

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175953

Admit Date : 04-Jul-2026

Admit Time : 06:55 AM **UHID** : BAH-00656424

Patient Details :
Patient Name : Mrs Y NIRMALA DEVI

Age : 66 Y 4 M 22 D

Guardian : Mr VENKATESWARLU

DOB : 12-02-1960

Gender : Female

Religion :

Occupation :

Martial Status : Married

Address (H) : #FLAT NO 307 BLOCK 6 DAIMOND ESTATES
KPHB Jntu Kukat pally Hyderabad Telangana
INDIA 500085

Phone No : 9121400777/

E-mail : nomailid@gmail.com

Admission Details :
Bed Type : DAY CARE

Bed No : RC 406

Ward Name : 4F-GYN RECOVERY

Room No : RC 406

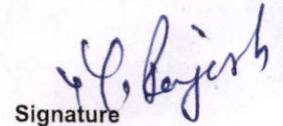
Admission Type : First Visit

Contact Details :
Name : Mr VENKATESWARLU

Relationship : Husband

Contact Address : #FLAT NO 307 BLOCK 6 DAIMOND ESTATES
KPHB Jntu Kukat pally Hyderabad Telangana
INDIA 500085

Phone No : 9121400777


Signature

Doctor Details :
Doctor Name : Dr. RAO BAHADUR BADUGU

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :
Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____

Date of Admission : _____ Time : _____

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

BAH-00656424 IP5-00175953
Mrs Y NIRMALA DEVI
12-02-1960 66 Y 4 M 22 D (F)
Dr. RAO BAHADUR BADUGU



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/7/20	9.30A	GYN	OT	Neey
4/7	11.30A	OT	GYN	Swamyar
4/7	3.30p.m.	GYN	307-A	Neey

Cross Consultation Visit

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

[illegible]

Investigations

Signature

9 Am GRSS 143 mg/dl

Key

3pm 4RBS 120 mg/dl

ka

[illegible]

Date _____

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

 $4 \overline{) 74}$

Coordinate notation

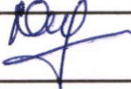
11.20 AM

3pm

9687336

key

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
1	PAC	op baseline		
4/7	20 pleunt	}	9657337	
4/7	Cablewreath			

ANY OTHER INFORMATION

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.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 4/7/20

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: 4th month pregnancy Doctor Notified on Admission: ☒ Yes ☐ No

Name of the Doctor: Dr. Sravati

Time Notified: 8 AM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>HTN</u> <u>DM</u> <u>verruco</u>	<u>B/L knee replacement</u> <u>right-hand surgery</u>	<u>MVI</u>

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

Obstetric History: G P L A

Previous LSCS:

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

Family History: ☒ No Abnormalities Detected

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

☐ Liver disease ☐ Other

Vital Signs / Measurements: Temp: 98.6°F HR: 88 bpm RR: 20 bpm
BP: 131/74 Weight: 68 kg Height: 147 cm BMI:

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



PHYSICAL ASSESSMENT

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

Fall Assessment: ☒ Yes ☐ No Score 25 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☒ Yes ☐ No Score 18 (complete the Braden Q Sheet)

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

SOCIAL SCREENING:

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

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

Social History: Lives With Family

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☒ Yes ☐ No Waste Disposal Explained: ☒ Yes ☐ No
Infusion Pump : ☒ Yes ☐ No Hand Hygiene Explained: ☒ Yes ☐ No ☐ Others

Above information given to patient

Name of Person Orientation was given to: Mrs. Nirmala

Orientation not given Reason:

Nurse Signature: [Signature]

Nurse Name: Neyy

Date & Time: 9/3/20 at 8 AM



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 9/7/2016 Time of Admission :

Allergies: None ☒ Not know any drug allergies

PRESENTING COMPLAINTS :

PIL / reached menopause in 1984
w/o pelvic organ prolapse. → had Vaginal
hysterectomy in 1984.

Cl → Man per vagina ∴ 2 yrs.
a/w: Incomplete voiding, NO Burning micturition.
normal - Bowel habit.

16/5/26 :- USG abdomen: mild hepatomegaly & fatty
Changes. UT → Post OP status, B/L adnexa - normal.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : <u>ML - 1973, 12 cm.</u>	Parity : <u>PIL</u>
Previous Periods : <u>1</u>	Mode of Delivery : <u>LCB - 1978, NVD</u>
LMP : <u>1</u>	Last Child Birth : <u>♂, 1 Aug 1984</u>
Contraception : <u>1</u>	<u>LCB - 1987.</u>

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
chr. HTN ∴ 8 yrs H2/DN ∴ 3 yrs Vertigo ∴ 3 yrs	Vaginal hysterectomy in 1984. B/L - knee replacement - 2010. 1985 → Rt hand Surgery R/H to w/o

FAMILY HISTORY:

NIL.

MEDICATION HISTORY:

T. Glycomet 500mg BD
 T. Gemerik 1440mg OD
 T. Telma 100mg OD
 T. Flavoxab 1440mg OD

INITIAL ASSESSMENT:

Date <u>4/7/2026</u>	Breasts	Local/Speculum Examination
Ht. _____ Wt. _____	<u>atrophied</u>	
BMI _____		
B.P. <u>131/81</u>		
Pallor <u>absent</u>		Bimanual Pelvic Examination
CVR <u>S1 S2 (+)</u>	Abdominal Examination	
Respiratory System <u>BA (+)</u>	<u>safe</u>	
Thyroid <u>(+)</u>		
PR: 90		

keliko: HTN, DM, Vertigo

PROVISIONAL DIAGNOSIS: P.I.L.I. E post hysterectomy ⁹ Vault prolapse for cystocele repair & perineal repair

INVESTIGATIONS ORDERED

PLAN OF MANAGEMENT

O + Vc
 29/6/26 Hb: 11.0
 Plt: 2.92
 WBC: 6.28
 29/6/26 PT: 14, INR: 1.0
 Posan - 30-35
 epite - 12-15
 TSH: 4.02
 Creat: 0.6

- admission
- NBM
- Monitor vitals - 4th
- prepare path
- Pte
- Consent - cystocele repair & perineal repair
- Drug as charted
- Shift to OT once

Name of the Doctor: Dr. SavantSignature of Doctor: [Signature]Date & Time: 4/7/2026, 8:30 AM

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



OPERATION THEATER NOTES

Patient's Name : Mrs Y. NIRMALA DEVI Age : 66y Gender : ☐ Male ☒ Female

UHID No.: BAH-00656424 Weight : 68kg Height :

Surgeon : DR. RAO BAHADUR Asst. Surgeon :

Anesthetist : DR. BRUNDA OT Nurse : Sr. parvathi OT Technician : Renesh.

Pre-Operative Diagnosis: cystocele

Surgical Procedure : cystocele repair with vault
suspension with perineal repair

Indications for Surgery : cystocele with lax perineum

Date : 4/7/26 Start Time : 9:50 Am. End Time : 11:20 Am.

Pre Operative Preparations:

Post Operative Diagnosis:

Peri-Operative Complications:

Operation Notes: pt in lithotomy position

bladder drained with metal catheter

lower end bladder freed

vaginal entry held with vatschyn

incision given on anterior ^{vaginal} wall.

bladder separated with vaginal wall

& pushed up.

Access vaginal tract excised.

Anterior ~~cysto~~ colporrhaphy done

Vault suspension with vaginal No 1, sutured

to perineal forscum

Both levator ani muscle approximated
posterior perineally close
Vaginal pedicle, close with roller
gauge.

No bleeding seen

pt with stand procedure well

Amount of Blood Loss: 100cc

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

- Ado
- NBM x shows
 - IV fluids - I & RL
I & NS.
 - 2mg Torxim 1pr 12hr
 - 2mg Metrogyl 500mg BD (12hrly)
 - Analgesia according to anaesthetist
 - GR BCL study - inform physician
and according to protocol
 - Bio chart
 - Ref son.

Name of the Surgeon:

Dr RAHATUJJE RAO

Signature of the Surgeon:

4/7/26

Date & Time:



①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/21 11:40 AM	<u>POD - Cystocoele repair</u> Gut air afebrile PR - 80/min BP - 120/80 mmHg SpO₂ - 98% @ RA <u>U/b - wound.</u> <u>vaginal pack (1)</u> P/A - rft.	<u>adv -</u> ① XEBM4 - 6h ② vitals 2nd h ③ Drugs as charted ④ n/p adv needs Inform. <u>Dr. Anubh</u> noted by neymin
4/7/26 2 PM	<u>POD - Cystocoele repair</u> Gut air afebrile PR - 84/min BP - 110/70 mmHg SpO₂ - 98% @ RA <u>U/b - wound.</u> <u>vaginal pack (1)</u> P/A - rft. B&O. GRes - 120 P/A - NAB.	<u>adv -</u> ① Foley's till further orders ② Blaliquids - SPM ③ Soft diet - 8pm ④ vitals 5th h ⑤ Drugs as charted ⑥ Foley w/ pack & bed ⑦ shift to room. <u>Dr. Anubh</u> noted by neymin

Date & Time	Progress Notes	Doctor's Order
4/7/2026 7:00pm	POD-0 / cystocoele repair C/L - fair BP - 120/74 mmHg PR - 78 BPM. SpO ₂ - 98% RA P/A - soft	Adv ① liquid diet ② soft diet 8 pm ③ Drugs as checked ④ monitor vitals + thins ⑤ w/f active bleeding ⑥ Inform SAs
VO - time (now) Clear		
Vaginal pack ④		
D/C - Cefotaxime.		
	<u>Dr. Dugg</u>	noted by Lickin 020953
4/7/2026 9:00pm	POD-1 / cystocoele repair C/L - fair BP - 120/69 mmHg PR - 79 BPM SpO ₂ - 98% RA P/A - soft.	Adv ① liquid soft diet ② Ambulation ③ Hydration ④ monitor vitals + thins ⑤ Drugs as checked ⑥ Inform SAs
VO - adequate		
Remove vaginal pack		
GRBS - 244 ng/dL		
	<u>Dr. Dugg</u>	

Date & Time	Progress Notes	Doctor's Order
	cl/w Dr. Behadur	
	→ plan discharge with foley → T. cefixime 200mg po QID x 5 days → T. pan 400mg po QID x 5 days → T. paracetamol 1gm po/TID → Review after 1 week. 13 or 14th July. → continue previous medication	
	once in 3 days -RS/PPBS and Review after 1 week with physician (Dr. Niveditha)	
	<u>Plan discharge</u>	Dr. Danya.

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

MEDICATION RECONCILIATION FORM

Drug Allergies: None

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From:

Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. GLYCOMETSR	500mg	P/O	BD	3/7	☐ C ☒ DC
2	T. Telma - ltycho chloride	40mg + 12.5mg	P/O	O.D	3/7	☐ C ☒ DC
3	T. vertin	16mg	P/O	O.D	3/7	☐ C ☒ DC
4	T. Gemersita	4tbl	P/O	O.D	3/7	☐ C ☒ DC
5	T. FLAVOXATE	4tbl	P/O	O.D	3/7	☐ C ☒ DC
6	T. cinnarazne	1tbl	P/O	O.D	3/7	☐ C ☒ DC
7						☐ C ☐ DC
						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Sankar

Date & Time : 4/7/2016, 8 AM

Nurse Name & Signature: Keerthi

Date & Time : 4/7/2016 at 8 AM

BAH-00656424 IP5-00175953
Mrs Y NIRMALA DEVI
12-02-1960 66 Y 4 M 22 D (F)
Dr. RAO BAHADUR BADUGU



Blood group O+K


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


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	29/6/24				
Time					
Hb	11.0				
PCV					
RBC					
WBC	6.38				
N/L					
Platelets	292				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.6				
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					



DRUG CHART

Date of Admission: 4/2/2020 Drug Allergies: None ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name

Weight. 68 kg Ward.

DRUG : <u>Ty. CEFOTAXIME</u>				Date/Time	<u>4/7/26</u>
Dose	Route	Frequency	Start Date		
<u>4gm</u>	<u>IV</u>	<u>BD</u>	<u>4/7</u>	<u>9AM</u>	<u>day 1</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>Dr. Sraute</u>					
Additional Instructions:				<u>2PM</u>	
Daily Doctor's Endorsement by a Sign					

DRUG : <u>TAB. PARACETAMOL</u>				Date/Time	<u>4/7/26</u>
Dose	Route	Frequency	Start Date		
<u>1GM</u>	<u>PO</u>	<u>TID</u>	<u>4/7/26</u>	<u>8AM</u>	<u>X</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>Dr. BRUNDA</u>					
Additional Instructions:				<u>10PM</u>	
Daily Doctor's Endorsement by a Sign					

DRUG : <u>TAB. DICOLOFENAC</u>				Date/Time	<u>4/7/26</u>
Dose	Route	Frequency	Start Date		
<u>50MG</u>	<u>PO</u>	<u>BD</u>	<u>4/7/26</u>	<u>11AM</u>	<u>OT</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>Dr. BRUNDA</u>					
Additional Instructions:				<u>11PM</u>	
Daily Doctor's Endorsement by a Sign					

DRUG : <u>TAB. TRAMADOL</u>				Date/Time	<u>4/7/26</u>
Dose	Route	Frequency	Start Date		
<u>100MG</u>	<u>PO</u>	<u>TID</u>	<u>4/7/26</u>	<u>11AM</u>	<u>X</u>
Name & Signature of the Doctor Starting the Drugs:					
<u>Dr. BRUNDA</u>					
Additional Instructions:				<u>5PM</u>	
Daily Doctor's Endorsement by a Sign					

Weight Ward

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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

[illegible]

I.V. FLUIDS CHART

Weight. 681cy Ward.

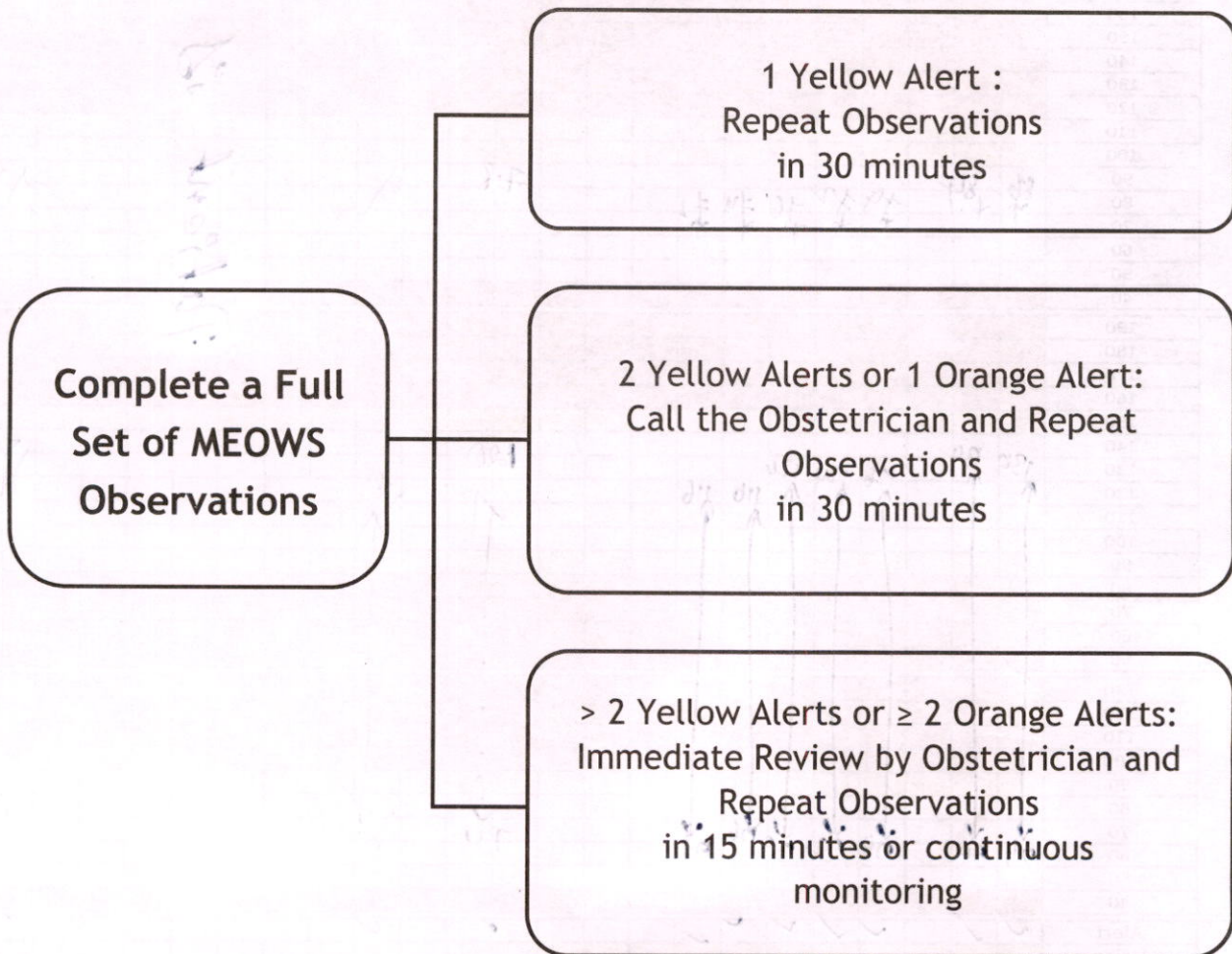
[illegible]



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

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

FLUID CHART

Sheet No. : (1)

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
		↓	Mouth	I.V	N.G							
	08:00 am	RL	N	100ml							0	ly
	09:00 am		P	100ml			N			150ml	0	
	10:00 am			100ml							0	
	11:00 am	↑	O	100ml							0	ly
	12:00 pm			100ml							0	
	01:00 pm			100ml							0	
Total Intake :						Total Output : U: 150ml - 0						
	02:00 pm	↓	N	100ml							0	ly
	03:00 pm	RL	P	100ml						300ml	0	
	04:00 pm		O	100ml			NP				0	
	05:00 pm	↑		100ml							0	ly
	06:00 pm		H2O	100ml							0	
	07:00 pm			100ml						80ml	0	
Total Intake :						Total Output : U: 380ml m: 0						
	08:00 pm			100ml							0	ly
	09:00 pm		H2O	100ml							0	
	10:00 pm			100ml							0	
	11:00 pm	RL		100ml			NP				0	ly
	12:00 am	↑	H2O	100ml						600ml	0	
	01:00 am			100ml							0	
Total Intake :						Total Output : U: 600ml m: 0						
	02:00 am										0	ly
	03:00 am		H2O								0	
	04:00 am						NP				0	
	05:00 am										0	ly
	06:00 am		H2O								0	
	07:00 am									1000ml	0	
Total Intake :						Total Output : U: 1000ml m: 0						

Total 24 hrs. Intake

1800ml

Total 24 hrs. Output

2130ml

Patient Sticker

FLUID CHART

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

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

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

BAH-00656424
Mrs Y NIRMALA DEVI IPS-00175953
12-02-1960 66 Y 4 M 22 D
Dr. RAO BAHADUR BADUGU (F)

NURSING CARE RECORD

Rainbow
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BirthRight
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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: Fear & Anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
7:00 AM	1 plan for vitals	7:05 AM	1 monitor vitals checked done	Patient is comfortable - vitals stable
7:10 AM	1 plan for skin preparation	7:15 AM	1 skin preparation done	
7:20 AM	1 plan for IV cannulation	7:25 AM	1 IV cannulation done	
7:30 AM	1 plan for IV fluid	7:35 AM	1 IV fluid RL on flow	
7:40 AM	1 plan for GRS checked	7:45 AM	1 GRS checked done	
8:00 AM	1 to Administer Medication as per order.	8:30 AM	1 Administer medication as per order.	
9:00 AM	1 plan shift to OT	9:05 AM	1 shift to OT	

Re-Assessment:

Special Notes:

1 NPO * IV fluid RL on flow

Nurse Signature: *[Signature]*

Nurse Name: Meghna

Date & Time: 4/7/26

BAH-00656424 IP5-00175953
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12-02-1960 66 Y 4 M 22 D (F)
Dr. RAO BAHADUR BADUGU



NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7/26.

Assessment: Acute 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
11:30A	→ to Assess the Patient condition.	11:45A	→ Assessed the patient condition.	→ patient is comfortable
11:50A	→ to monitor vital signs.	12:00P	→ Monitor vitals checked done	
12:05P	→ to Monitor 20 client	12:10P	→ Monitor 20 client	→ vitals stable
12:30P	→ to Administer Medications as per as order.	1Pm	→ Administer Medications as per as order.	
3:10P	→ NPO	3:50P	→ NPO	
6Pm	→ to provide physical support	6:30P	→ to provide physical support given.	
8:10P	→ Plan Shift to 9am	8:10P	→ Shift to 9am.	

Re-Assessment: Re-assessment done

Special Notes: * NPO till 5pm * advised to eat on flow
* 4RSS 8M hourly.

Nurse Signature: Reey Nurse Name: Reey

Date & Time: 4/7/26.

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/17/26

Assessment: Patient is having Pain & discomfort

Goals

☒ Maintain Airway and Oxygenation
☒ Maintain Personal Hygiene
☐ Identify Potential Complications

☒ Relieve Pain & Discomfort
☒ Prevent Infection
☐ Any Others. Specify

☒ Maintain Fluid Balance
☐ Meet Elimination Needs

☒ Improve Activity Tolerance
☒ Ensure Safety

☐ Maintain Good Nutritional Status
☐ Early Ambulation Reduce Anxiety

☐ Maintain Skin Integrity
☒ Patient & Family Education

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the patient General Condition	8:30pm	Assessed the patient General Condition	Also patient is stable
10pm	Administer medication as per chart	10:50pm	Administered medication as per chart	
12am	Maintain fluid Balance	12:30am	Maintained fluid Balance	
3am	Monitor vital signs	3:30am	Maintained vital signs & document in the	
7am	Ensure Safety	7:50am	Ensured safety	

Re-Assessment:

Re-Assessment done every 3rd hourly.

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Rima @

Date & Time: 5/7/26 @ 8am

Patient Sticker

NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. RAO BAHADUR Department: Case Date of Admission: 4/7/26

SITUATION	Diagnosis: <u>Ag to cel repairs</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:				
	Area	Shift Time	<u>4 PM</u> <u>3:30 PM</u>	<u>4 PM</u> <u>3:30 PM</u>	<u>4 PM</u> <u>3:30 PM</u>		
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>4 PM</u> <u>PM</u>	<u>4 PM</u> <u>PM</u>	<u>4 PM</u> <u>PM</u>		
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.6 F</u>	<u>97.6 F</u>	<u>98.9 F</u>		
		Res:	<u>20 w</u>	<u>21 blm</u>	<u>24 blm</u>		
		SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>100%</u>		
		Pulse:	<u>86 w</u>	<u>85 blm</u>	<u>79 blm</u>		
		BP:	<u>124/76</u>	<u>120/80</u>	<u>117/72</u>		
		Fall Risk Score:	<u>25</u>	<u>35</u>	<u>35</u>		
Pain Score:	<u>2/10</u>	<u>2/10</u>	<u>0/10</u>				
Recommendations	Safety Needs:	<u>Side</u> <u>down</u>	<u>side</u> <u>down</u>	<u>side</u> <u>down</u>			
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>-</u>	<u>NA</u>	<u>NA</u>			
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u>-</u>	<u>No</u>	<u>NA</u>			
Post Operative Procedure Special Orders:		<u>NPO</u> <u>+115 PM</u>	<u>NA</u>	<u>NA</u>			
Handed Over By Name :		<u>Key</u>	<u>Uicker</u>	<u>Key</u>			
Signature :		<u>Key</u>	<u>Uicker</u>	<u>Key</u>			
Date:		<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>			
Time:		<u>3:30 PM</u>	<u>4 PM</u>	<u>8 AM</u>			
Taken Over By Name :		<u>Key</u>	<u>Uicker</u>	<u>Key</u>			
Signature :		<u>Key</u>	<u>Uicker</u>	<u>Key</u>			
Date:		<u>4/7/26</u>	<u>4/7/26</u>	<u>4/7/26</u>			
Time:		<u>8:30 PM</u>	<u>8 PM</u>	<u>8 PM</u>			

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy: ☐ Yes ☐ No Tubes/Drains/Catheter: ☐ Yes ☐ No Vital Signs:	☐ Yes ☐ No ☐ Yes ☐ No Temp: Res: SpO ₂ : Pulse: BP: Fall Risk Score: Pain Score:	☐ Yes ☐ No ☐ Yes ☐ No 	☐ Yes ☐ No ☐ Yes ☐ No 	☐ Yes ☐ No ☐ Yes ☐ No 	☐ Yes ☐ No ☐ Yes ☐ No 	☐ Yes ☐ No ☐ Yes ☐ No
Recommendations	Safety Needs: Physiotherapy Others Specify: Special Diet:	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ 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:						

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	4/7/26 8pm	11/7/26 8am	Fall Risk Grading		
		Score			Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25					
	No	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15			
	No	0					
Ambulatory Aid	Furniture	30			Low Risk	0 - 24	Standard Fall Precaution
	Crutches, Cane(S), Walker	15					
	None /Bed Rest /Nurse Assist	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0			
GAIT / Transferring	Impaired	20					
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0	0	0			
Mental Status	Forgets limitations	15			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0			
Total Morse Fall Scale Score:			35	35			
		Signature	Key	Ramul			

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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DISCHARGE PLANNING FORM

Nationality:INDIAN.....

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

1. Anticipated Date of Discharge:As per doctor advised.....

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

Discharge Status:

☐ Self Care

☒ Family Home Care

☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☐ Yes ☒ No

☐ Bathing ☐ Yes ☒ No

☐ Eating ☐ Yes ☒ No

☐ Walking ☒ Yes ☐ No

☐ Dressing ☒ Yes ☐ No

☐ Toileting ☒ Yes ☐ No

no need
for stone
yes need
stone

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☒ Patient

☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☒ Patient

☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s:personal hygiene, Diet.....

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

☒ Patient

☒ Family Member

☐ Others:

Nurse Signature:Ney.....

Nurse Name:Ney.....

Date and Time:4/7/26 at 11AM.....

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/3/26	9 AM	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	-	Leayni
4/4/26	11 pm	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	-	Rimpy
5/4/26	6 am	0/10	-	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	-	Rimpy
				☐ 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:

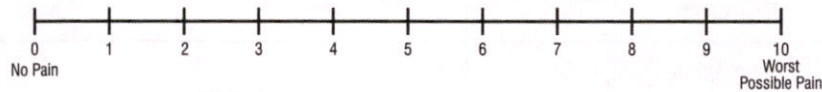
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years



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BRADEN 'Q' SCALE

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					Date : 4/3/2019		
					Time : 9A	SA	
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	
FRICION-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 of 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	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23							
					TOTAL SCORE	28	28
					Evaluator's Name	AD	Rm

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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CHECKLIST FOR THROMBOPHLEBITIS

4/7/26

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

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

Signature of Shift In Charge :

Signature : [Signature] Name : [Name]

Signature of Ward In Charge :

Signature : [Signature] Name : [Name]

PATIENT / FAMILY EDUCATION RECORD

Pa

Pat

Patient / Learner Literacy : ☒ Read ☒ Write ☒ Speak

Willingness to Learn : ☒ Yes ☐ No Healthcare Literacy : ☐ Yes ☐ No

Identified Education Needs :

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barries	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
4/1/16	9am	1/15	Dr R. care plan, patient info	PT	1	0	1	1	NT	Q
4/7	9A	2/15	Patient taught regarding	PT	1	0	1	1	-	ND
			English about India Conting							
4/7/16	3:00 pm	9	reassure liquid diet	PT	1	0	1	1	-	Saine

Part - III : CODES

Who was taught :		PT : Patient	F : Father	M : Mother	S : Spouse	Sn : Son	D : Daughter	C : Caregiver	O : Other (Specify).....															
Learning Barriers :		<table border="0"> <tr> <td>1. No Learning Barries</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process / Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural / Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barries</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Difference</td> <td>12. Impaired Vision / or Hearing</td> <td></td> </tr> </table>								1. No Learning Barries	4. Language Barrier	7. Impaired Thought Process / Cognitive limitations	10. Financial Difficulties	13. Cultural / Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)	3. Emotional Barries	6. Desire / Motivate to Learn	9. Cultural Difference	12. Impaired Vision / or Hearing	
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3. Emotional Barries	6. Desire / Motivate to Learn	9. Cultural Difference	12. Impaired Vision / or Hearing																					
Teaching Tools Used :		A : Audio	D : Demonstration	V : Video	O : Oral	P : Printed																		
Mechanism/s to overcome barrier/s :		<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify.....</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify.....	2. Obtain translator	4. Teach Family / others	6. Respect Cultural / Religion Preference								
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Understanding :		<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
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BAH-00656424
Mrs Y NIRMALA DEVI
12-02-1960 66 Y 4 M 22 D
Dr. RAO BAHADUR BADUGU (F)

MULTI-DISCIPLINARY PLAN OF CARE FORM

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Diagnosis:

Post hysterectomy & vault prolapse & HTR/DN1 Vaginal for cystocele

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
4/2/26 8:30a	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	P111 Vault Problems	Safe Painful	Cystocele repair + Perineal repair	But	☐ Nursing ☐ Others:
4/7/26 8:30a	☐ Medical ☒ Nursing ☐ Others:	☐ Initial ☒ Modified ☒ Per-Op ☐ Post Op	NPO Dyspareunia	to mention 2nd hydronephrosis	2nd void re on flow	do	☒ Medical ☐ Others:
4/7/26 3:50 pm	☐ Medical ☐ Nursing ☒ Others: dietician	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	POD-0 cystocele Repair	patient is on NPO	liquid diet	Saima	☐ 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:

Patient Sticker

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD



Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		

Part - III: CODES

Who was taught:	PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)
Learning Barriers:								
1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice				
2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)				
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing					
Teaching Tools Used:								
A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed				
Mechanism/s to overcome barrier/s:								
1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify					
2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference						
Understanding:								
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review						

Patient

BAH-00656424 IP5-00175953
Mrs Y NIRMALA DEVI
12-02-1960 66 Y 4 M 22 D (F)
Dr. RAO BAHADUR BADUGU

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Your Right to a Safe Delivery

POST-SURGICAL CARE PLAN FORM

Procedure Done: Cystocele repair.

Post-Surgical Diagnosis: P.O.-0

Post-Operative Monitoring Parameters /Frequency:

Temp, PR, BP, SpO2 Every 2 hrs

Wound Care:

⊖

Drain /Special Lines/Catheters:

⑩ catheters
Vaginal pack ⊖

Special Patient Positioning and Requirements:

Supine 14-16°

Nutritional Instructions:

NBM 4-6 hrs

When to Start Mobilization:

after Foley removed

Special Referrals:

⊖

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

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

Dr. BAHADUR RAO
4/7/26

Date: Time:

Note: Plan of care will be readjusted if necessary.

SURGICAL SAFETY CHECKLIST

Surgeon : DR. RAD. HADUR
 Asst. Surgeon :
 Anaesthetist : DR. BRUNDA
 Scrub Nurse : SV. prabatu

Patient Name :
 UHID No. :
 Date :

BAH-00656424 IP5-C 53
 Mrs Y NIRMALA DEVI
 12-02-1960 66 Y 4 M 22 D (F)
 Dr. RAO BAHADUR BADUGU


66y Gender : F
Cystolei Rami
perineal Repair
 Time : 11:30 AM


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 Your Right to a Safe Delivery

Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN		Time: <u>9:22 AM</u>
Patient Has Confirmed		
Identity	☒ Yes ☐ No	
Site	☒ Yes ☐ No	
Procedure	☒ Yes ☐ No	
Consent	☒ Yes ☐ No	
Site Marked	☐ Yes ☐ No ☒ NA	
Anaesthesia Safety Check Completed	☒ Yes ☐ No	
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No	
Does Patient have a:		
Known Allergy?	☐ Yes ☒ No	
Difficult Airway / Aspiration Risk?		
Yes, & Equipment / Assistance Available	☐ Yes ☒ No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?		
Yes, and Adequate Intravenous Access and Fluids Planned	☒ Yes ☐ No ☐ NA	
Blood Units Reserved	☒ Yes ☐ No ☐ NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes?		
	☒ Yes ☐ No ☐ NA	
Signature : <u>B de</u>		
Name : <u>Dr. Brunda</u>		

TIME OUT		Time: <u>9:59 AM</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No		
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm		
Correct Patient (Check ID Band)	☒ Yes ☐ No	
Correct Site	☒ Yes ☐ No	
Correct Procedure	☒ Yes ☐ No	
Anticipated Critical Events		
Surgeon Reviews:		
What are the Critical or Unexpected Steps, Operative Duration, <u>bleeding</u> , Anticipated Blood Loss? <u>50ml</u> ☒ Yes ☐ No ☐ NA		
Anaesthesia Team Reviews:		
Are There Any Patient-specific Concerns? <u>bleeding</u> ☒ Yes ☐ No ☐ NA		
Nursing Team Reviews:		
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA		
Is Essential Imaging Displayed? ☒ Yes ☐ No ☐ NA		
Power Supply, Earthing, Power Backup and functioning of equipment checked. ☒ Yes ☐ No		
Signature : <u>Neigmen</u>		
Name : <u>Neigmen</u>		

SIGN OUT		Time: <u>11:25 AM</u>
Nurse Verbally Confirms with the Team:		
The Name of the Procedure Recorded	☒ Yes ☐ No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA	
The Specimen is Labelled (including patient name)	☒ Yes ☐ No ☐ NA	
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA	
To Surgeon, Anaesthetist and Nurse:		
What are the key concerns for recovery and management of this patient? ☒ Yes ☐ No		
Signature : <u>DR BAHADUR RAO</u>		
Name : <u>4/7/25</u>		

BAH-00656424 IP5-00175953
Mrs Y NIRMALA DEVI
12-02-1960 66 Y 4 M 22 D (F)
Dr. RAO BAHADUR BADUGU

Patient St



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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 4/7/26

Department : PED- OT Duration of Procedure : 1 hour

Name of Surgeon : DR. RAO BAHADUR Date of Admission : 4/7/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☒ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☒ Yes ☐ No Name of the Antibiotic : 24: Cefotaxim 1gm	reyni
2.	Hair Removal ☒ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☒ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleansing surgical area with antiseptic agent)? ☒ Yes ☐ No	reyni
3.	Patient's body temperature immediately post operation (Recovery Room) 37.2°C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	reyni
4.	Name of doctor or staff administering the antibiotic : Dr. Reyni Date & Time of antibiotic administration : 4/7/26 at 8:30A Date & Time procedure started : 4/7/26 9:45A	reyni

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

Docu. No. : RCHBH/ FRM / CLINICAL / 038

PATIENT TRANSFER FORM

Patient Name & UHID No. BAH-00656424 IP5-00175953 Mrs Y NIRMALA DEVI 12-02-1960 66 Y 4 M 22 D (F) Dr. RAO BAHADUR BADUGU 		Date & Time of Admission 4/7/26 at 6:55AM	Date & Time of Transfer Order 4/7/26 at 3:30pm DR
		Transfer Ordered by DR SHRUTHI	Reason for Transfer Obscure
From Unit CW	To Unit 303-A	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?		Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films	Medications / Consumables / Surgicals / Hand over		
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dr. Neeymi		Name of Person Ordered Transfer DR SHRUTHI	
Patient & Clinical Records Received by : [Signature]			
Date & Time of Patient Received : 3:30pm 4/7/26			

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

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

CONSENT FOR ANAESTHESIA

 Authorization By: ☒ Patient ☒ Patient Attendant

 Operative Procedure: cystocele repair + vault repair

 Anaesthesiologist: Dr. Subramanyam Surgeon: Dr. Rao Bahadur

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

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: [Signature]
 Name: Rajesh Yalagadda
 Relationship with patient: Son
 Date & Time: 30/6/16 . 2:02 PM

Witness:

Signature: [Signature]
 Name: Bhargavi Yalagadda
 Date & Time: 30/06/26

Doctor (who is taking consent):

Signature: [Signature] Name: DR. KRISHNA RAMYA Date 30/6/16 Time: 2:08 PM

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.

రిజనల్ 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 రిస్క్:

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.
☐ రిజనల్ 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, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సింట్రిల్ వెనస్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రిజనల్ 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 స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్:

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name: Mrs. Y. NIRMALA DEVI Age: 66 Sex: F UHID No: BAH-00656424
Date: 29.6.26 Time: 4PM Proposed Operation: Cystocele + Perineal repair
Diagnosis: Vault prolapse / P14
B.P / CRT: 146/80 mmHg H.R: 68 bpm Weight: 68 kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

29/6/26

Hb A1c - 6.9

Laboratory Data:

Hgb: 11 Glucose: FBS-129 Protein: 4.5 HIV: NR X-Ray: NR
PCV: 38 Urea: 0.6 Alb: 0.3 HBS Ag: NR ECG: NR
WBC: 6.38 Creat: 0.6 Total Bill: 0.3 HCV: NR 2D Echo: NR
Plate: 14 Na: 0.1 Dir. Bill: 0.1 Blood group: O +ve Stress/Angio: NR
PT: 14 K: 2.4 LDH: NR T3: NR Other: NR
PTT: 38 Ca++: NR Alk phos: NR T4: NR
INR: 1 Mg++: NR Amylase: NR TSH: NR
Cl-: NR SGOT/SGPT: NR

A PT 38

Allergies: NKDA

Medical History: CVS: no cardiac issues Kldo HT 7-8 yrs
RESP: no breathlessness Diabetes: + 3 yrs
CNS: + Hypertension in T. VERTIN 16
Renal: +

Hepatic / GE: Physical Activity: METS > 4

Others: H/o kneepain H/o can climb a flight of stairs

Past Anaesthetic History: H/o LSCs, H/o hysterectomy, laparoscopic, GA may have back

Physical Exam: Alert, afebrile H/o B/L TKR CT in 2010, H/o elbow surgery Kyu ba

Airway: MP 1 2 3 4 Mouth Opening: > 3F Mento-hyoid Distance: > 3Fb Neck: adjuat Teeth: Intact

Lungs: BAC

Heart: 952P

CNS: NFM

Pregnant: ☐ Yes ☐ No ☒ NA

Venous Access Site: +

Spine Exam for regional: Papash

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

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

on 30/6/26, Review by DR. K. S. RA

CURRENT MEDICATIONS	DOSAGE
T. GLYCOMET SR	500 <u>OD</u> AD
T. FELMA-H	OD
T. VERTIN 16mg	OD
T. STUGERON	OD

Pre-Operative Instructions:

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

2DECO - EF-62
no RWM
Mi ID MR
chil DR
NO PAH
Cardiology opin
moderate vs

Signature: Am Name: Dr. Amreen 7 TO review & reports

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

30/6/26 DR. K. S. RA TO review 10 PM
- WITH - OHA on day 9/10
- WITH - Anti-hypertensive on day 9/10
7 TO WITH OHA on the day of sv.
RA consent pending

Fitnes gov.
By gual
phys
Follow
all Ad

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



Change in Patient Condition: ☐ Yes ☒ No		Fasting Status: <u>Adequate</u>	
Physical Status: ☒ Patient Identified ☒ Consent Present ☒ Chart Reviewed			
H.R.: <u>90bpm</u> B.P. / CRT: <u>134/82 mmHg</u> SpO₂: <u>95% on RA</u> R.R.: <u>16/min</u> Last Feed: <u>>6hrs</u>			
Pre-OP Diagnosis: <u>Vault Prolapse</u> Operation: <u>Cystocele + Perineal Repair</u> Date: <u>4/3/20</u>			
Surgeon: <u>Dr. Rao Bahadur</u> Anaesthesiologist: <u>Dr. Brunda</u> Technician: <u>Ramesh</u>			

TIME	9:30	10:30	11:30	12:30	13:30	14:30	15:30	16:30	17:30	18:30	19:30	20:30	21:30	22:30	23:30	24:30
N ₂ O / AIF / O ₂ / LPM																
HALO / SO / SEVO																
Drugs:																
Antibiotic																
Suppository																
PRAMIDOL 100mg PR																
DIKOFENAZ 100mg PR																
Blood Loss																
FiO ₂ / SaO ₂	95	98	100	100	100	100	100	100	100	100	100	100	100	100	100	100
ETCO ₂																
ECG	Lead	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR	NSR
Temperature																
Urine Output																
Fluids																
Blood																
PRIMER LAUNITE																
B.P.																
V Systolic																
A Diastolic																
X Mean																
* Heart Rate																
Tourniquet on Time																
Tourniquet off Time																
Throat Pack In																
Throat Pack Out																
LAB Values																
ABG																
CPAB																
Others																

☒ Equipment Checked and Functional ☒ BP <u>Left</u> ☐ Cuff Site: ☒ Art Site: ☒ EKG Lead <u>Lead</u> ☐ Temp Site ☐ FiO ₂ Monitor ☐ Agent Monitor ☒ Pulse Oximeter ☐ Capnograph ☐ Ventilator ☐ Nerve Stimulator Position: <u>Supine</u> ☒ Pressure Points Checked Eye Care: <u>Retinotomy</u> ☐ Oint ☐ Tape ☐ Padding ☒ Awake	Temp: ☐ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☒ Hugger's ☐ Cotton Wool ☒ Other <u>Draped sheets</u> Times: Anaes Start: <u>9:30 AM</u> OP Start: OP End: <u>11:30 AM</u> Leave OR: Anaesthesia: ☐ GA ☐ Monitored Anaesthesia Care ☒ Regional Line (Size & Location) ☐ CVP: ☐ ART: ☒ IV: <u>20G Left UL</u> ☐ 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: ☒ Spinal Specify: ☐ Epidural ☐ Caudal Others: Position: <u>Sitting</u> Site: <u>L3-L4 percut</u> Needle Size: <u>25G</u> Depth: Parasthesia ☐ Yes ☒ No Catheter at skin cm Drug Name & Conc: <u>0.5% H. Bupivac</u> Bolus: <u>15mg + 5mg</u> <u>Penthrin</u> Infusion: Block Level: <u>T6 - T6</u> Comments: Transportation to ☒ PACU ☐ ICU ☐ Other Relaxant Reversed ☐ Yes ☐ No ☒ NA Name of the Doctor: <u>Dr. Brunda</u> Signature of the Doctor: <u>B. Brunda</u>	Transcription to ☒ PACU ☐ ICU ☐ Other Relaxant Reversed ☐ Yes ☐ No ☒ NA Name of the Doctor: <u>Dr. Brunda</u> Signature of the Doctor: <u>B. Brunda</u>
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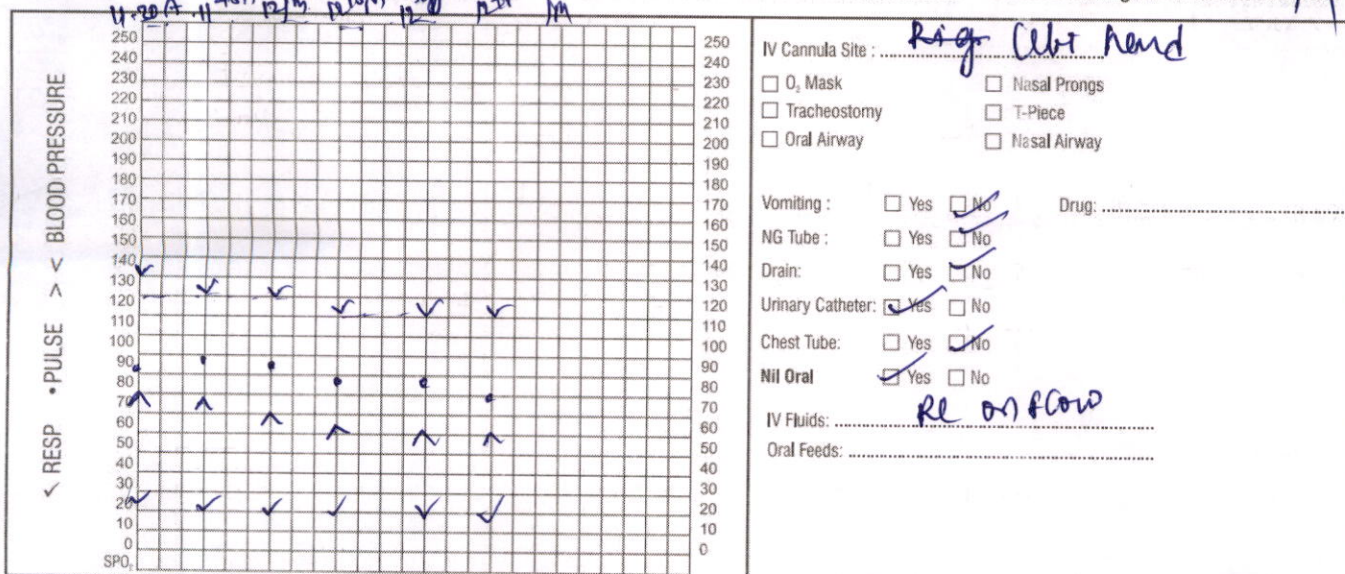


ANESTHESIA CARE UNIT RECORD

Received in PACU by: Sy. Meyneri

Time Received: 11:30 AM

Time Discharged: 3:30 PM



IV Cannula Site: Right Cebt hand

☐ O₂ 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: RL on flow

Oral Feeds:

POST ANAESTHESIA SCORE (Modified Aldrete Score)

	IN	MINUTES			OUT	SCORING INTERPRETATION
		30	60	90		
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						A Minimum Total Score of 8 is Required for Discharge
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic						Exceptions to this, are to be explained in the space below by the Discharging Physician:
BP $\pm$ 20 of Pre Anaesthetic level BP $\pm$ 20-50 of Pre Anaesthetic level BP $\pm$ 50 of Pre Anaesthetic level						
Fully awake Arousable on calling Not responding						
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic						
TOTAL						

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
4/7/26	11:30 AM	0/10	on sedation	<u>Meyneri</u>
4/7	1:30 PM	0/10	no intervention	<u>Meyneri</u>
4/7	3:30 PM	0/10	no intervention	<u>Meyneri</u>

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

Anaesthesiologist Name: Dr. SKURK

Anaesthesiologist Signature: [Signature]

Date & Time: 4/7/26 at

PACU Nurse Name: Meyneri

PACU Nurse Signature: [Signature]

Date & Time: 4/7/26 at 11:30 AM

Reassessment Frequency:

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

Transferred to Unit by (PACU): 307 - A

Date & Time: 4/7/26 at

EPIDURAL ANALGESIA RECORD

b)

[illegible]

Date and Time :

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

BAH-00656424 IP5-00175953
Mrs Y NIRMALA DEVI
12-02-1960 66 Y 4 M 22 D (F)
Dr. RAO BAHADUR BADUGU
It takes a lot to treat the little.

Right™
HOSPITALS
Safe Delivery

Patient Name : Y. NIRMALA DEVI Gender: ☐ Male ☒ Female Age : 66 ym
UHID No : BAH-00656424 Date : 4/2/2026

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)

CYSTOCELE REPAIR AND PERINEAL REPAIR

upon

(Name of the Patient) Mrs. Y. NIRMALA DEVI

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

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

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

CHANCE OF BLEEDING, BLOOD AND BLOOD PRODUCTS TRANSFUSION, INFECTION, INJURY TO ADJACENT ORGANS AND IT'S REPAIR

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. RAO BAHADUR

Consentee :

Signature : [Signature]
Name : Mrs. Y. NIRMALA DEVI
Date & Time : 4/2/2026, 7 AM

Witness :

Signature : [Signature]
Name : Nagaraj Meni
Date & Time : 4/2/26 at 8 AM

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

Patient Attendant :

Signature : [Signature]
Name : Y. Rajesh
Relationship with Patient : Son
Date & Time : 4/2/2026, 7 AM

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Dr. Sravanthi
Date & Time : 4/2/2026, 8 AM



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 4/7/26

Date of Removal:

Parameters	Date	Shift Time	<u>4/7/26</u> <u>SA-SP</u>						
Need for the Catheter	☒ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene	☒ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment	☒ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder	☒ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)	☒ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy	☒ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?	☒ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter	☒ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?	☒ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?	☒ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care	☒ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever	☐ Yes ☒ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion	☒ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse	<u>Key</u>								
Signature of the Nurse	<u>Key</u>								

BAH-00656424 IP5-00175953

Mrs Y NIRMALA DEVI

12-02-1960 66 Y 4 M 22 D (F)

Dr. RAO BAHADUR BADUGU



307A

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BY RAINBOW HOSPITALS
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NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 4/7/26

Time: 3:50pm

Origin: Indian

Height: 147cm

Weight: 68kgs

BMI: 27.6kg/m²

Food Allergies: No

Diagnosis: POD-0 / cytotec Repair

Medical History: HTN, DM, vertigo

Surgical History: Knee replacement, Rt hand surgery

☐ Vegetarian

☒ Non-Vegetarian

☐ Vegan

Diet Advised: patient is on NPO

liquid diet @ 5pm

Patient's / Attendant's

Signature: [Signature]

Name: Nirmala devi

Date & Time: 4/7/26
3:50pm

Dietician's

Signature: [Signature]

Name: SAIMA

Date & Time: 4/7/26
3:50pm

DIETARY NOTES

[illegible]

BAH-00656424 IPS-00175953
Mrs Y NIRMALA DEVI
12-02-1960 66 Y 4 M 22 D (F)
Dr. RAO BAHADUR BADUGU



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SURGERY DETAILS

80298

Date : 4/7/26

Patient Name: MRS. Y. NIRMALA DEVI Date of Birth: Age: 66y

Gender: F Ward: PEN-OT UHID No: BAH-00656424

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

Name of the Surgery: Cystocele Repair + vault Suspension. with Perineal. Repair

Time in : 9.30 AM Time Out : 11.30 AM

Cash
Svt

NAME

AMOUNT

- Surgeon : _____
- Anaesthetist : DR. BRUNDA
- Assistant Surgeon : _____
- OT Technician : DR. RAMCHH
- Circulating Nurse : SI. G. Meghni
- Assistant Nurse : SI. prabhat, swarna

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

Signature of the Surgeon: RAO BAHADUR RAO
4/7/26

Signature of Circulating Nurse: [Signature]

Order No: 9687722

Order by: [Signature]



SUBJECT: [illegible]

1/1/56

1/1/56

1/1/56

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1/1/56

DAH-00656424
Mrs. Minaladevi 664
525

Cystocel
Repair +
PERIAPAC

CONSUMABLES OF OT

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Circulating staff : Technician : Date : 4/7 Time : 9 AM

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube (7.0-7.5)	14	1	Major Pack	14	14	Inj Vit.K		
LMA 2.4	14	1	Sutures			Cord Clamp		
ECG leads : A / P / N	05	5	Vicryl 1.0.20.30	24	2	Suction Catheter		
HME filter (A / P / N)	01	1	2346 3317	14	1	Feeding Tube		
Syringes : 10 cc	10	10	2347	1	1	Vaccum Suction Set		
05 cc	10	10	Gloves 6.6.5 7.7.5	24	24	Surgical Gloves		
02 cc	10	10	6.6.5 7.7.5	24	24	Gauze Pack		
01 cc	5	1				Syringe 1ml / 2ml		
Cautery plate : A / P / N	01	1	Surgical blade 15.11.28	14	14	Surgical Blade # 20		
IV set	01	1	NG tube			Koochies (S)		
RL	01	1	Cautery pencil			NS 500ml		1
NS : 10ml / 100ml / 500ml / 1000ml	24	2	Koochies			Transo fix		1
oil & spice	01	1	Ointments			Jelly		1
Vacuum set	01	1	Suction Catheter			Loose fix		2
Fentanyl	01	1	Cap, Mask	515	1510	0.25 Narwin		1
Morphine			Gauze Pack	343	2	pop 9		1
Ketamine			Mop Pack	1	0	mimipde		1
Propofol	04	1	Steristrip			derma hauler		1
Rocuronium	01	1	Underpad	1	01			
Glycopyrolate	01	1	Draw sheet		1			
Myopyrolate	01	1	Abgel					
Ondansetron	01	1	Foleys catheter 12.14	14	1			
Pencan 25g/ Spinal Needle 22	01	1	Urobag	1	1			
Bupivacaine 0.25%	01	1	Chest Drainage Catheter					
Bupivacaine 0.25% (Heavy)	01	1	Romodrain bag					
Antibiotics			Bandage					
Supern	01	1	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol 100mg	01	1	Vaccum Suction set	1	1			
Justin : 12.5 mg / 25mg / 100mg	01	1	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		2			
3mg per 1000cm	14	1	Microshield		1			
Gauze + absorbent 61	14	24	Cotton Balls		1			
Dexa + (Tromex)	14	2	Latex Gloves					
IV coils 20/18	14	1	Ramdone Scrub	5	20			
Q nail, splint 1/3	14	1	Saral		1			

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9687352

Ordered by : [Signature]

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

ESTIMATION SLIP

Date: 16/05/2026 UNID / IP No.: BAH-00656429 Sl No. 80298
Name of Patient: Mrs. Y. Nirmala Devi Age: 66y Gender: F
Father's / Husband's Name: Mr. Venkatesh Reddy Corporate / Occupation:
Address: Phone: 9121400777 Email:
Procedure / Plan: Cystocele Repair with primary perineal Repair

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

TARIFF INFORMATION:

ROOM CATEGORY	GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE
Room Rent & Nursing Charges	1									
Doctor's Fee			16000							
L. Tax										

PARTICULARS

AMOUNT (₹)

Surgeon's / Anesthetists's Fee / O.T. Charges TSW. 40000

O.T. Consumables 9500

Instrument Charges Not Covered by TPA / Insurance company

Pharmacy, Consumables & Investigations As per actual - Not Included in Estimation

Equipment Charges	Monitor :	Oxygen :	Infusion pump / Syringe pump :
	Ventilator :	Conventional :	HFO-SLE 5000 :
	Phototherapy :	Single Surface :	Double Surface :

Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc. As per actual - Not Included in Estimation

Package

Others (High end equipment 15k to 35k per item)

Initial Minimum Deposit Appx - 1,70,000 & Final sum.

MARKS: (0750000.5000)

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

DECLARATION

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

Signature of the Client

Signature of the Client

Signature of the Financial Counselor