Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Children's Hospital - Banjara Hills

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

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176792 **Admit Date** : 23-Jul-2026 **Admit Time** : 01:47 AM **UHID** : BAH-00662464

Patient Details :

Patient Name	: Mrs SHITAL SHUBHAM BAJAJ	**Age**	: 28 Y 7 M 5 D
Guardian	: Mr SHUBHAM BAJAJ	**DOB**	: 18-12-1997
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: MAHESH HOUSING SOCIETY Udgir Latur Maharashtra INDIA 413517	**Phone No**	: 9049747222/ 9022256246
		E-mail	: NO@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD **Bed No** : SW 414 **Ward Name** : 4F-BIRTHING CENTRE

Room No : SW 414 **Admission Type** : First Visit

Contact Details :

Name : Mr SHUBHAM BAJAJ **Relationship** : Husband

Contact Address : MAHESH HOUSING SOCIETY Udgir Latur Maharashtra INDIA 413517 **Phone No** : 9049747222 / 9022256246

Signature

Doctor Details :

Doctor Name	: Dr. SHRUTHI REDDY/Dr.LAVANYA JANAGAMA	**Specialisation**	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: Dr Joshna hanam Shetty	**Phone No**	: 9480360247
Co-Consultant	:		

Payment Details :

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

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name :_____

BAH-00662464 IPS-00176792
Mrs SHITAL SHUBHAM BAJAJ
18-12-1997 28 Y 7 M 5 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
23/7	CUE ~~CU~~	26073943	Shobha
23/7	Urine culture	26073943	Shobha
23/7	Viability scan	2650367 ~~78~~	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/7	IV placement	①	9-11755	Sandeep.

ANY OTHER INFORMATION

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.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 23/7/2026 Time of Admission : .....

Allergies: NKDA ☐ Not know any drug allergies

PRESENTING COMPLAINTS :

Referred from Dr. Jyotsna (from Sangameshwar Hospl) @ Bidar.

G3P1L1E1 | Amenorrhea for 6+1 wks | previous LSCS

c/o severe pain in lower abdomen region and (L) side lower pelvis. tenderness (+)

a/w nausea since 16/7/2026 decreasing on taking Ns and starting again.

Not a/w bleeding / loose stools / fever.

UPT positive → 14/7/2026.

17/7/26 (TAS) ut - 9.2 X 6.2 X 4.1 cm, ET - 10-11mm, Early sac like structure along endometrium mis 8 X 6 X 5mm ~ 5+2 wks.

TVS - sac ~ 2.2 X 1.2 X 0.8 ~ 6+1 wks, NO yolk sac, small follicle in (L) ovary 1.4 X 1.8 cms

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 6 years	Parity : G3P1L1E1
Previous Periods : regular	Mode of Delivery : G1
LMP : 10/6/2026.	Last Child Birth : 2021
Contraception :	G1 - 2021 - LSCS - (Cord around neck) - Boy - 2.3kgs A/H.
NIL - 6 years.	E1 - 2023 - 8wk - Ectopic (Renal stone) - (L) salpingectomy (Lap)
	PP - sp. conception

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil	LSCS - 2021
	(L) Lap. salpingectomy - 2023

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18-12-1997 28 Y 7 M 5 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

Mother - HTN

MEDICATION HISTORY:

folic acid, Doxylamine.

INITIAL ASSESSMENT :

Date 23/7/26
Ht. 4.1 Feet Wt. 54kgs.
BMI 24.
B.P 105/79(84) mmHg
Pallor absent
CVR S1S2 (+)
Respiratory System BAE (+)
Thyroid (N)

Breasts (N)
PR-80 Bpm
Temp - 98.7°F
Abdominal Examination
tenderness over lower abdomen (+)
(L) side pelvic (+)

Local/Speculum Examination

Bimanual Pelvic Examination

PROVISIONAL DIAGNOSIS : G3P1L1E1 | 6 wks of GA | previous Ectopic | for observation. pain in abdomen + evaluation.

INVESTIGATIONS ORDERED

BGT - B positive.
Viral - NR.
18/7/26 Hb - 10.5
WBC - 5,600
PLT - 3.16L
RBS - 86
CUE - (N)
HbA1C - 5.2
TSH - 3.32

PLAN OF MANAGEMENT

- Admission
- Inj. PCM 1gm iv/stat
- Inj. Zofer 4mg iv/stat.
- Viability Scan today.

Name of the Doctor : Dr. Divya
Signature of Doctor
Date & Time : 23/7/26; 1:46 Am

BAH-00662464 IP5-00176792
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Dr. SHRUTHI REDDY/Dr.LAVANYA

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7/26 7:00 pm.	G3 P1L1F, / 6+ wks / previous Ectopic. ē (L) salpingectomy / pain in abdomen for evaluation	
	O/E GC - fair BP - 105/86 (86 hurry) PR - 86 bpm SpO2 - 98% RA	Pt comfortable after inj. pain c/o: mild pain (now) c/D/w Dr. Shruthi (1) Advised to do scan & Inform.
	Adv Inj. Tramadol 50mg in 100ml NS IV over 20 mins (2) w/f leaking / Bleeding per vagina (3) monitor vital 4th hrly (4) Inform SOS. Dr. Divya	
23/7/26	USG:- S/O: SLIUG, 6+ wks, G.sac, Yolk sac - visualised. fetal pole not seen	

Docu. No. : RCHBH /FRM / CLINICAL / 088 (P.T.O)

BAH-00662464 IP5-00176792
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18-12-1997 28 Y 7 M 5 D
Dr. SHRUTHI REDDY/Dr.LAVANYA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7/26 11:30 AM	POD: C/S/B -	Dr. Shruthi Reddy
	G3P1L1E1 / 6th wks /	pain abdomen for evaluation
	C/O: pain abdomen.	Rx
	GC: fair	1) Soft diet c̄ plenty of oral fluids
	B.P - 109/75	
	P.R - 86	2) Drug as charted
	SpO2 - 100% on RA	3) C/o P/V Bleeding pain abdomen
	P/A: soft	4) Monitor vitals, inform if BP < 100/60
	Sent - CUE	> PR > 100
	Urine C/S	Temp > 100 F
	Discharge	Dr Sravanthi

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RESULT SHEET

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

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

Culture and Sensitivities : .....

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Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 28/23/11/26

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: ..... Doctor Notified on Admission: ☑ Yes ☐ No

..... Observation ..... Name of the Doctor: Dr- Deepika

..... Time Notified: 1:30pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
nil	LSCS - 2021 Lap Salpingectomy	nil

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

..... Regular .....

Onset of Menarche: ..... 13 .....

Menstrual Cycle: ☑ Regular ☐ Irregular

Last Menstrual Period: 10/6/26

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 3 P D1 L 1 A E<

Previous LSCS: LSCS 2021

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: 98.6F HR: 86bpm RR: 18bpm

BP: 105/70 Weight: 57 Height: ..... BMI: .....

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

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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 .....

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: ..... Shital .....

Orientation not given Reason: .....

Nurse Signature: ..... Sandhya .....

Nurse Name: ..... Sandeep 01660 .....

Date & Time: ..... 27/7/26 @ 8pm .....

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RY PATIENT / FAMILY EDUCATION RECORD

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ndi | Telu

.....Patient / Learner Literacy : ☐ Read ☑ Write ☐ Speak Willingness to Learn : ☐ Yes ☐ No Healthcare Literacy : ☐ Yes ☐ No

Identified Education Needs :

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

Part - II

Date	Time	Need Indentified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barries	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
23/7/26	2:45PM	1,2,3,4	Diagnosis Treatment & care plan pain management.	PT/S	1	D	1	1		
23/7	2000	2	control infection	PT	1	D	1	1	—	

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 Barries
2. Physical Impairment
3. Emotional Barries
4. Language Barrier
5. Educational Level
6. Desire / Motivate to Learn
7. Impaired Thought Process / Cognitive limitations
8. Responsibilities at Home
9. Cultural Difference
10. Financial Difficulties
11. Beliefs and Values
12. Impaired Vision / or Hearing
13. Cultural / Religion Practice
14. Others (Specify) .....

Teaching Tools Used : **A** : Audio **D** : Demonstration **V** : Video **O** : Oral **P** : Printed

Mechanism/s to overcome barrier/s :
1. None
2. Obtain translator
3. Reassurance & Support
4. Teach Family / others
5. Respect values & beliefs
6. Respect Cultural / Religion Preference
7. Other, Specify.....

Understanding : 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review

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MULTI-DISCIPLINARY PLAN OF CARE FORM

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Di... o/Hwk of G1 | previous Ectopic | Pain evaluation.

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
23/7/26 2:00Am	☐ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	→ previous Ectopic	→ ~~Safe~~ → Pain management → To R/o Ectopic	→ observation	[signature]	☐ Nursing ☐ Others:
23-7 2A0	☐ Medical ☑ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	plan for safety	→ To reduce fear	Pt is stable	[signature]	☑ 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:

Patien

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MEDICATION RECONCILIATION FORM

Drug Allergies: NKDA ☑ Not known any Drug Allergies

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

Shifting From: — Shifted to: —

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T- folic acid	1tab	PO	OD	22/7/24	☑C ☐DC
2	T. Doxylamine + VitB6	1tab	PO	TID	22/7/24	☑C ☐DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Divya

Date & Time : 23/7/2024 ; 2:00 Am.

Nurse Name & Signature: Sandeep / (01668E)

Date & Time : 23/7/2024 2AM

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DRUG CHART

Date of Admission: 23/7/26 Drug Allergies: NKDA ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

Sign

VERIFIED BY : Name

BAH-00662464 IP5-00176792
Mrs SHITAL SHUBHAM BAJAJ
18-12-1997 28 Y 7 M 5 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

REGULAR PRESCRIPTIONS

Weight. 56kg Ward. OBS

DRUG : T. DUPHASTON	Date / Time													
Dose: 10mg / Route: P/O / Frequency: BD / Start Date: 23/7														
Name & Signature of the Doctor Starting the Drugs: Dr Shruthi														
Additional Instructions:														
Daily Doctor's Endorsement by a Sign														

DRUG : T. TRAMADOL	Date / Time													
Dose: 100mg / Route: P/O / Frequency: TID / Start Date: 23/7														
Name & Signature of the Doctor Starting the Drugs: Dr Shruthi														
Additional Instructions:														
Daily Doctor's Endorsement by a Sign														

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

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

BAH-00662464 IP5-00176792
Mrs SHITAL SHUBHAM BAJAJ
18-12-1997 28 Y 7 M 5 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

Weight 56 kg Ward. ORS

	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
23/7/26	1:50pm	INJ. PARACETMOL	1gm	IV	Dilleya	Sandeep Bhardi 1:5PM
23/7/26	1:50pm	INJ. ZOFER	4mg	IV	Dilleya	Sandeep Bhardi 1:5 PM
23/7/26	7:10 PM	INJ. TRAMADOL	50mg in 100ml NS	IV	Dilleya	Sandeep Bhardi
23/7/26	7:30	INJ. ZOFER	4mg	IV	Dilleya	Sandeep Bhardi

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

Dr. DARIVEMULA TEJASWINI
05-01-1995 31 Y 6 M 18 D (F)
Dr. NIVEDITHA CHALMEDA

I.V. FLUIDS CHART

Weight. 56kg Ward. [illegible]

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

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

BAH-00662464 IP5-00176792
Mrs SHITAL SHUBHAM BAJAJ
18-12-1997 28 Y 7 M 5 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

(1)

22/7/26

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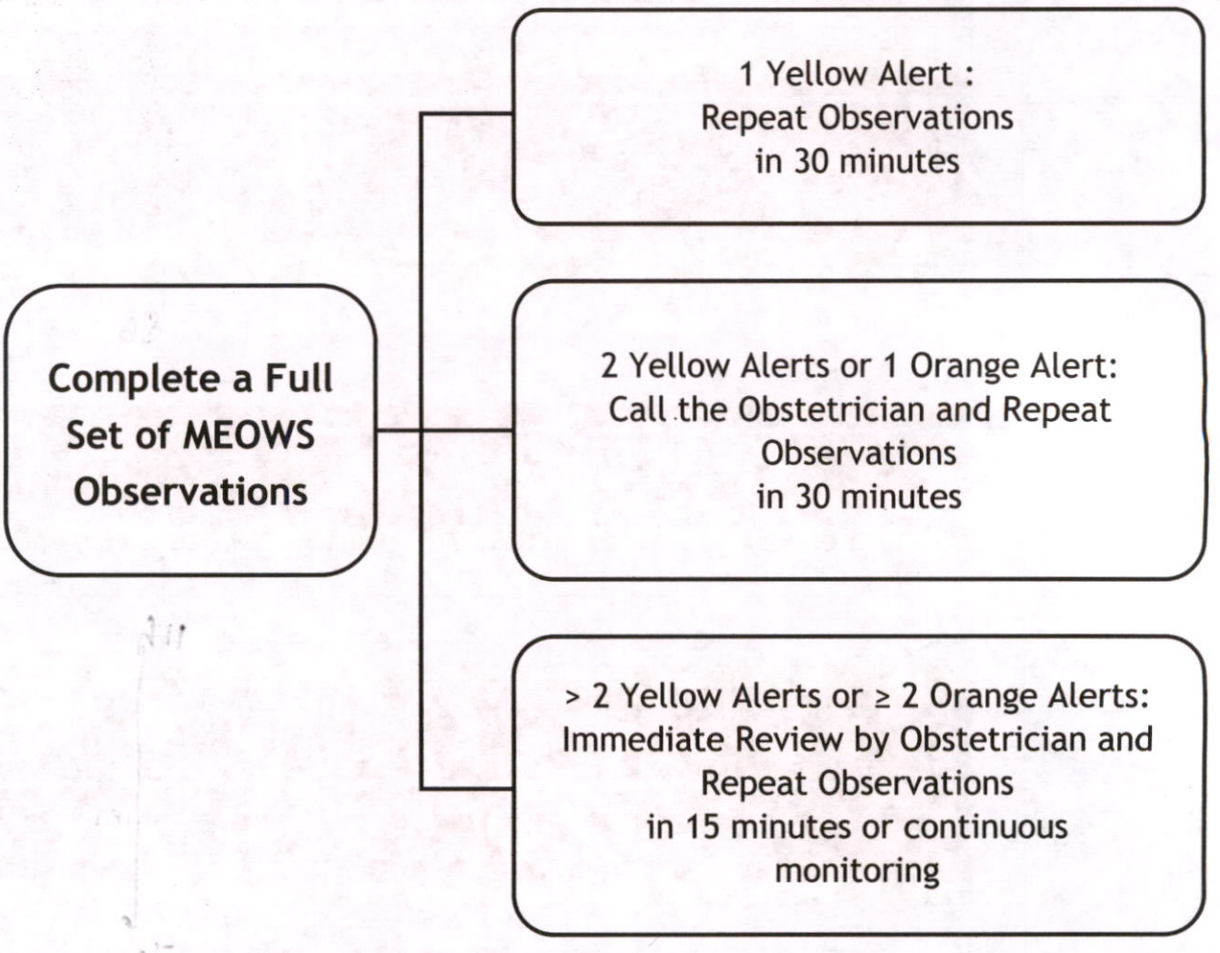
Early Warning Observation Score Chart - Obstetrics

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																				18				18	
	0 - 10																									
Saturations	94 - 100 %																				98%				98	
	< 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																				86				86	
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																			117				105		
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																				(85)				(96)	
	110																									
	100																									
	90																									
	80																									
	70																									
	60																				70				76	
	50																									
	40																									
NEURO RESPONSE [✓]	Alert																				✓				✓	
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																				✓				✓	
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES																					0				0	
TOTAL ORANGE SCORES																					0				0	
Nurse Initial																					SB				g	

Obstetrics and Gynaecology Early Warning Signs



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

BAH-00660232 IP5-00176765
Dr. DARIVEMULA TEJASWINI
05-01-1995 31 Y 6 M 18 D (F)
Dr. NIVEDITHA CHALMEDA

(2)

23/7/26

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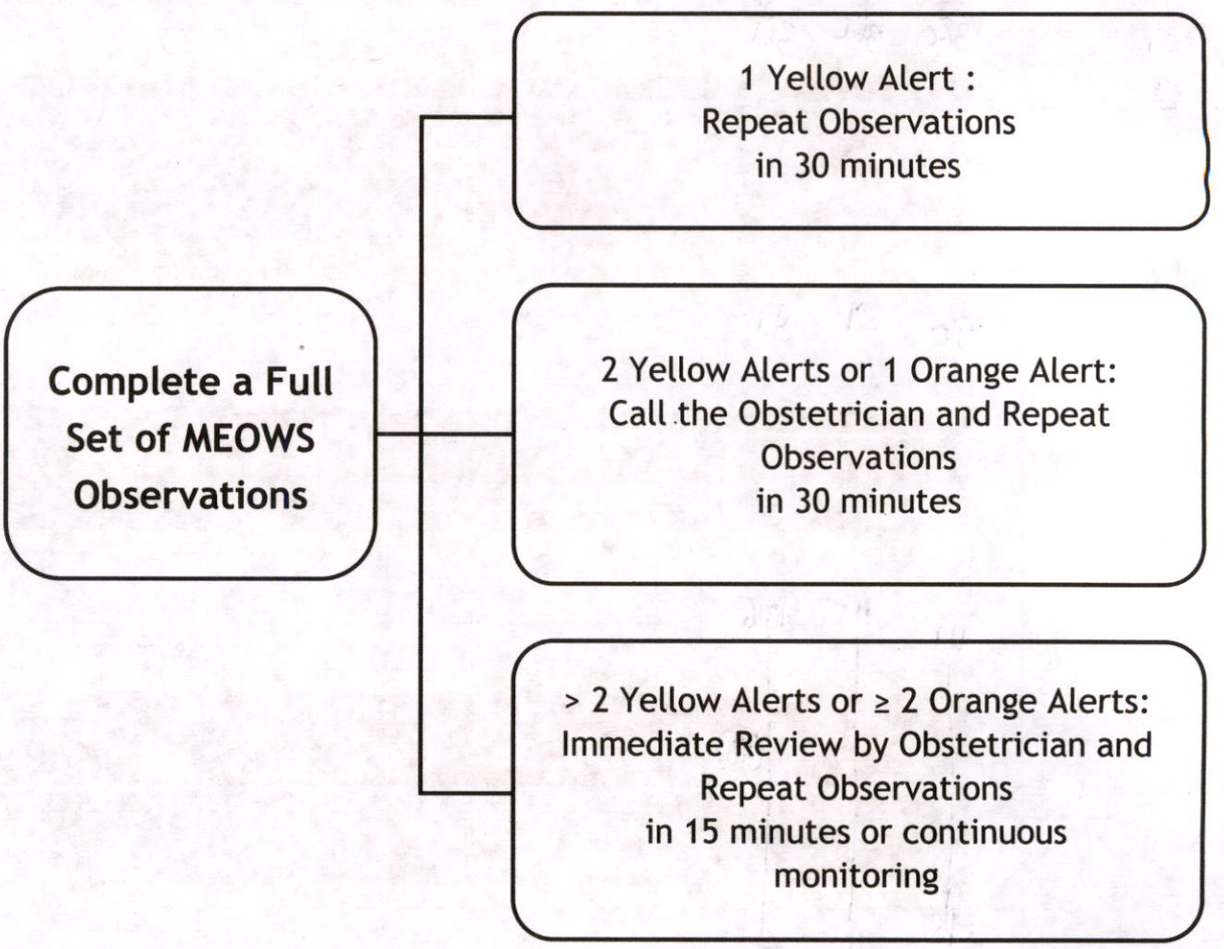
Early Warning Observation Score Chart - Obstetrics

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

23/7

		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	20			20		19																			
	0 - 10																									
Saturations	94 - 100 %	100			99		99																			
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36	36°C			36°C		36°C																			
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80	80			81		81																			
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120				115		136																			
	110	111																								
	100																									
	90																									
	80																									
	70																									
	60						(76)																			
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80	78			75																					
	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		0			0		0																			
TOTAL ORANGE SCORES		0			0		0																			
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

BAH-00662464 IP5-00176792
Mrs SHITAL SHUBHAM BAJAJ
18-12-1997 28 Y 7 M 5 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

(1)
22/7/26

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FLUID CHART

Sheet No. : (1)

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am		H2O								0	
	03:00 am		H2O								0	
	04:00 am						nil			✓	0	
	05:00 am		H2O								0	
	06:00 am									✓	0	
	07:00 am										0	
Total Intake :		Falco				**Total Output :**						

Sandeep

Total 24 hrs. Intake		Total 24 hrs. Output	

BAH-00662464 IP5-00176792
Mrs SHITAL SHUBHAM BAJAJ
18-12-1997 28 Y 7 M 5 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

28/7

(2)

FLUID CHART

Rainbow® Children's Hospital
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BirthRight BY RAINBOW HOSPITALS
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Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am		H2O									
	09:00 am						N					
	10:00 am		H2O									
	11:00 am											
	12:00 pm		H2O									
	01:00 pm											
Total Intake : Taken						**Total Output :** Taken						
	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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CHECKLIST FOR THROMBOPHLEBITIS

9217

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						
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					Shdy						

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 : Veena

Signature of Ward In Charge :

Signature : ..... Name : Sindu

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Mrs SHITAL SHUBHAM BAJAJ
18-12-1997 28 Y 7 M 5 D (F)
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NURSING CARE RECORD

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Shift: ☐ Morning ☐ ...oon ☑ Night

Date: 22/7/26

Assessment: patent complaint about pain at lower abdomen

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
12AM	~~Assess~~ the pt condition	1AM	~~Assessed~~ pt condition	pt is stable
1AM	monitor vital.	2AM	monitored vital.	
2AM	- for placement	3AM	- for cannulization done	
4AM	- preparation	4AM	preparation done	
5AM	- medication	~~5AM~~	~~administered~~ medication	
6AM	- I/O chart	6AM	maintained I/O chart	
~~7AM~~	- Ensure safety	8AM	- Ensured safety	

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

Special Notes: ectopic pregnancy.

Nurse Signature: Sandeepa Nurse Name: Sandeepa (01663...) Date & Time: 22/7/26 @ 8AM

NURSING CARE RECORD

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

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Shift: ☑ Morning ☐ Afternoon ☐ Night

Date: 28/7/25

Assessment: pt complain for 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
8 AM	Assess pt general condition	8:10 AM	Assess pt general condition	pt is
10 AM	monitor vital	10:30 PM	Bp spo2 pluse checked	Stable.
11 AM	Administration medications	11:30 PM	medication given as per doctor.	
12 PM	Ensure safety	2:30	Ensure safety provided	
7 PM	prevent infection	9:30 PM	To prevent infection.	

Re-Assessment: Re Assessment done

Special Notes:

Nurse Signature: S Nurse Name: Shobha Date & Time: 28/7/25 @ 2PM

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18-12-1997 28 Y 7 M 5 D (F)
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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Shruthi Department: OBS Date of Admission: 23/7/26

SITUATION

Diagnosis: G2P1L1A1 6+3 week for observation

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

BACKGROUND

Area / Shift Time	OBS 6pm-8AM	OBS 8pm-2pm				
Medical Condition (Any special condition to be noted):	N/A	N/A				

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:	98.6F	98.4F				
Res:	18bpm	18bpm				
SpO_2:	100%	100%				
Pulse:	86bpm	94bpm				
BP:	114/76	106/70				
Fall Risk Score:	20	20				
Pain Score:	0	0				

Recommendations

Safety Needs:	yes	Yes				
Physiotherapy	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Others Specify:	N/A	NA				
Special Diet:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:	N/A	ND				
Post Operative Procedure Special Orders:	N/A	ND				
Handed Over By Name :	Sarooja	Shobha				
Signature :						
Date:	23/7/26	23/7/26				
Time:	8AM	2pm				
Taken Over By Name :	Shobha					
Signature :						
Date:	23/7/26					
Time:	8AM					

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

BAH-00662464 IP5-00176792
Mrs SHITAL SHUBHAM BAJAJ
18-12-1997 28 Y 7 M 5 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

BRADEN 'Q' SCALE

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				Date : 28/7 29/7		
				Time : 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 extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	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
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
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
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4
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	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
				TOTAL SCORE		
				Evaluator's Name		Shal

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

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

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PAIN ASSESSMENT FORM

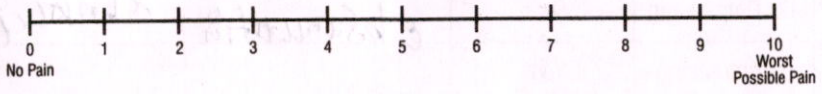
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
23/7	2AM	2/10	Abdo men	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Inj: PCM given	[signature]
23/7	5AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	[signature]
23/7	8AM	0/10	No pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	[signature]
				☐ 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		
				☐ 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:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

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

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, SaO_2	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

BAH-00662464 IP5-00176792
Mrs SHITAL SHUBHAM BAJAJ
18-12-1997 28 Y 7 M 5 D (F)
Dr. SHRUTHI REDDY/Dr.LAVANYA

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	22-7	23/7		Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0	0	0		Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	20	20				
IV / Heparin Lock or Saline	Yes	20				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
Mental Status	Forgets limitations	15						
	Oriented to own ability	0	0	0				
Total Morse Fall Scale Score:			20	20				
		Signature						

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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