

ACTIVITY RECORD FOR BILLING

Name: **KOH-00308785** IP2-00056515
Baby Of ANKITA BHATIA
 UHID No: **10-06-2026** 0 Y 0 M 0 D 3 H (M) ----- Consultant : ----- Dept : -----
Dr. DAVID SUVARNARAJU PARIMI
 Date of Admission: ----- Time: ----- Date of Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/6/26	4:45pm	4W	407	<i>[Signature]</i>

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
10/6/26	Blood group / Retic Count DCT / SBR	26007997	TW
10/6/26	ABG	26008000	TW
10/6/26	GRBS @ 9pm - 64 mg/dl	26008007	TW
10/6/26	GRBS @ 10:45pm - 7 mg/dl	26008008	TW
<p>cross checked done by <u>Deep</u> 10/6/26</p>			
11/6/26	GRBS 82 mg/dl @ 2pm ^{6th hrly}	26008035	Sis. Laxmi
11/6/26	GRBS 73 mg/dl @ 7am ^{12th hrly}	26008036	71
11/6/26	GRBS ⁶¹ mg/dl at 8pm	26008088	Sendhya
12/6/26	GRBS - 117 mg/dl 8pm	26008163	Sushma
12/6/26	SBR, NBS	26008164	Sushma
<p>cross checked done by <u>Anita</u> 13/6/26 @ 6am</p>			

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
11/6/26	D.P.V	}	done	Sondhya
	B.C.G			
	Hep-B			
11/6/26	D.A.G	①	944939	Sondhya
cross checked done BY Anitha 13/6/26 @ 6AM				

ANY OTHER INFORMATION

Baby kit given

Date: 10/6/26

Time: 10pm

Prepared By: Tyasa

Staff Nurse <u>Tyasa</u>	Shift / Ward 400 ↓ 402 Anitha	Billing Assistant	Billing Supervisor
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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Ankita Bhatia Age : Father's Name : Age :
 Date of Birth : 10/8/1987 Date of Admission : UHID No.:
 NICU Consultant : Dr. David 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 Ankita Mother's Blood Group : O-ve FBG - B+ve
 Gender : M F Blood Group :
 Date of Birth : 10/6/26 Time of Birth : 7.45pm Birth Weight (gms) : 3054 gm Length (cms) :
 Place of Birth : RCH OFC (cms) :
 Estimated Gesth Age : 37+5 wks

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 38y1 Ht : Wt : BMI : Married Life : LMP : 23/9/25 EDD : 26/1/26
 Conception : Spontaneous or with Rx :
 Booked at what GA. : 5+5 AN Steroids Drugs / Doses :
 Last Scans Details : 30/1/26 cephalic, 2824g, AC-80%, AFI-17.7cm, PL-AH, Doppler - (N)
 TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : <18 yrs > 35yrs
 Consanguinity : Yes No
 If yes, degree of consanguinity : 1 2 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 / REDF / Redistribution in MCA) / Ductus Venosus :
 AFI :

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
 (Malaria UTI TORCH TB HIV HBV)
 UTI : when : Any culture :

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



PAST OBSTETRIC HISTORY

U: P: A: L:

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
I	- LSCS		15, 3kg	Male	Anti D telen	
II	- PP					

PERINATAL HISTORY

Treating Obstetrician : Dr. Hauwhe Hospital : RCM Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig)</p> <p>Second stage (> 2 hours after dilation)</p> <p>LSCS : <input type="checkbox"/> Elective <input checked="" type="checkbox"/> Emergency Indication :</p> <p>Specify the reason : <u>prev. lvs in labour</u></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>
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NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : 27+5 Weeks :

SIGN	0	1	2
COLOUR	Blue or Pale	Acrocyanotic	Completely Pink
HEART RATE	Absent	< 100 Minutes	> Minutes
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	
	1	2	
	2	2	
	2	2	
TOTAL	<u>8/10</u>	<u>9/10</u>	

Resuscitation			
Minutes	1	5	10
Oxygen			
PPV / NCPAP			
ETT			
Chest Compressions			
Epinephrine			

Snapee II Score

	> 30 (0)	20-29 (9)	< 20 (19)	
Mean BP (mmHg)	> 96 (0)	96-95 (8)	< 95 (15)	
Lowest Temp (oF)	> 2.49 (0)	1-2.49 (5)	0.3-0.99 (15)	< 0.3 (28)
Pao2 / Fio2 (mmHg%)	> = 7.2 (0)	7.1-7.19 (7)	< 7.1 (16)	
Lowest Serum PH	No (0)	Yes (19)		
Multiple Seizures	> = 1 (0)	0. 1-0.9 (5)	< 0.1 (18)	
U. Output (ml / kg / hr)	> = 7 (0)	< 7 (18)		
Apgar Score	> = 1kg (0)	750 - 999 (10)	< 750 (17)	
Brith Weight	> 3rd percentile (0)	< 3rd (12)		
SGA				

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

Baby Of ANKITA BHATIA
10-06-2026 0 Y 0 M 0 D 3 H (M)
Dr. DAVID SUVARNARAJU PARIMI

Patient Sticker



History of Present Illness

Baby UAS



Dried and warmed



cord clamped and cut



If wt k imp in given



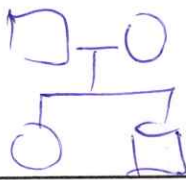
Baby vigorous

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :



Socio Economic History :



GENERAL EXAMINATION ON ADMISSION

General Disposition :

app
tone good
awake

VITALS : Temperature : HR : RR : NIBP : CFT :

Color of the extremities : *Acrocyanosis*

Jaundice : Pallor : SpO2 :

Anthropometry : Birth Weight : *3054* Length : HC : Present Weight :

Ponderal Index : AGA SGA : LGA :

HEAD TO TOE EXAMINATION

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

1-2

Facies :
 (Any Facial
 Dysmorphism)

1-2

**NECK and
 CLAVICLES :**
 Range of Motion :
 Asymmetry :
 Masses :

1-2

EYES :
 Symmetry :
 Red Reflex : *- eye to be checked*
 Discharge :

**EARS, NOSE
 MOUTH and
 THROAT :**
 Ear set / Shape :
 Periauricular Pits / Tags :
 Nasal shape / Patency :
 Palate :
 Gums :
 Lips :
 Tongue :

1-2

THORAX and BREASTS :

Shape of Thorax :
Position of Nipples and Number : 1~

ABDOMEN and UMBILICUS :

Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump : - 2A + 1V
Discharge :

GENITILIA :

Labia / Hymen :
Testicles / penis :
Anus : - patent

HERNIAL ORIFICES

free

TRUNK and SPINE :

1~

SKIN LESIONS :

1~

EXTREMITIES :

Fingers / Toes :
Deformities :
Hip Joint Examination :

Arms / Legs :
Mobility :

SYSTEMIC EXAMINATION

Respiratory System :

Breathing Pattern : Regular Periodic Shallow Gasping

Mention If baby has Respiratory distress : RR : 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 : ASI Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 155 BP : Precordial Activity :

Femoral Pulses : Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : N
Palpation : soft
Palpable masses :
Abdominal girth :

Hernia orifice : free
Anal Patency : patent
Umbilical Cord : 2A + 1V
First urine passed :
Meconium passed :

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

1/2

Nerves :

1/2

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

ATNR : Skull and Spine :

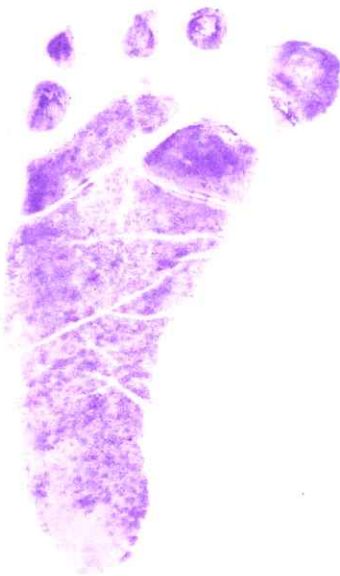
1/2

Any Congenital Anomalies :

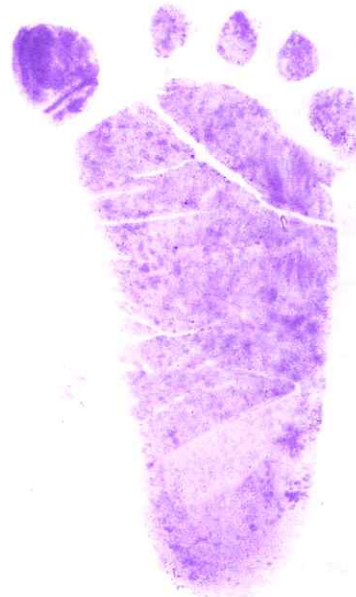
Diagnosis :

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : flaw

Name : flaw

Date & Time : 10/6/26, 7.41pm

Consultant :

Signature : rosy amir

Name : ulka lob

Date & Time :

Patient Sticker

DISCHARGE PLAN

Information given by: Family Friend

Will patient require transportation arrangements to go home: Yes No NA

Will Physiotherapy require at home: Yes No NA

Is home medical equipment anticipated: Yes No NA

Is home oxygen therapy anticipated: Yes No NA

Breastfeeding Yes No NA

Formula Feed Yes No NA

Are dressing needs at home anticipated: Yes No NA

Any other needs anticipated: Yes No If Yes Specify

Feeding Plan at the time of shifting :
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Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Discharge Details:

Neonatal Condition at Discharge:

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.....
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Feeding: Breastfeeding exclusively Breastfeeding and Formula Feeding Formula Feeding

Vitamin K given: Yes No

Vaccinations given BCG Hepatitis B Others:

Neonatal Screen Taken: Yes No, parents advised to have Neonatal Screen at National screening program center on:/...../.....

Hearing Test: Yes No

Jaundice: NIL Slight Moderate

Passed Urine: Yes No

Passed Meconium: Yes No

Weight at discharge:

Appointment was given for follow-up at OPD: Yes No

Date of Discharge:/...../.....

Discharge to Home Other:

Against Medical Advice: Yes No

Referred to another hospital: Yes No

Discharge Medications: Yes No

Details:

Final Diagnosis: C.P.L. 37+5w4 | T | Em. UCL (prev. UCL in labour)
CIAB (Mole 13054 f | AGA
M - GDM (Insulin)
Rh -ve preg

Doctor Signature: [Signature]

Doctor Name: [Signature]

Date & Time: 10/6/26, 7-11 pm

Down syndrome
 1: 294 (Intermed)
 NIPT - low risk

- plac
- Wt loss cau
- Feeds 2nd by PB bump
- OAF
- vaccination
- CRBS monitoring
3, 6, 12, 24, 48 hr
Input of 450
- (Hb) SBK, DLT, Reti count
Blood group in cord sample



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/26 9 a.m.	S/S Dr. David T 37+5 u	CNS / M 13054 12M Rheum preg
to replace	Baby well Accepting feed. Cry Tone / good activity	
	Moro's - complete Oral cavity Extremities Genitalia Spine Hip joint Red reflex :	Plan - Warm ear - Feeds 2 nd by rib bumping - GRRS monitoring Inform if < 10
	(check nodules)	
Noted by Sindhya 11/6/26 @ 9:00		

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 Baby Of ANKITA BHATIA
 10-06-2026 0 Y 0 M 2 D (M)
 Dr. DAVID SUVARNARAJU PARIMI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/2	CIB - Regular	
4:30 pm	TC 37.5) MCH 13054 / HbM 1 Rb me	
	Reflex	
	accepting DBP - well	
	No fresh lochia	
	C/I in good	Adv
	vital - stable	- Klausen care
	C/S	- DBF 116 bump
	R/S (N)	- SBR, MBS @ 4 8 H O L
	PIA	
		- GRBS @ 4 8 H O L
	Noted by Sandhya	12/06/26 @ 4:30 a



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/1/26		
10/06/26	s/s Dr. David	
	T M 2054g Rh ⁺	
	Baby well	
	Aceptly feeds	
	w/	
	time sud	plan
	activity	- Warm can
	CB: 1, 1, @	- SBR, NBS
	RI: 2 AF @	@ UPHNL
	PIA: 10g?	
12/1		noted
3-20p	s/s by	
	T M 2054g Rh ⁺	
	No issue.	
	Baby well	plan
		- Warm can
		- SBR, NBS @
		UPHNL
	* Noted by. Sushama	12/06/26 @ 3:30p

KOH-00308785 IP2-00056515
 Baby Of ANKITA BHATIA
 10-06-2026 0 Y 0 M 2 D (M)
 Dr. DAVID SUVARNARAJU PARIMI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6	qs/m Dr. David	
	A3/T) male 3854 gm Rh -ve ♀	
	2.827	<u>Plan</u>
	(7.4% ↓)	D/C today
	euthermic	
	warm	Pup Monday
	U/A - good	
	vitals - stable	- TCB - allow & inform
	C/S	if > 12 - DSPT
	R/S	
	P/A	
	(N)	
		noted by
		Sandhya 13/6/26 @ 10A



RESULT SHEET

Patient Name

Age :

I.D. No. :

KOH-00308785 IP2-00056515
 Baby Of ANKITA BHATIA
 10-06-2026 0 Y 0 M 2 D
 Dr. DAVID SUVARNARAJU PARIMI (M)



Date	12/6/26				
Time	@ 3:26 pm				
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	9.65 ^{0.9} 9.4				
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						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Doctor's Signature						

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :



KOH-00308785 IP2-00056515
 Baby of ANKITA BHATIA
 10-06-2026 0 Y 0 M 0 D 3 H (M)
 Dr. DAVID SUVARNARAJU PARIMI

10/6/26

VITALS CHART

Date →	Temp	HR	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										
12.00 pm										
1.00 pm										
2.00 pm										
3.00 pm										
4.00 pm										
5.00 pm										
6.00 pm										
7.00 pm	96.1°	146	50	100%						
8.00 pm										
9.00 pm	35.2°	139	49	98%	DBM	DBF				
10.00 pm										
11.00 pm	36.1°	140	48	99%		DBM				
12.00 am										
1.00 am								✓		
2.00 am						DBM				
3.00 am									✓	
4.00 am										
5.00 am						DBM				
6.00 am	98°F	142	46	100%					✓	
								U-1	M-1+	V-0
						TOTAL		U-1	M-2	V-0

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

DBF

Feeding Plan.....

Morning Shift

Clinical Diagnosis.....

Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

NIL

Handed Over by : Name & Signature

Received by : Name & Signature

Evening Shift

Clinical Diagnosis.....

Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

NIL

Handed Over by : Name & Signature

Received by : Name & Signature

Night Shift

Clinical Diagnosis..... *New born*

Nursing Diagnosis..... *New born care*

Plan of Care * *Asses condition of the baby* * *Monitor vital*
* *DBP 2nd hourly* * *Warm Care*
* *GRBS monitor as per Order*

Planned Investigations Procedures

Implementation * *Baby is stable* * *monitored vitals*
* *DBP 2nd hourly* * *Warm Care given*
* *GRBS monitored* * *Maintained temp by*

Handed Over by : Name & Signature

Received by : Name & Signature

Tyass @ 11:45pm *Sandhya 11:01/26*

11/6/26

VITALS CHART

Date →	Temp	HP	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am										
8.00 am						DBM				
9.00 am										
10.00 am	96.2°f	144	42	99%		DBM			I	I
11.00 am								✓		
12.00 pm						DBM				
1.00 pm	97.4°f	130	33	100%		DBM				
2.00 pm								U-1	M-0	V-0
3.00 pm						DBM		✓		
4.00 pm										
5.00 pm						DBM		✓		
6.00 pm	98.0°f	138	40	100%				✓	✓	I
7.00 pm						DBM				
8.00 pm								U-02	M-01	V-00
9.00 pm						DBM				
10.00 pm	98.5°f	148	40	99%						
11.00 pm						DBM				
12.00 am								✓		
1.00 am						DBM				
2.00 am										
3.00 am						DBM				
4.00 am										
5.00 am						DBM				
6.00 am	97.9°f	144	48	99%				✓	✓	
								U-2	M-1	V-0
								U-5	M-2	V-0
						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.....
Nursing Diagnosis..... ^{NB} New born care

Plan of Care → Assess the baby condition
→ check the vitals
→ maintain I/O chart

Planned Investigations Procedures

Implementation → Assessed the baby condition
→ checked the vitals
→ maintained I/O chart

Handed Over by : Name & Signature
Pragya 11/6/26 @ 8PM

Seema @ 8PM
Received by : Name & Signature
8/11/6/26

Evening Shift

Clinical Diagnosis.....
Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

NA

Handed Over by : Name & Signature

Received by : Name & Signature

Night Shift

Clinical Diagnosis.....
Nursing Diagnosis..... ^{NB} New born care

Plan of Care * Assess the baby conditions
* check vital signs
* maintain I/O chart

Planned Investigations Procedures

Implementation * Assessed the baby condition
* checked vital signs
* maintained I/O chart
* Encourage D/BM feeds

Handed Over by : Name & Signature
Seema @ 8PM

Received by : Name & Signature

8/12/6/26



VITALS CHART

Date →	18/6/26									
Time ↓	Temp	HP	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am						DBM				
8.00 am										
9.00 am						DBM				
10.00 am								↓	✓	↓
11.00 am										
12.00 pm	97.5°	133	34	100%		DBM				
1.00 pm										
2.00 pm						DBM		U-0	M-1	V-0
3.00 pm						DBM		✓		
4.00 pm									↓	↓
5.00 pm						DBM				
6.00 pm	98.0°	139	40	100%				✓	↓	↓
7.00 pm						DBM		U-0	M-00	V-00
8.00 pm										
9.00 pm						DBM				
10.00 pm	97.5°	148	42	100%						
11.00 pm						DBM		✓	✓	↓
12.00 am										
1.00 am						DBM				
2.00 am										
3.00 am						DBM				
4.00 am								✓	✓	↓
5.00 am						DBM				
6.00 am	98.7°	144	44	99%						
								U-2	M-2	V-0
						TOTAL		U-4	M-3	V-

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..... NB

Nursing Diagnosis..... NO complaints

Plan of Care .. ASSESS the baby condition.
checked vital sign
maintain the chart

Planned Investigations Procedures ..

Implementation .. ASSESS the baby condition.
checked vital sign
maintain the chart

Handed Over by : Name & Signature
Sandhya
12/6/26 @ 2PM

Received by : Name & Signature
Sunita
12/6/26
@ 8PM

Evening Shift

Clinical Diagnosis.....

Nursing Diagnosis.....

Plan of Care ..

Planned Investigations Procedures ..

Implementation ..

Handed Over by : Name & Signature

Received by : Name & Signature

Night Shift

Clinical Diagnosis..... NB

Nursing Diagnosis.....

Plan of Care .. ASSESS the baby condition
maintain the chart
provide warm care

Planned Investigations Procedures ..

Implementation .. ASSESS the baby condition
maintained the chart
provided warm care

Handed Over by : Name & Signature
Sunita
13/6/26 @ 8AM

Received by : Name & Signature
Sandhya
13/6/26 @ 8PM