

VIH-00205779 IP-00060294
Baby B/O NABIHA NAZEER
10-06-2026 0 Y 0 M 0 D 4 H (M)
Dr. KODICHERLA VISHNU VARDHAN

①

ACTIV

NG



Name: -

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

Date of Admission : 10/6/26 Time : 9:53 Am Date of Discharge : ----- Time: -----

Room / Bed No : 219-1 Ward : K/W Suggested Billable bed type : -----

WARD TRANSFERS

| Date | Time | From | To | Signature of Nurse |
|---------|------|------|-----------|--------------------|
| 10/6/26 | 12pm | K/W | Room (03) | M |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Cross Consultation Visit

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

| | | | |
|------------------------|---|-----------------------|------------------|
| Name | Baby B/O NABIHA NAZEER | UHID | VIH-00205779 |
| Father/Guardian | Mr MOHAMMED ASHFAQ | Age/Gender | 0 Y 0 M 1 D/Male |
| Address | HNO 25/40/48/2A ANANTHA SARASWATHI NAGAR EAST ANANDBAGH MALKAJGIRI, East Anand Bagh, Hyderabad, Telangana, INDIA, 500047 | | |
| IP No | IP-00060294 | Admission Date | 10-06-2026 |
| Ref Doctor | Dr., RAYAPUDI DIVYA HANUMA CHARANI | Discharge Date | 11-06-2026 |

DISCHARGE SUMMARY

Consultant: Dr. KODICHERLA VISHNU VARDHAN REDDY

MBBS, DNB (Pediatrics), DrNB (Pediatric Critical Care)

Fellow in PICU & CICU (RCPCH BCH UK)

CONSULTANT PEDIATRICIAN AND PEDIATRIC INTENSIVIST

Diagnosis: Early term /Appropriate for gestational age/Baby Boy

Mode of Delivery: Assisted Vaginal Delivery

Presentation: Cephalic

Anthropometry:

Weight at birth : 3.310 kgs

Weight at discharge : 3.200 kgs

Head circumference : 33 cms

Length : 49 cms

Mother Blood Group : "B" Positive

Baby Blood Group : "B" Positive

Risk Factors : Hypothyroid mother

Others:

TCB at 28 hours of life: 8.8 mg/dl

Treatment gap: 2.2

Vaccination: Baby was given following vaccination:

BCG / OPV / Hepatitis-B on : 11.06.2026

Hearing test (OAE): Done on 11.06.2026 was normal.

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

Saturation: Right upper limb 98% and left lower limb 98% at room air.

Red Reflex: Present and Symmetrical.

Name

Baby B/O NABIHA NAZEER UHID

VIH-00205779

History: Baby of Baby B/O NABIHA NAZEER is a early term (37+4 weeks) baby boy, delivered to a Primi gravida mother by Assisted Vaginal Delivery on 10.06.2026 at 07:16 am with birth weight of 3.310 kgs in Rainbow Children's Hospital, Karkhana. Baby cried immediately after birth. Apgar scores were 7/10 at 1 min, 8/10 at 5 min. Inj. Vitamin-K 1mg IM was given after delivery.

Maternal History: Mrs. NABIHA NAZEER is a 25 years old Primi gravida mother.

G1 - Present pregnancy, spontaneous conception, had regular ANC's. Antenatal scans were normal. She had history of Vaginal infection- Candidiasis at 20 weeks and was managed conservatively. Cervical Cerclage done at 20+2 weeks in view of Short Cervix and was removed at 35 weeks. History of spotting PV at 16 weeks and was managed conservatively. She was diagnosed with Hypothyroidism at 28 weeks & is on Tab. Thyroxine 25 mcg. No history of Antepartum Hemorrhage / Oligohydramnios / Polyhydramnios / Fever.

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. Bruise over right side of right eye. Mild positional right foot deformity present.

Management: Course during hospital: Hospital stay was uneventful.

Transcutaneous bilirubin before discharge was 8.8 mg/dl, it does not come under phototherapy range.

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

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

Name

Baby B/O NABIHA NAZEER

UHID

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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) 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. K. Vishnu Vardhan Reddy, Consultant Pediatrician & Intensivist Pediatric, on Saturday (13.06.2026) with 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).
11. Kindly consult Dr. Vidyasagar Chandankere, Consultant Pediatric Orthosurgeon, on Saturday (13.06.2026) in OPD with prior appointment (This consultation will be charged) (in view of Mild positional right foot deformity).

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.

Name

Baby B/O NABIHA NAZEER

UHID

VIH-00205779

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 :

Signature :

Relationship with patient :

This summary has been explained by :

Summary prepared by :Dr.Sameera

DEO

:Kalyan

Registrar/Resident/C.M.O

Jan Sameera

Dr. KODICHERLA VISHNU VARDHAN REDDY

MBBS, DNB (Pediatrics), DrNB (Pediatric Critical Care)

Fellow in PICU & CICU (RCPCH BCH UK)

CONSULTANT PEDIATRICIAN AND PEDIATRIC INTENSIVIST

APMC/FMR/79982

DEFICIENCY CHECK LIST OF MEDICAL CASE SHEET

VIH-00205779 IP-00060294
 Baby B/O NABIHA NAZEER
 10-06-2026 0 Y 0 M 0 D 5 H (M)
 Dr. KODICHERLA VISHNU VARDHAN



Patient Name

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 | 2 | — | — | |
| 8 | Consultation Sheets | | | | |
| 9 | General Consent for Treatment | 1 | — | — | |
| 10 | Conset for Surgery | | | | |
| | Consent for Blood Transfusion | | | | |
| | Consent for Chemotherapy | | | | |
| 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 | 2 | — | — | |
| 26 | Intake and Output chart (fluid Chart) | 2 | — | — | |
| | Drug Chart (Regular prescription) | 1 | — | — | |
| | 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 | | | | |
| | Empty - empty | 1 | — | — | |
| | Others | 5 | — | — | |
| | Total No. of Pages | 26 | | | |

Noted by
Beymike
11/6/26
@ 12pm

Signature and Date :

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

ADMISSION SHEET

Registration Details :



Admission No : IP-00060294

Admit Date : 10-Jun-2026

Admit Time : 09:53 AM UHID : VIH-00205779

Patient Details :

Patient Name : Baby B/O NABIHA NAZEER

Age : 0 D

Guardian : Mr MOHAMMED ASHFAQ

DOB : 10-06-2026 07:16 AM

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : HNO 25/40/48/2A ANANTHA SARASWATHI
NAGAR EAST ANANDBAGH MALKAJGIRI East
Anand Bagh Hyderabad Telangana INDIA
500047

Phone No : 9966554248/ 6301898157

E-mail : NA@GMAIL.COM

Admission Details :

Bed Type : BASINET

Bed No : CRDL-LW-219-1

Ward Name : N 2F-LABOUR WARD

Room No : CRDL-LW-219-1

Admission Type : First Visit

Contact Details :

Name : Mr MOHAMMED ASHFAQ

Relationship : Father

Contact Address : HNO 25/40/48/2A ANANTHA SARASWATHI
NAGAR EAST ANANDBAGH MALKAJGIRI East
Anand Bagh Hyderabad Telangana INDIA
500047

Phone No : 6301898157 / 9966554248


Signature

Doctor Details :

Doctor Name : Dr. KODICHERLA VISHNU VARDHAN
REDDY

Specialisation : NEONATOLOGY

Referral Doctor : SELF

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00


Payment Mode : Cash

Payor Name : SELF PAY

1

PATIENT TRANSFER FORM



| | | | |
|---|------------------------------|--|---|
| Patient Name & UHID No. VIH-00205779 IP-00060294 Baby B/O NABIHA NAZEER 10-06-2026 0 Y 0 M 0 D 4 H (M) Dr. KODICHERLA VISHNU VARDHAN  | | Date & Time of Admission 10/6/2026 | Date & Time of Transfer Order 10/6/26 @ 12pm |
| | | Transfer Ordered by Dr. Vishal | Reason for Transfer Observation |
| From Unit ICU | To Unit Room(103) | Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Number of Sheets in Clinical File 15 | Number of Imaging Films - | Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ? | |
| Medications / Consumables / Surgicals / Hand over | | | |
| Sl.No. | Item Name | Quantity | |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Dr. Vishal | | | |
| Name & Signature of Person who is Transferring Meghana | | Name of Person Ordered Transfer Dr. Vishal | |
| Patient & Clinical Records Received by : Sr. Bevanika | | | |
| Date & Time of Patient Received : 10/6/26 @ 12:15 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



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Blo Nabaha nazeer Mother's Name: Nabaha nazeer
Date of Birth: 10/6/26 Time of Birth: 7:16 am Gender: Male Female
Birth Weight: 3:310 Kgs HC: 36 cm Length: 49 cm
Meconium in Liquor: Yes No Cried at Birth: Yes No
Term / Pre-term / Post-term: term
Resuscitated: Yes No Blood Group: Mother: B positive Baby: -
Feeding: Breast Feeding Formula Both First Feed Time: 7:30 am

VIH-00201962 IP-00060289
Mrs NABIHA NAZEER
08-02-2001 25 Y 4 M 2 D (F)
Dr. RAYAPUDI DIVYA HANUMA

Mode of Delivery: Normal LSCS - Emergency/ Elective Instrume.
Indication: normal vaginal delivery

Physical Assessment of New Born:

Temp: 36.5 °C HR: 154 /Min RR: 42 /Min BP: - SpO₂: 98%

Pain Score: - (Follow N Pass)

Fall Risk Assessment: Yes No Score: 16 (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: Adeltheja Signature: [Signature] Date & Time: 10/6/26 @ 9:00 am



PERINATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Nabiha Nazee Age : 25 yrs Father's Name : Age :
 Date of Birth : Date of Admission : UHID No. :
 NICU Consultant : Dr. Vishnu Referring Consultant : Dr. Divya
Transferring Unit : OT Labour Room ER Ward
Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : B/O Nabiha Nazee Mother's Blood Group : B positive
 Gender : M F Blood Group :
 Birth Weight (gms) : 3.310 kg Length (cms) :
 Date of Birth : 10/6/26 Time of Birth : 7:16 AM OFC (cms) :
 Place of Birth : RCU Estimated Gesth Age : 37+4 wks

Current Obstetric History : (Booked / Unbooked Case) unbooked to RCU, Prev. ANC at Dr. Divya.
 Maternal Age : 25 yrs Ht : Wt : BMI : Married Life : 11 months LMP : 20/9/25 EDD : 24/6/26
 Conception : Spontaneous or with Rx. : spontaneous
 Booked at what GA : at Dr. Divya AN Steroids Drugs / Doses : 2 doses gives at 33 wks - beta-mithasa
 Last Scans Details : 7/6/26 - SCWF, 31 wks, AFI - 9-10 cm, EFW - 3609 gm, uphatic
 TT Immunization and Iron / Folic Acid : takes

MATERNAL RISK FACTORS

| | |
|--|---|
| <p>Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs Consanguinity : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 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 / Redistribtion in MCA) / Ductus Venosus : AFI : <u>9-10 cm</u></p> | <p>H/o GDM/ pre GDM/ on diet or insulin Controlled or not, recent values, HbA1 values : Compliance with Rx : Scans : LGA, TIFFA / Fetal Echo : <u>chronic subchorionic</u> H/o Hypothyroidism : when diagnosed ? Medication? <u>hypothyroid on 4 thyroxine 25 mcg</u> Any other Chronic Medical Problems, when detected drugs ? <u>h/o vaginal infection - candidiasis at 20 wks managed conservatively.</u> (Anemia, SLE, Jaundice, CHD, Heart Disease) Infection : H/O, Fever <u>cevicid overlap done</u> (<input type="checkbox"/> Malaria <input type="checkbox"/> UTI <input type="checkbox"/> TORCH <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> HBV) UTI : when : Any culture :</p> |
|--|---|

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



PAST OBSTETRIC HISTORY

G: P: A: L:

| Sl. No. | Age | GA wks | B. W | Gender | Significant | Details |
|---------|-------|--------|------|--------|-------------|---------|
| | Prina | | | | | |
| | | | | | | |
| | | | | | | |

PERINATAL HISTORY

Treating Obstetrician : Dr. Divya Hanuma Hospital : Ven Inborn Outborn

| | |
|---|---|
| Duration of Labour <u>Cephalic - Assisted vaginal delivery - forceps.</u> First stage (> 18 hours sig) Second stage (> 2 hours after dilation) LSCS : <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication : Specify the reason : Augmentation of Labour : <input type="checkbox"/> Induced <input checked="" type="checkbox"/> Assisted Vaginal | CTG : <input type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological MSL : Resuscitaion : <input type="checkbox"/> Yes <input type="checkbox"/> 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 |
|--------------|----------|-----------|------------|
| | 1 | 1 | |
| | 2 | 2 | |
| | 1 | 1 | |
| | 1 | 2 | |
| | 2 | 2 | |
| TOTAL | 7/10 | 8/10 | |

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

Snapee II Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



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

ABDOMEN and UMBILICUS : Shape :) (N)
 Organomegaly :) (N)
 Bowel Sounds :) (N)
 Umbilical Stump : 2A+IV (+)
 Discharge :

GENITILIA : Labia/Hymen : Ruby bag
 Testicles/penis : of testis descended
 Anus : (+)

HERNIAL ORIFICES) free

TRUNK and SPINE :) (N)

SKIN LESIONS :) nil

EXTREMITIES : Fingers / Toes :) (N)
 Arms / Legs :) (N)
 Deformities : mild positional deformity
 Mobility :) (N)
 Hip Joint Examination : (+) of both feet - Rt

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 :
 SpO₂ : 98% @ RA Auscultation : RAC (+) Breath Sounds : NVRS (+) Added Sounds : -

Cardiovascular System :
 HR : 174/min BP : Precordial Activity :
 Femoral Pulses :) full Murmurs : (-)
 Other Peripheral Pulses :) full Signs of Cardiac Failure :

Abdomen :
 Shape :) (N)
 Palpation : soft
 Palpable masses :
 Abdominal girth :
 Hernia orifice : free
 Anal Patency : Patent
 Umbilical Cord : 2A+IV (+)
 First urine passed :) not passed
 Meconium passed :)



Intellectual functions (Sensorium) :

State of wakefulness : CP/A - Good

Prechtle Score :

Nerves :

Motor System :

Passive Tone : 10

Active Tone : 10

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

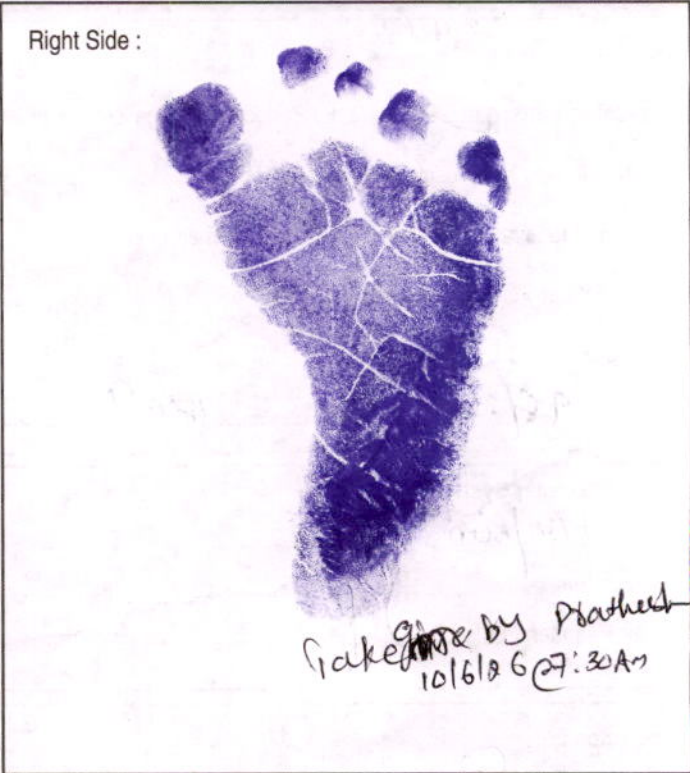
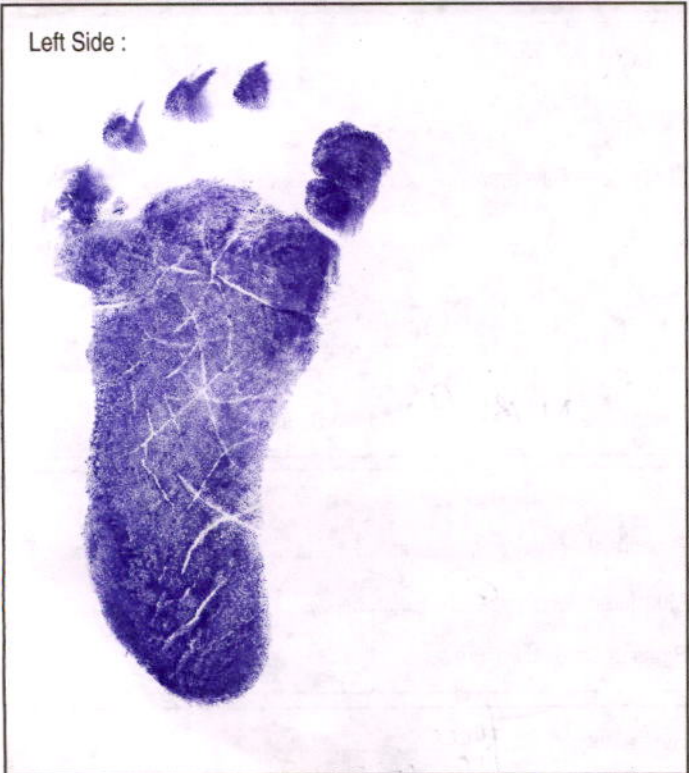
Moro's : DTR :

ATNR : Skull and Spine :

Any Congenital Anomalies : NO Obvious external congenital anomalies

Diagnosis : Term baby boy 3:310 c/g - A/A - AVD - forceps / hypotony void mottled
bruise on Rt side of eye / mild positional foot deformity right

FOOT PRINTS



Resident Doctor :
Signature : [Signature]
Name : Dr. Prathapishu
Date & Time : 10/6/26

Consultant :
Signature : [Signature]
Name : [Signature]
Date & Time : [Signature]



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 :

- 1) warmth care, cord care
- 2) DAF flb burping
- 3) Immunisation as per schedule
- 4) NRS, OAC, CSE bf dis charge
- 5) Red reflex before discharge
- 6) advised foot massage while feeding for positional deformity

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Noted by Prakash G/B/ab
Mr. Prathu

Discharge Details:

Neonatal Condition at Discharge:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

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:

Handwritten signature

Doctor Signature:

Doctor Name:

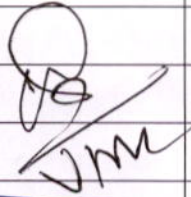
Date & Time:

VH-00205779 IP-00060294
 Baby B/O NABIHA NAZEER
 10-06-2026 0 Y 0 M 0 D 4 H (M)
 Dr. KODICHERLA VISHNU VARDHAN

PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|----------------------|---|---|
| 18.6.26 2.30PM | S/B Registration | |
| | Early Term (37 ⁴ wk) / AGA / baby boy / HDL-7 / AVD / Bruise / Bruise over R side of R eye / R mild partial foot deformity ICHM. | |
| MBU - B +ve | o/e baby warm ray. tone } (N) activity } | D/o Dr. Syali alt religious circumcision as per parents request. |
| BBA - B +ve | CUS - S, S (H) RS - BAEG, clear P/A - soft F - femorals - well felt | Plan -> DBM -> Warm care -> OAE -> Vaccination -> check Red reflex |
| urine ✓ matalin x | (Dr. Sameer) | Noted by |
| | | manasa 10/6 07PM |
| | | -1 |

PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---------------------------|--|---|
| 10/6/26 | <p style="text-align: center;"><u>C/S/B Dr. Vishnu</u></p> <p>HOL: 27hrs.</p> | |
| | Red reflex checked - B/L (N) | |
| Twt: 3-200g <u>ole</u> | <p>Uncl Alert Active</p> <p>Mucous</p> <p>CFA - Good</p> <p>CNS C3x</p> | <p style="text-align: center;"><u>Plan</u></p> <p>- TCB - How</p> <p>- Plan for d/c</p> <p style="margin-left: 20px;">Laparoscopy</p> |
| | | <p>- Flu after 2 2 days.</p> |
| | | <p>- OAG - today</p> <p>- NBS on flu.</p> |
| | | <p>- Consult orthopedics.</p> |
| |  <u>VM</u> | |
| | | <p>Noted by Benwika 11/6/26 @ 12pm</p> |

Patient's

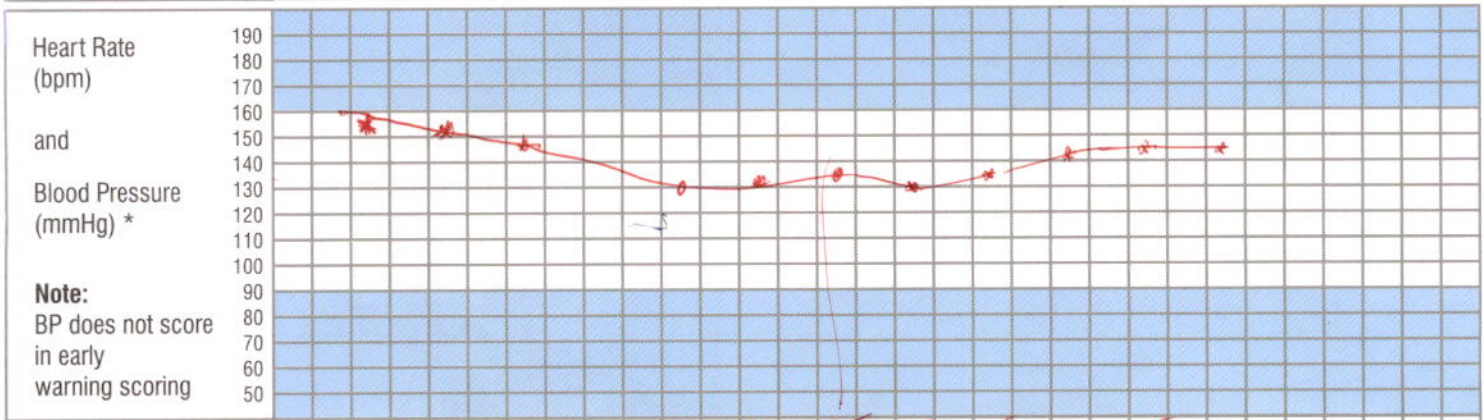
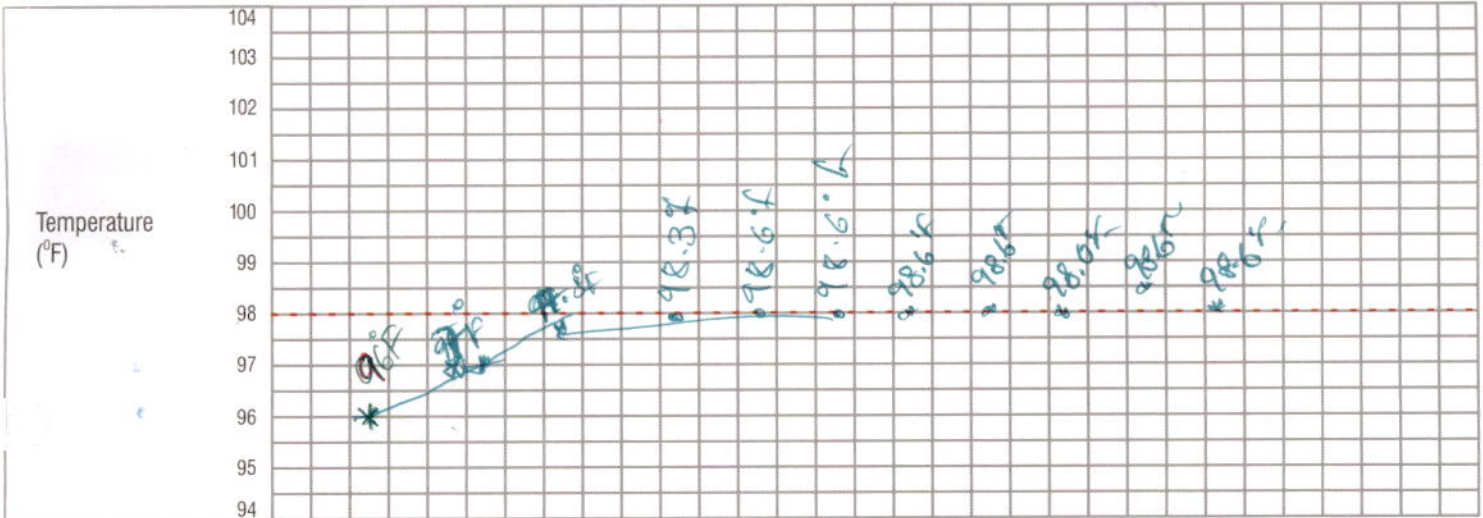


ICAL / 124

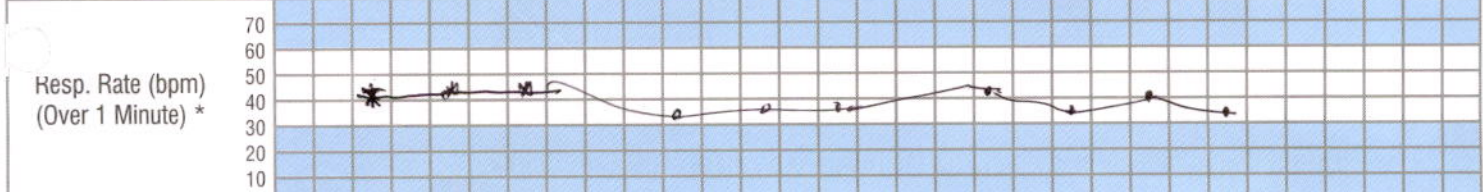
EARLY WARNING SCORE: CHILDREN'S UNIT

Date: 10/6/26 Time: 7 9 11 1 3 5 7 10 12 1 5 7

Doctor/Nurse/Family Concern? AM AM PM PM PM PM PM PM AM AM AM AM



Heart Rate (Number) 154 142 138 129 130 135 130 135 141 145 144



Resp Rate (Number) 40 42 42 38 36 37 42 35 40 35

Resp Mod/ Severe Distress None / Mild ✓ ✓ ✓

Receiving O₂ (l/min) O₂ Saturations (%) 96% 96% 98% 98% 98% 97% 98% 100% 99% 98% 96% 90%

Conscious Level Normal / Altered ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓

GCS * - - - 15 15 15 15 15 15 15 15 15

| | |
|------------------------|--|
| TOTAL SCORE | |
| Number of shaded boxes | <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> |
| Pain Score | <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> |
| Observer's Initials | <u>M</u> <u>K</u> <u>M</u> <u>M</u> <u>M</u> <u>M</u> <u>M</u> <u>SK</u> <u>SK</u> <u>SK</u> <u>SK</u> <u>SK</u> |

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

VH-00205779 IP-00080294
 Baby B/O NABIHA NAZEER
 10-06-2026 OYOMODSH (M)
 Dr. KODICHERLA VISHNU VARDHAN

/ FRM / CLINICAL / 124

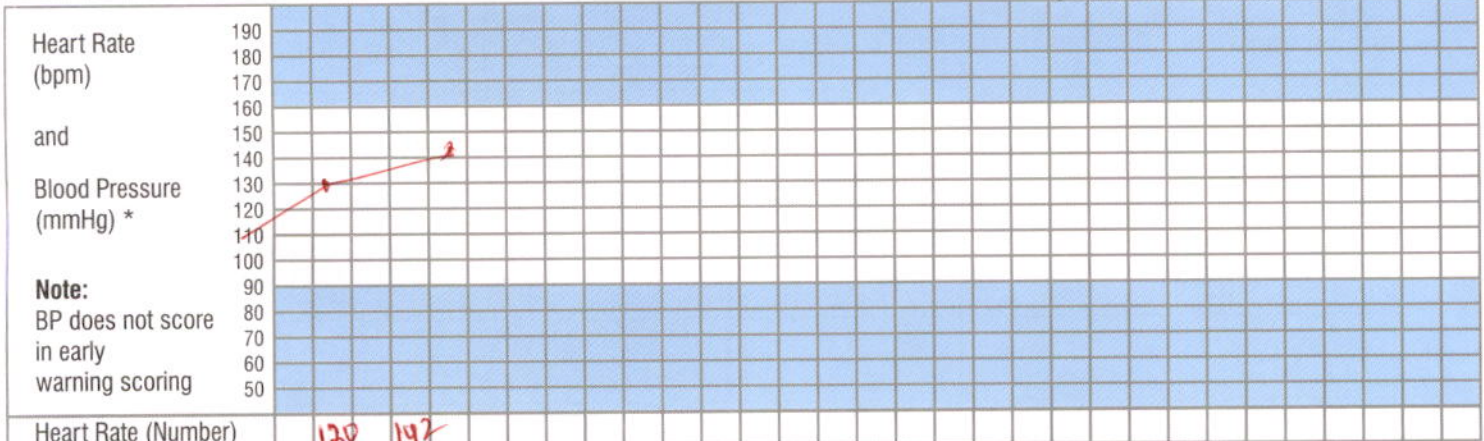
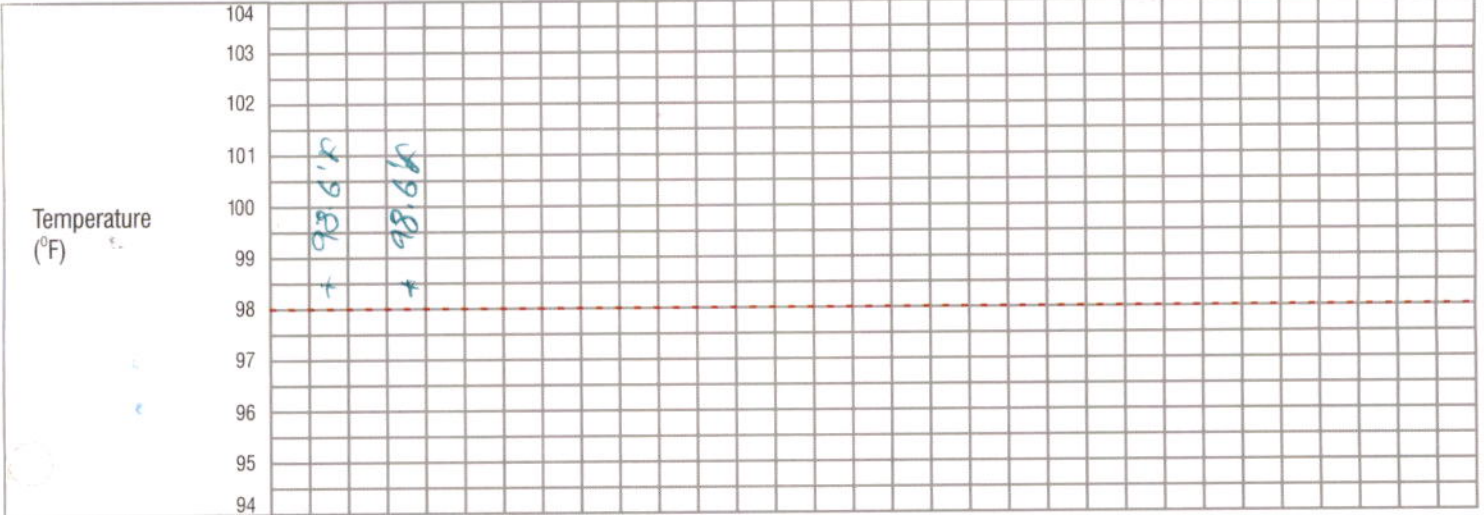
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



LY WARNING SCORE: CHILDREN'S UNIT

Date: 11/6/26 Time: 9:11

Doctor/Nurse/Family Concern? AN AN



| | |
|----------------------------------|--|
| Resp. Rate (bpm) over 1 Minute * | |
| Resp Rate (Number) | |

| | | |
|----------------------------------|-------------|-------|
| Resp Distress | Mod/ Severe | |
| | None / Mild | |
| Receiving O ₂ (l/min) | | |
| O ₂ Saturations (%) | 99 | 100 |
| Conscious Level | Normal | N |
| | Altered | N |
| GCS * | | 15 15 |

| | |
|------------------------|-----|
| TOTAL SCORE | |
| Number of shaded boxes | 0 0 |
| Pain Score | 0 0 |
| Observer's Initials | B B |

*Noted by
 Beemaika
 11/6/26
 @ 12pm*

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

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

CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

INSTRUCTIONS:

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

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

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

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

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

VIH-00205779 IP-00060294
 Baby B/O NABIHA NAZEER
 10-06-2026 0 Y 0 M 0 D 4 H (M)
 Dr. KODICHERLA VISHNU VARDHAN

FLUID CHART

Sheet No. : 1

10/6/26

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

| Date | Time | Intake | | | Output | | | | | IV Site Thrombophlebitis Score | Sign. Nurse | |
|-----------------------------|----------|-----------------|-------|-----|-----------------------|-----------|-------|----------|-------|--------------------------------|-------------|---|
| | | Nature of Fluid | Route | | NG | Diarrhoea | Vomit | Drainage | Urine | | | |
| | | | Mouth | I.V | N.G | | | | | | | |
| 10/6/26 | 08:00 am | DBF | | | | | | | | | | 10/6/26 12pm Beonika 02pm |
| | 09:00 am | | | | | | | | | | | |
| | 10:00 am | DBF | | | | | | | | | | |
| | 11:00 am | | | | | | | | | | | |
| | 12:00 pm | | | | | | | | ✓ | | | |
| | 01:00 pm | | DBM | | | | | | | | | |
| Total Intake : | | | | | Total Output : | | | | | | | |
| 10/6 | 02:00 pm | | | | | | | | | | | 10/6 03pm Manasa 10/6 07pm |
| | 03:00 pm | DBM | | | | | | | | | | |
| | 04:00 pm | | | | | | | | ✓ | | | |
| | 05:00 pm | DBM | | | | | | | | | | |
| | 06:00 pm | | | | | | | | | | | |
| | 07:00 pm | | DBM | | | | | | | | | |
| Total Intake : | | | | | Total Output : | | | | | | | |
| 10/6 | 08:00 pm | | | | | | | | | | | 10/6 09pm Subhan 10/6 @12AM |
| | 09:00 pm | DBM | | | | | | | | | | |
| | 10:00 pm | | | | | | | | | | | |
| | 11:00 pm | DBM | | | | | | | ✓ | | | |
| | 12:00 am | | | | | | | | | | | |
| | 01:00 am | | DBM | | | | | | | | | |
| Total Intake : | | | | | Total Output : | | | | | | | |
| 11/6 | 02:00 am | | | | | | | | | | | 11/6/26 03am subhan 11/6/26 @ 7AM |
| | 03:00 am | DBM | | | | | | | | | | |
| | 04:00 am | | | | | | | | | | | |
| | 05:00 am | DBM | | | | | | | | | | |
| | 06:00 am | | | | | | | | ✓ | | | |
| | 07:00 am | | | | | | | | | | | |
| Total Intake : | | | | | Total Output : | | | | | | | |
| Total 24 hrs. Intake | | | | | | | | | | | | |
| Total 24 hrs. Output | | 4 times | | | | | | | | | | |

VIH-00205779 IP-00060294
 Baby B/O NABIHA NAZEER
 10-08-2026 Q Y O M O D S H (M)
 Dr. KODICHERLA VISHNU VARDHAN



FLUID CHART

Sheet No. : 2

11/06/26

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

| Date | Time | Nature of Fluid | Intake | | | Output | | | | | IV Site Thrombophlebitis Score | Sign. Nurse | |
|-----------------------------|----------|-----------------|--------|-----|-----|-----------------------------|-----------|-------|----------|-------|--------------------------------|-------------|--|
| | | | Mouth | I.V | N.G | NG | Diarrhoea | Vomit | Drainage | Urine | | | |
| | 08:00 am | | | | | | | | | | | | |
| | 09:00 am | DBM | | | | | ✓ | | | ✓ | | | <i>Benonika</i> <i>11/6</i> <i>@12pm</i> |
| | 10:00 am | | | | | | | | | | | | |
| | 11:00 am | DBM | | | | | | | | | | | |
| | 12:00 pm | | | | | | | | | | | | |
| | 01:00 pm | DBM | | | | | | | | | | | |
| 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-00205779 IP-00060294
 Baby B/O NABIHA NAZEER
 10-06-2026 0 Y 0 M 0 D 5 H (M)
 Dr. KODICHERLA VISHNU VARDHAN



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 | | | | | IV Site Thrombo-phlebitis Score | Sign. Nurse | |
|-----------------------------|----------|-----------------|-------|-----|-----|-----------------------------|-------|----------|-------|--|---------------------------------|-------------|--|
| Date | Time | Nature of Fluid | Route | | NG | Diarrhoea | Vomit | Drainage | Urine | | | | |
| | | | Mouth | I.V | N.G | | | | | | | | |
| | 08:00 am | | | | | | | | | | | | |
| | 09:00 am | | | | | | | | | | | | |
| | 10:00 am | | | | | | | | | | | | |
| | 11:00 am | | | | | | | | | | | | |
| | 12:00 pm | | | | | | | | | | | | |
| | 01:00 pm | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| | 02:00 pm | | | | | | | | | | | | |
| | 03:00 pm | | | | | | | | | | | | |
| | 04:00 pm | | | | | | | | | | | | |
| | 05:00 pm | | | | | | | | | | | | |
| | 06:00 pm | | | | | | | | | | | | |
| | 07:00 pm | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| | 08:00 pm | | | | | | | | | | | | |
| | 09:00 pm | | | | | | | | | | | | |
| | 10:00 pm | | | | | | | | | | | | |
| | 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-00205779 IP-00060294
Baby B/O NABIHA NAZEER
10-06-2026 0 Y 0 M 0 D 4 H (M)
Dr. KODICHERLA VISHNU VARDHAN



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 | | | | | |

