


① 15/06/26

ACTIVITY RECORD FOR BILLING

KOH-00308810 IP2-00056556
 Name: --- **Baby Of AISHVARYA** -----
 15-06-2026 0 Y 0 M 0 D 3 H (M)
 UHID No:  ----- Consultant : ----- Dept : -----
 Date of Admission : ----- Time : ----- Date of Discharge : ----- Time : -----
 Room / Bed No : ----- Ward : *L111* ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<i>12/0/26</i>	<i>10:15 AM</i>	<i>CUU</i>	<i>508</i>	<i>[Signature] / Bandhy.</i>

Cross Consultation Visit

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

PROCEEDURE

Date	Procedure	Quantity	Order No.	Signature
15/6/26	O.P.V	}		
	B.C.U	}	done	Sandhya
	HEP-B	}		
16/6/26	O.A.C	/	946417	Ehy
Cross checked by Amy 16/6/26				

ANY OTHER INFORMATION

Date: 15/6/26 Time: 10:15 AM Prepared By: Pinee

Staff Nurse sis: Pinee	Shift / Ward LW to 508 Sandhya	Billing Assistant	Billing Supervisor
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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Aishvarya Age : 22yr Father's Name : Age :
 Date of Birth : 11/11/23 Date of Admission : 14/6/26 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 : Blo Aishvarya Mother's Blood Group : B+ve
 Gender : M F Blood Group : Birth Weight (gms) : 3.402kg Length (cms) :
 Date of Birth : 15/6/26 Time of Birth : 5:25am OFC (cms) :
 Place of Birth : RCH Estimated Gesth Age : 38+5wks

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 22yr Ht : Wt : 63kg BMI : Married Life : LMP : 16/9/25 EDD : 23/6/26
 Conception : Spontaneous or with Rx :
 Booked at what GA : 13+2 AN Steroids Drugs / Doses :
 Last Scans Details : 35+3 - cephalic EFR - 2.607 AC - 431, AFI 19.5
placenta - Ant, Doppler - ⊕ 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 : NT -> 2.8mm
Amyoioncenter - @ 16 wks - ⊕
 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

G : P : A : L :

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
		<i>Posture</i>				

PERINATAL HISTORY

Treating Obstetrician : *Dr Lakshmi Devi* Hospital : Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig) <i>50/1</i></p> <p>Second stage (> 2 hours after dilation)</p> <p>LSCS : <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</p> <p>Specify the reason :</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 : *38 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
TOTAL	<i>9/10</i>	<i>9/10</i>	

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

Snapee II Score

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

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

History of Present Illness:

Baby delivered by SVD



CLAB



Cord clamped & cut & aseptic cord



by M.T. K. M. M. M.

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.6°c HR : 147 RR : 58 NIBP : CFT :

Color of the extremities : acrocyanosis

Jaundice : Pallor : SpO2 : 92% @ R1

Anthropometry : Birth Weight : 3.408 Length : HC : Present Weight :

Ponderal Index : AGA : ✓ SGA : LGA :

HEAD TO TOE EXAMINATION

HEAD : Fontanelles :
 Sutures :
 Shape / Moulding :
 Edema / Bruising :
 Size - (H.C.) :
AP no cleft palate

Facies :
 (Any Facial Dymorphism)

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

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 :

GENITILIA : 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 : 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 : Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : BP : Precordial Activity :

Femoral Pulses : Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernia orifice :

Palpation : Anal Patency :

Palpable masses : Umbilical Cord :

Abdominal girth : First urine passed :
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 : *complete* DTR :

ATNR : Skull and Spine :

Any Congenital Anomalies :

Diagnosis : *Term (32 w) / SUP / Male / 3.403 kg*

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *[Signature]*

Name : *Archaudas*

Date & Time : *15/6/26 5:40pm*

Consultant :

Signature : *[Signature]*

Name : *JRM*

Date & Time : *15/6/26*

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:

.....
.....
.....
.....
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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: - *blaxm cap*

Final Diagnosis:
..... - *DBR + hb biopsy 2-3rd hly*
..... - *OAE vaccination @ 24 Hr of life*
..... - *SBR, NBS @ 434d*
..... - *Monitor vitals*

Doctor Signature: *[Signature]*

Doctor Name: *Ar chander*

Date & Time: *15/6/26*

Morning Shift

Clinical Diagnosis..... New born baby
Nursing Diagnosis..... New Born Care.

Plan of Care → Assess the baby condition, → Monitor the vital
→ Maintain I/O chart, → Buried the warm care
→ Buried the warm care.

Planned Investigations Procedures

Implementation → Assessed the baby condition,
→ Monitor the vital,
→ Buried the warm care,
→ Buried the breast feeding Burping,

Handed Over by : Name & Signature Sandhya @ 2pm 15/6/26 Received by : Name & Signature Sandhya 15/6/26 @ 2pm

Evening Shift

Clinical Diagnosis..... NB
Nursing Diagnosis..... NO complaint

Plan of Care Assessed baby condition,
check the vital sign
maintain I/O chart

Planned Investigations Procedures

Implementation Assessed baby condition,
checked vital sign
maintain I/O chart

Handed Over by : Name & Signature Sandhya 15/6/26 @ 8pm Received by : Name & Signature Chandmani @ 8pm

Night Shift

Clinical Diagnosis..... New born baby
Nursing Diagnosis..... Encourage DBM feeding

Plan of Care - Assess the baby condition
- Check vitals & signs
- 2nd-3rd hourly given DBM feeding

Planned Investigations Procedures

Implementation - Assessed the baby condition
- checked vitals & signs
- 2nd-3rd hourly given DBM feeding

Handed Over by : Name & Signature Chandmani @ 8am 16/6/26 Received by : Name & Signature Sandhya @ 8am 16/6/26

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15/06/26



VITALS CHART

Date →	Temp	HP	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am	98.5	149	50	100%		DBF				
8.00 am										
9.00 am						DBM				
10.00 am										
11.00 am						DBM		✓	✓	
12.00 pm	98.5	140	40	97%						
1.00 pm										
2.00 pm						DBM				
3.00 pm						DBM				
4.00 pm								✓		
5.00 pm						DBM			✓	
6.00 pm	98.5	144	42	100%		DBM		✓		
7.00 pm										
8.00 pm								U-2	M-1	V-2
9.00 pm						DBM				
10.00 pm	98.8	141	40	100%		DBM		✓	✓	
11.00 pm						DBM				
12.00 am										
1.00 am						DBM				
2.00 am								✓		
3.00 am						DBM				
4.00 am										
5.00 am	98.2	144	40	100%		DBM		✓	✓	
6.00 am										
								U-2	M-2	V-0
						TOTAL		U-8	M-4	V-0

water

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

Handed Over by : Name & Signature Received by : Name & Signature

NA

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..... *new born baby*
Nursing Diagnosis..... *new born care*

Plan of Care => *Assess the baby condition*
1. checked vital signs
2. No chest monitoring

Planned Investigations Procedures

Implementation => *Assess baby condition* => *Given DBP and heat*
1. checked vital signs => *Given Burping*
2. No chest monitoring => *Given warm care*
3. Blood grouping send lab

Handed Over by: *[Signature]* Name & Signature Received by : *[Signature]* Name & Signature
15/6/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/06	C/S/B Dr. David.	
	T/SVD / male / 2835 / 3408	
	G.S.V. ↓	<u>Plan</u>
	euthermic	DBF @ 2-3rd hour
	warm	115 temp
	CIT/A - good	OAE today
	Ventr - stable	warm care
	AS	monitor uter.
	RS	
	PIA	
	(N)	
		Prog
		Discharge
		Rem after 2 days
		rest

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1 15/6/26

THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
			15/6/26	15/6/26	15/6	15/6	15/6
Age	Less than 3 years old	4	-	4	4	4	4
	3 to less than 7 years old	3					
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2	2	2	2	2	2
	Female	1					
Diagnosis	Neurological Diagnosis	4	-				
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych/ Behavioral Disorders	2					
	Other Diagnosis	1	-	1	1	1	1
Cognitive Impairments	Not aware of Limitations	3	-				
	Forget Limitations	2					
	Oriented to own ability	1					
	History of Falls or Infant-Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or infant toddler in <u>crib</u> or Furniture / Lighting (Tripled Room)	3	3	3	3	3	3
	Patient Placed in Bed	2					
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3	-				
	Within 48 hours	2		2	2	2	2
	More than 48 hours/ None	1					
Medication Usage	Sedatives (Excluding ICU patients sedated and paralyzed)	3	-				
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1					
Total			5	13	13	13	13

-Fall Risk: Low Humpty Dumpty Score = 7-11, High Risk Humpty Dumpty Score = 12 or above

Intervention:

Bed in low position					
Call device within reach					
Wheels Locked					
Room free of clutter					
Adequate lighting					
Wheel chair support					
Other Intervention(s) Specify					
Nurse's Name:	Dany [Signature]				
Signature:	[Signature]				
Date:	15/6/26	15/6/26	15/6	15/6/26	16/6
Time:	7 AM	2 PM	10 PM	8 AM	