

DISCHARGE SUMMARY

Name	Baby Of P SAI NITHYA	UHID	HNH-00016175
Father/Guardian	Mr AADITYA SAI KIRAN	Age/Gender	0 Y 0 M 0 D 7 H/ Female
Address	FLAT NO. 307,VAIBHAV KUNCH,LOWER TANKBAND ROAD, Gandhi Nagar, Hyderabad, Telangana, INDIA, 110005		
IP No	IP26-00006651	Admission Date	26-06-2026
Ref Doctor	Dr Rajini Kumari		
Discharge Date	28.06.2026		

Consultant:

Dr. S TEJASWI REDDY

MBBS, MD Pediatrics, DM Neonatology
APMC/FMR/94068

DIAGNOSIS	ICD CODE
TERM (37 weeks + 4 days)/AGA/BABY GIRL/NEONATAL HYPERBILIRUBENIMIA	

History: Baby Of P SAI NITHYA is a term (37 weeks + 4 days) baby girl, delivered to a G2P1L1 mother by emergency LSCS on 26.06.2026 at 05:10 am with birth weight of 2.8 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

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cord clamping done. Fetal presentation was Vertex.

Maternal History: Mrs. P SAI NITHYA is a 33 years old G2P1L1 mother.
G1 - 2023 - Em LSCS (ind: SGA with ?abnormal Doppler with fibroids), boy, 3years, A&H

G2 - 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 B positive. Baby's blood group is B positive.

Examination: Baby was eutermic (36.5 *C), 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 : 2.8 kgs.
Weight at discharge : 2.62 kgs.
Head Circumference : 34 cms.
Length : 49 cms.

Investigations: Enclosed reports.

Management:

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Course during hospital:

Baby was clinically icteric on 34 hours of life , hence double surface phototherapy was started. Baby was continued with DBF and measured feeds .

Serum bilirubin at 48 hours of life was 9.1 mg/dl with indirect fraction of 9.0 mg/dl , hence phototherapy was stopped and baby is being discharged with following advice .

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	27.06.2026
OPV	Given	27.06.2026
HEPATITIS B	Given	27.06.2026

TEOAE (Transient Evoked Otoacoustic Emissions): Hearing test: To be done on follow up.

Newborn screening advanced / Newborn screening-4: Sent on 28.06.2026, report awaited.

SPO2 : 98 % at room air
Red Reflex: Present & Symmetrical

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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. Hearing test (TEOAE-Transient Evoked Otoacoustic Emissions) to be done on followup.**
- 3. Serum Bilirubin to be done on followup.**

Review consultation with Dr. S TEJASWI REDDY on Tuesday (30.06.2026) 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**

Anshu
Registrar/Resident/C.M.O



Dr. S TEJASWI REDDY
MBBS, MD Pediatrics, DM Neonatology
APMC/FMR/94068

CONSENT FOR FORMULA FEEDS



HNH-00016175 IP26-00006651
Baby Of P SAI NITHYA
26-06-2026 0 Y 0 M 1 D (F)
Dr. S TEJASWI REDDY

Patient Name : Age : Gender : Male Female

UHID No : Department : Date :



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 : *[Signature]*

Name :

Relationship with Patient : *father*

Date & Time : *25/6/26 @ 5 AM*

Witness :

Signature : *[Signature]*

Name : *Divya*

Date & Time : *24/6/26 2 PM*

Doctor (who is taking the consent) :

Signature : *[Signature]*

Name : *Dr. Archana*

Date & Time : *25/6/26 2 PM*



డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

రోగి పేరు: వయస్సు లింగం పు స్త్రీ

యు.హెచ్.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)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు


వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00016175 IP26-00006651 Baby Of P SAI NITHYA 28-06-2026 QYOMODSH (F) Dr. S TEJASW REDDY 		Date & Time of Admission 26/6/26 @ 5:10 AM	Date & Time of Transfer Order 26/6/26 @
		Transfer Ordered by DR. Prabhakar	Reason for Transfer Observation
From Unit Pae - post	To Unit Room	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 28	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input 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 Sis. Sujatha Ji		Name of Person Ordered Transfer DR. Pramar	
Patient & Clinical Records Received by : Divya 24/6/26 4 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

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006651 Admit Date : 26-Jun-2026 Admit Time : 05:40 AM UHID : HNH-00016175

Patient Details :

Patient Name : Baby Of P SAI NITHYA Age : 0 D
Guardian : Mr AADITYA SAI KIRAN DOB : 26-06-2026 05:10 AM
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : FLAT NO. 307,VAIBHAV KUNCH,LOWER TANKBAND ROAD Gandhi Nagar Hyderabad
Telangana INDIA 110005 Phone No : 9908626219/ 9849301139
E-mail : aaditya.sai.kiran@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 AADITYA SAI KIRAN Relationship : Father
Contact Address : FLAT NO. 307,VAIBHAV KUNCH,LOWER TANKBAND ROAD Gandhi Nagar Hyderabad
Telangana INDIA 110005 Phone No : 9908626219


Signature

Doctor Details :

Doctor Name : Dr. S TEJASWI REDDY Specialisation : NEONATOLOGY
Referral Doctor : SELF Phone No :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 10000.00
Payor Name : SELFPAY

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 Baby Of P SAI NITHYA
 28-08-2026 OYOMODOH (F)
 Dr. S TEJASWI REDDY



Handwritten notes: 991-995, 991-991

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : P. Sai Nithya Age : 33y Father's Name : Age :
 Date of Birth : Date of Admission : UHID No.:
 NICU Consultant : Dr. Tejaswi Referring Consultant :
 Transferring Unit : OT Labour Room ER Ward
 Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : P. Sai Nithya Mother's Blood Group : B+
 Gender : M F Blood Group : B+ Birth Weight (gms) : 2800g Length (cms) :
 Date of Birth : 26/08/26 Time of Birth : 5:10 AM OFC (cms) :
 Place of Birth : Estimated Gesth Age : 37w + 4d

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : Ht : Wt : BMI : Married Life : LMP : EDD :
 Conception : Spontaneous or with Rx : Spontaneous
 Booked at what GA : AN Steroids Drugs / Doses : Ty Betnoral @ 300
 Last Scans Details : (6/6/24) - SUIVU 24w + 6d / AFI - 13.2 (AL - 430)
ERBW - 2300 gm / fibroid @ Dopler @ Immunization and Iron/ Folic Acid : Yes

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

I: 2 P: 1 A: L: 1

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
<u>G1</u>					<u>Mch / 3y / Em USU</u>	
<u>G2 - PP</u>						

PERINATAL HISTORY

Treating Obstetrician : D. Rajani Kumar Hospital : Inborn Outborn

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

APGAR SCORE

Gestational Age : Weeks :

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

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

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

Comments : 7

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

Term (37 w + 4 d) / Female / B. wt: 2800 gm / CIAAB
AGA / Em USU.

Hi



Female baby born by Em SCU on 26/06/26 5:10 AM.

↓
Baby cried immediately

↓
Delayed cord clamping done

↓
Routine Newborn care given
Vit - K given

↓
Shift to mother side

Investigation details in previous Hospital :

Feeding History :



Handwritten notes in blue ink, including '10' and '20'.

Family History :

Handwritten notes in blue ink, including 'Delayed cord clamping done'.

Socio Economic History :

Handwritten notes in blue ink, including 'Shift to mother care'.

GENERAL EXAMINATION ON ADMISSION

General Disposition :

Blank space for general disposition notes.

VITALS : Temperature : $\textcircled{1}$ HR : *170/min* RR : *39/min* NIBP : CFT : $\textcircled{1}$

Color of the extremities : *pink*

Jaundice : $\textcircled{1}$ Pallor : $\textcircled{0}$ SpO2 : *94% @ RA*

Anthropometry : Birth Weight : *2800gm* Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

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Baby Of P SAI NITHYA

28-06-2026

0 Y 0 M 0 D 0 H (F)

Dr. S TEJASWI REDDY



HEAD TO TOE EXAMINATION

HEAD :

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

Facies :
(Any Facial
Dysmorphism)

**NECK and
CLAVICLES :**

Range of Motion :
Asymmetry :
Masses :

EYES :

Symmetry :
Red Reflex :
Discharge :

**EARS, NOSE
MOUTH and
THROAT :**

Ear set / Shape :
Periauricular Pits / Tags :
Nasal shape / Patency :
Palate :
Gums :
Lips :
Tongue :

Normal

**THORAX and
BREASTS :**

Shape of Thorax :
Position of Nipples and Number :

**ABDOMEN and
UMBILICUS :**

Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump :
Discharge :

GENITALIA :

Labia / Hymen :
Testicles/penis :
Anus :

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

EXTREMITIES :

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



SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

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

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

Mention if baby is on : Hood box CPAP Ventilator

Settings :

Spo2 : Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : BP : Precordial Activity :

Femoral Pulses : Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernia orifice :

Palpation : Anal Patency :

Palpable masses : Umbilical Cord :

Abdominal girth : First urine passed :
Meconium passed :

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

.....

.....

.....

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

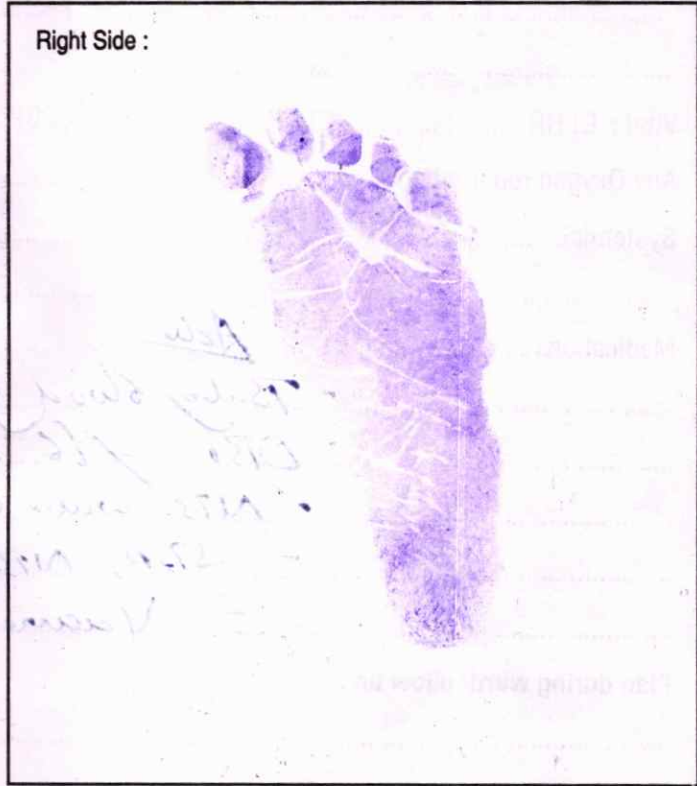
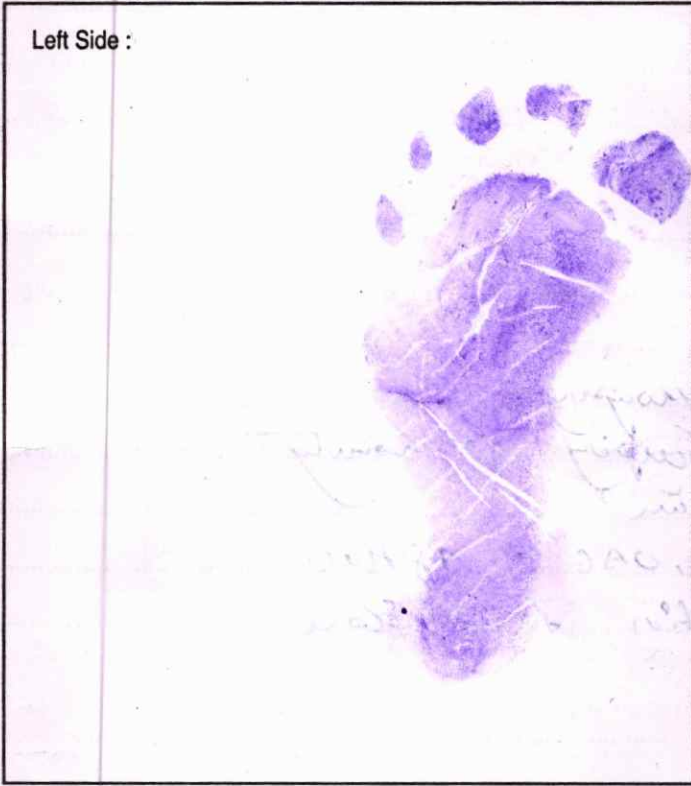
ATNR : Skull and Spine :



Any Congenital Anomalies: No

Diagnosis: Term (37w+9d) / Female / LGA / B.Wt 2800g
AGA (Gender)

FOOT PRINTS



Resident Doctor :

Signature : [Signature]

Name : Dr. Subhakar

Date & Time : 26/06/26 5:10 AM

Consultant :

Signature :

Name :

Date & Time :

PLEASE FILL UP THE FOLLOWING DETAILS

- Name of the referring Doctor :
- Name of the referring Hospital :
Address :
Contact Numbers :
- Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
- Name of the Doctor in Rainbow Team :
..... on whose name the 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 :
.....
- Baby blood grouping
- DSR for sleeping 2nd hourly
- NTB warm care
- STR, NTB, OAG @ 48 Hrs
- Vaccination to be done

Plan during ward follow up :
.....
.....
.....
.....

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

Screenings done during NICU Stay :
NSG :
Hearing Screen :
ROP :
TFT :
NP2 :

TSC P. Sai Nithya

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Baby Of P SAI NITHYA
28-08-2026 0 Y 0 M 0 D 0 H (F)
Dr. S TEJASWI REDDY



PATIENT STICKER

DATE: 26/06/20

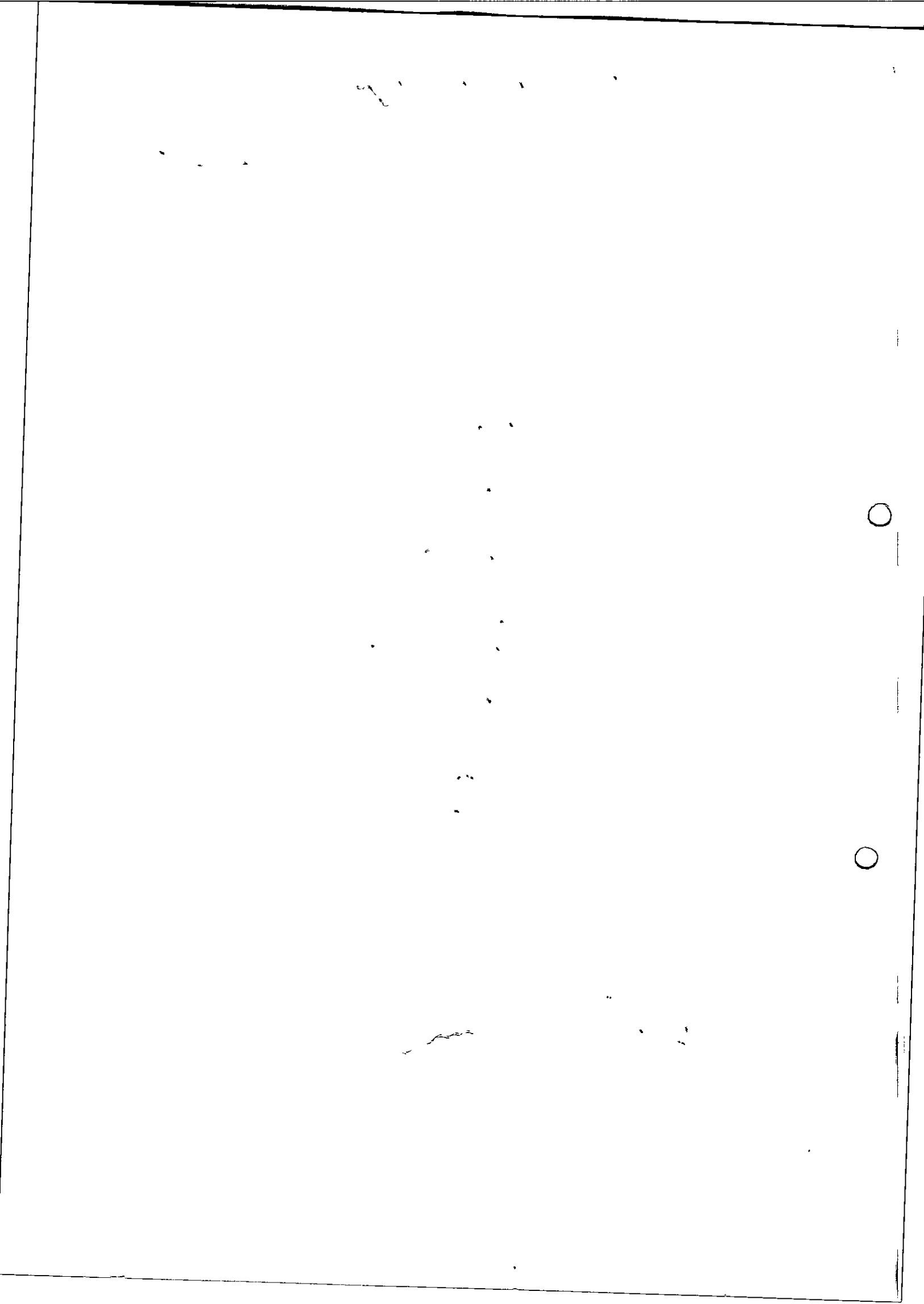
NEWBORN ANOMOLY ASSESSMENT CHECKLIST

S.NO	ASSESSMENT PARAMETERS	CHECKED BY REGISTRAR	CHECKED BY CONSULTANT	REMARKS
1.	Palate	No. cleft		
2	Pre natal teeth	normal		
3	Anal opening	normal ⊕		
4	Genitalia	Normal female genitalia		
5	Spine	normal		
6	Red reflex	} yet to see child		
7	4 limb saturation (before discharge)			

Sankar

Ped.Registrar signature

Ped.Consultant signature

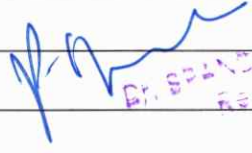


HNH-00016175
 Baby Of P SAI NITHYA
 28-06-2026
 Dr. S TEJASW REDDY

IP26-00006651
 O Y O M O D O H (F)




PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6/26 3pm	c/s/by dr spanclaw	
	Tw / 2.8kg / Female / CIAB	
	Baby Seethic Active	
	<u>vital</u> stable	
	<u>S/E</u>	
	Blk A E (+)	<u>Plan</u>
	(R/S) NIVIS	- DBF Only flb buypiz
	(LVS) size No massm	- plan care
		- Vaccination
		- check & limb spot
		- Monitor vitals
	 Dr. SPANDANA DASUPULETI REG. NO: 8092	

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 Baby Of P SAI NITHYA
 28-06-2026 0Y0M0D6H (F)
 Dr. S TEJASWI REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6 7Am	CB/B A Pranam / Dr. Vallu	
	D2 / FT / 37+4wk / Em LSCS / 1 girl / 2.8kg	
	T-Wt - 2.62 kg (180g) (6.4x low)	Materal Fed (P) (Post delivery) MBS / Bx BBx / Bx
	Baby Extern	Ph
	C } head T } A }	1) 2x am Calx
	R-S-B/L A E @	2) DBF / 16 bulging ant SOS - FF
	PIA - soft	3) Vaccination today
	ON DBF	4) SBR } e 20m MBS } OAE }
	Passed Uris & Stool	5) Monitor Vitals
		6) GRBS Monitor - 6 th hr
		7) SOS - N/A clean
		<u>Pranam</u>



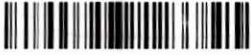
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6 9:30 AM	CLINICAL D. Tejaswi	
	FT 137 ⁺ 2h / 15 LSCS / Girl / 2.8 kg / Matured fetus (Past delivery) WT less - 6.4 y.	
	Baby on DBF Kanthelam Cup Tone Activity } Gal	Pl 1) DBF / 1h feeding and 2) FF - Top up 3) Vaccination today 4) SBR NBS SRE } TIM
	Passed urine & stool	5) CRBS - 1 st hour
27/6/26		6) Month visit
	BCG OPV HEP-B } given	<p>Dr. S of Noted by Mounika 28/6/26 (2) TEJASWI REDDY Registration No: 94068 Dr. Tejaswi</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/by Dr Anush	
27/6/26 2pm	T/ 32+4 / (IAB) 2.8kg	
	Baby active	<u>Plan</u>
	Cutluc	/ Plan feed.
	w/lytic	/ DBF ablylb buyri
	vital status	(SOS) #
	S/G MAD	/ Sample Tm
		/ GIBS Monitoring.
	<u>Al:</u>	/ Monitor vital
		Noted by Divya
		27/6/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6	C/S/B Do. Spandana	
8:00pm	T / 37-44 / C/AB / 2-8kg	
	Rectus (P) Euthemic C/T/A - Good	Plan
	Vitals - stable	- DBF 2nd hourly for burping
	R/S / NAD P/A /	- TCB now
	Oral cavity - (N)	- GRBS monitoring
	Chest & Abdomen - (N)	- SBR 28/6.
	NO cleft lip / palate NO sacral dimple	NBS 5:00Am OAE
	B/L red reflex - (N)	- monitor vitals
	<i>[Signature]</i>	N/A private.
	<i>[Signature]</i>	
	Dr. SPANDANA BASUPULETI REG. NO. 3092	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/6	<p>Dr. Spandana</p>	
	<p>Term / AGA / CIA B</p>	
	<p>Euthermic dT/A blood</p>	<p>plan</p>
	<p>ident</p>	<p>Trace vpt's</p>
	<p>Vitals stable</p>	<p>PBR 02/1</p>
	<p>S/E wnl</p>	<p>SBR 9.1</p>
	<p>P.S</p>	<p>→ Pinch today</p>

HNH-00016175 IP26-00006651

Baby Of P SAI NITHYA
28-06-2026 0Y0M0D0H (F)
Dr. S TEJASW REDDY



213 (05) (05) (05) (05)

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					



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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 28/6/26 Time: 6AM 8AM 12PM 5PM 10PM 12AM 6AM
 Doctor/Nurse/Family Concern?

Temperature (°F)	104										
	103										
	102										
	101										
	100										
	99										
	98	98.5	98.5	96.5	97.5	36.5C	36C	36C			
	97										
	96										
	95										
94											

Heart Rate (bpm)	190										
	180										
	170										
	160										
	150										
	140										
	130										
	120										
	110										
	100										
90											
80											
70											
60											
50											
50											

Heart Rate (Number) 144 145 142b/m 152b/m 140b/m 145 150

Resp. Rate (bpm) (Over 1 Minute) *	70										
	60										
	50										
	40	*	*	*	*						
	30										
	20										
	10										
	10										
	10										
	10										

Resp Rate (Number) 44 44 44b/m 55b/m 55 55 50

Resp Mod/ Severe Distress None / Mild

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

Conscious Level Normal Altered

GCS *

TOTAL SCORE											
Number of shaded boxes	0	0	0	0	1	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	et	et	et	et	et	et	et	et	et	et	et

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.

S	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)

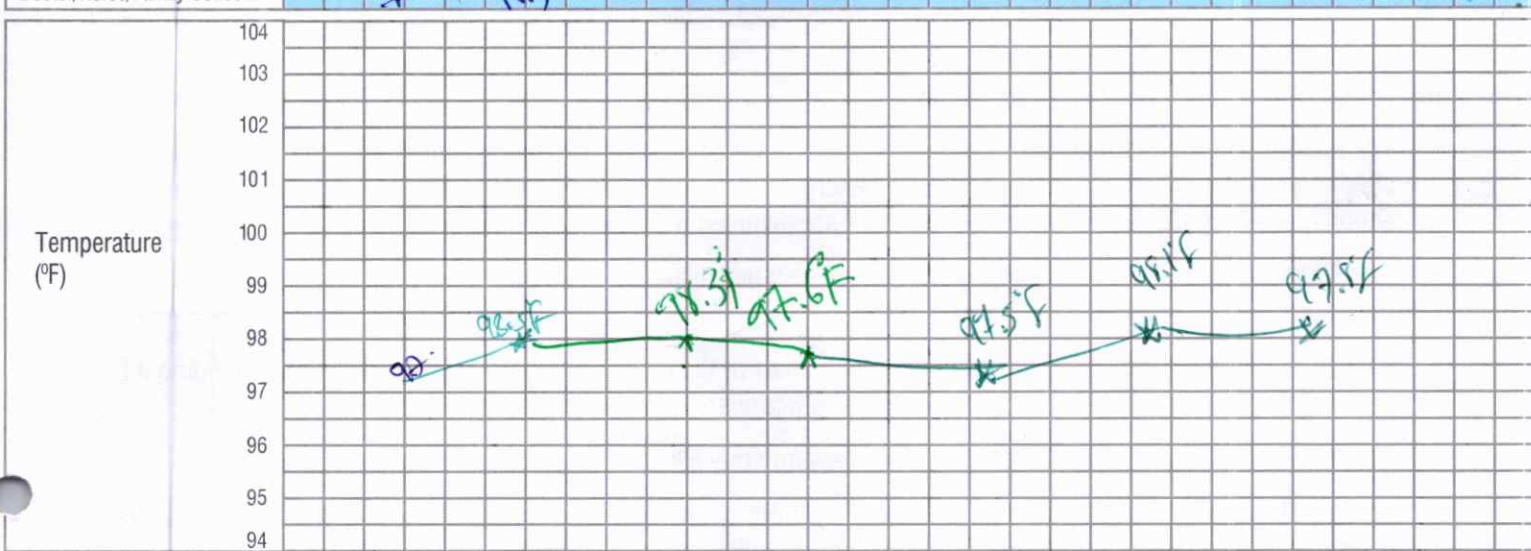


INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 27/8/24 Time: 10 AM 2 PM 9 PM 6 AM 10 PM 2 AM 6 AM
 Doctor/Nurse/Family Concern? AM PM



Heart Rate (bpm)	190					
and	180					
Blood Pressure (mmHg) *	170					
	160					
	150					
	140					
	130					
	120					
	110					
	100					
	90					
	80					
	70					
	60					
	50					

Heart Rate (Number) 130 138b/min 138b/min 140b/min 145b/min 146b/min

Resp. Rate (bpm) (Over 1 Minute) *	70					
	60					
	50					
	40					
	30					
	20					
	10					

Resp Rate (Number) 30 30b/min 35b/min 38b/min 42b/min 41b/min

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 0.2l 100% 100% 100% 100% 100%

Conscious Level Normal / Altered

GCS *

TOTAL SCORE						
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	1	0	0	0
Observer's Initials	S	S	A	S	S	S

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.

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

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- 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)

HNH-00016175
 Baby Of P SAI NITHYA
 28-08-2026
 Dr. S TEJASWI REDDY

IP26-00006651

O Y O M O D O H (F)

Dr. S TEJASWI REDDY



FLUID CHART

Sheet No. : 1.....

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G								
	08:00 am												
	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		DBF										
	06:00 am		DBF										
	07:00 am												
Total Intake : Taken						Total Output : Passed							
Total 24 hrs. Intake													
Total 24 hrs. Output													

FLUID CHART

Sheet No. : 07

- 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 Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
26/6/22	08:00 am	DBF										
	09:00 am											
	10:00 am	DBF										
	11:00 am											
	12:00 pm	DBF							✓			
	01:00 pm											
Total Intake : <u>taken</u>					Total Output : <u>passed</u>							
26/6	02:00 pm	DBF										
	03:00 pm											
	04:00 pm	DBF										
	05:00 pm											
	06:00 pm	DBF										
	07:00 pm								✓			
Total Intake : <u>taken</u>					Total Output : <u>passed</u>							
26/6/22	08:00 pm	DBF										
	09:00 pm											
	10:00 pm	DBF										
	11:00 pm											
	12:00 am	DBF										
	01:00 am											
Total Intake : <u>taken</u>					Total Output : <u>passed</u>							
27/6/22	02:00 am	DBF										
	03:00 am											
	04:00 am	DBF										
	05:00 am											
	06:00 am	DBF										
	07:00 am											
Total Intake :					Total Output :							
Total 24 hrs. Intake												
Total 24 hrs. Output												

HNH-00018175 IP26-00006651
 Baby Of P SAI NITHYA
 28-06-2026 0Y0M0D6H (F)
 Dr. S TEJASWI REDDY



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			
27/6/26	08:00 am												
	09:00 am	DBF											
	10:00 am												
	11:00 am	DBF											
	12:00 pm												
	01:00 pm	DBF											
Total Intake : taken						Total Output : 5 - 4							
27/6	02:00 pm												
	03:00 pm	DBF											
	04:00 pm												
	05:00 pm	DBF											
	06:00 pm												
	07:00 pm	DBF											
Total Intake :						Total Output : 12 - 11							
28/6	08:00 pm	DBF											
	09:00 pm	FF											
	10:00 pm												
	11:00 pm												
	12:00 am	DBF											
	01:00 am	FF											
Total Intake :						Total Output :							
28/6	02:00 am												
	03:00 am	DBF+FF											
	04:00 am												
	05:00 am	DBF+FF											
	06:00 am												
	07:00 am	DBF+FF											
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00016175 IP26-00006651

Baby O/P SAI NITHYA
 28-08-2028 OYOMOD6H (F)
 Dr. S TEJASWI REDDY



FLUID CHART

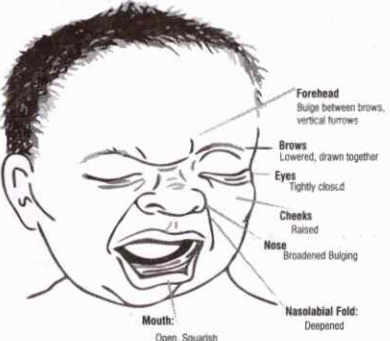
Sheet No. :

- 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 Thrombo-phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



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
						26/6	26/6	26/6	27/6				
						8 AM	8 AM	11	11				
	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				
	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					Gestational Age / Corrected Age	38+6	38+6	1	1			
						Total Pain / Agitation Score	-	-	1	1			
						Intervention	-	-	-	1			
						Effectiveness	-	-	-	1			
						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.



NURSING CARE RECORD



Date: 26/6/26

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		→ Plan for vital → Plan for DBF → Plan for warm cane.		→ vital checked & recorded. → provided DBF → provided warm cane	→ vital is normal	→ Baby is well	Madley @
Afternoon		_____		DAY DUTY	_____		
Night	8pm to 8am	→ Assess the patient condition → plan for vital → plan for blockage	8pm to 8am	→ Assessed the pt condition → maintain vital & RR → maintain blockage	patient is stable	vital is normal	Cindy

HNH-00016175 IP26-00006651
 Baby Of P SAI NITHYA
 28-08-2026 0 Y 0 M 1 D (F)
 Dr. S TEJASWI REDDY

NURSING CARE RECORD



Date: 27/6

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 pt condition → give ewy 2nd mly. feeding	8AM to 2pm	→ assessed the baby condition → monitored vials → maintain I&O	new pt is stable	rechecked vial	Med 1
Afternoon	2pm to 8pm	Assess the pt condition. Monitor vials & record maintain in special position. Provide the comfort position. Give 2nd hourly feed.	2pm to 8pm	Assessed the pt condition monitored vials & record maintained I&O. provided the comfort position. given 2nd hourly feed	Baby is stable vials normy.	pt is stable. vials normy.	Sn y
Night	8pm to 8AM	→ plan to start DSPT → SBR, NB3, OAE T/N @ 5AM. → DBF + FF give every 2nd hourly.	8pm to 8AM	→ planned to start DSPT → SBR, NB3, OAE T/N @ 5AM → DBF + FF given every 2nd hourly.	Baby is stable POV	rechecked vitals	De

HNH-00016175

IP26-00006651

Baby Of P SAI NITHYA

26-06-2026

OYOMODOH (F)

Dr. S TEJASWI REDDY



BRADEN 'Q' SCALE



					Date :	26/6	26/6	26	27
					Time :	8am	4	11	11
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		2	2	2	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.		2	3	2	2
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	3	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	2
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	3	4	2
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	3	4	2
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	3	4	2
TOTAL SCORE						26	25	26	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)
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: Department: Date of Admission:

SITUATION	Diagnosis: <i>ALB</i>		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known If Yes Specify:				
	BACKGROUND	Area	<i>26/6 AM</i>	<i>26/6 PM</i>	<i>26/6 NI</i>	<i>27/6 AM</i>	<i>27/6 PM</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	
	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	
	Vital Signs:	Temp:	<i>98.1</i>	<i>98.1</i>	<i>97</i>	<i>97</i>	<i>98.1</i>
		Res:	<i>24</i>	<i>25</i>	<i>25</i>	<i>25</i>	<i>25</i>
		SpO ₂ :	<i>99%</i>	<i>99%</i>	<i>99</i>	<i>99</i>	<i>99%</i>
		Pulse:	<i>144</i>	<i>130</i>	<i>158</i>	<i>120</i>	<i>130</i>
		BP:	-	-	-	-	-
	Fall Risk Score:	-	-	-	-	-	
Pain Score:	-	-	-	-	-		
Recommendations	Safety Needs:	-	-	-	-	<i>yes</i>	
	Physiotherapy	<input checked="" type="checkbox"/> Yes <input 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:	-	-	-	-	-	
	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	
	Other Special Orders / Medications:	-	-	-	<i>NR</i>	-	
Post Operative Procedure Special Orders:		-	-	-	<i>NR</i>	-	
Handed Over By Name :		<i>Madh</i>	<i>Aksh</i>	<i>Chud</i>	<i>Movi</i>	<i>Srin</i>	
Signature :		<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	
Date:		<i>26/6</i>	<i>26/6</i>	<i>27/6</i>	<i>27/6</i>	<i>27/6</i>	
Time:		<i>8AM</i>	<i>8PM</i>	<i>8PM</i>	<i>2PM</i>	<i>8PM</i>	
Taken Over By Name :		<i>Aksh</i>	<i>Chud</i>	<i>Movi</i>	<i>Srin</i>	<i>nahi</i>	
Signature :		<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	<i>(Signature)</i>	
Date:		<i>26/6</i>	<i>26/6</i>	<i>27/6</i>	<i>27/6</i>	<i>27/6</i>	
Time:		<i>8</i>	<i>8pm</i>	<i>8PM</i>	<i>2PM</i>	<i>8PM</i>	



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:							

HNH-00016175
Baby Of P SAI NITHYA
28-06-2026
Dr. S TEJASWI REDDY
IP26-00006651
O Y O M O D O H (F)



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Sai Nithya Mother's Name:

Date of Birth: 26/6/26 Time of Birth: 5:10 AM Gender: Male Female

Birth Weight: 2800 Kgs HC: 34 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:

AFFIX MOTHER'S IDENTIFICATION LABEL

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

Indication:

Physical Assessment of New Born:

Temp: 36 °C HR: 144 /Min RR: 44 /Min BP: SpO₂: 99%

Pain Score: (Follow N Pass)

Fall Risk Assessment: Yes No Score: (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: Nadkarni J

Signature: Nadkarni

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