MAH-00377098 IP5-00173773
Dr. POOJA MALI
18-11-1995 30 Y 5 M 27 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

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SURGERY DETAILS

Date : 13/5/26

Patient Name: Dr. pooja mali Date of Birth: ..... Age: 30y

Gender: female Ward : P 5T UHID No.: .....

Date of Surgery: 13/5/26 ☐ OT -1 ☐ OT -2 ☒ OT -3 ☐ ~~OT -4~~ ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Diagnostic laparoscopy

Time in : 2:30pm Time Out : 3:40pm

		NAME	AMOUNT
1.	Surgeon	: Dr. Shruthi Reddy	.....
2.	Anaesthetist	: Dr. Shinny	.....
3.	Assistant Surgeon	:	.....
4.	OT Technician	: Ravi	.....
5.	Circulating Nurse	: Robi	.....
6.	Assistant Nurse	: prabhat	.....

9606583

Special Equipment: ☒ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others ~~Hysteroscopy Sheets~~

Dr. Lavanya
Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9606582 Order by: Jyothi

Docu. No. : RCHBH/FRM/GENERAL/114

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : ____

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16-11-1995 30 Y 5 M 27 D (F)
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_____ Dept : _____

Date of Admission: _____ Time : _

_____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
13/5	2.30pm	CVSN	OT	
13/5	3.40p	OT	CVSN	
13/5	6.27pm	CVSN	3i Icu	

Cross Consultation Visit

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

INVESTIGATIONS			
Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
13/5	Ventilator	3.40pm		9606587	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
	PAC	op bags		
13/5	RV plant		9606586	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 13/5/26

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: planning for pregnancy

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Durga

Time Notified: 1pm

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

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

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

.....

Onset of Menarche: .....

Menstrual Cycle: ☑ Regular ☐ Irregular

Last Menstrual Period: .....

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: .....

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: 86 bpm RR: 20 cpm

BP: 110/72 Weight: ..... Height: ..... BMI: .....

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

MAH-00377098 IP5-00173773
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PHYSICAL ASSESSMENT

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

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

Risk of Pressure Sore: ☑ Yes ☐ No Score ..22.. (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

SOCIAL SCREENING:

1. **Marital Status:** ☐ Single ☑ Married ☐ Divorced ☐ Widow
2. **Special Habits:** **Smoker:** ☐ Yes ☑ No **Alcohol Abuse:** ☐ Yes ☑ No **Drug Abuse:** ☐ Yes ☑ No

Social History: Lives With ..Family.....

Orientation has been given regarding the following aspects:

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

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

Above information given to ..Patient.....

Name of Person Orientation was given to: ..MRS. Pooja.....

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: .....

Date & Time: 13/5/22

MAH-00377098
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18-11-1995
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DIAG LAP +/- HYSTEROSCOPY

CONSUMABLES OF OT

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3650

Circulating staff : ..... Technician : ..... Date : 18/5 Time : .....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube 7.0 7.5	1H	1	Major Pack dvP	1	1	Inj Vit.K		
LMA 3,4	1H	—	Sutures 1 eg yien	1	1	Cord Clamp		
ECG leads : A / P / N	05	3	TURP Set	1	1	Suction Catheter		
HME filter : A / P / N	01	1				Feeding Tube		
Syringes : 10 cc	10	6				Vaccum Suction Set		
05 cc	10	4	Gloves pr/s 6½ 7 7½ 8			Surgical Gloves		
02 cc	10	2				Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate : A / P / N	01	—	Surgical blade 11	1	1	Surgical Blade # 20		
IV set	01	—	NG tube Nelton 10	1	1	Koochies (S)		
RL	07	1	Cautery pencil			NS 500ml	2	1
NS : 10ml / 100ml / 500ml / 1000ml	01	1	Koochies			10%	2	1
mini spike	01	1	Ointments			Foaned HX	1	R
vacey set	01	1	Suction Catheter			Jelly	1	1
Fentanyl	01	1	Cap, Mask	3 6 5				
Morphine			Gauze Pack (N) + R	1 + 2				
Ketamine			Mop Pack	1	1			
Propofol	03	2	Steristrip					
Rocuronium	01	1	Underpad	1	1			
Glycopyrolate	01	1	Draw sheet	1	1			
Myopyrolate	01	1	Abgel					
Ondansetron	01	1	Foleys catheter					
Pencan 25g/ Spinal Needle 22	01	—	Urobag			O-T 2/3	1H	—
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			PA 28.30	1H	—
Bupivacaine 0.25%(Heavy)	07	—	Romodrain bag			O2 mod (A)	01	—
Antibiotics			Bandage			Ephidrine	01	—
IVPCM		1	Tegaderm			SCD Boots (S/M)	1H	—
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg	01	1	Vaccum Suction set	1	—			
Justin : 12.5 mg / 25mg / 100mg	01	—	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution	2	2			
Surgy (ocm + coocm	1H	—	Microshield	1	—			
Gauz + Gloves set	Stay	—	Cotton Balls	1	1			
Dexa + Tramese	1H	—	Latex Gloves	1 pr	1 pr			
IV Canula 20+18	1H	—	Ramdione Scrub					
Arte splint L/S	HH	—	Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 7606643 Ordered by : .....

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

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00173773 **Admit Date** : 13-May-2026 **Admit Time** : 12:43 PM **UHID** : MAH-00377098

Patient Details :

Patient Name	: Dr. POOJA MALI	**Age**	: 30 Y 5 M 27 D
Guardian	: Mr N NARESH KUMAR	**DOB**	: 16-11-1995
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: 2-2-213/6/1, GANESH NAGAR COLONY, MACHA BOLLARAM, ALWAL, SECUNDERABAD Alwal Hyderabad Telangana INDIA 500010	**Phone No**	: 8886461978/ 8019951797
		E-mail	: pooja.mail.0142@gmail.com

Admission Details :

Bed Type : DAY CARE **Bed No** : RC 408 **Ward Name** : 4F-GYN RECOVERY

Room No : RC 408 **Admission Type** : First Visit

Contact Details :

Name : Mr N NARESH KUMAR **Relationship** : Husband

Contact Address : 2-2-213/6/1, GANESH NAGAR COLONY, MACHA BOLLARAM, ALWAL, SECUNDERABAD Alwal Hyderabad Telangana INDIA 500010 **Phone No** : / 8886461978

Signature

Doctor Details :

Doctor Name	: Dr. SHRUTHI REDDY/Dr.LAVANYA JANAGAMA	**Specialisation**	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: Self	**Phone No**	:
Co-Consultant	:		

Payment Details :

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

Payor Name : SELFPAY

MAH-00377098 IP5-00173773
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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 13/5/25 Time of Admission : 1pm

Allergies: NKDA ☑ Not know any drug allergies

PRESENTING COMPLAINTS :

Anxious to conceive
- No c/o pain Abdomen white discharge PV.

Menstrual Hx. Regular cycles. 3-4 days of flow

MENSTRUAL HISTORY		OBSTETRIC HISTORY	
Year of Marriage :	2023, NCM	Parity :	—
Previous Periods :	Regular.	Mode of Delivery :	—
LMP :	3/5/25	Last Child Birth :	—
Contraception :	None.		

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Hypothyroidism : Yes on Tab Thyronorm 50mcg/OD	NO.

Patient Sticker

FAMILY HISTORY:	MEDICATION HISTORY:
father - HTN.	no Medical recommendation

INITIAL ASSESSMENT :

Date 13/3/26 Ht. 163 Wt. 64 BMI 24.6kg/m² B.P 104/70mmHg Pallor NO CVR S1S2 ⊕ Respiratory System BLNBLO Thyroid Ⓝ	Breasts Ⓝ Abdominal Examination soft nontender	Local/Speculum Examination Bimanual Pelvic Examination

PROVISIONAL DIAGNOSIS : Primary subfertility c̄ ? B/c tubal Block c̄ k/c/o Hypothyroidism for Diagnostic Hysterolaparoscopy + chromopertubation

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
12/3/26 B positive CBP. 12.2 / 8.38 / 2.92 L. TSH 4.20 Creat 0.77 HIV / HBsAg / HCV. NR Na+ / K+ / Cl- 141 / 4.2 / 105	- NBM - vitals hourly - prepare parts - consents - PAC - Rx - of medications - shift to OT on call

Name of the Doctor : Dr. [illegible]

Signature of Doctor [signature]

Date & Time : 13/3/26 @ 7am

MAH-00377098 IP5-00173773
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
13/5/26 3:40pm.	POD-0/ Diagnostic Laparoscopy.	
	O/E Cc-fair Bp-102/76mmhg PR-67Bpm. SpO2-100% in RA P/A-Soft CV-DVR	Adv 1) NBM for 2 hrs. followed by liquids 2) Monitor vitals 4th hrly 3) Inform SOS. 4) Drugs as charted DR Dr. Divya
	Noted	My My

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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OPERATION THEATER NOTES

Patient's Name : ..... Age : 30Y Gender : ☐ Male ☑ Female

UHID No.: ..... Weight : 64 kg Height : .....

Surgeon : Dr-Shruthi Reddy.	Asst. Surgeon :	
Anesthetist :	OT Nurse:	OT Technician:

Pre-Operative Diagnosis: Primary Subfertility ? B/L tubal block.

Surgical Procedure : Diagnostic laproscopy.

Indications for Surgery : ? B/L Proximal tubal block.

Date :	Start Time : 3:10 pm	End Time : 3:30 pm

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:

+ GA, Patient kept in lithotomy position. Procedure.
- Abdomen and perineum cleaned and draped in sterile condition.

1 5mm infraumbilical port.
1 5mm lateral port.

Findings:- uterus, AV, normal size.
- B/L ovaries - Normal.
- Right tube Normal - Dye test positive.
- left tube - Convoluted - Dye test positive. (Delayed spill)
- No adhesions.

Amount of Blood Loss:	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

Adv:-

(1) Tab. TAxIM - 200mg BD x 5 days

(2) Tab. Dolo 650 mg SOS.

Name of the Surgeon: Dr. Shruthi Reddy

Signature of the Surgeon: for Dr (Dr. Lavanya)

Date & Time: 13/5/26 3:30pm

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DRUG CHART

Date of Admission: 13/5/26 Drug Allergies: NKDA. ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

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

Patient Sticker

REGULAR PRESCRIPTIONS

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

DRUG : T. PARACETAMOL				Date ▸ / Time ▾
Dose	Route	Frequency	Start Date	
1gm	P/O	QID	13/05	
Name & Signature of the Doctor Starting the Drugs: DR SHINY [signature]				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

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

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

MAH-00377098
Dr. POOJA MALI
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Weight. ..... Ward. .....

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

VARIABLE DOSE DRUG : / Route / Start Date / Name & Signature of the Doctor / Additional Instructions:	Date ▸ Time	Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
		Dose	Dose	Dose	Dose
		Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
		Dose	Dose	Dose	Dose
		Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
		Dose	Dose	Dose	Dose
		Dr. Sign.	Dr. Sign.	Dr. Sign.	Dr. Sign.
		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
13/5/26	2pm	Inj. CEFOTAXIM	1gm	IV		
13/5/26	2:33PM	Inj. BUSCOPAN	1amp	IV		
13/05/26	3:24pm	SUP TRAMADOL	100mg	PR		
13/05/26	3:05 pm	Inj PARACETAMOL	1gm	IV		

MAH-00377098 IP5-00173773
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I.V. FLUIDS CHART

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

		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
13/05/26	1PM	RINGER LACTATE	IV	FF			13/5		
13/5	4pm	RINGER LACTATE	IV	FF			13/5		

Signature .....

VERIFIED BY : Name .....

Pati

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... NKDA ..... ☐ ~~Not known any Drug Allergies~~

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ..... NA ..... Shifted to: ..... NA .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab. THYRONORM	50	PO	OD	13/5	☐ C ☑ ~~DC~~
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr. Ramesha .....

Date & Time : ..... 13/5/26 @ 1pm .....

Nurse Name & Signature: ..... Neeshi .....

Date & Time : ..... 13/5/26 1pm .....

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Blood group B+ve

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RESULT SHEET

Date	12/5/26					
Time						
Hb	12.2					
PCV	35.1					
RBC	3.96					
WBC	8.38					
N/L						
Platelets	292					
CRP						
ESR						
PCT						
RBS						
Na	141					
K	4.2					
Cl	105					
Ca/Mg						
Phosphate						
Urea						
Creatinine	0.77					
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						
HIV, HB SAg VDRL HCV	-VE					

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

Patient Stic

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Dr. POOJA MALI
16-11-1995 30 Y 5 M 27 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Diagnostic laproscopy

Post-Surgical Diagnosis: POD-0

Post-Operative Monitoring Parameters /Frequency:
- Monitor vitals hrly

Wound Care:
- check for wound Soakage.

Drain /Special Lines/Catheters:
- foley's insitu

Special Patient Positioning and Requirements:
-

Nutritional Instructions:
- NBM x 2hrs
- followed by liquids

When to Start Mobilization:
- After 2hrs

Special Referrals:
-

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Dr (Dr Lavanya)
Treating Surgeon
(Signature & Stamp)

Date: 13/5/26 Time: 8:30pm

Note: Plan of care will be readjusted if necessary.

Patient Sticker

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

Date : 13/5/26

To Be Filled In By Assigned Nurse :

Department : P-ST Duration of Procedure : 1 hr

Name of Surgeon : Dr - Shruti Reddy Date of Admission : 13/5/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☑ Yes ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☑ Yes ☐ No Name of the Antibiotic : Inj. Taxim 1gm	
2.	Hair Removal ☑ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : ..... Skin preparation done (cleanse surgical area with antiseptic agent)? ☑ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 34.1 °C ☐ Oral Or ☑ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Nagini B Date & Time of antibiotic administration : @ 2pm, 13/5/26 Date & Time procedure started : @ 2:08pm, 13/5/26	

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

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SUF
SAF

Surgeon : .....
Asst. Surgeon : .....
Anaesthetist : Dr. Shinvay
Scrub Nurse : Pravabhati

Patient Name : Mrs. Pooja Age : 30Y Gender : F
UHID No. : 377693 Surgery Name : Diagnostic Laparoscopy + Hysteroscopy
Date : 13.5.26 In-time : 2:50 pm Out-time : 3:40 pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 2:43pm

Patient Has Confirmed
- Identity ☑ Yes ☐ No
- Site ☑ Yes ☐ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

Site Marked ☐ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

Does Patient have a:
- Known Allergy? ☐ Yes ☑ No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☐ Yes ☑ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☐ Yes ☐ No ☐ NA
- Blood Units Reserved ☐ Yes ☐ No ☐ NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑ Yes ☐ No ☐ NA

Signature : .....

Name : Dr. SHRUTHA

Before Skin Incision ➤➤

TIME OUT Time: 3:08 pm

Confirm all team members have introduced themselves by Name and Role ☑ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☐ Yes ☑ No
- Correct Procedure ☐ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Adison minimal ☐ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☑ Yes ☐ No ☐ NA

Nursing Team Reviews: Bronchospasm, Laryngospasm
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☐ Yes ☑ No ☐ NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑ Yes ☐ No

Signature : .....

Name : .....

Before Patient Leaves Operating Room

SIGN OUT Time: 3:35pm

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑ Yes ☐ No ☐ NA
- The Specimen is Labelled (including patient name) ☐ Yes ☑ No ☐ NA
- Whether there are any Equipment Problems to be addressed ☐ Yes ☑ No ☐ NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☑ Yes ☐ No

Signature : .....

Name : Dr. Lavanya

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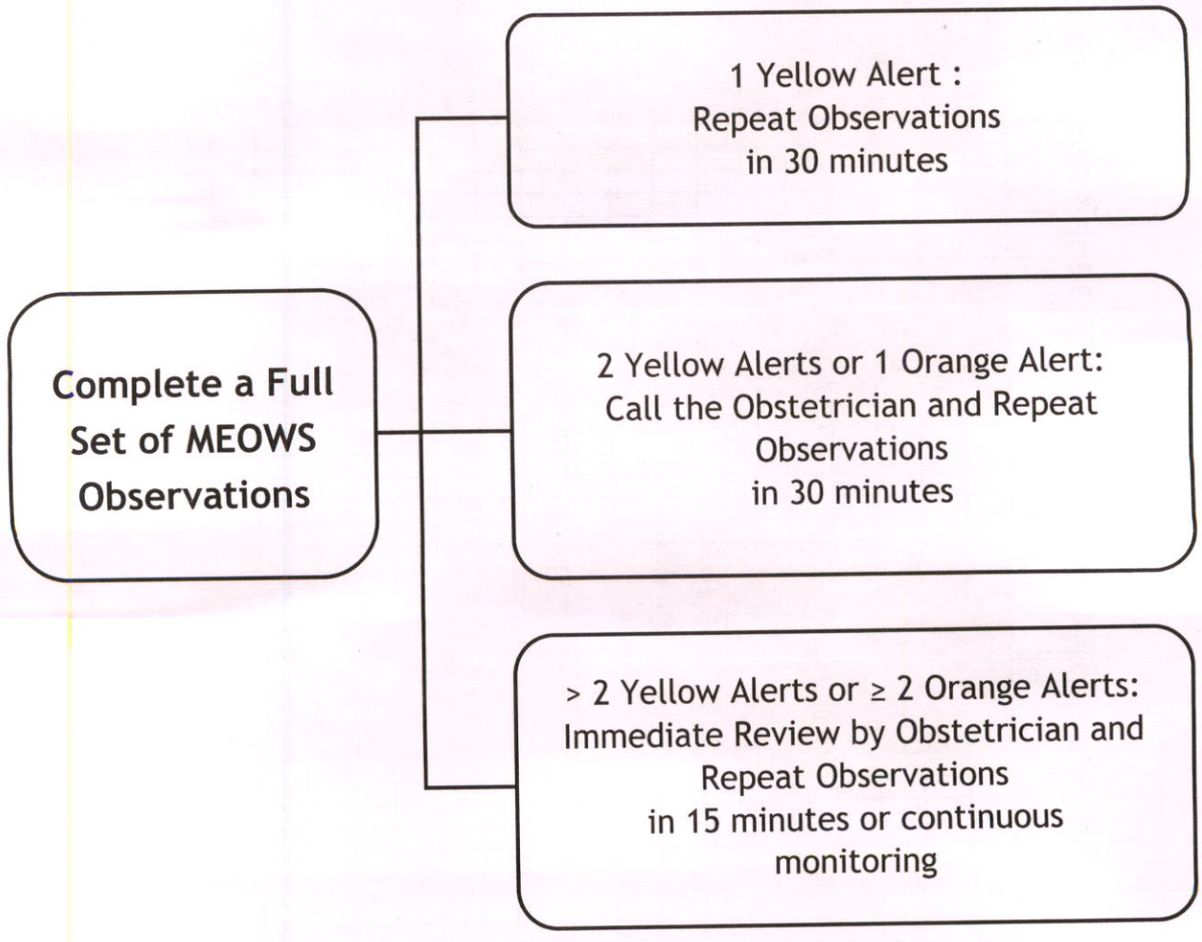
Early Warning Observation Score Chart - Obstetrics

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

		Date																							
		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																									
Saturations	94 - 100 %																									
	< 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



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

Patient Sticker

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

13/5	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																								
Saturations	94 - 100 %						•	•	•	•	✓														
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
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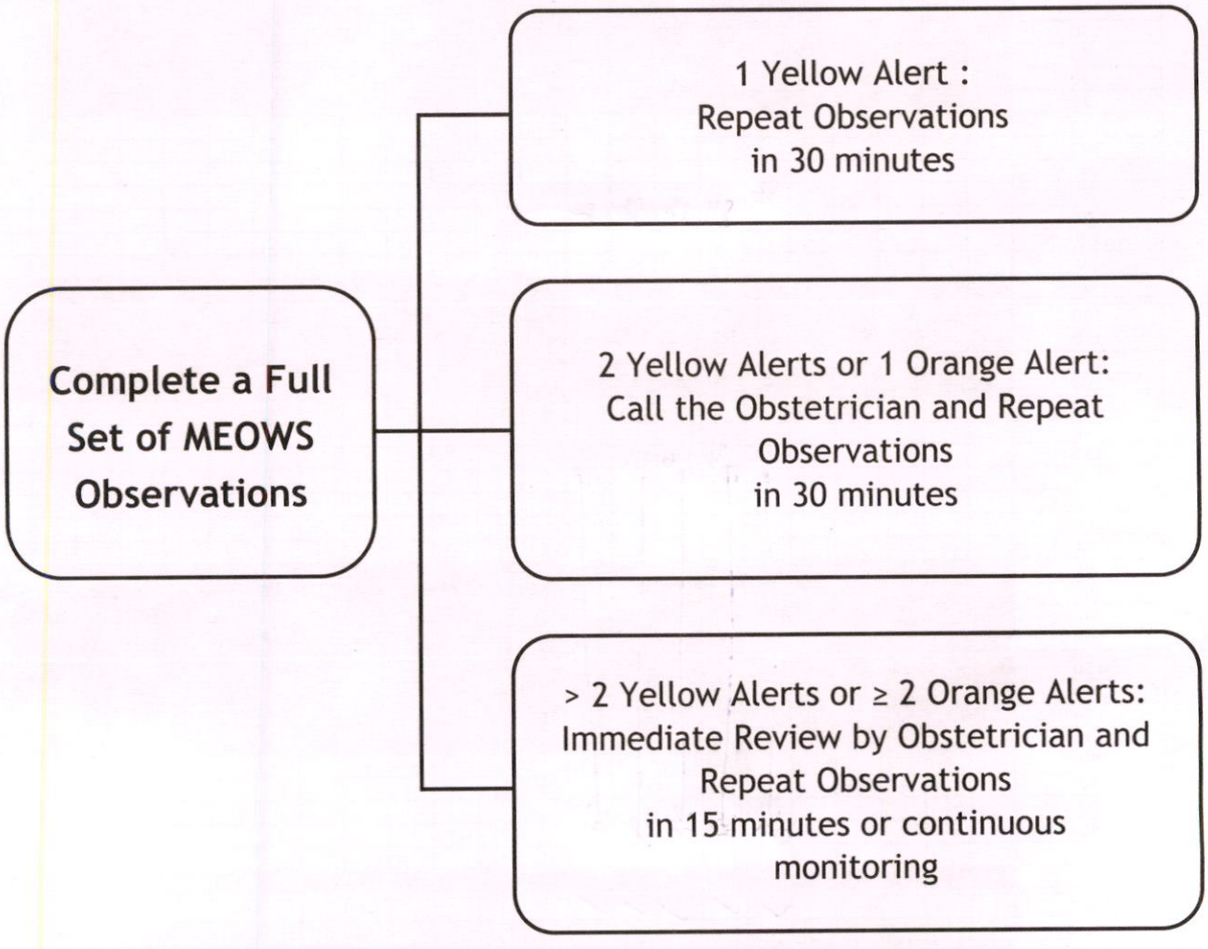
	38																								
	37						×	×	×	×	×														
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80						86	84	[illegible]	80	[illegible]														
	70																								
	60																								
	50																								
	40																								
↑ Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130						120	130	116	118	[illegible]														
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
↓ Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60						[illegible]	[illegible]	76	[illegible]	[illegible]														
	50																								
	40																								
NEURO RESPONSE [✓]	Alert						✓	✓	✓	✓	✓														
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30						✓																		
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal																								
	Heavy / Foul																								
Liquor	Clear / Pink																								
	Green																								
TOTAL YELLOW SCORES							0	0	0	0	0														
TOTAL ORANGE SCORES							0	0	0	0	[illegible]														
Nurse Initial							[illegible]	[illegible]	[illegible]	[illegible]	[illegible]														

Obstetrics and Gynaecology Early Warning Signs



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

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FLUID CHART

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Sheet No. : 1

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
13/5	10:00 am		M									
	11:00 am		J									
	12:00 pm		O									
	01:00 pm	RL		100 ml								
Total Intake :						**Total Output :**						
	02:00 pm		M	100 ml							0	
	03:00 pm	RL	A	100 ml							0	
13/5	04:00 pm		D	100 ml							0	
	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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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			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**	

HYPOTHYROIDISM

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Dr. POOJA MALI Age: 30y Sex: FEMALE UHID.No :

Date: 12/05/26 Time: 11.30 AM Proposed Operation: DIAGNOSTIC LAPAROSCOPY. HYSTEROSCOPY. on (14/5/26)

Diagnosis: PRIMARY SUB-INFERTILITY

B.P / ~~CRT~~: 80 bpm H.R: Weight: 64kg ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

120/78 mmHg.

Laboratory Data:

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

Allergies: NKDA.

Medical History: CVS : NAD.

RESP : NAD Diabetes : NAD

CNS : Sleep disturbance.

Renal : NAD.

Hepatic / GE : NAD. Physical Activity: NAD.

Others : NAD. HYPOTHYROIDISM (controlled)

Past Anaesthetic History: NAD.

Physical Exam: ACTIVE / AFEBRILE.

Airway: MP 1 (2) 3 4 Mouth Opening: Adequate Mentohyoid Distance: >3 fingerbreadth Neck: NAD Teeth: Intact

Lungs : Clinically NAD

Heart:

CNS:

Pregnant: ☐ Yes ☑ No ☐ NA Venous Access Site : Adequate Spine Exam for regional : NA.

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

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

CURRENT MEDICATIONS	DOSAGE
THYROXINE	50mcg/24HR.

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:

Signature: Ravi Name: RAVI

Docu. No. : RCHBH /FRM / CLINICAL / 044

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ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition:	☐ Yes ☑ No	Fasting Status: Confirmed	
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 79 bpm	B.P / ~~CRT:~~ 123/87	SpO: 100	R.R: 14 cpm	Last Feed: > 6 hrs	
Pre-OP Diagnosis: primary Subinfertility	Operation: Diagnostic laparoscopy	Date: 13/05/26			
Surgeon: Dr. Shruthi Reddy	Anaesthesiologist: DR. SARITHA / DR SHINY	Technician: RAMESH / AMAAN			

TIME: 3:00 pm → 4:00 pm

N_2O (AIR) O_2 LPM: 0.5 : 0.5 → →

HALO / ISO / SEVO: MAC = 1 → →

Drugs:
- Inj Midazolam 2mg IV
- Inj Fentanyl 100mcg IV
- Inj Propofol 100mg IV
- Inj Rocuronium 40mg IV

Antibiotic

Suppository: Sup Framadol 100mg PR

Blood Loss

FIO_2 / SaO_2	100	100	100
ETCO$_2$	35	35	35
ECG	SR	SR	SR
Temperature	34.5	34.6	34.8
Urine Output			
Fluids / Blood	RL - 500ml		

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values: ABG; GRBS; Others

☑ Equipment Checked and Functional
☑ BP
☐ Cuff Site: (R) UL
☐ Art Site: .....
☑ EKG Lead
☑ Temp Site Skin
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position: LITHOTOMY

☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

Temp:
☑ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☑ Hugger's ☐ Cotton Wool
☐ Other

Times:
Anaes Start: 2:55 pm
OP Start: .....
OP End: .....
Leave OR: 3:40 pm

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☑ IV: (R) UL 20G
☐ IV: .....
☐ IV: .....

Induction
☑ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# 7.0 at 19 cm
☑ Oral ☐ Nasal ☑ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: .....

☐ Awake ☑ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# 3 Attempts: 1
Difficulty Why? .....

☐ **Bilat = BS**
☐ Semi-Closed Circle
☑ Closed Circle
☐ Other

Regional:
Extremity Specify: .....
☐ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: .....
Site: .....
Needle Size: ..... Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: .....
Bolus: .....
Infusion: .....
Block Level: .....
Comments: .....

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☑ Yes ☐ No ☐ NA

Name of the Doctor: DR SHINY
Signature of the Doctor: KS

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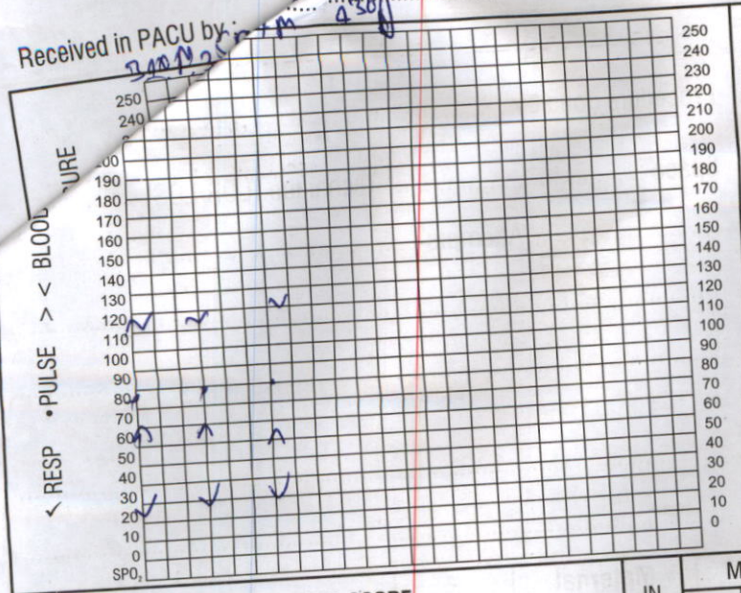
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: ..... Time Received : 3.40 pm Time Discharged : .....



IV Cannula Site : Rt'gut- hand

- ☐ O_2 Mask
- ☐ Tracheostomy
- ☐ Oral Airway
- ☐ Nasal Prongs
- ☐ T-Piece
- ☐ Nasal Airway

Vomiting : ☐ Yes ☑ No Drug: .....
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☐ Yes ☑ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☑ No
IV Fluids: RL on Flus
Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY	1	2	2		
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION	2	2	2		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION	2	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS	1	1	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR	2	2	2		
		TOTAL	8	9	10		

SCORING INTERPRETATION

A Minimum Total Score of 8 is Required for Discharge

Exceptions to this, are to be explained in the space below by the Discharging Physician:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
13/5	3.40pm	0		

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

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

Anaesthesiologist Name : .....
Anaesthesiologist Signature: .....
Date & Time: .....

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: 13/5/26 at 3.40pm.

Transferred to Unit by (PACU): BP Clung
Date & Time: 13/5/26

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal BP	Maternal Pulse	FHR	Comments

Delivery Details : Time : ..... APGAR: ..... SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

MAH-00377098 IP5-00173773
Dr. POOJA MALI
16-11-1995 30 Y 5 M 27 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Hospital
It takes a lot to treat the little.
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name : Dr. Pooja Mali Gender: ☐ Male ☑ Female Age : 30

UHID No : MAH - 00377098 Date : 13/5/26

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

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

DIAGNOSTIC LAPROSCOPY ± HYSTERO SCOPY

upon

POOJA MALI (Name of the Patient)

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

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

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

Hemorrhage, Sepsis, Injury to surrounding structures, Uterine perforation

My signature on this form indicates that

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

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

Consentee :

Signature :

Name : Dr Pooja Mali

Date & Time : 13/5/26 1:10pm.

Patient Attendant :

Signature : N. Naresh

Name : N. Naresh Kumar

Relationship with Patient: Husband

Date & Time : 13/5/26, 01:10pm

Witness :

Signature : Keerthi

Name : Nagamani

Date & Time : 13/5/26 at 1pm

Doctor (who is taking the consent) :

Signature :

Name : Dr. Saneera

Date & Time : 13/5/26 @ 1pm

Docu. No. : RCHBH /FRM / CLINICAL / 027