

ADMISSION SHEET

Registration Details :



Admission No : IP22-00023341 Admit Date : 21-Jun-2026 Admit Time : 06:48 PM UHID : HCV-00040957

Patient Details :


Patient Name : Baby B/O K MADHURIMA Age : 0 D
Guardian : Mr PRADEEP DOB : 21-06-2026 05:31 PM
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : P & T Colony Vishakhapatnam Andhra Pradesh INDIA 530013 Phone No : 9676782905
E-mail : no@gmail.com

Admission Details :

Bed Type : NICU Bed No : NICU 109 Ward Name : 1F-FIRST FLOOR-NICU
Room No : NICU 109 Admission Type : First Visit

Contact Details :

Name : Mr PRADEEP Relationship : Father
Contact Address : P & T Colony Vishakhapatnam Andhra Pradesh INDIA 530013 Phone No :


Signature

Doctor Details :

Doctor Name : Dr. R HARIHARAN Specialisation : NEONATOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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

ACTIVITY RECORD FOR BILLING

Name: B/O. Madhurima

UHID No: 40957 IP No: 23341 Consultant: Dr. Madhava Dept: NICU

Date of Admission: 21/6/26 Time: 6:45PM Date of Discharge: Time:

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/6/2026	6 PM	INR - I (Baby Side)	NICU	Ueb
22/6/26	1:50PM	NICU	309 (CRIL)	Mgubens

Cross Consultation Visit

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

Cross consult by IP



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : madhusima Age : 28 yrs Father's Name : Age :
 Date of Birth : 07-04-1998 Date of Admission : I.P. No. :
 NICU Consultant : Dr. Hanitharan Referring Consultant :
 Transferring Unit : OT Labour Room ER Ward
 Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : Blo madhusima Mother's Blood Group : 'O' positive
 Gender : M F Blood Group : C Birth Weight (gms) : 2.445kg Length (cms) :
 Date of Birth : 21/6/26 Time of Birth : 05:31 PM OFC (cms) :
 Place of Birth : PCH Visay Estimated Gesth Age : 37 weeks + 6 days

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : Ht : Wt : BMI : Married Life : 10 months LMP : 02/09/25 EDD : 09/06/26
 Conception : Spontaneous or with Rx : Spontaneous Conception
 Booked at what GA : AN Steroids Drugs / Doses :
 Last Scans Details : SLEPG, Cephalic, Placenta - posterior, AFI + 8.9
EFW + 2.408 kg, Doppler @, single loop around neck TT Immunization and Iron / Folic Acid : 2 IT - Aug 2026

MATERNAL RISK FACTORS

<p>Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs</p> <p>Consanguinity : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p> <p>H/o PIH (after 20 weeks) / PE</p> <p>How many Drugs / Doses / Since how long :</p> <p>H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) :</p> <p>IUGR - when detected :</p> <p>Doppler (Increased Resistance / ADEF / RDDF / Redistribution in MCA) / Ductus Venosus :</p> <p>AFI :</p>	<p>H/o GDM/ pre GDM/ on diet or insulin</p> <p>Controlled or not, recent values, HbA1 values :</p> <p><u>H/o GDM on oral</u></p> <p>Compliance with Rx : <u>hypoglycaemia</u></p> <p>Scans : LGA, TIFFA, Fetal Echo :</p> <p>H/o Hypothyroidism : when diagnosed ? Medication?</p> <p>.....</p> <p>Any other Chronic Medical Problems, when detected drugs ?</p> <p>(Anemia, SLE, Jaundice, CHD, Heart Disease)</p> <p>Infection : H/O, Fever</p> <p>(<input type="checkbox"/> Malaria <input type="checkbox"/> UTI <input type="checkbox"/> TORCH <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> HBV)</p> <p>UTI : when : Any culture :</p>
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PPROM : Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Prom for 1st hrs Duration :

PAST OBSTETRIC HISTORY

G: primi P: A: L:

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

PERINATAL HISTORY

Treating Obstetrician : Dr. Parga Sucha Hospital : Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig) <u>Normal vaginal delivery</u></p> <p>Second stage (> 2 hours after dilation)</p> <p>LSCS : <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</p> <p>Specify the reason :</p> <p>Augmentation of Labour : <input type="checkbox"/> Induced <input type="checkbox"/> Assisted Vaginal</p>	<p>CTG : <input type="checkbox"/> Normal <input type="checkbox"/> Suspicious <input type="checkbox"/> Pathological</p> <p>MSL :</p> <p>Resuscitation : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cord ABG :</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :</p>
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NEONATAL RESUSCITATION DETAILS

APGAR SCORE

Gestational Age : Weeks :

SIGN	0	1	2
COLOUR	Blue or Pale	Acrocyanotic	Completely Pink
HEART RATE	Absent	<100 / Minute	> 100 / Minute
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	
1	2	
1	2	
1	1	
1	2	
5	8	

TOTAL

Resuscitation			
Minutes	1	5	0
Oxygen			
PPV / NCPAP			
ETT			
Chest Compressions			
Epinephrine			

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

HOP1:

Baby delivered through NVD.



Baby didn't cry immediately after birth.



early cord clamping done



Baby initial steps of resuscitation given



tactile stimulation was given, baby had weak cry



started on PPV ventilation given for 2m



cry tone improved



Sup. Nit-k 1mg P.M given



In view, tachypnea, grunting, baby was started on CPAP with PEEP-5, FIO₂ 30%



Investigation details in previous Hospital :

Baby was shifted to Naco c CPAP support.

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Description :

cry }
tone } good
activity }

VITALS : Temperature : 36.5°C HR : 140/min RR : 45/min NIBP : - CFT : 23k

Colour of the extremities : Acrocyanosis

Jaundice : - Pallor : - SpO2 : 95% on CPAP Room air

Anthropometry : Birth Weight : 2.445kg Length : - HC : - Present Weight : -

Ponderal Index : - AGA : - SGA : - LGA : -

HEAD TO TOE EXAMINATION

HEAD : Fontanelles :
Sutures :
Shape / Moulding : } AP - 4 open
Edema / Bruising : } PF - 1 open
Size - (H.C.) :

Facies :
(Any Facial Dysmorphism) } (N)

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

EYES : Symmetry :
Red Reflex : → to be checked
Discharge :

EARS, NOSE MOUTH and THROAT : Ear set / Shape :
Preauricular Pits / Tags : }
Nasal shape / Patency : } no cleft lip & palate
Palate :
Gums :
Lips :
Tongue :

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

ABDOMEN and UMBILICUS : Shape :
Organomegaly :
Bowel Sounds : }
Umbilical Stump : } 2 arteries & 1 vein
Discharge : }

GENITALIA : Labia / Hymen : }
Testicles/penis : } ~~not~~ female external genitalia
Anus : } patent

HERNIAL ORIFICES → feel

TRUNK and SPINE :

SKIN LESIONS : } (N)

EXTREMITIES : Fingers / Toes :
Arms / Legs : }
Deformities : } (N)
Mobility :
Hip Joint Examination :

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

Mention If baby has Respiratory distress : RR : 5/min 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 : 96.1 on RA Auscultation : BIL AP @ clec Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 140/min BP : Precordial Activity :

Femoral Pulses : Murmurs : nil

Other Peripheral Pulses : feet Signs of Cardiac Failure :

Abdomen :

Shape : Hernial orifice :

Palpation : Anal Patency : patent

Palpable masses : (10) Umbilical Cord : 2A + 1Vey

Abdominal girth : First urine passed : her pass

Meconium passed : passed

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Cranial Nerves :

Cry tone activity } good

Motor System :

Passive Tone : (10)

Active Tone : (10)

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : (10) DTR :

ATNR : Skull and Spine :

Any Congenital Anomalies :

Diagnosis : TERM / AQA ? TTNB. (2022)

FOOT PRINTS

Left Side :



Right Side :



NOTED
By
USha

Resident Doctor :

Signature : [Signature]

Name : BALOOB

Date & Time : 21/6/26

Consultant :

Signature : [Signature]

Name : T-Paramel

Date & Time : 21/6/26

PLEASE FILL UP THE FOLLOWING DETAILS

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

AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

Vital : HR : RR : BP : SP02 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

- OG feeder → 12 ml / 2 hrly
- ~~Prot 10/1 D~~ → 60 ml/kg/day → ~~400~~
- CBC
- cep } after 4hrs of distress
- Blood clc } not subsided
- VBC
- ~~inj ppi/az~~ } stop
- ~~inj ampicillin~~ }

Cepbi → 85mg/dl

Feeding Plan at the time of shifting :

- GRBS monitoring @ 2hrly, @ 6hrly, @ 12hrly, @ 24hrly, @ 48hrly

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Pulse Oxymetry Screen :

New Born Screening :



NURSING INITIAL ASSESSMENT FOR NICU

Date of Admission: 21/6/2026 6:48 AM

Source of Admission: OPD Ward Labor Ward Other: O.T

Reason for Admission: TTNB

Admission Diagnosis:

Accompanied By: Parent Guardian Other Name:

Primary Language: Telugu English Hindi Other Specify

Do you require an interpreter? Yes No

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Source of Information: Family Others, Specify

Past Medical History	Past Surgical History	Last Hospital Admission

Significant History	Family History:
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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
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Observations:

Birth Weight: 2.445 kgs Head Circumference: cm Length: cm

Term Pre-Term Post-Term ~~.....~~

Blood Group: Mother: O+ve Baby:

Feeding: Breast Feeding Formula Both

Maternal Details: Age: 284 years, PARA: Prim Gestation: 37 Weeks, 6 Days

Risk Factors: PROM Fetal Distress Diabetes Mellitus / Gestational Diabetes

PH/Pre Eclampsia Others, Specify:

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

Indication:



Newborn Assessment:

Temp: 36.6 HR 133 / Min RR 54 / Min BP 69/56 SpO₂: 94

Pain Score (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: [Signature]

Orientation not given Reason:

DISCHARGE PLAN

Source of Information: Family Friend

Will patient require transportation arrangements to go home: Yes No

Will Physiotherapy require at home: Yes No

Is home medical equipment anticipated: Yes No

Is home oxygen therapy anticipated: Yes No

Breastfeeding Yes No

Formula Feed Yes No

Are dressing needs at home anticipated: Yes No

Any other needs anticipated: Yes No If Yes Specify

Discharge Medications: Yes No

Details:

Final Diagnosis:
.....
.....

Nurse Signature:

Nurse Name:

Date & Time:

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:



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Madhurima Mother's Name: Mrs. Madhurima
Date of Birth: 21/6/2026 Time of Birth: 5:31 PM Gender: Male Female
Birth Weight: 2.445 Kgs HC: cm Length: cm
Meconium in Liquor: Yes No Cried at Birth: Yes No
Term / Pre-term / Post-term: Term
Resuscitated: Yes No Blood Group: Mother: O+ve Baby:
Feeding: Breast Feeding Formula Both First Feed Time:

AFFIX MOTHER'S IDENTIFICATION LABEL

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

Physical Assessment of New Born:

Temp: 36 °C HR: 130.6 /Min RR: 30.6 /Min BP: SpO₂: 100%

Pain Score: (Follow N Pass)
Fall Risk Assessment: Yes No Score: 1.1 (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: Usha Signature: Usha Date & Time: 21/6/26 at: 6 PM

PROGRESS NOTES
(USE BALL POINT PEN ONLY)

Ref No: F/HW/PGN/INPR/15

HCV-00040957

IP22-00023341

Baby B/O K MADHURIMA

21-08-2026

0 Y 0 M 0 D 1 H (F)

Dr. R HARIHARAN



F

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
21/8/26	10:30 AM	<p>CLSB Dr. Paramah / Dr. Hanika / Dr. Balaji</p> <p>ISS: TERM / AGA / ? TTNB / GDM (37 weeks + 6 days)</p> <p>• Baby self Ventilatory on RA No distress, Tachypnea • hemodynamically stable color & perfusion - good • Cyl / renal activity - good • urine / stool paired</p> <p><u>Vitals:</u> • HR - 120/min • BP - 59/39 mmHg • SpO2 - 98% on RA</p> <p><u>Admission:</u> • OG feeds 12ml / 2nd hour • GRBS monitoring @ 6mly</p> <p>• TSB / NBS } after 4 hours of life</p> <p>BAEM</p>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Noted by
Sri Sunitha
21/8/26
@Lopm

2/6/26
SAM

CLSB Dr. Panamesh | Dr. Harikaran | Dr. Jayasurya | Dr. Sumin

Dis - Term / AGA | IDM | TTNB
(37+6 days)

Birth weight -
2.44 kg

15 hr of life

PS

Baby is self ventilating on room air

No episodes of apnea, desaturations

No episodes of bradycardia

No tachypnea, retractions

RR - 48/min SpO₂ - ~~95%~~ 95% ↓ RA

CRS

Hemodynamically stable

colour & perfusion - good

S₁S₂ ⊕, HR - 129 bpm

urine output - passed 3 times

FF

On 12 ml and hily spoon feeds

Tolerating well

No vomitings, aspirations

TV - 60 ml/kg/day

PIA

soft, not distended

urine, stool - passed

CNS

cuj ltnel activity - good

CRBS - 92 mg/dl @ 3Am

PROGRESS NOTES
(USE BALL POINT PEN ONLY)

HCV-00040957 IP22-00023341
Baby B/O K MADHURIMA
21-06-2026 0 Y 0 M 0 D 4 H (F)
Dr. R HARIHARAN

Patir
Age



I.P. No. :

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
		<u>Adv</u>
		1. 13ml and hly spom feeds @
		2. CRBS 6th hly monitoring
		3. Birth vaccination & red reflex to be checked
		4. TSB, NSB @ 48 hr of life
		5. Plan to shift to ward in aft evening
		6. Repeat TFT @ 72 hr of life on follow up.
		7. NIPE Before D/C
		8. TCB T/m before D/C
		9. D/c Gross after 3pm
		Paramed
		<i>[Signature]</i> (DJAYARAJAN)
		<i>[Signature]</i> N.B.V. 8/12/2026 6211066

NOTE : DO NOT WRITE OUTSIDE THE MARGINS