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DISCHARGE SUMMARY

Name	Mrs NANNAPANENI CHARISHMA	**UHID**	FDH-00006529
Father/Guardian	Mr KUNAPAREDDY PAVAN KUMAR	**Age/Gender**	29 Y 9 M 24 D/ Female
Address	~, Jntu Kukat pally, Hyderabad, Telangana, INDIA, 500085		
IP No	IP25-00020682	**Admission Date**	28-05-2026
Ref Doctor			
Discharge Date	28.05.2026		

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 9+2 WEEKS GESTATION WITH MISSED MISCARRIAGE FOR SERPC

History:
Presenting complaint:

Viability scan at 5weeks on 20.04.2026 showed,
Single intrauterine gestation sac is seen eccentrically along the fundus of the endometrial cavity, along the lateral upper angle or cornua of the uterus likely angular pregnancy. Gestational sac measure 1.3mm (MSD), Yolk sac and fetal pole not seen. Bilateral ovaries normal.
Follow up scan on 09.05.2026 showed, Single early intrauterine pregnancy of 6+6weeks, Yolk sac and fetal pole seen. FHR - 148bpm.

USG done on 27.05.2026 regular gestational scan seen at ~ 9+2 weeks, showed SLIUG, CRL - 25.1mm, FHS - Absent, Fetal pole - present, yolk sac - present. Impression : Missed Miscarriage.

Name	Mrs NANNAPANENI CHARISHMA	**UHID**	FDH-00006529
IP No	IP25-00020682	**Admission Date**	28-05-2026

Admitted for SERPC + CMA

Menstrual History:
LMP : 16.03.2026
Previous cycles: Regular.

Obstetric History:
Primigravida - present pregnancy, spontaneous conception

Medical History : H/o Hypothyroid (Used Homeopathic medication) since 1 year.
Started on Tab. Thyronorm 25 mcg since conception.
Surgical History : Laparoscopic Appendectomy in 2011.
Allergies : Nil
Family History : Mother - DM +HTN

Investigations: Enclosed.
Blood Group & Typing - " O " Rh Positive.

Surgery Notes:
Operation performed: SERPC

Indication: Missed miscarriage

Operative findings:
- Patient shifted to OT.
- Under GA, Patient kept in lithotomy position.
- Parts cleaned and draped with betadine.
- Anterior and posterior vaginal walls retracted with SIMs speculum.
- Anterior lip of cervix held with Vulsellum
- OS tightly stenosed.
- Hegar's dilators couldn't be passed.
- OS dilatation initiated with saline infiltration.
- Gradual OS dilation done with Hegar's dilators up to No.06.
- Ovum forceps could not be introduced.

Name	Mrs NANNAPANENI CHARISHMA	**UHID**	[illegible]00006529
IP No	IP25-00020682	**Admission Date**	28-05-2026

- Karmann's cannula no. 6 introduced
- Suction and evacuation of all products of conception done with Karmann's cannula no 6 Under ultrasound guidance.
- Products sent for CMA
- No active bleeding seen.
- Tab. Misoprostol 400mcg kept vaginally.
- Check scan done showed empty uterine cavity.

Post-Operative Notes: - Uneventful. Patient and attenders were informed about difficult entry, procedure was completed uneventfully under ultrasound guidance.

Advice:

1. Tab. Augmentin 625 mg twice daily till 03.06.2026 (9am - 9pm) after food.
2. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 03.06.2026
3. Tab. Dolo 650 mg twice daily (10am-10pm) after food till 03.06.2026
4. Tab. Misoprostol 200mcg twice daily after food (9am-9pm) till 30.05.2026
5. Tab. Pause 500mg once daily at bedtime (10pm) after food till 31.05.2026
6. To collect Microarray Report.
7. To do serum TSH after 6 weeks
8. To do RPOC scan after 1 week (04.06.2026)

Review consultation with Dr. PUJITHA DEVI SURANENI, on 05.06.2026 in Gynec OPD in Nankramguda (**Review consultation will be charged**).

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

Name	Mrs NANNAPANENI CHARISHMA	**UHID**	FDH-00006529
IP No	IP25-00020682	**Admission Date**	28-05-2026

In case of emergency like bleeding, fever kindly contact 8121039515 at Rainbow 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~~

FDH-00

28-05-2

Consultant:
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Senior Consultant-High Risk Obstetrician and Laparoscopic Surgeon
Reg. No: 55973

r/Res

FDH-00006529 IP25-00020682
Mrs NANNAPANENI CHARISHMA
04-08-1996 29 Y 9 M 24 D (F)
Dr. PUJITHA DEVI SURANENI

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SURGERY DETAILS

Date : 28/5/26

Patient Name: Mrs. Charishma Date of Birth: 04/08/1996 Age: 29Y

Gender: Femal Ward : OT UHID No.: FDH-00006529

Date of Surgery: 28/5/26 ☐ OT -1 ☐ OT -2 ☑ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : SELSC

Time in : 12:00 pm Time Out : 1:00 pm

		NAME	AMOUNT
1.	Surgeon	: Dr. pujitha	
2.	Anaesthetist	: Dr. srinivas	
3.	Assistant Surgeon	: Dr. pooja	
4.	OT Technician	: Sr. Subhalini	
5.	Circulating Nurse	: Br. Buddhadeb	
6.	Assistant Nurse	: Br. Hanumanth.	

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

Signature of the Surgeon [signature] Signature of Circulating Nurse [signature]

Order No: 8.1368/69 Order by: Amar

Docu. No. : RCH/FRM/GENERAL/114

FDH-00006529 IP25-00020682
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CONSUMABLES OF OT

.... Technician : .... Date : .... Time : ....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack LSCS		1	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / ~~P / N~~		03				Suction Catheter		
HME filter : A / ~~P / N~~		01				Feeding Tube		
Syringes : 10 cc		03				Vaccum Suction Set		
05 cc		02	Gloves 6½+6	3	3	Surgical Gloves		
02 cc		03				Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		02	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
Synto		02	Ointments					
Midaz		01	Suction Catheter					
Fentanyl			Cap, Mask					
Morphine			Gauze Pack		4			
Ketamine			Mop Pack		1			
Propofol		04	Steristrip					
Rocuronium		[illegible]	Underpad		2	Lox jelly		1
Glycopyrolate		01	Draw sheet					
Myopyrolate			Abgel			~~TOP~~ leggin		1
Ondansetron		01	Foleys catheter Nelton (10)		1			
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter			MMP (6)		1
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
O2 mask (A)		01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set		2			
Justin : ~~12.5 mg / 25mg~~ / 100mg		01	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		2			
Nasal Airway #28		01	Microshield					
			Cotton Balls					
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse Hanumantha OT Technician

Order No: 581359 NSS / 581374 (Jelly) .... Ordered by : Amar ....

Doc. No. : RCH / FRM / GENERAL / 125

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospitals - Financial District

Survey No 74, Nanakramaguda village, Serilingampally(M) ,Hyderabad ,Telangana, INDIA ,500032.
TEL NO :040-44665555
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP25-00020682 **Admit Date** : 28-May-2026 **Admit Time** : 09:11 AM **UHID** : FDH-00006529

Patient Details :

Patient Name	: Mrs NANNAPANENI CHARISHMA	**Age**	: 29 Y 9 M 24 D
Guardian	: Mr KUNAPAREDDY PAVAN KUMAR	**DOB**	: 04-08-1996
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: ~ Jntu Kukat pally Hyderabad Telangana INDIA 500085	**Phone No**	: 8464082559
		E-mail	: na123@rainbowhospitals.in

Admission Details :

Bed Type : MICU **Bed No** : LDR-02 **Ward Name** : 4F -LDR

Room No : LDR-02 **Admission Type** : First Visit

Contact Details :

Name : Mr KUNAPAREDDY PAVAN KUMAR **Relationship** : W/O

Contact Address : ~ Jntu Kukat pally Hyderabad Telangana INDIA 500085 **Phone No** :

K. Pavan

Signature

Doctor Details :

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

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : MDINDIA HEALTH INSURANCE TPA PVT LTD

9849686963

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ACTIVITY RECORD FOR BILLING

FDH-00006529 IP25-00020682
Mrs NANNAPANENI CHARISHMA
Name: --- 04-08-1996 29 Y 9 M 24 D (F) ----------
Dr. PUJITHA DEVI SURANENI

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/5/26	11:25 AM	MICU	OT	
28/5/26	1:00pm	OT	CMICU	Vaishali
28/5/26	4:10pm	MICU	Billing	Anu

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
~~28/5/26~~	~~Biopsy~~		~~[illegible]~~
28/5/26	microarray 750K+mcc	18764 ✓	madhuri

cross checked by
Anitha
28/5/26
@3pm

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
28/5/26	cardiac monitor	28/5/26 ~~[illegible]~~ 1:20pm	28/5/26 @ 5:20pm	1446 ✓	[illegible]

cross checked by Anitha 28/5/26 @ 3pm

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
28/5/26	IV placement	1	13982	

crops checked by Anish 28/5/26 3:10 pm

ANY OTHER INFORMATION

Date : 28/5/26 Time : @ 9:11 AM Prepared By : Renuka

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
Renuka	MCU		

EDH-00006529 IP25-00020682
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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: missed miscarriage.

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

Surgery / Procedure:

Post OP Day:

BACKGROUND	Date / Shift	28/5/26 E					
	Medical Condition (Any special condition to be noted):	Obs					
	Diet:	NBM					
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	RA					
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.6					
	Res:	20					
	SpO_2:	100					
	Pulse:	62					
	BP:	102/70					
	LOC:	Conscious					
	Fall Risk Score:	0/10					
	Pain Score:	0/10					
	Skin Integrity	Good					
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	N/A					
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	NBM					
	Critical Lab Test / Values:	N/A					
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	dependent					
Post Operative Procedure Special Orders:		-					
Handed Over By Name :		Anitha					
Signature / ID :							
Date:		28/5/26					
Time:		@2p					
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

D/C

Patient Sticker

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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:							

Ref. No. : F/GYNIC/18

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 28/5/26.

Time of Admission : _____

PERSONAL DETAILS

Name : Mrs. Charishma Age 29 Date of Birth _____

UHID No.: FDH 00006529 IP No.: _____

Department : OBG Consultant : Dr. Pujitha

PRESENTING COMPLAINTS

admitted for SERPC i/v/o missed miscarriage

USG (27/5/26): Regular GS scan seen
YS ⊕, FP ⊕.
FHS ⊖. s/o missed miscarriage
CRL – 25.1mm corresponding to 9+2 weeks.

G1 – P. P, spont. Conception

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 2023	Parity : A1
Previous Periods : Regular	Mode of Delivery
LMP : 16/3/26	Last Child Birth :
Contraception :	

MEDICAL HISTORY	SURGICAL HISTORY
Hypothyroidism ∴ 1yr (used Homeo meds). on T. Thyronorm 25mg ∴ conception	Lap. appendectomy - 2011
FAMILY HISTORY	**NOTES / ALLERGIES**
M - DM, HTN	Nil.

INITIAL ASSESSMENT :

Date	**Breasts**	**Local / Speculum Examination**
Ht. Wt.	Soft	Not done
BMI PR - 80bpm		**Bimanual Pelvic Examination**
B.P 100/70 mmHg.	**Abdominal Examination**	Not done.
Pallor	Soft	
CVS		
Respiratory System		
Thyroid		

PROVISIONAL DIAGNOSIS : MISSED MISCARRIAGE

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT	PRESCRIPTION
BGT - Serology - (24/5) Hb - 12.4 WBC - 7980 P. C - 252	SEMC	Admit Consent Pt. preparation Secure IV access Inform OT, Anesthesia preop medication.

Name of the Doctor : Dr. PUJITHA

Date : 28/5/26 **Time :** _____ **Signature of Doctor**

EDH-00006529 IP25-00020682
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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 28/5/26

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: ..... Doctor Notified on Admission: ☐ Yes ☐ No

..... come c missed miscarriage Name of the Doctor: Dr-pooja

..... Time Notified: .....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Hypothyroidism	lap appendectomy - 2011	—

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

.....

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: 16/3/26

Gynecology Surgical History:

Caesarean Section: ☐ No ☐ Yes

Cervical Cerclage: ☐ No ☐ Yes

Ectopic Pregnancy: ☐ No ☐ Yes

Myomectomy: ☐ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☐ No ☐ Yes

Vaginal Discharge: ☐ No ☐ Yes

Post-Coital Bleeding: ☐ No ☐ Yes

Infertility: ☐ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G — P — L — A —

Previous LSCS: —

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: 78 RR: 21

BP: 121/81 Weight: ..... 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 ...0/10... (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☐ No Score ...0/10... (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: ...Husband...

Orientation not given Reason: .....

Nurse Signature: ...RL...

Nurse Name: ...Renuka...

Date & Time: ...28/5/20 8pm...

FDH-00006529 IP25-00020682
Mrs NANNAPANENI CHARISHMA (F)
04-08-1996 29 Y 9 M 24 D
Dr. PUJITHA DEVI SURANENI

①

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/5/26	DPOD	
1 pm		Rx
	Ly cfair	NBM x 4-6 hrs
	Afeb	(M) vitals/BP/I/O
	PR - 96 bpm	Drugs as charted
	Bp - 106/66 mmhg	Inform SOS
	SpO2 - 99%	
	P/A - Soft	
	P/V - NAB	
		[signature]
		Arpoorna

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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Mrs NANNAPANENI CHARISHMA
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Dr. PUJITHA DEVI SURANENI

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RESULT SHEET

Date	27/5/26					
Time						
Hb	12.4					
PCV	38.1					
RBC	4.35					
WBC	7980					
N/L						
Platelets	252					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

B+T — O+ve.

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

=DH-00006529 IP25-00020682
Mrs NANNAPANENI CHARISHMA
04-08-1996 29 Y 9 M 24 D (F)
Dr. PUJITHA DEVI SURANENI

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... Nill ..... ☐ 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: ..... Shifted to: .....

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. Thyronorm	25 µg	PO	OD	28/5/26	☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. K. Ramya .....

Date & Time : 28/5/26 .....

Nurse Name & Signature: .....

Date & Time : .....

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

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DRUG CHART

Date of Admission: 28/5/26 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)

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

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

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

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

Patient Sticker

REGULAR PRESCRIPTIONS

Weight. .... Ward. ....

DRUG : T. PARACETAMOL			
Dose	Route	Frequency	Start Date
1gm	P/O	TID	28/5/26
Name & Signature of the Doctor Starting the Drugs: SW (Dr. SRINIVAS)			
Additional Instructions:			
Daily Doctor's Endorsement by a Sign			

DRUG :			
Dose	Route	Frequency	Start Date
Name & Signature of the Doctor Starting the Drugs:			
Additional Instructions:			
Daily Doctor's Endorsement by a Sign			

DRUG :			
Dose	Route	Frequency	Start Date
Name & Signature of the Doctor Starting the Drugs:			
Additional Instructions:			
Daily Doctor's Endorsement by a Sign			

DRUG :			
Dose	Route	Frequency	Start Date
Name & Signature of the Doctor Starting the Drugs:			
Additional Instructions:			
Daily Doctor's Endorsement by a Sign			

Date ▸ / Time ▾ (administration grid, blank)

Weight. ..... Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
28/5/26	11 AM	Inj. AUGMENTIN	1.2 gm	IV		
28/5/26	11 AM	Inj. METOCLOPRAMIDE	10mg	IV		
28/5/26	11 AM	Inj. PANTOPRAZOLE	40mg	IV		
28/5/26	10:30 AM	TAB. MISOPROSTOL	400mg	PV		
28/5	12:50 PM	SUPP. DICLOFENAC	100 mg.	P/R		Buddha Naga
28/5	12:50 PM	SUPP. TRAMADOL	100 mg	P/R		Buddha Mastha
28/5	1:15 PM	Inj. DROTIN	40mg.	IV		Buddha Sukhi

Patient Sticker

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
28/5	11:25 AM	10 RL.	IV	100 ml/hr			28/5		
28/5	12:15 PM	RL.	IV	200 ml/hr					

DIC

Signature .....

VERIFIED BY : Name .....

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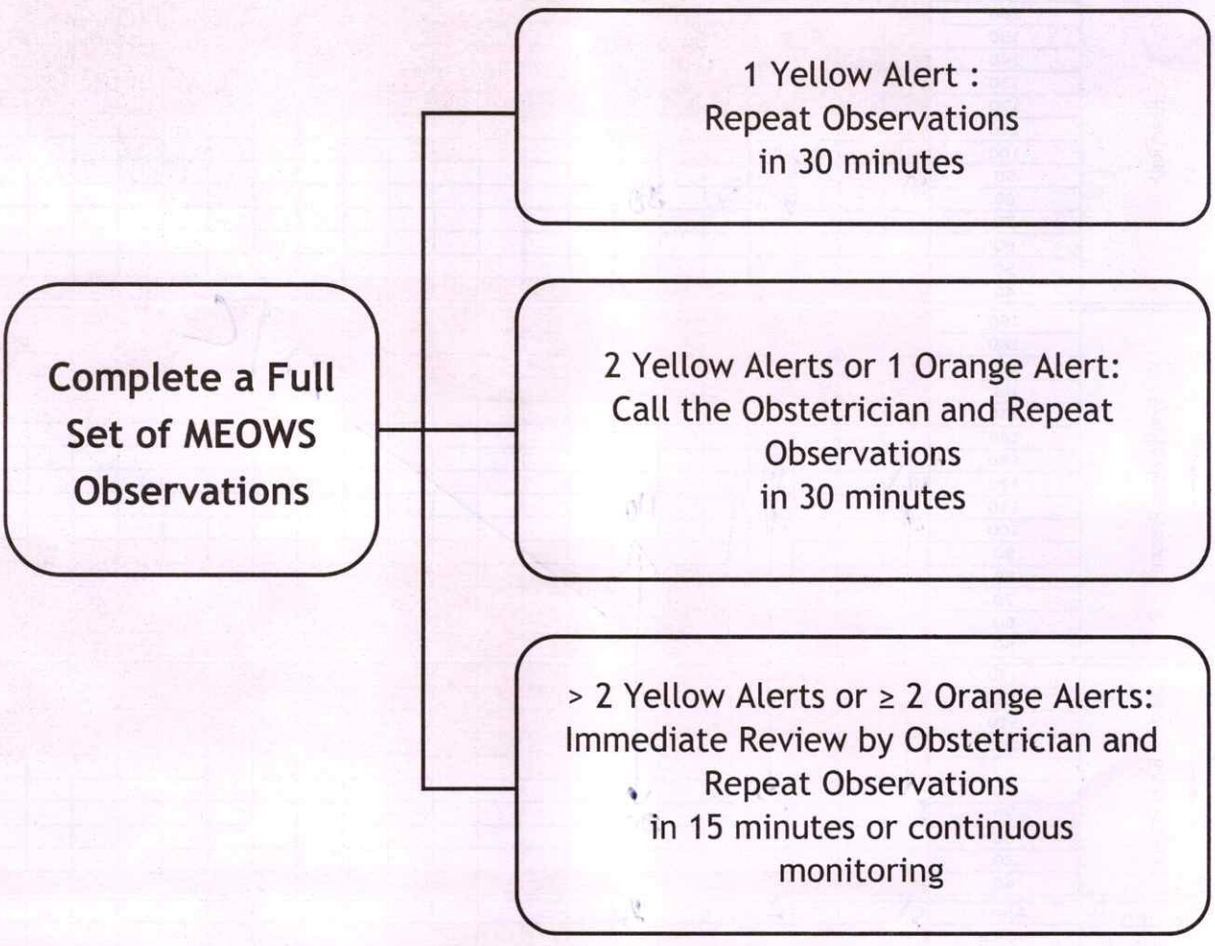
/arning Observation Score Chart - Obstetrics

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

		Date																							
		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	21				21	21		20																	
	0 - 10																									
Saturations	94 - 100 %	09				09	92		100																	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36	36.5				36.5	36°C		36																	
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80	99				80-90			80																	
	70																									
	60																									
	50																									
	40																									
↑ Systolic Blood Pressue	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120	120				110																				
	110						110		110																	
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
↓ Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70	80				70	80		90																	
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert	A				A	A		A																	
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30	>				>	>		>																	
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal	N				N	N		N																	
	Heavy / Foul																									
Liquor	Clear / Pink	C				C	C		C																	
	Green																									
TOTAL YELLOW SCORES		0				0	0		0																	
TOTAL ORANGE SCORES		0				0	0		0																	
Nurse Initial																										

DIC

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score **(MEOWS)**

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am	RL	NBM	100ml	–	–	–	–	–	✓	0	RL
	12:00 pm	RL	NBM	100ml	–	–	–	–	–	50ml	0	Vaishali
	01:00 pm	RL	NBM	100ml	–	–	–	–	–	–	0	RL
Total Intake :		300ml				**Total Output :** 0-1 c						
	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											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	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											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: N. Charishma Age: 29y Sex: F UHID.No :

Date: 27/5/26 Time: 3.45pm Proposed Operation: SEMPC

Diagnosis: Missed Miscarriage

B.P / CRT: 109/72 H.R: 86 Weight: 59.1 kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb:	Glucose:	Protein:	HIV: ?	X-Ray:
PCV:	Urea:	Alb:	HBS Ag: NR	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate:	Na:	Dir. Bill:	Blood group: O+ve	Stress/Anglo:
PT:	K:	LDH:	25/5 T3 1.08	Other:
PTT:	Ca++:	Alk phos:	T4 8.30	
INR:	Mg++:	Amylase:	TSH 6.88	
	Cl -:	SGOT/SGPT:		

Allergies: NKDA

Medical History: CVS : —

RESP : ? Diabetes : —

CNS : } Nothing significant

Renal :

Hepatic / GE :

Physical Activity: >4 METS

Others : Hypothyroidism since 1 Month

Past Anaesthetic History: Lap Appendectomy ↓ GA

Physical Exam:

Airway: MP 1 2 (3) 4 Mouth Opening: 3F Mentohyoid Distance: 6F Neck: (N) Teeth: (N)

Lungs : BAE (+)

Heart: S1 S2 (+)

CNS: NAD

Pregnant: ☐ Yes ☑ No ☐ NA | Venous Access Site : (+) | Spine Exam for regional : (N)/O Herniated disc, Sciatica (+) Pain in Rt leg

Anaesthetic Plan: ☑ MAC ☐ REGIONAL ☐ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☑ Yes ☐ No

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours ✓ ; → Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:

CBP.

Signature: Name: Rusha

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No			Fasting Status: 7 8 hrs
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 76/m	B.P / CRT: 124/76	SpO_2: 99%	R.R: 18/min	Last Feed: 9.00 PM

Pre-OP Diagnosis: Miscarriage Operation: SERPC Date: 28/5/26

Surgeon: Dr. Pujitha Anaesthesiologist: Dr. Srinivas Technician: Subhashini

TIME	12:00	12:30	1:00
N_2O /AIR /O_2 LPM			
HALO /SO /SEVO			
Drugs:			
Inj. Midaz	2mg.		
Inj. Fentanyl	100µg.		
Inj. Propofol	80+80+40	+80+40	
FIO_2 / SaO_2	100	100	100 / 100
$ETCO_2$	-	-	39 / 40
ECG	NSR	NSR	NSR / NSR
Temperature			
Urine Output			
Fluids / Blood	RL		

Antibiotic

Suppository

Blood Loss

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional
☑ BP
☐ Cuff Site: (L) UL.
☐ Art Site:
☑ EKG Lead
☐ Temp Site
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: LITHOTOMY
☑ 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: 12.00 PM.
OP Start:
OP End:
Leave OR: 1.00 PM.

Anaesthesia:
☑ GA
☑ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: (R) Hand 18G
☐ IV:
☐ IV:

Induction
☑ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☑ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ 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 Specify:
☐ Spinal ☐ Epidural ☐ Caudal
Others:
Position:
Site:
Needle Size: Depth:
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc:
Bolus:
Infusion:
Block Level:
Comments:

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA

Name of the Doctor: Dr. SRINIVAS
Signature of the Doctor:

Patient Sticker

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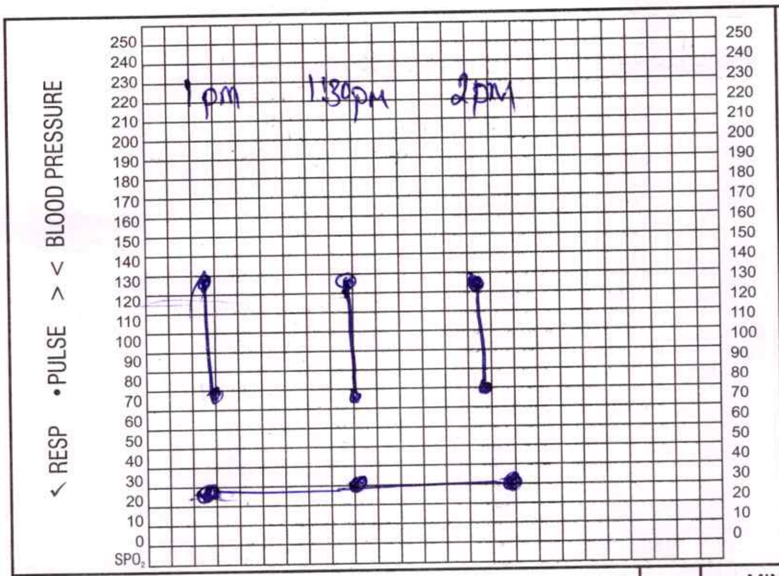
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Reneet ..... Time Received : @ 1pm. ..... Time Discharged : .....



IV Cannula Site : Right hand

☐ O_2 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. 100

Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
			(As per Anaon)	

Pain Tool Used: ☐ N PASS ☐ FLACC ☑ Wong Baker ☐ NPS

Anaesthesiologist Name : Dr. Srivinay

Anaesthesiologist Signature: .....

Date & Time: 28/5/26 1pm

PACU Nurse Name : Renuka

PACU Nurse Signature: Rl

Date & Time: 28/5/26 1PM

Reassessment Frequency:

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

Transferred to Unit by (PACU): .....

Date & Time: .....

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal		FHR	Comments
				BP	Pulse		

Delivery Details : Time : ..... APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. CHARISMA ..... Age : 29y ..... Gender : Male ☐ Female ☑

UHID NO: FD17-6529 ..... Surgeon Name: Dr. PUJITHA .....

Anaesthesiologist : Dr-SRINIVAS .....

Operative procedure planned : SERPL .....

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 arid 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 Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : .....

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 ..... the above mentioned operation / 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 : Chaithra N

Name : N Chaithra

Relationship with Patient: .....

Date & Time : 28/5/26 11:18 AM

Witness :

Signature : K. Pavan

Name : K. Pavan Kumar.

Date & Time 28/5/26 11:18 A.M

Doctor (who is taking the consent) :

Signature : SW

Name : SRINIVASA RAO K.

Date & Time : 28/5/26 11:18 A

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OPERATION THEATER NOTES

FDH-00006529 IP25-00020682
Mrs NANNAPANENI CHARISHMA
04-08-1996 29 Y 9 M 24 D (F)
Dr. PUJITHA DEVI SURANENI

Patient's I.................. Age : .... Gender : ....

UHID.: ....I.P.No. :.. Weight : ....

Surgeon :	Asst. Surgeon :
Anesthetist : Dr. Srinivas	OT Nurse : Br. hanumanth.

Surgical Procedure : SERPC

Indications for Surgery : Missed miscarriage

Date : 28/5/26.	Start Time :	End Time :

PRE-OPERATIVE PREPARATION : NBM
PAC
Consent
Preop medication
Inform OT/Anaesthesia

OPERATION NOTES:

- U AAP, GA, patient placed in lithotomy position
- Painting & draping done
- Anterior and posterior vaginal walls retracted c̄ Sim's speculum
- Anterior lip of cervix held c̄ vulsellum
- OS tightly stenosed
- Hegar's couldnt be passed
- OS dilated c̄ saline infusion
- Slow gradual OS dilation done c̄ Hegar's dilators upto no-6
- Ovum forceps couldnt be introduced
- Suction and evacuation of all products of conception done c̄ Karman's cannula no-6 under USG guidance
- Products sent for ~~HPE~~ CMA
- No active bleeding seen
- Post procedure scan showed empty uterine cavity.
- T. Misoprostol 400mcg Kept PR.

Patient attenders were informed about difficult entry, procedure completed uneventfully under USG guidance.

POST - OPERATIVE ORDERS :

Rx

NBM x 4-6 hours

Monitor Vitals/Bpv/Ho

Drugs as charted

Inform SOS

Dr. Rujitha

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 28/5/26 Time : 1 pm

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
DH-00006529 IP25-00020682 Mrs NANNAPANENI CHARISHMA 04-08-1996 29 Y 9 M 24 D (F) Dr. PUJITHA DEVI SURANENI	28/5/2026 @ 9:11AM	28/5/26 @ 12:30pm
	Transfer Ordered by Dr. Srinivas	Reason for Transfer post OP card
From Unit OT	To Unit MICU	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 25	Number of Imaging Films OP-1	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.	/	/
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
vaishali	Dr. Srinivas.

Patient & Clinical Records Received by : Ankita

Date & Time of Patient Received : 28/5/26 @ 1pm

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

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EDH-00006529 IP25-00020682
Mrs NANNAPANENI CHARISHMA
04-08-1996 29 Y 9 M 24 D (F)
Dr. PUJITHA DEVI SURANENI

Date & Time of Admission	Date & Time of Transfer Order
28/5/26 @ 9:11 AM	28/5/26 @ 11:25 AM
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. pujitha	Dr. pooja	—
From Unit	**To Unit**	**Information to Attendant**
MICU	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
1	1	Yes ☐ No ☐
		If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	/	1
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Jeevitha 28/5/26	Dr. pooja

Patient & Clinical Records Received by : Vaishu

Date & Time of Patient Received : 28/5/26 @ 11:50 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

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: MR. C. NANNAPANENI CHAITHIMA.		Age: 35Y		Gender: FEMALE	
UHID No: [illegible]	IP No: OTD20682.		Date: 28/05/2026	Time: 09:16 AM.	
Diagnosis: SE [illegible]					

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.	Remifentanil Hydrochloride Inj. 2MG	–	
4.	Remifentanil Hydrochloride inj. 1MG	–	

Doctor Name: Dr S MOHAN   Doctor Registration No: 36844

Signature: S

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: OTD20682.   **Date:** 28/05/2026

Aadhaar No. of the Patient (Optional): ....

1.	**Name :** MR. C. NANNAPANENI CHAITHIMA.	**Remarks**
2.	Complete postal address (with contact number, if any)	[illegible] HYDERABAD. TELANGANA. INDIA. [illegible]
3.	Brief description of the illness	SE [illegible].
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
28/05/2026	FENTANYL	ONE	C. Chaith[illegible]	

Dispensed by (Name & ID No.): SRINIVAS/[illegible]153 .... Signature: (S)

Received by (Name & ID No.): [illegible] .... Signature: [illegible]

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133

Rainbow Children's Hospital

BirthRight

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name		Age	Gender
UHID (Old / New)		Date	Time
Diagnosis			
PRESCRIPTION DETAILS (Only any one of the following)			
S.No	Drug Name	Dosage	Remarks
1	Tramadol Oxalate Inj 50mg/2 ml		
2	Morphine Sulphate Inj 15mg/ml		
3	Pentazocine Hydrochloride Inj 30mg		
4	Pentazocine Hydrochloride Inj 90mg		
Doctor Name		Doctor Registration No.	
Signature			

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

1	Name & Address of the Patient (Optional)	Date	
2	Complete postal address with contact number (if any)		
3	Brief description of the illness		
4	Details of registered with any other registered medical practitioner (if required medical opinion is to be obtained)		
5	Details of essential Narcotic Drug dispensed		

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any

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

Prescribed by (Name & ID No.) ..... Signature, Doctor Registration No. .....