


# ACTIVITY RECORD FOR BILLING

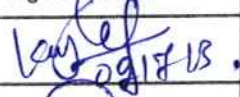
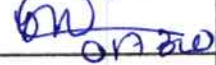
Name: SNC-00012580 IP24-00008746  
Master ADHVKA S  
08-03-2017 9 Y 3 M 12 D (N)  
Dr. KARTHIK NARAYANAN R

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
20/6/26	2:30 PM	ER	PIUW	
20/6/26	10:45 AM	PIUW	Ward	

## CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	Dr. Indhu	20/6/26	251871 ✓	
2.	Dr. Indumathi	21/6/26	2067 ✓	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

# INVESTIGATIONS

Date	Investigations	Order No.	Signature
20/6/26	CBC ✓, RP2 ✓, P.S. ✓, →	7555	
	CRP ✓, Bx. Trypkase ✓,	7549.	Way Jacobs
	Sr. IgE ✓, AEC. ✓	(7551) ✓	
	RBS (POCT) ✓	7550 ✓	Way Jacobs
20/6/26	RBS (POCT) ✓	7554 ✓	Way Jacobs
	C3 quantitation ✓		
	C4 quantitation ✓		
	Cost Add on for ✓	7558	Way Jacobs
	Special test [C1EIPA]		
	Cost Add on for		
	Special test [C1EIE]		



**PROCEDURE**

Date	Procedure	Quantity	Order No.	Signature
8/6/26	IV placement ✓	①	1849 ✓	[Signature]
20/6/26	Nebulization ✓	1	1854 ✓	[Signature]
20/6/26	Nebulization ✓	1	1854 ✓	[Signature]
21/				

**ANY OTHER INFORMATION:**

.....  
.....  
.....  
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.....  
.....  
.....


Date: 20/6/26 Time: 9AM Prepared By: [Signature]

Staff Nurse [Signature]	Shift / Ward	Billing Assistant	Billing Supervisor
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# ACTIVITY RECORD FOR BILLING

*ward*



Name: ..... SNC-00012580 IP24-00008746  
 Master: ADHVIK A S  
 08-03-2017 9 Y 3 M 12 D (M)  
 UHID No: ..... Dr. KARTHIK NARAYANAN R  
 Date of Admission:  Consultant: ..... Dept: .....  
 Room / Bed No: ..... Ward: ..... Date of Discharge: ..... Time: .....  
 Suggested Billable bed type: .....

## WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

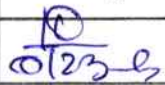
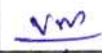

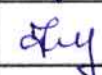

## CROSS CONSULTATION VISIT

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






**PROCEDURE**

Date	Procedure	Quantity	Order No.	Signature
20/6/20	Webi 0 2	2	1885 ✓	
21/6/20	Webi 0 2	1	1971 ✓	
21/6/20	Webi 0 2	1	1982 ✓	
21/6/20	Webi 0 1	1	1987 ✓	
22/6/20	Webi 0 2	1	2065 ✓	

**ANY OTHER INFORMATION:**

.....  
.....  
.....  
.....  
.....  
.....  
.....

Date: 22/6/2020 Time: 11 AM Prepared By: .....

Staff Nurse	Shift / Ward <i>Ramya K</i> <i>(10/22/20)</i> 	Billing Assistant	Billing Supervisor
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6/26 7AM	C/S/B DR. SHAMYUKTHA	
	Δ - Anaphylaxis (Angioedema	
	lip swelling + Eyelid swelling ↓	
wt - 38kg	rash subsiding NO stridor	
	WOB - (N)	
	O/E: PPWP / Angioedema ↓ sed. /	
	Vitals: RR - 80/min	comfortable
	SpO <sub>2</sub> - 99% on RA	
	RR - 23/min	
	CNS - S1 S2 ⊕	
	RS - S/I AE ⊕	
	P/A - 80/60	
	CNS - Alert	
		Plan
		1) Monitor vitals 2) w/o stridor and other symptoms 3) Continue as per orders
		Dr. Shamyuktha 1557630



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>3/3</u> 2. <u>Atle</u>	
20/6/26 8:00am	9yr 3m / Mch	
	Symptoms ↓   Edema ↓	
	no cough	
	Anaphylaxis / Angioedema	
	↓ itchy ⊕	chest work ⊕
	No trigger	off atle no stridor lips swelling ↓
H/o	sweating induced urticaria	WJ - S102 ⊕
		LA: BAE ⊕
		HA: soft
	HE - 90L	
	HA 1 #	
	BR - 11/60	
	RR 30/min	
	WOD ⊕	
	<u>TR</u>	
	SPI - 9A.1	
	in RA	
	① CS, w	
	② CI esterase inhibitor Assay - Quantitative functional	see J.F. ⊕
		TC ⊕
	③ Serum tryptase	AFT ⊕



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	Allergy history.	
	<ul style="list-style-type: none"> <li>• #/o hives following use of restrooms (freshly cleaned).</li> <li>• Currently no documented food/dmg allergy.</li> <li>• Episodes - all throughout year ? seasonal predilection (↑ episodes - summer).</li> </ul>	
	Indoor history.	
	<ul style="list-style-type: none"> <li>• Dry dusting ⊕</li> <li>• Wet mopping once a week</li> <li>No indoor plants/pets</li> <li>No use of incense/perfume</li> <li>No tobacco exposure</li> <li>• Cockroaches ⊕ (3m back - pest control measures taken).</li> </ul>	
	Residing in 11 <sup>th</sup> floor - good ventilation - construction work nearby ⊕.	
	No h/o turf exposure Outdoor play - minimal.	



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
	Family history	
	- maternal uncle - ? allergy to food colouring.	
	- mother - contact dermatitis.	
	O/E	
	• alert/ active	
	• HR - 90	
	B/P - 115/62 mmHg	
	CFT < 3 sec	
	PPWF (+)	
	S/E	
	RS - B/L no wheeze	AE (+), ? Reduced
	Other sys   (+)	
	Rx	
	• Neb. Adrenaline 3ml + 2ml NS stat	
	• Continue drug orders	
	• To do Serum Trypsin in samples taken @ admission.	
	• Skin Prick test later	
	• Parents counselled in detail regarding risk of further episodes of anaphylaxis, and treatment options	
		/sn/107742

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### PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/6. 6pm	o/s/B - Dr. Anil M	
	Anaphylaxis / Angioedema.	
	No cough.	
	Edema ↓	
	stridor ↓	
	Oral intake ↑	
	Wtine D/P - (N)	
	O/E - Active	
	PP WP	
	vitals (N)	
	CRT < 3 secs	
	S/E - WNL	
	Chest - B/c conducted	
	sound (N)	
	Actu	
	- Cont IV medication	
	- S' Neb · B uclato	



(a)

### PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/06	S/B Dr. Pavi Pragasal	
9:00 AM	Anaphylaxis / Angioedema	
	Symptoms resolved / Edema resolved	
	No cough / No respiratory distress	
	O/E: child conscious, oriented, afebrile. (HR/RR), CRT < 3 sec	
	S/E: CVS - S <sub>1</sub> , S <sub>2</sub> ⊕, no murmurs. RS - BAE ⊕, clear, no rales flx - soft CNS - Tm ⊕	
		<ul style="list-style-type: none"> <li>- IV Hydrocort 20mg</li> <li>- IV Emesal 10mg</li> <li>- IV Ranit 50</li> <li>- Neb. Budecort. q 4hr</li> </ul>

*[Signature]*  
24/06/17  
Dr. Pavi Pragasal

SNC-00012580 IP24-00008746

Master ADHIKA S

08-03-2017 9 Y 3 M 13 D

Dr. AKILA SIVAKUMAR



### PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/26	S/B <u>Dr. Pravi Raju</u>	
8PM		
	ale: child conscious,	
	oriented, alert	
	(HR/RR) CRT < 3sec	
	peripheries warm.	
	mild cough, occasional	
	Abdominal pain ⊕	
	SE: NS - S, S ⊕, no murmurs	
	AS - BAE ⊕, clear	
	PIA - soft, BS ⊕	
	CMS - FA ⊕ ⊕	
		R
		- SP. OMMAROTIC
		FORTI
		Sml - 0 - Sml
		- T. PTA 40mg qd

*[Handwritten signature]*



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/06/2017	Dr. Divakar	
8:00 AM	A - Anaphylaxis / Angioedema	
	No breath difficulty	
	No rash	
	edema ↓ ↓	
	S/E - Cx - alert & active	
	afebrile; CRTN	HR - 92/L
	moist m	RR - 24/L
	norm per	Bp - 100/60 mm
	S/E - Cx - S <sub>2</sub> ⊕	SpO <sub>2</sub> - 98% @ RA
	R <sub>2</sub> - BAE ⊕; Clear	
	PA - Sott / unrotated	
	Cm - Tox ⊕	
	Vital Sign	
		Plan:
		- Give medication as per chart
		- vital monitoring



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/1/20 10:50 AM	<p>SB Dr. Akila</p> <p>9hr 2nd IM</p>	
	<p>Anaphylaxis / Anaphylactoid reaction</p>	
	<p>no fresh complaints</p>	
	<p>O/E, Acet</p>	<p>WOB P</p>
		<p>no itchy</p>
AFC	<p>HE - 80L</p>	<p>W.S.</p>
Dg B	<p>tr 1A</p>	<p>U / MTD</p>
	<p>RR - 20L</p>	<p>RA - 50F</p>
	<p>WOB P</p>	
Gy	<p>BS</p>	
Gy	<p>Discharge today</p>	
Gy INB - ordered		



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		X. Anaphylaxis / Angiodema / <u>Constriction</u>
	① sy OMNACORTIL FORTE (15mg / ml)	(6ml) — 0 — (6ml) x ③ day
	② T. PAN 40 (1/2 cu lobe food)	① — 0 — ① x ④ day
	③ sy ATARAX (10mg / ml)	(7ml) — 0 — (7ml) x ② day
		① — 0 — ① x ② day
	④ sy ATARAX lobe for ex. App	① — 0 — ① x ② day
	Pre-filled Amp - 2 syringe - 0.3ml (1:1000)	x ① day

o Intra leaflet to be seen after ③ day in no. 1  
counseling  
 1221



SNC-00012580 IP24-00008746  
 Master ADHVIK A S  
 08-03-2017 9 Y 3 M 12 D (M)  
 Dr. KARTHIK NARAYANAN R



①

NURSES NOTES

Date/Time	Notes	Signature
	Revised notes - 20/6/26	
2:30 AM	Baby received from ER to PICU. Baby complaints of Anaphylaxis Angioedema; lips swelling, eye swelling.	[Signature]
3 AM	Baby IV line patent. Baby conscious and oriented. Baby NEM (OCL) on going SpO2 100%. Maintained.	[Signature]
4 AM	Baby urine raised. Baby coverts or stable. → →	[Signature]
5 AM	Baby was sleeping well. Baby conscious and oriented. Baby no any other complaints → →	[Signature]
6 AM	Baby sleeping well. Baby IV line patent. Baby case done. Baby	[Signature]
7 AM	Diocort maintained. vitals stable. NO any other complaints. Blood sample taken <del>to do</del> to do: "Tryptase, histamine"	[Signature]
	RBS - 116 mg/dL. Informed to Dr. Brauth sir	[Signature]
8 AM	Baby handing over given to morning duty SW	

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### NURSES NOTES

Date/Time		Signature
20/6/26 8AM	Morning duty 20/6/26	
	Baby details handing over	
	given by night duty staff	
9AM	Baby vital signs checked	
	and recorded.	
	Trio chart maintained.	[Signature]
	IV line patting. IV stop.	
10AM	sample send to Lab.	
	complaints of body pain 6AM	
	Abdominal pain 6AM.	
	mild severe eyes & lips.	
10:00AM	DR. Indhu manges in child.	
	advised to Drug chart	
10:45AM	Baby shift to ward	[Signature]

SNC-00012580 IP24-00008746  
 Master ADHVIK A S  
 08-03-2017 9 Y 3 M 12 D (M)  
 Dr. KARTHIK NARAYANAN R



### NURSES NOTES

Date/Time	Received notes [2016126]	Signature
11AM	Pt received from PICU to 2nd floor. Pt is conscious and oriented. Pt complaints for swelling in lips and breathing difficulty in 4th night. CB, Quantitation, CH Quantitation and s-tryptase send to lab in Dr. Anil Kumar advice. send in PICU staffs.	→ G.M's 012317  → G.M's if the 012319
	Check vital sign & record. 100 adrenalin given. Change sup: Avil Change to oral sup: Atarax	→ G.M's if the 012319
1PM	Reassessment done. no other complaints. Attention P/O chart	
2PM	Hand over given to evening duty staffs	→ G.M's 012319

**NURSES NOTES**

Date/Time	Notes	Signature
2pm	<p style="text-align: center; color: red;">Evening duty 20/06/26</p> <p>Baby details is handover taken from morning duty staff.</p>	
3pm	<p>Baby is active awakest →</p> <p>Pr time patient</p> <p>Baby slept well.</p>	<p>Jeyasri 020610</p>
5pm	<p>no any other complaints →</p> <p>vital signs is checked up recorded. Baby is</p>	<p>Jeyasri 020610</p>
7pm	<p>vitaly stable. →</p> <p>medications given as per drug chart. No chart is maintained. no any other complaints →</p>	<p>Jeyasri 020610</p>
8pm	<p>Baby details is handover given to the night duty staff →</p>	<p>Jeyasri 020610</p>

SNC-00012580 IP24-00008746  
 Master ADHVIK A S  
 08-03-2017 9 Y 3 M 12 D (N)  
 Dr. AKILA BIVAKUMAR



## NURSES NOTES

Date/Time		Signature
	<u>Night duty on 20/6/26</u>	
20/6/26 9pm	Baby details taken one hr from evening duty str.	
	Baby was conscious and oriented. Dr hr pattern. Rashes decreased and sneezing also decreased.	
	Do chart monitor. →	<u>MIS</u> 01/7/26
9pm	check vital signs and Recording. vital is stable.	
	Do chart monitor. →	<u>MIS</u> 01/7/26
11pm	Baby comfortable sleeping.	
21/6/26 1AM	Baby oral intake good. Baby vital is stable and Recording. ←	<u>MIS</u> 01/7/26
5AM	Baby said NO complaint.	
6AM	Baby Do chart monitor. →	<u>MIS</u> 01/7/26
8AM	Baby details handing over given to morning duty str. →	<u>MIS</u> 01/7/26

**NURSES NOTES**

Date/Time		Signature
8Am	<p style="text-align: center; color: red;">Morning duty 9/16</p> <p>Bahy hand over taken</p>	
	<p>from night duty</p>	
	<p>Bahy conscious and</p>	
	<p>oriented →</p>	
	<p>Bahy vitals checked</p>	
10Am	<p>and recorded.</p>	
	<p>Bahy no itching complaints</p>	
	<p>Bahy taken oral diet</p>	<p style="text-align: center;">Audle 020432</p>
	<p>No other complaints</p>	
11Am	<p>med- given →</p>	
	<p>Pr hydro change</p>	
	<p>to oral syrup →</p>	
12pm	<p>Bahy syrup taken oral</p>	
1pm	<p>Plo Chart maintain</p>	
2pm	<p>hand over given</p>	
	<p>to evening duty</p>	<p style="text-align: center;">Audle 020432</p>

**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 21/6/26</b>
21/6	2pm	Baby details taken over from the morning duty staff
		Baby was conscious and oriented vitally stable → Jency
		On line pattern vit stable also 0213
		no any other complain
		Baby sleep good
	5pm	Re-assessment done vitally stable & second → Jency
	6pm	medication given as per drug chart
	7pm	Teo chest monitoring
	8pm	Baby details handing over to night duty staff → Jency
		<b>Night duty on 21/6/26</b>
	8pm	Baby is taken over from evening duty staff. Baby is awake & active and about IV cannula present in (L) hand with 22 g vcomplan.
	9pm	vital signs are checked and recorded. Jency 0825

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

SNC-00012580 IP24-00008746  
 Master ADHVIA 9  
 08-03-2017 9 Y 3 M 13 D (N)  
 Dr. ANILA BIVAKUMAR



# NURSES NOTES

(USE BALL POINT PEN ONLY)

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

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
	10pm	Due medications given as per order.
	11pm	Baby slept well, no other complaints at present. <span style="float: right;">Sushmitha / 01/20/17</span>
	6am	Vital signs are checked and recorded.
	10am	No chart maintained.
	5am	Baby details handing over to morning duty staff. <span style="float: right;">Sushmitha / 01/20/17</span>
		<b>Morning duty 22/6/16</b>
22/6/16	8am	Patient details handing over taken from Night duty staff. Pt is conscious & oriented. Vitals are checked & recorded. <span style="float: right;">Sushmitha / 01/20/17</span>
	9am	Due medication are given as per doctors order. No charting maintained. <span style="float: right;">Sushmitha / 01/20/17</span>
	11am	Dr. Anila Ram Rounds done. Advised to plan for discharge. <span style="float: right;">Sushmitha / 01/20/17</span>
		File send to billing. <span style="float: right;">Sushmitha / 01/20/17</span>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS