

ACTIVITY RECORD FOR BILLING

Name: -----

UHID No : ----- IP No : ----- Dept : -----

Date of Admission : ----- Discharge : ----- Time: -----

Room / Bed No : ----- Ward : ----- ad Billable bed type : -----

KOH-00308766 IP2-00056484
Baby Of A SAI PRIYANKA
08-08-2026 0 Y 0 M 0 D 4 H (F)
Dr. KADIRI BHANU VARUN KUMAR



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/06/26	7:30 pm	1/w	307	<i>Poonal</i> 6/6/26 7:30 pm

Cross Consultation Visit

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

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
	vaccination			
	BCG			
6/6/26	OPV		done	pasner
	Hep-B			
6/6/26	O.A.E	-	943889	Bandhya
<p>buy (cross) checked by sisiba on 9/6/26 At 10:30 AM</p>				

ANY OTHER INFORMATION

 Baby kit Given.

Date: 6/06/26 Time: 7:30pm Prepared By: Ashu

Staff Nurse <i>Ashwani</i>	Shift / Ward <i>LW to 307</i>	Billing Assistant	Billing Supervisor
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*Pasner
6/6/26
@ 7:30pm*

KOH-00308766 IP2-00056484
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 08-08-2026 0 Y 0 M 0 D 4 H (F)
 Dr. KADIRI BHANU VARUN KUMAR



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : A Sai Priyanka Age 32yrs Father's Name : Age :
 Date of Birth : 21/3/94 Date of Admission : 6/6/26 UHID No. :
 NICU Consultant : Dr. Varun 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 Sai Priyanka Mother's Blood Group : O negative / Father - O+ve
 Gender : M F Blood Group : Birth Weight (gms) : 3.104 kg Length (cms) :
 Date of Birth : 6/6/26 Time of Birth : 1:23pm OFC (cms) :
 Place of Birth : PCH Roundapur Estimated Gesth Age : 38+3wk

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 32yrs Ht : Wt : BMI : Married Life : LMP : 14/9/23 EDD : 21/6/26

Conception : Spontaneous or with Rx :

Booked at what GA : AN Steroids Drugs / Doses :

Last Scans Details : 21wG, 30+6, cephalic, CFW, 63+, AC-55+, Placenta HI
AFI - 21.9 TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

<p>Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs</p> <p>Consanguinity : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3</p> <p>H/o PIH (after 20 weeks) / PE</p> <p>How many Drugs / Doses / Since how long :</p> <p>H/o value of recent BP recording, proteinuria, edema, oliguria, any investigations (LFT, platelet count) :</p> <p>IUGR - when detected :</p> <p>Doppler (Increased Resistance / ADEF / REDF / Redistrbution in MCA) / Ductus Venosus :</p> <p>AFI :</p>	<p>H/o GDM/ pre GDM/ on diet or insulin</p> <p>Controlled or not, recent values, HbA1 values :</p> <p>Compliance with Rx :</p> <p>Scans : LGA, TIFFA , Fetal Echo :</p> <p>H/o Hypothyroidism : when diagnosed ? Medication?</p> <p>Any other Chronic Medical Problems, when detected drugs ? <u>B. thalassemia trait</u></p> <p>(Anemia, SLE, Jaundice, CHD, Heart Disease) <u>(FCM infusion)</u></p> <p>Infection : H/O, Fever</p> <p>(<input type="checkbox"/> Malaria <input type="checkbox"/> UTI <input type="checkbox"/> TORCH <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> HBV)</p> <p>UTI : when : Any culture :</p>
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PPROM : Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :

Medication during Pregnancy : Duration :

History of Present Illness:

Baby delivered by EL-184



C/CAB



Cord clamped & cut & aseptic cord



1st Vit K. lay 1M stat given

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 35.3° F HR : 162 RR : 58/min NIBP : CFT : <3s
Color of the extremities : normal
Jaundice : Pallor : SpO2 : 96% @ RA

Anthropometry : Birth Weight : 3.104kg Length : HC : Present Weight :
Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

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

Facies :
(Any Facial
Dysmorphism)

NECK and CLAVICLES : Range of Motion :
Asymmetry :
Masses : (A)

EYES : Symmetry :
Red Reflex :
Discharge :

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

THORAX and BREASTS : Shape of Thorax :
Position of Nipples and Number :

ABDOMEN and UMBILICUS : Shape :
Organomegaly :
Bowel Sounds :
Umbilical Stump :
Discharge :

GENITALIA : Labia / Hymen :
Testicles/penis :
Anus :

HERNIAL ORIFICES

TRUNK and SPINE :

SKIN LESIONS :

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 : 58/min 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 : 96.1 Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :
HR : 162/min BP : Precordial Activity :
Femoral Pulses : (+) Murmurs :
Other Peripheral Pulses : (+) Signs of Cardiac Failure :

Abdomen : Hernia orifice :
Shape : Anal Patency :
Palpation : (+) Umbilical Cord : 2cm, 10v
Palpable masses : First urine passed :
Abdominal girth : Meconium passed : ✓

Nervous System : Higher intellectual functions (Sensorium) :
State of wakefulness :
Prechtle Score :

Nerves :

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

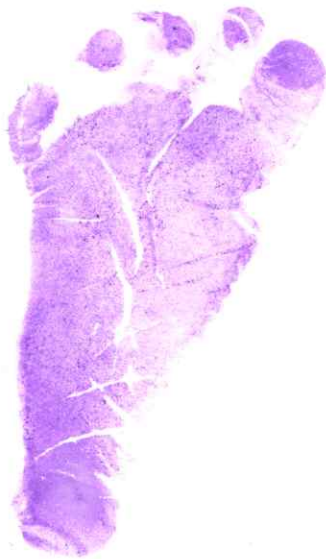
ATNR : Skull and Spine :

Any Congenital Anomalies :

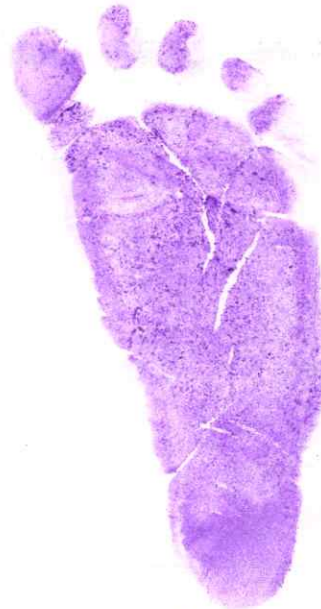
Diagnosis : Term (38+2) / 2.8kg / Female / 3.104kg / Rh+ve
Pregnancy / Mother B thalassaemia trait

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name : Dr. Chanda

Date & Time : 6/6/26 1:40pm

Consultant :

Signature :

Name : Dr. Vallu

Date & Time :

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 :
.....
.....
.....
.....
.....
.....
.....

Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Discharge Details:

Neonatal Condition at Discharge:

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

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: - *Wlaem case*

Final Diagnosis: - *DBP flb bumping - 2-3rd day*
..... - *Send SBR, DCT, retic count*

..... - *OAC vaccination today*
..... - *Monitor vital*

Doctor Signature: *[Signature]*

Doctor Name: *Dr. Chandane*

Date & Time: *6/6/26, 1:40pm*

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/6/26	SIB. Registry	
SPN		
	Euthen.	
	wash	
	accepting DBF - weed	
	C17A good	
	vital - stable	Ad.
	C17	- known case
	R1 (4)	- DBF - 10h busy
	P12	- OAE, vaccination
		- Monitor vitals
	<div style="text-align: right;">↙</div>	
	Noted by So. Abhivani 6/06/26 @ 6/6/26	

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 Baby of A SAI PRIYANKA
 08-06-2026 0 Y 0 M 0 D 2 H (F)
 Dr. KADIRI BHANU VARUN KUMAR



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/4/26 8:00	if shy 2. Vam	
	1940L Term (38 ^{W3}) excess ♀ β - thalassemia major	3.104kg RHD pregnancy
	if T/A: good bristling: none	R wound care
		MRB 2 ^d only fl 6 hrs
		SRR, NAS
		OAE
	Noted by poornu 7/6/26 at 8 AM	
7/6 4:40pm	feeding well no issues euthermic warm C/T/A - good	<u>Plan</u> et. same
Noted by Sandhya	7/6/26 @ 4:40pm	BNP

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	4/5/26	Dr. Varun
8/6	G2 1 EC. USC ♀ 3.104 Rh ⊖	
		Plan
	euthermic warm	1) DAF @ 2 - 3 rd mly PB hump
	G1/A - good	2) warm care
	CS RS ⊕ PIA	3) SBR NBS @ 4870L
	DAE vaccines ✓	4) Monitor vitals.
		<i>[Signature]</i>
Noted by srisisha on 8/6/26 At: 10:40 AM		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/6		
	<u>T1 Full / Ph - ve pregnancy</u>	
	Euthermic	<u>Advice</u>
	warm.	
	accepting feeds well	1) warmth level
	cry	2) Dop flb bumping 2nd hdy.
	tone	3) SRR
	activity good	4) Monitor vitals.
	C/S	Review in 5 days
	R/S	
	PIA	
	<u>Noted by sixisha on 9/6/26 At: 10:30 AM</u>	

KOH-00308766 IP2-00056484

Baby Of A SAI PRIYANKA

08-08-2026 0 Y 0 M 0 D 2 H (F)

Dr. KADIRI BHANU VARUN KUMAR



1

RESULT SHEET



Date	6/06/26	8/8/26			
Time	3.06 pm	11.14 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 / Un Conj.	2.0/0.2/18	10.1	0.2	9.9	
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						
Time						
CUE-Alb						
CUE-Sugar						
CUE - Ketones						
CUE-PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA/Cyst						
Occult Blood						
Blood Group :- O +ve						
8/06/26 DCJ Negative						
(Retiree) - 3						
8/06/26 NMS						

Culture and Sensitivities :

.....

.....

.....

Radiology: USG :

 X-Ray:.....

 ECHO:

 CT:

 MRI

 Others (ECG, Contrast Studies etc.):



VITALS CHART

Date →	6/06/26									
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										
12.00 pm										
1.00 pm	98.8°F	150	48	98%	9/10	-	-	-	-	-
2.00 pm	98.4°F	148	29	100%	9/10	DBF	-	-	-	-
3.00 pm										
4.00 pm	97.8°F	152	28	100%		DBF	20ml	-	-	-
5.00 pm										
6.00 pm	98.1°F	149	52	100%		DBF	-	-	-	-
7.00 pm										
8.00 pm								U-0	M-0	V-0
9.00 pm										
10.00 pm	98°F	148	48	100%		DBM		✓	✓	
11.00 pm						nanpro	20ml		✓	
12.00 am									✓	
1.00 am										
2.00 am						DBM			✓	
3.00 am						nanpro	20ml			
4.00 am										
5.00 am										
6.00 am	98°F	146	44	100%		DBM			✓	
								U-1	M-5	V-0
						TOTAL		U-1	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%

Feeding Plan..... DBF of Nanpro.

BAH-00466275 IP2-00056481
Mrs A SAI PRIYANKA
21-03-1994 32 Y 2 M 16 D (F)
Dr. CHINTHAPARTHY HARITHA



Morning Shift

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

Plan of Care

Planned Investigations Procedures

Implementation

Handed Over by : Name & Signature

Received by : Name & Signature

Evening Shift

Clinical Diagnosis..... *New Born Baby*
Nursing Diagnosis..... *New Born Care*

Plan of Care *> Assess the baby condition*
> provide warm care, cord care, eye care
> provide DBP & Do Burping

Planned Investigations Procedures

Implementation *> Assessed the baby condition*
> Monitored vital signs
> provided warm care, cord care, eye care
> provided DBP & Done Burping

Handed Over by : Name & Signature

Received by : Name & Signature

Night Shift

Clinical Diagnosis..... *NB*
Nursing Diagnosis..... *Warm Care*

Plan of Care *→ Assess Baby Condition*
→ Check the vitals
→ monitor glo chart

Planned Investigations Procedures

Implementation *→ Assessed Baby Condition*
→ checked vitals
→ monitored glo chart
→ Encouraged feeds & Burping

Handed Over by : Name & Signature

Received by : Name & Signature

7/6/26



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						DBM		✓	✓	I
11.00 am						Nan exp 30ml				I
12.00 pm	97.9	145	40	100%					✓	I
1.00 pm						DBM				
								U-1	m-2	V-0
2.00 pm						DBM+Nanpro 20ml				
3.00 pm										
4.00 pm								I	✓	I
5.00 pm						Nan exp 20ml				
6.00 pm	98.0	146	42	100%				I	✓	I
7.00 pm										
								U-0	m-2	V-0
8.00 pm								✓	✓	
9.00 pm						omel.				
10.00 pm	98.1	144	48	99%						
11.00 pm										I
12.00 am						omel				
1.00 am						Nanpro 30ml		✓		I
2.00 am										
3.00 am										
4.00 am						DBM				I
5.00 am										
6.00 am	97.8	144	46	100%		Nanpro 30ml				
								U-2	m-1	V-0
						TOTAL		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%

Feeding Plan..... DBM

Morning Shift

D

Clinical Diagnosis..... NB.
Nursing Diagnosis... Excessive Crying, related to New Environmental Adjust ment.
Plan of Care...
① Assess the General condition
② Monitor vital signs & I/O ch
③ Administer medication as per d

Planned Investigations Procedures
Implementation...
① Assessed the General condition
② Monitor vital signs & I/O ch
③ Administered medication as per d

Handed Over by: Name & Signature
Rajesh 7/6/26 @ 8pm

Received by: Name & Signature
Laxmi 7/6/26 @ 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... Warm Care
Plan of Care...
⇒ Assess Baby Condition
⇒ Check the vitals
⇒ monitor I/O Chart
Planned Investigations Procedures.....

Implementation...
⇒ Assessed Baby Condition
⇒ Checked vitals
⇒ monitored I/O chart
⇒ Encouraged feeds & Burping

Handed Over by: Name & Signature
Laxmi 7/6/26 @ 8AM
(602529)

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

Morning Shift

Clinical Diagnosis..... NB
Nursing Diagnosis..... Warm Care

Plan of Care → Assess the baby condition
→ Monitor vitals
→ Maintain I/O chart

Planned Investigations Procedures

Implementation → Assessed the baby condition
→ Monitored vitals
→ Maintained I/O chart

Shanthi
Handed Over by : Name & Signature
8/6/26 @ 2pm

Seena @ 2pm
Received by : Name & Signature
8/6/26

Evening Shift

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

Plan of Care * Assess the baby condition
* Check vital signs
* maintain I/O chart

Planned Investigations Procedures

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

Seena @ 8pm
Handed Over by : Name & Signature
8/6/26

Payal
Received by : Name & Signature
09/26/26

Night Shift

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

Plan of Care To assess the baby condition
maintain the I/O chart
check the vitals

Planned Investigations Procedures

Implementation To assessed the baby condition
maintained the I/O chart
checked the vitals
provided the warm care

Payal
Handed Over by : Name & Signature
9/6/26

Sandhya @ 8pm
Received by : Name & Signature
9/6/26