

① 10/6/26

ACTIVITY RECORD FOR BILLING

Name: ----- **KOH-00308780 IP2-00056506**
Baby Of SAMA LAXMI BHAVANI
 UHID No : ----- **10-06-2026 0 Y 0 M 0 D 3 H (F)**
Dr. DAVID SUVARNARAJU PARIMI ----- Consultant : ----- Dept : -----
 Date of Admis ----- Date of Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/6/26	1.30 PM	NICU	408	[Signature]
11/6/26	2 AM	NICU	405	[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
10/6/26	Blood grouping post feed	26007970	B
10/6/26	GRBS - 52 mg/dl	26007974	
10/6/26	GRBS - 38 mg/dl pre feed	26007975	
		Cross checked by Per 10/6/26 e 1 hr	
10/6/26	GRBS - 38 mg/dl - post feed	26007987	B
10/6/26	CBP, CRP	26007985	Sumit
"	GRBS @ 3pm 80 mg/dl	26007986	Sumit
10/06/26 @ 6pm	GRBS @ 6pm 71 mg/dl	26007988	Sumit
10/6/26	Blood clt @ 6:30 pm	7992	Sumit
10/6/26	GRBS @ 9pm - 72 mg/dl	26008005	M. Nagesh
11/6/26	GRBS @ 12AM - 81 mg/dl	26008028	M. Nagesh
11/6/26	GRBS @ 6AM - 101 mg/dl	26008029	M. Nagesh
		C. C done by Samina 11/6/26 @ 8am	
11/6/26	GRBS @ 12Pm 77 mg/dl	26008057	Sandhya
11/6/26	GRBS @ 6PM 58 mg/dl	26008058	Sandhya
12/6/26	GRBS @ 12AM 71 mg/dl	26008105	
12/6/26	GRBS @ 97 mg/dl 6AM	26008115	Sandhya
12/6/26	SBR, NBS, CRP	26008142	Sandhya
12/6/26	GRBS @ 81 mg/dl 12pm	26008143	Sandhya
12/6/26	GRBS 72 mg/dl @ 11 pm	26008174	
13/6/26	GRBS 70 mg/dl	26008178	


PROCEDURE


Date	Procedure	Quantity	Order No.	Signature
10/06/26	IV placement	①	944 944630	Di pati
C.C done by Sanjona				
11/6/26	O.A.G	①	944931	Sandhya
13/6/26	O.P.V B.C.V Hep-B	}	done	Sandhya

ANY OTHER INFORMATION

Baby given to Parents.

Date: 11/6/26 Time: 10A

Prepared By: 

<p>Staff Nurse</p> 	<p>Shift / Ward</p> <p>Nice ward Sandhya</p>	<p>Billing Assistant</p> <p>—</p>	<p>Billing Supervisor</p> <p>—</p>
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Name: -----
 UHID No : ----- IP No : ----- Dept : -----
 Date of Admission : ----- Ti ----- charge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

KOH-00308780 IP2-00056506
 Baby Of SAMA LAXMI BHAVANI (F)
 10-06-2026 0 Y 0 M 3 D
 Dr. DAVID SUVARNARAJU PARIMI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : LAXMI BHAVANI Age : 33yr Father's Name : Age :
 Date of Birth : 10/6 Date of Admission : 10/6 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 : 1/0 LAXMI BHAVANI Mother's Blood Group : O Positive
 Gender : M F Blood Group :
 Date of Birth : 10/6 Time of Birth : 9:56am Birth Weight (gms) : 3.769 Length (cms) :
 Place of Birth : RCH Kandapur OFC (cms) :
 Estimated Gesth Age : 37+4

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 33yr Ht : Wt : BMI : Married Life : LMP : 26/9/25 EDD : 27/6/26
 Conception : Spontaneous or with Rx : CU - PP - not conception
 Booked at what GA : @ REM => 8+6 weeks AN Steroids Drugs / Doses :
 Last Scans Details : 20/5/26 => scan ~ 36 | cephalic | EFU -> 2.976 | 67% | AC - 82% |
AFI - 12.8cm, placenta posthigh, P paper - 0
 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 :
(on OHA + insulin) - 19 weeks
 Compliance with Rx : on T. 4 by 1000 mg
 Scans : LGA, TIFFA , Fetal Echo :
INS 1 and 2 - 6
 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

..... P: 1 A: 2 L: 1

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
G ₁ 2019	44	37	3.9 kg	Female	REU / Pr. VL, (big-belly)	
G ₂ 2022	FOUR	36	4.1 kg	Female	(MORSE)	
G ₃ 2025	4	Mixed miscarriage			MORSE, Cyt-PP - sport conception	

PERINATAL HISTORY

Treating Obstetrician : Dr. V. V. Subramanian Hospital : REU / Gondapur 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 checked="" type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</p> <p>Specify the reason : <u>(C/M/O Rev. UCI)</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 : 37 Weeks : 4

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	
	2	2	
	1	2	
	2	2	
TOTAL	8/10	9/10	

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)
Birth Weight	> 3rd percentile (0)	< 3rd (12)	
SGA			

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

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10-06-2026 0 Y 0 M 1 D (F)
Dr. DAVID SUVARNARAJU PARIMI



Equipment check done.

↓

Baby received in warmer.

↓

CEAB

↓

umbilical CoA cut & clamped < 2A
1W.

↓

Int with lung to m given stat

2
stat - stable

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.5°C HR : 150/min RR : 40/min NIBP : CFT :

Color of the extremities : acrocyanosis

Jaundice : Pallor : SpO2 : 95%

Anthropometry : Birth Weight : 3.769 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 :
 Asymmetry : (N)
 Masses :

EYES :
 Symmetry :
 Red Reflex : to be checked
 Discharge :

EARS, NOSE
 MOUTH and
 THROAT :
 Ear set / Shape : (N)
 Periauricular Pits / Tags : no pre auricular pits tags
 Nasal shape / Patency : patent
 Palate :
 Gums : (N)
 Lips :
 Tongue :



THORAX and BREASTS : Shape of Thorax : 10
 Position of Nipples and Number :

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

GENITILIA : Labia / Hymen : (N)
 Testicles/penis :
 Anus : patent

HERNIAL ORIFICES appears free

TRUNK and SPINE : (N)

SKIN LESIONS : -

EXTREMITIES : Fingers / Toes : 10 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 :
 SpO₂ : 98% Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :
 HR : 150/min BP : Precordial Activity :
 Femoral Pulses : all palpable Murmurs : (N)
 Other Peripheral Pulses : felt Signs of Cardiac Failure :

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



Nervous System : Higher Intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves : CRTA - good

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : all symmetrical DTR :

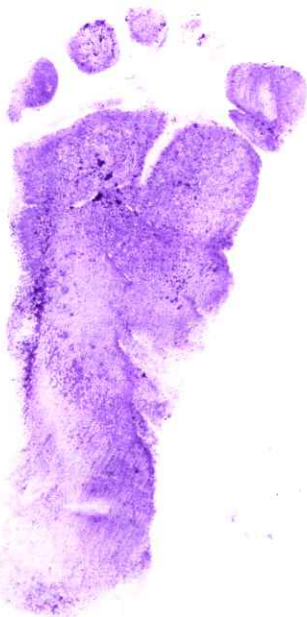
ATNR : Skull and Spine : (N)

Any Congenital Anomalies :

Diagnosis : TT37 +4 | 3.7691 PCU | AUA 1. IDM

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : Dr. Anurag

Name : Dr. Anurag

Date & Time : 10/6, 10:30am

Consultant :

Signature : Dr. Anurag

Name : Dr. Anurag

Date & Time : 10/6/26 9:25



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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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>10/06</u>	T/37+4 Ed. wca F/ CIAO/ 10M	
<u>3:30pm</u>	asymptomatic	hypoglycemia.
		<u>Plan</u>
	euthermic warm	
	CIA - good	1) Trace report
	AF @ N level	2) 60cc/kg/day
	passed urine	30ml 310 kshy feed.
	No meconium.	3) Check 3 consecutive prefeed sugars
	Vital - stable	Inform if sugars < 60mg/dl.
	UC	4) warm care.
	RA (N)	← Start by Piptaz, genta
	PIA	Pnang send blood clr
		10/06/26.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/6/26 0900pm	<p><u>RBS Down</u></p> <p>IDM baby mother on Insulin</p>	<p>Asynchronous Hypoglycemia</p>
	<p>Shifted to NLU in view of RBS @ 38 yrs</p>	
	<p>currently RBS satisfactory</p>	
	<p>on 3mly feeds</p>	<p>Prefeed RBS 78 ml/dl.</p>
		<p>Plan</p>
		<p>If 3 prefeed RBS ≥ 60 g/dl</p>
		<p>→ Check RBS 6mly</p>
		<p>→ Inform any RBS < 60 ml/dl</p>
		<p>→ cont IV AB</p>
		<p><u>Dr. Parimi</u></p>
		<p>Noted by. Nayal</p>
		<p>10/6/26</p>
		<p>@ 9pm</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/26 1-30 am	S/B Dr. Dakshini	
	F 37 + 40h US F IDM Asymp. hypoglycemia	
	V - Baby on RA Maint Act	
	N - Tx @ 6oc 1/day 30 ml 13rd hwy or 4 feeds	plan - Tx @ 6oc 1/day. 30 ml 3rd hwy feeds 35-40 ml 13rd hwy
	Cry tone good awake	- Cont IV Abx. - GRBS monitoring 6th hwy
	GRBS: 72/81/101	- Trau Blood cl. - OAE
	Red reflex - ++ oral cavity Extremities Genitalia Spine Rt hip joint Rt fingers - well perf	- Shift to room under Dr. David.
		<p style="text-align: right;"><i>David</i> Dr. David</p> <p>Noted by M. Reef 11/6/26 @ 7:30 am</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/26	S/B - David	
10/11/26	T (37.4) MSU/E	MDM lasynep hypoglyc
	Euthex	
	maintain sya	
	appm, feed well	
	CH/A - good	Adv
	vital - stable	- Meand feed - 35cc/ml
	O/S	- 3 d hrs
	R/ 10	- 7/18 IV antibiotic
	P/A	
		- GBS GRBS - 6 hrs
		S/SR + S/S
		postly

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Date & Time	Progress Notes	Doctor's Order
	Explain about SBR, NBS & CRP. to the parents.	
		✓ <u>Sagar</u> parents sign.
12/06/26 @ 10 am.		
12/6 5P	S/B Res	
	F / cur	IRBM Asymp Hypoglycemia
	Baby well Accepts feeds cry tone good awake	<u>Plan</u> - MF : 35 ml / 3rd day - CRIS 6th day
	SBR : 11.8	
noted by Sushma 12/6/26 @ 3pm		

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. David	
13/6		
	T 37.4 CSCS F 10M	
	asymptomatic	hypoglycemia / Disturb
	T.Wt ↓ B.G ↓	<u>Plan</u>
	enthermic	
	warm	1) Ct. feeds Q 2-3rd hrly
	CYA - good	
	vitals - stable	2) GRBS Q 6th hrly inform if <60mg/dl
	C/S	
	RS	
	PIA	3) trace blood C/S ↓ & then plan d/L
	on IV antibiotics.	
	SBR @ 11.8 mg/dl	
		pony
	noted by Sridhya	13/6/26 @ 10:00

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Dr. DR. LAKSHMI K VEDAPRAKASH



Xmi Bhavani

RESULT SHEET



Date	10/6/26	12/6/26				
Time	3pm	11:23AM				
Hb	21.0					
PCV	57.8					
RBC	5.49					
WBC	31.51					
N/L						
Platelets	234					
CRP	16	5.0 ↓				
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj		11.8 < 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						



REGULAR PRESCRIPTIONS

Weight. 3.789 kg Ward. Nw

DRUG : <i>1w PIP TAZ</i>				Date/Time																
Dose	Route	Frequency	Start Date	10/6	11/6	12/6	13/6													
375mg	IV	12hly	10/6	6 AM	N/A	<i>6 AM</i>	<i>9 AM</i>													
Name & Signature of the Doctor Starting the Drugs: <i>Dr Chandan</i>																				
Additional Instructions:				<i>6 PM Sing</i>																
Daily Doctor's Endorsement by a Sign				<i>m m m</i>																
DRUG : <i>1w GENTAMYCIN</i>				Date/Time																
Dose	Route	Frequency	Start Date	10/6	11/6	12/6	13/6													
12mg	IV	OD	10/6																	
Name & Signature of the Doctor Starting the Drugs: <i>D. GANDAN</i>																				
Additional Instructions:				<i>6 PM Sing</i>																
Daily Doctor's Endorsement by a Sign				<i>m m</i>																
DRUG :				Date/Time																
Dose	Route	Frequency	Start Date																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
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DRUG :				Date/Time																
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