

MAH-00389029 IP5-00174639  
 Mrs GISHWARYA 31 Y 0 M 5 D (F)  
 28-05-1995  
 Dr. SHRUTHI REDDY/Dr. LAVANYA

Mrs GISHWARYA (31 Y 0 M 5 D / F)  
 OTHERS  
 MIN/00212  
 BA26056033032

MAH-00389029



### SURGERY DETAILS

80487

Date : 02/06/14

Patient Name: G. Ishwarya Date of Birth: 28-05-1995 Age: 31y

Gender: Female Ward: P. OT UHID No: MAH-00389019

Date of Surgery: 02/06/14  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2

Name of the Surgery : Hysteroscopic Endometrial polypectomy + Endometrial curettage

Time in : 1:35 PM

Time Out : 2:25 PM  
 2:25 PM

	NAME	AMOUNT
1. Surgeon	Dr. Shrutti Reddy	
2. Anaesthetist	Dr. Ravi	
3. Assistant Surgeon	Dr. Sravanthi	
4. OT Technician	Ramesh	
5. Circulating Nurse	B. J. Phli	
6. Assistant Nurse	Ramesh	

Special Equipment:  Laparoscopy  Broncoscope  Harmonic  Morcelator  
 C-ARM  Cystoscopy  Versa Point  Liver Cusa  
 Neuro Cusa  Others ..... Hysteroscopy: - 9639582

Signature of the Surgeon: Dr. Shrutti Reddy

Signature of Circulating Nurse: B. J. Phli

Order No: 9639582

Order by: J. Ramasani

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 28-05-1995  
 Dr. SHRUTHI REDDY/Dr. LAVANYA

*Hydroscopy*  
*coly hydroscopy*  
**CONSUMABLES OF OT**

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

**BirthRight**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

Cir: *Romy* Technician: ..... Date: *2/6* Time: *2:00 PM*

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube <i>7.0-7.5</i>	14	—	Major Pack <i>Drape</i>	1	1	Inj Vit.K		
LMA <i>3.4</i>	14	1	Sutures <i>leggings</i>	2	2	Cord Clamp		
ECG leads: A/P/N	04	3				Suction Catheter		
HME filter: A/P/N	01	1				Feeding Tube		
Syringes : 10 cc	10	8				Vaccum Suction Set		
05 cc	10	6	Gloves <i>6.6 1/2 7-7 1/2</i>	2+2+2	3	Surgical Gloves		
02 cc	10	9	Pf-6.6 1/2 7-7 1/2	2+2+2	—	Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate <i>A/P/N</i>	01	—	Surgical blade			Surgical Blade # 20		
IV set	01	—	NG tube			Koochies (S)		
RL	01	1	Cautery pencil			NS. 500ml	1	—
NS : 10ml / 100ml / 500ml / 1000ml	1+1+2	4	Koochies			transofix	1	—
<i>win spill</i>	01	1	Ointments			Jelly	1	—
<i>Vacay set</i>	01	1	Suction Catheter			Netton 10*10	1	—
Fentanyl	01	1	Cap, Mask <i>NTR</i>	5	3	TARP set	1	1
Morphine			Gauze Pack	5	5			
Ketamine			Mop Pack	1	—			
Propofol	03	2	Steristrip					
Rocuronium	01	—	Underpad	1	1			
Glycopyrolate	01	1	Draw sheet	1	1			
Myopyrolate	01	1	Abgel					
Ondansetron	01	—	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag			<i>0.2 213</i>	1	—
Bupivacaine 0.25%	01	1	Chest Drainage Catheter			<i>0.2 28.50</i>	1	—
Bupivacaine 0.25%(Heavy)			Romodrain bag			<i>0.2 28.50</i>	01	—
Antibiotics			Bandage			<i>LoxiCo</i>	1	1
<i>IV pen</i>	01	1	Tegaderm			<i>nida</i>	1	1
Suppositories			loban			<i>xander</i>	1	1
Anamol : 80mg / 250mg / 170 mg			Double J Stent			<i>100</i>		
Supridol : 100mg	01	1	Vaccum Suction set	1	—	<i>refantaly</i>	1	1
Justin : 12.5 mg / 25mg / 100mg	01	—	Plastic Bed Sheet	1	1	<i>clonon</i>	1	1
Tab. Misoprost : 200mg			Betadine Solution	1	1			
<i>3oney 100ml + 100ml</i>	1	—	Microshield	1	1			
<i>Gauze 14x14</i>	5	—	Cotton Balls	1	1			
<i>Latex gloves</i>	14	14	Latex Gloves	10	10			
<i>IV gauge 20/10</i>	1	—	Ramdione Scrub					
<i>Oral splint</i>	1	1	Saral					

Surgeon: ..... Anaesthesiologist: *9639560* Nurse: *[Signature]* OT Technician: .....

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

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

# ESTIMATION SLIP

80487

Date: 28/05/2026 UHID / IP No.: BEA MAH-00389029  
 Name of Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: F  
 Father's / Husband's Name: Mrs. G. Ishwarya Corporate / Occupation: 314  
 Address: \_\_\_\_\_ Phone: Mr. Hemant Kumar Email: \_\_\_\_\_  
 Procedure / Plan: 9000435662  
Hysterectomy

MODE OF PAYMENT:  SELF  TPA: \_\_\_\_\_  GIPSA: \_\_\_\_\_  OTHERS

TARIFF INFORMATION:

ROOM CATEGORY	GW	SW	TSW	PVT	DLX	SDLX	NICU	PICU	MICU	DAILY CARE
Room Rent & Nursing Charges										
Doctor's Fee										
L. Tax										5500

PARTICULARS	AMOUNT (₹)												
Surgeon's / Anesthetists's Fee / O.T. Charges	<u>13860</u> (SF) <u>4160</u> (OT)												
O.T. Consumables	<u>10,000</u> (Investigation)												
Instrument Charges	Not Covered by TPA / Insurance company												
Pharmacy, Consumables & Investigations	As per actual - Not Included in Estimation												
Equipment Charges	<table border="1"> <tr> <td>Monitor :</td> <td>Oxygen</td> <td>Infusion pump / Syringe pump :</td> </tr> <tr> <td>Ventilator :</td> <td>Conventional :</td> <td>HFO-SLE 5000 :</td> </tr> <tr> <td>Phototherapy :</td> <td>Single Surface :</td> <td>HFO Sensormedix :</td> </tr> <tr> <td></td> <td>Double Surface :</td> <td>Triple Surface :</td> </tr> </table>	Monitor :	Oxygen	Infusion pump / Syringe pump :	Ventilator :	Conventional :	HFO-SLE 5000 :	Phototherapy :	Single Surface :	HFO Sensormedix :		Double Surface :	Triple Surface :
Monitor :	Oxygen	Infusion pump / Syringe pump :											
Ventilator :	Conventional :	HFO-SLE 5000 :											
Phototherapy :	Single Surface :	HFO Sensormedix :											
	Double Surface :	Triple Surface :											
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.	As per actual - Not Included in Estimation												
Package													
Others													
Initial Minimum Deposit	<u>15,000</u> (High End Equipment refer to 30th June)												

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-Medicinals, 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 7:00 AM), 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, Mrs. Ishwarya have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TPA/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: G. Ishwarya      Signatory Relationship: Self      Signature of the Financial Counselor: [Signature]

**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 : IP5-00174639      Admit Date : 02-Jun-2026      Admit Time : 11:44 AM      UHID : MAH-00389029

**Patient Details :**

Patient Name : Mrs G ISHWARYA      Age : 31 Y 0 M 5 D  
Guardian : Mr HEMANTH KUMAR      DOB : 28-05-1995  
Gender : Female      Religion :  
Occupation :      Martial Status : Single  
Address (H) : 3-7-310/5 street no. 17 A Attapur Hyderabad      Phone No : 9000435662/ 9502302478  
Telangana INDIA 500048      E-mail : ishwaiya95.ishu@gmail.com

**Admission Details :**

Bed Type : DAY CARE      Bed No : RC 408      Ward Name : 4F-GYN RECOVERY  
Room No : RC 408      Admission Type : First Visit

**Contact Details :**

Name : Mr HEMANTH KUMAR      Relationship : Husband  
Contact Address : 3-7-310/5 street no. 17 A Attapur Hyderabad      Phone No : 9000435662 / 9502302478  
Telangana INDIA 500048

*A. Radhumnatha Reddy*  
Signature

**Doctor Details :**

Doctor Name : Dr. SHRUTHI REDDY/Dr.LAVANYA JANAGAMA      Specialisation : OBSTETRICS AND GYNECOLOGY  
Referral Doctor : Self      Phone No :  
Co-Consultant :

**Payment Details :**

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


**ACTIVITY RECORD FOR BILLING**

Name : \_\_\_\_\_

UHID No. : \_\_\_\_\_ IP No : \_\_\_\_\_ Dept : \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Time : \_\_\_\_\_ Time: \_\_\_\_\_

Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

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**WARD TRANSFERS**

Date	Time	From	To	Signature of Nurse
2/6/26	1:50pm	AYAL	OT	Rajy
2/6/26	2:25pm	OT	AYAL	Babri
2/6/26	4:45pm	AYAL	Billing	Rajy

**Cross Consultation Visit**

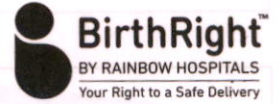
	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				







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## OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 21/6/26

**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: Mulligamida Doctor Notified on Admission:  Yes  No  
endometrial Polyp. Name of the Doctor: DR  
 Time Notified: .....

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>Nil</u>	

Gynecology Assessment: <input type="checkbox"/> Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History: .....	Caesarean Section: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Contraceptives: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Onset of Menarche: .....	Cervical Cerclage: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Vaginal Discharge: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Menstrual Cycle: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular	Ectopic Pregnancy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Post-Coital Bleeding: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
Last Menstrual Period: <u>26/5/26</u>	Myomectomy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Infertility: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes
	Others: .....	If Yes Type: <input checked="" type="checkbox"/> Primary <input type="checkbox"/> Secondary

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

Previous LSCS: .....

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

Family History:  No Abnormalities Detected

Heart Disease  Hypertension  Diabetes  Stroke  Seizures  Kidney disease

Liver disease  Other .....

Vital Signs / Measurements: Temp: 98.6°F HR: 86/nt RR: 20/nt  
 BP: 100/60/nt Weight: 51kg Height: 5 BMI: .....

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



**PHYSICAL ASSESSMENT**

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

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

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

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

Mobility problem  Walking Problem  No Abnormality Detected

Developmental Delay  Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

**NUTRITIONAL SCREENING:**  No Abnormality Detected

Overweight  Poor Appetite > 3 Days  Needs Therapeutic Diet.

Under Weight  Diabetes Mellitus  Hyperemesis Gravidarum

Inform consultant for positive criteria

**PSYCHOLOGICAL SCREENING:**

Calm & Cooperative  Restless  Depressed  Agitated  Confused

Others .....

Inform consultant for positive criteria

**SOCIAL SCREENING:**

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

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

**Social History:** Lives With .....

**Orientation has been given regarding the following aspects:**

Call Bell in Reach :  Yes  No Waste Disposal Explained:  Yes  No

Infusion Pump :  Yes  No Hand Hygiene Explained:  Yes  No  Others

Above information given to ..... *Patu at*

Name of Person Orientation was given to: ..... *MDs. Lavanya*

Orientation not given Reason: .....

Nurse Signature: ..... *Keyi*

Nurse Name: ..... *Keyi*

Date & Time: ..... *2/6/20*



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 26/8/26 Time of Admission : .....

Allergies: NKA  Not know any drug allergies

PRESENTING COMPLAINTS :

→ Nulligravida, referred by Dr. Preeti Reddy @ RCH Serilingampally for Hysteroscopy + Polypectomy.  
 → Oocyte retrieval done on 11/5/2026 for IUF in view of low AMH (0.39ng) - Nov, 2025.  
 21/8/26:  
 Sonogram: Ut - (M) 7.3 X 4 X 3.1cm, uterine length - 3.7cm, Ro - 2.7cc, Lo - 3.9cc, BL active spill.  
 Impression - echogenic lesions seen at fundal area m/s 0.9 X 0.6cm, on post-wall m/s 0.6 X 0.5cm S/O - Endometrial Polyp.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 2021, Previous Periods : Regular (Normal flow) LMP : 26/5/2026 Contraception : used OCPs for 6 months (Nov-2025 - Apr 2026)	Parity : Nulligravida, Mode of Delivery : - Last Child Birth : -

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
N/A	N/A



FAMILY HISTORY:

← father - DM

MEDICATION HISTORY:

T. Intafol, T. Fotas

INITIAL ASSESSMENT :

Date <u>2/6/26</u>	Breasts <u>(P)</u>	Local/Speculum Examination —
Ht. _____ Wt. _____		
BMI _____		
B.P _____		
Pallor <u>absent</u>	Abdominal Examination <u>(U)</u>	Bimanual Pelvic Examination —
CVR <u>S1S2 ⊕</u>		
Respiratory System <u>BAC ⊕</u>		
Thyroid <u>(N)</u>		

PROVISIONAL DIAGNOSIS :

Nulligravida / ? premature ovulation / insufficiency (AMH = 0.39) / Endometrial Polyp

INVESTIGATIONS ORDERED

BUT - Ab +ve.  
Viral - NR  
28/5/26 CBP - 12.6 / 7.93 / 3.37  
RBS - 85 mg/dL.  
TSH - 2.84.

PLAN OF MANAGEMENT

- 1) Admission
- 2) IV cannulation
- 3) PAC
- 4) part preparation
- 5) Drugs as charted
- 6) monitor vitals
- 7) Shift to OT on call

Name of the Doctor : Dr. Divya

Signature of Doctor [Signature]

Date & Time : 2/6/26 ; 12:00 pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/16/26 2:30 PM	POD - 0 / hysteroscopic polypectomy + Endometrial curettage	Be monitor vitals <sup>by x/ks</sup>
	G.C: fair B.P: 90/60 mmHg P.R: 61 bpm SPO <sub>2</sub> : 100% on RA P/A: soft P/V: NAB	1) NBM for 2-3 hrs 2) Flv / wts - loose / w 3) Drug as charted 4) w/f Flv Bleeding 5) Ambulation in Bed 6) Tylenol sos
		- Dr. Sravasthi
	noted by Neeraj	
2/16/26 4 PM	POD - 0 / hysteroscopic polypectomy + Endometrial curettage.	
<u>voided</u>	G.C: fair B.P - 110/80 P.R - 76 SPO <sub>2</sub> - 100% on RA P/A: soft Bs ⊕ P/V: NAB plan Discharge.	Be 1) Allow sip <sup>l</sup> soft water 2) liquid diet at 5 PM 3) salt diet at 6 PM 4) Monitor vitals 5) Drug as charted. 6) w/f Flv Bleeding 7) Ambulation 8) Tylenol sos



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Pa



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## OPERATION THEATER NOTES

Patient's Name : G. ISHWARYA Age : 31 Gender :  Male  Female

UHID No. : MAH-00389029 Weight : ..... Height : .....

Surgeon : Dr. Shrutii Reddy Asst. Surgeon : Dr. Lavanya

Anesthetist : ..... OT Nurse : ..... OT Technician : .....

Pre-Operative Diagnosis: Nulligravida & Endometrial polyp

Surgical Procedure : hysteroscopic endometrial polypectomy + Endometrial curettage.

Indications for Surgery : Endometrial polyp.

Date : 02/06/26 Start Time : 1:50 pm End Time : 2:20 pm.

Pre Operative Preparations: nil

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

Post Operative Diagnosis: POP-0

.....

Peri-Operative Complications: nil

.....

Operation Notes: ↓ G.A, ↓ Aseptic conditions, pub painted & draped

Anterior & posterior vaginal walls retracted & simp's speculum

anterior lip of Cervix held & wolsellum.

.....

hysteroscopy introduced into uterine cavity

1) Cervix, vagina - normal

2) B/L ostia seen.

4) A small polyp of size 0.7 x 0.5 cm

rooted at Right posterior wall of uterus

→ Proceeded & polypectomy - sent for

.....

- thickened endometrium noted.
- Curettage is done. — samples sent for HPE
- post procedure, patient is hemodynamically stable.

Amount of Blood Loss: 5ml

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

→ endometrial polyp + Endometrial curettage

Peri-Operative Complications:

### Discharge advice.

- 1) T. CEFIXIME 200mg P/O BD x 5 days
- 2) T. PARACETAMOL 1gm P/O TID x 5 days
- 3) T. PANTOPRAZOLE 40mg P/O OD x 5 days
- 4) T. ZINCOVIT 140mg P/O OD x 1 month

Collect HPE, & R/w after 10 days

— Dr. Sravanti  
BSc

Name of the Surgeon: Dr. Shrutika Reddy

Signature of the Surgeon: .....

Date & Time: 2/6/26, 2pm





REGULAR PRESCRIPTIONS

Weight. 51kg Ward. ....

DRUG : <u>T. CEFIXIME</u>				Date Time
Dose <u>200mg</u>	Route <u>P/O</u>	Frequency <u>BD</u>	Start Date <u>2/6/16</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sravath</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : <u>T. PANTOPRAZOLE</u>				Date Time
Dose <u>40mg</u>	Route <u>P/O</u>	Frequency <u>O.D</u>	Start Date <u>2/6/16</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sravathi</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : <u>T. PARACETAMOL</u>				Date Time
Dose <u>4gm</u>	Route <u>P/O</u>	Frequency <u>TID</u>	Start Date <u>2/6</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Sravathi</u>				
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				

Patient Sticker

Weight. 51kg 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
26/6/26	1pm	INJ. CEFOTAXIM	1gm	IV	RC	Nejmi 340tu
02/6/26	2:00 pm	PARACETAMOL	1gm	IV	RC	Nejmi 340tu
02/6/26	2:10 pm	DICLOFENAC	100mg	P.O	RC	Alexi Bovani

VERIFIED Name Signature





## MEDICATION RECONCILIATION FORM

Drug Allergies: Nka  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. INTAFOL	1tab	PO	OD	1/2/26	<input checked="" type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	T. ECOTASBY	1tab	PO	OD	1/2/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

Name & Signature: Dr D. D. D. D. D.

Date: 2/6/26 ; 12:08 pm

& Signature: Dr. D. D. D. D. D.

Date: 2/6/26 at 1pm.

MAH-00389029 IP5-00174639  
 Mrs GISHWARYA 31 Y O M 5 D (F)  
 28-05-1995  
 Dr. SHRUTHI REDDY/Dr.LAVANYA

Blood group

AB +ve

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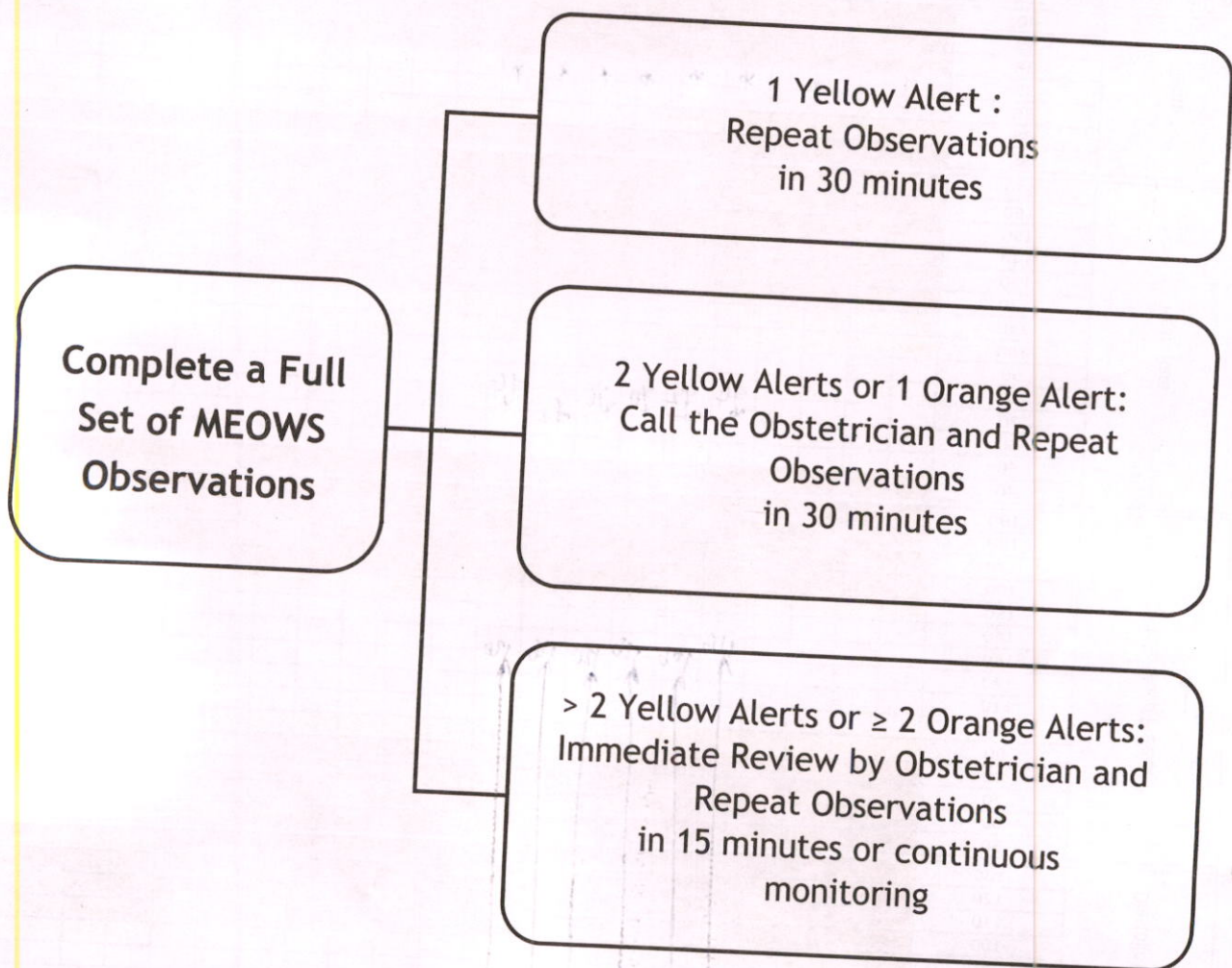
### RESULT SHEET

Date	28/5				
Time					
Hb	12.6				
PCV	37.7				
RBC					
WBC	7.93				
N/L					
Platelets	3.37				
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					






## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)

# FLUID CHART

Sheet No. : ..... 

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
2/6	08:00 am												
	09:00 am		RL									0	14
	10:00 am											0	
	11:00 am	RL		100ml								0	
	12:00 pm			100ml								0	
	01:00 pm			100ml								0	
<b>Total Intake :</b>												0	
	02:00 pm	RL		100ml								0	
	03:00 pm			100ml								0	
	04:00 pm			100ml								0	
	05:00 pm			100ml								0	
	06:00 pm			100ml								0	
	07:00 pm											0	
<b>Total Intake :</b>												0	
	08:00 pm											0	
	09:00 pm											0	
	10:00 pm											0	
	11:00 pm											0	
	12:00 am											0	
	01:00 am											0	
<b>Total Intake :</b>												0	
	02:00 am											0	
	03:00 am											0	
	04:00 am											0	
	05:00 am											0	
	06:00 am											0	
	07:00 am											0	
<b>Total Intake :</b>												0	

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

# 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.

Date	Time	Nature of Fluid	Intake			Output							
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombophlebitis Score	Sign. Nurse	
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
<b>Total Intake :</b>						<b>Total Output :</b>							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
<b>Total Intake :</b>						<b>Total Output :</b>							
<b>Total Intake :</b>						<b>Total 24 hrs. Output</b>							

Department of Anaesthesiology  
**PRE-ANAESTHETIC EVALUATION**

MAH-00389029 IP5-00174639  
 Mrs GISHWARYA  
 28-05-1995 31 Y 0 M 5 D (F)  
 Dr. SHRUTHI REDDY/Dr. LAVANYA



Name: Mrs. G. GISHWARYA Age: 31 Sex: F UHID.No: MAH-00389029  
 Date: 02/06/20 Time: 11:20 AM Proposed Operation: Hysteroscopic Polypectomy  
 Diagnosis: Endometrial Polyps  
 B.P / CRT: 120/70 H.R: 78/min Weight: 51kg ASA Physical Status:  1  2  3  4  5

**Laboratory Data:**  
 Hgb: 12.6 Glucose: 85mg/dl Protein: \_\_\_\_\_ HIV: Y/NR X-Ray: \_\_\_\_\_  
 PCV: 37.7 Urea: \_\_\_\_\_ Alb: \_\_\_\_\_ HBS Ag: Y/NR ECG: \_\_\_\_\_  
 WBC: 7930 Creat: \_\_\_\_\_ Total Bill: \_\_\_\_\_ HCV: \_\_\_\_\_ 2D Echo: \_\_\_\_\_  
 Plate: 3.37 lakh Na: \_\_\_\_\_ Dir. Bill: \_\_\_\_\_ Blood group: \_\_\_\_\_ Stress/Angio: \_\_\_\_\_  
 PT: \_\_\_\_\_ K: \_\_\_\_\_ LDH: \_\_\_\_\_ T3 \_\_\_\_\_ Other: \_\_\_\_\_  
 PTT: \_\_\_\_\_ Ca++: \_\_\_\_\_ Alk phos: \_\_\_\_\_ T4 \_\_\_\_\_  
 INR: \_\_\_\_\_ Mg++: \_\_\_\_\_ Amylase: \_\_\_\_\_ TSH 2.84 uIU/ml  
 Cl-: \_\_\_\_\_ SGOT/SGPT: \_\_\_\_\_

Allergies: NIL

Medical History: CVS: \_\_\_\_\_  
 RESP: \_\_\_\_\_ Diabetes: \_\_\_\_\_  
 CNS: \_\_\_\_\_  
 Renal: NIL SIGNIFICANT  
 Hepatic / GE: \_\_\_\_\_ Physical Activity: \_\_\_\_\_  
 Others: \_\_\_\_\_ USG: Echogenic lesion fundal area - 0.9 x 0.6 cm  
 Posterior area - 0.6 x 0.6 cm  
 Endometrial poly

Past Anaesthetic History: A/O Oocyte retrieval (11/5/20) w/e

Physical Exam:  
 Airway: MP 1 (2)3 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (N) Teeth: (N) Alignment  
 Lungs: BAC ⊕, Clear  
 Heart: S1, S2 ⊕  
 CNS: NAD  
 Pregnant:  Yes  No  NA Venous Access Site: Peripheral ⊕ Spine Exam for regional: Midline

Anaesthetic Plan:  MAC  REGIONAL  GA-ETT  LMA  
 Peri-Operative Plan Explained to the Patient:  Yes  No

CURRENT MEDICATIONS	DOSAGE
<u>T. INTAFOL</u>	<u>OD</u>
<u>T. ECOTAS BY (LACTOBACILLUS)</u>	<u>OD</u>

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

Signature: [Signature] Name: Dr. S.K. Ajeesh  
 Docu. No. : RCH / FRM / CLINICAL / 044



MAH-00389029 IP5-00174639  
 Mrs GISHWARYA 31 Y O M 5 D (F)  
 28-05-1995  
 Dr. SHRUTHI REDDY/Dr. LAVANYA

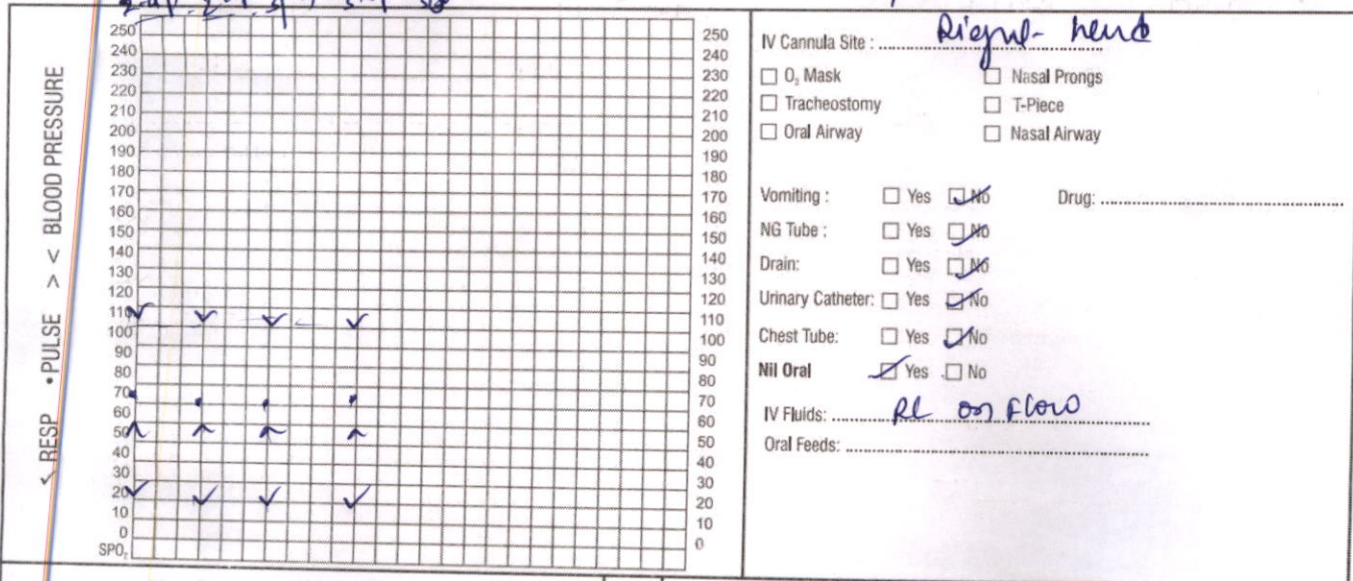


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POST ANAESTHESIA UNIT RECORD

Received in PACU by: Dr. Neeyan Time Received: 2:25 pm Time Discharged: .....



IV Cannula Site: Right hand

O<sub>2</sub> 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 on flow

Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
2/6/26	2:25 pm	0/10	on sedation	<i>[Signature]</i>
2/6/26	4:25 pm	0/10	No interventions	<i>[Signature]</i>

Pain Tool Used:  N PASS  FLACC  Wong Baker  MPS

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
  - Every 4 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

Anaesthesiologist Name: .....

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name: Neeyan

PACU Nurse Signature: *[Signature]*

Date & Time: 2/6/26 at 2:25 pm

Transferred to Unit by (PACU): NS Pling

Date & Time: 2/6/26



# INFORMED CONSENT FOR SURG SPECIAL PROCEDURE

MAH-00389029 IP5-00174639  
Mrs G ISHWARYA  
28-05-1995 31 Y O M 5 D (F)  
Dr. SHRUTHI REDDY/Dr. LAVANYA



Patient Name : Mrs. G. ISHWARYA Gender:  Male  Female Age : 28 years  
UHID No : MAH-00389029 Date : 2/6/2026

### 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)

MYSTROSCOPIC POLYPECTOMY

upon

(Name of the Patient) Mrs. G. ISHWARYA

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, Hypotension, fluid retention, Uterine perforation,

### My signature on this form indicates that

- I have read and understood the information provided in this form
- 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.
- I have had a chance to ask my surgeon questions.
- I have received all the information I desire concerning the operation or procedure and
- I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: Dr. Shruithi Reddy

### Consentee :

Signature : G. Ishwarya  
Name : Mrs. G. Ishwarya  
Date & Time : 2/6/26, 12:06 AM

### Patient Attendant :

Signature : G. Raghunath Reddy  
Name : G. Raghunath Reddy  
Relationship with Patient : Father  
Date & Time : 2/6/26, 12:07 AM

### Witness :

Signature : [Signature]  
Name : [Name]  
Date & Time : 2/6/26 at 12:07 PM

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

Signature : [Signature]  
Name : Dr. Divya  
Date & Time : 2/6/26, 12:05 AM