

DISCHARGE SUMMARY

Patient Name	MPI	IP#	Gender	Blood Group	Age	Marital Status
B/O Akanksha Chawla	1000000102051963	31556	Male	"A" Positive	3D	Single
Admission Date	Discharge Date	Admission Time			Discharge Time	
18-05-2024	21-05-2024	08:56 am			09:00am	
Admission Purpose	Date of surgery	Admitting Physician			Hospital Days/Nights	
New Born	NIL	Dr. Saurabh Kataria			3D	
Department	Ward	Room			Bed	
PEDIATRICS	FOURTH FLOOR	SUITE 3			SUITE 3 C1	

Discharge Type : On Doctor's Advice

CONSULTANT NAME : DR. SAURABH KATARIA

Final Diagnosis : Term (38 + 2 Weeks) / AGA / LSCS

BIRTH History :

G2 E1- Mother delivered BY LSCS

No resuscitation required

APGARs (1 min, 5 mins) 7,9 Respectively

Date of Birth : 18-05-2024, Time of Birth : 08:37 AM , MBG : "A" Positive

ANTHROPOMETRY :

Birth weight : 2.66 Kg, Birth OFC : 32 cm, Birth Length : 47 cm

COURSE DURING HOSPITAL STAY :

Baby was roomed in with mother & started on Breast feed soon after rooming in.

Baby passed urine & meconium after birth. There was no facial dysmorphism.

No obvious congenital abnormality detected, no facial dysmorphism.

Red reflex present bilateral.

Screening for DDH (Ortolani, Barlow): Negative

Pulse screening Screening for Critical CHDs: Negative

Vaccination (BCG, OPV, HepB1) : Done on 18-05-2024

INVESTIGATION :

BBG: "A" Positive (Pulse oxymetry screening : WNL)

Disclaimer : Final blood group should be confirmed again at 6 months of life

Discharge Weight : 2.440 KG, TCB : 14.2 mg/dl

GUTHRIE TEST : Done report awaited collect after 1 week

HEARING SCREENING : Both side ear pass



ADVICE AT DISCHARGE :

1. Breast feeding ad lib
2. Immunization as per schedule
3. DROP'S KIDRICH D3 0.5 ML ONCE DAILY FOR 12 MONTHS
4. BERA TEST TO BE DONE AT AGE OF 3 MONTHS
5. Keep baby warm, maintain asepsis Avoid Handling by visitors



Cloudnine Hospital™

KIDS CLINIC INDIA LTD.

C-9, Sector 51, New Okhla Industrial Development Area,
Gautam Budh Nagar, Noida - 201301, Uttar Pradesh

Phone : 99729 99729

www.cloudninemcare.com

DISCHARGE SUMMARY

EMERGENCY CONDITION :
Not waking up despite repeated stimulation for more than 4-6 hrs OR lethargic

- 1) Not waking up despite repeated stimulation for more than 4-6 hrs OR lethargic
- 2) Blue or Yellow discoloration of Skin.
- 3) Temp. >100 F for more than 12 hours
- 4) Not Passing Urine for more than 12 hrs
- 5) Difficulty in breathing.....

FOLLOW UP ADVICE : Review In OPD ON 23-05-2024 WITH DR. SAURABH KATARIA with prior appointment.

Kindly meet our Lactation Consultant for a Breastfeeding Follow Up two days post discharge.

In Case of symptoms like fever /pain in abdomen, vomiting, Giddiness or for any emergency please contact Cloudnine Hospital Noida
Emergency Helpline no 6230956230

Baby's Birth certificate acknowledgement Please contact Mr. Varun (MRD Department) 8799744886, 9643009784

DISCLAIMER : This discharge summary is prepared as per information given by consultant In charge of patient .Any discrepancies /inconsistencies to be addressed to the consultant

DR. SAURABH KATARIA

CONSULTANT

.....
Name & signature of the Consultant

DR. ROBIN

REGISTRAR

.....
Name & signature of the Registrar

GRE Verification : I , herein below signed confirm that i have checked all demographic details of the concerned patient & I confirm that they are correct & true

GRE Name : SAFI AHMAD

Signature :

Date : 21-05-2024

Registrar Verification : I , herein below signed confirm that i have checked all the medical details of the concerned patient & I confirm that they are correct & true





DISCHARGE SUMMARY

Registrar Name : DR. ROBIN
Signature : 
Date : 21-05-2024

Patient /Husband's /Parent(s) Verification : I, herein below signed confirm that I have verified all the relevant details in this discharge summary which includes date of admission , date of birth , date of discharge & the details of all the medical services provided & I acknowledge that the details are correct including the testes conducted .

I further acknowledge that I have received all the original copies of the test reports (including MRI & CT) & I acknowledge & agree that in no event hospital shall provided duplicate copies of MRI & CT reports

Name : (Father /Mother/Husband/Legal Guardian)
Relationship :
Signature: Date :

