


ACTIVE VIH-00205878 IP-00060336
Baby B/O Y SAI HARIKA
13-06-2026 0 Y 0 M 0 D 3 H (M)
Dr. KODICHERLA VISHNU VARDHAN

JG

Name: --  -----
UHID No. ----- Consultant: ----- Dept: Labour ward
Date of Admission: 13/6/26 Time: 4:5 pm Date of Discharge: ----- Time: -----
Room / Bed No: 221-1 Ward: LW Suggested Billable bed type: -----


WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
13/6/26	@ 9:50 pm	m ICU	Room 207	<i>[Signature]</i>

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	<i>[Large Blue Signature]</i>			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
15/6/20	TEOPAE	1	3090472	

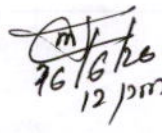
ANY OTHER INFORMATION

.....
.....
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.....
.....

Date: 16/6/20

Time: 12pm.

Prepared By: 

Staff Nurse Sushila	Shift / Ward  76/6/20 12pm.	Billing Assistant	Billing Supervisor
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ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

PATIENT TRANSFER FORM



VIH-00205878
 Baby B/O Y SAI HARIKA
 13-06-2026 0 Y 0 M 0 D 3 H (M)
 Dr. KODICHERLA VISHNU VARDHAN


IP-00060336

Date & Time of Admission 13/6/26 @ 4:5pm		Date & Time of Transfer Order 13/6/26 @ 9:50pm
Treating Consultant Name	Transfer Ordered by Dr. Shikar	Reason for Transfer for observation
From Unit MLU	To Unit Room (207)	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File (15)	Number of Imaging Films Nil	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.	1) Baby Icukey	1
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Dr. Srikar

Name & Signature of Person who is Transferring Sis Vardhan	Name of Person Ordered Transfer Dr. Srikar
---	---

Patient & Clinical Records Received by : Deepika 13/6/26 @ 9:50pm

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

ADMISSION SHEET

Registration Details :



Admission No : IP-00060336

Admit Date : 13-Jun-2026

Admit Time : 04:05 PM UHID : VIH-00205878

Patient Details :

Patient Name : Baby B/O Y SAI HARIKA

Age : 0 D

Guardian : Mr Y.BALAJI

DOB : 13-06-2026 03:10 PM

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : 30-191/24/A, Mahadevi Colony, Old Safilguda, Neredment 500056 Rajendra Nagar Hyderabad Telangana INDIA 500030

Phone No : 8125825027/ 9966118676

E-mail : saiharika93@gmail.com

Admission Details :

Bed Type : BASINET

Bed No : CRDL-LW-221-1

Ward Name : N 2F-LABOUR WARD

Room No : CRDL-LW-221-1

Admission Type : First Visit

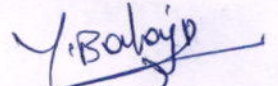
Contact Details :

Name : Mr Y.BALAJI

Relationship : Father

Contact Address : 30-191/24/A, Mahadevi Colony, Old Safilguda, Neredment 500056 Rajendra Nagar Hyderabad Telangana INDIA 500030

Phone No : 8125825027


Signature

Doctor Details :

Doctor Name : Dr. KODICHERLA VISHNU VARDHAN REDDY

Specialisation : NEONATOLOGY

Referral Doctor : DR.BHAVANA K

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

VIH-00205878 IP-00060336
Baby B/O Y SAI HARIKA
13-06-2026 0 Y 0 M 0 D 3 H (M)
Dr. KODICHERLA VISHNU VARDHAN



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/o sai harika Mother's Name: Mrs Sai harika
Date of Birth: 2-8-2026 Time of Birth: 3:10:15 pm Gender: Male Female
Birth Weight: 2.8.54 Kgs HC: 36 cm Length: 47 cm
Meconium in Liquor: Yes No Cried at Birth: Yes No
Term / Pre-term / Post-term: Late Term
Resuscitated: Yes No Blood Group: Mother: A positive Baby: -
Feeding: Breast Feeding Formula Both First Feed Time: 5:20 pm

VIH-00201686 IP-00060331
Mrs Y SAI HARIKA
28-04-1993 33 Y 1 M 16 D (F)
Dr. BHAVANA K



Mode of Delivery: Normal LSCS - Emergency/ Elective Instrum.
Indication: Emergency - LSCS

Physical Assessment of New Born:

Temp: 38.4 °C HR: 160 /Min RR: 21 /Min BP: - SpO₂: 99%

Pain Score: (Follow N Pass)

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

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

Behaviour Status on admission: Sleeping Crying Calm Drowsy

Findings:

General Appearance: Posture: Well-Flexed Asymmetry

Skin: Pink Meconium Stain Others, Specify: -

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

Vitamin K 1 mg T.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: Pooja

Signature: Pooja

Date & Time: 13/6/26 @ 5 pm



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Y HARIKA Age : 33yr Father's Name : _____ Age : _____
 Date of Birth : 28/04/93 Date of Admission : _____ UHID No. : _____
 NICU Consultant : Dr. Vishnu Referring Consultant : Dr. Bhavana
 Transferring Unit : OT Labour Room ER Ward
 Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : B/O Harika Mother's Blood Group : A Positive
 Gender : M F Blood Group : _____ Birth Weight (gms) : 2854g Length (cms) : _____
 Date of Birth : 13/6/26 Time of Birth : 3:10:15pm OFC (cms) : _____
 Place of Birth : RCH - VKP. Estimated Gesth Age : 36 + 4 wk

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 33yr Ht : 168 Wt : 86.5 BMI : _____ Married Life : 5yr LMP : 23/9/25 EDD : 6/7/26
 Conception : Spontaneous or with Rx : IUG Conception
 Booked at what GA : RCH @ 19WK AN Steroids Drugs / Doses : _____
 Last Scans Details : stg 28 - SCUF 35+4 / Cordicel PL-AW
AFI - 12.8cm / EDW - 2621g
poppr TT Immunization and Iron / Folic Acid : _____

MATERNAL RISK FACTORS

<p>Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs</p> <p>Consanguinity : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p> <p>H/o PIH (after 20 weeks) / PE</p> <p>How many Drugs / Doses / Since how long : _____ <u>T. Ecosporin 150mg OD stopped at 36 wk</u></p> <p>H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : _____ <u>Hematuria</u></p> <p>IUGR - when detected : _____</p> <p>Doppler (Increased Resistance / ADEF / REDF / Redistribution in MCA) / Ductus Venosus : _____</p> <p>AFI : _____</p>	<p>H/o GDM/ pre GDM/ on diet or insulin <u>GTS - low risk</u></p> <p>Controlled or not, recent values, HbA1 values : _____</p> <p>Compliance with Rx : _____</p> <p>Scans : LGA, TIFFA , Fetal Echo : <u>⊙</u></p> <p>H/o Hypothyroidism : when diagnosed ? Medication? : <u>Conception</u> <u>T. Thyronorm = 12.5mg OD.</u></p> <p>Any other Chronic Medical Problems, when detected drugs ? <u>Anemia -> Corrected</u></p> <p>(Anemia, SLE, Jaundice, CHD, Heart Disease)</p> <p>Infection : H/O, Fever</p> <p>(<input type="checkbox"/> Malaria <input type="checkbox"/> UTI <input type="checkbox"/> TORCH <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> HBV)</p> <p>UTI : when : _____ Any culture : _____</p>
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PPROM : Duration : _____ Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results : _____
 Medication during Pregnancy : _____ Duration : _____



PAST OBSTETRIC HISTORY

G: 3 P: 1 A: 2 L: 0

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
G1	6wk	sp. m/c	mf		1 Jan 2024	
G2	6wk	sp. m/c	mf		1 April 2024	
G3	pl-	mf			conception	

PERINATAL HISTORY

Treating Obstetrician : Dr. Bhavane Hospital : Put VKE Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig)</p> <p>Second stage (> 2 hours after dilation) <u>Hard</u></p> <p>LSCS : <input type="checkbox"/> Elective <input checked="" type="checkbox"/> Emergency Indication :</p> <p>Specify the reason :</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>Resuscitaion : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cord ABG :</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :</p>
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NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

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

Resuscitation			
Minutes	1	5	10
Oxygen			
PPV / NCPAP			<input checked="" type="checkbox"/>
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)	
Brith Weight	> = 1kg (0)	750 - 999 (10)	< 750 (17)
SGA	> 3rd percentile (0)	< 3rd (12)	

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



target SpO₂
reached at 2' of
1'fe

Equipment check done

↓
By Harika delivered via Em-UG

↓
Boy

↓
C/A/B

↓
Dec done for 60 sec

↓
Received into preheated
wornies

↓
Secretions cleared mouth → nose

↓
Dried and stimulated

↓
Cord clamp cut 2A + 1V ⊕

↓
Dry vit K given

Investigation details in previous Hospital :

↓
Baby vigorous

out 15' of 1'fe Baby had SpO₂ - 96

SCR HR 100

Tachypnea

Feeding History :

DR-CPAP given PEEP 6

↓ for 2 min FiO₂ 30

15' of 1'fe SCR ↓ but ⊕
Tachypnea ⊕

Past History :

observe for 1 hr
and
Reassess.

↓
Reassess after 1 hr

Family History :

RD - settling mild tachypnea ⊕

shift to mother side

Socio Economic History :



GENERAL EXAMINATION ON ADMISSION

General Disposition :
 Cl- vigrous
 Tone - (2)
 Activity - good flexion
 of U, U

VITALS : Temperature : 36.5°C HR : 160/min RR : 39/min NIBP : CFT : C3H
 Color of the extremities : Acrocyanosis
 Jaundice : - Pallor : - SpO2 : 100% RA

Anthropometry : Birth Weight : 2.854 kg Length : HC : Present Weight :
 Ponderal Index : AGA SGA : LGA :

HEAD TO TOE EXAMINATION

HEAD : Fontanelles :
 Sutures : Ab @ Left
 Shape / Moulding :
 Edema / Bruising : cephal + r
 Size - (H.C.) :

Facies : (Any Facial Dysmorphism) (2)

NECK and CLAVICLES : Range of Motion :
 Asymmetry : (2)
 Masses :

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

EARS, NOSE MOUTH and THROAT : Ear set / Shape :
 Periauricular Pits / Tags :
 Nasal shape / Patency : (2)
 Palate :
 Gums :
 Lips :
 Tongue :



horax :

2 in (P)
 @ Position

DREASIS : Position of Nipples and Number :

ABDOMEN and UMBILICUS :
 Shape :
 Organomegaly :
 Bowel Sounds :
 Umbilical Stump : 2A+1V (P)
 Discharge :

GENTILIA :
 Labia / Hymen :
 Testicles/penis : R/L Teste palpable
 Anus :

HERNIAL ORIFICES free

TRUNK and SPINE : (P)

SKIN LESIONS :

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

20F + 10T (P)

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

Mention If baby has Respiratory distress : RR : 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 : 98/100 Auscultation : 3A+E (P) Breath Sounds : NUBI (P) Added Sounds :

Cardiovascular System :

HR : 160/min BP : Precordial Activity : (P)

Femoral Pulses : (P) Murmurs :

Other Peripheral Pulses : (P) Signs of Cardiac Failure :

Abdomen :

Shape : Hernia orifice : free

Palpation : 10/12 Anal Patency : Patent

Palpable masses : Umbilical Cord : 2A+1V (P)

Abdominal girth : First urine passed : } not passed

Meconium passed : } not passed



stual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : 2/3 Moro's equivocal DTR :

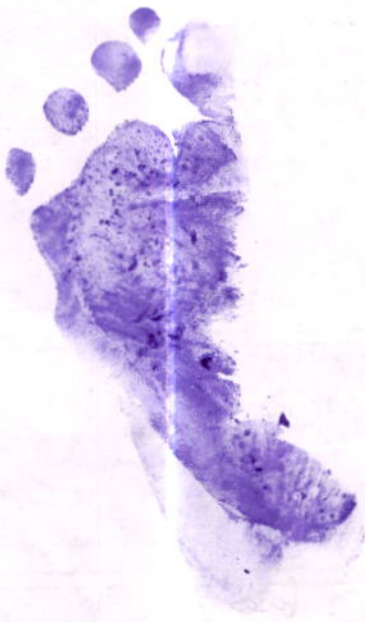
ATNR : ⊕ Skull and Spine :

Any Congenital Anomalies :

Diagnosis : Left Pop Emulser / nca / CIAB / 2.854 kg / AA-

FOOT PRINTS

Left Side :



Right Side :



Taken by
 Dr. Vardhan

Resident Doctor :

Signature : [Signature]

Name : Dr. Vardhan

Date & Time : 13/6/26 / 5:30 pm

Dr. Vishnu Vardhan Reddy
 Consultant
 Reg. No. MC/FMR/79982

Signature : [Signature]

Name : Vishnu Vardhan

Date & Time : 14/6/26 / 11:00 am



- 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: *Immuneization*

DBF 2nd day

NBS/SR2/AE Bld O/E

Wenemth care, cord care

*Noted
by
Pooja
13/6/26*

[Signature]

Doctor Signature:

Doctor Name:

Date & Time:



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p>14/6/26 9AM 18:10L</p>	<p>S/B Resident 36+4wk Late PT / EMLCCS (↓ FHR) Hypothyroid mother (12.5mcg Tab).</p>	<p>UIF conception. Mch / CRAB / 2.854 kg H/o Anemia. H/o PHT - currently not on meds</p>
<p>M } B } A-ME</p>	<p>Baby warm of T/A good CRT CRUC CVT-852 (+) PI-BAE (+)</p>	
<p>U : S :</p>	<p>PIA - soft</p>	<p>Plan</p>
<p>Wt: 2.854 Tw: 2.76 ↓ 94g 3.2 / 100g</p>		<ol style="list-style-type: none"> 1) continue DBF d/hy Burping 2) Vaccination done 3) warmth, cord care 4) OAE - after 24 hrs (T/m) 5) SBR/NBS - T/m, 3pm. 6) Monitor vitals inform res.
<p></p>	<p></p>	

Dr. Vishnu Vardhan Reddy
 Reg.No. APMC/FMR/79982

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	cf/b <u>Dr. Vishnu Vardhan</u>	
14/6/26	Red reflex: (N) Baby warm CF/A good CRT clear	WF conception P.O.M. EMILES (↓FHR)
	Orbit } passed Strab } Nodules - equinovocal	Plan
		1) ON DBF - amblyopia by Burping
	wt 10.5 - 3.27	2) DAG - r/b
	M } A+ve B }	3) GBR / NRS - T/m 3pm
		4) Monitor vitals Inform SAs
		5) Vaccination done
	<u>Dr. Vishnu Vardhan</u>	
	Dr. Vishnu Vardhan Reddy REG No. APMC/FRM/79982	
	Noted by Padma	
		14/6/26 @ 8pm



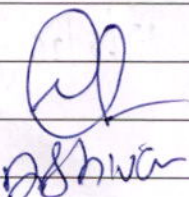
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/6/26 9AM	<u>CL&B Resident</u>	DOB → 13/6/26 TOB - 3:10pm
	CL&B Term / 36 + 4 wks / LScs / CLAB / male / 2.854 kg / Hypothyroid / Anemia / PIH / IVF	
	M. BG - Apaxime B. BG - Apaxime	
	P. wt - 2.76 kg T. wt - 2.66 kg (↓3.5%)	<u>Plan</u> → DBP fAb burpy 2ndly → OAB Today
	O/E Cl/TA good CRT < 3 sec CNS - S ₂ (N) RS - BUAEN (N) PA - syst vly stable	- SBR / NBS at 1 pm - Warm card care VMC Dr. Vishnu Vardhan Reddy Reg. No. ARMC/FMR/79982
	Noted by padma.	15/6/26 @ 2pm @ Bhuvan

VIH-00205878 IP-00080338
 Baby B/O Y SAI HARIKA
 13-08-2026 O Y O M O D O H (M)
 Dr. KODICHERLA VISHNU VARDHAN

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/8/26	<p> <u>Lactation note (Mrs. Ranuparkhi)</u> • 1st line mother • Normal breast condition • Drops of milk seen • Advised to feed every 2hrs • Move skin to skin • To track the feeding in the sheet given • Plus Ok 2:30pm </p>	
15/8/26	<p> <u>CDLW & Vishnu</u> </p>	
14:30	<p> SBR → 13.3mg/dl </p>	
	<p> <u>Plan</u> </p>	
	<p> → Start DSPT </p>	
	<p> → Repeat SBR 7/11 same time </p>	
	<p>  </p>	
	<p> noted by Sashi 16/8/26 2:12 PM </p>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16.6.26	<u>S/A Register</u>	
9.00 AM	Late PT (36 ⁺ wk) / AGA / <u>lady lady</u> / <u>102-66</u> / <u>stippled</u> <u>mother</u> / <u>NNHB</u>	
	o/s lady warm sup. tone } (N) schick } H/L - N/A P/A - sup	
Y.wt: 2.66 kg T.wt: 2.57 kg (690 gm) MBG } BBS } A+V.		<u>Plan</u> → SBR, s-electrolyte at 12.00 PM → R/A 48 hrs. • if Na > 145 ⇒ no discharge → 120 ml/kg/day - measured feeds → D&M + F.I.
	Samsa (Dr. Sampers)	
	Dr. Vishnu Vardhan Reddy Reg. No. AP/1998/FMR/79982 VIM	Noted by Sushila 16/6/26 at 12 PM

VIH-00205878 IP-00060336
 Baby B/O Y SAJ HARIKA
 13-05-2026 0 Y 0 M 1 D (M)
 Dr. KODICHERLA VISHNU VARDHAN



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/6/26	<u>lactation notes</u> (Mrs. Ranjyashree)	
	• Baby is undergoing phototherapy	

CONSENT FOR FORMULA FEEDS

Patient Name: Blo. Y. Sai Harika Age: Gender: Male Female

UHID no: 205876 Department / Ward: 2nd Floor Date: 16/6/26

I Mr / Mrs. : Y. Sai Harika Aged years, hereby declare that I
have admitted my son / daughter in Rainbow Children's Hospital, Hyderabad on

I hereby give consent for formula feed for my child. Doctors have explained me about the formula feeding benefits, risks, alternatives
in the language I best understand.

Patient Attendant / Guardian:

Signature: Y. Sai Harika

Name: Y. Sai Harika

Relationship with patient: Mother

Date & Time: 10:20 AM on 16/6/26

Witness

Signature: Subramanyam

Name: Y. Subramanyam

Date & Time: 10:20 AM on 16/6/26

Doctor (who is taking consent):

Signature: Sameera

Name: Dr. Sameera

Date & Time: 16/6/26 @ 10:20 AM

ఫారులూ ఫీడెల కోసం సమ్మతి

పేషెంట్ పేరు: వయస్సు: లింగం: మగ ఆడ
UHID సంఖ్య: విభాగం / వార్డు: తేదీ:

నేను శ్రీ / శ్రీమతి: , వృద్ధాప్యం
నేను నా కొడుకు / కూతురిని హైదరాబాద్‌లోని రెయిన్‌బో చిల్డ్రన్స్ హాస్పిటల్‌లో
..... నా బిడ్డ కోసం ఫారులూ ఫీడ్ కోసం నేను ఇందుమూలంగా సమ్మతి
ఇస్తున్నాను. నాకు బాగా అర్థమయ్యే భాషలో ఫారులూ ఫీడింగ్ ప్రయోజనాలు, రిస్కులు, ప్రత్యామ్నాయాల
గురించి వైద్యులు నాకు వివరించారు.

పేషెంట్ అటెండెంట్ / గార్డియన్: సాక్షి:
సంతకం: సంతకం:
పేరు: పేరు:
రోగితో సంబంధం: తేదీ & సమయం:
తేదీ & సమయం: తేదీ & సమయం:

డాక్టర్ (అనుమతి తీసుకుంటున్నవారు):
సంతకం:
పేరు:
తేదీ & సమయం:



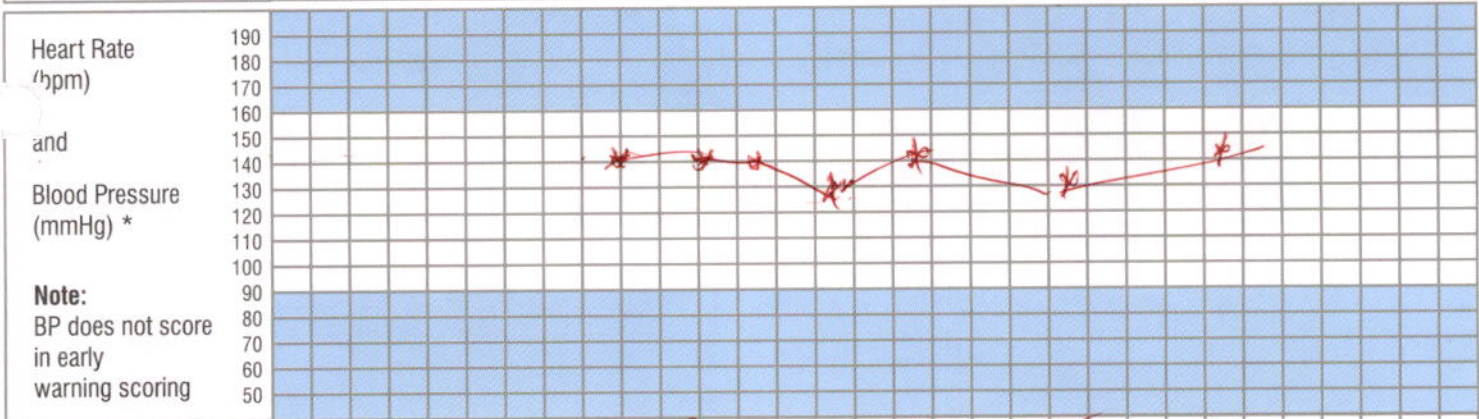
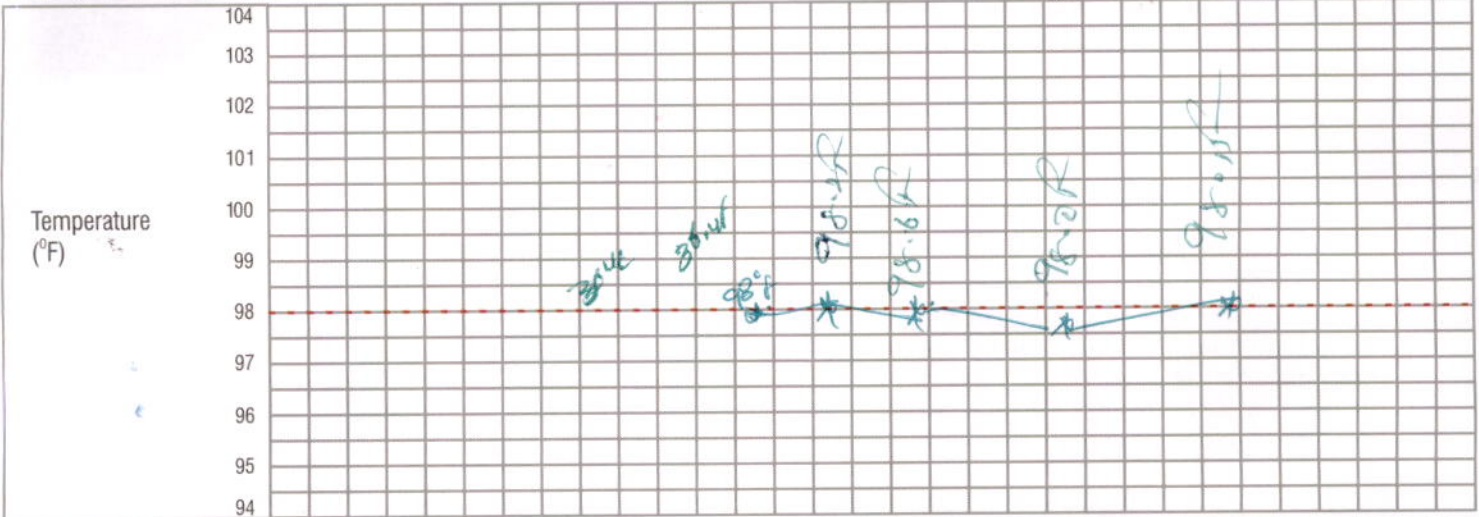
INFANT (<1 year)
 Children's Observation &
 Early Warning Scoring Chart



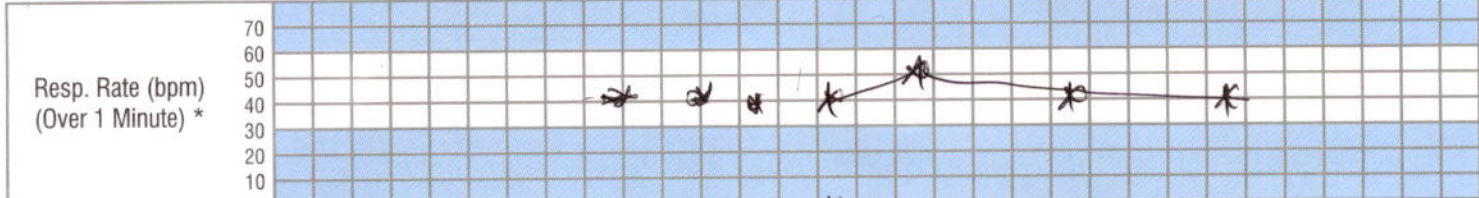
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 13/6/26 Time: 4pm 6pm 8pm 10pm 12am 4am 8am

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



Heart Rate (Number) 142 143 148 130 140 135 140



Resp Rate (Number) 48 51 55 40 45 40 40

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

TOTAL SCORE							
Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	<u>P</u>	<u>P</u>	<u>P</u>	<u>D</u>	<u>D</u>	<u>D</u>	<u>D</u>

ACTIONS

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

NB: Scores 3 should be recorded overleaf

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



CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

VIH-00205878 IP-00060336
 Baby B/O Y SAI HARIKA
 13-06-2026 0 Y 0 M 0 D 6 H (M)
 Dr. KODICHERLA VISHNU VARDHAN

FRM / CLINICAL / 124

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 14/6/26	Time: 10 AM	2 PM	6 PM	11 PM	3 AM	7 AM
Doctor/Nurse/Family Concern?						
Temperature (°F)	98.0	97.5	97.5	98.0	97.5	98.0
Heart Rate (bpm)	150	145	149	142	151	149
Blood Pressure (mmHg) *						
Resp Rate (bpm) (Over 1 Minute) *	36	40	39	42	41	45
Resp Mod/ Severe Distress						
Receiving O ₂ (l/min)						
O ₂ Saturations (%)	99	99	99	99	99	99
Conscious Level	C	C	C	C	C	C
GCS *	15	15	15	15	15	15
TOTAL SCORE						
Number of shaded boxes	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0
Observer's Initials	P	P	P	P	P	P

ACTIONS

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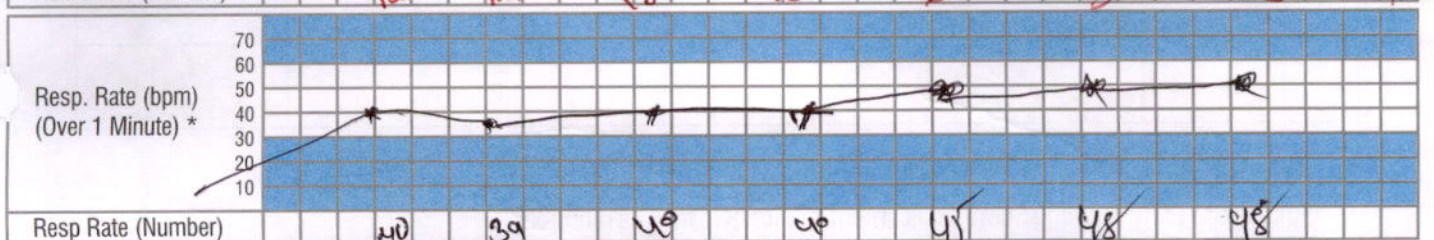
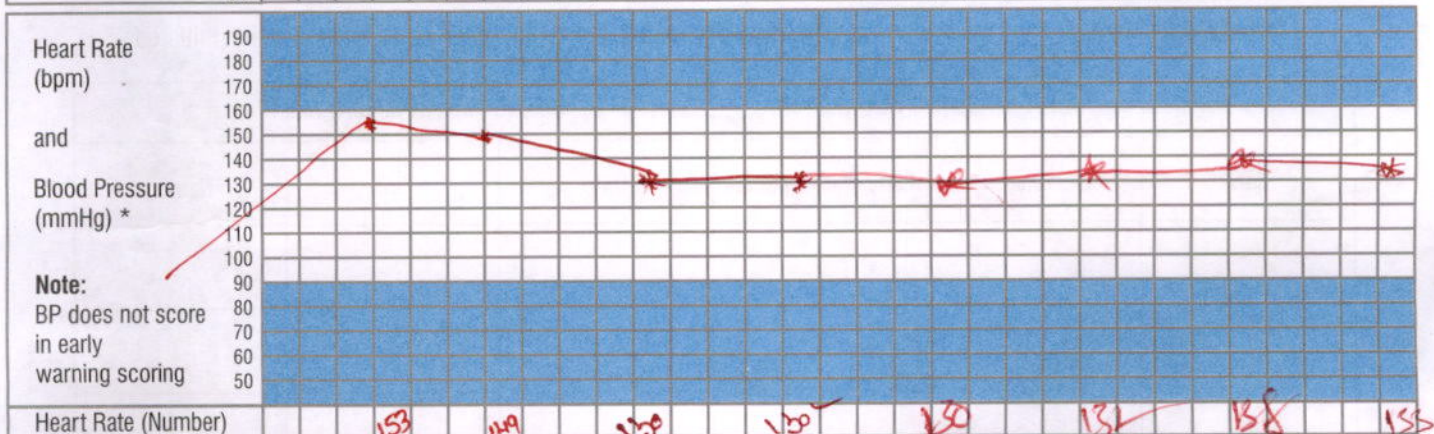
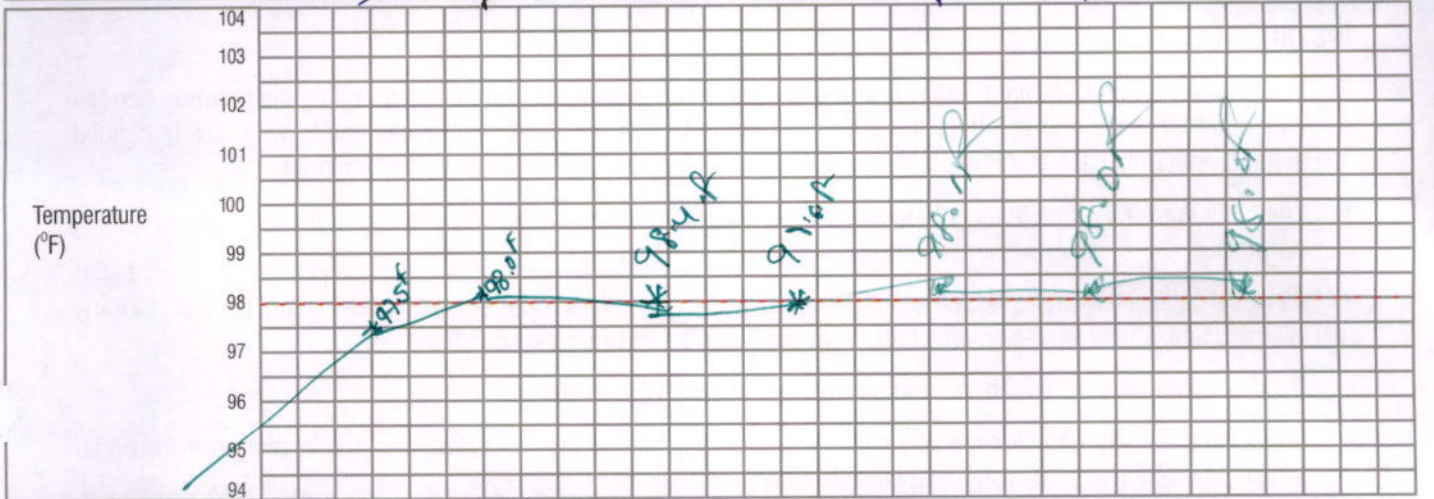


INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 15/6/26 Time: 10 2 4 7 10 1 4 7
 Doctor/Nurse/Family Concern? AM PM PM PM PM AM AM AM



Resp Mod/ Severe Distress	None / Mild						
Receiving O ₂ (l/min)	O ₂ Saturations (%)	99	99	99	99	99	99
Conscious Level	Normal / Altered	C	C				
GCS *		15	15	15	11		

TOTAL SCORE							
Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	P	P	S)	P	P	P

ACTIONS

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CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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

VIH-00205878 IP-00060338
 Baby B/O Y SAI HARIKA
 13-06-2026 0 Y 0 M 1 D (M)
 Dr. KODICHERLA VISHNU VARDHAN



: RCH/ FRM / CLINICAL / 124

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



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 16/5/22 Time: 10

Doctor/Nurse/Family Concern? AM

Temperature (°F)	104	
	103	
	102	
	101	
	100	
	99	
	98	<u>98.6 F</u>
	97	
	96	
	95	
	94	

Heart Rate (bpm) and Blood Pressure (mmHg) * Note: BP does not score in early warning scoring	190	
	180	
	170	
	160	
	150	
	140	
	130	
	120	
	110	
	100	
	90	
	80	
	70	
	60	
	50	
Heart Rate (Number)		

Resp. Rate (bpm) (Over 1 Minute) *	70		
	60		
	50		
	40		
	30		
	20		
	10		
	Resp Rate (Number)		

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

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

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



CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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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)

00205878 IP-00060336
 Baby B/O Y SAI HARIKA
 13-06-2026 0 Y 0 M 0 D 3 H (M)
 Dr. KODICHERLA VISHNU VARDHAN



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.

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

Total 24 hrs. Intake

Total 24 hrs. Output

VIH-00205878 IP-00080336
 Baby B/O Y SAI HARIKA
 13-06-2026 0 Y 0 M 0 D 19 H (M)
 Dr. KODICHERLA VISHNU VARDHAN

FLUID CHART

Sheet No. : (2)

14/6/26

- 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				
14/6	08:00 am													
	09:00 am	DBF							✓					
	10:00 am													
	11:00 am	DBF												
	12:00 pm						✓			✓				
	01:00 pm	DBF												
Total Intake :						Total Output :								
14/6	02:00 pm									✓				
	03:00 pm	DBF												
	04:00 pm													
	05:00 pm	DBF								✓				
	06:00 pm													
	07:00 pm	DBF												
Total Intake :						Total Output :								
15/6/26	08:00 pm													
	09:00 pm	DBM							✓					
	10:00 pm						✓							
	11:00 pm	DBM												
	12:00 am													
	01:00 am	DBM								✓				
Total Intake :						Total Output :								
15/6/26	02:00 am													
	03:00 am	DBM					✓			✓				
	04:00 am													
	05:00 am	DBM												
	06:00 am													
	07:00 am	DBM								✓				
Total Intake :						Total Output :								
Total 24 hrs. Intake												Total 24 hrs. Output		

FLUID CHART

Sheet No. : (3)

15/6/26

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	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse					
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage			Urine				
			Mouth	I.V	N.G											
15/6	08:00 am											}				
	09:00 am	DBM							✓		}					
	10:00 am												}			
	11:00 am	DBM												}		
	12:00 pm								✓						}	
	01:00 pm	DBM														}
Total Intake :					Total Output :											
15/6/26	02:00 pm											}				
	03:00 pm	DBM											}			
	04:00 pm													}		
	05:00 pm														}	
	06:00 pm	DBM														}
	07:00 pm															
Total Intake :					Total Output :											
15/6/26	08:00 pm											}				
	09:00 pm	DBM							✓				}			
	10:00 pm													}		
	11:00 pm	DBM							✓						}	
	12:00 am															}
	01:00 am															
Total Intake :					Total Output :											
15/6/26	02:00 am											}				
	03:00 am	DBM							✓				}			
	04:00 am													}		
	05:00 am														}	
	06:00 am															}
	07:00 am	DBM							✓							
Total Intake :					Total Output :											

Total 24 hrs. Intake

Total 24 hrs. Output

FLUID CHART

Sheet No. : 4

16/6/22

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			
	08:00 am	DBM											
	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

