DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

Rainbow Children's Hospital | BirthRight BY RAINBOW HOSPITALS Your Right to a Safe Delivery

Patient Name: VIH-00206230 IP-00060477 Baby B/O SAI RAVALI 25-06-2026 0Y0M0D13H (F) Dr. PREETHAM KUMAR

IP.No:

Ward:

DOA:

Sl.No	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission Sheet	1	–	–	
2	Discharge Summary	2	–	–	
3	Nursing Initial assessment form	1	–	–	
4	Patient Trasfer Forms	1	–	–	
5	In-patient Medical Record	4	–	–	
6	Doctors Progress Sheets	2	–	–	
7	Nurses Progress notes	3	–	–	
8	Consultation Sheets				
9	General Consent for Treatment	1	–	–	
10	Conset for Surgery				
11	Consent for Blood Transfusion				
12	Consent forChemotherapy				
13	Consent for High Risk				
14	Consent for Restraint				
15	DAMA Consent				
16	Consent for Special Procedure				
17	Consent for Radiological Investigations				
18	Consent for HIV Test				
19	Anaesthesia consent form				
20	Anaesthesia notes(Pre Anaesthesia & Post)				
21	Pre Operative checklist				
22	Surgical safety Checklist				
23	Operation Theatre notes				
24	Nurses Clinical Presentation				
25	TPR & BP chart	3	–	–	
26	Intake and Output chart (fluid Chart)	2	–	–	
27	Drug Chart (Regular prescription)	1	–	–	
28	Daily Investigation sheet				
29	Investigation Values (Result Sheet)	1	–	–	
30	Nebulization Chart				
31	Diabetic chart				
32	Nutritional Review chart				
33	MLC form (in case of MLC)				
34	Patient Education Form				
	Humpty Dumpty	2	–	–	
	Braden	4	–	–	
	Pain Assessment	6	–	–	
	Total No. of Pages	34			

Signature and Date : [signature] 8/6/26

ERROR LOG

LOCATION: - NICU / PICU / HDU / OT / GENERAL WARD

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

Rainbow Children's Hospital
BirthRight by Rainbow

Rainbow Children's Hospital - Secunderabad
H.No.3-7-222/223,Sy.No.51 to 54, pp.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-00060477 **Admit Date** : 25-Jun-2026 **Admit Time** : 11:17 AM **UHID** : VIH-00206230

Patient Details :

Patient Name	: Baby B/O SAI RAVALI	**Age**	: 0 D
Guardian	: Mr K ANJAN KRISHNA KUMAR	**DOB**	: 25-06-2026 10:00 AM
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: ALWAL Alwal Hyderabad Telangana INDIA 500010	**Phone No**	: 8121436555/ 9581571109
		E-mail	: ravalisharma96@gmail.com

Admission Details :

Bed Type	: BASINET	**Bed No**	: CRDL-MICU-227-1	**Ward Name**	: N 2F-MICU
Room No	: CRDL-MICU-227-1	**Admission Type**	: First Visit		

Contact Details :

Name	: Mr K ANJAN KRISHNA KUMAR	**Relationship**	: Father
Contact Address	: ALWAL Alwal Hyderabad Telangana INDIA 500010	**Phone No**	: 8121436555 / 9581571109

K. Anjan
Signature

Doctor Details :

Doctor Name	: Dr. PREETHAM KUMAR	**Specialisation**	: GENERAL PEDIATRICS
Referral Doctor	:	**Phone No**	:
Co-Consultant	:		

Payment Details :

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

Baby file

①

ACTI[illegible] ING

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0 Y 0 M 0 D 5 H (F)
Dr. PREETHAM KUMAR

Name: ----------

UHID N[illegible] ---------- Consultant : ---------- Dept : ----------

Date of Admission : 25/6/26 Time : ---------- Date of Discharge : ---------- Time: ----------

Room / Bed No : ---------- Ward : C/W ---------- Suggested Billable bed type : ----------

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/6/26	at 5pm	MICU	Room (206)	Rac

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
25/6/26	Blood Grouping.	26021468	[signature]
	cross checked by [illegible] 25/6/26		
26/6/26	RBS at 12:50pm – 51mg/dl	26021601	[signature]
26/6/26	GRBS at 2pm – 53mg/dl	26021602	[signature]
26/6/26	GRBS at 8:30pm – 56mg/dl	26021642	[signature]
27/6/26	GRBS at 2:30am – 74 mg/dl	26021643	
27/6/26	GRBS at 8:35Am – 72 mg/dl	26021718	
	TCB	26021681	[signature]

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
	IEOAE	1	3095143	[signature]

ANY OTHER INFORMATION

Date : 27/6/22 Time : 1 pm Prepared By : [signature]

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
[signature]	[signature] 27/6/22 7pm		

Name	Baby B/O SAI RAVALI	**UHID**	VIH-00206230
Father/Guardian	Mr K ANJAN KRISHNA KUMAR	**Age/Gender**	0 Y 0 M 1 D/Female
Address	ALWAL, Alwal, Hyderabad, Telangana, INDIA, 500010		
IP No	IP-00060477	**Admission Date**	25-06-2026
Ref Doctor		**Discharge Date**	27-06-2026

DISCHARGE SUMMARY

Consultant:
Dr. PREETHAM KUMAR
MBBS,DNB(PEDS),DCH,FELLOW NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS

Diagnosis: Early Term (37+6 weeks)/Large for gestational age/Baby Girl

Mode of Delivery: Elective Lower Segment Cesarean Section (Indication: Previous LSCS)

Anthropometry:

Weight at birth	: 3.508 kgs
Weight at discharge	: 3.37 kgs
Head circumference	: 35 cms
Length	: 51 cms

History: Baby of Baby B/O SAI RAVALI is a early term (37+6 weeks) baby girl, delivered to a Multi gravida mother by Elective Lower Segment Cesarean Section (Indication: Previous LSCS) on 25.06.2026 at 10:00 am with birth weight of 3.508 kgs in Rainbow Children's Hospital, Karkhana. Baby cried immediately after birth. Apgar scores were 7/10 at 1 min, 910 at 5 min. Inj. Vitamin-K 1mg IM was given after delivery.

Maternal History: Mrs. SAI RAVALI is a 31 years old Multi gravida (G2P1L1) mother.

G2 - Present pregnancy, spontaneous conception, had regular ANC's. Antenatal scans were normal. History of hypothyroidism present on Tablet Thyronorm 25 mcg. No history of Pregnancy-Induced Hypertension / Urinary Tract Infection / Antepartum Hemorrhage / Oligohydramnios / Polyhydramnios / Fever. Mother's blood group is "O" Positive. Baby's blood group is "B" Positive.

Examination: Baby was euthermic, euvolemic and was maintaining saturations at room air. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Bilateral femoral pulses well felt. Abdomen was soft with no organomegaly. Cry and activity were good. AF was at level.

Management: Course during hospital: Hospital stay was uneventful.

Transcutaneous bilirubin before discharge was 9.9 mg/dl, it does not come under phototherapy range.

Vaccination: Baby was given following vaccination:
BCG / OPV / Hepatitis-B on : 26.06.2026

Hearing test (TEOAE): Done on 27.06.2026 was normal.

Newborn screening (Advanced): To be done on follow up.

Saturation: Right upper limb and left lower limb 100% at room air.

Red Reflex: Present and Symmetrical.

Feeding: Breast feeding was initiated and baby tolerated the feeds well. In

view of weight loss, baby was started on top-up formula feeds.

Condition at discharge: Baby is pink, warm, active and on direct breast feeds.

Advice:

1. Keep the baby clean and warm.
2. Continue demand breastfeeding as advised.
3. Burping after each feed.
4. Immunization as per schedule.
5. Vitamin-D3 drops (1ml=800IU) 0.5ml once daily till one year of age.
6. Nasoclear nasal drops, 1 drop in each nostril (if needed) for nose block.
7. New Born Screening (Advanced) / Thyroid Function Test, Serum bilirubin to be done on follow up.
8. "Appointment for vaccinations to be taken during the 1st hour of the OPD slots of your respective consultant to avoid rush and minimum waiting period".
9. Kindly consult Dr. Preetham Kumar, Consultant Pediatrician & Neonatologist, on Wednesday (01.07.2026) in OPD with prior appointment (This consultation will be charged).
10. Kindly consult Ms. Ramya Ashwin, Lactation Consultant, within 3 days of discharge or in any kind of feeding difficulty, in OPD with prior appointment (This consultation will be charged).

Review back to hospital:

1. If baby is not feeding continuously for > 6 hours.
2. If breathing fast.
3. High grade fever.
4. Poor activity or lethargy.
5. Bluish discoloration of lips.
6. Increase in jaundice.
7. Abnormal movements.

In case of emergency contact 040-42462200 Extn: 2010 (or) 7337357870.

To take appointment for OPD consultation at Rainbow Children's Hospital, just dial one number 1800-2122 (between 8 a.m. to 8 p.m.) (or) log on to www.rainbowhospitals.in

Now booking appointments is much easy, download Rainbow Application for Free from Google play store.

The discharge advice and details on how to obtain emergency care has been explained to me in the language that I understand.

Name : Sai Ravali Signature : Sai Ravali

Relationship with patient : Mother

This summary has been explained by :

Summary prepared by :Dr. Shivam
DEO :Kalyan

Registrar/Resident/C.M.O

Dr. PREETHAM KUMAR
MBBS,DNB(PEDS),DCH,FELLOW NEONATOLOGY
SENIOR CONSULTANT PEDIATRICS
39859

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0 Y 0 M 0 D 5 H (F)
Dr. PREETHAM KUMAR

NURSING DEPARTMENT

NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: B/O - Sai Ravali Mother's Name: Mrs. Sai. Ravali

Date of Birth: 25/6/26 Time of Birth: 10:00 AM Gender: ☐ Male ☑ Female

Birth Weight: 3.508 Kgs HC: 40 cm Lenght: 49 cm

Meconium in Liquor: ☐ Yes ☑ No Cried at Birth: ☑ Yes ☐ No

Term / Pre-term / Post-term: Term

Resuscitated: ☐ Yes ☑ No Blood Group: Mother: O - positive Baby: ....

Feeding: ☑ Breast Feeding ☐ Formula ☐ Both First Feed Time: ....

VIH-00182886 IP-00060473
Mrs SAI RAVALI
06-10-1994 31 Y 8 M 19 D (F)
Dr. KAPPAGANTULA APARNA

Mode of Delivery: ☐ Normal ☑ LSCS - Emergency/ Elective ☐ Instrumental

Indication: Prev. LS-CS

Physical Assessment of New Born:

Temp: 98.6 °C HR: 145 b/mt /Min RR: 45 b/mt /Min BP: — SpO₂: 99%

Pain Score: — (Follow N Pass)

Fall Risk Assessment: ☑ Yes ☐ No **Score:** 15 (Fill the Humpty Dumpty Sheet)

Risk in Pressure Sore : ☐ Yes ☑ No (Braden Q Score) (Fill the Braden Q Sheet)

Behaviour Status on admission: ☑ Sleeping ☐ Crying ☐ Calm ☐ Drowsy

Findings:

General Appearance: Posture : ☑ Well-Flexed ☐ Asymmetry

Skin: ☑ Pink ☐ Meconium Stain ☐ Others, Specify: —

Nursing Management: (Please strike through If not applicable e.g. Yes / ~~No~~)

Vitamin K 1 mg I.M Administered: ✓Yes / No

Routine Care Provided: ✓Yes / No

Capillary Blood Glucose Monitoring Done: Yes / ✓No

Neonatal Screening Done: ✓Yes / No

1. Nutritional Screening: Feeding Problem Yes / ✓No
2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / ✓No
3. Socio History: Siblings ✓Yes / No

All information obtained from ☑ Mother ☐ Father ☐ Other Family Member

Newborn Screening Discussed: ✓Yes / No

Nurse Name: Rani Signature: Rani Date &Time: 25/6/26 @ 11Am

PATIENT TRANSFER FORM

VIH-00206230 IP-00060477 Baby B/O SAI RAVALI 25-06-2026 0Y0M0D5H (F) Dr. PREETHAM KUMAR	Date & Time of Admission 25/6/26 · 11:17am	Date & Time of Transfer Order 25/6/26 5pm
Treating Consultant Name	Transfer Ordered by Dr. Vishal	Reason for Transfer for observation
From Unit MCCU	To Unit (206)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 15	Number of Imaging Films –	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.	(1) Baby Leaches	(1)
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
pooja	Dr. Vishal

Patient & Clinical Records Received by : Sony

Date & Time of Patient Received : 25/6/26 @ 5pm

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

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : SAI RAVALI Age : .... Father's Name : .... Age : ....

Date of Birth : 09-10-94 Date of Admission : .... UHID No.: ....

NICU Consultant : Dr Preetham Referring Consultant : Dr. Aparna

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

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

BIRTH INFORMATION

Name : B/o Ravali

Gender : ☐ M ☑ F Blood Group : ....

Date of Birth : 25/06/26 Time of Birth : 10:00 Am

Place of Birth : RCH · VKP.

Mother's Blood Group : 'O' Positive

Birth Weight (gms) : 3.508 kg Length (cms) : ....

OFC (cms) : ....

Estimated Gesth Age : 37+6 wk

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 31yr. Ht : 159 Wt : 94 BMI : .... Married Life : 8yr. LMP : 19/10/25 EDD : 10/7/26.

Conception : Spontaneous or with Rx. : Spontaneous

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

Last Scans Details : 15/6/26 36+3 wk / cephalic / Pl. P/H / AFI - 17.6 / AC 53% / EFW - 85%.

Dopplers (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

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

Compliance with Rx : ....

Scans : LGA, TIFFA , Fetal Echo : —

H/o Hypothyriodism : when diagnosed ? Medication? ∵ Conception.

T. Thyronorm - 25mcg

Any other Chronic Medical Problems, when detected drugs ? —

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

Infection : H/O, Fever

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

UTI : when : 13+4 wk Any culture : E. coli.

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

Medication during Pregnancy : .... Duration : ....

VIH-00206230 IP-000...
Baby B/O SAI RAVALI
25-05-2026 0Y0M0D8H (F)
Dr. PREETHAM KUMAR

PAST OBSTETRIC HISTORY

G: .... P: ...1... A: ...0... L: ...1...

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
G1	female / 7yr / FT/LSCS / PROM / 3.4 kg / A&H.					
G2	P/P – SP. Conception.					

PERINATAL HISTORY

Treating Obstetrician : Dr. Aparna .... Hospital : RCH • VKP. .... ☑ Inborn ☐ Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

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

Specify the reason : Previous LSCS.

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 :

CIAB

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-08-2026 0Y0M0D8H (F)
Dr. PREETHAM KUMAR

Patient Sticker

History of Present Illness:

B/o Ravali delivered via Em. LSCS
↓
FCM
↓
CIAS
↓
Cord clamp cut
↓
Dried and stimulated
↓
Secretions cleared
↓
Inj. Vit K 1Mg given
↓
Cord clamp cut 2A+1V (+)
↓
Baby vigorous
↓
Shift to mother side

target SpO2 reached at 3' of life

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0Y0M0D8H (F)
Dr. PREETHAM KUMAR

Pa

RAL EXAMINATION ON ADMISSION

General Disposition : GA good

VITALS : Temperature : 36.4°C HR : 170/min RR : 42/min NIBP : .... CFT : <3 sec

Color of the extremities : Acrocyanosis (+)

Jaundice : – Pallor : – SpO2 : 94 (RA)

Anthropometry : Birth Weight : 3.508 kg Length : .... HC : .... Present Weight : ....

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

HEAD TO TOE EXAMINATION

HEAD :	Fontanelles : Sutures Shape / Moulding : Edema / Bruising : Size - (H.C.) :	AF @ level
Facies : (Any Facial Dysmorphism)		–
NECK and CLAVICLES :	Range of Motion : Asymmetry : Masses :	(N)
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)

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-05-2025 0 Y 0 M 0 D 8 H (F)
Dr. PREETHAM KUMAR

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

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : ☑ Regular ☐ Periodic ☐ Shallow ☐ Gasping

Mention If baby has Respiratory distress : RR : 42/min 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 : BAE (+) Breath Sounds : NVBS (+) Added Sounds : ....

Cardiovascular System :

HR : 170/min 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 (+)

First urine passed : passed

Meconium passed : —

Patient Sticker

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0Y0M0D8H (F)
Dr. PREETHAM KUMAR

Nervous System : Higher intellectual functions (Sensorium) : ....

State of wakefulness : ....

Prechtle Score : ....

Nerves : ....

....

Motor System :

Passive Tone : ....

Active Tone : ✓

Neonatal Reflexes : ....

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

Moro's : B/L Responsive (+) DTR : ....

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

Any Congenital Anomalies : —

....

Diagnosis : TERM / [illegible] / [illegible] / CAS / Infant of Hypothyroid / 3.508 kgs / LGA ~~AGA~~

....

FOOT PRINTS

Left Side :	Right Side :
	Taken by Vanitha @ 10'

Resident Doctor :

Signature : [signature]

Name : Dr. Shriker

Date & Time : 25/6/26 / 10:20am

Consultant :

Signature : [signature]

Name : ....

Date & Time : 25/6/26 3pm

Patient Sticker

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0 Y 0 M 0 D 8 H (F)
Dr. PREETHAM KUMAR

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-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0Y0M0D8H (F)
Dr. PREETHAM KUMAR

Feeding: ☐ Breastfeeding Exclusively ☐ Breastfeeding and Formula Feeding ☐ Formula Feeding

Vitamin K given: ☐ Yes ☐ No

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

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

Hearing Test: ☐ Yes ☐ No

Jaundice: ☐ NIL ☐ Slight ☐ Moderate

Passed Urine: ☐ Yes ☐ No

Passed Meconium: ☐ Yes ☐ No

Weight at discharge: ....

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

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

Discharge to ☐ Home ☐ Other: ....

Against Medical Advice: ☐ Yes ☐ No

Referred to another hospital: ☐ Yes ☐ No

Discharge Medications: ☐ Yes ☐ No

Details: ....

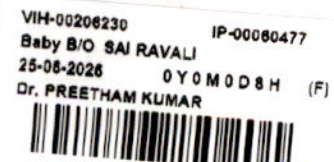
Final Diagnosis: ....

- DBF 2nd day
- SBR/NBC @ 48 HOL
- Immunization
- OAE B/F D/C
- monitor & inform (S.O.S)

Doctor Signature: [signature]

Doctor Name: Dr Shrikar

Date & Time: 25/6/26 | 10:20 am.



ESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25.6.26	Lactation notes (Mrs. Ranganayaki)	
•	Experienced Mother	
•	Normal breast Condition	
•	Drops of Milk Seen	
•	Advised to feed the baby every 2 hrs	
•	More skin to skin	
•	f/u tomorrow	
[signature] 6:40 pm	S/B Registrar	
26.6.26 9.00 AM	Early Term (37+6 wk) / LGA / baby girl / HOL-22 / Hypothyroid mother	
	O/E baby warm	
	cry, tone, activity (N)	
	MBG : O+ve	
	BBG : B+ve	Plan
	urine ✓ CVS - S1S2 (+)	→ DBM
	motion ✓ RS - BAE (+) clear	→ Warm care.
	B.wt : 3.508 kg P/A - soft	→ OAE today
	T.wt : 3.47 kg (↓38 gm)	→ TCB before D/C
		→ RBS 6th hrly (pre-feed)
	[signature]	[signature] (Dr. Sameera)
	[signature]	Noted by Sushma 26/6/26 at 12:30 pm

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0Y0M0D8H (F)
Dr. PREETHAM KUMAR

GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26.6.26 3.00 PM	s/b Registrar	
	Early Term (37+6 wk) / LGA / baby girl / HOL-28 / Hypothyroid mother	
	O/E baby warm, cry, tone, activity (N); H/L - NAD; P/A - soft	Plan → Warm care → RBS 6th hrly (pre-feed) → DBM + FF
	red reflex: present B/L symmetrical.	→ OAE today → Inform if RBS <40 mg
	(Dr. Sameer)	→ TCB before discharge
26/6/26	Lactation notes (Ms. Ramyashri)	Noted by [signature]
	• Mother confidently feeding the baby	
	• To continue DBF	
	• f/u	
2:10 PM		

Docu. No. : RCH /FRM / CLINICAL / 088

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0Y0M0D8H (F)
Dr. PREETHAM KUMAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/6/26 9AM	C/S/B Resident	DOB - 25/6/26 10AM
	Term/37+6wk/LSCS/AGA/B/gr1 /3.508kg	
	M:BG - O+ve B:BG - B+ve	
		Plan
	Y. wt - 3.47kg T. wt - 3.37kg (↓100gm)	- DBF f/b burping 2 hrly
	O/E C/P/A good CRT < 3 sec CVS - S1S2 (+) RS - B/L AE (+) PA - Soft V4 Stable	- Warm care & Cord care - OAB TO day
	d/c t/m.	
	Dr. [illegible] 27/6/26 9AM.	Dshivam
		noted by [illegible] 27/6/26 at 10Am

Docu. No. : RCH /FRM / CLINICAL / 088

(P.T.O)

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0 Y 0 M 0 D 8 H (F)
Dr. PREETHAM KUMAR

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0Y0M0D5H (F)
Dr. PREETHAM KUMAR

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: Term / EL-LSCS / Female / 3.50			Any Infection: ☐ Yes ☑ No ☐ Not Known If Yes Specify: —			
	Surgery / Procedure: —			Post OP Day:			
BACKGROUND	Date / Shift	25/6/26 M	25/6/26 E	25/6/26 E	26/6/26 N	26/6/26 M	26/6/26 E
	Medical Condition (Any special condition to be noted):	–	–	–	–	–	–
	Diet:	DBF	DBF	DBF	DBF	DBF	DBF
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Ventilation (RA, NP, NIV, VENTI):	–	–	–	RA	RA	RA
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No
	Vital Signs: Temp:	98.6°F	98.6°F	98.7°F	98.6°F	98.6°F	98.5°F
	Res:	48 b/m	40 b/m	20 b/m	39 b/m	40 b/m	41 b/m
	SpO_2:	99%	99%	99%	98%	99%	99%
	Pulse:	182 b/m	182 b/m	109 b/m	138 b/m	141 b/m	145 b/m
	BP:	–	–	–	–	–	–
	LOC:	conscious	Conscious	Conscious	conscious	conscious	Conscious
	Fall Risk Score:	15	15	15	15	'15'	15
	Pain Score:	'0'	'0'	0	0	'0'	0
	Skin Integrity	Intact	Intact	Intact	Intact	Intact	Intact
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No
	Physiotherapy:	–	–	–	–	–	–
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Special Diet:	DBF	DBF	DBF	DBF	DBF	DBF
	Critical Lab Test / Values:	–	–	–	–	–	–
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	ADL (Dependent / Non Dependent):	dependent	dependent	dependent	dependent	dependent	dependent
Post Operative Procedure Special Orders:		DBF 2nd hour	DBF 2nd hour	DBF 2nd hourly		-	–
Handed Over By Name :		pooja	pooja	Sony	Syed	sushila	Varsha
Signature / ID :		[signature]	[signature]	9050143	016447	16993	905042
Date:		25/6/26	25/6/26	25/6/26	26/6/26	26/6/26	26/6/26
Time:		@ 8am	@ 5pm	@ 8pm	@ 8am	@ 2pm	@ 8pm
Taken Over By Name :		pooja	Sony	Syed	sushila	Varsha	Bhanu
Signature / ID :		[signature]	9050143	016447	16993	905042	17887
Date:		25/6/26	25/6/26	25/6/26	26/6/26	26/6/26	26/6/26
Time:		@ 8pm	@ 5pm	@ 8pm	8 Am	@ 2pm	8pm

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0Y0M0D5H (F)
Dr. PREETHAM KUMAR

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: Term | baby girl | EL.LSCS | BW-3.5			Any Infection: ☐ Yes ☑ No ☐ Not Known If Yes Specify: —			
	Surgery / Procedure:			Post OP Day: —			
BACKGROUND	Date / Shift	26/6/26	27/6/26 M	27/6/26 E			
	Medical Condition (Any special condition to be noted):	–	–	nil			
	Diet:	DBF	DBF	DBF			
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA	RA	RA			
	Tubes/Drains/Catheter:	☑ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97.9°F	97.5°F	98.6F			
	Res:	40 b/m	41 b/m	46 b/mt			
	SpO_2:	99%	99%	96%			
	Pulse:	141 b/m	140 b/m	142 b/mt			
	BP:	–	–	–			
	LOC:	conscious	conscious	conscious			
	Fall Risk Score:	15	'15'	15			
	Pain Score:	0	'0'	0			
	Skin Integrity	Intact	Intact	Intact			
Recommendations	Safety Needs:	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	–	–	nil			
	Others Specify:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	DBF	DBF	DBF			
	Critical Lab Test / Values:	–	–	Nil			
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	dependent	Dependent	dependent			
Post Operative Procedure Special Orders:		–	nil	nil			
Handed Over By Name :		Bhanu	sushila	Sushila			
Signature / ID :		12882	816993	0160993			
Date:		27/6/26	27/6/26	27/6/26			
Time:		8Am	2PM	2 pm			
Taken Over By Name :		sushila	sushila				
Signature / ID :		816993	816993				
Date:		27/6/26	27/6/26				
Time:		8 AM	2PM				

Noted by Sushila 27/6/26 @ 2pm

Docu. No. : RCH /FRM / CLINICAL / 097

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0Y0M0D5H (F)
Dr. PREETHAM KUMAR

NURSING CARE RECORD

Date: 25/6/28

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	3pm 5pm	maintain PBF Ensure safety		2nd time baby provide side cribe	baby is taken 2nd time feeding JOPrumt feeling	Baby is good Baby is was good	[illegible] 25/6/2[illegible] A. 5pm
Night	9pm	Prevent Infection Ensure safety	9:30pm	provided hand rub. provided side rails.	prevented for dehydration prevented for fall risk	Re assessment done every 4th hrly vital checked pt is stable	[illegible] 26/6/26 @ 8Am

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Baby B/O SAI RAVALI
25-06-2026 0Y0M0D5H (F)
Dr. PREETHAM KUMAR

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0Y0M0D8H (F)
Dr. PREETHAM KUMAR

NURSING CARE RECORD

Date: 26/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9am	* Maintain fluid balance	11Am	* Every 2nd hourly feeding & Burping is given	* To prevent dehydration	* Re-Assessment was done Baby is safe & Active	Sushila 26/6/26 @2pm
Afternoon	4 pm	Ensure Safety	4 pm	* provided side rails	* prevent fall risks.	* Re-Assessment done baby is Safe	Vaishn 26/6/26 @5pm
Night	8pm	* maintain Personal Hygiene. * Ensure safety		- provided warm and cord care. - baby is safe	- OBF 2nd hourly given. - Ensure safety	- vitals 4th Hourly checking.	Bhanu 27/6/26 8pm

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0 Y 0 M 0 D 13 H (F)
Dr. PREETHAM KUMAR

NURSING CARE RECORD

Date: 27/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	9 Am	* provide DBF & Burping.	10 Am	* provided DBF & burping every 2nd hourly.	* prevent dehydration	* Re-Assessment done baby is stable.	Sushila 27/6/26 @ 10 Am
Afternoon	4pm	prevent Infection	4:10 pm	To maintain Hand hygiene	To prevented Infection	patient is stable	Sushila 27/6 at 8 pm
Night		Noted by Sushila 27/6/26 @ 2pm		Discharge Notes:— Doctor Come for Rounds Advice for discharge			

Docu. No: RCH /FRM / CLINICAL / 148

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0 Y 0 M 0 D 13 H (F)
Dr. PREETHAM KUMAR

NURSING CARE RECORD

Date: ....

Goals

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

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

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Baby B/O SAI RAVALI**	**Age :**	**0 Y 0 M 0 D 1 H**
IP No:	**IP-00060477**	**Sex:**	**Female**
Consultant:	**Dr. PREETHAM KUMAR**	**Ward/Bed No:**	**N 2F-MICU/CRDL-MICU-227-1**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:

1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
Receivers Signature:................ K. Anjan

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative: K. Anjan

Name: K. ANJAN KRISHNA KUMAR

Relationship: FATHER

Date: 25/06/2026 Time:

Wittness Name:

Wittness Signature:

Patient Address:
ALWAL Alwal Hyderabad Telangana
INDIA 500010

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0Y0M0D5H (F)
Dr. PREETHAM KUMAR

Patient

CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 25/6/26.

Time:	1pm	[illegible] pm	[illegible] pm	[illegible] pm	11 pm	3 Am	7 Am
Doctor/Nurse/Family Concern?							
Temperature (°F) (scale 94–104)	37	37	37	37	98.0°F	97.5°F	98.0°F
Heart Rate (bpm) and Blood Pressure (mmHg) * (scale 50–190)							
Heart Rate (Number)	140	138	144	149	130	140	138
Resp. Rate (bpm) (Over 1 Minute) * (scale 10–70)							
Resp Rate (Number)	48	51	52	53	35	40	38
Resp Distress – Mod/ Severe							
Resp Distress – None / Mild	✓	✓	✓	✓	✓	✓	✓
Receiving O_2 (l/min)							
O_2 Saturations (%)	99%	98%	99%	98%	99%	98%	99%
Conscious Level – Normal					N	N	N
Conscious Level – Altered							
GCS *					N	N	N
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	R	R	R	R	[illegible]	[illegible]	S

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-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0Y0M0D5H (F)
Dr. PREETHAM KUMAR

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-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0Y0M0D8H (F)
Dr. PREETHAM KUMAR

RCH/ FRM / CLINICAL / 124

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

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 26/6/26 Time:	10 PM	1 PM	4 PM	8 PM	11 PM	3 AM	7 AM
Doctor/Nurse/Family Concern?							
Temperature (°F)	98.6F	98.6F	98.4F	98.2F	98.7F	98.1F	98.5F
Heart Rate (Number)	143	150	149	148	147	150	149
Resp Rate (Number)	46	48	47	40	46	47	41
Resp Distress Mod/Severe							
Resp Distress None/Mild							
Receiving O_2 (l/min)							
O_2 Saturations (%)	96	99	99	99	99	99	99
Conscious Level Normal	N	N	N	N	N	N	N
Conscious Level Altered							
GCS *	15	15	15	15	15	15	15
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	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

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

Note: BP does not score in early warning scoring

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

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Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
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- 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-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0 Y 0 M 0 D 13 H (F)
Dr. PREETHAM KUMAR

Doc. No. : RCH/ FRM / CLINICAL / 124

INFANT (<1 year)

Children's Observation & Early Warning Scoring Chart

Date: 27/6/26 Time:	10 AM	1 PM
Doctor/Nurse/Family Concern?		
Temperature (°F)	98.5	98.6
Heart Rate (bpm) and Blood Pressure (mmHg) *	140	
Heart Rate (Number)	140	145
Resp. Rate (bpm) (Over 1 Minute) *	41	
Resp Rate (Number)	41	49
Resp Distress: Mod/ Severe / None / Mild		
Receiving O_2 (l/min)		
O_2 Saturations (%)	94	96
Conscious Level: Normal / Altered	N	N
GCS *	15	15
TOTAL SCORE Number of shaded boxes	0	0
Pain Score	0	0
Observer's Initials	[illegible]	[illegible]

Note: BP does not score in early warning scoring

Noted by Sushila 27/6/26 @ 2pm

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.

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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)
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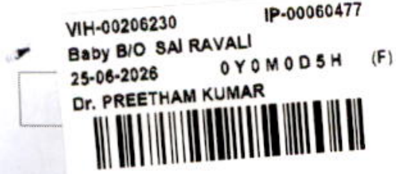
A	**ASSESSMENT :** I think the problem is (XXX) and I have ...(e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	**RECOMMENDATION :** I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime ? (e.g. stop the fluid/ repeat observation)



FLUID CHART

Sheet No. : ①

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
25/6	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am	DBf	✓								–	[illegible] 25/6
	12:00 pm									✓	–	
	01:00 pm	DBf	✓								–	
Total Intake :						Total Output :				Passed		
25/6	02:00 pm	DBf	✓								–	[illegible] 25/6/26 @ 7pm
	03:00 pm	DBf	✓				✓			✓	–	
	04:00 pm										–	
	05:00 pm	DBf									–	
	06:00 pm						✓				–	
	07:00 pm		DBF									
Total Intake :						Total Output :						
25/6	08:00 pm											[illegible] 25/6/26 @ 8pm
	09:00 pm		DBF									
	10:00 pm						✓					
	11:00 pm		DBF							✓		
	12:00 am											
	01:00 am		DBF									
Total Intake :						Total Output :						
26/6	02:00 am											[illegible] 26/6/26 @ [illegible]
	03:00 am		DBF									
	04:00 am									✓		
	05:00 am		DBF									
	06:00 am											
	07:00 am		DBF				✓			✓		
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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.

		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							
26/6/26	08:00 am											Sushila 26/6 at 1PM
	09:00 am	DBF								✓		
	10:00 am											
	11:00 am	DBF										
	12:00 pm									✓		
	01:00 pm	DBF										
Total Intake :						**Total Output :**						
26/6/26	02:00 pm											Vasuky 26/6 [illegible]
	03:00 pm		DBF							✓		
	04:00 pm											
	05:00 pm		DBF				✓					
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm		DBF									[illegible] 27/6/26
	09:00 pm											
	10:00 pm											
	11:00 pm		DBF				✓					
	12:00 am											
27/6/26	01:00 am		DBF									
Total Intake :						**Total Output :**						
	02:00 am											[illegible] 27/6/26
	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	

FLUID CHART

Sheet No. : ....

1. All measurements in ml.
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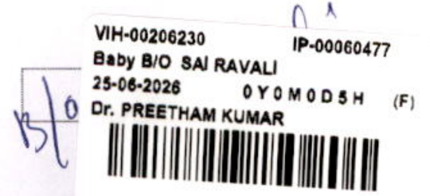
Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
										—		
27/6/26	08:00 am		DBF									Sushela 27/6/26 @ 1pm
	09:00 am											
	10:00 am		DBF								0	
	11:00 am						✓			—		
	12:00 pm											
	01:00 pm		DBF									
Total Intake :						Total Output :						
27/6/26	02:00 pm											
	03:00 pm		DBF									
	04:00 pm										0	RS 27/6/26 @7pm
	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 :						

Noted by Sushila 27/6/26 @ 2pm

Total 24 hrs. Intake	

Total 24 hrs. Output	



STAT / ONCE ONLY DRUGS

Name: ....

Weight: 3.508 kgs

Sheet No: 1

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
25/6/26	10:10AM	INJ. VITAMIN K	0.5cc	I/M	[signature]	Vanitha	Prasoona

VIH-00206230 IP-00060477
Baby B/O SAI RAVALI
25-06-2026 0Y0M0D5H (F)
Dr. PREETHAM KUMAR

RESULT SHEET

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

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood group:						

Culture and Sensitivities : ....

....

....

....

Radiology : USG : ....

X-Ray : ....

ECHO : ....

CT : ....

MRI ....

Others (ECG, Contrast Studies etc.,) : ....