

RE: Mrs. SANDHYA V (FDH-00040858) - Agreed Discount Package.

From Polepeddi Anand <anand.p@rainbowhospitals.in>

Date Sat 5/23/2026 1:41 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>; M Rajlingam Chitra <operations.fd@rainbowhospitals.in>; FD ADMISSION DESK <admissiondesk.fd@rainbowhospitals.in>; FD MOD <mod.fd@rainbowhospitals.in>; Tintu Joy <nursingmanager.fd@rainbowhospitals.in>

Approved from my end

Regards,
Anand

From: FD Financial Counsellor <financial.counsel.fd@rainbowhospitals.in>
Sent: 23 May 2026 11:27

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>; M Rajlingam Chitra <operations.fd@rainbowhospitals.in>; FD ADMISSION DESK <admissiondesk.fd@rainbowhospitals.in>; FD MOD <mod.fd@rainbowhospitals.in>; Tintu Joy <nursingmanager.fd@rainbowhospitals.in>

Subject: Mrs. SANDHYA V (FDH-00040858) - Agreed Discount Package.

Mrs SANDHYA V (FDH-00040858)

Dr. VASUDHA LAGADAPATI

Lap. Tubectomy Day care

Good morning, sir.

Sir, the above patient is given a **package of 60,000 all-inclusive for the lap. Tubectomy—Daycare (Including Biopsy)**. This package is given. 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

DISCHARGE SUMMARY

Name	Mrs SANDHYA V	UHID	FDH-00040858
Father/Guardian	Mr NAGA VENI	Age/Gender	30 Y 11 M 23 D/ Female
Address	d-1103,muppas melody osman nagar, Hyderabad, Hyderabad, Telangana, INDIA, 500001		
IP No	IP25-00020706	Admission Date	29-05-2026
Ref Doctor	Self		
Discharge Date	29/05/2026		

Consultants :

Dr. Vasudha Lagadapati

MBBS,MS,FMAS

Consultant-Obstetrician and Gynaecologist

Reg. No: 71881

Diagnosis: P2L2A1 WITH PREVIOUS LSCS FOR PERMANENT STERILIZATION.

Admitted for Laparoscopic Tubectomy

Menstrual History: LMP : 21.05.2026

Previous cycles: Irregular

Obstetric History: P2L2A1 / previous 2 LSCS.

LCB : 2 years.

Medical History : Prediabetic

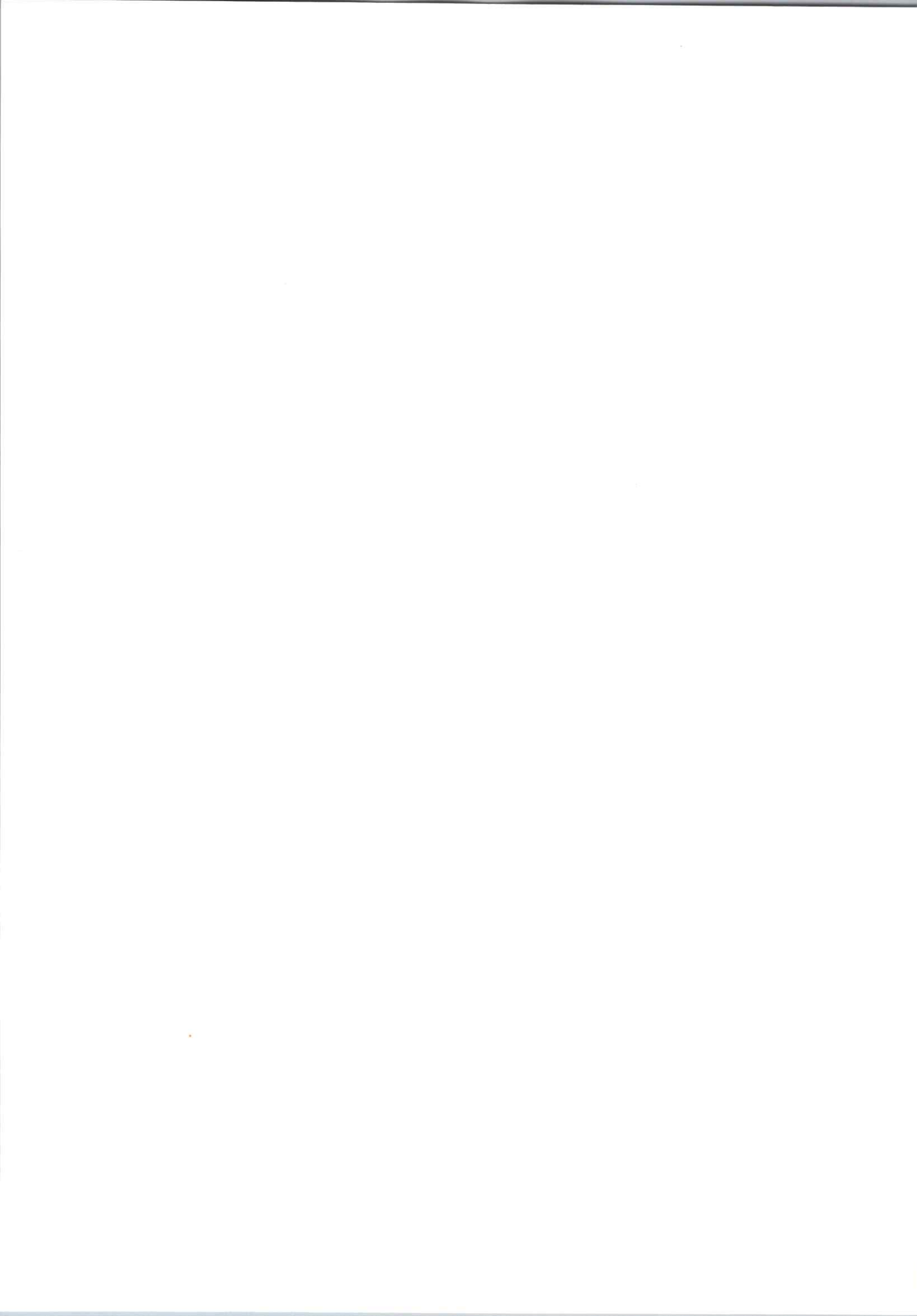
Surgical History : Cerclage during first pregnancy-2021

LSCS (2021,2024)

Allergies : Nil

Family History : Father- HTN+ DM+

Mother- HTN



Name	Mrs SANDHYA V	UHID	
IP No	IP25-00020706	Admission Date	29-05-2026

Investigations: Enclosed.
Blood Group - "B" Rh Positive.

Surgery Notes:
Operation performed:
Laparoscopic Bilateral Tubectomy done under GA.

Indication: P2L2A1 with previous 2LSCS.

Operative findings:

- Patient shifted to OT.
- Under GA, Parts cleaned and draped with Betadine, bladder drained .

Proceeded with laparoscopic Bilateral Tubectomy:

- A 5mm primary supraumbilical port introduced. Pneumoperitoneum created
- 7mm Accessory ports inserted on left side under vision.

Intraoperative Findings:

- Uterus normal.
- Bilateral fallopian tubes and ovaries appear normal
- Bilateral fallope rings applied on fallopian tubes using ring Applicator.
- No active bleeding seen.
- Ports removed under vision - Gas let out.
- port closed with Staples
- Patient withstood the procedure well.

Post-Operative Notes: - Uneventful.

Advice:

1. Tab. Taxim O 200mg (Cefixime 200mg) twice daily till 20.08.2025 (9am - 9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) Thrice daily till 20.08.2025 (7am-3pm-10pm) after food.
3. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 20.08.2025.
4. Tab .Zincovit once daily after breakfast for one month.



Name	Mrs SANDHYA V	UHID	FDH-00040858
IP No	IP25-00020706	Admission Date	29-05-2026

Review with **Dr.Vasudha Lagadapati** after one week on 08.06.2026 at postnatal clinic with prior appointment.

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 Nanakramguda or 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

Consultants :
Dr. Vasudha Lagadapati
MBBS,MS,FMAS
Consultant-Obstetrician and Gynaecologist
Reg. No: 71881



FDH-00040858 IP25-00020706
Mrs SANDHYA V
06-06-1995 30 Y 11 M 23 D (F)
Dr. VASUDHA LAGADAPATI



SURGERY DETAILS

Date : 29/5/26

Patient Name: Mrs. Sandhya Date of Birth: Age: 30 Y

Gender: Female Ward: OT-1 UHID No.: FDH-00040858

Date of Surgery: 29/5/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery : lap tubectomy

Time in : 10:45 Am

Time Out : 11:45 Am

	NAME	AMOUNT
1. Surgeon	Dr. Vasudha	
2. Anaesthetist	Dr. Usha	
3. Assistant Surgeon		
4. OT Technician	Sr. Subhasini	
5. Circulating Nurse	Br. Subhaaleep	
6. Assistant Nurse	Br. Ama Sr. Rajini	

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

Signature of the Surgeon

Signature of Circulating Nurse: Br. Subhaaleep

Order No: 581931/932

Order by: Baby

SURGE

10/1/77

11/1/77

Mid-Atlantic
Atlantic
Atlantic

Dr. 1
Dr. 2

Dr. 3
Dr. 4
Dr. 5

- 4. DT Technician
- 5. Consulting
- 6. Assistant

Special Equipment

11/1/77

11/1/77



Lap. Tubeectomy
CONSUMABLES OF OT



Circulating staff Technician : SUBHABINI Date : 29/05/2026 Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube <u>7.0mm</u>		01	Major Pack		1	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A/P/N		03				Suction Catheter		
HME filter : A/P/N		01				Feeding Tube		
Syringes : 10 cc		02				Vaccum Suction Set		
05 cc		03	Gloves <u>6/2 + 6</u>	3	2	Surgical Gloves		
02 cc		02				Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A/P/N			Surgical blade <u>11</u>		1	Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		02	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		01	Koochies					
<u>02 MASK (A)</u>		01	Ointments					
<u>AIRWAY (H)</u>		01	Suction Catheter					
<u>Fentanyl P.C.M.</u>		01	Cap, Mask					
<u>Morphine THREE WAY (1000)</u>		01	Gauze Pack		4			
Ketamine			Mop Pack		1			
Propofol		02	Steristrip		2			
Rocuronium		01	Underpad		2	<u>leggin</u>		1
Glycopyrolate			Draw sheet					
Myopyrolate		01	Abgel			<u>D. Aprons</u>		3
Ondansetron			Foleys catheter <u>Welfon</u>		1	<u>Silicon Tubal rings</u>		2
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			loban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set	1	1			
Justin : 12.5 mg / 25mg / 100mg		01	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		2			
			Microshield					
			Cotton Balls					
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse Amre OT Technician CP
 Order No. : 581907 (N89) / 581924 (TECH) Ordered by : Baly
 Doc. No. : RCH / FRM / GENERAL / 125

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by

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of the

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1000 1200 1400 1600 1800 2000

10

ADMISSION SHEET



Registration Details :

Admission No : IP25-00020706 Admit Date : 29-May-2026 Admit Time : 08:35 AM UHID : FDH-00040858

Patient Details :

Patient Name : Mrs SANDHYA V Age : 30 Y 11 M 23 D
Guardian : Mr NAGAVENI DOB : 06-06-1995
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : d-1103,muppas melody osman nagar Phone No : 9902329698/ 9902329698
Hyderabad Hyderabad Telangana INDIA E-mail : agtharun@gmail.com
500001

Admission Details :

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

Contact Details :

Name : Mr NAGAVENI Relationship : MOTHER
Contact Address : Phone No :

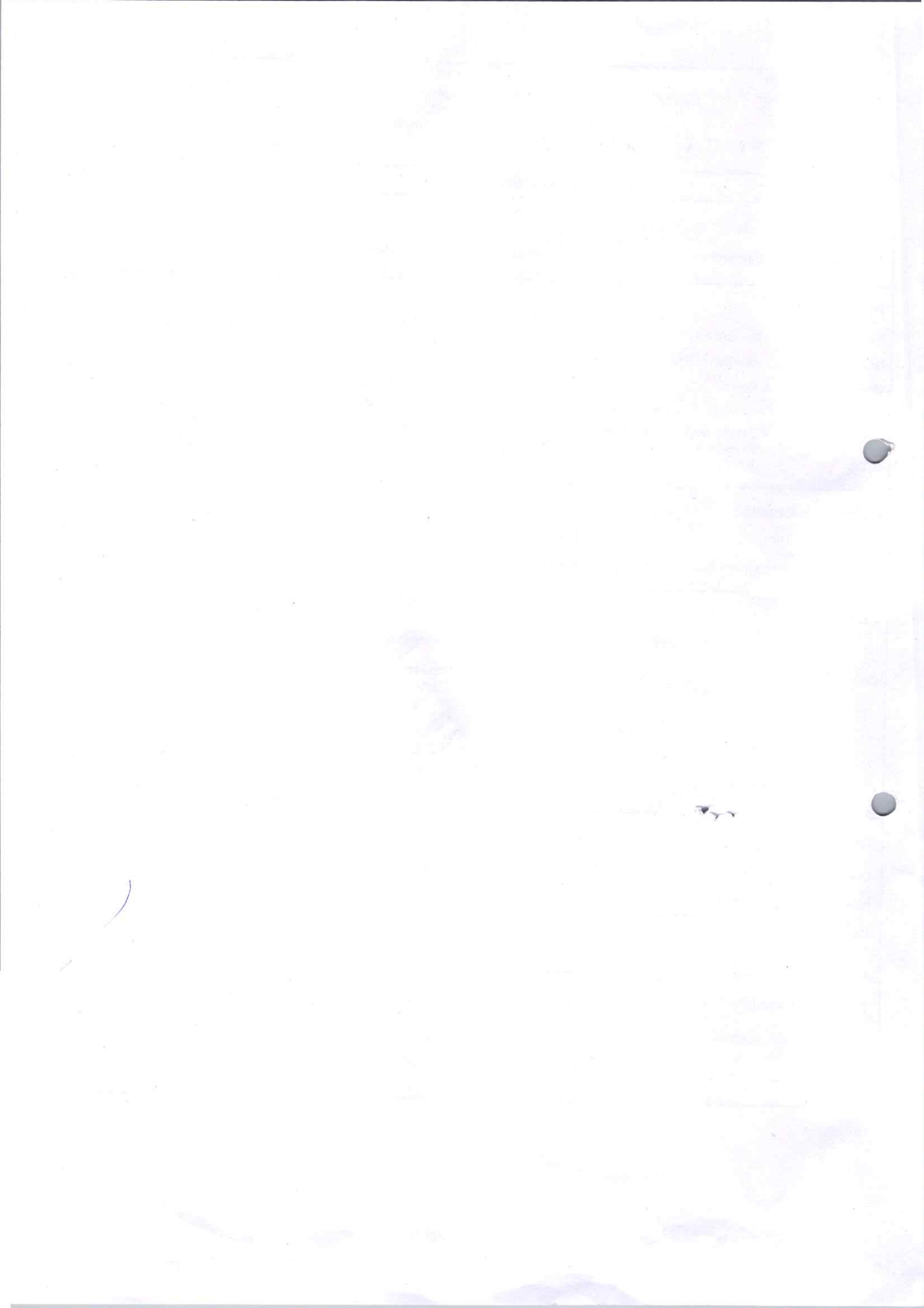
A.G. Tharun
Signature

Doctor Details :

Doctor Name : Dr. VASUDHA LAGADAPATI Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : SELFPAY



Gyne

FDH-00040858 IP25-00020706
Mrs SANDHYA V
06-06-1995 30 Y 11 M 23 D (F)
Dr. VASUDHA LAGADAPATI



ACTIVITY RECORD FOR BILLING

Name: Mrs. Sandhya.
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	10:30 AM	MICU	OT	<i>[Signature]</i>
29/5/26	11:50 AM	OT	MICU	<i>[Signature]</i>

Cross Consultation Visit

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

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
29/5	IV placement	①	✓ 1868	[Signature]
29/5	PAC IP		✓ 1869	[Signature]

ANY OTHER INFORMATION

Date: 29/5/26 Time: 8:35 AM Prepared By: [Signature]

Staff Nurse [Signature]	Shift / Ward Med	Billing Assistant	Billing Supervisor
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FDH-00040858 IP25-00020706

Mrs SANDHYA V

08-06-1995 30 Y 11 M 23 D (F)

Dr. VASUDHA LAGADAPATI



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	29/5/26						
	Shift	M						
	Medical Condition (Any special condition to be noted):	Obs						
	Diet:	NBM						
ASSESSMENT	Allergy:	<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	RA						
	Tubes/Drains/Catheter:	<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	36.5°C					
		Res:	22					
		SpO ₂ :	98					
		Pulse:	78					
		BP:	115/78					
		LOC:	C					
		Fall Risk Score:	0/10					
	Pain Score:	0/10						
	Skin Integrity	good						
Recommendations	Safety Needs:	<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 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:	NBM						
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<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 type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non Dependent):	Dependent							
Post Operative Procedure Special Orders:								
Handed Over By Name :		Sush						
Signature / ID :		[Signature]						
Date:		29/5/26						
Time:		@ 8am						
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								

Patient Sticker



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date							
	Shift							
	Medical Condition (Any special condition to be noted):							
	Diet:							
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	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 ₂ :						
		Pulse:						
		BP:						
		LOC:						
		Fall Risk Score:						
Pain Score:								
Skin Integrity								
Recommendations	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	
	ADL (Dependent / Non Dependent):							
	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	
	Post Operative Procedure Special Orders:							
	Handed Over By Name :							
	Signature / ID :							
	Date:							
	Time:							
	Taken Over By Name :							
	Signature / ID :							
	Date:							
	Time:							



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 29/5/26 @ 8:35 Am

Baseline Information:

Admission From: ER OPD Admission Desk Others, specify

Primary Language: Telugu English Hindi Others, specify

Do you require an interpreter? Yes No if Yes specify

Source of Information: Patient Family Others, specify

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Chief Complaints: Admission for dep. Lobectomy Doctor Notified on Admission: Yes No
 Name of the Doctor: A. Harshini
 Time Notified: @ 8 AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>pre-diabetic</u>	<u>LSCS 2021</u> <u>2024</u> <u>cerclage 2021</u>	<u>Nil</u>
Gynecology Assessment: <input checked="" type="checkbox"/> Not Applicable Menstrual History: Onset of Menarche: Menstrual Cycle: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular Last Menstrual Period:	Gynecology Surgical History: Caesarean Section: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Cervical Cerclage: <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes Ectopic Pregnancy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Myomectomy: <input type="checkbox"/> No <input type="checkbox"/> Yes Others:	Gynecological History: Contraceptives: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Vaginal Discharge: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Post-Coital Bleeding: <input type="checkbox"/> No <input type="checkbox"/> Yes Infertility: <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes Type: <input type="checkbox"/> Primary <input checked="" type="checkbox"/> Secondary

Obstetric History: G P 2 L 2 A

Previous LSCS: Yes

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

Family History: No Abnormalities Detected

Heart Disease Hypertension Diabetes Stroke Seizures Kidney disease
 Liver disease Other

Vital Signs / Measurements: Temp: 36.5 HR: 78 RR: 22
 BP: 103/603 Weight: Height: BMI:

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

PHYSICAL ASSESSMENT

General Appearance: Healthy ill looking Anxious Agitated Others:

Fall Assessment: Yes No Score 0 (complete the Morse Fall Risk Assessment Sheet)

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

- Calm & Cooperative
- Restless
- Depressed
- Agitated
- Confused
- Others

Inform consultant for positive criteria

SOCIAL SCREENING:

1. **Marital Status:** Single Married Divorced Widow
2. **Special Habits:** **Smoker:** Yes No **Alcohol Abuse:** Yes No **Drug Abuse:** Yes No

Social History: Lives With Family

Orientation has been given regarding the following aspects:

- Call Bell in Reach : Yes No
- Waste Disposal Explained: Yes No
- Infusion Pump : Yes No
- Hand Hygiene Explained: Yes No
- Others

Above information given to Patient

Name of Person Orientation was given to: Patient

Orientation not given Reason:

Nurse Signature: *[Signature]*

Nurse Name: *Lushme*

Date & Time: *29/5/26 @ 9am*

I.P. ADMISSION SHEET FOR GYNECOLOGY
Date of Admission : 29/5/26

Time of Admission : _____

PERSONAL DETAILS

Name : Mrs. Sandhya Age 30 Date of Birth _____
 UHID No.: FDH 0004 0858 IP No.: _____
 Department : OBG Consultant : Dr. Vasudha

PRESENTING COMPLAINTS

P₂L₂A₁ Admitted for laparoscopic bilateral tubectomy

G₁ - 2021, LMS, ♂, 3.2kg (maternal request)
 G₂ - 2024, LMS, ♀, 3.3kg
 G₃ - 2026, MERPC i/v/o unplanned
 Jan - preg at 6wks.

MENSTRUAL HISTORY

Year of Marriage : 2019
 Previous Periods : Irregular
 LMP : 11/2/25
 Contraception :

OBSTETRIC HISTORY

Parity : P₂L₂A₁
 Mode of Delivery LMS
 Last Child Birth : 2 yrs

MEDICAL HISTORY	SURGICAL HISTORY
pre diabetic	ceridge done 1st Aug - 2021. LSCS < 2024.
FAMILY HISTORY	NOTES / ALLERGIES
F - DM, HTN M - HTN	Nil

INITIAL ASSESSMENT :

Date _____ Ht. _____ Wt. _____ BMI <u>PR - 88 kgms</u> B.P <u>113/78 mmHg</u> Pallor _____ CVS _____ Respiratory System _____ Thyroid _____	Breasts Abdominal Examination P/A - soft	Local / Speculum Examination NOT done Bimanual Pelvic Examination NOT done
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PROVISIONAL DIAGNOSIS : PC₂A, i prev hrs for permanent sterilization

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT	PRESCRIPTION
BGT - B +ve Viral markers - NR Hb - 12 WBC - 6000 Plts - 349	LAPAROSCOPIC TUBECTOMY	NBM PAC Preop medication Counts Secure w canula Post preparation

Name of the Doctor : Dr. Anusha

Date : 29/5/26 Time : 10AM


[Signature]
Signature of Doctor

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

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

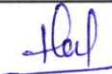
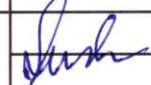
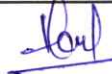
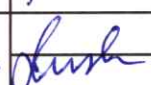
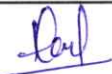
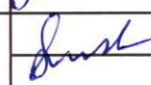

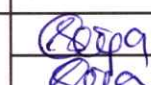

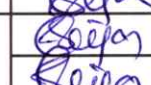

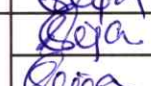
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Name & Signature of the Doctor Starting the Drugs:																			
Additional Instructions:																			
Daily Doctor's Endorsement by a Sign																			

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

V		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
		Dose		Dose		Dose		Dose	
DRUG :		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.	

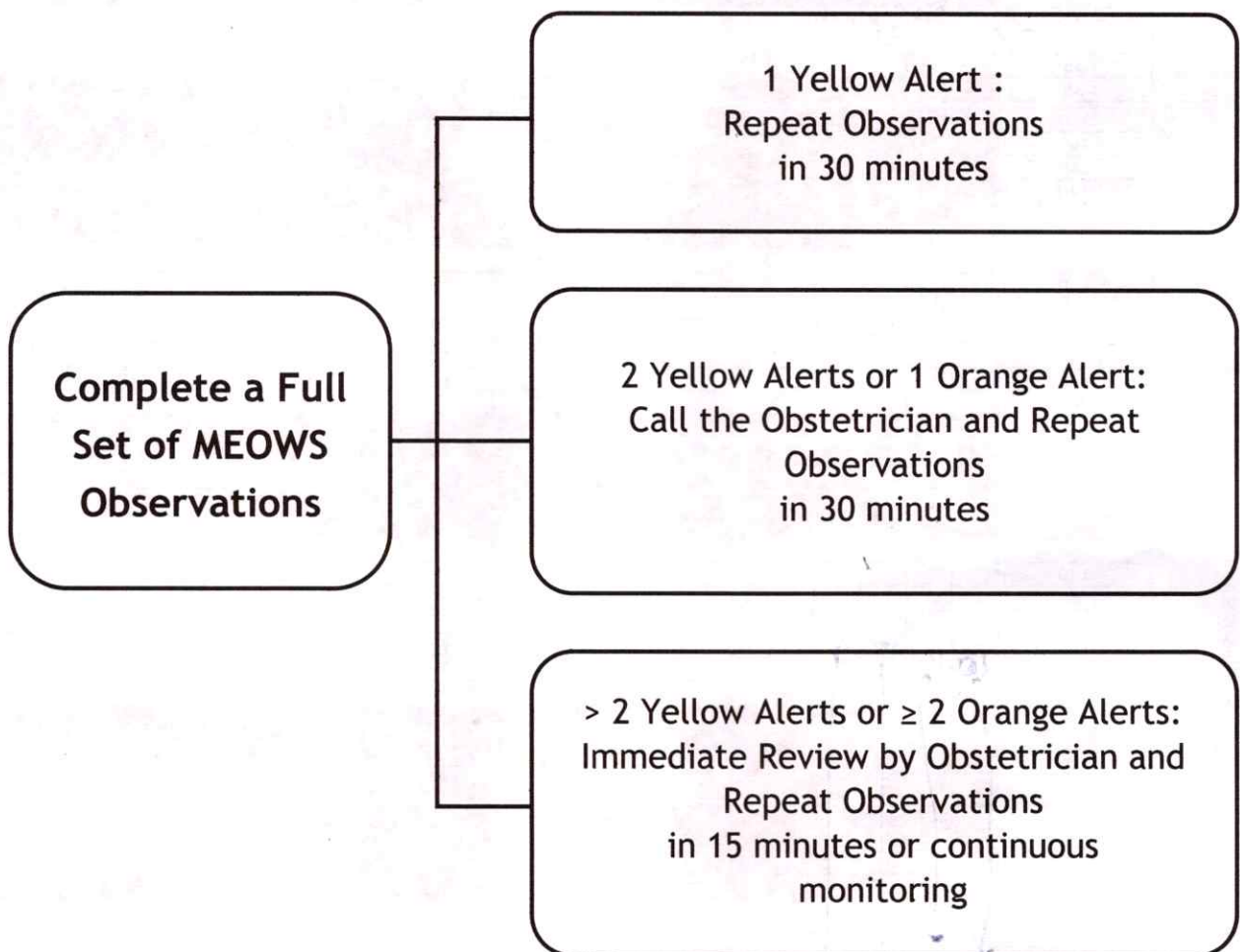
VARIABLE DOSE	Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
		Dose		Dose		Dose		Dose	
DRUG :		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Start Date	Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		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
29/05	9:45 AM	Inj CEFOTAXIME	1g	IV		
29/5	10:00 AM	Inj PANTOPRAZOLE	40 mg	IV		
29/5	10:00 AM	Inj METACLOPRAMIDE	10 mg	IV		
29/5	11:00 AM	INJ PARACETAMOL	1 gm	IV		
29/5	11:25 AM	SUPP TRAMADOL	100mg	PR		
29/5	11:25 AM	SUPP DICLOFENAC	100mg	PR		

VERIFIED BY: Name Signature

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Sandhya Age: 30yrs Sex: Female UHID.No:
 Date: 29/11/2026 Time: 10:30AM Proposed Operation: Laparoscopic tubal occlusion
 Diagnosis: P2L2 previous USG
 B.P / CRT: H.R: Weight: 65kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: <u>12g%</u>	Glucose: <u> </u>	Protein: <u> </u>	HIV: <u> </u>	X-Ray: <u> </u>
PCV: <u> </u>	Urea: <u> </u>	Alb: <u> </u>	HBS Ag: <u> </u>	ECG: <u> </u>
WBC: <u>6000</u>	Creat: <u>0.60</u>	Total Bill: <u> </u>	HCV: <u> </u>	2D Echo: <u> </u>
Plate: <u>3.49 lac/mm³</u>	Na: <u> </u>	Dir. Bill: <u> </u>	Blood group: <u>B+ve</u>	Stress/Angio: <u> </u>
PT: <u>14</u>	K: <u> </u>	LDH: <u> </u>	T3: <u> </u>	Other: <u> </u>
PTT: <u> </u>	Ca++: <u> </u>	Alk phos: <u> </u>	T4: <u> </u>	
INR: <u>1.0</u>	Mg++: <u> </u>	Amylase: <u> </u>	TSH: <u> </u>	
	Cl-: <u> </u>	SGOT/SGPT: <u> </u>		

Allergies: NIL

Medical History: CVS :

RESP : Diabetes :
 CNS : Nothing Significant
 Renal : no H/o fever/cold/cough
 Hepatic / GE : Physical Activity: >4 METS.
 Others :

Past Anaesthetic History: H/o previous USG - 2024 ISA, O/E
Physical Exam:

Airway: MP 1 234 Mouth Opening: 3finger MentoHyoid Distance: >3Hb Neck: (N) Teeth: (A)

Lungs: B/LC/AE @ clear

Heart: S2

CNS:

Pregnant: Yes No NA Venous Access Site : (F) 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:

- DVT Prophylaxis : NBM : 9pm
- NIL ORAL Water / ORS 2 Hours
Others 6 Hours
- Informed Consent: Standard High Risk
- Post Operative Pain Management: Discussed with Patient
- Other Instructions:

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

OPERATION THEATER NOTES

FDH-00040858 IP25-00020706

Mrs SANDHYA V

06-06-1995 30 Y 11 M 23 D (F)

Patient Dr. VASUDHA LAGADAPATI

Age : 30 yrs Gender : female

UHID: 

I.P.No. : 25-00020706 Weight :

Surgeon : Dr. Vasudha Asst. Surgeon :

Anesthetist : Dr. Usha OT Nurse : B.S. Anwar

Surgical Procedure :
Laparoscopic bilateral tubectomy

Indications for Surgery :
B₂L₂A₁ ♂ prev USG for permanent sterilization

Date : 29/5/2026 Start Time : 10:45 AM End Time : 11:45 AM

- PRE-OPERATIVE PREPARATION :
- 1) NBM
 - 2) part preparation
 - 3) PAC
 - 4) prep medication

OPERATION NOTES: Patient shifted to OT

- ↓ CAP, patient anesthetised, kept in position, ports painted & draped.
- A 5mm supraumbilical port introduced, pneumoperitoneum created.
- An accessory 7mm port introduced on (L) side under vision.

IOF: uterus appears (N)
B/i tubes and ovaries appear (N).

- proceeded ♂ Lap bilateral tubectomy.
- Fallope rings applied on B/i tubes.
- patient withstood the procedure well.
- ports removed under vision, gas let out
- port site closed ♂ staples
- Patient withstood the procedure well.

POST - OPERATIVE ORDERS :

- 1) NBM x 6 hrs
- 2) fluids as per AXON
- 3) Drugs as charted
- 4) w/ pain abdomen
- 5) (M) vitals Temp 80s

Dr. Vamshu

Consultant Surgeon's Name

Date : 29/5/16 Time : 12pm




Consultant Surgeon's Signature

PATIENT TRANSFER FORM

OT



Patient Name & UHID No. FDH-00040858 IP25-00020706 Mrs SANDHYA V 06-06-1995 30 Y 11 M 23 D (F) Dr. VASUDHA LAGADAPATI 		Date & Time of Admission 29/5/2026		Date & Time of Transfer Order 29/5/2026 @ 11:50AM	
		Transfer Ordered by Dr. Usha		Reason for Transfer Post op care	
From Unit OT		To Unit MICU		Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 25		Number of Imaging Films 1 op file.		Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over					
Sl.No.	Item Name	Quantity			
1.					
2.					
3.					
4.					
5.					
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
Name & Signature of Person who is Transferring Greeja @ 11:50AM			Name of Person Ordered Transfer Dr. Usha.		
Patient & Clinical Records Received by :					
Date & Time of Patient Received :					

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10


10/10/10

10/10/10

10/10/10

10/10/10

PATIENT TRANSFER FORM

Patient Name & UHID No. FDH-00040858 IP25-00020706 Mrs SANDHYA V 06-06-1995 30 Y 11 M 23 D (F) Dr. VASUDHA LAGADAPATI 		Date & Time of Admission <i>29/5/16</i>	Date & Time of Transfer Order <i>29/5/16 @ 10:30 Am</i>
		Transfer Ordered by <i>Dr. Vasudha</i>	Reason for Transfer <i>Sup. Delivery</i>
From Unit <i>M/W</i>	To Unit <i>W-OT</i>	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File <i>30</i>	Number of Imaging Films <i>108 files</i>	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> <i>✓</i> 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 <i>Sush</i>		Name of Person Ordered Transfer <i>Dr. Vasudha</i>	
Patient & Clinical Records Received by : <i>Sreelja</i>			
Date & Time of Patient Received : <i>@ 10:30 Am</i>			

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

- Unavailable Bed Nurse not Available Available Bed not ready

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

OT

NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

- 5817332 -

Patient Name: <u>MRS SANDHYA V</u>		Age: <u>27/4</u>	Gender: <u>FEMALE</u>
UHID No: <u>1825-00020716</u>		IP No: <u>1825-00020716</u>	Date: <u>20/10/20</u> Time: <u>9:00 AM</u>
Diagnosis: <u>LAP TUBECTOMY</u>			
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	15MG	---
3.	Remifentanyl Hydrochloride Inj. 2MG	---	---
4.	Remifentanyl Hydrochloride inj. 1MG	---	---
Doctor Name: <u>B S Reddy</u>		Doctor Registration No: <u>36840</u>	
Signature: <u>[Signature]</u>			

NARCOTIC DISPENSING FORM APPENDIX 4 - FORM NO. 3E

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

IP Registration No: 1825-00020716 Date: 20/10/20

Aadhaar No. of the Patient (Optional): _____

1.	Name: <u>MRS SANDHYA V</u>	Remarks		
2.	Complete postal address (with contact number, if any)	<u>[Address]</u>		
3.	Brief description of the illness	<u>LAP TUBECTOMY</u>		
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	<u>MORPHINE</u>		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
<u>20/10/20</u>	<u>MORPHINE</u>	<u>ONE</u>	<u>[Signature]</u>	-
		-		-

Dispensed by (Name & ID No.): R. PRANITHI (516000) Signature: _____

Received by (Name & ID No.): J. SURESH (105110) Signature: [Signature]

Time: 10:30 AM