



**DISCHARGE SUMMARY**

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Patient Name	: MS MALINI KANAGASABAPATHI	Patient Id	: 0002408192
Address	: PH:8, DR:4,2ND STREET MEENAKSHI AVE, OLD PERUNGALATHUR, CHENNAI TAMILNADU	IpNo	: 201811_001474844
		Age/ Gender	: 28 Years / FEMALE
Senior Consultant	: Dr. USHA RANI .G	Admit Date	: 22/11/2018
Consultant	: Dr. USHA RANI .G	Discharge Date	: 24/11/2018
Associate Consultant	: Dr.	Discharge Status	: RECOVERED
Assistant Consultant	: Dr.	Ward / Bed	: F4 / 4620
Department	: O B & G	Reg..No	:
Referral Doctor	: Dr.		

**FINAL DIAGNOSIS:** P1 L1 A1/SPONTANEOUS VAGINAL DELIVERY WITH  
EPISIOTOMY/HYPOTHYROID

**PROCEDURE DONE:** SPONTANEOUS VAGINAL DELIVERY WITH EPISIOTOMY ON 22/11/18.

**DRUG ALLERGY :** NIL

**ADMISSION COMPLAINT &  
BRIEF HISTORY OF  
PRESENTING ILLNESS:**

Informant: Self  
Reliability: Good  
Chief Complaints:  
LMP-18/02/2018  
EDD-25/11/18

Booked G2 A1 at 39 weeks + 2 days hypothyroid, previous second trimester abortion in view of down syndrome at 24 weeks in early labour. Complaints of pain abdomen on and off. No complaints of leaking or bleeding p/v. Perceives fetal movements well.

**HOPI:**

First trimester – Spontaneous conception. Confirmed by UPT at 45 days of amenorrhea. Dating scan done and dates corresponding. T. Folvite taken regularly. No history of drug exposure, radiation exposure, fever with rash. NT scan done. NT 2.6 mm amniocentesis done, normal karyotype. FISH normal. History of hyperemesis at 8 weeks.

Second trimester – Quickening felt at 5th month. T. Iron and calcium taken regularly. No history of elevated BP or blood sugars. Anomaly scan done and anomalies ruled out. Inj. TT two doses taken one month apart.

Third trimester – Continues to perceive fetal movements well. Growth scan done

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showed HC and FL more than 90th percentile. No history of elevated BP or blood sugars now admitted in early labour. Now admitted for further management.

**PAST MEDICAL HISTORY:** Not a known case of diabetes mellitus, hypertension, asthma, tuberculosis, epilepsy, cardiovascular disease. Known case of hypothyroidism on T. Thyronorm 25 mcg od.

**PERSONAL HISTORY:** Normal bowel and bladder habits.  
Normal appetite.

**PAST SURGICAL HISTORY:** Appendicectomy done at 10 years of age.

**OBSTETRIC/MENSTRUAL/MARITAL HISTORY:** Obstetric History:  
G1 – 2017 – MTP at 24 weeks in SRMC in view of down syndrome. Karyotyping abnormal. FISH indicative of Down's syndrome.

Menstrual History: Menarche attained at 12 years, menstrual cycle irregular 4-5/2-3 months.

Marital History: Married for 2 years, Nonconsanguineous marriage.

**PHYSICAL EXAMINATION:** Temperature – afebrile.  
PR – 82/min.  
RR – 15/min.  
BP – 110/80 mmHg.  
Height – 157 cm.  
Weight – 100.2 kg  
No pallor, icterus, cyanosis, clubbing, lymphadenopathy or edema  
Thyroid and breast clinically normal  
CVS - S1, S2 +.  
RS – bilateral air entry present  
CNS - No focal neurological deficit.  
P/A – Uterus corresponds to term size  
Relaxed  
Cephalic  
Clinically liquor normal  
FH present.  
P/V- Cervix soft, posterior  
1.5cm long  
3-4cm dilated  
Membranes forming  
PPVx@ -2 station



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LAB INVESTIGATIONS: **ENCLOSED**

IMAGING: **ENCLOSED**

COURSE IN THE HOSPITAL: Patient was admitted with the above mentioned complaints and all baseline investigations were done and found to be within normal limits. Hemoglobin done on 17/11/18 was 11.7. AFI was 15.7. Blood grouping done on 16/05/18 was B positive. Patient went into spontaneous labour. Labour was augmented with Inj. Oxitocin and with good uterine contractions patient delivered by spontaneous vaginal delivery with episiotomy on 22/11/18.

Baby details:

B – Boy

A – 8/10, 9/10

B – 3.20 kg

Y – 22/11/18 at 9:36 PM

P.no - 4441/18

M.no- 406/11

Postoperative period was uneventful. Baby kept on mother side on demand breast feed. Baby and mother are healthy , symptomatically better and hence being discharged with the following discharge medication.

CONDITION AT DISCHARGE: Vitals stable  
P/A – uterus well contracted.

L/E:

Epi intact.

Bleeding within normal limits.

Drugs	Morning (7.30-8.30 am)	Afternoon (1-2 pm)	Night (7.30-8.30 pm)	No Of Days	Frequency	RelationShip With Food
T. Taxim O 200 mg	1	0	1	x 3 days	bid	
T. Rantac 150mg	1	0	1	x 3 days	bid	
T. Dolo 650 mg	1	1	1	x 3 days	tid	
T. Thyronorm 25 mcg	1	0	0	to continue	od	
T. Metrogyl 400 mg	1	1	1	x 3 days	tid	
T Axfer Plus	1	0	0	x 3 months	od	
T. Dencal 500 mg	0	0	1	x 6 months	at bed time	
T Bact ointment for L/A				x 1 week		

## DISEASE SPECIFIC DISCHARGE ADVICE

Diet :

# DISCHARGE SUMMARY

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Wound Care Related: Keep wound dry

Ambulation Related/Resumption of Activities: Watch for pain abdomen or bleeding p/v.  
Postnatal exercises  
Temporary methods of contraception

Disease Related Discharge Advice : Avoid sitting cross legged or squatting.  
Avoid lifting heavy weights or straining.

Continuing Needs if any :

Special Education Needs:

To Obtain Emergency care if / Emergency review Particulars

If you have any one of the following signs and Symptoms, please call your doctor immediately or come to emergency department.  
Fever more than 100°F.

Follow up Appointment : DR USHA RANI

at C2 PVT CLINIC

On 11/12/2018

Name Of the Consultant Dr. USHA RANI .G

Reg No:

Dictated By : Dr. Pallavi

Name Of the person receiving Discharge Summary :

Signature:

Transcribed By 07654

Approved By:

Checked By Dr Sadhana

Relationship to the patient:

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## PLEASE CONTACT

Consultation appointment : Dr. USHA RANI .G

O B & G

/ C2

Direct Number : 044 - 4592 8518

Board Number : 044-45928500 Ext:-326 /8895

**KINDLY CONFIRM YOUR APPOINTMENT FOR YOUR REVIEW VISIT**

**EMERGENCY Please Contact : 044 - 40012345**

**AMBULANCE SERVICES : 044 - 24768402 / 044 - 40012345 / 9840999809**



**TO BOOK ONLINE APPOINTMENT**

**<https://www.sriramachandramedicalcentre.com>**

**ONLINE HELP DESK : 044 - 4592 8692**

*Copy to: patient/chart/primary Physician/Referral Doctor*



**SRI RAMACHANDRA MEDICAL CENTRE**  
**PORUR, CHENNAI-600116.**  
**CLINICAL PATHOLOGY**

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**Patient Name & Address**

MS MALINI KANAGASABAPATHI  
 PH:8, DR:4, 2ND STREET, MEENAKSHI AVE, OLD  
 PERUNGALATHUR, CHENNAI, TAMILNADU, INDIA

Ward : F4

Bed: 4620

**Referring Doctor**

USHA RANI .G

**Department**

O B & G

Patientid : 0002408192		AGE : 28	SEX : FEMALE	Name : MS MALINI KANAGASABAPATHI	
ResDate	Test Name		Result	BiologicalReference Interval	Unit
CLINICAL PATHOLOGY					

**CLINICAL PATHALOGY**

22/11/2018

ROUTINE URINE COMPLETE ANALYSIS (AUTOMATED)	-			
COLOUR (URINE)	Straw Yellow / Clear	-		
PH (URINE)	6.0	4.8-7.4		
SPECIFIC GRAVITY (URINE)	1.010	1.016-1.022		
GLUCOSE (URINE)	NEGATIVE	NEGATIVE	<30 mg/dl	
PROTEIN (URINE)	NEGATIVE	NEGATIVE	<10 mg/dl	
BILIRUBIN (URINE)	NEGATIVE	NEGATIVE	<0.2 mg/dl	
KETONE (URINE)	NEGATIVE	NEGATIVE	<5 mg/dl	
UROBILINOGEN (URINE)	NEGATIVE	NEGATIVE	<1 mg/dl	
ERYTHROCYTE	5+	NEGATIVE	<0-5 Ery/μL	
NITRITE	NEGATIVE	NEGATIVE		
LEUKOCYTE	NEGATIVE	NEGATIVE	<10 Leu/μL	
SEDIMENT (URINE)	-			
RBC	4.60	0-2	/ HPF	
PUS CELLS	2.70	<5 Cells	/ HPF	
SEC (Squamous Epithelial Cells)	8	0-4	/ HPF	
NEC (Non Squamous Epithelial Cells)	1	0-4	/ HPF	
CASTS	NIL	NIL	/ HPF	
CRYSTALS	NEGATIVE	NIL	/ HPF	
YEAST BUDS	NEGATIVE	NEGATIVE	/ HPF	
BACTERIA	2+	NEGATIVE	/ HPF	
HYALINE CAST	NEGATIVE	NIL	/ HPF	
MUCUS	POSITIVE	NEGATIVE		
OTHERS (URINE)	-	-		

**SRI RAMACHANDRA MEDICAL CENTRE**  
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**BLOOD BANK**

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SEX : FEMALE

Name : MS MALINI  
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**BLOOD BANK**

1

UNEXPECTED RED CELL ANTIBODY SCREEN

NEGATIVE

C 12122

Done By : RS

Checked By : 19250

Released By : 19250

**BE A BLOOD DONOR SAVE A LIFE**

All investigations have their limitations which are imposed by the limits of sensitivity and specificity of individual assay procedures as well as the quality of the specimen received by laboratory. Isolated laboratory investigations never confirm the final diagnosis of the disease. They only help in arriving at a diagnosis in conjunction with clinical presentation and other related investigations. The contents of this report may be used for statistical analysis and research purpose in this institute. PARTIAL REPRODUCTION OF THIS REPORT IS PROHIBITED.