

VIH-00206107 IP-00060424
Baby B/O SRI DIVYA VEETUKURI
20-06-2026 0 Y 0 M 0 D 4 H (F)
Dr. ATLURI KUNDANA PRIYA

ACTING



Name: _____

UHID No : _____ IP No : _____ Consultant : _____ Dept : _____

Date of Admission : 20/6/26 Time : 6:20pm Date of Discharge : 23/6/26 Time : 10

Room / Bed No : _____ Ward : micu Suggested Billable bed type : _____

WARD TRANSFERS

| Date | Time | From | To | Signature of Nurse |
|----------------|------------|-------------|------------|--------------------|
| <u>20/6/26</u> | <u>11u</u> | <u>micu</u> | <u>214</u> | <u>S</u> |
| | | | | |
| | | | | |
| | | | | |

Cross Consultation Visit

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

INVESTIGATIONS

| Date | Investigations | Order No. | Sign |
|---|-----------------------|------------|-------------|
| 20/6/26 | GRBS 6mg/dl 6:30pm | 26021032 ✓ | [Signature] |
| 20/6/26 | blood group Bg | 26021032 ✓ | [Signature] |
| <u>cross checked by manager 20/6/26 @ 11:30pm</u> | | | |
| 21/6/26 | GRBs at 1am - 65mg/dl | 26021038 ✓ | [Signature] |
| 22/6/12 | CRSS 7am - 64mg/dl | 26021039 ✓ | [Signature] |
| 21/6/26 | GRBS - 1pm - 72mg/dl | 26021097 ✓ | [Signature] |
| 21/6/26 | GRBS - 7pm - 63mg/dl | 26021098 ✓ | [Signature] |
| 22/6/12 | CRSS 1am - 64mg/dl | 26021114 ✓ | [Signature] |
| 22/6/12 | CRSS 7am - 56mg/dl | 26021145 ✓ | [Signature] |
| 22/6/12 | TCB | 26021182 ✓ | [Signature] |
| <u>cross check by [Signature]</u> | | | |

ADMISSION SHEET

Registration Details :



Admission No : IP-00060424

Admit Date : 20-Jun-2026

Admit Time : 06:20 PM UHID : VIH-00206107

Patient Details :

Patient Name : Baby B/O SRI DIVYA VEETUKURI

Age : 0 D

Guardian : Mr SRINIVAS

DOB : 20-06-2026 03:20 PM

Gender : Female

Religion :

Occupation :

Martial Status :

Address (H) : 2-2-220/56 , SRI SAI SURYA ENCLAVE
Bolaram Hyderabad Telangana INDIA 110005

Phone No : 9490478679/ 8106318960

E-mail : na123@gmail.com

Admission Details :

Bed Type : BASINET

Bed No : CRDL-MICU-229-1

Ward Name : N 2F-MICU

Room No : CRDL-MICU-229-1

Admission Type : First Visit

Contact Details :

Name : Mr SRINIVAS

Relationship : Father

Contact Address : 2-2-220/56 , SRI SAI SURYA ENCLAVE
Bolaram Hyderabad Telangana INDIA 110005

Phone No : 9490478679


Signature

Doctor Details :

Doctor Name : Dr. ATLURI KUNDANA PRIYA

Specialisation : NEONATOLOGY

Referral Doctor :

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY

PATIENT TRANSFER FORM

VIH-00206107 IP-00060424

Baby B/O SRI DIVYA VEETUKURI
20-06-2026 0 Y 0 M 0 D 4 H (F)
Dr. ATLURI KUNDANA PRIYA



| | | |
|--|--|---|
| Date & Time of Admission <i>20/6/26 at 6:20</i> | | Date & Time of Transfer Order <i>20/6/26 at</i> |
| Treating Consultant Name | Transfer Ordered by <i>Dr.</i> | Reason for Transfer <i>observation</i> |
| From Unit <i>micu</i> | To Unit | Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Number of Sheets in Clinical File <i>29</i> | Number of Imaging Films <i>10/1</i> | 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. | <i>small kneeheels - ①</i> | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

Shifting Summary / Notes Written by Doctor : Yes No

| | |
|--|---|
| Name & Signature of Person who is Transferring <i>Dr. S.S. Ravi</i> | Name of Person Ordered Transfer <i>Dr.</i> |
|--|---|

Patient & Clinical Records Received by :
Sony

Date & Time of Patient Received : *21/6/26 @ 12:30 AM*

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



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Blo. Divya Mother's Name: Mrs. Sri Divya
 Date of Birth: 20/6/26 Time of Birth: 3:20pm Gender: Male Female
 Birth Weight: 2.740kg Kgs HC: 35 cm Lenght: 47 cm
 Meconium in Liquor: Yes No Cried at Birth: Yes No
 Term / Pre-term / Post-term: Term
 Resuscitated: Yes No Blood Group: Mother: O positive Baby: _____
 Feeding: Breast Feeding Formula Both First Feed Time: 8pm

VIH-00159654 IP-00060421
 Mrs SRI DIVYA VEETUKURI
 20-06-1996 29 Y 10 M 0 D (F)
 Dr. KAPPAGANTULA APARNA

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

Physical Assessment of New Born:

Temp: 98.6 °C HR: 152 /Min RR: 52 /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 IM Administered: Yes / No

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

All information obtained from Mother Father Other Family Member

Newborn Screening Discussed: Yes / No

Nurse Name: K. Subarnie

Signature: [Signature]

Date & Time: 20/6/26 6pm



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : DIVYA Age : 29y 10M Father's Name : Age :
 Date of Birth : 20/8/1996 Date of Admission : UHID No.:
 NICU Consultant : Dr. KUNDANA MAM Referring Consultant :
Transferring Unit : OT Labour Room ER Ward
Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : B/O DIVYA Mother's Blood Group : O+ve
 Gender : M F Blood Group :
 Date of Birth : 20/6/26 Time of Birth : 3:20:5 PM Birth Weight (gms) : 2.740 kg Length (cms) :
 Place of Birth : RCH OFC (cms) :
 Estimated Gesth Age : 37.1 wks

Current Obstetric History : (Booked / Unbooked Case) (MISSED NT SCAN) 4y 17/9/25
 Maternal Age : 29y 10M Ht : 15.7 Wt : 83 BMI : Married Life : 17/9/25 LMP : 10/7/26 EDD : 10/7/26
 Conception : Spontaneous or with Rx : spontaneous
 Booked at what GA : @ 25 wks AN Steroids Drugs / Doses : 2 doses of prednisolone 30mg
 Last Scans Details : 17/6/26 - Growth scan, 30+3 wks, SLIUF, BVCCab, AFP-12.7cm, EFW-2339g, AC-22.7, FI-Fundal, Doppler-UA-increased FI
 TT Immunization and Iron / Folic Acid : YES

MATERNAL RISK FACTORS

Age : <18 yrs >35yrs no swelling over leg & feet 35+ wks managed conservatively
 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 : NO
 AFI : 12.7cm

H/o GDM/ pre GDM/ on diet or insulin
 Controlled or not, recent values, HbA1 values : GDM @ 27 wks on 70g MCE form'n 250mg BID
 Compliance with Rx :
 Scans : LGA, TIFFA , Fetal Echo : NO
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 : NO

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

Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

G: 2 P: 1 A: 0 L: 2

| Sl. No. | Age | GA wks | B. W | Gender | Significant | Details |
|---------|-------|-----------|---------|--------|--|---------|
| I | 34yrs | Model 3.2 | Ky / RT | LSCS | Maternal Yeagled / RCH - VBP / NICU - 24yrs / B-10 | |
| II | PP | Sion | torcord | | | |

PERINATAL HISTORY

Treating Obstetrician : Dr. K. APARNA Hospital : Inborn Outborn

| | |
|---|---|
| Duration of Labour First stage (> 18 hours sig) Second stage (> 2 hours after dilation) LSCS : <input checked="" type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication : Specify the reason : NO Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal | CTG : <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological MSL : NO Resuscitation : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cord ABG : Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc : |
|---|---|

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

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

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

Snapee II Score

| | | | |
|--------------------------|----------------------|----------------|--------------------------|
| 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 :

CIAB



History of Present Illness:

Baby delivered via LSC in
oblique lie.



CTAB, HR > 160/min

20/8/1996



Oronasal suction done



Delayed cord clamping was done
for 60 sec



Cord was clamped & cut
under aseptic condition
2 AAV



ENTRAGED AT SITE

17/9/25

Investigation details in previous Hospital :

Inj vit-K given



Shift to mother side

Feeding History :

Past History :

Family History :

Socio Economic History :



GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5°C HR : 152/min RR : 48/min NIBP : CFT : L3C
Color of the extremities : Acrocyanosis
Jaundice : NO Pallor : NO SpO2 : 96 % @ RA

Anthropometry : Birth Weight : 2.760 kg Length : HC : Present Weight :
Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

HEAD : Fontanelles : } (b) Bossing of forehead
Sutures : } (u)
Shape / Moulding :
Edema / Bruising :
Size - (H.C.) :

Facies : NO facial dysmorphism
(Any Facial Dysmorphism)

NECK and CLAVICLES : Range of Motion : } (u)
Asymmetry :
Masses :

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

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

Patient Sticker

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THORAX and BREASTS : Shape of Thorax : } \odot
Position of Nipples and Number :

ABDOMEN and UMBILICUS : Shape : }
Organomegaly : } \odot
Bowel Sounds : } \oplus
Umbilical Stump : } 2A + W
Discharge : NO

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

HERNIAL ORIFICES Free

TRUNK and SPINE : \odot

SKIN LESIONS : None

EXTREMITIES : Fingers / Toes : } \odot Arms / Legs :
Deformities : } Mobility :
Hip Joint Examination :

SYSTEMIC EXAMINATION

Respiratory System :
Breathing Pattern : Regular Periodic Shallow Gasping
Mention If baby has Respiratory distress : RR : 52/mⁿ 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 : 96.4 @ Rt Auscultation : BICA \oplus Breath Sounds : NVBS \oplus Added Sounds : -

Cardiovascular System :
HR : 152/mⁿ BP : Precordial Activity :
Femoral Pulses : } \odot Murmurs : } \odot
Other Peripheral Pulses : } Signs of Cardiac Failure :

Abdomen : Hernia orifice : Free
Shape : SOFT \odot Anal Patency : \oplus nt
Palpation : SOFT Umbilical Cord : 2A + W
Palpable masses : } none First urine passed : } yes
Abdominal girth : } Meconium passed :



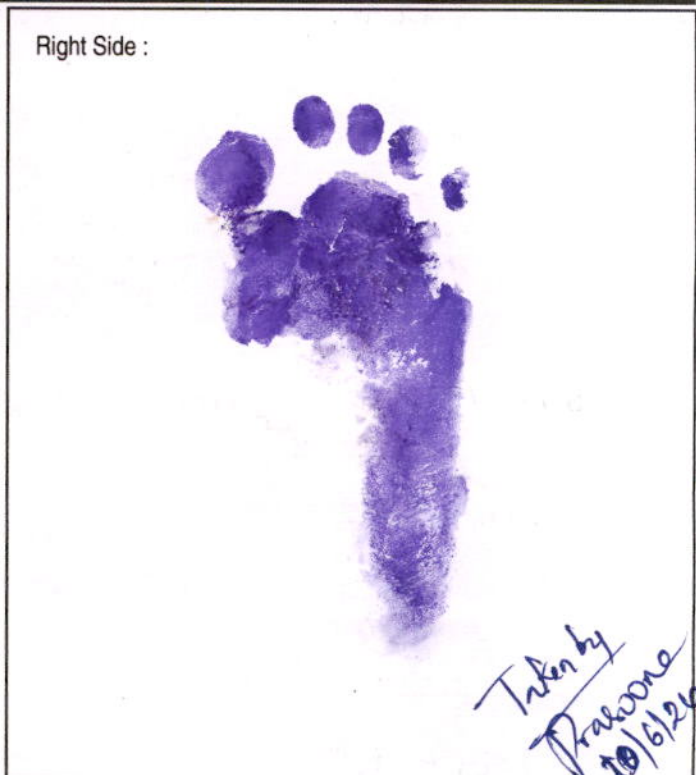
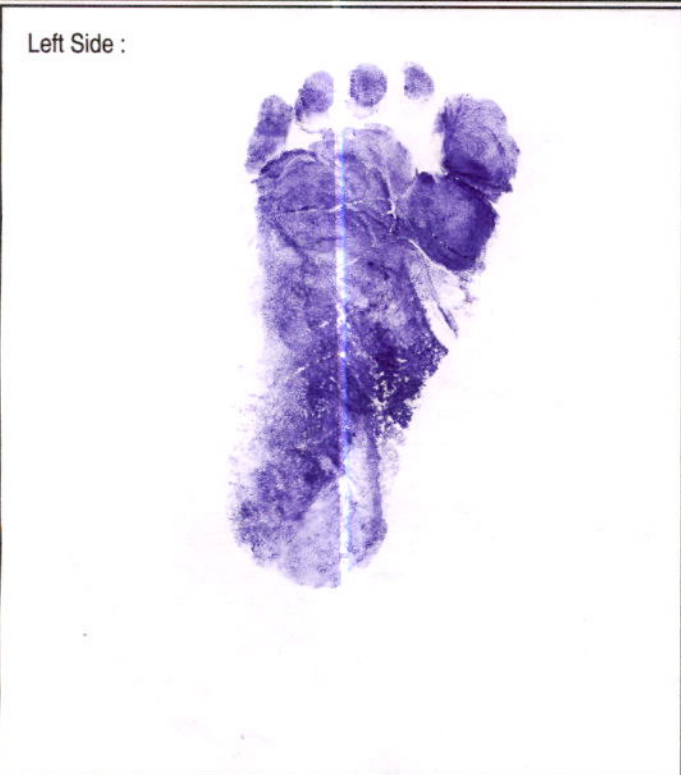
..... System : Higher Intellectual functions (Sensorium) : }
State of wakefulness : } C191A - AOK
Prechtle Score :

Nerves : @

Motor System :
Passive Tone : } @
Active Tone : } @
Neonatal Reflexes :
Grasp : Palmar Plantar Sucking Rooting Crossed adductor :
Moro's : BIL Symmetrical DTR :
ATNR : Skull and Spine : @

Any Congenital Anomalies : NO obvious visible external cong Anomalies
Diagnosis :

FOOT PRINTS



Resident Doctor :
Signature :
Name : Dr. HOYIDH
Date & Time :

Consultant :
Signature :
Name : Dr. KUNNATHA
Date & Time : 20/6/26 9AM
Page: 6/8

Patient Sticker

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



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: cold cor, warmth cor

- BF f/b B/P x 2hrly Q on demand

- OAC, SBP, NBS B/F discharge

- Vaccinations as per schedule

- CRBS - 6th hrly prefeed b'w 48 hrs

*Noted by
Prasanna
20/6/2026
ppm*

Doctor Signature:

Doctor Name:

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|--------------------------------|--|---|
| 21/6/26 9 AM | S/S Resident 27g Inc / Fcu / 2.7mg / ALLSCS / GDM - Tab metformin | |
| M) B } 9 AM | O/E - Baby born CPTA good CET clear CVL - 5/5, (+) RF - 1/1 (+) PLA - 1/1 (+) | URUe } STOOL } passed |
| | RBS: upto 48h. | plan |
| | VACC: TODAY | 1) DISE d/hy Burgeas Dist 2) Vaccination - today |
| | TCB - Bfr d/s. | 3) GRBS 6 th hly protocol (FPLU 48HOL) |
| | OAE: T/M. | 4) OAE T/M 5) TCB bld d/s. |
| Dr. Kundana 21/6/26 9 AM | | <p>marked</p> <p>noted by Swing 21/6/26 at 1 PM</p> |

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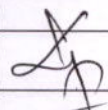
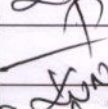
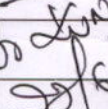
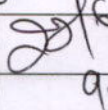
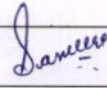
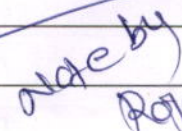
PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---------------------------|---|---|
| 21/6/26 9pm 22/6/26 | C/B Residua | |
| | o/e Baby warm c/t/a good CRT 13sec CRT - 512 (+) R/r - BAE (+) | |
| Dr. Vukwaja. | | <u>Plan</u> 1) DRF 02H flby Surpin 2) BRCS 6th day to be done 3) OAC 1/m 4) TCB before d/c. |
| | noted by Sony 22/6/26 @ 12:30 AM | |

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PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|--------------------|--|---|
| 22.6.26 9.00 AM | S/B Dr. Kundana | |
| | Early Term (37 wk) / NOC-42 / baby girl / IDM / AGA | |
| | o/f baby warm cry } tone } (N) activity } | |
| | Y. wt: 2.70 kg H/A - NAD | |
| | T. wt: 2.61 kg P/A - soft | Plan |
| | (↓ 90 gm) | → TCA now |
| | MBG } 0 + v.o. BBG } | → Warm care |
| |  | → Start formula |
| |  | → OAE today |
| |  | → Stop RBS monitoring |
| |  | |
| |  (Dr. Sameer) | |
| | | |
| | | |
| | | |
| | | |
| | |  |
| | | 22/6/26 |
| | | 9 AM |
| | | |
| | | |

PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|--------------------|--|--|
| 22.6.26 | <p><u>Lactation notes (Mrs. Rangasubini)</u></p> <ul style="list-style-type: none"> • 2nd time mother • Normal breast condition • Drops of milk seen • Assisted the Mother in feeding • Baby latching & suckling well • Advised to feed every 2hrs. • More skin to skin <p>flu 11:45 am</p> | |
| 22.6.26 4.00 PM | <p>S/B Registrar</p> <p>Early Term / AGA / baby girl / NOL-49 / IDM</p> <p>o/e baby warm resp. tone } (N) activity } US - S, S, D RS - RAET, clear P/a - soft</p> <p>Dr. Sameers (Dr. Sameers)</p> | <p>Plan</p> <ul style="list-style-type: none"> → DBM + FF → Warm care → Sweeping after every 4 <p>noted by Akashini 23/6/26 @23 am</p> |



Pat

M / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

| | | | | | | | |
|---|-------------|---|------|------|------|------|------|
| Date: | 20/6/26 | 6 | 8 | 10 | 12pm | 4 | 7 |
| Doctor/Nurse/Family Concern? | | pm | pm | pm | pm | Am | Am |
| Temperature (°F) | | 98.8 | 98.8 | 98.8 | 98.8 | 99.2 | 99.2 |
| Heart Rate (bpm) and Blood Pressure (mmHg) * | | 152 | 154 | 155 | 145 | 141 | 139 |
| Heart Rate (Number) | | 152 | 154 | 155 | 145 | 141 | 139 |
| Resp. Rate (bpm) (Over 1 Minute) * | | 45 | 52 | 50 | 45 | 30 | 45 |
| Resp Rate (Number) | | 45 | 52 | 50 | 45 | 30 | 45 |
| Resp Mod/ Severe Distress None / Mild | | | | | | | |
| Receiving O ₂ (l/min) O ₂ Saturations (%) | | 0 | 0 | 0 | 0 | 0 | 0 |
| Conscious Level Normal Altered | | | | | | | |
| GCS * | | | | | | | |
| TOTAL SCORE | | 0 | 0 | 0 | 0 | 0 | 1 |
| Number of shaded boxes | | 0 | 0 | 0 | 0 | 0 | 1 |
| Pain Score | | 0 | 0 | 0 | 0 | 0 | 0 |
| Observer's Initials | | S | SP | / | B | B | A |
| 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.

SERVATION 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: 21/6/26 | Time: | 10 | 1 | 4 | 6 | 8 | 1 | 5 | 8 |
|---|-------|--------|--------|--------|--------|--------|--------|--------|--------|
| Doctor/Nurse/Family Concern? | | Am | Pm | Pm | Pm | Pm | Am | Am | Am |
| Temperature (°F) | | 98.6 | 98.6 | 98.2 | 98.4 | 98.2 | 98.6 | 98.2 | 98.1 |
| Heart Rate (bpm) and Blood Pressure (mmHg) * | | 142 | 143 | 140 | 142 | 145 | 140 | 131 | 130 |
| Resp Rate (bpm) (Over 1 Minute) * | | 42 | 45 | 45 | 42 | 44 | 39 | 39 | 45 |
| Respiratory Distress | | | | | | | | | |
| Receiving O ₂ (l/min) / O ₂ Saturations (%) | | 0 / 96 | 0 / 99 | 0 / 95 | 0 / 99 | 0 / 99 | 0 / 99 | 0 / 99 | 0 / 99 |
| Conscious Level | | N | N | N | N | N | N | N | N |
| GCS * | | 15 | 15 | 15 | 15 | 15 | 15 | 15 | 15 |
| TOTAL SCORE | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Number of shaded boxes | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pain Score | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Observer's Initials | | AP | AP | AP | AP | AP | AP | AP | AP |

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.

VIH-00200107 IP-00000424
 Baby B/O SRI DIVYA VEETUKURI (F)
 20-06-2026 0 Y 0 M 0 D 9 H
 Dr. ATLURI KUNDANA PRIYA

OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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| 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: 20/6/26 | Time: 10 | 1 | 3 | 7 | 11 |
| Doctor/Nurse/Family Concern? | AM | PM | PM | PM | PM |
| Temperature (°F) | 98.6 | 98.6 | 98.6 | 98.6 | 98.6 |
| Heart Rate (bpm) and Blood Pressure (mmHg) * | 142 | 139 | 135 | 135 | 135 |
| Resp Rate (bpm) (Over 1 Minute) * | 42 | 50 | 35 | 45 | 41 |
| Resp Mod/ Severe Distress None / Mild | | | | | |
| Receiving O ₂ (l/min) O ₂ Saturations (%) | 0 | 0 | 0 | 0 | 0 |
| Conscious Level Normal / Altered | N | N | N | N | N |
| GCS * | 15 | 15 | 15 | 15 | 15 |
| TOTAL SCORE | 0 | 0 | 0 | 0 | 0 |
| Number of shaded boxes | 0 | 0 | 0 | 0 | 0 |
| Pain Score | 9 | 9 | 9 | 9 | 9 |
| Observer's Initials | g | ST | g | g | g |

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.
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- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

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

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

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| 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. : 1

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

| Date | Time | Nature of Fluid | Intake | | | Output | | | | | IV Site Thrombophlebitis Score | Sign. Nurse | |
|-----------------------|----------|-----------------|--------|-----|-----|-----------------------|-----------|-------|----------|-------|--------------------------------|---------------|--|
| | | | Route | | | NG | Diarrhoea | Vomit | Drainage | Urine | | | |
| | | | Mouth | I.V | N.G | | | | | | | | |
| | 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 | DBF | | | | | ✓ | | | ✓ | 0 | 28 | |
| | 07:00 pm | | | | | | | | | ✓ | 0 | 006/26 7pm | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| | 08:00 pm | DBF | | | | | | | | | 0 | 0 | |
| | 09:00 pm | | | | | | | | | | 0 | 0 | |
| | 10:00 pm | DBF | | | | | | | | ✓ | 0 | 0 | |
| | 11:00 pm | DBF | | | | | | | | | 0 | 0 | |
| | 12:00 am | | | | | | | | | | | | |
| | 01:00 am | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| | 02:00 am | | | | | | | | | | | | |
| | 03:00 am | DBF | | | | | | | | | | | |
| | 04:00 am | | | | | | | | | | | | |
| | 05:00 am | DBF | | | | | ✓ | | | | 0 | 0 | |
| | 06:00 am | | | | | | | | | ✓ | 0 | 0 | |
| | 07:00 am | DBF | | | | | | | | | 0 | 0 | |
| Total Intake : | | | | | | Total Output : | | | | | | | |

Total 24 hrs. Intake []

Total 24 hrs. Output []



FLUID CHART

Sheet No. :

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

| | | Intake | | | Output | | | | | IV Site Thrombophlebitis Score | Sign. Nurse | |
|-----------------------|----------|-----------------|-------|-----|-----------------------|-----------|-------|----------|-------|--------------------------------|-------------|------------------------------|
| Date | Time | Nature of Fluid | Route | | NG | Diarrhoea | Vomit | Drainage | Urine | | | |
| | | | Mouth | I.V | N.G | | | | | | | |
| 21/6/26 | 08:00 am | | | | | | | | | | ↓ | Soni 21/6/26 @ 11:00 |
| | 09:00 am | DBF | | | | ✓ | | | | 0 | | |
| | 10:00 am | | | | | | | | | | | |
| | 11:00 am | DBF | | | | | | | | | | |
| | 12:00 pm | | | | | | ✓ | | | | | |
| | 01:00 pm | DBF | | | | | | | | | | |
| Total Intake : | | | | | Total Output : | | | | | | | |
| 21/6/26 | 02:00 pm | | | | | | | | | | ↓ | Soni 21/6/26 @ 8:00 pm |
| | 03:00 pm | DBF | | | | ✓ | | | ✓ | | | |
| | 04:00 pm | | | | | | | | | | | |
| | 05:00 pm | DBF | | | | | | | ✓ | | | |
| | 06:00 pm | | | | | | | | | | | |
| | 07:00 pm | | | | | | | | | | | |
| Total Intake : | | | | | Total Output : | | | | | | | |
| 21/6/26 | 08:00 pm | | | | | | | | | | ↓ | Soni 21/6/26 @ 11:00 |
| | 09:00 pm | DBF | | | | ✓ | | | | | | |
| | 10:00 pm | | | | | | | | | | | |
| | 11:00 pm | DBF | | | | | | | ✓ | | | |
| | 12:00 am | | | | | | ✓ | | | | | |
| | 01:00 am | DBF | | | | | | | | | | |
| Total Intake : | | | | | Total Output : | | | | | | | |
| 22/6/26 | 02:00 am | | | | | | | | ✓ | | ↓ | Soni 22/6/26 @ 11:00 |
| | 03:00 am | DBF | | | | | | | | | | |
| | 04:00 am | | | | | | | | | | | |
| | 05:00 am | DBF | | | | | | | | | | |
| | 06:00 am | | | | | | ✓ | | ✓ | | | |
| | 07:00 am | DBF | | | | | | | | | | |
| Total Intake : | | | | | Total Output : | | | | | | | |

Total 24 hrs. Intake

Total 24 hrs. Output

VIH-00206107 IP-00060424
 Baby B/O SRI DIVYA VEETUKURI
 20-06-2026 0 Y 0 M 0 D 9 H (F)
 Dr. ATLURI KUNDANA PRIYA



FLUID CHART

Sheet No. :

22/6/26

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

| Date | Time | Nature of Fluid | Intake | | | Output | | | | | IV Site Thrombophlebitis Score | Sign. Nurse | |
|-----------------------|----------|-----------------|------------|-----|-----|-----------------------|-------------------------------------|-------|-------------------------------------|-------------------------------------|--------------------------------|---------------------------|--|
| | | | Mouth | I.V | N.G | NG | Diarrhoea | Vomit | Drainage | Urine | | | |
| <i>20/6/26</i> | 08:00 am | | | | | | | | | | | <i>20/6/26 @2pm</i> | |
| | 09:00 am | | <i>DBF</i> | | | | | | | | | | |
| | 10:00 am | | | | | | | | | | | | |
| | 11:00 am | | <i>DBF</i> | | | | <input checked="" type="checkbox"/> | | | | | | |
| | 12:00 pm | | | | | | | | <input checked="" type="checkbox"/> | | | | |
| | 01:00 pm | | <i>DBF</i> | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| <i>22/6/26</i> | 02:00 pm | | <i>DBF</i> | | | | | | | <input checked="" type="checkbox"/> | | <i>22/6/26 @2-8pm</i> | |
| | 03:00 pm | | | | | | | | | <input checked="" type="checkbox"/> | | | |
| | 04:00 pm | | <i>DBF</i> | | | | <input checked="" type="checkbox"/> | | | <input checked="" type="checkbox"/> | | | |
| | 05:00 pm | | | | | | | | | | | | |
| | 06:00 pm | | | | | | | | | | | | |
| | 07:00 pm | | <i>DBF</i> | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| <i>23/6/26</i> | 08:00 pm | | | | | | | | | | | <i>23/6/26 @2am</i> | |
| | 09:00 pm | | <i>DBM</i> | | | | | | | <input checked="" type="checkbox"/> | | | |
| | 10:00 pm | | | | | | | | | | | | |
| | 11:00 pm | | <i>DBF</i> | | | | | | | | | | |
| | 12:00 am | | | | | | | | | | | | |
| | 01:00 am | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| <i>23/6/26</i> | 02:00 am | | <i>DBM</i> | | | | | | | | | <i>23/6/26 @8am</i> | |
| | 03:00 am | | | | | | | | | | | | |
| | 04:00 am | | <i>DBM</i> | | | | | | | | | | |
| | 05:00 am | | | | | | | | | | | | |
| | 06:00 am | | | | | | | | | | | | |
| | 07:00 am | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |

Total 24 hrs. Intake

Total 24 hrs. Output