

BAH-00656248 IP5-00175938
Mrs SURAMYA KEDIA
04-03-1992 34 Y 4 M 1 D (F)
Dr. NIVEDITHA CHALMEDA



LBPAD445

BA26067167020

00656248



NINVD0840

BA26067167097

BAH-00656248



SURGERY DETAILS

Date : 5/7/26
Patient Name: Mrs. Suramya Kedia Date of Birth: 4/3/1992 Age:
Gender: F Ward: TB-11 UHID No.: BAH-00656248
Date of Surgery: 5/7/26 ☐ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery : Termination of pregnancy

Time in : 1 AM Time Out : 2 AM

NAME

AMOUNT

1. Surgeon	Dr. Sasi Kala	
2. Anaesthetist	Dr.	
3. Assistant Surgeon	Dr. Suramya	
4. OT Technician		
5. Circulating Nurse	Sr. Sindhu	
6. Assistant Nurse	Sr. Swarna	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9688340

Order by: Sr. Sindhu

ADMISSION SHEET

Registration Details :


Admission No : IP5-00175938 Admit Date : 03-Jul-2026 Admit Time : 05:55 PM UHID : BAH-00656248

Patient Details :

Patient Name	: Mrs SURAMYA KEDIA	Age	: 34 Y 3 M 29 D
Guardian	: Mr TIKKAVARAPU VIJAY REDDY	DOB	: 04-03-1992
Gender	: Female	Religion	:
Occupation	:	Marital Status	: Married
Address (H)	: H NO 54, ROAD NO 12 Banjara Hills Hyderabad Telangana INDIA 500034	Phone No	: 9654229010/ 9000555777
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : SUPER DELUXE Bed No : SDLX 328 Ward Name : 3F-ZONE C
 Room No : SDLX 328 Admission Type : First Visit

Contact Details :

Name	: Mr TIKKAVARAPU VIJAY REDDY	Relationship	: Husband
Contact Address	: H NO 54, ROAD NO 12 Banjara Hills Hyderabad Telangana INDIA 500034	Phone No	: 9654229010

Signature

Doctor Details :

Doctor Name	: Dr. NIVEDITHA CHALMEDA	Specialisation	: INTERNAL MEDICINE
Referral Doctor	: Self	Phone No	:
Co-Consultant	: Dr. SASIKALA KOLA		

Payment Details :

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

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ACTIVITY RECORD FOR BILLING

Name : _____

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
4/7/26	6 PM	336	BC	<i>[Signature]</i>

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
4/1/20	20 placement	01	9688341	Surpne

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

- c/o fever x 7 days (daily 1 episode)
- On & off vomiting
- Obstetric Formula:
- no decel, cough, loose stools
- no c/o rash, WOPV.
- Obstetric History:

- Travel history ⊕
 → Primi

Present Pregnancy Record:

- ML-2025; xcm
- Spontaneous conception.
- 8. hypothyroid on T. Thyrona

RISK FACTORS:

- NT Scan - Pred NT 3.2mm
 FIS = 1.694 (Intermediate risk)
- 18/4/26 - usg - left lobed sub
 serous - 3.5cm myoma.
- NIPT - low risk. [FF = 7.01%]
- CVS - GF Per - no aneuploidy
 wbs - awaited.

Height: cm

Weight: kg

Allergies: Allergic to Azithromycin

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: Conscious Pallor: } absent

Icterus: absent Edema: } absent

Temp: 101.5°F PR: 106bpm

BP: 94/58 [61] DTR: 4@

CVS: (1) RS 4@

Liver/Spleen: not palpable Urine Output: - (no)

DIAGNOSIS

Primi | 17 + 5 wks | (Subclinical) | 8. hypothyroid | 2 fibroid uteri.
 + fever + evaluation.

LMP: 1/3/26

EDD:

Corrected EDD: 6/12/26

GA: 17+5 wks

Menstrual History: Regular: ☒ Yes ☐ No

Obstetric Examination

Fundal Height: ut ~ 104

Ut. Activity: ☒ Relaxed ☐ Mild ☐ Mod ☐ Severe

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☐ Cephalic ☐ Breech Others _____

Head Fifts Palpable: _____

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

Not indicated

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Not indicated

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed _____ Dilated _____

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful



Family History: Mother - 1st degree hypothyroid Father - 1st degree HTN	Surgical History: → 2015 - endometrial & cervical polypectomy done → 2015-March - Parathyroid gland removal
Medical History: nil.	Medication History: See recent letter from
Plan of Care: <u>C/I/T: Dr Niveditha</u> - Admission. - Sand - LFT, Sr. Lactate, CRP, CRP, blood cultures - USG - abdomen (for gallstones) - Ty MONOCEF 2g IV BD 2g am sooty IV QID. - Monitor vitals 4th July FAS - TID. - Typhoid after reports.	Investigations: → AB positive. → Hb - NR. HbsAg - NR } 3/4/26 WCU - NR VDR - NR → 4/5/26. iPTH - 20 [n]. 1/7/26 → Urine culture - No growth ⇒ CRP = 21. Creat = 0.5. ⇒ LFT - AST = 122 ↑ ALT = 186 ↑ ⇒ Hb = 11.1 Tc = 11.8k. MT = 2.32L. ⇒ bile acids - 58.3 ↑. → Dengue NS + ag 42g M - negative. HAV IgG = 7.26 [positive].

Doctor Name: Dr. Senthil

Signature: Senthil

Date & Time: 3/7/20; 6:00 PM

Consultant Name: Dr. Sarikala/Dr. Niveditha

Signature: _____

Date & Time: _____

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/1/20		
9:30pm	Up/w Dr Niveditha Up ? SOB after Mannitol (Full dose) No Rash/itching Test dose (7:46pm) Gen/AF Vitals - BP - 95/53 (63) Temp - 97.4°F PB - 96 bpm SpO₂ - 96-97% on RA P/A - Vitals Relaxed HR checked on scan 138 bpm <u>Advice:</u> ✓ Nausea drops TID ✓ Monitor vitals/HR ✓ Inform SRS ✓ Continue same treatment ✓ Next Mannitol dose show IV (By Ch Deepika)	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/plw- Dr. Maithani / Nivedita	
	C/s/b- Dr. Deepika	
4/6/2022 7 AM	Primi / 1st 6 weeks / G. hypotensive / e fetal distress e fever/severe	
	C/c: / geiv	
	B-p - 100/64/72	
	P-R - 74	
	SpO ₂ - 100% on RA	1) Monitor vitals - 4ty
	Temp: 97.1°F	2) FHR - TID
	P/A: UF - 16-18cm relaxed	3) Drug as charted
	FHR ⊕	4) Soft diet & plenty of oral fluids
	(Not-clearly heard on scan)	5) Antibiotic
	- advise - USG abdomen (for fetal well-being) for viability (Doppler + AFI) - Dr. Sravathi	
	⊙ 9 AM	
	Limitations of scan has been explained to attend	
	True - Blood cultures sent	
	plan - CFT - tomorrow	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>4/7/26</u>	cls/B <u>Dr. C. Niveditha</u> . last episode of fever - 7pm yesterday passed - stool - minimal amount . ↳ feels better . o/e - PR - 86/min BP - 106/20 mm Hg . s/e WS: S, S⁺ U: B⁺, clean . <u>dobw</u> <u>LFT - tomorrow</u>	<u>81-</u> ✓ IVF - 10NS @ 100 ml/hr . 1 ORL ✓ Rest as per drug chart <i>[Signature]</i>

Date & Time	Progress Notes	Doctor's Order
12pm 4/7/20	C/S By Dr. Sani Kala Patient and attenders counseled about absent fetal Heart. Possible causes of miscarriage explained. Need to induce labour for fetal expulsion explained.	
	<u>Adv</u> 1. Tab Mifepristone 200mg (2) - at once 2. Tab PGE ₁ 200mg - P/O 4th hourly when pain starts (or) after 36 hours of Tab Mifepristone - whichever comes 3. Uterin 2-4 hourly 4. Enjoin of pain / bleeding P/O	
	<u>No</u> (Dr. MATHEW)	
	Noted by Latha @ 12PM	

Date & Time	Progress Notes	Doctor's Order
8:55pm	C/S / B Anon Anesthesia team primi / 17+6 weeks / G. hypothyroidism / Fibroid uterus / IUD Fever & Evaluation C/o pain O/E pt is on T. Mifepristone 200mg, T. PGE1 200mg.	<u>Adv.</u> • INT MORPHINE 4.5mg IV stat • INT PARACETAMOL 1gm IV • Monitor Vitals • Connect O₂ @ 5L/min with simple Face mask • Inform S.Os
9:30pm	<u>Case Reviewed</u> C/o pain <u>Adv</u> • INT MORPHINE 3mg IV stat send. PTINR, APTT	(DR SHILPA DR SHINY) SD SD

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/2026 1:53 AM	pt clo premature. encouraged bearing down.	
	MTP performed under aseptic conditions. products of conception were expelled completely. A male fetus of weighing <u>185 grams</u> at 1:35 AM and complete placenta of weighing <u>117g</u> infant membranes were delivered at 1:40 AM. uterus well contracted after procedure.	
	<u>O/F</u> Gr. fair Bp- 112/86 mmHg PR- 103 BPM SpO ₂ - 98% + RA Temp- 98.4° PlA- ut @ well Plv- BWNL	<u>Adv</u> ① N Diet. ② Drugs averted ③ Monitor vitals <u>and</u> <u>hwy</u> . ④ T. cabergolin 0.5mg ② tab Pol. stat. ⑤ NBM from 6:00 AM 5/7/2026 ⑥ Continue ny-monocet. ⑦ Inform SOS
	<u>Adv</u> shift to recovery room. → CBP @ 6 AM 5/7/2026 → RPOC scan by. Dr. Gowri → send for fetal autopsy → send for HPE placenta → send for placenta membrane culture sensitivity.	Dr. Divya

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26		
UAM	Pt - comfortable Pt clo - fever C - c - fair Temp - 100°F Ph - 101/min BP - 110/20 mmHg PIA - soft	Adv:- ① Regular diet ② Drugs as charted ③ Monitor vitals ④ Inform SOS hr (Dr. Lax)
5/7/26		
8AM	Pt - comfortable C - c - fair Temp - 98°F Ph - 98/min BP - 110/20 mmHg PIA - soft UE - NAB	Adv:- ① RPOC Scan Today ② Trace CBP ③ Regular diet ④ NBM ⑤ Drugs as charted ⑥ Monitor vitals w/ hr ⑦ Inform SOS hr (Dr. Lax)
Plan	Fetal Autopsy Placenta for HPE Placental membranes for c/s. Trace blood c/s	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/26 8:45 AM	ch/b Dr. C. Niveditha Pt. reviewed had 2 spikes of fever 10pm & 4 AM with abd. cramps	
	af - PR - 101/min BP - 100/60 mm Hg	
	af - CNS: BRT⁺ MS: BART, clear	
		af - ① Add T. Doxy 100mg / BD
	noted by Dr. Sona	M

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/11/2023	Fever spike 99.8°F Patient does not want IV medications - c/o Dr. Niveditha Counsellor Pts on phone. ✓ Stop IVF / IV PCM / IV PAN ✓ T. DOLO 650mg SOS ✓ Cont IV Monocet - ✓ Oral 3ltrs water 106/68(77)mmHg 98% RA 104bpm	Update @ 5:30pm Dr. Y. Suresh

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/2026 8pm	Pt comfortable PR: 90bpm BP: 85/55 (65) mm Hg SpO₂: 100% RA Temp: 96.6°F Pt Ambulating I/O charting	- plenty of oral fluids - Inform BP @ 9PM CBP, CRP, Sr lactate LFT, widal, Smear for Malaria, PT, aPTT, INR, 20 Blood c/s (5AM) Dr Y. Suresh
5/7/2026 10:30pm	96/64 (71) mm Hg 90bpm 99% RA 96.8°F H/O BP: 85/53 - 88/56. Counselling Pt & Attendees need for hydration / IV Antibiotics	✓ IVF @ 120ml/hr RL ✓ Cont IV Monocet. ✓ All as advised above Dr Y. Suresh noted by Suresh

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
8/7/2026 8 AM	No further fever spike (last 4 PM 5/7 99.8°F) Pt comfortable U✓ F✓ P/A: URW P/V: BWNL	
	PT: 14	- C-S-T
	INR: 1	
	APTT 31.85	
	Lactate 0.8	C/O/T Dr. Niveditha
	TB 0.7 < 0.4	R/w in person
	SGOT/SGPT 25/70	
	ACP 106	
	HB 40	
	CRP 162	
	Hb/Pit/TC: 8.9/2.62/14.82	
	Trace Blood cls	
		Dr. Y. Suresh
	Noted by Sis. Anika	

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RESULT SHEET

Date	3/7/26	5/7/26	6/7/2024		
Time	6.43pm	4am	5Am		
Hb	10.1	10.3	8.9		
PCV	30.3	30.7	27.4		
RBC	3.49	3.52	3.09		
WBC	11.85	20.54	14.82		
N/L	70.9/22.6	86.8/9.8			
Platelets	272	220	262		
CRP	24.0		162		
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP	182		106		
SGPT	164		70		
SGOT	78		25		
T.Bill/Conj	1.05/0.2		0.75/0.3		
T.Protein	6.0		4.8		
S.Albumin	3.1		2.3		
S.Globulin	2.9		2.5		
A/G Ratio	2.09		0.9		
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	14/1.0		14/1.0		
APTT	32		36		
CSF Protein / Sugar					
Cells- lactate			0.8		
N/L					



MEDICATION RECONCILIATION FORM

Drug Allergies: NEDA

☒ 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
	T. PAND.	40mg	PO	OD		☐ C ☒ DC
2	T. ZINCOVIT	1T	PO	OD		☐ C ☒ DC
3	SYP DUPHALAX	15ul	PO	OD		☐ C ☒ DC
4	T. THYRONORM	125mcg	PO	OD		☐ C ☒ DC
5	T. SUPORT		PO	OD		☐ C ☒ DC
6	T. CALCEMAR		PO	OD		☐ C ☒ DC
	T. FERRONORM		PO	OD		☐ C ☒ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Suthi, Suthi.

Date & Time: 3/7/26, 6:00pm

Nurse Name & Signature: Swapna

Date & Time: 3/7/26 6am



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Weight Ward BRF

Docu. No. : RCHBH /FRM / CLINICAL / 108

(P.T.O)

Sheet No: ①

REGULAR PRESCRIPTIONS

Weight

Ward B/P

DRUG : T. POLVITE				Date Time 4/7																
Dose 5mg	Route PO	Frequency OD	Start Dt. 3/7																	
Name & Signature of the Doctor Starting the Drugs: <i>U</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : T. VDIUV				Date Time 4/7	5/7	6/7														
Dose 300mg	Route PO	Frequency BD	Start Dt. 4/7	7AM	9AM	12PM	3PM	6PM												
Name & Signature of the Doctor Starting the Drugs: <i>U</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : T. DOXY				Date Time 5/7	6/7															
Dose 100mg	Route PO	Frequency BD	Start Dt. 5/7/26	2 AM	2 PM															
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Y. Suresh</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : T. PANTOP				Date Time 6/7	6/7															
Dose 40mg	Route BD	Frequency PO	Start Dt. 5/7/26	7PM	7PM															
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Y. Suresh</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

I.V. FLUIDS CHART

Weight. Ward.



Position of I.V. Fluid (in infusion, mention ml/hr = Mcg/kg/min. etc)		Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign	
3/2	9PM	Ringer Lactate	IV	100 ml/hr	A	Martha	3/2	Ge	Martha
3/2	4AM	Normal Saline	IV	100 ml/hr	A	Martha	3/2	Gi	Martha
4/2	6:30 PM	Ringer Lactate	IV	100 ml/hr	Bi	Lab	4/2	W	Lab
4/2	8:30 PM	RINGER LACTATE	IV	100ml hr	W	Scorpe	4/2	W	Scorpe
4/2	10:20 PM	RINGER LACTATE + OXYTOCIN 10 UNITS	IV	100ml hr	W	Scorpe	4/2	W	Scorpe
5/1/26	12AM	NORMAL SALINE	IV	100ml hr	W	Scorpe	5/1/26	W	Scorpe
5/2/26	6AM	RINGER LACTATE	IV	100ml hr	W	Scorpe	5/2/26	W	Scorpe
5/2	10PM	RINGER LACTATE	IV	120ml hr	W	Scorpe	5/2	W	Scorpe
6/2	3AM	RINGER LACTATE	IV	120ml hr	W	Scorpe	6/2	W	Scorpe



		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
		→ Tab Mefepain 200mg	stat	o3	single dose	
		→ Tab Cytotek 200µgms	patient experiences pain		stat when	
		→ 4 th July				
		→ Cap Tramadol	SOS			
04/07/26	8:00pm	INT PARACETAMOL	1gm	IV	hs	Swapne Sudhe
04/07/26	8:30pm	INT TRAMADOL	100mg	IV	hs	Swapne Sudhe
04/07/26	8:55pm	INT MORPHINE	4.5mg	IV	hs	Swapne Sudhe



DRUG CHART

Date of Admission: 3/7/20 Drug Allergies: Allergic to Azithromycin ☐ 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 : <u>Taj PARACETAMOL</u>				Date Time
Dose <u>500mg</u>	Route <u>PO</u>	Frequency <u>SOS</u>	Start Date <u>4/1/20</u>	
Doctor's Signature <u>[Signature]</u>		Valid Period	Pharm.	
Additional Instructions:				

*Stop Dr. Suresh . Y
5/7/20 4PM.*

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:				



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG : INJ. MONOCEF				Date Time	3/7	4H	5H	6H
Dose	Route	Frequency	Start Date					
2gm	IV	BD	3/7/26					
Name & Signature of the Doctor Starting the Drugs:				Dr. Suthi Suthi				
Additional Instructions:				after test dose. 9am 12pm 3pm 6pm 9pm				
Daily Doctor's Endorsement by a Sign								
DRUG : INJ PARACETAMOL				Date Time	3/7	4H		
Dose	Route	Frequency	Start Date					
500mg	IV	QID	3/7/26					
Name & Signature of the Doctor Starting the Drugs:				Dr. Suthi Suthi				
Additional Instructions:				6am 12pm 6pm 9pm Not given Not given Not given Not given				
Daily Doctor's Endorsement by a Sign				STOP Dr. Suthi				
DRUG : T. PANTOICAZOLE				Date Time				
Dose	Route	Frequency	Start Date					
400mg	PO	BD	3/7/26					
Name & Signature of the Doctor Starting the Drugs:				Dr. Suthi Suthi				
Additional Instructions:				stop				
Daily Doctor's Endorsement by a Sign								
DRUG : T. THYRONORM				Date Time	4/7			
Dose	Route	Frequency	Start Date					
120mg	PO	OD	3/8/26					
Name & Signature of the Doctor Starting the Drugs:				Dr. Suthi Suthi				
Additional Instructions:				stop				
Daily Doctor's Endorsement by a Sign								



Name: Suranya Kedia

Weight: kgs

Sheet No:

Docu. No. : RCHBH /FRM / CLINICAL / 136

BAH-00656248 IP5-00175938

Mrs SURAMYA KEDIA

04-03-1992 34 Y 3 M 29 D (F)

Dr. NIVEDITHA CHALMEDA



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part -

Patient's / Learner Language: English Patient / Learner Literacy: ☐ Read ☒ Write ☒ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☐ Yes ☒ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
3-7/26	6:00 AM	1, 2, 3, 4	Dx, Rx & Care Plan, pain management, wound care	PT, S	1	0	1	1		Sita
alt	8 PM	7	Infection Control measures	PTs	1	0	1	1		S
5/7/26	12:30 PM	9	High protein diet	PT	1	0	1	1		Saima

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)									
Learning Barriers: 1. No Learning Barriers 4. Language Barrier 7. Impaired Thought Process/Cognitive limitations 10. Financial Difficulties 13. Cultural/Religion Practice 2. Physical Impairment 5. Educational Level 8. Responsibilities at Home 11. Beliefs and Values 14. Others (Specify) 3. Emotional Barriers 6. Desire / Motivate to Learn 9. Cultural Differences 12. Impaired Vision/ or Hearing									
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed									
Mechanism/s to overcome barrier/s: 1. None 3. Reassurance & Support 5. Respect values & beliefs 7. Other, Specify 2. Obtain translator 4. Teach Family / Others 6. Respect Cultural / Religion Preference									
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review									

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Primi | 17+4 wks | E hypothyroid & fever & evaluation.

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
3/7/26	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fever	Marked & baby ratty.	Observation	Smith	☐ Nursing ☐ Others:
all up	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	fear and anxiety	→ to reduce fear and anxiety	→ Provided psychological support	Ly	☐ Medical ☐ Others:
5/7/26 12:30 pm	☐ Medical ☐ Nursing ☒ Others: dietitian	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	primi 17 th weeks	Normal diet	Normal high protein diet	scrie	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☒ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

IP5-00175938

04-03-1992 34 Y 3 M 29 D

34 Y 3 M 29 D

(F)

Dr. NIVEDITHA CHALMEDA


$$\frac{3}{2}$$


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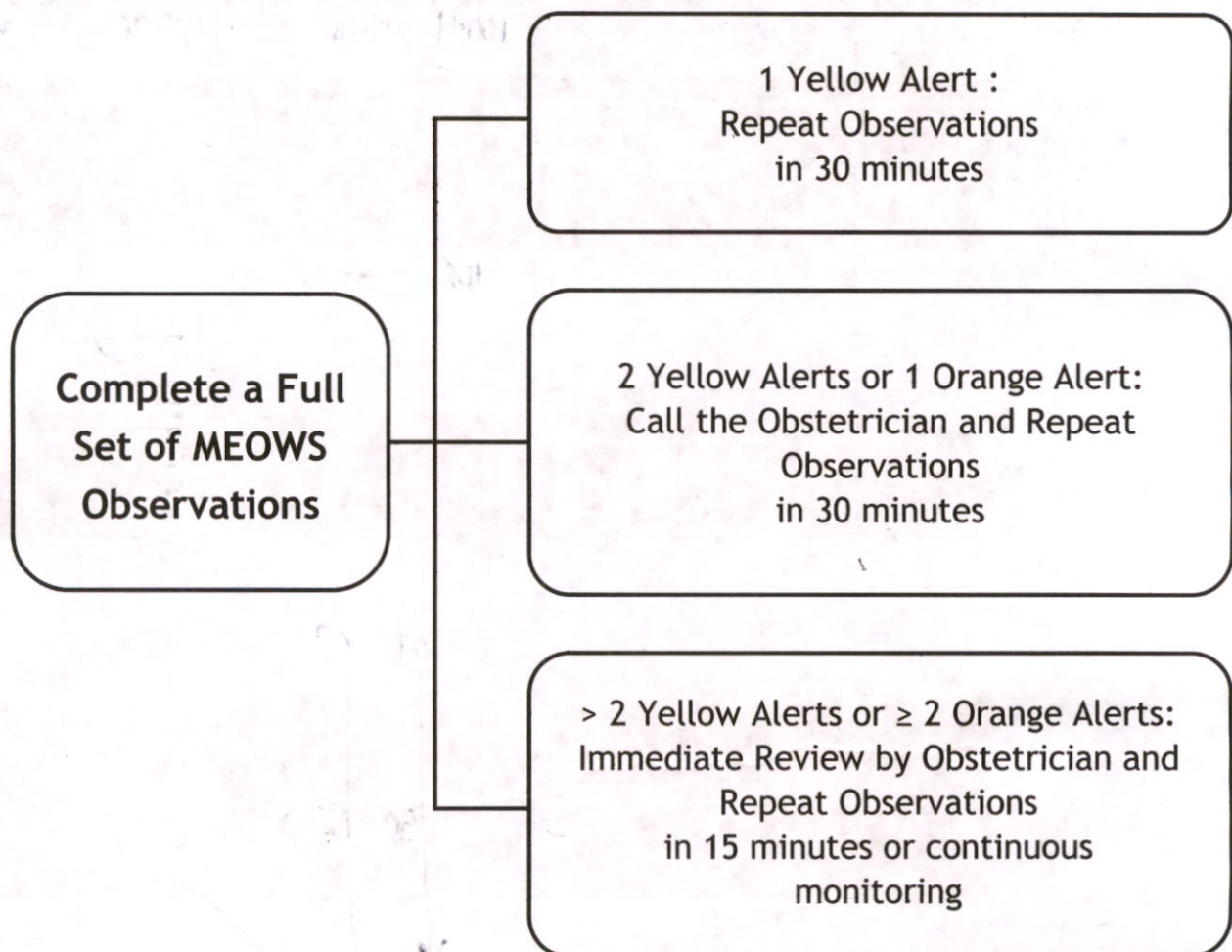


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TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



(F)

4/7/28

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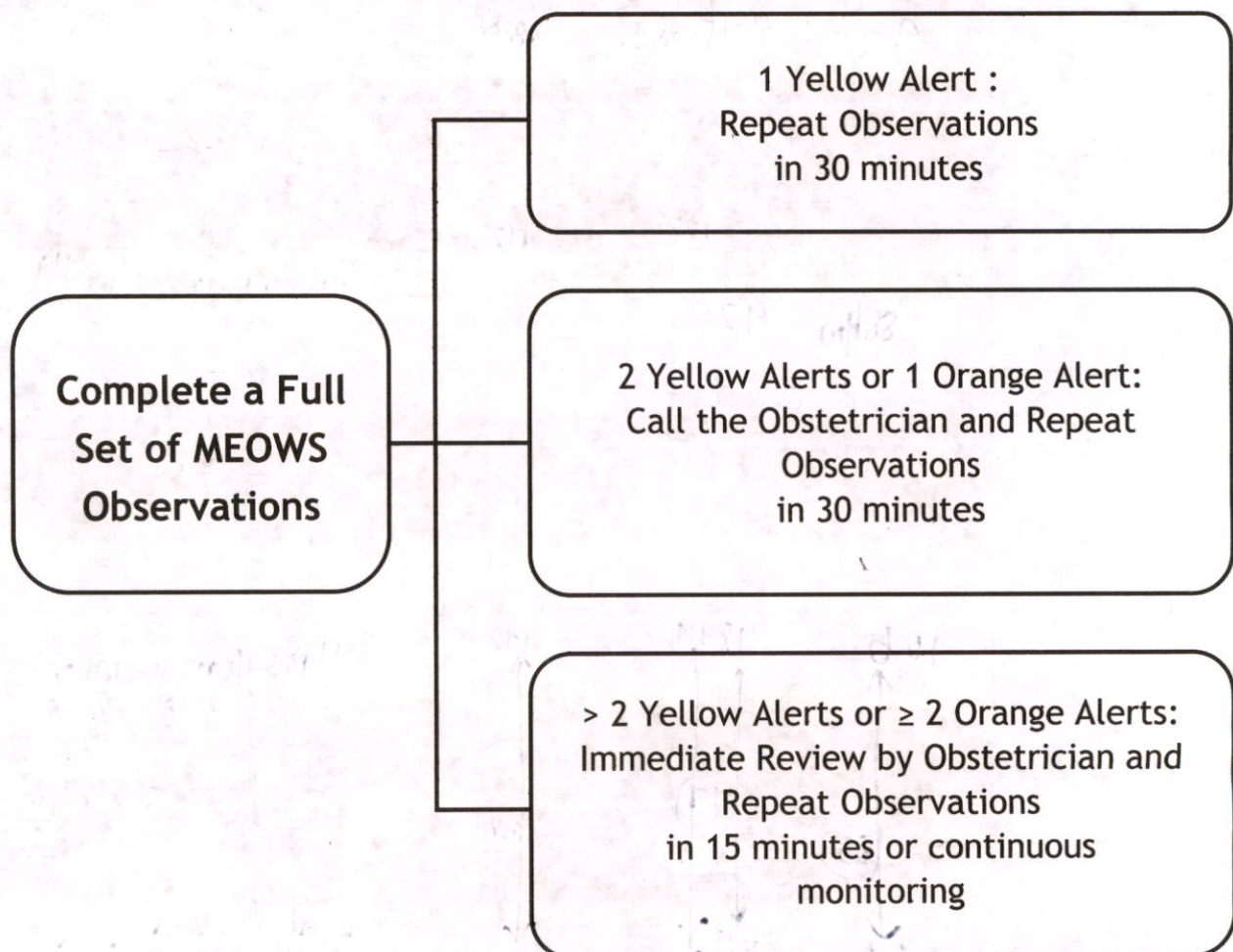
Your Right to a Safe Delivery

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT

TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

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IP5-00175938

Mrs SURAMYA KEDIA

04-03-1992

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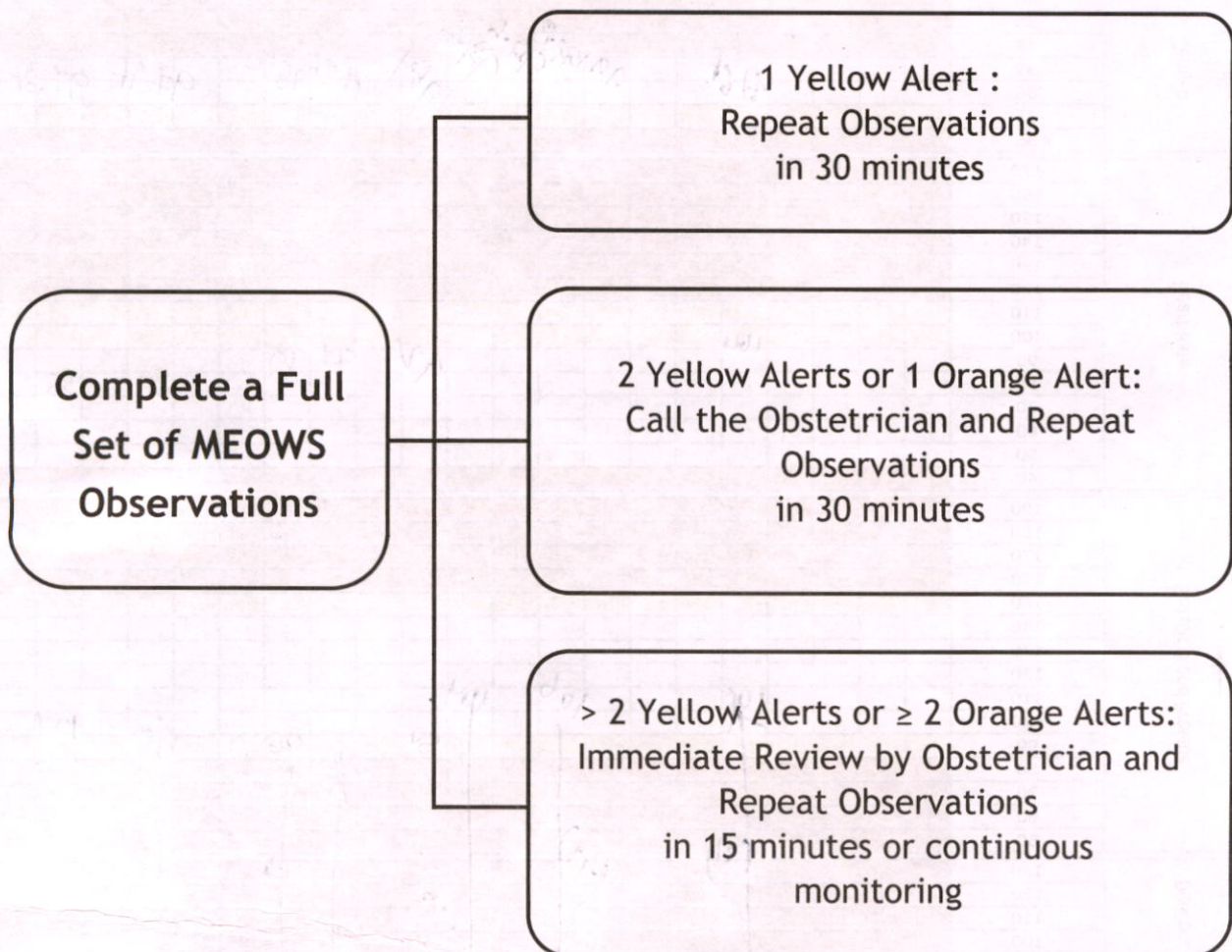
Learning Observation Score Chart - Obstetrics

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT

TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

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04-03-1992
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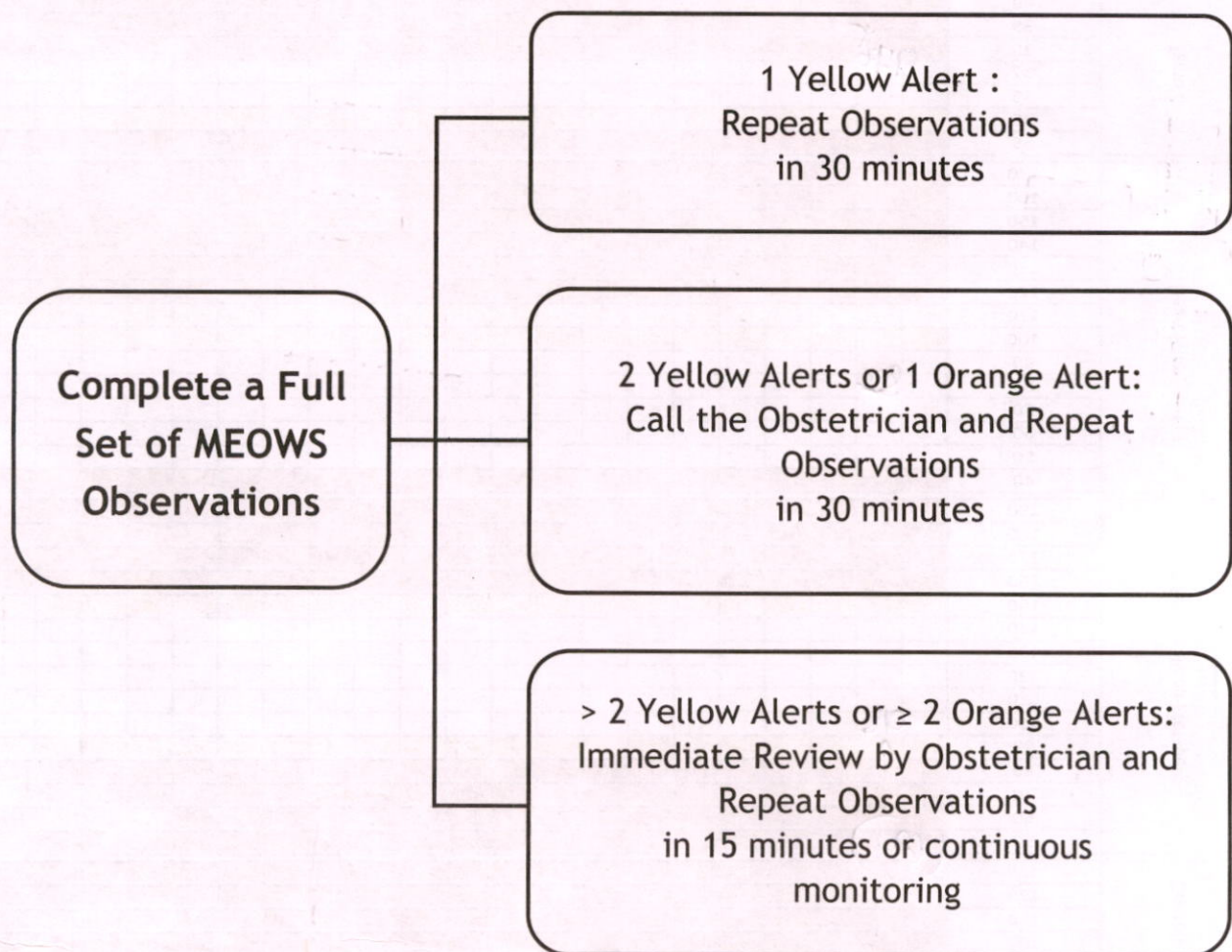
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Early Warning Observation Score Chart - Obstetrics

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

		Date																												
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7				
RESP (write rate in corresp. box)	> 30																													
	21 - 30																													
	11 - 20																													
	0 - 10																													
Saturations	94 - 100 %																													
	< 94 %																													
Administered O ₂ (L/min.)																														
Temp °C	40																													
	39																													
	38																													
	37																													
	36																													
	35																													
	< 35																													
Heart Rate	170																													
	160																													
	150																													
	140																													
	130																													
	120																													
	110																													
	100																													
	90																													
	80																													
	70																													
	60																													
	50																													
	40																													
	Systolic Blood Pressure	190																												
180																														
170																														

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

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 Mrs SURAMYA KEDIA
 04-03-1992 34 Y 3 M 29 D (F)
 Dr. NIVEDITHA CHALMEDA



FLUID CHART

Sheet No. :

7/3

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm	Water										
	06:00 pm						NP				0.7	
	07:00 pm						1				0.7	
Total Intake : <u>Water</u>						Total Output : <u>M - 0 U - 1</u>						
	08:00 pm										0.7	
	09:00 pm										0	maitha
	10:00 pm	RL 100me		100me							0	maitha
	11:00 pm	RL		100me			NP			500me	0	maitha
	12:00 am	RL H2O		100me						200me	0	
	01:00 am	RL		100me							6	
Total Intake :						Total Output : <u>m - 0 U - 700me</u>						
	02:00 am			100me							0.7	
	03:00 am	H2O		100me							0	maitha
	04:00 am	NS		-						300me	0	maitha
	05:00 am	NS H2O		100me			NP				0	maitha
	06:00 am	NS		100me							0	
	07:00 am	NS H2O		100me							0	maitha
Total Intake :						Total Output : <u>m - 0 U - 300me</u>						
Total 24 hrs. Intake		taken total										
Total 24 hrs. Output		m - 0 U - 1,000me										



FLUID CHART

Sheet No. : ②

4/7/26

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

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			100ml						✓	6	Lakshy	
	09:00 am	N	water	100ml			✓				0		
	10:00 am	S		100ml							0		
	11:00 am	N		-			✓			✓	0	Lakshy	
	12:00 pm	S	water	-			✓				0	Lakshy	
	01:00 pm			-							0		
Total Intake :						Total Output :						u - 2 m - 2	
	02:00 pm			-							0	Lakshy	
	03:00 pm	N	water	100ml			✓				0		
	04:30 pm	S		100ml							0		
	05:00 pm		water	100ml			✓				0	Lakshy	
	06:00 pm			100ml							0		
	07:00 pm			100f							0		
Total Intake : 500f						Total Output : 11 - 100ml							
	08:00 pm	Pow		100ml							0	Lakshy	
	09:00 pm	transder	-tho	100ml			✓				0		
	10:00 pm	Re		100ml							0		
	11:00 pm	Synto	tho	24ml			✓				0	Lakshy	
	12:00 am	Synto		24ml							0		
	01:00 am	Synto	tho	24ml							0		
Total Intake :						Total Output :							
	02:00 am										0	Lakshy	
	03:00 am		1120								0		
	04:00 am		100ml								0		
	05:00 am										0	Lakshy	
	06:00 am	Re	tho	100ml			✓				0		
	07:00 am	Re	tho	100ml							0		
Total Intake :						Total Output :							
Total 24 hrs. Intake			1350ml			Total 24 hrs. Output			26 m2				

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FLUID CHART

Sheet No. : 3

5/12/16

- 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		
5/12	08:00 am	Re 1Bm	100ml								0	Long
	09:00 am	Re	100ml							0	Long	
	10:00 am	Re 1Bm	100ml							0	Long	
	11:00 am	Re							✓	0	Long	
	12:00 pm	Re 1Bm	100ml							0	Long	
	01:00 pm	Re H2O							✓	0	Long	
Total Intake :			Taken 400ml			Total Output :					U = 1 m = passed	
5/12	02:00 pm	Re H2O								✓	0	Long
	03:00 pm	Re Juice								0	Long	
	04:00 pm								✓	0	Long	
	05:00 pm	Re H2O								0	Long	
	06:00 pm									0	Long	
	07:00 pm	Re H2O								0	Long	
Total Intake :			Taken			Total Output :					U = 2 m = 0	
	08:00 pm										0	Long
	09:00 pm	mono cat H2O	100ml							✓	0	Long
	10:00 pm	Re H2O	120ml							0	Long	
	11:00 pm	Re 1Bm	120ml						✓	0	Long	
	12:00 am	Re	120ml							0	Long	
	01:00 am	Re H2O	120ml							0	Long	
Total Intake :			1630ml			Total Output :					Passed, U = 2	
	02:00 am	Re	120ml								0	Long
	03:00 am	Re H2O	120ml						✓	0	Long	
	04:00 am	Re	120ml							0	Long	
	05:00 am	Re	120ml							0	Long	
	06:00 am	Re H2O	120ml							0	Long	
	07:00 am								✓	0	Long	
Total Intake :			780ml			Total Output :						
Total 24 hrs. Intake		2210		Total 24 hrs. Output		U = 8 m = 0						

FLUID CHART

Sheet No. :

6/7/26

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake			Output						IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am	H2O											
	09:00 am	100ml											
	10:00 am	H2O											
	11:00 am	100ml											
	12:00 pm												
	01:00 pm												
Total Intake :			Taken			Total Output :						200ml	
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/26

Assessment:

Antenatal mother under Observation

Goals

- | | | | | | |
|---|--|---|---|--|---|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☒ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☐ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
10pm →	Assess the general condition of patient	10pm →	Activity good	continue same
12AM →	Place for vitals	12AM →	vitals checked & Recorded	
2AM →	patient complain difficult breathing	2AM →	inform to doctors & given Nasollear drops	
4AM →	urine output monitor	4AM →	urine output good	
6AM →	FHR TSD	6AM →	checked with uterine sounds machine by doctor	

Re-Assessment:

patient was comfortable now

Special Notes:

FHR - TSD

Nurse Signature:

Maithe

Nurse Name:

Maithe

Date & Time:

4/7/26 @ 8am

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Mrs SURAMYA KEDIA
04-03-1992 34 Y 3 M 29 D (F)
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NURSING CARE RECORD


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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: patient is antenatal under observation

Goals

- | | | | | | |
|---|---|---|--|---|--|
| ☒ Maintain Airway and Oxygenation | ☒ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☒ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☒ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8am	* assess the general condition	8:10pm	* Assessed the general condition	patient is stable
9am	* monitor vitals and Record	9:10am	* monitored vitals and Recorded	
10am	* To do USG for fetus well being	10:10am	* USG for fetus well being done	
12pm	* medication administered as per chart	12:10pm	* medication administered as per chart	
1pm	* Ensure safety	1:10pm	* Ensured safety	

Re-Assessment: patient is Okay doing well

Special Notes: USG for fetus well being done today

Nurse Signature: Latha Nurse Name: Latha Date & Time: 4/7/26 @ 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7

Assessment:

pt is under observation.

Goals

- ☐ Maintain Airway and Oxygenation
☒ Maintain Personal Hygiene
☐ Identify Potential Complications

- ☒ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify.....

- ☒ Maintain Fluid Balance
☐ Meet Elimination Needs

- ☐ Improve Activity Tolerance
☒ Ensure Safety

- ☐ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

- ☐ Maintain Skin Integrity
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
2PM	* Assess the general condition of pt.	2:10PM	* assessed the pt condition.	pt is stable now.
4PM	* Monitor vital signs * Maintain s/o chest	4:15PM	* vitals checked & documented * s/o chest maintained	
6PM	* Administer the medications	6:15PM	* Administered the medications & IV fluids.	
8PM	* w/f for pain & any bleeding. * provide psychological support.	8PM	* w/f for pain & any bleeding. * Psychological support given.	

Re-Assessment:

pt is comfortable now & doing well.

Special Notes:

w/f for pain & fever & any bleeding.

Nurse Signature:

Nurse Name:

Date & Time:

4/7 @



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/1/2026

Assessment: patient complaint pain at lower abdomen

Goals

- | | | | | | |
|---|---|--|---|---|---|
| ☒ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☒ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ assess the patient condition	8:30pm	→ assessed the patient condition	→ Patient stable
11pm	→ monitor vitals	11:30pm	→ monitored vital	
1Am	→ administration of medication	1:20am	→ medication given as per drug chart	
3Am	→ ensure safety	3:30am	→ Provided side rails	
4Am	→ I/O chart monitoring	4Am	→ I/O chart monitored	
6Am	→ IV fluids	7Am	→ IV fluids are given	
7Am	→ ambulation	8Am	→ Ambulation done	

Re-Assessment: done pt stable

Special Notes: Rpoc Scan today. vitals monitoring

Nurse Signature: [Signature]

Nurse Name: Swapna

Date & Time: 5/1/2026 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment:

patient is having fears anxiety

Goals

- ☒ Maintain Airway and Oxygenation
- ☒ Relieve Pain & Discomfort
- ☐ Maintain Fluid Balance
- ☐ Improve Activity Tolerance
- ☐ Maintain Good Nutritional Status
- ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene
- ☐ Prevent Infection
- ☒ Meet Elimination Needs
- ☐ Ensure Safety
- ☐ Early Ambulation Reduce Anxiety
- ☐ Patient & Family Education
- ☐ Identify Potential Complications
- ☐ Any Others. Specify.....

Time	Plan of Care	Time	Implementation	Evaluation
8AM	Assess the patient general condition	8:30 AM	Assessed the patient general condition	- patient is stable & comfortable
9AM	monitor vitals	9:30 AM	monitoring vitals Bp, PR, RR SpO2, checked & recorded	
10AM	ABM	10:30 AM	ABM still further order	
11AM	IV fluids	11:30 AM	IV fluids are on flow	
12PM	RPOC scan	12:30 PM	RPOC scan today	
2PM	ensure safety	2PM	ensure safety provided	

Re-Assessment:

Special Notes:

RPOC scan today

Nurse Signature:

[Signature]

Nurse Name:

Long

Date & Time:

5/7/26 @ 2PM

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NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date:

Assessment: Anxious related to hospitalization.

Goals

- ☐ Maintain Airway and Oxygenation ☐ Relieve Pain & Discomfort ☐ Maintain Fluid Balance ☐ Improve Activity Tolerance ☐ Maintain Good Nutritional Status ☐ Maintain Skin Integrity
- ☐ Maintain Personal Hygiene ☐ Prevent Infection ☐ Meet Elimination Needs ☒ Ensure Safety ☐ Early Ambulation Reduce Anxiety ☐ Patient & Family Education
- ☐ Identify Potential Complications ☐ Any Others. Specify

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess general condition of the Patient.	2:30pm	Assessed general condition of the Patient.	Patient is comfortable
3pm	monitor vitals	3:20pm	vitals checked and recorded	
4pm	Qto chart monitoring	4:05pm	Qto chart monitoring done.	
5pm	Plan for hydration	5pm	hydration done	
6pm	Ensure safety	6:15pm	side rails kept.	
8pm	Ambulation	8pm	Ambulation done	

Re-Assessment: Re assessment done.

Special Notes: Lab's has to send tomorrow morning 5Am

Nurse Signature: *[Signature]*

Nurse Name: S. Sivasone

Date & Time: 5/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 16/11/2026

Assessment: patient complaint fear & Anxiety

Goals

- | | | | | | |
|---|---|--|---|---|---|
| ☐ Maintain Airway and Oxygenation | ☒ Relieve Pain & Discomfort | ☒ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☒ Maintain Personal Hygiene | ☒ Prevent Infection | ☐ Meet Elimination Needs | ☒ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ assess the patient condition	8:30pm	→ assessed the patient condition	→ patient stable
10pm	→ monitor vitals	10:30pm	→ monitored vitals	
12am	→ Ensure Safety	12:00am	→ Provided side rails	
2am	→ I/O chart monitoring	2:30am	→ I/O chart monitored	
4am	→ Ambulation	4:30am	→ Ambulation done	
6am	→ IV fluids	7am	→ IV fluids are given	
7am	→ administration of medication	8am	→ medication given as per drug chart	

Re-Assessment: done pt stable

Special Notes: IV fluids bowelhe. vitals temp & hourly

Nurse Signature: [Signature]

Nurse Name: Swapna

Date & Time: 16/11/2026 8am

BAH-00656248 IP5-00175938
Mrs SURAMYA KEDIA
04-03-1992 34 Y 4 M 1 D (F)
Dr. NIVEDITHA CHALMEDA



NURSING CARE RECORD


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


BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

- | | | | | | |
|---|--|---|---|---|---|
| ☐ Maintain Airway and Oxygenation | ☐ Relieve Pain & Discomfort | ☐ Maintain Fluid Balance | ☐ Improve Activity Tolerance | ☐ Maintain Good Nutritional Status | ☐ Maintain Skin Integrity |
| ☐ Maintain Personal Hygiene | ☐ Prevent Infection | ☐ Meet Elimination Needs | ☐ Ensure Safety | ☐ Early Ambulation Reduce Anxiety | ☐ Patient & Family Education |
| ☐ Identify Potential Complications | ☐ Any Others. Specify..... | | | | |

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Nivedita Department: BRP Date of Admission: 4/7/26

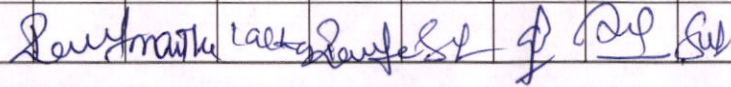
SITUATION		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: _____					
BACKGROUND	Diagnosis:	<u>prim 1st wk</u> <u>cerebral palsy</u>					
	Area	3rd floor 3rd floor 3rd floor 3rd floor 3rd floor 3rd floor 6PM-8PM 2PM-8PM 3PM-5PM 2PM-8PM 8PM-10PM 8PM-10PM					
ASSESSMENT	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: 100.4	97.4	97.1	97.2	98.3	98.3
	Res:	20b/m	19b/m	19b/m	20b/m	20b/m	19b/m
	SpO ₂ :	98%	98%	98%	99%	98%	100%
	Pulse:	108b/m	105b/m	90b/m	85b/m	103	101
	BP:	109/63	99/61	112/70	114/70	105/60	110/60
	Fall Risk Score:	0/10	0/10	0/10	0/10	0/10	0/10
	Pain Score:	-	-	-	-	-	-
Recommendations	Safety Needs:	side rails	yes	yes	side rails	side rails	side rails
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:	NA	NA	NA	NA	NA	NA
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	NA
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA
Handed Over By Name :		Ranjana	Manthe	Lakshmi	Ranjana	Swapna	Sona
Signature :		Ranjana	Manthe	Lakshmi	Ranjana	Swapna	Sona
Date:		3/7	4/7/26	4/7	4/7	5/7/26	5/7/26
Time:		8PM	8PM	2PM	8PM	8AM	2PM
Taken Over By Name :		Manthe	Lakshmi	Ranjana	Swapna	Sona	Sona
Signature :		Manthe	Lakshmi	Ranjana	Swapna	Sona	Sona
Date:		3/7	4/7	4/7	4/7	5/7/26	5/7/26
Time:		8PM	8AM	2PM	8AM	8-5AM	2-8PM

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Niveditha Department: BRP Date of Admission: 3/7/2026

SITUATION	Diagnosis: <u>Fever for evaluation.</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area	<u>Suite 3</u>	<u>Suite 3</u>			
	Shift Time	<u>2nd shift</u>	<u>8pm</u>			
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>96.4</u>	<u>98.5F</u>			
	Res:	<u>18</u>	<u>20b/min</u>			
	SpO ₂ :	<u>99%</u>	<u>98%</u>			
	Pulse:	<u>92</u>	<u>98b/min</u>			
	BP:	<u>86/50</u>	<u>100/60</u>			
	Fall Risk Score:	<u>20</u>	<u>20</u>			
	Pain Score:	<u>0</u>	<u>0</u>			
Recommendations	Safety Needs:	<u>side rails</u>	<u>side rails</u>			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	<u>-</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	<u>-</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>-</u>	<u>NA</u>			
Handed Over By Name :		<u>Swarna</u>	<u>Swarna</u>			
Signature :		<u>Swarna</u>	<u>Swarna</u>			
Date:		<u>5/6</u>	<u>6/7/26</u>			
Time:		<u>8pm</u>	<u>8am</u>			
Taken Over By Name :		<u>Swarna</u>	<u>Anita</u>			
Signature :		<u>Swarna</u>	<u>Anita</u>			
Date:		<u>6/6/26</u>	<u>6/7/26</u>			
Time:		<u>8pm</u>	<u>8am</u>			

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		—	—	—	—	—	—	—	—	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		—	—	—	—	—	—	—	—	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		—	—	—	—	—	—	—	—	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		—	—	—	—	—	—	—	—	
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		—	—	—	—	—	—	—	—	
Signature of the Nurse													

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature :  Name : Supriya

Signature of Ward In Charge :

Signature :  Name : Supriya

BAH-00658248
Mrs SURAMYA KEDIA
04-03-1992
Dr. NIVEDITHA CHALMEDA
IP5-00175938
34 Y 3 M 29 D (F)

BRADEN 'Q' SCALE

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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	3/7	3/8	4/7	4/8
					Time :	6pm-8pm	8pm-10pm	10am	12pm
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or gasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23									
Docu. No. : RCHBH /FRM / CLINICAL / 119									
					TOTAL SCORE				
					Evaluator's Name				
					28 25 28 28				
					Sul math last se				

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

BRADEN 'Q' SCALE

					Date :	5/2	5/7	5/11
					Time :	8am	2pm	8pm
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	
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FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
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Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	28
					Evaluator's Name	h	28	28

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
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Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7	6PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Self
3/7	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Mother
4/7	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Health
4/7	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Health
4/7	4PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Self
4/7	8pm	0/10	NO PAIN	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Swaps
4/7	10pm	0/10	lower abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Swaps
4/7	11pm	2/10	lower abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	2mg morphine given	Swaps
5/7	12am	03/10	lower abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	2mg morphine given	Self
5/7	4am	0/10	NO PAIN	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Swaps

Re-assessment Frequency:

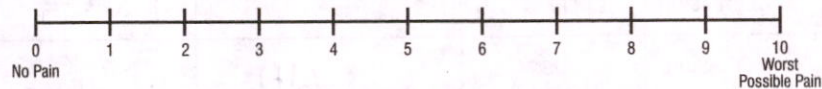
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

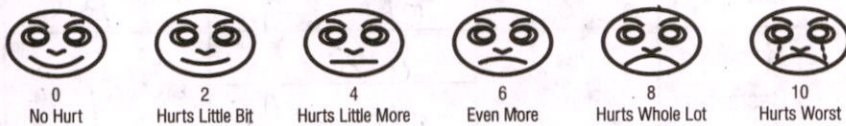
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7/26	8am	0	NO Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sc
5/7/26	10 AM	0	NO Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	SP
5/7/26	12pm	0	NO Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	P
5/7	6pm	-	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	is observation	Q
5/7/26	10pm	-	NO Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Swapna
6/7	2 AM	0	NO Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Swapna
6/7	6 AM	0	NO Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Swapna
6/7	8 AM	0	NO Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Swapna
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

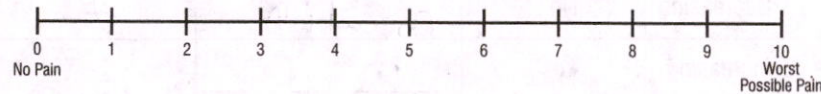
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs brawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

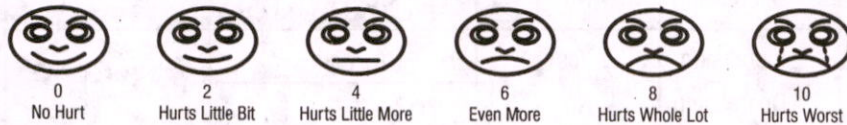
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



BAH-00658248 IP5-00175938
 Mrs SURAMYA KEDIA
 04-03-1992 34 Y 3 M 29 D (F)
 Dr. NIVEDITHA CHALMEDA

Morse Fall Risk Assessment Form

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading		
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25	Risk Level	Morse Fall Score (MFS)	Action
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	Low Risk	0 - 24	Standard Fall Precaution
	No	0			
Ambulatory Aid	Furniture	30	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0			
GAIT / Transferring	Impaired	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0			
Total Morse Fall Scale Score:		35	35	35	
Signature		Laxmi	martha	latha	

Tick (✓) whichever precaution taken.

Risk Level and Interventions

Low Risk (0 - 24) (Standard Falls Precautions)

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ Use chairs with arm rests
- ☐ Use safety straps on stretchers and wheelchairs while transporting patients

Moderate Risk (25-50) Apply all low risk intervention and

- ☐ Assist and/or supervise ambulation. Reinforce to always call for assistance
- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

High Risk (≥ 51) Apply all low and moderate risk interventions, and.

- ☐ Initiate constant observation by healthcare provider as appropriate to patient's needs

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	4/12/26	5/12/26	5/12/26	Fall Risk Grading		
		Score	8pm-8am	8am-2pm	2pm-8pm			
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15	Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			35	35	35			
Signature			Seapue	[Signature]	[Signature]			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

Low Risk (0 – 24) (Standard Falls Precautions)

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading		
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25	5/7/26		
	No	0	0		
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0		
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0		
IV / Heparin Lock or Saline	Yes	20	20		
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0		
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0		
Total Morse Fall Scale Score:			20		
Signature			Suapua		

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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