

ADMISSION SHEET



Registration Details :

Admission No : IP22-00023362 Admit Date : 23-Jun-2026 Admit Time : 05:11 PM UHID : HCV-00041007

Patient Details :

Patient Name : Baby B/O CHANDRA NAGA MANILA Age : 0 D
Guardian : Mr T SHRIKANTH DOB : 23-06-2026 04:33 PM
Gender : Male Religion :
Occupation : Martial Status :
Address (H) : Avn College Road Vishakhapatnam Andhra Pradesh INDIA 530001 Phone No : 8919172235/
E-mail : 8919172235@GMAIL.COM

Admission Details :

Bed Type : BASINET Bed No : CRDL-GW -331-1 Ward Name : 3F-THIRD FLOOR
Room No : CRDL-GW -331-1 Admission Type : First Visit

Contact Details :

Name : Mr T SHRIKANTH Relationship : Baby/O
Contact Address : Avn College Road Vishakhapatnam Andhra Pradesh INDIA 530001 Phone No :


Signature

Doctor Details :


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

Payment Details :

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

OPV done - 24/6/26
Bay 1 Hep. B done 24/6 Red Reflex done.

ACTIVITY RECORD FOR BILLING

Name:----- HCV-00041007 IP22-00023362
 UHID No :----- Baby B/O CHANDRA NAGA MANILA
 23-06-2026 0 Y 0 M 0 D 1 H (M) ...Consultant :----- Dept:-----
 Date of Admissi  Dr. R HARIHARANDate of Discharge:-----Time:-----
 Room / Bed NoWard :-----Suggested Billable bed type:-----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
23/6/26	6:20pm	LDR-I	336	<i>Pruvi</i>

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 : Naga Manila Age : Father's Name : Age :
 Date of Birth : Date of Admission : I.P. No. :
 NICU Consultant : Dr. Hariharan Referring Consultant : Ch. Raga Sridha
 Transferring Unit : OT Labour Room ER Ward
 Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : B/o Naga Manila Mother's Blood Group : O+ve
 Gender : M F Blood Group :
 Birth Weight (gms) : 2.504 kg Length (cms) :
 Date of Birth : 23/6/26 Time of Birth : 4:33 PM OFC (cms) :
 Place of Birth : RCH Vizag Estimated Gesth Age : 37wks + 4 days

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 33yrs Ht : Wt : BMI : Married Life : 7yrs LMP : 3/10/2025 EDD : 10/7/26
 Conception : Spontaneous or with Rx : Spontaneous
 Booked at what GA : AN Steroids Drugs / Doses :
 Last Scans Details : Cephalic presentation, Ant placenta, AFI-5.7 (Oligohydramnios)
EFW - 2.678 kg CPR -> 1.395 (41% PL) Doppler (D) - 2016 Hz gonium. 2f
 TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

<p>Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs Consanguinity : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 H/o PIH (after 20 weeks) / PE How many Drugs / Doses / Since how long : <u>Gestation HTW - 26wks 5 days</u> H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) : <u>used T. Labetalol 100mg</u> IUGR - when detected : <u>PE - < 37 (1:96)</u> Doppler (Increased Resistance / ADEF / RDDF / Redistribution 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>
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PPROM : Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :

G4 - Spontaneous conception, immunized, Regular antenatal

PAST OBSTETRIC HISTORY

G: 4 P: 1 A: 2 L: 1 *che dup.*

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
G1					→ missed abortion → medically managed	
G2					FT / mch / ant - 2.8 kg / 6 year at present / NVD	
G3					→ Missed abortion - 2025 → medically managed	

PERINATAL HISTORY

Treating Obstetrician : *Dr. Raga Sudha* Hospital : *RCH, Vizag* Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig) <i>NVD</i></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 : <i>MSL - grade III</i></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	
	2	2	
	2	2	
	2	2	
	2	2	
TOTAL	9	9	

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

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

HOP1:

A single live male baby is delivered via NVD

↓

Baby cried immediately after birth

↓

Cord clamped, Shift to warmer

↓

Routine newborn care given

↓

Cord clamped, clean cut given

↓

Inj. vit K 1mg IM given

↓

Baby shift to mother side

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Description :

cry / tone / activity - good

VITALS : Temperature : 36.5°C HR : 140bpm RR : NIBP : CFT : 23sec

Colour of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 97% ↓ RA

Anthropometry : Birth Weight : 2.504kg Length : HC : Present Weight :

Ponderal Index : AGA : ✓ SGA : LGA :

HEAD TO TOE EXAMINATION

HEAD : Fontanelles : } AF - open & at low
 Sutures }
 Shape / Moulding : }
 Edema / Bruising : }
 Size - (H.C.) :

Facies : (Any Facial Dysmorphism) (N)

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

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

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

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

ABDOMEN and UMBILICUS : Shape : }
 Organomegaly : }
 Bowel Sounds : }
 Umbilical Stump : → 2A + 1V
 Discharge :

GENITALIA : Labia / Hymen : male external genitalia
 Testicles/penis :
 Anus : B/L descended testis

HERNIAL ORIFICES (N)

TRUNK and SPINE : (N)

SKIN LESIONS : (N)

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

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

Mention if baby has Respiratory distress : RR : 44/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 : 96-2RA Auscultation : Breath Sounds : B/LCRA Added Sounds :

Cardiovascular System :

HR : 150bpm BP : Precordial Activity :

Femoral Pulses : feet Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernial orifice :

Palpation : soft Anal Patency : patent

Palpable masses : Umbilical Cord : 2A+IV

Abdominal girth : First urine passed : not passed
Meconium passed : passed

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness : (N)

Prechtle Score :

Cranial Nerves :

.....
..... (N)

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes : (N)

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

ATNR : Skull and Spine :

Any Congenital Anomalies :

Diagnosis :

Single / NVD / Term / 2. kgs / Fch / well baby
(374 days)

FOOT PRINTS

Left Side :



Right Side :



noted by Parva

Resident Doctor :

Signature : *[Signature]*

Name : *G. Suminera*

Date & Time : *23/6/26*

Consultant :

Signature : *[Signature]*

Name : *R. Honhan*

Date & Time : *24/6/26*

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 :

Adv

- 1. DBF end nly flb keeping
- 2. Vax Birth vaccination & red reflex to be checked
- 3. CCHD & TCB @ 24 hrs
- 4. Warmth care
- 5. Blood
- 5- end blood BGT, TSH, T4

Feeding Plan at the time of shifting :

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

h
Summer

noted by Parent

Pulse Oxymetry Screen : R.L-98% , R.A-99% , C.L-98% (L.H-98)

New Born Screening :

HCV-00041007 IP22-00023362
Baby B/O CHANDRA NAGA MANILA
23-06-2026 0 Y 0 M 0 D 1 H (M)
Dr. R HARIHARAN



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

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

Baby's Name: Chandra
B/O Naga Manila

Mother's Name: Mrs. Chandra Naga Manila

Date of Birth: 23/6/26

Time of Birth: 4:33pm

Gender: Male Female

Birth Weight: 2.50 Kgs

HC: cm

Length: cm

Meconium in Liquor: Yes No

Cried at Birth: Yes No

Term / Pre-term / Post-term:

Resuscitated: Yes No

Blood Group: Mother: o+ Baby:

Feeding: Breast Feeding

Formula

Both

First Feed Time: 5pm

KMV-00011435 IP22-00023355
Mrs CHANDRA NAGA MANILA
20-09-1992 33 Y (F)
Dr. CHUPPANA RAGA SUDHA



Mode of Delivery: Normal

LSCS - Emergency/ Elective

Instrumental

AVD

Indication:

Physical Assessment of New Born:

Temp: 36 °C HR: 148 /Min RR: 42 /Min BP: SpO₂: 99%

Pain Score: (Follow N Pass)

Fall Risk Assessment: Yes No

Score: 11 (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: paveni

Signature: [Signature]

Date & Time: 23/6/26 @

4:40pm

PROGRESS NOTES
(USE BALL POINT PEN ONLY)

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
24/6/26	8am	c/s/B Dr HH/Dr SV
		A - Single / NVD / Term / fcm 37+4
		c/T/A - $\text{\textcircled{A}}$ feed - DBF urine } stool } ✓
		Bw - 2.504 Cw - 2.466 1.57.
		<u>Plan</u> 1) TCB body 4:30 pm 2) Ad lib feed 3) GRBS @ 6 H. ES
		<u>ASH + 11.1</u> BCT + 'A' +ve + baby molty + 'O' +ve
24/6/26	5pm	cls Dr. Haritha / Dr. Balaji Noted by Dr. Balaji 24/6/26 @ 11am
		<u>TCB + 11.4</u> • on/renal activity - good urine } stool } paired <u>Ad lib</u> • Feeding + DBF • Start Sept coverage eyes & genitalia • Ad lib feeds Re BALAJI

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

25/6/26

SAM

40hr of life

CLSB Dr. Harsharan / Dr. Balaji

ASIS: TERM | AGA | NVD | FCH

(37wk + 4day)

↓ SSPT
cry/tonel activity - good

Birth wt + 2.504kg
C. wt + 2.440kg

wt loss + 2.5%

urine } paired
stool }

• Feeding + DBF

Advised:

- cont. SSPT
- Ad lib feed
- TSB → @ 4:30pm
- NBS
- stop QRS monitoring

Dr. Balaji

N. By Crown

25/6/26

SPSS

CLSB / Dr. Aishwarya / Dr. Balaji

- ↓ SSPT.
- cry/tonel activity + good
- urine } paired
stool }
- Feeding + DBF

Advised:

- cont. SSPT
 - Ad lib feed
 - Trace TSB & NBS
- Dr. Balaji N.B. Kalyani

RESULT SHEET

Patient I
Age :
I.D. No.

HCV-00041007 IP22-00023362
Baby B/O CHANDRA NAGA MANILA
23-06-2026 0 Y 0 M 0 D 1 H (M)
Dr. R HARIHARAN

3 / INPR / 17



lo. :
.....

Date	24/5	25/6			
Time					
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj	11.4	11.4	8.8	8.7	
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					
Doctor's Signature					

Date	23/6/26				
Time					
CUE - Alb					
CUE - Sugar					
CUE - Ketones					
CUE - PUS Cells					
CUE - RBC Cells					
CUE					
Stool Pus Cell					
OVA / Cyst					
Occult Blood					
Ty	10.7				
TSH	11.11				
BGT	A POSITIVE				
Doctor's Signature					

Culture and Sensitivities :

.....

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.):