

ACTIV

VIH-00205911 IP-00060347
Baby B/O HIRANMAYEE
15-06-2026 0 Y 0 M 0 D 1 H (F)
Dr. KODICHERLA VISHNU VARDHAN

ING

Name: _____



UHID No. _____

Consultant: _____ Dept: _____

Date of Admission: 15/6/26 Time: 6:02 AM Date of Discharge: 16/6/26 Time: 3 PM

Room / Bed No: _____ Ward: 4W Suggested Billable bed type: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/6/26	10:35 AM	4W	Room(204)	Ravi

Cross Consultation Visit

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

Name	Baby B/O HIRANMAYEE MOHAPATRA	UHID	VIH-00205911
Father/Guardian	Mr SUBHRANSU SEKHAR DAS	Age/Gender	0 Y 0 M 1 D/Female
Address	ratnanidhi residency, nacharam, telangana, Nacharam, Hyderabad, Telangana, INDIA, 500076		
IP No	IP-00060347	Admission Date	15-06-2026
Ref Doctor	SELF	Discharge Date	16-06-2026

DISCHARGE SUMMARY

Consultant: Dr. KODICHERLA VISHNU VARDHAN REDDY
MBBS, DNB (Pediatrics), DrNB (Pediatric Critical Care)
Fellow in PICU & CICU (RCPCH BCH UK)
CONSULTANT PEDIATRICIAN AND PEDIATRIC INTENSIVIST

Diagnosis: Term/Appropriate for gestational age/Baby Girl
Infant of hypothyroid mother

Mode of Delivery: Normal Vaginal Delivery

Presentation: Vertex

Anthropometry:

Weight at birth : 2.89 kgs

Weight at discharge : 2.81 kgs

Head circumference : 34 cms

Length : 48 cms

Mother Blood Group : "A" Positive

Baby Blood Group : "B" Positive

Risk Factors : Hypothyroidism

Others: NA

Vaccination: Baby was given following vaccination:

BCG / OPV / Hepatitis-B on : 16.062026

Hearing test (OAE): Done on 16.06.2026 was normal.

Newborn screening (Advanced) To be done on follow up.

Saturation: Right upper limb 98% and left lower limb 98% at room air.

Red Reflex: Present and Symmetrical.

Name

Baby B/O HIRANMAYEE
MOHAPATRA

UHID

VIH-00205911

History: Baby of HIRANMAYEE MOHAPATRA is a term (38+1 weeks) baby girl, delivered to a Multi gravida mother by Normal Vaginal Delivery on 15.06.2026 at 05:37 am with birth weight of 2.895 kgs in Rainbow Children's Hospital, Karkhana. Baby cried immediately after birth. Apgar scores were 7/10 at 1 min, 9/10 at 5 min. Injection Vitamin-K 1mg IM was given after delivery.

Maternal History: Mrs. HIRANMAYEE MOHAPATRA is a 25 years old Multigravida (G2A1) mother.

G2 - Present pregnancy, spontaneous conception, had regular ANC's. Antenatal scans were normal. History of Hypothyroidism on Tab. Thyronom 12.5 mcg. History of UTI at 24 weeks of GA. No history of Pregnancy-Induced Hypertension / Antepartum Hemorrhage / Oligohydramnios / Polyhydramnios / Fever.

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: Hospital stay was uneventful.

Feeding: Breast feeding was initiated and baby tolerated the feeds well.

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 as advised.
3. Burping after each feed.
4. Immunization as per schedule.

Name

Baby B/O HIRANMAYEE
MOHAPATRA

UHID



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. To do New Born Screening (Advanced) and SBR on follow up.
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".
9. Kindly consult Dr. K. Vishnu Vardhan Reddy, Consultant Pediatrician & Intensivist Pediatric, on 18.06.2026 (Thursday) with 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.

Name Baby B/O HIRANMAYEE
MOHAPATRA UHID VIH-00205911

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

Name : *Subhanga S. Das* Signature : 

Relationship with patient : *Father*

This summary has been explained by :

Summary prepared by : Dr. Sameera
DEO : Kalyan/Younus

For Sameer

Registrar/Resident/C.M.O

Dr. KODICHERLA VISHNU VARDHAN REDDY
MBBS, DNB (Pediatrics), DrNB (Pediatric Critical Care)
Fellow in PICU & CICU (RCPCH BCH UK)
CONSULTANT PEDIATRICIAN AND PEDIATRIC INTENSIVIST
APMC/FMR/79982

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET
Registration Details :

Admission No : IP-00060347

Admit Date : 15-Jun-2026

Admit Time : 06:21 AM **UHID** : VIH-00205911

Patient Details :
Patient Name : Baby B/O HIRANMAYEE MOHAPATRA

Age : 0 D

Guardian : Mr SUBHRANSU SEKHAR DAS

DOB : 15-06-2026 05:37 AM

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : ratnanidhi residency, nacharam, telangana
Nacharam Hyderabad Telangana INDIA
500076

Phone No : 6350063480/ 8114865794

E-mail : subhrabsut2@gmail.com

Admission Details :
Bed Type : BASINET

Bed No : CRDL-LW-223-1

Ward Name : N 2F-LABOUR WARD

Room No : CRDL-LW-223-1

Admission Type : First Visit

Contact Details :
Name : Mr SUBHRANSU SEKHAR DAS

Relationship : Father

Contact Address : ratnanidhi residency, nacharam, telangana
Nacharam Hyderabad Telangana INDIA 500076

Phone No : 6350063480 / 8114865794



Signature

Doctor Details :
Doctor Name : Dr. KODICHERLA VISHNU VARDHAN
REDDY

Specialisation : GENERAL PEDIATRICS

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Blo. Hiranmayee Mother's Name: Mrs. Hiranmayee
Date of Birth: 15/6/26 Time of Birth: 5:37 AM Gender: Male Female
Birth Weight: 2.895 Kgs HC: 34 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: A positive Baby: _____
Feeding: Breast Feeding Formula Both First Feed Time: 6 AM

VIH-00205241 IP-00060346
Mrs HIRANMAYEE MOHAPATRA
23-09-1997 28 Y (F)
Dr. SRILATA PATNAIK

Mode of Delivery: Normal LSCS - Emergency/ Elective Instrumental AVU

Indication: _____

Physical Assessment of New Born:

Temp: 98.8 °C HR: 152 /Min RR: 51 /Min BP: _____ SpO₂: 99%

Pain Score: 0 (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: K. Subashini Signature: [Signature] Date & Time: 15/6/26 6 AM

PATIENT TRANSFER FORM

VIH-00205911 IP-00060347 Baby B/O HIRANMAYEE 15-06-2026 0Y0M0D1H (F) Dr. KODICHERLA VISHNU VARDHAN 		Date & Time of Admission	Date & Time of Transfer Order
Treating Consultant Name }		Date & Time of Admission 15/6/26 at 6:21 AM	Date & Time of Transfer Order 15/6/26 at 11A
Transfer Ordered by Dr. Vishnu		Reason for Transfer Observation	
From Unit LW	To Unit Room 204	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 18	Number of Imaging Films —	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.	Small diaper pad - ①	—	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Dr. Vishnu			
Name & Signature of Person who is Transferring Rani		Name of Person Ordered Transfer Dr. Vishnu	
Patient & Clinical Records Received by : Sushu			
Date & Time of Patient Received : 15/6/26 11A			

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 : HIRANMAYEE Age : 28y Father's Name : Age :
 Date of Birth : 23-09-97 Date of Admission : UHID No. :
 NICU Consultant : Dr Vishnu Referring Consultant : Dr. Srilakshmi
 Transferring Unit : OT Labour Room ER Ward
 Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : 3/o Hiranmayee Mother's Blood Group : A Positive
 Gender : M F Blood Group : Birth Weight (gms) : 2895g Length (cms) :
 Date of Birth : 15/06/26 Time of Birth : 5:37 am OFC (cms) :
 Place of Birth : Res. UKP. Estimated Gesth Age : 38+1 wks

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 28y Ht : 158 Wt : 62 BMI : Married Life : Apr LMP : 2/9/25 EDD : 27/6/26

Conception : Spontaneous or with Rx. :

Booked at what GA : AN Steroids Drugs / Doses :

Last Scans Details : 23/5 SUF 35w4 Cephalic AFE - 13.01 AC 25%. EFW 2466g
Placenta Anterior TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

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

H/o GDM/ pre GDM/ on diet or insulin
 Controlled or not, recent values, HbA1 values :
 Compliance with Rx :
 Scans : LGA, TIFFA, Fetal Echo : (M)
 H/o Hypothyroidism : when diagnosed ? Medication?
on T-Thyronom 125mcg
 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 : 24 wks Any culture :

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



PAST OBSTETRIC HISTORY

..... 2 P: R A: 1 L:

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
41	5wks	MTP	1202g			
42	PP / SP.					

PERINATAL HISTORY

Treating Obstetrician : Dr. SriLatha Hospital : Rese NICE Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig) <u>Pre-eclampsia</u></p> <p>Second stage (> 2 hours after dilation)</p> <p>LSCS : <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</p> <p>Specify the reason : <u>NVD.</u></p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL :</p> <p>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	<u>7/10</u>	<u>9/10</u>	

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

CIA.

Target sps
reached at
3rd of life

Decreased uterine MVD
↓
Baby good
↓
C/S
↓
Sec for C/S
↓
Secutious bleed
↓
died and phinidated
↓
Inj vit K 10mg
↓

Investigation details in previous Hospital :

Cord clamp cut - 2A+1V ⊕
↓
Baby vigorous
↓
Shift to mother side

Feeding History :

Past History :

Family History :

Socio Economic History :



GENERAL EXAMINATION ON ADMISSION

General Disposition :

C/A good

VITALS : Temperature: 37.6°C HR : 120/min RR : 39/min NIBP : CFT :

Color of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 94% RA

Anthropometry : Birth Weight : 2895g Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

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

Facies :
(Any Facial
Dysmorphism)

NECK and CLAVICLES : Range of Motion :
Asymmetry : (O)
Masses :

EYES : Symmetry :
Red Reflex : } Not checked
Discharge :

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



THORAX and BREASTS : Shape of Thorax :
 Position of Nipples and Number : 2 in Mamma @ per 1

ABDOMEN and UMBILICUS : Shape :
 Organomegaly :
 Bowel Sounds : 2/4/10/0
 Umbilical Stump :
 Discharge :

GENITALIA : Labia / Hymen : (4)
 Testicles/penis :
 Anus :

HERNIAL ORIFICES : free

TRUNK and SPINE : (2)

SKIN LESIONS : (2)

EXTREMITIES : Fingers / Toes :
 Deformities :
 Hip Joint Examination :
 Arms / Legs :
 Mobility : (soft)

SYSTEMIC EXAMINATION

Respiratory System :
 Breathing Pattern : Regular Periodic Shallow Gasping
 Mention If baby has Respiratory distress : RR : 40/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 : BME (4) Breath Sounds : Added Sounds :

Cardiovascular System :
 HR : 130/min BP : (4) Precordial Activity : (2)
 Femoral Pulses : (4) Murmurs :
 Other Peripheral Pulses : (4) Signs of Cardiac Failure :

Abdomen :
 Shape :
 Palpation : soft
 Palpable masses :
 Abdominal girth :
 Hernia orifice : free
 Anal Patency : +
 Umbilical Cord : 2/4/10/0 (4)
 First urine passed : not passed
 Meconium passed : passed

Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtl Score :

Nerves :

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : Bl. equivocal DTR : f

ATNR : (+) Skull and Spine : (+)

Any Congenital Anomalies : no gross anomalies

Diagnosis : Term / NVD / fetal class / ApgA / 2.89 / Hypothyroid
not cur

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : [Signature]

Name : [Name]

Date & Time : 15/6/26 8:10 AM

Consultant :

Signature : [Signature]

Name : [Name]

Date & Time :



D

- 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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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:

- DBF 2nd leg
- immunization
- SBR (A/B/S) OAE SKD/C
- monitor & inform

*Noted by Subhina
15/6/26
5:50 AM*

Doctor Signature: *L*


Doctor Name: *D. Subhina*

Date & Time: *15/6/26 / 5:50 AM*

VIH-00205911 IP-00060347
 Baby B/O HIRANMAYEE
 15-06-2026 0 Y 0 M 0 D 1 H (F)
 Dr. KODICHERLA VISHNU YARDHAN



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>15/06/26</u> <u>10:30AM</u>	<u>CL/B Resident</u>	DOB - 15/6/26 5:37AM
	Term / 38+1 Ws / NVD / GAB / Female / 2.89kg	
	M.B.G - Aposim O/E C/T / PPOO WS - GS2 RS - BLUBB PA - 582	<u>Ra</u> - DBF / hb bury 2 way - OAB / GBA / NBS b / day - Vaccinal as per schedule - Red Reflex TLM
	Urine / Stool / Passed	
		Vitru noted by note 15/6/26 at 11:30 AM
 Dr. Vishnu Yarden		

VIH-00205911 IP-00060347
 Baby B/O HIRANMAYEE
 15-06-2026 0Y0M0D1H (F)
 Dr. KODICHERLA VISHNU VARDHAN



GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/26 8pm	<u>CLB Resident</u>	
	O/F C/T/A/0000 CR 7C 3/4 CW - S1S2 @ B - BLUAT @ PA - 5/7 Vuy Sdya	<u>Plan</u> - DBF flb. burp/200g - continue same
		@ Dshis
		noted by scsbib 16/6/26 @ 10:15pm

VIH-00205911 IP-00080347
 Baby B/O HIRANMAYEE
 15-06-2026 0Y0M0D5H (F)
 Dr. KODICHERLA VISHNU VARDHAN



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16.6.26 9:00 am	<p>S/A Register</p> <p>Term (AGA) baby girl / <u>HDL-27</u> / <u>Hypothyroid</u> mother / <u>NAD</u></p>	
	<p>O/E baby warm easy. tone } (2) active } H/A - NAD P/A - soft</p>	
	<p>B.wt: 2.895 kg</p>	<p>Plan</p>
	<p>T.wt: 2.810 kg (+85gm)</p>	<p>→ OAE today</p>
	<p>MAG: A+ve</p>	<p>" DBM</p>
	<p>BAG: B+ve</p>	<p>" Warm core.</p>
	<p>Vaccine ✓</p>	<p>HOLD → TCR before discharge.</p>
	<p>Red reflex: present & symmetrical.</p>	<p>" then discharge</p>
	<p>Same</p>	<p>" R/A 48 hours</p>
	<p>(Dr. Sameer)</p>	
		<p><i>[Signature]</i></p>
		<p><i>[Signature]</i></p>
		<p>noted by Swaha 16/6/26 at 10:15 AM</p>



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

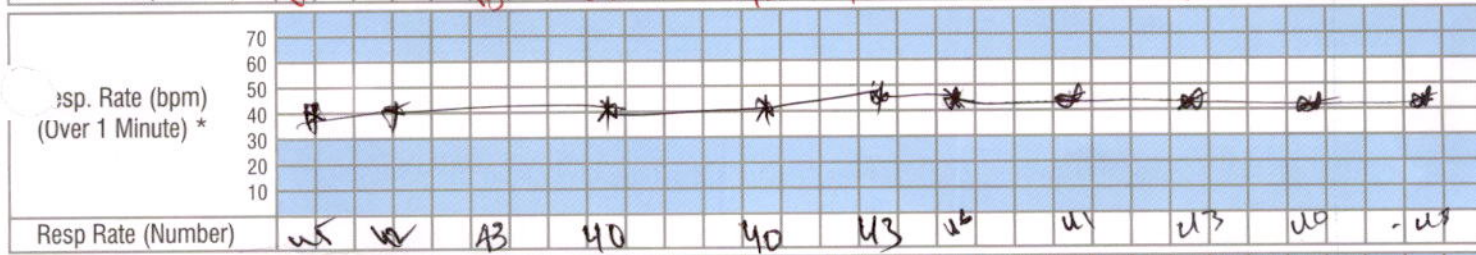
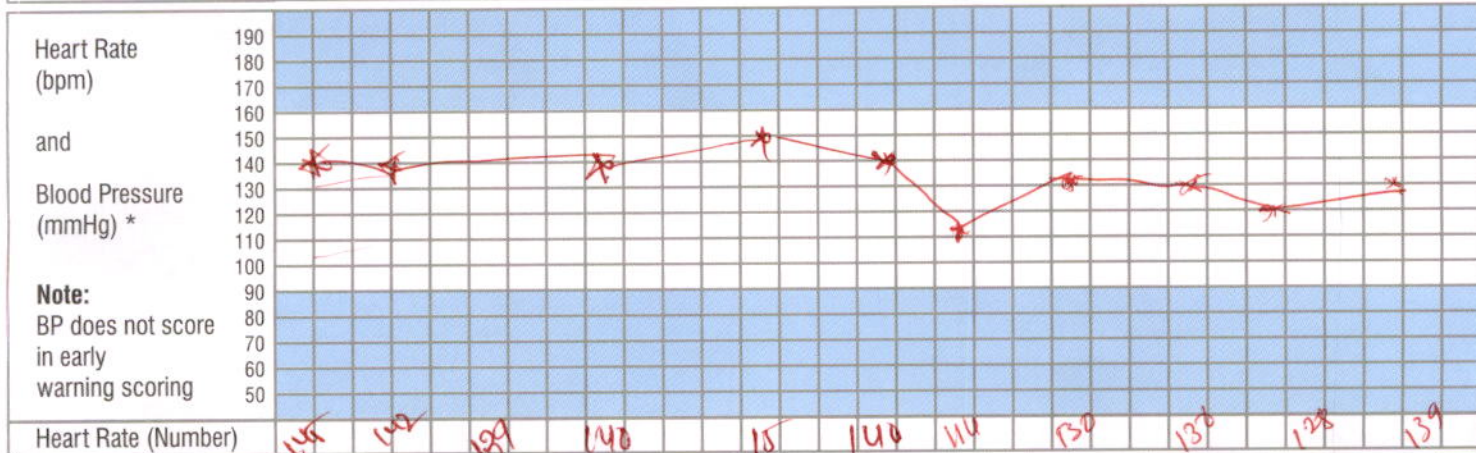
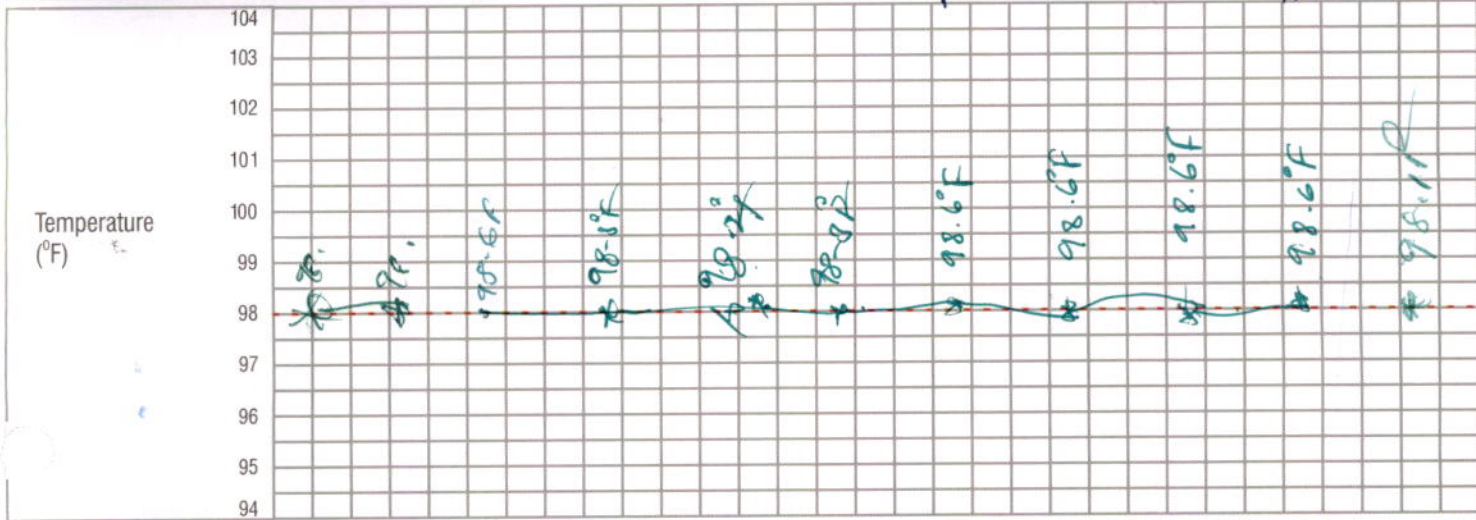
- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

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 Is there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 15/6/26	Time: 8 AM	10 AM	1	3	5	7	10	1	3	6	8
Doctor/Nurse/Family Concern?			PM	PM	PM	PM	PM	AM	AM	AM	AM



Resp Mod/ Severe Distress	None / Mild	✓	✓	N	N	N	N	N	N	N	N
Receiving O ₂ (l/min)	O ₂ Saturations (%)	✓	✓	99	99	99	99	99	99	99	99
Conscious Level	Normal / Altered	N	N	N	N	N	N	N	N	N	N
GCS *		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		g	D	D	D	P	R	N	N	N	N

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.
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Pa



FLUID CHART

Sheet No. : 1

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

		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 :							
15/6/26	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am	DBF					✓				✓	07	
	06:00 am							✓			03	} 15/6/26	
	07:00 am	DBF						✓			02		
Total Intake : DBF						Total Output : passed							
Total 24 hrs. Intake		DBF				Total 24 hrs. Output		passed					

VIH-00205011 IP-00060347
 Baby B/O HIRANMAYEE
 15-06-2026 OYOMOD1H (F)
 Dr. KODICHERLA VISHNU VARDHAN



FLUID CHART

Sheet No. :

②

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			
15/6/26	08:00 am	DBF	✓										
	09:00 am												
	10:00 am	DBF	✓										
	11:00 am												
	12:00 pm	DBF											
	01:00 pm												
Total Intake :						Total Output :							
15/6/26	02:00 pm	DBF											
	03:00 pm												
	04:00 pm	DBF								✓			
	05:00 pm												
	06:00 pm	DBF											
	07:00 pm												
Total Intake :						Total Output :							
15/6/26	08:00 pm	DBF											
	09:00 pm												
	10:00 pm	DBN					✓			✓			
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
16/6/26	02:00 am												
	03:00 am	DBN								✓			
	04:00 am												
	05:00 am	DBN					✓			✓			
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output



FLUID CHART

Sheet No. :

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			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
16/6/26	08:00 am	DBF										1 1 1 1 1 1	Sashi 16/6/26 @10AM
	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							