

ACTIVITY RECORD FOR BILLING

Name:

UHID No: GUC-00094205 IP24-00009029 Consultant: Dept:

Date of Admission: 13-05-2026 0 Y 2 M 16 D (F) Date of Discharge: Time:
Dr. ABIRAMI KRITHIGA J

Room / Bed No: Suggested Billable bed type:

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
29/5/26	7 AM	ER	Recovery	Julia Ortiz
29/5/26	9 am	RR	OT	df
29/5/26	10:50 am	OT	2nd floor. OT	df

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

[illegible]

ANY OTHER INFORMATION:

Procedure : B/L Inguinal Hernia Repair

Surgeon : Dr. Abirami Krishiga

Anaesthetist : Dr. Kiruthika / Dr. Senthila

In Time : 9:00 am Out Time : 10:30 am

Total Duration : 1 hour 30 minutes

Date: 30/11/26 Time: @ 10:30 AM Prepared By: Vinu 01/12/26

Vinod 01/11/16

SURGERY DETAILS

Date : 29/7/26

Patient Name: Baby Sanvika Date of Birth: Age: 2M

Gender: Female Ward: OT UHID No.: GUC 00094205/9029

Date of Surgery: 29/7/26 ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: Bilateral Paucinate Hyaline Rupture

Time in : 9:00 am

Time Out : 10:30 am

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon :	Dr. Abirami krithiga	
2. Anaesthetist :	Dr. kinuthika / Dr. Senthila	
3. Assistant Surgeon :	-	
4. OT Technician :	S/N. Vetri	
5. Circulating Nurse :	S/N. Lasmire	
6. Assistant Nurse :	S/N. Bhavani	

Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator

☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa

☐ Neuro Cusa ☐ Others


Signature of the Surgeon


Signature of Circulating Nurse

Order No: 9904

Order by: Ranani 015311



CONSUMABLES OF OT

Circulating staff : S/N. Jasmine Technician : Widya Vetri Date : 29/7/26 Time : 9:00 am

Anaesthesia Disposables		Qty	Surgical Disposables		Qty	Disposables (Baby Side)		Qty
Issued	Used		Issued	Used		Issued	Used	
ET tube <u>3.0 microcuff</u>		<u>01</u>	Major Pack <u>Rain's major pack</u>		<u>01</u>	Inj Vit.K		
LMA			Sutures <u>2305</u>		<u>01</u>	Cord Clamp		
ECG leads : A / P / R		<u>01</u>	<u>9.9913, 1.9915</u>		<u>01</u>	Suction Catheter <u>8.5"</u>		<u>01</u>
HME filter : A / P / N						Feeding Tube <u>10.5"</u>		<u>01</u>
Syringes : 10 cc		<u>02</u>				Vaccum Suction Set		
05 cc		<u>08</u>	Gloves <u>6.5 P.F</u>		<u>02</u>	Surgical Gloves		
02 cc		<u>02</u>	<u>6 P.F</u>		<u>01</u>	Gauze Pack		
01 cc		<u>01</u>	<u>(5.5) '07'</u>		<u>02</u>	Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade <u>15</u>		<u>01</u>	Surgical Blade # 20		
<u>IV set Rain's Set</u>		<u>01</u>	NG tube			Koochies (S)		
RL			Cautery pencil			<u>100 ml NS</u>		<u>01</u>
NS : 10ml / 100ml / 500ml / 1000ml			Koochies			<u>Inj. Pyralium (1.125g)</u>		<u>01</u>
			Ointments			<u>Inj. Arjail (2-ml)</u>		<u>01</u>
			Suction Catheter			<u>Inj. Robin (0.2%)</u>		<u>01</u>
Fentanyl			Cap, Mask			<u>Dowater (10ml)</u>		<u>06</u>
Morphine			Gauze Pack <u>Plain</u>		<u>02</u>	<u>Dextrose 10% (10ml)</u>		<u>01</u>
Ketamine			Mop Pack			<u>Pink Line (200mg)</u>		<u>01</u>
Propofol		<u>01</u>	Steristrip			<u>Inj. Nyogestmine (ml)</u>		<u>01</u>
Rocuronium			Underpad		<u>01</u>			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		<u>01</u>			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		<u>01</u>			
			Microshield					
			Cotton Balls					
			Latex Gloves					
			Ramdione Scrub					
			Saral					

Surgeon

Order No. : 9904

Doc. No. : RCH / FRM / GENERAL / 125

Anaesthesiologist

Nurse

OT Technician

Ordered by : Banerji



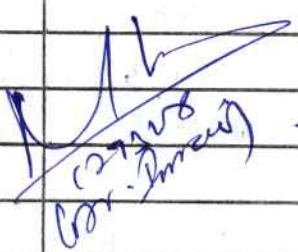
PROGRESS NOTES AND DOCTOR'S ORDER

wt - 3.1kg.

Date & Time	Progress Notes	Doctor's Order
29/7/2026	C/B Dr. Pavi Prasad	
3PM		
	Refer: BILATERAL Inguinal hernia Repair.	
	child alert, active, afebrile	
	vitals	
	HR - 140/min	
	RR - 50/min	
	SpO ₂ - 96% vRA	
	S/E	
	RS - S, S ₂ @ normal rates,	
	RS - BAF ₂ , clear,	
	fix - soft, B ₂ ,	
	CNS - T ₄ - 10	
		Rx
		- IUF @ 10% DNS
		@ 120mc/kg/day
		2) @ 15.5mc/h
		→ T-continue.
		↑ no drops
		0-3m (V-1-1)
		x 2 days.

stop to ward.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	S/B Dr. Moran.	
30/7/26.		
POD 1 10:00 am	B/L Agitated child was held as soft vital stable	Hemical Repair
	S/B	
	HR-2132/hr an - S122P RR → 45/min per - N133. SpO ₂ → 99% on P1A - SpH / B5(+) . CRT 2 sec RA CNO - Alert, moving PPHF + Lbm.	
	<u>Plan.</u>	
	- Remove IV line Removed - Plan discharge today	
		



OPERATION NOTES

Surgeon: <u>Dr. Aravaram</u>		Asst. Surgeon: <u>-</u>	
Anesthetist: <u>Dr. Kirthika / Dr. Santhia</u>		OT Nurse: <u>S/N. Bhavani</u>	
Pre-Operative Diagnosis: <u>Blk Right hernia</u>			
Surgical Procedure:			
<u>- Blk Right hernia Repair</u>			
Weight: <u>3.1 kg</u>	Date: <u>29/7/26</u>	Start Time: <u>9:00 am</u>	End Time: <u>10:30 am</u>
Post Operative Diagnosis:			
Peri-Operative Complications:			
Operation Notes: <u>↓ SpUA 1 caudal</u>			
Findings:			
<u>- Blk Right skin crease incision used</u>			
<u>- Subcutaneous layer opened</u>			
<u>- Sac identified & transfixed & ligated = 420 vessel</u>			
Procedure Notes: <u>- Subcutaneous & skin closed</u>			
<u>Post op order</u>			
<u>1. Nil per os</u>			
<u>2. Cholin drops 0.3ul 1-1-1 x 4/day</u>			
<u>3. Draining wound as Sutured</u>			
Amount of Blood Loss: <u>1</u>		Blood Transfused (In ML)	
Name and Number of Surgical Specimen sent for examination:			

Patient Sticker

POST-SURGICAL CARE PLAN FORM

Post-Operative Monitoring Parameters /Frequency:
Wound Care:
Drain /Special Lines/Catheters:
Special Patient Positioning and Requirements:
Nutritional Instructions:
When to Start Mobilization:
Special Referrals:
The new order for all required medications documented in the doctor order/medication sheet: ☐ Yes ☐ No
Any Other Post-Operative Care Needed including Required Follow Up

Name of the Surgeon: Dr. Arslan

Signature of the Surgeon: [Signature]

Date & Time: 27/1/20

PATIENT TRANSFER FORM

QUC-00094205
Baby SANVIKA B
13-05-2026 0 Y 2 M 16 D (F)
Dr. ABIRAMI KRITHIGA J



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Date & Time of Admission <i>29/7/26 @ 6:43 am</i>		Date & Time of Transfer Order <i>29/7/26 @ 10:50 am</i>
Treating Consultant Name <i>Dr. Abirami Krithiga</i>	Transfer Ordered by <i>Dr. Senthila</i>	Reason for Transfer <i>Post op management</i>
From Unit <i>DT</i>	To Unit <i>NICU</i>	Information to Attendant Yes ☒ No ☐
Number of Sheets in Clinical File <i>1p file @</i>	Number of Imaging Films <i>-</i>	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No..	Item Name	Quantity
1..		
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐		
Name & Signature of Person who is Transferring <i>[Signature]</i> <i>604470</i>		Name of Person Ordered Transfer <i>Dr. Senthila</i>
Patient & Clinical Records Received by :		
Date & Time of Patient Received :		
If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :		

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

10-11-12

10-11-12

10-11-12

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NURSES NOTES

☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
29/7	7.30 AM	<u>Received Notes</u> Baby Received From ER to BR. baby details hand over taken from ER Staff. baby vital's checked & monitored. NPO baby are slept well. Surgery consent, pre operative check list done. CBC, PT, APPT, INR send to Lab to be follow.	607628
	8 AM	Baby details hand over given to morning duty staff.	607628
		<u>Received Notes 29/7/26</u>	
29/7/26	8 am	Baby details hand over taken from night duty staff, Baby vital signs are stable @ Recorded, IV line Pattern, No chart maintained, Baby shifted to OT	607628
	9 am	<u>OT Notes 29/7/26</u> Baby Received from Recovery staff Baby Vital Signs are stable Sign in done, Baby & GA, Time out done, IV line Pattern, No chart maintained, Procedure started by Dr. Asirami Krithiga Baby vital signs are stable, Inj. Piptax	607628

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

GUC-00094205

IP24-00009029

Baby SANVIKA B

13-05-2026

0 Y 2 M 16 D

(F)

Dr. ABIRAMI KRITHIGA J



NURSES NOTES

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□ Drug Allergies

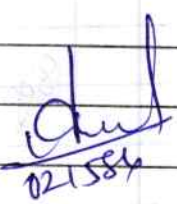
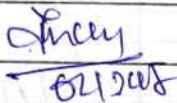
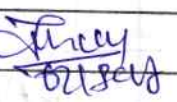
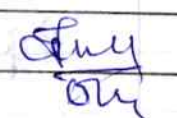
DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
29/7/26		300 mg IV given, IV line pattern, IV fluid on flow, 2/0 chart maintained, Baby side no any other complaints, Procedure done; Baby vital signs are stable, Neomol Suppo 80 mg PR given, Baby shifted to NICU	 607470
	10:30 am		 607470
		Nicu Receiving Note.	
		Baby came for observation purpose in 4 hours.	
		To monitored the vitals & and NI BP.	 02/5/26
		Baby in NPO. as Doctor's order. IV line patterned. No phlebitis. IVE - 1/2 DNS 15 ml/hr. Ongoing.	
	2pm.	NPO Broken. FF are given via Bottle feed. Baby feed tolerate well. No vomit & distat.	 02/5/26
	3pm.	Baby vitals are monitored & recorded. Baby vitally stable.	
	5pm.	Baby shifted to mother side in 2nd floor. Room NO:- 209.	
		Hand over given to 2nd floor staff.	 02/5/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ No Known Drug Allergies☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		<u>Note:-</u> Continue vital monitoring To give tolerate feed. Baby shifted toward in 2nd floor	
		Received notes on 29/7	
29/7	6pm	Baby details taken over from the ER staff Baby was conscious active good to him pulses NIP stable Oho no any other complains	
	6pm	Baby had feed 52 ml tolerate no vomiting N/A Soft	
	6.30pm	In Samyaletha man seen by baby advice to ER stop	
	7pm	No chest monitoring Baby details handing over to night duty staff	

NOTE : DO NOT WRITE OUTSIDE THE MARGINS



NURSES NOTES

☐ NO KNOWN Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)	SIGNATURE
		Night duty 29/5/26	
	8pm	Patient detail hand over taken from evening duty staff	
		Patient is conscious and Oriented	
	9pm	vital sign are checked and Recorded	Dyc 29/5/26
		Maintain I/O chart	
	10pm	Urine Pattern & swelling Medication and IVF was stopped.	
	1Am	There is no any complaint in Baby. Baby sleep well.	Dyc 29/5/26
	3Am	Maintain I/O Chart	
		Baby take DBP 2 hourly	
	5am	Baby Passed urine and Motion	
		Baby sleep well	
	6pm	vital sign are checked and Recorded	
		Maintain I/O chart	
	8am	Hand over given to morning duty staff	Dyc 29/5/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

(F)



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Patient Sticker



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NURSES NOTES

(USE BALL POINT PEN ONLY)

- ☐
- No Known Drug Allergies

- ☐ Drug Allergies

[illegible]

NOTE : DO NOT WRITE OUTSIDE THE MARGINS