

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176765 Admit Date : 22-Jul-2026 Admit Time : 12:44 PM UHID : BAH-00660232

Patient Details :

Patient Name	: Dr. DARIVEMULA TEJASWINI	Age	: 31 Y 6 M 17 D
Guardian	: Dr. NAGIPAGU SUVARNA NAIDU	DOB	: 05-01-1995
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Married
Address (H)	: Flat no 506 A block Ambience courtyard Survey No. 4, opposite Dream Valley, Tanasha Nagar, Manikonda, Telangana Manikonda Hyderabad Telangana INDIA 500089	Phone No	: 9666994996/ 9666994996
		E-mail	: Suvarna.naidu789@gmail.com

Admission Details :

Bed Type : SHARED WARD Bed No : SW 416 Ward Name : 4F-BIRTHING CENTRE
Room No : SW 416 Admission Type : First Visit

Contact Details :

Name : Dr. NAGIPAGU SUVARNA NAIDU Relationship : Husband
Contact Address : Phone No : / 9666994996


Signature

Doctor Details :

Doctor Name : Dr. NIVEDITHA CHALMEDA Specialisation : INTERNAL MEDICINE
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

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

ACTIVITY RECORD FOR BILLING

Name : _____ BAH-00660232 IP5-00176765
Dr. DARIVEMULA TEJASWINI
05-01-1993 31 Y 6 M 17 D (F)
Dr. NIVEDITHA CHALMEDA
UHID No. : _____ IP I  Int: _____ Dept : _____
Date of Admission: _____ Time : _____ Date of Discharge : _____ Time: _____
Room / Bed No : _____ Ward : _____ Suggested Billable bed type : _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

[illegible][illegible]

[illegible]

Date _____

Name of Equipment

Connecting Time

Disconnecting Time

Order No.

Signature

22/

Expansion pump

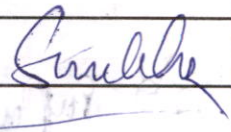
CPM

Leafh

09716832

Smell ha

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
22/7	IV placement order	1	09716831	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

do need BP recordings at home

Obstetric Formula:

Primu

Obstetric History:

Present Pregnancy Record:

Primu - IVF (unep Confidential)
Booked at 26 weeks

RISK FACTORS:

- IVF (Confidential)
- GHTN - 250Ks
- GDM m diet - 250Ks
- cerclage done C@ (6 weeks)
- Hypothyroid
- Early FGR, placenta
- central placenta previa

Height: 157 cm

Weight: 67 kg

Allergies: NKDA

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: fair

Icterus: absent

Temp: 96.6

BP: 122/80 mmHg (at)

CVS: 9.5/10

Liver/Spleen: not palpable

Urine Output: Normal, 500-600 ml/day

DIAGNOSIS

Primu 30wks/IVF / severe PG / GDM m diet / cerclage done /
Hypothyroid / FGR - doppler changes / central placenta previa
for observation / delivery

LMP: 24/12/25

EDD: 30/12/26

Corrected EDD: 30/12/26

GA: 30wks

Menstrual History: Regular: ☒ Yes ☐ No

Obstetric Examination

Fundal Height: 36w 30wks

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech Others

Head Fifts Palpable: u/r

FHS: ☐ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

- not done

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

- not done

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed Dilated

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful



Family History:

Parents - DM, HTN

Surgical History:

cerclage at 16 weeks

Medical History:

Hypothyroid: 2021
H/o TPO Antibodies +ve
Used HCC till ~12 weeks / 16 weeks

Medication History:

see medical
reconciliation form

Plan of Care:

- admission
- Trace CBP, LFT, PT/INR, APTT,
LDH, Sr. Urine accel, Spot PCR
Ratin,
Sr. Electrolytes, Sr. Creatinine.

- drugs as prescribed
- vitals regularly
- I/O charting
- NST-BD.
- FHR by doppler. q 4hly.
- W/F s/s Imminent
Eclampsia
- Stat ARBS → Symptol.

Investigations:

A positive

30/6 - CBP - 11.2 / 12.80 / 14.52
Sr creat - 0.6, LDH - 162
Spot PCR - 0.13
LFT - (N), SGOT / SGPT -
30.7 / 31.7.

Urab - NA.

4/6 - 28+4 wks, Bxch, 966 gm, (2-1.)
AC < LC, doppler - vRistance in
Blood flow + EHR, cerebral redistribution
Placenta - central placenta previa

30/6 - 2DECHO (N), EF - 68%, Fetal
ECG (N) MR/TR

22/6 - MRI + MEV Brain - headache.
(N) Arachnoid granulation
local narrowing of @ distal
transverse sinus.

Doctor Name: Dr. [Signature]

Signature: [Signature]

Date & Time: 22/5/20 @ 11:45 pm

Consultant Name: Dr. Niveditha

Signature: [Signature]

Date & Time: [Blank]

Date & Time	Progress Notes	Doctor's Order
21/6	- 29+6 wks, AFI 9.8cm. (se), placenta - posterior extending anteriorly, concealing the os, - central placenta previa. - Marginal and insertion at lower edge of placenta - no elo vasa previa - dopplm - fetal resistance to blood flow in umbilical artery & preDf & cerebral redistribution & (N) PR dopplm. - fetal resistance in ut. artery.	
	previous ANC @ Fernandez, screen +ve PE cerclage at 16 wks oplo short cervix MTAS: placenta previa Admitted 19.6.26 to 21.6.26 - oplo headache. MRS PMRV (N)	

Dr. NIVEDITHA CHALMEDA



PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



swini



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>22/7</u>	<u>Labs</u>	
	CBD $\rightarrow$ 11.7 / 15.750 / 3.82 L LDH - 158 Uric Acid - 5.6 CFI - TB < 0.2 0.1 ALP - 182 SUOT / SUP1 - 27 / 21 Na⁺ / K⁺ / Cl⁻ - 132 / 5.2 / 105 Creat - 0.6 spot PCR - 2.54	
	c/I/t Dr. Niveditha	Dr. Bhargavi
		Adv
	PR - 86 bpm BP - 180 / 109 mmHg SpO₂ 99% on RA	- Start IV - My 500 loading dose flb maintainance dose. for 24hrs - vitab and they - 2lb sterchably - Tab Labetalol 20mg PO Ant - ECG now - big steroid cover - Pre & post meal sugars ↓ Inform Dr. Niveditha



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/2/26 7:30 PM	C/Dfw - Dr. Niveditha Primi / 30w / Severe PE / GDM on diet Cerebral cysts, hypothyroid, FGR Doppler changes, central placenta previa for observation	
	NO Complaints	
U/O: 350 ml / 3w	G.C: per	1) Monitor vitals - 4/day
	R.P: 124/83 (96)	Temp if BP > 140/90
NI ST rectal @ 2 PM	P.R: 84 bpm	PR > 100 bpm
	SpO ₂ : 100% on RA	SpO ₂ < 98% on RA
G.RBS → 148 mg/dl	P/A: ut 30w	U/O < 30 ml / w
ECG ✓	relax	2) Tendon reflex
	FHR ⊕	3) w/f S/S of T.E
(+ Spot PCR + 2.54)		4) Pre & post meal sugar - Pufudr.
	NGT on flow	Niveditha
	ON T. Labetal 200mg TID	5) soft diet & plenty of oral fluid
NVC ✓	T. Nicardipine 20mg TID	6) Insulin 8u
Dr. Niveditha	Tab. Isolazine BD 1 tab	Dr. Subh.
@ 2 PM	Tab. Isolazine B.D 1/2 tab	
	T. Odipiv: 300mg OD	
	1st dose of steroid given at 3:40 PM	

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/1/2026 6:30 PM	C/S/B Dr. Bhargavi Vitals - BP - 145/97 (112) PR - 86 bpm SpO₂ - P/A - VTEMS relaxed FHR on Doppler. MySO₂ on flow 2nd dose steroid - 3:40 AM (23/1/26). NVC ✓ patient counseled regarding need to consider delivery following steroid if BPs uncontrolled. ✓ EBP, WHE & electrolytes, Spot PCR - 6 AM (23/1/26). ✓ Atst Dopplers (23/1/26) by Ch. Kupikars.	C/O/W Dr. Niveditha Tab. Isolazine 1/2 tab. PO - STAT ✓ to make T-Isolazine 1 tab TID.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 10:30pm	primi / 3ocelli / Serum pE / GDM on dte p1 complete no imminent sign. O/E Aetia on	Adv ① continue MgSO4 ② I/O charting ③ Monitor BP end hly ④ Drugs curve ⑤ Inform sos
MgSO4 on flow Till 4pm 23/7/26. 2nd steroid - 3:40pm 23/7/26.	Bp - 131/71 (q1 hly) PR - 70 bpm SPO2 - 98% RA PIA - ut relaxed FHR ⊕	
OU	Labetalol 20mg TID Nifedipine 20mg TID L-Ascorbic acid 1 tab POTID	Drugs
	CBP / Spot PCR / LFT / SIE - 23/7/26 (q1 hly)	
23/7/26 12:00 AM	Bp - 130/100 (q8) PR - 74 bpm SPO2 - 98% RA PIA - ut relaxed FHR ⊕	No imminent symptoms. 153/100 Adv Tab. isolarine given now. ① CST ② Inform sos.
VO - A6ome		
2nd 3 AM - steroid	Spot PCR / Serum electrolytes / 23/7/2026 ARI + Dopplers → Drugs	
	Early breakfast → NBM from 6 AM.	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26 2:00 AM	O/E NO imminent sign of PG Ci fair Bp-144/100 (144/100) Adv PR-84Bpm SPO₂ 98% RA PIA - ut relaxed JHR	① Monitor BP 2nd hourly ② Inform SAs ③ void measurement
		Dr. Diya
23/7/26 4:00 AM	O/E Ci fair Bp-145/100 (145/100) Adv PR-85Bpm SPO₂ 99% RA PIA - ut relaxed	① T. Nicardia 20mg po/stat ② Monitor BP 2nd hourly ③ self void measure ④ Inform SAs
		Dr. Diya

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7/2026 5:30 AM	Prim: 30wks / severe pF / GDM on diet Cerebral Insult / Hypothyroid, FGR Doppler changes, central placenta previa for observation.	Monitor vitals x 2nd mly Adv. FHR x 2nd mly
NNC ✓ (Dr. vijayamodi) steriod ✓ Mgso4 (till 4:00pm) ECG ✓	Gr. fair Bp = 135/96 (112) PR = 86 bpm Spa = 98/100 RA PLA - ut relaxed FHR 9	① Early breakfast. 11b & BMI ② AF 1 + Dopplers scan today ③ Spot PCR + SLE Send 1 trace ④ pre and post mce suga & Inform Dr. Niveditha. ⑤ wif BP > 140/90 & Inform. ⑥ Drugs as charted ⑦ voiding measurement. ⑧ wif Deep tendon reflexes ⑨ Inform SOS
T. Labetalol 20mg tid T. Nicardipine 20mg tid T. Isosorbide 10mg po tid	Total v/o - 1420ml from 14pm FBS - 117 (22/7/26)	NSI x TID Dr. Divya
Dr. Niveditha / Dr. Bhargava		
	✓ Continue same treatment ✓ Trace labs ✓ NBM ✓ AF 1 + Dopplers Growth Scan ✓ Decision for course of management After labs / scan by Dr. Deepika	



Dr. Tejaswini.

Dr. Pramathi Reddy.

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/1/2026 9:45 AM	U/S/B Dr. Pramathi. 30 th - Severe PE - on 3 anti-hypertensives - Central placenta previa. - Serum Potassium <u>5.5</u> (23/1/26)	
✓ Spot PCR - 2.25	✓ BPs not well controlled ✓ growth scan - today	
	steroid - (3:40 AM today - 2nd dose) NMC Dr. Vijayanand MgSO ₄ on flow (till 4 PM today)	
	✓ Explained need for close fetal/maternal monitoring	
	✓ Plan for ECVS - 24/1/2026 - 8:30 AM - 1:30 AM	
	✓ PAE (Informed Dr. Sundhara)	
	✓ Reserve Blood/Blood Products as per AXON.	
	✓ Need for Emergency delivery in case of ✓ fetal compromise ✓ uncontrolled BPs. ✓ Imminent symptoms	
		by Dr. Rupika

Date & Time	Progress Notes	Doctor's Order
23/7/26 12pm	ck/b3 on c-MinediHe History noted re-reviewed having high BP's despite 3 anti htn's E on MgSO₄	
	ck/b1- HR - 93/min BP - 142/100 mmHg ck/b1- VS: S₁ S₂+ no: RA ^{RA}, clear	
	① T-lobet 200 QID Rest CST	

[illegible]

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I,

Patient's / Learner Language : Patient / Learner Literacy : ☐ Read ☒ Write ☐ Spoken

Identified Education Needs :

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barries	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
22/8/20	11:30pm	12	Diagnosis, Treatment & care plan	PT, S	1 @	0	1	1		
22/8/20	3pm	10	fall Risk Education	PT, S	1	0	1	1		

Part - III : CODES

Who was taught :		PT : Patient	F : Father	M : Mother	S : Spouse	Sn : Son	D : Daughter	C : Caregiver	O : Other (Specify).....
Learning Barriers :									
1. No Learning 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 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			

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis:

OK / WF / severe PE / GDM moderate / ex enceph / Hypothyroid / Fetal doppler changes / central placenta previa

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
2/12/2020 @ 11:00pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Primu / severe WF / severe PE / GDM moderate / ex enceph / Hypothyroid / Fetal doppler changes / central placenta previa	for safe delivery	observation	[Signature]	☒ Nursing ☐ Others:
2/12/2020 @ 2pm	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Fear & Anxiety	To reduce the fear	Provided psychological support	[Signature]	☒ Medical ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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RESULT SHEET

Date	22/7/26				
Time	11:51 AM				
Hb	11.7				
PCV	35.0				
RBC	3.90				
WBC	15.75				
N/L					
Platelets	3.82				
CRP					
ESR					
PCT					
RBS					
Na	132				
K	5.2				
Cl	105				
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.6				
ALP	152				
SGPT	21				
SGOT	27				
T.Bill/Conj	0.2 / 0.1				
T.Protein	6.3				
S.Albumin	3.2				
S.Globulin	3.1				
A/G Ratio	1				
Uric Acid	5.6				
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	14 / 1.0				
APTT	33				
CSF Protein / Sugar					
Cells					
N/L	LDH 158				

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Patient

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MEDICATION RECONCILIATION FORM

Drug Allergies: NEKA ☒ Not known any Drug Allergies

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

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

Shifting From: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
	Tab' LABETALOL	200mg	PO	TID	22/7	☒ C ☐ DC
2	Tab' NICARDIPINE	20mg	PO	TID	22/7	☒ C ☐ DC
3	Tab' ISOSALING	1/2-1 tab	PO	BN	22/7	☒ C ☐ DC
4	Tab' ODILIV	80mg	PO	OD	22/7	☒ C ☒ DC
5	Tab' ECOSPIRIN	150mg	PO	OD	22/7	☒ C ☐ DC
6	Tab' SUSTEN	40mg	PO	OD	22/7	☒ C ☐ DC
7	hy' PROLTON	50mg	IM	Needing more	17/7	☒ C ☐ DC
8	Tab' IRON		PO	OD	22/7	☒ C ☐ DC
9	Tab' CALCIUM		PO	OD	22/7	☒ C ☐ DC
10	Tab' THYRONORM	75mcg	PO	Morn Fri	22/7	☒ C ☐ DC

11' Tab' THYRONORM 150mg PO

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature: Dr. Pameene

& Time: 22/7/26 @ 2:30pm

Name & Signature: Smellha

me: 22/7/26 @ 2pm

DRUG CHART

Date of Admission: 22/6 Drug Allergies: NICKDA ☒ 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

REGULAR PRESCRIPTIONS

Weight. Ward. B/C

DRUG : <u>Tab. LABETALOL</u>				Date Time																
Dose <u>20mg</u>	Route <u>PO</u>	Frequency <u>TID</u>	Start Date <u>22/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Darivemula Tejashwini</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Tab. NICARDIA R</u>				Date Time																
Dose <u>20mg</u>	Route <u>PO</u>	Frequency <u>TID</u>	Start Date <u>22/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Darivemula Tejashwini</u>																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Tab. ISOLAZINE</u>				Date Time																
Dose <u>1tab</u>	Route <u>PO</u>	Frequency <u>BD</u>	Start Date <u>22/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Darivemula Tejashwini</u>																				
Additional Instructions: <u>morning - evening</u>																				
Daily Doctor's Endorsement by a Sign																				
DRUG : <u>Tab. ISOLAZINE</u>				Date Time																
Dose <u>1tab</u>	Route <u>PO</u>	Frequency <u>OD</u>	Start Date <u>22/7</u>																	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Darivemula Tejashwini</u>																				
Additional Instructions: <u>in afternoon</u>																				
Daily Doctor's Endorsement by a Sign																				

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Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward 60

DRUG : Tab. SUSTEN				Date Time 22/7
Dose 500mg	Route P/V	Frequency OD	Start Dt. 22/7	
Name & Signature of the Doctor Starting the Drugs: Dr. Samene				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : Tab. CDILIV				Date Time 23/7
Dose 20mg	Route PO	Frequency OD	Start Dt. 22/7	
Name & Signature of the Doctor Starting the Drugs: Dr. Samene				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : Tab. ECOSPIRIN				Date Time
Dose 150mg	Route PO	Frequency OD	Start Dt. 22/7	
Name & Signature of the Doctor Starting the Drugs: Dr. Samene				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : Tab. THYRONORM				Date Time 23/7
Dose 75mcg	Route PO	Frequency OD	Start Dt. 22/7	
Name & Signature of the Doctor Starting the Drugs: Dr. Samene				
Additional Instructions: from Monday - Friday				
Daily Doctor's Endorsement by a Sign				

VERIFIED BY: Name:

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward *ELC*

DRUG :				Date	Time												
Dose	Route	Frequency	Start Dt.														
150mg	PO	OD	22/7														
Name & Signature of the Doctor Starting the Drugs:				<i>Dr. Sameer</i>													
Additional Instructions:				<i>Saturday - Sunday</i>													
Daily Doctor's Endorsement by a Sign																	
DRUG : TAB ISOTIAZINE				Date	Time												
Dose	Route	Frequency	Start Dt.														
1 Tab	PO	TID	22/7/26														
Name & Signature of the Doctor Starting the Drugs:				<i>Dr. Dupika</i>													
Additional Instructions:																	
Daily Doctor's Endorsement by a Sign																	
DRUG : ASTHALINE				Date	Time												
Dose	Route	Frequency	Start Dt.														
2mg	IN	TID	23/7														
Name & Signature of the Doctor Starting the Drugs:				<i>Dr. Sameer</i>													
Additional Instructions:																	
Daily Doctor's Endorsement by a Sign																	
DRUG : Tab CARBETACOL				Date	Time												
Dose	Route	Frequency	Start Dt.														
20mg	PO	QID	23/7														
Name & Signature of the Doctor Starting the Drugs:				<i>Dr. Sameer</i>													
Additional Instructions:																	
Daily Doctor's Endorsement by a Sign																	



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
22A	3:30pm	ly M8804 londex dnc	4gm	iv	A	Surekha Swathi
22A	3:40pm	ly BETAMETHASONE	12mg	IM	I	Surekha Swathi
23A	3:40pm	ly Betnasol	12mg	IM	hp	Shobha Sundhya
22A	6:45pm	TAB. I Spazine	1/2 Tab	PO	hp	Surekha Swathi
22/7/26	11:40pm	NO INT-NOVARAPID	2V	SLC	Dr	Sanjay P

Weight. Ward. B/C

Signature

VERIFIED BY : Name



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 22/7/26 Time of Arrival: 12pm Time Seen by Nurse: 12:05pm

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

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

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

3) **Vital Signs:** Temperature: 98.2 Pulse: 92 RR: 18 SpO₂: 100% BP: 130/90 Weight: 70kg

4) **Gestational Criteria:**

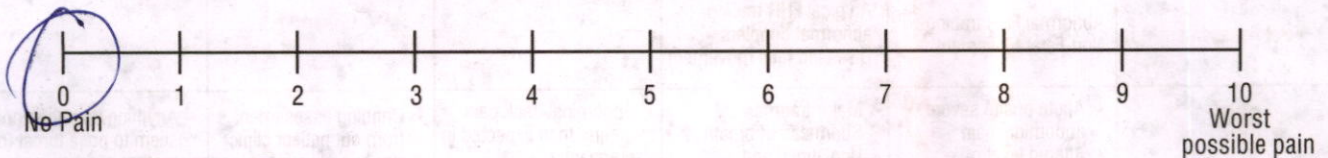
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LMP: 22/12/25 EDD: 30/9/26 Gestational Age: 30w4d

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: nil
- Frequency:
- Interventions:

6) **Past History:**

- a) Surgeries: Cesarean
- b) Medical: hypothyroid

7) Allergy: ☐ Yes ☒ No, If Yes :

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

9) Prenatal Medical History:

☒ None

☐ Chronic Hypertension

☐ Gestational Hypertension

☐ Diabetes

☐ Gestational Diabetes

☐ Low placenta

☐ Others if yes, specify

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: 12:30 PM

Nurse Name : Nurse Signature: \$

Date: 02/7/26 Time: 1 PM



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: <u>22/7/26</u>		
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: <u>need B-P levels</u>		Doctor Notified on Admission: ☒ Yes ☐ No Name of the Doctor: <u>Dr. Samena</u> Time Notified: <u>12:10pm</u>
Past Medical History: Obtained From ☐ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify)		
Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Hypothyroid</u>	<u>cesarean</u>	<u>NA</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
Obstetric History: G P <u>Prim</u> L A		
Previous LSCS:		
Current Medication: ☒ None ☐ Yes, If Yes, Fill the reconciliation form		
Family History: ☐ No Abnormalities Detected ☐ Heart Disease ☒ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease ☐ Liver disease ☐ Other		
Vital Signs / Measurements: Temp: <u>98.2°F</u> HR: <u>84</u> RR: <u>20</u> BP: <u>130/90</u> 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

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: Mr. Rajashwari

Orientation not given Reason: NA

Nurse Signature: [Signature]

Nurse Name: [Signature]

Date & Time: 22/7/25 @ 9pm

IP5-00176765

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31 Y 6 M 17 D
Dr. NIVEDITHA CHALMEDA

(F)



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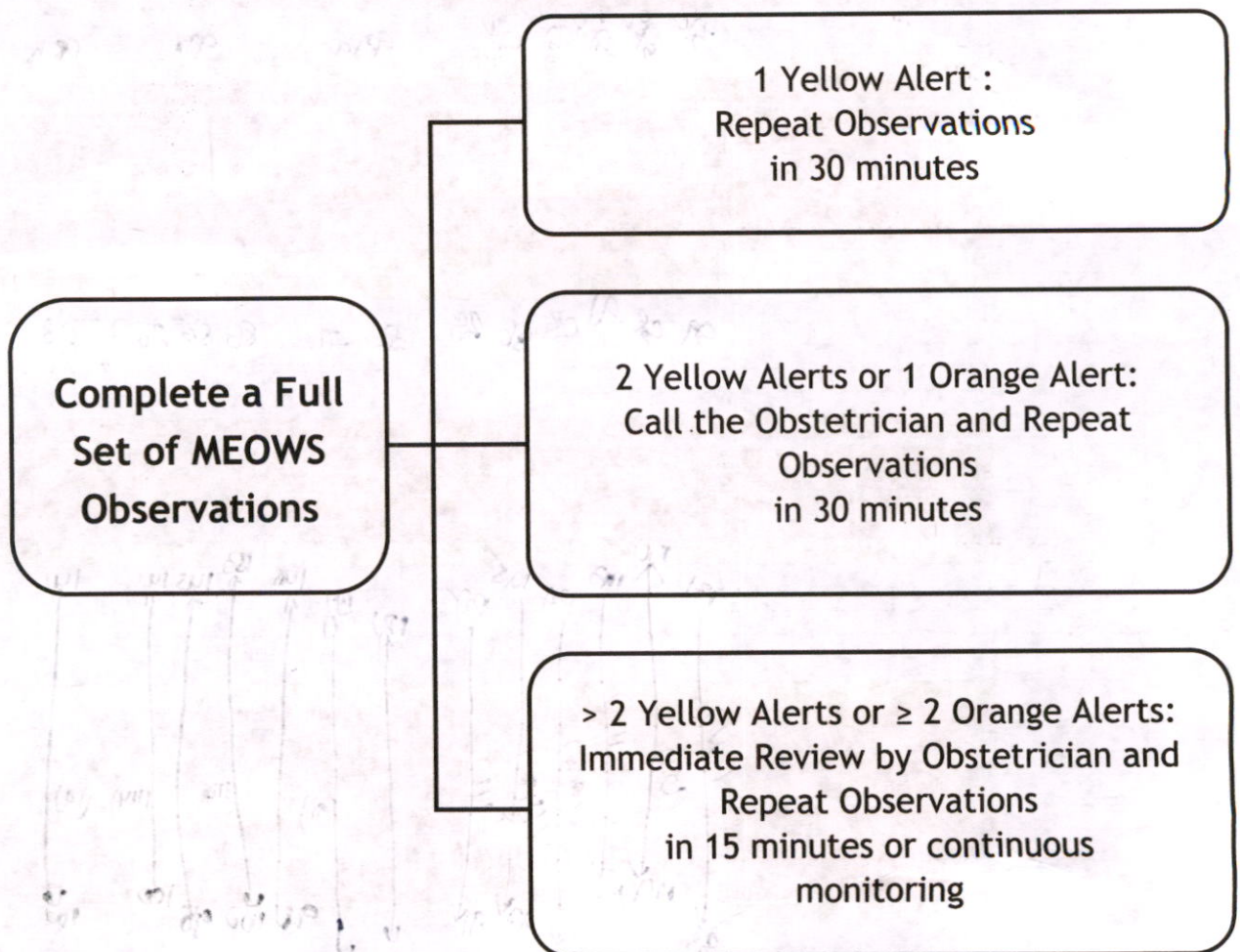
BirthRight™
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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT

TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



23/7/20



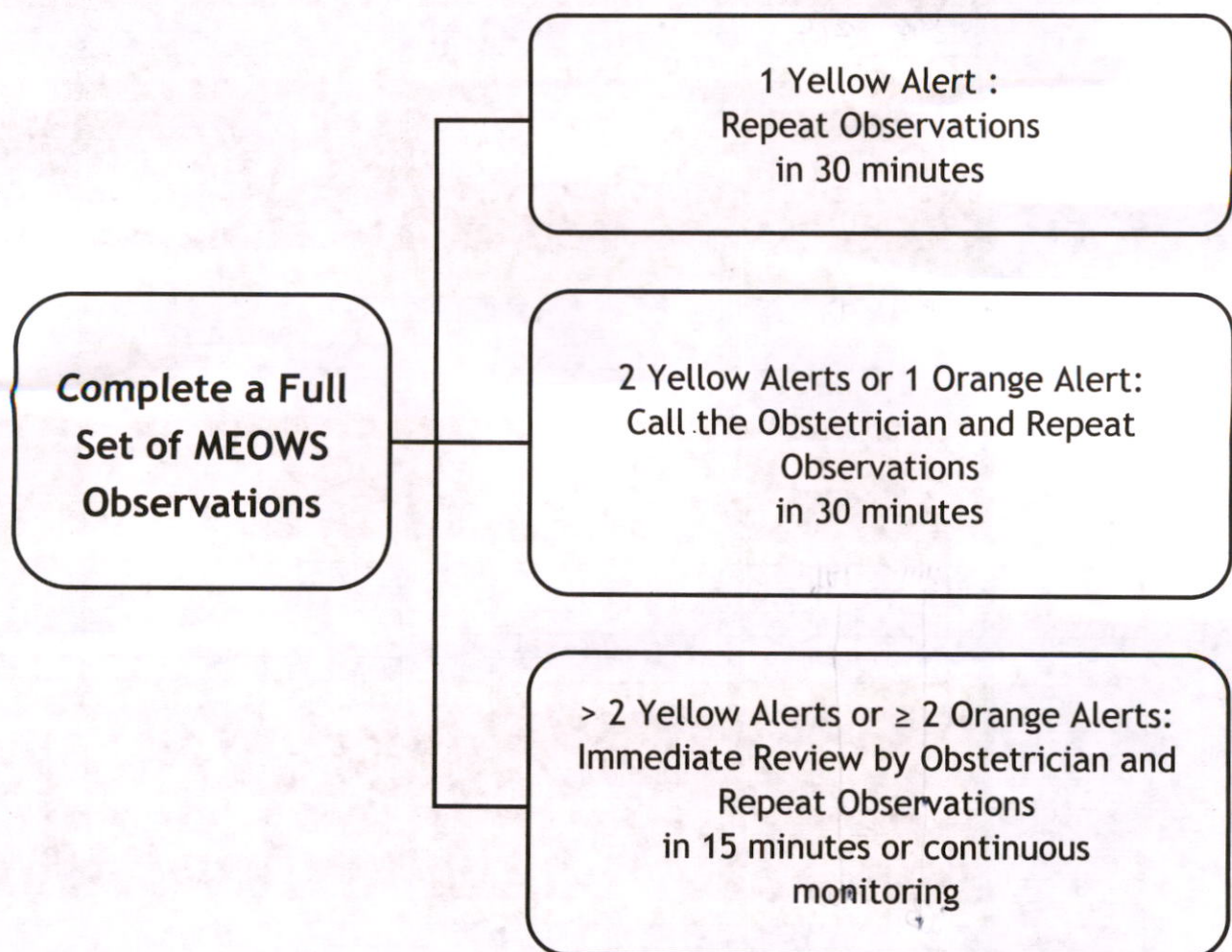
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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

FLUID CHART

Sheet No. : 0

22/7/26

- All measurements in ml.
- 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												
	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	tho											
	04:00 pm	tho											
	05:00 pm	tho											
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm	ngsoy											
	09:00 pm	ngsoy											
	10:00 pm	ngsoy tho											
	11:00 pm	ngsoy tho											
	12:00 am	ngsoy											
	01:00 am	ngsoy tho											
Total Intake :						Total Output :							
	02:00 am	ngsoy tho											
	03:00 am	ngsoy											
	04:00 am	ngsoy											
	05:00 am	ngsoy tho											
	06:00 am	ngsoy											
	07:00 am	ngsoy tho											
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

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23/7/26

FLUID CHART

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Sheet No. : 2

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

		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						

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 22/7/26

Assessment: Patient clo fear & anxiety

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess the general condition of the Patient.	2pm	Assessed the general condition of the Patient.	
3pm	IV placement	3pm	IV placement done	Patient is stable
4pm	Puff mgson	4pm	Puff mgson 25ml/hr on flow.	
5pm	ECA	5pm	ECA taken.	
6pm	No chat	7pm	Maintained 10 chat.	

Re-Assessment: It is comfortable

Special Notes: 25ml mgson

Nurse Name: \$ Bubble Date & Time: 22/7/26 @ 8pm

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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 22/1/20

Assessment: patent complaint about 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
8pm	Assess the pt condition	9pm	Assessed pt condition	pt is stable
10pm	monitor vital	11pm	monitored vitals	
12AM	ARBS	1AM	monitored ARBS informed to Dr. Nivedita	
1AM	medication	3AM	Administered medication	
2AM	FlO chart	5AM	FlO chart maintained	
6AM	IV fluids	7AM	mgson on flow.	
7AM	NST	8AM	NST BP	
	Ensure Safety			

Re-Assessment: done before and hourly pt is stable

Special Notes: FlO chart maintain / Self avoid mequm / mgson on flow / Trace LCH creatine Spot PCR / vital hourly / ARBS monitoring pre-post Sugar

Nurse Signature: Sandeepa

Nurse Name: Sandeepa Colabde

Date & Time: 22/1/20 8:00 AM

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Niveditha Department: ICU Date of Admission: 21/7/26

SITUATION	Diagnosis: <u>Prnltc 30 wky</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:				
BACKGROUND	Area	Shift Time	<u>Obs 2pm</u>	<u>Obs 4pm-6pm</u>			
	Medical Condition (Any special condition to be noted):		<u>Hypertension</u>	<u>GDM on diet</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>98.2°F</u>	Temp: <u>98.6°F</u>				
	Res:	<u>18b/min</u>	<u>18b/min</u>				
	SpO ₂ :	<u>100%</u>	<u>100%</u>				
	Pulse:	<u>88b/min</u>	<u>86b/min</u>				
	BP:	<u>141/98</u>	<u>141/95</u>				
	Fall Risk Score:	<u>35</u>	<u>35</u>				
Pain Score:	<u>0/10</u>	<u>1/10</u>					
Recommendations	Safety Needs:	<u>gdclean</u>	<u>yes</u>				
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Others Specify:	<u>NA</u>	<u>n/a</u>				
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Other Special Orders / Medications:	<u>AA</u>	<u>n/a</u>				
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>				
Handed Over By Name :		<u>Smulka</u>	<u>Sanayya</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>21/7/26</u>	<u>23/7</u>				
Time:		<u>5pm</u>	<u>8am</u>				
Taken Over By Name :		<u>Sanayya</u>					
Signature :		<u>[Signature]</u>					
Date:		<u>22/7/26</u>					
Time:		<u>8pm</u>					

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

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

BRADEN 'Q' SCALE

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Dr. NIVEDITHA CHALMEDA



		Date : 22/7/2021		Time : 2pm	
Mobility	When slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4
TOTAL SCORE				28	28
Evaluator's Name				[Signature]	

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

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

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05-01-1993 31 Y 6 M 17 D
Dr. NIVEDITHA CHALMEDA (F)

Morse Fall Risk Assessment Form



Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading				
		Score					
History of Falling (immediately or w/in 3 months)	Yes	25			Risk Level	Morse Fall Score (MFS)	Action
	No	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	Low Risk	0 - 24	Standard Fall Precaution
	No	0		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			
IV / Heparin Lock or Saline	Yes	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	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			
		Signature	[Signature]				

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ Use chairs with arm rests
- ☐ Use safety straps on stretchers and wheelchairs while transporting patients

Moderate Risk (25-50) Apply all low risk intervention and

- ☒ Assist and/or supervise ambulation. Reinforce to always call for assistance
- ☒ Hourly safety check
- ☒ Assess patient after visitors, leave to ensure safety measures in place

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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							
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 cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		✓	—							
Signature of the Nurse				Swathi									

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 : Swathi Name : Swathi

Signature of Ward In Charge :

Signature : Keena Name : Keena



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
22/7/25	6pm	10/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Swathe
22/7	10pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sanjay
23/7	2am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sanjay
23/7	6am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sanjay
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

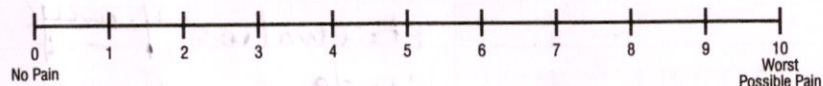
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, 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

