

ACTIV KOH-00308752 IP2-00056444 **NG**

Baby Of VEMULA BHAVANA
01-08-2026 0 Y 0 M 0 D 1 H (F)
Dr. KADIRI BHANU VARUN KUMAR

Name: ---
UHID No _____ Consultant : _____ Dept : _____



Date of Admission : 11/6/26 Time : _____ Date of Discharge : _____ Time: _____

Room / Bed No : _____ Ward : 4W Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
<u>11/6/26</u>	<u>10:30pm</u>	<u>4W</u>	<u>410</u>	<u>[Signature]</u>

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
1/6/26	Blood group	7594 ✓	Tya
1/6/26	ABG	7599 ✓	
	Cross Chem Assemblu 1/6/26		
3/6/20	SBB; NBS	26007676	H

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
2/6/26	OAE	①	942593	Aurilla
2/6/26	BCG	}	}	Aurilla
	OPV			
	Hep-B			

ANY OTHER INFORMATION

Baby Cef given

Date: 1/6/26

Time: 10 pm

Prepared By: Tyasa

Staff Nurse

Abhrami

Shift / Ward

Mw to 410

Billing Assistant

Billing Supervisor



NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : Vemula Bhavana 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 Bhavana Mother's Blood Group : A+ve
 Gender : M F Blood Group :
 Date of Birth : 1/6/26 Time of Birth : 5:51pm
 Place of Birth : H. Kondaipm Birth Weight (gms) : 3.420 Length (cms) :
 OFC (cms) :
 Estimated Gesth Age : 40 wkr

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 31yrs Ht : Wt : BMI : Married Life : LMP : EDD :
 Conception : Spontaneous or with Rx :
 Booked at what GA : 21 + 6 AN Steroids Drugs / Doses :
 Last Scans Details : 18/5 - S.MVF / 38+1 / cephalic / 3.355 / 47% / AFI-14.5
PL - A/H , doppler - @ 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 / Redistribution 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) <input checked="" type="checkbox"/> UTI : when : <u>33+2</u> Any culture :
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PPROM : Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :

Patient Sticker

PAST OBSTETRIC HISTORY

G: P: A: L:

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
		primi				

PERINATAL HISTORY

Treating Obstetrician : Dr. Aakshmi Devi Hospital : ELH Inborn Outborn

Duration of Labour

First stage (> 18 hours sig)

Second stage (> 2 hours after dilation)

LSCS : Elective Emergency Indication :

Specify the reason : 11/10 NPOK

Augmentation of Labour : Induced Assisted Vaginal

CTG : Normal Suspicious Pathological

MSL :

Resuscitation : Yes No

Cord ABG :

Placenta : (weight, surface, No. of cotyledons, calcifications, malformations, clots etc :

NEONATAL RESCUSTITION DETAILS

APGAR SCORE

Gestational Age : 40 wks 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
TOTAL	<u>8/10</u>	<u>7/10</u>	

Resuscitation

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

Snapee II Score

	> 30 (0)	20-29 (9)	< 20 (19)
Mean BP (mmHg)	> 96 (0)	96-95 (8)	< 95 (15)
Lowest Temp (oF)	> 2.49 (0)	1-2.49 (5)	0.3-0.99 (15) < 0.3 (28)
Pao2 / Fio2 (mmHg%)	> = 7.2 (0)	7.1-7.19 (7)	< 7.1 (16)
Lowest Serum PH	No (0)	Yes (19)	
Multiple Seizures	> = 1 (0)	0. 1-0.9 (5)	<0.1 (18)
U. Output (ml / kg / hr)	> = 7 (0)	< 7 (18)	
Apgar Score	> = 1kg (0)	750 - 999 (10)	< 750 (17)
Brith Weight	> 3rd percentile (0)	< 3rd (12)	
SGA			

POSTNATAL / HISTORY OF PRESENT ILLNESS

Chief Complaints :

History of Present Illness:

Equipment check done

↓

BCIAB

Vc clamped & cut (24 hrs)

inj. Vit K 1mg IM given

↓

0
Vital stable

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : HR : 146 bpm RR : NIBP : CFT :

Color of the extremities : acrocyanosis

Jaundice : Pallor : SpO2 :

Anthropometry : Birth Weight : 3.420 Length : HC : Present Weight :

Ponderal Index : AGA SGA : LGA :

HEAD TO TOE EXAMINATION

HEAD : Fontanelles : mid caput (+)
Sutures :
Shape / Moulding : (N)
Edema / Bruising :
Size - (H.C.) :
↓

Facies :
(Any Facial Dysmorphism) :

NECK and CLAVICLES : Range of Motion :
Asymmetry : (N)
Masses :

EYES : Symmetry :
Red Reflex : to be seen
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 :

| (N)

ABDOMEN and UMBILICUS :

Shape : (N)
Organomegaly : No
Bowel Sounds :
Umbilical Stump : 2A + IV
Discharge :

GENITILIA :

Labia / Hymen : (N)
Testicles/penis :
Anus : patent

HERNIAL ORIFICES

appears free

TRUNK and SPINE :

(N)

SKIN LESIONS :

-

EXTREMITIES :

Fingers / Toes :
Deformities :
Hip Joint Examination :

|

(N)

Arms / Legs :
Mobility :

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 : 100% Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 142 bpm BP : Precordial Activity : (N)

Femoral Pulses : b/c palpable Murmurs : -

Other Peripheral Pulses : Signs of Cardiac Failure : -

Abdomen :

Shape : (N) Hernia orifice : appears free

Palpation : soft Anal Patency : patent

Palpable masses : No Umbilical Cord : 2A + IV

Abdominal girth : First urine passed : -
Meconium passed : msd

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score : C/T/A - good

Nerves :

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : B/c symmetrical

DTR :

ATNR :

Skull and Spine : (N)

Any Congenital Anomalies :

Diagnosis :

Primi | 1/40 wks | Emasa iku NPOK F/cra
3.420 | AGA | Msk - grade II

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature :

Name :

Date & Time :

Dr. Bhanani
1/06/21

Consultant :

Signature :

Name :

Date & Time :

Dr. Bhanani

DISCHARGE PLAN

Information given by: Family Friend

Will patient require transportation arrangements to go home: Yes No NA

Will Physiotherapy require at home: Yes No NA

Is home medical equipment anticipated: Yes No NA

Is home oxygen therapy anticipated: Yes No NA

Breastfeeding Yes No NA

Formula Feed Yes No NA

Are dressing needs at home anticipated: Yes No NA

Any other needs anticipated: Yes No If Yes Specify

Feeding Plan at the time of shifting :

Plan

1) OBF @ 2 - 3rd mly
@ 1h mly

Screenings done during NICU Stay :

2) cranial care

NSG :

3) vaccination | today
OAE

Hearing Screen :

ROP :

4) SBR | @ 48Hr
NR1

TFT :

NP2 :

Discharge Details:

5) monitor vitals

Neonatal Condition at Discharge:

~~amp~~

Feeding: Breastfeeding Exclusively Breastfeeding and Formula Feeding Formula Feeding

Vitamin K given: Yes No

Vaccinations given BCG Hepatitis B Others:

Neonatal Screen Taken: Yes No, parents advised to have Neonatal Screen at National screening
program center on:/...../.....

Hearing Test: Yes No

Jaundice: NIL Slight Moderate

Passed Urine: Yes No

Passed Meconium: Yes No

Weight at discharge:

Appointment was given for follow-up at OPD: Yes No

Date of Discharge:/...../.....

Discharge to Home Other:

Against Medical Advice: Yes No

Referred to another hospital: Yes No

Discharge Medications: Yes No

Details:


Final Diagnosis:
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.....
.....
.....
.....
.....
.....
.....

Doctor Signature:

Doctor Name:

Date & Time:

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6 10 AM	T/Fell 3.420	Acft
	Baby - well Euthermic accepting feeds well cry tone good activity	<u>Advice</u> 1) warmth care 2) feeds 2 nd hly HB burping 3) SBG 48uL MS 4) ORG vaccination 24uL 5) Monitor vitals.
	CVS - S3 (A) RIS - ALLTCM P/A - soft	
		
	noted By <u>Srischa</u> 2/6/26 @ 10 AM	


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 01-06-2026 0 Y 0 M 0 D 1 H (F)
 Dr. KADIRI BHANU VARUN KUMAR



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26	S/B - Registrar	
8:30pm	T (40wks) / Em. (48) / C-AB/ 3.4kg / MASL-11	
	Euthetic	
	weight	
	accepting feeds well	
	C/T/A - good	
	urine & stool - passed	Ad
	vital - stable	Warm Care
	cur	
	RS (N)	- DBF-fib biopsy 2-3dk
	PIA	- LBR, NBS @ 48hr
		- monitor vital
	noted by Anitha 2/6/26 @ 8:30pm	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/6/26	S/S Dr. Vallu	
	T / uoww / uu	3.44 / MSL - II
	Baby New	
	Accepting feeds.	
7.7% wt	cup	
1cm	bone food	
	activity	
A+K/A+K	es; si; co	Plan
	R: BAE &	- Inform care
	PIA: so/A	- feeds 2nd by 1% bump up
		- SBR, NBS @ 11:30 2pm.
		If ≥ 12 weight - DSPT
		≤ 12 - Review in 
		2 days.

Noted by sishu on 3/6/26 At 9:30 AM

RESULT SHEET

Ref No : F / HW / RS / INPR / 17

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Baby Of VEMULA BHAVANA

01-06-2026

0 Y 0 M 0 D 5 H (F)

Dr. KADIRI BHANU VARUN KUMAR

Patient Name :

Age :

I.D. No. :



Date	3/8/26				
Time	2:51 pm				
Hb					
PCV					
RBC					
WBC					
N/L					
Platelets					
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj	11.1 → 50.1 → 11.0				
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein/Sugar					
Cells					
N/L					
Doctor's Signature					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Doctor's Signature						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :



VITALS CHART

Date →	01/06/26									
Time ↓	Temp	HR	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am										
8.00 am										
9.00 am										
10.00 am										
11.00 am										
12.00 pm										
1.00 pm										
2.00 pm										
3.00 pm										
4.00 pm										
5.00 pm	36.1°C	155	50	99%				-	-	-
6.00 pm						DBF	①	-	-	-
7.00 pm	36.1°C	148	49	98%				-	-	-
8.00 pm						DBF	①	-	-	-
9.00 pm	97.8°C	152	48	100%						
10.00 pm						DBM				
11.00 pm										
12.00 am						DBM		✓	✓	
1.00 am										
2.00 am						DBM				
3.00 am								✓		
4.00 am						DBM				
5.00 am										
6.00 am	98.2°C	148	46	99%		DBM		✓		
								U-3	M-1	V-0
						TOTAL		U-3	M-1	V-0

Temperature 97.5 to 99.5 F
HR 120 to 160 per minute
RR 30 to 60 per minute
SP02 93-100%

Feeding Plan..... DBF with in One hour

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 Baby Of VEMULA BHAVANA
 01-06-2026 OYOMODIH (F)
 Dr. KADIRI BHANU VARUN KUMAR



Morning Shift

Clinical Diagnosis.....
 Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

Handed Over by : Name & Signature

Received by : Name & Signature

Evening Shift

Clinical Diagnosis..... New born
 Nursing Diagnosis..... New born Care

Plan of Care * Assess condition of the baby * Monitored vitals
 * Provide warm care * Provided cord care
 * DBF and hourly followed by burping

Planned Investigations Procedures

Implementation * Assessed baby's condition * Monitored vitals & recorded
 * Provided warm care * Provided cord care * DBF and hourly provided followed by burping

Handed Over by : Tijasa 11/6/26 @ 8:30pm Name & Signature

Received by : Abhinav Ash Name & Signature

Night Shift

Clinical Diagnosis..... New Born Baby
 Nursing Diagnosis..... New Born Care

Plan of Care Assess the condition of baby
 > Monitor the vitals & provide DBF & Do Burping
 > provide warm care, cord care & Gyn care

Planned Investigations Procedures

Implementation > Assessed the condition
 > Monitored the vital signs
 > provided DBF & Done Burping
 > provided warm care, cord care & Gyn care

Handed Over by : Abhinav Ash Name & Signature

Received by : Shanthe Name & Signature
11/6/26 at 8AM

2/6/26



VITALS CHART

Date →	Temp	HP	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am										
8.00 am						DBM		I	I	
9.00 am										
10.00 am										
11.00 am										
12.00 pm	98.2 F	138	40	99%		DBM		I	I	
1.00 pm								u-0	m-0	v-0
2.00 pm						DBM				
3.00 pm										
4.00 pm						DBM			I	
5.00 pm										
6.00 pm	98.7 F	140	45	98%		DBM		✓	I	
7.00 pm										
								u-1	m-0	v-0
8.00 pm						DBM				
9.00 pm										
10.00 pm	97.6 F	137	40	99%		DBM				
11.00 pm								✓	✓	
12.00 am						DBM				
1.00 am								✓	✓	
2.00 am										
3.00 am						DBM				
4.00 am										
5.00 am						DBM				
6.00 am	98.7 F	140	49	100%					✓	
						TOTAL		u-2	m-3	v-0

Temperature 97.5 to 99.5 F
HR 120 to 160 per minute
RR 30 to 60 per minute
SP02 93-100%

Feeding Plan..... DBM

Morning Shift

Clinical Diagnosis..... NB
Nursing Diagnosis..... New born care

Plan of Care → Assess the baby condition
→ Monitor vitals
→ Maintain I/O chart

Planned Investigations Procedures

Implementation → Assessed the baby condition
→ monitored vitals
→ maintained I/O chart

Handed Over by : Name & Signature
Shreelal
2/6/26 @ 2pm

Received by : Name & Signature
Amitha
2/6/26 @ 2pm

Evening Shift

Clinical Diagnosis..... NB
Nursing Diagnosis..... no complaints

Plan of Care → Assess the baby condition
→ vitals check and record
→ maintain the I/O chart

Planned Investigations Procedures

Implementation → Assessed the baby condition
→ vitals checked and recorded
→ Maintained the I/O chart
→ provided warm care and given DBM feeds

Handed Over by : Name & Signature
Amitha
2/6/26 @ 8pm

Received by : Name & Signature
Sandhya @ 8pm
2/6/26

Night Shift

Clinical Diagnosis..... NB
Nursing Diagnosis.....

Plan of Care → Assess the baby condition
→ Monitor vitals
→ Encourage DBM feeds → Encourage Burping

Planned Investigations Procedures

Implementation → Assessed the baby condition
→ Monitored vitals
→ Encouraged DBM feeds
→ Encouraged Burping

Handed Over by : Name & Signature
Sandhya @ 8Am
2/6/26

Received by : Name & Signature
Shaoth
2/6/26 @ 8pm

Morning Shift

Clinical Diagnosis..... NB
Nursing Diagnosis..... New born care

Plan of Care → Assess the baby condition
→ Monitor vitals
→ maintain I/P Chart encouraged oral feed 2-3rd bly

Planned Investigations Procedures

Implementation → Assessed the baby condition
→ Monitored vitals
→ maintained I/P Chart
→ encouraged oral feed 2-3rd bly

Shanta
Handed Over by : Name & Signature
3/6/26 @ 2pm

Deeshra
Received by : Name & Signature
3/6/26 @ 2pm

Evening Shift

Clinical Diagnosis.....
Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

Handed Over by : Name & Signature

Received by : Name & Signature

Night Shift

Clinical Diagnosis.....
Nursing Diagnosis.....

Plan of Care

Planned Investigations Procedures

Implementation

Handed Over by : Name & Signature

Received by : Name & Signature