

ACTIVITY RECORD FOR BILLING

SNC-00026089 IP24-00008920
Mrs KOTA CHARISHMA
01-08-1994 32 Y 1 M 17 D (F)
Dr. SURA PUSHPALATHA
hRight
IOW HOSPITALS
to a Safe Delivery

Name: MRS. Kotacharishma
UHID No: SNC-00026089 IP No: 8920 Consultant: Dr. sura push palatha Dept:
Date of Admission: 16/07/2026 Time: 5:29 AM Date of Discharge: Time:
Room / Bed No: Ward: Suggested Billable bed type:

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
7/6/2026	8:20 AM	RR	OT	
16/7/26	9:30 AM	OT	RR	
16/7/26	12 PM	RR	ward	

CROSS CONSULTATION VISIT

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

[illegible]

Investigations

Signature

Blood Reservation

6813

[Handwritten signature]

16K126

C/34, P/7AP/T/INR

8854



[illegible]

Date _____

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

1617

CTGT

7 Am

7. 20-Arm

4674



PROCEDURE

[illegible]

ANY OTHER INFORMATION:

IN TIME: 8.15AM OUT TIME: 9.30AM

SURGERY: ELECTIVE LSCS

SURGEON: DR. SURA PUSHPALATHA.

ANALGESIA: ✓ SA

ANAESTHETIST : DR. LIRUTHILA

DURATION: 1 hr 15 min Δ

Date: Time: Prepared By:

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/20 11:30 AM	45 IB Dr. KUSHNATH	
	P14; Post HCO hypothyroid; P00	
	BP - 98/64 mmHg CO 400 HR 88/min Resp 12/min CNS	
	Dr. KUSHNATH	Dr. KUSHNATH
	Uterus well Contractile. No bleeding exposed intact.	Shift to ward. Follow Dr. KUSHNATH.
	Dr. KUSHNATH No excessive bleeding Dr. KUSHNATH	
	Baby m.p. Cord - 150ml/hr.	Dr. KUSHNATH 16002

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/2020 11:20 am	S/B Physiotherapy Thiirika (M)	
	P, L, : Post LSCs ; Hypothyroid ; POD - 2	
	o/p : state awake ; conscious Vitals stable	
	O/E : NOB (N) Chest clear (+)	
	<u>Rx:</u>	
	- Breathing exercises - Active toe movements - Ankle pumps given - Heel slides done actively - Encouraged to mobilize out of bed - Do's & Don'ts advised to patient - Feeding position taught - Splinted coughing taught to patient	
		f. Thiirika

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/12/2016 9:30 AM POD# 2	S/S Dr. Vidhyalekshmi	
	PT reviewed	
	comfortable	
	to	OK: again
	Pr: bol	ap: hile
	ap: 10/10	PP: 100
	mm: 10/10	- Soft diet
	Baby is	LA: soft, (B+) - Plenty of oral fluids
	3/4 breast	ct: contracted, - vitals monitoring
	soft.	Dr: not start - follow drug chart
		no change. - Breast feed
		X: no undue - Ambulation
	voiding freely	bleeding PV. - note w/le bleeding
		- 2/3000 ml
		Chalge
		12/2/2017

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

CAESAREAN SECTION OPERATIVE NOTES

Name: MR. KOTA CHARISTINA Consultant I/C: Dr. SURAP Reg. No: _____

Surgeon's Name: <u>Dr. SURAP</u>	Date of delivery: <u>14/7/26</u>
Assistant surgeon: <u>Dr. Ambukana</u>	Time of delivery: <u>8:38 AM</u>
Anaesthetist: <u>Dr. Kuthike</u>	Sex of baby: <u>Boy</u>
Type of Anaesthesia: <u>Spinal</u>	Weight of baby: <u>2.684 kg</u>
Paediatrician: <u>Dr. Monnang</u>	Apgar score: <u>8/10; 9/10</u>
Scrub Nurse: <u>Dr. TAO</u>	NICU Admission: <u>NO</u>

Elective ☒ Emergency ☐

Indication: Oligohydramnios / Fetal

Urgency

- ☐ Immediate threat to life of woman or fetus
☐ Maternal or fetal compromise not immediately life threatening
☐ No maternal or fetal compromise but needs early delivery
☐ Delivery timed to suit woman and staff

alarm signal

Decision time: _____

Knife to rectus: _____

CTG description

Reactive

If there was a delay give the reasons: _____

EXAMINATION FINDINGS WHEN APPROPRIATE

Presentation: ☒ cephalic ☐ breech ☐ other _____

Cervical dilatation: _____ cm

5th palpable: _____

Fetal position: _____

Station: ☒ -3 ☒ -2 ☐ -1 ☐ 0 ☐ +1 ☐ 2 ☐

Moulding: None ☒ + ☐ ++ ☐ +++ ☐

Caput: ☒ + ☐ ++ ☐ +++ ☐

Meconium: None ☒ + ☐ ++ ☐ +++ ☐

Bladder catheterized Yes ☒ No ☐

Urine: Clear ☒ Blood stained ☐

Skin incision: Pfannenstiel ☒ Transverse ☐ midline ☐ other ☐

Uterine incision: Lower segment ☒ Classical ☐ Inverted T ☐ J incision ☐

Previous scar: Intact ☐ Thinned out ☐ Ruptured ☐ No scar ☒

Incision through placenta: Yes ☐ No ☒

Delivery of head: Manual ☒ Forceps ☐

Liquor: Clear ☒ Meconium: I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not offensive ☐

Delivery of placenta: Manual ☒ CCT ☐ Complete ☐ Incomplete ☐ Piecemeal ☐

Cord appearance: ☒ Cord around the neck Yes ☐ No ☒

Appearance of placenta: Placenta adherent; cystic degeneration Cavity explored Yes ☒ No ☐

Uterus, tubes and ovaries: Normal ☒ Not normal ☐ Sterilization Yes ☐ No ☒

Complications / Comments: Single loop of cord around neck.
Nil Liquor. Placenta delivered difficult.

Uterine closure: One layer ☐ Two layers ☒ 1- Vicryl Suture

Peritoneal closure: Pelvic ☐ Abdominal ☐ None ☐ Suture

Sheath closure: 1- Vicryl Suture

Fat closure: Yes ☐ No ☐ Suture

Skin closure: Subcuticular ☒ Mattress ☐ 30 mononyl Suture

Vagina evacuated: Yes ☒ No ☐ Estimated blood loss: 100 ml

Drain: Yes ☐ No ☒ Remove in _____ days Await instructions ☐

Catheter: Yes ☒ No ☐ Remove in 1 days Await instructions ☐

Swap & instruments count correct? Yes ☒ No ☐ Post-op antibiotics Yes ☒ No ☐

Intraoperative antibiotics cover: Yes ☒ No ☐ Thromboprophylaxis: Yes ☒ No ☐

Post operative Comments: _____

① 1000 cc blood
② 10 cc saline 1.5 gm
③ 10 cc saline 4 gm
④ 10 cc saline 1 gm
⑤ 20 cc
20 cc
10 cc
100 ml/hr.

⑥ 10 cc KETOROLAC
10 cc IM for
⑦ 10 cc CLOXACIN
0.25 g
After 12 hrs
⑧ 10 cc chertini
⑨ BP chertini
⑩ 1000 cc sup 0.25

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**S NOTES**

POINT PEN ONLY)

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☐ No Known Drug Allergies☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
16/07/26	6 AM	<u>Admission Notes</u> MRS. KOTACHARISHMA 32y/F Pt Came for Elective LSCS Part preparation done Pt vitals are stable monitoring The vitals maintained I/O chart Provided comfortable Bed and position Iv Placoment done pre operative Check list done consent All Taken Pt conscious and oriented Pt Active and good Inj. Sufacet 1.5 g in 100ml NS (ATD) Iv given, Inj. Emeset 4mg Iv Inj. Pan 40mg Iv given as per doctor order, Catheterisation done RL 500ml on going Pt Shifted TO OT Pt details hand over given TO OT Staff ————— <u>ABD</u> <u>02/07/26</u>
		<u>OT Note</u> Patient Received OR-2 patient 8-15 PM with Team Sign In Done. Procedure LSCS Done. Patient supine. Position. Figure out done with all Team members Elective LSCS proceed with Dr. Sura pushpalathu. 8-25 AM Assisted Dr. Arulkarani.

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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NURSES NOTES

(USE BALL POINT PEN ONLY)

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DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Baby: Boy / Time: 8.38 AM / wt.
		Baby's Sucktail Assessment Done after pediatric Doctors.
16/07/2024	9.30 AM	Mop, Game, Discharge Expects Chelized and verified. Sigeri out Done. Documented. Patient Shifted Recovery Vitals Normal orientation All Records and Reports put up Order all hand out Recovery Staff. U. May 0211212
16/7/24	9.30 AM	Recovery Nili pt. moved from OT. pt with an able, rounded & monitored. In hi patient. DRT - DNS ongoing. urine output clear. Baby Mother with pt in room. Follow the day chart. DRT men. feeding well. Suckling well.
	10.30 AM	c/o. Mithun, warmer given. Now settled.
	11.30 AM	SLB pr. Vardana Nam, PV feeding checked, no under bleeding. AG - 86 cm
	12 PM	pt shifted to ward. Handover given to ward staff.

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- ☐
- No Known Drug Allergies

- ☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Received note 16/7
	12pm	patient hand over taken from RR staff patient conscious and oriented → patient vitals stable. patient on NPO patient PR bleeding normal →
		patient IV line ⊕ patient npo bracketed
	4pm	no vomiting complaints patient on liquid diet → pain killer given urine output well IVF onflow
	6pm	IV medication sites SIB Dr. Suram
	8pm	Continue medication hand over night duty JH
		Audif 0200
		Audif 0200
		J 0157m

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- ☐
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
16/7	8PM	Night duty on 16/7/26 Pt. details taken from Evening duty staff. Pt. is stable. Vitals are checked and recorded. Due medications were given as per order. COPD SLO chart maintained 2x Leno Pattern Resp as usual / bronchus. She slept well.
17/7	12AM	No any other complaints She awake maintained her personal hygiene
	4AM	SLO chart maintained
	5AM	Vitals are stable. No medications were given
	8AM	Handing over given to morning duty staff. — <i>[Signature]</i>

Docu. No. : RCH /FRM / CLINICAL / 089



NURSES NOTES

(USE BALL POINT PEN ONLY)

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☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		DAY DUTY 17/08/20
	8AM	pt hand over taken from night duty SR
	9am	pt US checked 6 Recently pt clear fluid diet CBD present output clear Bio chart maintain medication given testin supray PIR given
	10 AM	publeeding normal pt side no any other new complaints
	12 PM	SR Dr. Sura mam adm- pt mobilize after CBD Remove
	2pm	PT give No complaint
	4pm	urine output was clear the Patient was walking
	5pm	she slept well
	6pm	Medication was given as Per doctor's order
	7pm	vital sign are stable CBD was Removed
	8pm	hand over given to night duty staff

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NURSES NOTES

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DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Day duty
18/2/26	8am	Patient hand over taken from Night duty. Patient is conscious and Oriented vital sign are checked and Recorded <i>dp</i> Maintain I/O chart <i>bot 18/2/26</i> CBO was Removed Patient void urine. Patient is mobilized well. Medication was given as per doctor's order There is no any complaint in Patient side <i>dp</i> <i>bot 18/2/26</i>
	10am	SIB Dr vidhya mam advise pt today dis charge
	1pm	SIB Dr. Sura mam advise pt today dis charge pt stool not passes
	2:30 pm	Dressing Pending pt dis charge file send <i>dp</i> to Billing <i>bot 18/2/26</i>

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