

ACTIVITY RECORD FOR BILLING

Name: Mrs. Ragavi R
UHID No: 000 27182 IP No: 0008989 Consultant: Dr. Nivedita Dept:
Date of Admission: 23/7/26 Time: 9:22 pm Date of Discharge: Time:
Room / Bed No: RR- 412 Ward: Suggested Billable bed type:

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
23/7/26	11:55 PM	RR	ward	<u>[Signature]</u> 02024
24/7/26	6:20 AM	ward	RR	<u>[Signature]</u> 607844
24/7/26	6:30 AM	RR	LDR	<u>[Signature]</u> 02024
24/7/26	9:30 am	LDR	RR	<u>[Signature]</u> 607844
24/7/26	12: 50 pm	RR	ward	<u>[Signature]</u> 607844

CROSS CONSULTATION VISIT

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

[illegible]

Investigations

Signature

8707

9341

[illegible]

ANY OTHER INFORMATION:

Procedure : Normal Vaginal Delivery

Surgeon : Dr. Nivedita

Asst Surgeon : Dr. Vidhya

Anaesthesia : Dr. Senthil

Start time : 8 am End time : 9 am

Total Duration : 1 hour

Date: Time: Prepared By:

~~Ramya. R~~ 069641
~~000~~

SNC-00027182

IP24-00008989

Mrs RAQAVI R

09-11-1996

29 Y 8 M 14 D

(F)

Dr. NIVEDITA S



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/O no yuvam p/u.	
11 pm	ex unepbale d or parious mtr adomib, flter membrane up at born Petrus gynecy	
	↓ SAP, hel induction done on 23/7/20 at 11 pm	
	Post induction - NRS - reaction	
	Shift to ward.	
	S/O no yuvam	
24/7/20	c/o abdomen pain	14
5:30 am	o/c: Pt ac fair afebrile	up / down NRS 4 m only w/ f umbilic
P.N	no palp no pe	
11:00 pm	cvs / R - mtr	
mm kg	p/a uterine	
PN 10/00	act 7	
Spn 700	feed va	
	FHE	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7/2016 8:27 AM	Slr Dr. Nivedita Normal vaginal delivery - RMC Slr Dr. Nivedita Als Dr. Vidhyalekshmi Slr Bhavani	
	USAP & Epidural analgesia. Patient in lithotomy position. Pains painted & dropped. xx with full cervical dilatation, with good maternal efforts, with crowning, RMC given. Baby delivered as vertex. who cried immediately after birth. Cord clamped & cut. Baby handed over to pediatrician. Single loop of cord around the neck found. Sy' Lynto 100 ml to CO added to 2nd drip. Placenta & membranes removed in toto. Epistomy sutured in layers. Hemostasis achieved. PA: Uterus contracted. PV: No undue bleeding.	
B	alive term 8th baby	
A	24/7/2016 @ 8:27 AM.	Ad
B	3-116 kg	- Soft diet
Y	8/100 g/100.	- Plenty of oral fluids
		- vitals monitoring
		- Follow dengue chart
		- T. Ceftriaxone 500mg IV
		- T. Pantoprazole 40mg



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
		- T. Zerdol P 1-07
		- S172 bath
		- perineal care
		- w/f bleeding PV.
		- dysmints
		<i>Indhye</i> 128024.
24/7/2026 11:20 AM	s/s Dr. Vidhyalakshmi	
	PT reviewed.	
	Comfortable	
	OK. up air	
	apathic	ad
	PR: 80L	POPEO
	Dr: 110/70	PA: Soft BS @.
	mmkg.	ut contracted
	Baby - NW	XIE Epi wound
	Cloided	healty
	IL breast	no undue
	soft	bleeding PV.
		- Soft diet
		- Plenty of oral fluids
		- Vitals monitoring
		- Follow drug chart
		- S172 bath
		- perineal care
		- T. bath ointment
		<i>Indhye</i> 2/1 1-07
		128024 - Breast feeding
		- Ambulation

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...GRESS NOTES AND DOCTOR'S ORDER

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Date & Time	Progress Notes	Doctor's Order
24/8/26	8/2022. Anbu Maravi	
8.30pm	P2h / NVD 2 mm / Dob	
POB	No complaint	
	O/B: Genu	
	Other	
	no pain / PE	
	CV / MM	
	P/A: open fund contract	
	HR: 140bpm	
		- (S) diet
		- (C) vitals
		- vital chart
		- T/C
		A 1123m
25/8/26	4.15 PM SPKATION	
8AM	P2h 2; NVD 2 PMLE; PND 1.	
BP-100/70mm	GC fair	
HR-84/min	Reop / NVD	
	US	
	P/A	
	uterus well	
	contracted.	
	P/R	
	- episiotomy wound	
	Intact	
	no excessive bleed	
		1) follow
		2) vitals Both +
		Bedside
		3) Physio
		Opinion.
		4) Mobilize
		well
		5) soft diet
		6) OP LAURE
		2-2-2 V
		7) G/LAG
		21PM OTM
		172032

Docu. No. : RCH / FRM / CLINICAL / 088

9/9 total

Pr
21PM OTM
172032

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

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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)
23/7/26		<u>Admission notes on 23/7/26</u>
	10:00 pm	Mrs. Ragavi R. 29y1p G2P11 previous NVD GNA 39 weeks + 4 days pt came for Induction of labour Admission done under Dr. Nivedita mam post preparation done, vitals checked and recorded vitals are He stable BP-120/80 mm/hg, pulse 70bpm SpO ₂ 100% LET, PET, PT, APTT, PNR @ PRBC blood Reservation Sample send lab 20 mints CTU done FHR is good 142bpm Induction of labor consent done. → <u>Dr. Nivedita</u> CTU shows tachycardia, informed to Dr. Nivedita Mam, first stripping the Membrane after 20 mins put the CTU. → <u>Dr. Nivedita</u> 23/7 10:20PM Stripping done. → <u>Dr. Nivedita</u> 10:50PM CTU connected, FHR is good, Acceleration present, sometimes FHR shows tachycardia. Maximum it will goes 170 bpm. Informed to Dr. Nivedita Mam, cerripine gel plan. IOL consent taken. → <u>Dr. Nivedita</u> 11:10PM Under aseptic technique, cerripine gel kept by Dr. Yuvraj Mam, pt in left lateral position. → <u>Dr. Nivedita</u> 11:40PM CTU connected. FHR is good, CTG - Reactive, pt 23/7/26 11:55PM Moved to ward. Handover given to ward staff. → <u>Dr. Nivedita</u>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

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DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Received notes 23/7
	12.05 Am	patient received from RR staff → patient vitals stable patient gel kept patient no pain complaints
	2Am	patient slept well. Speed <u>02043</u> BLo Chart maintained
	5.30 Am	patient complaints of pain. —→ Performed pyelocystogram, pr checked 2cm dilatation
24/7/00	6Am	Iv line done → Eri-para given Shift to RR hand over by RR Staff → Speed <u>02043</u>

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DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
24/7/21		<i>Received notes</i>
	6:20 AM	pt Received ward to DR at 6:20 AM
		pt billing Epidural pt shifted to the LDR
		Epidural purpose Anaesthetic consent
	6:30 AM	none.
		<i>Received Note LDR</i>
		pt Received LDR monitoring connecting
		vitals are stable BP- 110/76 mm/hg, pulse 80bpm
		SpO2 100% IV P R @ Recorded epidural done
		by Dr. Anish sir FHR is good 138bpm
		pt pv done by Dr. Yuvarani mam 2cm
		dilatation pt details handing over glun
	8 AM	to morning duty staff →
		<i>Morning Duty notes 24/7/21</i>
	8 AM	pt details hand over taken from
		morning duty staff, pt vital signs are
		stable @ Recorded, IV line. Pattern,
		IV fluid 100 ml/hr on flow, pt on full
		dilatation. Delivery at 8:27 am, Baby
	8:27 am	Sex: Girl, Baby Weight: 3.116 kg, Baby
		shifted to NICU, pt vital signs are
		stable, IV line. Pattern IV fluid RL
		100 ml/hr on flow, Inj. Synto 10 U IM given
		8:28 am, Inj. Synto 10 U IV given,
	8:30 am	8:35 am, Episiotomy suturing done by

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DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
24/7/26		Dr. Nivedita mam, Pt vital signs are stable, IV line Pattern, I/O chart maintained, Pt side no any complaints, Pt shifted to RR
	9:30 am	Received Notes on 24/7/26
	9:30 am	Pt details Received from IDR staff, Pt vital signs are stable & Recorded, IV line Pattern, I/O chart maintained, IV fluid RL 100 ml/hr on flow, Pt had breakfast
	10:30 am	Re - Assessment 24/7/26
	11:30 am	Pt details Received, vital signs are stable, Pt IV line Pattern, I/O chart maintained, Pv checked by Dr. Nivedita mam, No heavy bleeding, Pt shifted to ward
		<u>Reviewed Notes 24/7/26.</u>
24/7/26	1pm	Patient details handing over taken from RR staff. Patient is conscious & oriented, vitals are checked & Recorded. —→ sushmita 6/12/26

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Mrs. Ragini.
Patient Sticker

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DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		I/O chart is maintained. Patient taking soft diet. Pv bleeding is good. IV line is present. → Sushmita Borst. 2pm. Patient details handing over given to Evening duty staff. → Sushmita Borst. Evening duty on 24/7/26. 2pm Postnatal mother is taken over from morning duty staff nurse. she is afebrile. → Medh Borst. 4pm. IV line present IV line patent. patient complaints of pain tab. Zorodol administered. → Medh Borst. Epidural removed and mobilized. 5pm pt vitals stable. Newborn recorded. 5-20pm pt compliances for pain. I have informed to Dr. vandhana. mom advised Inj. paracetamol 1gm give. Then I have given. 7pm pt I/O chart maintain.

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DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		pt No chart maintain,
	8pm	patient handing over to nurses night duty S/N
		Navy/016457
		night duty 24/7
	8pm	patient hand over taken from evening duty patient conscious and oriented →
		patient vitals stable
	10pm	patient no other complaints →
		patient taken soft diet
		patient oral medicines taken →
		IV line present
	12pm	patient slept well
	5Am	patient passed urine →
	7Am	RV chart maintain
	8Am	hand over given to morning duty
		deep 0204

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