


ACTIVITY RECORD FOR BILLING

Name: -----
 UHID No : -----
 Date of Admi -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

KOH-00308781 IP2-00056558
 Baby Of MAMATHA BEVARA
 10-06-2026 0 Y 0 M 5 D (F)
 Dr. DAVID SUVARNARAJU PARIMI

----- Consultant : ----- Dept : -----
 ----- Date of Discharge : ----- Time: -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/6/26	1.33pm	ER	U11	

Cross Consultation Visit

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



**Rainbow[®]
Children's
Hospital**
It takes a lot to treat the little.

**PEDIATRIC IN-PATIENT
MEDICAL RECORD**

KOH-00308781 IP2-00056558
Baby Of MAMATHA BEVARA
10-06-2026 0 Y 0 M 5 D (F)
Dr. DAVID SUVARNARAJU PARIMI

Patient Name: _____



UHID ID: _____

Department: _____

PAEDIATRICS -

Consultant: _____

DR. DAVID,

KOH-00308781

IP2-00056558

Baby Of MAMATHA BEVARA

10-06-2026

0 Y 0 M 5 D

(F)

Dr. DAVID SUVARNARAJU PARIMI



Pediatric Multiorgan History & Physical Examination

Name : D/o . MAMATHA BEVARA . Age/Sex 5 days .

Information given by : _____ Relationship father .

Chief Presenting Complaints & Duration (Chronologically)

yellowish discoloration . of .
skin . present .

History of present illness :

yellowish discoloration of skin present .

cry
tone | good
activity

all meals - breast
AFE level

day - 5 of
life

mother => 0 positive

baby => 0 positive .

R. wt => ~~3.45~~ 3.683

T. wt => 3.45 kg .

D. wt => 3.509

6.3% wt loss .

accepting feeds
well .

paned urine/stool - @

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Pediatric Multiorgan History & Physical Examination

Past History : (Including details of any previous investigation or treatment)

Birth & Neonatal History:

T/AGA/FCM/3.683/SVD.

Birth & Socio Economic History:

About Father : _____

About Mother : _____

Any additional Information : _____

Developmental History :

Immunization History :

Birth vaccine given



Pediatric Multiorgan History & Physical Examination

Anthropometry :

Head Circum (cms) _____ (Centile _____) Height (cms): _____ (Centile) _____)

Weight (kgs)) 3.5 kg (Centile _____)

On Examination :

Temperature : 97.9 F Pulse Rate : 136 bpm B.P. _____ SPO2 98%

Resp. rate and type of breathing : regular, @ for age

Rash _____

Lymphadenopathy _____ } no

Oedema : _____

Allergies (if any): _____

Respiratory System :

Inspection (any s/o distress) : (N)

Air entry & breath sounds : B/L A/E (+)

Any addes sounds : no added sounds

Relevant data from outside (Chest X-Ray, ABG, etc.,) _____

Cardiovascular System :

Inspection of procordium : (N)

Heart Sounds : S1S2 (+)

Any murmur : _____

Relevant data from outside (Chest X-Ray, ECG, ECHO, etc.,) : _____

Per Abdomen :

Inspection (N)

Palpation : soft, nontender

Ausculation : _____

Spine : _____ External Genitalia : _____

Relevant data from outside (CT, USG etc.,) _____

Pediatric Multiorgan History & Physical Examination

Central Nervous System :

Level of Consciousness : AVPU/GCS score : _____

Cranial Nerves : _____

Motor System:

Nutriton : _____

Tone: _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

(N)

DTR

Superficials:

Plantars _____

Sensory System :

Bladder / Bowel : _____

Clinical Summary & Diagnostic:

NNT



Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment: _____

Desired goals of the treatment : _____

Planned Labs:

TCR - 14.3 my/dl

SRR 11m ~~6am~~

after rounds.

Noted by Pooja (a) 15/6
1.15 PM

Planned Management

1) warmth care

2) SPT eye &

prophylactic ward

3) SRR tomorrow

after rounds ~~morning 6am~~

4) Monitor vitals

5) feeding 2nd hly

flb burping.

Signature of the Doctor: _____

Name of the Doctor: Dr. Anwesha

Date & Time: _____

Signature of the Consultant: _____

Name of the Consultant: _____

Date & Time: _____



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		<p>USIA Reg</p>
<p>15/6</p>		<p><u>Δ - NNT</u></p>
<p>4:00 PM</p>		
	<p>Baby - well</p>	<p><u>Advice</u></p>
	<p>Euthemic.</p>	<p>1) warmth over</p>
	<p>accepting feeds well</p>	<p>2) SSPT C-eyes &</p>
	<p>conf</p>	<p>genitalia covered.</p>
	<p>tone good.</p>	<p>3) SBR 7m after</p>
	<p>activity</p>	<p>rounds.</p>
		<p>4) feeds 2nd half. fib.</p>
	<p>RTS : OLA (+)</p>	<p>bumping.</p>
	<p>PIA : SSPT.</p>	<p>5) monitor vitals.</p>
	<p>WS : SIB₂ (+).</p>	
		<p>plg 15/6</p>
		<p><u>Plan</u></p>
<p>15/6</p>		
<p>8 PM</p>		
	<p>euthemic</p>	<p>ct. same</p>
	<p>norm</p>	<p>SBR 7m same</p>
	<p>MTA - good</p>	
	<p>ritan - stable -</p>	<p>norm</p>

noted by Anita 15/6/26 @ 8 PM.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>16/06</u>	C/S/B Dr. David	
<u>10/06</u>	D6 7 NNY	
	↓ SSP1	<u>Plan</u>
	euthrombic	continue SSP1
	warm	DBF & 2-3rd hly
	CT/A - good	Hb husp
	neuro - stable	warm case
	C/S RS PIA ↓ ⊙	Monitor vitals
		trace SBA
		Discharge
		Plan after 2 day
		<u>Asst</u>



NURSING ASSESSMENT SHEET IN EMERGENCY ROOM

Ref.No. : F/ER/NUR/

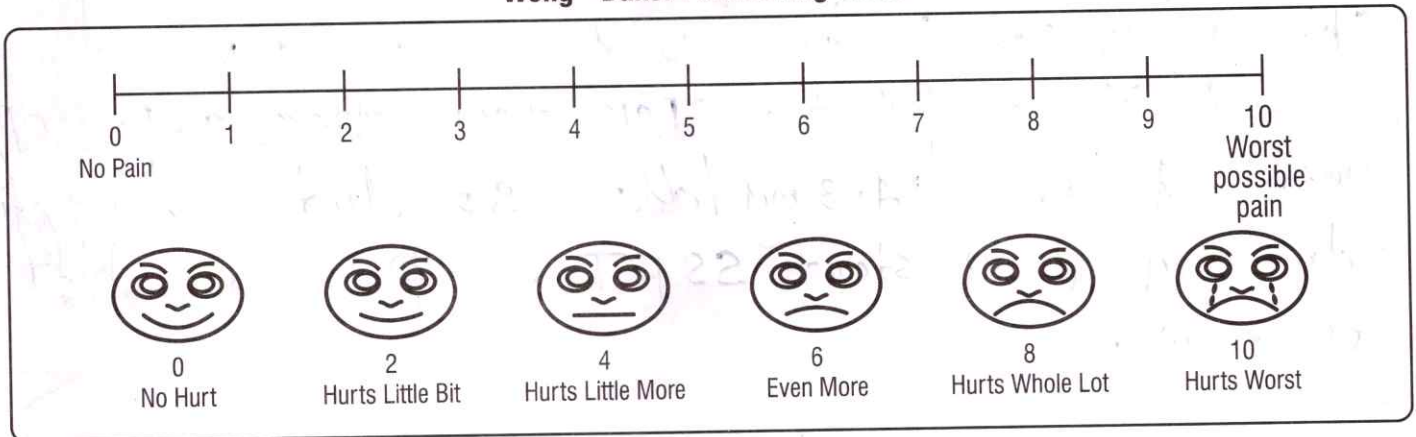
Name : ..KOH-00308781
 Baby Of MAMATHA BEVARA IP2-00056558
 Age :10-06-2026 0 Y 0 M 5 D (F)
 IP No.: ..Dr. DAVID SUVARNARAJU PARIMI
 UHID : ..
 F

Date : ..15/6/26 Time of arrival : ..11.53 am

VITALS : Temperature : ..37.9° F HR : ..136 b/m SP02 : ..97%

BP : ..- RR: ..40 bn/m Height : .. Weight : ..3.45 kg

PAIN ASSESSMENT - ABOVE 5 YEARS Wong - Baker Pain Rating Scale



Do you have pain now : Yes No, If yes location of pain : ..

Pain Score : ..

Plan of action if score > 5 : ..

PAIN ASSESSMENT FOR CHILDREN < 5 YEARS AGE

CATEGORY	SCORING		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown withdraw disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth tense	Arched, right or jerking
Cry	No cry (awake or asleep)	Moans or whimpers Occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching hugging or being talked to, distractible	Difficult to console or comfor

Investigation sent	Time	Result Collected	Result to be collected

Nursing Notes: Patient came to ER with a/o (yellowish discoloration) skin & eyes. Doctor assess the child. vitals are checked & recorded it. TCB test done as per op basis & its 14.3 mg/dl. so, doctor advice for admission & to start SSPT. Patient shift to room.

DISCHARGED FROM EMERGENCY ROOM TO :

- Ward
 OT
 HOME
 DAMA
 Died
 PICU
 NICU
 MICU
 Labour Room

Nurse Signature

Nurse Name :

Date : 15/6/26 Time : 12pm

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 Baby Of MAMATHA BEVARA
 10-06-2026 0 Y 0 M 5 D (F)
 Dr. DAVID SUVARNARAJU PARIMI



RESULT SHEET

Date	16/6/26				
Time	6:18 AM				
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	0.1 11.6 < 11.5				
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					

Date	15/6/20				
Time					
CUE - Alb					
CUE - Sugar					
CUE - Ketones					
CUE - PUS Cells					
CUE - RBC Cells					
CUE					
Stool Pus Cell					
OVA / Cyst					
Occult Blood					
5/6/20 1-3 bars TEB (Opbasis)	14.3				

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :

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.Pulse Rate : Normal Rate by Age (beats/minute) Reference:PALS Guidelines, 2015

Age	Awake Rate	Sleeping Rate	
Neonate(<28days)	100-205	90-160	
Infant (1 month-1yr)	100-180	90-160	
Toddler (1-2yr)	98-140	80-120	
Preschool (3-5 yr)	80-120	65-100	
School -age (6-11yr)	75-118	58-90	
Adolescent (12-15yr)	60-100	50-90	

Respiratory Rate: Normal Respiratory Rate by Age (breaths/minute) Reference:PALS Guidelines, 2015

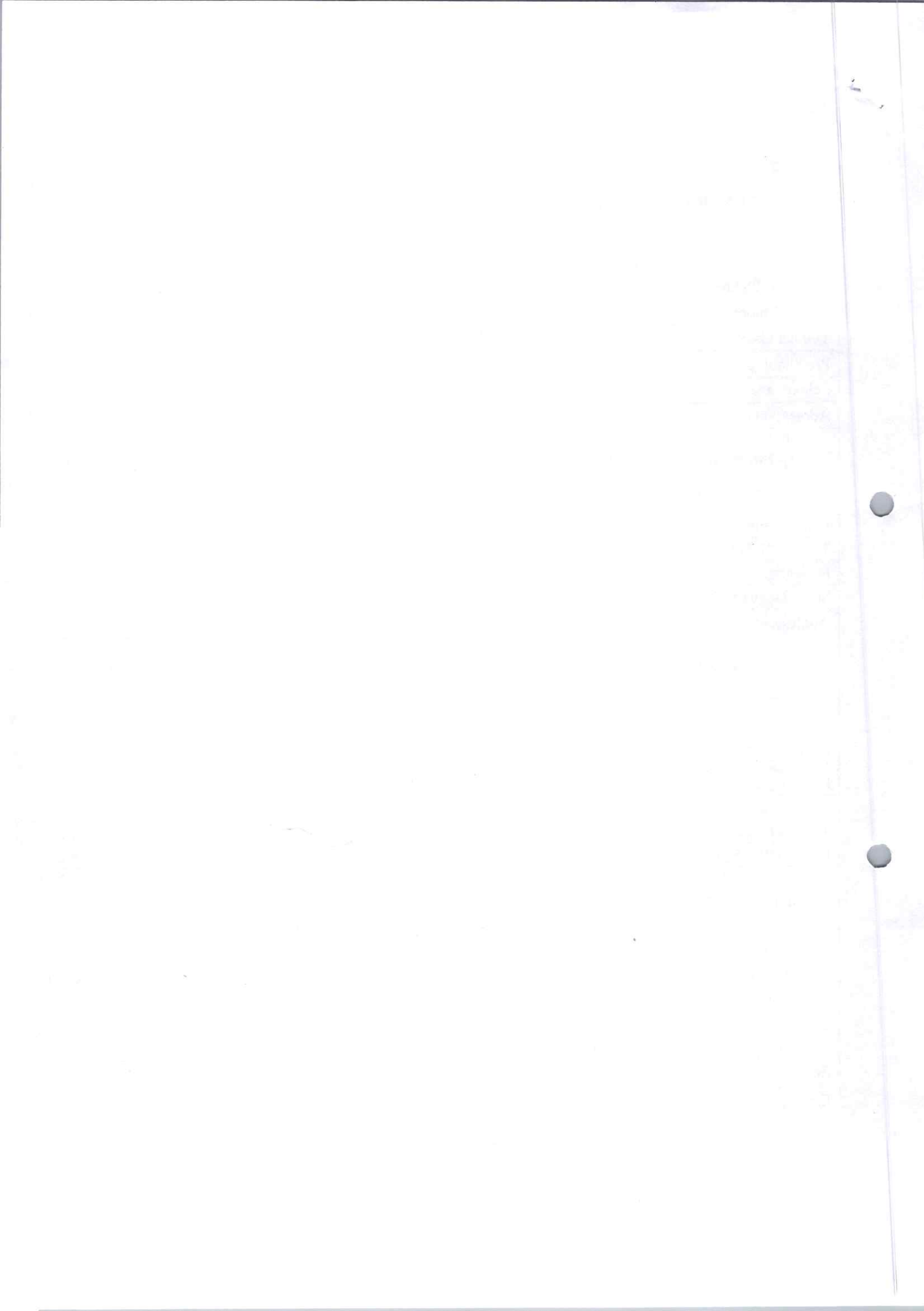
Age	Normal Respiratory Rate		
Infant (1 month-1yr)	30-53		
Toddler (1-2yr)	22-37		
Preschool (3-5 yr)	20-28		
School -age (6-11yr)	18-25		
Adolescent (12-15yr)	12-20		

Blood Pressure:Normal Blood Pressure by Age (mm/hg) Reference:PALS Guidelines, 2015

Age	Systolic Pressure	Diastolic Pressure	Systolic Hypo tension
Birth	39-59	16-76	<40-50
Birth	60-76	31-45	<50
Neonate(<28days)	67-84	35-53	<60
Infant (1 month-1yr)	72-104	37-56	<70
Toddler (1-2yr)	86-106	42-63	<70 + (age in years x 2)
Preschool (3-5 yr)	89-112	46-72	<70 + (age in years x 2)
School -age (6-11yr)	97-115	57-76	<70 + (age in years x 2)
Pre-adolescent (10-11y)	102-120	67-80	<90
Adolescent (12-15yr)	110-132	64-83	<90

Temperature :Normal Temperature Range by Method Reference: CPS Position Statement on Temperature Measurement in Pediatrics, 2015

Method	Normal Range (°C)	Normal Range (°F)
Rectal	36.6-38	97.8-100.4 °F
Ear	35.8-38	96.4-100.4 °F
Oral	35.5-37.5	95.9-99.5 °F
Axillary	36.5-37.5	97.7-99.5 °F





VITALS CHART

Date →	15/6/26									
Time ↓	Temp	HP	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am										
8.00 am										
9.00 am										
10.00 am										
11.00 am	97.5 F	136b/m	40w/m	97%	0	DBM		✓	-	↓
12.00 pm										
1.00 pm						DBM		U-1	m-0	V-0
2.00 pm										
3.00 pm						DBM		✓	✓	
4.00 pm									✓	↓
5.00 pm								✓	✓	
6.00 pm	98° F	138	40	99%		DBM		✓		↓
7.00 pm										
8.00 pm						DBM		U-3	m-3	V-
9.00 pm								✓	✓	↓
10.00 pm						DBM			✓	
11.00 pm	98.1 F	134	40	99%		DBM		✓	✓	↓
12.00 am						DBM		✓	✓	
1.00 am										
2.00 am						DBM		✓		
3.00 am										
4.00 am						DBM				
5.00 am	98.1 F	130	39	100%		DBM			✓	↓
6.00 am						DBM				
								U-3	m-3	V-0
								U-7	m-6	V-
						TOTAL				

Temperature 97.5 to 99.5 F
HR 120 to 160 per minute
RR 30 to 60 per minute
SP02 93-100%

Feeding Plan..... DBM

Morning Shift

Clinical Diagnosis: Yellowish discoloration of skin
Nursing Diagnosis: Yellowish discoloration of skin

Plan of Care: To assess the baby condition and eyes
maintained the vitals
→ Checks the vitals

Planned Investigations Procedures: None
Implementation: To assess the baby condition
maintained the vitals
→ Checks the vitals
→ provided SSPT

Handed Over by: Name & Signature Laxmi 15/6/26
apm Received by: Name & Signature Laxmi 15/6/26
@apm

Evening Shift

Clinical Diagnosis: Yellowish discoloration of eyes & skin
Nursing Diagnosis: Yellowish discoloration of eyes & skin

Plan of Care: → Assess Baby Condition
→ Check the vitals
→ Monitor I/O chart

Planned Investigations Procedures: None
Implementation: → Assessed Baby condition
→ checked vitals
→ monitored I/O chart
→ Encouraged feeds & Bumping

Handed Over by: Name & Signature Laxmi 15/6/26
@8pm Received by: Name & Signature Pooja 15/6/26

Night Shift

Clinical Diagnosis: Yellowish discoloration of the skin
Nursing Diagnosis: Yellowish discoloration of the skin

Plan of Care: → Assess the baby condition
→ checked vitals

Planned Investigations Procedures: SBR T/M 6 AM
Implementation: → Assess the baby condition
→ checked vitals
→ provided SSPT
→ provided feeding

Handed Over by: Name & Signature Pooja 15/6/26
@8pm Received by: Name & Signature Radhika 16/6/26