

ADMISSION SHEET

Registration Details :

Admission No : IP5-00176119

Admit Date : 08-Jul-2026

Admit Time : 05:57 PM UHID : BAH-00641654.

Patient Details :

Patient Name : Mrs POTHULA AKSHITHA

Age : 21 Y 0 M 6 D

Guardian : Mr PRADEEP KUMAR KOTHAPALLY

DOB : 02-07-2005

Gender : Female

Religion :

Occupation :

Marital Status : Married

Address (H) : DOOR NO - 1408, AW2, NEBULA AVAS ,
Bachupally Hyderabad Telangana INDIA
500090

Phone No : 8125082873/ 6305586410

E-mail : NOMAIL@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

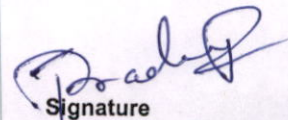
Contact Details :

Name : Mr PRADEEP KUMAR KOTHAPALLY

Relationship : Husband

Contact Address : DOOR NO - 1408, AW2, NEBULA AVAS ,
Bachupally Hyderabad Telangana INDIA 500090

Phone No : 8125082873 / 6305586410


Signature

Doctor Details :

Doctor Name : Dr. DR.M PRATHYUSHA REDDY

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. : _____

Date of Admission: _____

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

BAH-00641654 IP5-00176119
Mrs POTHULA AKSHITHA
02-07-2003 21 Y 0 M 6 D (F)
Dr. DR. M PRATHYUSHA REDDY



Consultant: _____ Dept : _____

Date of Discharge : _____ Time: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/2/25	10pm	OBS	33A	Suman

Cross Consultation Visit

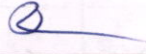
	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
8/2/26	IV placement	1	9693947	
9/2/26	Catheterization	1	9694122	Kamg
9/2/26	PAC	1	9694121	Kamg

ANY OTHER INFORMATION

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00641654 IP5-00176119
Mrs POTHULA AKSHITHA
02-07-2003 21 Y O M 6 D (F)
Dr. DR.M PRATHYUSHA REDDY




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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Came for IOL

Obstetric Formula: primigravida

Obstetric History:

I - PP - 8p. conception - Booked
at 7+1 wks of GA.

Present Pregnancy Record:

ANC - Anemia in 1st
trimester.
used oral tablets.

RISK FACTORS:

Height: 155 cm

Weight: 56 kg

Allergies: NKA

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: c/c

Icterus: absent

Temp: afebrile

BP: 116/68 (79)

CVS: S1S2+

Liver/Spleen: not
palpable

Pallor: absent

Edema: 1

PR: 83 BPM

DTR: (+)

RS BAE+

Urine Output: adequate

LMP: 10/10/2025

Corrected EDD: 22/12/25

Menstrual History: Regular: ☒ Yes ☐ No

Obstetric Examination

Fundal Height: ~ term

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech Others

Head Fifths Palpable: 4/5

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

Cervix: ☒ Long ☐ Partially effaced ☐ Effaced

Os: Closed Dilated 1cm

Membranes: ☒ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☒ Vertex ☐ Breech ☐ Others

Sutton: ☒ -3 ☒ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☒ Adequate ☐ Doubtful

DIAGNOSIS

Primigravida @ 38 wks / Came for IOL

BAH-00641654

IP5-00176119

Mrs POTHULA AKSHITHA

02-07-2003

21 Y O M 6 D

(F)

Dr. DR.M PRATHYUSHA REDDY



Heterozygous pathognomonic variant
c799 c>T in MECP2 gene.
→ tremor's while walking.
→ global developmental delay.

Family History: 4/10 → Rett syndrome Husband's sister-daughter. Patient's sister → Developmental delay	Surgical History: No
Medical History: No not evaluated.	Medication History: f c, ca
Plan of Care: ✓ Admission ✓ IV Consultation ✓ Post preparation - PAC - JOL - - written & Informed consent - NST 3rd hly - Monitor vitals 4th hly - Inform SDS - send & trace CBP.	Investigations: BUT - Viral - NR <u>21/4/26</u>: Mb - 11 gram PLT - 2.6L <u>1/7/26 (65)</u> 37 wks. SUL, cephalic, AFI - 13.3cm, Fetal dopplers - (N), uterine artery dopplers show ↑ resistance BF <u>24/6/26</u> SUL, 36 wks, cephalic PLT → post Heterogenous AFI - 11cm, AC - <1%, FFW - 2, 12+gms (3%), FGR - stage 1 Dopplers - (N)

DR. M PRATHYUSHA REDDY
Registration No: 53755

Doctor Name: Dr. Divya

Signature:

Date & Time: 8/7/26; 4:45 pm

Consultant Name: Dr. Prathyusha Reddy

Signature:

Date & Time: 8/7/26 7 pm

BAH-00641654 IP5-00176119
 Mrs POTHULA AKSHITHA (F)
 02-07-2005 21 Y 0 M 8 D
 Dr. DR.M PRATHYUSHA REDDY

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: Dr. Prathyusha Reddy	Date of Delivery: 9/7/26
Assistant Surgeon: Dr. Sneha	Time of Delivery: 3:33 pm
Anaesthetist's Name: Dr. Amreen	Gender of Baby: female
Type of Anaesthesia: Epidural	Weight of Baby: 2.265
Neonatologist: Dr. Neethu	AGPAR Score:
Scrub Nurse: Srs. Bhavathi	NICU Admission: ☐ Yes ☒ No

Pre-Operative Diagnosis: Primi 38⁺ 90L

☐ Elective ☒ Emergency Indication: N.P.O.L

Urgency

☐ Immediate Threat to life of woman or fetus

☐ Maternal or fetal compromise not immediately life threatening

☒ No maternal or fetal compromise but needs early delivery

☒ Delivery timed to suit woman and staff

Decision time: Knief to rectus:

CTG Description: reactive

If there was a delay give the reasons:

Surgical Procedure: Em. vcs

Post Operative Diagnosis: POD - 0 Em. vcs

Peri-Operative Complications: Nil

Amount of Blood Loss: 200ml Blood Transfused (in ML):

Name and Number of Surgical Specimen sent for examination:

Examination Findings when Appropriate:

Presentation: ☒ Cephalic ☐ Breech ☐ Other

Cervical Dilatation: 2cm cm

5th Palpable:

Fetal Position:

Station: ☒ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Moulding: ☐ None ☐ + ☐ ++ ☐ +++

Caput: ☐ + ☐ ++ ☐ +++

Meconium: ☐ None ☐ + ☐ ++ ☐ +++

Bladder Catheterized: ☒ Yes ☐ No

Urine: ☐ Clear ☐ Blood Stained

Skin Incision: ☒ Pfannenstiel ☐ Transverse

☐ Midline ☐ Other

Uterine Incision: ☒ Lower Segment ☐ Classical

☐ Inverted T ☐ J Incision

Previous Scar: ☐ Intact ☐ Thinnedout

☐ Ruptured ☒ No Scar

Incision Through Placenta: ☒ Yes ☐ No

Delivery of head: ☒ Manual ☐ Forceps

Liquor: ☒ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not Offensive

Delivery of Placenta: ☐ Manual ☒ CCT ☒ Complete ☐ Incomplete ☐ Piecemeal

Cord Appearance: N Cord around the neck ☐ Yes ☒ No

Appearance of placenta: N Cavity explored ☒ Yes ☐ No

Uterus, tubes and ovaries: ☒ Normal ☐ Not Normal Sterilization: ☐ Yes ☒ No

Uterine Closure: ☐ One Layer ☒ Two Layers

Peritoneal Closure: ☐ Pelvic ☒ Abdominal ☐ None

Sheath Closure:

Fat Closure: ☒ Yes ☐ No

Skin Closure: ☒ Subcuticular ☐ Mattress

1-Vicryl Suture

2-0 Vicryl rapide Suture

1-Vicryl Suture

2-0 Vicryl rapide Suture

2-0 Vicryl rapide Suture

Vaginal Evacuated ☒ Yes ☐ No

Drain: ☐ Yes ☒ No ☐ Remove in days ☐ Await instructions

Catheter ☒ Yes ☐ No ☐ Remove in 2 wks days ☐ Await instructions

Swap & Instruments count correct? ☒ Yes ☐ No ☐ Post-op Antibiotics ☐ Yes ☒ No

Intra-Operative Antibiotics Cover: ☒ Yes ☐ No ☐ Thromboprophylaxis ☐ Yes ☒ No

Post-Operative Notes:

① NBM - 4 hrs

② IVF @ 120 ml/hr RL

③ Drugs as chart

④ w/ Bleeding PV

⑤ 2uform 805

⑥ vitals I/O 1/2 hourly.

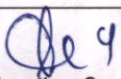
Doctor Name: Dr Sneha

Doctor Signature: [Signature]

Date & Time: 9/7/26 4:30PM

BAH-00641654
Mrs POTHULA AKSHITHA
02-07-2006 21 Y O M 8 D (F)
Dr. M PRATHYUSHA REDDY

POST-SURGICAL CARE PLAN FORM

Procedure Done:	fm. ves
Post-Surgical Diagnosis:	POD-0 fm. ves
Post-Operative Monitoring Parameters /Frequency:	Vitals, I/O 1/2 hourly
Wound Care:	Dressing x 48 hrs
Drain /Special Lines/Catheters:	Foleys x 24 hrs
Special Patient Positioning and Requirements:	can move sideways on bed.
Nutritional Instructions:	NBM x 4 hrs
When to Start Mobilization:	After foleys removal
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: 9/7/26 Time: 4pm
Note: Plan of care will be readjusted if necessary.	

Docu. No. : RCHBH /FRM / CLINICAL / 088

BAH-00641654

IP5-00176119

Mrs POTHULA AKSHITHA

02-07-2005

21 Y 0 M 6 D

(F)

Dr. DR. M. PRATHYUSHA REDDY



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24 9/2/26 1:00 AM	pt comfortable NST @ 12 AM - Reactive 3rd run of Tab. PGE ₂ 2mg PO given @ 12 AM. O/E ac-fair vitals-stable P/A uterus contractile.	Adv w/F PDC - vitals continuing - CTG 3rd run - Inform M Dr. Samudra
9/2/26 4:30 AM	Prm/ 38 th wk (PGR) O/E ac-fair PR - 90 bpm BP - 119/80 mm Hg (72) SPO ₂ 100% on RA P/A uterus contractile. P/v - CX - finger base 1/2 inch long ARM done. clean & moist up-stator	Adv w/F PDC - vitals continuing - Epidural - CTG 3rd run - Pl Enema - Inform M Dr. Samudra



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/12/20		C/ILT Dr. Prathyusha
6:30 AM	At comfortable	Adv
	O/B	- Stand oxytocin @ 6 ml/hr
	W/face	- O/F PDL
↓ epidural	Vital signs -	- Continuous FHR
	P/A ulcers	monitor
	contable	- CTG Bradley
		- Inform
9/12/20		
9:30 AM	- Prim/38H wks / FGR.	
	- NO c/o	
	- AFM ⊕	
	- O/B ac - fair	Adv
	BP = 103/68 [79]	① Continue syntocin augmentation
	HR = 102 bpm	② Continuous FHR monitor
	SpO ₂ = 98%	③ Vitals hourly
	Temp = 98.7 °F	④ NST - Trace - 3rd hel
	- P/A - C/H mildly acting	⑤ w/ labor progress
	Cephalic, Eng ⊕	
	Plv - Cx = 1-cm dilated, 1/2 inch long	
	Vx = -3 station	
	membrane ⊕	
	clear liquor ⊕	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/17/2026 12:20pm	pt stable C/o increasing pain Vitals (N) P/A - uterine aching, episodic FHR - good V/E - Cx 50% effaced os 2cm, V ₂ - 2 Adv - FHR monitoring - Start syntocinon - Inj Biotin 1amp IV stat	
9/17/2026	DR.M PRATHYUSHA REDDY Registration No: 59755 NSGKANS CORR/ST/ C/O S/B Dr. Prathyusha Bp-118/74/89mm RR-86BPM V/E - Same finding pt cancelled for fm. lscu ilub - non progression of labour - current ✓	Adv - STOP synto - Part preparate - Progs ahead - Shift to o/a on call Dr. Prathyusha

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/2026 5:30pm.	POD-0/Em-Lscy	
	<u>O/E</u> Gc-fair	<u>Adv</u>
Baby-well.	Bp- 109/76/82/mmHg	① IV @ 100ml/hy
	PR- 86 BPM	② NBM for 6hrs
VO- 200ml emptied	SPO2- 98% RA	③ Monitor I/O charting
<u>Now- 100ml</u>	PIA- ut @ uel	④ Monitor vitals 4th hrs
	Plu- BW	⑤ Drugs as charted
		⑥ ut after bleeding
		⑦ Inhouse svs.
9/7/2026 7:30pm	POD-0/Em-Lscy.	Dr. Divya
	<u>O/E</u> Gc-fair	<u>Adv</u>
Baby-well	Bp- 102/76/82/mmHg	① NBM till 10:30PM
VO- 300ml clean	PR- 92 BPM	② Sips of water from 10:30pm
	SPO2- 98% RA	③ If tolerated liquid diet from 11:30pm
	PIA- ut	④ Soft diet diet from 8:00 AM 10/7/26
	Breeding- Intact	⑤ Drugs as charted
		⑥ Monitor vitals
		⑦ Inhouse mns
		⑧ I/O charting
		⑨ Foley removal at 12:00PM.
		⑩ Inhouse svs.
		10/7/2026
		Dr. Divya

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 8:45 AM	POD-1) EMBRY	
B well V/O good S(+) (X)	PT: comfortable Ge: air Vitals: stable P/A: W(+) well Soft, dist R/W: N/A	1) soft diet & plenty of oral fluid 2) Drug as charted 3) w/f Plv Bleeding 4) Amelutation 5) I/O charting 6) Remove Foley at 12pm 7) Temp 5s Note by [Signature] @ 8:45 AM - Dr. Prathi
10/7/26 12:45 PM	POD-1 PT stable Vitals (N) P/A - ut R/W P/V - R/d W/L Baby A 9h	Adv Bulcolay 100mg (N) at 4pm today - Drugs as advised - Amelutation Remove foley now
Urine output clear adequate		DR. M PRATHYUSHA REDDY Registration No: 59133 NB: [Signature] 11:00 PM [Signature]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/1/26 1:20pm	Pt comfortable O/G ac-tain vital: stable P/A uterus retracted well 4/5 lochia heating	Adv - soft diet, plenty of oral fluids - drugs as per checked - vitals uterine - Ambulate - I/O charting - Informatics NBI all set 1:50pm Dr. Sameer
7/1/26	POD-1 / Fm 1m O/G G-tain vital stable P/A- ut @ well LIF-BWNL Drilling Intal	Adv ① soft diet ② hydration ③ Ambulation ④ w/ active bleeding ⑤ mgs as charted ⑥ Informatics Dr. Dings

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RESULT SHEET

Date	8/7/26				
Time					
Hb	13.6				
PCV	41.1				
RBC	5.13				
WBC	11.87				
N/L					
Platelets	2.5				
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 O+ve						

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

BAH-00641654 IP5-00176119
Mrs POTHULA AKSHITHA
02-07-2003 21 Y 0 M 6 D (F)
Dr. DR.M PRATHYUSHA REDDY



MEDICATION RECONCILIATION FORM

Drug Allergies: ☒ 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:

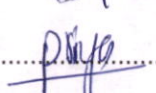
S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. Iron	1tab	PO	bp		☐ C ☒ DC
2	T. Meleal	1tab	PO	od		☐ C ☒ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : 

Date & Time : 8/7/24 4:30pm

Nurse Name & Signature: 

Date & Time : 8/7/24 4:30pm

BAM-00641654 IP5-00176119
Mrs POTHULA AKSHITHA
02-07-2005 21 Y 0 M 8 D (F)
Dr. DR.M PRATHYUSHA REDDY



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Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG: T. PARACETMOL				Date/Time
Dose	Route	Frequency	Start Dt.	
400mg	PO	BD	9/7/2026	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG: T. PANTOP				Date/Time
Dose	Route	Frequency	Start Dt.	
40mg	PO	BD	9/7/2026	10/7/12
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG: T. CEFIXIME				Date/Time
Dose	Route	Frequency	Start Dt.	
200mg	PO	BD	10/7	10/7
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG: T. IRAMADOL				Date/Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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																				



9 780130 265550



Date of Admission: 8/1/26 Drug Allergies: N/A ☒ 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. |

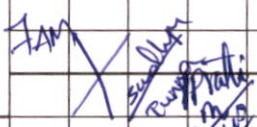
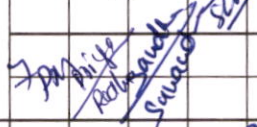
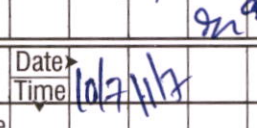
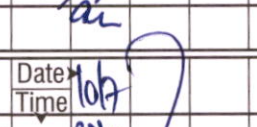
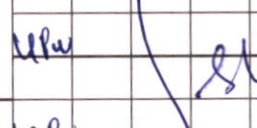
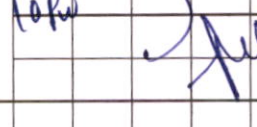
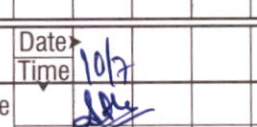
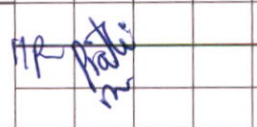
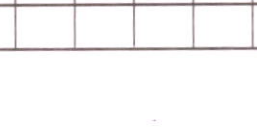
SOS / PRN (As Required Medication)

[illegible][illegible][illegible]



REGULAR PRESCRIPTIONS

Weight. 56 kgs.. Ward. B/C.....

DRUG : <u>Inj. CEFOTAXIME</u>				Date/Time	<u>9/7/26</u>
Dose	Route	Frequency	Start Date		
<u>1gm</u>	<u>IV</u>	<u>BD</u>	<u>8/7/26</u>		
Name & Signature of the Doctor Starting the Drugs:				 <u>Dr. PRATHYUSHA</u>	
Additional Instructions:				 <u>Dr. PRATHYUSHA</u>	
Daily Doctor's Endorsement by a Sign				 <u>Dr. PRATHYUSHA</u>	
DRUG : <u>Tab. PARACETAMOL</u>				Date/Time	<u>10/7/26</u>
Dose	Route	Frequency	Start Date		
<u>650mg</u>	<u>PO</u>	<u>QID</u>	<u>9/7/26</u>		
Name & Signature of the Doctor Starting the Drugs:				 <u>Dr. K. Sri Surya</u>	
Additional Instructions:				 <u>Dr. K. Sri Surya</u>	
Daily Doctor's Endorsement by a Sign				 <u>Dr. K. Sri Surya</u>	
DRUG : <u>Tab. TRAMADOL</u>				Date/Time	<u>10/7/26</u>
Dose	Route	Frequency	Start Date		
<u>100mg</u>	<u>PO</u>	<u>TID</u>	<u>9/7/26</u>		
Name & Signature of the Doctor Starting the Drugs:				 <u>Dr. K. Sri Surya</u>	
Additional Instructions:				 <u>Dr. K. Sri Surya</u>	
Daily Doctor's Endorsement by a Sign				 <u>Dr. K. Sri Surya</u>	
DRUG : <u>Tab. DICLOFENAC</u>				Date/Time	<u>10/7/26</u>
Dose	Route	Frequency	Start Date		
<u>50mg</u>	<u>PO</u>	<u>TID</u>	<u>9/7/26</u>		
Name & Signature of the Doctor Starting the Drugs:				 <u>Dr. K. Sri Surya</u>	
Additional Instructions:				 <u>Dr. K. Sri Surya</u>	
Daily Doctor's Endorsement by a Sign				 <u>Dr. K. Sri Surya</u>	



Weight. 56 kg. Ward. B/L

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
8/7	5pm	Tab. PGE ₁	25mcg	PO	[Signature]	Reddy
8/7/26	9pm	T. PGE ₁	25mcg	P/O	[Signature]	Swamy
9/7/26	12AM	Tab. PGE ₁	25mcg	P/O	[Signature]	Tunna
9/7/26	3AM	Tab. PGE ₁	25mcg	P/O	[Signature]	Swamy
9/7/26	6:30AM	Tab. PGE ₁	25mcg	P/O	[Signature]	Tunna
9/7/26	5:30AM	PC Enema	1	P/K	[Signature]	Swamy
9/7/26	1pm	Luj. TROTIW	1amp	IV	[Signature]	Tunna
9/7/26	2:35PM	INT. (FFOTAKIM)	1gm	IV	[Signature]	Swamy
9/7/26	2:30 PM	INT. PANTOP	40mg	IV	[Signature]	Reddy
9/7/26	2:30 PM	INT. PERINOM	10mg	IV	[Signature]	Swamy

Signature

VERIFIED BY: Name



I.V. FLUIDS CHART

Weight: 50kg Ward: B

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
9/7/26	5AM	Tab PMS RINGER LACTATE	IV	ff	<i>[Signature]</i>	<i>[Signature]</i>	9/7/26	<i>[Signature]</i>	<i>[Signature]</i>
9/7/26	7:10AM	RINGER LACTATE normal + 10IU OXYTOCIN Halt at 6ml/hr	IV	6ml/hr	<i>[Signature]</i>	<i>[Signature]</i>	9/7/26	<i>[Signature]</i>	<i>[Signature]</i>
9/7/26	8AM	w/f contraction RINGER LACTATE	IV	100ml/hr	<i>[Signature]</i>	Kany Shon	9/7/26	<i>[Signature]</i>	Kany Shon
9/7/26	11AM	RINGER LACTATE	IV	100ml/hr	<i>[Signature]</i>	Kany Shon	9/7/26	<i>[Signature]</i>	Kany Shon
9/7/26	1PM	RINGER LACTATE	IV	100ml/hr	<i>[Signature]</i>	Kany Shon	9/7	<i>[Signature]</i>	Anjali Bharathi
9/7/26		RINGER LACTATE	IV	100ml/hr	<i>[Signature]</i>	Anjali Bharathi	9/7	<i>[Signature]</i>	Anjali Bharathi
9/7/26	3:30pm	10 RINGER LACTATE	IV	500ml/hr	<i>[Signature]</i>	Anjali Bharathi	9/7	<i>[Signature]</i>	Anjali Bharathi
9/7/26	4:00pm	10 RINGER LACTATE + 20 U OXYTOCIN	IV	100ml/hr	<i>[Signature]</i>	Anjali Bharathi	9/7	<i>[Signature]</i>	Anjali Bharathi
9/7	8PM	RINGER LACTATE	IV	100ml/hr	<i>[Signature]</i>	Sudha Siddha	9/7	<i>[Signature]</i>	Sudha

Signature

VERIFIED BY : Name



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

primi 38 wks 400 lbs

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
8.7/21 4:34	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Foal	safe delivery	NVD	[Signature]	☐ Nursing ☐ Others:
8/8/20 5 hr	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	primi 38 wks	safe delivery	NVD	[Signature]	☐ Medical ☐ Others:
10/3/26 8am	☐ Medical ☐ Nursing ☒ Others: dietitian	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	POD-1 Em. LSCs	soft diet	soft High protein diet	Sains	☐ 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:

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		
8/7/25	9:30pm	14.	Informed consen	PI	1	0	1	1		
8/7/26	5pm	1, 7	Infection control measure	PI	1	0	1	1	-	Pip
10/7/26	8:10 am	9	Lactation diet	PI	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 Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)	3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	
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2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)																			
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing																				
Teaching Tools Used:	A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed																		
Mechanism/s to overcome barrier/s:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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Understanding:	<table border="0"> <tr> <td>1. Verbalizes Understanding</td> <td>2. Demonstrates Understanding</td> <td>3. Needs Review</td> </tr> </table>								1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review												
1. Verbalizes Understanding	2. Demonstrates Understanding	3. Needs Review																					



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 8/7/21 Time of Arrival: 5pm Time Seen by Nurse: 5:5pm

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: 2OL

3) Vital Signs: Temperature: 98.1° Pulse: 83 RR: 20 SpO₂: 100 BP: 101/68 Weight: 51kg

4) Gestational Criteria:

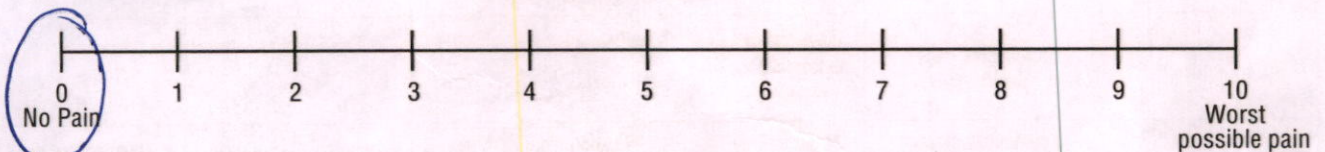
Gravida:	G	P <u>3</u>	L	A
----------	---	------------	---	---

LMP: 10.10.2005 EDD: 17.1.2006 Gestational Age: (38wks)

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:

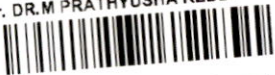
Numerical Pain Scale (NPS)



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

6) Past History:

- a) Surgeries: still
b) Medical: still



7) ☐ 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: 5:10 pm

Nurse Name: Radha Nurse Signature: [Signature]

Date: 8/7/24 Time: 6 pm



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 8/7/24

Baseline Information:

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

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

Chief Complaints: Doctor Notified on Admission: ☒ Yes ☐ No
Came for IOL Name of the Doctor: Dr. Arshya
..... Time Notified: 5:10 pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Nil	Nil	No

Gynecology Assessment: ☐ Not Applicable Menstrual History: Regular Onset of Menarche: Menstrual Cycle: ☐ Regular ☐ Irregular Last Menstrual Period:	Gynecology Surgical History: Caesarean Section: ☒ No ☐ Yes Cervical Cerclage: ☒ No ☐ Yes Ectopic Pregnancy: ☒ No ☐ Yes Myomectomy: ☒ No ☐ Yes Others:	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 P 2mi L A

Previous LSCS: No

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 Left Syndrome husband's sister daughter

Vital Signs / Measurements: Temp: 98.10F HR: 82 bpm RR: 20 bpm
BP: 101/65 Weight: 56 kg Height: 1.55 m 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 20 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☐ No Score 28 (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: Akshitha

Orientation not given Reason: NA

Nurse Signature: [Signature]

Nurse Name: Radha

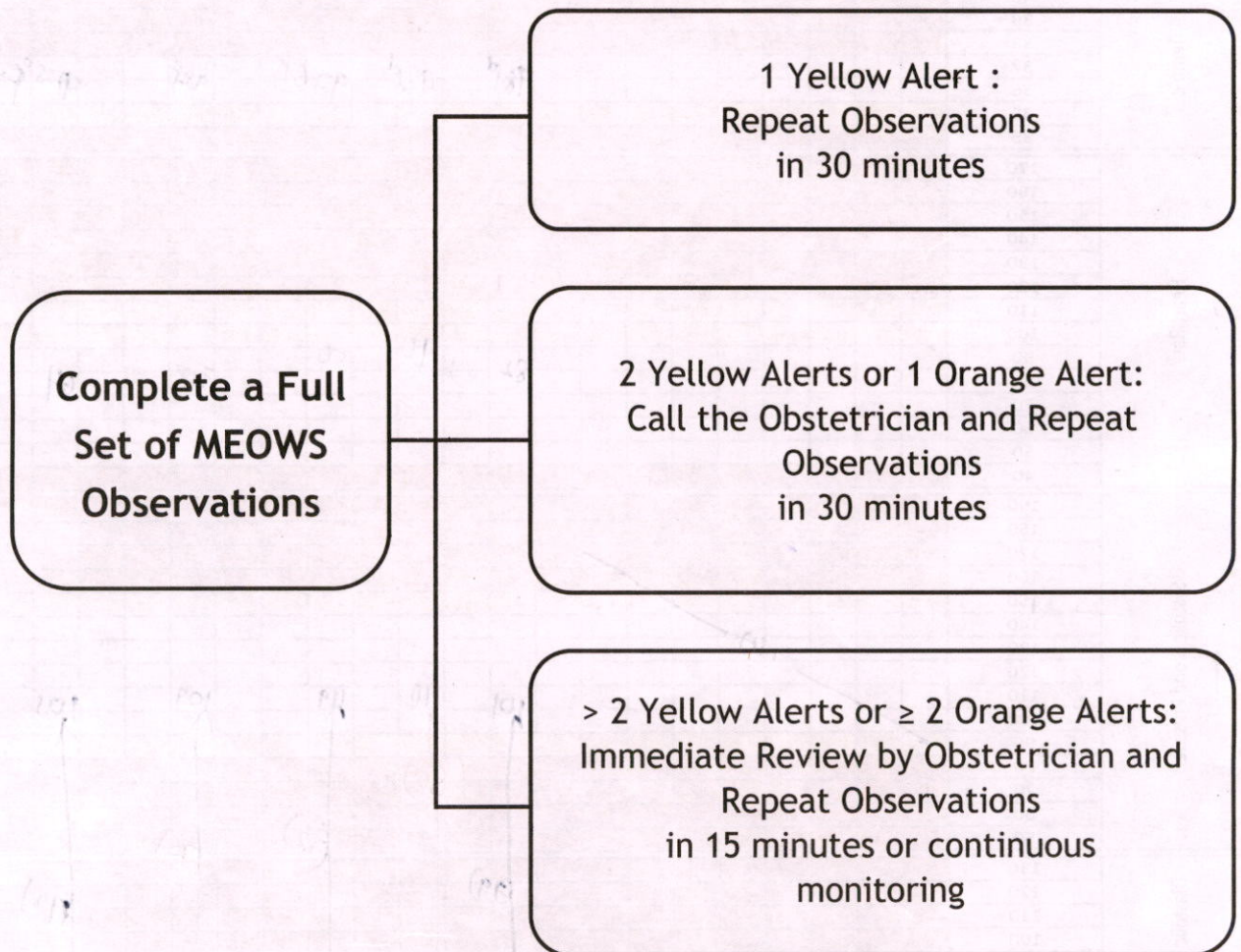
Date & Time: 8/7/25 @ 6pm



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)



9/2/28



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

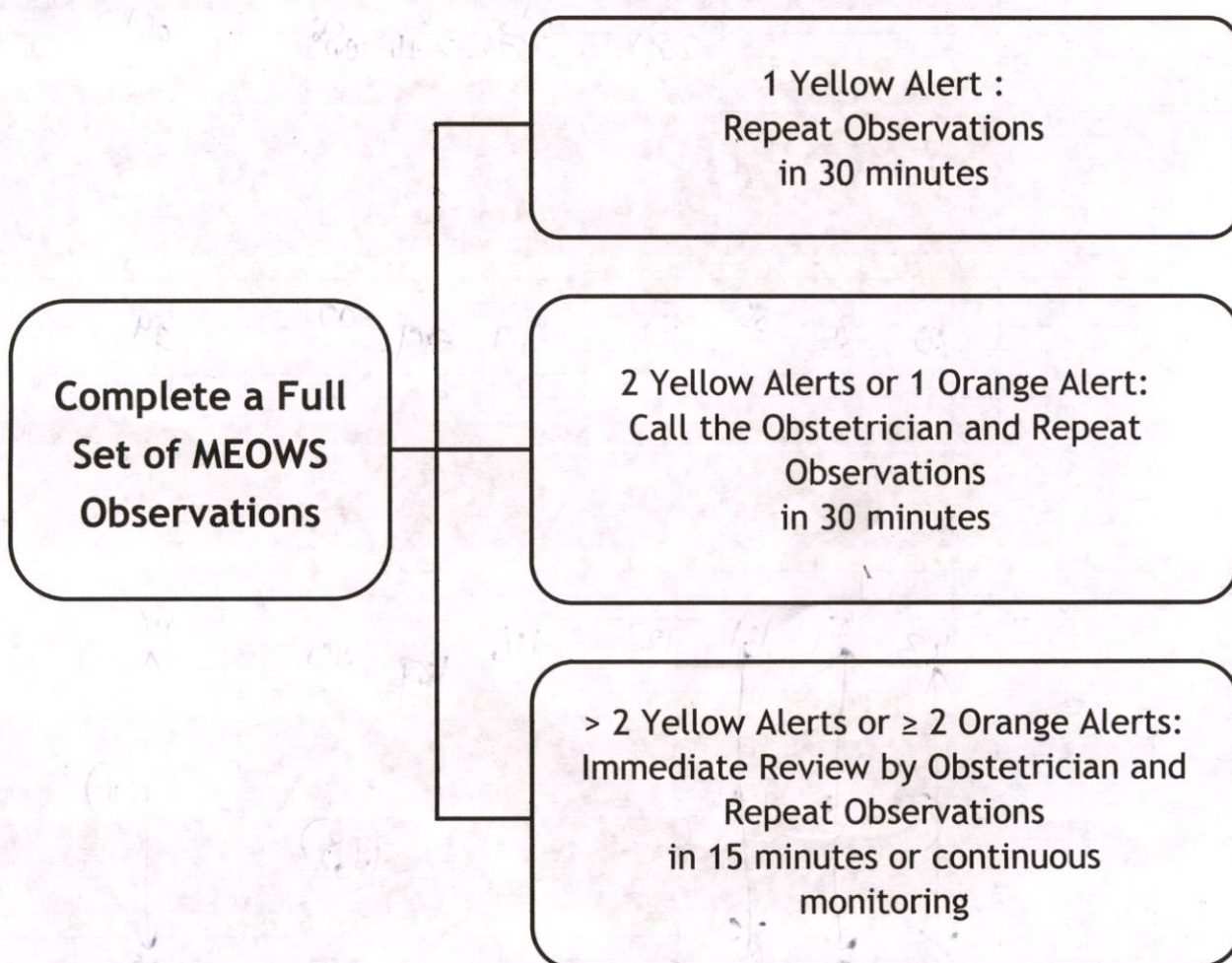


BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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)

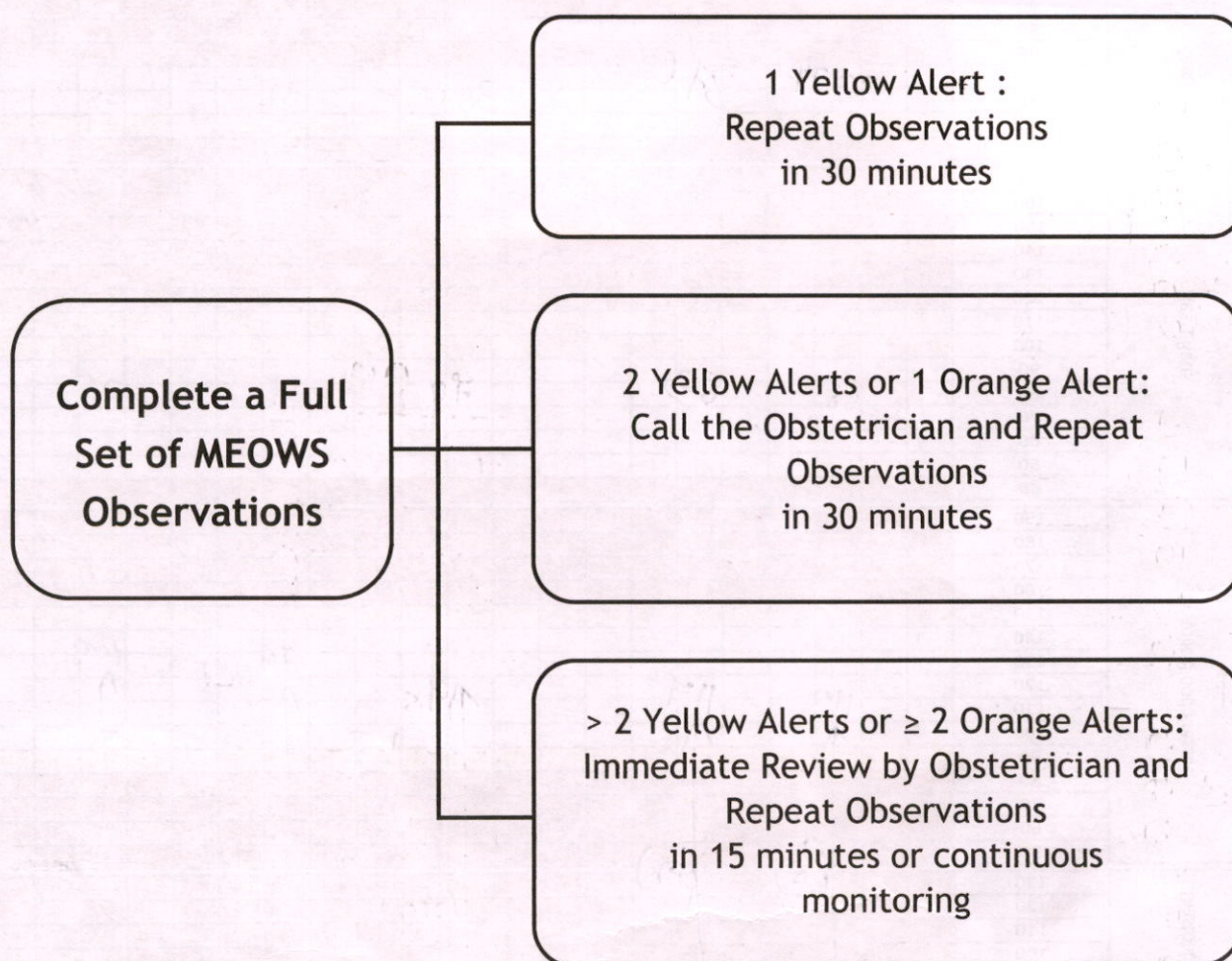
10/7



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

8/2/26

- 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											
	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										0	} Radio
	05:00 pm	H ₂ O							✓		0	
	06:00 pm										0	
	07:00 pm	H ₂ O							✓		0	
Total Intake : Taken						Total Output : passed (U) - 2						
	08:00 pm	H ₂ O									0	sandy
	09:00 pm	meal								✓	0	sandy
	10:00 pm	H ₂ O									0	sandy
	11:00 pm						NP			✓	0	sandy
	12:00 am	H ₂ O									0	sandy
	01:00 am	H ₂ O								✓	0	sandy
Total Intake : Taken						Total Output : passed U - 3						
8/2/26	02:00 am	H ₂ O								✓	0	sandy
	03:00 am										0	sandy
	04:00 am	RL H ₂ O 100ml								✓	0	sandy
	05:00 am	RL 100ml									0	sandy
	06:00 am	RL H ₂ O 100ml							✓		0	sandy
	07:00 am	RL idly 100ml									0	sandy
Total Intake : Taken						Total Output : passed U - 2						
Total 24 hrs. Intake			Taken .									
Total 24 hrs. Output			m - 1, u - 7									



FLUID CHART

Sheet No. : 2

9/7/20

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							
9/7	08:00 am						✓			0		
	09:00 am	H ₂ O								0		
	10:00 am								400ml	0		
	11:00 am	H ₂ O								0		
	12:00 pm									0		
	01:00 pm	H ₂ O							400ml	0		
Total Intake :			Taken			Total Output :						
9/7	02:00 pm									0		
	03:00 pm			RL					500ml	0		
	04:00 pm			500ml					200ml	0		
	05:00 pm			RL						0		
	06:00 pm			500ml					200ml	0		
	07:00 pm									0		
Total Intake :			TBM			Total Output :			ml 800			
9/7	08:00 pm	RL	100ml	100ml						0		
	09:00 pm	RL	100ml	100ml						0		
	10:00 pm	RL	Barley w water	100ml					400	0		
	11:00 pm	RL		100ml						0		
	12:00 am	RL		100ml						0		
	01:00 am	RL		100ml						0		
Total Intake :			Taken			Total Output :			a-400ml - Np			
9/7	02:00 am	RL		100ml						0		
	03:00 am	RL	Barley water	100ml					200ml	0		
	04:00 am	RL		100ml						0		
	05:00 am	RL		100ml						0		
	06:00 am		40	100ml						0		
	07:00 am									0		
Total Intake :			Taken			Total Output :			u-200ml - Np			

Total 24 hrs. Intake	Taken
----------------------	-------

Total 24 hrs. Output	u- 2400ml m- 1
----------------------	-------------------

FLUID CHART

Sheet No. : 3

10/7/26

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								
10/7/26	08:00 am						1			300	0	Latta	
	09:00 am	water								0	0		
	10:00 am	Soup					NP			0	0	Latta	
	11:00 am									0	0		
	12:00 pm	water					1			700	0	Latta	
	01:00 pm									0	0		
Total Intake : Taken						Total Output : 6 - 1000							
10/7/26	02:00 pm						1				0	Latta	
	03:00 pm	H2O								0	0		
	04:00 pm						NP			0	0	Latta	
	05:00 pm	Water								0	0		
	06:00 pm						1			0	0	Latta	
	07:00 pm	H2O								0	0		
Total Intake : Taken						Total Output : m-0 u-2							
10/7/26	08:00 pm										0	Latta	
	09:00 pm	water								0	0		
	10:00 pm						✓			0	0	Latta	
	11:00 pm	water								0	0		
	12:00 am									0	0	Latta	
	01:00 am	water								0	0		
Total Intake : taken						Total Output : m-1 u-3							
10/7/26	02:00 am						1				0	Latta	
	03:00 am	water								0	0		
	04:00 am						NP			0	0	Latta	
	05:00 am	water								0	0		
	06:00 am						1			0	0	Latta	
	07:00 am									0	0		
Total Intake : taken						Total Output : m-0 u-0							
Total 24 hrs. Intake		Taken											
Total 24 hrs. Output		m-1 u-6											

BAH-00641654 IP5-00176119
 Mrs POTHULA AKSHITHA
 02-07-2005 21 Y 0 M 9 D (F)
 Dr. DR.M PRATHYUSHA REDDY



11/7/26

FLUID CHART

Rainbow Children's Hospital
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Sheet No. : 4

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-00641654 IP5-00176119
Mrs POTHULA AKSHITHA
02-07-2003 21 Y 0 M 6 D
Dr. DR.M PRATHYUSHA REDDY (F)

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 8/7/26

Assessment: Patient having fear of 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
5 pm	⇒ Assess the General Condition of the patient	5:10 pm	⇒ Assessed the General Condition of the patient	Patient was Comfortable
6 pm	⇒ Monitor vitals	5:5 pm	⇒ Vitals Monitored & Recorded	
6:30 pm	⇒ NST	6:35 pm	⇒ NST 2nd hourly	
7 pm	⇒ Administer Medication	7:20 pm	⇒ Medications administered as per chart	
8 pm	⇒ Maintain fluid balance	8:5 pm	⇒ Fluid balance maintained	

Re-Assessment: Re-assessment done patient was comfortable

Special Notes: NST 2nd hourly

Nurse Signature: [Signature]

Nurse Name: Radha

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

BAH-00641654 IP5-00176119
Mrs POTHULA AKSHITHA
02-07-2003 21 Y 0 M 6 D (F)
Dr. DR.M PRATHYUSHA REDDY



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 08/07/2026

Assessment: patient having fear and 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
8 PM	⇒ Assess the patient condition	8:30 PM	⇒ Assessed the patient condition	⇒ patient is stable.
10 PM	⇒ monitor vitals	10:30 PM	⇒ monitor vitals checked recorded.	
12 AM	⇒ Administer medication	12:30 AM	⇒ Administer medication as for drug chart.	
2 AM	⇒ NST 3rd hourly monitor	2:30 AM	⇒ NST 3rd hourly done	
4 AM	⇒ maintain personal hygiene	4:30 AM	⇒ maintain personal hygiene	
6 AM	⇒ ensure safety needs	7:30 AM	⇒ Ensured safety needs	

Re-Assessment: Re-Assessment done 2nd hourly

Special Notes: monitoring NST 3rd hourly

Nurse Signature:

Nurse Name: sandhya

Date & Time: 09/07/26 @ 8 AM

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Mrs POTHULA AKSHITHA
02-07-2005 21 Y 0 M 6 D (F)
Dr. DR.M PRATHYUSHA REDDY



NURSING CARE RECORD

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Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 9/7/26

Assessment: Patient complains 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
8am	Assess the pt general condition	8am	Assessed the pt genl condition	
	Monitor vitals		Monitored vitals	
10am	Administer Medication	11am	Administered medications.	
11am	provide diet	12pm	Provided diet	
	Monitor NST		Monitored NST	
1pm	Ensure pt Safety.	2pm	Provided Safety.	
				Patient is stable.

Re-Assessment: Re-assessment was done

Special Notes: all monitor

Nurse Signature: [Signature]

Nurse Name: Samsa Conner

Date & Time: 9/7/26

BAH-00641654 IP5-00176119
 Mrs POTHULA AKSHITHA
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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 9/7/20

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
2pm	Assess the pt condition	2:30 M	Assessed the Pt condition	
3pm	monitoring vitals.	4pm	vitals checked & good	pt is
	NST &		NST done	
4pm	I/o chest monitoring	5pm	I/o chest medication given	Compatable
6pm	observation	7:30 M	observation done	

Re-Assessment:

Re-Assessment 6th hour

Special Notes:

Nurse Signature:

Nurse Name: Rudra

Date & Time: 9/7/20 8pm

BAH-00641654 IP5-00176119
Mrs POTHULA AKSHITHA
02-07-2006 21 Y O M B D (F)
Dr. DR.M PRATHYUSHA REDDY



NURSING CARE RECORD

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☒ Night

Date: 9/7/26 @ 8pm

St.

Assessment: Patient seems to have fatigue.

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 patient's general condition.	8:10 pm	Assessed patient's condition.	Patient is Stable.
10pm	Ensure safety.	10:10 pm	Provided siderails.	
12am	monitor vitals.		monitored vitals.	
3am	maintain fluid balance.	12:10 am	I/O chart 100ml/hr RL.	
6am	soft diet at 6am -	3:10 am	nutritional status.	
6am	Foley to remove	6:10 am	planned Tm - 12pm.	
8am	Patient family education.	8:10 am	Educated patient preclude	

Re-Assessment: NA

Special Notes: Foley - 12pm, soft diet - 6am.

Nurse Signature: *[Signature]*

Nurse Name: Sanjanthi

Date & Time: 10/7/26 @ 8am.

BAH-00641654 IP5-00176119
 Mrs POTHULA AKSHITHA
 02-07-2005 21 Y 0 M 8 D (F)
 Dr. DR.M PRATHYUSHA REDDY

NURSING CARE RECORD

SI ☒ Afternoon ☐ Night

Date: 10/7/26

Assessment: patient having pain

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 general condition	8:10AM	* Assessed the general condition	Baby is stable
9AM	* monitor vitals and Record	9:10AM	* monitored vitals and Recorded	
10AM	* medication administered as per chart	10:10AM	* medication administered as per chart	
12pm	* plan to Remove at 12pm	12:10PM	* Removed Foley	
2pm	* Ensure safety	2:10PM	* Ensured safety	

Re-Assessment: patient is doing well

Special Notes: Foley removed at 12pm

Nurse Signature: Latha

Nurse Name: Latha

Date & Time: 10/7/26 @ 2pm

BAH-00641654 IPS-00176119
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 Dr. DR.M PRATHYUSHA REDDY



NURSING CARE RECORD

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Shift: _____

☐ Night

Date: 10/7/26

Assessment: Encourage orally

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
	→ Assess the general condition of patient → WIF bleeding → Plan for medication → Encourage orally → Educate the mother about feeding		→ Assess the condition & checked vitals → WIF bleeding → Administer medication → oral intake good → Mother was reassuring & confident about feeding	continue same

Re-Assessment: at patient was stable

Special Notes: follow doctors orders

Nurse Signature: M

Nurse Name: neetha

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



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 10/7/26

Assessment: Patient having pain in abdomen 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
8pm	Assess general condition of the patient	8:10pm	Assessed general condition of the patient	Patient is stable.
10pm	monitor vitals.	10:10pm	monitored vitals.	
12am	maintain I/O chart	12:15am	maintained I/O chart	
4am	Ensure safety	4:10am	Ensured safety	
6am	Administer medication as per medication chart	6:30am	Administered medication as per medication chart	
8am	w/ active bleeding	8:10am	w/ active bleeding	

Re-Assessment: Re-assessment done

Special Notes: ~~ESP~~ not

Nurse Signature: Syokhy

Nurse Name: Syokhy

Date & Time: 11/7/26 @ 8am

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Prathyusha Department: ORL Date of Admission: 8/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known					
	Primigravida 138 wks / came for IOL		If Yes Specify:					
BACKGROUND	Area	Shift Time	08:30-12:00	12:00-02:00	02:00-04:00	04:00-08:00	08:00-12:00	12:00-02:00
	Medical Condition (Any special condition to be noted):		NA	NA	NA	NA	NA	NA
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	98.1°F	98.1°F	98.1°F	98.1°F	98.1°F	98.1°F
	Res:	20 bpm	19 bpm	20 bpm	20 bpm	20 bpm	19 bpm	
	SpO ₂ :	100%	98%	98%	98%	100%	98%	
	Pulse:	82 bpm	86 bpm	85 bpm	85 bpm	82 bpm	85 bpm	
	BP:	101/65	112/64	120/80	110/76	110/70	112/70	
	Fall Risk Score:	20	20	20	25	35	35	
Pain Score:	0	0	0	0	0	0/10		
Recommendations	Safety Needs:	Side rails	side rails	Yes	side rails	side rails	side rails	
	Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	NA	NA	NA	NA	NA	NA	
	Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	NA	
Handed Over By Name :		Radha	sandhya	Laxmi	Radha	sandhya	Laxmi	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		8/7/26	9/7/26	9/7/26	9/7/26	10/7/26	10/7/26	
Time:		8pm	8pm	8pm	8pm	@ 8am	@ 2pm	
Taken Over By Name :		sandhya	Laxmi	Radha	sandhya	Laxmi	Manu	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		8/7/26	9/7/26	9/7/26	9/7/26	10/7/26	10/7/26	
Time:		8pm	8pm	2pm	@ 8pm	@ 8am	@ 2pm	



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. Prathyush Department: 3rd floor Date of Admission: 8/7/26

SITUATION	Diagnosis: <u>Primigravida 38 weeks / Came for IOL.</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	Area	Shift Time	<u>3rd floor</u> <u>4pm-8pm</u>	<u>3rd floor</u> <u>8pm-8am</u>				
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>				
ASSESSMENT	Allergy:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:	<u>98.1F</u>	<u>98.1F</u>				
		Res:	<u>19</u>	<u>20</u>				
		SpO ₂ :	<u>98%</u>	<u>99%</u>				
		Pulse:	<u>79</u>	<u>81 b/m</u>				
		BP:	<u>110/61</u>	<u>115/62</u>				
		Fall Risk Score:	<u>-</u>	<u>-</u>				
	Pain Score:		<u>0/10</u>	<u>0/10</u>				
	Recommendations	Safety Needs:	<u>Yes</u>	<u>Yes</u>				
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Others Specify:		<u>NA</u>	<u>NA</u>					
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>					
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>					
Handed Over By Name :		<u>Maathe</u>	<u>Syathy</u>					
Signature :		<u>(Signature)</u>	<u>(Signature)</u>					
Date:		<u>10/7</u>	<u>10/7/26</u>					
Time:		<u>@8PM</u>	<u>@8AM</u>					
Taken Over By Name :		<u>Syathy</u>	<u>Syathy</u>					
Signature :		<u>(Signature)</u>	<u>(Signature)</u>					
Date:		<u>10/7/26</u>	<u>11/7</u>					
Time:		<u>@8PM</u>	<u>9AM</u>					



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
8/7/26	5pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Radha
8/7/26	7pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Radha
8/7/26	9pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sandhya
8/7/26	11pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sandhya
9/7/26	1AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sandhya
9/7/26	3AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sandhya
9/7/26	6AM	0/10	Abdominal pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Spedural given	Sandhya
9/7/26	8AM	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sandhya
9/7/26	10AM	0/10	NO pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Kannu
9/7/26	12pm	0/10	NO pin	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under Observation	Kannu

Re-assessment Frequency:

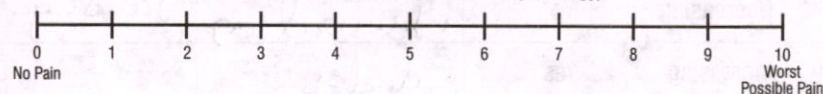
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

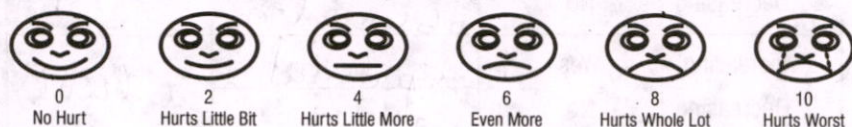
Numerical Pain Scale (Obstetric and Gynecology)



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
9/7/16	2m	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Pdly
9/7/16	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Feedly
9/7/16	7pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Feedly
9/7/16	10pm	0/10	Abdominal pain	☐ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	med gms	Sy
10/7/16	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sy
10/7	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Laktg
10/7	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Laktg
10/7	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sydy
11/7	12am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sydy
11/7	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Sydy

Re-assessment Frequency:

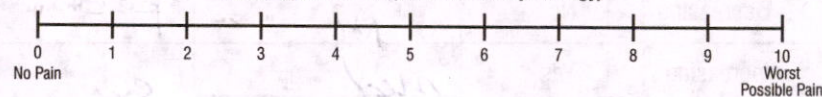
- Every eight hours for all hospitalized patients.
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 - Then every 4 hours.
 - Prior to pain relieving intervention.
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PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
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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

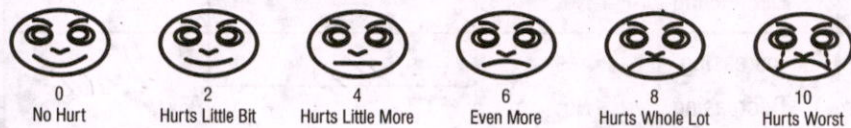
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
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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
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Wong - Baker (Pediatrics) Above 7 Years



BAH-00641654 IP5-00176119
Mrs POTHULA AKSHITHA
02-07-2005 21 Y O M 6 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 :	8/7/26	8/7/26	8/7/26	9/7/26
					Time :	2pm-8pm	8pm-2am	2am-8am	2am-8am
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or e:treimity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	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	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	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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.		4	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	4
					TOTAL SCORE	28	28	28	28
					Evaluator's Name	Sadha	Janu	Kam	B

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

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

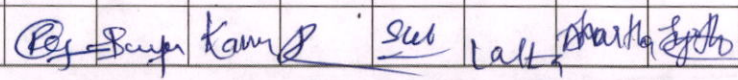
BAH-00641654
Mrs POTHULA AKSHITHA
02-07-2005 21 Y 0 M 8 D
Dr. DR.M PRATHYUSHA REDDY (F)

		Date : 02/7/26 11/11/26		Time : 10pm 6Am	
Mobility	in slight changes in body 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
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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	26
Docu. No. : RCHBH /FRM / CLINICAL / 119				Evaluator's Name	Subh

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CHECKLIST FOR THROMBOPHLEBITIS

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	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													

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 : Sudhe Name : Sudhe

Signature of Ward In Charge :

Signature : Veena Name : veena

BAH-00641654 IP5-00176119
Mrs POTHULA AKSHITHA
02-07-2005 21 Y 0 M 6 D (F)
Dr. DR. M PRATHYUSHA REDDY



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	8/7/26	8/7/26	9/7/26	Fall Risk Grading		
		Score	3pm-6pm	5pm-8pm	8am-2pm	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			20	20	20			
		Signature	Kadla	Surjer	Kannu			

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

BAH-00641654 IP5-00176119
 Mrs POTHULA AKSHITHA
 02-07-2005 21 Y 0 M 8 D (F)
 Dr. DR.M PRATHYUSHA REDDY

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			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:			35	35	35
Signature					

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 9/7/26

Date of Removal:

Parameters	Date	Shift Time	9/7/26 10pm	10/7/26 12pm					
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			Sudhanti	Pooja					
Signature of the Nurse			<i>[Signature]</i>	<i>[Signature]</i>					

BAH-00641654 IP5-00176119
Mrs POTHULA AKSHITHA
02-07-2005 21 Y 0 M 8 D (F)
Dr. DR.M PRATHYUSA REDDY



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BirthRight™
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Your Right to a Safe Delivery

NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 10/7/26

Time: 8 am

Origin: Indian

Height: 155 cm

Weight: 56 kgs

BMI: 27.36 kg/m²

Food Allergies: No

Diagnosis: POP-φ / Em- LSCS (emergency lower segment Cesarean section)

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 foods

Patient's / Attendant's

Dietician's

Signature: _____

Signature: Saima

Name: P-2008 / Sandhya

Name: SAJMA

Date & Time: 10/7/26

Date & Time: 10/7/26
8 am

DIETARY NOTES

[illegible]

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00641654 IP5-00176119
Mrs POTHULA AKSHITHA
02-07-2005 21 Y 0 M 6 D (F)
Dr. DR. M PRATHYUSHA REDDY

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Name: Ms. P. Akshitha Age: 21Y Sex: F UHID.No: BAH-00641654

Date: 9/07/2026 Time: 5am Proposed Operation: Epidural Analgesia

Diagnosis: Primigravida 38wks.

B.P / CRT: 116/68 H.R: 83/min Weight: 56kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: <u>13.6</u>	Glucose:	Protein:	HIV:	X-Ray:
PCV: <u>41.1</u>	Urea:	Alb:	HBS Ag:	ECG:
WBC: <u>11,870</u>	Creat:	Total Bill:	HCV:	2D Echo:
Plate: <u>250</u>	Na:	Dir. Bill:	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: Not significant

Hepatic / GE: Physical Activity: Active

Others: Not significant

Past Anaesthetic History: -

Physical Exam: -

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: 2FB Neck: N Teeth: intact

Lungs: BAE+ Clear

Heart: S1S2+

CNS: HMFB+

Pregnant: ☒ Yes ☐ No ☐ NA Venous Access Site: Radial Spine Exam for regional: N

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

Signature: [Signature] Name: Dr. Tejaswini

BAH-00641654 IP5-00176119
 Mrs POTHULA AKSHITHA
 02-07-2005 21 Y 0 M 8 D (F)
 Dr. DR.M PRATHYUSHA REDDY



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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Radha Time Received : Time Discharged :

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 SPO ₂		250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site :
			☐ O ₂ Mask ☐ Tracheostomy ☐ Oral Airway ☐ Nasal Prongs ☐ T-Piece ☐ Nasal Airway Vomiting : ☐ Yes ☒ No NG Tube : ☐ Yes ☒ No Drain : ☐ Yes ☒ No Urinary Catheter : ☒ Yes ☐ No Chest Tube : ☐ Yes ☒ No Nil Oral : ☐ Yes ☒ No IV Fluids : Oral Feeds :

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
9/17	8pm	0	No Pain	G

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

Anaesthesiologist Name : Dr. Sri Surya

Anaesthesiologist Signature : [Signature]

Date & Time : 9/17/2026 9:15 pm

PACU Nurse Name : Swapna

PACU Nurse Signature : [Signature]

Date & Time : 9/17/2026 9:15 pm

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): OB

Date & Time : 9/17/2026 9:15 pm

EPIDURAL ANALGESIA RECORD

Date and Time : 9/7/26 9:15 pm

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

BAH-00641654 IP5-00176119
Mrs POTHULA AKSHITHA
02-07-2003 21 Y O M 7 D (F)
Dr. DR.M PRATHYUSHA REDDY



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Patient Name : Mrs. POTHULA AKSHITHA Gender: ☐ Male ☒ Female Age : 21 years

UHID No : BAH-00641654 Date : 9/7/26

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)

EMERGENCY LOWER SEGMENT CAESAREAN SECTION

upon

(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 bowel & bladder, Need for blood transfusion

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 : R Akshitha

Name : Mrs. Akshitha

Date & Time : 9/7/26; 2:30pm

Witness :

Signature : Pradeep

Name : Pradeep

Date & Time : 9/7/26; 3pm

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

Patient Attendant :

Signature : Pradeep

Name : K. Pradeep Kumar

Relationship with Patient : Husband

Date & Time : 9/7/26; 2:30pm

Doctor (who is taking the consent) :

Signature : Dr. Prady

Name : Dr. Prady

Date & Time : 9/7/26; 2:30pm

CONSENT FOR ANAESTHESIA

Authorization By: ☒ Patient ☐ Patient Attendant

Operative Procedure: Emergency UCs

Anaesthesiologist: Dr. Subhramanyam Surgeon: Dr. Prathyusha

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 Shivering, Ptching, Bleeding.

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: P. Akshitha
Name: Akshitha
Relationship with patient: self
Date & Time: 9/07/26 2:30pm

Witness:

Signature: P. Pradeep
Name: K. Pradeep Kumar
Date & Time: 9/07/26 2:30pm

Doctor (who is taking consent):

Signature: Dr. Sub Name: Dr. Subhramanyam Date: 9/7/26 Time: 2:30pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అబిండెంట్

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 లిస్ట్:

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 అబిండెంట్

- 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 ఇంజక్షన్ 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 అబిండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

BAH-00641654 IP5-00176119
Mrs POTHULA AKSHITHA
02-07-2003 21 Y O M 6 D (F)
Dr. DR.M PRATHYUSHA REDDY



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INDUCTION OF LABOR CONSENT

Name: Akshitha Age: 21 yrs. Gender: Male ☐ Female ☒
UHID.No: 641654 Date: 8/7/2021

You are scheduled for an induction of labor on 8/7/2021 (date) at 38 (weeks of gestation).

The reason for your induction is Term

The goal of induction of labor is to achieve vaginal delivery by starting uterine contractions before the spontaneous start of labor.

Induction of labor for a medical indication is done when continuation of pregnancy is considered detrimental to the health of the mother or fetus. This can be done at any stage of pregnancy irrespective of fetal maturity if there is a valid indication.

Elective induction of labor (scheduled induction without a medical indication) may not be done until you are at least 39 weeks. This is important so that your newborn does not have complications due to possible prematurity.

The alternative to induction of labor is to wait for labor to start spontaneously.

I have read the information provided and also discussed the process with my doctor.

I understand the risks and benefits of this procedure and wish to proceed.

Patient
Signature: P. Akshitha
Name: Akshitha
Date & Time: 8/7/2021; 5:00pm

Patient Attendant:
Signature: Pradeep
Name: K. Pradeep Kumar
Relationship with Patient: Husband
Date & Time: 8/7/2021; 5:00pm

Doctor:
Signature: Dr. Prathyusha
Name: Dr. Prathyusha
Date & Time: 8/7/2021; 4:34PM

Witness
Signature: [Signature]
Name: Sudhakar
Date & Time: 8/7/2021 @ 10pm