

ANC-00018184 IP28-00004545
 Baby Of SHWETA JAISWAL
 09-06-2028 0 Y 0 M 2 D (M)
 Dr. SHOBANA RAJENDRAN



DISCHARGE TRACKING SHEET

UHID : FLOOR: CONSULTANT NAME: DR.

ACTIVITY	IN TIME	OUT TIME	REMARKS	<To be filled by Admin>
Activity Sheet updated by Nursing		12/6/26 11:45pm	AS 011/26	
Activity Sheet updated by Pharmacy		12:32 pm	AS	

ACTIVITY RECORD FOR BILLING


Name:

UHID No: Consultant: *Dr. Shobana Rajendran* Dept: *26101 P*

Date of Admission: Date of Discharge: Time: *08:00 AM*

Room / Bed No: Suggested Billable bed type: *298 4425 10/01*

ANC-00016164 IP28-00004545
Baby Of SHWETA JAISWAL
09-06-2026 0 Y 0 M 0 D 17 H (M)
Dr. SHOBANA RAJENDRAN



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<i>09/06/26</i>	<i>6:30 PM</i>	<i>01-2</i>	<i>NICU</i>	<i>[Signature]</i>

CROSS CONSULTATION VISIT

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

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 Baby Of SHWETA JAISWAL
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RESULT SHEET

BSG: 'B' positive

Date	9/6/26				
Time					
Hb	17.9				
PCV	50				
RBC					
WBC	12020				
N/L	59/30				
Platelets	2.41 lakh				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/26 8am	SIB Dr. Shobana	
	continue HFNC 15ml Q 2H → 20ml Q 2H	SL 25-1
	taper Nitrogliserin	
10/6/26	SIB Dr. Shobana	
	LGA PTL 36 ⁺³ Boy 1	2.48kg A/G/A E SCS / mic 12DS
	Dol - - 16 hours	BWT - 2.48kg
	RS - on HFNC	5L/min, 25% FiO ₂
	RD - 83/min	
	Tachypnoe @	No retractions
	B/L AB @	clear
	SpO ₂ - 96%	
	C/S - pink, perfusion - good.	
	CP/PP -	
	HR - 150 - 155/min	
	S/S @	1 NO murmur

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 Baby Of SHWETA JAISWAL
 09-06-2028 0Y0M0D16H (M)
 Dr. SHOBANA RAJENDRAN



2



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	on Dobutamine @ SpO ₂ - 96%	2mcg/kg/min
	CNS - T/A - good AF - No Term Seizures Not on AED	
	P/A - soft, no distension BSØ - , Meconium - not passed on 15ml and hly feed. Plan - by evening - 20ml and hly.	
	FEE - Not on Sepsis - No TI	IV fluids - , CBO - Euglycemia
	Not on antibiotics , Blood clt - Awaited. Hb - 17.9 / Plt - 2.41	WBC - 12020
	Plan - Feed - 20ml Taper & stop ? Wean off	20ml and by evening 1mg Dobutamine to O ₂ after reassessment RA (Signature)



3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/26	9/13 m. Dineya sec	
9-30 am		
	Lact PT 36 ⁺ 3 Boy 2.48 kg New LSCS PRS	
	DOL - 40 hours of life	B.Wt - 2.48 CMT - 2.48 (↓100g)
	RS - on P2 cannula @ 0.4 L/min	
	RR - B/L AE ⊕, rllar No retractions	SPO ₂ - 100% RA
	CUS - Pharynx - CRT - 3 sec, Puls vol amv - bet	
	HR - 140 - 150/min	
	SIS ⊕, No trachea N.I. or Inotropic support SPO ₂ - 100% V.O - 2 ml/kg/hr	

4

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	CNS - AF - (-)	
	LITIA - good	
	Posture - (A/A)	
	Not on ACD	
	PIA - soft, No distension	
	on. oral feeds - 20ml 2nd hily - Nanpro	
	~100ml/kg/day	
	1 Paladar feeds given	
	Tolerating well, suckling - good	
	Stool - once	
	FPE - Not on	INF
	Sepsis - Blood	C/S - Awaited.
	NBC -	12020, Pct - 2.41
	Not on	Antibiotics.
	Plan - taper	stop 1.02
	? Paladar	feed - 25ml 2nd hourly

Dr
10/15/26

(5)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/26 10:30am	S/B m.	shobana / hr Thiruv
	Remove DBF feed.	
	3 feeds & RR - 260/min - shift.	
	RR - 260/min - shift.	
	DBF by in NICU	
		@
11/6/26 9pm	S/B m. range sev	
	shifting to ward.	
	IS - on PA, RR - 59/min	
	B/LAE @, clear	
	SpO ₂ - 100%	
	CUS - Pmb, CP/PIR - H/H, Peds vol - good	
	reflexion - good	
	HR - 140 - 150/min	
	SIS 2 @, No tremor	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/26 10:30 PM		S/B Dr Sugima
		Baby shifted to ward.
	Color, tone, activity	
	RR + 62/min	Chest - N/AE ⊕
	SpO2 - 99%	Cvs - S1S2 ⊕
		PA - Soft, NT
		+ pallor + DBF
		Adm
		- w/f distress
		- Monitor Saturation, vitals
		- Plan vaccination / OAE / NBS / TCB
		- Blood c/s to be traced



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/16/26 9 AM	S/B Dr. Anush / Dr. Shobana	
	Late PT (36+3) Boy baby LSCS MUD RDS.	Bwt - 2.45kg AGA
	Day 3 of life.	
	Baby Feeding 15-20ml FF + DBF	
	Passing urine & stools @ily	
	Baby pink	Bwt - 2.450kg
	Cry J	Twt - 2.
	Tone J (N)	
	Activity J	
	pulses well felt	TCB - 10.6 head.
	CRT < 3sec	9.1 chest
	S/E RS - B/CAE (+)	Blood c/s - 48 hrs
	CNS - AF @ level	no growth
	P/A - soft	
	CVCs - S2 (+)	
	DIC	Vaccination
	'R' Tuesday	OAE
	DBF + paladar	Red reflex
	Vit D.	NBS
	Calicemax + 2.5ml BD	Anush 163765
	x 6 weeks.	
	[Signature]	

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09-06-2026 0 Y 0 M 2 D (M)

Dr. SHOBANA RAJENDRAN



FLUID CHART

Sheet No. : 1

11/6/26

- 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												
	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	DMP FF 15ml											
	11:00 pm												
	12:00 am												
	01:00 am	DMP+FF 15ml											
Total Intake :						Total Output :							
	02:00 am												
	03:00 am	DMP+FF 15ml											
	04:00 am												
	05:00 am	DMP+FF 20ml											
	06:00 am												
	07:00 am	DMP+FF - 15ml											
Total Intake :						Total Output :							
Total 24 hrs. Intake		DMP = 5line FF = 80ml				Total 24 hrs. Output		U = 3 M = 2					

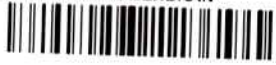
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FLUID CHART

12/6/26

- All measurements in ml.
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Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
	08:00 am											SS
	09:00 am	EBH	10ml						✓			01798
	10:00 am	DBF	✓									SS
	11:00 am											01798
	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											
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Total Intake :					Total Output :							
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	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												



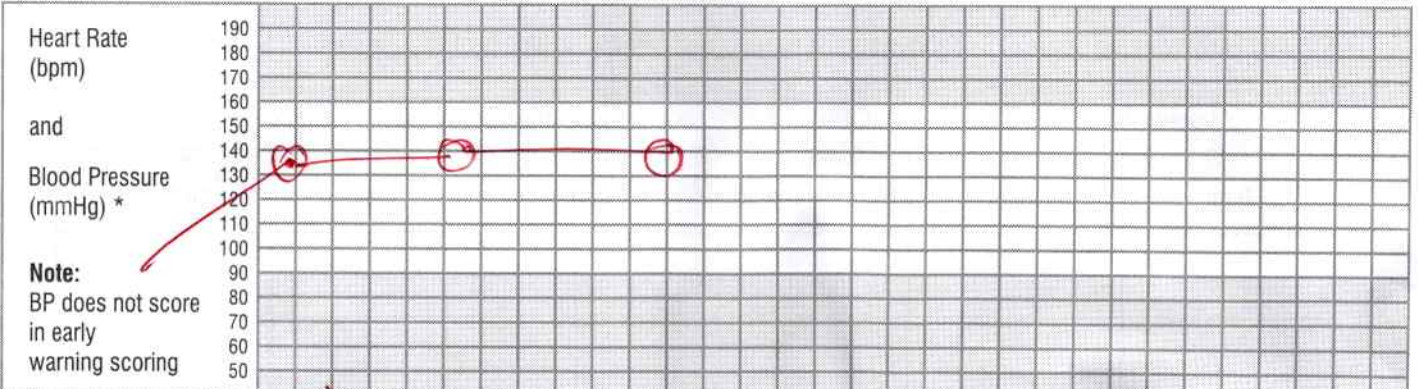
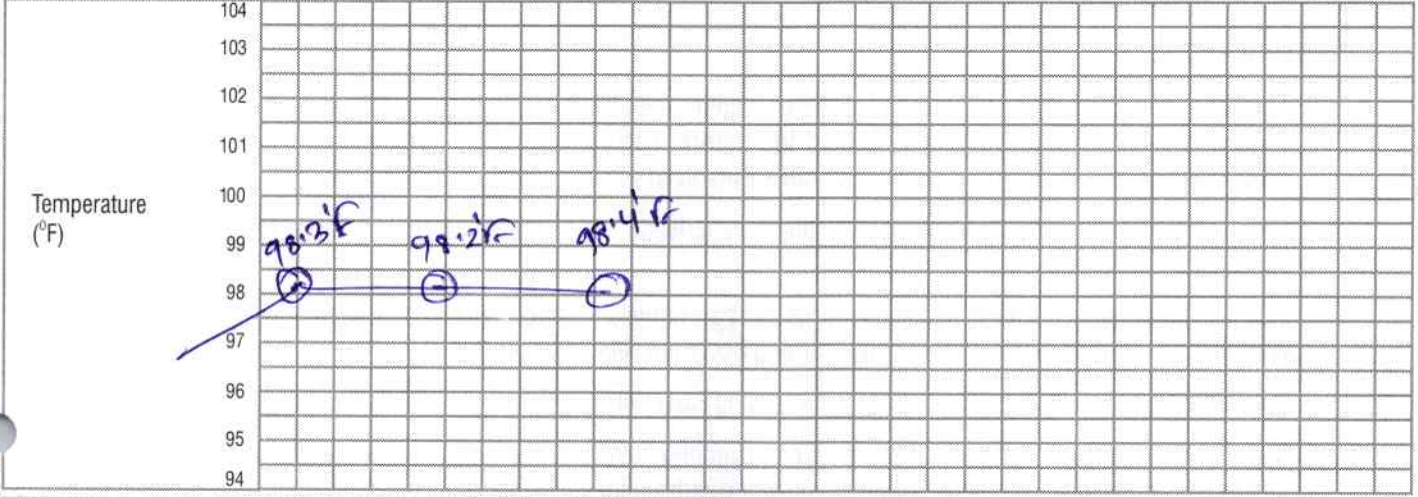
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

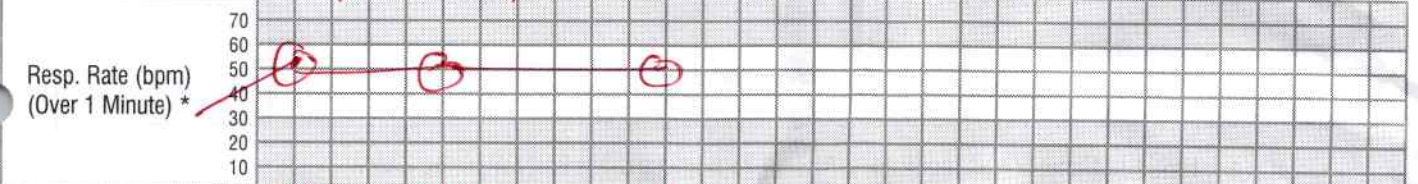
Date: 11/06/26 Time: 10pm 12AM 4AM

Doctor/Nurse/Family Concern?



Note:
 BP does not score in early warning scoring

Heart Rate (Number) 136b/m 142b/m 144b/m



Resp Rate (Number) 51b/m 50b/m 49b/m

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) 0 0 0
 O₂ Saturations (%) 99% 100% 98%

Conscious Level Normal Altered

GCS * 5/5 5/5 5/5

TOTAL SCORE Number of shaded boxes 0/10 0/10 0/10

Pain Score 0/10 0/10 0/10

Observer's Initials SH SH SH

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)



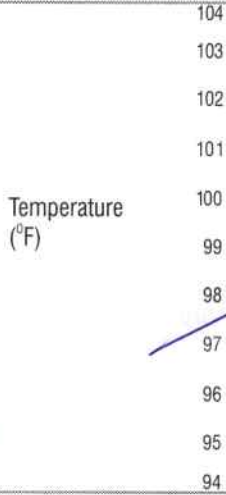
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Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 12/0/26 Time: 8 AM

Doctor/Nurse/Family Concern?



Heart Rate (bpm) and Blood Pressure (mmHg) *

Note: BP does not score in early warning scoring



Heart Rate (Number)

120 bpm

Resp. Rate (bpm) (Over 1 Minute) *



Resp Rate (Number)

40 bpm

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) O₂ Saturations (%)

99.1

Conscious Level Normal Altered

GCS *

4/3

TOTAL SCORE

Number of shaded boxes

0

Pain Score

0/10

Observer's Initials

SR

ACTIONS

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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)



NURSES NOTES
 (USE BALL POINT PEN ONLY)

- No Known Drug Allergies
- Drug Allergies *NA*

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
9/16/26	4:50 PM	Baby delivered at 4:50pm. Baby delayed cord clamp done. Baby cord blood collected. Baby routine care given and. Inj. vit: k. 1-cc. Inj given @ 4:55 PM. Baby Birth Details. BABY Birth Time: 4:50pm Birth Date: 9/16/26 BABY Sex: M/CF BABY KIT: 2.480 kg Baby cord blood sent for lab. Baby had grunting, nasal flaring, distress. Informed to Dr. Pagan, advice to send to NICU. and hand. over given to NICU staff.
9/16/26	7 PM	Reviewing Notes Baby received from OT, Birth <i>wt</i> 2.480 kg. Admission wt - 2.460 kg. Baby having grunting and respiratory distress. Baby received to O2 prongs. Now Baby is on CPAP support.
	7:30 PM	Baby feed started 10ml Nanpro given through OB. Baby feed tolerated. There is NO vomiting. NO desaturation.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



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NURSES NOTES
 (USE BALL POINT PEN ONLY)

- No Known Drug Allergies
 Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
	8 pm	Baby details hand over given to night duty staff. S. S. S. S.
		<u>Night duty notes</u>
9/6/26	8 pm	Baby details handing over taken by Evening duty staff Baby general condition are stable and vitals are checked and record in line if done.
	9 pm	Baby color and Baby active & Baby eyes very good Baby are stable Baby feeding given nasogastric 10ml OR given no vomiting and Baby are stable. S. S. S. S.
	11 pm	Baby feed Nasogastric 10ml to thorough ok Lung no chest no Brady. S. S. S. S.
	12 am	Baby diaper changed found in urine. S. S. S. S.
	1 am	Baby feed 10ml of OR gm to The Baby. Baby position also changed. S. S. S. S.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES



- No Known Drug Allergies
 Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
	2am	Baby sleeping well. feed also holdrate. Rate also coming 50 to 60 bpm only.	AD 02/16/26
	3am	feed for through O ₂ during no vomiting	
	4am	Morning Care given to The Baby Nuroleer also applied.	AD 02/16/26
	5am	feed to given to Baby 10ml Non-pro during no dist no	AD 02/16/26
	6.30am	Ready. Baby HFNC changed	
	7am	feed to given to 10ml of Non-pro to through O ₂ during no dist no Ready.	
	8am	Baby details hand over given to next duty staff	AD 02/16/26
		Morning Duty Notes	AD 02/16/26
	8am	Baby in detail handover taken from night Duty staff Baby is on HFNC support 25/5	
	9am	15 ml Non-pro feed given through O ₂ no vomit no flow change vitals are stable	

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 09-06-2026 0 Y 0 M 0 D 15 H (M)
 Dr. SHOBANA RAJENDRAN



NURSES NOTES



- No Known Drug Allergies
- Drug Allergies M

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
16	10 am	Dr. Thinesh sir follow up tapper due FiO_2 21% and plan to use tapper and change into oxygen up to evening	<i>[Signature]</i>
	11 am	15ml Non-Pro feed given 0% no vomit no colour change vitals are stable	<i>[Signature]</i>
	11:30 pm	change the tapper wire passed small amount	<i>[Signature]</i>
	12 pm	Baby having tracy preg upto 87 bpm improved to Duty doctor	
	1 pm	15ml Non-Pro feed given through 0% no vomit no colour change vitals are stable	<i>[Signature]</i>
	3 pm	Baby is maintaining stable no desat no Brady 15ml Non-Pro feed given 0% no vomit no colour change vitals are stable	<i>[Signature]</i>
	4 pm	Tapper due Rebutaine to 0.3 ltr	<i>[Signature]</i>
	5 pm	15ml Non-Pro given 0% no vomit no colour change vitals are stable	<i>[Signature]</i>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

(Handwritten initials)

NURSES NOTES



NO Known Drug Allergies

Drug Allergies *Ma*

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
	6pm	• Change the Diaper as urine passed	
	7pm	• 20ml Non-pro feed given • 0y no vomit no colour • diam. vitals are stable	<i>(Signature)</i>
	8pm	• Baby defaultly handover given to next duty staff	<i>(Signature)</i>
		<i>night duty: 10/6/26</i>	
	8pm	Baby defaultly handed over to next evening duty staff while taken handed over baby kept on warmer @ 32°C - 3/21 • Color pink Uro-p good activity good • Feed - 20ml Feed Nonpro with Play & Concha.	<i>(Signature)</i>
	9pm	Provide feed 20ml Nonpro baby taken well no vomit no desche.	<i>(Signature)</i>
	11pm	Provide feed 20ml Nonpro baby taken well no vomit no desche. Baby maintained good.	<i>(Signature)</i>
12/6/26	12PM	PR - still 67b/min & provide feed 20ml baby taken well no vomit no desche.	<i>(Signature)</i>
	3PM	provide feed 20ml Nonpro baby taken well no vomit no desche.	<i>(Signature)</i>
	5PM	T.V. out remove & discharge Staff.	
	5PM	Provide feed 20ml Nonpro baby taken	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



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NURSES NOTES

- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		given well no vomit no	
		deside	
	8 AM	mother care given hat clothes	
		2-48hrs ↓ body N&S & oral care	
		given hat am well no vomit	
		no deside	
	10 AM	provide JCS - Pure Nappie hat	
		the well no vomit no deside	
	8 PM	closed the vitis & received &	
		babat bottles handed over	
		given & just rest during shift	
	11/6/26	! Mummy Duty Notes!	
	@ 8am	• Baby handed over taken from night duty staff	
		• Baby is active, tone is normal & pink in color up	
		• Baby is on prone position under the warmer	
		• Baby is on 2 lit O ₂ cannula	
	9 am	• paladar feed → 20ml	
		Q&S gives	
		• ↓ O ₂ → 1 lit (Baby's saturation maintained)	
	10 am	• 2/3 Dr. Shobana advised	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



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NURSES NOTES
 (USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
11/6/26		to followed by, if baby is having less than 60 of RR
		plan to shift room side.
	11 am	<ul style="list-style-type: none"> • post feeds baby having rate of 60. • $6 \rightarrow 0.4$ lit • Baby was tolerating feed well
	12 pm	<ul style="list-style-type: none"> • no % Nasal E. as a • O₂ stopped \rightarrow Baby was
	1 pm	<ul style="list-style-type: none"> • Baby passed stool • Othe... contain the same • if maintain plan to shift room side • 20ml of paracetamol feeds
	2 pm	<ul style="list-style-type: none"> • Baby handed over to evening duty staff
		Evening Duty Notes
	2pm	<ul style="list-style-type: none"> • Baby details hand over taken from evening duty staff vitals are stable

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



8

NURSES NOTES
 (USE BALL POINT PEN ONLY)



- No Known Drug Allergies
 Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
	3pm	• 20ml Non-Pro feed given Befas Direct Breast feed given taken well no distat no Brady
	4pm	• Monitoring the vitals are stable no distat No Brady midle bracypnea is there
	5pm	• 20 ml Na-Pro feed given paradas no vomit no colour change vitals are stable
	6pm	• Change the Diapers urine and stool passed
	7pm	• 20ml Non-Pro feed given Bef father taken well post feed no bracypnea
	8pm	• Baby details handover given to next duty staff
	9PM	• Provide feed- ISM EDM both given well P/E motor given no vomit no distat baby vitals are stable maintain feed
	9:30pm	• baby shifted to MU unit shifted by mainted feed & baby bottle handed over given to the - Shiwandini night staff

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

ANC-00016164 IP28-00004545
 Baby Of SHWETA JAISWAL
 09-06-2026 0 Y 0 M 2 D (M)
 Dr. SHOBANA RAJENDRAN



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

NURSES NOTES

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Night duty Notes
	9:20pm	Baby received from NCV staff. When checked on mother maintains the vitals. Stable feeding. RR 15 to 20/min and hourly -
	11pm	Assured the baby feeding. baby feed well 15ml RR + SpO ₂ .
12/6/20	12am	vitals checked and documented vitals. Stable patient - stable.
	2AM	Assured the feeding baby feed well.
	4am	Baby vitals checked and documented vitals. Stable RR maintaining.
	6am	Morning care given to the patient baby active and pink. D/o assessed and documented patient stable.
	8am	Vitals checked and documented
	8:30	Handing over given for the next duty staff.

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