

11/6/26
①

ACTIVITY RECORD FOR BILLING

KOH-00308791 IP2-00056535
Baby Of ANUJA GUNNAM
11-06-2026 0 Y 0 M 0 D 2 H (F)
Dr. DAVID SUVARNARAJU PARIMI

Name: -----

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
11/6/26	10 pm	CW	504	(TW) / Laxmi

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
12/6/26	Vaccination	} Done	①	} Laxmi
	BCG			
	OPV			
	Hep-B			
12/6/26	O.A.E	①	945370 ✓	Laxmi
cross checked done by manish @ 3Am				

ANY OTHER INFORMATION

 Baby kit Given.

Date : 11/6/26 Time : 11pm Prepared By : Deepika

Staff Nurse <i>Tuyasa</i>	Shift / Ward 9to to 504	Billing Assistant	Billing Supervisor
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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : ANUJA Age : 34yrs Father's Name : Age :
 Date of Birth : 11/6 Date of Admission : 11/6 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 : O/o ANUJA
 Gender : M F Blood Group : O Negative
 Date of Birth : 11/6/26 Time of Birth : 3:48 pm Birth Weight (gms) : 2995 Length (cms) :
 Place of Birth : RCH Kandelput OFC (cms) :
 Estimated Gesth Age : 39 w 1

Current Obstetric History : (Booked / Unbooked Case)

Maternal Age : 34yrs Ht : Wt : BMI : Married Life : LMP : 6/9/25 EDD : 17/6/26
 Conception : Spontaneous or with Rx : G2 - P1 - 1st Conception
 Booked at what GA : 5+2w19 AN Steroids Drugs / Doses :
 Last Scans Details : 22/5/26 → 36+2 Cephalic EWA → 2.637gm, 27%, Ae - 45%
 AFI - 1.8cm, PL - PL, LAP - @
 TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

Age : <input type="checkbox"/> <18 yrs <input type="checkbox"/> > 35yrs Consanguinity : <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, degree of consanguinity : <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 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 : H/o Hypothyroidism : when diagnosed ? Medication? Any other Chronic Medical Problems, when detected drugs ? (Anemia, SLE, Jaundice, CHD, Heart Disease) Infection : H/O, Fever (<input type="checkbox"/> Malaria <input type="checkbox"/> UTI <input type="checkbox"/> TORCH <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> HBV) UTI : when : Any culture :
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PPROM : Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :

PAST OBSTETRIC HISTORY

G: 2 P: 1 A: L: 1

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
<u>1</u>	<u>2020</u>	<u>40/1</u>	<u>2.6 kg</u>	<u>♀</u>	<u>140 MSL, Baby 0 hr → ant¹-D.</u>	
<u>2</u>	<u>19</u>	<u>36</u>	<u>3.0</u>	<u>♀</u>	<u>Conception</u>	

PERINATAL HISTORY

Treating Obstetrician : Hospital : Rey Kondapur 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 type="checkbox"/> Elective <input checked="" type="checkbox"/> Emergency Indication : <u>(Hypotension - MSL)</u></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 : <u>-2</u></p> <p>Resuscitation : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cord ABG : <u>PH - 7.24 / PCO₂ - 34.5 / PO₂ - 18</u></p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :</p>
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NEONATAL RESCUSTITION DETAILS

APGAR SCORE Gestational Age : 39 Weeks : 1

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
	<u>1</u>	<u>1</u>	
	<u>2</u>	<u>2</u>	
	<u>2</u>	<u>2</u>	
	<u>1</u>	<u>2</u>	
	<u>2</u>	<u>2</u>	
TOTAL	<u>8/10</u>	<u>9/10</u>	

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)
Pao ₂ / Fio ₂ (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 :

History of Present Illness:

Equipment check done

↓

Baby received in warmer

↓

CPAP

↓

umbilical cord cut & clamped ← 2A
10

↓

INS vit K 1mg 1.0m given stat

↓

stable stable

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 36.8°C HR : 143/min RR : 48/min NIBP : CFT :

Color of the extremities : Acrocyanosis

Jaundice : Pallor : SpO2 : 98%

Anthropometry : Birth Weight : 2.995 Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :

HEAD TO TOE EXAMINATION

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

| N

Facies :
 (Any Facial
 Dysmorphism)

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

| N

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

**EARS, NOSE
 MOUTH and
 THROAT :**

Ear set / Shape : N
 Periauricular Pits / Tags : no preauricular
 Nasal shape / Patency : patent tag pits
 Palate :
 Gums :
 Lips :
 Tongue : | N

THORAX and BREASTS :

Shape of Thorax :
Position of Nipples and Number : (N)

ABDOMEN and UMBILICUS :

Shape : (N)
Organomegaly : NO
Bowel Sounds :
Umbilical Stump : 2A+1V
Discharge :

GENITILIA :

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

HERNIAL ORIFICES

appears free

TRUNK and SPINE :

(N)

SKIN LESIONS :

EXTREMITIES :

Fingers / Toes :
Deformities : (N)
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 : 98% Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 143/min BP : Precordial Activity : (N)

Femoral Pulses : normal Murmurs :

Other Peripheral Pulses : felt Signs of Cardiac Failure :

Abdomen :

Shape : (N) Hernia orifice : appears free

Palpation : soft Anal Patency : patent

Palpable masses : NO Umbilical Cord : 2A+1V

Abdominal girth : First urine passed : f

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 : *Bilateral symmetrical* DTR :

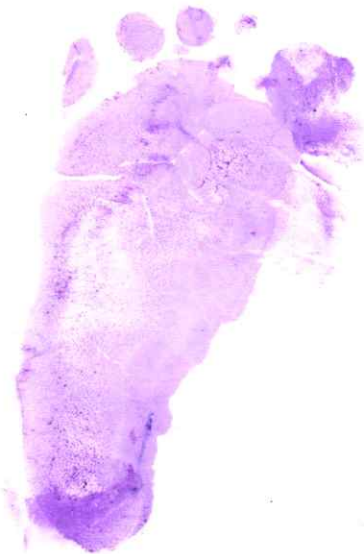
ATNR : Skull and Spine : *(N)*

Any Congenital Anomalies :

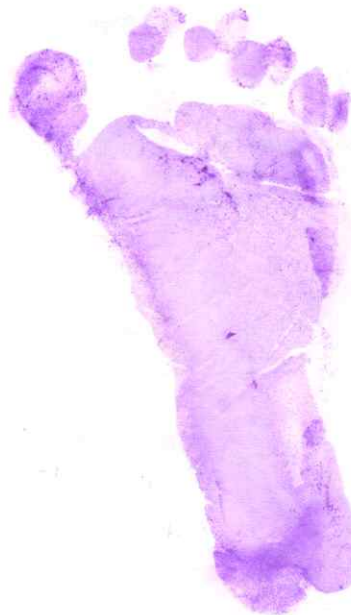
Diagnosis : *T139 | AcA | 2.995 | FCN | Rh - ve*
MSC - I - pregnancy

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *[Signature]*

Name : *Dr. M. K. ...*

Date & Time : *11/6, 9:00pm*

Consultant :

Signature : *[Signature]*

Name : *[Name]*

Date & Time : *12/16/26*

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 :

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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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Fee..... 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:

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Advice
 1) warmth care
 2) ~~DBF~~ flb burping
 and only
 3) OAT
 vaccination / parol.
 4) sony / yash
 MS
 5) monitor vitals
 6) injerm
 cord blood
 samples. AM
 11/6

Doctor Signature: [Signature]
 Doctor Name: Dr. Arun
 Date & Time: 11/6, 4:30pm

KOH-00308791 IP2-00056535
 Baby Of ANUJA GUNNAM
 11-06-2026 0 Y 0 M 0 D 2 H (F)
 Dr. DAVID SUVARNARAJU PARIMI

①

Rainbow[®]
 Children's
 Hospital
 It takes a lot to treat the little.

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/6/26	S/B. Pr. David / Dr. Varun	0-ve/0+ve
9am	T (39wt) / A/GA / 2.995kg / FeH / RH-ve / M/J/L	
	Euthenic	
	warm	
	cervix 1st abd - para	
	accepting DBF well	
	cl/HA - good	
	vital - stable	
	aus / R / P/A	AD -
	AF - level	- labours case
	Moro - complete	- DBF + 16 deeping - 2-3rd by
	red reflex -	- OAE, VOA - @ 24 Hz
	Eye/ear - (M)	- SBR, NIBI @ 48 Hz
	Spine (Bump) (M)	
	arexia	
	Amu - para	- know for vital
	B/Lc wps (M)	
	B/Lc femoral - blue jet	
Noted by Laxmi 12/6/26 @ 1pm		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	CS/B Dr. David.	
13/06 10 AM	A2 T ABA 2.995 F Rhove f	
		o-ve / o-ve
	6 Y. ↓	<u>Plan</u>
	eutermic	1) DBF A 2-3 rd half
	warm	blb hup
	CS/A - good	2) warm care
	vital - same	3) SBR
	CU	NBS @ USHC
	RS	@ 4pm
	PSA	4) monitor vitals.
		<u>Buy</u>
		mostly
	Noted by - Sushma 13/6/26 @ 10 AM	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/6	S/B Register	
3pm	T LGA 2.995 / Rh -ve	
	Euthus	
	way	
	accepting APF well	Adv
	S/B A - good	- Intram Calc
	vital - stable	- DBF - S/B longer
	w/	
	R/S (M)	- SBR, NBS @ 4840 L
	P/A	
		- Monitor vital

Noted by Laxmi; 13/6/26 @ 8AM

KOH-00308791 IP2-00056535

Baby Of ANUJA GUNNAM

11-06-2026 0 Y 3 M 2 D (F)

Dr. DAVID SUVARNARAJU PARIMI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Dr. David</u>	
<u>19/6</u>	<u>TTAUA / 2.995 / Rh -ve pregnancy.</u>	
	Baby - well Euthenic accepting feeds well. cry tone good activity	Advice 1) warmth here 2) feeds 2 nd hly fls. burping. 3) monitor vitals.
	CVS MS PIA	<u>D/S.</u> Review after 2 days - fls - Tuesday
		<u>noisy</u>
	<u>noted by Laxmi 01864 @ 10 AM</u> <u>14/6/26</u>	



RESULT SHEET

Patient Name: **KOH-00308791** IP2-00056535
 Baby Of **ANUJA GUNNAM**
 Age : **11-06-2026** **0 Y 0 M 2 D** (F)
 Dr. **DAVID SUVARNARAJU PARIMI**
 I.D. No. : .. 

Date	13/6/26				
Time	4:12pm				
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	9.1 ^{0.1} 9.0				
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					
Doctor's Signature					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Doctor's Signature						

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc.) :

11/6/26



KOH-00308791 IP2-00056535
 Baby Of ANUJA GUNNAM
 11-06-2026 0 Y 0 M 0 D 2 H (F)
 Dr. DAVID SUVARNARAJU PARIMI

VITALS CHART

Date →	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										
2.00 pm										
3.00 pm										
4.00 pm	36.5°C	148	45	99%	9/10	DBF	1	-	-	-
5.00 pm										
6.00 pm										
7.00 pm	36.5°C	150	48	99%	9/10	DBF	1	-	-	-
8.00 pm						DBM				
9.00 pm						DBM				
10.00 pm						DBM				
11.00 pm	98°F	142	42	100%	9/10			✓	✓	
12.00 am						DBM				
1.00 am										
2.00 am						DBM		✓	✓	
3.00 am										
4.00 am						DBM				
5.00 am	97°F	148	45	100%	9/10			✓	✓	
6.00 am						DBM				
								U-3	M-3	V-0
						TOTAL		U-3	M-3	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

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 conditions*
→ To provide the alarm Care & Card
→ To provide the D&F & burpings

Planned Investigations Procedures

Implementation *→ Assessed baby conditions*
→ provided alarm Care & Card Care
→ monitored vital sign
→ provided D&F & burpings

Handed Over by : Name & Signature
(Deepika)

Received by : Name & Signature
Seema @ 8Pm

Night Shift

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

Plan of Care ** Assess the baby conditions*
** check vital sign*
** maintain I/O chart*

Planned Investigations Procedures

Implementation ** Assessed the baby conditions*
** checked vital sign*
** maintained I/O chart*
** Encourage DM feeds*

Handed Over by : Name & Signature
Seema @ 8Am

Received by : Name & Signature
Laxmi (018641) @

8/12/6/26

12/6/26 @ 8Am

12/6/26



KOH-00308791 IP2-00056535
 Baby Of ANUJA GUNNAM
 11-06-2026 0 Y 0 M 0 D 2 H (F)
 Dr. DAVID SUVARNARAJU PARIMI



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				
11.00 am										
12.00 pm	98.6°F	147	42	99%		DBM		✓		
1.00 pm										
2.00 pm								U-02	M-0	V-0
3.00 pm	98.0°F	145	44	99%		DBM				
4.00 pm						DBM		✓		
5.00 pm										
6.00 pm	98.4°F	148	40	99%		DBM		✓		
7.00 pm										
8.00 pm								U-02	M-0	V-0
9.00 pm						DBM				
10.00 pm	98°F	146	45	100%		DBM				
11.00 pm										
12.00 am						DBM		✓		
1.00 am										
2.00 am						DBM				
3.00 am						DBM		✓		
4.00 am										
5.00 am										
6.00 am	98.0°F	136	42	100		DBM		✓	✓	
								U-23	M-20	V-20
						TOTAL		U-27	M-27	V-20

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

12/6/26



Morning Shift

Clinical Diagnosis..... NB

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

Plan of Care → Assess 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 & burping

Handed Over by : Name & Signature
Daxmi (018641228)
12/6/26 @ 8pm

Received by : Name & Signature
manish (018641228)
12/06/26 @ 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..... encouraged DBM.

Plan of Care → Assess the baby condition

* provide comfortable position

* check the monitor vital

Planned Investigations Procedures

Implementation → givened warm care, card and

* encouraged DBM feeds 2nd hourly

* attended pt calling bells

Handed Over by : Name & Signature
manish (018641228)
13/06/26 @ 8pm

Received by : Name & Signature
Sreshma
13/6/26 @ 8pm

KOH-00308791 IP2-00056535
 Baby Of ANUJA GUNNAM
 11-06-2028 0 Y 0 M 1 D (F)
 Dr. DAVID SUVARNARAJU PARIMI

13/06/20 (M)



VITALS CHART

Date →	Temp	HR	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am						DBM				
8.00 am										
9.00 am						DBM				
10.00 am								✓	✓	
11.00 am						DBM				
12.00 pm	98.3 F	143	46	99%						
1.00 pm						DBM				
2.00 pm								U-1	M-1	V-0
3.00 pm						DBM				
4.00 pm									✓	
5.00 pm						DBM		✓		
6.00 pm	98.6 F	147	45	99%						
7.00 pm						DBM				
8.00 pm								U-0	M-0	V-0
9.00 pm						DBM				
10.00 pm	98.7 F	148	40	99%				✓		
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	98.6	129	46	99		DBM				
								U-3	M-2	V-0
						TOTAL		U-5	M-4	V-0

Reference Ranges:

Temperature 97.5 °C to 99.5 °C Feeding Plan..... DBM

HR 120 to 160 per minutes

RR 30 to 60 per minutes

SPO₂ 93% - 100%

Morning Shift

Clinical Diagnosis..... ^{NB}

Nursing Diagnosis..... New born care.

Plan of Care → Assess the baby condition.
→ check the vital
→ maintain I/O chart.

Planned Investigations Procedures..... -

Implementation Assessed the baby condition.
checked the vital
maintained I/O chart.
provided warm care

Handed Over by: Deeshma Name & Signature
13/6/26 @ 2pm

Received by: Laxmi (0186212) Name & Signature
13/6/26 @ 2pm

Evening Shift

Clinical Diagnosis..... ^{NB}

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

Plan of Care → Assess 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 hdy

Handed Over by: Laxmi (018641) Name & Signature
13/6/26 @ 8pm

Received by: Sanjeev Name & Signature
13/6/26 @ 8pm

Night Shift

Clinical Diagnosis..... ^{NB}

Nursing Diagnosis..... Related to New born care

Plan of Care → Assess the baby condition
→ maintain I/O chart
→ encourage feeding 2-3rd hdy

Planned Investigations Procedures.....

Implementation → Assessed the baby condition
→ maintained I/O chart
→ encouraged feeding 2-3 hdy

Handed Over by: Sanjeev Name & Signature
14/6/26 @ 8pm

Received by: Laxmi (018641) Name & Signature
14/6/26 @ 8pm