

DISCHARGE SUMMARY

| | | | |
|------------------------|--|-----------------------|------------------------|
| Name | Mrs P. PRAVALLIKA | UHID | FDH-00044927 |
| Father/Guardian | Mr PAVAN KALYAN KAPA | Age/Gender | 26 Y 10 M 30 D/ Female |
| Address | green space prime block a flat 305 puppal guda manikonda, Manikonda, Hyderabad, Telangana, INDIA, 500089 | | |
| IP No | IP25-00020542 | Admission Date | 20-05-2026 |
| Ref Doctor | | | |
| Discharge Date | 22.05.2026 | | |

Consultants :

Dr. Himabindu Annamraju

MBBS, MRCOG (UK), CCT (UK)

Consultant-Obstetrician, Gynaecologist and Laparoscopic Surgeon
Specialist in High-Risk Pregnancy

Reg. no: 51697

Diagnosis : PRIMIGRAVIDA AT 37 WEEKS GESTATION WITH
1. GDM ON OHA
2. FOR INDUCTION OF LABOUR

NORMAL VAGINAL DELIVERY DONE, DELIVERED A LIVE MALE BABY AT 11:50 AM WEIGHT 2.710 KGS ON 21.05.2026.

History:

LMP: 04.06.2025

Obstetric formula: Primigravida

EDD: 01.06.2026

Gestation at admission: 37 weeks

Obstetric History:

G1 - Present pregnancy Spontaneous conception.

Medical History :



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|--------------|-------------------|-----------------------|--------------|
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H/O GDM diagnosed at 33+5 weeks gestation, started on OHA at 35+5 weeks now on Tab. Glycomet SR 500mg AD.

Surgical History: B/L Lasik Surgery in 2023.

Allergies : Nil

Family History : Nil

Antenatal Details:

Mrs P. PRAVALLIKA was booked to Rainbow hospital at 32+6 weeks of gestation. She had regular antenatal checkups and investigations as advised elsewhere. NT scan at 14+5 weeks was normal & FTS normal, TIFFA scan at 19 weeks showed no anomalies & Fetal Echo was normal. LGA diagnosed at 32+6 weeks EFW 91%, AC 78%. She was diagnosed with GDM since 33+5 weeks, on OHA at 35+5 weeks, now on Tab. Glycomet SR 500mg AD. Serial growth scans were normal. USG done on 11.05.2026 showed at 35+5 weeks, cephalic, placenta anterior and high, AFI 14.2cm, EFW 2922grams(68%), AC 65% with normal fetal dopplers. She was admitted at 37 weeks for induction of labour.

Investigations: Enclosed.

Blood group & Typing - "B" Rh positive.

Management:

Course in hospital and Delivery Details: At admission on clinical examination the vitals were stable, uterus was relaxed, cervix was 1cm long and 1-2cm dilated. Fetal well being was confirmed by an admission CTG which was found to be reactive. Informed consent taken for Induction of labour. Labour induced with 1 dose of PGE1. Artificial rupture of membranes done at 2 cms dilatation revealing clear liquor. As per hospital protocol she was started on IV. Taxim in view of ruptured membranes. Partographic monitoring of labour was done. Patient opted for epidural analgesia at 2-3 cm dilatation for pain relief. The same was sited by an anesthetist after informed consent. Further augmentation was done by oxytocin infusion. She



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progressed to full dilatation at 11:30 am. She was put into position for vaginal birth. Parts painted with betadine solution and draped to ensure full asepsis. She was encouraged to bear down. At crowning of head episiotomy was given under local anesthesia (10 ml of 2 % xylocaine solution).

Baby was delivered by Spontaneous vaginal delivery, Cord clamped and cut and baby handed over to pediatrician. Cord blood collected for blood grouping and Rh typing. Placenta and membranes delivered completely with controlled cord traction. Prophylactic syntocinon given. Episiotomy inspected. No extensions or additional vaginal tears found. Episiotomy sutured in layers. Instrument and swab count checked. 600 mcg of misoprostol given per rectally as prophylaxis against post partum hemorrhage. Vagina cleaned with betadine solution.

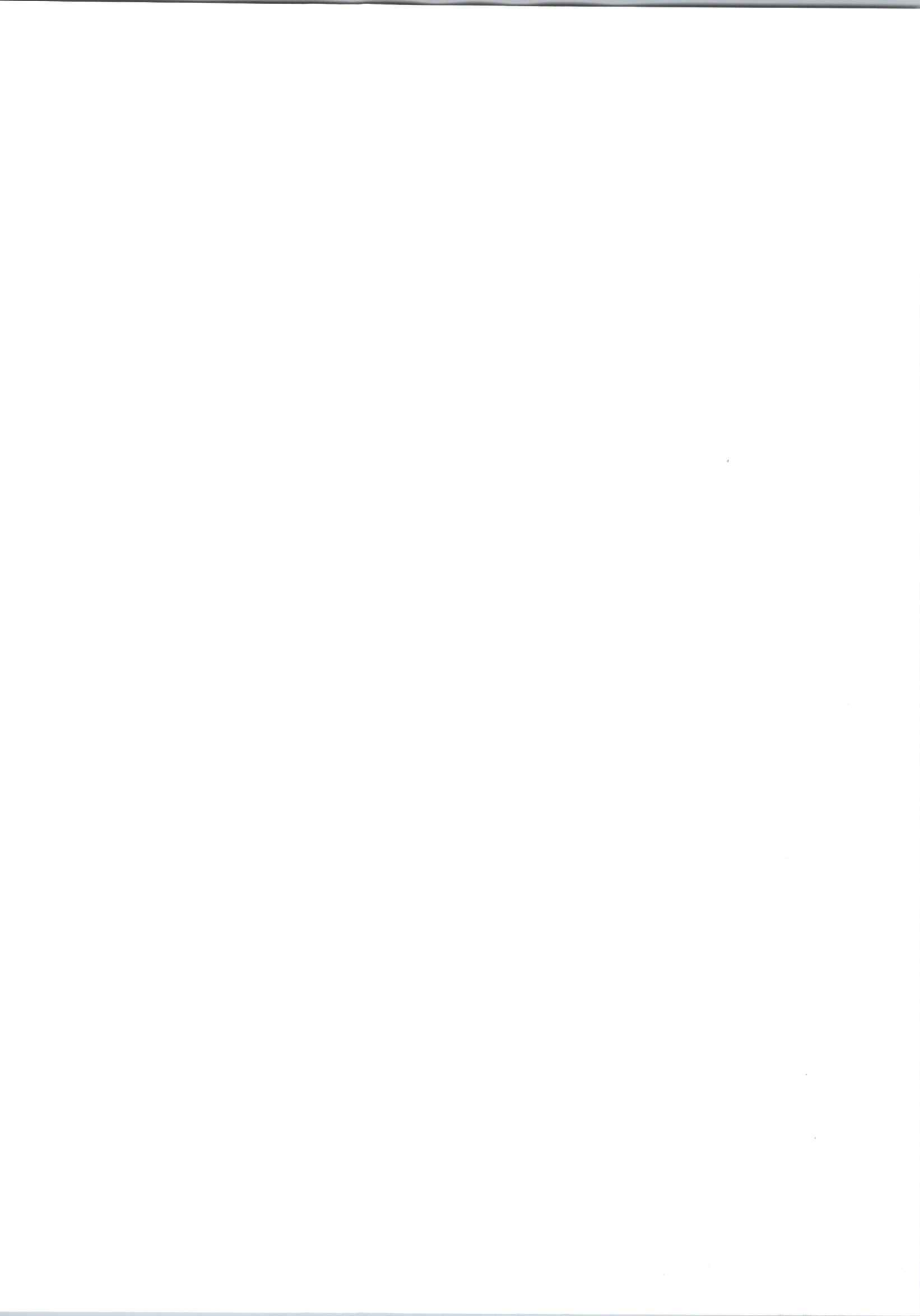
Delivery Details:

Date : 21.05.2026
Time of Delivery: 11:50 AM
Type of Labour : Labour induced with 1 dose of PGE1
Type of Delivery: Spontaneous vaginal delivery
Analgesia : Epidural

Baby Details:

Date : 21.05.2026
Time : 11:50 AM
Sex : Male
Weight : 2.710 KGS
Apgar : 8/9, 9/10
Gestational Age: 37 weeks
NICU Admission: No.

Post-Partum Notes: She was closely monitored for post partum hemorrhage. Breast feeding initiated. Vitals were stable; patient ambulated and was shifted



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to room. Patient was encouraged for spontaneous voiding. Dietary advice given. Her postpartum period following that was uneventful. On first postpartum day episiotomy wound was healthy and intact. **Her blood sugars were monitored postnatally and were normal.** 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 (Cefixime 200mg) twice daily till 27.05.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 27.05.2026 (8am-2pm-10pm) after food.
3. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 27.05.2026 (7am-7pm) before food.
4. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 27.05.2026 (9am-3pm-11pm) after food.
5. Tab. Livogen (Elemental iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500 mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
7. Betadine ointment for local application.
8. Sy. Duphalac 15 ml (Lactulose 3.33gm/5ml) at bed time for one week.
9. **To do FBS, PLBS & HBA1C after 6 weeks.**

Care of the episiotomy (refer to chapter 2 Page no.5 -6 in the postpartum book).

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 Consultation) after one week on



| | | | |
|-------|-------------------|----------------|--------------|
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28.05.2026 with prior appointment.

Review with Dr. HIMABINDU ANNAMRAJU, after one week on 28.05.2026 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 [please refer to postpartum book for further details - Chapter II page 6] 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

Dr. Anisha
Registrar/Resident/C.M.O

Consultants :

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Consultant-Obstetrician, Gynaecologist and Laparoscopic Surgeon

Specialist in High-Risk Pregnancy

Reg. no: 51697



ADMISSION SHEET

Registration Details :



Admission No : IP25-00020542 Admit Date : 20-May-2026 Admit Time : 07:10 PM UHID : FDH-00044927

Patient Details :

Patient Name : Mrs P. PRAVALLIKA Age : 26 Y 10 M 29 D
Guardian : Mr PAVAN KALYAN KAPA DOB : 21-06-1999
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : green space prime block a flat 305 puppal guda manikonda Manikonda Hyderabad
Telangana INDIA 500089 Phone No : 9492676431
E-mail :

Admission Details :

Bed Type : MICU Bed No : MICU-03 Ward Name : 4F -MICU
Room No : MICU-03 Admission Type : First Visit

Contact Details :

Name : Mr PAVAN KALYAN KAPA Relationship : Husband
Contact Address : green space prime block a flat 305 puppal guda manikonda Manikonda Hyderabad
INDIA 500089 Phone No :

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

GENERAL CONSENT FOR TREATMENT

Patient Name: Mrs P. PRAVALLIKA Age : 26 Y 10 M 29 D
IP No: IP25-00020542 Sex: Female
Consultant: Dr. HIMABINDU ANNAMRAJU Ward/Bed No: 4F -MICU/MICU-03

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:

1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name:

Relationship:

Date:

Witness Name:

Witness Signature:

Patient Address:


green space prime block flat 305
puppall guda manikonda manikonda
Hyderabad Telangana IDIA 500089

Time:

ACTIVITY RECORD FOR BILLING

FDH-00044927 IP25-00020542
Mrs P. PRAVALLIKA
21-06-1999 26 Y 10 M 29 D (F)
Dr. HIMABINDU ANNAMRAJU

Name: -----

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

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

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

WARD TRANSFERS

| Date | Time | From | To | Signature of Nurse |
|---------|------|------|------|--------------------|
| 21/5/26 | 5 pm | MICU | Ward | Gang |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Cross Consultation Visit

| | Doctors Name | Date | Order No. | Signature |
|-----|--------------|---------|-----------|-----------|
| 1. | Dr. valbhani | 22/5/26 | 8473 | D. Bahar |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

C.C. done by Dr. Bahar 22/5/26

INVESTIGATIONS

| Date | Investigations | Order No. | Sign |
|--------------------------|---|------------------|----------|
| 20/5/26 | URBS 7:30pm 95mg/dl | 7863 ✓ | Majule |
| 20/5/26 | NST - (1) | 6351 ✓ | |
| 20/5/26 | CBP, PT APTT PT APTT | 7862 ✓ 7865 ✓ | |
| 21/5/26 | NST - (2) | 6378 ✓ | Sadhua |
| 21/5/26 | GRBS - 92mg/dL (12AM) | 7869 ✓ | |
| 21/5/26 | NST - (3) | 6379 ✓ | |
| 21/5/26 | GRBS - 91mg/dL (4AM) | 7915 ✓ | |
| 21/5/26 | NST - (4) | 6380 ✓ | |
| 21/5/26 | GRBS - 104mg/dL (8AM) | 7916 ✓ | |
| 21/5/26 | NST - (5) | 6381 ✓ | |
| 21/5/26 | NST - (6) | 6382 ✓ | |
| 21/5/26 | NST - (7) | 6436 ✓ | |
| 21/5/26 | NST - (8) | 6437 ✓ | |
| 21/6/26 | NST - (9) | 6438 ✓ | MGS |
| 21/5/26 | NST - (10) | 6439 ✓ | |
| 22/5/26 | FBS - 90mg/dL (6AM) | 8010 ✓ | halephue |
| 22/5/26 | PPBS - 70mg/dL done. P (cross by number) | 8036 ✓ | Rahar |
| 22/5/26 | PLBS - Normal | 8037 ✓ | Rahar |
| 22/5/26 | NHA | 8472 ✓ | Rahar |
| done by Rahar 22/5/26 | | | |

PROCEEDURE

| Date | Proceedure | Quantity | Order No. | Signature |
|---------|------------------|----------|-----------|--------------------|
| 20/5/26 | IV placement | ① | 7769 | <i>[Signature]</i> |
| 21/5/26 | PAC | ① | 8128 | |
| 21/5/26 | Catheterization | ① | 8128 | |
| 22/5/26 | IV placement | ① | 8363 | Sangai |
| | Cross check Done | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |
| | | | | |

ANY OTHER INFORMATION

→ B+ve Blood availability is Ayush
 → ARM Done at 4AM
 → Enema given at 6AM
 → Op file given to pt attendant * @ balala

Date: 20/5/26

Time: 8AM

Prepared By: Sakhia

| | | | |
|-------------|--------------|-------------------|--------------------|
| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
| | | | |

DH-00044927 IP25-00020542
 Mrs P. PRAVALLIKA
 1-06-1999 26 Y 10 M 29 D (F)
 Jr. HIMABINDU ANNAMRAJU



NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 22/5/26 Time: 9:30am

Origin: Rudra Height: 160 Weight: 73.6 BMI: 28.8 kg/m²

Food Allergies: —

Diagnosis: primi - 37 weeks - GDM on OHA for Doc
GDM on OHA

Medical History: —

Surgical History: —

Vegetarian Non-Vegetarian Vegan

Diet Advised: Balanced diet with optimal protein
oil free

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

Dietician's Signature: [Signature]

Name: Pravali G

Name: [Name]

Date & Time: 22/5/26 9:30

Date & Time: 22/5/26 9:30



NURSING SHIFT HAND OVER FORM

| | | | | | | | | | |
|--|---|---|---|---|--|--|--|--|--|
| SITUATION | Diagnosis: <i>primigravida @ 37wks GAC</i> <i>GDM on OHA for 3ol</i> | | | | 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 | <i>20/5/26</i> | <i>21/5/26</i> | <i>21/5/26</i> | <i>21/5/26</i> | | | | |
| | Shift | <i>N</i> | <i>M</i> | <i>E</i> | <i>N</i> | | | | |
| | Medical Condition (Any special condition to be noted): | <i>3ol</i> | <i>3ol</i> | <i>NVD</i> | <i>NVD</i> | | | | |
| Diet: | <i>S/D</i> | <i>D.D</i> | <i>N/D</i> | <i>N/D</i> | | | | | |
| ASSESSMENT | 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 type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Ventilation (RA, NP, NIV, VENTI): | <i>RA</i> | <i>RA</i> | <i>RA</i> | <i>RA</i> | | | | |
| | Tubes/Drains/Catheter: | <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 type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Vital Signs: | Temp: | <i>36°C</i> | <i>36°C</i> | <i>36°C</i> | <i>98.6</i> | | | |
| | | Res: | <i>20</i> | <i>20</i> | <i>22</i> | <i>20</i> | | | |
| | | SpO ₂ : | <i>100%</i> | <i>100%</i> | <i>100%</i> | <i>99%</i> | | | |
| | | Pulse: | <i>88</i> | <i>99</i> | <i>99</i> | <i>78</i> | | | |
| | | BP: | <i>116/69</i> | <i>119/78</i> | <i>112/65</i> | <i>110/70</i> | | | |
| | | LOC: | <i>conscious</i> | <i>conscious</i> | <i>conscious</i> | <i>conscious</i> | | | |
| | | Fall Risk Score: | <i>0/10</i> | <i>0/10</i> | <i>0/10</i> | <i>0/10</i> | | | |
| | | Pain Score: | <i>0/10</i> | <i>0/10</i> | <i>0/10</i> | <i>0/10</i> | | | |
| | Skin Integrity | <i>Good</i> | <i>Good</i> | <i>Good</i> | <i>good</i> | | | | |
| 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 type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Physiotherapy: | | | | | | | | |
| | 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 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 | |
| | Special Diet: | <i>S/D</i> | <i>D.D</i> | <i>N/D</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 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 | |
| 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 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 | | |
| 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 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 | | |
| ADL (Dependent / Non Dependent): | <i>Dependent</i> | <i>Depend</i> | <i>Dependent</i> | <i>Dependent</i> | | | | | |
| Post Operative Procedure Special Orders: | | | <i>Radiation</i> | | | | | | |
| Handed Over By Name : | <i>Sadhika</i> | <i>Sri Mani</i> | <i>Govy</i> | <i>Lakshmi</i> | | | | | |
| Signature / ID : | <i>Sadhika</i> | <i>PM</i> | <i>AS</i> | <i>22/5/26</i> | | | | | |
| Date: | <i>20/5/26</i> | <i>21/5/26</i> | <i>21/5/26</i> | <i>22/5/26</i> | | | | | |
| Time: | <i>@ 8AM</i> | <i>@ 2pm</i> | <i>@ 2pm</i> | <i>8AM</i> | | | | | |
| Taken Over By Name : | <i>Scintika</i> | <i>Govy</i> | <i>Lakshmi</i> | | | | | | |
| Signature / ID : | <i>021859</i> | <i>AS</i> | <i>21/5/26</i> | | | | | | |
| Date: | <i>21/5/26</i> | <i>21/5/26</i> | <i>21/5/26</i> | | | | | | |
| Time: | <i>@ 8AM</i> | <i>2pm</i> | <i>8AM</i> | | | | | | |

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): | <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: 20/5/26 @ 7:10 PM

Baseline Information:

Admission From: ER OPD Admission Desk Others, specify

Primary Language: Telugu English Hindi Others, specify

Do you require an interpreter? Yes No if Yes specify

Source of Information: Patient Family Others, specify

Allergies: Yes No Medications Blood Transfusion Food Other:

If yes, identify

Chief Complaints: Doctor Notified on Admission: Yes No
 Name of the Doctor: Dr. Parvika
 Time Notified:

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

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

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

Obstetric History: G P L A

Previous LSCS:

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

Family History: No Abnormalities Detected

Heart Disease Hypertension Diabetes Stroke Seizures Kidney disease
 Liver disease Other

Vital Signs / Measurements: Temp: 36°C HR: 85 RR: 20
 BP: 116/68 Weight: 72.6 kg 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

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:

Orientation not given Reason:

Nurse Signature: Sachika

Nurse Name: Sachika

Date & Time: 20/5/26 @ 7:30 p.m.



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

for IOL

LMP: 4/6/26

EDD:

Corrected EDD: 1/6/26

GA: 37 weeks

Obstetric Formula: Primigravida

Menstrual History: Regular: Yes No

Obstetric History:

Obstetric Examination

G1 - P.P. Spontaneous Conception
Booked @ 32+6 weeks

Fundal Height:

Present Pregnancy Record: NT/FTS (N)

Ut. Activity: Relaxed Mild Mod Severe

TJFA (N)

Liquor: Adequate Oligo Poly

Fetal Echo (N)

PP: Cephalic Breech Others _____

LGA @ 32+6wks scan -> (N)

Head Fifths Palpable: _____

RISK FACTORS:

FHS: Normal Tachy Brady Absent

GDM on OHA

Per Speculum Examination

Draining: Present Absent Bleeding

Colour of Liquor: Clear Meconium Blood Stained

Vaginal Examination

Cervix: Long ^{1cm} Partially effaced Effaced

Os: Closed _____ Dilated 1-2cm

Height: 160 cm

Membranes: Present Absent

Weight: 73.6 kg

Liquor: Clear Meconium Blood Stained

Allergies: Nil

Breast: Normal Abnormal

Presenting Part: Vertex Breech Others

General Examination:

Consciousness: Pallor: .

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

Icterus: Edema:

Temp: PR: 86 bpm

Pelvis: Adequate Doubtful

BP: 110/60 mmHg DTR:

CVS: RS

Liver/Spleen: Urine Output:

DIAGNOSIS

Primigravida @ 37 weeks GA @ GDM on OHA
for IOL

Patient Sticker

| | |
|--|--|
| <p>Family History: -</p> | <p>Surgical History: Laser BL - 2023</p> |
| <p>Medical History: GDM on diet :: 33+5 weeks on OHA :: 35+5 weeks</p> | <p>Medication History: Now on T. Lylycomet SR 500mg AD</p> |
| <p>Plan of Care: Admitt Consent NST Pacis preparation IV access check blood availability CBP/PT/INR/APTT/CRBS W/f vitals/FHR/contⁿ/PCL NST 4th hourly CRBS 4th hourly T. misoprostol 25mg plv @ 12Am Inform SDS 1 2</p> | <p>Investigations: BCT - <u>B+ve</u> Serology - NR <u>USG (11/5/26)</u> SLJUG 35+5 weeks Cephalic Placenta A/H AFI - 14.2cm EFW - 2922 gm (68.1) AC - 65.1 Dopplers^(M) CRBS @ 7:30pm - 95 mg/dl</p> |

Doctor Name: Dr. P. P. ...
Signature: [Signature]
Date & Time: 20/5/26 @ 7 pm

Consultant Name: Dr. Himabindu
Signature: [Signature]
Date & Time: 20/5/26 @ 7 pm



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------------------|--|---|
| <u>21/5/26</u> 12 AM | Vitals stable PLA - ut FT Relaxed FHR ⊕ 140 bpm plv - 2 cm dilated Cx 1 cm long memb ⊕ sm 1-2 NST (R) CRBS - 92 mg/dl | R ₀ (M) vitals / FHR / count wlf pol T. misoprostol 25mcg plv kept NST 4th hly CRBS 4th hly Infom 80s ↓ Dr. Praveen |
| <u>4 AM</u> | Vitals stable PLA - ut FT Irritable FHR ⊕ 140 bpm plv - 2 cm dilated 60% effaced ARM done clear liquor sm 1-2 NST (R) | R ₀ (M) vitals / FHR / count wlf pol Continue NST CRBS 4th hly Inf syntocin for augmentation Inf Tamoxifen 10mg IV (ATO) Exercises Infom 80s ↓ Dr. Praveen |

PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|-------------|--------------------|-------------------------|
| 7:45 AM | | |
| | w/ epidural | R ₀ |
| | pla - ut FT | w/ vitals / PRK contr |
| | 2-3 cm / 20" | w/ pol |
| | FHR ⊕ 146 bpm | Epidural analgesia |
| | plu - 3cm dilated | NST |
| | 70-1% effaced | Informs |
| | memb ⊖ | Exercises |
| | Clear liquor | |
| | Station 1-2 | |
| | NST ⊕ | |
| | | Anpoja |
| | | |
| | Us by Dr NIMABINDU | |
| | epidural | A ₁ |
| | ac juv | 11 MT |
| | vitals stable | 21 ut systolic & |
| | PA ut contr ⊕ | diastole |
| | FHR ⊕ | 31 Epidural counselling |
| | PR CX 70% effaced | 41 w/ contraction |
| | 5-6cm dilated | 51 w/ progress of labor |
| | PR ut-3 | 61 Exercises |
| | | 71 Anpoja |
| | | 260 |

FDH-00044927

IP25-00020542

Mrs P. PRAVALLIKA
21-06-1999 26 Y 10 M 29 D (F)
Dr. HIMABINDU ANNAMRAJU



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---------------|--|---|
| 21/5 1pm | <p style="text-align: center;"><u>PN0 - 0</u></p> <p style="text-align: center;">Acfar</p> <p style="text-align: center;">ajkl</p> <p>BP - 110/80mmHg</p> <p>PR - 84bpm</p> <p>SPO2 - 95% O2NA</p> <p>Ab UPW</p> <p>PR - NBS</p> | <p style="text-align: center;"><u>Adv</u></p> <p>- @ diet</p> <p>- plenty good fluids</p> <p>- dep as chart</p> <p>- wj bar</p> <p>- suction on / Pass PRS 10 2/5 on 21/5</p> <p>- perineal care</p> <p>- wjbs</p> <p>- tyros</p> |
| bath | | ndg |
| 21/5 4pm | <p style="text-align: center;"><u>PN0 - 0</u></p> <p style="text-align: center;">Acfar</p> <p style="text-align: center;">ajkl</p> <p>BP - 120/80mmHg</p> <p>PR - 92bpm</p> <p>SPO2 - 99% O2NA</p> <p>Ab - UPW</p> <p>PR - NBS</p> | <p style="text-align: center;"><u>Adv</u></p> <p>- @ diet</p> <p>- plenty good fluids</p> <p>- dep as chart</p> <p>- wj bar</p> <p>- Pass, PRS, PUB on 21/5</p> <p>- perineal care</p> <p>- GSR</p> <p>- wjbs</p> <p>- tyros</p> |
| Shift to room | | ndg |

PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|--|--|--|
| 21/5/26 8pm. | PND-0 G/C fair Afebrile PR-90bpm BP-122/73mmHg. P/A ut(⊙) well P/V - NAB | <u>Adv</u> 1) Diabetic diet 2) Plenty of oral fluids 3) Drugs as charted 4) Perineal care 5) EBF / Ambulation 6) No do FBS, PPBS, PUS on 22/5/26 7) Monitor vitals 8) Inform SOS |
| 22/5/26 6:30AM | <u>PND-1</u> G.C fair Afebrile BP=100/78mmHg PR=84bpm SpO2=100% @ RA P/A= Uterus P/V=NABSPV | <u>Adv</u> 1. Diabetic diet 2. Ambulation 3. plenty of oral fluids 4. EBF 2 nd baby. 5. Drugs as charted 6. ut SPV 7. FBS, PPBS, PUS 22/5/26 8. (⊙) vitals (uterus &) 9. perineal care |
| Baby m/s | | Handwritten signature |
| Handwritten notes: Baby m/s G FC m | | |
| FBS=90 | | |
| Sugar today | | |
| D/c today | | |

FDH-00044927 IP25-00020542
 Mrs P. PRAVALLIKA 26 Y 10 M 29 D (F)
 21-06-1999
 Dr. HIMABINDU ANNAMRAJU



RESULT SHEET

| | | | | | |
|---------------------|-----------|--|--|--|--|
| Date | 20/5/26 | | | | |
| Time | | | | | |
| Hb | 13.6 | | | | |
| PCV | 41.3 | | | | |
| RBC | 5.28 | | | | |
| WBC | 11.79 | | | | |
| N/L | | | | | |
| Platelets | 251 | | | | |
| CRP | | | | | |
| ESR | | | | | |
| PCT | | | | | |
| RBS | | | | | |
| Na | | | | | |
| K | | | | | |
| Cl | | | | | |
| Ca/Mg | | | | | |
| Phosphate | | | | | |
| Urea | | | | | |
| Creatinine | | | | | |
| ALP | | | | | |
| SGPT | | | | | |
| SGOT | | | | | |
| T.Bill/Conj | | | | | |
| T.Protein | | | | | |
| S.Albumin | | | | | |
| S.Globulin | | | | | |
| A/G Ratio | | | | | |
| Uric Acid | | | | | |
| S.Amylase | | | | | |
| Sr.Lipase | | | | | |
| Blood Lactate | | | | | |
| S.Cholesterol | | | | | |
| PT/INR | 15.4/0.98 | | | | |
| APTT | 30.7 | | | | |
| CSF Protein / Sugar | | | | | |
| Cells | | | | | |
| N/L | | | | | |

| | | | | | | |
|-----------------|-------|--|--|--|--|--|
| Date | | | | | | |
| Time | | | | | | |
| CUE - Alb | | | | | | |
| CUE - Sugar | | | | | | |
| CUE - Ketones | | | | | | |
| CUE - PUS Cells | | | | | | |
| CUE - RBC Cells | | | | | | |
| CUE | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Stool Pus Cell | | | | | | |
| OVA / Cyst | | | | | | |
| Occult Blood | | | | | | |
| | | | | | | |
| BGIT | B+ve | | | | | |
| | | | | | | |
| HIV | } NR. | | | | | |
| HCU | | | | | | |
| HBSAg | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: Shifted to:

| S.No | MEDICATION NAME (GENERIC NAME CAPITAL LETTERS) | DOSE (mg, mcg) | ROUTE (PO, NG, SC, IV) | FREQUENCY | LAST DOSE Date / Time | ON ADMISSION / SHIFTING |
|------|---|-------------------|---------------------------|-----------|--------------------------|---|
| 1 | T. Glycomet SR | 500mg | PO | OD | | <input checked="" type="checkbox"/> C <input type="checkbox"/> DC |
| 2 | | | | | | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 3 | | | | | | <input type="checkbox"/> C <input 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: *P. Praveena*

Date & Time: 20/5/26 @ 7pm

Nurse Name & Signature: *Sadhika Sadhika*

Date & Time: 20/5/26 @ 7pm





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)

| | | | | | | | | | | | | | | | | | | | |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : | | | | Date Time | | | | | | | | | | | | | | | |
| Dose | Route | Frequency | Start Date | ↓ | | | | | | | | | | | | | | | |
| Doctor's Signature | | Valid Period | Pharm. | | | | | | | | | | | | | | | | |
| Additional Instructions: | | | | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : | | | | Date Time | | | | | | | | | | | | | | | |
| Dose | Route | Frequency | Start Date | ↓ | | | | | | | | | | | | | | | |
| Doctor's Signature | | Valid Period | Pharm. | | | | | | | | | | | | | | | | |
| Additional Instructions: | | | | | | | | | | | | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : | | | | Date Time | | | | | | | | | | | | | | | |
| Dose | Route | Frequency | Start Date | ↓ | | | | | | | | | | | | | | | |
| Doctor's Signature | | Valid Period | Pharm. | | | | | | | | | | | | | | | | |
| Additional Instructions: | | | | | | | | | | | | | | | | | | | |

Signature
VERIFIED BY: Name



REGULAR PRESCRIPTIONS

Weight. 73.6kg. Ward. M.I.C.U.

| | | | | | | | | | | | | | | | | | | | | | |
|--|-------|-----------|------------|------------|------|------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : <u>1g CEFOTAXIME</u> | | | | Date | 21/5 | 22/5 | | | | | | | | | | | | | | | |
| Dose | Route | Frequency | Start Date | Time | | | | | | | | | | | | | | | | | |
| 1g | IV | BD | 21/5 | 6pm | 9pm | 6pm | | | | | | | | | | | | | | | |
| Name & Signature of the Doctor Starting the Drugs: | | | | <u>ndj</u> | | | | | | | | | | | | | | | | | |
| Additional Instructions: | | | | x 24 hrs | | | | | | | | | | | | | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | | | | | | | | | | | | | | | | | |
| DRUG : <u>2g METRONIDAZOLE</u> | | | | Date | 21/5 | 22/5 | | | | | | | | | | | | | | | |
| Dose | Route | Frequency | Start Date | Time | | | | | | | | | | | | | | | | | |
| 400mg | IV | TID | 21/5 | 12pm | 4pm | 8pm | | | | | | | | | | | | | | | |
| Name & Signature of the Doctor Starting the Drugs: | | | | <u>ndj</u> | | | | | | | | | | | | | | | | | |
| Additional Instructions: | | | | x 24 hrs. | | | | | | | | | | | | | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | | | | | | | | | | | | | | | | | |
| DRUG : <u>T. PARALDEANOL</u> | | | | Date | 21/5 | 22/5 | | | | | | | | | | | | | | | |
| Dose | Route | Frequency | Start Date | Time | | | | | | | | | | | | | | | | | |
| 1g | PO | TID | 21/5 | 6am | 9pm | 6pm | | | | | | | | | | | | | | | |
| Name & Signature of the Doctor Starting the Drugs: | | | | <u>ndj</u> | | | | | | | | | | | | | | | | | |
| Additional Instructions: | | | | x 24 hrs | | | | | | | | | | | | | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | | | | | | | | | | | | | | | | | |
| DRUG : <u>P DICLOFENAC</u> | | | | Date | 21/5 | 22/5 | | | | | | | | | | | | | | | |
| Dose | Route | Frequency | Start Date | Time | | | | | | | | | | | | | | | | | |
| 50mg | PO | BD | 21/5 | 8am | 8pm | 8pm | | | | | | | | | | | | | | | |
| Name & Signature of the Doctor Starting the Drugs: | | | | <u>ndj</u> | | | | | | | | | | | | | | | | | |
| Additional Instructions: | | | | x 24 hrs | | | | | | | | | | | | | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | | | | | | | | | | | | | | | | | |

FDH-00044927
 Mrs P. PRAVALLIKA IP25-00020542
 21-06-1999 26 Y 10 M 29 D (F)
 Dr. HIMABINDU ANNAMRAJU



Dept. 73.6.kgs Ward MICU

REGULAR PRESCRIPTIONS

Sheet No:

| | | | | | |
|--|-----------|------------|-------------|-------------|---------------------------------|
| DRUG : <u>SPYDUMAL</u> | | | | Date/Time | <u>21/5</u> |
| Dose | Route | Frequency | Start Dt. | | |
| <u>1ml</u> | <u>PO</u> | <u>NS</u> | <u>21/5</u> | | |
| Name & Signature of the Doctor Starting the Drugs: | | | | <u>10pm</u> | <u>Sangeeta Taneja</u> |
| Additional Instructions: | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | |
| DRUG : <u>BETADINE OINTMENT</u> | | | | Date/Time | <u>21/5</u> <u>22/5</u> |
| Dose | Route | Frequency | Start Dt. | | |
| | <u>LA</u> | <u>TID</u> | <u>21/5</u> | <u>6am</u> | <u>X</u> <u>Sangeeta Taneja</u> |
| Name & Signature of the Doctor Starting the Drugs: | | | | <u>2pm</u> | <u>5pm</u> |
| Additional Instructions: | | | | <u>10pm</u> | <u>Sangeeta Taneja</u> |
| Daily Doctor's Endorsement by a Sign | | | | | |
| DRUG : <u>BETADINE SOLUTION</u> | | | | Date/Time | <u>21/5</u> <u>22/5</u> |
| Dose | Route | Frequency | Start Dt. | | |
| | | <u>TID</u> | <u>21/5</u> | <u>6am</u> | <u>X</u> <u>Sangeeta Taneja</u> |
| Name & Signature of the Doctor Starting the Drugs: | | | | <u>2pm</u> | <u>5pm</u> |
| Additional Instructions: | | | | <u>10pm</u> | <u>Sangeeta Taneja</u> |
| Daily Doctor's Endorsement by a Sign | | | | | |
| DRUG : <u>SPY PANDOPRANOL</u> | | | | Date/Time | <u>20/5</u> |
| Dose | Route | Frequency | Start Dt. | | |
| <u>400</u> | <u>IV</u> | <u>OD</u> | <u>21/5</u> | <u>6am</u> | <u>Sangeeta Taneja</u> |
| Name & Signature of the Doctor Starting the Drugs: | | | | | |
| Additional Instructions: | | | | | |
| Daily Doctor's Endorsement by a Sign | | | | | |

Signature
VERIFIED BY : Name

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

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

Signature
Name

DRUG :

Dose Route Frequency Start Dt.

Date
Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose Route Frequency Start Dt.

Date
Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose Route Frequency Start Dt.

Date
Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose Route Frequency Start Dt.

Date
Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

(P.T.O.)

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

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

STAT / ONCE ONLY DRUGS

| Date | Time | Medication | Dosage & Other Instructions | Route | Signature | Nurses |
|---------|----------|-----------------|-----------------------------|-------|-------------|--------------------|
| 21/5/26 | 12 AM | T. misoprostol | 25 mcg | PV | [Signature] | Sadhvi |
| 21/5/26 | 4 AM | Inj Cefotaxime | 1gm | IV | [Signature] | Sadhvi |
| 21/5 | 11:51 AM | Inj SYNDOCON | 100 | IM | [Signature] | Mary Catherine |
| 21/5 | 11:54 AM | Inj TRAMEXA | 1g | IV | [Signature] | Mary Catherine |
| 21/5 | 12:10 PM | T. misoprostol | 600ug | PR | [Signature] | Mary Sandra |
| 21/5 | 12:10 PM | SUMAMEN | 10g | PR | [Signature] | Mary Catherine |
| 21/5/26 | 12:30 PM | Inj PARACETOMOL | 1g | CV | [Signature] | Sonia Christine |
| | | | | | | |
| | | | | | | |

VERIFIED BY: Name Signature

I.V. FLUIDS CHART

Weight: 73.6 kg, Ward: M.I.C.U.

| 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 |
|------|-------|---|-------|--------------------|----------------|---------------|---------------------|----------------|---------------|
| 2/15 | 4 AM | Inf Systain 10 J4 in 10RL | Iv | 6ml/hr | [Signature] | [Signature] | 2/15/20 | | [Signature] |
| 2/15 | 10 AM | 10RL | Iv | 100 ml | | [Signature] | 2/15 | | [Signature] |
| | | | | | | | | | |
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| | | | | | | | | | |

VERIFIED BY: Name Signature

**Obstetrics and Gynaecology
Early Warning Signs**

**Complete a Full
Set of MEOWS
Observations**

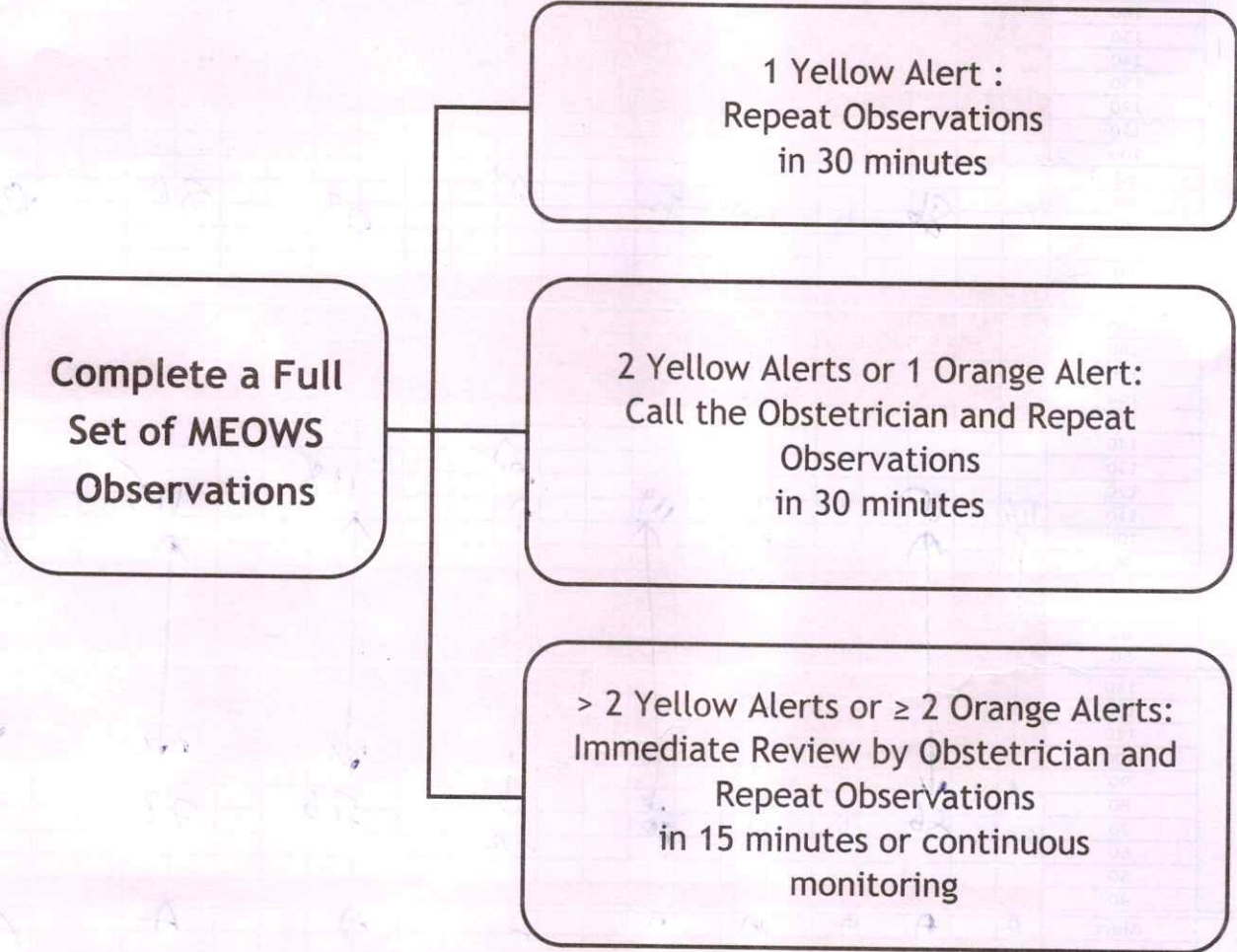
**1 Yellow Alert :
Repeat Observations
in 30 minutes**

**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)

20/5/26



FLUID CHART

Sheet No. : (1)

- 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 | | | | | | | | | | | | |
| | 09:00 am | | | | | | | | | | | | |
| | 10:00 am | | | | | | | | | | | | |
| | 11:00 am | | | | | | | | | | | | |
| | 12:00 pm | | | | | | | | | | | | |
| | 01:00 pm | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| | 02:00 pm | | | | | | | | | | | | |
| | 03:00 pm | | | | | | | | | | | | |
| | 04:00 pm | | | | | | | | | | | | |
| | 05:00 pm | | | | | | | | | | | | |
| | 06:00 pm | | | | | | | | | | | | |
| | 07:00 pm | | | | | | | | | | | | |
| Total Intake : | | | | | | Total Output : | | | | | | | |
| | 08:00 pm | | H ₂ O 100ml | | | | | | | ✓ | 0 | | } |
| | 09:00 pm | | | | | | | | | | 0 | | |
| | 10:00 pm | | H ₂ O 200ml | | | | | | | ✓ | 0 | | |
| | 11:00 pm | | | | | | | | | | 0 | | |
| | 12:00 am | | H ₂ O 200ml | | | | | | | ✓ | 0 | | |
| | 01:00 am | | | | | | | | | | 0 | | |
| Total Intake : 500ml | | | | | | Total Output : 0-3 | | | | | | | |
| | 02:00 am | | | | | | | | | ✓ | 0 | | } |
| | 03:00 am | | H ₂ O 200ml | | | | | | | | 0 | | |
| | 04:00 am | | | | | | | | | | 0 | | |
| | 05:00 am | | H ₂ O 100ml | | | | | | | ✓ | 0 | | |
| | 06:00 am | | | | | | | | | | 0 | | |
| | 07:00 am | R/L | H ₂ O 100ml | 100ml | | | | | | ✓ | 0 | | |
| Total Intake : 400ml | | | | | | Total Output : 0-3 | | | | | | | |

Total 24 hrs. Intake 900ml

Total 24 hrs. Output 0-6 M-1

FDH-00044927

IP25-00020542

Mrs P. PRAVALLIKA

21-06-1999

26 Y 10 M 29 D (F)

Dr. HIMABINDU ANNAMRAJU



21/5/26



FLUID CHART

Sheet No. : A

- 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 | NG | NG | Diarrhoea | Vomit | Drainage | Urine | | |
| 21/5/26 | 08:00 am | RL H ₂ O | 100ml | 100ml | 100ml | - | - | - | - | 100ml | 0 | } |
| | 09:00 am | RL H ₂ O | 100ml | 100ml | 100ml | - | - | - | - | 0 | 0 | |
| | 10:00 am | RL H ₂ O | 100ml | 100ml | 100ml | - | - | - | - | 0 | 0 | |
| | 11:00 am | RL H ₂ O | 100ml | 100ml | 100ml | - | - | - | - | 0 | 0 | |
| | 12:00 pm | RL H ₂ O | 100ml | 100ml | 100ml | - | - | - | - | 0 | 0 | |
| | 01:00 pm | RL H ₂ O | 100ml | 100ml | 100ml | - | - | - | - | 0 | 0 | |

Total Intake : 600ml

Total Output : U-1 100ml emptied.

| | | | | | | | | | | | |
|----------|------------------|-------|---|---|---|-----|---|---|---|---|---|
| 02:00 pm | H ₂ O | 100ml | - | - | - | no | - | - | - | 0 | } |
| 03:00 pm | H ₂ O | 100ml | - | - | - | - | - | - | 0 | 0 | |
| 04:00 pm | H ₂ O | 100ml | - | - | - | - | - | - | 0 | 0 | |
| 05:00 pm | H ₂ O | 100ml | - | - | - | - | - | - | 0 | 0 | |
| 06:00 pm | H ₂ O | 200ml | - | - | - | - | - | - | 0 | 0 | |
| 07:00 pm | H ₂ O | 200ml | - | - | - | no. | - | - | 0 | 0 | |

Total Intake : 500ml

Total Output : U= 2 gm=0

| | | | | | | | | | | | |
|----------|------------------|-------|----|----|----|----|----|----|----|---|---|
| 08:00 pm | H ₂ O | 100ml | no | no | no | no | no | no | no | 0 | } |
| 09:00 pm | H ₂ O | 100ml | no | no | no | no | no | no | 0 | 0 | |
| 10:00 pm | H ₂ O | 100ml | no | no | no | no | no | no | 0 | 0 | |
| 11:00 pm | H ₂ O | 100ml | no | no | no | no | no | no | 0 | 0 | |
| 12:00 am | H ₂ O | 100ml | no | no | no | no | no | no | 0 | 0 | |
| 01:00 am | H ₂ O | 200ml | no | no | no | no | no | no | 0 | 0 | |

Total Intake : 400ml

Total Output : U-1 m-

| | | | | | | | | | | | |
|----------|------------------|-------|----|----|----|----|----|----|----|---|---|
| 02:00 am | H ₂ O | 200ml | no | no | no | no | no | no | no | 0 | } |
| 03:00 am | H ₂ O | 200ml | no | no | no | no | no | no | 0 | 0 | |
| 04:00 am | H ₂ O | 200ml | no | no | no | no | no | no | 0 | 0 | |
| 05:00 am | H ₂ O | 200ml | no | no | no | no | no | no | 0 | 0 | |
| 06:00 am | H ₂ O | 200ml | no | no | no | no | no | no | 0 | 0 | |
| 07:00 am | H ₂ O | 200ml | no | no | no | no | no | no | 0 | 0 | |

Total Intake : 600ml

Total Output : U-2 m-1

Total 24 hrs. Intake 2600ml

Total 24 hrs. Output U-6 m-0

Department of Anaesthesiology



PF FDH-00044927 IP25-00020542
 Mrs P. PRAVALLIKA
 21-06-1999 26 Y 10 M 29 D (F)
 Dr. HIMABINDU ANNAMRAJU

TION

Name: Age: Sex: UHID.No :

Date: Time: Proposed Operation: Labour Spinal

Diagnosis:

B.P / CRT: 135/81 H.R: Weight: ASA Physical Status: 1 2 3 4 5

Laboratory Data:

| | | | | |
|------------------------|------------------|-------------------|--------------------|---------------------|
| Hgb: <u>13.6</u> | Glucose: | Protein: | HIV: | X-Ray: |
| PCV: | Urea: | Alb: | HBS Ag: | ECG: |
| WBC: | Creat: | Total Bill: | HCV: | 2D Echo: |
| Plate: <u>2,51,000</u> | Na: | Dir. Bill: | Blood group: | Stress/Anglo: |
| PT: <u>15-6</u> | K: | LDH: | T3 | Other: |
| PTT: | Ca++: | Alk phos: | T4 | |
| INR: <u>0.98</u> | Mg++: | Amylase: | TSH | |
| Cl-: | SGOT/SGPT: | | | |

Allergies: nil

Medical History: CVS:

RESP: Diabetes:

CNS: K/c/o GDM : 35wks on ky

Renal:

Hepatic / GE: Physical Activity: Active

Others:

Past Anaesthetic History: LASIX 2024

Physical Exam:

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

Lungs:

Heart: normal

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

Pre-Operative Instructions:

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

Signature: Ashy Name: Dr. ASHWARYA

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: 21/5/26 Time: 9 AM Procedure done by Dr. ASHWARYA

CSE / Spinal / Epidural (Epidural) Position: Sitting Space: L3-L4 Technique (LOR/LOS) (LOS)

Depth: 5cm Catheter at Skin: 9cm Attempts: 1

Parasthesia : Yes/No if yes details :

Solution Composition : 0.1% Bupivacaine + Emergenol Pentanyl

Any other issues :

a) Catheter @ 10 cms -> intravascular ; pulled out to 9cms.

b)

| Time | Infusion Rate (ml/hr) | Bolus (ml) | Level | | Maternal | | FHR | Comments |
|----------------|-----------------------|--------------------------------|-----------|-----------|---------------|-----------|--------------|----------|
| | | | Left | Right | BP | Pulse | | |
| <u>9:05 AM</u> | | <u>8ml of 0.8% bupivacaine</u> | | | <u>127/73</u> | <u>88</u> | <u>130 L</u> | |
| <u>9:15 AM</u> | <u>8 ml/hr</u> | | <u>T8</u> | <u>T8</u> | <u>118/68</u> | <u>72</u> | <u>128 L</u> | |
| | | | | | | | | |
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| | | | | | | | | |

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

Catheter Removed by and Tip Inspected : Dr. Srinivas

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :

CONSENT FOR SPECIAL PROCEDURES



Patient Name : PRAVALIKA Gender: Male Female

UHID No : FDH-44927 Department : Date : 21/5/26

I Pravallika S/D/W/O

Here by give consent for procedure of : labour spinal

The doctors have clearly explained to me that the procedure has following possible complications:
PDPH, patchy block, itching, shivering

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :
IV opioids, Entonox

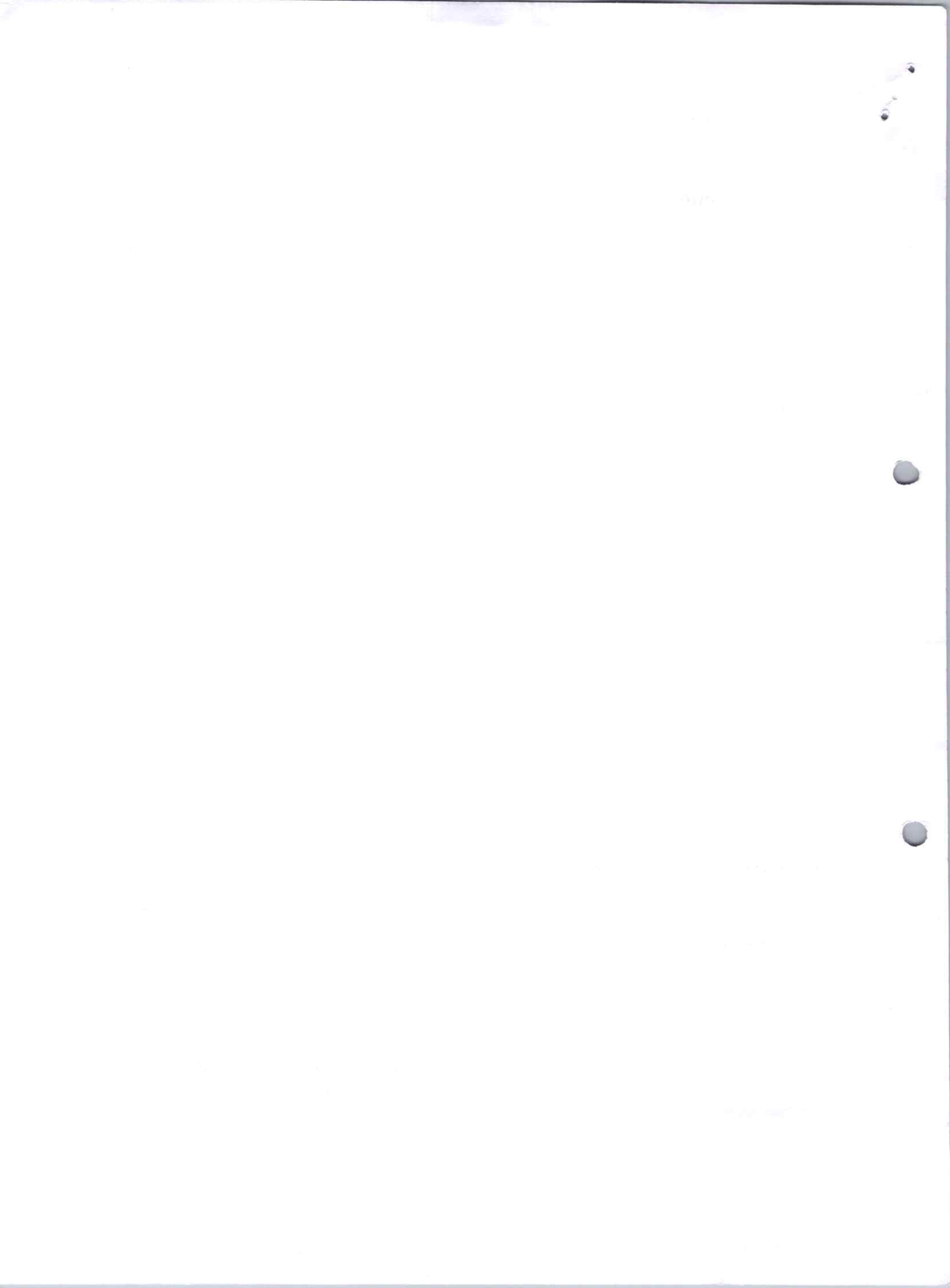
I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. ASHWARYA

Patient / Patient Attendant :
Signature : P. Peral
Name : PRAVALIKA
Relationship with Patient: Self
Date & Time : 21/5/26; 8:30 AM

Witness :
Signature : P. Krishnaveni
Name : KRISHNAVENI
Date & Time : 21/5/26; 8:30 AM

Doctor (who is taking the consent) :
Signature : Ashw
Name : Dr. ASHWARYA
Date & Time : 21/5/26; 8:30 AM



Labour Record

LABOUR

Labour : Spont IOL-PGE1 E2 Others

Indications for IOL-Accel : None Oxytocin

Memb. Repture Type : SRM PROM ARM

Presentation : Vertex Breech Others

INTRA PARTUM COMPLICATIONS

Maternal : None Pyrexia HTN Others

Liquor : Adequate Oligo Poly Clear

Blood Meconium Cord :

Shoulder Dystocia : Yes No

DELIVERY DETAILS

Anesthesia : None Epidural

Non-epi : Local Spinal General

Del. Type : SVD Asst. Breech Twins

AVD : Outlet Low Forceps Ventouse

Trail of Forceps

Indications :

Application, Locking & Traction :

Duration of Instrumentation :

No. of Pulls :

Catheterised : Yes No

Type : Foleys Plain

Perineum : Intact Episiotomy Tear

Suture Material Used : *Vicryl no 2*

STAGE III

Placenta : Normal Abnormal RP Clots

CCT Retained MRP

PPH : Atonic Traumatic None

Lacerations :

Cervical :

Perineal : *Episiotomy sutured*

Prophylaxis : Syntocinon Prostin

Blood Loss : *500ml*

Blood Transfusion : *-*

Other Details (if any) : *-*

Rectal Examination : *rectal mucosa intact*

DURATION OF LABOUR

1st Stage :

2nd Stage : *30 minutes*

3rd Stage : *5 minutes*

Duration of Active Pushing : *30 minutes*

No. of VES : *5*

BABY DETAILS

Gender : *male*

Weight : *2.710 kg*

APGAR : *8/10, 9/10*

Date and Time Delivery : *21/5/26, 11:50 AM*

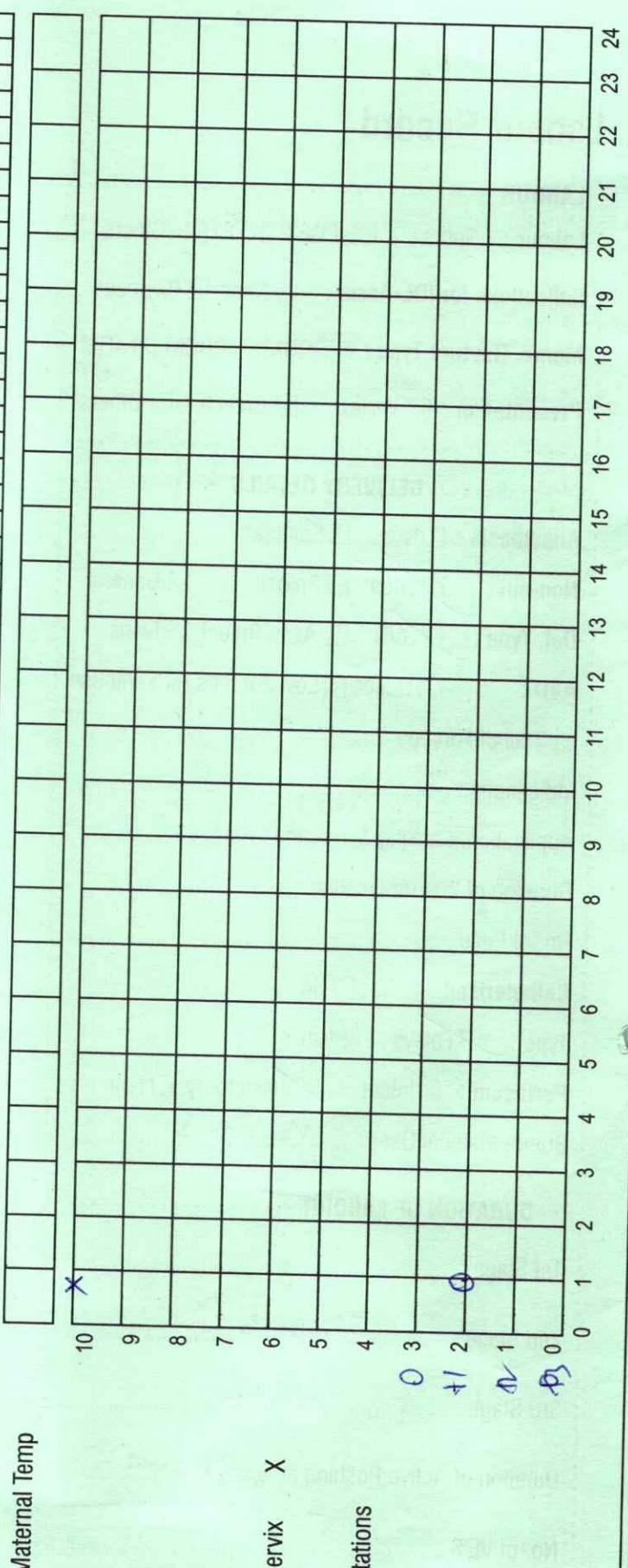
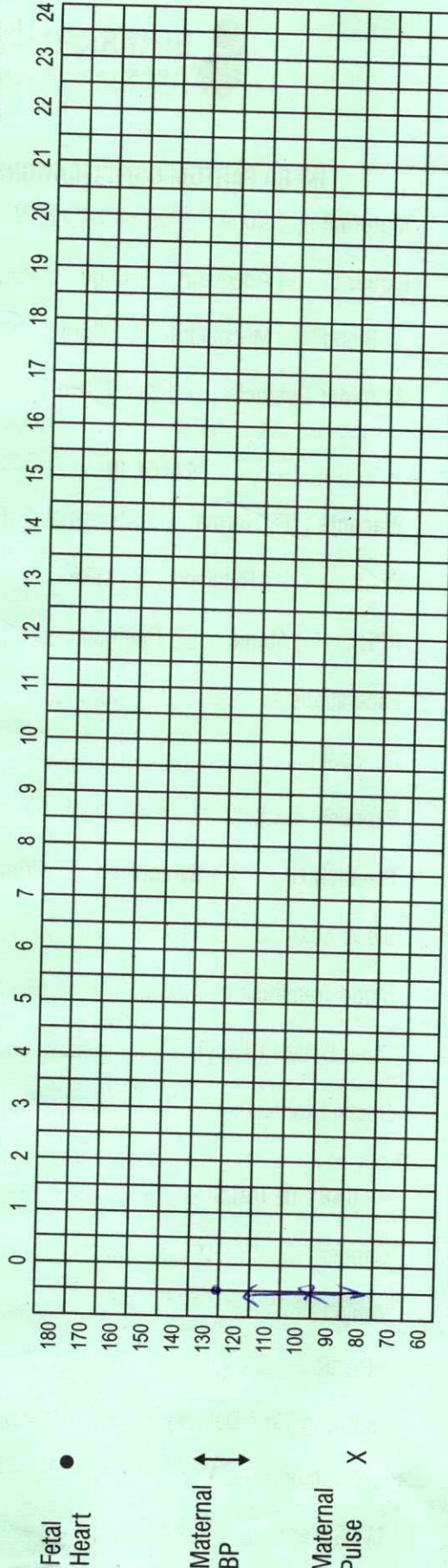
LW Doctor : *Dr. Kumaradine, Dr. Vidy*

LW Sister : *Mani*

PARTOGRAPH

Name : Ms Banalu Obstetric Formula : 3-0-0-0 Blood Group Type :

Memb. Returned : SROM PROM ARM Risk Factors : C.M.O.M.O.N



Fetal Heart ●

Maternal BP ↔

Maternal Pulse X

Maternal Temp

Cervix X

Stations

RECORD OF LABOUR

Maternal Condition :

Fetal Condition :

Progress of Labour :

Management :

Time : Signature : *[Signature]*

*nikshak
spekshak*
Cejully dull, july efford
of RL, contractions, 6/24/00

Maternal Condition :

Fetal Condition :

Progress of Labour :

Management :

Time : Signature :

Maternal Condition :

Fetal Condition :

Progress of Labour :

Management :

Time : Signature :

Maternal Condition :

Fetal Condition :

Progress of Labour :

Management :

Time : Signature :

Maternal Condition :

Fetal Condition :

Progress of Labour :

Management :

Time : Signature :

NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

| Patient Name: <i>MRS. L. P. D. DILLI</i> | | Age: <i>35</i> | Gender: <i>F</i> |
|---|-------------------------------------|---------------------------------------|--|
| UHID No: <i>10000000000000000000</i> | | IP No: <i>005000000000000000</i> | Date: <i>25/06/2024</i> Time: <i>9:37 AM</i> |
| Diagnosis: <i>POSTNATAL DEPRESSION</i> | | | |
| PRESCRIPTION DETAILS (Tick only one of the following) | | | |
| S.No | Drug Name | Dosage | Remarks |
| 1. | Fentanyl Citrate Inj. 50mcg/ML | <i>10mcg</i> | |
| 2. | Morphine Sulphate Inj. 15mg/ML | | |
| 3. | Remifentanyl Hydrochloride Inj. 2MG | | |
| 4. | Remifentanyl Hydrochloride inj. 1MG | | |
| Doctor Name: <i>A. S. Kulkarni</i> | | Doctor Registration No: <i>358004</i> | |
| Signature: <i>A. S. Kulkarni</i> | | | |

NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

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

IP Registration No: *10050000000000000000* Date: *25/06/2024*

Aadhaar No. of the Patient (Optional):

| 1. | Name : <i>MRS. L. P. D. DILLI</i> | Remarks | | |
|------|---|----------|--|-----------------|
| 2. | Complete postal address (with contact number, if any) | | | |
| 3. | Brief description of the illness | | | |
| 4. | Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded) | | | |
| 5. | Details of essential Narcotic drug dispensed | | | |
| Date | Name of the Essential Narcotic Drugs | Quantity | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| | | | | |
| | | | | |

Dispensed by (Name & ID No.): Signature: *[Signature]*

Received by (Name & ID No.): *S. S. Kulkarni* Signature: *[Signature]*

Time: *9:42 AM*



NARCOTIC PRESCRIPTION FORM
 (MEDICAL RECORD)

| Patient Name: | | Age: | | Gender: | |
|---|------------------------------------|--------------------------|---------|---------|--|
| IP No.: | | Date: | | Time: | |
| PRESCRIPTION DETAILS (Tick only one of the following) | | | | | |
| S.No. | Drug Name | Dosage | Remarks | | |
| 1 | Fentanyl Citrate Inj 50mcg/ml | | | | |
| 2 | Morphine Sulfate Inj 15mg/ml | | | | |
| 3 | Remifentanyl hydrochloride Inj 2MG | | | | |
| 4 | Remifentanyl hydrochloride Inj 1MG | | | | |
| Doctor Name: | | Doctor Registration No.: | | | |
| Signature: | | | | | |

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

IP Registration No. Date:


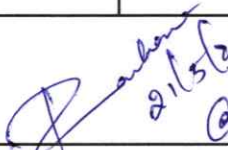
Address No. of the Patient (Optional):

| 1 | Name: | Remarks | | |
|------|---|----------|--|-----------------|
| 2 | Complete postal address (with contact number, if any) | | | |
| 3 | Brief description of the illness | | | |
| 4 | Whether registered with any other registered medical professional recognized medical institution (If yes, details of the institution) | | | |
| 5 | Details of essential Narcotic drug dispensed | | | |
| Date | Name of the Essential Narcotic Drugs | Quantity | Signature (Thumb impression of the patient) Patient Attender | Remarks, if any |
| | | | | |
| | | | | |

Dispensed by (Name & ID No.) Signature:

Received by (Name & ID No.) Signature:

PATIENT TRANSFER FORM

| | | | |
|---|-------------------------|--|---|
| Patient Name & UHID No. FDH-00044927 IP25-00020542 Mrs P. PRAVALLIKA 21-06-1999 26 Y 10 M 29 D (F) Dr. HIMABINDU ANNAMRAJU  | | Date & Time of Admission 20/5/26 @ 7:10 PM | Date & Time of Transfer Order 21/5/26 @ 5 PM |
| | | Transfer Ordered by Dr. Swetha | Reason for Transfer observation |
| From Unit MICU | To Unit Ward | Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Number of Sheets in Clinical File | Number of Imaging Films | Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what ? | |
| Medications / Consumables / Surgicals / Hand over | | | |
| Sl.No. | Item Name | Quantity | |
| 1. | NA | | |
| 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 Sr. Goung | | Name of Person Ordered Transfer Dr. Swetha | |
| Patient & Clinical Records Received by :  21/5/26 @ 5:10 PM | | | |
| Date & Time of Patient Received : | | | |

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

ANTENATAL RECORD



Antenatal No. 7895/f026

Reg. No : FDH-00044927

Consultant : Dr. HB

PERSONAL DETAILS

Name : Mrs. P. Anavallika Age: 26y Date of Birth 21/6/1999 Education : _____
 Occupation : soft ware Phone No. : 9492676431 Mobile : _____
 Husband's Name _____ Age _____ Education : _____ Occupation: _____
 Address : Next Greenspace Prime block a flat 305 Puppal gudde mane kondur Hyderabad Telangana
 Mobile : 9492676431 E-mail Id : _____

IMPORTANT FEATURES

SUGGESTED MANAGEMENT

Porto.
 ADM
 ON OHA

Ryby
 Dr. Nand
 Krishna

Corrected EDD

EDD: 16/26
 [LMP - 4/16/26]

HISTORY

Year of Marriage : 7yrs Menstrual History : Previous Periods Regular c/m LMP 31/9/25 EDD _____ Corrected EDD 4/16/26
 Consanguinity : _____ Contraception : spont OBSTETRIC FORMULA _____
 Gravida 1 Para _____ Live _____ Abortions _____

OBSTETRIC HISTORY

| Sl No. | DATE OF DELIVERY | GA WEEKS | ANTENATAL DETAILS | MODE OF DELIVERY | BABY | WT | REMARKS |
|--------|------------------|----------|--|------------------|------|----|---------|
| | | | Primigravida - I Spont Conception Booked by @ 33 rd wks Hrudaya hospital @ Warangal Dr. Jyothi. | | | | |

Medical History : - Nil

Family History :

Surgical History : - Nil

Allergies :

INVESTIGATIONS

21/4/26

MATERNAL EVALUATION

Blood group & Rh : Wife **B⁺ve** Husband **ICT**

VDRL **-nr** HIV **-nr** HbSAg **-nr** TSH

GCT $\left\{ \begin{array}{l} 86 \\ 174 \\ 136 \end{array} \right.$

ROUTINE INVESTIGATIONS

HCV - nr

SPECIFIC INVESTIGATIONS

| Date | GA Weeks | Investigations | Report | Date | GA Weeks | Investigations | Report |
|-------------------------|----------|---------------------------------|--------|------|----------|----------------|--------|
| 16/10/25 | | 11/2/26 HB - 10.5 | | | | | |
| RBS - 89 | | H2A1C - 4.9 | | | | | |
| T. Bilirubin - 0.8 | | <u>21/4/26</u> | | | | | |
| ST cr - 0.8 | | HB - 12.3 | | | | | |
| B. Urea - 20 | | WBC - 11.83 | | | | | |
| BT - 1.55 ^{cm} | | PLT - 2.68 | | | | | |
| CT - 4.50 ^{cm} | | SH - 3.13 | | | | | |
| HB - 9.0 | | | | | | | |

Tetanus Toxoid : 1st dose

2nd dose

FETAL EVALUATION

ULTRASONOGRAPHY

| | | | | | | | | | | |
|----------------------------|--|------------------|------------|----|------|---------|-----------------|------|-------------|---------|
| 8/12/25 First Trimester | SLF 7 (10 th wk) fHR - 153 bpm / CRL - 87.4 mm / WT - 1.3 mg CXL - 3.4 | | | | | | | | | |
| 9/1/26 TIFFA | SLF 7 10 th wk / EFW - 283g - 25.1 / AC - 13.3 / CXL - 28.6 mm Placenta - anterior mid upper segment grade 1 | | | | | | | | | |
| | Date | GA Weeks | Indication | PP | Wt. | Centile | Growth Velocity | AFI | Placenta | Remarks |
| Growth scan | 3/6/26 | 23 rd | G3 | | 635 | 93% | AC - 18.66 | | f. Anterior | |
| | 21/6/26 | 32 nd | G2 | L | 2516 | 91% | AC - 78.1 | 17.6 | u-h | D - (2) |
| | 11/5/26 | 35 th | G3 | C | 2922 | 68% | AC - 65.1 | 11.2 | a-h | 2 - (2) |
| Others | | | | | | | | | | |

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

| DATE | GA / Weeks | TYPE OF TEST | INDICATION | REPORT |
|------|------------|--------------|------------|--------|
| | | | | |

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 : _____ Appgar score: _____

Postpartum Period : _____
