

ACTIVITY RE

VIH-00205203 IP-00060277
Baby B/O K SUPRIYA TWIN-1
22-05-2026 0 Y 0 M 17 D (M)
Dr. SURENDER RAO DUSA

Name: -----



UHID No : -----

----- Consultant : ----- Dept : pediatrics

Date of Admission : 8/6/26 Time : ----- Date of Discharge : ----- Time: -----

Room / Bed No : ----- Ward : NICU Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>8/6/26</u>	<u>2:55 PM</u>	<u>ER</u>	<u>NICU</u>	<u>[Signature]</u>

Cross Consultation Visit

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



Patient Name : _____

VIH-00205203 IP-00060277
 Baby B/O K SUPRIYA TWIN-1
 22-05-2026 0 Y 0 M 17 D (M)
 Dr. SURENDER RAO DUSA

Registration No.: -



RBS

NEBULISATION CHART

Date	Time	Drug	Nurse	Parents Signature
8/6/26	00.00	9pm RBS - 72mg/dl	[Signature]	26019772 ✓
9/6/26	1.00	6am RBS - 90 mg/dl	[Signature]	26019773 ✓
20/6/26	2.00	6am RBS - 98mg/dl	Deepa	26019851 ✓
	3.00	6am RBS - 98mg/dl	[Signature]	26019851 ✓
11/6	4.00	RBS - 96 mg/dl.	[Signature]	26019851 ✓
	5.00			
	6.00			
	7.00			
	8.00			
	9.00			
	10.00			
	11.00			
	12.00			
	13.00			
	14.00			
	15.00			
	16.00			
	17.00			
	18.00			
	19.00			
	20.00			
	21.00			
	22.00			
	23.00			

Name	Baby B/O K SUPRIYA TWIN-2	UHID	VIH-00205204
Father/Guardian	Mr SAI LAXMANAND	Age/Gender	0 Y 0 M 19 D/Female
Address	1-30-319/1/1, PLOT NO 2, TELECOM COLONY, TIRUMULGIRI, SEC-BAD, Trimulgherry, Hyderabad, Telangana, INDIA, 500015		
IP No	IP-00060278	Admission Date	08-06-2026
Ref Doctor	VAMSHI KRISHNA	Discharge Date	

SHIFTING
DISCHARGE SUMMARY

Consultant:

Dr. SURENDER RAO DUSA

MD (Pediatrics), Fellowship in Neonatology
SENIOR CONSULTANT PEDIATRICS

Diagnosis:

**Very preterm (31+5 weeks) / AGA / Baby Girl/DCDA Twin -2
Suspected Sepsis**

Chronological age: 19 days

PMA: 34+1 weeks

History : Baby of K. SUPRIYA TWIN-2 is a very preterm (31+5 weeks) / SGA / baby girl of birth weight 1.66 kgs, born to primi mother delivered by Emergency Lower Segment Cesarean Section (Indication: DCDA twins with preterm labour) on 22.05.2026 at 01:41:36 sec pm. Baby cried immediately after birth. Apgar scores were 8 & 9 at 1 & 5 minutes respectively. CPAP and admitted in NICU for prematurity, Low birth weight and preterm care. Baby got discharged on day 15 of life. On day 16 of life baby had 3 episodes of fever spikes, 5 episodes of loose stools and lethargy for which baby was brought to emergency room and baby was examined and admitted to NICU, Rainbow Children's Hospital, Karkhana, for further management.

Name	Baby B/O K SUPRIYA TWIN-2	UHID	VIH-00205204
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Maternal History : Mrs. K SUPRIYA is a 34 years old primi mother with marital life of 8 years. Non consanguineous marriage. Mother's blood group is "A" Positive. Expected delivery date: 18.07.2026.

G1 : Present pregnancy, IVF conception.

History of hypothyroidism present on Tablet Thyroxine 25 mcg

History of cervical cerclage present.

She had regular antenatal checkups and antenatal scans were normal. There was no history of Urinary tract infection / Abortions / Hydramnios / Premature Rupture of Membranes/ diabetes / Hypertension / Cardiac / Renal abnormalities. She received calcium, iron supplementation and TT prophylaxis.

On examination: At the time of admission baby was febrile (101.5°F), baby and maintaining saturations at room air. Her heart rate was 178/min, respiratory rate was 50/min. On auscultation of chest, air entry was bilaterally equal with normal heart sounds. Abdomen was soft without organomegaly. Baby had decreased activity. There were no obvious external congenital anomalies.

Weight on Admission : 1.68 kgs

Weight on Discharge : ___ kgs

Head circumference : ___ cms

Length : ___ cms

Baby blood group : "A" Positive (Blood group to be repeated after 4 months).

Investigations: Enclosed.

Management: Suspected sepsis: Baby was nursed in thermoneutral environment. She was screened for sepsis and was started on intravenous fluids, intravenous antibiotics after sending blood culture. Her complete hemogram showed hemoglobin 13.9 gm%, white blood cells count 17,360

Name	Baby B/O K SUPRIYA TWIN-2	UHID	VIH-00205204
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cells/cumm, platelet count 3.96 lakhs/cumm. C. Reactive protein 9.0 mg/L. Serum electrolytes showed serum sodium - 135 mmol/L, serum potassium - 6.2 mmol/L, serum chloride - 104 mmol/L, serum calcium 10.9 mg/dl, blood urea 50.6 mg/dl, serum creatinine 0.5 mg/dl. Last hemogram done on 10.06.2026 showed hemoglobin 12.9 gm%, white blood cells count 10,200 cells/cumm, platelet count 3.58 lakhs/cumm, C. Reactive protein 2.0 mg/L. Blood culture sent at the time of admission was sterile. Baby had no episode of fever spike in the course of admission. IV antibiotics stopped after 72 hours.

Feeding : She was started on oral feeds were started on day- 1 of admission, which she accepted and tolerated well. At present, baby is on demand oral feeds, which she is accepting and tolerating well.

At the time of discharge: Baby was active, hemodynamically stable and maintaining saturations at room air, accepting feeds well.

Advice :

1. Warmth care.
2. Continue demand oral feeding.
3. Encourage breast feeding.
4. Immunization as per schedule.
5. Vitamin D3 drops (1ml=800IU), 0.5 ml once daily till one year of age.
6. Syp. Ossopan-D 1.5ml thrice daily till further advice.
7. Zincovit drops 0.5ml once daily till further advice.
8. Kindly consult Dr. Surender Rao Dusa, Consultant Pediatrician & Neonatologist, on _____ in OPD with prior appointment (This consultation will be charged).

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

ERROR LOG

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

ICD CODE :-

OBSERVATION: -

DATE :

MRD EXECUTIVE

Rainbow
Children's
Hospital



Check List for ICU Shift. Juts

CASH / TPA

VIH-00205203 IP-00060277
Baby B/O K SUPRIYA TWIN-1
22-05-2026 0 Y 0 M 18 D (M)
Dr. SURENDER RAO DUSA



Special remarks

13

S.No	Parameters	Responsibility	Signature
1	Due clearance from IP Billing & Financial Counselling for the accomodation to be shifted	BILLING STAFF	
2	Room Ready to Occupy - Checking done for A/C , Lighting , Plumbing, Cleaning & Bedsheets	FLOOR COORDINATOR / MOD	
3	Shift summary is prepared or not Whether any Pharmacy Consumables are to be Replaced /Returns / Indent required Pharmacy Clearance	NURSING STAFF	Bhadra.

ADMISSION SHEET



Registration Details :

Admission No : IP-00060277 Admit Date : 08-Jun-2026 Admit Time : 07:08 PM UHID : VIH-00205203

Patient Details :

Patient Name	: Baby B/O K SUPRIYA TWIN-1	Age	: 0 Y 0 M 17 D
Guardian	: Mr SAI LAXMANAND	DOB	: 22-05-2026 01:41 PM
Gender	: Male	Religion	:
Occupation	:	Martial Status	:
Address (H)	: 1-30-319/1/1, PLOT NO 2, TELECOM COLONY, TIRUMULGIRI, SEC-BAD Trimulgherry Hyderabad Telangana INDIA 500015	Phone No	: 9966267728
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD Bed No : ER 101 Ward Name : N 0 GF-EMERGENCY
Room No : ER 101 Admission Type : First Visit

Contact Details :

Name : Mr SAI LAXMANAND Relationship : Father
Contact Address : 1-30-319/1/1, PLOT NO 2, TELECOM COLONY,TIRUMULGIRI, SEC-BAD Trimulgherry Hyderabad Telangana INDIA 500015 Phone No : 9966267728 / 8142766614

[Handwritten Signature]
Signature

Doctor Details :

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

Payment Details :

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

Patient Name : B/O. K SUPRIYA TWIN-1 UHID : VIH-00205203 IPD : IP-00060277 Gender : Male Age : 0 Y 0 M 17

VIH-00205203 IP-00060277
 Baby B/O K SUPRIYA TWIN-1
 22-05-2026 0 Y 0 M 17 D (M)
 Dr. SURENDER RAO DUSA



WT : 1.94 Kg

EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/o Supriya Age : 18 D Gender : Male Female
 Date : 8/6/26 Time of Arrival : 6:25 PM

Allergies : No Yes Food Medications Blood Transfusion Other (Specify): _____ Not known

Source of Information : Parents Others (Specify) _____

Mode of Arrival : Ambulatory Wheelchair Ambulance

Initial Vital Signs: Temp: 99.7°F PR: 162b/m BP: crying RR: 36b/m SpO₂: 92%

Chief Complaints: C/O Fever x Today

INITIAL PHYSIOLOGICAL CATEGORIZATION Appearance <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sick Looking Circulation / Colour <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Bleeding		Work of Breathing <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Gasping / Apnea		INITIAL PHYSIOLOGICAL STATUS <input checked="" type="checkbox"/> Stable <input type="checkbox"/> Unstable : <input type="checkbox"/> Not - Life - Threatening <input type="checkbox"/> Life - Threatening	
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Triage Classification	CTAS
<input type="checkbox"/> Level 1: Resuscitation	<input type="checkbox"/> Immediate
<input type="checkbox"/> Level 2: EMERGENT: Life or limb threatening	<input type="checkbox"/> < 15 min
<input type="checkbox"/> Level 3: URGENT: Significant illness / injury with potential to become life or limb threatening	<input type="checkbox"/> 30 min
<input type="checkbox"/> Level 4: LESS URGENT: Significant illness but not life threatening	<input checked="" type="checkbox"/> 60 min
<input type="checkbox"/> Level 5: NON - URGENT: May receive care when convenient	<input type="checkbox"/> > 20 min

NOTE: All immunocompromised children and preterm babies to be considered Level 2.
 All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

[Signature]
 Signature of Parent / Guardian
 Triage Completion Time : 6:28 PM

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

- Have you had fever (elevated temperature) in the past 2 weeks Yes No
- Have you had cough or a rash in the past 2 weeks Yes No
- Have you had shortness of breath or difficulty breathing in the past 2 weeks Yes No

PART B. For patients reporting fever and respiratory/rash symptoms: Not applicable

- Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? Yes No
 If yes, State Location: _____
- Are your parents / close contacts at home is/a healthcare worker? (please encircle the choices) (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? Yes No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

- Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough
- Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

- Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.
- The patient should be given a surgical mask immediately, if not already wearing one.
- Both patient and triage staff should perform hand hygiene.
- The staff should use PPE (as appropriate).

Name of Triage Nurse : Aschitha
 Date & Time : 8/6/26 @ 6:28 PM

[Signature]
 Signature of Triage Nurse : _____

Patient Name : B/O. K SUPRIYA TWIN-1 UHID : VIH-00205203 IPD : IP-00060277 Gender : Male Age : 0 Y 0 M 17

VIH-00205203 IP-00060277
Baby B/O K SUPRIYA TWIN-1
22-05-2026 0 Y 0 M 17 D (M)
Dr. SURENDER RAO DUSA



NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 8/6/26 Time of arrival : 6:30 PM

Chief Complaints : CLU Fever x Today RBS : ---

Height : --- Weight : 1.94 kg BMI : --- Head Circumference (<2 years) : ---

Allergies: Yes No Medications Blood Transfusion Food Other: ---

If yes, identify ---

Pain Screening: Yes No If Yes, Pain Score: 0 Pain Tool Used: N Pass FLACC Wong Baker

Character --- Location --- Frequency --- Duration ---

RISK FOR FALL:

- If patient is < 6 years
tick below fall risk intervention directly
- If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months Yes No

Ambulatory Aids:

- Wheelchair Yes No
- Uses furniture for support Yes No

Gait/Transferring:

- Bedrest / immobile Yes No
- Weak Yes No
- Impaired Yes No

Mental Status: Forgets limitations Yes No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

- Escort while ambulating
- Assist Patient
- Educate patient and family on fall precautions/prevention

Functional Screening: No Abnormalities Detected

- Mobility Problem
- Walking Problem
- Developmental Delay
- Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

Nutritional Screening: No Abnormalities Detected

- Underweight
- Overweight
- Feeding Problem
- Special diet
- Special feeding method

Inform consultant for positive criteria

Psychological Screening: No Significant Findings

Unusual concerns about patient's Psychological Status: Yes No

If Yes Consultant Notified: --- (Date/Time): ---

Social History: Lives With Family

Siblings in household Yes No (if yes How Many?) 1

Time of Initial assessment completed by ER Nurse : 6:33 PM

Patient Name : B/O. K SUPRIYA TWIN-1 UHID : VIH-00205203 IPD : IP-00060277 Gender : Male Age : 0 Y 0 M 17

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
6:25pm	* patient came to ER
6:27pm	* vitals checked and Recorded
6:50pm	* Dr. Seen the patient & advised admission
	* Admission process done
7:55pm	* patient shifted to NICU

Samples collected by: _____

Time: _____

Samples sent by : _____

Time: _____

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1
Nil					

Condition of patient at time of shift - out :	Details of Shift - out
HR: 160 b/m BP: crying CFT: 2 sec	Shift - out from ER to: NICU
RR: 36 b/m SPO ₂ : 97%	Time of Shift - out: 8/6/26 @ 7:55pm
GCS: 15 Temperature: 99.7°F	Handover given to: SA.
Pain Score: 0	(Nurse's Name)
Repeat RBS (if applicable): -	

Tick as applicable: MLC LAMA BROUGHT DEAD

Procedures done with details (if any):

Name of the Nurse : Anuitha

Signature of the Nurse : AS

Date & Time : 8/6/26 @ 7:55pm



NURSING INITIAL ASSESSMENT FOR NICU

Date of Admission: 8/6/26

Source of Admission: OPD Ward Labor Ward Other: ER

Reason for Admission: S:

Admission Diagnosis: Suspected sepsis

Accompanied By: Parent Guardian Other Name:

Primary Language: Telugu English Hindi Other Specify

Do you require an interpreter? Yes No

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Source of Information: Family Others, Specify

Past Medical History	Past Surgical History	Last Hospital Admission
<u>Nil</u>	<u>Nil</u>	<u>Nil</u>

Significant History	Family History: <u>Nil</u>
----------------------------	----------------------------

Has the child or close family member had recent contact with a communicable disease? Yes No

If yes please list,

Was the child's birth normal? Yes No If No, please describe problems:

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

Current Medications	Taking Medications? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, Fill the reconciliation form Medicine brought to the hospital? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
----------------------------	--

Observations:

Birth Weight: kgs Head Circumference: cm Length: cm

Term Pre-Term Post-Term

Blood Group: Mother: Baby:

Feeding: Breast Feeding Formula Both

Maternal Details: Age: years, **PARA:** **Gestation:** 31 Weeks, 5 Days

Risk Factors: PROM Fetal Distress Diabetes Mellitus / Gestational Diabetes

PH / Pre Eclampsia Others, Specify:

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

Indication:



Temp: 36.5c HR 151b/Min RR 42/Min BP 61/34(49) SpO2 97%

Pain Score 0 (Follow N Pass and Document)

Fall Risk Intervention Done: Yes

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

General Appearance: Posture Well-Fixed Asymmetry

Behavioural Status on Admission:

Sleeping Crying Calm Drowsy

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

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

Developmental Delay Musculoskeletal Congenital Abnormality No Abnormalities Detected

Inform Consultant for Positive Criteria

Nutritional Screening:

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

Inform Consultant for Positive Criteria

Social History: Lives With

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

All Information Obtained From Patient Mother Father Other Family Member

Orientation has been given regarding the following aspects:

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

Orientation given to: Family Others

Name of Person Orientation was given to: Supriya

Orientation not given Reason:

DISCHARGE PLAN

Source of Information: Family Friend

Will patient require transportation arrangements to go home: Yes No

Will Physiotherapy require at home: Yes No

Is home medical equipment anticipated: Yes No

Is home oxygen therapy anticipated: Yes No

Breastfeeding Yes No

Formula Feed Yes No

Are dressing needs at home anticipated: Yes No

Any other needs anticipated: Yes No If Yes Specify



Yes No

Details:

Final Diagnosis: *Suspected sepsis*
.....
.....

Nurse Signature: *[Signature]*

Nurse Name: *Sandhya*

Date & Time: *2/6/26 9pm*

Discharge Details: (To be completed by discharging Nurse)

Neonatal Condition at Discharge:

.....
.....

Feeding: Breastfeeding Exclusively Breastfeeding and Formula Feeding Formula Feeding

Vitamin K given: Yes No

Vaccinations given BCG Hepatitis B Others:

Neonatal Screen Taken: Yes No, parents advised to have Neonatal Screen at National screening

program center on:/...../.....

Hearing Test: Yes No

Jaundice: NIL Slight Moderate

Passed Urine: Yes No

Passed Meconium: Yes No

Weight at discharge:

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

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

Discharge to Home Other:

Against Medical Advice: Yes No

Referred to another hospital: Yes No


Nurse Signature:

Nurse Name:

Date & Time:

PATIENT TRANSFER FORM



Patient Name & UHID No. VIH-00205203 IP-00060277 Baby B/O K SUPRIYA TWIN-1 22-05-2026 0 Y 0 M 17 D (M) Dr. SURENDER RAO DJSA 		Date & Time of Admission 8/6/26 @ 9:08 PM	Date & Time of Transfer Order 8/6/26 @ 7:55 PM
		Transfer Ordered by Dr. Shrikrishna	Reason for Transfer Admission
From Unit ER	To Unit NICU	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 25	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input 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 No

Name & Signature of Person who is Transferring Samuel / Jan	Name of Person Ordered Transfer Dr. Shrikrishna
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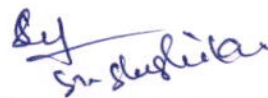
Patient & Clinical Records Received by : *Dr. Sandeep*
8/6/26

Date & Time of Patient Received : *8/6/26*

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

PATIENT TRANSFER FORM

Patient Name & UHID No. VIH-00205203 IP-00060277 Baby B/O K SUPRIYA TWIN-1 22-05-2026 0 Y 0 M 18 D (M) Dr. SURENDER RAO DUSA 		Date & Time of Admission 8/6/26 7pm	Date & Time of Transfer Order 10/6/26 9.55 pm
		Transfer Ordered by Dr. Surender Rao	Reason for Transfer Stable.
From Unit NICU - II	To Unit 1st floor II	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 30	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	D.W 10ml	1 BOX	
2.	Oipexs	4	
3.	Baby wipeg	2	
4.	piptax	4	
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring By 		Name of Person Ordered Transfer Dr. Hanshu	
Patient & Clinical Records Received by : Manasa			
Date & Time of Patient Received : 2pm 10/6/26			

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



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Supriya Age : 34yrs Father's Name : Age :
 Date of Birth : Date of Admission : UHID No. :
 NICU Consultant : Dr. Surender Rao Referring Consultant :
Transferring Unit : OT Labour Room ER Ward
Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : B.O. Supriya T-I Mother's Blood Group : A+ve
 Gender : M F Blood Group : Birth Weight (gms) : 1.77kg Length (cms) :
 Date of Birth : 22/5/26 Time of Birth : 1:41:16 PM OFC (cms) :
 Place of Birth : V-REH Estimated Gesth Age : 31+5w0

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 34yrs Ht : 160cm Wt : 60kg BMI : Married Life : 8yrs LMP : EDD : 18/7/26
 Conception : Spontaneous or with Rx : IVF
 Booked at what GA : since conception AN Steroids Drugs / Doses : NO
 Last Scans Details : (2)
 TT Immunization and Iron / Folic Acid : YES

MATERNAL RISK FACTORS

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 : <u>NO</u> Doppler (Increased Resistance / 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 : <u>NO</u> Scans : LGA, TIFFA , Fetal Echo : H/o Hypothyroidism : when diagnosed ? Medication? <u>YES, 705 thyroxine - 25mcg</u> Any other Chronic Medical Problems, when detected drugs ? <u>NO</u> (Anemia, SLE, Jaundice, CHD, Heart Disease) Infection : H/O, Fever (<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 : <u>NO</u> Any culture : <u>NO</u>
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PPROM : Duration : NO Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results : NO
 Medication during Pregnancy : Duration :



PAST OBSTETRIC HISTORY

G: P: A: L:

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
	primi					

PERINATAL HISTORY

Treating Obstetrician : Hospital : Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig)</p> <p>Second stage (> 2 hours after dilation)</p> <p>LSCS : <input type="checkbox"/> Elective <input checked="" type="checkbox"/> Emergency Indication :</p> <p>Specify the reason : <u>Protective labour CDCA twin</u></p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL : <u>NO</u></p> <p>Resuscitation : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Cord ABG : <u>-</u></p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc : <u>2</u>)</p>
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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	<u>8/10</u>	<u>9/10</u>	

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)		
Birth Weight	> = 1kg (0)	750 - 999 (10)	< 750 (17)	
SGA	> 3rd percentile (0)	< 3rd (12)		

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

CTAB



History of Present Illness:

Baby was delivered in RCH, VIKP I/V/O - Preterm labour -
shifted to NICU, VU/O - PFA/PDS.

↓

Managed for 10 days shifted to room

& discharged on 20-1-16

↓

PE come 2 clo PCR
(2 CT's w/dst)
LC large

Investigation details in previous Hospital :

↓
shifted to NICU I/V/O sept

Feeding History :

Past History :

Family History :

Socio Economic History :



GENERAL EXAMINATION ON ADMISSION

General Disposition :

[Faint handwritten notes in this section]

VITALS : Temperature : 99.7 F HR : 160/min RR : 48/min NIBP : 90/60 CFT : 23mm
 Color of the extremities : pink
 Jaundice : - Pallor : - SpO2 : 96% PD

Anthropometry : Birth Weight : 1.78 kg Length : 48 cm HC : 34 cm Present Weight : 7.86 kg
 Ponderal Index : 13.2 AGA : ✓ SGA : - LGA : -

HEAD TO TOE EXAMINATION

HEAD : Fontanelles : 1/0
 Sutures : 1/0
 Shape / Moulding : 1/0
 Edema / Bruising : 1/0
 Size - (H.C.) : 1/0

Facies : (Any Facial Dysmorphism) : 1/0

NECK and CLAVICLES : Range of Motion : 1/0
 Asymmetry : 1/0
 Masses : 1/0

EYES : Symmetry : 1/0
 Red Reflex : 1/0
 Discharge : 1/0

EARS, NOSE MOUTH and THROAT : Ear set / Shape : 1/0
 Periauricular Pits / Tags : 1/0
 Nasal shape / Patency : 1/0
 Palate : 1/0
 Gums : 1/0
 Lips : 1/0
 Tongue : 1/0



THORAX and BREASTS :	Shape of Thorax : Position of Nipples and Number :	
ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : Discharge :	Ⓟ
GENITILIA :	Labia / Hymen : Testicles/penis : Anus :	
HERNIAL ORIFICES		
TRUNK and SPINE :		
SKIN LESIONS :		
EXTREMITIES :	Fingers / Toes : Deformities : Hip Joint Examination :	Arms / Legs : Mobility : Ⓟ

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

Mention If baby has Respiratory distress : RR : 48/m 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 : 96% RA Auscultation : RA80 Breath Sounds : clear Added Sounds : _____

Cardiovascular System :

HR : 160/m BP : _____ Precordial Activity : _____

Femoral Pulses : _____ Murmurs : _____

Other Peripheral Pulses : well felt Signs of Cardiac Failure : _____

Abdomen :	Hernia orifice : _____
Shape : _____	Anal Patency : _____
Palpation : _____	Umbilical Cord : <u>Ⓟ falls</u>
Palpable masses : _____	First urine passed : _____
Abdominal girth : _____	Meconium passed : <u>per rect</u>



Nervous System : Higher intellectual functions (Sensorium) :
State of wakefulness :
Prechtle Score :

Nerves : *T1/T1A - ANA*

Motor System :
Passive Tone :
Active Tone : *(N)*
Neonatal Reflexes :
Grasp : Palmar Plantar Sucking Rooting Crossed adductor :
Moro's : *R/L Symmetrical Asym* DTR :
ATNR : Skull and Spine :

Any Congenital Anomalies : *NO Visible Congenital Anomalies*

Diagnosis : *Day 17 / VPT (31 weeks) - 13 weeks pMA (1.77 kg / ANA / male / 454)
CIPA / suspected temp*

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :
Signature : *[Signature]*
Name : *D Vishal*
Date & Time : *8/6/26*

Consultant :
Signature :
Name :
Date & Time :



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:

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....



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: *IV - 150ml / 15/day.*

Final Diagnosis: *NI - 150 P.*

..... *Plan to start feeds after report*

..... *NI-2, Blood co.*

..... *CXR, ABG J05.*

..... *w/ fever spikes, 1/8 shock*

..... *monitored vitals.*

*Noted by
Dr. Semalhy*

Doctor Signature:


Doctor Name:

Date & Time:



①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26 9AM	Day 17 / VPS (31.75 wks) → 34 to wk PMA / B.Wt - 1.77kg / Aars 2 Aars - 1.86kg / Baby boy / Suspected sepsis.	
	Issues - Met-	
	T-WR - 1.88 (170gms)	NOMOTHERMIL -
	S/O - 154/75	CNS - G.S. ⊕
	U/O - 3.5ml / 15 / day hrs.	CNS - T/M/RANA
	S/O - NP	PT - BAB ⊕
	UPRS - 90mg/dl.	PA - G.P.H. B.S. ⊕
	<u>Plan</u>	
	Target SpO ₂ >90%	
	Target MAP >34.	
	Oral demand feeds.	CBP, CAP T/M
	TV - 150ml / K ₁ / day.	
	Trace PLWd CS.	
	⊕ Luj Piptaz.	
	w/ft fever spikes, shock.	
	Plan to send CUE.	
	monthly vitals.	
D. Vishal	Noted by Sr. Swathi 9/6/26 @ 10am	 Dr. Surender Rao 9/6/26 10:25 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6/26	Bony sun	
5pm	spike	
	blue & acute	
	Taking oral feeds well	
	Adv -	
	csp, car (r/m)	
	/	



2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/26 9AM	Dist VPT (31+5) → 34+1 wks PMA 1.77kg twin-1 5gpf suspected sepsis	
	NO fever spikes	
	wt - 1.91kg (↑ 30g)	O/A - Normothermic
	SpO ₂ - 35% / 143mmHg	on RA
	U/O - 3:1 refug for	C/T/A - Good
	SpO ₂ - 4 lines	oes - 2/3 (+)
	GRR -	R/S - NAC (+)
		P/A - 1gfr
	<u>Plan</u>	
	- Target SpO ₂ > 90%	
	- Target MAP > 39	
	- oral demand feeds	
	- trace r/c	
	- inc fluids - D ₃	
	- shift to room	
	- SpO ₂ clarity, vitals count	
	- crib care	
B nfr	<p>noted by Dr. Suresh 10/6/26 10:30am</p>	<p>Dr. Surender Rao 10/6/26 10:30AM</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Shifting notes.</u>	
10/6/26 1:15 pm	Day 18 (UP51) 1.77/37 31+5 → 34-4	min 2 Meel Suspected Sepsis
	→ Birth w/o	
	Managed for 10 days in NICU with re-premedication in NICU	
	d/c on 21st of life	
	Prz → Presented with fever and Grim Activity	
	→ Started on Empirical ABx and Symptomatic Management.	
	Plan	
	- no further fever episodes → shift to room	
	- Continue Supplements	
	- Continue ABx.	
	trace BILs report	
	Dr. Sunker	Noted by Dr. Sunker 10/6/26 @ 7 PM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/24	<u>CLIA Resident</u>	
4:00pm	Day 18 VPT (3150k - 34 + 1wk pma) 1.27kg Boy	
	duplex cysts:	
	<u>o/c</u>	
	chud Alert	
	CTA good	
	CUT 3ue	
	CU: 112 @	
	M: 131 @	
	P/A: 111	
	CNE: 111	
A. Manisha		<u>Plan</u>
		- Inf-pipt 2-03
		- Continu oral duplexer
		- Trans/di-repr
		- Mont nitels
		- Infr (111)
		Noted By
		Manisha
		10/6/26
		@ 8pm

VIH-00205203 IP-00060277
 Baby B/O K SUPRIYA TWIN-1 (M)
 22-05-2026 0 Y 0 M 18 D
 Dr. SURENDER RAO DUSA

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/26 10:00 AM	<p><u>CLIB Resident</u></p> <p>Day 14 / VPT / 3150kgs → 3420kgs pMA 1.77yr Boy</p> <p>Suspected sepsis.</p>	
	<p>No clo feces.</p> <p>Maintains saturations @ RA-99-100%</p>	
B/ck + No	<p>growth after 4 hrs.</p> <p><u>O/S</u></p> <p>chest Alert</p> <p>CTA-Good</p> <p>CATL3K</p> <p>CU: SIG ⊕</p> <p>M: B/LAC ⊕</p> <p>P/A: Holt</p> <p>CRU: NAD</p>	
	<p>noted by manojo 11/6 @ 11:50 AM</p>	<p><u>Plan</u></p> <p>- Inf. piperac-D3</p> <p>- Desferrioxamine body</p> <p>- ROP T/m</p> <p>- Continued supplement</p>
		<p>- monitor vitals</p> <p>- T/m @ 2h</p>
		<p>Dr. Surender Rao 11/6/26 11:40 AM</p>

GENERAL CONSENT FOR TREATMENT

Patient Name: Baby B/O K SUPRIYA TWIN-1 **Age :** 0 Y 0 M 17 D
IP No: IP-00060277 **Sex:** Male
Consultant: Dr. SURENDER RAO DUSA **Ward/Bed No:** N 0 GF-EMERGENCY/ER 101

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.

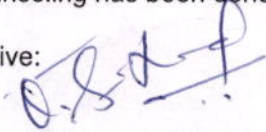
I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal 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. In case of failing the submission, I will pay 200/- Rs.
(receivers Signature:.....)
- 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:




Name: LAXMANAWD

Relationship: father

Date: 08/06/26

Wittness Name: Ramy

Wittness Signature: 

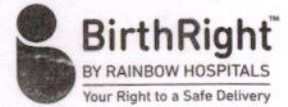
Time: 07:08 PM

Patient Address:

1-30-319/1/1, PLOT NO 2, TELECOM COLONY, TIRUMULGIRI, SEC-BAD Trimulgherry Hyderabad Telangana INDIA 500015



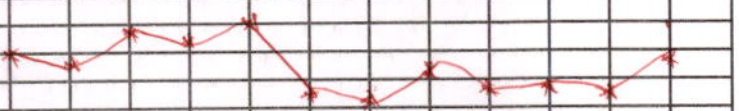
NURSES ASSESSMENT CHART



Date: 8/6/26 Diagnosis: Suspected Sepsis Weight: 1.86kg Chart No.: ①

Guide	Time	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
COLOUR CODE	200																								
	210																								
RED - PULSE	200																								
BLACK - RESP	105																								
GREEN - TEMP	104																								
BLUE - NIBP	103																								
	102																								
	101																								
A- ALERT	100																								
V-VOICE	99																								
P-PAIN	98																								
U-UNRESPONSIVE	97																								
	96																								
VERBAL	95																								
5-ORIENTED	80																								
4-CONFUSED	70																								
3-IN APPROPRIATE WORDS	60																								
2-INCOMPREHENSIBLE SOUND	50																								
1-NONE	40																								
	35																								
MOTOR	30																								
6-OBEYS	28																								
5-LOCALISES PAIN	26																								
4-WITHDRAWS	24																								
3-FLECTION	22																								
2-EXTENSION	20																								
1-NONE	18																								
	16																								
	14																								
	12																								
	10																								
O2																									
SPO2																									
RBS																									
SUCTION																									
PHYSIOTHERAPY																									
AVPU																									

160 159 178 173 179 156 147 153 149 148 146 160



98.6 98.6 98.6 98.6 98.6 98.6 98.6 98.6 98.6 98.6 98.6 98.6 98.6 98.6

74 71 80 96 66 70 66 76 65 62 90 66

↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑

(66) (58) (64) (62) (55) (62) 50 (53) (52) (46) (70) 57

↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓ ↓

(62) 53 57 58 49 54 42 40 45 40 55 52

30 33 29 30 38 39 45 55 30 31 54 44

95 98 99 98 97 99 98 99 97 96 95 98

- - - - - - - - - - - - - -

- - - - - - - - - - - - - -

S S S A A A A A A A A A

Signature of the Nurse :

Morning Shift :

Evening Shift :

Night Shift : Randy
9/6/26
8Am



NURSES ASSESSMENT CHART



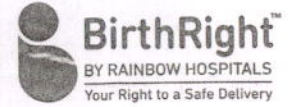
Date : 9/6/26 Diagnosis : Suspected Sepsis Weight : 1.88 (+20) Chart No. : 2

Guide	Time	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
COLOUR CODE	200																								
	210	142	159	150	145	148	143	152	149	160	141	137	163	170	159	178	148	155	148	140	141	175	139	169	153
RED - PULSE	200																								
BLACK - RESP	105																								
GREEN - TEMP	104																								
BLUE - NIBP	103																								
	102																								
	101	98.6	99.6	99.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	
A- ALERT	100																								
V-VOICE	99																								
P-PAIN	98																								
U-UNRESPONSIVE	97																								
	96																								
VERBAL	95																								
5-ORIENTED	80	35	46	52	31	29	35	35	52	24	40	20	22	28	19	23	39	50	46	33	45	64	41	28	27
4-CONFUSED	70																								
3-IN APPROPRIATE WORDS	60																								
2-INCOMPREHENSIBLE SOUND	50																								
1-NONE	40																								
	35																								
MOTOR	30																								
6-OBEYS	28	36	29	62	51	60	62	68	70	72	70	68	60	62	59	70	61	81	62	65	60	75	65	45	81
5-LOCALISES PAIN	26																								
4-WITHDRAWS	24																								
3-FLECTION	22	42	19	42	39	33	40	48	38	66	51	50	48	51	44	33	42	40	42	51	42	61	49	32	61
2-EXTENSION	20																								
1-NONE	18																								
	16	34	47	38	33	43	40	38	40	62	40	48	49	45	38	48	36	36	38	43	39	54	43	24	51
	14																								
	12																								
	10																								
O2		95	100	98	95	99	100	99	87	100	99	98	99	97	95	98	98	96	97	100	100	100	99	97	95
SPO2																									
RBS																									
SUCTION																									
PHYSIOTHERAPY																									
AVPU		A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A

Signature of the Nurse : Morning Shift : [Signature] @ 2PM Evening Shift : [Signature] @ 8PM Night Shift : [Signature] @ 8PM



NURSES ASSESSMENT CHART



I.P. NO
 Date : 10/6/26 Diagnosis : Suspected Sepsis Weight : 1.91kg Chart No. : 3

Guide	Time	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7	
COLOUR CODE	200																									
	210																									
RED - PULSE	200		138	141	139	153	165	164																		
BLACK - RESP	105																									
GREEN - TEMP	104																									
BLUE - NIBP	103																									
	102																									
	101																									
A- ALERT	100																									
V-VOICE	99		36.5	36.5	36.5	36.5	36.5	36.5																		
P-PAIN	98																									
U-UNRESPONSIVE	97																									
	96																									
VERBAL	95																									
5-ORIENTED	80																									
4-CONFUSED	70		21	32	48	41	27	47																		
3-IN APPROPRIATE WORDS	60																									
2-INCOMPREHENSIBLE SOUND	50																									
1-NONE	40																									
	35																									
MOTOR	30																									
6-OBEYS	28																									
5-LOCALISES PAIN	26		67	70	76	67		64																		
4-WITHDRAWS	24																									
3-FLECTION	22		↑	↑	↑	↑		↑																		
2-EXTENSION	20																									
1-NONE	18		47	41	54	48		42																		
	16																									
	14		↓	↓	↓	↓		↓																		
	12																									
	10		37	31	45	30		20																		
O2																										
SPO2																										
RBS			96	100	95	99	98	99																		
SUCTION			-	-	-	-	-	↑																		
PHYSIOTHERAPY			-	-	-	-	-	-																		
AVPU			A	A	A	A	A	A																		

Signature of the Nurse : Lima

Morning Shift : 10/6/26 @ 2 PM

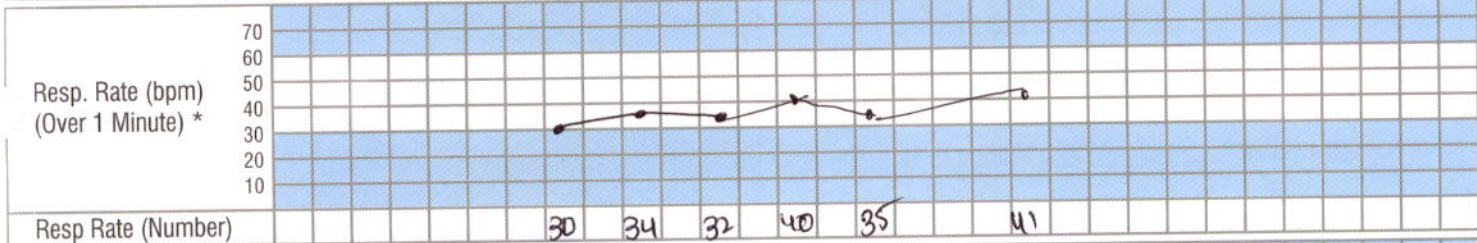
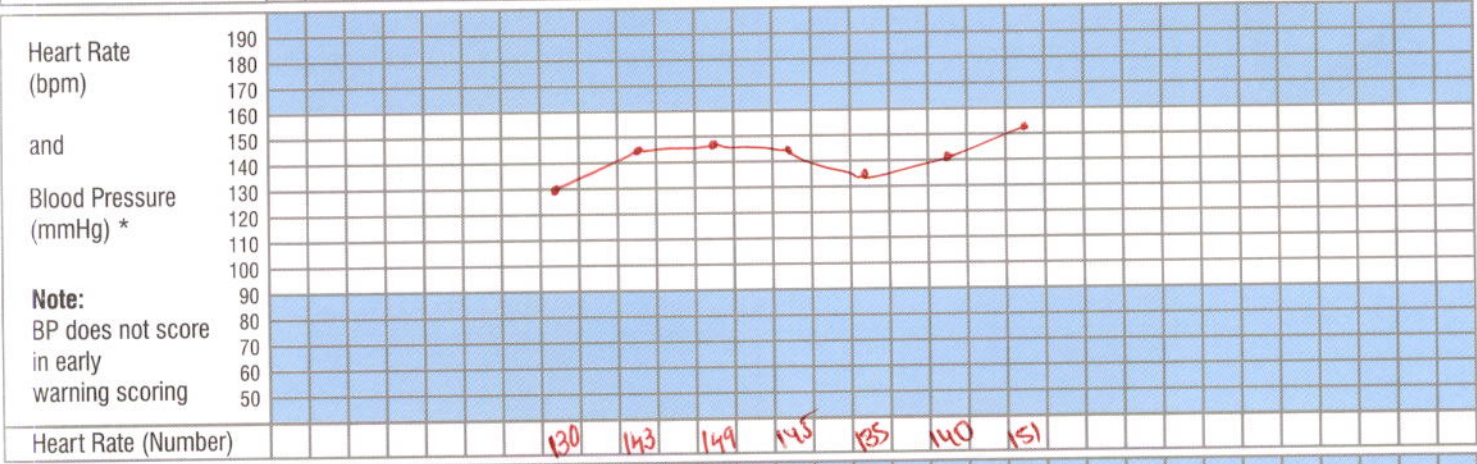
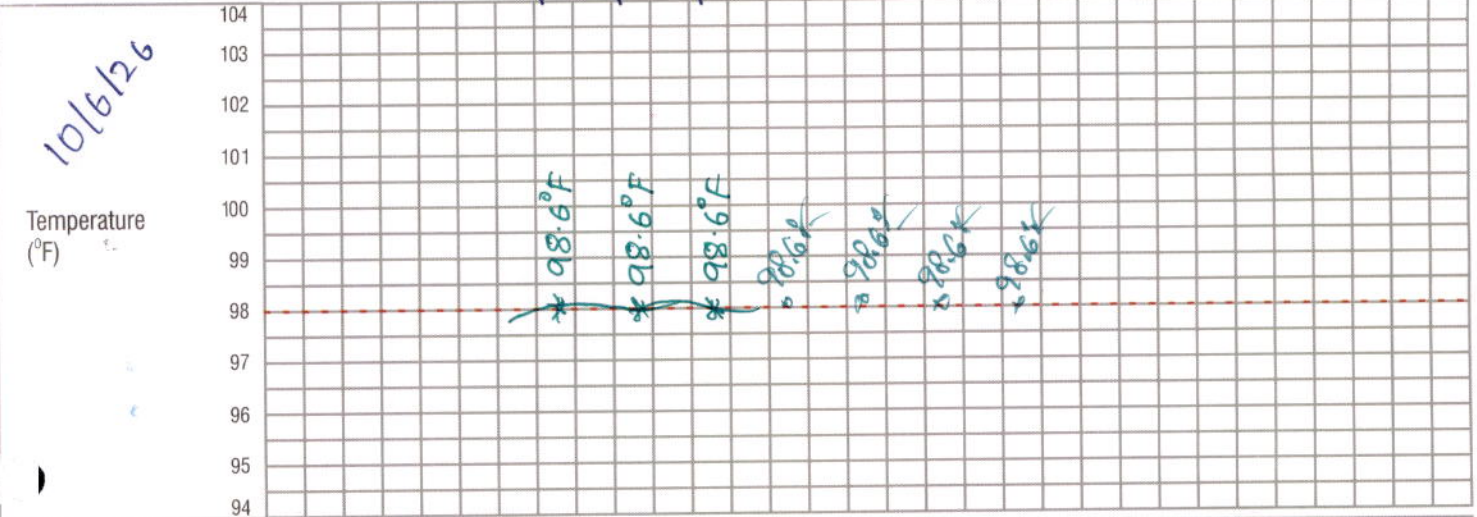
Evening Shift :

Night Shift :

EARLY WARNING SCORE: CHILDREN'S UNIT

Date: Time: 3 5 7 10 1 4 7

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



Resp Distress	Mod/ Severe None / Mild	N	N	N	N	N	N
Receiving O ₂ (l/min)	O ₂ Saturations (%)	98	98	97	96	97	99
Conscious Level	Normal Altered	N	N	N	N	N	N
GCS *		15	15	15	15	15	15
TOTAL SCORE	Number of shaded boxes	0	0	0	0	0	0
Pain Score		0	0	0	0	0	0
Observer's Initials		MM	MM	MM	SK	SK	SK

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.

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-00205203 IP-00060277
 Baby B/O K SUPRIYA TWIN-1
 22-05-2026 0 Y 0 M 19 D (M)
 Dr. SURENDER RAO DUSA

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

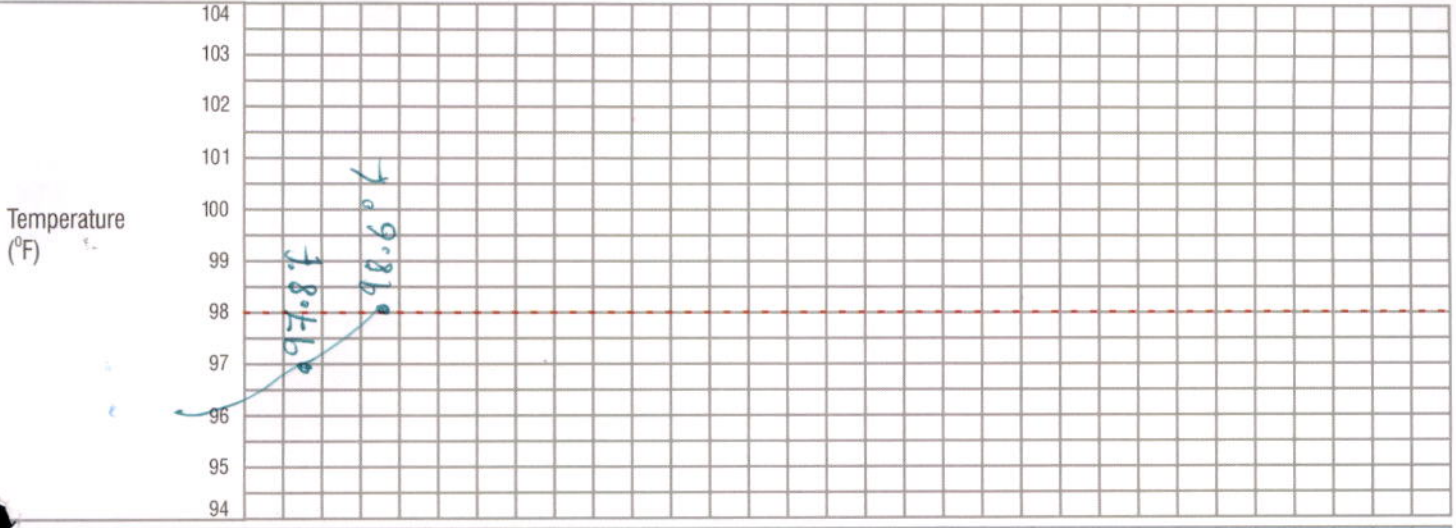
INFANT (<1 year)
Children's Observation & Early Warning Scoring Chart



EARLY WARNING SCORE: CHILDREN'S UNIT

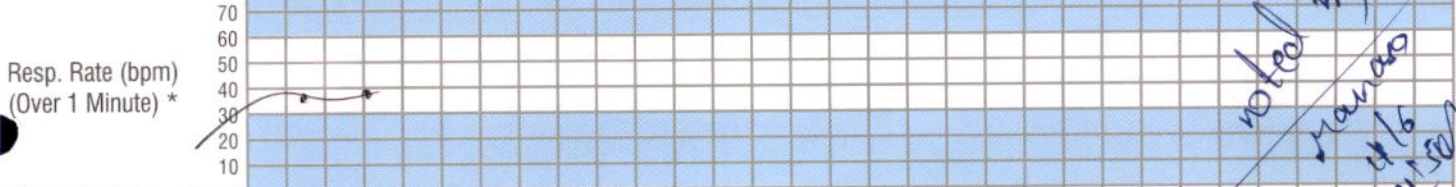
Date: 11/6 Time: 9 AM

Doctor/Nurse/Family Concern? AM AM



Note:
 BP does not score in early warning scoring

Heart Rate (Number) 135 137



Resp Rate (Number) 33 36

Resp Distress Mod/ Severe None / Mild

Receiving O₂ (l/min) 09 08
 O₂ Saturations (%)

Conscious Level Normal Altered 2 2

GCS * 15 15

TOTAL SCORE
 Number of shaded boxes 0 0

Pain Score 0 0

Observer's Initials ma mw

noted by Manasa 11/6 PM 5:00

- 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: Scores 3 should be recorded overleaf

* 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)

FLUID CHART

Sheet No. : ①

8/6/26

- 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	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	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										0		
	09:00 pm			11.6							0		
	10:00 pm			11.6					25ml		0		
	11:00 pm			11.6							0		
	12:00 am	Apptant	30ml	STOP					10ml		0		
	01:00 am										0		
Total Intake : 64.8ml						Total Output : 35ml							
	02:00 am	Apptant	30ml								0		
	03:00 am								15ml		0		
	04:00 am	Apptant	30ml								0		
	05:00 am										0		
	06:00 am	Apptant	30ml						25ml		0		
	07:00 am										0		
Total Intake : 90ml / 154.8ml						Total Output : 40ml / 75ml							
Total 24 hrs. Intake			166.4cc/kg/day			Total 24 hrs. Output			3.3cc/kg/hr				

VIH-00205203 IP-00060277
 Baby B/O K SUPRIYA TWIN-1
 22-05-2026 0 Y 0 M 17 D (M)
 Dr. SURENDER RAO DUSA



FLUID CHART

Sheet No. : 9

9/6/26

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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am	Aptamil	30ml						15ml	0		@ 2pm
	09:00 am									0		
	10:00 am	Aptamil	30ml							0		
	11:00 am								20ml	0		
	12:00 pm	Aptamil	25 ml				✓			0		
	01:00 pm									0		
Total Intake :			85 ml			Total Output :					35	
	02:00 pm	Aptamil	30ml						10ml	0		@ 8pm
	03:00 pm									0		
	04:00 pm	Aptamil	30ml							0		
	05:00 pm								25ml	0		
	06:00 pm	Aptamil	30ml				✓			0		
	07:00 pm									0		
Total Intake :			90ml			Total Output :					35	
	08:00 pm	Aptamil	28ml						75ml	0		@ 8pm
	09:00 pm									0		
	10:00 pm	Aptamil	30ml				✓		10ml	0		
	11:00 pm									0		
	12:00 am	Aptamil	30ml						13	0		
	01:00 am									0		
Total Intake :			88 ml			Total Output :					38ml	
	02:00 am	Aptamil	30ml						10ml	0		@ 8pm
	03:00 am									0		
	04:00 am	Aptamil	30ml				✓		10ml	0		
	05:00 am									0		
	06:00 am	Aptamil	30ml						15	0		
	07:00 am								05	0		
Total Intake :			90ml ⇒ 353ml			Total Output :					35 ⇒ 143ml	
Total 24 hrs. Intake			184.8 cc/kg/day			Total 24 hrs. Output			8.1 cc/kg/hl			



FLUID CHART

Sheet No. : 3

10/6/26

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	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
10/6/26	08:00 am	Aptamil 30ml								10ml	0	} @ 2PM
	09:00 am										0	
	10:00 am	Aptamil 30ml					✓			30ml	0	
	11:00 am										0	
	12:00 pm	Aptamil 30ml								30ml	0	
	01:00 pm										0	
Total Intake :						Total Output : 70ml						
10/6/26	02:00 pm	Aptamil 30ml									0	} Manisha 10/6/26 @ 3pm
	03:00 pm										0	
	04:00 pm	Aptamil 30ml							✓		0	
	05:00 pm										0	
	06:00 pm	Aptamil 30ml									0	
	07:00 pm										0	
Total Intake :						Total Output :						
10/6	08:00 pm	EBM 30ml									0	} Subha 10/6
	09:00 pm										0	
	10:00 pm	EBM 20ml					✓				0	
	11:00 pm										0	
	12:00 am	Aptamil 30ml					✓				0	
	01:00 am										0	
Total Intake : 80ml						Total Output :						
11/6	02:00 am	Aptamil 20ml									0	} Subha 11/6 @ 7AM
	03:00 am										0	
	04:00 am	EBM 30ml									0	
	05:00 am						✓				0	
	06:00 am	EBM 30ml									0	
	07:00 am										0	
Total Intake : 80ml						Total Output : 60ml						

Total 24 hrs. Intake 330ml

Total 24 hrs. Output 60ml



FLUID CHART

Sheet No. : (u)

11/6/20

- 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			
11/6			Mouth	I.V	N.G							
	08:00 am		20ml									
	09:00 am											
	10:00 am		20ml							✓		
	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							

*noted by
 MONIKA
 11/6
 01:40*

Patient Sticker

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 Thrombophlebitis 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-00205203 IP-00060277
 Baby B/O K SUPRIYA TWIN-1
 22-09-2026 0 Y 0 M 18 D (M)
 Dr. SURENDER RAO DUSA



MEDICATION RECONCILIATION FORM

Drug Allergies: all Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: NICU - 5 Shifted to: ICU Floor 113

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	ENT PIPERACILLIN + TAZOBACTAM	186mg	IV	8 th hourly	10/6 11 AM	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	ZINCovit DROPS	0.5ml	PO	once daily	10/6	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
3	SUP- OSCOPAN D	2.5ml	PO	8 th hourly	10/6	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
4	VITAMIN D DROPS	0.5ml	PO	once daily	10/6	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Shrivikar

Date & Time: 10/6/26 1:15 pm

Nurse Name & Signature: Shubika

Date & Time: 10/6/26 1:15



DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

DRUG : PARACETMOZ DROPS				Date Time															
Dose	Route	Frequency	Start Date																
0.3 mg	oral	SOS.	8/6.																
Doctor's Signature		Valid Period	Pharm.																
<i>[Signature]</i>		8/6.	<i>[Signature]</i>																
Additional Instructions:																			
10-15mg/kg/day.																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

VERIFIED BY Name



RESULT SHEET

Date	8/6/26	10/6			
Time		@8am			
Hb	15.2	15.1			
PCV	40.4	40.4			
RBC	4.36	4.37			
WBC	16.09	13.99			
N/L	34.0/49.7	22.4/59.5			
Platelets	432	409			
CRP	10	2.0			
ESR					
PCT					
RBS					
Na	134				
K	5.8				
Cl	102				
Ca/Mg	10.8				
Phosphate					
Urea	46.0				
Creatinine	0.4				
ALP					
SGPT					
SGOT					
T.Bill/Conj	5.4	<0.1	5.3		
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					

