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ALLERGIC To otvc

I.P. No. **UNITS** **DATE**



Narayana Medical College Hospital
Chinthareddypalem, Nellore-524003. Ph.0861-2355511

PATIENT DETAILS (RESPIRATORY MEDICINE)

Date : 12-SEP-2024
RegNo : 20231151619 - IP No: 240912045 Ward: PUL-G29-Third floor- General Time : 10:50:36 AM
Name : ~~XXXXXXXXXXXX~~ Age : 78 Y/M
Company : NARAYANA AROGYAMASTHU Bed No : H3029-0008

RegNo: 20231151619



IP No 240912045



Patient Name : _____ **Age** _____ **Sex** _____

**PLEASE RETURN THIS TO
Medical Record Department**

540



NARAYANA
Medical College & Hospital

NARAYANA HOSPITAL

Narayana Medical College, Chinthareddypalem, NELLORE - 2

NOT TO BE HANDLED BY THE PATIENT



[Signature]
Principal
SREE NARAYANA NURSING COLLEGE
Chinthareddypalem,
NELLORE-524 002

9/14/24, 5:32 AM

about blank

9/15/24, 6:14 AM



NARAYANA MEDICAL COLLEGE HOSPITAL

Chinthareddypalem, NELLORE - 524 003, A.P., India.
Ph : 0861-2355511, Extn : 2228

Central Clinical Laboratory Report

ReportUser: 45603798

PATIENT NAME: ~~XXXXXXXXXX~~
REG NO: 20231151619
WARD NAME: H3029-0008-RESPIRATORY MEDICINE-MALE
SAMPLEDT: 14-SEP-2024 09:14 PM

AGE: 78 YY SEX: Male
DATE: 14/09/2024
COMMON NO: 554 A
REPT: 14-SEP-2024 10:14 PM

CLINICAL Pathology REPORT

INVESTIGATION	RESULT	UNITS	BIOLOGICAL REF.INTERVAL
COLOUR	LIGHT YELLOW		PALE YELLOW
APPEARANCE [Method: Photometry]	CLEAR		CLEAR
PH [Method: Strip/Reflectometer reading]	7.0		>7.2
SPECIFIC GRAVITY [Method: Strip/Reflectometer reading]	1.010		1.015 - 1.060
ALBUMIN	NIL		NIL
SUGAR	NIL		NIL
KETONE BODIES	NEGATIVE		NEGATIVE
WBC CELLS [Method: Flowcytometry]	0-1	/HPF	OCCASIONAL
EP CELLS	0-1	/HPF	OCCASIONAL
R.B.C	0-1	/HPF	NIL
CRYSTALS	NIL	/HPF	NIL
CASTS	NIL	/HPF	NIL
YEAST	NIL	/HPF	NIL
BACTERIA	NIL	/HPF	NIL
OTHERS	NIL	/HPF	NIL

VERIFIED BY TECHNICIAN

- End of Report -

PATHOLOGIST



Principal
SREE NARAYANA NURSING COLLEGE
Chinthareddypalem,
NELLORE-524 002



Dr. Nandamuri Taraka Rama Rao Vaidya Seva Trust
డా|| నందమూరి తారక రామారావు వైద్య సేవ ట్రస్ట్
PATIENT REGISTRATION FORM
పేషెంట్ నమోదు ఫారము
NARAYANA MEDICAL COLLEGE HOSPITAL

Name of the Patient/Mobile No. / పేరు/ నంబరు :	Nagalapaatti Bujireddy / 9989598596	Registration No. / రిజిస్ట్రేషన్ నంబరు :	AP17760488	Date/Time / తేదీ / సమయం :	12/09/2024 10:06:00 AM		
Sex / లింగం / వయస్సు / ముద్ర :	78yr(s)8month(s)11day(s)/Male	Card No. / కార్డ్ నంబరు :	WAP092514800141/01	UHID No. :	UHID10101938461	Patient District / పేషెంట్ ప్రదేశం :	SPSR NELLORE
Address / చిరునామా :	00, KALEPADU	Referral Source / సిఫార్సు కేంద్రం :	Direct	Referral Card No. / రిఫరల్ కార్డ్ నంబరు :	DIRECT		

The Patient is Referred to the Vaidya Seva OP of NARAYANA MEDICAL COLLEGE HOSPITAL Hospital for Cashless Diagnosis & Treatment
 డా|| సి ఉచిత వైద్య సంప్రదింపులు మరియు వైద్య పరీక్షల నిమిత్తం NARAYANA MEDICAL COLLEGE HOSPITAL ఆస్పత్రిలోని డా|| ఎన్.టి.ఆర్
 వైద్య సేవ ఓ.పి వద్దకు సిఫార్సు చేయబడినది

Name of Medcol/Contact No. : D NAGARJUN / Not Available
 పేరు/ఫోన్ నంబరు :
 Name of Vaidyamithra /Contact No. /Signature: M.Sudha Rani/
 వైద్య మిత్ర పేరు /ఫోన్ నంబరు /సంతకము : 8333814451

(Handwritten signature and stamp)



(Handwritten signature)
Principal
SREE NARAYANA NURSING COLLEGE
 Chinthareddy Palem,
 NELLORE-524 002



NARAYANA GENERAL HOSPITAL

NELLORE

AUTHORIZATION FOR MEDICAL AND/OR SURGICAL TREATMENTS

Place: Nellore

Date: 12-Sep-2024 10:50:36 AM

I. I here by authorize doctors of Narayana Hospital, Nellore to perform the following Operating or Procedure on

Name of the Patient: **Bujji Reddy Nagalapati** Reg.No: **20231151619** IPNo: **240912045** Age : **78 Y Y** Sex : **Male**
Name of the Operation or Procedure _____

- The nature of my condition and the hazards of the Operation or Procedure including biopsy and any unwanted untoward complications that may arise have been explained to me by my Physician(s) Surgeon(s).
- I consent to the administration of Anaesthesia as advisable in my case. I also consent to the administration of any other drug relevant to the procedure.
- I further authorize the said Physician(s) Surgeon(s) to perform such additional operations or procedure including administration of a Blood or Blood Products as they or he may consider reasonably necessary or proper in the event of any emergency or if any unanticipated conditions should be discovered during the course of the operation.
- I hereby authorize the hospital, its agents or devisees to dispose off any removed issue or amputated member of my body as a result of the surgical operation in any manner deemed proper by the hospital.
- All the above points have been explained to me in the language which I understand.

Name of the Patient In Capital

Signature of the Patient

BUJJI REDDY NAGALAPATI

If the Patient cannot sign or is a Minor, spouse, parent or guardian has to sign

Relationship to the patient : _____

Witness : _____

Address : _____

AGAINST ADVICE FORM

Name of the Patient _____

IPNO _____ Ward : **RESPIRATORY MEDICINE-MALE**

I am responsible for taking the above patient out of the hospital against advice of the doctor I/C

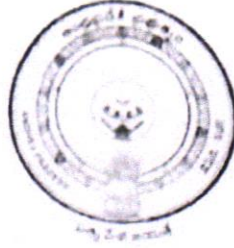
Signature of the relative _____

ATTENDANT NAME : **SESHA REDDY / 998959859**

Relationship _____



Principal
SREE NARAYANA NURSING COLLEGE
Chinthareddypalem,
NELLORE-524 002



Dr. Nandamuri Taraka Rama Rao Vaidya Seva Trust
డా|| నందమూరి తారక రామారావు వైద్య సేవ ట్రస్ట్
Diagnostic Test Requisition Slip
డయాగ్నోస్టిక్ టెస్ట్ రిక్విజిషన్ స్లిప్
NARAYANA MEDICAL COLLEGE HOSPITAL

Name of the Patient పేషెంట్ పేరు Nagalapaatti Bujjireddy Date తేదీ :
Health Card No/White Ration Card No /CMCO Reference No /AHS Card No హెల్త్ కార్డ్ / తెల్ల రేషన్ కార్డ్ నెం :
Age వయస్సు : 78yr(s)8month(s)11day(s) Sex ప్రే / పురుషుడు :
Patient Id పేషెంట్ ఐడీ : AP17760488

14/09/2024 10:07:56 am
WAP09251405
Male

Provisional Diagnosis ప్రావిజనల్ డయాగ్నోసిస్ :
Medical Management of Emphysema Without Respirative Failure

Tests Advised సూచించిన పరీక్షలు :
2D ECHO

Name and Signature of Medco/Treating Doctor మెడికల్ ఆఫీసర్ పేరు / సంతకం :
Date తేదీ 14/09/2024 10:07:56 am

NOTE All the Tests as prescribed by the doctor will be done free of cost.
వైద్యునిచే సూచించబడిన వైద్య పరీక్షలన్నియు ఉచితముగా చేయబడును
Any Difficulty Please Call Helpline Number-104
ఎటువంటి ఇబ్బందులు ఎదురైనను హెల్ప్ లైన్ నంబరు- 104 యందు సహప్రదించగలరు



Principal
SREE NARAYANA NURSING COLLEGE
Chinthareddypalem,
NELLORE-524 002

Report User: 45605328

PATIENT NAME : BUJJI REDDY NAGALAPATI
REG NO : 20231151619
WARD NAME : H3029-0008-RESPIRATORY MEDICINE-MALE
SAMPLEDT : 13-SEP-2024 12:45 PM

AGE : 28 YR SEX : Male
DATE : 13/09/2024
COMMON NO : 382 A
REPT : 13-SEP-2024 03:02 PM

CLINICAL Biochemistry REPORT

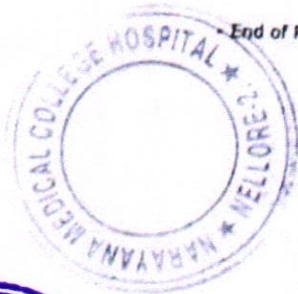
INVESTIGATION	RESULT	UNITS	BIOLOGICAL REF.INTERVAL
SERUM TOTAL BILIURBIN [Method:Jendrassic-GROF/ Diazo Method DPD]	1.43	mg/dl	0.1-1.2 mg/dl Adults Children-1month: 0.2-1.0 mg/dl Neonates: 24 hrs upto 8.7 mg/dl 2nd day : 1.3-11.3 mg/dl 3rd day : 0.7-12.7 mg/dl 4th-6th day : 0.1-12.6 mg/dl mg/dl
SERUM BILIRUBIN DIRECT [Method:Jendrassic-GROF/ Diazo Method DPD]	0.89	mg/dl	0-0.20 mg/dl
SGOT [Method:IFCC Kinetic]	119.03	U/L	Male: 37 IU/L Female:31 IU/L U/L
SGPT [Method:IFCC Kinetic]	74.85	U/L.	Male : 42 IU/L Female: 32 IU/L U/L.
ALKALINE PHOSPHATASE [Method:IFCC, AMP Buffer]	218.98	U/L.	Male : 80-306 U/L Female : 64-306 U/L Children upto 15 yrs : upto 644 U/L Children upto 17 yrs : upto 483 U/L U/L.
TOTAL PROTEIN [Method:Biuret]	6.29	g/dl.	6.40-8.40 g/dl.
SERUM ALBUMIN [Method:Bromo Cresol Green]	3.86	g/dl	3.80-5.10 g/dl
GLOBULIN	2.4	g/dl.	2.30-3.50
A/G RATIO	1.5		1.39-2.23

VERIFIED BY TECHNICIAN

End of Report -

Dr. S. Veeresh

BIOCHEMIST



Principal
SREE NARAYANA NURSING COLLEGE
Chinthareddypalem,
NELLORE-524 002

about:blank
NARAYANA MEDICAL COLLEGE HOSPITAL

Chinthareddypalem, NELLORE - 524 003, A.P., India.
 Ph : 0861-2355511, Extn : 2228

Central Clinical Laboratory Report

ReportUser:auto

PATIENT NAME	: BUJJI REDDY NAGALAPATI	AGE	: 78 YY SEX : Male
REG NO	: 20231151619	DATE	: 12/09/2024
WARD NAME	: H3029-0008-RESPIRATORY MEDICINE-MALE	COMMON NO.	: 452 A
SAMPLEDT	: 12-SEP-2024 03:56 PM	REPDT	: 12-SEP-2024 04:34 PM

CLINICAL Pathology REPORT

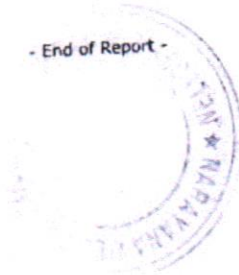
INVESTIGATION	RESULT	UNITS	BIOLOGICAL REF.INTERVAL
HAEMOGLOBIN [Method: Spectrophotometric method]	12.2	gm/dl	F12-15 M13.6-17.2 gm/dl
TOTAL COUNT WBC [Method: Electrical Impedance]	5,200	Cells/cumm	4000-11000 Cells/cumm
NEUTROPHILS [Method: Volume Conductivity Scatter]	57	%	40-75 %
LYMPHOCYTES [Method: Volume Conductivity Scatter]	33	%	20-40 %
EOSINOPHILS [Method: Volume Conductivity Scatter]	2	%	1-6 %
MONOCYTES [Method: Volume Conductivity Scatter]	8	%	2-8 %
BASOPHILS [Method: Volume Conductivity Scatter]	0	%	0-1 %
PLATELET COUNT [Method: Electrical Impedance]	1,69,000	Per cumm	150000-400000 Per cumm
RBC COUNT	3.64	mill/cumm	F3.5-5 M4.3-5.9 mill/cumm
PCV	37	vol%	F38-47 M40-54 vol%
MCV	100	Fl	80-100 Fl

[Signature]

PATHOLOGIST

VERIFIED BY TECHNICIAN

- End of Report -



[Signature]

Principal
SREE NARAYANA NURSING COLLEGE
 Chinthareddypalem,
 NELLORE-524 002

about blank
NARAYANA MEDICAL COLLEGE HOSPITAL

Chinthareddypalem, NELLORE - 524 003, A.P., India.
 Ph : 0861-2355511, Extn : 2228

Central Clinical Laboratory Report

ReportUser: 45605210

PATTENT NAME	BUJJI REDDY NAGALAPATI	AGE : 78 YY SEX : Male
REG NO	20231151619	DATE : 12/09/2024
WARD NAME	H3029-0008-RESPIRATORY MEDICINE-MALE	COMMON NO. 452 A
SAMPLEDT	12-SEP-2024 03:55 PM	REPDT : 12-SEP-2024 07:18 PM

CLINICAL Biochemistry REPORT

INVESTIGATION	RESULT	UNITS	BIOLOGICAL REF.INTERVAL
SODIUM [Method:ISE Direct]	141	meq/L	(M)(M)130-143 mEq/L
POTASSIUM	3.6	meq/L	(M)(M)3.50-5
CHLORIDE [Method:ISE Direct]	101	meq/L	93-110mEq/L
RANDOM PLASMA GLUCOSE [Method:GOD-POD PAP]	92.17	mg/dl	M80-140 mg/dl mg/dl
SERUM TOTAL BILIRUBIN [Method:Jendrassic-GROF/ Diazo Method DPD]	1.01	mg/dl	0.1-1.2 mg/dl Adults Children-1month: 0.2-1.0 mg/dl Neonates:24 hrs upto 8.7 mg/dl 2nd day : 1.3-11.3 mg/dl 3rd day :0.7-12.7 mg/dl 4th-6th day :0.1-12.6 mg/dl mg/dl
SERUM BILIRUBIN DIRECT [Method:Jendrassic-GROF/ Diazo Method DPD]	0.59	mg/dl	0-0.20 mg/dl
SGOT [Method:IFCC Kinetic]	131.86	U/L	Male: 37 IU/L Female:31 IU/L U/L
SGPT [Method:IFCC Kinetic]	87.39	U/L	Male :42 IU/L Female: 32 IU/L U/L.
ALKALINE PHOSPHATASE [Method:IFCC, AMP Buffer]	209.63	U/L	Male : 80-306 U/L Female : 64-306 U/L Children upto 15 yrs : upto 644 U/L Children upto 17 yrs : upto 483 U/L U/L.
TOTAL PROTEIN [Method:Biuret]	6.88	g/dl.	6.40-8.40 g/dl.
SERUM ALBUMIN [Method:Bromo Cresol Green]	4.00	g/dl	3.80-5.10 g/dl
GLOBULIN	2.8	g/dl.	2.30-3.50
A/G RATIO	1.4		1.39-2.23
SERUM UREA [Method:Urease GLDH]	21.16	mg/dl.	10-50 mg/dl mg/dl.
CREATININE [Method:JAFPE'S/Alkaline Picrate]	0.71	mg/dl.	Premature Neonates : 0.29-1.04 mg/dl Full Term Neonates : 0.24-0.85 ma/dl 2-12 Month : 0.17-0.42 mg/dl 1-3 yrs : 0.24-0.41 mg/dl 3-5 yrs : 0.31-0.47 mg/dl 5-7 yrs : 0.32-0.59 mg/dl 7-9 yrs : 0.40-0.60 mg/dl 9-11 yrs : 0.39-0.73 mg/dl 11-13 yrs : 0.53-0.79 mg/dl 13-15 yrs : 0.57-0.87 mg/dl Adult Male : 0.7-1.3 mg/dl Adult Female : 0.5-1.0 mg/dl mg/dl.



(Handwritten Signature)

Principal
SREE NARAYANA NURSING COLLEGE
 Chinthareddypalem,
 NELLORE-524 002

9/13/24, 7:32 AM



NARAYANA MEDICAL COLLEGE HOSPITAL

Chinthareddypalem, NELLORE - 524 003, A.P., India.
Ph : 0861-2355511, Extn : 2228

Central Clinical Laboratory Report

PATIENT NAME :BUJJI REDDY NAGALAPATI
REG NO :20231151619
WARD NAME :H3029-0008-RESPIRATORY MEDICINE-MALE
SAMPLEDT :12-SEP-2024 03:56 PM

ReportUser:45604960

AGE :78 YY SEX :Male
DATE :12/09/2024
COMMON NO. :452 A
REPDT :12-SEP-2024 05:52 PM

CLINICAL Microbiology REPORT

INVESTIGATION	RESULT	UNITS	BIOLOGICAL REF.INTERVAL
H.I.V	NON-REACTIVE	NA	REACTIVE / NON-REACTIVE
HBs Ag	NON-REACTIVE	NA	REACTIVE / NON-REACTIVE
HCV	NON-REACTIVE	NA	REACTIVE / NON-REACTIVE

* PLEASE NOTE : THIS IS ONLY A SCREENING TEST.THIS IS NOT A CONFIRMATORY TEST.BOTH FALSE POSITIVES AND FALSE NEGATIVES ARE POSSIBLE.TEST HAS TO BE CONFIRMED BY 'RT-PCR' TECHNIQUE.

VERIFIED BY TECHNICIAN

- End of Report -

MICROBIOLOGIST



Principal
SREE NARAYANA NURSING COLLEGE
Chinthareddypalem,
NELLORE-524 002

**A.P. STATE AIDS CONTROL SOCIETY, HYDERABAD
INTEGRATED COUNSELING AND TESTING CENTRE**

Narayana Medical College & Hospital

LABORATORY REPORT FORM

1 Date 12.7.24 2 PID No 1405711 3 Age 73 yrs
 4 Identification Marks : A _____ B _____
 5 Date when sample received : 12.7.24
 6 Result of HIV antibody test A. NON Reactive B. _____

First Test: HIV-1 / HIV-2 / HIV 1 & 2 Reactive / Non - reactive
 Name of the Kit : COMB AIDS
 Expiry Date : 26/11/25
 Second Test : HIV-1 / HIV-2 / HIV 1 & 2 Reactive / Non - reactive
 Name of the Kit :
 Expiry Date :
 Third Test : HIV-1 / HIV-2 / HIV 1 & 2 Reactive / Non - reactive
 Name of the Kit :
 Expiry Date :

*ICTC
Lab Technician
[Signature]*

7. Any Comment ? NON Reactive.

[Signature]
Signature of Doctor

Date : 12.7.24

Department of Gyn & OBGS
NARAYANA MEDICAL COLLEGE & HOSPITAL
Chintharoddypalem, Nellore

Note :
 1) This report should be signed by the incharge of the HIV test laboratory or any authorised person.
 2) The HIV test report should be sent by the authorised person to the counsellor in ICTC for hand-



[Signature]
Principal
SREE NARAYANA NURSING COLLEGE
Chintharoddypalem,
NELLORE-524 002



NARAYANA MEDICAL COLLEGE HOSPITAL
Chinthareddypalem, Nellore - 524 002

DEPARTMENT OF RADIOLOGY & IMAGING
ULTRASONOGRAPHY - ABDOMEN & PELVIS

NAME: Bujji Reddy. N AGE/SEX: 78/M
OP NO./IP NO.: 2 IP RADIO - RG NO.: _____ DATE: 13/9/24

LIVER SIZE :

ECHO TEXTURE :

NORMAL	INCREASE	DECREASE
✓		
NORMAL	INCREASE	
✓		

No focal lesions ✓
NO IHRD ✓

PV :

CBD :

GALL BLADER :

PANCREAS :

SPLEEN :

KIDNEYS :

URINARY BLADDER :

PROSTATE :

OTHERS :

NORMAL ✓

NORMAL

NORMAL ✓ (partially distended)

Visualised proximal body appear normal

RIGHT: } Normal size and Echotexture

LEFT: } PCS - compact, CMD maintained

minimally distended.

Normal

No free fluid noted in peritoneal cavity grossly at the time of scan.

PELVIS :

UTERUS :

ENDOMETRIUM :

OVARIES : RIGHT :

LEFT :

PDO :

IMPRESSION :- NO significant sonological abnormalities detected

Dr. P. Ravi
RADIOLOGIST

Principal
SREE NARAYANA NURSING COLLEGE
Chinthareddypalem,
NELLORE-524 002



09/09/2024 11:31 AM

PATIENT NAME: BILU REDDY NAGALAPATI
 RES NO: 20231151819
 WARD NAME: 113029 0008 RESPIRATORY MEDICINE MALE
 SAMPLED: 11 SEP 2024 12:45 PM

Report User: 45605138
 AGE: 78 YR SEX: Male
 DATE: 11/09/2024
 COMPLAIN NO: 382 A
 REPORT: 11 SEP 2024 03:02 PM

CLINICAL Biochemistry REPORT

INVESTIGATION	RESULT	UNITS	BIOLOGICAL REF. INTERVAL
SERUM TOTAL BILIRUBIN [Method: Jendrassik-GROFF/Diazo Method (DPI)]	1.43	mg/dl	0.1-1.2 mg/dl Adults Children: 1 month: 0.2-1.0 mg/dl Neonates: 24 hrs upto 8.7 mg/dl 2nd day: 1.3-11.3 mg/dl 3rd day: 0.7-12.7 mg/dl 4th-6th day: 0.1-12.6 mg/dl mg/dl
SERUM BILIRUBIN DIRECT [Method: Jendrassik-GROFF/Diazo Method (DPI)]	0.89	mg/dl	0-0.20 mg/dl
SGOT [Method: IFCC Kinetic]	119.03	U/L	Male: 37 U/L Female: 31 U/L U/L
SGPT [Method: IFCC Kinetic]	74.85	U/L	Male: 42 U/L Female: 32 U/L U/L
ALKALINE PHOSPHATASE [Method: IFCC, AMP Buffer]	218.98	U/L	Male: 60-306 U/L Female: 64-306 U/L Children upto 15 yrs: upto 644 U/L Children upto 17 yrs: upto 483 U/L U/L
TOTAL PROTEIN [Method: Biuret]	6.29	g/dl	6.40-8.40 g/dl
SERUM ALBUMIN [Method: Bromo Cresol Green]	3.86	g/dl	3.80-5.10 g/dl
GLOBULIN	2.4	g/dl	2.30-3.50
A/G RATIO	1.5		1.39-2.23

Dr. S. Venesh

BIOCHEMIST

VERIFIED BY TECHNICIAN

- End of Report -



Principal
 SREE NARAYANA NURSING COLLEGE
 Chintharoddypalem,
 NELLORE-524 002



about bla...

BKGD000 Ver 5.10w 10 Biomet. Co., Ltd.

PATIENT NAME BUJJI REDDY NAGALAPATI
 REG NO 20231151610
 WARD NAME H3029-0008 RESPIRATORY MEDICINE MALE
 SAMPLE DT 13-SEP-2024 12:46 PM

Report/Issr auto
 AGE 78 YR SEX Male
 DATE 13/09/2024
 COMMON NO 384 A
 REPT 13-SEP-2024 01:24 PM

CLINICAL Pathology REPORT

INVESTIGATION	RESULT	UNITS	BIOLOGICAL REF. INTERVAL
HAEMOGLOBIN [Method: Spectrophotometric method]	12.1	gm/dl	F12-15 M13.6-17.2 gm/dl
TOTAL COUNT WBC [Method: Electrical Impedance]	7,800	Cells/cumm	4000-11000 Cells/cumm
NEUTROPHILS [Method: Volume Conductivity Scatter]	70	%	40-75 %
LYMPHOCYTES [Method: Volume Conductivity Scatter]	18	%	20-40 %
EOSINOPHILS [Method: Volume Conductivity Scatter]	2	%	1-6 %
MONOCYTES [Method: Volume Conductivity Scatter]	10	%	2-8 %
BASOPHILS [Method: Volume Conductivity Scatter]	0	%	0-1 %
PLATELET COUNT [Method: Electrical Impedance]	2,34,000	Per cumm	150000-400000 Per cumm
RBC COUNT	3.43	mill/cumm	F3.5-5 M4.3-5.9 mill/cumm
PCV	34	vol%	F38-47 M40-54 vol%
MCV	100	fl	80-100 fl

N. M. Reddy

PATHOLOGIST

VERIFIED BY TECHNICIAN

- End of Report -



Principal

Principal
 SREE NARAYANA NURSING COLLEGE
 Chintharoddypalem,
 NELLORE-524 002



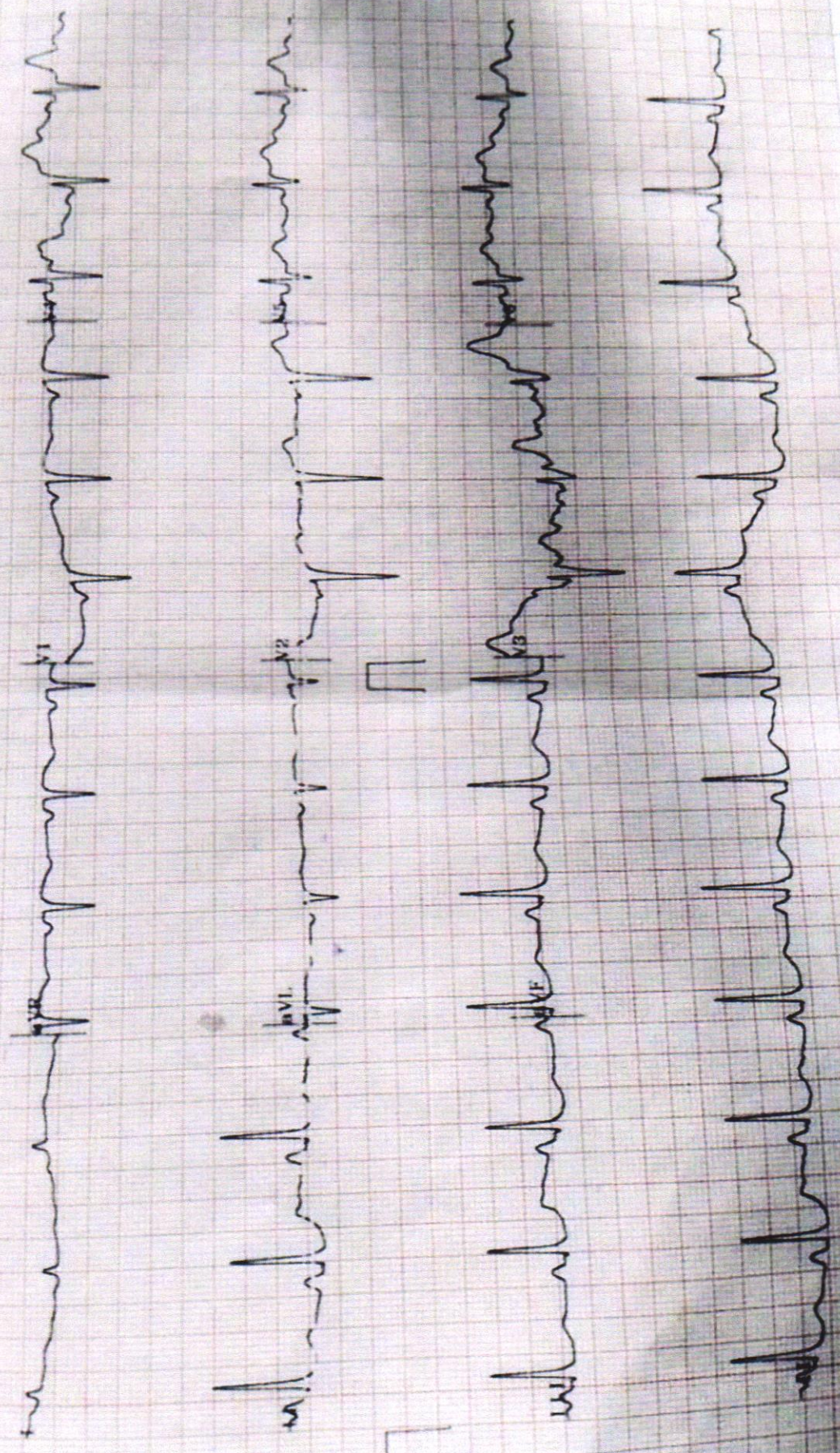
SAAG 000 Ver 5.104.10 Biomet Col. Ltd.

Hospital: NARAYANA CLINICS
 Prescribed by:
 (To be finally confirmed by cardiologist)

B. Sridhar Reddy

Heart Rate: 80 bpm
 PR Int.: 144 ms
 QRS Dur.: 98 ms
 QT/QTc: 402/461 ms
 P-R-T axes: I Normal ECG

80 80 5

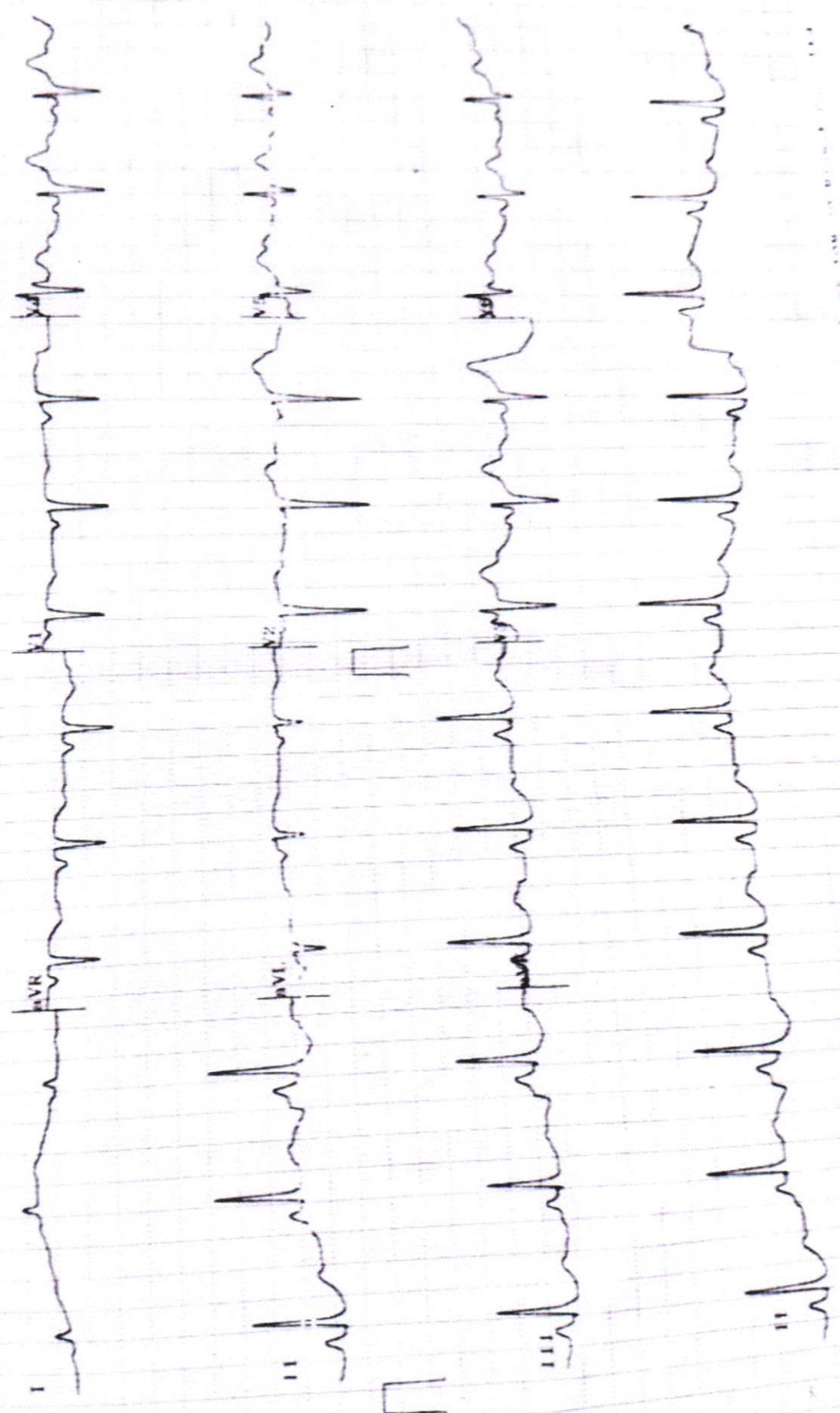


(Signature)

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 NELLORE-524 002

Heart Rate: 74bpm
PR Int.: 142 ms
QRS Dur.: 100 ms
QT/QTc: 408/456 ms
P-R-T axis: 83 80 67

Bujji Reddy



[Signature]
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NELLORE-524 002

Narayana Medical College Hospital

Chinthareddypalem, Nellore-524003, Ph:0861-2355511



RegNo 20231151619



IP No 240912045



ADMISSION RECEIPT

Date : 12-SEP-2024
 Reg No : 20231151619
 Name : BUJJI REDDY NAGALAPATI
 Department : RESPIRATORY MEDICINE
 Address : 00, BRAHMADEVAM, KALIVELA
 Company : NARAYANA AROGYAMASTHU

IP No : 240912045
 Age : 78 Y/M
 Doctor: DR JYOTHI PEETHALA
 PALEM, Muthukur, NELLORE
 User ID: 45601048

Time : 10:50:36 AM
 Bill No: 3201595878
 Bed No: H3029-0008
 City : NELLORE
 Pass No: 1
 Admission Charge: 100.00
 Paid Amount: 0.00

Authorized Signatory

ADMISSION RECEIPT (OFFICE COPY)

Date : 12-SEP-2024
 Reg No : 20231151619
 Name : BUJJI REDDY NAGALAPATI
 Department : RESPIRATORY MEDICINE
 Address : 00, BRAHMADEVAM, KALIVELA
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 Bill No: 3201595878
 Bed No: H3029-0008
 City : NELLORE
 Pass No: 1
 Admission Charge: 100.00
 Paid Amount: 0.00

Authorized Signatory

PATIENT DETAILS (PUL)

Date : 12-SEP-2024
 RegNo : 20231151619 - IP No: 240912045
 Name : BUJJI REDDY NAGALAPATI
 Company: NARAYANA AROGYAMASTHU

Ward: PUL-G29-Third floor- General
 Age : 78 Y/M
 Bed No : H3029-0008

RegNo 20231151619



IP No: 240912045



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Chinthareddypalem,
NELLORE-524 002

12:00 PM - 10:30 AM



Narayana Medical College & Hospital
(A Unit of Narayana Educational Society)
Chinthareddypalem, Nellore - 524 003, A.P., India
Ph: 0861-2317963, 2317964, Ambulance: 2324111
www.narayanamedicalcollege.com

COMPNAME : NARAYANA AROGYAMASTHU
NAME : BUJI REDDY NAGALAPATI
AGE : 78 Y. SEX : M
REGNO : 20231151619
OPID : 1024809352
DEPT : Respiratory Medicine
DOCT : DR. JYOTHI PEETHALA
DATE : 12-SEP-2024 08:37:36 AM
Op Timings : 9AM to 4PM 11 AM to 6 PM

OUT PATIENT CARD

PROVISIONAL DIAGNOSIS

DATE & TIME

9:45 AM



UNIT-II

Look's, Note, etc



Co. curm e
Spahr aural nature - ↑ 10 days

Sos e enlu

Ho fiddem

↓ Appetite

Wgt: 36 kg - Bil wheeze, etc
Bil Snot fine w/4

? COPD - Acute APD

APD
HR
DM
PTB

Smoker
- Alcoholic
- Ho inhaler use

SpO₂: 93% RA
PR: 96 bpm

NAME : BUJI REDDY NAGALAPATI
REGNO : 20231151619
DEPT : Respiratory Medicine
DOCT : DR. JYOTHI PEETHALA
USERID : 45605152
COMPNAME : NARAYANA AROGYAMASTHU
UPI : NGH20231151619.03@cmsidfc

OPID : 1024809352
CONS DATE : 12-SEP-2024 08:37:36 AM

BILLNO : 82409120089
VISIT : 1
REFNO :



Signature

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రెండు రోజులూ మాత్రమే వర్తించును - స్పెషలిస్టు డాక్టర్లచే 24 గంటల అభ్యుపసార నిరీక్షా విభాగము

DATE :

A dent

↓

~~Asp Nam~~

↓

Dr. Jyoti wane

↓

Mab puluo - II

[Handwritten signature]

Bringing Life to Lives

వార్షిక
వార్షిక
పూర్వ
పూర్వ
వెంటన, కిచ్చిలాన్

సర్టిఫైడ్ గ్రాడ్యుయేట్ ఎంబ్రాలజీ
ఎండోక్రైనాలజీ
జనరల్ మెడిసిన్
జనరల్ సర్జరీ

పల్లెటూరు
రెవి, ముక్కు గొంతు
దంత వైద్యం
మానసిక వ్యాధులు
ఉపరితమలు, శ్వాసక
వ్యాధులు, గర్భాశయ

24 గం. యాక్సిడెంట్ & ఎమర్జెన్సీ సర్వీసులు
కీళ్ళు విముక్తల విభాగం
కాన్సల్టం, గర్భాశయ

[Handwritten signature]

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NELLORE-524 002





NARAYANA MEDICAL COLLEGE HOSPITAL
Page 2
CHINTHAREDDYPALEM, NELLORE - 2, A.P. Ph: 08612317963,64,68
CASE RECORD

IP No: 240912045

Name of the Patient : **BUJJI REDDY NAGALAPATI**

Age : **78 Y Y** Sex : **Male** Religion : _____

Father / Husband's Name / relation : **SUBBARAMI REDDY NAGALAPATY**

Full Address : **00, BRAHMADEVAM, KALIVELA PALEM**

Muthukur, NELLORE, Phone No : **8500075397**

AADHAR : **714777658912**

Final Diagnosis : _____ Code No: _____

Date of Admission : **12-Sep-2024 10:50:36 AM 10:50:36 AM** Ward : _____

Date of operation and operation procedure : _____ Code No: _____

Date of Discharge : _____

Results :

Cured	Relieved	Otherwise	Died	Length of Stay

DISCHARGE SUMMARY

Symptoms

Physical Findings

Treatment

Operations

Biopsy Findings



Signature of the Chief

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NARAYANA MEDICAL COLLEGE HOSPITAL

Page 3

CHINTHAREDDYPALEM, NELLORE - 2, A.P. Ph: 08612317963,64,68

HISTORY

IP No: 240912045

Name of the Patient : **BUJJI REDDY NAGALAPATI**

Age : **78 Y Y** Sex : **Male** Ward : **RESPIRATORY MEDICINE-MALE** Religion : _____

Complaint :
 History of Present Illness :
 History of Previous Illness : clo SOB :: 2 months on Excretion
 Habits :
 Family History : clo cough :: 20 days
 Physical Examination : clo LOA (+) :: 2 months
 Remarks : clo generalised weakness :: 5 days
 clo giddiness :: 1 month

PHYSICAL EXAMINATION

pt was apparently (N) 2 month later which he developed
 clo SOB :: 2 months also wheeze, insidious onset, gradually
 progressive to G-III mmRE, Orthopnea (+), PND (+), No H/o any
 variations. aggravates on Excretion relieves on rest

clo cough ± sputum :: 20 days, scanty, white mucoid
 non-foul smelling & not blood tinged. No H/o postural,
 seasonal & diurnal variations

clo giddiness :: 1 month
 clo LOA (+) :: 2 months also Nausea

clo generalised weakness :: 5 days

No clo chest pain / fever / palpitations / rhinitis / Hemoptysis

No clo low

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 NELLORE-524 002



Pass H/o :- H/o similar complaints :- 7 yrs
 H/o Inhaler usage :- 7 yrs (R)
 N/K/C/O (COPD/ COP/ BDM) HTN/ CVA/ Epilepsy/ PTB/ Ps. Asthma/
 covid-19
 covid vaccination - Not taken
 No H/o dust allergy

Personal H/o :- Takes mixed diet
 Bowel & Bladder habits (N)
 Sleep & appetite (N)

Smoker :- 60 yrs 1 pack beed/day
 Alcoholic :- 60 yrs last taken
 ↓
 1 month back.

PY-60
 LI-1200

No other addictions

Family H/o :- Nil significant

Occupation :- Tractor driver

G/E :- pt is clele

moderately built & Nourished

P ⊕, I ⊖, C ⊖, E ⊖, L ⊕, E ⊖

Vitals

Temp - Afebrile

BP : 130/80 mmHg

PR : 85 Bpm

R : 23 cpm

S/E

CUS :- S₁S₂ ⊕

RS :- B/L N/B ⊕

B/L wheeze

B/L Base/ crep R ⊕ nt



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 Chintharoddyalem,
 NELLORE-524 002

14, 10:43 AM
 NI
 Reg No:
 Name:
 Doctor
 Transf
 Inform
 Modeo

NARAYANA MEDICAL COLLEGE AND HOSPITAL

Chinthareddypalem, Nellore

Hospital Billing Record

Reg No:	20231151619	IpNo:	240912045	Wardname:	Respiratory Medicine-Male
Name:	Bujji Reddy Nagalapati Dr Jyothi Peethala	Age/Sex:	78 Y Y/Male	BedNo:	H3029-0008
Doctor:		Admission Date:	12-Sep-2024 10:50:36 AM	Admit Time:	10:50:36 AM
Transfer Information: From		To:		D/Time:	
Mode of Payment:		Cash:		Credit/Debit Card	

Total Charges	Amount
Bedcharges	
Consultations	
Nursing	
Pharmacy	
Investigations	
Procedures	
Packages	
Miscellaneous	
Others	
Total	



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**నారాయణమెడికల్ కాలేజి
హాస్పిటల్**

**చింతారెడ్డి పాళెం, నెల్లూరు
ఆరోగ్యసేవా పథకము వర్తించని పేషంట్లు
వ్రాసి ఇచ్చే హామీ పత్రము**

తేదీ _____

పేషంట్ పేరు : **BUJJI REDDY NAGALAPATI**

జిఫ్టర్ నెం : **20231151619**

ఈనెల తెలుపబడిన పేషంట్లైన నాకు కలిగిన వ్యాధికి ఆరోగ్యసేవా పథకము వర్తించనందున లేదా మాకు ఆరోగ్యశ్రీ సౌకర్యము లేనందున అన్నీ సౌకర్యములు బిల్లులు చెల్లించి వైద్యము చేయించుకొనుటకు అన్ని విధములుగా మేము సంగీకరించుచున్నాము.

పేషంట్ తరపున బంధువు సంతకము

పేషంట్ సంతకము

పేషంట్ చిరునామా

UBBARAMI REDDY NAGALAPATY

2, BRAHMADEVAM

ALIVELA PALEM

uthukur

ELLORE

P, INDIA

ఫోన్ : **8500075397**



(Handwritten signature)

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Chinthareddy Palem,
NELLORE-524 002



NARAYANA MEDICAL COLLEGE & HOSPITAL, NELLORE

NURSING INITIAL ASSESSMENT FORM

(Initial Assessment must completed within 30 minutes of admission)

PATIENT IDENTIFICATION

P No 240a/204to Name Biji Reddy
 Age 49 Sex: M / F Ward Pulmo Bed No _____

Date admitted 12/9/24 Time admitted 11:30 AM Arrived by: Wheelchair / Stretcher / walking
 Patient accompanied by _____ Contact Number _____
 Type of payment NAM (Self / Company, NAM/VSP/Paid, etc)
 Reason for coming to hospital / Presenting complaints: Asthma, pneumonia

cough

HEALTH HISTORY

Present medical treatment history: _____

Past Surgical History: Hypertension DM TB IHD Renal Others
 Previous hospitalization: Yes No
 Previous surgeries: Yes No

ALLERGIES / ADVERSE REACTIONS

Known or suspected allergies to:
 1 Medication/Drug : Yes / No
 2 Blood Transfusion : Yes / No
 2 Other allergies : Yes / No

ASSESSMENTS

1 Assessment for all risk (Fall risk assessment tool to be used) Score
 2 Assessment for pressure ulcers Score
 3 Assessment for pain (Assess using the applicable scale) Score

FAMILY HISTORY

No. of Children 2 Any others _____

HABITS

Smoking Yes No Tobacco chewing Yes No
 Alcohol Yes No Drug abuse Yes No




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Sleeping Pattern

Hours Day

4 hrs Night *8 hrs*

Any sleep disturbance Yes No

Elimination history

Bowel movements

Frequency of micturition

Normal

Constipation

Loose stools / night

HEALTH ASSESSMENT

General appearance

Well built

Thin

Obses

Behavior

Anxious

Distressed

Cheerful

Level of consciousness

Conscious

Altered consciousness (use GCS)

Altered sensation

Yes

No

Vision

Normal

Impaired

Ear: Pain

Yes

No

Discharge

Yes

No

Hearing

Normal

Limited Rt / Lt

Uses hearing aid

Yes

No

Mobility

Ambulant Not ambulant difficulty in performing ADL

can sit up altered ROM

Circulation: Cyanosis

Yes

No

Clubbing

Yes

No

BP

120/80 mmHg

Nutrition: Htcms;

Wt.....kgs BMI..... Normal BMI Range(18.5-22.9 kg)

Appetite

Good

Poor

Weight Loss

No weight loss

> 6 kg

< 6 kg

Any feeding difficulty

Yes

No

Therapeutic if any specify

If alternation in BMI or with feeding difficulty inform the dietary department

ORIENTATION TO PATIENT ENVIRONMENT (Thik in the box)

Ward Orientation

Call for assistance

Dietary Services

Receipts

Side rails

Visitors

Waste Management

Hospital Orientation

Care of Valuables

(Ward Orientation: Kitchen, Toilet, Television (If applicable), Hand wash area, Nurses station, Linen Hospital Orientation: Chapel, Canteens, ATM machines, Post office)

Signature With EMP. No. Date and Time

by Nursing Incharge

Counter Signed by Sr. Nurse/Nursing Supervisor

assessment to the recorded with date, time, emp. no and signature in the Nurses Record



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I.P. DOCTOR'S ORDERS

Patient Name Buji Reddy Age 78y Sex M Ward pul I.P. No 2045

History, Examination, Investigation, Treatment and Progress

Date
12/10/17
8:45:30 PM

Adv
CBP
LFT
RFT
SE
US
ECG
CXR-PA
RBS
2DECHO
Sputum
AFB
Sputum
als cl,
LoH
HRCTch

ASIS:- COPD ± AE ± APD ? Alcoholic liver disease

pt is clc
elo SOB (+)
elo cough (+)
elo giddiness (+)

Vitals

BP - 130/80 mm Hg

PR - 85 bpm

RR - 23 CPM

Temp - 97.5 F

SPO₂ - ~~94~~ RA

S/E 94 % ↓ RA

CNS: S₁S₂ (+) N

RS:- Blk NBS (+)

Blk wheeze (+)

Blk basal crept (+) N

- Ro
- P, (1) Inj. Augmentin 1.2 gm I-V 1-1-1
(2) Inj. PAN 40mg I-V 1-0-0
(3) cap. ABphylline 100mg 1-0-1
(4) Neb $\left\{ \begin{array}{l} \text{Duolin + 2cc NS 1-1-1} \\ \text{Budecort + 2cc NS 1-0-1} \end{array} \right.$
(5) cap. Beasules 0-1-0
(6) Syp. Remos 4 10ml v-v-v
(7) IUF 10ml 2 mVI @ 7ml/kg
v-0-0

[Signature]



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I.P. DOCTOR'S ORDERS

Patient Name Buji Reddy Age 78y Sex F Ward Pal I.P. No 214

Date _____ History, Examination, Investigation, Treatment and Progress

13/9/24

T. 100

Asis: COPD ± AE ± APD ? Alcoholic liver dx

pt is c/o
c/o SOB ⊕
c/o cough ⊕

Vitals

Temp - Afebrile

BP - 150/90 mmHg

PR - 102 bpm

RR - 18 cpm

SpO₂ - 92% ↓ RA

S/E

Cvs - S₁ S₂ ⊕

RA - B/L AE ⊕

occ. wheeze ⊕

R

(1) Inj. Augmentin 1.2gm IV 1-1-1

(2) Inj. PAN 40mg I-4 1-0-1

(3) cap. Aphylline 100mg 1-0-1

(4) Neb $\left\{ \begin{array}{l} Duolin ~~1-1-1~~ \\ Budecort 1-0-1 \end{array} \right.$

(5) sup. Reswar 4 smk ✓-✓-✓

(6) cap. Becosulex 0-1-0

(7) IVF 10ml c/mus @ 12ml/hr

✓-0-0

Adv

6. mg referral

ultra demage

LFT ✓

Sputum AFB ✓

Gl. cl. KOH

USG Abdo ✓

Relaxing

HRET chest ✓

PS

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CHINTHAREDDYPALEM, NELLORE - 524 003. A.P., INDIA. PH 0861-2317963, 2317964

I.P. DOCTOR'S ORDERS

Patient Name Biji Reddy Age 78 Sex F Ward pul I.P. No. 2045

Date	History, Examination, Investigation, Treatment and Progress
<u>12/7/24</u>	<p style="text-align: center;"><u>2D Echo</u></p> <ul style="list-style-type: none"> → view core seen in subcostal view → poor echo windows → normal LV function → mild MR/TR/PAT → NO LALLV clot → NO PE <p style="text-align: right;">EF! - 58%</p> <div style="border: 1px solid black; padding: 5px; display: inline-block; margin-top: 10px;"> TRPG1 - 23mmHg RVSP - 33mmHg </div>



Keethu

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I.P. DOCTOR'S ORDERS

Patient Name Bujji Reddy Age 78y Sex M Ward pub I.P. No. 2045

History, Examination, Investigation, Treatment and Progress

Date

13/9/24

Referral Notes

To
The Consultant
Department of psychiatry
NMCH,
Nellore.

Respected Madam/sir

This is a case of COPD +
-AC + APD? alcoholic liver disease. This
case is referred to you for ~~change~~
~~cessation~~ of alcohol and smoking. Kindly
examine the patient and do the needful.

Thanking you

Yours sincerely
Dr. Jyothi.



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I.P. DOCTOR'S ORDERS

Patient Name Bujji Reddy Age 75y Sex M Hospital ID No. 20215

Date	History, Examination, Investigation, Treatment and Progress
13/9/24	<p style="text-align: center;"><u>Referral Note</u></p> <p>To The Consultant Department of Internal General Medicine NHCH, Nellore.</p> <p style="text-align: center;">Respected Madam/Sir</p> <p>AE is APD & alcoholic liver disease. This case is referred to you I/O arranged for kindly examine the patient and do needful.</p> <p style="text-align: center;">Thanking you</p> <p style="text-align: right;">Yours sincerely Dr. Jyothi.</p>



Jyothi
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I.P. DOCTOR'S ORDERS

Patient Name: Buggi Reddy Age: 55y Sex: M Ward: 101 IP No: 2045

History, Examination, Investigation, Treatment and Progress

Date: 18/09/24
3:00pm

C/S/A Psychiatry Dept

Thanks for Referral

Dr. M. Arshad

This is a case of Fog/M (↓ Dr. T. Renu Manika),
 COPD ⊕ AEC ⊕ APD ? Alcohol Liver disease.

Informant - Reported alone.

Excessive consumption of Alcohol :-
 1 year & takes 1-2 quarts on every Sunday.

- Last drink 2 months ago
- Sleep disturbances ⊕ :- ⊕ months
- Appetite - Adequate.
- Leg pains ⊕
- Generalised weakness ⊕

[Signature]

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I.P. | DOCTOR'S ORDERS

Patient Name Buji Reddy Age 38 Sex M Ward / Sub IP No 20115

Date	History, Examination, Investigation, Treatment and Progress
	<ul style="list-style-type: none"> - NO H/O seizures ⊕ - K/O Anxieties & Anxieties 2-3 cigarettes/day & Anxieties 10 beads/day - Headache & fullness of head ⊕ - Giddiness ⊕ - N/K/O DM, HTN, Asthma, Epilepsy, CVA, CAD & Thyroid abnormalities. - Suicidal ideations ⊕ <p>Substance H/O: pt is known case of alcohol, ∴ 38 years. Initially started c 1 peg & later on due to peer pressure increased to 1-2 pegs daily. From the past year, pt had taking alcohol 1-2 quarters of brandy on every Sunday.</p>



[Handwritten Signature]

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NELLORE-524 002

I.P. DOCTOR'S ORDERS

Patient Name

Bugji Reddy *tsy* Sex *M* Ward *pub* I.P. No. *2015*

History, Examination, Investigation, Treatment and Progress

Date

Last drink @ 2 months ago.

w/o suicidal death @ 2 years ago

MSE: pt is conscious, coherent

Oriented to time, place, person

PMA - CONL

Speech - RT - (N)

T, T, V (N)

w/o wife expired 4 years ago

Thought - @ pre-occupation

Mood - worried

Affect - congruent to mood

Perception - NAD

Rx

1. T. BACLOFEN 10mg
1 - 0 - 1

2. T. NEXITO PLUS
0 - 0 - 1

3. T. MELTOFAST 5mg
0 - 0 - 1

4. NICLONZ PASTILL
ES

5. Review after 2 weeks to psy OPD
WATER ↓ Dr. T. Renu Monica

4. NICLONZ PASTILL
ES
fmg

SGOT - 131
SbPT - 88



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Chinthareddypalem,
NELLORE-524 002



NARAYANA MEDICAL COLLEGE HOSPITAL

CHINTHAREDDYPALEM, NELLORE - 524 003 A.P. INDIA. PH. 0861-2317963, 2317964

I.P. DOCTOR'S ORDERS

Patient Name Bujji Noddy Age 75y Sex M Ward 1 I.P. No 2015

Date _____ History, Examination, Investigation, Treatment and Progress

13/9/24

CLSI by Gm-V ↓ or m.p values

Thanks for referral.

History Noted

Reports Reviewed.

Advised :-

1. Tab. UDILIV 300mg BD 1-0-1
x 7 days
2. Tab. N-Acetylcysteine 0-1-0
OD x 7 days
3. LFT (3 days after)

[Signature]

6



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NARAYANA
Medical College & Hospital

I.P. DOCTOR'S ORDERS

Patient Name Bujji Reddy Age 78y Sex M Ward pul I.P. No 2045

History, Examination, Investigation, Treatment and Progress

Date _____

13/1/24
6:00pm

cls/by Pulmonologist (↓ Dr Jyothi manj)

Δs - COPD ⊖ AE ⊖ APD? Alcoholic liver

vitals

BP - 130/80 mmHg.
PR - 100 bpm
RR - 18cpm
Temp - Afebrile.
SpO₂ - 98% URA

Rx

1) CST.

S/E

CVS - S₁ S₂ ⊕
RS - B/L AE ⊕
oo wheeze ⊕



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CHINTHAREDDYPALEM, NELLORE - 524 003 A.P. INDIA. PH. 0861-2317963, 2317964

I.P. DOCTOR'S ORDERS

Patient Name Bajji Reddy Age 75y Sex M Ward pub.I.P.No 20125

Date _____ History, Examination, Investigation, Treatment and Progress

14/1/24
8:30

calby pulmonologist (Dr. B. Jyothimam, Dr. Bhavana)

Asis:- COPD AE E ADD ? Alcoholic liver disease

pt is etc.
clo SOB in
clo cough ⊕ : clo ~~etc~~ colored sputum

Rx

Vitals
Temp - Afebrile
BP - 120/70 mmHg.
RR - 18 cpn
HR - 100 bpm.
SpO₂ - 97% JEA

Adv
LFT (after 2 days)
CUE

SLE
Cus - S₁, S₂ ⊕

R₃ - B/L AE ⊕
B/L wheeze ⊕

⊕ Gls, ct Kott.

R₃ (1) Inj. Augmentin 12gm I-V 1-1-1
(2) Inj. PAN 40mg I-V 1-0-0
(3) Cap. ABphylline 100mg 1-0-1
(4) Neb $\left\{ \begin{array}{l} \text{Puolin 1-1-1} \\ \text{Budecort 1-0-1} \end{array} \right.$
(5) Syr. Reswasu 5ml v-v-v
(6) Cap. Becosules 0-1-0
(7) IIVF 10ml Emul @ 75ml/h v-0-0
(8) T. Baclofen 10mg 1-0-1
(9) T. Nexitoplu 0-0-1
(10) T. meltofast 5mg 0-0-1
(11) T. Niclon 2 pastilles 1-1-1



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I.P. DOCTOR'S ORDERS

Patient Name Bhaji Reddy Age 45 Sex M Ward PH IP No 2000

History, Examination, Investigation, Treatment and Progress

Date	History, Examination, Investigation, Treatment and Progress
	<p>o. med { (12) T. udiliv 300mg 1-0-1 (13) T. N-acetyl cysteine 0-1-0</p>

[Handwritten Signature]



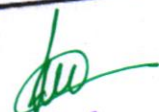
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I.P. DOCTOR'S ORDERS

Patient Name Sujji Reddy Age 78y Sex M Ward Med I.P. No. 2025

Date	History, Examination, Investigation, Treatment and Progress
<p><u>14/9/24</u> <u>6:00pm</u></p> <p><u>Adm</u></p>	<p><u>C/S/By Pulmonologist</u> [Dr. T. G. H. K. M. Dr. Bharan]</p> <p><u>Dis:</u> COPD ± AE ± APD? Alcoholic liver disease</p> <p><u>VITALS</u></p> <p>BP - 130/80 mmHg</p> <p>PR - 904 bpm</p> <p>RR - 18cpm</p> <p>Temp - Afebrile</p> <p>SpO₂ - 97% ↓ RA</p> <p><u>S/E:</u></p> <p>CVS - S₁, S₂ ⊕</p> <p>RS - B/L AE ⊕ occ. wheeze ⊕</p> <p><u>Rx</u></p> <p><u>CST</u></p>




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I.P. DOCTOR'S ORDERS

Patient Name Puffi Reddy Age 75y Sex M Ward Prd I.P. No 2045

History, Examination, Investigation, Treatment and Progress

Date	History, Examination, Investigation, Treatment and Progress
15/9/24	<p>els/By <u>pulmonologist</u></p> <p>↓ Dr. Tyothli Dr. Bhavana</p> <p>8:30 AM</p> <p><u>Prob!</u> - COPD & AE & APD. & ? Alcoholic liver disease</p> <p>pt is ole alo SOB ↓ elo cough ↓</p> <p><u>Rx</u></p> <p>Q₄ 1) Inf. Augmentin 1.2g IV q-1-1 2) Inf. pan 40mg I.V 1-0-0 3) cap. Adphylline 100mg 1-0-1 4) Neb - [salin. 1-1-1-1 Budecort 1-0-1 5) syp. Remesol 15 ml v-v-v 6) Cap. Becosuber 0-1-0 7) IVF 10NS & MV3 @ 75ml/hr v-0-0 8) T. Baclofen 10mg 1-0-1 9) T. Nexitoplur 0-0-1 10) T. Melthofast 5mg 0-0-1 11) T. Niclonz paritiled 4g 1-1-1</p>
	<p><u>Vitals</u></p> <p>Bp 120/80 mmHg PR - 55 bpm RR - 22 cpm temp - Afebrile SpO₂ - 91% J.R.A.</p> <p><u>ST</u></p> <p>CUS - 4s, (+)nt Rt - Blc NBS (+) Blc wheeze</p>
	<p><u>Adv</u></p> <p>⊕ sputum als, als, kou</p>



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I.P. DOCTOR'S ORDERS

Patient Name Sanjay Reddy Age 38y Sex M Ward Int I.P. No 2045

Date

History, Examination, Investigation, Treatment and Progress

Gen med Rx [(1) T. Udiliv 200mg 1-0-1
(2) T. N-acetyl eyelets 0-1-0]



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I.P. DOCTOR'S ORDERS

Patient Name Bujji Reddy Age 75y Sex M Ward pub I.P. No 20

History, Examination, Investigation, Treatment and Progress

Date
15/9/24
6:00pm

C/S/ By Pulmonologist

↓ Dr. Jyothi K
 Dr. Bhavani

Dis: COPD & AEE & APD & ? Alcoholic liver disease

VITALS:

BP - 120/70 mmHg

PR - 84 bpm

RR - 20 cpm

Temp - Afebrile

Spo2 - 94% JRA

S/E

CVS - S1S2 (+) nt

RS - B/L NBS (+)

B/L wheeze

Rx

CST



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I.P. DOCTOR'S ORDERS

Patient Name Bujji Reddy Age 78y Sex M Ward pub I.P. No. 2015

Date	History, Examination, Investigation, Treatment and Progress
16/9/24 5:40 AM	<p><u>Asis</u> :: COPD \bar{c} AE \bar{c} APD \bar{c} ? Alcoholic liver disease</p> <hr/> <p>pt's clc clc weaken</p>
IFT-23UP ↓ i SGOT SGPT-157+	<p><u>vitals</u></p> <p>Temp - Afebrile</p> <p>BP - 110/70 mmHg</p> <p>PR - 88 bpm</p> <p>RR - 20 bpm</p> <p>SPO₂ - 95% J RA</p>
<u>Adv</u> G. med review	<p><u>Rx</u></p> <p>(1) Inj Augmentin 1.2 gm I-V 1-1-1</p> <p>(2) Inj PAN 40mg I-V 1-0-0</p> <p>(3) cap. ABphylline 100mg 1-0-1</p> <p>(4) Neb $\left\{ \begin{array}{l} \text{Duolin 1-1-1-1} \\ \text{Budecort 1-0-1} \end{array} \right.$</p> <p>(5) syp. Resuxal U 5ml v-v-v</p> <p>(6) cap. Becosules 0-1-0</p> <p>(7) IVF 10NE \bar{c} mVI @ 75ml/hr (sos)</p> <p>(8) T. Baclofen 10mg 1-0-1</p> <p>(9) T. Nexitoplu 0-0-1</p> <p>(10) T. meltofast 5mg 0-0-1</p> <p>(11) T. Niclor\bar{c} pastilles 1mg 1-1-1</p> <p>(12) T. cediliv 300mg 1-0-1</p> <p>(13) T. N-acetyl cysteine 0-1-0</p>
	<p><u>S/E</u></p> <p>CVS - S₁S₂ ⊕</p> <p>RJ - B/C N/A ⊕</p> <p>B/c wheeze</p> <p>⊕ISA (same lpts) ⊕</p> <p>psych Rx</p> <p>G. med Rx</p>



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Medical College & Hospital

Nursing Drug Administration Chart

Patient Name: Rajikoddy Age: 78 Sex: M Ward: 100 Unit: IT IP No: 2045

Weight	Height	Registration No			
Allergies :					
Drug :	<u>INT-AUGMENTIN</u>	Route :	<u>IV</u>	Date :	<u>12/11/24</u>
Dose :	<u>1.2 (6M)</u>	Frequency :	<u>TID</u>	T :	<u>12/11/24</u>
Start Date :	<u>12/11/24</u>	Doctor :	<u>JYOTHI</u>	I :	<u>12/11/24</u>
Other Instructions : <u>MAN</u>					
M					
E					
Drug :	<u>INT-PAN</u>	Route :	<u>IV</u>	Date :	<u>12/11/24</u>
Dose :	<u>40M5</u>	Frequency :	<u>OD</u>	T :	<u>12/11/24</u>
Start Date :	<u>12/11/24</u>	Doctor :	<u>JYOTHI</u>	I :	<u>12/11/24</u>
Other Instructions : <u>MAN</u>					
M					
E					
Drug :	<u>CAP-AB-PHYLLINE</u>	Route :	<u>ORAL</u>	Date :	<u>12/11/24</u>
Dose :	<u>100 MG</u>	Frequency :	<u>BD</u>	T :	<u>12/11/24</u>
Start Date :	<u>12/11/24</u>	Doctor :	<u>JYOTHI</u>	I :	<u>12/11/24</u>
Other Instructions : <u>MAN</u>					
M					
E					
Drug :	<u>NEB-BUCCIN</u>	Route :		Date :	<u>12/11/24</u>
Dose :		Frequency :	<u>TID</u>	T :	<u>12/11/24</u>
Start Date :	<u>12/11/24</u>	Doctor :	<u>JYOTHI</u>	I :	<u>12/11/24</u>
Other Instructions : <u>MAN</u>					
M					
E					
Drug :	<u>NEB-BUDECORT</u>	Route :		Date :	<u>12/11/24</u>
Dose :		Frequency :	<u>BD</u>	T :	<u>12/11/24</u>
Start Date :	<u>12/11/24</u>	Doctor :	<u>JYOTHI</u>	I :	<u>12/11/24</u>
Other Instructions : <u>MAN</u>					
M					
E					
Drug :	<u>SYP-RESWALS</u>	Route :	<u>ORAL</u>	Date :	<u>12/11/24</u>
Dose :	<u>5M5</u>	Frequency :	<u>TID</u>	T :	<u>12/11/24</u>
Start Date :	<u>12/11/24</u>	Doctor :	<u>JYOTHI</u>	I :	<u>12/11/24</u>
Other Instructions : <u>MAN</u>					
M					
E					

Once Only Drugs

Drug	Date / Time	Dose	Route	Doctor	Nurse



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Nursing Drug Administration Chart



Patient Name

Rajji dandy

Age

Sex

Ward

pub

Unit

1

Registration No.

Weight	Height	Registration No.
Weight		
Allergies		
Drug	ROXOL	Date: 12/10/24
Dose	100mg	Frequency: OD
Start Date	12/10/24	Doctor: JYOTHY MAM
Other Instructions:		T I M E
Drug	Baclofen	Date: 14/9/24
Dose	10mg	Frequency: BD
Start Date	14/9/24	Doctor: JYOTHY MAM
Other Instructions:		T I M E
Drug	Nitroglycerin	Date: 14/9/24
Dose		Frequency: OD
Start Date	14/9/24	Doctor: JYOTHY MAM
Other Instructions:		T I M E
Drug	Meloxicam	Date: 14/9/24
Dose	7.5mg	Frequency: OD
Start Date	14/9/24	Doctor: JYOTHY MAM
Other Instructions:		T I M E
Drug	Nitroglycerin	Date: 14/9/24
Dose	PARO 11	Frequency: QID
Start Date	14/9/24	Doctor: JYOTHY MAM
Other Instructions:		T I M E
Drug		Date:
Dose		Frequency:
Start Date		Doctor:
Other Instructions:		T I M E

Once Only Drugs

Drug	Date / Time	Dose	Route	Doctor



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NURSES CHART

Patient Name Buyji Reddy Age 78 Sex M Hair Grey No 2045

Date	Time	Medication and Diet	Nurses	Signature
<u>Admission Note</u>				
12/12/24	11:30am	Patient admitted to the pulmonology ward		
		B/E done		
		ECG done		
		Chest X-ray done		
		2 D Echo send		
	1pm	Case hand over given to the evening duty staff		<p style="text-align: right;"><u>VP/10/24</u> RS</p>



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NURSES CHART

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Patient Name Baji Reddy Age 78 Sex M Ward Pulao IP 1

Date	Time	Medication and Diet	Notes
12/9/2024		Evening Duty Staff Report	
	1pm	Case hand over taken from morning duty staff	
	2pm	Administration of medication as per doctor's order	
	3pm	Vitals checked and recorded	
		Patient have no chest complaint Doctor's rounds followed Health education given Patient stable and oriented	

Patient Name
 Date



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12/9
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PITAL
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NURSES CHART

to 78

Signature

Patient Name Buji Reddy Age 78y Sex M Ward pul IP No 7175

Date	Time	Medication and Diet	Notes	Signature
<u>12/9/24</u>		Night duty <u>Staff Report</u>		
	<u>7pm</u>	Case hand over from Evening duty staff		
<u>13/9/24</u>	<u>8pm</u>	Administered medications to patient as per doctor's orders.		
	<u>9pm</u>	Doctors round followed.		
	<u>10pm</u>	Monitored vitals and documented.		
	<u>11pm</u>	Patient have no any fresh complaints.		
	<u>12Am</u>	Patient is sleeping.		
	<u>5Am</u>	Bed making done.		
	<u>6Am</u>	Monitored vitals and documented.		
	<u>7Am</u>	Case hand over given to morning duty staff.		<u>Smy</u> <u>5372</u>



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NURSES CHART

Patient Name: Pruffy medically history see in ward admission

Date	Time	Medication and Diet	Nurses
13/9/20		Morning duty staff report	
	2 AM	Case hand over taken from night duty staff	
	6 AM	Treatment given as per doctor's order	
	9 AM	patient had no further complaints	
	10 AM	Doctors duty finished	
	11 AM	provide health education	
	12 PM	patient is taking rest	
1 PM	Case hand over given to the evening duty staff		



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NURSES CHART

Patient Name Beggs Reddy Age 72 Sex m Ward pu I.P. No 9619

Date	Time	Medication and Diet	Notes	Signature
<u>13/9/24</u>		<u>Evening Duty staff reports</u>		
	1pm	⇒ Case hand over taken from morning duty staff		
	2pm	⇒ Administered medication to the patient as per doctors orders		
	3pm	⇒ Duty takes rounds followed		
	4pm	⇒ patient is oriented		
	5pm	⇒ patient is stable and conscious		
	6pm	⇒ provided comfortable position to the patient ⇒ Case hand over given to night duty staff		<u>Altha Das</u>



[Signature]

NURSES CHART

Patient Name Beggs Reddy Age 72 Sex m Ward paud I.P. No 9619

Date	Time	Medication and Diet	Notes	Signature
<u>13/9/24</u>		<u>Evening Duty staff reports</u>		
	1pm	⇒ Case hand over taken from morning duty staff		
	2pm	⇒ Administered medication to the patient as per doctors orders		
	3pm	⇒ Duty staff rounds followed		
	4pm	⇒ patient is oriented		
	5pm	⇒ patient is stable and conscious		
	6pm	⇒ provided comfortable position to the patient		
7pm	⇒ Case hand over given to night duty staff			<u>[Signature]</u>



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NURSES CHART

Patient Name Pragathi Reddy Age 75y Sex M Ward Pub I.P. No. 201

Date	Time	Medication and Diet	Notes
<u>12/9/24</u>		Night duty staff report -	
		9pm - Case hand over to morning evening duty staff	
		8pm - Administered medications to patient as per doctor's orders.	
		7pm - Doctor's rounds followed.	
		10pm - Monitored vitals and documented.	
		11pm - Patient have no any gross complaints.	
		12Am - Patient is sleeping.	
		5Am - Bed making done.	
		6Am - Monitored vitals and documented.	
		7Am - Case hand over to evening morning duty staff.	



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NURSES CHART

Patient Name Bujj Reddy Age 78 Sex m Ward pu IP No.

Date	Time	Medication and Diet	Notes	Signature	
14/9/24		morning duty staff			
	7am	Case handover taken from night duty staff			
	8am	Deep Administered medication given as per doctor note			Jpau 10/8
	9am	Assist the patient condition			
	10am	patient stable			
	12am	patient is seated			
	12pm	patient had no complaint			
	7pm	Case handover given to Evening staff			



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NURSES CHART

Patient Name: Ravi Reddy Age: 45y Sex: M Ward: 10 IP: 12

Date	Time	Medication and Diet	Notes
		Evening Duty	START REPORT
<u>18/10/20</u>	2:00PM	Case hand over taken from morning duty staff	
	2:00PM	Assessed the patient general condition	
	3:00PM	Administration and medication given to patient as per doctor's order.	
	4PM	Monitoring vitals and recorded	signs detected
	5PM	provided the psychological support	
	6PM	provided the health education	
	7PM	Case handover to night duty staff	



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NURSES CHART

Patient Name Bujji Reddy Age 75y Sex M Ward pul IP No 7125

Date	Time	Medication and Diet	Notes	Signature
15/9/24			<p>Night duty staff</p> <p>7pm -> case handed over taken from the evening duty staff.</p> <p>8pm -> Administration, medication as per doctor order's</p> <p>8 -> Assessed the patient.</p> <p>General condition</p> <p>9pm -> doctor's orders followed</p> <p>10pm -> monitor, vitals checked & recorded</p> <p>11pm -> health education given</p> <p>12am -> patient is sleeping</p> <p>1am -> Bed making done</p> <p>6am -> monitor vitals checked & recorded</p> <p>7am -> case handed over given to morning duty staff</p>	



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NURSES CHART

Patient Name B. Vijay Reddy Age 78y Sex Ward pubu 1 P No.

Date	Time	Medication and Diet	Notes
		<u>Morning</u>	<u>duty staff report</u>
	<u>7Am</u> →		<u>Case hand over is taken from night duty staff</u>
	<u>8Am</u> →		<u>Treatment is given as per doctors orders.</u>
	<u>9Am</u> →		<u>patient - had only no fresh complaints</u>
	<u>10Am</u> →		<u>Doctors rounds followed.</u>
	<u>11Am</u> →		<u>provide health education patient is taking rest</u>
	<u>12pm</u> →		
	<u>1pm</u> →		<u>Case hand over is given to the evening duty staff</u>



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NURSES CHART

Patient Name Buyi Reddy

Age 78y

Sex M

Ward put

I.P. No 7175

Date	Time	Medication and Diet	Notes	Signature
		EVENING DUTY		
		STAFF REPORT		
<u>15/9/24</u>	1:00 PM	⇒ Case hand over taken from morning duty staff.		<u>Sadhu</u> 5207
	2:00 PM	⇒ Assessed the patient general condition.		
	3:00 PM	⇒ Administration and medication given to patient as per doctors order.		
	4:00 PM	⇒ monitoring vitals signs checked and recorded.		
		⇒ provided the health education		
		⇒ provided the psychology care support.		
	5:00 PM	⇒ Duty doctors rounds followed		
	6:00 PM	⇒ patient is normal		
	7:00 PM	⇒ case hand over given to night duty staff.		



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NURSES CHART

Patient Name Buggi Steddy Age 78y Sex M Ward pul I.P. No 204

Date	Time	Medication and Diet	Notes	Signature
<u>15/9/24</u>		<u>Night duty staff report</u>		
	<u>7pm</u>	→	Case hand over taken from Evening duty staff.	
	<u>8pm</u>	→	Administered medications to patient as per doctor's orders.	
	<u>9pm</u>	→	Doctor's rounds followed.	
	<u>10pm</u>	→	Monitored vitals and documented.	
	<u>11pm</u>	→	patient have no any fresh complaints.	
	<u>16/9/24</u>	<u>12Am</u>	→	patient is sleeping.
<u>5Am</u>		→	Bed making done.	
<u>6Am</u>		→	Monitored vitals and documented.	
<u>7Am</u>		→	Case hand over given to morning duty staff.	



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NURSES CHART

Patient Name: Bejjreddy Age: 78y Sex: M Ward: 9th IP No: 2045

Date	Time	Medication and Diet	Notes	Signature
		morning duty staff Report		
<u>16/9/24</u>	7:00 AM	⇒ Case hand over taken from night duty staff.		<u>[Signature]</u> 5203
	8:00 AM	⇒ Assessed the patient general condition.		
	9:00 AM	⇒ Administration and medication given to patient as per doctors order.		
	10:00 AM	⇒ monitoring vitals signs checked and recorded. ⇒ Duty doctors rounds followed ⇒ provided the psychological support. ⇒ provided the health education.		



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PH 0861 230511 EXT 2228

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CLINICAL CHART

Pt Name		Bujji Reddy										Age	Sex	Religion	Marital	Ward No	Room No		
DATE		12/9/24		13/9/24		14/9/24		15/9/24		16/9/24		50	M	Hindu	Married	10	205		
Day PO (or) PP		1		2		3		4		5									
TEMPERATURE		AM		PM		AM		PM		AM		PM		AM		PM			
C	F	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10
41.1°	106°																		
40.5°	105°																		
40°	104°																		
39.4°	103°																		
38.8°	102°																		
38.3°	101°																		
37.7°	100°																		
37.2°	99°																		
36.6°	98°																		
36.1°	97°																		
35.5°	96°																		
Sign of Sister		B.R. Reddy		S. Reddy		S. Reddy		S. Reddy		S. Reddy		S. Reddy		S. Reddy		S. Reddy		S. Reddy	
PULSE RATE		92/86		89/86		88/86		88/86		88/86		88/86		88/86		88/86		88/86	
RESPIRATION		22/23		22/23		22/24		22/24		22/24		22/24		22/24		22/24		22/24	
BLOOD PRESSURE		130/90 120/80		110/90		130/90 120/80		130/90 120/80		130/90 120/80		130/90 120/80		130/90 120/80		130/90 120/80		130/90 120/80	
URINE		-		-		-		-		-		-		-		-		-	
BOWELS		-		-		-		-		-		-		-		-		-	
WEIGHT/HEIGHT																			
DIET		② Diet		② Diet		② Diet		② Diet		② Diet		② Diet		② Diet		② Diet		② Diet	
BLOOD TRANSFUSION																			

PT IS sleeping

PT IS sleeping

PT IS sleeping

Bujji Reddy



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NELLORE-524 002

NARAYANA MEDICAL COLLEGE & HOSPITAL

Chinthareddypalem, Nellore - 524 003 A. P. INDIA.
Ph: 0861 - 2355511



NARAYANA
Medical College & Hospital

BILLING ABSTRACT

DETAILS	Amount	ADVANCE PAYMENT		
		Date	Receipt No	Amount
1. Room / Bed Charges				
2. Consultant Fees				
1.				
2.				
3.				
3. Intensivist Charges				
4. Surgeons Fees				
5. Asst Surgeon Fees				
6. Anaesthetist Fees				
7. Delivery Charges				
8. O.T. Charges				
9. I.C.U. Charges				
10. Intensivist Fee				
11. Intensive Nursing Charges				
12. Nursing Charges				
13. Duty Doctor Charges				
14. Laboratory Charges				
15. Radiology Charges				
16. OT/ICU/NICU Consumable Charges				
17. Special Test Charges				
PFT, TMT, 2D Echo				
18. Medical Equipment Charges				
A.				
B.				
C.				
19. Special Procedure Charges				
A.				
B.				
C.				
20. Oxygen Charges				
21. Telephone Charges				
22. Miscellaneous-1				
23. Miscellaneous-2				
Grand Total				
			Grand Total	
			(-) Advance	
			Total Balance	



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Patient's Name _____ Age / Sex _____ IP NO _____

GENERAL CONSENT

I, _____ (Patient's Name), Aged _____
S/o W/o D/o _____ hereby declare that I am
willingly getting admitted in Narayana Medical College & Hospitals for my treatment as advised by my consultant
Dr _____ under the following conditions

- 1) I will make all others related to me / patient, agree & abide by the rules and regulations of the hospital including visiting hours, which are conveyed to us by the hospital staff.
- 2) I will take full responsibility to clear all dues to the hospital and promise to deposit sufficient advance amounts to meet emergency treatment, also as and when payment slips are issued according to the experience.

The above points have been explained to me in the language (_____), which I understand by
Mr / Mrs / Dr _____ of Narayana Hospital. This consent is given by me in
my full senses and on my own free will.

Admission Executive / CMO

Signature : _____

Place : _____

Date : _____

Patient / Patient Representative

Signature : _____

Place : _____

Date : _____

Contact No. _____



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CONSENT FOR SELECTION OF ROOM

PATIENTS NAME _____

AGE / SEX _____

IP NO _____

SELECTION OF ROOM

I/We have been explained in detail the difference in the following Room Tariff for various types of Rooms available and I/We have selected the room as per my/our choice.

1. Cubicle (General Ward)
2. Semi Private (Non A/C Sharing)
3. Semi Private Deluxe (A/C Sharing)
4. Private (Non A/C Single)
5. Deluxe Private (A/C Single)
6. Suite

Name of Patient / Relative _____

Date: _____

Signature _____

Time: _____

CHANGE OF ROOM

I/We have been explained in detail the difference in Room Rent, Surgery Package and difference in Investigation Charges for the types of Room. I/We have selected the room which is available in the Hospital.

1. Cubicle (General Ward)
2. Semi Private (Non A/C Sharing)
3. Semi Private Deluxe (A/C Sharing)
4. Private (Non A/C Single)
5. Deluxe Private (A/C Single)
6. Suite

Name of Patient / Relative _____

Date: _____

Signature _____

Time: _____

CREDIT

I/We/Am are eligible for _____

Room. But
Room. I/We

I/We opted for _____

agree to pay the difference of the amount over & above the Company / Corporate eligibility.

Date: _____

Name of Patient / Relative _____

Time: _____

Signature _____

DUAL OCCUPANCY

I/We here by agree to take the private / deluxe room at additional cost for attenders usage, as our patient is staying in AMCU / SICU / ICCU / CTICU. In case of an emergency when the hospital needs the bed for a patient's hospitalization, I/We will willingly oblige to vacate the room.

Date: _____

Name of Patient / Relative _____

Time: _____

Signature _____



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Chinthareddypalem,
NELLORE-524 002

E
NAM

Dr. Po with sir

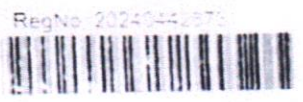
ALLERGIC To



Narayana Medical College Hospital
Chintareddypalem, Nellore-524003, Ph.0861-2355511

PATIENT DETAILS (ORTHOPAEDICS)

Date : 05-SEP-2024 Time : 10:49:58 AM
RegNo : 20240442873 -IP No: 240905044 Ward: ORT-G28-Third floor- General
Name : ~~Expire~~ Age : ~~22~~
Company: NARAYANA AROGYAMASTHU Bed No : H327A-0017



Patient Name : _____ Age _____ Sex _____

PLEASE RETURN THIS TO
Medical Record Department



NARAYANA
Medical College & Hospital

NARAYANA HOSPITAL

Narayana Medical College, Chintareddypalem, NELLORE - 2

NOT TO BE HANDLED BY THE PATIENT




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NELLORE-524 002



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Ph : 0861-2355511, Extn : 2228

Central Clinical Laboratory Report

ReportUser: 41000315

PATIENT NAME	: VEPATI SYAMALAMMA	AGE	: 78 YY	SEX	: Female
REG NO	: 20240442873	DATE	: 05/09/2024	COMMON NO.	: 373 A
WARD NAME	: H327A-0017-ORTHO-FEMALE	REPORT	: 05-SEP-2024 03:35 PM		
SAMPLEDT	: 05-SEP-2024 12:57 PM				

CLINICAL Microbiology REPORT

INVESTIGATION	RESULT	UNITS	BIOLOGICAL REF.INTERVAL
H.I.V	NON-REACTIVE	NA	REACTIVE / NON-REACTIVE
HBs Ag	NON-REACTIVE	NA	REACTIVE / NON-REACTIVE
HCV	NON-REACTIVE	NA	REACTIVE / NON-REACTIVE

* PLEASE NOTE : THIS IS ONLY A SCREENING TEST. THIS IS NOT A CONFIRMATORY TEST. BOTH FALSE POSITIVES AND FALSE NEGATIVES ARE POSSIBLE. TEST HAS TO BE CONFIRMED BY 'RT-PCR' TECHNIQUE.

MICROBIOLOGIST

VERIFIED BY TECHNICIAN

- End of Report -

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Ph : 0861-9355511, Extn : 2228

Central Clinical Laboratory Report

ReportUser: auto

PATIENT NAME : VEPATI SYAMALAMMA
REG NO : 20240442873
WARD NAME : H327A-0017-ORTHO-FEMALE
SAMPLEDT : 05-SEP-2024 12:57 PM

AGE : 78 YY SEX : Female
DATE : 05/09/2024
COMMON NO. : 373 A
REPDT : 05-SEP-2024 01:43 PM

CLINICAL Pathology REPORT

INVESTIGATION	RESULT	UNITS	BIOLOGICAL REF.INTERVAL
HAEMOGLOBIN [Method: Spectrophotometric method]	11.6	gm/dl	F12-15 M13.6-17.2 gm/dl
TOTAL COUNT WBC [Method: Electrical Impedance]	6,700	Cells/cumm	4000-11000 Cells/cumm
NEUTROPHILS [Method: Volume Conductivity Scatter]	63	%	40-75 %
LYMPHOCYTES [Method: Volume Conductivity Scatter]	28	%	20-40 %
EOSINOPHILS [Method: Volume Conductivity Scatter]	3	%	1-6 %
MONOCYTES [Method: Volume Conductivity Scatter]	6	%	2-8 %
BASOPHILS [Method: Volume Conductivity Scatter]	0	%	0-1 %
PLATELET COUNT [Method: Electrical Impedance]	2,09,000	Per cumm	150000-400000 Per cumm
RBC COUNT	4.31	mill/cumm	F3.5-5 M4.3-5.9 mill/cumm
PCV	37	vol%	F38-47 M40-54 vol%
MCV	86	Fl	80-100 Fl
ESR [Method: Westergren method]	45	mm/1hr	(M)0-10 (F)0-20

B. Syam Sundaram

PATHOLOGIST

VERIFIED BY TECHNICIAN

- End of Report -



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Ph : 0861-2355511, Extn : 2228

Central Clinical Laboratory Report

ReportUser:45604420

PATIENT NAME : VEPATI SYAMALAMMA
REG NO : 20240442873
WARD NAME : H327A-0017-ORTHO-FEMALE
SAMPLEDT : 05-SEP-2024 12:56 PM
AGE : 28 YY SEX : Female
DATE : 05/09/2024
COMMON NO. : 373 A
REPT : 05-SEP-2024 03:13 PM

CLINICAL Biochemistry REPORT

INVESTIGATION	RESULT	UNITS	BIOLOGICAL REF.INTERVAL
SERUM TOTAL BILIRUBIN [Method:Jendrassic-GROF/ Diazo Method DPD]	0.45	mg/dl	0.1-1.2 mg/dl Adults Children-1month: 0.2-1.0 mg/dl Neonates;24 hrs upto 8.7 mg/dl 2nd day : 1.3-11.3 mg/dl 3rd day :0.7-12.7 mg/dl 4th-6th day :0.1-12.6 mg/dl
SERUM BILIRUBIN DIRECT [Method:Jendrassic-GROF/ Diazo Method DPD]	0.29	mg/dl	0-0.20
SGOT [Method:IFCC Kinetic]	20	U/L	(M)Male: 37 IU/L (F)Female:31 IU/L
SGPT [Method:IFCC Kinetic]	17	U/L	(M)Male : 42 IU/L (F)Female: 32 IU/L
ALKALINE PHOSPHATASE [Method:IFCC, AMP Buffer]	185	U/L	(M)Male : 80-306 U/L (F)Female : 64-306 U/L Children upto 15 yrs : upto 644 U/L Children upto 17 yrs : upto 483 U/L
TOTAL PROTEIN [Method:Biuret]	7.2	g/dl.	6.40-8.40
SERUM ALBUMIN [Method:Bromo Cresol Green]	4.4	g/dl	3.80-5.10
GLOBULIN	2.8	g/dl.	2.30-3.50
A/G RATIO	1.5		1.39-2.23

Dr. S. Venish

BIOCHEMIST

VERIFIED BY TECHNICIAN

- End of Report -



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NELLORE-524 002



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Ph : 0861-2355511, Extn : 2228

Central Clinical Laboratory Report

Report User: 456/4426

PATIENT NAME	: VEPATI SYAMALAMMA	AGE	: 78 Yr SEX Female
REG NO	: 20240442873	DATE	: 05/09/2024
WARD NAME	: H327A-0017-ORTHO-FEMALE	COMMON NO.	: 373 A
SAMPLEDT	: 05-SEP-2024 12:56 PM	REPDT	: 05-SEP-2024 03:12 PM

CLINICAL Biochemistry REPORT

INVESTIGATION	RESULT	UNITS	BIOLOGICAL REF. INTERVAL
SODIUM [Method:ISE Direct]	145	meq/L	(M)(F) 135-145 mEq/L
POTASSIUM	3.8	meq/L	(M)(F) 3.5-5
CHLORIDE [Method:ISE Direct]	107	meq/L	93-110 mEq/L
RANDOM PLASMA GLUCOSE [Method:GOD-POD PAP]	84.03	mg/dl	80-140 mg/dl mg/dl
SERUM UREA [Method:Urease GLDH]	32	mg/dl	10-50 mg/dl
CREATININE [Method:JAFFE'S/Alkaline Picrate]	0.66	mg/dl	Premature Neonates : 0.29-1.04 mg/dl Full Term Neonates : 0.24-0.85 mg/dl 2-12 Month : 0.17-0.42 mg/dl 1-3 yrs : 0.24-0.41 mg/dl 3-5 yrs : 0.31-0.47 mg/dl 5-7 yrs : 0.32-0.59 mg/dl 7-9 yrs : 0.40-0.60 mg/dl 9-11 yrs : 0.39-0.73 mg/dl 11-13 yrs : 0.53-0.79 mg/dl 13-15 yrs : 0.57-0.87 mg/dl (M)Adult Male : 0.7-1.3 mg/dl (F)Adult Female : 0.5-1.0 mg/dl

Dr. S. Venesh

BIOCHEMIST

VERIFIED BY TECHNICIAN

- End of Report -



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Ph : 0861-2355511, Extn : 2228

Central Clinical Laboratory Report

PATIENT NAME
REG NO
WARD NAME
SAMPLEDT

:VEPATI SYAMALAMMA
:20240442873
:H327A-0017-ORTHO-FEMALE

AGE :78 YY SEX :Female
DATE :05/09/2024
COMMON NO. :373 A
REPDT :05-SEP-2024 04:16 PM

ReportUser:

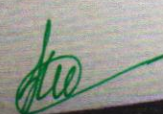
BLOOD BANK REPORT

INVESTIGATION	RESULT
BLOOD GROUP:	" B " POSITIVE

BLOOD BANK

VERIFIED BY TECHNICIAN




Principal
SREE NARAYANA NURSING COLLEGE
Chinthareddypalem,
NELLORE-524 002



NARAYANA GENERAL HOSPITAL

NELLORE

AUTHORIZATION FOR MEDICAL AND / OR SURGICAL TREATMENTS

Place: Nellore

Date: 05-Sep-2024 10:49:58 AM

- I hereby authorize doctors of Narayana Hospital, Nellore to perform the following Operating or Procedure on

Name of the Patient: **Vepati Syamalamma** Reg.No: **20240442873** IPNo: **240905044** Age: **78 Y Y** Sex: **Female**
 Name of the Operation or Procedure _____

- The nature of my condition and the hazards of the Operation or Procedure including biopsy and any unwanted untoward complications that may arise have been explained to me by my Physician(s) Surgeon(s).
- I consent to the administration of Anaesthesia as advisable in my case. I also consent to the administration of any other drug relevant to the procedure.
- I further authorize the said Physician(s) Surgeon(s) to perform such additional operations or procedure including administration of a Blood or Blood Products as they or he may consider reasonably necessary or proper in the event of any emergency or if any unanticipated conditions should be discovered during the course of the operation.
- I hereby authorize the hospital, its agents or devisees to dispose off any removed issue or amputated member of my body as a result of the surgical operation in any manner deemed proper by the hospital.
- All the above points have been explained to me in the language which I understand.

Name of the Patient In Capital

Signature of the Patient

VEPATI SYAMALAMMA

If the Patient cannot sign or is a Minor, spouse, parent or guardian has to sign

Relationship to the patient : _____

Witness : _____

Address : _____

AGAINST ADVICE FORM

Name of the Patient _____

IPNO _____ Ward : ORTHO-FEMALE

I am responsible for taking the above patient out of the hospital against advice of the doctor
I/C

Signature of the relative _____
 ATTENDANT NAME : SIDDARADA / 7993396399
 Relationship _____

Date _____



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భారత విశ్వ గుర్తింపు ప్రాధికార సంస్థ

भारत सरकार

Government of India

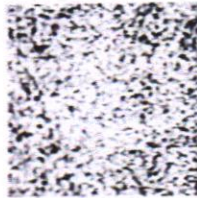
Registration No. 06541210047095

Generated On: 21/07/2024

Generated On: 21/07/2024

To: వేపతి స్యమలమ్మ
Vepati Syamalamma
CAO V Ramalathilathel
W012
Kaddipalem
NSC Bose Road
opposite MRK tyres
Nellore
Nellore
Nellore Andhra Pradesh - 524001
5441380738

Signature valid



మీ ఆదార్ సంఖ్య / Your Aadhaar No. :

9146 9601 0829

VID: 9113 7313 8470 2737

నా ఆదార్, నా గుర్తింపు



భారత ప్రభుత్వం
Government of India



వేపతి స్యమలమ్మ
Vepati Syamalamma
పుట్టిన తేదీ: 01/01/1946
FEMALE

9146 9601 0829

VID: 9113 7313 8470 2737

నా ఆదార్, నా గుర్తింపు



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8/5/24 10:48 AM

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NARAYANA MEDICAL COLLEGE HOSPITAL

Page 2
CHINTHAREDDYPALEM, NELLORE - 2, A.P. Ph: 08612317963,64,68
CASE RECORD

IP No: 240905044

Name of the Patient : **VEPATI SYAMALAMMA**

Age : **78 Y Y** Sex : **Female** Religion : _____

Father / Husband's Name / relation : VEPATI RAMAIAH

Full Address : 9/712, NSC BOSE ROAD OPPOSITE MRF, TYRES NELLORE

CHINTHAREDDYPALEM, Nellore Town 1, Phone No : 9441380738

MOBIL NO : 914696010829

Final Diagnosis : _____ Code No: _____

Date of Admission : **05-Sep-2024 10:49:58 AM 10:49:58 AM** Ward : _____

Date of operation and operation procedure : _____ Code No: _____

Date of Discharge : _____

Results :

Cured	Relieved	Otherwise	Died	Length of Stay

DISCHARGE SUMMARY

Symptoms

Physical Findings

Investigations

Diagnosis

Findings

Signature of the Chief

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NARAYANA MEDICAL COLLEGE HOSPITAL

Page 3
CHINTHAREDDYPALEM, NELLORE - 2, A.P. Ph: 08612317963,64,68

HISTORY

IP No: 240905044

Name of the Patient : VEPATI SYAMALAMMA

Age : 78 Y Y Sex : Female Ward : ORTHO-FEMALE Religion : _____

Complaint : A 78 years old female patient by name

History of Present Illness : Mrs. Syamalamma came to OPD with

History of Previous Illness : Chief complaint of pain over right hip

Habits : She is a housewife

Family History : Diabetes & Heart Disease

Physical Examination : Patient was apparently Normal 1 month

Remarks : Back then she developed pain over right

PHYSICAL EXAMINATION

Pain which is insidious in onset, gradually progressive especially with movement, relieved to some extent by rest but medication pain is associated with tingling and numbness

- No Swelling and redness of affected part

- No H/o sudden weight loss & loss of appetite

- No cough, cold, fever 1 week back

- No H/o other joint involvement

- No H/o morning stiffness

- No H/o evening pain & tenderness

History : Known case of Essential Hypertension treated on medication 1 and half years

Known case of Chronic Kidney Disease since 3 years

on regular medication Procox 400 BP 120

Diabetes, CAD, CVA, Dizziness, Epilepsy



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- History of ^{Completed} ~~Binocular~~ ~~Acute Arthritis~~ 4/20/2020

General status

- She conscious, oriented
- Sleep and Appetite normal
- Bowel and Bladder movements unaltered
- NO edema

General Examination

- Patient is conscious, alert, cooperative
- She is thin built & Nourished

Vitals

BP: 120/80 mmHg
 PR: 90 BPM
 RR: 20 CPM
 Temp: Afebrile

Systemic Examination

CVS: S1, S2 (+)
 CNS: NFN
 RES: BAF (+)
 Pkts: Soft, Non tender

Local Examination

Joint: Antalgic gait

Attitude: Patient is in supine position. Head is at center. Bk down, at same level. Bk down by the side of the body. Umbilicus is at center. Bk Hip in neutral position. Bk knee in extension. Bk patella flexion 100%. Bk ankle in neutral position. Bk lateral border 4 fingers and touching the lower. NO Muscle Weak

Inspection

- A 20x1 cm healed scar present over lateral aspect proximal



[Signature]

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 Chinthareddypalem,
 NELLORE-524 002

05/24 10:49AM

NARAYANA MEDICAL COLLEGE AND HOSPITAL

Chinthareddypalem, Nellore

Hospital Billing Record

Reg No:	20240442873	IpNo:	240905044	wardname:	Ortho-Female
Name:	Vepati Syamalamma	Age/Sex:	78 Y Y/Female	BedNo:	H327A-0017
Doctor:	Dr Juvvalapati Rohith	Admission Date:	05-Sep-2024 10:49:58 AM	Admit Time:	10:49:58 AM
Transfer Information from:		To:		D/Time:	
Mode of Payment:		Cash:		Credit/Debit Card:	

Total Charges	Amount
Bedcharges	
Consultations	
Nursing	
Pharmacy	
Investigations	
Procedures	
Packages	
Miscellaneous	
Others	
Total	

- NO unopposed Ven
 - NO visible deformity

Palpation

- All Insults finding are confirmed on palpation
 - NO local SW & temperature
 - Tenderness present over lateral aspect of mid thigh

Movements

Range of motion

Diagnosis: Post traumatic loss of Right Ankle Dorsiflexion

Signature

Management



Dr. S. Govinda Rao
10/09/24

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నారాయణమెడికల్ కాలేజి
హాస్పిటల్

చింతారెడ్డి పాళం, నెల్లూరు
ఆరోగ్యసేవా పథకము వర్తించని పేషంట్లు

వ్రాసి ఇచ్చే హామీ పత్రము

తేది _____

పేరు : VEPATI SYAMALAMMA

ఆఫీస్ నెం : 20240442873

నాకు తెలుపబడిన పేషంట్లైన నాకు కలిగిన వ్యాధికి ఆరోగ్యసేవా పథకము వర్తించనందున లేదా మాకు ఆరోగ్యశ్రీ సౌకర్యము లేనందున అన్ని సౌకర్యములు ముందు చెల్లించి వైద్యము చేయించుకొనుటకు అన్ని విధములుగా మేము సంగీకరించుచున్నాము.

పేషంట్ తరపున బంధువు సంతకము

(Handwritten Signature)
పేషంట్ సంతకము

పేషంట్ చిరునామా

VEPATI RAMAIAH

712, NSC BOSE ROAD OPPOSITE MRF

CHINTHAREDDY NELLORE

CHINTHAREDDY PALEM

Nellore Town 1

NELLORE, AP

9441380738



(Handwritten Signature)

Principal
SREE NARAYANA NURSING COLLEGE
Chinthareddypalem,
NELLORE-524 002



NARAYANA MEDICAL COLLEGE & HOSPITAL, NELLORE

NURSING INITIAL ASSESSMENT FORM

(Initial Assessment must be completed within 30 minutes of admission)

NARAYANA

PATIENT IDENTIFICATION

Reg No	NO 44	Name	Syano Sanku
Age	24/11	Sex	M / F <input checked="" type="checkbox"/>
		Ward	149/10
		Bed No	

Date admitted: 11/11/20
 Time admitted: 11:00
 Arrived by: Wheelchair / Stretcher / walking
 Patient accompanied by: _____
 Contact Number: _____
 Type of payment: ABM
 (Self / Company / NAM/VSP / Paid etc)
 Reason for coming to hospital / Presenting complaints: COPD

HEALTH HISTORY

Present medical treatment history: COPD, medicine

Past surgical history: Hypertension DM TB IHD Renal Others

Previous hospitalization: Yes No

Previous surgeries: Yes No

ALLERGIES / ADVERSE REACTIONS

Known or suspected allergies to:

1. Medication/Drug: Yes / No

2. Blood Transfusion: Yes / No

2. Other allergies: Yes / No

ASSESSMENTS

1. Assessment for fall risk (Fall risk assessment tool to be used) Score:

2. Assessment for pressure ulcers Score:

3. Assessment for pain (Assess using the applicable scale) Score:

FAMILY HISTORY

No. of children: _____ Any others: _____

HABITS

Smoking: Yes No

Tobacco chewing: Yes No

Alcohol: Yes No

Drug abuse: Yes No




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Elimination history
 Bowel movements: Day 4/14 Night 0/14
 Frequency of micturition: 4/14 / day
 Any sleep disturbance Yes No

HEALTH ASSESSMENT
 General appearance: Normal Constipation Loose stools / night
 Behavior: Well built Thin Obses
 Level of consciousness: Conscious Distressed Cheerful
 Altered sensation: Yes No Altered consciousness (use GCS)
 Vision: Normal Impaired
 Ear: Pain: Yes No

Discharge: Yes No
 Hearing: Yes No
 Uses hearing aid: Yes No

Mobility: Ambulant Not ambulant difficulty in performing ADL
 can sit up altered ROM

Circulation: Cyanosis: Yes No Clubbing: Yes No
 BP: Both mmHg

Nutrition: Ht: _____ cms; Wt: _____ kgs BMI: _____ Normal BMI Range (18.5-22.9 kg/m²)
 Appetite: Good Poor
 Weight Loss: No weight loss > 6 kg < 6 kg
 Any feeding difficulty: Yes No

Therapeutic if any specify _____
 If alternation in BMI or with feeding difficulty inform the dietary department

ORIENTATION TO PATIENT ENVIRONMENT (Thik in the box)
 Ward Orientation Call for assistance Dietary Services
 Receipts Side rails Visitors
 Waste Management Hospital Orientation Care of Valuables

(Ward Orientation: Kitchen Toilet Television (if applicable) Hand wash area, Nurses station, Linen
 Hospital Orientation: Chapel Canteens ATM machines, Post office)

Signature with EMP: _____ Date and Time: 16/10/2025
 by Nursing Incharge: _____
 Counter Signature by _____ Nurse/Nursing Supervisor

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I.P. DOCTOR'S ORDERS

Patient Name Syamabamma Age 48y Sex F Ward Ortho I.P. No 5044

Date	History, Examination, Investigation, Treatment and Progress
<p>5/4/24 @ 9pm</p>	<p><u>Cl 1/1 by ortho - I</u></p> <p><u>Diagnosis</u> → ? Right Hip Pain for 6 months</p> <p><u>Plan</u> → Conservative Management</p> <p>→ PR Clo Pam over Right Hip.</p> <p><u>Vitals</u></p> <p>BP 110/70 mmHg</p> <p>RR - 20 bpm</p> <p>PR - 80 bpm</p> <p>Temp Afebrile</p> <p><u>Rx</u></p> <p>1) Inj. PCM 1gm IV QD.</p> <p>2) Inj. PAN 40 1-0</p> <p>3) Inj. OPTIMALON 1amp in 100ml NS IV QD</p>

Jr. Resident
Department of Orthopaedics
Narayana Medical College & Hospital
Chinthareddypalem, Nellore - 524 003

Sr. Resident
Department of Orthopaedics
Narayana Medical College & Hospital
Chinthareddypalem, Nellore - 524 003

Unit Chief
Department of Orthopaedics
Narayana Medical College & Hospital
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(A Unit of Narayana Educational Society)

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 Ph: 0861-2317963, 2317964, Ambulance 232411
 www.narayanameicalcollege.com

COMPNAME: NARAYANA AROGYAMASTHU
 NAME: VEPATI SYAMALAMMA
 AGE: 78 Y SEX: F
 REGNO: 20240442873
 OPID: 1024789511
 DEPT: Orthopaedics
 DOCT: DR JUVVALAPATI ROHITH
 DATE: 05-SEP-2024 09:50:55 AM
 Op Timings: 9AM to 4PM TEMP: 0.00

OUT PATIENT CARD

PROVISIONAL DIAGNOSIS



Handwritten notes

DATE & TIME



Handwritten notes:
 -> Pt Clo pain over Right Hip Since 1 week
 -> K/K/O post operative Case of
 Right Central Bipolar Hip Arthroplasty

Vertical handwritten notes:
 Adm
 ↓
 Inop
 ↓
 Dr. Rohith
 ↓
 J. Sankar
 ↓
 J. Sankar
 ↓
 J. Sankar

NAME: VEPATI SYAMALAMMA
 REGNO: 20240442873
 DEPT: Orthopaedics
 DOCT: DR. JUVVALAPATI ROHITH
 OPID: 1024789511
 COMPNAME: NARAYANA AROGYAMASTHU

OPID: 1024789511
 CONS DATE: 05-SEP-2024 09:50:55 AM

BILLNO: 82409050233
 VISIT: 2
 REFNO:



Handwritten signature

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I.P. DOCTOR'S ORDERS

Patient Name Syanabamma Age 78y Sex F Ward F 0300 IP No 5049

Date	History, Examination, Investigation, Treatment and Progress
<p><u>6/7/24</u> <u>OSTA</u></p> <p><u>AFT</u> <u>Lumbac</u></p> <p><u>Back</u> <u>Grav</u></p>	<p><u>C/S by ortho-I</u></p> <p><u>Diagnosis</u> → <u>Post-operative care of</u> <u>Right lateral bony Hemi-arthroplasty.</u></p> <p><u>Plan</u> → <u>Conservative Management.</u></p> <p><u>Vitals</u></p> <p><u>Sp 110/70 mmHg</u> <u>RR 18</u> <u>Temp 36.5</u> <u>PR 80bpm</u></p> <p><u>Rx</u></p> <p><u>1) Inj. PGM 1gm IV BD</u> <u>Lot</u></p> <p><u>2) Inj. Pain Long IV CD</u></p> <p><u>3) T. PREGABALIN</u> <u>25 mg 0-0-1</u></p> <p><u>Dr. K. H. (S)</u> <u>(ortho)</u></p>



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Unit Chief
Department of Orthopaedics
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I.P. DOCTOR'S ORDERS

Patient Name Syamabamma Age 78y Sex F Ward F.01150 I.P. No. 5044

Date	History, Examination, Investigation, Treatment and Progress
<u>6/9/24</u> <u>10:30 AM</u>	<p><u>C/S</u> by <u>physiotherapist</u></p> <p><u>Asis</u> : <u>(RT)</u> post op case of <u>central bipolar hemiarthroplasty</u></p> <p><u>Plan</u> : <u>conservative management</u></p> <p><u>Rx</u> : <u>IFT - LBA</u></p> <p><u>Back strengthening exercises</u></p> <p><u>- or. prakitha</u></p>



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Unit Chief
Department of Orthopaedics

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I.P. DOCTOR'S ORDERS

Patient Name Syamalamma Age 78y Sex F Ward F.01150 I.P. No 5004

History, Examination, Investigation, Treatment and Progress

Date	History, Examination, Investigation, Treatment and Progress
<p>7/10/24 6:30pm</p> <p>IPT Low back</p> <p>Bell Sp Acute</p>	<p><u>AS/bj 01/20-I</u></p> <p><u>Diagnosis</u> → Post-operative care of Right cerebral bipolar Hemispheric palsy.</p> <p><u>Plan</u> → Conservative Management.</p> <p><u>Vitals</u></p> <p>Sp 120/80 mmHg.</p> <p>PR - 20 bpm.</p> <p>Temp - Afebrile</p> <p>PR - 80 bpm.</p> <p><u>Rx</u></p> <p>1) Inj. PLY 1gm BD hot</p> <p>2) Inj. PAN 40 mg IV OD.</p> <p>3) T. PRG GABAPALIN 75 mg o.d.</p> <p>Dr. Kant (Pg) (Dr. Kant)</p>



[Signature]
Sr. Assistant

[Signature]
Principal



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I.P. DOCTOR'S ORDERS

Patient Name Syamaamma Age 78y Sex F Ward F.01150 I.P. No 5044

Date	History, Examination, Investigation, Treatment and Progress
<p>8/1/24 SAM</p> <p>Wb. into bed</p> <p>Rest</p> <p>Co. ok</p> <p>Pale</p> <p>Sp</p> <p>Grav</p>	<p style="text-align: center;"><u>CS/ortho - I</u></p> <p><u>Diagnosis</u> → Post-operative case of right cerebral bipolar Hemispheroplasty.</p> <p><u>Plan</u> → Conservative Management</p> <p>→ PE Clo to H. H. over right side, tingling... sustained</p> <p><u>Vitals</u></p> <p>BP - 120/80 mmHg. <u>R</u></p> <p>RR - 20 rpm.</p> <p>Temp - Afebrile</p> <p>PR - 80 bpm.</p> <p>1) Inj. PAM 1gm BD</p> <p>2) Inj. PAM 40 mg IV OD</p> <p>3) T. PR + GABA LAM 75mg o-o</p> <p>Dr. Kantappa I)</p> <p>(Kantappa I)</p>



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I.P. DOCTOR'S ORDERS

Patient Name Syamalamma Age 78y Sex F Ward F.01150 I.P. No 5044

Date	History, Examination, Investigation, Treatment and Progress
09/12/11	<p>DOB Physiological</p> <p>Dominant - post operative</p> <p>bi-pedal - new atropine</p> <p>para - coarctative manure</p> <p>Physiological - I & T low back</p> <p>Back sound</p> <p>bow</p> <p>Approved</p> <p>St Resident</p>



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I.P. DOCTOR'S ORDERS

Patient Name Syrimalamma Age 78y Sex F Ward/Other/OP No 5044

Date	History, Examination, Investigation, Treatment and Progress
<p><u>22-24</u> <u>800hr</u></p>	<p align="center"><u>(1st/8 OP 110)</u></p> <p><u>Diagnosis</u> Post operative care of right Cemented <u>Diagnosis</u> Right Atrial flutter <u>Plan</u> Conservative management</p> <p>→ Patient clo mild pain one liter hb, tingling sensation (7)</p> <p><u>VITALS</u></p> <p>BP: 150/90 mm Hg PR: 88 bpm RA: 22°C Temp: Afebrile</p> <p><u>Adv</u></p> <p>+ WAI Bed for dxr Bed - Bed rest Exm.</p> <p align="right">Dr. M. R. Nanthan (Signature)</p>



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I.P. DOCTOR'S ORDERS

Patient Name Syamalanma Age 18y Sex F Ward Ortho I.P. No. 5014

Date _____ History, Examination, Investigation, Treatment and Progress

9/9/24

C/S by physiotherapy

Diagnosis: (A) post op case of central bipolar
hemiarthralgia

Plan: conservative management

Rx: Hot wax bath for back
Back exercises.



P. Praveen Kumar

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I.P. DOCTOR'S ORDERS

Patient Name Syanalamma Age 78y Sex F Ward F-152 P No 5044

Date	History, Examination, Investigation, Treatment and Progress
<p><u>9-9-20</u> <u>5:00 PM</u></p>	<p style="text-align: center;"><u>C/S/E 08/11/20</u></p> <p><u>Diagnosis:</u> Post operative Care of Right femoral Fracture Distal humeral</p> <p><u>Plan:</u> Conservative management</p> <p><u>Status:</u> 110 mild pain over right hip, tingling numbness</p> <p><u>VITALS:</u></p> <p>BP: 120/90 mmHg PR: 80 bpm RR: 20 cpm Temp: Afebrile</p> <p><u>Adv:</u></p> <ul style="list-style-type: none"> - Warm Bath - Bed down Bank - Back straighten <p style="text-align: right;">Dr. M. Lavanku (10/11/20)</p>



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I.P. DOCTOR'S ORDERS

Patient Name: Syamalanaras Age: 50y Sex: F Ward: Ortho I.P. No: 5004

Date	History, Examination, Investigation, Treatment and Progress
<p>10-2-21</p> <p>8.00 AM</p>	<p style="text-align: center;"><u>C/S/B OP1110-1</u></p> <p><u>Diagnosis:</u> Post operative Care of Right Cemented Hip Joint Arthroplasty</p> <p><u>Plan:</u> Conservative management</p> <p>→ LLO Mild pain over right hip, tingling sensation</p> <p><u>Vitals:</u></p> <p>BP: 150/90 mm Hg</p> <p>PR: 80 BPM</p> <p>RA: 20 CPM</p> <p>Temp: Afebrile</p> <p><u>Adv:</u></p> <p>- Wax Bath qoe</p> <p>Local Bath</p> <p>- Bed strength</p> <p style="text-align: right;">Dr. M. Praveen</p>

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I.P. DOCTOR'S ORDERS

Patient Name Age Sex Ward I.P. No

Date	History, Examination, Investigation, Treatment and Progress
<p>10.06.24 5:00 PM</p>	<p style="text-align: center;"><u>CLSB ORTHO-1</u></p> <p><u>Diagnosis:</u> Post operative care of right cemented Acetabula Hemis Acetabuloplasty</p> <p><u>Plan:</u> Conservative management</p> <p>→ Nil pain over right hip, tingling sensation absent</p> <p><u>VITALS</u></p> <p>BP: 120/80 mmHg RA: 80 bpm RA: 22°C Temp: Afebrile</p> <p><u>Adms:</u></p> <ul style="list-style-type: none"> - Warm bath for lower limb - Bed stretch Exercises <p style="text-align: right;">Dr. M. Anand (P) COR1110 D</p>



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Dist. Registrar, Chinthareddypalem
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I.P. DOCTOR'S ORDERS

Patient Name Age Sex Ward I.P. No.

Date	History, Examination, Investigation, Treatment and Progress
<p>11-9-24 8:00 AM</p>	<p style="text-align: center;"><u>CLINIC ORTHO-1</u></p> <p><u>Diagnosis:</u> Post operative Care of Right Cemented Hip Acute Atrophy Pain Conservative Management - xlo Pain over right hip, tingling sensation below</p> <p><u>VITALS</u></p> <p>BP: 120/80 mmHg HR: 90 bpm RR: 22 (P) Temp: Afebril</p> <p><u>Advice</u></p> <p>- Was call for home care - Care strengthen Exercise</p> <p style="text-align: right;">Dr. M. Venkata (16) (1097110)</p>



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I.P. DOCTOR'S ORDERS

Patient Name Syamalanma Age 78y Sex F Ward F-01/119 No 5047

Date	History, Examination, Investigation, Treatment and Progress
<p><u>11/9/24</u> <u>10:00AM</u></p>	<p><u>d/s/</u> by <u>physiotherapist</u></p> <p><u>Δsis</u> : post op case of (R) cemented Bipolar Hemi arthroplasty</p> <p><u>plan</u> : conservative management</p> <p><u>RE</u> : wax bath - LBA Back strengthening exercises</p> <p style="text-align: right;">- H. Mahitha -</p>




 Unit Chief
 Department of Orthopaedics
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 Chinthareddypalem, Nellore - 524 003

Sree Narayana Nursing College
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I.P. DOCTOR'S ORDERS

Patient Name Srinivasan Age 50 Sex M Ward Ortho I.P. No 1044

Date	History, Examination, Investigation, Treatment and Progress
<p>11-09-24</p> <p>500m</p>	<p style="text-align: center;"><u>CLINICAL</u></p> <p><u>Diagnosis:</u> Case of acute case of Acute Cemented Bands from Intertrochanteric</p> <p><u>Plan:</u> Conservative Management do low one leg cast.</p> <p><u>Vitals:</u> R:</p> <p>BP: 150/90 mm Hg PR: 88 bpm RR: 23/17 Temp: Afebrile</p> <p><u>Advice:</u></p> <ul style="list-style-type: none"> - One Bath for low cast - Cast strengthening exercises <p style="text-align: right;">Dr. M. Renuka (MC) (102110-9)</p>




 Dr. M. Renuka
 Department of Orthopaedics
 Sree Narayana Nursing College
 Chinthareddypalem, Nellore-524 002

Unit Chief
 Department of Orthopaedics
 Sree Narayana Medical College & Hospital
 Chinthareddypalem, Nellore-524 002

I.P. DOCTOR'S ORDERS

Patient Name: Syamalamma Age: 54y Sex: F Ward: Ortho IP No: 1014

History, Examination, Investigation, Treatment and Progress

Date	History, Examination, Investigation, Treatment and Progress
<p><u>12-09-24</u> <u>8:00 AM</u></p>	<p><u>CLB Ortho</u></p> <p><u>Diagnosis:</u> Post operative case of right cemented hip <u>Biomechanical dysfunction</u></p> <p><u>Plan:</u> Conservative Management</p> <p><u>UO</u> pain over right hip</p> <p><u>VITALS:</u></p> <p>BP: 130/80 mm Hg RR: 22/min Temp: Afebrile</p> <p><u>Advice:</u></p> <ul style="list-style-type: none"> - Wear brace for lower back - Back strengthening exercises <p><u>Medication:</u></p> <ul style="list-style-type: none"> 1) PREGABALIN 300mg BID 2) T. PCM 650mg 1-1-1 <p><u>Dr. S. Srinivasulu</u> <u>Ortho</u></p>



Sr. Resident
 Principal



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I.P. DOCTOR'S ORDERS

Patient Name Syamalamma Age 58y Sex F Ward Ortho I.P. No. 5044

Date History, Examination, Investigation, Treatment and Progress

17-2-24
5.00 PM

CLINICAL

Diagnosis Post operative care of right cemented
Brodie's Hemiarthroplasty

Plan: Conservative management

- Pain free right hip during walking

VITALS

BP: 130/80 mmHg
PR: 98 BPM
RR: 23 /min
Temp: Afebrile
① P. PCN 650 mg BID
② P. PAN 40mg OD
③ P. PREGABALIN 75mg HS

Advice

- Wax bath for
lower limb & both feet
- Back stretching
exercise

Dr. M. Venkatesh
(Ortho)



Resident _____ Sr. Resident _____ Unit Chief _____
Department of Orthopaedics
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I.P. DOCTOR'S ORDERS

Patient Name Preyimalamy Age 78y Sex F Ward Ortho No 5543

History, Examination, Investigation, Treatment and Progress

Date
13-2-21
8:00 AM

C/Sx 081100 ->

Diagnosis: Post operative Call of legs cemented hip
Mini dictum later

Plan: Conservative Management

- Pain over right hip decrease

Vitals:

BP: 130/80 mmHg

PR: 88 BPM

RR: 24/cmn

Temp: 37.0°C

Rx

① P. 24 650mg TID 1-1-1

② P. PAN 40mg OD 1-1-1

③ P. PARACETAMOL 500mg TID 1-1-1

Advice:

- Warm bath for
hips, back and both legs

- Best strength

Examination:

Dr. M. Ramesh (A)
(Signature)



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I.P. DOCTOR'S ORDERS

Patient Name Sonalamma Age 57y Sex f Ward Ortho IP No 3014

Date	History, Examination, Investigation, Treatment and Progress
12/10/2011	<p>CLBP Physiotherapy</p> <p>Diagnosis: Post operative care of right cemented Bipolar hip arthroplasty</p> <p>Plan: conservative management</p> <p>Rx: Hot soak</p> <p>Back strengthening exercises</p>

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Dr. Resident
Department of Orthopaedics
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Unit Chief
Department of Orthopaedics
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I.P. DOCTOR'S ORDERS

Patient Name Sepamamma Age 78y Sex F Ward F-08 I.P. No. 5044

Date _____ History, Examination, Investigation, Treatment and Progress

13/9/24
9:40AM

cls by physiotherapist

Disis : post op care of (R) Cemented Bipolar hemiarthroplasty

plan : conservative management

Rx :
 WAX bath - LBA
 Back strengthening exercises
 — M. Mahitha



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Department of Orthopaedics

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I.P. DOCTOR'S ORDERS

Patient Name Syamalamma Age 78 Sex F Ward Ortho P. No. 8014

Date	History, Examination, Investigation, Treatment and Progress
<p>13-09-20</p> <p>5:00 PM</p>	<p style="text-align: center;"><u>C/S/B ORTHO - 2</u></p> <p><u>Diagnosis:</u> Post operative care of Right Cemented Bipolar Head Prosthesis</p> <p><u>Plan:</u> Conservative Management</p> <p>- Pain over right hip dorsum</p> <p><u>VITALS:</u></p> <p>BP: 130/80 mmHg</p> <p>HR: 88 bpm</p> <p>RR: 22 rpm</p> <p>Temp: Afebrile</p> <p><u>ADVICE:</u></p> <p>- Wet bath for Lower limb</p> <p>- Back strengthening Exercises</p> <p style="text-align: right;">Dr. M. Sivaram (11) (Ortho - 2)</p> <p style="text-align: right;">Unit Chief Department of Orthopaedics NARAYANA MEDICAL COLLEGE & HOSPITAL Chinthareddypalem, Nellore - 524 003</p>



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I.P. DOCTOR'S ORDERS

Patient Name Sybilamma Age 74 Sex F Ward CHD I.P. No. _____

Date	History, Examination, Investigation, Treatment and Progress
<p><u>14-9-24</u> <u>8:00 AM</u></p>	<p style="text-align: center;"><u>CHD DR 110-1</u></p> <p><u>Diagnosis</u>, <u>low quality</u> <u>can of</u> <u>liver</u> <u>connective</u> <u>tissue</u> <u>disorder</u></p> <p><u>Plan</u>: <u>Conservative</u> <u>management</u></p> <p>- <u>low</u> <u>on</u> <u>high</u> <u>his</u> <u>demand</u> <u>gradually</u></p> <p><u>VITALS</u></p> <p>BP: <u>130/80 mmHg</u></p> <p>PR: <u>88 bpm</u></p> <p>RR: <u>24 bpm</u></p> <p>Temp: <u>Afebrile</u></p> <p><u>Advice</u></p> <p>- <u>was</u> <u>both</u> <u>for</u> <u>low</u> <u>and</u></p> <p>- <u>Best</u> <u>Strength</u> <u>Exercise</u></p>
	<p style="text-align: right;">Dr. M. Ramesh Babu (Attending)</p> <p style="text-align: center;">Principal</p> <p style="text-align: right;">Unit Chief</p>





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I.P. DOCTOR'S ORDERS

Patient Name Sejanalamma Age 75 Sex F Ward W-10 I.P. No. 5011

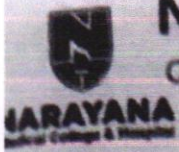
Date	History, Examination, Investigation, Treatment and Progress
<u>14/9/24</u> <u>9:30 AM</u>	<p style="text-align: center;"><u>C/S</u> by <u>physiotherapist</u></p> <p><u>Asis</u> : post op case of <u>(Rt)</u> cemented Bipolar Hemiarthroplasty</p> <p><u>Plan</u> : conservative management</p> <p><u>Rx</u> : wax bath - LBA Back strengthening exercises</p> <p style="text-align: right;">- M. Mahitha</p>



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Department of Orthopaedics
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Unit Chief
Department of Orthopaedics
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I.P. DOCTOR'S ORDERS

Patient Name Syamabamma Age 70y Sex F Ward Ortho I.P. No 5044

Date	History, Examination, Investigation, Treatment and Progress
16/09/24	<p>CB/By physiotherapy</p> <p>Diagnosis : post comm case of</p> <p>Right commere B/polar Arthroplesia etc</p> <p>Rt : : Hot wax</p>



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I.P. DOCTOR'S ORDERS

Patient Name Syamulamma Age 78y Sex F Ward Chintha I.P. No. 5044

Date	History, Examination, Investigation, Treatment and Progress
<p>16-02-21 E.O.P</p>	<p>(112 0214-3)</p> <p>Prasoon) Post operative care & legio Cemented bridge</p> <p>Bein full recovery</p> <p>Man' Conservative management</p> <p>Leg over leg in ↓</p> <p>VITALS</p> <p>BP: 120/80 mmHg</p> <p>HR: 80 bpm</p> <p>RR: 22 bpm</p> <p>Temp: 37.2°C</p> <p>2nd detail</p> <p>Adv</p> <p>- Bath 4 times</p> <p>Bein</p> <p>- Not can bath</p> <p>for lower bath</p> <p>Dr. M. Lakshmi</p> <p>(Signature)</p>



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Narayana Medical College & Hospital

Chinthareddypalem, Nellore

Nursing Drug Administration Chart

Patient Name : *Syanabaine*

Age / Sex : *78y / F* Ward : *F-08160* Unit : *2*

IP No : *5004*

Registration No : *5004*

Weight	Height			Date	T	I	M	E
		NOT KNOWN	Route : ORAL	<i>13/11/24</i>				
Allergies :			Frequency : OP					
Drug : <i>P. PRAPABALIN</i>			Doctor : <i>Am. Reddy</i>					
Dose : <i>1 tab</i>								
Start Date : <i>6/9/24</i>								
Other Instructions :								
Drug		Route		Date	T	I	M	E
Dose		Frequency						
Start Date		Doctor						
Other Instructions :								
Drug		Route		Date	T	I	M	E
Dose		Frequency						
Start Date		Doctor						
Other Instructions :								
Drug		Route		Date	T	I	M	E
Dose		Frequency						
Start Date		Doctor						
Other Instructions :								
Drug		Route		Date	T	I	M	E
Dose		Frequency						
Start Date		Doctor						
Other Instructions :								
Drug		Route		Date	T	I	M	E
Dose		Frequency						
Start Date		Doctor						
Other Instructions :								

Once Only Drugs

Drug	Date / Time	Dose	Route	Doctor



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Registering the drugs

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NURSES CHART

Name: Syamalamma Age: 75 Sex: F Ward: 40 IP No: 5044

Time	Medication and Diet	Notes	Signature
	Admission Recd		
4 AM	Case Recd from the op. room female of the ward → con ds DOA from Dr. Rohith Adm Recd - V. Syamalamma Adm Recd ward physician done		
8 AM	Adm Recd On Sample Procure food → to the lab (EP)		
	Adm Recd Con diet stable / can see		
1 PM	Case Recd Recd day over (E) recd staff	Arrive to the	Singh 11/12



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NURSES CHART

Patient Name: Syanalamma Age: 78y Sex: F Ward: Female I.P. No: 5043

Date	Time	Medication and Diet	Notes	Signature
<u>19/7/24</u>		<u>Evening Duty Staff</u>		
		case hand over taken from morning duty staff		
		monitored vital & recorded		
		Patient is conscious		
		Patient have no fresh complaints.		
		health education given → personal hygiene		
		monitored vital & recorded		
		Case hand over given to night duty staff		




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NURSES CHART

Patient Name Sekunabanne Age 70y Sex F Ward F 0150 IP No 5044

Date	Time	Medication and Diet	Notes	Signature
<u>5/9/24</u>			<p><u>Night duty staff report</u></p> <p>7pm Case hand over taken from evening duty staff</p> <p>8pm Administered medications as per doctors orders</p> <p>9pm monitored vitals & recorded</p> <p>10pm Health Education given about personal hygiene</p> <p>11pm patient have no any fresh complaints.</p>	
<u>6/9/24</u>	<p>12AM</p> <p>5AM</p> <p>6AM</p> <p>7AM</p>		<p>patient is sleeping</p> <p>bed making done</p> <p>monitored vitals & recorded</p> <p>case hand over given to morning duty staff.</p>	<p><i>[Signature]</i></p>



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NURSES CHART

Patient Name Syamalamma Age 78y Sex F Ward Front P No 504y

Date	Time	Medication and Diet	Notes	Signature
<u>6/1/24</u>		<u>Morning Duty Staff Report</u>		
	<u>7am</u>	<u>Case heading over taken from the @ duty staff</u>		
		<u>→ Recd by Home Siken</u>		
		<u>@ Patient Conscious & oriented to Room</u>		
		<u>Dist - @ hip pain for evaluation</u>		
	<u>8am</u>	<u>@ Patient Admini started med</u>		
		<u>Given as per doctor's order.</u>		
		<u>Condition - Stable / no heart</u>		
	<u>9am</u>	<u>@ Patient Doctor seen & followed</u>		
	<u>10am</u>	<u>by DR. Vasei For her in</u>		
		<u>Dist - HF low back</u>		
	<u>11am</u>	<u>@ Patient Physio therapy done & Daily</u>		
	<u>12pm</u>	<u>@ Patient have no such compla</u>		
	<u>1pm</u>	<u>@ Case heading over Given to the @ Duty Staff</u>		

Signature
1/1/24

[Handwritten Signature]

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NURSES CHART

Patient Name Syamaamma Age 78y Sex F Ward F-01B P No 5044

Date	Time	Medication and Diet	Notes	Signature
6/9/24			<p><u>Evening duty staff</u></p>	
	1pm →		<p>case hand over taken from morning duty staff</p>	
			<p>Ass - (R) hip pain for evaluation</p>	
	2pm →		<p>Patient is conscious</p>	
	3pm →		<p>monitored. vitals & recorded</p>	
	4pm →		<p>patient have no fresh complaints.</p>	
	5pm →		<p>health education given personal hygiene.</p>	
6pm →		<p>monitored vitals & recorded</p>		
7pm →		<p>case hand over given to night duty staff</p>		
			<p>Durgam</p>	



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NURSES CHART

Patient Name Syama Lakshmi Age 45 Sex F Room 128 Ward 128

Date	Time	Medication and Diet	Signature
<u>6/9/24</u>	Night duty Staff report		
	7pm	Case hand over taken from Evening duty staff S/S off pain for evaluation	
	8pm	Administered medications as per doctor's orders	
	9pm	monitored vitals & recorded	
	10pm	Health education given about personal hygiene	
	11pm	patient have no any fresh complaints	
	<u>7/9/24</u>	12Am	patient is sleeping
	5Am	Bed making is done	
	6Am	monitored vitals & recorded	
	7Am	Case hand over given to morning duty staff	



[Signature]

NURSES CHART

Patient Name Syamaamma Age 78y Sex F Ward F.02/50 IP No 5044

Date	Time	Medication and Diet	Notes	Signature
<u>7/9/20</u>		<u>Morning duty staff report</u>		
	<u>7AM</u>	<u>Case hand over taken from night-duty staff</u>		
		<u>50% Hip pain for evaluation</u>		
	<u>8AM</u>	<u>Medication administration as per as doctor</u>		
		<u>Monitor vitals signs checked & recorded</u>		
	<u>9AM</u>	<u>Health education given personal hygiene</u>		
<u>10AM</u>	<u>Doctor rounds followed by Dr. Abeer sir</u>			
<u>11AM</u>	<u>patient is conscious</u>			<u>Ramya</u> <u>1158</u>
<u>12pm</u>	<u>patients have no fresh complaint</u>			
<u>1pm</u>	<u>Case hand over given to evening duty staff</u>			



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NURSES CHART

Patient Name Syanalamma Age 78y Sex F Ward F-0 IP No 844

Date	Time	Medication and Diet	Notes	Signature
<u>7/9/24</u>		Evening duty staff Report		
		1pm → case hand over taken from Morning duty staff Report		
		2pm → vitals checked and recorded → Medication given as per doctor's order.		
		3pm → doctor's rounds followed.		
		4pm → Health education given.		
		5pm → pt is conscious and stable.		
		6pm → vitals checked and recorded.		
		7pm → Case hand over given to night duty staff.		



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NURSES CHART

Patient Name Syamalaamma Age 78y Sex F Ward F.O IP No 5044

Date	Time	Medication and Diet	Notes	Signature
<u>7/9/24</u>			<u>Night duty staff report</u>	
	<u>7pm</u>		<u>Case hand over taken from evening duty staff.</u>	
	<u>8pm</u>		<u>Rt hip pain for evaluation administered medications as per doctors orders.</u>	
	<u>9pm</u>		<u>patient is stable & conscious</u>	
	<u>10pm</u>		<u>Health education given about personal hygiene</u>	
	<u>11pm</u>		<u>monitored vitals & recorded</u>	
<u>8/9/24</u>	<u>12Am</u>		<u>patient is sleeping</u>	
	<u>5Am</u>		<u>bed making is done</u>	
	<u>6Am</u>		<u>monitored vitals & recorded</u>	
	<u>7Am</u>		<u>case hand over given to morning duty staff</u>	<u>May</u> <u>6024</u>



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NURSES CHART

Patient Name Syamabamma Age 78y Sex F Ward F O IP No 544

Date	Time	Medication and Diet	Notes	Signature
5/1/24		Morning duty staff report		
	7Am	Care hand over taken from		
		Night duty staff		
		ASU tip for evolution		
	8Am	Administration Medication as per doctor		
	9Am	Dr. P.G. Sir rounds followed		
	10Am	Monitor vitals checked		
	11Am	Health education is given about Physical exercise		
12pm	To provide comfortable position			
1pm	Care hand over given to Evening duty staff			



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NURSES CHART

Patient Name Syamalanma Age 50y Sex F Ward Ortho P No 5044

Date	Time	Medication and Diet	Notes	Signature
			Evening duty staff report	
	1pm		case handed over taken from morning duty staff (Gloria)	
			Asis: Right cemented broken hemipelvis Plan: conservative management	Praya 186
8/9/24	2pm		Monitor vitals signs & Recorded	
	3pm		Health education is given TOPIC: Personal hygiene	
	4pm		Patient is conscious & oriented	
	5pm		Patient having no fresh complaints	
	6pm		Monitor vitals signs & Recorded	



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NURSES CHART

Patient Name: Syamalamma Age: 78y Sex: F Ward: Ortho P No. 0114

Date	Time	Medication and Diet	Notes	Signature
	7pm		→ case handover given to night duty staff. Night duty staff report	
21/9/24	7pm		Case handover taken from evening duty staff ASIS (RT) cemented bipolar hemi ortho plasty / post operative Plan - conservative management	
	8pm		Administered medication as per doctors orders	
	9pm		patient is conscious and oriented	
	10pm		monitor vital checked and recorded	
	11pm		patient have no any fresh complaint	
	12am		patient is sleeping	



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NURSES CHART

Patient Name Syama Laxmi Age 77y Sex F Ward F-10 I.P. No. 544

Date	Time	Medication and Diet	Notes	Signature
9/9/24	5AM	Bed making done		<i>[Signature]</i>
	6AM	Monitor vital checked and recorded		
	7AM	Care hand over given morning duty staff		
			Morning duty staff Report	
	7AM	This care handover taken from night duty staff.		
		dx: stroke. Completed Bipolar Hemispherectomy.		
		→ Patient is Conscious & oriented		
	8AM	→ Administer medication is given by doctor orders.		
	8AM	→ Patient is Conscious & oriented		



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NURSES CHART

Name Syama Lakshmi Age 84 Sex F Ward 27th IP No 5046

Date	Time	Medication and Diet	Notes	Signature
	9 Am		Followed by Dr. Vamsi Srinivasulu sounds.	
	10 Am		Monitor vitals & recorded	
	11 Am		Health education is given for personal hygiene	
	12 pm		Patient have no fresh complaints	
	1 pm		Care handover given to evening duty staff.	

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NURSES CHART

Patient Name Sigala Laxmi Age 70y Sex F Ward Ortho IP No 5049

Date	Time	Medication and Diet	Notes	Signature
<u>7/9/24</u>		<u>Evening Duty Staff</u>		
	<u>1pm</u>	<u>cease hand over from morning duty staff</u>	<u>over fatigue</u>	
	<u>2pm</u>	<u>monitored</u>	<u>vital 2 recorded</u>	
	<u>3pm</u>	<u>monitored</u>	<u>vital 2 recorded</u>	
	<u>4pm</u>	<u>patient is conscious</u>		
	<u>5pm</u>	<u>patient has no complaints.</u>		
	<u>6pm</u>	<u>monitored</u>	<u>vital 2 recorded</u>	
<u>7pm</u>	<u>cease hand over given to night duty staff</u>			

Aug 2024



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NURSES CHART

NAI

Name: Sepanalaruna Age: 74 Sex: F Ward: ICU IP No: 541

Date	Time	Medication and Diet	Notes	Signature
		<u>Night Duty Staff Report</u>		
9/9/24	7pm	Case hand over taken from evening duty staff		
		ASIS Bipolar hemi-anthroplasty		
	8pm	Administered medication as per doctors orders		
	9pm	Patient is conscious and oriented		
	10pm	Monitor vital checks and recorded		
	11pm	Patient to have no any fresh complaint		
10/9/24	12pm	Patient is sleeping		
	5am	Bed making done		
	6am	Monitor vital checks and recorded		
	7am	Case hand over given to morning duty staff		



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NURSES CHART

Patient Name Syamalamma Age 70y Sex F Ward F- OIP No 5014

Date	Time	Medication and Diet	Notes	Signature	
10/9/24		Morning duty shift Report			
	7am	This case handover taken from night duty shift			
		A/C: Connected Bipolar Hemodialysis			
		Patient is conscious & oriented			
	8am	Administer medication as given by doctor order.			
	9am	Followed by Dr. Varma Sir Rounds			
	10am	Monitor vitals & recorded			
	11am	Health Education is given for personal Hygiene			
12pm	Patient have no fresh complaints				
1pm	Case handover given to Evening duty shift.				

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NURSES CHART

Patient Name Syanaamma Age 70y Sex F Ward F-110 IP No 5044

Date	Time	Medication and Diet	Notes	Signature
<u>10/9/24</u>		<u>Evening duty staff</u>		
	1pm	Case hand overtaken from morning duty staff		
		<u>Sp</u> - hemi althoplasty		
	2pm	monitored vitals 2 recorded		
	3pm	Patient is conscious		
	4pm	Patient have no fresh complaints.		
	5pm	health education given → personal hygiene.		
	6pm	monitored vitals 2 recorded		
7pm	case hand over given night duty staff			



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NURSES CHART

Patient Name Syamamma Age 35y Sex F Ward Ortho P No 5844

Date	Time	Medication and Diet	Notes	Signature	
10/9/24		Night Duty Staff Report			
	7pm		Case hand over taken from evening duty staff		
			ASD hemi arthroplasty plan - conservative management		
	8pm		Administered medication as per doctors orders		
	9pm		patient is conscious and oriented		
	10pm		monitor vital checked and recorded		
	11pm		patient have no any fresh complaint		
	12am		pt is sleeping		
1am		pt has no any fresh complaints			
5am		Bed making done			
6am		recorder for the vitals and recorded			
		Case handover is given to relf staff			



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NURSES CHART

Patient Name Syamshamma Age 78y Sex F Ward F.Ortho IP No 5044

Date	Time	Medication and Diet	Notes	Signature
11/9/24		Morning duty staff Peter		
	7Am	Case hand over	taken from	
		Night duty staff		
		Dr Bipolar hemiarthroplasty		
	8Am	Administration Medication as per doctor order		
	9Am	Dr. Vinay sir rounds followed Advice. Physiotherapy		
10Am	Monitor vitals checked			
11Am	Patient lent in physiotherapy			
12pm	To provide comfortable position			
1pm	Case hand over given to Evening duty staff			

78y
0591



[Signature]

Principal

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NELLORE-524 002

NURSES CHART

Patient Name Syama Kumar Age 75y Sex F Ward F-10/10 IP No 3049

Date	Time	Medication and Diet	Notes	Signature
<u>11/9/24</u>			<p><u>Evening duty Staff</u></p> <p>1pm → This case hand over taken from morning duty staff</p> <p>Δsis - Bipolar hemiparesis</p> <p>→ patient is conscious & recalls</p> <p>2pm → Administered medication as per doctor order</p> <p>→ patient is right hand Coma present</p> <p>3pm → vital check & Record</p> <p>patient is stable</p> <p>4pm → Health education given</p> <p>5pm → vital check & Record</p> <p>6pm → Case hand over given to night duty staff</p>	

malha



tu

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CHINTHAREDDYPALEM NELLORE 524 003 A.P. INDIA PH 0861-2355511 EXT - 2228

NURSES CHART

Patient Name: Dyanulamma Age: 80y Sex: F Ward: F 1017 P No: 504

Date	Time	Medication and Diet	Notes	Signature
12/9/24		<u>Night Duty Staff Report</u>		
	7pm		Case hand over taken from evening duty staff	
			ASIS bipolar hemianthoplasty plan - conservative management	
	8pm		Administered medication as per doctors orders	
	9pm		patient is conscious and oriented	
	10pm		monitor vital checked and recorded	
	11pm		patient has no any fresh complaint	
12/9/24	12am		patient is sleeping	
	5am		Bed making done	
	6am		monitor vital checked and recorded	
	7am		case hand over given morning duty staff	



[Signature]

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NURSES CHART

Patient Name Siva malamma Age 75y Sex F Ward Ortho P No 5044

Date	Time	Medication and Diet	Notes	Signature
12/10/20		Morning duty staff. Report		
	7Am	Case hand over taken from Night duty staff		
		Δ's Bipolar hemiarthroplasty		
	8Am	Administration medication as per doctor order		
	9Am	Dr Vamsi Simmonds followed Tablets formation corrected		
	10Am	Monitor vitals checked		
	11Am	Patient went in Physiotherapy		
12Pm	To provide a comfortable position			
1Pm	Case hand over given to Evening duty staff			

Glovy
09/11



[Signature]

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NURSES CHART

Patient Name: Syamalamma Age: 74 Sex: F Ward: Ortho IP No: 1204

Date: 12/9/24

Date	Time	Medication and Diet	Notes	Signature
		<u>Evening duty staff Report</u>		
	1:30pm	→ case handover taken from morning duty staff [Glory]		
		ASIS - Right cemented Bipolar hemiarthroplasty		
		Plan - conservative management		
	2pm	→ monitor vitals signs & Recorded		
	3pm	→ Health Education is given TOPIC - calcium diet		
	4pm	→ Patient is conscious & oriented.		
	5pm	→ Patient having no breath complaints.		
	6pm	→ monitor vitals signs & Recorded.		



[Signature]



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NURSES CHART

Patient Name: Syamalaamma Age: 18 Sex: F Ward: ICU IP No: 10117

Date	Time	Medication and Diet	Notes	Signature
	7 PM		Case handed over to night duty staff	<i>[Signature]</i>
			Night Duty Staff Report	
12/9/24	7 PM		Case handed over to evening duty staff	
			AS: Right arm of Bipolar hemianthopsia Plan: conservative management	
	8 PM		Administered medication as per doctors orders	
	9 PM		patient is conscious and oriented	
	10 PM		monitor vital checked and recorded	
	11 PM		patient have no any fresh complaints	
	12 AM		patient is sleeping	
13/9/24	5 AM		Bed making done	
	6 AM		monitor vital checked and recorded	
	7 AM		Case handed over given morning duty staff	<i>[Signature]</i>



[Signature]

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NURSES CHART

Patient Name Sybilakanni Age 51 Sex F Ward Ortho IP No 504

Date	Time	Medication and Diet	Notes	Signature
13/1/24		Morning duty, sub report		
	4am	This case handover taken from night duty staff		
		Assess Conscious level Homarthropathy patient is conscious & oriented		
	8am	Administer medications as given by doctor orders		
	9am	followed by Dr. Varni Sir rounds		
	10am	Monitor vitals & recorded.		
	11am	Health Education is given for personal hygiene		
12pm	Patient have no fresh complaints			
1pm	Case handover given to Evening duty staff			

[Signature]
10/2

[Signature]



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NURSES CHART

Patient Name Syamalanamma Age 74 Sex F Ward ortho I.P. No. 5044

Date	Time	Medication and Diet	Notes	Signature
<u>13/9/24</u>		<u>Evening duty staff</u>		
	<u>1pm</u>	<u>Case hand over taken from morning duty staff</u>		
		<u>Dr's (Rt) commented bipolar Hemorrhagic subclavary</u>		
	<u>2pm</u>	<u>Administered medications as per doctors orders</u>		
	<u>3pm</u>	<u>monitored vitals & recorded</u>		
	<u>4pm</u>	<u>Health education given about personal hygiene.</u>		
	<u>5pm</u>	<u>patient is conscious & stable</u>		
	<u>6pm</u>	<u>patient have no any fresh complaints.</u>		
	<u>7pm</u>	<u>Case hand over given to night duty staff.</u>		

Shree
Reddy

Shree



NURSES CHART

Name Syamsalamma Age 74 Sex F Ward ortho I.P. No. 5044

Date	Time	Medication and Diet	Notes	Signature
12/04		<u>Night duty staff report</u>		
	7 pm	Case hand over taken from evening duty staff		
		Asst cement cast by palan heri in the Plasty		
	8 pm	Administered medication as per doctors orders		
	9 pm	patient is conscious and oriented		
	10 pm	Monitor vital checked and recorded		
	11 pm	patient has no any fresh complaint		
	12 pm	patient is sleeping		
	5 Am	Bed making done		
	6 Am	Monitor vital checked and recorded		
	7 Am	Case hand over given to morning duty staff		

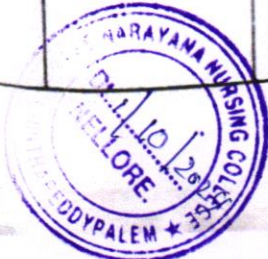


[Signature]
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NURSES CHART

Patient Name Syamalamma Age 75 Sex F Ward Ortho IP No 5044

Date	Time	Medication and Diet	Notes	Signature	
<u>14/9/24</u>		Morning duty staff Report			
	7 AM		This case handover taken from night duty staff		
			Dr. Computed Bipolar hemioctoplasty		
			Patient is conscious & oriented		
	8 AM		Administer medications as given by doctor orders.		
	9 AM		Followed by Dr. Parulk for removal.		
	10 AM		Monitor vitals & recorded.	<u>[Signature]</u> 1052	
	11 AM		Health education is given for personal hygiene		
12 PM		Patient have no fresh complaints			
1 PM		Case handover given to Evening duty staff			



[Signature]



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NURSES CHART

Name: Jamalamma Age: 75 Sex: F Ward: Ortho IP No: 5014

Time	Medication and Diet	Notes	Signature
<u>Evening Duty Staff Report</u>			
1 Pm	→ case handover taken from morning duty staff [Jhansi]	ASIS - Rt cemented Bipolar hemi prosthesis Plan - conservative management	
2 Pm	→ monitor vitals signs & recorded		
3 Pm	→ Health Education is given TOPIC - calcium diet.		
4 Pm	→ Patient is conscious & recorded		
5 Pm	→ Patient having no fresh complaints.		
6 Pm	→ monitor vitals signs & recorded.		
7 Pm	→ case handover given from night duty staff.		

14/9/24



[Signature]

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NURSES CHART

Patient Name Syca Malanona Age 70y Sex F Ward 4th I.P. No 50111

Date	Time	Medication and Diet	Notes	Signature
14/9/24			<u>Night duty staff Report</u>	
	1 pm		case hand over Inleen from evening duty staff	
			ASIA RT cemented Bipodan arthroplasty	
			plan - conservative management	
	8 pm		Administered medication as per doctors orders	
	9 pm		Doctors round and followed	
	10 pm		monitor vitals checked and recorded	
15/9/24	11 pm		patient have no any fresh complaints	
	12 Am		patient is sleeping	
	5 Am		Bed making done	
	6 Am		monitor vital checked and recorded	
	7 Am		case hand over given morning duty staff	

[Handwritten initials]



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NURSES CHART

Patient Name: Shunubaru Age: 78 Sex: F Ward: Ortho IP No: 50

Date	Time	Medication and Diet	Notes	Sign
5/1/24	7Am	Morning duty staff report Case hand over taken from night duty staff		
	8Am	Administered medications as per doctors orders.	AS (R) cemented bipolar hemiarthro plasty	
	9Am	monitored vitals & recorded		
	10Am	Doctors rounds followed		
	11Am	Health education given about personal hygiene		
	12pm	patient have no any fresh complaints.		
	1pm	Case hand over given to evening duty staff.		

[Signature]



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NURSES CHART

Patient Name Shamudani Age 78 Sex F Ward Ortho P No 3044

Date	Time	Medication and Diet	Notes	Signature
<u>15/9/20</u>			<p>Evening duty staff report</p> <p>10am base hand over taken from morning duty staff.</p> <p>Disist - (RM) amputated bipolar hemi arthroplasty.</p> <p>2pm Administred medications as per as doctor orders.</p> <p>3pm Patient is conscious & oriented</p> <p>4pm Health education is given (about personal hygin)</p> <p>5pm Patient walk freely. no complaints.</p> <p>6pm monitor vital signs recorded</p> <p>7pm base hand over given night duty staff.</p>	



[Handwritten Signature]



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NURSES CHART

Patient Name: Shamala Devi Age 78 Sex F Ward 01112 IP No 1

Date	Time	Medication and Diet	Notes	Signature		
<u>15/9/14</u>		Night duty staff report				
	7pm	Case hand over taken from evening duty staff				
	8pm	medication administered as per doctor orders				
	9pm	monitor vitals signs checked & recorded				
		health education given personal hygiene				
	10pm	patients conscious				
	11pm	patients have no fresh complaints				
		patients is sleeping				
	<u>16/9/14</u>	12AM	bed making done			
	1AM	monitor vitals signs checked & recorded				
6AM	case hand over given to morning duty staff					



[Handwritten signature]

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NURSES CHART

Patient Name Syamalamma Age 78y Sex F Ward Ortho No 1044

Date	Time	Medication and Diet	Notes	Signature
16/9/20			Morning duty staff report	
			7am care hand over taken from night duty staff	
			Asist - (R) comminuted bipolar hemiarthroplasty	
			• Patient is conscious & oriented	
			8am Administered medications as per doctor orders	
			9am monitor vital signs recorded	
			10am Doctor Routhu sir rounds finished	
		11am Patient has fresh no complaints Physiotherapy is done		

Sept 16
5592



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CLINICAL CHART

Pt Name		Syanalamma																													
Age		78y				Sex		F				Ward		F-0		Hosp No.															
DATE		5/9/24				6/9/24				7/9/24				8/9/24				9/9/24													
Day P.O. (or) P.P.																															
TEMPERATURE		A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.								
C	F	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10	2	6	10
41.1°	106°																														
40.5°	105°																														
40°	104°																														
39.4°	103°																														
38.8°	102°																														
38.3°	101°																														
37.7°	100°																														
37.2°	99°																														
36.6°	98°																														
36.1°	97°																														
35.5°	96°																														
Pulse		[Handwritten pulse values]																													
Respiration		[Handwritten respiration values]																													
Blood Pressure		[Handwritten blood pressure values]																													
Urine		[Handwritten urine values]																													
Stools		[Handwritten stool values]																													
Height		[Handwritten height values]																													
Insulin		[Handwritten insulin values]																													
Intake		[Handwritten intake values]																													
Output		[Handwritten output values]																													



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Pt Name		Age		Sex	Ward	Hosp No							
Syanalamma		78y		F									
DATE		10/9/24		11/9/24	12/9/24	13/9/24							
By PO (or) PP													
TEMPERATURE		AM		PM		AM		PM		AM		PM	
C	F	2	6	10	2	6	10	2	6	10	2	6	10
41.1°	106°												
40.5°	105°												
40°	104°												
39.4°	103°												
38.8°	102°												
38.3°	101°												
37.7°	100°												
37.2°	99°												
36.6°	98°												
36.1°	97°												
35.5°	96°												
Pulse of Sister		80		82	84	86	88	90	92	94	96	98	100
PULSE RATE		80		82	84	86	88	90	92	94	96	98	100
RESPIRATION		20		21	20	20	20	20	20	20	20	20	20
BLOOD PRESSURE		130/90		120/90	110/80	120/80	120/80	120/80	120/80	120/80	120/80	120/80	120/80
URINE													
STOOLS		0		0	0	0	0	0	0	0	0	0	0
WEIGHT/HEIGHT													
DIET		N/D		N/D	N/D	N/D	N/D	N/D	N/D	N/D	N/D	N/D	N/D
BLOOD TRANSFUSION		-		-	-	-	-	-	-	-	-	-	-
TOTAL INTAKE		-		-	-	-	-	-	-	-	-	-	-
TOTAL OUTPUT		-		-	-	-	-	-	-	-	-	-	-





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CLINICAL CHART

Pt Name Syomalamma Age 78 Sex F Ward 4 Hosp. No. 5044

DATE 15/9/24 16/9/24

Day PO. (or) P.P.

TEMPERATURE A.M. P.M. A.M. P.M. A.M. P.M. A.M. P.M. A.M. P.M. A.M. P.M.

C F 2 6 10 2 6 10 2 6 10 2 6 10 2 6 10 2 6 10 2 6 10 2 6 10

41.1° 106°

40.5° 105°

40° 104°

39.4° 103°

38.8° 102°

38.3° 101°

37.7° 100°

37.2° 99°

36.6° 98°

36.1° 97°

35.5° 96°

Sign of Sister

PULSE RATE

RESPIRATION

BLOOD PRESSURE

URINE

STOOLS

HEIGHT/WEIGHT

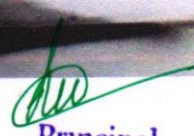
FOOD

CONFUSION

FLUID INTAKE

FLUID OUTPUT




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DIET PLAN SHEET

PATIENTS NAME Syamalamma AGE / SEX 78y / F IP NO _____

Doctor		Dietitian		Nurse Sign with date & Time
DATE & TIME	Diet order with Signature	DATE & TIME	Notes with Signature	
<u>19/11</u>	<u>✓</u> <u>Subal</u> <u>(N)</u> <u>Dud En</u>			<u>[Signature]</u>

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BILLING ABSTRACT

DETAILS	Amount	ADVANCE PAYMENT		
		Date	Receipt No.	Amount
1. Room / Bed Charges				
2. Consultant Fees				
1.				
2.				
3.				
3. Intensivist Charges				
4. Surgeons Fees				
5. Asst. Surgeon Fees				
6. Anaesthetist Fees				
7. Delivery Charges				
8. O.T. Charges				
9. I.C.U. Charges				
10. Intensivist Fee				
11. Intensive Nursing Charges				
12. Nursing Charges				
13. Duty Doctor Charges				
14. Laboratory Charges				
15. Radiology Charges				
16. OT/ICU/NICU Consumable Charges				
17. Special Test Charges				
PFT, TMT, 2D Echo				
18. Medical Equipment Charges				
A.				
B.				
C.				
19. Special Procedure Charges				
A.				
B.				
C.				
20. Oxygen Charges				
21. Telephone Charges				
22. Miscellaneous-1				
23. Miscellaneous-2				
Grand Total				
		Grand Total		
		(-) Advance		
		Total Balance		



[Handwritten Signature]

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NON - DRUG ORDERS

(TO BE FILLED BY DOCTORS)

Patients name

Syamamma

Age / Sex

78y

IP No

5044

Date & Time

NON - DRUG ORDERS

Sign with Name

Note : Please use this page for ordering diet, physiotherapy or any other non-drug orders!

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PATIENT AND FAMILY EDUCATION CHART

Patient Name Syamalanama AGE / SEX 75y/F IP NO 5044

Date & Time	INFORMATION PROVIDED	TO whom	PATIENT (OR) PATIENT ATTENDANT SIGN	EDUCATORS SIGNATURE WITH NAME
	<p>అధ్యయనం వల్ల వచ్చిన కుటుంబ సభ్యులకు ఆరోగ్యం → పాఠం అందించారు</p>			



Use for Special / Teller made. To be filled by the person who educated patient and family
Nurses, Doctors, Physiotherapist etc.

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Patient's Name

Syamalamma

Age / Sex

8y/8

IP NO

5044

GENERAL CONSENT

I, Syamalamma

(Patient's Name), Aged 7y

S/o W/o D/o

hereby declare that I am

willingly getting admitted in Narayana Medical College & Hospitals for my treatment as advised by my consultant

Dr. Dr. Rohith under the following conditions

- 1) I will make all others related to me / patient, agree & abide by the rules and regulations of the hospital including visiting hours which are conveyed to us by the hospital staff.
- 2) I will take full responsibility to clear all dues to the hospital and promise to deposit sufficient advance amounts to meet emergency treatment, also as and when payment slips are issued according to the experience.

The above points have been explained to me in the language (Telugu) which I understand by Mr / Mrs / Dr. Dr. Rohith of Narayana Hospital. This consent is given by me in my full senses and on my own free will.

Admission: Executive / CMO

Patient / Patient Representative

Signature

Signature

Place

Place

Date

Date

Contact No



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CONSENT FOR SELECTION OF ROOM

PATIENT'S NAME Syanaamma AGE / SEX 78y / F IP NO 5644

SELECTION OF ROOM

I/We have been explained in detail the difference in the following Room Tariff for various types of Rooms available and I/We have selected the room as per my/our choice.

- 1 Cubicle (General Ward)
- 2 Semi Private (Non A/C Sharing)
- 3 Semi Private Deluxe (A/C Sharing)
- 4 Private (Non A/C Single)
- 5 Deluxe Private (A/C Single)
- 6 Suite

Name of Patient / Relative

Date: _____

Signature

Time: _____

CHANGE OF ROOM

I/We have been explained in detail the difference in Room Rent, Surgery Package and difference in Investigation Charges for the types of Room. I/We have selected the room which is available in the Hospital

- 1 Cubicle (General Ward)
- 2 Semi Private (Non A/C Sharing)
- 3 Semi Private Deluxe (A/C Sharing)
- 4 Private (Non A/C Single)
- 5 Deluxe Private (A/C Single)
- 6 Suite

Name of Patient / Relative

Date: _____

Signature

Time: _____

CREDIT

I/We/Am are eligible for _____

I/We opted for _____

agree to pay the difference of the amount over & above the Company / Corporate eligibility

Date: _____

Name of Patient / Relative

Time: _____

Signature

DUAL OCCUPANCY

I/We here by agree to take the private / deluxe room at additional cost for attenders usage, as our patient is staying in AMCU / SICU / ICCU / CTICU. In case of an emergency when the hospital needs the bed for a patient's hospital, I/We will willingly oblige to vacate the room.

Date: _____

Time: _____



[Signature]

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NARAYANA
Medical College & Hospital

గది ఎంపిక / సమ్మతి

లోగి పేరు

UMR నంబరు IP నంబరు

గది ఎంచుకొనుట

నాకు / మాకు ఆసుపత్రిలో లభించు వివిధ రకాల గదుల గురించి, వాటి ఆర్టింగులోని సేదాలు వివరించబడినవి. వీటిని మేము మా ఇష్ట ప్రకారము శ్రీందివాటి నుండి ఎంచుకొనుచున్నాము.

1. క్యూబిక్లర్ (జనరల్ వార్డు)
2. సెమి ప్రైవేటు (నాన్ ఎగ్జి ప్రైవింగ్)
3. సెమి ప్రైవేటు డీలక్సు (నాన్ ఎగ్జి ప్రైవింగ్)
4. ప్రైవేటు (నాన్ ఎగ్జి సింగిల్)
5. డీలక్సు ప్రైవేటు (ఎగ్జి సింగిల్)
6. సూట్

లోగి/ బంధువు పేరు

సంతకము తేదీ
..... సమయం

గదుల మార్పు

నాకు / మాకు గది అద్దె, శస్త్ర చికిత్సల ప్యాకేజీ మరియు గదులు యొక్క రకాలు, పరిశోధన ఛార్జీల వ్యత్యాసాలను వివరించు వివరించబడినవి.

1. క్యూబిక్లర్ (జనరల్ వార్డు)
2. సెమి ప్రైవేటు (నాన్ ఎగ్జి ప్రైవింగ్)
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6. సూట్

లోగి/ బంధువు పేరు

సంతకము తేదీ
..... సమయం

క్రెడిట్

నేను / మేము గదిలో ఉండుటకు అర్హత కల్గియున్నాము. కానీ

మేము గది కేసుకోసం దానిని అద్దె గది ఛార్జీల వ్యత్యాసము, కంపెనీ, లోగి

లోగి / బంధువు పేరు

సంతకము తేదీ
..... సమయం

ద్వంద్వ వాడుక (Dual Occupancy)

మా లోగి AMCU/SICU/CCU/CTICU లో ఉంటున్నందున అతని / ఆమె సహాయకుల వాడుక కోసం అదనపు ఛార్జీ

డీలక్సు గది కేసుకోసం దానిని అందుమూలముగా నేను / మేము అంగీకరిస్తున్నాము.

ఒకటి అక్కడను సమయములో వేరే లోగి ఆసుపత్రిలో వేరు సమయంలో మరలం అనుభవమైనచో అవసరం

ఉద్దేశ్యముతో లోగి చేయుటకు అంగీకరిస్తున్నాము.

నేను / మేము

సంతకము తేదీ
..... సమయం



[Signature]
Principal

NARAYANA MEDICAL COLLEGE & HOSPITAL

Chinthareddypalem, Nellore - 524 003. A. P. INDIA.
Ph : 0861 - 2355511



NARAYANA
Medical College & Hospital

PAIN ASSESSMENT SCALE

PATIENTS NAME Syamalanima

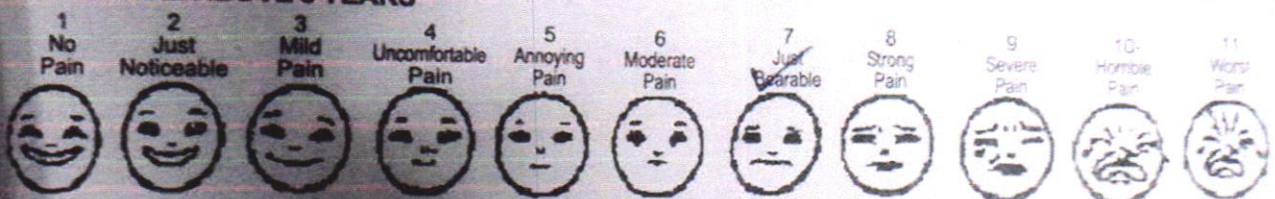
AGE / SEX 78y/f

IP NO 5044

Pain Scale : 0-5 YEARS

Category	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn disinterested	Frequent to constant quivering chin Clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging	Difficult to console or comfort

PAIN SCALE: ABOVE 5 YEARS



PATIENT FALL RISK ASSESSMENT SCALE

RISK FACTOR	SCALE	SCORE	FALL SCORE
1. HISTORY OF FALLS	Yes	25	HIGH RISK 45 AND HIGHER
	No	0	
2. SECONDARY DIAGNOSIS	Yes	15	MODERATE RISK 25-44
	No	0	
3. AMBULATORY AID	Furniture	30	LOW RISK 0-24
	Crutches / Cane / Walker	15	
4. IV / HEPARIN LOCK	Non / Bedrest / Wheel	0	9. REMARKS
	Chair / Nurse		
5. GAIT / TRANSFERRING	Yes	20	
	No	0	
6. MENTAL STATUS	Impaired	20	
	Weak	10	
	Normal / Bedrest / Immobile	0	
	Forgets Limitations	15	
	Oriented To Own Ability	0	

7. PATIENT FALL RISK ASSESSMENT SCORE (TOTAL)

Tick (High Risk / Moderate Risk / Low Risk)

Sign with Name

Time : Date :

"CONFIDENTIAL"



Principal
SREE NARAYANA NURSING COLLEGE
Chinthareddypalem,
NELLORE-524 002