

# ACTIVITY RECORD FOR BILLING

Name: .....  
 UHID No: .....  
 Date of Admission: .....  
 Room / Bed No: .....

IP24-00008764  
 SNC-00028576  
 Mrs SHALINI K  
 04-07-1998  
 Dr. SRI SUDHA

27 Y 11 M 20 D (F)  
 Consultant: ..... Dept: .....  
 Date of Discharge: ..... Time: .....  
 Suggested Billable bed type: .....

## WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
24/6/26	10am	RR	ward (212)	[Signature]
24/6/26	1 PM	ward	RR	[Signature]
24/6/26	2:30 pm	RR	OT	[Signature]
24/6/26	3:40 pm	OT	RR	[Signature]
24/6/26	7 pm	RR	ward	[Signature]

## CROSS CONSULTATION VISIT

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







nam. molini  
Patient Sticker 274 F

ENC - 00028750 / 24-8764



### SURGERY DETAILS

Date: 24/06/26  
Patient Name: Mrs. Shalini Date of Birth: 4/7/98 Age: 27Y/1F  
Gender: Female Ward: OT UHID No.: 00028576

Date of Surgery: 24/06/26  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2

Name of the Surgery: LAPAROSCOPIC (L) PARA OVARIAN DEROOFING WITH CHROMOPERTUBATION.

Time in: 2.30p.m. Time Out: 3.30p.m.

	NAME	AMOUNT
1. Surgeon	Dr. Srisudha	
2. Anaesthetist	Dr. Nivedita	
3. Assistant Surgeon	Dr. Juvani	
4. OT Technician	Mrs. Vetri	
5. Circulating Nurse	SN - Manikandan / SN - Loli	
6. Assistant Nurse	SN - Bhamani	

Special Equipment:  Laparoscopy  Bronchoscope  Harmonic  Morcelator  
 C-ARM  Cystoscopy  Versa Point  Liver Cusa  
 Neuro Cusa  Others .....

Signature of the Surgeon: [Signature]  
Signature of Circulating Nurse: [Signature]

Order No.: 252397 / 252398  
Order by: [Signature]





### CONSUMABLES OF OT

Circulating staff: Shr. Manigandan Technician: Ms. Vethi Date: 24/6/21 Time: @ 2:30 pm

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube <u>7.0 cuffed</u>		01	Major Pack (A)		01	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads (A/P/N)		03				Suction Catheter		
HME filter: A/P/N						Feeding Tube		
Syringes : 10 cc		05				Vaccum Suction Set		
05 cc		05	Gloves <u>7*pp</u>		02	Surgical Gloves		
02 cc		02	<u>7*pp</u>		01	Gauze Pack		
01 cc <u>20ml</u>		01	<u>6*pp</u>		01	Syringe 1ml / 2ml		
Cautery plate: (A/P/N)		01	Surgical blade <u>22, 11</u>		01+01	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		02	Cautery pencil			<u>2* Parac (1g)</u>		01
NS : 10ml / 100ml / 500ml / 1000ml		04	Koochies			<u>D. Water (10ml)</u>		01
			Ointments			<u>02 Milk (P)</u>		01
			Suction Catheter			<u>2* Loxi (anal) (10ml)</u>		01
Fentanyl <u>(already raised)</u>		01	Cap, Mask			<u>2* Reverse (2AP)</u>		02
Morphine			Gauze Pack <u>R10</u>		02	<u>5ml Syringe</u>		01
Ketamine			Mop Pack			<u>uterovect catheter</u>		01
Propofol		02	Steristrip			<u>methylene blue</u>		01
Rocuronium		02	Underpad		01	<u>skin stapler</u>		01
Glycopyrolate		01	Draw sheet			<u>irrigation set</u>		01
Myopyrolate			Abgel			<u>2* D. Water (2ml)</u>		01
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine <del>0.25% (Heavy)</del>			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm <u>8582</u>		03+02			
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		02			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution					
			Microshield					
			Cotton Balls					
			Latex Gloves					
			Ramdione Serub <del>0.25%</del>					
			Saral <u>3MM skin prem</u>		01			

Surgeon: \_\_\_\_\_ Anaesthesiologist: \_\_\_\_\_ Nurse: \_\_\_\_\_ OT Technician: \_\_\_\_\_  
 Order No.: \_\_\_\_\_ Ordered by: \_\_\_\_\_  
 Loc. No.: RCH / FRM / GENERAL / 125

*Handwritten notes and signatures:*  
 252297, 252398  
 2506, 2502, 2504  
 [Signatures]

mp 100 20/2/26 10/10/11

WSE 10/10/11

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>27/6/20</del> 8 AM		Dr. SRI SUDHA Dr. VANATHA
	① perineal wound	AP
	Planned for today	② 1 AM
	ac fair	③ shift to ward.
	Resp / NTO	④ shift to open cell.
	US	⑤ IVF / ORL.
	PT comfortable.	
<del>27/6/20</del> 6:15 PM		Dr. VANATHA
		AP
	PT comfortable.	
	ac fair	① follow PT of orders
	Resp / NTO	② shift to ward.
	US	

*[Handwritten signature]*

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**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
24/6/20	S/B - Dr. Lawaya	
Pren		
	Laparoscopic left para ovarian deroofing & chemoembolization	
	o/e - afebrile	
	No pain	
	No pedal edema	
	T - N	
	PR - 80/120	CRS - 1.52 T
	BP - 110/80 mmHg	RE - 100% S+ &
	P/A - soft	liquid flb
	No wound soaks	- soft solid diet
		- follow drug chart
		- vitals monitoring
		- ambulation
		Sri Sudha



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/9/26 <del>SMT</del>	<p>CLIN Dr. Sri Sudha.          CLIN Dr. VANASHTA</p>	
	<p>Post; Kap ① paracetamol</p>	
	<p>Relieving a diarrhoea</p>	
BP - 114/80 mmHg	<p>ac fair</p>	
HR - 80/min	<p>Resp 18</p>	
SpO2 - 98%	<p>UR</p>	<p>tdw</p>
	<p>P/S.</p>	<p>① soft diet.</p>
	<p>apt.</p>	<p>② follow drug chart</p>
	<p>Orally intak.</p>	<p>③ vitals monitoring</p>
	<p>Bowel sounds ④</p>	<p>④ plan discharge today</p>
	<p>apt voided freely.</p>	<p>⑤ Mobilize well.</p>
	<p>④ comfortable.</p>	

Handwritten signature and date: 25/9/26



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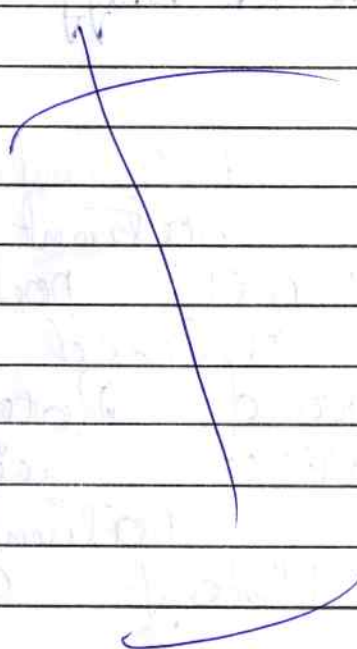


# NURSES NOTES

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<i>Admission notes 24/6/06</i>
	8am.	<p>Mrs. Shalini Dey (E) DR. CRISUELHA</p> <p>Patient has irregular periods USG finding ovarian cyst plan for left PAB overwain cyst. In placement done Consent taken. Promolice</p>
	10pm.	<p>Patient shifted to ward handover given to ward staff given by Parvathy</p>
		<i>Regis</i>
		

*Dr. S. S.*

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



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

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<del>Admit</del>
		Received notes 24/6/26
24/6	10:30am	patient details is handover taken from RR staff
	11am	patient is conscious up oriented → S Jayasri IV line patient IV fluids ongoing pt is on NPO → S Jayasri
	12 pm	Reassessment is done. Pt is vitally stable.
	1pm	pt shifted to RR, <del>pt data</del> as per Dr. Vandana mam order. pt details is handover given to the RR staff → S Jayasri
		Received notes 26/5/26
	1pm	patient Received from ward patient conscious and oriented, vitals checked and recorded, medication given. informed of staff → S Jayasri patient shifted to OT Staff given by Pranjaya

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



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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<b>Evening duty on 24/6/26</b>
24/6/26	2pm	pt details handing over taken to morning duty staff pt vitals are the stable BP-102/64 mmHg/p/r 74 bpm spo <sub>2</sub> 100%. pt urine passed pt shifted the OT
		<b>OT notes</b>
		pt received in side the of monitoring connecting vitals checked and recorded vitals are the stable BP-104/74 mmHg, pulse 72bpm, spo <sub>2</sub> 100% - VWA gfm sign in done Hmc out done, procedure on the laproscopic @ para ovarian de-roofing F/B chromo percutanum done by dr. nivedita mem, HPE biopsy taken & pt low lithotomy positioning vitals are the stable bt
	3:30 pm	shifted to the OR room →
		<b>Received notes</b>
	3:40 pm	pt received OT to OR pt vitals are the stable BP-100/60 mmHg, pulse 57bpm, spo <sub>2</sub> 100% IVF NS 100ml/hr ongoing
		<b>Re-Assessment notes</b>
	5:40 pm	pt Re-Assessment done vitals are stable BP- 102/62 mmHg, pulse 57bpm, spo <sub>2</sub> 100% IVF NS 100ml/hr ongoing
	pm	

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



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

NO KNOWN DRUG ALLERGIES

Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Received Notes AT 7pm (evening duty 24/6/26)
	7pm	pt returned to recovery to ward at 7pm pt is conscious & oriented pt is afebrile.
	7:30pm	pt NPO break no vomiting & followed by clear liquid diet.
	8pm	pt vitals chart maintain maintain. pt handing over to night duty S/N
		Alarop elbur.
		<u>Night duty on 24/6/26:</u>
	8pm	⇒ patient details received from evening duty S/N → Mf ⇒ while receiving the patient. 607844 conscious & oriented. → Mf 607844
	9pm.	⇒ vitals are checked & recorded. ⇒ Medications are given as per order. → Mf 607844
		⇒ patient on semi-solid diet. → Mf 607844

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# NURSES NOTES

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
	9:30 pm	SIB Dr. S Shwarya mam semi solid diet pt mobilized w/ ne pattern
	11 pm	no medication given as per doctor order, patient sleep well
25/6	2 AM	LVF output patient vitals stable
	6 AM	patient is stable no medication given
	8 AM	pt hand over given morning duty sw
	8 am	<u>nooning duty on 25/6/26</u> patient is taken over from night duty sw. she is afebrile. she had semi solid diet.
	9 am	vital signs are checked and recorded.
	10 am	pt got discharge today. file sent to billing dept.

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