

ACTIVITY RECORD FOR BILLING

SNC-00030816 IP24-00009006
Ms CHRISTINA M S
23-05-2019 7 Y 2 M 2 D (F)
Dr. AKILA SIVAKUMAR

Name:

UHID No: Consultant: Dept:

Date of Admission: Time: Date of Discharge: Time:

Room / Bed No: Ward: Suggested Billable bed type:

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/7	12:25am	R2	Ward	✓

CROSS CONSULTATION VISIT

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
25/7	CBE ✓, CRP ✓, RFT ✓, SGOT ✓, SGPT ✓	9422	[Signature]
	RBS ✓	9423 ✓	[Signature]
25/7/26	SGE	9440 ✓	[Signature]
26/7/26	U/R	9447 ✓	[Signature]
25/7/26	SLR ✓, Occult Blood ✓, stool biotest ✓	9471	[Signature]
26/7/26	IGG ✓, IGA ✓, IGM ✓, PS ✓, Vit D ₂₅ ✓, Hydroxy.	9497 ✓	[Signature]
25/7/26	USG ✓ Abdomen	4933 ✓	[Signature]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
25/7/26	✓ IV plasma	①	909-8 ✓	hug-off 29

ANY OTHER INFORMATION:

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Date: 27/7/26 Time: 6AM Prepared By: G. Kithu

Staff Nurse D. O'Brien	Shift / Ward Ramya - 1c 01/07/24	Billing Assistant	Billing Supervisor
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>S/A Dr. Akila</u>	
27/7/26 12:30am	7yr 2m / Feb /	
	Admitted to Stigella dysentery / pedicellulid reaction	Utracaria - 2 day ↑ Risk today
	Discharged on 9/7/26	And pain - severe perianthilias she every loose stool - on 7 episodes
	O/E Tired wob. @ afebrile	
	HR - 190/min Tr 1 hr RR - 60/min RL - 30/min wob @	Utracaria @ Enphatolone Epigam Tadur @
		Acute Utracaria no Angiodema Acute gastritis



ISIC Christina

SNr: 30816 **PROGRESS NOTES AND DOCTOR'S ORDER**

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



Christina

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<i>25/7/26</i>	<i>SLB</i>	<i>Dr. Aparna</i>
<i>10am</i>	<i>Alc Urticaria</i>	<i>/</i>
	<i>urticarial rash ⊕</i>	<i>by VRE.</i>
<i>at</i>	<i>Alert /</i>	<i>by HYDROCORTISONE</i>
	<i>Apple</i>	<i>35mg. 1000mg IV stat</i>
	<i>Vitals - stable</i>	<i>⊕</i>
	<i>WOB ⊕</i>	<i>by SRE / ocul + blood</i>
	<i>Sx ⊕</i>	<i>stool biops</i>
	<i>hydration - fair</i>	
<i>No abx</i>		
<i>ampicillin</i>		<i>⊕</i>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/07/2016	S/B Dr. Pavi Pogal	
12PM	A/C UTERINE	
	OE: Alert/active/afebrile	
	Vitals stable - stable	
	SE:	
	CVS - S, S, normal	
	RS - BAC, clear	
	PA - soft	
	CNS - T, T	
		Rx
		- IVF - DNS @ 50mc/hr
25/7/16	S/B Dr. Aparna Q	
	A/C Uterine	
	rash (x)	1) Symp PREDNISOLONE
	Alert	ROUTE (mg/kg)
	Afebrile	6mg - 00
	Vitals - stable	
	Apix - (x)	2) Symp NANOME (25/5)
	hydration for	(2kg) 3ml - 0 - 30
	abdomen - medication	Phosphate enema - 5ml

Fy/F



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BirthRight
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Date & Time	Progress Notes	Doctor's Order
26/07/16. 10:30 AM	S/B Dr. Ravi Raju	
	A: A/C ortho	
	Symptoms better	
	OE: child alert/active/afebrile (HRF/FF), CRT < 3Sec	
S. IgE 2780 IU/mL	S/E: r/s - S, S ₂ ⊕, no murmur PS - Bx ⊕, clear pA - S ⊕ r/s - Taw ⊕	
Start bio		R ₀ - Vitals monitor - Drugs to continue as per order
Tada		
Ig A Ig G Ig M Pentavalent 25(0.1) - 1.1 D ₃		



NURSES NOTES

(USE BALL POINT PEN ONLY)

- ☐
- No Known Drug Allergies

- ☐
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Received. nots 25/7
	2 Am	patient hand over taken from ER staff Baby complaints of whole body rashes Baby vitals checked and recorded T - 97.7 F / P - 116 / mit RR - 26 / bmt / BP - 89 / 65 mmHg Baby IV line ⊕ 3 Am IV fluids onflow 50ml / hr → Baby slept well. Baby urine passed. Baby no Itching complaints → Loose stools no 5 am vitals checked 7 Am Baby Elo Chart maintained → 8 Am hand over given to morning duty
		Audle 02043
		Audle 02043

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

IP24-00009006

23-05-2019

7Y2M2D

(F1)

Dr. APARNA G



NURSES NOTES

(USE BALL POINT PEN ONLY)



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☐ No known drug interactions☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		morning duty 25/7/26
	8am	Pt hand over taken from night duty SS PT vs checked 6 Records today vs Abdomen Scan vs Abdomen done PT vs stable Guline pattern GVR DNS SIB Dr. Aparna mam Advice to VOME ROUTINE, OGE SI ROUTE, occult blood, stool Biotin UP sent the Flow chart maintain PT side no any other new complaints 1pm 2pm PT Guline pattern R & ortho handover given to evening duty SS eh 6/2/26

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

ms Christina

Patient Sticker



NURSES NOTES

(USE BALL POINT PEN ONLY)

☐ No Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Evening duty on 25/7/26
25/7	2pm	Baby details taken over from the morning duty staff → Jenny
		Baby was conscious and oriented vitals were stable & well
	3pm	Dr. Lince out informed to Dr. Aparna mam tabate no vomiting total no re cannulate
	4pm	Dr. Aparna mam seen by advice to bring given add sup ranter, sup prednisolone Ralte
	5pm	Re-assessment done vitals were stable Bring given → Jenny
	5:30pm	Baby passed motion PIR, stool ¹²⁵ Blood, stool biofine send to Lab
	6pm	Baby active good no any other complaints
		Do chart monitoring
	8pm	At shift to 2nd floor, staff hand over gins.

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)
		Night duty 25/7/26.
	8pm	Baby details handing over taken from Evening duty Staff Baby is good conscious and oriented and no special complain to there
	9pm	checked the vital signs baby handing normal vital's and baby is active.
	10pm	given all medicine as per the doctor order
	1 AM	and checked the vital signs baby handing normal vital's maintain I to chart →
		no other complaints.
	6 AM	Maintain I to chart.
	8 AM	Hand over given to morning duty staffs →

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

Patient Sticker

style



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(USE BALL POINT PEN ONLY)

- ☐
- No Known Drug Allergies

- ☐
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		morning duty 26/7/20
26/7	8AM	Baby details is handover taken from night duty staff
		Baby is active up alert
	9AM	vital signs is checked up recorded. Baby is vitally stable
		Dr. Ravi Raghu sir after seen advised continue medications up
	11AM	PuA, PuM, PuE, PS, Vit D as hydroxy samples should be done
	1pm	samples taken sent to lab
		2lo chart is maintained
		no any other complaints
	2pm	Baby details is handover given to the evening duty staff

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

(USE BALL POINT PEN ONLY)

- ☐
- Drug Allergies

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(USE BALL POINT PEN ONLY)

- ☐
- Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		<i>night duty (26/7/2021)</i>
	<i>8pm.</i>	<i>PT hand over taken from evening duty staffs. PT is conscious and oriented. 210</i>
	<i>9pm</i>	<i>Check vital sign & record. D/o Medicine given. 210</i>
	<i>11pm</i>	<i>Maintain I/O Chart. 210</i>
		<i>No other complaints.</i>
	<i>1Am</i>	<i>Check vital sign & record. PT slept well. No other complaints. 210</i>
	<i>3Am</i>	<i>Maintain I/O Chart. 210</i>
	<i>5Am</i>	<i>Check vital sign & record.</i>
	<i>7Am</i>	<i>100 D/o Medicine given. Maintain I/O Chart.</i>
	<i>8Am</i>	<i>Hand over given to Morning duty staffs. 210</i>

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

Patient Sticker



(USE BALL POINT PEN ONLY)

- ☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
27/8		<u>Morning duty on 27/8/6</u>
	8AM	Baby details taken over from night duty & W. Baby was conscious and oriented. → mid afternoon
	9AM	checking vital signs and Recording.
	10PM	Dr. Apaiwa man round done. Baby was stable so DC today.
	10:30AM	Baby felt sent to bed → mid afternoon

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