

## SURGERY DETAILS

Date : 9/17/26

Patient Name: Reshika Rao Date of Birth: 22/2/1999 Age: 28y

Gender: Female Ward: OBG OT UHID No: SAA 00637114

Date of Surgery: 9/17/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☒ OBG OT-2

Name of the Surgery : Emergency lvs. ↓ SA

Time in : 4:10pm

Time Out : 5:16pm

|                      | NAME          | AMOUNT |
|----------------------|---------------|--------|
| 1. Surgeon           | Dr. Tharabide |        |
| 2. Anaesthetist      | Dr. Suresh    |        |
| 3. Assistant Surgeon | Dr. Arshya    |        |
| 4. OT Technician     | Dr. Kulkarni  |        |
| 5. Circulating Nurse | Dr. Seetha    |        |
| 6. Assistant Nurse   | Dr. Shantika  |        |

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

Signature of the Surgeon  
Dr. Arshya

Signature of Circulating Nurse  
Shap

9696927

Order by: Dr. Ravi



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

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

**ADMISSION SHEET****Registration Details :**

Admission No : IP5-00176131      Admit Date : 09-Jul-2026      Admit Time : 06:35 AM      UHID : BAH-00660194

**Patient Details :**

Patient Name : Mrs R RADHIKA      Age : 49 Y  
Guardian : Mr VENKANNA      DOB : 09-09-1976  
Gender : Female      Religion :  
Occupation :      Martial Status : Married  
Address (H) : #R VENKANNA H.NO:6-2-514/3, VINAYAKA      Phone No : 9490090668/ 9642811141  
GROUND N G COLLEGE BACK SIDE SRI      E-mail : nomailid@gmail.com  
NAGAR COLONY Nalgonda Nalgonda  
Telangana INDIA 508001

**Admission Details :**

Bed Type : DAY CARE      Bed No : RC 406      Ward Name : 4F-GYN RECOVERY  
Room No : RC 406      Admission Type : First Visit

**Contact Details :**

Name : Mr VENKANNA      Relationship : Husband  
Contact Address : #R VENKANNA H.NO:6-2-514/3, VINAYAKA      Phone No : 9490090668 / 9642811141  
GROUND N G COLLEGE BACK SIDE SRI  
NAGAR COLONY Nalgonda Nalgonda  
Telangana INDIA 508001

*R Venkanna*  
Signature

**Doctor Details :**

Doctor Name : Dr. HIMABINDU VEERLA      Specialisation : OBSTETRICS AND GYNECOLOGY  
Referral Doctor : Self      Phone No :  
Co-Consultant :

**Payment Details :**

Payment Mode : Cash      Deposit Amount : 0.00  
Payor Name : STAR HEALTH AND ALLIED  
INSURANCE CO LTD



BAH-00637114 IP5-00176130  
Mrs RISHIKA RAO KANAKANDULA  
27-02-1999 27 Y 4 M 12 D (F)  
Dr. HIMABINDU VEERLA



# CONSUMABLES OF OT

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Circulator: ..... Technician: Kulsum Date: 9/7 Time: .....

| Anaesthesia Disposables            | Qty    |      | Surgical Disposables        | Qty    |      | Disposables (Baby Side)      | Qty    |      |
|------------------------------------|--------|------|-----------------------------|--------|------|------------------------------|--------|------|
|                                    | Issued | Used |                             | Issued | Used |                              | Issued | Used |
| ET tube                            |        |      | Major Pack <u>See Drage</u> | ✓      | ✓    | Inj Vit.K                    |        | ✓    |
| LMA                                |        |      | Sutures <u>2346</u>         | ✓      | ✓    | Cord Clamp                   |        | ✓    |
| ECG leads (A) P / N                | ✓      | ✓    | <u>2364</u>                 | ✓      | ✓    | Suction Catheter <u>8NO</u>  |        | ✓    |
| HME filter : A / P / N             |        |      | <u>2762</u>                 | ✓      | ✓    | Feeding Tube                 |        | ✓    |
| Syringes : 10 cc                   |        |      |                             | ✓      | ✓    | Vaccum Suction Set           |        | ✓    |
| 05 cc                              | ✓      | ✓    | Gloves <u>6.6 1/2 17</u>    | ✓      | ✓    | Surgical Gloves <u>6 1/2</u> |        | ✓    |
| 02 cc                              | ✓      | ✓    | <u>P.F 6 1/2</u>            | ✓      | ✓    | Gauze Pack                   |        | ✓    |
| 01 cc                              |        |      |                             | ✓      | ✓    | Syringe 1ml / 2ml            |        | ✓    |
| Cautery plate (A) P / N            | ✓      | ✓    | Surgical blade <u>22</u>    | ✓      | ✓    | Surgical Blade # 20          |        | ✓    |
| IV set                             |        |      | NG tube                     | ✓      | ✓    | Koochies (S) <u>1'S</u>      |        | ✓    |
| RL                                 | ✓      | ✓    | Cautery pencil              | ✓      | ✓    | <u>Heparin</u>               |        | ✓    |
| NS : 10ml / 100ml / 500ml / 1000ml | ✓      | ✓    | Koochies <u>XC</u>          | ✓      | ✓    |                              |        |      |
| <u>mini spike</u>                  | ✓      | ✓    | Ointments                   | ✓      | ✓    |                              |        |      |
| <u>60x27</u>                       | ✓      | ✓    | Suction Catheter            | ✓      | ✓    |                              |        |      |
| Fentanyl                           | ✓      | ✓    | Cap, Mask                   | ✓      | ✓    |                              |        |      |
| Morphine                           |        |      | Gauze Pack                  | ✓      | ✓    |                              |        |      |
| Ketamine                           |        |      | Mop Pack                    | ✓      | ✓    |                              |        |      |
| Propofol                           |        |      | Steristrip <u>20ne</u>      | ✓      | ✓    |                              |        |      |
| Rocuronium                         |        |      | Underpad                    | ✓      | ✓    |                              |        |      |
| Glycopyrolate                      |        |      | Draw sheet <u>Autoclave</u> | ✓      | ✓    |                              |        |      |
| Myopyrolate                        |        |      | Abgel                       | ✓      | ✓    |                              |        |      |
| Ondansetron                        | ✓      | ✓    | Foleys catheter             |        |      |                              |        |      |
| Pencan 25g/ Spinal Needle 22       | ✓      | ✓    | Urobag                      |        |      |                              |        |      |
| Bupivacaine 0.25%                  |        |      | Chest Drainage Catheter     |        |      |                              |        |      |
| Bupivacaine 0.25%(Heavy)           | ✓      | ✓    | Romodrain bag               |        |      |                              |        |      |
| Antibiotics <u>Tranexa</u>         | ✓      | ✓    | Bandage                     |        |      |                              |        |      |
| <u>methergin</u>                   | ✓      | ✓    | Tegaderm                    |        |      |                              |        |      |
| Suppositories                      |        |      | Ioban                       |        |      |                              |        |      |
| Anamol : 80mg / 250mg / 170 mg     |        |      | Double J Stent              |        |      |                              |        |      |
| Supridol : 100mg                   | ✓      | ✓    | Vaccum Suction set          | ✓      | ✓    |                              |        |      |
| Justin : 12.5 mg / 25mg / 100mg    | ✓      | ✓    | Plastic Bed Sheet           |        |      |                              |        |      |
| Tab. Misoprost : 200mg             | ✓      | ✓    | Betadine Solution           | ✓      | ✓    |                              |        |      |
| <u>Oxytocin</u>                    | ✓      | ✓    | Microshield                 | ✓      | ✓    |                              |        |      |
| <u>glove 6 1/2</u>                 | ✓      | ✓    | Cotton Balls                | ✓      | ✓    |                              |        |      |
| <u>gauze</u>                       | ✓      | ✓    | Latex Gloves                | ✓      | ✓    |                              |        |      |
| <u>Epiderin</u>                    | ✓      | ✓    | Ramdione Scrub              | ✓      | ✓    |                              |        |      |
|                                    |        |      | Sara DIA                    | ✓      | ✓    |                              |        |      |

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9696940

Ordered by : Bis R

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



## ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_ BAH-00660194 IP5-00176131  
Mrs R RADHIKA  
09-09-1976 49 Y (F)  
UHID No. : \_\_\_\_\_ Dr. HIMABINDU VEERLA  
Date of Admission: \_\_\_\_\_ ultant: \_\_\_\_\_ Dept : \_\_\_\_\_  
of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_  
Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_



## WARD TRANSFERS

| Date    | Time   | From  | To    | Signature of Nurse |
|---------|--------|-------|-------|--------------------|
| 9/7/26  | 8:00AM | MICU  | P.O.T | Rajeeva            |
| 9/7/26  | 2pm    | P.O.T | MICU  | Rajeeva            |
| 10/7/26 | 4pm    | MICU  | 340   | Rajeeva            |
|         |        |       |       |                    |
|         |        |       |       |                    |

## Cross Consultation Visit

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



[illegible]

Signature

Dep

СВР

05/5/12

4/5/12



### MEDICAL EQUIPMENT (WARD & ICU)

[illegible]









## I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 9/7/26 Time of Admission : 6:30 AM  
Allergies : NKDA ☒ Not know any drug allergies

### PRESENTING COMPLAINTS :

c/o heavy Bleeding during periods : Sep' 2025.  
associated w passage of clots & pain Abdomen.

USG. Abdomen & Pelvis. uterus Anteverted, ill defined  
(12.8x9.5x11.3cm)  
mixed echoc lesion in anterior wall measuring.  
8.6x5.2cm - Adenomyosis, ET- 28mm.

28/10/25 PAP- NILM  
11/11/25 Biopsy < chronic endocervicitis squamous metaplasia,  
w of proliferative phase of endocervix.

| MENSTRUAL HISTORY                    | OBSTETRIC HISTORY             |
|--------------------------------------|-------------------------------|
| Year of Marriage : 1993              | Parity : B6                   |
| Previous Periods : Regular, 2-4 / 30 | Mode of Delivery : NVD        |
| LMP : 16/6/26                        | Last Child Birth : LCB - 1996 |
| Contraception : none                 |                               |

| PAST MEDICAL HISTORY | PAST SURGICAL HISTORY                |
|----------------------|--------------------------------------|
| - Nil                | NK<br>Nov 2025 - Endometrial Biopsy. |



|                                                |                                                                  |
|------------------------------------------------|------------------------------------------------------------------|
| <b>FAMILY HISTORY:</b><br><br>Another- HTN, DM | <b>MEDICATION HISTORY:</b><br><br>see medical consultation form. |
|------------------------------------------------|------------------------------------------------------------------|

|                                                                                                                                                                                                              |                                                                                                                                         |                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <b>INITIAL ASSESSMENT :</b>                                                                                                                                                                                  |                                                                                                                                         |                                                                   |
| Date <u>9/7/26</u><br>Ht. <u>155</u> Wt. <u>64.6</u><br>BMI <u>26.89 kg/m<sup>2</sup></u><br>B.P. _____<br>Pallor <u>about</u><br>CVR <u>SSR</u><br>Respiratory System <u>clear</u><br>Thyroid <u>normal</u> | Breasts<br><div style="text-align: center;">(N)</div><br><br>Abdominal Examination<br><u>soft, nontender</u><br><u>R/A. at 16 weeks</u> | Local/Speculum Examination<br><br><br>Bimanual Pelvic Examination |

|                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>PROVISIONAL DIAGNOSIS :</b> <u>P212 C per NVD</u> <u>(AUB - A)</u> <u>1 pr TCT + BCL</u><br><u>Salpingitis</u>                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                              |
| <b>INVESTIGATIONS ORDERED</b><br><br><u>A negative</u><br><br><u>6/7/26</u><br><u>CBP - 10.8 / 7,400 / 3671</u><br><br><u>2DECHO - Grade 1 diastolic</u><br><u>dysplasia, ER72/</u><br><br><u>3/6/26</u><br><u>TSH - 4.44</u><br><u>Creat - 0.54</u><br><u>Na<sup>+</sup>/K<sup>+</sup>/Cl<sup>-</sup> - 138 / 104</u><br><u>2810 hrs</u> <u>urab-NR-</u> | <b>PLAN OF MANAGEMENT</b><br><br><u>Admission</u><br><ul style="list-style-type: none"> <li>- NBM</li> <li>- IV fluids @ 100ml/hr</li> <li>- Serial PAc</li> <li>- Serial urine</li> <li>- Pre-op mechanical</li> <li>- Shift to OT on call</li> </ul> <div style="text-align: right;"> <b>DR. HIMABINDU VEERLA</b><br/>           Registration No: 5724501 u         </div> |

Name of the Doctor : Dr. Himabindu  
 Date & Time : 9/7/26 @ 6:30 AM

(Dr. Himabindu)  
 Signature of Doctor



## OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 9/7/26

### Baseline Information:

Admission From: ☐ ER ☐ OPD ☒ Admission Desk ☐ Others, specify \_\_\_\_\_  
Primary Language: ☒ Telugu ☐ English ☐ Hindi ☐ Others, specify \_\_\_\_\_  
Do you require an interpreter? ☐ Yes ☐ No if Yes specify \_\_\_\_\_  
Source of Information: ☐ Patient ☒ Family ☐ Others, specify \_\_\_\_\_

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: \_\_\_\_\_  
If yes, identify \_\_\_\_\_

Chief Complaints: { severe bleeding every 2 days came for Painless Surgery } Doctor Notified on Admission: ☒ Yes ☐ No  
Name of the Doctor: Dr. Samudra Time Notified: 6:10 AM

Past Medical History: Obtained From ☐ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify) \_\_\_\_\_

| Past Medical History | Past Surgical History       | Previous Hospital Admission |
|----------------------|-----------------------------|-----------------------------|
| nil -                | Endometrial Biopsy<br>nil - | nil -                       |

**Gynecology Assessment:** ☐ Not Applicable  
Menstrual History: \_\_\_\_\_  
Onset of Menarche: \_\_\_\_\_  
Menstrual Cycle: ☒ Regular ☐ Irregular  
Last Menstrual Period: 16/6/26  
**Gynecology Surgical History:**  
Caesarean Section: ☒ No ☐ Yes  
Cervical Cerclage: ☒ No ☐ Yes  
Ectopic Pregnancy: ☒ No ☐ Yes  
Myomectomy: ☒ No ☐ Yes  
Others: \_\_\_\_\_  
**Gynecological History:**  
Contraceptives: ☒ No ☐ Yes  
Vaginal Discharge: ☒ No ☐ Yes  
Post-Coital Bleeding: ☒ No ☐ Yes  
Infertility: ☒ No ☐ Yes  
If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G \_\_\_\_\_ P 2 L 2 A \_\_\_\_\_

Previous LSCS: nil -

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

Family History: ☒ No Abnormalities Detected  
☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease  
☐ Liver disease ☐ Other \_\_\_\_\_

Vital Signs / Measurements: Temp: 98.2 F HR: 88 bpm RR: 18 bpm  
BP: 110/70 mmHg Weight: \_\_\_\_\_ Height: \_\_\_\_\_ BMI: \_\_\_\_\_

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





### PHYSICAL ASSESSMENT

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

**Fall Assessment:** ☐ Yes ☐ No Score 25 (complete the Morse Fall Risk Assessment Sheet)

**Risk of Pressure Sore:** ☐ Yes ☐ No Score 25 (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 Family

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

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

Above information given to .....

Name of Person Orientation was given to: patient Mrs. Radhika

Orientation not given Reason: .....

Nurse Signature: Rajeev

Nurse Name: Rajeev

Date & Time: 9/12/2024 @ 2:52





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- Procedure - B/L round ligaments, fallopian tubes & ovarian ligaments are identified & cut.  
 - UU fold of peritoneum is opened & bladder is pushed down  
 - uterine vessels, macrovessels & uterosacral on both sides are identified & cut.  
 - vault is opened & uterus is removed through vagina. B/L Salpingo-oophorectomy done & specimen reviewed.  
 - vault is sutured & vaginal. Hemostasis is secured & ports are closed.

Amount of Blood Loss:

500ml

Blood Transfused (in ML)

Nil

Name and Number of Surgical Specimen sent for examination:

uterus & both tubes for HPR.

Peri-Operative Complications:

Nil

Discharge advice.

① AUGMENTIN. DUO - (14)

1 - 1

625mg

② PAN - 1 / OD

③ T. ACICLO - P / TID - (7)

④ Zincovit - 1 / Mouth

⑤ divogen / OD - 3 months

⑥ vofolplus / OD - 3 months

Name of the Surgeon:

Dr. Himabindu

Signature of the Surgeon:

Dr. Himabindu

Date & Time:

9/7/26 . 3 PM

DR. HIMABINDU  
Registration No: 37242



## POST-SURGICAL CARE PLAN FORM

Procedure Done: LAP + B/L Salpingectomy

Post-Surgical Diagnosis: Adenomyosis & Adenomyoma

Post-Operative Monitoring Parameters /Frequency:

PR/BP/SPO - every 2 hr for 3 hrs  
followed by 3rd hourly

Wound Care:

Routine

Drain /Special Lines/Catheters:

Foley's to be removed after  
24 hrs.

Special Patient Positioning and Requirements:

As per pt's convenience.

Nutritional Instructions:

NBM till further instructions.

When to Start Mobilization:

After 24 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

Treating Surgeon  
(Signature & Stamp)

Date: 9/7/26 Time: 3 PM

Note: Plan of care will be readjusted if necessary.



## ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /  
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time             | Progress Notes                                                                                                               | Doctor's Order                                                                                                                                           |
|-------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| 9/7/26<br>2:30pm        | POD-01 TLM + BIL salpingectomy<br><br>O/E<br>Gravidity<br>Bp = 106/57/72 mmHg<br>PR - 78 bpm<br>SpO2 - 98% LRA<br>PlA - soft | on 02 3/4 made.<br>Adv<br>① NBM for 6 hrs<br>② I/O charting<br>③ Monitor vital every 15 mins<br>④ Drugs as charted<br>⑤ w/ active bleeding<br>⑥ Informed |
|                         | VO - 50ml<br>dur                                                                                                             | Dr. Divya                                                                                                                                                |
|                         | Reviewed by                                                                                                                  | revisited                                                                                                                                                |
| 9/7/26<br>5PM           | 8/10. Mrs. Himabindu<br>Patel +<br>PR - 78/min<br>SpO2 - 98%<br>BP - 112/63 mmHg<br>PA - soft<br>PU - no active bleeding     | ① NBM till<br>further orders                                                                                                                             |
| 0.0<br>150ml<br>dur CBP |                                                                                                                              | DR. HIMABINDU VEERLA<br>Registration No. 100. Himabindu                                                                                                  |









## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time    | Progress Notes                                                                                                                                                                                                  | Doctor's Order                                                                                                                              |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 10/7/26<br>3am | Patient is comfortably sleeping<br><br>Gefar.<br>afebrile.<br>PR - 90/min<br>BP - 110/74 mmHg<br>U/O - 30ml. SpO <sub>2</sub> - 100% @ 3L lit O <sub>2</sub><br>P/A - soft<br><br>P/A - MAP<br>vaginal pack (+) | adv ① vitals Monitor<br>② Iy Fem on 10/7/26<br>③ Foley till further orders<br>④ KUB till further order.<br>⑤ Drop a charted.<br>⑥ Inform to |
| 10/7/26<br>4am | Code / TLH + B1<br>No Complaints<br><br>Gefar<br>afebrile<br>PR - 80/min<br>BP - 124/80 mmHg<br>U/O = 20ml. SpO <sub>2</sub> - 94% @ PR<br>P/A - soft.<br>vaginal pack (+)                                      | adv ① vitals Monitor<br>② Iy Fem Labors<br>③ Foley till further orders<br>④ KUB till 11<br>⑤ Drop a chart<br>⑥ Informer                     |



BAH-00660194 IP5-00176131

Mrs R RADHIKA

09-09-1976

49 Y

(F)

Dr. HIMABINDU VEERLA



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## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes                                                                                                                                                                                  | Doctor's Order                                                                      |
|-------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 10/7/26     |                                                                                                                                                                                                 |                                                                                     |
| 8:15 AM     | <p>Pt conscious coherent</p> <p>PR: 77bpm</p> <p>BP: 113/63 (78) mmHg</p> <p>SpO<sub>2</sub>: 97% RA</p> <p>P/A: Soft</p> <p>BS (+)</p> <p>U/O: 2500ml Input: 3100ml</p> <p>pack Insitu Vg.</p> | <p>✓ Spirometry</p> <p>✓ Ambulate slowly</p>                                        |
|             |                                                                                                                                                                                                 | dry mouth                                                                           |
| 10/7/26     | 8/8 Dr. Hema Bindu                                                                                                                                                                              |                                                                                     |
| 9:45 AM     | <p>Pt - Comfortable</p> <p>Pain +</p> <p>PR - 81/min - SpO<sub>2</sub> - 94%</p> <p>BP - 113/63</p> <p>PA - Soft</p> <p>BS - Sluggish</p>                                                       | <p>① Liquids - followed by soft diet</p> <p>② Remove foley's &amp; vaginal pack</p> |
|             | <p>✓ Vaginal Pack removed</p> <p>✓ foley's removed</p>                                                                                                                                          | <p>DR. HIMABINDU VEERLA</p> <p>Registration No: 37245</p>                           |





## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time         | Progress Notes                                                                                                     | Doctor's Order                                                                                                                                                    |
|---------------------|--------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 10/6/26<br>1pm.     | A comfortable.<br>PR - 106 bpm<br>BP - 106/65 mmHg<br>SpO <sub>2</sub> - 97% on room air<br>P/A soft<br>umbilicus. | Adv<br>- drugs as per charted<br>- vitals monitoring<br>- w/f active<br>Bleeding per<br>- Ambulate<br>- Spironolactone<br>- Inform her                            |
| 10/7/2026<br>7:00pm | Shift to room after voiding<br>Plan discharge tomorrow.                                                            | Dr. Sannu                                                                                                                                                         |
| 10/7/2026<br>7:00pm | POD-1/TLM<br>Femv<br>O/F<br>Gc-tailor<br>Vitals stable<br>P/A - soft<br>UE - NAD.                                  | NB for Lanna (Cottar)<br>Adv<br>① Soft diet<br>② Hydration<br>③ Ambulation<br>④ Drugs as charted.<br>⑤ Spironolactone<br>⑥ Urt after bleeding per<br>⑦ Inform her |



BAH-00660194

IP5-00176131

Mrs R RADHIKA

09-09-1976

49 Y

(F)

Dr. HIMABINDU VEERLA



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## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time      | Progress Notes            | Doctor's Order        |
|------------------|---------------------------|-----------------------|
| 11/7/2026        | POD-2 / TLH               |                       |
| 7:30 am          | o/e                       | Adv                   |
| FCM ✓            | Bp - 106/80 mmHg          | ① Soft diet           |
|                  | PR - 76 bpm               | ② Ambulation          |
|                  | SpO <sub>2</sub> - 98% RA | ③ Hydration           |
| Plan & Discharge | p/A - ut @ uic            | ④ Migs acetate        |
| ✓                | LIE - BWM                 | ⑤ monitor vital & the |
| ✓                |                           | ⑥ self care bleed     |
| SX               |                           | ⑦ Inhouse             |
|                  |                           | Dr. Diya              |
|                  |                           | shir                  |



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Blood group A-ve

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## RESULT SHEET

|                     |        |  |  |  |  |
|---------------------|--------|--|--|--|--|
| Date                | 1/7/26 |  |  |  |  |
| Time                |        |  |  |  |  |
| Hb                  | 10.8   |  |  |  |  |
| PCV                 |        |  |  |  |  |
| RBC                 | 3.52   |  |  |  |  |
| WBC                 | 7.4    |  |  |  |  |
| N/L                 |        |  |  |  |  |
| Platelets           | 367    |  |  |  |  |
| CRP                 |        |  |  |  |  |
| ESR                 |        |  |  |  |  |
| PCT                 |        |  |  |  |  |
| RBS                 |        |  |  |  |  |
| Na                  |        |  |  |  |  |
| K                   |        |  |  |  |  |
| Cl                  |        |  |  |  |  |
| Ca/Mg               |        |  |  |  |  |
| Phosphate           |        |  |  |  |  |
| Urea                |        |  |  |  |  |
| Creatinine          | 0.84   |  |  |  |  |
| 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                 |        |  |  |  |  |







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MEDICATION RECONCILIATION FORM

Drug Allergies: INCPA ☐ 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: MA Shifted to: MA

| S.No | MEDICATION NAME<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ SHIFTING                          |
|------|---------------------------------------------------|-------------------|---------------------------|-----------|--------------------------|--------------------------------------------------------|
| 1    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
|      |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 3    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 4    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 5    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 6    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 7    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
|      |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 9    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 10   |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |

\* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Suresh

Date & Time : 8/2/26 @ 6:30 AM

Nurse Name & Signature: Reeyan

Date & Time : 8/2/26 at 8 AM



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Mrs R RADHIKA  
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Sheet No: .....

REGULAR PRESCRIPTIONS

Weight .....

Ward .....

| DRUG : INJ. MAGNEX FORTE                                                             |       |           |           | Date   | Time  |
|--------------------------------------------------------------------------------------|-------|-----------|-----------|--------|-------|
| Dose                                                                                 | Route | Frequency | Start Dt. | 9/7/26 | 10 PM |
| 1.5gm                                                                                | IV    | BD        | 9/7/26    |        |       |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><i>Dr. Himabindu Veerla</i> |       |           |           |        |       |
| Additional Instructions:<br>fill discharge                                           |       |           |           |        |       |
| Daily Doctor's Endorsement by a Sign                                                 |       |           |           |        |       |

| DRUG INJ. METROGYL                                                                   |       |           |           | Date   | Time  |
|--------------------------------------------------------------------------------------|-------|-----------|-----------|--------|-------|
| Dose                                                                                 | Route | Frequency | Start Dt. | 9/7/26 | 11 AM |
| 500MG                                                                                | IV    | TID       | 9/7/26    |        |       |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><i>Dr. Himabindu Veerla</i> |       |           |           |        |       |
| Additional Instructions:<br>continue till discharge                                  |       |           |           |        |       |
| Daily Doctor's Endorsement by a Sign                                                 |       |           |           |        |       |

| DRUG : INJ. PANTOPRAZOLE                                                             |       |           |           | Date   | Time  |
|--------------------------------------------------------------------------------------|-------|-----------|-----------|--------|-------|
| Dose                                                                                 | Route | Frequency | Start Dt. | 9/7/26 | 11 AM |
| 40M                                                                                  | IV    | BD        | 9/7/26    |        |       |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><i>Dr. Himabindu Veerla</i> |       |           |           |        |       |
| Additional Instructions:                                                             |       |           |           |        |       |
| Daily Doctor's Endorsement by a Sign                                                 |       |           |           |        |       |

| DRUG : I. PARACETAMOL                                                                |       |           |           | Date   | Time  |
|--------------------------------------------------------------------------------------|-------|-----------|-----------|--------|-------|
| Dose                                                                                 | Route | Frequency | Start Dt. | 9/7/26 | 11 AM |
| 1gm                                                                                  | IV    | TID       | 9/7/26    |        |       |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><i>Dr. Himabindu Veerla</i> |       |           |           |        |       |
| Additional Instructions:                                                             |       |           |           |        |       |
| Daily Doctor's Endorsement by a Sign                                                 |       |           |           |        |       |



BAH-00660194  
Mrs R RADHIKA  
09-09-1976 49 Y (F)  
Dr. HIMABINDU VEERLA

IP5-00176131



Sheet No: .....

**REGULAR PRESCRIPTIONS**

Weight ..... Ward .....

|                                                    |       |           |           |           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|----------------------------------------------------|-------|-----------|-----------|-----------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b> 2 Clonidine                          |       |           |           | Date/Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                               | Route | Frequency | Start Dt. |           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1mg                                                | SC    | OD        | 10/7/26   |           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor Starting the Drugs: |       |           |           |           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                           |       |           |           |           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign               |       |           |           |           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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

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

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

Signature  
Name



## DRUG CHART

Date of Admission: 9/8/26 Drug Allergies: NICKA ☐ Not known any Drug Allergies

### FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
  - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
  - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
  - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
  - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
- 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

### SOS / PRN (As Required Medication)

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|                          |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--------------------------|-------|--------------|------------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b>            |       |              |            | Date<br>Time |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                     | Route | Frequency    | Start Date |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions: |       |              |            |              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |







BAH-00660194 IP5-00176131  
 Mrs R RADHIKA 49 Y (F)  
 09-09-1976  
 Dr. HIMABINDU VEERLA

Weight. 64 kg Ward. ....

| Date<br>Time                   | Nurse Sig. | Dose      | Nurse Sig. | Dose      | Nurse Sig. | Dose      | Nurse Sig. |
|--------------------------------|------------|-----------|------------|-----------|------------|-----------|------------|
|                                |            |           |            |           |            |           |            |
|                                |            | Dose      |            | Dose      |            | Dose      |            |
|                                |            | Dr. Sign. |            | Dr. Sign. |            | Dr. Sign. |            |
| Route                          | Start Date | Dose      |            | Dose      |            | Dose      |            |
|                                |            | Dr. Sign. |            | Dr. Sign. |            | Dr. Sign. |            |
| Name & Signature of the Doctor |            | Dose      |            | Dose      |            | Dose      |            |
|                                |            | Dr. Sign. |            | Dr. Sign. |            | Dr. Sign. |            |
| Additional Instructions:       |            | Dose      |            | Dose      |            | Dose      |            |
|                                |            | Dr. Sign. |            | Dr. Sign. |            | Dr. Sign. |            |

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

STAT / ONCE ONLY DRUGS

| Date    | Time    | Medication          | Dosage & Other Instructions | Route | Signature | Nurses         |
|---------|---------|---------------------|-----------------------------|-------|-----------|----------------|
| 9/7     | 9AM     | INS. PARACETAMOL    | 1GM                         | IV    | B de      | Key<br>wopi    |
| 9/7     | 9:15AM  | INS. TRANEXAMICACID | 1GM                         | IV    | B de      | Key<br>wopi    |
| 9/7     | 9:30AM  | INS. MORPHINE       | 6MG                         | IV    | B de      | Key<br>wopi    |
| 9/7     | 2:00pm  | SUPP. TRAMADOL      | 100MG                       | PR    | B de      | Key<br>wopi    |
| 9/7     | 2:00pm  | SUPP. DICOLOFENAC   | 100MG                       | PR    | B de      | Key<br>wopi    |
| 10/7/26 | 12:30pm | Inj Fen             | 1gm                         | IV    | Sh        | Key<br>Shan    |
| 10/7/26 | 7:20pm  | Inj. Tramadol 100mg | 100mg<br>over 20-30 min     | IV    | Wade      | Shan<br>Ravati |
|         |         |                     |                             |       |           |                |
|         |         |                     |                             |       |           |                |
|         |         |                     |                             |       |           |                |





I.V. FLUIDS CHART

Weight. 64 kg Ward. ....

| Date   | Time    | Composition of I.V. Fluid<br>(If infusion, mention ml/hr = Mcg/kg/min. etc) | Route | Flow Rate<br>ml/hr | Doctor<br>Sign | Nurse<br>Sign   | Date of<br>Stopping | Doctor<br>Sign | Nurse<br>Sign   |
|--------|---------|-----------------------------------------------------------------------------|-------|--------------------|----------------|-----------------|---------------------|----------------|-----------------|
| 9/7/26 | 7:00 AM | RINGER LACTATE                                                              | IV    | 1000<br>hr         |                | deja<br>Kranthi | 9/7                 | B              | Key<br>copi     |
| 9/7    | 9 AM    | RINGER LACTATE                                                              | IV    | 500ml<br>HR        | B              | Key<br>copi     | 9/7                 | B              | Key<br>copi     |
| 9/7    | 9:45 AM | RINGER LACTATE                                                              | IV    | 500ml<br>HR        | B              | Key<br>copi     | 9/7                 | B              | Key<br>copi     |
| 9/7    | 11 AM   | RINGER LACTATE                                                              | IV    | 500ml<br>HR        | B              | Key<br>copi     | 9/7                 | B              | Key<br>copi     |
| 9/7    | 1 PM    | RINGER LACTATE                                                              | IV    | 500ml<br>HR        | B              | Key<br>copi     | 9/7                 |                | Key<br>copi     |
| 9/7    | 4 PM    | RINGER LACTATE                                                              | IV    | 500ml              |                | Key<br>Kranthi  | 9/7                 |                | Key<br>Kranthi  |
| 9/7    | 7 PM    | RINGER LACTATE                                                              | IV    | 500ml              |                | deja<br>Kranthi | 9/7                 |                | deja<br>Kranthi |
| 9/7    | 11 PM   | RINGER LACTATE                                                              | IV    | 500ml              |                | deja<br>Kranthi | 10/7                |                | deja<br>Kranthi |
| 10/7   | 3 AM    | RINGER LACTATE                                                              | IV    | 1000               |                | deja<br>Kranthi | 10/7                |                | deja<br>Kranthi |
| 10/7   | 7 AM    | RINGER LACTATE                                                              | IV    | 1000<br>hr         |                | deja<br>Kranthi | 10/7                |                | deja<br>Kranthi |

Signature

VERIFIED BY : Name





# FLUID CHART

Sheet No. : ①

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

| Date                 | Time           | Nature of Fluid | Intake               |                |     | Output |           |       |          |       | IV Site Thrombophlebitis Score | Sign. Nurse |
|----------------------|----------------|-----------------|----------------------|----------------|-----|--------|-----------|-------|----------|-------|--------------------------------|-------------|
|                      |                |                 | Mouth                | I.V            | N.G | NG     | Diarrhoea | Vomit | Drainage | Urine |                                |             |
| 9/7                  | 08:00 am       | RL              | NP                   | ✓ 100ml        |     |        |           |       |          |       | 0                              | }           |
|                      | 09:00 am       |                 | P                    | 100ml          |     |        |           |       | 500ml    | 0     |                                |             |
|                      | 10:00 am       |                 | P                    | 100ml          |     |        |           |       |          | 0     |                                |             |
|                      | 11:00 am       |                 | O                    | 100ml          |     |        |           |       |          | 0     |                                |             |
|                      | 12:00 pm       |                 |                      | 100ml          |     |        |           |       |          | 0     |                                |             |
|                      | 01:00 pm       |                 |                      | 100ml          |     |        |           |       |          | 0     |                                |             |
|                      | Total Intake : |                 |                      | Total Output : |     |        |           |       |          |       |                                |             |
| 9/7                  | 02:00 pm       | RL              | NP                   | 100ml          |     |        |           |       | 800ml    | 0     | }                              |             |
|                      | 03:00 pm       |                 |                      | 100ml          |     |        |           |       |          | 0     |                                |             |
|                      | 04:00 pm       |                 | P                    | 100ml          |     |        |           |       |          | 0     |                                |             |
|                      | 05:00 pm       |                 | O                    | 100ml          |     |        |           |       |          | 0     |                                |             |
|                      | 06:00 pm       | M               |                      | 100ml          |     |        |           |       |          | 0     |                                |             |
|                      | 07:00 pm       | M               |                      | 100ml          |     |        |           |       | 600ml    | 0     |                                |             |
|                      | Total Intake : |                 |                      | Total Output : |     |        |           |       |          |       |                                |             |
|                      | 08:00 pm       | RL              |                      | 500ml          |     |        |           |       |          | 0     | }                              |             |
|                      | 09:00 pm       |                 |                      |                |     |        |           |       |          | 0     |                                |             |
|                      | 10:00 pm       |                 |                      |                |     |        |           |       |          | 0     |                                |             |
|                      | 11:00 pm       | RL              |                      | 500ml          |     |        |           |       |          | 0     |                                |             |
|                      | 12:00 am       |                 |                      |                |     |        |           |       | 600ml    | 0     |                                |             |
|                      | 01:00 am       |                 |                      |                |     |        |           |       |          | 0     |                                |             |
|                      | Total Intake : |                 |                      | Total Output : |     |        |           |       |          |       |                                |             |
|                      | 02:00 am       | RL              |                      | 150ml          |     |        |           |       |          | 0     | }                              |             |
|                      | 03:00 am       |                 |                      | 100ml          |     |        |           |       |          | 0     |                                |             |
|                      | 04:00 am       |                 |                      | 150ml          |     |        |           |       |          | 0     |                                |             |
|                      | 05:00 am       |                 |                      | 150ml          |     |        |           |       |          | 0     |                                |             |
|                      | 06:00 am       |                 |                      | 150ml          |     |        |           |       |          | 0     |                                |             |
|                      | 07:00 am       | RL              |                      | 150ml          |     |        |           |       | 500ml    | 0     |                                |             |
|                      | Total Intake : |                 |                      | Total Output : |     |        |           |       |          |       |                                |             |
| Total 24 hrs. Intake |                |                 | Total 24 hrs. Output |                |     |        |           |       |          |       |                                |             |



# FLUID CHART

Sheet No. : .....

10/7/26

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.

|                      |          | Intake               |       |     |     | Output         |           |       |          |       |   | IV Site<br>Thrombo-<br>phlebitis<br>Score | Sign.<br>Nurse |
|----------------------|----------|----------------------|-------|-----|-----|----------------|-----------|-------|----------|-------|---|-------------------------------------------|----------------|
| Date                 | Time     | Nature<br>of Fluid   | Route |     |     | NG             | Diarrhoea | Vomit | Drainage | Urine |   |                                           |                |
|                      |          |                      | Mouth | I.V | N.G |                |           |       |          |       |   |                                           |                |
|                      | 08:00 am |                      |       |     |     |                |           |       |          |       | 0 | Kanna                                     |                |
|                      | 09:00 am |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 10:00 am |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 11:00 am |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 12:00 pm |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 01:00 pm |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
| Total Intake : 1000  |          |                      |       |     |     | Total Output : |           |       |          |       |   |                                           |                |
|                      | 02:00 pm |                      |       |     |     |                |           |       |          |       | 0 | Kanna                                     |                |
|                      | 03:00 pm |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 04:00 pm |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 05:00 pm |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 06:00 pm |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 07:00 pm |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
| Total Intake : 1000  |          |                      |       |     |     | Total Output : |           |       |          |       |   |                                           |                |
|                      | 08:00 pm |                      |       |     |     |                |           |       |          |       | 0 | Kanna                                     |                |
|                      | 09:00 pm |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 10:00 pm |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 11:00 pm |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 12:00 am |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 01:00 am |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
| Total Intake : 1000  |          |                      |       |     |     | Total Output : |           |       |          |       |   |                                           |                |
|                      | 02:00 am |                      |       |     |     |                |           |       |          |       | 0 | Kanna                                     |                |
|                      | 03:00 am |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 04:00 am |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 05:00 am |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 06:00 am |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
|                      | 07:00 am |                      |       |     |     |                |           |       |          | 0     |   |                                           |                |
| Total Intake : 1000  |          |                      |       |     |     | Total Output : |           |       |          |       |   |                                           |                |
| Total 24 hrs. Intake |          | Total 24 hrs. Output |       |     |     |                |           |       |          |       |   |                                           |                |



BAH-00660194 IP5-00176131  
 Mrs R RADHIKA  
 09-09-1976 49 Y (F)  
 Dr. HIMABINDU VEERLA



# FLUID CHART

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

Sheet No. : .....

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

|                             |                       | Intake             |       |     |     | Output                |                               |       |          |       |   | IV Site<br>Thrombo-<br>phlebitis<br>Score | Sign.<br>Nurse |
|-----------------------------|-----------------------|--------------------|-------|-----|-----|-----------------------|-------------------------------|-------|----------|-------|---|-------------------------------------------|----------------|
| Date                        | Time                  | Nature<br>of Fluid | Route |     |     | NG                    | Diarrhoea                     | Vomit | Drainage | Urine |   |                                           |                |
|                             |                       |                    | Mouth | I.V | N.G |                       |                               |       |          |       |   |                                           |                |
| 11/7/21                     | 08:00 am              |                    |       |     |     |                       |                               |       |          |       | ✓ | 0                                         | Devi           |
|                             | 09:00 am              | Food               |       |     |     |                       |                               |       |          |       |   | 0                                         |                |
|                             | 10:00 am              | mo                 |       |     |     |                       |                               |       |          |       |   | 0                                         |                |
|                             | 11:00 am              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 12:00 pm              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 01:00 pm              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | <b>Total Intake :</b> |                    |       |     |     |                       | <b>Total Output :</b> m - 3 r |       |          |       |   |                                           |                |
|                             | 02:00 pm              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 03:00 pm              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 04:00 pm              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 05:00 pm              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 06:00 pm              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 07:00 pm              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
| <b>Total Intake :</b>       |                       |                    |       |     |     | <b>Total Output :</b> |                               |       |          |       |   |                                           |                |
|                             | 08:00 pm              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 09:00 pm              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 10:00 pm              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 11:00 pm              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 12:00 am              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 01:00 am              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
| <b>Total Intake :</b>       |                       |                    |       |     |     | <b>Total Output :</b> |                               |       |          |       |   |                                           |                |
|                             | 02:00 am              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 03:00 am              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 04:00 am              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 05:00 am              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 06:00 am              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
|                             | 07:00 am              |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
| <b>Total Intake :</b>       |                       |                    |       |     |     | <b>Total Output :</b> |                               |       |          |       |   |                                           |                |
| <b>Total 24 hrs. Intake</b> |                       |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |
| <b>Total 24 hrs. Output</b> |                       |                    |       |     |     |                       |                               |       |          |       |   |                                           |                |



Patient Sticker

## FLUID CHART

Sheet No. : .....

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

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



BAH-00660194 IPS-00176131

Mrs R RADHIKA

09-09-1976

49 Y

(F)

Dr. HIMABINDU VEERLA



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Children's  
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Your Right to a Safe Delivery

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

To Be Filled In By Assigned Nurse :

Date : 09/07/26

Department : P-OT-IV

Duration of Procedure : 3 hours

Name of Surgeon : Dr. HEMABINDU

Date of Admission : 09/07/26

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

|    |                                                                                                                                                                                                                                                                                                                                                                                                                      | Staff Signature |
|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| 1. | Antibiotic given prior to surgery ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><input checked="" type="checkbox"/> Single Dose Antibiotic or Long Antibiotic Regime<br>Antibiotic administered within 60 minutes prior to incision ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Name of the Antibiotic : <u>Augmentin 1gm</u>                                | <u>Key</u>      |
| 2. | Hair Removal <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No if Yes : Surgical Clipper<br>Department where Hair Removed : <input checked="" type="checkbox"/> Ward <input type="checkbox"/> Operating Room<br><input type="checkbox"/> Other : _____<br>Skin preparation done (cleanse surgical area with antiseptic agent)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <u>Key</u>      |
| 3. | Patient's body temperature immediately post operation (Recovery Room) <u>37.2</u> °C<br><input type="checkbox"/> Oral Or <input checked="" type="checkbox"/> Axilla (Goal : 36-37 °C)                                                                                                                                                                                                                                | <u>Key</u>      |
| 4. | Name of doctor or staff administering the antibiotic : <u>Dr. HEMABINDU</u><br>Date & Time of antibiotic administration : <u>9/7/26 at 8 AM</u><br>Date & Time procedure started : <u>9/7/26 9.12 AM</u>                                                                                                                                                                                                             | <u>Key</u>      |

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

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



# SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Hema Bindu V  
Asst. Surgeon : -  
Anaesthetist : Dr. Arunda Prabhakar  
Scrub Nurse : Prabhakar

Pat  
UH  
Da

BAH-00660194  
Mrs R RADHIKA  
09-09-1976 49 Y  
Dr. HIMABINDU VEERLA  
IP5-00176131

Age : 49y Gender : F  
Time : 7:15 PM Out-time : 8:55 PM

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## Before Induction of Anaesthesia >>

| SIGN IN                                                                  |                                                                                                 | Time: <u>8:26am</u> |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------|
| <b>Patient Has Confirmed</b>                                             |                                                                                                 |                     |
| Identity                                                                 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                     |
| Site                                                                     | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                     |
| Procedure                                                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                     |
| Consent                                                                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                     |
| <b>Site Marked</b>                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA |                     |
| <b>Anaesthesia Safety Check Completed</b>                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                     |
| <b>Pulse Oximeter on Patient &amp; Functioning</b>                       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                     |
| <b>Does Patient have a:</b>                                              |                                                                                                 |                     |
| Known Allergy?                                                           | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |                     |
| <b>Difficult Airway / Aspiration Risk?</b>                               |                                                                                                 |                     |
| Yes, & Equipment / Assistance Available                                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |                     |
| <b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>               |                                                                                                 |                     |
| Yes, and Adequate Intravenous Access and Fluids Planned                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |                     |
| Blood Units Reserved                                                     | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                     |
| <b>Has Antibiotic Prophylaxis been given within the last 60 minutes?</b> |                                                                                                 |                     |
|                                                                          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                     |
| Signature : <u>B. de</u>                                                 |                                                                                                 |                     |
| Name : <u>Dr. Arunda Prabhakar</u>                                       |                                                                                                 |                     |

## Before Skin Incision >>

| TIME OUT                                                                                                                                                                                                |                                                                     | Time: <u>8:57 AM</u> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------|
| <b>Confirm all team members have introduced themselves by Name and Role</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                         |                                                                     |                      |
| <b>Surgeon, Anaesthesia Professional and Nurse Verbally Confirm</b>                                                                                                                                     |                                                                     |                      |
| Correct Patient (Check ID Band)                                                                                                                                                                         | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                      |
| Correct Site                                                                                                                                                                                            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                      |
| Correct Procedure                                                                                                                                                                                       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                      |
| <b>Anticipated Critical Events</b>                                                                                                                                                                      |                                                                     |                      |
| <b>Surgeon Reviews:</b>                                                                                                                                                                                 |                                                                     |                      |
| What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? <u>3 hours</u> <u>300ml</u> <u>bleeding</u>                                                                      |                                                                     |                      |
| <b>Anaesthesia Team Reviews:</b>                                                                                                                                                                        |                                                                     |                      |
| Are There Any Patient-specific Concerns? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA                                                                |                                                                     |                      |
| <b>Nursing Team Reviews:</b>                                                                                                                                                                            |                                                                     |                      |
| Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                                                                     |                      |
| <b>Is Essential Imaging Displayed?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA                                                                  |                                                                     |                      |
| Power Supply, Earthing, Power Backup and functioning of equipment checked. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                                     |                      |
| Signature : <u>Prabhakar</u>                                                                                                                                                                            |                                                                     |                      |
| Name : <u>Nugman</u>                                                                                                                                                                                    |                                                                     |                      |

## Before Patient Leaves Operating Room

| SIGN OUT                                                                                                                                   |                                                                                                 | Time: <u>1:55pm</u> |
|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------|
| <b>Nurse Verbally Confirms with the Team:</b>                                                                                              |                                                                                                 |                     |
| The Name of the Procedure Recorded                                                                                                         | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                     |
| That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)                                                                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                     |
| The Specimen is Labelled (including patient name)                                                                                          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                     |
| Whether there are any Equipment Problems to be addressed                                                                                   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |                     |
| <b>To Surgeon, Anaesthetist and Nurse:</b>                                                                                                 |                                                                                                 |                     |
| What are the key concerns for recovery and management of this patient? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                 |                     |
| Signature : <u>Hema</u>                                                                                                                    |                                                                                                 |                     |
| Name : <u>Dr. Hema Bindu V</u>                                                                                                             |                                                                                                 |                     |



# **URGICAL** **SAFETY CHECKLIST**

Surgeon : .....  
Asst. Surgeon : .....  
Anaesthetist : .....  
Scrub Nurse : .....

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



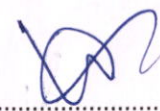
## Before Induction of Anaesthesia ➤ ➤

## Before Skin Incision ➤ ➤

## Before Patient Leaves Operating Room

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

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

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



Department of Anaesthesiology  
PRE-ANAESTHETIC EVALUATION

Name: Mrs. Radhika Age: 49 Sex: F UHID No: BAH-00660194

Date: 29.6.26 Time: 1:30 PM Proposed Operation: Total Laparoscopic Hysterectomy

Diagnosis: AVB - Adenomyosis & Adenomyoma / P2 L2 (MVD) B/c salphage

B.P / CRT: 115/60 H.R: 72/min Weight: 64 kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 12.1 Glucose: 5.5 Protein: 0.07 HIV: --- X-Ray: ---  
PCV: 30.1 Urea: 12.54 Alb: 0.2 HBS Ag: --- ECG: ---  
WBC: 6.5 Creat: 0.54 Total Bill: 0.07 HCV: --- 2D Echo: ---  
Plate: 301 Na: --- Dir. Bill: 0.2 Blood group: --- Stress/Angle: ---  
PT: --- K: --- LDH: --- T3: --- Other: ---  
PTT: --- Ca++: --- Alk phos: --- T4: ---  
INR: --- Mg++: --- Amylase: --- TSH: 4.44  
Cl-: --- SGOT/SGPT: ---

Allergies: NCDA

Medical History: CVS: No cardiac issue

RESP: ⊖

Diabetes: ⊖

CNS: ⊖

Renal: ⊖

Hepatic / GE: ---

Physical Activity: Active

Others: ---

Past Anaesthetic History: Nil

Physical Exam: apb

Airway: MP 1 2 3 4

Mouth Opening: >3F

Mento-hyoid Distance: ⊖

Neck: adequat Teeth: ⊖ Intall

Lungs: BATE

Heart: S/S2

CNS: NPAM

Pregnant: ☐ Yes ☐ No ☒ NA

Venous Access Site: ⊕

Spine Exam for regional: ⊕

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

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

| CURRENT MEDICATIONS | DOSAGE |
|---------------------|--------|
|                     |        |
|                     |        |
|                     |        |
|                     |        |

Pre-Operative Instructions:

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

Signature: Amr Name: Dr. Anshu



|                                     |                                                        |                                                                     |                                                     |                                 |                                                    |
|-------------------------------------|--------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------|---------------------------------|----------------------------------------------------|
| <b>Change in Patient Condition:</b> |                                                        | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                     | <b>Fasting Status:</b> Adequate |                                                    |
| <b>Physical Status:</b>             | <input checked="" type="checkbox"/> Patient Identified |                                                                     | <input checked="" type="checkbox"/> Consent Present |                                 | <input checked="" type="checkbox"/> Chart Reviewed |

|                                            |                       |                                          |                         |                      |
|--------------------------------------------|-----------------------|------------------------------------------|-------------------------|----------------------|
| H.R.: 86bpm                                | B.P / CRT: 129/30mmHg | SpO <sub>2</sub> : 99% on RA             | R.R.: 16/min            | Last Feed: 72hrs ago |
| Pre-OP Diagnosis: P.L. & AUB - Adenomyosis |                       | Operation: TLH + R Salpingectomy         |                         | Date: 9/7/26         |
| Surgeon: Dr. Himabindu Kesla               |                       | Anaesthesiologist: Dr. Sanyal Dr. Brunda | Technician: Ramesh Gopi |                      |

| TIME  | N/O AIR/O LPM | HALO /SO /BEVO | Drugs                   | Antibiotic | Suppository | Blood Loss | NOTES |
|-------|---------------|----------------|-------------------------|------------|-------------|------------|-------|
| 9:30  |               |                | Inj MIDAZOLAM 2mg IV    | Gfrev      |             |            |       |
| 10:00 |               |                | PENTANYL 100mcg IV      |            |             |            |       |
| 10:30 |               |                | PROPOFOL 1SD mg IV      |            |             |            |       |
| 11:00 |               |                | ROCURONIUM 40 mcg IV    |            |             |            |       |
| 11:30 |               |                | TRANEKAMIC ACID 16mg IV |            |             |            |       |
| 12:00 |               |                | PARACETAMOL 16mg IV     |            |             |            |       |
| 12:30 |               |                | Inj MORPHINE 6mg IV     |            |             |            |       |
| 13:00 |               |                |                         |            |             |            |       |
| 13:30 |               |                |                         |            |             |            |       |
| 14:00 |               |                |                         |            |             |            |       |
| 14:30 |               |                |                         |            |             |            |       |
| 15:00 |               |                |                         |            |             |            |       |
| 15:30 |               |                |                         |            |             |            |       |
| 16:00 |               |                |                         |            |             |            |       |
| 16:30 |               |                |                         |            |             |            |       |
| 17:00 |               |                |                         |            |             |            |       |
| 17:30 |               |                |                         |            |             |            |       |
| 18:00 |               |                |                         |            |             |            |       |
| 18:30 |               |                |                         |            |             |            |       |
| 19:00 |               |                |                         |            |             |            |       |
| 19:30 |               |                |                         |            |             |            |       |
| 20:00 |               |                |                         |            |             |            |       |
| 20:30 |               |                |                         |            |             |            |       |
| 21:00 |               |                |                         |            |             |            |       |
| 21:30 |               |                |                         |            |             |            |       |
| 22:00 |               |                |                         |            |             |            |       |
| 22:30 |               |                |                         |            |             |            |       |
| 23:00 |               |                |                         |            |             |            |       |
| 23:30 |               |                |                         |            |             |            |       |
| 24:00 |               |                |                         |            |             |            |       |

**Fluids**

B.P.

V Systolic

A Diastolic

X Mean

• Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

ABG

LAB Values

GRBS

Others

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Equipment Checked and Functional<br><input checked="" type="checkbox"/> BP<br><input type="checkbox"/> Cuff Site: RTUL<br><input type="checkbox"/> Art Site:<br><input checked="" type="checkbox"/> EKG Lead<br><input checked="" type="checkbox"/> Temp Site<br><input checked="" type="checkbox"/> FIO <sub>2</sub> Monitor<br><input checked="" type="checkbox"/> Agent Monitor<br><input checked="" type="checkbox"/> Pulse Oximeter<br><input checked="" type="checkbox"/> Capnograph<br><input checked="" type="checkbox"/> Ventilator<br><input type="checkbox"/> Nerve Stimulator | <b>Temp:</b><br><input checked="" type="checkbox"/> HME<br><input type="checkbox"/> Cling Film<br><input checked="" type="checkbox"/> Hugger's<br><input type="checkbox"/> Other<br><br><b>Times:</b><br>Anaes Start: 8:45 AM<br>OP Start:<br>OP End:<br>Leave OR: 2 PM<br><br><b>Anaesthesia:</b><br><input checked="" type="checkbox"/> GA<br><input type="checkbox"/> Monitored Anaesthesia Care<br><input type="checkbox"/> Regional | <b>Induction</b><br><input checked="" type="checkbox"/> IV<br><input type="checkbox"/> Pre O <sub>2</sub><br><input type="checkbox"/> Others<br><br><input type="checkbox"/> Mask<br><input type="checkbox"/> Airway<br><input checked="" type="checkbox"/> Oral<br><input type="checkbox"/> Tracheostomy<br><input type="checkbox"/> Drug: Rocuronium<br><br><input type="checkbox"/> Awake<br><input type="checkbox"/> Video Laryngoscopy<br><input type="checkbox"/> Fiberoptic<br>Blade # 3 Attempts: 1<br>Difficulty Why? | <b>Regional:</b><br>Extremity Specify:<br><input type="checkbox"/> Spinal<br><input type="checkbox"/> Epidural<br><input type="checkbox"/> Caudal<br>Others:<br>Position:<br>Needle Size: Depth:<br>Parasthesia Yes No<br>Catheter at skin cm<br>Drug Name & Conc:<br>Bolus:<br>Infusion:<br>Block Level:<br>Comments:<br>Transportation to PACU ICU Other<br>Relaxant Reversed Yes No NA<br>Name of the Doctor: Dr. Brunda<br>Signature of the Doctor: |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Position:** Supine

**Pressure Points Checked:** Litho + Trendelenburg

**Eye Care:**

☐ Oint

☒ Tape

☒ Padding

☐ Awake

**Line (Size & Location)**

☐ CVP

☐ ART

☒ IV: REG left UL

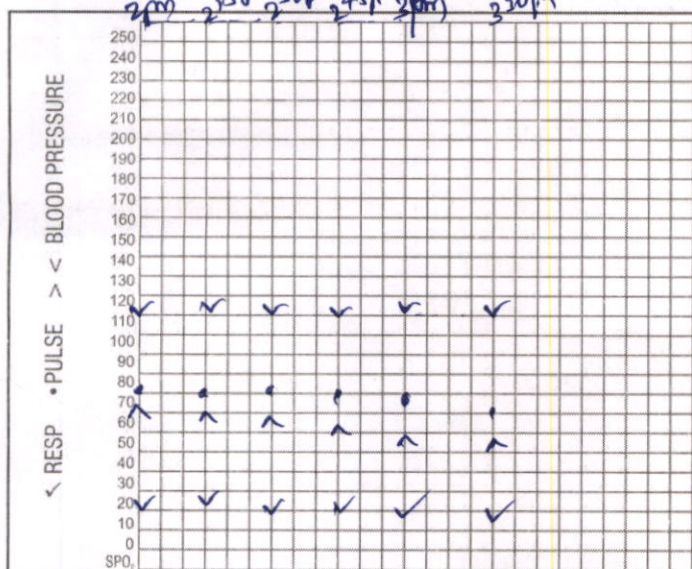
☐ IV:

☐ IV:



Received in PACU by: Dr. Nguyen  
2pm 2:50p 3:30p 4:45p 5:30pm 3:30pm

Time Received : 2pm Time Discharged : 4pm



IV Cannula Site: left hand

☐ O<sub>2</sub> Mask      ☐ Nasal Prongs  
☐ Tracheostomy      ☐ T-Piece  
☐ Oral Airway      ☐ Nasal Airway

Vomiting : ☐ Yes ☒ No

Drug: .....

NG Tube : ☐ Yes ☒ No

Drain: ☐ Yes ☒ No

Urinary Catheter: ☒ Yes ☐ No

Chest Tube: ☐ Yes ☒ No

Nil Oral ☒ Yes ☐ No

IV Fluids: DL on flow

Oral Feeds: \_\_\_\_\_

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

| Date | Time | Pain Score | Intervention | Signature |
|------|------|------------|--------------|-----------|
| 9/13 | 2pm  | 0/10       | on sedation  | Reuf      |
| 9/13 | 9pm  | 0/10       | on sedation  | Reuf      |
|      |      |            |              |           |
|      |      |            |              |           |

Anaesthesiologist Name : DR. K. R. RAMYA.

Anaesthesiologist Signature: \_\_\_\_\_

Date & Time: 10/4/2024

PACU Nurse Name : Neeraj

PACU Nurse Signature: \_\_\_\_\_

Date & Time: 9/7/20 at 2pm

**Reassessment Frequency:**

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

Transferred to Unit by (PACU): MLW

Date & Time: 10/2/2020 04



#### Patient Sticker

## EPIDURAL ANALGESIA RECORD

Date and Time : .....



BAH-00660194 IP5-00176131

Mrs R RADHIKA

09-09-1976

49 Y

(F)

Dr. HIMABINDU VEERLA



## CONSENT FOR ANAESTHESIA

Authorization By: ☒ Patient ☐ Patient Attendant

Operative Procedure: Total laparoscopic hysterectomy

Anaesthesiologist: Dr. Subramanyam Surgeon: Dr. Himabindu Veerla

### Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery. Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☒ Others Bronchospasm, Laryngospasm, Bleeding, Hemodynamic instability

### Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team  
☐ Regional Anaesthesia ☒ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

### Patient / Patient Attendant:

Signature: R. Radhika

Name: R. Radhika

Relationship with patient: self

Date & Time: 29.6.26 @ 2pm.

### Witness: Husband

Signature: R. Venkanna

Name: R. Venkanna

Date & Time: 29.6.26

### Doctor (who is taking consent):

Signature: Amr Name: Dr. Amreen

Date 29.6.26 Time: 2pm.



## అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: .....

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

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అవస్థాపక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోదు, నొప్పి అనుభవించదు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

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

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

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

☐ ఇతరవి: .....

రోగి / రోగి అటెండెంట్

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

రోగి / రోగి అటెండెంట్:

సాక్షి:

సంతకం: .....

సంతకం: .....

పేరు: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

తేదీ & సమయం: .....

డాక్టర్ :

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



# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : R. Radhees Gender: ☐ Male ☒ Female Age : 49  
UHID No : BAH-00660194 Date : 9/17/26

## Instruction:

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

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

TOTAL LAPROSCOPIC HYSTERECTOMY + BILATERAL SALPINGECTOMY  
upon \_\_\_\_\_  
(Name of the Patient)

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

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

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

Hemorrhage, Septic, Injury to Bowel & Bladder, Injury to  
major blood vessels, Need for Bowel & blood products,  
Need for prolonged Hospital stay.

## My signature on this form indicates that

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

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

## Consentee :

Signature : R. Radhika  
Name : R. Radhika  
Date & Time : 9/17/26 @ 6:30pm

## Witness :

Signature : Navy  
Name : Neelgani  
Date & Time : 9/17/26 at 7 Am.

## Patient Attendant :

Signature : R. Venkanna  
Name : \_\_\_\_\_  
Relationship with Patient: Husband  
Date & Time : 9/17/26 @ 6:30pm

## Doctor (who is taking the consent) :

Signature : Dr. Suneeta  
Name : Dr. Suneeta  
Date & Time : 9/17/26 @ 6:30pm



BAH-00660194  
Mrs R RADHIKA  
09-09-1976 49 Y  
Dr. HIMABINDU VEERLA  
IP5-00176131  
(F)

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## URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 9/7/26

Date of Removal: 10/7/26

| Parameters                                       | Date   | Shift Time |                                                                                     |        |      |                                                                                      |                                                          |                                                          |
|--------------------------------------------------|--------|------------|-------------------------------------------------------------------------------------|--------|------|--------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| Need for the Catheter                            | 9/7/26 | 8 AM       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                 | 9/7/26 | 8 AM | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hand Hygiene                                     |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                 |        |      | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Usage of Sterile Equipment                       |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                 |        |      | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the Collection bag below the level of bladder |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                 |        |      | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Check the Tube for Obstruction (Free of Kinking) |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                 |        |      | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is Catheter dated as policy                      |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                 |        |      | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Collecting bag is been emptied regularly?        |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                 |        |      | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Maintenance of closed system for the catheter    |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                 |        |      | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dressing clean and dry?                          |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                 |        |      | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the line removed as Policy?                   |        |            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                 |        |      | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Performance of Perineal Care                     |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                 |        |      | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Onset of New Fever                               |        |            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                 |        |      | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asses for the leakage at the site of insertion   |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                 |        |      | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Name of the Nurse                                |        |            | Bis Ravi                                                                            |        |      | Ravi                                                                                 |                                                          |                                                          |
| Signature of the Nurse                           |        |            |  |        |      |  |                                                          |                                                          |



# PATIENT TRANSFER FORM

|                                                                                                                                                                                                                              |                                  |                                                                                                                                                                 |                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| Patient Name & UHID No.<br><br>BAH-00660194      IP5-00176131<br>Mrs R RADHIKA<br>09-09-1976      49 Y      (F)<br>Dr. HIMABINDU VEERLA<br> |                                  | Date & Time of Admission<br><br>9/7/26 @ 6:30 AM                                                                                                                | Date & Time of Transfer Order<br><br>10/7/26 @ 4 PM |
|                                                                                                                                                                                                                              |                                  | Transfer Ordered by<br><br>Dr. Himabindu                                                                                                                        | Reason for Transfer<br><br>RtH                      |
| From Unit<br><br>NICU                                                                                                                                                                                                        | To Unit<br><br>NICU Room (260)   | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                 |                                                     |
| Number of Sheets in Clinical File<br><br>30                                                                                                                                                                                  | Number of Imaging Films<br><br>— | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input type="checkbox"/> No <input type="checkbox"/><br>If yes, what ? |                                                     |
| Medications / Consumables / Surgicals / Hand over                                                                                                                                                                            |                                  |                                                                                                                                                                 |                                                     |
| Sl.No.                                                                                                                                                                                                                       | Item Name                        | Quantity                                                                                                                                                        |                                                     |
| 1.                                                                                                                                                                                                                           |                                  |                                                                                                                                                                 |                                                     |
| 2.                                                                                                                                                                                                                           |                                  |                                                                                                                                                                 |                                                     |
| 3.                                                                                                                                                                                                                           |                                  |                                                                                                                                                                 |                                                     |
| 4.                                                                                                                                                                                                                           |                                  |                                                                                                                                                                 |                                                     |
| 5.                                                                                                                                                                                                                           |                                  |                                                                                                                                                                 |                                                     |
| Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                                             |                                  |                                                                                                                                                                 |                                                     |
| Name & Signature of Person who is Transferring<br><br>Saruna                                                                                                                                                                 |                                  | Name of Person Ordered Transfer<br><br>Dr. Singh                                                                                                                |                                                     |
| Patient & Clinical Records Received by :<br><br>Revathi                                                                                                                                                                      |                                  |                                                                                                                                                                 |                                                     |
| Date & Time of Patient Received :<br><br>10/7/26 @ 4:30 PM                                                                                                                                                                   |                                  |                                                                                                                                                                 |                                                     |

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready



# PATIENT TRANSFER FORM

|                                                                                                                                                                                                               |                                    |                                                                                                                                                                            |                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| Patient Name & UHID No.<br><br>BAH-00660194 IP5-00176131<br>Mrs R RADHIKA<br>09-09-1976 49 Y (F)<br>Dr. HIMABINDU VEERLA<br> |                                    | Date & Time of Admission<br><br>9/7/26 @ 6:35 AM                                                                                                                           | Date & Time of Transfer Order<br><br>9/7/26 @ 8:00 AM |
|                                                                                                                                                                                                               |                                    | Transfer Ordered by<br><br>Dr. Sameena                                                                                                                                     | Reason for Transfer<br><br>For ICH                    |
| From Unit<br><br>OBG (MICU)                                                                                                                                                                                   | To Unit<br><br>Pediatric OT        | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                            |                                                       |
| Number of Sheets in Clinical File<br><br>45                                                                                                                                                                   | Number of Imaging Films<br><br>Nil | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>If yes, what ? |                                                       |
| Medications / Consumables / Surgicals / Hand over                                                                                                                                                             |                                    |                                                                                                                                                                            |                                                       |
| Sl.No.                                                                                                                                                                                                        | Item Name                          | Quantity                                                                                                                                                                   |                                                       |
| 1.                                                                                                                                                                                                            |                                    |                                                                                                                                                                            |                                                       |
| 2.                                                                                                                                                                                                            |                                    |                                                                                                                                                                            |                                                       |
| 3.                                                                                                                                                                                                            |                                    |                                                                                                                                                                            |                                                       |
| 4.                                                                                                                                                                                                            |                                    |                                                                                                                                                                            |                                                       |
| 5.                                                                                                                                                                                                            |                                    |                                                                                                                                                                            |                                                       |
| Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                              |                                    |                                                                                                                                                                            |                                                       |
| Name & Signature of Person who is Transferring<br><br>Dr. Sameena                                                                                                                                             |                                    | Name of Person Ordered Transfer<br><br>Dr. Sameena                                                                                                                         |                                                       |
| Patient & Clinical Records Received by :<br><br>Dr. Shanda                                                                                                                                                    |                                    |                                                                                                                                                                            |                                                       |
| Date & Time of Patient Received :<br><br>7/7/26                                                                                                                                                               |                                    |                                                                                                                                                                            |                                                       |

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready



BAH-00660194 IP5-00176131  
Mrs R RADHIKA  
09-09-1976 49 Y (F)  
Dr. HIMABINDU VEERLA



340

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## NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 10/7/26

Time: 4:30pm

Origin: Indian Height: 155cm Weight: 64kg BMI: 33.3kg/m<sup>2</sup>

Food Allergies: No

Diagnosis: pap-1 1 TLH + BS

Medical History: -

Surgical History: Endometrial Biopsy

☒ Vegetarian ☐ Non-Vegetarian ☐ Vegan

Diet Advised: liquids

followed by soft diet

Patient's / Attendant's

Signature: R. Radhika

Name: Radhika

Date & Time: 4:30pm / 10-7-26

Dietician's

Signature: sarma

Name: sarma

Date & Time: 10/7/26

4:30pm



### DIETARY NOTES

[illegible]



BAH-00660194 IP5-00176131  
Mrs R RAO KA  
09-09-1976 49 Y (F)  
Dr. HIMABINDU VEERLA



## NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/7/26

Assessment: Case for Surgery  
Anxiety for Hospitalization

Goals

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

| Time    | Plan of Care                       | Time    | Implementation                   | Evaluation      |
|---------|------------------------------------|---------|----------------------------------|-----------------|
| 7:30 Am | → plan for preparation             | 7:40 Am | → preparation done,              | → patient       |
| 7:30 Am | → provide comfortable bed          | 7:45 Am | → provided comfortable Bed,      | comfortable     |
| 7:50    | → plan for IV Cefazolin            | 7:55 Am | → pre medication given           | → vitals stable |
| 8 Am    | → plan for pre med cat             | 8:05 Am | → pre medication given.          |                 |
| 8:10    | → plan for 10 PRBC ordered         | 8:15 Am | → 10 PRBC ordered                |                 |
|         | → to provide psychological support |         | → provided psychological support |                 |

Re-Assessment:

Special Notes: upo & ur fluid re on flow.

Nurse Signature: Raju

Nurse Name: Raju

Date & Time: 9/7/26 @ 8:00



### Patient Sticker

# NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: .....

Assessment: .....

## Goals

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

[illegible]

Re-Assessment: .....

**Special Notes:** .....

Nurse Signature: .....

Nurse Name: .....

Date &amp; Time: .....



Patient Sticker

# NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: .....

Assessment: .....

**Goals**

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

| Time     | Plan of Care                                                   | Time     | Implementation                                            | Evaluation                                    |
|----------|----------------------------------------------------------------|----------|-----------------------------------------------------------|-----------------------------------------------|
| 11:00 AM | Assess vital signs, pain level, and fluid intake/output.       | 11:15 AM | Administer pain medication as ordered.                    | Pain level decreased from 8 to 4.             |
| 12:00 PM | Monitor vital signs and patient response to medication.        | 12:30 PM | Assess patient's ability to walk with assistance.         | Patient able to walk with minimal assistance. |
| 1:00 PM  | Provide emotional support and education to patient and family. | 1:30 PM  | Assess patient's understanding of discharge instructions. | Family understands discharge instructions.    |
| 2:00 PM  | Monitor vital signs and patient response to medication.        | 2:30 PM  | Assess patient's ability to walk with assistance.         | Patient able to walk with minimal assistance. |
| 3:00 PM  | Provide emotional support and education to patient and family. | 3:30 PM  | Assess patient's understanding of discharge instructions. | Family understands discharge instructions.    |
| 4:00 PM  | Monitor vital signs and patient response to medication.        | 4:30 PM  | Assess patient's ability to walk with assistance.         | Patient able to walk with minimal assistance. |
| 5:00 PM  | Provide emotional support and education to patient and family. | 5:30 PM  | Assess patient's understanding of discharge instructions. | Family understands discharge instructions.    |

Re-Assessment: .....

Special Notes: .....

Nurse Signature: .....

Nurse Name: .....

Date & Time: .....





## NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/26

Assessment: Acute pain

**Goals**

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

| Time    | Plan of Care                             | Time    | Implementation                        | Evaluation               |
|---------|------------------------------------------|---------|---------------------------------------|--------------------------|
| 2pm     | → to Assess the patient condition.       | 2:15 pm | → Assessed the patient condition.     | → patient is comfortable |
| 2:20 pm | → to Monitor vital signs.                | 2:25 pm | → Monitor vital signs checked done    |                          |
| 3pm     | → to Monitor I/O Count                   | 3:10 pm | → Monitor I/O Count                   | → vitals stable          |
| 3:30 pm | → NPO                                    |         | → NPO                                 |                          |
| 4:10 pm | → to Administer medication as per order. | 4pm     | → Administer medication as per order. |                          |
| 4:10 pm | → to provide psychological support       | 5pm     | → provided psychological support      |                          |
| 5pm     | → ensure safety                          | 8:10pm  | → provided side rails                 |                          |

Re-Assessment: Re-Assessment done

Special Notes: NPO till further orders.

Nurse Signature: [Signature] Nurse Name: Neeraj Date & Time: 9/7/26 at



BAH-00660194 IP5-00176131

Mrs R RADHIKA

09-09-1976 49 Y (F)

Dr. HIMABINDU VEERLA



## 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: 9/7/26

Assessment: Surgery Sk pain

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  | → To Assist the patient condition                       | 830pm  | → Stable the patient condition.                              | → patient comfortable |
| 9pm  | → provide comfortable Bed                               | 930pm  | → provided comfortable Bed.                                  |                       |
| 10pm | → doctor advised to Spirometer                          | 1030pm | → Spirometer continued.                                      |                       |
| 11pm | → psychological support<br>→ only IV medications given. | 1130pm | → psychological support given.<br>→ educate the hand Hygiene |                       |

Re-Assessment: Re assessment after 6 hours

Special Notes:

Nurse Signature: *Shari*Nurse Name: *Shari*

Date &amp; Time: 10/7/26 @ 8u



BAH-00660194  
Mrs R RADHIKA  
09-09-1976 49 Y (F)  
Dr. HIMABINDU VEERLA

IP5-00176131

## NURSING CARE RECORD

**Rainbow Children's Hospital**  
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Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 10/7/26

Assessment: patient Complaint mild pain on Surgical site

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            |
|------|-----------------------------------------------------|---------|-----------------------------------------------------------|-----------------------|
| 9Am  | → TO Assess the patient condition<br>Monitor vitals | 9:30Am  | → Assesed the patient condition vitals checked & Recorded | Patient is stable now |
| 10Am | → Monitor I/O chart                                 | 10:30   | → Monitored I/O charting                                  |                       |
| 12Pm | → Administer medication                             | 12:30pm | → medication given                                        |                       |
| 4Pm  | ⇒ provide comfortable position                      | 4:30pm  | → provided side rails                                     |                       |
| 7Pm  | ⇒ ENSURE safety                                     | 7:30pm  | → ENSURED safety                                          |                       |

Re-Assessment: Re-Assmt done pt is stable

Special Notes:

Nurse Signature: 

Nurse Name: Karuna (Co. PRN)

Date & Time: 10/7/26 @ 8pm



BAH-00660194 IP5-00176131  
Mrs R RADHIKA  
09-09-1976 49 Y (F)  
Dr. HIMABINDU VEERLA



## NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/2/28

Assessment: patient having mild pain at surgical site

- |              |                                                           |                                                    |                                                 |                                                     |                                                                      |                                                                |
|--------------|-----------------------------------------------------------|----------------------------------------------------|-------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------|
| <b>Goals</b> | <input type="checkbox"/> Maintain Airway and Oxygenation  | <input type="checkbox"/> Relieve Pain & Discomfort | <input type="checkbox"/> Maintain Fluid Balance | <input type="checkbox"/> Improve Activity Tolerance | <input checked="" type="checkbox"/> Maintain Good Nutritional Status | <input type="checkbox"/> Maintain Skin Integrity               |
|              | <input type="checkbox"/> Maintain Personal Hygiene        | <input type="checkbox"/> Prevent Infection         | <input type="checkbox"/> Meet Elimination Needs | <input checked="" type="checkbox"/> Ensure Safety   | <input type="checkbox"/> Early Ambulation Reduce Anxiety             | <input checked="" type="checkbox"/> Patient & Family Education |
|              | <input type="checkbox"/> Identify Potential Complications | <input type="checkbox"/> Any Others. Specify.....  |                                                 |                                                     |                                                                      |                                                                |

| Time | Plan of Care                                 | Time    | Implementation                                | Evaluation          |
|------|----------------------------------------------|---------|-----------------------------------------------|---------------------|
| 8pm  | Assess the patient.<br>General condition     | 8:05pm  | Assessed the patient.<br>General condition    | Patient was stable. |
| 10pm | Monitor the vitals.                          | 10:05pm | Monitored the vitals.                         |                     |
| 12AM | Maintain I/O chart.                          | 12:05AM | Maintained I/O chart.                         |                     |
| 2AM  | Provide comfortable.<br>Position to patient. | 2:05AM  | Provided comfortable.<br>Position to patient. |                     |
| 4AM  | To encourage orally Intake.                  | 4:05AM  | Encouraged orally Intake.                     |                     |
| 7AM  | To Administer medication.                    | 7:05AM  | Administer medication.                        |                     |

Re-Assessment: after providing comfortable position patient was stable

Special Notes: - NA -

Nurse Signature:

Nurse Name: Shini Sh

Date & Time: 11/2/28 8AM



BAH-00660194  
Mrs R RADHIKA  
08-09-1976 49 Y (F)  
Dr. HIMABINDU VEERLA



## NURSING CARE RECORD

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

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

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: .....

Assessment: .....

Goals

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

| Time | Plan of Care | Time | Implementation | Evaluation |
|------|--------------|------|----------------|------------|
|      |              |      |                |            |

Re-Assessment: .....

Special Notes: .....

Nurse Signature: .....

Nurse Name: .....

Date & Time: .....



BAH-00660194 IP5-00176131  
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Your Right to a Safe Delivery

## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Himabindu Department: Med Date of Admission: 9/7/26

|                                          |                                                           |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                                                                                                                |  |
|------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|--|
| SITUATION                                | Diagnosis:                                                | <u>TCH</u>                                                          |                                                                     |                                                                     |                                                                     |                                                                     | Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |  |
|                                          | Area                                                      |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                                                                                                                |  |
| BACKGROUND                               | Shift Time                                                | <u>Med 8am-2pm</u>                                                  | <u>Med 2pm-8pm</u>                                                  | <u>Med 8pm-5am</u>                                                  | <u>Med 5am-8pm</u>                                                  | <u>Med 8pm-5am</u>                                                  |                                                                                                                                                |  |
|                                          | Medical Condition<br>(Any special condition to be noted): | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           |                                                                                                                                                |  |
| ASSESSMENT                               | Allergy:                                                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            |  |
|                                          | Tubes/Drains/Catheter:                                    | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                            |  |
|                                          | Vital Signs:                                              | Temp:                                                               | <u>98.2 F</u>                                                       | <u>98.6 F</u>                                                       | <u>98.2 F</u>                                                       | <u>98.1 F</u>                                                       | <u>98.1 F</u>                                                                                                                                  |  |
|                                          |                                                           | Res:                                                                | <u>18/min</u>                                                       | <u>20/min</u>                                                       | <u>18/min</u>                                                       | <u>18/min</u>                                                       | <u>20/min</u>                                                                                                                                  |  |
|                                          |                                                           | SpO <sub>2</sub> :                                                  | <u>99</u>                                                           | <u>100%</u>                                                         | <u>99%</u>                                                          | <u>100%</u>                                                         | <u>100%</u>                                                                                                                                    |  |
|                                          |                                                           | Pulse:                                                              | <u>80</u>                                                           | <u>86/min</u>                                                       | <u>80</u>                                                           | <u>89/min</u>                                                       | <u>89/min</u>                                                                                                                                  |  |
|                                          |                                                           | BP:                                                                 | <u>110/70</u>                                                       | <u>116/74</u>                                                       | <u>112/72</u>                                                       | <u>106/70(85)</u>                                                   | <u>110/70</u>                                                                                                                                  |  |
|                                          | Fall Risk Score:                                          | <u>20</u>                                                           | <u>20</u>                                                           | <u>20</u>                                                           | <u>20</u>                                                           | <u>20</u>                                                           |                                                                                                                                                |  |
| Pain Score:                              | <u>0</u>                                                  | <u>2/10</u>                                                         | <u>2/10</u>                                                         | <u>2/10</u>                                                         | <u>2/10</u>                                                         |                                                                     |                                                                                                                                                |  |
| Recommendations                          | Safety Needs:                                             | <u>Side rail</u>                                                    | <u>Side rail</u>                                                    | <u>Side rail</u>                                                    | <u>Side rail</u>                                                    | <u>Side rail</u>                                                    |                                                                                                                                                |  |
|                                          | Physiotherapy                                             | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            |  |
|                                          | Others Specify:                                           | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           | <u>NA</u>                                                           |                                                                                                                                                |  |
|                                          | Special Diet:                                             | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  |                                                                                                                                                |  |
| Signature :                              |                                                           | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  |                                                                                                                                                |  |
| Date:                                    |                                                           | <u>9/7/26</u>                                                       | <u>9/7/26</u>                                                       | <u>9/7/26</u>                                                       | <u>10/7/26</u>                                                      | <u>11/7/26</u>                                                      |                                                                                                                                                |  |
| Time:                                    |                                                           | <u>8:00</u>                                                         | <u>8pm</u>                                                          | <u>8pm</u>                                                          | <u>8pm</u>                                                          | <u>8pm</u>                                                          |                                                                                                                                                |  |
| Taken Over By Name :                     |                                                           | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  |                                                                                                                                                |  |
| Signature :                              |                                                           | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  | <u>[Signature]</u>                                                  |                                                                                                                                                |  |
| Date:                                    |                                                           | <u>9/7/26</u>                                                       | <u>9/7/26</u>                                                       | <u>10/7/26</u>                                                      | <u>10/7/26</u>                                                      | <u>11/7/26</u>                                                      |                                                                                                                                                |  |
| Time:                                    |                                                           | <u>8:30pm</u>                                                       | <u>8am</u>                                                          | <u>8am</u>                                                          | <u>8pm</u>                                                          | <u>8am</u>                                                          |                                                                                                                                                |  |



## NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

|                                          |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
|------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| <b>SITUATION</b>                         | Diagnosis:                                                |                                                          | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                          |                                                          |                                                          |                                                          |
|                                          |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| <b>BACKGROUND</b>                        | Area                                                      |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
|                                          | Shift Time                                                |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
|                                          | Medical Condition<br>(Any special condition to be noted): |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| <b>ASSESSMENT</b>                        | Allergy:                                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Tubes/Drains/Catheter:                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Vital Signs:                                              | Temp:                                                    |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
|                                          | Res:                                                      |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
|                                          | SpO <sub>2</sub> :                                        |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
|                                          | Pulse:                                                    |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
|                                          | BP:                                                       |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
|                                          | Fall Risk Score:                                          |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
|                                          | Pain Score:                                               |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
|                                          |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| <b>Recommendations</b>                   | Safety Needs:                                             |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
|                                          | Physiotherapy                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Others Specify:                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
|                                          | Special Diet:                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Other Special Orders / Medications:                       |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Post Operative Procedure Special Orders: |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Handed Over By Name :                    |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Signature :                              |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Date:                                    |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Time:                                    |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Taken Over By Name :                     |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Signature :                              |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Date:                                    |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Time:                                    |                                                           |                                                          |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |



# BRADEN 'Q' SCALE

Patient ID

|                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date :                  | 9/14/2019 10:12 AM |   |   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------|---|---|--|
|                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time :                  | 8:45 PM            |   |   |  |
| Mobility                                                                                                                                                                    | 1. <b>Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | 2. <b>Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | 3. <b>Slightly limited:</b><br>Makes frequent through slight changes in body or e.tremity position independently.                                                                                                                                                                               | 4. <b>No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          | 4                       | 4                  | 4 | 4 |  |
| "Activity The degree of physical activity"                                                                                                                                  | 1. <b>Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | 2. <b>Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | 3. <b>Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | 4. <b>All patients too young to ambulate; OR walks frequently:</b><br>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. <b>Completely limited:</b><br>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. <b>Very limited:</b><br>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. <b>Slightly limited:</b><br>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. <b>No impairment:</b><br>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. <b>Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | 2. <b>Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | 3. <b>Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | 4. <b>Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   | 4                       | 4                  | 4 | 4 |  |
| <b>FRICION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | 1. <b>Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | 2. <b>Problem:</b><br>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. <b>Potential problem:</b><br>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. <b>No apparent problem:</b><br>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. <b>Very Poor:</b><br>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. <b>Inadequate:</b><br>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. <b>Adequate:</b><br>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. <b>Excellent:</b><br>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. <b>Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | 2. <b>Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | 3. <b>Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | 4. <b>Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               | 4                       | 4                  | 4 | 4 |  |
| <b>Severe Risk : less than 9   High Risk : 10-12   Moderate Risk : 13-14   Mild Risk : 15-18   Not at Risk: 19-23</b>                                                       |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>TOTAL SCORE</b>      |                    |   |   |  |
|                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>Evaluator's Name</b> |                    |   |   |  |



BAH-00660194 IP5-00176131  
Mrs R RADHIKA  
09-09-1976 49 Y (F)  
Dr. HIMABINDU VEERLA

Rainbow<sup>®</sup>  
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## Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category   |                               | Date / Time | 9/7/26<br>8:00 AM | 10/1/26<br>8:02 AM | 11/7<br>8 AM | Fall Risk Grading |                        |                                                           |
|------------------------------------------------------|-------------------------------|-------------|-------------------|--------------------|--------------|-------------------|------------------------|-----------------------------------------------------------|
|                                                      |                               | Score       |                   |                    |              | Risk Level        | Morse Fall Score (MFS) | Action                                                    |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          |                   |                    |              |                   |                        |                                                           |
|                                                      | No                            | 0           | 0                 | 0                  | 0            |                   |                        |                                                           |
| Secondary Diagnosis<br>(more than one diagnosis)     | Yes                           | 15          |                   |                    |              |                   |                        |                                                           |
|                                                      | No                            | 0           | 0                 | 0                  | 0            |                   |                        |                                                           |
| Ambulatory Aid                                       | Furniture                     | 30          |                   |                    |              | Low Risk          | 0 - 24                 | Standard Fall<br>Precaution                               |
|                                                      | 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<br>Moderate Fall<br>Prevention<br>Intervention  |
|                                                      | No                            | 0           |                   |                    |              |                   |                        |                                                           |
| GAIT / Transferring                                  | Impaired                      | 20          |                   |                    |              |                   |                        |                                                           |
|                                                      | Weak (uses touch for balance) | 10          |                   |                    |              |                   |                        |                                                           |
|                                                      | Normal /On Bed Rest /Immobile | 0           | 0                 | 0                  | 0            |                   |                        |                                                           |
| Mental Status                                        | Forgets limitations           | 15          |                   | 0                  | 0            | High Risk         | ≥ 51                   | Implement High<br>Risk Fall<br>Prevention<br>Intervention |
|                                                      | Oriented to own ability       | 0           | 0                 |                    |              |                   |                        |                                                           |
| Total Morse Fall Scale Score:                        |                               |             | 20                | 20                 | 20           |                   |                        |                                                           |
|                                                      |                               | Signature   |                   |                    |              |                   |                        |                                                           |

Tick (✓) whichever precaution taken.

### Risk Level and Interventions

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

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

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

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

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

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





# CHECKLIST FOR THROMBOPHLEBITIS

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

**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 : Kritika Name : Kritika

Signature of Ward In Charge :

Signature : Veenu Name : Veenu





## PAIN ASSESSMENT FORM

| Date    | Time | Pain Score (0/10) | Location    | Duration                                                                                | Acuity                                                                        | Character                                                                                                                                   | Modifying Factors                                                                     | Patient / Family Educated                                              | Intervention        | Sign   |
|---------|------|-------------------|-------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------|--------|
| 9/7/26  | 9am  | 0                 | abd         | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | patient-comfortable | ok     |
| 9/7     | 2pm  | 0                 | na          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | na                  | 3      |
| 9/7     | 8pm  | 0                 | na          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | na                  | 2      |
| 10/7    | 10am | 02/10             | Suture site | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input checked="" type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | under observation   | na     |
| 10/7    | 1pm  | 01/10             | —           | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | observation         | na     |
| 10/7/26 | 2pm  | 1/10              | s/s         | <input type="checkbox"/> Continuous<br><input checked="" type="checkbox"/> Intermittent | <input checked="" type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input checked="" type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input checked="" type="checkbox"/> Decreasing | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | in pain given       | Kauna  |
| 10/7    | 3pm  | 0/10              | na          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | under observation   | Kauna  |
| 10/7    | 10pm | 3/10              | s/s         | <input type="checkbox"/> Continuous<br><input checked="" type="checkbox"/> Intermittent | <input checked="" type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input checked="" type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input checked="" type="checkbox"/> Decreasing | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | Inj: paracetamol    | slight |
| 10/7    | 11pm | 0/10              | na          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | under observation   | slight |
| 11/7/1  | 6am  | 3/10              | s/s         | <input type="checkbox"/> Continuous<br><input checked="" type="checkbox"/> Intermittent | <input checked="" type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input checked="" type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input checked="" type="checkbox"/> Decreasing | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | Inj: paracetamol    | slight |

**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.

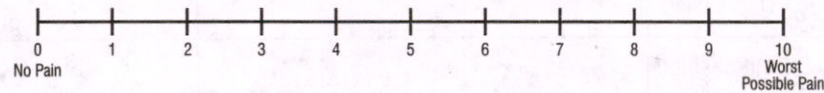


# PAIN ASSESSMENT TOOLS

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

| CATEGORY      | SCORING                                      |                                                                             |                                                          |
|---------------|----------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------|
|               | 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                          |

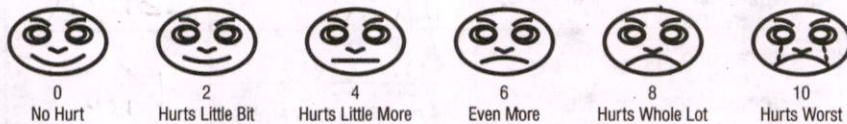
**Numerical Pain Scale (Obstetric and Gynecology)**



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

| Assessment Criteria                            | Sedation                                                |                                                             | Normal                                        | Pain / Agitation                                                                           |                                                                                                                                                         |
|------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                | -2                                                      | -1                                                          | 0                                             | 1                                                                                          | 2                                                                                                                                                       |
| <b>Crying Irritability</b>                     | 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                                                                                                      |
| <b>Behavior State</b>                          | No arousal to any stimuli<br>No spontaneous movement    | Arouses minimally to stimuli<br>Little spontaneous movement | Appropriate for gestational age               | Restless, squirming<br>Awakens frequently                                                  | Arching, kicking constantly awake or<br>Arouses minimally / no movement (not sedated)                                                                   |
| <b>Facial Expression</b>                       | Mouth is lax<br>No expression                           | Minimal expression with stimuli                             | Relaxed Appropriate                           | Any pain expression intermittent                                                           | Any pain expression continual                                                                                                                           |
| <b>Extremities Tone</b>                        | No grasp reflex<br>Flaccid tone                         | Weak grasp reflex<br>decreased muscle tone                  | Relaxed hands and feet<br>Normal Tone         | Intermittent clenched toes, fists or finger splay<br>Body is not tense                     | Continual clenched toes, fists, or finger splay<br>Body is tense                                                                                        |
| <b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b> | No variability with stimuli<br>Hypoventilation or apnea | Less than 10% variability from baseline with stimuli        | Within baseline or normal for gestational age | Increase 10-20% from baseline<br>SaO <sub>2</sub> 76-85% with stimulation - quick recovery | Increase greater than 20% from baseline, SaO <sub>2</sub> 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    |
|---------|------|-------------------|----------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|-------------------|---------|
| 11/7/20 | 7 AM | 0/10              | RLH      | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | under observation | skincel |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                   |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                   |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                   |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                   |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                   |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                   |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                   |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                   |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                   |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                   |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                   |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                   |         |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                   |         |

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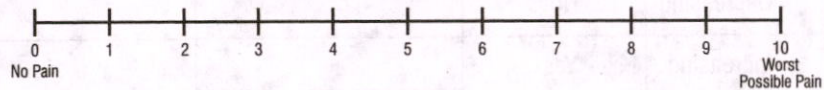


# PAIN ASSESSMENT TOOLS

**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                                                                                                                                                       |
| <b>Crying Irritability</b>                    | 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                                                                                                      |
| <b>Behavior State</b>                         | No arousal to any stimuli<br>No spontaneous movement    | Arouses minimally to stimuli<br>Little spontaneous movement | Appropriate for gestational age               | Restless, squirming<br>Awakens frequently                                                  | Arching, kicking constantly awake or<br>Arouses minimally / no movement (not sedated)                                                                   |
| <b>Facial Expression</b>                      | Mouth is lax<br>No expression                           | Minimal expression with stimuli                             | Relaxed Appropriate                           | Any pain expression intermittent                                                           | Any pain expression continual                                                                                                                           |
| <b>Extremities Tone</b>                       | No grasp reflex<br>Flaccid tone                         | Weak grasp reflex<br>decreased muscle tone                  | Relaxed hands and feet<br>Normal Tone         | Intermittent clenched toes, fists or finger splay<br>Body is not tense                     | Continual clenched toes, fists, or finger splay<br>Body is tense                                                                                        |
| <b>Vital Signs HR RR, BP, SaO<sub>2</sub></b> | No variability with stimuli<br>Hypoventilation or apnea | Less than 10% variability from baseline with stimuli        | Within baseline or normal for gestational age | Increase 10-20% from baseline<br>SaO <sub>2</sub> 76-85% with stimulation - quick recovery | Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator |

**Wong - Baker (Pediatrics) Above 7 Years**





9/27/26

PRE - (

BAH-00660194 IP5-00176131  
Mrs R RADHIKA  
09-09-1976 49 Y (F)  
Dr. HIMABINDU VEERLA

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Patient's I



Age :

49Y

Date :

9/27/26

Gender :

☐ M ☒ F

Blood Grp

Planned Surgery: TUB + R/L Salpingostomy Surgeon: Dr. Himabindu

Anesthetist: Dr. Subramanyam Date & Time of Operation: 9/27/26

Tick Appropriate Boxes, To be filled by Nurse Incharge / Senior Nurse :

| S.No. | INSTRUCTIONS                                                                                                                                 | ER/Ward,Nurse                       |                                     |                                     | OT Nurse                 |                          |                          |
|-------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|
|       |                                                                                                                                              | Yes                                 | No                                  | NA                                  | Yes                      | No                       | NA                       |
| 1     | Weight checked recorded ? <i>62kg</i>                                                                                                        | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|       | Is the patient fasting for over 6 hours Pre-Operatively ?                                                                                    | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3     | Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT, APTT, Viral Screening, CXR etc) Available before starting the procedure | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4     | Enema given / Bowel Preparation                                                                                                              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5     | Remove all ornaments, earrings, toe rings, nose rings etc and implants, dentures                                                             | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6     | Sterile Gown Given                                                                                                                           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7     | Is Blood arranged as required ? <i>o-ve</i>                                                                                                  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8     | If Blood has been ordered - is Blood bag ready ?                                                                                             | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9     | IV Cannula to be placed / IV fluids if Indicated                                                                                             | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10    | Pre Anesthetic consultation with anesthesiologist                                                                                            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11    | Pre Medications Given ? (Sedatives / etc)                                                                                                    | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12    | Skin Preparation                                                                                                                             | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13    | Site is marked                                                                                                                               | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14    | Surgery Consent / High Risk consent taken by surgeon?<br>(Consent should be taken by the operating surgeon only)                             | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|       | Implants are available                                                                                                                       | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16    | Equipment is available                                                                                                                       | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17    | Antibiotic Prophylaxis is given within the last 60 minutes                                                                                   | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18    | Other (if any)                                                                                                                               | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

NOTE : if any of above is ticked "NO" Discuss with the registrar / consultant immediately

Billing Clearance Taken : ☐ Yes ☐ No

Billing Executive Name : OT Nurse Name : *Heayin* ER/Ward Nurse Name : *Salu*

Billing Executive Signature : Signature of OT Nurse : Signature of ER/Ward Nurse :

Date & Time : Date & Time : 9/27/26 Date & Time : 9/27/26

Doc. No. : RCHBH/ FRM / CLINICAL / 107

8-30A

8-40A



BAH-00660194 IP5-00176131  
Mrs R RADHIKA  
09-09-1976 49 Y (F)  
Dr. HIMABINDU VEERLA



## INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

### Identified Education Needs:

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

### Part - II

| Date   | Time    | Need Identified | Information Taught                                   | Use codes from the list in part III |                   |                |                                   |               | Comments | Designation / Signature |
|--------|---------|-----------------|------------------------------------------------------|-------------------------------------|-------------------|----------------|-----------------------------------|---------------|----------|-------------------------|
|        |         |                 |                                                      | Person Taught                       | Learning Barriers | Teaching Tools | Mechanism/s to overcome barrier/s | Understanding |          |                         |
| 9/1/16 | 4:30 PM | 1/2/4           | Diagnosis, Treatment & care plan, informed consent   | PT, S                               | 1                 | 2              | 1                                 | 1             |          | <i>[Signature]</i>      |
| 9/1/16 | 8 AM    | 2/5<br>6,7      | patient taught regarding to include control measures | PT                                  | 1                 | 0              | 1                                 | 1             | -        | <i>[Signature]</i>      |
|        |         |                 |                                                      |                                     |                   |                |                                   |               |          |                         |
|        |         |                 |                                                      |                                     |                   |                |                                   |               |          |                         |

### Part - III: CODES

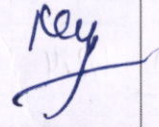
|                                                                                                                     |                               |                                                   |                                 |                                |  |  |  |  |  |
|-----------------------------------------------------------------------------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



# MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

B22 / AUB-A / for TCH-TBS

| Date Time         | Discipline                                                                                                          | Type                                                                                                                                                               | Patient Needs / Problem List | Goal                         | Plan / Intervention  | Signature                                                                           | Team Verification                                                                                        |
|-------------------|---------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------|----------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| 9/7/26<br>6:30 AM | <input checked="" type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: | <input checked="" type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op            | B22 / AUB-A                  | for eye procedure            | TCH-TBS              |  | <input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:                                     |
| 9/7/26<br>7 AM    | <input type="checkbox"/> Medical<br><input checked="" type="checkbox"/> Nursing<br><input type="checkbox"/> Others: | <input checked="" type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input checked="" type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op | Neo<br>separation            | to maintain<br>w/ separation | w/ mid<br>se on flow |  | <input type="checkbox"/> Medical<br><input type="checkbox"/> Others:                                     |
|                   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op                       |                              |                              |                      |                                                                                     | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: |
|                   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op                       |                              |                              |                      |                                                                                     | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: |
|                   | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others:            | <input type="checkbox"/> Initial<br><input type="checkbox"/> Modified<br><input type="checkbox"/> Per-Op<br><input type="checkbox"/> Post Op                       |                              |                              |                      |                                                                                     | <input type="checkbox"/> Medical<br><input type="checkbox"/> Nursing<br><input type="checkbox"/> Others: |



(F)



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

| Date                                    |                          |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|-----------------------------------------|--------------------------|-------|---|----|----|----|---|----|-----|-----|-----|-----|---|----|-------|-------|-------|-------|-------|-------|-----|---|---|---|---|
| Time                                    |                          | 8     | 9 | 10 | 11 | 12 | 1 | 2  | 3   | 4   | 5   | 6   | 7 | 8  | 9     | 10    | 11    | 12    | 1     | 2     | 3   | 4 | 5 | 6 | 7 |
| RESP<br>(write rate in<br>corresp. box) | > 30                     |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 21 - 30                  |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 11 - 20                  | 18    |   |    |    |    |   | 18 | 18  | 20  | 20  |     |   | 18 | 20    | 18    | 18    | 20    | 18    |       |     |   |   |   |   |
|                                         | 0 - 10                   |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
| Saturations                             | 94 - 100 %               | 99    |   |    |    |    |   | 99 | 99  | 100 | 99  |     |   | 99 | 98    | 99    | 98    | 99    | 98    | 99    |     |   |   |   |   |
|                                         | < 94 %                   |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
| Administered O <sub>2</sub> (L/min.)    |                          |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
| Temp °C                                 | 40                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 39                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 38                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 37                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 36                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 35                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | < 35                     |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
| Heart Rate                              | 170                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 160                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 150                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 140                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 130                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 120                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 110                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 100                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 90                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 80                       | 75 kb |   |    |    |    |   |    | 76  | 78  | 74  | 81  |   |    | 62 kb | 62 kb | 64 kb | 72 kb | 72 kb | 72 kb |     |   |   |   |   |
|                                         | 70                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 60                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 50                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
| 40                                      |                          |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
| Systolic Blood Pressure                 | 190                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 180                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 170                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 160                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 150                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 140                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 130                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 120                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 110                      | 117   |   |    |    |    |   |    | 116 | 118 | 116 | 118 |   |    | 112   | 118   | 114   |       |       | 114   | 123 |   |   |   |   |
|                                         | 100                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 90                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 80                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 70                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
| 60                                      |                          |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
| 50                                      |                          |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
| Diastolic Blood Pressure                | 130                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 120                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 110                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 100                      |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 90                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 80                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 70                       | 60    |   |    |    |    |   |    | 74  | 72  | 74  | 71  |   |    | 72    | 62    | 64    |       |       | 72    | 78  |   |   |   |   |
|                                         | 60                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 50                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | 40                       |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         | NEURO<br>RESPONSE<br>[✓] | Alert | ✓ |    |    |    |   |    | ✓   | ✓   | ✓   | 0   |   | ✓  | ✓     | ✓     |       |       | ✓     |       |     |   |   |   |   |
|                                         |                          | Voice |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
|                                         |                          | Pain  |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
| Unresponsive                            |                          |       |   |    |    |    |   |    |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |
| URINE<br>mls / hour                     | > 30                     | ✓     |   |    |    |    |   | ✓  |     |     |     |     |   |    |       |       |       |       |       |       |     |   |   |   |   |



## Obstetrics and Gynaecology Early Warning Signs

Complete a Full  
Set of MEOWS  
Observations

1 Yellow Alert :  
Repeat Observations  
in 30 minutes

2 Yellow Alerts or 1 Orange Alert:  
Call the Obstetrician and Repeat  
Observations  
in 30 minutes

> 2 Yellow Alerts or  $\geq 2$  Orange Alerts:  
Immediate Review by Obstetrician and  
Repeat Observations  
in 15 minutes or continuous  
monitoring

\* The Modified Early Warning Score (MEOWS)



IP5-00176131

49 Y

(F)

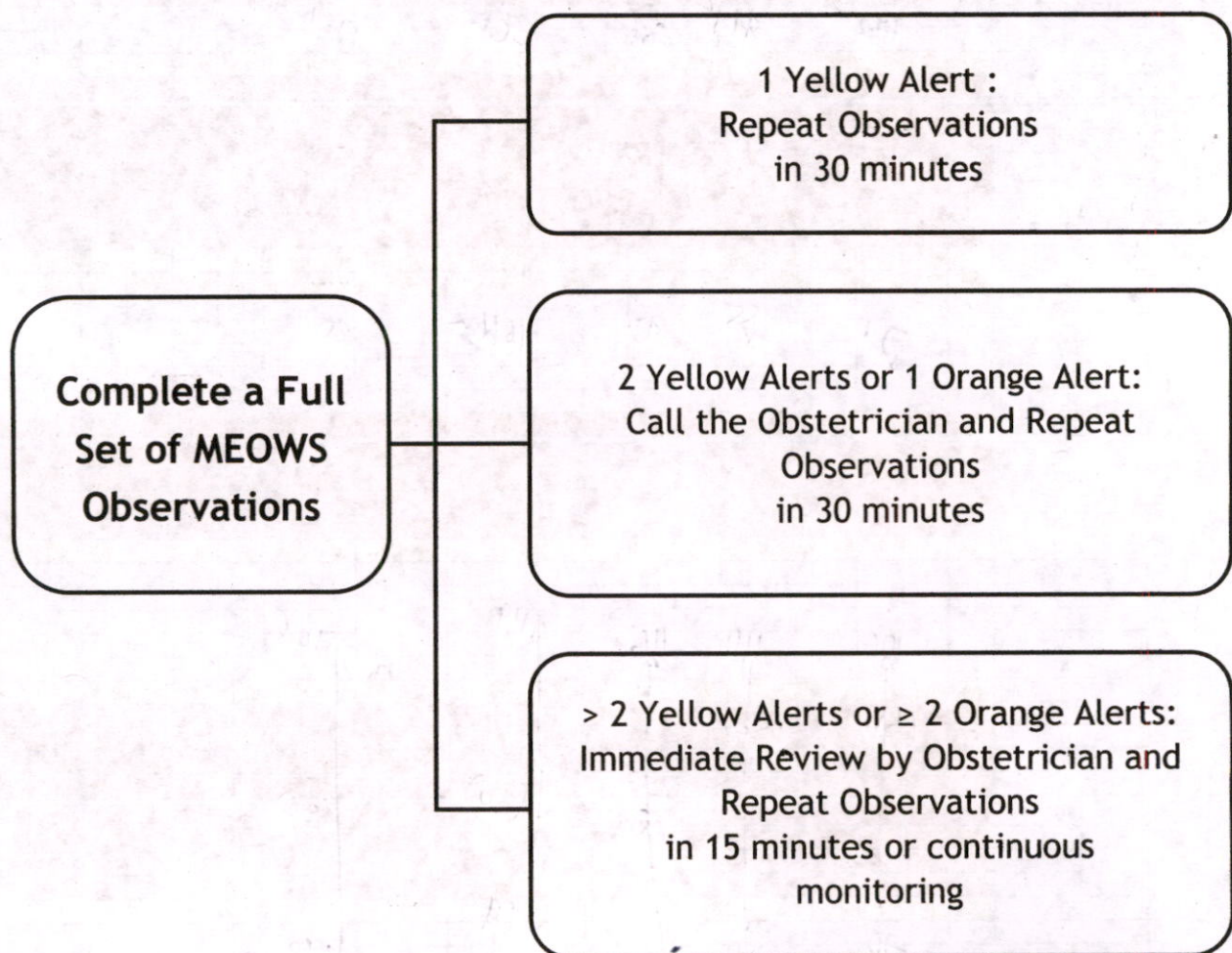
10/7/26

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<br>(write rate in<br>corresp. box) | > 30       |      |   |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |
|                                         | 21 - 30    |      |   |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |
|                                         | 11 - 20    |      |   |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |
|                                         | 0 - 10     |      |   |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |
| Saturations                             | 94 - 100 % |      |   |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |
|                                         | < 94 %     |      |   |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |
| Administered O <sub>2</sub> (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<br>↑            | 190        |      |   |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |
|                                         | 180        |      |   |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |
|                                         | 170        |      |   |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |
|                                         | 160        |      |   |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |
|                                         | 150        |      |   |   |    |    | </ |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



BAH-00660194  
Mrs R RADHIKA  
09-09-1976 49 Y  
Dr. HIMABINDU VEERLA (F)

Rainbow<sup>®</sup>  
Children's  
Hospital  
It takes a lot to treat the little.

BirthRight<sup>™</sup>  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## DISCHARGE PLANNING FORM

Nationality: INDIAN

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

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

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

☐ Transfer  
Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

|                                     |                              |                                        |
|-------------------------------------|------------------------------|----------------------------------------|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| <input type="checkbox"/> Bathing    | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| <input type="checkbox"/> Eating     | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| <input type="checkbox"/> Walking    | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| <input type="checkbox"/> Dressing   | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
| <input type="checkbox"/> Toileting  | <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |

Remarks

No need  
Assistance

Nutritional Plan:

☐ Dietary Instruction Discussed with the:  
☒ Patient ☒ Family Member

☐ Others: .....

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others: .....

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Personal Hygiene

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

☒ Patient ☒ Family Member

☐ Others: .....

Nurse Signature: Reyini

Nurse Name: Reyini

Date and Time: 9/7/26

Docu. No. : RCHBH / FRM / CLINICAL / 191