

RADIOLOGY / SCANS

Date	Service	Signature	Date	Service	Signature
17/6	x-ray chart ✓	[Signature]	19/6/20	USY ✓	[Signature]
17/6	ECG ① ✓	[Signature]			
17/6	NSY ✓	[Signature]			
17/6	USY ✓	[Signature]			
17/6	2 D Echo ✓	[Signature]			

SUPPORT SERVICES

Date	Physiotherapy	Signature	Date	Others Services	Signature

BLOOD BANK

Date									

ANY OTHER INFORMATION

Date: 19/6/24 Time: 12:30pm

Prepared By: [Signature]

Staff Nurse / Floor Co-ordinator [Signature]	Nursing Supervisor [Signature]	Billing Assistant	Billing Supervisor
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No due at Pharmacy [Signature] 1:22 PM 19/6

DISCHARGE SUMMARY	
Name: Baby B/O KAVYA	MRN: JNB-00137796
Father/Guardian: KAVYA	IP No: IP11-00056668
Age: 0 Y 0 M 0 D 10 H	Gender: Female
Address: #20 9th cross krishna layout hulimavu, Bannerghata Road, Bangalore, Karnataka, INDIA, 560076	Admission Date: 17-06-2026
Referral Doc: SELF	Discharge Date: 19/06/2026

Consultants:

Dr. PRAKASH VEMGAL

DCH, MRCPI (IRL) MRCPC (UK), FRCPC (UK), FELLOW-NEONATOLOGY (AUSTRALIA), FELLOW-PAEDIATRIC CRITICAL CARE (CANADA), DIRECTOR-DEPARTMENT OF NEONATOLOGY & PAEDIATRICS
CONSULTANT NEONATOLOGIST & PEDIATRICIAN
Reg. No.: KMC#33619

DIAGNOSIS	ICD CODE
LATE PRETERM (36 WEEKS 6 DAYS) / BIRTH WEIGHT (2.9KGS) / PERINATAL ASPHYXIA / RESPIRATORY DISTRESS SYNDROME / NEONATAL HYPERBILIRUBINEMIA	

History

Baby of Mrs. Kavya is a late preterm baby, delivered to a Primi mother by Full term vacuum assisted vaginal delivery (IND: Poor maternal efforts) on 17.6.2026 at 6.46am with birth weight 2.9kgs in Rainbow Children's Hospital, Bannerghatta Road, Bangalore. Baby did not cry immediately after birth. Apgar scores were 5/ 10 at 1 min, 8/ 10 at 5 min. Inj. Vitamin K was given after delivery.

Maternal History: Mrs. Kavya is a 20 years old primi mother, non consanguinous marriage, marital life of 1 years.

G1 - Present pregnancy, spontaneous conception, had regular ANC's, received



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2 doses of Inj.TT. Antenatal scans were normal. No history of PIH/ UTI/ APH/ Hypothyroidism/ Oligohydramnios/ Polyhydramnios/ PROM/ Fever.

Examination and findings: Baby was not maintaining saturations at room air. On auscultation of chest air entry was bilaterally equal with normal heart sounds. Abdomen was soft with no organomegaly. Cry and activity were good. AF was at level.

Anthropometry:

Weight at birth : 2.9kgs.
 Weight at discharge : kgs.
 Head Circumference : cms.
 Length : cms.

Investigations: Enclosed.

Course in the hospital :

Respiratory distress syndrome

Neonate shifted to NICU in view of pre term and respiratory distress.

Baby was started on CPAP support [PEEP 6 Fio2 30%] in view of respiratory distress. CPAP was gradually weaned and baby shifted to room air on D2 of life.

Risk of sepsis

Baby was started on IVF and IV antibiotics [Inj Meropenem and Inj Amikacin] after sending blood culture in view of risk of sepsis. As blood culture remained sterile antibiotics were stopped.

Nutrition

Baby was started on minimal enteral feeds on D1 of life and feeds were



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gradually increased as per unit protocol. Direct breast feeds were initiated and Neonate tolerated feeds well. Passed urine and meconium within first 24 hrs of life. Baby blood sugars were stable throughout stay.

Cardiovascular

2D ECHO done on 17/06/2026 showed PFO, L-R shunt, Intact IVS, No COA/PDA, Normal chambers/valves, no PAH, Normal biventricular function

Neurology

Neurosonogram done on 17/06/2026 showed no significant abnormality.

Dr. Rashmi Adiga opinion was sought in view of encephalopathy due to perinatal asphyxia and advised no cooling as baby does not satisfy cooling criteria and clinically baby improving.

Last investigations

Last investigations : Date: 18/06/2026

Hb: **9.6** g/ dL

PCV: 26.3 VOL%

Platelet count: 429 Lakhs/mm³

WBC count: 20530 Cell/mm³

Creatinine: 0.8 mg/dl

Na + 149 mmol/L

Potassium 3.9 mmol/L

Chloride 120 mmol/L

CRP 03mg/L

SBR 6.5

DCT Negative

TCB done on 19/06/2026-

Newborn screening



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Bio7 Screening test sent on ----- , report is awaited.

Pulse Oximetry - normal

Hearing test (OAE) to be done on follow up.

Red reflex - normal.

Clinical Hip examination was normal.

Feeding: Pallada feeding was initiated and baby tolerated the feeds well.

Vaccination:

Hepatitis B- 17/06/2026

BCG / OPV- 19/06/2026

Condition at discharge:

On Direct breast feeds, taking feeds well

O/E

Baby alert and active

peripheries warm

CFT <3 secs

AF: open, flat, at level of cranium

S/E:

CVS: S1,S2 present+

RS: B/L air entry present

P/A: Soft, non-distended, Inguinals - normal

CNS: alert, active, cry+, tone- normal;

Advice on discharge

Direct breast feeds + demand pallada feeds

Keep the baby clean & warm

Immunization as per schedule

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Deksel (0.5ml=400IU) 0.5ml once daily x 01 year (per orally)
Nasoclear Nasal drops 2 drops in each nostril SOS for nose block.
Hearing test (OAE) to be done on follow up with prior appointment

Review on 22/06/2026 with Dr Prakash Vemgal with prior appointment.

Neurodevelopmental follow up 3rd monthly till 2 years of age

Review at age of 3 weeks for ROP screening with Dr Sumanth with prior appointment. Continue ROP screening as advised till complete maturation of retina.

Review back to Hospital:

If baby is not feeding continuously for > 6 hours, If breathing fast, Fever or poor activity or lethargy, Bluish discolouration of lips, Increase in jaundice, Abnormal movements occurs.

For booking appointment to call 18002122

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

Summary prepared by : Dr Kavippriya

Summary checked by : Dr.Rupa

Consultant Name & signature

Dr. PRAKASH VEMGAL

DCH,MRCPI(IRL)MRCPCH(UK),FRCPCH (UK), FELLOW-NEONATOLOGY(AUSTRALIA), FELLOW-
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Summary explained and understood by me

Name: Baby. B/O KAVYA	MRN: JNB-00137796
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Registrar Name & Signature

Signature of patient and Attendant

**Summary explained and handed over by
Nurse Name & Signature:**

