

ACTIVITY RECORD FOR BILLING

Name:
 UHID No: SNC-00031365 IP24-00009021
 Date of Admission: 02-07-2018 8 Y 0 M 25 D (F) Dr. ASIRAMI KRITHIGA J
 Room / Bed No: ward: Suggested Billable bed type:
 Consultant: Dept:
 Date of Discharge: Time:

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/7/26	1 PPM	ER	ward	[Signature]

CROSS CONSULTATION VISIT

	Doctor Name	Date	Order No.	Signature
1.	Dr. Somasekaran	27/7/26	9#66 ✓	[Signature]
2.	Dr. Subhasini	28/7/26	9#65 ✓	[Signature]
3.	Dr. Sravanthini	29/7/26	9959 ✓	[Signature]
4.	(pediatric) opinion			
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
27/7	pay abdomen	1	5006	[Signature]
	greet			
28/7	Dr placement	1	9750	[Signature]

ANY OTHER INFORMATION:

Date: 29/7/2026 Time: 2pm Prepared By: _____

Staff Nurse S/N. Jancy	Shift / Ward Ramya K 018968 [Signature]	Billing Assistant	Billing Supervisor
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/4/26	S/B dr. ABIRAMI	
	- do fever, difficulty in swallowing x 3 days	
	- do episodes of hemiparesis (day book)	
	- No loose stools x week book	
	AE child irritable	
	phic.	
	oral cavity - no visible ulcer / inflammation	
	PE - Epigast. tenderness (+)	
	- no distension	
	AE - irrit. - reduced (+) - clear liquid (add)	
		- POF - full water
		- sup. par 1 sup 2 BA
		- sup. chest sup in sup
		- sup. Mucosa gel B. 5 ml
		1-1-1
		- Dr. Saravakumar
		- Dr. Sathya



ADDRESS NOTES AND DOCTOR'S ORDER

[illegible]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/7/2018	S/B Dr. Imman.	
8:30am	△ - Hematemesis ↓ Evaluation. ? Malting vein tear. on clear fluid. no further episode of hematemesis. no C/O fever	
	①/E Active, Alert, stable S/B CM - SIS 2(F). Rb - MBS Pla - left 1350	
	Plan:	
	1) Vitals monitoring	
	2) w/f hematemesis	
	3) Red gastro splenic today	
	4) Soft diet	
	5) PO follow pending reports	
	<i>(Signature)</i> 127328 (Dr. Imman)	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/7/26	S/B Dr. Arunima	
	- Kldo henchman	
	- Shildlo dry cough	
	- Ho Spontaneously better	
	- no further spreading cough	
	AR child well	
	oxygenation @	
	PA - 6/8	
	<u>all</u>	
	Dr - Arunima - Acid test, circumed spray bal	
	- Exp to	
	- Syp Enureset, Dantrol, Syp. amoxicillin	
	- 2 Kldo SOS	
	- R/W - Dr. Arunima primary	
	PROBATION	
	- Histapres 5ml - 3 days → 3 days HS	
	- Levolin 4ml BD × 3 days	
	- on follow up → laparoscopic	
	<u>Dr. Arunima</u>	
29/7/26	S/B Dr. Arunima	
Hicam	add 1) Syp. HISTAPRES 5ml BD Pto	
	2) Syp. Levolin 4ml BD Pto	

- ☐
- Drug Allergies

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)
		<u>Morning duty on 22/7/16</u>
	8am	Baby details taken over the from night duty s/n. Baby was conscious and oriented. In his pattern. Dns 55ml/h on flow. No chart maint'n. Baby taken night shift. → <u>into OT/16</u>
	9am	checking vital signs and Recording. vital is stable.
	10am	Baby taken clear night shift. → <u>into OT/16</u>
	11:30am	Dr. Abirami main rounds down soft diet, Ice Cream vanilla flavor advised. and New Dr his secured blood sample collected. → <u>into OT/16</u>
	12:30pm	To secured 22G venflon Dr line @ hand. to collected blood sample send to Lab. → <u>into OT/16</u>
	1pm	checking vital signs and Recording. vital is stable. No chart maint'n. → <u>into OT/16</u>
	2pm	Baby details handing over given to evening duty s/n. → <u>into OT/16</u>

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(USE BALL POINT PEN ONLY)

- ☐
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<u>Evening duty 28/7/26</u>
<u>28/7/26</u>	<u>2pm</u>	Baby details is handover taken from morning duty staff Baby is active & alert → Jeyaraj 020040
	<u>3pm</u>	Pv line patent medications given as per drug chart → Jeyaraj 020040
	<u>5pm</u>	vital signs is checked up recorded. Baby is vitally stable. Suppositories given as per day chart Jeyaraj 020040
	<u>7pm</u>	Dietary is maintained, Baby passed stool blackish No further complaints Referred to Dr. Veetharaman
	<u>8pm</u>	Hand over given to night duty staff to [Signature] 28/7/26

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- ☐
- Drug Allergies

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NURSES NOTES

(USE BALL POINT PEN ONLY)

☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
29/5		<u>Morning duty on 29/5/26</u>
	2pm	Baby details handed over given to night duty s/o. Baby was conscious and oriented. Dr in pattern. D/E D/S 55ml/hr on flow. No chart matter. <u>Swiss</u> <u>Office</u>
	9am	checking vital signs and recording. Vital is stable. <u>Swiss</u> <u>Office</u>
	11:30am	Dr. Abirami's round done. Baby was stable so D/S today. but baby complaint was cough. So paracetamol given to do.
	12pm	To inform Dr. Praveen's opinion. To assess the baby condition. advised to do Dengue NSI, IgM Old sample will do. and to add cough Syrup. After reports come to decide. <u>Swiss</u> <u>Office</u>
	3pm	Baby details taken over from the morning duty staff Baby discharge to day Dr. Jayanthi main told file send to billing dept <u>Swiss</u> <u>Office</u>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

