





CLINICAL CONDITION

T-04012427657314

SYSTEMIC EXAMINATION

OVS	S ₁ S ₂ (+)
RESPIRATORY	R SCR (+), ICR (+), Crackles (+)
PER ABDOMEN	Soft, BS (+)
CNS	Morcklow (+)
OTHER SIGNIFICANT FINDING	

TREATMENT ADVISED : On Admission

- Rx 1) IVF D₁₀ 4.3 ml/hr
 2) Inj Cefotaxime 65mg IV BD
 3) Inj Amikacin 0.3 ml IV OD

INVESTIGATIONS ADVISED : On Admission

- 4) O₂ by CPAP - FIO₂ 0.6
 PEEP-6.
 5) Inj Vitamin K 1mg IV stat



Print of Newborn (Left Foot)

सहमति पत्र

इसे डॉक्टर द्वारा बताया गया है कि हमारा शिशु अभी तक स्वस्थ है और हमें पूर्ण रूप से विदित है कि उपचार के दौरान हमें अपने बच्चे को देखभाल करने में मदद करनी होगी। इन सभी बातों को अवगत होने के बाद भी हम हमारे बच्चे को एस.एम.सी.यू. जिला चिकित्सालय में उपचार नहीं करने के लिये सहमत हैं।

Doctor's Name and Sign
प्रकृति आधिकारी
जन्म चिकित्सालय
प्रसवगृह (सम)

अभिभावक के द्वारा
Pony

FINAL OUTCOME

Successfully Discharged / Left Against Medical Advice / Referred / Expired

In Case of Death : Mention Cause of Death (✓ The Most Relevant Single Indication)

- | | | |
|---|---|---|
| 1. Respiratory Distress Syndrome | 6. Meningitis | 11. Cause not established |
| 2. Meconium Aspiration Syndrome | 7. Major Congenital Malformation | 12. Any Other : A (Please specify as per ICD-10 classification) |
| 3. HIE / Moderate-Severe Birth Asphyxia | 8. E.L.B.W. (Wt. less than 1000g) | |
| 4. Sepsis | 9. Prematurity (<28 weeks of Gestation) | |
| 5. Pneumonia | 10. Neonatal Tetanus | |

This Sheet has to be filled on Admission by Doctor on Duty

MOTHER'S INFORMATION : Past History and ANC Period

Mother's Age 22 Yrs. Mother's Wt. _____ Kgs. Age at Menarche _____ Yrs.

Consecutivity: Yes [] No [] Birth Spacing: < 1 Yr [] 1-2 Yr [] 2-3 Yr [] > 3 Yr [] Not Applicable []

Gravida: _____ Para: R+ Live Birth: L+ Abortus: A0

LMP: _____ EDD: _____ Gestation Weeks: _____

Artificial Vag. _____ TT-Doses: None [] / 1 [] / 2 []

Hb: _____ Blood Group: _____

PH: No [] Yes [] Hypertension / Pre-Eclampsia / Eclampsia

Drug: No [] Yes [] Radiation: Yes [] No []

Smear: Maternal TB / Jaundice / Rash with Fever [] / UTI / Dysuria / Other [] NO

A/H: Yes [] No [] ✓ GDM: Yes [] No [] ✓

Thyroid: Euthyroid [] / Hypothyroid [] / Hyperthyroid [] / Not Known []

YDR: Not Done [] + Wt [] ✓ HbsAg: Not Done [] + Wt [] ✓

Hiv Testing: Date / Not Done [] Amniotic Fluid Volume: Adequate [] / Polyhydramnios [] / Oligohyd []

Other Significant Information: _____

MOTHER'S INFORMATION : During Labour

Antenatal Steroids: Yes [] No [] If Yes, Betamethasone [] / Dexamethasone []

No. of doses: (1) [] (2) [] (3) [] (4) [] Time Between Last Dose & Delivery: _____ hrs. Days: _____

NO Fever: In 1st Trimester / In 2nd Trimester / In 3rd Trimester / During Labor only > 100.4F

Foul Smelling Discharge: Yes [] No [] Uterine Tenderness: Yes [] No []

Leaking PV > 24 Hours: Yes [] No [] 3-4 days PH: Hypertension / Pre-Eclampsia / Eclampsia

PPH: Yes [] No [] ✓

Amniotic Fluid: Clear [] Blood Stained [] Meconium Stained [] Foul Smelling []

Presentation: Vertex [] Breech [] Transverse [] Labour: Spontaneous [] / Induced []

Course of Labour: Unventful [] / Prolonged 1st stage [] / Prolonged 2nd stage [] / Obstructed []

E/D Fetal Distress: Yes [] No [] Type of Delivery: LSCS [] / A/V/D [] / NVD []

Indication for Caesarean, if Applicable: (Cephalo Pelvic Disproportion) [] (Malpresentation) [] (Placenta Previa) [] (Obstructed Labor) [] (Fetal Distress) [] (Prolonged Labour) [] (Cord Prolapse) [] (Failed Induction (Dystocia)) [] (Previous LSCS) [] (Other) []

Delivery Attended by: (Doctor) [] (Nurse) [] (ANM) [] (Dai) [] (Relative) [] (Any Other) []

Other Significant Information: _____

If information is not available, leave the field blank. Do Not ✓ "No" []



TREATMENT CONTINUATION SHEET

SNCL/Reg No. CS Date of Admission _____
 Baby of (Mother's name) B/o Pinki Sex _____
 Birth Weight _____ Doctor Incharge _____

	LO4 Date <u>01/12/24</u> WI <u>13 logs</u> WPC PND	Date _____ WI _____ PND _____
Oxygen and Other Supportive Care	① O ₂ by CPAP <u>10 L/min</u> → <u>CPAP</u> <u>PEEP 6 cmH₂O</u>	<u>FiO₂ 0.21</u> <u>Leads</u>
I/V Drugs	Du ② <u>iv Cefotaxime 50mg IV BD</u> Dy ③ <u>iv Amikacin (10mg 0.4cc IV OD)</u> ④ <u>IVF 130p @ 5ml/hr</u> ⑤ <u>SSPT 2 all precautions</u>	
I/V Fluids	⑥ <u>OG feed 2ml/other</u> → <u>stop</u>	
Oral Drugs and Feeding	⑦ <u>Am cefepime</u> → <u>4:30 AM 01/12/24</u> <u>1.5 cc + 10ml</u> → <u>abdomen distended</u> <u>brassy</u> - <u>stool OG feed</u> <u>brassy</u> - <u>Scrotal swelling</u>	
Investigations Advised	Plan for CRAP → <u>Stool</u> - <u>urine output monitor</u> <u>Ure flow</u> - <u>add Mebo</u> <u>add Ramidex</u> <u>advice</u> - <u>LFT, RFT</u> <u>FPA</u>	
Planning for Next Day	<u>DR. NITIN GUPTA</u> <u>Assistant Professor</u> <u>Pediatric Dept. Jangam</u> <u>Govt. Medical College</u> <u>Imphal</u>	<u>iv Ramidex 0.1cc/100</u> <u>iv metformin 10mg N BD</u> <u>Spice 5ml</u>

This Sheet has to be filled by Doctor Incharge of Patient
186 Blank PTO
CH + 238
RR - 45 B/L



TREATMENT CONTINUATION SHEET

SNCU Reg. No. 2218 Date of Admission _____
 Baby of (Mother's name) B. C. Dinda Sex _____
 Birth Weight _____ Doctor Incharge _____

	Date <u>4/1/24</u>	Date <u>5/1/24</u>
	L.O. WI <u>1320g</u> PND _____ H.O. WI _____ PND _____ H.O. WI _____ PND _____	L.O. WI <u>1320g</u> PND _____ H.O. WI _____ PND _____ H.O. WI _____ PND _____
Oxygen and Other Supportive Care	① O_2 by CPAP $\text{FiO}_2 = 0.21$ ② O_2 by CPAP $\text{FiO}_2 = 0.21$	RBS = 140 mg/dl $\text{FiO}_2 = 0.21$ ① O_2 by CPAP $\text{FiO}_2 = 0.21$ ② O_2 by CPAP $\text{FiO}_2 = 0.21$
I/V Drugs	③ I_2 Cefotaxime 60mg IV ④ I_2 Ampicillin 100mg IV ⑤ I_2 D10% 10ml	③ I_2 Cefotaxime 60mg IV ④ I_2 Ampicillin 100mg IV ⑤ I_2 Cal glu 1.5ml IV ⑥ I_2 Cal glu 1.5ml IV
I/V Fluids	⑦ I_2 Cal glu 1.5ml IV ⑧ I_2 Cal glu 1.5ml IV	⑦ I_2 Cal glu 1.5ml IV ⑧ I_2 Cal glu 1.5ml IV ⑨ I_2 Cal glu 1.5ml IV
Oral Drugs and Feeding		
Investigations Advised	CXA Plan suggested	
Planning for Next Day		



04012427641647

BABY'S INFORMATION: At Birth

Cried (wined) after Birth	Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>	Wt. at Birth _____ Kgs.
Gestational age	_____ In completed weeks	Maturity Preterm (<32 Wk) / Full Term / Post term (>42 Wk)
APGAR at 1 Min	_____ / Not Available	APGAR at 5 Min _____ / Not Available
Resuscitation Required	NO <input checked="" type="checkbox"/> / Yes <input type="checkbox"/>	Tactile Stimulation / Oral Oxygen / Bag & Mask Duration _____ min / Intubation / Chest Compression / Adrenaline
Warmth K. Exam	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	Breast Fed within 1 Hour Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>

BABY'S INFORMATION : On Admission

PRESENTING COMPLAINTS: *- meconium Aspirated*

GENERAL EXAMINATION

General Condition	(Alert) <input checked="" type="checkbox"/> / Lethargic <input type="checkbox"/> / Comatose <input type="checkbox"/>	Temperature _____ °C	Heart Rate: <i>130</i> /min
Apnea	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	RR: <i>50</i> /min	BP: _____
Grunting	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	Chest Inrawing	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>
Head Circumference	_____ cm	Length	_____ cm
Color	Pink / Pale / Central Cyanosis / Peripheral Cyanosis		
CRT >3 secs	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	Skin pinch > 2 secs	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>
Meconium Stained Cord	Yes <input checked="" type="checkbox"/> / No <input type="checkbox"/>	Cry: Absent / Feeble / Normal / High Pitch	
Tone	Limp / Active / Increase tone	Convulsions: Present on Admission / Past History (No)	
Jaundice	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/> If Yes, extent (Face) (Chest) (Abdomen) (Legs) (Palms) (Soles)		
Bleeding	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/> If Yes, specify site (Skin) (Mouth) (Rectal) (Umbilical)		
Bulging Anterior Fontanel	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>	Taking Breast Feeds	Yes <input type="checkbox"/> / No <input checked="" type="checkbox"/>
Sucking	[Good] / [Poor] / [No Sucking]	Attachment: (Well attached) / (Poorly attached) / (Not attached)	
Umbilicus	(Red) / (Discharged) / (Normal)	Skin Pustules: (No) / (Yes <10) / (Yes >10) / (Abscess)	
Congenital Malformation	No <input type="checkbox"/> / Yes <input type="checkbox"/>	Diaphragmatic Hernia / Hydrocephalus / M.M.C. / Imperforate Anus / T.O. Fistula / Cong. Heart Disease / Cleft Palate / Cleft Lip / Cleft Palate with Cleft Lip / Cong. Deformity of Hip / Cong. Deformity of Feet / Other _____	
Blood Sugar	_____	Oxygen Saturation	_____
Other Significant Information	_____		

If Information is Not Available, Leave the Field Blank, Do Not ✓ "No" !

T-04062427-681314

BABY'S INFORMATION: At Birth

Gest Inset, after Birth	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Wt. at Birth: 1325 gms
Gestational age	28 weeks	Completed weeks: <input checked="" type="checkbox"/> Preterm (<37 wks) / Full term / Post term (>42 wks)
APOAR at 1 Min	Not Available	APOAR at 5 Min: Not Available
Resuscitation Required	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> Tactile Stimulation / Dry Oxygen / Bag & Mask (Duration: _____ min) / Intubation / Chest Compressions / Adrenaline	
Umbilical Clamped	Yes <input type="checkbox"/> No <input type="checkbox"/> No C <input type="checkbox"/>	Breast Fed within 1 Hour: Yes <input type="checkbox"/> No <input type="checkbox"/>

BABY'S INFORMATION: On Admission

PRESENTING COMPLAINTS

Prematurity
Respiratory Distress

GENERAL EXAMINATION

General Condition	[Well] <input checked="" type="checkbox"/> [Mildly] <input type="checkbox"/> [Distress]	Temperature _____ °C	Heart Rate 140 /min
Apnea	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	RR 60 /min	BP _____
Grunting	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Chest indrawing: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Head Circumference	_____ cm	Length _____ cm	
Color	Yes / Pale / Central Cyanosis / Peripher. Cyanosis		
CRT > 3 secs	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Skin pinch > 2 secs: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Mucous Membr. Stained Cool	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Cry: Absent / Weak / Normal / High PWT	
Tone	Limbs / Active / Increase Tone	Convulsions: Present on Admission / Past History <input checked="" type="checkbox"/>	
Jaundice	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If Yes, extent (Face) (Chest) (Abdomen) (Limbs) (Palm) (Sole)		
Bleeding	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If Yes, specify site (Skin) (Mouth) (Rectal) (Umbilicus)		
Bulging Anterior Fontanel	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Taking Breast Feeds: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Sucking	[Good] <input checked="" type="checkbox"/> [No Sucking]	Attachment: [Well attached] [Poorly Attached] [Not attached]	
Umbilicus	[Red] [Discharge] [Mild]	Skin Pasterns: [Soft] [Rus > 10] [Rus > 15] [Abscess]	
Congenital Malformation	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> [Diaphragmatic Hernia / Hydrocephalus / M.M.C. / Imperforate Anus / T.O. Fistula / Cong. Heart Disease / Cleft Palate / Cleft Lip / Cleft Palate with Cleft Lip / Cong. Deformity of Hip / Cong. Deformity of Foot / Other]		
Blood Sugar		Oxygen Saturation _____	
Other Significant Information			

If Information is Not Available, Leave the Field Blank, Do Not ✓ "No" !



ZANANA HOSPITAL BHARATPUR

MORI CHAR SAG BHARATPUR

Sample ID	37	Patient ID	518
Name	B/O-PINGU	Sample Type	SERUM
Category	-	Collection Date	04-Jan-2024
Age	-	Req. Date	04-Jan-2024
Ref. Dr	-	Analyst	
Sample Remark		Location	

Sr.No.	Test	Result	Flag	Normal Range
1	Calcium	9.5 mg/dL		9.5 - 10.2 mg/dL
2	C-Reactive Protein	1.3 mg/L		0.0 - 6.0 mg/L

Patient Remark

Completion Date 04-Jan-2024 13:20

Note: Tests have been performed on fully automated analyzer:- EM 200

Print Date 04-Jan-2024 13:20 Page 1 of 1



TREATMENT CONTINUATION SHEET

SNCO Reg. No. 68 Date of Admission _____
 Baby of (Mother's name) Bhu Panki Sex Male
 Birth Weight _____ Doctor Incharge _____

	Date <u>7/1/24</u> Wt <u>1317g</u> PND _____	Date _____ Wt _____ PND _____
Oxygen and Other Supportive Care	<u>CO5</u> <u>40%</u> PND _____ <u>AB5</u> <u>FiO2 7.0g/dl</u> <u>O2 6g CPAP</u> <u>ctio2 40</u> <u>PEEP 3</u>	
I/V Drugs	<u>D5</u> ① <u>ig Cefotaxime 15g IV QD</u> <u>D5</u> ② <u>ig Amikacin (100) 0.4ml IV QD</u> ③ <u>IV Isop @ 5ml/h</u> ④ <u>SSPT @ all reactions</u>	
I/V Fluids	⑤ <u>Ig Amisulide 0.15mg</u> <u>with</u>	
Oral Drugs and Feeding	⑥ <u>Ig Pirofen 2.5ml</u> <u>0.6ml</u> ⑦ <u>Ig metronidazole 2ml IV QD</u> <u>TDS</u>	
Investigations Advised	<u>(Urine output monitor)</u> • CBC • FEFT • FPA - X-ray	
Planning for Next Day		

AG