ANC-00013659 IP28-00004509
Mrs DEEPA SEKAR .
07-10-1996 29 Y 7 M 26 D (F)
Dr. NANDINI L

DISCHARGE TRACKING SHEET

CONSULTANT NAME: DR.

ACTIVITY	IN TIME	OUT TIME	REMARKS	<To be filled by Admin>
Activity Sheet updated by Nursing	3/6/26 @ 12pm			
Activity Sheet updated by Pharmacy		12:25 pm		

ACTIVITY RECORD FOR BILLING

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IP 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
3/6/26	10 pm	LDR	M Hoos	DR

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
2/6/26	CBC	7470	
"	Coagulation profile		
"	Blood Reservation	8331	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
2/6/26	IV placement	1	8330	
2/6/26	CTG	2	4134	
2/6/26	CTG	1	4139	
3/6/26	Nutritional Assessment	1	8427	

ANY OTHER INFORMATION:

Date: 3/6/26 Time: 12m Prepared By: Sugashini

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Suga 01/3/26	Suga 01/3/26		

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DRUG CHART

Date of Admission: 2/6/26 Drug Allergies: Nill ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line I through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

DRUG :				Date / Time
Dose	Route	Frequency	Start Date	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

Signature .....

VERIFIED BY : Name .....

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REGULAR PRESCRIPTIONS

Weight. 63 Ward. CDR

DRUG : T. CEFTUM

Dose	Route	Frequency	Start Date
500MG	P/O	1-0-1	2/6/26

Name & Signature of the Doctor Starting the Drugs: [signature] 120101

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	2/6/26	3/6
	9 pm RR 021142	9 Am [signature]
		9 pm

DRUG : T. PANTOP

Dose	Route	Frequency	Start Date
40MG	P/O	1-0-1	2/6/26

Name & Signature of the Doctor Starting the Drugs: [signature] 120101

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	2/6/26	3/6
	9 pm RR 021142	8 Am [signature]
		7 pm

DRUG : T. ACTON-OR

Dose	Route	Frequency	Start Date
	P/O	1-1-1	2/6/26

Name & Signature of the Doctor Starting the Drugs: [signature] 120101

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	2/6/26	3/6
	9 pm RR 021142	9 Am [signature]
		2 pm
		10 pm

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time

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Dr. NANDINI L

Weight. 63 Ward. C DR

DRUG :	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
Route / Start Date		Dose		Dose		Dose		Dose	
Name & Signature of the Doctor		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
Route / Start Date		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
Additional Instructions:		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
2/6/26	6.30pm	JUSTIN suppository	100mg	P/R	Sup	
2/6/26	6.45pm	INJ. SYNTOCINON	10 UNITS	IM	Sup	

Signature .....

VERIFIED BY : Name .....

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07-10-1996 29 Y 7 M 26 D (F)
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I.V. FLUIDS CHART

Weight. 63 Ward. CDR

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
2/6/26	2pm	RL 1000	IV	100ml/hr	Sig	Sig	2/6/26		Sig
2/6/26	4pm	1000 RL	IV	100ml/hr	Sig	Sig	2/6/26		Sig
2/6/26	5.30pm	1000 RL + Syntho 15U + 10U	IV	8 drops/min	Sig	Sig	2/6/26		Sig

Signature .....

VERIFIED BY : Name .....

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I. ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints
C/o pain abdomen on & off.

Obstetric Formula: G2P1L1

Obstetric History:
G1 → 2yrs - Boy - 2.8kg - Alive - Breech
G2 → PP. Spontaneous Conception

Present Pregnancy Record:
Booked & Immunised
Cx stitch @ 18wks

RISK FACTORS:
Cx stitch in situ. (done at 18wks ↓ Short - Cervical length - Cervix 2-3 cm)

LMP: 30/9/25 EDD: 07/07/26
Corrected EDD: GA: 35 wks
Menstrual History: Regular : ☑ Yes ☐ No

Obstetric Examination
Fundal Height: 34-36 wks 2/20" Lie
Ut. Activity: ☐ Relaxed ☐ Mild ☐ Mod ☐ Severe
Liquor: ☑ Adequate ☐ Oligo ☐ Poly
PP: ☑ Cephalic ☐ Breech Others _____
Head Fifths Palpable: (3/5)
FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent 160 bpm

Per Speculum Examination
Draining: ☐ Present ☐ Absent ☐ Bleeding
Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination 1.5cm long.
Cervix: ☐ Long ☐ Partially effaced ☐ Effaced
Os: Closed _____ Dilated 1-2 cm
Membranes: ☑ Present ☐ Absent flat.
Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained
Presenting Part: ☑ Vertex ☐ Breech ☐ Others
Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2
Pelvis: ☑ Adequate ☐ Doubtful

Height: 152 cm
Weight: 63 kg
Allergies: Dust Allergy
Breast: ☑ Normal ☐ Abnormal
General Examination:
Consciousness: (+) Pallor: –
Icterus: – Edema: –
Temp: PR: 119 bpm
BP: 110/70 mm Hg DTR:
CVS: S1S2 (+) RS BLAE (+)
Liver/Spleen: (N) Urine Output: (N)

DIAGNOSIS
G2P1L1 / 35 wks / Previous NVD / In Labour
Cx stitch in situ

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Family History: Mother - HTN; father - DM	Surgical History: H/o Carpal tunnel Sx Rt hand - done
Medical History: H/o Allergic wheeze	**Medication History:** —
Plan of Care: - Admit; - Prepare parts; - CTG monitoring; - W/F progress of labour; - Inform SOS.	**Investigations:** Blood group - O +ve; 19/4/26 Hb - 10.9 gm/dl; ECG normal, (27/11/25) ECHO

1/6/2026 - Growth scan - SLF ~ 34+6 wks; cephalic; plac - anterior high; Doppler - (N); EFW - 2.4 kg; AFI - 11.3 cm

* FTS - Normal
* 25/2/26 - Anomaly scan - SLF ~ 21+1 wks, no gross anomalies. Cx length - 3 cm

29/12/25 - NT - 1.4 mm; SLF ~ 12+6 W

Doctor Name: Dr. Raaga
Signature: ...
Date & Time: 2/6/26 at 2pm

Consultant Name: Dr. L. Nandini
Signature: ...
Date & Time: 2/6/26 at 2pm

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/2026 6:10 pm	Patient complains of straining. Head seen.	Inj Pavon
2/6/2026 6:17 PM	LABOUR NATURAL WITH INTACT PERINEUM ↓ASP, patient in lithotomy position, parts painted and draped. With good uterine contraction and full cervical dilatation, good maternal efforts, delivered an alive girl baby of weight 2.040 kg. Baby cried immediately at birth. Cord clamped, cut and baby handed over to pediatrician. Placenta and membranes delivered in toto by AMTSL. Inj. Synto 10 U IM and 10 U IV given after delivery of baby. P/A – Uterus firm & contracted. L/E – No undue bleeding pv. B – An alive girl baby A – DOB – 2/6/2026 B – TOB – 6:17 pm Y – B.Wt – 2.040 kg – APGAR – 8/10, 9/10	Dr.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/2026 2:15 pm	S/B Dr. L. Nandini (OG)	
	Pt. reviewed, vitals stable. c/o ↑ pains on & off.	
T - (N)		
BP - 108/76 mmHg	O/E - Afebrile, no pallor	
PR - 100/min	P/A - Uterus ~ 34-36 wks, acting (2/15-20"/10 mins), FHR fooded - 150 to 160 bpm	
	P/V - cervix 1 cm long, OS 4 cm dilated, membranes (+) Vertex at -2' station.	
	↓ASP, cervical stitch removed done.	
2/6/26 4:40 pm	S/B Dr. L. Nandini / Dr. Sarupa (OG)	Sig - 12/10/1
	Pt. reassessed.	
CTG - Reactive	- c/o ↑ pains vitals stable. P/A -	Uterus ~ 34-36 wks acting (3/20-25"/10 mins), FHR fooded
	P/V - cervix 0.5 cm long, OS 5-6 cm dilated, memb (+). Vertex at '0' station	
	↓. ASP, ARM done and about 10-15 cc of clear liquor drained.	Sig 12/10/1

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/26 9pm	S/By pe Charlie	
	Pt is comfortable	
	Vitals stable	
	P/A Sop	
	UT well contracted	Dr. [illegible]
		Cr call
	U - [illegible]	
3/6/26 8:30 AM	S/B Dr. Sivasarupa	[signature]
(PND-1)	Pt. reviewed	
T - (N)	no complaints, vitals stable.	
BP - 108/80mmHg	O/E - Afebrile, no pallor	
PR - 76/min	P/A - Soft, uterus well contracted,	
	L/E - Bleeding pv WNL	
	S/B Dr. Nandini :	PND-1 [signature]
T - (N)		Adv
	P/A - sop	
BP - 100/80	UT involuting	- Pt. can be
PR - 76/min	well.	discharged
	Baby in NICU	today.

Review after 1 wk
C. Lactare [illegible]

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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RESULT SHEET

Date	19/4/26		Blood group – O +ve			
Time						
Hb	– 10.9 gm/dl					
PCV						
RBC						
WBC	– 10,340					
N/L						
Platelets	– 4/7000					
CRP						
ESR						
PCT						
RBS	FBS – 82				Urine R/E – WNL	
Na	PPBS – 106					
K					HIV	
Cl					HBsAg	
Ca/Mg					anti-HCV	– Negative
Phosphate						
Urea	– 18					
Creatinine	– 0.5				HBAIC – 5%	
ALP	– 73					
SGPT	– 16					
SGOT	– 14					
T.Bill/Conj						
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						

(P.T.O)

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

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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NURSES NOTES

(USE BALL POINT PEN ONLY)

☐ No Known Drug Allergies Nil.

☐ Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Admission Note
	8pm	Patient got admission on baby labour in Dr. Nandini Corpl 4 + 3 weeks
	2:30pm	patient vitals checked and recorded BP 108/73mm/Hg pulse - 86 b/m spo2 - 99% patient vitals are stable.
	2:35pm	S/B Dr. Nandini mam CT strip removed advice IOPL continue
	3pm	patient FHR @ 152 b/m baby good.
	4pm	S/B Dr. Sevapa mam PV done 5 to 6 cm dilated patient vitals checked and recorded. baby patient FHR @ 143 b/m @ good
	4:40pm	S/B Dr. Nandhini mam PV and PAM done clear liquor 5-6 cm cervix at 0 station
	5:30pm	Dr. Nandhini mam advice IORL & added in 5% Dynoto 24 ml started.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

(USE BALL POINT PEN ONLY)

☐ ~~No Known Drug Allergies~~
☐ Drug Allergies .... Nil.

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Delivery Note
2/6/26	6:15pm to 7:30pm	patient vital signs checked and recorded vitals are stable FHR a good 148 b/m Lithotomy position done full dilatation ✓ Inj. LOA 2% xylocaine given. Episiotomy cut ND done. Baby full grown baby delivery through vaginaly baby Female ♀ baby good & well active Dr. Divya Sree and Dr. Jinesh kumar Sir. placenta Expelled Completely uterus Contracted p/v bleeding Normal Inj. Syntocinon 10 U IV and 1 IM given. Durcut 4-0 suture done Fustim
	8pm	patient suppo p/r done.
	8pm	patient Urine passed clear clean patient duties handing over to Night duty staff.
	8 pm	patient handing over taken by Evening duty staff
		→ patient vitals checked and recorded

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NURSES NOTES

☑ No Known Drug Allergies

☐ Drug Allergies ..... Nil .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
	10 pm	Dr. Chaithra p/v checked	
		p/v bleeding is normal	
		advices patient vitals stable	
		patient shifted to ward	
		patient Recived from	
		ward	
3/6/26	12 AM	=> patient vitals checked	
		and Recorded	
		=> patient p/v bleeding	
		is normal.	
	2 AM	=> patient IV line	Ss 03/6/26
		is Good	
	4AM	vitals checked and recorded	
		patient is slept no other complaints	
	7AM	T-pan 1amg p/o given Episitomy	
		care done	
	8AM	patient vitals stable no fever spike	
		patient hand over to next duty staff	Ss 03/6/26
		B => Both Breast is soft	
		U => Uterus is soft	
		B => Bowel sound is present	
		B => urine voided	
		L => Lochia rubra present	
		E => Episitomy care done	
		H => Homan Sign negative	
		E => Emotionaly stable	
			Ss 03/6/26

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NURSES NOTES

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☑ No Known Drug Allergies
☐ Drug Allergies ....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
3/6/26	8:00Am	Morning duty report	
	8am	Patient detail Handover taken from night duty staff	K. Kiya 607887
	8:45am	→ On observation patient looks discomfort pain score 1/10 verbalized by patient, oriented	K.
	9AM	→ Educated the mother about comfortable position and given Reltum. tab. Action OR as per the drug Sheet	K. Kiya 607887
	12pm	S/B Dr. Nandini mam ordered to discharge today. Inj. perinorm and Lactare added.	K. Kiya 607887 [signature]
	12:10h	→ Billing process initiated. file send to the pharmacy.	[signature]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS