
Heat Stroke Bed

75 साल स्वास्थ्य सेवा में — 1933-2008
75 YEARS OF HEALTH CARE 1933-2008

भारत सरकार
GOVERNMENT OF INDIA

स्ना. चि. शि. अनु. सं. — डा. राम मनोहर लोहिया अस्पताल, नई दिल्ली
PGIMER - DR. RAM MANOHAR LOHIA HOSPITAL, NEW DELHI

जिन्दगी चुनें : तम्बाकू नहीं
CHOOSE LIFE : Not Tobacco

20240754252

केस शीट / CASE SHEET

(क) भर्ती संबंधी आँकड़े / Admission Data : AADHAR NO.........................

क. प. संख्या / CR No.	202462543	वार्ड / Ward	ECS 3rd Floor Paed Department		
यूनिट सं. Unit No.	P2B Fri	क्या चिकित्सा विधिक मामला है / if MLC		नहीं (No)	हाँ/नहीं Yes/No
यूनिट अध्यक्ष Unit Head	Dr. Vishal Kumar - Doctor	भेजने वाले का नाम Referred from			
भर्ती की तारीख एवं समय Date & Time of Admission	2024-09-20 6:02 pm	स्थानान्तरण Transfer to			

(ख) रोगी के संबंध में आँकड़े / Patient Data :

नाम / Name	Miss. SHRAYA	आयु एवं लिंग / Age & Sex	1 Months / Female
माता-पिता/पति का नाम Mother / Father / Husband's Name	DEEPAK KUMAR	ब.रो.वि. / आपातकालीन विभाग संख्या / OPD / Emergency No	******8207
पता / Address	LEDHUA REETHI JAUNPUR ,UTTAR PRADESH,Jaunpur,INDIA,	के.स.स्वा.यो. टोकन सं. CGHS Token No	
		दूरभाष / Phone Nos.	

(ग) नैदानिक आँकड़े Clinical Data :

अंतिम निदान / Final Diagnosis		आईसीडी कोड / ICD Code	
अपनाई गई शल्यक्रिया Operative Procedure		ऑपरेशन की तारीख Date of Operation	

(घ) छुट्टी/मृत्यु संबंधी आँकड़े Discharge/Death Details :

छुट्टी भेज जाने वाला पत्र/ मृत्यु होने की तारीख एवं समय Date & Time of Discharge Referral/LAMA/Absc/Death		अस्पताल में भर्ती रहने की अवधि / Hospital Stay	
मृत्यु का कारण Cause of Death			

	कनिष्ठ रेजीडेन्ट Junior Resident	वरिष्ठ रेजीडेन्ट Senior Resident	चि. अधि/विशेषज्ञ/यूनिट अध्यक्ष M.O. / Specialist / HOU
नाम / Name			
हस्ताक्षर / Signature			

PH.: 011-23404040, 23365525

डॉ० राम मनोहर लोहिया अस्पताल, नई दिल्ली – 110001

DR. RAM MANOHAR LOHIA HOSPITAL, NEW DELHI - 110001

बाह्य पंजीकरण कार्ड

OPD Registration Card

बा० रो० वि० पंजीकरण सं०
OPD Regd. No. : 20240754252

दिनांक/Date 20/9/24

के० स० स्वा० यो० कार्ड
CGHS Token No. :

Prepared by:Mr. SANTOSH RAJORIA

RML

Mobile No ******207

निदानशाला/Clinic : CASUALITY

यूनिट/Unit : Casualty

कमरा सं० /Room No. :

20-09-2024 05:51:10 PM

Dept Reg No: 2024/026/0184644

रोगी का नाम
Patient Name : SHRAYA

Room/Queue: Casualty Counter / 499

MON,TUE,WED,THU,FRI,SAT

आयु /Age : 1M 15D

वर्ष /Years

माह /Month

लिंग /Sex : Female

1m 15d/F

निदान
Diagnosis :

GYR

Presented with similar C/O Y/N

Adv (3 kg)

- Neb ĉ ADR 0.5mg + 3ml

Inj ĉ 3% NaCl

S/C ADR 0.03 mg

Kindly Admit & P2 B unit (Dr.

Dr. Lalan Kumar
PG Resident
Department of Pediatrics
ABVIMS & Dr. RML Hospital
New Delhi

AK
Department of
ABVIMS & Dr. RML
New Delhi-110

Atal Bihari Vajpayee Institute of Medical Sciences and Dr Ram Manohar Lohia Hospital

Baba Kharak Singh Marg, New Delhi-110001

DOCTOR'S INITIAL ASSESSMENT SHEET

PATIENT NAME: SHREYA AGE: 40 day SEX: female

S/O, D/O ✓, W/O: Vandana. CONTACT NO.:

CR NO./UHID: BED NO./WARD

MLC NO.(IF ANY) DATE: 20/9/24 TIME: 5:40 Pm.

ADDRESS:

ADMITTED WITH COMPLAINT OF:

40 d) cough x 3-4 days.
fever x 1 days.
fast breathing since night.
dec oral intake. since night

HISTORY OF PRESENT ILLNESS:

HOPI → Child was apparently well 3-4 day back, then started having cough, insidious onset, progressive, non paroxysmal, non spasmodic, no diurnal variation noted, no aggravating/ relieving factor noted.

fever x 1 days, undocumented, [illegible] 220pium., relieved on its own, [illegible]

HISTORY OF PAST ILLNESS:

Fast breathing since yesterday night, Acute onset, progressive in nature, a/w Chest retraction & noisy breathing..

a/w. dec oral intake, dec activity & playfulness., but no h/o dec urine output

RISK FACTORS:

no H/o Vomiting/loose stools/Abdominal distension.

~~[illegible]~~

no H/o yellowish discolouration of eye/urine.

no H/o Pustules/Boils/Rash over body./ear discharge/ [illegible]

LOCAL EXAMINATION:

no H/o crying during micturation.

⇓

With these complaints they visited Hinduraо Hospital where they recorded HR→156/min, SPO₂→70%-RA, RR>60/min RBS→156mg/dl ↓ on O₂ 100%.

NS i Adrenaline was given then ~~[illegible]~~ on O₂ via NP & Referred.

⇓

@RMLH, ECS III Floor, upon arrival - Child was found to having ab(N) body movement F/s/o tightening & posture of neck/trunk i UROE & Frothing from mouth i LOC ⊕.

↓

Inj Midazolam 0.4mg was given after ~~[illegible]~~ the ab(N) body movement aborted.

GENERAL PHYSICAL EXAMINATION:

BP(mmHg):

PULSERATE (PER MINUTE):

TEMPERATURE:

SpO2%

PALLOR:

OEDEMA:

ICTERUS:

CLUBBING:

/S:

~~[illegible]~~

Past H/o → H/o cough & cold @ D4 of life lasted 2-3 days

no H/o Prior Admission

no H/o Nebulization

Birth H/o→ S/term/VD/ CIA[illegible]

CARE PLAN

Dx → [redacted] severe pneumonia c sepsis c meningitis c fluid Responsive shock c Resp. failure. (ET intub

→ IVF NS bolus 60ml over 30min

↓

Recheck

PREVENTIVE CARE:

→ Inf midaz 0.4mg IV stat ✓

() VACCINATION/IMMUNIZATION

() SMOKING CESSATION

() CONTRACEPTIVES

() ALCOHOL/SUBSTANCE ABUSE

() DIET MODIFICATION

() EXERCISE

() BED SORE PROPHYLAXIS

() DVT PROHYLAXIS

ANY OTHERS:

Adv (Wt → 3.2kg)

ET tube in situ, @ 4 NG in situ, Head

1) Continue manual IPPV, ET care.

2) INJ. Cefotaxime 200mg IV tds + 5ml DS

3) Inf Aminouin. 45mg IV OD. + 5ml DS.

4) Inj PCM 45mg IV SOS. for fever.

5) Inf. Levera 60mg IV stat over 15-20m [10ml DS] [to ml]

↓ 5/kg

Inf levera 30mg IV BD. (10ml) + (5ml DS)

6) [redacted]. IVF N/2 c DS : 100 ml @ 10ml/hr

7) V/m

7) Inf midaz (4.6mg + 12mins) @ 0.5ml/kg @ 5 mg/kg/min

Dr. Ratan Kumar
PG Resident
Department of Pediatrics
ABVIMS & DRML Hospital
New Delhi

SR. RESIDENT:

NAME: DR. RITU DATE/TIME 20/9/22 @ 6:00 SIGNATURE

FACULTY:

NAME: DATE/TIME SIGNATURE

रा०म०लो०अ०-11
R.M.L.H.-11

(R-I,

लगातार चार्ट / CONTINUATION CHART

नाम/Name SHREYA 40 days/F कमरा/शय्या सं/Room/Bed No.

नाम/Date	प्रतिदिन विवरण और चिकित्सा/Daily Notes and Treatment	आहार/Diet
20/9/14. 5:40pm	Intubation notes	
	Child was in Severe Respiratory distress & grunting so she was intubated i/v/o Impending Respiratory failure c̄ ET size 3.5mm & fixed @ 9.5cm.	
	Post intubation vitals. HR → 150/m, RR → on MV, PP/pulse ⊕/+, Sat → WNL, CRT < 3 sec	
Plan: VBG after 30 min, CXRAY.		
	Adv (wt → 3.4kg)	
	1) manual IPPV, Head end elevation, ET care	
	2) IVF NS bolus 60 ml over 30 min ↓ Reassess	
	3) Inj midaz (4.6 mg + 72 ml NS) @ 0.5 ml/hr @ 1 mcg/kg/min	
	4) V/m	

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ECS PICU / HDU DAYCARE SHEET

DEPARTMENT OF PEDIATRICS

Name	Shraya	Date / Time- 20/09/2024 7:10 pm	DOA- 20/09/24
Age/Gender	1M 10days/F	CR. No. - 62543	DOPICU / HDU D1
Weight	3 kg	Bed number (1)	DOMV- D1
Diagnosis	Severe pneumonia c sepsis c ? meningitis c fluid responsive shock c RF		

Current issues

Issue	Intervention	Current status
(1) RD →	RR - 60/min with SCR/ICR retraction Grunting ⊕nt, Intubated in Em 1 /u/o Impending RF currently in HDU → on MV → SIMV mode	
(2) Pneumonia →	RD and, B/L crepts ⊕nt.	Plan - X-Ray Chest.
(3) Sepsis →	Septic look, fever ⊕nt. →	Plan → CB c sepsis screen → CRP, Blood c/s
(4) ?Meningitis →	Abnormal body movement → Posturing + UROE + frothing x 1 min. aborted c midaz.	

Respiratory system

Support	SIMV/PSV/CPAP/HFNC Morning	Evening	ABG/VBG	Time- Morning	Evening
Delta P/PS	10+5/8		PH		
PEEP	5		PCO2		
MAP	12		HCO3		
RR (T/Vent)	35/60		BE		
VTE/VTi	20		PO2		
Min Vent	1.1		OI		
FiO2 / SPO2	50% /100%.		ICa		
C/R			P/F ratio		
CXR/USG			Anion Gap		
Examination + Other issues with Mx	B/L AE ⊕nt B/L crepts ⊕nt				

ET size	3.5
Fixed at	9.5 cm
Changed on	

VAP---

ICDT----
(drain volume)

other drains