

BAH-00630218
Ms G NITHYA PRIYA
12-03-2011 15 Y 4 M 10 D (F)
Dr. SASIKALA KOLA

Ms G NITHYA PRIYA (15 Y 4 M 10 D / F)
BA26073676032

nbow
ldren's
spital
It takes a lot to treat the little.

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

SURGERY DETAILS

Date : 22/09/26

Patient Name: Ms. G. NITHYA PRIYA Date of Birth: 12-03-2011 Age: 15Y

Gender: F Ward: P-OT UHID No.: 0176268

Date of Surgery: 22/09/26 ☒ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : laparoscopic AECM excision

Time in : 03:15 pm

Time Out : 05:00 pm

	NAME	AMOUNT
1. Surgeon	Dr. Sasi Kala	
2. Anaesthetist		
3. Assistant Surgeon		
4. OT Technician	Nishanth, Ramesh	
5. Circulating Nurse	Anu	
6. Assistant Nurse	Rana	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 09717003

Order by: [Signature]

BAH-00630218 IP5-00176763
 Ms G NITHYA PRIYA
 12-03-2011 15 Y 4 M 10 D (F)
 Dr. SASEKALA KOLA



LAPAROSCOPIC
 UTERINE ANOMALY
 50218 CONSUMABLES

Technician: *Nithya*

Date: _____ Time: _____

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
	Issued	Used		Issued	Used		Issued	Used
ET tube 6.0/6.5	14	01	Major Pack	1	1	Inj Vit.K		
LMA 3.4	14	1	Sutures 2346			Cord Clamp		
ECG leads: A/P/N	5	05				Suction Catheter		
HME filter A/P/N	1	01				Feeding Tube		
Syringes: 10 cc	10	6				Vacuum Suction Set		
05 cc	10	6	Gloves			Surgical Gloves		
02 cc	10	4	6.6/1 2 1/2	4	3+4	Gauze Pack		
01 cc	3	1	PR 6.6/1 2 1/2	24	24	Syringe 1ml / 2ml		
Cautery plate: A/P/N	1	1	Surgical blade 15.12	14	1	Surgical Blade # 20		
IV set	1	1	NG tube			Koochies (S)		
RL	1	01	Cautery pencil			MS 500ml	1	1
NS: 10ml / 100ml / 500ml / 1000ml	4+12	01+11	Koochies			Transphir	1	1
minispike	1	01	Ointments			100ml saline	24	1
vacuum set	1	01	Suction Catheter			fully	1	1
Fentanyl	1	01	Cap, Mask			5/5 10/10	1	1
Morphine			Gauze Pack	2	PR	5/5 10/10	1	1
Ketamine			Mop Pack	1	1	TURP set	1	1
Propofol	4	02	Steristrip	1	1	leggs	2	1+1
Rocuronium	2	01	Underpad	1	1	Inj Anakin 0.25%	1	1
Glycopyrolate	1	01	Draw sheet	1	0	silicon dressing	4	4
Myopyrolate	1	01	Abgel					
Ondansetron	1	01	Foleys catheter 10.12 (W)	14	1			
Pencan 25g / Spinal Needle 22	1	1	Urobag	1	1			
Bupivacaine 0.25%	1	1	Chest Drainage Catheter					
Bupivacaine 0.25% (Heavy)	1	1	Romodrain bag					
Antibiotics			Bandage					
AVPCM	1	01	Tegaderm					
Suppositories			Ioban					
Anamol: 80mg / 250mg / 170 mg			Double J Stent					
Supridol: 100mg	1	1	Vacuum Suction set	1	1			
Justin: 12.5mg / 25mg / 100mg	1	1	Plastic Bed Sheet	1	0			
Tab. Misoprost: 200mg			Betadine Solution	1	1			
3 way 10x10x6cm	14	1	Microshield	1	1			
9 blue all gauge	44	1	Cotton Balls	1	1			
tra hexa to hexa	24	1	Latex Gloves	1	1			
02 mask (A)	1	1	Ramdione Scrub	1	20			
1v cannula (1820)	14	1	Saral					

Surgeon: _____
 Order No.: 97 16857 / Anaesthesiologist: 97 16881
 Doc. No.: RCH / FRM / GENERAL / 125

Nurse: _____
 Ordered by: _____
 OT Technician: _____

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176763

Admit Date : 22-Jul-2026

Admit Time : 12:00 PM UHID : BAH-00630218

Patient Details :

Patient Name : Ms G NITHYA PRIYA

Age : 15 Y 4 M 10 D

Guardian : Mr G SATHISH KUMAR

DOB : 12-03-2011

Gender : Female

Religion :

Occupation :

Martial Status : Single

Address (H) : H NO- 5-1-68/7, SANTOSH NAGAR COLONY ,
SHANTHI NAGAR Zahirabad Telangana INDIA
502220

Phone No : 9989601363/ 9440277216

E-mail : NOMAIL@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 G SATHISH KUMAR

Relationship : Father

Contact Address : H NO- 5-1-68/7, SANTOSH NAGAR COLONY ,
SHANTHI NAGAR Zahirabad Telangana INDIA
502220

Phone No :

Signature

Doctor Details :

Doctor Name : Dr. SASIKALA KOLA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELF PAY

ACTIVITY RECORD FOR BILLING

BAH-00630218 IP5-00176763
Ms G NITHYA PRIYA
12-03-2011 15 Y 4 M 10 D (F)
Dr. SASIKALA KOLA



Name : _____

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/08/26	9:30 PM	OT	323 (A)	Alan

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/07/26	PAC	1	9716854	Alam
22/07/26	IV Placement	1	9716853	Alam
22/07/26	Catheterisation	1	9716853	Alam

ANY OTHER INFORMATION

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 22/7/26 Time of Admission : 11:40 AM
 Allergies : NKDA ☐ Not know any drug allergies

PRESENTING COMPLAINTS :

14 year old c severe dysmenorrhea.
 since 1 1/2 year.
 - Not responding with analgesics.
Scan done showed (6/7/26)
 - Uterus - normal
 - 2.5 x 2.2 cm in Right cornual
 myomelioma - shows small well circumscribed
 cantal lesion. - S/O Acute
 B/v ovaries - Normal

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage :	Parity :
Previous Periods : Regular	Mode of Delivery : Unmarried
LMP : 13/7/26	Last Child Birth :
Contraception : 4/30 days cycle	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil	Nil

Patient Sticker

FAMILY HISTORY: Nil	MEDICATION HISTORY: Nil
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INITIAL ASSESSMENT :		
Date <u>22/7/25</u> Ht. <u>158cm</u> Wt. <u>41.2kg</u> BMI <u>16.5 kg/m²</u> B.P. <u>112/68 mmHg</u> Pallor <u>Absent</u> CVR <u>S₁ S₂</u> Respiratory System <u>Clear</u> Thyroid <u>Normal</u>	Breasts <u>appear - normal</u> Abdominal Examination <u>P/A - soft</u>	Local/Speculum Examination <u>Not done</u> Bimanual Pelvic Examination <u>Not done</u>

PROVISIONAL DIAGNOSIS : <u>Acute (pus-filled) infected uterus mass) with severe dysmenorrhea</u>	
INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
<u>19/7/25</u> <u>Hb - 11.6</u> <u>Plt - 2.75</u> <u>PBS - 86</u> <u>S. Creat - 0.8</u> <u>HIV</u> <u>HbSAg</u> <u>MR</u> <u>HCV</u> <u>TSH - 1.23</u> <u>Urine Cx - E.coli</u> <u>7105 cfu/ml.</u>	<u>admit</u> <u>PAE</u> <u>Surgery consent</u> <u>pre op preparation</u> <u>and medication</u>

Name of the Doctor : Dr. Sarikala
Date & Time : 12pm 22/7/25
Signature of Doctor [Signature]
(DR. MATHEW)

DR. MATHEW MALHOTRA
Registration No. 69919



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 22/7/26

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: 14 years old severe
asthma

Doctor Notified on Admission: ☒ Yes ☐ No

Name of the Doctor: Dr. Rithika

Time Notified: 12:30 PM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Nil</u>	<u>Nil</u>	<u>Nil</u>
Gynecology Assessment: ☐ Not Applicable Menstrual History: Onset of Menarche: Menstrual Cycle: ☒ Regular ☐ Irregular Last Menstrual Period: <u>12/7/26</u>	Gynecology Surgical History: Caesarean Section: ☐ No ☐ Yes Cervical Cerclage: ☐ No ☐ Yes Ectopic Pregnancy: ☐ No ☐ Yes Myomectomy: ☐ No ☐ Yes Others:	Gynecological History: Contraceptives: ☐ No ☐ Yes Vaginal Discharge: ☐ No ☐ Yes Post-Coital Bleeding: ☐ No ☐ Yes Infertility: ☐ No ☐ Yes If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G P 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: 108 bpm RR: 20 bpm
 BP: 116/74 mmHg Weight: 43 kg Height: BMI:

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

PHYSICAL ASSESSMENT

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

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

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

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 parents

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 mother

Name of Person Orientation was given to: Mrs.

Orientation not given Reason:

Nurse Signature: Key

Nurse Name: Keyin

Date & Time: 22/7/2022 at 1.30pm.



OPERATION THEATER NOTES

Patient's Name : Mrs. G. NITHYA PRIYA Age : 1.57 Gender : ☐ Male ☒ Female

UHID No.: 0194763 Weight : 41 Kg Height :

Surgeon : DR. Sasikala Kola Asst. Surgeon :

Anesthetist : DR. S. S. Srinivas OT Nurse : P. R. R. OT Technician : Ramesh

Pre-Operative Diagnosis: AECM c. severe dysmenorrhea

Surgical Procedure : laparoscopic AECM excision

Indications for Surgery : AECM c. severe dysmenorrhea

Date : 22/03/26 Start Time : 4:00pm End Time : 9:52pm

Pre Operative Preparations: all pre op medications given

Post Operative Diagnosis: POD-0 post AECM excision

Peri-Operative Complications: Nil

- (1) 10mm umbilical port
- (2) 5mm left lateral port (1) 5mm Right lateral port

Operation Notes: 1) Uterus normal size

2) B/L tubes and ovaries - normal

3) Uterus - Right cornual bulge seen

4) Incision given over the uterus over the cornual bulge (AECM)

5) AECM separated from the uterus and excised. During excision cavity of AECM opened inadvertently, Chocolate colored fluid drained.

6) Uterine Incision on uterus closed c. watertight.

with intermittent sutures

- Specimen (ACM) sent for HPG
- Blood loss - minimal
- Duration of surgery - 40 min

Amount of Blood Loss: minimal (<50ml) Blood Transfused (in ML) Nil

Name and Number of Surgical Specimen sent for examination:

Accessory ciliary uterus lesion

Peri-Operative Complications: Nil

Adv

1. NBM
2. vitals $\frac{1}{2}$ hourly for 2 hours
found by 2nd hourly
3. drugs as per chart

Name of the Surgeon: D. Sankar

Signature of the Surgeon: (R. MAITHA)

Date & Time: 5pm, 22/7/20



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 5:20pm	POD-0 / Laparoscopic Acum excision o/f Gefeg Bp-126/83(95)mmHg PP-85 Bpm p/A-soft	Adv ① NBM for 4-6 hrs ② Monitor vitals ③ w/ active bleeding ④ I/O charting ⑤ Monitor Drugs as charted ⑥ Inform SAs
VO-100ml (clear)		Dr. Diya
22/7/2026 7:00pm.	POD-0 / Lap. Acum excision o/f Bp-108/71(81)mmHg PR-107 Bpm SpO2-99%-RA p/A-soft BS ①	Adv ① NBM till 12:00 AM ② Allow sips from 12:00 AM I/O liquids from 1:00 PM ③ soft diet 6:00 PM ④ Drugs as charted ⑤ Monitor vital signs ⑥ Inform SAs
VO-180ml.	on inf. ciprofloxacin 500mg.	
Shift to Room		MDiay

Date & Time	Progress Notes	Doctor's Order
9am 23/2/20	POB - 0 Glyc wals - (N) P/A - soft	
U/o good		
	Adv	
Remove Foley Catheter	- Can be discharged - ensure voiding before discharge	
	DR. MAITHRI MALLEMALA Registration No: 69919	
		Noted by Ashwin 9:10 AM

BAH-00630218 IPS-00176763
 Ms G NITHYA PRIYA
 12-03-2011 15 Y 4 M 10 D (F)
 Dr. SASIKALA KOLA

blood group B+ve

Patient Stic



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

BirthRight™
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 Your Right to a Safe Delivery

RESULT SHEET

Date	19/7/26				
Time					
Hb	11.6				
PCV					
RBC	4.58				
WBC	7.010				
N/L					
Platelets	2.75				
CRP					
ESR					
PCT					
RBS	86				
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.8				
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	19/7/26					
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
HIV, HBSAg, HCV						

HIV, HBSAg, HCV } -VE

Culture and Sensitivities :

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Radiology : USG :

X-Ray :

ECHO :

CT :

MRI

Others (ECG, Contrast Studies etc.) :



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: 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						☐ 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: Manu (Dr. Mathan)

Date & Time: 22/7/26, 12pm

Nurse Name & Signature: Keyu Keyu

Date & Time: 22/7/26 at 12pm



Sheet No: 22

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : <u>1AM-COP</u>				Date Time															
Dose	Route	Frequency	Start Dt.																
<u>4mg</u>	<u>P/O</u>	<u>Bd</u>	<u>22/2</u>	<u>6AM</u>	<u>6PM</u>														
Name & Signature of the Doctor Starting the Drugs:																			
<u>Mrs G Nithya Priya</u>																			
Additional Instructions:																			
<u>6PM</u>																			
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																			

VERIFIED BY : Name

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

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

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

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

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



DRUG CHART

Date of Admission: 22/7/20 Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY: Name Signature

REGULAR PRESCRIPTIONS

Weight. 41 kg Ward.

DRUG: <u>CEFO-TAX IM</u>				Date Time																
Dose <u>1gm</u>	Route <u>IV</u>	Frequency <u>Bd</u>	Start Date <u>22/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>M. D. MATHAN</u>				STOP <u>Mai</u> (D. MATHAN) 12pm 122/7/26																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>CIPROFLOXACIN</u>				Date Time	<u>22/7</u>	<u>23/7</u>														
Dose <u>500mg</u>	Route <u>IV</u>	Frequency <u>Bd</u>	Start Date <u>22/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>M. D. MATHAN</u>																				
Additional Instructions:				<u>9.30 AM</u> <u>NOV</u> <u>Proth</u> <u>Ang</u> <u>ge</u> <u>me</u>																
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>PARACETAMOL</u>				Date Time	<u>22/7</u>	<u>23/7</u>														
Dose <u>1gm</u>	Route <u>IV</u>	Frequency <u>TID</u>	Start Date <u>22/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>M. D. MATHAN</u>																				
Additional Instructions:				<u>2R NOV</u> <u>ge</u> <u>10P Proth</u> <u>me</u>																
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>DICLOFENAC</u>				Date Time	<u>23/7</u>															
Dose <u>50mg</u>	Route <u>P/O</u>	Frequency <u>Bd</u>	Start Date <u>21/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>M. D. MATHAN</u>																				
Additional Instructions:				<u>1PR</u>																
Daily Doctor's Endorsement by a Sign																				

Patient Sticker

Weight. 41 kg Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
22/7/26	3:30pm	Inj-PARACETAMOL	600mg	IV	(K)mg	Nishanth AKhi

Page: 4/4

BAH-00630218 IP5-00176763
 Ms G NITHYA PRIYA
 12-03-2011 15 Y 4 M 10 D (F)
 Dr. SASIKALA KOLA



MULTI-DISCIPLINARY PLAN OF CARE FORM

Rainbow Children's Hospital
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Diagnosis: with severe dysmenorrhea

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
22/7/20 12pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Severe dysmenorrhea	exclusion of ACW	laparoscopic surgery	<i>[Signature]</i>	☐ Nursing ☐ Others:
22/7/20 12-30pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Npo Dysmenorrhea	to mention EUF in diet	EUF in diet Re on flow	<i>[Signature]</i>	☐ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part

Patient's / Learner Language: Telugu 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		
22/7/26	12pm	1, 2, 4	about the procedure and its implications	F, M	1	0	1	1	-	<i>Mr</i>
22/7/26	12pm	2, 5	Patient taught regarding							
	12pm	6, 7	English about insulin control	F, M	1	0	1	1	-	<i>Mr</i>

Part - III: CODES

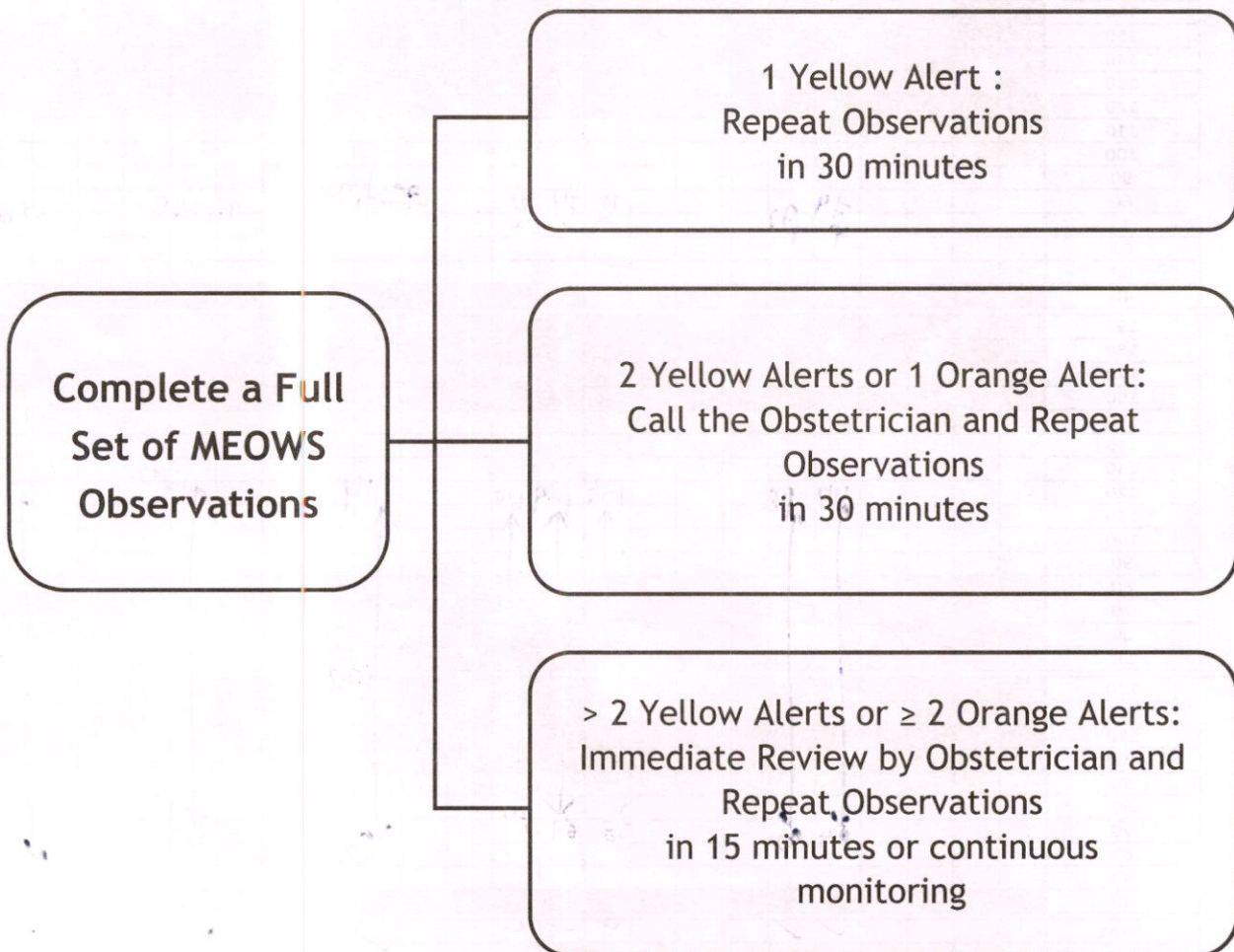
Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)							
Learning Barriers: 1. No Learning Barriers 4. Language Barrier 7. Impaired Thought Process/Cognitive limitations 10. Financial Difficulties 13. Cultural/Religion Practice 2. Physical Impairment 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							



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

22/04/2016

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm	RL		80ml									
	01:00 pm			80ml									
Total Intake :						Total Output :							
	02:00 pm			100ml									
	03:00 pm	RL		80ml									
	04:00 pm												
	05:00 pm	RL	NPO	80ml						25ml			
	06:00 pm	RL	NPO	80ml						120ml			
	07:00 pm	RL	NPO	80ml						25ml			
Total Intake :						Total Output :							
	08:00 pm			100ml									
	09:00 pm			100ml									
	10:00 pm			100ml									
	11:00 pm			100ml									
	12:00 am			100ml						400ml			
	01:00 am			100ml									
Total Intake :						Total Output :							
	02:00 am			100ml									
	03:00 am			100ml									
	04:00 am			100ml									
	05:00 am			100ml									
	06:00 am			100ml						500ml			
	07:00 am			100ml									
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							



FLUID CHART

Sheet No. : 2

23/7/26

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

		Intake				Output						IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G									
	08:00 am													
	09:00 am													
	10:00 am													
	11:00 am													
	12:00 pm													
	01:00 pm													
Total Intake :						Total Output :								
	02:00 pm													
	03:00 pm													
	04:00 pm													
	05:00 pm													
	06:00 pm													
	07:00 pm													
Total Intake :						Total Output :								
	08:00 pm													
	09:00 pm													
	10:00 pm													
	11:00 pm													
	12:00 am													
	01:00 am													
Total Intake :						Total Output :								
	02:00 am													
	03:00 am													
	04:00 am													
	05:00 am													
	06:00 am													
	07:00 am													
Total Intake :						Total Output :								
Total 24 hrs. Intake						Total 24 hrs. Output								

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 12-03-2011 15 Y 4 M 10 D (F)
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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/7/16

Assessment: 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
12pm	plan for writing	12:10pm	Monitor vitals child done	patient is comfortable vitals stable
12:15pm	plan for skin preparation	12:15pm	skin preparation done	
12:30pm	plan for ev catheter	12:40pm	ev catheter done	
1pm	plan for ev fluid	1:15pm	ev fluid re on flow	
2pm	to Administer medication as per order, to provide psychological support	2:15pm	Administer medication as per order. provided psychological support given.	

Re-Assessment:

Special Notes: NPO & ev fluid re on flow

Nurse Signature: [Signature] Nurse Name: Rejini Date & Time: 22/7/16 at 2pm



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/4/2015 8 PM

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
8 PM	→ assess the general condition of the patient and check vital	8 PM	→ assessed the general condition of the patient and checked vital.	patient is stable
10 PM	→ Giving medication as advised.	10 PM	→ Given medication as advised.	
12 AM	→ Continue w fluid 100 ml/hr.	12 AM	→ Continued w fluid 100 ml/hr.	
4 AM	→ Maintaining good nutritional status.	4 AM	→ Maintained good nutritional status.	
6 AM	→ checking urine output.	6 AM	→ checked urine output.	
8 AM	→ Ensure safety.	8 AM	→ Ensured safety.	

Re-Assessment: pain reduced now

Special Notes: Salt diet 6 AM

Nurse Signature: *P. N.*

Nurse Name: *P. N.*

Date & Time: 23/4/2015 8 AM

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sasi Kala Department: P.O.T Date of Admission:

SITUATION	Diagnosis: <u>Lap myomectomy</u>		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
	Area	Shift Time	OT 3-9pm	2nd floor 9:30pm-11pm		
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>nr</u>	<u>na</u>		
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:	<u>98.32</u>	<u>97.92</u>		
		Res:	<u>16/min</u>	<u>18/min</u>		
		SpO ₂ :	<u>99%</u>	<u>99%</u>		
		Pulse:	<u>80/min</u>	<u>78/min</u>		
		BP:	<u>120/80</u>	<u>118/78</u>		
	Fall Risk Score:		<u>0</u>	<u>0</u>		
Pain Score:		<u>0</u>	<u>0/10</u>			
Recommendations	Safety Needs:		<u>yes</u>	<u>yes</u>		
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		<u>nr</u>	<u>na</u>		
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:		<u>nr</u>	<u>na</u>		
Post Operative Procedure Special Orders:		<u>npo</u>	<u>na</u>			
Handed Over By Name :		<u>Kalyan</u>	<u>Puj</u>			
Signature :		<u>[Signature]</u>	<u>Puj</u>			
Date:		<u>22/7</u>	<u>23/7/26</u>			
Time:		<u>9:30pm</u>	<u>8pm</u>			
Taken Over By Name :		<u>Puj</u>	<u>Ashini</u>			
Signature :		<u>Puj</u>	<u>Ashini</u>			
Date:		<u>22/7/26</u>	<u>23/7/26</u>			
Time:		<u>8pm</u>	<u>8AM</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
	Area							
BACKGROUND	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	
	Others Specify:							
	Special Diet:		☐ 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:								

CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : Name : Keyin

Signature of Ward In Charge :

Signature : Name : Rakt / Knt / Pakt

BAH-00630218
Ms G NITHYA PRIYA
12-03-2011
Dr. SAsIKALA KOLA
15 Y 4 M 10 D
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(F)

BRADEN 'Q' SCALE

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					Date :	22/4/24		
					Time :	9:30 AM	8 PM	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	2		
"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	1		
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	2		
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	3		
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	3		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	3		
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		
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	18	
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	RD	Pujy	

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

BAH-00630218
Ms G NITHYA PRIYA
12-03-2011 15 Y 4 M 10 D (F)
Dr. SASIKALA KOLA
IPS-00176763

Morse Fall Risk Assessment Form

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Choose Highest Applicable Score from each Category		Date / Time	22/2/24	24/2		Fall Risk Grading		
		Score		6/20/24		Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0	0				
Secondary Diagnosis (more than one diagnosis)	Yes	15				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0	0				
Ambulatory Aid	Furniture	30				Low Risk	0 - 24	Standard Fall Precaution
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0				
IV / Heparin Lock or Saline	Yes	20	20	20		Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0				
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0				
Total Morse Fall Scale Score:			20	20				
		Signature	ney	hys				

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
22/3/26	12pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	-	very
22/3/26	6pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	na	high
22/3/26	10pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	na	high
23/3/26	2Am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		high
23/3/26	6Am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	na	high
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

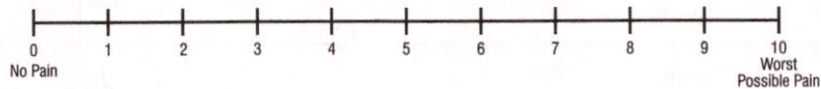
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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





CHECKLIST FOR THROMBOPHLEBITIS

02/7/26

23 1/7/26

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

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 : [Signature]

Signature of Ward In Charge :

Signature : [Signature] Name : [Signature]



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 22/07/26

Date of Removal:

Parameters	Date	Shift Time	22/07/26 8 pm	22/07/26 Morning				
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	Alam	Piya						
Signature of the Nurse	Alam	Piya						

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Sasikala Kola
Asst. Surgeon :
Anaesthetist : Dr. Thirumala
Scrub Nurse : Rana

Patient No:
UHID No.
Date : ...

BAH-00630218
Ms G NITHYA PRIYA
12-03-2011 15 Y 4 M 10 D (F)
Dr. SASIKALA KOLA
IP5-00176763

Gender : 15Y
lap Acrom
Out-time : 05:00pm
3:15pm

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Before Induction of Anaesthesia >>

SIGN IN		Time: <u>3:10pm</u>
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 : <u>[Signature]</u>		
Name : <u>Dr. Arun K.</u>		

Before Skin Incision >>

TIME OUT		Time: <u>3:50pm</u>
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? <u>1:30hr</u> <u>150ml</u>		
☐ Yes ☐ No ☐ NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☒ NA		
Nursing Team Reviews:		
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 : <u>[Signature]</u>		
Name : <u>Arjun</u>		

Before Patient Leaves Operating Room

SIGN OUT		Time: <u>4:52pm</u>
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 : <u>[Signature]</u>		
Name : <u>Dr. Arun K.</u>		

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist :
Scrub Nurse :

Patient Name : Age : Gender :
UHID No. : Surgery Name :
Date : In-time : Out-time :



Before Induction of Anaesthesia ➤ ➤

SIGN IN		Time:.....
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 :		

Before Skin Incision ➤ ➤

TIME OUT		Time:.....
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? ☐ Yes ☐ No ☐ NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☐ NA		
Nursing Team Reviews:		
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:.....
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 :		



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 22/07/2016

Department : P.O.T. Duration of Procedure : 1:30 hrs

Name of Surgeon : Dr. Sasikala Kola Date of Admission : 22/07/2016

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 : <u>2g cefazolin</u>	
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) <u>36.4</u> °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : <u>Nagambig</u> Date & Time of antibiotic administration : <u>22/07/2016 @ 3:00pm</u> Date & Time procedure started : <u>22/07/2016 @ 4:00pm</u>	

- 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



POST-SURGICAL CARE PLAN FORM

Procedure Done: Acum excision laparoscopic

Post-Surgical Diagnosis: POD-0 post Acum excision

Post-Operative Monitoring Parameters /Frequency:

BP, PR, U/O - charting $\frac{1}{2}$ hourly x 2 hours
2nd hourly

Wound Care:

Nil

Drain /Special Lines/Catheters:

IV Cannula
foley

Special Patient Positioning and Requirements:

Nil

Nutritional Instructions:

liquid diet followed by soft
diet after 4 hours

When to Start Mobilization:

on POD-1 after foley's Removal.

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

-

Treating Surgeon
(Signature & Stamp)

(Dr. MARTIN)

Date: 22/7/20 Time: 5pm

Note: Plan of care will be readjusted if necessary.

BAH-00630218
Ms G NITHYA PRIYA
12-03-2011 15 Y 4 M 10 D (F)
Dr. SASIKALA KOLA



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DISCHARGE PLANNING FORM

Nationality: INDIAN

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

1. Anticipated Date of Discharge: As per as doctor Advised

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 for 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: perineal hygiene

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

☒ Patient ☒ Family Member

☐ Others: _____

Nurse Signature: Key

Nurse Name: Keyin

Date and Time: 22/3/2016 at 2pm.

CONSENT FORM FOR ANAES



Patient Name : NITHYA PRIYA Age : 15y Gender : Male ☐ Female ☒

UHID NO : _____ Surgeon Name : Dr Sasikala

Anaesthesiologist : Dr. Sundhaa Operative procedure planned : Laparoscopic Accessory
cavitating Uterine mass excision

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- ☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure
☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Acidosis
☐ Incapacitating Chronic Obstructive Pulmonary Disease ☐ Others : Bleeding

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia (☐ Regional / ☒ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthesia team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : Sundhaa

Name : SUNITHA

Relationship with Patient : Mother

Date & Time : 22/7/26 12pm

Doctor (who is taking the consent) :

Signature : Sundhaa

Docu. No. : RCH / FRM / CLINICAL / 021

Witness :

Signature : Satish Kumar

Name : SATISH KUMAR

Date & Time : 22/7/26, 12pm

Father

Name : Dr Sundhaa

Date & Time : 22/7/26, 12pm



INFORMED CONSENT FOR SURGERY ON SPECIAL PROCEDURE

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Patient Name : MS. G. NETHYA priya Gender: ☐ Male ☒ Female Age : 15/F
UHID No : BAH-00630218 Date : 22/7/20

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)

LAPAROSCOPIC AECUM (ACCESSORY CAVITATED UTERINE
MASS) EXCISION upon

(Name of the Patient) Mrs

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.

bleeding, need for blood transfusion, infection, injury
to bowel, bladder, ureter

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. SASIKALA

Consentee :

Signature : _____

Name : _____

Date & Time : _____

Witness :

Signature : [Signature]

Name : C. Srinivas

Date & Time : 22/07/20 12.12

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

Patient Attendant :

Signature : [Signature]

Name : G. Sathish

Relationship with Patient : Father

Date & Time : 22/07/20 12.12

Doctor (who is taking the consent) :

Signature : [Signature]

Name : (Dr. NATHAN)

Date & Time : 22/7/20, 12pm



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: NITHYA RIYA Age: 15y Sex: F UHID.No: _____
 Date: 22/7/26 Time: 12pm Proposed Operation: Laparoscopic Mass Excision
 Diagnosis: Accessory Cavitating Uterine mass & Severe Dysmenorrhea
 B.P / CRT: 112/68 H.R: 102 Weight: 41 kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 11.6 Glucose: 86 Protein: _____ HIV: _____ X-Ray: _____
 PCV: _____ Urea: _____ Alb: _____ HBS Ag: NA ECG: _____
 WBC: 1010 Creat: 0.8 Total Bill: _____ HCV: NA 2D Echo: _____
 Plate: 2.75 Na: _____ Dir. Bill: _____ Blood group: B+ve Stress/Anglo: _____
 PT: _____ K: _____ LDH: _____ T3 _____ Other: _____
 PTT: _____ Ca++: _____ Alk phos: _____ T4 _____
 INR: _____ Mg++: _____ Amylase: _____ TSH: 1.23
 Cl -: _____ SGOT/SGPT: _____

Allergies: _____

Medical History: CVS: _____

RESP: _____

Diabetes: _____

CNS: _____

Renal: _____

Hepatic / GE: _____

Physical Activity: Active

Others: _____

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: N Mentohyoid Distance: N Neck: N Teeth: N

Lungs: _____

Heart: Clear NAD

CNS: _____

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site: e

Spine Exam for regional: N

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

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

CURRENT MEDICATIONS	DOSAGE
/	/
/	/
/	/
/	/

Pre-Operative Instructions:

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

8:15 AM Dose

Signature: Sundhar Name: Dr. Sundhar

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment: 3:15pm

Change in Patient Condition: ☐ Yes ☒ No

Fasting Status: Adequate

Physical Status: ☒ Patient Identified☒ Consent Present☒ Chart Reviewed

H.R: 106

B.P / CRT: 92/60

SpO₂: 100%

R.R: 14

Last Feed: >6 hrs

Pre-OP Diagnosis: Accessory cavitating nodule max Operation: Acum excision Date: 22/9/22

Surgeon: Dr. Sasikala

Anaesthesiologist: Dr. Akhilok

Technician: Nishanth

TIME 9:15 9:45 9:55 9:55 9:55

N.O (AIR) 0.5

HALO/ISO (SEVO) 0.5

Drugs:

Dr. MIDAZOLAM 2mg
Dr. PENTANYL 100mcg
Dr. PROPOFOL 100mg
Dr. ROCURONIUM 20mg

Dr. PARACETAMOL 600mg
Dr. MYOPYCLATE 4ml

FIO₂ / SaO₂ETCO₂

ECG

Temperature

Urine Output

Fluids

Blood

B.P

V Systolic

A Diastolic

X Mean

• Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

B.P

V Systolic

A Diastolic

X Mean

• Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

B.P

V Systolic

A Diastolic

X Mean

• Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

B.P

V Systolic

A Diastolic

X Mean

• Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

B.P

V Systolic

A Diastolic

X Mean

• Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

LAB Values

ABG

GRBS

Others

☒ Equipment Checked and Functional☒ BP☒ Cuff Site: OUL☐ Art Site:☐ EKG Lead☒ Temp Site: skin☒ FIO₂ Monitor☒ Agent Monitor☒ Pulse Oximeter☒ Capnograph☒ Ventilator☐ Nerve Stimulator

Position: Supine

☐ Pressure Points Checked

Eye Care:

☐ Oint☒ Tape☐ Padding☐ Awake

Temp:

☒ HME☐ Cling Film☒ Hugger's☐ Other

Times:

Anaes Start: 3:15pm

OP Start:

OP End:

Leave OR: 5pm

Anaesthesia:

☒ GA☐ Monitored Anaesthesia Care☐ Regional

Line (Size & Location)

☐ CVP:☐ ART:☒ IV: OUL 20G☐ IV:☐ IV:☐ IV:☐ IV:☐ IV:

Induction

☒ IV☒ Pre O₂☐ Others☐ Mask☐ Airway

ETT # 6.0 at 17 cm

☒ Oral☐ Tracheostomy☐ Drug: Rocuronium☐ Awake☐ Video Laryngoscopy☐ Fiberoptic

Blade # MAC3 Attempts: 1

Difficulty Why?

☒ Bilat = BS☐ Semi-Closed Circle☒ Closed Circle☐ Other

Regional:

Extremity

☐ Spinal

Others:

Position:

Site:

Needle Size:

Parasthesia ☐ Yes ☐ No

Catheter at skin cm

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Transportation to

☐ PACU☐ ICURelaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor:

Signature of the Doctor:

Specify:

☐ Epidural☐ Caudal

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Dr. Alam

Time Received : 05:03 pm

Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site : ☒ O ₂ Mask ☒ Nasal Prongs ☒ Tracheostomy ☒ T-Piece ☒ Oral Airway ☒ Nasal Airway				
		Vomiting : ☐ Yes ☒ No Drug : NG Tube : ☐ Yes ☒ No Drain : ☐ Yes ☒ No Urinary Catheter : ☒ Yes ☐ No Chest Tube : ☐ Yes ☒ No Nil Oral : ☒ Yes ☐ No IV Fluids : Oral Feeds : <u>All on</u>				
POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN MINUTES OUT		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:		
		30	60		90	
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0 ACTIVITY		1	1	2	2	2
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0 RESPIRATION		2	2	2	2	2
BP $\pm$ 20 of Pre Anaesthetic level = 2 BP $\pm$ 20-50 of Pre Anaesthetic level = 1 BP $\pm$ 50 of Pre Anaesthetic level = 0 CIRCULATION		2	2	2	2	2
Fully awake = 2 Arousable on calling = 1 Not responding = 0 CONSCIOUSNESS		1	1	2	2	2
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0 COLOR		2	2	2	2	2
TOTAL		8	8	10	10	10

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

Anaesthesiologist Name : Dr. Alam

Anaesthesiologist Signature: Alam

Date & Time: 22/07/26 @ 9:30

PACU Nurse Name : Alam

PACU Nurse Signature: Alam

Date & Time: 22/07/26 @ 9:30

Reassessment Frequency:

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

Transferred to Unit by (PACU): 323 (A)

Date & Time: 22/07/26 @ 9:30

Patient Sticker

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		FHR	Comments
					BP	Pulse		

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 :

ESTIMATION SLIP

D/W Mrs. Arun
On pri with
78657 C-8

Date : 29/01/2026 UHID / IP No. : BAH-0063026 St. No. 78657 C-8
Name of Patient : Ms. G. Nithya. Priya. Age: 14y. Gender: F.
Father's / Husband's Name : Mr. Sathish Kumar Corporate / Occupation : General Store (Bam)
Address : Phone : 9989601363 / 9440277216 Email :
Procedure / Plan : Laparoscopic excision of the Aden.

MODE OF PAYMENT : ☒ SELF ☐ TPA : ☐ GIPSA : ☒ OTHERS

TARIFF INFORMATION :

ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges										(11-6hr)
Doctor's Fee										
L. Tax										5200

PARTICULARS				AMOUNT (₹)			
Surgeon's / Anesthetists's Fee / O.T. Charges				Subject to approval by TPA / Insurance Company			
O.T. Consumables				Not Covered by TPA / Insurance company			
Instrument Charges				As per actual - Not Included in Estimation			
Pharmacy, Consumables & Investigations				As per actual - Not Included in Estimation			
Equipment Charges	Monitor :		Oxygen :		Infusion pump / Syringe pump +		
	Ventilator :		Conventional :		HFO-SLE 5000 :		
	Phototherapy :		Single Surface :		Double Surface :		
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.				As per actual - Not Included in Estimation			
Package				As per actual - Not Included in Estimation			
Others				As per actual - Not Included in Estimation			
Initial Minimum Deposit				As per actual - Not Included in Estimation			

REMARKS: 25k. High cost equipment 15k to 25k. Approx: 70,000 & Final Bill 100k.

- The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
- The estimated surgical charges may vary subject to surgeon's decisions / Complications / Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.
- In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
- Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.
- Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/Insurance Company at later stage.
- For Non-Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.
- During Non-working hours of O.T (8:00 PM to 7:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm
- Difference, if any between the final bill amount and amount permitted/ approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
- Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

DECLARATION

I, Mr. Sathish Kumar, have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital

Signature of the Client: Mr. Sathish Kumar
Signatory Relationship: Father
Signature of the Financial Counselor: Aritha