

ADMISSION SHEET

Registration Details :



Admission No : IP5-00175982 Admit Date : 05-Jul-2026 Admit Time : 08:09 AM UHID : FDH-00026418

Patient Details :

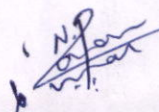
Patient Name	: Mrs RACHURI SOUMYA	Age	: 33 Y 9 M 17 D
Guardian	: Mr NADIMINTI PAVAN KUMAR	DOB	: 18-09-1992
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Married
Address (H)	: #FLAT 301 LEGEND VASUDEVA , GAGAN MAHAL STREET NO 7 Domalguda Hyderabad Telangana INDIA 500029	Phone No	: 9000830220/ 8297441169
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type : SHARED WARD Bed No : SW 414 Ward Name : 4F-BIRTHING CENTRE
Room No : SW 414 Admission Type : First Visit

Contact Details :

Name	: Mr NADIMINTI PAVAN KUMAR	Relationship	: Husband
Contact Address	: #FLAT 301 LEGEND VASUDEVA , GAGAN MAHAL STREET NO 7 Domalguda Hyderabad Telangana INDIA 500029	Phone No	: 9000830220 / 8297441169


Signature

Doctor Details :

Doctor Name	: Dr. DR.M PRATHYUSHA REDDY	Specialisation	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: Self	Phone No	:
Co-Consultant	:		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: MEDI ASSIST INSURANCE TPA PVT LTD

7

FDH-00026418 IP5-00175982
Mrs RACHURI SOUMYA
18-09-1992 33 Y 9 M 17 D (F)
Dr. DR.M PRATHYUSHA REDDY



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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
6/7/26	1:00 AM	OBG OT	ORP	Sandhya
6/7/26	6:20 AM	4th floor	3rd floor (306)	Sandhya

Cross Consultation Visit

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

[illegible]

Signature

Am

By

2

10/10/20

Turner

Sans

Tareq

[illegible]

[illegible]

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Came with leaking per vagina
since 4:30 am, alw pain.

Obstetric Formula: Primigravida

Obstetric History:

I - PP - sp. conception

resent Pregnancy Record:

Booked at 14 + 2 wks
of GA.

LMP:

6/10/2025

EDD:

6/7/26

Corrected EDD:

6/7/2026

GA:

39 + 6 wks

Menstrual History: Regular: ☒ Yes ☐ No

Obstetric Examination

Fundal Height: NTCM

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech Others

Head Fifths Palpable:

4/5

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

RISK FACTORS:

Per Speculum Examination

Draining: ☒ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☒ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☐ Long ☒ Partially effaced ☐ Effaced

Os: Closed Dilated 1 finger

Membranes: ☐ Present ☒ Absent

Liquor: ☒ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☒ Vertex ☐ Breech ☐ Others

Sutton: ☒ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☒ Adequate ☐ Doubtful

Height: 159 cm

Weight: 74.9 kg

Allergies: NKA

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: alert

Pallor: absent

Icterus: absent

Edema: absent

Temp: 98.2°F

PR: 110 bpm

BP: 112/82 mmHg

DTR: (+)

CVS: S1,2 (+)

RS: BAE (+)

Liver/Spleen:

Urine Output: adequate

DIAGNOSIS

Primigravida | 39 + 6 wks | in Early labour
Rh negative preg. (S ROM)

FDH-00026418

IP5-00175982

Mrs RACHURI SOUMYA

18-09-1992

33 Y 9 M 17 D

(F)

Dr. DR.M PRATHYUSHA REDDY



Family History: Mother - HTN Father - CAD Grand mother - DM	Surgical History: Nil
Medical History: Nil	Medication History: Nil
Plan of Care: 1. Admission 2. IV cannulation 3. NST 4. Monitor vitals 5. Drugs as charted. 6. PAC 7. Epidural S/S 8. Part preparation 9. Frenum. 10. Inform S/S 11. Send trace CBP.	Investigations: BAT - B negative Husband. A negative. Virals - NR <u>4/6/2026</u> Hb - 13.6. WBC - 13,240 PLT - 2.2L TBS - 94mg/dL PBS - 105 Ca - 9 Mg - 1.90 <u>10/6/26 (4s)</u> S1UL, 36+1wks, 2.6kg (32%). AC - 13%, EFW - 2,670 grams (32%). UA Dopplers (M) AFI - 17.6cm. PLT - Post 11 HgH TIFFA - (N) NT - 1.2mm. FTS - Low risk. NIPT - Low risk.

Doctor Name: Dr. Divya

Signature: Dr. Divya

Date & Time: 5/10/2026; 7:30am

Consultant Name: Dr. Prathyusha

Signature: Dr. Prathyusha

Date & Time:

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Mrs RACHURI SOUMYA
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Dr. DR.M PRATHYUSHA REDDY



①

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/11/25 9.30 AM	Gutai, akboulle, PR - sul muni LP - 112 170 mm. SPG - 131. @ RA P/A - ut. Mildly active FHR ①	adv ① Not 3rdly ② vitals & FHR 4th ③ w/p PR
5/11/25 1.20 PM	No complaints Gutai akboulle Vitals stable P/A - ut. mildly active FHR ①	adv - Not 3rdly - vitals & FHR 4th - w/p PR
	<u>P/A</u> - 2. long 1 cm.	Dr. Arshya L.

Patient Sticker

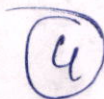
PROGRESS NOTES AND DOCTOR'S ORDER

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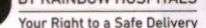


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Dr. DR.M PRATHYUSHA REDDY



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PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

IP5-00175982

18-09-1992 33 Y 9 M 17 D

(F)

Dr. DR. M. PRATHYUSHA REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

FDH-00026418 IP5-00175982
 Mrs RACHURI SOUMYA
 18-09-1992 33 Y 9 M 17 D (F)
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RESULT SHEET

Date	5/7/26					
Time	9AM					
Hb	13.7					
PCV						
RBC	5.13					
WBC	1704					
N/L						
Platelets	227					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood group → B-ve.						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

Ward

(P.T.O)



Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

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



Weight. 74kg Ward. DBS

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
5/7/26	9:30 AM	T. PGE ₁	50mg	PO	[Signature]	Kannu Sandeep
5/7/26	1:40 PM	T. PGE ₁	25mg	PO	[Signature]	Kannu Sandeep
5/7/26	4:40 PM	Inj METROGIL	500mg	IV	[Signature]	Tunna Rajames
5/7/26	7 PM	T. PGE ₁	25mg	PO	[Signature]	Tunna Rajames
5/7	11:50 PM	Inj Oxytocin	100	IM	[Signature]	Bhaath Sudha
5/7	11:50 PM	JUSTIN	100mg	PR	[Signature]	Bhaath Sudha
5/7	11:50 PM	T. PGE ₁	400mg	PR	[Signature]	Bhaath Sudha
6/7/26	1:10 AM	Sup. DICLOFENAC	100mg	PR	[Signature]	Bhaath Sudha
6/7/26	1:10 AM	Sup. TRAMADOL	100mg	PR	[Signature]	Bhaath Sudha

Signature

VERIFIED BY: Name



I.V. FLUIDS CHART

Weight. 76 kg Ward. OPD

Signature
Verified By : Name

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
5/7/2026	8am	RINGER LACTATE	IV	100ml	Dr. J	Sanjay	5/7		Sanjay
5/7/26	4pm	RINGER LACTATE	IV	150	Dr. J	Tunne Rajeshwar	5/7		Tunne Rajeshwar
5/7/26	5pm	RINGER LACTATE	IV	150	Dr. J	Tunne Rajeshwar	5/7		Tunne Rajeshwar
6/7/26	12AM	RINGER LACTATE	IV	500 ml FF	Dr. J	Sanjay Sudar	6/7		Sanjay Sudar
6/7/26	12:30 AM	RINGER LACTATE	IV	500ml FF	Dr. J	Sanjay Sudar	6/7		Sanjay Sudar
6/7/26	12:10 AM	GIFLOFUXINE	IV	300ml mcg	Dr. J	Sanjay Sudar	6/7		Sanjay Sudar
6/7	12:15 AM	PRBC	IV	50 ml/hr	Dr. J	Bhargava Sudar	6/7		Sanjay Sudar
6/7	3am	RINGER LACTATE	IV	1500 ml/hr		Sanjay Sudar	6/7		Sanjay Sudar
6/7	6am	RINGER LACTATE	IV	1500 ml/hr		Sanjay Sudar			

FDH-00026418
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IP5-00175982

DRUG CHART

Date of Admission: 5/7/2026 Drug Allergies: NKDA ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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



REGULAR PRESCRIPTIONS

Weight. 70 kg Ward. 085

DRUG : INTJ.CEFOTAXIM				Date Time	
Dose <u>1gm</u>	Route <u>IV</u>	Frequency <u>BD</u>	Start Date <u>5/1/2020</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Divya</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : T. PGE1				Date Time	
Dose <u>40</u>	Route	Frequency	Start Date		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : T. PARACETAMOL				Date Time	
Dose <u>1gm</u>	Route <u>PO</u>	Frequency <u>TID</u>	Start Date <u>5/1/20</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Arthy L.</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG : T. DICOFENAC				Date Time	
Dose <u>50mg</u>	Route <u>PO</u>	Frequency <u>TID</u>	Start Date <u>5/1/20</u>		
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Arthy L.</u>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					



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FDH-00026410

SIAT / ONCE ONLY DRUGS

Weight: 74.6 kg

Sheet No:

ABH / FRM / CLINICAL / 136



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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

**Complete a Full
Set of MEOWS
Observations**

1 Yellow Alert :
Repeat Observations
in 30 minutes

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

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

* The Modified Early Warning Score (MEOWS)

617126



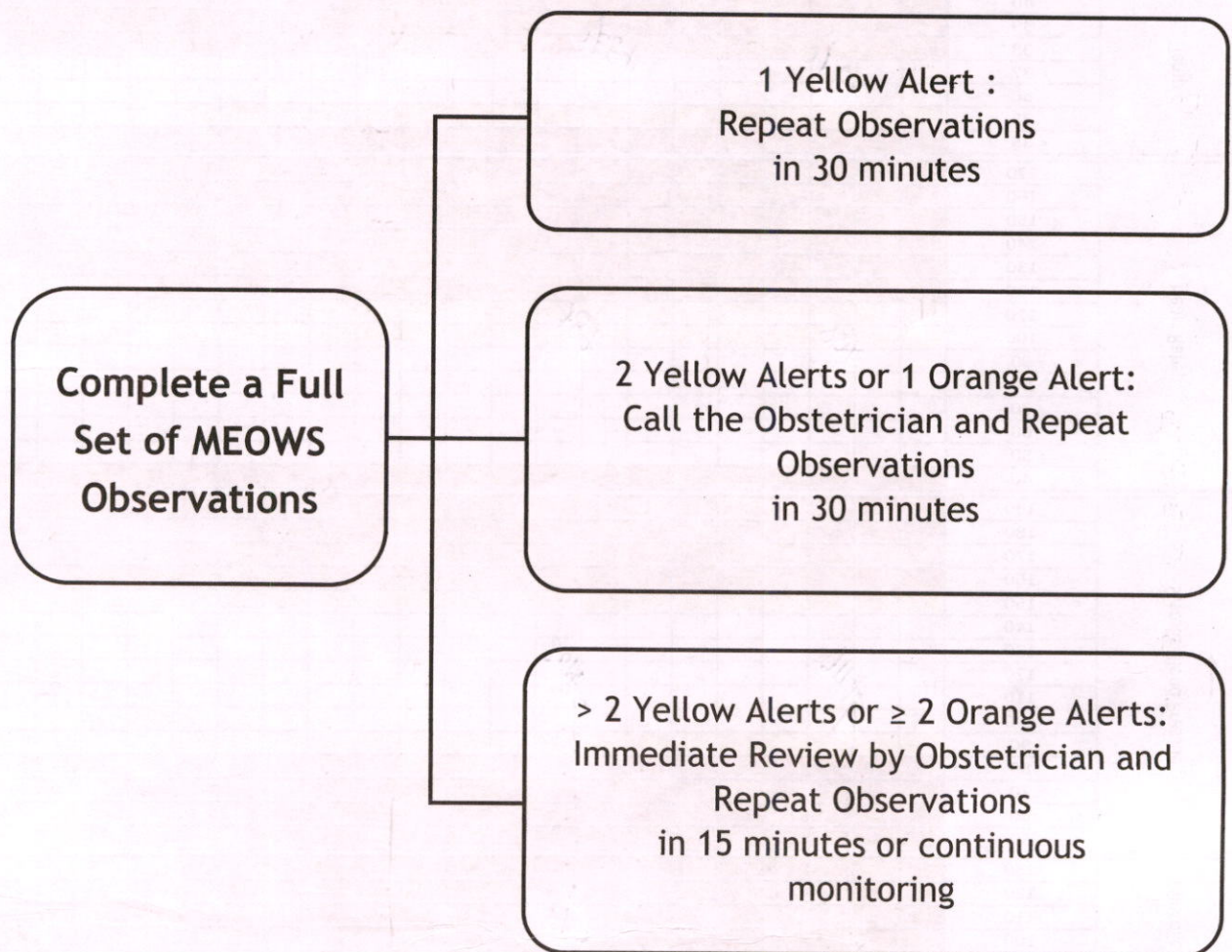
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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : ①

5/7/28

- All measurements in ml.
- 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	Orally	100ml							0	Kann
	09:00 am	R		100ml							0	
	10:00 am	RL		100ml							0	
	11:00 am	RL		100ml							0	
	12:00 pm	L	Hro								0	
	01:00 pm	RL									0	

Total Intake :

Total Output :

	02:00 pm		H2O								0	Shobha
	03:00 pm										0	
	04:00 pm		H2O								0	
	05:00 pm										0	
	06:00 pm		H2O								0	
	07:00 pm										0	Shobha

Total Intake :

Total Output : 6 - 3 1M - 0

	08:00 pm	RL		100ml							0	Sandeep
	09:00 pm	RL	H2O	100ml						100ml	0	
	10:00 pm	RL	H2O	100ml							0	
	11:00 pm	RL		100ml							0	
	12:00 am	RL	H2O	100ml							0	
	01:00 am	RL		100ml						300ml	0	

Total Intake :

Total Output : Passed

	02:00 am	RL	H2O	100ml							0	Sandeep
	03:00 am	RL		100ml							0	
	04:00 am	RL	H2O	100ml							0	
	05:00 am	RL		100ml							0	
	06:00 am	RL	H2O	100ml						100ml	0	
	07:00 am	R		100ml							0	

Total Intake :

Total Output : 100ml

Total 24 hrs. Intake	1200ml
----------------------	--------

Total 24 hrs. Output	1400ml M - 0
----------------------	--------------



FLUID CHART

Sheet No. : ②

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am										0	Sush	
	09:00 am										0	Sush	
	10:00 am										0	Sush	
	11:00 am										0	Sush	
	12:00 pm										0	Sush	
	01:00 pm										0	Sush	
Total Intake :						Total Output : M-						2	
	02:00 pm										0	Sush	
	03:00 pm										0	Sush	
	04:00 pm										0	Sush	
	05:00 pm										0	Sush	
	06:00 pm										0	Sush	
	07:00 pm										0	Sush	
Total Intake :						Total Output : M-						2	
	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							

Patient Sticker

FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site 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													

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.
3. 24 hrs. total to be entered in the kardex in RED.

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

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NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: patient - complaints about fear & 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 general condition of the patient	8:30am	* Assessed the general condition of the patient	* patient is stable
9am	* Monitor vitals	9:30am	* monitored vitals	
10am	* NST	10:30am	* NST done 3rd hourly	
11am	* IV cannulization	11:30am	* IV cannulization	
12pm	* Soft Diet	12:30pm	* Soft Diet given	
1pm	* Safety	2pm	* Ensure safety provided	

Re-Assessment: Re-assessment was done.

Special Notes: NST monitor

Nurse Signature: [Signature]

Nurse Name: kanun a

Date & Time: 5/7/26 @ 8:15 am

FDH-00026418 IP5-00175982

Mrs RACHURI SOUMYA

18-09-1992 33 Y 9 M 17 D (F)

Dr. DR.M PRATHYUSHA REDDY



NURSING CARE RECORD



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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/6/2020

Assessment: pt complain for 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
2pm	Assess pt general condition	2:10 pm	Assessed pt general condition	pt is stable
3pm	monitor vital	3:10 pm	Bp spo2 pulse checked and recorded	
4pm	Administration medication	4:10 pm	medication as per doctor order	
6pm	Ensure safety	6:10 pm	Ensure safety provided	
7pm	prevent infection	7:10 pm	To prevent infection	

Re-Assessment: re assessment done

Special Notes:

Nurse Signature: 

Nurse Name: Shobha

Date & Time: 5/6/2020 @ 8pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 6/7/20

Assessment: patient complaint about pain at lower abdomen

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	assess the pt condition	9pm	assessed pt condition	pt is stable
9pm	monitor vitals	10pm	monitored vitals	
10pm	NIET	11pm	NIET 3rd hourly	
12AM	do chart	11pm	maintained do chart	
4AM	administration of medication	1AM	administered medication	
6AM	iv fluids	5AM	continued iv fluid	
7AM	blood transfusion	8AM	done 1 PRBC	

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

Special Notes: NIET 3rd hourly (Blood Transfusion done / exploration done / ambulation)

Nurse Signature: Sangeeta (016628)

Nurse Name: Sangeeta

Date & Time: 6/7/20 e 8AM

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 6/7/26

Assessment: patient is having discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	* Assess the patient condition and vitals check	8:30 AM	* Assessed the patient condition and vitals	* now patient condition is stable
10am	* monitor the I/O chart	10:30 AM	* checked * monitored the I/O chart	
12pm	* maintain personal hygiene	12:30 PM	* maintained personal hygiene	
3pm	* check the pain assessment	3:30 PM	* checked the pain assessment	
6pm	* Administer medicine as per chart	6:30 PM	* Administered medicine as per chart	
7pm	* ensure safety	7:30 PM	* ensured safety	

Re-Assessment: Assess the condition of the patient, now it is stable

Special Notes: Nil

Nurse Signature: Sneh

Nurse Name: Sneh - 607635

Date & Time: 6/7/26 @ 8pm

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Mrs RACHURI SOUMYA
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NURSING CARE RECORD


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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:

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. prathyusha Reddy Department: Obs. Date of Admission: 5/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known			
	primi 39+6 wks for early labour (SDom)		If Yes Specify:			
BACKGROUND	Area	Shift Time	OBS 8am-2pm	OBS 2pm-8pm	OBS 8pm-12am	OBS 12am-8am
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA
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:	98.1°F	98°F	98.6°F	97.6°F
	Res:	18b/m	20b/m	18b/m	22b/m	
	SpO ₂ :	100%	99%	98%	99%	
	Pulse:	110b/m	112b/m	113b/m	116b/m	
	BP:	112/80	112/68	117/76	118/81	
	Fall Risk Score:	20	35	38	38	
	Pain Score:	0	0	0	0	
	Recommendations	Safety Needs:	Side rails	yes	yes	yes
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		NA	NA	NA	NA	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	
Handed Over By Name :		Faruna	Shobhi	Sandhya	Sudha	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	
Date:		5/7/26	5/7/26	6/7/26	6/7/26	
Time:		2:15pm	8pm	8am	8pm	
Taken Over By Name :		Shobhi	Sandhya	Sudha		
Signature :		[Signature]	[Signature]	[Signature]		
Date:		5/7/26	5/7/26	6/7/26		
Time:		8pm	8pm	8pm		

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

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CHECKLIST FOR THROMBOPHLEBITIS

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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	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				Dy. Suba			Suba Suba						

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 : Dy. Rebecca Name : Rebecca

Signature of Ward In Charge :

Signature : Dy. Veena Name : Veena

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 Dr. DR.M PRATHYUSHA REDDY

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	5/7/20	5/7/20	5/7/20	Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15		15	15	Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15	15	15	15			
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			20	35	35			
Signature			Dr. Shobha Sanyal					

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

Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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- ☐ Hourly safety check
- ☐ Assess patient after visitors, leave to ensure safety measures in place

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

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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7/26	8:15 am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	By
5/7/26	11A	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	By
5/7/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Shobha
5/7/26	4pm	0/10	Abdomen	☐ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Shobha
5/7/26	8pm	3/10	Abdomen	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	under observation	Shobha
5/7/26	9pm	4/10	Abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	epidural on flow	Sandhya
5/7/26	11pm	9/10	Abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	epidural on flow	Shobha
6/7/26	11am	1/10	Abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under analgesia	Sandhya
6/7	5AM	1/10	Abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	PRN given	Sandhya
6/7	8AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Durga

Re-assessment Frequency:

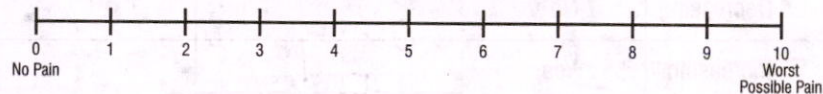
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

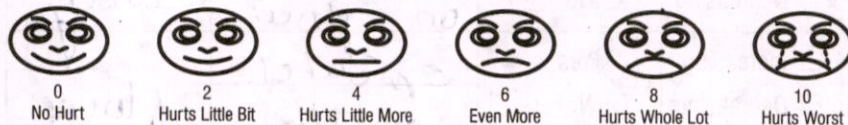
Numerical Pain Scale (Obstetric and Gynecology)



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





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/26	10Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suchu
6/7/26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suchu
6/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suchu
6/7/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suchu
				☐ 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:

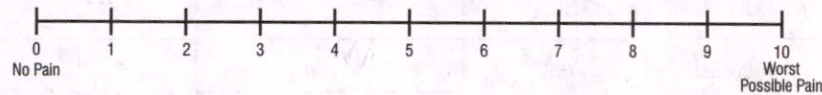
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 - Prior to pain relieving intervention.
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PAIN ASSESSMENT TOOLS

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)



Wong - Baker (Pediatrics) Above 7 Years



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

FDH-00026418 IP5-00175982
Mrs RACHURI SOUMYA
18-09-1992 33 Y 9 M 17 D (F)
Dr. DR.M PRATHYUSHA REDDY



BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	5-10-2021	5-10-2021	5-10-2021
					Time :	8 am to 2 pm	2 pm to 8 pm	8 pm to 8 am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e.tremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	2	
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	1	
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23								
Docu. No. : RCHBH /FRM / CLINICAL / 119								
					TOTAL SCORE	28	28	21
					Evaluator's Name	Dr. Shobha		

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



BRADEN 'Q' SCALE

2

					Date :			
					Time :			
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Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE			
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name			

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MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: primi / 3q twily. / Rh negative preg / SROM

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
5/7/26 7:30pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	primi / 3q+6 / Rh negative / SROM	Safe delivery	+ vaginal deliver	[Signature]	☐ Nursing ☐ Others:
5/7/26 @ 2pm	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Safety	prevent infection	Antibiotic given	[Signature]	☒ Medical ☐ Others:
6/7/26 8:30 am diebhan	☐ Medical ☐ Nursing ☒ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	PND - 0 AVD	Soft diet	soft high protein diet	[Signature]	☐ Medical ☐ Nursing ☒ Others:
6/7/26 2:45pm	☐ Medical ☐ Nursing ☒ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	PND	Post partum recovery	Deep core retraining & functional training	[Signature]	☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:



INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

**Rainbow[®]
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It takes a lot to treat the little.

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

Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
5/7/26	7:36am	443	Diagnosis, Treatment & care plan, Pain management & Informed consent	PT/S	1	0	1	1		<u>Wiley</u>
5/7/26	1pm	7	EXPLAIN about infection control	PT, S	1	0	1	1		<u>Purney</u>
6/7/26	8:30 am	9	Lactation diet	PT	1	0	1	1		<u>Nikola</u>

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							



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 5/7/20

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: for IOL Doctor Notified on Admission: ☒ Yes ☐ No
Name of the Doctor: Dr. Divya
Time Notified: 8am

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	

Gynecology Assessment: ☐ Not Applicable Menstrual History: Regular Onset of Menarche: Menstrual Cycle: ☒ Regular ☐ Irregular Last Menstrual Period: 10/10/25	Gynecology Surgical History: Caesarean Section: ☐ No ☐ Yes Cervical Cerclage: ☐ No ☐ Yes Ectopic Pregnancy: ☒ No ☐ Yes Myomectomy: ☒ No ☐ Yes Others:	Gynecological History: Contraceptives: ☒ No ☐ Yes Vaginal Discharge: ☒ No ☐ Yes Post-Coital Bleeding: ☒ No ☐ Yes Infertility: ☐ No ☐ Yes If Yes Type: ☐ Primary ☐ Secondary
---	---	--

Obstetric History: G 1 P - L - A -

Previous LSCS: -

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: 98.4 HR: 100 RR: 20
BP: 110/70 Weight: - Height: - BMI: -

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



PHYSICAL ASSESSMENT

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

Fall Assessment: ☐ Yes ☐ No Score 35 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☐ No Score 29 (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: Karuna

Orientation not given Reason:

Nurse Signature: [Signature]

Nurse Name: Karuna

Date & Time: 51.7.26 08:5am



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 5/7/26 Time of Arrival: 8:00am Time Seen by Nurse: 8:5am

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

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

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

3) **Vital Signs:** Temperature: 98.5F Pulse: 110 RR: 18 SpO₂: 100% BP: 112/82 Weight: 74.9kg

4) **Gestational Criteria:**

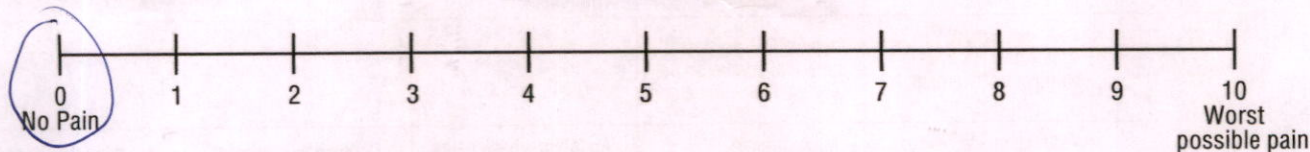
Gravida:	G 1	P	L	A
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LMP: 6/10/26 EDD: 6/7/26 Gestational Age: 39+6 WKS

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

5) **Pain Screening:**

Numerical Pain Scale (NPS)



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

6) **Past History:**

- a) Surgeries: Nil
b) Medical: Nil



7) Allergy: ☐ Yes ☒ No, If Yes :

8) Current Medications: ☐ Prenatal Vitamin ☒ None ☐ Others:

9) Prenatal Medical History:

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 8:00 am

Nurse Name : Kanura Nurse Signature: [Signature]

Date: 5/3/26 Time: 8:15 am

FDH-00026418 IP5-00175982
 Mrs RACHURI SOUMYA
 18-09-1992 33 Y 9 M 17 D (F)
 Dr. DR.M PRATHYUSHA REDDY

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OPERATION THEATER NOTES

Patient's Name : Age : Gender : ☐ Male ☐ Female

UHID No.: Weight : Height :

Surgeon :		Asst. Surgeon :	
Anesthetist :	OT Nurse:	OT Technician:	
Pre-Operative Diagnosis:			
Surgical Procedure : <i>Anterior vaginal tear + posterior tear repair post AVO.</i>			
Indications for Surgery :			
Date :	Start Time :	End Time :	
Pre Operative Preparations:			
Post Operative Diagnosis:			
Peri-Operative Complications: <i>AVD</i>			
Operation Notes:			
Findings: There is a tear in the anterior vaginal wall laterally extending downwards the towards the posterior vaginal wall laterally.			
Examination under anaesthesia done and tear sutured separately			
hemostasis secured.			

Amount of Blood Loss:

800ml

Blood Transfused (in ML)

Nil

Name and Number of Surgical Specimen sent for examination:

Nil

Peri-Operative Complications:

- Inj. Piptaz 1gm IV TID

- Inj. Metogyl 100ml IV TID

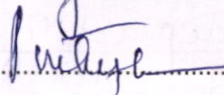
- TPR/BP $\frac{1}{2}$ hourly.

- To continue blood transfusion

Name of the Surgeon:

Dr. Pradyumn Reddy

Signature of the Surgeon:



Date & Time:

6/7/26 1:20 AM

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POST-SURGICAL CARE PLAN FORM

Procedure Done: vaginal hysterectomy

Post-Surgical Diagnosis: PODO

Post-Operative Monitoring Parameters /Frequency:

Temp PR, BP, SpO2 every 2nd hr.

Wound Care:



Drain /Special Lines/Catheters:

① Conub
Foley ①

Special Patient Positioning and Requirements:

Supine 14-16h

Nutritional Instructions:

NRM 4-6h.

When to Start Mobilization:



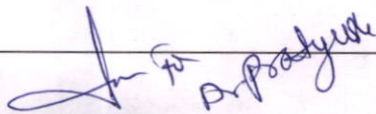
Special Referrals:



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: 6.11.26 Time: 4:40pm

Note: Plan of care will be readjusted if necessary.

PATIENT TRANSFER FORM

Patient Name & UHID No. FDH-00026418 IP5-00175982 Mrs RACHURI SOUMYA 18-09-1992 33 Y 9 M 18 D (F) Dr. DR.M PRATHYUSHA REDDY 		Date & Time of Admission <i>5/11/26 6:40am</i>	Date & Time of Transfer Order <i>6/11/26 6:40am</i>
		Transfer Ordered by <i>Dr. Sneha</i>	Reason for Transfer <i>Observation</i>
From Unit <i>4th floor</i>	To Unit <i>3rd floor (306)</i>	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File <i>35</i>	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 <i>nil</i>			
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 <i>Sneha</i>		Name of Person Ordered Transfer <i>Dr. Sneha</i>	
Patient & Clinical Records Received by : <i>Durgamane @ 6:40am 6/11/26</i>			
Date & Time of Patient Received :			

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

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

BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 6/7/26 Time: 12:40 AM

Blood Group of the Patient: B negative Blood Group on the Blood Bag: B negative

Blood Bank Issue No: BAH-26 01405 Date of Collection: 12/6/26 Date of Expiry: 25/7/26

Date & Time of Starting Transfusion: 6/7/26 12 AM Planned duration of Transfusion: 1 hour

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Sudha Nurse 2: Sandhya

Before starting transfusion vitals: Temp: 98.6 F HR: 86 bpm RR: 18 bpm BP: 100/70 SpO₂: 100

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO ₂	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
6/7	15 Min	88	98.6 F	112/70	100%	-	-	-	-
6/7	15 Min	93	98.6 F	112/70	100%	-	-	-	-
6/7	30 Min	93	98.2 F	121/80	100%	-	-	-	-
6/7	30 Min								
	30 Min								
	1 Hr								
	1 Hr								

Comments:

Name of the Incharge-Nurse: Sudha

Name of the Nurse: Sandhya (016638)

Signature of the Incharge-Nurse: Sudha

Signature of the Nurse: Sandhya

Date & Time: 6/7/26 12 AM

Date & Time: 6/7/26 12 AM

Rainbow Hospital Blood Centre, Rainbow Childrens Hospital
D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road No.2,
Banjara Hills, Hyderabad, Telangana State
Lic.No. 46/HD/TS/2018/BB/G

LEUCO REDUCED BLOOD CELLS I.P

Qty. 270 ml. Prepared from Whole human blood collected in 63 ml. of C.P.D.A.
Solution.



Rh Negative

HIV I & II/ HBsAG/ HCV - Non
reactive
VDRL - Non reactive
MP - Negative
NAT(HIV I & II/ HBsAG/ HCV)- Non
reactive

Unit No.: BAH26-01405
Blood Group: B Rh Negative
Collection Date: 13/Jun/2026
Expiry Date: 25/Jul/2026

1) Administer Without Warming. 2) Shake Gently Before Use. 3) Do Not
Add Any Medication. 4) Check Blood Group on Label & Recipient's
Group Before Administration. 5) Use Sterile Transfusion Set
With There Appr Antil

Issue Label / CrossMatching Report

Patient : MRS.RACHURI SOUMYA -
Patient's Blood Group : B Rh Negative
Hosp/Dr : Rainbow Childrens Hospital, DR prathyusha reddy
UHID No.: FDH-00026418 Wd-Bed No.:

Product : L.R-PRBC

Blood Group : B Rh Negative

Unit No.: BAH26-01405

XMatching Report: Compatible

X-matched by: PILLEM

Issue Dt : 06/Jul/2026

Colln. Dt : 13/Jun/2026

Exp. Dt : 25/Jul/2026

Issued By : PILLEM

**Rainbow Hospital Blood Centre, Rainbow Childrens
Hospital**

D.No.8-2-120/103/1,2,3,4 & 5, 1st floor, Sy.No.129/11, 403/P, Road
No.2, Banjara Hills, Hyderabad, Telangana State
Lic No. 46/HD/TS/2018/BB/G

Repeat CBP showed Hb:12
No Need of further blood transfusion.

Dr. Rejasmuni
CR

CONSENT FOR BLOOD TRANSFUSION

FDH-00026418 IP5-00175982

Mrs RACHURI SOUMYA

18-09-1992 33 Y 9 M 17 D (F)

Dr. DR.M PRATHYUSHA REDDY

Name:

Age:

Gender: Male ☐ Female ☒

UHID.No :



Date: 6/7/20

Type of Blood Product:

☐ Fresh Frozen Plasma

☒ Packed Red Blood Cells

☐ Random Donor Platelets

☐ Cryoprecipitate

☐ Single Donor Platelet

☐ Whole Blood

☐ Albumin

☐ Red Blood Cell

☐ Others

I hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Doctor (Who is talking the consent)

Signature: *Rachuri Soumya*

Signature: *Dr. Tejaswini*

Name: *Soumya*

Name: *Tejaswini*

Date & Time: 6/7/20 2:12AM

Date & Time: 6/7/20 2:12AM

Witness

Signature: *Nadiminti Pavan Kumar*

Name: *NADIMINTI PAVAN KUMAR*

Date & Time: 6/7/20 12:00

FDH-00026418 IP5-00175982

Mrs RACHURI SOUMYA

18-09-1992 33 Y 9 M 18 D (F)

Dr. DR. M PRATHYUSHA REDDY



omya.

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

FDH-00026418. CONSENT FOR LABOUR ANALGESIA

Authorization By: ☒ Patient ☐ Patient Attendant

I, the undersigned do hereby acknowledge the following:

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

☒ Epidural Analgesia ☐ Intravenous Analgesia (Remifentanyl)

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

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

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

- I understand that labour analgesia is offered to reduce labour pain and make the birthing process more comfortable, by reducing pain and stress and promoting better cooperation during childbirth.
- I have been clearly explained about the benefits, risk, and alternative of the procedures.
- I authorize Dr. TEJASVINI and his / her team to perform the above procedure(s) upon the patient / myself.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: R. Soumya

Name: R. Soumya

Relationship with patient: Self

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

Witness:

Signature: N. Pavan Kumar

Name: NADIMINTI PAVAN KUMAR

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

Doctor (who is taking consent):

Signature: Dr. Tejasvini

Name: Dr. Tejasvini

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

ప్రసవ నొప్పి నివారణ కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

వైద్యులు నాకు తెలిసిన భాషలో క్రింది విధానాల గురించి సమగ్రంగా వివరించారు:

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

- ఈ విధానాల వల్ల సంభవించగలిగే సమస్యలను కూడా నాకు వివరించారు:

ఎపిడ్యూరల్ సంబంధించినవి:

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

రెమిఫెంటాసిల్ సంబంధించినవి:

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

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

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Patient Sticker

PROCEDURE SAFETY CHECK LIST (TIMEOUT OUTSIDE OT)

Procedure Name: Epidural Analgesia Date: 5/7/2026 In-Time: _____ Out-Time: _____
 Doctor Performing Procedure: Dr. Tejasini Doctor Giving Sedation: Epidural Assisting Nurse: Tunne

SIGN IN		TIME OUT		SIGN OUT	
Time: <u>2:30pm</u>		Time: <u>2:35pm</u>		Time: <u>2:55pm</u>	
	Yes No NA		Yes No NA		Yes No NA
Patient is verified using two identifiers (Name & UHID)	☒ ☐ ☐	Correct Patient	☒ ☐ ☐	Name of the Surgical / Invasive Procedure is recorded	☒ ☐ ☐
All required documents, images, studies are available	☒ ☐ ☐	Correct Site	☒ ☐ ☐	Instrument, Sponge and Needle Count Completed	☒ ☐ ☐
NPO Status Checked from Patient / Patient Attendant	☒ ☐ ☐	Correct Procedure	☒ ☐ ☐	Specimens are labeled	☐ ☒ ☐
Consent is Signed	☒ ☐ ☐	All the team members introduced	☒ ☐ ☐	Any equipment problems are addressed	☐ ☒ ☐
Any need for blood products	☐ ☒ ☐				
If Yes Comment: _____					
Any Risk of Hemodynamic Compromise	☒ ☐ ☐				
If Yes Comment: _____					
Any drug or food allergy	☐ ☒ ☐				
If Yes Comment: _____					
Correct Site of Procedure Marked	☒ ☐ ☐				
All resources required are correct, available and functioning	☒ ☐ ☐				
Signature of the Doctor: <u>Dr. Tejasini</u>		Signature of the Nurse: <u>TM</u>		Signature of the Nurse: <u>TM</u>	
Name of the Doctor: <u>Dr. Tejasini</u>		Name of the Nurse: <u>Tunne</u>		Name of the Nurse: <u>Tunne</u>	

Any Adverse / Unexpected Events

INFORMED CONSENT FOR SPECIAL PROCEDURE

FDH-00026418 IP5-00175982
Mrs RACHURI SOUMYA
18-09-1992 33 Y 9 M 18 D (F)
Dr. DR. M. PRATHYUSHA REDDY

inbow
children's
hospital
is a lot to treat the little.

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name : Soumya

Gender: ☐ Male ☒ Female

Age : 11.50 PM

UHID No : FDH-00026418

Date : 5/1/20

Instruction:

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

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

vaginal + Cervical EXPLORATION. UNDER ANAESTHESIA.

upon Soumya
(Name of the Patient)

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

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

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

Bleeding, Infection, Injury to surrounding structures

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. Prathyusha

Consentee :

Signature : [Signature]

Name : R. Soumya

Date & Time : 5/1/20 11:50 PM

Patient Attendant :

Signature : [Signature]

Name : Dr. Paron Kumar

Relationship with Patient : Husband

Date & Time : 5/1/20 11:50 PM

Witness :

Signature : [Signature]

Name : Sameer (016638)

Date & Time : 5/1/20 11:50 PM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Prathyusha

Date & Time : 5/1/20 11:50 PM

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

FDH-00026418 IP5-00175982
Mrs RACHURI SOUMYA
18-09-1992 33 Y 9 M 18 D (F)
Dr. DR.M PRATHYUSHA REDDY

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Name: Mrs. Rachuri Soumya Age: 33Y Sex: F UHID.No: FDH-00026418
Date: 5/7/2026 Time: 7:15PM Proposed Operation: Epidural Analgesia
Diagnosis: Primigravida 39+6wks
B.P / CRT: H.R: Weight: 74.9 ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 13.7 Glucose: Protein: HIV: X-Ray:
PCV: Urea: Alb: HBS Ag: ECG:
WBC: 17,040 Creat: Total Bil: HCV: 2D Echo:
Plate: 227 Na: Dir. Bil: Blood group: Stress/Angio:
PT: K: LDH: T3 Other:
PTT: Ca++: Alk phos: T4
INR: Mg++: Amylase: TSH
Cl-: SGOT/SGPT:

Allergies:

NKDA

Medical History: CVS:

RESP:

Diabetes:

CNS:

NOT significant

Renal:

Hepatic / GE:

Physical Activity: Active

Others:

Past Anaesthetic History:

Physical Exam:

Airway:

MP 1 2/3/4

Mouth Opening: Adequate

Mentohyoid Distance: 2FB

Neck:

Teeth:

Lungs:

BAE+ clear

Heart:

S1+S2+

CNS:

MMF+

Pregnant: ☒ Yes ☐ No ☐ NA

Venous Access Site: 18G RUL

Spine Exam for regional:

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

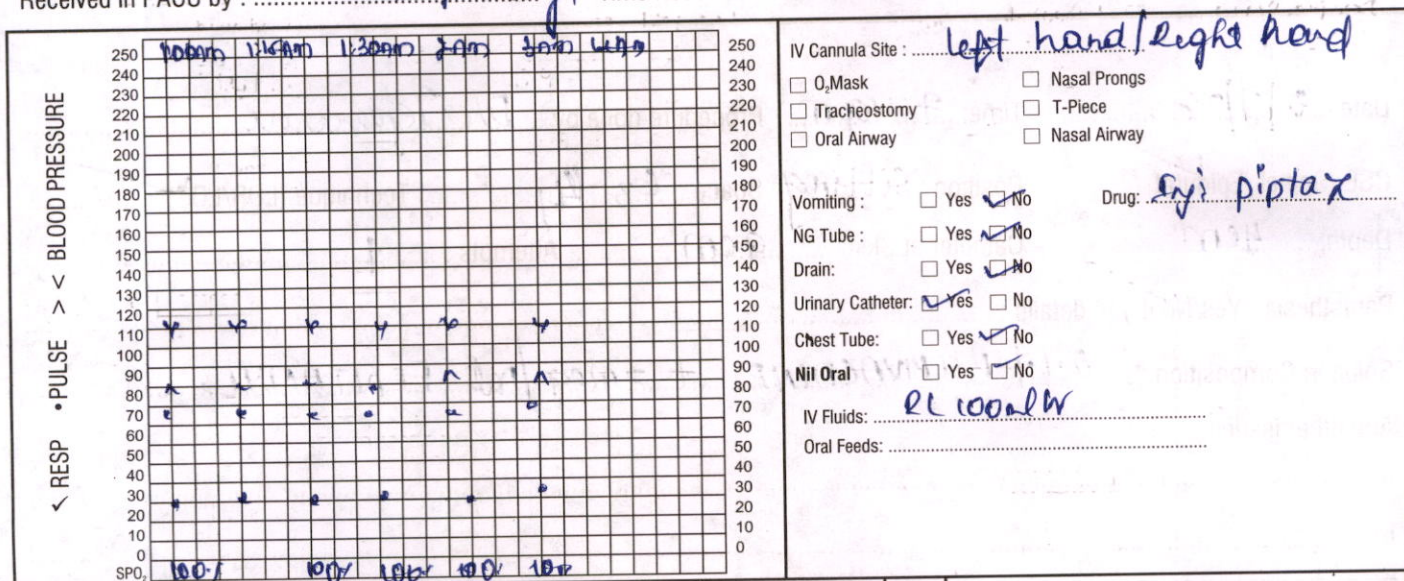
- DVT Prophylaxis:
 - Water / ORS 2 Hours
 - Others 6 Hours
- NIL ORAL
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions:

Signature:

Name:

Dr. Gejamm

Received in PACU by : 1:00am / Sandeepa Time Received : 1:00am Time Discharged : _____



POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES			OUT	SCORING INTERPRETATION
			30	60	90		
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0	ACTIVITY	1	2	2	2	1	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 = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION	1	2	2	2	1	
BP $\pm$ 20 of Pre Anaesthetic leve = 2 BP $\pm$ 20-50 of Pre Anaesthetic leve = 1 BP $\pm$ 50 of Pre Anaesthetic leve = 0	CIRCULATION	1	2	2	2	1	
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	1	2	2	2	1	
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	1	2	2	2	1	
TOTAL		5	10	10	10	5	

Date	Time	Pain Score	Intervention	Signature
6/7/1	10:00	1/10	under analgesia	} Sandy (01663
6/7/1	20:00	1/10	under analgesia	
6/7	30:00	1/10	under analgesia	

Date & Time: 6/7/20 e 1 AM

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 relieving intervention
 - d. With in 30-60 minutes after pain relief intervention

Date & Time:



Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: 5/7/26 Time: 7:40pm Procedure done by Dr. Tejaswini

CSE / Spinal / Epidural ☒ Position: Sitting Space: L3-4 Technique (LOR/LOS) ☒

Depth: 4cm Catheter at Skin: 9cm Attempts: 1

Parasthesia: Yes/No if yes details:

Solution Composition: 0.1% BUPIVACAINE + 2mcg/ml FENTANYL

Any other issues:

a)

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right		Maternal		FHR	Comments
					BP	Pulse		
7:50pm		3ml + 1.8ml 1.8% LOR + APR T8 T10			106/72	102/min	137/min	comfortable.
9:50pm	8ml/hr			T8 T10	100/60	100/min	135/min	comfortable.
11pm	8ml/hr	3ml 1.8% + APR Bolus			102/68			

Delivery Details: Time: 11:02pm APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected: Yes ventouse

Patient Satisfaction: Comfortable

Discharge / Shifting ordered by

Doctor Signature: Dr. Tejaswini

Doctor Name: Dr. Tejaswini

Date and Time: 5/7/26 6:15pm



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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 6/7/26 Time: 8:30am

Origin: Indian Height: 159cm Weight: 74.4kgs BMI: 33.3kg/m²

Food Allergies: No

Diagnosis: PND-0 / AVO (assisted vaginal delivery)

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

Diet Advised:

Soft High protein diet
Include plenty of oral liquids
Avoid spicy, chilled and outside food

Patient's / Attendant's

Signature: R Anuradha

Name: Soumya

Date & Time: 6/7/26
8:30am

Dietician's

Signature: Nikitha

Name: Nikitha

Date & Time: 6/7/26
8:30am

DIETARY NOTES

[illegible]