

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176210

Admit Date : 10-Jul-2026

Admit Time : 11:36 AM UHID : BAH-00646550

Patient Details :

Patient Name : Mrs DIVYA TIRUPATI

Age : 33 Y 10 M 17 D

Guardian : MR VISHVA KAMAL KONDAPALLY

DOB : 23-08-1992

Gender : Female

Religion :

Occupation :

Martial Status : Married

Address (H) : EMAMI SWAN LAKE APTS, TOWER 2- 1316, Kukatpally Hyderabad Telangana INDIA 500072

Phone No : 9966286674/

E-mail : NO@gmail.com

Admission Details :

Bed Type : SHARED WARD

Bed No : SW 415

Ward Name : 4F-BIRTHING CENTRE

Room No : SW 415

Admission Type : First Visit

Contact Details :

Name : MR VISHVA KAMAL KONDAPALLY

Relationship : Husband

Contact Address : EMAMI SWAN LAKE APTS, TOWER 2- 1316, Kukatpally Hyderabad Telangana INDIA 500072

Phone No : 9985552310 / 9966286674

[Signature]
Signature

Doctor Details :

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

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

ACTIVITY RECORD FOR BILLING

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
14/7/26	6:50am	BB-II	3rd Floor Room No (BIF)	Sandhya

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Tuheena Sharan (PT)	11/7/26		
2				
3				
4				
5				
6				
7				
8				
9				
10				

[illegible]

94

Graph Check

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/1	IV placement	1	96972817	
10/7	pac	1	9697280	
10/7	catheterization	1	9697281	

Chon Uccard

ANY OTHER INFORMATION

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.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Clot-bleeding Plb.
2 hours.

Obstetric Formula:

Primigravida

Obstetric History:

1st - 1st. Conception.

Booked at 16 wks.

Present Pregnancy Record:

Custom Diet 24 hrs

RISK FACTORS:

Height: 1.58 cm

Weight: 73.7 kg

Allergies: Nil

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: clear

Icterus: absent

Temp: 37.2

BP: 110/60

CVS: S1S2

Liver/Spleen: not

Pallor: absent

Edema: absent

PR: normal

DTR: 1

RS: BAE

Urine Output: adequate

LMP: 18/10/25

EDD: 24/7/26

Corrected EDD: 24/7/2026 GA: 38 wks.

Menstrual History: Regular: ☐ Yes ☐ No

Obstetric Examination

Fundal Height: Term - imbricate

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech Others

Head Fifts Palpable:

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination - NA

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination - 50%

Cervix: ☐ Long ☒ Partially effaced ☐ Effaced

Os: Closed Dilated 2 cm

Membranes: ☒ Present ☐ Absent

Liquor: ☒ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☒ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☒ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☒ Adequate ☐ Doubtful

DIAGNOSIS

Primigravida / Custom Diet / 38 wks / SRM.
Early labor.



Family History: <i>mother - DM</i> <i>father - HTN</i>	Surgical History: <i>Hysteroscopy + curettage + Polypectomy; Sept 2019.</i>
Medical History: <i>None.</i>	Medication History: <i>- on C-Pink C-Dien. By Bactera 300.</i>
Plan of Care: <i>- for delivery.</i> <i>- delivery, Prepartum Exam.</i> <i>- PHE, 25mg daily.</i> <i>- NST x 1 and hourly.</i> <i>- verbal stimulation.</i> <i>- Give Cefotaxime 1g IV (after Test Date).</i> <i>- fetal Blood availability.</i> <i>- send a tran CBP.</i>	Investigations: <i>'B' Rn porting.</i> <i>14/6/24 - CBP - 12.4 / 10.36 / 1.94 L</i> <i>1/6/2026</i> <i>SLT, 32+3 wks.</i> <i>Cephalic.</i> <i>wt - 1916.</i> <i>(32nd centile)</i> <i>Ac - 19.1cm.</i> <i>PI - Ant.</i> <i>Doppler - normal.</i>

Doctor Name: *Dr. Shreyas*

Signature: *[Signature]*

Date & Time: *20/7/2020, 11:30 PM*

Consultant Name: *Dr. Shreyas*

Signature: *[Signature]*

Date & Time: *10/1/2026, 11:30*

SHRUTHI REDDY/PODDUTOOR
Registration No: 46820

IP5-00176210

Mrs DIVYA PRASAD
23-08-1992 33 Y 10 M 19 D (F)

23-08-1992

33 Y 10 M 19 D

Dr. SHRUTHI REDDY/Dr.LAVANYA



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Hospital**
It takes a lot to treat the little.

It takes a lot to treat the little



BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	3			
5	In-patient Medical record	1			
6	Doctors progress sheets	3			
7	Nursing plan of care and handover sheets	4			
8	Consultation sheet	1			
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion	1			
12	Consent for chemotherapy	1			
13	Consent for high risk	1			
14	Consent for Restraint	1			
15	LAMA consent	1			
16	Consent for special procedure / Sedation	2			
17	Consent for Formula feed	1			
18	Consent for MTP	1			
19	Consent for Radiological Investigations	1			
20	Consent for HIV test	1			
21	Anaesthesia notes (Pre Anaesthesia & post)	2			
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
28	Nurses clinical Presentation	2			
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart	1			
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)	1			
36	Consent for Admission in PICU / NICU	1			
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list	1			
40	PICU bed formula Dilution feeds	1			
41	Gastro monitoring chart	1			
42	Rch ED doctors note	1			
43	BP Monitoring chart	1			
44	RBS monitoring chart	1			
	Total No. of Pages	44			

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

BAH-00646550 IP5-00176210
Mrs DIVYA TIRUPATI
23-08-1992 33 Y 10 M 17 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



Divya Tirupati

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>10/7/2026</u>	<u>4/5/8 Dr. Shruthi</u>	
<u>12:40 PM</u>	✓ Elective Epidural Siting ✓ Oxypren infusion - 6ml/hr - 3PM ✓ Proctolysis enema ✓ oral hydration ✓ Sept diet ✓ w/f progress of labor ✓ Inform soc	
<u>10/7/26</u>		<u>by Ch. Deepika</u>
<u>4 PM</u>		<u>Adv</u>
On Synto @ 12ml/hr	O/E AC - fair vitals - stable PA - uterus mild acty ⊕ FHR ⊕	- w/f POC - Synto titration - vitals closely - CTG closely - Inform w/f
NS1 → Reactive	P/R - G - 3 modulated line h long clear liquor Vk - 2 stalks	
		<u>Dr. Samir</u>

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 6:00 PM	Pl is stable NO C/O BP- 110/70 mmHg PR- 86 bpm SpO₂- 100% on RA P/A- ut well retracted. UT acting. Cephalic FHS NST- reactive.	Active Epidermal now - CIG trace 3rd hly - Continuous FHR Vitals monitoring
11/8/26 2:00 AM	A/L - PND-O Immediate post delivery CL- Fair BP- 108/55 (69) PR- 100 bpm Temp- 98°F SpO₂- 100% on RA P/A- ut well retracted UG- BUNL UGD - 300 mL Clear	Active ① Monitor vitals 15 min for 1st hr 1 hr for 2nd hr ② Drugs as charted ③ Tachy sos. ④ Soft diet ⑤ Hydrant & ambital. ⑥ Wt hypotension tachycardia & bleeding

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/2026 6:55 AM	- P/L - PND-O - Pt is stable - No cl - BP - 110/71 (80) PR - 84bpm SpO₂ - 98% on R Temp - 97°F PLA - ut well retracted. LE - BWNL. - Episiotomy healthy; no trickling / no swelling. VF - Copul, clear. → Shift to ward - ⇒ Remove Foley @ 10 AM. →	<u>Advice:</u> ① Soft diet ② Hydrate & ambulate ③ Drugs as charted. ④ Vitals qth hly ⑤ wlf hypertension, tachycardia, heavy bleed. ⑥ perineal care.
11/7/2026 8:00 AM	P/L - PND-O Q/L G. f. air vital stabl atfbrde PLA - ut @ uen LE - BWNL Episiotomy healthy.	<u>Adv</u> ① soft diet ② Hydrate & ambulate ③ vital qth hly ④ wlf active bleeding per vagin ⑤ perineal care ⑥ Drugs as charted ⑦ Intra h Dr. Divya

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/12/2026 4pm	PND-O / P/LI	1) 4pm on diet
B-NICO	GC: fair Vitals: stable P/A: UT @ ear salt BS @ P/V: NAB	1) soft diet 2) plenty of oral fluid 3) Drug as charted 4) w/f Plw Bleeding 5) Ambulation 6) Temp 50s
		— Dr. Sravanti
11/12/2026 7pm	PND-O / P/LI	1) 4pm on diet
B-NICO	GC: fair Vitals: stable P/A: UT @ ear salt BS @ P/V: NAB	1) soft diet & plenty of oral fluid 2) Drug as charted 3) w/f Plw Bleeding 4) Ambulation 5) Temp 50s
		— Dr. Sravanti

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00646550 IP5-00176210
 Mrs DIVYA TIRUPATI
 23-08-1992 33 Y 10 M 17 D (F)
 Dr. SHRUTHI REDDY/Dr.LAVANYA



RESULT SHEET

Date	10/7/20				
Time					
Hb	12.5				
PCV	38.0				
RBC	4.09				
WBC	12.11				
N/L					
Platelets	2.05				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

MEDICATION RECONCILIATION FORM

Drug Allergies: None

☒ 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-PINK	1kg	PO	once	P/O (9/7)	☐ C ☒ DC
2	C-DENG	1kg	PO	once	P/O (9/7)	☐ C ☒ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: [Signature]

Date & Time: 10/7/2024

Nurse Name & Signature: [Signature]

Date & Time: 10/7/26 12pm

DRUG CHART

Date of Admission: 10/7/2016 Drug Allergies: Penicillin ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG: <u>ANT CEBOTAXIME</u>				Date Time	<u>10/7</u>	<u>11/7</u>														
Dose	Route	Frequency	Start Date																	
<u>1gm</u>	<u>IV</u>	<u>BD</u>	<u>10/7</u>		<u>3am</u>	<u>11/7</u>														
Name & Signature of the Doctor Starting the Drugs:					<u>3pm</u>	<u>11/7</u>														
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>T. PARACETAMOL</u>				Date Time	<u>11/7</u>	<u>12/7</u>														
Dose	Route	Frequency	Start Date																	
<u>1g</u>	<u>PO</u>	<u>QID</u>	<u>11/7/26</u>		<u>12AM</u>	<u>12/7</u>														
Name & Signature of the Doctor Starting the Drugs:					<u>6AM</u>	<u>12/7</u>														
Additional Instructions:					<u>12PM</u>	<u>12/7</u>														
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>T. DICLOFENAC</u>				Date Time	<u>11/7</u>	<u>12/7</u>														
Dose	Route	Frequency	Start Date																	
<u>50mg</u>	<u>PO</u>	<u>TID</u>	<u>11/7/26</u>		<u>7AM</u>	<u>12/7</u>														
Name & Signature of the Doctor Starting the Drugs:					<u>3PM</u>	<u>12/7</u>														
Additional Instructions:					<u>11PM</u>	<u>12/7</u>														
Daily Doctor's Endorsement by a Sign																				
DRUG: <u>T. PANTOPRAZOL</u>				Date Time	<u>11/7</u>	<u>12/7</u>														
Dose	Route	Frequency	Start Date																	
<u>40mg</u>	<u>PO</u>	<u>BD</u>	<u>11/7/26</u>		<u>6AM</u>	<u>12/7</u>														
Name & Signature of the Doctor Starting the Drugs:					<u>6AM</u>	<u>12/7</u>														
Additional Instructions:					<u>6AM</u>	<u>12/7</u>														
Daily Doctor's Endorsement by a Sign																				

BAH-00646550
Mrs DIVYA TIRUPATI
23-08-1992 33 Y 10 M 17 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA

IP5-00176210

Weight. Ward.



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
10/7	12pm	PUGI	25mg	PO	B	Swarna veena
10/7	7pm	PC ENMA	1	P/O	f	Ajase Bharathi
10/7/26	1:30 AM	JUSTIN SOPROSA	100mg	P/K	At	Shobha Kranthi
10/7/26	1:35 AM	TIMOLOLOL	400mg	P/K	SH	Shobha Kranthi
10/7/26	1:40 AM	INT OXYTOCIN	100	IM	SH	Shobha Kranthi
11/7/26	1:45 AM	10% TRANEXAMIC ACID	1g	IV	SH	Shobha Kranthi
11/7/26	1:45 AM	IV ZOFER	4mg	IV	SH	Shobha Kranthi

Signature
VERIFIED BY: Name

BAH-00646550

IP5-00176210

Mrs DIVYA TIRUPATI
23-08-1992 33 Y 10 M 17 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



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
10/7/26	5:30 pm	RINGER LACTATE.	IV 100ml	100ml	D	Shobha Kanth	10/7	D	Shobha Kanth
10/7/26	3:30 pm	RINGER LACTATE + OXYTOCIN 10units	IV	6ml/hr ↓ 10ml/hr	D	Shobha Kanth	10/7		Shobha Kanth
				10ml/hr					
10/7/26	8:30 pm	RINGER LACTATE 500ml	IV	100ml/hr	Shobha Kanth	Shobha Kanth	10/7	D	Shobha Kanth
10/7	10:00 pm	RINGER LACTATE 500ml	IV	100ml/hr	Shobha Kanth	Shobha Kanth	11/7	Shobha	Shobha Kanth
11/7	12:00 Am	RINGER LACTATE	IV	100ml/hr	Shobha Kanth	Shobha Kanth	11/7	Shobha	Shobha Kanth
11/7	2:00 Am	RINGER LACTATE	IV	100ml/hr	Shobha Kanth	Shobha Kanth	11/7	D	Shobha Kanth

Signature

VERIFIED BY : Name

BAH-00646550 IP5-00176210
 Mrs DIVYA TIRUPATI
 23-08-1992 33 Y 10 M 18 D (F)
 Dr. SHRUTHI REDDY/Dr.LAVANYA



Sheet No: **REGULAR PRESCRIPTIONS** Weight Ward

DRUG : <u>SYP. DOPHOLAC</u>				Date Time	<u>11/7/20</u>														
Dose	Route	Frequency	Start Dt.																
<u>15ml</u>	<u>PO</u>	<u>OD</u>	<u>11/7/20</u>																
Name & Signature of the Doctor Starting the Drugs:																			
<u>Dr. S. S. S. S.</u>				<u>10 PM Divya</u>															
Additional Instructions:																			
<u>@ night</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 Signature

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

Signature

VERIFIED BY : Name

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																			

BAH-00646550 IP5-00176210
Mrs DIVYA TIRUPATI 33 Y 10 M 17 D (F)
23-08-1992 Dr. SHRUTHI REDDY/Dr.LAVANYA

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

BAH-00646550 IP5-00176210
Mrs DIVYA TIRUPATI 33 Y 10 M 17 D (F)
23-08-1992 Dr. SHRUTHI REDDY/Dr.LAVANYA

W's
I
le little.

BirthRight
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Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
10/7/22	1:30pm	1,2,3,4	Diagnosis, treatment & care plan Pain management & Informed consent	PT/s	1 0		1	1	NA	Wiley
10/7/24	1pm	7	Education about hand hygiene	PT/s	1 0		1	1	NA	Guy
11/7/26	8am	9	lactation diet	PT	1 0		1	1	- Same	

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:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								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	
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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:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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Understanding:	<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review																					

BAH-00646550

IP5-00176210

Mrs DIVYA TIRUPATI

23-08-1992

33 Y 10 M 17 D (F)

Dr. SHRUTHI REDDY/Dr. LAVANYA



MULTI-DISCIPLINARY PLAN OF CARE FORM

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BirthRight
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Your Right to a Safe Delivery

Diagnosis:

primi / born on diet / 35wks / SROD / Early labour

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
10/7/26 1pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	- for delivery	- for safe delivery	- Preparation - Enema - Wt Progress	P	☒ Nursing ☐ Others:
10/7/26 1pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	for safe delivery	coming given by late delivery	Self delivery	Sham	☒ Medical ☐ Others:
11/7/26 8am	☐ Medical ☐ Nursing ☒ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	pno	normal diet	normal high protein diet	Sham	☐ Medical ☐ Nursing ☒ Others:
11/7/26 5:15pm	☐ Medical ☐ Nursing ☒ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	PND	Post partum recovery	Deep core retraining & functional training	T.S	☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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Mrs DIVYA TIRUPATI
23.08.2023

23-08-1992

33 Y 10 M 17 D

(F)

Dr. SHRUTHI REDDY/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

[illegible]

Syato 8:30pm 3HR.
6ml. 134b/min
12ml 4pm 141b/min
18ml 4:30pm 138b/min

Obstetrics and Gynaecology Early Warning Signs

Complete a Full
Set of MEOWS
Observations

1 Yellow Alert :
Repeat Observations
in 30 minutes

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

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

* The Modified Early Warning Score (MEOWS)

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TIRUPATI

Mrs DIVYA
08-1992

Mrs DIVYA TIRUPATI 33 Y 10 M 17 D
23-08-1992
Dr. SHRUTHI REDDY/Dr.LAVANYA



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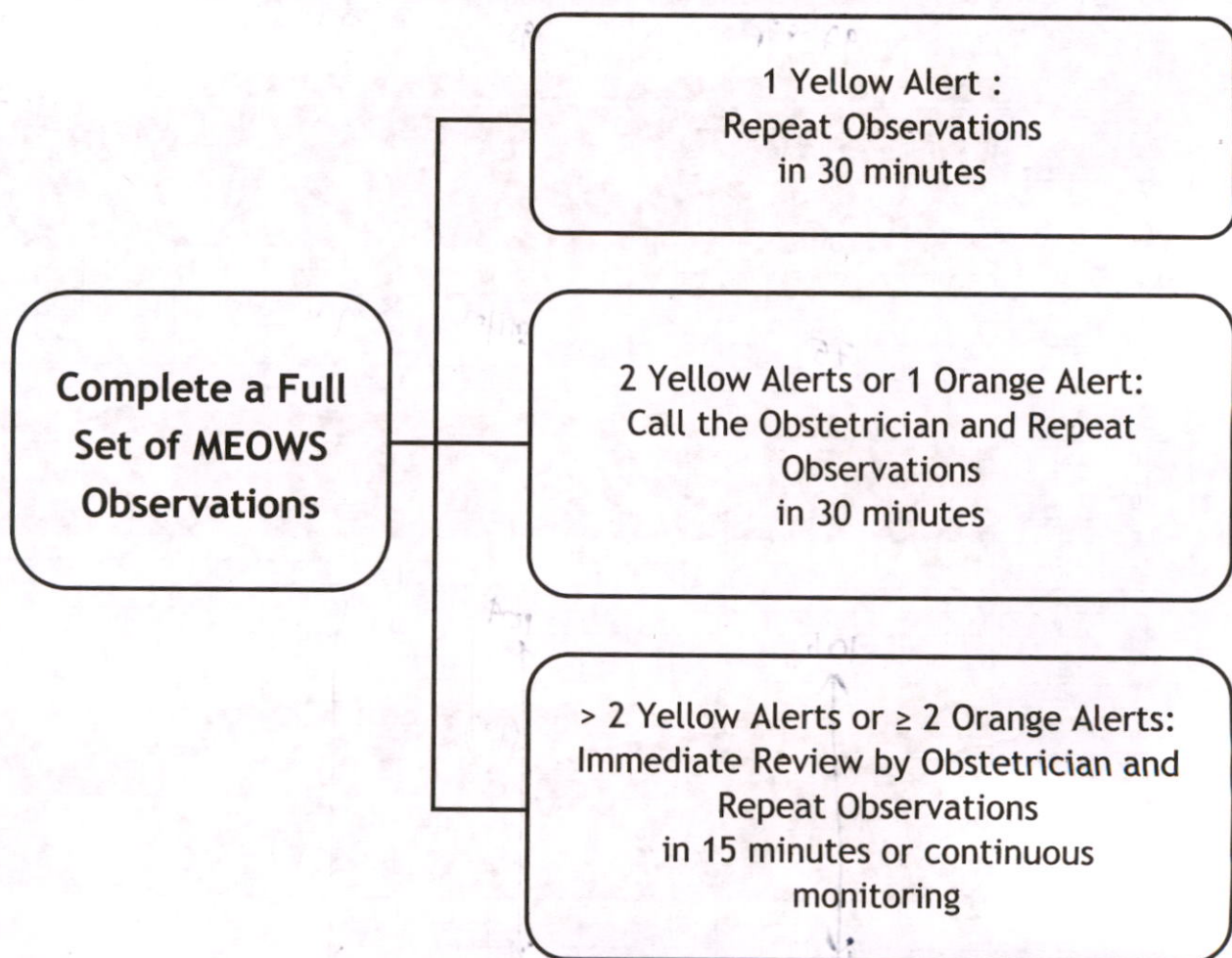
Early Warning Observation Score Chart - Obstetrics

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																									
Systemic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	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)

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FLUID CHART

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Sheet No. : C

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

Date	Time	Nature of Fluid	Intake			NG	Diarrhoea	Vomit	Output			IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G				Drainage	Urine			
10/7	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm		40								0		
	01:00 pm		40								0		
	Total Intake :			Total Output :									
10/7	02:00 pm	re		100ml							0		
	03:00 pm	re		100ml						0			
	04:00 pm	re		100ml						0			
	05:00 pm	rh		100ml						0			
	06:00 pm	rh		100ml						0			
	07:00 pm	rh		100ml						0			
	Total Intake :			Total Output :									
10/7	08:00 pm			100							0		
	09:00 pm	rh	100	100ml						0			
	10:00 pm			100ml						0			
	11:00 pm	rh	100	100ml					600ml	0			
	12:00 am	rh		100ml						0			
	01:00 am	rh		100ml						0			
	Total Intake : Taken			Total Output : U-600ml m-0									
11/7	02:00 am	rh		100ml						0			
	03:00 am	rh	100	100ml						0			
	04:00 am		100	100ml					1000ml	0			
	05:00 am									0			
	06:00 am		100						400ml	0			
	07:00 am									0			
	Total Intake : Taken			Total Output : U-1400ml m-0									
Total 24 hrs. Intake		1400ml											
Total 24 hrs. Output		2000ml											

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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					IV Site Thrombophlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G						
11/7/26	08:00 am									0	Satya
	09:00 am	Edly								0	
	10:00 am	2120							200ml	0	
	11:00 am									0	
	12:00 pm									0	
	01:00 pm									0	
Total Intake :					Total Output : M-1					U-	
11/7	02:00 pm									0	Lalvani
	03:00 pm	H ₂ O								0	
	04:00 pm									0	
	05:00 pm	H ₂ O								0	
	06:00 pm	H ₂ O								0	
	07:00 pm									0	
Total Intake :					Total Output : M=0					U=22	
	08:00 pm									0	Sambharkhi
	09:00 pm									0	
	10:00 pm	H ₂ O								0	
	11:00 pm									0	
	12:00 am									0	
	01:00 am									0	
Total Intake :					Total Output :						
	02:00 am									0	Sambharkhi
	03:00 am	H ₂ O								0	
	04:00 am									0	
	05:00 am									0	
	06:00 am									0	
	07:00 am									0	
Total Intake :					Total Output :						
Total 24 hrs. Intake		Total 24 hrs. Output									

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 Mrs DIVYA TIRUPATI
 23-08-1992 33 Y 10 M 17 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA



NURSING CARE RECORD



Date: 10/7/24

Shift: ☒ Morning ☒ Afternoon ☐ Night

Assessment: pv leaking, Abdominal pain

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

Time	Plan of Care	Time	Implementation	Evaluation
12pm	⇒ Assess patient condition Check for vitals.	12:10pm	⇒ patient stable vitals recolored in chair	patient stable
2pm	⇒ NST	2:10pm	⇒ NST Recolored	
3pm	⇒ IV placement and inj. Taxim 1gm.	3:10pm	⇒ IV placement done and Taxim 1gm given	
5pm	⇒ Synto titration	5:10pm	⇒ Synto 6ml every 5min titrated	
6pm	⇒ B charting	6:10pm	⇒ maintained B chart	
7pm	⇒ Safety	7:10pm	⇒ Safety provided.	

Re-Assessment: Re-assess done

Special Notes: Synto on going

Nurse Signature: [Signature] Nurse Name: Shreetha

Date & Time: 10/7/24, 8pm

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Dr. SHRUTHI REDDY/Dr. LAVANYA (F)

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/26

Assessment: pt complain Abdominal pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess pt general condition	8:10 PM	Assessed pt general condition	pt is stable.
10pm	monitor vital	10:10 PM	moniter vital Bp SpO2 pulse	
12am	Administration medication	12:10 AM	checked and recorded medication given as per doctor	
4am	Ensure safety	4:10 AM	Ensure safety	
7am	prevent infection	7:10 AM	TO prevent infection	

Re-Assessment: Re assessment done 3rd hourly 1st

Special Notes: Remove Foley's at 10AM

Nurse Signature: 

Nurse Name: Shobha

Date & Time: 10/7/26 @ 8AM

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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 11/7/24

Assessment: patient having mild pain at lower abdomen

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess the patient's general condition	8.10am	patient is stable comfortable	pt stable
9am	monitor vitals	9.10am	vitals stable	
10am	monitor f10 chart	10.10am	monitored f10 chart documented	
11am	to removal Foley's catheter	11.10am	removed and urine passed well ambulation	
12pm	to encourage voiding	12.00pm	urine passed	
1pm	to administer medication	1.30pm	administered medication	

Re-Assessment: Re-assessed after 2 hrs pt stable

Special Notes: Foley's removed

Nurse Signature: Satya

Nurse Name: Satya

Date & Time: 11/7/24 @ 2pm

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NURSING CARE RECORD

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BirthRight
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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 11/7/26

Assessment: Mild pain and discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	→ To assess the general condition of the pt	2:00pm	→ Assessed the general condition of the pt	Patient is stable Vitals normal
4pm	→ To monitor vital signs	4:00pm	→ Monitored vitals and recorded.	
5pm	→ To provide comfortable position	5:30pm	→ Provided comfortable position	
6pm	→ To encourage oral intake	6:15pm	→ Encouraged oral intake	
7pm	→ To administer medications	7:00pm	→ Administered medicines	

Re-Assessment: Pain reduced after providing comfortable position

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Kalyani

Date & Time: 11/7/26 8pm

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 11/7/26

Assessment: patient having mild pain & discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient General condition	8:30 pm	Assessed the patient General condition on bed	→ patient is stable
10pm	To monitor vitals	10:30 pm	monitored patient vitals	
12am	To monitor I/O chart	12:30 am	monitored patient I/O chart	
2am	To Administered medication	2:30 am	Administered medication	
4am	To provide comfortable position	4:30 am	provided patient comfortable position	
6am	To maintain personal hygiene	6:30 am	maintained patient personal hygiene	

Re-Assessment:

provide patient comfortable position administered medication

Special Notes:

NA

Nurse Signature: Subhasini

Nurse Name: Subhasini

Date & Time: 12/7/26 @ 8:00 am

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Shrothi Department: BIC Date of Admission: 10/7/20

SITUATION	Diagnosis: <u>Primid GDM on diet</u> <u>38 wks (ROM) early labor</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify: _____					
	Area	Shift Time	<u>OBS</u> <u>am</u> <u>8pm</u>	<u>BB=11</u> <u>8am</u>	<u>3rd floor</u> <u>2pm</u>	<u>3rd floor</u> <u>8pm</u>	<u>3rd floor</u> <u>8am</u>	
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>CPM</u> <u>ABG</u>	<u>6PM</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.6°F</u>	<u>98.6°F</u>	<u>97.9°F</u>	<u>98°F</u>	<u>98.0°F</u>	
		Res:	<u>20</u>	<u>20</u>	<u>19</u>	<u>20b/m</u>	<u>20b/m</u>	
		SpO ₂ :	<u>99</u>	<u>99</u>	<u>99%</u>	<u>98%</u>	<u>99%</u>	
		Pulse:	<u>81</u>	<u>81</u>	<u>82</u>	<u>76b/m</u>	<u>92b/m</u>	
		BP:	<u>110/60</u>	<u>110/73</u>	<u>108/70</u>	<u>104/70</u>	<u>101/70</u>	
		Fall Risk Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>35</u>	<u>35</u>	
Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>			
Recommendations	Safety Needs:	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>side rails</u>	<u>yes</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Shruthi</u>	<u>Shobha</u>	<u>Satya</u>	<u>Kalyani</u>	<u>Subhashini</u>		
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>		
Date:		<u>10/7</u>	<u>10/7</u>	<u>11/7/20</u>	<u>11/7</u>	<u>12/7</u>		
Time:		<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>	<u>8am</u>		
Taken Over By Name :		<u>Shobha</u>	<u>Subhashini</u>	<u>Kalyani</u>	<u>Shruthi</u>			
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>10/7</u>	<u>11/7/20</u>	<u>11/7</u>	<u>11/7</u>			
Time:		<u>8pm</u>	<u>8am</u>	<u>2pm</u>	<u>8pm</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

BAH-00646550 IP5-00176210
Mrs DIVYA TIRUPATI
23-08-1992 33 Y 10 M 17 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



CHECKLIST FOR THROMBOPHLEBITIS

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S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	10h DAY-1			11h DAY-2			12/7/26 DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	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				Shy Shy Shobu Sato Kalyani Sathya									

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 : Rebecca Name : Rebecca

Signature of Ward In Charge :

Signature : reena Name : reena

BAH-00646550

IP5-00176210

Mrs DIVYA TIRUPATI

23-08-1992 33 Y 10 M 17 D (F)

Dr. SHRUTHI REDDY/Dr. LAVANYA



BRADEN 'Q' SCALE

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				Date :	10/7	10/7	12/7	
				Time :	8am	8pm	8am	
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e. extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
FRICITION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
TOTAL SCORE					28	28	28	
Evaluator's Name					Bey Shobu			

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

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Morse Fall Risk Assessment Form

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Choose Highest Applicable Score from each Category		Date / Time	10/2/26	10/7/20	12/2	Fall Risk Grading		
		Score				Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			20	20	20			
Signature			sky	shobky	Subba			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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PAIN ASSESSMENT FORM

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(U/10)			Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7	12pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shy
10/7	4pm	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Shy
10/7	8pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	shobha
10/7	10pm	2/10	Abdo mild pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Paracetamol	shobha
10/7	12AM	1/10	Lower Abdominal pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	breathing	Shobha
10/7	1pm	1/10	SLs	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sobha
10/7	6am	0/10	SLs	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sobha
10/7	7am	0/10	SLs	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sobha
10/7/26	9am	2/10	SLs	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	7. Tramadol	Saty
11/7/26	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Saty

Re-assessment Frequency:

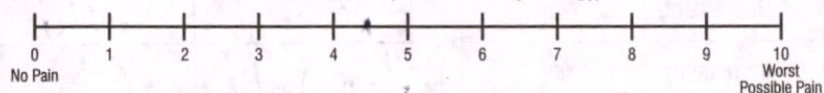
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

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

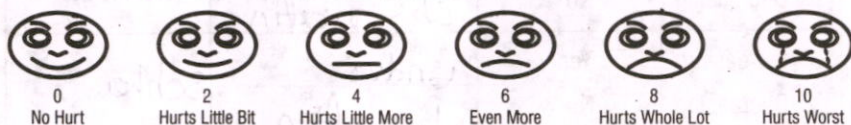
Numerical Pain Scale (Obstetric and Gynecology)



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 - 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



0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Even More 8 Hurts Whole Lot 10 Hurts Worst



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/7	3pm	9/10	Abdominal pain	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Tab. Diclofenac	Kalyani
11/7	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under Observation	Kalyani
12/7	12am 3pm	9/10	Abdominal pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Tab. Diclofenac given	Annamma
12/7	1pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Annamma
12/7	6am	4/10	Abdominal pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	T. Calpal give	Annamma
12/7	7am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Annamma
				☐ 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:

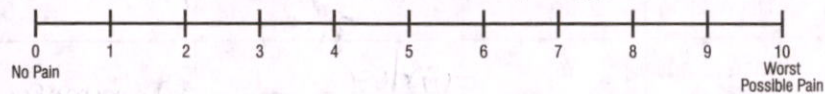
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 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
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FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
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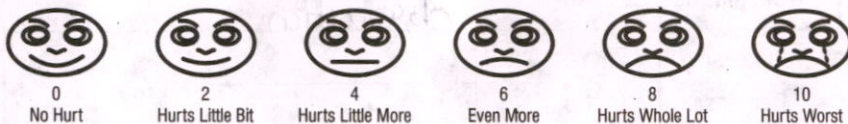
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Vital Signs HR RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



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URINARY CATHETER BUNDLE CHECK LIST

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Date of Insertion: 10/7/26

Date of Removal: 11/7/26 @ 10.20 am

Parameters	Date	Shift Time						
Need for the Catheter	10/7/26	8am-8pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene	10/7/26	8am-8pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment	10/7/26	8am-8pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder	10/7/26	8am-8pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)	10/7/26	8am-8pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy	10/7/26	8am-8pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?	10/7/26	8am-8pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter	10/7/26	8am-8pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?	10/7/26	8am-8pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?	10/7/26	8am-8pm	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care	10/7/26	8am-8pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever	10/7/26	8am-8pm	☐ Yes ☒ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion	10/7/26	8am-8pm	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse	Shobha	Saty						
Signature of the Nurse								

BAH-00646550 IP5-00176210
Mrs DIVYA TIRUPATI
23-08-1992 33 Y 10 M 18 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA




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POST – PARTUM ASSESSMENT FORM – IN-PATIENT

Date: 11/7/26

Chief Complaint : Pain at the suture site

Obstetric/ Birthing History : PIL1, PND - 6

Previous Surgical/Medical History : -

Assessment :

On Observation: Mother seen in lying down /sitting/ reclined position ✓

Mother is active & alert / drowsy / tired or exhausted / mobile by herself & ambulatory / needs assistance with mobility ✓

Iv line + / - ✓

Catheter + / - ✓

Postural alignment -

On Palpation : Edema – absent / up to ankle / up to knee/ above knee ✓

On Examination : Breathing pattern – abdominal/ apical/ diaphragmatic ✓

Diastasis recti abdominis – present / absent / could not be assessed ✓

Able to initiate Pelvic Floor Activation – ☒ Yes ☐ No

Spl Notes -

Treatment Plan :

☒ Lateral Breathing

☒ Pelvic Floor Activation

☒ Transversus Abdominis Activation

☒ Gluteus Activation

☒ Active Motion for Limbs

☒ Transfer Training & Mobility

☒ Sit to Stand

☒ Monitored Walk

☒ Posture & Ergonomic Education

Signature : T.S.

Name : Dr. Teheena Sharma (PT)

Date & Time: 11/7/26 5:15pm

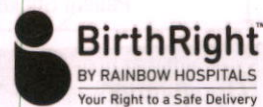
PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00646550 IPS-00176210 Mrs DIVYA TIRUPATI 23-08-1992 33 Y 10 M 18 D (F) Dr. SHRUTHI REDDY/Dr. LAVANYA 		Date & Time of Admission 10/7/26 @ 11:36am	Date & Time of Transfer Order 11/7/26 @ 6:30am
		Transfer Ordered by Dr Shruthi Reddy	Reason for Transfer observation
From Unit BB - II	To Unit 3rd Floor Room No (317)	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 35 -	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?		Patient shifted with ID band: Yes ☐ No ☐ If No:
Number of Imaging Films 4 -			
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Sandhya		Name of Person Ordered Transfer Dr Shruthi	
Patient & Clinical Records Received by : Soubhanni 11/7/26 @ 7AM			
Date & Time of Patient Received :			

If the transfer order time & Completion time is more than 30 minutes, please tick the reason mentioned below :

- ☐ Unavailable Bed
 ☐ Nurse not Available
 ☐ Available Bed not ready

BAH-00646550 IP5-00176210
 Mrs DIVYA TIRUPATI
 23-08-1992 33 Y 10 M 17 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 10/7/2024 Time of Arrival: 11 AM Time Seen by Nurse: 11:20 AM

1) Level of Consciousness: ☒ Conscious ☐ Semi-Conscious ☐ Unconscious

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

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

3) Vital Signs: Temperature: 98.6 F Pulse: 81 RR: 20 SpO₂: 100 BP: 110/80 Weight: 73.7

4) Gestational Criteria:

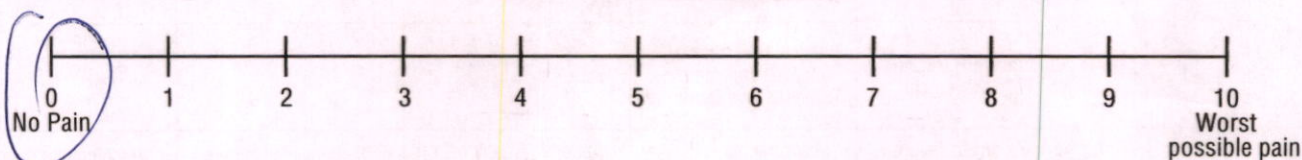
Gravida:	G <u>1</u>	P	L	A
----------	------------	---	---	---

LMP: 18/10/23 EDD: 24/7/24 Gestational Age: 28 weeks

Uterine Contraction	☐ Yes ☒ No ☐ NA	Onset	Time	Frequency:
Membrane Rupture	☒ Yes ☐ No ☐ NA	Onset <u>morning</u>	Time <u>9 AM</u>	Fluid Color: <u>clear</u>
Vaginal bleeding	☐ Yes ☒ No ☐ NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	☐ Yes ☒ No ☐ NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	☒ Yes ☐ No ☐ NA	If No specify:		

5) Pain Screening:

Numerical Pain Scale (NPS)



- Location:
- Duration: Days / Weeks/ Months (Strike out which is not applicable)
- Character: na
- Frequency:
- Interventions:

6) Past History:

- a) Surgeries: Hysteroscopy - polypectomy
 b) Medical: nil



7) Allergy: ☐ Yes ☒ No, If Yes :

8) Current Medications: ☐ Prenatal Vitamin ☐ None ☒ Others: *Prev. Calicew*

9) Prenatal Medical History:

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

Triage Category: (Please tick on the category)

Refer to **OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)**

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: *14:25AM*

Nurse Name : *Shaf* Nurse Signature: *Shaf*

Date: *10/7/20* Time: *12pm*



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 10/11/2026

Baseline Information:

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

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

Chief Complaints: pv leaking Doctor Notified on Admission: ☒ Yes ☐ No
Name of the Doctor: Dr. Bhargavi
Time Notified: 11:25 AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Hysteroscopy Polypectomy	Nil
Gynecology Assessment: ☐ Not Applicable Menstrual History: Onset of Menarche: Menstrual Cycle: ☒ Regular ☐ Irregular Last Menstrual Period: 18/10/25	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 1 P L A

Previous LSCS: Nil

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: 81 RR: 20
BP: 110/70 Weight: 73.7 Height: BMI:

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

BAH-00646550 IP5-00176210
Mrs DIVYA TIRUPATI
23-08-1992 33 Y 10 M 17 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA

Patient



PHYSICAL ASSESSMENT

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

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

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

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

SOCIAL SCREENING:

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

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

Social History: Lives With Ganiv

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. Divya

Orientation not given Reason:

Nurse Signature: Shap

Nurse Name: Shante

Date & Time: 10/7/20 + 12pm

BAH-00646550
Mrs DIVYA TIRUPATI IP5-00176210
23-08-1992 33 Y 10 M 17 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA

DISCHARGE PLANNING FORM

Nationality: India

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

1. Anticipated Date of Discharge: 12/07/2016

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

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: Hygiene

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

☒ Patient ☐ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time: 10/7/16, 12pm

BAH-00646550 IP5-00176210
Mrs DIVYA TIRUPATI
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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 11/7/26 Time: 8am

Origin: Indian Height: 156cm Weight: 73.7kg BMI: 29.36 kg/m²

Food Allergies: No

Diagnosis: pmo-o / post NORMAL delivery

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

Diet Advised:

Soft high protein diet
with plenty of oral fluids
Avoid spic, chilled & outside foods

Patient's / Attendant's

Signature: [Signature]

Name: T. Divya

Date & Time: 11/7/26 8am

Dietician's

Signature: [Signature]

Name: Larina

Date & Time: 11/7/26 8am

DIETARY NOTES[illegible]

BAH-00646550
Mrs DIVYA TIRUPATI
23-08-1992
Dr. SHRUTHI REDDY/Dr. LAVANYA
33 Y 10 M 17 D
IP5-00176210
(F)

BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?

☐ a. Yes

☒ b. No

2. If No, Reason

Baby not

3. Nipple condition:

☐ a. Nipple well formed

☐ b. Flat nipple

☐ c. Inverted nipple

☐ d. Short nipple

4. Milk flow:

☐ a. Good

☐ b. Drops of colostrums

☐ c. Dry

5. Steps for Positioning and attachment:

☐ a. Baby goes to the breast

☐ b. Mother always sits with a back support

☐ c. Ear-shoulder-hip should be in a straight line

☐ d. The baby takes a latch on the areola and not on the nipple



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- ☐ a. Yes
☒ b. No

7. For Caesarian mothers:

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

8. NICU admission:

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

9. Additional notes:

Baby shifted to NICU

Date:

11/7/26

Continuity of Care:

Handover given by

Shobha

Handover taken by

Surekha

Signature

[Signature]

Signature

[Signature]

Date & Time:

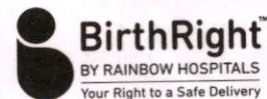
11/7/26 @ 6:25 AM

Date & Time:

11/7/26 @ 7 AM

Department
PRE-ANA

BAH-00646550 IP5-00176210
Mrs DIVYA TIRUPATI
23-08-1992 33 Y 10 M 17 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



Name: DIVYA TIRUPATI Age: 33 Sex: F UHID No: BAH-00646550

Date: 10/11/20 Time: 9:30 PM Proposed Operation:

Diagnosis: pmi / 1st 1st on Diet / 38wks (scan)

B.P / CRT: H.R: Weight: 74 ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: <u>10-4</u>	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag:	ECG:
WBC: <u>10.36</u>	Creat:	Total Bill:	HCV:	2D Echo:
Plate: <u>1-9</u>	Na:	Dir. Bill:	Blood group: <u>B+</u>	Stress/Angio:
PT:	K:	LDH:	T3:	Other:
PTT:	Ca++:	Alk phos:	T4:	
INR:	Mg++:	Amylase:	TSH:	
	Cl-:	SGOT/SGPT:		

Allergies: -

Medical History:

CVS: NS

RESP: NS

Diabetes: -

CNS: NS

Renal: NS

Hepatic / GE: NS

Physical Activity:

Others:

Past Anaesthetic History:

Physical Exam:

Airway: MP 1 2 3 4

Mouth Opening: 2cm

Mento-hyoid Distance: 2cm

Neck: NS

Teeth: NS

Lungs: Clear

Heart: NS

CNS: NS

Pregnant: ☒ Yes ☐ No ☐ NA

Venous Access Site: U

Spine Exam for regional: -

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

Epidural

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis:
- NIL ORAL $\left\{ \begin{array}{l} \rightarrow \text{Water / ORS 2 Hours} \\ \rightarrow \text{Others 6 Hours} \end{array} \right.$ Explained
- Informed Consent: ☐ Standard ☐ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:

last meal 2nd date

Signature: [Signature] Name: DR. K. R. RAMYA A.

Patient Sticker

ANAESTHESIA CHART



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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ No

Fasting Status:

Physical Status:

☐ Patient Identified☐ Consent Present☐ Chart Reviewed

H.R.:

B.P. / CRT:

SpO₂:

R.R.:

Last Feed:

Pre-OP Diagnosis:

Operation:

Date :

Surgeon:

Anaesthesiologist:

Technician:

TIME

N₂O / AIR / O₂ LPM

HALO / SO / SEVO

Drugs:

Antibiotic

Suppository

Blood Loss

NOTES

FIO₂ / SaO₂ETCO₂

ECG

Temperature

Urine Output

Fluids
Blood

B.P.

240

V Systolic

220

A Diastolic

200

X Mean

180

• Heart Rate

160

Tourniquet on Time

140

Tourniquet off Time

120

Throat Pack In

100

Throat Pack Out

80

60

40

20

10

0

LAB Values

ABG

GRBS

Others

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

Position:

☐ 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:

OP Start:

OP End:

Leave OR:

Anaesthesia:

☐ GA☐ Monitored Anaesthesia Care☐ Regional

Line (Size & Location)

☐ CVP:☐ ART:☐ IV:☐ IV:☐ IV:

Induction

☐ IV☐ Inhal☐ Pre O₂☐ RSI☐ Others☐ Mask☐ SGA☐ Airway☐ Oral☐ Nasal

ETT#

at cm

☐ Oral☐ Nasal☐ Cuff☐ Tracheostomy☐ Topical☐ Drug:☐ Awake☐ Direct Vision☐ Video Laryngoscopy☐ Stylette / Bougie☐ Fiberoptic

Blade#

Attempts:

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☐ OtherRelaxant Reversed ☐ Yes☐ No☐ NA

Name of the Doctor :

Signature of the Doctor :

Date & Time: _____

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: 10/7/2026 Time: 9:10 PM Procedure done by DR. KRIRAMYA

CSE / Spinal / Epidural Position: sitting Space: L3-L4 Technique (LOR/LOS) LOS

Depth: 4 cm Catheter at Skin: 9 cm Attempts: 2 attempts

Parasthesia : Yes/No if yes details :

Solution Composition : 0.1% Bupivacaine + 2 mg/ml Fentanyl

Any other issues : Epidural catheter inserted at 9:20 PM

a) Drug given

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		Maternal		FHR	Comments
			Left	Right	BP	Pulse		
9:20 PM		0.8% LOS	T8	T8	112/70	62	143	Controlable
9:45 PM	10 ml/hr	10 ml	T8	T8	108/60	60	140	Controlable
11:15 PM	6 ml/hr		T8	T8	110/70	62	142	Controlable
1:45 PM	8 ml/hr	2 ml 0.8% LOS	T12	T12	110/90	100		Pain after episiotomy

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

Catheter Removed by and Tip Inspected : DR. KRIRAMYA Tip inspected by shobha

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature: [Signature]

Doctor Name: DR. KRIRAMYA

Date and Time : 10/7/2026 11:02 AM

BAH-00646550 IP5-00176210
 Mrs DIVYA TIRUPATI
 23-08-1992 33 Y 10 M 17 D (F)
 Dr. SHRUTHI REDDY/Dr. LAVANYA



PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)

Procedure Name: Date: 10/7 In-Time: 7:00pm Out-Time: 7:30pm

Doctor Performing Procedure: Doctor Giving Sedation: Assisting Nurse: Shobha

SIGN IN		TIME OUT		SIGN OUT	
Time: <u>7:10 PM</u>		Time: <u>7:25 PM</u>		Time: <u>7:30 PM</u>	
	Yes No NA		Yes No NA		Yes No NA
Patient is verified using two identifiers (Name & UHID)	☒ ☐ ☐	Correct Patient	☒ ☐ ☐	Name of the Surgical / Invasive Procedure is recorded	☒ ☐ ☐
All required documents, images, studies are available	☒ ☐ ☐	Correct Site	☒ ☐ ☐	Instrument, Sponge and Needle Count Completed	☒ ☐ ☐
NPO Status Checked from Patient / Patient Attendant	☒ ☐ ☐	Correct Procedure	☒ ☐ ☐	Specimens are labeled	☐ ☐ ☒
Consent is Signed	☒ ☐ ☐	All the team members introduced	☒ ☐ ☐	Any equipment problems are addressed	☐ ☒ ☐
Any need for blood products	☐ ☒ ☐				
If Yes Comment:					
Any Risk of Hemodynamic Compromise	☐ ☒ ☐				
If Yes Comment:					
Any drug or food allergy	☐ ☒ ☐				
If Yes Comment:					
Correct Site of Procedure Marked	☒ ☐ ☐				
All resources required are correct, available and functioning	☒ ☐ ☐				
Signature of the Doctor: <u>[Signature]</u>		Signature of the Nurse: <u>Ajayali</u>		Signature of the Nurse: <u>Ajayali</u>	
Name of the Doctor: <u>DR. SRI RAMYA</u>		Name of the Nurse: <u>Ajayali</u>		Name of the Nurse: <u>Ajayali</u>	

Any Adverse / Unexpected Events

BAH-00646550 IP5-00176210
Mrs DIVYA TIRUPATI
23-08-1992 33 Y 10 M 17 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



CONSENT FOR LABOUR ANALGESIA

Authorization By: ☒ Patient ☐ Patient Attendant

I, the undersigned do hereby acknowledge the following:

- I have been made aware by the doctors in language known to me the details of the procedure as follows:

☒ Epidural Analgesia ☐ Intravenous Analgesia (Remifentanyl)

- I have been made aware of the possible complications from the procedures as follows:

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

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

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

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

- I authorize Dr. K-SRI RAMYA and his / her team to perform the above procedure(s) upon the patient / myself.

- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: T. Divya

Name: T. Divya

Relationship with patient:

Date & Time:

Witness:

Signature: Viswa Kamal K.

Name: Viswa Kamal K.

Date & Time:

Doctor (who is taking consent):

Signature: Dr. K-Sri Ramya Name: DR-K-SRI RAMYA Date 10/7/2016 Time: 9:09 PM

ప్రసవ నొప్పి నివారణ కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

వైద్యులు నాకు తెలిసిన భాషలో క్రింది విధానాల గురించి సమగ్రంగా వివరించారు:

- ☐ ఎపిడ్యూరల్ అనాల్జీసియా
☐ శిరస్రావం ద్వారా నొప్పి నివారణ (రెమిఫెంటానిల్)

- ఈ విధానాల వల్ల సంభవించగలిగే సమస్యలను కూడా నాకు వివరించారు:

ఎపిడ్యూరల్ సంబంధించినవి:

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

రెమిఫెంటానిల్ సంబంధించినవి:

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

- ప్రసవ నొప్పిని తగ్గించడం, ప్రసవ ప్రక్రియను సాకార్యవంతంగా చేయడం, నొప్పి మరియు ఒత్తిడిని తగ్గించడం, ప్రసవ సమయంలో సహకార మెరుగు పరచడం కోసం లేబర్ అనాల్జీసియా అందించబడుతుందని నేను అర్థం చేసుకున్నాను.
- ఈ విధానాల ప్రయోజనాలు, ప్రమాదాలు మరియు ప్రత్యామ్నాయాల గురించి నాకు స్పష్టంగా వివరించబడింది.
- డాక్టర్ _____ గారికి మరియు వారి బృందానికి, పై విధానం(లు)ను నాకు / రోగికి నిర్వహించడానికి నేను అనుమతి ఇస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు ఆ ప్రశ్నలకు నాకు అర్థమయ్యే భాషలో సంతృప్తికరంగా సమాధానాలు అందాయి. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన చిత్తంతో ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

INFORMED CONSENT FOR VAGINAL BIR

BAH-00646550 IP5-00176210
Mrs DIVYA TIRUPATI
23-08-1992 33 Y 10 M 17 D (F)
Dr. SHRUTHI REDDY/Dr. LAVANYA



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name : Mrs. DIVYA TIRUPATI

UHID No : BAH-00646550

Gender : ☐ Male ☒ Female Date : 10/7/2026

Time : 11:30 AM

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr. Shruthi Reddy

Consentee :

Signature : Divya Tirupati

Name : Divya

Date & Time : 10/7/26, 11:30 AM

Witness :

Signature : Shruthi Reddy

Name : Shruthi Reddy

Date & Time : 10/7/26, 11:30 AM

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

Patient Attendant :

Signature : T. Divya

Name : T. Divya

Relationship with Patient :

Date & Time : 10/7/26, 11:30 AM

Doctor (who is taking the consent) :

Signature : Dr. Shruthi Reddy

Name : Dr. Shruthi Reddy

Date & Time : 10/7/26, 11:30 AM

సహజ ప్రసవం కొరకు సమ్మతి పత్రము

రోగి పేరు : వయస్సు : లింగం పు స్త్రీ

యు.పొప్.బి.డి. బిభాగము

తేదీ

ఈ ప్రక్రియ యొక్క వివరములను నేను ఆమోదించాను:

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

● ఈ ప్రక్రియ యొక్క ఉద్దేశ్యం బిడ్డను సహజమయిన పద్ధతిలో ప్రసవించటం
సహజ ప్రసవం (యోని జననం) యొక్క ప్రక్రియ సహజంగా లేదా శక్తిని ఉపయోగించి గర్భాశయం ద్వారా శిశువును ప్రసవించడం.
వాక్యూమ్ ద్వారా శిశువును వెలికితీయడం, ఎపిసియోటమీ (యోని మరియు యోని మధ్య భాగంలో యోని మార్గమును సుగమం చేయుట కొరకు చేసిన కోత (కట్), సహజ ప్రసవం కొరకు చేయు ప్రక్రియలలో భాగము.

సహజ ప్రసవం విజయవంతం కాకపోతే, తగిన అనస్థీసియా ఇచ్చి పొత్తికడుపు కోతతో సిజేరియన్ ద్వారా డెలివరీ చేయవలసిన అవసరం కలగవచ్చు

సహజంగా లేదా పరికరం సహాయంతో అంటే ఫోర్స్స్ లేదా వాక్యూమ్ సహాయంతో బిడ్డను ప్రసవించే ప్రయత్నంలో, ప్రమాదాలు ఉండవచ్చు: అంటువ్యాధులు, అలెర్జీ, మచ్చలు, రక్త నష్టం, రక్త మూర్చిడి అవసరం పడటం, నొప్పి మరియు అశోకర్షం, మూత్ర నాళానికి గాయం, శిశువుకు గాయం అయ్యే అవకాశం (ప్రెసరేషన్, హెమటోమా, పుర్రె గాయం అయే అవకాశం, సరాలకు గాయం మరియు మెదడు గాయం) మరియు భవిష్యత్తులో కటి ప్రదేశంలోని ఎముకల వలయం పనిచేయకపోవడం

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

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

ఇక్కడ వివరించిన లేదా సూచించిన విధానాలకు నేను స్వచ్ఛందంగా సమ్మతిస్తున్నాను. ఈ ప్రక్రియ అర్హతగల నైసకాలజిస్ట్ వేత నిర్వహించబడతాయని నేను తెలుసుకున్నాను

ఈ ప్రక్రియను నిర్వహించే డాక్టరు పేరు:

సహాయకుడు(అటెండెంట్) సాక్షి

సంతకము సంతకము

పేరు పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో) తేదీ మరియు సమయము

సంతకము

పేరు