Outlook

## RE: Mrs. NAVANEETHA (KUH-00088742) - Agreed Discount Package.

**From** Polepeddi Anand <anand.p@rainbowhospitals.in>
**Date** Thu 5/28/2026 7:30 PM
**To** FD Financial Counsellor <financial.counsel.fd@rainbowhospitals.in>
**Cc** Shashidhar A <shashidhar.a@rainbowhospitals.in>; FD IP BILLING <ipbilling.fd@rainbowhospitals.in>; Internal Audit FD <internalaudit.fd@rainbowhospitals.in>; FD MOD <mod.fd@rainbowhospitals.in>; M Rajlingam Chitra <operations.fd@rainbowhospitals.in>; Tintu Joy <nursingmanager.fd@rainbowhospitals.in>; FD ADMISSION DESK <admissiondesk.fd@rainbowhospitals.in>

Approved from my end

Regards,
Anand

**From:** FD Financial Counsellor <financial.counsel.fd@rainbowhospitals.in>
**Sent:** 28 May 2026 19:10
**To:** Polepeddi Anand <anand.p@rainbowhospitals.in>
**Cc:** Shashidhar A <shashidhar.a@rainbowhospitals.in>; FD IP BILLING <ipbilling.fd@rainbowhospitals.in>; Internal Audit FD <internalaudit.fd@rainbowhospitals.in>; FD MOD <mod.fd@rainbowhospitals.in>; M Rajlingam Chitra <operations.fd@rainbowhospitals.in>; Tintu Joy <nursingmanager.fd@rainbowhospitals.in>; FD ADMISSION DESK <admissiondesk.fd@rainbowhospitals.in>
**Subject:** Mrs. NAVANEETHA (KUH-00088742) - Agreed Discount Package.

**Mrs NAVANEETHA (KUH-00088742)**
**Dr. Sahitya**
**Hysteroscopy + Cop-T removal—Day care**

Good evening, Sir.

The above patient is given a **package for 50,000 all-inclusive for only daycare**. Considering the patient's financial constraints and the importance of patient retention.

The agreed package excludes any extra treatment, blood/blood products, extra day stay, etc.

Need your approval for the same

Regards,

Vivek

Rainbow® Children's Hospital
It takes a lot to treat the little.
BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

# DISCHARGE SUMMARY

| Name | Mrs NAVANEETHA | UHID | KUH-00088742 |
|---|---|---|---|
| Father/Guardian | Mr GANGA RAM | Age/Gender | 41 Y 6 M 20 D/ Female |
| Address | CHANDANAGAR HYDERABAD, Chandanagar, Hyderabad, Telanga[illegible]A, 500050 | | |
| IP No | IP25-00020708 | Admission Date | 29-05-2026 |
| Ref Doctor | Self | | |
| Discharge Date | 29.05.2026 | | |

**Consultants :**
**Dr. Sahitya Bammidi**
**MBBS,DGO,DNB,FIAOG,FMAS,FCG(USA)**
Senior Consultant-Obstetrician and Gynaecologist
Laparoscopic and Aesthetic Surgeon
Reg. No: 64696

**Diagnosis: P2L2A1 WITH PREVIOUS 2 LSCS FOR HYSTEROSCOPIC COPPER T REMOVAL**

**S/P HYSTEROSCOPIC COPPER T REMOVAL DONE ON 29.05.2026.**

**History:**
Presenting complaint: NO Fresh complaints.
She is admitted for Hysteroscopic Copper T Removal.

USG TVS done on 18.05.2026 showed,
Uterus 92x45x61mm,Bulky in size, ET 6.6mm, Copper T Insitu. B/L Ovaries normal.

Admitted for Hysteroscopic Copper T Removal.

Menstrual History:
LMP - 13.05.2026
Previous cycles : Regular

Obstetric History: P2L2A1 / 2 LSCS.

| Name | Mrs NAVANEETHA | UHID | KUH-00088742 |
|---|---|---|---|
| IP No | IP25-00020708 | Admission Date | 29-05-2026 |

LCB: 11 years

Medical History : Nil
Family History : Mother- HTN & Father- DM
Surgical History: Two LSCS & Diagnostic 2007 operative endometriotic cyst excision.
Allergies : Nil

**Investigations:** Enclosed.
Blood group & Typing - "AB" Positive.

**Surgery Notes:**
**Operation Performed By:** Hysteroscopic Copper T Removal done 29.05.2026.

**Indication:**

**Operative findings:**
- Under AAP, under short GA, parts painted & draped in lithotomy position.
- Bladder drained.
- Anterior & posterior vaginal wall retracted with Sim's Speculum.
- Anterior lip of cervix held with vulsellum.
- Serial and gentle dilation of internal OS done using Hegar's dilators.
- Hysteroscope slowly introduced into uterine cavity.

**IOF:**
- Stem of Copper T seen embedded deep into endometrium.
- thread of Copper T held with grasper and cu T removed.
- Hemostasis secured.
- Vagina cleaned with betadine.
- removed copper T shown to patient and attender.

**Post-Operative Notes:** - Uneventful.

**Advice:**
1. Tab. Taxim 200mg twice daily till 04.06.2026 (9am - 9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs)twice daily till

04.06.2026 (9am-9pm) after food.

3. Tab. Pantodac 40 mg (Pantoprazole 40mg) twice daily (7am-7pm) before food till 04.06.2026.

Review consultation with **Dr. Sahitya Bammidi**, on 06.06.2026 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

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**

**Consultant:**
**Dr. Sahitya Bammidi**
**MBBS,DGO,DNB,FIAOG,FMAS,FCG(USA)**
Senior Consultant-Obstetrician and Gynaecologist
Laparoscopic and Aesthetic Surgeon
Reg. No: 64696

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** : IP25-00020708 **Admit Date** : 29-May-2026 **Admit Time** : 10:08 AM **UHID** : KUH-00088742

## Patient Details :

| | | | |
|---|---|---|---|
| **Patient Name** | : Mrs NAVANEETHA | **Age** | : 41 Y 6 M 20 D |
| **Guardian** | : Mr GANGA RAM | **DOB** | : 09-11-1984 |
| **Gender** | : Female | **Religion** | : |
| **Occupation** | : | **Martial Status** | : Married |
| **Address (H)** | : CHANDANAGAR HYDERABAD Chandanagar Hyderabad Telangana INDIA 500050 | **Phone No** | : 9493123036 |
| | | **E-mail** | : NO@GMAIL.COM |

## Admission Details :

| | | | | | |
|---|---|---|---|---|---|
| **Bed Type** | : MICU | **Bed No** | : PRE-OP-02 | **Ward Name** | : 4F -OT |
| **Room No** | : PRE-OP-02 | **Admission Type** | : First Visit | | |

## Contact Details :

| | | | |
|---|---|---|---|
| **Name** | : Mr GANGA RAM | **Relationship** | : W/O |
| **Contact Address** | : CHANDANAGAR HYDERABAD Chandanagar Hyderabad Telangana INDIA 500050 | **Phone No** | : |

**Signature**

## Doctor Details :

| | | | |
|---|---|---|---|
| **Doctor Name** | : Dr. SAHITYA BAMMIDI | **Specialisation** | : OBSTETRICS AND GYNECOLOGY |
| **Referral Doctor** | : Self | **Phone No** | : |
| **Co-Consultant** | : | | |

## Payment Details :

| | | | |
|---|---|---|---|
| **Payment Mode** | : Cash | **Deposit Amount** | : 0.00 |
| | | **Payor Name** | : SELFPAY |

Gyne

Rainbow® Children's Hospital
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KUH-00088742 IP25-00020708
Mrs NAVANEETHA
09-11-1984 41 Y 6 M 20 D (F)
Dr. SAHITYA BAMMIDI

## ACTIVITY RECORD FOR BILLING

Name: Mrs. Navaneetha

UHID No : --------------- IP 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 |
|---|---|---|---|---|
| 29/5/26 | 11:15Am | M/W | OT | [signature] |
| 29/5/26 | 12:25pm | OT | MICU | [signature] |
| | | | | |
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## Cross Consultation Visit

| | Doctors Name | Date | Order No. | Signature |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
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| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

Docu. No. : RCH / FRM / GENERAL / 145

## INVESTIGATIONS

| Date | Investigations | Order No. | Sign |
|---|---|---|---|
| ~~[illegible]~~26 | ~~Biopsy~~ | | |
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**MEDICAL EQUIPMENT ( WARD & ICU)**

| Date | Name of Equipment | Connecting Time | Disconnecting Time | Order No. | Signature |
|---|---|---|---|---|---|
| 29/5/26 | Cardiac Monitor | 12:25PM | } 4:30 Pm | } 1939 | } RA |
| 29/5/26 | Infusion Pump | 12:25 Pm | | | |
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c/c by [signature] 29/5/26 1:30 Pm

## PROCEEDURE

| Date | Proceedure | Quantity | Order No. | Signature |
|---|---|---|---|---|
| 29/5/26 | IV placement | ① | 1940 | [signature] |
| 29/5/26 | PAC - IP | IP | 1938 | |
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c/c by [signature] 29/5/26 13:40pm

## ANY OTHER INFORMATION

Date : 29/5/26  Time : 10:10AM  Prepared By : [signature]

| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|---|---|---|---|
| [signature] | MICU | | |

KUH-00088742 IP25-00020708
Mrs NAVANEETHA
09-11-1984 41 Y 6 M 20 D (F)
Dr. SAHITYA BAMMIDI

Patier

# NURSING SHIFT HAND OVER FORM

| SITUATION | | |
|---|---|---|
| Diagnosis: | Any Infection: ☐ Yes ☑ No ☐ Not Known<br>If Yes Specify: ............................................ | |
| Surgery / Procedure: | Post OP Day: | |

| Section | Item | Date / Shift | Date / Shift | Date / Shift | Date / Shift | Date / Shift | Date / Shift |
|---|---|---|---|---|---|---|---|
| BACKGROUND | Date / Shift | 29/5 M | | | | | |
| | Medical Condition (Any special condition to be noted): | | | | | | |
| | 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°F | | | | | |
| | Res: | 20 | | | | | |
| | $SpO_2$: | 98% | | | | | |
| | Pulse: | 90 | | | | | |
| | BP: | 161/99 | | | | | |
| | LOC: | Conscious | | | | | |
| | Fall Risk Score: | 0/15 | | | | | |
| | Pain Score: | 0/10 | | | | | |
| | Skin Integrity | Good | | | | | |
| Recommendations | Safety Needs: | ☐ Yes ☑ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Physiotherapy: | NA | | | | | |
| | Others Specify: | ☐ Yes ☑ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | Special Diet: | NBM | | | | | |
| | 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): | dependent | | | | | |
| | Post Operative Procedure Special Orders: | - | | | | | |
| | Handed Over By Name : | Sushma | | | | | |
| | Signature / ID : | [signature] | | | | | |
| | Date: | 29/5/26 | | | | | |
| | Time: | @ 2pm | | | | | |
| | Taken Over By Name : | | | | | | |
| | Signature / ID : | | | | | | |
| | Date: | | | | | | |
| | Time: | | | | | | |

Docu. No. : RCH /FRM / CLINICAL / 097

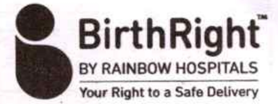
Patient Sticker

# NURSING SHIFT HAND OVER FORM

| SITUATION | | |
|---|---|---|
| | Diagnosis: | Any Infection: ☐ Yes ☐ No ☐ Not Known<br>If Yes Specify: ........................................... |
| | Surgery / Procedure: | Post OP Day: |

| | Date / Shift | | | | | | |
|---|---|---|---|---|---|---|---|
| BACKGROUND | 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: | | | | | | | |

KUH-00088742 IP25-00020708
Mrs NAVANEETHA
09-11-1984 41 Y 6 M 20 D (F)
Dr. SAHITYA BAMMIDI



# OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 29/5/2c

**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

Name of the Doctor: ............

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

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

| Past Medical History | Past Surgical History | Previous Hospital Admission |
|---|---|---|
| | | |

**Gynecology Assessment:** ☐ Not Applicable

Menstrual History: ............

Onset of Menarche: ............

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: ............

**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: 98°F HR: 90 RR: 20

BP: 162/99 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 .................. (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 ..............................................................................................

**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 ..............................................................................

Name of Person Orientation was given to: ..........................................................

Orientation not given Reason: ...........................................................................

Nurse Signature: ..................................................

Nurse Name: ..................................................

Date & Time: ..................................................

Ref. No. : F/GYNIC/18

# I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 29/5/26

Time of Admission : 9 AM

## PERSONAL DETAILS

Name : NAVANEETHA Age 44 Date of Birth

UHID No.: KUH-00088742 IP No.:

Department : OBG Consultant : Dr. SAHITHYA

## PRESENTING COMPLAINTS :

Admitted for Hysteroscopic CuT removal

CuT inserted 6yrs ago

18/5/26

TVS – uterus 92 x 45 x 61 mm
bulky in size
ET – 6.6 mm
CuT insitu

(N) ovaries

| MENSTRUAL HISTORY | OBSTETRIC HISTORY |
|---|---|
| Year of Marriage : 18yr | Parity : $P_2 L_2 A_1$ |
| Previous Periods : RMP | Mode of Delivery: prev 2LSCS |
| LMP : 13/5/26 | Last Child Birth : 11y |
| Contraception : | |

| MEDICAL HISTORY | SURGICAL HISTORY |
|---|---|
| – | – Prev 2 LSCS<br>– Lap. { Diagnostic 2007<br>operative – endometriotic cyst excision |
| **FAMILY HISTORY** | **NOTES / ALLERGIES** |
| M – DM, HTN | – |

**INITIAL ASSESSMENT :**

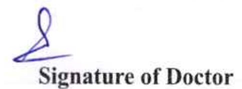
| | Breasts | Local / Speculum Examination |
|---|---|---|
| Date 29/5/26<br>Ht. ______ Wt. ______<br>BMI ______<br>B.P 140/90 mmHg<br>Pallor ⊖<br>CVS S1 S2 ⊕<br>Respiratory System NVBS ⊕<br>Thyroid (N) | (N)<br><br>**Abdominal Examination**<br><br>Soft | Cu-T thread not visible<br><br>**Bimanual Pelvic Examination**<br><br>ND |

**PROVISIONAL DIAGNOSIS :** P2 L2 A1 / prev 2 LSCS / for Hysteroscopic CuT removal

| INVESTIGATIONS ORDERED | PLAN OF MANAGEMENT | PRESCRIPTION |
|---|---|---|
| 28/5<br>Hb – 11.6<br>Plt – 3.18 | Hysteroscopy<br>copper-T removal | – NBM<br>– PAC<br>– secure IV canula<br>– Preop medication<br>– Part preparation<br>– Consents |

Name of the Doctor : Dr SAHITHYA

Date : 29/5/26 Time : 8 AM



Signature of Doctor

# PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---|---|---|
| | POD - 0 | |
| 29/I/26 | Pt conscious | Rx |
| 14:35pm | oriented | - NBM x 4 hrs |
| | BP - 140/90 mm | - Drugs as charted |
| | PR - [illegible] | - [illegible] bleeding PV |
| | SpO₂ - 99% @ RA | - [illegible] (SOS) |
| | [illegible] - [illegible] | |
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Patient Sticker

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

# PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---|---|---|
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# PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---|---|---|
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# PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---|---|---|
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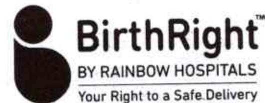
KUH-00088742 IP25-00020708
Mrs NAVANEETHA
09-11-1984 41 Y 6 M 20 D (F)
Dr. SAHITYA BAMMIDI

Mrs. Navaneetha




# RESULT SHEET

| Date | 28/5/26 | | | | | |
|---|---|---|---|---|---|---|
| Time | | | | | | |
| Hb | 11'6 | | | | | |
| PCV | 35'9 | | | | | |
| RBC | 4'6 | | | | | |
| WBC | 7700 | | | | | |
| N/L | | | | | | |
| Platelets | 318000 | | | | | |
| CRP | | | | | | |
| ESR | | | | | | |
| PCT | | | | | | |
| RBS | | | | | | |
| Na | | | | | | |
| K | | | | | | |
| Cl | | | | | | |
| Ca/Mg | | | | | | |
| Phosphate | | | | | | |
| Urea | 23 | | | | | |
| Creatinine | 0'8 | | | | | |
| 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 | 15'4 / 0'98 | | | | | |
| APTT | - | | | | | |
| CSF Protein / Sugar | | | | | | |
| ~~Cells~~ Hba1c | 5'1 | | | | | |
| ~~N/L~~ FBS | 87 | | | | | |

| Date | | | | | | |
|---|---|---|---|---|---|---|
| Time | | | | | | |
| CUE - Alb | | | | | | |
| CUE - Sugar | | | | | | |
| CUE - Ketones | | | | | | |
| CUE - PUS Cells | | | | | | |
| CUE - RBC Cells | | | | | | |
| CUE | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Stool Pus Cell | | | | | | |
| OVA / Cyst | | | | | | |
| Occult Blood | | | | | | |
| | | | | | | |
| BGT | AB +ve | | | | | |
| | | | | | | |
| | | | | | | |
| HIV I & 2, HCV HBsAg, | NR. | | | | | |
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Culture and Sensitivities : ..............................

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Radiology : USG : ..............................

X-Ray : ..............................

ECHO : ..............................

CT : ..............................

MRI ..............................

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

Patient Sticker

# 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: ............................................................ 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 | | | | | | ☐ 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 Hayline ..........................................

Date & Time : 29/5/26 @ ..........................................

Nurse Name & Signature: ..........................................

Date & Time : ..........................................

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

KUH-00088742 IP25-00020708
Mrs NAVANEETHA
09-11-1984 41 Y 6 M 20 D (F)
Dr. SAHITYA BAMMIDI

# DRUG CHART

Date of Admission: .................................. 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 / 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. CEFIXIME-O

| Dose | Route | Frequency | Start Date |
|---|---|---|---|
| 200mg | P/O | BD | 29/5 |

Name & Signature of the Doctor Starting the Drugs: Dr Oncom

Additional Instructions:

**Daily Doctor's Endorsement by a Sign**

Date ▸ Time ▾

**DRUG :** T. PANTAPRAZOLE

| Dose | Route | Frequency | Start Date |
|---|---|---|---|
| 40mg | P/O | OD | 29/5 |

Name & Signature of the Doctor Starting the Drugs: Dr Preme

Additional Instructions:

**Daily Doctor's Endorsement by a Sign**

Date ▸ Time ▾

**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 ▾

**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 ▾

KUH-00088742 IP25-00020708
Mrs NAVANEETHA
09-11-1984 41 Y 6 M 20 D (F)
Dr. SAHITYA BAMMIDI

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No: .............

# REGULAR PRESCRIPTIONS

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

| DRUG : | | | | Date▸ / Time▾ |
|---|---|---|---|---|
| Dose | Route | Frequency | Start Dt. | |
| Name & Signature of the Doctor Starting the Drugs: | | | | |
| Additional Instructions: | | | | |
| Daily Doctor's Endorsement by a Sign | | | | |

| DRUG : | | | | Date▸ / Time▾ |
|---|---|---|---|---|
| Dose | Route | Frequency | Start Dt. | |
| Name & Signature of the Doctor Starting the Drugs: | | | | |
| Additional Instructions: | | | | |
| Daily Doctor's Endorsement by a Sign | | | | |

| DRUG : | | | | Date▸ / Time▾ |
|---|---|---|---|---|
| Dose | Route | Frequency | Start Dt. | |
| Name & Signature of the Doctor Starting the Drugs: | | | | |
| Additional Instructions: | | | | |
| Daily Doctor's Endorsement by a Sign | | | | |

| DRUG : | | | | Date▸ / Time▾ |
|---|---|---|---|---|
| Dose | Route | Frequency | Start Dt. | |
| Name & Signature of the Doctor Starting the Drugs: | | | | |
| Additional Instructions: | | | | |
| Daily Doctor's Endorsement by a Sign | | | | |

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

Patient Sticker

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No: ............

# REGULAR PRESCRIPTIONS

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

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

| DRUG : | | | | Date ➤ / Time ▼ |
|---|---|---|---|---|
| Dose | Route | Frequency | Start Dt. | |
| Name & Signature of the Doctor Starting the Drugs: | | | | |
| Additional Instructions: | | | | |
| **Daily Doctor's Endorsement by a Sign** | | | | |

| DRUG : | | | | Date ➤ / Time ▼ |
|---|---|---|---|---|
| Dose | Route | Frequency | Start Dt. | |
| Name & Signature of the Doctor Starting the Drugs: | | | | |
| Additional Instructions: | | | | |
| **Daily Doctor's Endorsement by a Sign** | | | | |

| DRUG : | | | | Date ➤ / Time ▼ |
|---|---|---|---|---|
| Dose | Route | Frequency | Start Dt. | |
| Name & Signature of the Doctor Starting the Drugs: | | | | |
| Additional Instructions: | | | | |
| **Daily Doctor's Endorsement by a Sign** | | | | |

| DRUG : | | | | Date ➤ / Time ▼ |
|---|---|---|---|---|
| Dose | Route | Frequency | Start Dt. | |
| Name & Signature of the Doctor Starting the Drugs: | | | | |
| Additional Instructions: | | | | |
| **Daily Doctor's Endorsement by a Sign** | | | | |

KUH-00088742 IP25-00020708
Mrs NAVANEETHA
09-11-1984 41 Y 6 M 20 D (F)
Dr. SAHITYA BAMMIDI

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

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

| **VARIABLE DOSE** | Date ➤ / Time | | Nurse Sig. | | Nurse Sig. | | Nurse Sig. | | Nurse Sig. |
|---|---|---|---|---|---|---|---|---|---|
| **DRUG :** | | Dose | | Dose | | Dose | | Dose | |
| | | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | |
| Route / Start Date | | Dose | | Dose | | Dose | | Dose | |
| | | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | |
| Name & Signature of the Doctor | | Dose | | Dose | | Dose | | Dose | |
| | | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | | Dr. Sign. | |
| Additional Instructions: | | 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 |
|---|---|---|---|---|---|---|
| 29/5 | 10:00 Am | Inj CEFOTAXIME | 1g | IV | [signature] | [signature] RENUKA |
| 29/5 | 10:45Am | Inj PANTOPRAZOLE | 40mg | IV | [signature] | [signature] |
| 29/5 | 10:45Am | Inj METACLOPRAMIDE | 10mg | IV | [signature] | [signature] |
| 29/5 | 11Am | T. MISOPROSTOL | 400mcg | P/V | [signature] | [signature] |
| | | | | | | |
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VERIFIED BY : Name ............ Signature ............

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 |
|---|---|---|---|---|---|---|---|---|---|
| 29/15 | 11:40 AM | RL | iv | FF | [signature] | | | | |
| | | | | | | | | | |
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VERIFIED BY : Name ........................ Signature ........................

KUH-00088742
Mrs NAVANEETHA IP25-00020708
09-11-1984 41 Y 6 M 20 D (F)
Dr. SAHITYA BAMMIDI

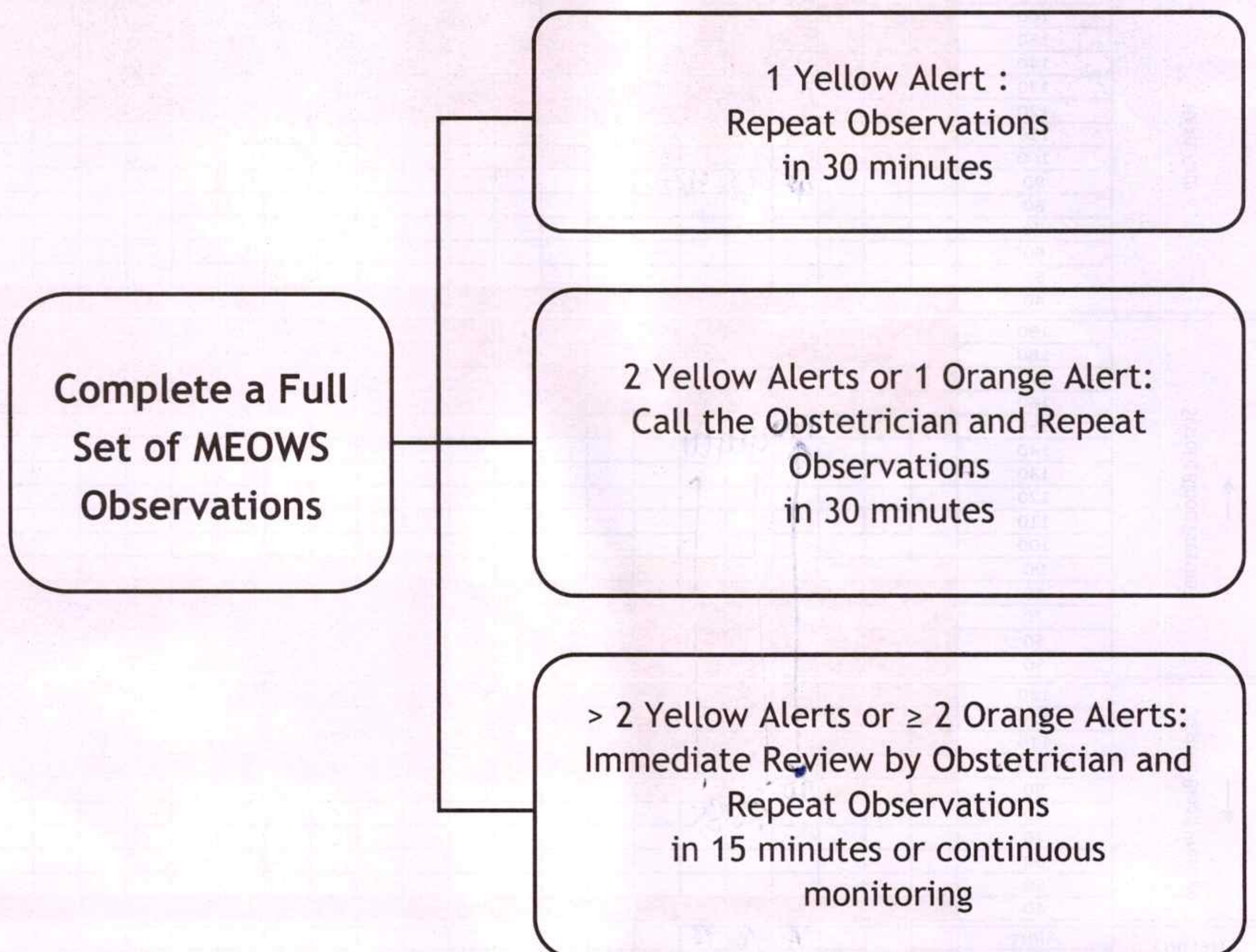
29/1/26

# Early Warning 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 | | | | 22 | 20 | 22 | | | | | | | | | | | | | | | | | | |
| | 0 - 10 | | | | | | | | | | | | | | | | | | | | | | | | |
| Saturations | 94 - 100 % | | | | 99 | 99 | 99 | | | | | | | | | | | | | | | | | | |
| | < 94 % | | | | | | | | | | | | | | | | | | | | | | | | |
| Administered $O_2$ (L/min.) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Temp°c | 40 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 39 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 38 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 37 | | | | 37 | 37 | 37 | | | | | | | | | | | | | | | | | | |
| | 36 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 35 | | | | | | | | | | | | | | | | | | | | | | | | |
| | < 35 | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Rate | 170 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 160 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 150 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 140 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 130 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 90 | | | | 92 | 92 | 93 | | | | | | | | | | | | | | | | | | |
| | 80 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 70 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 50 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 40 | | | | | | | | | | | | | | | | | | | | | | | | |
| ↑ Systolic Blood Pressure | 190 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 180 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 170 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 160 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 150 | | | | 140 | | | | | | | | | | | | | | | | | | | | |
| | 140 | | | | | 144 | 144 | | | | | | | | | | | | | | | | | | |
| | 130 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 90 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 80 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 70 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 50 | | | | | | | | | | | | | | | | | | | | | | | | |
| ↓ Diastolic Blood Pressure | 130 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 90 | | | | 90 | | | | | | | | | | | | | | | | | | | | |
| | 80 | | | | | 85 | 85 | | | | | | | | | | | | | | | | | | |
| | 70 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 50 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 40 | | | | | | | | | | | | | | | | | | | | | | | | |
| NEURO RESPONSE [✓] | Alert | | | | A | A | A | | | | | | | | | | | | | | | | | | |
| | Voice | | | | | | | | | | | | | | | | | | | | | | | | |
| | Pain | | | | | | | | | | | | | | | | | | | | | | | | |
| | Unresponsive | | | | | | | | | | | | | | | | | | | | | | | | |
| URINE mls / hour | > 30 | | | | - | - | - | | | | | | | | | | | | | | | | | | |
| | < 30 | | | | | | | | | | | | | | | | | | | | | | | | |
| Proteinuria | Protein + + | | | | | | | | | | | | | | | | | | | | | | | | |
| | Protein > + + | | | | | | | | | | | | | | | | | | | | | | | | |
| Lochia | Normal | | | | - | - | - | | | | | | | | | | | | | | | | | | |
| | Heavy / Foul | | | | | | | | | | | | | | | | | | | | | | | | |
| Liquor | Clear / Pink | | | | | | | | | | | | | | | | | | | | | | | | |
| | Green | | | | | | | | | | | | | | | | | | | | | | | | |
| TOTAL YELLOW SCORES | | | | | 2 | 0 | 0 | | | | | | | | | | | | | | | | | | |
| TOTAL ORANGE SCORES | | | | | 0 | 0 | 0 | | | | | | | | | | | | | | | | | | |
| Nurse Initial | | | | | 8 | 0 | [illegible] | | | | | | | | | | | | | | | | | | |

## Obstetrics and Gynaecology Early Warning Signs




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

KUH-00088742 IP25-00020708
Mrs NAVANEETHA
09-11-1984 41 Y 6 M 20 D (F)
Dr. SAHITYA BAMMIDI

# FLUID CHART

Sheet No. : 01

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 Thrombo-phlebitis Score | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date | Time | Nature of Fluid | Route | | | NG | Diarrhoea | Vomit | Drainage | Urine | | Sign. Nurse |
| | | | Mouth | I.V | N.G | | | | | | 0 | |
| | 08:00 am | RL | | | | | | | | | 0 | |
| | 09:00 am | R | | | | | | | | | 0 | |
| | 10:00 am | | | | | | | | | | 0 | |
| | 11:00 am | RL | NBM | ff | – | – | | | | 100ml (OT) | 0 | |
| | 12:00 pm | RL | NBM | ff | – | | | | | | 0 | |
| | 01:00 pm | RL | NBM | 100 | – | | | | | | 0 | |
| 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 | |
|---|---|---|---|

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 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | |
|---|---|

Docu. No. : RCH /FRM / CLINICAL / 092

Department of Anaesthesiology

# PRE-ANAESTHETIC EVALUATION

Name: navaneetha Age: 41Y Sex: Female UHID.No :

Date: 29/5/2026 Time: 10:35pm Proposed Operation: hysteroscopy + copper-T removal.

Diagnosis:

B.P / CRT: 95.6/107 H.R: Weight: 67kg ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

**Laboratory Data:**

| | | | | |
|---|---|---|---|---|
| Hgb: 11.6g% | Glucose: | Protein: | HIV: NR | X-Ray: |
| PCV: | Urea: | Alb: | HBS Ag: NR | ECG: |
| WBC: 7700 | Creat: 0.8 | Total Bill: | HCV: NR | 2D Echo: |
| Plate: 3.18 lakhs | Na: | Dir. Bill: | Blood group: AB+ve | Stress/Anglo: |
| PT: 15.4 | K: | LDH: | T3 | Other: |
| PTT: | Ca++: | Alk phos: | T4 | |
| INR: 0.95 | Mg++: | Amylase: | TSH | |
| | Cl -: | SGOT/SGPT: | | |

**Allergies:** NO.

**Medical History:** CVS :

RESP : Diabetes :

CNS : nothing significant

Renal : no H/o fever/cold/cough.

Hepatic / GE : Physical Activity:

Others :

**Past Anaesthetic History:** H/o 2 previous LSCS & H/o laparoscopic 2 times under GA

**Physical Exam:** O/E

**Airway:** MP 1 (2) 3 4 Mouth Opening: 3 fingers Mentohyoid Distance: >3 fb Neck: (N) Teeth:

**Lungs :** B/L AE (=) clear

**Heart:** S1S2

**CNS:**

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site : (+) Spine Exam for regional :

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

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

| CURRENT MEDICATIONS | DOSAGE |
|---|---|
| | |
| | |
| | |
| | |

**Pre-Operative Instructions:**

1. DVT Prophylaxis : NBM :- 8:30pm..
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:

Signature: [signature] Name: Dr. S. Sridhar

Docu. No. : RCH /FRM / CLINICAL / 044

Patient Sticker

# ANAESTHESIA CHART

## Pre Induction Assessment:

**Change in Patient Condition:** ☐ Yes ☑ No | Fasting Status: Confirmed

**Physical Status:** ☑ Patient Identified | ☑ Consent Present | ☐ Chart Reviewed

H.R: 92bpm | B.P / CRT: 140/92mmHg | $SpO_2$: 99% | R.R: | Last Feed: 10pm

Pre-OP Diagnosis: ............ Operation: hysteroscopy + Coppa-T | Date 29/5/18

Surgeon: Dr. Sahitya | Anaesthesiologist: Dr. S. Mohan | Technician: Suren

| TIME | 11:40 | 11:45 | 12:00PM |
|---|---|---|---|
| $N_2O$ / AIR / $O_2$ LPM | 1L/m | → | → |
| HALO / ISO / SEVO | 1 MAC | → | → |
| Drugs: | | | |
| Inj. MIDAZOLAM | 2 mg | | |
| FENTANYL | 100 µg IV | | |
| PROPOFOL | 100mg + 40mg IV | | |
| $FIO_2$ / $SaO_2$ | 100 | 100 | 100 |
| $ETCO_2$ | 33 | 34 | 35 |
| ECG | SR | SR | SR |
| Temperature | | | |
| Urine Output | | | |
| Fluids / Blood: RL | ① | | |

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: Rt hand
☐ 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: 11:40AM
OP Start: ↓
OP End: ↓
Leave OR: 12:00pm

**Anaesthesia:**
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

**Line (Size & Location)**
☐ CVP: ............
☐ ART: ............
☑ IV: Rt hand 20G
☐ IV: ............
☐ IV: ............

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

☐ Mask ☑ SGA I-gel - 4 size
☐ 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. S. Mohan

Signature of the Doctor: [signature]

Patient Sticker

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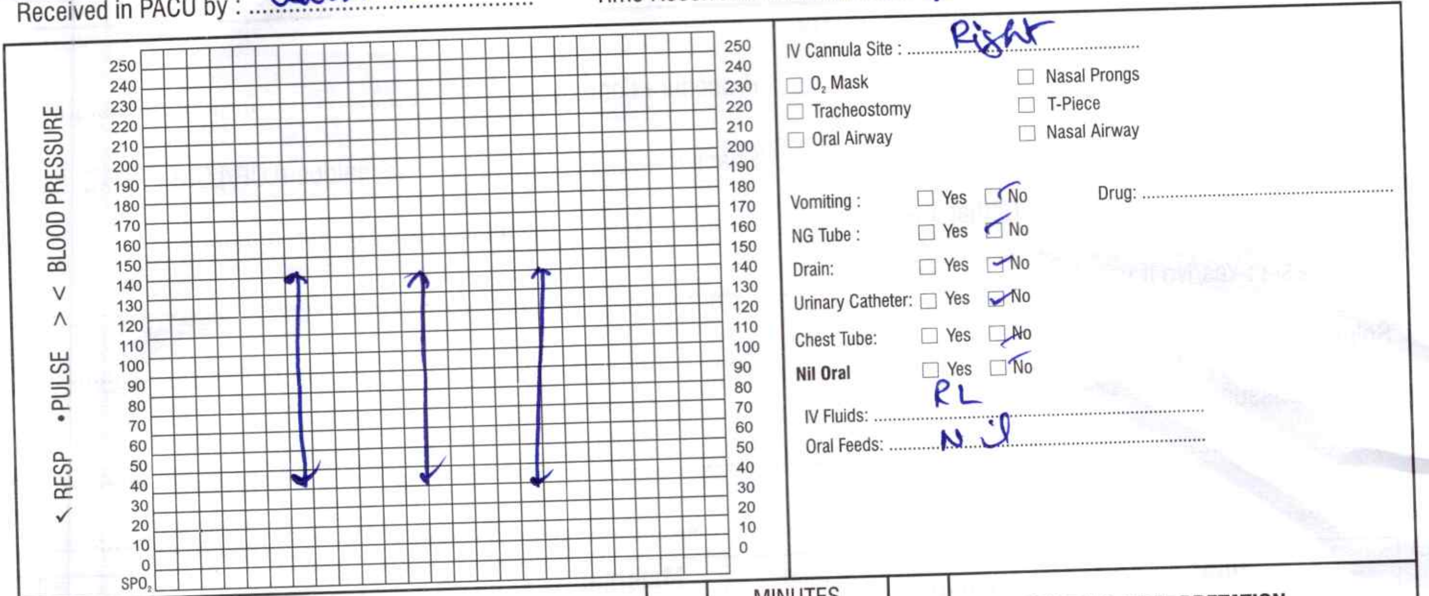
# POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sushma    Time Received : 12:25 pm    Time Discharged :



IV Cannula Site : Right

- ☐ $O_2$ Mask
- ☐ Nasal Prongs
- ☐ Tracheostomy
- ☐ T-Piece
- ☐ Oral Airway
- ☐ Nasal Airway

| | | |
|---|---|---|
| Vomiting : | ☐ Yes | ☑ No |
| NG Tube : | ☐ Yes | ☑ No |
| Drain: | ☐ Yes | ☑ No |
| Urinary Catheter: | ☐ Yes | ☑ No |
| Chest Tube: | ☐ Yes | ☑ No |
| **Nil Oral** | ☐ Yes | ☑ No |

Drug:

IV Fluids: RL

Oral Feeds: Nil

| POST ANAESTHESIA SCORE (Modified Aldrete Score) | | | IN | MINUTES 30 | 60 | 90 | OUT |
|---|---|---|---|---|---|---|---|
| Able to move 4 extremities voluntary or on command<br>Able to move 2 extremities voluntary or on command<br>Able to move 0 extremities voluntary or on command | = 2<br>= 1<br>= 0 | ACTIVITY | | 1 | ✓ | ✓ | |
| Able to deep breathe & cough freely<br>Dyspnea or limited breathing<br>Apneic | = 2<br>= 1<br>= 0 | RESPIRATION | | 2 | ✓ | ✓ | |
| BP ± 20 of Pre Anaesthetic leve<br>BP ± 20-50 of Pre Anaesthetic leve<br>BP ± 50 of Pre Anaesthetic leve | = 2<br>= 1<br>= 0 | CIRCULATION | | 2 | ✓ | ✓ | |
| Fully awake<br>Arousable on calling<br>Not responding | = 2<br>= 1<br>= 0 | CONSCIOUSNESS | | ✓ | ✓ | ✓ | |
| Pink<br>Pale, dusky, blotchy, jaundiced, other<br>Cyanotic | = 2<br>= 1<br>= 0 | COLOR | | 2 | 2 | 2 | |
| | | TOTAL | | 9 | 10 | 10 | |

**SCORING INTERPRETATION**

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:

## PAIN ASSESSMENT AND MANAGEMENT FORM

| Date | Time | Pain Score | Intervention | Signature |
|---|---|---|---|---|
| | | | | |
| | | | As per Anaes | |
| | | | | |
| | | | | |

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

Anaesthesiologist Name : Dr. Mohan.

Anaesthesiologist Signature:

Date & Time: 29/5/26

PACU Nurse Name : Sushma

PACU Nurse Signature: [signature]

Date & Time: 29/5/21

**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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# 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 BP | Maternal Pulse | FHR | Comments |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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 : ......................................................................

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# OPERATION THEATER NOTES

Patient's Name : Mrs. D Navaneetha Age : 41Y Gender : F

UHID.: KOH - 00088742 I.P.No. : Weight :

| Surgeon : Dr. Sahithay | Asst. Surgeon : – |
|---|---|
| Anesthetist : Dr. Mohan | OT Nurse : Br. Amar, Br. Buddha |

**Surgical Procedure :**

Hysteroscopic CuT removal

**Indications for Surgery :**

| Date : 29/5/26 | Start Time : 11:40 Am | End Time : 12:00pm |
|---|---|---|

**PRE-OPERATIVE PREPARATION :**

- NBM
- Inj. CEFOTAXIM 1gm IV stat
- Inj. PANTAPRAZOLE 40mg IV stat
- Inj. METACLOPRAMIDE 10mg IV stat

**OPERATION NOTES:**

USA, patient in lithotomy position, parts painted & draped, posterior vaginal wall depressed with sims speculum & anterior lip of cervix held with sponge holder & hysteroscope introduced. Stem of CuT seen deeply embedded in endometrium. CuT thread held with grasper & CuT removed.
Hemostasis achieved
no bleeding PV
patient withstood procedure well

POST - OPERATIVE ORDERS :

- NBM x 6hr
- Sit up as desired
- W/f bleeding PV
- Inform (SS)

Dr S. ANANDYA

Consultant Surgeon's Name

Date : 29/8/26 Time : 11 am

Consultant Surgeon's Signature

# PATIENT TRANSFER FORM

| Patient Name & UHID No. | Date & Time of Admission | Date & Time of Transfer Order |
|---|---|---|
| Mrs. Navaneetha | 29/5/26 @ 10:08 AM | 29/5/26 @ 12:25 PM |
| **Treating Consultant Name** | **Transfer Ordered by** | **Reason for Transfer** |
| Dr. Sahithay | Dr. Mohan | post op care |
| **From Unit** | **To Unit** | **Information to Attendant** |
| OT | MICU | Yes ☑ No ☐ |
| **Number of Sheets in Clinical File** | **Number of Imaging Films** | **Personal belongings including clinical documents. If any handed over to attendant** |
| 29 | op file - 1 | 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 |
|---|---|
| Br. Subhadeep (signature) 29/5/26 @ 12:25 PM | Dr. Mohan. |

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

Docu. No. : RCH /FRM / CLINICAL / 102

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# PATIENT TRANSFER FORM

| Patient Name & UHID No. | Date & Time of Admission | Date & Time of Transfer Order |
|---|---|---|
| KUH-00088742 IP25-00020708<br>Mrs NAVANEETHA<br>09-11-1984 41 Y 6 M 20 D (F)<br>Dr. SAHITYA BAMMIDI | 29/5/26 | 29/5/26 @ 11:15 pm |
| | **Transfer Ordered by**<br>Dr. Anusha | **Reason for Transfer**<br>Hysteroscopy |
| **From Unit**<br>MICU | **To Unit**<br>OT | **Information to Attendant**<br>Yes ☑ No ☐ |
| **Number of Sheets in Clinical File**<br>30 | **Number of Imaging Films**<br>10 P file | **Personal belongings including clinical documents. If any handed over to attendant**<br>Yes ☑ No ☐<br>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 |
|---|---|
| Sushma | Dr. Anusha. |

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

O.T

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# NARCOTIC PRESCRIPTION FORM
## (MEDICAL RECORD)

(581789b)

| Patient Name: MRS. NAVANEETHA | Age: 41Y | Gender: FEMALE |
|---|---|---|
| UHID No: KUH-00088742 IP No: 25-00020708. | Date: 29/05/26. | Time: 10:38AM. |
| Diagnosis: HYSTEROSCOPY COPPER-T REMOVAL | | |

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: KODE USHA Doctor Registration No: TSMC/FMR/01535

Signature: [signature]

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

IP Registration No: 25-00020705. Date: 29/05/2026

Aadhaar No. of the Patient (Optional): –

| | | Remarks |
|---|---|---|
| 1. | Name : MRS. NAVANEETHA. | |
| 2. | Complete postal address (with contact number, if any) | CHANDANAGAR, HYDERABAD TELANGANA, INDIA – 500050. |
| 3. | Brief description of the illness | HYSTEROSCOPY COPPER-T REMOVAL |
| 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 CITRATE |

| Date | Name of the Essential Narcotic Drugs | Quantity | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
|---|---|---|---|---|
| 29/5/26 | FENTANYL CITRATE | ONE | V Navaneetha | – |
| – | – | – | – | – |

Dispensed by (Name & ID No.): K. PRASANTH (016007) Signature: [signature]

Received by (Name & ID No.): M. PRASHANTH (010494) Signature: [signature]

Time: @11:57Am

Docu. No: RCH / FRM / CLINICAL / 133

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# NARCOTIC PRESCRIPTION FORM
## (MEDICAL RECORD)

| Patient Name: | Age: | Gender: |
|---|---|---|
| CR No: | IP No: | Date: | Time: |
| Diagnosis: | | |

PRESCRIPTION DETAILS ( Tick only one of the following)

| S No | Drug Name | Dosage | Remarks |
|---|---|---|---|
| 1 | Fentanyl Citrate Inj. 50mcg/Ml | | |
| 2 | Morphine Sulphate Inj. 15mg/Ml | | |
| 3 | Remifentanil Hydrochloride Inj. 2MG | | |
| 4 | Remifentanil Hydrochloride Inj. 1MG | | |

Doctor Name: Doctor Registration No:

Signature:

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

**IP Registration No:** .................... **Date:** ....................

Aadhaar No. of the Patient (Optional):

| | | Remarks |
|---|---|---|
| 1. | Name : | |
| 2. | Complete postal address (with contact number if any) | |
| 3. | Brief description of the illness | |
| 4. | Whether registered with any other registered medical practitioner / recognized medical institution ( if yes, details of the recorded) | |
| 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 ....................

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

Time: