

SURGERY DETAILS

Date : 02/08/2028

Patient Name: Dr. Ammreen Syed Date of Birth: 23/10/1994 Age: 31 y

Gender: Female Ward: OBG UHID No.: BAH-00555756

Date of Surgery: ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☒ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Elective lower segment Caesarean Section
R/S P. Reddy LSA

Time in : 10.30 AM

Time Out : 11.20 AM

	NAME	AMOUNT
1. Surgeon	Dr. Shanthi Reddy	
2. Anaesthetist	Dr. Shilpa	
3. Assistant Surgeon	Dr. Lavanya	
4. OT Technician	S.S. Kulsum	
5. Circulating Nurse	S.S. Sushma	
6. Assistant Nurse	Sis. Lakshmi	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9684201

Order by: S.S. Ravi

CONSUMABLES OF OT

 Circulating staff : Technician : Kulsum Date : 02/7 **3684** Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <u>LSCS</u>	<u>01</u>	<u>01</u>	Inj Vit.K	<u>02</u>	<u>02</u>
LMA			Sutures <u>2346</u>	<u>01</u>	<u>01</u>	Cord Clamp	<u>01</u>	<u>01</u>
ECG leads <u>(A) P/N</u>	<u>05</u>	<u>05</u>	<u>2364</u>	<u>01</u>	<u>01</u>	Suction Catheter <u>8G</u>	<u>01</u>	<u>01</u>
HME filter : A / P / N	<u>01</u>	<u>01</u>	<u>2762</u>	<u>01</u>	<u>01</u>	Feeding Tube		
Syringes : 10 cc	<u>08</u>	<u>08</u>				Vacuum Suction Set	<u>01</u>	<u>01</u>
05 cc	<u>03</u>	<u>03</u>	Gloves <u>642/A</u>	<u>05/2</u>	<u>05/2</u>	Surgical Gloves <u>7/642</u>	<u>01</u>	<u>01</u>
02 cc	<u>03</u>	<u>03</u>				Gauze Pack <u>N</u>	<u>01</u>	<u>01</u>
01 cc	<u>03</u>	<u>03</u>	PF 7	<u>01</u>	<u>01</u>	Syringe 1ml / 2ml	<u>02</u>	<u>02</u>
Cautery plate <u>(A) P/N</u>	<u>01</u>	<u>01</u>	Surgical blade <u>22</u>	<u>01</u>	<u>01</u>	Surgical Blade # 20	<u>01</u>	<u>01</u>
IV set	<u>01</u>	<u>01</u>	NG tube	<u>01</u>	<u>01</u>	Koochies (S) <u>1'S</u>	<u>01</u>	<u>01</u>
RL	<u>03</u>	<u>03</u>	Cautery pencil	<u>01</u>	<u>01</u>	<u>02 mask</u>	<u>01</u>	<u>01</u>
NS : 10ml / 100ml / 500ml / 1000ml	<u>01</u>	<u>01</u>	Koochies <u>x2</u>	<u>01</u>	<u>01</u>	<u>underpad</u>	<u>01</u>	<u>01</u>
<u>box 27</u>	<u>01</u>	<u>01</u>	Ointments					
<u>ephedrine</u>	<u>01</u>	<u>01</u>	Suction Catheter	<u>01</u>	<u>01</u>			
Fentanyl	<u>01</u>	<u>01</u>	Cap, Mask	<u>01</u>	<u>01</u>			
Morphine			Gauze Pack <u>RN</u>	<u>03</u>	<u>03</u>	<u>9686083</u>	<u>084</u>	<u>084</u>
Ketamine			Mop Pack	<u>01</u>	<u>01</u>	<u>Adrenaline</u>	<u>01</u>	<u>01</u>
Propofol			Steristrip <u>Sterizone</u>	<u>01</u>	<u>01</u>			
Rocuronium			Underpad	<u>01</u>	<u>01</u>			
Glycopyrolate	<u>01</u>	<u>01</u>	Draw sheet <u>Quicksuit</u>	<u>01</u>	<u>01</u>			
Myopyrolate			Abgel	<u>01</u>	<u>01</u>			
Ondansetron	<u>01</u>	<u>01</u>	Foleys catheter <u>16F</u>	<u>01</u>	<u>01</u>			
<u>Pencan 25g/ Spinal Needle 22</u>	<u>01</u>	<u>01</u>	Urobag	<u>01</u>	<u>01</u>			
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)	<u>01</u>	<u>01</u>	Romodrain bag					
Antibiotics : <u>01</u>			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg	<u>01</u>	<u>01</u>	Vacuum Suction set	<u>01</u>	<u>01</u>			
Justin : 12.5 mg / 25mg / 100mg	<u>01</u>	<u>01</u>	Plastic Bed Sheet					
Tab. Misoprost : 200mg	<u>02</u>	<u>02</u>	Betadine Solution	<u>02</u>	<u>02</u>			
<u>Oxytoch</u>	<u>03</u>	<u>03</u>	Microshield	<u>01</u>	<u>01</u>			
<u>glove (6)</u>	<u>03</u>	<u>03</u>	Cotton Balls	<u>01</u>	<u>01</u>			
<u>gauze</u>	<u>01</u>	<u>01</u>	Latex Gloves	<u>01</u>	<u>01</u>			
<u>Tranexa</u>	<u>02</u>	<u>02</u>	Ramdone Scrub	<u>01</u>	<u>01</u>			
			Saraf <u>D/A</u>	<u>01</u>	<u>01</u>			

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9685992Ordered by : Sis. Rapi

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

ADMISSION SHEET


Registration Details :

Admission No : IP5-00175854 Admit Date : 02-Jul-2026 Admit Time : 07:25 AM UHID : BAH-00555756

Patient Details :

Patient Name	: Dr. AMMREEN SYED	Age	: 31 Y 8 M 9 D
Guardian	: Mr RIZWAN SHAIK	DOB	: 23-10-1994
Gender	: Female	Religion	: Muslim
Occupation	:	Martial Status	: Married
Address (H)	: COLLECTER CAMP OFFICE JOGULAMBA Gadwal Telangana INDIA 509125	Phone No	: 9701518689/ 9703978769
		E-mail	: DRAMREENQHADRI786@GMAIL.COM

Admission Details :

Bed Type : PRESIDENTIAL SUITE Bed No : PRESIDENTIAL SUITE 1 (422) Ward Name : 4F-BIRTHRIGHT PREMIUM
Room No : PRESIDENTIAL SUITE 1 (422) Admission Type : First Visit

Contact Details :

Name : Mr RIZWAN SHAIK Relationship : Husband
Contact Address : COLLECTER CAMP OFFICE JOGULAMBA Phone No : 9701518689 / 9703978769
Gadwal Telangana INDIA 509125

Signature

Doctor Details :

Doctor Name : Dr. SHRUTHI REDDY PODDUTOOR 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. : _____

Date of Admission: _____

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

BAH-00555756
Dr. AMMREEN SYED
23-10-1994 31 Y 8 M 9 D (F)
Dr. SHRUTHI REDDY PODDUTOOR
IP5-00175854

Consultant: _____ Dept : _____

Date of Discharge : _____ Time: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Khreya ✓	2/2/26	9685929	} Amy
2	Dr. Bandlani ✓	3/2/26	9685929	
3	Dr. Bandlani ✓	2/2	9685929	
4	NAH ✓	3/2/26	9685928	Anita
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE				
Date	Procedure	Quantity	Order No.	Signature
2/7	IV placed ✓	1	9684457	[Signature]
2/7	Catheterization ✓	1		
2/7	PAC ✓	1	9684456	
ANY OTHER INFORMATION				
.....				
.....				
.....				
.....				
.....				
.....				
Date : Time : Prepared By :				
Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor	



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

For Fetus

Obstetric Formula:

G2P1

Obstetric History:

1-2023, Fetus, Embryo - NPL
Boy, 3kg - AEM.

Present Pregnancy Record:

2 - sp conception, booked at
16 weeks.

RISK FACTORS:

1preeclampsia

Height: cm

Weight: 65 kg

Allergies: neu

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: Conscious

Pallor: absent

Icterus: absent

Edema: absent

Temp: afebrile

PR: 70/min

BP: 104/74 mmHg

DTR:

CVS: 92bpm

RS: BAE

Liver/Spleen: Not palpable

Urine Output: adequate

DIAGNOSIS

G2P1 38+1 wks 1preeclampsia for Fetus.

LMP: 6/10/25

EDD: 31/07/26

Corrected EDD: 15/11/26

GA: 38+1

Menstrual History: Regular: ☐ Yes ☐ No

Obstetric Examination

Fundal Height: Term

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech ☐ Others

Head Fifts Palpable:

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed Dilated

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

BAH-00555756 IP5-00175854

Dr. AMMREEN SYED

23-10-1994 31 Y 8 M 9 D (F)

Dr. SHRUTHI REDDY PODDUTOOR



Family History: Mother. HTN, Hypothyroid. Father, Husband - pharyngeal cancer 2023	Surgical History:
Medical History: Nil	Medication History: T. Tran T. Melicel.
Plan of Care: Admission Nil on admission prep of patient Check blood availability and CBP Uteral & PVR Monitor INformed Consent Send OT note	Investigations: A&C. Uteral. PR 25% 3#1 / cephalic 12.523/90 AC 22 / AP1-18.4 / PI-UN / Topple (R)

Doctor Name: Dr. Ashu

Signature: [Signature]

Date & Time: 27/12/2023 8:00 AM

Consultant Name: Dr. Shruthi Reddy

Signature: [Signature]

Date & Time: 27/12/2023 8:00 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>2/7/2026</u>	<u>POD-0 / elective US / P2b2</u>	
<u>11:30 AM</u>		<u>Advice</u>
<u>Baby well</u>	<u>comfortable</u>	
<u>v/o - 150ml, emptied</u>	<u>gc fair / afebrile</u>	<u>✓ NBM for 2-4 hours</u>
	<u>vitals - BP - 96/65 (73)</u>	<u>✓ monitor vitals</u>
	<u>PR - 79 bpm</u>	<u>✓ Drugs as charted</u>
	<u>SpO₂ - 99% on RA</u>	<u>✓ mobilization</u>
	<u>P/A - Vtoms retracted well</u>	<u>✓ w/f excessive</u>
	<u>soft</u>	<u>bleeding</u>
	<u>VVE - Minimal Bleeding</u>	<u>✓ v/o monitoring</u>
		<u>✓ Inform SRS</u>
		<u>by CR Deepika</u>
<u>2/7/2026</u>	<u>POD-0 / P2b2 / elective US</u>	<u>Advice</u>
<u>2 PM</u>	<u>comfortable</u>	<u>✓ Allow H₂O sips x</u>
<u>Baby well</u>	<u>gc fair / afebrile</u>	<u>8:30 PM f/b liquid</u>
<u>v/o - 500ml, clear</u>	<u>vitals - BP - 107/75 (82)</u>	<u>✓ soft diet x 7 PM</u>
	<u>PR - 85 bpm</u>	<u>✓ monitor vitals</u>
	<u>SpO₂ - 100% on RA</u>	<u>✓ Drugs as charted</u>
	<u>P/A - Vtoms retracted well</u>	<u>✓ v/o monitoring</u>
	<u>soft, BS (+)</u>	<u>✓ w/f excessive bleeding</u>
	<u>VVE - Minimal Bleeding</u>	<u>✓ Inform SRS</u>
		<u>by CR Deepika</u>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/16 6:40pm	A comfortable v/o ac fair PR - 84bpm BP 102/72mmHg (MAP 65) SpO₂ - 98% on RA P/A uterine retracted null, BSG+ No - Bleeding none	Adv Allow sip of water → if tolerating liquids - 1st dose 9pm - dump as prescribed , vitals & fundus - No cramping , with active Bleeding in (Inpmt 10)
3/7/16 7:45am	had goldfishers / Sweetsy. Cereals T ② P - 80bpm Sp - 98% on (MAP - 65) P/A - soft R/B Adv - no R/B - no	Adv ① Soft stool ② Antibiotics ③ vitals & fundus ④ Encourage to walk ⑤

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 11:00pm	POD-L PT c/o giddiness BP- 100/60 (64) PR- 80bpm SpO ₂ - 100% on RA P/A- ut well @ mild soft distension @ BS @ Dressing dry & intact c/o- BURN.	① Soft diet ② Hydrate & ambulate ③ Vitals 4th hrly ④ w/p heavy bleeding ph ⑤ Drugs as charted ⑥ Inferior 20S
	Noted by Nurse	Smile
3/7/26 7:00pm	NODY R is stable No c/o Vitals stable P/A- ut well retracted c/o- backache @; healthy	Admin Continue same meds
	Noted by SIS - Anita	Smile



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>C/S / B: Dr. Shanthi</u> POD - 2 PT is stable No c/o BP - 96 / 68 (78) PR - 82 bpm SpO₂ - 98% on RA PIA - UT well retracted. Deeming day 2 without 4e lockwire; healthy Noted by nurses	<u>Advice</u> 1 soft diet 2 Hydrate & ambulate 3 Drops as charted 4 vitals at hourly 5 Remove cannula 6 Can be discharged today <u>Shanthi</u>
4/7/26 2:30pm At comfortable UV ✓ SV ✓	o/e ac - full vital - stable PIA - uterus retracted well 4e - lockwire healthy	<u>Adv</u> - drops no prr charted - vitals 6 hourly - w/p active bleeding - Ambulate - Inform

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/2/20 9pm	O/E w-c-fair vitals - stable P/A clear unobstructed well No lochia healthy	Adv - drugs as per charted - vitals 6 hourly - Ambulate - soft diet, plenty of fluids - Inform pt
✓ ✓ ✓		
O/E ✓ S/E due		
		Noted by Sis Anita
5/2/20 8pm	PT - stable G-c-fair Afebrile vitals - stable P/A - at R well LLE - NAB	Adv:- ① Regular Diet ② oral hydration ③ Drugs as charted ④ Monitor vitals ut ⑤ Inform SOS
✓ ✓ ✓		
Baby - Mother S/E		
O/E ✓ S/E due		
	Noted by Sister	(Dr. Sam)

IP5-00175854

Dr. AMMREEN STEB
23-10-1994 31 Y 8 M 12 D

23-10-1994

31 Y 8 M 12 D

(F)

Dr. SHRUTHI REDDY PODDUTOOR



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



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/2026 4PM	PT comfortable vitals stable O✓ F✓ S✓ <u>SE due</u> <u>Noted by Paulina</u>	Dr Y Smeu

BAH-00555756 IP5-00175854
Dr. AMMREEN SYED
23-10-1994 31 Y 8 M 9 D (F)
Dr. SHRUTHI REDDY PODDUTOOR



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

P2

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
2/7/20	8 AM		Lactation care	PT	1	0	1	1		L
3/7/20	9am	9	Lactation diet	PT	1	0	1	1		N. K. K. K.

Part - III: CODES

Who was taught:	PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)															
Learning Barriers:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)	3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	
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Teaching Tools Used:	A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed																		
Mechanism/s to overcome barrier/s:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
2/11/20 9AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	For Files	Safe delivery	Files		☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Others:
3/7/20 9am	☐ Medical ☐ Nursing ☒ Others: dietician	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	POD-1 [USCS]	soft diet	soft high protein diet	Nikhil	☐ Medical ☐ Nursing ☒ Others:
8/11	☐ Medical ☐ Nursing ☒ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	post partum recovery	deep abdominal & pelvic floor recovery, functional training	deep core, pelvic floor activation, pelvic mobility		☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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: Neu

Shifted to: Neu

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. Iron	1tab	PO	OP		☐ C ☒ DC
2	T. Sheleal	1tab	PO	OP		☐ C ☒ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ashay

Date & Time : 2/9/20, 7AM

Nurse Name & Signature: SP

Date & Time : 2/7/20 @ 7:30AM

Date of Admission: 1/7/20 Drug Allergies: ☐ Not known any Drug Allergies

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

- Use approved pharmaceutical names, **BLOCK LETTERS**, metric dosage. English instructions.

- Any changes in drug therapy must be ordered by a **NEW PRESCRIPTION**. Do not alter existing instructions.

- Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.

- The date and time of stopping the drug along with the doctors name and sign must be mentioned.

- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the **FIVE RIGHTS** before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- **AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR).** Follow Hospitals's Verbal Order Policy.

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:				



REGULAR PRESCRIPTIONS

Weight. Ward. **B1C**

DRUG : TAB PARACETAMOL				Date Time	2/7	3/7	4/7	5/7												
Dose	Route	Frequency	Start Date																	
1gm	PO	QID	2/7																	
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Shree</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : TAB DIPHENHYDRAMINE				Date Time	2/7	3/7	4/7	5/7												
Dose	Route	Frequency	Start Date																	
50mg	PO	TID	2/7																	
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Shree</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : TAB TRAMADOL				Date Time	2/7	3/7														
Dose	Route	Frequency	Start Date																	
100mg	PO	TID	2/7																	
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Shree</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : TAB PANTOPRAZOLE				Date Time	2/7	3/7	4/7	5/7												
Dose	Route	Frequency	Start Date																	
40mg	PO	BD	2/7																	
Name & Signature of the Doctor Starting the Drugs: <i>Dr. Shree</i>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				



ker

Weight. Ward. PKP

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
2/7	8:40 AM	Inj CEFOTAXIME	1gm	IV	[Signature]	[Nurses]
2/7	8:30 PM	Inj PANTOP	40mg	IV	[Signature]	[Nurses]
2/7	8:35 AM	Inj PERINORM	10mg	IV	[Signature]	[Nurses]
02/7/26	6:40 AM	Inj PARACETAMOL	1gm	IV	[Signature]	[Nurses]
2/7	11:30 AM	sup DULOGENAC	100mg	Pla	[Signature]	[Nurses]
2/7	11:30 AM	sup TRAMADOL	100mg	Pla	[Signature]	[Nurses]
2/7	6 PM	INJ PARACETAMOL	1gram	IV	[Signature]	[Nurses]
04/7	6 PM	inj PERINORM	1mg	IM	[Signature]	[Nurses]
05/7/26	7:00 AM	DULCO SUPPU	2	PIR	[Signature]	[Nurses]



I.V. FLUIDS CHART

Weight. Ward.

B.R.

[illegible]

Signature _____

VERIFIED BY: Name

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Dr. AMMREEN SYED

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <u>Dr. Shanthi Reddy</u>	Date of Delivery: <u>02/07/2020</u>
Assistant Surgeon: <u>Dr. Lavanya</u>	Time of Delivery: <u>10:31 AM</u>
Anaesthetist's Name: <u>Dr. Ambreen</u>	Gender of Baby: <u>female</u>
Type of Anaesthesia: <u>↓ Spinal</u>	Weight of Baby: <u>2.610 kg</u>
Neonatologist: <u>Dr. Lokith.</u>	AGPAR Score: <u>9, 10</u>
Scrub Nurse: <u>Dr. Laxmi</u>	NICU Admission: ☐ Yes ☒ No

Pre-Operative Diagnosis: Gest. 1, 38+ weeks / Prev-LSC / EL-LSC

☒ Elective ☐ Emergency Indication: Prev-LSC

Urgency

☐ Immediate Threat to life of woman or fetus

☐ Maternal or fetal compromise not immediately life threatening

☒ No maternal or fetal compromise but needs early delivery

☐ Delivery timed to suit woman and staff

Decision time: Knife to rectus: 2 mins.

CTG Description: Reactive

If there was a delay give the reasons:

Surgical Procedure: EL-LSC + SA

Post Operative Diagnosis: Pod-01 P212 / EL-LSC + SA

Peri-Operative Complications: Nil

Amount of Blood Loss: ~ 500 ml Blood Transfused (in ML): Nil

Name and Number of Surgical Specimen sent for examination:

Examination Findings when Appropriate:Presentation: ☐ Cephalic ☐ Breech ☐ Other

Cervical Dilatation: cm

5th Palpable:

Fetal Position:

Station: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2Moulding: ☐ None ☐ + ☐ ++ ☐ +++Caput: ☐ + ☐ ++ ☐ +++Meconium: ☐ None ☐ + ☐ ++ ☐ +++Bladder Catheterized: ☐ Yes ☐ NoUrine: ☐ Clear ☐ Blood StainedSkin Incision: ☒ Pfannenstiel ☐ Transverse ☐ Midline ☐ OtherUterine Incision: ☒ Lower Segment ☐ Classical ☐ Inverted T ☐ J IncisionPrevious Scar: ☒ Intact ☐ Thinned out ☐ Ruptured ☐ No ScarIncision Through Placenta: ☐ Yes ☒ NoDelivery of head: ☒ Manual ☐ ForcepsLiquor: ☒ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not OffensiveDelivery of Placenta: ☐ Manual ☒ CCT ☒ Complete ☐ Incomplete ☐ PiecemealCord Appearance: Normal Cord around the neck ☐ Yes ☒ NoAppearance of placenta: Normal Cavity explored ☒ Yes ☐ NoUterus, tubes and ovaries: ☒ Normal ☐ Not Normal Sterilization: ☐ Yes ☒ NoUterine Closure: ☐ One Layer ☒ Two Layers Vicryl 1-0 SuturePeritoneal Closure: ☒ Pelvic ☐ Abdominal ☐ None Rapid vicryl 2-0 Suture

Sheath Closure: Vicryl - 1 Suture

Fat Closure: ☒ Yes ☐ No Rapid vicryl 2-0 SutureSkin Closure: ☒ Subcuticular ☐ Mattress Rapid vicryl 2-0 SutureVaginal Evacuated ☒ Yes ☐ NoDrain: ☐ Yes ☒ No ☐ Remove in days ☐ Await instructionsCatheter ☒ Yes ☐ No ☐ Remove in 2 hrs days ☐ Await instructionsSwap & Instruments count correct? ☒ Yes ☐ No ☐ Post-op Antibiotics ☐ Yes ☒ NoIntra-Operative Antibiotics Cover: ☒ Yes ☐ No ☐ Thromboprophylaxis ☐ Yes ☒ No

Post-Operative Notes:

- NBM x 6 hrs

- IV fluids Acov

- Drugs as charted

- Monitor vitals by

- w/ excessive bloody plv

- T.b. chesty -

- Inform cos

Doctor Name: Dr. Lavanya

Doctor Signature: [Signature]

Date & Time: 21/7/26 11:00 AM



RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS

(Postnatal Assessment and Management (to be assessed on delivery suite))

Pre-Existing Risk Factors Tick Score	Tick	Score
Previous VTE (except a single event related to major surgery)	X	4
Previous VTE provoked by major surgery	X	3
Known high-risk thrombophilia	X	3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory poly arthropathy or inflammatory bowel disease; nephrotic syndrome; type-I diabetes mellitus with nephropathy; sickle cell disease; current intravenous drug user	X	3
Family history of unprovoked or estrogen-related VTE in first-degree relative	X	1
Known low-risk thrombophilia (no VTE)	X	1
Age (? 35 years)	X	1
Obesity	X	1 or 2
Parity ≥ 3	X	1
Smoker	X	1
Gross varicose veins	X	1
Obstetric Risk Factors		
Pre-eclampsia in current pregnancy	X	1
ART/IVF (antenatal only)	X	1
Multiple pregnancy	X	1
Caesarean section in labour	X	2
Elective caesarean section	1	1
Mid-cavity or rotational operative delivery	X	1
Prolonged labour (? 24 hours)	X	1
PPH (? 1 litre or transfusion)	X	1
+0 Preterm birth? 37 weeks in current pregnancy	X	1
Still birth in current pregnancy	X	1
Transient Risk Factors		
Any surgical procedure in pregnancy or puerperium except immediate repair of the perineum, e.g. appendectomy, postpartum sterilization	X	3
Hyperemesis	X	3
OHSS (first trimester only)	X	4
Current systemic infection	X	1
Immobility, dehydration	X	1
Total	2	

Signature of the Doctor: Dr. Amreen Syed Date: 21/7/26 Time: 11 AMAction Plan: Hydration and Ambulation**Risk Assessment Tool for Deep Vein Thrombosis**

- ☐ If total score ≥ 4 antenatally, consider thromboprophylaxis from the first trimester.
☐ If total score 3 antenatally, consider thromboprophylaxis from 28 weeks.
☐ If total score > 2 postnatally, consider thromboprophylaxis for at least 10 days.
☒ If total score = 2, Hydration & Ambulation.
☐ If admitted to hospital antenatally consider thromboprophylaxis.
☐ If prolonged admission (≥ 3 days) or readmission to hospital within the puerperium consider thromboprophylaxis.
☐ For patient with an identified bleeding risk, the balance of risks of bleeding and thrombosis should be discussed in consultation with a haematologist with expertise in thrombosis and bleeding in pregnancy.

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POST-SURGICAL CARE PLAN FORM

Procedure Done: El. USG + SA.

Post-Surgical Diagnosis: POD-01 P2121 El. USG

Post-Operative Monitoring Parameters /Frequency:

- Monitor vitals hrs
- S/O charting

Wound Care:

- Check for wound soilage

Drain /Special Lines/Catheters:

- Foley's insitu

Special Patient Positioning and Requirements:

Nutritional Instructions:

- NBM x 6 hrs
- followed by liquids

When to Start Mobilization:

- After 12 hrs

Special Referrals:

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

☒ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

[Signature]
Treating Surgeon
(Signature & Stamp)

Date: 2/7/26 Time: 11 AM

Note: Plan of care will be readjusted if necessary.

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RESULT SHEET

Date	2/7/26				
Time					
Hb	11.8				
PCV	35.9				
RBC	4.14				
WBC	10.00				
N/L	78.4 / 14.7				
Platelets	2.31				
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						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 2/2/26 Time of Arrival: 2:25 AM Time Seen by Nurse: 2:30 AM

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: EL-LSC

3) Vital Signs: Temperature: 98.6°F Pulse: 72 RR: 18 SpO₂: 100 BP: 95/62 Weight: 65

4) Gestational Criteria:

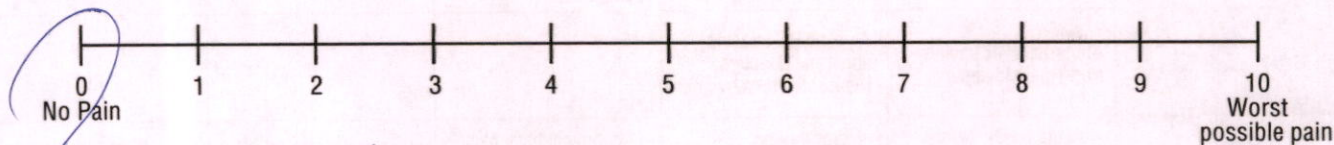
Gravida:	G 2	P 1	L 1	A
----------	-----	-----	-----	---

LMP: 6/10/25 EDD: 15/2/25 Gestational Age: 38+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: Nil
- Duration: Nil Days / Weeks/ Months (Strike out which is not applicable)
- Character: Nil
- Frequency: Nil
- Interventions: Nil

6) Past History:

- a) Surgeries: LSCS - 2023
- b) Medical: T. FX


☒ No, If Yes :

 8) Current Medications: ☐ Prenatal Vitamin ☒ None ☐ Others:

9) Prenatal Medical History:

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

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 - Altered level of consciousness - Cord prolapse - Severe respiratory distress - Suspected sepsis	- Major trauma - Shortness of breath - Unplanned and unattended birth	- Abdominal/back pain greater than expected in pregnancy - Flank pain / hematuria - Nausea /vomiting and /or diarrhea with suspected dehydration	- Ongoing assessment from out patient clinic (for hypertension, blood work) - Minor trauma (minor MVC/fall) - Nausea/Vomiting and /or diarrhea - Signs of infection (ie dysuria ,cough, fever, chills)	- Anything that does not seem to pose threat to mother or fetus - Cervical ripening - Out patient placenta previa protocols - Pre-booked visits (ie Rh and progesterone injections, NST) - Assessment for version - Rashes

Time seen by Doctor: 9:00 A

Nurse Name: Member Nurse Signature:

Date: 21/26 Time: 8:30 A

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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: <u>2/2/26</u>		
Baseline Information:		
Admission From: ☐ ER ☐ OPD ☒ Admission Desk ☐ Others, specify		
Primary Language: ☐ Telugu ☒ English ☒ Hindi ☐ Others, specify		
Do you require an interpreter? ☐ Yes ☒ No if Yes specify		
Source of Information: ☒ Patient ☒ Family ☐ Others, specify		
Allergies: ☐ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: If yes, identify		
Chief Complaints: <u>EL-LSCS</u>		Doctor Notified on Admission: ☒ Yes ☐ No
Name of the Doctor: <u>Dr. Sravathi</u>		Time Notified: <u>8:15</u>
Past Medical History: Obtained From ☐ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify)		
Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Niu</u>	<u>2023</u> <u>LSCS</u>	
Gynecology Assessment: ☐ Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History: <u>Regu</u>	Caesarean Section: ☐ No ☐ Yes	Contraceptives: ☐ No ☐ Yes
Onset of Menarche:	Cervical Cerclage: ☐ No ☐ Yes	Vaginal Discharge: ☐ No ☐ Yes
Menstrual Cycle: ☒ Regular ☐ Irregular	Ectopic Pregnancy: ☐ No ☐ Yes	Post-Coital Bleeding: ☐ No ☐ Yes
Last Menstrual Period: <u>6/10/24</u>	Myomectomy: ☐ No ☐ Yes	Infertility: ☐ No ☐ Yes
	Others:	If Yes Type: ☐ Primary ☐ Secondary
Obstetric History: G <u>2</u> P <u>4</u> L <u>2</u> A		
Previous LSCS: <u>2023</u>		
Current Medication: ☒ None ☐ Yes, If Yes, Fill the reconciliation form		
Family History: ☒ No Abnormalities Detected		
☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease		
☐ Liver disease ☐ Other		
Vital Signs / Measurements: Temp: <u>98.9</u> HR: <u>72</u> RR: <u>18</u>		
BP: <u>101/62</u> Weight: <u>67</u> 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

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: Amreen

Orientation not given Reason:

Nurse Signature: Amreen

Nurse Name: Amreen

Date & Time: 21/2/21

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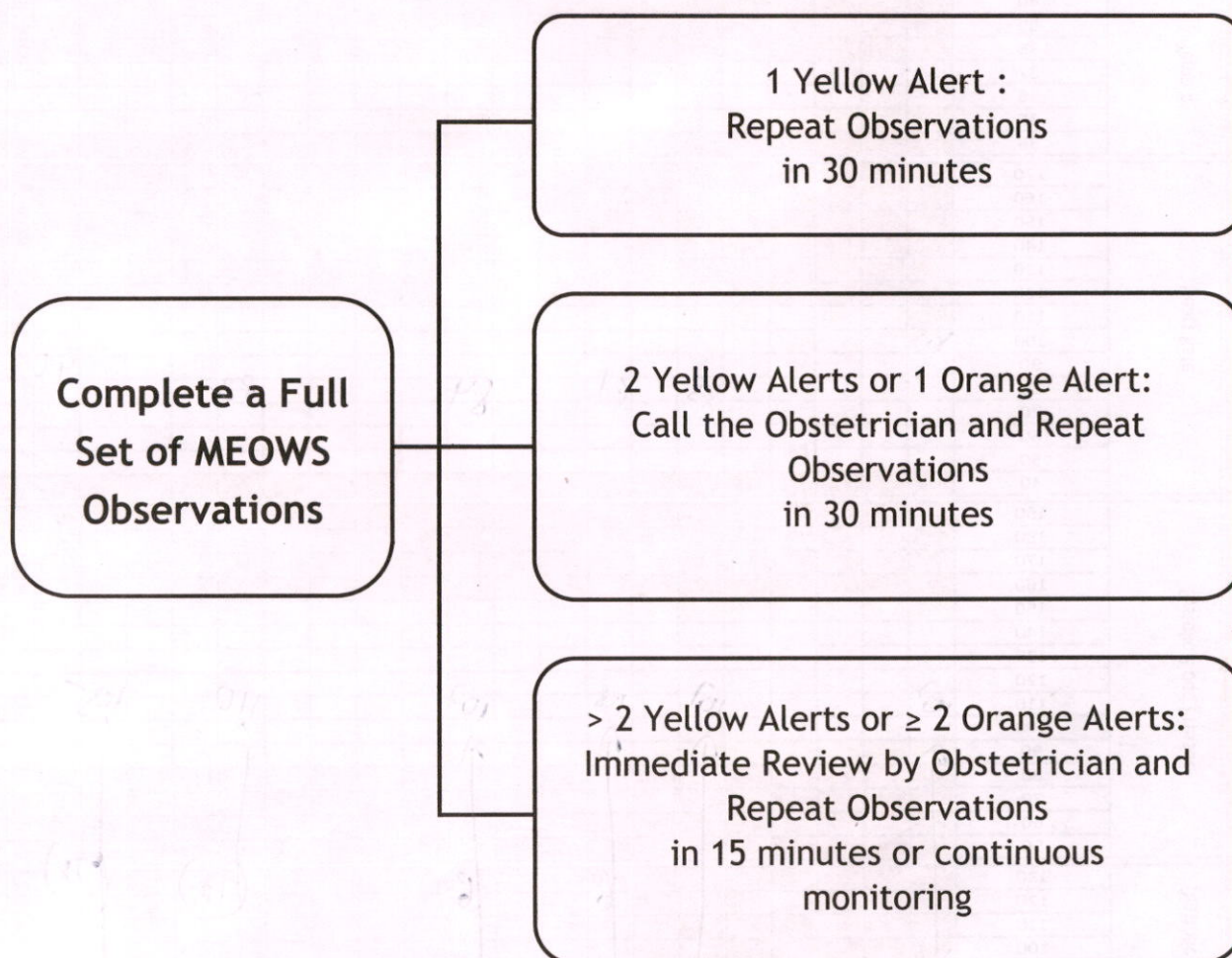
Early Warning Observation Score Chart - Obstetrics

CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT

TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

Date		Time																							
		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20																								
	0 - 10																								
Saturations	94 - 100 %	100				100	98	98								98				99					100
	< 94 %																								
Administered O ₂ (L/min.)																									
Temp °C	40																								
	39																								
	38																								
	37																								
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100	61																							
	90																								
	80																								
	70						85	81			84					82				90				72	
	60																								
	50																								
40																									
Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

3/7/26



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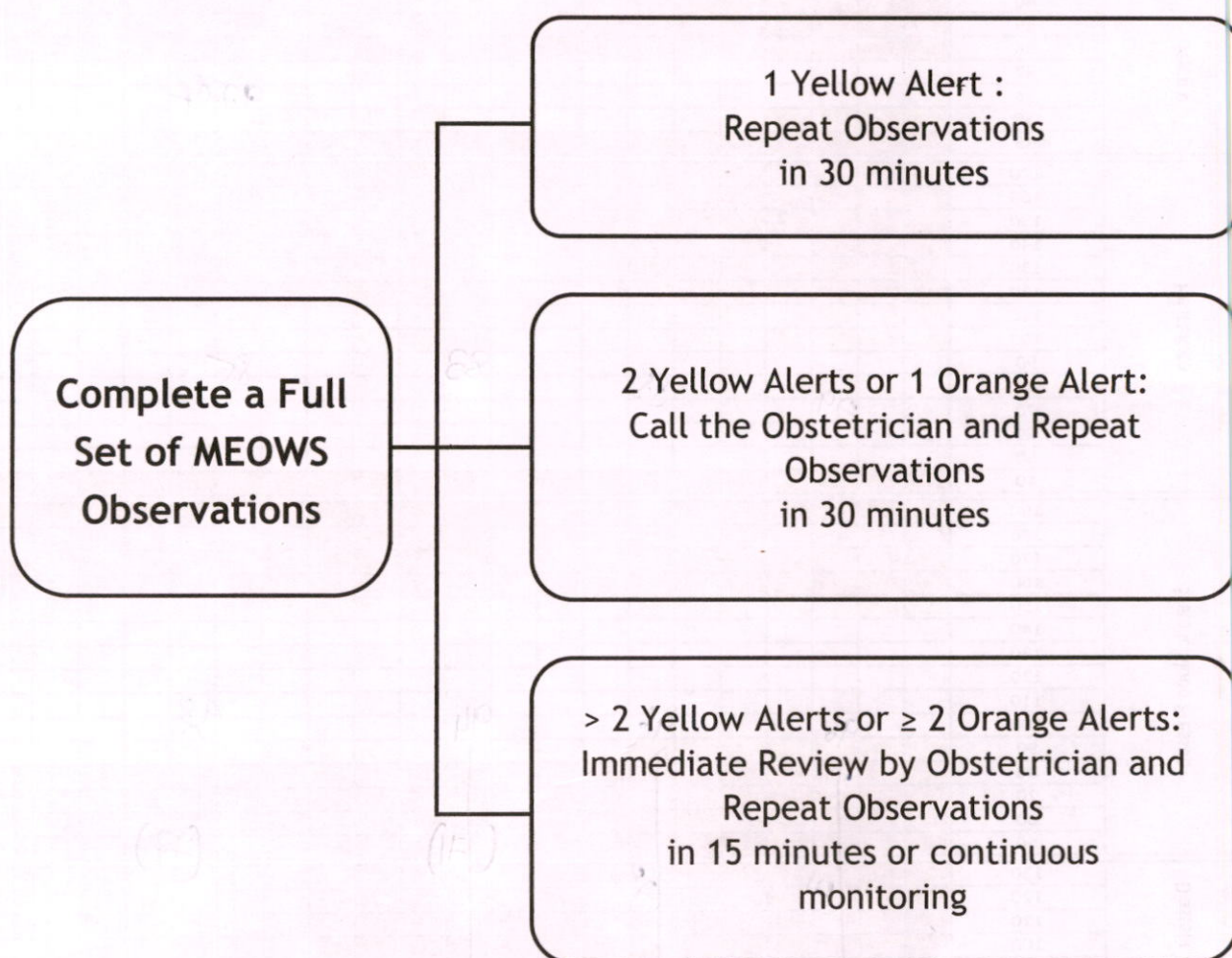


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

Date		Time																							
3/2/26		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20																								
	0 - 10																								
Saturations	94 - 100 %			99			100				98						99								98
	< 94 %																								
Administered O ₂ (L/min.)																									
Temp °C	40																								
	39																								
	38																								
	37																								
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70			79				85				82					85								82
	60																								
	50																								
40																									
Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								

Obstetrics and Gynaecology Early Warning Signs

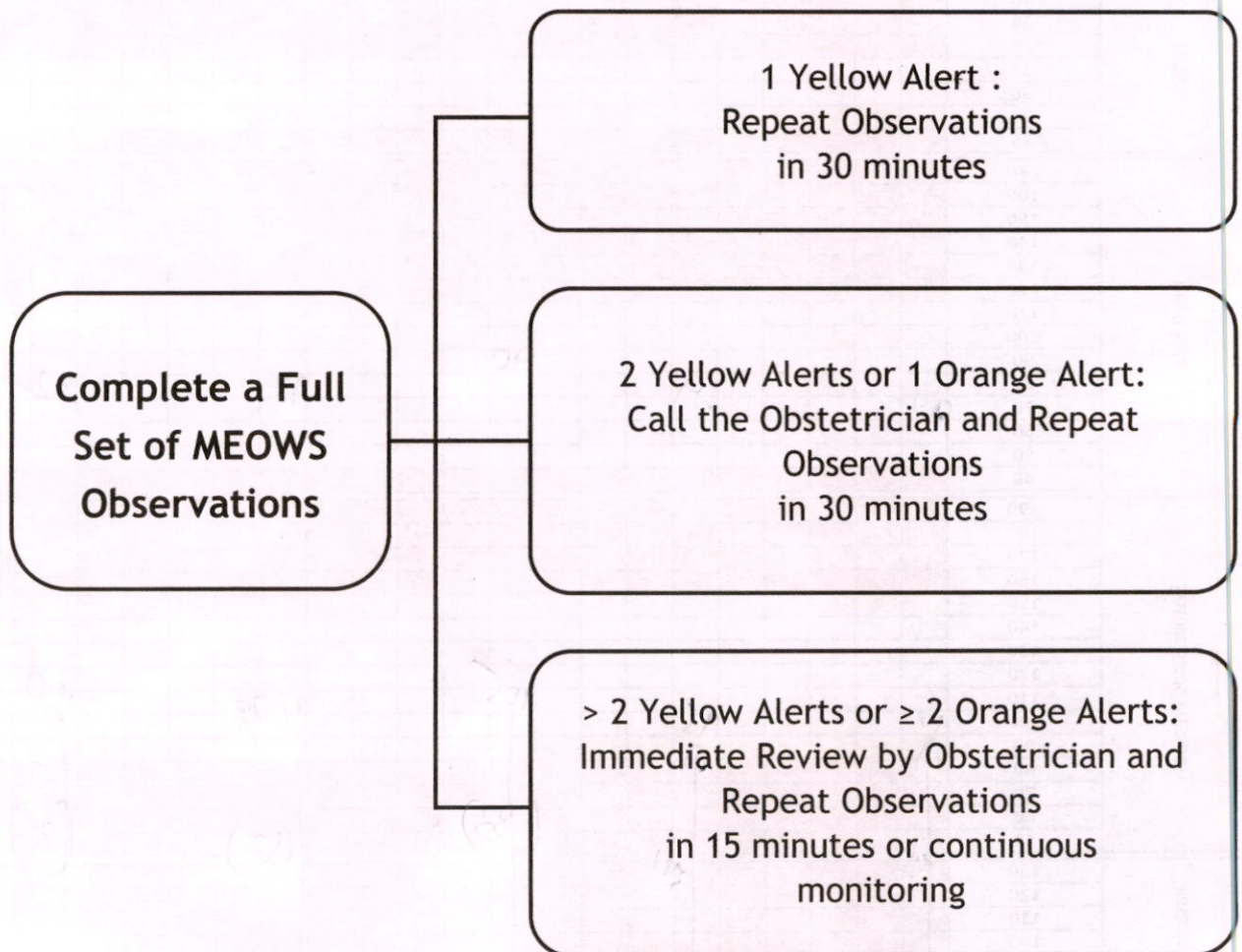


* The Modified Early Warning Score (MEOWS)

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

[illegible]

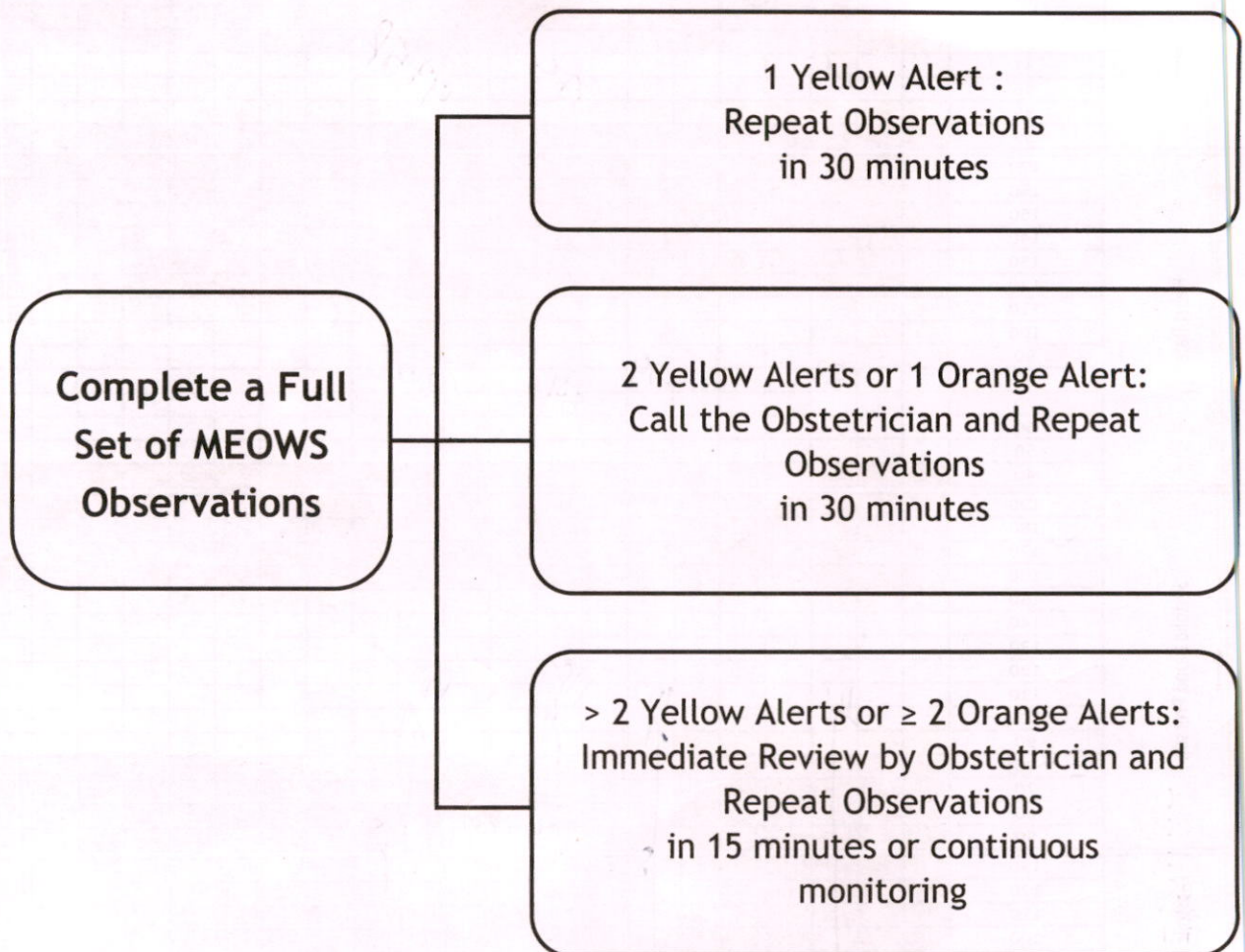
Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

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

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

BAH-00555756 IP5-00175854

Dr. AMMREEN SYED

23-10-1994 31 Y 8 M 9 D (F)

Dr. SHRUTHI REDDY PODDUTOOR



Rainbow
Children's
Hospital

It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am	PL		100ml			1				✓	0	Heath
	09:00 am	PL	N	100ml								0	Heath
	10:00 am	PL	B	100ml			NP					0	Heath
	11:00 am	PL	M	100ml						150ml		0	Heath
	12:00 pm	PL		100ml			1					0	Heath
	01:00 pm	PL		100ml						500ml		0	Heath
Total Intake :			Taken			Total Output :			650ml				
	02:00 pm						1			500		0	Heath
	03:00 pm						1					0	Heath
	04:00 pm		H2O									0	Heath
	05:00 pm						NP			500		0	Heath
	06:00 pm		H2O				1					0	Heath
	07:00 pm						1					0	Heath
Total Intake :			Taken			Total Output :			passed 1000ml				
	08:00 pm						1					0	Yammy
	09:00 pm		H2O	100ml			1					0	Yammy
	10:00 pm						NP			700ml		0	Yammy
	11:00 pm		H2O	150ml			1					0	Yammy
	12:00 am						1			200ml		0	Yammy
	01:00 am		H2O	100ml			1					0	Yammy
Total Intake :			Taken			Total Output :			200ml				
	02:00 am						1					0	Yammy
	03:00 am		H2O	200ml			1					0	Yammy
	04:00 am						NP					0	Yammy
	05:00 am						1					0	Yammy
	06:00 am		H2O	100ml			1			500ml		0	Yammy
	07:00 am						1					0	Yammy
Total Intake :			Taken			Total Output :			500ml				
Total 24 hrs. Intake			Taken			Total 24 hrs. Output			600ml				



FLUID CHART

Sheet No. : (2)

3/7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am	PL		100ml							0	mil	
	09:00 am	PL	H2O	100ml							0	mil	
	10:00 am	PL	H2O	100ml							0	mil	
	11:00 am										0	mil	
	12:00 pm		H2O								0	mil	
	01:00 pm										0	mil	
Total Intake :			Taken			Total Output :			passed				
	02:00 pm		H2O								0	} Anika	
	03:00 pm						little				0		
	04:00 pm		H2O								0		
	05:00 pm										0		
	06:00 pm		H2O								0		
	07:00 pm										0		
Total Intake :			Taken			Total Output :			0-2 m-1				
	08:00 pm										0	Yancy	
	09:00 pm		H2O								0	Yancy	
	10:00 pm										0	Yancy	
	11:00 pm		H2O								0	Yancy	
	12:00 am		H2O								0	Yancy	
	01:00 am										0	Yancy	
Total Intake :			Taken			Total Output :			Taken, 0-1 m-1				
	02:00 am		H2O								0	Yancy	
	03:00 am										0	Yancy	
	04:00 am		H2O								0	Yancy	
	05:00 am										0	Yancy	
	06:00 am		H2O								0	Yancy	
	07:00 am		H2O								0	Yancy	
Total Intake :			Taken			Total Output :			Taken, 0-1 m-0				
Total 24 hrs. Intake		Taken											
Total 24 hrs. Output		0-5 m-2											



FLUID CHART

Sheet No. : ⑨

4/7/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am												
	09:00 am	H ₂ O											
	10:00 am												
	11:00 am	H ₂ O											
	12:00 pm												
	01:00 pm	H ₂ O											
Total Intake :			Taken			Total Output :					Paused		
	02:00 pm	H ₂ O											
	03:00 pm												
	04:00 pm	H ₂ O											
	05:00 pm	H ₂ O											
	06:00 pm												
	07:00 pm	H ₂ O											
Total Intake :			Taken			Total Output :					Paused		
	08:00 pm												
	09:00 pm	H ₂ O											
	10:00 pm												
	11:00 pm	H ₂ O											
	12:00 am												
	01:00 am	H ₂ O											
Total Intake :			Taken			Total Output :					U-2 M-0		
	02:00 am												
	03:00 am	H ₂ O											
	04:00 am												
	05:00 am	H ₂ O											
	06:00 am												
	07:00 am	H ₂ O											
Total Intake :			Taken			Total Output :					U-2 M-0		
Total 24 hrs. Intake			Taken			Total 24 hrs. Output			U-2 M-0				



FLUID CHART

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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Sheet No. : 2

5/6/26

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
5/6	08:00 am									✓			
	09:00 am	tho											
	10:00 am												
	11:00 am									✓			
	12:00 pm	tho											
	01:00 pm	meds											
Total Intake :			taken			Total Output :						passed	
5/6	02:00 pm	tho								✓			
	03:00 pm												
	04:00 pm	tho								✓			
	05:00 pm												
	06:00 pm												
	07:00 pm	tho											
Total Intake :			taken			Total Output :						passed	
	08:00 pm	tho											
	09:00 pm												
	10:00 pm	tho											
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :			taken			Total Output :						V - M -	
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :			taken			Total Output :						V - M -	

Total 24 hrs. Intake

Total 24 hrs. Output

PAIN ASSESSMENT FORM

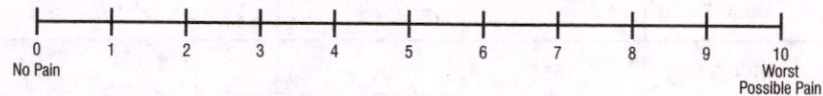
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
2/7	8AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Dr. [Signature]
2/7	9AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Dr. [Signature]
2/7	4PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Dr. [Signature]
2/7	PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Dr. [Signature]
2/7	11PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Young
3/7	2AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Young
3/7	5AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Young
3/7	7AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Young
2/7	9AM	2/10	Surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Tab: Pictorial	mother
3/7	12M	2/10	Surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Tab: Pictorial	mother

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



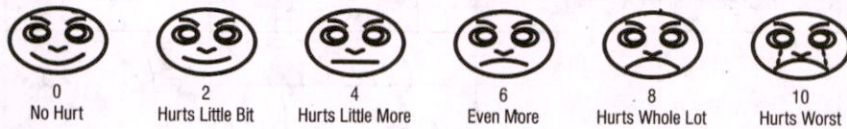
FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Any
3/7/26	3pm	2/10	Surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	given Tab. Diclofenac	Anita
3/7/26	4pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Anita
3/7/26	6pm	1/10	Surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Given Tab. Calpol	Anita
3/7/26	7pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Anita
3/7/26	10pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Yammy
4/7/26	12am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Yammy
4/7/26	3am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Yammy
4/7/26	6am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Yammy
4/7	10AM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Any

Re-assessment Frequency:

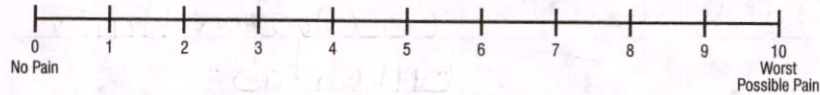
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
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 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

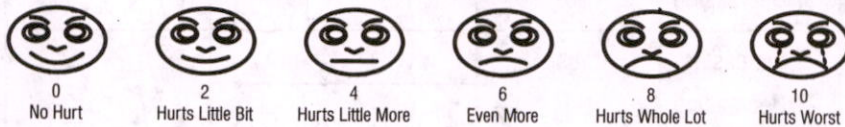
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
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Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

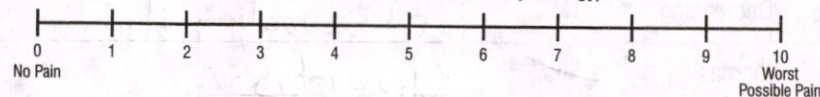
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/7	12pm	1/10	Surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☒ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	Tab. Pm	Any
4/7	2pm	1/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Any
4/7	3pm	0/10	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Any
4/7	6pm	1/10	Surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Given tab. Calpol	Any
4/7	7pm	0/10	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Any
4/7	11pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Yammy
5/7	2am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Yammy
5/7	5am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Yammy
5/7	7am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Yammy
5/7	10am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Ref

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



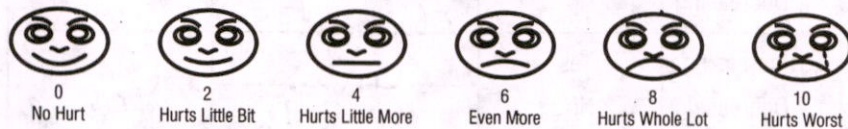
FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, 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

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

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

Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/10/21	12pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	L
5/10/21	2pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	no	Swelling
5/10/21	3pm	1/10	pain in surgical site	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	T-calcipap spray	Swelling
5/10/21	4pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	under observation	Swelling
5/10/21	6pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	no	Swelling
5/10/21	9pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Swelling
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

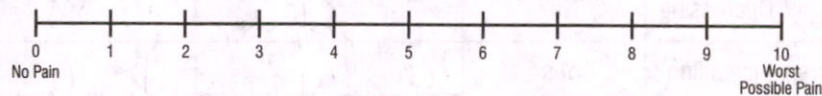
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

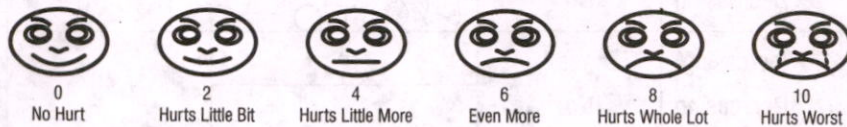
FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
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Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown , quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, 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		1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 25/10			DAY-2 26/10			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	-	-	-	-	-					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-	-	-					
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-	-	-					
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-	-	-					
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-	-	-					
Signature of the Nurse				Anita Yammal			Anita Yammal						

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 : Shruthi Name : Shruthi

Signature of Ward In Charge :

Signature : Ullas Name : Ullas

BAH-00555756
 Dr. AMMREEN SYED
 23-10-1994 31 Y 8 M 9 D (F)
 Dr. SHRUTHI REDDY Poddutoor

IP5-00175854

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	2/17/26	2/17/26	2/17/26	Fall Risk Grading		
		Score	8A-8P	8P-2P	8A-2P	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0		0				
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0		0				
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0		0				
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0		0				
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0		0				
Total Morse Fall Scale Score:			35	35	35			
		Signature	Amey	Yamya	Wendy			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	2/7/26	3/2/26	4/7/20	Fall Risk Grading		
		Score	3pm	8pm-8am	FA 21	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0				
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0				
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0				
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0				
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0				
Total Morse Fall Scale Score:			20	20	20			
Signature			Anita	Yammy	Quay			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

- ☒ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☒ Use chairs with arm rests
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Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

- ☒ Ensure patients use their prescribed eye glasses if any, in the hospital
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- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

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

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

BRADEN 'Q' SCALE

					Date :	2/7	28/26	8/2	3/7/26
					Time :	8A 12	8pm	8A 2m	3pm
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:remity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be < 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	Dr. Ammreen Syed	Dr. Shruthi Reddy	Anita	

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

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

H-00555756
 AMMREEN SYED
 10-1994 31 Y 8 M 10 D (F)
 SHRUTHI REDDY PODDUTOOR

BRADEN 'Q' SCALE

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

					Date :	2/7/2022	2/7/2022	2/7/2022	2/7/2022
					Time :	8:30 AM	10:30 AM	12:30 PM	2:30 PM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
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Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
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Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE				
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name				
					Yamini Reddy				

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

BAH-00555756

IP5-00175854

Dr. AMMREEN SYED

23-10-1994 31 Y 8 M 10 D (F)

Dr. SHRUTHI REDDY PODDUTOOR



BRADEN 'Q' SCALE

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	4/12/2023	5/12/2023	6/12/2023	7/12/2023
					Time :	8pm-9pm	9pm-10pm	10pm-11pm	11pm-12am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE				
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name				

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

BRADEN 'Q' SCALE

					Date :				
					Time :				
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e: extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.					
"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.					
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.					
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.					
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."					
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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.					
					TOTAL SCORE				
					Evaluator's Name				

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

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

BAH-00555756

IP5-00175854

Dr. AMMREEN SYED

23-10-1994 31 Y 8 M 9 D (F)

Dr. SHRUTHI REDDY PODDUTOOR



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 2/7/21

Assessment: patient having fever and anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	As After. The Baby general condition	8:10 PM	As After. The patient general condition	As patient is
11 AM	Vital check.	11:10 M	Vital checked and documented	Stable
12 M	As I/O chart monitor	12:30 M	As I/O chart monitoring	
1 PM	As Relieve pain and Discomfort	1:20 M	As Administer medication	
4 PM	As prevent infection	4:10 M	As maintaining lead diaper	
5 PM	As Soft diet	5:20 M	As Soft diet taken	
6 PM	As ambulation	6:20 PM	As ambulation done	
8 PM	As Ensure safety	8 PM	As Ensure safety needs	

Re-Assessment:

Special Notes: on baby

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 2/7/21 6:00 PM

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/7/2026

Assessment: Patient having mild pain over surgical site.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the general condition of the patient	10pm	→ Assessed general condition of the patient.	→ Patient is stable
10pm	→ monitor vitals	12am	→ monitored vitals.	
12am	→ Administer medication as per order.	2am	→ Administered medication as per doctor ordered.	
2am	→ monitor I/O chart	4am	→ Monitored I/O chart	
4am	→ Relieve pain & discomfort	6am	→ Relieved pain and discomfort by medication.	
6am	→ Ensure safety	8am	→ Ensured safety by side rails.	

Re-Assessment:

Special Notes:

Ambulation, soft diet

Nurse Signature: Yamini

Nurse Name: Yamini

Date & Time: 2/7/26 @ 8am

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 3/2/26

Assessment: patient having fear and anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8AM	Assess the patient general condition	8:10 AM	Assessed the patient general condition	patient is stable
9AM	vital check	9:20 AM	vital checked and documented	
10AM	SpO2 chart monitor	10:20 AM	SpO2 chart monitoring	
11AM	ambulation	11:30 AM	ambulation done	
1PM	prevent infection	1:20 PM	maintaining hand hygiene	
2PM	ensure safety	2PM	ensured safety needs	

Re-Assessment:

Special Notes: NA

Nurse Signature: [Signature]

Nurse Name: Nandees

Date & Time: 2/2/26 2PM

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NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment: patient having pain on surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the patient condition	2:30 pm	→ Assessed the patient general condition	→ Patient is fine
3pm	→ Monitor Vitals	3:20 pm	→ checked vitals & recorded	
3:30 pm	→ Administer medication	3:45 pm	→ Administered medication as per drug chart	
4pm	→ I/O chart	4:30 pm	→ monitoring I/O chart	
5pm	→ Ensure safety	5:20 pm	→ Provided side rail	
6pm	→ Ambulation	6:30 pm	→ Pt walking well	
7pm	→ Relieve pain & Discomfort	7:30 pm	→ Given comfortable position	

Re-Assessment: Patient comfortable pain relieved after taking medication

Special Notes: No significant

Nurse Signature:

Nurse Name: Sis. Anita

Date & Time: 3/7/26 @ 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 3/7/2026

Assessment: Patient having mild pain over surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the general condition of the patient.	10pm	→ Assessed general condition of the patient.	→ Patient is stable.
10pm	→ monitor vitals.	12am	→ monitored & charted vitals and recorded.	
12am	→ Relieve pain and discomfort.	2am	→ Relieved pain by medications.	
2am	→ Improve activity tolerance.	4am	→ Improved activity by ambulation.	
4am	→ monitor I/O chart.	6am	→ monitored I/O chart.	
5am	→ soft diet.	6 ³⁰ am	→ soft diet given.	
6am	→ Ensure safety.	8am	→ Ensured safety by side rails.	

Re-Assessment:

Patient hydrating well, Ambulating.

Special Notes:

Soft diet, Ambulation, oral hydration.

Nurse Signature: Yamuna

Nurse Name: Yamuna

Date & Time: 4/7/26 @ 8am

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NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: Patient having fear and anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
9AM	Assessed the patient general condition	9:10 AM	Assessed the patient general condition	Patient is stable.
10AM	Vital check.	10:30 AM	Vital checked and documented	
11AM	SpO2 chart monitoring	11:20 AM	SpO2 chart monitoring	
12M	Ambulation done	12:30 PM	Ambulation done	
1PM	Prevent Infection	1:20 PM	Maintaining hand hygiene	
2PM	Ensure safety	2:30 PM	Ensured safety needs	

Re-Assessment:

Special Notes: 1/1

Nurse Signature: [Signature]

Nurse Name: Nisha

Date & Time: 4/7/26 8pm



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

Assessment:

patient is having pain at surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ Assess the patient general condition	2:30 PM	→ Assessed the patient general condition	- patient is stable & comfortable.
3pm	→ Monitor Vitals		→ checked Vitals & Recorded	
4pm	→ Administer medication	3:30 PM	→ Administered medication as per drug chart	
5pm	→ I/O Monitoring	4:30 PM	→ I/O chart monitoring done	
6pm	→ Ensure safety	5:30 PM	→ Provided side rails	
7pm	- Soft diet	6:30 PM	- Soft diet taken	

Re-Assessment:

Patient comfortable

Special Notes:

WIF Bleeding

Nurse Signature:

sp

Nurse Name:

Sona

Date & Time:

4/7/26 @ 8pm

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Dr. AMMREEN SYED

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NURSING CARE RECORD

Rainbow Children's Hospital
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BirthRight™
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Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 11/2/26

Assessment: Patient having mild pain over surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the general condition of the patient	10pm	→ Assessed general condition of the patient	→ Patient is stable
10pm	→ monitor vitals.	12am	→ monitored vitals.	
12am	→ Relieve pain and discomfort	2am	→ Relieved pain by medication.	
2am	→ Improve activity tolerance.	4am	→ Improved activity by ambulation.	
4am	→ monitor I/O chart	6am	→ monitored I/O chart	
6am	→ Ensure safety	8am	→ Ensured safety by side rails.	

Re-Assessment: Ambulating well.

Special Notes: soft diet

Nurse Signature: Yamini

Nurse Name: Yamini

Date & Time: 11/2/26 @ 8am



NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/9/26

Assessment: patient is having low anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assessed the patient General condition	8:30 AM	Assessed the patient General condition	→ patient is stable & comfortable
10am	monitor vitals	10:30 AM	Monitoring vitals, BP, PR RR, SpO2 checked & recorded.	
11am	Soft diet	11:30 AM	Soft diet taken	
12pm	hydration	12:30pm	Oral hydration given	
2pm	Ensure safety.	1:30pm	Ensure safety provided	

Re-Assessment:

Special Notes: ulc. Bleeding

Nurse Signature: *[Signature]*

Nurse Name: Sona

Date & Time: 5/9/26 @ 2pm

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NURSING CARE RECORD

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Patient having mild pain in surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the pt condition	2pm	Assessed the pt condition	Patient is comfortable
3pm	Monitor vitals	3pm	Vitals checked & recorded	
4pm	No chest	4pm	No chest maintained	
5pm	Safety	4:30pm	pt ensured safety	
7pm	personal hygiene	5:30pm	personal hygiene maintained	
8pm	Salt diet	7pm	Salt diet given	
	Drug Administration	8:05pm	Medication given as per drug chart	

Re-Assessment: Now patient comfortable after giving Medication

Special Notes: Not significant

Nurse Signature: 

Nurse Name: Anilpa

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



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10th

Assessment: Patient Complaints on her 4 Anky

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ Assess the pt condition	8:10pm	→ Assessed the pt condition	→ pt is stable
10pm	→ monitor vitals	10:10pm	→ vitals checked and recorded	
12AM	→ No diet	12:10AM	→ No diet - maintenance	
2AM	→ 4 Safety	2:10AM	→ Cured 4 Safety	
4AM	→ Regular diet	4:10AM	→ Regular diet provided	
6AM	→ Ambulation	6:10AM	→ Ambulation done	
8AM	→ Administer medication	8:10AM	→ Administered medication	

Re-Assessment: Vitals checked and recorded

Special Notes:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 10/10/2020 8AM

BAH-00555756 IP5-00175854
Dr. AMMREEN SYED
23-10-1994 31 Y 8 M 12 D (F)
Dr. SHRUTHI REDDY PODDUTOOR



NURSING CARE RECORD


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


BirthRight™
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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Shruthi Reddy Department: BRP Date of Admission: 2/2/26

SITUATION		Diagnosis: <u>82A 4381 week</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	BRP 5AM-8AM	BRP 8AM-11AM	BRP 11AM-2PM	BRP 2PM-8PM	BRP 8PM-8AM		
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:		Temp:	<u>98.0F</u>	<u>98.4F</u>	<u>98.6F</u>	<u>98.6F</u>	<u>98.4F</u>	<u>98.6F</u>
			Res:	<u>18</u>	<u>19b/m</u>	<u>20b/m</u>	<u>18b/m</u>	<u>19b/m</u>	<u>20b/m</u>
			SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>98%</u>	<u>99%</u>	<u>99%</u>	<u>100%</u>
			Pulse:	<u>82</u>	<u>79b/m</u>	<u>82b/m</u>	<u>83b/m</u>	<u>78b/m</u>	<u>78</u>
			BP:	<u>116/72</u>	<u>118/75</u>	<u>101/62</u>	<u>94/64</u>	<u>98/72(77)</u>	<u>98/52</u>
			Fall Risk Score:	<u>35</u>	<u>35</u>	<u>35</u>	<u>20</u>	<u>20</u>	<u>19</u>
Pain Score:		<u>0/10</u>	<u>0/10</u>	<u>0/10</u>	<u>0</u>	<u>0/10</u>	<u>0/10</u>		
Recommendations	Safety Needs:		<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:			<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :			<u>Yamung</u>	<u>Yamung</u>	<u>Yamung</u>	<u>Anita</u>	<u>Yamung</u>	<u>Yamung</u>	
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:			<u>2/2</u>	<u>2/2/26</u>	<u>2/2/26</u>	<u>2/2/26</u>	<u>4/2/26</u>	<u>4/2/26</u>	
Time:			<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	
Taken Over By Name :			<u>Yamung</u>	<u>Yamung</u>	<u>Anita</u>	<u>Yamung</u>	<u>Yamung</u>	<u>Anita</u>	
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:			<u>2/2/26</u>	<u>3/7</u>	<u>2/2/26</u>	<u>3/7/26</u>	<u>4/7</u>	<u>4/7/26</u>	
Time:			<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. SK Department: RPP Date of Admission: 2/7/26

SITUATION	Diagnosis: <u>G2 P1 4 38+1 wks</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify: _____				
BACKGROUND	Area	Shift Time	<u>RPP 2pm-8pm</u>	<u>RPP 8pm-midnight</u>	<u>RPP 8am-2pm</u>	<u>PS-I 2pm-8pm</u>	<u>PS-II 8pm-midnight</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: <u>98.2 F</u>	Temp: <u>98.4 F</u>	Temp: <u>98.4 F</u>	Temp: <u>98.6 F</u>	Temp: <u>98.5 F</u>
	Res:		<u>19b/m</u>	<u>20b/m</u>	<u>19b/m</u>	<u>20b/m</u>	<u>20b/m</u>
	SpO ₂ :		<u>100%</u>	<u>100%</u>	<u>100%</u>	<u>99%</u>	<u>99%</u>
	Pulse:		<u>72b/m</u>	<u>74b/m</u>	<u>74b/m</u>	<u>78b/m</u>	<u>77b/m</u>
	BP:		<u>102/62</u>	<u>100/62</u>	<u>110/69</u>	<u>119/80</u>	<u>118/80</u>
	Fall Risk Score:		<u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>
Recommendations	Safety Needs:		<u>side rails</u>	<u>side rails</u>	<u>side rails</u>	<u>side rails</u>	<u>side rails</u>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Handed Over By Name :		<u>Sona</u>	<u>Yamini</u>	<u>Sona</u>	<u>Deelvi</u>	<u>Sona</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>4/7/26</u>	<u>5/7/26</u>	<u>5/7/26</u>	<u>5/7/26</u>	<u>6/7/26</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>	
Taken Over By Name :		<u>Yamini</u>	<u>Sona</u>	<u>Deelvi</u>	<u>Sona</u>	<u>Deelvi</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>4/7/26</u>	<u>5/7/26</u>	<u>5/7/26</u>	<u>5/7/26</u>	<u>5/7/26</u>	
Time:		<u>8pm</u>	<u>8:30am</u>	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	

URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 2/2/25

Date of Removal:

Parameters	Date	Shift Time						
Need for the Catheter	<u>2/2</u>	<u>PM</u>	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse			<u>nambe</u>					
Signature of the Nurse			<u>[Signature]</u>					

BAH-00555756
Dr. AMMREEN SYED
23-10-1994 31 Y 8 M 9 D (F)
Dr. SHRUTHI REDDY PODDUTOOR

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge:

2. Destination Post Discharge: ☒ Home
Family Members Notified (Person Contacted)

☐ Transfer
Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

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

No Need

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☒ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☒ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hand hygiene

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

☒ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Name]

Date and Time: 21/2/26 PM



PS-9

NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 3/7/26

Time: 9am

Origin: Indian Height: 155cm Weight: 65kgs BMI: 27kg/m²

Food Allergies: No

Diagnosis: P00-1 (LSCS) lower segment cesarean section

Type of Diet: ☐ Liquid ☒ Soft ☐ Normal ☐ Diabetic
☐ Vegetarian ☒ Non-Vegetarian ☐ Vegan

Diet Advised:

Soft high protein diet

plenty of oral liquids

- Avoid spicy, chilled, outside foods

Patient's / Attendant's

Signature: [Signature]

Name: Ammeen

Date & Time: 3/7/26, 9am

Dietician's

Signature: [Signature]

Name: Nikitha

Date & Time: 3/7/26, 9am

DIETARY NOTES[illegible]

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00555756 IP5-00175854
Dr. AMMREEN SYED
23-10-1994 31 Y 8 M 9 D (F)
Dr. SHRUTHI REDDY PODDUTOOR



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Name: Age: Sex: UHID.No:

Date: 2/7/21 Time: 8.30 Proposed Operation: Elective Cesarean

Diagnosis: G2 P1 L1 38+1 wks 1pwr LSCS For 12-15cm

B.P / CRT: 104/74 H.R: 96 Weight: ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: Glucose: Protein: HIV:
PCV: Urea: Alb: HBS Ag:
WBC: Creat: Total Bill: HCV:
Plate: Na: Dir. Bill: Blood group:
PT: K: LDH: T3: 1.13
PTT: Ca++: Alk phos: T4: 8.25
INR: Mg++: Amylase: TSH: 0.37
Cl-: SGOT/SGPT:

X-Ray: tachycardic
ECG: no RWM
2D Echo: normal
Stress/Angio: normal
Other: normal

Allergies: W

Medical History: CVS: 410 of palpitations (may) → only 20-30 sec
RESP: Diabetes: → tachycardic during
CNS: recently no episode of tachycardic palpitations
Renal: WT 5, 6 months

Hepatic / GE: Physical Activity: BT 2 Floor
Others: HYPERTHYROID not on medication

Past Anaesthetic History: 10 pwr LSCS → epidural top up

Physical Exam:

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

Lungs: AERATE

Heart: S1 S2

CNS: normal

Pregnant: ☒ Yes ☐ No ☐ NA

Venous Access Site: W 20h

Spine Exam for regional:

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Signature: Adil Name: Dr. Adil - CBC, EV, communication
- ETC

BAH-00555756 IP5-00175854
Dr. AMMREEN SYED
23-10-1994 31 Y 8 M 9 D (F)
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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:

B.P / CRT:

SpO₂:

R.R:

Last Feed:

Pre-OP Diagnosis:

Operation:

El. inc

Date:

2/7/20

Surgeon:

Dr. Shruthi Reddy

Anaesthesiologist:

Dr. Shilpa

Technician:

Kulsum

TIME

N₂O / AIR / O₂ LPM

HALO / SO / SEVO

Drugs:

PE 100

Oxytocin 3 IU

FI_{O₂} / SaO₂

ETCO₂

ECG

Temperature

Urine Output

Antibiotic

Suppository

Blood Loss

NOTES

Fluids
Blood

Re + 30 Oxytocin

B.P

V Systolic

A Diastolic

X Mean

• Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

LAB Values

ABG

GRBS

Others

☒ Equipment Checked and Functional

☒ BP

☒ Cuff Site:

☒ Art Site:

☒ EKG Lead

☐ Temp Site

☐ FI_{O₂} Monitor

☐ Agent Monitor

☒ Pulse Oximeter

☐ Capnograph

☐ Ventilator

☐ Nerve Stimulator

Position: Supine

☐ 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: 10/20

OP Start:

OP End: 11/20 AM

Leave OR:

Anaesthesia:

☐ GA

☐ Monitored Anaesthesia Care

☒ Regional

Line (Size & Location)

☐ CVP:

☐ ABT:

☒ IV: 18.4

☐ IV:

☐ 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: 1-8u of 0.25% (M)

Site: Supi +

Needle Size:

Depth: 20-25 of dentangle

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

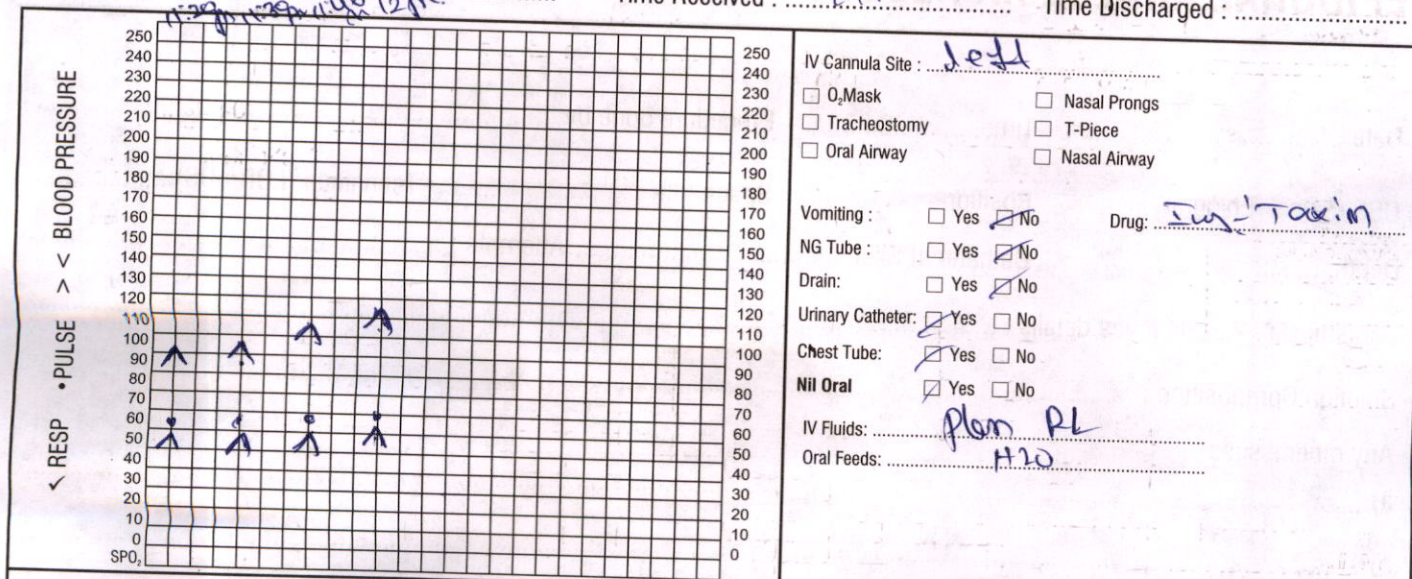
Signature of the Doctor:

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Monika

Time Received : 11.20 AM

Time Discharged :



IV Cannula Site : Left
☐ O₂ Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☒ No

Drug : Insulin

NG Tube : ☐ Yes ☒ No

Drain : ☐ Yes ☒ No

Urinary Catheter : ☒ Yes ☐ No

Chest Tube : ☒ Yes ☐ No

Nil Oral ☒ Yes ☐ No

IV Fluids : Plan PL

Oral Feeds : H2O

POST ANAESTHESIA SCORE (Modified Aldrete Score)

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES			OUT	SCORING INTERPRETATION
				30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY	1	2	2	2	1	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 move 2 extremities voluntary or on command	= 1							
Able to move 0 extremities voluntary or on command	= 0							
Able to deep breathe & cough freely	= 2	RESPIRATION	2	2	2	2		
Dyspnea or limited breathing	= 1							
Apneic	= 0							
BP $\pm$ 20 of Pre Anaesthetic level	= 2	CIRCULATION	2	2	2	2		
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1							
BP $\pm$ 50 of Pre Anaesthetic level	= 0							
Fully awake	= 2	CONSCIOUSNESS	2	2	2	2		
Arousable on calling	= 1							
Not responding	= 0							
Pink	= 2	COLOR	2	2	2	2		
Pale, dusky, blotchy, jaundiced, other	= 1							
Cyanotic	= 0							
TOTAL			9	10	10	10	9	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
2/7	12P	0/10	NA	Monika
2/7	3PM	0/10	NA	Monika
2/7	6P	0/10	NA	Monika

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

Anaesthesiologist Name : Dr. Shilpa

Anaesthesiologist Signature : [Signature]

Date & Time : 2/7/2016

PACU Nurse Name : Monika

PACU Nurse Signature : [Signature]

Date & Time :

Reassessment Frequency:

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

Transferred to Unit by (PACU): BRP

Date & Time : 2/7/2016 12P

Date and Time :