

# ACTIVITY RECORD FOR BILLING

SNC-00029025 IP24-00008613  
 Mrs ALAGAMMAL M  
 03-05-1996 30 Y 0 M 25 D (F)  
 Dr. SELF



Name: MRS. Alagammal

UHID No: 000 29025 IP No: 8613 Consultant: DR. Nithiyaa Dept: .....

Date of Admission: 28/5/26 Time: 12:30 AM Date of Discharge: ..... Time: .....

Room / Bed No: 112 Ward: RR Suggested Billable bed type: .....

## WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/5/26	<del>12:30 AM</del> 7 AM	RR	LDR	<u>Kennil</u> 6062
28/5/26	9 am	LDR	RR	<u>Sheela</u> 6064
28/5/26	10:30 am	RR	ward	<u>Sheela</u> 6064

## CROSS CONSULTATION VISIT

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











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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26	S/B M. Ambulancasi	
7.1.7am	do pushing sensitive	
	O/B:	
	Cervix	
	Dilat	
	Nagor/PE	
	at 10am	
	P/A:	
	very firm	- m/f
	achis	- w/contract
	Head engaged	- crown
	at foot	
	Dr. ca well effed	
	as fully dilated	
	memb ⊕	
	brake. + 2 stir	
	pelvic exam	
	show ⊕	
	LMP: Ann done	
	clearing drugs	11/26/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>28/5/26</del>	<u>No c/note</u>	
	<p>with good uterine contraction, cervix well effaced, as sub optimal with good maternal power. The delivery an elective term and baby of B.wt: 3.307kg. Baby cord immediate after birth and clamped and cut with my hands towards navel given placenta and membranes delivered with epurated cord in bag. Vaginal tears done</p>	
	<p>Pl: uterine fund contract          Px: (10) bleeding</p>	
<p>Minimem          anal          Time 7:40am          Date: 28/5/26.          B.Wt: 3.307kg          lb, 9lb.</p>		<p>(10) did          plan of the          1st 2nd month          1. CEFUM 500mg p.o. B          2. PAN. Army Bd          3. Gambitlan 1 Bd          - w/f bleeder</p> <p><i>[Signature]</i></p>

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**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
<del>28/5/2026</del> <del>8:30 AM</del>	w/s Dr. Vidhyalekshmi	
POD	PT renewed comfortable	
to	O/E: affair	Ad
PR: 80L	apixile	
ap: 110/20	PEPE	- soft diet
mmky	Pa: ut firm & contracted.	- Plenty of suck feeds
Baby m	X/E spi wound	- vitals monitoring
M breast s/s	healty	- follow drug chart.
	no undue	- Breast feed
	bleeding w/	- Ambulation
		- w/o bleeding w/
		- diaper bag
<del>28/5/2026</del> <del>10:30 AM</del>	PT voided	Vedya 108974
	- shift to ward	
		Vedya 108974

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(F)

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**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
28/5/20 3PM	S/B for yuvam	
T- 98.0 F		
MP-100/60	D-P24H NVD / NVD	Rp
mmHg		
PR-78/min	H/P fever & episode in	SOTI mixer
SpO2-100%	the mxy	Plenty of fluids
	o/e: pt ac fair	MSP/ea monitoring
Baby m/s	apetite	Follow drug chart
B/L mucous	no pallor/nope	Breast feeding
Sgr	Cvs/rt-nms	with bleed on
	P/A ut contracted well	Lbm(205)
	(P/v-no bleeding av	Bt para 15 iv (205)
		P 14/3.2
	S/B Dr Nitay	
		Inj Sepacel x 2 d
		12 d
		Inj paracod IV 3d x 2 dy
		litz Ben

~~Act 2 d~~  
 Galactose  
 Hox/05



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/05/20	9.15 AM	AS NUSUWA
	P2L2;	KUDZ PAME - PND-1 Aptolysol.
	no further	
10/05/20	episodes of fever.	g/c
	PH.	to continue to
	uterus well	Antibiotics +
	contracted	Analgesics
	PH	3 soft diet
	no excessive	3 soft supplements
	bleeding per	urinary
	Baby mother's side	to starting of
	apolo present.	fluids

Dr. SELF

Patient Sticker



### PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/5/16	s/m ror mimic	
3:30 PM	pt examined	
	vital stable	
	- passed stools	
	- plan discharge today	
	- Review after 5 days	
		R [Signature]
		141352



**NURSES NOTES**  
 (USE BALL POINT PEN ONLY)



- No Known Drug Allergies
- Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
28/5/26	12:30 pm	<p><u>Admission Notes</u> 28/5/26</p> <p>MRS. ALAGAMMAI 30y/F G2 P1 L1                      38 weeks + 4 days pt came for admitted under by DR. NITHIYAA mam for indication pt vital's checked &amp; recorded. IV placement done. CTG done FHR Reactive. part preparation done. Blood grouping, ① unit Rhomaxation sent to Lab. pt PU examination done by DR. Anbukarasi mam. 25y. effacement 2cm dilatation. pt provide comfortable bed position. pt are stable. → Vennilga 601628</p>
28/5/26	2 AM	<p><u>Reassessment</u></p> <p>pt vital's checked &amp; recorded. IV placement done. pt for sleeping well. Ilo chart maintained. pt provide comfortable bed position. pt are stable. → Vennilga 601628</p>
	5 AM	<p><u>Reassessment</u></p> <p>pt vital's checked &amp; recorded                      pt conscious &amp; oriented. liquid diet given. pu examination done by DR. Anbukarasi mam. 25y. effacement 2cm dilatation. CTG done FHR: 138 b/min Reactive. pt provide comfortable bed position. pt are stable. → Vennilga 601628</p>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

# NURSES NOTES

(USE BALL POINT PEN ONLY)

No Known Drug Allergies

Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
28/5/26	7 AM	Tab. Thyronam 25mg oral given by doctor by DR. Anbukarasi Mam. → Kernilg 607628
	7:15 PM	pt shifted to RR to LDR. IV Fluids RL 500ml on going. pt continue pain full dilatation.
	7:30 PM	pt vital's checked & Recorded pt Local Anesthesia given epididomy given Delivery sign in 7:40 AM female baby Baby wt: 3.307 kg. Inj. Synto 10 units Im Given. Inj. Synto 10 units IV Given. Inj. Methosgen 1amp Im Given Inj. Frapic 18mg c 100ml NS Given. Baby cord around the neck, cord clamped & cutting. Inj. Synto 5 units c 500ml RL ongoing. pt in sign out procedure site dropping & cleaning. pt vital are checked & Recorded.
	8 PM	pt details hand over taken from morning duty staff → Kernilg 607628
	8 AM	pt details Received from night duty staff. pt Conscious & Oriented, pt vital signs are stable, IV line Pattern, Inj. Synto 2.5 units DBF 2 <sup>nd</sup> hourly given to Baby, pt on
	9 AM	on diet, pt side no any fresh complaints

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SNC-00028025  
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 03-05-1986  
 Dr. SELF  
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 30 Y 0 M 25 D  
 (F)



# NURSES NOTES

(USE BALL POINT PEN ONLY)

- NO ...
- Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<u>Re - Assessment Notes 28/5/26</u>
	9:30 am	PT Conscious & Oriented, Iv line Pattern, Iv checked by Dr. Vidhya mam no heavy bleeding, pt had N diet,
	10:30 am	PT passed urine, I/O chart maintained PT shifted to ward 10:30 am
		<u>Morning &amp; Evening duty Notes:-</u> <u>ON 28/5/26</u> (Received Notes)
2	11 AM	=> PT details received from night duty S/n. ✓ pt. is conscious and oriented vitals are checked and recorded
	12 pm	MO.F informed to Dr. vidhya mam advised no need now combiflam. no give T-Acton OR after I have given.
	1 pm	to recheck the Temp. 98.6°F no compliances pu bleeding normal.
	4 pm	SIB Dr. nithya mam advised to changed the IV Antibiotic and Iv para for days Nally/olbu

*[Signature]*  
 607470

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**NURSES NOTES**  
 (USE BALL POINT PEN ONLY)

Drug Allergies .....

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Morning duty 29/5/26
29/5	8AM	pt taken over from night duty SIN pt is conscious & oriented pt mobilized out of the bed.
	9AM	pt vitals stable, Nallyolbus. postnatal Assessment. B- Both breasts is soft colostrum milk U- uterus is involed B- Bowel sound is normal B- Bladder pattern is good. L- Lochia present. E- surgical site is Blueberg. H- Homan's sign - Absent. E- Emotional pattern good. pt I/O chart maintain, Nally olbus.
	10AM	glact granule pt is not taken. for no need for now after I have taken. to today. Nallyolbus.
		No medications are given as per order.

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*Sekha*  
 02/25/26

