

5/6/26

**ACTIVITY RECORD FOR BILLING**

Name: ----- **KOH-00308761 IP2-00056468** -----  
**Baby Of PIRIDI MOUNIKA**  
 UHID No: ----- **05-06-2026 0 Y 0 M 0 D 1 H (F)** -----  
**Dr. KADIRI BHANU VARUN KUMAR**  
 Date of Admission: ----- Date of Discharge: ----- Time: -----  
 Room / Bed No: ----- Ward: **Yw** ----- Suggested Billable bed type: -----


**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
5/6/26	11:00 AM	Yw	Y11	[Signature]

**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
5/6/26	Blood grouping	26007751	
	cross checked	by sis Deepika	5/6/26
7/6/26	SBR, TFT	26007864	Chand
	cross checked by Chandmai @ 7/6/26 @ 10:30 AM		



**PROCEEDURE**

Date	Proceedure	Quantity	Order No.	Signature
5/6/26	O.P.V	}		
	B.C.G		done	Sandy a
	HEP-B			
7/6/26	O.A.E	①	943853	Sushu

**ANY OTHER INFORMATION**

-----  
 -----  
 Baby kit given  
 -----  
 -----  
 -----

Date: 5/6/26

Time: 11:40 AM

Prepared By: Tijasa

<p>Staff Nurse</p> <p>Deepika</p>	<p>Shift / Ward</p> <p>1100 to 1111 Sandy</p>	<p>Billing Assistant</p>	<p>Billing Supervisor</p>
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# NEONATAL IN-PATIENT MEDICAL RECORD

## ADMISSION INFORMATION

Mother's Name : Mounika Age : ..... Father's Name : ..... Age : .....  
 Date of Birth : ..... Date of Admission : ..... UHID No.: .....  
 NICU Consultant : ..... 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 Mounika Mother's Blood Group : A+ve  
 Gender :  M  F Blood Group : .....  
 Date of Birth : 5/06/26 Time of Birth : 7:08am Birth Weight (gms) : 3288 Length (cms) : .....  
 Place of Birth : Kandapur OFC (cms) : .....  
 Estimated Gesth Age : 38+2

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 31 yrs Ht : ..... Wt : ..... BMI : ..... Married Life : ..... LMP : 4/9/24 EDD : 17/6/26

Conception : Spontaneous or with Rx : .....

Booked at what GA : 20+2 AN Steroids Drugs / Doses : .....

Last Scans Details : 29/5 - 37+5 | cephalic | 3236 gm | 64% | AFI-13.3cm  
PL - A/H, VAD - (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 / Redistribtion 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?  
on Thyronorm  
 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 : .....



History of Present Illness:

Equipment check done

↓

Many CIAB

↓

received ↓ warmer

VC clamped & cut (dA+IV)

Inj. vit K 1mg IM given

↓

vitamin status .

Investigation details in previous Hospital :

—

Feeding History :

—

Past History :

—

Family History :

—

Socio Economic History :

—

**GENERAL EXAMINATION ON ADMISSION**

General Disposition :

VITALS : Temperature : ..... HR : 152 bpm RR : ..... NIBP : ..... CFT : .....

Color of the extremities : ..... acrocyanosis (P)

Jaundice : ..... Pallor : ..... SpO2 : 97.1 .

Anthropometry : Birth Weight : 3.288 Length : ..... HC : ..... Present Weight : .....

Ponderal Index : ..... AGA : ..... SGA : ..... LGA : .....

**HEAD TO TOE EXAMINATION**

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

**Facies :**  
(Any Facial  
Dysmorphism)

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

**EYES :** Symmetry : .....  
Red Reflex : to be seen  
Discharge : .....

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

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

**ABDOMEN and UMBILICUS :** Shape : (N)  
Organomegaly : No  
Bowel Sounds :  
Umbilical Stump : 2A+IV  
Discharge :

**GENITILIA :** Labia / Hymen : (N)  
Testicles/penis :  
Anus : patient

**HERNIAL ORIFICES** appears free

**TRUNK and SPINE :** (N)

**SKIN LESIONS :** -

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

**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 : .....  
SpO<sub>2</sub> : 97% ..... Auscultation : ..... Breath Sounds : ..... Added Sounds : .....

**Cardiovascular System :**  
HR : 152bpm ..... BP : ..... Precordial Activity : (N)  
Femoral Pulses : B/L palpable ..... Murmurs : -  
Other Peripheral Pulses : ..... Signs of Cardiac Failure : -

**Abdomen :** Hernia orifice : appears free  
Shape : (N) ..... Anal Patency : patient  
Palpation : soft ..... Umbilical Cord : 2A+IV  
Palpable masses : No ..... First urine passed : .....  
Abdominal girth : ..... Meconium passed : .....

**Nervous System** : Higher intellectual functions (Sensorium) : .....

State of wakefulness : .....

Prechtle Score : ..... C/T/A - good

Nerves : .....

**Motor System :**

Passive Tone : ..... | (N)

Active Tone : .....

Neonatal Reflexes : .....

Grasp :  Palmar  Plantar  Sucking  Rooting  Crossed adductor : .....

Moro's : ..... symmetrical DTR : .....

ATNR : ..... Skull and Spine : ..... (N)

Any Congenital Anomalies : .....

Diagnosis : ..... T | 38+2 | E. & SCS | F | CIAD | AGA .  
3.28 kg.

**FOOT PRINTS**

Left Side :



Right Side :



**Resident Doctor :**

Signature : ..... Dr. Bhup

Name : ..... Dr. Bhavani

Date & Time : ..... 5/06/26

**Consultant :**

Signature : .....

Name : .....

Date & Time : .....



DIS

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 : .....

plan

BF @ 2-3<sup>rd</sup> hourly  
PB burp

Warm care

Screenings done during NICU Stay :

NSG : .....

vaccines /  
OAE / today

Hearing Screen : .....

ROP : .....

Monitor near

TFT : .....

NP2 : .....

SBP /  
NBS / @ 48 HOU

Discharge Details:

Neonatal Condition at Discharge:

Bnapp

Patient Sticker

**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: .....

.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....

Doctor Signature: *[Handwritten Signature]* .....

Doctor Name: *D. Mhere* .....

Date & Time: *7/6/2016* .....





## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6		
10 AM	S/R Dr. Varun	
	T   38+2 wks   USG	F   3.288 kg
AFC/A	Baby well	
A	Accepting feeds	
G.I	cy	
10 AM	tone   good	plan
	activity	- Warm can
		- feeds 2nd by b/b
		bump
		- OAE
		- SBR, NRS @ USG

*[Signature]*

Noted by Chandmani @ 10 AM 6/6/26



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26	SIP. Registered	
8:35 pm	T (35+L) (LUL) F / 3.235ly	
	Lethargic	
	warm	
	accepting DBT well	NIC
	GIT/A - good	- alarm call
	vital stable	- feed. 2 hrs - 1lb keeps
		- OAC
		- SBR, AIBS @ 45 + 0L
	<p>Noted by Smadhya 6/6/26 @ BIRBH</p>	
		EF

KOH-00308761 IP2-00056468

Baby Of PIRIDI MOUNIKA

05-06-2026 0Y0M0D1H (F)

Dr. KADIRI BHANU VARUN KUMAR



# PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
n/b sun	4/5 Aug 21/2026	
	Term 38 <sup>+</sup> 2   ELUSUS (previous)   CIAS	
	o/s 4/11/21: post	warm care
	peripheric: warm	D RR 2nd baby 16/10/21
	etc.	SRR, NRS now
		D AE

KOH-00308781 IP2-00056468  
 Baby Of PRIDI MOUNIKA  
 05-06-2026 0 Y 0 M 2 D (F)  
 Dr. KADIRI BHANU VARUN KUMAR



## RESULT SHEET

Date	7/06/26				
Time	10:41				
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	10.6	0.1			
T.Protein	10.5				
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					



28/26



**VITALS CHART**

Date →	Temp	HR	RR	SPO <sub>2</sub>	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am	36.1°	143	50	100%	9/10					
8.00 am						DBF	(1)	-	-	-
9.00 am	36.2°	145	51	98%	9/10					
10.00 am						DBF				
11.00 am	36.5°	150	50	99%	9/10					
12.00 pm						DBM.				
1.00 pm								U-00	M-00	V-00
2.00 pm						DBM				
3.00 pm										
4.00 pm						DBM				
5.00 pm										
6.00 pm	98°F	140	41	100%		DBM				
7.00 pm								U-0	M-0	V-0
8.00 pm						DBM				
9.00 pm										
10.00 pm	97.5°	142	41	100%		DBM				
11.00 pm										
12.00 am						DBM				
1.00 am										
2.00 am						DBM				
3.00 am										
4.00 am						DBM				
5.00 am										
6.00 am	98°F	140	41	100%		DBM				
								U-3	M-3	V-0
						<b>TOTAL</b>		U-3	M-5	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 with in One hour

Feeding Plan.....

**Morning Shift**

Clinical Diagnosis... New born  
Nursing Diagnosis... New born Care

Plan of Care \* Assess condition of the baby \* Monitor vitals  
\* Provide warm care \* Provide cord care  
\* DBF and hourly \* Maintain hand hygiene

Planned Investigations Procedures

Implementation \* Assessed baby's condition Monitored vitals  
\* Provided warm care \* Provided cord care  
\* DBF and hourly \* Maintain hand hygiene  
(Deeplks)

Handed Over by : Name & Signature Sapthika  
5/6/26

Received by : Name & Signature Seema @ 2PM  
5/6/26

**Evening Shift**

Clinical Diagnosis... NB  
Nursing Diagnosis... New born care

Plan of Care \* Assess the baby condition  
\* check vital sign  
\* Maintain I/O chart

Planned Investigations Procedures

Implementation \* Assessed the baby condition  
\* checked vital sign  
\* Maintained I/O chart  
\* Encourage DBM feeds

Handed Over by : Name & Signature Seema @ 8 PM  
5/6/26

Received by : Name & Signature Pooja @ 8PM  
5/6/26

**Night Shift**

Clinical Diagnosis... New born  
Nursing Diagnosis... New born care

Plan of Care \* Assess condition of the baby  
\* Provide warm care  
\* Maintained I/O chart

Planned Investigations Procedures

Implementation \* Assessed condition of the baby  
\* provided warm care  
\* Maintained I/O chart

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

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

6/6/26



**VITALS CHART**

Date →	Temp	HP	RR	SPO <sub>2</sub>	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am										
8.00 am						DBM				
9.00 am										
10.00 am						DBM				
11.00 am										
12.00 pm	98°F	142	42	100%		DBM				
1.00 pm										
2.00 pm						DBM		U-0	M-1	V-0
3.00 pm										
4.00 pm						DBM				
5.00 pm										
6.00 pm	98.2°F	142	48	99%		DBM		<del>U-0</del>		
7.00 pm										
8.00 pm						DBM		U-0	M-0	V-0
9.00 pm						DBM				
10.00 pm	97°F	147	48	100%						
11.00 pm						DBM		✓	✓	
12.00 am										
1.00 am										
2.00 am						DBM		✓	✓	
3.00 am										
4.00 am						DBM		✓	✓	
5.00 am	98°F	142	48	100%						
6.00 am										
								U-3	M-3	V-0
								U-4	M-4	V-0
						<b>TOTAL</b>				

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 .....

6/6/26



**Morning Shift**

Clinical Diagnosis..... NB  
Nursing Diagnosis..... New born care

Plan of Care \* ASSESS the baby condition  
\* check vital sign  
\* maintain I/O chart

Planned Investigations Procedures .....

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

Handed Over by : Name & Signature  
Seema @ 2pm  
6/6/26

Received by : Name & Signature  
Bushra / 018782  
6/6/26 @ 2pm

**Evening Shift**

Clinical Diagnosis..... NB  
Nursing Diagnosis..... Related to new born care

Plan of Care → Asses the baby condition  
→ check for vital  
→ provide warm care

Planned Investigations Procedures .....

Implementation → Assessed the baby condition  
→ checked for vital  
→ provided warm care  
→ encouraged feeding 2-3rd hourly

Handed Over by : Name & Signature  
Narmi / 01864126  
6/6/26 @ 6pm

Received by : Name & Signature  
Roopa / 6/6/26  
@ 5pm

**Night Shift**

Clinical Diagnosis..... NB  
Nursing Diagnosis..... New born care

Plan of Care → ASSESS the baby condition  
→ check vital sign  
→ maintain I/O chart

Planned Investigations Procedures .....

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

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

Received by : Name & Signature  
Chandran  
@ 8 AM  
7/6/26