

BAH-00653464 IP5-00175939
Mrs CHARLAPALLY AKHILA
12-08-1992 33 Y 10 M 22 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date: 4/7/26

Patient Name: Mrs. Charlapally Akhila Date of Birth: Age: 33 yrs

Gender: Female Ward: OBG UHID No.: BAH-00653464

Date of Surgery: 4/7/26 ☐ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☒ OBG OT-2

Name of the Surgery: Emergency lower segment Caesarean Section
LSCA

Time in: 8:15pm

Time Out: 9:15pm

	NAME	AMOUNT
1. Surgeon	Dr. Lavanya	
2. Anaesthetist	Dr. Shyni	
3. Assistant Surgeon	Dr. Sameera	
4. OT Technician	Rashanth	
5. Circulating Nurse	Sis. Sudha	
6. Assistant Nurse	Sis. Bhargathi	

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

Signature of the Surgeon
Dr. Lavanya

Signature of Circulating Nurse
Sudha

Order No: 7688072

Order by: Bhargathi



CONSUMABLES OF OT

4/3/23 3697

Circulating staff : Bharathi

Technician : Prashanth

Date : 4/3/23

Time : 2:50pm

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <u>1 deape</u>		01	Inj Vit.K		02
LMA			Sutures <u>2346</u>		02	Cord Clamp		01
ECG leads : <u>A/P/N</u>		3	<u>2364</u>		01	Suction Catheter		
HME filter : A/P/N			<u>2762</u>		01	Feeding Tube		
Syringes : 10 cc		3				Vaccum Suction Set		
05 cc		3	Gloves <u>6/2, 16</u>		04, 01	Surgical Gloves <u>6/2</u>		02
02 cc		3	<u>PF 6/2</u>		01	Gauze Pack		01
01 cc						Syringe 1ml / 2ml		01
Cautery plate : <u>A/P/N</u>		1	Surgical blade <u>22</u>		01	Surgical Blade # <u>20</u>		01
IV set			NG tube			Koochies (S)		01
RL		2	Cautery pencil		01			
NS : 10ml / 100ml / 500ml / 1000ml			Koochies <u>XL</u>		01	<u>Adult 02 mask</u>		01
<u>tranexa</u>		2	Ointments					
<u>methorgine</u>		1	Suction Catheter					
Fentanyl			Cap, Mask		10+10			
Morphine			Gauze Pack		02			
Ketamine			Mop Pack		02			
Propofol			Steristrip <u>1 sterizor</u>		01			
Rocuronium			Underpad		01			
Glycopyrolate		1	Draw sheet					
Myopyrolate			Abgel		02			
Ondansetron		1	Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
<u>midazolam</u>		1	Tegaderm					
Suppositories			loban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol <u>100mg</u>		1	Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / <u>100mg</u>		1	Plastic Bed Sheet					
Tab. Misoprost : <u>200mg</u>		2	Betadine Solution		02			
<u>oxytocin</u>		3	Microshield		01			
<u>Tramadol</u>		1	Cotton Balls		2			
			Latex Gloves		20			
			Ramdione Scrub					
			Saral		02			

968805-084

Surgeon

Anaesthesiologist

Nurse

OT

Order No. :

Ordered by :

technician

2000

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ADMISSION SHEET

Registration Details :



Admission No : IP5-00175939

Admit Date : 03-Jul-2026

Admit Time : 06:33 PM **UHID** : BAH-00653464

Patient Details :

Patient Name : Mrs CHARLAPALLY AKHILA

Age : 33 Y 10 M 21 D

Guardian : Mr SIRIMALLA SAI SHIVA RAMA KRISHNA

DOB : 12-08-1992

Gender : Female

Religion :

Occupation :

Marital Status : Married

Address (H) : FLAT NO 206, RV KAUSTUBHA, PIPE LINE
ROAD, NEAR NATIONAL MART Jeedimetla
Hyderabad Telangana INDIA 500055

Phone No : 9491997249/ 6304487279

E-mail : akhila.charlapally@gmail.com

Admission Details :

Bed Type : SHARED WARD

Bed No : SW 416

Ward Name : 4F-BIRTHING CENTRE

Room No : SW 416

Admission Type : First Visit

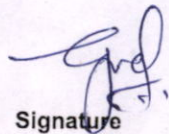
Contact Details :

Name : Mr SIRIMALLA SAI SHIVA RAMA

Relationship : Husband

Contact Address : FLAT NO 206, RV KAUSTUBHA, PIPE LINE
ROAD, NEAR NATIONAL MART Jeedimetla
Hyderabad Telangana INDIA 500055

Phone No : 9491997249



Signature

Doctor Details :

Doctor Name : Dr. SHRUTHI REDDY/Dr.LAVANYA
JANAGAMA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLIN

BAH-00653464 IP5-00175939
Mrs CHARLAPALLY AKHILA
12-08-1992 33 Y 10 M 21 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA



Name : _____

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/11	2:45 PM	CBS	Room 310	[Signature]

Cross Consultation Visit

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

[illegible]

Groß	Chokolad
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[illegible]

cross check

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/7/26	IV placement	1	968693	Sumi He
4/15/26	PAC	1	968731	Tonn
	Computerized Printout	1	968732	
			cross check of	

ANY OTHER INFORMATION

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Primigravida @ 36th wks
for IOL

Obstetric Formula:

ML-2023, NCM

Obstetric History:

I → PP → OI Conception
Booked at 24th wks.

Present Pregnancy Record:

LMP: 25/10/25

EDD: 1/7/26

Corrected EDD: 25/7/26

GA: 36th wks

Menstrual History: Regular ☒ Yes ☐ No

Obstetric Examination

Fundal Height: Term.

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech ☐ Others

Head Fifths Palpable: _____

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

RISK FACTORS:

OI Conception.

Doppler → UAD → ↑ resistance
→ 30 wks

Umbilical artery doppler ↑ resistance 36th wks
↑ EPPF + cerebral artery redshift.

Height: 163 cm

Weight: 77 kg

Allergies: NADA

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: Coma Pallor: absent

Icterus: absent Edema: absent

Temp: Afebrile PR:

BP: DTR: ⊕

CVS: S1 S2 ⊕ RS BAE ⊕

Liver/Spleen: Non-palpable. Urine Output: adequate.

Per Speculum Examination

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☒ Long ☐ Partially effaced ☐ Effaced

Os: Closed 1F Dilated

Membranes: ☒ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☒ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☒ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☒ Adequate ☐ Doubtful

DIAGNOSIS

Primigravida @ 36th wks @ OI Conception
total
@ Doppler changes for IOL.

Family History: father- DM2 & HTN	Surgical History: NIL.												
Medical History: PCOS ∴ 2015	Medication History: T. Iron OD T. Calcium O.D												
Plan of Care: • admission • NST- now • NST- 3rd baby • Enema (80s) • Epidural (80s) • Consent - NVD, TOL • fokeys- induction • Monitor vitals • Send CB P • prepare parts • PACE • SFT POL • NNC ✓ Dr. poojitha	Investigations: A+ve. Virals - NR Reactive → Rubella. <table border="0"> <tr> <td>26/11/16</td> <td>Hb → 12.5</td> <td>3/7/16</td> <td>Hb: 13.4</td> </tr> <tr> <td></td> <td>Plt: 1.98 L</td> <td></td> <td>Plt: 2.32</td> </tr> <tr> <td></td> <td>WBC - 8730</td> <td></td> <td>WBC: 11.44</td> </tr> </table> NT → 2.0mm. 1 FTS - high risk for 21 (1 in 100) NPT → Low risk & fetal fraction (7.3%) Fetal echo → @ 21wks - @ Echo 2 single echogenic intracardiac focus in @ Ventricle. & t 1/7/16 → 36⁺ 5 1/2 IUG, cephalic. 2759 gm (32%), ACN 21%. AFT: 7.3, placenta → A/H.	26/11/16	Hb → 12.5	3/7/16	Hb: 13.4		Plt: 1.98 L		Plt: 2.32		WBC - 8730		WBC: 11.44
26/11/16	Hb → 12.5	3/7/16	Hb: 13.4										
	Plt: 1.98 L		Plt: 2.32										
	WBC - 8730		WBC: 11.44										

Doctor Name: Dr. Shruthi
 Signature: Shri
 Date & Time: 3/7/2016, 9:20pm

Umbilical artery resistance, + EDF
 & cerebral artery redistribution

Consultant Name: Shruthi Reddy
 Signature: Shruthi Reddy
 Date & Time: 3/7/2016, 9:20pm



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



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/2/16 7:20am	Primi gravida 36th wks 70% concept Doppler checks for FHR	
	↓ Aseptic conditions patient placed in lithotomy position parts painted & draped. → Foley's bulb in trachea placed and instilled 40ml of distilled water	
	Pit procedure	R
	GC: air	1) Wt & P/L
	B.P - 105/64 (71)	2) Monitor vitals - 4th
	P.R - 84	3) FHR - 4th
	SpO₂ - 100% on RA	4) NST - 3rd
	P/A: Ut - Tem	5) Drug as charted
	rebed	6) Insulin 50
	FHR ⊕	
	r/w: long	
	OS: AF	→ Dr. Sravanthi
	True - CBP	
	HLB	
	Sanaya 7:20pm	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/06 12:20 AM	Primi 37 wks OI Conception / C Doppler checks for FOL	
NST - active	GC: fair B.P - 100/57 (G2) P.R - 70 bpm SpO ₂ - 100% on RA P/A: Ut - term acting Cephalex	1) w/L POL 2) Monitor vitals - 4hr 3) Drug as charted 4) w/L RA Progression Kethen 4) NST 3rd hr 5) FHR - 4hr 6) Imlus 50 7) Cema (500) 8) Epidural (500)
	② Deserof PGE ₁ given, Last duell: 11:40 am.	
17/06 3 AM	Primi 37 wks OI Conception C Doppler checks for FOL	- Dr Sneha Giri
NST - active 2 AM	GC: fair pt: sleeping	1) CST 2) Drug as charted
NB Santoya 2:10:50		- Dr Sneha



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 9:40am	C/S/G:- Dr Shruthi → Prim / 3 weeks / 1st OJ Conception = Doppler changes BP- 100/61 (74) PR- 86bpm sp₂- 100% on M. PIA- ut irritable Cephalic FHS ⊕ Plw. G- 2cm dilated 1/2 inch long AKM done, clear liquor ix- high up	
decided to do Misc - using Test done 9:30am	NB Bone	Adams CTG Continue vitals & FHS monitoring Sruti





PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/6/26 10:00pm	POD-0/Em. lscy	
B = well	O/F	
VO - 300ml emptied (High colour)	G. fair	Adv
	BP - 93/54/67/mmHg	① NBM for 6 hrs
	PR - 66 BPM	② WF @ 100ml/hr
	SpO ₂ - 98% RA	③ Drugs as charted
	PIA - ut @ well	④ WF after bleeding
	LIF - BWN	⑤ S/O charting
		⑥ Monitor vitals every 30 mins
At B Sandeep 10:15pm		⑦ Inform SW
	Dr. Diluige	
4/6/26 11:15pm	O/F	
	BP - 128/81mmHg	Adv
	PR - 68 BPM	GS
	SpO ₂ - 98% RA	Monitor vitals
	PIA - ut @ well	Infirm SW
	LIF - BWN	
Gond - VO - emptied. High color		Dr. Diluige

Date & Time	Progress Notes	Doctor's Order
5/6/26 <u>2 AM</u>	<u>P.O.-of Pili / Em-Use</u>	
Baby-Mother side	Pt-stable	Adv:-
G.O.-200ml	G.c-fair	(1) NBM till 6AM.
	Afebrile	(2) Liquid diet at 6AM
	PR-Falmin	(3) Soft diet at 9AM.
	BP-90/60mmHg	(4) Drugs as checked
	P/A - ut @ well	(5) Monitor vitals wtk
	BS (+)	(6) Stool charty
	LLE-NAB	(7) wlt excessive bleeding plw
- Remove bley's tomorrow at 12 PM		(8) Inform SOS hr (Dr-lavay)
	- Shift to room	
	<u>not by shift</u>	
5/6/26 <u>9 AM</u>	<u>P.O.-of Pili / Em-Use</u>	
Baby-Mother side	Pt-stable.	Adv:-
G.O.-200ml clear	G.c-fair	(1) Soft Diet.
Ix	Afebrile	(2) oral hydrate.
	PR-Falmin	(3) Antibiotic.
	BP-100/60mmHg	(4) Drugs as checked
	P/A - ut @ well	(5) Monitor vitals wtk
	BS (+)	(6) Inform SOS
- Remove bley's at 12 PM	LLE-NAB	(Dr-lavay)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5.7.26.	POD 1, P/L / Embrs	
5pm	Gut a/c atb/c	ad - soft diet - vitals ok - Drug as charted
B. well	PR - 80/min BP - 105/50 mmHg.	
CV	SpO2 - 98% @ RA	- No active bleed
FX	P/A - ut (P) well Plu - clear	- Inform
		Dr. Arshya
	Inform whether she passed urine / not after 6 hrs	
		Noted by Nikhil
5.7.26.	POD 1	
7Am	Gut a/c atb/c	adu ① Soft diet ② Vitals ok ③ Drug as charted
B. well	PR - 80/min BP - 105/50 mmHg	④ No active bleed
CV	SpO2 - 98% @ RA	⑤ Ambulation.
FX	P/A - ut (P) well Plu - clear	⑥ Inform
		⑦ Ombolaxys
		Dr. Arshya
	plan discharge in evening.	

IP5-00175939

12-08-1992 33 Y 10 M 23 D (F)

Dr. SHRUTHI REDDY/Dr.LAVANYA



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



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00653464 IP5-00175939
 Mrs CHARLAPALLY AKHILA
 12-08-1992 33 Y 10 M 21 D (F)
 Dr. SHRUTHI REDDY/Dr.LAVANYA



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

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

RESULT SHEET

Date	3/2/26				
Time					
Hb	13.4				
PCV	38.6				
RBC	4.36				
WBC	11.44				
N/L					
Platelets	232				
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					
T/INR					
PTT					
F Protein / Sugar					

Ward

VERIFIED

VERIFIED
Signature

VERIFIED BY: Nam

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																				



DRUG CHART

Date of Admission: 31/7/2016 Drug Allergies: None ☒ 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



VERIFIED

VERIFIED

VERIFIED

VERIFIED

DRUG : Jcy CEFOTAXIME				Date Time	3/7/17	5P
Dose	Route	Frequency	Start Date			
1gm	IV	BD	3/7	11 AM		
Name & Signature of the Doctor Starting the Drugs:				11 AM 10 PM Stop Dr. Ashu 6/7/17 after morning dose		
Additional Instructions:				x 2 cubes followed by oral.		
Daily Doctor's Endorsement by a Sign				L L L		
DRUG : T. PARACETAMOL				Date Time	5/7	6/4
Dose	Route	Frequency	Start Date			
1gm	P/O	QID	04/07	12 AM		
Name & Signature of the Doctor Starting the Drugs:				6 AM 12 PM 6 PM more		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign				L L		
DRUG : T. TRAMADOL				Date Time	5/7	6/4
Dose	Route	Frequency	Start Date			
100mg	P/O	TID	04/07	1 AM		
Name & Signature of the Doctor Starting the Drugs:				9 AM 5 PM reduced		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign				L L		
DRUG : T. DICLOFENAC				Date Time	4/7	5/7 6/4
Dose	Route	Frequency	Start Date			
50mg	P/O	TID	04/07	3 AM		
Name & Signature of the Doctor Starting the Drugs:				3 PM 11 PM more reduced		
Additional Instructions:						
Daily Doctor's Endorsement by a Sign				L L		

Patient Sticker

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 Mrs CHARLAPALLY AKHILA
 12-08-1992 33 Y 10 M 21 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA

Weight: 77kg Ward: 081

VARIABLE DOSE



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

VARIABLE DOSE

Date
Time

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/2/26	7:49pm	T. PGE ₁	25ugm	p/o	Shr	Kanny shobh
3/2/26	11:40PM	T. PGE ₁	25mg	p/o	hup	Sandeep Radeh
4/2/26	2:30AM	T. PGE ₁	25mg	p/o	Cup	Sandeep Radeh
4/2/26	6:30AM	T. PGE ₁	25ugm	p/o	Shr	Sandeep Radeh
4/7	9:30am	T. PGE ₁	25ugm	p/o	h	Tunel Ranthi
4/7	10:30	ENEMA	1	p/R	h	Tunel Ranthi
4/2/26	7:40pm	INT. CEFOTAXIM	1gm	iv	Wany	Shobha Ajali
4/7/26	7:45pm	INT. ZOFR	4mg	iv	Wany	Bharathi Ajali
4/7/26	7:50pm	INT. PERMORM	10mg	iv	Wany	Bharathi Ajali

Deel colox supp

I.V. FLUIDS CHART

Weight. 71kg Ward. 083

Date	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
4/7/26	ppm RINGER LACTATE	IV	100ml/hr	Dr. Shobha	Tunny	4/7	f	Shobha Koruvu
4/7	12:30 pm RINGER LACTATE + 10U OXYTOCIN	IV	Good hr	Dr. Shobha	Tunny Shardha	4/7		Shobha Koruvu Rddy Sundar
	To increase bc every 30min if no adequate contractions.							
4/7	3pm RINGER LACTATE	IV	FF	Dr. Shobha	Koruvu	4/7	f	Shobha Koruvu
4/7	5pm RINGER LACTATE	IV	FF	Dr. Shobha	Koruvu	4/7		Shobha Koruvu Anjali Shardha
4/7/26	6pm RINGER LACTATE	IV	100ml/hr		Anjali Shardha	4/7	eg	Anjali Shardha
04/07/26	8:05pm DNS	FF	IV	eg	Anjali Shardha	4/7	eg	Anjali Shardha
04/07/26	8:30pm RINGER LACTATE	IV	FF	eg	Anjali Shardha	4/7	eg	Anjali Shardha
04/07/26	9:00pm RINGER LACTATE	IV	500 ml/hr	eg	Anjali Shardha	4/7	h	Rddy Sundar
4/7/26	4 PM RINGER LACTATE	IV	100ml/hr	h	Rddy Sundar	4/7	h	Rddy Sundar

I.V. FLUID CHART

[illegible]



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STAT / ONCE ONLY DRUGS

Weight: 7.7 kgs

Sheet No:

No. : RCHBH /FRM / CLINICAL / 136



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 3/2/26 Time of Arrival: 6:20pm Time Seen by Nurse: 6:20pm

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:

3) **Vital Signs:** Temperature: 98.1 Pulse: 80b/m RR: 20 SpO₂: 100% BP: 116/72 Weight: 77kg

4) **Gestational Criteria:**

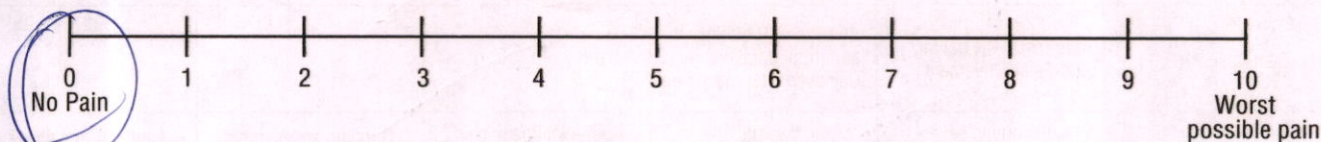
Gravida:	G	P	<u>4mi</u>	L	A
----------	---	---	------------	---	---

LMP: 25/10/25 EDD: 1/8/26 Gestational Age: 36¹⁶ 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: sharp
- Frequency: 2-3 times
- Interventions: analgesics

6) **Past History:**

- a) Surgeries: Mie
b) Medical: new 2025



1) Allergy: ☐ Yes ☒ No, If Yes :

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

9) Prenatal Medical History:

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 6:00 PM

Nurse Name : Kanne Nurse Signature: [Signature]

Date: 3/7/22 Time: 6:45 PM

BAH-00653464 IP5-00175939
Mrs CHARLAPALLY AKHILA
12-08-1992 33 Y 10 M 21 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 8/7/2026

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: primigravida 7 30+6 wks Doctor Notified on Admission: ☒ Yes ☐ No
for DOL Name of the Doctor:
Time Notified:

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>pos: 1024</u>	<u>Nil</u>	<u>—</u>
Gynecology Assessment: ☐ Not Applicable Menstrual History: <u>Regular</u> Onset of Menarche: Menstrual Cycle: ☐ Regular ☐ Irregular Last Menstrual Period: <u>2/10/24</u>	Gynecology Surgical History: Caesarean Section: ☐ No ☐ Yes Cervical Cerclage: ☐ No ☐ Yes Ectopic Pregnancy: ☐ No ☐ Yes Myomectomy: ☐ No ☐ Yes Others:	Gynecological History: Contraceptives: ☐ No ☐ Yes Vaginal Discharge: ☐ No ☐ Yes Post-Coital Bleeding: ☐ No ☐ Yes Infertility: ☐ No ☐ Yes If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G P Am L A

Previous LSCS:

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

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

Vital Signs / Measurements: Temp: 98.7 HR: 80 RR: 20
BP: 116/72 Weight: 77 Height: 163 BMI:

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

BAH-00653464 IP5-00175939
Mrs CHARLAPALLY AKHILA
12-08-1992 33 Y 10 M 21 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



PHYSICAL ASSESSMENT

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

Fall Assessment: ☒ Yes ☐ No Score 80 (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 Pansky

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: Dr. Akhila

Orientation not given Reason: NA

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 3/12/2020 6:00 PM

BAH-00653464 IP5-00175939
 Mrs CHARLAPALLY AKHILA
 12-08-1992 33 Y 10 M 21 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA



①

3/7/2026
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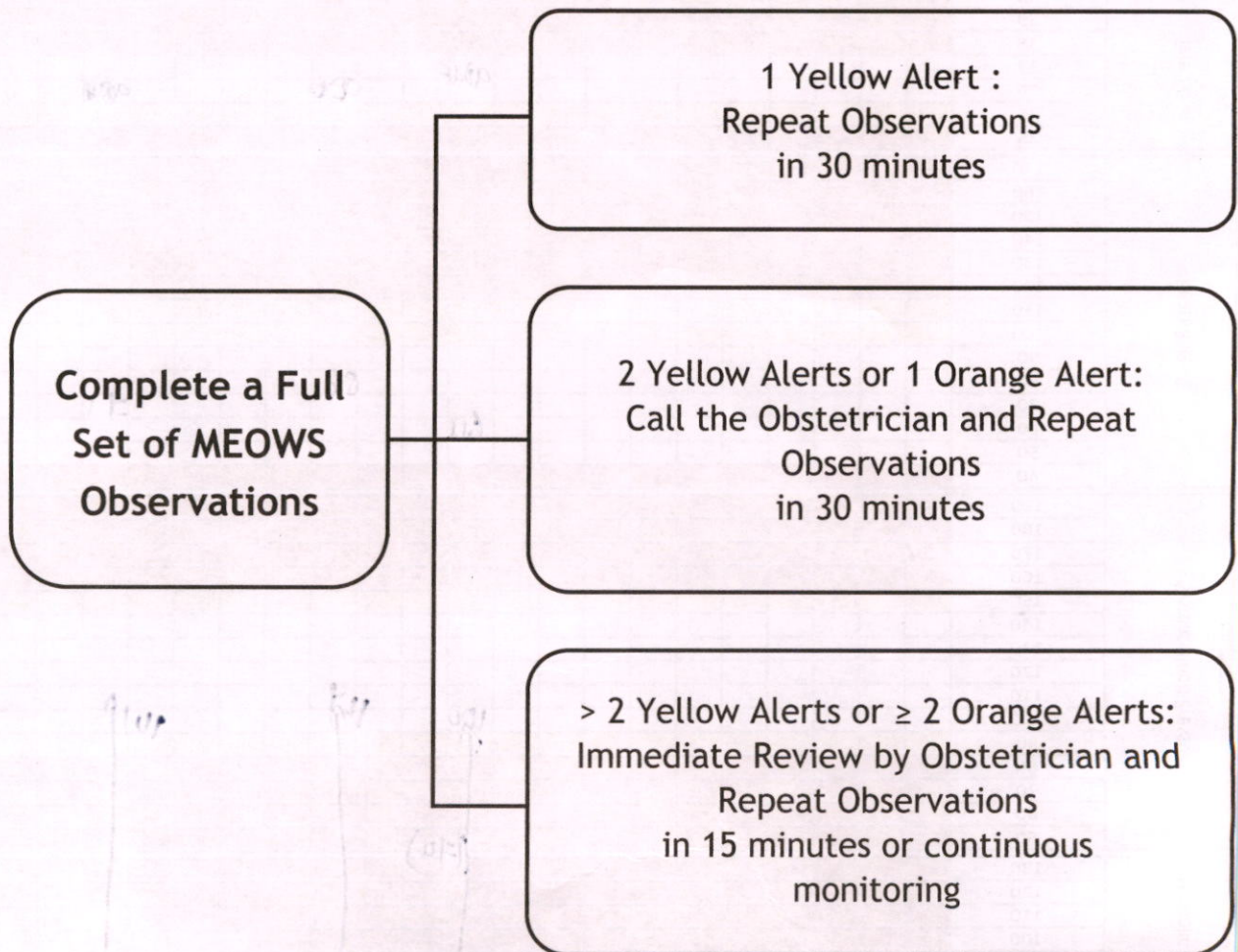
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Early Warning Observation Score Chart - Obstetrics

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

		Date	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
		Time											6:50													
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20												19		18						18				18	
	0 - 10																									
Saturations	94 - 100 %												100		98						98				98	
	< 94 %																									
Administered O ₂ (L/min.)																										
Temp °C	40																									
	39																									
	38																									
	37																									
	36												98.4		98.6						98.4				98.1	
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80														86						71				72	
	70																									
	60												64													
	50																									
	40																									
Systolic Blood Pressure	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100												100		107						107				104	
	90																									
	80																									
	70																									
	60																									
50																										
Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
50																										
40																										
NEURO RESPONSE [✓]	Alert												A		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						0				0	
Nurse Initial													SH		J						f				8	

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

BAH-00653464

IPS-00175939

Mrs CHARL ABALLY

12-08-1993

33 Y 10 M 22 D

(F)


$$u \nmid 7126.$$

②



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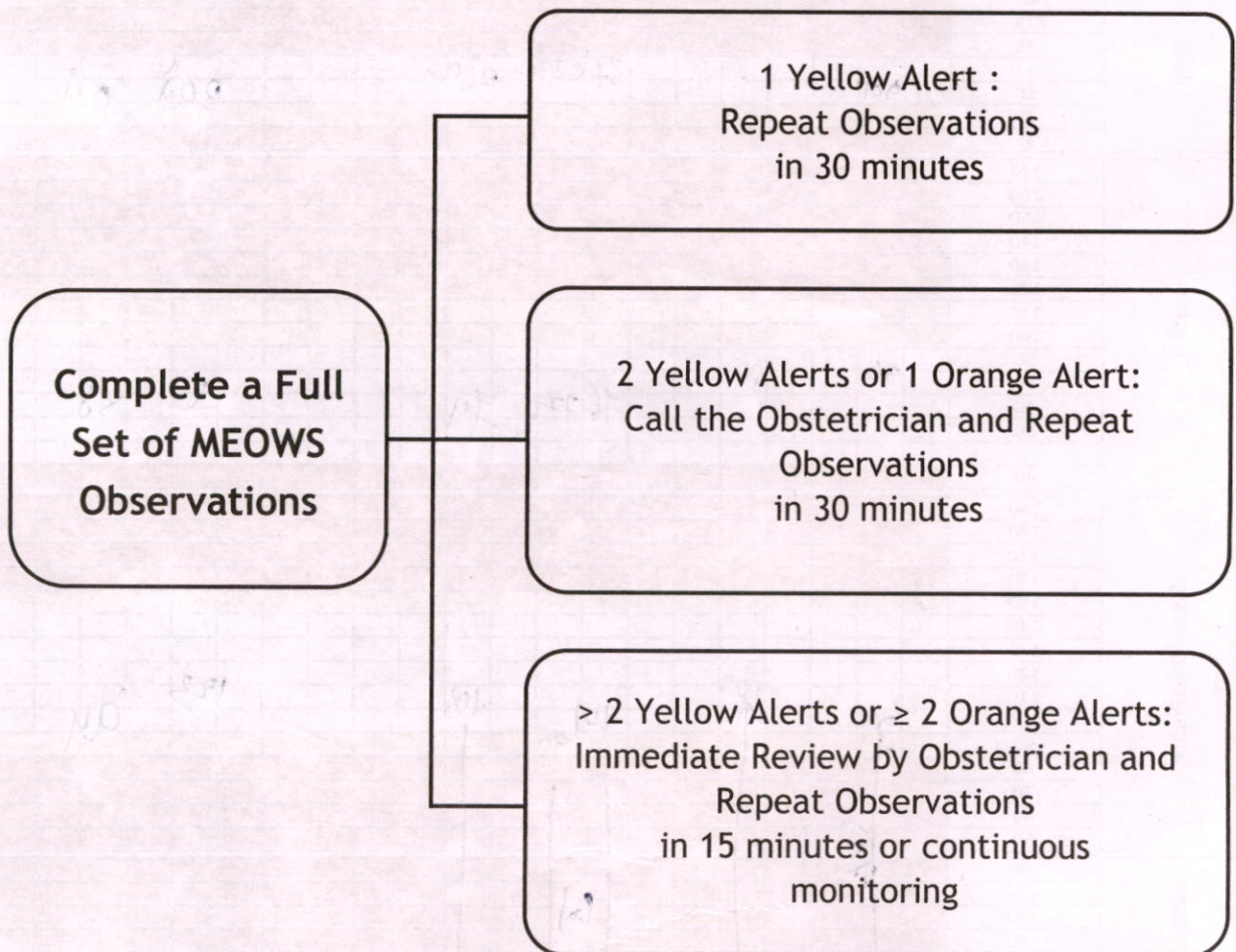
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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT

TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Dr. SHRUTHI REDDY/Dr.LAVANYA

[illegible]

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)



FLUID CHART

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											

Total Intake :

Total Output :

3/4/26	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm	H ₂ O								✓	0	Smith
	07:00 pm	H ₂ O									0	Smith

Total Intake :

Total Output :

	08:00 pm	H ₂ O					1				0	
	09:00 pm	H ₂ O					nto				0	
	10:00 pm										0	
	11:00 pm						1			✓	0	Sanjay
	12:00 am	H ₂ O									0	
	01:00 am										0	

Total Intake :

Total Output :

	02:00 am	H ₂ O					1				0	
	03:00 am										0	
	04:00 am	H ₂ O					nto			✓	0	
	05:00 am										0	
	06:00 am	H ₂ O					1				0	
	07:00 am									✓	0	

Total Intake :

Total Output :

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

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

FLUID CHART

Sheet No. :

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am										0	Tunn
	09:00 am	tho								✓	0	Tunn
	10:00 am	tho								✓	0	Tunn
	11:00 am	tho					✓			✓	0	Tunn
	12:00 pm										0	Tunn
	01:00 pm	tho								✓	0	Tunn
Total Intake : Taken						Total Output : U-3, M-1						
	02:00 pm			36ml			1				0	Exp
	03:00 pm	Plc. Glycerin		12ml			1				0	Exp
	04:00 pm			4ml			1				0	Exp
	05:00 pm	th		100ml			1				0	Shake
	06:00 pm	th		100ml			1				0	Shake
	07:00 pm	th		100ml						Ampl	0	Shake
Total Intake : Taken						Total Output :						
	08:00 pm	RL	100ml				1			300ml	0	
	09:00 pm	RL	100ml				1				0	
	10:00 pm	RL	100ml				1			300ml	0	
	11:00 pm	RL	100ml				1				0	Sandys
	12:00 am	RL	100ml				1				0	
	01:00 am	RL	100ml				1			200ml	0	
Total Intake : NSB m						Total Output : U-550ml						
	02:00 am	RL	100ml				1				0	
	03:00 am	RL	100ml				1				0	
	04:00 am	RL	100ml				1				0	
	05:00 am	RL	100ml				1				0	
	06:00 am	RL	100ml				1			400ml	0	Shake
	07:00 am	RL	100ml				1				0	
Total Intake :						Total Output : U-400ml M-1						
Total 24 hrs. Intake		T-1574 ml										
Total 24 hrs. Output		U-4,800ml M-1										

BAH-00653464 IP5-00175939
 Mrs CHARLAPALLY AKHILA
 12-08-1992 33 Y 10 M 22 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA

FLUID CHART

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Sheet No. : (3)

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

		Intake			Output					IV Site	Sign. Nurse	
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score		
			Mouth	I.V	N.G							
	08:00 am					1					0	L'ao
	09:00 am	H2O									0	L'ao
	10:00 am					no			280ml		0	L'ao
	11:00 am					1					0	L'ao
	12:00 pm	H2O				1			300ml		0	L'ao
	01:00 pm										0	L'ao
Total Intake :					Total Output : U: 580ml M: 0							
	02:00 pm					1					0	ama
	03:00 pm	H2O									0	ama
	04:00 pm					NP					0	ama
	05:00 pm					1					0	L'ao
	06:00 pm	H2O									0	L'ao
	07:00 pm										0	L'ao
Total Intake :					Total Output : U-1 M-0							
	08:00 pm					1					0	R'ao
	09:00 pm	H2O									0	R'ao
	10:00 pm										0	R'ao
	11:00 pm					NP					0	R'ao
	12:00 am	H2O				1					0	R'ao
	01:00 am										0	R'ao
Total Intake :					Total Output : U-2 M-0							
	02:00 am					1					0	R'ao
	03:00 am	H2O									0	R'ao
	04:00 am										0	R'ao
	05:00 am					NP					0	R'ao
	06:00 am	H2O				1					0	R'ao
	07:00 am										0	R'ao
Total Intake :					Total Output : U-2 M-0							
Total 24 hrs. Intake			Total 24 hrs. Output U-7 M-0									

BAH-00653484 IP5-00175939
 Mrs CHARLAPALLY AKHILA
 12-08-1992 33 Y 10 M 23 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA



8/7/26

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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	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											
	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									

Patient Sticker

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	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												
	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							

Patient Sticker

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Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	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												
	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													

BAH-00653464 IP5-00175939
Mrs CHARLAPALLY AKHILA
12-08-1992 33 Y 10 M 21 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



①

NURSING CARE RECORD

Rainbow®
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BirthRight™
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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 3/7/26

Assessment: patient complaint is 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
5pm	* Assess the patient General condition	5:10 PM	* Assessed the patient General condition	patient is stable
6pm	* provide monitor vitals	6:15 PM	* provided monitor vitals	
	* provide I/O chart		* provided I/O chart	
7pm	* provide NST 3rd hly	7:10 PM	* provided NST 3rd hly	
	* provide comfortable position		* provided comfortable position	
8pm	* provide patient Safety	8:15 PM	* provided patient Safety	

Re-Assessment: Re-Assessment is done

Special Notes: 3rd hly NST.

Nurse Signature: [Signature] Nurse Name: Smith Date & Time: 3/7/26 @ 8pm

Patient Sticker

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:

2

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 2/7/20

Assessment: patient complaint about fear and anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the pt condition	9pm	Assessed pt condition	pt is stable
10pm	monitor vital.	11pm	monitored vitals	
12am	No chart	1am	Maintained I/O chart	
2am	Administration of medication	3am	Administered medication	
6am	Ambulation	7am	Ambulated	
7am	Not NBT	8am	Every 2nd hourly done	

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

Special Notes: NBT 2nd hourly/ maintain hydration.

Nurse Signature: Sandhya Nurse Name: Sandhya (0166357) Date & Time: 8:41 PM 2/7/20

BAH-00653464

IPS-00175939

Mrs CHARLAPALLY AKHILA

12-08-1992 33 Y 10 M 22 D (F)

Dr. SHRUTHI REDDY/Dr. LAVANYA



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: Patient Complaints of ↓ fetal movement

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	⇒ Assess the pt condition.	9am	⇒ Assessed the pt condition	patient is comfortable
9am	⇒ FHR monitoring	10am	⇒ NST done.	
10am	⇒ maintain fluid balance	11am	⇒ Water, Juices given	
11am	⇒ Ensure Safety	12pm	⇒ Side rails provided.	
12pm	⇒ Epidural Siting	1pm	⇒ Epidural Siting done.	
1pm	⇒ U/O monitoring	2pm	⇒ U/O monitoring done.	

Re-Assessment:

FHR is good.

Special Notes:

NST 3rd hourly, @ pain assessment

Nurse Signature:

Nurse Name: Tuny

Date & Time: 4/7/26 @ 2pm

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7/20

Assessment: Acute pain related to delivery process

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the patient's condition.	2:10 pm	* Assessed the patient's condition.	pt is stable.
3pm	* NST Every 30 min	3:10 pm	* NST done 30 min.	
3:30 pm	* Complaints of contraction pains.	3:35 pm	* Epidural given. Started dose.	
4pm	* cuff progress of labor.	4:10 pm	* 30 min at 3pm.	
5pm	* Ensure safety	5:10 pm	* Ensure safety provided	
6pm	* prevent infection	6:10 pm	* To prevent infection	

Re-Assessment: Re Assessment done

Special Notes: NST 30 min

Nurse Signature: [Signature]

Nurse Name: Shobha

Date & Time: 4/7/20 @ 8pm

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 Dr. SHRUTHI REDDY/Dr. LAVANYA

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NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26

Assessment: Patient complaint about pain at surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient condition		Assessed pt condition	Patient is stable
10pm	monitor vitals		monitored vitals	
	administration of medication		administered medication	
12am	iv fluids		continued iv fluids	
4am	flow chart		maintained flow chart	
8am	mobilization		mobilization done on bed	
11am	Ensure safety		Ensured safety	

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

Special Notes: NBM/ Foley's remove 11am. Di 10mls

Nurse Signature: Sandeepa (016638) Nurse Name: Sandeepa

Date & Time: 4/7/26 8am

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Shift: ☒ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: Pt having 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
8AM	→ Assess the Pt condition	8AM	→ Assessed the Pt condition	Pt is stable
11AM	→ vital chart maintain	11AM	→ vital chart maintained	
12PM	→ Ensure safety	12PM	→ Ensured safety	
4PM	→ Encourage oral	4PM	→ maintain good nutritional	
8PM		8PM		

Re-Assessment:

Special Notes: - ml - ml -

Nurse Signature: [Signature]

Nurse Name: Likitha

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

BAH-00653464 IP5-00175939
 Mrs CHARLAPALLY AKHILA
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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Patient is having Discomfortable

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the general condition of the patient.	8:30pm	Assessed the general condition of the patient.	Now is the patient stable
10pm	Administers the medication as per Drug Chart.	10:30pm	Administered the medication as per Drug Chart.	
2Am	Monitor the vitals.	2:30Am	vitals checked and recorded.	
5Am	Maintain the Hand Hygiene.	5:30Am	Maintaining the Hand Hygiene.	
7Am	Ensure the safety.	7:30Am	Provided the side rails up.	

Re-Assessment: Re-Assessment Done 4th hourly vital.

Special Notes: Nil

Nurse Signature:

Nurse Name: Rima

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

Patient Sticker

NURSING CARE RECORD

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:

Patient Sticker

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:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sravanthi Department: OBS Date of Admission: 3/7/26

SITUATION	Diagnosis: <u>Primigravida 36th weeks of</u> <u>conception 2 drops changed for 50L</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:				
	Area	Shift Time	<u>OBS</u> <u>2pm-8pm</u>	<u>OBS</u> <u>8pm-8am</u>	<u>OBS</u> <u>8am</u>	<u>OBS</u> <u>8am-2pm</u>	<u>OBS</u> <u>2pm-8pm</u>
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:		Temp: <u>98.6°F</u>	<u>98.0°F</u>	<u>98°F</u>	<u>98°F</u>	<u>98°F</u>
	Res:		<u>19</u>	<u>18b/m</u>	<u>20b/m</u>	<u>20</u>	<u>18b/m</u>
	SpO ₂ :		<u>100</u>	<u>100%</u>	<u>99%</u>	<u>99%</u>	<u>99%</u>
	Pulse:		<u>64</u>	<u>70b/m</u>	<u>86b/m</u>	<u>75b/m</u>	<u>68b/m</u>
	BP:		<u>100/62/70</u>	<u>101/62/70</u>	<u>100/61</u>	<u>108/6</u>	<u>101/60</u>
	Fall Risk Score:		<u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>
	Pain Score:		<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
	Recommendations	Safety Needs:		<u>Yes</u>	<u>Yes</u>	<u>Yes</u>	<u>Yes</u>
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		<u>NO</u>	<u>NO</u>	<u>NO</u>	<u>NO</u>	<u>NA</u>	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Karuna Sanayya</u>	<u>Sanayya</u>	<u>Tunna</u>	<u>Shobha Sanayya</u>	<u>Titika</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>3/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>5/7/26</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	
Taken Over By Name :		<u>Sanayya</u>	<u>Tunna</u>	<u>[Signature]</u>	<u>Sanayya</u>	<u>Titika</u>	
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:		<u>3/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>	<u>5/7/26</u>	
Time:		<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Shruithi Department: 3rd Floor Date of Admission: 3/7/26

SITUATION	Diagnosis: <u>Primigravida at 36+1 week</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:					
	Area	Shift Time						
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>MA</u>						
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ 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	☐ Yes ☐ No
	Vital Signs:	Temp: <u>97.4°F</u>						
		Res: <u>24 b/m</u>						
		SpO ₂ : <u>100%</u>						
		Pulse: <u>84 b/m</u>						
		BP: <u>110/74</u>						
		Fall Risk Score: <u>20</u>						
Recommendations	Pain Score: <u>0/10</u>							
	Safety Needs: <u>yes</u>							
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify: <u>NA</u>							
	Special Diet: ☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Other Special Orders / Medications: <u>NA</u>							
Post Operative Procedure Special Orders: <u>NA</u>								
Handed Over By Name: <u>Rim</u>								
Signature: <u>Rim</u>								
Date: <u>6/7/26</u>								
Time: <u>8PM</u>								
Taken Over By Name: <u>Shruithi</u>								
Signature: <u>Shruithi</u>								
Date: <u>6/7/26</u>								
Time: <u>8PM</u>								

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	3/7/26	3/7/26	4/7/26	Fall Risk Grading		
		Score	2pm 8pm	6pm 8pm	8am 2pm	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk ✓	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			20	20	20			
		Signature	Swathi	Sangeetha	Purnima			

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			
History of Falling (immediately or w/in 3 months)	Yes	25	8/7/26	5/7/26	
	No	0	2pm-8pm	4pm-8pm	
Secondary Diagnosis (more than one diagnosis)	Yes	15		6	
	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	26	
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	20	20	
Total Morse Fall Scale Score:				20	
Signature			Buy	Rint	

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

Full. maintenance.

9/7/26

<u>Guinea.</u>		
1:30pm	15 ml/hr.	145bt/mt
2:00pm	24 ml/hr.	145bt/mt
2:30pm	30 ml/hr.	150bt/mt.
3:00pm	36ml/hr.	145bt/mt
3:20pm	42ml/hr.	145bt/mt
4:00pm.	48ml/hr.	Stopped. 106bt/mt.

Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ 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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7/26	5pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Smith
3/7/26	7pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Smith
3/7	10pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	\$areys
4/7	10am	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	\$areys
4/7	5pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	\$areys
4/7	8am	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	\$areys
4/7/26	10 AM	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Tunne
4/7/26	2pm	2/10	Abdominal Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	breathing breathout	Tunn
4/7/26	3:30 pm	3/10	Abdominal Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☒ Burning	☐ Increasing ☒ Decreasing	☐ Yes ☐ No	Carbon Crystal	Shah
4/7/26	5pm	3/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Shoblo

Re-assessment Frequency:

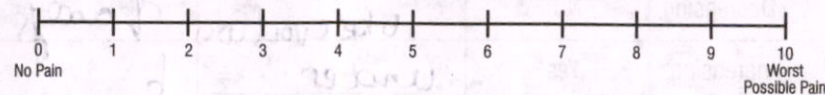
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

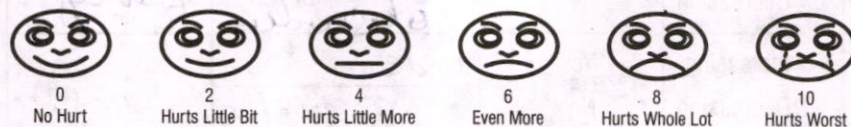
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
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



BAH-00653464 IP5-00175939
Mrs CHARLAPALLY AKHILA 33 Y 10 M 22 D (F)
12-08-1992
Dr. SHRUTHI REDDY/Dr. LAVANYA



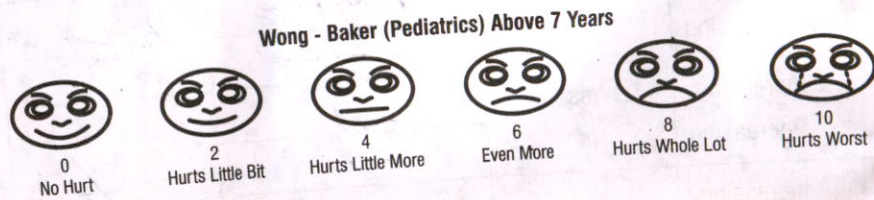
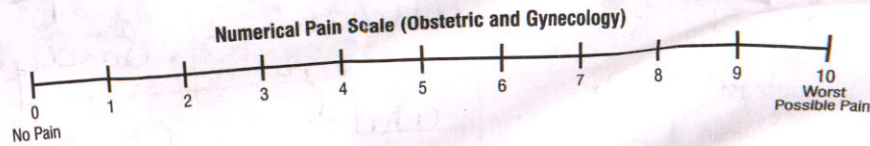
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/7	6pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Aching ☐ Dull ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Shobha
4/7	8pm	4/10	lower abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Aching ☐ Dull ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	shifted to OT	Sandya
5/7	2am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Aching ☐ Dull ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under analgesia	Sandya
5/7	8AM	2/10	Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Aching ☐ Dull ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sandya
5/7	12PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Aching ☐ Dull ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	no tab. PCA	Liba
5/7	7PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Aching ☐ Dull ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Liba
6/7	12AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Aching ☐ Dull ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rim
6/7	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Aching ☐ Dull ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Rim

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS



FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)			
CATEGORY	SCORING		
Face	0	1	2
Legs	No Particular expression	Occasional Grimace or Frown, withdraw, Disoriented	Frequent
Activity	Laying quietly in normal position, moves easily	Uneasy, restless, tense	
Cry	No Cry (Awake)	Reassured by occasional touching, hugging, or being talked to, distractible	
Consolability	Content, relaxed		Difficult to console or comfort

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

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

CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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										
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										

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 : *Swarna*

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

Signature of Ward In Charge :

Signature : *[Signature]*

Name : *Vecna*

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CHECKLIST FOR THROMBOPHLEBITIS

SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
			M	E	N	M	E	N	M	E	N	
IV site appears healthy	No signs of phlebitis / Observe cannula	0										
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										
Two of the following signs are evident: Pain at IV site Redness All of the following signs are evident: Pain along Path of cannula Redness around Site Swelling	Early stage of phlebitis / Resite Cannula	2										
5 All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Medium stage of phlebitis / Resite Cannula Consider Treatment	3										
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 phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4										
	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5										
Signature of the Nurse												

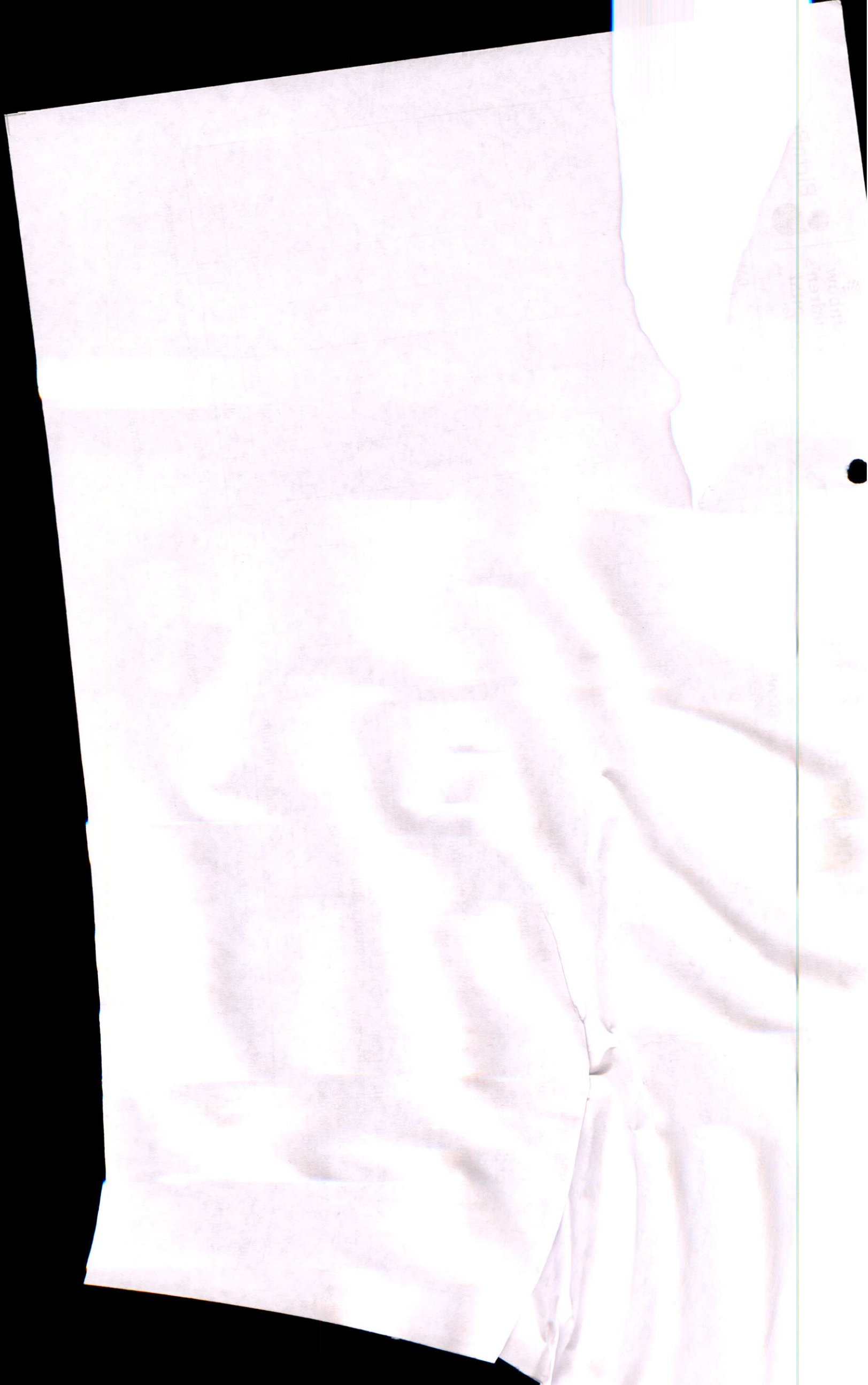
NOTE : Phlebitis greater than grade 2 should be reported to physicians and other appropriate health care personal ongoing observation of the site should continue for 48 hours post removal to detect post infusion phlebitis.

Signature of Shift In Charge :

Signature : Name :

Signature of Ward In Charge :

Signature : Name :



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LAPALLY
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AVANYA

1

BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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:treimity position independently.		4. No limitations: Makes major and frequent changes in position without assistance.			
Activity The degree of physical activity		1. Bedfast: Confined to bed		2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."		3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.		4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.			
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 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.			
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another		1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.		2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.		3. Potentially 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. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.			
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. 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."			
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.			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23 cu. No. : RCHBH /FRM / CLINICAL / 119											
TOTAL SCORE								27	28	28	28
Evaluator's Name								Seni	84	mary	slady

Date : 3/7 3/7 4/7 4/7
Time : 2pm 8pm 8pm 8pm

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

BAH-00653464 IP5-00175939
Mrs CHARLAPALLY AKHILA
12-08-1992 33 Y 10 M 22 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



BRADEN 'Q' SCALE

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

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BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

				Date: 01/10/2023	Time: 8:40 AM	Time: 8:40 AM	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2	2	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.	1	1	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
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
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
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
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
				TOTAL SCORE	23	23	23
				Evaluator's Name	L	8	R/n

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
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Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
3/8/20	6pm, 12/13	7	A, R, Care plan, patient Informed consent	PT	7	0	7	1	Nil	A
3/7/20	6:15 pm	7	Infection control measures	P.T	1	0	1	1	Nil	Swathi
3/7/20	9am	9	Lactation diet	PT	1	0	1	1	-	Sainu

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: Primi E 36th wks E OT Coapt E Doppler claps for Fds

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
3/2/26 @ 6pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Primi E 36 th wks OT Coapt E Doppler claps for	Safe Pregnancy	Fds	SR	☐ Nursing ☐ Others:
3/7/26 @ 6:10 PM	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	patient complaint is fear and Anxiety	provided patient is Safety and care	plan for the psychological Support.	Swathi	☒ Medical ☐ Others:
5/3/26 9am	☐ Medical ☐ Nursing ☒ Others: dietician	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	POD-0 Em LSCS	soft diet	soft High protein diet	seemz	☐ 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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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 5/7/26 Time: 9am

Origin: Indian Height: 163cm Weight: 77kg's BMI: 30.49/m²

Food Allergies: No

Diagnosis: POP-0 / Em-LSCS (Lower Segment Cesarean Section)

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

Diet Advised:

soft High protein diet
include plenty of oral liquids
Avoid spicy, chilled and outside foods

Patient's / Attendant's

Signature: [Signature]

Name: Akhila

Date & Time: 5/7/26
9am

Dietician's

Signature: [Signature]

Name: Saima

Date & Time: 5/7/26
9am

DIETARY NOTES[illegible]

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

Patient ID

BRADEN 'Q' SCALE

					Date :			
					Time :			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.				
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.				
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.				
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.				
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."				
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.				
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.				
					TOTAL SCORE:			
					Evaluator's Name			

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