BAH-00284459 IP5-00176806
Mrs RAJSHREE JAIN
23-10-1982 43 Y 9 M 0 D (F)
Dr. PRANATHI REDDY A

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SURGERY DETAILS

Date : 23/7/26

Patient Name: Mrs. Rajshree Jain Date of Birth: 23/10/1982 Age: 43 yrs

Gender: Female Ward : B/C UHID No.: 284459

Date of Surgery: 23/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : EUA & Copper T Removal ↓ Sedation

Time in : 9:30am Time Out : 10 am

		NAME	AMOUNT
1.	Surgeon	: Dr. Pranathi Reddy	
2.	Anaesthetist	: Dr. Subramanyam	
3.	Assistant Surgeon	: —	
4.	OT Technician	: —	
5.	Circulating Nurse	: SV. Veera	
6.	Assistant Nurse	: SV. Sreelatha	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9717918

Order by: SV. Veera

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

Signature and Date :

(P.T.O)

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

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 : IP5-00176806 **Admit Date** : 23-Jul-2026 **Admit Time** : 09:37 AM **UHID** : BAH-00284459

Patient Details :

Patient Name	: Mrs RAJSHREE JAIN	**Age**	: 43 Y 9 M 0 D
Guardian	: MR. SIDDHARTH JAIN	**DOB**	: 23-10-1982
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: 8-2-674/6-10, FLAT NO A301, A401, FORTUNE ENCLAVE Himayat Sagar Hyderabad Telangana INDIA 500034	**Phone No**	: 9949993001
		E-mail	: na123@gmail.com

Admission Details :

Bed Type : SHARED WARD **Bed No** : SW 418 **Ward Name** : 4F-BIRTHING CENTRE

Room No : SW 418 **Admission Type** : First Visit

Contact Details :

Name : MR. SIDDHARTH JAIN **Relationship** : Husband

Contact Address : 8-2-674/6-10, FLAT NO A301, A401, FORTUNE ENCLAVE Himayat Sagar Hyderabad Telangana INDIA 500034 **Phone No** : / 9949993001

Signature

Doctor Details :

Doctor Name : Dr. PRANATHI REDDY A **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

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

Payor Name : SELFPAY

Venkataramana

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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

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
23/2	Art Placement	1	9717884	
23/2	PAC		9767890	

ANY OTHER INFORMATION

....

....

....

....

....

....

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 : 23/7/26 Time of Admission : 9AM

Allergies: NKDA ☑ Not know any drug allergies

PRESENTING COMPLAINTS :

- P2L2 (prev 2VSLS) came for Cu-T removal

22/7/26
- uterus - Retroverted, Bulky (90x75x45mm)
  ET-8mm
- IUCD noted in lower uterine segment
- B/L ovaries - Ⓝ

MENSTRUAL HISTORY	
Year of Marriage :	2010
Previous Periods :	Regular
LMP :	30/6/26
Contraception :	- IUCD insitu

OBSTETRIC HISTORY	
Parity :	P2L2
Mode of Delivery :	VSLS
Last Child Birth :	LCB - 2015

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
k/c/o protein C def not on any medication	2 - VSLS Ⓘ 2015

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FAMILY HISTORY:	MEDICATION HISTORY:
Father - ATN Mother - Hypothyroid	No medical medication

INITIAL ASSESSMENT :

Date 23/7/26 Ht. ____ Wt. 63 kg BMI ____ B.P 110/70 mmHg Pallor absent CVR absent Respiratory System (N) Thyroid [illegible]	Breasts (N) Abdominal Examination soft, nontender	Local/Speculum Examination Bimanual Pelvic Examination

PROVISIONAL DIAGNOSIS : [illegible] ca-T [illegible] protein C deficiency for CuT removal

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
B positive	- NBM - IV fluids @ 150 ml/hr - Serum [illegible] - Prepare parts - PAC - Shift to OT on call

Name of the Doctor : Dr Sameere

Signature of Doctor

Date & Time : 23/7/26 @ 9:20 pm

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7/20		
11 Am	Pt comfortable	Adv
		- NBM for 1-2hrs
	O/E a/c-fair	- vitals every
	PR- 84bpm	15min for 2hrs
	BP 105/72mmHg	f/b 2ndhrly
	SpO2- 98%/RA	- w/f active
	P/A soft, nontender	bleeding PV
		- Inform Dr
	- can be discharged.	Dr Sameera

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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OPERATION THEATER NOTES

Patient's Name : Raja Shree Jain Age : 43yr Gender : ☐ Male ☑ Female

UHID No.: BAH-00284459 Weight : .... Height : ....

Surgeon : Dr. Pranathi Reddy	Asst. Surgeon : Dr Deepika.

Anesthetist : Dr Subramanyam	OT Nurse:	OT Technician:

Pre-Operative Diagnosis: P2L2 (prev 2LSCS) c̄ h/o protein c deficiency c̄ copper-T insitu for

Surgical Procedure : copper-T removal. in-Trenvel

Indications for Surgery :

Date : 23/7/24	Start Time :	End Time :

Pre Operative Preparations:

- NBM for 6hrs
- pre-op medication

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes:
↓ sedation
- Patient put in lithotomy position
- parts painted & draped
- Anterior and posterior vaginal wall retracted with sim's speculum
- Anterior lip of cervix held c̄ sponge holder
- copper-T removed
- Patient withstood the procedure well

Amount of Blood Loss: —	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

- NBM. for 2hrs
- Vitals every 15min for 1hr f/b 2nd hrly
- Encourage coughing
- Tab. Myfral spas BD

Name of the Surgeon: Dr Sameera

Signature of the Surgeon: Rw

Date & Time: 23/7/25 @ 10:30am

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Copper-T removal

Post-Surgical Diagnosis: P2L2 Cper 2 years for cu-T removal

Post-Operative Monitoring Parameters /Frequency:

vitals every 15min for 1hr

Wound Care:

–

Drain /Special Lines/Catheters:

IV line @

Special Patient Positioning and Requirements:

Nutritional Instructions:

NBM for 12hrs

....n to Start Mobilization:

After 2hrs

Special Referrals:

–

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

☑ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Date: 23/10/24 Time: 11 AM

Note: Plan of care will be readjusted if necessary.

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MEDICATION RECONCILIATION FORM

Drug Allergies: NKDA ☐ Not known any Drug Allergies

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

Shifting From: NA Shifted to: NA

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr Rajshree

Date & Time : 23/10/16 @ 9:30 AM

Nurse Name & Signature: .....

Date & Time : .....

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I,

Patient's / Learner Language : Hindi, English ..... 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		
23/8/24	9:30 Am	1,2,4	Diagnosis, Treatment & care plan. Informed consent	PT, S	1	O	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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Diagnosis: [illegible] c Cu-T insitu c H/o [illegible] for Cu-T removal

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
23/7/[illegible] @ 9:30Am	☑ Medical ☐ Nursing ☐ Others:	☑ Initial ☐ Modified ☐ Per-Op ☐ Post Op	[illegible] Cu-T insitu	for safe procedure	Cu-T removal	[signature]	☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ 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:

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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 : Tab. MEFTAL SPAS				Date / Time
Dose	Route	Frequency	Start Date	
250mg/tab	PO	TID	23/7.	
Doctor's Signature		Valid Period	Pharm.	
Additional Instructions:				

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

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

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

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REGULAR PRESCRIPTIONS

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

DRUG : TAB MENAL SR

Dose	Route	Frequency	Start Date

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

DRUG :	Date➤ / Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		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

Signature .....
VERIFIED BY / Name .....

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I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
23/10/24		RINGER LACTATE 500ml	IV	110ml/hr	S	Not given			

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

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 23/7/26

Baseline Information:

Admission From: ☐ ER ☐ OPD ☑ Admission Desk ☐ Others, specify .....

Primary Language: ☐ Telugu ☑ English ☐ Hindi ☐ Others, specify .....

Do you require an interpreter? ☐ Yes ☑ No if Yes specify .....

Source of Information: ☐ Patient ☐ Family ☐ Others, specify .....

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes, identify .....

Chief Complaints: .....

Copper-T

.....

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr Deepthi

Time Notified: 9:20 am

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

Past Medical History	Past Surgical History	Previous Hospital Admission
-	-	-

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

Regular

Onset of Menarche: .....

Menstrual Cycle: ☑ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☐ No ☐ Yes

Cervical Cerclage: ☐ No ☐ Yes

Ectopic Pregnancy: ☐ No ☐ Yes

Myomectomy: ☐ No ☐ Yes

Others: _____

NA

Gynecological History:

Contraceptives: ☐ No ☐ Yes

Vaginal Discharge: ☐ No ☐ Yes

Post-Coital Bleeding: ☐ No ☐ Yes

Infertility: ☐ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

NA

Obstetric History: G ..... P ..... L ..... A .....

Previous LSCS: .....

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

Family History: ☑ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 98.6 HR: 80 RR: 20

BP: 110/70 Weight: ..... 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 20 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☐ No Score 23 (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 ..... Husband .....

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: ..... my .....

Orientation not given Reason: ..... NA .....

Nurse Signature: .....

Nurse Name: ..... Cany .....

Date & Time: ..... 23/Nov 12h .....

BAH-00284459 IP5-00176806
Mrs RAJSHREE JAIN
23-10-1982 43 Y 9 M 0 D (F)
Dr. PRANATHI REDDY A

23/7/26

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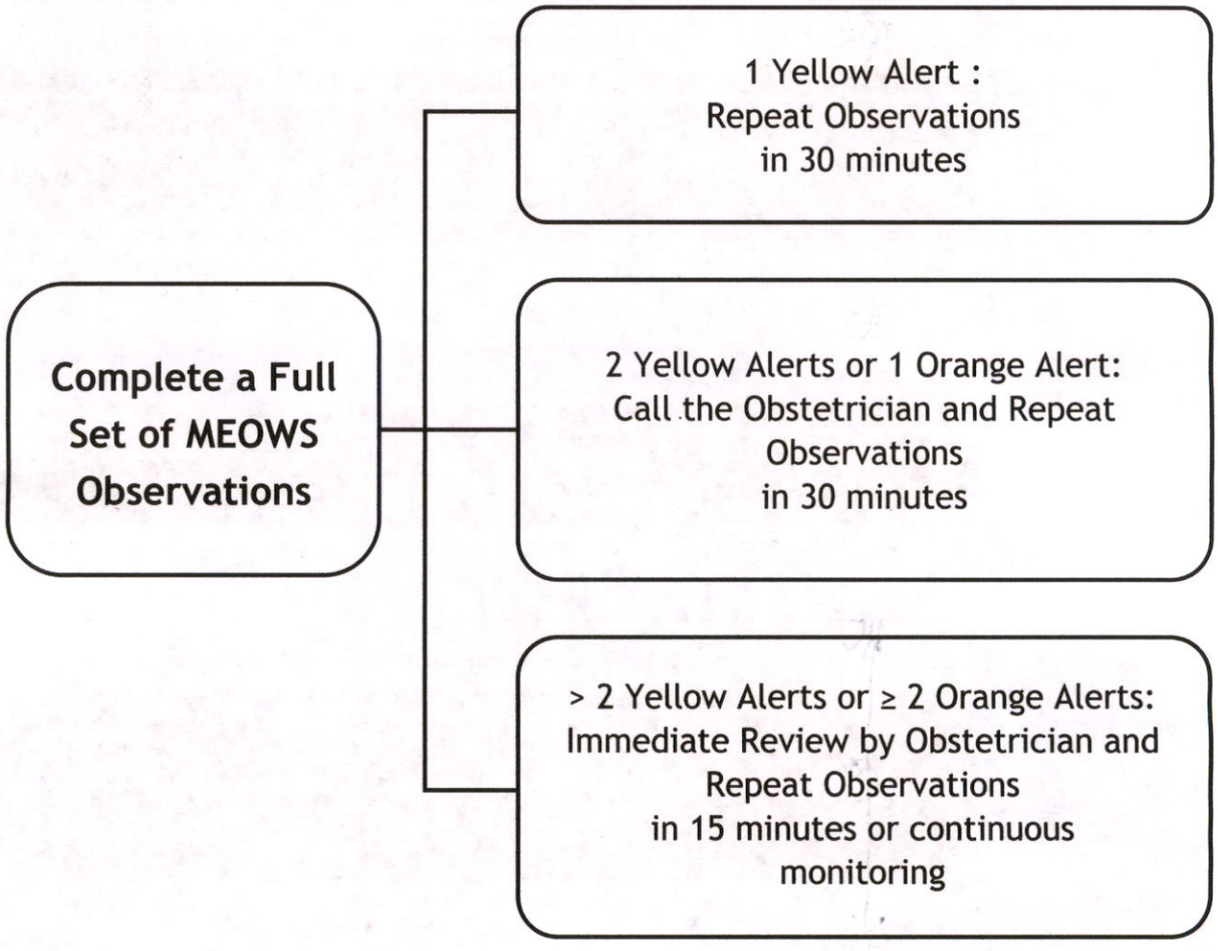
Early Warning Observation Score Chart - Obstetrics

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

		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				15																					
	0 - 10																									
Saturations	94 - 100 %				99																					
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36			97.8																						
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80			80																						
	70																									
	60																									
	50																									
	40																									
↑ Systolic Blood Pressue	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110				110																					
	100																									
	90																									
	80																									
	70																									
	60																									
	50				80																					
↓ Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70			72																						
	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																					
TOTAL ORANGE SCORES					0																					
Nurse Initial					SM																					

Obstetrics and Gynaecology Early Warning Signs



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

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23-10-1982 43 Y 9 M 0 D (F)
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FLUID CHART

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Sheet No. : 1 23/1/22

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am		H20				Nil				0	
	11:00 am										0	
	12:00 pm						1				0	Preeti
	01:00 pm										-	
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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CHECKLIST FOR THROMBOPHLEBITIS

237

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									
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		Suf									

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 : .....

Signature of Ward In Charge :

Signature : Suf Name : Veena

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PAIN ASSESSMENT FORM

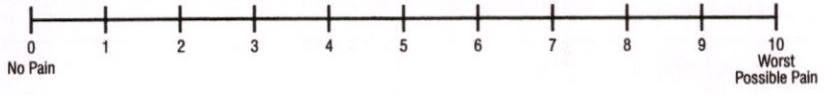
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
23/7	10Am	0/10	No Pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	N-A	[signature]
23/7	12pm	0/10	No pain	☐ 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		
				☐ 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

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BRADEN 'Q' SCALE

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					Date : 23/7			
					Time : 8AM 2PM			
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			
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
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			
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			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
				TOTAL SCORE	28			
				Evaluator's Name	SH			

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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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	23/7		
		Score	8 pm 2 pm		
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	20		
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:			20		
		Signature			

Fall Risk Grading		
Risk Level	**Morse Fall Score (MFS)**	**Action**
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

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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NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 23/7/26

Assessment: patient Complent fear and Anxiety

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
8AM	Assess the patient General condition	8:5 AM	Assessed the pt General Condition	patient is Stable
10AM	moniter vital chart	10,15 AM	provied monite vitals	
11AM	provide I/O chart	11.5 AM	provied I/O chart.	
12pm	provide comftable pogision	12:5 pm	provied comftable pogision	
2pm	provide pt safety	2:10 pm	provied pt Safety	

Re-Assessment: Re-Assessment is done

Special Notes:

Nurse Signature: Sf Nurse Name: Sruthi Date & Time: 23/7/26 @ 2pm

Patient Sticker

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: .....

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Mrs. Rajshree Jain. Age: 43 yr. Sex: female. UHID.No : BAH-00284459.

Date: 22/07/26 Time: 8.56 am Proposed Operation: copper-T Removal ↓ sedation

Diagnosis: copper-T insertion.

B.P / CRT: 104/76 H.R: 78/m Weight: ..... ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

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

Allergies: NKDA.

Medical History: CVS : nil significant.

RESP : Diabetes : (-).

CNS :

Renal :

Hepatic / GE : Physical Activity: METS 7y.

Others :

Past Anaesthetic History: NO ICSCS & SABS.

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: 2F Mentohyoid Distance: (W) Neck: (W) Teeth: Intact

Lungs : BLNK (+), clear

Heart: S1S2 (+)

CNS: HMF (+)

Pregnant: ☐ Yes ☑ No ☐ NA Venous Access Site : accessible Spine Exam for regional : (W)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis : last intake-yesterday night
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours — water - 6 pm today
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions: ~ Consent to be taken

Signature: Name: DR. M. VAISHNAVI

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

BAH-00284459 IP5-00176806
Mrs RAJSHREE JAIN
23-10-1982 43 Y 9 M 0 D (F)
Dr. PRANATHI REDDY A

ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R.: 86 | B.P / CRT: 100/76 | SpO₂: 100% | R.R.: 16 | Last Feed: 9 PM

Pre-OP Diagnosis: Copper T in situ | Operation: Removal of copper T | Date: 23/7/26

Surgeon: Dr Pranathi | Anaesthesiologist: Subrahmanyam | Technician: Ramesh

TIME	9¹⁵	(30)	
N_2O /AIR /O_2 LPM			
HALO /SO /SEVO			
Drugs:			
Midazolam 1.5 mg			
Propofol 100 mg			
FIO_2 / SaO_2 50% O_2	100	100	
$ETCO_2$	36	35	
ECG			
Temperature			
Urine Output			
Fluids / Blood			

Antibiotic

Suppository

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values: ABG / GRBS / Others

☑ Equipment Checked and Functional
☑ BP
☐ Cuff Site: R UL
☐ Art Site:
☑ EKG Lead 3
☐ Temp Site
☑ FIO_2 Monitor
☑ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Lithotomy
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 9.15
OP Start:
OP End:
Leave OR: 9.30 AM

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☐ IV:
☐ IV:
☐ IV:

Induction
☑ IV ☐ Inhal
☐ Pre O_2 ☐ 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 ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA

Name of the Doctor: M. Subrahmanyam
Signature of the Doctor: [signature]

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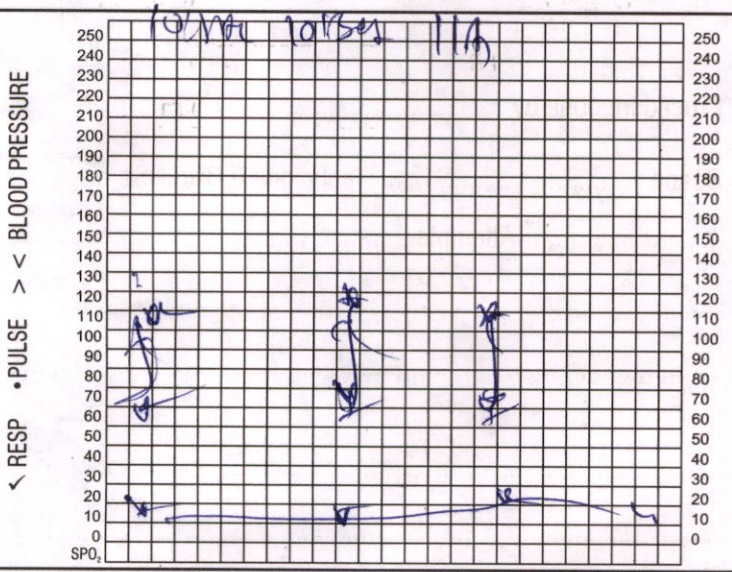
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sr Veena Time Received : 10.45 Time Discharged : .....



IV Cannula Site : Rt
☐ O_2 Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☐ No Drug: .....
NG Tube : ☐ Yes ☐ No
Drain: ☐ Yes ☐ No
Urinary Catheter: ☐ Yes ☐ No
Chest Tube: ☐ Yes ☐ No
Nil Oral ☐ Yes ☐ No

IV Fluids: .....
Oral Feeds: .....

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY	2	1	2	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION		2	2	2		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION		2	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS		2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		2	2	2		
		TOTAL		9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
23/07/26	10.2	0	NIL	Veena

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

Anaesthesiologist Name : DR. M. VINEETHA
Anaesthesiologist Signature: M
Date & Time: 23/07/26 @ 11am

PACU Nurse Name : Veena
PACU Nurse Signature: V
Date & Time: 23/7/26 @ 11am

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

Transferred to Unit by (PACU): Ward
Date & Time: 23/7/26 @ 11.45 am

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr Pra[illegible]
Asst. Surgeon : Dr Deepa
Anaesthetist : Dr Subramony
Scrub Nurse : Sr Laxmi

Mrs RAJSHREE [illegible] (F)
23-10-1982 43 Y 9 M 0 D
Dr. PRANATHI REDDY A

Age : ..... Gender : F
Name : .....
Date : ..... In-time : 9.10am Out-time : 10.50am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 9.35

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

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : [signature]
Name : Dr M Subramanyam

Before Skin Incision ➤➤

TIME OUT Time: 9.40am

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

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

Anticipated Critical Events

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

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

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

Signature : [signature]
Name : [illegible]

Before Patient Leaves Operating Room

SIGN OUT Time: 10.50am

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

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

Signature : [signature]
Name : .....

SURGICAL SAFETY CHECKLIST

Surgeon : .....
Asst. Surgeon : .....
Anaesthetist : .....
Scrub Nurse : .....

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

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Before Induction of Anaesthesia ➤➤

SIGN IN Time:.....

Patient Has Confirmed

- Identity ☐Yes ☐No
- Site ☐Yes ☐No
- Procedure ☐Yes ☐No
- Consent ☐Yes ☐No

Site Marked ☐Yes ☐No ☐NA

Anaesthesia Safety Check Completed ☐Yes ☐No

Pulse Oximeter on Patient & Functioning ☐Yes ☐No

Does Patient have a:

- Known Allergy? ☐Yes ☐No

Difficult Airway / Aspiration Risk?

- Yes, & Equipment / Assistance Available ☐Yes ☐No

Risk of > 500ml Blood Loss (7ml/kg In Children)?

- Yes, and Adequate Intravenous Access and Fluids Planned ☐Yes ☐No ☐NA
- Blood Units Reserved ☐Yes ☐No ☐NA

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

Signature :.....

Name :.....

Before Skin Incision ➤➤

TIME OUT Time:.....

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

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm

- Correct Patient (Check ID Band) ☐Yes ☐No
- Correct Site ☐Yes ☐No
- Correct Procedure ☐Yes ☐No

Anticipated Critical Events

Surgeon Reviews:

- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☐Yes ☐No ☐NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? ☐Yes ☐No ☐NA

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☐Yes ☐No ☐NA

Is Essential Imaging Displayed? ☐Yes ☐No ☐NA

Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐Yes ☐No

Signature :.....

Name :.....

Before Patient Leaves Operating Room

SIGN OUT Time:.....

Nurse Verbally Confirms with the Team:

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

To Surgeon, Anaesthetist and Nurse:

- What are the key concerns for recovery and management of this patient? ☐Yes ☐No

Signature :.....

Name :.....

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Mrs RAJSHREE JAIN
23-10-1982 43 Y 9 M 0 D (F)
Dr. PRANATHI REDDY A

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CONSENT FOR SPECIAL PROCEDURES

Patient Name : Rajashree jain Gender: ☐ Male ☐ Female

UHID No : BAH-00284459 Department : OBG Date : 23/7/2026

I Rajashree Jain S / D / W / O Siddharth Jain

Here by give consent for procedure of : Copper T Removal Under Sedation

For my patient, Named : Rajashree jain

The doctors have clearly explained to me that the procedure has following possible complications:

Infection, Bleeding

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

No alternatives

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr Pranathi Reddy

Patient Attendant

Signature :

Name : Siddharth Jain

Relationship with Patient: Husband

Date & Time : 23/7/26 @ 9.10 Am

Witness :

Signature :

Name : Sr. Veena

Date & Time : 23/7/26 @ 9:10 am

Doctor (who is taking the consent) :

Signature :

Name : Dr Rupika

Date & Time : 23/7/2026 9 AM

Patient:
Signature:
Name: RAJSHREE JAIN
Date & Time: 23/7/26, 9:10AM

ప్రత్యేక విధానాలకు సమ్మతి

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రోగి పేరు ..... లింగం ☐ పురుషుడు ☐ స్త్రీ

యు.హెచ్.ఐ.డి ..... విభాగం ..... తేదీ .....

నేను ..... S/D/W/O .....

ప్రత్యేక విధానాలకు సమ్మతి ఇవ్వడం ద్వారా .....

నా రోగికి, పేరు : .....

ఈ ప్రక్రియ కోసం ప్రత్యామ్నాయాలు, నష్టాలు మరియు ప్రయోజనాలు గురించి డాక్టర్ నాకు తెలిసిన భాషలో వివరించా

.....

.....

.....

నాకు తెలిసిన భాషలో పైన పేర్కొన్న విషయాన్ని నేను అర్థం చేసుకున్నాను మరియు ప్రక్రియకు సమ్మతిని తెలియజేస్తున్నాను.

ప్రక్రియ చేస్తున్న వైద్యుని పేరు : .....

సహాయకుడు(అటెండెంట్)

సంతకము .....

పేరు .....

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

సంతకము .....

పేరు .....

సాక్షి

సంతకము .....

పేరు .....

తేదీ మరియు సమయము .....

BAH-00284459 IP5-00176806
Mrs RAJSHREE JAIN
23-10-1982 43 Y 9 M 0 D (F)
Dr. PRANATHI REDDY A

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Rajashree Jain Gender: ☐ Male ☐ Female Age : 43yrs

UHID No : BAH-DO284459 Date : 23/1/2026

Instruction:

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

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

Copper T Removal under Sedation

upon Rajashree Jain (Name of the Patient)

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

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

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

Infection, Bleeding

My signature on this form indicates that

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

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

Consentee :

Signature :

Name : Rajshree Jain

Date & Time : 23/1/26 9 am

Patient Attendant :

Signature :

Name : Siddharth Jain

Relationship with Patient: Husband

Date & Time : 23/1/26 am

Witness :

Signature :

Name : Veer

Date & Time : 23/1/26 am

Doctor (who is taking the consent) :

Signature :

Name : Dr Rupika

Date & Time : 23/1/2026, 9:10AM

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

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Mrs RAJSHREE JAIN
23-10-1982 43 Y 9 M 0 D (F)
Dr. PRANATHI REDDY A

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CONSENT FOR ANAESTHESIA

Authorization By: ☑ Patient ☐ Patient Attendant

Operative Procedure: CERCLAGE U SEDATION.

Anaesthesiologist: Dr. Subramanyam. Surgeon: Dr. Pranathi Reddy

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others Desaturation, Post op O2 support.

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
  ☐ Regional Anaesthesia ☐ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- 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: .....
Name: Rajshree Jain
Relationship with patient: Self
Date & Time: 23/7/26 9:10am

Witness:
Signature: .....
Name: Veena
Date & Time: 23/7/26 9:10 am

Doctor (who is taking consent):
Signature: ..... Name: DR M. VINEETHA Date 22/7/26 Time: 9:10 AM

Patient Sticker

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అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స: .....

అనస్థీషియా వైద్యుడు: ..... శస్త్రచికిత్స నిపుణుడు: .....

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్రావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రీజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్కోటిక్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్స్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి: .....

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
  ☐ రీజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జీ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెనస్ యాక్సెస్, ఆర్టీరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రీజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్పష్టమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....

BAH-00284459 IP5-00176806
Mrs RAJSHREE JAIN
23-10-1982 43 Y 9 M 0 D (F)
Dr. PRANATHI REDDY A

Patien

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CONSENT FOR PROCEDURAL SEDATION

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 sedation planned for the procedure
  Copper T Removal & sedation
- I have been made aware of the possible complications from the procedure of sedation as follows:
- Changes in heart rate, blood pressure, need for oxygen supplementation, allergic reactions, upper airway obstruction, laryngospasm, conversion to general anaesthesia
- I have been made aware that the sedation is being advised to relieve pain and anxiety during the procedure. It will help me remain calm, comfortable, and cooperative, allowing the procedure to be performed smoothly and safely.
- I have been clearly explained about the benefits, risk, and alternative of the sedation which is General Anaesthesia.
- I authorize Dr. Subramanyam. and his / her team to perform the procedural sedation 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: .....

Name: Rajshree Jain

Relationship with patient: Self

Date & Time: 23/7/26 9:08 am

Witness:

Signature: .....

Name: SIDDHARTH JAIN

Date & Time: 23/7/26 9:00 AM

Doctor (who is taking consent):

Signature: ..... Name: DR. M. VIJAYALAKSHMI Date 23/07/26 Time: 9 AM

Patient Sticker

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ప్రొసీజరల్ సెడేషన్‌కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, క్రింది విషయాలను అంగీకరిస్తున్నాను:

నాకు తెలిసిన భాషలో, వైద్యులు ఈ క్రింది ప్రొసీజర్‌కు ఇచ్చే సెడేషన్ గురించి పూర్తి వివరాలు నాకు తెలిపారు:

_____

- సెడేషన్ వల్ల సంభవించగల సాధ్యమైన క్రింది సమస్యలు/ప్రమాదాలు గురించి నాకు తెలిపారు:
  గుండె వేగం మారడం, రక్తపోటు మారడం, ఆక్సిజన్ అవసరం, అలర్జీ ప్రతిచర్యలు, ఎగువ శ్వాసనాళ అడ్డంకి, లారింజోస్పాసమ్, జనరల్ అనస్థీషియాగా మారాల్సిన అవకాశం.
- ప్రొసీజర్ సమయంలో నొప్పి, భయం, ఆందోళన తగ్గించేందుకు సెడేషన్ ఇవ్వడం అవసరం అని నాకు వివరించారు. ఇది ప్రొసీజర్ సజావుగా, సురక్షితంగా జరగడానికి సహాయపడుతుంది.
- సెడేషన్కు సంబంధించిన ప్రయోజనాలు, ప్రమాదాలు, ప్రత్యామ్నాయం (జనరల్ అనస్థీషియా) గురించి నాకు స్పష్టంగా వివరించారు.
- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ ప్రొసీజర్ సెడేషన్ చేయడానికి నేను అనుమతిస్తున్నాను.
- పై సమాచారాన్ని నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ఉన్న ప్రశ్నలన్నీ, నాకు అర్థమయ్యే భాషలో సమాధానమిచ్చారు. ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం: .....

పేరు: .....

రోగితో సంబంధం: .....

తేదీ & సమయం: .....

సాక్షి:

సంతకం: .....

పేరు: .....

తేదీ & సమయం: .....

డాక్టర్ :

సంతకం: ..... పేరు: ..... తేదీ & సమయం: .....