

BAH-00641483 IP5-00176611
Mrs NAGAM DURGA BAI
21-08-1997 28 Y 10 M 29 D (F)
Dr. DR.M PRATHYUSHA REDDY



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Hospital
It takes a lot to treat the little.

323-13
BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

Date : 20/7/26
Patient Name: Mrs. Nagam Durga Bai Date of Birth: 21/8/1997 Age: 28y
Gender: f Ward: BB-11 UHID No.: BAH-00641483
Date of Surgery: 20/7/26 ☐ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: SVD E Epidural

Time in : 5pm

Time Out : 6pm

	NAME	AMOUNT
1. Surgeon	Dr. Prathyusha Reddy	
2. Anaesthetist	Dr. Sunidara	
3. Assistant Surgeon	Dr. Samcena	
4. OT Technician		
5. Circulating Nurse	Sy. Suroopa	
6. Assistant Nurse		

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9713248

Order by: [Signature]

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176611

Admit Date : 19-Jul-2026

Admit Time : 05:53 PM UHID : BAH-00641483

Patient Details :

Patient Name : Mrs NAGAM DURGA BAI

Age : 28 Y 10 M 28 D

Guardian : Mr NALLA KONDILLA RAJA KUMAR

DOB : 21-08-1997

Gender : Female

Religion :

Occupation :

Marital Status : Married

Address (H) : H NO - 2-50, LAXMIPUR, PEDDAMPET , Odela
Karimnagar Telangana INDIA 505152

Phone No : 9390489002 / 8790245456

E-mail : n.durgabai547@gmail.com

Admission Details :

Bed Type : SHARED WARD

Bed No : SW 418

Ward Name : 4F-BIRTHING CENTRE

Room No : SW 418

Admission Type : First Visit

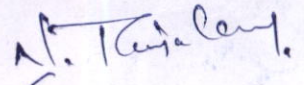
Contact Details :

Name : Mr NALLA KONDILLA RAJA KUMAR

Relationship : Husband

Contact Address : H NO - 2-50, LAXMIPUR, PEDDAMPET ,
Odela Karimnagar Telangana INDIA 505152

Phone No : 9390489002 / 8790245456


Signature

Doctor Details :

Doctor Name : Dr. DR.M PRATHYUSHA REDDY

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : FAMILY HEALTH PLAN INSURANCE
TPA LTD

ACTIVITY RECORD FOR BILLING

Name : BAH-00641483 IPS-00176611
Mrs NAGAM DURGA BAI
21-08-1997 28 Y 10 M 28 D (F)
Dr. DR.M PRATHYUSHA REDDY

UHID 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
20/7/25	9 PM	OBS	323-A	Gayatri

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

4457079

[illegible]

[illegible]

This image shows a single sheet of white paper with horizontal dashed lines, typical of primary-ruled notebook paper. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Primigravida @ 38 wks
for IOL

Obstetric Formula:

Obstetric History: M1-2015, NCM

I + PP - SP. Conception
Booked @ 6th Mo.

Present Pregnancy Record:

LMP: 14/10/2015

EDD: 22/7/2016

Corrected EDD: 22/7/2016

GA: 39th 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 Fifts Palpable:

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

RISK FACTORS:

Per Speculum Examination

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☒ Long ☐ Partially effaced ☐ Effaced

Os: Closed ☒ Dilated

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☒ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☒ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

Height: 152 cm

Weight: 69.5 kg

Allergies: N/A

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: Conscious Pallor: absent

Icterus: absent Edema: absent

Temp: Afebrile PR: 72

BP: 114/70 DTR: (+)

CVS: S1S2 (+) RS BAE (+)

Liver/Spleen: Not palpable Urine Output: adequate

DIAGNOSIS

Primigravida @ 39th wks for IOL



Family History: Mother - DM. father → Empiroid legs back	Surgical History: NIL.
Medical History: NIL.	Medication History: T. Iron O.D T. Calcium O.D
Plan of Care: • admission • Consent - IOL, NVD • Monitor vitals - Hourly • Prepare post • PAC • Drug as charted • w/f POL • Send - CBP • Ethena (ss) • Epidural Cmg	Investigations: O +ve Vitals - NR. NT: 1.8 mm. FTS: Low risk. <u>6/6/26</u> 33 + 3 w, cephalic 2296 gms (56%) AC ~ 54% AFI: 15.7 cm, placenta → 4/H Doppler ⊕ <u>19/7/26</u> Hb: 12.4 PLT: 2.26 WBC: 10.43

Doctor Name: Dr. Prathyusha Reddy
 Signature: [Signature]
 Date & Time: 19/7/2026, 6 pm

M PRATHYUSHA REDDY
 Reg. No: 59755

Consultant Name: Dr. Prathyusha Reddy
 Signature: [Signature]
 Date & Time: 19/7/2026, 6 pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	patient Placed in Lithotomy position ✓ Aseptic Condition Parts painted & draped Vaginal wall retracted & Sims speculum anterior lip of Cervix held & sponge holder Intra cervical fold placed & inserted & 40ml of distilled water	
	Post procedure vitals: stable	
19/12/20		
7pm	Primigravida & 38wks for IOL	
	Cc: per B-P: 110/70 mmHg P-R: 72 bpm SpO₂: 100% on RA P/A: UT - Term ruled FHR (+) P/V: Cu-Lang OS: AF PPV₂: -2 True - CBP	1) Monitor vitals - 4hr 2) Drug as charted 3) W/H POL 4) FHR - 4hr 5) NST - 3rd day - Dr. Suresh



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/8/26 10 PM	Primigravida @ 38wks for JOL C/O: mild pain GC: /per, Afebrile. BP: 117/71 mmHg P-R: 82 bpm SpO ₂ : 100% on RA P/A: Ut - Tend NST: reactive. Irritable	R 1) Monitor vitals & fhr 2) Drug as charted 3) w/f pain abdomen 4) Oflec - 50, NST 3 ^{day} 5) Infuse SS
		Dr. Sanku
20/8/26 12:30 AM	Primigravida / 38 th wks / JOL pt - comfortable GC: /per B-P: - 115/60 mmHg P-R: 80 bpm SpO ₂ : 99% on RA P/A: Ut - Tend NST: reactive at 11:30 PM FHR: (+) Plv: Cu - Long CS - 3cm F PPV ₂ : - 2 M (+)	R 1) w/f pain abdomen 2) w/f POC 3) Monitor vitals & fhr 4) NST - 3 ^{day} 5) FHR - 4 ^{day} 6) Infuse SS
		Dr. Sanku



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/2/26	Primie / 38 th wks / IOL.	
3:30 AM	Pt - Comfortable on Epidural Gc - fair Atebribe PR - 78/min. BP - 110/20 mmHg P/A - at Term, Acting, FHS (+) VLE - cx - 1/4" lg. OS - 2-3 cm, PP - vx st - 2', Membrs (+) + ASP, ABR - clear, liquor clear.	Adv:- ① w/f progress of labor ② FHR Monitoring ③ NST - 3rd hr ④ Drugs as charted ⑤ Inform SOS hr (Dr. Lavanya)
20/2/26	Pt - Comfortable on Epidural	
5:30 AM	Gc - fair Atebribe PR - 78/min BP - 110/20 mmHg P/A - at Term, Acting, FHS (+) VLE - cx - 1/4" lg. OS - 3 cm, PP - vx st - 2' Clear liquor	Adv:- ① w/f progress of labor ② FHR Monitoring ③ NST - 3rd hr ④ Drugs as charted ⑤ Monitor vitals utv ⑥ Inform SOS hr (Dr. Lavanya)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 9:30 AM	Primi 39+5wks Lx IOL BP- 122/82 [93] PR- 102bpm SpO ₂ - 98% on RA Temp - 98.7°F P/A - Lt acting Cephalic, FHR (+) P/v - Cx 3cm dilated, effaced. V _x - -2, clear liquor.	
→ On Epidural → 4 doses RLE → Synto - 24wks → NST @ 9:30 AM reactive		Advice: - Syntocin augmentation - CTG monitoring continue, trace 3rd hrly. - vitals & FHR 1hrly. - Hydrate.
noted by sr. Yanning (018268)		Smith
20/7/26 12 PM	pt stable PR : 88/min BP : 119/73 mmHg SpO ₂ - 99% P/A - uterine acting Cephalic. FHR - good V/E - Cx 70% effaced, applied 3cm V _x - -2, clear liquor	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	On Synto 100 at 5um/hr	Adv - FHR monitoring - w/ prep for labor - Intute Synto
20/7/26 1:40 PM	Pt is stable c/o pain abdomen BP - 115/75 [88] PR - 97bpm SpO ₂ - 97% on RA P/A - ut acting cephalic	
✓ Synto - 78ml ✓ Epidural	Plv - G - 3cm; Well effaced. U _x - -2cm; clear liquor, caput (+) U/p - 150ml; high coloured.	
instel 110pm + reactive		
	CHIT:- Dr Prathyusha	
	- Augment Synto @ 6ml/hr every 30min.	
	- Inf. Dextro 10mg IV stat.	
	- CTG trace - 3rd hly	
	- Continuous FHR monitoring	
	- Vitale 1hly.	
	Noted by Dr. Yashwanth (61828)	

Smile

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2026 7:00pm	PND-0 / P/L1 O/E G. tany BP-127/83 mmHg PR-83 pm SpO2-98% RA pA- ut @ ul L/E B/WL	Adv ① ② diet ③ ambulation ④ Hydration ⑤ Drugs as chart ⑥ Monitor vitals 4th hr ⑦ ulf bleeding per vag. n ⑧ Inform sw
11FV 10-Tone (clw)		
Shift to Room		Dr. Divya
	to legs removal 6:00pm 21/7/2026.	noted by Rign @ 7PM
20/7/2026 8:30pm	PND-0 / P/L1 pt comfortable	
B-ur V/E ✓ Voids S/E-pul.	O/E G. tany vital - stable pA- ut @ ul L/E B/WL	Adv ① ② diet ③ ambulation ④ Hydration ⑤ Drugs as chart ⑥ Monitor vitals ⑦ ulf after bleeding plw ⑧ Inform sw
Play Discharge by evening		Dr. Divya →



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PROGRESS NOTES AND DOCTOR'S ORDER

Docu. No. : RCHBH /FRM / CLINICAL / 088

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RESULT SHEET

Date	19/7/22					
Time	6:24 PM					
Hb	12.4					
PCV	37.3					
RBC	4.42					
WBC	10.43					
N/L						
Platelets	236					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

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

Culture and Sensitivities :

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.....

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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MEDICATION RECONCILIATION FORM

Drug Allergies: NKA ☒ Not known any Drug Allergies

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

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

Shifting From: Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T- Iron	144b	p/o	OD	18/7	☐ C ☒ DC
2	T- Calcium	144b	p/o	OD	18/7	☐ C ☒ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Name & Signature: Dr. Prathusha Reddy

: 19/7/2016, 6PM

Signature: [Signature]

: 19/7/2016 @ 7PM

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DRUG CHART

Date of Admission: 19/08/20 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:				



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG : Ty CEPOTAXIME				Date Time	19/7	20/7														
Dose	Route	Frequency	Start Date	9	Am															
1gm	PO	BD	19/7																	
Name & Signature of the Doctor Starting the Drugs:				Dr. Saravathi																
Additional Instructions:				9 PM 10 PM 11 PM																
Daily Doctor's Endorsement by a Sign				9 PM 10 PM 11 PM																
DRUG : Tab. PARACETAMOL				Date Time	20/7															
Dose	Route	Frequency	Start Date	1gm	PO	TD	20/7													
Name & Signature of the Doctor Starting the Drugs:				Dr. Saravathi																
Additional Instructions:				9 PM 10 PM 11 PM																
Daily Doctor's Endorsement by a Sign				9 PM 10 PM 11 PM																
DRUG : Tab. RANTOPRAZOLE				Date Time	20/7															
Dose	Route	Frequency	Start Date	1gm	PO	OD	20/7													
Name & Signature of the Doctor Starting the Drugs:				Dr. Saravathi																
Additional Instructions:				9 PM 10 PM 11 PM																
Daily Doctor's Endorsement by a Sign				9 PM 10 PM 11 PM																
DRUG : Tab. DICLOFENAC				Date Time	20/7															
Dose	Route	Frequency	Start Date	1gm	PO	TD	20/7													
Name & Signature of the Doctor Starting the Drugs:				Dr. Saravathi																
Additional Instructions:				9 PM 10 PM 11 PM																
Daily Doctor's Endorsement by a Sign				9 PM 10 PM 11 PM																



Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
19/7/2020	6:30pm	T-PGEI	25mcg	p/o	[Signature]	Sunitha
19/7	10:30pm	T-PGEI	25mcg	p/o	[Signature]	Sunitha
20/7	2:30am	T-PGEI	25mcg	p/o	[Signature]	Sunitha
20/7	5:30am	T-PGEI	25mcg	p/o	[Signature]	Sunitha
20/7	10pm	Ethamec	1pacc	p/o	[Signature]	Sunitha
20/7	2pm	INT PROTIN	1amp	iv	[Signature]	Sunitha
20/7	3:30pm	Int BUSCOBAN	1amp	iv	[Signature]	Sunitha
20/7	5:30	T. MISOPROSTOL	400mcg	p/r	[Signature]	Sunitha
20/7	5:30	INT. OXYTOCIN	10 units	IM	[Signature]	Sunitha
20/7	5:25	INT. PCM	1gm	iv	[Signature]	Sunitha



I.V. FLUIDS CHART

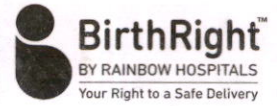
Weight. Ward.

Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
19/7	11 PM	Ringer lactate	IV	100 ml/hr		Sona paldi	20/7		Sona priya
19/7	12 AM	Ringer lactate	IV	100 ml/hr		Sona priya	20/7		Sona priya
19/7	9:30 AM	RINGER LACTATE	IV	100 ml/hr		Yammy Shoba	20/7		Yammy
20/7	7:40 AM	RINGER LACTATE + SYNTOCIN	IV	100 ml/hr		Sona priya	20/7		Yammy Yammy
20/7	10 AM	RINGER LACTATE	IV	150		Yammy Shoba	20/7		Yammy Shoba
20/7	12 PM	RINGER LACTATE	IV	150		Yammy Shoba	20/7		Yammy Shoba
20/7	2 PM	RINGER LACTATE	IV	150		Yammy Shoba	20/7		Smita Swarupa
20/7	5 PM	RINGER LACTATE	IV	150		Smita Swarupa	21/7		Smita Swarupa

Signature

VERIFIED BY: Name

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 21-08-1997 28 Y 10 M 28 D (F)
 Dr. DR.M PRATHYUSHA REDDY



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG :				Date Time												
Dose	Route	Frequency	Start Dt.													
1ml	PO	ON	20/7													
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 :				Date Time												
Dose	Route	Frequency	Start Dt.													
Name & Signature of the Doctor Starting the Drugs:																
Additional Instructions:																
Daily Doctor's Endorsement by a Sign																

Signature

VERIFIED BY : Name

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

Signature
VERIFIED BY : Name



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: Pimi T 38 wks for IOL

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
<u>17/1/2026</u>	☒ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>Pimigrade</u> <u>38 wks for IOL</u>	<u>Safe</u> <u>Precy</u>	<u>IOL</u>	<u>[Signature]</u>	☒ Nursing ☐ Others:
<u>19/1/26</u>	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	<u>IOL</u>	<u>Safe delivery</u>	<u>provided IOL</u>	<u>[Signature]</u>	☒ Medical ☐ Others:
<u>21/1/26</u> <u>8:40 am</u>	☐ Medical ☐ Nursing ☒ Others: <u>dictation</u>	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	<u>PND - 4</u>	<u>Normal</u> <u>diet</u>	<u>Normal High</u> <u>protein diet</u>	<u>[Signature]</u>	☐ 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:

Patient Sticker

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Part - I.

Patient's / Learner Language: Telegu/Kan 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		
19/12/2026	6pm	12/10 4	Δ, R, Complex, Patient Infection Cont	PT	1	0	1	1	Nil	DL
19/12/2026	8pm	7	Infection control measures	PT	1	0	1	1	Nil	Sith
21/12/2026	8:40 am	9	Lactation diet	PT	1	0	1	1	-	Saima

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						

OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 19/7/26 Time of Arrival: 5pm Time Seen by Nurse: 4:50pm

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: came for POC

3) Vital Signs: Temperature: 98.6°F Pulse: 84 RR: 19 SpO₂: 99 BP: 120/80 Weight: -

4) Gestational Criteria:

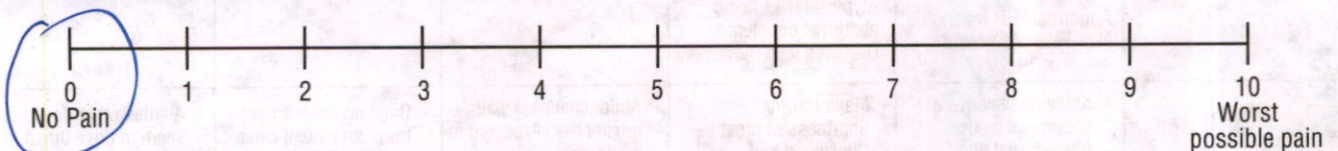
Gravida:	G	P	L	A
----------	---	---	---	---

LMP: EDD: Gestational Age:

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:
• Frequency:
• Interventions:
NO pain

6) Past History:

- a) Surgeries: Nill
b) Medical: Iron and T. Colicure 20



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

Time seen by Doctor: Dr. Lavanya

Nurse Name : Smitha Nurse Signature: [Signature]

Date: 19/7/26 Time: 5:10pm

OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 19/4/26

Baseline Information:

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

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

Chief Complaints: primigravida 32wks for DOL Doctor Notified on Admission: ☒ Yes ☐ No
Name of the Doctor: Dr. prathyusha.R
Time Notified: 5pm

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

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

Gynecology Assessment: ☐ Not Applicable Menstrual History: Regular Onset of Menarche: Menstrual Cycle: ☒ Regular ☐ Irregular Last Menstrual Period: 14/10/2025	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 L A

Previous LSCS: 14/10/2025

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

Family History: ☒ No Abnormalities Detected

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

Vital Signs / Measurements: Temp: 98.6°F HR: 84b/m RR: 19b/m
BP: 120/82(98) Weight: 69.5 Height: 152 BMI:

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



PHYSICAL ASSESSMENT

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

Fall Assessment: ☒ Yes ☐ No Score 20 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☒ Yes ☐ No Score 26 (complete the Braden Q Sheet)

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

Cultural & Spiritual Needs: ☐ Yes ☒ No if Yes specify Inform consultant for positive criteria.

SOCIAL SCREENING:

1. **Marital Status:** ☐ Single ☒ Married ☐ Divorced ☐ Widow

2. **Special Habits:** **Smoker:** ☐ Yes ☒ No **Alcohol Abuse:** ☐ Yes ☒ No **Drug Abuse:** ☐ Yes ☒ No

Social History: Lives With

Orientation has been given regarding the following aspects:

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

Above information given to Patient

Name of Person Orientation was given to: Bai

Orientation not given Reason: No

Nurse Signature: [Signature]

Nurse Name: [Name]

Date & Time: 19/08/2024



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

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

Obstetrics and Gynaecology Early Warning Signs

**Complete a Full
Set of MEOWS
Observations**

1 Yellow Alert :
Repeat Observations
in 30 minutes

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

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

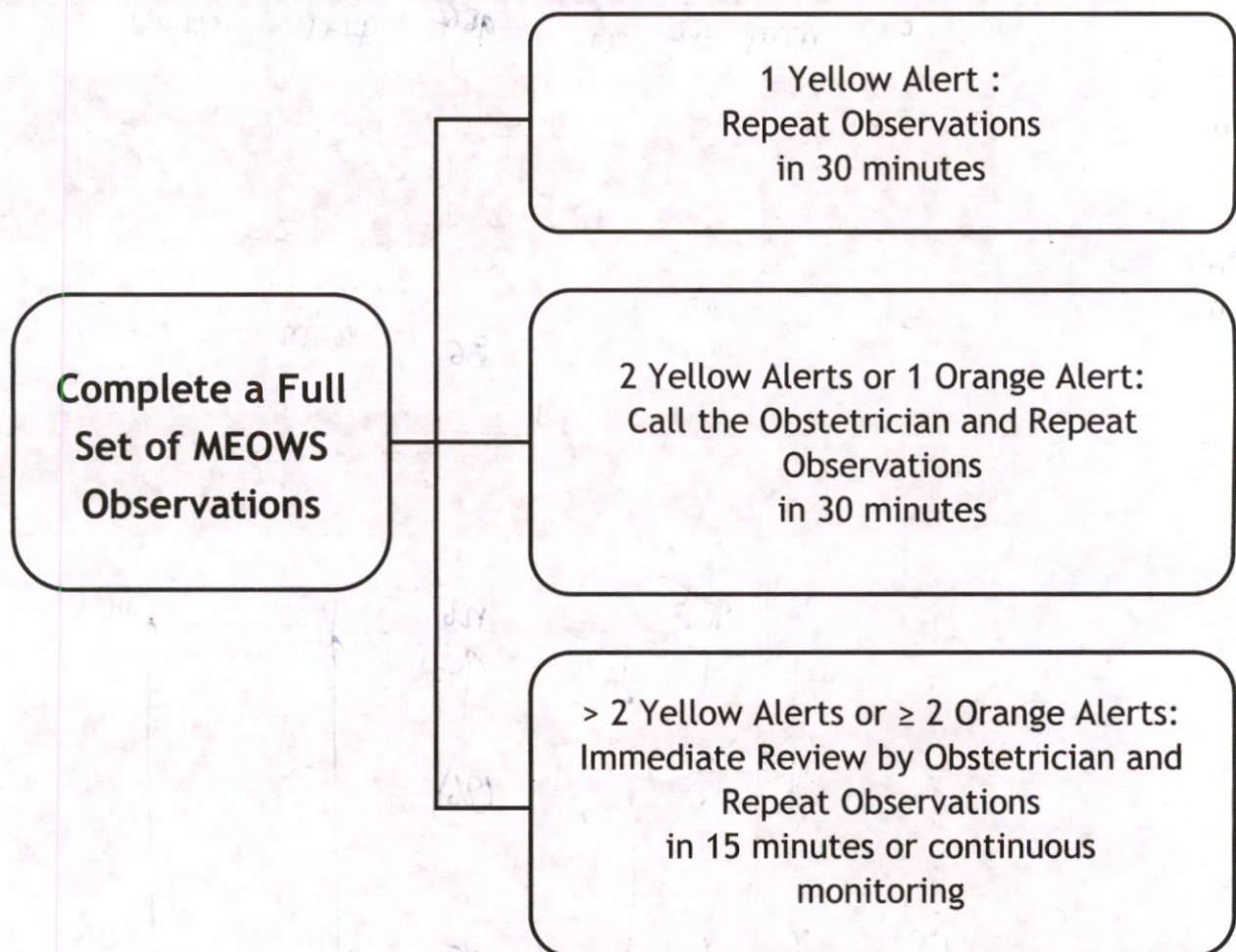
* The Modified Early Warning Score (MEOWS)



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)



FLUID CHART

Sheet No. : ①

19/7/24

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

		Intake			Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine		
			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 :

19/7	02:00 pm										
	03:00 pm										
	04:00 pm										
	05:00 pm	H ₂ O							✓		
	06:00 pm										
	07:00 pm	H ₂ O									

Total Intake : Taken

Total Output : U = m = passed

19/7	08:00 pm									0	done
	09:00 pm	H ₂ O								0	done
	10:00 pm					✓			✓	0	done
	11:00 pm	H ₂ O								0	done
	12:00 am	pl		100ml						0	done
	01:00 am	pl	H ₂ O	100ml						0	done

Total Intake : Taken

Total Output : U = m =

19/7	02:00 am								✓	0	done
	03:00 am	H ₂ O								0	done
	04:00 am									0	done
	05:00 am	H ₂ O								0	done
	06:00 am									0	done
	07:00 am	H ₂ O							200ml	0	done

Total Intake : Taken

Total Output : passed. U = m =

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00641483 IP5-00176611
Mrs NAGAM DURGA BAI
21-08-1997 28 Y 10 M 28 D (F)
Dr. DR. M PRATHYUSHA REDDY



FLUID CHART

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It takes a lot to treat the little.

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Your Right to a Safe Delivery

Sheet No. : 2

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

		Intake				Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G							
20/7/26	08:30 am	RL NBOM		100ml						250ml	0	Pass
	09:00 am	RL NBOM		100ml							0	
	10:00 am	RL NBOM		100ml							0	
	11:00 am	RL NBOM		100ml							0	
	12:00 pm	RL NBOM		100ml							0	
	01:00 pm	RL NBOM		100ml							0	
Total Intake : Taken					Total Output : 0.250ml = 0							
21/7/26	02:00 pm	RL		PLA						150ml	0	Pass
	03:00 pm	RL H2O		synd							0	
	04:00 pm									100ml		
	05:00 pm	H2O										
	06:00 pm	H2O								100ml	0	
	07:00 pm	H2O										
Total Intake : Taken					Total Output : 350ml							
20/7/26	08:00 pm			100ml							0	Pigs
	09:00 pm	L water		100ml						100ml	0	
	10:00 pm	L		100ml							0	
	11:00 pm			100ml						50ml	0	
	12:00 am	water		100ml							0	
	01:00 am			100ml							0	
Total Intake :					Total Output : 100ml = 0							
21/7/26	02:00 am			100ml							0	Pigs
	03:00 am	L water		100ml						300ml	0	
	04:00 am	L		100ml							0	
	05:00 am			100ml							0	
	06:00 am	water		100ml							0	
	07:00 am			100ml						600ml	0	
Total Intake :					Total Output : 1000ml = 0							

Total 24 hrs. Intake

Total 24 hrs. Output 1000ml = 0



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 19/2/20

Assessment: Patient complain fear & anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
3m	* Assess the pt general condition	4m	* Assessed the pt general condition	
	* Monitor vitals		* Monitored vitals	
5m	* Administered medication	5m	* Administered medication	
	* provide diet		* provided diet	
6m	* Monitor NST	6m	* Monitored NST	
7m	* Ensure pt safety.	7m	* Provided pt safety.	* Patient is stable

Re-Assessment: Re-assessment was done

Special Notes: NST monitor

Nurse Signature: [Signature] Nurse Name: Kanak Ojha Date & Time: 19/2/20



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 19/7/26

Assessment: patient is having lower abdominal 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
8pm	- Assess the patient general condition	8:30 pm	- Assessed the patient general condition	- patient is stable & comfortable
10pm	- monitor vitals	10:30 pm	- monitoring vitals Bp, PR, RR, SpO2, checked & recorded.	
12AM	- Soft diet	12:30 AM	- Soft diet taken	
2AM	- Epidural	2:30 AM	- Epidural taken	
3AM	- IV medication	3:30 AM	- IV medication given as per doctor order & noted by	
6AM	- NGT 3rd try	6AM	- NGT done every 2 hrs by	
8AM	- Ensure safety	8AM	- ensure safety provided	

Re-Assessment:

Special Notes: Epidural taken NGT 3rd try

Nurse Signature: [Signature] Nurse Name: Sona Date & Time: 19/7/26 @ 8AM

BAH-00641483 IP5-00176611
Mrs NAGAM DURGA BAI
21-08-1997 28 Y 10 M 28 D (F)
Dr. DR.M PRATHYUSHA REDDY



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 20/7/26

Assessment: Patient having fear and anxiety about labour.

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 general condition of the patient	8 ³⁰ am	Assessed general condition of the patient	Patient is Stable
9am	monitor vitals	9 ³⁰ am	monitored vitals and recorded	
10am	Administer medication	10 ³⁰ AM	Administered medication as per order.	
11am	monitor I/O chart	11 ³⁰ AM	monitored I/O chart	
12pm	Psychological support	12 ³⁰ pm	Psychological support given	
1pm	Ensure Safety	1 ³⁰ pm	Ensured Safety by side rails	

Re-Assessment: Patient cervical dilation 3-4 cm.

Special Notes: on epidural and Fentanyl.

Nurse Signature: Yael

Nurse Name: Yaming

Date & Time: 20/7/26 @ 2pm

BAH-00641483
Mrs NAGAM DURGA BAI
21-08-1997 28 Y 10 M 28 D (F)
Dr. DR.M PRATHYUSHA REDDY

IP5-00176611

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 20/7/26

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
2pm	* Assess the patient General Condition	2:10 pm	* Assessed the patient. General condition	patient is stable
4pm	* provide monitor vitals	4:12 pm	* provided monitor vitals	
	* provide I/O chart		* I/O chart	
6pm	* provide comfortable position	6:10 pm	* provided comfortable position	
7pm	* provide medication	7:15 pm	* provided medication	
8pm	* provide Good Nutritional status.	8:10 pm	* provided Good Nutritional status.	

Re-Assessment: Re-Assessment is done

Special Notes:

Nurse Signature: *sf*

Nurse Name: Sunitha

Date & Time: 20/7/26 @ 2pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 20/7/25 @ 8pm

Assessment: acute pain in surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	→ assess the general condition of the patient and check vital signs.	8:10pm	→ advised the general condition of the patient and checked vital signs.	patient is stable
10pm	→ Giving medication as advised.	10:10pm	→ Given medication as advised.	
12AM	→ Continue IV fluid 100ml/hr.	12:10AM	→ Continued IV fluid 100ml/hr.	
4AM	→ Maintaining good nutritional status.	4:10AM	→ maintained good nutritional status.	
6AM	→ Plan for removing Foley's @ 8AM.	6:10AM	→ Removed Foley's @ 8AM.	
8AM	→ Ensure safety.	8:10AM	→ Ensured safety.	

Re-Assessment:

Special Notes:

Foley's Removal Plan @ 8 AM + 12

Nurse Signature: *[Signature]*

Nurse Name: *[Signature]*

Date & Time: 21/7/25 @ 8AM

BAH-00641483 IP5-00176611
Mrs NAGAM DURGA BAI
21-08-1997 28 Y 10 M 29 D (F)
Dr. DR.M PRATHYUSHA REDDY



NURSING CARE RECORD


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

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

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

- | | | | | | |
|---|--|---|---|---|---|
| ☐ 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. Prathyusha Department: OBS Date of Admission: 19/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:					
	<u>COL</u>							
BACKGROUND	Area	Shift Time	<u>OBS 8PM-11PM</u>	<u>OBS 8PM-11PM</u>	<u>OBS 8PM-11PM</u>	<u>OBS 8PM-11PM</u>	<u>OBS 8PM-11PM</u>	<u>OBS 8PM-11PM</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	<u>98.1F</u>	<u>98.1F</u>	<u>98.5F</u>	<u>98.1F</u>	<u>97.8F</u>	<u>97.9F</u>
		Res:	<u>20b/m</u>	<u>19b/m</u>	<u>20b/m</u>	<u>20b/m</u>	<u>19</u>	<u>18b/m</u>
		SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>98%</u>	<u>100%</u>	<u>99b/m</u>	<u>99%</u>
		Pulse:	<u>80</u>	<u>82</u>	<u>85</u>	<u>87b/m</u>	<u>88b/m</u>	<u>80b/m</u>
		BP:	<u>109/70</u>	<u>115/80</u>	<u>118/78</u>	<u>115/65</u>	<u>121/70(80)</u>	<u>118/65</u>
	Fall Risk Score:		<u>-</u>	<u>-</u>	<u>20</u>	<u>25</u>	<u>35</u>	<u>35</u>
Pain Score:		<u>-</u>	<u>-</u>	<u>0/10</u>	<u>0</u>	<u>0</u>	<u>0/10</u>	
Recommendations	Safety Needs:		<u>Yes</u>	<u>Yes</u>	<u>side rails</u>	<u>side rails</u>	<u>side rails</u>	<u>side rails</u>
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>
Post Operative Procedure Special Orders:			<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :			<u>Kannu</u>	<u>Song</u>	<u>Yamuna</u>	<u>Swathi</u>	<u>Piyas</u>	
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:			<u>19/7/26</u>	<u>20/7/26</u>	<u>20/7/26</u>	<u>20/7/26</u>	<u>21/7/26</u>	
Time:			<u>8PM</u>	<u>8AM</u>	<u>8PM</u>	<u>8PM</u>	<u>8AM</u>	
Taken Over By Name :			<u>Song</u>	<u>Yamuna</u>	<u>Polly</u>	<u>Swathi</u>	<u>Piyas</u>	
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	
Date:			<u>19/7/26</u>	<u>20/7/26</u>	<u>20/7/26</u>	<u>20/7/26</u>	<u>21/7/26</u>	
Time:			<u>8:30PM</u>	<u>8AM</u>	<u>5PM</u>	<u>8PM</u>	<u>8AM</u>	

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 21-08-1997 28 Y 10 M 29 D (F)
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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
19/7	5pm	0/10	NA pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sunithe
19/7	7pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sunithe
19/7	8pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sunithe
19/7	10pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Song
19/7	11pm	02/10	lower abdomen R/R	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	epidural taken	Song.
20/7	12am	02/10	Abdominal site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	epidural on flow	S
20/7	4am	02/10	lower abdomen R/R	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	epidural on flow	Song
20/7	6am	02/10	lower abdomen R/R	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	epidural on flow	Song
20/7	8am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	
20/7	10am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Y

Re-assessment Frequency:

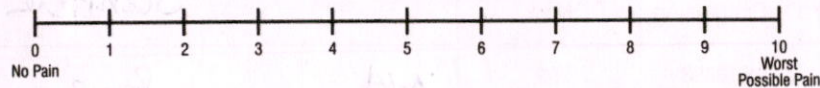
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

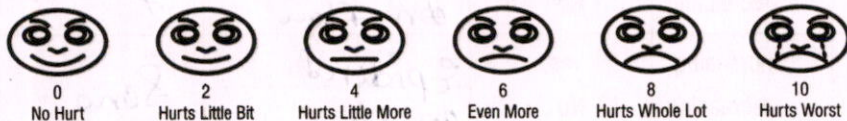
Numerical Pain Scale (Obstetric and Gynecology)



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





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
20/7	12pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Yamini
20/7	2pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Yamini
20/7	4pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Radhika
20/7	5pm	4/10	pain	☐ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	PRM paracetamol	Sunitha
20/7/16	7pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sunitha
20/7/16	8pm	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sunitha
21/7/16	8am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Priya
21/7/16	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Priya
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

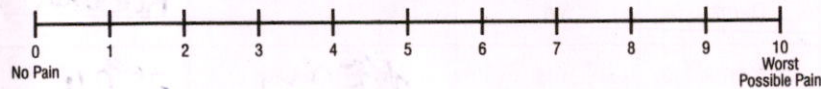
- Every eight hours for all hospitalized patients.
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 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

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Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
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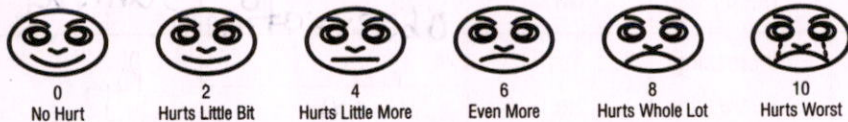
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Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
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Wong - Baker (Pediatrics) Above 7 Years



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21-08-1997 28 Y 10 M 28 D (F)
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BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	9/7	10/7	20/7	2017
					Time :	8pm	8pm	2:40	8pm
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e. extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	9	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	9	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	9	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	9	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	9	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	9	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23									
Docu. No. : RCHBH /FRM / CLINICAL / 119									
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	Runita	4	5	Runita

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

BRADEN 'Q' SCALE

					Date :			
					Time :			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:xtremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	2017 8/20	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4		
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4		
					TOTAL SCORE	28		
					Evaluator's Name	Piya		

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

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



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1 19/8 2019			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0		0	0	0	0					
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		-	-	-	1	-				Cannula changed
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		-	-	-	-	-				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		-	-	-	-	-				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		-	-	-	-	-				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		-	-	-	-	-				
Signature of the Nurse				Senthil Kumar									

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

Signature of Shift In Charge :

Signature : [Signature] Name : Sudha

Signature of Ward In Charge :

Signature : [Signature] Name : Neena

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	19/7	19/7	20/7	Fall Risk Grading		
		Score	2pm-8pm	8pm-11pm	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						
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			Scunthorpe	4	Yamney			

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

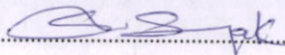
High Risk (≥ 51) Apply all low and moderate risk interventions, and.

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



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Procedure Name: Epidural Date: 19/7/26 In-Time: 10:30pm Out-Time: 11pm
Doctor Performing Procedure: Dr. Sri Ramya Doctor Giving Sedation: — Assisting Nurse: S. S. Poulas

SIGN IN		Time: 10:30 pm		TIME OUT		Time:		SIGN OUT		Time:	
	Yes	No	NA		Yes	No	NA		Yes	No	NA
Patient is verified using two identifiers (Name & UHID)	☒	☐	☐	Correct Patient	☒	☐	☐	Name of the Surgical / Invasive Procedure is recorded	☒	☐	☐
All required documents, images, studies are available	☒	☐	☐	Correct Site	☒	☐	☐	Instrument, Sponge and Needle Count Completed	☒	☐	☐
NPO Status Checked from Patient / Patient Attendant	☒	☐	☐	Correct Procedure	☒	☐	☐	Specimens are labeled	☐	☒	☐
Consent is Signed	☒	☐	☐	All the team members introduced	☐	☒	☐	Any equipment problems are addressed	☐	☒	☐
Any need for blood products	☐	☒	☐								
If Yes Comment:											
Any Risk of Hemodynamic Compromise	☐	☒	☐								
If Yes Comment:											
Any drug or food allergy	☐	☒	☐								
If Yes Comment:											
Correct Site of Procedure Marked	☒	☐	☐								
All resources required are correct, available and functioning	☒	☐	☐								
Signature of the Doctor: 				Signature of the Nurse: 				Signature of the Nurse: 			
Name of the Doctor: Dr. K. S. Seng				Name of the Nurse: Paula				Name of the Nurse: Paula			

Any Adverse / Unexpected Events

Notreng Sègnificant

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00641483 IP5-00176611
Mrs NAGAM DURGA BAI
21-08-1997 28 Y 10 M 28 D (F)
Dr. DR.M PRATHYUSHA REDDY



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pital
ot to treat the little.

Birth
BY RAINBOW
Your Right to

Name: Nagam Durga Bai Age: 28y Sex: F UHID.No: BAH-00641

Date: 19/7/26 Time: 10:20pm Proposed Operation: _____

Diagnosis: Primigravida @ 38 weeks

B.P / CRT: 110/70 H.R: 72 Weight: 69.5kg ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

19/7/26

Hgb: 12.4
PCV: 37.2
WBC: 10.43
Plate: 236000
PT: _____
PTT: _____
INR: _____

Glucose: _____ Protein: _____
Urea: _____ Alb: _____
Creat: _____ Total Bill: _____
Na: _____ Dir. Bill: _____
K: _____ LDH: _____
Ca++: _____ Alk phos: _____
Mg++: _____ Amylase: _____
Cl-: _____ SGOT/SGPT: _____

Laboratory Data:

HIV: + X-Ray: _____
HBS Ag: NR ECG: _____
HCV: + 2D Echo: _____
Blood group: O positive Stress/Anglo: _____
T3 _____ Other: _____
T4 _____
TSH _____

Allergies: NADA

Medical History: CVS: Not Significant

RESP: _____ Diabetes: Nil

CNS: _____

Renal: _____

Hepatic / GE: _____ Physical Activity: METSIN before

Others: _____ Breathless ness on 1st flight

Past Anaesthetic History: _____

Physical Exam: _____

Airway: MP 1 2 3 4 Mouth Opening: _____ Mentohyoid Distance: (2) Neck: (2) Teeth: +

Lungs: BAE @, clear

Heart: S1S2 @

CNS: Groody Intact

Pregnant: ☒ Yes ☐ No ☐ NA Venous Access Site: RG Spine Exam for regional: (2)

Anaesthetic Plan: ☐ MAC ☒ REGIONAL ☐ GA-ETT ☐ LMA (18) hand

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Signature: [Signature] Name: Dr. R. S. Sanyal

Department of Anaesthesiology

DURAL ANALGESIA RECORD

19/7/26

Time: 10:50pm

Procedure done by Dr R. S. Suresh

Spinal / Epidural

Position: Sitting

Space: L2-L4

Technique (LOR/LOS) LOS

Level: L4

Catheter at Skin: 9cm

Attempts: 2

Analgesia : Yes/No if yes details :

Analgesia Composition : 0.1% Bupivacaine + 2mcg/ml Fentanyl

Other issues :

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		
5pm		8ml			112/83	82/min	148bpm	0.8% LIGNOCAINE + ADRENALINE
10AM	8ml/hr	8ml	T8	T8	110/80	83/min	145bpm	0.1% BUPIVACAINE + 2mcg/ml FENTANYL
10AM	8ml/hr		T8 partial	T8	120/80	80/min	144bpm	
10AM	8ml/hr	—						
30AM	10ml/hr	—	T8	T8	117/77	88	147	clo mild pain
0pm	10ml/hr	8ml	T8	T10	115/75	88	151	pain in perineal area
0pm	8ml	10ml of 1% 10xAdr	T6	T6	115/77	108	132	"

Surge Details : Time : 7pm

APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Wound Removed by and Tip Inspected :

Patient Satisfaction :

Surge / Shifting ordered by

Signature: Dr. Suresh R. K.

Name: Dr. Suresh R. K.

and Time : 20/7/26 @ 7pm

BAH-00641483 IP5-00176611
Mrs NAGAM DURGA BAI
21-08-1997 28 Y 10 M 28 D (F)
Dr. DR.M PRATHYUSHA REDDY



CONSENT FOR LABOUR ANALGESIA

Authorization By: ☒ Patient ☐ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of the procedure as follows:
 - ☒ Epidural Analgesia
 - ☐ Intravenous Analgesia (Remifentanyl)
- I have been made aware of the possible complications from the procedures as follows:

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

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

- I understand that labour analgesia is offered to reduce labour pain and make the birthing process more comfortable, by reducing pain and stress and promoting better cooperation during childbirth.

I have been clearly explained about the benefits, risk, and alternative of the procedures.

- I authorize Dr. Subhramanyam and his / her team to perform the above procedure(s) upon the patient / myself.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: N. Durga Bai

Name: N. Durga Bai

Relationship with patient: Self

Date & Time: 19/07/2026 10:30 PM

Witness:

Signature: N. T. Ganesan

Name: N. T. Ganesan

Date & Time: 19/07/2026 10:30 PM

Doctor (who is taking consent):

Signature: [Signature] Name: Dr. R. Srinivas

Date 19/07/2026 Time: 10:30 PM

Patient Sticker

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ప్రసవ నొప్పి నివారణ కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

వైద్యులు నాకు తెలిసిన భాషలో క్రింది విధానాల గురించి సమగ్రంగా వివరించారు:

☐ ఎపిడ్యూరల్ అనాల్జీసియా

☐ శిరస్రావం ద్వారా నొప్పి నివారణ (రెమిఫెంటానిల్)

ఈ విధానాల వల్ల సంభవించగలిగే సమస్యలను కూడా నాకు వివరించారు:

ఎపిడ్యూరల్ సంబంధించినవి:

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

రెమిఫెంటానిల్ సంబంధించినవి:

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

ప్రసవ నొప్పిని తగ్గించడం, ప్రసవ ప్రక్రియను సాకార్యవంతంగా చేయడం, నొప్పి మరియు ఒత్తిడిని తగ్గించడం, ప్రసవ సమయంలో సహకారం మెరుగు పరచడం కోసం లేబర్ అనాల్జీసియా అందించబడుతుందని నేను అర్థం చేసుకున్నాను.

ఈ విధానాల ప్రయోజనాలు, ప్రమాదాలు మరియు ప్రత్యామ్నాయాల గురించి నాకు స్పష్టంగా వివరించబడింది.

డాక్టర్ _____ గారికి మరియు వారి బృందానికి, పై విధానం(లు)ను నాకు / రోగికి నిర్వహించడానికి నేను అనుమతి ఇస్తున్నాను.

పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు ఆ ప్రశ్నలకు నాకు అర్థమయ్యే భాషలో సంతృప్తికరంగా సమాధానాలు అందాయి. ఈ అనుమతి నేను పూర్తిగా స్వేచ్ఛగా చిత్తంతో ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం:

పేరు:

తేదీ & సమయం:



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 20/7/26

Date of Removal:

Parameters	Date	Shift Time	20/7/26 8AM-8PM	20/7 2PM-8PM				
Need for the Catheter	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse	Saf	Smith						
Signature of the Nurse	Sara.	Sf						

File and tape

2/16/02



323-A

NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 21/7/26

Time: 8:40am

Origin: Indian

Height: 152 cm

Weight: 69.5 kg

BMI: 30.3 kg/m²

Food Allergies: No

Diagnosis: PND-1 (post Normal delivery)

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

Diet Advised:

Normal diet (High protein)
include plenty of oral liquids
avoid spicy, chilled & outside foods

Patient's / Attendant's

Signature: N. Durga Bai

Name: Durga Bai

Date & Time: 21/7/26
8:40am

Dietician's

Signature: Saima

Name: SAJMA

Date & Time: 21/7/26
8:40am

125

1

BAH-00641483
Mrs NAGAM DURGA BAI
21-08-1997
Dr. DR.M PRATHYUSHA REDDY
IPS-00176611
28 Y 10 M 28 D (F)

BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?

- ☒ a. Yes ☐ b. No

2. If No, Reason

3. Nipple condition:

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

4. Milk flow:

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

5. Steps for Positioning and attachment:

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



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- ☒ a. Yes
☐ b. No

7. For Caesarian mothers:

- ☐ a. Mother is required sit and feed from the 4th feed
☒ b. Please explain football hold

8. NICU admission: no

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

9. Additional notes:

Continuity of Care:

Date: 20/7/26

provided DBF and Burping

provided warm care

ok

Handover given by Smith

Handover taken by Pur

Signature Sf

Signature Pur

Date & Time: 20/7/26 @ 6:32pm

Date & Time: 20/7/26 @ 9am

BAH-00641483 IP5-00176611
 Mrs NAGAM DURGA BAI
 21-08-1997 28 Y 10 M 28 D (F)
 Dr. DR.M PRATHYUSHA REDDY

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge:

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

☐ Transfer
 Hospital Facility Notified (Person Contacted)

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

☐ Needs Assistance In:

Remarks

☐ Medication ☐ Yes ☐ No

☐ Bathing ☐ Yes ☐ No

☐ Eating ☐ Yes ☐ No

☐ Walking ☐ Yes ☐ No

☐ Dressing ☐ Yes ☐ No

☐ Toileting ☐ Yes ☐ No

no need to assistance

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☒ Patient ☐ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☒ Patient ☐ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: About personal hygiene

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

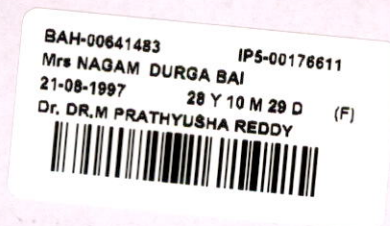
☐ Patient ☐ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 19/08/2018



INDUCTION OF LABOR CONSENT

Name: N. DURGA BAI Age: 28y Gender: Male ☐ Female ☒
UHID.No: 641483 Date: 19/7/2020

You are scheduled for an induction of labor on 19/7/2020 (date) at 38 (weeks of gestation).

The reason for your induction is

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

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

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

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

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

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

Patient

Signature: N. Durga Bai

Name: N. Durga Bai

Date & Time: 19/7/2020, 6pm

Patient Attendant:

Signature: N. T. Rajalakshmi

Name: N. T. Rajalakshmi

Relationship with Patient: Hubbys

Date & Time: 19/7/2020, 6pm

Doctor:

Signature: Dr. S. Ravarthy

Name: Dr. S. Ravarthy

Date & Time: 19/7/2020, 6pm

Witness

Signature: [Signature]

Name: [Name]

Date & Time: 19/7/2020, 6pm

INFORMED CONSENT FOR VAGINAL BIRTH

Patient Name : N. DURGA BAI UHID No : 641483
Gender: ☐ Male ☒ Female Date : 19/7/2016 Time : 6pm

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr. prathusha reddy

Consentee :

Signature : N. Durga Bai

Name : N. Durgabhai

Date & Time : 19/7/2016, 6pm

Witness :

Signature : [Signature]

Name : Kannu

Date & Time : 19/7/2016 6:30

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

Patient Attendant :

Signature : [Signature]

Name : N. Rajakumar

Relationship with Patient: Husband

Date & Time : 19/7/2016, 6pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. prathusha

Date & Time : 19/7/2016, 6pm

సహజ ప్రసవం కొరకు

సమ్మతి పత్రము

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.హెచ్.ఐ.డి. విభాగము

తేదీ

ఈ ప్రక్రియ యొక్క వివరములను నేను ఆమోదించాను:

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

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

సహజ ప్రసవం విజయవంతం కాకపోతే, తగిన అనస్థీసియా ఇచ్చి పాత్రికడుపు కోతతో సిజేరియన్ ద్వారా డెలివరీ చేయవలసిన అవసరం కలిగవచ్చు

సహజంగా లేదా పరికరం సహాయంతో అంటే ఫోర్సెప్స్ లేదా వాక్యూమ్ సహాయంతో బిడ్డను ప్రసవించే ప్రయత్నంలో, ప్రమాదాలు ఉండవచ్చు: అంటువ్యాదులు, అలెర్జీ, మచ్చలు, రక్త నష్టం, రక్త మార్పిడి అవసరం పడటం, నొప్పి మరియు అసౌకర్యం, మూత్ర నాళానికి గాయం, శిశువుకు గాయం అయ్యే అవకాశం (లేసరేషన్, హెమటోమా, పురై గాయం ఆయె అవకాశం, నరాలకు గాయం మరియు మెదడు గాయం) మరియు భవిష్యత్తులో కటి ప్రదేశంలోని ఎముకల వలయం పనిచేయకపోవడం

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

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

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

ఈ ప్రక్రియను నిర్వహించే డాక్టరు పేరు:

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు