



# ACTIVITY RECORD FOR BILLING



Name: .....  
 UHID No: .....  
 Date of Admission: ..... Time: .....  
 Room / Bed No: ..... Ward: ..... Suggested Billable bed type: .....  
 Consultant: ..... Dept: .....  
 Date of Discharge: ..... Time: .....

ANC-00018094  
 Baby ADVITH AMIT HADAGALI  
 03-11-2023 2 Y 7 M 4 D  
 Dr. SOMU SIVABALAN (M)

## WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<del>07/06/26</del> 07/6/26	<del>5:00</del> 1:20 pm	<del>313</del> ER	313	

## CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	Dr. Badma	08/6/26	149186	
2.	balaji			
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

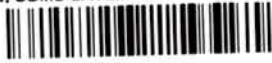






Bem A

ANC-00018094 IP28-00004531  
 Baby ADVITH AMIT HADAGALI  
 03-11-2023 2 Y 7 M 4 D (M)  
 Dr. SOMU SIVABALAN



RESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/10/23	R/v Or-Nesage	2yr 7m / male HT: 44 cm / wt: 9.13 kg HT: - 88cm 80th centile
	<p><u>Background:-</u></p> <ul style="list-style-type: none"> <li>- Term baby</li> <li>- Neonatal seizures - Hypoglycemia</li> <li>- Hypocalcemia</li> <li>- (absent of keraticus &amp; hardened) teard</li> <li>- Feb to May 2022 - 2 x tonic seizures</li> <li>- 1 min of stiffness of the</li> <li>- eyes rolling upwards</li> <li>- on Frisium</li> <li>- So far no MRI of FEH have been done</li> </ul>	
	<p><u>Current Problems:-</u></p> <ul style="list-style-type: none"> <li>- Diarrhoea - 2 day been settled</li> <li>- Vomiting from day before 1 pm</li> <li>- yesterday 3 times</li> <li>- Only food &amp; fluids / non-appetite</li> <li>- No fever / cold / cough</li> <li>- Oral intake very poor</li> <li>- hardly took couple of spoons of food &amp; fluids overnight</li> <li>- urine output poor</li> </ul>	
	<p><u>Today event</u> - This morning was crying a lot</p> <ul style="list-style-type: none"> <li>- unsettled</li> <li>- parents get into auto to hospital</li> <li>- after that he became stiff eyes</li> <li>- eyes rolling upwards</li> <li>- no decodling</li> </ul>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Reached hospital	
	Ongoing stiffness of the arms, unresponsiveness for further 1-2 mins / Chh-18 → right	
	Received IV Midazolam	
	Patient responded immediately	
	Baby alert, active	
	active, No cry, distended abdomen	
	Chest - R/L	PERLA
	CVS - S4 heard	
	No mucus?	
	Pa - soft	HR -
	CVS - normal	RR -
	good tone	
	Throat normal	SpO2 Chh - 95% (at rest)
	Impr: Non tetanic seizures (2 clonus) Hypoglycemia / Microcephaly	mid specul
	Phen 4) IV chess	Hypoglycemia critical
	2) IVF - full maintenance	park
	3) Emerg IV	
	4) Pentop IV	
	5) Fenamiv b-doral only if Dr. Padma Bahup	
	6) EKG, MRI → today	
	4) please nyam	
	5) Hold off IV Hemocritam	
	To discuss with Dr. Padma Bahup	
	9) Dr. Swathi to R/L	
	10) To R/L blood tests & bone	
	& call about Abx's	
	11) Informed Dr. Sivabalan	
	12) Ph arrange MRI	



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/6/23		
1 PM	HR = 70-80/min	otherwise HD-stable.
	↓	
	ECG done	
	↓	
	D/w Dr. Giridhar	
	- lines arrhythmias / ⊕ ectopic	
	- Watch and watch / Reassessment	
	- Will Review tomorrow	
7/6/26	s/b Dr. Aneesha	
10 PM	Child reviewed.	
	No further hypoglycemic episodes	
	No further seizure episodes.	
	Child alert playful.	CBG
	pulses well felt off -	3pm - 76mg/dl
	CRT < 3sec	9pm - 99mg/dl
	S/E - CVS	
	PS	HR - 92/m
	CNS	RR - 26/m
	P/A	
	NAD	6 AM - CBG.
		Aneesha
		163765



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/2024 9 AM	C/S/B Dr. Sishu Kumar	
	Δ - ? seizure disorder / microcephaly	hypoglycemia /
	child reviewed no new complaints no further episodes of hypoglycemia / seizures.	
	Taking orally well. passing urine normally.	
	o/k: alert active playful. hydration good.	
	S/B: Ws: S <sub>1</sub> S <sub>2</sub> ⊕	
	W: BAB ⊕	
	RA: soft K ⊕	
	O/S: ⊕ tone	
	• B/L P&R	
	normal gait	
	responds well to verbal commands.	
	HD-stable.	
		plan
		- MRQ today ? Anesthetist
		- to continue oral Desipri 12:30 pm
		- <del>Dr. SCS</del> @ 10 AM.

CSU @ 6 AM  
 8 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	- NPO from 12:30 pm	
	- Dr Swathi opinion.	
	- Dr Giridhar opinion.	
	- w/t Selvam	
	<i>[Signature]</i>	
	10:30 AM	
8/6/2023	S/B Dr Somu Subh.	
10:35 AM	- Term IUGR	Birth = 2.1 kg
	- D <sub>2</sub> severe ↓ ca & ↓ glc	
	- Dev - Speech ?? on all 54	
	- KC = 44 (↓ in cereb.)	
	- 2 Scan pitted	Brain
	- 1 aphic scan	opinion & Hydrocephalus (no ketohz)
	Cerebral ↑	
	metab ↓	
	Plan → EEG	<u>Todo:</u>
	→ MR 2 brain	- Allergy test (Asper)
		Dr Swathi (Endo op)
		- cont Tempil one to
		<i>[Signature]</i>



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/6/2023 2:55pm	<u>Shri Dr. Somu Sivabala</u>	
	came to see not found in bed / ward	
	Punct. Not willing for MZ2 drug	
	↓ Add	
Eth 4hrs	→ can be done in OPD before seeing	
	→ Endocrine opinion	
	↓ pls TMS & whole	} <del>Shri Dr. Somu Sivabala</del>
		} case sequis
8/6/23 4pm	case discussed with Dr. Sama Sivabala	
	plan - To send blood (TMS)	
	d whole exome sequency ✓	
	+ mitochondrial sequency	
	- plan to discuss to day	



Advit Amit



RESULT SHEET

Date	7/6/26				
Time					
Hb	11.1				
PCV	32				
RBC	4.24				
WBC	9.23				
N/L	48/41				
Platelets	2.34				
CRP	<5				
ESR					
PCT	Bicarb- 21				
RBS	19 → 20 → 95 → 117				
Na	136				
K	4.2				
Cl	ical-1.18 106				
Ca/Mg	9.3/2.0				
Phosphate	Phosphorus 4.8				
Urea	25				
Creatinine	0.29				
ALP					
SGPT	12				
SGOT	45				
T.Bill/Conj	0.3/0				
T.Protein	6.6				
S.Albumin	4.1				
S.Globulin	2.5				
A/G Ratio	1.6				
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate	1.6				
S.Cholesterol	Ammonia 49				
PT/INR	Cortisol 14.0				
APTT	Insulin <0.200				
CSF Protein / Sugar					
Cells	Ketone- 2.9 mg/dl				
N/L					





Patie \_\_\_\_\_ I.P. No. \_\_\_\_\_ Sheet No. \_\_\_\_\_ Wards \_\_\_\_\_ Weight (kg) 9.1 kg

REGULAR PRESCRIPTIONS

**DRUG :** INS. PAN 70 P

Dose	Route	Frequency	Start Dt.	Date	Time
<u>10 mg</u>	<u>IV</u>	<u>OD</u>	<u>7/5/24</u>	<u>7/6/24</u>	<u>1:30 PM</u>

Name & Signature of the Doctor starting the Drugs:  
P. Srinivas  
 114284

Additional Instructions:

Daily Doctor's Endorsement by a Sign.

**DRUG :** SYRUP LEVIPIL

Dose	Route	Frequency	Start Dt.	Date	Time
<u>1 ml</u>	<u>PO</u>	<u>12<sup>th</sup>ly</u>	<u>7/6/24</u>	<u>8/6</u>	<u>1 PM</u>

Name & Signature of the Doctor starting the Drugs:  
P. Srinivas  
 114284

Additional Instructions: (From 1 am) 8/6/24  
(1 ml/100 mg)

Daily Doctor's Endorsement by a Sign.

**DRUG :** INS. EMESET

Dose	Route	Frequency	Start Dt.	Date	Time
<u>2 mg</u>	<u>IV</u>	<u>8<sup>th</sup>ly</u>	<u>7/6/24</u>	<u>7/6/24</u>	<u>1:30 PM</u>

Name & Signature of the Doctor starting the Drugs:  
P. Srinivas  
 114284

Additional Instructions: stop  
9 PM Not given

Daily Doctor's Endorsement by a Sign.

**DRUG :** \_\_\_\_\_

Dose	Route	Frequency	Start Dt.	Date	Time

Name & Signature of the Doctor starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign.



Patient Sticker



Sheet No: .....

### REGULAR PRESCRIPTIONS

Weight .....

Ward .....

<b>DRUG :</b>				Date- Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
<b>Daily Doctor's Endorsement by a Sign</b>																				

<b>DRUG :</b>				Date- Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
<b>Daily Doctor's Endorsement by a Sign</b>																					

<b>DRUG :</b>				Date- Time																		
Dose	Route	Frequency	Start Dt.																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
<b>Daily Doctor's Endorsement by a Sign</b>																						

<b>DRUG :</b>				Date- Time																			
Dose	Route	Frequency	Start Dt.																				
Name & Signature of the Doctor Starting the Drugs:																							
Additional Instructions:																							
<b>Daily Doctor's Endorsement by a Sign</b>																							

VERIFIED BY : Name ..... Signature .....

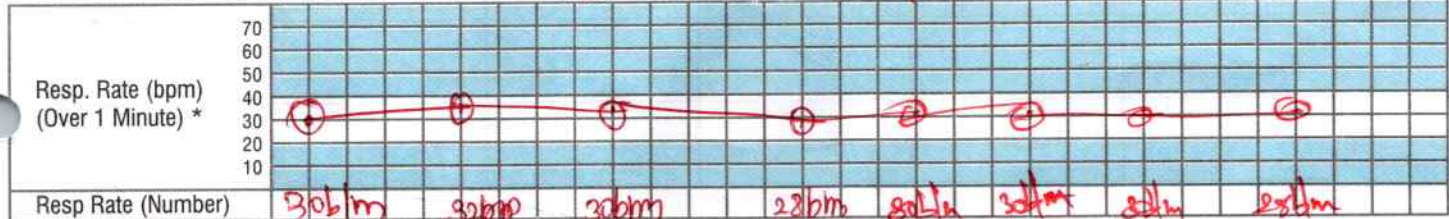
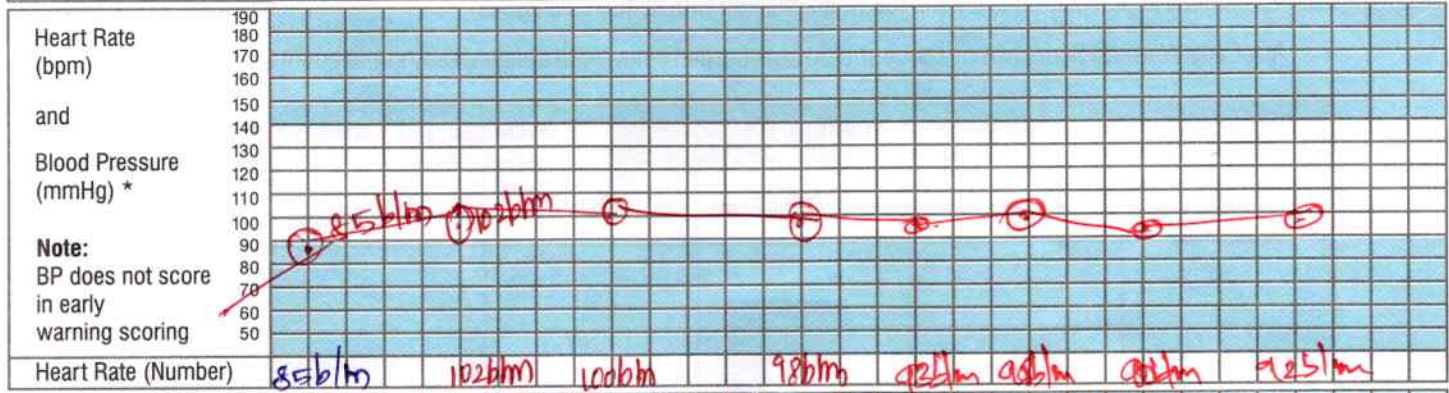
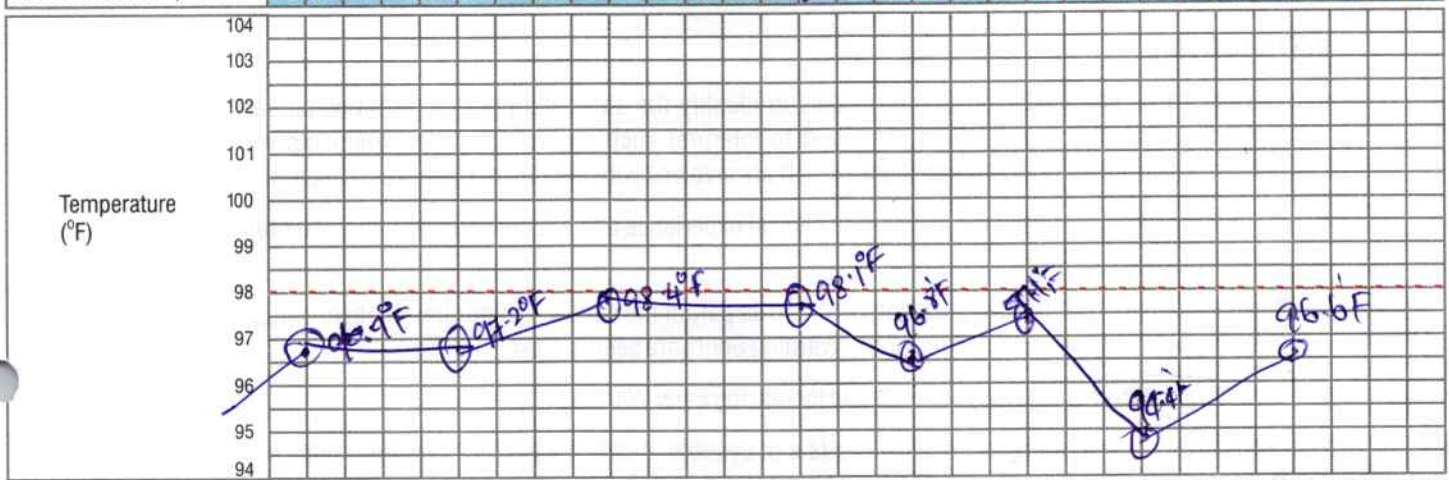






**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date: 11/5/23	Time: 1:28pm	3pm	4pm	7pm	10pm	11pm	2am	6am
Doctor / Nurse / Family Concern? <input checked="" type="checkbox"/>								



Resp Distress	Mod/ Severe None / Mild	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Receiving O <sub>2</sub> (l/min)	O <sub>2</sub> Saturations (%)	100%	99%	99%	99%	100%	99%	100%
Conscious Level	Normal / Altered	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
GCS *		15/15	15/15	15/15	15/15	15/15	15/15	15/15

<b>TOTAL SCORE</b>								
Number of shaded boxes	02	01	01	01	01	01	01	01
Pain Score	0/10	0/10	0/10	0/10	0/10	0/10	0/10	0/10
Observer's Initials	SS	SS	SS	SS	SS	SS	SS	SS

<b>ACTIONS</b> NB: Scores 3 should be recorded overleaf	Score 1	: Continue normal observation by staff nurse
	Score 2	: Shift in charge nurse to be informed and continue hourly observations
	Score 3	: Shift in charge AND ER doctor/Floor Registrar to see and half hourly to hourly Observation to continue.
	Score 4	: Shift in charge AND treating consultant(till 8 PM) or On call night duty consultant to see
	Score 5 & 6	: Shift in charge AND PICU fellow or PICU consultant to be informed.

\* NB: If GCS is below 12 or the Oxygen requirement is >3 Lit./min. , then irrespective of rest of the score, the Nurse MUST inform the PICU team.

## CHILDREN'S OBSERVATION and EARLY WARNING SCORING TOOL

### INSTRUCTIONS:

- The paediatric Early Warning Score i) seeks to identify the abnormal physiological finding seen during serious childhood illnesses and ii) offers a method to interpret such physiological derangements with clearly defined actions, ensuring that suitably experienced staff are involved with the care of the sickest children.
- The Early Warning Score does not replace clinical experience and acumen and should not be relied upon for such purpose.
- 6 clinical parameters are assessed and recorded as part of the child's routine clinical observation, providing a Early Warning Score between 0-6 (Higher Early Warning Score are seen in sicker children)
- Detailed actions are described according to increasing Early Warning Score.
- Some children with complex medical needs e.g. cyanotic heart disease may require modification to their trigger thresholds/ action plan- this should follow discussion with senior colleagues.
- Any Early Warning Score of 3 or above should be recorded below with details of any subsequent action initiated

Record Details when EARLY WARNING SCORE > 3			Record Time of Review and Plan		
Date	Time	Early Warning Score	Date	Time	Name

- If at any time additional help is required, call help – regardless of the Early Warning Score!
- Following a Early Warning Score assessment, senior help may be required

The SBAR communication tool (situation, background, assessment, recommendations) is a helpful mnemonic that can be used to describe a child's clinical condition to a colleague.

I	<b>IDENTITY:</b> I am (name), a nurse on ward (X). I am calling about (child X)
S	<b>SITUATION:</b> I am calling because I am concerned that ... (e.g. BP is low/high, pulse is XXX, Temperature is XX, Early Warning Score is XX)
B	<b>BACK GROUND:</b> Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
A	<b>ASSESSMENT:</b> I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
R	<b>RECOMMENDATION:</b> I need you to ... come to see the child in the next (XX mins) AND is there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)



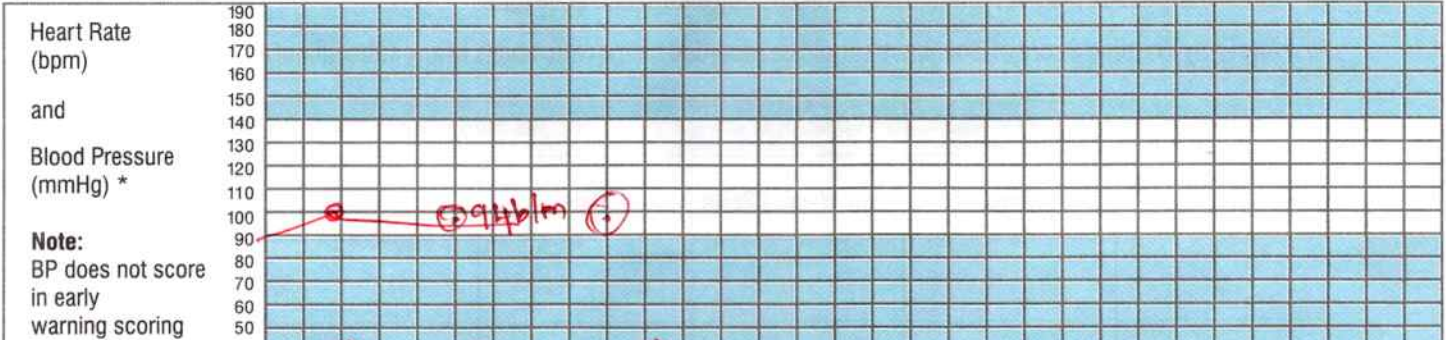
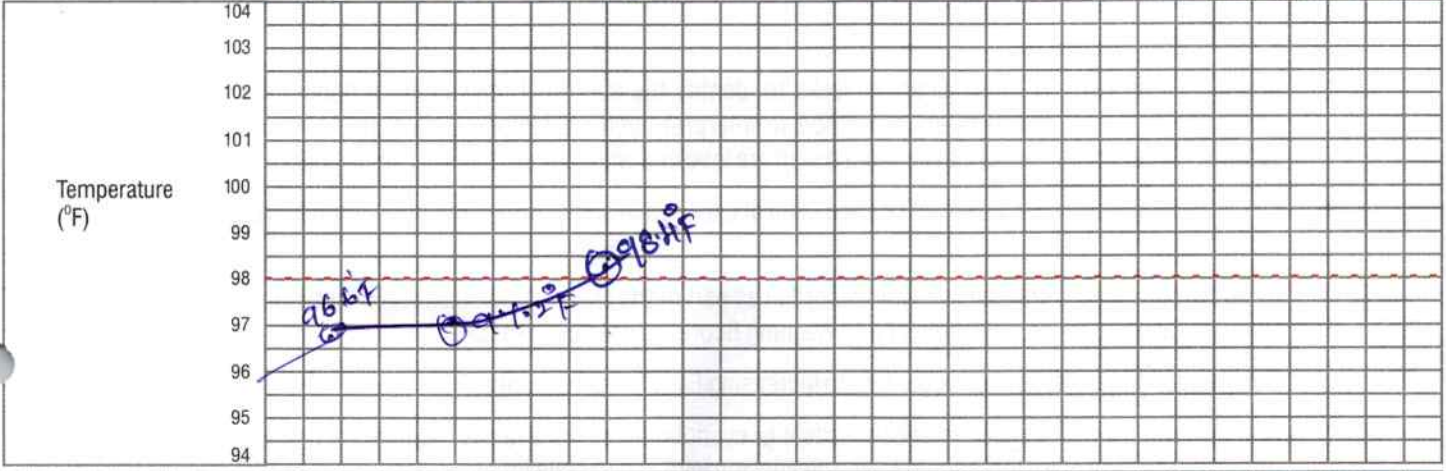
**PRESCHOOL (1-5 years)**  
**Children's Observation & Early Warning Scoring Chart**



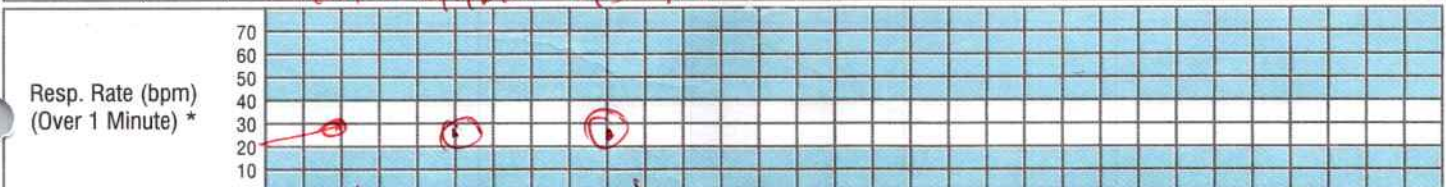
**EARLY WARNING SCORE: CHILDREN'S UNIT**

Date : 8/6/23 Time: 6am 10am 2:30pm

Doctor / Nurse / Family Concern?



Heart Rate (Number) 92b/m 94b/m 95b/m



Resp Rate (Number) 28b/m 29b/m 30b/m

Resp Distress Mod/ Severe None / Mild

Receiving O<sub>2</sub> (l/min) O<sub>2</sub> Saturations (%) 100% 99% 99%

Conscious Level Normal Altered

GCS \* 15/15 15/15 15/15

**TOTAL SCORE**  
 Number of shaded boxes 01 01 01  
 Pain Score 0/10 0/10 0/10  
 Observer's Initials AS AS AS

**ACTIONS**  
 NB: Scores 3 should be recorded overleaf

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<b>B</b>	<b>BACK GROUND:</b> Child (X) was admitted on (XX date) with (e.g. respiratory infection). They have had (X operation/ procedure/ investigation). Child (X)'s condition has changed in the last (XX mins). Their last set of observations were (XXX). The child's normal condition is ... (e.g. alert/ drowsy/ confused, pain free)
<b>A</b>	<b>ASSESSMENT:</b> I think the problem is (XXX) and I have ... (e.g. given O2/ analgesia, stopped the infusion), OR I am not sure what the problem is but child (X) is deteriorating, OR I don't know what's wrong but I am really worried.
<b>R</b>	<b>RECOMMENDATION:</b> I need you to ... come to see the child in the next (XX mins) AND I s there anything I need to do in the meantime? (e.g. stop the fluid/ repeat observation)



# FLUID CHART

Sheet No. : 11

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
21/06/25													
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm	Received the baby from ER at 1 PM											
	01:00 pm											0	SW
Total Intake :						m=0 Total Output : u=0							
	02:00 pm			75ml								0	
	03:00 pm			75ml								0	
	04:00 pm	milk	100ml	DC								0	
	05:00 pm			DC								0	
	06:00 pm	R20	100ml	50ml						✓		0	May
	07:00 pm			50ml								0	
Total Intake : 200 + 250 = 450ml						m=0 Total Output : u=1 time							
	08:00 pm	1190	100ml	DC						✓		0	
	09:00 pm			50ml								0	
	10:00 pm			50ml								0	
	11:00 pm			50ml								0	
	12:00 am			50ml								0	
	01:00 am			50ml								0	
Total Intake : 100 + 250 = 350ml						m=0 Total Output : u=1 time							
	02:00 am			50ml						✓		0	
	03:00 am			50ml								0	
	04:00 am			50ml						✓		0	
	05:00 am			50ml								0	
	06:00 am			50ml						✓		0	
	07:00 am			50ml								0	
Total Intake : 300ml						m=0 Total Output : u=3 time							
Total 24 hrs. intake		1100ml											
Total 24 hrs. Output		m=0, u=5 time											



# FLUID CHART

Sheet No. : ..... 2 .....

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G							
<u>08/6/20</u>	08:00 am	H <sub>2</sub> O	10ml	DC						✓	0	} 20
	09:00 am	NPO		DC							0	
	10:00 am	NPO		DC							0	
	11:00 am			DC							0	
	12:00 pm	H <sub>2</sub> O	10ml	DC						✓	0	
	01:00 pm			DC							0	
<b>Total Intake :</b>			<u>20ml</u>		<b>Total Output :</b>			<u>m=0</u> <u>U = 2 times</u>				
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
<b>Total Intake :</b>					<b>Total Output :</b>							
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
<b>Total Intake :</b>					<b>Total Output :</b>							
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
<b>Total Intake :</b>					<b>Total Output :</b>							
<b>Total 24 hrs. Intake</b>					<b>Total 24 hrs. Output</b>							



**NURSES NOTES**  
 (USE BALL POINT PEN ONLY)

- No Known Drug Allergies
- Drug Allergies ..... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<b>Receiving Notes</b>
7/6/26	1pm	Baby details received from ER staff. Baby is stable and active. Ir line present and patent. IVF is going on Dns = 75ml/hr. Over 5hrs Inj. Levipil administered as per the start order.
	1:30pm	administered Inj. Pand and Emese + as per the drug chart.
	2pm	Baby details hand over given to evening duty staff. <i>dhg</i>
		<b>Evening duty notes:-</b>
7/6/26	2:30pm	Baby details handing over taken from morning duty staff. Baby is active and conscious.
	3pm	CBG checked as per physician order. CBG is 76mg. Inform Dr. Aareesh sir.
	4pm	Baby vitals checked and recorded. vitals are stable. Ir line patent. IV Dns Flow on 75ml/hr. Baby is active no seizure activities. He had milk.
	4:15pm	IV fluids 5hrs over. Inform Dr. Aareesh he said stop IV fluids. Then IV fluids 50ml/hr continue said Dr. Pannan.
	7pm	vitals checked and recorded. vitals are stable.
	8pm	Baby details handing over given to night duty staff. <i>dhg</i>

**NOTE : DO NOT WRITE OUTSIDE THE MARGINS**



# NURSES NOTES

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies ..... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<i>Night duty notes</i>
<i>7/10/23</i>	<i>8PM</i>	Baby detail had over taken from evening staff. Baby is active and conscious. Tracheal present and patent.
	<i>9pm</i>	Baby CBR was checked 99 mg/l and recorded. Inf: onset is not given. Baby is not vomiting. Inform the Dr. Anest. sir.
	<i>10pm</i>	Baby vitals checked and recorded. Vitals is stable.
	<i>11PM</i>	Baby vitals checked and recorded. Spap (Kupipil 1ml) was given as per drug chart order.
	<i>6am</i>	Check the baby vitals sign and recorded.
	<i>6am</i>	Baby CBR was checked and recorded. Administer the inj: par was given as per drug chart order. Baby vitals checked and recorded.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

**NURSES NOTES**

(USE BALL POINT PEN ONLY)

- No Known Drug Allergies  
 Drug Allergies ..... Nil

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
	8 Am	Baby details hand over given to morning duty staff
		Morning duty staff
8/6/26	5:30 Am	Baby details hand over taken from night duty staff. Baby is stable and active. urine present and Wp is stopped.
	9 Am	Npo started.
	10 Am	Vitals checked documented in file.
	11 Am	There is no any other specific complaints for the baby.
	12:30 pm	Syp: Levipil administered as per the drug chart. after that the
	1 pm	shifted to EEG.
	2 pm	Hand over given to evening duty staff
		Evening duty notes
8/6/26	2:30 pm	Wid handover taken from <del>evening</del> morning duty staff. Patient don't want to do MRI and EEG. So, DR. Sivabalan Sir said to DIS the patient

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

