

ADMISSION SHEET

Registration Details :



Admission No : IP25-00020515

Admit Date : 19-May-2026

Admit Time : 09:18 AM UHID : FDH-00046016

Patient Details :

Patient Name : Baby B/O ROSHANI SONI

Age : 0 D

Guardian : Mr SAURABH JAIN

DOB : 19-05-2026 08:32 AM

Gender : Male

Religion :

Occupation :

Martial Status :

Address (H) : Houser vivantis Hyderabad Hyderabad
Telangana INDIA 500001

Phone No : 7435008420/ 7435008420

E-mail : Jroshani146@gmail.com

Admission Details :

Bed Type : BASINET

Bed No : CRDL MICU 4-1

Ward Name : 4F -MICU

Room No : CRDL MICU 4-1

Admission Type : First Visit

Contact Details :

Name : Mr SAURABH JAIN

Relationship : Father

Contact Address :

Phone No :


Signature

Doctor Details :

Doctor Name : Dr. KONDAM PRADEEP REDDY

Specialisation : NEONATOLOGY

Referral Doctor :

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY



FDH-00046016 IP25-00020515
 Baby B/O ROSHANI SONI
 19-05-2026 0 Y 0 M 0 D 1 H (M)
 Dr. KONDAM PRADEEP REDDY



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: NBC			Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:			
	Surgery / Procedure: New born care			Post OP Day:			
BACKGROUND	Date	Shift	19/5/26 M	19/05/26 E	19/5/26 N		
	Medical Condition (Any special condition to be noted):		NBC	NBC	New Born		
	Diet:		DBF	DBF	DBF		
ASSESSMENT	Allergy:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):		RA	RA	RA		
	Tubes/Drains/Catheter:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:		Temp:	36.5°C	36.3°C	37°C	
			Res:	46	48	42	
			SpO ₂ :	99%	96%	95%	
			Pulse:	152	148	138	
			BP:	-	-	-	
			LOC:	conscious	conscious	conscious	
			Fall Risk Score:	0/10	0/10	0/10	
		Pain Score:	0/10	0/10	0/10		
		Skin Integrity	Good	Good	Good		
Recommendations	Safety Needs:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:		-	-			
	Others Specify:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:		DBF	DBF	DBF		
	Critical Lab Test / Values:		-	-			
	Other Special Orders / Medications:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	PU Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DVT Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADL (Dependent / Non Dependent):		dependent	dependent	dependent			
Post Operative Procedure Special Orders:							
Handed Over By Name :		Sriyani	S.Hait	neha			
Signature / ID :							
Date:		19/5/26	19/05/26	20/5/26			
Time:		2pm	at 8pm	@ 8AM			
Taken Over By Name :		S.Hait	neha				
Signature / ID :							
Date:		19/05/26	19/5/26				
Time:		at 2pm	@ 8pm				

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date						
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:						
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	PU Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
DVT Prophylaxis:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADL (Dependent / Non Dependent):							
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

ACTIVITY RECORD FOR BILLING

FDH-00046016 IP25-00020515
Baby B/O ROSHANI SONI
19-05-2026 0 Y 0 M 0 D 4 H (M)
Dr. KONDAM PRADEEP REDDY

Name: ----- *B/o Roshani* -----
UHID No : ----- IP No : ----- Cons ----- - 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
<i>19/05/26</i>	<i>2:18 pm</i>	<i>MICU</i>	<i>ward</i>	<i>Srida Srivani</i>
<i>20/05/26</i>	<i>12:00 pm</i>	<i>ward</i>	<i>Billing</i>	<i>Seema</i>

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
17/5/26	BGT, CRP, DCT	7661 ✓	Wong
19/5/26	Bilirubin, Coxa Blood		
19/5/26	RCT		
20/5/26	TCBR 7.5	7702	Lums
20/5/26	OAE	7513 ✓	Lums
			Lums 20/05/26

L checked by Wong 19/5/26 @ 12:20PM

~~L by Lums 20/05/26~~

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

Date: 19/5/26

Time: 9:18AM

Prepared By: Srivani

Staff Nurse Srivani	Shift / Ward MICU	Billing Assistant	Billing Supervisor
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NEWBORN HEARING SCREENING

FDH-00046016 IP25-00020515
Baby B/O ROSHANI SONI
19-05-2026 0 Y 0 M 0 D 15 H (M)
Dr. KONDAM PRADEEP REDDY



Hearing screening was done using TEOAEs

Right ear - Hearing screening results indicate **PASS** (presence of TEOAEs), suggestive of normal outer hair cell functioning.

Left ear - Hearing screening results indicate **PASS** (presence of TEOAEs), suggestive of normal outer hair cell functioning.

Startle: Present

Recommendation –

Monitor communication development

Follow up if any hearing concerns exist.

[Signature]
20/5/2026

Dr. Suganya Reddy Mitta

AUDIOLOGIST & SPEECH LANGUAGE PATHOLOGIST

Note- OAEs were pass(present) bilaterally is an indicative of normal hearing sensitivity, however it must be noted that presence of OAEs (PASS) indicates structurally and functionally normal middle ear and outer hair cell functioning. OAE test does not assess the exact hearing threshold. A BERA test can be administered at the age of 3 months (if necessary) for objective evaluation of hearing thresholds.



NURSING DEPARTMENT NEWBORN - NURSING ASSESSMENT FORM

(Select and 'tick mark' [✓] the boxes as applicable)

Baby's Name: Mother's Name: B/O Roshani
 Date of Birth: 19/05/26 Time of Birth: 8:22 AM Gender: Male Female
 Birth Weight: 2.821 Kgs HC: cm Length: cm
 Meconium in Liquor: Yes No Cried at Birth: Yes No
 Term / Pre-term / Post-term: Term
 Resuscitated: Yes No Blood Group: Mother: B+ve Baby:
 Feeding: Breast Feeding Formula Both First Feed Time:

AFFIX MOTHER'S IDENTIFICATION LABEL

Mode of Delivery: Normal LSCS - Emergency/ Elective Instrumental AVD
 Indication:

Physical Assessment of New Born:

Temp: 36.5°C HR: 152 /Min RR: 46 /Min BP: SpO₂: 99%

Pain Score: 0/10 (Follow N Pass)

Fall Risk Assessment: Yes No Score: 0/10 (Fill the Humpty Dumpty Sheet)

Risk in Pressure Sore: Yes No (Braden Q Score) (Fill the Braden Q Sheet)

Behaviour Status on admission: Sleeping Crying Calm Drowsy

Findings:

General Appearance: Posture: Well-Flexed Asymmetry

Skin: Pink Meconium Stain Others, Specify:

Nursing Management: (Please strike through if not applicable e.g. Yes / ~~No~~)

Vitamin K 1 mg I.M Administered: Yes / No

Routine Care Provided: Yes / No

Capillary Blood Glucose Monitoring Done: Yes / No

Neonatal Screening Done: Yes / No

1. Nutritional Screening: Feeding Problem Yes / No

2. Functional Screening: Musculoskeletal Congenital Abnormality Yes / No

3. Socio History: Siblings Yes / No

All information obtained from Mother Father Other Family Member

Newborn Screening Discussed: Yes / No

Nurse Name: Sarvani

Signature: [Signature]

Date & Time: 19/5/26 @ 2pm



FDH-00046016 IP25-00020515
 Baby B/O ROSHANI SONI
 19-05-2026 0 Y 0 M 0 D 1 H (M)
 Dr. KONDAM PRADEEP REDDY



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Age : Father's Name : Age :
 Date of Birth : Date of Admission : UHID No.:
 NICU Consultant : Referring Consultant :
Transferring Unit : OT Labour Room ER Ward
Transported ? Yes No - If yes : Long (> 30 kms) Short (< 30 kms)

BIRTH INFORMATION

Name : B/o ROSHANI Mother's Blood Group : O negative
 Gender : M F Blood Group : Birth Weight (gms) : 2821g Length (cms) :
 Date of Birth : 19/5 Time of Birth : 8:32am OFC (cms) :
 Place of Birth : Estimated Gesth Age : 38+3 wks

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 30yr 4mo Ht : Wt : BMI : Married Life : LMP : 20/8/24 EDD : 28/1/26
 Conception : Spontaneous or with Rx :
 Booked at what GA : 4+5 weeks AN Steroids Drugs / Doses :
 Last Scans Details : 10/5- SUP 36+6 wks AFI-10.5cm Doppler @
6m 2509gm 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 / Redistribtion 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 :

FDH-00046016 IP25-00020515
 Baby B/O ROSHANI SONI
 19-05-2026 0 Y 0 M 0 D 1 H (M)
 Dr. KONDAM PRADEEP REDDY



PAST OBSTETRIC HISTORY

P: A: L:

B. W	Gender	Significant	Details

PERINATAL HISTORY

Treating Obstetrician : Hospital : Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig)</p> <p>Second stage (> 2 hours after dilation) <i>AVD</i></p> <p>LSCS : <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</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 :</p> <p>Resuscitaion : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cord ABG :</p> <p>Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :</p>
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NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : Weeks :

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
<i>7/10</i>	<i>9/10</i>	

TOTAL

Resuscitation			
Minutes	1	5	10
Oxygen			
PPV / NCPAP			
ETT			
Chest Compressions			
Epinephrine			

Comments :

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :



A single live A Boy delivered via
A VD
↓
i Group of wood around
neck
~~CIAD~~
↓
wood clamped a cut away
↓
Do vit & inst stab
↓
Shift to motor side

Investigation details in previous Hospital :

o

Feeding History :

o



[Empty box for patient information]

Family History :

0

Socio Economic History :

0

GENERAL EXAMINATION ON ADMISSION

General Disposition :

0

VITALS : Temperature : HR : 158 RR : NIBP : CFT :

Color of the extremities : Anurocyanosis

Jaundice : Pallor : SpO2 :

Anthropometry : Birth Weight : 2821 kg Length : HC : Present Weight :

Ponderal Index : AGA : SGA : LGA :



HEAD TO TOE EXAMINATION

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

Facies :
(Any Facial
Dysmorphism)

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

EYES : Symmetry :
Red Reflex : *ⓐ*
Discharge :

**EARS, NOSE
MOUTH and
THROAT :** Ear set / Shape :
Periauricular Pits / Tags :
Nasal shape / Patency :
Palate :
Gums : *ⓐ*
Lips :
Tongue :

**THORAX and
BREASTS :** Shape of Thorax :
Position of Nipples and Number :

**ABDOMEN and
UMBILICUS :** Shape :
Organomegaly : *ⓐ*
Bowel Sounds :
Umbilical Stump :
Discharge :

GENITILIA : Labia / Hymen :
Testicles/penis : *male type*
Anus :

HERNIAL ORIFICES

fontal hernias

TRUNK and SPINE :

SKIN LESIONS :

EXTREMITIES : Fingers / Toes : *ⓐ*
Arms / Legs :
Deformities :
Mobility :
Hip Joint Examination :



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: clear Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 158 BP : 118 Precordial Activity :

Femoral Pulses : felt Murmurs :

Other Peripheral Pulses : Signs of Cardiac Failure :

Abdomen :

Shape : Hernia orifice :

Palpation : S/D Anal Patency :

Palpable masses : Umbilical Cord : 2A 14

Abdominal girth : First urine passed :

Meconium passed :

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves :

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

Motor System :

Passive Tone : Active Tone :
.....

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : DTR :

ATNR : Skull and Spine :



Any Congenital Anomalies :

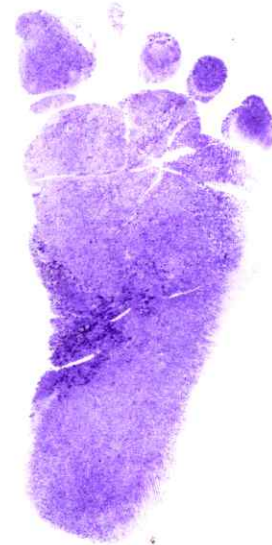
Diagnosis : TOMIAGA / AVO / D. Boy / CAG / rh neg neg
(cur)

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *Dr. Malavika*

Name : *Dr. Malavika*

Date & Time : *19/5*

Consultant :

Signature :

Name :

Date & Time :

PLEASE FILL UP THE FOLLOWING DETAILS

1. Name of the referring Doctor :
2. Name of the referring Hospital :
Address :
Contact Numbers :
3. Contact Details of the referring Doctor :
Mobile No. : E-mail ID :
4. Name of the Doctor in Rainbow Team :
..... on whose name the patient is being referred.



AT THE TIME OF TRANSFER TO THE WARD

Final Diagnosis :

Present Issues :

Vital : HR : RR : BP : SPO2 : Weight :

Any Oxygen requirement :

Systemic :

Medications :

Plan during ward follow up :

Keep baby warm
OBF & wt fls sleeping
to do Blood group &
DGT
Cord Bilirubin
Retc count
CBP

Feeding Plan at the time of shifting :

Vaccination
OAE

Screenings done during NICU Stay :

MDS
SBR YUSTOL

NSG :

Hearing Screen : to decide on CBP

ROP :

TFT :

NP2 :




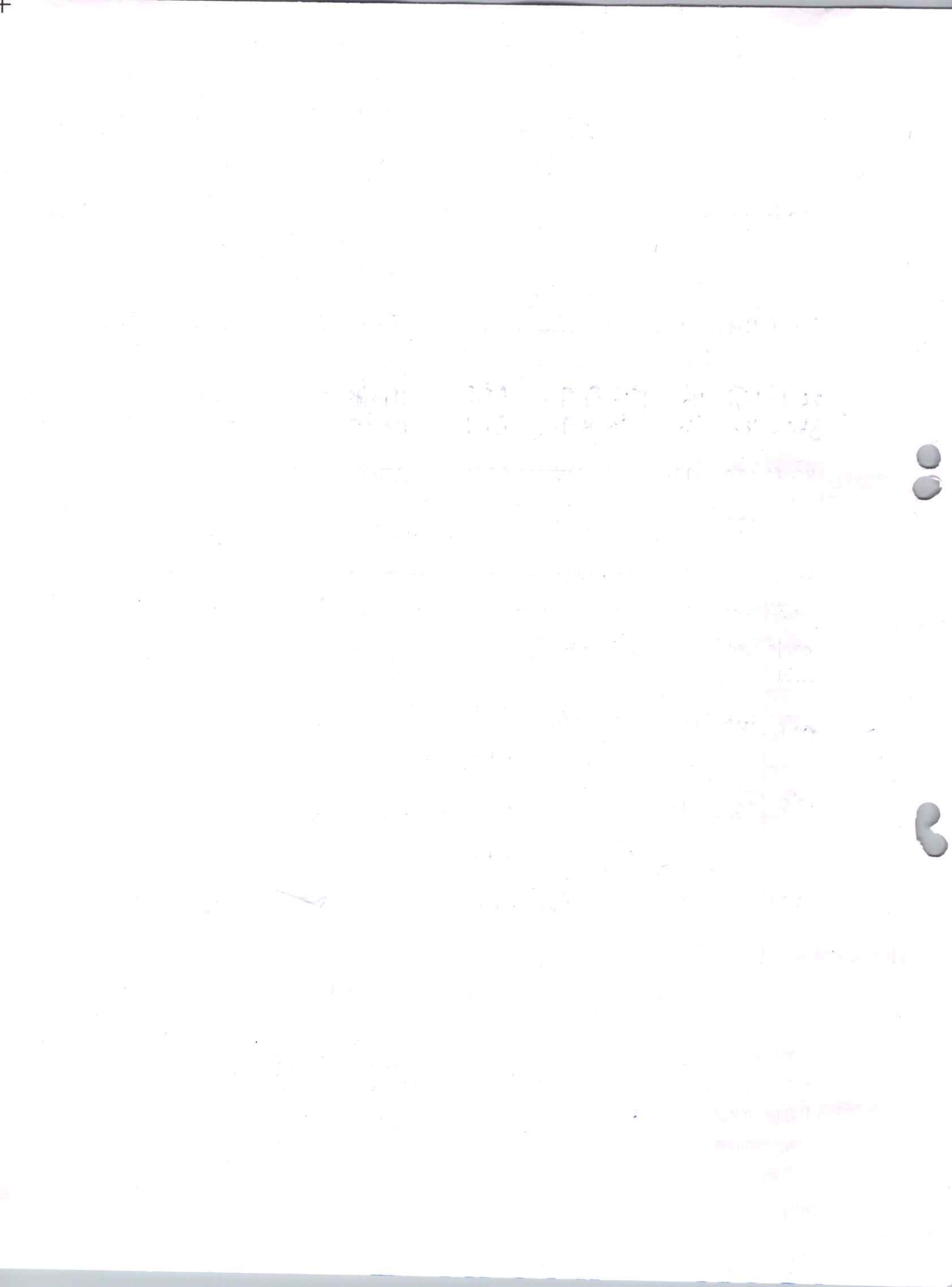
19/05/26
 1

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/5/24 3:30 PM		<p>class Dr. Sejal</p> <p>3 bed</p> <p>on DBF</p> <p>accepts feeds well</p> <p>CLT in bed</p> <p>vom stools (wet passed)</p>
		<p>ph</p> <ul style="list-style-type: none"> - cont DBF - valentim - feeds - OAF - TM - STR, NBI @ 4/5/24 - Trace DCF
		<p>Sp</p>
20/5	S/B. Dr. Vinodha (CLPT)	<p>Breastfeeding counselling given</p>


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/5/2026 9 AM	y 2/B Dr. Prad eep Dr. Sneh	
	S: 24 wks / term / AUA / And / meh Phase pregnancy	
	G: stable cord Bilirubin: 2.04	
	Vitals HR: 140/min RR: 40/min Temp: 36.5°C SpO2: 98% RA	Plan DBF show SBR, NBS @ 48h OAG Vaccination Red reflex
		@ 24h 





FORM

Patient Name & UHID No FDH-00046016 IP25-00020515 Baby B/O ROSHANI SONI 19-05-2026 0 Y 0 M 0 D 4 H (M) Dr. KONDAM PRADEEP REDDY 		Date & Time of Admission 19/5/26 @ 9:18 Am	Date & Time of Transfer Order 19/5/26 @ 2:25 pm
		Transfer Ordered by DR. Rameya	Reason for Transfer New born girl
From Unit MICU	To Unit ward	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 10	Number of Imaging Films 7	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	card clam	7	
2.	Inj-vit-k	1	
3.	provided warm		
4.	2nd hrsly DBF		
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Srivani		Name of Person Ordered Transfer DR. Rameya	
Patient & Clinical Records Received by : S. Hait 19/05/26 at 2:25 pm			
Date & Time of Patient Received :			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- Unavailable Bed
 Nurse not Available
 Available Bed not ready



<p>1. Name of Patient</p> <p>Mr. J. S. Smith</p>	<p>2. Date of Birth</p> <p>12/15/1945</p>	<p>3. Room & Bed</p> <p>Room 101, Bed 10</p>
<p>4. Reason for Transfer</p> <p>Admission to Hospital</p>	<p>5. Referring Physician</p> <p>Dr. J. K. Brown</p>	<p>6. Receiving Hospital</p> <p>St. Mary's Hospital</p>
<p>7. Referring Hospital</p> <p>St. Mary's Hospital</p>	<p>8. Referring Physician</p> <p>Dr. J. K. Brown</p>	<p>9. Receiving Physician</p> <p>Dr. M. N. Green</p>
<p>10. Referring Hospital</p> <p>St. Mary's Hospital</p>	<p>11. Referring Physician</p> <p>Dr. J. K. Brown</p>	<p>12. Receiving Physician</p> <p>Dr. M. N. Green</p>
<p>13. Referring Hospital</p> <p>St. Mary's Hospital</p>	<p>14. Referring Physician</p> <p>Dr. J. K. Brown</p>	<p>15. Receiving Physician</p> <p>Dr. M. N. Green</p>
<p>16. Referring Hospital</p> <p>St. Mary's Hospital</p>	<p>17. Referring Physician</p> <p>Dr. J. K. Brown</p>	<p>18. Receiving Physician</p> <p>Dr. M. N. Green</p>

