

DISCHARGE SUMMARY

Name	Baby Of MULA ROHITHA	UHID	HNH-00015791
Father/Guardian	Mr RAKESH KANDI	Age/Gender	0 Y 0 M 0 D 6 H/ Male
Address	2-2-185/24/111/B, MALLIKARJUNA NAGAR , Bagh Amberpet, Hyderabad, Telangana, INDIA, 110005		
IP No	IP26-00006496	Admission Date	04-06-2026
Ref Doctor	Self.		
Discharge Date	06.06.2026		

Consultant:
Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

DIAGNOSIS	ICD CODE
TERM (37 weeks + 4 days)/AGA/CIAB/BABY BOY/B/L- CONGENITAL HYDROCELE	

History: Baby Of MULA ROHITHA is a term (37 weeks + 4 days) baby boy, delivered to a G2P1L1 mother by elective LSCS on 04.06.2026 at 11:12 am with birth weight of 3.200 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. MULA ROHITHA is a 29 years old G2P1L1 mother.

G1 - 2023 - PT-LSCS at 36 weeks (Ind:PPROM with Oligohydramnios),

Female, 3.03kg, A&H

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

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

Examination: Baby was euthermic (36.5 °C), euvoletic 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. USG Scrotum was done which showed bilateral hydrocele.

Anthropometry:

Weight at birth : 3.200 kgs.

Weight at discharge : 2.940 kgs.

Head Circumference : 36 cms.

Length : 47 cms.

Investigations: Enclosed reports.

Name	Baby Of MULA ROHITHA	UHID	HNH-00015791
IP No	IP26-00006496	Admission Date	04-06-2026

USG scrotum shows

* Moderate bilateral congenital hydroceles.

Management:

Course during hospital:

In view of bilateral hydrocele Dr. Jyothi (paediatric surgeon) consult was sought who has given reassurance and advised follow up after 1 year.

Serum bilirubin at 48 hours of life was 9.1 mg/dl with indirect fraction of 9.0 mg/dl.

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

Vaccination: Baby was given following vaccination:

Vaccine Name	Status	Date
BCG	Given	05.06.2026
OPV	Given	05.06.2026
HEPATITIS B	Given	05.06.2026

TEOAE (Transient Evoked Otoacoustic Emissions): Hearing test: Report awaited.

Newborn screening advanced/Newborn sreening-4 : Sent on 06.06.2026, report awaited.

SPO2 : 98% at room air

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IP No	IP26-00006496	Admission Date	04-06-2026

**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.

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 : Sent ,report to be collected on followup.**
- 2. Hearing test (TEOAE-Transient Evoked Otoacoustic Emissions) : report awaited.**

Review consultation with Dr. SINDHURA MUNUKUNTLA on (08.06.2026) Monday 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**


Registrar/Resident/C.M.O

Dr. SINDHURA MUNUKUNTLA
MBBS, DCH, DNB PEDIATRICS
66970

HNH-00015791 IP26-00006496
Baby Of MULA ROHITHA
04-06-2026 0 Y 0 M 0 D 15 H (M)
Dr. SINDHURA MUNUKUNTLA



CROSS CONSULTATION FORM

Doctor Name: Dr. Tyathi Date: 6/5/16 Time: 12:30 PM

Diagnosis: BLL - hydrocele Testes AT MICZAD

Hospital: RCH - GMR

Type of Referral :

Emergency

Urgent

Non Urgent

Referred for: Opinion Co-Management Transfer of care

Reason for Referral: If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

LE: BLL - hydrocele ⊕

USA - status

Plan

→ BLL long hydrocele - Reassurance
moderate

No evidence

of hernia

- Can wait till
18 months
of age

- 7/1 up after
1 year

Consultant:

Name: Dr. Jyoti Bote Signature: [Signature] Date & Time: 6/6/16 12:30 PM

ADMISSION SHEET



Registration Details :

Admission No : IP26-00006496 Admit Date : 04-Jun-2026 Admit Time : 11:58 AM UHID : HNH-00015791

Patient Details :

Patient Name : Baby Of MULA ROHITHA Age : 0 D
Guardian : Mr RAKESH KANDI DOB : 04-06-2026 11:12 AM
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : 2-2-185/24/111/B,MALLIKARJUNA NAGAR Phone No : 9959300199
Bagh Amberpet Hyderabad Telangana INDIA E-mail : kandirakesh12@gmail.com
110005

Admission Details :

Bed Type : BASINET Bed No : CRDL-HNPDA-414-1 Ward Name : 4F -OT
Room No : CRDL-HNPDA-414-1 Admission Type : First Visit

Contact Details :

Name : Mr RAKESH KANDI Relationship : Father
Contact Address : 2-2-185/24/111/B,MALLIKARJUNA NAGAR Phone No : 9959300199
Bagh Amberpet Hyderabad Telangana INDIA
110005



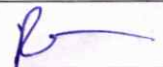

Signature

Doctor Details :

Doctor Name : Dr. SINDHURA MUNUKUNTLA Specialisation : GENERAL PEDIATRICS
Referral Doctor : Self. Phone No :
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 15000.00
Payor Name : SELFPAY

Date	Time	Investigation	Result	Order No.	Signature
4/6	12/10pm	Blood grouping		93081	
6/6/26	vscg scotum.			6801	
6/6	Dr. mukti subhash			4712	
	S	SBR		9420	
		WBS			

Cross checked done by sum



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Mula Rohitha Age : 29y Father's Name : Age :
 Date of Birth : Date of Admission : UHID No. :
 NICU Consultant : Referring Consultant :
 Transferring Unit : OT Labour Room ER Ward
 Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : <u>Alo Mula Rohitha</u> Gender : <input checked="" type="checkbox"/> M <input type="checkbox"/> F Blood Group : Date of Birth : <u>04/06/2028</u> Time of Birth : <u>11:12am</u> Place of Birth : <u>DCM, Anna</u>	Mother's Blood Group : <u>R Positive</u> Birth Weight (gms) : <u>3200gm</u> Length (cms) : OFC (cms) : Estimated Gesth Age : <u>37w + 4d</u>
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Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 29y Ht : Wt : BMI : Married Life : LMP : 19/9/25 EDD : 21/6/26
 Conception : Spontaneous or with Rx : Spontaneous
 Booked at what GA : AN Steroids Drugs / Doses :
 Last Scans Details : USG on 30/5/26 - (CF) 36w + 2d of Age; AFI - 12.6 - AC - 27.1; Fw - 2552gm; 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? <u>P. Thyroxin 50ug OD</u> <u>9 62.5ug</u> Any other Chronic Medical Problems, when detected drugs ? (Anemia, SLE, Jaundice, CHD, Heart Disease) Infection : H/O, Fever (<input type="checkbox"/> Malaria <input type="checkbox"/> UTI <input type="checkbox"/> TORCH <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> HBV) UTI : when : Any culture :
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PPROM : Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

G:.....2..... P:.....+..... A:.....⊙..... L:.....

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
1	2022	- PT	LSC (36w)	(F)	PPROM + Oligo	P; 3.07kg AG (H)
2	PP	3, 4, 5, 6, 7, 8, 9, 10, 11, 12				

PERINATAL HISTORY

Treating Obstetrician : Hospital : Inborn Outborn

Duration of Labour First stage (> 18 hours sig) Second stage (> 2 hours after dilation) LSCS : <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication : Specify the reason : 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 : Resuscitaion : <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 : 32w 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
TOTAL		8	9

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



Baby cried immediately after birth
 ↓
 Tj V.K.K given
 ↓
 Initial steps done
 ↓
 Delayed cord clamping ⊕
 ↓
 Shifted to mother's side
 Breast milk advised.

Investigation details in previous Hospital :

Feeding History :



[Empty box for patient information]

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : HR : RR : NIBP : CFT :
Color of the extremities :
Jaundice : Pallor : SpO2 :

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



HEAD TO TOE EXAMINATION

HEAD :	Fontanelles : Sutures Shape / Moulding : Edema / Bruising : Size - (H.C.) :		
Facies : (Any Facial Dysmorphism)			
NECK and CLAVICLES :	Range of Motion : Asymmetry : Masses :		
EYES :	Symmetry : Red Reflex : Discharge :		(R)
EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Periauricular Pits / Tags : Nasal shape / Patency : Palate : Gums : Lips : Tongue :		
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number :		
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : Discharge :		→ 2A + 2V
GENITILIA :	Labia / Hymen : Testicles/penis : Anus :		 Patent Blc Hydrocele ⊕ ⊕
HERNIAL ORIFICES			
TRUNK and SPINE :			6
SKIN LESIONS :		(R)	
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 :

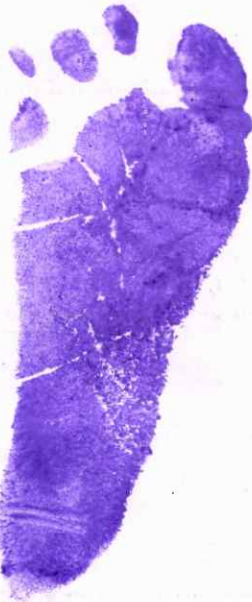


Diagnosis :

Term / male / AUA / CSAB / 3.2 kg / Infant
Bilateral Hydrocele / of Hypothyroid

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

[Signature]
Dr. Althya
4/6/26 : 12 pm

Consultant :

Signature :

Name :

Date & Time :

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 : *Preterm - 34 weeks 1 day / 1000g / 34 weeks*

Present Issues :

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

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

- (i) SLT to mother's side
 - (ii) DRF - Q# Jls during
 - (iii) SRR, NBS, OAE at 48 hrs
 - (iv) 'USG' screening at 48 hrs
- Feeding Plan at the time of shifting : *(v) Good care; Eye care*

Screenings done during NICU Stay :

NSG :
Hearing Screen :
ROP :
TFT :
NP2 :

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26	c/s/hy <u>Dr. Anubh</u>	
8:00 am	Term /AGA /Male / CIAB / ^{congenit} hydrops	
		m/bv B. / B+ve
	T. wt 3.060	
	wt loss <u>↓ 1100g</u> <u>4.3%</u>	
	urine - ✓	USG Scrotal & usitol
	Stools - ✓	Paed Sx Opinion Inlc Care
	vital stab	DBF Qbz jlb kumpiy vaccinat Pends
	Euthic / Pink	Red reflex to child 4 limb spore chie
	SLC BLAC (+) NVBS (+)	
5/6/26	BLG	
11:36 AM	OPV	
	<u>Hep B Giner</u>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	1/8/23 - Dr. Sindhura	
11/26 AM	Term / AGA / male / CIAB	Congenital Hydronephrosis
	MBG Bt	
	BRG Bt	
	Bwt - 3200	
	Twt - 3060	
0/8	4 limb sp ₂ ✓	USG Scrotum @ 48 Hrs
	B/L kid reflex ✓	Paeds Spg opinion
	Euthetic ✓	DBF
	CTA	Ag 4 limb sp ₂
	Good	
		M. Sundara
		NB Sundara

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 1PM	<u>Lactation care plan</u>	
	<ul style="list-style-type: none"> - well formed breast & nipples - prim - colostrum seen - baby sucking observed. - baby is not sucking continuously, starting to suck with strong stimulation. 	
	<u>Advice:-</u>	
	<ul style="list-style-type: none"> - Direct Breast Feeding - Aim for deep latch as demonstrated in cross cradle hold. - make baby suck 15-20 mins on each side - stimulate baby continuously. - baby ^{demand} feeding do not exceed 2-2 1/2 hours as per early hunger cues - To start Lactare (IP) 1 g tablet ^{BD} 4 Scoops (water dilution). 	
		<p>Sathwik G Pediatrician 5/6/26 1:5PM</p>

GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26	c/s/b Dr. Bindhura	
6:30 PM	Term / A1 A1 - Cong. hydrocele / Male.	
	- Baby is euthermic; feeding well.	
	- Cong Tau Activity	Normal.
		Plan
		- Warm Care
	S/E = vitals stable.	- DRF Q2H.
	S/E = WNL.	- Peds. Sx opinion
		- UCR scrotum
		@ 46110
		of medicine
		Antibiotics
		Noted by Meds.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26	S/B Dr. Sindhura	
10 AM	Δ Tail AUA / CIA / Cong hydrocele	
	Baby further	Plg
	WT - 2450g H - 24 - 4cm	DBF + FE 2ml + Bury 2ml
	PLA Tail CIA good	- Paed. surgeon opinion today
	T. wt 2940g 120g wt loss cannula 28.1	SBR NBS OAB } @ 11 AM today
		MA mandley
6/6/26	SRB - 9.1	NBS smear
2 PM	↓ Discharge	J. Sundara Anuram
	Auti.	

HNH-00015791 IP26-00006496
 Baby Of MULA ROHITHA
 04-06-2026 0 Y 0 M 0 D 1 H (M)
 Dr. SINDHURA MUNUKUNTLA



Handwritten notes in purple and green ink: a stick figure, '12 (B)', and other illegible scribbles.

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

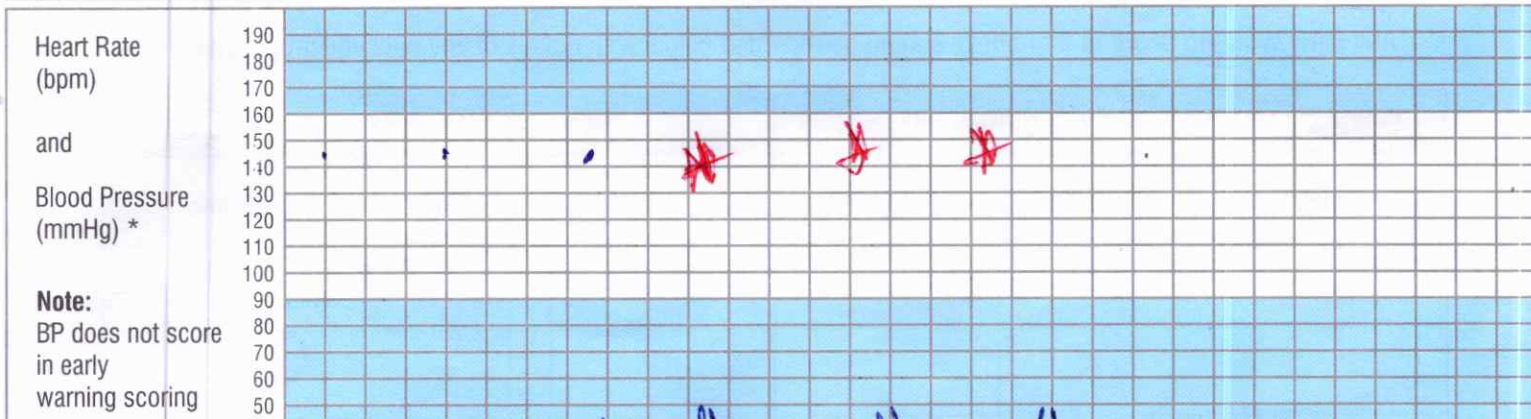
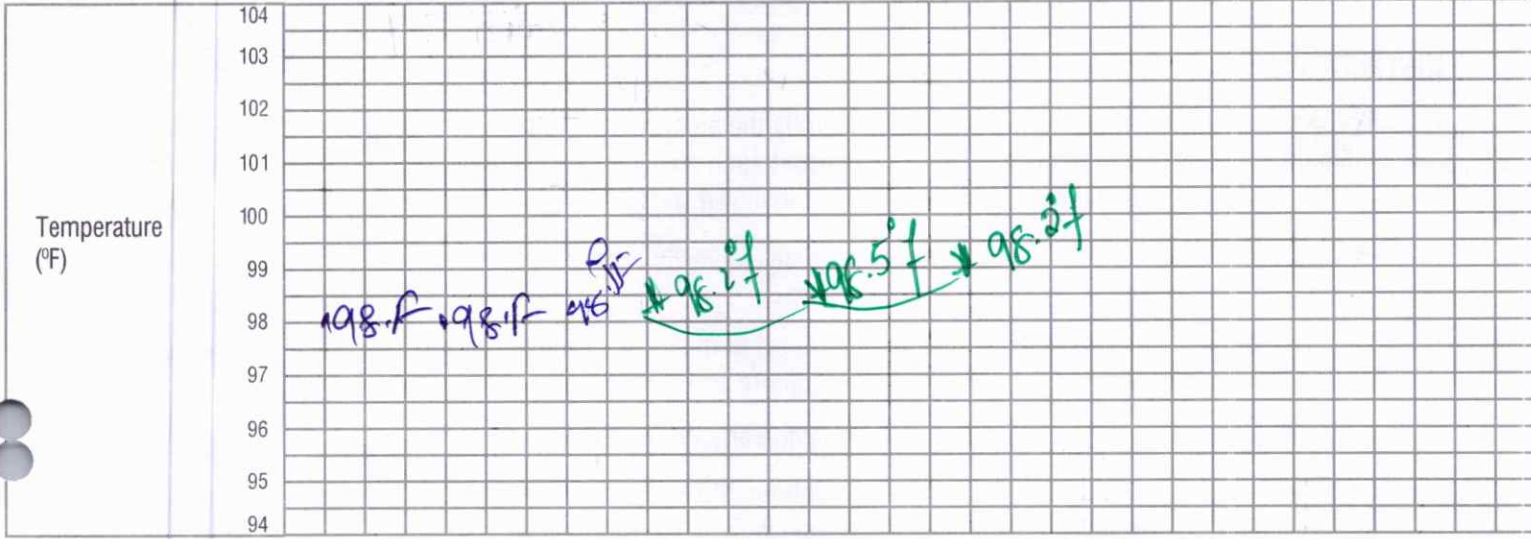
BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

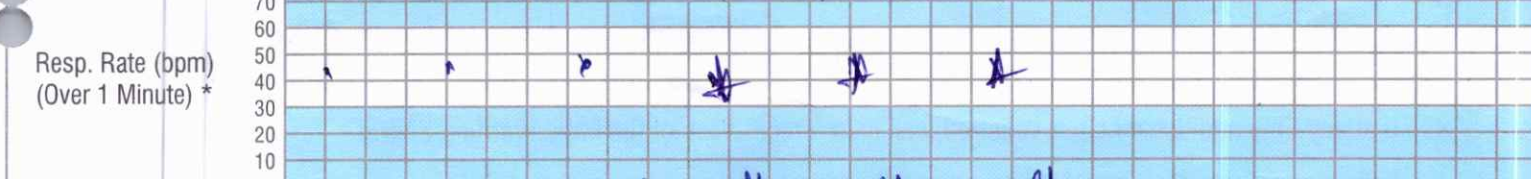
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Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 4/6 Time: 12pm 2pm 5pm 8pm 10pm 2Am
 Doctor/Nurse/Family Concern?



Heart Rate (Number) 144 146 139 145 145 145



Resp Rate (Number) 44 45 47 48 48 48

Resp Distress: Mpd/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 00% 99% 98% 98% 99% 99%

Conscious Level: Normal Altered
 GCS *

TOTAL SCORE
 Number of shaded boxes 0 0 0 0 0 0
 Pain Score 1 2 2 2 2 2
 Observer's Initials [Signature] [Signature] [Signature] [Signature] [Signature] [Signature]

ACTIONS
 NB: Scores 3 should be recorded overleaf

- 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.

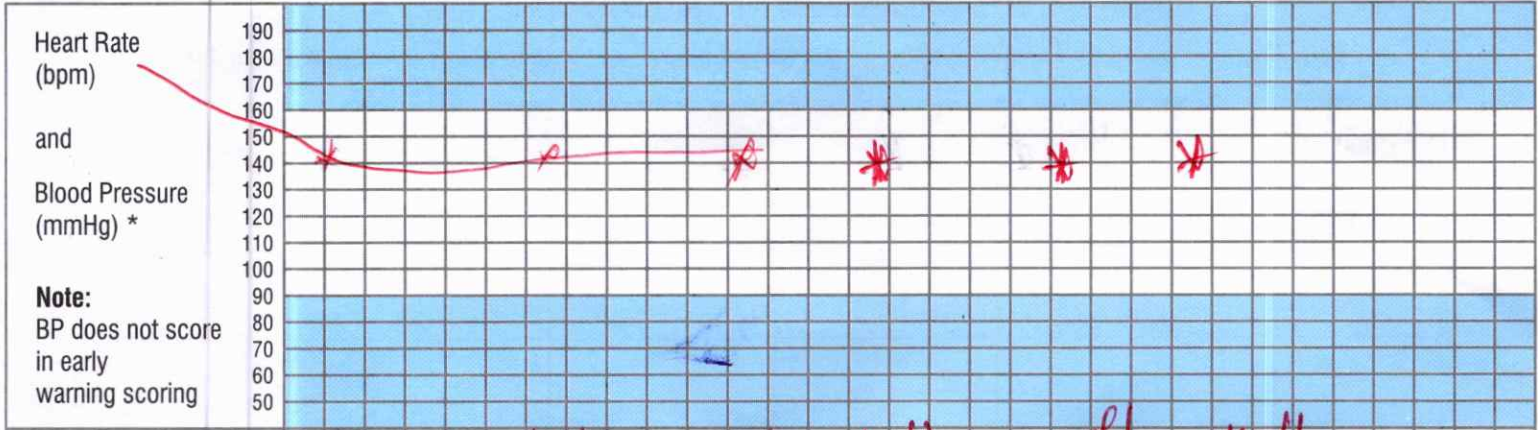
I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION: I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). 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 I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

Patient Sticker

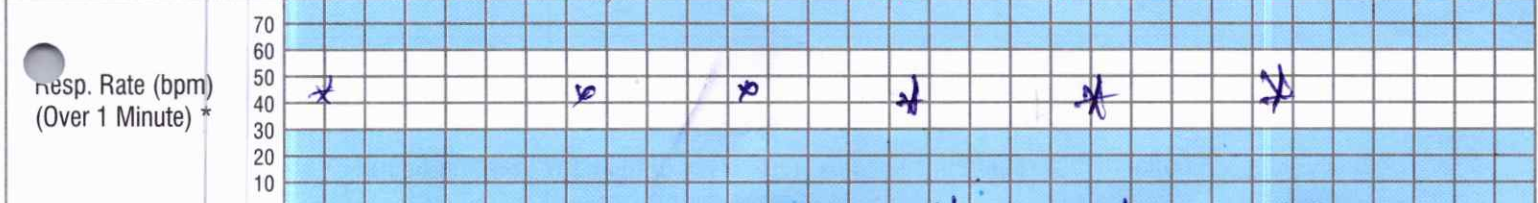
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 5/06/26 Time: 10 AM 2 PM 5:30 PM 10 PM 2 AM 6 AM

Doctor/Nurse/Family Concern?



Heart Rate (Number) 142 bpm 140 bpm 140 bpm 140 bpm 138 bpm 140 bpm



Resp Rate (Number) 42 bpm 40 bpm 42 bpm 40 bpm 40 bpm 48 bpm

Resp Distress Mod/ Severe None / Mild

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

Conscious Level Normal Altered

GCS *

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

ACTIONS
 NB: Scores 3 should be recorded overleaf

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 ¹ ... (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)

HNH-00015791 IP26-00006496
 Baby Of MULA ROMITHA
 04-06-2026 0 Y 0 M 0 D 15 H (M)
 Dr. SINDHURA MUNUKUNTLA

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



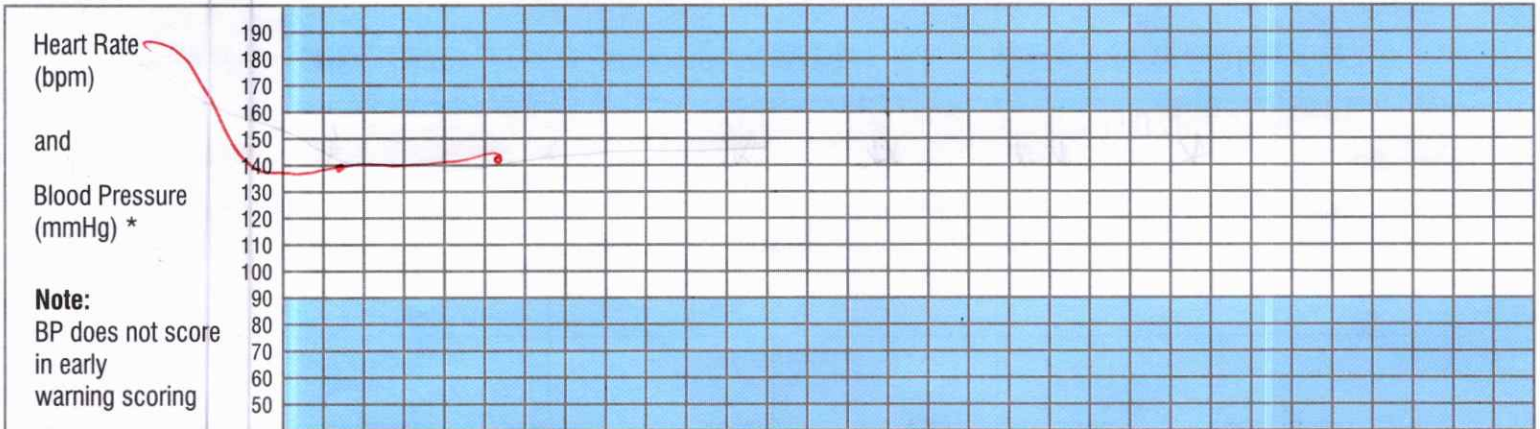
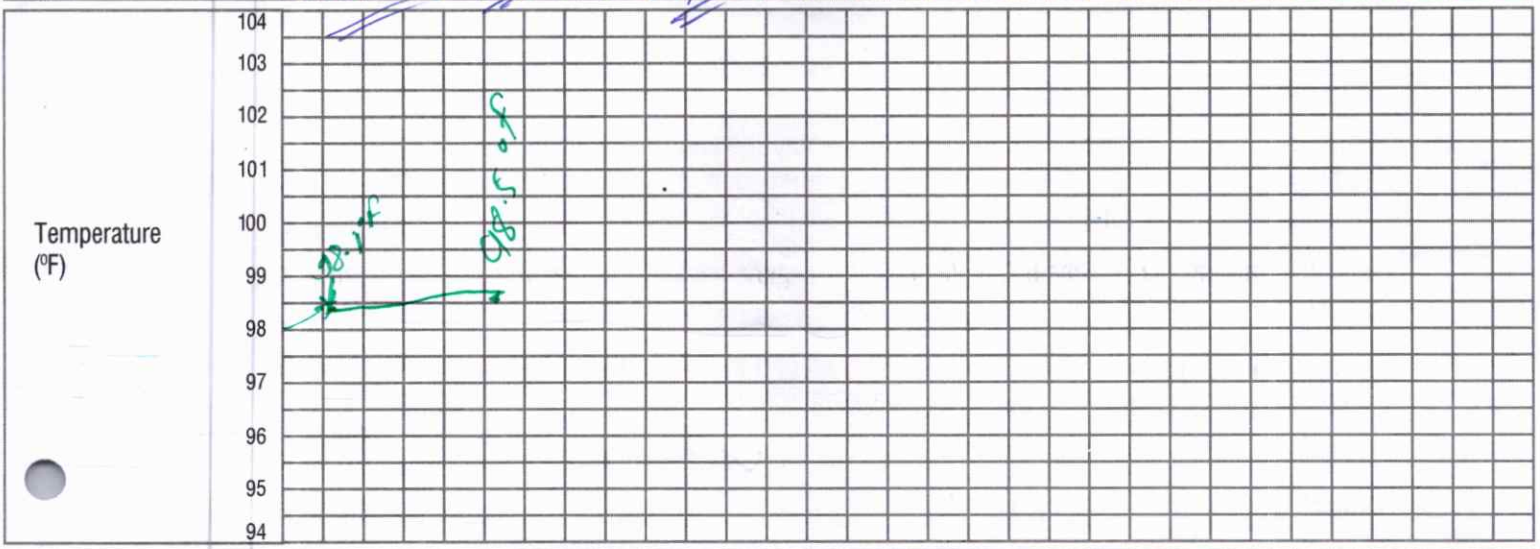
124

Patient Sticker

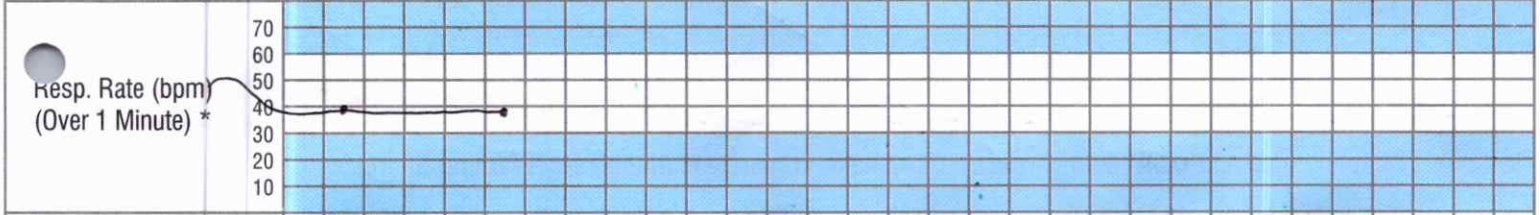
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 6/6 Time: 10 2 6

Doctor/Nurse/Family Concern? Am pm pm



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



Resp Rate (Number) 40b/m 38b/m

Resp Distress: Mod/Severe None/Mild

Receiving O₂ (l/min) O₂ Saturations (%) 09% 98%

Conscious Level: Normal/Altered

GCS * 14/15 14/15

TOTAL SCORE Number of shaded boxes 0 0

Pain Score 0 0

Observer's Initials 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
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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-00015791 IP26-00006496
 Baby Of MULA ROHITHA
 04-06-2026 0 Y 0 M 0 D 1 H (M)
 Dr. SINDHURA MUNUKUNTLA



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.

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
4/6	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm	DBF										
	01:00 pm											
Total Intake :		Taken			Total Output :							
4/6/20	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 :							
4/6/20	08:00 pm											
	09:00 pm	DBF										
	10:00 pm											
	11:00 pm	DBF										
	12:00 am											
	01:00 am	DBF										
Total Intake :		Taken			Total Output :							
5/6/20	02:00 am											
	03:00 am	DBF										
	04:00 am											
	05:00 am	DBF										
	06:00 am											
	07:00 am	DBF										
Total Intake :		Taken			Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00015791 IP26-00006496
 Baby Of MULA ROHITHA
 04-06-2026 0 Y 0 M 0 D 15 H (M)
 Dr. SINDHURA MUNUKUNTLA



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 Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
5/6/26	08:00 am		DBF			/						}
	09:00 am					/						
	10:00 am	o	DBF			/	✓	NA	✓	o		
	11:00 am					/						
	12:00 pm		DBF			/						
	01:00 pm					/						
Total Intake :						Total Output : U- M-						
5/6/26	02:00 pm		DBF			/						}
	03:00 pm					/	✓					
	04:00 pm	o	DBF			/	✓	NA	✓	o		
	05:00 pm					/						
	06:00 pm		DBF			/						
	07:00 pm					/						
Total Intake :						Total Output : U-2 M-2						
5/6/26	08:00 pm		DBF			/						}
	09:00 pm					/						
	10:00 pm	o	DBF			/	✓	NA	✓	o		
	11:00 pm					/						
	12:00 am		DBF			/						
	01:00 am					/						
Total Intake : Takeen						Total Output : U-2 M-1						
6/5/26	02:00 am		DBF			/						}
	03:00 am					/						
	04:00 am		DBF			/	✓			o		
	05:00 am	o				/						
	06:00 am		DBF			/						
	07:00 am					/						
Total Intake : Takeen						Total Output : U-2 M-1						

Total 24 hrs. Intake

Total 24 hrs. Output

Patient

HNH-00015791 IP26-00006496
 Baby Of MULA ROHITHA
 04-06-2026 0 Y 0 M 0 D 15 H (M)
 Dr. SINDHURA MUNUKUNTLA



FLUID CHART

Sheet No. :

1. All measurements in ml.
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Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
6/6	08:00 am	DBF									0	} SW	
	09:00 am										0		
	10:00 am	DBF									0		
	11:00 am										0		
	12:00 pm	DBF									0		
	01:00 pm										0		
Total Intake :						Total Output :						U-2 ml	
6/6	02:00 pm	DBF									0	} SW	
	03:00 pm										0		
	04:00 pm	DBF									0		
	05:00 pm										0		
	06:00 pm	DBF									0		
	07:00 pm										0		
Total Intake :						Total Output :						U-2 ml	
	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-00015701 IP26-00006496
 Baby Of MULA ROHITHA
 04-06-2026 0 Y 0 M 0 D 15 H (M)
 Dr. SINDHURA MUNUKUNTLA



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.

		Intake			Output					IV Site Thrombophlebitis 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	
-----------------------------	--

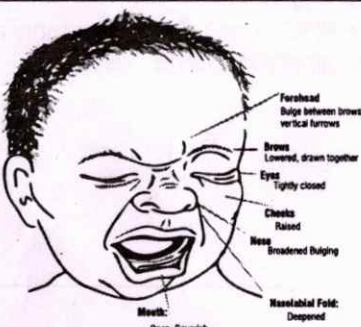
HNH-00015791 IP26-00006496
 Baby Of MULA ROHITHA
 04-06-2026 0 Y 0 M 0 D 1 H (M)
 Dr. SINDHURA MUNUKUNTLA



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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

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	4/6 Time	4/6 Time	4/6 Time	5/6 Time	5/6 Time	6/6 Time		
						M6	E2	N	M6	N	M6		
	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	-	-	-	-	-	-		
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)	-	-	-	-	-	-		
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	-	-	-	-	-	-		
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	-	-	-	-	-	-		
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	-	-	-	-	-	-		
 <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	6	0	0	0	0							
	Total Pain / Agitation Score	0	0	0	0	0							
	Intervention	0	0	0	0	0							
	Effectiveness	0	0	0	0	0							
	Signature	C	[Signature]	[Signature]	[Signature]	[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-00015791

IP26-00006496

Baby Of MULA ROHITHA

04-06-2026 0Y0M0D1H (M)

Dr. SINDHURA MUNUKUNTLA



BRADEN 'Q' SCALE



It takes a lot to treat the little.

BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	4/6	4/6	4/6	4/6
					Time :	10:30	12:00	14:00	16:00
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	2
"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	2	2	1
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		3	3	3	3
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times.		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4	4	4	4
TOTAL SCORE						23	23	23	22
Evaluator's Name						CD	CD	CD	CD

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 CARE RECORD

Date: 4/6/26

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	8 Am to 2pm	=> Assess the patient condition => plan for vital => plan for Stochart => plan for DBF	8 am to 2pm	=> Assessed the patient condition => maintain vital & Record => maintain Stochart => DBF 2nd hourly	patient is stable	vital is warm	Chait
Afternoon	2pm to 8pm	=> Assess the pt condition => check the vital's => Stochart plan => plan for DBF	2pm to 8pm	=> Assessed pt condition => checked vital's & Record => maintained Stochart => 2nd hourly DBF	vital's is normal	Baby is stable	Rusha
Night	8pm to 8Am	=> assess the Baby condition => Monitor vital's & record => maintain Stochart => DBF every 2nd hourly	8pm to 8Am	=> assessed the baby condition => monitored vital's & recorded => maintained Stochart => DBF every 2nd hourly	Baby is good	Rechecked vital	

HNH-00015791 IP26-00006496
 Baby Of MULA ROHITHA
 04-06-2026 0 Y 0 M 0 D 15 H (M)
 Dr. SINDHURA MUNUKUNTLA



Patient Sticker

NURSING CARE RECORD



Date: 5/6/26

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	8AM	Assess the Baby Condition	8AM	Assessed the Baby Condition	Baby is stable now	Vitals is normal	Kushboo
	2PM	monitor vitals Maintain Ilochart DBF every 2nd hourly.	2PM	monitored vitals Maintained Ilochart DBF every 2nd hourly			
Afternoon	2PM	→ Assess the Baby condition	2PM	→ Assess the Baby condition	Baby is stable now	Vitals are normal	Sadeh
	8PM	⇒ monitor vitals ⇒ maintain Ilochart ⇒ DBF every 2nd hourly	8PM	⇒ monitor vitals ⇒ Ilo chart ⇒ DBF every 2nd			
Night	8PM	⇒ Assess the baby condition	8PM	⇒ assessed the baby condition	⇒ Baby is stable	⇒ Rechecked vitals	Sreetha
	8PM	⇒ monitor vitals & record ⇒ Maintain Ilochart ⇒ DBF 2nd hdy	8AM	⇒ Monitored vitals & recorded ⇒ maintained Ilochart ⇒ DBF 2nd hdy			

HNH-00015791 IP26-00006496
 Baby Of MULA ROHITHA
 04-06-2026 0 Y 0 M 0 D 15 H (M)
 Dr. SINDHURA MUNUKUNTLA



NURSING CARE RECORD



Date: 6/16/26

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	2pm 10 8pm	Assess the baby condition Monitor vitals & record. Maintain T10 & ant. Provide the comfortable position. Medication give warm care.	2pm 10 8pm	Assessed the baby condition Monitored vitals & recorded Maintained T10 & ant. Provided the comfortable position. Given warm care.	Baby is Stable. Vital's normal	Maintain T10 & ant.	Sree e
Night							

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-00015791 IP26-00006496
 Baby Of MULA ROHITHA
 04-08-2026 0 Y 0 M 0 D 1 H (M)
 Dr. SINDHURA MUNUKUNTLA









NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: NB		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date	4/6	4/6	4/6	5/6	5/6	6/6	
	Shift	N6	E2	N	M6	E2	H	
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Diet:	DBF	DBF	DBF	DBF	DBF	DBF	
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	-	-	-	-	-	-	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	37.2	37.6	38.5	38.6	38.4	38.2
		Res:	20	22	25	40	40	40
		SpO ₂ :	99%	99%	99%	100%	100%	100%
		Pulse:	146	139	140	140	140	140
		BP:	-	-	-	-	-	-
		LOC:	-	-	-	-	-	-
Fall Risk Score:	-	-	-	-	-	-		
Pain Score:	-	-	-	-	-	-		
Skin Integrity:	-	-	-	-	-	-		
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-	-	-	-	-	-	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	DBF	DBF	DBF	DBF	DBF	-	
	Critical Lab Test / Values:	-	-	-	-	-	-	
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	ADL (Dependent / Non Dependent):	-	-	-	-	-	-	
Post Operative Procedure Special Orders:		-	-	-	-	-	-	
Handed Over By Name :		Maddy	Anusha	Shruti	Divya	Nusha	Shruti	
Signature / ID :		(M)	(A)	(S)	(D)	(N)	(S)	
Date:		4/6	4/6	4/6/26	5/6/26	5/6/26	6/6/26	
Time:		2pm	8pm	8pm	2pm	8pm	8am	
Taken Over By Name :		Anusha	Shruti	Divya	Nusha	Shruti	Sr	
Signature / ID :		(A)	(S)	(D)	(N)	(S)	(S)	
Date:		4/6	4/6/26	5/6/26	5/6/26	6/6/26	6/6	
Time:		2pm	8am	8am	2pm	8pm	2pm	

PATIENT STICKER

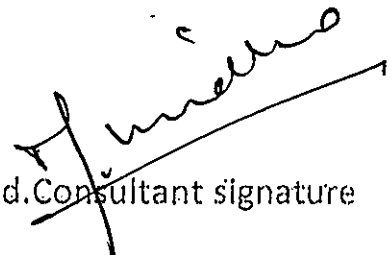
DATE: 7/6/26

NEWBORN ANOMOLY ASSESSMENT CHECKLIST

S.NO	ASSESSMENT PARAMETERS	CHECKED BY REGISTRAR	CHECKED BY CONSULTANT	REMARKS
1.	Palate			
2	Pre natal teeth		None	
3	Anal opening	Patent	Patent	
4	Genitalia	Ble Hydrocele	Ble-hydrocele	
5	Spine			
6	Red reflex	Yet to check	to be checked  Normal - 8/6/26 ✓	
7	4 limb saturation (before discharge)	Yet to check	Normal	



Ped.Registrar signature



Ped.Consultant signature



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Mother's Name:

Date of Birth: 4/6/26 Time of Birth: 11:12 AM Gender: Male Female

Birth Weight: 3.2 Kgs HC: 36 cm Length: 47 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: 36.5 °C HR: 150 /Min RR: 42 /Min BP: SpO₂: 100%

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: C. Sindhura

Signature: CP

Date & Time: 4/6/26

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015791 IP26-00006496 Baby Of MULA ROHITHA 04-06-2026 0 Y 0 M 0 D 1 H (M) Dr. SINDHURA MUNUKUNTLA 		Date & Time of Admission 4/6/26 @	Date & Time of Transfer Order 4/6/26 @ 5PM
		Transfer Ordered by DR Alekhyia	Reason for Transfer OBS
From Unit pre-past	To Unit	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 28	Number of Imaging Films NA	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" 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 Anurag		Name of Person Ordered Transfer Dr. Alekhyia	
Patient & Clinical Records Received by : Priyanka			
Date & Time of Patient Received : 4/6/26 @ 5PM			

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