

DISCHARGE SUMMARY

Name	Baby Of RUCHI LAHOTI	UHID	HNH-00015883
Father/Guardian	Mr AKSHAY MUNDADA	Age/Gender	0 Y 0 M 0 D 11 H/ Male
Address	PRAGATHI RESIDENCY, East Maredpalli, Hyderabad, Telangana, INDIA, 500026		
IP No	IP26-00006543	Admission Date	08-06-2026
Ref Doctor	SELF		
Discharge Date	10.06.2026		

Consultant:
Dr. DILNAAZ FAROOQUI
MBBS DNB
56763

DIAGNOSIS	ICD CODE
TERM (37 weeks + 4 days)/AGA/BABY BOY	

History: Baby Of RUCHI LAHOTI is a term (37 weeks + 4 days) baby boy, delivered to a primi mother by emergency lscs on 08.06.2026 at 09:40 pm with birth weight of 2.82 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.

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Maternal History: Mrs. RUCHI LAHOTI is a 28 years old primi mother.

G1 - Present pregnancy, spontaneous conception, had regular Antenatal checkup's, 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 euthermic (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 : 2.82 kgs.
 Weight at discharge : 2.720 kgs.
 Head Circumference : 35 cms.
 Length : 47 cms.

Investigations: Enclosed reports.

Management:

Course during hospital:

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Serum bilirubin was sent report was awaited.

Feeding: Breast feeding was initiated (First feed was given within 30 minutes), measured feeds were started. Baby tolerated the feeds well.

Vaccination: Baby was given following vaccination:

Vaccine Name	Status	Date
BCG	Given	09.06.2026
OPV	Given	09.06.2026
HEPATITIS B	Given	09.06.2026

TEOAE (Transient Evoked Otoacoustic Emissions): Hearing test: Not done , advised at follow up

Newborn screening advanced / Newborn sreening-4 : Not done, advised at follow up

SPO2 : 98 % at room air

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.

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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/ Thyroid function test to be done on followup.**
2. **Hearing test (TEOAE-Transient Evoked Otoacoustic Emissions) to be done on followup.**
3. **Serum Bilirubin report to be collected on followup.**

Review consultation with Dr. DILNAAZ FAROOQUI on Friday(12.06.2026) at Himayatnagar with prior appointment (**Review consultation will be charged**).

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

Rushanti

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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

Registrar/Resident/C.M.O

Dr. DILNAAZ FAROOQUI
MBBS DNB
56763

CONSENT FOR FORMULA FEEDS



Patient Name : Age : Gender : Male Female

UHID No : Department : Date :

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

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Baby Of RUCHI LAHOTI
08-08-2026 0 Y 0 M 0 D 0 H (M)
Dr. DILNAAZ FAROOQUI



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 : Akshay Mundada

Name : Akshay Mundada

Relationship with Patient: Husband Father

Date & Time :

Witness :

Signature : Anita

Name : Anita mundada

Date & Time :

Doctor (who is taking the consent) :

Signature : B

Name : B. Sreegh

Date & Time : 9/6/16 10 AM



డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.పెచ్.ఐ.డి. రిజిస్ట్రేషన్ 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

ADMISSION SHEET



Registration Details :

Admission No : IP26-00006543 Admit Date : 08-Jun-2026 Admit Time : 10:31 PM UHID : HNH-00015883

Patient Details :

Patient Name : Baby Of RUCHI LAHOTI Age : 0 D
Guardian : Mr AKSHAY MUNDADA DOB : 08-06-2026 09:40 PM
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : PRAGATHI RESIDENCY East Maredpalli Phone No : 9581185439/ 7799063752
Hyderabad Telangana INDIA 500026 E-mail : RUCHI.LAHOTI133@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 AKSHAY MUNDADA Relationship : Father
Contact Address : PRAGATHI RESIDENCY East Maredpalli Phone No : 9581185439
Hyderabad Telangana INDIA 500026


Signature

Doctor Details :


Doctor Name : Dr. DILNAAZ FAROOQUI Specialisation : GENERAL PEDIATRICS
Referral Doctor : SELF Phone No :
Co-Consultant :

Payment Details :

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

PATIENT TRANSFER FORM



Patient Name & UHID No. HNH-00015883 IP26-00006543 Baby Of RUCHI LAHOTI 08-06-2026 0 Y 0 M 0 D 0 H (M) Dr. DILNAAZ FAROOQUI 		Date & Time of Admission 8/6/26 @ 10:31PM	Date & Time of Transfer Order 9/6/26 @ 9:40 AM
		Transfer Ordered by Dr. Dilnaaz	Reason for Transfer observation
From Unit PDE & Post	To Unit Floor	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File (20)	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.	Kooches - ①		
2.	Baby wipal - ①		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Dilnaaz		Name of Person Ordered Transfer Dr. Dilnaaz	
Patient & Clinical Records Received by : Supriya			
Date & Time of Patient Received : @ 11:20 AM, 9/6/26			

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



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Ruchi Lahoti Age : 28y Father's Name : Age :
 Date of Birth : Date of Admission : 8/6/26 UHID No. :
 NICU Consultant : Dr. Dilnaaz 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 Ruchi Lahoti Mother's Blood Group : O+ Positive
 Gender M F Blood Group : Birth Weight (gms) : 2.820kg Length (cms) :
 Date of Birth : 8/6/26 Time of Birth : 9:40pm OFC (cms) :
 Place of Birth : Rainbow Estimated Gesth Age : 37+8

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 28 Ht : Wt : BMI : Married Life : LMP : 15/9/25 EDD : 24/6/26
 Conception : Spontaneous or with Rx : Spontaneous
 Booked at what GA : AN Steroids Drugs / Doses :
 Last Scans Details : S/F / cephalic / EFW - 2647 / Doppler (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 / 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 (<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: P: A: L:

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

PERINATAL HISTORY

Treating Obstetrician : Hospital : Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig) <i>Emergency</i></p> <p>Second stage (> 2 hours after dilation) <i>180</i></p> <p>LSCS : <input type="checkbox"/> Elective <input checked="" 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 checked="" type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL : <i>(circle)</i></p> <p>Resuscitaion : <input type="checkbox"/> Yes <input checked="" 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
	1	2	
	2	2	
	2	2	
	2	2	
	2	2	
TOTAL	8/10	9/10	

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints : *primi / 34+4 / oligohydramnios / molar Hypothyroidism*



Baby cried immediately after birth



Good clamped & cut



Reg-vit - k given



Vitals - SpO₂ - 98% NO RI
RR - 52
HR - 128



Shipped to mother side.

Investigation details in previous Hospital :

Feeding History :

Pat



Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

T (37+4) | AGA | 2.820kg | male | CIAB,
Mature Hypothyroidism

VITALS : Temperature : 36°C HR : 132 RR : 52 NIBP : CFT :

Color of the extremities : Pink

Jaundice : Pallor : SpO2 : 98%

Anthropometry : Birth Weight : 2.820kg Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

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

| (N)

Facies :
 (Any Facial
 Dysmorphism)

| (N)

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

| (N)

EYES : Symmetry :
 Red Reflex :
 Discharge :

Yet to be done

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

| (N)
 No cleft palate.
 (N)

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

| (N)

**ABDOMEN and
 UMBILICUS :** Shape :
 Organomegaly :
 Bowel Sounds :
 Umbilical Stump :
 Discharge :

| (N)
 2A + 1V

GENITALIA : Labia / Hymen :
 Testicles/penis :
 Anus :

(N) Male Genitalia. Testis descended in scrotum

HERNIAL ORIFICES

| (N)

TRUNK and SPINE :

SKIN LESIONS :

(N)

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

| (N)



SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

Mention If baby has Respiratory distress : RR : 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 : 98.1 Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 132 BP : Precordial Activity :

Femoral Pulses : well feel Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernia orifice :

Palpation : soft, nontender Anal Patency :

Palpable masses : Umbilical Cord :

Abdominal girth : First urine 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 : T(37+4) / ACA / 2-820 Gy / male / CIAR
Maternal Hypolipidemia

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *[Signature]*
Name : Dr. Mucipanya
Date & Time : 8/6/26

Consultant :

Signature : *[Signature]*
Name : Dr. Dilnaaz
Date & Time : 8/6/26

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :
2. Name of the referring Hospital :
Address :
Contact Numbers :
3. Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
4. Name of the Doctor in Rainbow Team :

..... on whose name the patient is being referred.



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :
.....
.....

Present Issues :
.....
.....

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

Any Oxygen requirement :

Systemic :

Medications :
.....
.....
.....

Plan during ward follow up :

DBF 2nd hourly for burping - Vaccination ← Hep-B
BCG
OPV.
SBR } 48 Hrs.
NBS }
OAC } - Shift to mother side.

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

Screenings done during NICU Stay :

NSG :
Hearing Screen :
ROP :
TFT :
NP2 :



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26	S/B Dr Dilnaz	
10 am		
	Baby accepting breast feeds	
	Passing urine & meconium	
	°/E Enternic	
		Active
		Vitals - stable
		Tone
		Cry
		Activity } ⊕
	Today's wt = 2.80 kgs	
	↓ 20 gms/last night	
		1) warm care
		2) DBF every 2 hrs
		3) BCG } today
		OPV } today
		Hep B } today
		4) SBR } 248 HCL
		NBS } 248 HCL
		OAE } 248 HCL
		5) check 4 limb saturation
		6) USA spine before discharge
		Dilnaz



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11:30 am	Baby looks icteric	- Advised TCB at 5pm
		<u>Dilnaaz</u>
		NB - Supine 10/5/26 @ 10AM
9/6/26	SIB Dr. Sastry	
2:45 PM	Δ Ten / AUA / Mal / CIAD P6	
	Baby Gutman's	- Dof + Bugly 2006
	W - S, S, @	- Warm care
	R - BLK AIF@	
	PIA 506	- SBA } e 9-40 PM
	CTA 5001	- OAE } on 10/6/26
		✓ 13-4

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 08-08-2026 0 Y 0 M 0 D 17 H (M)
 Dr. DILNAAZ FAROOQUI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/26	S/B. Dr. Balhath / Dr. Noorneen	
8AM.	T/A/G/A/O/CIAB	
	Baby stable	
	accepts feed	<u>Plan</u>
	TWT - passing urine/stool.	
	8-720 kg	1) Warm care
	3.6% wt loss.	AFOSF
	(80g ↓).	2) DBF Q2H C
	S/E MAD	3) SBK
		OAE
		NBS
		9pm today
		N/B Supriya @ 8AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/26	C/Sib Dr. Sindhu	
10:30 AM	Term / AGA / O ² / CTAB.	
	Baby stable.	
	- Accepting feeds well.	
	SE - vitals stable.	
	SE - WNL.	Plan
		- Wound Care.
		- DBF Q2H + PF.
		- Send SBR / NBS
		ct 6pm today.
		- OAE to be done now.
		H. Sindhu DR - SINDHU (M)
		Noted by Sr. Sandhya
		10/6/26
		@10:30am

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6	CSIS Por-Naipuya	
2:00pm	T/AGA/CIAB	
	on room Air.	<u>Plan</u>
	Vitals - stable	- SBR } 6pm
	CIT A - Good	NBS }
	RIS NAD	- OAG during followup
	BIA	- plan DIC after
		SBR report
		@net
		noted by sr. sandhya
		10/6/26
		2pm

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 Dr. DILNAAZ FAROOQUI

315



Blood Group - O +ve

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					
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					
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					

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

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 Baby Of RUCHI LAHOTI
 08-08-2026 OYOMODOH (M)
 Dr. DILNAAZ FAROQUI

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

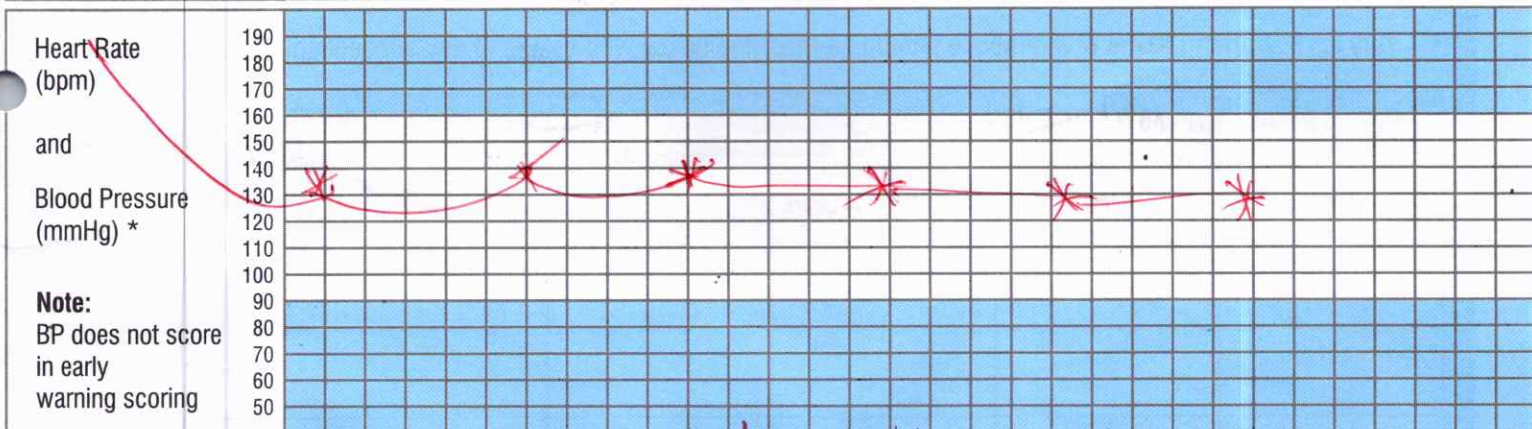
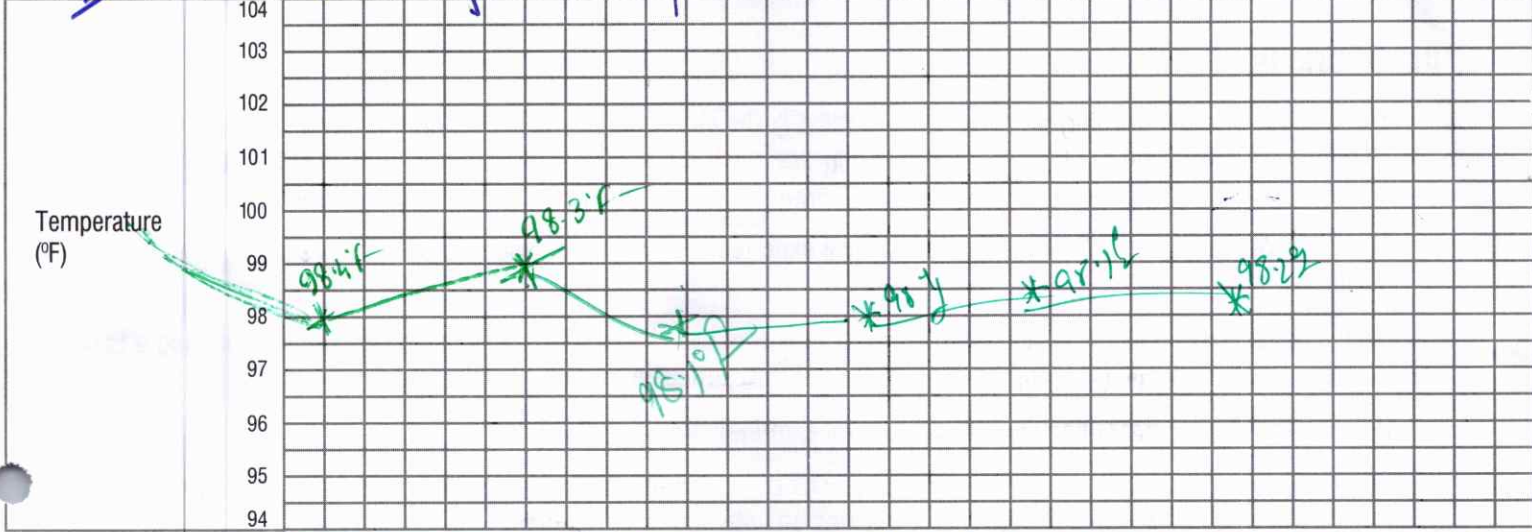


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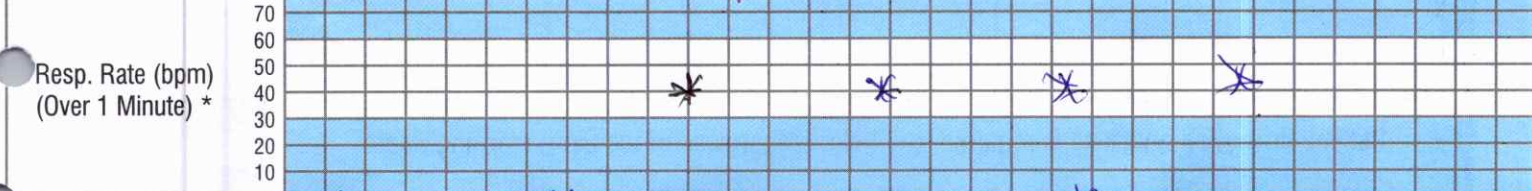
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 9/6/25 Time: 10 AM 2 PM 6 PM 10 PM 2 AM 6 AM

Doctor/Nurse/Family Concern? AM PM PM PM AM AM



Heart Rate (Number) 140b/m 142b/m 140b/m 138b/m 138b/m 140b/m



Resp Rate (Number) 40b/m 42b/m 42b/m 40b/m 41b/m 40b/m

Resp Distress: Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 100% 99% 99% 99% 99% 99%

Conscious Level: Normal Altered GCS * 15/15 15/15 15/15 15/15 15/15 15/15

TOTAL SCORE
 Number of shaded boxes 0 0 0 0 0 0
 Pain Score 0 0 0 0 0 0
 Observer's Initials [Signature] [Signature] [Signature] [Signature] [Signature] [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.
 - Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
 - Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

Patient Stic

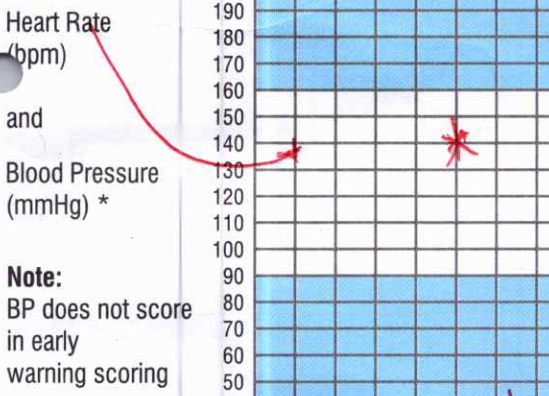
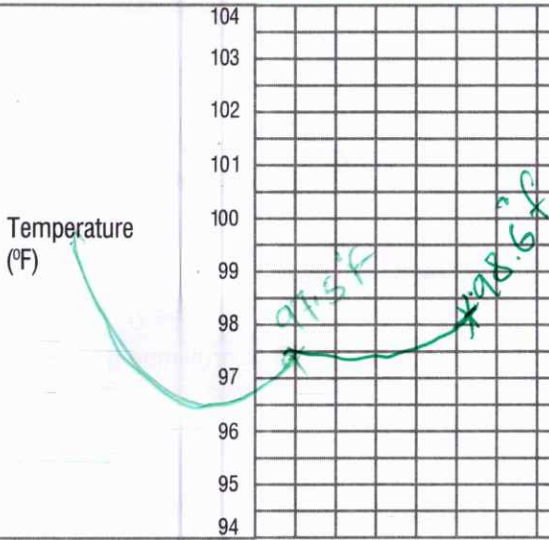
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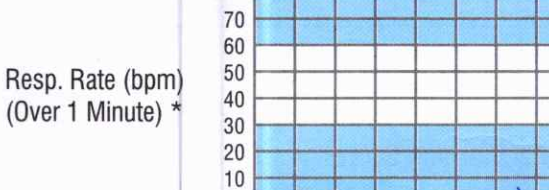
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 10/6/26 Time: 10 am 2pm

Doctor/Nurse/Family Concern?



Heart Rate (Number) 138b/m 140b/m



Resp Rate (Number) 42b/m 48b/m

Resp Distress | Mod/ Severe
None / Mild

Receiving O₂ (l/min)
O₂ Saturations (%) 99% 99%

Conscious Level | Normal
Altered

GCS *

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

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 - Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed
- NB: Scores 3 should be recorded overleaf

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

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R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



FLUID CHART

Sheet No. : C

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output



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	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
9/6/20	08:00 am	DBF+FF					✓				} A. S.	
	09:00 am											
	10:00 am	DBF+FF										
	11:00 am											
	12:00 pm	DBF+FF										
	01:00 pm							✓				
Total Intake :		Packed				Total Output :					Packed	
9/6/20	02:00 pm	DBF+FF									} A. S.	
	03:00 pm											
	04:00 pm	DBF+FF					✓		✓			
	05:00 pm											
	06:00 pm	DBF+FF										
	07:00 pm											
Total Intake :						Total Output :					U- M-	
9/6/20	08:00 pm	DBF+FF									} A. S.	
	09:00 pm						✓		✓			
	10:00 pm	DBF+FF										
	11:00 pm											
	12:00 am	DBF+FF										
	01:00 am											
Total Intake :						Total Output :						
10/6/20	02:00 am	DBF+FF									} A. S.	
	03:00 am											
	04:00 am	DBF+FF						✓	✓			
	05:00 am											
	06:00 am	DBF+FF										
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake						Total 24 hrs. Output						

HNH-00015883 IP26-00006543
 Baby Of RUCHI LAHOTI
 08-06-2026 0 Y 0 M 0 D 17 H (M)
 Dr. DILNAAZ FAROOQUI



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			
10/6/28	08:00 am		DBF+ FF										
	09:00 am												
	10:00 am	0											
	11:00 am												
	12:00 pm												
	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	
-----------------------------	--

Patient Sticker



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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
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Total Intake :						Total Output :							
	02:00 pm												
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	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-00015883 IP26-00006543
 Baby Of RUCHI LAHOTI
 08-06-2026 0Y0M0D0H (M)
 Dr. DILNAAZ FAROOQUI



NURSING CARE RECORD



Date: 8/6/26

- 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							
Afternoon							
Night	8pm	<p>→ ASSESS the baby condition</p> <p>→ monitor the vitals & reflex</p> <p>8am → DRF 2nd baby & husband</p> <p>→ maintain blood sugar level</p>	8pm	<p>→ ASSESS the baby condition</p> <p>→ monitor the vitals & recorded</p> <p>→ DRF 2nd baby & husband</p> <p>8am → maintained blood sugar</p>	Baby is stable	maintain I/O chart & record	<p><u>Arif</u></p> <p>Ⓢ</p>

HNH-00015883 IP26-00006543
 Baby Of RUCHI LAHOTI
 08-08-2026 0 Y 0 M 0 D 11 H (M)
 Dr. DILNAAZ FAROOQUI



NURSING CARE RECORD



Date: 9/6/26

- 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 to 2pm	<ul style="list-style-type: none"> → Assess the general condition on ab ft. → Monitor vitals. → Maintain O₂ chart. → Administer medication plan to give 2nd hourly 	8am to 2pm	<ul style="list-style-type: none"> → Assess the general condition ab ft. → Monitor vitals. → Maintain O₂ chart → Act 2nd hourly 	→ Baby is stable	<ul style="list-style-type: none"> → Re-checked the vitals → I/O → Vaccination to be done 	Supriya
Afternoon	← Day Duty →						
Night	8pm to 8am	<ul style="list-style-type: none"> Assess the Baby Condition Monitor vital & O₂ chart DBL 2nd hourly 		<ul style="list-style-type: none"> Assess the Baby Condition Monitor vitals & chart DBL 2nd hourly 	Baby is stable	Rechecked vitals	

HNH-00015883 IP26-00006543
 Baby Of RUCHI LAHOTI
 08-06-2026 0Y0M0D0H (M)
 Dr. DILNAAZ FAROOQUI



NURSING CARE RECORD

Date: 10/6/26

- 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 to 2pm	- Assess the Baby Condition - monitor the v/s - maintain the I/O - DBF + FF 2nd hourly	8am to 2pm	- Assess the baby Condition - Monitor the v/s - maintain the I/O - DBF + FF 2nd hourly	- Now baby is stable	- Rechecked the v/s	
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

HNH-00015883
 Baby Of RUCHI LAHOTI
 08-06-2026 0Y0M0D0H (M)
 Dr. DILNAAZ FAROOQUI



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		
						8/6	9/6	9/6	10/6						
						PM	MG	MG	MG						
						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						
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						
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						
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						
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						
<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	34w 34w	32w 32w	32w 32w	32w 32w										
	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-00015883

IP26-00006543

Baby Of RUCHI LAHOTI

08-06-2026

O Y O M O D O H (M)

Dr. DILNAAZ FAROOQUI



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:	8/6/26	9/6/26	9/16/26
					Time:	11	15	17
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	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.		3	3	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	4	3
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		3	3	3
FRICION-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	3
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		3	3	3
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.		2	4	4
TOTAL SCORE						20	25	25
Evaluator's Name						A	A	A

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

Docu. No. : RCH /FRM / CLINICAL / 119

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<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



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Dilnaz Department: LDR Date of Admission: 8/6/26

SITUATION	Diagnosis: <u>Newborn</u>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Area	<u>8/6/26 N1</u>	<u>9/6/26 N5</u>	<u>10/6/26 N1</u>	<u>10/6/26 M6</u>			
BACKGROUND	Shift Time							
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>-</u>	<u>-</u>	<u>-</u>			
ASSESSMENT	Allergy:	<input checked="" 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:	<u>97.9°F</u>	<u>98.1°F</u>	<u>98.9</u>	<u>98.5°F</u>		
		Res:	<u>52b/m</u>	<u>42b/m</u>	<u>42b/m</u>	<u>42b/m</u>		
		SpO ₂ :	<u>99.1</u>	<u>99.1</u>	<u>99.1</u>	<u>99.1</u>		
		Pulse:	<u>81b/m</u>	<u>143b/m</u>	<u>140b/m</u>	<u>142b/m</u>		
		BP:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>		
Fall Risk Score:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>				
Pain Score:	<u>-</u>	<u>0</u>	<u>0</u>	<u>0</u>				
Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>			
	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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Others Specify:	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>			
	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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Other Special Orders / Medications:	<u>NA</u>	<u>-</u>	<u>-</u>	<u>-</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>-</u>	<u>-</u>	<u>-</u>			
Handed Over By Name :		<u>Akhila</u>	<u>Sujaya</u>	<u>Arjun</u>	<u>Sumeda</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>9/6/26</u>	<u>9/6/26</u>	<u>10/6/26</u>	<u>10/6/26</u>			
Time:		<u>8AM</u>	<u>8pm</u>	<u>8AM</u>	<u>2pm</u>			
Taken Over By Name :		<u>Sujaya</u>	<u>Arjun</u>	<u>Sumeda</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>9/6/26</u>	<u>9/6/26</u>	<u>10/6/26</u>				
Time:		<u>8AM</u>	<u>8AM</u>	<u>8AM</u>				

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
BACKGROUND	Area							
	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Tubes/Drains/Catheter:-	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
Fall Risk Score:								
Pain Score:								
Recommendations	Safety Needs:							
	Physiotherapy	<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	<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 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:							
	Post Operative Procedure Special Orders:							
	Handed Over By Name :							
	Signature :							
	Date:							
	Time:							
	Taken Over By Name :							
	Signature :							
	Date:							
	Time:							



DATE: 8/6/26.

NEWBORN ANOMOLY ASSESSMENT CHECKLIST

S.NO	ASSESSMENT PARAMETERS	CHECKED BY REGISTRAR	CHECKED BY CONSULTANT	REMARKS
1.	Palate	No cleft Palate	No cleft Palate	No cleft Palate
2	Pre natal teeth	Absent	Absent	Nil
3	Anal opening	Patent	Patent	Patent anal orifice
4	Genitalia	Ⓜ male genitalia	Ⓜ male genitalia	Ⓜ male genitalia B/L Descended Teste
5	Spine	Sacral dimple Ⓜ ⊕	Sacral dimple Ⓜ ⊕	Sacral dimple ⊕
6	Red reflex	Yet to be done	Yet to be done	Red reflex seen in both eyes
7	4 limb saturation (before discharge)	Yet to be done	Yet to be done	

[Signature]

Ped.Registrar signature

[Signature]

Ped.Consultant signature

HNH-00015883 IP26-00006543
 Baby Of RUCHI LAHOTI
 08-08-2026 0 Y 0 M 0 D 0 H (M)
 Dr. DILNAAZ FAROOQUI



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Ruchi Lahoti Mother's Name: _____
 Date of Birth: 8/6/26 Time of Birth: 9:40 AM Gender: Male Female
 Birth Weight: 2.820 Kgs HC: _____ cm Length: _____ cm
 Meconium in Liquor: Yes No Cried at Birth: Yes No
 Term / Pre-term / Post-term: _____
 Resuscitated: Yes No Blood Group: Mother: O+ve Baby: _____
 Feeding: Breast Feeding Formula Both First Feed Time: _____

AFFIX MOTHER'S IDENTIFICATION LABEL

Mode of Delivery: Normal LSCS Emergency/ Elective Instrumental AVD
 Indication: _____

Physical Assessment of New Born:

Temp: 36 °C HR: 140 /Min RR: 55 /Min BP: _____ SpO₂: 99%

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: [Signature] Signature: [Signature] Date & Time: 8/6/26