

ACTIV VIH-00206078 IP-00060419 **NG**

Baby B/O HAJERA TARANNUM
20-06-2026 0 Y 0 M 0 D 1 H (M)
Dr. ATLURI KUNDANA PRIYA

Name: -----



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

Date of Admission: 20/6/26 Time: 10:37 AM Date of Discharge: ----- Time: -----

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/6/26	12:10 AM	MICU	2nd floor	[Signature]

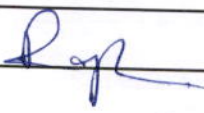
Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
20/6/26	blood grouping	✓ 126020982 ✓	[Signature]
20/6/26	ABG.	✓ 126021033 ✓	[Signature]
cron checked by mangra 20/6/26 @ 11:30am			
22/6/26	TCB	260 21181	[Signature]
23/6/26	SBR	260 21230	[Signature]

PROCEDURE


Date	Procedure	Quantity	Order No.	Signature
22/06/26	TEOAE	1	3093191	


ANY OTHER INFORMATION

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.....
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.....

Date: 23/6/26

Time: 9 AM

Prepared By: 

Staff Nurse	Shift / Ward  23/6/26 9 AM	Billing Assistant	Billing Supervisor
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ADMISSION SHEET

Registration Details :



Admission No : IP-00060419

Admit Date : 20-Jun-2026

Admit Time : 10:37 AM UHID : VIH-00206078

Patient Details :

Patient Name : Baby B/O HAJERA TARANNUM

Age : 0 D

Guardian : Mr MIRZA KAZIM BAIG

DOB : 20-06-2026 08:49 AM

Gender : Male

Religion :

Occupation :

Marital Status :

Address (H) : HOUSE NO 1-11-41,NEAR RLY STATION
CUSTOMS BAsthi BEGUMPET,
SECUNDRABAD, BEGUMPET Ameerpet X
Road Hyderabad Telangana INDIA 500016

Phone No : 9700055154/ 9700055154

E-mail : na123@rainbowhospitals.in

Admission Details :

Bed Type : BASINET

Bed No : CRDL-MICU-226-2

Ward Name : N 2F-MICU

Room No : CRDL-MICU-226-2

Admission Type : First Visit

Contact Details :

Name : Mr MIRZA KAZIM BAIG

Relationship : Father

Contact Address : HOUSE NO 1-11-41,NEAR RLY STATION
CUSTOMS BAsthi BEGUMPET,
SECUNDRABAD, BEGUMPET Ameerpet X Road
Hyderabad Telangana INDIA 500016

Phone No : 9700055154 / 9000635010

Signature

Doctor Details :

Doctor Name : Dr. ATLURI KUNDANA PRIYA

Specialisation : GENERAL PEDIATRICS

Referral Doctor :

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

PATIENT TRANSFER FORM

VIH-00206078 IP-00060419

Baby B/O HAJERA TARANNUM
20-06-2026 0 Y 0 M 0 D 1 H (M)
Dr. ATLURI KUNDANA PRIYA



Date & Time of Admission <i>20/6/26 @ 10:37 AM</i>		Date & Time of Transfer Order <i>20/6/26 @ 12 AM</i>	
Treating Consultant Name		Transfer Ordered by <i>Dr.</i>	
Reason for Transfer <i>observation</i>		Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
From Unit <i>MICU</i>		To Unit <i>Room (203)</i>	
Number of Sheets in Clinical File <i>30</i>		Number of Imaging Films <i>-</i>	
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.	<i>small kuries</i>	<i>1</i>	
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 <i>Sis. Rami</i>		Name of Person Ordered Transfer <i>Dr.</i>	
Patient & Clinical Records Received by : <i>Sony</i>			
Date & Time of Patient Received : <i>21/6/26 @ 12:30 AM</i>			

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

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Baby B/O HAJERA TARANNUM
20-06-2026 0 Y 0 M 0 D 1 H (M)
Dr. ATLURI KUNDANA PRIYA



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Hajera Tarannum Mother's Name: Hajera Tarannum
Date of Birth: 20/6/26 Time of Birth: 8:49:30am Gender: Male Female
Birth Weight: 2.925 Kgs HC: cm Length: cm
Meconium in Liquor: Yes No Cried at Birth: Yes No
Term / Pre-term / Post-term: Term
Resuscitated: Yes No Blood Group: Mother: B positive Baby:
Feeding: Breast Feeding Formula Both First Feed Time:

KUH-00155024 IP-00060413
Mrs HAJERA TARANNUM
04-07-1991 34 Y 11 M 16 D (F)
Dr. KAPPAGANTULA APARNA

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

Physical Assessment of New Born:

Temp: 36.4 °C HR: 158 /Min RR: 49 /Min BP: SpO₂: 94%

Pain Score: 0 (Follow N Pass)

Fall Risk Assessment: Yes No Score: 16 (Fill the Humpty Dumpty Sheet)

Risk in Pressure Sore: Yes No (Braden Q Score) (Fill the Braden Q Sheet)

Behaviour Status on admission: Sleeping Crying Calm Drowsy

Findings:

General Appearance: Posture: Well-Flexed Asymmetry

Skin: Pink Meconium Stain Others, Specify:

Nursing Management: (Please strike through if not applicable e.g. Yes / ~~No~~)

Vitamin K 1 mg IM Administered: ~~Yes~~ / No

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: ~~Yes~~ / No

1. Nutritional Screening: Feeding Problem Yes / ~~No~~

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / ~~No~~

3. Socio History: Siblings ~~Yes~~ / No

All information obtained from Mother Father Other Family Member

Newborn Screening Discussed: Yes / No

Nurse Name: Adithyan

Signature: Adithyan

Date & Time: 20/6/26 @ 2pm



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Hajera Tarannum Age : Father's Name : Age :
 Date of Birth : 4/2/91 Date of Admission : UHID No. :
 NICU Consultant : Dr Kundana Referring Consultant : Dr Aparna
Transferring Unit : OT Labour Room ER Ward
Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : R/o Hajera Mother's Blood Group : O Positive
 Gender : M F Blood Group : Birth Weight (gms) : 2925 kg Length (cms) :
 Date of Birth : 20/6/26 Time of Birth : 8:49:30 am OFC (cms) :
 Place of Birth : RUH - VKP Estimated Gesth Age : 36-36 wk

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 34yr Ht : Wt : BMI : Married Life : 7yr LMP : 4/10/25 EDD : 11/2/26

Conception : Spontaneous or with Rx :

Booked at what GA : at 14 wk AN Steroids Drugs / Doses : 200 mg Salmetamide 2mg @ 33-32 / 33-14 wk

Last Scans Details : 16/6/26 SUPT (36^W) AD - 1400/1000/1000 @ 1

TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs Consanguinity : <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 H/o PIH (after 20 weeks) / PE How many Drugs / Doses / Since how long : <u>T-Nicardipine 10mg TID</u> H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : IUGR - when detected : Doppler (Increased Resistance / ADEF / REDF / Redistribtion 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 : <u>(2)</u> H/o Hypothyroidism : when diagnosed ? Medication? Any other Chronic Medical Problems, when detected drugs ? (Anemia, SLE, Jaundice, CHD, Heart Disease) Infection : H/O, Fever <u>Recent UTI @</u> (<input type="checkbox"/> Malaria <input type="checkbox"/> UTI <input type="checkbox"/> TORCH <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> HBV) UTI : when : Any culture :
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PPROM : Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

P: 1 A: 3 L:

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
1	9 wks	14	1800 gm	Female	Miscarriage 2018	
2	19-25 wks	24	1800 gm	Female	Miscarriage 2021	
3	19-25 wks	24	1800 gm	Female	Miscarriage 2021	

PERINATAL HISTORY

Treating Obstetrician : Dr. Aswini Hospital : PCCP UGA 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 checked="" type="checkbox"/> Emergency Indication :</p> <p>Specify the reason : LFA 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>Resuscitation : <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>
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NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

	1 Minute	5 Minutes	10 Minutes
TOTAL	7/10	9/10	

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

Snapee II Score

	> 30 (0)	20-29 (9)	< 20 (19)	
Mean BP (mmHg)	> 96 (0)	96-95 (8)	< 95 (15)	
Lowest Temp (oF)	> 2.49 (0)	1-2.49 (5)	0.3-0.99 (15)	< 0.3 (28)
Pao2 / Fio2 (mmHg%)	> = 7.2 (0)	7.1-7.19 (7)	< 7.1 (16)	
Lowest Serum PH	No (0)	Yes (19)		
Multiple Seizures	> = 1 (0)	0. 1-0.9 (5)	< 0.1 (18)	
U. Output (ml / kg / hr)	> = 7 (0)	< 7 (18)		
Apgar Score	> = 1kg (0)	750 - 999 (10)	< 750 (17)	
Brith Weight	> 3rd percentile (0)	< 3rd (12)		
SGA				

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

Cutis.



Delivered by Embrace

↓
C/O
↓
Cut deep cut immediately

↓
Scalp as cleared

↓
Cord clamp 2A+IV ⊕

↓
Inf vit K given

at 5 min of life

SpO₂ = 95% SCR ⊕ / Pappm ⊕
HR > 100

Investigation details in previous Hospital :

↓
DE CPAP given for 2 min
PEEP: 6 HR
NO DR SpO₂ = 90 > 100

Feeding History :

↓
Belly is grow
↓
Right to mother side

Past History :

Family History :

Socio Economic History :



GENERAL EXAMINATION ON ADMISSION

General Disposition :

GA good

VITALS : Temperature : 36.6°C HR : 138/min RR : 49/min NIBP : CFT : CR

Color of the extremities : cyanosis

Jaundice : Pallor : SpO2 : 94RA

Anthropometry : Birth Weight : 2.92kg Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

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

Facies :
(Any Facial Dysmorphism) N

NECK and CLAVICLES : Range of Motion :
Asymmetry : 60
Masses :

EYES : Symmetry :
Red Reflex : not centered
Discharge :

EARS, NOSE MOUTH and THROAT : Ear set / Shape :
Periauricular Pits / Tags :
Nasal shape / Patency : / 0
Palate :
Gums :
Lips :
Tongue :



THORAX and BREASTS : Position of Nipples and Number : 2

ABDOMEN and UMBILICUS :
 Shape : 1
 Organomegaly :
 Bowel Sounds : 2/4/4/0
 Umbilical Stump :
 Discharge :

GENITILIA :
 Labia / Hymen :
 Testicles/penis : PL testis palpable in scrotum
 Anus :

HERNIAL ORIFICES : Free

TRUNK and SPINE : 2

SKIN LESIONS : -

EXTREMITIES :
 Fingers / Toes :
 Deformities : 10/10/10/10
 Hip Joint Examination :
 Arms / Legs :
 Mobility :

SYSTEMIC EXAMINATION

Respiratory System :
 Breathing Pattern : Regular Periodic Shallow Gasping
 Mention If baby has Respiratory distress : RR : 45/min SCR / ICR / See - Saw breathing :
 Scoring of respiratory distress if present (Silverman or Downe's) :
 Mention if baby is on : Hood box CPAP Ventilator
 Settings :
 SpO₂ : 98% Auscultation : 2/2/0 Breath Sounds : Normal Added Sounds :

Cardiovascular System :
 HR : 160/min BP :
 Femoral Pulses : +
 Other Peripheral Pulses : +
 Precordial Activity : 2
 Murmurs : 1
 Signs of Cardiac Failure :

Abdomen :
 Shape :
 Palpation : soft
 Palpable masses :
 Abdominal girth :
 Hernia orifice : Free
 Anal Patency : +
 Umbilical Cord : 2/4/4/0
 First urine passed :
 Meconium passed :

VIH-00206078

IP-00060419

Baby B/O HAJERA TARANNUM

20-06-2026

0 Y 0 M 0 D 1 H (M)

Dr. ATLURI KUNDANA PRIYA



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 : 3/4 removed DTR :

ATNR : Skull and Spine :

Any Congenital Anomalies :

Diagnosis : Low AT / Absent MCL CAS / AAA 2.9.25.

FOOT PRINTS

Left Side :



Right Side :



*Taken by
Sri Vanitha*

Resident Doctor :

Signature : [Signature]

Name : Dr. Shriram

Date & Time : 20/6/26

Consultant :

Signature : [Signature]

Name : Dr. Kundana Priya

Date & Time : 21/6/26

Dr. Kundana Priya
Reg. No. A.M.C./F.M.S./97354



DISC

Information given by: Family Friend

Will patient require transportation arrangements to go home: Yes No NA

Will Physiotherapy require at home: Yes No NA

Is home medical equipment anticipated: Yes No NA

Is home oxygen therapy anticipated: Yes No NA

Breastfeeding Yes No NA

Formula Feed Yes No NA

Are dressing needs at home anticipated: Yes No NA

Any other needs anticipated: Yes No If Yes Specify

Feeding Plan at the time of shifting :

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Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Discharge Details:

Neonatal Condition at Discharge:

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Feeding: Breastfeeding Exclusively Breastfeeding and Formula Feeding Formula Feeding

Vitamin K given: Yes No

Vaccinations given BCG Hepatitis B Others:

Neonatal Screen Taken: Yes No, parents advised to have Neonatal Screen at National screening program center on:/...../.....

Hearing Test: Yes No

Jaundice: NIL Slight Moderate

Passed Urine: Yes No

Passed Meconium: Yes No

Weight at discharge:

Appointment was given for follow-up at OPD: Yes No

Date of Discharge:/...../.....

Discharge to Home Other:

Against Medical Advice: Yes No

Referred to another hospital: Yes No

Discharge Medications: Yes No

Details:

Final Diagnosis:

- DBA 2nd hly
- OBT SRAL NRS R/O D/E
- monitor & inform (1u)
- warm the care, cold care noted
20/6/26

Doctor Signature:

Doctor Name:

Date & Time:

[Handwritten signature]
[Handwritten name]
[Handwritten date]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/6/2024	<p>S/B Resident</p> <p>late PT / emcee / mch / CRAB / 2.925kg</p>	
<p>m } B } 0+re</p> <p>m } m } passed</p>	<p>Baby wear</p> <p>CTA - 810d</p> <p>CRT c3cc</p> <p>CVS - 810 (f)</p> <p>pls - BAP (f)</p> <p>PLA - soft</p>	
<p>NACC: TODAY</p> <p>OAE: VM</p>		<ol style="list-style-type: none"> 1) Start on FF 2) DDF dby Burping 2nd hrly 3) DAG 1/m 4) vaccination Today 5) wormtbl. cord care
<p>Dr. KUNDANA PRIYA 21/6/24 9 AM</p>	<p><u>completing</u></p>	
		<p>note by Raja Per 21/6/24 @ 10:45</p>

VIH-00208078 IP-00080419
 Baby B/O HAJERA TARANNUM
 20-06-2026 0 Y 0 M 0 D 15 H (M)
 Dr. ATLURI KUNDANA PRIYA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6/26	S/B Resident	
4 PM	OLT	
31th Oct	Baby worm	
	C/T/A good	
	CET like	
	CR - S/S (+)	
	R/S - BAE (+)	
	P/A - not	
		Plan
	1)	OAE / m
	2)	TCB b/d d/s
	3)	DNF @ 2A by Bupry
	4)	Pupom ms.
Dr. Y. K. Kwaja		Noted by Sony
		22/6/26 @ SDH

VIH-00208078 IP-00080419
 Baby B/O HAJERA TARANNUM
 20-08-2026 0 Y 0 M 2 D (M)
 Dr. ATLURI KUNDANA PRIYA



2

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22.6.26	S/B dr. Keendana	
9.00 AM	Late PT (36 ⁺⁶ wu) / AGA / baby boy / H02-48	
	o/e baby marks	
	ichth ⁺ upto umbilicus	
	veg. tone } (1)	
	Y.wt: 2.83 kg. actively	
	T.wt: 2.76 kg (↓70gm) H/L - NAD	Plan
	MBG } 0 tra. P/A - soft	→ TCB next = If > 12
		→ OAE today start
		→ DBM + Fi ² DSP7
		→ Warm expo
	Dr. Keendana	Saneers
	22/6/26 9 AM	(Dr. Saneers)
	D/w dr. Keendana	
	TCB: 13.5	Plan
		→ Start DSP7.
	Saneers	(Dr. Saneers)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22.6.26	<p><u>Lactation notes (Ms. Ranjitha)</u></p> <ul style="list-style-type: none"> 1st time Mother Short nipple both sides Drops of milk seen C/o low milk supply TF introduced Strategies to improve supply discussed Advised to feed every 2-3hrs Rx Plan: KMC + DBF + TF Flucloxacillin (if breast pump) <p>Hi. Mani</p>	
22.6.26 4.00 PM	<p>S/B Registrar</p> <p>Late PT (36⁺ wk) / AGA / baby boy / NINHA</p> <p>On DSPT</p> <p>c/E baby warm</p> <p>oxy. } (M)</p> <p>tone } (M)</p> <p>activity } (M)</p> <p>H/L - NA</p> <p>P/A - soft</p> <p>Dr. Sameer (Dr. Sameer)</p>	<p>Plan</p> <ul style="list-style-type: none"> → DBM + TF → SRR T/m GAM → Cont DSPT → Burping after every feed.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/6/26 8:45 AM	<p><u>CB/B Resident</u></p> <p>late PT / 36+6 wks / LSCs / CBAB / male / 2.925 kg</p> <p>M.BG - O +ve B.BG - O +ve</p>	
		<u>Plan</u>
	<p>Y. wt - 2.76 kg T. wt - 2.76 kg (same)</p>	- DBP flb burpy 2wks
	<p>O/E C/T/Agood CUS-SB2 ⊕ RS-B/LAB ⊕ PA-Sgt vly stable</p>	- Stop DSPT
		- Discharge NBS at flw.
	<p>Vaccinatn dne OAS dne</p>	- Flup m 27/6/26
	<p>SBR - 5.5 mg/dl</p>	
<p>flw 5 days</p> <p>Dr. Kundana Priya 23/6/26 9 AM</p>		<p></p> <p>Dr. Kundana Priya Reg. No. MC/MB/197354</p>

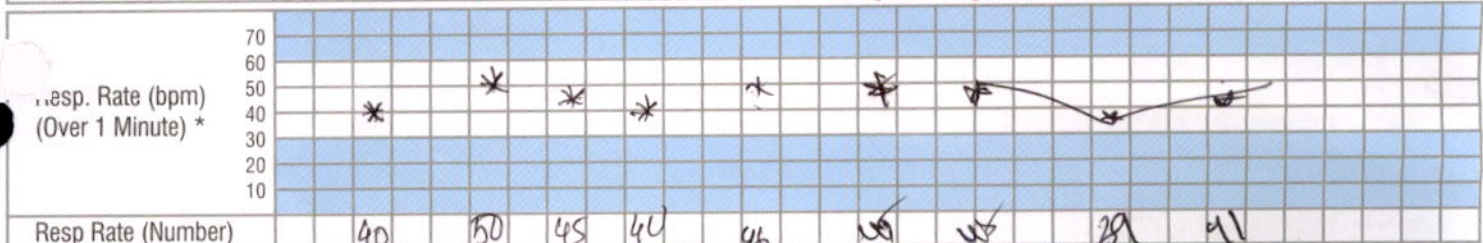
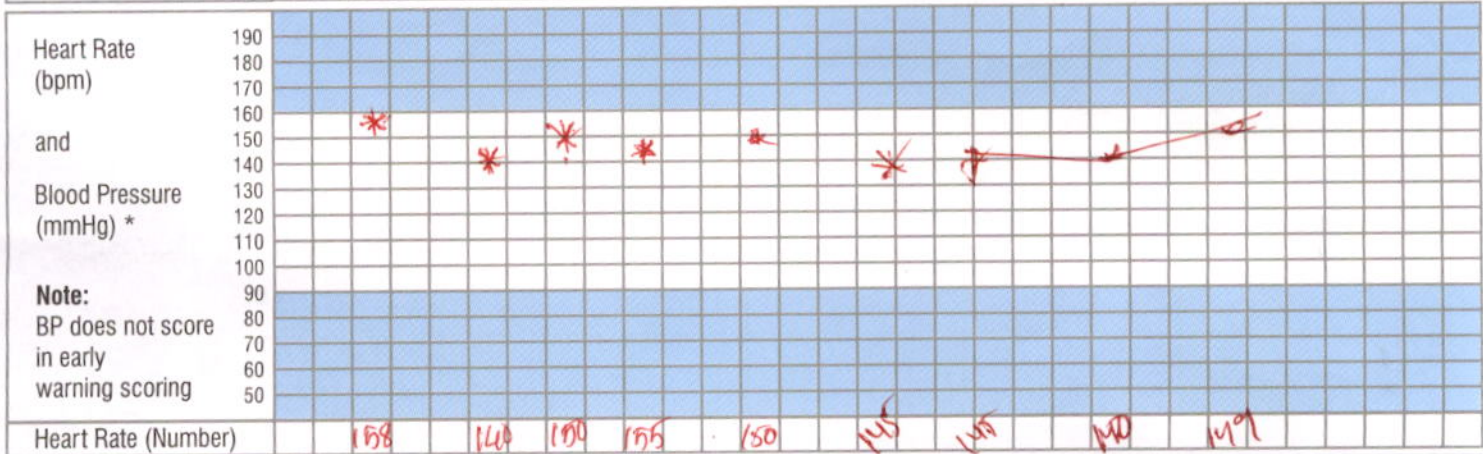
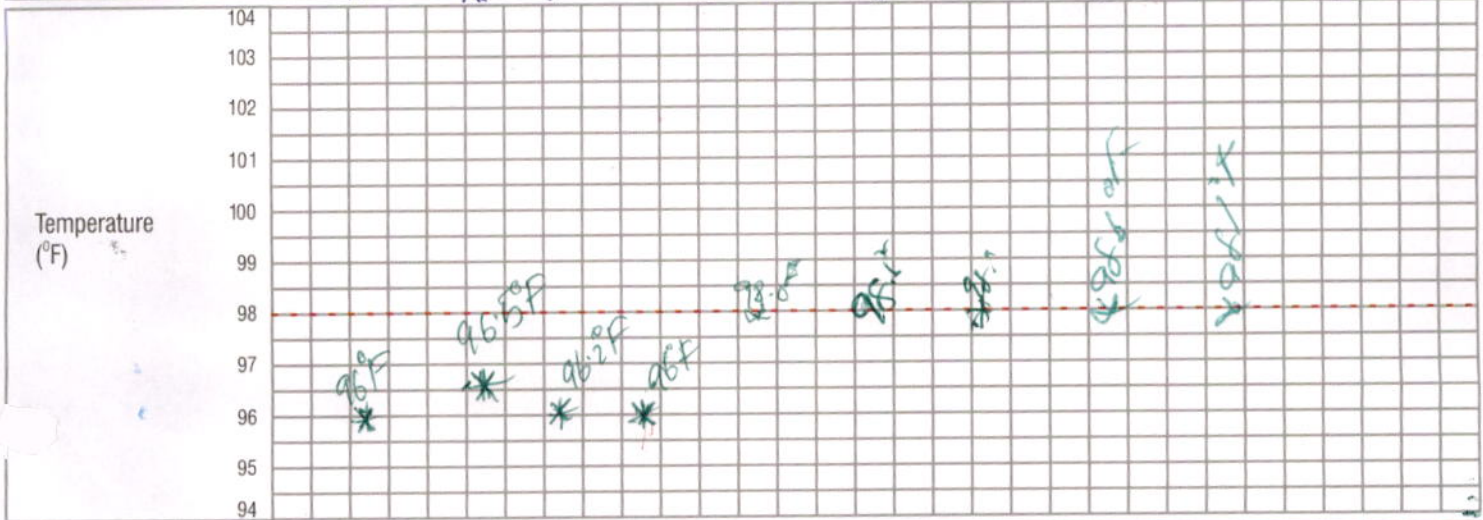


INFANT (<1 year)
 Children's Observation &
 Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/6/26	Time: 9:00	11	1	3	5	7	9	11	4	7
Doctor/Nurse/Family Concern?	Am	Am	Pm	Am	Pm	Pm	Pm	Am	Am	Am



Resp Distress	Mod/ Severe None / Mild	✓	✓	✓	✓	✓	✓	✓	✓	✓
Receiving O ₂ (l/min)	O ₂ Saturations (%)	99	99	98	99	98	98	99	99	99
Conscious Level	Normal / Altered	NA	NA	NA	NA	NA	NA	5	5	5
GCS *		NA	NA	NA	NA	NA	5	5	5	5

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

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 in charge and PICU /NICU fellow or PICU/NICU consultant to be informed

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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A	ASSESSMENT: I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION: I need you to ... come to see the child in the next (XX mins) AND Is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)

VIH-00206078 IP-00060419
 Baby B/O HAJERA TARANNUM
 20-08-2028 0 Y 0 M 0 D 15 H (M)
 Dr. ATLURI KUNDANA PRIYA

Doc. No. : RCH/FRM / CLINICAL / 124

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

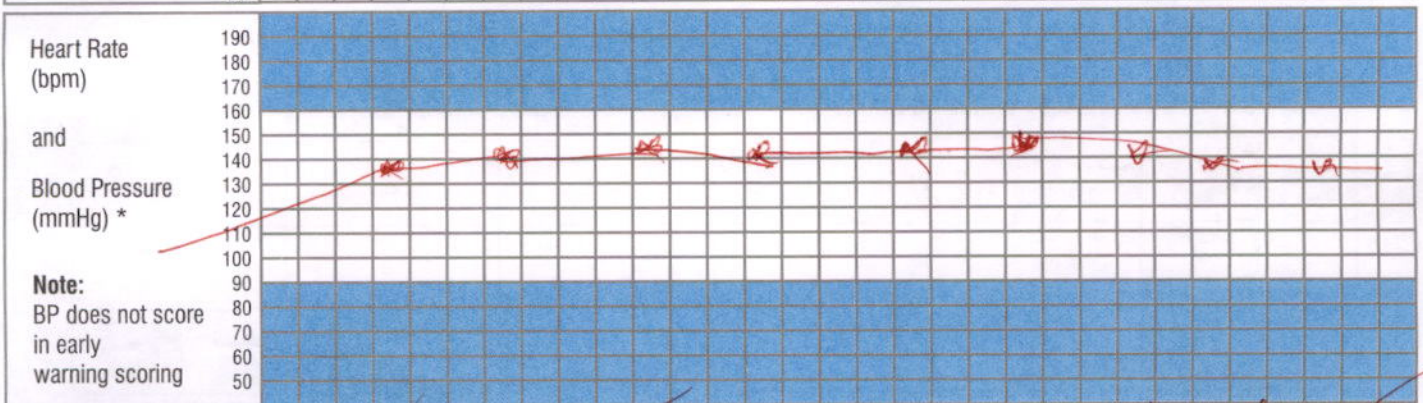
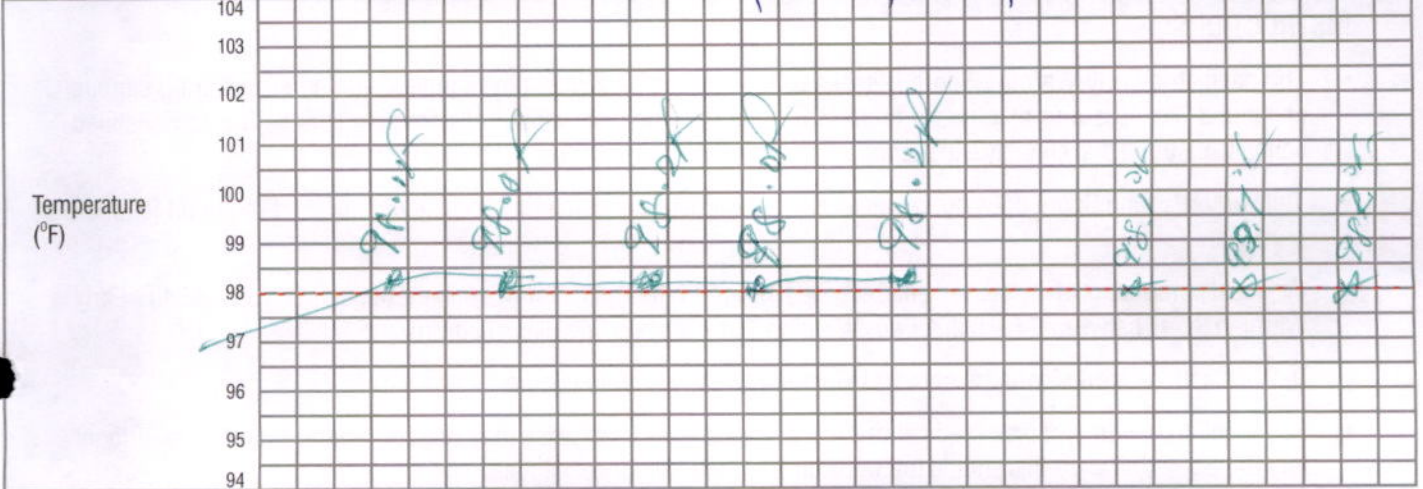
Rainbow®
 Children's
 Hospital
 It takes a lot to treat the little.

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

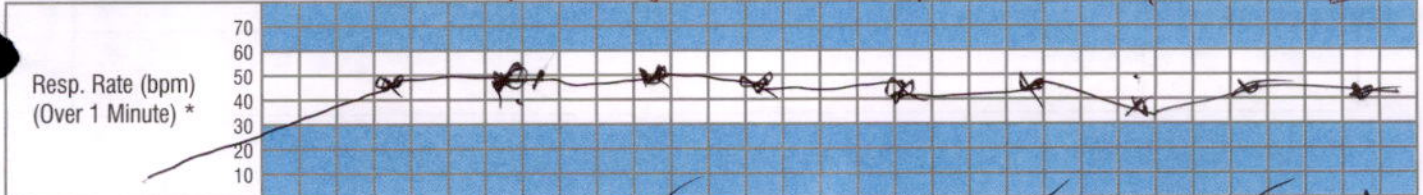
Date: 20/8/28 Time: 9 AM 11 AM 2 PM 4 PM 6 PM 8 PM 9 PM 11 PM 12 AM

Doctor/Nurse/Family Concern? Am Am Pm Pm Pm Pm Am Am Am



Note:
 BP does not score
 in early
 warning scoring

Heart Rate (Number) 138 140 145 140 142 140 141 137 135



Resp Rate (Number) 41 43 45 42 40 45 39 45 41

Resp Distress	Mod/ Severe None / Mild	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Receiving O ₂ (l/min)	O ₂ Saturations (%)	<u>99</u>	<u>99</u>	<u>99</u>	<u>99</u>	<u>99</u>	<u>99</u>	<u>99</u>	<u>99</u>
Conscious Level	Normal Altered	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
GCS *		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>

TOTAL SCORE									
Number of shaded boxes	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Pain Score	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Observer's Initials	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>

ACTIONS

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

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

VIH-00206078 IP-00080419
 Baby B/O HAJERA TARANNUM
 20-05-2025 0 Y 0 M 0 D 15 H (M)
 Dr. ATLURI KUNDANA PRIYA

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

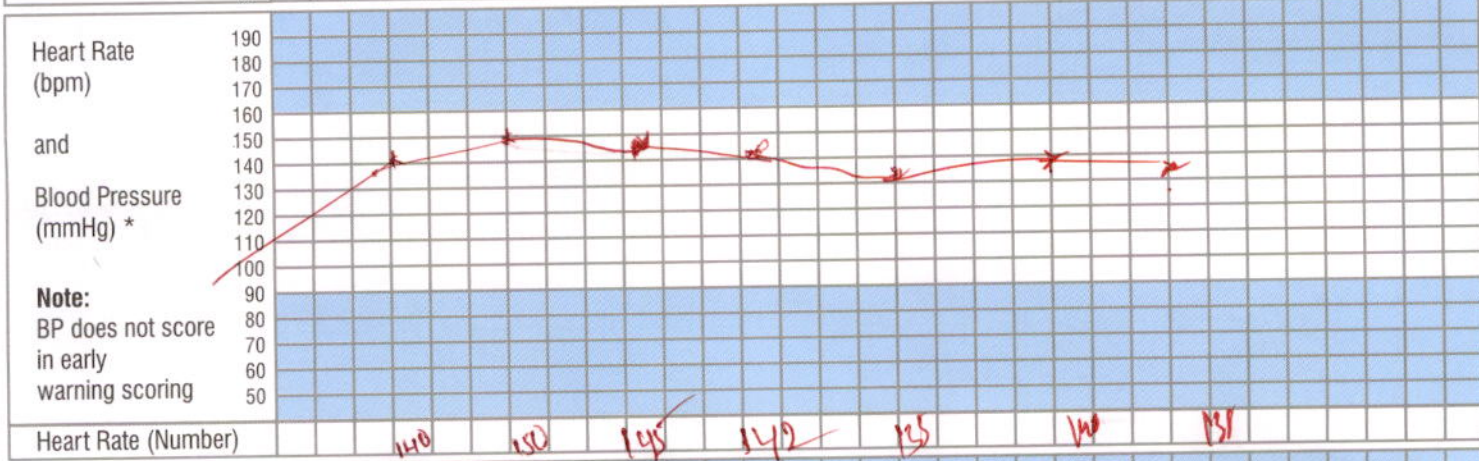
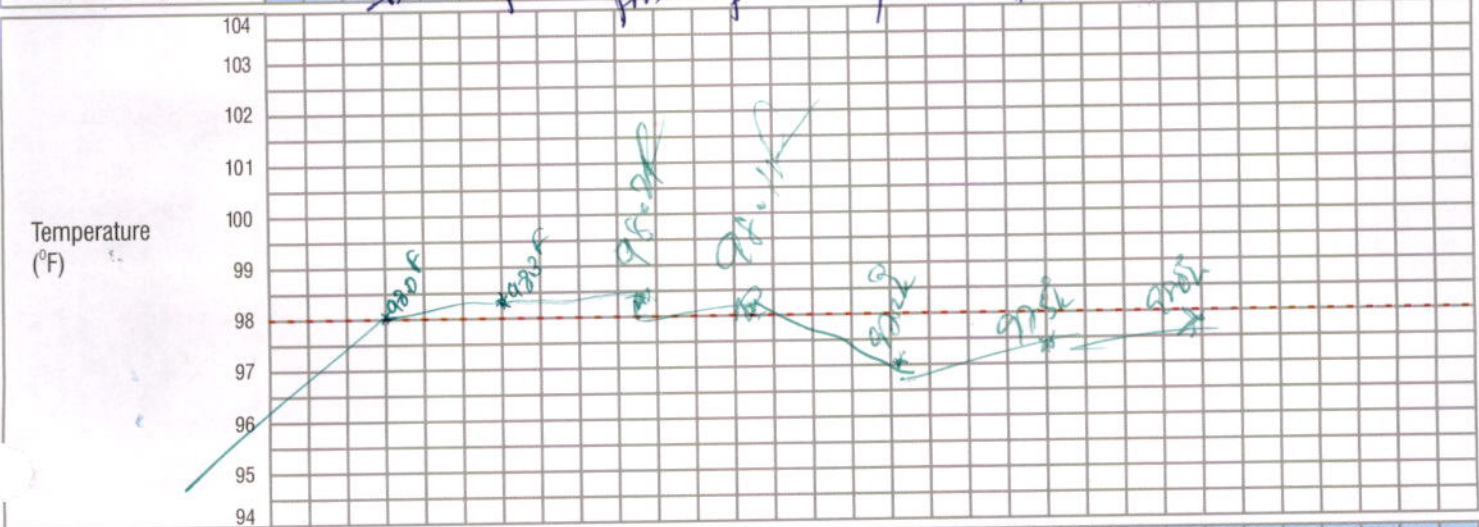
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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B	BACK GROUND: Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
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EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 22/6/26 Time: 10 2 5 7 11 3 7
 Doctor/Nurse/Family Concern? pm pm pm pm pm Am Am



Note:
 BP does not score in early warning scoring



Heart Rate (Number)	140	150	145	142	135	140	137
Resp Rate (Number)	39	40	42	45	40	36	35
Resp Mod/ Severe Distress None / Mild							
Receiving O ₂ (l/min)							
O ₂ Saturations (%)	99	99	99	99	98	98	98
Conscious Level Normal / Altered	OK	OK	OK	OK	OK	OK	OK
GCS *	15	15	15	15	15	15	15
TOTAL SCORE	0	0	0	0	0	0	0
Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	PT	PT	PT	PT	PT	PT	PT

ACTIONS

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- 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

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

VIH-00206078 IP-00080419
 Baby BIO HAJERA TARANNUM (M)
 20-06-2028 0 Y 0 M 2 D
 Dr. ATLURI KUNDANA PRIYA



CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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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	
			Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
20/6	08:00 am												
	09:00 am												
	10:00 am	DBF											
	11:00 am									✓	0	} 20/6/26 @ 2PM	
	12:00 pm	DBF								✓	0		
	01:00 pm									✓	0		
Total Intake :						Total Output :						Passed	
20/6	02:00 pm	DBF									0	} 20/6/26 @ 8PM	
	03:00 pm									✓	0		
	04:00 pm	DBF								✓	0		
	05:00 pm	DBF									0		
	06:00 pm									✓	0		
	07:00 pm	DBF									0		
Total Intake : DBF						Total Output :						Passed	
21/6	08:00 pm	DBF									0	} 21/6/26 @ 12.30 AM	
	09:00 pm										0		
	10:00 pm	DBF									0		
	11:00 pm										0		
	12:00 am	DBF								✓	0		
	01:00 am										0		
Total Intake :						Total Output :							
21/6/26	02:00 am										0	} 21/6/26 @ 8AM	
	03:00 am	DBF									0		
	04:00 am									✓	0		
	05:00 am	DBF								✓	0		
	06:00 am									✓	0		
	07:00 am	DBF									0		
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

VIH-00206078 IP-00060419
 Baby B/O HAJERA TARANNUM
 20-06-2026 010 M O D 15 H (M)
 Dr. ATLURI KUNDANA PRIYA

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
21/6/24	08:00 am											Rosa 21/6/24 @2	
	09:00 am	DBF+FF					✓			✓			
	10:00 am												
	11:00 am												
	12:00 pm	DBF+FF											
	01:00 pm												
Total Intake :						Total Output :							
21/6/24	02:00 pm	DBF+FF					✓			✓		Vaishali 21/6/24 @8pm	
	03:00 pm												
	04:00 pm	DBF+FF								✓			
	05:00 pm												
	06:00 pm	DBF+FF					✓						
	07:00 pm												
Total Intake :						Total Output :							
21/6	08:00 pm											Somya 22/6/24 @noon	
	09:00 pm	DBF+FF											
	10:00 pm						✓			✓	4		
	11:00 pm	DBF+FF											
	12:00 am												
	01:00 am	DBF+FF											
Total Intake :						Total Output :							
22/6	02:00 am						✓					Somya 22/6/24 @8am	
	03:00 am	DBF+FF											
	04:00 am												
	05:00 am	DBF+FF											
	06:00 am						✓			✓			
	07:00 am	DBF+FF											
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

VIH-00206078 IP-00060419
 Baby B/O HAJERA TARANNUM
 20-06-2026 0 Y 0 M 0 D 16 H (M)
 Dr. ATLURI KUNDANA PRIYA



FLUID CHART

Sheet No. : 3

22/6/26

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			
22/6	08:00 am												
	09:00 am	DBB +FF								✓			Pedmg 22/6/26 @ 2pm Santha. 22/6/26 @ 8pm
	10:00 am												
	11:00 am												
	12:00 pm	DBB +FF								✓			
	01:00 pm												
Total Intake :						Total Output :							
22/6	02:00 pm												Santha. 22/6/26 @ 8pm
	03:00 pm	DBB +FF								✓			
	04:00 pm												
	05:00 pm	DBB +FF								✓			
	06:00 pm												
	07:00 pm	DBB +FF								✓			
Total Intake :						Total Output :							
22/6	08:00 pm												Santha. 22/6/26 @ 12pm
	09:00 pm	DBB +FF											
	10:00 pm												
	11:00 pm	DBB +FF											
	12:00 am	DBB +FF								✓			
	01:00 am	DBB +FF											
Total Intake :						Total Output :							
23/6	02:00 am												Santha. 23/6/26 @ 8am
	03:00 am	DBB +FF											
	04:00 am												
	05:00 am	DBB +FF								✓			
	06:00 am	DBB +FF											
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

VIH-00206078 IP-00060419
 Baby B/O HAJERA TARANNUM
 20-06-2026 0 Y 0 M 2 D (M)
 Dr. ATLURI KUNDANA PRIYA



FLUID CHART

Sheet No. :

1. All measurements in ml.
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Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
<i>20/6/26</i>	08:00 am											
	09:00 am		<i>DBF 100</i>									
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :					Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output :							
Total 24 hrs. Intake					Total 24 hrs. Output							

