

**DISCHARGE SUMMARY**

<b>Name</b>	Baby Of PAMMI UJWALA	<b>UHID</b>	HNH-00016046
<b>Father/Guardian</b>	Mr NAGA PRASAD	<b>Age/Gender</b>	0 Y 0 M 7 D/ Male
<b>Address</b>	RTC X Road, Hyderabad, Telangana, INDIA, 500020		
<b>IP No</b>	IP26-00006633	<b>Admission Date</b>	24-06-2026
<b>Ref Doctor</b>	Self.		
<b>Discharge Date</b>	26-06-2026		

**Consultant:**  
**Dr. SPANDANA PASUPULETI**  
MBBS, MRCPCH  
30925

<b>DIAGNOSIS</b>	<b>ICD CODE</b>
NEONATAL HYPERBILIRUBINEMIA	

**History:** Baby Of PAMMI UJWALA is a 0 Y 0 M 5 D old baby boy presented with history of yellowish discolouration of skin and eyes since 1 day prior to admission. For the above complaints, he was investigated on OPD basis (Transcutaneous bilirubin was 18.3 mg/dl). In view of hyperbilirubinemia, he was shifted to NICU, for further management.

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

**Examination:** He was euthermic, euvolemic & maintaining saturations at room air. Heart Rate- 120/min and Respiratory Rate - 40/min. Icterus was present. Chest was clear with normal heart sounds . Abdomen was soft without organomegaly. Cry, tone, activity and newborn reflexes were normal. There were no obvious external congenital anomalies .

Weight on admission : 3.90 kilo grams

Name	Baby Of PAMMI UJWALA	UHID	HNH-00016046
IP No	IP26-00006633	Admission Date	24-06-2026

Weight at discharge : 3.980 kilo grams.

**Investigations:** Enclosed reports.

**Management:** Baby was admitted in NICU in view of Transcutaneous bilirubin was 18.3 mg/dl on admission done on OP basis. He was started on triple surface phototherapy. Baby was continued on demand breast feeds + measured feeds. His serum bilirubin levels were regularly monitored which showed decreasing trend, hence phototherapy adjusted accordingly. Last serum bilirubin on 7 day of life was 11.3 mg/dl with indirect fraction of 11.2 mg/dl. This does not come under phototherapy range, hence phototherapy was stopped.

He remained hemodynamically stable and is being discharged with the following advice.

**At the time of discharge :** Baby was active, afebrile, hemodynamically stable, maintaining temperature, accepting & tolerating feeds well.

**Advice:**

Warmth care.

Exclusive breast feeding.

Continue direct breast feeds + measured feeds as advised.

Burping after each feed.

Monitor urine output.

Immunization to be given as per schedule.

Vitamin D3 Drops (1ml/800IU) 0.5ml once daily till further advice.

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

T-bact Ointment L/A TID for 3 DAYS

Review consultation with Dr. SPANDANA PASUPULETI on (Monday) 29.06.2026 in OPD 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

Name	Baby Of PAMMI UJWALA	UHID	HNH-00016046
IP No	IP26-00006633	Admission Date	24-06-2026

acknowledge.

Parent/ Attender

In case of emergency contact 9154865030 emergency pediatrician on duty.

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

You can also take appointments at any time by going **online** to our website **[www.rainbowhospitals.in](http://www.rainbowhospitals.in)**

Registrar/Resident/C.M.O

**Dr. SPANDANA PASUPULETI**  
MBBS, MRCPCH  
30925



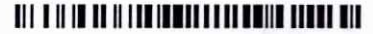


### Rainbow Childrens Hospital-Himayatnagar

Rainbow 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>

## ADMISSION SHEET

### Registration Details :



Admission No : IP26-00006633      Admit Date : 24-Jun-2026      Admit Time : 05:15 PM      UHID : HNH-00016046

### Patient Details :

Patient Name : Baby Of PAMMI UJWALA      Age : 0 Y 0 M 5 D  
Guardian : Mr NAGA PRASAD      DOB : 19-06-2026 10:01 AM  
Gender : Male      Religion :  
Occupation :      Martial Status :  
Address (H) : RTC X Road Hyderabad Telangana INDIA      Phone No : 6304330037/  
500020      E-mail : PRASORE3@gmail.com

### Admission Details :

Bed Type : DAY CARE      Bed No : ER01      Ward Name : GF -EMERGENCY  
Room No : ER01      Admission Type : First Visit

### Contact Details :

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

  
Signature

### Doctor Details :

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

### Payment Details :

Deposit Amount : 50000.00  
Payment Mode : DC/CC Card      Payor Name : SELFPAY

**ACTIVITY** ----- **FOR BILLING**

HNH-00016046 IP26-00006633  
Baby Of PAMMI UJWALA  
19-06-2026 0 Y 0 M 5 D (M)  
Dr. SPANDANA PASUPULETI

Name: -----

UHID No: ----- Consultant: ----- Dept: -----

Date of Admission: ----- Time: ----- Date of Discharge: ----- Time: -----

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

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
24/6/26	5:30pm	ER	NICU	SH
25/6/26	11:30 AM	NICU	3rd floor (305)	Ty

**Cross Consultation Visit**

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





**PROCEEDURE**

Date	Proceedure	Quantity	Order No.	Signature

**ANY OTHER INFORMATION**

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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Ref.No. F/IN/PR/10



**Rainbow<sup>®</sup>  
Children's  
Hospital**

**PEDIATRIC IN-PATIENT  
MEDICAL RECORD**

HNH-00016046 IP26-00006633  
Baby Of PAMMI UJWALA  
19-06-2026 0 Y 0 M 6 D (M)  
Dr. S TEJASWI REDDY

Patient Name : \_\_\_\_\_

Patient ID# : \_\_\_\_\_

Consultant : DR. SPANDANA.

Final Diagnosis : NNH.

Pediatric Multiorgan History & Physical Examination

Name: BO UTWALA

Age/Sex 5 days/ male

Informant \_\_\_\_\_

Reliability \_\_\_\_\_

Chief Presenting Complaints & Duration (Chronologically):

Yellowish discoloration of eyes & skin x 1 day.

History of present illness:

40 yellowish discoloration of eyes & skin since 1 day.

- No h/o bad urination, activity, poor feeding.

- No h/o refusal to feeds.

B.W - 4180gms.

D.W - 3960gms.

T.W - 3900gms.

g.i. - 6.6g.

OAE -  
NBS  
2D echo } Normal.

24/5/21 - TUB 18.3  
15.1

**Pediatric Multiorgan History & Physical Examination**

Past History : (Including details of any previous investigation or treatment)

- Nil premonitory -

Birth & Neonatal History :

Term (37 wks) / LFA / IDM / NNH / NKG.

MBG	0+ve
BBG	0+ve

Birth & Socio Economic History :

About Father : \_\_\_\_\_

About Mother : \_\_\_\_\_

Any additional information : \_\_\_\_\_

Developmental History :

(M)

Immunization History :

Bism vaccination done.

**Pediatric Multiorgan History & Physical Examination**

**Anthropometry**

Head Circum (cms) \_\_\_\_\_ (Centile \_\_\_\_\_ ) Height (cm) : \_\_\_\_\_ (Centile \_\_\_\_\_ )

Weight (kgs) 39.00gms (Centile \_\_\_\_\_ )

**On Examination :**

Temperature : \_\_\_\_\_ Pulse Rate: \_\_\_\_\_ Description \_\_\_\_\_

B.P. \_\_\_\_\_ SPO2 100% at RA.

Resp. rate and type of breathing : \_\_\_\_\_

Rash \_\_\_\_\_ Icterus (+)

Lymphadenopathy \_\_\_\_\_

Oedema : \_\_\_\_\_

**Respiratory system :**

Inspection (any s/o distress) : \_\_\_\_\_

Air entry & breath sounds : \_\_\_\_\_ Normal.

Any addes sounds : \_\_\_\_\_

Relevant data from outside (Chest X-Ray, ABG, etc.,) \_\_\_\_\_

**Cardiovasclular System :**

Inspection of procordium : \_\_\_\_\_ Normal.

Heart Sounds : \_\_\_\_\_

Any murmur : \_\_\_\_\_

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) \_\_\_\_\_

**Per Abdomen :**

Inspection \_\_\_\_\_ Normal.

Palpation : \_\_\_\_\_

Ausculation : \_\_\_\_\_

Spine: \_\_\_\_\_ External Genitelia : \_\_\_\_\_

Relevant data from outside (CT, USG etc.,) \_\_\_\_\_

**Pediatric Multiorgan History & Physical Examination**

**Central Nervous System :**

Level of Consciousness : AVPU/GCS Score : \_\_\_\_\_

Cranial Nerves : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Motor System :**

Nutrition : \_\_\_\_\_

Tone : \_\_\_\_\_ Power \_\_\_\_\_

Co-ordinator : \_\_\_\_\_

Posture : \_\_\_\_\_ *Moving all 4 limbs spontaneously*

Involuntary Movements : \_\_\_\_\_

**Reflexes :**

**DTR**

**Superficials :**

Plantars \_\_\_\_\_

**Sensory System :**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Bladder / Bowel : *(N)* \_\_\_\_\_

**Clinical Summary & Diagnostic :**

*NEONATAL HYPERBILIRUBINEMIA*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Pediatric Multiorgan History & Physical Examination**

Preventive aspects of the treatment :

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Desired goals of the treatment :

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**Planned Labs :**

- SBR tomorrow ct  
bam.

**Planned Management :**

- Krom care.  
- DIBF Q2H + PF cell/b.  
- TSPT with eyes &  
goggles covered.

**Please fill up the following details**

1. Name of the Referring Doctor : \_\_\_\_\_
2. Name of the Referring Hospital : \_\_\_\_\_  
(Including the name of City)
3. Contact number of the Referring Doctor : \_\_\_\_\_  
(Preferring Mobile #)
4. Name of the doctor in Rainbow Team Dr. Spandana on  
whose name the patient is being referred


Doctor's Signature Name Dr. Bam Date \_\_\_\_\_ Time \_\_\_\_\_

Dr. Spandana Pasupuleti  
Consultant Neonatologist and Pediatrician  
Reg. No: 30925



# CONSENT FOR ADMISSION IN NEONATAL INTENSIVE CARE UNIT



Name: HNH-00018046 IP26-00006633  
Baby Of PAMMI UJWALA  
18-06-2026 0 Y 0 M 5 D (M) Age: 5 D Gender: Male  Female   
 Dr. SPANDANA PASUPULETI  
 UHID.No:  Date: 25/6/26

I Naga prasad S/o, D/o, W/o UJwala hereby  
 declare that our patient Mr. / Ms B/o - UJwala who is related to me as  
Son is getting admitted in the Neonatal Intensive Care Unit of Rainbow Children's Hospital  
 on 24/6/26

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

The doctors have clearly explained to me that my patient B/o UJwala 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 B/o Pammi Ujwala  
 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 : [Signature]  
 Name : Amritha  
 Relationship with Patient: mother  
 Date & Time : 24/06/26 5:30pm

**Witness :**  
 Signature : [Signature]  
 Name : Shreyashini  
 Date & Time : 24/6/26 @ 5:30pm

**Doctor (who is taking the consent) :**  
 Signature : [Signature]  
 Name : Anuritha  
 Date & Time : 24/6/26 5:30pm



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/6 9:00pm	<p>CLINIC Dr. Naipunya / Dr. Anusha</p> <p>T   AGA   4.180kg   IDM   NNT</p>	
	on <del>DR</del> TSPT	Plog
	<p>C/T/A - Good,</p> <p>Vitals - HR - 141          - RR - 38          - SpO<sub>2</sub> - 97%</p>	<p>- DBF @ 2H + FF.          2nd hourly for keepings</p> <p>- Cont TSPT</p>
	<p>RLS / VAN          P/A</p>	<p>- Repeat SBR @ 6:00AM          (25/6)</p> <p>- Monitor vitals</p>
	<p>ef/ky: 2s</p>	<p>@ney</p>
<p>Noted by Lanno          24/6/26          9pm</p>		



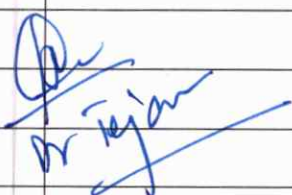
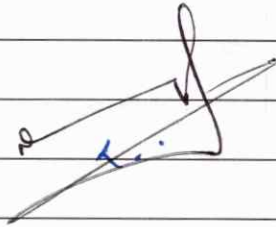
## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>25/6/26</del> 8 AM	c/s by Dr. Anubh / Dr. N. Raju Term / LGA / Male / NNTJ	
	Baby active Euthic / on TSPT	Plan
	<u>vital</u>	- (F) SBR
	HR = 132/min RR = 48/min SpO <sub>2</sub> = 95% RA CRT < 3 SEC	- DBF + FF Only j/b = buyping - U TSPT
	S/G	- Monitor vitals.
	(P/L) BL AC (+) NURS (+)	
	(CVS) S/L (+) ab musmua	
Noted by <i>Caru</i> 25/6/26 at 8 AM		

HNH-00018048 IP26-00006633  
 Baby Of PAMMI UJWALA O Y O M & D (M)  
 19-08-2026  
 Dr. SPANDANA PASUPULETI



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/2026 10am	Bo. Pammi Ujjwala Baby - wt. gain of 100 gm. SBR - (11) Report	Counselling
	Baby to be shifted to room side	continue DSP 1
	 Dr. S. TEJASWI REDDY Registration No: 94068	

HNH-00016046 IP26-00006633  
 Baby Of PAMMI UJWALA  
 19-08-2026 0 Y 0 M 6 D (M)  
 Dr. SPANDANA PASUPULETI



## GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/D Dr - Tejswari Manu	
25/6	<u>Shifting Notes</u>	
11 AM		
	D7 / FT / USC / 4.18 kg / LGA / 10m / NWHB	
	WT gain (↑ 100g)	
	SBR - 11.3	
	Baby ↓ Phototherapy	Phs
	Baby Feeding:	1) Shift to room
	C) } Good	2) Change to DSPTE
	T) }	eyes & genital covered
	A) }	
	Vital stable	3) DBF jlb burping Q2H
	Passing urine & stool	& FF (as per need)
		4) Monitor vital
		Suja SOS
		Pranav



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**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
<del>25/6/26</del>	<del>CL/6 Dr. Verma</del>	
2:30 PM	D7/PT/USUS/LG M EDM/ NNT (SEVERE)	
	- wt. gain ↑ -	
	↓ DSPT.	Plan
	Cray } Tone } Good. Activity }	1) Ct. DSPT. 2) DBF Q 2H + FF 3) Warm Care.
	O/E - vitals stable.	4) Monitor vitals.
	S/E - (N)	



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26	ds/b Dr. Spandana	
3:30 PM.	Term / LGA / Male / VNH.	
	- ↓ DSPT.	
	- wt. gain ↑	
		[Plan]
	S/E - vitals stable.	- Warm Care.
	S/E - WNL	- <u>Nesporin</u> powder L/A
		over umbilicus
		- DSF @ 2H + FF.
		- ct DSPT.
		- D/S tomorrow.
		w/b pyjama.

Dr. Spandana Pasupuleti  
 Consultant Neonatologist and Pediatrician  
 Reg. No. 30925



(3)

## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/6/26 7:45 AM	S/B Dr. Sneeghan Δ Ten / AUA / Male / NNT Plg	
	Baby Eukheria - CF DSPT	
	CUS - S, S, @ - DBF + Bumpig 2nd Pt - 34 - ACP @	
	- Plan discharge	
	CTA good PLA - 500	
	T wt: - 3.980 kg (2 age wt low @)	15/2 Noted by mother

HNH-00016046 IP26-00006633  
 Baby Of PAMMI UJWALA  
 19-06-2026 0 Y 0 M 6 D (M)  
 Dr. SPANDANA PASUPULETI



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<i>Cl 1's - G. Jyanti</i>	
<i>26/06/20</i> <i>9 AM</i>		
	<i>Baby Euthemic</i>	
	<i>No - fever</i>	
	<i>Key / Temp Activity - good</i>	
	<i>SG: NAD</i>	
		<i>Act</i>
		<i>- DBC / LS Surgery 2nd hourly</i>
		<i>- USPT</i>
		<i>- plan cl 1 today</i>
		<i>- T. Part Ointment</i>
		<i>See cl 1</i>
		<i>See on Monday</i>
		<i>noted by</i>
		<i>Gr Sandhya</i>
		<i>26/6/26</i>
		<i>2:30 PM</i>



## DRUG CHART

Date of Admission: 24/06/26 Drug Allergies: N/A  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)

<b>DRUG :</b>				Date Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

<b>DRUG :</b>				Date Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

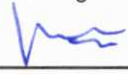

<b>DRUG :</b>				Date Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

VERIFIED BY : Name ..... Signatur



**REGULAR PRESCRIPTIONS**

Weight. 3.9 kg Ward. ....

<b>DRUG :</b> <u>VITAMIN D3</u>				Date Time	<u>5/6</u>															
Dose	Route	Frequency	Start Date																	
<u>0.5ml</u>	<u>PO</u>	<u>OD</u>	<u>24/6</u>																	
Name & Signature of the Doctor Starting the Drugs:				 																
Additional Instructions:																				
<b>Daily Doctor's Endorsement by a Sign</b>																				

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

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

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





I.V. FLUIDS CHART



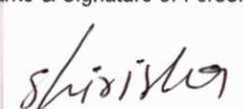
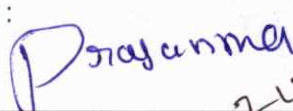
Weight. .... Ward. ....

Date	Time	Composition of I.V. Fluid (if infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

Signature .....

VERIFIED BY : Name .....

# PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00016046 IP26-00006633 Baby Of PAMMI UJWALA 19-06-2026 0 Y 0 M 5 D Dr. SPANDANA PASUPULETI (M)		Date & Time of Admission 24/06/26 @	Date & Time of Transfer Order 24/06/26
		Transfer Ordered by Dr. Vasun	Reason for Transfer Admission
From Unit GR	To Unit NICU.	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 15-1-	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Vasun	
Patient & Clinical Records Received by :  24/6/26 at 5:30 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



wt . 3.9 kg



# EMERGENCY ROOM TRIAGE FORM

Patient's Name : P.D. Pammijuwala Age : 5 days Gender:  Male  Female

Date : 24/06/26 Time of Arrival : 4:40 PM

Allergies:  No  Yes  Food  Medications  Blood Transfusion  Other (Specify):  Not known

Source of Information:  Parents  Others (Specify):

Mode of Arrival:  Ambulatory  Wheelchair  Ambulance

Initial Vital Signs: Temp: 98.2 PR: 120b/m BP: RR: 40b/m SpO<sub>2</sub>: 98%

Chief Complaints: cto yellowish discoloration all over the body

<b>INITIAL PHYSIOLOGICAL CATEGORIZATION</b> Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking Circulation / Colour <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		<b>INITIAL PHYSIOLOGICAL STATUS</b> <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not -- Life - Threatening <input type="checkbox"/> Life --Threatening	
Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea			

Triage Classification	CTAS
<input type="checkbox"/> Level 1 : Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2 : EMERGENT : Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3 : URGENT : Significant illness / Injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4 : LESS URGENT : Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5 : NON - URGENT : May receive care when convenient	<input type="checkbox"/> 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.  
All Children less than 2 years age with high fever to be considered Level 3.

\* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : .....

## Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks  Yes  No
- Have you had cough or a rash in the past 2 weeks  Yes  No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks  Yes  No

PART B. For patients reporting fever and respiratory/rash symptoms:  Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks?  Yes  No  
If yes, State Location: .....
- Are your parents / close contacts at home is/a healthcare worker? (please encircle the choices) (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease?  Yes  No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- The patient should be given a surgical mask immediately, if not already wearing one.
- Both patient and triage staff should perform hand hygiene.
- The staff should use PPE (as appropriate).

Name of Triage Nurse : shirisha

Signature of Triage Nurse : [Signature]

Date & Time : 24/06/26 @ 4:40 PM



## NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 24/06/25 Time of arrival : 4:44 PM  
 Chief Complaints : clo yellowish discoloration all over the body  
 Height : ..... Weight : 3.9 kg Head Circumference (<2 years) : .....

Allergies:  Yes  No  Medications  Blood Transfusion  Food  Other: .....  
 If yes, identify .....

Pain Screening:  Yes  No If Yes, Pain Score: ..... Pain Tool Used:  N Pass  FLACC  Wong Baker  
 Character .....  Location .....  Frequency .....  Duration .....

<p><b>RISK FOR FALL:</b></p> <p>If patient is &lt; 6 years <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No              If 'Yes' tick below fall risk intervention directly</p> <p>If Patient is &gt; 6 years              If 'Yes' Assess the below parameters</p> <p>History of Falling: within past 3 months <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>Ambulatory Aids:</b></p> <ul style="list-style-type: none"> <li>• Wheelchair <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>• Uses furniture for support <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> </ul> <p><b>Gait/Transferring:</b></p> <ul style="list-style-type: none"> <li>• Bedrest / immobile <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>• Weak <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> <li>• Impaired <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</li> </ul> <p><b>Mental Status:</b> Forgets limitations <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p><b>IF YES FOR ANY CATEGORY = RISK FOR FALLING</b></p> <p><b>Fall Risk Intervention:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Escort while ambulating</li> <li><input type="checkbox"/> Assist Patient</li> <li><input type="checkbox"/> Educate patient and family on fall precautions/prevention</li> </ul>	<p><b>Functional Screening:</b> <input type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mobility Problem</li> <li><input type="checkbox"/> Walking Problem</li> <li><input type="checkbox"/> Developmental Delay</li> <li><input type="checkbox"/> Musculoskeletal Congenital Abnormality</li> </ul> <p><b>Inform consultant for positive criteria</b></p> <p><b>Nutritional Screening:</b> <input type="checkbox"/> No Abnormalities Detected</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Underweight</li> <li><input type="checkbox"/> Overweight</li> <li><input type="checkbox"/> Feeding Problem</li> <li><input type="checkbox"/> Special diet</li> <li><input type="checkbox"/> Special feeding method</li> </ul> <p><b>Inform consultant for positive criteria</b></p>
---	---

**Psychological Screening:**  No Significant Findings  
 Unusual concerns about patient's Psychological Status:  Yes  No

**If Yes Consultant Notified:** ..... (Date/Time): .....

**Social History:** Lives With family .....

Siblings in household  Yes  No (if yes How Many?) .....

Time of Initial assessment completed by ER Nurse : 4:46 PM .....

**Nursing Care Plan (Including Labs / Medications / Other Care):**

Time	Nursing Notes
4:48 PM	Assess the patient's condition monitor the vital signs

Samples collected by:

Time:

Samples sent by :

Time:

*MLA*

*MLA*

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	Details of Shift - out
HR: ..... BP: ..... CFT: ..... RR: ..... SPO2 at FiO2: ..... GCS: ..... Temperature : ..... Pain Score: ..... Repeat RBS (if applicable): .....	Shift - out from ER to: <i>MLA</i> Time of Shift - out: ..... Handover given to: ..... (Nurse's Name)

Tick as applicable:  MLC  LAMA  BROUGHT DEAD

Procedures done with details (if any): .....

..... *MLA* .....

Name of the Nurse : *Shirley*

Signature of the Nurse : *[Signature]*

Date & Time : *24/06/16 @*

HNH-00016046 IP26-00006633  
 Baby Of PAMMI UJWALA  
 19-06-2026 0 Y 0 M 6 D (M)  
 Dr. SPANDANA PASUPULETI



## MEDICATION RECONCILIATION FORM

Drug Allergies: .....  Not known any Drug Allergies

**Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.  
 (Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)**

Shifting From: ..... Shifted to: .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	VITAMIN D3 drops	400 IU (0.5ml)	PO	QD		<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

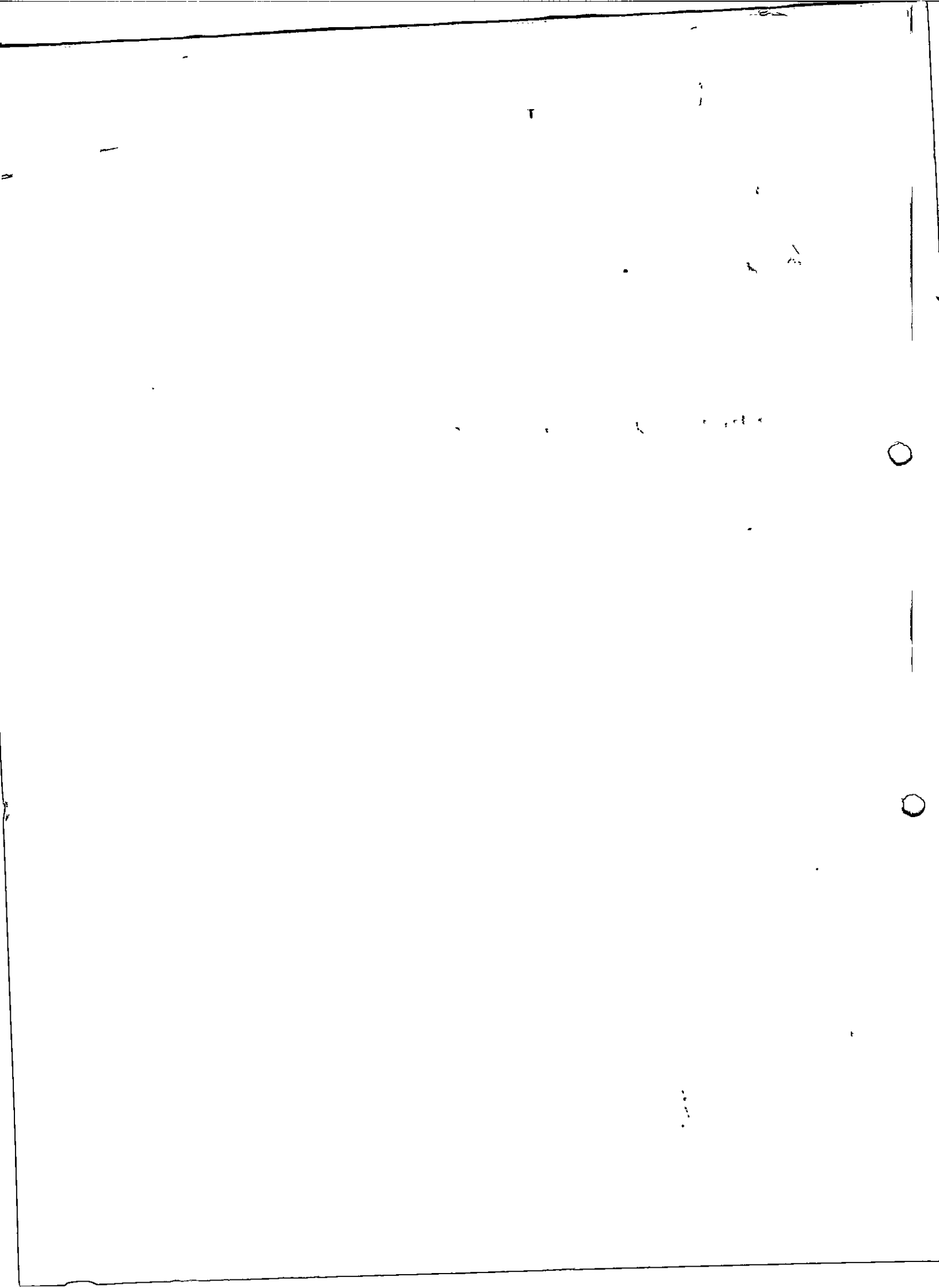
Doctor Name & Signature : .....

Date & Time : .....

Nurse Name & Signature: .....

Date & Time : .....

Docu. No. : RCH / FRM / GENERAL / 090



HNH-00016046 IP26-00006633  
 Baby Of PAMMI UJWALA  
 19-06-2028 0 Y 0 M 6 D (M)  
 Dr. SPANDANA PASUPULETI



## MEDICATION RECONCILIATION FORM

Drug Allergies: ..... N/A .....  Not known any Drug Allergies

**Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.  
 (Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)**

Shifting From: ..... GR ..... Shifted to: .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						<input type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C- Continue, DC - Discontinue

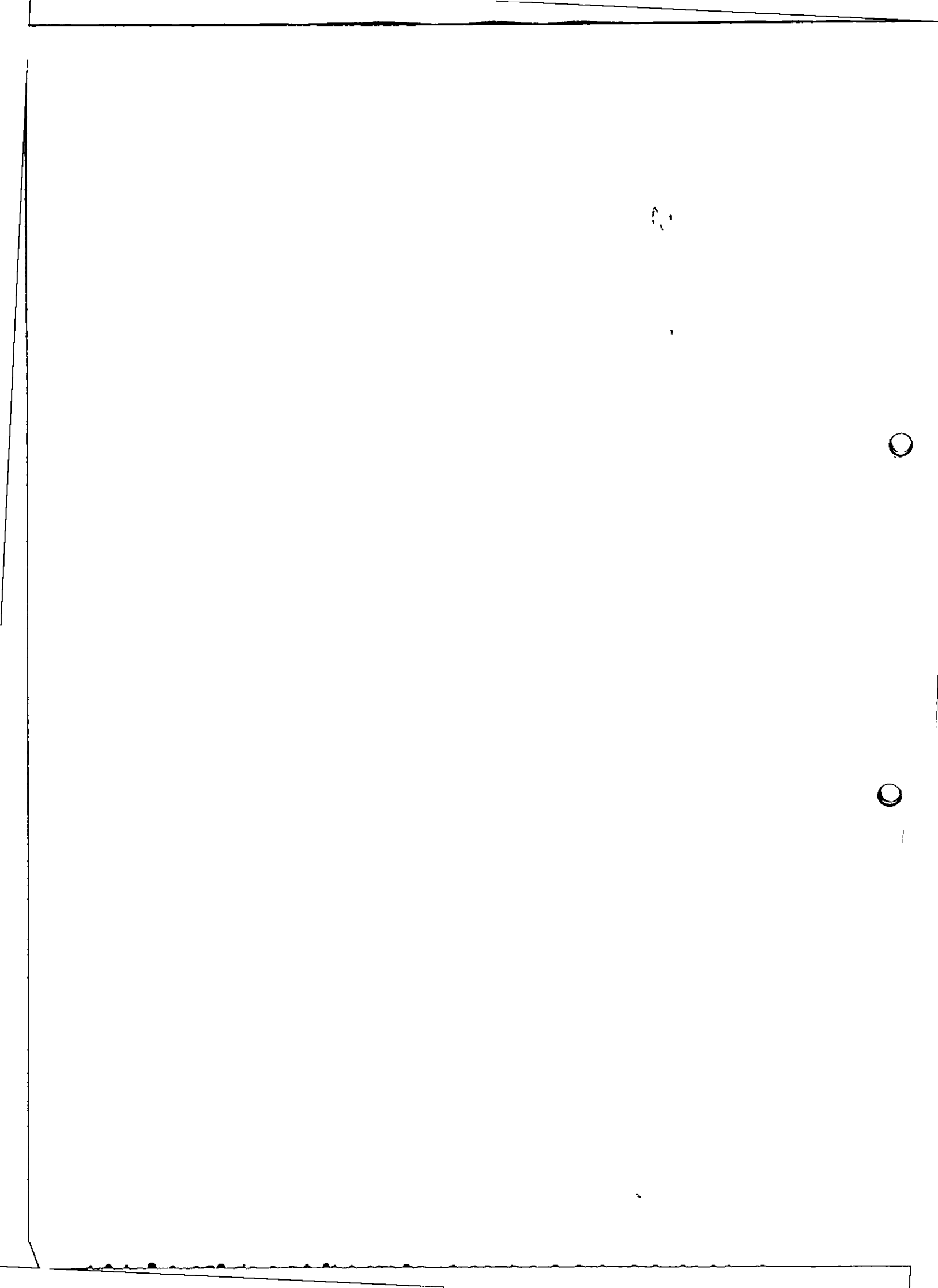
**MEDICATION HISTORY RECORDED / VERIFIED BY**

Doctor Name & Signature : ..... Dr. Vaxun .....

Date & Time : ..... 24/06/24 @ .....

Nurse Name & Signature: ..... Shivani .....

Date & Time : ..... 24/06/24 .....





## INTENSIVE CARE UNIT PRESENTATION FORMAT FOR NURSES AND DOCTORS

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

Gest Age: ..... Birth Weight: 3.9 kg

Date: <u>25/6/26</u>	Date: <u>26/6/26</u>	Date:
DOL <u>25/6/26</u> D6 Weight <u>4 kg</u>	DOL Weight <u>3.980 kg</u>	DOL Weight
Problems: <u>NNJ</u>	Problems:	Problems:
Rs. <u>30-60b/m</u> Exam <u>Done</u> Vent. Setting <u>RIA</u> ABG <u>SOS</u> CXR	Rs. Exam Vent. Setting ABG CXR	Rs. Exam Vent. Setting ABG CXR
CVS <u>Normal</u> HR <u>120-160b/m</u> BP <u>84/49</u> Map <u>(69)</u> Cap Refil <u>&lt; 2 spoc</u>	CVS HR BP Map Cap Refil	CVS HR BP Map Cap Refil
F/E/N T. Fluids CC/kg/day I/O/RBS: <u>92mg/dL</u> U Output: (CC/kg/hr) Exam <u>105ml</u> <u>2.1cc/lab</u> T. Bil/D Na Hc03 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 Hc03 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 Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results  CRP Antibiotics	C/s Results  CRP Antibiotics	C/s Results  CRP Antibiotics
Med  Neuro:	Med  Neuro:	Med  Neuro:
Assessment <u>-Done</u>	Assessment	Assessment
Plan <u>RBS-OD</u>	Plan	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 Cap Refill Map	CVS HR BP Cap Refill Map	CVS HR BP Cap Refill Map
F/E/N T. Fluids CC/kg/day I/O/RBS: U Output: (CC/kg/hr) Exam T. Bil/D Na Hc03 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 Hc03 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 Hc03 K BUN Cl Crea Hemat HB: WCC Plats Transfusion
C/s Results CRP Antibiotics	C/s Results CRP Antibiotics	C/s Results CRP Antibiotics
Med Neuro:	Med Neuro:	Med Neuro:
Assessment	Assessment	Assessment
Plan	Plan	Plan

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 Baby Of PAMMI UJWALA  
 19-06-2026 0 Y 0 M 6 D (M)  
 Dr. SPANDANA PASUPULETI



## RESULT SHEET

Date	25/6/26				
Time	6 AM				
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bil/Conj	11.35 <sup>0.1</sup> 11.2				
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology :    USG : .....

                  X-Ray : .....

                  ECHO : .....

                  CT : .....

                  MRI : .....

                  Others (ECG, Contrast Studies etc.) : .....

HNM-00018048 IP26-00006633  
 Baby Of PAMMI UJWALA  
 18-06-2026 0 Y 0 M 6 D (M)  
 Dr. SPANDANA PASUPULETI

FRM / CLINICAL / 124

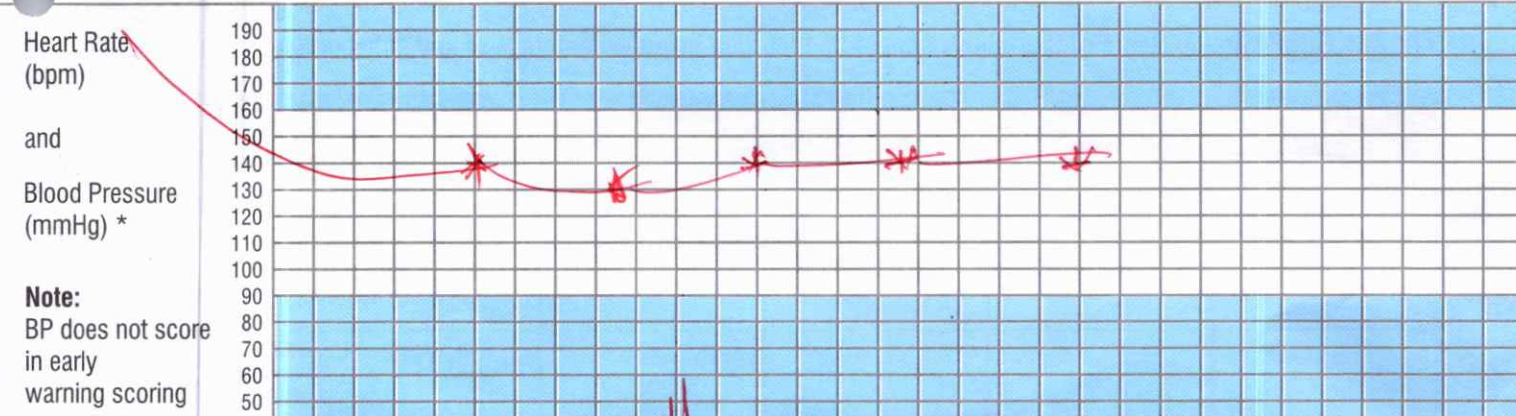
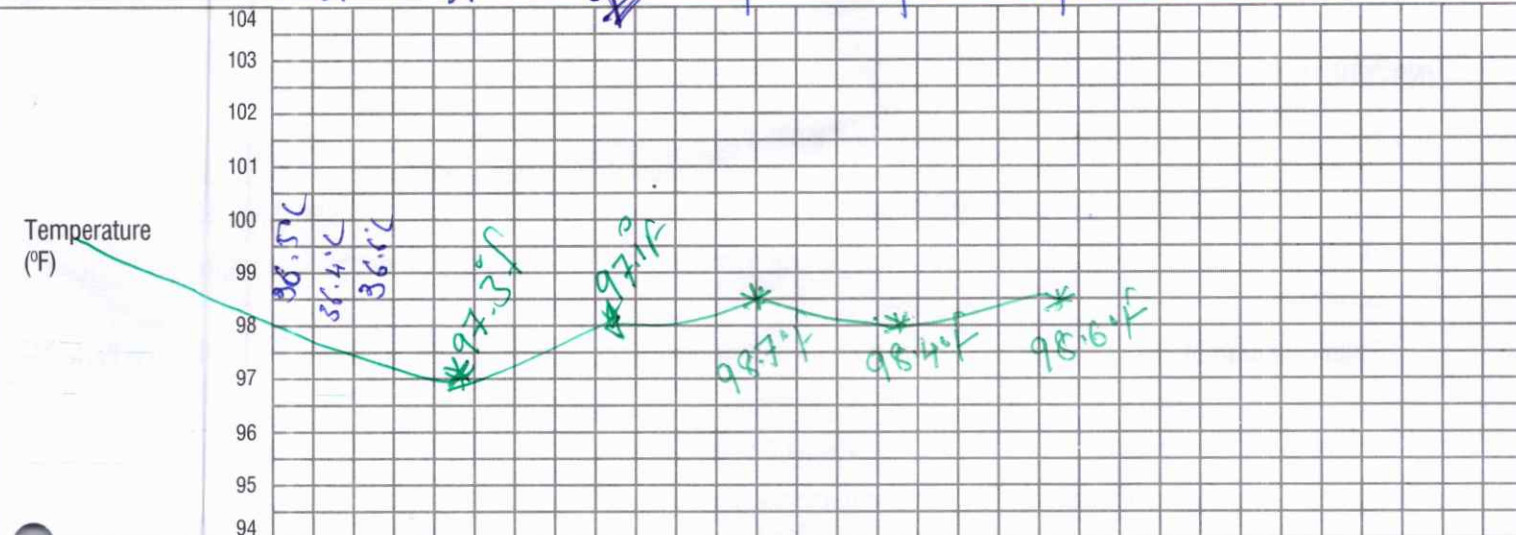
**INFANT (<1 year)**  
**Children's Observation & Early Warning Scoring Chart**



**WARNING SCORE: CHILDREN'S UNIT**

Date: \_\_\_\_\_

Doctor/Nurse/Family Concern? *8PM 9PM 10PM 6PM 10 PM 2 AM 6 AM*



**Note:**  
 BP does not score in early warning scoring

Heart Rate (Number) *140 140 140 140 142 143 145*



Resp Rate (Number) *50 50 50 42 42 42 42*

Resp Distress | Mod/ Severe Distress | None / Mild

Receiving O<sub>2</sub> (l/min) | O<sub>2</sub> Saturations (%) *100 100 98 99 100 100 100 99*

Conscious Level | Normal | Altered

GCS \* *15/15 15/5 15/5 15/5*

**TOTAL SCORE**  
 Number of shaded boxes *0 0 0 0*

Pain Score *0 0 0 0 0 0 0*

Observer's Initials *P P P P P P P*

- 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

SpO<sub>2</sub> is below 92 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.

<b>I.</b>	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
<b>S.</b>	<b>SITUATION :</b> 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>B.</b>	<b>BACK GROUND :</b> 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)
<b>A.</b>	<b>ASSESSMENT :</b> 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.
<b>R.</b>	<b>RECOMMENDATION :</b> 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)



# NURSING CARE RECORD



Date: 25/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am 2pm	<ul style="list-style-type: none"> <li>→ Assess the baby condition</li> <li>→ Monitored vitals</li> <li>→ 2nd hourly DBF + Spontaneous</li> <li>→ SBR traced</li> <li>→ DSPT continue</li> </ul>	8am 2pm	<ul style="list-style-type: none"> <li>→ Baby on Room air</li> <li>→ Monitored vitals.</li> <li>→ Given 2nd hourly DBF</li> <li>→ SBR traced.</li> <li>→ DSPT continue</li> </ul>	vitals are stable	Done.	 25/6/26
Afternoon	2pm 8pm	<ul style="list-style-type: none"> <li>→ Assess the Baby condition</li> <li>→ Monitor vitals &amp; records</li> <li>→ Maintain I/O chart</li> <li>→ DBF + FF 2nd hourly</li> <li>→ Cont. DSPT</li> </ul>	2pm 8pm	<ul style="list-style-type: none"> <li>→ Assessed the baby condition</li> <li>→ Monitored vitals &amp; records</li> <li>→ maintained I/O chart</li> <li>→ DBF + FF 2nd hourly</li> <li>→ Cont. DSPT</li> </ul>	Baby is stable now	Re-checked vitals	
Night	8pm	<ul style="list-style-type: none"> <li>→ Assess the Baby condition.</li> <li>→ Monitor vitals</li> <li>→ Maintained I/O chart</li> <li>→ DBF + FF 2nd hourly</li> </ul>	8pm	<ul style="list-style-type: none"> <li>→ Assess the Baby condition.</li> <li>→ Monitored vitals</li> <li>→ Maintained I/O chart</li> <li>→ DBF + FF 2nd hourly</li> </ul>	Baby is stable now	Re-checked vitals	

HNH-00016046 IP26-00006633  
 Baby Of PAMMI UJWALA  
 19-06-2026 0 Y 0 M 6 D (M)  
 Dr. SPANDANA PASUPULETI



# NURSING CARE RECORD

Date: .....

Goals

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

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

HNH-00018046  
 Baby Of PAMMI UJWALA IP26-00006633  
 19-08-2026 0 Y 0 M 6 D  
 Dr. SPANDANA PASUPULETI (M)  


# FLUID CHART

Sheet No. : .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Route	NG	Diarrhoea	Vomit	Drainage	Urine					
			Mouth	I.V	N.G								
25/6/26	08:00 am	DBF					✓			20ml			
	09:00 am												
	10:00 am	DBF											
	11:00 am												
	12:00 pm	EBM 30ml								✓			
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
25/6/26	02:00 pm	DBF											
	03:00 pm												
	04:00 pm												
	05:00 pm	DBF											
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
25/6/26	08:00 pm	DBF											
	09:00 pm	DBF + FF					✓						
	10:00 pm	DBF + FF					✓						
	11:00 pm	DBF + FF					✓						
	12:00 am	DBF + FF					✓						
	01:00 am						✓						
<b>Total Intake :</b>						<b>Total Output :</b>							
26/6/26	02:00 am	DBF + FF											
	03:00 am						✓						
	04:00 am	DBF + FF											
	05:00 am						✓						
	06:00 am	DBF + FF											
	07:00 am						✓						
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis: <span style="font-size: 1.2em; color: blue;">NNT</span>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....					
	Surgery / Procedure: <span style="color: blue;">-</span>	Post OP Day: <span style="color: blue;">1/6</span>					
<b>BACKGROUND</b>	Date	<span style="color: blue;">24/6/26</span> <span style="color: blue;">6g</span>	<span style="color: blue;">24/6</span> <span style="color: blue;">2g</span>	<span style="color: blue;">25/6</span> <span style="color: blue;">7g</span>	<span style="color: blue;">25/6</span> <span style="color: blue;">8g</span>		
	Shift						
	Medical Condition (Any special condition to be noted):	NNT	NNT	NNT	-		
	Diet:	-	-	-	-		
<b>ASSESSMENT</b>	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	
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA	-		
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	36.5°C	36.6°C	36.5°C	37.2°C	
		Res:		40b/m	40	40b/m	
		SpO <sub>2</sub> :	100%	100%	100%	100%	
		Pulse:	138b/m	134b/m	132	140b/m	
		BP:	81/48/50	70/40	60/54	-	
		LOC:	-	-	-	-	
	Fall Risk Score:	-	-	-	-		
Pain Score:	-	-	-	-			
Skin Integrity	-	-	-	-			
<b>Recommendations</b>	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	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	
	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	
	ADL (Dependent / Non Dependent):	-	-	-	-		
	Post Operative Procedure Special Orders:	-	-	-	-		
	Handed Over By Name :	Shivaleela	Dhanu	Poornima	Prayalca		
	Signature / ID :						
	Date:	24/6/26	25/6	25/6/26	25/6/26		
	Time:	8pm	8pm	2pm	8pm		
	Taken Over By Name :	Dhanu	Poornima	Prayalca			
	Signature / ID :						
	Date:	24/6/26	25/6/26	25/6/26			
	Time:	8pm	8pm	2pm			

HNH-00018046 IP26-00006633  
 Baby Of PAMMI UJWALA (M)  
 18-06-2026 0 Y 0 M 8 D  
 Dr. SPANDANA PASUPULETI



## NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....					
	Surgery / Procedure:	Post OP Day:					
<b>BACKGROUND</b>	Date	/	/				
	Shift:						
	Medical Condition (Any special condition to be noted):						
	Diet:						
<b>ASSESSMENT</b>	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	
	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	
	Vital Signs:	Temp:					
		Res:					
		SpO <sub>2</sub> :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
<b>Recommendations</b>	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	
	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	
	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	
	ADL (Dependent / Non Dependent):						
	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	
	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	
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature / ID :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature / ID :						
	Date:						
	Time:						

HNH-00016046 IP26-00006633  
 Baby Of PAMMI UJWALA  
 19-06-2026 0 Y 0 M 5 D (M)  
 Dr. SPANDANA PASUPULETI

# BRADEN 'Q' SCALE



Date: 26/6 29/6 25/6 05/6  
 Time: 6:2 00:1 Me 6:2

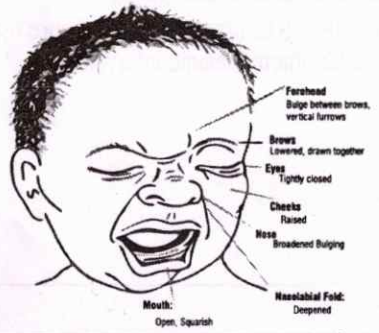
	26/6	29/6	25/6	05/6
<b>Mobility</b>	4	4	4	4
<b>'Activity The degree of physical activity'</b>	4	4	4	4
<b>Sensory Perception</b>	4	4	4	4
<b>Moisture Degree to which skin is exposed to moisture</b>	4	4	4	4
<b>FRICION-SHEAR</b> Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	4	4	4	4
<b>Nutritional Usual food intake pattern</b>	4	4	4	4
<b>Tissue Perfusion &amp; Oxygenation</b>	4	4	5	4
<b>TOTAL SCORE</b>	28	28	28	28
<b>Evaluator's Name</b>	[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	<b>Support Surfaces</b> (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"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	<ul style="list-style-type: none"> <li>• Use the Same Protocol as for "At Risk" Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	<ul style="list-style-type: none"> <li>• Follow the same protocol as for "Moderate Risk" Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>	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"> <li>• Use same protocol as for "High Risk" Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

HNH-00016046 IP26-00006633  
 Baby Of PAMMI UJWALA 0 Y 0 M 5 D (M)  
 19-06-2028 Dr. SPANDANA PASUPULETI

## 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	28/6	28/6	28/6	28/6				
						Time	Time	Time	Time	Time	Time	Time	Time
						E2	NA	M6	E2				
	Procedure →												
<b>Crying Irritability</b>	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	NA				
<b>Behavior State</b>	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				
<b>Facial Expression</b>	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual	NA	NA	NA	NA				
<b>Extremities Tone</b>	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				
<b>Vital Signs HR RR, BP, SaO<sub>2</sub></b>	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 <sub>2</sub> 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator	NA	NA	NA	NA				
 <p><b>Premature Pain Assessment: Scoring</b>        +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><b>Intervention</b>        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>	<b>Gestational Age / Corrected Age</b>	39 wks	39 wks	37 wks									
	<b>Total Pain / Agitation Score</b>	-	-	-	-								
	<b>Intervention</b>	-	-	-	-								
	<b>Effectiveness</b>	-	-	-	-								
	<b>Signature</b>												

## NPASS: Neonatal Pain, Agitation & Sedation Scale

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

**GENERAL CONSENT FOR TREATMENT**

Patient Name: **Baby Of PAMMI UJWALA** Age : **0 Y 0 M 5 D**  
IP No: **IP26-00006633** Sex: **Male**  
Consultant: **Dr. SPANDANA PASUPULETI** Ward/Bed No: **GF -EMERGENCY/ER01**

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:

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

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

(Receivers Signature:.....)

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

4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Ujwal

Relationship: mother

Date: \_\_\_\_\_

Witness Name: U Saiju

Witness Signature: [Signature]

Time: \_\_\_\_\_

Patient Address:

RTC X Road Hyderabad Telangana  
INDIA 500020

PA

HNH-00018048 IP26-00006633  
 Baby Of PAMMI UJWALA  
 19-08-2026 OYOMED (M)  
 Dr. SPANDANA PASUPULETI



**TRANSFER FORM**



Date & Time of Admission 24/6/26 @ 5:15pm		Date & Time of Transfer Order 25/6/26 at 1
Treating Consultant Name Dr. Spandana	Transfer Ordered by Dr. Tejaswi Reddy	Reason for Transfer stable
From Unit NICU	To Unit 3rd floor (305)	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File 30	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name & Signature of Person who is Transferring Pammi Ujwala		Name of Person Ordered Transfer Dr. Tejaswi Reddy.
Patient & Clinical Records Received by :		
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