

**DISCHARGE SUMMARY**

<b>Name</b>	Mrs AMRUTA PARMAR EDDULA	<b>UHID</b>	FDH-00036908
<b>Father/Guardian</b>	Mr SANDEEP EDDULA	<b>Age/Gender</b>	32 Y 6 M 10 D/ Female
<b>Address</b>	Kokapet, Hyderabad, Telangana, INDIA, 500075		
<b>IP No</b>	IP25-00020423	<b>Admission Date</b>	13-05-2026
<b>Ref Doctor</b>	Self		
<b>Discharge Date</b>	15.06.2026		

**Consultant :**

**Dr. Manasa Badveli**

**MBBS,MS,MRCOG (UK),FCG(USA),FMAS,FIAOG**

Senior Consultant-Obstetrician and Gynaecologist

Laparoscopic and Aesthetic Surgeon.

Reg. No : 88518

**Diagnosis:G2P1L1 AT 39 WEEKS GESTATION WITH PREVIOUS LSCS FOR ELECTIVE LSCS + BILATERAL TUBECTOMY**

ELECTIVE LSCS + BILATERAL TUBECTOMY + UMBILICAL REPAIR DONE, DELIVERED A LIVE MALE BABY AT 10:23 AM, WEIGHT 3.885 KGS ON 13.05.2026.

**History:**

LMP: 16.08.2025

Obstetric formula: G2P1L1

EDD: 20.05.2026

Gestation at admission: 39 weeks

**Obstetric History:**

G1 - 2021 ,female, FT LSCS(i/v/o GDM), 3.2kg, A&H.

G2 - Present pregnancy Spontaneous conception.



Name	Mrs AMRUTA PARMAR EDDULA	UHID	UH-00036908
IP No	IP25-00020423	Admission Date	13-05-2026

Medical History: Nil

Family History : Mother & Father- Prediabetic.

Surgical History: Nil

Allergies : Allergic to Hazelnut, Chestnut & Brinjal

### Antenatal Details:

Mrs. AMRUTA PARMAR EDDULA was booked to Rainbow hospital at 7+3 weeks of gestation. She had regular antenatal checkups and investigations as advised. NT scan at 12+4weeks was normal. TIFFA scan at 19+3weeks was normal. USG done on 22.04.2026 showed SLIUF at 36 weeks, cephalic ,Placenta anterior and high, AFI 11.7cms, AC - 94%, EFW 3143 grams(81%) with normal fetal dopplers. She was admitted at 39 weeks with previous LSCS for EL.LSCS + Bilateral tubectomy+ umbilical hernia.

**Investigations:** Enclosed.

Blood group & Typing - "B" Rh positive.

### Management: Course in hospital:

She was prepared for elective C- section 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. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given. Patient shifted to theatre.

### Surgery Notes:

Under spinal anesthesia she was painted and draped as per hospital protocol. The previous scar excised. 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. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given.



Name	Mrs AMRUTA PARMAR EDDULA	UHID	PH-00036908
IP No	IP25-00020423	Admission Date	13-05-2026

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 600 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

- \* **Bilateral tubectomy done, Tubal fragments sent for HPE.**
- \* **Umbilical defect of 1.5cm repaired with Vicryl No.1.**

#### Delivery Details:

Date : 13.05.2026  
Time of Delivery: 10:23 AM  
Type of Delivery: Elective LSCS  
Indication : Previous LSCS  
Analgesia : Spinal

#### Baby Details:

Date : 13.05.2026  
Time : 10:23 AM  
Sex : Male  
Weight : 3.885 KGS  
Apgar : 8/10, 9/10  
Gestational Age: 39 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. 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



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to patient supplemented by written information. She was given the postpartum book for further reference.

**Advice:**

1. Tab. Augmentin 625mg twice daily till 19.05.2026 (9am-9pm) after food.
2. Tab. Calpol (Paracetamol 500mg) 2 tablets thrice daily till 19.05.2026 (8am-2pm-10pm) after food.
3. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 19.05.2026 (7am-7pm) before food.
4. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
5. Tab. Shelcal (Elemental Calcium 500mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
6. Nebasulf Powder for local application.
7. To collect HPE report.

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 23.05.2026 with prior appointment.

Review with **Dr. MANASA BADVELI**, after one week on 23.05.2026 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.



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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, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Patient/ Attender

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**

**Registrar/Resident/C.M.O  
Consultant :**

**Dr. Manasa Badveli**

**MBBS,MS,MRCOG (UK),FCG(USA),FMAS,FIAOG**

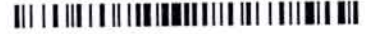
Senior Consultant-Obstetrician and Gynaecologist

Laparoscopic and Aesthetic Surgeon.

Reg. No : 88518



ADMISSION SHEET



Registration Details :

Admission No : IP25-00020423      Admit Date : 13-May-2026      Admit Time : 08:19 AM      UHID : FDH-00036908

Patient Details :

Patient Name : Mrs AMRUTA PARMAR EDDULA      Age : 32 Y 6 M 10 D  
Guardian : Mr SANDEEP EDDULA      DOB : 03-11-1993  
Gender : Female      Religion :  
Occupation :      Martial Status :  
Address (H) : Kokapet Hyderabad Telangana INDIA 500075      Phone No : 7620258223/ 7795077836  
E-mail :

Admission Details :

Bed Type : SUITE      Bed No : BIRTH SUITE-02      Ward Name : 4F -BIRTH SUITE  
Room No : BIRTH SUITE-02      Admission Type : First Visit

Contact Details :

Name : Mr SANDEEP EDDULA      Relationship : Husband  
Contact Address : Kokapet Hyderabad Telangana INDIA 500075      Phone No :

*E. Sandeep*

Signature

Doctor Details :

Doctor Name : Dr. MANASA BADVELI      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



FDH-00036908 IP25-00020423  
Mrs AMRUTA PARMAR EDDULA  
03-11-1993 32 Y 6 M 10 D (F)  
Dr. MANASA BADVELI



### SURGERY DETAILS

Date : 13/5/2026

Patient Name: Mrs. Amruta Date of Birth: 3-11-1993 Age: 32 yrs

Gender: female Ward: OT UHID No.: FDH-00036908

Date of Surgery: 13/5/2026  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2

Name of the Surgery : Elective LSCS + BTL + Umbilical hernia repair

Time in : 10:05 AM

Time Out : ~~11:35 AM~~  
11:35 AM

	NAME	AMOUNT
1. Surgeon	Dr. Manasa	
2. Anaesthetist	Dr. Usha	
3. Assistant Surgeon	Dr. Vidhya	
4. OT Technician	Sr. Navya	
5. Circulating Nurse	Sr. Sreeja	
6. Assistant Nurse	Sr. Parvathi	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 574900/901

Order by: Parvathi

URGENT DETAILS

10:00

11:00

12:00

13:00

14:00

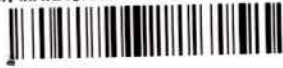
15:00

16:00

17:00

18:00

19:00



LSC + Tubectomy

**CONSUMABLES OF OT**

Circulating staff : ..... Technician : Manya Date : 13/05/26 Time : .....

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <u>LSC</u>		<u>01</u>	Inj Vit.K		<u>01</u>
LMA			Sutures			Cord Clamp		<u>01</u>
ECG leads <u>A/P/N</u>		<u>03</u>	<u>2347</u>		<u>03</u>	Suction Catheter		<u>01</u>
HME filter : A/P/N			<u>2762</u>		<u>01</u>	Feeding Tube		
Syringes : 10 cc ✓		<u>02</u>				Vaccum Suction Set		<u>01</u>
05 cc ✓		<u>02</u>	Gloves <u>6, 6 1/2</u>		<u>3+3</u>	Surgical Gloves		<u>01</u>
02 cc ✓		<u>02</u>				Gauze Pack		<u>01</u>
01 cc ✓						Syringe 1ml / 2ml		<u>01</u>
Cautery plate : <u>A/P/N</u>		<u>01</u>	Surgical blade <u>22</u>		<u>01</u>	Surgical Blade # 20		<u>01</u>
IV set			NG tube			Koochies (S)		<u>01</u>
RL ✓		<u>01</u>	Cautery pencil		<u>01</u>	<u>Underpad</u>		<u>01</u>
NS : 10ml / 100ml / 500ml / 1000ml			Koochies			<div style="border: 2px solid black; padding: 5px; transform: rotate(-15deg); display: inline-block;"> <b>Baby Side</b>  <u>574895</u> </div>		
<u>Carbetocin</u>		<u>01</u>	Ointments					
<u>CUROPINE</u>		<u>01</u>	Suction Catheter					
<u>Fentanyl</u>		<u>01</u>	Cap, Mask					
<u>Morphine</u>			Gauze Pack		<u>03</u>			
<u>Ketamine</u>			Mop Pack		<u>02</u>			
<u>Propofol</u>			Steristrip <u>Sterizon</u>		<u>01</u>			
<u>Rocuronium</u>			Underpad		<u>02</u>			
<u>Glycopyrolate</u>			Draw sheet					
<u>Myopyrolate</u>			Abgel		<u>01</u>			
<u>Ondansetron</u>			Foleys catheter <u>NO:14</u>		<u>01</u>			
<u>Pencan 25</u> / Spinal Needle 22		<u>01</u>	Urobag		<u>01</u>	<u>DIV Apron</u>		<u>03</u>
<u>Bupivacaine 0.25%</u>			Chest Drainage Catheter			<u>Misoprost</u>		<u>04</u>
<u>Bupivacaine 0.25% (Heavy)</u>		<u>01</u>	Romodrain bag			<u>New MOM pad</u>		<u>01</u>
Antibiotics			Bandage			<u>D/W water</u>		<u>05</u>
			Tegaderm			<u>DIV 10cc</u>		<u>02</u>
Suppositories			Ioban					
Anamol : 80mg / 250mg / 470 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>02</u>			
			Microshield					
			Cotton Balls					
			Latex Gloves		<u>20</u>			
			Ramdione Scrub		<u>020</u>			
			Saral					

Surgeon ..... Anaesthesiologist Pamvathy Nurse Pamvathy OT Technician .....  
 Order No. 574893 (NSG) / 575003 (JPH) Ordered by : .....  
 Doc. No. : RCH / FRM / GENERAL / 125

Introduction to...

of...

...

...

...

...

...

...

...


OBLG

**ACTIVITY RECORD FOR BILLING**

FDH-00036908 IP25-00020423

Name: -----  
Mrs AMRUTA PARMAR EDDULA  
03-11-1993 32 Y 6 M 10 D (F) -----

Dr. MANASA BADVELI

UHID No : ---  ----- Consultant : ----- Dept : -----

Date of Admission : ----- Date of Discharge : ----- Time: -----

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

**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
13/5/26	9.55AM	MICU	OT	RJ
13/5/26	11.40AM	OT	MICU	Seena
13/5/26	4.45PM	MICU	3 <sup>rd</sup> floor	Manu
14/5/26				neha

**Cross Consultation Visit**

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





**PROCEEDURE**

Date	ProceEDURE	Quantity	Order No.	Signature
13/5/26	Iv placement	1	<del>4886</del>	[Signature]
13/5/26	Catheterization	1	<del>4886</del>	[Signature]
	PAC OP	OP		
<p>cross checked by [Signature] 13/5/26 @ 11M</p>				
<p><del>Not Done by [Signature]</del></p>				

**ANY OTHER INFORMATION**

B<sup>+</sup>ve Blood available in anyuch Blood Bank  
 o.p file given to patient attendes

[Signature: S. Sandeep]

Date: 13/5/26

Time: 8:20AM

Prepared By: [Signature: Naveen]

Staff Nurse [Signature: Naveen]	Shift / Ward MSCW	Billing Assistant	Billing Supervisor
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**ELECTRONIC MEDICINE PRESCRIPTION**

MRN : FDH-00036908      Name : Mrs AMRUTA PARMAR EDDULA  
 Age / Sex : 32 Y 6 M 10 D / Female      Doctor : MANASA BADVELI  
 Adm/Reg Date/Time : 13/05/2026 08:19      Payor : MEDI ASSIST INSURANCE TPA PVT LTD  
 Order Date : 13/05/2026 16:58      Ordernumber : 25-0000575025  
 Visit ID : IP25-00020423      Ward/Bed No : 3F -PRIVATE ROOM / PVT-325  
 Patient Address : Kokapet, Hyderabad, Telangana, INDIA, 500075

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	AEQUIMENTIN INJ 1.2GM	AMOXICILLIN 1000 & CLAVULANIC ACID 200 M	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
2	NOVAMOX-CV 625 TABLETS 1 X10'S		1 Nos	Combination / BID	1 Days		10 Nos	Dispensed
3	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	1 Days		1 Bottle	Dispensed
4	AIMA FLO 40MG INJ		1 Nos	Combination / Once Daily	1 Days		3 Nos	Dispensed
5	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	1 Days		1 Bottle	Dispensed
6	POLYFLUSH 3ML	POLYFLUSH 3ML	1 Nos	Combination / Once Daily	1 Days		3 Nos	Dispensed
7	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
8	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
9	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
10	NS IV 1000 ML BOTTLE		1 Bottle	/ Once Daily	3 Days		3 Bottle	Dispensed
11	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
12	ZOVANTA 40MG TAB 15S	PANTAPRAZOLE 40MG TAB	1 Tabs	/ Once Daily	5 Days		5 Nos	Dispensed
13	BUPICAIN HEAVY 80MG INJ 4ML	BUPIVACAINE 80MG INJ	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
14	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	Rectal / Once Daily	1 Days		1 Nos	Dispensed
15	ACTININ SUPPOSITORIES 100 MG 5 S		1 Nos	Rectal / Once Daily	1 Days		1 Nos	Dispensed
16	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
17	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	Combination / Once Daily	1 Days		5 Nos	Dispensed
18	NEWMOM DISPOSABLE PADFIXATOR-XXLARGE	NEWMOM DISPOSABLE PADFIXATOR-XXLARGE	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
19	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	1 Nos	/ Once Daily	20 Days		20 Nos	Dispensed
20	CALPOL TAB 500MG15S		1 Tabs	Oral / THREE TIMES A DAY	1 Days		20 Tabs	Dispensed
21	BCV-INTRAFIX SAFESET		1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
22	RILIGOL 100 MCG INJ CARBITOCIN		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
23	NEW MOM DISP MATERNITY PADS MAXIPAD	NEW MOM DISP MATERNITY PADS MAXIPAD 5 S	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
24	PENCAN 25G*3 1 2	PENCAN 25G*3 1 2	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed



**ELECTRONIC MEDICINE PRESCRIPTION**

MRN : FDH-00036908      Name : Mrs AMRUTA PARMAR EDDULA  
 Age / Sex : 32 Y 6 M 10 D / Female      Doctor : MANASA BADVELI  
 Adm/Reg Date/Time : 13/05/2026 08:19      Payor : MEDI ASSIST INSURANCE TPA PVT LTD  
 Order Date : 13/05/2026 16:26      Ordernumber : 25-0000575003  
 Visit ID : IP25-00020423      Ward/Bed No : 4F -MICU / CRDL MICU 3-2  
 Patient Address : Kokapet, Hyderabad, Telangana, INDIA, 500075

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	BUPICAIN HEAVY 80MG INJ 4ML	BUPIVACAINE 80MG INJ	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
2	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	1 Days		1 Bottle	Dispensed
3	THEMICAR 30MG INJ 10ML		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
4	PENCAN 25G*3 1 2	PENCAN 25G*3 1 2	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	Rectal / Once Daily	1 Days		1 Nos	Dispensed
6	RILIGOL 100 MCG INJ CARBITOCIN		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
7	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	/ Once Daily	1 Days		2 Nos	Dispensed
8	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
9	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
10	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	Rectal / Once Daily	1 Days		1 Nos	Dispensed
11	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
12	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
13	CUROPINE (ATROPINE) INJ 1 ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed

**MANASA BADVELI**  
**OBSTETRICS AND GYNECOLOGY**

Reg No : 12176

*Attendant Signature*  
*E. Sandeep*

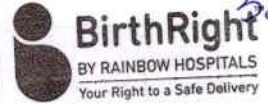
\* This document is just for reference purpose only. Not to be considered as primary report.

**Note**

\* This prescription is valid only for specified duration.

\* Do not refill medicines.

FDH-00036908 IP25-00020423  
Mrs AMRUTA PARMAR EDDULA  
03-11-1993 32 Y 6 M 11 D (F)  
Dr. MANASA BADVELI



323-1A  
325

# NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 14/5/20 Time: 9:30a

Origin: Durgam Height: 169 Weight: 94.3 BMI:  ~ 26 kg/m<sup>2</sup>  
 ~ 28 kg/m<sup>2</sup>  
 ~ 30 kg/m<sup>2</sup>

Food Allergies: Bronchial, Asthma

Diagnosis: specific protein for safe curd

- Type of Diet:  Liquid  Soft  Normal  Diabetic  
 Vegetarian  Non-Vegetarian  Vegan

Diet Advised:

Liquid Diet – ORS/ Coconut Water / Butter Milk / Barley Water / Soups

Normal Diet – Rice, Rotis, Dal and Soft Cooked Vegetables and Curd

Soft Diet – Soft Rice, Dal and Vegetable Curries Soft Cooked, Curd

Diabetic Diet – Brown Rice / Oats/ Dahlia/ Rotis, Dal and Vegetables and Curd (Avoid Roots / Tubers)

Patient's / Attendant's  
Signature: *[Signature]*

Name: Amruta

Date & Time: 14/5/20 9:30a

Dietician's  
Signature: *[Signature]*

Name: Dhoni

Date & Time: 14/5/20 9:30a





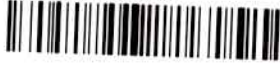
### NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>Placenta Previa Lacer 39 wks GA with safe confinement</i>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	<i>13/5/26</i>	<i>13/5/26</i>	<i>13/5/26</i>	<i>14/5/26</i>	<i>14/5/26</i>	<i>15/5/26</i>	
	Shift	<i>M</i>	<i>N</i>	<i>M</i>	<i>E</i>	<i>N</i>	<i>M</i>	
	Medical Condition (Any special condition to be noted):	-	-	-	-	-	-	
Diet:	<i>NBM</i>	<i>S/D</i>	<i>S/H</i>	<i>N/D</i>	<i>N/D</i>	<i>N/D</i>	<i>N/D</i>	
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	Ventilation (RA, NP, NIV, VENTI):	-						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	Vital Signs:	Temp:	<i>38.9</i>	<i>38.6</i>	<i>38.1</i>	<i>37.0</i>	<i>38.6</i>	<i>38.5</i>
		Res:	<i>20</i>	<i>20</i>	<i>21</i>	<i>20</i>	<i>20</i>	<i>21</i>
		SpO <sub>2</sub> :	<i>95</i>	<i>99</i>	<i>100</i>	<i>100</i>	<i>99</i>	<i>99</i>
		Pulse:	-	-	-	<i>86</i>	<i>86</i>	<i>85</i>
		BP:	<i>82/54</i>	<i>100/70</i>	<i>100/70</i>	<i>120/80</i>	<i>120/80</i>	<i>120/85</i>
		LOC:	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>conscious</i>
	Fall Risk Score:	<i>0/10</i>	<i>0/10</i>	<i>0/10</i>	<i>0/10</i>	<i>0/6</i>	<i>0/6</i>	
Pain Score:	<i>0/10</i>	<i>0/10</i>	<i>0/10</i>	<i>0/10</i>	<i>0/10</i>	<i>0/10</i>		
Skin Integrity	<i>Good</i>	<i>Good</i>	<i>Good</i>	<i>Good</i>	<i>Good</i>	<i>Good</i>		
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	Physiotherapy:	-						
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	Special Diet:	<i>N/D</i>						
	Critical Lab Test / Values:	-						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	ADL (Dependent / Non Dependent):	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	
Post Operative Procedure Special Orders:	-							
Handed Over By Name :	<i>Neha</i>	<i>Bhavara</i>	<i>Sume</i>	<i>neha</i>	<i>Bhavara</i>	<i>Ankitha</i>		
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:	<i>13/5/26</i>	<i>14/5/26</i>	<i>14/5/26</i>	<i>14/5/26</i>	<i>15/5/26</i>	<i>15/5/26</i>		
Time:	<i>8:30 AM</i>	<i>8 AM</i>	<i>2 PM</i>	<i>@ 8 PM</i>	<i>8 AM</i>	<i>@ 2 PM</i>		
Taken Over By Name :	<i>Bhavara</i>	<i>Sume</i>	<i>neha</i>	<i>Bhavara</i>	<i>Ankitha</i>			
Signature / ID :	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>			
Date:	<i>13/5/26</i>	<i>14/5/26</i>	<i>14/5/26</i>	<i>14/5/26</i>	<i>15/5/26</i>			
Time:	<i>8 PM</i>	<i>8 AM</i>	<i>@ 2 PM</i>	<i>8 AM</i>	<i>@ 8 AM</i>			



### NURSING SHIFT HAND OVER FORM

<b>SITUATION</b>	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify: .....					
	Surgery / Procedure:	Post OP Day:					
<b>BACKGROUND</b>	Date	/	/	/	/	/	/
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
<b>ASSESSMENT</b>	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
	Ventilation (RA, NP, NIV, VENTI):						
	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 <sub>2</sub> :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
<b>Recommendations</b>	Safety Needs:	<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
	Physiotherapy:						
	Others Specify:	<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
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<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
	PU Prophylaxis:	<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
DVT Prophylaxis:	<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	
ADL (Dependent / Non Dependent):							
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							



## OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 13/11/20 at 8:19 AM

**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:** for safe confinement Doctor Notified on Admission:  Yes  No  
 Name of the Doctor: Dr. Pooja  
 Time Notified: 8 AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>—</u>	<u>yes</u>	<u>—</u>

Gynecology Assessment: <input type="checkbox"/> Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History: .....	Caesarean Section: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Contraceptives: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Onset of Menarche: .....	Cervical Cerclage: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Vaginal Discharge: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Menstrual Cycle: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular	Ectopic Pregnancy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Post-Coital Bleeding: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Last Menstrual Period: <u>16/10/25</u>	Myomectomy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<b>Infertility:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
	Others: .....	<b>If Yes Type:</b> <input type="checkbox"/> Primary <input type="checkbox"/> Secondary

**Obstetric History:** G 2 P 1 L 1 A —

**Previous LSCS:** yes

**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 HR: 80/nt RR: 20/nt  
 BP: 130/86 Weight: 90.5 kg Height: ..... BMI: .....

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

Patient Sticker

**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 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: maria .....

Orientation not given Reason: .....

Nurse Signature: [Signature] .....

Nurse Name: Maria .....

Date & Time: 13.5.26 at 8:45 AM .....



# IP ADMISSION SHEET FOR OBSTETRICS

**Presenting Complaints**

For safe confinement

LMP: 16/8/25

EDD: 23/5/26

Corrected EDD: 20/5/26

GA: 39 weeks

Obstetric Formula: G2 P1 L1 E preve LSCC

Menstrual History: Regular:  Yes  No

**Obstetric History:**

G1 - FTHSCS / elective caesarean (V) / 2021  
 GDM on MNT / 4y old / A2H

**Obstetric Examination**

Fundal Height: Term gestation

Ut. Activity:  Relaxed  Mild  Mod  Severe

Liquor:  Adequate  Oligo  Poly

PP:  Cephalic  Breech  Others \_\_\_\_\_

Head Fifths Palpable: 4/5th palpable

FHS:  Normal  Tachy  Brady  Absent

**Present Pregnancy Record:**

T1 - Booked e our unit e 7<sup>th</sup> week

T2 } uneventful NT scan  
 T3 } TIF scan

**RISK FACTORS:**

- preve LSCC

**Per Speculum Examination**

Draining:  Present  Absent  Bleeding

Colour of Liquor:  Clear  Meconium  Blood Stained

**Vaginal Examination - Not done**

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: 169 cm

Weight: 94.3 kg

Allergies: Nil

Breast:  Normal  Abnormal

**General Examination:**

Consciousness: c/c/c Pallor: ⊖

Icterus: ⊖ Edema: ⊖

Temp:afebrile PR:

BP: DTR:

CVS: S1S2 ⊕ RS BAE ⊕

Liver/Spleen: Urine Output:

**DIAGNOSIS**

G2 P1 L1 E preve LSCC 39 weeks GA for safe confinement

Patient Sticker

Family History:

Mother } prediabetic  
 Father }

Surgical History:

~~KH~~  
 LSCS - 2021

Medical History:

Nil

Medication History:

~~Choc~~ Allergic to Hazelnut,  
 Chestnut & Brinjal

Plan of Care:

- 1) LSCM
- 2) postpreparation
- 3) Secure IV access
- 4) Admission NST
- 5) preop drugs as charted
- 6) Informed consent
- 7) check Blood availability

Investigations:

<sup>G/S</sup> CBP - 12.5 / 8.8K / 2.33L

BGT - B+ve

HIV }  
 HBSAg } NR  
 VDRL }  
 HCV }

PTNR - 11.09

22/4/26

SLUF ~ 36wks

Cephalic,

pla - ant, high

AFI - 11.7cms

( AC - 94% )  
 ( EFW - 81% )

EFW - 3143 gms

dopplers - @

Doctor Name: Dr. M. Poorna

Signature: *[Signature]*

Date & Time: 13/5/26

Consultant Name: Dr. M. A. K. ASA

Signature: !

Date & Time: 13/5/26

Completed



1

# PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>13/5</del> <del>11:40 AM</del>	<p><u>POD-0</u> a/c/air a/febr RI - 110/80 mmHg PR - 80 bpm SpO<sub>2</sub> 99% @ RT M - well PV - NAB U/O - 50ml (emptied in OT)</p>	<p><u>Adv</u> - NBM 4 hrs - fluids as per A/NON   dys as wanted - I/O charty - Vitalab - Infomps</p>
<del>13/5</del> <del>4:30 PM</del>	<p><u>0 - POD</u> G/C fair A/febrile PR - 86 bpm BP - 124/86 mmHg SpO<sub>2</sub> - 98% @ RT P/A - UT @ well P/V - NAB U/O - 100ml (clear)</p>	<p><u>Adv</u></p> <ol style="list-style-type: none"> <li>1) Oral sips → liquid diet</li> <li>2) Plenty oral fluids</li> <li>3) soft @ 8:30 pm.</li> <li>4) In b ambulation</li> <li>5) Drugs charted</li> <li>6) WIPV, I/O</li> <li>7) Vitalab</li> <li>8) m SOS</li> <li>9) removal @ 6am t/mr</li> </ol>
Baby - mb	Shift to ward	

indy





## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/5 2:30 pm	POD - F ac fam apch	- @ diet
bagms mv	SP - 110 / sommy PR - 84 bpm SWS - 99 / 10 M P/A - VAW PR - NMS	- plenty of stool feeds - disp as child - w/ SRV - ambulatory / EBF - @ diet - Infomes
14/5 7 am	POD I ac fam apch	- @ diet
bagms mv	SP - 124 / tummy PR - 80 bpm SWS - 99 / 10 M P/A VAW PR NMS	- plenty of stool feeds - disp as checked - w/ SRV - ambulatory / EBF - @ diet - Infomes



FDH-00036908 IP25-00020423  
 Mrs AMRUTA PARMAR EDDULA  
 03-11-1993 32 Y 6 M 10 D (F)  
 Dr. MANASA BADVELI



## 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: ..... 325 .....

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	T. LIUDGEC	1tab	PO	OD	12/5/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	T-SHEICAC	1tab	PO	OD	12/5/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3	T-MONTEC-IC	1tab	PO	BD	12/5/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
4	gyp. ASCORIC-V	1Tab	PO	BD	12/5/26	<input type="checkbox"/> C <input checked="" 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. N. Parag, Nijr

Date & Time: 13/5/26

Nurse Name & Signature: Mano

Date & Time: 13/5/26 at 8:30 AM

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



## DRUG CHART

Date of Admission: 13/5/26 Drug Allergies:  Not known any Drug Allergies

### FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).  
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.  
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.  
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.  
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.  
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.  
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time  
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

### SOS / PRN (As Required Medication)

<b>DRUG :</b>				Date Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

<b>DRUG :</b>				Date Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

<b>DRUG :</b>				Date Time																
Dose	Route	Frequency	Start Date																	
Doctor's Signature		Valid Period	Pharm.																	
Additional Instructions:																				

VERIFIED BY: Name



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

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

**STAT / ONCE ONLY DRUGS**

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
13/5/26	9:30 AM	INJ-CEFOTAXIME	1gm	IV	[Signature]	Nano
13/5/26	9:30 AM	INJ-PANTOPRAZOLE	40mg	IV	[Signature]	Nano
13/5/26	9:30 AM	INJ-METOCLOPRAMIDE	10mg	IV	[Signature]	Nano
13/5	10:18 AM	INJ-CARBETOCIN	100µg	IV	[Signature]	Beja
13/5	11:00 AM	SUPP-TRAMADOL	100mg	PR	[Signature]	Beja
13/5	11:30 AM	SUPP-DICLOFENAC	100mg	PR	[Signature]	Beja
13/5	4:30 PM	T-PARACETAMOL	1gm	IV	[Signature]	Mali
19/5	6 PM	Ly PARACETAMOL	1g	IV	[Signature]	sini neh

Signature  
Verified by Name

I.V. FLUIDS CHART

Weight: ..... Ward: .....

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
13/5	10:00 AM	RINGERLACTATE	IV	FF			13/5/26		
13/5/26	10:45 AM	RINGERLACTATE	IV	120 ml/hr			13/5/26		
13/5/26	3 PM	RINGER LACTATE	IV	100ml/hr			13/5/26		

Signature

VERIFIED BY: Name



REGULAR PRESCRIPTIONS

Weight 94.5kg Ward MBCW

Sheet No: .....

VERIFIED BY: Name ..... Signature .....

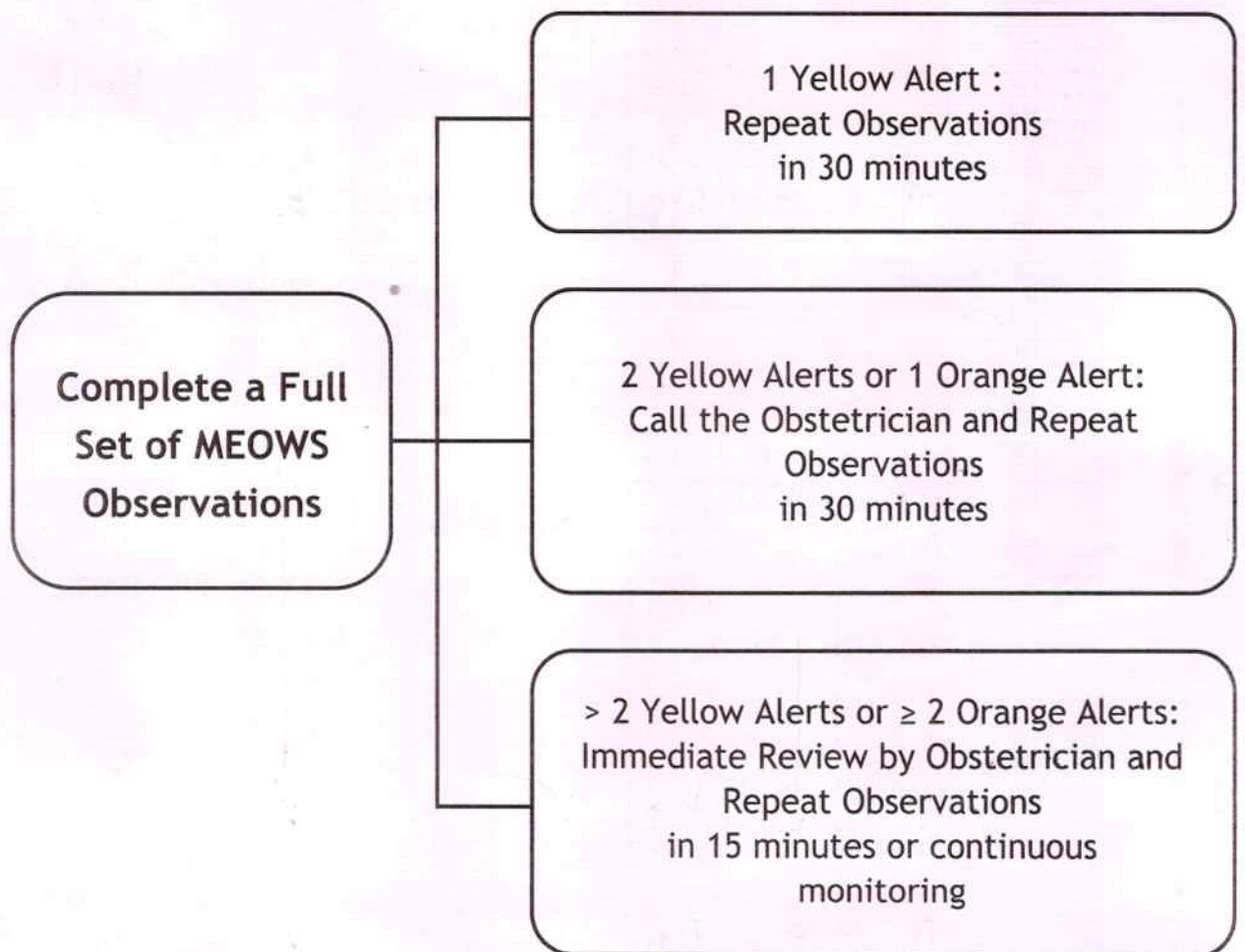
VERIFIED

<b>DRUG : Inj AUGMENTIN</b>				Date Time	13/5	14/5														
Dose	Route	Frequency	Start Dt.																	
1.2g	IV	BD	13/5	10AM																
Name & Signature of the Doctor Starting the Drugs: <u>ndeyu</u>																				
Additional Instructions: <u>824hrs</u>				<p>10pm <u>Dr. Badvel</u> <u>Dr. Badvel</u></p> <p><u>STOP</u></p> <p><u>10/5</u></p>																
Daily Doctor's Endorsement by a Sign				<u>ndeyu</u>																
<b>DRUG : Inj PANTOPRAZOLE</b>				Date Time	14/5															
Dose	Route	Frequency	Start Dt.																	
40mg	IV	OD	13/5	6AM																
Name & Signature of the Doctor Starting the Drugs: <u>ndeyu</u>																				
Additional Instructions:				<p><u>STOP</u></p> <p><u>10/5</u></p>																
Daily Doctor's Endorsement by a Sign				<u>ndeyu</u>																
<b>DRUG : T. AUGMENTIN</b>				Date Time	14/5															
Dose	Route	Frequency	Start Dt.																	
600mg	PO	BD	14/5	8AM																
Name & Signature of the Doctor Starting the Drugs: <u>ndeyu</u>																				
Additional Instructions: <u>10am</u>																				
Daily Doctor's Endorsement by a Sign				<u>ndeyu</u>																
<b>DRUG : T. PANTO PRAZOLE</b>				Date Time	15/5															
Dose	Route	Frequency	Start Dt.																	
40mg	PO	OD	14/5	6AM																
Name & Signature of the Doctor Starting the Drugs: <u>ndeyu</u>																				
Additional Instructions:				<p><u>STOP</u></p> <p><u>10/5</u></p>																
Daily Doctor's Endorsement by a Sign				<u>ndeyu</u>																





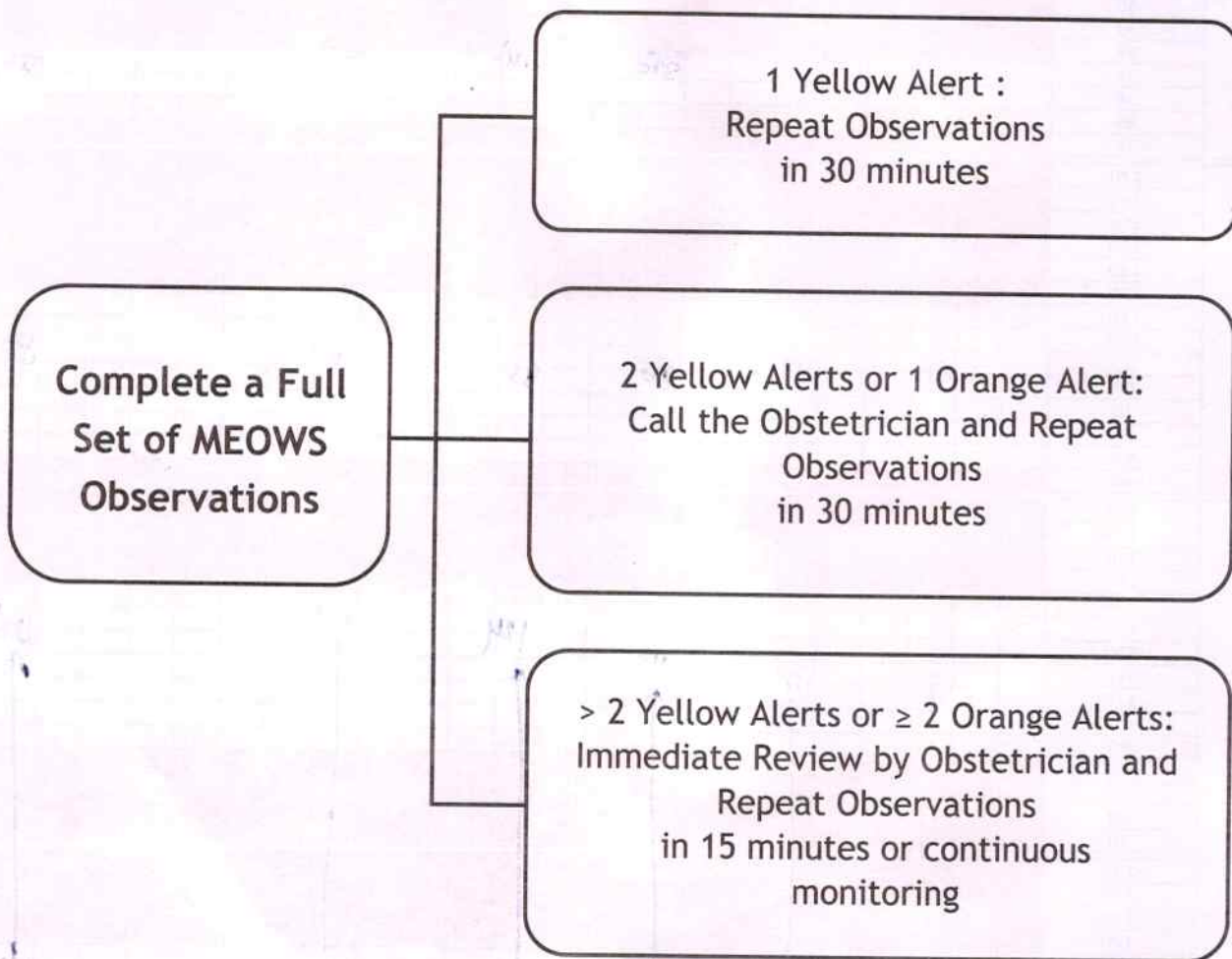
## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



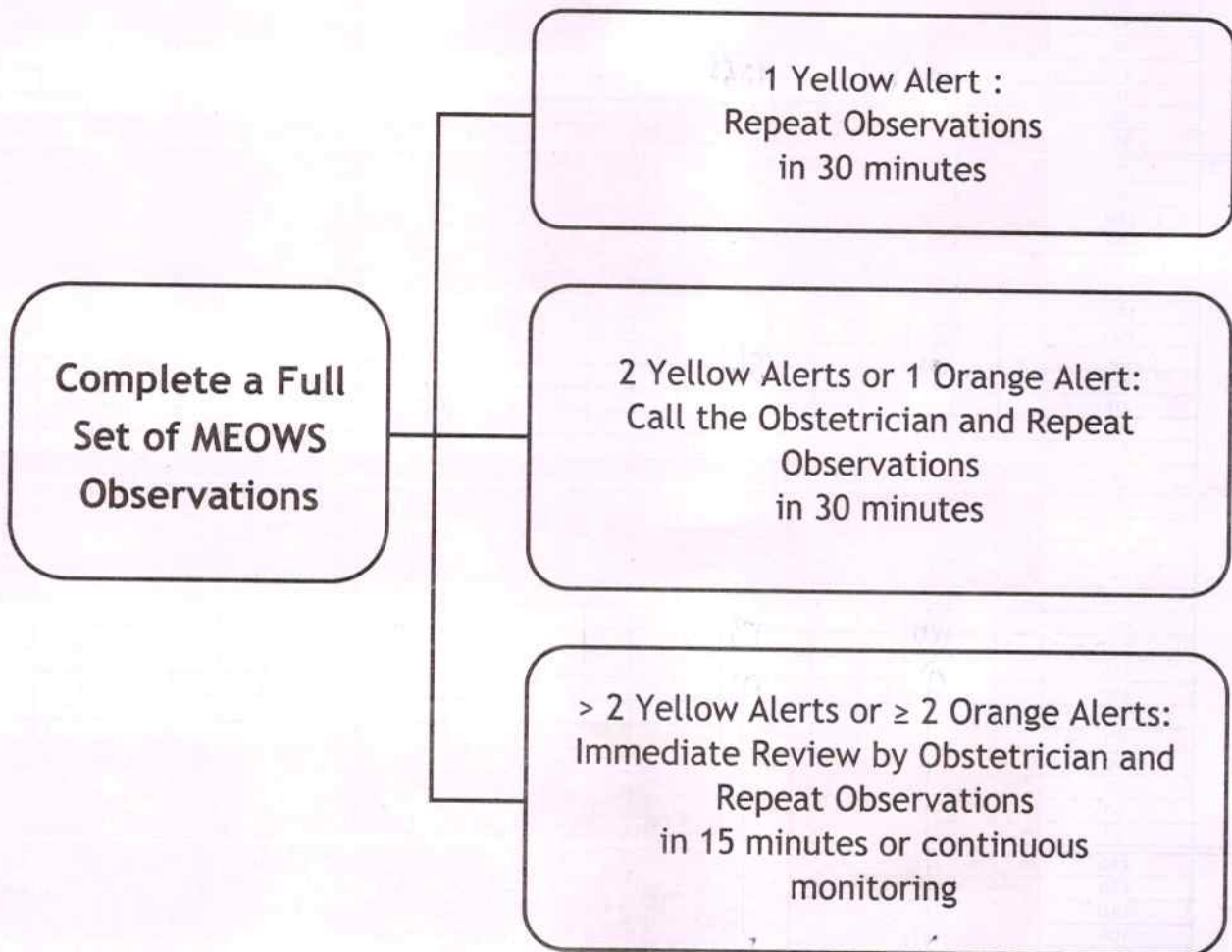
## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



13/5/20

**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 Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
13/5/20	08:00 am	PL NBM	100ml							✓	0	
	09:00 am	PL NBM	100ml								0	
	10:00 am	PL NBM	100ml								0	
	11:00 am	PL NBM	100ml							50ml	0	
	12:00 pm	PL NBM	100ml								0	
	01:00 pm	PL NBM	100ml							100ml	0	
<b>Total Intake :</b>			600ml			<b>Total Output :</b>					150ml + U-2 times Passed	
13/5/20	02:00 pm	PL NBM	100ml							50ml	0	
	03:00 pm	PL NBM	100ml								0	
	04:00 pm	PL water 30ml	100ml								0	
	05:00 pm	PL LP 200ml	100ml							150ml	0	
	06:00 pm	PL	100ml								0	
	07:00 pm	PL	100ml								0	
<b>Total Intake :</b>			920ml			<b>Total Output :</b>					U-200ml	
	08:00 pm											
	09:00 pm	H <sub>2</sub> O 1000										
	10:00 pm											
	11:00 pm	H <sub>2</sub> O 2000										
	12:00 am											
	01:00 am	H <sub>2</sub> O 2000										
<b>Total Intake :</b>			5000			<b>Total Output :</b>					700	
	02:00 am											
	03:00 am	H <sub>2</sub> O 1000										
	04:00 am											
	05:00 am	H <sub>2</sub> O 2000										
	06:00 am											
	07:00 am	H <sub>2</sub> O 1000										
<b>Total Intake :</b>			5000			<b>Total Output :</b>					4000 H <sub>2</sub> O	

**Total 24 hrs. Intake** 2520ml

**Total 24 hrs. Output** U=1450 H<sub>2</sub>O

14/5/26

**FLUID CHART**

Sheet No. : .....

- 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			
						NO		NO	NO				
	08:00 am			NO	NO	NO	✓	NO	NO	✓			
	09:00 am	H <sub>2</sub> O	200ml										
	10:00 am									✓			
	11:00 am												
	12:00 pm	H <sub>2</sub> O	200ml										
	01:00 pm			NO	NO	NO		NO	NO	✓			
<b>Total Intake :</b>			600ml			<b>Total Output :</b>						U=3 M=1	
2PM to 8PM	02:00 pm			NO	NO	NO	NO	NO	NO	NO	0		
	03:00 pm	H <sub>2</sub> O	200ml								0		
	04:00 pm										0		
	05:00 pm	H <sub>2</sub> O	100ml								0		
	06:00 pm										0		
	07:00 pm	H <sub>2</sub> O	200ml	NO	NO	NO	NO	NO	NO	NO	0		
<b>Total Intake :</b>			500ml			<b>Total Output :</b>						U=2 M=0	
	08:00 pm												
	09:00 pm	H <sub>2</sub> O	200ml	↑	↑	↑	↑	↑	↑	↑	0		
	10:00 pm												
	11:00 pm	H <sub>2</sub> O	100ml	↓	↓	↓	↓	↓	↓	↓	0		
	12:00 am										0		
	01:00 am	H <sub>2</sub> O	200ml	↑	↑	↑	↑	↑	↑	↑	0		
<b>Total Intake :</b>			500ml			<b>Total Output :</b>						U=1 M=0	
	02:00 am												
	03:00 am	H <sub>2</sub> O	100ml	↑	↑	↑	↑	↑	↑	↑	0		
	04:00 am												
	05:00 am	H <sub>2</sub> O	200ml	↓	↓	↓	↓	↓	↓	↓	0		
	06:00 am										0		
	07:00 am	H <sub>2</sub> O	200ml	↑	↑	↑	↑	↑	↑	↑	0		
<b>Total Intake :</b>			500ml			<b>Total Output :</b>						U=1 M=0	
<b>Total 24 hrs. Intake</b>		1900ml											
<b>Total 24 hrs. Output</b>		U=5 M=0											



15/5/26

# 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.

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am	h <sub>2</sub> O 200ml	NO	NO	NO	NO	NO	NO	NO	✓	0	} <i>MB</i>	
	09:00 am									✓	0		
	10:00 am	h <sub>2</sub> O 100ml								✓	0		
	11:00 am									✓	0		
	12:00 pm									✓	0		
	01:00 pm	h <sub>2</sub> O 200ml	NO	NO	NO	NO	NO	NO	NO	✓	0		
<b>Total Intake :</b> 500ml						<b>Total Output :</b> U=3 M=0							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

Patient Sticker



# 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.

		Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							

<b>Total 24 hrs. Intake</b>	
-----------------------------	--

<b>Total 24 hrs. Output</b>	
-----------------------------	--

**Department of Anaesthesiology**  
**PRE-ANAESTHETIC EVALUATION**



Name: Arunita Pawar Age: 32 yrs Sex: F UHID.No: EDM-36908

Date: 6/5/26 Time: 2:40 pm Proposed Operation: LSCS + b/L tubectomy

Diagnosis: G2 P.L. = 38<sup>+</sup> POG

B.P / CRT: ..... H.R: ..... Weight: 94.5 kg ASA Physical Status:  1  2  3  4  5

**Laboratory Data:**

Hgb: <u>12.5</u>	Glucose: .....	Protein: .....	HIV: .....	X-Ray: .....
PCV: .....	Urea: .....	Alb: .....	HBS Ag: <u>NR</u>	ECG: <u>sinus rhythm</u>
WBC: .....	Creat: .....	Total Bill: .....	HCV: <u>B+ive</u>	2D Echo: .....
Plate: <u>2.33</u>	Na: .....	Dir. Bill: .....	Blood group: <u>B+ive</u>	Stress/Angio: .....
PT: <u>15.8</u>	K: .....	LDH: .....	T3: .....	Other: .....
PTT: <u>33.5</u>	Ca++: .....	Alk phos: .....	T4: .....	
INR: <u>1.09</u>	Mg++: .....	Amylase: .....	TSH: .....	
	Cl -: .....	SGOT/SGPT: .....		

**Allergies:** Hazelnut, Fish, Brinjhal.

**Medical History:** CVS: .....

RESP: NO known comorbidities Diabetes: .....

CNS: h/o ADM in first pregn.

Renal: .....

Hepatic / GE: .....

Others: .....

Physical Activity: SOB on 2 flights of stairs.

Past Anaesthetic History: prev - LSCS in 2021 ↓ SAB; VLE.

**Physical Exam:**

Airway: MP 1 2 3 4 Mouth Opening: 7.5 Mentohyoid Distance: (N) Neck: (N) Teeth: intact.

Lungs: WNL.

Heart: WNL.

CNS: .....

Pregnant:  Yes  No  NA Venous Access Site: ..... Spine Exam for regional: (N)

Anaesthetic Plan:  MAC  REGIONAL  GA-ETT  LMA

Peri-Operative Plan Explained to the Patient:  Yes  No

CURRENT MEDICATIONS	DOSAGE
<u>/</u>	

**Pre-Operative Instructions:**

- DVT Prophylaxis: Explained
- 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:
  - ECG to be done.
  - CBL, PT, INR to be done.
  - Review to after ECG.

Signature: Ashy Name: Dr. ASHWARYA

Pre Induction Assessment:

Change in Patient Condition: Yes No Fasting Status: >6 hr

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R.: 72/min B.P./CRT: 112/84 SpO2: 99% R.R.: 16/min Last Feed: 12/5

Pre-OP Diagnosis: G.I. 138 wks Operation: Cereus Date: 12/5/06

Surgeon: Dr Manasa Anaesthesiologist: Dr Khe Technician: Naveya

Table with columns for TIME (10:00 Am, 10:30, 11:00 Am, 11:30 Am) and rows for N2O/AIR/O2, HALO/SO/SEVO, Drugs (Carbetocin, Glycopyrrate, Morphine, Diclofenac), Antibiotic, Suppository, Blood Loss, FIO2/SaO2, ETCO2, ECG, Temperature, Urine Output, Fluids Blood, BP, V Systolic, A Diastolic, X Mean, Heart Rate, Tourniquet on/off Time, Throat Pack in/out.

LAB Values: ABG, CRBS, Others

Equipment Checked and Functional: BP, Cuff Site, Art Site, EKG Lead, Temp Site, FIO2 Monitor, Agent Monitor, Pulse Oximeter, Capnograph, Ventilator, Nerve Stimulator, Position: supine, Pressure Points Checked, Eye Care: Oint, Tape, Padding, Awake

Temp: HME, Fluid Warmer, Cling Film, OH Warmer, Hugger's, Cotton Wool, Other. Times: Anaes Start: 10:05 AM, OP Start, OP End: 11:35 AM, Leave OR. Anaesthesia: GA, Monitored Anaesthesia Care, Regional. Line (Size & Location): CVP, ART, IV: RL, IV, IV

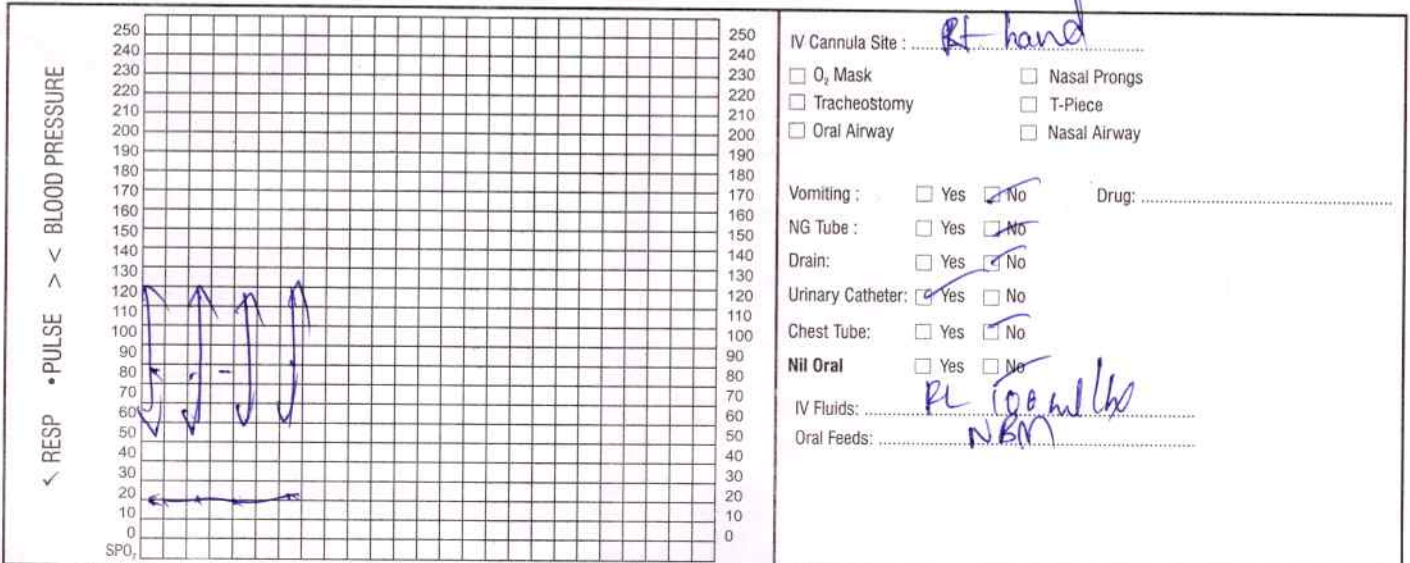
Induction: IV, Inhal, Pre O2, RSI, Others, Mask, SGA, Airway, Oral, Nasal, ETT#, Oral, Nasal, Cuff, Tracheostomy, Topical, Drug, Awake, Direct Vision, Video Laryngoscopy, Stylette/Bougie, Fiberoptic, Blade#, Attempts, Difficulty Why? Bilat = BS, Semi-Closed Circle, Closed Circle, Other

Regional: Extremity, Spinal, Epidural, Caudal, Others, Position: sitting, Site: L5-S1, Needle Size, Depth, Parasthesia, Catheter at skin, Drug Name & Conc: 0.5% bupivacaine, Bolus, Infusion: 2 sytensanyl, Block Level, Comments, Transportation to PACU, ICU, Relaxant Reversed, Yes, No, Name of the Doctor: Reshma, Signature of the Doctor: Reshma

Patient Sticker

### POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Maio Time Received : 11:40 AM Time Discharged : .....



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
			<u>As per Axon</u>	

Pain Tool Used:  N PASS  FLACC  Wong Baker  NPS

Anaesthesiologist Name : Dr. usha

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : Maio

PACU Nurse Signature: [Signature]

Date & Time: 13/5/26 at 11:40AM

#### 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): Maio

Date & Time: 13/5/26 at



# CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : Amruta Parmar Age : 32yr. Gender : Male  Female

UHID NO: FDH-36908 Surgeon Name: .....

Anaesthesiologist : Dr. ASHWARYA

Operative procedure planned : CESAREAN SECTION + b/l TUBECTOMY.

## 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 : desaturation, High spinal, Hypotension.

Comments : Shivering.

- 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 Amruta the above mentioned operation / Diagnostic / Therapeutic procedures Cesarean section + b/l tubectomy.

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 : Amruta

Name : Amruta Parmar Eddule

Relationship with Patient : self

Date & Time : 6/5/26 ; 2:55pm

**Witness :**

Signature : E. Sandeep

Name : Sandeep Eddule

Date & Time : 6/5/26 ; 2:55PM

**Doctor (who is taking the consent) :**

Signature : Ashwarya

Name : Dr. AISHWARYA

Date & Time : 6/5/26 ; 2:55pm



## CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <u>Dr. Manasa</u>	Date of Delivery: <u>13/5/2026</u>
Assistant Surgeon: <u>Dr. Vidhya</u>	Time of Delivery: <u>10:23 AM</u>
Anaesthetist's Name: <u>Dr. Usha</u>	Gender of Baby: <u>Male</u>
Type of Anaesthesia: <u>↓ SA</u>	Weight of Baby: <u>3.885 kgs</u>
Neonatologist: <u>Dr. Shraavathi</u>	AGPAR Score: <u>8/10, 9/10</u>
Scrub Nurse: <u>So. parvathi</u>	NICU Admission: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

**Pre-Operative Diagnosis:**

Elective       Emergency

Indication: previous Obst. hb

**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: .....      Knife to rectus: .....

CTG Description: Reactive

If there was a delay give the reasons: .....

**Surgical Procedure:**

POD elective ces + B/L tubectomy + umbilical hernia repair

**Post Operative Diagnosis:**

POD elective ces + B/L tubectomy + umbilical hernia repair

**Peri-Operative Complications:**

B/L tubectomy done, tubes sent for HPE  
umbilical defect of 1.5cm repaired c vinyl no. 1

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:  Pfannensteil  Transverse  Midline  Other .....  
 Uterine Incision:  Lower Segment  Classical  Inverted T  J Incision  
 Previous Scar:  Intact  Thinnedout  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: ..... (N) ..... Cord around the neck  Yes  No  
 Appearance of placenta: ..... (D) ..... Cavity explored  Yes  No  
 Uterus, tubes and ovaries:  Normal  Not Normal Sterilization:  Yes  No

Uterine Closure:  One Layer  Two Layers } ..... Suture  
 Peritoneal Closure:  Pelvic  Abdominal  None } ..... Suture  
 Sheath Closure: ..... } ..... Suture  
 Fat Closure:  Yes  No } ..... Suture  
 Skin Closure:  Subcuticular  Mattress } ..... Suture  
 Vaginal Evacuated  Yes  No  
 Drain:  Yes  No  Remove in ..... days  Await instructions  
 Catheter:  Yes  No  Remove in ..... 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: .....  
 - NBM 4 hrs  
 - fluids as per AROV  
 - dyp as charted  
 - w/ Bv  
 - Elo charted  
 - w/ tabs  
 - Dp 0/1

Doctor Name: ..... Dr. Vidya Reddy ..... Doctor Signature: ..... vidya .....  
 Date & Time: ..... 13/5/20, 11:30 am .....

# PATIENT TRANSFER FORM

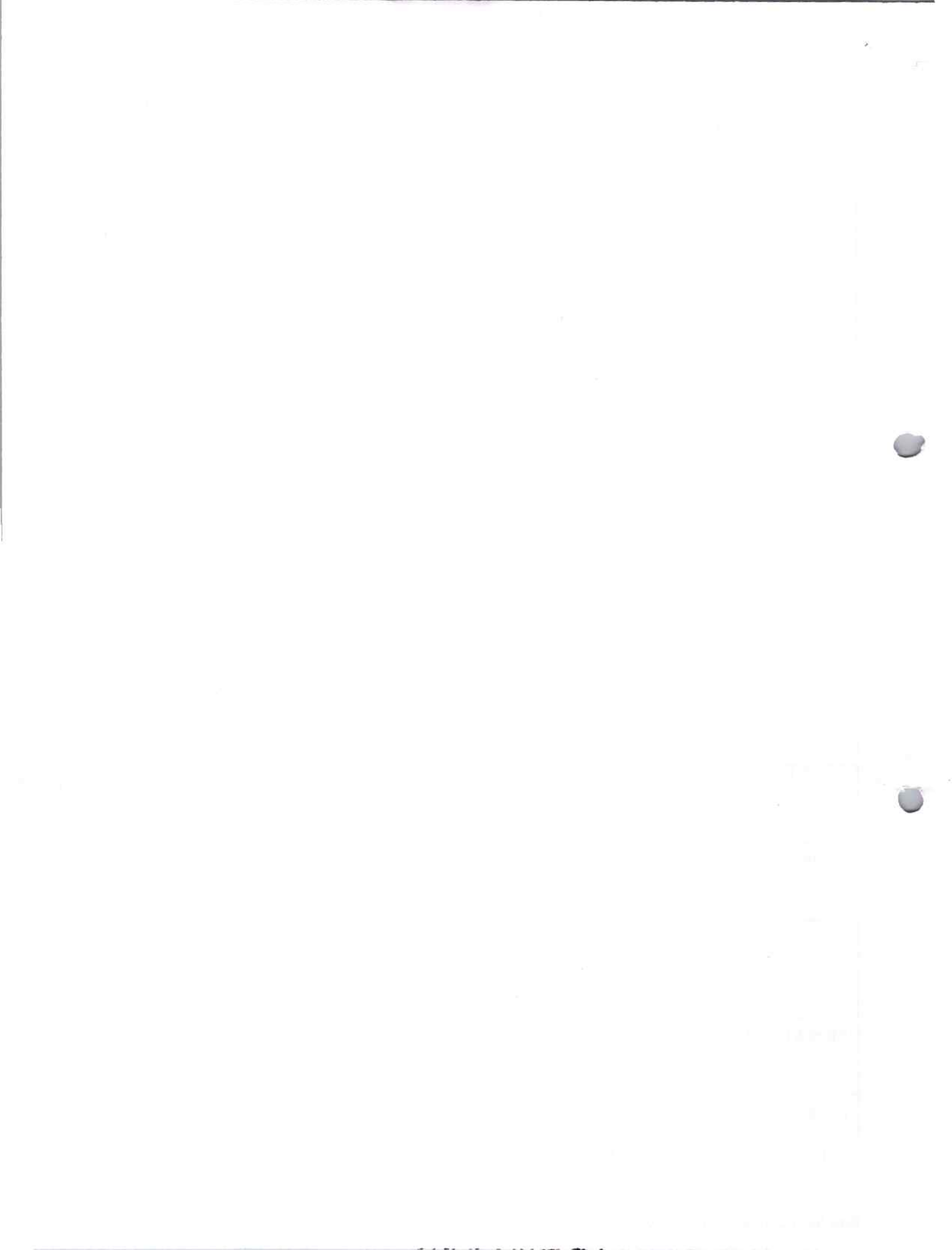
OT



Patient Name & UHID No. FDH-00036908 IP25-00020423 Mrs AMRUTA PARMAR EDDULA 03-11-1993 32 Y 6 M 10 D (F) Dr. MANASA BADVELI 		Date & Time of Admission 13/5/2026 8:19 AM	Date & Time of Transfer Order 13/5/2026 @ 11:40 AM
		Transfer Ordered by Dr. Usha.	Reason for Transfer Post operative care
From Unit OT	To Unit MICU	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 30	Number of Imaging Films 2 op file.	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" 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 Sreeja  @ 11:40 AM		Name of Person Ordered Transfer Dr. Usha.	
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

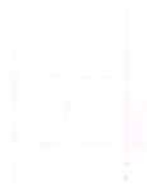


Patient Name & UHID No. <i>MM Anshita</i>		Date & Time of Admission <i>13/5/26 at 8:19AM</i>	Date & Time of Transfer Order <i>13/5/26 at 9:55AM</i>
Treating Consultant Name <i>Dr. Manasa</i>		Transfer Ordered by <i>Dr. Manasa</i>	Reason for Transfer <i>EL-UCI f/ B/L Tubercy</i>
From Unit <i>MSW</i>	To Unit <i>OT</i>	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.	<i>Ty-Taxim</i>	<i>1gm</i>	
2.	<i>Ty-Pao</i>	<i>40 mg</i>	
3.	<i>Ty-Pecindm</i>	<i>10 mg</i>	
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring <i>Manasa DIS JBR</i>		Name of Person Ordered Transfer <i>Dr. Manasa</i>	
Patient & Clinical Records Received by : <i>Sreeja</i>			
Date & Time of Patient Received : <i>@ 9:55AM</i>			

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

100




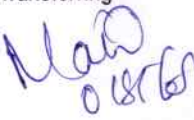
100

100

100

# PATIENT TRANSFER FORM



Patient Name & UHID No. FDH-00036908      IP25-00020423 Mrs AMRUTA PARMAR EDDULA 03-11-1993      32 Y 6 M 10 D (F) Dr. MANASA BADVELI 		Date & Time of Admission 13/5/26 at 8.19 AM	Date & Time of Transfer Order 13/5/26 at 4.45 PM
		Transfer Ordered by Dr. Manasa	Reason for Transfer Post-op Care
From Unit MICU	To Unit 3rd Floor		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.			
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. Manasa	
Patient & Clinical Records Received by : Suma 13/5/26 @ 5.15 PM			
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



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DILMUN, QUEZON CITY

# PATIENT TRANSFER FORM

PATIENT INFORMATION	TRANSFER FROM	TRANSFER TO
Name: _____ Age: _____ Sex: _____ Room No.: _____ Ward: _____	Department: _____ Unit: _____ Date: _____ Time: _____	Department: _____ Unit: _____ Date: _____ Time: _____
Referring Physician: _____ Attending Physician: _____	Referring Physician: _____ Attending Physician: _____	Referring Physician: _____ Attending Physician: _____
Reason for Transfer: _____ _____ _____	Reason for Transfer: _____ _____ _____	Reason for Transfer: _____ _____ _____
Patient's Condition: _____ _____ _____	Patient's Condition: _____ _____ _____	Patient's Condition: _____ _____ _____
Transfer Method: _____ _____ _____	Transfer Method: _____ _____ _____	Transfer Method: _____ _____ _____
Signature of Referring Physician: _____ _____ _____	Signature of Referring Physician: _____ _____ _____	Signature of Referring Physician: _____ _____ _____
Signature of Attending Physician: _____ _____ _____	Signature of Attending Physician: _____ _____ _____	Signature of Attending Physician: _____ _____ _____
Date: _____ Time: _____	Date: _____ Time: _____	Date: _____ Time: _____

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DILMUN CAMPUS

FORM NO. \_\_\_\_\_

DATE: \_\_\_\_\_

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### NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

574707

Patient Name: MRS. AMRUTA PARMAR EDDULA Age: 32Y Gender: FEMALE  
 UHID No: FDH-0003096 IP No: 25-00020423 Date: 13/05/26 Time: 09:05AM  
 Diagnosis: G72 P. L. 1 2 38+1 WEEKS

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML ✓	100 MCG	-
2.	Morphine Sulphate Inj. 15mg/ML	-	-
3.	Remifentanyl Hydrochloride Inj. 2MG	-	-
4.	Remifentanyl Hydrochloride inj. 1MG	-	-

Doctor Name: K. De V. V. Doctor Registration No: 1001000101535  
 Signature: K. De V. V.

### NARCOTIC DISPENSING FORM

#### APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 25-00020423 Date: 13/05/26  
 Aadhaar No. of the Patient (Optional): .....

1.	Name :	<u>MRS. AMRUTA PARMAR EDDULA</u>	Remarks	
2.	Complete postal address (with contact number, if any)	<u>KOKAPET HYDERABAD.</u>	<u>TELANGANA INDIA - 501205</u>	
3.	Brief description of the illness	<u>G72 P. L. 1 2 38+1 WEEKS</u>		
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	<u>FENTANYL CITRATE</u>		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
<u>13/05/26</u>	<u>FENTANYL CITRATE</u>	<u>ONE</u>	<u>[Signature]</u>	<u>-</u>

Dispensed by (Name & ID No.): Bhaskar (011984) Signature: [Signature]  
 Received by (Name & ID No.): M. PRASHANTH (010494) Signature: [Signature]  
 Time: 9:24 Am

NARCOTIC PRESCRIPTION FORM  
(MEDICAL RECORD)

Patient Name: Mr. J. M. Smith  
 Date: 10/15/52  
 Doctor: J. M. Smith  
 PRESCRIPTION DETAILS (Check only one of the following)

S No	Drug Name	Dosage	Remarks
1	Propylthiouracil 50mg	1 tablet 3 times daily	
2	Morphine Sulphate 10mg	1 tablet 4 times daily	
3	Propylthiouracil 50mg	1 tablet 3 times daily	
4	Propylthiouracil 50mg	1 tablet 3 times daily	

Doctor's Signature: J. M. Smith  
 Doctor's Registration No.: 12345

NARCOTIC DISPENSING FORM  
APPENDIX A - FORM NO. 3E  
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

Patient's Name: Mr. J. M. Smith  
 Date: 10/15/52  
 Doctor's Name: J. M. Smith  
 Doctor's Registration No.: 12345

Date	Name of the Essential Narcotic Drug	Quantity	Signature of the Patient's Attorney	Signature of the Doctor	Remarks, if any

Dispensed by (Name & ID No.) J. M. Smith (12345)  
 Received by (Name & ID No.) Mr. J. M. Smith (12345)  
 Date: 10/15/52