

ACTIVITY RECORD FOR BILLING



Name: SNC-00030547 IP24-00008775
 Master SHASHVATH V
 UHID No: 12-01-2015 11 Y 6 M 13 D (M)
 Dr. BRAVANTHI KOSURI
 Date of Admissio Consultant: Dept:
 Room / Bed No: Ward: Date of Discharge: Time:
 Suggested Billable bed type:







WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/6/20	2pm	ER	ward	hujor/39

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
25/6/26	CBC ✓ CRP ✓ RFT ✓ LEP ✓ ESR ✓ 1 Blood c/s ✓	7766	
25/6/26	RBS ✓	7767 ✓	
25/6/26	V/R ✓	7773 ✓	
25/6/26	Stool biochem	7790 ✓	

25/6/26 ~~USG~~ Abdomen

4101 ✓


 [Illegible text]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		} B - Dr. Divakar
25/6/20		
7:00 PM	A - Persistent diarrhoea Severe dehydration	
	no loose stools Tolerating oral feeds	
	CPO - Adequate	
	of E - Contd. diet ERDA not in waxing	
	Se - Pt - off waxing	
	Waxing on	
		<u>Plan</u>
		- CPO no medication as adequate
		- Vitam check
		- Electrolytes

[Handwritten signature]

SNC-00030547 IP24-00008775

Master SHASHVATH V

12-01-2018

11 Y 6 M 13 D

(M)

Dr. BRAVANTHI KOSURI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/6		
9am.	C/S/B - Dr. Bravanthi	
	Persistent diarrhoea / Some dehydration	
	Loose stools + oral intake of w/ine ⊕	
	O/E - Unconscious PPWP Vitals ⊕ CPT < 3 secs	
	S/E - WNL P/A - soft, BS ⊕	
	<u>Adv</u>	
	- cont PAN & zinc	
	Dis today	

~~169282~~

SNC-00030547 IP24-00008775
 Master SHASHVATH V
 12-01-2018 11 Y 5 M 13 D (M)
 Dr. BRAVANTHI KOSURI

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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)
25/6/26		<u>Received notes on 25/6/26</u>
	2pm	Baby Received from ER to ward. Baby details given over from ER SW. Baby was conscious and oriented. In his pattern. Dose NO need baby oral intake good so no need. As per doctor order. Stool biopsy to do, use Abdomen to do. 210 chart maintain. → Vini OT 19/6
	3pm	checking vital signs and Recording vital in table. → Vini OT 19/6
	5pm	Dr. Bravanthi's main rounds done to continue medication. Stool biopsy to do. → Vini OT 19/6
	6pm	USG Abdomen taken. Reports Normal. → Vini OT 19/6
	7pm	Baby D/o chart maintain.
	8pm	Baby details handed over given to night duty SW. → Vini OT 19/6

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<u>Night duty on 25/6/26:</u>
<u>25/6/26</u>		
	8pm	⇒ Baby details handover taken from evening duty S/N. → <u>Alf</u> 607844
		⇒ While receiving the Baby conscious & active good.
	9pm.	⇒ vitals are checked & recorded.
		⇒ IV line patterned. → <u>Alf</u>
		⇒ Baby on soft diet 607844
	1AM	⇒ slept well. NO other complaints → <u>Alf</u>
	5AM	Maintain 8/10 chart <u>Alf</u>
	6AM	Discharge medicines given.
	8AM	Hand over given to morning duty staffs → <u>Alf</u> 0120587

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

