

ACTIV VIH-00206080 IP-00060420 **ING**

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

Name:
UHID N



Date of Admission : 20/6/26 Time : 10:45am Date of Discharge : _____ Time : _____
 Room / Bed No : 227-2 Ward : micu Suggested Billable bed type : _____
 Consultant : _____ Dept : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/6/26	6:20pm	micu	Room (108)	<i>[Signature]</i>

Cross Consultation Visit

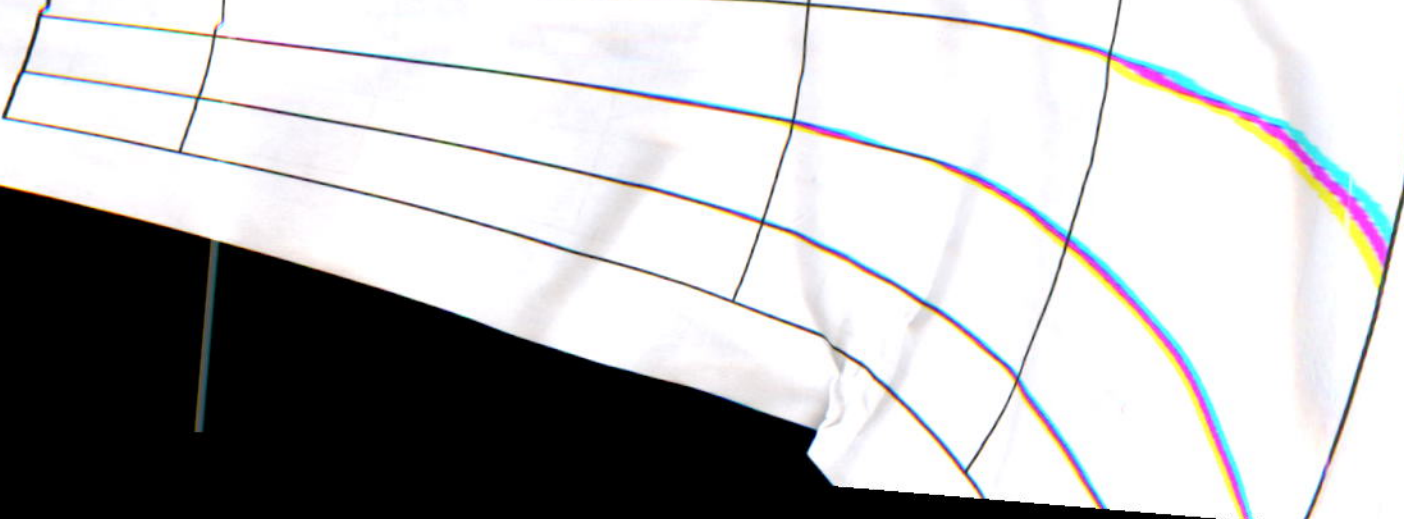
	Doctors Name	Date	Order No.	Signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
20/6/26	Blood Grouping	✓ 126020981	Alex
20/6/26	reticulocyte count, CBP		
20/6/26	bilirubin (indirect fraction)		
20/6/26	DCT		

~~checked by Tina 20/6/26 at 4:40 PM~~

22/6	TCB	26021146	Gm
23/6	SBR	26021259	Gp



Name	Baby B/O SAHARA YASMEEN	UHID	VIH-00206080
Father/Guardian	Mr THANMAI SINGH	Age/Gender	0 Y 0 M 3 D/Female
Address	DOOR NO-401 AIBALA RESIDENCY NAGARAM, Nagaram, Hyderabad, Telangana, INDIA, 500083		
IP No	IP-00060420	Admission Date	20-06-2026
Ref Doctor		Discharge Date	23-06-2026

DISCHARGE SUMMARY

Consultant: Dr. KUNDANA PRIYA ATLURI

MBBS, MD Pediatrics,
Fellowship in Neonatology (IAP)
Consultant Pediatrician & Neonatologist
TSMC-27182

**Diagnosis: Early Term/Appropriate for gestational age/Baby Girl
Rh negative pregnancy
Neonatal hyperbilirubinemia**

Mode of Delivery: Elective Lower Segment Cesarean Section (Indication: High BMI)

Anthropometry:

Weight at birth : 2.87 kg
Weight at discharge : 2.88 kg
Head circumference : 32 cms
Length : 45 cms

History: Baby of SAHARA YASMEEN is a early term (37+1 weeks) baby girl, delivered to a Multigravida mother by elective Lower Segment Cesarean Section (Indication: High BMI) on 20.06.2026 at 9:16 am with birth weight of 2.875 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. Inj. Vitamin-K 1mg IM was given after delivery.

Name

Baby B/O SAHARA
YASMEEN

UHID

VIH-00206080

Maternal History: Mrs. SAHARA YASMEEN is a 33 years old Multigravida (G3P1A1L1) mother.

G3 - Present pregnancy, spontaneous conception, had regular ANC's. Antenatal scans were normal. No history of Pregnancy-Induced Hypertension / Urinary Tract Infection / Antepartum Hemorrhage / Oligohydramnios / Polyhydramnios / Fever. Mother's blood group is "O" Negative. Baby's blood group is "O" 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: Hospital stay was uneventful.

In view of Rh negative pregnancy, hemogram, Direct coombs test and reticulocyte count were done. Hemogram showed Hemoglobin of 11.8 gm%, White blood cells count of 16,360 cells/cumm and platelet count of 3.23 lakhs/cumm. Direct coombs test was Positive (4+). Reticulocyte count 6.5%.

Transcutaneous bilirubin done on 22.06.2026 was 16 mg/dl for which double surface phototherapy was started. Repeat serum bilirubin before discharge was 8.2 mg/dl with indirect fraction of 8.0 mg/dl, it does not come under phototherapy range, hence phototherapy was stopped.

Vaccination: Baby was given following vaccination:

BCG / OPV / Hepatitis-B on : 21.06.2026

Hearing test (TEOAE): Done on 22.06.2026 was normal.

Name

Baby B/O SAHARA
YASMEEN

UHID


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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Newborn screening (Advanced): to be done on follow up.

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 insufficient mother feed, baby was started on top-up formula 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. New Born Screening (Advanced) / Thyroid Function Test to be done 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. Atluri Kundana Priya, Consultant Pediatrician & Neonatologist, on 27.06.2026 (Saturday) 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.

Name

Baby B/O SAHARA
YASMEEN

UHID

VIH-00206080

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 : *Ranmay Singh*

Signature : 

Relationship with patient : *Father*

This summary has been explained by :

Summary prepared by : Dr. Sameera
DEO : MD Younus Pasha

Registrar/Resident/C.M.O

For Sameera

Dr. KUNDANA PRIYA ATLURI

MBBS, MD Pediatrics,

Fellowship in Neonatology (IAP)

Consultant Pediatrician & Neonatologist

TSMC-27182

PatientName : Baby B/O SAHARA YASMEEN
Age/Gender : 0 Y 0 M 0 D 3 H/ Female
Ward/Bed : N 2F-MICU/ CRDL-MICU-227-2

Inpatient No. : IP-00060420
Admit Date : 20-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
BILIRUBIN (INDIRECT / DIRECT) (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :20-06-2026 11:01
TOTAL BILIRUBIN (Azobilirubin)	4.0	mg/dl	
CONJUGATED BILIRUBIN (Spectrophotometric)	0.1	mg/dl	<0.6
UNCONJUGATED BILIRUBIN (Spectrophotometric)	3.9	mg/dl	



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
BLOOD GROUPING (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :20-06-2026 11:01
BLOOD GROUP	O		
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
COMPLETE BLOOD PICTURE (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :20-06-2026 11:01
HEMOGLOBIN (Colorimetry)	11.8	g/dL	L 14.25 - 22.5
RBC COUNT (DC detection method)	3.22	10 ¹² /L	L 4 - 6.6
PCV/HCT (Calculated)	33.4	VOL%	L 45 - 67
MCV (Calculated)	103.9	fL	95 - 121
MCH (Calculated)	36.6	pg/cells	31 - 37
MCHC (Calculated)	35.2	g/dL	29 - 37
RDW-CV (Calculated)	14.6	%	13 - 18
PLATELET COUNT (DC Detection Method)	323	10 ⁹ /L	150 - 450
MPV (Calculated)	7.8	fL	6.5 - 10
WBC COUNT (DC Detection Method)	16.36	10 ⁹ /L	9 - 35
Differential Count			
NEUTROPHILS (Microscopy, Leishman stain)	62	%	32 - 62
LYMPHOCYTES (Microscopy, Leishman stain)	30	%	H 19 - 29

PatientName	: Baby B/O SAHARA YASMEEN	Inpatient No.	: IP-00060420
Age/Gender	: 0 Y 0 M 0 D 2 H/ Female	Admit Date	: 20-06-2026
Ward/Bed	: N 2F-MICU/ CRDL-MICU-227-2	Discharge Date	:

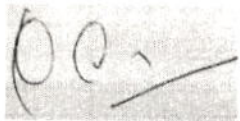
Investigation	Result	Unit	Biological Reference Interval
MONOCYTES (Microscopy, Leishman stain)	04	%	L 6 - 18
EOSINOPHILS (Microscopy, Leishman stain)	04	%	1 - 4
PERIPHERAL SMEAR (Microscopy, Leishman stain)	RBC : ANISOCYTOSIS WITH NORMOCYTIC / HYPOCHROMIC 4-6 nRBC/100WBC MICROCYTES(+) WBC : MORPHOLOGY NORMAL PLATELETS : ADEQUATE		



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
DIRECT COOMBS TEST (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :20-06-2026 11:01
DIRECT COOMBS TEST	POSITIVE (4+)		


Dr. SUREKHA DEVI ALLANKI, SENIOR CONSULTANT, TRANSFUSION
CONSULTANT,

Investigation	Result	Unit	Biological Reference Interval
RETICULOCYTE COUNT (Specimen : BLOOD)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :20-06-2026 11:01
RETICULOCYTE COUNT (Microscopy, New methylene blue stain)	6.5	%	H 2 - 6



Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

Investigation	Result	Unit	Biological Reference Interval
TRANSCUTEANOUS BILIRUBIN			TEST RESULT STATUS : REPORT AUTHORISED Order Date :22-06-2026 07:44
TRANSUTANEOUS BILIRUBIN	16	mg/dl	

Mrs MARY ELIZABETH

Investigation	Result	Unit	Biological Reference Interval
BILIRUBIN (INDIRECT / DIRECT) (Specimen : SERUM)			TEST RESULT STATUS : REPORT AUTHORISED Order Date :23-06-2026 07:31

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 ,500002
040-42462200, Ext 2000,2001,2002,



PatientName : Baby B/O SAHARA YASMEEN
Age/Gender : 0 Y 0 M 3 D/ Female
Ward/Bed : N 2F-MICU/ CRDL-MICU-227-2

Inpatient No. : IP-00060420
Admit Date : 20-06-2026
Discharge Date :

Investigation	Result	Unit	Biological Reference Interval
TOTAL BILIRUBIN (Azobilirubin)	8.2	mg/dl	<8.2
CONJUGATED BILIRUBIN (Spectrophotometric)	0.2	mg/dl	<0.6
UNCONJUGATED BILIRUBIN (Spectrophotometric)	8.0	mg/dl	H 0.6 - 7.6

Dr. SRUJANA SHYAMALA, MD, DNB

Consultant Pathologist, Reg No : 39356

ADMISSION SHEET

Registration Details :



Admission No : IP-00060420

Admit Date : 20-Jun-2026

Admit Time : 10:42 AM UHID : VIH-00206080

Patient Details :

Patient Name : Baby B/O SAHARA YASMEEN

Age : 0 D

Guardian : Mr THANMAI SINGH

DOB : 20-06-2026 09:16 AM

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : DOOR NO-401 AIBALA RESIDENCY NAGARAM
Nagaram Hyderabad Telangana INDIA
500083

Phone No : 8143883013

E-mail : NA@GMAIL.COM

Admission Details :

Bed Type : BASINET

Bed No : CRDL-MICU-227-2

Ward Name : N 2F-MICU

Room No : CRDL-MICU-227-2

Admission Type : First Visit

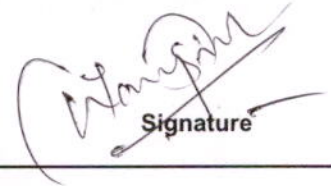
Contact Details :

Name : Mr THANMAI SINGH

Relationship : Father

Contact Address : DOOR NO-401 AIBALA RESIDENCY
NAGARAM Nagaram Hyderabad Telangana
INDIA 500083

Phone No : 8143883013 / 6301542302



Signature

Doctor Details :

Doctor Name : Dr. ATLURI KUNDANA PRIYA

Specialisation : GENERAL PEDIATRICS

Referral Doctor :

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY

PATIENT TRANSFER FORM

VIH-00206080 IP-00060420
Baby B/O SAHARA YASMEEN
20-06-2026 0 Y 0 M 0 D 1 H (F)
Dr. ATLURI KUNDANA PRIYA



Date & Time of Admission <i>20/6/26 @ 10:40am</i>		Date & Time of Transfer Order <i>20/6/26 @ 6:10PM</i>
Treating Consultant Name <i>—</i>	Transfer Ordered by <i>Dr. Kundana</i>	Reason for Transfer <i>Observation</i>
From Unit <i>m/cu</i>	To Unit <i>Room (108)</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>28</i>	Number of Imaging Films <i>—</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	<i>small kushies</i>	<i>1</i>
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Name & Signature of Person who is Transferring <i>Sis. [Signature]</i>	Name of Person Ordered Transfer <i>Dr. Kundana</i>
---	---

Patient & Clinical Records Received by :
[Signature]

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

VIH-00206080 IP-00060420
Baby B/O SAHARA YASMEEN
20-06-2026 0 Y 0 M 0 D 1 H (F)
Dr. ATLURI KUNDANA PRIYA



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/O: Sahara Yasmeen Mother's Name: MDS: Sahara Yasmeen
Date of Birth: 20/6/26 Time of Birth: 9:16:46sec AM Gender: Male Female
Birth Weight: 2.875 kg Kgs HC: cm Lenght: cm
Meconium in Liquor: Yes No Cried at Birth: Yes No
Term/Pre-term/Post-term: Term
Resuscitated: Yes No Blood Group: Mother: O Negative Baby:
Feeding: Breast Feeding Formula Both First Feed Time: 10:00 AM

VIH-00206073 IP-00060416
Mrs SAHARA YASMEEN
03-08-1992 33 Y 10 M 17 D (F)
Dr. PRASHANTHI ELIZABETH

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

Physical Assessment of New Born:

Temp: 98.02 °C HR: 160 /Min RR: 35 /Min BP: SpO₂: 99%

Pain Score: (Follow N Pass)

Fall Risk Assessment: Yes No Score: 1.5 (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: S. Shekhavathi

Signature: [Signature]

Date & Time: 20/6/26 @ 11 AM

VIH-00206080 IP-00060420
Baby B/O SAHARA YASMEEN
20-06-2026 0 Y 0 M 0 D 1 H (F)
Dr. ATLURI KUNDANA PRIYA



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B.O. Sahara Yasmeen Mother's Name: Mrs S. Sahara Yasmeen

Date of Birth: 20/6/26 Time of Birth: 9.16.46 Secam Gender: Male Female

Birth Weight: Kgs HC: cm Length: cm

Meconium in Liquor: Yes No Cried at Birth: Yes No

Term / Pre-term / Post-term:

Resuscitated: Yes No Blood Group: Mother: Baby:

Feeding: Breast Feeding Formula Both First Feed Time:

VIH-00206073 IP-00060416
Mrs SAHARA YASMEEN
03-08-1992 33 Y 10 M 17 D (F)
Dr. PRASHANTHI ELIZABETH

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

Indication: Elective LSCS

Physical Assessment of New Born:

Temp: °C HR: /Min RR: /Min BP: SpO₂:

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: Anil

Signature: Anil

Date & Time: 20/6/26 @ 6.40pm



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Sahara Yasmeen Age : Father's Name : Age :
 Date of Birth : 3/8/92 Date of Admission : UHID No.:
 NICU Consultant : Dr. Kundana Referring Consultant : Dr. Prashanthu
Transferring Unit : OT Labour Room ER Ward
Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : B/o yasmeen Mother's Blood Group : O Negative
 Gender : M F Blood Group : Birth Weight (gms) : 2.875kg Length (cms) :
 Date of Birth : 20/6/26 Time of Birth : 9:16:42 AM OFC (cms) :
 Place of Birth : NH - V.K.P. Estimated Gesth Age : 37+1 w/c

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 33yr Ht : Wt : BMI : Married Life : 9yr LMP : 2/10/25 EDD : 9/7/26

Conception : Spontaneous or with Rx : Spontaneous

Booked at what GA : Unbooked to null AN Steroids Drugs / Doses : Amor D taken at 28 wk

Last Scans Details : 35th w/c 21 w/c (cephalic) Pl-Aneurism AB -129 cm

Acidosis: EFW - 2.5 ± 529 gm 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 :
Ecosprin 75mg OD.

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 : (A)

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 :

History of Present Illness:

target spot
reached at
2nd of life

Delivered via H. LSC
↓
Baby good
↓
CIAB
↓
Dix done for coffee
↓
Seems man cleared
↓
cord clamp cut 2A+IVB
↓
Inf. Vit K given ita
↓
Baby vigorous

Investigation details in previous Hospital :

shift to mother side

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

CIA good

VITALS : Temperature : 36.5°F HR : 160/min RR : 39/min NIBP : CFT :

Color of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 98% RA

Anthropometry : Birth Weight : 2.875kg Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

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

Facies :
(Any Facial
Dysmorphism)

NECK and CLAVICLES : Range of Motion :
Asymmetry : | (N)
Masses :

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

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



THORAX and BREASTS : Shape of Thorax : _____
 Position of Nipples and Number : 2 An no at per h u

ABDOMEN and UMBILICUS : Shape : _____
 Organomegaly : _____
 Bowel Sounds : (⊙ 2 A + V ⊙)
 Umbilical Stump : _____
 Discharge : _____

GENITALIA : Labia / Hyman : _____
 Testicles/penis : _____
 Anus : _____

HERNIAL ORIFICES free

TRUNK and SPINE : ⊙

SKIN LESIONS : _____

EXTREMETIES : Fingers / Toes : _____ Arms / Legs : _____
 Deformities : 10E + 10T ⊙ Mobility : _____
 Hip Joint Examination : _____

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 (Pa) Auscultation : RA ⊙ Breath Sounds : WLP ⊙ Added Sounds : r

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

Abdomen : Hernia orifice : free
 Shape : _____ Anal Patency : ⊕
 Palpation : Soft Umbilical Cord : 2 A + V ⊕
 Palpable masses : _____ First urine passed : _____
 Abdominal girth : _____ Meconium passed : _____

Nervous System : 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 : DTR :

ATNR : Skull and Spine :

Any Congenital Anomalies :

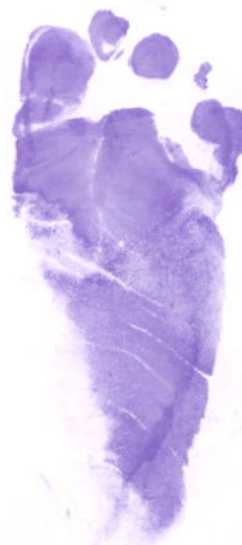
Diagnosis : Term / E. Sec 1 / Rh -ve / Fem / GAS / 2.8g / AEA

FOOT PRINTS

Left Side :



Right Side :



*Taken by
Pravone*

Resident Doctor :

Signature : *[Signature]*

Name : *Dr. Shrikar*

Date & Time : *20/4/26 / 9:40 am*

Consultant :

Signature : *[Signature]*

Name : *Dr. Dipanwita*

Date & Time : *21/6/26 9AM*

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 :

.....

.....

.....

.....

.....

.....

.....

.....

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Discharge Details:

Neonatal Condition at Discharge:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

VIH-00206080 IP-00060420
Baby B/O SAHARA YASMEEN
20-06-2026 0 Y 0 M 0 D 1 H (F)
Dr. ATLURI KUNDANA PRIYA



usively 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 2ndly
- CBP, PCF, Rbc count, Blood Grouping, SBR
- immunization
- monitis of inform (see)
Noted by Venitha 20/6/26 @ 9.45hr

Doctor Signature: 

Doctor Name: Dr. Srikrishna

Date & Time: 9:42 am / 20/6/26



GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/6/26 9AM	S/B Resident.	
	Term / e/e/e/e / Plu-eu pregnancy / Fch / 2.87kg / AGA	
	Baby wtm	
	C/T/A good	
	CRT e/e/e	
	CRS - 8/8 ⊕	
	P/A - BAE ⊕	
	P/A - 8/8	
		plan
VACC: TODAY		1) Trace. reports
		2) DBF Hbip (Purpury) Q2H
		3) Vaccination slow
OAE J/Tm		4) OAE T/m
TCB J/Tm		TCR T/m
Dr. Kundana 21/6/26 9AM	Dr. Kundana	Noted by Benprika 21/6/26 @ 2pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>S/B Resident</u>	
21/6/25 3PM	o/e Baby warm c/T/A good CRT CSsec CVI - 6 1/2 (P) epi - BAE (P)	
		Play 1) DBF / by Nursing Order 2) TCR T/m OAE T/m.
20/6/2025		3) Perform sus
		Noted by Subhan 21/6/26 @ 7PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/6/2026 8:30 AM	37+1 / ♀	2.875 ↓ 2.750 G3 P1A1 L4 ELLSU SCM1-Ⓜ
M - O ⁻ B - B ⁺	C/A Good CRT < 3 sec AF Ⓜ CVS more - E fetal. CMA RS Ⓜ PA	HOL-D2/47.
LBR 11 AM	<p>ICB-16 forming above the tongue.</p> <p>↓</p> <p>advised DSPT.</p> <p>up plan discussed 22/6/26 9 AM</p>	<p>Plan</p> <ul style="list-style-type: none"> - OAE TD - IF DSPT started - Repeat SBRT/M - Continue stent. - vitals 6 hrly. - Inform SAs <p>Dr. _____</p> <p>Noted by Beenuka 22/6 @ 2 PM</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22.6.26	<p>lactation notes (Mrs. Ranjitha)</p> <ul style="list-style-type: none"> • 2nd time Mother • Normal breast condition. • Drops of milk seen • Baby is undergoing phototherapy • Advised to feed every 2-3hrs • DBF-IF • To track the feeding in the sheet given 	
12:10pm		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>22/6/26 4:30 PM Day 3 of life</p>	<p>S/B Resident</p>	
	<p>Term / ELLCCe / Rh -ve pregnancy / Fch / 2-8 kg / AGA</p>	
	<p>Baby warm</p>	<p>NIUHB</p>
	<p>CT/A good</p>	
	<p>CRV clear</p>	
	<p>CVS - HSA (+)</p>	
	<p>R/S - BAE (+)</p>	
	<p>PIA - soft</p>	
		<p>plan</p>
	<p>1)</p>	<p>Continue DSPT</p>
	<p>2)</p>	<p>Repeat SBR T/m. 6 AM.</p>
	<p>3)</p>	<p>DBF flby Burping Q4H</p>
	<p>4)</p>	<p>warmth cord care</p>
	<p>5)</p>	<p>monitor vitals</p>
<p>Dr. Ushwaja</p>		<p>noted by Bevonika 22/6/26 @ 8pm</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/6/26 8:30 AM	S/B Resident	
	Term / (LUSC) / (ph sup neg) Fch / (2.83kg) / ASA UNHB	
	Baby warm c/T/A good CRT < 3 sec	
	CVC - S12 (+)	
	R/S - BAE (+)	
	P/A - R/T	Plan
	SBR < 0.2 S2 > 8.0	<ol style="list-style-type: none"> 1) DBF d/hy Burry Am 2) Alarmite, cord care 3) plan d/c Today 4) BAE done
Dr. Uthappa	d/c TODAY	vaccination done
	fw after 5 days	5) R/w Saturday
Dr. Kundana	23/6/26 9 AM	Noted by Subbar 23/6/26 @ 10:30 AM

VIH-00206080 IP-00060420
 Baby B/O SAHARA YASMEEN
 20-06-2026 0 Y 0 M 0 D 1 H (F)
 Dr. ATLURI KUNDANA PRIYA



FORM / CLINICAL / (24)

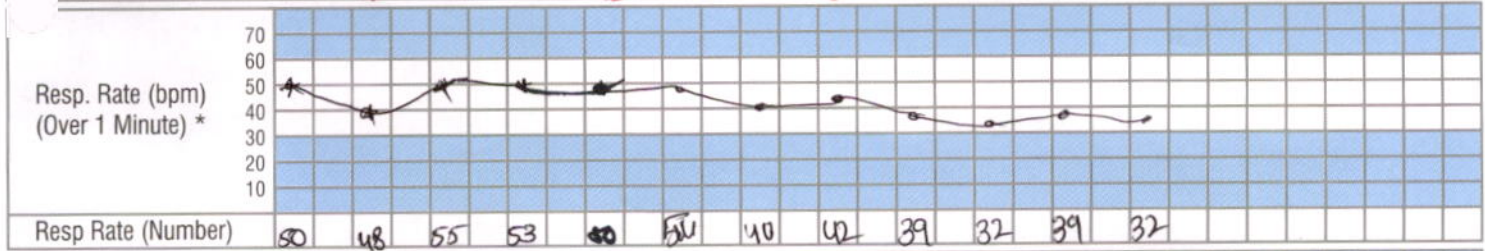
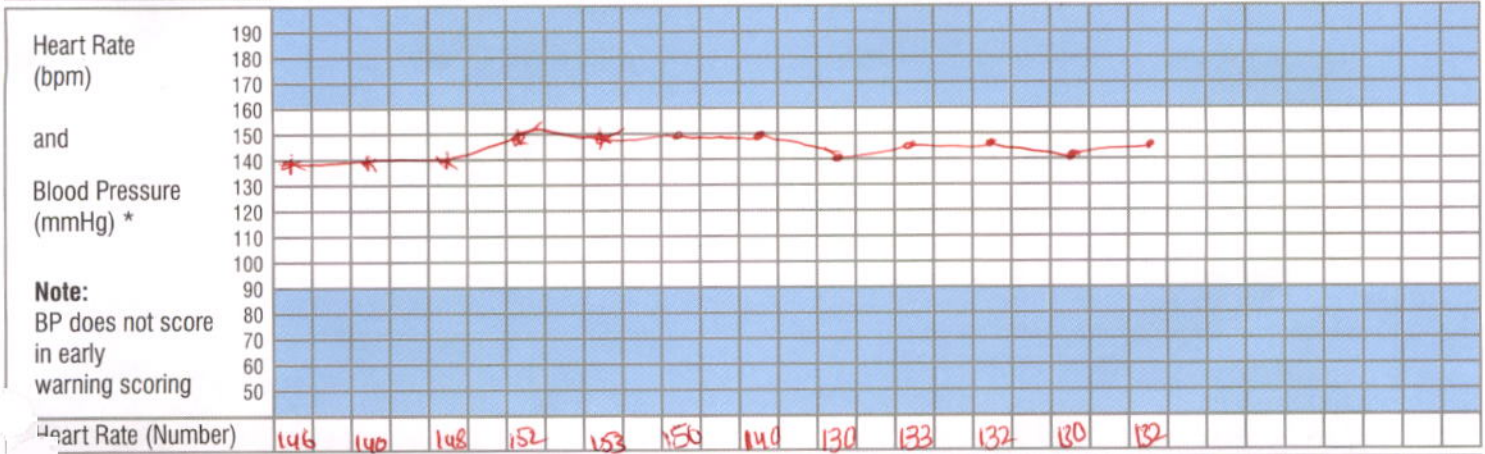
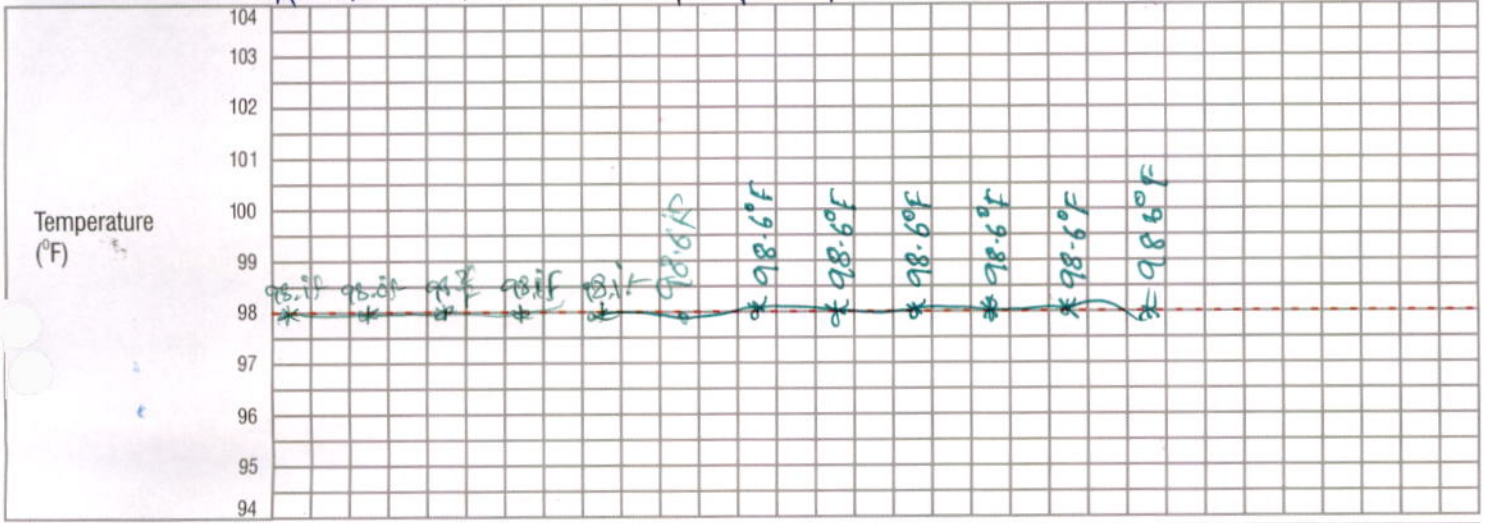
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 20/6/26 Time: 10 12 2 4 6 8 9 11 1 3 5 7

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



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

TOTAL SCORE	Number of shaded boxes	0	0	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	K	B	K	K	K	A	M	M	M	M	M	M

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-00206080 IP-00060420
 Baby B/O SAHARA YASMEEN
 20-06-2028 0 Y 0 M 0 D 1 H (F)
 Dr. ATLURI KUNDANA PRIYA

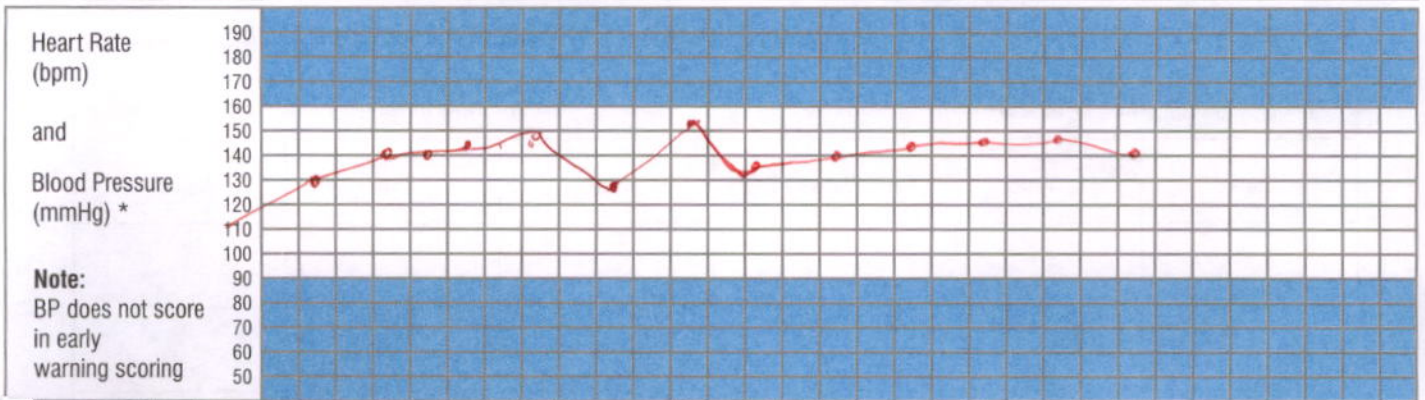
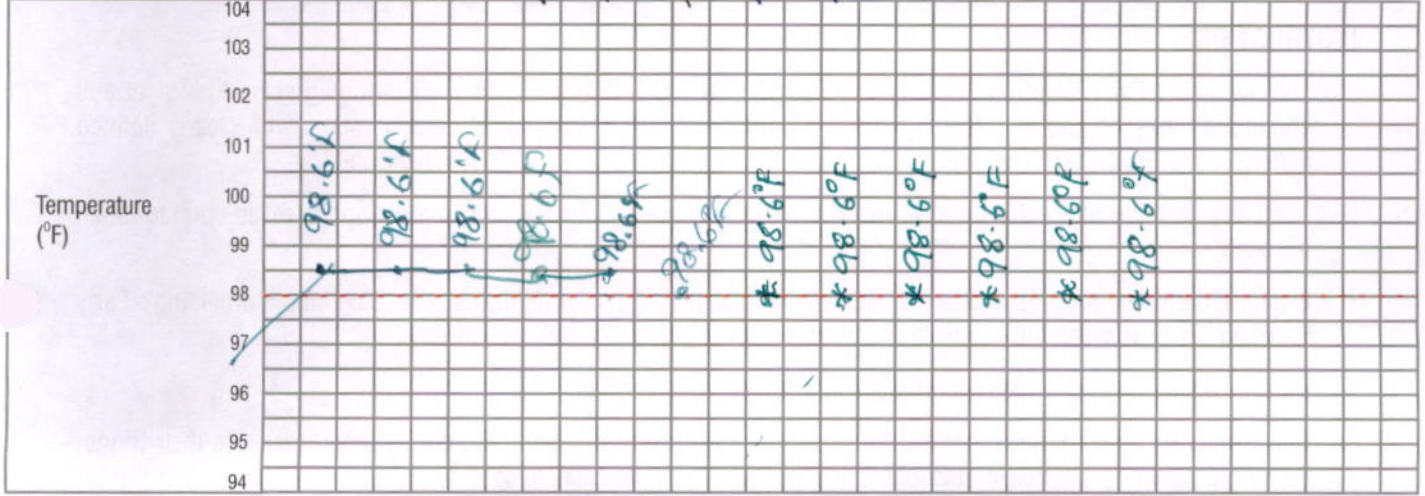
RCH/ FRM / CLINICAL / 124

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 21/6/26	Time: 9	11	1	3	5	7	9	11	1	3	5	7
Doctor/Nurse/Family Concern?	AM	AM	PM	PM	PM	PM	PM	PM	AM	AM	AM	AM



Heart Rate (Number)	130	140	142	150	129	151	129	130	132	134	135	130
---------------------	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----



Resp Rate (Number)	38	40	42	44	50	48	39	42	40	38	37	42
--------------------	----	----	----	----	----	----	----	----	----	----	----	----

Resp Distress	None	None	None	None	None	None	None	None	None	None	None	None
Mod/ Severe Distress	None	None	None	None	None	None	None	None	None	None	None	None

Receiving O ₂ (l/min)	0	0	0	0	0	0	0	0	0	0	0	0
O ₂ Saturations (%)	99	98	98	99	95	96	97	98	99	98	99	98

Conscious Level	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal
Normal Level	N	N	N	N	N	N	N	N	N	N	N	N
Altered												

GCS *	15	15	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	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	B	B	B	A	SK	SK	M	M	M	M	M	M

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)

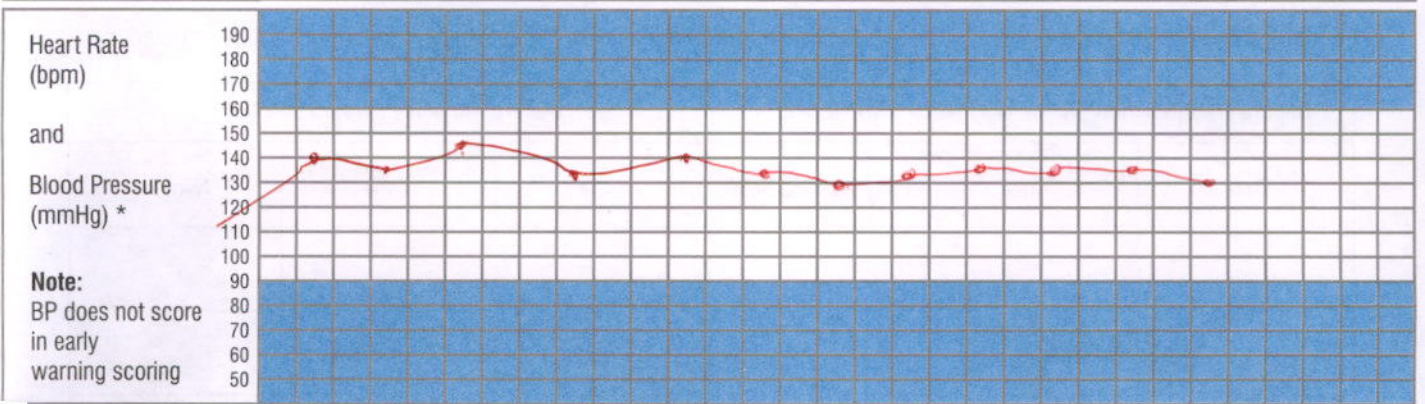
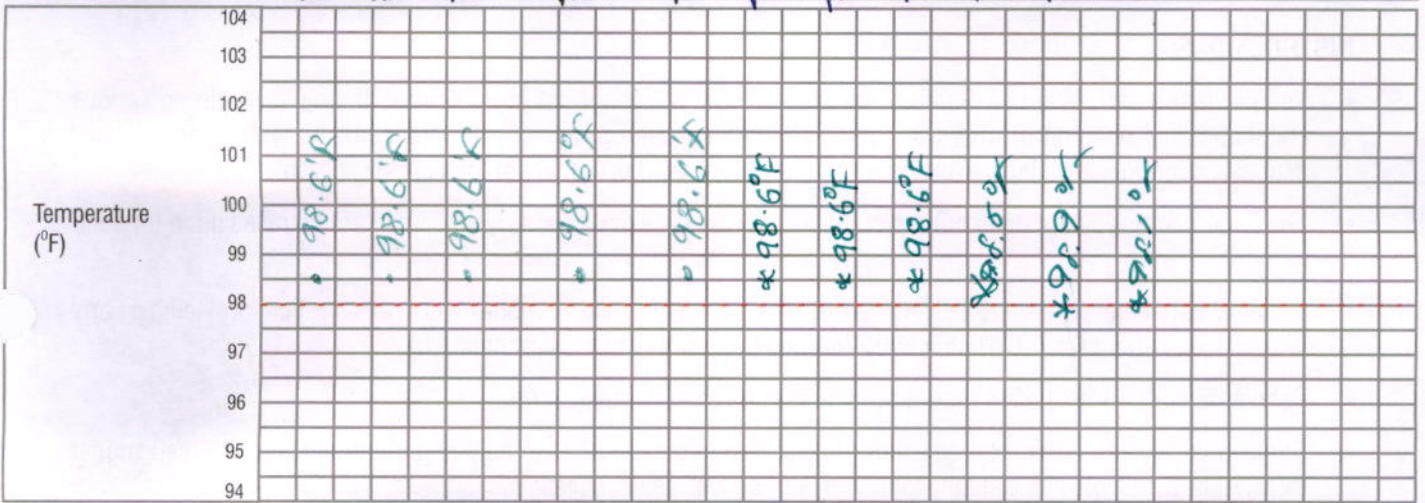


INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart

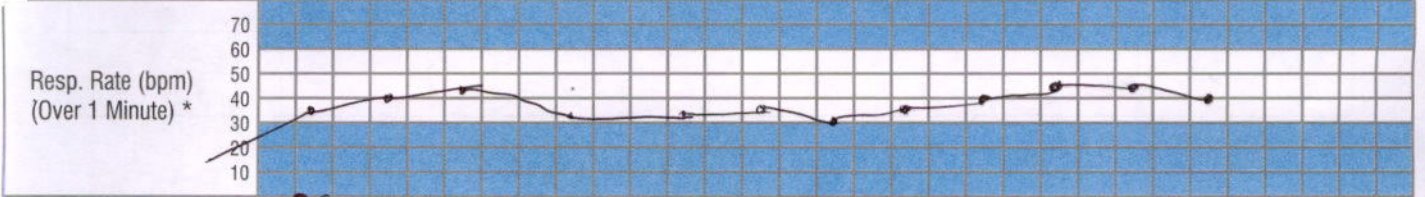


EARLY WARNING SCORE: CHILDREN'S UNIT

Date: <u>22/6/26</u> Time:	9	11	1	4	7	9	11	1	3	5	7
Doctor/Nurse/Family Concern?	am	am	pm	pm	pm	pm	pm	pm	pm	am	am



Heart Rate (Number)	140	138	145	135	140	135	130	132	139	135	134	130
---------------------	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----



Resp Rate (Number)	35	40	42	32	33	32	30	34	40	43	42	30
--------------------	----	----	----	----	----	----	----	----	----	----	----	----

Resp Distress	None	None	None	None	None	None	None	None	None	None	None	None
Receiving O ₂ (l/min)	0	0	0	0	0	0	0	0	0	0	0	0
O ₂ Saturations (%)	99	100	98	99	100	99	98	99	100	99	99	99
Conscious Level	N	N	N	N	N	N	N	N	N	N	N	N
GCS *	15	15	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	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0	0	0
Observer's Initials	B	B	B	B	B	M	M	M	M	M	M	M

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)

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)



FLUID CHART

Sheet No. :

20/6/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
20/6	08:00 am				Nil							
	09:00 am											
	10:00 am	DBF										
	11:00 am	DBF								✓		
	12:00 pm											
	01:00 pm	DBF								✓		
	Total Intake :			Total Output :								
20/6	02:00 pm						✓					
	03:00 pm	DBF								✓		
	04:00 pm											
	05:00 pm											
	06:00 pm	DBF								✓		
	07:00 pm											
Total Intake :			Total Output :									
	08:00 pm											
	09:00 pm	DBF								✓		
	10:00 pm	PPP										
	11:00 pm											
	12:00 am	DBF										
	01:00 am	PPP										
Total Intake :			Total Output :									
	02:00 am									✓		
	03:00 am	DBF										
	04:00 am	PPP										
	05:00 am											
	06:00 am	DBM										
	07:00 am	PPP								✓		
Total Intake :			Total Output :									
Total 24 hrs. Intake			Total 24 hrs. Output									

VIH-00206080 IP-00060420
 Baby B/O SAHARA YASMEEN
 20-06-2026 0 Y 0 M 0 D 1 H (F)
 Dr. ATLURI KUNDANA PRIYA

FLUID CHART

Sheet No. : (2)

21/6/26

- 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	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
21/6	08:00 am											} @ 1pm	
	09:00 am	DBM					✓			✓			
	10:00 am	DBM											
	11:00 am	FF											
	12:00 pm						✓			✓			
	01:00 pm												
Total Intake :						Total Output :							
21/6	02:00 pm	DBM										} @ 8pm	
	03:00 pm	+ FF								✓			
	04:00 pm												
	05:00 pm												
	06:00 pm	DBM +											
	07:00 pm	FF					✓			✓			
Total Intake :						Total Output :							
21/6	08:00 pm	DBM +										} @ 21/6	
	09:00 pm	FF											
	10:00 pm									✓			
	11:00 pm	DBM +											
	12:00 am	FF											
	01:00 am									✓			
Total Intake :						Total Output :							
22/6	02:00 am	DBM +										} @ 22/6	
	03:00 am	FF											
	04:00 am									✓			
	05:00 am	DBM +					✓						
	06:00 am	FF											
	07:00 am									✓			
Total Intake :						Total Output :							

Total 24 hrs. Intake []

Total 24 hrs. Output []

VIH-00206080 IP-00060420
 Baby B/O SAHARA YASMEEN
 20-06-2026 0 Y 0 M 0 D 12 H (F)
 Dr. ATLURI KUNDANA PRIYA



FLUID CHART

Sheet No. : 3

22/6/26

- 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	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
22/6/26	08:00 am												
	09:00 am	Dona								✓			Benanka 22/6/26 @2pm
	10:00 am	30ml FF											
	11:00 am												
	12:00 pm	Aptamil 30ml								✓			
	01:00 pm												
Total Intake :						Total Output :							
22/6	02:00 pm												Benanka 22/6 @7pm
	03:00 pm	Aptamil 45 ml											
	04:00 pm												
	05:00 pm	Aptamil 40ml					✓						
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
22/6	08:00 pm	Aptamil 60ml											Manisha
	09:00 pm									✓			
	10:00 pm	Aptamil 35ml											
	11:00 pm						✓						
	12:00 am	Aptamil 40ml									0		
	01:00 am												
Total Intake :						Total Output :							
23/6/26	02:00 am												Manisha 23/6/26 @8am
	03:00 am	FF + 40ml					✓			✓			
	04:00 am												
	05:00 am	FF + 60ml								✓	0		
	06:00 am												
	07:00 am	FF +											
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART

Sheet No.: 4

23/6/26

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

		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							
23/6	08:00 am									20ml		<div style="font-size: 1.5em;">17</div> <div style="font-size: 1.5em;">06/8</div> <div style="font-size: 1.5em;">23/6</div> <div style="font-size: 1.5em;">@ 10:45</div>
	09:00 am		DBP									
	10:00 am		FF									
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											<div style="font-size: 2em;">/</div>
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											<div style="font-size: 2em;">/</div>
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											<div style="font-size: 2em;">/</div>
	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

