

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175992 Admit Date : 05-Jul-2026 Admit Time : 06:08 PM UHID : BAH-00657750

Patient Details :

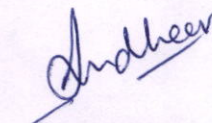
Patient Name	: Mrs SRIRAM SUSHMITA	Age	: 26 Y 9 M 3 D
Guardian	: Mr SETTY VENKATA SAI SUDHEER	DOB	: 02-10-1999
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Married
Address (H)	: PLOT NO - 32, AYYAPPA SOCIETY ,SRI SAI NAGAR , Madhapur Hyderabad Telangana INDIA 500081	Phone No	: 8332952197 / 7893186527
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD Bed No : SW 418 Ward Name : 4F-BIRTHING CENTRE
Room No : SW 418 Admission Type : First Visit

Contact Details :

Name : Mr SETTY VENKATA SAI SUDHEER Relationship : Husband
Contact Address : PLOT NO - 32, AYYAPPA SOCIETY ,SRI SAI NAGAR , Madhapur Hyderabad Telangana INDIA 500081 Phone No : 8332952197 / 7893186527


Signature

Doctor Details :

Doctor Name : Dr. DR.M PRATHYUSHA REDDY Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

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ACTIVITY RECORD FOR BILLING

Name : _____

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

Date of Admission: _____ 1 _____ Charge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
6/7/26	1:30 PM	OBS	BB=III	Shobha
6/8/26	6:35 PM	BB=III	Room (302)	Reddy

Cross Consultation Visit

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

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
5/2/26	I/V placement	1	9689555	Sundhya
6/1/26	collaterization	①		Sunaga
6/17/26	pac		9689555	

ANY OTHER INFORMATION

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.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00657750 IP5-00175992
Mrs SRIRAM SUSHMITA
02-10-1999 26 Y 9 M 4 D (F)
Dr. DR.M PRATHYUSHA REDDY



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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Foa Jol.

LMP: 24/9/25

EDD:

Corrected EDD: 9/11/25

GA: 39+3

Obstetric Formula:

P₂A₁

Obstetric History:

1- 2025 Biochemical pregnancy

2- Sp conception booked at 34 weeks

Present Pregnancy Record:

Previous ANe at Ethenber.

given 2.5gm Fem at 34 weeks

RISK FACTORS:

4.10 Anemia

Obstetric Examination

Fundal Height: Term

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech ☐ Others

Head Fifts Palpable:

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☒ Long ☐ Partially effaced ☐ Effaced

Os: Closed closed Dilated

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

Height: cm

Weight: kg

Allergies: Nil

Breast: ☐ Normal ☐ Abnormal

General Examination:

Consciousness: conscious Pallor: absent

Icterus: absent Edema: absent

Temp: 100.4 PR: 84/min

BP: 110/70 DTR: +

CVS: normal RS: normal

Liver/Spleen: not palpable Urine Output: adequate

DIAGNOSIS

P₂A₁ 39+3 wks. Foa Jol.
Hb. Anemia



Family History: Father - DM Mother - HTN.	Surgical History: RT Fibroadenoma Excision - 2023.
Medical History: Nil	Medication History: T. Iron T. Med.
Plan of Care: Admission Nil on admission prep of part check blood availability Send CRP. Foley catheterization (induction). Monitor Vital. AS + 3014 w/f POL.	Investigations: OGive. Vital - NP. 5/7/2026 Hb - 11.1 WBC - 12,36 PLT - 2.86 11/6/26. 37 / cephalic / wt. 2.71 kg Ae - 14.7 / AFI - 9.2 cm / p1 - P/H/K UA Doppler - 1 stenosis.

Doctor Name: Dr. Prathyusha

Signature: [Signature]

Date & Time: 5/1/26, 6 PM

Consultant Name: Prathyusha

Signature: [Signature]

Date & Time: 5/1/26, 6 PM

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02-10-1999 26 Y 9 M 5 D (F)
Dr. DR.M PRATHYUSHA REDDY



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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	3			
5	In-patient Medical record	1			
6	Doctors progress sheets	4			
7	Nursing plan of care and handover sheets	3			
8	Consultation sheet	1			
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk	2			
14	Consent for Restraint	1			
15	LAMA consent				
16	Consent for special procedure / Sedation	2			
17	Consent for Formula feed	1			
18	Consent for MTP	1			
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia & post)	2			
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	2			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart	1			
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale	1			
39	Bed side check list	1			
40	PICU bed formula Dilution feeds	2			
41	Gastro monitoring chart				
42	Rch ED doctors note	1			
43	BP Monitoring chart				
44	RBS monitoring chart				
	Total No. of Pages	58			

Doc. No. : RCHBH/ FRM / GENERAL / 126

Signature and Date :

(P.T.O)

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

BAH-00657750 IP5-00175992
 Mrs SRIRAM SUSHMITA
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①

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/20 7:40pm	↓ aseptic precaution, perineum cleaned & draped. Foley's left intra-uterine, inflated with distilled H ₂ O. H/A - ut relaxed FHS ① P _h - cx - long. closed.	ad - NGT 3 rd h - vital & FHR - w/p R
5/7/20 10pm	Patient is comfortable	ad - 2 nd dose 7. PGE 25mg po now - NGT 3 rd h - vital & FHR 4 th h - w/p R
5/7/20 11am	Patient wants Epidural sting.	ad ① Epidural. 8 th h ② 7. PGE 25mg. (3 rd dose), ③ Monitor vital & FHR, ④ NGT 3 rd h, ⑤ w/p R

Dr. Arshya

Dr. Arshya

Dr. Arshya

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/11/25. 4 AM	Foley bulb expelled spontaneously	
	Intact	adv - NSI 3 rd 4
	PR - 81 mm	- vital & FHR 7 th 11
	RP - 115 / 38 mmHg	- DO NOT NEX
	Spq - 90% @ 4	- w/ POL
	p/a - at cutting	
6/11/25	FHR 110	
pl - 2.86	pl. Cc - 10 mg.	
NSI - 12.36	2 cm. w3.	
	ARM done	Dr. Arunachal
	clear lig.	
6/11/26. 6 AM	1st Dr. product	
	adv ① To start oxytocin at 2 AM @ 6 ml/h	
	② w/ POL.	
	③ NSI 3 rd 4	
	④ vital & FHR Monitor	
		Dr. Arunachal

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/2026 8 AM	Pt comfortable on epidural P/A: Mild Action P/V: 1/2", soft, 2-3cm clear leak 114/75 (87); 86bpm; 99% RA	✓ CTG now ✓ Oxy titration Dr. Y. Suresh
6/7/26 9:30 AM	Q2A1 30% work c/o mild pain on Synto @ 2cc/ml/hr ↓ Epidural. P/A: mild action P/R: 73bpm BP: 133/73mmHg (90) SpO₂: 98% in RA P/A: mild action P/R: 73bpm	Adv. - w/f POC - CTG 3rd hdy - Continuous - FHR monitoring - Synto titration - Examine 01 Dr. Suresh



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26 10:30 AM	pt stable vitals @ P/A = ut line acting cephalic FHR good v/c - G 70% effaced not well applied 3-4 cm N₂ = 2 Caput (+)	Adv - FHR monitoring - w/f preparing labor
6/7/26 11:25 AM	cls/ Dr. Bhargava FHR ↓ Synto stopped NST - Early deceleration @	- NST now - Inj. Dextin 1 amp IV set for 2 hours
Continue NST monitoring	VL - 5-6 cm dilated VX - head not applied Clear liquor 70-80% effaced Bp - 109/71 (86) mmHg PR - 82 bpm SpO₂ - 98% at rest	Adv 1 IO RL FF 2 Repeat mtr
	Dr. Pradyumna	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/2026 12:45 PM.	cl/b Dr. Samu o/f C. fair Tem - 98.2 f BP - 139/81/49 mm PR - 75 bpm SpO₂ - 98% RA NST - reactive deceleration on contraction upto 120 bpm. Plv - 5 cm. at 70-80g. VX, extra - 2g Liquor clear.	Adv ① w/f POL ② fHR monitoring ③ monitor vital ④ Infusion Dr. Divya Noted by Shobha
6/7/26 9 PM	PRD-0 / SVD / PCLIA C. fair B.P: 122/71 mm P.R: 72 bpm Spa: 100% on RA PlA: 14 (R) well Soft, BS (+) Plv: NAB	1) Soft diet & plenty of oral fluid 2) Drug as charted 3) w/f Plv Bleeding 4) Flo charting 5) Ambulation 6) Monitor vitals - 1hr x 2 7) Temp 4x Dr. Sankar

Date & Time	Progress Notes	Doctor's Order
6/2/26 12:00pm	PND-O (SVD)	P14A1
		E
B. cool	G.C. / air	1) soft diet c
P. cool	B.P. - 116/41	plenty of oral fluid
	P.R. 175 bpm	2) Drug. as charted
V/E ✓	Spo2: 100% on RA	3) w/ P/v Bleeding
	P/A: Ut (2) well	4) Auscultation
	Soft	5) Monitor vitals - 4th
	BS (+)	6) I/O charting
	P/v: NAB	7) Temp ser
	- Shift to Room	
	- Remove Foley's at 6AM 2/7/2026	→ Dr. Smiley
	Not by (Signature)	6/2/26 6:30 PM

KATHYUSHA REDDY

(F)



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Date & Time	Progress Notes	Doctor's Order
7/7/26 8:30 AM	PND-1	SUN/PIL/A1
VV VLEV	Certain vital stable p/A - ut @ uen P/R 8 w/w	Adv ① soft diet ② Hydration ③ Ambulation ④ Encourage BF ⑤ Drugs checked ⑥ Monitor vital signs ⑦ Informs
plan discharge by evening		Dr. Dwyer

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00657750 IP5-00175992
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RESULT SHEET

Date	6/8/16				
Time	6pm				
Hb	11.1				
PCV	36.5				
RBC	4.76				
WBC	12.36				
N/L					
Platelets	286				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From:

Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. Joy	1tab	PO	OD		☐ C ☒ DC
2	T. Skeletal	1tab	PO	OD		☐ C ☒ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature :

Signature: Sandhya (16035)

Sheet No: ②

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : T. DICLOFENAC				Date Time	6/7
Dose	Route	Frequency	Start Dt.		
50mg	P/O	TID	6/7	7AM	
Name & Signature of the Doctor Starting the Drugs:					
Dr. Praveen				3PM	
Additional Instructions:					
				11PM	
Daily Doctor's Endorsement by a Sign					
DRUG : T. PANTOPRAZOLE				Date Time	6/7
Dose	Route	Frequency	Start Dt.		
40mg	P/O	O'D	6/7	6AM	
Name & Signature of the Doctor Starting the Drugs:					
Dr. Praveen				6AM	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : Syp-DUPHALAC				Date Time	6/7
Dose	Route	Frequency	Start Dt.		
15ml	P/O	TLS	6/7	10PM	
Name & Signature of the Doctor Starting the Drugs:					
Dr. Praveen				10PM	
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG :				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
 VERIFIED BY : Name

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

DRUG :				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
VERIFIED BY : Name

BAH-00657750
Mrs SRIRAM SUSHMITA IP5-00175992
02-10-1999 26 Y 9 M 4 D
Dr. DR.M PRATHYUSHA REDDY (F)

DRUG CHART

Date of Admission: 5/7/20 Drug Allergies: ☒ 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)

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

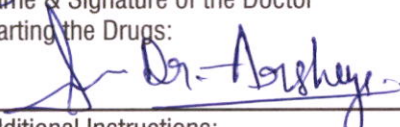
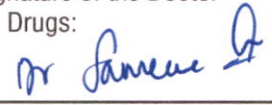
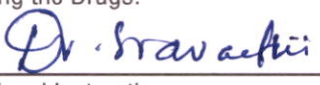
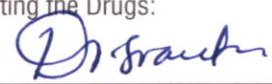
DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

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



REGULAR PRESCRIPTIONS

Weight. 10 kg Ward. 085

DRUG: <u>Inj CEFOTAXIME</u>				Date/Time																
Dose	Route	Frequency	Start Date																	
1gm	IV	BD	5/7/20	5/7/20																
Name & Signature of the Doctor Starting the Drugs:				 9pm 9am																
Additional Instructions:				STOP Dr. Arshaya																
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>Inj CEFOTAXIME</u>				Date/Time																
Dose	Route	Frequency	Start Date																	
1gm	IV	BD	6/7/20	6/7/20																
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				X HN Discharge																
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>Inj. METROGVL</u>				Date/Time																
Dose	Route	Frequency	Start Date																	
500mg	IV	TID	6/7/20	6/7/20																
Name & Signature of the Doctor Starting the Drugs:				 3pm 7/17/26 8:30pm																
Additional Instructions:				X 24hr & STOP																
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>T. PARACETAMOL</u>				Date/Time																
Dose	Route	Frequency	Start Date																	
1gm	PO	TID	6/7/20	6/7/20																
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:				10pm																
Daily Doctor's Endorsement by a Sign																				



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
5/7/26	6:20 pm	T. PG E ₂	50mg	PO	[Signature]	Shibi
5/7/26	10:40 pm	T. PG E ₂	25mg	PO	[Signature]	Tanna
6/7/26	1:30 Am	T. PG E ₂	25mg	PO	[Signature]	Sandhya
5/7/26	11:20 pm	ENEMA	1	P/R	[Signature]	Shudha
6/7/26	4:40 Am	T. PG E ₂	25mg	PO	[Signature]	Sandhya
6/7/26	10:30 Am	Inj. DROTIN	1amp	IV	[Signature]	Shudha
6/7/26	5 AM	Inj. CEFOTAXIME	1gm	IV	[Signature]	Shudha
6/7/26	12:30 pm	Inj. NTG.	2ml	IV	[Signature]	Shobha
6/7	3:05 M	Inj. SYNTOCIP	10units	IV	[Signature]	Tanna
6/7	3:35 M	T. PG E ₂	400mg	P/R	[Signature]	Shudha
6/7	3:20 M	T. PG E ₂	100mg	P/R	[Signature]	Shudha



I.V. FLUIDS CHART

Weight. 104 kg Ward. OBS

Signature

VERIFIED BY : Name

Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
6/7	2 AM	RINGER LACTATE	IV	100	[Signature]	Sandhya Sudha	6/7	[Signature]	Shobha Sudha
6/7	3 AM	RINGER LACTATE	IV	100	[Signature]	Sandhya Sudha	6/7	[Signature]	Sandhya Sudha
6/7	8 AM	RINGER LACTATE	IV	100	[Signature]	Sandhya Sudha	6/7	[Signature]	Sandhya Sudha
6/7	1:00 AM	RINGER LACTATE + OXYTOCIN 10 UNITS		6 ml/hr ↓ 6 ml/hr every 20-30 mins if NST is negative.	[Signature]	Sandhya Sudha	6/7	[Signature]	Radha Anjali
								[Signature]	
6/7/26	12:00 PM	RINGER LACTATE	IV	FF	[Signature]	Shobha Tunna	6/7	[Signature]	Shobha Tunna
6/7/26	1:30 PM	RINGER LACTATE	IV	FF	[Signature]	Shobha Tunna	6/7	[Signature]	Radha Anjali
3/26	2:30 PM	Ringer Lactate	IV	FF	[Signature]	Radha Tunna	6/7		Radha Tunna

5/6/26 (1)



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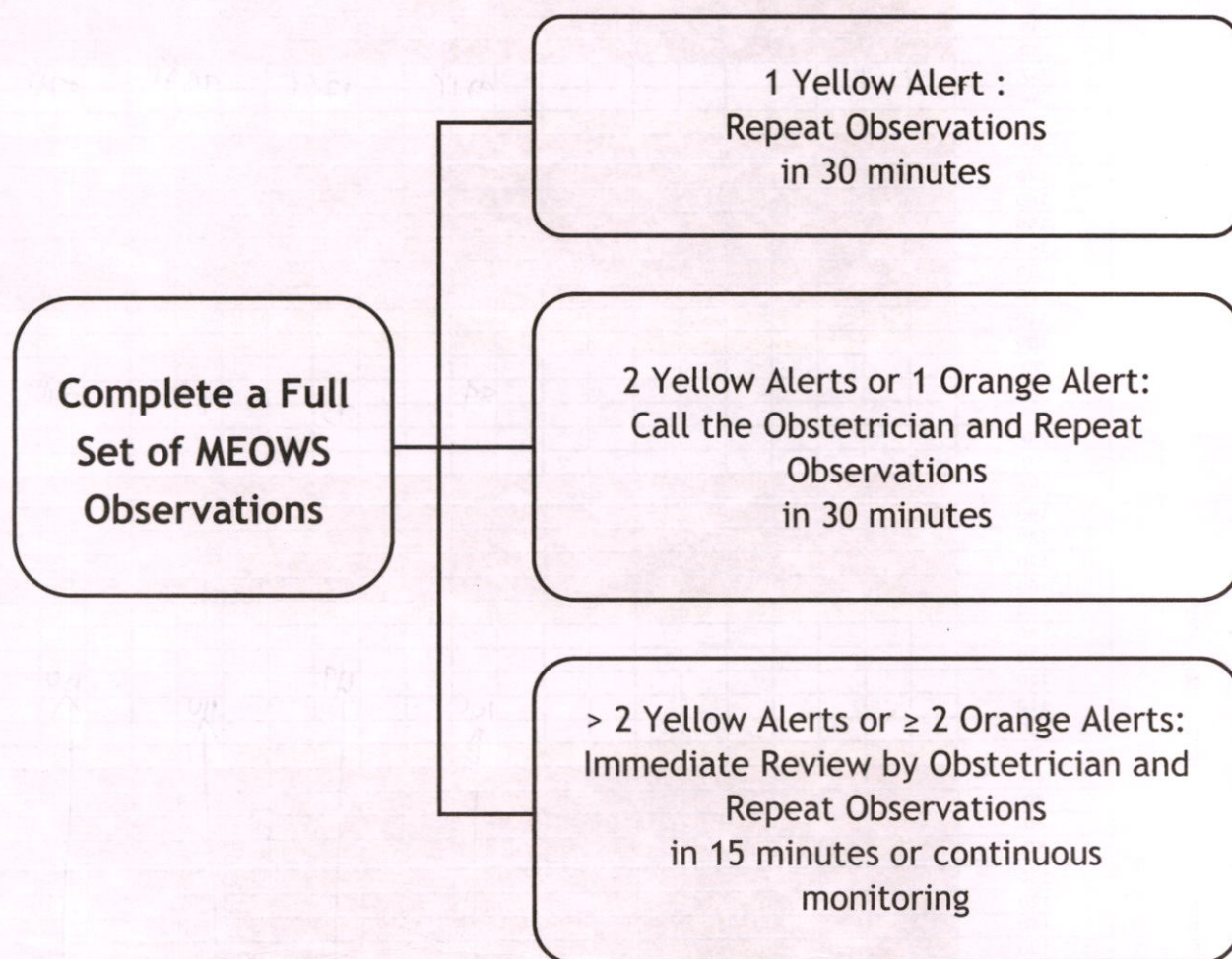


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

BAH-00657750

IP5-00175992

Mrs SRIRAM SUSHMITA

02-10-1999

26 Y 9 M 4 D

Dr. DR.M PRATHYUSHA REDDY



617128

②



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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT

TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

		Date																								
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20	20		20		19		20		20		20					19			20					19	
	0 - 10																									
Saturations	94 - 100 %	100		99		100		100%		99%		99%					98%			98%					98%	
	< 94 %																									
Administered O ₂ (L/min.)																										
Temp °C	40																									
	39																									
	38																									
	37																									
	36	36°C		36°C		36°C		36°C		36°C		36°C					37°C			37°C					38°C	
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80	80		81		81		88		79		80					81			95					82	
	70																									
	60																									
	50																									
40																										
Systolic Blood Pressure	190																									
	180																									
	170																									
	160						</																			

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 ≥ 2 Orange Alerts:
Immediate Review by Obstetrician and
Repeat Observations
in 15 minutes or continuous
monitoring

* The Modified Early Warning Score (MEOWS)

BAH-00657750
Mrs SRIRAM SUSHMITA
02-10-1999 26 Y 9 M 4 D
Dr. DR.M PRATHYUSHA REDDY (F)

FLUID CHART

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Sheet No. : 5/11/26

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

Date	Time	Nature of Fluid	Intake			Output					IV Site 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											

Total Intake :

Total Output :

	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm	H ₂ O										Per
	07:00 pm											

Total Intake : taken

Total Output : passed

	08:00 pm	H ₂ O									0	Sandhya
	09:00 pm										0	Sandhya
	10:00 pm	meals								✓	0	Sandhya
	11:00 pm	H ₂ O									0	Sandhya
	12:00 am										0	Sandhya
	01:00 am	H ₂ O									0	Sandhya

Total Intake : taken

Total Output : passed

	02:00 am	H ₂ O								✓	0	Sandhya
	03:00 am										0	Sandhya
	04:00 am	H ₂ O									0	Sandhya
	05:00 am										0	Sandhya
	06:00 am	H ₂ O								✓	0	Sandhya
	07:00 am									✓	0	Sandhya

Total Intake :

Total Output :

Total 24 hrs. Intake	
----------------------	--

Total 24 hrs. Output	
----------------------	--

FLUID CHART

Sheet No. : 6/7/20 ②

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
6/7/20			Mouth	I.V	N.G						0	Shobha	
	08:00 am	H ₂ O					1			✓	0		
	09:00 am						2				0		
	10:00 am	H ₂ O					2				0		
	11:00 am	Rh	100ml				1				0		
	12:00 pm	Rh	100ml				1				0		
	01:00 pm	Rh	100ml							250ml	0	Shobha	
Total Intake : Taken 300ml						Total Output :							
6/7/20	02:00 pm	H ₂ O					✓			250ml	0	Shobha	
	03:00 pm	H ₂ O					✓			200ml	0		
	04:00 pm	H ₂ O					✓			200ml	0		
	05:00 pm	H ₂ O					✓			200ml	0		
	06:00 pm	H ₂ O					✓			200ml	0		
	07:00 pm										0		
Total Intake : 1000ml						Total Output : 1000ml U - 650ml							
	08:00 pm	H ₂ O									0	Durga	
	09:00 pm	H ₂ O									0		
	10:00 pm	H ₂ O									0		
	11:00 pm	H ₂ O								900ml	0		
	12:00 am	H ₂ O									0		
	01:00 am										0		
Total Intake :						Total Output : U - 900ml M - 0							
	02:00 am	H ₂ O									0	Durga	
	03:00 am	H ₂ O								200ml	0		
	04:00 am	H ₂ O									0		
	05:00 am	H ₂ O									0		
	06:00 am	H ₂ O								200ml	0		
	07:00 am										0		
Total Intake :						Total Output : U - 400ml M - 1							
Total 24 hrs. Intake		300ml											
Total 24 hrs. Output		U + 950ml M - 1											

①

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 05/07/2028

Assessment: patient having fear and Anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 pm	⇒ Assess the patient condition	8:30 pm	⇒ Assessed the patient condition	⇒ patient is stable.
10 pm	⇒ monitor the vitals	10:30 pm	⇒ monitoring the vitals checked and recorded	
12 AM	⇒ NST 3rd hourly	12:30 PM	⇒ NST 3rd hourly done	
2 AM	⇒ Administer medication	2:30 AM	⇒ Administered medication as per drug chart	
4 AM	⇒ provide psychological support	4:30 AM	⇒ provided psychological support	
7 AM	⇒ Ensure safety needs	7:30 AM	⇒ Ensured safety needs	

Re-Assessment: Re-Assessment done. after 2nd hourly pt is stable

Special Notes: NST 3rd hourly monitoring.

Nurse Signature: [Signature]

Nurse Name: sandhya

Date & Time: 05/07/28 @ 8pm

BAH-00657750 IP5-00175992
 Mrs SRIRAM SUSHMITA
 02-10-1999 26 Y 9 M 4 D (F)
 Dr. DR.M PRATHYUSHA REDDY

NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 6/7/20

Assessment: pt complain for anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 AM	Assess pt general condition	8:10 AM	Assessed pt general condition	pt is stable
10 AM	monitor vital	10:30 AM	Bp SpO2 pulse checked and recorded	
11 AM	Administration medication	11:30 AM	medication given as per doctor	
12 PM	ensure safety	12:30 PM	ensure safety provided	
1 PM	prevent infection	1:10 PM	TO prevention infection	

Re-Assessment: Re Assessment done

Special Notes:

Nurse Signature: [Signature] Nurse Name: Shobha Date & Time: 6/7/20 2 PM

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 Mrs SRIRAM SUSHMITA
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 Dr. DR. M PRATHYUSHA REDDY

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 6/7/20

Assessment: Patient Complaint for pain.

- 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
2 ^{pm}	Assess the Pt condition	2:30 ^{pm}	Assessed the Pt condition	Pt is Capable.
3 ^{pm}	monitoring vitals.	3:20 ^{pm}	vitals checked & record.	
4 ^{pm}	NST	4:30 ^{pm}	NST done normal.	
5 ^{pm}	D/o chest medication	5:30 ^{pm}	D/o chest medication given	
6 ^{pm}	oral hydration	7:30 ^{pm}	oral hydration given	
6 ^{pm}	Observations		Observation done.	

Re-Assessment: Post Assessment 30 hourly NST

Special Notes: Foley's removed. T/M 6am 7/7/26

Nurse Signature: [Signature]

Nurse Name: Rüdler

Date & Time: 6/7/20 On

BAH-00657750 IP5-00175992
 Mrs SRIRAM SUSHMITA
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 Dr. DR.M PRATHYUSHA REDDY

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/26

Assessment: Pt having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	* Assess the general condition of the Pt	9pm	* assessed the general condition of the Pt	* Now Pt is stable
10pm	* Monitor the vital's	11pm	* monitored the vital's	
12am	* Administer medication as per chart	1am	* Administered medication as per chart	
2am	* Relieve pain & discomfort	3am	* Relieved pain & discomfort	
4am	* maintain I/O chart	5am	* maintained I/O chart	
6am	* ensure safety	7am	* ensured safety	

Re-Assessment: re-assessment done

Special Notes:

Nurse Signature: *[Signature]*

Nurse Name: Durga (607539)

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

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02-10-1999 26 Y 9 M 4 D (F)
Dr. DR. M PRATHYUSHA REDDY

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sushmita Department: OBS Date of Admission: 5/7/26

SITUATION	Diagnosis:	<u>G2A1 39+3 wks come for IOL</u>				Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:		
	Area							
BACKGROUND	Shift Time	<u>OBS 8pm-5am</u>	<u>OBS 8pm-5pm</u>	<u>BBS-III 2pm-5pm</u>	<u>Brdg 8pm-5am</u>			
	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>			
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>97.8</u>	<u>97.8</u>	<u>98.2</u>	<u>98.0</u>		
		Res:	<u>20b/m</u>	<u>20</u>	<u>25</u>	<u>35</u>		
		SpO ₂ :	<u>99.1</u>	<u>99</u>	<u>99.1</u>	<u>98.1</u>		
		Pulse:	<u>84b/m</u>	<u>83b/m</u>	<u>80b/m</u>	<u>89b/m</u>		
		BP:	<u>119/64</u>	<u>123/65</u>	<u>127/81</u>	<u>102/65</u>		
	Fall Risk Score:	<u>20</u>	<u>20</u>	<u>35</u>	<u>20</u>			
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>				
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>sider</u>	<u>yes</u>			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>sandhya</u>	<u>shobha</u>	<u>Rudra</u>	<u>surge</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>05/7/26</u>	<u>6/7/26</u>	<u>6/7/26</u>	<u>7/7/26</u>			
Time:		<u>8am</u>	<u>2pm</u>	<u>5pm</u>	<u>8am</u>			
Taken Over By Name :		<u>shobha</u>	<u>Rudra</u>	<u>Alanya</u>	<u>blanika</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>05/7/26</u>	<u>6/7/26</u>	<u>6/7/26</u>	<u>7/7/26</u>			
Time:		<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8am</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

BAH-00657750
Mrs SRIRAM SUSHMITA
02-10-1999 26 Y 9 M 4 D
Dr. DR.M PRATHYUSHA REDDY (F)

BRADEN 'Q' SCALE

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					Date :	05/12/2016	6/12/17	7/17
					Time :	8am-8pm	8am-8pm	8am-8pm
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:tremitry position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28	20
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	Dr. Shobha	Dr. S. S. S.	Dr. S. S. S.

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

CHECKLIST FOR THROMBOPHLEBITIS

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

NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : *[Signature]* Name : *Sudha*

Signature of Ward In Charge :

Signature : *[Signature]* Name : *Veena*



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7/20	8pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sandhya
5/7/20	10pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sandhya
6/7/20	12AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sandhya
6/7/20	2AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sandhya
6/7/20	5AM	4/10	Abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	fontanylean flow	Sandhya
8/7/20	8AM	0/10	Abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Shobu
6/7/20	10AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Shobu
6/7/20	12PM	2/10	Abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	fontanylean	Shobu
6/7/20	2PM	0/10	Abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	epidural on going	Pully
6/7/20	4PM	0/10	NO PAIN	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NO	Pully

Re-assessment Frequency:

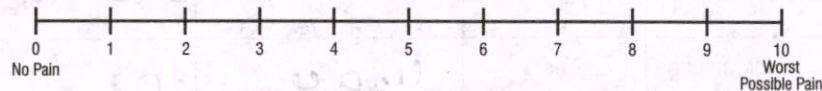
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs 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

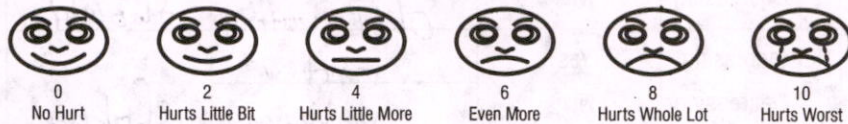
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

2

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/25	6pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pollen
7/7/26	12AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durge
7/7/26	5AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durge
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

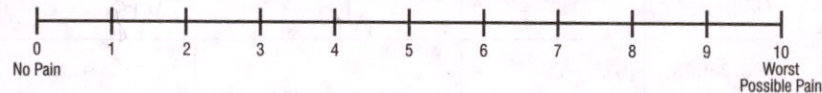
- Every eight hours for all hospitalized patients.
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PAIN ASSESSMENT TOOLS

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 drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
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Wong - Baker (Pediatrics) Above 7 Years



PAIN ASSESSMENT FORM

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

Re-assessment Frequency:

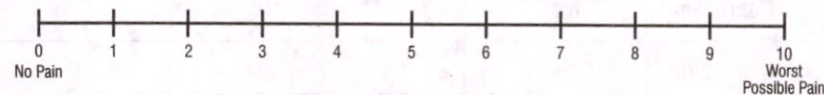
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Wong - Baker (Pediatrics) Above 7 Years



BAH-00657750 IP5-00175992

Mrs SRIRAM SUSHMITA

02-10-1999 26 Y 9 M 4 D (F)

Dr. DR.M PRATHYUSHA REDDY



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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



Morse Fall Risk Assessment Form

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

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



BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?

- ☒ a. Yes ☐ b. No

2. If No, Reason

no

3. Nipple condition:

- ☒ a. Nipple well formed
☐ b. Flat nipple
☐ c. Inverted nipple
☐ d. Short nipple

4. Milk flow:

- ☒ a. Good
☐ b. Drops of colostrums
☐ c. Dry

5. Steps for Positioning and attachment:

- ☒ a. Baby goes to the breast
☐ b. Mother always sits with a back support
☐ c. Ear-shoulder-hip should be in a straight line
☐ d. The baby takes a latch on the areola and not on the nipple



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

☐ a. Yes

☒ b. No

7. For Caesarian mothers:

☐ a. Mother is required sit and feed from the 4th feed

☐ b. Please explain football hold

8. NICU admission:

NO

☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes:

Continuity of Care:

Date: 6/21

DBM given.

burping done.

gown worn

Handover given by

Handover taken by

Signature

Signature

Date & Time: 6/21/2020 4pm

Date & Time:

BAH-00657750
Mrs SRIRAM SUSHMITA
02-10-1999
Dr. DR.M PRATHYUSHA REDDY
26 Y 9 M 4 D
IP5-00175992
(F)

URINARY CATHETER BUNDLE CHECK LIST

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Date of Insertion: 6/7/26 Date of Removal: 7/7/26

Parameters	Date	Shift Time						
Need for the Catheter	6/7/26	8pm to 2pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene	6/7/26	8pm to 2pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment	6/7/26	8pm to 2pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder	6/7/26	8pm to 2pm	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)	6/7/26	8pm to 2pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy	6/7/26	8pm to 2pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?	6/7/26	8pm to 2pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter	6/7/26	8pm to 2pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?	6/7/26	8pm to 2pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?	6/7/26	8pm to 2pm	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care	6/7/26	8pm to 2pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever	6/7/26	8pm to 2pm	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion	6/7/26	8pm to 2pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse	Shobha	Rudra						
Signature of the Nurse								

NT TRANSFER FORM

Patient Name & UHID No. ID: 00657750 IP5-00175992 SRIRAM SUSHMITA 10-1999 26 Y 9 M 4 D (F) DR. M PRATHYUSHA REDDY 		Date & Time of Admission 5/6/2020 6:30 PM	Date & Time of Transfer Order 6/7/2020 6:35 PM
		Transfer Ordered by Dr. S. Sankarshini	Reason for Transfer observation
From Unit BB-41	To Unit Room (302)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 25	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If Yes, what?		Patient shifted with ID band: Yes ☐ No ☐ If No:
Number of Imaging Films 6			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring S.S. Reddy		Name of Person Ordered Transfer Dr. Sankarshini	
Patient & Clinical Records Received by : Alexy			
Date & Time of Patient Received : 6/7/20 7 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

BAH-00657750 IP5-00175992
Mrs SRIRAM SUSHMITA
02-10-1999 26 Y 9 M 4 D (F)
Dr. DR.M PRATHYUSHA REDDY



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 05/07/2026

Baseline Information:

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

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

Chief Complaints: Doctor Notified on Admission: ☒ Yes ☐ No
come for fol Name of the Doctor: Dr. shanthi
..... Time Notified: 5:39 pm
.....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Well	Rt fibroadenoma. Excision 2023	Well
Gynecology Assessment: ☐ Not Applicable Menstrual History: Onset of Menarche: Menstrual Cycle: ☒ Regular ☐ Irregular Last Menstrual Period: <i>Regular</i>	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 2 P L A 1

Previous LSCS:

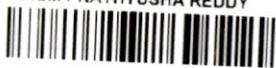
Current Medication: ☒ None ☐ Yes, If Yes, Fill the reconciliation form

Family History: ☒ No Abnormalities Detected

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

Vital Signs / Measurements: Temp: 97.6 F HR: 80 bpm RR: 20 bpm
BP: 119/64 Weight: 104 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 ...20... (complete the Morse Fall Risk Assessment Sheet)

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

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

Orientation has been given regarding the following aspects:

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

Above information given to patient

Name of Person Orientation was given to: sushmita

Orientation not given Reason: NA

Nurse Signature: [Signature]

Nurse Name: sushmita

Date & Time: 5/7/2020 10 pm



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 5/2/26 Time of Arrival: 5:40pm Time Seen by Nurse: 5:42pm

1) **Level of Consciousness:** ☒ Conscious ☐ Semi-Conscious ☐ Unconscious

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

- ☐ Severe Pain / Moderate Pain ☐ Preterm rupture of Membranes / Leaking Water PV
☐ Bleeding PV: Slight / Heavy ☐ Preterm Labor/ Labor
☐ Decreased Fetal Movement ☐ Spontaneous Rupture of Membrane / Leaking Water PV
☐ No Fetal Movement ☐ Other Reason: 20L

3) **Vital Signs:** Temperature: 97.2 Pulse: 84b/min RR: 20b/min SpO₂: 99.1 BP: 119/69 Weight: 104

4) **Gestational Criteria:**

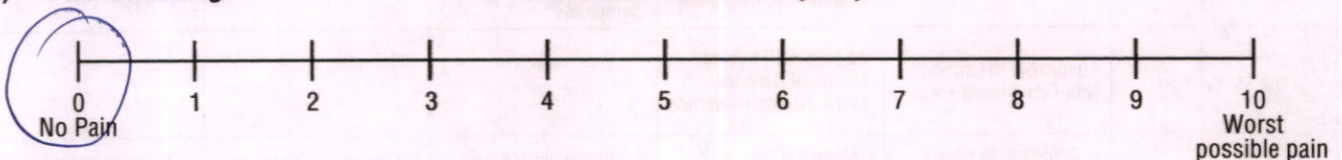
Gravida:	G <u>2</u>	P <u>-</u>	L <u>-</u>	A <u>1</u>
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LMP: 29/9/25 EDD: 9/2/26 Gestational Age: 39+3 wks

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

5) **Pain Screening:**

Numerical Pain Scale (NPS)



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

6) **Past History:**

- a) Surgeries: well
b) Medical: well



7, If Yes :

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

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: Dr. Suthi

Nurse Name : Sandhya Nurse Signature: [Signature]

Date: 5/2/20 Time: 10pm

BAH-00657750 IP5-00175992
Mrs SRIRAM SUSHMITA
02-10-1999 26 Y 9 M 4 D (F)
Dr. DR.M PRATHYUSHA REDDY

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Part
Pati

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

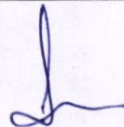
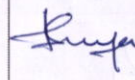
Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
5/7/20	6pm	4	Informed Consent	PI	1	0	1	1		
5/7/20	10pm	2	Infection control measures	PI	1	0	1	1	-	

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: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
5/7/22 6pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	for JOL	Safe delivery	NWD		☐ Nursing ☐ Others:
5/7/26 10pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient having fear and Anxiety	Reduce the fear and Anxiety	provided Psychological support		☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

BAH-00657750 IP5-00175992

Mrs SRIRAM SUSHMITA

02-10-1999

26 Y 9 M 4 D

(F)

Dr. DR.M PRATHYUSHA REDDY



CONSENT FOR LABOUR ANALGESIA

Authorization By: ☒ Patient ☐ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of the procedure as follows:

☒ Epidural Analgesia ☐ Intravenous Analgesia (Remifentanyl)

- I have been made aware of the possible complications from the procedures as follows:

For Epidural: Fall in blood Pressure, Numbness, Itching, Headache, Shivering, Occasional incomplete pain relief, Need for Re-Siting the epidural.

For Remifentanyl: Drowsiness, nausea, vomiting, need for oxygen supplementation, itching, fall in blood pressure, heart rate and Respiratory Rate.

- I understand that labour analgesia is offered to reduce labour pain and make the birthing process more comfortable, by reducing pain and stress and promoting better cooperation during childbirth.
- I have been clearly explained about the benefits, risk, and alternative of the procedures.
- I authorize Dr. Tejaswini and his / her team to perform the above procedure(s) upon the patient / myself.
- 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: S. Sushmita

Name: Sushmita

Relationship with patient: self

Date & Time: 6/7/26

Witness:

Signature: S. Chaitanya

Name: S. Chaitanya

Date & Time: 6/7/26 1:20 AM

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. Tejaswini

Date: 6/7/26 Time: 1:20 AM

ప్రసవ నొప్పి నివారణ కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

వైద్యులు నాకు తెలిసిన భాషలో క్రింది విధానాల గురించి సమగ్రంగా వివరించారు:

- ☐ ఎపిడ్యూరల్ అనాల్జీసియా
☐ శిరస్రావం ద్వారా నొప్పి నివారణ (రెమిఫెంటానిల్)

- ఈ విధానాల వల్ల సంభవించగలిగే సమస్యలను కూడా నాకు వివరించారు:

ఎపిడ్యూరల్ సంబంధించినవి:

రక్తపోటు తగ్గడం, మందత్వం/ స్వల్పలేమి, దద్దుర్లు/ దురద, తలనొప్పి, వణుకు, అప్పుడప్పుడు పూర్తిగా నొప్పి తగ్గకపోవడం, ఎపిడ్యూరల్ మళ్ళీ పెట్టాల్సిన అవసరం.

రెమిఫెంటానిల్ సంబంధించినవి:

నిద్రమత్తు, వాంతి భావం, వాంతులు, ఆక్సిజన్ అవసరం పెరగడం, దద్దుర్లు/ దురద, రక్తపోటు తగ్గడం, గుండె వేగం తగ్గడం, శ్వాస రేటు తగ్గడం.

- ప్రసవ నొప్పిని తగ్గించడం, ప్రసవ ప్రక్రియను సాకర్వవంతంగా చేయడం, 'నొప్పి మరియు ఒత్తిడిని తగ్గించడం, ప్రసవ సమయంలో సహకారం మెరుగు పరచడం కోసం లేబర్ అనాల్జీసియా అందించబడుతుందని నేను అర్థం చేసుకున్నాను.
- ఈ విధానాల ప్రయోజనాలు, ప్రమాదాలు మరియు ప్రత్యామ్నాయాల గురించి నాకు స్పష్టంగా వివరించబడింది.
- డాక్టర్ _____ గారికి మరియు వారి బృందానికి, పై విధానం(లు)ను నాకు / రోగికి నిర్వహించడానికి నేను అనుమతి ఇస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు ఆ ప్రశ్నలకు నాకు అర్థమయ్యే భాషలో సంతృప్తికరంగా సమాధానాలు అందాయి. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన చిత్తంతో ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

INFORMED CONSENT FOR VAGINAL BIRTH

BAH-00657750
Mrs SRIRAM SUSHMITA
02-10-1993 26 Y 9 M 4 D (F)
Dr. DR. M PRATHYUSHA REDDY
IP5-00175992

thRight™
JINBOW HOSPITALS
Right to a Safe Delivery

Patient Name : Mrs. Sushmita UHID No : 657750
Gender: ☐ Male ☒ Female Date : 5/7/20 Time : 6pm

I hereby authorized the performance of the following procedure:

- The Procedure has been explained to me in general terms and I understand that:
- The indication requiring the procedure of vaginal birth is pregnancy.
- The purpose of this procedure of vaginal birth pregnancy.
- The purpose of this procedure is to deliver the bay vaginally.

The outcome of the vaginal birth is the delivery of infant through birth canal either naturally or with possible use of force vacuum extraction. An episiotomy (a cut performed for enlarging of the vaginal opening in the space between the vaginal and the rectum) may be performed as part of a vaginal delivery.

Should vaginal delivery be unsuccessful, delivery by cesarean section with an abdominal incision under appropriate anesthesia may be necessary.

In an attempt to deliver the baby either naturally or with the help of instrument i.e. forceps or vacuum, there may be risks of: infection, allergic reaction, scarring, blood loss, need for blood transfusion, pain and discomfort, injury to urinary tract, possible injury to the baby (laceration, hematoma, skull fracture, nerve injury and brain injury) and possible future pelvic floor dysfunction,

I understand and accept that there are complications, benefits, alternatives including the remote risk of death or serious disability, which exists for me and my baby.

I am aware that in most cases, vaginal delivery results in a healthy mother and baby; however, I realize that there are no guarantees.

I voluntarily consent to the procedures described or otherwise referred to herein. I am aware that they will be performed by a qualified gynecologist.

Name of the Doctor performing the procedure: Dr. Prathyusha

Consentee :

Signature : S. Sushmita

Name :

Date & Time : 5/7/20 @ 6pm

Witness :

Signature : [Signature]

Name : Sandhya

Date & Time : 5/7/20 @ 9pm

Docu. No. : RCHBH / FRM / CLINICAL / 028

Patient Attendant :

Signature : S. Chaitanya

Name : S. Chaitanya

Relationship with Patient : Sister

Date & Time : 5/7/20 @ 6pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Prathyusha

Date & Time : 5/7/20 @ 6pm

సహజ ప్రసవం కొరకు సమ్మతి పత్రము

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. బిభాగము

తేదీ

ఈ ప్రక్రియ యొక్క వివరములను నేను ఆమోదించాను:

- ఈ ప్రక్రియ నాకు సాధారణ పద్ధతిలో బివరించబడింది మరియు నేను అర్థం చేసుకున్నాను:
- గర్భం దాల్చిన వారికి సహజ ప్రసవ ప్రక్రియ అవసరమవుతుంది.
- ఈ ప్రక్రియ యొక్క ఉద్దేశ్యం (యోని) ద్వారా సహజ ప్రసవం చేయడం.
- ఈ ప్రక్రియ యొక్క ఉద్దేశ్యం జడ్డను సహజమయిన పద్ధతిలో ప్రసవించటం

సహజ ప్రసవం (యోని జననం) యొక్క ప్రక్రియ సహజంగా లేదా శక్తిని ఉపయోగించి గర్భాశయం ద్వారా శిశువును ప్రసవించడం. వాక్యూమ్ ద్వారా శిశువును వెలికితీయడం, ఎసిసియోటమీ (యోని మరియు యోని మధ్య ఖాళీలో యోని మార్గమును సుగమం చేయుట కొరకు చేసిన కోత (కట్). సహజ ప్రసవం కొరకు చేయ ప్రక్రియలలో భాగము.

సహజ ప్రసవం బిజయవంతం కాకపోతే, తగిన అనస్థీసియా ఇచ్చి పొత్తికడుపు కోతతో సిజేరియన్ ద్వారా డెలివరీ చేయవలసిన అవసరం కలగవచ్చు

సహజంగా లేదా పరికరం సహాయంతో అంటే ఫోర్స్ప్స్ లేదా వాక్యూమ్ సహాయంతో జడ్డను ప్రసవించే ప్రయత్నంలో, ప్రమాదాలు ఉండవచ్చు: అంటువ్యాదులు, అలెర్జి, మచ్చలు, రక్త నష్టం, రక్త మార్పిడి అవసరం పడటం, నొప్పి మరియు అశాకర్మ్యం, మూత్ర నాళానికి గాయం, శిశువుకు గాయం అయ్యే అవకాశం (ప్రెనరేషన్, హిమటోమా, పుర్రె గాయం ఆయె అవకాశం, నరాలకు గాయం మరియు మెడడు గాయం) మరియు భవిష్యత్తులో కటి ప్రదేశంలోని ఎముకల వలయం పనిచేయకపోవడం

నాకు మరియు నా జడ్డకు మరణం లేదా తీవ్రమైన వైకల్యం వంటి సమస్యలు తలెత్తు అవకాశం, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు ఉన్నాయని నేను అర్థం చేసుకుని అంగీకరిస్తున్నాను.

చాలా సందర్భాలలో, యోని ద్వారా ప్రసవించడం వల్ల తల్లి మరియు జడ్డ ఆరోగ్యంగా ఉంటారని నాకు తెలుసు; అయితే, ఎటువంటి హామీలు ఇవ్వలేరని నేను గ్రహించాను

ఇక్కడ బివరించిన లేదా సూచించిన విధానాలకు నేను స్వచ్ఛందంగా సమ్మతిస్తున్నాను. ఈ ప్రక్రియ అర్హతగల గైనకాలజిస్ట్ చేత నిర్వహించబడతాయని నేను తెలుసుకున్నాను

ఈ ప్రక్రియను నిర్వహించే డాక్టరు పేరు:

సహాయకుడు(అటెండెంట్) సాక్షి

సంతకము సంతకము

పేరు పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో) తేదీ మరియు సమయము

సంతకము

పేరు

BAH-00657750 IP5-00175992
Mrs SRIRAM SUSHMITA
02-10-1999 26 Y 9 M 4 D (F)
Dr. DR.M PRATHYUSHA REDDY
[Barcode]

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INDUCTION OF LABOR CONSENT

Name: Mrs Sushmita Age: 27 Gender: Male ☐ Female ☒
UHID.No : 657750 Date: 5/7/20

You are scheduled for an induction of labor on 5/7/20 (date) at 3:30 (weeks of gestation).

The reason for your induction is Term

The goal of induction of labor is to achieve vaginal delivery by starting uterine contractions before the spontaneous start of labor.

Induction of labor for a medical indication is done when continuation of pregnancy is considered detrimental to the health of the mother or fetus. This can be done at any stage of pregnancy irrespective of fetal maturity if there is a valid indication.

Elective induction of labor (scheduled induction without a medical indication) may not be done until you are at least 39 weeks. This is important so that your newborn does not have complications due to possible prematurity.

The alternative to induction of labor is to wait for labor to start spontaneously.

I have read the information provided and also discussed the process with my doctor.

I understand the risks and benefits of this procedure and wish to proceed.

Patient

Signature: S. Sushmita

Name: _____

Date & Time: 5/7/20 @ 6pm

Patient Attendant:

Signature: S. Chaitanya

Name: S. Chaitanya

Relationship with Patient: Sister

Date & Time: 5/7/20 @ 6pm

Doctor:

Signature: [Signature]

Name: Dr. Arshay

Date & Time: 5/7/20 @ 6pm

Witness

Signature: [Signature]

Name: Sandhya

Date & Time: 5/7/20 @ 9pm

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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 05/07/2016

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☒ Transfer

Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

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

No need assistance

4. Nutritional Plan:

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

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: Hand hygiene

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

☐ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Sandhya

Date and Time: 5/7/2016 @ 10pm

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Time Received : Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂											250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0
	IV Cannula Site : ☐ O ₂ 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: Oral Feeds:										

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

Anaesthesiologist Name :

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time:

Reassessment Frequency:

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

Transferred to Unit by (PACU):

Date & Time:



Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: 6/7/2026 Time: 2:15 AM Procedure done by Dr. Tejaswini

CSE / Spinal / Epidural ☒ Position: Sitting Space: L3-L4 Technique (LOR/LOS) ☒

Depth: 6.5 cm Catheter at Skin: 12 cm Attempts: 1

Parasthesia: Yes/No if yes details:

Solution Composition: 0.1% BUPIVACAINE + 2mcg/ml FENTANYL

Any other issues:

a)

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right		Maternal		FHR	Comments
					BP	Pulse		
6 AM		6ml 1.8% LOR + ADK			125/66	82/min	137/min	comfortable
6:05 AM	8ml/hr					83/min	128/min	comfortable
8:36 AM	8ml/hr	2.5 ml	T6	T8	116/70	76/min	116/min	comfortable
10:00 AM	8ml/hr	8ml 1.8% LOR + ADK	T8	T8	120/70	78/min	119/min	comfortable
12 pm	8ml/hr				118/68	81	140	

Delivery Details: Time: 3:02 PM APGAR: 8, 9 SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected:

Patient Satisfaction:

Discharge / Shifting ordered by

Doctor Signature:

Doctor Name: Dr. Sushma

Date and Time: 6/7/26 2:15 pm

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00657750 IP5-00175992
Mrs SRIRAM SUSHMITA (F)
02-10-1999 26 Y 9 M 4 D
Dr. DR.M PRATHYUSHA REDDY

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Name: Sriram Sushmita Age: 26 Y Sex: Female UHID.No: BAH-00657750
Date: 6/7/2026 Time: 1:20AM Proposed Operation: Labour Epidural
Diagnosis: G1A1 39+3 wks.
B.P / CRT: H.R: Weight: 99kgs ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 11.1 Glucose: Protein: HIV: X-Ray:
PCV: Urea: Alb: HBS Ag: ECG:
WBC: 12,360 Creat: Total Bill: HCV: 2D Echo:
Plate: 2.86 Na: Dir. Bill: Blood group: Stress/Anglo:
PT: K: LDH: T3: Other:
PTT: Ca++: Alk phos: T4:
INR: Mg++: Amylase: TSH:
Cl-: SGOT/SGPT:

Allergies: NKDA.

Medical History: CVS :

RESP :

Diabetes :

CNS :

not significant.

Renal :

Hepatic / GE :

Physical Activity: Active

Others :

Past Anaesthetic History:

Physical Exam:

Airway:

MP 1 2 3 4

Mouth Opening: Adequate

Mentohyoid Distance: 2FB

Neck: (N)

Teeth: intact

Lungs :

Heart:

CNS:

Pregnant: ☒ Yes ☐ No ☐ NA

Venous Access Site: 18G RUL Spine Exam for regional: (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Signature: [Signature] Name: Dr. Tejaswini