

ADMISSION SHEET



Registration Details :

Admission No : IP22-00023419

Admit Date : 28-Jun-2026

Admit Time : 12:55 AM UHID : HCV-00039931

Patient Details :

Patient Name : Mrs AVUPATI BHARATHI

Guardian : A SRINIVASA RAO

Gender : Female

Occupation :

Address (H) : Porlupalem Visakhapatnam Andhra Pradesh
INDIA 530047

Age : 18 Y 9 M 7 D

DOB : 21-09-2007

Religion :

Martial Status :

Phone No : 9000548610

E-mail : NO@GMAIL.COM

Admission Details :

Bed Type : GENERAL WARD

Room No : GW 320

Bed No : GW 320

Admission Type : First Visit

Ward Name : 3F-THIRD FLOOR

Contact Details :

Name : A SRINIVASA RAO

Relationship : W/O

Contact Address : Porlupalem Visakhapatnam Andhra Pradesh
INDIA 530047

Phone No :

Signature

Doctor Details :

Doctor Name : Dr. CHUPPANA RAGA SUDHA

Referral Doctor : Family

Co-Consultant :

Specialisation : OBSTETRICS AND GYNECOLOGY

Phone No :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : EASTERN NAVAL COMMAND

ACTIVITY RECORD FOR BILLING

Name:

UHID No : IP No : HCV-00039931 IP22-00023419 Dept:

Date of Admission : 21-09-2007 18 Y 9 M 7 D (F) Discharge: Time:

Room / Bed No : Dr. CHUPPANA RAGA SUDHA ted Billable bed type:



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/6/26	1:30 Am	NICU	320	Cabe

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	MOTHER MLEE	29/6/26	216.3	Cover
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Cross check by

MEDICAL EQUIPMENT (WARD & ICU)					

[illegible]

INVESTIGATIONS

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

Date: 30/6
Time: 11pm
Prepared By: Leen

Staff Nurse Cum	Shift / Ward M. Craig 10:50 AM. 30/6/26	Billing Assistant	Billing Supervisor
--------------------	--	-------------------	--------------------



Mrs. Bharathi

Rainbow
Children's
Hospital
It takes a lot to treat the little.

(18)/F
BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

I.P. ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints Pt came c
c/o labour pains : 10pm

Obstetric Formula : Primi

Obstetric History: Primi

Present Pregnancy Record

- Spontaneous conception
- Regular ANC visit

RISK FACTORS: - Immunized

Nil

Height : 149 cm

Weight : 60 kg

Allergies : Nil

Breast ☒ Normal ☐ Abnormal

General Examination:

Consciousness : Alert

Icterus : (-)

Temp: Afebrile

BP: 122/70 mmHg

CVS: S1S2 (+)

Liver / Spleen : (-)

Pallor: (-)

Edema: (-)

PR: 80/min

DTR: (+)

RS BLAE (+)

Urine Output: adequate

LMP : 3/10/25

EDD: 12/7/26

Corrected EDD: 20/7/2026 GA: 38w 6days

Menstrual History : Regular ☒ Yes ☐ No

Obstetric Examination ML - 9 mths, NCM

Fundal Height Teem 36"/25"/10min

Ut. Activity: ☐ Relaxed ☐ Mild ☒ Mod ☐ Severe

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech Others _____

Head Fifths Palpable _____

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination (-)

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: uneffaced, posterior, 1/2 inch long. ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed Dilated tip of finger, admitting

Membranes : ☒ Present ☐ Absent

Liquor : ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☒ Vertex ☐ Breech ☐ Others

Sutton: ☒ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☒ Adequate ☐ Doubtful

DIAGNOSIS

Primi | 38 wks ~~preg~~ | for SPOL.
POC



Family History Nil	Surgical History Nil
Medical History: Nil	Medication History: Nil
Plan of Care: ①. Admission ②. parts preparation ③. CTG 4 ^m hourly monitoring ④. FHR hourly monitoring ⑤. w/f uterine action & labour progression ⑥. vitals monitoring ⑦. w/f Bleeding (or) leaking P/V ⑧. Inpsem sds Bedside scan done ↳ SFO: 2450 gms	Investigations: BAT - B+ve 20/5/26 Hb - 10.4 g/dl Pcv - 31.2 Plt - $300 \times 10^9/L$ ESR - GCT - 115 mg/dl HIV HDsAg } - (NR) HCV VDRL } Scan: (29/5/26) - presentation: Cephalic - placenta: Anterior - AFI: 11.3 - EFW: 1794 gms (25-ile) - Doppler: Normal - BPD: 5-ile

Doctor Name: Dr. Nishini
 Signature:
 Date & Time: 27/6/26

Consultant Name: Dr. Raga Sudha
 Signature:
 Date & Time: 27/6/26

HCV-00039931 IP22-00023419
 Mrs AVUPATI BHARATHI
 21-09-2007 18 Y 9 M 7 D (F)
 Dr. CHUPPANA RAGA SUDHA

Pati



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: Arrival 27/6/26 at: 11:40 pm

Baseline Information:

Admission From: ☐ ER ☐ OPD ☐ Admission Desk ☒ Others, specify MICU
 Primary Language: ☒ Telugu ☐ English ☐ Hindi ☐ Others, specify _____
 Do you require an interpreter? ☐ Yes ☒ No If Yes specify _____
 Source of Information: ☒ Patient ☐ Family ☐ Others, specify _____

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: _____
 If yes, identify _____

Chief Complaints: labour pain Doctor Notified on Admission: ☒ Yes ☐ No
 Name of the Doctor: Dr. K. Kupakshita
 Time Notified: at: 11:50 pm

Past Medical History: Obtained From ☒ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify) _____

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>NO</u>	<u>NO</u>	<u>NO</u>
Gynecology Assessment: ☐ Not Applicable Menstrual History: <u>13 Yrs</u> Onset of Menarche: <u>3-5 days</u> Menstrual Cycle: ☒ Regular ☐ Irregular Last Menstrual Period: <u>3/10/2025</u>	Gynecology Surgical History: Caesarean Section: ☒ No ☐ Yes Cervical Cerclage: ☒ No ☐ Yes Ectopic Pregnancy: ☒ No ☐ Yes Myomectomy: ☒ No ☐ Yes Others: _____	Gynecological History: Contraceptives: ☒ No ☐ Yes Vaginal Discharge: ☒ No ☐ Yes Post-Coital Bleeding: ☒ No ☐ Yes Infertility: ☐ No ☐ Yes If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G Prim P _____ L _____ A _____

Previous LSCS: NO

Current Medication: ☒ None ☐ Yes, If Yes, Fill the reconciliation form

Family History: ☒ No Abnormalities Detected

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease
☐ Liver disease ☐ Other _____

Vital Signs / Measurements: Temp: 98° HR: 83b/min RR: 20b/min
 BP: 112/64(77) Weight: 59.90 Kg Height: 149 cm BMI: 26.98 Kg/m²

Pain Assessment: Pain: ☐ Yes ☒ No (If Yes, complete the Pain Assessment / Reassessment Form)



PHYSICAL ASSESSMENT

General Appearance: ☒ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others:

Fall Assessment: ☐ Yes ☒ No Score (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☒ No Score (complete the Braden Q Sheet)

FUNCTIONAL SCREENING: If a patient needs assistance with any of the following inform consultant

- ☐ Mobility problem ☐ Walking Problem ☒ No Abnormality Detected
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☐ No Abnormality Detected

- ☐ Overweight ☐ Poor Appetite > 3 Days ☐ Needs Therapeutic Diet.
☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

- ☒ Calm & Cooperative ☐ Restless ☐ Depressed ☐ Agitated ☐ Confused
☐ Others

Inform consultant for positive criteria

SOCIAL SCREENING:

1. **Marital Status:** ☐ Single ☒ Married ☐ Divorced ☐ Widow
 2. **Special Habits:** **Smoker:** ☐ Yes ☒ No **Alcohol Abuse:** ☐ Yes ☒ No **Drug Abuse:** ☐ Yes ☒ No

Social History: Lives With Husband

Orientation has been given regarding the following aspects:

- Call Bell in Reach: ☒ Yes ☐ No Waste Disposal Explained: ☒ Yes ☐ No
 Infusion Pump: ☐ Yes ☒ No Hand Hygiene Explained: ☒ Yes ☐ No ☐ Others

Above information given to Patient

Name of Person Orientation was given to: Mrs. Bharathi. A.

Orientation not given Reason:

Nurse Signature: Usha

Nurse Name: Usha

Date & Time: 27/6/26 at: 11:46 pm

PROGRESS NOTES

(USE BALL POINT PEN ONLY)

Ref. No. : F / HW / PGN / INPR / 15

Patient

HCV-00039931 IP22-00023419
Mrs AVUPATI BHARATHI

Age : .

21-09-2007 18 Y 9 M 7 D (F)
Dr. CHUPPANA RAGA SUDHA

I.P. No



DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
28/06/2026	3:30 AM	CLSB Dr. Nikita (Reg) Dr. Nisha (Pn)
		Premi 38 weeks pga for SPOL
		MC fair <u>ads</u>
		Afebrile
		BP - 116 mmHg 78
		PR - 72 bpm
		RR - 14 bpm
		+/- No abnormality detected
		PA - uterus <u>relax</u> term
		cephalic
		FHS (+)
		but mild acting
		(1) Regular but with plenty of oral bleed
		(2) CTG with only tracing
		(3) FHR monitoring every hourly
		(4) w/ uterine activity & label progression
		(5) w/ leaking PV / bleeding PV
		(6) monitor vitals
		(7) inform sds
		<u>Nisha</u>
		<u>Nisha</u>

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

28/06/2026

4pm

CSB Dr. Nikita (Reg)

Dr. Nisha (Pa)

Pain | 38 weeks | SPOL

AC fine
Afebrile

BP - $\frac{110}{70}$ mmHg

PR - 82 bpm

RR - 14 bpm

H/C - No abnormality detected

PA - Uterus term size

Cephalic
FHS (+)

at mild tightening

Growth & Doppler Scan
tomorrow.

note

1) Regular diet with plenty
of oral fluid

2) CTG 6th hourly

3) FHR monitoring hourly

4) w/ uterine action &
progression of labour

5) monitor vitals

6) inform SOS

note

CSB Dr. Karpashina (Reg)

Dr. Nisha (Pa)

28/6/2026

9:30 pm

Pain | 38 weeks | SPOL

AC fine

Afebrile

BP - $\frac{106}{60}$ mmHg

PR - 80 bpm

RR - 14 bpm

H/C - No abnormality detected

PA - Uterus term size

Cephalic
FHS (+)

CTG

@ 11pm

2 b/b next CTG

@ 7:30am tomorrow

note

1) Regular diet & plenty of fluid

2) FHR monitoring hourly

3) w/ uterine action &
progression of labour

4) monitor vitals

5) inform SOS

note

29/6/21

10:20am

C/SB (Dr. Raga Sudh (Consultant))

Primid 3 weeks + 1 day / SPO L

Gc: Fair, vitals: stable

delo

HL E: No abnormality detected

1) Rest in LLP / DMIC

PLA: uterus ~ firm

2) CTC 6th hourly monitoring

Cephalic

3) FHR monitoring every 2nd hour

FHS (+)

4) w/lt uterine action

ctrcy ~ 2/25 sec/10 min

5) w/lt labour progression

6) Monitor vitals

Plv: ex: unengaged, lateral

7) Inform...

closed

PP: Vertex @ high up

Pelvis: adequate and gynaecoid

Cervix & doppler today

N/B garden on 220

Next CTC @ 3pm

CVE sent

C. Nikhita

C/S (By Dr. Nikhita (Reg))

Dr. Sanyal (Pg) / Dr. Nikhita (Pg)

Primid 38 weeks + 1 day / for observation

PARM (+)

29/6/21

3pm

Gc: no pain

R

Afebrile

1) Borel up

Bp: 110/70 mmHg

2) FHR (+) 2nd hourly

PR: 84 bpm

3) CTG (+) 6th hourly

RR: 16/min

4) w/lt any uterine action, labo progress
bed plus sample

Adv CTG

ut released

R₂

- 1) 6th Huly CTG
- 2) w/f ut action
- 3) Vitals monitoring

W.B. Houlden

PROGRESS NOTES

(USE BALL POINT PEN ONLY)

Ref. No. F / HW / PGN / INPR / 15

HCV-00039931

IP22-00023419

Ms. AVUPATI BHARATHI

Pi 21-09-2007

18 Y 9 M 9 D

(F)

Dr. CHUPPANA RAGA SUDHA

Ac



1.8

DATE	TIME	(SIGN ALL ENTRIES, DATE & TIME OF EACH ENTRY IS COMPULSORY)
		S/B Dr. Ashwath (Reg)
30/6/2026		Dr. Sonny (Pa) / Dr. Anand (Pa)
5:00 PM		Dr. Anand (Pa) / Dr. Anand (Pa)
		Dr. Anand / 35W +2 POG / for observation
		PA Am (+)
		at 10:00 AM
		at 10:00 AM
		BP - 114/70 mmHg
		PR - 80 bpm
		RA - 120 bpm
		H/L - No abnormality
		Detected
		PA - uterus retracted
		Cephalic
		FHS (+)
		It relaxed
		① Rest in LCP / AM
		② 1 CTG before discharge
		③ FHR 2nd half mon
		④ w/ wife
		⑤ monitor while
		⑥ inform S.O.
		10:00 AM

NOTE : DO NOT WRITE OUTSIDE THE MARGINS

CLEARANCE FOR SURGERIES / PROCEDURE

DATE:

28/6/2026

DEPARTMENT

OBG

NAME:

Mrs. A. Bharathi

UHID / I.P.NO.:

HCV - 00039931

WARD / BED NO.:

EMERGENCY / NON EMERGENCY

TYPE OF SURGERY / PROCEDURE:

NVD | LSCS

ESTIMATION OF THE COST OF THE SURGERY

ADVANCE AMOUNT PAID:

DATE:

28/6/2026

RECEIPT NO:

CLEARANCE GIVEN BY:
NAME OF THE BILLING EXECUTIVE:

SIGNATURE:



S. Nigam

PATIENT TRANSFER FORM

Patient Name / I.P. No Mrs. Bharathi. V IP NO:	Date & Time of Admission 28/6/26 at: 12:55Am	Date & Time of Transfer Order 28/6/26 at: 1:30Am	
Treating Consultant Dr. Rajarudra	Transfer ordered by Dr. Krupatehika	Reason for Transfer for SPOL. observation	
From Bed / Ward / Hospital MICU	To Bed / Ward / Hospital 320	Information to attendant Yes ☐ No ☒	
Number of Sheets in clinical file (28)	Number of Imaging films NST - (1)	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, What ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Underpad	(1)	
2.			
3.			
4.			
5.			
Shifting Summary / Notes written by Doctor: Dr. Krupatehika			
Name and Signature of Person filling this part Usha	Name of person ordering transfer Dr. Krupatehika	Name & Signature of Nurse Supervisor	Referral note & referral Doctor Name:
Patient & Clinical records received by: Mouli Kesh			
Signature with Date & Time 28/6/26 @ 1:30Am.			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below:

Unavailable bed

☐ Nurse not available

☐ Available bed not ready