

216

DISCHARGE SUMMARY

| | | | |
|------------------------|---|-----------------------|---------------------|
| Name | Baby Of HEENA JAIN | UHID | HNH-00015817 |
| Father/Guardian | Mr VAIBHAV JAIN | Age/Gender | 0 Y 0 M 2 D/ Female |
| Address | 3-6-465 to 467, flat no 604, legend siddi apt sreat 5, himayathnagar, hyd, Himayathnagar, Hyderabad, Telangana, INDIA, 500029 | | |
| IP No | IP26-00006512 | Admission Date | 05-06-2026 |
| Ref Doctor | SELF | | |
| Discharge Date | 08.06.2026 | | |

DR. S. TEJASWI REDDY
MBBS, MD (Paed) DM Neonatology
CONSULTANT PEDIATRICIAN AND
INTENSIVIST
APMC/FMR/94068

DR. SPANDANA PASUPULETI
MBBS, MRCPCH
CONSULTANT PEDIATRICIAN AND
INTENSIVIST
Reg No: 30925

Diagnosis: TERM /39 WEEKS/AGA/ TTNB/ ASSISTED VAGINAL DALIVERY / DELAYED TRANSITION.

History: Baby Of HEENA JAIN is a (39 weeks) / AGA / baby girl of birth weight 3.320 kgs, born to primi mother assisted vaginal delivered by LSCS on 05.06.2026 at 12:59 pm. Baby cried immediately after birth. Apgar scores and resuscitation details were 3/10 at 1 min, 6/10 at 5 min. Baby developed respiratory distress after birth for which DR CPAP was given and baby was

| | | | |
|-------|--------------------|----------------|--------------|
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shifted to NICU - for further management.

Maternal History : Mrs. HEENA JAIN is a 28 years old primi mother.

G1 : Present pregnancy, spontaneous conception. She had regular antenatal checkups and antenatal scans were normal. There was no history of UTI/ Abortions/ Hydramnios/ PROM/ Diabetes/ Hypertension/ Cardiac/ Renal abnormalities/ PIH/ APH/ Hypothyroidism/ Oligohydramnios/ Polyhydramnios / Fever. She received calcium, iron supplementation and TT prophylaxis.

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

Examination: At the time of birth, baby had weak cry, hypotonic, color was pale and saturations <60% at room air. Her heart rate was 100/min, respiratory rate was 60/min. Tachypnoea and grunt present. Subcoastal and intercoastal retractions were present. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Abdomen was soft without organomegaly. There were no obvious external congenital anomalies. Caput present.

Weight on Admission : 3.320 kgs

Weight on Discharge : 3.28 kgs

Head circumference : 35 cms

Length : 46 cms

Investigations: Enclosed reports.

Initial hemogram showed Hemoglobin of 17.8 gm%, White Blood Cell count of 32230 cells/cumm, platelet count of 2.75 lakhs/cumm and C-Reactive Protein of 5.0 mg/l.

Blood culture shows: No growth after 24 hrs of incubation

| | | | |
|--------------|--------------------|-----------------------|--------------|
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Repeat hemogram showed Hemoglobin of 16.7 gm%, White Blood Cell count of 22650 cells/cumm, platelet count of 2.38 lakhs/cumm and C-Reactive Protein of 5.0 mg/l.

serum bilirubin was 9.3 mg/dl with indirect fraction of 9.2 mg/dl.

Chest X ray shows Bilateral increased perihilar streaky markings noted, likely in keeping with transient tachypnea of new born.

Management:

NIPPV : Baby was nursed in thermoneutral environment, DR-CPAP was given and shifted to NICU. In NICU baby was initially kept on NIPPV and shifted to CPAP (PEEP-6, FiO2-25%) after improvement of respiratory distress . Chest Xray shows Bilateral increased perihilar streaky markings noted, likely in keeping with transient tachypnea of new born.. Cord Blood Gas showed pH of 7.42, pCO2 of 35.2 mmHg, pO2 of 52 mmHg, HCO3 of 22.8 mmol/L and BE of -1.7 mmol/L baby was started on empirically antibiotics after sending sepsis screening. Repeat CBP,CRP done on 06.06.2026 which was normal, IV antibiotics were stopped after blood culture were sterile. Blood gas analysis was serially monitored. Transcutaneous bilirubin was done which was normal. DR-CPAP was gradually weaned off to room air at DOL 2 as the respiratory distress settled. Now baby is maintaining saturation at room air without any respiratory distress.

Vaccination: Baby was given following vaccination:

| | | | |
|-------|--------------------|----------------|--------------|
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| Vaccine Name | Status | Date |
|--------------|--------|------------|
| BCG | Given | 08.06.2026 |
| OPV | Given | 08.06.2026 |
| HEPATITIS B | Given | 08.06.2026 |

Feeding: Once baby was hemodynamically stable, she was started on OG feeds, followed by spoon feeds, which she accepted and tolerated well. At present baby is on direct breast feeds, which she is tolerating well.

TEOAE (Transient Evoked Otoacoustic Emissions): Hearing test:
Parents not willing .

Newborn screening advanced / Newborn screening-4: Sent on 07.06.2026, report awaited.

SPO2 : 99% at room air
Red Reflex: Present & Symmetrical
Hip Examination was normal.

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

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

Advice:
Keep the baby clean & warm
Regular breast feeding

| | | | |
|--------------|--------------------|-----------------------|--------------|
| Name | Baby Of HEENA JAIN | UHID | HNH-00015817 |
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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.**
- 4. To collect final blood culture report on follow up.**

Review consultation with Dr. S TEJASWI REDDY on Wednesday(10.06.2026) at Himayatnagar with prior appointment **(Review consultation will be charged).**

Review back to Hospital: If baby is not feeding continuously for > 6 hours, If breathing fast, Fever or poor activity or lethargy, Bluish discolouration of lips, Increase in jaundice, Abnormal movements occurs.

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

Parent/ Attender

| | | | |
|--------------|--------------------|-----------------------|--------------|
| Name | Baby Of HEENA JAIN | UHID | HNH-00015817 |
| IP No | IP26-00006512 | Admission Date | 05-06-2026 |

In case of emergency contact 9154865030 emergency pediatrician on duty.

To take appointment for OPD consultation at Rainbow **Himayathnagar / 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**


Sushree H.
Registrar/Resident/C.M.O



DR. SPANDANA PASUPULETI
MBBS, MRCPCH
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Reg No: 30925

DR. S. TEJASWI REDDY
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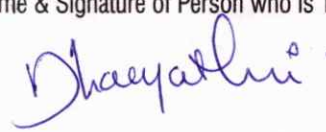
PATIENT TRANSFER FORM

| | | | |
|--|------------------------------|--|--|
| Patient Name & UHID No. HNH-00015817 IP26-00006512 Baby Of HEENA JAIN 05-06-2026 0 Y 0 M 2 D (F) Dr. S TEJASWI REDDY  | | Date & Time of Admission 5/6/26 @ 2:08 pm | Date & Time of Transfer Order 7/6/26 @ 11:30 am |
| | | Transfer Ordered by DR. Sreeghan | Reason for Transfer Shifting |
| From Unit NICU | To Unit Ward. | Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Number of Sheets in Clinical File 30 | Number of Imaging Films 1 | Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ? | |

Medications / Consumables / Surgicals / Hand over

| Sl.No. | Item Name | Quantity |
|--------|-----------|----------|
| 1. | X-ray | 1 |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

Shifting Summary / Notes Written by Doctor : Yes No

| | |
|---|---|
| Name & Signature of Person who is Transferring  | Name of Person Ordered Transfer DR. Sreeghan |
|---|---|

Patient & Clinical Records Received by :
 Srinivas 11:30 am

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 : IP26-00006512 Admit Date : 05-Jun-2026 Admit Time : 02:08 PM UHID : HNH-00015817

Patient Details :

Patient Name : Baby Of HEENA JAIN Age : 0 D
Guardian : Mr VAIBHAV JAIN DOB : 05-06-2026 12:59 PM
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : 3-6-465 to 467, flat no 604,legend siddi apt
sreat 5, himayathnagar,hyd Himayathnagar
Hyderabad Telangana INDIA 500029 Phone No : 9700409144/ 9521776976
E-mail : heenakjain06@gmail.com

Admission Details :

Bed Type : NICU Bed No : NICU1-401 Ward Name : 4F -NICU 1
Room No : NICU1-401 Admission Type : First Visit

Contact Details :

Name : Mr VAIBHAV JAIN Relationship : Father
Contact Address : 3-6-465 to 467, flat no 604,legend siddi apt
sreat 5, himayathnagar,hyd Himayathnagar
Hyderabad Telangana INDIA 500029 Phone No : 9700409144


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 : 20000.00
Payor Name : SELFPAY

CONSENT FOR ADMISSION IN NEONATAL INTENSIVE CARE U

HNH-00015817 IP26-00006512
Baby Of HEENA JAIN
05-06-2026 0 Y 0 M 0 D 3 H (F)
Dr. S TEJASWI REDDY



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: B/o. Heena Jain Age: 03 Gender: Male Female

UHID.No: GALT-0001581A Date: 5/6/26

I Vaibhav Jain S/o, D/o, W/o Mahavir Jain hereby declare that our patient Mr. / Ms who is related to me as is getting admitted in the Neonatal Intensive Care Unit of Rainbow Children's Hospital on

The doctors have explained to me in a language understood by me that my child has following health related issues :

.....
.....
.....

The doctors have clearly explained to me that my patient B/o during his / her stay in the Neonatal Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical ventilation, Umbilical Artery Catheter, Umbilical Vein and Arterial Lines, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Neonatal Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Neonatal Intensive Care Unit with multiple medical and surgical procedures performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child B/o in the Neonatal Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Neonatal Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :

Signature : Vaibhav Jain

Name : Vaibhav Jain

Relationship with Patient: Parent

Date & Time : 5/6/26 @ 4:30pm

Witness :

Signature : Dheeraj

Name : Dheeraj

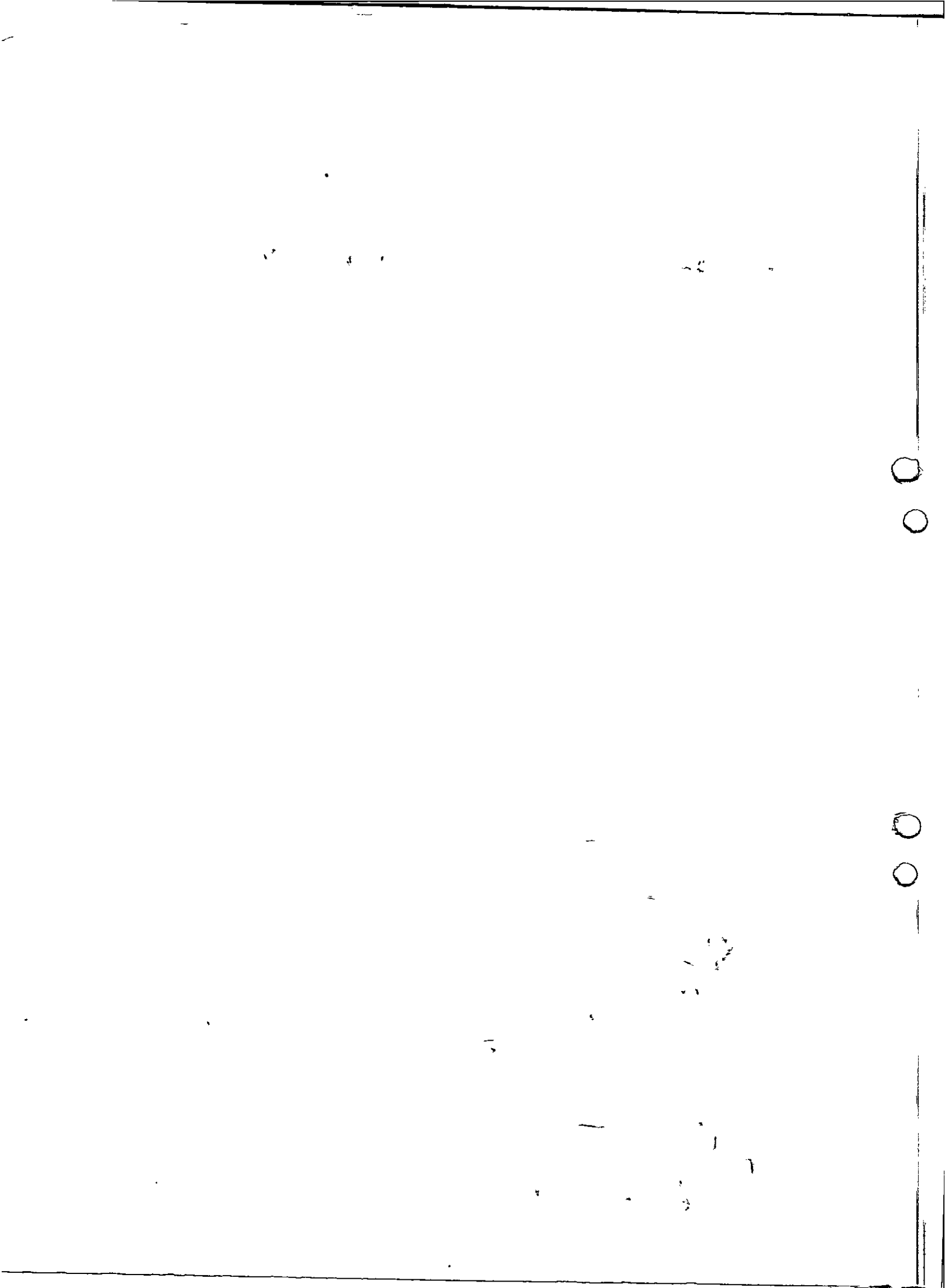
Date & Time : 5/6/26

Doctor (who is taking the consent) :

Signature : Dr. S. Tejaswi Reddy

Name : Dr. S. Tejaswi Reddy

Date & Time : 5/6/26 @ 4:30pm



CONSENT AND SPECIAL PROCEDURES

HNH-00015817 IP26-00006512
Baby Of HEENA JAIN
05-06-2026 0Y0M0D3H (F)
Dr. S TEJASWI REDDY

Patient Name : Gender: Male Female
UHID No : Department : OB/GYN Date : 5/6/26

I Vaibhav Jain S/D/W/O Maharaj Jain

Here by give consent for procedure of :

For my patient, Named :

The doctors have clearly explained to me that the procedure has following possible complications:
C-P.A.P.

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :
.....

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure:

Patient Attendant :
Signature : [Signature]
Name : Vaibhav Jain
Relationship with Patient: father
Date & Time : 5/6/26 @ 4:30pm

Witness :
Signature : [Signature]
Name : [Name]
Date & Time : 5/6/26 @ 4:30pm

Doctor (who is taking the consent) :
Signature : [Signature]
Name : Mr. Gaudere
Date & Time :

CONSENT FOR FORMULA FEEDS



Patient Name: ^{NH-00015817} ^{IP26-00006512} Baby Of HEENA JAIN Age : Gender : Male Female
UHID No : ⁵⁻⁰⁶⁻²⁰²⁶ ^{0 Y 0 M 0 D 1 H (F)} r. S TEJASWI REDDY 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 : *[Name]*
Relationship with Patient: *Parent*
Date & Time : *5/6/26 @ 3pm*

Witness :
Signature : *[Signature]*
Name : *[Name]*
Date & Time : *5/6/26 @ 3pm*

Doctor (who is taking the consent) :
Signature : *[Signature]*
Name : *Dr. Vaishya*
Date & Time : *6/6/26*

ACTIVITY RECORD FOR BILLING

Name: **HNN-00015817** **IP26-00006512**
Baby Of HEENA JAIN
05-06-2026 **0 Y 0 M 0 D 3 H (F)**
Dr. S TEJASWI REDDY

UHID No: 
 Consultant: _____ Dept: _____

Date of Admission: _____ Date of Discharge: _____ Time: _____

Room / Bed No: _____ Ward: _____ Suggested Billable bed type: _____

WARD TRANSFERS

| Date | Time | From | To | Signature of Nurse |
|--------|----------|------|------|--------------------|
| 5/6/26 | 2pm | OT | NICU | <i>[Signature]</i> |
| 7/6/26 | 11:30 am | NICU | ward | <i>[Signature]</i> |
| | | | | |
| | | | | |

Cross Consultation Visit

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

PROCEDURE

| Date | Procedure | Quantity | Order No. | Signature |
|--|--------------|----------|-----------|-----------|
| 5/6/26 | RU placement | ① | 4510 | Dhen |
| cross checked done by Dhen 5/6/26 @ 8pm | | | | |
| | | | | |
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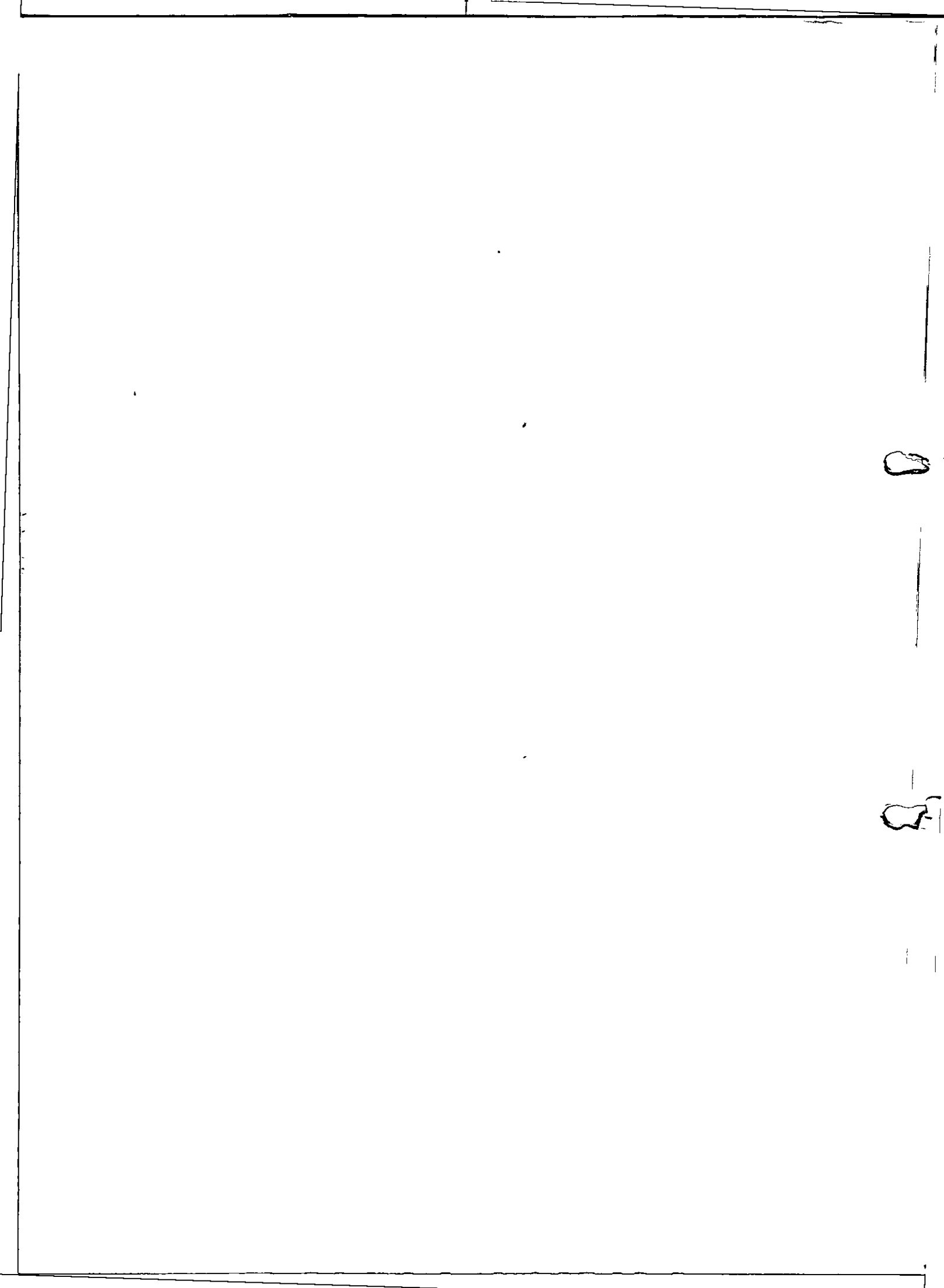
ANY OTHER INFORMATION

Date :

Time :

Prepared By :

| | | | |
|-------------|--------------|-------------------|--------------------|
| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|-------------|--------------|-------------------|--------------------|





NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Mrs. Heena Jain Age : 28yrs 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 : B/o Heena Jain Mother's Blood Group : R Positive
 Gender : M F Blood Group : Birth Weight (gms) : 3.32kg Length (cms) :
 Date of Birth : 5/6/26 Time of Birth : 12:59pm OFC (cms) :
 Place of Birth : RCH; HNMR Estimated Gesth Age : 39 weeks

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 28yrs Ht : Wt : BMI : Married Life : Agd LMP : 25/9/25 EDD : 14/01/26
 Conception : Spontaneous or with Rx : Spontaneous
 Booked at what GA : 31/5/26 AN Steroids Drugs / Doses :
 Last Scans Details : Cephalic; placenta posterior; left bleed; AFI - 14.2cm; FRW - 3005g
 (V. A) Doppler - (-) TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : <18 yrs > 35yrs
 Consanguinity : Yes No
 If yes, degree of consanguinity : 1 2 3
H/o PIH (after 20 weeks) / PE
 How many Drugs / Doses / Since how long :
 H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) :
 IUGR - when detected :
 Doppler (Increased Resistance / ADEF / REDF / Redistribution in MCA) / Ductus Venosus :
 AFI :

H/o GDM/ pre GDM/ on diet or insulin
 Controlled or not, recent values, HbA1 values :
 Compliance with Rx :
 Scans : LGA, TIFFA , Fetal Echo :
H/o Hypothyroidism : when diagnosed ? Medication?
 Any other Chronic Medical Problems, when detected drugs ?
 (Anemia, SLE, Jaundice, CHD, Heart Disease)
 Infection : H/O, Fever
 (Malaria UTI TORCH TB HIV HBV)
 UTI : when : Any culture :

PPROM : Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

G: 3 P: A: L:

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

PERINATAL HISTORY

Treating Obstetrician : Hospital : Inborn Outborn

| | |
|--|--|
| <p>Duration of Labour</p> <p>First stage (> 18 hours sig)</p> <p>Second stage (> 2 hours after dilation)</p> <p>LSCS : <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</p> <p>Specify the reason :</p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p> | <p>CTG : <input type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL :</p> <p>Resuscitaion : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cord ABG :</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :</p> |
|--|--|

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : 29 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>0</u> | <u>1</u> | <u>2</u> |
| | <u>2</u> | <u>2</u> | <u>2</u> |
| | <u>0</u> | <u>1</u> | <u>1</u> |
| | <u>0</u> | <u>1</u> | <u>1</u> |
| TOTAL | <u>1</u> | <u>1</u> | <u>7</u> |

| Resuscitation | | | |
|--------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| Minutes | 1 | 5 | 10 |
| Oxygen | | | |
| PPV / NCPAP | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| ETT | | | |
| Chest Compressions | | | |
| Epinephrine | | | |

Comments : 6 7

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

Patient Sticker



History of Present Illness:

Baby cried immediately after birth

↓

Baby had no tone & colour was pale

↓

HR checked was \rightarrow 100bpm

Saturations $<$ 60%

↓

After initial steps not much improvement

started on DR-CPAP

↓

Colour improved by 10mins.

Target saturations not achieved by 10m

↓
Reassessed after 15mins of DR-CPAP

↓
grunt @ @ \rightarrow Continued on DR-CPAP for another 15mins.

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

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

Color of the extremities :

Jaundice : Pallor : SpO2 :

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

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

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

*Head - Caput PP
 Mark on the right & left forehead*

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 : *AR*

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

ABDOMEN and UMBILICUS : Shape :
 Organomegaly :
 Bowel Sounds :
 Umbilical Stump : *→ 2 A A 2 ✓*
 Discharge :

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

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

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



SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

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

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

Mention if baby is on : Hood box CPAP Ventilator

Settings :

Spo2 : Auscultation : 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 : 2A + 2V

Abdominal girth : First urine passed :
 Meconium passed : Gpassed.

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

.....

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

ATNR : Skull and Spine :

Any Congenital Anomalies :

Diagnosis :

Term / Female / A cof / Delayed transition
Assisted vaginal delivery / TTAB.

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

[Signature]
Dr. Akhya; Dr. Basanthi
5/6/26; 1:30 pm

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 : SP02 : Weight :

Any Oxygen requirement :

Systemic :

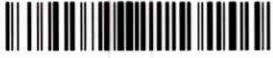
Medications :

Plan during ward follow up :

- (1) Shift to N2W
- (2) Start on NIPPV.
- (3) Send CBP; CRP; VBG; Blood culture.
- (4) Start Ampicillin & Gentamycin

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 | | |
| 2pm | <p>Case of TTNB.</p> <p>Delayed 2nd stage Assisted vaginal delivery.</p> | <p>Advise:</p> |
| | <p>Ole -</p> <p>Tachypnea Nasal flaring Diaphoresis</p> | <p>(i) Continue Niprov</p> <p>(ii) Send CBC VBC CAP Blood Culture</p> |
| | <p>Cry Ice Activity ↑ good.</p> | <p>(iii) Continue Antibiotics.</p> <p>(iv) Trace Investigations.</p> |
| | | |
| | | |
| | | <p>Done by [Signature] 5/6/26 @ 2pm</p> |



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------|---|----------------|
| 5/06/26 | Dr. Spandana | |
| 16.10 PM | | |
| | Breathing support - CPAP FiO ₂ - 25% | |
| | Infection - Abx started | |
| | CRP / <u>CRP</u> / BC | |
| | BC - <u>48 hours</u> | |
| | to memo - Blood kit. | |
| | CXR - explained | |
| | Feed - 5mls | |
| | <u>NLEW</u> - 3 days | |
| | Dr. Jain | P. S. |
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PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|----------------------|---|---|
| 05/06/26 10:00 AM | <p>Chd's. Dr. Sanketh / D. Tharal</p> <p>Baby on CPAP (PEEP-6: FiO2-25%) O2 feeds. 2ml 2nd hourly O/C.</p> <p>HR: 137/min SpO2: 99% @ CPAP RR: 43/min TPR: 60/44 mmHg</p> | |
| | | <p><u>Adm</u> + IV fluids @ 5ml/hr - O2 feeds 2ml 2nd hourly Trovancin feeds/ 2ml 2nd hourly (↓ 80 fluids 1ml) 2nd hourly</p> <p>- Cont. Try Ampicillin Cefotaxime - Treat TBlood C/S - Monitor vitals and Temp 201</p> <p>Sanketh</p> |
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| | | |
| | <p>Noted by shivaleela 5/6/26 @ 10pm</p> | |

MNH-00015817

IP26-00006512

Baby Of HEENA JAIN

05-06-2026

0 Y 0 M 0 D 5 H (F)

Dr. S TEJASWI REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|------------------|---|--|
| 06/06/25 7 AM | C106- Dr. Srinanth / Dr. Tharini / Dr. Srinivasan | |
| | Term (39w) / B.wt: 3.320 gm / MGA / female / Delayed transition / AVD / TTMB | |
| | Baby in room with On feeds 13ml 2nd hourly | |
| | O/G: Euthymic HR: 150/min RR: 68/22 min/4 PR: 48/min SpO2: 99% @ RA No retractions | |
| | S/G: RI: BUA6⊕ | |
| | | <p style="text-align: center;"><u>Adv</u></p> <p>CRP, CRP in the evening Trace Blood Clots Cont. Antibiotics - Start spoon feeds (13ml 2nd hourly) (Teach mother) - Monitor vitals well Temp 36 - Strip & feeds Simble</p> |
| | Noted by Laxmiprasanna 6/6/25 @ 7 AM | |

HNH-00015817 IP26-00006512
 Baby Of HEENA JAIN
 05-06-2026 0 Y 0 M 1 D (F)
 Dr. S TEJASWI REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-----------------|---|----------------|
| 6/6 11:00 AM | <p style="text-align: center;"><u>Counselling notes</u></p> | |
| | <p>- Baby is off CPAP, now on room Air</p> | |
| | <p>- Baby taking feeds well, spoon feeds involve mother today</p> | |
| | <p>- CBP, CRP, Plan to send today</p> | |
| | <p>= Blood Cfs report awaited.</p> | |
| | <p>- Plan to continue and Nilsu stay today.</p> | |
| | <p>= If CBP, CRP normal plan to shift out tomorrow.</p> | |
| | <p style="text-align: center;">Sign</p> | |
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B/o Heena Jain

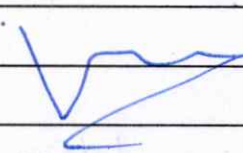


PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|------------------|--|---|
| 6/6/24 4:30pm | Counselling notes (Mrs Spondan) | |
| | - Baby coughs on Room Air | |
| | - No distre | |
| | - Establishes <u>DBF</u> → | 4. taking well ↓ |
| | | - Shift plan downward by TM. |
| | - Tolerates feeds well. | |
| | - Doing Blood Investigate | - CBP, CRP |
| | ← Send (CBP) (CRP) | ⊕ Normal B/Clt - NG ↓ Stop IV Antibiot |
| | | ⊕ Abn ↓ continue Antibiotics. |
| | - Inform Sathvik (Lactation Consultant) while feeding. | P.S. |
| | Heena Jain | |



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------|--|---|
| 6/6/26 | 4:16 Dr. Varun | |
| 11 PM | Term/Ag of delayed transition/TTNB. | |
| | Dr. Varun Sir. | |
| | - NO respiratory distress. | |
| | RF - HR - 160/min. RR - 42/min. SpO2 - 92% @ RA. | Plan |
| | SpO2 - LNL. | - Ct. SF 25ml @ 24. - Trac blood 4s. |
| | | - Monitor vitals. |
| | | - Inform SOS. |
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| | | Noted by Supriya 6/6/26 upm |



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|----------------|--------------------------------------|--|
| 7/6/26 6 AM | <u>S/B. Dr. Prabhat</u> | |
| | T / A GA Delayed transition / TTNB | |
| | Balae +22ml | Accepting 25 cc SF O2H ↓ RA |
| | pawing 2/5 no clo | <u>Adv</u> |
| | <u>O/S</u> Vitals stable | ① CT SF 25cc O2H |
| | AP OSE | ② Monitor Vitals Injom 100 |
| | PA 6/8 | ③ Trace Blood cl + plan to stop antibiotic |
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*checked by swinid
 7/6/26
 6 AM*



Patient Sticker



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|--------------------|----------------------------------|----------------|
| 7/6/26 10:55 AM | Dr. <u>Chandelana</u> | |
| | SVIA | |
| | Baby stable | |
| | Feeding feeds, tolerating feeds. | |
| | CRP - normal | |
| | BC - awaiting report. | |
| | if negative - Abx stopped. | |
| | -> Shift baby to mother side. | |
| | -> vaccinations - tomorrow. | |
| | -> Hearing test | |
| | -> <u>SRR</u> - today. | |
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| | Heena Jain | P.S. Reddy |
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PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------|-------------------|----------------------|
| 7/6/26 | with Dr. Manni | |
| 6pm | term / AHA / TTNB | |
| | - feeds ✓ | |
| | - urine ✓ | |
| | - stools ✓ | |
| | OTC ceftriaxone | |
| | UTIA = good | |
| | BF = flat | Plan |
| | meals (+) | 1) warm call |
| | CRT: L 2 sec | 2) DBF every 24h |
| | vitals: stable | Ab keeping |
| | | 3) trace SBR, NBS |
| | | 4) monitor meals. |
| | hr | |
| | | noted by Sr. Sandhya |
| | | 7/6/26 |
| | | 6:00 |

HNH-00015817 IP26-00006512
 Baby Of HEENA JAIN
 05-06-2026 OYOMOD3H (F)
 Dr. S TEJASWI REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------------|--|---|
| 8/6/26 7:25 AM | S/E Dr. Sreehan Δ Ten IANA / TTM3 | |
| | Baby Full term T.wt: - 3.280 kg (Same weight) | Plan Warm car |
| | W - S, S, S to R - S, S, S P/A soft | - DBF + Bupig 2nd - Plan disch |
| | CTA good 13 sup | |
| 8/6/26 9:50 AM | 48h SBR-9.3 c/s/by Dr. Tejaswi | |
| | Baby Euthic. Active. 2uh - NG | Plan |
| | vital stable. | Warm car. |
| | S/E P/A soft. CVS - S, L (F). | DBF + Bupig 1th buping (T) Blis disch today. - Vaminat Now - Masoches nail dress 3 days |

HNH-00015817 IP26-00006512
Baby Of HEENA JAIN
05-06-2026 0 Y 0 M 0 D 3 H (F)
Dr. S TEJASWI REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------------|----------------|----------------|
| 8/6/26 | | |
| | BCG | |
| | OPV | |
| | HepB } given | |
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HNH-00015817 IP26-00006512
 Baby Of HEENA JAIN
 05-06-2026 0Y0M0D6H (F)
 Dr. S TEJASWI REDDY



DRUG CHART

Date of Admission: Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 - 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

| | | | | | | | | | | | | | | | | | | | |
|--------------------------|-------|--------------|------------|-------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : | | | | Date | | | | | | | | | | | | | | | |
| | | | | Time | | | | | | | | | | | | | | | |
| Dose | Route | Frequency | Start Date | | | | | | | | | | | | | | | | |
| Doctor's Signature | | Valid Period | Pharm. | | | | | | | | | | | | | | | | |
| Additional Instructions: | | | | | | | | | | | | | | | | | | | |

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|--------------------------|-------|--------------|------------|-------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : | | | | Date | | | | | | | | | | | | | | | |
| | | | | Time | | | | | | | | | | | | | | | |
| Dose | Route | Frequency | Start Date | | | | | | | | | | | | | | | | |
| Doctor's Signature | | Valid Period | Pharm. | | | | | | | | | | | | | | | | |
| Additional Instructions: | | | | | | | | | | | | | | | | | | | |

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|--------------------------|-------|--------------|------------|-------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : | | | | Date | | | | | | | | | | | | | | | |
| | | | | Time | | | | | | | | | | | | | | | |
| Dose | Route | Frequency | Start Date | | | | | | | | | | | | | | | | |
| Doctor's Signature | | Valid Period | Pharm. | | | | | | | | | | | | | | | | |
| Additional Instructions: | | | | | | | | | | | | | | | | | | | |

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. Ward.

| | | | | | | | | | |
|---|-------|-----------|------------|--|--------|--------|---|-----|---|
| DRUG : INT. AMPICILLIN | | | | Date Time | 5/6/26 | 7/6/26 | | | |
| Dose | Route | Frequency | Start Date | | | | | | |
| 165mg | IV | TID | 5/6/26 | 6pm | X | 5pm | X | 8am | X |
| Name & Signature of the Doctor Starting the Drugs: | | | | 2pm X 5pm X 8am X | | | | | |
| Additional Instructions: | | | | 4.7ml of wfi to 50mg vial. Take 5ml qad 10pm. 5ml of 0.9% NS & injure over 10 minutes. | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | | | | | |

| | | | | | | | | | |
|---|-------|-----------|------------|-----------------------------------|--------|--------|--|--|--|
| DRUG : INT GENTAMYCIN | | | | Date Time | 5/6/26 | 7/6/26 | | | |
| Dose | Route | Frequency | Start Date | | | | | | |
| 17mg | IV | OD | 5/6/26 | | | | | | |
| Name & Signature of the Doctor Starting the Drugs: | | | | 6pm X | | | | | |
| Additional Instructions: | | | | 2ml + 0ml NS Inj over 10 minutes. | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | | | | | |

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|---|-------|-----------|------------|--------------|--|--|--|--|--|
| DRUG : | | | | Date Time | | | | | |
| Dose | Route | Frequency | Start Date | | | | | | |
| | | | | | | | | | |
| Name & Signature of the Doctor Starting the Drugs: | | | | | | | | | |
| Additional Instructions: | | | | | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | | | | | |

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|---|-------|-----------|------------|--------------|--|--|--|--|--|
| DRUG : | | | | Date Time | | | | | |
| Dose | Route | Frequency | Start Date | | | | | | |
| | | | | | | | | | |
| Name & Signature of the Doctor Starting the Drugs: | | | | | | | | | |
| Additional Instructions: | | | | | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | | | | | |



NURSING SHIFT HAND OVER FORM

| SITUATION | Diagnosis: | | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known | | | | | |
|--|-------------------------------------|---|--|---|---|---|---|---|
| | Surgery / Procedure: | | If Yes Specify: | | | | | |
| BACKGROUND | Date | Shift | 5/6/26 E2 | 6/6/26 N1 | 6/6/26 M4 | 6/6/26 E2 | 6/6/26 N1 | 7/6/26 M5 |
| | | Medical Condition (Any special condition to be noted): | | RD | TTNB | TTNB | RD | RD |
| | Diet: | | Ready | | | Ready | Ready | Ready |
| ASSESSMENT | Allergy: | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | Ventilation (RA, NP, NIV, VENTI): | | NIU | CPAP | PIA | PIA | PIA | PIA |
| | Tubes/Drains/Catheter: | | <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | Vital Signs: | | Temp: 36.8C | 36.5C | 36.5C | 36.6C | 36.5C | 36.5C |
| | | | Res: 40b/m | 36bpm | 30bpm | 30b/m | 30b/m | 30b/m |
| | | | SpO ₂ : 100% | 100% | 100% | 100% | 100% | 100% |
| | | | Pulse: 126b/m | 142bpm | 142b/m | 126b/m | 122b/m | 125b/m |
| | | | BP: 72/64 | 60/44/40 | 69/44/32 | 79/60 | 69/48 | 71/42 |
| | | | LOC: - | - | - | - | - | - |
| | | | Fall Risk Score: - | - | - | - | - | - |
| | | Pain Score: - | - | - | - | - | 0 | |
| | | Skin Integrity: - | - | - | - | - | Good | |
| Recommendations | Safety Needs: | | <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 |
| | 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: | | - | - | - | - | - | - |
| | 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 |
| | PU Prophylaxis: | | <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 |
| DVT Prophylaxis: | | <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 : | | | Dheer | Shivaloka | Syda | Dheer | Saipriya | Manisha |
| Signature / ID : | | | (u) | (u) | (u) | (u) | (u) | (u) |
| Date: | | | 5/6 | 6/6/26 | 6/6/26 | 6/6 | 7/6/26 | 7/6/26 |
| Time: | | | 8pm | 8AM | 8AM | 8pm | 8AM | 8pm |
| Taken Over By Name : | | | Shivaloka | Syda | Dheer | Saipriya | Manisha | |
| Signature / ID : | | | (u) | (u) | (u) | (u) | (u) | |
| Date: | | | 5/6/26 | 6/6/26 | 6/6 | 6/6/26 | 7/6/26 | |
| Time: | | | 8pm | 8AM | 2pm | 8pm | 8AM | |

Patient Sticker



NURSING SHIFT HAND OVER FORM

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| SITUATION | Diagnosis: | 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 | / | / | | | | | |
| | Shift | | | | | | | |
| | Medical Condition (Any special condition to be noted): | | | | | | | |
| | Diet: | | | | | | | |
| 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 | |
| | Ventilation (RA, NP, NIV, VENTI): | | | | | | | |
| | 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: | | | | | | |
| | | LOC: | | | | | | |
| | | Fall Risk Score: | | | | | | |
| | Pain Score: | | | | | | | |
| | Skin Integrity | | | | | | | |
| Recommendations | Safety Needs: | <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 | |
| | Physiotherapy: | | | | | | | |
| | Others Specify: | <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 | |
| | Special Diet: | | | | | | | |
| | Critical Lab Test / Values: | | | | | | | |
| | Other Special Orders / Medications: | <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 | |
| | PU Prophylaxis: | <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 | |
| | DVT Prophylaxis: | <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 | |
| ADL (Dependent / Non Dependent): | | | | | | | | |
| Post Operative Procedure Special Orders: | | | | | | | | |
| Handed Over By Name : | | | | | | | | |
| Signature / ID : | | | | | | | | |
| Date: | | | | | | | | |
| Time: | | | | | | | | |
| Taken Over By Name : | | | | | | | | |
| Signature / ID : | | | | | | | | |
| Date: | | | | | | | | |
| Time: | | | | | | | | |



**INTENSIVE CARE UNIT
 TATION FORMAT FOR NURSES AND DOCTORS**

Maternal Blood Group: B+ve Baby's Blood Group: B+ve Sheet No: ①

Gest Age: 39 weeks Birth Weight: 3.320kg

| | | |
|---|---|--|
| Date: <u>6/6/26</u> | Date: <u>7/6/26</u> | Date: <u>8/6/26</u> |
| DOL <u>D1</u> Weight <u>3.300 ↓ 20gm</u> | DOL <u>D2</u> Weight <u>3.280 ↓ 20gm</u> | DOL <u>D3</u> Weight <u>3.280</u> |
| Problems: <u>RDS</u> | Problems: <u>RDS</u> | Problems: |
| Rs. <u>30-60 bpm</u> Exam <u>Done</u> Vent. Setting <u>CPAP</u> ABG } <u>50s</u> CXR } <u>50s</u> | Rs. <u>30-60 bpm</u> Exam <u>Done</u> Vent. Setting <u>Room/Air</u> ABG } <u>50s</u> CXR } <u>50s</u> | Rs. Exam Vent. Setting ABG CXR |
| CVS <u>Normal</u> HR <u>130-160 bpm</u> BP <u>60/44 Map(40)</u> Cap Refil <u>< 3sec</u> | CVS <u>Normal</u> HR <u>130-160 bpm</u> BP <u>69/48 Map(55)</u> Cap Refil <u>2.3sec</u> | CVS HR BP <u>Map</u> Cap Refil |
| F/E/N T. Fluids CC/kg/day I/O/RBS: <u>(105 mg/dl)</u> U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion | F/E/N T. Fluids CC/kg/day I/O/RBS: <u>(105 mg/dl)</u> U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion | F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion |
| C/s Results CRP <u>5.0</u> Antibiotics | C/s Results CRP Antibiotics | C/s Results CRP Antibiotics |
| Med Neuro: | Med Neuro: | Med Neuro: |
| Assessment - <u>Done</u> | Assessment <u>Done</u> | Assessment |
| Plan <u>GRBS-TID</u> | Plan <u>GRBS-OD</u> | Plan |

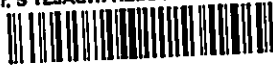
INTENSIVE CARE UNIT CLINICAL PRESENTATION FORMAT FOR NURSES AND DOCTORS

Maternal Blood Group: Baby's Blood Group: Sheet No:

Gest Age: Birth Weight:

| | | |
|---|---|---|
| Date: | Date: | Date: |
| DOL Weight | DOL Weight | DOL Weight |
| Problems: | Problems: | Problems: |
| Rs. Exam Vent. Setting ABG CXR | Rs. Exam Vent. Setting ABG CXR | Rs. Exam Vent. Setting ABG CXR |
| CVS HR BP Map Cap Refill | CVS HR BP Map Cap Refill | CVS HR BP Map Cap Refill |
| F/E/N T. Fluids CC/kg/day I/O/RBS U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion | F/E/N T. Fluids CC/kg/day I/O/RBS U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion | F/E/N T. Fluids CC/kg/day I/O/RBS U Output: (CC/kg/hr) Exam T. Bil/D Na HcO3 K BUN Cl Crea Hemat HB: WCC Plats Transfusion |
| C/s Results | C/s Results | C/s Results |
| CRP Antibiotics | CRP Antibiotics | CRP Antibiotics |
| Med | Med | Med |
| Neuro: | Neuro: | Neuro: |
| Assessment | Assessment | Assessment |
| Plan | Plan | Plan |

HNH-00015817 IP26-00006512
 Baby Of HEENA JAIN
 05-06-2026 0Y0M0D5H (F)
 Dr. S TEJASWI REDDY



RESULT SHEET

| | | | | | |
|---------------------|-----------|--|--|--|--|
| Date | 5/6/26 | | | | |
| Time | 4:40pm | | | | |
| Hb | 17.8 | | | | |
| PCV | 49.5 | | | | |
| RBC | 5.12 | | | | |
| WBC | 32.23 | | | | |
| N/L | 79.5/10.4 | | | | |
| Platelets | 275 | | | | |
| CRP | 5.0 | | | | |
| ESR | | | | | |
| PQT | | | | | |
| 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 | | | | | |

HNH-00015817 IP26-00006512
 Baby Of HEENA JAIN
 05-06-2026 0 Y 0 M 2 D (F)
 Dr. S TEJASWI REDDY

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



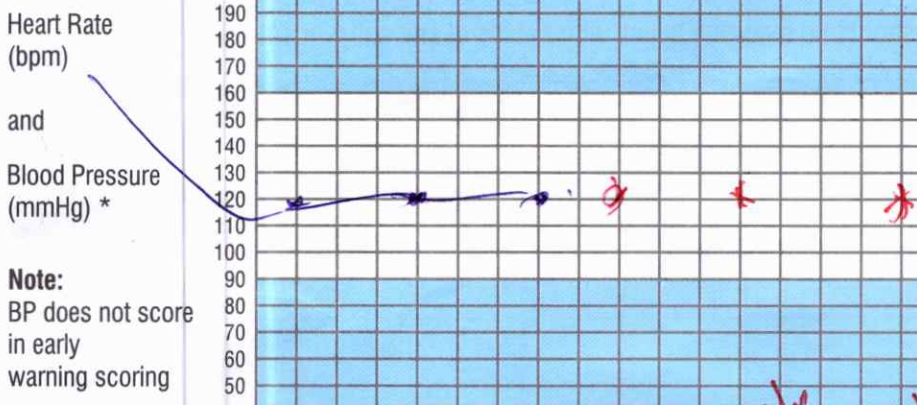
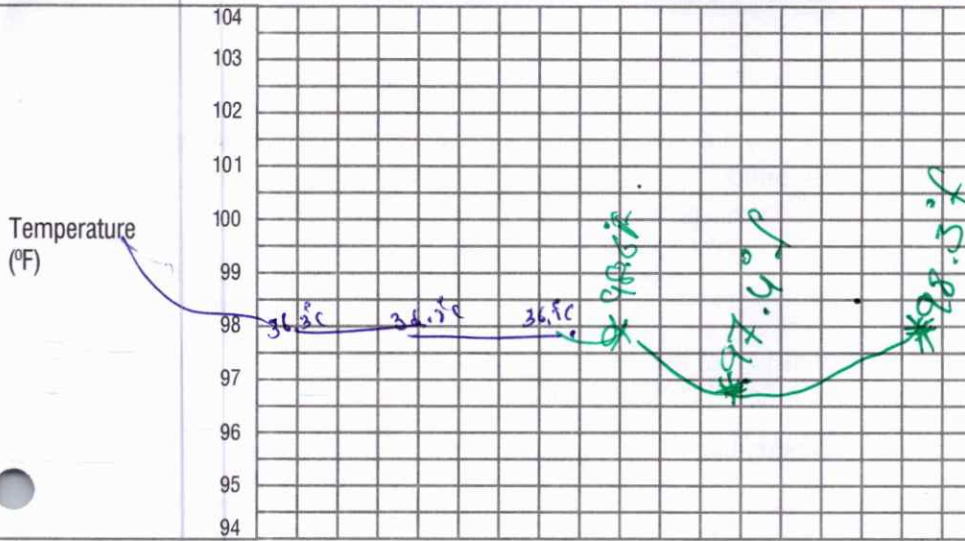
Patient

CLINICAL / 124

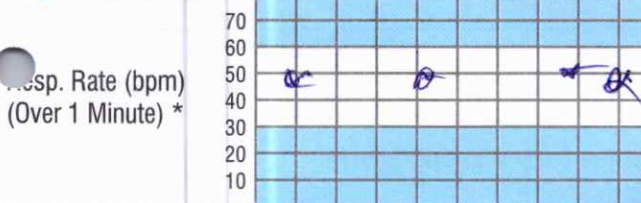
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 7/16/26 Time: 9am 10am 2pm 6pm 10pm

Doctor/Nurse/Family Concern? *pm*



Heart Rate (Number) *124 112 130 135 135*



Resp Rate (Number) *53 56 50 46 35*

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) *100% 100% 100% 102% 99% 99%*

Conscious Level Normal Altered

GCS *

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

ACTIONS

- Score 1 : Continue normal observation by staff nurse
- Score 2 : Shift in charge nurse to be informed and continue hourly observations
- Score 3 : Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
- Score 4 : Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
- Score 5 & 6 : Shift incharge and PICU /NICU fellow or PICU/NICU consultant to be informed

NB: Scores 3 should be recorded overleaf

* 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 | BACKGROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free) |
| A | ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried. |
| R | RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation) |

Patie



FLUID CHART

Sheet No. :

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

| Date | Time | Nature of Fluid | Intake | | | Output | | | | | IV Site Thrombophlebitis Score | Sign. Nurse |
|-----------------------|----------|-----------------|--------|-----|-----|-----------------------|-----------|-------|----------|-------|--------------------------------|-------------|
| | | | Mouth | I.V | N.G | NG | Diarrhoea | Vomit | Drainage | Urine | | |
| 7/6/26 | 08:00 am | | DBF+ff | / | / | | ✓ | / | ✓ | | } | A |
| | 09:00 am | | | / | / | | | / | | | | |
| | 10:00 am | | DBF+ff | / | NA | | | NA | | | | |
| | 11:00 am | | | / | / | | | / | ✓ | | | |
| | 12:00 pm | | DBF+ff | / | / | | ✓ | / | | | | |
| | 01:00 pm | | | / | / | | | / | | | | |
| Total Intake : | | | Taken | | | Total Output : | | | | | U-2 M-2 | |
| 7/6/26 | 02:00 pm | | DBF+ff | / | / | | | / | | | } | A |
| | 03:00 pm | | | / | / | | | / | ✓ | | | |
| | 04:00 pm | | DBF+ff | / | NA | | ✓ | NA | | | | |
| | 05:00 pm | | | / | / | | | / | | | | |
| | 06:00 pm | | DBF+ff | / | / | | | / | ✓ | | | |
| | 07:00 pm | | | / | / | | | / | | | | |
| Total Intake : | | | Taken | | | Total Output : | | | | | U-2 M-1 | |
| | 08:00 pm | | | | | | | | | | } | |
| | 09:00 pm | | | | | | | | | | | |
| | 10:00 pm | | | | | | | | | | | |
| | 11:00 pm | | | | | | | | | | | |
| | 12:00 am | | | | | | | | | | | |
| | 01:00 am | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | |
| | 02:00 am | | | | | | | | | | } | |
| | 03:00 am | | | | | | | | | | | |
| | 04:00 am | | | | | | | | | | | |
| | 05:00 am | | | | | | | | | | | |
| | 06:00 am | | | | | | | | | | | |
| | 07:00 am | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | |

Total 24 hrs. Intake

Total 24 hrs. Output

Patient Sticker

NURSING CARE RECORD



Date:

- 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 ↓ 2PM | ASSESS the Pt. condition monitor vitals Maintain I/O chart. Drug Give at per drug chart. | 8AM ↓ 2PM | Assessed the Pt. condition monitored vitals Maintained I/O chart. Drug given at per drug chart. | Patient is stable now | Rechecked vitals | Klustroo KW |
| Afternoon | | | | | | | |
| Night | | | | | | | |

Patient Sticker

NURSING CARE RECORD



Date:

Goals

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

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

Patient Sticker



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 | 8/6/26 | | | | | | |
| | Shift | | | | | | | |
| | Medical Condition (Any special condition to be noted): | | | | | | | |
| | Diet: | | | | | | | |
| 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 | |
| | Ventilation (RA, NP, NIV, VENTI): | | | | | | | |
| | 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: | | | | | | |
| | | LOC: | | | | | | |
| | | Fall Risk Score: | | | | | | |
| Pain Score: | | | | | | | | |
| Skin Integrity | | | | | | | | |
| Recommendations | Safety Needs: | <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 | |
| | Physiotherapy: | | | | | | | |
| | Others Specify: | <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 | |
| | Special Diet: | | | | | | | |
| | Critical Lab Test / Values: | | | | | | | |
| | Other Special Orders / Medications: | <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 | |
| | PU Prophylaxis: | <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 | |
| | DVT Prophylaxis: | <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 | |
| ADL (Dependent / Non Dependent): | | | | | | | | |
| Post Operative Procedure Special Orders: | | | | | | | | |
| Handed Over By Name : | | | | | | | | |
| Signature / ID : | | | | | | | | |
| Date: | | | | | | | | |
| Time: | | | | | | | | |
| Taken Over By Name : | | | | | | | | |
| Signature / ID : | | | | | | | | |
| Date: | | | | | | | | |
| Time: | | | | | | | | |

Patient Sticker



NURSING SHIFT HAND OVER FORM

| | | | | | | | | |
|--|--|---|--|--|--|--|--|--|
| SITUATION | Diagnosis: | 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 | | | | | | | |
| | Shift | | | | | | | |
| | Medical Condition (Any special condition to be noted): | | | | | | | |
| | Diet: | | | | | | | |
| 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 | |
| | Ventilation (RA, NP, NIV, VENTI): | | | | | | | |
| | 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: | | | | | | |
| | | LOC: | | | | | | |
| | Fall Risk Score: | | | | | | | |
| Pain Score: | | | | | | | | |
| Skin Integrity | | | | | | | | |
| Recommendations | Safety Needs: | <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 | |
| | Physiotherapy: | | | | | | | |
| | Others Specify: | <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 | |
| | Special Diet: | | | | | | | |
| | Critical Lab Test / Values: | | | | | | | |
| | Other Special Orders / Medications: | <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 | |
| | PU Prophylaxis: | <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 | |
| DVT Prophylaxis: | <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 | | |
| ADL (Dependent / Non Dependent): | | | | | | | | |
| Post Operative Procedure Special Orders: | | | | | | | | |
| Handed Over By Name : | | | | | | | | |
| Signature / ID : | | | | | | | | |
| Date: | | | | | | | | |
| Time: | | | | | | | | |
| Taken Over By Name : | | | | | | | | |
| Signature / ID : | | | | | | | | |
| Date: | | | | | | | | |
| Time: | | | | | | | | |

HNH-00015817 IP26-00006512
 Baby Of HEENA JAIN
 05-06-2026 0 Y 0 M 0 D 3 H (F)
 Dr. S TEJASWI REDDY

BRADEN 'Q' SCALE



| | | | | | Date : | 5/6 | 6/6 | 6/6 | 6/6 |
|---|--|--|---|--|--------|-------------|-------------|-------------|-------------|
| | | | | | Time : | 52 | 20 | 144 | 21 |
| Mobility | 1. Completely immobile: Does not make even slight changes in body or extremity position without assistance. | 2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently. | 3. Slightly limited: Makes frequent through slight changes in body or extremity position independently. | 4. No limitations: Makes major and frequent changes in position without assistance. | | 4 | 4 | 4 | 4 |
| "Activity The degree of physical activity" | 1. Bedfast : Confined to bed | 2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair." | 3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair. | 4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours. | | 4 | 4 | 4 | 4 |
| Sensory Perception | 1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface. | 2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body. | 3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities. | 4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort. | | 4 | 4 | 4 | 4 |
| Moisture Degree to which skin is exposed to moisture | 1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned. | 2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours. | 3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours. | 4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours. | | 4 | 4 | 4 | 4 |
| FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another | 1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction. | 2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. | 3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down. | 4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times." | | 4 | 4 | 4 | 4 |
| Nutritional Usual food intake pattern | 1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement. | 2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. | 3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. | 4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. | | 4 | 4 | 4 | 4 |
| Tissue Perfusion & Oxygenation | 1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes. | 2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40. | 3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal. | 4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds. | | 4 | 4 | 4 | 4 |
| TOTAL SCORE | | | | | | 28 | 28 | 28 | 28 |
| Evaluator's Name | | | | | | (Signature) | (Signature) | (Signature) | (Signature) |

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

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

Patient ID

BRADEN 'Q' SCALE

| | | | | Date : | 7/6/26 | | | |
|---|--|--|---|--|--------|--|--|--|
| | | | | Time : | 15 | | | |
| Mobility | 1. Completely immobile: Does not make even slight changes in body or extremity position without assistance. | 2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently. | 3. Slightly limited: Makes frequent through slight changes in body or extremity position independently. | 4. No limitations: Makes major and frequent changes in position without assistance. | 4 | | | |
| "Activity The degree of physical activity" | 1. Bedfast : Confined to bed | 2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair." | 3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair. | 4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours. | 4 | | | |
| 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 | | | |
| 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 | | | |
| 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 | | | |
| 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 | | | |
| 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 | | | |
| TOTAL SCORE | | | | | 28 | | | |
| Evaluator's Name | | | | | 5 | | | |

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 |

Patient ID

BRADEN 'Q' SCALE

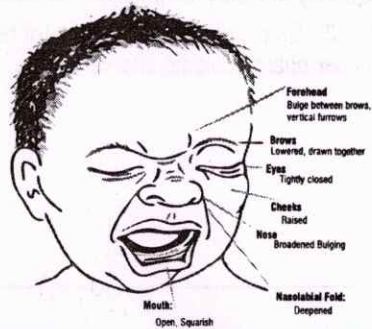
| | | | | | Date : | | | | |
|---|--|--|---|--|-------------------------|--|--|--|--|
| | | | | | Time : | | | | |
| Mobility | 1. Completely immobile: Does not make even slight changes in body or extremity position without assistance. | 2. Very limited: Makes occasional slight changes in body or extremity 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. | | | | | |
| *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. | | | | | |
| 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. | | | | | |
| 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. | | | | | |
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| Nutritional Usual food intake pattern | 1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement. | 2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. | 3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. | 4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. | | | | | |
| 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. | | | | | |
| | | | | | TOTAL SCORE | | | | |
| | | | | | Evaluator's Name | | | | |

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 |



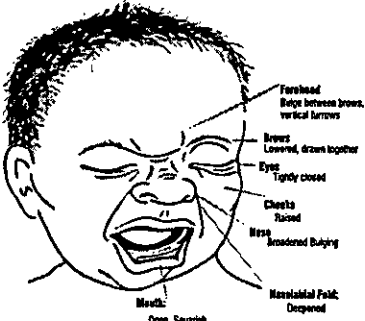
NEONATAL PAIN AGITATION SEDATION SCORE (N-PASS)

| Assessment Criteria | Sedation | | Normal | Pain / Agitation | | Date | Date | Date | Date | Date | Date | Date | Date |
|---|---|---|---|--|--|-------------|-------------|-------------|-------------|------|------|------|------|
| | -2 | -1 | 0 | 1 | 2 | 5/6 Time | 6/6 Time | 6/6 Time | 7/6 Time | | | | |
| | | | | | | NI | MY | NI | MS | | | | |
| | 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 | NA | NA | NA | NP | | | | |
| 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) | NA | NA | NA | NA | | | | |
| Facial Expression | Mouth is lax No expression | Minimal expression with stimuli | Relaxed Appropriate | Any pain expression intermittent | Any pain expression continual | NA | NA | NA | NP | | | | |
| 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 | NA | NA | NA | NA | | | | |
| 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 | NA | NA | MY | NP | | | | |
|  <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 | 34+ weeks | 34+ weeks | 34+ weeks | 37 weeks | | | | | | | | |
| | Total Pain / Agitation Score | - | - | - | - | | | | | | | | |
| | Intervention | - | - | - | - | | | | | | | | |
| | Effectiveness | - | - | - | - | | | | | | | | |
| | Signature | | | | | | | | | | | | |

NPASS: Neonatal Pain, Agitation & Sedation Scale

| | Sedation | Pain / Agitation |
|-------------------------------|--|--|
| How to use | <ul style="list-style-type: none"> • Observe the infant for a minute before selecting a score for each behavior. • Stimulate the infant and observe and select a score for each behavior. • Select only one numeric value (Highest) per behavior. | <ul style="list-style-type: none"> • Observe the infant for a minute before selecting a score for each behavior. • Select only one numeric value per behavior. |
| Scoring/ Documentation | <ul style="list-style-type: none"> • Sedation scores are negative scores only • Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age) • NPASS Sedation total score has a range from 0 to -10 possible. • Document total NPASS Sedation score in the medical record. | <ul style="list-style-type: none"> • Pain/Agitation scores are positive scores only • Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria. • Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score. • NPASS Pain/Agitation total score has a range from 0 to 13 possible. • Document the total NPASS Pain/Agitation score in the medical record |
| Interpretation | <ul style="list-style-type: none"> • Desired levels of sedation vary according to the situation. • Discuss and determine sedation goal with provider. <ul style="list-style-type: none"> • "Deep sedation": goal score of -10 to -5 <ul style="list-style-type: none"> • Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea • "Light sedation": goal score of -5 to -2 • Reassess patient per frequency in local sedation policy • A negative score without the administration of opioids/ sedatives may indicate: <ul style="list-style-type: none"> • The premature infant's response to prolonged or persistent pain/stress • Neurologic depression, sepsis, or other pathology | <ul style="list-style-type: none"> • Does not provide pain intensity rating. • Any score greater than 3 indicates the possibility of the presence of pain in the infant <ul style="list-style-type: none"> • Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological). • Reassess patient per frequency of local pain policy. • If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention. |

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 | |
| 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 | | | | | | | | |
| | | | | | | Total Pain / Agitation Score | | | | | | | | |
| | | | | | | Intervention | | | | | | | | |
| | | | | | | Effectiveness | | | | | | | | |
| | | | | | | Signature | | | | | | | | |

NPASS: Neonatal Pain, Agitation & Sedation Scale

| | Sedation | Pain / Agitation |
|-------------------------------|--|--|
| How to use | <ul style="list-style-type: none"> • Observe the infant for a minute before selecting a score for each behavior. • Stimulate the infant and observe and select a score for each behavior. • Select only one numeric value (Highest) per behavior. | <ul style="list-style-type: none"> • Observe the infant for a minute before selecting a score for each behavior. • Select only one numeric value per behavior. |
| Scoring/ Documentation | <ul style="list-style-type: none"> • Sedation scores are negative scores only • Add the scores from the 5 individual behavior areas to generate a total NPASS Sedation score. (Do not add points for correcting gestational age) • NPASS Sedation total score has a range from 0 to -10 possible. • Document total NPASS Sedation score in the medical record. | <ul style="list-style-type: none"> • Pain/Agitation scores are positive scores only • Determine if scoring needs to be adjusted based on the patient's gestational age. See Premature Pain Assessment criteria. • Add the scores from the 5 individual behavior areas and for corrected gestational age (if indicated) to generate a total NPASS Pain/Agitation score. • NPASS Pain/Agitation total score has a range from 0 to 13 possible. • Document the total NPASS Pain/Agitation score in the medical record |
| Interpretation | <ul style="list-style-type: none"> • Desired levels of sedation vary according to the situation. • Discuss and determine sedation goal with provider. <ul style="list-style-type: none"> • "Deep sedation": goal score of -10 to -5 <ul style="list-style-type: none"> • Deep sedation is not recommended unless an infant is receiving ventilator support, related to the high potential for hypoventilation and apnea • "Light sedation": goal score of -5 to -2 • Reassess patient per frequency in local sedation policy • A negative score without the administration of opioids/ sedatives may indicate: <ul style="list-style-type: none"> • The premature infant's response to prolonged or persistent pain/stress • Neurologic depression, sepsis, or other pathology | <ul style="list-style-type: none"> • Does not provide pain intensity rating. • Any score greater than 3 indicates the possibility of the presence of pain in the infant <ul style="list-style-type: none"> • Continue evaluation to determine individualized patient interventions (non-pharmacological and pharmacological). • Reassess patient per frequency of local pain policy. • If upon reassessment, the NPASS pain/agitation total score remains consistent or higher, consider pharmacologic intervention. |




CHECKLIST FOR THROMBOPHLEBITIS


| S. No. | SITE OBSERVATION | STAGE / ACTION | SCORE | DAY-1 5/6/26 6/6/26 | | | DAY-2 7/6/26 | | | DAY-3 | | | Remarks |
|------------------------|--|---|-------|---------------------|---|---|--------------|-----|----|-------|----|---|---------|
| | | | | M | E | N | M | E | N | M | E | N | |
| 1 | IV site appears healthy | No signs of phlebitis / Observe cannula | 0 | | | 0 | 0 | 0 | 0 | 0 | 0 | | |
| 2 | One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site | Possibly first signs of phlebitis / Observe cannula | 1 | | | 0 | 0 | 0/0 | NA | NA | NA | | |
| 3 | Two of the following Signs are evident: Pain at IV site Redness | Early stage of phlebitis / Resite Cannula | 2 | | | 0 | 0 | 0/0 | NA | NA | NA | | |
| 4 | All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling | Medium stage of phlebitis / Resite Cannula Consider Treatment | 3 | | | 0 | 0 | 0/0 | NA | NA | NA | | |
| 5 | All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord | Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment | 4 | | | 0 | 0 | 0/0 | NA | NA | NA | | |
| 6 | All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia | Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula | 5 | | | 0 | 0 | 0/0 | NA | NA | NA | | |
| Signature of the Nurse | | | | | | 0 | 0 | 0/0 | NA | NA | NA | | |

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature :  Name : Shivaleela

Signature of Ward In Charge :

Signature :  Name : Bhanani

22

1 1 1 1

1 1 1 1

1 1 1 1

1 1 1 1

1 1 1 1

1 1

0 0 0 0 0 0 0 0

Patient Sticker



CHECKLIST FOR THROMBOPHLEBITIS

| S. No. | SITE OBSERVATION | STAGE / ACTION | SCORE | DAY-1 | | | DAY-2 | | | DAY-3 | | | Remarks |
|------------------------|---|---|-------|-------|---|---|-------|---|---|-------|---|---|---------|
| | | | | M | E | N | M | E | N | M | E | N | |
| 1 | IV site appears healthy | No signs of phlebitis / Observe cannula | 0 | | | | | | | | | | |
| 2 | One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site | Possibly first signs of phlebitis / Observe cannula | 1 | | | | | | | | | | |
| 3 | Two of the following Signs are evident: Pain at IV site Redness | Early stage of phlebitis / Resite Cannula | 2 | | | | | | | | | | |
| 4 | All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling | Medium stage of phlebitis / Resite Cannula Consider Treatment | 3 | | | | | | | | | | |
| 5 | All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord | Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment | 4 | | | | | | | | | | |
| 6 | All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia | Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula | 5 | | | | | | | | | | |
| Signature of the Nurse | | | | | | | | | | | | | |

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



CHECKLIST FOR THROMBOPHLEBITIS

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|------------------------|--|--|-------|-------|---|---|-------|---|---|-------|---|---|---------|
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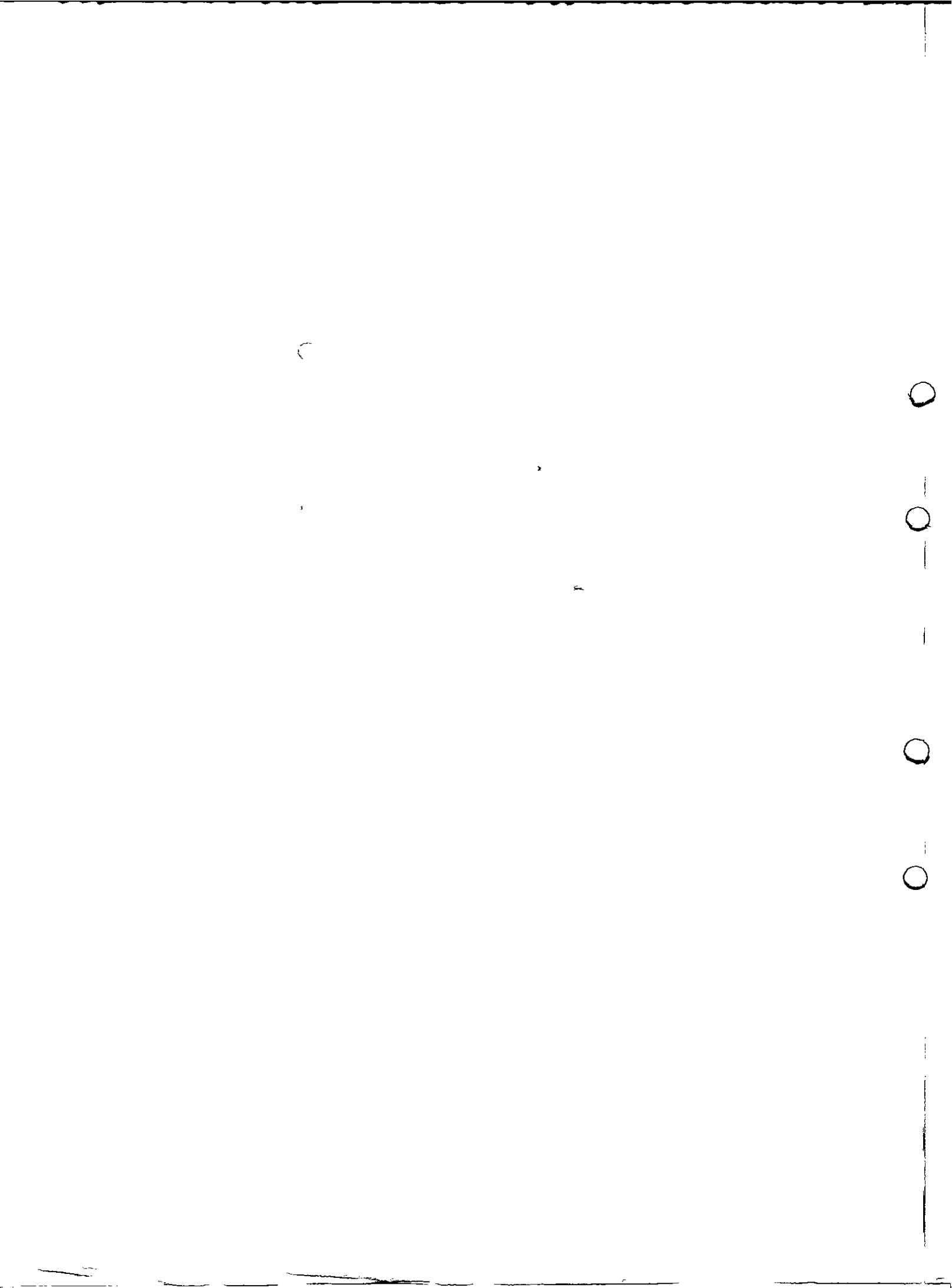
NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personnel ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

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Signature : Name :

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CHECKLIST FOR MAINTAINING CPAP / HFNC / NIV

Date: 5/6/26

| | CRITERIA MET / NOT MET <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Comments by Duty Registrar |
|--|---|---------|--------|----------------------------|
| | Morning | Evening | Night | |
| CIRCUIT and BUBBLER: | | | | |
| Blended Air / Oxygen Gas Supply | | | ✓ | |
| Flow Between 5-7 Litres / Min | | | ✓ | |
| Humidifier Temperature Correct (36.5-37.5°C) | | | ✓ | |
| Humidifier Water Level Correct | | | ✓ | |
| Proper Oxygen Tubing From Blender to Humidifier. | | | ✓ | |
| Tubing Correctly Placed (Position & Leak) | | | ✓ | |
| Excess Fainout (Afferent Tubing) Drained | | | ✓ | |
| Excess Rainout (Efferent Tubing) Drained | | | ✓ | |
| Temperature Probe away from Heat / Cover with Aluminium Foil | | | ✓ | |
| Gas Bubbling Continuously | | | ✓ | |
| Water Level at Desired Level in Bubble Chamber. | | | ✓ | |
| INTERFACE: | | | | |
| Nasal Prong / Mask Correct Size | | | ✓ | |
| Nasal Prong/ Mask Correctly Placed | | | ✓ | |
| Hat Fits Snugly | | | ✓ | |
| Moustache Suitable and Effective | | | ✓ | |
| Nasal Bridge Intact | | | ✓ | |
| Septum Intact | | | ✓ | |
| POSITION: | | | | |
| Head Position Correct | | | ✓ | |
| Head Roll - Correct Size and Position | | | ✓ | |
| MONITORING/ SUCTIONING | | | | |
| SpO ₂ Probe Monitoring | | | ✓ | |
| Oro Nasal Suctioning Documentation | | | ✓ | |
| OG Tube in SITU | | | ✓ | |
| Baby Comfortable | | | ✓ | |
| Chest Retractions | | | ✓ | |
| Name of the Nurse: | | | shinde | |
| Signature of the Nurse: | | | | |
| Date & Time: | | | 5/6/26 | |

*If CPAP is being given through Dragger ventilator then make sure that: Flow to be set at 5 litres/min & PIP to be set between 12-15 cm.

HNH-00015817 IP26-00006512
 Baby Of HEENA JAIN
 05-06-2026 0Y0M0D3H (F)
 Dr. S TEJASWI REDDY

Patient



CHECKLIST FOR MAINTAINING CPAP / HFNC / NIV

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| OG Tube in SITU | | | | |
| Baby Comfortable | | | | |
| Chest Retractions | | | | |
| Name of the Nurse: | | | | |
| Signature of the Nurse: | | | | |
| Date & Time: | | | | |

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Patient Sticker

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| Name of the Nurse: | | | | |
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Patient Sticker



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HNH-00015817 IP26-00006512
Baby Of HEENA JAIN
05-06-2026 0 Y 0 M 0 D 3 H (F)
Dr. S TEJASWI REDDY



DATE :

NEWBORN ANOMOLY ASSESSMENT CHECKLIST

| S.NO | ASSESSMENT PARAMETERS | CHECKED BY REGISTRAR | CHECKED BY CONSULTANT | REMARKS |
|------|--------------------------------------|----------------------|-----------------------|---------|
| 1. | Palate | (N) | | |
| 2 | Pre natal teeth | (-) | | |
| 3 | Anal opening | Patent | | |
| 4 | Genitalia | (N) | | |
| 5 | Spine | (N) | | |
| 6 | Red reflex | Not to check | | |
| 7 | 4 limb saturation (before discharge) | Not to check | | |

Ped.Registrar signature

Ped.Consultant signature



BILLING POLICY

- **Billing cycle:** - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card / Demand draft or online payment.
- In the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged 30% extra.
- Patient Government ID proof is mandatory to submit during the admission.
- TPA processing charges Rs.500 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any

INTERIM BILLING


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

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

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

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.5,000/- will be refund through NEFT in three Bank working days.


Name & signature of Patient/Attendant


(Signature of Admission Desk executive)

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

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

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

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

Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR

- T: 6464 2020 | KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | HIMAYATNAGAR - 40 488 73000 | MARATHAHALLI, BENGALURU - T:
+91 807111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345

MNH-00015817
Baby Of HEENA JAIN
05-06-2026
Dr. S TEJASWI REDDY
IP26-00006512
0 Y 0 M 0 D 1 H (F)

Rainbow Childrens Hospital-Himayatnagar

bow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.

TEL NO :040-48873000

WEB : <https://rainbowhospitals.in>

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby Of HEENA JAIN Age : 0 Y 0 M 0 D 1 H
IP No: IP26-00006512 Sex: Female
Consultant: Dr. S TEJASWI REDDY Ward/Bed No: 4F -NICU 1/NICU1-401

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:

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

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

(Receivers Signature: *[Signature]*)

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

4 Financial and billing counseling has been done to me.

Signature of Patient/Relative: *[Signature]*

Name: Vaibhav Jain

Relationship: Father

Date: 05/6/2026

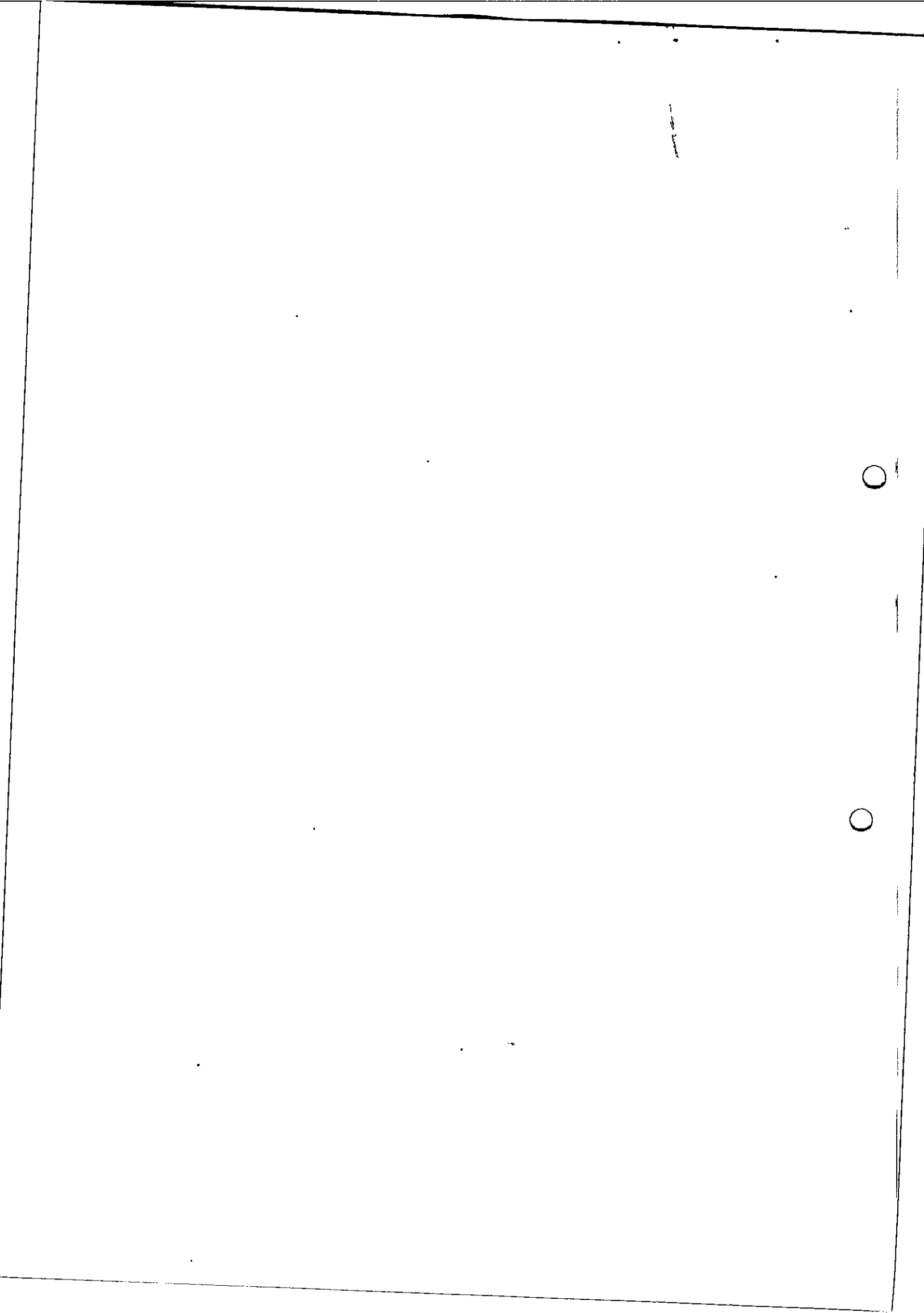
Time: 2PM

Witness Name:

Witness Signature: *[Signature]*

Patient Address:

3-6-465 to 467, flat no 604, legend siddi apt sreat 5, himayathnagar, hyd Himayathnagar Hyderabad Telangana INDIA 500029



HNH-00015817
Baby Of HEENA JAIN
05-06-2026
Dr. S TEJASWI REDDY
IP26-00006512
0 Y 0 M 0 D 1 H (F)



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

25
years
of being the leading light
in Pediatric Endocrinology, Shining Bright


UNDERTAKING FOR BALANCE DEPOSIT

To
The Management,
Rainbow Children's Hospital, Himayatnagar
Hyderabad-500029

Sub:- Undertaking Balance Deposit

I ~~Mr./Mrs./Ms.~~ Vaibhav Jain (Father/
Mother/ Other _____) of Master/ Baby/ Baby of/
Mrs. / Ms. B/D Heena Jain was
bought to your hospital on Emergency basis on 05/06/26
at 14:00. Admitted in NICU. Approximate charges
deposit details were explained by the Pharmacy executive on duty.
I have to pay the amount of 300 as a caution deposit but for
now I'm depositing 200. The remaining amount _____ I'll
deposit on _____ at _____.

Thanking You


Signature

Name:- Vaibhav Jain

Ph. No.:- 9700409144

