ACTIVITY RECORD FOR BILLING

Name: --

UHID No : --------------- IP No : ------------------ Consultant : ----------------------- Dept : ----------------

Date of Admission : 5/6/26 Time : 4:36 pm Date of Discharge : ---------------- Time: -----------

Room / Bed No : 226-1 Ward : MICU Suggested Billable bed type : -----------------------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/6/26	8:30PM	MICU	Room (105)	[signature]

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
5/6/26	ABG	VI26019437	[signature]
5/6/26	Blood grouping	VI26019428	[signature]
	Cross checked by	Slam;ui	@8pm
	TCB - 6.6mg/dl	26019570	[signature]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
	Sedya 7/6 @9:30Am		

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Secunderabad

H.No.3-7-222/223,Sy.No.51 to 54,Opp.Karkhana P S,Karkhana Main Road,Kakaguda, Karkhana ,Hyderabad ,Telangana, INDIA ,500009.
TEL NO :040-42462200, Ext 2000,2001,2002
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP-00060242 **Admit Date** : 05-Jun-2026 **Admit Time** : 04:36 PM **UHID** : VIH-00205659

Patient Details :

Patient Name	: Baby B/O MADASU NIHARIKA	**Age**	: 0 D
Guardian	: Mr MANISH CHOUTI	**DOB**	: 05-06-2026 02:49 PM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: flat no 203 indu residency kompally Kulsumpura Hyderabad Telangana INDIA 500067	**Phone No**	: 7702603730/
		E-mail	: na@gmail.com

Admission Details :

Bed Type : BASINET **Bed No** : CRDL-MICU-226-1 **Ward Name** : N 2F-MICU

Room No : CRDL-MICU-226-1 **Admission Type** : First Visit

Contact Details :

Name	: Mr MANISH CHOUTI	**Relationship**	: Father
Contact Address	: flat no 203 indu residency kompally Kulsumpura Hyderabad Telangana INDIA 500067	**Phone No**	: 7702603730 / 8801134613

Signature

Doctor Details :

Doctor Name	: Dr. AKHEEL SYED RIZWAN	**Specialisation**	: NEONATOLOGY
Referral Doctor	: DR.BHAVANA K	**Phone No**	:
Co-Consultant	:		

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash **Payor Name** : SELFPAY

PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
VIH-00205659 IP-00060242 Baby B/O MADASU NIHARIKA 05-06-2026 0Y0M0D6H (F) Dr. AKHEEL SYED RIZWAN	5/6/26 @ 4:36pm	5/6/26 @ 8:30PM
	Transfer Ordered by Dr. Shrikar	**Reason for Transfer** Observation
From Unit MICU	**To Unit** Room (105)	**Information to Attendant** Yes ☑ No ☐
Number of Sheets in Clinical File 15	**Number of Imaging Films** Abg - 1	**Personal belongings including clinical documents. If any handed over to attendant** Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	Small Kuchis - 1	
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐ Dr. Shrikar

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Kamala	Dr. Shrikar

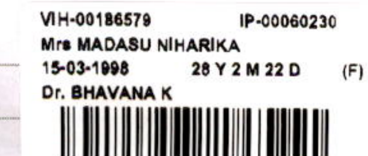
Patient & Clinical Records Received by : [signature] 5/6/26

Date & Time of Patient Received : [signature] @ 8:30 pm

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

Docu. No. : RCH /FRM / CLINICAL / 102


VIH-00186579 IP-00060230
Mrs MADASU NIHARIKA
15-03-1998 28 Y 2 M 22 D (F)
Dr. BHAVANA K

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : M. Niharika Age : .... Father's Name : .... Age : ....

Date of Birth : 15-03-98 Date of Admission : .... UHID No.: ....

NICU Consultant : Dr Akheel Rizwan Referring Consultant : Dr. Bhavana

Transferring Unit : ☑ OT ☐ Labour Room ☐ ER ☐ Ward

Transported ? ☐ Yes ☑ No - If yes : ☐ Long (> 30 kms) ☐ Short (< 30 kms)

BIRTH INFORMATION

Name : B/o Niharika

Gender : ☐ M ☑ F Blood Group : ....

Date of Birth : 5/6/26 Time of Birth : 2:49pm

Place of Birth : RCH VKP.

Mother's Blood Group : 'A' Positive

Birth Weight (gms) : 2.839 kg Length (cms) : ....

OFC (cms) : ....

Estimated Gesth Age : 37+2 wk.

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 28yr Ht : 157 Wt : 64 BMI : .... Married Life : 2yr LMP : 16/9/25 EDD : 23/6/26

Conception : Spontaneous or with Rx. : Spontaneous

Booked at what GA. : Since conception AN Steroids Drugs / Doses : ....

Last Scans Details : 2/6/26 - SLIUF/37wk/ Cephalic Pl. Ugh / AFI 12.6cm / AC-8%. Efw- 2626gr Doppler (N)

TT Immunization and Iron / Folic Acid : ....

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 Resistence / ADEF / REDF / Redistrbution in MCA) / Ductus Venosus : —

AFI : —

H/o GDM/ pre GDM/ on diet or insulin FRS low side

Controlled or not, recent values, HbA1 values : ....

Compliance with Rx : ....

Scans : LGA, TIFFA , Fetal Echo : (N)

H/o Hypothyriodism : when diagnosed ? Medication? —

Any other Chronic Medical Problems, when detected drugs ? —

(Anemia, SLE, Jaundice, CHD, Heart Disease)

Infection : H/O, Fever 28th wk.

(☐ Malaria ☑ UTI ☐ TORCH ☐ TB ☐ HIV ☐ HBV)

UTI : when : .... Any culture : —

PPROM : Duration : .... ☐ Uterine Tenderness ☐ Foul Smelling Liquor ☐ HVS (if taken) - Results : —

Medication during Pregnancy : — Duration : —

CIN : L85110TG1998PLC029914

VIH-00186579
Mrs MADASU NIHARIKA (F)
28 Y 2 M 22 D
15-03-1998
Dr. BHAVANA K

PAST OBSTETRIC HISTORY

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

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
2.	13 wk / cystic hygroma / MTP / MERPC					RLH VKP / Dec 2024

PERINATAL HISTORY

Treating Obstetrician: Dr Bhavana Hospital: RLH VKP ☑ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : ☐ Elective ☑ Emergency Indication : ....

Specify the reason : NPOL

Augmentation of Labour : ☐ Induced ☐ Assisted Vaginal

CTG : ☐ Normal ☐ Suspicious ☐ Pathological

MSL : ....

Resuscitaion : ☐ Yes ☐ No

Cord ABG : ....

Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc : ....

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : .... Weeks : ....

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

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

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

Snapee II Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

GiAB.

Mrs MADASU NIHARIKA IP-00060230
15-03-1998 28 Y 2 M 22 D (F)
Dr. BHAVANA K

B/o Niharika delivered v/s Em LSCS
↓
Baby girl
↓
CIAB
↓
DCC done for 60 Sec
↓
Dried stimulated, secretions cleared
↓
Cord clamp cut 2A+1V ⊕
↓
Inj vit K given i/m
↓
Baby v/s grows
Shift to mother side.

target SpO2 reached at 2' of life

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

Patient Sticker

GENERAL EXAMINATION ON ADMISSION

General Disposition :

GA good

VITALS : Temperature : 36.5 °C HR : 160 b/m RR : 38 /m NIBP : .... CFT : <3 Sec

Color of the extremities : Acrocyanosis

Jaundice : .... Pallor : .... SpO2 : 96 - RA

Anthropometry : Birth Weight : 2.839 kg Length : .... HC : .... Present Weight : ....

Ponderal Index : .... AGA : (circled) .... SGA : .... LGA : ....

HEAD TO TOE EXAMINATION

HEAD :	Fontanelles : Sutures Shape / Moulding : Edema / Bruising : Size - (H.C.) :	AF Level —
Facies : (Any Facial Dysmorphism)		(N)
NECK and CLAVICLES :	Range of Motion : Asymmetry : Masses :	Normal
EYES :	Symmetry : Red Reflex : Discharge :	not checked
EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Periauricular Pits / Tags : Nasal shape / Patency : Palate : Gums : Lips : Tongue :	(N)

Patient Sticker

THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number : (N)
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : 2A+1V(P) Discharge :
GENITILIA :	Labia / Hymen : Testicles/penis : Anus :
HERNIAL ORIFICES	free
TRUNK and SPINE :	(N)
SKIN LESIONS :	—
EXTREMETIES :	Fingers / Toes : 10F+10T(P) Deformities : Hip Joint Examination : Arms / Legs : Mobility :

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☑ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress : RR : 40/m SCR / ICR / See - Saw breating : —

Scoring of respiratory distress if present (Silverman or Downe's) : ....

Mention if baby is on : ☐ Hood box ☐ CPAP ☐ Ventilator —

Settings : ....

SpO$_2$: 96(RA) Auscultation : B/L= (P) Breath Sounds : NVBS(P) Added Sounds : —

Cardiovascular System :

HR : 160/m BP : ....

Femoral Pulses : (+)

Other Peripheral Pulses : —

Precordial Activity : (N)

Murmurs : —

Signs of Cardiac Failure : —

Abdomen :

Shape : ....

Palpation : Soft

Palpable masses : ....

Abdominal girth : ....

Hernia orifice : free

Anal Patency : ....

Umbilical Cord : 2A+1V(P).

First urine passed : ....

Meconium passed : ....

VIH-00186579 IP-00060230
Mrs MADASU NIHARIKA
15-03-1998 28 Y 2 M 22 D (F)
Dr. BHAVANA K

functions (Sensorium) : ...

State of wakefulness : ...

Prechtle Score : ...

Nerves : ...

...

Motor System :

Passive Tone : ...

Active Tone : ...

Neonatal Reflexes : ...

Grasp : ☐ Palmar ☐ Plantar ☐ Sucking ☐ Rooting ☐ Crossed adductor : ...

Moro's : B/L equivocal DTR : ...

ATNR : ... Skull and Spine : ...

Any Congenital Anomalies : —

...

Diagnosis : Term / cimlsed Fem / CiA2 / 2.83 kg / AGA

...

FOOT PRINTS

Left Side :

Right Side :

Taken by Sr. Ruby 3/6/26

Resident Doctor :

Signature : ...

Name : Dr. ...

Date & Time : ...

Consultant :

Signature : ...

Name : ...

Date & Time : ...

Patient Sticker

VIH-00186579 IP-00060230
Mrs MADASU NIHARIKA
15-03-1998 28 Y 2 M 22 D (F)
Dr. BHAVANA K

DISCHARGE PLAN

Information given by: ☐ Family ☐ Friend

Will patient require transportation arrangements to go home: ☐ Yes ☐ No ☐ NA

Will Physiotherapy require at home: ☐ Yes ☐ No ☐ NA

Is home medical equipment anticipated: ☐ Yes ☐ No ☐ NA

Is home oxygen therapy anticipated: ☐ Yes ☐ No ☐ NA

Breastfeeding ☐ Yes ☐ No ☐ NA

Formula Feed ☐ Yes ☐ No ☐ NA

Are dressing needs at home anticipated: ☐ Yes ☐ No ☐ NA

Any other needs anticipated: ☐ Yes ☐ No If Yes Specify ....

Feeding Plan at the time of shifting : ....

....

....

....

....

....

....

Screenings done during NICU Stay :

NSG : ....

Hearing Screen : ....

ROP : ....

TFT : ....

NP2 : ....

Discharge Details:

Neonatal Condition at Discharge:

....

....

....

....

....

....

....

....

VIH-00186579 IP-00060230
Mrs MADASU NIHARIKA
15-03-1998 28 Y 2 M 22 D (F)
Dr. BHAVANA K

Exclusively ☐ Breastfeeding and Formula Feeding ☐ Formula Feeding

Vitamin K given: ☐ Yes ☐ No

Vaccinations given ☐ BCG ☐ Hepatitis B ☐ Others: ....

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

Hearing Test: ☐ Yes ☐ No

Jaundice: ☐ NIL ☐ Slight ☐ Moderate

Passed Urine: ☐ Yes ☐ No

Passed Meconium: ☐ Yes ☐ No

Weight at discharge: ....

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

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

Discharge to ☐ Home ☐ Other: ....

Against Medical Advice: ☐ Yes ☐ No

Referred to another hospital: ☐ Yes ☐ No

Discharge Medications: ☐Yes ☐No

Details: ....

Final Diagnosis: ....

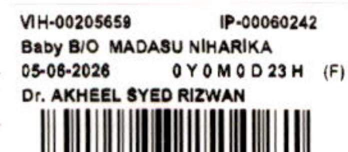
- DBF 2nd Wly
- Immunization
- OAE/CBB/NBS s/f D/C
- monitor & inform SOS

Noted by Ruby P 5/6/26

Doctor Signature: [signature]

Doctor Name: [signature]

Date & Time: 5/6/26 15:03.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26 10:00 Am	C/S/B Resident	
	HOL :- 19 hrs. Term / Emcs / Baby girl / CIAB / 2.83 kg / AGA (37+2) wks. NPOL. / Iothm.	
	TWT 2.77 kg (+60 gm) 2.1% wt loss	
	O/E	
	Child Alert, Active.	
	vitals stable	
	MBG - Atve	CTA - Good	
	BBG - ABtve.	CRT <3 sec	Plan
	CVS: S1S2 (+)	
	Immunization done	RS: B/L AE (+)	- DBF & burping 2nd hrly
	P/A: soft	
	CNS: NAD.	
		- OAE - today
	Dr. Madhuri.	
		- TCB, NBS T/m @ 2pm
		- Monitor vitals
		- Inform (SOS)

VIH-00186579 IP-00060230
Mrs MADASU NIHARIKA
15-03-1998 28 Y 2 M 22 D (F)
Dr. BHAVANA K

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26	Lactation notes (Mrs. Ramyashree)	
	• 1st time Mother	
	• Normal breast condition	
	• Drops of milk seen	
	• c/o low milk supply	
	• TF introduced on pediatrician advice.	
	• Advised to do more skin to skin	
	• To track the feeding in the sheet given	
	• Rx Plan: KMC + DBF + TF	
12:30pm	C/S/B Resident	
	D/E	
	Child Alert	
	CTA - Good	
	CRT < 3s	
	CVS: S1S2 (+)	
	RS: B/L AE (+)	
	P/A: Soft	
	CNS: NAD	Plan
		– DBF f/b burping and then OAE t/m
		– TCB, NBS t/m @ 2pm.
		– monitor vitals.
		D/C t/m
		f/u on reminders

Noted by
Deepika
7/6/26 @ 12:30pm

VIH-00205659 IP-00060242
Baby B/O MADASU NIHARIKA
05-06-2026 0Y0M0D6H (F)
Dr. AKHEEL SYED RIZWAN

CH/ FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 5/6/26

Time:	3 pm	5 pm	7 pm	10 pm	1 Am	4 Am	7 Am
Doctor/Nurse/Family Concern?							
Temperature (°F) (scale 94–104)	98.6	98.9F	98.3F	97.9F	98.1F	97.9F	98.2F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)							
Heart Rate (Number)	142	138	136	143	141	139	140
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)							
Resp Rate (Number)	45	42	42	44	43	44	47
Resp Distress – Mod/ Severe							
Resp Distress – None / Mild	✓	✓	✓				
Receiving O_2 (l/min)							
O_2 Saturations (%)	96%	98%	96%	99%	99%	99%	99%
Conscious Level – Normal	✓	✓	✓				
Conscious Level – Altered							
GCS *	+	—	—				
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0
Observer's Initials	Ny	Ny	Ny	B	B	B	B

Note: BP does not score in early warning scoring

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

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

VIH-00205659 IP-00060242
Baby B/O MADASU NIHARIKA
05-06-2026 0Y0M0D6H (F)
Dr. AKHEEL SYED RIZWAN

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

VIH-00205659 IP-00060242
Baby B/O MADASU NIHARIKA
05-06-2026 0Y0M0D9H (F)
Dr. AKHEEL SYED RIZWAN

/ CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

WARNING SCORE: CHILDREN'S UNIT

Date: 6/6 Time:	9 pm	11 pm	1 pm	3 pm	5 pm	7 pm	10 pm	1 am	4 am	7 am
Doctor/Nurse/Family Concern?										
Temperature (°F) (scale 94–104)	98.3F	98.6F	98.3F	98.6F	98.3F	98.6F	98.6F	98.6F	98.6F	98.6F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190) Note: BP does not score in early warning scoring										
Heart Rate (Number)	140	138	135	140	135	140	130	135	140	138
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)										
Resp Rate (Number)	28	30	28	30	32	30	40	35	38	30
Resp Distress: Mod/ Severe										
Resp Distress: None / Mild										
Receiving O_2 (l/min)										
O_2 Saturations (%)	98	97	98	98	97	98	97	98	99	98
Conscious Level: Normal	N	N	N	N	N	N	N	N	N	N
Conscious Level: Altered										
GCS *	15	15	15	15	15	15	15	15	15	15
TOTAL SCORE Number of shaded boxes	0	0	0	0	0	0	0	0	0	0
Pain Score	0	0	0	0	0	0	0	0	0	0
Observer's Initials	Bn	Bn	B	Bn	Bn	Bn	B	B	B	B

ACTIONS		
NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
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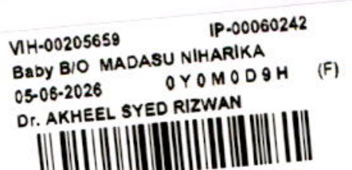

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

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

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

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

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

VIH-00205659 IP-00060242
Baby B/O MADASU NIHARIKA
05-06-2026 0 Y 0 M 0 D 23 H (F)
Dr. AKHEEL SYED RIZWAN

D. : RCH/ FRM / CLINICAL / 124

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 7/6/26 Time:	10 AM
Doctor/Nurse/Family Concern?	
Temperature (°F) (104–94)	98.4°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (190–50) Note: BP does not score in early warning scoring	140
Heart Rate (Number)	140
Resp. Rate (bpm) (Over 1 Minute) * (70–10)	40
Resp Rate (Number)	40
Resp Distress Mod/ Severe	
Resp Distress None / Mild	N
Receiving O_2 (l/min)	
O_2 Saturations (%)	99%
Conscious Level Normal	N
Conscious Level Altered	
GCS *	-
TOTAL SCORE Number of shaded boxes	0
Pain Score	0
Observer's Initials	D

Noted by Deepika
7/6/26 @ 10Am

ACTIONS

NB: Scores 3 should be recorded overleaf

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

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

Patient Sticker

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
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R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)

VIH-00205659 IP-00060242
Baby B/O MADASU NIHARIKA
05-06-2026 0Y0M0D9H (F)
Dr. AKHEEL SYED RIZWAN

FLUID CHART

Sheet No. : IV

5/6/26

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am			— Nil —								
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
5/6/26	03:00 pm	DBF										Meghna
	04:00 pm	DBF					✓			✓		
	05:00 pm										0	
	06:00 pm	DBF										
	07:00 pm											
Total Intake :						Total Output : passed.						
	08:00 pm	DBF										
	09:00 pm											
	10:00 pm	DBF										
	11:00 pm											
	12:00 am	DBF										Bhanu 06/06/26
	01:00 am						✓			✓		
Total Intake :						Total Output :						
	02:00 am	DBF										
	03:00 am											
	04:00 am	DBF										
	05:00 am											
	06:00 am	DBF								✓		
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

VIH-00205659 IP-00060242
Baby B/O MADASU NIHARIKA
05-06-2026 0Y0M0D9H (F)
Dr. AKHEEL SYED RIZWAN

FLUID CHART

Sheet No. : 6/6/26

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

Date	Time	Intake				Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
6/6	08:00 am									✓		Brinda @2pm 6/6/26
	09:00 am		DBM									
	10:00 am		×				✓				0	
	11:00 am		DBM							✓		
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
6/6	02:00 pm											Brinda @8pm 6/6/26
	03:00 pm		DBM							✓		
	04:00 pm										0	
	05:00 pm		×									
	06:00 pm		DBM							✓		
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm		DBM									Beronika 7/6 @7am
	09:00 pm		+FF							✓		
	10:00 pm											
	11:00 pm		DBM								0	
	12:00 am		+FF							✓		
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											Beronika 7/6 @7am
	03:00 am		DBM							✓		
	04:00 am		+FF									
	05:00 am											
	06:00 am		DBM								0	
	07:00 am		+FF							✓		
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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Baby B/O MADASU NIHARIKA
05-06-2026 0Y0M0D9H (F)
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FLUID CHART

Sheet No. : ....

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

Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
7/6/26	08:00 am		DBF									Deepika 7/6/26 @2pm
	09:00 am						✓					
	10:00 am		DBF									
	11:00 am											
	12:00 pm		DBF							✓		
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake	

Total 24 hrs. Output	

VIH-00205659 IP-00060242
Baby B/O MADASU NIHARIKA
05-06-2026 0Y0M0D9H (F)
Dr. AKHEEL SYED RIZWAN

STAT / ONCE ONLY DRUGS

Name: B/O. Niharika.

Weight: 2.839 kgs

Sheet No: (1)

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
5/6/26	2:54am	INJ. VITAMIN K	0.1 cc	I/M	[signature]	[signature]	[signature]