

Immunization as per schedule

Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice (after 5 days of life).

Nasoclear Nasal drops 2 drops in each nostril SOS for nose block.

Plan:

- 1. Newborn screening advanced / Newborn screening-4 report to be collected on followup.**
- 2. Serum Bilirubin to be done on followup.**
- 3. Follow up with 2 D Echo report**

Review consultation with Dr. SPANDANA PASUPULETI on Wednesday (24.06.2026) at Himayatnagar with prior appointment (**Review consultation will be charged**).

Review back to Hospital: If baby is not feeding continuously for > 6 hours, If

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breathing fast, Fever or poor activity or lethargy, Bluish discolouration of lips, Increase in jaundice, Abnormal movements occurs.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor in a language that I can understand and I acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Himayatnagar / Banjara Hills / Rainbow Clinic Madhapur / Kukatpally / Vikrampuri / LB Nagar** dial just one toll free number **18002122**.

You can also take appointments at any time by going **online** to our website **www.rainbowhospitals.in**

Aachya
Registrar/Resident/C.M.O

Dr. SPANDANA PASUPULETI
MBBS, MRCPCH
30925

CONSENT FOR FORMULA FEEDS



Patient Name : HNH-00016046 IP26-00006609 Age : Gender : Male Female
Baby Of PAMMI UJWALA

UHD No : 19-06-2026 0 Y 0 M 0 D 2 H (M) Department : Date :
Dr. SPANDANA PASUPULETI



I Mr / Mrs. : aged years, hereby declare that I have

admitted my son / daughter in the Neonatal Intensive Care Unit of Rainbow Children's Hospital, Hyderabad on

..... I hereby give consent for formula feed for my child. Doctors have explained me

about the formula feeding benefits, risks, alternatives in the language I best understand.

Patient Attendant :

Signature : 

Name : P. Nageswara Prasad

Relationship with Patient: Father

Date & Time : 19/06/26 @ 12:00 PM

Witness :

Signature : 

Name : Madhu

Date & Time : 19/6/26 @ 12:00 PM

Doctor (who is taking the consent) :

Signature : 

Name : Anu

Date & Time : 19/6/26 10:30 AM



డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. లిజిస్ట్రేషన్ నెం.: విభాగము

తేదీ

నేను శ్రీ/శ్రీమతి వయస్సు సంవత్సరాలు

నా కుమార్తె/కుమారుడు రెయిన్ఫో ఆసుపత్రిలో నవజాత శిశువుల ఇంటెన్సివ్ కేర్ లో అడ్మిట్ చేసినాము మరియు (ఫార్ములా ఫీడ్) డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుచున్నాను. డాక్టర్లు డబ్బా పాలు త్రాగించడం వల్ల కలుగు

ఉపయోగాలు, ప్రత్యామ్నాయాలు, మరియు నష్టాలు గురించి నాకు అర్థమైన భాషలో వివరించారు.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : B Pammi Ujwala Age 34 yrs Father's Name : Naga Prasad Age :
 Date of Birth : Date of Admission : 19/06/2026 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 : <u>B/o Pammi Ujwala</u> Gender : <input checked="" type="checkbox"/> M <input type="checkbox"/> F Blood Group : <u>O positive</u> Date of Birth : <u>19/06/2026</u> Time of Birth : <u>10:01 AM</u> Place of Birth :	Mother's Blood Group : Birth Weight (gms) : <u>4180 gms</u> Length (cms) : <u>49 cm</u> OFC (cms) : <u>40 cm</u> Estimated Gesth Age : <u>37 wks</u>
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Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 34 yrs Ht : Wt : BMI : Married Life : LMP : 15/9/25 EDD : 22/6/26
 Conception : Spontaneous or with Rx :
 Booked at what GA : AN Steroids Drugs / Doses :
 Last Scans Details : AFI (13.7 cms), AC (96%), Dopplers (N)
 TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs Consanguinity : <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 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 / Redistrbution in MCA) / Ductus Venosus : AFI :	<u>H/o GDM</u> pre GDM/ on diet or insulin <u>on OHA</u> 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 (<input type="checkbox"/> Malaria <input type="checkbox"/> UTI <input type="checkbox"/> TORCH <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> HBV) UTI : when : Any culture :
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PPROM : Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

G: 2 P: 1 A: 0 L: 1

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
<u>G1</u>	<u>3 yrs</u>	<u>FT</u>	<u>3 kgs</u>	<u>MCU</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 type="checkbox"/> Emergency Indication :</p> <p>Specify the reason :</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>Resuscitaion : <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 : FT Weeks : 37 wks

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

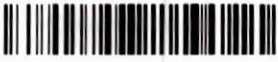
	1 Minute	5 Minutes	10 Minutes
TOTAL	<u>8/10</u>	<u>9/10</u>	

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

Comments :
Acyanosis.

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :
G2P1L1 with 37wk POG with GDM on OHA
with previous CSU came for safe confinement



Baby delivered via SC case.



CIAB.



warm/dry / suction done



cord care given

vit K Given



shifted to moth side.

Investigation details in previous Hospital :

Feeding History :



[Empty box for patient information]

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :
Asymptotic

VITALS : Temperature : *36.5* HR : *156/min* RR : NIBP : CFT : *<3sec*
Color of the extremities : *Asymptotic*
Jaundice : Pallor : SpO2 : *97% RA*

Anthropometry : Birth Weight : *4.180kg* Length : HC : Present Weight :
Ponderal Index : AGA : SGA : LGA



HEAD TO TOE EXAMINATION

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

Facies :
(Any Facial Dysmorphism) (n)

NECK and CLAVICLES : Range of Motion : (n)
Asymmetry :
Masses :

EYES : Symmetry :
Red Reflex : to check
Discharge :

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

THORAX and BREASTS : Shape of Thorax : (n)
Position of Nipples and Number :

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

GENITALIA : Labia / Hymen :
Testicles/penis : B/c testis descended.
Anus :

HERNIAL ORIFICES (n)

TRUNK and SPINE : (n)

SKIN LESIONS : (n)

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



SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gaspings

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 : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : BP : Precordial Activity :

Femoral Pulses : Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hemia orifice :

Palpation : Anal Patency :

Palpable masses : Umbilical Cord :

Abdominal girth : First urine passed :

Meconium passed :

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

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Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

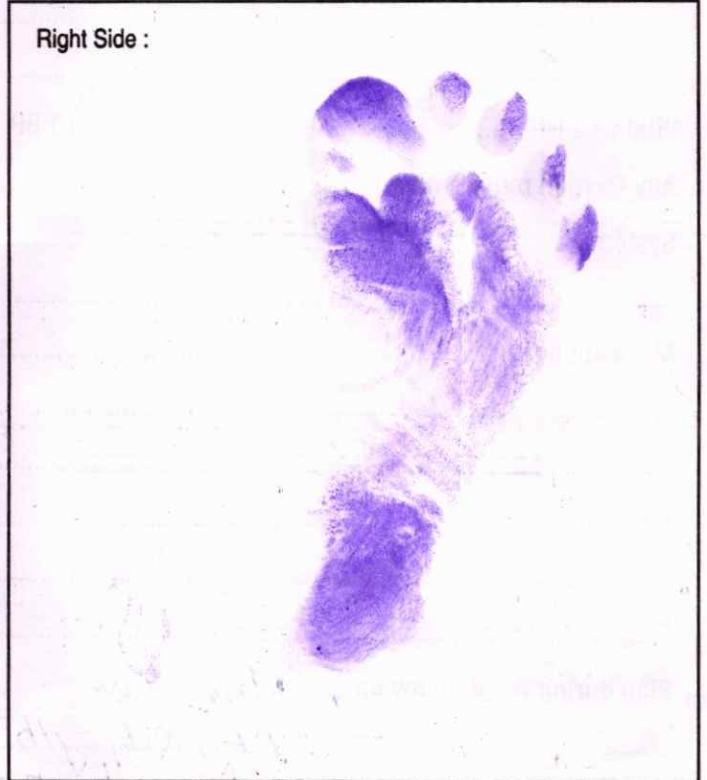
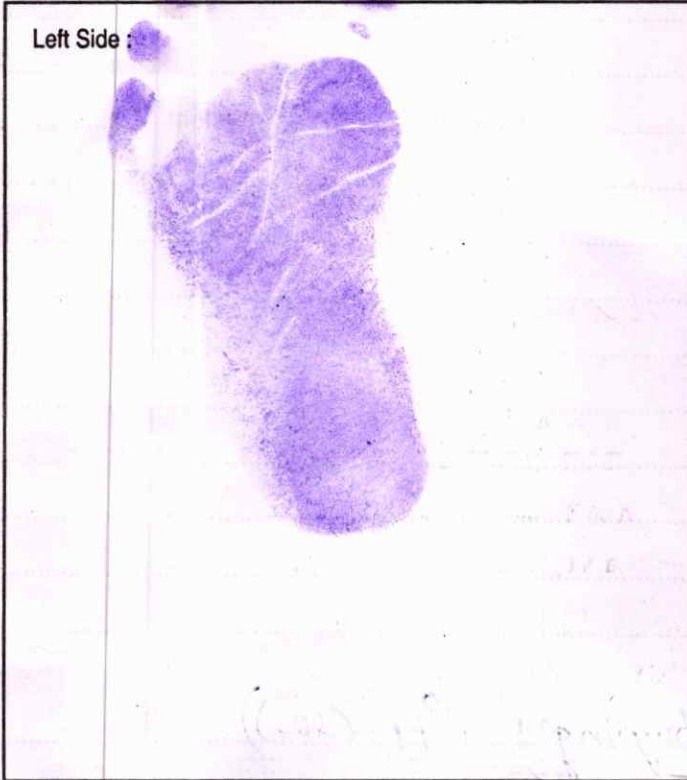
Moro's : DTR :

ATNR : Skull and Spine :



Diagnosis : Term / Male / 4.180kg / LGA / Infant of GDM mother

FOOT PRINTS



Resident Doctor :
Signature : [Signature]
Name : Anushe
Date & Time : 19/6/26 10:30 AM

Consultant :
Signature :
Name :
Date & Time :

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :
2. Name of te 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 :

Present Issues :

Vital : HR : RR : BP : SPO2 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :-
- Alarm can
- D.B.F. only jlb buying (FF (SOS))
- Send cord BGT
- vaccination BCG, OPV, Hep B
- SRBS Monitoring 2h, 4h, 6h, 8h, 12h, 16h, 20h
- @ 98HOL SRBS, NBS, OAE - 36h, 48h, 72h
- Hyform SOL.

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

*feeding time
10:35 to 10:45 AM*



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/6/26	c/i by Dr. Spandana	
5:45 pm	Term / LGA / GDM mother / 4.18 kg	
	Baby Euthic Pink	
	c/i/A Good.	- vaccinated 7 limb spo.
	vital stable.	- GRBS Monitoring
		- DBF + FF only jlb bumping
		- Monitor vital
	P.G	- Plan 2D Echo @ USHOL
		- Sample e usHOL
		Noted by Dr. SPM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/06/26	C/S/G. Dr. Subantha/ D. Narayana	
8 AM	Term/ Male/ LGA/ GDM mother	
	Baby Euthemic	TB. wts 4.180 kg
	Accepting feeds	T. wts 4.120 kg
	(DISE + FE)	(↓ 60 gm)
	Cry / Tone / Activity - good	
	Vitals stable	
	S/G. NAD	
		<p><u>Act</u></p> <ul style="list-style-type: none"> - DISE + FE f/b feeding 2nd hourly - 20 Gcho @ 48HOL - Sample @ 48HOL - Vaccination to be done ↳ ARBS monitoring - Monitor vitals and
		<p>Inform Sr</p> <p>Noted by Divya</p> <p>20/6/26 Subantha</p>

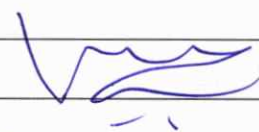


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/26	c/o by Dr Tejan	
<u>10 am</u>	O/E - Baby Euthenic	
	Taking feeds well	
	Intabs stable	Re
20/6/26	BCG OPV Hep-B given	→ Vaccination today.
		→ ARDS monitoring every 6 hours.
		→ DRF + FF every 2nd hly.
		Noted by Divya 20/6/26 @ 10am
		Dr Tejan



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/26	C/S/b dr. Varma / Dr. Baner.	
2:30 PM	D - Term / GAJ IDH / Male.	
	- Baby is active.	
	- cry font activity } <u>Good.</u>	
	Vitals stable.	Plan - Echo @ 48 Hrs. - SBM / NRS / OAE @ 48 Hrs.
	Vaccination done	- GRBS monitoring - - DBF + PP QM.
		- Monitor vitals.
		
		Noted by Madhvi @ 2:30 PM



PROGRESS NOTES AND DOCTOR'S ORDER

21/6/26
 8 AM

Date & Time	Progress Notes	Doctor's Order
	c/s/hy. Dr. Anushe	
	Term / CGA / Male / IDM moth.	
		<u>Plan</u>
	Twt 4.000	
	wt loss 3.3%	- Max 2DEcho
	Baby Euthic.	- Samples @ 10AM - SBL, NIBS, OAE
	<u>vital stable.</u>	- GRBS Monitg
	Euglycic	- DBF + FF only - flb keeping
	<u>slc</u>	- Monitor vit
	B/LAC (+)	
	R/S NIBS (+)	Noted by Anushe
	Ces ⁺ sim (+) No mm.	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/6/26. 9:45 AM	<p>c/s/hy. Dr. Tjauwi</p> <p>Term / LGA / Male / 10M moth.</p>	
	<p>Baby Lethic.</p> <p>Active</p> <p>Euglycic</p> <p>vital stable</p>	<p>2D Echo. Tm / today.</p> <p>Sample @ 10 AM (+)</p> <p>DBF + FF only</p> <p>flb burp.</p> <p>Monitor vital.</p>
		<p>Noted by Divya Dr. Tjauwi 21/6/26 @ 9:45 AM</p>
21/6 1 pm	<p>c/s/B Dr. Nazneen</p> <p>SBR - 12.7</p> <p>Baby Eutonic</p> <p>C } Good T } A }</p> <p>Vital Stable</p>	<p>Plan</p> <p>1) Start DSIT @ eyes & genital canal</p> <p>2) SBR - T/m</p> <p>3) 2D echo - T/m</p> <p>4) GT - DBF flb burping + FF</p> <p>Noted by Divya 21/6/26 @ 1 PM Brown (P.T.O)</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/06/2026 3:30 pm	s/s Dr. Nameer / Dr. Pranav Term (GA) male (10m) NNS	
	↓ DSPT. Lethargic, accepting feeds well. Maintaining GRBS	Plan ① ct DSPT @ eyes and genitalia covered ② ct DSPT every 2nd hly flb bumping ③ SBR 1hr ④ 2D Echo 1hr ⑤ Monitor vitals noted by Madhuri 21/6/25 @ 3:30 PM (Dr. Nameer)
22/6 7:30 AM	s/s Dr. Pranav / Dr. Nameer Term (GA) male (10m) NNS / 4.18kg (220g... birth) T. wt - 3.960 (↓ 80g :: yest) % wt loss - 5.2 % WT 4hr Lethargic; ↓ DSPT accepting feeds well. Maintaining sugars. Chest - clear urine ✓ stool ✓ umbilicus ✓	Plan ① ct DSPT + FF every 2nd hly flb bumping ② ct DSPT @ eyes and genitalia covered ③ SBR ^{Today} 1hr @ 10 am ④ 2D Echo 1hr ⑤ Monitor vitals Qn 4 noted by Sneha Prann



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6	C/S/B Dr. Tejaswi	
9:00 AM	T AGA male	IDM NUS 4.18 kg
	Athenic	Plan
	C/T/A - Good	DBI = + PR 2nd
	Vitals - stable	howls SBR @ 10:00M
		Plan discuse after
		SBR report
		2D echo today
		Noted by Divya 22/6/26
		Dr. Tejaswi

HNH-00016046 IP26-00006609
 Baby Of PAMMI UJWALA
 19-06-2026 0 Y 0 M 0 D 2 H (M)
 Dr. SPANDANA PASUPULETI



309

100%
 100%
 99%
 99%

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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	21/6/26				
Time					
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj	12.7	0.1	12.6		
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

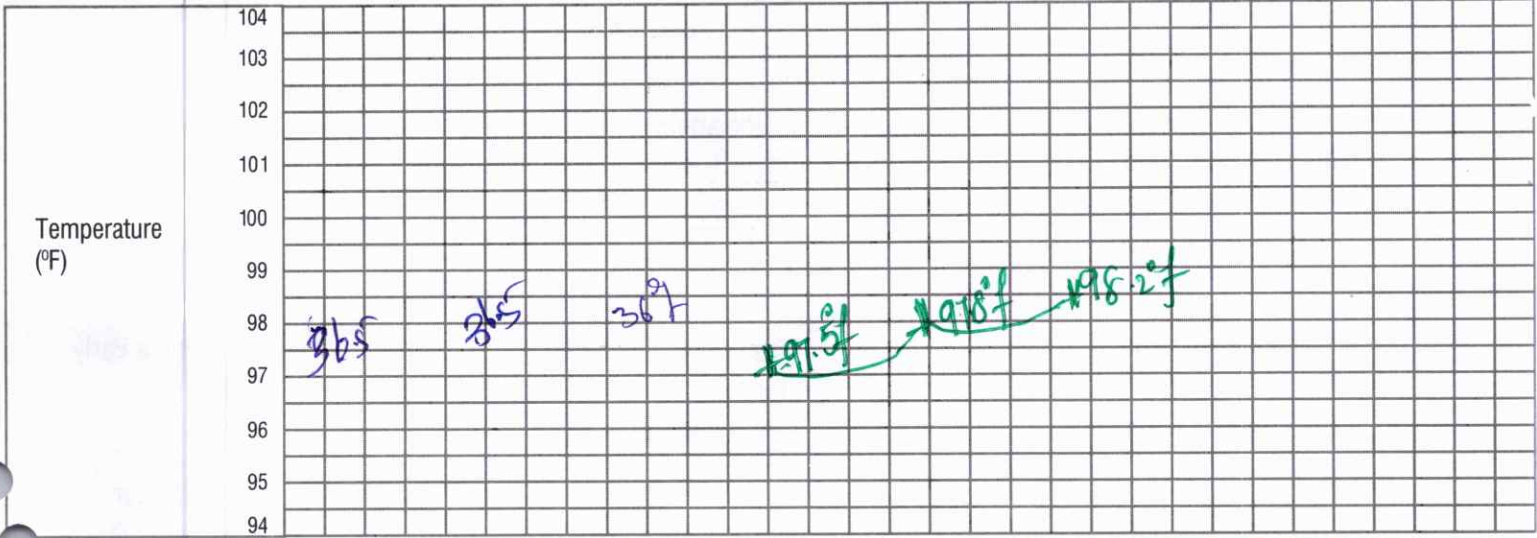
 Others (ECG, Contrast Studies etc.) :

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 16/6 Time: 10AM 2PM 6PM 10PM 2AM 6AM
 Doctor/Nurse/Family Concern?



Parameter	10AM	2PM	6PM	10PM	2AM	6AM
Heart Rate (bpm)	150	165	159	141b/min	142b/min	138b/min
Blood Pressure (mmHg) *			130	130	130	130

Note: BP does not score in early warning scoring

Parameter	10AM	2PM	6PM	10PM	2AM	6AM
Resp. Rate (bpm) (Over 1 Minute) *	42	42b/min	43b/min	40b/min	38b/min	41b/min

Resp Distress	Mod/ Severe	None / Mild				
Receiving O ₂ (l/min)	0.6l	0.6l	0.6l	0.6l	0.6l	0.6l
O ₂ Saturations (%)	96.7	99.1	99.1	99.1	100%	99.1
Conscious Level	Normal	Altered				
GCS *	5	5	5	5	5	5

Parameter	10AM	2PM	6PM	10PM	2AM	6AM
TOTAL SCORE	1	1	1	1	1	1
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	AS	AS	AS	AS	AS	AS

- 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

* 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

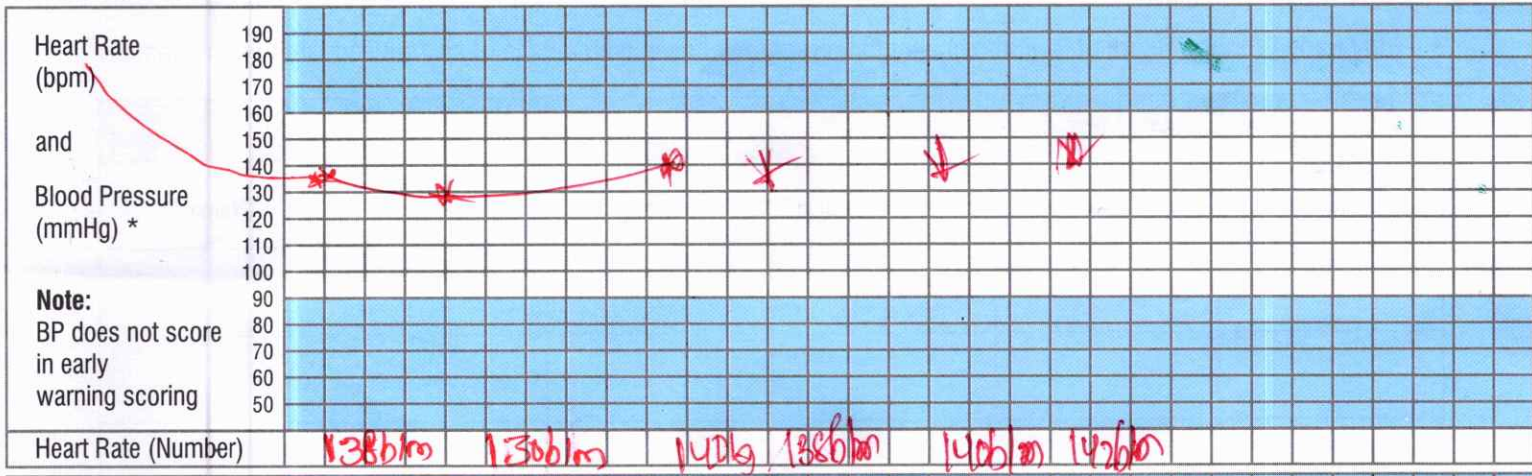
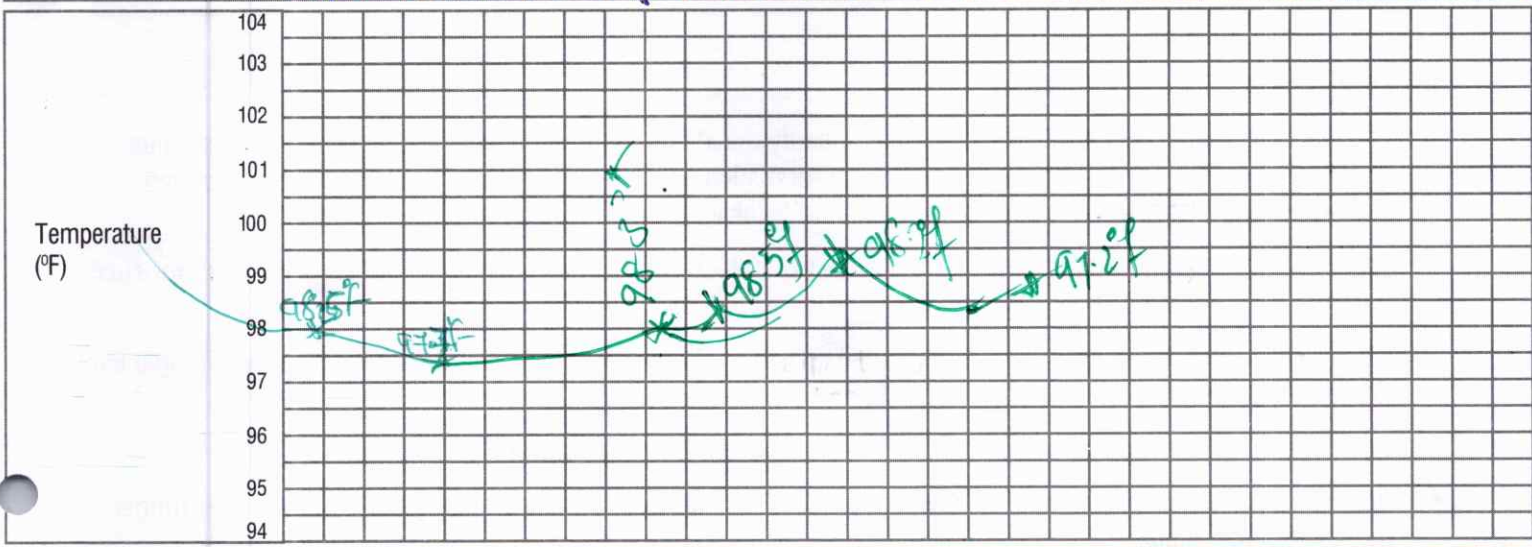
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I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted 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)



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/6/26 Time: 10 2 5 10 5 6 AM
 Doctor/Nurse/Family Concern? Am Pm Pm Pm Pm Pm



Heart Rate (Number)	138bpm	130bpm	140b	138bpm	140bpm	142bpm
Resp Rate (Number)	30bpm	30bpm	30bpm	32bpm	35bpm	35bpm
Resp Mod/ Severe Distress						
Receiving O ₂ (l/min)						
O ₂ Saturations (%)	100%	100%	100%	100%	100%	100%
Conscious Level						
GCS *						

TOTAL SCORE						
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	Am	Pm	Pm	Pm	Pm	Pm

ACTIONS

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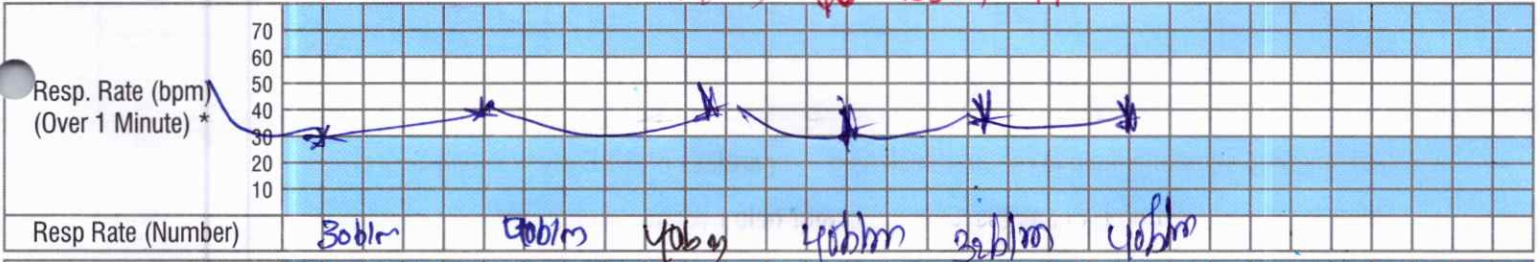
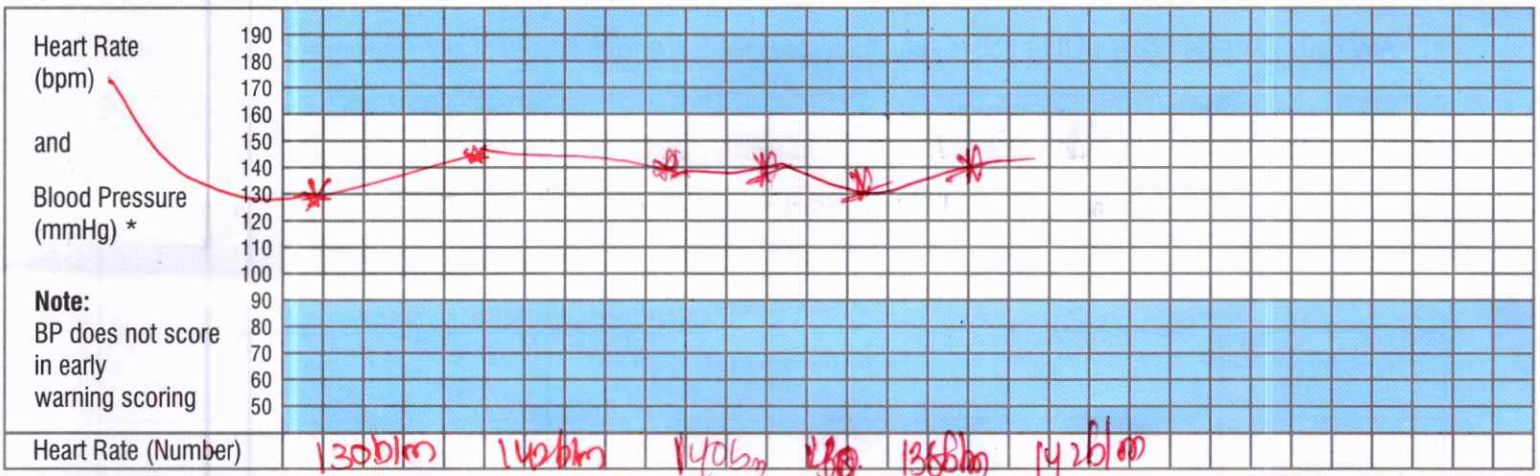
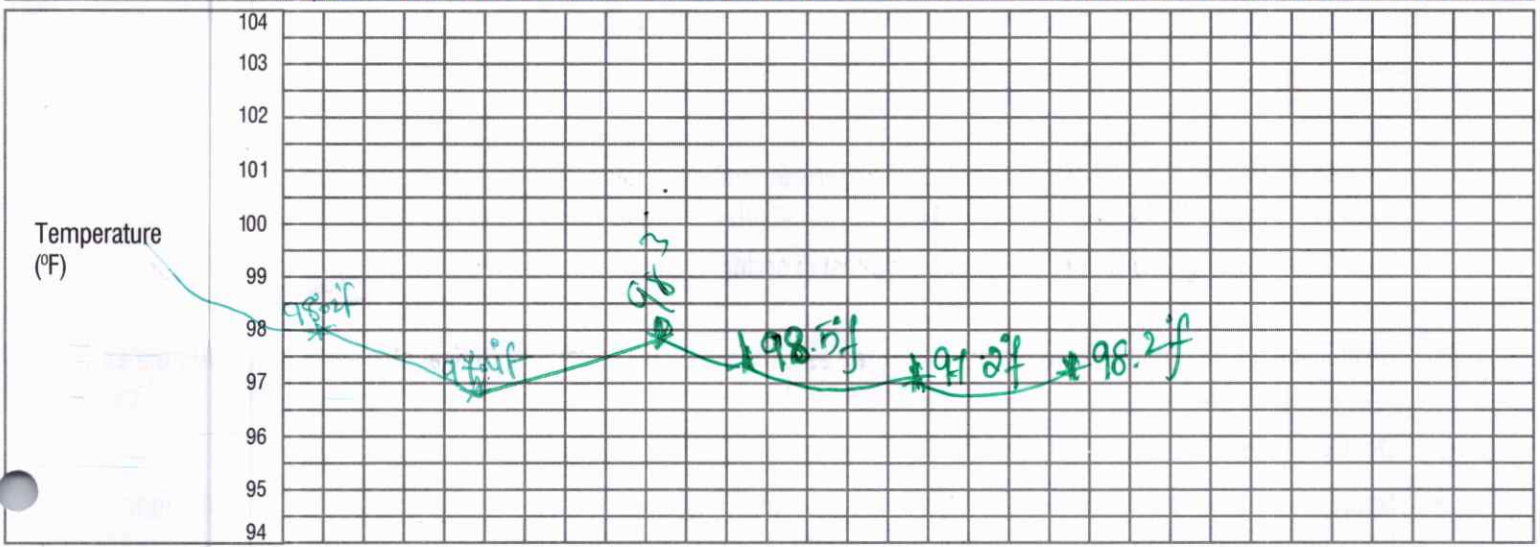
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 21/6/26	Time: 10	9	6 PM	10 PM	9 AM	6 AM
Doctor/Nurse/Family Concern?	Am	Pm	Pm	10 PM	9 AM	6 AM



Resp Distress	Mod/ Severe	None / Mild
Receiving O ₂ (l/min)	100%	
O ₂ Saturations (%)	100%	
Conscious Level	Normal	
GCS *		

TOTAL SCORE	
Number of shaded boxes	0
Pain Score	0
Observer's Initials	[Signature]

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.
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HNH-00016046 IP26-00006609
 Baby Of PAMMI UJWALA
 19-06-2026 0 Y 0 M 1 D (M)
 Dr. SPANDANA PASUPULETI



RCH / FRM / CLINICAL / 124

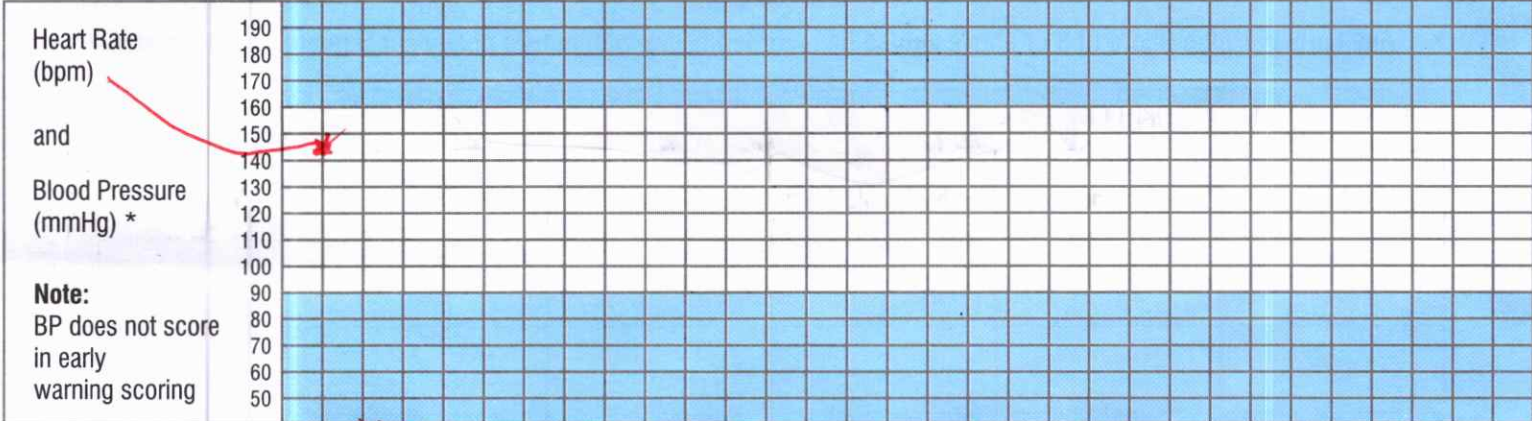
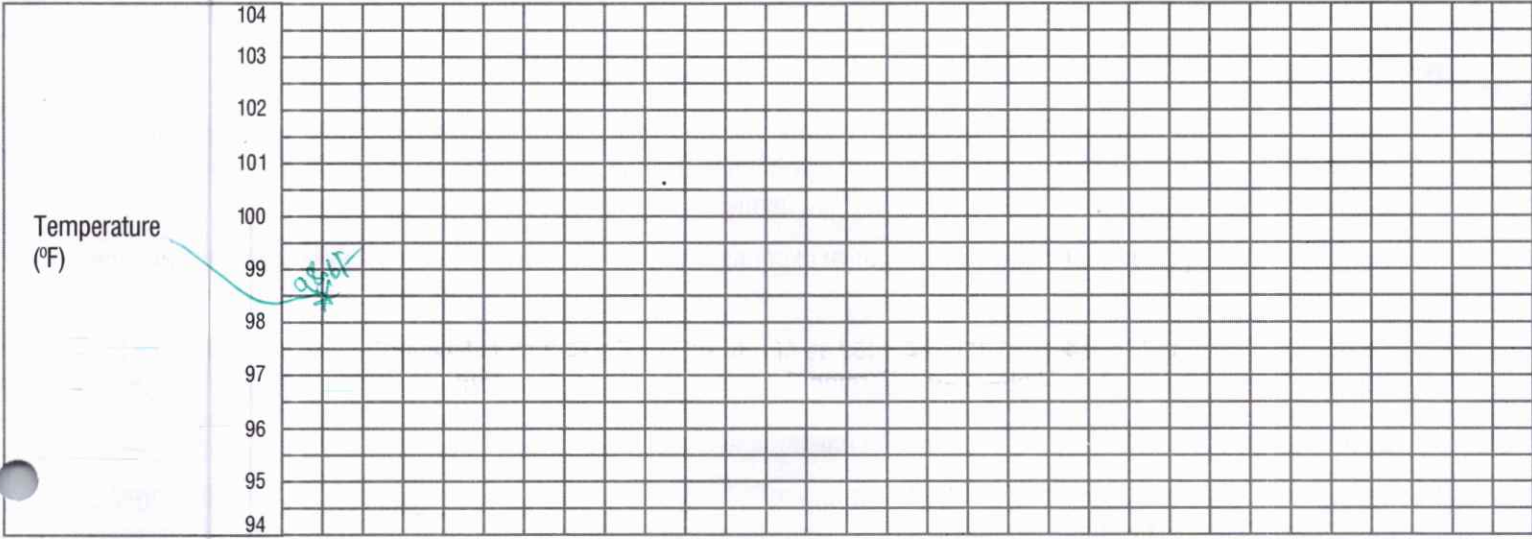
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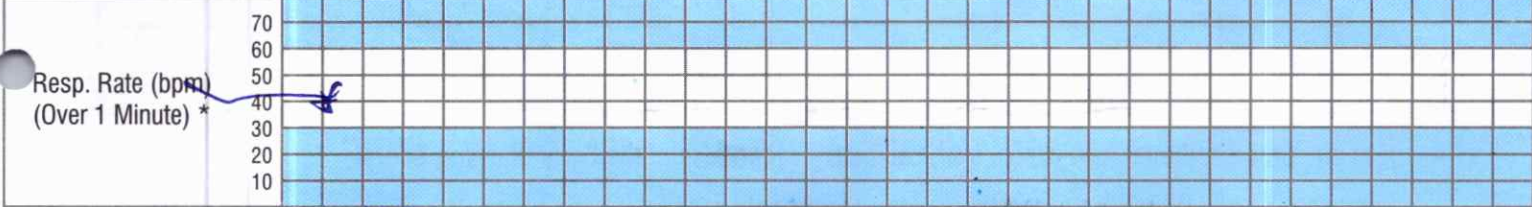
Date: 02/16/25 Time: 10

Doctor/Nurse/Family Concern? No



Note:
 BP does not score in early warning scoring

Heart Rate (Number) 140 bpm



Resp Rate (Number) 40 bpm

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 100%

Conscious Level Normal Altered

GCS *

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

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FLUID CHART

Sheet No. : 01

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

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
19/6/26			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am	DBF										
	11:00 am											
	12:00 pm	FF										
	01:00 pm											
Total Intake : Taken					Total Output : Not passed.							
19/6/26	02:00 pm											
	03:00 pm	DBF										
	04:00 pm	TH										
	05:00 pm											
	06:00 pm	DBF										
	07:00 pm	TH										
	Total Intake :					Total Output :						
19/6/26	08:00 pm											
	09:00 pm											
	10:00 pm	DBF										
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output : 0-2 m-0							
20/6/26	02:00 am											
	03:00 am	DBF										
	04:00 am											
	05:00 am	DBF										
	06:00 am											
	07:00 am											
Total Intake : Taken					Total Output : 0-2 m-2							

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. :

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

		Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
20/6/26	08:00 am											
	09:00 am	DBF										
	10:00 am	JFF										
	11:00 am	DBF										
	12:00 pm	JFF										
	01:00 pm	DBF+JFF										
Total Intake : <i>taken</i>					Total Output :							
20/6/26	02:00 pm	DBF+JFF										
	03:00 pm											
	04:00 pm	DBF+JFF										
	05:00 pm											
	06:00 pm	DBF+JFF										
	07:00 pm											
Total Intake :					Total Output :							
20/6/26	08:00 pm	DBF+JFF										
	09:00 pm											
	10:00 pm	DBF+JFF										
	11:00 pm											
	12:00 am											
	01:00 am	DBF+JFF										
Total Intake : <i>taken</i>					Total Output : <i>U-2 M. 2</i>							
21/6/26	02:00 am											
	03:00 am											
	04:00 am	DBF+JFF										
	05:00 am											
	06:00 am											
	07:00 am	DBF+JFF										
Total Intake : <i>taken</i>					Total Output : <i>U-2 M 2</i>							

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 Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
21/6/26	08:00 am												
	09:00 am		DBF				✓		✓				
	10:00 am	o	FF					NA		o			
	11:00 am							NA					
	12:00 pm		DBF				✓		✓				
	01:00 pm		FF										
Total Intake : taken						Total Output : U-2 M-2							
21/6/26	02:00 pm		DBF										
	03:00 pm		FF				✓		✓				
	04:00 pm	o						NA		o			
	05:00 pm		DBF					NA					
	06:00 pm		FF				✓		✓				
	07:00 pm												
Total Intake :						Total Output : U- M-							
21/6/26	08:00 pm												
	09:00 pm		DBF						✓				
	10:00 pm	o	FF					NA		o			
	11:00 pm							NA					
	12:00 am		DBF				✓		✓				
	01:00 am		FF										
Total Intake :						Total Output : U-2 M-2							
22/6/26	02:00 am												
	03:00 am		DBF				✓		✓				
	04:00 am	o	FF					NA		o			
	05:00 am							NA					
	06:00 am		DB				✓		✓				
	07:00 am												
Total Intake :						Total Output : U-2 M-2							

HNH-00016046
 Baby Of PAMMI UJWALA IP26-00006609
 19-06-2026 O Y O M 1 D
 Dr. SPANDANA PASUPULETI (M)



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
22/6/26	08:00 am											
	09:00 am											
	10:00 am	0	PBF JFA			NA		NA				
	11:00 am											
	12:00 pm		PBF JFA									
	01:00 pm											
Total Intake :						Total Output :						U-M
	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						

HNH-00016046 IP26-00006609
 Baby Of PAMMI UJWALA
 19-06-2026 0 Y 0 M 0 D 2 H (M)
 Dr. SPANDANA PASUPULETI



BRADEN 'Q' SCALE



Date : 19/6/2026
 Time : 8am

					19/6/2026 8am	20/6/2026 9am	20/6/2026 10am	20/6/2026 11am
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	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.	4	4	4	4
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."	4	4	4	4
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.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
TOTAL SCORE					23	23	23	23
Evaluator's Name					SP	SP	SP	SP

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

HNH-00016046 IP26-00006609
 Baby Of PAMMI UJWALA (M)
 19-06-2026 0 Y 0 M 1 D
 Dr. SPANDANA PASUPULETI

BRADEN 'Q' SCALE

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

					Date	20/6/20	20/6/20	21/6/20	21/6/20
					Time	2pm	10pm	M6	E2
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.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
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."		4	4	4	4
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.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	[Signature]	[Signature]	[Signature]	[Signature]

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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Less than 9	Severe Risk	<ul style="list-style-type: none"> • 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: 21/6/26 22/6/26
 Time: 11:30 AM MB

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.	4	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
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TOTAL SCORE					28	28		
Evaluator's Name					[Signature]			

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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Less than 9	Severe Risk	<ul style="list-style-type: none"> • 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



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	
						19/8	19/8	19/8	20/8	21/8	21/8	21/8	22/8	
						8:27 AM	8:27 AM	10:30 AM	11:00 AM	11:00 AM	11:00 AM	11:00 AM	11:00 AM	
						Procedure →								
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable	0	0	0	0	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	
<p>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</p> <p>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</p>														
	Gestational Age / Corrected Age	36 w	37 w	36 w	36 w	0	0	0	0	0	0	0	0	
	Total Pain / Agitation Score	-	-	-	-	-	-	-	-	-	-	-	-	-
	Intervention	-	-	-	-	-	-	-	-	-	-	-	-	-
	Effectiveness	-	-	-	-	-	-	-	-	-	-	-	-	-
Signature														

NPASS: Neonatal Pain, Agitation & Sedation Scale

	Sedation	Pain / Agitation
How to use	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Observe the infant for a minute before selecting a score for each behavior. Select only one numeric value per behavior.
Scoring/ Documentation	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Desired levels of sedation vary according to the situation. Discuss and determine sedation goal with provider. <ul style="list-style-type: none"> "Deep sedation": goal score of -10 to -5 <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> The premature infant's response to prolonged or persistent pain/stress Neurologic depression, sepsis, or other pathology 	<ul style="list-style-type: none"> Does not provide pain intensity rating. Any score greater than 3 indicates the possibility of the presence of pain in the infant <ul style="list-style-type: none"> 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.

HNH-00016046 IP26-00006609
 Baby Of PAMMI UJWALA
 19-06-2026 0 Y 0 M 0 D 2 H (M)
 Dr. SPANDANA PASUPULETI



NURSING CARE RECORD

Date: 19/6/2026

- 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	Nurse Name & Signature
Morning	8Am	→ Assess the patient condition	8Am	→ Assessed the patient condition	patient is stable	vital is normal	Candy
	10	→ plan for vital	10	→ maintain vital & record			
		→ plan for Biochart		→ maintain Biochart			
	2pm	→ plan for DBF	2pm	→ DBF 2nd hourly			
Afternoon	2pm	→ Assess the Baby condition		→ Assessed the Baby condition	pt is stable	Rechecked vitals	[Signature]
		→ Monitor vital & I/O chart		→ Monitored vital & I/O chart			
		→ DBF + H 2nd hourly give		→ DBF + H 2nd hourly give			
Night	8pm	→ Assess the Baby condition		→ Assessed the baby condition	→ Baby is stable	Rechecked vitals	[Signature]
	8pm	→ Monitor vital & record	8pm	→ Monitored vital & record			
	10	→ Maintain Biochart	10	→ maintained Biochart			
	8Am	→ DBF + H 2nd hourly	8Am	→ DBF + H 2nd hourly			
		→ Provide warm care		→ provided warm care.			

HNH-00016046 IP26-00006609
 Baby Of PAMMI UJWALA
 19-06-2026 0 Y 0 M 0 D 10 H (M)
 Dr. SPANDANA PASUPULETI



NURSING CARE RECORD



Date: 20/6/20

- 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	Nurse Name & Signature
Morning	8am	→ assess the baby condition → monitor vitals → maintain I/O chart → medication by DBF+ff 2nd hourly → warm care	8am	→ assessed the baby condition → monitored vitals & recorded → maintained I/O chart → DBF+ff 2nd hourly → CT GRBS monitoring	→ Baby is stable	→ rechecked vitals	[Signature]
	9pm	→ CT GRBS monitoring	9pm				
Afternoon	2pm to 8pm	→ Assess the Baby Condition → maintain I/O chart → DBF+ff 2nd hourly → warm care → CT GRBS monitor	2pm to 8pm	→ Assess the Baby Condition → maintained I/O chart → DBF+ff 2nd hourly → CT GRBS monitoring	Baby is stable	→ re-check the vitals	[Signature]
	8pm		8pm				
Night	8pm to 8am	→ assess the baby condition → monitor vitals & record → maintain I/O chart → DBF+ff 2nd hourly → CT GRBS monitor → provide warm care	8pm to 8am	→ assessed the baby condition → monitored vitals & recorded → maintained I/O chart → DBF+ff 2nd hourly → CT GRBS monitoring → provided warm	→ Baby is stable	→ rechecked vitals	[Signature]



NURSING CARE RECORD



Date: 21/6/26

- 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	Nurse Name & Signature
Morning	8am	→ Assess the baby condition	8am	→ Assessed the baby condition	→ Baby is stable → 2 Decho today → SBR, NBS, OAG today.	→ rechecked vitals	[Signature]
	2pm	→ monitor vitals → maintain Qlochart → DBF + ff 2nd hourly → warm cover	2pm	→ monitored vitals & recorded → maintained Qlochart → DBF + ff 2nd hourly → warm cover			
Afternoon	2pm	- Assess the baby condition	2pm	- Assess the baby condition	- Baby is stable	- Recheck the v/s	[Signature]
	8pm	- monitor the v/s - maintain the I/O - DBF + ff 2nd hourly	8pm	- monitor the v/s - maintain the I/O - DBF + ff 2nd hourly			
Night	8pm	→ Assess the baby condition	8pm	→ Assessed the baby condition	→ Baby is stable	⇒ Rechecked vitals	[Signature]
	8pm	→ Monitor vitals & record → Maintain Qlo chart → DBF + ff 2nd hourly	8pm	→ Monitored vitals & record → Maintained Qlochart → DBF + ff 2nd hourly			

HNH-00016046 IP26-00006609
 Baby Of PAMMI UJWALA
 19-06-2026 0 Y 0 M 1 D (M)
 Dr. SPANDANA PASUPULETI



NURSING CARE RECORD

Date: 22/6/26

- 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	Nurse Name & Signature
Morning	8am	<ul style="list-style-type: none"> → ASSESS the baby condition → monitored vitals & recorded → maintain glo chart → baby DBF + FF hourly 	8am	<ul style="list-style-type: none"> → assessed the baby condition → monitored vitals & recorded → maintained glo chart → Ct DSPT → baby DBF + FF 2nd hourly 	<ul style="list-style-type: none"> → baby is stable → baby on DSPT → (P) SBR → 2 Decho today. 	→ rechecked vitals	Rje
Afternoon	2pm	<ul style="list-style-type: none"> → Ct DSPT → 2 Decho today 	2pm	<ul style="list-style-type: none"> → Ct DSPT → 2 Decho today 			
Night							



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis: <i>new born baby</i>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:						
	BACKGROUND	Area	19/6/26 <i>8am</i>	19/6/26 <i>2pm</i>	19/6/26 <i>8am</i>	20/6/26 <i>N/B</i>	20/6/26 <i>8am</i>	20/6/26 <i>N</i>
	Shift Time							
	Medical Condition (Any special condition to be noted):	-	-	-	-	-	-	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	<i>36.5</i>	<i>36.1</i>	<i>36.5</i>	<i>36.4</i>	<i>36.3</i>	<i>36.3</i>
		Res:	<i>42</i>	<i>40</i>	<i>42</i>	<i>40</i>	<i>42</i>	<i>40</i>
		SpO ₂ :	<i>97</i>	<i>98.1</i>	<i>99.1</i>	<i>100%</i>	<i>100%</i>	<i>100%</i>
		Pulse:	<i>156</i>	<i>149</i>	<i>138</i>	<i>140</i>	<i>140</i>	<i>138</i>
		BP:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>
	Fall Risk Score:	<i>0/10</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
Pain Score:	<i>0</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>		
Recommendations	Safety Needs:	<i>yes</i>	<i>yes</i>	<i>yes</i>	<i>yes</i>	<i>yes</i>	<i>yes</i>	
	Physiotherapy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Others Specify:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	Special Diet:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Other Special Orders / Medications:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	Post Operative Procedure Special Orders:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	Handed Over By Name :	<i>Alex</i>	<i>Amrta</i>	<i>Divya</i>	<i>Divya</i>	<i>Madhe</i>	<i>Divya</i>	
	Signature :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
	Date:	<i>19/6/26</i>	<i>19/6/26</i>	<i>20/6/26</i>	<i>20/6/26</i>	<i>20/6/26</i>	<i>20/6/26</i>	
	Time:	<i>2pm</i>	<i>8pm</i>	<i>8AM</i>	<i>2pm</i>	<i>8pm</i>	<i>8AM</i>	
	Taken Over By Name :	<i>Amrta</i>	<i>Divya</i>	<i>Divya</i>	<i>Madhe</i>	<i>Divya</i>	<i>Divya</i>	
	Signature :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
	Date:	<i>19/6/26</i>	<i>19/6/26</i>	<i>20/6/26</i>	<i>20/6/26</i>	<i>20/6/26</i>	<i>21/6/26</i>	
	Time:	<i>8pm</i>	<i>8pm</i>	<i>8AM</i>	<i>8pm</i>	<i>8pm</i>	<i>8AM</i>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis: NB	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
BACKGROUND	Area	21/6/26 N6	21/6/26 E2	21/6/26 N1	22/6/26 N6			
	Shift Time							
	Medical Condition (Any special condition to be noted):		—	—	—			
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	98.2F	98.3F	98.5F	97.2F		
		Res:	20b/m	22b/m	22b/m	20b/m		
		SpO ₂ :	99%	99%	99%	100%		
		Pulse:	130b/m	132b/m	138b/m	140b/m		
		BP:	—	—	—	—		
Fall Risk Score:	—	40%	—	—				
Pain Score:	—	40%	—	—				
Recommendations	Safety Needs:	—	yes	yes	yes			
	Physiotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Others Specify:	—	—	—	—			
	Special Diet:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Other Special Orders / Medications:	na	NA	NA	NA			
Post Operative Procedure Special Orders:				—	—			
Handed Over By Name :		Divya	madhavi	Shwetha	Divya			
Signature :								
Date:		21/6/26	21/6/26	21/6/26	22/6/26			
Time:		2pm	8pm	8am	2pm			
Taken Over By Name :		madhavi	Shwetha	Divya				
Signature :								
Date:		21/6/26	21/6/26	22/6/26				
Time:		2pm	8pm	8am				

PATIENT STICKER
 HNH-00016046 IP26-00006609
 Baby Of PAMMI UJWALA
 19-06-2026 0 Y 0 M 0 D 2 H (M)
 Dr. SPANDANA PASUPULETI

DATE: AP



NEWBORN ANOMOLY ASSESSMENT CHECKLIST

S.NO	ASSESSMENT PARAMETERS	CHECKED BY REGISTRAR	CHECKED BY CONSULTANT	REMARKS
1.	Palate	No cleft palate / lip	Noemal	
2	Pre natal teeth	No.	No	
3	Anal opening	Patent (meconium not stained)	Present	
4	Genitalia	B/L testis descended	B/L testis descended	
5	Spine	(N)	(N)	
6	Red reflex		(N)	
7	4 limb saturation (before discharge)	J to check.		


AP

Ped.Registrar signature

Dr. Tejan

Ped.Consultant signature

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00016046 IP26-00006609 Baby Of PAMMI UJWALA 19-06-2026 0 Y 0 M 0 D 2 H (M) Dr. SPANDANA PASUPULETI 		Date & Time of Admission 19/6/26 @ 3:30 PM	Date & Time of Transfer Order 19/6/26 @ 3:30 PM
		Transfer Ordered by Dr. Spandana	Reason for Transfer
From Unit pre-part	To Unit 309.	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 5	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Mounika		Name of Person Ordered Transfer Dr. Spandana	
Patient & Clinical Records Received by : Machhat 19/6/26 @ 3:30 PM			
Date & Time of Patient Received :			

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

- Unavailable Bed Nurse not Available Available Bed not ready



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

(Select and 'tick mark' [✓] the boxes as applicable)

Baby's Name: Mother's Name:

Date of Birth: 19/6/26 Time of Birth: 10:01 AM Gender: Male Female

Birth Weight: Kgs HC: 40 cm Length: 49 cm

Meconium in Liquor: Yes No Cried at Birth: Yes No

Term / Pre-term / Post-term:

Resuscitated: Yes No Blood Group: Mother: Baby:

Feeding: Breast Feeding Formula Both First Feed Time: 10:48 AM

AFFIX MOTHER'S IDENTIFICATION LABEL

Mode of Delivery: Normal LSCS - Emergency/ Elective Instrumental AVD

Indication:

Physical Assessment of New Born:

Temp: 36.5 °C HR: 156 /Min RR: /Min BP: SpO₂: 97 .

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: Yes No Score: 0 (Fill the Humpty Dumpty Sheet)

Risk in Pressure Sore: Yes No (Braden Q Score) (Fill the Braden Q Sheet)

Behaviour Status on admission: Sleeping Crying Calm Drowsy

Findings:

General Appearance: Posture: Well-Flexed Asymmetry

Skin: Pink Meconium Stain Others, Specify:

Nursing Management: (Please strike through If not applicable e.g. Yes / ~~No~~)

Vitamin K 1 mg I.M Administered: Yes / No

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

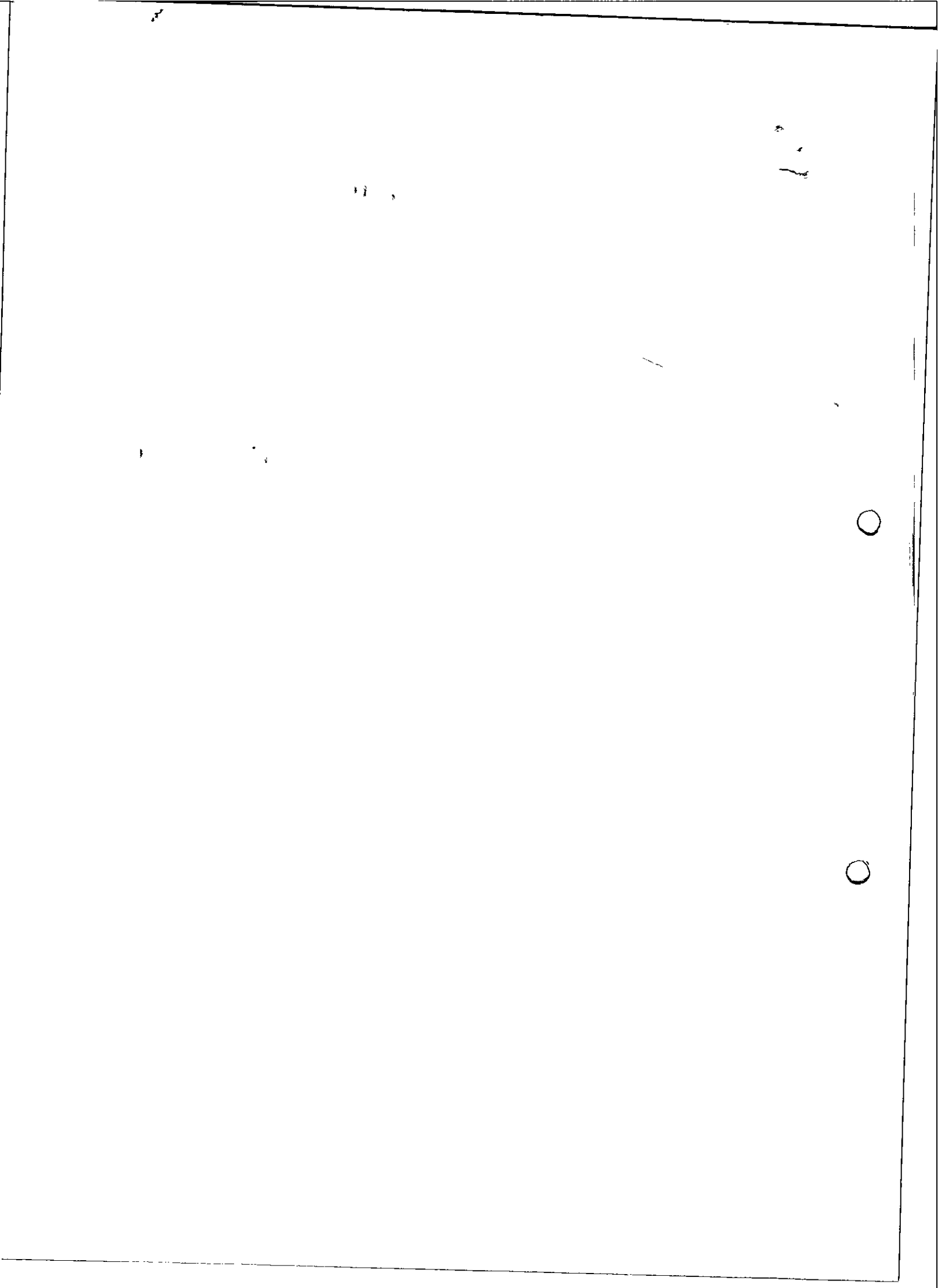
All information obtained from Mother Father Other Family Member

Newborn Screening Discussed: Yes / No

Nurse Name: Alex

Signature: Alex

Date & Time: 19/6/26



GENERAL CONSENT FOR TREATMENT

Patient Name: Baby Of PAMMI UJWALA Age : 0 Y 0 M 0 D 0 H
IP No: IP26-00006609 Sex: Male
Consultant: Dr. SPANDANA PASUPULETI Ward/Bed No: 4F -OT/CRDL-HNPDA-415-1

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:

1 We do not allow use of medication brought from outside by the patient.

2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.

(Receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.

4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name:

P. Naga Prasad

Relationship:

Father

Date:

19/06/2026

Time:

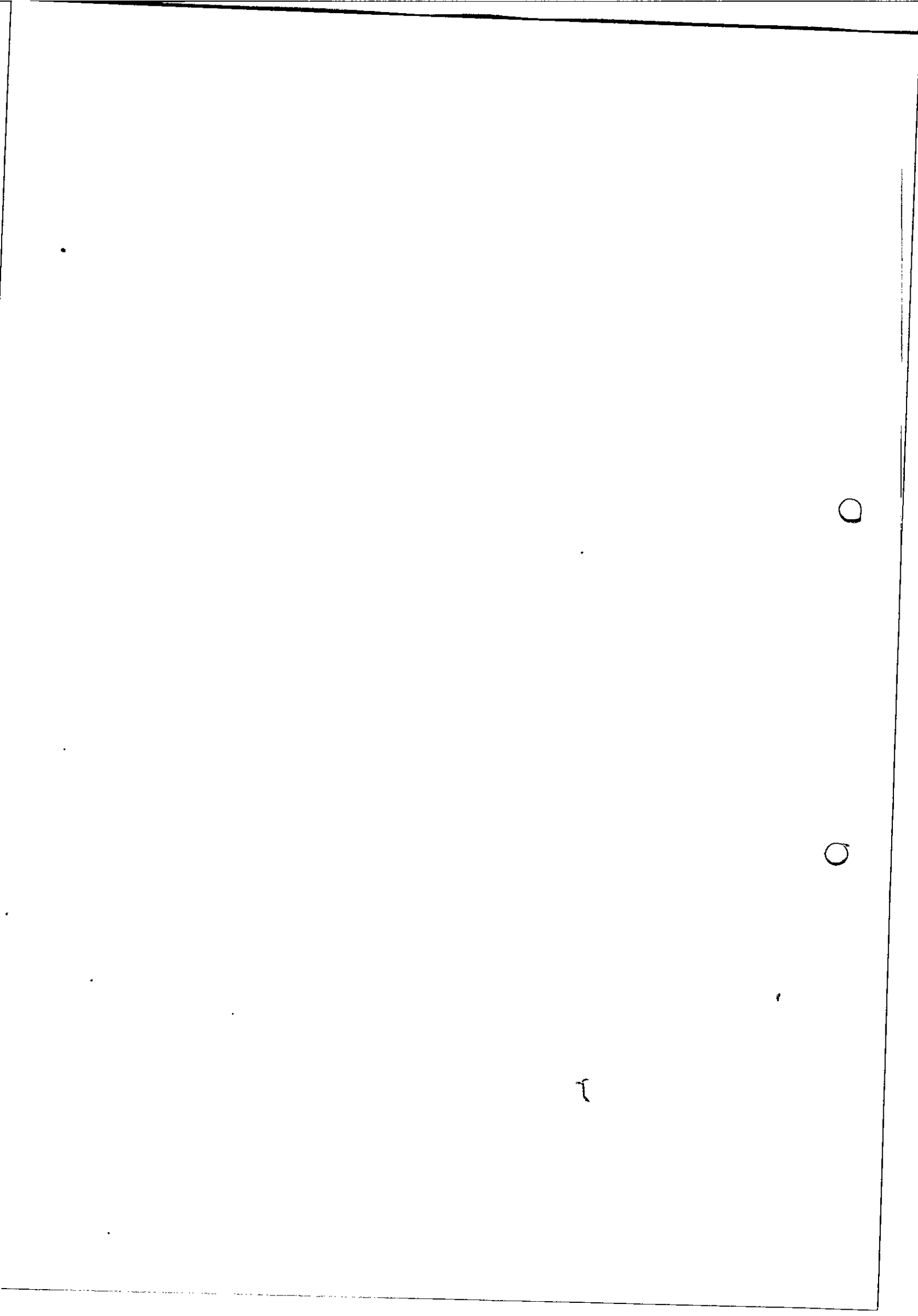
10:36

Witness Name:

Witness Signature:

Patient Address:

RTC X Road Hyderabad Telangana
INDIA 500020



HNH-00018046 IP26-00006609
Baby Of PAMMI UJWALA
19-06-2026 0 Y 0 M 0 D 0 H (M)
Dr. SPANDANA PASUPULETI



BILLING POLICY

- **Billing cycle:** - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpain the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.

Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.

Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR
- T: 6464 2020 | KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80
7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

