F/P 9/AR/BIL/01

JNB-00137836 IP11-00056683
Baby KHUSHI
09-11-2024 1Y7M8D (F)
Dr. N VAIKUNTA SHENOY

BirthRight BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Cash: ☐ Credit: ☒

Name: Baby Khushi Age: 1y7m Gender: Female

UHID No. 137836 IP No. 56689 Consultant: Dr. N V Shenoy Dept:

Date of Admission: 17/6/26 Time: 9:35 pm Date of Discharge: Time:

Room / Bed No: 120 Ward: Room Bed No.: Ward:

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/6/26	10:10 pm	ER	P. ward	PW

Upated on						

DOCTORS VISITS

	Consultants	Date 18/6 AM	PM	Date 19/6 AM	PM	Date 20 AM	PM	Date AM	PM	Date AM	PM	Date AM	PM	Date AM	PM	Date AM	PM	Date AM	PM
1																			
2	N. V Shenoy	✓	✓	✓	✓	✓													
3	Dr. Kalyan				✓														
4																			
5																			
6																			

SURGERY / PROCEDURE CHART

Surgery / Procedure Details:		Surgery / Procedure Details:	
Date: Duration:		Date: Duration:	
Start Time: End Time:		Start Time: End Time:	
a. Surgeon:		a. Surgeon:	
b. Assistant:		b. Assistant:	
c. Anaestheist		c. Anaestheist	
Instruments		Instruments	
OT Equipment		OT Equipment	
Any Other Information		Any Other Information	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Connecting Time	Disconnecting Time	Total Consumption	Remarks	Signature
18/6/26	@ 10pm	20/6/26 @9am		Infusion pump	puspa
18/6/26	@10:30pm	20/6/26 @ 8am		Syringe pump	puspa

INVESTIGATIONS / PROCEDURES

Date	Time	Investigations	Sign	Date	Time	Procedures	Sign
17/6	9:45 pm	GRBS - 78 mg/dl	PW	17/6/26	9:45 pm	IV placement	PW
		CBC, CRP		20/6/26		IV placement	
		Blood C/S					
		LFT, RFT					
18/6/26 5pm		Urine C/S					
14/6		Flu panel					
19/6		Urine rout					
		CBC, CRP,					
20/6 9pm.		ESR, S. Ferritin, S. iron profile					

PHOTOTHERAPY / OTHER SERVICES

Date	Connecting Time	Disconnecting Time	Total Consumption	Remarks	Signature

RADIOLOGY / SCANS

Date	Service	Signature	Date	Service	Signature
18/6/26	USG abdomen and pelvis.				
19/6/26	2D ECHO				

SUPPORT SERVICES

Date	Physiotherapy	Signature	Date	Others Services	Signature

BLOOD BANK

Date										
Units										
Remarks										

ANY OTHER INFORMATION

Date : 20/6/26. Time : 10.12 Am Prepared By : Thusha

Staff Nurse / Floor Co-ordinator	Nursing Supervisor	Billing Assistant	Billing Supervisor

NO Due in Pharmacy (20.6.26 - 9.50 AM)

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DISCHARGE SUMMARY	
Name: Baby KHUSHI	**MRN:** JNB-00137836
Father/Guardian: PANCHARAM BHATI	**IP No:** IP11-00056689
Age: 1 Y 7 M 9 D	**Gender:** Female
Address: Doddanekkundi, Bangalore, Karnataka, INDIA, 560037	**Admission Date:** 17-06-2026
Referral Doc: SELF	**Discharge Date: 20/06/2026**

Consultants:
Dr. N VAIKUNTA SHENOY

CONSULTANT PEDIATRICIAN
Reg. No.:

DR. RASHMI ADIGA
MBBS, DCH, MRCPCH(UK),
CCT(UK), FRCPCH(UK)
CONSULTANT PAEDIATRIC NEUROLOGIST & PAEDIATRICIAN
50101

DIAGNOSIS	ICD CODE
FEVER UNDER EVALUATION ?ENTERIC FEVER	

History:
C/o Fever since 5 days
H/o redness of eyes since 2 days
No h/o Cough / cold
H/o loose stools since 4 days (No h/o loose stools today)stopped now

Reason for admission:
H/o Fever since 5 days, intermittent in nature, not associated with rash, not

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Ph: 1800 2122

Bannerghatta Road:
No 178/1 & 178/2,
Opposite Janardhan Towers,
Bilekahalli,Bengaluru - 560 076.
Ph: 080-66902200

Hebbal:
No.247/248/288/100
Byatarayanapura Village,
Yelahanka Hobli, Bengaluru - 560 092.
Ph: 1800 2122

Sarjapur Road :
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Varthur Hobli, Sarjapur Road
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Name: Baby. KHUSHI	**MRN:** JNB-00137836
IP No: IP11-00056689	**Admission Date:** 17-06-2026

relieved on medication
H/o redness of eyes noted since 2 days
H/o loose stools 1 day ago
No h/o eye discharge
No h/o cough / cold

Past History:
Nothing significant

Birth History:
Term / LSCS / No h/o NICU admission

Immunization has been done as per schedule

Family history:
Nothing significant

Developmental History:
Gross motor:
Neck holding - 3MONTHS
Sitting independently , Standing - 9 months
Walking independently - 13 months
Run - 15months

Fine Motor:
Hand to mouth - 7 months
Hand to hand 7 months
Pincer grasp - 12 months

Language:
Babbling - 8 months
First words- 12 months

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Name: Baby. KHUSHI	**MRN:** JNB-00137836
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Social:
Pointing to things - 10 months
Waving bye - 10 months

Examination and findings:
She was febrile, maintaining saturations at room air and was hemodynamically stable. there was mild bilateral non-purulent conjunctivitis, perianal excoriation, ?strawberry tongue, bilateral cervical lymphadenopathy. Temp: 100.3°F, HR:143/min, and RR : 28/min. Wt: 10.2kgs. On auscultation of chest, air entry was bilaterally equal with normal heart sounds and there was no murmur. Abdomen was soft with hepatomegaly 2cm below RCM. Bowel sounds were heard. On neurological examination: Child was alert. Pupils were bilaterally equal and reacting to light. DTR normal. Tone normal. Plantars up bilaterally flexors. There were no focal neurological or cranial nerve deficits. There were no signs of raised intracranial pressure.

Investigations: Enclosed

Treatment given
IV fluids / Inj. Paracetamol / Inj. Xone /Inj. Amikacin / Inj. Pan / Justin suppository

Management:
She was admitted in the ward , relevant investigations were done reports enclosed and was treated with iv Ceftriaxone and iv Amikacin for 3 days. Investigations were suggestive of iron deficiency anemia, with thrombocytosis and TLC of 10,370(neutrophilic). CRP was very high initially(193mg/l) with mild raised GGT(104U/L), USG abdo pelvis showing mild hepatomegaly. Urine RE and flu panel were negative. 2D ECHO was done to rule out any coronary artery abnormalities as clinical picture was s/o incomplete Kawasaki, which was normal. Post 3 days of antibiotics, fever subsided, patient improved clinically and oral intake was satisfactory. Rpt CRP was 65mg/L(reduced) and

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blood culture after 18 hours of incubation was sterile, hence was planned for discharge with plan to continue antibiotic course to complete total 5 days(till 22/06/2026).

At the time of discharge : She is active, afebrile and hemodynamically stable.

Advice on discharge

Inj Ceftriaxone 800mg iv OD till 22/06/2026
Inj Amikacin 150mg iv OD till 22/06/2026
To trace final blood and urine culture reports after 2 days.
Syp. Zincovit 2.5ml 1-0-0 to continue for 30 days.
To start oral Iron therapy Syp. Tonoferon(80mg/5ml) 3.7ml 0-0-1 for 3months
Diet as advised.

Review consultation Dr. N Vaikunta Shenoy at Rainbow Bannerghatta opd after 2 days with prior appointment.

Follow up immediately in Emergency Room if high grade fever, vomiting, altered sensorium, abnormal behaviour, seizures, breathlessness or refusal to feed occurs.

In case of medical emergency contact Doctor Number: 7997079970/ 7338466521

For booking appointment to call 18002122

Any emergency visit nearest hospital (or) nearest Rainbow Branch.

Call for emergency.

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Do not stop any medication without prior consultation
Continue these medication even in presence of fever/cough/ cold/diarrhoea
Sudden stoppage causes recurrence of seizures.

"The content of the patient discharge summary/ medication/ food & drug interaction/ care to be provided at home/ nutrition/ immunization and safe parenting/ when and how to obtain emergency care etc also have been explained by doctor".

Summary prepared by : Dr Uma H (TCMC 76945)
Summary checked by:

Consultant Name & signature

Summary explained and understood by me

Dr. N VAIKUNTA SHENOY

CONSULTANT PEDIATRICIAN
Reg. No:

Registrar Name & Signature

Signature of patient and Attendant

Summary explained and handed over by
Nurse Name & Signature:

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