Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176172 **Admit Date** : 09-Jul-2026 **Admit Time** : 10:21 PM **UHID** : BAH-00635073

Patient Details :

Patient Name	: Mrs.B SHRUJITHA	**Age**	: 28 Y 0 M 24 D
Guardian	: Mr SAI CHARAN REDDY	**DOB**	: 15-06-1998
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: #FLAT NO 402, KSR TIRUMALA RESIDENCY Hastinapuram Hyderabad Telangana INDIA 500074	**Phone No**	: 9247733756/ 9985531519
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : SHARED WARD **Bed No** : SW 414 **Ward Name** : 4F-BIRTHING CENTRE

Room No : SW 414 **Admission Type** : First Visit

Contact Details :

Name : Mr SAI CHARAN REDDY **Relationship** : Husband

Contact Address : #FLAT NO 402, KSR TIRUMALA RESIDENCY Hastinapuram Hyderabad Telangana INDIA 500074 **Phone No** : 9247733756 / 9985531519

Signature

Doctor Details :

Doctor Name : Dr. SHRUTHI REDDY/Dr.LAVANYA JANAGAMA **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 0.00

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

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ACTIVITY RECORD FOR BILLING

Name :_ BAH-00635073 IP5-00176172
Mrs B SHRUJITHA
15-06-1998 28 Y 0 M 25 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

UHID No _____ Consultant: _____ Dept : _____

Date of Admission: _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7/26	4:10 pm	OR3	Room(303)	Jun

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
9/7/24	CBP	26068790	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
9/7/24	IV placement	1	9695462	Tunne

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00635073 IP5-00176172
Mrs B SHRUJITHA
15-06-1998 28 Y 0 M 25 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

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BY K... Your Right...

BAH-00635073

I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 9/1/26 Time of Admission : .....

Allergies: ..... ☐ ~~Not~~ know any drug allergies

PRESENTING COMPLAINTS :

G2A1 Sp conception booked at. 7weeks, scan done at 12 weeks showed kyphoscoliosis. of thoraco Lumbar spine.
9/1/26. SLF/16th wks / spine kyphoscoliosis. of thoraco/lumbar spine.
Consulted paediatric Neurosurgeon, Geneticist

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 2022.	Parity : G2A1.
Previous Periods : irregular.	Mode of Delivery : 1- Sp miscarriage at 11 weeks. MERPC, Pb removal of RPOC
LMP : 27/2/26. EDD- 14/12/26.	Last Child Birth : (DFC).
Contraception :	2- Sp Conception

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil.	Nil.

[redacted] SHRUJITHA IP5-00176172
28 Y 0 M 25 D (F)
15-06-1998
Dr. SHRUTHI REDDY/Dr.LAVANYA

	MEDICATION HISTORY:
Fathe - HTN.	T. Mifegest 200mg. stat (8/7/26). T. Fcm T. shelcal.

INITIAL ASSESSMENT :

Date 9/7/26 Ht. ____ Wt. ____ BMI ____ B.P 110/70 Pallor (-) CVR S1S2 (+) Respiratory System BAE (+) Thyroid (N)	Breasts Abdominal Examination	Local/Speculum Examination P/V, Cx long, closed. Bimanual Pelvic Examination

PROVISIONAL DIAGNOSIS : G2A1. 17+2 wks, Kyphoscoliosis in fetus for TOP.

INVESTIGATIONS ORDERED	**PLAN OF MANAGEMENT**
A(+)ve Urals - NR.	Admission prep of parts send CBP Check blood availability urals 4th T. PGE2 800mcg P/V stat. (WES, SMA) → Test. Present

Name of the Doctor : Dr. Arshey

Signature of Doctor ____

Date & Time : 9/7/26, 11pm.

BAH-00635073 IP5-00176172
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26. 2.12 Am	Male: Fetus Expelled at 2.10 Am, wt 1990gm placenta expelled at 2.25 Am wt 100gm	
	Gravida afebrile. PR - 84/min BP - 110/70 mmHg. SpO2 - 99% @ RA P/A - Ut retracted well. P/V - NAD	adv - vitals 4th hrly - Drug as charted - send Fetus for fetal testing (1) WES + SMA test (Spinal muscular atrophy Carrier Screen) - N/p cath Bleeding - Informed Dr Ashaye
10/7/26 4 Am	No Complaints Gravida afebrile PR - 90/min BP - 110/70 mmHg SpO2 - 98% @ RA P/A - Ut (R) well P/V - NAD	adv (1) NBM From 7 Am (2) RBC Scan today (3) Start (1/4) Fluids at 7 Am (4) Drug method (5) N/p cath Bleeding (6) Vital Monitory (7) Inform Dr Noted BM Sumaya

Patient Sticker

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150 baby
109 placenta

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/4/2025 9Am	A2 (PAD-0)	
	GC: fair vitals: stable P/A: soft BS (+) P/V: NAB	1) NBM 2) IV fluids - 100ml/hr 3) RPOC - @ LG scan @ 10 hrs 4) Drug as charted 5) w/f P/V Bleeding 6) Monitor vitals q4h 7) Inform SOS
Adv informed consent.		- Dr. Swathi
	Under aseptic conditions, perineum painted and draped. ant and post vaginal wall retracted with Sim's speculum. Ant. lip of cervix held with sponge holder. Under USG scan guidance, RPOC removed. Post procedure USG scan done no evidence of RPOC / minimal RPOC.	
plan Discharge		

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/2026 12:41PM	A2 - Post Dilatation & curettage pt comfortable and stable	
	O/E	
	Afebrile	Adv
	BP-100/85mmHg	① Tab dicl
	PR- 82 bpm	② Hydration
	SpO2 - 98% RA	③ Ambulation
	P/A- soft	④ Drug as charted
	ot ⓡ clear.	⑤ Monitor vitals 4th hrly
voided		⑥ Inform SOS
Shift to Room		
Plan discharge		Dr. Dilraj

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

BAH-00635073 IP5-00176172
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15-06-1998 28 Y 0 M 25 D (F)
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RESULT SHEET

Date	9/7/25					
Time	@ 11pm					
Hb	9.8					
PCV	31.3					
RBC	4.24					
WBC	13.54.					
N/L						
Platelets	3.10					
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 → Ave.						
Mantoux - NR.						

Culture and Sensitivities : .....

.....

.....

.....

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: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. Iron	1tab	Po	OD		☐ C ☐ ~~DC~~
2	T. Shelcal	1tab	Po	∞		☐ C ☐ DC
3	T. Nifegest.	Loomy	Po	Stat		☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr Arthy
Date & Time : 9/7/25, 10pm.

Nurse Name & Signature: Tunnel.
Date & Time : 9/7/26 @ 10pm

BAH-00635073 IP5-00176172
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DRUG CHART

Date of Admission: 9/7/26 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:				

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

Mrs B SHRUJITHA
15-06-1998 28 Y 0 M 25 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

REGULAR PRESCRIPTIONS

Weight. .... Ward. OBG

DRUG : Inj CEFOTAXIME				Date/Time	10/7
Dose	Route	Frequency	Start Date		
1gm	IV	BD	10/7	6 AM	
Name & Signature of the Doctor Starting the Drugs: Dr. Arathy					
Additional Instructions:				6 pm	
Daily Doctor's Endorsement by a Sign					

DRUG : T. PARACETAMOL				Date/Time	10/7
Dose	Route	Frequency	Start Date		
1gm	PO	TID	10/7	6AM	
Name & Signature of the Doctor Starting the Drugs: Dr Arathy					
Additional Instructions:				2PM	
				10PM	
Daily Doctor's Endorsement by a Sign					

DRUG : T. PANTOP				Date/Time	10/7
Dose	Route	Frequency	Start Date		
40mg	PO	BD	10/7	6AM	
Name & Signature of the Doctor Starting the Drugs: Dr. [illegible]					
Additional Instructions:				6PM	
Daily Doctor's Endorsement by a Sign					

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

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15-06-1998 28 Y 0 M 25 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

Weight. ..... Ward. ..... DPY

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
9/11/25	11pm	T. PCM	800mg	P/V	dm.	Tunny Prasanth
10/11/25	12AM	Inj PARACETAMOL	1gm	IV	dh.	Tunny Prasanth
—	—	T PCM	400mg	P/O	d.	Not given
10/7	2:15 AM	Inj oxyflocin	100	IM	A	Tunny Prasanth
10/7	2:30 AM	T. PCM	400mg	P/O	L.	Tunny Prasanth
10/7	3AM	T. CABERGOLINE	0.5mg×2	P/O	L.	Tunny Prasanth
10/7	2AM	Inj TRAMADOL	100mg	IV	dh.	Tunny Prasanth

BAH-00033073 IP-3011701172

Mrs B SHRUJITHA

15-06-1998 28 Y 0 M 25 D (F)

Dr. SHRUTHI REDDY/Dr.LAVANYA

I.V. FLUIDS CHART

Weight. - Ward. OBS

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
10/7	2:30 AM	RINGER LACTATE	IV	100		Tunny / Keerthi	10/7		Tunny / Keerthi
10/7	7AM	RINGER LACTATE	IV	100		SM / SM			
10/7	10A	RINGER LACTATE	IV	100					

Signature .....

VERIFIED BY : Name .....

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Early Warning Observation Score Chart - Obstetrics

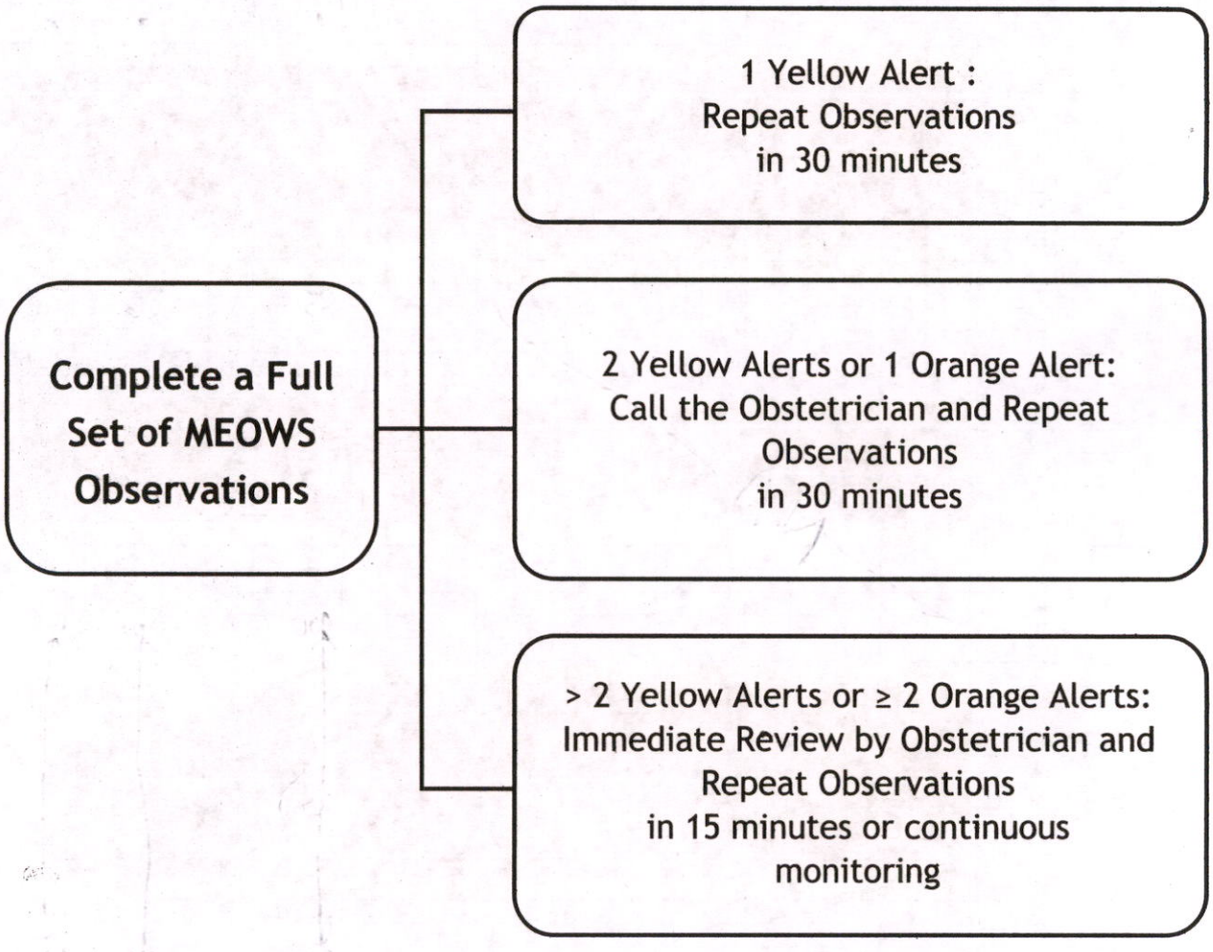
CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

		Date	9/7/24																							
		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																19				19		20		21	
	0 - 10																									
Saturations	94 - 100 %																98				98		98		97	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																85				86		84		87	
	80																									
	70																									
	60																									
	50																									
	40																									
↑ Systolic Blood Pressue	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																100				100		100		108	
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
↓ Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert																A				A		A		✓	
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																✓				✓		✓		✓	
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																								✓	
	Heavy / Foul																									
Liquor	Clear / Pink																								✓	
	Green																									
TOTAL YELLOW SCORES																	0				0		0		0	
TOTAL ORANGE SCORES																	0				0		2		1	
Nurse Initial																	TUN				TUN		TUN		✓	

NA

(84) (87)

Obstetrics and Gynaecology Early Warning Signs



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

BAH-00635073 IP5-00176172
Mrs B SHRUJITHA
15-06-1998 28 Y 0 M 25 D (F)
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10/7/26

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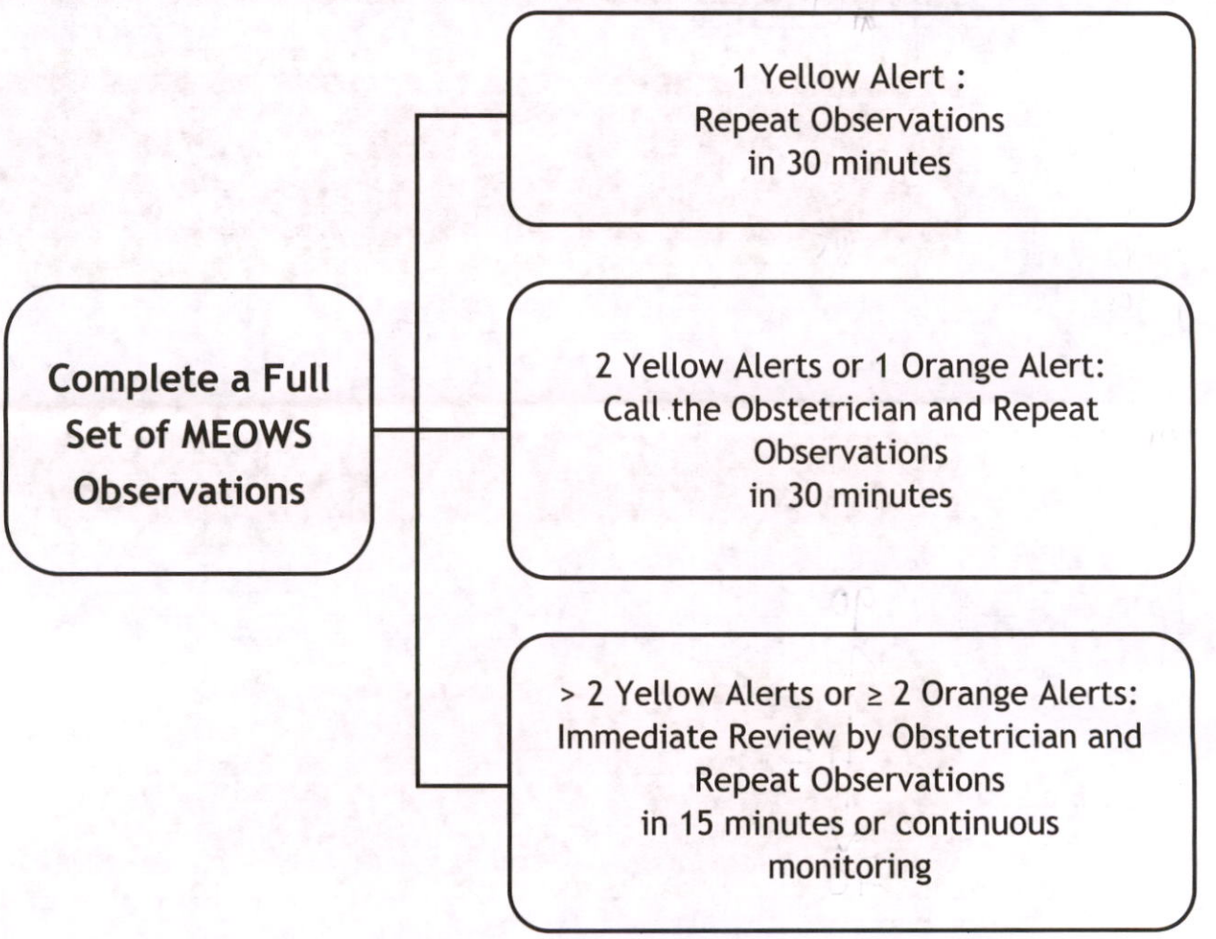
CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

		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			21																						
	0 - 10																									
Saturations	94 - 100 %			98%																						
	< 94 %																									
Administered O, (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37			97.6°F																						
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110				87																					
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120			90																						
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90			70																						
	80																									
	70																									
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert			✓																						
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES					0																					
TOTAL ORANGE SCORES					0																					
Nurse Initial					B																					

Obstetrics and Gynaecology Early Warning Signs



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

BAH-00635073 IP5-00176172
Mrs B SHRUJITHA
15-06-1998 28 Y 0 M 25 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

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FLUID CHART

Sheet No. : 1

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

Date	Time	Intake: Nature of Fluid	Intake: Route: Mouth	Intake: Route: I.V	Intake: Route: N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm									✓	0	Tunny
a/t	11:00 pm		H2O				NP 1				0	Tunny
	12:00 am									✓	0	Tunny
	01:00 am		H2O								0	Tunny
Total Intake : Taken						**Total Output :** U - 2 IM - 0						
	02:00 am		H2O								0	Tunny
	03:00 am		H2O				1			✓	0	Tunny
	04:00 am						NP				0	Tunny
	05:00 am		H2O				1				0	Tunny
	06:00 am										0	Tunny
	07:00 am		NBM								0	Tunny
Total Intake : Taken						**Total Output :** U - 1 M - 0						

Total 24 hrs. Intake		Total 24 hrs. Output	U - 3 M - 0

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10/7/26

FLUID CHART

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Sheet No. : 2

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G						0	
	08:00 am	↓		100ml							0	
	09:00 am	↓	NPO	100ml							0	
	10:00 am			100ml							0	
	11:00 am	RL		100ml							0	
	12:00 pm	↑										
	01:00 pm	↑										
Total Intake :						Total Output : U:- M:-						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☑ Night

Date: 9/7/26

Assessment: Patient complaints of fear & 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
10pm	=> Assess the pt condition	11pm	=> Assessed the pt condition	pt is comfortable
12Am	=> Regular diet	2Am	=> IDDy given	
1Am	=> Administration medication	2Am	=> medication given as per drug chart	
3Am	=> IV placement & IV fluids	5Am	=> IV placement done & IV fluids ongoing	
5Am	=> Ensure safety	6Am	=> Side rails provided	
7Am	=> U/O monitoring	8Am	=> U/O monitoring done.	

Re-Assessment: Vitals Stable, pt Comfortable.

Special Notes: W/f bleeding P/V, Pain assessment

Nurse Signature: PM Nurse Name: Punny Date & Time: 10/7/26 @ 8Am

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night Date: .....

Assessment: .....

.....

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment: .....

.....

Special Notes: .....

.....

Nurse Signature: ..... Nurse Name: ..... Date & Time: .....

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr Shruthi Department: OBG Date of Admission: 9/7/26

SITUATION	Diagnosis: G2A1/1T+2 wks / Kyphoscoliosis in fetus for TOP				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time	OBG 8PM-8AM					
	Medical Condition (Any special condition to be noted):	NA					
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:	98°F					
	Res:	20					
	SpO_2:	98%					
	Pulse:	82bpm					
	BP:	100/60					
	Fall Risk Score:	20					
	Pain Score:	0					
Recommendations	Safety Needs:	Yes					
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	NO					
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	NA					
Post Operative Procedure Special Orders:		NA					
Handed Over By Name :		TJM					
Signature :							
Date:		10/7/26					
Time:		8AM					
Taken Over By Name :		Lakshmi					
Signature :							
Date:		10/7/26					
Time:		8AM					

Patient Sticker

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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:							

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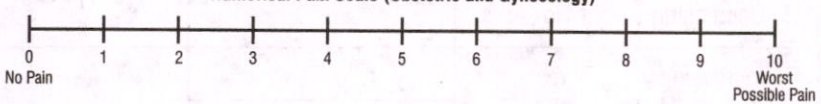
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7/26	10 pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Tunny
10/7/26	2 Am	4/10	Abdomen pain	☐ Continuous ☑ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Inj. Tramadol given	Tunny
10/7/26	3 Am	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Delivered	Tunny
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Patient ID

BRADEN 'Q' SCALE

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				Date :	9/4/24			
				Time :	8pm - 8am			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	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			
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			
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			
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
				TOTAL SCORE	28			
				Evaluator's Name	TVM			

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 9/7			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			—							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			—							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			—							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			—							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			—							
			Signature of the Nurse			Tunny							

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 : ..... Name : Kranthi

Signature of Ward In Charge :

Signature : ..... Name : Veeny

Docu. No. : RCHBH /FRM / CLINICAL / 137

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Morse Fall Risk Assessment Form

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Choose Highest Applicable Score from each Category		Score	Date / Time: 9/7/26 8PM		
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0		
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0		
IV / Heparin Lock or Saline	Yes	20	20		
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0		
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0		
Total Morse Fall Scale Score:			20		
		Signature	Tunal		

Fall Risk Grading

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

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

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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
9/7/26 10pm.	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Kyphoscoliosis.	Termination of pregnancy	Termination. Pregnancy		☐ Nursing ☐ Others:
9/7/26 @10pm	☐ Medical ☑ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Safety	prevent infection	Hand hygiene Maintain	Tunne	☐ 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:

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need 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		
9/8/26	11pm	1,7	Informed Consn	PT	1	0	1	1		
9/8/26	11 pm	7	Explain about infection Control	P, S	1	0	1	1		Tunny

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
2. Physical Impairment
3. Emotional Barriers
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process/Cognitive limitations
8. Responsibilities at Home
9. Cultural Differences
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision/ or Hearing
13. Cultural/Religion Practice
14. Others (Specify .....

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

Mechanism/s to overcome barrier/s:

1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / Others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify .....

Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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Mrs B SHRUJITHA
15-06-1998 28 Y 0 M 25 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 9/7/26 Time of Arrival: 10:00 PM Time Seen by Nurse: 10:15 PM

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

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

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

3) **Vital Signs:** Temperature: 98°F Pulse: 82 RR: 20 SpO_2: 99% BP: 100/70 Weight: —

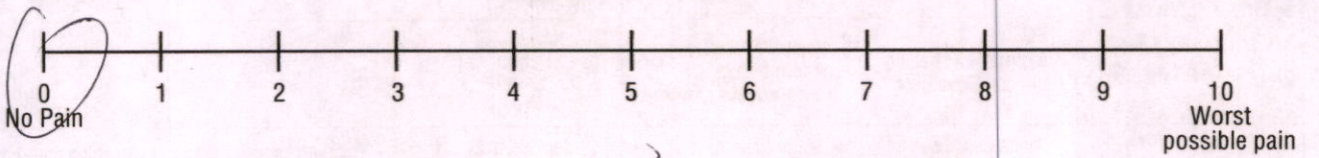
4) **Gestational Criteria:**

Gravida:	G 1	P —	L —	A —

LMP: 27/2/26 EDD: 14/12/26 Gestational Age: 17+2 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: ——
- Duration: ..... Days / Weeks/ Months (Strike out which is not applicable)
- Character: No Pain
- Frequency: .....
- Interventions: .....

6) **Past History:**

a) Surgeries: Nil

b) Medical: Nil

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

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

9) Prenatal Medical History:

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 Hours)
Re-Assessment	Continuous Nursing Care	Every 15 Minutes	Every 15 Minutes	Every 30 Minutes	Every 60 Minutes
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SROM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (<spotting) <37 weeks	Bleeding associated with cramping (>spotting) >37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension >140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	• Acute onsite severe abdominal pain • 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: 10:20 pm.

Nurse Name : Tunny Nurse Signature: .....

Date: 9/7/26 Time: 10:30 pm

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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: .....

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: TOP

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Arshiya

Time Notified: 10:20 pm.

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	Nil

Gynecology Assessment: ☐ Not Applicable

Menstrual History: Regular

Onset of Menarche: —

Menstrual Cycle: ☑ Regular ☐ Irregular

Last Menstrual Period: 27/2/26

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 2 P — L — A 1

Previous LSCS: NO

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

Family History: ☐ No Abnormalities Detected

☐ Heart Disease ☑ Hypertension (CP) ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 98°F HR: 89 RR: 20

BP: 100/60 Weight: — Height: — BMI: —

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

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PHYSICAL ASSESSMENT

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

Fall Assessment: ☑ Yes ☐ No Score .....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 ..family.....

Orientation has been given regarding the following aspects:

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

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

Above information given to .....patient.....

Name of Person Orientation was given to: .....Tunu.....

Orientation not given Reason: .....NA.....

Nurse Signature: .....TM.....

Nurse Name: .....Tunu.....

Date & Time: .....9/7/26 @ 10:30pm

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00635073 IP5-00176172 Mrs B SHRUJITHA 15-06-1998 28 Y 0 M 25 D (F) Dr. SHRUTHI REDDY/Dr.LAVANYA	9/7/26 @ 10:21 pm	10/7/26 @ 4Am
	Transfer Ordered by Dr. Arshiya	Reason for Transfer Observation
From Unit OBS	To Unit Room (303)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 40	Number of Imaging Films Nil	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.	Nil	
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Tunu	Dr. Arshiya

Patient & Clinical Records Received by : Sumana

Date & Time of Patient Received : 10/7/26 @ 4:30Am

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

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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: 12/7/26

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	No need assistance.
☐ Dressing	☐ Yes	☐ No	
☐ Toileting	☐ Yes	☐ No	

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: Infection control
   ☐ Patient's Educational Topic/s discussed with the:
   ☑ Patient ☐ Family Member ☐ Others: .....

Nurse Signature: .....
Nurse Name: TUNU
Date and Time: 9/7/26 @ 10 PM