

ACTIVI

Baby B/O PAREPALLI SANJANA
04-06-2026 0 Y 0 M 0 D 1 H (M)
Dr. AKHEEL SYED RIZWAN

IG

Name: ---



UHID No :

Consultant :

Dept :

Date of Admission : 4/6/26

Time : 3:42pm

Date of Discharge :

Time:

Room / Bed No : 220-1

Ward : CRD-140

Suggested Billable bed type :

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/6/26	6:30	UW	Room C 106	[Signature]

Cross Consultation Visit

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

ADMISSION SHEET

Registration Details :



Admission No : IP-00060226

Admit Date : 04-Jun-2026

Admit Time : 03:42 PM UHID : VIH-00205622

Patient Details :

Patient Name : Baby B/O PAREPALLI SANJANA

Age : 0 D

Guardian : Mr RAHUL PAREPALLI

DOB : 04-06-2026 02:40 PM

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : villa-119, villa orchids,kowkoo Hyderabad
Hyderabad Telangana INDIA 500001

Phone No : 7337326514/

E-mail : na@gmail.com

Admission Details :

Bed Type : BASINET

Bed No : CRDL-LW-220-1

Ward Name : N 2F-LABOUR WARD

Room No : CRDL-LW-220-1

Admission Type : First Visit

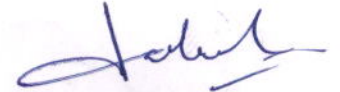
Contact Details :

Name : Mr RAHUL PAREPALLI

Relationship : Father

Contact Address : villa-119, villa orchids,kowkoo Hyderabad
Hyderabad Telangana INDIA 500001

Phone No : 7337326514 / 9618646713



Signature

Doctor Details :

Doctor Name : Dr. AKHEEL SYED RIZWAN

Specialisation : NEONATOLOGY

Referral Doctor : self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

VIH-00205622 IP-00060226
Baby B/O PAREPALLI SANJANA
04-06-2026 0 Y 0 M 0 D 1 H (M)
Dr. AKHEEL SYED RIZWAN



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Mrs. PAREPALLI SANJANA Mother's Name: Mrs. PAREPALLI SANJANA
Date of Birth: 4/6/26 Time of Birth: 2:40pm Gender: Male Female
Birth Weight: 2.8 Kgs HC: 36 cm Length: 47 cm
Meconium in Liquor: Yes No Cried at Birth: Yes No
Term / Pre-term / Post-term: term
Resuscitated: Yes No Blood Group: Mother: B positive Baby: _____
Feeding: Breast Feeding Formula Both First Feed Time: 3:30pm

VIH-00199211 IP-00060221
Mrs PAREPALLI SANJANA
16-06-1999 26 Y 11 M 19 D (F)
Dr. KAPPAGANTULA APARNA

Mode of Delivery: Normal LSCS - Emergency/ Elective Instrume
Indication: Normal

Physical Assessment of New Born:
Temp: 36.2 °C HR: 136 /Min RR: 48 /Min BP: _____ SpO₂: 96.1

Pain Score: 0 (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 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: prathibha Signature: A Date & Time: 4/6/26 @ 3pm

PATIENT TRANSFER FORM

VIH-00205622 IP-00060226
Baby B/O PAREPALLI SANJANA
04-06-2026 0 Y 0 M 0 D 1 H (M)
Dr. AKHEEL SYED RIZWAN



Date & Time of Admission <i>4/6/26 @ 3:42pm</i>	Date & Time of Transfer Order <i>4/6/26 @ 6:30p</i>
Treating Consultant Name	Transfer Ordered by <i>Dr. Srikar</i>
Reason for Transfer <i>For observation</i>	Information to Attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
From Unit <i>Hw</i>	To Unit <i>Room (306)</i>
Number of Sheets in Clinical File <i>- 15 -</i>	Number of Imaging Films <i>- Nil -</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 koochi's</i> — <i>(1)</i>	
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes No

Dr. Srikar

Name & Signature of Person who is Transferring <i>Sr Pooja</i>	Name of Person Ordered Transfer <i>Dr. Srikar</i>
---	--

Patient & Clinical Records Received by : *Subhan*

Date & Time of Patient Received : *4/6/26 @ 7p*

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- Unavailable Bed
- Nurse not Available
- Available Bed not ready



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Sanjana Age : 26yrs Father's Name : Age :
 Date of Birth : 16-06-99 Date of Admission : UHID No.:
 NICU Consultant : Dr. Akheel Rizwan Referring Consultant : Dr. Aparna
 Transferring Unit : OT Labour Room ER Ward
 Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : B/O Sanjana Mother's Blood Group : O Positive
 Gender : M F Blood Group : Birth Weight (gms) : 2.8kg Length (cms) :
 Date of Birth : 4/6/26 Time of Birth : 2:40pm OFC (cms) :
 Place of Birth : Estimated Gesth Age : 38+3 wks

Current Obstetric History : Booked / Unbooked Case
 Maternal Age : 26yrs Ht : 164 Wt : 91 BMI : Married Life : 5yrs LMP : 31/8/25 EDD : 14/6/26
 Conception : Spontaneous or with Rx :
 Booked at what GA : AN Steroids Drugs / Doses :
 Last Scans Details : 27/5/26 Af Doppler 37+3 (sup/Red) Af - 12 wks Doppler
pt. Anst Hx TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs Consanguinity : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 H/o PIH (after 20 weeks) / PE How many Drugs / Doses / Since how long : <u>T-Ecosprin 150mg : 12wks</u> <u>stopped at 32wks</u> 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 <u>As loco 36</u> Controlled or not, recent values, HbA1 values : Compliance with Rx : Scans : LGA, TIFFA, Fetal Echo : <u>(M)</u> H/o Hypothyroidism : when diagnosed ? Medication? Any other Chronic Medical Problems, when detected drugs ? (Anemia, SLE, Jaundice, CHD, Heart Disease) Infection : H/O, Fever (<input type="checkbox"/> Malaria <input type="checkbox"/> UTI <input type="checkbox"/> TORCH <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> HBV) UTI : when : Any culture :
--	--

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: 1

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
<u>I</u>	<u>Male (kg)</u>	<u>37 wks</u>	<u>2.1 kg</u>	<u>Male</u>	<u>Acute Aca</u>	<u>Acute Aca</u>
<u>II</u>	<u>Female (kg)</u>	<u>37 wks</u>	<u>2.1 kg</u>	<u>Female</u>		

PERINATAL HISTORY

Treating Obstetrician : Dr. Akhery Hospital : Rem UKD Inborn Outborn

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

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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

	1 Minute	5 Minutes	10 Minutes
TOTAL	<u>9/10</u>	<u>9/10</u>	

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

Snapee II Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

CiAs



target for
achieved at
2' of life

Equipment check done
↓
S/o Sanjane delivered in good on
16/20 at 2:40 pm
↓
Baby C:AS ; Boy
↓
Delayed cord clamp done for 60 sec
↓
Received into pre heated warmer
↓
dried and stimulated
↓
Secernicious cleared mouth + nose
↓
Iy. vit K surge

Investigation details in previous Hospital :

Cord clamp cut 2A+10Ⓢ
↓
Baby vigorous
↓
Shift to mother side

Feeding History :

Past History :

Family History :

Socio Economic History :



GENERAL EXAMINATION ON ADMISSION

General Disposition :

Cry - vigorous
Tone (M)
Activity - good flexion of U, A

VITALS : Temperature : 36.5°C HR : 155/min RR : 40/min NIBP : CFT : CFT

Color of the extremities : Acyanous

Jaundice : Pallor : SpO2 : 94% RA at SL. AB

Anthropometry : Birth Weight : 2.8kg Length : HC : Present Weight :

Ponderal Index : (AGA) SGA : LGA :

HEAD TO TOE EXAMINATION

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

Facies : no dysmorphism
(Any Facial Dysmorphism)

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

EYES : Symmetry :
Red Reflex :
Discharge :

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



THORAX and BREASTS: Position of Nipples and Number: 2 in @ @ pos.h.

ABDOMEN and UMBILICUS: Shape: _____
 Organomegaly: _____
 Bowel Sounds: 2A+IV @
 Umbilical Stump: _____
 Discharge: _____

GENITALIA: Labia / Hymen: _____
 Testicles/penis: 1/2 Testes descended
 Anus: _____

HERNIAL ORIFICES: free

TRUNK and SPINE: @

SKIN LESIONS: _____

EXTREMITIES: Fingers / Toes: _____ Arms / Legs: _____
 Deformities: 10F + 10T @ Mobility: _____
 Hip Joint Examination: _____

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: 99/100 Auscultation: 2A+IV @ Breath Sounds: NUBS @ Added Sounds: ~

Cardiovascular System:

HR: 155/min BP: _____ Precordial Activity: P

Femoral Pulses: ↑ Murmurs: ~

Other Peripheral Pulses: _____ Signs of Cardiac Failure: _____

Abdomen:

Shape: _____ Hernia orifice: _____

Palpation: soft Anal Patency: _____

Palpable masses: _____ Umbilical Cord: 2A+IV @

Abdominal girth: _____ First urine passed: passed.

Meconium passed: _____

Nervous System : Higher intellectual 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 : *slk moros eqivocal* DTR :

ATNR : *⊕* Skull and Spine :

Any Congenital Anomalies :

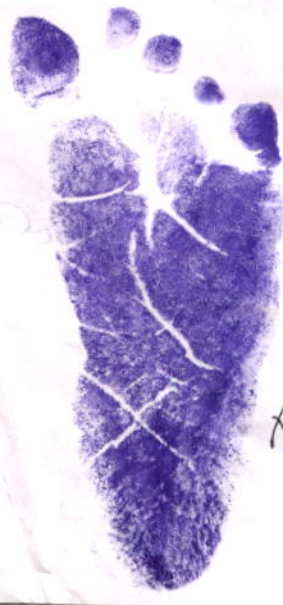
Diagnosis : *Trem / NUD / Mch / Ci / As / 2.8 kg / Aca*

FOOT PRINTS

Left Side :



Right Side :



*taken by
 Pooja
 4/6/26*

Resident Doctor : *[Signature]*
 Signature :

Name : *Dr. Santhosh*

Date & Time : *4/6/26 11:15:04*

Consultant : *[Signature]*
 Signature :

Name : *A. Rizwan*

Date & Time : *5/4/26*

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:

- DRF 2nd baby
- immunization
- OAE/NBS/SBR etc etc
- cord care was with care
- monitor in infant room

Noted by
pope

Doctor Signature: 

Doctor Name: Dr. Akheel Syed Rizwan

Date & Time: 4/16/24 15:04



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/8/26 8:45 AM	<p><u>CL/B Resident</u></p> <p>Term / 38+3 wks / NOVO (CAB) male / 2.8 kg / ABA</p> <p>M. BA - O positive B. BA - B positive</p> <p>T. WT - 2.70 kg (↓ 100 gm)</p> <p>OTB Baby warm CIT / A good CRT < 2 sec CUS - S₁ S₂ ⊙ P₂ - B / A ⊙ PA ↑ ↓</p> <p>Soft swellly now 0.5 cm x 0.5 cm over vly stable epigastria</p>	<p><u>18 hrs of life</u></p> <p><u>Ads</u></p> <p>- DBP / Ab prep every 2 hrs - OAE / SBR / TBS b/f discharge - Warm care - Cord care</p>
		<p>SM A. Brown</p>
<p>⊙ B. Brown</p>		<p>Noted by Sdr O/P 5/8/26</p>



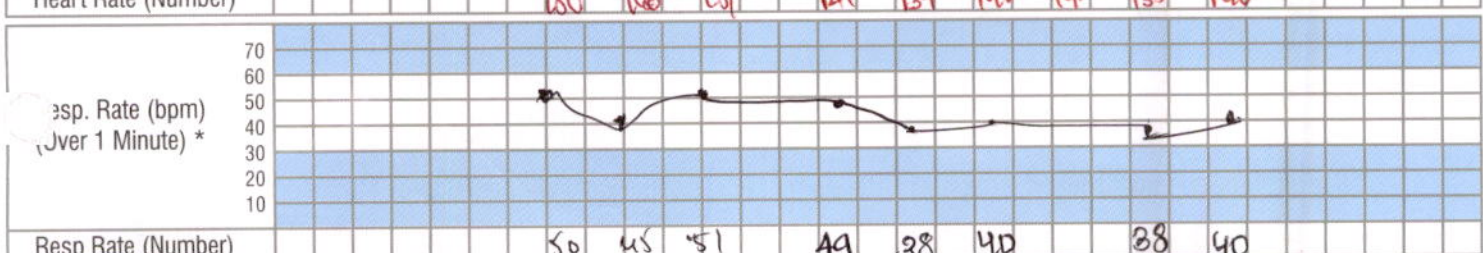
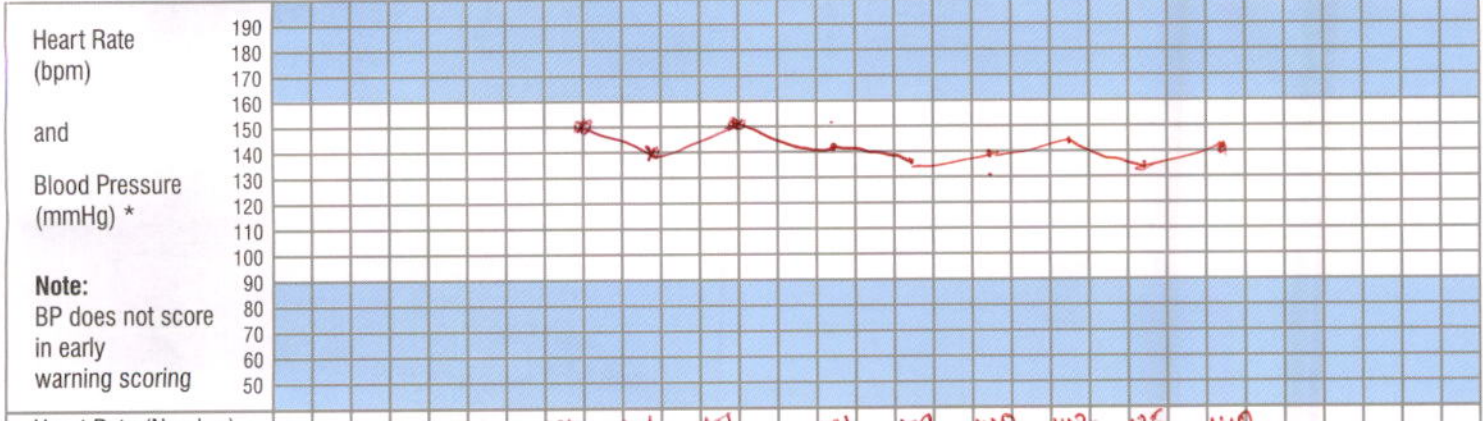
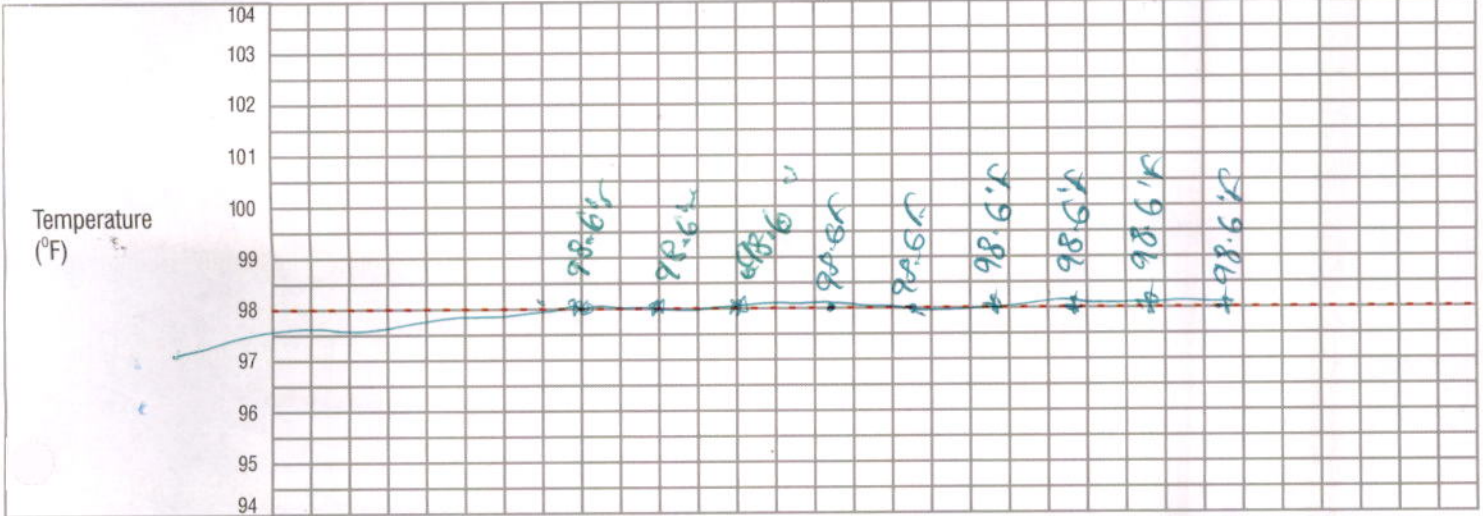
INFANT (<1 year)
 Children's Observation &
 Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 6/6/26 Time: 8 10 12 2 4 6 8 10 12 2 4 6 8

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



Resp Mod/ Severe Distress	None / Mild	-	-	-	0	0	0	0	0
Receiving O ₂ (l/min)	O ₂ Saturations (%)	-	-	-	99	99	99	100	99
Conscious Level	Normal / Altered	NA	NA	NA	2	2	2	2	2
GCS *		NA	NA	NA	15	15	15	15	15

TOTAL SCORE	
Number of shaded boxes	0
Pain Score	0
Observer's Initials	R, Y, R, S, S, B, B, B, B

ACTIONS

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

NB: Scores 3 should be recorded overleaf

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- 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-00205622 IP-00060226
 Baby B/O PAREPALLI SANJANA
 04-06-2026 0 Y 0 M 0 D 16 H (M)
 Dr. AKHEEL SYED RIZWAN



CH/ FRM / CLINICAL / 124

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

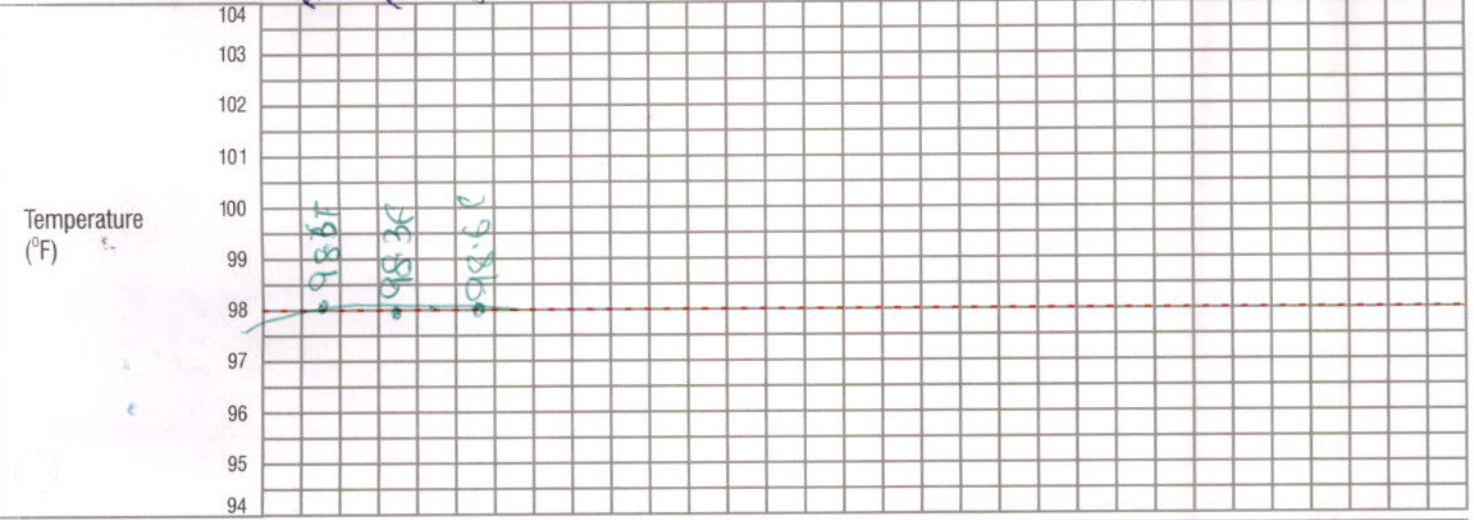
Rainbow Children's Hospital
 It takes a lot to treat the little.

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 04/06/2026 Time: 9:11 AM

Doctor/Nurse/Family Concern? [Handwritten initials]



Heart Rate (bpm)	190		
and Blood Pressure (mmHg) *	180		
	170		
	160		
	150		
	140		
	130		
	120		
	110		
	100		
	90		
	80		
	70		
	60		
	50		
Heart Rate (Number)	135	140	135

Resp. Rate (bpm) per 1 Minute *	70		
	60		
	50		
	40		
	30		
	20		
	10		
Resp Rate (Number)	32	30	28

Resp Distress	Mod/ Severe None / Mild		
Receiving O ₂ (l/min)			
O ₂ Saturations (%)			
Conscious Level	Normal / Altered	2	2
GCS *		5	5

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

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
	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.



FLUID CHART

Sheet No. : 1

4/6/26

- 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		
	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	DBF										
	04:00 pm								✓			
	05:00 pm	DBF										
	06:00 pm											
	07:00 pm	DBF							✓			
Total Intake :						Total Output : Paused						
	08:00 pm											
	09:00 pm	DBF							✓			
	10:00 pm											
	11:00 pm	DBF										
	12:00 am								✓			
	01:00 am	DBM										
Total Intake :						Total Output :						
	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

VIH-00205622 IP-00060226
 Baby B/O PAREPALLI SANJANA
 04-06-2026 0 Y 0 M 0 D 16 H (M)
 Dr. AKHEEL SYED RIZWAN



FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
5/6/26	08:00 am		DBM									2ndy @ 7pm 5/6/26	
	09:00 am								✓				
	10:00 am												
	11:00 am		DBM										
	12:00 pm												
	01:00 pm		DBM							✓			
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											Noted by @ 7pm 5/6/26	
	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							

