


ACTIVITY RECORD FOR BILLING

Name: ----- **KOH-00308727 IP2-00056388**
Baby Of ARADHANA TALLADA
28-05-2026 0 Y 0 M 0 D 3 H (M)
Dr. V VAMSI KRISHNA

UHID No : ----- 

Date of Admission : ----- Consultant : ----- Dept : -----
 Date of Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----


WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
26/5/26	3:45 PM	C/W	302	<i>R. Key</i>

Cross Consultation Visit

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

PROCEEDURE

Date	ProceEDURE	Quantity	Order No.	Signature
26/05/26	vaccine	1		
	opr		done	
	BCG			
	Hep-B			
27/5/26	O.AE	1	9100918	CS
<hr/>				
Cross checked Done By - Sushma 28/5/26				
@ 11 PM				


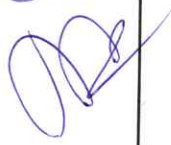
ANY OTHER INFORMATION

 Ket given

Date: 26/5/26

Time: 3:45 PM

Prepared By: T. Cavany

Staff Nurse 	Shift / Ward L/W - 302 	Billing Assistant	Billing Supervisor
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NEONATAL IN-PATIENT MEDICAL RECORD

ADMISSION INFORMATION

Mother's Name : ARADHANA Age : 32yr Father's Name : Age :
 Date of Birth : 26/5 Date of Admission : 26/5 UHID No.:
 NICU Consultant : Dr. Vamsi 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 Aradhana Mother's Blood Group : B positive
 Gender : M F Blood Group : Birth Weight (gms) : 3.114kg Length (cms) :
 Date of Birth : 26/5 Time of Birth : 11:26am OFC (cms) :
 Place of Birth : Reu Kandy Estimated Gesth Age : 38 wks + 1 day

Current Obstetric History : (Booked / Unbooked Case)
 Maternal Age : 32yr Ht : Wt : BMI : Married Life : LMP : 11/9/25 EDD : 8/6/25
 Conception : Spontaneous or with Rx. :
 Booked at what GA : AN Steroids Drugs / Doses :
 Last Scans Details : (20w ~ 24w6d (24w), Ac-to-l, AFP-16, Pl-post, B/Mer)
 TT Immunization and Iron / Folic Acid :

MATERNAL RISK FACTORS

<p>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 :</p>	<p>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 :</p>
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PPROM : Duration : Uterine Tenderness Foul Smelling Liquor HVS (if taken) - Results :
 Medication during Pregnancy : Duration :

PAST OBSTETRIC HISTORY

G: 3 P: 1 A: 6 L: 1

Sl. No.	Age	GA wks	B. W	Gender	Significant	Details
1st	Reg	2019	4.4	♂	CR. wt - 3.02 kg.	cord around neck, NPO.
2nd	Reg	2025 (July)			monogenic preg	1 MERA.
					Conception	

PERINATAL HISTORY

Treating Obstetrician : Dr. Lalitha Devi Hospital : Kullu Kangra Inborn Outborn

<p>Duration of Labour</p> <p>First stage (> 18 hours sig)</p> <p>Second stage (> 2 hours after dilation)</p> <p>LSCS : <input checked="" type="checkbox"/> Elective <input type="checkbox"/> Emergency Indication :</p> <p>Specify the reason : C/S - 10 Rev 4</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>Resuscitation : <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 : 38 Weeks : 1

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
	1	1	
	2	2	
	2	2	
	1	2	
	2	2	
TOTAL	8/10	9/10	

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



Baby received in warmer .



CRAB



umbilical cord cut & clamped ← 2A
RV



ENT with 1mg 1.0m given stat



stable - stable .

Investigation details in previous Hospital :

Feeding History :

Past History :

Family History :

Socio Economic History :

GENERAL EXAMINATION ON ADMISSION

General Disposition :

VITALS : Temperature : 37.5°C HR : 140/min RR : 48/min NIBP : CFT :

Color of the extremities : acrocyanosis

Jaundice : Pallor : SpO2 : 98%

Anthropometry : Birth Weight : 3.114 Length : HC : Present Weight :

Ponderal Index : AGA SGA : LGA :

HEAD TO TOE EXAMINATION

HEAD :
 Fontanelles :
 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 : N
 Discharge :

EARS, NOSE
 MOUTH and
 THROAT :
 Ear set / Shape :
 Periauricular Pits / Tags : N no periauricular
 Nasal shape / Patency : patent tear/pits
 Palate :
 Gums :
 Lips : N
 Tongue :

THORAX and BREASTS :

Shape of Thorax :
Position of Nipples and Number : 10

ABDOMEN and UMBILICUS :

Shape : 10
Organomegaly : NO
Bowel Sounds : 2A + IV
Umbilical Stump :
Discharge :

GENITILIA :

Labia / Hymen :
Testicles/penis : BIL palpable
Anus : patent

HERNIAL ORIFICES

appears free

TRUNK and SPINE :

10

SKIN LESIONS :

EXTREMITIES :

Fingers / Toes :
Arms / Legs :
Deformities : 10
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 : 92% Auscultation : Breath Sounds : Added Sounds :

Cardiovascular System :

HR : 140/min BP : Precordial Activity :

Femoral Pulses : BIL palpable Murmurs : 10

Other Peripheral Pulses : felt Signs of Cardiac Failure :

Abdomen :

Shape : 10 Hernia orifice : appears free

Palpation : Soft Anal Patency : patent

Palpable masses : NO Umbilical Cord : 2A + IV

Abdominal girth : First urine passed : |

Meconium passed : |

Nervous System : Higher intellectual functions (Sensorium) :

State of wakefulness :

Prechtle Score :

Nerves : *CFSA - good*

Motor System :

Passive Tone :

Active Tone :

Neonatal Reflexes :

Grasp : Palmar Plantar Sucking Rooting Crossed adductor :

Moro's : *Bilateral* DTR :

ATNR : Skull and Spine : *(N)*

Any Congenital Anomalies :

Diagnosis : *TT 38 + 11 Aq A 3.14.14*

FOOT PRINTS

Left Side :



Right Side :



Resident Doctor :

Signature : *[Signature]*

Name : *Dr. Khwera*

Date & Time : *26/5, 11:30pm*

Consultant :

Signature : *[Signature]*

Name : *V. Vams*

Date & Time : *28/5*

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 :

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Screenings done during NICU Stay :

NSG :

Hearing Screen :

ROP :

TFT :

NP2 :

Discharge Details:

Neonatal Condition at Discharge:

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Patient Sticker

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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Advice

- 1) wash with ant
- 2) DDF + 16 burping 2nd baby

3) ute
raccemoter / 2000L

4) ssn
ms / 480L

5) mander way

Doctor Signature: Dr. M. M. W. S. S.

Doctor Name: Dr. M. M. W. S. S.

Date & Time: 26/5, 11:30am

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 Baby Of ARADHANA TALLADA
 28-05-2026 0 Y 0 M 0 D 3 H (M)
 Dr. V VAMSI KRISHNA



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5 8am	cls by Dr. Vamsi	
	2140L 2m 38 ⁺ A4A 3.114kg.	
	2140L 2	
	C/T/A : good	Dx
	peripheries : warm.	warm core.
	C/S : S, S, ⊕	OBS 2nd hly Hb hct
	R/S : RAS ⊕	GRBS
	P/A : soft.	SRR, NRS
	AR : @ level.	OAE, vaccination
	B/L hct : ⊕.	
	Ext. genitalia : Male.	
	Red reflex : ⊕	
	paper by	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/5	<u>C/SIB Reg.</u>	
4 PM.	<u>T138+1 / AGA / 3.114</u>	
		<u>Advice</u>
	Baby - well	1) warmth here
	cutaneous	2) feed 2nd hly
	accepting feeds well	+16 burping
	cry	3) OK SDR / 48 hly
	tone / good	water NRS
	activity	
		4) Monitor uter
	CVS: S/S (+)	
	RS: B/C/E (+)	
	PLA: soft	
		D.V. 28/5

noted by Registrar.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5	c/s by Registrar	
4pm	Lum 138 ⁺ / 44A	
	c/s : good	
	perforations : none.	2a warm cure
		. 2nd baby Hb buff
		. 500cc, NBS @ 4pm
	Noted by - Rajlaxmi 28/5/26 @ 4pm	

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 Dr. V VAMSI KRISHNA



RESULT SHEET

Date	28/05/26			
Time	4.50pm			
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	10.2	0.2		
T.Protein		10.0		
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				



26/5/26

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 26-05-2026 0 Y 0 M 0 D 3 H (M)
 Dr. V VAMSI KRISHNA



VITALS CHART

Date →	Temp	HP	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	38.8	138	38			DBF				
1.00 pm										
2.00 pm										
3.00 pm	38.6	140	40			DBF		✓		
4.00 pm										
5.00 pm						DBM				
6.00 pm	98.6	140	40	100%		DBM		✓	✓	
7.00 pm										
								U-2	M-1	V-0
8.00 pm										
9.00 pm						DBM				
10.00 pm	97.5	130	40	100%						
11.00 pm						DBM		✓		
12.00 am										
1.00 am						DBM				
2.00 am										
3.00 am						DBM				
4.00 am										
5.00 am	98.5	148	45	100%		DBM				
6.00 am								✓	✓	
								U-2	M-1	V-0
						TOTAL		U-4	M-2	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

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.....
 Nursing Diagnosis..... Risk for Newborn Intection related to immature immune system
 Plan of Care
 Planned Investigations Procedures
 Implementation

T. Lavanya P. Lenny
 Handed Over by : Name & Signature
 26/5/26 4pm

Shanika Provided DBF & warm care
 Seema @ 8H
 Received by : Name & Signature
 26/5/26

Night Shift

Clinical Diagnosis..... NB
 Nursing Diagnosis..... New born care
 Plan of Care
 Planned Investigations Procedures

Implementation
 * Assessed the baby condition
 * checked the vital signs
 * maintain I/O chart
 * Encourage DBM feeds

Seema @ 8AM
 Handed Over by : Name & Signature
 8 27/5/26

Pooja
 Received by : Name & Signature
 27/5/26
 8AM

27/5



VITALS CHART

Date →	Temp	HP	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am										
8.00 am						DBM				
9.00 am								✓	↓	↓
10.00 am						DBM				
11.00 am										
12.00 pm	98.1f	138	40	99%		DBM			↓	↓
1.00 pm								U-1	m-0	v-0
2.00 pm										
3.00 pm						DBM		✓	✓	↓
4.00 pm										
5.00 pm						DBM				
6.00 pm	98.5f	140	40	99%						
7.00 pm						DBM				
8.00 pm								U-1	M-1	U-0
9.00 pm						DBM		✓		
10.00 pm	97.0f	145	42	100%						
11.00 pm						DBM ^{Non}	10ml			
12.00 am										
1.00 am						DBM ^{Non}	25ml			
2.00 am										
3.00 am						DBM ^{Non}	10ml			
4.00 am										
5.00 am								✓	✓	
6.00 am	98.2f	142	48	99%						
								U-2	m-1	v-0
						TOTAL		U-4	m-2	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 + formula

Morning Shift

Clinical Diagnosis..... *new born*
Nursing Diagnosis..... *Weight loss related to - emedize DBM*

Plan of Care.....
 → *Assess the baby condition*
 → *maintain I/O charting*

Planned Investigations Procedures.....
 Implementation → *Assess the baby condition*
 → *feeding 2-3rd fully*
 → *breastfeeding properly*

Handed Over by: Name & Signature *Pooja 27/5/26 at 2pm*
 Received by: Name & Signature *Shanthe \$ 27/5/26 @ 2pm*

Evening Shift

Clinical Diagnosis..... *NB*
 Nursing Diagnosis..... *New born care*
 Plan of Care.....
checked vitals
maintain I/O chart
Monitor vitals & Giving feed & Burping

Planned Investigations Procedures.....
 Implementation → *Assessed the baby condition*
 → *Monitor vitals*
 → *Maintain I/O chart*

Handed Over by: Name & Signature *Shanthe \$ 27/5/26 @ 8pm*
 Received by: Name & Signature *Seena @ 8pm \$ 27/5/26*

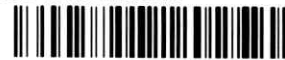
Night Shift

Clinical Diagnosis..... *NB*
 Nursing Diagnosis..... *New born care*
 Plan of Care.....
** Assess the baby condition*
** check vital sign*
** maintain I/O chart*

Planned Investigations Procedures.....
 Implementation ** Assessed the baby condition*
** checked vital sign*
** maintained I/O chart*
** Encourage DBM feeds*

Handed Over by: Name & Signature *Seena @ 8AM \$ 28/5/26*
 Received by: Name & Signature *Chris \$ 28/5/26*

28/5



VITALS CHART

Date →	Temp	HP	RR	SPO ₂	Score	Type of Feed	Qty	Urine	Stool	Vomit
7.00 am						DBM				
8.00 am										
9.00 am						DBM	15ml	✓	I	I
10.00 am								✓	I	I
11.00 am										
12.00 pm	98.5	136	41	100%		DBM		✓		
1.00 pm								✓	M-20	V-0
2.00 pm						DBM		✓		
3.00 pm										
4.00 pm						DBM		✓	I	I
5.00 pm										
6.00 pm	98.5	138	40	99%		DBM				
7.00 pm								0-2	M-0	V-0
8.00 pm						DBM				
9.00 pm										
10.00 pm	98.2	142	48	100%		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	98.3	139	46	99%		DBM				
								U-2	M-1	V-0
						TOTAL		U-7	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..... DBM + Formula

Morning Shift

Clinical Diagnosis..... NB
 Nursing Diagnosis..... Risk for inadequate nutrition, ^{feeding} _{feeding}
 Plan of Care..... Assess for pt condition
 - DBM feed q 2h
 Planned Investigations Procedures..... SBR, NB & Upry
 O.A.S. abdominal distention
 Implementation.....
 - DBM feed on time
 - No vomit or regurgitation

Handed Over by: Name & Signature
 Laxmi 28/5/26
 @8pm

Received by: Name & Signature
 Laxmi 28/5/26
 @8pm

Evening Shift

Clinical Diagnosis..... NB
 Nursing Diagnosis..... Warm Care
 Plan of Care.....
 → Assess Baby Condition
 → Check the vitals
 → Monitor I/O chart
 Planned Investigations Procedures.....
 Implementation.....
 → Assessed Baby Condition
 → checked vitals
 → monitored I/O chart
 → Encouraged feeds & Burping

Handed Over by: Name & Signature
 Laxmi 28/5/26
 @8pm

Received by: Name & Signature
 Seema @ 8pm
 28/5/26

Night Shift

Clinical Diagnosis..... NB
 Nursing Diagnosis..... New born care
 Plan of Care.....
 * Assess the baby condition
 * check vital signs
 * maintain I/O chart
 Planned Investigations Procedures.....
 Implementation.....
 * Assessed the baby condition
 * checked vital signs
 * maintained I/O chart
 * Encourage DBM feeds and burping

Handed Over by: Name & Signature
 Seema @ 8 AM
 29/5/26

Received by: Name & Signature
 Laxmi 29/5/26
 @ 8 AM

