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Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name :_____ KOH-00308752 IP2-00056470
Baby Of VEMULA BHAVANA
01-06-2026 0 Y 0 M 4 D (F)
Dr. KADIRI BHANU VARUN KUMAR
_____

UHID No. : _____ Consultant: _____ Dept : _____

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
5/6/26	10.49 am	ER	3TD	Pooja 10:49pm

Cross Consultation Visit

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

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
5/6/26	DSPT	11:40 Am		943281	Geetha

INVESTIGATIONS

Date	Investigations	Order No.	Signature
5/6/20	TCB - 17[illegible]9 mg/dl	26007757	Pooja
	INER cross check	done by Uji	5/6/20
5/6/20	SBP. CBP	26007767	
8/06/20	CBP	26007804	
		Cross Checked in Reg	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

* OP file given to parents

Date : 5/6/26 Time : 9.20 AM Prepared By : Pooja

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Pooja	ER TO Geeta		

Ref.No. F/IN/PR/10

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Hospital

PEDIATRIC IN-PATIENT MEDICAL RECORD

KOH-00308752 IP2-00056470
Baby Of VEMULA BHAVANA
01-06-2026 0 Y 0 M 4 D (F)
Dr. KADIRI BHANU VARUN KUMAR

Patient Name : _____

Patient ID# : _____

Consultant : _____

Final Diagnosis : _____ ENT

Organ History & Physical Examination

KOH-00308752 IP2-00056470
Baby Of VEMULA BHAVANA
01-06-2026 0 Y 0 M 4 D (F)
Dr. KADIRI BHANU VARUN KUMAR

Name : _____ Age/Sex _____

Informant _____ Reliability _____

Chief Presenting Complaints & Duration (Chronologically):

yellowish discolouration of eyes & skin

History of present illness :

c/o - yellowish discolouration of eyes & skin

Term (40 wks) | AGA | ♀ | Emlscs (NPOL) |
C/S.

B.wt : 3.420.
T.wt : 3.12

MBG
BBG } A ⊕ -

Pediatric Multiorgan History & Physical Examination

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

Birth & Neonatal History :

See HOPI

Birth & Socio Economic History :

About Father :

About Mother : educated

Any additional Information :

Developmental History :

Immunization History :

as per NIS

Pediatric Multiorgan History & Physical Examination

Anthropometry

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

Weight (kgs)_____(Centile _____)

On Examination :

Temperature : _____ Pulse Rate: _____Description _____

B.P. _____SPO2_____ at _____

Resp. rate and type of breathing : _____

Rash_____

Lymphadenopathy _____

Oedema : _____

Respiratory system :

Inspection (any s/o distress) : _____

Air entry & breath sounds : BAE (+)

Any addes sounds : _____

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

Cardiovasclular System :

Inspection of procordium : _____

Heart Sounds : S_1S_2 (+)

Any murmur : _____

Relevant date from outside (Chest X-Ray, ECG, ECHO, Etc.,) _____

Per Abdomen :

Inspection _____

Palpation : soft.

Ausculation : _____

Spine: _____ External Genitelia : _____

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 :

Nutrition : _____

Tone : _____ Power _____

Co-ordinator : _____

Posture : _____

Involuntary Movements : _____

Reflexes :

DTR **Superficials :**

Plantars _____

Sensory System :

_____

_____

_____

Bladder / Bowel : _____

Clinical Summary & Diagnostic :

_____

_____

NNJ.

_____

_____

Pediatric Multiorgan History & Physical Examination

Preventive aspects of the treatment :

—

Desired goals of the treatment :

—

Planned Labs :

TCB → 17.39 mg/dl

Noted by Bro. Ujjwal
5/6/26 @ 9:30 pm.

→ Send SBR
CBP.
TFT.

Planned Management :

. ~~DSPT.~~ DRRF, 2nd hrly f/b hrly
. DSPT c̄ E & G covered.
Send SBR (tomorrow ~~Mg @ 6am~~ afterwards)

Please fill up the following details

1. Name of the Referring Doctor :
2. Name of the Referring Hospital :
   (Including the name of City)
3. Contact number of the Referring Doctor :
   (Preferring Mobile #)
4. Name of the doctor in Rainbow Team ______ on whose name the patient is being referred

Doctor's Signature Name [signature] Date ______ Time ______

KOH-00308752 IP2-00056470
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01-06-2026 0 Y 0 M 4 D (F)
Dr. KADIRI BHANU VARUN KUMAR

Patient

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/6/26 9pm	S/B Dr. Varun:	
	Baby on DSPT	
	TSB: 15.2mg/dl	Rx T/c DSPT.
		TSB - 7/m
	noted by Cns 5/6/26 9pm	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6 9 Am	S/B Dr. Vaun	
	T(uowu) F / AGA	/ NNJ
A+ve/A+ve	Baby well under PT	
6.7% wt loss (1770g)	Accepting feeds.	
	cry / tone / activity | good	plan
		- Cont PT
	15.2	Discharge - Review on Monday.
	↓ DSPT	
		[signature]

Noted by poorni 6/6/26 11:00

Ref.No. : F/ER/NUR/

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NURSING ASSESSMENT SHEET IN EMERGENCY ROOM

Name : KOH-00308752 IP2-00056470
Baby Of VEMULA BHAVANA
Age : ..... 01-06-2026 0 Y 0 M 4 D (F)
Dr. KADIRI BHANU VARUN KUMAR
IP No.: :.....
UHID : .....

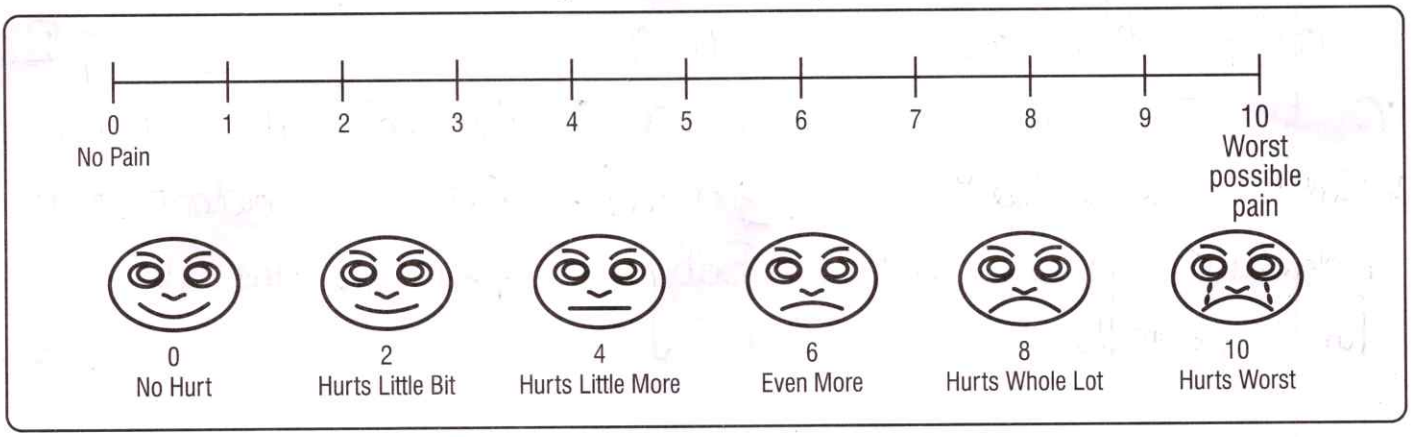
Date : 5/6/26 Time of arrival : 9.20 am

VITALS : Temperature : 97.9°F HR : 132 bpm SPO2 98 %

BP : — RR: 40 bpm Height : — Weight 3.12 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 kegs 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
	NA		

Nursing Notes : Baby came to the ER with complaints of yellowish discoloration of skin & eyes. Vitals checked & Recorded. Doctor assessed baby condition & checked the TCB value. the value is 17.3mg/dl. Advised admission. Admission process done. Baby shifted to the ward for phototherapy c OSPI

DISCHARGED FROM EMERGENCY ROOM TO :

☑ Ward ☐ OT ☐ HOME ☐ DAMA ☐ Died

☐ PICU ☐ NICU ☐ MICU ☐ Labour Room

Nurse Signature ..... Pooja .....

Nurse Name :..... Pooja .....

Date : 5/6/26 .....Time : 9:30am.....

KOH-00308752 IP2-00056470
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EMERGENCY ROOM TRIAGE FORM

Patient's Name : B/O Bhavana Age : 4d **Gender:** ☐ Male ☑ Female

Date : 5/6/2026 Time of Arrival : 9.20 am

Allergies: ☐ No ☐ Yes ☐ Food ☐ Medications ☐ Blood Transfusion ☐ Other (Specify): ☑ Not known

Source of Information : ☑ Parents ☐ Others (Specify)

Mode of Arrival : ☑ Ambulatory ☐ Wheelchair ☐ Ambulance

Wt-) 3.12 Kg

Initial Vital Signs: Temp: 97.9°F PR: 132b/m BP: - RR: 40b/m SpO_2: 98%

Chief Complaints: C/O Yellowish discolouration Skin & eyes.

INITIAL PHYSIOLOGICAL CATEGORIZATION

Appearance
☑ Normal
☐ Sick Looking

Circulation / Colour
☐ Normal ☐ Abnormal ☐ Bleeding

Work of Breathing
☑ Normal ☐ Increased
☐ Decreased ☐ Gasping / Apnea

INITIAL PHYSIOLOGICAL STATUS
☑ Stable
☐ Unstable :
- ☑ Not – Life - Threatening
- ☐ Life – Threatening

Triage Classification	CTAS
☐ Level 1 : Resuscitation	☐ Immediate
☐ Level 2 : EMERGENT : Life or limb threatening	☐ < 15 min
☐ Level 3 : URGENT : Significant illness / injury with potential to become life or limb threatening	☑ 30 min
☐ Level 4 : LESS URGENT : Significant illness but not life threatening	☐ 60 min
☐ Level 5 : NON – URGENT : May receive care when convenient	☐ 120 min

NOTE : All immunocompromised children and preterm babies to be considered Level 2.
All Children less than 2 years age with high fever to be considered Level 3.

* CTAS - Canadian Triage and Acuity Scale

Signature of Parent / Guardian

Triage Completion Time : 2 min

Communicable Disease Triage Screening

PART A. The following questions should be asked to all patients at the initial screening:

1. Have you had fever (elevated temperature) in the past 2 weeks ☐ Yes ☑ No
2. Have you had cough or a rash in the past 2 weeks ☐ Yes ☑ No
3. Have you had shortness of breath or difficulty breathing in the past 2 weeks ☐ Yes ☑ No

PART B. For patients reporting fever and respiratory/rash symptoms: ☐ **Not applicable**

1. Have you travelled outside the INDIA? or had close contact with someone who has recently travelled outside the INDIA, in the past two weeks? ☐ Yes ☑ No

   If yes, State Location: .....
2. Are your parents / close contacts at home is/a healthcare worker? {please encircle the choices} (e.g., nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer, or laboratory worker, others) who has had a recent exposure to an individual with a highly communicable disease or unexplained, severe febrile respiratory or rash disease? ☐ Yes ☑ No

PART C. A positive communicable disease triage screening is considered for any patient who meets one of the two following criteria:

☐ Any patient with Fever / Rash / Vesicles / Discharge from Eyes and Cough

☐ Any patient with fever and respiratory symptoms who answered "YES" to any of the questions on epidemiologic risk factors in "PART B" of the triage screening above.

PART D. ACTION / INTERVENTION: (for positive suspected communicable disease triage screening)

☐ Patients should be immediately isolated in a negative pressure room or a single room (as appropriate) for pending evaluation.

☐ The patient should be given a surgical mask immediately, if not already wearing one.

☐ Both patient and triage staff should perform hand hygiene.

☐ The staff should use PPE (as appropriate).

Name of Triage Nurse : Vijaya

Date & Time : 5/6/26 @ 9.30 am

Signature of Triage Nurse : .....

Docu. No. : RCH /FRM / CLINICAL / 085

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NURSING INITIAL ASSESSMENT IN EMERGENCY ROOM

Date : 5/6/26 Time of arrival : 9.20 am

Chief Complaints: c/o yellowish discolouration skin & eyes. RBS: .....

Height : ..... Weight : 3.12 Kg BMI : ..... Head Circumference (<2 years) .....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

Pain Screening: ☐ Yes ☑ No If Yes, Pain Score: ..... Pain Tool Used: ☐ N Pass ☐ FLACC ☐ Wong Baker

☐ Character ..... ☐ Location ..... ☐ Frequency ..... ☐ Duration .....

RISK FOR FALL:

☑ If patient is < 6 years
tick below fall risk intervention directly

☐ If Patient is > 6 years
Assess the below parameters

History of Falling: within past 3 months ☐ Yes ☐ No

Ambulatory Aids:

- Wheelchair ☐ Yes ☐ No
- Uses furniture for support ☐ Yes ☐ No

Gait/Transferring:

- Bedrest / immobile ☐ Yes ☐ No
- Weak ☐ Yes ☐ No
- Impaired ☐ Yes ☐ No

Mental Status: Forgets limitations ☐ Yes ☐ No

IF YES FOR ANY CATEGORY = RISK FOR FALLING

Fall Risk Intervention:

☑ Escort while ambulating
☑ Assist Patient
☑ Educate patient and family on fall precautions/prevention

Functional Screening: ☑ No Abnormalities Detected

- ☐ Mobility Problem
- ☐ Walking Problem
- ☐ Developmental Delay
- ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

.....

.....

Nutritional Screening: ☐ No Abnormalities Detected

- ☐ Underweight
- ☐ Overweight
- ☐ Feeding Problem
- ☐ Special diet
- ☐ Special feeding method

Inform consultant for positive criteria

Psychological Screening: ☑ No Significant Findings

Unusual concerns about patient's Psychological Status: ☐ Yes ☐ No

If Yes Consultant Notified: ..... (Date/Time): .....

Social History: Lives With Parents.

Siblings in household ☐ Yes ☑ No (if yes How Many?) .....

Time of Initial assessment completed by ER Nurse : 2min

Nursing Notes (Including Labs / Medications / Other Care):

Time	Nursing Notes
9.20am	vitals are check & record it.

Samples collected by: Time:

Samples sent by : Time:

Medication given in ER:

Date / Time	Medication	Route	Dosage & Instructions	Doctor Sign	Nurse Sign 1

Condition of patient at time of shift - out :	**Details of Shift - out**
HR: 130 b/m BP: – CFT: <2 sec RR: 38 br/m SPO_2: 99% GCS: Temperature : 97.9°F Pain Score: Repeat RBS (if applicable):	Shift - out from ER to: Time of Shift - out: Handover given to: (Nurse's Name)

Tick as applicable: ☐ MLC ☐ LAMA ☐ BROUGHT DEAD

Procedures done with details (if any):

Name of the Nurse : Uj

Date & Time : 5/6/26

Signature of the Nurse :

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RESULT SHEET

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Date	5/6/26	16/06/26				
Time	1PM	7.45Am				
Hb	15.7					
PCV	43.3					
RBC	4.56					
WBC	9.66					
N/L						
Platelets	276					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj	15.2/0.1	15.1/9.9	9.9/0.2	9.7		
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	5/6/26					
Time						
CUE-Alb						
CUE-Sugar						
CUE - Ketones						
CUE-PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
ICB	17.39 mg/dl.					

5/6/26

Culture and Sensitivities : .....

.....

.....

.....

Radiology: USG : .....

X-Ray:.....

ECHO: .....

CT: .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

.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 (^{0}C)	Normal Range (^{0}F)
Rectal	36.6-38	97.8-100.4 ^{0}F
Ear	35.8-38	96.4-100.4 ^{0}F
Oral	35.5-37.5	95.9-99.5 ^{0}F
Axillary	36.5-37.5	97.7-99.5 ^{0}F

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VITALS CHART

Date →	5/6/26									
Time ↓	Temp	HR	RR	SPO2	Score	Type of Feed	Qty	Urine	Stool	Vomit
7:00 am										
8:00 am										
9:00 am	97.9°F	132bpm	40RR	98%.	0	DBM				
10:00 am										
11:00 am						DBM				
12:00 pm	98.1°F	140h	40h	97%		EBM	5M	✓		
1:00 pm						NEP	25M			
								U-1	m-0	V-0
2:00 pm										
3:00 pm						EBM+NEPRO 5ml	30ml	✓	✓	
4:00 pm										
5:00 pm						DBM+				
6:00 pm	98.2°F	140	40	98%		NEP-	30ml	✓		
7:00 pm										
								U-02	m-1	V-0
8:00 pm										
9:00 pm						DBM +				
10:00 pm	98°F	142	40	100%		nanpro	30ml			
11:00 am										
12:00 am										
1:00 am						DBM+Nanpro	20ml			
2:00 am										
3:00 am										
4:00 am						Nanpro	25ml	✓		
5:00 am										
6:00 am	98.1°F	140	40	100%				✓		
								U-2	m-0	V-0
						Total		U-5	m-1	✓ 0

Temperature : 97.5 to 99.5 °F
HR : 120 to 160 per minute
RR : 30 to 60 per minute
SPO2: 93-100%

Feeding Plan..... DBM+EBM+NEP

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Morning Shift

Clinical Diagnosis: NNJ

Nursing Diagnosis: yellowish discoloration of the pt condition

Plan of Care: – Assess the pt condition
– DBM + EBM at NGP.

Planned Investigations Procedures: Continue DSPT

Implementation: – sended to CBP, SBR. ®
1502 continue DSPT till 7hrs

Handed Over by : Name & Signature
6300
5/6/26. 2pm

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

Evening Shift

Clinical Diagnosis: NNJ

Nursing Diagnosis: yellowish discolouration of the skin

Plan of Care: + Assess the baby condition
+ maintain I/O chart
+ provide DBM + EBM

Planned Investigations Procedures:

Implementation: + Assessed the baby condition
+ maintained I/O chart
+ provided DBM + EBM

Handed Over by : Name & Signature
Sunita
5/6/26
8pm

Received by : Name & Signature
Sandhya @ 8pm

Night Shift

Clinical Diagnosis: NNJ

Nursing Diagnosis: Yellowish discoloration of skin and eye.

Plan of Care: To assess the baby condition
→ maintain the I/O chart
→ check the vital sign

Planned Investigations Procedures: SBR 6Am 7/hrs.

Implementation: To assessed the baby condition,
maintained the I/O chart.
→ 2-3 hrly feeding.

Handed Over by : Name & Signature
6/06/26.
8Am.

Received by : Name & Signature
Poonee
6/6/26
at 8Am