

ANC-00016129 IP28-00004534
 Baby Of MENAKA DEVI
 08-06-2026 0 Y 0 M 2 D (F)
 Dr. SHOBANA RAJENDRAN



Rainbow
 Children's
 Hospital
To Give a lot to have the little

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

DISCHARGE TRACKING SHEET

UHID: *ANC-16129*

FLOOR: *ANC level-7*

CONSULTANT NAME: DR. *shobana*

ACTIVITY	IN TIME	OUT TIME	REMARKS	<To be filled by Admin>
Activity Sheet updated by Nursing	<i>8/6/26 at 10am</i>	<i>8/6/26 at 9am</i>	<i>D. G. 1732</i>	
Activity Sheet updated by Pharmacy	<i>8:56</i>	<i>8:59</i>	<i>J. J. 1732</i>	

ACTIVITY RECORD FOR BILLING

Name: Bla. Menaka devi
 UHID No: IP No: ANC-00016129 IP28-00004534
 Date of Admission: Time: 08-06-2026 0 Y 0 M 0 D 9 H (F) Dept: NICU
 Room / Bed No: Ward: Dr. SHOBANA RAJENDRAN Time: 10:01am
 Suggested Billable bed type:



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
8/6/26	9:30am	Rudhran Hospital	RCH [NICU]	<i>[Signature]</i>

CROSS CONSULTATION VISIT

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

ANC-00018129
Baby Of MENAKA DEVI
08-08-2026
Dr. SHOBANA RAJENDRAN
IP28-00004534
O Y O M O D S H (F)

**IN
CARE UNIT**



Name: B/o Menaka Devi Age: Gender: Male Female

UHID.No: Date: 8/6/26

I S/o, D/o, W/o hereby declare that our patient Mr. / Ms who is related to me as is getting admitted in the Neonatal Intensive Care Unit of Rainbow Children's Hospital on

The doctors have explained to me in a language understood by me that my child has following health related issues :

hati Paetean i Respiratory distress

The doctors have clearly explained to me that my patient B/o during his / her stay in the Neonatal Intensive Care Unit may undergo various medical and surgical procedures like airway management, mechanical ventilation, Umbilical Artery Catheter, Umbilical Vein and Arterial Lines, Peripherally Inserted Central Catheter Line and arterial line placements, chest drain, or peritoneal drain insertion etc.

I have been told by the doctors that while performing such procedures I will be informed and a separate consent for this procedure shall be taken. However, in case of any life threatening emergency if the time is not available for taking informed consent it is implied that I give consent for various invasive procedure to save the life of my child.

I understand that a sick child in Neonatal Intensive Care Unit has life threatening medical conditions.

I understand that when a child is sick in the Neonatal Intensive Care Unit with multiple medical and surgical procedures performed upon him/her, there are inherent risks due to these high risk procedures, and high risk medications, in the form of infections, bleeding, air leaks, skin and other tissue damage etc.

I give my consent to the team of doctors to go ahead and admit the child B/o : in the Neonatal Intensive Care Unit fully understanding the associated risk, benefits and alternatives involved from various procedures, high risk medications and infections in the Neonatal Intensive Care Unit and treat him/her with all necessary means.

The doctors have explained to me in the language best understood to me.

Patient Attendant :
Signature :
Name : J-JUDE ASAY
Relationship with Patient: FATHER
Date & Time : 8/6/26

Witness :
Signature :
Name : Divya
Date & Time : 8/6/26

Doctor (who is taking the consent) :
Signature :
Name : Dr. Rangaraj
Date & Time : 8/6/26



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Mrs. Menaka Devi Age : 37 Father's Name : Age :
 Date of Birth : 8/6/26 Date of Admission : UHID No. :
 NICU Consultant : Dr. 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 MENAKA DEVI Mother's Blood Group : B positive
 Gender : M F Blood Group : Birth Weight (gms) : 2.2kg Length (cms) :
 Date of Birth : 8/6/26 Time of Birth : 6.57am OFC (cms) :
 Place of Birth : New Rudran Hospital Estimated Gesth Age :

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 37 Ht : Wt : BMI : Married Life : LMP : 26/9/25 EDD : 3/7/26.

Conception : Spontaneous or with Rx :
 Booked at what GA : AN Steroids Drugs / Doses :
 Last Scans Details : 5/6 scan - 35 + 2 Placenta - fundal @ lateral wall
cephalic, liquor - mid reduced, EFW - 2644 ± 386g.
 TT Immunization and Iron / Folic Acid : 67.5am

MATERNAL RISK FACTORS

Age : <18 yrs >35yrs
 Consanguinity : Yes No
 If yes, degree of consanguinity : 1 2 3
 H/o PIH (after 20 weeks) / PE
 How many Drugs / Doses / Since how long :
 H/o value of recent BP recording, proteinuria, edema,
 oliguria, any investigations (LFT, platelet count) :
mid reduced liquor - scan on 5/6
 IUGR - when detected :
 Doppler (Increased Resistance / ADEF / REDF /
 Redistribution in MCA) / Ductus Venosus :
 AFI : 3.04 - AFI - 10.6 cm
(Bilateral reduced)

H/o GDM/ pre GDM/ on diet or insulin
 Controlled or not, recent values, HbA1 values :
 Compliance with Rx :
 Scans : LGA, TIFFA , Fetal Echo :
 H/o Hypothyroidism : when diagnosed ? Medication?
 Any other Chronic Medical Problems, when detected
 drugs ?
 (Anemia, SLE, Jaundice, CHD, Heart Disease)
 Infection : H/O, Fever
 (Malaria UTI TORCH TB HIV HBV)
 UTI : when : Any culture :

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



Delivered at New Puducherry Hospital.
at 6.57 am.

cried after birth.

↓
developed distress in form of

tachypnoea - RR - 86/min.

↓
started on oxygen in nasal prongs

@ 1 Ltr/min.

↓
shifted to NICU for further
management.

Investigation details in previous Hospital :

Feeding History :



HEAD TO TOE EXAMINATION

Fontanelles :	AFC
Sutures	
Shape / Moulding :	(N)
Edema / Bruising :	
Size - (H.C.) :	
Facies : (Any Facial Dysmorphism)	(N)
NECK and CLAVICLES :	Range of Motion : Asymmetry : Masses :
	(N)
EYES :	Symmetry : Red Reflex : Discharge :
	to be checked
EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Periauricular Pits / Tags : Nasal shape / Patency : Palate : Gums : Lips : Tongue :
	(N) patent No cleft
THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number :
	(N)
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : Discharge :
	2 A+IV
GENITALIA :	Labia / Hymen : Testicles/penis : Anus :
	Major looking normal
HERNIAL ORIFICES	(N)
TRUNK and SPINE :	(N)
SKIN LESIONS :	
EXTREMITIES :	Fingers / Toes : Arms / Legs : Deformities : Mobility : Hip Joint Examination :
	(N)



any congenital anomalies :

Diagnosis :

late PT / 36 wk / B.Wt - 2.2kg / CBW /
girl / severe oligohydramnios / LSCS.

FOOT PRINTS

Left Side :

Right Side :

Resident Doctor :

Signature : RA
Name : Dr. kalya ni
Date & Time : 8/6/26 at 9am

Consultant :

Signature :
Name : Dr. Shobana
Date & Time : 8/6/26 at 9am

PLEASE FILL UP THE FOLLOWING DETAILS

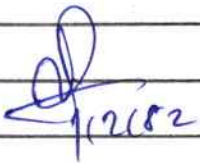

- Name of the referring Doctor :
- Name of the referring Hospital :
Address :
Contact Numbers :
- Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
- Name of the Doctor in Rainbow Team :

..... on whose name the patient is being referred.



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>S/B. Dr. Shobana</u>	
8/6/26 10.30 am		
	CXR now	
	CBC, CRP SOS.	
	10ml / Q2H OG	
	Saline nasal	
	↓ flow to 1L/min	 11/2/26
8/6/26 2 PM	<u>S/B. Dr. Ragh</u>	
	RS - pink, B/L AE (+), clear	
	RR = 68/min, SpO ₂ = 99% @ 30% FiO ₂	
	Heard SCL (+)	
	CXR = 7-8 space expansion	
	= acutal borders.	
	@U CPAP 5(30%)	
	CVS - pink, ppof. @ normal, CRT C 2.	
	HR - 160/min, RR =	
	SCL 2 (+). No aus.	
	R/A - soft, no distals	
	@ feeds - paladai OG - 10ml / Q2H	
	CNS - AF, C/T/A = A/A	
	FLE = passed w/o. No TX	
	SpO ₂ = NOTI - No A/O.	 11/2/26



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B m - diuretic sei	
	Lot 171 spec 1 - 36 Wk / 2.7kg / 1A1A / LSCC / phosphate / HMB	
	DAL - 2	B.Wt - 2.2kg
	CGA - 38%	C.Wt - 2.080 (100g)
	PS - Pn1 O2	Flow turned @ 0.4 → 0.2 L/min
	RR 64/min	60-70/min
	Very minimal TCR	
	SpO2 - 100%	
	plan to stop O2	
	EUS - Pink, reflexion - good	
	CP/PP - +/+	
	Flow vol - CP/PP - +/+	
	HR - 140 - 155/min	BP - 59/34 (50-95)
	SI @, No tremor	
	U.O - 2.4ml/kg/hr	
	Hb - 16.1 g/dl	
	on bobolomon @ 1mg/kg/min	



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26	S/B M.	shobana
10:45 am		
	stop eb Dobutamine ✓	
	Paladai feed	- 15ml and hly. ✓
	stop O2	✓
	tomorrow -	Plan discharge.
9/6/26	S/B M.	shobana
11 am		
	2-3 paladai feed	st. + tang keel - Plan discharge.
	- Monitor vitals,	BP.
		Su 10/6/26



Sheet No: ①

REGULAR PRESCRIPTIONS

Weight 2.2kg Ward New

DRUG : IND PIP 242				Date Time	8/6	8/6	10/6													
Dose	Route	Frequency	Start Dt.	8	X	VA	8/6													
220 mg	IV	Q12H	8/6	am	X	B	PS													
Name & Signature of the Doctor Starting the Drugs:				8	ST	AT														
Additional Instructions:				pm	KH	ET														
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

VERIFIED BY : Name Signature



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Blo. Menaka devi Mother's Name: Mrs. Menaka devi
Date of Birth: 8/6/26 Time of Birth: 6.57am Gender: Male Female
Birth Weight: 2.2 Kgs HC: cm Length: cm
Meconium in Liquor: Yes No Cried at Birth: Yes No
Term / Pre-term / Post-term: Term
Resuscitated: Yes No Blood Group: Mother: B+ve Baby:
Feeding: Breast Feeding Formula Both First Feed Time: 11am

AFFIX MOTHER'S IDENTIFICATION LABEL

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

Physical Assessment of New Born:

Temp: 36.0 °C HR: 145 b /Min RR: 70 b /Min BP: 54/36(93) SpO₂: 99%

Pain Score: 0/10 (Follow N Pass)

Fall Risk Assessment: Yes No Score: 13 (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~~

- Nutritional Screening: Feeding Problem Yes / ~~No~~
- Functional Screening: Musculoskeletal Congenital Abnormality Yes / ~~No~~
- Socio History: Siblings Yes / ~~No~~

All information obtained from Mother Father Other Family Member

Newborn Screening Discussed: Yes / ~~No~~

Nurse Name: A.S. Sarany Signature: [Signature] Date & Time: 8/6/26 @ 9:30am



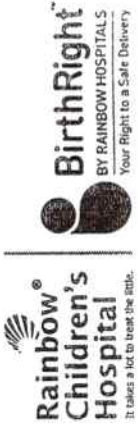
NURSING CARE RECORD

Date: 21/6/26

- Goals**
- Maintain Airway and Oxygenation
 - Relieve Pain & Discomfort
 - Maintain Fluid Balance
 - Improve Activity Tolerance
 - Maintain Good Nutritional Status
 - Maintain Skin Integrity
 - Maintain Personal Hygiene
 - Prevent Infection
 - Meet Elimination Needs
 - Ensure Safety
 - Early Ambulation
 - Reduce Anxiety
 - Patient & Family Education
 - Identify Potential Complications
 - Any Others. Specify: N/A

Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning 9 AM	<ul style="list-style-type: none"> → maintain airway oxygenation → maintain nutritional status 	2 PM	<ul style="list-style-type: none"> → continue CPAP → 10ml normal given q4h 	<ul style="list-style-type: none"> Baby no desaturated or expired 	<ul style="list-style-type: none"> Baby vitals are monitored 	<i>[Signature]</i>
Afternoon 3 PM	<ul style="list-style-type: none"> → plan to continue CPAP ⇒ RBS 6th hour 	3 PM	<ul style="list-style-type: none"> ON CPAP support vitals stable ⇒ RBS checked 	<ul style="list-style-type: none"> Baby vitals stable 	<ul style="list-style-type: none"> Baby color pink 	<i>[Signature]</i>
Night 8 PM	<ul style="list-style-type: none"> To provide feed orally 10 ml to the baby 	9 PM	<ul style="list-style-type: none"> provided feed 10 ml of Nuropro thorough given 	<ul style="list-style-type: none"> Baby feed tolerated well 	<ul style="list-style-type: none"> Giving feed NO complaints 	<i>[Signature]</i>

ANC-00018129 IP28-00004534
 Baby Of MENAKA DEVI
 08-08-2026 0 Y 0 M 2 D (F)
 Dr. SHOBANA RAJENDRAN



NURSING CARE RECORD

Date: 10/6/2026

- Goals**
- Maintain Airway and Oxygenation
 - Relieve Pain & Discomfort
 - Maintain Fluid Balance
 - Improve Activity Tolerance
 - Maintain Good Nutritional Status
 - Maintain Skin Integrity
 - Maintain Personal Hygiene
 - Prevent Infection
 - Meet Elimination Needs
 - Early Ambulation Reduce Anxiety
 - Patient & Family Education
 - Identify Potential Complications
 - Any Others. Specify.....

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							



①

NURSES NOTES
 (USE BALL POINT PEN ONLY)

- No Known Drug Allergies
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<u>Receiving Notes</u>
<u>8/6/26</u>		
	9:00am	Baby received from transport, Baby is on O ₂ prongs support 1 lit and checked weight 2.2kg and changed to radiant warmer changed dpaper and connected O ₂ 2.0pt due to retraction and nasal flarance AS 08/06/26
		→ OG 10ml 6size fixed @ 12cm AS 08/06/26
	10am	→ Dr. shobana mam rounds came advised to take one x-ray and give nasal drops and watch for retraction & grunting & nasal flarance and tapper O ₂ lit and tachynea and if any worsene do CBC, csp and start feed 10ml q4h and continue the same
	10:30am	→ X-ray done to the baby and after x-ray and mam advised to connect CPAP and connected 30/5
		→ OGIF 10ml nanpro given no vomiting & aspiration AS 08/06/26
	1pm	→ OGIF 10ml nanpro given no vomiting & aspiration AS 08/06/26
	2pm	→ Baby details hand over given to next duty staff AS 08/06/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



3

NURSES NOTES

No Known Drug Allergies

Drug Allergies Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
8.6.26	9pm	-> Feed given 10 ml of Nappero through OG given. During feed no complaints.	[Signature]
	10pm	-> Dr. Aishwarya told to change O ₂ cannula 2 liters. Dr. Shobana mam told to order. Aishwarya told. -> So I changed O ₂ cannula 2 liters. -> Baby stool passed so diaper changed.	[Signature]
		-> And Dobutamine Increased 4 micks by Dr. Aishwarya Mam.	[Signature]
	11pm	-> Feed given 10 ml of Nappero through OG given. During feed no complaints. -> CBG checked for the baby. 115 mg/dl.	[Signature]
8.6.26	11pm	-> Dobutamine taper 3 mick by Dr. Aishwarya Mam. -> O ₂ taper 1.5 liters by Mam.	[Signature]
9.6.26	12am	-> Baby vitals are Monitoring and Recorded.	
	1am	-> Feed given 10 ml of Nappero through OG given. During feed no complaints.	[Signature]
	2am	-> Baby urine passed so diaper changed.	[Signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



5

NURSES NOTES

No Known Drug Allergies

Drug Allergies ... nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
9/5/26	8AM	Morning duty Note:-	
		Baby details Hand over taken from Night duty staff	
		* Baby is under the warmer	
		* Baby is on 02 oil litter	
		* Baby cry activity ass done	
		* Baby colour good in pink colour	BTB2
	9AM	Baby feed 10 ml 2nd hourly Nanpro Full on feed is green No vomiting No distension	BTB2
	10AM	Dr: Shobana mam Advise Baby Feed 15 ml on removed Full paladai T/m Discharge	BTB2
	11AM	Baby feed 15 ml 2nd hourly Nanpro Full paladai feed is green No vomiting No distension Baby is on room on support	BTB2
	1PM	Baby feed 20 ml 2nd hourly Nanpro feed Full paladai feed is green No vomiting No distension Baby diaper changed urine passed Diaper changed	BTB2
	2PM	Baby details Hand over given to evening duty staff	BTB2

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



7 8

NURSES NOTES

No Known Drug Allergies

Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
9.6.26	9pm	=> Feed given 20ml of Nupra through palada given. During Feed no Complaints.	[Signature]
	10pm	=> Baby diaper changed urine passed. => I/O chart Maintained	[Signature]
	11pm	=> Feed given 20 ml of Nupra through palada given. During Feed no Complaints.	[Signature]
	12am	=> Baby vitals are stable => Baby sleeping well.	[Signature]
10.6.26	1am	=> Feed given 20 ml of Nupra through palada given no Complaints.	[Signature]
	2am	=> Baby position changed => urine passed so diaper changed.	[Signature]
	3am	=> Feed given 20ml of Nupra through palada given. During Feed no Complaints.	[Signature]
	4am	=> Vitals are Monitoring and Recorded. => I/O chart Maintained and Recorded.	[Signature]
	5am	=> Feed given 20ml of Nupra through palada given. NO Complaints.	[Signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS