

BAH-00483384 IPS-00176641
Mrs VEDAVALLI SNEHA REDDY
01-09-1989 36 Y 10 M 19 D (F)
Dr: SASIKALA KOLA



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ENTERED
21/83
SURGERY DETAILS

Date : 20/7/2026

Patient Name: Mrs. Vedavalli sneha Reddy Date of Birth: 01/09/1989 Age: 36 years

Gender: Female Ward: OT-IV UHID No.: BAH-00483384

Date of Surgery: 20/7/2026 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☒ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Left ovarian cystectomy + partial Right Salpingectomy
Laparoscopic

Time in : 2:50pm

Time Out : 4:50pm

	NAME	AMOUNT
1. Surgeon	Dr. Sasikala	
2. Anaesthetist	DR.	
3. Assistant Surgeon		
4. OT Technician	Ramesh	
5. Circulating Nurse	Swapna	
6. Assistant Nurse	Prabhavathe	

Special Equipment: ☒ Laparoscopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others 9713409

Signature of the Surgeon (Dr. MATTHAN)

Signature of Circulating Nurse

Order No: 9713408

Order by: Benjamin



LAP OVARIAN CYSTECTOMY
CONSUMABLES OF OT

Rainbow Children's Hospital
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Your Right to a Safe Delivery

Technician : Date : *20/7* Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube (7.0-7.5)	14	1	Major Pack + Loggenn	14	1+1	Inj Vit.K		
LMA 3.4	14	—	Sutures			Cord Clamp		
ECG leads A / P / N	5	3	2364	2	1	Suction Catheter		
HME filter A / P / N	01	1				Feeding Tube		
Syringes 10 cc	10	7				Vacuum Suction Set		
05 cc	10	6	Gloves 6.65 7-7.5	2+2	1+2	Surgical Gloves		
02 cc	10	4	6.65 9-9.5	2+2	1	Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate: A / P / N	01	—	Surgical blade 11.15	1+1	1	Surgical Blade # 20		
IV set	01	—	NG tube			Koochies (S)		
RL	01	3	Cautery pencil	1	—	NS 500ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	1+3	1+3	Koochies			Trans fix	1	1
no respire	01	1	Ointments			(ote) 5u	2	2
Vacuum set	01	1	Suction Catheter			to Anawin 0.25	1	—
Fentanyl	01	1	Cap, Mask	5/5	5+5	Jelly.	1	—
Morphine	1	1	Gauze Pack (N/A)	25	4	Anawin-0.25	1	—
Ketamine			Mop Pack	1	1	Top p out	1	1
Propofol	4	2	Steristrip Silkondr	4	3	Endo bag	1	1
Rocuronium	01	2	Underpad	1	1			
Glycopyrolate	01	1	Draw sheet	1	1			
Myopyrolate	01	1	Abgel					
Ondansetron	01	1	Foleys catheter 14	1	1	OA 2/3	14	—
Pencan 25g/ Spinal Needle 22			Urobag	1	1	NA 28-30	14	1
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			o2 m2e (g)	01	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			SCD roots (same)	01	—
Antibiotics			Bandage			Big Epine	01	1
SV pen	01	1	Tegaderm			Amig (A)	1	1
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : (100mg)	01	1	Vacuum Suction set	1	1			
Justin : 12.5 mg / 25mg / (100mg)	01	1	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
3way 10cm + 100cm	14	1	Microshield	1	1			
Gauze + gloves	5+1	—	Cotton Balls	1	1			
Deso + Transene	1+2	2	Latex Gloves	10	10			
SV cable 20/18	14	—	Ramdone Scrub					
			Saral					

Surgeon : Anaesthesiologist : Nurse : OT Technician :
Order No. : *9712993* Ordered by : *Y. S. S.*
Doc. No. : RCH / FRM / GENERAL / 125

ESTIMATION SLIP

Date: 17-July-26 UHID / IP No.: BAH-00483384 SI No. 81183
Name of Patient: Mrs. P. Snpa Reddy Age: 36yrs Gender: Female
Father's / Husband's Name: Mrs. Shivarajula Reddy Corporate / Occupation: Citro group
Address: Hyderabad Phone: 9866089938 Email: -
Procedure / Plan: left ovarian endometriotic cyst

MODE OF PAYMENT: ☐ SELF ☒ TPA: MA / Magma ☐ GIPSA: - OTHERS: -

TARIFF INFORMATION:

ROOM CATEGORY		GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Per Day)	Room Rent & Nursing Charges				In Dkg						
	Doctor's Fee				Per day - NA						
	L. Tax										
PARTICULARS					AMOUNT (₹)						
Surgeon's / Anesthetists's Fee / O.T. Charges					In Dkg						
O.T. Consumables					9500						
Instrument Charges					Subject to approval by TPA / Insurance Company						
Pharmacy, Consumables & Investigations					Not Covered by TPA / Insurance company						
Equipment Charges					As per actual - Not Included in Estimation						
Monitor :		Oxygen :			Infusion pump / Syringe pump :						
Ventilator :		Conventional :			HFO-SLE 5000 :		HFO Sensormedix.:				
Phototherapy :		Single Surface :			Double Surface :		Triple Surface :				
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.					Extra/- Pr - SW As per actual - Not Included in Estimation						
Package					71610 64460						
Others					Note: High end equipment perage 15-25K Not included in estimation						
Initial Minimum Deposit					15000/- included in estimation						

REMARKS:

- The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
- The estimated surgical charges may vary subject to surgeon's decisions / Complications / Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.
- In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
- Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.
- Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/Insurance Company at later stage.
- For Non-Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.
- During Non-working hours of O.T (8:00 PM to 7:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm
- Difference, if any between the final bill amount and amount permitted/ approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
- Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

DECLARATION

I Snpa have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TRA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital

Signature of the Client

Signatory Relationship

Signature of the Financial Counselor

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176641

Admit Date : 20-Jul-2026

Admit Time : 12:21 PM UHID : BAH-00483384

Patient Details :

Patient Name : Mrs VEDAVALLI SNEHA REDDY

Age : 36 Y 10 M 19 D

Guardian : MR. V SHIVANANDA REDDY

DOB : 01-09-1989

Gender : Female

Religion : Hindu

Occupation :

Martial Status : Married

Address (H) : PLOT NO. 79, NAVA NIRMAN NAGAR COLONY,
ROAD NO. 71 Hyderabad Jubilee HO
Hyderabad Telangana INDIA 500033

Phone No : 9666089982/ 9100017777

E-mail : snehareddy89@gmail.com

Admission Details :

Bed Type : DAY CARE

Bed No : RC 407

Ward Name : 4F-GYN RECOVERY

Room No : RC 407

Admission Type : First Visit

Contact Details :

Name : MR. V SHIVANANDA REDDY

Relationship : Husband

Contact Address : PLOT NO. 79, NAVA NIRMAN NAGAR
COLONY, ROAD NO. 71 Hyderabad Jubilee HO
Hyderabad Telangana INDIA 500033

Phone No : / 9666089982


Signature

Doctor Details :

Doctor Name : Dr. SASIKALA KOLA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : MEDI ASSIST INSURANCE TPA PVT
LTD

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ Dept : _____

Date of Admission: _____ Ti _____ arge : _____ Time: _____

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

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Dr. SASIKALA KOLA



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7/26	2.10pm	CYN	BT	Raeey
20/7/26	5 M	BT	OKS.	Swamy

Cross Consultation Visit

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

[illegible]

Cher Chetty
by her

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
20/7	PAC		9712556	
20/7	2 v placent		9712555	key
20/7	Catheterization		9713926	key

over check
by key

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 20/7/26 Time of Admission : 09:15 AM
Allergies : NKA ☒ Not know any drug allergies

PRESENTING COMPLAINTS :

→ P/L1, planning 2nd pregnancy.
c/o: left side hip pain radiating towards leg leg since 2 months.
c/o: painless mensturation since 15 years.
14/7/26: MRI of lumbosacral spine - grade - 3

09/10/25: USG abd & pelvis - ut AV, 74x35x55cm, ET-8.8cm, RO-4x1.6cm, LO-5x3cm, ELO-3.4x2.9cm well defined cystic lesion, noted showing low level internal echos and oblique solid mural nodules. Imp-① Ovarian cyst.

MENSTRUAL HISTORY

Year of Marriage : 2018
Previous Periods : Regular
LMP : 29/06/2026
Contraception : Nil

OBSTETRIC HISTORY

Parity : P/L1
Mode of Delivery : LSCS
Last Child Birth : 2022

PAST MEDICAL HISTORY

→ Nil

PAST SURGICAL HISTORY

LSCS - 2022
2025 - Appendectomy Laparoscopy.



FAMILY HISTORY:

Father - HTN
Mother - DM2

MEDICATION HISTORY:

combiflam
Endoplex

INITIAL ASSESSMENT :

Date <u>20/07/2026</u>	Breasts <u>⊕</u>	Local/Speculum Examination
Ht. <u>186</u> Wt. <u>80.3 kg</u>		
BMI <u>23.2/kg</u>		
B.P. _____		
Pallor _____		
CVR <u>SS. ⊕</u>	Abdominal Examination	Bimanual Pelvic Examination
Respiratory System <u>BAEO</u>		
Thyroid <u>⊕</u>		

PROVISIONAL DIAGNOSIS :

PIL, / planning pregnancy / For Laproscopic ovarian cystectomy ⊕

INVESTIGATIONS ORDERED

16/7/26
Bht - ⊕ Positive.
Vital - NR
CBP - 12.8 / 9.32 / 1.79
CR - 0.6 / TSH - 1.71
RBS - 87
Urine cl - no growth
CUF - PC - 2-3 / FC - 5-6

PLAN OF MANAGEMENT

- Admission
- IV cannulation
- Drugs as needed
- Monitor vital signs
- Written and Informed Consent

Name of the Doctor : Dr. Sasi

Signature of Doctor [Signature]

Date & Time :

20/7/26 ; 12:30pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2026 6:30pm	POD-0 o/f Ceftriaxone BP - 105/60 mmHg (71) PR - 86 bpm SpO ₂ - 98% RA p/A - soft	Lap (D) ovarian cystectomy (2) Partial Salpingectomy / P/L Adv ① NBM for till 12:00 AM ② T/O charting ③ IV @ 100ml/hr ④ Drugs as charted ⑤ Monitor vitals q4h ⑥ Inform SOS
20/7/2026 4:00pm	POD-0 o/f Ceftriaxone BP - 113/64 mmHg PR - 65 BPM SpO ₂ - 95% RA p/A - soft	Dr. Divya Adv ① NBM till 12:00 AM ② Sips of water from 12:00 pm f/b liquids ③ soft diet from 6:00 am 21/7/26 ④ IV @ 100ml/hr till 12:00 pm ⑤ Drugs as charted ⑥ Monitor vitals q4h ⑦ Inform SOS
	VO - 90ml clear Shift to Room	Dr. Divya

20/7/26
10 PM

21/7/2026
2 AM



Patient Sticker

OPERATION THEATER NOTES

Patient's Name : Mrs. Vedavalli Sneha Reddy Age : 36 years Gender : ☐ Male ☒ Female

UHID No. : BAH-00483384 Weight : 80.31 kg Height :

Surgeon : Dr. Sasikala Kola Asst. Surgeon :

Anesthetist : Dr. Danya OT Nurse : Prabha OT Technician : Ramesh

Pre-Operative Diagnosis:

Surgical Procedure : laparoscopic left ovarian cystectomy + Right (partial) Salpingectomy

Indications for Surgery : laparoscopic left ovarian cystectomy

Date : 20/7/26 Start Time : 3:15 pm End Time :

Pre Operative Preparations: All pre-op indications given.

Post Operative Diagnosis: 100% post laparoscopic left ovarian cystectomy + partial Right Salpingectomy

Peri-Operative Complications:

Operation Notes: 1) Uterus Normal in size

2) FOAM lesions present on the surface of Uterus. lesions cauterized

3) left ovarian cyst (endometriosis) - 4x5cm

4) left ovary c cyst stuck to posterior surface of uterus and lateral pelvic wall.

During adhesiolysis, inadvertent rupture of ovarian cyst. ~ 30ml of chocolate colour fluid drained. Cyst wall excised and sent for HPE.

5) sigmoid colon - adherent (fleshy adhesions) to the left lateral pelvic wall.

Adhesiolysis done

6) Right side - medial part of tube visible lateral part of tube buried in the ovarian cyst also continuity to any tissue
fimbrial end of tube absent.

Partial Salpingectomy done and sent for HPE

7) fat like tissue present over the ~~ovary~~ right

Amount of Blood Loss: 50ml

Blood Transfused (in ML) Nil

Name and Number of Surgical Specimen sent for examination:

left ovarian cyst wall + partial Right tube + fat like tissue

Peri-Operative Complications:

ovarian surface. Tissue excised and sent for HPE

8) peritoneal adhesions (+)

9) hemostasis secured

10) specimen (left endometrial ovarian cyst wall + partial right fallopian tube + fat like tissue on right ovarian surface retrieved through endobag and sent for HPE

11) trocars removed & washed

12) duration of surgery - 1 hour 30 min

Name of the Surgeon: Dr. Sakikale

Signature of the Surgeon: Dr. MATHAN

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 6AM	PR: 86 BP: 100/60 SpO ₂ : 100% RA P/A: Soft BS ⊕ P/V: NAB U/O: Adequate Remove Foley's	① Soft diet ② plenty of oral fluids ③ Ambulate ④ encourage Voiding ⑤ vitals qhly ⑥ inform DS ⑦ stop IVF ⑧ Remove SCD
	<u>Plan Discharge</u>	Dr Y. Sneha
21/7/26 9AM	POD, / Lap ⊕ Ovarian cystectomy, ⊕ ⊕ Salpingectomy O/E	Patient <u>Adv</u> - soft diet, plenty of oral fluids - Ambulate - encourage voiding - vitals qhly - Inform DS
	ac. fair wtd PR - 81kg BP - 108/69 mmHg SpO ₂ - 98% max P/A - soft, nontender. BS ⊕ - Plan discharge after voiding	Mrs. S. Sankar

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Date of Admission: 20/7/2021 Drug Allergies: NKA ☒ Not known any Drug Allergies

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)

[illegible][illegible]

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



REGULAR PRESCRIPTIONS

Weight. 80.3 kg Ward.

DRUG : IM - Cefotaxime				Date Time	2/7
Dose	Route	Frequency	Start Date	2	20/7/2019
1gm	IV	BD	20/7/2019	6am	5pm
Name & Signature of the Doctor Starting the Drugs:				2	pm
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : PARACETAMOL				Date Time	2/7
Dose	Route	Frequency	Start Date	6	20/7/2019
500mg	P/O	TID	20/7/2019	6am	5pm
Name & Signature of the Doctor Starting the Drugs:				2	pm
Additional Instructions:				10	pm
Daily Doctor's Endorsement by a Sign					
DRUG : DICLOFENAC				Date Time	2/7
Dose	Route	Frequency	Start Date	9	20/7/2019
50mg	P/O	BD	20/7/2019	9am	9pm
Name & Signature of the Doctor Starting the Drugs:				9	pm
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : DEXA PANTOP				Date Time	2/7
Dose	Route	Frequency	Start Date	6	20/7/2019
40mg	P/O	BD	20/7/2019	6am	5pm
Name & Signature of the Doctor Starting the Drugs:				6	pm
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					



Weight. 20.3 kg Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
20/1/26	2PM	1M. (EFUTAXIM	1gm	IV	Dr. S	Sneha Reddy
20/1/26	3:20PM	2WT PARACET MOL.	1gm	IV	S	Sneha Reddy
20/1/26	4:00PM	2WT TRANAXMOLIC ACID	1g	IV	S	Sneha Reddy
20/1/26	4:05PM	1WT MORPHINE	6mg	IV	S	Sneha Reddy
20/1/26	4:30PM	sup. DICLOFENAC	100mg	P/R	S	Sneha Reddy
20/1/26	4:20PM	sup. TRAMADOL	100mg	P/R	S	Sneha Reddy



I.V. FLUIDS CHART

Weight. 80.3kg Ward.

Signature

VERIFIED BY : Name

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
20/7/20	12:30pm	RINGER LACTATE	IV	100ml/hr	[Signature]	ray Sudha	20/7	[Signature]	ray Sudha
20/7/20	3:00	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature] Sudha	20/7	[Signature]	[Signature] Sudha
20/7/20	3:51pm	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature] Sudha	20/7	[Signature]	[Signature] Sudha
20/7/20	4:20pm	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature] Sudha	20/7	[Signature]	[Signature] Sudha
20/7/20	6:30 Even	RINGER LACTATE 100ml	IV	FF	[Signature]	[Signature] Sudha	20/7	[Signature]	[Signature] Sudha
20/7/20	7:30 PM	RINGER LACTATE 100ml	IV	FF	[Signature]	[Signature] Sudha	20/7	[Signature]	[Signature] Sudha
20/7/20	7:30 PM	RINGER LACTATE 100ml	IV	FF	[Signature]	[Signature] Sudha	20/7	[Signature]	[Signature] Sudha
20/7/20	8:20pm	RINGER LACTATE 100ml	IV	100ml/hr	[Signature]	Ashwika Sudha	20/7	[Signature]	[Signature] Sudha

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Mrs VEDAVALLI SNEHA REDDY
01-08-1988 36 Y 10 M 19 D (F)
Dr. SASIKALA KOLA



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient's / Learner Language: English / Telugu

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		
20/7/26	12:39 pm	1, 4, 3, 4	Diagnosis, Treatment & Care plan, pain management & Informed cons	PT	1	0	1	1		Dr. S
20/7/26	1 pm	2, 5, 6, 7	patient Target according	PT	1	0	1	1	-	Key
			Explained Infection Control							
			Review							

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:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								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	
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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:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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Understanding:	<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
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MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

Pit. / planning pregna

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
20/7/26 1pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☒ Per-Op ☐ Post Op	→ ① ovarian cyst	→ safe surgery	Laparoscopic ovarian cystectomy	Dan	☐ Nursing ☐ Others:
20/7/26 1pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☒ Per-Op ☐ Post Op	NPO dehydration	to maintain w/ fluid intake	20% mid re on flow	Ray	☐ Medical ☐ 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:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00463384 IPS-00176641
Mrs VEDAVALLI SNEHA REDDY
01-09-1989 36 Y 10 M 19 D (F)
Dr. SASIKALA KOLA

Patient



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RESULT SHEET

Date	14/7/20				
Time					
Hb	12.8				
PCV	39.8				
RBC	4.61				
WBC	9.32				
N/L					
Platelets	179				
CRP					
ESR					
PCT					
RBS	87				
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.6				
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					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date	16/7/26					
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
HIV, HBSAg, HCV	-VE					

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :



MEDICATION RECONCILIATION FORM

Drug Allergies: None

☒ 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. Endoplex	1 tab	PO	OD	19/7/20	☐ C ☒ DC
2	T. Combiplex	1 tab	PO	OD	19/7/20	☐ C ☒ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. N. Siva

Date & Time: 20/7/20 : 12:30 PM.

Nurse Name & Signature: Neelini Seep

Date & Time: 20/7/20 at 1 PM.



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: <u>20/7/26</u>		
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: <u>P.L.I. planning and pregnancy</u>		Doctor Notified on Admission: ☒ Yes ☐ No Name of the Doctor: <u>Dr. Dinger</u> Time Notified: <u>1:10pm</u>
Past Medical History: Obtained From ☒ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify)		
Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Nil</u>	<u>LSCS - 2022</u> <u>2015 Lap Appendectomy</u>	<u>Nil</u>
Gynecology Assessment: ☐ Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History:	Caesarean Section: ☐ No ☒ Yes	Contraceptives: ☒ No ☐ Yes
Onset of Menarche:	Cervical Cerclage: ☒ No ☐ Yes	Vaginal Discharge: ☒ No ☐ Yes
Menstrual Cycle: ☒ Regular ☐ Irregular	Ectopic Pregnancy: ☒ No ☐ Yes	Post-Coital Bleeding: ☒ No ☐ Yes
Last Menstrual Period: <u>29/6/2026</u>	Myomectomy: ☒ No ☐ Yes	Infertility: ☒ No ☐ Yes
	Others:	If Yes Type: ☐ Primary ☐ Secondary
Obstetric History: G P L ₁ A		
Previous LSCS: <u>LSCS 2022</u>		
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: <u>98.6°F</u> HR: <u>86 wt</u> RR: <u>20 wt</u>	BP: <u>116/74 mmHg</u> Weight: <u>52 kg</u> Height: <u>186 cm</u> BMI: <u>23.21 kg/m²</u>
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 20 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☒ Yes ☐ No Score 28 (complete the Braden Q Sheet)

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

SOCIAL SCREENING:

1. **Marital Status:** ☐ Single ☒ Married ☐ Divorced ☐ Widow

2. **Special Habits:** **Smoker:** ☐ Yes ☒ No **Alcohol Abuse:** ☐ Yes ☒ No **Drug Abuse:** ☐ Yes ☒ No

Social History: Lives With Family

Orientation has been given regarding the following aspects:

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

Above information given to patient

Name of Person Orientation was given to: 14 yrs. v-smitha Reddy

Orientation not given Reason:

Nurse Signature: Neelgi

Nurse Name: Neelgi

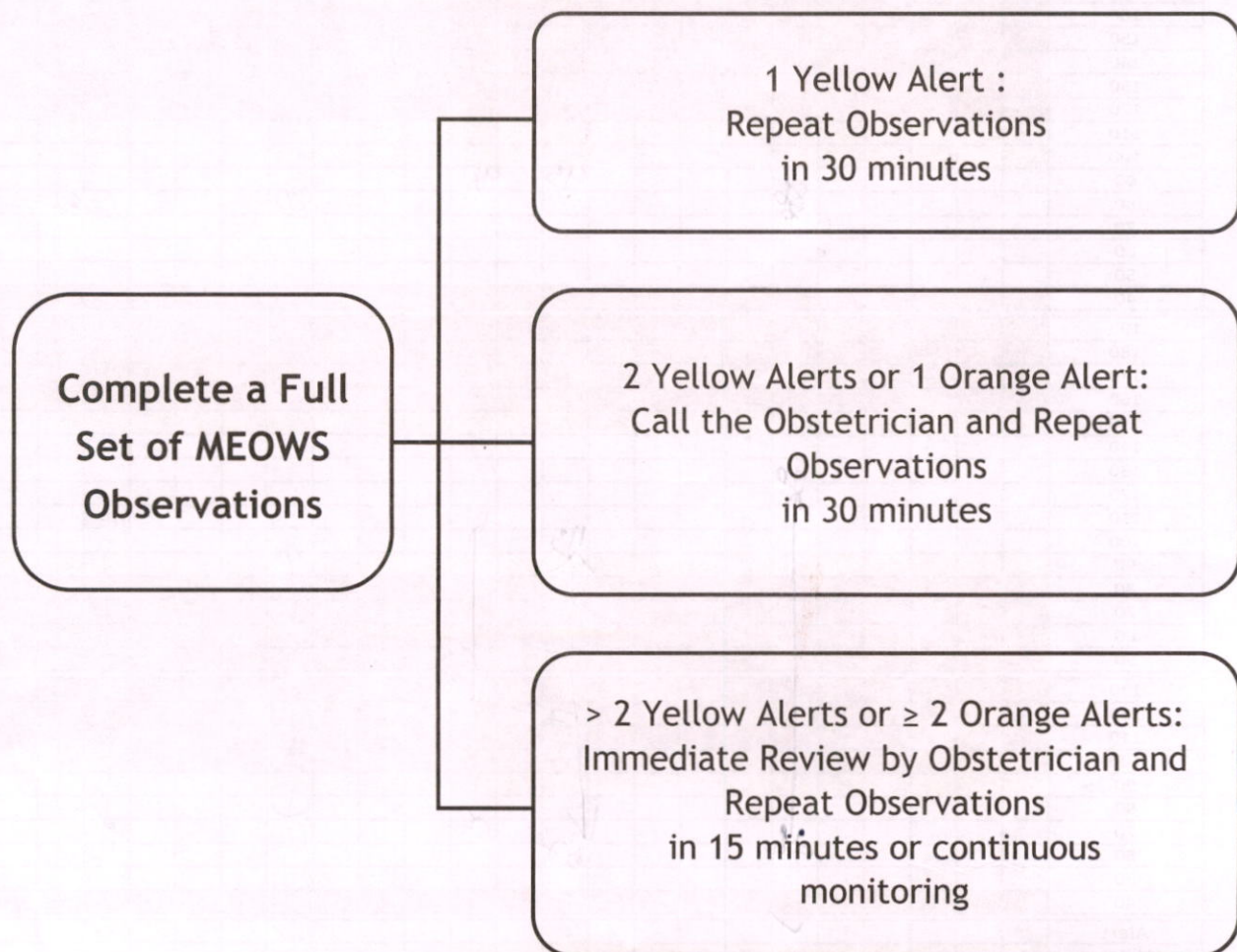
Date & Time: 20/7/26 at 1:15pm



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

Date 20/7/26		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																											
	160																											
	150																											
	140																											
	130																											
	120																											
	110																											
	100																											
	90																											
	80																											
	70																											
60																												
50																												
Diastolic Blood Pressure	130																											
	120																											
	110																											
	100																											
	90																											
	80																											
	70																											
	60																											
	50																											
	40																											
	NEURO RESPONSE [✓]	Alert																										
		Voice																										
		Pain																										
Unresponsive																												
URINE mls / hour	> 30																											
	< 30																											
Proteinuria	Protein ++																											
	Protein > ++																											
Lochia	Normal																											
	Heavy / Foul																											
Liquor	Clear / Pink																											
	Green																											
TOTAL YELLOW SCORES																												
TOTAL ORANGE SCORES																												
Nurse Initial																												

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

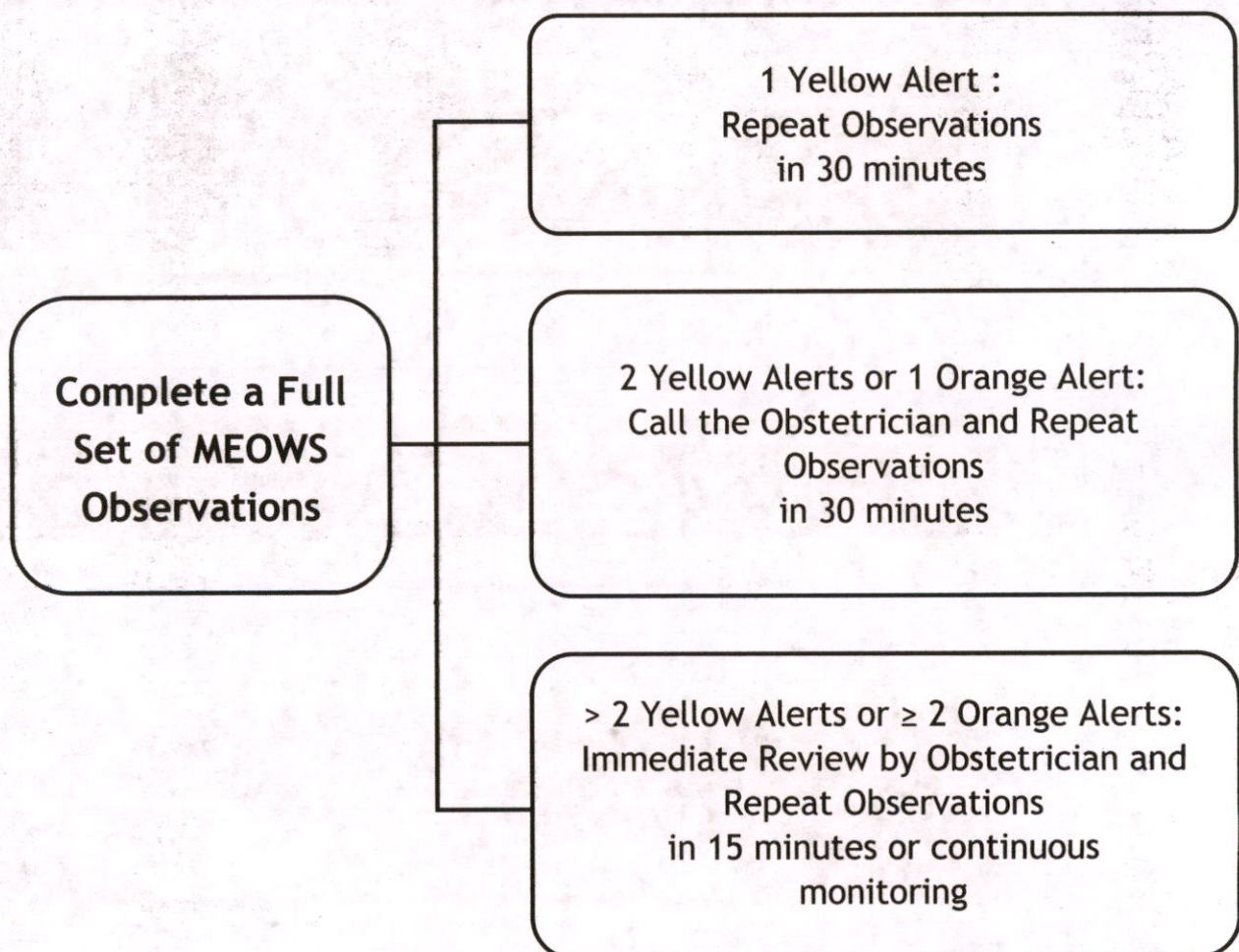
BAH-00483384 IP5-00176641
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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

		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																													
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Administered O ₂ (L/min.)																														
Temp °C	40																													
	39																													
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	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)



FLUID CHART

Sheet No. : ①

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		
20/9			Mouth	I.V	N.G							
	08:00 am											
	09:00 am		N									
	10:00 am		8									
	11:00 am		0									
	12:00 pm	RL		100ml								
	01:00 pm			100ml								

Total Intake :

Total Output :

20/9	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											

Total Intake :

Total Output :

20/9	08:00 pm	RL	N	120ml/hl								
	09:00 pm	RL	B	120ml/hl								
	10:00 pm	RL		120ml/hl						100ml		
	11:00 pm	RL	M	120ml/hl								
	12:00 am	RL	Sgt. chad	120ml/hl								
	01:00 am	RL		120ml/hl								

Total Intake :

Total Output :

21/9	02:00 am	RL		120ml/hl						200ml		
	03:00 am	RL	HTO	120ml/hl								
	04:00 am	RL		120ml/hl								
	05:00 am	RL		120ml/hl								
	06:00 am	RL	HTO	120ml/hl						500ml		
	07:00 am		Edly									

Total Intake :

Total Output :

Total 24 hrs. Intake	1,920 ml.	Total 24 hrs. Output	1600ml.
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FLUID CHART

Sheet No. :

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

		Intake				Output					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												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake													
Total 24 hrs. Output													

Patient Sticker

FLUID CHART

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
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											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake												
Total 24 hrs. Output												

Patient Sticker

FLUID CHART

Sheet No. :

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

		Intake				Output					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												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
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	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													

BAH-00483384 IP5-00176641
Mrs VEDAVALLI SNEHA REDDY
01-09-1989 36 Y 10 M 19 D (F)
Dr. SASIKALA KOLA

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: 20/7/26.

Assessment: Fear & Anxiety

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
12:25pm	→ plan for vitals	12:30pm	→ vitals noted done	→ patient is comfortable vitals stable
12:40pm	→ plan for skin preparation	12:45pm	→ skin preparation done	
12:50pm	→ plan for EV cannulation	12:55pm	→ EV cannulation done	
1pm	→ plan for Wfluid	1:05pm	→ Wfluid RL on flow	
1:20pm	→ to Administer medication as per as orders.	1:30pm	→ Administer medication as per as orders.	
6pm	→ to provide psychological support	7:30 M	→ provided psychological support given.	

Re-Assessment:

Special Notes: NPO * Wfluid RL on flow
* PAC done

Nurse Signature: *Neelvi*

Nurse Name: Neelvi

Date & Time: 20/7/26 at

BAH-00483384 IPS-00176641
 Mrs VEDAVALLI SNEHA REDDY
 01-09-1989 36 Y 10 M 20 D (F)
 Dr. SASIKALA KOLA



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: 20/7/26

Assessment: Patient Complaints of 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
8:00pm	Assess the general condition	8:10pm	Assessed the general condition	pt is stable
10:00pm	monitor vitals	10:10pm	Vitals checked BP, PULSE, SPO2, RSP	
12:00am	Allow sips of water	12:10am	Given sips of water	
2:00am	monitor flo chart	2:10am	Flo chart monitored	
4:00am	liquid diet	4:10am	liquid diet provided	
6:00am	Remove folleys	6:10am	folleys removed	
8:00am	provide safety	8:10am	Ensured safety	

Re-Assessment:

Special Notes:

Nurse Signature: Abhita

Nurse Name: Abhitha

Date & Time: 21/7/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 21/12/20

Assessment: Patient here for a surgery

- 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
8h	Assess the pt genl condition	9h	Assess the genl condition	Patient is stable
9h	monitor vitals	10h	monitored vitals	
10h	Administer medications	11h	Administer medications	
11h	provide diet	12h	provided diet	
	discharge		discharged	

Re-Assessment: Re-assessment was done

Special Notes:

Nurse Signature: [Signature] Nurse Name: Kanu Coran Date & Time: 21/12/20

Patient Sticker

NURSING CARE RECORD

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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. Sashikala Department: ICU Date of Admission: 20/7/26

SITUATION	Diagnosis: <u>P.L.C. Plenary myel</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area	<u>ICU</u>	<u>ICU</u>	<u>ICU</u>	<u>ICU</u>		
	Shift Time	<u>5pm</u>	<u>5pm</u>	<u>5pm</u>	<u>5pm</u>		
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<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>98.6</u>	<u>98.6</u>	<u>98.6</u>	<u>98.6</u>	
		Res:	<u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>	
		SpO ₂ :	<u>100%</u>	<u>99%</u>	<u>100%</u>	<u>100%</u>	
		Pulse:	<u>86</u>	<u>86</u>	<u>86</u>	<u>86</u>	
		BP:	<u>110/70</u>	<u>113/70</u>	<u>111/69</u>	<u>111/70</u>	
		Fall Risk Score:	<u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>	
	Pain Score:	<u>0/10</u>	<u>0</u>	<u>0</u>	<u>0</u>		
	Safety Needs:	<u>Side rails</u>	<u>Side rails</u>	<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>	<u>NA</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>	<u>NA</u>	<u>NA</u>			
Post Operative Procedure Special Orders:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>			
Handed Over By Name :	<u>Neel</u>	<u>Pudh</u>	<u>Ashwita</u>	<u>Ram</u>			
Signature :	<u>Neel</u>	<u>Pudh</u>	<u>Ashwita</u>	<u>Ram</u>			
Date:	<u>20/7/26</u>	<u>20/7/26</u>	<u>20/7/26</u>	<u>20/7/26</u>			
Time:	<u>5pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>			
Taken Over By Name :	<u>Neel</u>	<u>Ashwita</u>	<u>Ram</u>				
Signature :	<u>Neel</u>	<u>Ashwita</u>	<u>Ram</u>				
Date:	<u>20/7/26</u>	<u>20/7/26</u>	<u>20/7/26</u>				
Time:	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>				

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area						
	Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	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:					
	Res:						
	SpO ₂ :						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
	Recommendations	Safety Needs:					
Physiotherapy		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Others Specify:							
Special Diet:		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:							
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/8/26	1pm	0/10		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	-	Key
20/8/26	5pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Fullly
20/8/26	7pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Fullly
20/8/26	11pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sore
20/8/26	4am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sore -
21/8	6am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sore
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ 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:

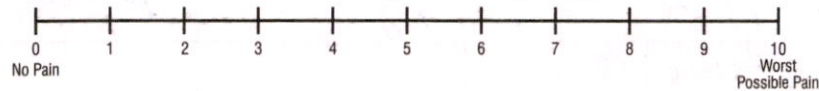
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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



Patient Sticker

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
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Re-assessment Frequency:

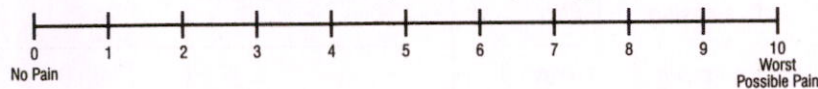
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Wong - Baker (Pediatrics) Above 7 Years



Patient Sticker

PAIN ASSESSMENT FORM

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It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
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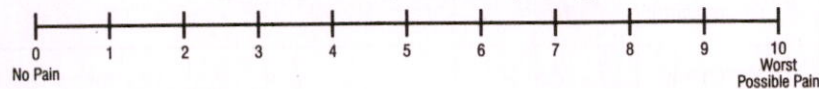
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PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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Wong - Baker (Pediatrics) Above 7 Years





CHECKLIST FOR THROMBOPHLEBITIS

20/7/26

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							
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				Key	Key	Asheet							

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 : [Signature] Name : Neerajin

Signature of Ward In Charge :

Signature : [Signature] Name : Debi Kmi



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										
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										
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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										
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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 of Ward In Charge :

Signature : Name :

Signature : Name :



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	20/7/26 20/7/26 20/7/26 2 1 1 8pm 8pm 8pm			Fall Risk Grading		
		Score				Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15		15		Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0					
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate 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			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0		0			
Total Morse Fall Scale Score:			20	30	20			
Signature			Key	2	Atul Kola			

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

BAH-00483384 IP5-00176641
 Mrs VEDAVALLI SNEHA REDDY
 01-09-1989 36 Y 10 M 20 D (F)
 Dr. SASIKALA KOLA

Morse Fall Risk Assessment Form

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 It takes a lot to treat the little.

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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						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15						
	Oriented to own ability	0						
Total Morse Fall Scale Score:								
Signature								

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				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:								
Signature								

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



BRADEN 'Q' SCALE

					Date :	20/5/26/2024	20/5/26	
					Time :	10 AM	8:15 AM	8:30 AM
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 extremity 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	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) 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	
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	
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	
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	
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
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	AD	←	ashwini

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

BAH-00483384 IP5-00176641
 Mrs VEDAVALLI SNEHA REDDY
 01-09-1989 36 Y 10 M 20 D (F)
 Dr. SASIKALA KOLA



BRADEN 'Q' SCALE

					Date :				
					Time :				
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:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.					
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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."					
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					TOTAL SCORE				
					Evaluator's Name				

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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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SURGICAL SAFETY CHECKLIST

Surgeon : DR. Sasi
Asst. Surgeon :
Anaesthetist : DR. Ranya
Scrub Nurse : Prabhavathi

BAH-00483384 IP5-00176641
Mrs VEDAVALLI SNEHA REDDY
01-09-1989 36 Y 10 M 19 D (F)
Dr. SASIKALA KOLA



Age : 36y Gender : Female
Name : lap ovarian cystectomy
Date : 20/7/26 Out-time :



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>2:45 PM</u>
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☐ Yes ☐ No ☐ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☐ Yes ☒ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☒ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA	
Blood Units Reserved	☐ Yes ☒ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	☒ Yes ☐ No ☐ NA	
Signature : <u>[Signature]</u>		
Name : <u>DR. K. SR. Ranya</u>		

TIME OUT		Time: <u>3:15 PM</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews: <u>Nothing</u>		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☐ Yes ☒ No ☐ NA		
Anaesthesia Team Reviews: <u>Nothing</u>		
Are There Any Patient-specific Concerns? ☐ Yes ☒ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA		
Is Essential Imaging Displayed? ☐ Yes ☒ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No		
Signature : <u>[Signature]</u>		
Name : <u>Swapna</u>		

SIGN OUT		Time:
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☒ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☒ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☐ Yes ☒ No		
Signature : <u>[Signature]</u>		
Name : <u>DR. MARTIN</u>		

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

Patient Name : Age : Gender :
UHID No. : Surgery Name :
Date : In-time : Out-time :



Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time:.....
Patient Has Confirmed		
Identity	☐ Yes ☐ No	
Site	☐ Yes ☐ No	
Procedure	☐ Yes ☐ No	
Consent	☐ Yes ☐ No	
Site Marked	☐ Yes ☐ No ☐ NA	
Anaesthesia Safety Check Completed	☐ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☐ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☐ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☐ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☐ No ☐ NA	
Blood Units Reserved	☐ Yes ☐ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?	☐ Yes ☐ No ☐ NA	
Signature :		
Name :		

Before Skin Incision ➤ ➤

TIME OUT		Time:.....
Confirm all team members have introduced themselves by Name and Role ☐ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☐ Yes ☐ No	
Correct Site	☐ Yes ☐ No	
Correct Procedure	☐ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☐ Yes ☐ No ☐ NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☐ Yes ☐ No ☐ NA		
Is Essential Imaging Displayed? ☐ Yes ☐ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐ Yes ☐ No		
Signature :		
Name :		

Before Patient Leaves Operating Room

SIGN OUT		Time:.....
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☐ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☐ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☐ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☐ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient?	☐ Yes ☐ No	
Signature :		
Name :		

Patient Sti

BAH-00483384

IP5-00176641

Mrs VEDAVALLI SNEHA REDDY

01-09-1989

36 Y 10 M 19 D

(F)

Dr. SASIKALA KOLA



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 20/07/26

Department : P.O.F - IV Duration of Procedure :

Name of Surgeon : Date of Admission : 20/07/26

Bundle Care Criteria : (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☒ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☒ Yes ☐ No Name of the Antibiotic : <u>Aug. Cefotaxime 1gm</u>	<u>[Signature]</u>
2.	Hair Removal ☒ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☒ Ward ☐ Operating Room ☐ Other : _____ Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☐ No	<u>[Signature]</u>
3.	Patient's body temperature immediately post operation (Recovery Room) _____ °C ☐ Oral Or ☐ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : <u>Dr. Sasikala / Mayana</u> Date & Time of antibiotic administration : <u>20/07/26 @ 2pm</u> Date & Time procedure started : <u>20/07/26 @</u>	<u>[Signature]</u>

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

Docu. No. : RCHBH/ FRM / CLINICAL / 038

BAH-00483384 IP5-00176641
Mrs VEDAVALLI SNEHA REDDY
01-09-1989 36 Y 10 M 19 D (F)
Dr. SASIKALA KOLA



POST-SURGICAL CARE PLAN FORM

Procedure Done:

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

- BP/PR/PO2 every 30 min for 2hr

Wound Care:

- Nil

Drain /Special Lines/Catheters:

- Nil

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: Time:

Note: Plan of care will be readjusted if necessary.



DISCHARGE PLANNING FORM

Nationality: INDIAN

NOTES: * To be completed by a NURSE within (24) hours of admission.

1. Anticipated Date of Discharge: As per as doctor advised

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication	☐ Yes	☒ No
☐ Bathing	☐ Yes	☒ No
☐ Eating	☐ Yes	☒ No
☐ Walking	☐ Yes	☒ No
☐ Dressing	☐ Yes	☒ No
☐ Toileting	☐ Yes	☒ No

No need for assistance

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☒ Patient ☐ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: personal hygiene

☐ Patient's Educational Topic/s discussed with the:

☒ Patient ☒ Family Member

☐ Others:

Nurse Signature: Reep

Nurse Name: Reep

Date and Time: 20/2/20 at 1pm

CONSENT FORM FOR ANAESTHESIA

Patient Name : Mrs. Sneha Reddy Age : 36 yrs Gender : Male ☐ Female ☒
UHID NO: BAH-00483384 Surgeon Name: Dr. Sarikala. Iyer
Anaesthesiologist : Dr. Lavitha Operative procedure planned : Laparoscopic ovarian
left sided cystectomy

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- | | | | |
|---|---------------------------------------|---|--|
| ☐ Heart disease | ☐ Hypertension | ☐ Diabetes mellitus | ☐ Renal failure |
| ☐ Hepatic disorders | ☐ Shock | ☐ Multiple organ failure | ☐ Polytrauma / Renal Tubular Acidosis |
| ☐ Incapacitating Chronic Obstructive Pulmonary Disease ☐ Others : | | | |

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia (☐ Regional / ☒ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthesia team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : [Signature]
Name : Mrs. Sneha Reddy
Relationship with Patient : Self
Date & Time : 20/7/26 12:45pm

Witness :

Signature : [Signature]
Name : V. SHIVA
Date & Time : 20/7/26 12:45pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Lavitha

Date & Time : 20/7/26 12:45pm

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

BAH-00483384 IP5-00176641
Mrs VEDAVALLI SNEHA REDDY
01-09-1989 36 Y 10 M 19 D (F)
Dr. SASIKALA KOLA



Patient Name :

BAH-00483384 IP5-00176641
Mrs VEDAVALLI SNEHA REDDY
01-09-1989 36 Y 10 M 19 D (F)
Dr. SASIKALA KOLA

10Y

Gender: ☐ Male ☒ Female

Age : 36 years

UHID No :



Date : 20/07/2026

Instruction:

This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)

LAPROSCOPIC LEFT OVARIAN CYSTECTOMY

upon

(Name of the Patient) Mrs. P. Sneha Reddy

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery /procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

Bleeding, infection, injury to adjacent structures

My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
- I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: Mrs. Dr. Sasikala Kola

Consentee :

Signature : Sneha Reddy

Name : Mrs. P. Sneha Reddy

Date & Time : 20/7/2026 ; 12:45PM

Witness :

Signature : Neeyan

Name : Neeyan

Date & Time : 20/7/26 at 1pm

Docu. No. : RCHBH /FRM / CLINICAL / 027

Patient Attendant :

Signature : U. Shiva

Name : U. SHIVA

Relationship with Patient: Husband

Date & Time : 20/7/26 ; 12:45PM

Doctor (who is taking the consent) :

Signature : Dr. Draga

Name : Dr. Draga

Date & Time : 20/7/2026 ; 12:30PM



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Age: Sex: UHID.No :

Date: 20/7/26 Time: Proposed Operation: Lap. ovarian cystectomy

Diagnosis: Left ovarian Endometriotic cyst

B.P / CRT: 103/66 H.R: 90/min Weight: 80.3 kgs ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb:	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate:	Na:	Dir. Bill:	Blood group:	Stress/Angio:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	
	Cl-:	SGOT/SGPT:		

Allergies: Nil

Medical History: CVS :

RESP :

Diabetes :

CNS :

Renal :

Hepatic / GE :

Physical Activity:

Others :

Past Anaesthetic History:

H/O prev. lcs in 2012 + SAB & Lap. Appendectomy + GA
back & urinary

Physical Exam:

Airway: MR 1 2 3 4

Mouth Opening: Adequate

Mentohyoid Distance: 3F

Neck: (C)

Teeth: (C)

Lungs: cl. clear

Heart: S5

CNS:

Pregnant: ☐ Yes ☒ No ☐ NA

Venous Access Site :

Spine Exam for regional :

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL
 Water / ORS 2 Hours
 Others 6 hours
3. Informed consent ☒ Standard ☐ Standard
4. Post Operative Pain Management ☒ Standard ☐ Standard
5. Other Instructions

Signature: [Signature]

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



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Age: Sex: UHID.No :

Date: 20/7/26 Time: Proposed Operation: Lap. ovarian cystectomy

Diagnosis: Left ovarian Endometriotic cyst

B.P / CRT: 103/66 H.R: 80mt Weight: 80.3kgs ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb:	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate:	Na:	Dir. Bill:	Blood group:	Stress/Angio:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	
	Cl -:	SGOT/SGPT:		

Allergies: Nil

Medical History: CVS :

RESP :

Diabetes :

CNS :

Renal :

Hepatic / GE :

Physical Activity:

Others :

Past Anaesthetic History: H/O prev. lcs in 2012 for SAB & Lap. Appendectomy for G1A
Physical Exam: back & venum

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: 3F Neck: @ Teeth: @

Lungs: cl. clear

Heart: S5

CNS:

Pregnant: ☐ Yes ☒ No ☐ NA

Venous Access Site :

Spine Exam for regional :

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL
 Water / ORS 2 Hours
 Others 6 Hours
3. Informed Consent: ☒ Standard ☐ High Risk

4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

Signature: [Signature]

Name: [Signature]



ANAESTHESIA CHART

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Pre induction Assessment:

Change in Patient Condition:

☐ Yes ☒ No

Physical Status:

☒ Patient Identified

Fasting Status:

Continue

☒ Consent Present

☒ Chart Reviewed

H.R:

99

B.P / CRT:

110/60/16

SpO₂:

99

Pre-OP Diagnosis:

(1) Endometriosis

R.R:

Surgeon:

Dr. Sharadika

Operation:

Laparoscopic ovariectomy

Last Feed:

7:30 PM

Anaesthesiologist:

Dr. RK

Technician:

Gopi

Drugs:

IV MIDAZOLAM

IV FENTANYL

IV PROPOFOL

IV ROCURONIUM

IV PARACETAMOL

IV MORPHINE

FiO₂ / SaO₂

ETCO₂

ECG

Temperature

Urine Output

Antibiotic

Suppository

Sup. Diclofenac

Sup. PRAMA

Blood Loss

MDL

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B.P
V Systolic
A Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

LAB Values

☒ Equipment Checked and Functional

☒ BP

☒ Cuff Site: (1)

☒ Art Site:

☒ EKG Lead: 3 lead

☒ Temp Site: 3 lead

☒ Temp Site: 3 lead

☒ Temp Site: 3 lead

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Temp:

☐ HME

☐ Cling Film

☐ Hugger's

☐ Other

☐ Fluid Warmer

☐ OH Warmer

☐ Cotton Wool

Times:

Anaes Start:

OP Start:

Induction:

☒ IV

☐ Pre O₂

☐ Others

☐ Inhal

☐ RSI

☐ Mask

☐ Airway

☐ Oral

☐ Tracheostomy

☐ Drug:

☐ SGA

☐ Oral

☐ Nasal

☐ Cuff

☐ Topical

☒ Direct Vision

☒ Sphygmomanometer / Bougie

Regional:

Extremity

☐ Spinal

Others:

Position:

Site:

Needle Size:

Parasthesia

Catheter at skin

Drug Name & Conc:

Bolus:

Infusion:

Blood Level:

Comments:

Transportation to

☒ PACU

Relaxant Reversed

☐ ICU

☐ No

☐ Yes

☐ Other

☐ NA

Name of the Doctor:

Signature of the Doctor:

Dr. K. SRIRAMU



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Age: Sex: UHID.No :

Date: 20/7/26 Time: Proposed Operation: Lap. ovarian cystectomy

Diagnosis: Left ovarian Endometriotic cyst

B.P / CRT: 103/66 H.R: 60/min Weight: 80.3 kgs ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb:	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate:	Na:	Dir. Bill:	Blood group:	Stress/Angio:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	
	Cl-:	SGOT/SGPT:		

Allergies: Nil

Medical History: CVS:

RESP:

Diabetes:

CNS:

Renal:

Hepatic / GE:

Physical Activity:

Others:

Past Anaesthetic History: H/O prev. lcs in 2012 - SAB & Lap. Appendicectomy - GA 1yr back / uneventful

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mento-hyoid Distance: 3.5 Neck: @ Teeth: @

Lungs: cl. clear

Heart: 55

CNS:

Pregnant: ☐ Yes ☒ No ☐ NA

Venous Access Site:

Spine Exam for regional:

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Signature: Name: Dr. S. Pruthi

BAH-00483384 IP5-00176641
Mrs VEDAVALLI SNEHA REDDY
01-09-1989 36 Y 10 M 20 D (F)
Dr. SASIKALA KOLA

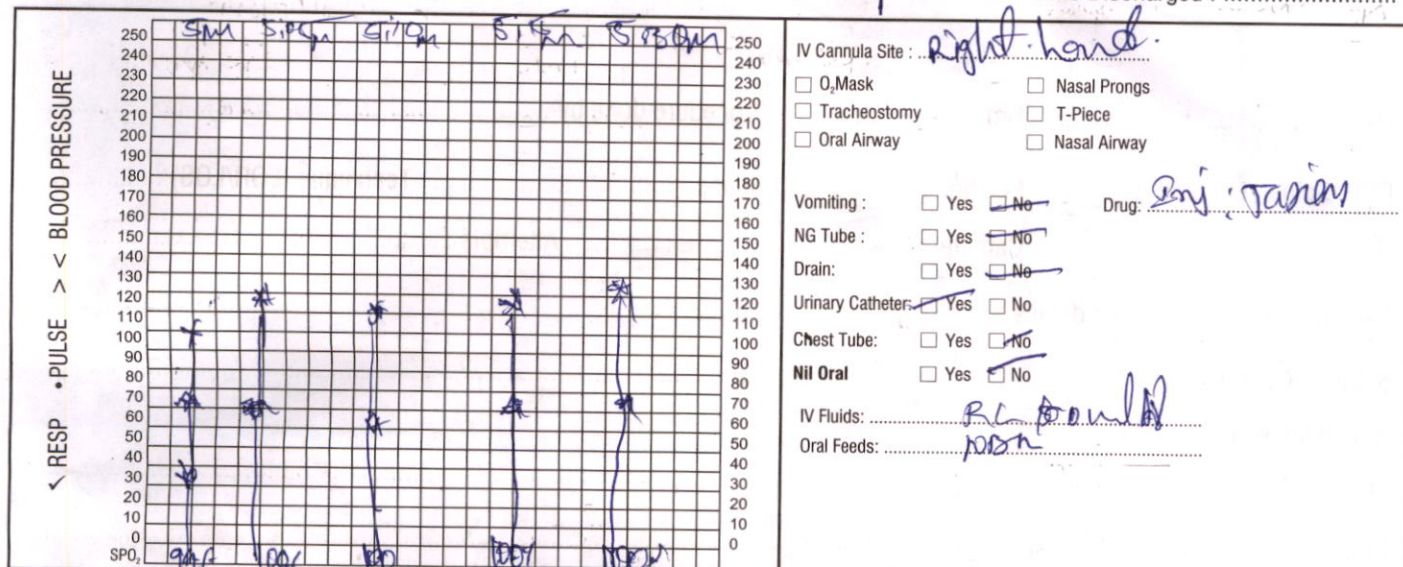


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Children's
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Your Right to a Safe Delivery

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Pedley Time Received : 5 PM Time Discharged :



POST ANAESTHESIA SCORE (Modified Aldrete Score)		MINUTES			OUT	SCORING INTERPRETATION
		IN	30	60	90	
Able to move 4 extremities voluntary or on command	= 2	1	2	2	2	A Minimum Total Score of 8 is Required for Discharge
Able to move 2 extremities voluntary or on command	= 1					
Able to move 0 extremities voluntary or on command	= 0					
Able to deep breathe & cough freely	= 2	1	2	2	2	Exceptions to this, are to be explained in the space below by the Discharging Physician:
Dyspnea or limited breathing	= 1					
Apneic	= 0					
BP $\pm$ 20 of Pre Anaesthetic level	= 2	1	2	2	2	
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1					
BP $\pm$ 50 of Pre Anaesthetic level	= 0					
Fully awake	= 2	1	2	2	2	
Arousable on calling	= 1					
Not responding	= 0					
Pink	= 2	1	2	2	2	
Pale, dusky, blotchy, jaundiced, other	= 1					
Cyanotic	= 0					
TOTAL		5	10	10	10	5

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
20/7/16	5 PM	9/10	under sedation	Pedley
20/7/16	5:30 PM	1/10	under sedation	
20/7/16	6 PM	1/10	under sedation	

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

Anaesthesiologist Name :

Anaesthesiologist Signature :

Date & Time :

PACU Nurse Name : Pedley

PACU Nurse Signature :

Date & Time : 20/7/16 2:5 PM

Reassessment Frequency:

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

Transferred to Unit by (PACU):

Date & Time :

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

CSE /Spinal /Epidural Position : Space : Technique (LOR/LOS)

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :