

VIH-00205713 IP-00060263
 Baby Of AMULYA
 04-05-2026 0 Y 1 M 4 D (M)
 Dr. SURENDER RAO DUSA

ACTIVITY RECORD FOR BILLING

Name: -----
 UHID No : ----- IP No : ----- Consultant : ----- Dept : -----
 Date of Admission : ----- Time : ----- Date of Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Mohd. Abdul Khalid	8/6/26	3088017	[Signature]
2.	Dr. Murtaza Kamal	8/6/26	3088022	[Signature]
3.	Dr. Murtaza Kamal	11/06/26	3089075	[Signature]
4.	Dr. Nageswara Rao Konek	12/6/26	3689486	Uma
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
8/6/26	CBP CRP SLG Urea		umg
"	creatinine cat LFT		umg
"	RetEcount	26019620	umg
"	Blood culture 2P		umg
"	ABU ^① RBS	26019625	umg
"	X-ray ^①	209127	umg
"	RBS	26019636	umg
8/6/26	Phosphorus	26019631	Puy
	PT/APTT	26019638	Puy
	DCT	26019643	Puy
	ABG ^②	26019644	Puy
	Hemoglobin	26019647	Puy
	NSU, USU	26009161	Puy
	ABG ^③	26019680	Puy
	RBS	26019682	Puy
8/6	2D Echo	26009162	Puy
8/6	ABG ^④ , RBS	26019736	z
8/6	RBS	26019737	z
8/6	RBS	26019752	z
9/6	CBP, CRP, SE, Urea, Creatinine	26019768	Puy
	Calcium, SBR		
	ABG ^⑤ , RBS	26019769	
	X Ray ^⑥	26009208	



①

DAIV INVESTIGATION SHEET

VIH-00205713 IP-00060263

Baby Of AMULYA

04-05-2026 0 Y 1 M 4 D (M)

Patient Name :

Dr. SURENDER RAO DUSA



Age :

O. :

Date	Investigation	Ward	Nurse Signature	Bill No.	Received Date & Signature
9/6	RBS	NICU	[Signature]		26019808
09/6	ABG ⁶	NICU	[Signature]		26019806
9/6	RBS	NICU	[Signature]		26019832
9/6	ABG, RBS ⁷	NICU	[Signature]		26019839
10/6	ABG, RBS ⁸	NICU	[Signature]		26019859
10/6	X-ray ³	NICU	[Signature]		26009252
10/6	ABG ⁹	NICU	[Signature]		26019879
10/6	RBS	NICU	[Signature]		26019905
10/6	RBS , ABG	NICU	[Signature]		26019938
11/6/26	CBP, CRP, S/E, cal, urea, creat, LFT	NICU	[Signature]		26019953
11/6/26	CXR ⁴	NICU	[Signature]		26009333
	ABG ¹⁰ , RBS	NICU	[Signature]		26019952
11/6	2 Echo	NICU	[Signature]		↓ 3689077 26009352
11/6	VBG ¹¹	NICU	[Signature]		26020010
11/6	X-ray ⁵	NICU	[Signature]		26-009389
11/6	ET Culture	NICU	[Signature]		26019937
11/6	ABU RBS	NICU	[Signature]		26020072
cross checked done by S/S Uma 11/6/26					
12/6	ABG, RBS	NICU	[Signature]		26020020
	CXR				26009403
12/6	2 Echo	NICU	[Signature]		009409

①

RBS

Patient Name : -



Registration No.:

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
8/6	00.00	3am RBS 192 mg/dl	Uma	26019625
8/6	1.00	8am RBS 97 mg/dl	Uma	26019636
8/6	2.00	2pm RBS 122 mg/dl	Jay	26019682
8/6	3.00	6pm RBS - 55 mg/dl	J	26019736
	4.00	7pm RBS - 60 mg/dl	J	26019731
	5.00	8pm RBS - 137 mg/dl	J	26019743
8/6	6.00	10pm RBS - mg/dl	J	26019752
9/6	7.00	4Am RBS - 113 mg/dl	J	26019769
9/6	8.00	10am - RBS - 92 mg/dl	J	26019803
9/6	9.00	4pm - RBS - 116 mg/dl	J	26019832
	10.00	10pm RBS 78 mg/dl	Jay	26019839
10/6	11.00	8pm - RBS - 104 mg/dl	J	26019905
10/6	12.00	10pm RBS - 98 mg/dl	J	26020072
	13.00	cross checked done by sis Uma 10/6/26		
12/6	14.00	6am RBS - 70 mg/dl	J	26020130
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

ADMISSION SHEET

Registration Details :



Admission No : IP-00060263 **Admit Date** : 08-Jun-2026 **Admit Time** : 02:52 AM **UHID** : VIH-00205713

Patient Details :

Patient Name : Baby Of AMULYA **Age** : 0 Y 1 M 4 D
Guardian : Mr T.VIJAY KUMAR **DOB** : 04-05-2026 01:00 AM
Gender : Male **Religion** :
Occupation : **Martial Status** :
Address (H) : H NO 1-183/1 INDARAM DORGARIPALLY **Phone No** : 8106143257/ 9492742319
Jaipur Adilabad Adilabad Telangana INDIA **E-mail** : NA@GMAIL.COM
504216

Admission Details :

Bed Type : NICU **Bed No** : NICU 247 **Ward Name** : N 2F-NICU I
Room No : NICU 247 **Admission Type** : First Visit

Contact Details :

Name : Mr T.VIJAY KUMAR **Relationship** : Father
Contact Address : H NO 1-183/1 INDARAM DORGARIPALLY **Phone No** : 8106143257
Jaipur Adilabad Adilabad Telangana INDIA
504216

Signature

Doctor Details :

Doctor Name : Dr. SURENDER RAO DUSA **Specialisation** : GENERAL PEDIATRICS
Referral Doctor : Dr G Srinivas **Phone No** : 9440469925
Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 40000.00
Payor Name : SELFPAY

ADMISSION SHEET
Registration Details :


Admission No : IP-00060263 **Admit Date** : 08-Jun-2026 **Admit Time** : 02:52 AM **UHID** : VIH-00205713

Patient Details :

Patient Name : Baby Of AMULYA	Age : 0 Y 1 M 4 D
Guardian : Mr T.VIJAY KUMAR	DOB : 04-05-2026 01:00 AM
Gender : Male	Religion :
Occupation :	Martial Status :
Address (H) : H NO 1-183/1 INDARAM DORGARIPALLY Jaipur Adilabad Adilabad Telangana INDIA 504216	Phone No : 8106143257/ 9492742319
	E-mail : NA@GMAIL.COM

Admission Details :

Bed Type : NICU **Bed No** : NICU 247 **Ward Name** : N 2F-NICU I
Room No : NICU 247 **Admission Type** : First Visit

Contact Details :

Name : Mr T.VIJAY KUMAR **Relationship** : Father
Contact Address : H NO 1-183/1 INDARAM DORGARIPALLY
Jaipur Adilabad Adilabad Telangana INDIA
504216 **Phone No** : 8106143257

T. Vijay
Signature

Doctor Details :

Doctor Name : Dr. SURENDER RAO DUSA **Specialisation** : GENERAL PEDIATRICS
Referral Doctor : SELF **Phone No** :
Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00
Payor Name : SELFPAY



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Anulya Age : 30yrs Father's Name : Age :
 Date of Birth : Date of Admission : I.P. No. :
 NICU Consultant : Dr. Suresh Referring Consultant : Dr. Girivar
Transferring Unit : OT Labour Room ER Ward
Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : R/o Anulya Mother's Blood Group : O Negative
 Gender : M F Blood Group : O positive Birth Weight (gms) : 650 grams Length (cms) :
 Date of Birth : 4/5/26 Time of Birth : 1:05 AM OFC (cms) :
 Place of Birth : Sura Maternity Hospital, Meerut Estimated Gesth Age : 25 wks

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 30yrs Ht : Wt : 58 BMI : Married Life : 7yrs LMP : EDD : 17/8/26
 Conception : Spontaneous or with Rx : OI conception
 Booked at what GA : AN Steroids Drugs / Doses : Not known
 Last Scans Details : DCDA spontaneously reduced to singleton.
2/4/26 - SUDF AFI 9-10 cm, TT Immunization and Iron / Folic Acid : Taken.

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) :
 IUGR - when detected :
 Doppler (Increased Resistance / ADEF / REDF / Redistribution in MCA) / Ductus Venosus :
 AFI : Oligohydramnios

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 ? Det negative
 (Anemia, SLE, Jaundice, CHD, Heart Disease)
 Infection : H/O, Fever
 (Malaria UTI TORCH TB HIV HBV)
 UTI : when : Any culture :

PPROM : Duration : 15-20 days from 25/4/26 Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :

PAST OBSTETRIC HISTORY

G: 2 P: A: 1 L:

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
G ₁					<i>Spontaneous abortion</i>	
G ₂					<i>P.P. - 1 fetus no heart beat at 5 wks.</i>	

PERINATAL HISTORY

Treating Obstetrician : Hospital : Inborn Outborn

<p>Duration of Labour <i>Normal</i></p> <p>First stage (> 18 hours sig) <i>vaginal</i></p> <p>Second stage (> 2 hours after dilation) <i>delivery</i></p> <p>LSCS : <input type="checkbox"/> Elective <input 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>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 RESCUSTION 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	<i>Not</i>	<i>known</i>

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

HOP1:

Extremely Preterm (x) / Baby boy / 680 gm / EUSWVD

↓
said to be cured immediately after birth

↓
shifted to Mallikarjuna Hosp. mechanical on low flow

↓
started on CPAP for RDS for 3 days, later to
HFNC for 5 days & then to low flow FiO_2 .

Initially started on cefotaxim & Amikacin - stopped after
5 days.

On 24th day of life baby has apneas & desaturations →
blood cfr positive - Klebsiella.

↓
started on antibiotics & repeat blood cfr-report
available.

↓
from day 31 of life baby has repeated apneas &
desaturation for which septic screen was done
which are within normal limit.

↓
DICE line was removed on day 33 of life.

Investigation details in previous Hospital: On Day 33 of life baby had apnea
followed by desaturations which did not respond to
PPV, hence intubated.
milk was seen in oropharynx.

Feeding History:

↓
Baby was requiring high frequencies & FiO_2 hence
referred to Rainbow
↓
Baby is transferred

Past History :

7/6/26 - CRP - 116 - 8.3 CRP - 2.02
WBC - 11,400 S/E - 138/5.2/92
PLT - 3,36,000

Blood c/s → 7/5/26 → Klebsiella pneumoniae

Family History :

4/6/26 - No growth after 48 hrs
on meropenem, vancomycin, fluconazole

Socio Economic History :

na

GENERAL EXAMINATION ON ADMISSION

General Disposition :

on ventilator

CFR - full activity
hypotonic

GRS - 128 updat

iq furosemide 0.5 mg/kg sion

VITALS : Temperature : 36.5°C HR : 173/min RR : 40/min NIBP : 41/31(50) CFT : < 30

Color of the extremities : pink

Jaundice : ⊖ Pallor : ⊕ SpO2 : 99% on MV

Anthropometry : Birth Weight : 650 grams Length : HC : Present Weight : 1.01 kg

Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

HEAD : Fontanelles : } AF - full
Sutures :
Shape / Moulding :
Edema / Bruising :
Size - (H.C.) :

Facies : } NO facial dysmorphism
(Any Facial
Dysmorphism)

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

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

EARS, NOSE MOUTH and THROAT : Ear set / Shape : } (N)
Periauricular Pits / Tags :
Nasal shape / Patency :
Palate : NO cleft
Gums :
Lips :
Tongue :

THORAX and BREASTS : Shape of Thorax : } (N)
Position of Nipples and Number :

ABDOMEN and UMBILICUS : Shape : } (N)
Organomegaly :
Bowel Sounds :
Umbilical Stump :
Discharge :

GENITILIA : Labia / Hymen : } baby boy
Testicles/penis :
Anus :

HERNIAL ORIFICES } free

TRUNK and SPINE : } (N)

SKIN LESIONS : } nail

EXTREMITIES : Fingers / Toes : } (N)
Arms / Legs :
Deformities :
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 : NV - 25/6, P10, -50%. Rate 50

Spo2 : 99% UV Auscultation : RAE (+) Breath Sounds : NVRS (+) Added Sounds :

Cardiovascular System :

HR : 172 fine BP : 71/30 (45) ^{wide pulse pressure} Precordial Activity :

Femoral Pulses : felt Murmurs : continuous murmur (+)

Other Peripheral Pulses : bounding pulses Signs of Cardiac Failure :

Abdomen :

Shape : (N) soft Hernia orifice : free

Palpation : Anal Patency : patent

Palpable masses : Umbilical Cord :

Abdominal girth : First urine passed : passed

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness : lethargic

Prechtle Score :

Nerves :

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

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

ATNR : Skull and Spine :

Any Congenital Anomalies : NO obvious external congenital anomalies

Diagnosis : Extreme PT (25) / Day 34 / 29+6 wgt PDA of 680 grams / ext of
RDS - CPAP - N/A / apnea / late onset sepsis - Klebsiella
pneumoniae positive / pneumonia / PDA

FOOT PRINTS

Left Side :

Right Side :

Resident Doctor :

Signature : [Signature]
Name : Mr. Prathyush
Date & Time : 8/6/26

Consultant :

Signature : [Signature]
Name : Dr. Surender Rao Dasa
Date & Time : 8/6/26 @ 10am

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :
2. Name of the referring Hospital :
Address :
Contact Numbers :
3. Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
4. Name of the Doctor in Rainbow Team :
..... on whose name the patient is being referred.

AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

Vital : HR : RR : BP : SPO2 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

- 1) SIMV + P.S → 22/6, late to, P_{ao2} - 40
- 2) W - 150 cc/kg/day - sf. 150 P
- 3) NP, blood cl, LFT
- 4) 20 EMO, NIG
- 5) Pice line
- 6) Gels - monitoring - 6th only. (preferred)

Feeding Plan at the time of shifting : 7) NPO.

- 8) UCC if needed.
- 9) inf. monitoring

Screenings done during NICU Stay : 10) LP (7/m)

NSG : 11) ARG - TIP

Hearing Screen : 12) CXR - (7/m)

ROP :
TFT :

NP2 :

noted by
uma
8/6/26
sar



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/26 8 AM	single / EPT / 25 wks / 37 days / 29 ⁺ wks PMA / 680g EFW / ROS - CAP - HMC - MV / apnea of PT / CNS - Mucicella / Pneumonia / PDA / anemia -	
	Issues - - Anemia - CRBC req sent - RO or	Salicylic acid + murine (2 PDA)
	Twt - 1.09 hr	Normothermia
	SpO ₂ - 25 / 15	SpO ₂ - PS PIP PEEP Rate FiO ₂ 20 6 40 40% → 35%
	VIO -	
	slo -	Chest - BAE ⊕, CNS - 7 APR AGA CNS - AF - full
	CRBS - 192	CRBS - 5% ⊕, sent. murine P/D - soft, BS ⊕
	Adv - SpO ₂ - PS - W - 150 cal/day - CR - OD, ABG - sent , CRBS - 564 PDA feeds → 4ml 5% (ERM/DBM) → NPD 2D echo, NSG, USG abdomen (Plon. PC M) ROP on 12/6/26 Inj meropenem, fluconazole, linezolid - trace of ds, DCF send PT, APTT, INR c next ABG assess Plan - PDA if PDA → based on 2D echo - lsm. Arterial line → ABG Now - NPI +/m.	

af
 Dr. Surender RAO DUSA

Noted by
 Suresha
 8/6/26
 10:50 AM
 Dr. Surender RAO DUSA
 8/6/26
 10:50 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26 7AM	35 days / single / Ext PT 2 subs → ³⁰ 28 subs PMA / 680gms / ELBW / PDS - CPAP - HFNC - MV / Apnoea of PT / LONS - Klebsiella / pneumonia / PDA x 1 Perm / Anemia x ILRDL.	
	Issues: Anemia.	
	G-wt - S/O - 167.3 / 153w U/O - 5-0ml / 15h S/O - 2 times. CRBS - 113 mg/dL	Normothermic. SIMV PS - PIP = 12/6 Fiw = 30-40 Rate - 210. chest BAEC, CNS-TAR AUA CNS-S.S.C, murmur, PA-soft
	Adv: Target SpO2 90-96%, MAP > 29. IV - 150ml / Kg / day, = 10x 500P + MVZ + 8ml / 19 G. CXR - OD, ABx - 8thly, CRBS 6thly Befed. NPO → Plan to start feeds - ind x 2ndly (FBM / DBM), aspirate 6thly befed. ROP on 12/6/26. Ix: fluconazole, meropenem, Linezolid. Trace blood Cs. A/A latix. trace NPI. Plan to wean Ventilator settings. monitor vitals.	
	PCU-D ₂ Feeds 20ml 2ndly ↑ 1ml 8thly.	NP, + LFT on Thursday Dr. Surender 9/6/26 10:30 AM (P.T.O)

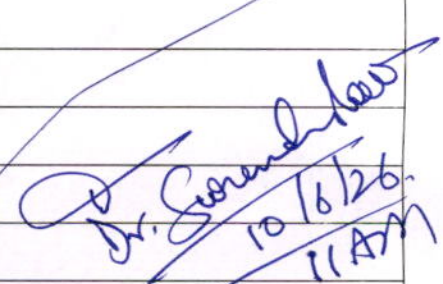
3



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	P7V → 17/6, Rate - 40, Cio - 30f.	
		noted by Sr. Harish 09/06/26 @ 12 PM
9/6/26	5PM → Baby received → NO clo RECV. → NO PE → OLG - Vitals stable CRT - C3SCC SpO ₂ - 96% on venti P _{7V} - good.	ADV - PCM - P ₂ - 2ml - 2nd hrly (7ml x 8hrly) - CXR - T/M - NP, + LFT on Thursday
		Noted by Sr. Harish 9/6/26 @ 6 PM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/26		
9 AM	D36 / Single / ERPT (10) → 30+1 w/c PMA of 680 grams ELBW / ROS - CPAP - HFNC - MV / Apnea of PT / KONS (- ketonides) U/PDA - IXPCL / Anemic IXCRA / G-29 ml	
	T. wt - I/O - 162 / 103 U/O - 3.9 cc/kg/hr S/O - 3 times GRS - 102 ml/dl	O/A - Normothermic on PTV - 17/6, Rate - 40 P _i O ₂ - 25 f C/P/A - Good CR - SIS (+) mucus (+) R/S - KAC (+) P/A - Cop.
	<p><u>Plan</u></p> <ul style="list-style-type: none"> - Target SpO₂ 90-96 % - Target MAP > 29 - on PTV - 17/6, Rate - 40, P_iO₂ - 25 f → 15 f, 40 f/m - ABC - TID, CXR - OD, GRS - 60 - IV - 150 cc/kg/day - 10% 180 P + 10 + MN on feeds - Hum P₂ U (↑ mucus P₂ U) - inf fluconazole, meropenem, kingonid - Trace R/S - ROP - 12/6/26 - inf PLM - D₃ - 2D Echo - 7/m - NP, + LFT 7/m - I/O stability, vitals monitoring 	<p style="text-align: right;">  Dr. Surender Rao 10/6/26 11 AM </p>

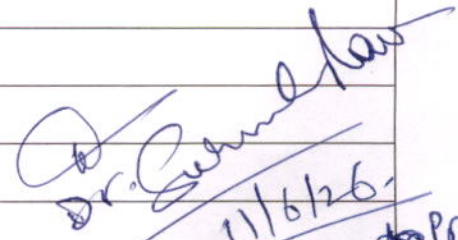


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>BP perennile</u>	
	50th	95th
		99th.
SRP	65	80
DRP	40	55
MAP	48	65
		68.
	20th → check in BP - If persistently > 85/60 (68) - inform.	f
<u>10/6/26</u>		
3PM	2D Echo screening done size ↑ 2.2 mm.	
	<u>Adv</u> - A/F ↓ TV @ 120 ml/kg day - WLF urine output (inform if < 7ml in 6hrs).	f
<u>10/6/26</u>	BP persistently > 99th centile.	
7PM		
	<u>Adv</u> - Digoxin - 0.5 mg/kg/day - stat & then after 12 hrs. (total 2 doses).	
	- 2D Echo (T/M) → also look for aorta & circulation area	
	- NPI + UET (T/M)	
	- Nephro concentration (T/M).	f



PROGRESS NOTES AND DOCTOR'S ORDER

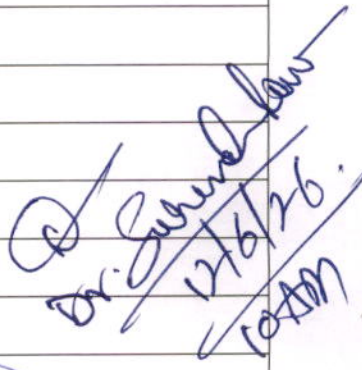
Date & Time	Progress Notes	Doctor's Order
11/6/26 8 AM	D37 single GPT/25 → 30 ⁺ wt PMA 680 g GROW ROS - CPAP - MNC - MV Apnea of PT LONS - Meckel's HIDA - IFCM Anemia - URBC Grade ? amn. decomp hypoxa.	
	<u>Issues -</u>	
	Cvt - 20 - 141/140 U/O - 5.3 slo - 2 ARDS - 101	Normothermic 16/5 16/5, 35/m, 25f. → 15f's Chest - BAE ⊕ CUS - 4.5 ⊕ wide PP. mumm ⊕ CNS - 7(A/R ACA, AF at level D/A - left, RS ⊕.
Adv -	Target SpO ₂ - 90-96%, MAP > 30 on MV - ABG - TID, ARDS - B0, COPD-OD. TV - 120 ml/yl/day. OG feeds - full g2H (↑ 1ml g2H) - T/F - 10ml g2H. Drugs Fluconazole, meropenem, linezolid. blf trace. → 18hrs NO growth. ROP - (T/M) PCM - D4 (from 2PM). 2D echo today NPI + LAT trace TET after hemodynamic stability. Nephro consultation if BP persistently (> 2 readings above - 85/60 (60)) Trace ET c/s.	<p style="text-align: right;">  11/6/26 12:15 PM </p>

2/

3/



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/26 9AM	D3sf single (EXPT CT) → 30+3 wks PMAf 680gm/ ELBW RDS - CPAP - HFNC - MV Apnea of PT Lungs - Klebsiella HSPDA - XIPCV anemia xixasc grade-1 GMI / Asymp. myocoe	
	T. wt - SpO ₂ - 133.3 / 128ml U/O - 4.5 cefkyfm S/O - GRS - 70 mglal.	Off - Normochemic P TV - 16/8, Rati - 3s, FiO ₂ - 2s C/T/A - Good Cess - SIS (+), mucus (+) Bounding fullse (+) R/S - SAE (+) P/O sup
	<p><u>Plan</u></p> <ul style="list-style-type: none"> - Target SpO₂ 90 - 96% - Target map > 30 if > 2 reading high MAP (68) - TV - 120 cefkyf day. - NPO as PDA device closure is planned. - inf neopenem, fluonazole, dirizolid - ROP (19/6/26) - PCU - Ds- - planned PDA device closure is RCM - trace ET off 	ALG - TID, GRS - BD <div style="text-align: right;">  Dr. Surendra Rao 12/6/26 10AM </div> Notes by umg 12/6/26 10am



DRUG CHART

Date of Admission: 8/6/26 Drug Allergies: Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
- 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG :				Date Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:																					

DRUG :				Date Time																	
Dose	Route	Frequency	Start Date																		
Doctor's Signature		Valid Period	Pharm.																		
Additional Instructions:																					

Signature
VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight: 1.09kg Ward: Nky

Dr. SURENDER RAO DUSA
 8/16/26

DRUG : INJ. MEROPENEM				Date	8/6	9/6	10/6	11/6				
				Time	8/6	9/6	10/6	11/6				
Dose	Route	Frequency	Start Date									
40mg	W	8 TH HOURLY	8/6	6AM once pro 24 24 24 24 24								
Name & Signature of the Doctor Starting the Drugs:				Mr. Prathap 8AM 24 24 24 24 24								
Additional Instructions:				10PM 24 24 24 24 24								
Additional Instructions:				40mg / kg / DOSE								
Daily Doctor's Endorsement by a Sign												

Dr. SURENDER RAO DUSA

DRUG : INT CAFFEINE				Date	9/6	10/6	11/6	12/6				
				Time	9/6	10/6	11/6	12/6				
Dose	Route	Frequency	Start Date									
6mg	IV	ONCE DAILY	8/6	6AM 24 24 24 24 24								
Name & Signature of the Doctor Starting the Drugs:				9/6								
Additional Instructions:				5mg / kg / DOSE								
Daily Doctor's Endorsement by a Sign												

Dr. SURENDER RAO DUSA

DRUG : REBUNATE SACHET				Date	8/6	9/6	10/6	11/6	12/6			
				Time	8/6	9/6	10/6	11/6	12/6			
Dose	Route	Frequency	Start Date									
1 SACHET	OG.	TWICE DAILY	8/6	6AM X 24 24 24 24 24								
Name & Signature of the Doctor Starting the Drugs:				6PM X 24 24 24 24 24								
Additional Instructions:				PROBIOTIC								
Daily Doctor's Endorsement by a Sign												

Dr. SURENDER RAO DUSA

DRUG : INT LINEZOLID.				Date	8/6	9/6	10/6	11/6	12/6			
				Time	8/6	9/6	10/6	11/6	12/6			
Dose	Route	Frequency	Start Date									
11mg	IV.	THREE DAILY	8/6	2AM X 24 24 24 24 24								
Name & Signature of the Doctor Starting the Drugs:				10AM X 24 24 24 24 24								
Additional Instructions:				6PM X 24 24 24 24 24								
Additional Instructions:				10mg / kg / DOSE								
Daily Doctor's Endorsement by a Sign												

Patient ID	I.P. No.	Sheet No. (2)	Wards N1W	Weight (kg) 1.09kg
------------	----------	----------------------	------------------	---------------------------

REGULAR PRESCRIPTIONS

DRUG : INT FLUCONAZOLE				Date	8/6/26	8/7/26	8/8/26	8/9/26	8/10/26	8/11/26	8/12/26	8/13/26	8/14/26	8/15/26	8/16/26	8/17/26	8/18/26	8/19/26	8/20/26	8/21/26	8/22/26	8/23/26	8/24/26	8/25/26	8/26/26	8/27/26	8/28/26	8/29/26	8/30/26	8/31/26
				Time	8/6	8/7	8/8	8/9	8/10	8/11	8/12	8/13	8/14	8/15	8/16	8/17	8/18	8/19	8/20	8/21	8/22	8/23	8/24	8/25	8/26	8/27	8/28	8/29	8/30	8/31
Dose	Route	Frequency	Start Dt.																											
6.5mg	IV	ONCE DAILY	8/6																											
Name & Signature of the Doctor starting the Drugs:				TWICE WEEKLY 6pm Dr. [Signature]																										
Additional Instructions:				Monday & Thursday 6mg/kg/dose																										
Daily Doctor's Endorsement by a Sign.																														

DRUG : INT PARACETAMOL				Date	8/6	8/7	8/8	8/9	8/10	8/11	8/12	8/13	8/14	8/15	8/16	8/17	8/18	8/19	8/20	8/21	8/22	8/23	8/24	8/25	8/26	8/27	8/28	8/29	8/30	8/31
				Time	8/6	8/7	8/8	8/9	8/10	8/11	8/12	8/13	8/14	8/15	8/16	8/17	8/18	8/19	8/20	8/21	8/22	8/23	8/24	8/25	8/26	8/27	8/28	8/29	8/30	8/31
Dose	Route	Frequency	Start Dt.																											
10mg	Oral	6 times	8/6																											
Name & Signature of the Doctor starting the Drugs:				Dr. [Signature]																										
Additional Instructions:				10-15mg/kg/dose																										
Daily Doctor's Endorsement by a Sign.																														

DRUG : INT FUROSEMIDE				Date	8/6	8/7	8/8	8/9	8/10	8/11	8/12	8/13	8/14	8/15	8/16	8/17	8/18	8/19	8/20	8/21	8/22	8/23	8/24	8/25	8/26	8/27	8/28	8/29	8/30	8/31
				Time	8/6	8/7	8/8	8/9	8/10	8/11	8/12	8/13	8/14	8/15	8/16	8/17	8/18	8/19	8/20	8/21	8/22	8/23	8/24	8/25	8/26	8/27	8/28	8/29	8/30	8/31
Dose	Route	Frequency	Start Dt.																											
0.6mg	IV	Twice Daily	8/6																											
Name & Signature of the Doctor starting the Drugs:				Dr. [Signature]																										
Additional Instructions:				0.5 mg/kg/dose x 2 doses & then stop																										
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.																															

Dr. Jaha
 Dr. Surender
 Dr. Palleedra
 10/6/26
 6pm
 8/6/26
 8/7/26
 8/8/26
 8/9/26
 8/10/26
 8/11/26
 8/12/26
 8/13/26
 8/14/26
 8/15/26
 8/16/26
 8/17/26
 8/18/26
 8/19/26
 8/20/26
 8/21/26
 8/22/26
 8/23/26
 8/24/26
 8/25/26
 8/26/26
 8/27/26
 8/28/26
 8/29/26
 8/30/26
 8/31/26

Patient Name



I.P. No.

Sheet No.

Wards

Weight (kg)

REGULAR PRESCRIPTIONS

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.																			

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.																			



Weight. 1.9 kg ... Ward. NICE

VARIABLE DOSE		Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :			Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Start Date		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor			Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:			Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE		Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :			Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Start Date		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor			Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:			Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
8/6/26	12:30 PM	WBC TRANSFUSION	20 ml / hr	IV OVER 4 HRS	sf	Shwetha Sushanti
9/6/26	11 AM	INJ. FUROSEMIDE	0.5 mg / kg	IV	B	Hast Jai, J.
11/4/26	5 PM	INJ. FURAZEMIDE	0.5 mg / kg	IV	L	Uma Prasanna

VERIFIED Name Signature

Moles



I.V. FLUIDS CHART

Weight: 1.09kg Ward: NICU

Date	Time	Position of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
8/6	3am	IV - 150ml/kg/day 5-f. 150 + MV2.	IV	6.3ml	[Signature]	ump prosa	8/6	[Signature]	[Signature]
8/6	3am	INJ. AMINOVEN 2.5 gm/kg/day	IV	1.8ml	[Signature]	ump prosa			
8/6	4pm	Inj Hep NS 25 UNITS IN 50ML NS	IV	0.3ml	[Signature]	[Signature]	9/6		[Signature]
8/6	7pm	INS 150ml/kg/day 10% 280P + MV2 + 8ml/kg	IV	6.3	[Signature]	[Signature]		[Signature]	[Signature]
10/6	2pm	IME 120 ml/kg/day 10% 180P + MV2 + Ca	IV	1.8 ml	[Signature]	prosa dehid			

Original
 Signature
 8/6
 9/6
 10/6

VERIFIED BY : Name

Patient Name	Baby Of AMULYA	Patient Ph. No	8106143257
Age	0 Y 1 M 7 D	Requisition No	R26-009352
Gender	Male	Billed on	11-06-2026 10:42 AM
IP / Bill No.	IP-00060263	Scanned on	11-06-2026 11:31 AM
UHID No.	VIH-00205713	Reported on	11-06-2026 11:31 AM
Ref. Doctor	SURENDER RAO DUSA	Ward / Bed No	

PEDIATRIC ECHOCARDIOGRAM REPORT

Situs & Cardiac Looping	Situs Solitus Levocardia
Systemic Veins	To RA
Pulmonary Veins	To LA
Atrio ventricular connection	Concordance
Ventricular arterial connection	Concordance
Great artery relationship	NRGA
Right atrium	Normal
Left atrium	Normal
Inter atrial septum	PFO L-->R SHUNT
Mitral Valve	Normal
Tricuspid Valve	Normal
Right ventricle	Normal
Left ventricle	Normal
Inter ventricular septum	Intact
Aorta and aortic arch	Left Arch / No COA
Pulmonary artery and branch PA	Normal
Aortic Valve	Normal
Pulmonary valve	Normal
Coronaries	Normal
PDA	<u>2.2mm</u> <u>LARGE PDA L-->R</u> <u>SHUNT</u>
Pericardium	Nil
Others	Nil

MEASUREMENTS:

Print Date/Time : 11-06-2026 11:31 AM

Printed By : RANGANATH
RELANGI

Page: 1 of 2

For Further Details
Scan QR Code



Patient Name	Baby Of AMULYA	Patient Ph. No	8106143257
Age	0 Y 1 M 7 D	Requisition No	R26-009352
Gender	Male	Billed on	11-06-2026 10:42 AM
IP / Bill No.	IP-00060263	Scanned on	11-06-2026 11:31 AM
UHID No.	VIH-00205713	Reported on	11-06-2026 11:31 AM
Ref. Doctor	SURENDER RAO DUSA	Ward / Bed No	

PARAMETER	ABSOLUTE cm)	Z score	PARAMETER	ABSOLUTE cm)	Z score
AO	0.5		Tricuspid Annulus		
LA	0.7		Mitral Annulus		
IVSd	0.3		Aortic Annulus		
LVIDd	1.4		PA Annulus		
LVPWd	0.3		RPA		
IVSs	0.4		LPA		
LVIDS	0.9		MPA		
LVPWs	0.3		AO Isthmus		
EF	69%		LV Mass		
FS	35%		Others		

Impression

SITUS , SOLITUS, LEVOCARDIA
2.2mm LARGE PDA L-->R SHUNT
PFO L-->R SHUNT
GOOD BIVENTRICULAR FUNCTION
LEFT ARCH , NO COA

Dr. NAGESWARA RAO KONETI

MBBS,MD,DM,FELLOWSHIP IN PAEDIATRIC CARDIOLOGY

Reg No: 19320

Note: Clinically Correlate, Kindly discuss if necessary.

Print Date/Time : 11-06-2026 11:31 AM

Printed By : RANGANATH
RELANGI

Page: 2 of 2

For Further Details
Scan QR Code



DBM

CONSENT FOR FORMULA FEEDS



Patient Name : B/O Anuleya Age : 36w Gender : Male Female

UHID No : 205713 Reg. No. : 60263 Department : NICU Date : 9/6/26

I Mr / Mrs. : T. Vijay Kumar aged 31 years, hereby declare that I have admitted my son / daughter in the Neonatal Intensive Care Unit of 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 :

Signature : T. Jayu

Name : T. Vijay Kumar

Relationship with Patient: Father

Date & Time : 09/06/26 @ 4pm

Witness :

Signature : Jhanni

Name : Jhanni

Date & Time : 9/6/26 @ 4pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. for aty ash

Date & Time : 10/6/26 @ 4pm

డబ్బా పాలు పట్టించుటకు సమ్మతి పత్రం

రోగి పేరు : వయస్సు : లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. రిజిస్ట్రేషన్ నెం: బిభాగము

తేదీ

నేను శ్రీ / శ్రీమతి వయస్సు : సంవత్సరాలు

నా కుమార్తె / కుమారుడు రెయిన్ఫో ఆసుపత్రిలో నవజాత శిశువుల ఇంటెన్సివ్ కేర్ లో అడ్మిట్ చేసినాము మరియు (ఫార్ములా

ఫీడ్) డబ్బా పాలు పట్టించుటకు నా పూర్తి అంగీకారం తెలుపుచున్నాను. డాక్టర్లు డబ్బా పాలు త్రాగించడం వల్ల కలుగు

ఉపయోగాలు, ప్రత్యామ్నాయాలు, మరియు సన్నాలు గురించి నాకు అర్థమైన భాషలో వివరించారు.

సహాయకుడు(అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

CONSENT FOR SPECIAL PROCEDURES

Patient Name : B/o Amulya Gender: Male Female

UHID No : 205713 Department : NICU Date : 8/06/26

I T. Vijaykumar S/D/W/O Venkanna

Here by give consent for procedure of : Arterial line

For my patient, Named : b/o Harish

The doctors have clearly explained to me that the procedure has following possible complications:

thrombosis, gangrene, compartment syndrome

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

Avoid repeated puncts, Easy access to arterial line

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr Vishal

Patient Attendant :

Signature : T. Vijaykumar

Name : T. Vijaykumar

Relationship with Patient: FATHER

Date & Time : 8/6/26 6pm

Witness :

Signature : Marie

Name : A

Date & Time : 8/6/26 6pm

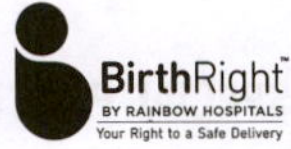
Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr Vishal

Date & Time : 8/6/26 6pm

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం పురుషుడు స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

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

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము



CONSENT FOR ADMISSION IN NEONATAL INTENSIVE CARE UNIT (NICU)

I T. Vijay Kumar S/o Mr/ Ms Venkanna.
 hereby declare that our patient Mr. / Ms Blo Amulya. who is related to me as
Son is getting admitted in the Neonatal Intensive Care Unit (NICU) of Rainbow Children's
 Hospital on 8/6/26 with UHID No. : 205713

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

The doctors have clearly explained to me that my patient Mr./ Ms. Blo Amulya
 during his / her stay in the NICU may undergo various medical and surgical procedures like airway
 management, mechanical ventilation, UAC, UVC (Umbilical Vein and Arterial Lines) PICC 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 NICU has life threatening medical conditions.

I understand that when a child is sick in the NICU 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 Mr. / Ms Blo Amulya
 in the NICU fully understanding the associated risks involved from various
 procedures, high risk medications and infections in the NICU and treat him/her with all necessary means.

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

Patient Attendant :

Signature : T. Vijay Kumar
 Name : T. Vijay Kumar
 Relationship with Patient: husband - Father
 Date & Time : 08/06/26 = 04:16

Witness :

Signature : Uma
 Name : Uma
 Date & Time : 8/6/26 4am

Doctor (who is taking the consent) :

Signature : [Signature]
 Name : Dr. Prathapasha
 Date & Time : 8/6/26 4am



నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ (ఎన్. ఐ. సి. యు) సమ్మతి పత్రం

రోగి పేరు వయస్సులింగం పు / స్త్రీ
 యు.హెచ్. ఐ.డి
 నేను చి

..... అనే బాలుడు / బాలిక యొక్క చికిత్స మేరకు రేయిన్ఫో చిల్డ్రన్ హాస్పిటల్ లోని నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్లో తేది నాడు పూర్తి సమ్మతితో చేర్చితిని. మా బాలుడి/బాలికలో ఈ క్రింద తెలిపిన ఆరోగ్య సమస్యల గురించి వైద్య నిపుణుడు నాకు అర్థమగు భాషలో వివరించితిరి.

నవజాత శిశువుల ఇంటెన్సివ్ కేర్ యూనిట్ లో మా పాప /బాబుకు వైద్య పరంగా అవసరమగు అన్ని రకాల చికిత్స విధానాలకు మరియు ప్రక్రియలను (ఉదా కృత్రిమ శ్వాస వెంటిలేటర్, ఆర్థోలియర్ లైన్, సింట్రిల్ లైన్ చ్రెస్ట్ డ్రైయిన్, పెరిటోనియల్ డ్రైయిన్ ఇంకా ఇతర వంటి ప్రక్రియలను డాక్టరు గారు నాకు అర్థమగు భాషలో(సవివరంగా) వివరించారు.

పైన తెలుపబడిన శస్త్ర ప్రక్రియలు చేసేముందు సమ్మతి తీసుకునే వీలు లేనిచో మా బాలుడు / బాలికను కాపాడుటకు అవసరమైన వైద్య శస్త్ర ప్రక్రియలు మా సమ్మతి లేకుండానే చేయవచ్చని నేను సమ్మతిస్తున్నాను.

ఆరోగ్య సమస్యలతో బాధపడుతున్న మా బాలుడికి/బాలికకు రుగ్గుతలచే ప్రాణహాని కలుగవచ్చిన నాకు వైద్యుడు అర్థమగు భాషలో వివరించితిరి.

మా బాలుడు / బాలిక ఎన్.ఐ.సి. యు లో ఉన్నప్పుడు ఎన్నో విధాల వైద్య మరియు శస్త్ర ప్రక్రియలు ఇంకా వివిధ చికిత్స విధానాలు అవసరం పడతాయని మరియు వాటివల్ల దుష్పరిణామాలు కలగవచ్చని అర్థం చేసుకున్నాను. ఆ పరిణామాలు ఎటువంటివి అనగా రక్తస్రావ ప్రమాదం కణజాలం దెబ్బతినడం మొదలగునవి.

మా బాలుడిని/బాలికను అడ్మిట్ చేయుటకు మరియు ఎన్. ఐ. సి.యు. లో ఉన్నప్పుడు జరుగు చికిత్స విధానాలు మరియు శస్త్ర ప్రక్రియలు వలన కలిగే అపాయాలను నేను అంగీకరిస్తున్నాను. మా పేషంట్ ను తగినన విధంగా చికిత్స చేయడానికి వైద్యునికి నా పూర్తి అంగీకారం తెలియజేస్తున్నాను. వైద్యుడు నాకు అర్థమగు భాషలో అంతా వివరించారు.

మా బాలుడు / బాలిక ను ఇంటెన్సివ్ కేర్ యూనిట్ (ఎన్.ఐ.సి.యు) లో చేర్చుకొని అవసరమయ్యే వైద్యం చేయుటకు నేను వైద్య బృందానికి నా సమ్మతి ధృవపరుస్తున్నాను.

సహాయకుడు (అటెండ్లెంట్)
 సంతకము
 పేరు
 తేది మరియు సమయము

సాక్షి
 సంతకము
 పేరు
 తేది మరియు సమయము

డాక్టర్
 సంతకము
 పేరు
 తేది మరియు సమయము

CONSENT FOR BLOOD TRANSFUSION



Name: Blo Amulya Age: 34 Gender: Male Female
UHID.No : 205213 Date: 8/6/26

- Type of Blood Product:**
- | | | |
|--|--|---|
| <input type="checkbox"/> Fresh Frozen Plasma | <input checked="" type="checkbox"/> Packed Red Blood Cells | <input type="checkbox"/> Random Donor Platelets |
| <input type="checkbox"/> Cryoprecipitate | <input type="checkbox"/> Single Donor Platelet | <input type="checkbox"/> Whole Blood |
| <input type="checkbox"/> Albumin | <input type="checkbox"/> Red Blood Cell | <input type="checkbox"/> Others |

I Padma hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immuno-deficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: S. Padma
Name: Padma
Date & Time 8/6/26 6am

Doctor (Who is talking the consent)

Signature: [Signature]
Name: Dr. Lakshmi
Date & Time 8/6/26 @ 10am

Witness

Signature: [Signature]
Name: [Signature]
Date & Time 8/6/26 6am

రక్త మార్పిడి కొరకు అంగీకార పత్రము

రోగి పేరు: వయస్సు: లింగము పురుషుడు స్త్రీ
UHID. సంఖ్య: తేదీ:

- రక్త ఉత్పత్తి రకాలు:**
- | | | |
|---|---|---|
| <input type="checkbox"/> తాజా ఘనీభవించిన ప్లాస్మా | <input type="checkbox"/> ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు | <input type="checkbox"/> Random Donor Platelets |
| <input type="checkbox"/> క్రయో ప్రెసిపిటేట్ | <input type="checkbox"/> ఒకే ధాత ప్లేటిలెట్స్ | <input type="checkbox"/> Whole Blood |
| <input type="checkbox"/> మొత్తం రక్తం | <input type="checkbox"/> ఎర్ర రక్త కణం | <input type="checkbox"/> ఇతరులు..... |

నేను ఇందు మూలముగా రెయిన్ఫో ఆసుపత్రిలో అడ్మిట్ అయి ఉన్నప్పుడు పూర్తి చికిత్సలో భాగంగా నాకు గాని/ నా రోగికి గాని రక్తమార్పిడికై/ రక్త రక్త ఉత్పత్తుల మార్పిడికి అంగీకారం తెలుపుతున్నాను. దాత రక్తాన్ని హెచ్ ఐ వి యాంటీ బడిస్, హైపటైటిస్ బి సర్వేస్ యాంటిజన్, హైపటైటిస్ యాంటిబడిస్, మలేరియా మరియు సిఫిస్ లక్షణాలు లేవని పరీక్షించి బడినది అని వివరించడమైనది. రక్త పరీక్ష నిర్ణయ కాల పరిమితి లో జరిగినప్పటికీ పరీక్షలో కనబడని అనేక ఇతర ఇన్ఫెక్షన్ ద్వారా అతి అరుదుగా ఇన్ఫెక్షన్లు సోక వచ్చునని కూడా తెలియపరచడమైనది. ఏదైన రక్త ఉత్పత్తుల మార్పిడికి సంబంధించిన ప్రతిచర్యలు సోకే ప్రమాదం వుందని, ప్రసరణ వ్యవస్థలో అదనపు ద్రవం మొదలగు అరుదైనది పర్యవసానాలు తెలెత్తవచ్చు అని నేను అర్థం చేసుకున్నాను.

ఈ ప్రక్రియకు ప్రత్యామ్నాయం గురించి డాక్టర్ నాకు వివరించారు

పైన పేర్కొన్న అన్ని ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు నాకు / నా రోగికి చికిత్స చేస్తున్న డాక్టర్ ద్వారా నాకు వివరించబడ్డాయి. చికిత్స చేస్తున్న సమయంలో అన్ని రకముల రక్తమార్పిడులకు (మొత్తం రక్తం / లేదా రక్త ఉత్పత్తులు ప్యాక్ చేయబడిన ఎర్ర రక్త కణాలు, ఎర్ర రక్త కణాలు, ప్లేట్ లెట్స్, ప్లెష్ ప్రాజెన్ ప్లాస్మా, క్రయో ప్రెసిపిటేట్ మొదలైనవి) నా అంగీకారము తెలుపుతున్నాను. నాకు పూర్తిగా అర్థమగు భాషలో నాకు నా రోగికి వివరించారు మరియు నేను దానిని సమ్మతిస్తున్నాను

సహాయకుడు(అటెండెంట్)	సాక్షి
సంతకము	సంతకం
పేరు	పేరు
తేదీ మరియు సమయము	తేదీ మరియు సమయము

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)
సంతకము
పేరు

LRBC

Ref. No. : F / HW / BTM / NSG / 03

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Name of the patient : Blo Amulya UHID : 205713 I.P. No. : 60263

Age : 14/10 Gender : M Department : NW Ward : NW

Blood group of the patient : O+ve Blood group on the Blood bag : O+ve

Blood bank issue no : BAH 26-01243 Date of collection : 23/5/26 Date of expiry : u/7/26

Date & Time of starting transfusion : 8/6/26 @ 12:30 pm Planned duration of transfusion : 4 hrs

PLEASE MONITOR THE FOLLOWING EVERY 30 MINUTES

Time	HR	Temperature	Blood pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
12:30 pm	174	36.5°C	91/32(52)	89	-	-	-	-
1pm	181	36.5°C	77/30(49)	93	-	-	-	-
1:30 pm	198	36.5°C	85/40(58)	97	-	-	-	-
2pm	189	36.5°C	88/40(58)	95	-	-	-	-
2:30pm	189	36.5°C	86/51(62)	96	-	-	-	-
3:00pm	185	36.5°C	75/36(49)	98	-	-	-	-
3:30pm	179	36.5°C	77/39(52)	98	-	-	-	-

Comments : NO REACTIONS

Nurse Name : M Nurse Signature : b

BIACH&RI OPERATOR ST DATE: 8/06/26
BLOOD BANK Hospital
 id No.2,
 25 Gy INDICATOR [REDACTED] IRRADIATED

Qty. 30 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D./SAGM Solution.

 Rh Negative	HIV I & II/ HBsAG/ HCV - Non reactive VDRL - Non reactive MP - Negative NAT(HIV I & II/ HBsAG/ HCV)- Non reactive
	Unit No.: BAH26-01243 Blood Group: O Rh Negative Collection Date: 23/May/2026 Expiry Date: 04/Jul/2026

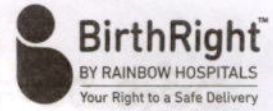
1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not Add Any M Group and With Filter There is At Appropriate Antibodies

Issue Label / Cross Matching Report

Patient : **B/o. Amulya -**
 Patient's Blood Group : **O Rh Positive**
 Hosp/Dr : **Rainbow Childrens Hospital, dr surender rao**
 UHID No. : **VIH-00205713** Wd-Bed No. :
 Product : **LR-PRBC Pedia-1**
 Blood Group : **O Rh Negative**
 Unit No. : **BAH26-01243** Issue Dt : **08/Jun/2026**
 XMatchig Report: **Compatible** Colln. Dt : **23/May/2026**
 X-matched by: **Premalatha** Exp. Dt : **04/Jul/2026**
 Issued By : **Premalatha**

Rain bow Hospital Blood Centre, Rainbow Childrens Hospital
 D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P. Road
 No.2, Banjara Hills, Hyderabad, Tejangana State
 Lic No. 46/1D/TS/2018/BB/G

CONSENT FOR SPECIAL PROCEDURES



Patient Name : Gender: Male Female

UHID No : Department : Date :

I S / D / W / O

Here by give consent for procedure of :

For my patient, Named :

The doctors have clearly explained to me that the procedure has following possible complications:

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

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

.....
.....

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure:

Patient Attendant :

Signature :

Name :

Relationship with Patient:

Date & Time :

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature :

Name :

Date & Time :

ప్రత్యేక విధానాలకు సమ్మతి



రోగి పేరు లింగం పురుషుడు స్త్రీ

యు.హెచ్.ఐ.డి విభాగం తేదీ

నేను S/D/W/O

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా

నా రోగికి, పేరు :

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు :

సహాయకుడు (అటెండెంట్)

సంతకము

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము

పేరు

సాక్షి

సంతకము

పేరు

తేదీ మరియు సమయము

CONSULTATION FORM

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



Doctor Name :

Date : Hour :

Hospital :

Type of Referral : Emergency (within one hr.)

Urgent (within 6 hrs.) Non Urgent (within 24 hrs.)

Referred for : Opinion Co-Management

Transfer of care

Date : Time : By :

Reason for Consultant : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: [Signature] M.D.

Report of Findings and Recommendations :

preterm 25wks → Day 38

BW : 700 → 1.0 kg

RDS → ventilated

→ retrieved & transported from
Mumbai

Arteries: Bowley age: 51st centile

exn: CGR 0.55 Amlertay

Size: 3.5 mm PDA 0.1 x 1

Dilated left heart

(10) LV fr

Consultant :

Name : NATYESWARA RAO KONETI Signature : Date & Time :

NOTE : If more space is required use another consultation sheet as continuation



ph: PDA David Day

Handwritten signature

12.06.2026

Consultant:

Name

Specialist

Day & Time

NOTE: If more space is required use another consultation sheet as appropriate.

CONSULTATION FORM



Doctor Name :

Date : Hour :

Hospital :

Type of Referral : Emergency (within one hr.)

Urgent (within 6 hrs.) Non Urgent (within 24 hrs.)

Referred for : Opinion Co-Management

Date : Time : By :

Transfer of care

Reason for Consultant : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

M.D.

Report of Findings and Recommendations :

Consultant :

Name : Signature : Date & Time :

NOTE : If more space is required use another consultation sheet as continuation

VIH-00205713

IP-00060263

Baby Of AMULYA

04-05-2026

0 Y 1 M 4 D

(M)

Dr. SURENDER RAO DUSA



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/6	4AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Una
8/6	2pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Shrey
8/6	8pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	A
9/6	8AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Shrey
9/6	2PM	0	NICU	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Shrey
9/6	8pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Shrey
10/6	8am	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Shrey
10/06	2PM	0	NICU	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Hanuman
10/6/26	8pm	0	NICU	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Shrey
11/6	2PM	0	NICU	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	-	Hanuman

Re-assessment Frequency:

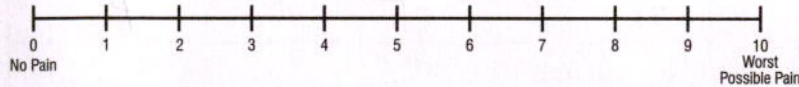
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ , 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/6/26	8pm	0	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	—	emp
12/6/26	8Am	0	—	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	—	JLH
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

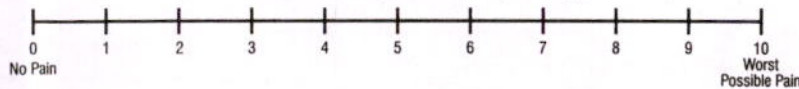
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Even More 8 Hurts Whole Lot 10 Hurts Worst



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

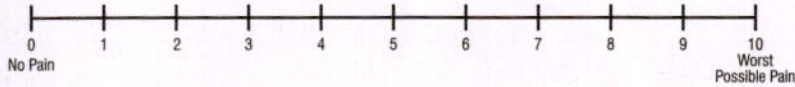
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

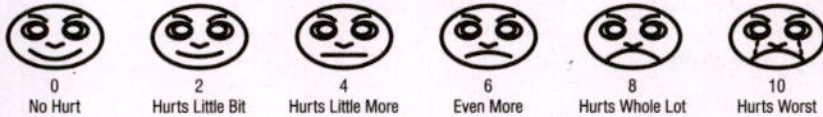
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ , 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ , less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





THE HUMPTY DUMPTY SCALE

8/6 9/6

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	8/6	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3		3	3	3	3
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not aware of Limitations	3		3	3	3	3
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4	4		4	4	4
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
Total			15	16	16	16	16

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		X	X	X	X	X
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair cup		X	X	X	X	X
Other Intervention(s) Specify		✓	X	X	X	X
Nurse's Name:		Ung	Shweta	H	P	Shweta
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		8/6	8/6	8/6	9/6	9/6
Time:		2 AM	9 PM	8 PM	8 AM	2 PM

VIH-00204742 IP-00059882
 Baby Of RAMAVATHI
 30-04-2026 0 Y 0 M 9 D (M)
 Dr. SURENDER RAO DUSA



THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope/Dizziness, etc.)	3	3	3	3	3	3
	Psych/Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3	3	3	3	3	3
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2	2	2
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1	1	1
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
Total			16	16	16	16	16

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓	✓	✓
Call device within reach		x	x	x	x	x
Wheels Locked		✓	✓	✓	✓	✓
Room free of clutter		✓	✓	✓	✓	✓
Adequate lighting		✓	✓	✓	✓	✓
Wheel chair support		x	x	x	x	x
Other Intervention(s) Specify		x	x	x	x	x
Nurse's Name:		Jani	Shreya	Shreya	Shreya	Jani
Signature:		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]
Date:		9/6/24	10/6	10/6	10/6	11/6
Time:		8pm	8am	9am	8pm	8am



THE HUMPTY DUMPTY SCALE

11/06

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4	4	4	4		
	3 to less than 7 years old	3					
	7 to less than 13 years old	2	2	2	2		
	13 years old and above	1					
Gender	Male	2					
	Female	1					
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3	3	3	3		
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1					
Cognitive Impairments	Not aware of Limitations	3	3	3	3		
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2	2	2		
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours/ None	1	1	1	1		
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3	1	1	1		
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2	1	1	1		
	Other Medications / None	1	1	1	1		
Total			16	16	16		

Intervention:

-Fall Risk: Low Humpty Dumpty Score = 7-11,

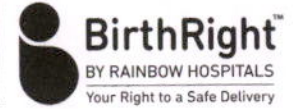
High Risk Humpty Dumpty Score = 12 or above

Bed in low position		✓	✓	✓		
Call device within reach		X	+	+		
Wheels Locked		✓	✓	✓		
Room free of clutter		✓	✓	✓		
Adequate lighting		✓	✓	✓		
Wheel chair support		X	X	X		
Other Intervention(s) Specify		X	X	X		
Nurse's Name:		Harshika	Harshika	Harshika		
Signature:		[Signature]	[Signature]	[Signature]		
Date:		11/06	11/06	11/06		
Time:		9:45	11:00	8:00		

VIH-00205713 IP-00060263
 Baby Of AMULYA
 04-05-2026 0 Y 1 M 4 D (M)
 Dr. SURENDER RAO DUSA



①



CHECKLIST FOR THROMBOPHLEBITIS

8/6/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			-	-	-	-	-	-	-	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	-	-	-	-	-	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			-	-	-	-	-	-	-	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			-	-	-	-	-	-	-	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			-	-	-	-	-	-	-	
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : [Signature] Name : Shweta

Signature of Ward In Charge :

Signature : [Signature] Name : Jyoti



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	10/6 DAY-1			11/06 DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-	-				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-	-				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-	-				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-	-				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-	-				
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :
Signature : Sr. Jyoti Name : Sr. Jyoti

Signature of Ward In Charge :
Signature : Sr. Jyoti Name : Sr. Jyoti

VIH-00205713
 Baby Of AMULYA
 04-05-2026 0 Y 1 M 4 D (M)
 Dr. SURENDER RAO DUSA
 IP-00060263



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Re-assessment Frequency:

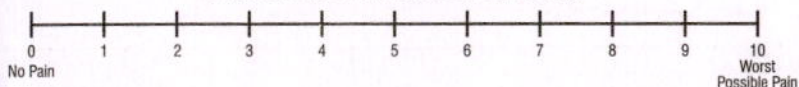
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

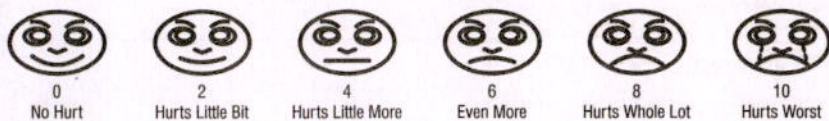
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



0 No Hurt
2 Hurts Little Bit
4 Hurts Little More
6 Even More
8 Hurts Whole Lot
10 Hurts Worst



VENTILATOR CARE BUNDLE CHECK LIST

Date of Intubation: 7/6/26

No of Days on Ventilation:

Date of Tracheostomy:

Parameters	Date	Shift Time	8/6/26	8/6/26	8/6/26	9/6/26	10/6	10/6	10/6/26
			8am-2pm	2pm-8pm	8pm-8am	8am-8pm	8pm-8am	8am-8pm	8pm-8pm
Ready for Extubation today? (Discuss during the clinical round)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is Sedation holiday discussed? (Discuss during the clinical round)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is Ventilator Circuit visibly soiled? (If Yes - Please Change)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is Suction container visibly Soiled? (If Yes - Please Change)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Inline Suction Used?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is AMBU bag soiled? (If Yes - Please Change)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Check AMBU bag kept in a clean, Non-Sealed plastic bag? (If No - please change)			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Is there condensate in the ventilatory circuit? (If Yes - drain away from the patient)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Is Head End elevated by 15°-30° (for neonates 10°-15°)? (If No - please change)			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Oral and Nasal Care every 4 Hrs			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Mouth Care with EBM (Only for Neonatal Patient)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Is ET / Oral Suction needed (2nd hrly)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Sterile Suctioning Done			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
DVT Prophylaxis			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Name of the Nurse			Suretha	Harsh	Shruti	Shruti	Suretha	Harsh	Shruti
Signature of the Nurse									



VENTILATOR CARE BUNDLE CHECK LIST

Date of Intubation:

No of Days on Ventilation:

Date of Tracheostomy:

Parameters	Date	Shift Time	10/6/26 Spm 8m	11/6/26 Spm - 9pm	11/6/26 Spm 0800K	11/6/26 Spm 8m			
Ready for Extubation today? (Discuss during the clinical round)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Sedation holiday discussed? (Discuss during the clinical round)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Ventilator Circuit visibly soiled? (If Yes - Please Change)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Suction container visibly Soiled? (If Yes - Please Change)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inline Suction Used?			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is AMBU bag soiled? (If Yes - Please Change)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check AMBU bag kept in a clean, Non-Sealed plastic bag? (If No - please change)			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there condensate in the ventilatory circuit? (If Yes - drain away from the patient)			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Head End elevated by 15°-30° (for neonates 10°-15°)? (If No - please change)			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oral and Nasal Care every 4 Hrs			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth Care with EBM (Only for Neonatal Patient)			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Is ET / Oral Suction needed (2nd hrly)			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sterile Suctioning Done			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DVT Prophylaxis			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the Nurse			Juni	Hanjan	cap	Juni			
Signature of the Nurse			<i>Juni</i>	<i>Hanjan</i>	<i>cap</i>	<i>Juni</i>			



NURSING INITIAL ASSESSMENT FOR NICU

Date of Admission: 8/6/26
 Source of Admission: OPD Ward Labor Ward Other: _____
 Reason for Admission: PT - 25 cuts sepsis
 Admission Diagnosis: PT - 25/1/28
 Accompanied By: Parent Guardian Other Name: _____
 Primary Language: Telugu English Hindi Other Specify _____
 Do you require an interpreter? Yes No
 Allergies: Yes No Medications Blood Transfusion Food Other: _____
 If yes, identify _____
 Source of Information: Family Others, Specify _____

Past Medical History	Past Surgical History	Last Hospital Admission
-	-	-

Significant History
 Family History: _____

Has the child or close family member had recent contact with a communicable disease? Yes No
 If yes please list, _____
 Was the child's birth normal? Yes No If No, please describe problems: _____

 Are the child's immunization up to date? Yes No

Current Medications
 Taking Medications? Yes No
 If yes, Fill the reconciliation form
 Medicine brought to the hospital? Yes No

Observations:
 Birth Weight: 68 gms kgs Head Circumference: _____ cm Length: _____ cm
 Term Pre-Term Post-Term
Blood Group: Mother: 0-ve Baby: 0+ve
Feeding: Breast Feeding Formula Both
Maternal Details: Age: _____ years, **PARA:** _____ **Gestation:** _____ Weeks, _____ Days
Risk Factors: PROM Fetal Distress Diabetes Mellitus / Gestational Diabetes
 PH/Pre Eclampsia Others, Specify: _____
Mode of Delivery: Normal LSCS - Emergency / Elective Instrumental AVD
Indication: _____



Newborn Assessment:

Temp: 98.6°F HR: 206/Min RR: 28/Min BP: 81/35(52) SpO₂: 98%

Pain Score 0 (Follow N Pass and Document)

Fall Risk Intervention Done: Yes

Risk of Pressure Sore: Yes No (Fill Braden Q Sheet)

General Appearance: Posture Well-Fixed Asymmetry

Behavioural Status on Admission :

Sleeping Crying Calm Drowsy

Skin: Pink Meconium Stain Others, Specify.....

Functional Screening: If a patient needs assistance with any of the following inform consultant

Developmental Delay Musculoskeletal Congenital Abnormality No Abnormalities Detected

Inform Consultant for Positive Criteria

Nutritional Screening:

Underweight Overweight Special Feeding Method
 Feeding Problem Special Diet No Abnormalities Detected

Inform Consultant for Positive Criteria

Social History: Lives With family

Siblings in household Yes No (if yes How Many?)

All Information Obtained From Patient Mother Father Other Family Member

Orientation has been given regarding the following aspects:

- ID Band in situ
- Bedside safety explained
- NICU Routine: Doctor's rounds/Medication time
- Visiting policy explained

Orientation given to: Family Others

Name of Person Orientation was given to: Mother (Amulya)

Orientation not given Reason:

DISCHARGE PLAN

Source of Information: Family Friend

Will patient require transportation arrangements to go home: Yes No

Will Physiotherapy require at home: Yes No

Is home medical equipment anticipated: Yes No

Is home oxygen therapy anticipated: Yes No

Breastfeeding Yes No

Formula Feed Yes No

Are dressing needs at home anticipated: Yes No

Any other needs anticipated: Yes No If Yes Specify



Discharge Medications: Yes No

Details:

Final Diagnosis: PT-25 wks

Nurse Signature: Sr. Uma rani

Nurse Name: Uma

Date & Time: 8/6/26 @ 2:30Am

Discharge Details: (To be completed by discharging Nurse)

Neonatal Condition at Discharge:

Feeding: Breastfeeding Exclusively Breastfeeding and Formula Feeding Formula Feeding

Vitamin K given: Yes No

Vaccinations given BCG Hepatitis B Others:

Neonatal Screen Taken: Yes No, parents advised to have Neonatal Screen at National screening program center on:/...../.....

Hearing Test: Yes No

Jaundice: NIL Slight Moderate

Passed Urine: Yes No

Passed Meconium: Yes No

Weight at discharge:

Appointment was given for follow-up at OPD: Yes No

Date of Discharge:/...../.....

Discharge to Home Other:

Against Medical Advice: Yes No

Referred to another hospital: Yes No

Nurse Signature: Sr. umasani

Nurse Name: uma

Date & Time: 8/6/26 @ 2:30Am



ANTIBIOTIC JUSTIFICATION FORM

Date of Admission:

Antibiotic Name	Date & Time	Reason	48 Hours Culture	Antibiotic Reviewed at 72 Hours (If No Please Justify)
INS MENOPEMEM	8/6/26.	Culture Positive Sepsis	outside culture true for Klebsiella.	

<p>A. Reasons for Starting Empirical Antibiotics:</p> <ol style="list-style-type: none"> Preterm's with risk factors: <ol style="list-style-type: none"> PPROM Positive Maternal Culture (HVS/Urine C/S Maternal Pyrexia / Chorioamnionitis Term Babies <ol style="list-style-type: none"> PROM > 18 hours Sepsis Screen Positive at 12 hours <ol style="list-style-type: none"> High TLC/ High CRP / High PCT / Thrombocytopenia / Leukopenia Shift to left / Bank forms / Neutrophilia on PS Out born with suspected sepsis Culture negative Sepsis 	<ol style="list-style-type: none"> Clinical Sepsis <ol style="list-style-type: none"> Frequent Apnoea's attributed to suspected sepsis Hemodynamic instability Temperature instability Suspected NEC Lethargy VAP Congenital Pneumonia Meningitis Aspiration Pneumonia Any sick newborn 	<p>B. Prophylactic Antifungals</p> <p>B1 – Extreme PT (<28 Weeks) or ELBW (<1000 grams) B2 – Central line in situ (PICC / UVC) in < 28 weeks & or < 1kg. B3 – Septic Shock</p> <p>C. Culture Positive Sepsis</p>
---	---	--

Consultant Name & Signature : *for Surender Siv Dr. Harish*
 Date & Time : *08/06/26*

Name & Signature of Infection Control Nurse : *Dr. Anus A*
 Date & Time : *08/06/26*

Patient Name	Baby Of AMULYA	Patient Ph. No	8106143257
Age	0 Y 1 M 4 D	Requisition No	R26-009162
Gender	Male	Billed on	08-06-2026 02:02 PM
IP / Bill No.	IP-00060263	Scanned on	08-06-2026 03:26 PM
UHID No.	VIH-00205713	Reported on	08-06-2026 03:26 PM
Ref. Doctor	SURENDER RAO DUSA	Ward / Bed No	

PEDIATRIC ECHOCARDIOGRAM REPORT

Situs & Cardiac Looping	Situs Solitus Levocardia
Systemic Veins	To RA
Pulmonary Veins	To LA
Atrio ventricular connection	Concordance
Ventricular arterial connection	Concordance
Great artery relationship	NRGA
Right atrium	Normal
Left atrium	Normal
Inter atrial septum	PFO L-->R SHUNT
Mitral Valve	Normal
Tricuspid Valve	Normal
Right ventricle	Normal
Left ventricle	Normal
Inter ventricular septum	Intact
Aorta and aortic arch	Left Arch / No COA
Pulmonary artery and branch PA	Normal
Aortic Valve	Normal
Pulmonary valve	Normal
Coronaries	Normal
PDAal Valve	2.0mm PDA WITH L-->R SHUNT
Pericardium	Nil
Others	Nil

Print Date/Time : 08-06-2026 03:26 PM

Printed By : MOHAMMED
HUSSAIN

Page: 1 of 3

For Further Details
Scan QR Code



Patient Name	Baby Of AMULYA	Patient Ph. No	8106143257
Age	0 Y 1 M 4 D	Requisition No	R26-009162
Gender	Male	Billed on	08-06-2026 02:02 PM <small>Page 1 of 3</small>
IP / Bill No.	IP-00060263	Scanned on	08-06-2026 03:26 PM
UHID No.	VIH-00205713	Reported on	08-06-2026 03:26 PM
Ref. Doctor	SURENDER RAO DUSA	Ward / Bed No	

DOPPLER / TISSUE Variables		Gradients	Regurgitation
Mitral flow			
Tricuspid flow			
Aortic flow			
Pulmonary flow			
Mitral	E'	A'	S'
Medial LV	E'	A'	S'
Tricuspid	E'	A'	S'
Time intervals	IVRT	IVCT	DT
Others			

MEASUREMENTS:

A
P
M
N
T
I
D
C
M



Patient Name	Baby Of AMULYA	Patient Ph. No	8106143257
Age	0 Y 1 M 4 D	Requisition No	R26-009162
Gender	Male	Billed on	08-06-2026 02:02 PM Page: 2 of 2
IP / Bill No.	IP-00060263	Scanned on	08-06-2026 03:26 PM
UHID No.	VIH-00205713	Reported on	08-06-2026 03:26 PM
Ref. Doctor	SURENDER RAO DUSA	Ward / Bed No	

PARAMETER	ABSOLUTE cm)	Z score	PARAMETER	ABSOLUTE cm)	Z score
AO	0.6		Tricuspid Annulus		
LA	0.9		Mitral Annulus		
IVSd	0.3		Aortic Annulus		
LVIDd	1.5		PA Annulus		
LVPWd	0.4		RPA		
IVSs	0.3		LPA		
LVIDS	0.8		MPA		
LVPWs	0.7		AO Isthmus		
EF	70%		LV Mass		
FS	36%		Others		

Impression

SITUS , SOLITUS , LEVOCARDIA
 2.0mm PDA WITH L-->R SHUNT , (LA/AO:2.2)
 PFO L-->R SHUNT
 GOOD BIVENTRICULAR FUNCTION
 LEFT ARCH , NO COA

Dr. MURTAZA KAMAL
 MBBS, MD, DNB, DrNB
 Reg No: TSMC/FMR/26664

Print Date/Time : 08-06-2026 03:26 PM

Printed By : MOHAMMED
 HUSSAIN

Page: 3 of 3

For Further Details
 Scan QR Code



Dr. MURTAZA KAMAL

Patient Name	Baby Of AMULYA	Patient Ph. No	8106143257
Age	0 Y 1 M 4 D	Requisition No	R26-009162
Gender	Male	Billed on	08-06-2026 02:02 PM
IP / Bill No.	IP-00060263	Scanned on	08-06-2026 03:26 PM
UHID No.	VIH-00205713	Reported on	08-06-2026 03:26 PM
Ref. Doctor	SURENDER RAO DUSA	Ward / Bed No	

PEDIATRIC ECHOCARDIOGRAM REPORT

Situs & Cardiac Looping	Situs Solitus Levocardia
Systemic Veins	To RA
Pulmonary Veins	To LA
Atrio ventricular connection	Concordance
Ventricular arterial connection	Concordance
Great artery relationship	NRGA
Right atrium	Normal
Left atrium	Normal
Inter atrial septum	PFO L-->R SHUNT
Mitral Valve	Normal
Tricuspid Valve	Normal
Right ventricle	Normal
Left ventricle	Normal
Inter ventricular septum	Intact
Aorta and aortic arch	Left Arch / No COA
Pulmonary artery and branch PA	Normal
Aortic Valve	Normal
Pulmonary valve	Normal
Coronaries	Normal
PDA	2.0mm PDA WITH L-->R SHUNT
Pericardium	Nil
Others	Nil

Print Date/Time : 08-06-2026 03:26 PM

Printed By : RANGANATH
RELANGI

Page: 1 of 3

For Further Details
Scan QR Code



Note: Clinically Correlate, Kindly discuss if necessary.

Patient Name	Baby Of AMULYA	Patient Ph. No	8106143257
Age	0 Y 1 M 4 D	Requisition No	R26-009162
Gender	Male	Billed on	08-06-2026 02:02 PM
IP / Bill No.	IP-00060263	Scanned on	08-06-2026 03:26 PM
UHID No.	VIH-00205713	Reported on	08-06-2026 03:26 PM
Ref. Doctor	SURENDER RAO DUSA	Ward / Bed No	

DOPPLER / TISSUE Variables		Gradients	Regurgitation
Mitral flow			
Tricuspid flow			
Aortic flow			
Pulmonary flow			
Mitral	E'	A'	S'
Medial LV	E'	A'	S'
Tricuspid	E'	A'	S'
Time intervals	IVRT	IVCT	DT
Others			

MEASUREMENTS:



Patient Name	Baby Of AMULYA	Patient Ph. No	8106143257
Age	0 Y 1 M 4 D	Requisition No	R26-009162
Gender	Male	Billed on	08-06-2026 02:02 PM Page 2 of 3
IP / Bill No.	IP-00060263	Scanned on	08-06-2026 03:26 PM
UHID No.	VIH-00205713	Reported on	08-06-2026 03:26 PM
Ref. Doctor	SURENDER RAO DUSA	Ward / Bed No	

PARAMETER	ABSOLUTE cm)	Z score	PARAMETER	ABSOLUTE cm)	Z score
AO	0.6		Tricuspid Annulus		
LA	0.9		Mitral Annulus		
IVSd	0.3		Aortic Annulus		
LVIDd	1.5		PA Annulus		
LVPWd	0.4		RPA		
IVSs	0.3		LPA		
LVIDS	0.8		MPA		
LVPWs	0.7		AO Isthmus		
EF	70%		LV Mass		
FS	36%		Others		

Impression

SITUS , SOLITUS , LEVOCARDIA
 2.0mm PDA WITH L-->R SHUNT , (LA/AO:2.2)
 PFO L-->R SHUNT
 GOOD BIVENTRICULAR FUNCTION
 LEFT ARCH , NO COA

Dr. MURTAZA KAMAL
 MBBS, MD, DNB, DrNB
 Reg No: TSMC/FMR/26664

Note: Clinically Correlate, Kindly discuss if necessary.



ULTRA SOUND ABDOMEN REQUEST FORM

VIH-00205713 IP-00080263
Baby Of AMULYA
04-05-2026 0 Y 1 M 4 D (M)
Dr. SURENDER RAO DUSA

PATIENT

UHID:

DATE:

LIVER : Normal in size ^{5.8cm} and echotexture. No intra hepatic biliary duct dilatation. Portal vein is normal. No focal lesions.

GALL BLADDER : Distended well and appears normal. No evidence of calculi or wall thickening. Common bile duct appears normal.

SPLEEN : Normal in size and echotexture.

PANCREAS : Normal in size and echotexture. MPD not dilated. No calcification noted.
Pancreas obscured by bowel gas shadows

KIDNEYS : Right kidney : ³¹ mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

Left kidney : ³² mm. Normal in size and echotexture and shows smooth contour. No hydronephrosis or calculi.

URINARY BLADDER : Distended well and appears normal.

No ascites / Lymphadenopathy. No evidence bowel wall thickening / edema.

Bowel appears normal

IMPRESSION: No obvious sonological abnormality in abdomen.

Rest unremarkable

Suggested clinical correlation.

DR MOHD ABDUL KHALID MD, DNB.

DR V. MAHIDHAR (MD)

DR VAISHNAVI REDDY B (MD)

(Consultant Radiologist)

NEUROSONOGRAM REQUEST FORM

VIH-00205713
Baby Of AMULYA
04-05-2026 0 Y 1 M 4 D (M)
Dr. SURENDER RAO DUSA
IP-00080263

UHID/ NUMBER:

205713

DATE/TIME :

8/6/16

FINDINGS

~~Both the lateral and third ventricles are normal. No hydrocephalus.~~

Atrium of right lateral ventricle - 7mm.

mild lateral ventriculomegaly

Atrium of left lateral ventricle - 8.5mm.

Fourth ventricle is normal.

Posterior fossa structures are grossly normal.

No e/o intraventricular echoes.

~~Visualized cerebral parenchyma is normal.~~

Both thalami are normal.

No evidence of lenticulostriate artery calcification.

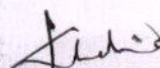
IMPRESSION:

~~No significant intracranial abnormality.~~

① Absent septum pellucidum & inferiorly displaced fornical columns

② - Minimal septum pellucidum in anterior aspect along genu of corpus callosum

③ Grade I amth on both sides


DR MOHD ABDUL KHALID MD, DNB.

DR V. MAHIDHAR (MD)

DR VAISHNAVI REDDY B (MD)

(Consultant Radiologist)