

ACTIVITY RECORD FOR BILLING

Name: **SNC-00021627** **IP24-00008885**
Baby SAYAKSHVI
25-04-2025 **1 Y 2 M 15 D** (F)
 UHID No: **Dr. MONISHA R** Consultant: Dept:
 Date of Admission: Date of Discharge: Time:
 Room / Bed No: Ward: Suggested Billable bed type:

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7/26	3:30pm	ER	ward	N. [Signature]

CROSS CONSULTATION VISIT

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

[illegible]

9/7/26

CBC. CRP. Blood c/s

8590

they

RP2

VBG, RBS

(8589)

10/7/26

Stool Routine

(8598) ✓

10/7/26

VBG, RB8

Q 74

U/R ✓, RBs ✓

90 74

u/f/oe,

VP 4

8616

11/17

Electrolysis, CRP

8686

12/7/26

Stool reducing substance, 8F10

Stool biopsies ✓

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
9/7/26	IV placement ✓	①	255752	Jess 017349
10/7/26	IV placement ✓	①	8169	<u>Karen</u>

ANY OTHER INFORMATION:

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Date: 13/07/26 Time: 12:45pm Prepared By: G. Visitha

Staff Nurse AD 0229	Shift / Ward Ramya - 1c 018964 AD	Billing Assistant	Billing Supervisor
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/4/25 4 PM	C/O/W Dr. Monisha Malani	
	1) To repeat VBR after 4 hours @ 4 PM	
	2) Vitals monitoring	
	3) F/O monitoring	
	4) Allow ORS + Rice Kari	
	R. <u>Shaykh</u> 155630	
10/7 4 PM	C/S/B - Dr. Parthi	
	AGE 2 Dengue fever	
	Loose stools (+)	
	urine ✓	
	oral intake ↓	
	⊙ 18 Active	
	Pink	
	PPWT	
	vitals ⊙	
	Adm S/E - WNC	
	CONF IV Antibiotics	
	- Strict I/O charting	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26 9:00 AM	C/S/B - no Anal	
	Δ : Acute dehydration	
	Stool & Stool In	
	Stool	10 episode of loose stool
	Stool R/E - N	4 fever spikes P , periorbital swelling P
	$\text{Na}^+ \rightarrow 136$	no vomiting
	$\text{K}^+ \rightarrow 4.9$	oral intake good
	$\text{urea} \rightarrow 23$	O/E
	$\text{Creat} \rightarrow 0.3$	C/T/A good
	$\text{CRP} \rightarrow 13$	Afebrile
	$\text{CBC} \rightarrow \text{Hb} : 12.1$	T/T/T
	WBC	$\text{CRF} < 3 \text{ sec}$
	$\text{WBC} \rightarrow 7,95,000$	hydration fair
	$\text{N} \rightarrow 49$	S/E , P/A
	$\text{L} \rightarrow 33$	Soft, non tender, no organomegaly
	$\text{M} \rightarrow 15$	BSG
		$\text{R/L AB} \text{ P} \text{ NURS}$
		S/S $\text{CNS} : \text{S, S, P}$
		$\text{CNB} : \text{done @}$
	$\text{RR} \rightarrow 29/\text{min}$	
	$\text{HR} \rightarrow 129/\text{min}$	
	$\text{SpO}_2 \rightarrow 98\% \text{ on RA}$	Plan
	$\text{BP} \rightarrow 94/50 (70)$	1) DKA - DNS 3 ml/hr
		2) Inj. DONE 2 30 mg RUSG
		3) vitals Monitoring
		4) Inj. PAN
		5) Inj. Emesal

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/10/26	SB to Pavi Raga	
8PM	8 episodes of Loose stool since afternoon	
	No fever spikes	
	oral intake adequate	
	SLE: CUS-SIS ⊕, No marmar,	
	⊕ BxFO, clear,	
	FA - soft, Bx ⊕,	
	CUS - Tm ⊕.	
		- Todo
		- CRP, VBG,
		S-Electrolytes
		FUF → 100mc/hr 100mc/hr
		DNS
		@ 100mc/hr
		over 4hr
		fb
		@ 34mc/hr



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
12/07/26 9 AM	S/B Dr. Pari Rogul Δ - AUE 0 dehydration <u>C/E:</u> 10-12 times loose stools (consistently improving) No fever; Aupts orally, formula & liquids <u>O/E:</u> Mild peri-orbital edema CNS - SI S, ⊕ RS - B/L AE ⊕ P/A - soft CNS - Alert	
	<u>On:</u> Inj. Ceftriaxone (D3) Inj. Pantop Inj. Enixim → STOP. Bifidac Ab ZnO drops	<u>Plan</u> 1) Monitor vitals 2) Encourage oral liquids - ORS, Rice Kanji 3) Send stool for reducing lactose & stool bicarb 4) Stop IV fluids 5) Add. Inj. Amikacin
	R. Chakraverty 15/07/26	

Date & Time	Progress Notes	Doctor's Order
12/1/26 6 PM	9/5/15 Dr. SHANNON Δ - AGE = dehydration C/E: Loose stools frequency ↓ oral intake better O/E: W/S - S1 S2 ⊕ RS - S1 AE ⊕ P/A - Soft CVS - Mild	
	Plan 1) Monitor vitals 2) Trace stool Bogen	
	On: Oral Ceftriaxone (A3) Oral Ampicillin Bifidobacterium 200 drops Oral Agee.	
	R. Shannon 186630	

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(F)

Dr. MONISHA R



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/7/26 9:00 AM	C/S/B - Dr. Anil	
	Δ : AGE 7 dehydration	
	Oral feeds → tolerating	
	- 2 episodes in last 12 hours	
	Q/O : - Alert / active / afebrile	
	- ++ / +r	
Stool reducing substance ⊕⊕		CRP < 3 sec
Ⓟ of xone		Phosphorus
Relatives Pxo.	S/E : NAD	
		By
		① Dry xone 430mg (VBS)
		② Dry-Pan 15mg OD
		③ Bipilac 4g sachet OD
		④ Z k D drops 1ml OD
		⑤ Zebok sachet 1 sachet 5DS

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Date & Time	Progress Notes	Doctor's Order
13/7/26	<u>S/S constant</u>	
	<u>Viral A&E</u> (Rotavirus ⊕ in stool sample)	
	Oral acceptance improved Urine output ⊕	
	No signs of dehydration No fever.	
	Vitals ⊕	Stool x 2 times last 12h Semisolid
	<u>Plan</u> ① Stop Antibiotics ② Continue Bifidac Zed Zedott. ③ U/O monitoring Stool ④ Plan D/S evening.	
	<u>Signature</u> 9692	

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



NURSES NOTES

(USE BALL POINT PEN ONLY)

☐ No Known Drug Allergies☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Received notes [10/7/2025].
	4pm	Pt received from ER to 2nd Floor Pt complaints for loose stool abdominal pain mild dehydration IV line Patten. Dr. Samudra mam seen the Baby condition advice to Plan 7pm - CBG and VBG to do Check vital sign & second. BP - 81 - 53 mmHg —————> Giving this at 5pm
	6pm	Reassessment done.
	7pm	VBG and CBG and checking. CBG - 50 mg/dl. Informed to Dr. Arathi mam advice to connect Dr. - 30ml/hr -
	8pm	Hand over given to night duty staffs —————> Giving this at 8pm

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

SNC-00021627
Baby SAYAKSHVI
25-04-2025
Dr. MONISHA R

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☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
		Night duty.
10/7/26	8pm	Patient detail hand over taken from evening duty staff → Patient is conscious and Oriented
	9pm	vital signs are checked and recorded Maintain I/O chart
	10pm	Temp: 100.1 P-250m 2.5ml was given. Medication was given as Per doctor's order
	11pm	Reassessment was done Temp: 98.8 F.
	1am	Baby was sleep well IV F inflow. 32 ml of DNS
	3am	there is no complaint in Baby.
	4am	medication given as per drug Chart
	8am	I/O Chart monitoring Baby details handing over to our morning staff

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NURSES NOTES

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Known Drug Allergies

☐ Drug Allergies

DATE	TIME	(ALL ENTRIES MUST BE SIGNED, DATED AND TIMED)
11/4/26		<u>Morning duty on 11/4/26</u>
	8am	Baby details taken over from night duty Sr. Baby was conscious and oriented. Dr. his pattern. DUF DNS same/hr on flow. No chart <u>noted</u> . <u>W/o</u> <u>OT/19/26</u>
	9am	checking vital signs and recording. infant in distress. Baby was irritable crying not cooperative for DUF to inform Dr. Awas Sr. <u>W/o</u> <u>OT/19/26</u>
	12pm	Dr. Monisha main rounds down to continue same treatment and to do U/R, to check for urine output and baby wt also and to stop DUF DNS as per doctor order. <u>W/o</u> <u>OT/19/26</u>
	1pm	checking vital signs and recording. Baby parents complaint was diaper rash to inform Dr. Awas Sr. advised by to add B4 Nappy cream as per doctor order. <u>W/o</u> <u>OT/19/26</u>
	2pm	Baby details handing over given to evening duty Sr. <u>W/o</u> <u>OT/19/26</u>

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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)
		night duty on 11/7/26
11/7	8pm	Baby details taken over from the Evening duty staff
		Baby was conscious and record vitals are stable → Jenny
	9pm	Dr Ling out Introduced to Dr Paul Dr Ling advice to keep how long Dr Ling pattern up since do no any Other complains → Jenny
	11pm	Dr fluid 32 ml/hr on flow → Jenny
12/7	1pm	Re-assessment done vitals are stable & record → Jenny
	2pm	Baby sleep well no any other complains → Jenny
	6pm	medication given as per duty chart Dr chart monitoring
	8pm	Baby details handing over to morning duty staff → Jenny

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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)
12/7		<u>Evening duty on 12/7/26</u>
	2pm	Baby's default taken on the From morning duty. Baby was Conscious and oriented. In his pattern. DRE SOS only. To send stool for Reducing substance and stool biopsy. No chart written. To add Mom Dr antibiotic Int! Acetyromycin (26mg) but our hospital not available so outsaid hospital to checking and to informed Dr. Monisha nam also. → <u>W/O 01/7/26</u>
	4:30pm	To collect the stool and to send to Lab. → <u>W/O 01/7/26</u>
	4:45pm	To give Int! Acetyromycin first to given test does order to check for any rash after to given full dose.
	5pm	To collect the Int! Acetyromycin (26mg) given. before No allergy. → <u>W/O 01/7/26</u>
	5:20pm	Dr. Monisha nam rounds down. to explain about baby condition and to collect the stool reports.
	6pm	Checking vital signs and Recording. infant is stable. No chart written. → <u>W/O 01/7/26</u>

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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)
12/7/20		contin notes
	6:10pm	To exam stool reducing substance Reports, Reports was positive (2+) to send to Dr. Monisha mam and Dr. Sanyuktha mam also. S. Viro diff case
	6:20pm	To Need for Re sample stool So to try to collect the stool sample.
	7:30pm	Baby passed loose stools loose amount to send to sample lab.
		No chart monitor. → Viro diff case
	8pm	Baby details handing over given to night duty Sr. → Viro diff case
		Night duty 12/7/20
12/7	8pm	Baby details is handover taken from evening duty staff Baby is active up alert → S. Jeyasri
	9pm	Dr. Monisha mam came after seen the baby advised. Fedetl sachet TDS up with hold for 24h Azithromicine → S. Jeyasri
		Fedetl sachet given to the baby
	11pm	Baby is vitally stable. Baby slept well.

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by SAYAKSHVI
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