

DISCHARGE SUMMARY

Name	Mrs PRIYA JAIN	UHID	FDH-00023248
Father/Guardian	Mr Arihant Jain	Age/Gender	33 Y 7 M 26 D/ Female
Address	Nanakramguda, Hyderabad, Telangana, INDIA, 500008		
IP No	IP25-00020595	Admission Date	23-05-2026
Ref Doctor	SELF		
Discharge Date	27.05.2026		

Consultant:

Dr. Pujitha Devi Suraneni

MBBS,MS(Obs & Gynae),FMAS, FICRS (Robotic Surgeon)

Senior Consultant-High Risk Obstetrician and Laparoscopic Surgeon

Reg. No: 55973

Diagnosis: PRIMIGRAVIDA AT 36+5 WEEKS GESTATION WITH MCA REDISTRIBUTION WITH GESTATIONAL HYPOTHYROID FOR STEROID COVERAGE AND FURTHER MANAGEMENT.

EMERGENCY LSCS DONE, IN VIEW OF MATERNAL REQUEST, DELIVERED A SINGLE LIVE MALE CHILD WEIGHING 2.910KGS ON 25.05.2026 AT 08:01AM.

History:

LMP: 09.09.2025

Obstetric formula: Primigravida

EDD: 16.06.2026

Gestation at admission: 36 + 5 weeks

Obstetric History:



Name	Mrs PRIYA JAIN	UHID	PH-00023248
IP No	IP25-00020595	Admission Date	23-05-2026

G1 - Present pregnancy, Spontaneous conception.

Medical History: H/O Hypothyroid since 16 weeks on Tab. Thyronorm 25mcg once daily. Family History : Nil

Surgical History: Nil

Allergies : Nil

Antenatal Details:

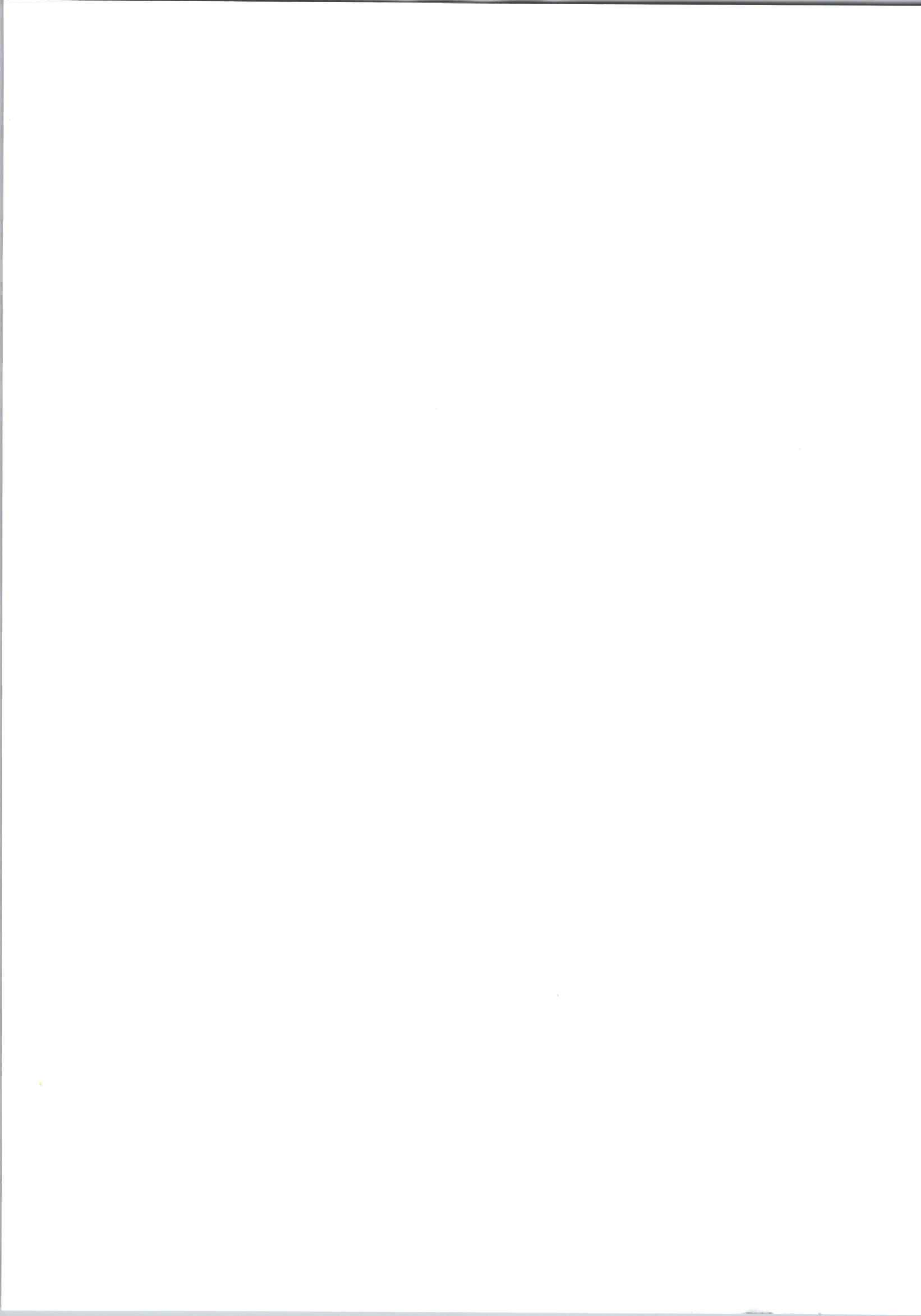
Mrs. PRIYA JAIN was booked to Rainbow hospital at 15+4 weeks of gestation. She had regular antenatal checkups and investigations as advised. EFTS showed low risk, NT scan at 12+1weeks was normal. Gestational hypothyroid since 16 weeks on Tab. Thyronorm 25mcg once daily. TIFFA scan at 20+3weeks showed no anomalies, placenta - anterior, lower margin partially covering the internal os. Growth scan at 26+4 weeks was normal with placenta - anterior, high. Scan done at 36 weeks showed MCA redistribution, EFW at 36 weeks showed 3030 grams (72%), AC 67%. Scan done on 23.05.2026 showed SLIUF at 36+4weeks gestation in cephalic , AFI 12cm, placenta anterior, high, Fetal dopplers - Umbilical artery doppler was normal, MCA redistribution , CP ratio 1.26. Couple explained regarding the scan findings , need for steroid coverage and delivery explained. She was admitted at 36 + 5 weeks for steroid coverage and further management.

Investigations: Blood group & Typing- "B" Rh positive.

Management:

Course in hospital and Delivery Details:

At admission on clinical examination the vitals were stable, uterus was relaxed Fetal well being was confirmed by an admission CTG which was found to be reactive. Steroid coverage with Inj. Betamethasone 12 mg intramuscularly, 12 hours apart given. Serial monitoring of blood sugars done and endocrinologist opinion taken and orders followed. Fetal well being monitored with serial NSTs. Couple counselled for induction of labor on



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24.05.2026. Informed consent taken for induction of labor. Labor induced with 2 doses of PGE1. Spontaneous rupture of membranes happened at 1cm dilatation, revealing clear liquor. As per hospital protocol she was started on IV. Augmentin in view of ruptured membranes. Further augmentation of labor done with Inj. syntocinon. Patient and patient attenders denied further augmentation and epidural analgesia and wanted emergency LSCS.

She was decided for emergency C- section in view of maternal request, prepared with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Patient shifted to theatre.

Surgery Notes:

Under spinal anesthesia she was painted and draped as per hospital protocol. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 400 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

* **Floating head.**

* **Baby passed meconium at the time of delivery.**

* **Mild atonic PPH present, managed with Inj. Methergine 0.2mg IM, Inj. Carboprost 0.25mg IM, Inj. Tranexamic acid 1gram IV.**

Delivery Details :

Date : 25.05.2026

Name	Mrs PRIYA JAIN	UHID	FPH-00023248
IP No	IP25-00020595	Admission Date	23-05-2026

Time of Delivery: 08:01AM
 Type of Delivery: Emergency LSCS
 Indication : Maternal request
 Analgesia : SA

Baby Details:

Date : 25.05.2026
 Time : 08:01AM
 Sex : Male
 Weight : 2.910 Kgs
 Apgar : 7,9
 Gestational Age: 36 +6 weeks
 NICU Admission: No

Post-Operative Notes:

She was closely monitored. Her vital signs remained stable. Uterus was well retracted with no Postpartum hemorrhage. Breast feeding initiated. She was shifted to room. Her postoperative period following that was uneventful. Blood sugars were monitored on postoperative day 2 and were normal. On second postoperative day dressing was changed. On inspection wound was healthy. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

Advice:

- 1.Tab. Augmentin 625 mg twice daily till 31.05.2026 (9am-9pm) after food.
- 2.Tab. Acton - OR thrice daily till 31.05.2026 (9am-2pm-9pm) after food.
- 3.Tab. Pan 40mg once daily till 31.05.2026 (8am) before breakfast.
- 4.Tab. Lyser-D twice daily till 31.05.2026 (10am-10pm) after food.
- 5.Tab. Solfe extra once daily (8pm) for two months after dinner.
- 6.Tab. Gemcal XT once daily (2pm) till breast feeding after lunch.



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7. Megaheal gel for local application.
8. Nip care ointment for local application.
9. To do S.TSH after 6 weeks and review.

We urge all of you to read the postpartum book thoroughly. It contains useful advice and will clear most of your doubts.

Review with Dr. Vinodha Vunnam (Lactation Consultant) after one week on 01.06.2026 with prior appointment.

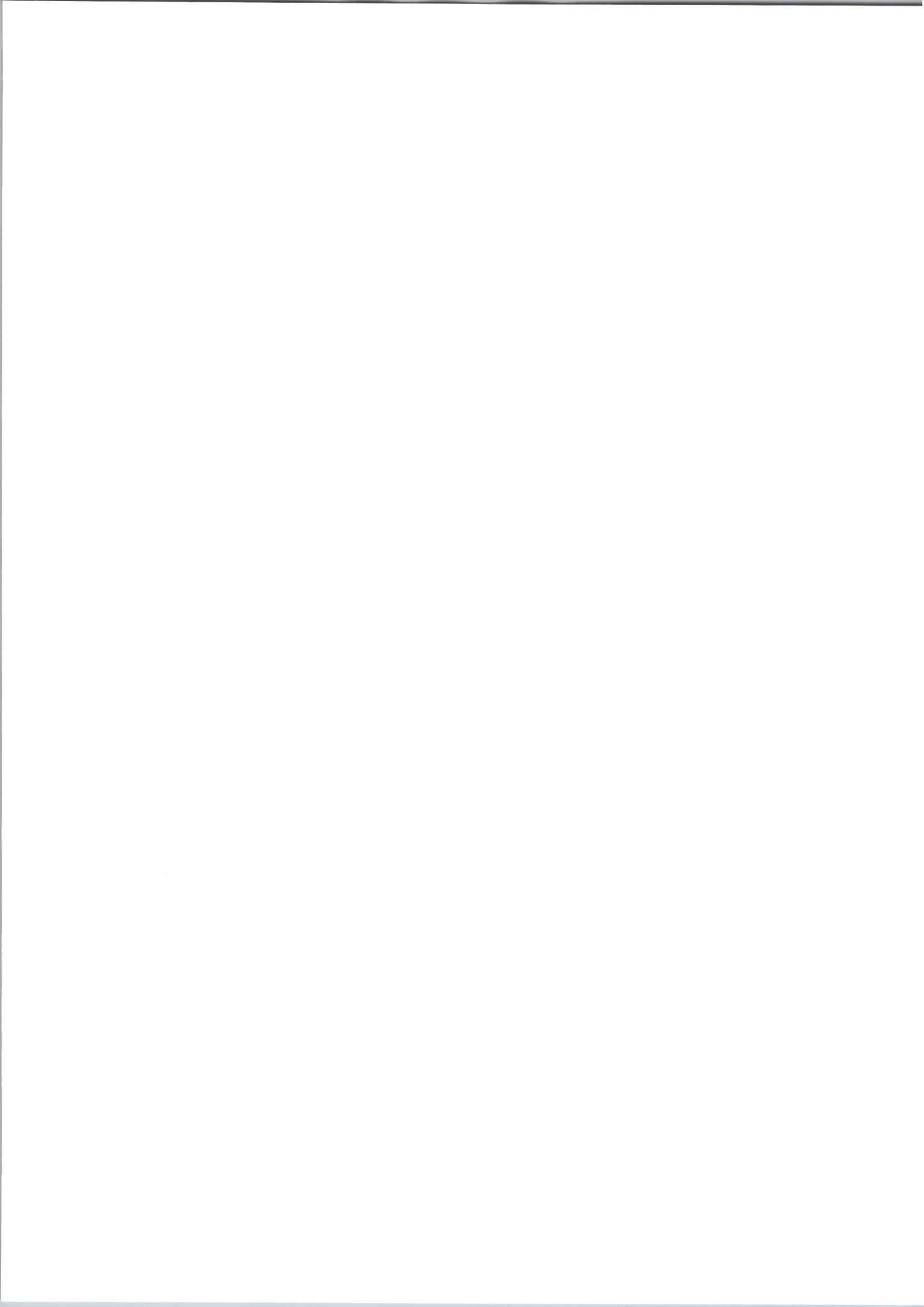
Review with Dr. PUJITHA DEVI SURANENI after one weeks on 01.06.2026 at postnatal clinic with prior appointment **(Review consultation will be charged)**.

For Women Who Have Had a Cesarean Section Care of the wound:

1. You can bath and shower.
2. The wound can get wet during a bath or shower. Dry it thoroughly and gently by dabbing with a gauze piece. Do not rub the wound.
3. This gauze piece needs to be discarded after one use.
4. Prior to touching the wound clean hands thoroughly with Microshield solution and allow them to air dry or use disposable paper napkins.
5. Apply Nebasulf or Neomycin dusting powder on the wound after it is dry.
6. Do not touch the wound with unwashed hands.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, immunization and safe parenting, when and how to obtain emergency care etc also have been explained by doctor

Patient/ Attender



Name	Mrs PRIYA JAIN	UHID	DH-00023248
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In case of emergency like bleeding, fever please refer to postpartum book for further details - Chapter II page 6 kindly contact 8121039515 at Financial District just dial one toll free number - 18002122.

You can also take appointments at any time by going online to our website www.rainbowhospitals.in

Dr. Prasa
Registrar/Resident/C.M.O

S. Pujitha Devi
Dr. Pujitha Devi Suraneni
MBBS,MS(Obs & Gynae),FMAS, FICRS (Robotic Surgeon)
Senior Consultant-High Risk Obstetrician and Laparoscopic Surgeon
Reg. No: 55973



FDH-00023248 IP25-00020595
 Mrs PRIYA JAIN
 29-09-1992 33 Y 7 M 25 D (F)
 Dr. PUJITHA DEVI SURANENI



SURGERY DETAILS

Date : 25/5/26

Patient Name: Mrs. priya jain Date of Birth: 29/09/1992 Age: 33Y

Gender: female Ward : OT UHID No.: FDH 00023248

Date of Surgery: 25/5/26 OT -1 OT -2 OT -3 OT -4 OBG OT-1 OBG OT-2

Name of the Surgery :

Time in : 7:50 Am

Time Out : 8:50 Am

	<u>NAME</u>	<u>AMOUNT</u>
1. Surgeon	<u>Dr. Pujitha</u>
2. Anaesthetist	<u>Dr. Mohan</u>
3. Assistant Surgeon	<u>Dr. Harshini</u>
4. OT Technician	<u>Br. Rambabu</u>
5. Circulating Nurse	<u>Br. Subhadeep</u>
6. Assistant Nurse	<u>Br. Rana</u>

Special Equipment: Laparoscopy Broncoscope Harmonic Morcelator
 C-ARM Cystoscopy Versa Point Liver Cusa
 Neuro Cusa Others

Signature of the Surgeon

Bimal
 Signature of Circulating Nurse

Order No: 579899 19800

Order by: Baly

10/10/10

2010

Handwritten notes and diagrams, possibly a flowchart or process map, with various lines and arrows connecting different points.

- 1. 01. Introduction
- 2. 02. Objectives
- 3. 03. Methodology
- 4. 04. Results
- 5. 05. Conclusion

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SPINAL

CONSUMABLES OF OT

Circulating Staff: Technician: RAMBABU Date: 25/05/2026 Time:

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <u>LSCS</u>		<u>01</u>	Inj Vit.K		<u>01</u>
LMA			Sutures			Cord Clamp		<u>01</u>
ECG leads: A/P/N		<u>03</u>	<u>2342</u>		<u>03</u>	Suction Catheter		<u>01</u>
HME filter: A/P/N			<u>2762</u>		<u>02</u>	Feeding Tube		
Syringes: 10 cc		<u>03</u>				Vaccum Suction Set		<u>01</u>
05 cc		<u>02</u>	Gloves <u>6 1/2 + 7</u>		<u>04+02</u>	Surgical Gloves <u>6 1/2</u>		<u>03</u>
02 cc		<u>02</u>				Gauze Pack <u>1x5</u>		<u>02</u>
01 cc						Syringe <u>1ml/2ml</u>		<u>01</u>
Cautery plate: A/P/N		<u>01</u>	Surgical blade # <u>22</u>		<u>01</u>	Surgical Blade # 20		<u>01</u>
IV set		<u>01</u>	NG tube			Koochies (S)		
RL		<u>03</u>	Cautery pencil		<u>01</u>			
NS: 10ml / 100ml / 500ml / 1000ml			Koochies					
<u>RILISOL</u>		<u>01</u>	Ointments					
<u>EVA TOCIN</u>		<u>05</u>	Suction Catheter					
Fentanyl <u>BIOXAMIC</u>		<u>02</u>	Cap, Mask					
Morphine <u>THEMICAR</u>		<u>01</u>	Gauze Pack <u>1x5</u>		<u>05</u>			
Ketamine			Mop Pack <u>1x5</u>		<u>03</u>			
Propofol			Steristrip <u>zone</u>		<u>01</u>	<u>Dispo packs</u>		<u>03</u>
Rocuronium			Underpad		<u>02</u>			
Glycopyrolate			Draw sheet			<u>10130 200</u>		<u>03</u>
Myopyrolate			Abgel		<u>01</u>	<u>legent</u>		<u>01</u>
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22		<u>01</u>	Urobag			<u>Newman AD</u>		<u>01</u>
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25% (Heavy)		<u>01</u>	Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol: 80mg / 250mg / 170 mg			Double J Stent					
Supridol: 100mg		<u>01</u>	Vaccum Suction set		<u>01</u>			
Justin: 12.5 mg / 25mg / 100mg		<u>01</u>	Plastic Bed Sheet					
Tab. Misoprost: 200mg			Betadine Solution <u>100ml</u>		<u>02</u>			
			Microshield					
			Cotton Balls					
			Latex Gloves		<u>10</u>			
			Ramdione Scrub					
			Saral					

579793
Baby side

Order No.: 579722 (TECH) Ordered by: [Signature]
 No.: RCH / FRM / GENERAL / 125 579725
 Anaesthesiologist: DR. MOHAN Nurse: [Signature] OT Technician: [Signature]

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ADMISSION SHEET



Registration Details :

Admission No : IP25-00020595 Admit Date : 23-May-2026 Admit Time : 10:05 PM UHID : FDH-00023248

Patient Details :

Patient Name : Mrs PRIYA JAIN Age : 33 Y 7 M 24 D
Guardian : Mr Arihant Jain DOB : 29-09-1992
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : Nanakramguda Hyderabad Telangana INDIA Phone No : 9990848809
500008 E-mail :

Admission Details :

Bed Type : MICU Bed No : MICU-01 Ward Name : 4F -MICU
Room No : MICU-01 Admission Type : First Visit

Contact Details :

Name : Mr Arihant Jain Relationship : Husband
Contact Address : Nanakramguda Hyderabad Telangana INDIA Phone No : / 9990848809
500008

Arihant Jain

Signature

Doctor Details :

Doctor Name : Dr. PUJITHA DEVI SURANENI Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : SELF Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD



DH-00023248 IP25-00020595
Mrs PRIYA JAIN
9-09-1992 33 Y 7 M 24 D (F)
r. PUJITHA DEVI SURANENI



ACTIVITY RECORD FOR BILLING

Name: Mrs Priyanka

UHID No : _____ IP No : _____ Consultant : _____ Dept : _____

Date of Admission : 23/5/26 Time : 10:05pm Date of Discharge : _____ Time : _____

Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
24/5/26	12:50pm	MW	Ward	<i>[Signature]</i>
24/5/26	5:00pm	339	MICU	<i>[Signature]</i>
24/5/26	7:30AM	MICU	OT	<i>[Signature]</i>
24/5/26	9:25AM	OT	MICU	<i>[Signature]</i>
24/5/26	4:00pm	MICU	Ward	<i>[Signature]</i>

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
23/5/26	GIRBS - 96 mg/dl . (9:50pm)	• 8254 ✓	} Surba
23/5/26	NST - (1)	• 6717 ✓	
24/5/26	NST - (2)	• 6718 ✓	
24/5/26	FBS - 132 mg/dl . (6:30am)	• 8272 ✓	} Bhagya
24/5/26	Post breakfast sugars - 9:30am (57)	• 8273 ✓	
24/5/26	NST - (3)	• 6726 ✓	
	NST - (4)	• 6727 ✓	
24/5/26	GIRBS - 100		
24/5/26	Pre meal - 131 mg/dl .	• 18284 ✓	Juna
24/5/26	Post lunch sugars - 162	• 8290 ✓	Phalasa
24/5/26	NST - (5)	• 6732 ✓	Phalasa
<p><i>c.t. done by Phalasa 24/5/26</i></p>			
24/5/26	Pre meal GIRBS [7:25am] 106 mg/dl	• 8305 ✓	} Surba
24/5/26	Post dinner GIRBS 113 mg/dl (10:30pm)	• 8306 ✓	
24/5	NST - (6)	• 6741 ✓	
24/5	NST - (7)	• 6742 ✓	
24/5/26	NST - (8)	• 6743 ✓	
25/5	NST - (9)	• 6744 ✓	
25/5	NST - (10)	• 6745 ✓	
25/5	NST - (11)	• 6746 ✓	
	NST - (12)		
	POST - 10		

c.t. done by bhime 26/5/26

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
25/5/20	Infusion pump	1:30 AM ^{25/5/20}	2:30 AM ^(25/5/20)	• 9879	Signature
25/5	Cardiac Monitor	1:30 AM	2:30 AM	• 9879	Signature
				C.C. Sushant 25/5/20 3pm	
25/5/20	Cardiac monitor	9:30 AM ^{25/5/20}	4 PM ^{25/5/20}	• 9880	Signature
25/5/20	Infusion pump	9:30 AM		C.C. Sushant 25/5/20 3pm	

C.C. Done by vbhima
25/5/20

FDH-00023248 IP25-00020595
Mrs PRIYA JAIN
29-09-1992 33 Y 7 M 25 D (F)
Dr. PUJITHA DEVI SURANENI



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

332
BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 25/05/26 Time: 5:15PM

Origin: Indian Height: 152cm Weight: 64Kgs BMI: 27.7kg/m²

Food Allergies: Nil

Diagnosis: Pree at 36+4wks GA & Cerebral & distribution for BMX use

Medical History: K/c/o test: hypothyroidism

Surgical History: Nil

Vegetarian Non-Vegetarian Vegan

Diet Advised: Advised soft diet & plenty of oral liquids

Patient's / Attendant's

Signature: *Arhanant Jain*

Name: ARHANANT JAIN

Date & Time: 25/5/26 5:15pm

Dietician's

Signature: *Anhiya*

Name: Anhiya

Date & Time: 25/05/26 5:15PM

ACTIVITY RECORD FOR BILLING

Name: -----
 UHID No : ----- IP No : ----- Dept : -----
 Date of Admission : ----- Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

FDH-00023248
 Mrs PRIYA JAIN IP25-00020595
 29-09-1992 33 Y 7 M 25 D (F)
 Dr. PUJITHA DEVI SURANENI



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
27/5/26	12:43pm	ward	Billing	[Signature]

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. Vaibhavi	27/5/26	80778	[Signature]
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

PROCEEDURE

Date	ProceEDURE	Quantity	Order No.	Signature

ANY OTHER INFORMATION

8 pt op loci Gown to Fla pt Att, dep
- Paul →

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
-------------	--------------	-------------------	--------------------



1

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: G2A1 E36 + weeks GA E (exh) redishuman 2 chest hypothyroidism for fetal surveillance						Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:							
	Surgery / Procedure:						Post OP Day:							
BACKGROUND	Date	23/5/26 N		24/5/26 M		24/5/26 E		24/5/26 N		25/5/26 M		25/5/26 E		
	Medical Condition (Any special condition to be noted):	OBS		Observation		elavation		OBS		OBS		EM LSC		
	Diet:	DID		DID		NID		NID		ND		NBM		
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	Ventilation (RA, NP, NIV, VENTI):	RA		RA		RA		RA		RA		RA		
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	Vital Signs:	Temp:	36.5°C		36.5°C		98.3°F		98.8°F		98.6°F		98°F	
		Res:	22		21		20		20/N		18/hf		20	
		SpO ₂ :	98%		100%		99%		99%		99%		99	
		Pulse:	95		98		89		86/N		86		76	
		BP:	114/75		120/82		103/58		110/70		116/78		116/60	
		LOC:	C		conscious		C		conscious		conscious		conscious	
	Fall Risk Score:	0/10		0/10		1/10		0/10		0/10		0/10		
Pain Score:	0/10		0/10		1/10		0/10		0/10		0/10			
Skin Integrity	good		good		good		good		good		good			
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	Physiotherapy:													
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	Special Diet:	DID		DID		NID		ND		NBM		NBM		
	Critical Lab Test / Values:													
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
ADL (Dependent / Non Dependent):	dependent		dependent		dependent		dependent		independent		dependent			
Post Operative Procedure Special Orders:			Sims											
Handed Over By Name :	Sushma		Bhagyaa		Dahar		Sushma		Sushma		Nalinee			
Signature / ID :	[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]			
Date:	23/5/26		24/5/26		24/5/26		25/5/26		25/5/26		25/5/26			
Time:	@ 10pm		@ 9pm		@ 8pm		@ 2pm		@ 2pm		@ 4:20pm			
Taken Over By Name :	Bhagyaa		Dahar		Sushma		Sushma		Nalinee		VLC			
Signature / ID :	[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]			
Date:	24/5/26		24/5/26		24/5/26		25/5/26		25/5/26		25/5/26			
Time:	@ 8 AM		@ 2pm		@ 8pm		@ 2pm		@ 2pm		4:30			



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>G2 A1 @ 36+4 wks GA @ cerebral distribution @ gest Hypothyroidism der detail surveillance.</i>					Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known	
	Surgery / Procedure:					Post OP Day:	
BACKGROUND	Date	<i>25/5/26</i>	<i>25/5/26</i>	<i>26/5/26</i>	<i>26/5/26</i>	<i>27/5/26</i>	
	Shift	<i>E.</i>	<i>N</i>	<i>MEE</i>	<i>N</i>	<i>M.</i>	
	Medical Condition (Any special condition to be noted):	<i>EM. LSCS</i>	<i>EM LSCS</i>	<i>EM LSCS</i>	<i>EM LSCS</i>	<i>EM LSCS</i>	
Diet:	<i>SD</i>	<i>S/D</i>	<i>SD</i>	<i>S/D</i>	<i>SD</i>		
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>RA</i>		<i>RA</i>		<i>RA</i>	
	Tubes/Drains/Catheter:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	<i>98.6 F</i>	<i>98.6</i>	<i>98.6 F</i>	<i>98.5 F</i>	
		Res:	<i>20</i>	<i>20</i>	<i>20</i>	<i>20</i>	
		SpO ₂ :	<i>100%</i>	<i>98.1</i>	<i>99%</i>	<i>99%</i>	
		Pulse:	<i>83</i>	<i>74</i>	<i>85</i>	<i>86</i>	
		BP:	<i>94/64</i>	<i>100/70</i>	<i>92/54</i>	<i>99/60</i>	
		LOC:	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>
		Fall Risk Score:	<i>2/10</i>	<i>0</i>	<i>0</i>	<i>0/10</i>	<i>0/10</i>
	Pain Score:	<i>2/10</i>	<i>0</i>	<i>0</i>	<i>0/10</i>	<i>0/10</i>	
	Skin Integrity	<i>surgical site</i>	<i>-</i>	<i>surgical site</i>	<i>S/S</i>	<i>surgical site</i>	
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	<i>-</i>		<i>-</i>		<i>-</i>	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<i>SD.</i>		<i>S/D</i>		<i>SD</i>	
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	<i>Nondependent</i>		<i>dependent</i>		<i>dependent</i>		
Post Operative Procedure Special Orders:							
Handed Over By Name :		<i>Ukemi</i>	<i>lakshmi</i>	<i>Ukemi</i>	<i>Ankitha</i>	<i>Ukemi</i>	
Signature / ID :		<i>Ukemi</i>	<i>lakshmi</i>	<i>Ukemi</i>	<i>Ankitha</i>	<i>Ukemi</i>	
Date:		<i>25/5/26</i>	<i>26/5/26</i>	<i>26/5/26</i>	<i>27/5/26</i>	<i>27/5/26</i>	
Time:		<i>8pm</i>	<i>8pm</i>	<i>8pm</i>	<i>8pm</i>	<i>2pm</i>	
Taken Over By Name :		<i>lakshmi</i>	<i>Ukemi</i>	<i>Ankitha</i>	<i>Ukemi</i>		
Signature / ID :		<i>lakshmi</i>	<i>Ukemi</i>	<i>Ankitha</i>	<i>Ukemi</i>		
Date:		<i>25/5/26</i>	<i>26/5/26</i>	<i>26/5/26</i>	<i>27/5/26</i>		
Time:		<i>8pm</i>	<i>8pm</i>	<i>8pm</i>	<i>8pm</i>		



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
BACKGROUND	Area							
	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
Fall Risk Score:								
Pain Score:								
Recommendations	Safety Needs:							
	Physiotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Others Specify:							
	Special Diet:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Other Special Orders / Medications:							
	Post Operative Procedure Special Orders:							
	Handed Over By Name :							
	Signature :							
	Date:							
	Time:							
	Taken Over By Name :							
	Signature :							
	Date:							
	Time:							

Patient Sticker



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
BACKGROUND	Area							
	Shift Time							
	Medical Condition (Any special condition to be noted):							
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:						
		Res:						
		SpO ₂ :						
		Pulse:						
		BP:						
Fall Risk Score:								
Pain Score:								
Recommendations	Safety Needs:							
	Physiotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Others Specify:							
	Special Diet:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Other Special Orders / Medications:							
	Post Operative Procedure Special Orders:							
	Handed Over By Name :							
	Signature :							
	Date:							
	Time:							
	Taken Over By Name :							
	Signature :							
	Date:							
	Time:							

DH-00023248
 Mrs PRIYA JAIN 33 Y 7 M 24 D (F)
 9-09-1992
 Ir. PUJITHA DEVI SURANENI

IP25-00020595



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 23/05/26 @ 10:05pm

Baseline Information:

Admission From: ER OPD Admission Desk Others, specify

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: Admission for observation
 Doctor Notified on Admission: Yes No
 Name of the Doctor: @ 9:30 pm
 Time Notified: Dr. Nayuni

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

Past Medical History	Past Surgical History	Previous Hospital Admission
G. Hypothyroid	Nil	Nil
Gynecology Assessment: <input checked="" type="checkbox"/> Not Applicable Menstrual History: Onset of Menarche: Menstrual Cycle: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular Last Menstrual Period:	Gynecology Surgical History: Caesarean Section: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Cervical Cerclage: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Ectopic Pregnancy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Myomectomy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Others:	Gynecological History: Contraceptives: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Vaginal Discharge: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Post-Coital Bleeding: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Infertility: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes Type: <input checked="" type="checkbox"/> Primary <input type="checkbox"/> Secondary

Obstetric History: G 2 P L A 1

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: 36.5°C HR: 78 RR: 22
 BP: 114/75 Weight: 15 Height: 64 BMI: -

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 0 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: Yes No Score 0 (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 Family

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: Patient

Orientation not given Reason:

Nurse Signature: [Signature]

Nurse Name: Swarna

Date & Time: 23/5/26 @ 10:30 pm



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

No Complaints at Present
 Perceives fetal movements well

LMP: 06/09/25

EDD: 16/06/26

Corrected EDD:

GA: 36 + 4 wks.

Obstetric Formula:

Primigravida

Menstrual History: Regular: Yes No

Obstetric History:

married : 5 yrs
 Ncm

Obstetric Examination

Fundal Height: 36 - wky

Present Pregnancy Record:

- Spont. Conception
 - Booked at 9 wks

Ut. Activity: Relaxed Mild Mod Severe

Liquor: Adequate Oligo Poly

PP: Cephalic Breech Others _____

Head Fifths Palpable: 4/5

RISK FACTORS:

- Gest Hypothyroidism

FHS: Normal Tachy Brady Absent

Per Speculum Examination

Draining: Present Absent Bleeding

Colour of Liquor: Clear Meconium Blood Stained

Vaginal Examination

Cervix: Long Partially effaced Effaced

Os: Closed _____ Dilated _____

Membranes: Present Absent

Liquor: Clear Meconium Blood Stained

Presenting Part: Vertex Breech Others

Sutton: -3 -2 -1 0 +1 +2

Pelvis: Adequate Doubtful

Height: 152 cm

Weight: 64 kg

Allergies: Nil

Breast: Normal Abnormal

General Examination:

Consciousness: Pallor:

Icterus: Edema:

Temp: 101.70 PR: 82/m

BP: DTR:

CVS: RS SpO₂ - 98% on RA

Liver/Spleen: Urine Output:

DIAGNOSIS

Prime
 (G2A), @ 36 + 4 wks GA @ Cerebral redistribution
 @ Gest Hypothyroidism for fetal surveillance.



<p>Family History:</p> <p>Nil</p>	<p>Surgical History:</p> <p>Nil</p>
<p>Medical History:</p> <p>Klolo hest. Hypothyroidism</p>	<p>Medication History:</p> <p>Tab. Thysonorm 25mcg</p>
<p>Plan of Care:</p> <ul style="list-style-type: none"> - Admission - Post Preparation - Secure IV Cannula - NST 6th haly - Ty Betnesol 12mg I/m 12 haly. x 2 doses - JOL on 24/05/20 - DO FBS & PPBS tomorrow Do Pre & Post meal tomorrow 	<p>Investigations:</p> <p>BGT - 'B' positive ^{19/05} HB - 10.5 TLC 8030 HBARS PLT 150000 S. Creat 0.42 TSH - 1.7 OGTT - 81/130/130 HIV HCV HbsAg } NR VDRL <u>19/05/20</u> SLIUP 36 wky Cephalic PPH AFI - 13 EFW - 3030gms (72%) MCA Doppler shows cerebral redistribution</p>

Doctor Name: Dr. Mayuri
 Signature: [Signature]
 Date & Time: 23/05/20 9 pm

Consultant Name: Dr. Pujitha
 Signature: [Signature]
 Date & Time: 23/05/20 9 pm

DH-00023248

IP25-00020595

Mrs PRIYA JAIN

9-09-1992

33 Y 7 M 24 D

(F)

Dr. PUJITHA DEVI SURANENI



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/05/20 7 AM	<p>pt stable</p> <p>PR-80/m</p> <p>BP-110/80mm Hg</p> <p>SpO₂-98% on RA</p> <p>PIA ut 36wk</p> <p>cephalic</p> <p>relaxed</p> <p>FBS-132 mg/dl</p> <p>↓</p> <p>HT at Shree</p> <p>& Ty Human Actosipid</p> <p>5mls s/c</p> <p>before breakfast</p> <p>& Ty Lantus 12mls s/c</p> <p>NST- Reache</p>	<p>1x</p> <p>- diet Regular</p> <p>- Do Pre & Post meal GRRS</p> <p>- 2nd dose Ty Betnesol 12mg at 10 AM</p> <p>- NST 6th hly</p> <p>- Vitals monitoring</p> <p>- Tiscor</p>
24/05/20 10 AM	<p>Gestational hypotension & cerebral redistribution</p> <p>for steroid steroid course</p> <p>& induction of labour.</p> <p>Adeq</p> <p>c.c fair</p> <p>Alert</p> <p>BP=110/70mmHg</p> <p>PR=86bpm</p> <p>SpO₂=100% on RA</p> <p>PIA = ut = 36wk relaxed</p> <p>FBS ⊕</p>	<p>1. Normal diet</p> <p>2. pre & post meal GRRS</p> <p>3. 2nd dose of 1mg Betnesol 12mg at 10 AM.</p> <p>4. NST 4th hly</p> <p>5. Vitals Inform SOS.</p> <p>7. strict fetal kick count</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>24/5/26</u> 10:00 AM	<p><u>CLINIC TO DR. STEFF MAM (Endocrinologist)</u></p> <p>↓</p> <p>→ Post breakfast GROSS - 157 mg/dl</p> <p>→ Inj. HAI 50 S.C. (Humulin Akapid)</p> <p>→ pre lunch GROSS (Insulin)</p>	
<u>24/5/26</u> 10:00 AM	<p><u>CLINIC TO DR. PUJITHA MAM</u></p> <p>→ Shift to Room now</p> <p>→ shift to MICU at 5 pm</p> <p>→ next with baby</p> <p>→ pre & post meal sugars</p> <p>→ strict total kick count</p> <p>→ Shift to MICU at 4:30 pm - 24/5/26</p>	<p><u>Pearns</u></p> <p><u>Pearns</u></p>
<u>24/5/26</u> 2:00 PM	<p><u>CLINIC TO DR. STEFF MAM (Endocrinologist)</u></p> <p>→ pre lunch GROSS - 130 mg/dl</p> <p>→ Inj. Humulin Akapid insulin 50 S.C</p> <p>→ inform post lunch GROSS</p>	<p><u>Pearns</u></p>



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/5/26 4:30pm	c/I/T to Dr. Shree (Endocrinology) - Post lunch - 168 mg/dL - Inj. Heman Atapid insulin 4.0 SC stat - Insulin pre-dinner GRBS	
		<u>Shree</u>
24/5/26 5:30pm	↓ IOL Gefan Afebrile PR - 78 bpm BP - 127/70 mmHg. P/A-UT = 36 wks, relaxed FHS ⊕ cephalic. CTG - Reactive Plv - Ex-long Os closed.	1) 10 Misoprostol 50mcg Plustat 2) w/F contractions, POL 3) NST q 15 min 4) Monitor vitals 5) Inform SOS 6) PRBS 7) Check pre dinner GRBS
		<u>Shree</u>
7:30pm	Pre dinner GRBS - c/I/T Dr Shree Adv 1) Inj HAI 10 U SC stat 2) Inform post dinner GRBS	
		<u>Shree</u>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/5/26 9:30pm	c/o leaking P/v ↓ IOL GC fair Afebrile PR - 84 bpm BP - 126/70 mmHg SpO ₂ - 97% on RA P/A - Ut = 36wks, cephalic irritable, FHS ⊕ CTG - Reactive P/v - Cr - 50% effaced Os - 1cm dilated. PPVx station - 2 SROM, liquor clear absent membranes	e/i/t Dr Pujitha <u>Adv</u> 1) T. Misoprostol 25mcg P/O stat 2) w/f contractions, POI 3) Monitor vitals 4) NST 2nd hly. 5) Inform SOS 6) To do post dinner GRBS 7) Enema. 8) Inj Augmentin 1.2g wstat <u>Dr</u>
25/5/26 1:30am	↓ IOL GC fair Afebrile Vitals - stable P/A - Ut - 36wks, cephalic irritable, FHS ⊕ CTG - Reactive P/v - Cr - 50% effaced Os - 2cm dilated. PPVx station - 2 clear liquor	<u>Adv</u> 1) Inj Oxytocin 10U in 10RL @ 6ml/hr 2) w/f contractions, POI 3) Monitor vitals 4) NST monitoring 5) To do FBS 6) Inform SOS <u>Dr</u>



3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5/26 6:00 AM	<p>C/S/20 Dr. Pujitha V.T.O.C</p> <p>G.C. Fair Afebrile</p> <p>Bp = 110/80 mmHg PR = 88 bpm SpO₂ = 100% @ RA PIA = ut = 36 wks Cephalic irritable fHS (148 bpm)</p> <p>phx. ex. Plv - patient is not willing.</p>	<p>Ades</p> <ol style="list-style-type: none"> NBM Continue NST monitoring ICP RL 100 mmHg / hr. O₂ by mask (M) vitals 5 down 5 up Epidural counselling
	<p>NST = cassette</p> <p>Couple were counselled regarding epidural analgesia, but they denied epidural and asking for cesarean section if no maternal request</p>	<p><i>feun</i></p>
25/5/26 9:28 AM	<p>POO - 0</p> <p>pt G.C. fair afebrile</p> <p>BP - 108/70 mmHg PR - 76/min SpO₂ - 99% @ et</p> <p>Plv - uterus well contracted breeding no leakage Plv - no under PV bleeding V/O - loose emptied in OT</p>	<p><i>hallo</i></p> <p>A₂</p> <ul style="list-style-type: none"> NBM x 6 hrs IVF as per AXON monitor vitals (bleeding / pain abdomen / vomiting) strict I/O chart Drugs as charted temp (601)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/5/24	POD-1	
9am	are complay O/E pt in clinic	Rx
	afebrile	1) normal diet
	PR - 98/62	2) plenty of oral fluids
Baby (m/f)	BP - 96/49 mmHg	3) Drugs as charted.
	SpO ₂ - 98% on R	4) exclusive BF
Ux	PIA - Uxw	5) Ambulation
Fv	PIV - Uxw	6) FBS
Mx		PPBS } 27/5/24
		PLBS }
		7) vitals monitoring
		8) informatics
26/5/26	POD-1	
2:30pm	G.C fair	1) Normal diet
	Afebrile	2) Ambulation
	Bp = 100/70 mmHg	3) plenty of oral fluids
	PR = 88 bpm	4) Drugs as charted
Baby (m/f)	SpO ₂ = 100% on R	5) cut R PV
	PIA = Uxw	6) FBS, PPBS, PLBS 27/5/26
	PIV = Uxw	7) vitals under scg
Ux		
Fv		
Mx		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 7pm	<p><u>POD I</u></p> <p>A.C. fast</p> <p>Afebrile</p> <p>Sp = 100/60 mmHg</p> <p>PR = 86 bpm</p> <p>SpO2 = 100% @ RA</p> <p>PLA = clear</p> <p>AV = N/A SpV</p>	<p><u>Adv</u></p> <ol style="list-style-type: none"> 1. Ambulation 2. Nauseal diet 3. plenty of oral fluids 4. Drugs as dictated 5. w/ k SpV 6. FBS, PPKS, PUS - 27/5/26 <p>⊗ (M) vitals under S/S</p>
<p>Salivary S/S</p> <p>up fe and</p>		<p><i>[Signature]</i></p>
27/5 6:30 am	<p><u>POD II</u></p> <p>A.C. fast</p> <p>Afebrile</p> <p>Sp - 90/60 mmHg</p> <p>PR - 80 bpm</p> <p>SpO2 99% @ RA</p> <p>PLA clear</p> <p>AV = N/A SpV</p>	<p><u>Adv</u></p> <ul style="list-style-type: none"> - soft diet - plenty of oral fluids - dep antibiotics - w/ k SpV - Inj am PPKS PUS - ambulation / etc <p><i>[Signature]</i></p> <p>Inj am</p>
<p>m</p> <p>FBS - 80</p>		<p><i>[Signature]</i></p>

DH-00023248 IP25-00020595
 Mrs PRIYA JAIN 33 Y 7 M 24 D (F)
 19-09-1992
 Dr. PUJITHA DEVI SURANENI



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ICU Shifted to: WARD

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	TAB. THYRONORM	25mcg	PO	OD	22/5/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	TAB Felca	1tbl	PO	OD	24/5/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

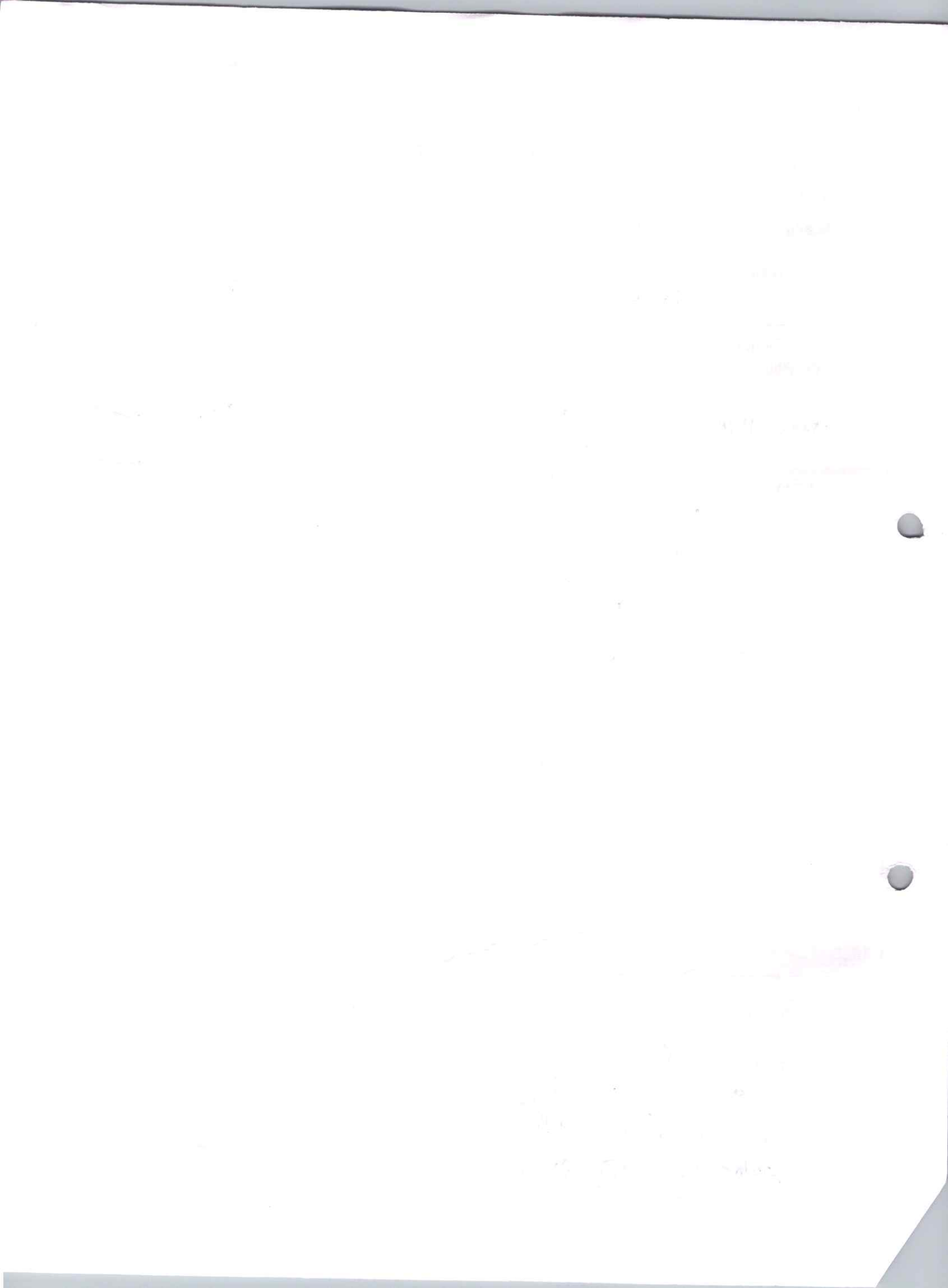
Doctor Name & Signature: Dr. K. Jayaraman

Date & Time: 24/5/26 9:00AM

Nurse Name & Signature: Shubha

Date & Time: 23/05/26 @ 9:30pm

Docu. No. : RCH / FRM / GENERAL / 090





REGULAR PRESCRIPTIONS

Weight. 60kg Ward. MW

DRUG : TAB. PARACETAMOL				Date Time	25/5	26/5	27/5													
Dose	Route	Frequency	Start Date																	
1gm	PO	QID	25/5/26	12AM	X															
Name & Signature of the Doctor Starting the Drugs: <u>Dr. S. Mohan</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

DRUG : T. DICLOFENAC				Date Time	25/5	26/5	27/5														
Dose	Route	Frequency	Start Date																		
50mg	PO	TID	25/5/26	7AM	X																
Name & Signature of the Doctor Starting the Drugs: <u>Dr. S. Mohan</u>																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

DRUG : T. TRAMADOL				Date Time																	
Dose	Route	Frequency	Start Date																		
100mg	PO	TID	25/5/26																		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. S. Mohan</u>																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

DRUG : AUGMENTIN				Date Time	25/5	26/5															
Dose	Route	Frequency	Start Date																		
1.2gm	PO	BD	25/5/26	7AM	X																
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Praveen R</u>																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

DH-00023248 IP25-00020595
 Mrs PRIYA JAIN
 29-09-1992 33 Y 7 M 24 D (F)
 Dr. PUJITHA DEVI SURANENI



REGULAR PRESCRIPTIONS

Weight 6.4 kg Ward M/W

Sheet No. 01

DRUG : <u>Metronidazole</u>				Date Time
Dose	Route	Frequency	Start Dt.	
<u>500mg</u>	<u>IV</u>	<u>TID</u>	<u>25/5/20</u>	<u>2:30</u> <u>2:30</u> <u>2:30</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr Priya J</u>				<u>6pm</u> <u>1</u>
Additional Instructions: <u>x 24hrs</u>				<u>2am</u> <u>x</u> <u>Change</u> <u>label</u>
Daily Doctor's Endorsement by a Sign				

DRUG : <u>Pantoprazole</u>				Date Time
Dose	Route	Frequency	Start Dt.	
<u>40mg</u>	<u>IV</u>	<u>QD</u>	<u>25/5/20</u>	<u>2:30</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr Priya J</u>				<u>6am</u> <u>Stop</u>
Additional Instructions:				<u>1</u> <u>pr</u> <u>change</u>
Daily Doctor's Endorsement by a Sign				

DRUG : <u>Tab Augmentin</u>				Date Time
Dose	Route	Frequency	Start Dt.	
<u>625mg</u>	<u>PO</u>	<u>BD</u>	<u>27/5</u>	<u>2:30</u> <u>Despite</u> <u>allergy</u>
Name & Signature of the Doctor Starting the Drugs: <u>R</u>				<u>3pm</u>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : <u>Tab Pantoprazole</u>				Date Time
Dose	Route	Frequency	Start Dt.	
<u>40mg</u>	<u>PO</u>	<u>BD</u>	<u>27/5</u>	<u>6am</u> <u>Despite</u> <u>allergy</u>
Name & Signature of the Doctor Starting the Drugs: <u>R</u>				<u>6pm</u>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

Signature
Name
VERIFIED BY :

Handwritten notes on the left side of the page, including the word "conclude" at the top.

Faint handwritten notes in the middle-left section of the page.

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DH-00023248

IP25-00020595

Mrs PRIYA JAIN

29-09-1992

33 Y 7 M 24 D

(F)

Jr. PUJITHA DEVI SURANENI



Weight: 64 Kgs... Ward: Mlu

Date Time	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	Nurse Sig.		
DRUG :											
Route	Start Date		Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	
Name & Signature of the Doctor			Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	
Additional Instructions:			Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	

VARIABLE DOSE		Date Time	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	Nurse Sig.	
DRUG :												
Route	Start Date		Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.		
Name & Signature of the Doctor			Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.		
Additional Instructions:			Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.	Dose	Dr. Sign.		

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
23/05	10:10 AM	INS. Betnesol	12mg	IM	[Signature]	[Signature]
24/5	7 AM	INS Human Actrapid	5 units	SLC	[Signature]	[Signature]
24/5/26	8:50 AM	INS. LANTUS	12 units	SLC	[Signature]	[Signature]
24/5/26	10:05 AM	Inj. Human Actrapid	5U	SLC	[Signature]	[Signature]
24/5	10:10 AM	INS. BETANESOL	12mg	IM	[Signature]	[Signature]
24/05/26	2 PM	INS. HUMAN ACTRAPID	8 units	SLC	[Signature]	[Signature]
24/5/26	5 PM	INS. HUMAN ACTRAPID	4U	SLC	[Signature]	[Signature]
24/5/26	5:30 PM	F. MISOPROSTOL	50mcg	PLV	[Signature]	[Signature]
24/5/26	7:40 PM	Inj Human actrapid insulin	10 units	SLC	[Signature]	[Signature]

Signature

VERIFIED BY: Name

DH-00023248

IP25-00020595

Mrs PRIYA JAIN

29-08-1992

33 Y 7 M 24 D (F)

Jr. PUJITHA DEVI SURANENI



I.V. FLUIDS CHART

Weight: 64 kgs Ward: MLW

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
25/5/26	1:30am	Tuj Oxytocin 100 ml 10KL	IV	6ml/hr	[Signature]	[Signature]	25/5/26	[Signature]	[Signature]
25/5/26	2 AM	RINGER LACTATE	IV	100 ml/hr	[Signature]	[Signature]	25/5/26	[Signature]	[Signature]
26/5/26	7:50AM	RINGER LACTATE	iv	FF	[Signature]	[Signature]	26/5	[Signature]	[Signature]
26/5/26	8:30AM	RINGER LACTATE + 200 OXYTOCIN	iv	150ml hr	[Signature]	[Signature]	26/5	[Signature]	[Signature]
25/5/26	12:27	10 RL	IV	150ml	[Signature]	[Signature]	26/5	[Signature]	[Signature]

Signature

VERIFIED BY: Name

Obstetrics and Gynaecology Early Warning Signs

Complete a Full
Set of MEOWS
Observations

1 Yellow Alert :
Repeat Observations
in 30 minutes

2 Yellow Alerts or 1 Orange Alert:
Call the Obstetrician and Repeat
Observations
in 30 minutes

> 2 Yellow Alerts or \geq 2 Orange Alerts:
Immediate Review by Obstetrician and
Repeat Observations
in 15 minutes or continuous
monitoring

* The Modified Early Warning Score (MEOWS)

DH-00023248
 Mrs PRIYA JAIN
 29-09-1992
 33 Y 7 M 24 D (F)
 Dr. PUJITHA DEVI SURANENI

IP25-00020595

2

24/5/26

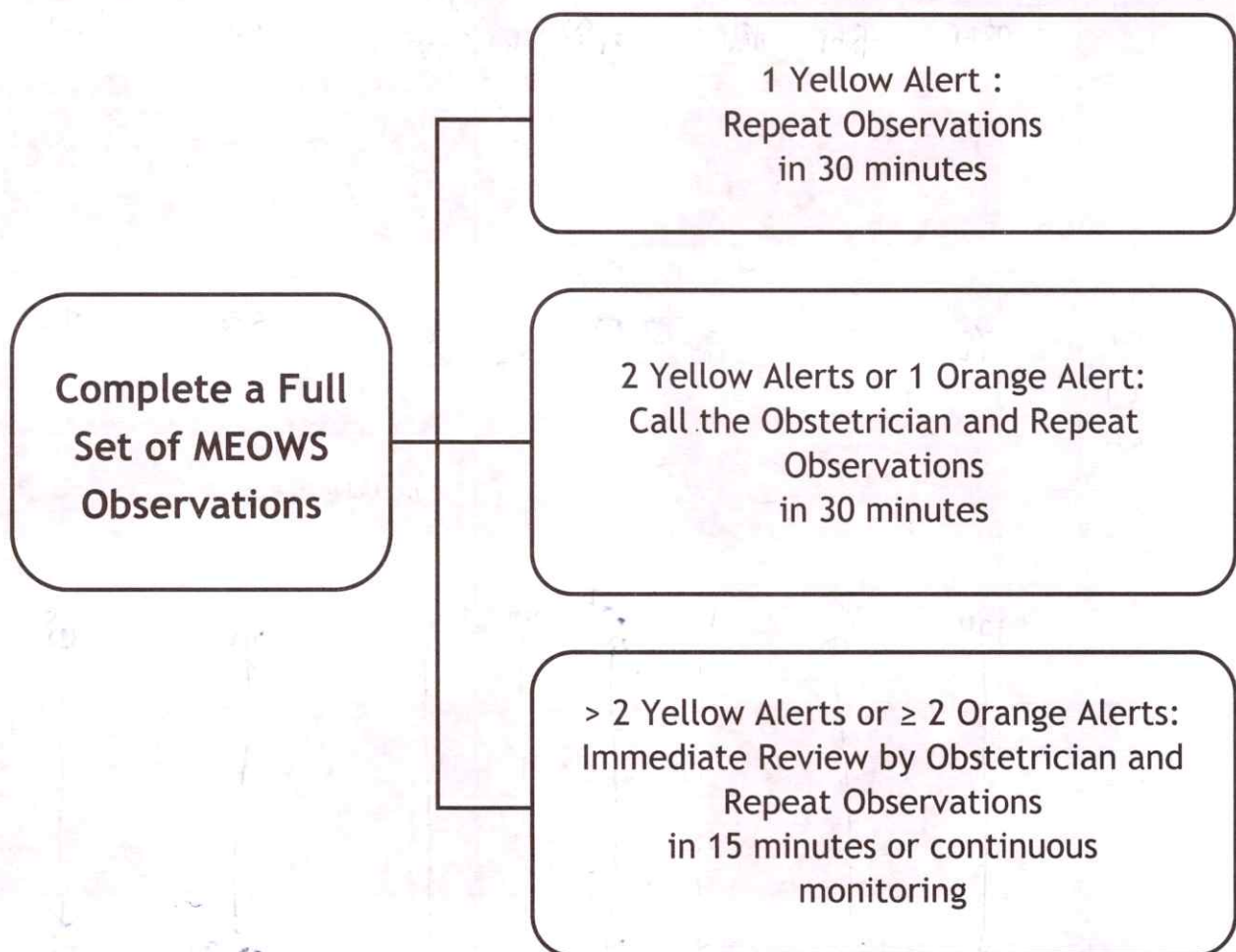


Monitoring Observation Score Chart - Obstetrics

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

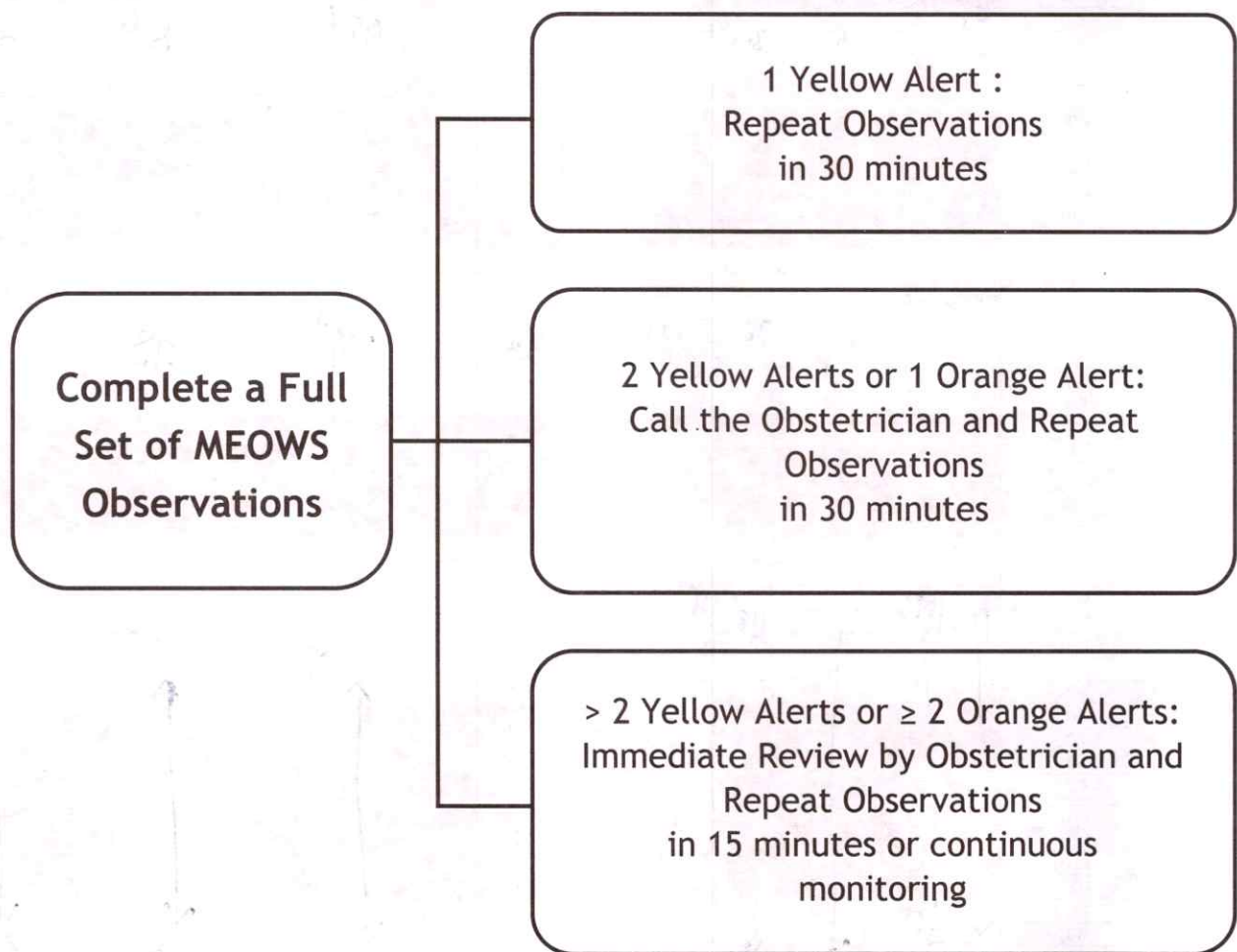
		Date	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	
RESP (write rate in corresp. box)	> 30																										
	21 - 30																										
	11 - 20		20		20			20		21		20		24					22				22				
	0 - 10																										
Saturations	94 - 100 %		100		99			99		98		98		99					99				99				
	< 94 %																										
Administered O ₂ (L/min.)																											
Temp ^c	40																										
	39																										
	38																										
	37																										
	36		98.6		98.6			98.6		98.8		98.8		98.5		98.5				98				98			
	35																										
	< 35																										
Heart Rate	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100																										
	90																										
	80		78		86			82		89		76		80						85				75			
	70																										
	60																										
	50																										
40																											
Systolic Blood Pressure	190																										
	180																										
	170																										
	160																										
	150																										
	140																										
	130																										
	120																										
	110																										
	100																										
	90																										
	80																										
	70																										
60																											
50																											
40																											
Diastolic Blood Pressure	130																										
	120																										
	110																										
	100																										
90																											
80																											
70																											
60																											
50																											
40																											
NEURO RESPONSE [✓]	Alert		A		A			A		A		A		A					A				A				
	Voice																										
	Pain																										
	Unresponsive																										
URINE mls / hour	> 30		✓		✓			✓		✓																	
	< 30																										
Proteinuria	Protein ++																										
	Protein > ++																										
Lochia	Normal		N		N			N		N		N		N													
	Heavy / Foul																										
Liquor	Clear / Pink		C		C			C		C																	
	Green																										
TOTAL YELLOW SCORES			0		0			0		0		0		0					0				0				
TOTAL ORANGE SCORES			0		0			0		0		0		0					0				0				
Nurse Initial			X		X			X		X		X		X					X				X				

Obstetrics and Gynaecology Early Warning Signs



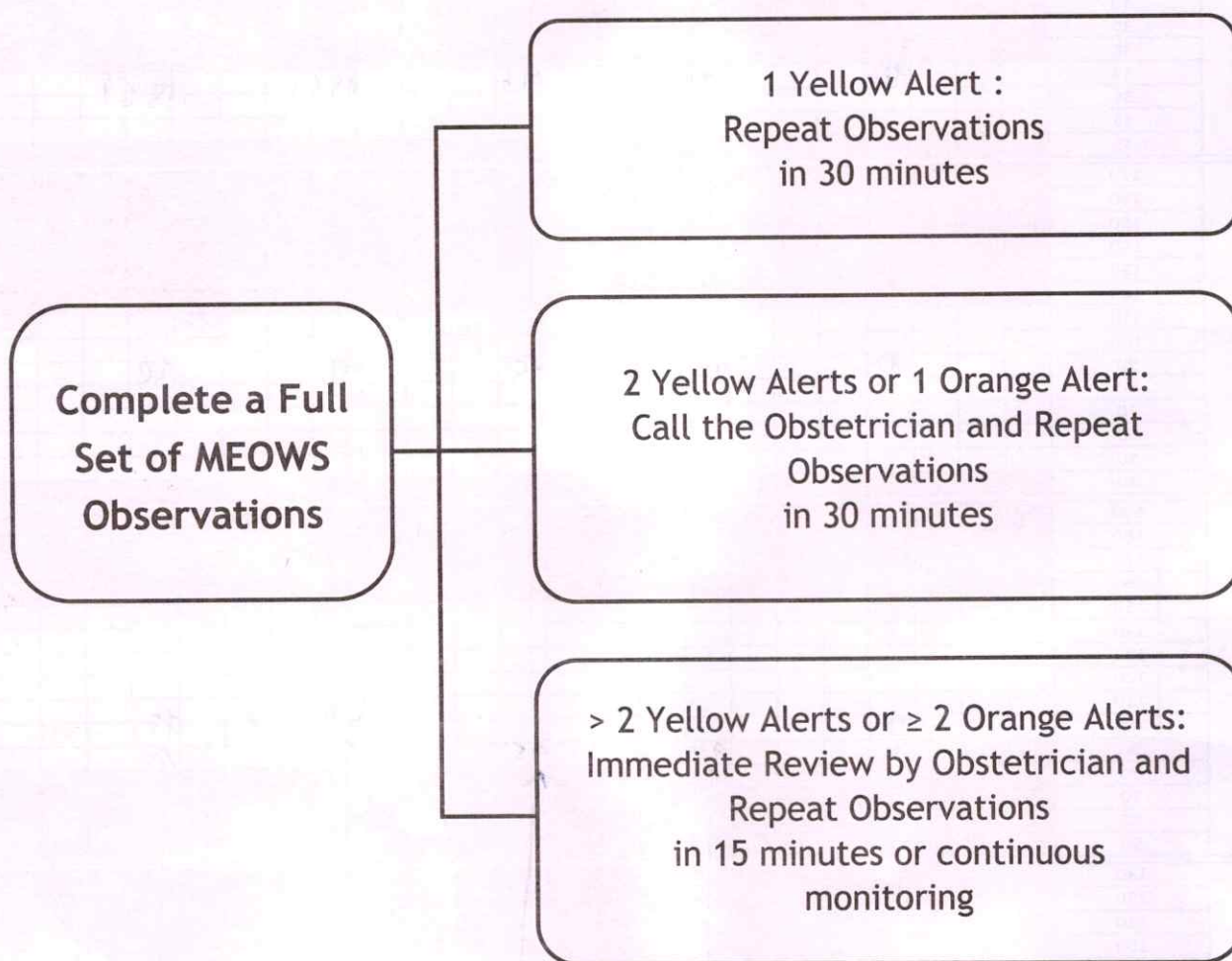
* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



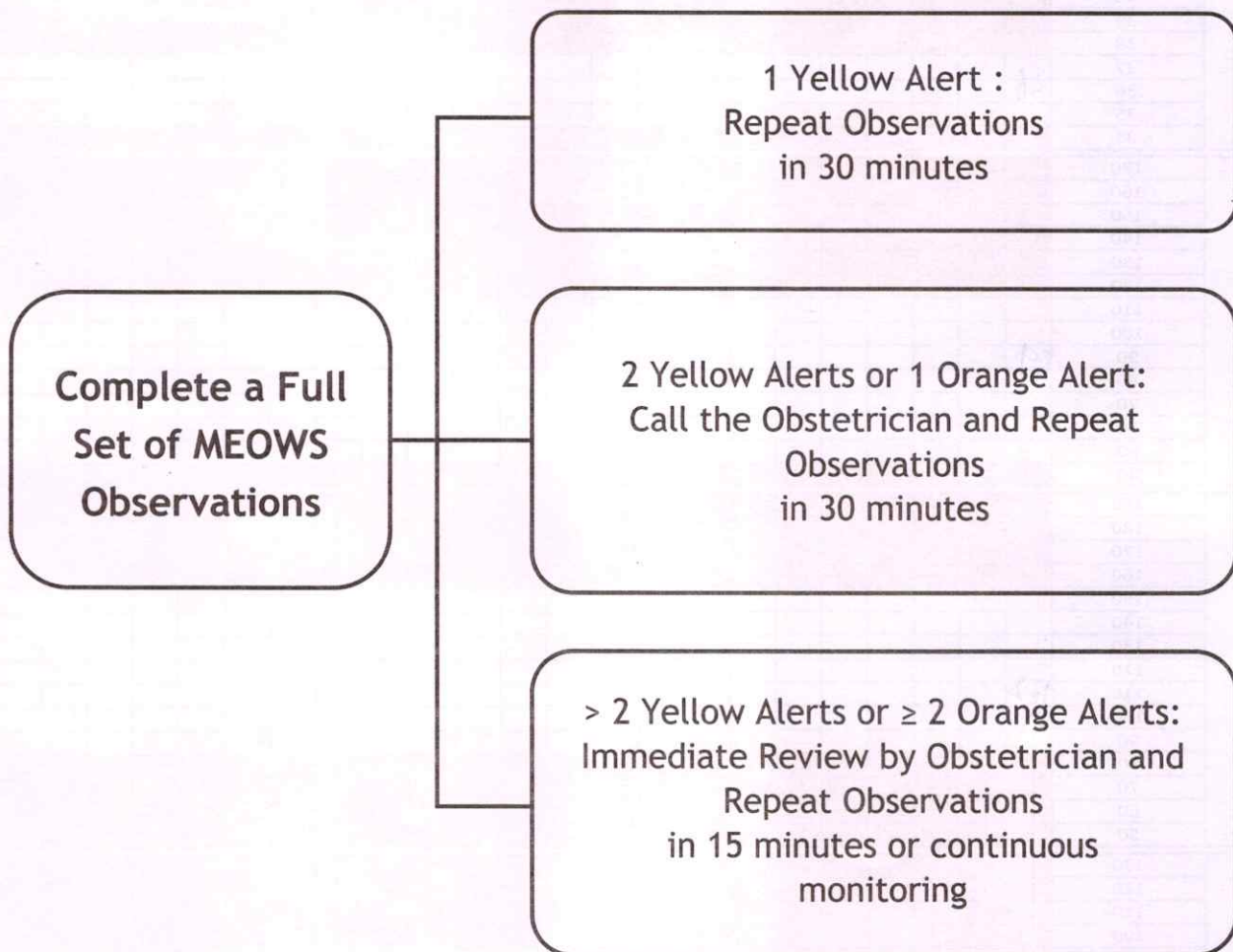
* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

DH-00023248
 Mrs PRIYA JAIN
 29-08-1992
 Dr. PUJITHA DEVI SURANENI
 IP25-00020595
 33 Y 7 M 24 D (F)

23/05/26



FLUID CHART

Sheet No. : 01

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm	H ₂ O								✓			
	11:00 pm	200ml											
	12:00 am	H ₂ O											
	01:00 am	100ml								✓			
Total Intake : 300 ml						Total Output : U-2.							
	02:00 am	H ₂ O											
	03:00 am	100ml								✓			
	04:00 am												
	05:00 am	H ₂ O											
	06:00 am	100ml								✓			
	07:00 am												
Total Intake : 200ml						Total Output : U-2, M							
Total 24 hrs. Intake		500ml											
Total 24 hrs. Output		U-4, M											



24/5/26



FLUID CHART

Sheet No. : 07

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
24/5/26	08:00 am	H ₂ O 100ml		NO	NO	NO	NO	NO	NO		0	} <i>Dr. Pankaj</i>
	09:00 am	H ₂ O 100ml								✓	0	
	10:00 am										0	
	11:00 am										0	
	12:00 pm	H ₂ O 100ml								✓	0	
	01:00 pm	H ₂ O 200ml		NO	NO	NO	NO	NO	NO		0	
Total Intake :			400ml			Total Output :					U-2	
25	02:00 pm			NO	NO	NO	NO	NO	NO	✓	0	} <i>Dr. Pankaj</i>
	03:00 pm	H ₂ O 200ml								✓	0	
	04:00 pm	H ₂ O 100ml									0	
	05:00 pm	H ₂ O 100ml								✓	0	
	06:00 pm	H ₂ O 100ml								✓	0	
	07:00 pm	H ₂ O 300ml								✓	0	
Total Intake :			600ml			Total Output :					U-4 ml	
25	08:00 pm	H ₂ O 100ml									0	} <i>Dr. Pankaj</i>
	09:00 pm	H ₂ O 100ml								✓	0	
	10:00 pm	H ₂ O 100ml								✓	0	
	11:00 pm	H ₂ O 100ml									0	
	12:00 am	H ₂ O 100ml								✓	0	
	01:00 am	H ₂ O 100ml								✓	0	
Total Intake :			400ml			Total Output :					U-3	
25	02:00 am	H ₂ O 100ml									0	} <i>Dr. Pankaj</i>
	03:00 am	H ₂ O 100ml								✓	0	
	04:00 am										0	
	05:00 am	H ₂ O 100ml								✓	0	
	06:00 am	H ₂ O 100ml									0	
	07:00 am	RL NAM 100ml									0	
Total Intake :			200ml			Total Output :					U-2	
Total 24 hrs. Intake		1600 ml										
Total 24 hrs. Output		420 ml										

25/5/26.

FLUID CHART

Sheet No. : 2

- All measurements in ml.
- Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:30 am	RL FF	-	-	-	-	-	-	-	-	0	Vaidhesh Sudhant
	09:00 am	RL 150ml	150ml	-	-	-	-	-	-	0		
	10:00 am	RL 150ml	150ml	-	-	-	-	-	-	0		
	11:00 am	RL 150ml	150ml	-	-	-	-	-	75ml	0		
	12:00 pm	RL 150ml	150ml	-	-	-	-	-	75ml	0		
	01:00 pm	RL 150ml	150ml	-	-	-	-	-	50ml	0		
Total Intake :			1250ml			Total Output :					600ml	
	02:00 pm	RL 150ml	150ml	-	-	-	-	-	-	0	Sudhant Whome	
	03:00 pm	RL 100ml	100ml	-	-	-	-	-	100ml	0		
	04:00 pm	RL 100ml	100ml	-	-	-	-	-	100ml	0		
	05:00 pm			-	-	-	-	-				
	06:00 pm	H+METRIS 100ml	100ml	-	-	-	-	-				
	07:00 pm	H+METRIS 100ml	100ml	-	-	-	-	-	80ml			
Total Intake :			850ml			Total Output :					180ml	
	08:00 pm	H ₂ O 100ml	100ml	NO	NO	NO	NO	NO	NO	NO	Sudhant	
	09:00 pm	H ₂ O 200ml	200ml	NO	NO	NO	NO	NO	NO	NO		
	10:00 pm	H ₂ O 200ml	200ml	NO	NO	NO	NO	NO	NO	NO		
	11:00 pm	H ₂ O 200ml	200ml	NO	NO	NO	NO	NO	NO	NO		
	12:00 am	H ₂ O 100ml	100ml	NO	NO	NO	NO	NO	100ml	0		
	01:00 am	H ₂ O 200ml	200ml	NO	NO	NO	NO	NO	NO	0		
Total Intake :			400ml			Total Output :					100ml	
	02:00 am	H ₂ O 100ml	100ml	NO	NO	NO	NO	NO	NO	NO	Sudhant	
	03:00 am	H ₂ O 200ml	200ml	NO	NO	NO	NO	NO	50ml	0		
	04:00 am	H ₂ O 200ml	200ml	NO	NO	NO	NO	NO	NO	0		
	05:00 am	H ₂ O 200ml	200ml	NO	NO	NO	NO	NO	NO	0		
	06:00 am	H ₂ O 100ml	100ml	NO	NO	NO	NO	NO	100ml	0		
	07:00 am	H ₂ O 200ml	200ml	NO	NO	NO	NO	NO	NO	0		
Total Intake :			400ml			Total Output :					600ml	
Total 24 hrs. Intake		2900ml										
Total 24 hrs. Output		600ml										



26/5/26

FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
26/5/26	08:00 am	tho 200ml									0	Whin
	09:00 am									0		
	10:00 am		NA	NA	NA		NA	NA		0		
	11:00 am	tho 200ml					passed			0		
	12:00 pm	coconut 150ml								0		
	01:00 pm									0		
Total Intake : 550ml.			Total Output : U-1 M-1									
	02:00 pm	tho 200ml					NO				0	Whin
	03:00 pm	tho 200ml								0		
	04:00 pm			NA	NA		NA			0		
	05:00 pm		NA							0		
	06:00 pm	tho 200ml								0		
	07:00 pm						NO			0		
Total Intake : 400ml.			Total Output : U-4 M-0									
	08:00 pm	tho 200ml	NO	NO	NO	NO	NO	NO	NO	NO	0	Whin
	09:00 pm									0		
	10:00 pm									0		
	11:00 pm	tho 200ml								0		
	12:00 am									0		
	01:00 am	tho 200ml	NO	NO	NO	NO	NO	NO	NO	0		
Total Intake : 500ml			Total Output : U-2 M-0									
	02:00 am	tho 200ml	NO	NO	NO	NO	NO	NO	NO	NO	0	Whin
	03:00 am									0		
	04:00 am									0		
	05:00 am	tho 200ml								0		
	06:00 am									0		
	07:00 am	tho 200ml	NO	NO	NO	NO	NO	NO	NO	0		
Total Intake : 500ml			Total Output : U-2 M-0									
Total 24 hrs. Intake		U-2 1950ml										
Total 24 hrs. Output		U-8 M-1										

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: PRIYA TAIN. Age: 33y Sex: Female UHID.No :
 Date: 25/5/2028 Time: 6:45AM Proposed Operation: Emergency US
 Diagnosis: A2A, E 36+4 weeks GA. E gestational hypothyroidism
 B.P / CRT: H.R: Weight: 64kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: <u>10.6</u>	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag: <u>NK</u>	ECG:
WBC: <u>8030</u>	Creat: <u>0.42</u>	Total Bill:	HCV: <u>NK</u>	2D Echo:
Plate: <u>1.5 lakh</u>	Na:	Dir. Bill:	Blood group: <u>B +ve</u>	Stress/Angio:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH: <u>1.7</u>	
	Cl-:	SGOT/SGPT:		

Allergies:

Medical History: CVS: gestational hypothyroidism on Rx
 RESP: nothing significant Diabetes:
 CNS:
 Renal: no H/O fever/cold/cough
 Hepatic / GE: Physical Activity: > 4 METS
 Others:

Past Anaesthetic History: NO

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: 3 finger Mentohyoid Distance: > 3.5 Neck: (5) Teeth: (20)
 Lungs: BLAE ⊕ clear
 Heart: S2
 CNS:

Pregnant: Yes No NA Venous Access Site : Spine Exam for regional :

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>T-Thyroxine</u>	<u>25mcg OD</u>

Pre-Operative Instructions:

- DVT Prophylaxis :
 - Water / ORS 2 Hours
 - NIL ORAL $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: Dr. S. Kishan

Patient Sticker

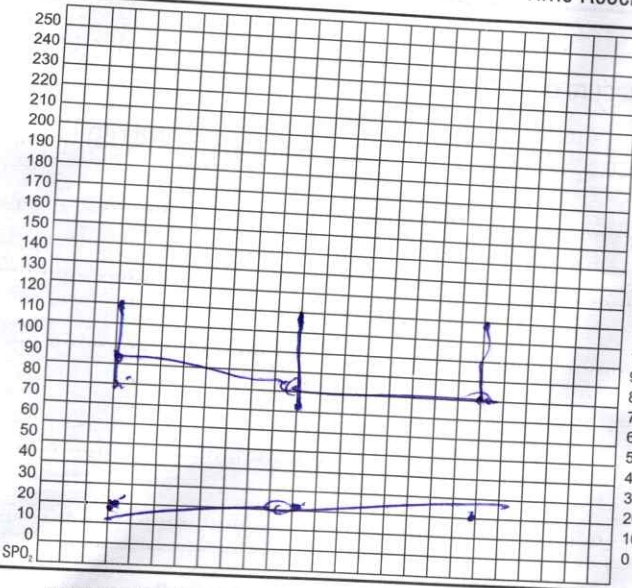
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Suharit

Time Received: 9:30am

Time Discharged: 10:30am

RESPIRATORY & PULSE



IV Cannula Site: left hand

O₂ Mask Nasal Prongs
 Tracheostomy T-Piece
 Oral Airway Nasal Airway

Vomiting: Yes No Drug: _____
 NG Tube: Yes No
 Drain: Yes No
 Urinary Catheter: Yes No
 Chest Tube: Yes No
 Nil Oral Yes No
 IV Fluids: plain RL 500ml
 Oral Feeds: NBM

POST ANAESTHESIA SCORE (Modified Aldrete Score)	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	1	2	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	2	2	2		
BP ± 20 of Pre Anaesthetic level = 2 BP ± 20-50 of Pre Anaesthetic level = 1 BP ± 50 of Pre Anaesthetic level = 0	CIRCULATION	2	2	2		
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	2	2	2		
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2		
TOTAL		9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name: DR MOHAN / DR SRINIVAS

Anaesthesiologist Signature: [Signature]

Date & Time: 25/06/20

PACU Nurse Name: [Signature]

PACU Nurse Signature: [Signature]

Date & Time: 25/6/20 @ 8AM

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): _____

Date & Time: _____

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : PRIYA JAIN Age : 33yr Gender : Male Female

UHID NO: Surgeon Name: Dr. Pujitha Devi

Anaesthesiologist : Dr. Shrinivas

Operative procedure planned : Emergency Uter.

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- Heart disease Hypertension Diabetes mellitus Renal failure
- Hepatic disorders Shock Multiple organ failure Polytrauma / Renal Tubular Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease

Others : POPH, Achup, Shivering, Bleeding

Comments :

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient PRIYA JAIN the above mentioned Emergency Uter. / Diagnostic / Therapeutic procedures

I authorize and give consent for anaesthesia (Regional / General Anesthesia / Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant : Yes No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : [Signature]
Name : Arha Jain
Relationship with Patient : Sey
Date & Time : 25/5/2026, 6:50AM

Witness :

Signature : [Signature]
Name : ARHA JAIN
Date & Time : 25/5/26, 6:30AM

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Dr. S. Mohan
Date & Time : 25/5/2026, 6:50AM

FDH-00023248 IP25-00020595
 Mrs PRIYA JAIN
 29-09-1992 33 Y 7 M 25 D (F)
 Dr. PUJITHA DEVI SURANENI



CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <i>Dr. Pujitha</i>	Date of Delivery: <i>25/5/26</i>
Assistant Surgeon: <i>Dr. Harshini</i>	Time of Delivery: <i>8:01 AM</i>
Anaesthetist's Name: <i>Dr. Mohan</i>	Gender of Baby: <i>Male</i>
Type of Anaesthesia: <i>ASA</i>	Weight of Baby: <i>2.910 kgs</i>
Neonatologist: <i>Dr. Pradeep</i>	AGPAR Score: <i>7/10 9/10</i>
Scrub Nurse: <i>Br. Rana</i>	NICU Admission: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Pre-Operative Diagnosis:

- Elective Emergency

Indication: *Maternal request*

Urgency

- Immediate Threat to life of woman or fetus
 Maternal or fetal compromise not immediately life threatening
 No maternal or fetal compromise but needs early delivery
 Delivery timed to suit woman and staff

Decision time: Knief to rectus:

CTG Description: *Reactive.*

If there was a delay give the reasons:

Surgical Procedure: *Emergency ces ↓SA.*

Post Operative Diagnosis: *0-POD*

Peri-Operative Complications: *1) Floating head (+) 2) Mild atonic PPH (+)*

Jug Methergin 0.2mg IM, Jug Carboprost 0.25mg IM Jug Tranexa 1g IV given

3) Hemostasis secured.

Amount of Blood Loss: *500ml* Blood Transfused (in ML):

Name and Number of Surgical Specimen sent for examination:

Examination Findings when Appropriate:

Presentation: Cephalic Breech Other Cervical Dilatation: cm
5th Palpable: Fetal Position:
Station: -3 -2 -1 0 +1 +2 Moulding: None + ++ +++
Caput: + ++ +++ Meconium: None + ++ +++
Bladder Catheterized: Yes No Urine: Clear Blood Stained

Skin Incision: Pfannenstiel Transverse Midline Other
Uterine Incision: Lower Segment Classical Inverted T J Incision
Previous Scar: Intact Thinned out Ruptured No Scar
Incision Through Placenta: Yes No
Delivery of head: Manual Forceps
Liquor: Clear Meconium: I II III Blood Offensive Not Offensive
Delivery of Placenta: Manual CCT Complete Incomplete Piecemeal
Cord Appearance: Normal Cord around the neck Yes No
Appearance of placenta: Normal Cavity explored Yes No
Uterus, tubes and ovaries: Normal Not Normal Sterilization: Yes No


Uterine Closure: One Layer Two Layers 1-0 vicryl Suture
Peritoneal Closure: Pelvic Abdominal None Suture
Sheath Closure: 1-0 vicryl Suture
Fat Closure: Yes No 2-0 rapid vicryl Suture
Skin Closure: Subcuticular Mattress Suture
Vaginal Evacuated Yes No
Drain: Yes No Remove in days Await instructions
Catheter Yes No Remove in 1 days Await instructions
Swap & Instruments count correct? Yes No Post-op Antibiotics Yes No
Intra-Operative Antibiotics Cover: Yes No Thromboprophylaxis Yes No

Post-Operative Notes:
..... MBM x 6 hrs
..... IV fluids as per AXON
..... Drugs as charted
..... W/F BPV, JLO
..... Monitor vitals
..... Inform SAs

Doctor Name: Dr Pujitha Doctor Signature: [Signature]
Date & Time: 25/01/26 @ 9:15 AM

5

PATIENT TRANSFER FORM

Patient Name & UHID No. DH-00023248 IP25-00020595 Mrs PRIYA JAIN 29-09-1992 33 Y 7 M 25 D (F) Dr. PUJITHA DEVI SURANENI 		Date & Time of Admission 23/05/26 @ 1:05 pm.	Date & Time of Transfer Order 25/5/26 @ 4 pm.
		Transfer Ordered by DR Praveen	Reason for Transfer Observation.
From Unit MICU	To Unit ward	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 30	Number of Imaging Films 1 op for C/	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sr. Malini		Name of Person Ordered Transfer DR Praveen.	
Patient & Clinical Records Received by : - - - - - Vheni			
Date & Time of Patient Received : 25/5/26 @ 4:20 pm			

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

Unavailable Bed


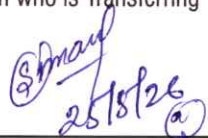
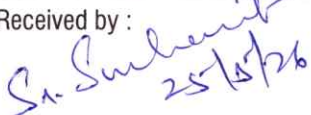
Nurse not Available

Available Bed not ready



PATIENT TRANSFER FORM



Patient Name & IUID No FDH-00023248 IP25-00020595 Mrs PRIYA JAIN 29-09-1992 33 Y 7 M 25 D (F) Dr. PUJITHA DEVI SURANENI 		Date & Time of Admission	Date & Time of Transfer Order 25/5/26 @ 9:28 AM
		Transfer Ordered by Dr. Mohan	Reason for Transfer post op care
From Unit 07	To Unit MICU	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 29	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	/		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Br. Subhadeep 		Name of Person Ordered Transfer Dr. Mohan	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received :			

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



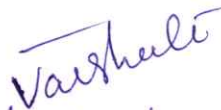
- Unavailable Bed
 Nurse not Available
 Available Bed not ready



PATIENT TRANSFER FORM

3




Patient Name & UHID No. FDH-00023248 IP25-00020595 Mrs PRIYA JAIN 33 Y 7 M 25 D (F) 29-09-1992 Dr. PUJITHA DEVI SURANENI 		Date & Time of Admission 24/5/26	Date & Time of Transfer Order 25/5/26 @ 7:30 AM
		Transfer Ordered by Dr. Ranje	Reason for Transfer EMDCS
From Unit MICU	To Unit OT	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 30	Number of Imaging Films 100 files	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Ranje	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 25/5/26			

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



PATIENT TRANSFER FORM

Patient Name & UHID No. FDH-00023248 IP25-00020595 Mrs PRIYA JAIN 29-09-1992 33 Y 7 M 25 D (F) Dr. PUJITHA DEVI SURANENI 		Date & Time of Admission 23/5/26 @ 10:05 PM	Date & Time of Transfer Order 24/5/26 @ 4:30 PM
		Transfer Ordered by DR. RAMYA	Reason for Transfer FOR IOL
From Unit Ward	To Unit MICU	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Human Actegrid	1	
2.	Cantus	1	
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Rachana 24/5/26 @ 5:00 PM		Name of Person Ordered Transfer DR. RAMYA	
Patient & Clinical Records Received by : Supriya Suraneni			
Date & Time of Patient Received :			

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

PATIENT TRANSFER FORM

<p>1. Patient Name: <i>Mr. J. Smith</i></p>	<p>2. Room No: <i>101</i></p>	<p>3. Date: <i>10/10/20</i></p>
<p>4. Referring Doctor: <i>Dr. J. Doe</i></p>	<p>5. Referring Department: <i>Medicine</i></p>	<p>6. Receiving Doctor: <i>Dr. A. Brown</i></p>
<p>7. Reason for Transfer: <i>Medical Advice</i></p>	<p>8. Referring Doctor's Signature: <i>[Signature]</i></p>	<p>9. Receiving Doctor's Signature: <i>[Signature]</i></p>
<p>10. Date of Transfer: <i>10/10/20</i></p>	<p>11. Time of Transfer: <i>10:00 AM</i></p>	<p>12. Signature of Transferor: <i>[Signature]</i></p>
<p>13. Signature of Recipient: <i>[Signature]</i></p>	<p>14. Signature of Nurse: <i>[Signature]</i></p>	<p>15. Signature of Bedside Nurse: <i>[Signature]</i></p>
<p>16. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>17. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>18. Signature of Bedside Nurse: <i>[Signature]</i></p>
<p>19. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>20. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>21. Signature of Bedside Nurse: <i>[Signature]</i></p>
<p>22. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>23. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>24. Signature of Bedside Nurse: <i>[Signature]</i></p>
<p>25. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>26. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>27. Signature of Bedside Nurse: <i>[Signature]</i></p>
<p>28. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>29. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>30. Signature of Bedside Nurse: <i>[Signature]</i></p>
<p>31. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>32. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>33. Signature of Bedside Nurse: <i>[Signature]</i></p>
<p>34. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>35. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>36. Signature of Bedside Nurse: <i>[Signature]</i></p>
<p>37. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>38. Signature of Bedside Nurse: <i>[Signature]</i></p>	<p>39. Signature of Bedside Nurse: <i>[Signature]</i></p>

If the transfer order time & destination time is not the same, please list the reason in the space below.

Unusable:


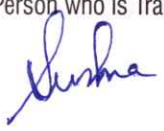

None of the above:

Date: *10/10/20*

PATIENT TRANSFER FORM

①



Patient Name & UHID No. DH-00023248 IP25-00020595 Mrs PRIYA JAIN 29-09-1992 33 Y 7 M 24 D (F) Dr. PUJITHA DEVI SURANENI 		Date & Time of Admission 23/5/26 @ 10:15 pm	Date & Time of Transfer Order 24/5/26 @ 12:50 pm
Dr. Pujitha		Transfer Ordered by Dr. Mayuri	Reason for Transfer observation
From Unit MICU	To Unit Ward	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 30	Number of Imaging Films 101 file	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring 		Name of Person Ordered Transfer Dr. Mayuri	
Patient & Clinical Records Received by : 			
Date & Time of Patient Received : 24/05/26 @ 11:04 pm			

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



Handwritten text at the top, possibly a title or header, which is mostly illegible due to fading.

Handwritten text on the left side, possibly a name or address.

Handwritten text in the center, possibly a name or address.

Handwritten text in the center, possibly a name or address.

Handwritten text on the right side, possibly a name or address.

Handwritten text in the center, possibly a name or address.




Handwritten text at the bottom left, possibly a signature or date.

Handwritten text at the bottom right, possibly a signature or date.

**NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)**

579690

0.5

Patient Name: MP'S. PRIYA JAIN	Age: 33 Y	Gender: FEMALE	
UHID No: EDHI-00022218	IP No: 00020595	Date: 22/10/2026 Time: 07:04 AM.	
Diagnosis: G2A12.36 ^{XX} WKS GA 2 4400+MPCIONCM.			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	100MCG.	
2.	Morphine Sulphate Inj. 15mg/ML	-	
3.	Remifentanyl Hydrochloride Inj. 2MG	-	
4.	Remifentanyl Hydrochloride inj. 1MG	-	
Doctor Name: DR. S. MOHAN		Doctor Registration No: 36844	
Signature: 			

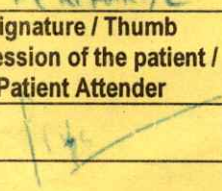
NARCOTIC DISPENSING FORM

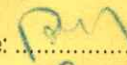
APPENDIX 4 – FORM NO. 3E

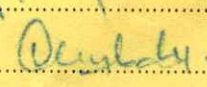
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 00020595 Date: 22/10/2026

Aadhaar No. of the Patient (Optional):

1.	Name : MP'S. PRIYA JAIN	Remarks		
2.	Complete postal address (with contact number, if any)	MANAKIANGUTTA, HUDA, AL. TELANGANA. GNDIA, 00008, PHONE NO: 9990548809.		
3.	Brief description of the illness	L.C.CS.		
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)			
5.	Details of essential Narcotic drug dispensed	FENTANYL		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
	FENTANYL	ONE		

Dispensed by (Name & ID No.): PRASANTHI (011600) Signature: 

Received by (Name & ID No.): Ravi Kumar (01011711) Signature: 

Time: 7:20 AM



NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

Patient Name: M. C. LUNA Age: 10 Gender: Female

UID No: 10000000000000000000 Date of Birth: 10/10/00

Diagnosis: ADHD

PRESCRIPTION DETAILS (Tick only one of the following)

S. No.	Drug Name	Dosage	Remarks
1	Paroxetine HCL 30mg	30mg	
2	Morphine Sulphate 10mg	10mg	
3	Paroxetine HCL 30mg	30mg	
4	Paroxetine HCL 30mg	30mg	

Doctor Name: M. C. LUNA Doctor Registration No: 30844

Signature: _____

NARCOTIC DISPENSING FORM APPENDIX A FORM NO. 35

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 10000000000000000000 Date: 10/10/00

Address No. of the Patient (Optional): _____

S. No.	Name of the Patient	Complete postal address (with contact number, if any)	Brief description of the illness	Whether registered with any other registered medical practitioner (specify medical institution if yes, details of the treatment)	Details of essential Narcotic drug dispensed	Date	Name of the Essential Narcotic Drugs	Quantity	Signature of the patient / Patient Attender	Signature of the Dispenser	Remarks, if any
1	<u>M. C. LUNA</u>	<u>10000000000000000000</u>	<u>ADHD</u>	<u>Not registered</u>	<u>30mg Paroxetine HCL</u>	<u>10/10/00</u>	<u>Paroxetine HCL 30mg</u>	<u>30mg</u>	<u>M. C. LUNA</u>	<u>M. C. LUNA</u>	

Dispensed by (Name & ID No.): _____ Signature: _____

Received by (Name & ID No.): _____ Signature: _____

Date: _____

Form No. 35 - PART CLINICAL 1/00