



Patient Sticker

SURGERY DETAILS

Date : 22/7/26
Patient Name: Mrs. Gauri Date of Birth: 27-04-1966 Age: 60 Y
Gender: Female Ward: P-57 UHID No: BAH-00559170
Date of Surgery: 22/7/26 ☐ OT-1 ☐ OT-2 ☐ OT-3 ☒ OT-4 ☐ OBG OT-1 ☐ OBG OT-2
Name of the Surgery: LAH + BL Laparotomy

Time in : 9:15 am

Time Out : 12:15 pm

	NAME	AMOUNT
1. Surgeon	Dr. Sasikala	
2. Anaesthetist	Dr. Aditi	
3. Assistant Surgeon		
4. OT Technician	Pashu	
5. Circulating Nurse	Bebi	
6. Assistant Nurse	Pravabhai	

Special Equipment: ☒ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others vesiclex → 9716316
Ligasure → 9716316

Signature of the Surgeon: f. mar (Q. MATHAN)

Signature of Circulating Nurse: J. Ramasani

Order No: 9716315

Order by: J. Ramasani



CONSUMABLES OF OT

Technician : Date : Time :

Anaesthesia Disposables			Surgical Disposables			Disposables (Baby Side)		
Issued	Used		Issued	Used		Issued	Used	
ET tube 7.0/7.5	1	1	Major Pack Drape	1	1	Inj Vit.K		
LMA 3.4	1	1	Sutures			Cord Clamp		
ECG leads A/P/N	5	3	2347	22	4	Suction Catheter		
HME filter: A/P/N	1	1	23/7	2	1	Feeding Tube		
Syringes : 10 cc	20	7				Vaccum Suction Set		
05 cc	20	6	Gloves	1+4	1	Surgical Gloves		
02 cc	20	4	6/12 12 1/2	24	2	Gauze Pack		
01 cc	10	1	PF 6/12 12 1/2	24	1+2	Syringe 1ml / 2ml		
Cautery plate: A/P/N	1	1	Surgical blade		1+2	Surgical Blade # 20		
IV set	1	1	NG tube	1	2	Koochies (S)		
RL	1	2	Cautery pencil			NS 500ml	1	1
NS : 10ml / 100ml / 500ml / 1000ml	1+24	24	Koochies			Transfix	1	1
minisplice	1	1	Ointments			POC scanner	24	4
vaccumset	1	1	Suction Catheter			Self	1	1
Fentanyl	1	1	Cap, Mask	5	1	Any. anaes. 20ml	1	1
Morphine	1	1	Gauze Pack	1	2+4	TURP set	1	1
Ketamine			Mop Pack	1	2	legends	2	1
Propofol	4	2	Sterisrip	4	3	20ml H tube holder	1	1
Rocuronium	2	2	Underpad	1	1	Ribon gauze	1	1
Glycopyrolate	1	1	Draw sheet	1	1	Springs	3	3
Myopyrolate	1	1	Abgel			Adrenaline + Prop	1	1
Ondansetron	1	1	Foleys catheter 12.4	1	1	Ephedrine + PC	1	1
Pencan (25g) Spinal Needle 22	1	1	Urobag	1	1	midazolam	1	1
Bupivacaine 0.25%	1	1	Chest Drainage Catheter			lorazepam (10mg)	1	1
Bupivacaine 0.25%(Heavy)	1	1	Romodrain bag			SEP (1.5Lm)	1	1
Antibiotics			Bandage			Dexmed (100mg)	1	1
lv pcm	1	1	Tegaderm			soctpmolines	24	1
Suppositories			loban			stopcock	2	1
Anamol : 80mg / 250mg / 170 mg			Double J Stent			N.A.C (28,30)	1	1
Supridol : 100mg	1	1	Vaccum Suction set	1	1	O.A (3.4)	1	1
Justin : 12.5 mg / 25mg / 100mg	1	1	Plastic Bed Sheet	1	1	Pyke's 14,16	1	1
Tab. Misoprost : 200mg			Betadine Solution	1	1	Nabal Monoz	1	1
3way 10x100cm	1	1	Microshield	1	1	etho2 (A)		
Glove all + Gauze	44	1	Cotton Balls	1	1	Gauze (A)	1	1
Tranexa + bexa	24	1	Latex Gloves	1	102			
O2 mask (A)	1	1	Ramdione Scrub					
lv cannula 18,20	1	1	Saral	1	1			

ADMISSION SHEET

Registration Details :



Admission No : IP5-00176744

Admit Date : 22-Jul-2026

Admit Time : 06:08 AM UHID : BAH-00559170

Patient Details :

Patient Name : Mrs GAURI REDDY, M
Guardian : Mr NARESH REDDY, M
Gender : Female
Occupation :
Address (H) : 8-2-703 ROAD NO 12 Banjara Hills
Hyderabad Telangana INDIA 500034

Age : 60 Y 2 M 25 D
DOB : 27-04-1966
Religion :
Marital Status : Married
Phone No : 9848043658 / 9686817873
E-mail : nomallid@gmail.com

Admission Details :

Bed Type : DAY CARE

Bed No : RC 406

Ward Name : 4F-GYN RECOVERY

Room No : RC 406

Admission Type : First Visit

Contact Details :

Name : Mr NARESH REDDY

Relationship : Husband

Contact Address : 8-2-703 ROAD NO 12 Banjara Hills Hyderabad
Telangana INDIA 500034

Phone No : 9848043658 / 9686817873

[Handwritten Signature]
Signature

Doctor Details :

Doctor Name : Dr. SASIKALA KOLA

Specialisation : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self

Phone No :

Co-Consultant :

Payment Details :

Deposit Amount : 0.00

Payment Mode : Cash

Payor Name : FAMILY HEALTH PLAN INSURANCE
TPA LTD

[illegible]

3	9716962	key
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This image shows a blank sheet of white paper designed for handwriting practice. It features five sets of horizontal dashed lines, each set consisting of two parallel lines. These lines are evenly spaced across the page to guide letter height and placement. There are no other markings, text, or illustrations on the paper.

Prepared By :

Billing Supervisor



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 22/7/20

Baseline Information:

Admission From: ☐ ER ☐ OPD ☒ Admission Desk ☐ Others, specify

Primary Language: ☒ Telugu ☐ English ☐ Hindi ☐ Others, specify

Do you require an interpreter? ☐ Yes ☒ No if Yes specify

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

Allergies: ☐ Yes ☒ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other:

If yes, identify

Chief Complaints: 1 episode of spotting
plv

Doctor Notified on Admission: ☒ Yes ☐ No

Name of the Doctor: DR. Dinger

Time Notified:

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>HTN</u>	<u>usu.</u> <u>Appendicectomy</u>	

Gynecology Assessment: ☐ Not Applicable Menstrual History: 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
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Obstetric History: G P 1 L 1 A 2

Previous LSCS: 1 CSU

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 Bone Ca⁺

Vital Signs / Measurements: Temp: 98.6 F HR: 80/nt RR: 20/nt
 BP: 130/74 mmHg Weight: Height: BMI:

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

PHYSICAL ASSESSMENT

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

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

Risk of Pressure Sore: ☒ Yes ☐ No Score 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

SOCIAL SCREENING:

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

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

Social History: Lives With Family

Orientation has been given regarding the following aspects:

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

Above information given to patient

Name of Person Orientation was given to: Mr. Guza Reddy

Orientation not given Reason:

Nurse Signature: Key

Nurse Name: Meeyneri

Date & Time: 02/2/2020 at



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 22/7/26 Time of Admission : 6:15 AM

Allergies : N/A ☒ Not know any drug allergies

PRESENTING COMPLAINTS :

- No episode of bleeding spotting plv.
- Since 6/6/26 fibroid.
- 8/7/26 - Ut bulky, anteverted. 11.6 x 8.5 x 7.8 cm.
- hypoechoic lesion of 7 x 4.4 x 6.3 cm in anterior myometrium involving entire uterine body & abutting compressing the endometrial cavity - FIGO - type 3 fibroid ET = 5.6 mm.
- Few nabothian cyst in cervix
- b/l ovaries (N)
- TVS = 8.7 mm.

MENSTRUAL HISTORY

Year of Marriage : 1
Previous Periods : Post menopausal
LMP : x 6 yrs.
Contraception : Regular, heavy menstrual bleeding.

OBSTETRIC HISTORY

Parity : P₁ L₄ A₂ - 1 LSCS
Mode of Delivery : LSCS
Last Child Birth : LCO - 34 yrs. ago.

PAST MEDICAL HISTORY

- HTN x 28 yrs.
- No overactive bladder.
↓
On T. Tamsin 2mg-OD.

PAST SURGICAL HISTORY

→ LSCS x 34 yrs.
→ Appendicectomy x 25 yrs.

FAMILY HISTORY:

1/10/10 breast & lung cancer
 Mothers all 3 sisters had breast CA.

MEDICATION HISTORY:

See reconciliation form.

INITIAL ASSESSMENT:

Date _____	Breasts	Local/Speculum Examination
Ht. _____ Wt. _____		P/S - Cervix & Vagina healthy.
BMI _____	(N)	Bimanual Pelvic Examination
B.P. 150/85 [105]; PR-73		UT ~ 12 weeks; mobile, fornices free.
Pallor _____; SpO ₂ - 100% on RA.	Abdominal Examination	
CVR _____	thick, obese	
Respiratory System (N)	obesity (+)	
Thyroid _____		

PROVISIONAL DIAGNOSIS:

P₁ L₄ A₂ / E previous LSCs - Post menopausal spotting -
 fibroid & endo ET - 10/10 HTN

INVESTIGATIONS ORDERED

13/7/26 ☺ positive
 Hb = 13.8
 Plt = 3.2L
 Tc = 8.6k
 FBS - 89 mg/dl
 Creat = 0.63
 HIV, HbsAg, HCV - NR
 PT = 13.2
 INR = 0.9
 APTT = 32.2
 TSH = 4.2
 CUE - (N);

Urine culture -
 no growth
 chest xray 2d Echo (N)

PLAN OF MANAGEMENT

Admission
 NBM
 PNC
 Prepare route
 drug as charted
 Shift to OT on call
 10 PRBC x send

DR. MAITHRI MALLEMALA
 Registration No. 69919

Name of the Doctor: Dr. Sankala

Date & Time: 22/7/26, 8:00am

Signature of Doctor

Dr. Maithri Mallema
 (Dr. MAITHRI)



OPERATION THEATER NOTES

Patient's Name: Mrs. Gauri Reddy Age: 60 y Gender: ☐ Male ☒ Female
UHID No.: BAH-00559170 Weight: 78 kg Height:

Surgeon :		Asst. Surgeon :	
Anesthetist : <u>Dr. Aditi</u>	OT Nurse: <u>Pratharathi/Boh</u>	OT Technician: <u>Group</u>	
Pre-Operative Diagnosis: <u>P14 A2 c AUB-L (3)</u>			
Surgical Procedure : <u>AUB-L (3)</u>			
Indications for Surgery : <u>→ LAVH + B/L Salpingectomy</u>			
Date : <u>22/07/26</u>	Start Time : <u>9:53 am</u>	End Time : <u>12:50 PM</u>	
Pre Operative Preparations: <u>all pre op medication given</u>			
Post Operative Diagnosis: <u>P14 P00-0 post LAV + B/L Salpingectomy</u>			
Peri-Operative Complications: <u>Nil</u>			
(1) 5mm umbilical port created			
(2) 5mm left lateral port			
Operation Notes: 1) Uterus is 12 weeks size			
2) B/L ovaries and tubes - normal.			
3) B/L Round ligaments and tuboovarian canthens and clamped cut and by			
4) Proceeded vaginally			
Cervix and c vulvum			
Anteriorly UV fold opened			
Posteriorly upper 1/3 of vagina stuck to cervix			
- Careful blunt dissection done and vagina			
Separated from cervix and P00 carefully			

opened

- B/L mackenrodt's and uterosacral clamped cut and ligated
- B/L Uterus clamped cut and doubly ligated.
- Specimen (Uterus + fundus + B/L tubes) Retrieved through incision and dissection
- Vault closed + vicryl in continuous sutures.

Amount of Blood Loss:

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

- Hemostasis checked laparoscopically
- Small serosal tear noticed on the R uterus. tear sutured
- Tissues removed under vision
- Specimen (Uterus with fundus + B/L tubes) sent for HPC
- weight of specimen - 365 grams
- Blood loss - 250ml
- Duration of surgery - 1.5 hours.

Adv

1. NRM
2. Uterus Monitoring as advised
3. Drugs as per chart

Name of the Surgeon: Dr. Sarikala

Signature of the Surgeon: M. A. MATHEW

Date & Time: 12pm, 22/7/20



Patient

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 2pm	<u>POD-0</u> AC - desurey afirell BP - 131/70 mmHg PR - 60/min P/A - soft	<u>Adv</u> 1. NBM 2. vitals - 1/2 hourly till 3pm followed by 2-4 hourly 3. drugs as per chart <u>CR MARTHA</u>
3:30pm		
22/7/26	<u>POD-0</u> AC - desurey afirell BP - 137/73 mmHg PR - 90/min P/A - soft	<u>Adv</u> 1. chart handed forward by soft diet 2. vitals 2-4 hourly 3. drugs as per chart <u>CR MARTHA</u>
U/o good Shift to Room		
antihypertensives as advised based on BP		

noted by Sucha 22/7/26 @ 8pm



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 7:30pm	POD-0 / LAUT + B/L Salpinge 1 episode of nausea O/E Gut fair vitals stable PLA - soft BS (+)	Adv ① Liquid diet ② Monitor vitals & t.h.h ③ Drugs as charted ④ Inform Ss ⑤ w/ abdominal bleeding ⑥ Inform Ss Dr. Deepa
VO - 200ml ad guae on T. Telma 8mg BD T. Cino d 20mg BD		
		Noted by Dr. Rm
23/7/26 7:30AM	POD-1 / LAUT + B/L Salpingeotomy Comfortable Gut / A/E vitals - stable PLA - soft, BS (+) V/E - minimal spotting Can be discharged	Advice ✓ liquids ✓ soft diet ✓ Drugs as charted ✓ Monitor vitals ✓ Ambulation ✓ Inform Ss by Dr. Deepa
VO - 200ml Voided ✓ Flat ✓		

BAH-00559170
Mrs GAURI REDDY M
27-04-1966 60 Y 2 M 25 D (F)
Dr. SASIKALA KOLA

IP5-00176744

Blood group O +ve

Patient



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

RESULT SHEET

Date	13/7/20				
Time					
Hb	13.8				
PCV					
RBC					
WBC	8.6				
N/L					
Platelets	3.2				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.63				
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					

BAH-00559170 IP5-00176744
Mrs GAURI REDDY M
27-04-1966 60 Y 2 M 25 D (F)
Dr. SASIKALA KOLA



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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies: None ☐ Not known any Drug Allergies

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

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

Shifting From: ICU Shifted to: 314

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	<u>T. TELMA</u>	<u>80mg</u>	<u>PO</u>	<u>100.</u>	<u>21/7/20</u>	☐ C ☒ DC
2	<u>T. SILCA</u>	<u>20mg</u>	<u>PO</u>	<u>101</u>		☐ C ☒ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Smita Smita

Date & Time: 22/7/20 7:45 AM

Nurse Name & Signature: Neelgi my

Date & Time: 22/7/20 at 6:00

Weight Ward

Patient Sticker

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																				



DRUG CHART

Date of Admission: 22/7/24 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name _____ Signature _____

Weight. 78 kg Ward.

Page: 2/4



Weight. 78kg Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
22/7	9 AM	INJ CEFOTAXIM	1g	IV	Srth	ney deshy
22/7	8:15 AM	INJ PANTOPRAZOL	40mg	IV	Srth	ney deshy
22/7	10:00	INJ MORPHINE	4.5mg	IV	Aditi	ney deshy
22/7	10:15	INJ MORPHINE	3mg	IV	Aditi	ney deshy
22/7	10:30	INJ PARACETAMOL	1gm	IV	Aditi	ney deshy
22/7	12:00	PRAMIDOL	100mg	PR	Aditi	ney deshy
22/7	12:00	NSCLOFENAZ	100mg	PR	Aditi	ney deshy
22/7	4 PM	INJ ZOFER	8mg	IV	ney	monito 4:30p Sneha

Weight. 78 kg Ward.

[illegible]

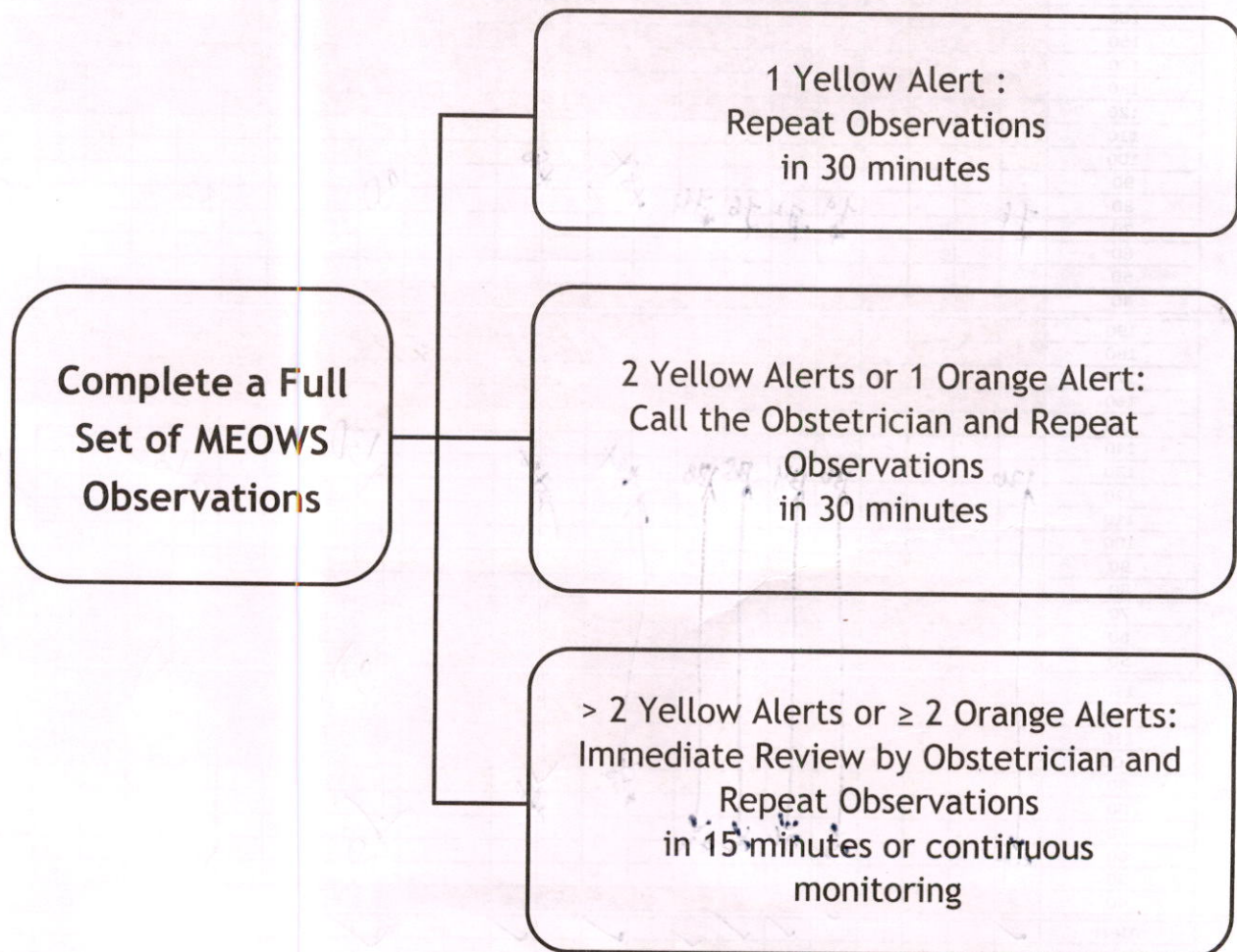
r. SASIKALA KOLA



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

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : ①

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am									100ml	0	Reg
	09:00 am	RL	H	100ml							0	
	10:00 am		P	100ml					200ml	0		
	11:00 am		O	100ml						0		
	12:00 pm			100ml					200ml	0		
	01:00 pm			100ml						0		14
Total Intake :						Total Output : M-0 U-500ml						
	02:00 pm	RL	H	100ml						0	Sub	
	03:00 pm		water	200ml					400ml	0		
	04:00 pm	RL		100ml						0		
	05:00 pm		H ₂ O	100ml					100ml	0		
	06:00 pm	RL		100ml						0		
	07:00 pm		H ₂ O	100ml					200ml	0	Sub	
Total Intake :						Total Output : M-0 U-700ml						
	08:00 pm			100ml						0	Rim	
	09:00 pm		H ₂ O	100ml						0		
	10:00 pm	RL		100ml						0		
	11:00 pm			100ml						0		
	12:00 am		H ₂ O	100ml						0		
	01:00 am								600ml	0	Rim	
Total Intake :						Total Output : U-300ml M-0						
	02:00 am			100ml						0	Rim	
	03:00 am		H ₂ O	100ml						0		
	04:00 am			100ml						0		
	05:00 am	RL		100ml						0		
	06:00 am		H ₂ O	100ml					300ml	0		
	07:00 am									0	Rim	
Total Intake :						Total Output : U-300ml M-0						
Total 24 hrs. Intake			1800ml			Total 24 hrs. Output			U-2100ml M-0			

FLUID CHART

Sheet No. :

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

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

BAH-00559170 IP5-00176744
Mrs GAURI REDDY M
27-04-1966 60 Y 2 M 25 D (F)
Dr. SASIKALA KOLA



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 22/2/26

Assessment: * Fear & Anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
6:45A	→ play for m'tes	6:50A	→ 1 printer m'tes chud done	→ 1 patient is
7A	→ play for skin preparation	7:10A	→ skin preparation done	conclude
7:15A	→ play for 2v centralization	7:30A	→ 2v centralization done	→ m'tes start
8A	→ play for 2v fluid	8:05A	→ 2v fluid re on flow	
8:15A	→ to Administer medication as per as order.	8:20A	→ Administer medication as per as order.	
9A	→ to provide psychological support	9:05A	→ provide psychological support given.	

Re-Assessment:

Special Notes:

repo * 2v fluid re on flow

* 2v fluid re on flow * 10 PRBC received done

Nurse Signature:

Neeyan

Nurse Name:

Neeyan

Date & Time:

22/2/26 at 10AM.

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NURSING CARE RECORD

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: Fear & Anxiety

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
12pm	→ to Assess the patient condition.	12:10pm	→ Assessed the patient condition.	Patient is comfortable - vitals stable
12:15pm	→ to monitor vital signs.	12:20pm	→ Monitor vitals checked done	
12:30pm	→ to Monitor 210 Count	1pm	→ Monitor 210 Count	
1:20pm	→ NPO	2pm	→ NPO	
2:30pm	→ to Administer medication as per order.	2:40pm	→ Administer medication as per order.	
3pm	→ to provide psychological support	3:15pm	→ provided psychological support given	
	→ plan shift to noon.		→ shift to noon.	

Re-Assessment:

Re-Assessment done

Special Notes: * NPO * 210 fluid RL on a low

Nurse Signature: Neeraj

Nurse Name: Neeraj

Date & Time: 22/7/26 at 10pm

AH-00550170 IP5-00176744
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 27-04-1966 60 Y 2 M 25 D (F)
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NURSING CARE RECORD

Rainbow
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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: patient is having a bit of discomfort

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
4pm	* patient shift to Room	4:30 pm	* patient shifted to Room	* now patient condition is stable.
4:10pm	* Assess the patient condition and vitals check	4:15 pm	* Assessed the patient condition and vitals checked	
4:30pm	* monitor the I/O chart	4:35 pm	* monitored the I/O chart	
5pm	* maintain personal hygiene	5:30 pm	* maintained the personal hygiene	
6pm	* Administer medicine as per chart	6:30 pm	* Administered medicine as per chart	
7pm	* Ensure Safety	7:30 pm	* Ensured Safety	

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

Special Notes: nil

Nurse Signature: _____ Nurse Name: Sneha - 607635

Date & Time: 22/7/26 @ 8pm

NURSING CARE RECOR

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 22/7/26

Assessment: Patient is having Discomfort.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8 pm	Assess the general condition of the patient.	8:30pm	Assessed the general condition of the patient.	Now is Patient stable.
10pm	Monitor the vitals.	10:30pm	vitals checked and recorded.	
11 pm	Administer the medication as per Drug Chart.	11:30pm	Administered the medication as per Drug Chart.	
5 Am	Maintain the I/O Chart.	5:30Am	Maintaining the I/O Chart.	
7pm	Ensure the Safety	7:30Am	provided the side rail up.	

Re-Assessment: Re-Assessment done 4th hly vitals.

Special Notes:

Nurse Signature: Riw

Nurse Name: Riw

Date & Time: 23/7/26 @ 8 Am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sasikala Department: CYN Date of Admission: 22/7/26

SITUATION	Diagnosis: <u>P.L. A2 LSC.</u>		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:			
	Area	Shift Time	<u>away</u> <u>3-30 PM</u> <u>2nd floor</u> <u>Room 81</u>	<u>3rd Floor</u> <u>Room 81</u>		
BACKGROUND	Medical Condition (Any special condition to be noted):		<u>HTN</u>	<u>HTN</u>	<u>HTN</u>	
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp: <u>98.6°F</u>	<u>97.6°F</u>	<u>98.1°F</u>		
	Res:	<u>20w</u>	<u>22bmt</u>	<u>24blm</u>		
	SpO ₂ :	<u>100%</u>	<u>100%</u>	<u>100%</u>		
	Pulse:	<u>86wt</u>	<u>88bmt</u>	<u>80b/m</u>		
	BP:	<u>142/76</u>	<u>124/88</u>	<u>130/80</u>		
	Fall Risk Score:	<u>35</u>	<u>35</u>	<u>35</u>		
Recommendations	Safety Needs:	<u>side</u> <u>bar</u>	<u>side</u> <u>rails</u>	<u>side</u> <u>rails</u>		
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:	<u>-</u>	<u>-</u>	<u>NA</u>		
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:	<u>-</u>	<u>-</u>	<u>NA</u>		
Post Operative Procedure Special Orders:		<u>clavicle</u> <u>at 4pm</u>	<u>NA</u>	<u>NA</u>		
Handed Over By Name :		<u>Key</u>	<u>Sushu</u>	<u>Rim</u>		
Signature :		<u>Key</u>	<u>Sushu</u>	<u>Rim</u>		
Date:		<u>22/7/26</u>	<u>22/7/26</u>	<u>23/7</u>		
Time:		<u>4 PM</u>	<u>8 PM</u>	<u>8 PM</u>		
Taken Over By Name :		<u>Sushu</u>	<u>Rim</u>	<u>Sushu</u>		
Signature :		<u>Sushu</u>	<u>Rim</u>	<u>Sushu</u>		
Date:		<u>22/7/26</u>	<u>22/7/26</u>	<u>23/7/26</u>		
Time:		<u>8:15 PM</u>	<u>8 PM</u>	<u>8 AM</u>		

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

BAH-00550170 IP5-00176744
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BRADEN 'Q' SCALE

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				Date :	22/7	23/7		
				Time :	8A	8Am		
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4		
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4		
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4		
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4		
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4		
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
TOTAL SCORE					20	20		
Evaluator's Name					Arim			

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

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

BAH-00559170

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Mrs GAURI REDDY M

27-04-1986 60 Y 2 M 25 D (F)

Dr. SASIKALA KOLA



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
22/7/26	8A	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	—	Keypuri
22/7/26	10Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suehu
22/7/26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suehu
22/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suehu
22/7/26	5pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Inj: PCM not given	Suehu
22/7/26	7pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Suehu
23/7/26	1Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rino
23/7/26	6Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Rino
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

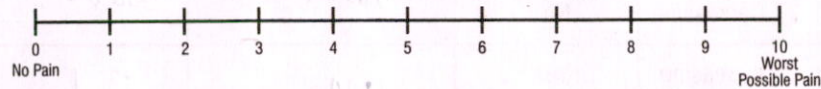
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

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





CHECKLIST FOR THROMBOPHLEBITIS

22/7/26

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

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

Signature of Shift In Charge :

Signature : Name :

Signature of Ward In Charge :

Signature : Name :

BAH-00559170

IP5-00176744

Mrs GAURI REDDY M

27-04-1986 60 Y 2 M 25 D (F)

Dr. SASIKALA KOLA



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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	22/7/26	23/7/26	Fall Risk Grading		
		Score	8:00 to 8:30 pm	8 pm - 8 AM			
History of Falling (immediately or w/in 3 months)	Yes	25			Risk Level	Morse Fall Score (MFS)	Action
	No	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	Low Risk	0 - 24	Standard Fall Precaution
	No	0					
Ambulatory Aid	Furniture	30			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15					
	None /Bed Rest /Nurse Assist	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0					
GAIT / Transferring	Impaired	20			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0	0	0			
Mental Status	Forgets limitations	15			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0			
Total Morse Fall Scale Score:			35	35			
		Signature	Key	Rim			

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-00559170

IP5-00176744

Mrs GAURI REDDY M

27-04-1966

60 Y 2 M 25 D

(F)

Dr. SASIKALA KOLA



MULTI-DISCIPLINARY PLAN OF CARE FORM

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Post menopausal spotting & fibroid.

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
22/7/26 4:45 AM	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☒ Modified ☒ Per-Op ☐ Post Op	Post menopausal spotting & fibroid	Fibroid uterus removed	ZARH + B/L Salpingectomy	Srkte	☐ Nursing ☐ Others:
22/7/26 8A	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☒ Per-Op ☐ Post Op	MPO very dense	to mention w/ mydent	200 mg d RL on P/L	SR	☐ Medical ☐ Others:
22/7/26 4:30 PM	☐ Medical ☐ Nursing ☒ Others: hichin	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	post-op vaginal hysterectomy	soft diet @ 5 PM	soft diet	SR	☐ 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:

FAMILY EDUCATION RECORD

Part - I,

Part - I,
Patient's / Learner Language : Telugu English 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 | 14. Activity / Exercise |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 15. Social Rehabilitation Needs |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 16. Special Discharge / Follow-up Education / Coping Skills |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's Family Rights | 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		
22/7/26		7:45am	23, 4	Dr, As & Plan P lane, Pain management, Wound care	PT, S	1	0	1	1		<i>[Signature]</i>
22/7/26		8am	215 612	patient taught regarding to inherit control measures	pt	1	0	1	1	-	<i>[Signature]</i>
22/7/26		4:30pm	9	Soft diet	pt	1	0	1	1	-	<i>[Signature]</i>

Part - III : CODES

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

BAH-00559170 IPS-00176744
Mrs GAURI REDDY M
27-04-1966 60 Y 2 M 23 D (F)
Dr. SASIKALA KOLA



DISCHARGE PLANNING FORM

Nationality: INDIAN

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

1. Anticipated Date of Discharge: As per as doctor advised
2. Destination Post Discharge: ☒ Home
Family Members Notified (Person Contacted)
☐ Transfer
Hospital Facility Notified (Person Contacted)
3. Discharge Status: ☐ Self Care ☒ Family Home Care ☐ Home Professional Assistance
- ☐ Needs Assistance In:
- | | | | |
|-------------------------------------|------------------------------|--|---|
| ☐ Medication | ☐ Yes | ☒ No | <div>Remarks</div> <p><u>no need assistance</u></p> |
| ☐ Bathing | ☐ Yes | ☒ No | |
| ☐ Eating | ☐ Yes | ☒ No | |
| ☐ Walking | ☐ Yes | ☒ No | |
| ☐ Dressing | ☐ Yes | ☒ No | |
| ☐ Toileting | ☐ Yes | ☒ No | |
4. Nutritional Plan:
☐ Dietary Instruction Discussed with the:
☒ Patient ☒ Family Member ☐ Others:
5. Discharge Planning Discussed with the:
☐ Patient ☒ Family Member ☐ Others:
6. Patient/Family Educational Plan:
☐ Educational Topic/s: personal hygiene
☐ Patient's Educational Topic/s discussed with the:
☒ Patient ☒ Family Member ☐ Others:

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date and Time:

PATIENT TRANSFER FORM

Patient Name & UHIN No. BAH-00559170 Mrs GAURI REDDY M 27-04-1966 60 Y 2 M 25 D (F) Dr. SASIKALA KOLA 		Date & Time of Admission 22/7/26 at 6:08 AM	Date & Time of Transfer Order 22/7/26 at 3:30 pm Dr. Muthus
		Transfer Ordered by Dr. Muthus	Reason for Transfer observation
From Unit CYN	To Unit 314	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?	Patient shifted with ID band: Yes ☒ No ☐ If No:	
Number of Imaging Films	Medications / Consumables / Surgicals / Hand over		
SI.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Dr. Meyni		Name of Person Ordered Transfer Dr. Muthus	
Patient & Clinical Records Received by : Sushu			
Date & Time of Patient Received : 22/7/26 @ 3:50 pm			

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

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

Patient Sticker

BAH-00559170 IP5-00176744
 Mrs GAURI REDDY M
 27-04-1966 60 Y 2 M 25 D (F)
 Dr. SASIKALA KOLA

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 22/7/20

Department : P-OT Duration of Procedure : 2m

Name of Surgeon : Dr. Sasikala Date of Admission : 22/7/20

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☒ Yes ☐ No Name of the Antibiotic : 1m - Taxim 1gm	
2.	Hair Removal ☒ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☒ Yes ☐ No	
3.	Patient's body temperature immediately post operation (Recovery Room) 33 °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	
4.	Name of doctor or staff administering the antibiotic : Nayan K Date & Time of antibiotic administration : @ 9 AM, 22/7/20 Date & Time procedure started : @ , 22/7/20	

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

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Sasikala
 Asst. Surgeon : Dr. Aditi
 Anaesthetist : Dr. Aditi
 Scrub Nurse : pranathi, Bebi

BAH-00559170 IP5-00176744
 Mrs GAURI REDDY M
 27-04-1966 60 Y 2 M 25 D (F)
 Dr. SASIKALA KOLA



Age : 60y Gender : F
 Name : LAVH + BK Selvaraj
 Out-time : 12pm



22/7/26 9:15 AM

Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN	Time: <u>9:12</u>
Patient Has Confirmed	
Identity	☒ Yes ☐ No
Site	☒ Yes ☐ No
Procedure	☒ Yes ☐ No
Consent	☒ Yes ☐ No
Site Marked	☐ Yes ☐ No ☒ NA
Anaesthesia Safety Check Completed	☒ Yes ☐ No
Pulse Oximeter on Patient & Functioning	☐ Yes ☒ No
Does Patient have a:	
Known Allergy?	☐ Yes ☒ No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	☒ Yes ☐ No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	☒ Yes ☐ No ☐ NA
Blood Units Reserved	☒ Yes ☐ No ☐ NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	
	☒ Yes ☐ No ☐ NA
Signature : <u>Aditi</u>	
Name : <u>Dr Aditi</u>	

TIME OUT	Time: <u>9:53am</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	☒ Yes ☐ No
Correct Site	☒ Yes ☐ No
Correct Procedure	☒ Yes ☐ No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? <u>monopausal bleeding</u>	
☒ Yes ☐ No ☐ NA	
Anaesthesia Team Reviews: <u>Hypertension</u>	
Are There Any Patient-specific Concerns? <u>bleeding</u>	
☐ Yes ☐ No ☐ NA	
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	
☒ Yes ☐ No ☐ NA	
Is Essential Imaging Displayed?	
☐ Yes ☒ No ☐ NA	
Power Supply, Earthing, Power Backup and functioning of equipment checked.	
☐ Yes ☒ No	
Signature : <u>Swapna</u>	
Name : <u>Swapna</u>	

SIGN OUT	Time: <u>11:50</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	☒ Yes ☐ No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA
The Specimen is Labelled (including patient name)	☒ Yes ☐ No ☐ NA
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient?	
☐ Yes ☒ No	
Signature : <u>Manu</u>	
Name : <u>(Dr. Manu)</u>	

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Mrs GAURI REDDY M
27-04-1966 60 Y 2 M 25 D (F)
Dr. SASIKALA KOLA

Patient St




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POST-SURGICAL CARE PLAN FORM

Procedure Done: LAVH + B/L Salpingectomy
Post-Surgical Diagnosis: P.Y.A. - POD-0 post LAVH + B/L Salpingectomy

Post-Operative Monitoring Parameters /Frequency:

BP, PR, Urin output - $\frac{1}{2}$ hourly for 2 hours
followed by 2nd hourly

Wound Care:

Nil

Drain /Special Lines/Catheters:

IV cannula
foley's

Special Patient Positioning and Requirements:

li's

Nutritional Instructions:

on POD-1 after foley's Removal

When to Start Mobilization:

liquid diet followed by soft diet
after 4 hours

Special Referrals:

Nil

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

☒ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

(Dr. MATHEW)

Date: 22/7/16 Time: 12pm

Note: Plan of care will be readjusted if necessary.



Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Gauri Reddy Age: 60 yrs Sex: F UHID.No:
Date: 15/7/26 Time: 10 Am Proposed Operation: LAH + B/L salphingoctomy
Diagnosis: fibroid / menopause
B.P / CRT: 157/104 H.R: Weight: 78 kg ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 13.8 Glucose: 89 mg/dl Protein: HIV: X-Ray: Normal
PCV: NIL - 33/60 Urea: Alb: HBS Ag: 1 NR ECG: LVIH / NHR
WBC: Creat: 0.62 Total Bill: HCV: 2D Echo: concentric LVH
Plate: 3.22 Na: Dir. Bill: Blood group: O +ve Stress/Angio: Grade 1
PT: 13.2/10.9 K: LDH: T3: Other:
PTT: 32.2 Ca++: Alk phos: T4:
INR: 0.9 Mg++: Amylase: TSH:
Cl -: SGOT/SGPT:

Allergies:

nil

Medical History: CVS :

HTN @ 28 years

RESP :

Diabetes :

CNS :

USG fibroid - 7x4.4x6.3cm

Renal :

Type - 3 fibroid

Hepatic / GE :

normal

Physical Activity:

METS 74

Others :

Past Anaesthetic History:

⊕ appendicectomy 25 years back

Physical Exam:

Airway:

MP 1 2 3 4

Mouth Opening:

> 2 cm

Mentohyoid Distance:

⊕

Neck:

⊕

Teeth:

crooked on the back teeth

Lungs :

Heart:

CNS:

normal

Pregnant: ☐ Yes ☒ No ☐ NA

Venous Access Site : ⊕

Spine Exam for regional : ⊕

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

Serial monitoring of BP @ home

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

if DBP > 100 → Physician → medication

CURRENT MEDICATIONS	DOSAGE
<u>Telma</u>	<u>80mg - 1 to 1</u>
<u>Aspirin</u>	<u>20mg daily 1 to 1</u>

Pre-Operative Instructions:

- DVT Prophylaxis : Water / ORS 2 Hours | Explained
- NIL ORAL Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions: * To Resume 10 PRBC

Signature: Dr. Shree

Name: Dr. Shree



ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition:

☐ Yes ☒ No

Fasting Status:

Adequate

Physical Status:

☒ Patient Identified

☒ Consent Present

☒ Chart Reviewed

H.R.: 74/min

B.P./CRT: 150/88

SpO₂: 98 on RA

R.R.: 216

Last Feed: 76 hrs

Pre-OP Diagnosis:

Operation: LAVH + SALPINGECTOMY

Date: 12/7/26

Surgeon:

Dr. Chushikola

Anaesthesiologist:

Dr. Aditi

Technician:

Ramushyona

TIME

N₂O / A/R / O₂ / LPM

HALO / SEVO

Drugs:

INT MIDAZOLAM 2mg

INT FENTANYL 100mcg

INT PROPOFOL 100mg

INT ROCURONIUM 10mg

INT MORPHINE 7.5mg

INT KETOROLAC 10mg

INT Dexamethasone 8mg

INT Atropine 1mg

INT ECG

Temperature

Urine Output

Fluids

Blood

B.P.

V Systolic

A Diastolic

X Mean

• Heart Rate

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

LAB Values

ABG

GRBS

Others

Equipment Checked and Functional

BP

Cuff Site:

Art Site:

EKG Lead

Temp Site

FIO₂ Monitor

Agent Monitor

Pulse Oximeter

Capnograph

Ventilator

Nerve Stimulator

Position: Supine

Pressure Points Checked

Eye Care:

Oint

Tape

Padding

Awake

Temp:

HME

Cling Film

Hugger's

Other

Times:

Anaes Start: 9.20

OP Start: 9.40

OP End:

Leave OR:

Anaesthesia:

GA

Monitored Anaesthesia Care

Regional

Line (Size & Location)

CVP:

ART:

IV: RUC

IV:

IV:

IV:

IV:

IV:

Induction

IV

Pre O₂

Others

Mask 3

Airway

ETT # 7

Oral

Tracheostomy

Drug: RAUCORNIUM

Awake

Video Laryngoscopy

Fiberoptic

Blade # 3

Attempts: 1

Difficulty Why?

Difficulty Why?

Difficulty Why?

Difficulty Why?

Difficulty Why?

Difficulty Why?

Difficulty Why?

Difficulty Why?

Difficulty Why?

Difficulty Why?

Difficulty Why?

Regional:

Extremity

Spinal

Others:

Position:

Site:

Needle Size:

Parasthesia

Catheter at skin

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Specify:

Epidural

Caudal

Others:

Position:

Site:

Needle Size:

Parasthesia

Catheter at skin

Drug Name & Conc:

Bolus:

Infusion:

Block Level:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Comments:

Name of the Doctor: DRADITIN

Signature of the Doctor:

BAH-00559170 IP5-00176744
Mrs GAURI REDDY M
27-04-1966 60 Y 2 M 25 D (F)
Dr. SASIKALA KOLA

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Dr. Neeyan Time Received: 12:15 PM Time Discharged: 3:45 PM

BLOOD PRESSURE PULSE RESP	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	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: <u>right hand</u> ☐ O ₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway Vomiting: ☐ Yes ☒ No Drug: _____ NG Tube: ☐ Yes ☒ No Drain: ☐ Yes ☒ No Urinary Catheter: ☒ Yes ☐ No Chest Tube: ☐ Yes ☒ No Nil Oral ☒ Yes ☐ No IV Fluids: <u>RL on flow</u> 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	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							
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 $\pm$ 20 of Pre Anaesthetic level	= 2	CIRCULATION	2	2	2	2		
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1							
BP $\pm$ 50 of Pre Anaesthetic level	= 0							
Fully awake	= 2	CONSCIOUSNESS	1	1	2	2	2	
Arousable on calling	= 1							
Not responding	= 0							
Pink	= 2	COLOR	2	2	2	2	2	
Pale, dusky, blotchy, jaundiced, other	= 1							
Cyanotic	= 0							
TOTAL			8	9	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
22/7/26	12pm	0/10	on sedation	key
22/7	2pm	0/10	no intervention	key
22/7	4pm	0/10	no intervention	key

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

Anaesthesiologist Name: Dr. De

Anaesthesiologist Signature: [Signature]

Date & Time: 22/7/26 at 4pm

PACU Nurse Name: Neeyan

PACU Nurse Signature: [Signature]

Date & Time: 22/7/26 at 1:45pm

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 medication

EPIDURAL ANALGESIA RECORD

b)

[illegible]

connected:

Patient Sticker

Gami Goy

314

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NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 22/7/26

Time: 4:30pm

Origin: India

Height: 155cm

Weight: 78kg

BMI: 33.3 kg/m²

Food Allergies: No

Diagnosis: p.o.b vaginal hysterectomy

Medical History: HTN X 26yrs.

Surgical History: LSCS + Appendectomy

☒ Vegetarian

☐ Non-Vegetarian

☐ Vegan

Diet Advised: soft diet @ 5pm

Patient's / Attendant's

Signature: [Signature]

Name: Blunt

Date & Time: 22/7/26 4:30 pm

Dietician's

Signature: [Signature]

Name: [Signature]

Date & Time: 22/7/26

4:30pm

DIETARY NOTES

[illegible]