BAH-00633054 IP5-00173756
Mrs PRATHIMA K
01-05-1991 35 Y 0 M 12 D (F)
Dr. K BHARGAVI REDDY

# SURGERY DETAILS

Date : 13/5/26

Patient Name: Mrs PRATHIMA K. Date of Birth: ........ Age: ........

Gender: ........ Ward : ........ UHID No.: ........

Date of Surgery: 13/05/2026 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☑ OBG OT-2

Name of the Surgery : Cerclage. + Spiral

Time in : ........ Time Out : ........

| | | NAME | AMOUNT |
|---|---|---|---|
| 1. | Surgeon | Dr. Prathima. K | |
| 2. | Anaesthetist | Dr. Shilpa | |
| 3. | Assistant Surgeon | — | |
| 4. | OT Technician | Aman | |
| 5. | Circulating Nurse | Kranthi | |
| 6. | Assistant Nurse | Srilatha | |

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: ........ Order by: ........

Docu. No. : RCHBH/FRM/GENERAL/114

BAH-00633054
Mrs PRATHIMA K IP5-00173756
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Cerclage

# CONSUMABLES OF OT

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Technician : ........................ Date : 12/1/24 3342 Time : 9 AM

| Anaesthesia Disposables | Qty Issued | Qty Used | Surgical Disposables | Qty Issued | Qty Used | Disposables (Baby Side) | Qty Issued | Qty Used |
|---|---|---|---|---|---|---|---|---|
| ET tube | | | ~~Major Pack~~ | | | Inj Vit.K | | |
| LMA | | | Sutures 5061 | | 01 | Cord Clamp | | |
| ECG leads (A) / P / N | | 03 | Proto gonon | | 02 | Suction Catheter | | |
| HME filter : A / P / N | | – | | | | Feeding Tube | | |
| Syringes : 10 cc | | ~~0~~ | | | | Vaccum Suction Set | | |
| 05 cc | | 01 | Gloves 6½ | | 02 | Surgical Gloves | | |
| 02 cc | | 02 | | | | Gauze Pack | | |
| 01 cc | | | | | | Syringe 1ml / 2ml | | |
| Cautery plate : A / P / N | | | Surgical blade | | | Surgical Blade # 20 | | |
| IV set | | | NG tube | | | Koochies (S) | | |
| RL | | 02 | Cautery pencil | | | | | |
| NS : 10ml / (100ml) / 500ml / 1000ml | | 00 | Koochies | | | | | |
| Mini Spike | | 00 | Ointments | | | | | |
| Lox 2% | | 01 | Suction Catheter | | | | | |
| Fentanyl | | | Cap, Mask | | 5+5 | | | |
| Morphine | | | Gauze Pack | | 01 | | | |
| Ketamine | | | Mop Pack | | | | | |
| Propofol | | | Steristrip | | | | | |
| Rocuronium | | | Underpad | | 01 | | | |
| Glycopyrolate | | | Draw sheet | | | | | |
| Myopyrolate | | | Abgel | | | | | |
| Ondansetron | | | Foleys catheter | | | | | |
| Pencan (25g) / Spinal Needle 22 | | 01 | Urobag | | | | | |
| Bupivacaine 0.25% | | | Chest Drainage Catheter | | | | | |
| Bupivacaine (0.25%(Heavy)) | | 01 | Romodrain bag | | | | | |
| Antibiotics | | | Bandage | | | | | |
| | | | Tegaderm | | | | | |
| Suppositories | | | Ioban | | | | | |
| Anamol : 80mg / 250mg / 170 mg | | | Double J Stent | | | | | |
| Supridol : (100mg) | | 01 | Vaccum Suction set | | | | | |
| Justin : 12.5 mg / 25mg / 100mg | | | Plastic Bed Sheet | | | | | |
| Tab. Misoprost : 200mg | | | Betadine Solution | | 01 | | | |
| gauze glove (6) | | 0+1 | Microshield | | | | | |
| | | | Cotton Balls | | 01 | | | |
| | | | Latex Gloves | | | | | |
| | | | Ramdione Scrub | | | | | |
| | | | Saral | | | | | |

Dr Bhargavi Reddy — Surgeon    Dr Philips — Anaesthesiologist    [signature] — Nurse    [signature] — OT Technician

Order No. : 96059 81/80 .......... Ordered by : ..........

Doc. No. : RCHBH/ FRM / GENERAL / 125

Rainbow Children's Hospital | BirthRight by Rainbow

**Rainbow Children's Hospital - Banjara Hills**

8-2-120/103/1,2,3,4 and 5,Road No: 2, Banjara Hills, Telangana, Hyderabad, INDIA Banjara Hills ,Hyderabad ,Telangana, India ,500034.
TEL NO :+91-40-4466 5555
WEB : https://rainbowhospitals.in

# ADMISSION SHEET

## Registration Details :

**Admission No** : IP5-00173756 **Admit Date** : 13-May-2026 **Admit Time** : 07:10 AM **UHID** : BAH-00633054

## Patient Details :

**Patient Name** : Mrs PRATHIMA K
**Guardian** : Mr SASIDEEP KOMMAREDDY
**Gender** : Female
**Occupation** :
**Address (H)** : #SRI SAI VILLA APTS, G1, 6-3-1216/12 METHODIST COLONY, KUNDAN BAGH EXTENSION Begumpet Hyderabad Telangana INDIA 500016

**Age** : 35 Y 0 M 12 D
**DOB** : 01-05-1991
**Religion** :
**Martial Status** : Married
**Phone No** : 9849930006/ 9494251234
**E-mail** : nomailid@gmail.com

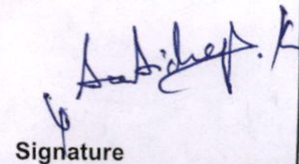
## Admission Details :

**Bed Type** : DAY CARE **Bed No** : BC DC 419 **Ward Name** : 4F-BIRTHING CENTRE
**Room No** : BC DC 419 **Admission Type** : First Visit

## Contact Details :

**Name** : Mr SASIDEEP KOMMAREDDY
**Contact Address** : #SRI SAI VILLA APTS, G1, 6-3-1216/12 METHODIST COLONY, KUNDAN BAGH EXTENSION Begumpet Hyderabad Telangana INDIA 500016

**Relationship** : Husband
**Phone No** : 9849930006 / 9494251234



**Signature**

## Doctor Details :

**Doctor Name** : Dr. K BHARGAVI REDDY
**Referral Doctor** : Self
**Co-Consultant** :

**Specialisation** : OBSTETRICS AND GYNECOLOGY
**Phone No** :

## Payment Details :

**Payment Mode** : Cash

**Deposit Amount** : 0.00
**Payor Name** : SELFPAY

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## ACTIVITY RECORD FOR BILLING

BAH-00633054 IP5-00173756
Mrs PRATHIMA K
01-05-1991 35 Y 0 M 12 D (F)
Dr. K BHARGAVI REDDY

Name : ______________________________

UHID No. : ____ Consultant: __________ Dept : __________

Date of Admissi[on] ____ Date of Discharge : ________ Time: ________

Room / Bed No : __________ Ward : __________ Suggested Billable bed type : ______________

## WARD TRANSFERS

| Date | Time | From | To | Signature of Nurse |
|---|---|---|---|---|
| | | | | |
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## Cross Consultation Visit

| | Doctors Name | Date | Order No. | Signature |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
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| 10 | | | | |

Docu. No. RCHBH/FRM/GENERAL/145

**INVESTIGATIONS**

| Date | Investigations | Order No. | Signature |
|---|---|---|---|
| 13/5/26 | CBP | 26048524 | [signature] |
| 13/5/26 | HVS | 26048606 | [signature] |
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## MEDICAL EQUIPMENT (WARD & ICU)

| Date | Name of Equipment | Connecting Time | Disconnecting Time | Order No. | Signature |
|---|---|---|---|---|---|
| 13/5/21 | Cardiac monitor. | 10:45Am | 12pm | 9606031 | Swapna |
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## PROCEDURE

| Date | Procedure | Quantity | Order No. | Signature |
|---|---|---|---|---|
| 13/5 | Po placement | 01 | 9605657 | Swapne |
| 13/5 | PAC | | 9605656 | |
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## ANY OTHER INFORMATION

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Date : Time : Prepared By :

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

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# I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 13/5/26 Time of Admission : 9AM

Allergies: Cephamycin / Doxycycline / Minocycline / Tetracyclin / Trimethoprims Diaminopyrimidines ☐ Not know any drug allergies

**PRESENTING COMPLAINTS :**

cervical cerclage i/v/o short cervix

| MENSTRUAL HISTORY | OBSTETRIC HISTORY |
|---|---|
| Year of Marriage : 2015, NCM | Parity : Primi |
| Previous Periods : Regular | Mode of Delivery : OI conception |
| LMP : 16/5/25 EDD 22/9/26 | Last Child Birth : |
| Contraception : Nill | Booked @ 7 wks |

| PAST MEDICAL HISTORY | PAST SURGICAL HISTORY |
|---|---|
| Hypothyroid | Nill |

BAH-00633054 IP5-00173756
Mrs PRATHIMA K
01-05-1991 35 Y 0 M 12 D (F)
Dr. K BHARGAVI REDDY

| FAMILY HISTORY: | MEDICATION HISTORY: |
|---|---|
| Father DM | See reconciliation |

**INITIAL ASSESSMENT :**

| | Breasts | Local/Speculum Examination |
|---|---|---|
| Date 13/5/26 | soft | – |
| Ht. 169 Wt. 80.90 | | |
| BMI 28.33 | | Bimanual Pelvic Examination |
| B.P 100/70 | Abdominal Examination | – |
| Pallor – | ~ 21wks | |
| CVR 88bpm | | |
| Respiratory System | | |
| Thyroid | | |

**PROVISIONAL DIAGNOSIS :** Primi 21+1 | Short cervix | Hypothyroid

| INVESTIGATIONS ORDERED | PLAN OF MANAGEMENT |
|---|---|
| HIV<br>HBsAg<br>HCV<br>VDRL } NR<br><br>O positive<br><br>8/5/26: SLIUG 20+3<br>breech CL 25mm<br>369g (58%) echogenic<br>AC 29.1 ICF - LV | NBM<br>consent<br>Parts prep<br>vitals<br>FHR<br>PAC<br>CBP |

Name of the Doctor : Dr. Y. Sneha

Signature of Doctor Sn. Y

Date & Time : 13/5/26 7AM

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# PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---|---|---|
| 13/5/26 10:35am | POD0 / cerclage | |
| | Pt conscious O/E | Adv |
| | GC: fair, afebrile | - NBM for 4hrs |
| | PR-96bpm | - vitals every 15min |
| | BP-110/68mmHg (MAP 83) | - w/f bleeding PV, pain abdomen |
| | SpO2-100% on RA | - drugs as per charted |
| | P/A: ut 20wks size Relaxed | - Encourage voiding |
| | | - Inform DS |
| | | Dr. Sameena |

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# PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes | Doctor's Order |
|---|---|---|
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# MEDICATION RECONCILIATION FORM

Drug Allergies: ........................................ ☑ Not known any Drug Allergies

**Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.**
**(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)**

Shifting From: ........................................ Shifted to: ........................................

| S.No | MEDICATION NAME (GENERIC NAME CAPITAL LETTERS) | DOSE (mg, mcg) | ROUTE (PO, NG, SC, IV) | FREQUENCY | LAST DOSE Date / Time | ON ADMISSION / SHIFTING |
|---|---|---|---|---|---|---|
| 1 | Cap SUSTEN | 200mg | PO | BD | 13/5/26 | ☑ C ☐ DC |
| 2 | T Thyronorm | 50mcg 75mg | PO | OD | 13/5/26 | ☐ 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 : [signature] Dr. Y. Sneha

Date & Time : 13/5/26 7AM

Nurse Name & Signature: Swapna

Date & Time : 13/5/2026 4am

Docu. No. : RCHBH /FRM / GENERAL / 090

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# DRUG CHART

Date of Admission: 13/5/2026 Drug Allergies: Cephamycin Diaminopyrimidine Trimethoprime & Doxycycline Minocycline Tetracycline ☐ Not known any Drug Allergies

**FOR THE SAFETY OF THE PATIENT**

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

## SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name

BAH-00633054 IP5-00173756
Mrs PRATHIMA K
01-05-1991 35 Y 0 M 12 D (F)
Dr. K BHARGAVI REDDY

# REGULAR PRESCRIPTIONS

Weight. .................. Ward. ....OBS......

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

| DRUG : TAB PARACETAMOL | | | | Date ▸ / Time ▾ |
|---|---|---|---|---|
| Dose | Route | Frequency | Start Date | |
| 650mg | P/o. | QID | 13/5/26 | |
| Name & Signature of the Doctor Starting the Drugs: Dr Shilpa | | | | |
| Additional Instructions: | | | | |
| Daily Doctor's Endorsement by a Sign | | | | |

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

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

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Weight. .................. Ward. OBS

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

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

**STAT / ONCE ONLY DRUGS**

| Date | Time | Medication | Dosage & Other Instructions | Route | Signature | Nurses |
|---|---|---|---|---|---|---|
| 13/5 | 8am | Inj CEFOTAXIME | 1gm | IV | [signature] Y | Swapna Sandhya |
| 13/5 | 8:5Am | Inj PANTOP | 40mg | IV | [signature] Y | Swapna Sandhya |
| 13/5 | 8:10Am | Inj PERINORM | 10mg | IV | [signature] Y | Swapna Sandhya |
| 13/5 | 8:30Am | Inj PROLUTON | 500mg | IM | [signature] Y | Swapna Sandhya |
| 13/5 | 10:15Am | SUP. TRAMADOL | 100mg | P/R | [signature] | [signature] Kranti |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

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

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# I.V. FLUIDS CHART

Weight. .................. Ward. OBS

| | | 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 |
|---|---|---|---|---|---|---|---|---|---|
| 13/5 | 8am | RINGER LACTATE 500ml | IV | 100ml/hr | [signature] | [signature] / [signature] | 13/5 | | [signature] / [signature] |
| 13/5 | 10am | RINGER LACTATE 500 ml | IV | 100ml/hr | [signature] | [signature] / [signature] | 13/5 | [signature] | [signature] / [signature] |
| 13/5 | 12pm | RINGER LACTATE 500ml | IV | 150ml/hr | [signature] | [signature] / [signature] | 13/5 | [signature] | |
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VERIFIED BY : Name .................. Signature ..................

# INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

**Part - I,**

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

**Identified Education Needs :**

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

**Part - II**

| Date | Time | Need Indentified | Information Taught | Use codes from the list in part III | | | | | Comments | Designation / Signature |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Person Taught | Learning Barries | Teaching Tools | Mechanism/s to overcome barrier/s | Understanding | | |
| 13/5/26 | 7AM | 1,2,4 | D, Rx, care plan, consent | PT/S | 1 | O | 1 | 1 | | [signature] |
| 13/5 | 8AM | 7 | Infection control measures | Pt/s | 1 | O | 1 | 1 | O | [signature] |
| | | | | | | | | | | |
| | | | | | | | | | | |

**Part - III : CODES**

**Who was taught :** PT : Patient F : Father M : Mother S : Spouse Sn : Son D : Daughter C : Caregiver O : Other (Specify).......................

**Learning Barriers :**
1. No Learning Barries
2. Physical Impairment
3. Emotional Barries
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process / Cognitive limitations
8. Responsibilities at Home
9. Cultural Difference
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision / or Hearing
13. Cultural / Religion Practice
14. Others (Specify) .......................

**Teaching Tools Used :** A : Audio D : Demonstration V : Video O : Oral P : Printed

**Mechanism/s to overcome barrier/s :**
1. None
2. translator
3. Reassurance & Support
4. Teach Family / others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify.......................

**[Understa]nding :** 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

RCHBH / FRM / CLINICAL / 187

Patient Sticker

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# MULTI-DISCIPLINARY PLAN OF CARE FORM

**Diagnosis:**

| Date Time | Discipline | Type | Patient Needs / Problem List | Goal | Plan / Intervention | Signature | Team Verification |
|---|---|---|---|---|---|---|---|
| 13/5/26 7Am | ☑ Medical<br>☐ Nursing<br>☐ Others: | ☑ Initial<br>☐ Modified<br>☐ Per-Op<br>☐ Post Op | Primi short cervix | cerclage | Cervical cerclage | [signature] | ☐ Nursing<br>☐ Others: |
| 13/5/26 8Am | ☐ Medical<br>☑ Nursing<br>☐ Others: | ~~☐ Initial~~<br>☐ Modified<br>☐ Per-Op<br>☐ Post Op | fear and Anxiety | → To reduce fear and anxiety | → Provided psychological supp | [signature] | ☐ Medical<br>☐ Others: |
| | ☐ Medical<br>☐ Nursing<br>☐ Others: | ☐ Initial<br>☐ Modified<br>☐ Per-Op<br>☐ Post Op | | | | | ☐ Medical<br>☐ Nursing<br>☐ Others: |
| | ☐ Medical<br>☐ Nursing<br>☐ Others: | ☐ Initial<br>☐ Modified<br>☐ Per-Op<br>☐ Post Op | | | | | ☐ Medical<br>☐ Nursing<br>☐ Others: |
| | ☐ Medical<br>☐ Nursing<br>☐ Others: | ☐ Initial<br>☐ Modified<br>☐ Per-Op<br>☐ Post Op | | | | | ☐ Medical<br>☐ Nursing<br>☐ Others: |

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# RESULT SHEET

| Date | 13/5/24 | | | | | |
|---|---|---|---|---|---|---|
| Time | | | | | | |
| Hb | 11.7 | | | | | |
| PCV | 35.6 | | | | | |
| RBC | 4.56 | | | | | |
| WBC | 13.67 | | | | | |
| N/L | | | | | | |
| Platelets | 343 | | | | | |
| CRP | | | | | | |
| ESR | | | | | | |
| PCT | | | | | | |
| RBS | | | | | | |
| Na | | | | | | |
| K | | | | | | |
| Cl | | | | | | |
| Ca/Mg | | | | | | |
| Phosphate | | | | | | |
| Urea | | | | | | |
| Creatinine | | | | | | |
| ALP | | | | | | |
| SGPT | | | | | | |
| SGOT | | | | | | |
| T.Bill/Conj | | | | | | |
| T.Protein | | | | | | |
| S.Albumin | | | | | | |
| S.Globulin | | | | | | |
| A/G Ratio | | | | | | |
| Uric Acid | | | | | | |
| S.Amylase | | | | | | |
| Sr.Lipase | | | | | | |
| Blood Lactate | | | | | | |
| S.Cholesterol | | | | | | |
| PT/INR | | | | | | |
| APTT | | | | | | |
| CSF Protein / Sugar | | | | | | |
| Cells | | | | | | |
| N/L | | | | | | |

| Date | | | | | | |
|---|---|---|---|---|---|---|
| Time | | | | | | |
| CUE - Alb | | | | | | |
| CUE - Sugar | | | | | | |
| CUE - Ketones | | | | | | |
| CUE - PUS Cells | | | | | | |
| CUE - RBC Cells | | | | | | |
| CUE | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Stool Pus Cell | | | | | | |
| OVA / Cyst | | | | | | |
| Occult Blood | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
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| | | | | | | |
| | | | | | | |

Culture and Sensitivities : ....................................................................................................

....................................................................................................

....................................................................................................

....................................................................................................

Radiology : USG : ....................................................................................................

X-Ray : ....................................................................................................

ECHO : ....................................................................................................

CT : ....................................................................................................

MRI ....................................................................................................

Others (ECG, Contrast Studies etc.,) : ....................................................................................................

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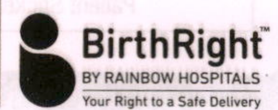



# OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 13/5/26 Time of Arrival: 7:10AM Time Seen by Nurse: 7:15AM

1) **Level of Consciousness:** ☑ Conscious ☐ Semi-Conscious ☐ UnConscious

2) **Chief Complaint (Reason for Visit):** (Circle the item as appropriate)

☐ Severe Pain / Moderate Pain ☐ Preterm rupture of Membranes / Leaking Water PV
☐ Bleeding PV: Slight / Heavy ☐ Preterm Labor/ Labor
☐ Decreased Fetal Movement ☐ Spontaneous Rupture of Membrane / Leaking Water PV
☐ No Fetal Movement ☐ Other Reason: ......

3) **Vital Signs:** Temperature: 98.1F Pulse: 80 RR: 20 $SpO_2$: 99% BP: 110/65 Weight: ......

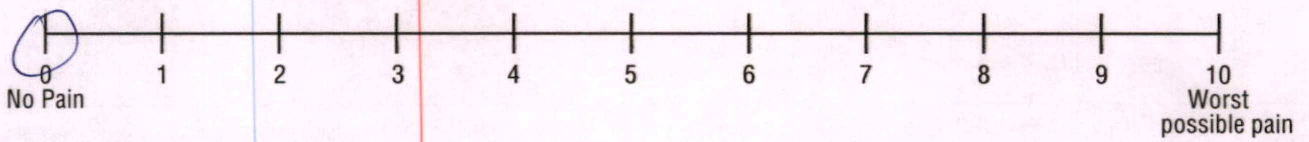
4) **Gestational Criteria:**

| Gravida: | G 1 | P | L | A |
|---|---|---|---|---|

LMP: 16/5/25 EDD: 22/9/26 Gestational Age: 21+1

| | | | | | | |
|---|---|---|---|---|---|---|
| Uterine Contraction | ☐ Yes | ☑ No | ☐ NA | Onset | Time | Frequency: |
| Membrane Rupture | ☐ Yes | ☑ No | ☐ NA | Onset | Time | Fluid Color: |
| Vaginal bleeding | ☐ Yes | ☑ No | ☐ NA | Onset | Time | Amount: |
| Pre Eclampsia Symptoms | ☐ Yes | ☑ No | ☐ NA | If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting | | |
| Good fetal Movement | ☑ Yes | ☐ No | ☐ NA | If No specify: | | |

5) **Pain Screening:** **Numerical Pain Scale (NPS)**




- Location: ......
- Duration: ...... Days / Weeks/ Months (Strike out which is not applicable)
- Character: ......
- Frequency: Nill Significant
- Interventions: ......

......

6) **Past History:**

a) Surgeries: Nill
b) Medical: Hypothyroidism

Docu. No. : RCHBH /FRM / CLINICAL / 098 (P.T.O.)

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**7) Allergy:** ☐ Yes ☑ No, If Yes : ..........

**8) Current Medications:** ☑ Prenatal Vitamin ☐ None ☐ Others: ..........

**9) Prenatal Medical History:**

- ☑ None
- ☐ Chronic Hypertension
- ☐ Gestational Hypertension
- ☐ Diabetes
- ☐ Gestational Diabetes
- ☐ Low placenta
- ☐ Others if yes, specify ..........

**Triage Category:** (Please tick on the category)

***Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)***

- ☐ **Category I:** Resuscitative (Time to Physician: Immediate & Reassessment: Continuous nursing care)
- ☐ **Category II:** Emergent (Time to Physician: ≤ 15 minutes & Reassessment: Every 15 minutes)
- ☐ **Category III:** Urgent (Time to Physician: ≤ 30 minutes & Reassessment: Every 15 minutes)
- ☑ **Category IV:** Less Urgent (Time to Physician: ≤ 60 minutes & Reassessment: Every 30 minutes)
- ☐ **Category V:** Non Urgent (Time to Physician: ≤ 120 minutes & Reassessment: Every 60 minutes)

**OBCU Obstetrical Triage Acuity Scale (OTAS)**

| OTAS | Level 1 (Resuscitative) | Level 2 (Emergent) | Level 3 (Urgent) | Level 4 (Less Urgent) | Level 5 (Non Urgent) |
|---|---|---|---|---|---|
| Level 1 (Resuscitative) | Immediate | ≤ 15 minutes | ≤ 30 minutes | ≤ 60 minutes | ≤ 120 minutes (2 Hours) |
| Re-Assessment | Continuous Nursing Care | Every 15 Minutes | Every 15 Minutes | Every 30 Minutes | Every 60 Minutes |
| Labour / Fluid | Imminent Birth | Suspected Pre-term Labour / PPROM < 37 Weeks | Signs of Active Labour > 37 weeks | Signs of Early Labour/ SROM > 37 weeks | Discomforts of Pregnancy |
| Bleeding | Active Vaginal bleeding with/ without abdominal pain | Bleeding associated with cramping (<spotting) <37 weeks | Bleeding associated with cramping (>spotting) >37 weeks | Spotting | |
| Hypertension | Seizure activity | Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain | Mild hypertension >140/90 with/without associated signs and symptoms | | |
| Fetal Assessment | Abnormal FHR tracing Non-Fetal Movement | Atypical FHR tracing, abnormal dopplers Diseased fetal movement | | | |
| Others | • Acute onsite severe abdominal pain<br>• Altered level of consciousness<br>• Cord prolapse<br>• Severe respiratory distress<br>• Suspected sepsis | • Major trauma<br>• Shortness of breath<br>• Unplanned and unattended birth | • Abdominal/back pain greater than expected in pregnancy<br>• Flank pain / hematuria<br>• Nausea /vomiting and /or diarrhea with suspected dehydration | • Ongoing assessment from out patient clinic (for hypertension, blood work)<br>• Minor trauma (minor MVC/fall)<br>• Nausea/Vomiting and /or diarrhea<br>• Signs of infection (ie dysuria ,cough, fever, chills) | • Anything that does not seem to pose threat to mother or fetus<br>• Cervical ripening<br>• Out patient placenta previa protocols<br>• Pre-booked visits (ie Rh and progesterone injections, NST<br>• Assessment for version<br>• Rashes |

Time seen by Doctor: 7:10AM

Nurse Name : Swapna Nurse Signature: [signature]

Date: 13/3/26 Time: 5AM

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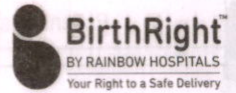


# OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 13/5/2026

**Baseline Information:**

Admission From: ☐ ER ☐ OPD ☑ Admission Desk ☐ Others, specify ......

Primary Language: ☑ Telugu ☐ English ☐ Hindi ☐ Others, specify ......

Do you require an interpreter? ☐ Yes ☑ No if Yes specify ......

Source of Information: ☑ Patient ☐ Family ☐ Others, specify ......

**Allergies:** ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: ......

If yes, identify ......

**Chief Complaints:** Came for Cerclage.

Doctor Notified on Admission: ☐ Yes ☐ No

Name of the Doctor: ......

Time Notified: ......

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

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

**Gynecology Assessment:** ☐ Not Applicable

Menstrual History: ......

Onset of Menarche: Regular

Menstrual Cycle: ☑ Regular ☐ Irregular

Last Menstrual Period: ......

**Gynecology Surgical History:**

Caesarean Section: ☑ No ☐ Yes

Cervical Cerclage: ☐ No ☑ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: ______

**Gynecological History:**

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

**Infertility:** ☑ No ☐ Yes

**If Yes Type:** ☐ Primary ☐ Secondary

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

**Previous LSCS:** ......

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

**Family History:** ☑ No Abnormalities Detected

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease

☐ Liver disease ☐ Other ......

**Vital Signs / Measurements:** Temp: 98.1F HR: 80 RR: 20

BP: 110/65 Weight: ...... Height: ...... BMI: ......

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

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## PHYSICAL ASSESSMENT

**General Appearance:** ☑ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others: ....................

**Fall Assessment:** ☐ Yes ☐ No Score ....35.... (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

Cultural & Spiritual Needs: ☐ Yes ☑ No if Yes specify .................... 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 ....Husband and 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: ....Prathima....

Orientation not given Reason: ....—....

Nurse Signature: ....[signature]....

Nurse Name: ....Swapna....

Date & Time: ....13/5/26 8AM....

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# CHECKLIST FOR THROMBOPHLEBITIS

B/J

| 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 | | | | | | | | | |
| 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 cordpyrexia | Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula | 5 | — | | | | | | | | | |
| | | | Signature of the Nurse | Sy | | | | | | | | | |

**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 : ........Kranthi........

Signature of Ward In Charge :

Signature : ........[signature]........ Name : ........R.G. Veena........

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# PAIN ASSESSMENT FORM

| | | [illegible]e | Location | Duration | Acuity | Character | Modifying Factors | Patient / Family Educated | Intervention | Sign |
|---|---|---|---|---|---|---|---|---|---|---|
| 13/5 | 8AM | 0 | NA | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☐ Yes ☐ No | NA | [signature] |
| 13/5 | 11AM | 0 | NA | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☐ Yes ☐ No | NA | Swapna |
| 13/5 | 2pm | 0 | NA | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☐ Yes ☐ No | NA | Swapna |
| | | | | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☐ Yes ☐ No | | |
| | | | | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☐ Yes ☐ No | | |
| | | | | ☐ 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 | | |
| | | | | ☐ Continuous ☐ Intermittent | ☐ Acute ☐ Chronic | ☐ Sharp ☐ Dull ☐ Aching ☐ Burning | ☐ Increasing ☐ Decreasing | ☐ Yes ☐ No | | |

**Re-assessment Frequency:**

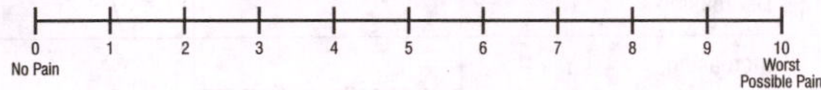
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours
   b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention.
   d) Within 30 – 60 minutes after pain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

# PAIN ASSESSMENT TOOLS

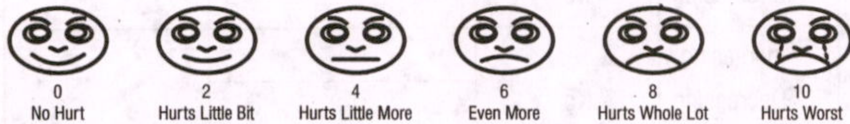
## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

## Numerical Pain Scale (Obstetric and Gynecology)




## Wong - Baker (Pediatrics) Above 7 Years




## 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, $SaO_2$ | 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 |

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# BRADEN 'Q' SCALE

Patient ID

| | | | | Date : / Time : | 12/5 / 8am | | | |
|---|---|---|---|---|---|---|---|---|
| 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. | 1 | | | |
| "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. | 1 | | | |
| 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. | 2 | | | |
| 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. | 2 | | | |
| **FRICTION-SHEAR** **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another | **1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction. | **2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. | **3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down. | **4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times." | 4 | | | |
| 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 mean and dairy products. Occasionally eats between meals. Does not require supplementation. | 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 | | | |
| | | | | **TOTAL SCORE** | 18 | | | |
| | | | | **Evaluator's Name** | [signature] | | | |

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

Docu. No. : RCHBH /FRM / CLINICAL / 119

| 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<br>• Enable as much activity as possible<br>• Protect the heels<br>• Use pressure redistribution surfaces<br>• Manage moisture, friction and shear<br>• Advance to a higher level of risk if other major risk factors are present | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay |
| 13-14 | Moderate Risk | • Use the Same Protocol as for **"At Risk"** Patients<br>• Position patient at 30 degree lateral incline using foam wedges | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay |
| 10-12 | High Risk | • Follow the same protocol as for **"Moderate Risk"** Patients<br>• In addition to regular turning schedule<br>• Make small shifts in their position frequently | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay |
| Less than 9 | Severe Risk | • Use same protocol as for **"High Risk"** Patients<br>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors. | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay |

Patient Sticker

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# Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category | | Date / Time | 13/5/26 | | |
|---|---|---|---|---|---|
| | | Score | [illegible] | | |
| History of Falling (immediately or w/in 3 months) | Yes | 25 | | | |
| | No | 0 | 0 | | |
| Secondary Diagnosis (more than one diagnosis) | Yes | 15 | 15 | | |
| | No | 0 | | | |
| Ambulatory Aid | Furniture | 30 | | | |
| | Crutches, Cane(S), Walker | 15 | | | |
| | None /Bed Rest /Nurse Assist | 0 | 0 | | |
| IV / Heparin Lock or Saline | Yes | 20 | 20 | | |
| | No | 0 | | | |
| GAIT / Transferring | Impaired | 20 | | | |
| | Weak (uses touch for balance) | 10 | | | |
| | Normal /On Bed Rest /Immobile | 0 | 0 | | |
| Mental Status | Forgets limitations | 15 | | | |
| | Oriented to own ability | 0 | 0 | | |
| Total Morse Fall Scale Score: | | | 35 | | |
| | | Signature | [illegible] | | |

| Fall Risk Grading | | |
|---|---|---|
| **Risk Level** | **Morse Fall Score (MFS)** | **Action** |
| Low Risk | 0 - 24 | Standard Fall Precaution |
| Moderate Risk | 25 - 50 | Implement Moderate Fall Prevention Intervention |
| High Risk | ≥ 51 | Implement High Risk Fall Prevention Intervention |

...) whichever precaution taken.

**...Level and Interventions**

**...sk (0 – 24) (Standard Falls Precautions)**

...e patients use their prescribed eye glasses if any, in the hospital

...irs with arm rests

... 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

Tick (
Risk
Low R
☐ Ensu
☐ Use cha
☑ Use safety

Docu. No. : RCHBH / FRI

BAH-00633054 IP5-00173756
Mrs PRATHIMA K
01-05-1991 35 Y 0 M 12 D (F)
Dr. K BHARGAVI REDDY

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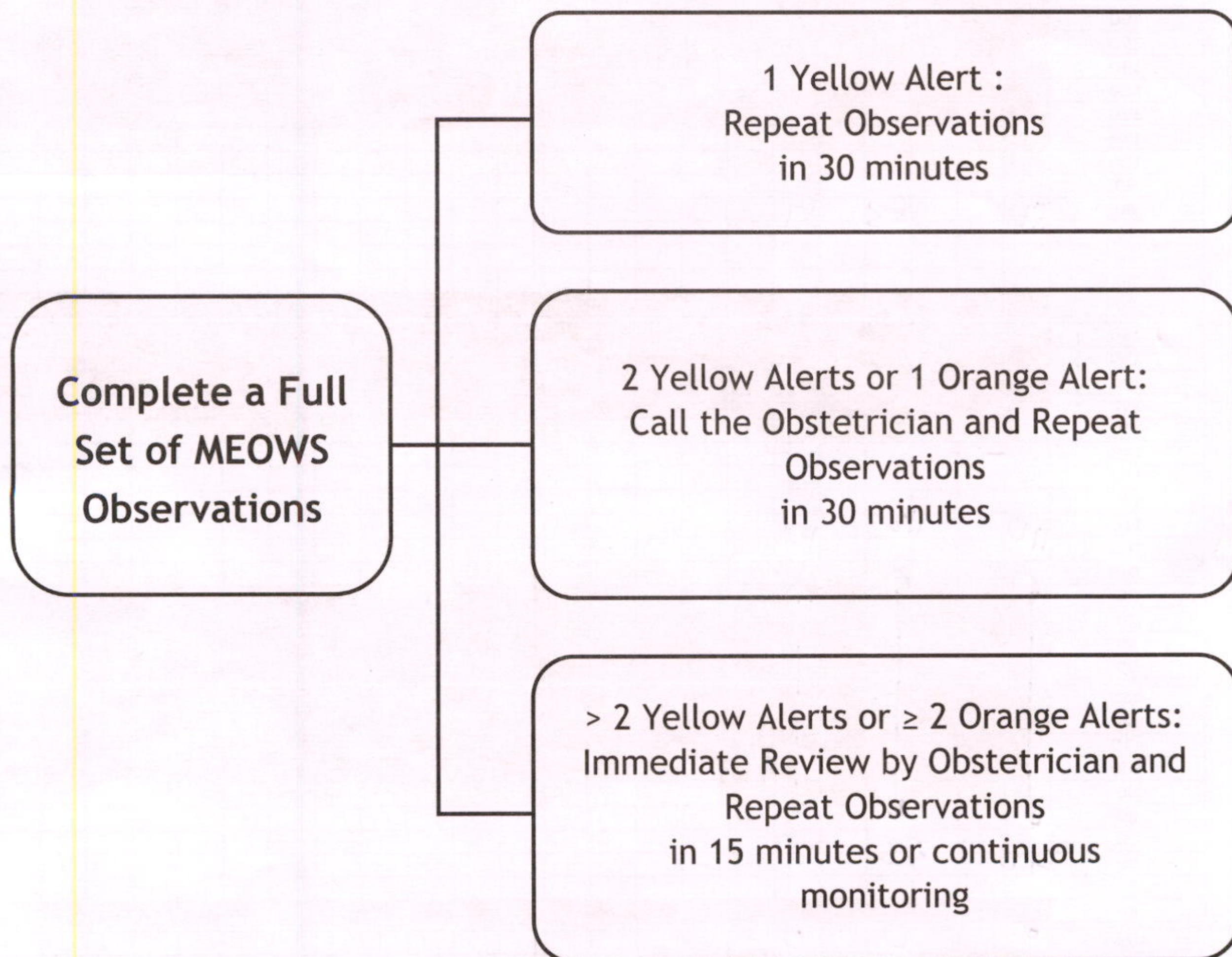
# Early Warning Observation Score Chart - Obstetrics

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

| 13/5 | Date | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Time | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| RESP (write rate in corresp. box) | > 30 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21 - 30 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11 - 20 | 20 | | | 20 | | 20 | | | | | | | | | | | | | | | | | | |
| | 0 - 10 | | | | | | | | | | | | | | | | | | | | | | | | |
| Saturations | 94 - 100 % | 99 | | | 98% | | 99% | | | | | | | | | | | | | | | | | | |
| | < 94 % | | | | | | | | | | | | | | | | | | | | | | | | |
| Administered $O_2$ (L/min.) | | | | | | | | | | | | | | | | | | | | | | | | | |
| Temp°c | 40 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 39 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 38 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 37 | 98.3F | | | 98.2F | | 98.1F | | | | | | | | | | | | | | | | | | |
| | 36 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 35 | | | | | | | | | | | | | | | | | | | | | | | | |
| | < 35 | | | | | | | | | | | | | | | | | | | | | | | | |
| Heart Rate | 170 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 160 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 150 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 140 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 130 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 90 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 80 | 80 | | | 83 | | 81 | | | | | | | | | | | | | | | | | | |
| | 70 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 50 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 40 | | | | | | | | | | | | | | | | | | | | | | | | |
| ↑ Systolic Blood Pressure | 190 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 180 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 170 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 160 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 150 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 140 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 130 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 110 | 110 | | | 112 | | 108 | | | | | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 90 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 80 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 70 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 60 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 50 | | | | | | | | | | | | | | | | | | | | | | | | |
| ↓ Diastolic Blood Pressure | 130 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 120 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 110 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 100 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 90 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 80 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 70 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 60 | 70 | | | 73 | | 70 | | | | | | | | | | | | | | | | | | |
| | 50 | | | | | | | | | | | | | | | | | | | | | | | | |
| | 40 | | | | | | | | | | | | | | | | | | | | | | | | |
| NEURO RESPONSE [✓] | Alert | 0 | | | 0 | | 0 | | | | | | | | | | | | | | | | | | |
| | Voice | | | | | | | | | | | | | | | | | | | | | | | | |
| | Pain | | | | | | | | | | | | | | | | | | | | | | | | |
| | Unresponsive | | | | | | | | | | | | | | | | | | | | | | | | |
| URINE mls / hour | > 30 | 0 | | | 0 | | 0 | | | | | | | | | | | | | | | | | | |
| | < 30 | | | | | | | | | | | | | | | | | | | | | | | | |
| Proteinuria | Protein + + | | | | | | | | | | | | | | | | | | | | | | | | |
| | Protein > + + | | | | | | | | | | | | | | | | | | | | | | | | |
| Lochia | Normal | 0 | | | 0 | | 0 | | | | | | | | | | | | | | | | | | |
| | Heavy / Foul | | | | | | | | | | | | | | | | | | | | | | | | |
| Liquor | Clear / Pink | ✓ | | | ✓ | | ✓ | | | | | | | | | | | | | | | | | | |
| | Green | | | | | | | | | | | | | | | | | | | | | | | | |
| TOTAL YELLOW SCORES | | 0 | | | 0 | | 0 | | | | | | | | | | | | | | | | | | |
| TOTAL ORANGE SCORES | | 0 | | | 0 | | 0 | | | | | | | | | | | | | | | | | | |
| Nurse Initial | | [illegible] | | | [illegible] | | [illegible] | | | | | | | | | | | | | | | | | | |

## Obstetrics and Gynaecology Early Warning Signs




* The Modified Early Warning Score **(MEOWS)**

BAH-00633054 IP5-00173756
Mrs PRATHIMA K
01-05-1991 35 Y 0 M 12 D (F)
Dr. K BHARGAVI REDDY

# 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.

| 13/5/26 | | Intake | | | | Output | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date | Time | Nature of Fluid | Route | | | NG | Diarrhoea | Vomit | Drainage | Urine | IV Site Thrombo-phlebitis Score | Sign. Nurse |
| | | | Mouth | I.V | N.G | | | | | | | |
| | 08:00 am | RL | | 100ml | | | | | | | 0 | |
| | 09:00 am | RL | N | 100ml | | | | | | ✓ | 0 | |
| | 10:00 am | RL | | 100ml | | | N | | | ✓ | 0 | |
| | 11:00 am | RL | B | 100ml | | | P | | | | 0 | Swapna |
| | 12:00 pm | RL | | 100ml | | | | | | | 0 | |
| | 01:00 pm | RL | M | 100ml | | | | | | | 0 | |
| **Total Intake :** | | | NBM | | | | | **Total Output :** | | Passed | | |
| | 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

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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 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date | Time | Nature of Fluid | Route | | | NG | Diarrhoea | Vomit | Drainage | Urine | IV Site Thrombo-phlebitis Score | Sign. Nurse |
| | | | Mouth | I.V | N.G | | | | | | | |
| | 08:00 am | | | | | | | | | | | |
| | 09:00 am | | | | | | | | | | | |
| | 10:00 am | | | | | | | | | | | |
| | 11:00 am | | | | | | | | | | | |
| | 12:00 pm | | | | | | | | | | | |
| | 01:00 pm | | | | | | | | | | | |
| **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** | |
|---|---|

Docu. No. : RCHBH/FRM/CLINICAL/092

BAH-00633054 IP5-00173756
Mrs PRATHIMA K
01-05-1991 35 Y 0 M 12 D (F)
Dr. K BHARGAVI REDDY

Patient Sticker

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# OPERATION THEATER NOTES

Patient's Name : Mrs PRATHIMA K Age : 35 yrs Gender : ☐ Male ☑ Female

UHID No.: BAH-00633054. Weight : .................. Height : ..................

| Surgeon : Dr Bhargavi | | Asst. Surgeon : Dr |
|---|---|---|
| Anesthetist : Dr Shilpa. | OT Nurse: Sr Smitha | OT Technician: - |
| Pre-Operative Diagnosis: Primi / 20+ wks / Short cervix. | | |
| Surgical Procedure : Cerclage & spiral. | | |
| Indications for Surgery : Short cervix. | | |
| Date : 13/5/2026. | Start Time : | End Time : |
| Pre Operative Preparations: Pre-op medication given. | | |
| Post Operative Diagnosis: '0' POD / Post cerclage. | | |
| Peri-Operative Complications: Nil | | |
| Operation Notes:<br>- cervix - Short.<br>- Mc Donald cerclage done.<br>c̄ silk.<br>- knot - Anterior.<br>- H/o tablets.<br>- Procedure - uneventful. | | |

Doc. No. : RCHBH/ FRM / CLINICAL / 099 (P.T.O.)

Amount of Blood Loss: < 10ml

Blood Transfused (in ML) –

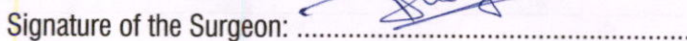
Name and Number of Surgical Specimen sent for examination:

Nil

Peri-Operative Complications:

- water after 2 hours.
- Iv fluids - Anaesthetist Advice.
- Tb Taxim-O 200mg BD × 5days
- Tb Pantop 40mg once Daily
- Cp sustain 200mg BD till further Advice.
- Ct medication (Previous).
- Review after 4weeks c̄ OCTT / CBP.
- Discharge by 3pm after voiding.

Name of the Surgeon: Dr Bhargavi Reddy



Signature of the Surgeon: ..............................

Date & Time: 13/5/2026, 11:30PM.

Patient Sticker

BAH-00633054 IP5-00173756
Mrs PRATHIMA K
01-05-1991 35 Y 0 M 12 D (F)
Dr. K BHARGAVI REDDY

# BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

***To Be Filled In By Assigned Nurse :*** Date : 13/05/26

Department : OBG-OT Duration of Procedure : 1/2 hr.

Name of Surgeon : Dr. Bhargavi reddy Date of Admission : 13/05/26

**undle Care Criteria : (Tick (✓) if done)**

| | | Staff Signature |
|---|---|---|
| 1. | Antibiotic given prior to surgery ? ☑ Yes ☐ No<br>☑ Single Dose Antibiotic or Long Antibiotic Regime<br>Antibiotic administered within 60 minutes prior to incision ? ☑ Yes ☐ No<br>Name of the Antibiotic : Inj. Taxim 1gm | [signature] |
| 2. | Hair Removal ☑ Yes ☐ No if Yes : Surgical Clipper<br>Department where Hair Removed : ☑ Ward ☐ Operating Room<br>☐ Other : ..........<br>Skin preparation done (cleanse surgical area with antiseptic agent)? ☑ Yes ☐ No | [signature] |
| 3. | Patient's body temperature immediately post operation (Recovery Room) 37 °C<br>☐ Oral Or ☑ Axilla (Goal : 36-37 °C) | [signature] |
| 4. | Name of doctor or staff administering the antibiotic : Dr. Saveena<br>Date & Time of antibiotic administration : 13/5/26 8 Am<br>Date & Time procedure started : 13/5/26 @10 Am | [signature] |

- 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

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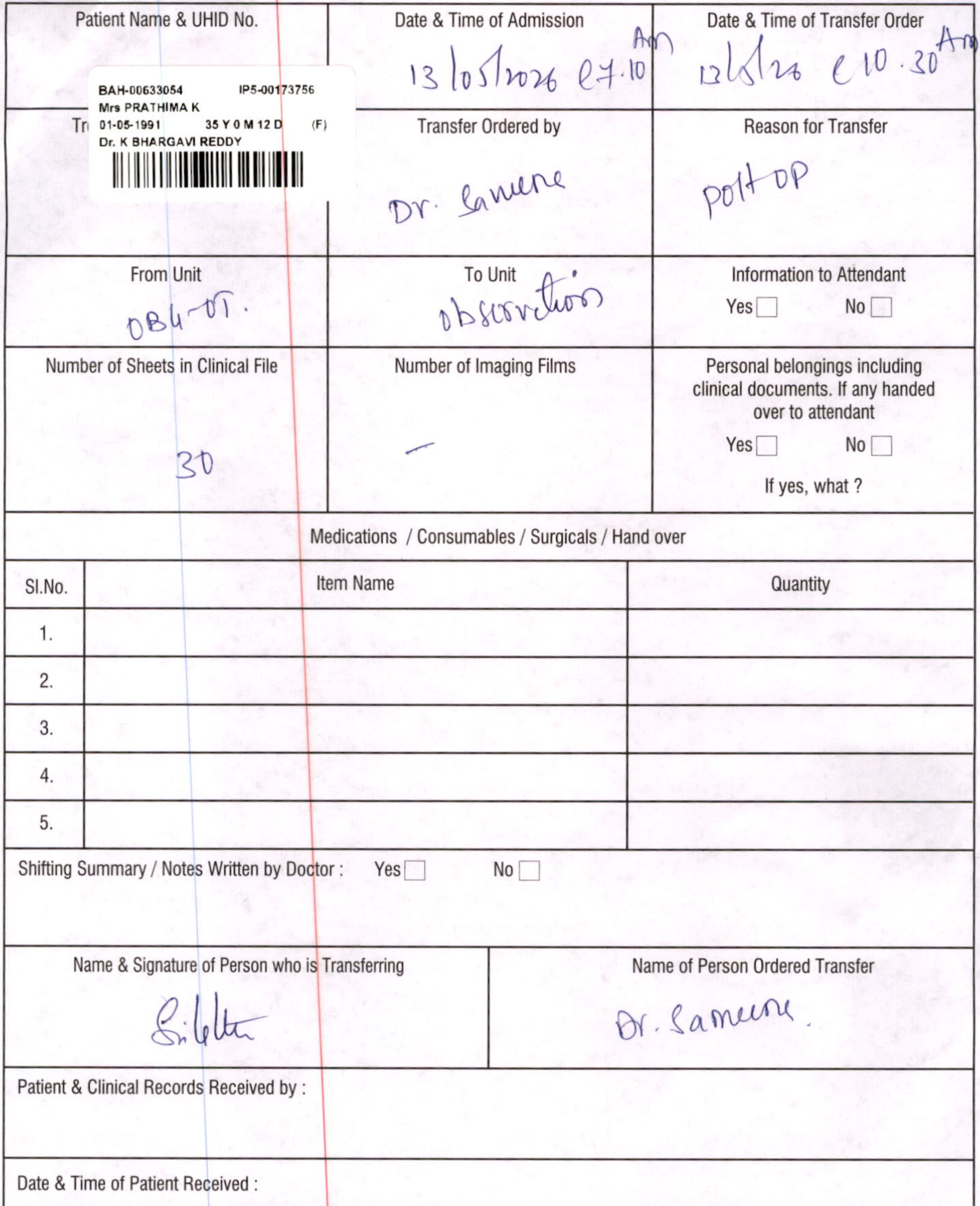
# PATIENT TRANSFER FORM



| Patient Name & UHID No. | Date & Time of Admission | Date & Time of Transfer Order |
|---|---|---|
| BAH-00633054 IP5-00173756<br>Mrs PRATHIMA K<br>01-05-1991 35 Y 0 M 12 D (F)<br>Dr. K BHARGAVI REDDY | 13/05/2026 @7.10 Am | 13/5/26 @10.30 Am |
| Tr | Transfer Ordered by<br>Dr. Sameera | Reason for Transfer<br>post op |
| From Unit<br>OBG-OT. | To Unit<br>observation | Information to Attendant<br>Yes ☐ No ☐ |
| Number of Sheets in Clinical File<br>30 | Number of Imaging Films<br>— | Personal belongings including clinical documents. If any handed over to attendant<br>Yes ☐ No ☐<br>If yes, what ? |

Medications / Consumables / Surgicals / Hand over

| Sl.No. | Item Name | Quantity |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

| Name & Signature of Person who is Transferring | Name of Person Ordered Transfer |
|---|---|
| [signature] | Dr. Sameera. |

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

☐ Unavailable Bed ☐ Nurse not Available ☐ Available Bed not ready

Docu. No. : RCHBH /FRM / CLINICAL / 102

## Department of Anaesthesiology
# PRE-ANAESTHETIC EVALUATION

BAH-00633054 IP5-00173756
Mrs PRATHIMA K
01-05-1991 35 Y 0 M 12 D (F)
Dr. K BHARGAVI REDDY

Name: Mrs. Prathima K. Age: 34Y Sex: Female UHID.No: BAH-00633054.

Date: 13/05/2026 Time: 7:20Am Proposed Operation: Cervical cerclage. 1/V/O short cervix.

Diagnosis: Primi 21wks.

B.P / CRT: 100/70 H.R: 88/min Weight: 80 kgs. ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

**Laboratory Data:**

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

**Allergies:** Allergic to Diaminopyrimidine. Trimethoprim. Cephamycin Doxycycline, Minocycline, Tetracycline

**Medical History:** CVS: / RESP: / CNS: / Renal: / Hepatic / GE: — Not significant.

Diabetes:

Physical Activity: Active.

Others: Hypothyroidism (+).

**Past Anaesthetic History:** (−)

**Physical Exam:** (N)

**Airway:** MP 1 2 ③ 4 Mouth Opening: Adequate Mentohyoid Distance: 2FB Neck: (N) Teeth: intact.

**Lungs:** BAE (+) clear

**Heart:** S1S2 (+)

**CNS:** HMF (+).

Pregnant: ☑ Yes ☐ No ☐ NA | Venous Access Site: 18G (L) DUC | Spine Exam for regional: (N).

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

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

| CURRENT MEDICATIONS | DOSAGE |
|---|---|
| T. THYRONORM | 50mcg PO. |
| | |
| | |
| | |

**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:
   CBP.

Signature: [signature] Name: ..............

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

BAH-00633054 IP5-00173756
Mrs PRATHIMA K
01-05-1991 35 Y 0 M 12 D (F)
Dr. K BHARGAVI REDDY

# ANAESTHESIA CHART

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## Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No | Fasting Status: Adequate

Physical Status: ☑ Patient Identified ☑ Consent Present ☐ Chart Reviewed

H.R.: 101/min 120/80 | B.P / CRT | SpO₂: 100% | R.R: 20/min | Last Feed: last night

Pre-OP Diagnosis: .................. Operation: Cx Cerclage ........ Date : 13/5/20

Surgeon: Dr. Bhargavi Reddy Anaesthesiologist: Shilpa Technician: Aman

| TIME | 9/40 | 10/10 | Antibiotic |
|---|---|---|---|
| $N_2O$ /AIR /$O_2$ LPM | | | |
| HALO /SO /SEVO | | | |
| Drugs: | | | Suppository |
| FIO₂ / SaO₂ | 100 | 100 | Blood Loss |
| $ETCO_2$ | | | |
| ECG | SR | SR | |
| Temperature | | | NOTES |
| Urine Output | | | |
| Fluids / Blood | RL | | |

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate
Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: ..................
☐ Art Site: ..................
☑ EKG Lead
☐ Temp Site
☐ FIO₂Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Lithotomy
☐ Pressure Points Checked

**Eye Care:**
☐ Oint
☐ Tape
☐ Padding
☐ Awake

**Temp:**
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☐ Other

**Times:**
Anaes Start: 9/40
OP Start: ..................
OP End: ..................
Leave OR: 10/10

**Anaesthesia:**
☐ GA
☐ Monitored Anaesthesia Care
☑ Regional

**Line (Size & Location)**
☐ CVP: ..................
☐ ART: ..................
☐ IV: ..................
☑ IV: 20 G
☐ IV: ..................

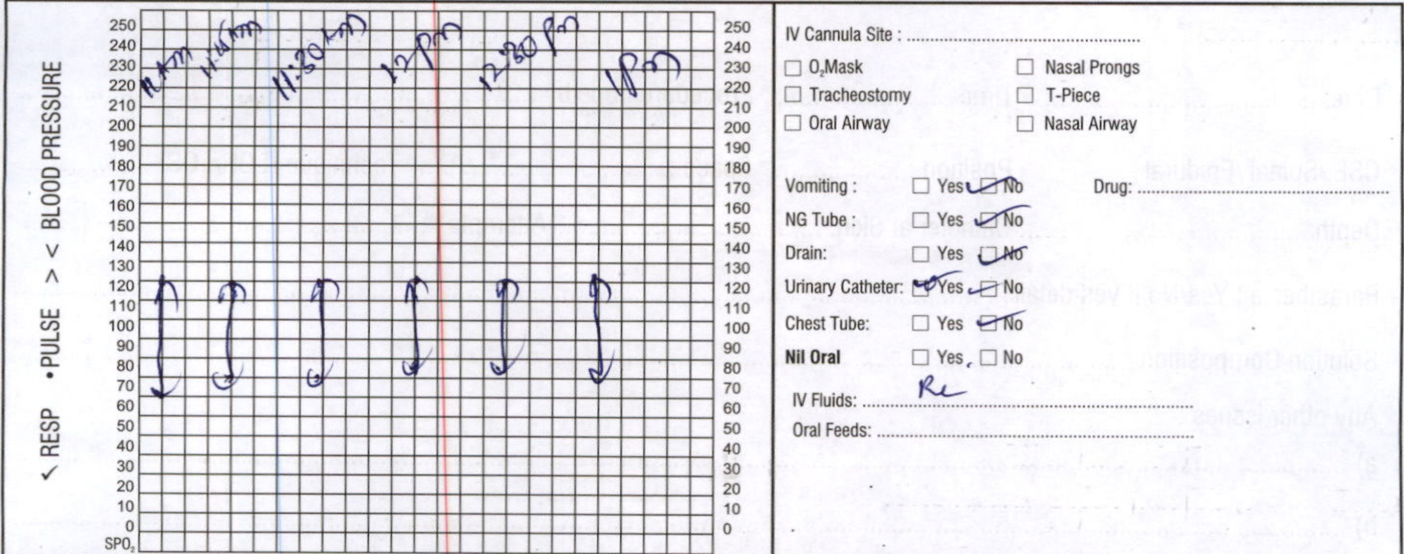
**Induction**
☐ IV ☐ Inhal
☐ Pre O₂ ☐ RSI
☐ Others
☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# .............. at .............. cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: ..................
☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# .............. Attempts: ..............
Difficulty Why? ..................
☐ Bilat = BS
☐ Semi-Closed Circle
☐ Closed Circle
☐ Other

**Regional:**
Extremity Specify: ..................
☑ Spinal ☐ Epidural ☐ Caudal
Others: ..................
Position: ..................
Site: 1.5 cc of 0.5% Bupi (H)
Needle Size: .............. Depth: ..............
Parasthesia ☐ Yes ☐ No
Catheter at skin .............. cm
Drug Name & Conc: ..................
Bolus: ..................
Infusion: ..................
Block Level: ..................
Comments: ..................
Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA
Name of the Doctor : Dr SHILPA
Signature of the Doctor : [signature]

BAH-00633054 IP5-00173756
Mrs PRATHIMA K
01-05-1991 35 Y 0 M 12 D (F)
Dr. K BHARGAVI REDDY

# POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Swapne  Time Received : 11am  Time Discharged : ..................




IV Cannula Site : ..................

☐ O2 Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☑ No  Drug: ..................
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☑ Yes ☐ No
Chest Tube: ☐ Yes ☑ No
**Nil Oral** ☐ Yes ☐ No
IV Fluids: RL
Oral Feeds: ..................

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

## PAIN ASSESSMENT AND MANAGEMENT FORM

| Date | Time | Pain Score | Intervention | Signature |
|---|---|---|---|---|
| 13/5 | 11Am | 0 | NA | [signature] |
| | | | | |
| | | | | |
| | | | | |

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

**Reassessment Frequency:**
1. Every eight hours for all hospitalized patients.
2. For post surgical patient, patient with chronic pain, patient with severe pain
   a. Every 2 hours for first 24 hours
   b. After 24 hours every 4 hours
   c. Prior to pain reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name : ..................
Anaesthesiologist Signature: ..................
Date & Time: ..................

PACU Nurse Name : Swapne
PACU Nurse Signature: Swapne
Date & Time: 13/5/2026 10Am

Transferred to Unit by (PACU): OBS
Date & Time: 13/5/2026 12pm

Patient Sticker

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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 Left | Level Right | Maternal BP | Maternal Pulse | FHR | Comments |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
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| | | | | | | | | |
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| | | | | | | | | |
| | | | | | | | | |

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 : ...........................................................

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# CONSENT FOR ANAESTHESIA

Authorization By: ☑ Patient ☐ Patient Attendant

Operative Procedure: Cervical cerclage

Anaesthesiologist: Dr. Tejaswini Surgeon: Dr. Bhargavi Reddy.

**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 can be achieved by infusing weak solutions of local anaesthetics 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 ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others Desaturation.

**Declaration by Patient Attendant**

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team

  ☐ Regional Anaesthesia ☑ General Anaesthesia ☐ Monitored Anaesthesia Care

- 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, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also 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 if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

**Patient / Patient Attendant:**

Signature: B. Prathima

Name: Prathima. K.

Relationship with patient: Self

Date & Time: 13/05/2026 7:25Am.

**Witness:**

Signature: Sasideep K

Name: SASIDEEP. KOMMAREDDY

Date & Time: May-13-2026 / 7:25. AM

**Doctor (who is taking consent):**

Signature: [signature] Name: Dr. Tejaswini Date 13/5/26 Time: 7:25Am

Patient Sticker

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# అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: ..........

అనస్థీషియా వైద్యుడు: .......... శస్త్రచికిత్స నిపుణుడు: ..........

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు. రీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్స్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి: ..........

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
  ☐ రీజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జీ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టీరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రీజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్పష్టమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: ..........

పేరు: ..........

రోగితో సంబంధం: ..........

తేదీ & సమయం: ..........

సాక్షి:

సంతకం: ..........

పేరు: ..........

తేదీ & సమయం: ..........

డాక్టర్ :

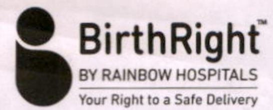
సంతకం: .......... పేరు: .......... తేదీ & సమయం: ..........

Docu. No. : RCHBH / FRM / CLINICAL / 021



(P.T.O)

# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE




Patient Name : Mrs. Prathima. K Gender: ☐ Male ☑ Female Age : 34

UHID No : BAH-00633054 Date : 13/5/2026

**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)

CERVICAL CERCLAGE

upon (Name of the Patient) Mrs. Prathima. k

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, Damage to surrounding organs

**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.
4. 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: Dr. Bhargavi

**Consentee :**

Signature : B.Prathima

Name : Mrs. Prathima. K

Date & Time : 13/5/26 7am

**Patient Attendant :**

Signature : [signature]

Name : SASIDEEP. KOMMAREDDY

Relationship with Patient:

Date & Time : 13/5/26 7AM

**Witness :**

Signature : [signature]

Name : Swapna

Date & Time : 13/5/2026 8am

**Doctor (who is taking the consent) :**

Signature : Dr. Y

Name : Dr. Y. Sneha

Date & Time : 13/5/2026; 7am