



ஸ்ரீ மணக்குள விநாயகர்
மருத்துவக் கல்லூரி
மற்றும் மருத்துவமனை
கலிதீர்த்தாள்குப்பம், புதுச்சேரி-605 107.

OUT PATIENT BOOK

Name

பெயர்

Address

முகவரி

Age

வயது

Sex

இனம் :

Hospital No.:

ம. எண் :

Date :

தேதி :

Hospital No : 019579
Reg. Date : 19-05-2005 12:00 AM
Name : ~~XXXXXXXXXX~~
S/o : PALANI
Age & Sex : ~~XXXXXXXXXX~~
Address : pandiyan nagar
9751111161 VILLUPURAM
VILLUPURAM
Department :

**SRI MANAKULA VINAYAGAR
MEDICAL COLLEGE AND HOSPITAL**

Kalitheerthalkuppam, Madagadipet,
Puducherry - 605 107. ☎ : 0413 - 2643000
E-mail : principal@smvmch.ac.in Website : www.smvmch.ac.in

மறுமுறை வரும்போது இந்த புத்தகத்தை தவறாமல் எடுத்து வரவும்

4.2.2
D)

Dr. KAGNE. R.N
DEAN
SRI MANAKULA VINAYAGAR
MEDICAL COLLEGE & HOSPITAL
KALITHEERTHALKUPPAM,
PUDUCHERRY-605107.

இலவச பரிசோதனைகள்

BIO-CHEMISTRY


- ❖ Glucose Fasting
- ❖ Glucose PP
- ❖ Glucose Random
- ❖ Urea
- ❖ Creatinine
- ❖ Cholesterol
- ❖ Triglycerides
- ❖ Glucose tolerance Test (Routine)
- ❖ Glucose tolerance Test (pregnancy)
- ❖ Glucose Challenge Test (GCT)

HAEMATOLOGY

- ❖ Haemoglobin (Hb)
- ❖ Haematocrit (PCV)
- ❖ RBC Count
- ❖ Total Leucocyte Count (TC)
- ❖ Differential Count (DC)
- ❖ Platelet Count
- ❖ Erythrocyte Sedimentation Rate (ESR)
- ❖ Bleeding Time (BT)
- ❖ Clotting Time (CT)
- ❖ Urine Routine

MICROBIOLOGY

- ❖ Sputum AFB
- ❖ Stool Ova / Cyst
- ❖ HIV, VDRL
(TB & Chest,
Dermatology,
Antenatal Cases)


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4 JAN 2023

OPD INITIAL ASSESSMENT FORM

Presenting Complaint :

~~Shortness of breath~~

- 45/M.
- Co-morbidities (CAD → Diagnosed EAM²
(2008), Thrombolytic
✓ on T → (yes unknown)
✓ DVT in both lower limb
(Byem back) → on T. Dabigatran
✓ Diagnosed as Hypertension

Allergy : Yes / No, if Yes At present none

Past Health History : Review. No specific
complaint present

Previous Hospitalization : Hypertension

Diabetes Asthma

TB Smoking Alcoholism

Others stopped since
1 year

Family History

Diabetes Hypertension Heart Disease

Kidney Disease Others Hypercholesterolemia (+)

Physical Examination :

Height cms, Weight Kgs, RR

B.P. 150/100 mmHg, Pulse rate : 87/min, Temp: °F

Pallor : No / Yes, Icterus : No / Yes, Cyanosis : No / Yes,

Others (+) leg edema (+) (low pitting)

Systemic Examination :

RS : N VIBS ⊕
 no added sounds

CVS : S₁ S₂ ⊕
 no murmur/no added sounds

G.I : Soft / NO organomegaly

CNS : Conscious / oriented
 no focal Neurological Deficit

Others :

Provisional Diagnosis :

Care Plan :
 ✓ Hemodynamic
 ✓ Post-Hypertensive CVT & DVT

Investigations :
 ✓ CAD (Thrombolysis)
 2017

? Newly Diagnosed IHT -
 to Review

Final Diagnosis :

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Treatment Plan

Sl. No.	Drugs	Duration
	<u>Plan</u>	
①	Alcohol & Smoking Abstinence to continue.	5
②	Lifestyle changes has been explained	
③	Check Blood pressure & weight maintain BP chart (Home monitoring)	
④	Review E BP chart	
⑤	Continue T. <u>Dabigatran</u>	

Review Date : 18.7.22. E BP chart
 (Home monitoring)

Doctor's Name Dr. Premkumar Sign. [Signature]

Date & Time : 07.07.22.
 12:50 PM

Dr. G. PREM Kumar, M.D.,
 Regn. No: 82692
 Associate Professor
 Dept. of General Medicine
 Sri Manakula Vinayagar Medical College & Hospital
 Madagadipet, Pondicherry



Sri Manakula Vinayagar Medical College and Hospital



Kalitheerthalkuppam, Madagadipet, Puducherry - 605 107.

INPATIENT ADMISSION FORM

(To be filled in by the Admitting Doctor)

MLC Yes NO

MLC No

Name of Patient with Address  * B 2 5 6 5 4 8 * B256548 - 65/Male S/o: MAYIL ANANTHAM		Age & Sex
Hospital No. B256548	Date & Time of Admission 19/1/23 07.10 PM	
Admitting Department / Unit GM-4	Ward M.Med	
Professor Prof. Dr. S. GIRIJA	Provisional Diagnosis - AFI - Dengue?	
Probable duration of stay at hospital	3-5 days.	
Proposed Surgery / Procedure	-	
Admitting Doctor / Unit	Name	Dr. S. Madhan Kumar
	Signature	 DR. S. MADHAN KUMAR, M.D., Regd. No: 98504 ASSISTANT PROFESSOR DEPARTMENT OF GENERAL MEDICINE Sri Manakula Vinayagar Medical College & Hospital Kalitheerthalkuppam, Puducherry - 605 107.
	Designation	AP
	Date & Time	19/1/23. 07.10. PM

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MEDICAL COLLEGE & HOSPITAL
KALITHEERTHALKUPPAM,
MADAGADIPET, PUDUCHERRY-605 107.

AUTHORISATION FOR TREATMENT / PAYMENT

(To be filled in at the Admission Counter)

I hereby authorise the administrators, medical, nursing, and paramedical staff of SMVMC hospital to investigate, treat and administer such drugs as may be necessary and to perform such operations/Procedures under anaesthesia or otherwise as may be deemed necessary and/or advisable in the diagnosis and treatment of my illness.

I..... (Relationship)
I hereby authorise on behalf of

the administrators, medical, nursing and paramedical staff of SMVMC hospital to investigate, treat and administer such drugs as may be necessary and to perform such operations under anaesthesia or otherwise as may be deemed necessary and/or advisable in the diagnosis and treatment of his illness.

I also undertake to settle all the bills due to the hospital on a periodic basis and in any case before getting discharged from the hospital.

In case of default, I authorise the hospital authorities to proceed against me legally as well to transfer me/the patient to any other hospital for further treatment at my own cost.

I also acknowledge having been informed of the rules and regulations of the hospital and will abide by it

I will not hold the hospital responsible for the loss of my personal belongings.

I have read all / have been explained of the contents of this form in my vernacular.

சிகிச்சை மற்றும் பணம் செலுத்துதற்கான ஒப்புதல் வழங்குதல்

இதன் மூலம் நான் இம்மருத்துவமனையின் நிர்வாகம், மருத்துவர், செவிலியர் மற்றும் மருத்துவ ஊழியர்கள் எனக்குத் தேவையான சோதனைகளை செய்து மருந்துகள் கொடுக்கவும், மயக்கமருந்து கொடுத்து அறுவை சிகிச்சை மற்றும் அறுவை சிகிச்சை சார்ந்த சோதனைகளையும் செய்யவும் அதிகாரம் அளிக்கிறேன்.

திரு..... அகிய
நான்..... அவர்
சார்பாக இம்மருத்துவமனையின் நிர்வாகம், மருத்துவர், செவிலியர் மற்றும் மருத்துவ ஊழியர்கள் எனக்குத் தேவையான சோதனைகளை செய்து மருந்துகள் கொடுக்கவும், மயக்கமருந்து கொடுத்து அறுவை சிகிச்சை மற்றும் அறுவை சிகிச்சை சார்ந்த சோதனைகளையும் செய்யவும் அதிகாரம் அளிக்கிறேன்.

மேலும் இம்மருத்துவமனையில் ஆகும் செலவுகளை அவ்வப்போது செலுத்தவும், எப்படியும் மருத்துவமனையிலிருந்து அனுப்பப்படுவதற்கு முன்பு எல்லா செலவினங்களையும் செலுத்தத்தவறாமாட்டேன் என்பதற்கும் உறுதியளிக்கிறேன்.

ஒருவேளை அப்படி பணம் செலுத்தத் தவறினால் என் மீது சட்டபூர்வமான நடவடிக்கை எடுக்கவும் என்னை / நோயாளியை வேறு மருத்துவமனைக்கு என் சொந்த செலவில் மாற்றம் செய்யும் மருத்துவமனைக்கு அதிகாரம் அளிக்கிறேன்.

மருத்துவமனையின் சட்டதீடல்கள் பற்றி எனக்குப்பிரியும்படி எடுத்துக்கூறப்பட்டது. அவற்றை நான் கடைப்பிடிப்பேன் என்றும் உறுதியளிக்கிறேன்.

என்னுடைய உடைமைகள் மற்றும் பணம்போன்றவை காணாமல் போனால் மருத்துவமனையை எந்த விதத்திலும் பொருப்பாக்க மாட்டேன்.

மேற்கூறிய அனைத்தையும் நான் படித்து தெரிந்து கொண்டேன். எனக்கு விளங்கும்படி எனது மொழியில் எடுத்துக்கூறப்பட்டது என்பதையும் தெரிவித்துக்கொள்கிறேன்.

Signature of Admitting Authority
அனுமதியாளர் கையொப்பம்

TRUE COPY ATTESTED
DEAN
SRI MANJULA VINAYAGAR
MEDICAL COLLEGE & HOSPITAL
KALITHEERTHALKUPPAM,
MADAGADIPET, PUJUCHERRY-605 107.

Signature of Patient / Relative
நோயாளி / உறவினர் கையொப்பம்
Nature of Relationship
உறவு முறை

Name :
Date :



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Kalitheerthalkuppam, Puducherry - 605 107.

TA FORM

Hospital No : B256548
 D.O.A. : 19-01-2023
 Name : ~~XXXXXXXXXX~~
 S/o : ~~XXXXXXXXXX~~
 Age & Sex : ~~XXXXXXXXXX~~
 Address : SOUTH ST
 9159987135 PERIYAKATTUPALAYAM
 CUDDALORE,
 Department : GENERAL MEDICINE

Hospital No.	
MLC <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	MLC No.
Married <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Ward M. Med. 302	Bed No.

Date & Time of Admission 19.01.23 @ 11.00 AM	Date of Surgery -	Date & Time of Discharge 28/1/23 @ 4.30 PM	No. of days in the hospital 9 days
Admitting Department G.M.		Unit IV	
Condition of the Patient at Discharge		<input type="checkbox"/> Cured <input type="checkbox"/> Unchanged <input checked="" type="checkbox"/> Improved <input type="checkbox"/> referred <input type="checkbox"/> Expired <input type="checkbox"/> before 48 hrs. <input type="checkbox"/> after 48 hrs	
Type of Discharge		<input checked="" type="checkbox"/> Routine <input type="checkbox"/> At request <input type="checkbox"/> Against Medical Advice <input type="checkbox"/> Absconded	
Final Diagnosis (To be written in CAPITALS)	→ SCROB TYPHUS IgM REACTIVE - RESOLVED		ICD Code A73.3
Associated Diagnosis Conditions			
Associated Complications			
Surgical Procedures Underwent			

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 MADAGADIPET, PUDUCHERRY-605 107.

Dr. S. MADHAN KUMAR, M.D.,
 Regd. No: 98504
 ASSISTANT PROFESSOR
 DEPARTMENT OF GENERAL MEDICINE
 Sri Manakula Vinayagar Medical College & Hospital
 Kalitheerthalkuppam, Puducherry - 605 107.
 Professor / Assoc. Prof. / Senior Resident

Name:	[REDACTED]
Address:	
Age/Sex:	62y/m
Hospital Number:	B256548
Unit:	IV
Ward:	M.Med
Bed Number:	

DEPARTMENT OF GENERAL MEDICINE

Date & Time: 19.1.23 at 8:00PM

PATIENT CASE RECORD

CHIEF COMPLAINTS:

- Fever x 4 days.
- Headache x 4 days

HISTORY OF PRESENTING ILLNESS:

- Pt. was apparently before 4 days, after which he developed fever x 4 days, continuous, high grade fever associated with chills and rigor. H/o Headache x 4 days, generalized headache to Nausea , No h/o Vomiting. No h/o loose stools. H/o Arthralgia , H/o Retro-orbital pain , No h/o burning micturition.

PAST HISTORY: (if yes specify duration/ treatment/ significant issues to the disease)

- Diabetes: NO/ YES
- Hypertension: NO/ YES
- Infectious disease: NO/ YES
- Tuberculosis: NO/ YES
- CAD/ Stroke: NO/ YES
- Seizure disorder: NO/ YES

- H/o Bleeding gums -
- No h/o other bleeding manifestations.
- H/o Abdominal pain

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Chronic kidney disease: NO / YES

Bleeding diseases: NO / YES

Any other disease: NO / YES

Toxic exposure: NO / YES

Loose stools: NO / YES

TREATMENT HISTORY: No significant history.

SURGICAL HISTORY, H/O DRUG ALLERGY:

No H/o surgery in the past.

VACCINATION HISTORY: 2 dose of Covid 19 vaccinated.

PERSONAL HISTORY:

Milestones: Delayed/ Normal Barefoot walking NO

Physical habits: Sedentary/ Moderately active/ Very active

Diet: Vegetarian/ Non-vegetarian

Tobacco: No Yes (Smoking/chewing) Amount:

Insomnia: No Yes Defecation: Open air/ Closed

Alcoholic beverages consumption: (Specify in detail pattern)

Bowel habits:] Normal

Bladder habits:

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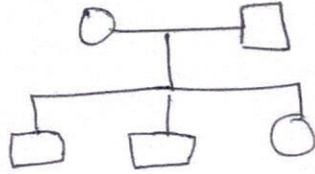
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Chronic
Smoker for 30y
Chronic alcoholic
since for 30y
Stopped since
20 year

FAMILY HISTORY:

Nil

FAMILY TREE:



OBSTETRIC HISTORY (for females)

Age at menarche — Age at marriage — Periods (flow, pain, duration)

Contraception: No Yes (safe period, IUCD, pill, other)

Pregnancies: — Para: Gravida: LMP:

Income per year: — Economic status: Rich, middle class, poor, very poor

A **SUMMARY:** 62 year old Male came with clo fever, headache, Nausea, Bleeding gums, Retroorbital Pain

GENERAL PHYSICAL EXAMINATION:

Weight: kg Height: cm BMI: Waist circumference:

Nutrition: Good fair poor

Congenital malformations:

Throat: (N) Tongue: (N) Hair: (N)

Teeth: (N) Gums: (N) Goitre: (N)

Skin: (N)

Skeletal malformation: Yes/No Optic fundus (draw):

Pallor: (N) Icterus: (N) Cyanosis: (N) Clubbing: (N)

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Edema (Pitting/Non-pitting):

0

Lymphadenopathy (look all lymph nodes):

0

Pulse:

Rate: 78/Min

Rhythm: Regular

Volume: 2

Special character:

Nil

Arterial Thickening: Yes/No

Carotid: R L Radial: R L Brachial: R L Femoral: R L D.Pedis: R L P.Tibial: R L

Jugular venous pulse: -

Jugular venous pressure:

Blood pressure (lying, standing, sitting):

	Upper	Upper
Right	90/60 mmHg	Left
	Lower	Lower

Signs of liver cell failure: -

Neurological markers: -

Peripheral signs of cardiac disease: -

CARDIO VASCULAR SYSTEM:

Inspection: Apical impulse not seen.

Palpation: Apical impulse felt at 5th IC space, 1/2 an inch medial to MCL. TRUE COPY ATTESTED

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Auscultation: SOUNDS

Describe sounds yes/no, loud/ soft	Mitral area	Tricuspid area	Pulmonary area	Aortic area
1 st sound	+	+	f	+
2 nd sound	f	f	f	f
Pulmonary component				
Aortic component				
Opening snap				
Ejection click				
3 rd heart sound				
Rub				

MURMURS

Grade 1-6, timing, duration, time to peak, character, quality, pitch, conduction, relationship to posture, respiration, Valsalva manoeuvres at each site. Represent graphically and describe in words:

Mitral area: }
 Tricuspid area:
 Pulmonary area: ~~SD~~ No murmur
 Aortic area:

RESPIRATORY SYSTEM:

Chest wall deformities:

Trachea: *Appears to be in midline*

Chest expansion: Upper Posterior
 Sinus: Dilated veins Scars

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Palpation:

Trachea: *In midline*

Chest dimensions: AP Transverse

Chest circumference: Inspiration: Expiration: Expansion:

Tactile fremitus (all area):

Vocal fremitus (all area):

Chest wall tenderness:

Percussion (all areas):

Tidal percussion: Traube space: Shifting dullness:

Auscultation (All areas- describe breath sounds present or absent, type, added sounds in detail and special auscultation maneuver)

B/L AEP, No added sounds

ABDOMEN:

Inspection:

Scars: *(N)* Sinus: *(-)* Dilated veins: *(-)* Hernia: Flanks: Skin:
Umbilicus:

Palpation:

Warmth: *(+)* tenderness: *(+)* over epigastric, *(C)* Hypochondrium
Liver: *] not palpable*
Spleen:

Percussion:

Liver:

Spleen:

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Free fluid: *No free fluid*
 Auscultation:

CENTRAL NERVOUS SYSTEM:

Conscious: */* GCS: *15/15* Orientation: */*
 Handedness: Memory: Behavior:

Speech:

CRANIAL NERVES	R	L		R	L
1 st cranial nerve			7 th cranial nerve		
2 nd cranial nerve					
3 rd cranial nerve	<i>Intact</i>	<i>Intact</i>	8 th cranial nerve	<i>Intact</i>	<i>Intact</i>
4 th cranial nerve			9 th cranial nerve		
6 th cranial nerve			10 th cranial nerve		
5 th cranial nerve			11 th cranial nerve		
			12 th cranial nerve		

MOTOR SYSTEM	RIGHT	LEFT
Bulk	<i>(N)</i>	<i>(N)</i>
Tone	<i>(N)</i>	<i>(N)</i>
Power	<i>5/5</i>	<i>5/5</i>
<i>UL</i>	<i>5/5</i>	<i>5/5</i>
<i>LL</i>	<i>5/5</i>	<i>5/5</i>

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Reflexes (superficial & deep)		
Biceps	+	+
Triceps	+	+
Knee	+	+
Ankle	+	+
Plantar	+	+
Coordination & gait	(N)	(N)
Involuntary movements	(N)	(N)

SENSORY SYSTEM			
Spinothalamic tract	} Intact	} Intact	
Posterior column			
Cortical sensations			

CEREBELLUM: Intact

AUTONOMIC SYSTEM: N

SPINE & CRANIUM: N

PROVISIONAL DIAGNOSIS: Fever ↓ EVALUATION.

? Dengue

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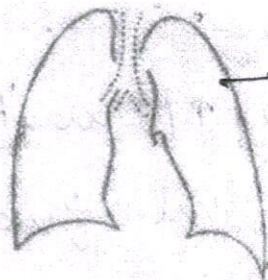
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PLAN OF MANAGEMENT:

IV fluids
supportive care

ECG: sinus Rhythm, HR- 78/min, No acute ST/T changes

CHEST X RAY:



Normal lung parenchyma

Notes written by with date:

Checked by with date:

Dr Shilpa (Plt)

- o Blood c/s
- o Urine c/s

INVESTIGATIONS

ECG, CXR, RBS, CBC, ESR, RFT, LFT, U/R, s. electrolytes,
 Blood c/s, urine c/s, Dengue Igm antibody, scrub Typhus Igm antibody,
 Dengue NSI antibody, PT/INR, P/Bs c/ RL

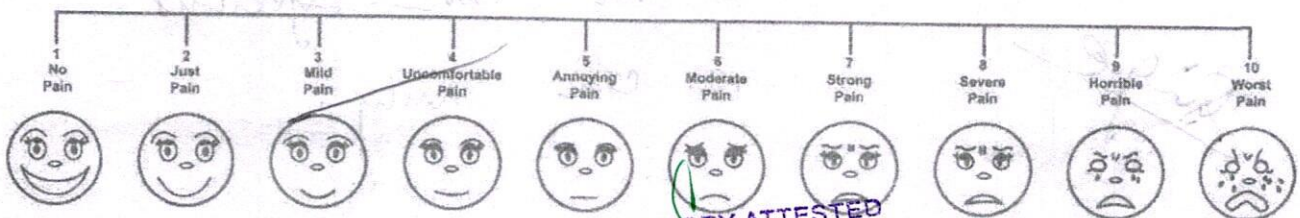
VENOUS THROMBOEMBOLISM (VTE) PROPHYLAXIS NEEDED?

YES/NO

If YES

(Drug name/ Mechanical)

PAIN SCORE:



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 SRIMANJALAN VINAYAGAR
 MEDICAL COLLEGE & HOSPITAL
 KALITHEERTHAKUPPAM,
 MADAGADIPET, PUDUCHERRY-605 007.

RFT: 49/1.2
Electrolytes: (N)

TREATMENT ADVICE:

DOCTOR SIGNATURE & SEAL:

DATE: 19/1/23

TIME: 8.00 pm

Hb: 14.3 g/dl

Hct: 40, 500

Plt: 159,000

Adv

- 1) TPR / RR / SpO₂ / I/O charting.
- 2) Plenty of oral fluids 2 L/day.
- 3) IVF 20NS @ 100ml/hr.

(Di)

A.C. DOXY 100mg 1-0-1

5. inj. PANTOPRAZOLE 40mg iv
(100 CB/F)

6. inj. UNISSET 4mg iv 808

7. T. PRA 650mg 1-0-1

8. w/f Bleeding manifestations

9. No im injections

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Shilpa

Dr. SHILPA PAUL
Reg. No: 74307
Post Graduate
Gen. Med. SMVMCH

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SRINIVASA VINAYAGAR
MEDICAL COLLEGE & HOSPITAL
KALITHEER THALKURPAM,
MADAGADIPET, PUDUCHERRY-605 107.



Sri Manakula Vinayagar Medical College and Hospital

Kalitheerthalkuppam, Puducherry - 605 107.

INPATIENT LAB INVESTIGATION REPORTS

Patient Name	XXXXXXXXXXXX	Age & Sex	66/100
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Hospital No.	13256548	Ward & Department	mmw	Consultant	Dr. [Signature]
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Date :

Haematology							
TLC	11500						
DLC							
Hb	14.3						
PCV	41.6						
Others							
MP / MF							
ESR	22/40						
Urine							
Albumin							
Sugar							
Micro							
Stool							
Oval / Cyst							
Occult blood							
Biochemistry							
Blood Sugar							
Urea							
Creatinine							
Bilirubin							
SGOT							
Alk. Phospatase							
Total Protein							
Serum Albumin							

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Name of Patient with Address : [REDACTED], SOUTH ST, PERIYAKATTUPALAYAM, CUDDALORE, TAMILNADU,.		Hospital No. B256548 Age / Sex 66 / Male
Date of Admission 19/01/2023	Date of Discharge 28/01/2023	Ward : Male Medical -> Ward 303
Consultant : Dr.Girija.S.		Department : General Medicine

Diagnosis

SCRUB TYPHUS IgM REACTIVE- RESOLVED

Surgical Procedure

NIL

Clinical History

C/o. Patient was apparently normal before 4 days, after which he developed fever X 4 days, continuous, high grade fever associated with chills and rigor
 H/o headache X 4 days, generalized headache present
 H/o nausea present
 H/o abdominal pain present
 No H/o vomiting
 No H/o loose stools
 H/o arthralgia present
 H/o retro- orbital pain present
 No H/o burning micturation
 H/o bleeding gums
 No H/o other bleeding manifestations
 NOT/k/c/o epilepsy /asthma/CV/SHTN/ thyroid disorder

Physical Findings

O/E : conscious, oriented, Afebrile
 Pallor (+), no icterus, no clubbing, no cyanosis, no lymphadenopathy, no pitting pedal edema, no dehydration,

PR : 95bpm
 BP : 120/80mmHg
 CVS : S1, S2 +
 RS : B/L AE+,
 P/A : soft,
 CNS : NFND, GCS-15/15

Lab Investigation

Reports enclosed

Treatment Given

1. IV Fluids
2. INJ. PAN 40 mg IV BF 1-0-0

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Sri
MANAKULA VINAYAGAR



Medical College and Hospital
(A Unit of Sri Manakula Vinayaga Educational Trust)

DISCHARGE SUMMARY

Hospital No. :B256548

Name : Mr. ~~XXXXXXXXXX~~

Age / Sex :66/Male

3. INJ. EMESET 4 mg IV 1-0-0
4. T. NAXDOM 500 MG SOS
5. T. NEUROKIND 1-0-0
6. C. SOMPRAZ D 1-0-0
7. C. DOXY LDR 1-0-1
8. SYP. LACTIHEP 15 ml 1-0-1 SOS

CourseStay

A 50 year old male patient with no known comorbidities presented with c/o fever for pas 4 days. Patient was apparently normal before 4 days, after which he developed fever which was continuous , high grade fever associated with chills and rigor. H/o headache present, h/o arthralgia present, h/o retro orbital pain present, h/o bleeding gums, H/o abdominal pain present. o/e BP - 90/60 mm Hg. No eschar / lymphadenopathy. Investigations showed mild (?Prerenal) AKI, Normal LFT, electrolytes, thrombocytopenia and leukocytosis. Scrub IgM ELISA was positive. Blood and Urine culture was negative. Patient was treated with Oral Doxycycline and supportive measures. RFT improved and Serial CBG monitoring showed increasing platelets and patient had no fever in last 3 days hence Patient discharged as routine.

DischargeAdvice

1. T. NAXDOM 500 MG SOS 3 tablets
2. T. NEUROKIND 1-0-0 x 2 weeks
3. SYP. LACTIHEP 15 ml 1-0-1 SOS

REVIEW AFTER X 2 week IN MEDICINE OPD
IF EMERGENCY / CONTACT THIS NUMBER 0413-2643000 EXT - 1015

Summary Prepared by
Name & Designation

Dr. JOHN HELIO
TCMC Reg.No: 78954
PG RESIDENT
Verified by
Name & Designation
Dr. S. MADHAN KUMAR
SMVMCH, PUDUCHERRY

Dr.S.MADHAN KUMAR,M.D.,
Regd. No: 98504
CONSULTANT / PROFESSOR
DEPARTMENT OF GENERAL MEDICINE
Sri Manakula Vinayagar Medical College & Hos
Kalitheerthalkuppam, Puducherry - 605 1

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INPATIENT PROGRESS RECORD

Patient Name	Age / Sex	Department - unit	Ward	Hospital no.
XXXXXXXXXX	66 / M	GM-4	MMW	13256548

1 No Pain	2 Just Pain	3 Mild Pain	4 Uncomfortable Pain	5 Annoying Pain	6 Moderate Pain	7 Strong Pain	8 Severe Pain	9 Horrible Pain	10 Worst Pain

Date & Time	Examination & progress notes	Doctor's orders (with Signature)
20/1/23 8am	<p>Ai - 1) Fever & evaluation</p> <p>2) Dengue?</p> <p>SCRUB Typhus IgM - Reactive</p> <p>c/o fever headache</p> <p>OLE: conscious, oriented</p> <p>BP: 90/60</p> <p>PR: 67/min</p> <p>SIE: CVS: S1S2 ⊕</p> <p>RS: B/L A ⊕</p> <p>PA: warmth ⊕, Tenderness ⊕ epigastrium</p> <p>abd: ⊕ Hypochondrium</p> <p>CNS: NFND</p>	<p>Advise</p> <p>1) TPR/ BP/ SpO2 / TO charting</p> <p>2) plenty of oral fluids 2L/day</p> <p>3) IVF 20NS @ 100ml/hr</p> <p>4) Inj - PAN 40mg IV 1-0-0 (B)</p> <p>5) Inj - EMESET 4mg IV SOS</p> <p>6) C. DOXY LDR 100mg 1-0-1</p> <p>7) T. PARA 600mg 1-1-1</p> <p>8) W/F Bleeding manifestations</p> <p>9) No IM injections</p> <p>10) CBC daily</p> <p>11) T. NARXOM 500mg SOS</p> <p>12) Daily CBC</p>
	<p>Collect - Dengue/scrub Rept -</p> <p>Indus opuntia for papillidol</p> <p>FBS, PPBS tomorrow</p>	<p>TRUE COPY ATTESTED</p> <p>(Staff)</p> <p>DR. NARAYAN</p> <p>DR. NARAYAN</p> <p>DR. NARAYAN</p>



NURSING DIAGNOSIS AND CARE PLAN RECORD

PATIENT LABEL

Diet Advised : *ND*
Diet Taken : *Taken*

Date : *22/1/23*
Shift : *8 am to 2 pm*
2 pm to 8 pm
8 pm to 8 am

NURSING DIAGNOSIS :

Knowledge deficit Regarding home care management :-

NURSING CARE PLAN :

NURSING INTERVENTIONS	NURSING IMPLEMENTATIONS	OUTCOMES
To maintain vital signs	<i>T - 98 °F, PR - 82 bpm, BP - 110/70 mmHg</i>	<i>Monitor Vital</i>
To alleviate pain	<i>Pain score - 2/10</i>	
To maintain fluid and electrolyte balance	<i>Patient taken oral fluids</i>	
Care of catheters	<i>To be present</i>	<i>To be present</i>
a) Peripheral	<i>for</i>	
b) Urinary		
c) NG Tube		
d) Drains		
To ensure safety	<i>due drug given.</i>	
a) Medication	<i>Follow doctor's advice Patient is self voided.</i>	
b) Infection		
c) Environment		
To meet elimination needs	<i>→ Patient voided is self voided</i>	<i>To Patient DVT</i>
To promote early ambulation	<i>→ Patient voided well</i>	
To meet psychological needs	<i>→ P by the hospital</i>	
To provide PFE	<i>support given</i>	<i>To improve knowledge</i>

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Name of Nurse :

S. Srilashmi

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KALITHEER (VILLAGE),
MADAGADIPET, PUDUCHERRY-605 107.

Signature : *for*

TIME	SPECIAL NOTES
22/1/23 @ 9am	<p>→ Patient vitals stable - Due drug 800m. USG Abdomen & pelvis to be taken. IPR - vs on flowdy - ILO chart / ILO chart maintenance - s/w</p>
12pm	<p>→ Patient vitals checked and recorded - due drug 800m - no any other complaints - s/w s-wj</p>
3pm	<p>Patient vitals are checked & recorded. One drugs to be given as per order. USG abdomen pelvis plan. s/w vijay</p>
6pm	<p>Patient vitals are checked & recorded. USG abdomen plan. ILO chart, IPR chart maintained. one drugs to be given. s/w vijay</p>
9:30pm	<p>patient conscious and oriented checked vitals are stable No any other complaints patient general condition fair. USG abdomen to be done s/w jayapriya</p>

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 KALITHEENTHAIKOPPAM,
 MADAGADIPEI, PUDUCHERRY-605 006

Name of Nurse :

Jayapriya

Signature



NUTRITION CARE PLAN

Diet Plan: ND / SRD / LPD / BD / BD (SRD) / DD / DD (SRD) / DD (LPD)

RICE KANJEE / MILK / RT feed / HPD / NPO / PN / EN

Diet prescription instructions by treating consultant

Date	Type of Diet	Doctor Signature	Calorie	Protein	Any other nutrient	Remarks	Signature of Dietician
20/01/23	BD	<p>Dr. S. MANJHAN KUMAR, M.D., Regd. No: 92504 ASSISTANT PROFESSOR DEPARTMENT OF GENERAL MEDICINE Sri Manakula Vinayagar Medical College & Hospital Kalitheerthakuppam, Pudukkottai - 605 007.</p>	2000 kcal	55 g	Iron 17 mg	Plenty of oral fluids	[Signature]

ND - Normal Diet	DD (LPD) - Diabetic with Low Protein Diet
SRD - Salt Restricted Diet	RT feed - Ryles Tube feed
LPD - Low Protein Diet	HPD - High Protein Diet
BD - Bland Diet	NPO - Nil Per Oral
BD (SRD) - Bland with Salt Restricted Diet	PN - Parenteral Nutrition
DD - Diabetic Diet	EN - Enteral Nutrition
DD (SRD) - Diabetic with Salt Restricted Diet	

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4.2.2
f)

Sri **MANAKULA VINAYAGAR** Medical College and Hospital

4.2.2 F

The figure displays ten screenshots of the MEDPLUS software interface, arranged in a 5x2 grid. Each screenshot shows a different module of the system, including 'Registration', 'Investigation', 'Inpatient Medical Data', 'Bed Master', 'Unit Master', and 'Test Parameter'. The interface features a blue header with the hospital's logo and name, and a white main area with various data entry fields and buttons. Copyright information for SMVSS, Puducherry, and the phone number 0413-4900322 is visible in the bottom right of each screenshot.

MEDICAL RECORDS DEPARTMENT

Dr. KAGNE, R.N
DEAN

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MEDICAL COLLEGE & HOSPITAL
HEERTHALKUPPAM,
PUDUCHERRY-605107.

MANAKULA VINAYAGAR
Medical college and Hospital

Birth Details

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MANAKULA VINAYAGAR
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Death Details

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Inpatient Medical Data

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Surgery Details

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REGISTRATION

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Registration

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Patient Revisit

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Patient Search

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Patient Admission

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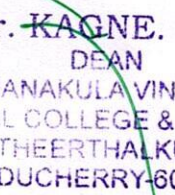
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