

ACTIVE | VIH-00205637 IP-00060237
Baby B/O SONALI BANERJEE
05-06-2026 0 Y 0 M 3 D (M)
Name: Dr. SURENDER RAO DUSA

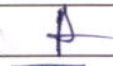

G

UHID N:  Consultant: _____ Dept: _____


Date of Admission: 5/6/26 Time: 9:24am Date of Discharge: _____ Time: _____

Room / Bed No: 226-1 Ward: MICU Suggested Billable bed type: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/6/26	3 PM	MICU	Room (102)	
9/6/26	3:5pm	NICU	1st floor 102	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. MD Khalid	8/6	3082999	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

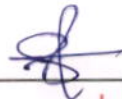

INVESTIGATIONS

Date	Investigations	Order No.	Sign
5/6/26	USG Abdomen Scan - (+)	R26-009034	[Signature]
5/6/26	Blood grouping	V126019389	[Signature]
	Cross checked	by U. Shanini	5/6/26 at 1:30 pm
08/06/26	TCB	26019569	Ggp
	SBR, NRS Advanced	26019640	Ggp
	Cross checked by	Ggp	08/06/26 @ 11:40 AM
09/06/26	CBP, CRP, WBC WBC, creatinine, SBR, S/E	26019766	
	RBS Calcium		
	RBS	26019767	
	Cross checked by	Pajeshwari	9/6/26 @ 11 AM
10/6	RBS - 84 mg/dl	26019861	[Signature]
10/6/26	TCB - 8.4 ug/dl	26019880	[Signature]
	Cross checked by	Coalpane	10/6 @ 10:40 AM



Patient No: **VIH-00205637** **IP-00060237**
Baby B/O SONALI BANERJEE
05-06-2026 0 Y 0 M 3 D (M)
 Registrati: **Dr. SURENDER RAO DUSA**


NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
09/06/26	00.00	RBS - 84 mg/dl		26019767
	1.00	ACROSS checked by Sujeshu - 9/6/26 @ 11AM		
10/6/26	2.00	GRBS at 6AM - 84 mg/dl		26019880
	3.00			
	4.00			
	5.00			
	6.00			
	7.00			
	8.00			
	9.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

Name	Baby B/O SONALI BANERJEE	UHID	VIH-00205637
Father/Guardian	Mr VANSHUJ	Age/Gender	0 Y 0 M 2 D/Male
Address	302,GAYATHRI RESIDENCY 55 ISHAQ COLONY PICKET, Secunderabad, Hyderabad, Telangana, INDIA, 500003		
IP No	IP-00060237	Admission Date	05-06-2026
Ref Doctor	DR.BHAVANA K	Discharge Date	10-06-2026

DISCHARGE SUMMARY

Consultant: Dr. SURENDER RAO DUSA

MD (Pediatrics), Fellowship in Neonatology
SENIOR CONSULTANT PEDIATRICS

Diagnosis: Term/Appropriate for gestational age/Baby Boy
Neonatal Hyperbilirubinemia
Hypernatremic Dehydration

Mode of Delivery: Elective Lower Segment Cesarean Section (Indication: Floating Head)

Anthropometry:

Weight at birth : 3.61 kg
Weight at discharge : 3.45 kg
Head circumference : 35 cms
Length : 48 cms

History: Baby of SONALI BANERJEE is a term (38+5 weeks) baby boy, delivered to a Primigravida mother by Elective Lower Segment Cesarean Section (Indication: Floating head) on 05.06.2026 at 08:17 am with birth weight of 3.618 kgs in Rainbow Children's Hospital, Karkhana. 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.

Maternal History: Mrs. SONALI BANERJEE is a 32 years old Primigravida mother.

G1 - Present pregnancy, OI conception, had regular ANC's. Antenatal scans (TIFFA) showed echogenic bowel. History of GDM at 23+1 weeks, on diet and Metformin 500 mg. No history of Pregnancy-Induced Hypertension / Urinary Tract Infection / Antepartum Hemorrhage / Oligohydramnios / Polyhydramnios / Fever. Mother's blood group is "B" Positive. Baby's blood group is "B" Positive.

Examination: Baby was euthermic, euvolemic and was maintaining saturations at room air. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Bilateral femoral pulses well felt. Abdomen was soft with no organomegaly. Cry and activity were good. AF was at level.

Management: Course during hospital: Neonatal Hyperbilirubinemia: Transcutaneous bilirubin done at 48 hours of life on 07.06.2026 was 12.6 mg/dl, for which double surface phototherapy was started. Repeat serum bilirubin before discharge was 8.0 mg/dl with indirect fraction of 7.9 mg/dl, it does not come under phototherapy range, hence phototherapy was stopped.

In view of echogenic bowel, ultrasound abdomen done which was normal.

Hypernatremic dehydration: On day-3 of life baby had significant weight loss 11% for which serum electrolytes done showed serum sodium 154 mmol/L, serum potassium 4.7 mmol/L and serum calcium was 117 mmol/L, for which baby was shifted to NICU. During the NICU stay, baby was started on IV fluids and continued on oral demand feeds. Hb 18.6 gm%, WBC count of 10,210 cells/cumm, platelet count of 2.76 lakhs/cumm and CRP 10 mg/l. Serum sodium 144 mmol/L, Serum potassium 4.9 mmol/L and Serum calcium was 108 mmol/L. Serum calcium 10.2.

Name

Baby B/O SONALI BANERJEE



As baby is taking and tolerating feeds well and gaining weight and there were no signs of dehydration, baby was shifted back to ward for further management. Transcutaneous bilirubin done before discharge (on 10.06.2026) was 8.4 mg/dl, which does not comes under phototherapy range.

Vaccination: Baby was given following vaccination:

BCG / OPV / Hepatitis-B on : 06.06.2026

Hearing test (TEOAE): Done on 07.06.2026 was normal.

Newborn screening (Advanced): Done on 08.06.2026 - report awaited.

Saturation: Right upper limb and left lower limb 100% at room air.

Red Reflex: Present and Symmetrical.

Feeding: Breast feeding was initiated and baby tolerated the feeds well. In view of weight loss, baby was started on measured feeds.

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

Advice:

1. Keep the baby clean and warm.
2. Continue demand breastfeeding + top up formula feed as advised.
3. Burping after each feed.
4. Immunization as per schedule.
5. Vitamin-D3 drops (1ml=800IU) 0.5ml once daily till one year of age.
6. Nasoclear nasal drops, 1 drop in each nostril (if needed) for nose block.
7. Trace New Born Screening (Advanced) report.
8. "Appointment for vaccinations to be taken during the 1st hour of the OPD slots of your respective consultant to avoid rush and minimum waiting period".

Name	Baby B/O SONALI BANERJEE	UHID	VIH-00205637
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9. Kindly consult Dr. Surender Rao Dusa, Senior Consultant Pediatrics, on 12.06.2026 (Friday) in OPD with prior appointment (This consultation will be charged).
10. Kindly consult Ms. Ramya Ashwin, Lactation Consultant, within 3 days of discharge or in any kind of feeding difficulty, in OPD with prior appointment (This consultation will be charged).

Review back to hospital:

1. If baby is not feeding continuously for > 6 hours.
2. If breathing fast.
3. High grade fever.
4. Poor activity or lethargy.
5. Bluish discoloration of lips.
6. Increase in jaundice.
7. Abnormal movements.

In case of emergency contact 040-42462200 Extn: 2010 (or) 7337357870.

To take appointment for OPD consultation at Rainbow Children's Hospital, just dial one number 1800-2122 (between 8 a.m. to 8 p.m.) (or) log on to www.rainbowhospitals.in

Now booking appointments is much easy, download Rainbow Application for Free from Google play store.

The discharge advice and details on how to obtain emergency care has been explained to me in the language that I understand.

Name

Baby B/O SONALI BANERJEE



Name :

Signature :

Relationship with patient :

This summary has been explained by :

Summary prepared by : Dr. B. Prashanthi
DEO : MD Younus Pasha

Registrar/Resident/C.M.O

Dr. SURENDER RAO DUSA

MD (Pediatrics), Fellowship in Neonatology
SENIOR CONSULTANT PEDIATRICS
47776

Rainbow Children's Hospital - Secunderabad

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009. 040-42462200, Ext 2000,2001,2002,



INSURANCE COPY



PatientName : Baby B/O SONALI BANERJEE Inpatient No. : IP-00060237
 Age/Gender : 0 Y 0 M 0 D 3 H/ Male Admit Date : 05-06-2026
 Ward/Bed : N 2F-MICU/ CRDL-MICU-226-1 Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
BLOOD GROUPING (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :05-06-2026 09:28
BLOOD GROUP	B		
RH (D) TYPE	POSITIVE		

NOTE :- BLOOD GROUPING TO BE REPEATED AFTER FOUR MONTHS.

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TRANSCUATEOUS BILIRUBIN			TEST RESULT STATUS : REPORT AUTHORISED Order Date :07-06-2026 07:17
TRANSUTANEOUS BILIRUBIN	12.6	mg/dl	

Mrs MARY ELIZABETH

Investigation	Result	Unit	Biological Reference Interval
BILIRUBIN (INDIRECT / DIRECT) (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :08-06-2026 09:18
TOTAL BILIRUBIN (Azobilirubin)	8.0	mg/dl	<11.7
CONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl	<0.6
UNCONJUGATED BILIRUBIN (Spectrophotometric)	7.9	mg/dl	0.6 - 10.5

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356



MC-7373

PatientName :	Baby B/O SONALI BANERJEE	Inpatient No. :	IP-00060237
Age/Gender :	0 Y 0 M 4 D/ Male	Admit Date :	05-06-2026
Ward/Bed :	N 2F-MICU/ CRDL-MICU-226-1	Discharge Date :	

Investigation	Result	Unit	Biological Reference Interval
NEONATAL SCREENING ADVANCED (Specimen : BLOOD SPOT)		TEST RESULT STATUS : REPORT AUTHORISED Order Date :08-06-2026 09:18	
BIOCHEMICAL PARAMETERS			
THYROID STIMULATING HORMONE (Eclia)	2.4	uU/ml	<10
17 OHP (17 HYDROXY PROGESTERONE) (Enzyme assay)	2.4	ng/ml	<30
G6PD (GLUCOSE 6 PHOSPHATE DEHYDROGENASE) (Enzyme assay)	5.7	U/ghb	>2
TOTAL GALACTOSE (Fluorometric)	1.37	mg/dl	<15
BIOTINIDASE (Fluorometric)	193.6	U	>50
PHENYLALANINE NEONATAL IRT	0.64	mg/dl	<2.5
	19.8	ng/ml	<70

Rashida

Dr. RASHIDA MAHREEN, MBBS,MD
CONSULTANT BIOCHEMIST, Reg No : HMC13081

PatientName : Baby B/O SONALI BANERJEE
Age/Gender : 0 Y 0 M 3 D/ Male
Ward/Bed : N 2F-MICU/ CRDL-MICU-226-1

Inpatient No. : IP-00060237
Admit Date : 05-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
ELECTROLYTES (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED Order Date :08-06-2026 12:47	
SODIUM (Direct ISE)	154	mmol/L	H 133 - 146
POTASSIUM (Direct ISE)	4.7	mmol/L	3.2 - 6
CHLORIDE (Direct ISE)	117	mmol/L	H 96 - 110

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)		TEST RESULT STATUS : REPORT ENTERED Order Date :08-06-2026 15:22	
RANDOM BLOOD GLUCOSE (GOD/POD)	77	mg/dl	70 - 140

Investigation	Result	Unit	Biological Reference Interval
BILIRUBIN (INDIRECT / DIRECT) (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED Order Date :09-06-2026 05:34	
TOTAL BILIRUBIN (Azobilirubin)	8.5	mg/dl	<11.7
CONJUGATED BILIRUBIN (Spectrophotometric)	0.2	mg/dl	<0.6
UNCONJUGATED BILIRUBIN (Spectrophotometric)	8.3	mg/dl	0.6 - 10.5

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
CALCIUM (Specimen : SERUM)		TEST RESULT STATUS : REPORT AUTHORISED Order Date :09-06-2026 05:34	
CALCIUM (Arsenazo dye)	10.2	mg/dl	7.3 - 11.7

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
COMPLETE BLOOD PICTURE (Specimen : BLOOD)		TEST RESULT STATUS : REPORT AUTHORISED Order Date :09-06-2026 05:34	

PatientName : Baby B/O SONALI BANERJEE
Age/Gender : 0 Y 0 M 4 D/ Male
Ward/Bed : N 2F-MICU/ CRDL-MICU-226-1
Inpatient No. : IP-00060237
Admit Date : 05-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
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Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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ELECTROLYTES (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :09-06-2026 05:34

SODIUM (Direct ISE)	144	mmol/L	133 - 146
POTASSIUM (Direct ISE)	4.9	mmol/L	3.2 - 6
CHLORIDE (Direct ISE)	108	mmol/L	96 - 110



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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UREA (Specimen : SERUM)

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :09-06-2026 05:34

UREA (Kinetic, Urease)	23.7	mg/dl	9 - 26
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Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
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RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)

TEST RESULT STATUS : REPORT ENTERED

Order Date :09-06-2026 05:35

RANDOM BLOOD GLUCOSE (GOD/POD)	84	mg/dl	70 - 140
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RANDOM BLOOD GLUCOSE(POCT) (Specimen : PLASMA)

TEST RESULT STATUS : REPORT ENTERED

Order Date :10-06-2026 06:59

RANDOM BLOOD GLUCOSE (GOD/POD)	84	mg/dl	70 - 140
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Investigation	Result	Unit	Biological Reference Interval
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TRANSCUATEOUS BILIRUBIN

TEST RESULT STATUS : REPORT AUTHORISED

Order Date :10-06-2026 11:21

TRANSUTANEOUS BILIRUBIN	8.4	mg/dl	
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Mrs MARY ELIZABETH

Baby B/O SONALI BANERJEE

9673291796

0 Y 0 M 0 D 5 H

R26-009034

Male

05-06-2026 01:23 PM

IP-00060237

05-06-2026 03:05 PM

VIH-00205637

AKHEEL SYED RIZWAN

DRAFT

ULTRASOUND ABDOMEN

LIVER : Normal in size 5.9 cm and echotexture. No intra hepatic biliary duct dilatation. Portal vein is normal. No focal lesions.

GALL BLADDER : Distended well and appears normal. No evidence of calculi or wall thickening. Common bile duct appears normal.

SPLEEN : Normal in size 4.3 cm and echotexture, No obvious focal lesions.

PANCREAS : Normal in size and echotexture. MPD not dilated. No calcification noted.

KIDNEYS :

Right kidney : 39 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : 38 mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended well and appears normal.

No ascites / lymphadenopathy. No evidence bowel wall thickening /edema.

Impression

No obvious sonological abnormality in abdomen.

Suggested clinical correlation.

DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

VIH-00205637 IP-00060237
 Baby B/O SONALI BANERJEE
 05-06-2026 0 Y 0 M 5 D (M)
 Dr. SURENDER RAO DUSA



Patient Name

IP.No:

Ward:

DOA:



Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	1	—	—	
2	Discharge Summary	3	—	—	
3	Nursing Initial assessment form	2	—	—	
4	Patient Transfer Forms	3	—	—	
5	In-patient Medical Record	4	—	—	
6	Doctors Progress Sheets	6	—	—	
7	Nurses Progress notes	6	—	—	
8	Consultation Sheets				
9	General Consent for Treatment	1	—	—	
10	Consent for Surgery				
	Consent for Blood Transfusion				
12	Consent for Chemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure				
17	Consent for Radiological Investigations				
18	Consent for HIV Test				
19	Anaesthesia consent form				
20	Anaesthesia notes (Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	8	—	—	
26	Intake and Output chart (fluid Chart)	9	—	—	
	Drug Chart (Regular prescription)	3	—	—	
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	1	—	—	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart				
33	MLC form (in case of MLC)				
34	Patient Education Form				
	Humpty - dumpty	4	—	—	
	Thromboprophylaxis	1	—	—	
	Pain Assessment	1	—	—	
	Others	10	—	—	
	Total No. of Pages	63			

Noted by
Beevrike
10/6/26
@ 12pm

Signature and Date :

ERROR LOG

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

VIH-00205637 IP-00060237
 Baby B/O SONALI BANERJEE
 05-06-2026 0 Y 0 M 0 D 13 H (M)
 Dr. AKHEEL SYED RIZWAN

NEW BORN DETAILS



B/O Sonali Banerjee

DOB: 05/06/26

Sex: male

Maternal Blood Group: B⁺

Time: 8:17 AM

Birth Weight: 3.61kg

Baby Blood Group: B⁺

SVD / LSCS: _____

Indication: _____

Diagnosis: single term / 38⁺ wks / BW-3.61kg / AGA / EL-LSES

Any Maternal Complications: _____

Spo2 Pre ductal Right Upper Limb: 99%

Inference : if the value <92 or difference between preductal and post ductal is >3 eslate the situation

Spo2 Post ductal Left Lower Limb: 99%

Any Specific Remarks: _____ Thyroid Screening: _____ : NBS: _____

Hearing Test (OAE): _____ Red Reflex: _____

Head Circumference: 35 cms Length: 48 cms

Vaccination: opv, BCG, Hep-B vaccine given on 6/6/26 @ 8:55 AM

Date	Day of life	Weight	Weight Loss (> 10% Escalate)	Urine	Stool	DBM/FF	TCB/SBR
6/6/26	1	3.44 ↓	(0.170gms) (4.9%)	✓	✓	DBM	-
			(170gms)				7:30 AM TCB-12.6
			(4.9%)				
7/6/26	2	3.35kgs	(7.2%)	✓	✓	DBM	7:20 AM TCB-12.6 mg/dl
8/6/26	3	3.20kgs	(11.3%)	✓	✓	DBM	
10/6/26	5	3.450kgs		✓	✓	GBM+FF	11:25 AM TCB-8.4 mg/dl

ADMISSION SHEET



Registration Details :

Admission No : IP-00060237

Admit Date : 05-Jun-2026

Admit Time : 09:24 AM UHID : VIH-00205637

Patient Details :

Patient Name : Baby B/O SONALI BANERJEE

Age : 0 D

Guardian : Mr VANSHUJ

DOB : 05-06-2026 08:17 AM

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : 302,GAYATHRI RESIDENCY 55 ISHAQ COLONY
PICKET Secunderabad Hyderabad Telangana
INDIA 500003

Phone No : 9673291796/ 9673292538

E-mail : na123@rainbowhospitals.in

Admission Details :

Bed Type : BASINET

Bed No : CRDL-MICU-226-1

Ward Name : N 2F-MICU

Room No : CRDL-MICU-226-1

Admission Type : First Visit

Contact Details :

Name : Mr VANSHUJ

Relationship : Father

Contact Address : 302,GAYATHRI RESIDENCY 55 ISHAQ
COLONY PICKET Secunderabad Hyderabad
Telangana INDIA 500003

Phone No : 9673291796


Signature

Doctor Details :

Doctor Name : Dr. AKHEEL SYED RIZWAN

Specialisation : NEONATOLOGY

Referral Doctor : DR.BHAVANA K

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Bhasonali Banerjee Mother's Name: Sonali Banerjee
Date of Birth: 5/6/26 Time of Birth: 8:17:03 am Gender: Male Female
Birth Weight: 3.618 Kgs HC: 36 cm Length: 47 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: 9:30 Am

VIH-00060052 IP-00060234
Mrs SONALI BANERJEE
11-01-1994 32 Y 4 M 25 D (F)
Dr. BHAVANA K

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

Physical Assessment of New Born:

Temp: 36.4 °C HR: 150 /Min RR: 65 /Min BP: _____ SpO₂: 95%

Pain Score: 16 (Follow N Pass)

Fall Risk Assessment: Yes No Score: 15 (Fill the Humpty Dumpty Sheet)

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

Behaviour Status on admission: Sleeping Crying Calm Drowsy

Findings:

General Appearance: Posture: Well-Flexed Asymmetry

Skin: Pink Meconium Stain Others, Specify: _____

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

Vitamin K 1 mg I.M Administered: Yes / No

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

All information obtained from Mother Father Other Family Member

Newborn Screening Discussed: Yes / No

Nurse Name: prathyusha

Signature: _____

Date & Time: 5/6/26 @ 11 am

PATIENT TRANSFER FORM

VIH-00205637 IP-00060237
Baby B/O SONALI BANERJEE
05-06-2026 0 Y 0 M 0 D 4 H (M)
Dr. AKHEEL SYED RIZWAN



	Date & Time of Admission 5/6/26 @ 9:24 AM	Date & Time of Transfer Order 5/6/26 @ 3 PM
Treating Consultant Name	Transfer Ordered by Dr. Barsha	Reason for Transfer For observation
From Unit MICU	To Unit Room (102)	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File - 15 -	Number of Imaging Films US-G Abdomen film	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.	Small Koochi's - (1)	
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Dr. Barsha

Name & Signature of Person who is Transferring Dr. Pradyumn	Name of Person Ordered Transfer Dr. Barsha
--	---

Patient & Clinical Records Received by :

Akanksha

Date & Time of Patient Received : 5/06/2026 @ 3:45 PM.



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


PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00205637 IP-00060237 Baby B/O SONALI BANERJEE 05-06-2026 0 Y 0 M 3 D (M) Dr. SURENDER RAO DUSA 		Date & Time of Admission 9/6/26 @ 9:24am	Date & Time of Transfer Order 9/6/26 @ 3:55pm
		Transfer Ordered by Dr. Surender	Reason for Transfer Stable
From Unit NICU	To Unit 103	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 47	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.	Aptamil Gold	1	
2.	Kooches	2	
3.	wet wipes	1	
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sherly		Name of Person Ordered Transfer	
Patient & Clinical Records Received by :  Dr. Bevonika			
Date & Time of Patient Received : 9/6/26 @ 3:20 pm			

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

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00205637 IP-00060237 Baby B/O SONALI BANERJEE 05-06-2026 0 Y 0 M 2 D (M) Dr. AKHEEL SYED RIZWAN 		Date & Time of Admission 5/6/26 @ 9:24AM	Date & Time of Transfer Order 8/6/26 @ 8:55PM
		Transfer Ordered by Dr. Shivam	Reason for Transfer Sick
From Unit 1st Floor (102)	To Unit NICU	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 31	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.	Aptamil - ①		
2.	Feeding bottle - ①		
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis. Sushila		Name of Person Ordered Transfer Dr. Shivam	
Patient & Clinical Records Received by : Sr. Khawar 8/6/26 Begun.			
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



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : SONALI BANERJEE Age : 32y Father's Name : Age :
 Date of Birth : Date of Admission : UHID No. :
 NICU Consultant : Dr. Akheel Bhowan Referring Consultant : Dr. Shavana K.
 Transferring Unit : OT Labour Room ER Ward
 Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : Sho Sonali Banerjee Mother's Blood Group : B positive
 Gender : M F Blood Group : Birth Weight (gms) : 3.618 Length (cms) :
 Date of Birth : 5/6/26 Time of Birth : 8:17:03 AM OFC (cms) :
 Place of Birth : V. KCH Estimated Gesth Age : 38⁺ wks.

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 32y Ht : Wt : BMI : Married Life : 7-5yrs LMP : 6/9/25 EDD : 12/6/26
 Conception : Spontaneous or with Rx : OT
 Booked at what GA : 16⁺ wks. AN Steroids Drugs / Doses :
 Last Scans Details : (20/5/26) - surf, 26⁺ wks, cephalic, pt. Ant. High, AFI - 11.3 cm, AC - 837.
ERW - 3252g, Dop (N) TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

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

H/o GDM/ pre GDM/ on diet or insulin GDM.
 Controlled or not, recent values, HbA1 values :
28⁺ wks on diet & metformin 500
 Compliance with Rx :
 Scans : LGA, TIFFA, Fetal Echo : FTS - low nsh
NT - 1.6 mm.
 H/o Hypothyroidism : when diagnosed ? Medication?
 Any other Chronic Medical Problems, when detected drugs ?
 (Anemia, SLE, Jaundice, CHD, Heart Disease)
 Infection : H/O, Fever
 (Malaria UTI TORCH TB HIV HBV)
 UTI : when : Any culture :

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



PAST OBSTETRIC HISTORY

P: A: L:

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
	<i>Primi</i>					

PERINATAL HISTORY

Treating Obstetrician : *Dr. Khawana* Hospital : *V-RCU* 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 checked="" type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</p> <p>Specify the reason : <i>Placental mald.</i></p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL : <i>(-)</i></p> <p>Resuscitaion : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cord ABG :</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :</p>
--	---

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : 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	<i>8/10</i>	<i>9/10</i>	

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 :



0 e (Term 38⁺5 wks | BW - 3.6 kg | A&A | Ep. USG)

only CAB

↓
DCC done

↓
shifted to warmer

↓
2 min - spo₂ - 96%
HR - 140/m.

↓
cord clamped & cut
dry nit u - (my in seal)

↓
5 min -
spo₂ - 93%
HR - 150/m

Investigation details in previous Hospital :

↓
shift to mother side

2f

Feeding History :

Past History :

Family History :

Socio Economic History :



GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.4°C HR : 150/m RR : 55/m NIBP : CFT : Clear

Color of the extremities : Acrocyanosis

Jaundice : ⊖ Pallor : ⊖ SpO2 : 95% JKA

Anthropometry : Birth Weight : 3618 g Length : HC : Present Weight :

Ponderal Index : AGA : ✓ SGA : LGA :

HEAD TO TOE EXAMINATION

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

Facies :
 (Any Facial Dysmorphism) no dysmorphism

NECK and CLAVICLES :
 Range of Motion : Ⓝ
 Asymmetry : ⊖
 Masses : ⊖

EYES :
 Symmetry : Ⓝ
 Red Reflex :
 Discharge : ⊖

EARS, NOSE MOUTH and THROAT :
 Ear set / Shape : Ⓝ
 Periauricular Pits / Tags : ⊖
 Nasal shape / Patency : patent
 Palate : no cleft
 Gums :
 Lips : Ⓝ
 Tongue :



THORAX and BREASTS : Shape of thorax : \textcircled{N}
 Position of Nipples and Number : 2 in no, normal position

ABDOMEN and UMBILICUS : Shape : \textcircled{N}
 Organomegaly : \ominus
 Bowel Sounds : \oplus
 Umbilical Stump : 2A+1V
 Discharge : \ominus

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

HERNIAL ORIFICES free

TRUNK and SPINE : \textcircled{N}

SKIN LESIONS : \ominus

EXTREMITIES : Fingers / Toes :
 Deformities : \textcircled{N}
 Hip Joint Examination :
 Arms / Legs :
 Mobility :

SYSTEMIC EXAMINATION

Respiratory System :
 Breathing Pattern : Regular Periodic Shallow Gasping
 Mention If baby has Respiratory distress : RR : 65/m 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 : 95% Auscultation : RAE \oplus Breath Sounds : Added Sounds :

Cardiovascular System :
 HR : BP :
 Femoral Pulses : 2 free
 Other Peripheral Pulses :
 Precordial Activity : \textcircled{N}
 Murmurs : \ominus
 Signs of Cardiac Failure : \ominus

Abdomen :
 Shape : \textcircled{N}
 Palpation : soft
 Palpable masses : \ominus
 Abdominal girth : \textcircled{N}
 Hernia orifice : free
 Anal Patency : \oplus
 Umbilical Cord : 2A+1V
 First urine passed :
 Meconium passed :



Nervous System : Higher intellectual functions (Sensorium) :
State of wakefulness :
Prechtl Score :

Nerves :

Motor System :

Passive Tone : *ACA*

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : *complete & symmetrical* DTR :

ATNR : Skull and Spine :

Any Congenital Anomalies : *none*

Diagnosis : *Single | Lump 3618 g | ACA | boy | EMB*

FOOT PRINTS

Left Side :



Right Side :



*Taken by
SO-Ruby-P
5/6/26*

Resident Doctor :

Signature : *[Signature]*

Name : *Darshan*

Date & Time : *5/6/26*

Consultant :

Signature :

Name :

Date & Time :

Patient Sticker

VIH-00205637
Baby B/O SONALI BANERJEE
05-06-2026 0 Y 0 M 3 D
Dr. SURENDER RAO DUSA (M)

DISCHARGE PLAN

- 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 :

Immunise as per schedule

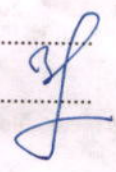
DRF of all for temping

warm care, cold care.

OAE, SMA, NRS before discharge.

usu abdomen. (11/10 urgentive bowel on TFFA)

Noted by
Ruby P
st/16



Screenings done during NICU Stay :

- NSG :
- Hearing Screen :
- ROP :
- TFT :
- NP2 :

Discharge Details:

Neonatal Condition at Discharge:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....



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:
.....
.....
.....
.....
.....
.....
.....
.....

Doctor Signature:

Doctor Name:

Date & Time:

VIH-00205637 IP-00060237
 Baby B/O SONALI BANERJEE
 05-06-2026 0Y0M0D7H (M)
 Dr. AKHEEL SYED RIZWAN



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>6/6/26 9:30 AM</p>	<p>Term (38+5 wks) Bwt: 3.618 kg AUA SL-MS. IODM. <u>Prima</u></p>	
	<p>Hol: 2 hrs.</p>	
	<p><u>0/E</u></p>	
<p>TW: 3.44 kg (+ 120 gm) (4-7%)</p>	<p>Child Alert & Active vitals stable CU: <u>NI</u> ⊕ N: <u>BLAC</u> ⊕ P/A: <u>COIT</u> CN: <u>NAD</u>.</p>	<p><u>Plan</u> - PBt + Hb bumping endhely</p>
<p>MBG - Bire</p>		
<p>BBG - Bire.</p>		
		<p>- Warmth & Circulation</p>
<p>Vaccination done</p>		<p>- OAG - today</p>
		<p>- NBS, TCB - 1/10. @ 8:00 AM.</p>
<p>MBG - Bire</p>		<p>- USG Abd - 1/10 ↓ echogenic bowel.</p>
		<p><u>SLU on Wednesday.</u></p>
<p>Noted by</p>		<p>- Lactation Consultation.</p>
<p>Beeonika</p>		
<p>6/6/26</p>		
<p>2pm</p>		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26	<p><u>lactation notes (Mrs. Banerjee)</u></p> <ul style="list-style-type: none"> • 1st time mother • Normal breast condition • Beautifully feeding the baby. • Baby latching & sucking well • Advised to feed every 2hrs • Move skin to skin • To track the feeding in the sheet <p>12:50pm</p>	<p>→ To try football hold position next feed</p>
	<p><u>C/S/B Resident</u></p>	
6/6/26		
4:00pm	<p><u>O/S</u></p> <p>Vital stable</p> <p>CTA - Good</p> <p>CEP - 3mc</p> <p>CV - 1.12A</p> <p>RU: B/CAGE</p> <p>PLA: top</p> <p>ENI: VAT.</p>	<p style="text-align: center;"><u>Plan</u></p> <p>→ D/B flb burping</p> <p style="padding-left: 150px;">2nd time</p> <p>→ Warm the breast</p> <p>→ OAT T/m</p> <p>→ HBS, TCB</p> <p style="text-align: right;">T/m @ 8:30am.</p>

Emmucation
 Increased.

A. pradh

Noted by
 Beenukha
 6/6 @ 8pm

→ O/C T/m
 → Flu on wed.
 → us onhd i/vc
 → us on bladder



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/26 9:30 AM	c/s/B Resident Term (38+5wks) / Bot: 3.618 kgs / AUA / 2LWU. IODM / prini	
TCB @ 48 hrs ↓ 12:6	O/E Vital stable CTA - Good CPT = 3 sec	
Tot: 3.350 kgs. (7.2%)	CV: CIC (A) M: BLA (A) PIA: 60A	Plan - DBF Hb burp in 2nd heel
MB4 } B+ve B134 }	CNS: NAT	- Warmth cord cell - OAE - Today
		- NIBS, IPR J/m (@ 9:00 AM)
Dr. prakash		- start DSPT
		Noted by Bevika 7/6/26 @ 2pm

MH-00205637 IP-00060237
 Baby Bio SONALI BANERJEE
 05-06-2026 0 Y 0 M 0 D 13 H (M)
 Dr. AKHEEL SYED RIZWAN

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>7/6/26</u> <u>4:30pm</u>	<u>CLB Resident</u>	
	Term (38+5wks) Bwt 3.6kg AUA 2-150 Ibm 1 pmi.	
	NNTB on DSP	
	<u>OK</u> chud Alert & Awake vitals stable	
<u>Dr. Prabhu</u>	CX RI P/A dia	<u>Plan</u> - continue DSP
	NAD	- SPT, NBS 7m @ 9:00am
		- Plan for d/c after the reports.
		- DBT to be kepting 2nd half
		- Inform (to)
		Noded by <u>Shrey</u>

PROGRESS NOTES AND DOCTOR'S ORDER


Date & Time	Progress Notes	Doctor's Order
<p>8/6/26 <u>11:00 AM</u></p>	<p><u>C/S/B Resident</u></p>	
	<p>Term 38+5 wks Bwt: 3.6 kgs AuA si-ura 100m primi.</p>	
	<p>MNH3 on DSP 0/2</p>	
	<p>SBR @ 9:00 pm ↓ 8-1 mld</p>	
	<p>Child Alert & Active vitz table</p>	
<p>Twt: 3-2 kgs (11-3%) w/low.</p>	<p>CU } M } PLA } MAD. CU }</p>	<p><u>Plan</u> - Plan for d/c today - Flu on Tuesday. - Recheck the wt. - DRP s/s burp seen → Start Formula feed. - want and care [Repeats electrolytes in same sample] - monitor sample - Rpt (am)</p>

~~Dr. Pratik~~

noted by Dr. Pratik
 @ 11 AM
 8/6/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>8/6/26 14:45</p>	<p>CLWB Dr Akheel</p>	
	<p>3 Day old Baby B. wt - 3.6 kg Mom's wt - 32 kg Now wt - 3.19 kg</p>	<p>with weight loss</p>
	<p>Sr. Na - 154 Sr. K - 4.7 Sr. Cl - 117</p>	
		<p><u>Plan</u></p> <ul style="list-style-type: none"> - Child cannot be discharged - Shift to NICU for IV fluids & feeding
<p> Dr. Akheel Syed Rizwan</p>		<p>Sm A. Rizwan</p>
		<p>no teddy sushi 8/6/26 act 4 pm</p>

VIH-00205637 IP-00060237
 Baby B/O SONALI BANERJEE
 05-06-2026 0 Y 0 M 2 D (M)
 Dr. AKHEEL SYED RIZWAN



GROSS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/16/26 14:55	<p style="text-align: center;"><u>Shifty Note</u></p>	
	<p>3 day old male baby admitted to cradle post deliv. Had developed NNHB, DSPT was gives, child had 11% weight loss, with hypernatremic dehydration, so child's baby shifted for the future management to NICU</p>	
		<p style="text-align: center;">@</p>
		<p style="text-align: center;">Dr. Shyam</p>
		<p style="text-align: center;">noted by saki 8/16/26 at 3:50 PM</p>

VIH-00205637 IP-00060237
 Baby B/O SONALI BANERJEE
 05-06-2026 0 Y 0 M 3 D (M)
 Dr. SURENDER RAO DUSA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Receiving Notes	Doctor's Order
M: 3:30 PM		Dr. S. Surender Rao	
		Di: Hypertensive Dehydration	
	Plan.		
	→ IV fluids	Pso. 8 100cc/1day.	
	→ Opt S/E for 6hrs		
	→ w/o signs of dehydration		
K Dr. Surender			
		Noted by R. Suman 8/6/26	
8/6/26 9 PM			<ol style="list-style-type: none"> ① NPI + Im ② Oral demand/food ③ 60ml/kg/day IV - Pso.
			Noted by Sr. Sumanjali 08/06/26 @10:30 PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26 7:45	Day 4 / term / 38+5wks / B-wt - 3.618kg / A-wt - 3.22kg / 20m / Hypnatremic dehydration - wt loss 11%.	
	Issues - nil.	
	T-wt - 3.40 kg (↑180gms). I/O - 128/95 ml. U/O - 2.1ml/kg/hr. S/O - 2hms GRRS - 84mg/dl.	Normothermic. CVS - S, h ⊕ CNI - T/APR AUA PS - BAE ⊕ PIA - soft NT
	<p><u>Plan</u></p> <ul style="list-style-type: none"> - Target SpO₂ 790, MAP 73. - GRRS OD. - IVF - 60ml/kg/day → stop after Reports - oral demand feeds. - trace NPI - monitor vitals. - shift to room today. 	
Lishal	<p>Agutter in Dr. Sherry 9/6/26 10:30 AM</p>	<p>Dr. Surender Rao 9/6/26 10:30 AM</p>

VIH-00205637

IP-00060237

Baby B/O SONALI BANERJEE

05-06-2026 0 Y 0 M 3 D (M)

Dr. SURENDER RAO DUSA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Shipping Summary</u>	
	Day 4 Sunf 38 ⁺ wts 3.618 kg poor dehydration & wt loss 10ml hypovola dehydration	
	Baby read admitted in new 9/16 dehydration & significant wt loss.	
	Adv.	
	- oral demand feed q3h	
	- 2 clinic, send spec (1M)	
		sf ↓
		Noted by Bharan a/b/h



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>CLTB Resident</u>	
10/6/26 10:00pm.	Day 5 / Term (38+5w0d) 3.6kg Hypertonic dehydration mild Icterus (int).	dehydrated w/lab
Just 3.450kgs (↑ 50gm)	o/e Child Alert vital stable CTA - Good CRT 2 sec CU: 11.5 ⊕ M: BLUA ⊕ Pln: 10k ME: NAD.	<u>Plan</u> - DBT + lb burping - on Bliff - - warm he care - monitor vitals
Dr. Praveen	- TCB ↓ IF Normal Discharge.	- Inj (for ...)
Noted by B. Srinika 10/6/26 @ 11am	Flu on Friday.	Dr. Surender Rao 10/6/26 11AM

LABOUR WARD

05/06/2026

AFTERNOON

ULTRA SOUND ABDOMEN REQUEST FORM

PATIENT NAME :

UHID:

DATE:

VIH-00205637 IP-00060237
Baby B/O SONALI BANERJEE
05-06-2026 0 Y 0 M 0 D 4 H (M)
Dr. AKHEEL SYED RIZWAN



TO BE FILLED BY DOCTOR

HISTORY :

IMPORTANT CLINICAL FINDING :

SIGNIFICANT LAB REPORTS :

WORKINGS DIAGNOSIS :

DOCTORS NAME & SIGNATURE

S. 92
LIVER : Normal in size and echotexture. No intra hepatic biliary duct dilatation. Portal vein is normal. No focal lesions.

GALL BLADDER : Distended well and appears normal. No evidence of calculi or wall thickening. Common bile duct appears normal.

4.30
SPLEEN : Normal in size and echotexture.

PANCREAS : Normal in size and echotexture. MPD not dilated. No calcification noted.

KIDNEYS : Right kidney *39* mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney *34* mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended well and appears normal. No ascites / Lymphadenopathy. No evidence bowel wall thickening / edema.

IMPRESSION: No obvious sonological abnormality in abdomen.

Rest unremarkable

Suggested clinical correlation.

Shahid
DR MOHD ABDUL KHALID MD, DNB.
(Consultant Radiologist)

DR V. MAHIDHAR (MD)
(Consultant Radiologist)

DR VAISHNAVI REDDY B (MD)
(Consultant Radiologist)



CONSENT FOR ADMISSION IN NEONATAL INTENSIVE CARE UNIT (NICU)

I Vanshuj S/o Mr./ Ms
hereby declare that our patient Mr. / Ms Bhasmalji who is related to me as
son is getting admitted in the Neonatal Intensive Care Unit (NICU) of Rainbow Children's
Hospital on 8/6/26 with UHID No. : VH-00205337

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

Dehydrates
hypernatremic

The doctors have clearly explained to me that my patient Mr./ Ms. Mo. Sardi
during his / her stay in the NICU may undergo various medical and surgical procedures like airway management, mechanical ventilation, UAC, UVC (Umbilical Vein and Arterial Lines) PICC 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 NICU has life threatening medical conditions.

I understand that when a child is sick in the NICU 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 Mr. / Ms Bhasmalji
..... in the NICU fully understanding the associated risks involved from various procedures, high risk medications and infections in the NICU and treat him/her with all necessary means.

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

Patient Attendant :

Witness :

Signature :

Signature :

Name : Vanshuj

Name : Dr. Sherry

Relationship with Patient: father

Date & Time : 8/6/26 3pm

Date & Time : 8/6/26 3pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Deshvami

Date & Time : 8/6/26 3pm



నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ (ఎన్. ఐ. సి. యు) సమ్మతి పత్రం

రోగి పేరు వయస్సులింగం పు / స్త్రీ
 యు.హెచ్. ఐ.డి
 నేను చి

..... అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రేయిన్స్టో చిల్డ్రన్ హాస్పిటల్ లోని నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్లో తేది నాడు పూర్తి సమ్మతితో చేర్చితిని. మా బాలుడి/బాలికలో ఈ క్రింద తెలిపిన ఆరోగ్య సమస్యల గురించి వైద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ లో మా పాప /బాబుకు వైద్య పరంగా అవసరమగు అన్ని రకాల చికిత్స విధానాలకు మరియు ప్రక్రియలను (ఉదా కృత్రిమ శ్వాస వెంటిలేటర్, ఆర్థోలియర్ లైన్, సింట్రిల్ లైన్ డ్రైప్స్ డ్రెయిన్, పెరిటోనియల్ డ్రెయిన్ ఇంకానర్కన్ వంటి ప్రక్రియలను డాక్టరు గారు నాకు అర్థమగు భాషలో(సవివరంగా) వివరించారు.

పైన తెలుపబడిన శస్త్ర ప్రక్రియలు చేసేముందు సమ్మతి తీసుకునే వీలు లేనిచో మా బాలుడ / బాలికను కాపాడుటకు అవసరమైన వైద్య శస్త్ర ప్రక్రియలు మా సమ్మతి లేకుండానే చేయవచ్చని నేను సమ్మతిస్తున్నాను.

ఆరోగ్య సమస్యలతో బాధపడుతున్న మా బాలుడికి/బాలికకు రుగ్గుతలచే ప్రాణహాని కలుగవచ్చిన నాకు వైద్యుడు అర్థమగు భాషలో వివరించితిరి.

మా బాలుడు / బాలిక ఎన్.ఐ.సి. యు లో ఉన్నప్పుడు ఎన్నో విధాల వైద్య మరియు శస్త్ర ప్రక్రియలు ఇంకా వివిధ చికిత్స విధానాలు అవసరం పడతాయని మరియు వాటివల్ల దుష్ప్రణామాలు కలగవచ్చని అర్థం చేసుకున్నాను. ఆ పరిణామాలు ఎటువంటివి అనగా రక్తస్రావ ప్రమాదం కణజాలం దెబ్బతినడం మొదలగునవి.

మా బాలుడిని/బాలికను అడ్మిట్ చేయుటకు మరియు ఎన్. ఐ. సి.యు. లో ఉన్నప్పుడు జరుగు చికిత్స విధానాలు మరియు శస్త్ర ప్రక్రియలు వలన కలిగే అపాయాలను నేను అంగీకరిస్తున్నాను. మా పేషంట్ ను తగినన విధంగా చికిత్స చేయడానికి వైద్యునికి నా పూర్తి అంగీకారం తెలియజేస్తున్నాను. వైద్యుడు నాకు అర్థమగు భాషలో అంతా వివరించారు.

మా బాలుడు / బాలిక ను ఇంటెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు (అటెండెంట్)
 సంతకము
 పేరు
 తేది మరియు సమయము

సాక్షి
 సంతకము
 పేరు
 తేది మరియు సమయము

డాక్టర్
 సంతకము
 పేరు
 తేది మరియు సమయము

CONSENT FOR FORMULA FEEDS

Patient Name: B/O SONALI BANERJEE Age: 32

Gender: M F - IP No: 205627 Reg. No.: —

Department: new Date: 8/6/2026

I Mr/Mrs: SONALI BANERJEE S/W/D/o: VANSHUJ ARORA

aged 32 years. Hereby declare that I have admitted my son / daughter

In the NICU of Rainbow Children's Hospital, Hyderabad on 08th JUNE, 2026. Here by giving consent for formula feeding for my child. Doctors have explained me about the formula feeding benefits and risks involved in the language I best understand.

Patient Attendant :

Signature: Vanshuj

Name: Vanshuj Arora

Relationship with Patient: Father

Date & Time: 8/6/26 @ 15:50hrs

Witness :

Signature: Sabrina Banerjee

Name: Sabrina Banerjee

Date & Time: 8/6/26 @ 15:50hrs

Doctor (who is taking the consent) :

Signature: [Signature]

Name: Dr Shivam

Date & Time: 8/6/26 3pm

డబ్బా పాలు పట్టించుటకు అనుమతి పత్రం

రోగి పేరు :వయస్సు : లింగం :పు స్త్రీ

రిజిస్ట్రేషన్ నం : ఐ.పి. నం :

నేను శ్రీ/శ్రీమతి : S/W/D/O:

వయస్సు : సంవత్సరాలు, నా కుమార్తెని/కుమారుడును రెయిన్ బో పిల్లల ఆసుపత్రి, ఎన్ఐసియూలో అడ్మిట్ చేసినాము మరియు డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుతున్నాను. డాక్టర్లు డబ్బాపాలు త్రాగించడం వల్ల కలుగు ఉపయోగాలు మరియు నష్టాల గురించి నాకు అర్థమైన భాషలో వివరించారు.

సహాయకుడు :

సాక్షి

సంతకము : _____

సంతకము : _____

పేరు : _____

పేరు : _____

తేది మరియు సంతకము : _____

తేది మరియు సమయము : _____

డాక్టర్ :

సంతకము : _____

పేరు : _____

తేది మరియు సమయము : _____

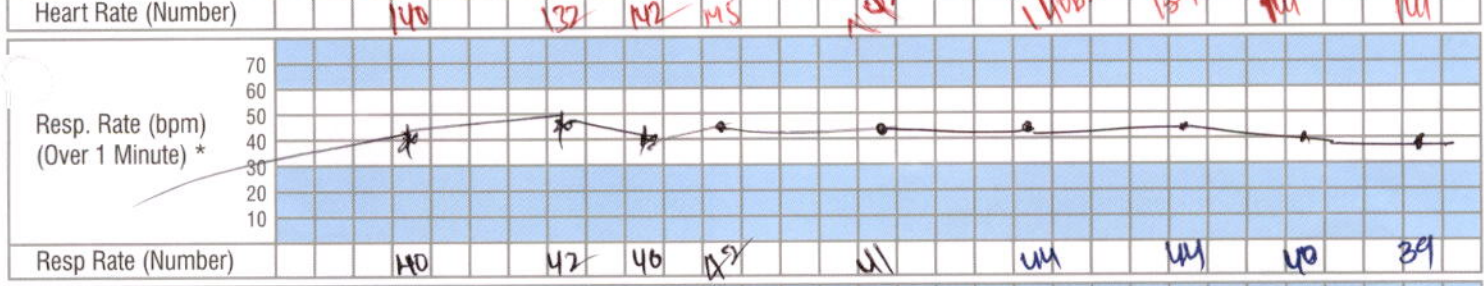
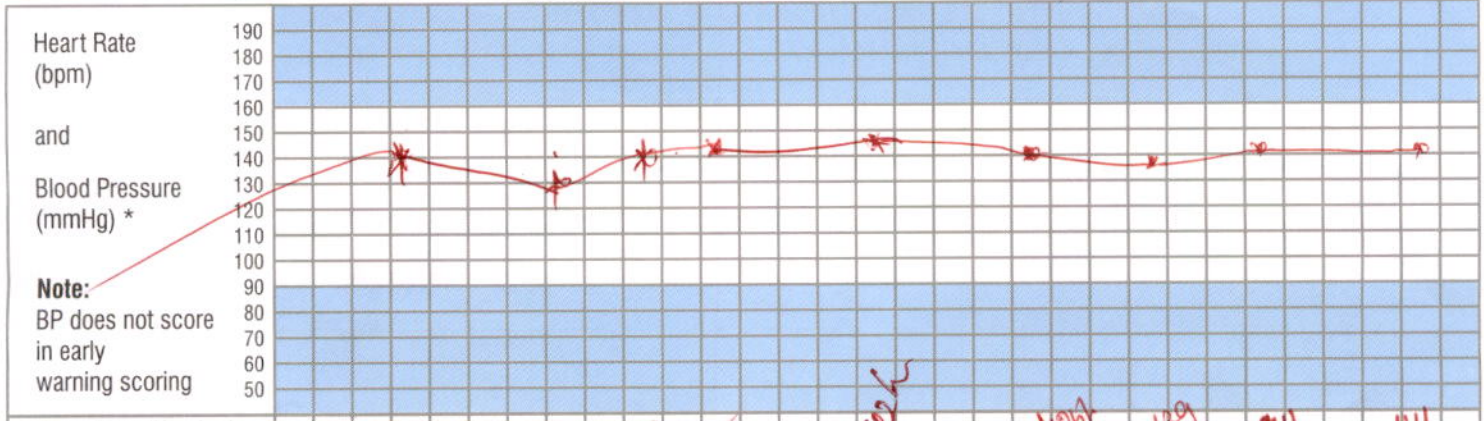
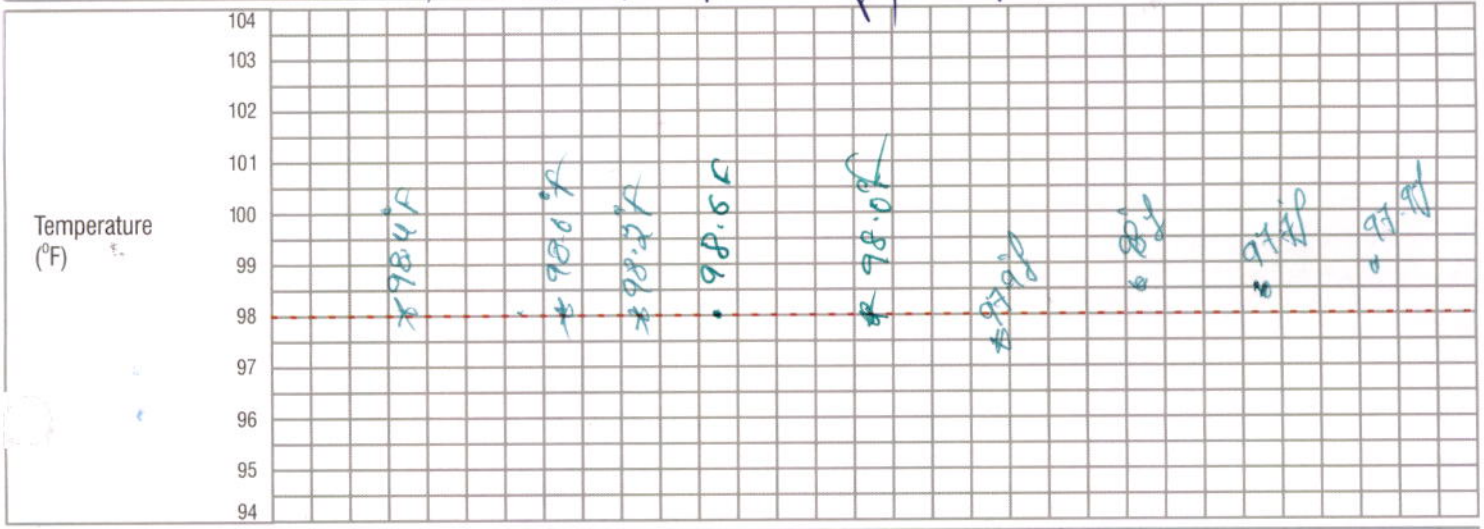


INFANT (<1 year)
Children's Observation &
Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 5/6/26	Time:	9	10	11	12	3	0	10	1	4	9
Doctor/Nurse/Family Concern?		AM		AM	PM	PM	PM	PM	AM	AM	AM



Heart Rate (Number)	140	132	142	145	145	140	139	141	141
Resp Rate (Number)	40	42	40	45	41	44	44	40	39
Resp Mod/ Severe Distress None / Mild	N	N	N	C	C				
Receiving O ₂ (l/min)									
O ₂ Saturations (%)	99%	99%	99	98	98%	99%	99%	99%	99%
Conscious Level Normal / Altered	N	N	N	N	C	C	C		
GCS *	-	-	-	13	14	14	14	14	14
TOTAL SCORE									
Number of shaded boxes	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0
Observer's Initials	P	P	P	E	A	H	J	S	B

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

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



CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	BACK GROUND : Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	ASSESSMENT : I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	RECOMMENDATION : I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

VIH-00205637

IP-00060237

Baby B/O SONALI BANERJEE

05-06-2026

0 Y 0 M 0 D 5 H (M)

Dr. AKHEEL SYED RIZWAN



No. : RCH/ FRM / CLINICAL / 124

INFANT (<1 year)

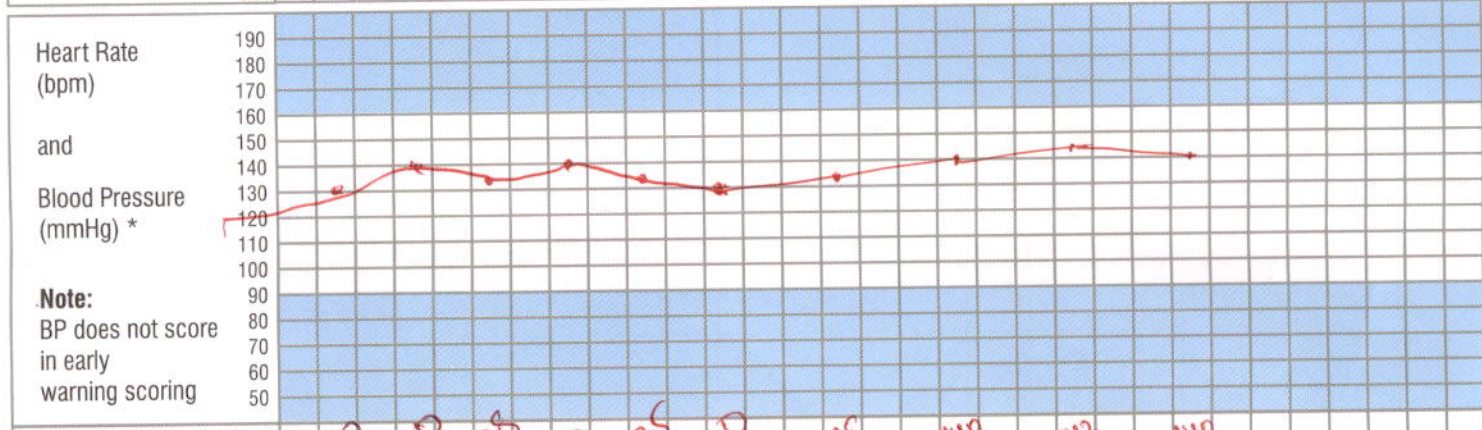
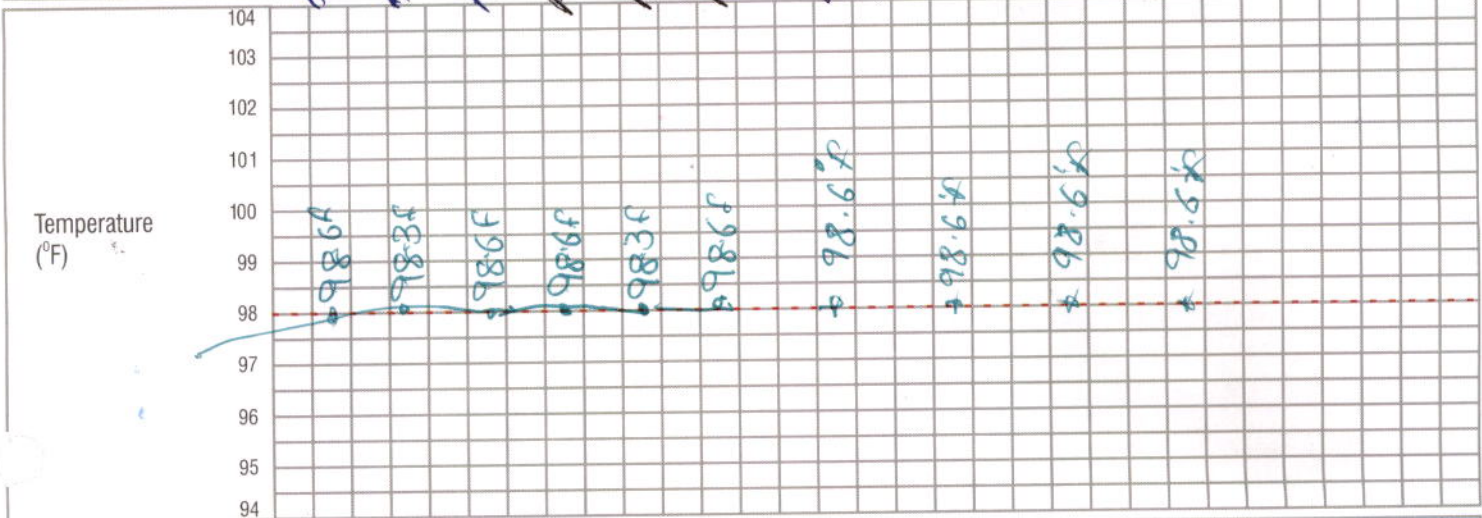
Children's Observation & Early Warning Scoring Chart



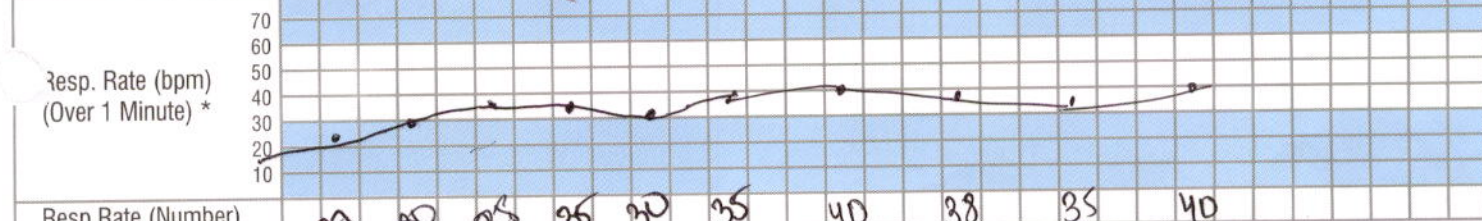
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 05/06/2026 Time: 9 AM 10 AM 11 AM 9 PM 5 PM 7 PM 10 PM 1 AM 4 AM 7 AM

Doctor/Nurse/Family Concern? M M M M M M P M M M M



Heart Rate (Number) 130 140 135 140 135 130 135 140 142 140



Resp Rate (Number) 25 30 35 35 30 35 40 38 35 40

Resp Mod/ Severe Distress None / Mild

Receiving O₂ (l/min) O₂ Saturations (%) 0.98 97 98 97 98 98 99 97 98 99

Conscious Level Normal Altered 2 2 2 2 2 2 2 2 2 2

GCS * 15 15 15 15 15 15 15 15 15 15

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 SR SR SR SR SR SR B B B B

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
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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)



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

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 7/6	Time: 9	11	1	3	5	7	10	1	4	7
Doctor/Nurse/Family Concern?	AM	AM	PM	PM	PM	PM	PM	AM	AM	AM
Temperature (°F)	98.8	98.8	98.6	98.8	98.8	98.6	98.1	98.8	98.8	98.0
Heart Rate (bpm)	135	140	143	140	135	140	139	140	136	138
Blood Pressure (mmHg) *	135	140	143	140	135	140	139	140	136	138
Resp. Rate (bpm) (Over 1 Minute) *	30	32	30	32	30	32	40	42	38	43
Resp Mod/ Severe Distress										
Receiving O ₂ (l/min)										
O ₂ Saturations (%)	97	97	98	98	97	98	99	98	98	98
Conscious Level	N	N	N	N	N	N	N	N	N	N
GCS *	15	15	15	15	15	15	15	15	15	15
TOTAL SCORE	0	0	0	0	0	0	0	0	0	0
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	MR	MR	MR	BR	BR	BR	BR	BR	BR	BR
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										

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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-00205637 IP-00060237
 Baby B/O SONALI BANERJEE
 05-06-2026 0 Y 0 M 1 D (M)
 Dr. AKHEEL SYED RIZWAN

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

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 9/6/26	Time: 9	11	1	3
Doctor/Nurse/Family Concern?	A	A	PM	PM
Temperature (°F)	98.6	98.3	98.6	98.6
Heart Rate (bpm)	140	148	156	148
Blood Pressure (mmHg) *				
Resp. Rate (bpm) (Over 1 Minute) *	30	32	48	45
Resp Mod/ Severe Distress None / Mild				
Receiving O ₂ (l/min) O ₂ Saturations (%)	08	07	08	07
Conscious Level Normal / Altered	2	2	1	
GCS *	15	15	15	15
TOTAL SCORE	0	0	0	0
Number of shaded boxes	0	0	0	0
Pain Score	0	0	0	0
Observer's Initials	A	A	S	A

*Noted by Andu
 @/AM
 8/6/*

ACTIONS

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

NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

I	IDENTITY: I am (name), a nurse on ward (X). I am calling about (child X)
S	SITUATION : I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	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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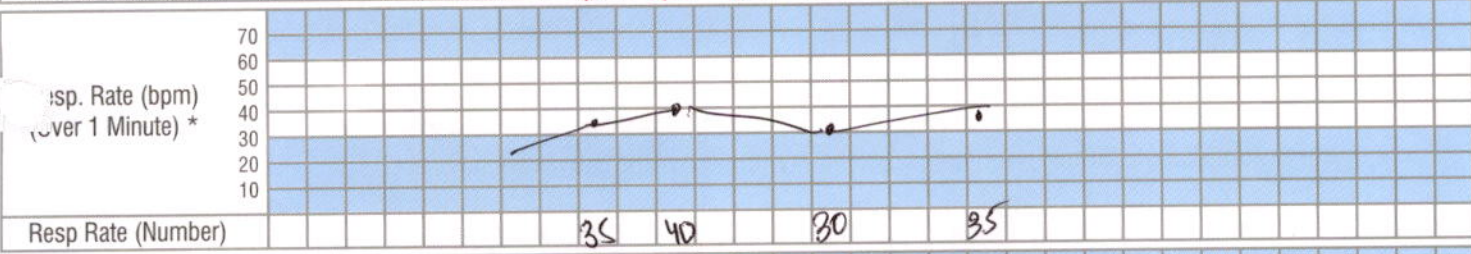
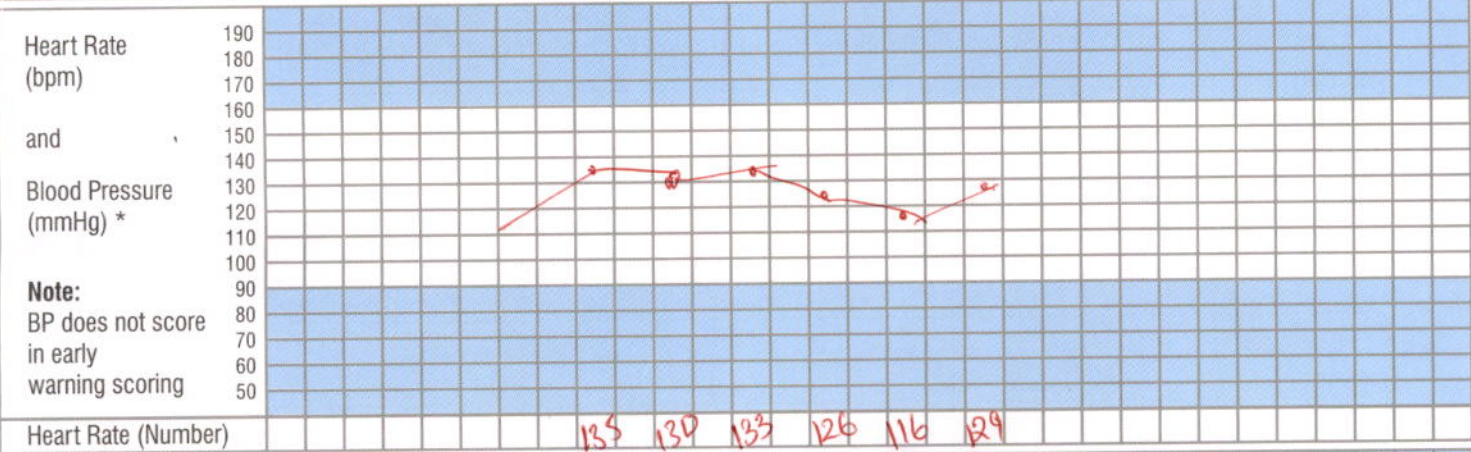
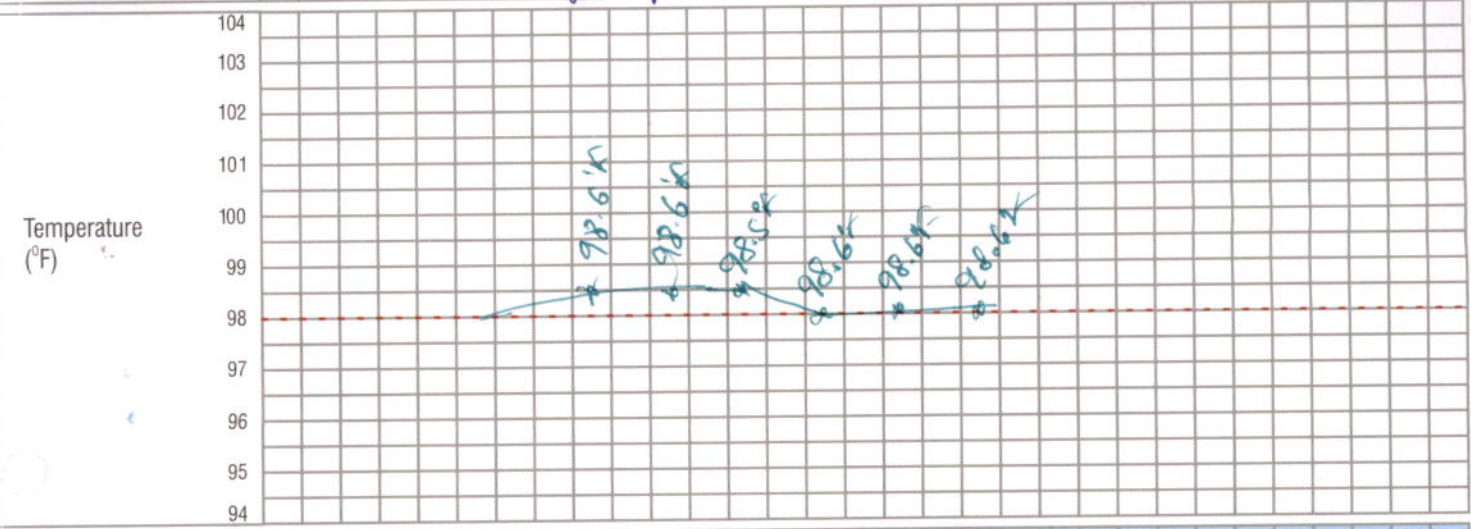
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 9/6/26 Time: 4 7 10 1 4 7

Doctor/Nurse/Family Concern? Pm Pm PM AM AM AM



Resp Distress	Mod/ Severe	None / Mild				
			N	N	N	N
Receiving O ₂ (l/min)	O ₂ Saturations (%)		97	98	100	99
			96	96	97	
Conscious Level	Normal	Altered	N	N	N	N
GCS *			15	15	15	15

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

ACTIONS

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VH-00205637 IP-00060237
 Baby B/O SONALI BANERJEE (M)
 05-08-2026 0 Y 0 M 4 D
 Dr. SURENDER RAO DUSA



RCH/ FRM / CLINICAL / 124

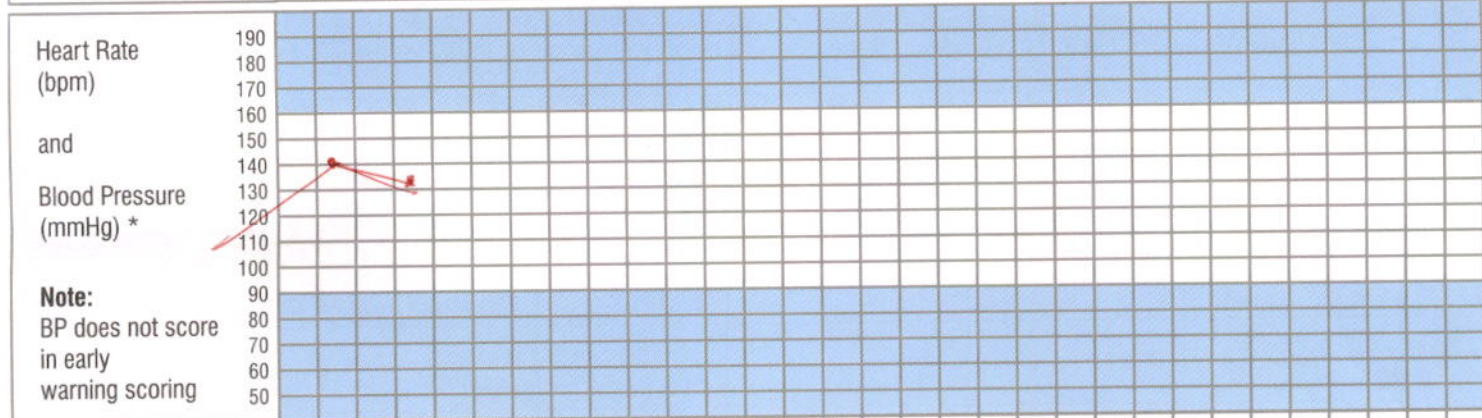
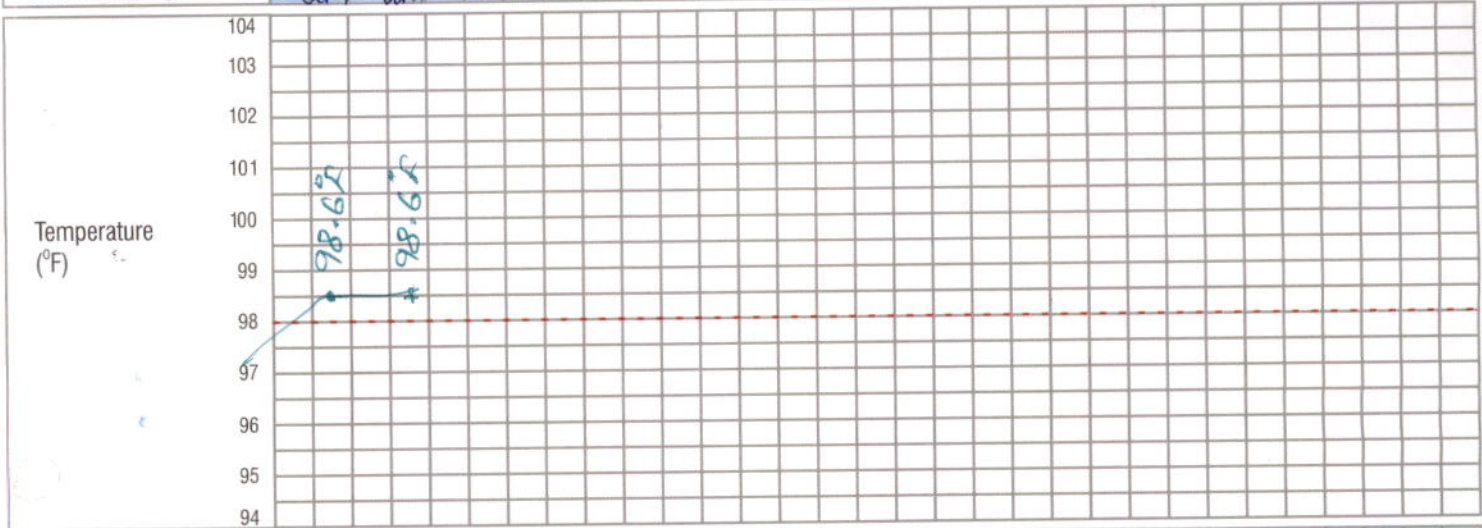
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



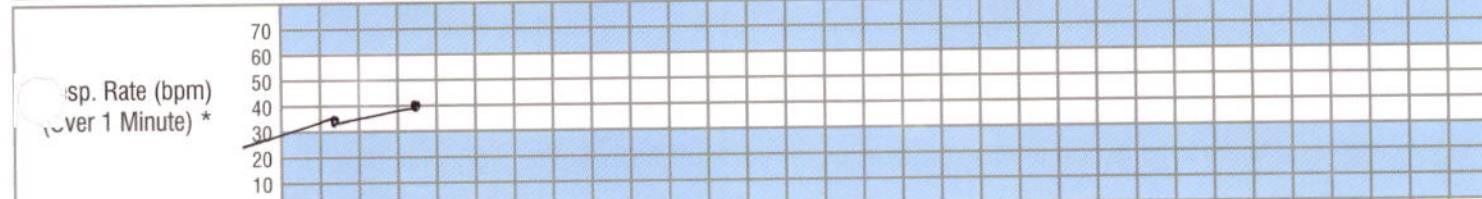
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 10/6/26 Time: 9 11

Doctor/Nurse/Family Concern? am am



Heart Rate (Number) 140 135



Resp Rate (Number) 35 40

Resp Distress: Mod/ Severe None / Mild N N

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

Conscious Level: Normal Altered N N

GCS * 15 15

TOTAL SCORE Number of shaded boxes 0 0

Pain Score 0 0

Observer's Initials B B

*Noted by
 Banerjee
 10/6
 @ Nam*

- ACTIONS**
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Ref No. F/INPR/19
 Patient Name :
 I.P. No

VIH-00205637 IP-00060237
 Baby B/O SONALI BANERJEE
 05-06-2026 0 Y 0 M 3 D (M)
 Dr. SURENDER RAO DUSA



NURSES ASSESSMENT CHART



Date : 08/06/26 Diagnosis : dehydration Weight : 3.2 kg Chart No. : ①

Guide	Time	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
COLOUR CODE	200																								
	210																								
RED - PULSE	200																								
BLACK - RESP	105																								
GREEN - TEMP	104																								
BLUE - NIBP	103																								
	102																								
	101																								
A- ALERT	100																								
V-VOICE	99																								
P-PAIN	98																								
U-UNRESPONSIVE	97																								
	96																								
VERBAL	95																								
5-ORIENTED	80																								
4-CONFUSED	70																								
3-IN APPROPRIATE WORDS	60																								
2-INCOMPREHENSIBLE SOUND	50																								
1-NONE	40																								
	35																								
MOTOR	30																								
6-OBEYS	28																								
5-LOCALISES PAIN	26																								
4-WITHDRAWS	24																								
3-FLECTION	22																								
2-EXTENSION	20																								
1-NONE	18																								
	16																								
	14																								
	12																								
	10																								
O2																									
SPO2																									
RBS																									
SUCTION																									
PHYSIOTHERAPY																									
AVPU																									

104 106 103 123 124 106 138 118 112 126 128 154 158 119 128 135

36.5 36.5 36.4 36.4 36.5 36.5 36.5 36.5 36.5 36.5 36.8 36.5 36.5 36.5 36.8

U U U 30 34 35 31 38 55 28 59 58 46 38 63 48 80

61 61 69 65 74 73 73 63 78 51 64 64 65 66 78

50 51 54 51 57 61 61 52 68 48 51 57 51 53 61

U U U 46 38 49 54 59 47 50 53 40 49 43 48 59

91 94 84 98 91 98 97 96 99 98 96 99 100 100 99 99

Signature of the Nurse :

Morning Shift :

Evening Shift : Bhavan
8/6/26
SM

Night Shift : Sumanjali
8/6/26
@ 8PM

VIH-00205637 IP-00060237
 Baby B/O SONALI BANERJEE
 05-06-2026 0 Y 0 M 3 D (M)
 Dr. SURENDER RAO DUSA



NURSES ASSESSMENT CHART



I.P. No :
 Date : 09/06/26 Diagnosis : dehydration Weight : 3.2 kg Chart No. : (2)

Guide	Time	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
COLOUR CODE	200																								
	210																								
RED - PULSE	200	119	120	125	140	150	150	150																	
BLACK - RESP	105	190																							
GREEN - TEMP	104	180																							
BLUE - NIBP	103	170																							
	102	160																							
	101	150																							
A- ALERT	100	140																							
V-VOICE	99	130	36.5	36.5	36.5	36.5	36.5	36.5	36.5																
P-PAIN	98	120																							
U-UNRESPONSIVE	97	110																							
	96	100	40	45	50	43	55	40	45																
VERBAL	95	90																							
5-ORIENTED	80																								
4-CONFUSED	70																								
3-IN APPROPRIATE WORDS	60																								
2-INCOMPREHENSIBLE SOUND	50																								
1-NONE	40																								
	35																								
MOTOR	30																								
6-OBEYS	28	72	75	54	63	78	61	49																	
5-LOCALISES PAIN	26																								
4-WITHDRAWS	24																								
3-FLECTION	22	58	60	44	57	66	49	50																	
2-EXTENSION	20																								
1-NONE	18																								
	16	49	55	40	54	59	42	44																	
	14																								
	12																								
	10																								
O2																									
SPO2		96	95	96	96	95	94	95																	
RBS																									
SUCTION																									
PHYSIOTHERAPY																									
AVPU		A	A	A	A	A	A	A																	

Signature of the Nurse : Sherly

Morning Shift : my
9/6/26

Evening Shift :

Night Shift :



FLUID CHART

Sheet No. : 1

5/6

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 Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
5/6/26	08:00 am	DBF										Prathya ho 5/6/26 @ 2pm	
	09:00 am								✓				
	10:00 am	DBF					✓						
	11:00 am												
	12:00 pm	DBF											
	01:00 pm												
Total Intake :						Total Output :						Paused	
5/6/26	02:00 pm	DBF										Prathya 5/6/26 @ 3pm	
	03:00 pm												
	04:00 pm								✓				
	05:00 pm	DBF											
	06:00 pm												
	07:00 pm									✓			
Total Intake :						Total Output :							
	08:00 pm	DBF										Prathya 5/6/26 @ 8pm	
	09:00 pm												
	10:00 pm	DBF											
	11:00 pm												
	12:00 am	DBF											
	01:00 am												
Total Intake :						Total Output :							
	02:00 am	DBF										Prathya 6/06/26 JRM	
	03:00 am												
	04:00 am	DBF											
	05:00 am												
	06:00 am	DBF					✓			✓			
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART

Sheet No. : 2

7/6

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

Date	Time	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
7/6	08:00 am		DBM								} Managed 7/6 @ 9 PM	
	09:00 am											
	10:00 am											
	11:00 am		DBM									
	12:00 pm											
	01:00 pm		DBM									
Total Intake :					Total Output :							
7/6	02:00 pm										} Produ @ 8 PM 7/6/26	
	03:00 pm		DBM									
	04:00 pm											
	05:00 pm		DBM									
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
7/6/26	08:00 pm										} 7/6/26	
	09:00 pm		DBM									
	10:00 pm											
	11:00 pm		DBM									
	12:00 am											
	01:00 am		DBM									
Total Intake :					Total Output :							
8/6/26	02:00 am		DBM								} 8/6/26	
	03:00 am											
	04:00 am		DBM									
	05:00 am											
	06:00 am		DBM									
	07:00 am											
Total Intake :					Total Output :							
Total 24 hrs. Intake												
Total 24 hrs. Output												

FLUID CHART

Sheet No. : 27

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
8/6	08:00 am											2nd over 8th	
	09:00 am		DOM										
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
8/6	02:00 pm											1 CG 2 CG 8th etc	
	03:00 pm		AP trail 30 ml										
	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							

VIH-00205637 IP-00060237
 Baby B/O SONALI BANERJEE
 05-08-2026 0 Y 0 M 3 D (M)
 Dr. SURENDER RAO DUSA



FLUID CHART

Sheet No. : 8

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm										0	} Sharan Blh 8W	
	03:00 pm										0		
	04:00 pm			5.15g							0		
	05:00 pm			16.1						20ml	6		
	06:00 pm			16.6							0		
	07:00 pm			8.0						20ml	0		
	07:00 pm			8.0							0		
Total Intake :			35.7 ml			Total Output :					40ml		
	08:00 pm			8.1							0	} Sumanjit oslope am	
	09:00 pm	EBM	30ml	8.1							0		
	10:00 pm			8ml							0		
	11:00 pm			8ml							0		
	12:00 am	EBO	50ml	8ml					20ml		0		
	01:00 am			8ml							0		
	01:00 am			8ml							0		
Total Intake :			128ml			Total Output :					20 ml		
	02:00 am			8ml							0	} Sumanjit oslope am	
	03:00 am	EBM	30ml	8ml							0		
	04:00 am			8ml					2ml		0		
	05:00 am	Aptm	30ml	8ml							0		
	06:00 am			8ml							0		
	07:00 am	EBM	20ml	8ml					10ml		0		
	07:00 am			8ml							0		
Total Intake :			128ml			Total Output :					35 ml		
Total 24 hrs. Intake		291ml ⇒ 128cc (kg/cent/kg)				Total 24 hrs. Output		95 ml					

Stool passed - 2 times
 No vomitings
 CURBS - sum9/14



FLUID CHART

Sheet No : 8

9/6/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	NG	NG	Diarrhoea	Vomit	Drainage	Urine			
9/6/26	08:00 am										0		
	09:00 am										0		
	10:00 am	EBM 50ml					✓		15ml		0	Shayana	
	11:00 am									0			
	12:00 pm	EBM 60ml					✓		30ml		0		
	01:00 pm										0	9/6	
Total Intake :			110 ml.			Total Output :						0	@
9/6	02:00 pm												
	03:00 pm	Aptamil 40ml					✓					Beenaika	
	04:00 pm												
	05:00 pm	EBM 40ml					✓						
	06:00 pm											9/6	
	07:00 pm	Aptamil 30ml					✓					@ 8pm	
Total Intake :						Total Output :						1	
9/6	08:00 pm												
	09:00 pm	EBM 30ml										Subha	
	10:00 pm												
	11:00 pm	EBM											
	12:00 am											9/6	
	01:00 am												
Total Intake :						Total Output :						1	
10/6/26	02:00 am	Aptamil 60ml										Subha	
	03:00 am												
	04:00 am												
	05:00 am	EBM										10/6	
	06:00 am												
	07:00 am												
Total Intake :						Total Output :						1	
Total 24 hrs. Intake						Total 24 hrs. Output							9 times

Patient Sticker

FLUID CHART

Sheet No. :

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

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

Patient Sticker

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
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Total Intake :						Total Output :							
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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	
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Total 24 hrs. Output	
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Patient Sticker

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
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Total Intake :						Total Output :							
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	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



MEDICATION RECONCILIATION FORM

Drug Allergies: Nil 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: NICU Shifted to: 103

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	<u>Nil</u>					<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: [Signature]

Date & Time: 06/06/20 @ 2PM

Nurse Name & Signature: [Signature]

Date & Time: 06/06/20 @ 2PM

VIH-00205637 IP-00080237
 Baby B/O SONALI BANERJEE
 05-06-2026 0 Y 0 M 3 D (M)
 Dr. SURENDER RAO DUSA



Blood gts:
 M / B (B+ve.)

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

RESULT SHEET

Date	8/6/26	9/6/26			
Time	1pm	7Am			
Hb		18.6	/		
PCV		49.1	/		
RBC		5.09	/		
WBC		10.21	/		
N/L		40/44	/		
Platelets		276.	/		
CRP		10	/		
ESR					
PCT					
RBS					
Na	154	144.	/		
K	4.7	4.9	/		
Cl	117	108.	/		
Ca/Mg		10.2.	/		
Phosphate					
Urea		23.7	/		
Creatinine		0.6.	/		
ALP					
SGPT					
SGOT					
T.Bill/Conj		8.5 < 0.2	/		
T.Protein		8.3			
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					

