

**DISCHARGE SUMMARY**

<b>Name</b>	Mrs MANISHA KUMARI	<b>UHID</b>	FDH-00043879
<b>Father/Guardian</b>	Mr JASHBANT KUMAR SINGH	<b>Age/Gender</b>	33 Y 2 M 28 D/ Female
<b>Address</b>	F1703 Aparna zenith Serilingampally, Hyderabad, Hyderabad, Telangana, INDIA, 500001		
<b>IP No</b>	IP25-00020487	<b>Admission Date</b>	18-05-2026
<b>Ref Doctor</b>			
<b>Discharge Date</b>	20.05.2026		

**Consultant:**

**Dr. Himabindu Annamraju**

**MBBS, MRCOG (UK), CCT (UK)**

Consultant-Obstetrician, Gynaecologist and Laparoscopic Surgeon

Specialist in High-Risk Pregnancy

Reg. No : 51697

**Diagnosis: G3P1L1A1 AT 37+3 WEEKS GESTATION**

**1. ONE PREVIOUS LSCS**

**2. GDM ON OHA**

**3. POLYHYDRAMNIOS WITH HYPOTHYROID**

**4. OBSTETRIC CHOLESTASIS**

**5. FOR ELECTIVE LSCS.**

ELECTIVE LSCS DONE, IN VIEW OF PREVIOUS LSCS, DELIVERED A LIVE FEMALE BABY AT 09:16 AM, WEIGHT 2.694 KGS ON 18.15.2026.

**History:**

LMP: 29.08.2025

Obstetric formula: G3P1L1A1

EDD: 05.06.2026

Gestation at admission: 37+3 weeks



<b>Name</b>	Mrs MANISHA KUMARI	<b>UHID</b>	FDH-00043879
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**Obstetric History:**

G1 - 2020/ LSCS (Ind: Oligohydramnios at 35 weeks) / Female / B. Weight 2.6kgs / A&H.  
 G2 - 2024 / Missed Miscarriage at 10 weeks, MERPC f/b SERPC done.  
 G3 - Present pregnancy Spontaneous conception.

**Medical History:** H/O Hypothyroid since 1 year on Tab. Thyronorm 25mcg(12.5mcg Pre- pregnancy).  
 H/O GDM since 34 weeks on Tab. Glycomet SR 500mg OD,  
 H/O Obstetric Cholestasis since 35+4 weeks on Tab. Udiliv 300 mg TID.

**Surgical History:** Laparoscopic Cholecystectomy in 2020.  
 H/O LSCS in 2020 & SERPC in 2024.

Allergies : Nil

Family History : Father- DM

**Antenatal Details:**

Mrs MANISHA KUMARI was booked to Rainbow hospital at 30weeks of gestation. She had regular antenatal checkups and investigations as advised elsewhere. EFTS low risk, NIPT was normal, NT at 12+1 weeks showed subchorionic hemorrhage~ 21x7.7x9.8mm. USG done at 16+3weeks showed 23x23x3.6mm small retroplacental clot along the left lower edge of placenta. TIFFA at 20+1 weeks showed 2 echogenic foci 1.6mm, 0.9mm in left ventricle. Scan at 33+1 weeks showed Polyhydramnios- 28.1cm. H/O GDM since 34 weeks, on Tab. Glycomet SR 500mg AD, H/O Obstetric Cholestasis, Bile acids 87 since 35+4 weeks, on Tab. Udiliv 300 mg TID. USG done on 05.05.2026 showed SLIUF at 35+4 weeks, cephalic, placenta anterior and high, EFW 2540 grams (31%), AFI 26.8cm, AC 6% with normal fetal doppler. She was admitted at 37+3 weeks with previous LSCS for EL.LSCS.

**Investigations:** Enclosed.



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Blood group & Typing - "O" Rh positive.

**Management: Course in hospital:**

She was prepared for elective C- section with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given. Patient shifted to theatre.

**Surgery Notes:**

Under spinal anesthesia she was painted and draped as per hospital protocol. The previous scar excised. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A Lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 600 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

- \* **Head delivered by Forceps.**
- \* **Short cord noted.**
- \* **Tab. Misoprostol 800mg Kept in PV.**

**Delivery Details:**

Date : 18.05.2026.  
Time of Delivery : 9:16AM  
Type of Delivery : Elective LSCS  
Indication : Previous LSCS



Name	Mrs MANISHA KUMARI	UHID	FDH-00043879
IP No	IP25-00020487	Admission Date	18-05-2026

Analgesia : Spinal

**Baby Details:**

Date : 18.05.2026  
Time : 09:16 AM  
Sex : Female  
Weight : 2.694 KGS  
Apgar : 8/9, 9/10  
Gestational Age: 37+3 weeks  
NICU Admission: No.

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

**Advice:**

1. Tab. Taxim O 200mg twice daily till 24.05.2026 (9am-9pm) after food.
2. Tab. Calpol (Paracetamol 500mg) 2 tablets thrice daily till 24.05.2026 (8am-2pm-10pm) after food.
3. Tab. Voveran (Diclofenac-50mg) 1 tablet thrice daily till 24.05.2026 (9am-3pm-11pm) after food.
4. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 24.05.2026 (7am-7pm) before food.
5. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500mg, vitamin D3 250 IU) once daily



Name	Mrs MANISHA KUMARI	UHID	FDH-00043879
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(2pm) till breast feeding after food.

7. Tab. Thyronorm 12.5 mcg once daily before breakfast till further orders.
8. Nebasulf Powder for local application.
9. **To do Sr. TSH after 6 weeks.**
10. **To do FBS, PLBS & HBA1C after 6 weeks.**
11. **To do LFT after 1 week.**

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

Review with Dr. Vinodha Vunnam (Lactation Consultant) after one week on 27.06.2026 with prior appointment.

Review with **Dr. HIMABINDU ANNAMRAJU**, after one week on 27.06.2026 at postnatal clinic with prior appointment (**Review consultation will be charged**).

### For Women Who Have Had a Cesarean Section

#### Care of the wound:

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

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.



<b>Name</b>	Mrs MANISHA KUMARI	<b>UHID</b>	
<b>IP No</b>	IP25-00020487	<b>Admission Date</b>	18-05-2026

  
Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for further details - Chapter II page 6] kindly contact 8121039515 at Financial District just dial one toll free number - 18002122.

You can also take appointments at any time by going online to our website [www.rainbowhospitals.in](http://www.rainbowhospitals.in)

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

  
**Consultant:**

**Dr. Himabindu Annamraju**  
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Specialist in High-Risk Pregnancy  
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FDH-00043879 IP25-00020487  
 Mrs MANISHA KUMARI  
 20-02-1993 33 Y 2 M 28 D (F)  
 Dr. HIMABINDU ANNAMRAJU



## SURGERY DETAILS

Date : 18/5/2026

Patient Name: Mrs. Manisha Date of Birth: Age: 33 yrs.

Gender: female Ward: OT UHID No.:

Date of Surgery: 18/5/2026  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2

Name of the Surgery : EUS.

Time in : 9:00 AM

Time Out : 10:00 AM


	NAME	AMOUNT
1. Surgeon	Dr. Himabindu	
2. Anaesthetist	Dr. Srinivas	
3. Assistant Surgeon	Dr. Anusha	
4. OT Technician	Br. Anil	
5. Circulating Nurse	Sr. Sreeja	
6. Assistant Nurse	Sr. parvathi	

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

  
 Signature of the Surgeon

  
 Signature of Circulating Nurse

Order No: 576761/162

Order by: 

11/8

SURGE

John H. Smith

1000 North Main Street

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NAME

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*SPINAR  
ELSES*



**CONSUMABLES OF OT**

Circulating staff : ..... Technician : *Ane* Date : *18/5/20* Time : .....

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <i>LSU</i>		<i>01</i>	Inj Vit.K		<i>01</i>
LMA			Sutures			Cord Clamp		<i>01</i>
ECG leads : A/P/N		<i>5</i>	<i>2762</i>		<i>01</i>	Suction Catheter <i>8</i>		<i>01</i>
HME filter : A/P/N			<i>2347</i>		<i>02</i>	Feeding Tube		
Syringes : 10 cc		<i>1</i>				Vaccum Suction Set		<i>01</i>
05 cc		<i>3+3</i>	Gloves <i>6 1/2, 6</i>		<i>4+2</i>	Surgical Gloves		<i>02</i>
02 cc		<i>1</i>				Gauze Pack		<i>01</i>
01 cc						Syringe 1ml / 2ml		<i>01</i>
Cautery plate : A/P/N		<i>1</i>	Surgical blade <i>22</i>		<i>01</i>	Surgical Blade # 20		<i>01</i>
IV set			NG tube			Koochies (S)		<i>01</i>
RL		<i>1+2</i>	Cautery pencil		<i>01</i>	underpad		<i>01</i>
NS : 10ml / 100ml / 500ml / 1000ml		<i>1</i>	Koochies					
<i>MINT SPIKE</i>		<i>1</i>	Ointments					
<i>PILICOR</i>		<i>2</i>	Suction Catheter			<i>576758</i>		
Fentanyl			Cap, Mask			<i>Baby side</i>		
Morphine			Gauze Pack		<i>03</i>			
Ketamine			Mop Pack		<i>02</i>			
Propofol			Steristrip <i>sterizon</i>		<i>01</i>			
Rocuronium			Underpad		<i>02</i>			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel		<i>01</i>			
Ondansetron			Foleys catheter					
Pencan 25g / Spinal Needle 22		<i>1</i>	Urobag			<i>DLV Aprons</i>		<i>03</i>
Bupivacaine 0.25%			Chest Drainage Catheter			<i>Misoprost</i>		<i>0A</i>
Bupivacaine 0.25% (Heavy)		<i>2</i>	Romodrain bag					
Antibiotics			Bandage					
<i>LOX 2% IM</i>		<i>1</i>	Tegaderm			<i>New Mom pad</i>		<i>01</i>
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		<i>1</i>	Vaccum Suction set		<i>01</i>			
Justin : 12.5 mg / 25mg / 100mg		<i>1</i>	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		<i>02</i>			
<i>ATROPINE</i>		<i>1</i>	Microshield					
<i>ADROG LARE</i>		<i>1</i>	Cotton Balls					
<i>BLOXAMEE</i>		<i>2</i>	Latex Gloves		<i>20</i>			
<i>MEM</i>		<i>01</i>	Ramdione Scrub					
			Saral					

Surgeon *Dr. Himabindu* 576734/33 Anaesthesiologist *Dr. Anurag* Nurse *Paan* OT Technician *Beah*  
 Order No. : ..... Ordered by : .....  
 Doc. No. : RCH / FRM / GENERAL / 425

2021-19  
2021-20  
2021-21

Year	Month	Day	Time	Location	Notes
2021	Jan	1	10:00	...	...
2021	Jan	2	10:00	...	...
2021	Jan	3	10:00	...	...
2021	Jan	4	10:00	...	...
2021	Jan	5	10:00	...	...
2021	Jan	6	10:00	...	...
2021	Jan	7	10:00	...	...
2021	Jan	8	10:00	...	...
2021	Jan	9	10:00	...	...
2021	Jan	10	10:00	...	...
2021	Jan	11	10:00	...	...
2021	Jan	12	10:00	...	...
2021	Jan	13	10:00	...	...
2021	Jan	14	10:00	...	...
2021	Jan	15	10:00	...	...
2021	Jan	16	10:00	...	...
2021	Jan	17	10:00	...	...
2021	Jan	18	10:00	...	...
2021	Jan	19	10:00	...	...
2021	Jan	20	10:00	...	...
2021	Jan	21	10:00	...	...
2021	Jan	22	10:00	...	...
2021	Jan	23	10:00	...	...
2021	Jan	24	10:00	...	...
2021	Jan	25	10:00	...	...
2021	Jan	26	10:00	...	...
2021	Jan	27	10:00	...	...
2021	Jan	28	10:00	...	...
2021	Jan	29	10:00	...	...
2021	Jan	30	10:00	...	...
2021	Jan	31	10:00	...	...

**ADMISSION SHEET**



**Registration Details :**

Admission No : IP25-00020487      Admit Date : 18-May-2026      Admit Time : 07:07 AM      UHID : FDH-00043879

**Patient Details :**

Patient Name	: Mrs MANISHA KUMARI	Age	: 33 Y 2 M 28 D
Guardian	: Mr JASHBANT KUMAR SINGH	DOB	: 20-02-1993
Gender	: Female	Religion	:
Occupation	:	Marital Status	:
Address (H)	: F1703 Aparna zenith Serilingampally Hyderabad Hyderabad Telangana INDIA 500001	Phone No	: 9739499025/ 9739499025
		E-mail	: jashbant@gmail.com

**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 JASHBANT KUMAR SINGH      Relationship : Husband  
Contact Address :      Phone No :

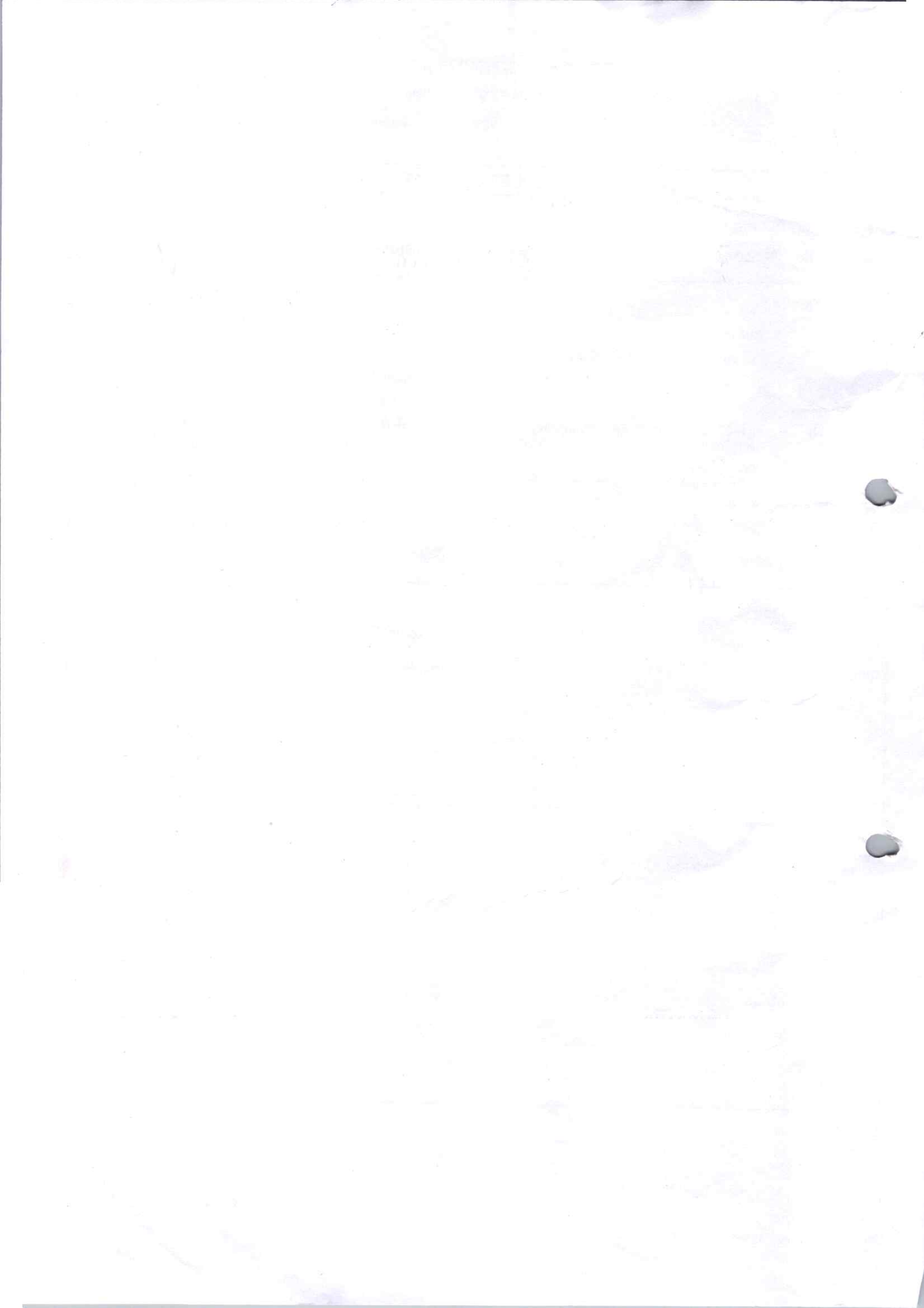
*Jashbant Kumar Singh*  
Signature

**Doctor Details :**

Doctor Name : Dr. HIMABINDU ANNAMRAJU      Specialisation : OBSTETRICS AND GYNECOLOGY  
Referral Doctor :      Phone No :  
Co-Consultant :

**Payment Details :**

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



**ACTIVITY RECORD FOR BILLING**

Name : \_\_\_\_\_ FDH-00043879 IP25-00020487  
 Mrs MANISHA KUMARI  
 20-02-1993 33 Y 2 M 28 D (F)  
 UHID No. : \_\_\_\_\_ Dr. HIMABINDU ANNAMRAJU  
 \_\_\_\_\_ 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
18/5/26	8:35am	Micu	OT	<i>[Signature]</i>
18/5/26	10:30am	OT	Micu	<i>[Signature]</i>
18/5/26	4:04pm	Micu	ward	<i>[Signature]</i>
20/5/26	1:55pm.	Ward	Billing	<i>[Signature]</i>

**Cross Consultation Visit**

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







FDH-00043879 IP25-00020487

Mrs MANISHA KUMARI  
20-02-1993 33 Y 2 M 28 D (F)  
Dr. HIMABINDU ANNAMRAJU



# NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 18/5/26 Time: 4:12pm

Origin: Durgam Height: 165 Weight: 83.5 BMI:  ~26 kg/m<sup>2</sup>  
 ~28 kg/m<sup>2</sup>  
 ~30 kg/m<sup>2</sup>

Food Allergies: \_\_\_\_\_

Diagnosis: Uterus at 37 weeks to term on OGA to polyhydramnios

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

Diet Advised:

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

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

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

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

Patient's / Attendant's Manisha Kumari

Dietician's

Signature: \_\_\_\_\_

Signature: [Signature]

Name: Manisha

Name: [Name]

Date & Time: 18/5/26 4:30pm

Date & Time: 18/5/26 4:30pm





### NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>S3 P, L, at 37 weeks @ prev LSCS</i> <i>GDM on ONR &amp; Polyhydramnios Hypothyroid &amp; etc</i>	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known						
	Surgery / Procedure: <i>EL LSCS</i>	If Yes Specify: .....						
BACKGROUND	Date	<i>18/05/26</i>	<i>18/05/26</i>	<i>18/5/26</i>	<i>19/05/26</i>	<i>19/5/26</i>	<i>20/5/26</i>	
	Shift	<i>M</i>	<i>E</i>	<i>N</i>	<i>E</i>	<i>N</i>	<i>M</i>	
ASSESSMENT	Medical Condition (Any special condition to be noted):							
	Diet:	<i>NBM</i>	<i>SAD</i>	<i>soft + D/D</i>	<i>S/D</i>	<i>DND</i>	<i>ND</i>	
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>RA</i>	<i>RA</i>	<i>RA</i>	<i>KA</i>	<i>RA</i>	<i>RA</i>	
	Tubes/Drains/Catheter:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	<i>37C</i>	<i>36.4F</i>	<i>37F</i>	<i>98.0F</i>	<i>98.0F</i>	<i>98.6F</i>
		Res:	<i>22</i>	<i>20</i>	<i>20</i>	<i>20</i>	<i>20</i>	<i>20</i>
		SpO <sub>2</sub> :	<i>98%</i>	<i>96%</i>	<i>99%</i>	<i>99%</i>	<i>99%</i>	<i>98%</i>
		Pulse:	<i>77</i>	<i>72</i>	<i>82</i>	<i>82</i>	<i>83</i>	<i>84</i>
		BP:	<i>119/78</i>	<i>119/72</i>	<i>120/80</i>	<i>116/70</i>	<i>117/70</i>	<i>132/83</i>
LOC:		<i>conscious</i>	<i>conscious</i>	<i>conscious</i>	<i>C</i>	<i>C</i>	<i>conscious</i>	
Fall Risk Score:		<i>0/10</i>	<i>0/10</i>	<i>0/10</i>	<i>0/10</i>	<i>0/10</i>	<i>0/10</i>	
Pain Score:	<i>0/10</i>	<i>0/10</i>	<i>0/10</i>	<i>0/10</i>	<i>1/10</i>	<i>0/10</i>		
Skin Integrity	<i>good</i>	<i>good</i>	<i>Good</i>	<i>Good</i>	<i>Good</i>	<i>Good</i>		
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	<i>-</i>	
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	<i>NBM</i>	<i>SD</i>	<i>soft + D/D</i>	<i>S/D</i>	<i>DND</i>	<i>ND</i>	
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	<i>Dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>dependent</i>	<i>Dependent</i>	<i>Dependent</i>		
Post Operative Procedure Special Orders:								
Handed Over By Name :		<i>Nashira</i>	<i>S. Hait</i>	<i>Neha</i>	<i>P. M.</i>	<i>Neha</i>	<i>Uli</i>	
Signature / ID :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	
Date:		<i>18/5/26</i>	<i>18/05/26</i>	<i>18/5/26</i>	<i>19/5/26</i>	<i>20/5/26</i>	<i>20/5/26</i>	
Time:		<i>@ 2pm</i>	<i>@ 8pm</i>	<i>@ 8AM</i>	<i>@ 8PM</i>	<i>@ 8AM</i>	<i>2pm</i>	
Taken Over By Name :		<i>S. Hait</i>	<i>Neha</i>	<i>P. M.</i>	<i>Neha</i>	<i>Uli</i>		
Signature / ID :		<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>	<i>[Signature]</i>		
Date:		<i>18/05/26</i>	<i>18/5/26</i>	<i>19/05/26</i>	<i>19/5/26</i>	<i>20/5/26</i>		
Time:		<i>@ 4pm</i>	<i>@ 8PM</i>	<i>@ 2PM</i>	<i>@ 8PM</i>	<i>@ 8AM</i>		

Patient Sticker



## NURSING SHIFT HAND OVER FORM

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

FDH-00043879 IP25-00020487  
 Mrs MANISHA KUMARI  
 20-02-1993 33 Y 2 M 28 D (F)  
 Dr. HIMABINDU ANNAMRAJU



## OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 18/5/2026

**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:** come for EL. LSCS. Doctor Notified on Admission:  Yes  No  
 Name of the Doctor: Dr. Himabindu  
 Time Notified: .....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
—	<u>LSCS - 2020</u> <u>Laparoscopic cholecystectomy</u> <u>SERPC - 2024</u>	—
<b>Gynecology Assessment:</b> <input checked="" type="checkbox"/> Not Applicable Menstrual History: ..... Onset of Menarche: ..... Menstrual Cycle: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular Last Menstrual Period: <u>29/8/25</u>	<b>Gynecology Surgical History:</b> Caesarean Section: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Cervical Cerclage: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Ectopic Pregnancy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Myomectomy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Others: .....	<b>Gynecological History:</b> Contraceptives: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Vaginal Discharge: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Post-Coital Bleeding: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <b>Infertility:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes Type: <input type="checkbox"/> Primary <input type="checkbox"/> Secondary

**Obstetric History:** G 3 P 1 L 1 A 1

**Previous LSCS:** Yes.

**Current Medication:**  None  Yes, If Yes, Fill the reconciliation form

**Family History:**  No Abnormalities Detected  
 Heart Disease  Hypertension  Diabetes  Stroke  Seizures  Kidney disease  
 Liver disease  Other: GDM & ONM

**Vital Signs / Measurements:** Temp: 37°C HR: 73 RR: 20  
 BP: 119/70 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 ..... (complete the Morse Fall Risk Assessment Sheet)

**Risk of Pressure Sore:**  Yes  No Score ..... 0 ..... (complete the Braden Q Sheet)

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

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

Inform consultant for positive criteria

**NUTRITIONAL SCREENING:**  No Abnormality Detected

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

Above information given to ..... Patient .....  Others

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

Orientation not given Reason: .....

Nurse Signature: *AS*

Nurse Name: *Nashia*  
*15/11/26 @ 8pm.*

# IP ADMISSION SHEET FOR OBSTETRICS

## Presenting Complaints

for ELUS

LMP: 29/8/15

EDD:

Corrected EDD: 31/6/16

GA: 37+3 wks

Menstrual History: Regular:  Yes  No

## Obstetric Examination

Fundal Height: ut term  
 Wt: 6 kg - Ash

Ut. Activity:  Relaxed  Mild  Mod  Severe

Liquor:  Adequate  Oligo  Poly

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

Head Fifths Palpable: \_\_\_\_\_

FHS:  Normal  Tachy  Brady  Absent

Per Speculum Examination  
 Draining:  Present  Absent  Bleeding  
 Colour of Liquor:  Clear  Meconium  Blood Stained

## Vaginal Examination

Cervix:  Long  Partially effaced  Effaced

Os: Closed \_\_\_\_\_ Dilated \_\_\_\_\_

Membranes:  Present  Absent

Liquor:  Clear  Meconium  Blood Stained

Presenting Part:  Vertex  Breech  Others

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

Pelvis:  Adequate  Doubtful

## Obstetric History:

I - 2020 - 6 mo p 35 wks in vls oligo - fun -

II - 2024 - ~~spont~~ mixed mole e low wk  
 MPEPC - 1 SERPC

## Present Pregnancy Record:

III - PP - conceived spontaneously

- registered e 30 wks

- Effs - low wk, NIP low wk

## RISK FACTORS:

MT e 12+1 wk - (u); TIFPA  
 SCH - 21 x 7.7 x 9.8 mm  
 20+1 - (u) → 2 Echogenic foci 1.6 mm x 0.9 mm in (L) ventricle

- Hypomyoid → Polyhydramnios e 33+1 - 28'1cm
- GDM on OA
- Ob chole
- previxis
- Polyhydramnios (26.8 cm)

Height: 165 cm

Weight: 83.5 kg

Allergies: Nil

Breast:  Normal  Abnormal

## General Examination:

Consciousness: CIC Pallor: -

Icterus: - Edema: -

Temp: - PR: 88 bpm

BP: 120/90 DTR: -

CVS: - RS: -

Liver/Spleen: - Urine Output: -

## DIAGNOSIS

G3P1L1 at 37+3 wks GA e 1 previxis e GDM on OA e Polyhydramnios  
 Hypomyoid e Ob. cholestasis e ELUS

Patient Sticker

Family History:

F-DM

Surgical History:

Laparoscopic cholecystectomy - 2020  
 LSH - 2020  
 SERPC - 2024

Medical History:

<sup>KLU</sup> Hypothyroidism : 1 year  
 GDM Aed 34 wk  
 Obstructive Cholestasis Aed 35+4

Medication History:

on T. Thyronorm 25mg (12.5mg PR)  
 T. Glycomet SR 500mg AD  
 T. UPILIV 300mg TD

Plan of Care:

- Admit
- Consent
- Pains preparation
- NST
- secure IV cannula
- Pre op Medication
- Foley's cannulation
- Inform OT, Anesthetist, Paediatrician.
- Shift to OT

Investigations:

BGT-OTK

NIU  
 USG  
 NG / MR  
 VMA

12/5 - Hb - 11.6 g/dL

Plt Count - 1,10,000

WBC - 6410

5/5/26

SLUF / 35+4 wk / cephalic

Placenta - Anterior

AFI - 26.8 cm (poly)

EFW - 2540g (3rd)

AC 6.1

fetal doppler

Doctor Name: Dr. BSUNIA  
 Date: 18/5/26  
 Time: 7 AM

Consultant Name: Dr. HIMANSHU  
 Signature: \_\_\_\_\_  
 Date & Time: 18/5/26 7 AM



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/5/26 10:30 Am.	<p><u>POD-0</u></p> <p>G.C - fair</p> <p>Afebrile</p> <p>BP - 110/80 mmHg</p> <p>PR - 86 bpm</p> <p>PIA - U/W</p> <p>PIV - NAB</p> <p>U/O - 100ml clear empties</p>	<p><u>Adv.</u></p> <ul style="list-style-type: none"> <li>- NBM x 4 hrs</li> <li>- fluids as per AXON</li> <li>- drugs as charted</li> <li>- w/ active bpm</li> <li>- (M) vitals Inform SOS</li> <li>- sugars on 20/5/26.</li> </ul> <p style="text-align: right;"><i>[Signature]</i></p>
18/5/26 2:30 pm	<p><u>POD-0</u></p> <p>G.C fair</p> <p>Afebrile</p> <p>BP - 100/70 mmHg</p> <p>PR - 88 bpm</p> <p>SPO<sub>2</sub> - 100% @ RA</p> <p>PIA - 2 U/W, soft.</p> <p>PIV - NAB pm</p> <p>U/O - 100ml clear</p>	<p><u>Adv</u> in bed ambulation</p> <ol style="list-style-type: none"> <li>1. Sip of oral fluids</li> <li>2. Drugs as charted</li> <li>3. w/ active bpm</li> <li>4. Still 2/10 claudication</li> <li>5. (M) vitals Inform SOS</li> <li>6. sugars 20/5/26</li> <li>7. For 6 AM T/M</li> <li>8. shift to room if tolerating to liquids well.</li> </ol> <p style="text-align: right;"><i>[Signature]</i></p>
<u>As advised</u>		<ol style="list-style-type: none"> <li>9. Ent 2<sup>nd</sup> hly</li> <li>10. Soft diet 6:30 pm</li> </ol> <p style="text-align: right;"><i>[Signature]</i></p>



## PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<del>18/5</del> <del>pm</del>	<u>RORE</u> ac fast ajch	<u>Adv</u> ⊖ Diabetic diet - disp as charted - plenty of oral fluid - w/ 50% PLO
<del>18/5</del> <del>pm</del>	BP - 112/80 mmHg RR - 24 bpm SpO <sub>2</sub> - 99% / 2M P/A U/W P/V NBS U/O - 90 ml, clear	- fully removed from diet - FBS, PPBS, PUS on 2 o/s - @ vital - progress
<del>17/5</del> <del>pm</del>	<u>RORE</u> ac fast ajch	<u>Adv</u> ⊖ Diabetic diet - disp as charted - plenty of oral fluid - w/ 50% PLO
<del>17/5</del> <del>pm</del>	BP - 112/80 mmHg RR - 24 bpm SpO <sub>2</sub> - 99% / 2M P/A U/W P/V NBS	- insulin 100% - FBS, PPBS, PUS on 2 o/s - @ vital - progress
18/5 19/5 20/5 21/5 22/5 23/5 24/5 25/5 26/5 27/5 28/5 29/5 30/5 31/5		



**PROGRESS NOTES AND DOCTOR'S ORDER**

Date & Time	Progress Notes	Doctor's Order
19/5/26 3 pm Saliv mts U ✓ M ✓ F ✓	<u>POD-1</u> G.C fair Afebrile SpO <sub>2</sub> = 100% @ room air PR = 86 bpm SpO <sub>2</sub> = 100% @ RA P/A = URCW P/V = N/A BPV	<u>Adv Amelutiation</u> 1. Normal diabetic diet 2. plenty of oral fluids 3. mgs as clauded 4. EBF 2nd haly 5. cwf BPV 6. fbs, pps, plss - 20/5/26 7. (u) vitals inter 6h [Signature]
19/5/26 7 pm Saliv mts U ✓ M ✓ F ✓	<u>POD-1</u> G.C fair Afebrile SpO <sub>2</sub> = 110% @ room air PR = 86 bpm SpO <sub>2</sub> = 100% @ RA P/A = URCW P/V = N/A BPV	<u>Adv</u> 1. Amelutiation 2. Normal diabetic diet 3. plenty of oral fluids 4. mgs as clauded 5. EBF 2nd haly 6. cwf BPV 7. fbs, pps, plss 20/5/26 8. (u) vitals inter 6h [Signature]





## 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: ..... M/15 ..... Shifted to: ..... 326 .....

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	25mg	PO	∞	18/5	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	T. UDILIV	300mg	PO	TID	18/5	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3	T. glycomet SR	500mg	PO	BD	18/5	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C - Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Praveena Sultana .....

Date & Time : 18/5/26 9AM .....

Nurse Name & Signature: Sr. Madhira .....

Date & Time : 18/5/26 2PM .....

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# 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 **I** through it and a similar line through subsequent recording panels.  
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.  
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.  
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time  
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

**SOS / PRN (As Required Medication)**

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

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

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

VERIFIED BY: Name .....



REGULAR PRESCRIPTIONS

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

VERIFIED

VERIFIED

VERIFIED

DRUG : <u>Lj CEFOTAXIME</u>				Date Time	<u>18/05/15</u>																	
Dose	Route	Frequency	Start Date																			
<u>18m</u>	<u>IV</u>	<u>BD</u>	<u>18/5/16</u>	<u>8Am</u>	<u>X</u>	<u>stop</u>																
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:				<u>8Pm</u> <u>Pain</u> <u>50mg</u> <u>stop</u> <u>Dr. K. Ramesh</u>																		
Daily Doctor's Endorsement by a Sign																						

DRUG : <u>Lj PANTOPRAZOLE</u>				Date Time	<u>19/05</u>																	
Dose	Route	Frequency	Start Date																			
<u>40M</u>	<u>IV</u>	<u>OD</u>	<u>18/5/16</u>	<u>6Am</u>	<u>stop</u>																	
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						

DRUG : <u>Lj TRANEXAMIC ACID</u>				Date Time	<u>18/05/15</u>																	
Dose	Route	Frequency	Start Date																			
<u>18m</u>	<u>IV</u>	<u>TID</u>	<u>18/5/16</u>	<u>1Am</u>	<u>X</u>	<u>stop</u>																
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:				<u>9Am</u> <u>stop</u> <u>5Pm</u> <u>Pain</u> <u>stop</u> <u>Dr. Ramesh</u>																		
Daily Doctor's Endorsement by a Sign																						

DRUG : <u>T. THYRONORM</u>				Date Time	<u>19/05/15</u>																	
Dose	Route	Frequency	Start Date																			
<u>12.5M</u>	<u>PO</u>	<u>OD</u>	<u>19/5/16</u>	<u>5Am</u>	<u>stop</u>																	
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						

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

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

**STAT / ONCE ONLY DRUGS**

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
18/5	8 am	IV CEFOTAXIME	1gram	IV	Q	AB
18/5	8 am	IV PANTOPRAZOLE	40mg	IV	Q	AB
18/5	8 am	IV METAMIZOLONE	10mg	IV	Q	AB
18/5	9.16 am	INJ CARBETO LIN	100mg	IV	Q	Sreja
18/5	9.55 am	SUPP TRAMADOL	100mg	PR	Q	Sreja
18/5	9.55 am	SUPP DICLOFENAC	100mg	PR	Q	Sreja.
18/5	12.44 pm	IV PARACETAMOL	1gm	IV	Sreja	AB

Signature

VERIFIED BY: Name

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
18/6/26	8 am	RL	IV	100ml/hr	<i>[Signature]</i>	<i>[Signature]</i> <i>[Signature]</i>	18/6/26	<i>[Signature]</i>	<i>[Signature]</i> <i>[Signature]</i>
18/6/26	10 am	RL	IV	100ml/hr	<i>[Signature]</i>	<del><i>[Signature]</i></del> <del><i>[Signature]</i></del>	18/6/26	<i>[Signature]</i>	<i>[Signature]</i> <i>[Signature]</i>
18/6/26	9.30 Am	RINGER LACTATE	IV	150 ml/hr	<i>[Signature]</i>	<i>[Signature]</i> <i>[Signature]</i>	<del>18/6/26</del> 18/6/26	<i>[Signature]</i>	<i>[Signature]</i> <i>[Signature]</i>
18/6/26	12 PM	10 RINGER LACTATE	IV	100ml/hr	<i>[Signature]</i>	<i>[Signature]</i> <i>[Signature]</i>	18/6/26		<i>[Signature]</i> <i>[Signature]</i>
18/6/26	7:40 PM	RL	IV	100ml/hr		<i>[Signature]</i> <i>[Signature]</i>	17/5/26		<i>[Signature]</i> <i>[Signature]</i>

Signature

VERIFIED BY: Name



Sheet No: ..... **REGULAR PRESCRIPTIONS** Dept.....Ward.....

<b>DRUG :</b> TABS CEFIXIME				Date Time	20/5															
Dose	Route	Frequency	Start Dt.																	
200mg	PO	BD	20/5	8AM 8:00 AM 8:30 AM																
Name & Signature of the Doctor Starting the Drugs:				[Signature]																
Additional Instructions:																				
<b>Daily Doctor's Endorsement by a Sign</b>																				

<b>DRUG :</b> PARACETANOL				Date Time	18/05	19/5	20/5													
Dose	Route	Frequency	Start Dt.																	
1gm	ORAL	TID	18/5	6AM X 5PM Nela 10PM Nela 3PM Nela																
Name & Signature of the Doctor Starting the Drugs:				[Signature]																
Additional Instructions:				10PM Nela 3PM Nela 10PM Nela																
<b>Daily Doctor's Endorsement by a Sign</b>				[Signature]																

<b>DRUG :</b> DICLOFENAC				Date Time	18/5	19/5	20/5													
Dose	Route	Frequency	Start Dt.																	
50mg	ORAL	TID	18/5	7AM X 5PM Nela 3PM Nela 11PM Nela																
Name & Signature of the Doctor Starting the Drugs:				[Signature]																
Additional Instructions:				11PM Nela 3PM Nela 10PM Nela																
<b>Daily Doctor's Endorsement by a Sign</b>				[Signature]																

<b>DRUG :</b> TABS. PARACETAZOL				Date Time	20/5															
Dose	Route	Frequency	Start Dt.																	
100mg	PO	BD	19/5/20	6AM 8:00 AM 8:30 AM																
Name & Signature of the Doctor Starting the Drugs:				[Signature]																
Additional Instructions:																				
<b>Daily Doctor's Endorsement by a Sign</b>				[Signature]																

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

VERIFIED

[Handwritten signature]

Patient Sticker

Sheet No: .....

**REGULAR PRESCRIPTIONS**

Dept.....Ward.....

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

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



**Obstetrics and Gynaecology  
Early Warning Signs**

**Complete a Full  
Set of MEOWS  
Observations**

**1 Yellow Alert :  
Repeat Observations  
in 30 minutes**

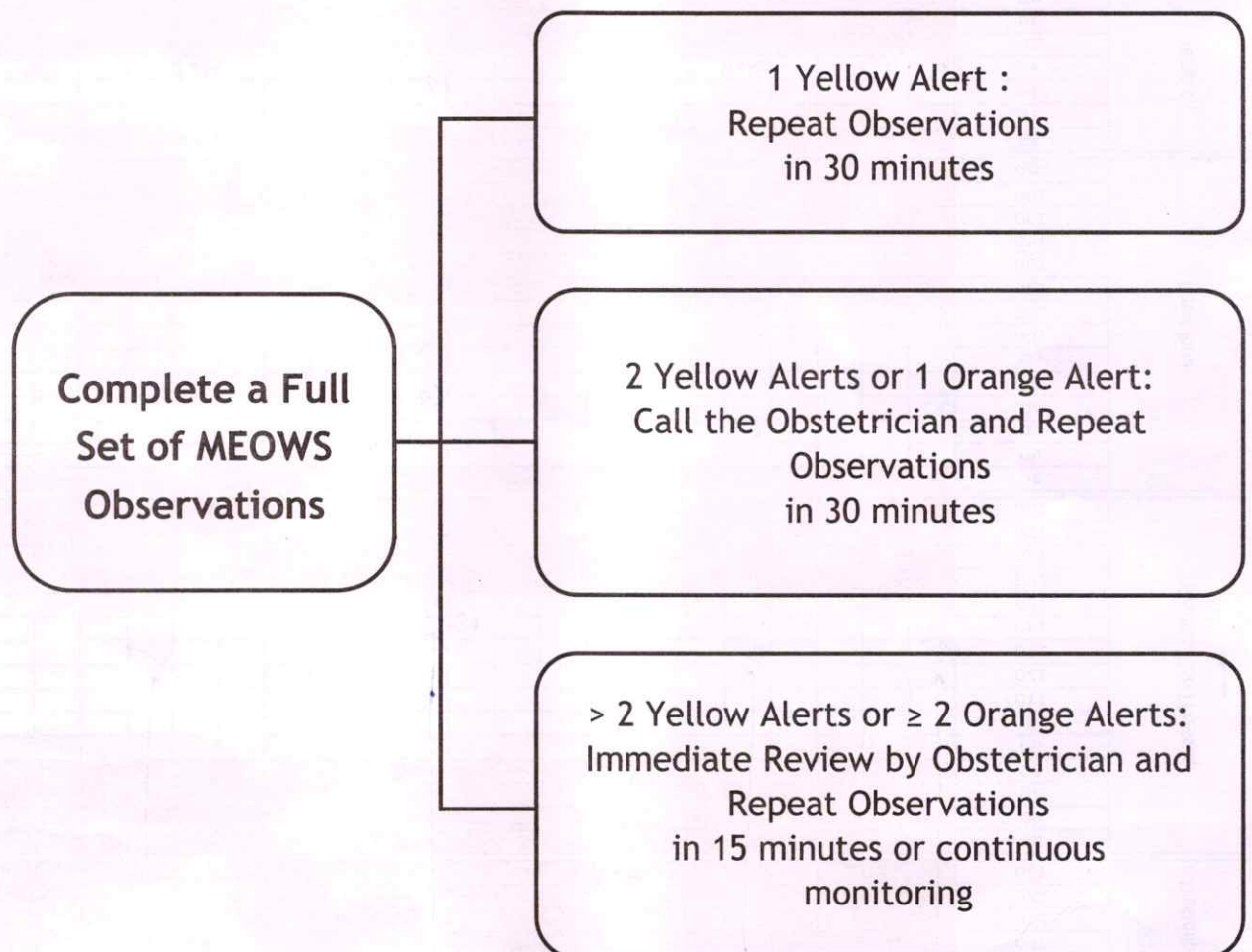
**2 Yellow Alerts or 1 Orange Alert:  
Call the Obstetrician and Repeat  
Observations  
in 30 minutes**

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

\* The Modified Early Warning Score (MEOWS)



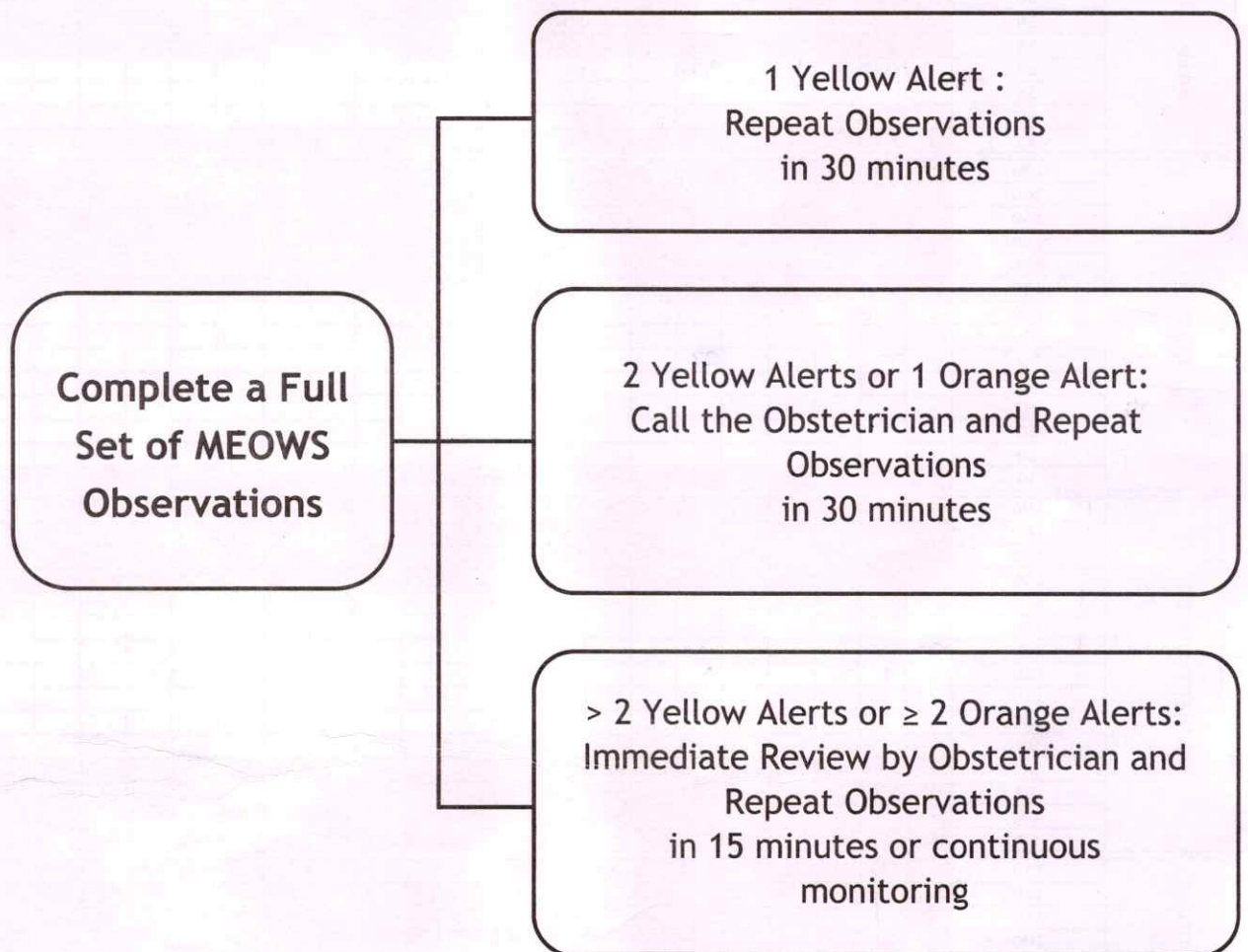
## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)

# FLUID CHART

Sheet No. : 1

18/05/20

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G						0	}	
	08:00 am	NBM	100ml							100ml	0		
	09:00 am	NBM	100ml							100ml emptied	0		
	10:00 am	NBM	100ml			NO	NO	NO	NO	NO	0		
	11:00 am	NBM	100ml							100ml	0		
	12:00 pm	NBM	100ml							100ml	0		
	01:00 pm	NBM	100ml								0		
<b>Total Intake :</b>			→ 800 ml/hr			<b>Total Output :</b> U-200ml							
	02:00 pm	H <sub>2</sub> O	20ml							100ml	0	}	
	03:00 pm	RL	100ml/hr								0		
	04:00 pm	RL	100ml							200ml	0		
	05:00 pm	RL	100ml			NO	NO	NO	NO	NO	0		
	06:00 pm	RL	100ml								0		
	07:00 pm	RL	200ml								0		
<b>Total Intake :</b>			820ml			<b>Total Output :</b> U-90ml						M=0	
	08:00 pm	RL	100ml/hr			NO	NO	NO	NO	NO	0	}	
	09:00 pm	RL	200ml/hr								0		
	10:00 pm	RL	100ml/hr								0		
	11:00 pm	RL	200ml/hr								0		
	12:00 am	RL	100ml/hr							500ml	0		
	01:00 am	RL	100ml/hr			NO	NO	NO	NO	NO	0		
<b>Total Intake :</b>			1000ml			<b>Total Output :</b> U=500ml M=0							
	02:00 am					NO	NO	NO	NO	NO	0	}	
	03:00 am	H <sub>2</sub> O	200ml							500ml	0		
	04:00 am										0		
	05:00 am	H <sub>2</sub> O	100ml								0		
	06:00 am										0		
	07:00 am	H <sub>2</sub> O	200ml			NO	NO	NO	NO		0		
<b>Total Intake :</b>			400ml			<b>Total Output :</b> U=1 M=0							

**Total 24 hrs. Intake** 3020ml

**Total 24 hrs. Output** U=1200ml M=1



19/5/26



# FLUID CHART

Sheet No. : .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am	H <sub>2</sub> O	200ml				<del>NO</del>				0	
	09:00 am	H <sub>2</sub> O	100ml							✓	0	
	10:00 am									✓	0	Shirish
	11:00 am				NO		NO	NO	NO	✓	0	
	12:00 pm	H <sub>2</sub> O	200ml							✓	0	
	01:00 pm										0	
<b>Total Intake :</b>			500ml.			<b>Total Output :</b>					U3 - 3 M-	
	02:00 pm										0	
	03:00 pm	H <sub>2</sub> O	200ml								0	P2
	04:00 pm									✓	0	
	05:00 pm										0	
	06:00 pm	H <sub>2</sub> O	200ml								0	
	07:00 pm									✓	0	
<b>Total Intake :</b>			400ml			<b>Total Output :</b>					U-2, M-0	
	08:00 pm										0	}
	09:00 pm	H <sub>2</sub> O	200ml							✓	0	
	10:00 pm										0	
	11:00 pm	H <sub>2</sub> O	100ml							✓	0	
	12:00 am										0	
	01:00 am	H <sub>2</sub> O	200ml							✓	0	
<b>Total Intake :</b>			500ml			<b>Total Output :</b>					U-3, M-1	
	02:00 am										0	}
	03:00 am	H <sub>2</sub> O	100ml								0	
	04:00 am									✓	0	
	05:00 am	H <sub>2</sub> O	200ml								0	
	06:00 am									✓	0	
	07:00 am	H <sub>2</sub> O	100ml								0	
<b>Total Intake :</b>			400ml			<b>Total Output :</b>					U-2, M-0	
<b>Total 24 hrs. Intake</b>		1800ml										
<b>Total 24 hrs. Output</b>		U-10, M-1										



**FLUID CHART**

20/5/26

Sheet No. : .....

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
											0	
	08:00 am										0	
	09:00 am	200ml	200ml	↓	↓						0	
	10:00 am			↓	No	No	1. Pamp	No	No		0	
	11:00 am			No							0	
	12:00 pm	200ml	200ml								0	
	01:00 pm										0	
<b>Total Intake :</b>			400ml			<b>Total Output :</b>					Urine-3	M-Ipand.
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
<b>Total Intake :</b>						<b>Total Output :</b>						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

Patient Sticker



# FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombophlebitis 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											
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
<b>Total Intake :</b>						<b>Total Output :</b>						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
<b>Total Intake :</b>						<b>Total Output :</b>						
<b>Total 24 hrs. Intake</b>												
<b>Total 24 hrs. Output</b>												

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



Name: Manisha Kumari Age: 33yr Sex: 33yr UHID.No: FDH-43879  
 Date: 3/5/21 Time: 4:25pm Proposed Operation: Cesarean section  
 Diagnosis: G3 P.L.A. @ 36<sup>+</sup>5 POG. @ prev. LSCS  
 B.P / CRT: 136/81 H.R: ..... Weight: 84kg ASA Physical Status:  1  2  3  4  5

Laboratory Data:				
Hgb: <u>11.6</u>	Glucose: <u>91</u>	Protein: <u>5.9</u>	HIV: .....	X-Ray: .....
PCV: .....	Urea: .....	Alb: <u>3.1</u>	HBS Ag: <u>NR</u>	ECG: .....
WBC: .....	Creat: .....	Total Bill: <u>0.2</u>	HCV: <u>NR</u>	2D Echo: .....
Plate: <u>1,10,000</u>	Na: .....	Dir. Bill: <u>0.15</u>	Blood group: <u>O<sup>+</sup></u>	Stress/Angio: .....
PT: .....	K: .....	LDH: .....	T3 .....	Other: .....
PTT: .....	Ca++: .....	Alk phos: <u>371</u>	T4 .....	
INR: .....	Mg++: .....	Amylase: .....	TSH: <u>3.370</u>	
	Cl-: .....	SGOT/SGPT: <u>110/218</u>		
	<u>HbA1c - 4.8</u>			
Allergies: <u>nil</u>				

**Medical History:** CVS: .....  
 RESP: K/O Gest. Hypothyroid Diabetes 2 months  
 CNS: K/O Gest DM 2 weeks on Rx  
 Renal: .....  
 Hepatic / GE: ..... Physical Activity: Active  
 Others: .....

**Past Anaesthetic History:** Laparoscopic cholecystectomy, U/E.  
**Physical Exam:** D9 @ 2yrs back @ prolonged sore throat  
prev. LSCS @ SAB, U/E.  
 Airway: MP 1 2 3 4 Mouth Opening: >3F Mentohyoid Distance: (N) Neck: (N) Teeth: intact  
 Lungs: .....  
 Heart: WNL  
 CNS: .....

Pregnant:  Yes  No  NA Venous Access Site: ..... Spine Exam for regional: (N)  
**Anaesthetic Plan:**  MAC  REGIONAL  GA-ETT  LMA

Peri-Operative Plan Explained to the Patient:  Yes  No

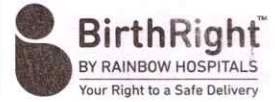
CURRENT MEDICATIONS	DOSAGE
<u>Thyronorm</u>	<u>25mcg</u>
<u>Glycomet</u>	<u>500mg</u>

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

Signature: Ashy Name: Dr. AISHWARYA  
 Docu. No. : RCH / FRM / CLINICAL / 044

Patient Sticker

# ANAESTHESIA CHART



## Pre Induction Assessment:

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

Physical Status:  Patient Identified       Consent Present       Chart Reviewed

H.R: 92/min      B.P / CRT: 120/80      SpO<sub>2</sub>: 99 tra      R.R: 16/min      Last Feed: 12/10/18  
 Pre-OP Diagnosis: 93 PCLIA 38 wks      Operation: Excision      Date: 18/1/26

Surgeon: Dr. Hinebinder      Anaesthesiologist: Dr. Srinivas      Technician: Dr. J

TIME	9:00 am	9:30	10:00 am																		
N <sub>2</sub> O /AIR /O <sub>2</sub> LPM																					
HALO /SO /SEVO																					
Drugs:																					
Antibiotic																					
Suppository																					
Blood Loss																					
NOTES																					
FI <sub>O<sub>2</sub></sub> / Sa <sub>O<sub>2</sub></sub>	<u>97</u>	<u>99</u>	<u>100</u>	<u>100</u>																	
ETCO <sub>2</sub>																					
EKG	<u>3 leads</u>	<u>SE</u>	<u>SE</u>	<u>SE</u>																	
Temperature																					
Urine Output																					
Fluids Blood	<u>ll</u>	<u>ll</u>																			
B.P																					
V Systolic																					
A Diastolic																					
X Mean																					
Heart Rate																					
Tourniquet on Time																					
Tourniquet off Time																					
Throat Pack In																					
Throat Pack Out																					

LAB Values

ABG

GRBS

Others

Equipment Checked and Functional

BP UL

Cuff Site: .....

Art Site: .....

EKG Lead

Temp Site

FIO<sub>2</sub> Monitor

Agent Monitor

Pulse Oximeter

Capnograph

Ventilator

Nerve Stimulator

Position: supine

Pressure Points Checked

Eye Care:

Oint

Tape

Padding

Awake

Temp:

HME       Fluid Warmer

Cling Film       OH Warmer

Hugger's       Cotton Wool

Other

Times:

Anaes Start: 9:00 AM

OP Start: .....

OP End: 10:00 AM

Leave OR: .....

Anaesthesia:

GA

Monitored Anaesthesia Care

Regional

Line (Size & Location)

CVP: .....

ART: .....

IV: .....

IV: UL

IV: .....

Induction

IV       Inhal

Pre O<sub>2</sub>       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: Attending

Site: l3/4

Needle Size: 27G      Depth: .....

Parasthesia  Yes  No

Catheter at skin ..... cm

Drug Name & Conc: 3ml of 0.5% Bupivacaine

Bolus: .....

Infusion: .....

Block Level: to T10

Comments: to Dr. Srinivas

Transportation to

PACU       ICU       Other

Relaxant Reversed  Yes  No       NA

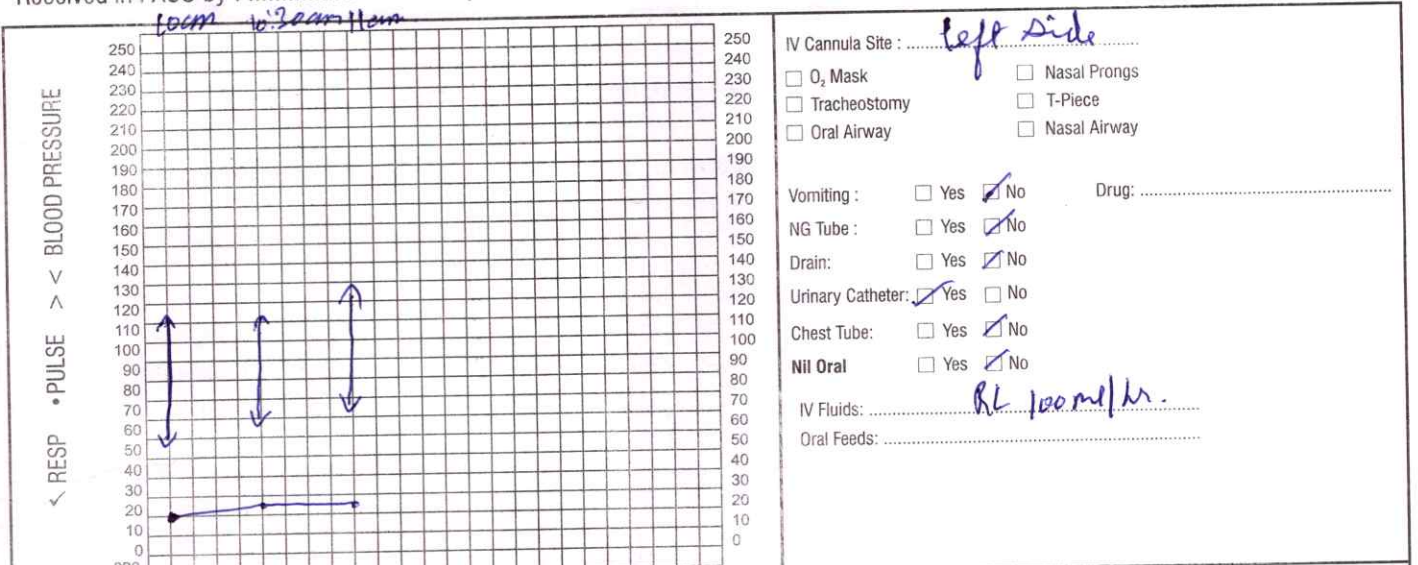
Name of the Doctor: .....

Signature of the Doctor: [Signature]

Patient Sticker

### POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. Nadhira Time Received : 10 am. Time Discharged : .....



IV Cannula Site : left side

O<sub>2</sub> 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 : RL 100ml/hr.

Oral Feeds : .....

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

### PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
			<u>As per Axon.</u>	

Pain Tool Used:  N PASS  FLACC  Wong Baker  NPS

Anaesthesiologist Name : Dr. Prinevas

Anaesthesiologist Signature: .....

Date & Time: 18/5/26 @ 10am

PACU Nurse Name : Dr. Nadhira

PACU Nurse Signature: [Signature]

Date & Time: 18/5/26 @ 10am

Reassessment Frequency:

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

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

Date & Time: .....



FDH-00043879 IP25-00020487  
 Mrs MANISHA KUMARI  
 20-02-1993 33 Y 2 M 28 D (F)  
 Dr. HIMABINDU ANNAMRAJU



## CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <u>Dr. Himabindu</u>	Date of Delivery: <u>18/5/2026</u>
Assistant Surgeon: <u>Dr. Anusha</u>	Time of Delivery: <u>9:16 AM</u>
Anaesthetist's Name: <u>Dr. Srinivas</u>	Gender of Baby: <u>Female</u>
Type of Anaesthesia: <u>↓ SA</u>	Weight of Baby: <u>2.694 kgs.</u>
Neonatologist: <u>Dr. Pradeep</u>	AGPAR Score: <u>7/10, 9/10</u>
Scrub Nurse: <u>Sr. Parvathi</u>	NICU Admission: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Pre-Operative Diagnosis:

Elective       Emergency      Indication: previous LSCS

Urgency

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

Decision time: .....      Knief to rectus: .....

CTG Description: Reassuring

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

Surgical Procedure: Elective lower segment cesarean section

Post Operative Diagnosis: POD-0 US

Peri-Operative Complications: - Head delivered by forceps.  
- Short cord noted.  
- T. Misoprostol 800ug kept PR.

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

Name and Number of Surgical Specimen sent for examination:

**Examination Findings when Appropriate:**

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

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

Uterine Closure:  One Layer  Two Layers ..... NOT single Suture  
 Peritoneal Closure:  Pelvic  Abdominal  None ..... Suture  
 Sheath Closure: ..... No 1 layer Suture  
 Fat Closure:  Yes  No ..... 2- orapad vicryl Suture  
 Skin Closure:  Subcuticular  Mattress ..... Suture  
 Vaginal Evacuated  Yes  No  
 Drain:  Yes  No  Remove in ..... days  Await instructions  
 Catheter  Yes  No  Remove in ..... days  Await instructions  
 Swap & Instruments count correct?  Yes  No  Post-op Antibiotics  Yes  No  
 Intra-Operative Antibiotics Cover:  Yes  No  Thromboprophylaxis  Yes  No



Post-Operative Notes: .....  
 1) NBM x 4hrs  
 2) fluids as per AXON  
 3) Drugs as charted  
 4) w/ active bp  
 5) (m) vital signs - Inflow 80%

Doctor Name: Dr. Himabindu  
 Date & Time: 18/5/26, 11:30am

Doctor Signature: [Signature]

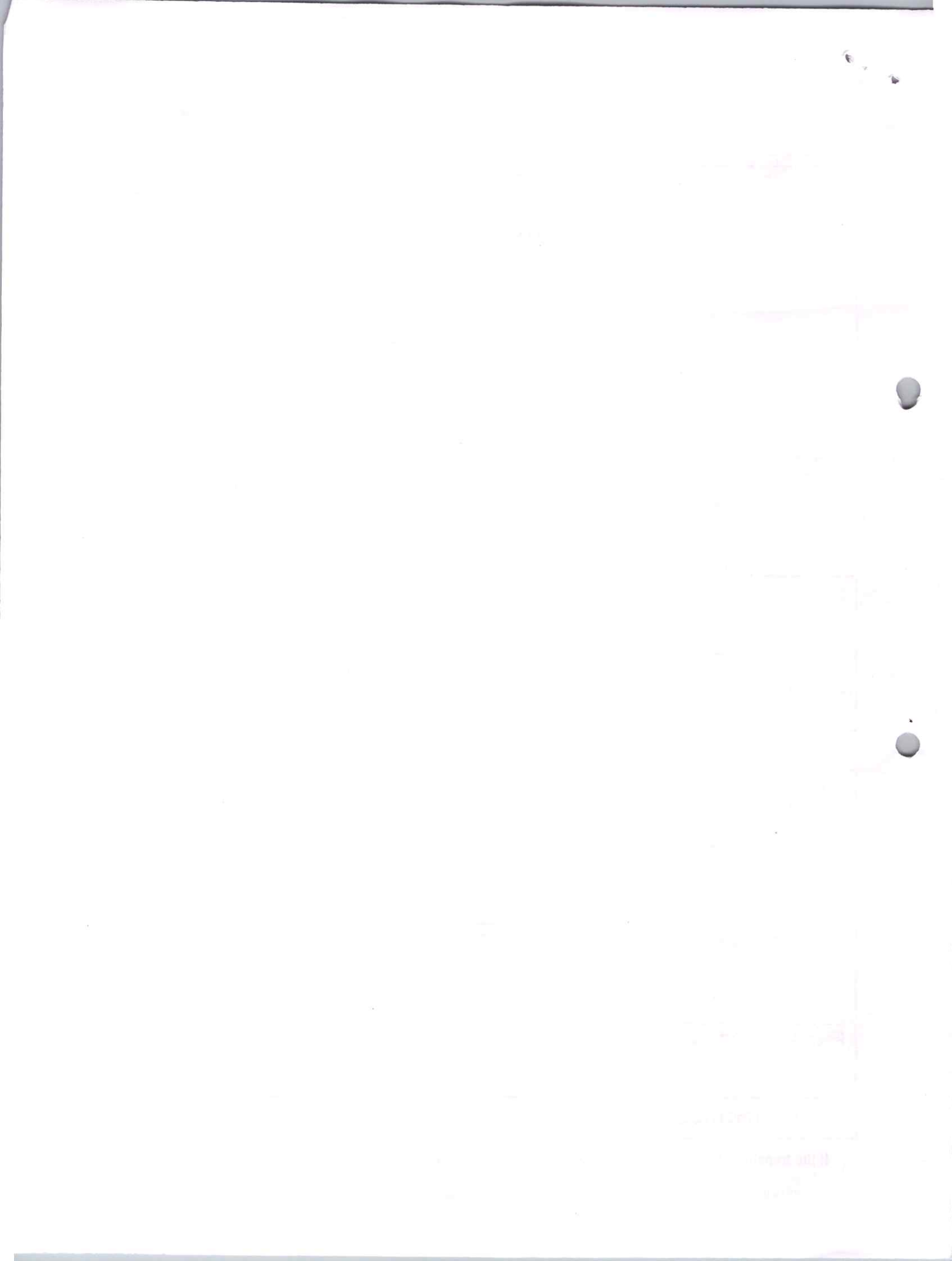
# PATIENT TRANSFER FORM



Patient Name & UHID No.  FDH-00043879      IP25-00020487 Mrs MANISHA KUMARI 20-02-1993      33 Y 2 M 28 D      (F) Dr. HIMABINDU ANNAMRAJU 	Date & Time of Admission	Date & Time of Transfer Order
	Transfer Ordered by	Reason for Transfer
From Unit	To Unit	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?
Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity
1.		
2.		
3.		
4.		
5.		
Shifting Summary / Notes Written by Doctor :    Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name & Signature of Person who is Transferring	Name of Person Ordered Transfer	
Patient & Clinical Records Received by :		
Date & Time of Patient Received :		

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

- Unavailable Bed                     
  Nurse not Available                     
  Available Bed not ready



# PATIENT TRANSFER FORM

Patient Name & UHID No. <i>Ms. Manelsha</i>	Date & Time of Admission <i>18/5/26 @ 7:07 am</i>	Date & Time of Transfer Order <i>18/5/26 @ 8:35 am</i>
Treating Consultant Name <i>Dr. Himabindu</i>	Transfer Ordered by <i>Dr. Suresh</i>	Reason for Transfer <i>GL-LSCS</i>
From Unit <i>M LU</i>	To Unit <i>07</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>25</i>	Number of Imaging Films <i>-</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	<i>Orj pantop</i>	<i>1</i>
2.	<i>Orj perinorm</i>	<i>1</i>
3.	<i>Orj tuxim</i>	<i>1</i>
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes  No

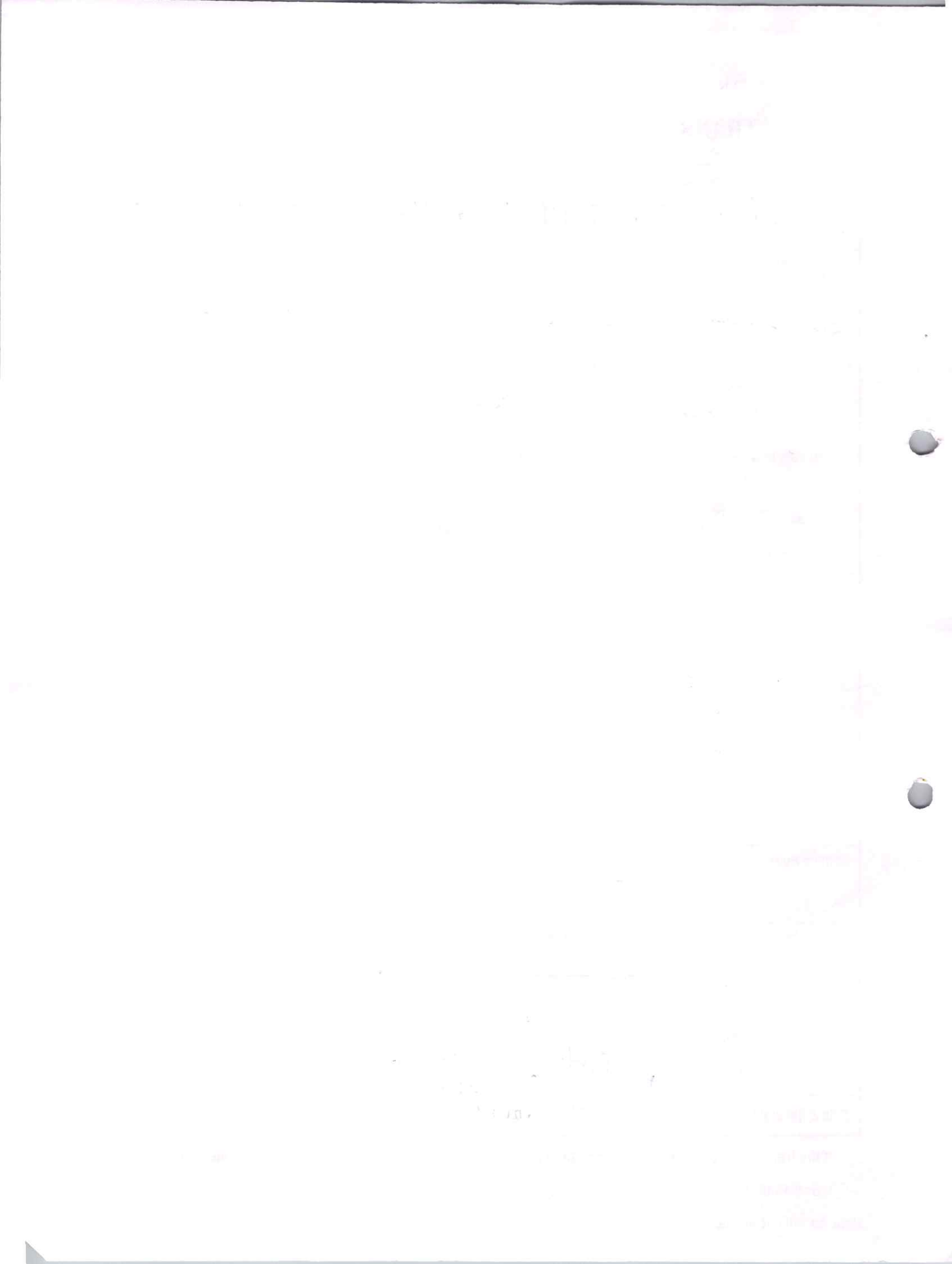
Name & Signature of Person who is Transferring <i>S. Madhira</i>	Name of Person Ordered Transfer <i>Dr. Suresh</i>
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Patient & Clinical Records Received by :  
*Br. Buddha 8:35 am*

Date & Time of Patient Received :  
*18/5/26*

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

- Unavailable Bed       Nurse not Available       Available Bed not ready



# PATIENT TRANSFER FORM



Patient Name & UHID No. <i>MRS. MANESHA</i>	Date & Time of Admission <i>18/5/26</i> <i>7:7 AM</i>	Date & Time of Transfer Order <i>18/5/26</i> <i>@ 10:30 AM</i>
Treating Consultant Name <i>DR. HIMABINDU</i>	Transfer Ordered by <i>DR. SRINIVAS</i>	Reason for Transfer <i>POST OP CASE</i>
From Unit <i>OT</i>	To Unit <i>NICU</i>	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>
Number of Sheets in Clinical File <i>25</i>	Number of Imaging Films <i>2 OP FILE</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

Shifting Summary / Notes Written by Doctor : Yes  No

Name & Signature of Person who is Transferring <i>Greega</i>	Name of Person Ordered Transfer <i>DR. SRINIVAS</i>
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Patient & Clinical Records Received by : *Dr. Nadhira*


Date & Time of Patient Received : *18/5/26 @ 10:30 am.*

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

- Unavailable Bed                     
  Nurse not Available                     
  Available Bed not ready



# PATIENT TRANSFER FORM

Patient Name & UHID No.  FDH-00043879      IP25-00020487 Mrs MANISHA KUMARI 20-02-1993      33 Y 2 M 28 D      (F) Dr. HIMABINDU ANNAMRAJU 		Date & Time of Admission <i>18/5/26 @ 9.7 am.</i>	Date & Time of Transfer Order <i>18/5/26 @ 4.7 PM</i>
		Transfer Ordered by	Reason for Transfer <i>OBS</i>
From Unit <i>Micu</i>	To Unit <i>ward</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File <i>25</i>	Number of Imaging Films <i>—</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	/	/	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor :      Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring <i>Dr. Nadhira</i>		Name of Person Ordered Transfer <i>Dr. Anuska</i>	
Patient & Clinical Records Received by :  <i>S. Haid</i> <i>18/05/26</i> <i>at 4:4 PM</i>			
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

1974

1974


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## NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

Patient Name: MR'S. MANISHA KUMARI		Age: 32Y	Gender: FEMALE
UHID No: EDH-00418779		IP No: UTD 20487	Date: 18/05/2020 Time: 07:11AM
Diagnosis: G-ALIA 2 36 <sup>+</sup> PUG. PREV L.C.C.S.			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	100MGs.	
2.	Morphine Sulphate Inj. 15mg/ML	-	
3.	Remifentanil Hydrochloride Inj. 2MG	-	
	Remifentanil Hydrochloride inj. 1MG	-	
Doctor Name: Dr. S. HOLLAN		Doctor Registration No: 36844	
Signature: 			

## NARCOTIC DISPENSING FORM

### APPENDIX 4 – FORM NO. 3E

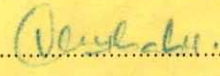
#### (Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: ..... UTD 20487 ..... Date: 18/05/2020 .....

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

1.	Name : MR'S. MANISHA KUMARI	Remarks		
2.	Complete postal address (with contact number, if any)	E-1703 APARNA SANGHVI CHILDRN HOSPITAL JOLLY, HYDRABAD, TELANGANA.		
3.	Brief description of the illness	L.C.C.S.		
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
18/05/2020	FENTANYL	ONE	Manisha Kumari	

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

Received by (Name & ID No.): ..... (Manisha Kumari) (1010474) ..... Signature: 

Time: .....

NARCOTIC PRESCRIPTION FORM  
(MEDICAL RECORD)

Patient Name: XXXXXXXXXXXXXXXXXXXX  
 Date: XXX/XX/XX  
 Age: XX  
 Sex: Male  
 Diagnosis: XXXXXXXXXXXXXXXXXXXX  
 PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1	Fentanyl Citrate 100mcg/ml	100mcg	
2	Morphine Sulphate 10mg/ml		
3	Ramifenil Hydrochloride 1mg		
4	Ramifenil Hydrochloride 1mg		

Doctor Name: XXXXXXXXXXXXXXXXXXXX  
 Doctor Registration No: XXXXXXXXXXXXXXXXXXXX

NARCOTIC DISPENSING FORM  
APPENDIX 4 - FORM NO. 3E

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

IP Registration No: XXXXXXXXXXXXXXXXXXXX  
 Date: XXX/XX/XX  
 Hospital No. of the Patient (Optional): XXXXXXXXXXXXXXXXXXXX

Date	Name of the Essential Narcotic Drugs	Quantity	Signature (Thumb Impression of the patient) Patient Attender	Remarks, if any
XXX/XX/XX	XXXXXXXXXXXXXXXXXXXX	XXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX

1. Name: XXXXXXXXXXXXXXXXXXXX  
 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 institution)  
 5. Details of essential Narcotic drug dispensed

Dispensed by (Name & ID No.): XXXXXXXXXXXXXXXXXXXX  
 Received by (Name & ID No.): XXXXXXXXXXXXXXXXXXXX  
 Signature: XXXXXXXXXXXXXXXXXXXX  
 Signature: XXXXXXXXXXXXXXXXXXXX  
 Date: XXX/XX/XX  
 Time: XXX:XX  
 Form No. 3E (FORM) CLINICAL 1/77

(H)

**ANTENATAL RECORD**



Antenatal No. 7737/60/26

Reg. No: FDH - 00043879

Consultant: Dr. HB

**PERSONAL DETAILS**

Name: Mrs. Maricho Kumeri Age: 33 Date of Birth: \_\_\_\_\_ Education: \_\_\_\_\_

Occupation: \_\_\_\_\_ Phone No.: \_\_\_\_\_ Mobile: \_\_\_\_\_

Husband's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Mobile: 9739499025 E-mail Id: \_\_\_\_\_

IMPORTANT FEATURES	SUGGESTED MANAGEMENT
<p><u>P-1-C1</u></p> <p><u>COM on OHA</u></p> <p><u>D.O.C (BA: 71.3)</u></p>	<p>Corrected EDD</p> <p><u>5/6/26</u></p> <p><u>G3P1L1A1</u></p>

**HISTORY**

Year of Marriage: \_\_\_\_\_ Menstrual History: Previous Periods \_\_\_\_\_

Consanguinity: -Ncu Contraception: -spont

LMP: 29/8/25 EDD: \_\_\_\_\_ Corrected EDD: 5/6/26

OBSTETRIC FORMULA

Gravida 3 Para 1 Live 1 Abortions 1

**OBSTETRIC HISTORY**

Sl No.	DATE OF DELIVERY	GA WEEKS	ANTENATAL DETAILS	MODE OF DELIVERY	BABY	WT	REMARKS
<u>P1</u>	<u>2020</u>	<u>35wks</u>	<u>CS for ovulo.</u>	<u>C-section</u>	<u>girl</u>	<u>2.6</u>	
<u>P2</u>	<u>2021</u>	<u>10wks</u>	<u>fh. PVB MERPC-SERPC</u>				
<u>P3</u>	<u>2025</u>	<u>---</u>	<u>PP sent conception booked by (30<sup>th</sup> wks)</u> <u>[CITIZENS specialty hospital]</u> <u>Dr. Jyothi.K.</u>				

Medical History: -Thy. 12.5 -> 25mcg Family History: \_\_\_\_\_

Surgical History: Lap chd: 2023 Allergies: \_\_\_\_\_

CSX 1, DEC-1

### INVESTIGATIONS

**MATERNAL EVALUATION**

Blood group & Rh : Wife OTVC Husband \_\_\_\_\_ ICT \_\_\_\_\_  
 VDRL -ND HIV -ND HbSAG -ND TSH \_\_\_\_\_

28/3/26  
 GCT ← 93  
 152  
 101

**ROUTINE INVESTIGATIONS** HCV-ND

**SPECIFIC INVESTIGATIONS**

Date	GA Weeks	Investigations	Report	Date	GA Weeks	Investigations	Report
<u>9/10/25</u>		<del>HB-13.1</del>	cr-0.56	<u>2/5/26</u>		PLT-110000	
VitB12-	60.2	HPLC-	TSH-4.70	HBALC-	4.90	Bile Acid-18.10	
VitD-	35.6	Thalassemia	C/S-ND	C/S-ND		TSH 3.378	
LFT		hemo	<u>20/1/25</u>	<u>28/3/26</u>		LFT	
ALT/SOPT	39	HB-13.1	<u>19/2/25</u>	HB-10.9		T.BIL Rubin- 0.22	
AST/SOPT	24	RBC-6.9	HB-11.1	WBC-9,000		ALT-218	
ALP-	103.0	TLC-7.1	TLC-9.7	TSH-2.700		AST-110	
		PLT-2.35	PLT-1.50			ALP-371	
		CUE-Ⓢ				HBALC-4.8	
				<u>12/5/26</u>			
				HB-11.6			
				WBC-6110			

Tetanus Toxoid : 1<sup>st</sup> dose  TT 2<sup>nd</sup> dose

**FETAL EVALUATION**

**ULTRASONOGRAPHY**

<u>22/1/25</u> First Trimester	SLT $\approx$ 12 wks / HR-142bpm / CRL-54.4 mm / NT-1.33 CXL-3.90cm									
<u>17/1/26</u> TIFFA	SLT $\approx$ 20 wks / EFW-306.31% / AC-25% / CXL-30cm placenta-fundo anterior.									
Growth scan	Date	GA Weeks	Indication	PP	Wt.	Centile	Growth Velocity	AFI	Placenta	Remarks
	<u>18/4/24</u>	33+1	Gs	C	2400	43%	AC-11%	8.5	A, H	O-Ⓢ
Others										

Were any Prenatal diagnostics done - Yes  No  If yes please specify the details below :

DATE	GA / Weeks	TYPE OF TEST	INDICATION	REPORT
			FTS - low risk NIPT - Low risk	



ANTENATAL ADMISSION

DOA	DOD	GA Weeks	Complaint	Management	Advice

BRIEF DELIVERY NOTES

Gestational age \_\_\_\_\_ Date & time of delivery : \_\_\_\_\_

Type of labour : Spontaneous

Induction : Indication \_\_\_\_\_

Method - PGE 1  PGE 2

Mode of delivery : SVD  AVD  Vacuum  Forceps

Indication : \_\_\_\_\_

Caesarean section : Emergency  Elective

Indication : \_\_\_\_\_

SALIENT FEATURES :

Baby details : Girl  Boy  Wt : \_\_\_\_\_ Apgar score: \_\_\_\_\_

Postpartum Period : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_