

ADMISSION SHEET

Registration Details :



Admission No : IP22-00023304

Admit Date : 18-Jun-2026

Admit Time : 01:27 AM

UHID : HCV-00040870

Patient Details :

Patient Name : Baby Of RAMALAKSHMI

Age : 0 D

Guardian : ANIL KUMAR

DOB : 17-06-2026 01:00 AM

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : Gajuvaka Vishakhapatnam Andhra Pradesh
INDIA 530026

Phone No : 9703901401

E-mail : no@gmail.com

Admission Details :

Bed Type : NICU

Bed No : NICU 113

Ward Name : 1F-FIRST FLOOR-NICU

Room No : NICU 113

Admission Type : First Visit

Contact Details :

Name : ANIL KUMAR

Relationship : Father

Contact Address : Gajuvaka Vishakhapatnam Andhra Pradesh
INDIA 530026

Phone No :


Signature

Doctor Details :

Doctor Name : Dr. TIRUMALASETTY PARAMESH

Specialisation : NEONATOLOGY

Referral Doctor : LAXMIKANTH P

Phone No :

Co-Consultant : Dr. R HARIHARAN

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name:-----

UHID No :..... HCV-00040870 IP22-00023304 ...Consultant :.....Dept:.....
Baby Of RAMALAKSHMI

Date of Admiss 17-06-2026 QYOM1D (M)Date of Discharge:.....Time:.....
Dr. TIRUMALASETTY PARAMESH

Room / Bed NoSuggested Billable bed type:.....



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
18/6/20	2:10am	CR	NEW	Ramy

Cross Consultation Visit

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



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Rama lakshmi Age : 26yM Father's Name : Age :
 Date of Birth : Date of Admission : I.P. No.:
 NICU Consultant : Dr. Hanikaran 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 Rama lakshmi Mother's Blood Group :
 Gender : M F Blood Group : Birth Weight (gms) : 3.5kg Length (cms) :
 Date of Birth : 17/6/26 Time of Birth : 8:37AM OFC (cms) :
 Place of Birth : Satyasai hospital Estimated Gesth Age : 38wks.

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : Ht : Wt : BMI : Married Life : LMP : EDD :
 Conception : Spontaneous or with Rx. :
 Booked at what GA. : AN Steroids Drugs / Doses :
 Last Scans Details :

TT Immunization and Iron / Folic Acid : RTD Drug given

MATERNAL RISK FACTORS

<p>Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs Consanguinity : <input type="checkbox"/> Yes <input 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 / RDDF / Redistrbution in MCA) / Ductus Venosus : AFI :</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 : H/o Hypothyroidism : when diagnosed ? Medication? Any other Chronic Medical Problems, when detected drugs ? (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 : Any culture :</p>
--	---

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

PAST OBSTETRIC HISTORY

G: 2 P: 1 A: L: 1

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
	G1 →	2 1/2 yrs			lact / PRM	
	G2 →	present			pregnancy	

PERINATAL HISTORY

Treating Obstetrician : Hospital : Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig) <i>Elective</i></p> <p>Second stage (> 2 hours after dilation) <i>Emergency</i></p> <p>LSCS : <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</p> <p>Specify the reason : <i>prior ULS</i></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>
--	---

NEONATAL RESCUSTITION 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 Responce	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>9</u>	<u>9</u>	<u>9</u>

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

HOP1:

• Baby cried immediately after birth

↓

• Delayed cord clamping done

↓

Inj. Vit-K 1mg IM given

↓

Baby had tachypnea & subcostal retraction
started on HFNC @ 6 l/min,
SpO₂ + agt.

↓

• IVF + 10% Dextrose.

• Inj. Lanem →

} given x 1 day

↓

In view of tachypnea, baby was referred
to NSEU

Investigation details in previous Hospital :

Feeding History :

Formula feeds

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Description :

cray
tone }
activity } good

VITALS : Temperature : 36.5°C HR : 140/min RR : 45/min NIBP : CFT : 23 sec
Colour of the extremities : pink
Jaundice : Pallor : SpO2 : 95% on RA

Anthropometry : Birth Weight : 3.5 kg Length : HC : Present Weight : 3.5 kg
Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

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

Facies : (Any Facial Dismorphism)	} (N)
---	-------

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

EYES :	Symmetry : Red Reflex : Discharge :	} (N)
---------------	---	-------

EARS, NOSE MOUTH and THROAT :	Ear set / Shape : Preauricular Pits / Tags : Nasal shape / Patency : Palate : Gums : Lips : Tongue :	} (N)
--------------------------------------	--	-------

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

ABDOMEN and UMBILICUS :	Shape : Organomegaly : Bowel Sounds : Umbilical Stump : Discharge :	} (N)
--------------------------------	---	-------

GENITILIA :	Labia / Hymen : Testicles/penis : Anus :	} (N)
--------------------	--	-------

HERNIAL ORIFICES	→ free
-------------------------	--------

TRUNK and SPINE :	} (N)
--------------------------	-------

SKIN LESIONS :	} (N)
-----------------------	-------

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

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

Mention If baby has Respiratory distress : RR : 38/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 : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 140/min BP : Precordial Activity :

Femoral Pulses : Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernial orifice :

Palpation : Anal Patency :

Palpable masses : Umbilical Cord :

Abdominal girth : First urine passed :

Meconium passed :

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Cranial Nerves :

.....
Cry tone activity } good
.....

Motor System :

Passive Tone :

Active Tone : (A)

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

ATNR : (A) Skull and Spine :

Any Congenital Anomalies :

Diagnosis : TERM (AGAL) ? TTNB.
(38wks)

FOOT PRINTS

Left Side :

Right Side :

out side

Resident Doctor :

Signature :
Name : BALASA
Date & Time : 18/6/26

Consultant :

Signature : Paramel
Name : P. Paramel
Date & Time : 18/6/26

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :
2. Name of the referring Hospital :
Address :
Contact Numbers :
3. Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
4. 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 :

- Npo.
- GVF 10% D 60ml/kg/day
- CBE
- Blood cl
- sup. Pipraz
- sup. Amikacin
- Chest X ray
- ABG & lactate
- GPRC monitoring @ 6th hourly

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Pulse Oxymetry Screen :

New Born Screening :

Advice

- ① IVFs Continue 60ml/kg 10% Dextrose
- ② Feeds 5ml $\xrightarrow{(2)}$ 10ml $\xrightarrow{(2)}$ 15ml Q 2Hly. $\xrightarrow{(2)}$ 20ml Q 2H
- ③ Continue Iv antibiotics
- ④ CRP Tomorrow Morning.
- ⑤ ~~Give~~ PARACETAMOL (10mg/kg) Q 6Hly.
Syp

5ml feeds \rightarrow 6-2ml/hr
 10ml feeds \rightarrow 3-7ml/hr
 15ml \rightarrow 7-2ml/hr
 20ml \rightarrow D/c IV fluids

Rettenhaem

Noted by
 Aparna (020706)
 18/6/26 @ 9:30 AM

CLSB Dr. Hariharan | Dr. Suminava

18/6/26
6PM

Baby reviewed

Baby on room air self ventilating

No sign of distress

cry / tone / activity - good

Colour & perfusion - good

OLC

RR - 65/min

HR - 139 bpm

SpO₂ - 92%


Adv

- 1. cont IV fluids
- 2. cont ~~15~~ ¹⁵ ml \rightarrow 20ml 2nd huly
- 3. cont IV antibiotics
- 4. CRP t/m

Suminava



PROGRESS NOTES
(USE BALL POINT PEN ONLY)

Patient HCV-00040870 IP22-00023304
 Baby Of RAMALAKSHMI
 Age : 17-06-2026 0 Y 0 M 1 D (M)
 Dr. TIRUMALASETTY PARAMESH
 I.P. No 

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
18/6/26	11pm	C/S/B Dr Ananth/ Dr Sivasub
		Baby Reviewed,
		Currently on Room air
		No distress / apnea
		HR- 123/min
		spo ₂ - 100% @ R.O
		Colour + perfusion- good
		C/T/A- good
		feed- 20ml @ 2nd h
		respir- good
		<u>Plan</u>
		1) CRP t/m
		2) Cont feeds 20ml @ 2nd h
		3) Cont of piptaz t of amikac
		Nby - 8/10 - Seville @ 11pm.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

19/6/26

8AM

C/S/B De Paramesh / Dr. Haerhaer / Dr. Jayasuya / Dr. Shanmugam

Teem / AGA / ? EONS / ? TTNB

Day 3 of life

wt → 3.481 kg

RS. No desat / brady / apnoea

Self ventilaty on room air

Intermittent tachypn (RR → 60-65/m)

CVS

- Clave G perfusion - good

Pulse - good w/c 2.8m/kg/hr

vital

HR → 131/min

SpO₂ → 97%

P/A

- Soft, no distension

stool passed

CNS

- Tone / Activity - Good

AF - open

CRP →

R-hand - 97%

R-leg - 98%

L-hand - 95%

L-leg - 97%

Advice

→ Cont adlib spoon feed ~~FRD~~

→ Cont IV PIPTAZ (D₂) AMIKACIN + all culture report

→ Birth vaccine & red refer

→ CCHD screen show

→ Plan D/c Tomorrow

→ TSB at 10AM

Dr. Jayasuya

Paramesh

NI 134
Shanmugam
19/6/26


PROGRESS NOTES
(USE BALL POINT PEN ONLY)

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
20/8/26	8 AM	CLSB Dr. Panamash Dr. Harikaran Dr. Jayaraja Dr. Sumithra
		Am - Term / AGA ? EONS ? JTB
		Day 7 of life Birth weight - 3.52 kg Current weight - 3.46 kg
		Baby is self ventilating under room air No apnea, desaturation No signs of distress RR - 50/min SpO ₂ - 100% CVS
		Hemodynamically stable colour & perfusion good S, S ₂ (+), HR - 110 bpm urine output - 2.9 ml/kg/hr P/F
		30ml and only feeds - spoon feeds Tolerating feeds well No vomitings, aspirations CNS
		eng / tone / activity - good P/A
		soft, not distended
		<u>Rittharan</u>
		20/8/26 Plan → Stop antibiotics → discharge → TFT / B. Group / NBS / heavy test on OPD basis.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Noted by s/m meena
01/08/26
20/8/26
CBA

PATIENT TRANSFER FORM

Patient Name / I.P. No HCV-00040870 IP22-00023304 Baby Of RAMALAKSHMI 17-06-2026 0 Y 0 M 1 D (M) Dr. TIRUMALABETTY PARAMESH 	Date & Time of Admission 18/5/26 1:27 AM	Date & Time of Transfer Order 18/5/26 1:10 AM
	Transfer ordered by Dr. Balaji	Reason for Transfer Admission
From Bed / Ward / Hospital ER	To Bed / Ward / Hospital NICU	Information to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in clinical file 18	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:

Name of Signature of Person filling this part [Signature]	Name of person ordering transfer Dr. Balaji	Name & Signature of Nurse Supervisor [Signature]	Referral note & referral Doctor Name: [Signature]
--	--	---	--

Patient & Clinical records received by:

meenu

[Signature] 18/5/26

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