

LBH-00092644 IP5-00175911
Dr. NABEELA SHEERIN
23-03-1998 28 Y 3 M 10 D (F)
Dr. SASIKALA KOLA



Dr. NABEELA SHEERIN (28 Y 3 M 10 D)
F)
OTHERS
NIN: 00213
BA26066633032

LBH-00092644

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

BirthRight
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Your Right to a Safe Delivery

SURGERY DETAILS

Date : 03/8/26

Patient Name: Mrs Nabeela Date of Birth: 23/3/1998 Age: 28yrs

Gender: Female Ward: Obstetrics UHID No: LBH-00092644

Date of Surgery: 3/8/26 ☐ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☒ OBG OT-2

Name of the Surgery: Elective LSCS + left dermoid ovarian cystectomy & Sx

Time in : 11:40 AM 12:00 PM

Time Out : 1:00 PM

	NAME	AMOUNT
1. Surgeon	Dr. Saenkale	
2. Anaesthetist	Dr. Shabna	
3. Assistant Surgeon	Dr. Maithri	
4. OT Technician	Kubum	
5. Circulating Nurse	Rebika	
6. Assistant Nurse	Siletta	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9685977

Order by:

ADMISSION SHEET



Registration Details :

Admission No : IP5-00175911 Admit Date : 03-Jul-2026 Admit Time : 08:56 AM UHID : LBH-00092644

Patient Details :

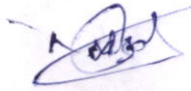
Patient Name : Dr. NABEELA SHEERIN Age : 28 Y 3 M 10 D
Guardian : Mr SYED SALMAN DOB : 23-03-1998
Gender : Female Religion :
Occupation : Martial Status : Married
Address (H) : H NO: 17-1-182/S/76, SALAHUDDIN NAGAR, SANTOSH NAGAR Saidabad Hyderabad, Telangana INDIA 500059 Phone No : 8121553360
E-mail : nabeelasheerin23@gmail.com

Admission Details :

Bed Type : MICU Bed No : MICU 427 Ward Name : 4F-BIRTHING CENTRE
Room No : MICU 427 Admission Type : First Visit

Contact Details :

Name : Mr SYED SALMAN Relationship : Husband
Contact Address : H NO: 17-1-182/S/76, SALAHUDDIN NAGAR, SANTOSH NAGAR Saidabad Hyderabad Telangana INDIA 500059 Phone No : 8501054928 / 8121553360


Signature

Doctor Details :

Doctor Name : Dr. SASIKALA KOLA Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : Self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 0.00
Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name LBH-00092644 IP5-00175911

Dr. NABEELA SHEERIN

23-03-1993 28 Y 3 M 10 D (F)

UHID | Dr. SASIKALA KOLA



Date c. e : Date of Discharge : Time :

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
31/7/26	11:50am.	ORs	OT	Sumi
31/7/26	1:40	OT	ORs	Sumi.
31/7/26	PM.	ORs.		Shobha
31/7/26	9:30 pm	ORs	3rd floor	Sandeep

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Tuhena Sharan (PT)	4/7/26	\$ 9687830	Shobha Shani
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

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CONSUMABLES OF OT

Technician: Kulsum

Date: 3/12/26

Time: 3 PM

Circulating staff:

	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
Anaesthesia Disposables								
ET tube			Major Pack <u>44 drape</u>	<u>01</u>	<u>01</u>	Inj Vit.K	<u>01</u>	<u>01</u>
LMA			Sutures <u>2347 DAISY</u>	<u>01</u>	<u>01</u>	Cord Clamp	<u>1</u>	<u>1</u>
ECG leads: <u>A/P/N</u>	<u>03</u>	<u>03</u>	<u>2762</u>	<u>01</u>	<u>01</u>	Suction Catheter <u>6ml</u>	<u>1</u>	<u>1</u>
HME filter: <u>A/P/N</u>			<u>Protene 883</u>	<u>01</u>	<u>01</u>	Feeding Tube		
Syringes : 10 cc						Vaccum Suction Set	<u>1</u>	<u>1</u>
05 cc	<u>03</u>	<u>03</u>	Gloves <u>6 1/2</u>	<u>03</u>	<u>03</u>	Surgical Gloves	<u>6</u>	<u>6</u>
02 cc	<u>03</u>	<u>03</u>	<u>6</u>	<u>02</u>	<u>02</u>	Gauze Pack	<u>1</u>	<u>1</u>
01 cc			<u>P.F 1</u>	<u>03</u>	<u>03</u>	Syringe 1ml / 2ml	<u>2</u>	<u>2</u>
Cautery plate: <u>A/P/N</u>	<u>01</u>	<u>01</u>	Surgical blade <u>NO 22</u>	<u>01</u>	<u>01</u>	Surgical Blade #20	<u>1</u>	<u>1</u>
IV set			NG tube			Koochies (S) <u>1'S</u>	<u>0</u>	<u>0</u>
RL	<u>03</u>	<u>03</u>	Cautery pencil	<u>01</u>	<u>01</u>			
NS : 10ml / 100ml / 500ml / 1000ml	<u>00</u>	<u>00</u>	Koochies <u>Adult XL</u>	<u>01</u>	<u>01</u>			
<u>minidrip</u>	<u>00</u>	<u>00</u>	Ointments					
<u>10 x 2.1</u>	<u>00</u>	<u>00</u>	Suction Catheter					
Fentanyl	<u>01</u>	<u>01</u>	Cap, Mask	<u>10</u>	<u>10</u>			
Morphine			Gauze Pack <u>R/P</u>	<u>01</u>	<u>02</u>			
Ketamine			Mop Pack	<u>03</u>	<u>03</u>			
Propofol			Steristrip <u>steinzone</u>	<u>01</u>	<u>01</u>			
Rocuronium			Underpad	<u>01</u>	<u>01</u>	<u>Adrenalin</u>	<u>1</u>	<u>1</u>
Glycopyrolate			Draw sheet <u>quick</u>	<u>01</u>	<u>01</u>	<u>Atrophin</u>	<u>1</u>	<u>1</u>
Myopyrolate			Abgel					
Ondansetron	<u>00</u>	<u>00</u>	Foleys catheter					
Pencan 25g/ Spinal Needle 22	<u>01</u>	<u>01</u>	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)	<u>01</u>	<u>01</u>	Romodrain bag					
Antibiotics : <u>Ephedrine</u>	<u>01</u>	<u>01</u>	Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg	<u>01</u>	<u>01</u>	Vaccum Suction set	<u>01</u>	<u>01</u>			
Justin : 12.5 mg / 25mg / 100mg	<u>01</u>	<u>01</u>	Plastic Bed Sheet					
Tab. Misoprost : 200mg	<u>02</u>	<u>02</u>	Betadine Solution	<u>02</u>	<u>02</u>			
<u>Oxytech</u>	<u>05</u>	<u>05</u>	Microshield	<u>00</u>	<u>00</u>			
<u>glove 6 1/2</u>	<u>00</u>	<u>00</u>	Cotton Balls	<u>01</u>	<u>01</u>			
<u>Gauze</u>	<u>00</u>	<u>00</u>	Latex Gloves	<u>20</u>	<u>20</u>			
<u>Transa</u>	<u>02</u>	<u>02</u>	Ramdione Scrub					
			Saral					

9687835 | 9687837

Adrenalin
Atrophin

Dr. Sasikala
Surgeon

Dr. Shubra
Anaesthesiologist

Nurse

OT Technician

Order No. :

9687833

Ordered by :

S.S. Rajen

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

57.8

90

1

circled by:

[illegible]

cross checked

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/7	Iv placement	96860159		
	PAC			
	Catheterization			

was checked

ANY OTHER INFORMATION

.....

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.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

come for FL US +
dermoid cystectomy

Obstetric Formula: G2P1L1.

Obstetric History:

I - 2024 - FTLSCS / 5 / 2.5 kgs /
P/V - Low AFI, FGR

Present Pregnancy Record: @ Fernandez By
Dr. Shreehari.

II - pp. sp. conception.

RISK FACTORS:

Height: 156 cm

Weight: 77 kg

Allergies: NKDA

Breast: ☒ Normal ☐ Abnormal

General Examination:

Consciousness: c/c

Icterus: absent

Temp: afebrile

BP: 100/65 (77)

CVS: S1S2 (+)

Liver/Spleen: not palpable

Pallor: absent

Edema: absent

PR: 80 BPM

DTR: (+)

RS: BAF (+)

Urine Output: adequate

LMP: 23/10/2025

EDD: 30/7/2026

Corrected EDD: 30/07/2026 GA: 36+1wks of GA

Menstrual History: Regular ☒ Yes ☐ No

Obstetric Examination

Fundal Height: ~ Term

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

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech Others _____

Head Fifths Palpable: 4/5

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination not indicated

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination not indicated

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

DIAGNOSIS

G2P1L1 / DCDA twins / 36+1wks of GA / Dermoid cyst / OGD
Hypothyroid / for FL US + Dermoid cystectomy



Family History: father - HTN Mother - Hypothyroid	Surgical History: 1scs - 2024
Medical History: Hypothyroid since 13/6/2026. KICLO-UCD = 2023.	Medication History: le, ca, Thyronorm, Duphaston,
Plan of Care: 1) Admission 2) IV cannulation 3) NST 4) written and informed consent. 5) Part Preparation 6) PAC 7) med Drugs are charted. 8) send a Trac BP. 11:20pm GRBS - 90mg/dL	Investigations: BCET - B+ve Virech - NR. 12/6/26 → 12.5/8600/2.08 L 18/6/2026 (Cns) S10L, 34 wks, Breech, PLT - low, post. High AC - SVP - 4.0cm, AC - 41. 1st Twin - Breech, EFW - 1809g (41) PLT - post High FGR, SVP SVP - 4.0cm, red vessel in um. art with positive EDF with cerebral redistribution & DV Doppler. (N) Twin-2: PLT - Ant/High, cephalic, EFW - 16th centile (2,061 gram) SVP - 4.1cm, umbilical & DV Doppler. (N) MCA shows - cerebral redistribution. Birth wt discordance Btw both fetes - 12.2%. uterine art Doppler. (N)

Doctor Name: Dr. Divya
Signature:
Date & Time: 3/7/26, 9:00 AM

Consultant Name: Dr. Sasikala
Signature:
Date & Time: 2pm, 3/7/26

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/26 10:00 AM	+ TIFIA - (W) + NT - 1mm (Twin-1) 1.3mm (Twin-2) FTS - low risk.	
	<u>Dr. Dwyer</u>	
2/5/6/2026	35wks, DCDA twins, Twin 1 - Breech, PLT - lower pole, post High SUP - 4.7cm, red umb. artery resistance to bf then with ext cerebral redistribution & DV Doppler (w) Twin 2 - PLT - cephalic, upper pole, Ant/H.M. SUP - 2.7cm, fetal Doppler (w)	
	MB Sandeys 10:15 AM	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2pm 3/7/26	POD-0 G/C: fair apilex vitals (N) Babes - mother and U/O good	P/A: uterus Retracted well Plu. bleeding normal
*** Skin - Plolene Intuss - Lumbar on 3/10 and dressing at discharge	Dr. MAITHAN 099019	(D) MAITHAN
3/7/26 6pm	POD-0 / P ₂ L ₃ / EL. Ws + Left demod Ovarian Cystectomy	
B ₂ - well U/O: 100ml WV	G/C: fair B.P - 120/60 (32) P.R - 66 SpO ₂ - 96% on RA P/A: Ut (R) well soft, DS (+) P/V: NARS	1) Allow of liquid - no liquid diet at 7pm, soft diet at 8pm 2) I/V fluids - 100ml/hr 3) Monitor vitals - q4h 4) T/O charting 5) W/F Plu Bleeding 6) Drug as charted
	shift to Room	

Patient

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	CLDW - AXON	
3/2/26 9 PM	POD-0 / P/Ls / ELUs + Left dermoid. ovarian Cystectomy / OCD	
	GC: fair	
	B.P - 122/73 (87)	
	PR: 71	1) Soft diet c plenty of oral fluid
B - well	SpO ₂ : 96% on RA	2) I/V fluids - 100ml/hr
V/O: 200ml 2hr	PLA: UT (2) well	3) Monitor vitals - 4hrly
	Soft 1B1 (+)	4) I/O Charky
	P/V: NAB	5) w/f PLV Bleeding
	Chest - Clear	6) Ambulation.
	Shift to Room	7) Temp 5hr
	Remove Foley's	
	at 12 pm	
	Temp 11 pm	Dr. Sankar
4/2/26 9 AM	POD-1 / P/Ls / ELUs + Left dermoid ovarian Cystectomy / OCD	
	GC: fair	
	Vitals stable	
	SpO ₂ : 96% on RA	1) Soft diet c plenty of oral fluid
	PLA: UT (2) well	2) I/V fluids - 100ml/hr
	Soft 1B1 (+)	3) Monitor vitals - 4hrly
	P/V: NAB	4) w/f PLV Bleeding
	Remove Foley's - new	5) Ambulation

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 2:00pm	POD-1 / p213 / EL. 114 + (L) Dermoid cystic mass OAD clo: pain abdomen O/E GC - fair Bp - 120/80 mmHg PR - 92 bpm SpO2 98% RA PLA - ut @ ucu LIF - BwNL Breathing healthy Dymex PLA - soft. Asking for analgesia for pain	Adv soft diet Ambulation with crutches Drugs as charted Monitor vitals 6th hr Inform SRS Dr. Diney
4/7/26 2:00pm	POD-1 / p213 O/E GC - fair vitals stable PLA - ut @ ucu LIF BwNL	Adv 1 soft diet 11 Ambulation 1) hydration 4) ut catheter bleeding 5) pain relieved 4th hr 6) Inform SRS Dr. Diney N.B. Soubhannam



3

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/2016 8:00 AM	POD-2 / PL3 / ① Demoid cystectomy Pt comfortable Ambulating Adv	① soft diet ② Ambulation ③ Hydration ④ w/ blocking per vagina ⑤ mgts as charted ⑥ Zandu Jus
Babiu-MJ VV fv sf	vital stable pla-ut @ 120/80 plr BWM pla soft	Dr. Divya
my. ceratotomy SIE dis plan discharge		
5/7/2016 11 AM	cto Lower abdominal pain cto upper backache pain Gutai afebrile PR - 86/min BP - 118/85 mmHg SpO2 - 98% @ RA P/A - ut (P) 120/80 Bld @ soft P/A - NAB	adv ① Justine supp ② vitals Monitor ③ Drop as charted ④ w/ back bleed ⑤ Informers ⑥ w/ pain & pain reduce plan discharge Dr. Arun N/S Subhashini



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5.11.20.	Pod 2	
6pm	no complaints	
B. well	Acute	ad @ dub
A/c	at home	- what's the
u	unstable	- Don't contact
L	P/A at P. 10.00	- w/ path (med)
	P/A - nap	- Inform
		Defusing
		1/3
		seems

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INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
3/7/20	9:30 am	1, 2, 3, 4	Diagnosis, Treatment & care plan Pain management, Informed consent	PT	1	0	1	1		(Duty)
3/9/20	10 am	4	Infection Control measures	PT-S	1	0	1	1	-	R
4/8/20	8 am	9	Isolation bid	pt	1	0	1	1	-	Same

Part - III: CODES

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

MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: 42 P, L₁ / DCDA twins / 36+ weeks / Demoid cyst / Hypothyroid

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
3/7/26 9:30am	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☒ Per-Op ☐ Post Op	Demoid cyst Hypothyroid DCDA twins	→ safe surgery	→ EL-LSU + Demoid cystectomy	<i>[Signature]</i>	☐ Nursing ☒ Others:
3/7/26 10am	☐ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	42 P, L ₁ DCDA 36+ weeks	safe delivery	EL-LSU	<i>[Signature]</i>	☒ Medical ☐ Others:
4/7/26 8am	☐ Medical ☐ Nursing ☒ Others: <i>hichien</i>	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	POB-1/LSU	soft dice	soft high protein dice	<i>[Signature]</i>	☐ Medical ☐ Nursing ☒ Others:
4/7/26 2:45pm	☐ Medical ☐ Nursing ☒ Others:	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	Post LSCS	Post partum recovery	Deep core retraining & functional training	<i>T.S</i>	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

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RESULT SHEET

Date	31/7/28				
Time					
Hb	12.0				
PCV	35.6				
RBC					
WBC	9.71				
N/L					
Platelets	1.45				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

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MEDICATION RECONCILIATION FORM

Drug Allergies: NKA

☒ Not known any Drug Allergies

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

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

Shifting From:

Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. Thyronorm	150mcg	PO	OD	2/7/26	☐ C ☒ DC
2	T. Duphaston	10mg	PO	BD	25/6/26	☐ C ☒ DC
3	T. Fluvoxamine	50mg	PO	OD	2/7/26	☐ C ☐ DC
4	T. Ferromin Plus	1tab	PO	OD	2/7/26	☐ C ☒ DC
5	T. Calumoy Total	1tab	PO	OD	2/7/26	☐ C ☐ DC
6	T. par 40mg	1tab	PO	OD	2/7/26	☐ 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. Durga

Date & Time: 3/7/26 ; 9:30 am

Nurse Name & Signature: Sush

Date & Time: 3/7/26 9 AM

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REGULAR PRESCRIPTIONS

Weight Ward

DRUG: PARACETAMOL

Date
Time

Dose Route Frequency Start Dt.

5mg P/o TID 3/2

Name & Signature of the Doctor
Starting the Drugs:

(Dr. NATHAN)

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: DICLOFENAC

Date
Time

Dose Route Frequency Start Dt.

50mg P/o Bd 3/2

Name & Signature of the Doctor
Starting the Drugs:

(Dr. NATHAN)

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: PANTOP

Date
Time

Dose Route Frequency Start Dt.

40mg P/o Bd 3/2

Name & Signature of the Doctor
Starting the Drugs:

(Dr. NATHAN)

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG: FLUOXAMINE

Date
Time

Dose Route Frequency Start Dt.

50mg P/o OD 3/2

Name & Signature of the Doctor
Starting the Drugs:

(Dr. NATHAN)

Additional Instructions:

to inform
panduratan

Daily Doctor's Endorsement by a Sign

Patient Sticker

REGULAR PRESCRIPTIONS

Weight Ward

Signature.....

VERIFIED BY: Name

[illegible]

DRUG CHART

Date of Admission: 3/1/25 Drug Allergies: NKA ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

REGULAR PRESCRIPTIONS

Weight. Ward. *ORS*



Cefotaxime				Date	Time
Dose	Route	Frequency	Start Date		
1gm	IV	Bid	3/7	10 AM	9/7
Name & Signature of the Doctor					
Starting the Drugs:					
<i>(Signature)</i>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : T-PARACETAMOL				Date	Time
Dose	Route	Frequency	Start Date		
1g	oral	6hly	3/7/20		
Name & Signature of the Doctor					
Starting the Drugs:					
<i>(Signature)</i>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : T-DICLOFENAC				Date	Time
Dose	Route	Frequency	Start Date		
50mg	oral	8hly	3/7		
Name & Signature of the Doctor					
Starting the Drugs:					
<i>(Signature)</i>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : T-IRAMADOL				Date	Time
Dose	Route	Frequency	Start Date		
100mg	oral	6hly	3/7		
Name & Signature of the Doctor					
Starting the Drugs:					
<i>(Signature)</i>					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

LBH-00092644

IP5-00175911

Dr. NABEELA SHEERIN

23-03-1998

28 Y 3 M 10 D

(F)

Dr. SASIKALA KOLA

Weight. Ward. ORS

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/7/26	10:10 am	INJ. CEFOTAXIME	1gm	IV	Dhanya	Sup
3/7/26	9:50 am	INJ. PERINORM	10MG	IV	Dhanya	Sup
3/7/26	9:55 am	INJ. PANTOP	40MG	IV	Dhanya	Sup
3/7/26	1:05 pm	DICLOFENAC suppository	100mg	PR	SL	Praxmi emilat
3/7/26	1:06 pm	TRAMADOL suppository	100mg	PR	SL	Praxmi emilat
3/7/26	11:20 pm	INJ. PARACETAMOL	1gm	IV	Praxmi	Sup
		INJ. PARACETAMOL	1gm	IV	Praxmi	Sup
4/7/26	5pm	INJ. TRAMADOL	100MG in 100ml NS	IV	Dhanya	Sup
5/7/26	10:30 pm	INJ. TRAMADOL	100MG in 100ml NS	IV	Dhanya	Sup

10:11 am

9:51 am

9:56 am

VERIFIED BY : Name

Signature

Weight. Ward. OKS

[illegible]



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 3/2/26 Time of Arrival: 8:30am Time Seen by Nurse: 8:55pm

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: gmsc

3) **Vital Signs:** Temperature: 97.1f Pulse: 84b RR: 20b SpO₂: 99l BP: 119/73 Weight:

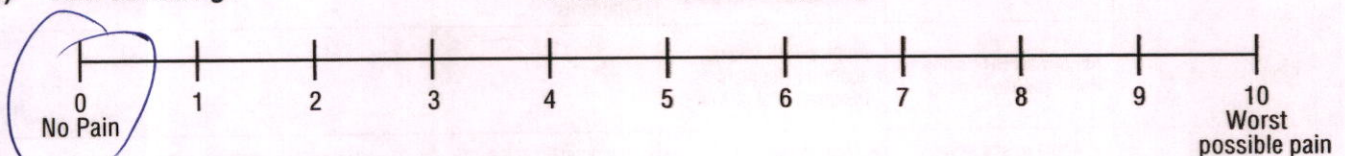
4) **Gestational Criteria:**

Gravida:	G <u>2</u>	P <u>1</u>	L <u>1</u>	A
----------	------------	------------	------------	---

LMP: 23/10/2025 EDD: 30/1/26 Gestational Age: 36+1 wks

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

5) **Pain Screening:** **Numerical Pain Scale (NPS)**



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

6) **Past History:**

- a) Surgeries: well
- b) Medical: well



1) Allergy: ☐ Yes ☒ No, If Yes :

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

9) Prenatal Medical History:

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 Hours)
Re-Assessment	Continuous Nursing Care	Every 15 Minutes	Every 15 Minutes	Every 30 Minutes	Every 60 Minutes
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SRM > 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: ...Dr. Senthil...

Nurse Name : ...Shasadh... Nurse Signature: ...

Date: ...3/7/26... Time: ...1pm...

OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 3/2/26

Baseline Information:

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

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

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

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

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

If yes, identify

Chief Complaints: for LSCS Doctor Notified on Admission: ☒ Yes ☐ No
Name of the Doctor: Dr. Suthi?
Time Notified: 8:30 pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Neck hypothyroidism since 15/6/2023	LSCS 2024	Neck hypothyroidism
Gynecology Assessment: ☐ Not Applicable Menstrual History: regular Onset of Menarche: Menstrual Cycle: ☒ Regular ☐ Irregular Last Menstrual Period:	Gynecology Surgical History: Caesarean Section: ☒ No ☐ Yes Cervical Cerclage: ☒ No ☐ Yes Ectopic Pregnancy: ☒ No ☐ Yes Myomectomy: ☒ No ☐ Yes Others:	Gynecological History: Contraceptives: ☒ No ☐ Yes Vaginal Discharge: ☒ No ☐ Yes Post-Coital Bleeding: ☒ No ☐ Yes Infertility: ☒ No ☐ Yes If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G 2 P 1 L 1 A

Previous LSCS: 1 LSCS 2024

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: 97.6°F HR: 80 bpm RR: 20 bpm
BP: 119/64 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 20 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☒ Yes ☐ No Score 28 (complete the Braden Q Sheet)

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

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

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

Inform consultant for positive criteria

Cultural & Spiritual Needs: ☐ Yes ☐ No if Yes specify Inform consultant for positive criteria.

SOCIAL SCREENING:

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

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

Social History: Lives With

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: Shasadh

Orientation not given Reason: NA

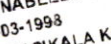
Nurse Signature: [Signature]

Nurse Name: Shasadh

Date & Time: 3/7/26 @ 1 p.m.

LBH-00092644
Dr. NABEELA SHEERIN
23-03-1998
Dr. SASIKALA KOLA

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Early



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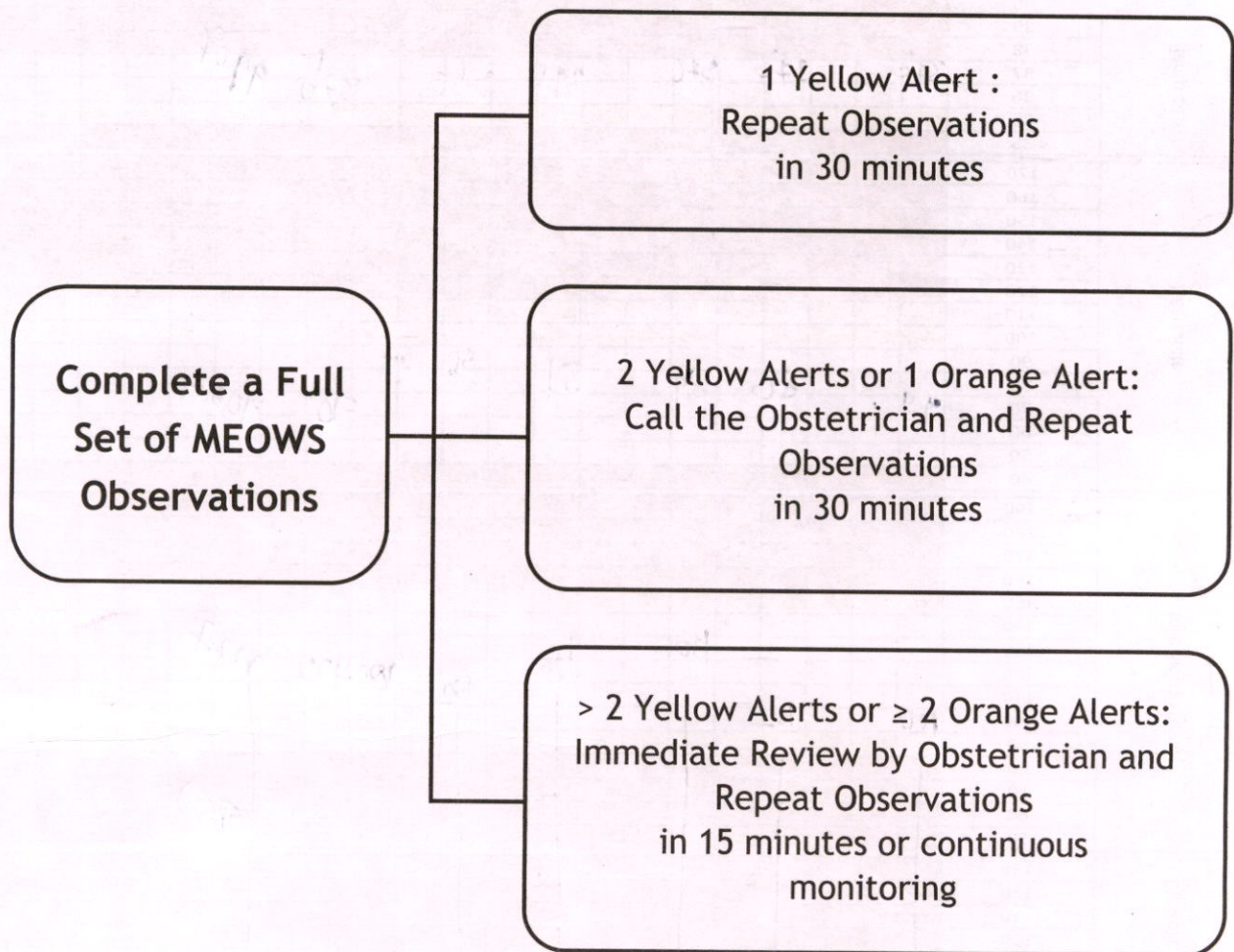
BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Early Warning Observation Score Chart - Obstetrics

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)

4/7/2026



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It takes a lot to treat the little.

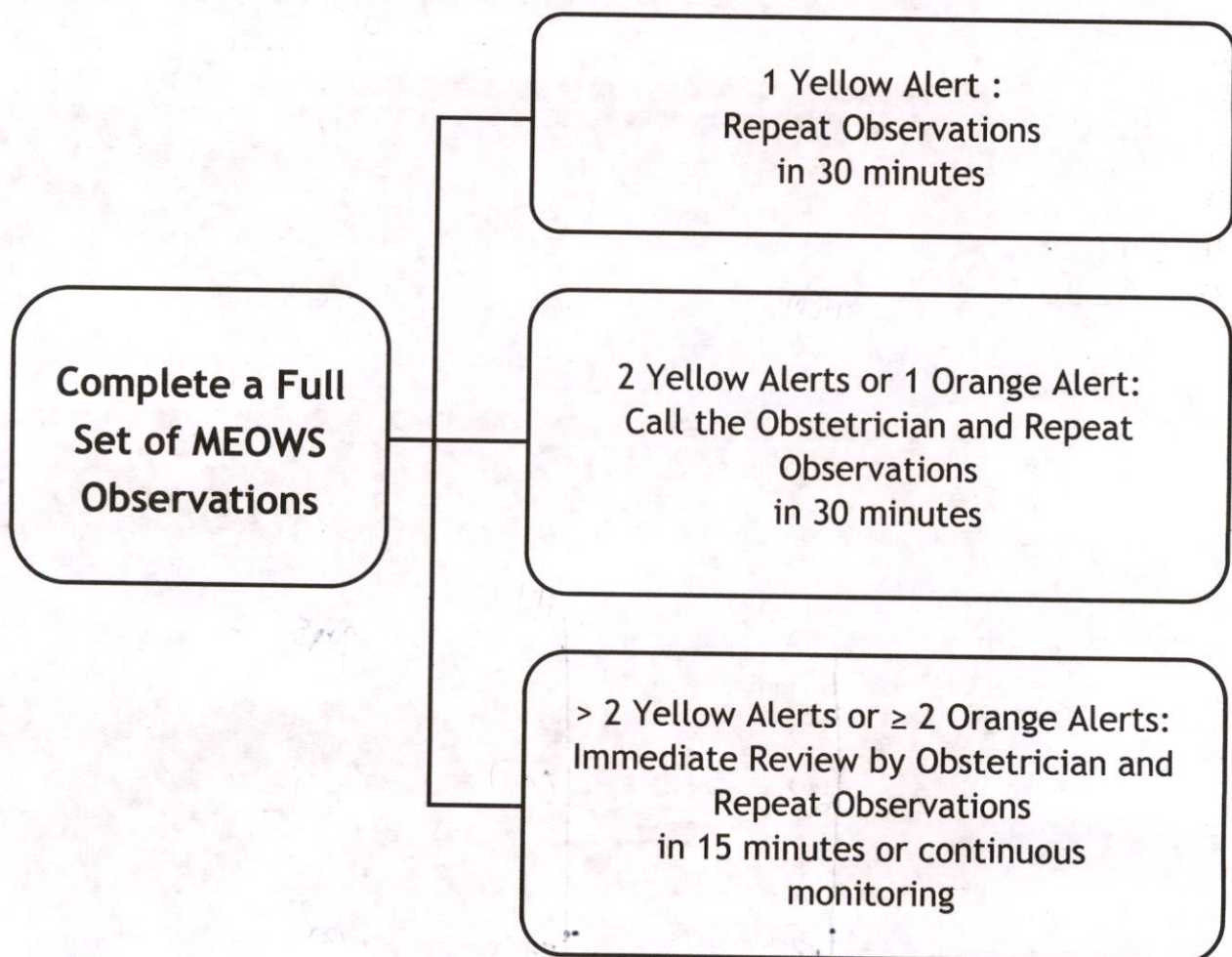


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Dr. SASIKALA KOLA

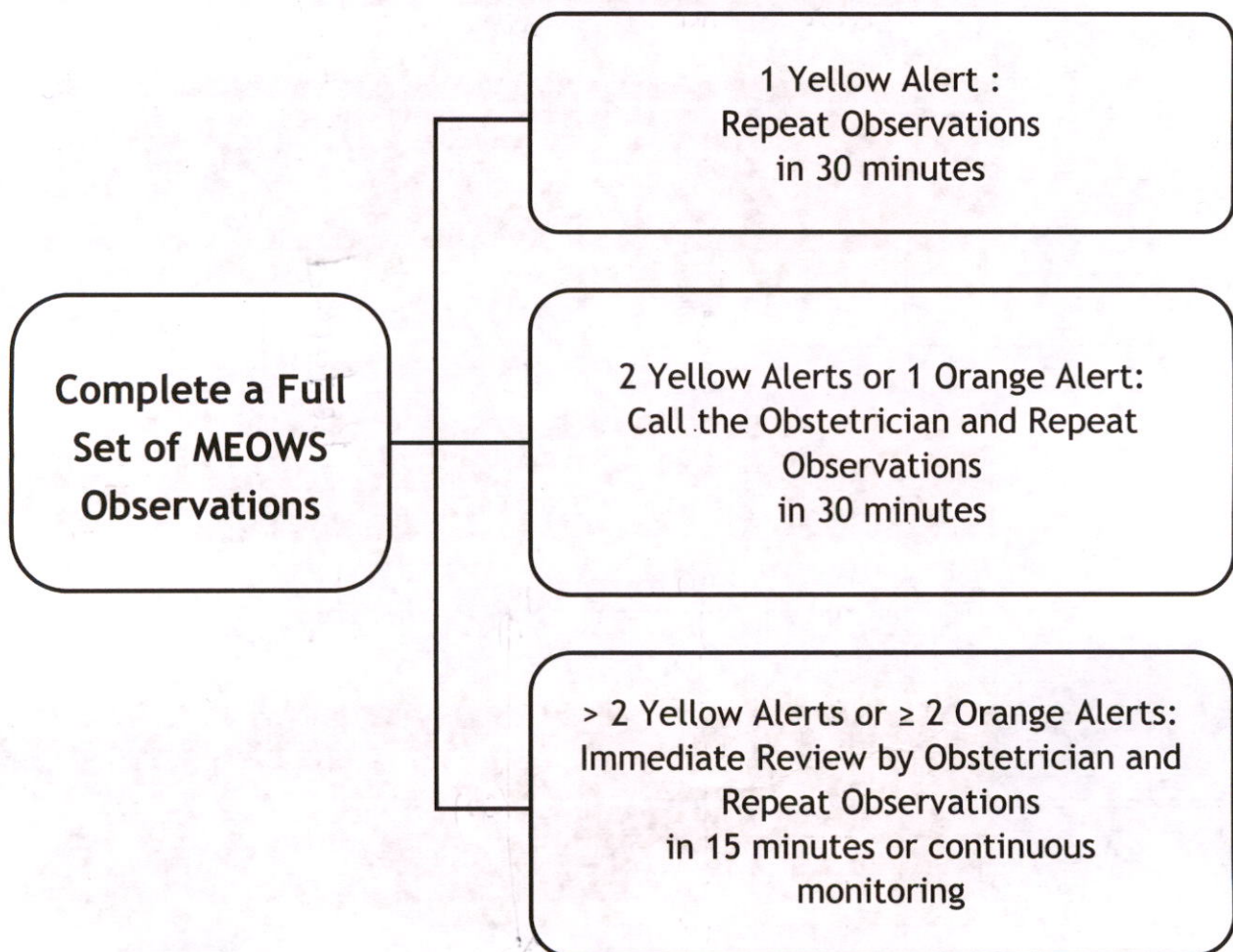


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : 6

- 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 Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
3/2/26	08:00 am											
	09:00 am											
	10:00 am	RL	N	100ml					✓	0	Shirish	
	11:00 am	RL	S	100ml						0	Shirish	
	12:00 pm	RL	S	100ml						0	Shirish	
	01:00 pm	RL	M	100ml					300	0	Shirish	
	Total Intake : taken						Total Output : passed.					
3/2	02:00 pm	RL		100ml						0	Shirish	
	03:00 pm	RL		100ml						0	Shirish	
	04:00 pm	RL		100ml						0	Shirish	
	05:00 pm	RL		100ml					800ml	0	Shirish	
	06:00 pm	RL	I	100ml						0	Shirish	
	07:00 pm	RL	H2O	100ml						0	Shirish	
	Total Intake :						Total Output : 800ml - M-O					
3/2	08:00 pm	RL	H2O	100ml						0	Shirish	
	09:00 pm	RL		100ml					200ml	0	Shirish	
	10:00 pm	RL	H2O	100ml						0	Shirish	
	11:00 pm			-						0	Shirish	
	12:00 am			-						0	Shirish	
	01:00 am			-						0	Shirish	
	Total Intake : taken						Total Output : m-o					
4/2	02:00 am			100ml						0	Shirish	
	03:00 am		H2O	100ml						0	Shirish	
	04:00 am			100ml						0	Shirish	
	05:00 am	RL	H2O	100ml						0	Shirish	
	06:00 am		H2O	100ml					700ml	0	Shirish	
	07:00 am			100ml						0	Shirish	
	Total Intake :						Total Output : m-o 700ml					
Total 24 hrs. Intake			Total 24 hrs. Output									
			m-o 2,000 ml									



FLUID CHART

Sheet No. : 2

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

		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										
4/7/26	08:00 am										0	✓			
	09:00 am	Soly									0				
	10:00 am	✓ H.O									0				
	11:00 am										0				
	12:00 pm										0				
	01:00 pm										0				
Total Intake :						Total Output :									
4/7	02:00 pm	Geal									0	✓			
	03:00 pm						✓			✓	0				
	04:00 pm	H/O									0				
	05:00 pm										0				
	06:00 pm	H/O								✓	0				
	07:00 pm										0				
Total Intake :						Total Output : M-10 U-2									
4/7	08:00 pm										0	✓			
	09:00 pm	no									0				
	10:00 pm										0				
	11:00 pm									✓	0				
	12:00 am	no									0				
	01:00 am										0				
Total Intake :						Total Output : m-0 u-1									
4/7	02:00 am										0	✓			
	03:00 am										0				
	04:00 am	H/O								✓	0				
	05:00 am										0				
	06:00 am										0				
	07:00 am										0				
Total Intake :						Total Output : m-0 u-1									
Total 24 hrs. Intake												Total 24 hrs. Output		m-1 u-10	

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Dr. NABEELA SHEERIN
23-03-1998 28 Y 3 M 10 D (F)
Dr. SASIKALA KOLA



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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
	08:00 am										0	Southe	
	09:00 am										0		
	10:00 am	NO DUF	Hand								0		
	11:00 am										0		
	12:00 pm		Hand								0		
	01:00 pm										1		
Total Intake :						Total Output : m-0 u-2							
	02:00 pm										0	Sema	
	03:00 pm		Hand								0		
	04:00 pm										0		
	05:00 pm		Hand								0		
	06:00 pm										0		
	07:00 pm		Hand								0		
Total Intake :						Total Output : m-0 u-2							
	08:00 pm										0	Dey	
	09:00 pm		Hand								0		
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

Patient Sticker

FLUID CHART

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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																								
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	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: 3/7/26

Assessment: patient having severe 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
9am	⇒ Assess the patient condition	9:05am	⇒ Assessed the patient condition	patient's comfortable.
10am	⇒ monitor the vitals	10:10 am	⇒ monitor the vitals checked and recorded	
12pm	⇒ Administer medication	12:10 pm	⇒ Administered medication as for drug chart.	
1pm	⇒ maintain I/O chart	1:10 pm	⇒ maintaining I/O chart	
1:30 pm	⇒ provide IV fluids	1:35 pm	⇒ provided IV fluids	
2pm	⇒ ensure safety needs	2:10pm	⇒ ensure safety needs	

Re-Assessment: Re-Assessment done

Special Notes: monitoring vitals

Nurse Signature:

Nurse Name: Shasadhya

Date & Time: 3/7/26 @ 1pm

LBH-00092644
Dr. NABEELA SHEERIN
23-03-1993 28 Y 3 M 10 D (F)
Dr. SAsIKALA KOLA

NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 2/7/20

Assessment: pt complain for Abdominal pain

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	Assess pt general condition	2:10 pm	Assessed pt general condition	pt is stable
3pm	monitor vital	3:10 pm	moniter vital Bp SpO2 pulse checked and recorded	
4pm	Administration medication	4:10pm	medication as per doctor order	
5pm	Ensure safety	5:10pm	ensure safety provided	
7pm	prevent infection	7:10pm	To prevent infection	

Re-Assessment: Re Assessment done

Special Notes:

Nurse Signature: [Signature]

Nurse Name: Shobha

Date & Time: 3/7/20

LBH-00092644 IP5-00175911
 Dr. NABEELA SHEERIN
 23-03-1998 28 Y 3 M 10 D (F)
 Dr. SASIKALA KOLA

③

NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 3/7/20

Assessment: patent complaint about pain at surgical site

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	Assess the pt condition	8pm	Assessed pt condition	pt is stable
	monitor vital		monitored vital,	
9pm	do chart	9pm	maintained do chart	
10pm	shift to room	12:10 AM	shifts to room	
12AM	⇒ to encourage oral intake	11:10 AM	⇒ encouraged oral intake	
2AM				
6pm	⇒ provide comfortable position	6:20 AM	⇒ provided comfortable position	

Re-Assessment: done after 2 hourly pt is stable

Special Notes: Foley's removed tm 12pm 12pm

Nurse Signature: Sandhya Nurse Name: Sandhya (016638) Date & Time: 4/7/20 2 PM

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NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/2026

Assessment: Pain & Discomfort (LSCS)

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
8:30 am	Assist the pt Condition.	9 AM	Assist the pt On bed	
	Monitor Bleeding & vitals.		lying comfortable having mild	
10 AM	Encourage orally / Ambulation	10 AM	Pain Polys cath removed	
	POLYS cath to be removed		Encourage voiding.	
2 PM	Observed for voiding.		orally soft diet start.	After
4 PM	Medication Asper	2: PM	well - Ambulate	Abx & pain killers
4 PM	Chart Administered	8:00 PM	had. sponge Bath.	Administration.
	Pain Management.		V/S checked & recorded	well Abulated
				reduced pain
				& Anxiety.

Re-Assessment: Patient was stable.

Special Notes: - N/A

Nurse Signature: Shobhashini

Nurse Name: Shobhashini

Date & Time: 4/7/26 8 PM

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Dr. NABEELA SHEERIN
23-03-1998 28 Y 3 M 10 D (F)
Dr. SASIKALA KOLA



NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26

Assessment: patient having mild pain

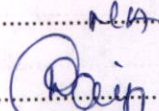
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8pm	=> Assess the patient General condition	8:10 pm	=> Assessed the patient General condition	patient is comfortable
10pm	=> Assess the patient vitals signs	10:20 pm	=> Assessed the patient vitals signs	
12Am	=> To maintain I/O chart	12:10 Am	=> maintain I/O chart	
2Am	=> To encourage oral intake	2:15 Am	=> encourage oral intake	
6Am	=> To provide comfortable position	6:10 Am	=> provided comfortable position	

Re-Assessment: patient is comfortable

Special Notes:

Nurse Signature: 

Nurse Name: Deepa

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

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: Pain in surgical site related to post op

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
8am	Assess to the patient condition	8:15 am	Assessed to the pt on sleep	patient well
10am	maintain y/o chart.	10am	maintained y/o chart.	
11am	to monitor vitals.	11am	monitored vitals.	
12pm	plan to give iv tramadol & Justin supositor.	12:30 pm	iv tramadol & Justin sup- given.	
1pm	plan to encourage orally	1:30 pm	patient taking soft diet.	
1:30pm	plan to do ambulation on medication.	1:45 pm	patient ambulated.	
			medication given as advised.	

Re-Assessment:

Special Notes: Reassessment after 2hr pt feels good.
cannula removed as patient request

Nurse Signature: [Signature]

Nurse Name: Soekhaiini

Date & Time: 5/7/26 @ 2pm

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 Dr. NABEELA SHEERIN
 23-03-1998 28 Y 3 M 12 D (F)
 Dr. SASIKALA KOLA



NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/11/20

Assessment: patient having mild pain in surgical site.

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
2pm	* Assess the patient condition	2:30 pm	* Assessed the patient condition, patient is stable.	* patient is stable
3pm	* plan to monitor vitals			
4pm	* plan to maintain I/O chart.	3:10 pm	* monitor vitals stable.	
			* maintain I/O chart	
5pm	* plan to ambulation	4:20 pm	* patient ambulated.	
7pm	* plan to soft diet	5:30 pm	* patient taken soft diet	
8pm	* plan to medication.	7:20 pm	* given medication as per doctor orders	
		8pm		

Re-Assessment:

provide comfortable position

Special Notes:

Nurse Signature: [Signature] Nurse Name: Nema

Date & Time: 5/11/20 @ 8pm

Patient Sticker

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Sushth? Department: OBG Date of Admission: 3/7/16

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
BACKGROUND	Area	Shift Time	<u>OBG 2am-4pm</u>	<u>OBG 4pm-8pm</u>	<u>OBG 8pm-12am</u>	<u>3rd floor 8pm</u>	<u>3rd floor 8am</u>	<u>3rd floor 2pm</u>
	Medical Condition (Any special condition to be noted):		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>MM</u>	<u>NA</u>	<u>US</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>98.6°F</u>	<u>98.6°F</u>	<u>98.6°F</u>	<u>98°F</u>	<u>98.0°F</u>	<u>97.2°F</u>
			Res: <u>20b/m</u>	<u>19</u>	<u>18b/m</u>	<u>20</u>	<u>20b/m</u>	<u>22</u>
			SpO ₂ : <u>99%</u>	<u>100</u>	<u>100%</u>	<u>97</u>	<u>99%</u>	<u>97</u>
			Pulse: <u>84b/m</u>	<u>83b/m</u>	<u>86b/m</u>	<u>85</u>	<u>80b/m</u>	<u>88</u>
			BP: <u>119/64</u>	<u>112/64</u>	<u>117/76</u>	<u>114/79(84)</u>	<u>115/80</u>	<u>139/82(92)</u>
			Fall Risk Score: <u>20</u>	<u>20</u>	<u>20</u>	<u>35</u>	<u>35</u>	<u>35</u>
			Pain Score: <u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>02</u>	<u>02/10</u>
	Recommendations	Safety Needs:		<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>
Physiotherapy		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Others Specify:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>MM</u>	<u>NA</u>	<u>MM</u>	
Special Diet:		☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
Other Special Orders / Medications:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>MM</u>	<u>NA</u>	<u>MM</u>	
Post Operative Procedure Special Orders:			<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>MM</u>	<u>NA</u>	<u>MM</u>
Handed Over By Name :			<u>Shoradha</u>	<u>Shobh</u>	<u>Sandya</u>	<u>Souhami</u>	<u>Devi</u>	<u>Souhami</u>
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:			<u>3/7/16</u>	<u>3/7/16</u>	<u>3/7/16</u>	<u>3/7/16</u>	<u>3/7/16</u>	<u>3/7/16</u>
Time:			<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8am</u>	<u>2pm</u>
Taken Over By Name :			<u>Shobh</u>	<u>Sandya</u>	<u>Shoradha</u>	<u>Devi</u>	<u>Souhami</u>	<u>Seema</u>
Signature :			<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>
Date:			<u>3/7/16</u>	<u>3/7/16</u>	<u>3/7/16</u>	<u>3/7/16</u>	<u>3/7/16</u>	<u>3/7/16</u>
Time:			<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8pm</u>	<u>2pm</u>



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. S.K. Department: 2nd Floor Date of Admission: 3/7/26

SITUATION	Diagnosis: <u>LSCS</u>		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:			
BACKGROUND	Area	<u>2nd Floor</u>				
	Shift Time	<u>8pm</u>				
	Medical Condition (Any special condition to be noted):	<u>LSCS</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>97.7f</u>				
		Res: <u>20b/m</u>				
		SpO ₂ : <u>100%</u>				
		Pulse: <u>65b/m</u>				
		BP: <u>131/80</u>				
		Fall Risk Score: <u>35</u>				
		Pain Score: <u>0/10</u>				
	Recommendations	Safety Needs:	<u>yes</u>			
Physiotherapy		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Others Specify:		<u>NA</u>				
Special Diet:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:		<u>NA</u>				
	Post Operative Procedure Special Orders:	<u>NA</u>				
	Handed Over By Name :	<u>Sreem</u>				
	Signature :	<u>[Signature]</u>				
	Date:	<u>5/7/26</u>				
	Time:	<u>@ 8pm</u>				
	Taken Over By Name :	<u>[Signature]</u>				
	Signature :	<u>[Signature]</u>				
	Date:	<u>5/7/26</u>				
	Time:	<u>@ 8pm</u>				

LBH-00092644

IP5-00175911

Dr. NABEELA SHEERIN

23-03-1998 28 Y 3 M 10 D (F)

Dr. SASKALA KOLA



BRADEN 'Q' SCALE

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					Date : 31/12/2017		
					Time : 8:40 PM		
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	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28	28
Docu. No. : RCHBH /FRM / CLINICAL / 119					Evaluator's Name	B. S. P.	Rega

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



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0	0			
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	-	-	-	-	-	-				Removed cannula
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													

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 : Rebeca Name : Rebeca

Signature of Ward In Charge :

Signature : Veenag Name : Veenag



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7/26	10am	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	shoradhe
3/7/26	12pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	shoradhe
3/7/26	2pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	shoradhe
3/7/26	4pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	shobly
3/7/26	8pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	shobly
3/7/26	9pm	1/10	surgical site	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Sanjay
4/7/26	6pm	1/10	sls	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	T-carpal	Deep
4/7/26	7am	0/10	nca	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Deep
4/7/26	2:30 pm	1	sls	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	T-carpal given	paushen
4/7/26	3pm	0	na	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	paushen

Re-assessment Frequency:

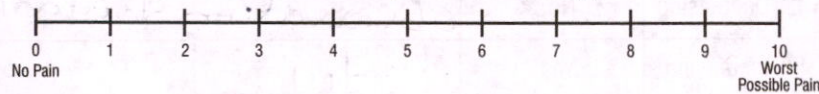
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

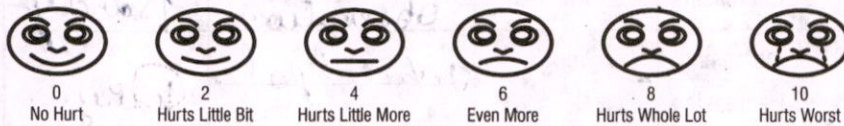
Numerical Pain Scale (Obstetric and Gynecology)



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

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

Wong - Baker (Pediatrics) Above 7 Years





PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7/26	6 AM	1/10	SLs	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Tab. paracetamol	Devy
5/7/26	7 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Devy
5/7/26	10:30 AM	2	SLs	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Eni - Tramadol / Jmure	Southan
5/7/26	11:40 AM	1	SLs	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Sub - Justia Jmure	Southan
5/7/26	1 PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Southan
5/7/26	3 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Seema
5/7/26	7 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Seema
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

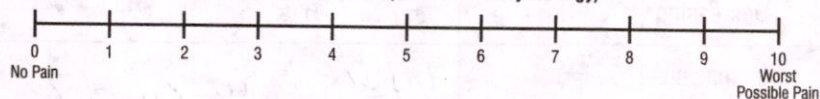
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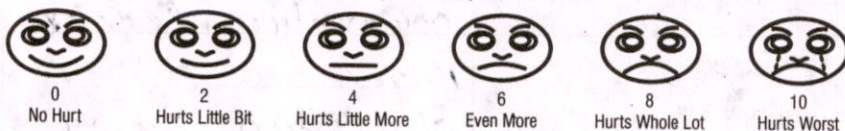
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Wong - Baker (Pediatrics) Above 7 Years





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

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



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 31/7/2026

Date of Removal: 7/7/26 9.30 AM

Parameters	Date	Shift Time						
Need for the Catheter	31/7/26	8AM-2PM	☒ Yes ☐ No	31/7/26	8PM-8AM	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene			☒ Yes ☐ No			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment			☒ Yes ☐ No			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder			☒ Yes ☐ No			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)			☒ Yes ☐ No			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy			☒ Yes ☐ No			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?			☒ Yes ☐ No			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter			☒ Yes ☐ No			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?			☒ Yes ☐ No			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?			☐ Yes ☒ No			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care			☒ Yes ☐ No			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever			☐ Yes ☒ No			☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion			☒ Yes ☐ No			☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse			sharada Sandeys					
Signature of the Nurse			[Signature]					



322

NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 4/7/26 Time: 8 am

Origin: India Height: 156 cm Weight: 77.1 kg BMI: 28.13/m²

Food Allergies: No

Diagnosis: pnb-1/654 lower segment Caesarian section

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

Diet Advised:

Soft high protein diet
with plenty of oral liquids
→ Avoid spicy, chilled & outside foods

Patient's / Attendant's

Signature: [Signature]

Name: Nabeela Sheerin

Date & Time: 4/7/26 8 am

Dietician's

Signature: [Signature]

Name: Sarma

Date & Time: 4/7/26 8 am

DIETARY NOTES[illegible]

BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?

- ☒ a. Yes ☐ b. No

2. If No, Reason

3. Nipple condition:

- ☒ a. Nipple well formed
☐ b. Flat nipple
☐ c. Inverted nipple
☐ d. Short nipple

4. Milk flow:

- ☐ a. Good
☒ b. Drops of colostrums
☐ c. Dry

5. Steps for Positioning and attachment:

- ☒ a. Baby goes to the breast
☐ b. Mother always sits with a back support
☐ c. Ear-shoulder-hip should be in a straight line
☐ d. The baby takes a latch on the areola and not on the nipple



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- ☒ a. Yes
☐ b. No

7. For Caesarian mothers:

- ☐ a. Mother is required sit and feed from the 4th feed
☒ b. Please explain football hold

8. NICU admission:

- ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes:

Continuity of Care:

Date: 03/07/26

* DBM and burping 2nd hourly
* warm care given
* monitor the vitals

Handover given by Sharadha

Handover taken by Sandeys

Signature

Signature Sandeys (016635)

Date & Time: 3/7/26 @ 2pm

Date & Time: 3/7/26 @ 5pm

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

LBH-00092644 IP5-00175911
Dr. NABEELA SHEERIN
23-03-1998 28 Y 3 M 10 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

Name: Dr. Nabeela Sheerin Age: 27y Sex: F UHID.No: LBH-00092644
Date: 3/7/26 Time: 8:55 AM Proposed Operation: Elective LCS
Diagnosis: G2 P1 L1 E prev LCS E DCDA twins E Hypothyroid
B.P / CRT: H.R: Weight: 78kg ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 bleb Demand Cyst

Laboratory Data:

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

Allergies: NRDA

Medical History: CVS:

* Ditching : 2 years

RESP:

Diabetes: Nil

CNS:

Renal:

Hepatic / GE:

Physical Activity: MBTS 74

Others: bleb hypothyroid on Tab-Thyronorm 150mcg

Past Anaesthetic History: A/b LCS & BA in 2024 (uneventful)

Physical Exam:

Airway: MP 1 (2) 3 4 Mouth Opening: adequate Mento-hyoid Distance: (N) Neck: (N) Teeth: All teeth intact

Lungs: BAE (N), clear

Heart: S1 S2 (+)

CNS: Grossly Intact

Pregnant: ☒ Yes ☐ No ☐ NA

Venous Access Site:

Spine Exam for regional: (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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

2/7/26 meal: 9:30 pm
3/7/26 liquid: 7:00 pm

Signature: [Signature] Name: Dr. K. Srinivas

Received in PACU by : Time Received : 12:40 pm Time Discharged : 9:45



Patient Sticker

EPIDURAL ANALGESIA RECORD

b)

[illegible]

Patient Satisfaction :

Date and Time :



POST – PARTUM ASSESSMENT FORM – IN-PATIENT

Date: 4/7/26

Chief Complaint : Pain at the suture site

Obstetric/ Birthing History : G2P2L3, LSCS, POD-1

Previous Surgical/Medical History : OCD, Hypothyroid

Assessment :

On Observation: Mother seen in lying down /sitting/ reclined position

Mother is active & alert / drowsy / tired or exhausted / mobile by herself & ambulatory / needs assistance with mobility

Iv line + / -

Catheter + / -

Postural alignment -

On Palpation : Edema – absent / up to ankle / up to knee/ above knee

On Examination : Breathing pattern – abdominal/ apical/ diaphragmatic

Diastasis recti abdominis – present / absent / could not be assessed

Able to initiate Pelvic Floor Activation – ☒ Yes ☐ No

Spl Notes -

Treatment Plan :

- | | | |
|--|---|--|
| ☒ Lateral Breathing | ☒ Pelvic Floor Activation | ☒ Transversus Abdominis Activation |
| ☒ Gluteus Activation | ☒ Active Motion for Limbs | ☒ Transfer Training & Mobility |
| ☒ Sit to Stand | ☒ Monitored Walk | ☒ Posture & Ergonomic Education |

Signature : T.S.

Name : Dr. Tahera Sharma (PD)

Date & Time: 4/7/26 2:45pm

LBH-00092644
Dr. NABEELA SHEERIN
23-03-1993
Dr. SASIKALA KOLA
IP5-00175911
28 Y 3 M 10 D (F)
Barcode

PERINEAL SECTION OPERATIVE NOTES

Surgeon's Name: <u>Dr. Sasikala</u>	Date of Delivery: <u>12/3/26</u> <u>3/7/26</u>
Assistant Surgeon: <u>Dr. Mathai</u>	Time of Delivery: <u>12:23 PM</u> <u>12:24 PM</u>
Anaesthetist's Name: <u>Dr. Shabnam</u>	Gender of Baby: <u>male</u> <u>male</u>
Type of Anaesthesia: <u>ASA</u>	Weight of Baby: <u>2.14 kg</u> <u>2.31 kg</u>
Neonatologist: <u>Dr. Lohith</u> <u>Dr. Ishu</u>	AGPAR Score: <u>8/8</u> <u>8/8</u>
Scrub Nurse:	NICU Admission: ☐ Yes ☒ No

Pre-Operative Diagnosis: G.P. 4 at 36th weeks / DCOA tumor c left ovarian
cyst

☒ Elective ☐ Emergency Indication: DCOA tumor

Urgency

- ☐ Immediate Threat to life of woman or fetus
- ☐ Maternal or fetal compromise not immediately life threatening
- ☐ No maternal or fetal compromise but needs early delivery
- ☒ Delivery timed to suit woman and staff

Decision time: Knief to rectus: 1 min

CTG Description:

If there was a delay give the reasons: No

Surgical Procedure: Elective LSCS + left ovarian
ovarian cystectomy

Post Operative Diagnosis: L4 1000 post elective LSCS + ovarian
cystectomy

Peri-Operative Complications: Left 4x3cm - left ovarian dermoid
cyst with sebaceous material, hair, fat globules
Cystectomy done and cyst wall + contents sent for HPE

Amount of Blood Loss: 500 ml Blood Transfused (in ML): Nil

Name and Number of Surgical Specimen sent for examination:
left ovarian dermoid cyst wall with
contents

Examination Findings when Appropriate: Both

Presentation: ☐ Cephalic ☒ Breech ☐ Other

Cervical Dilatation: cm

5th Palpable:

Fetal Position:

Station: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Moulding: ☐ None ☐ + ☐ ++ ☐ +++

Caput: ☐ + ☐ ++ ☐ +++

Meconium: ☐ None ☐ + ☐ ++ ☐ +++

Bladder Catheterized: ☒ Yes ☐ No

Urine: ☒ Clear ☐ Blood Stained

Skin Incision: ☒ Pfannenstiel ☐ Transverse

☐ Midline

☐ Other

Uterine Incision: ☒ Lower Segment ☐ Classical

☐ Inverted T

☐ J Incision

Previous Scar: ☐ Intact ☒ Thinned out

☐ Ruptured

☐ No Scar

Incision Through Placenta: ☐ Yes ☒ No

Delivery of head: ☐ Manual ☒ Forceps

Liquor: ☒ Clear ☐ Meconium: ☐ I ☐ II ☐ III

☐ Blood

☐ Offensive

☐ Not Offensive

Delivery of Placenta: ☒ Manual ☒ CCT

☒ Complete

☐ Incomplete

☐ Piecemeal

Cord Appearance: Normal

Cord around the neck ☒ Yes ☐ No

Appearance of placenta: Normal

Cavity explored ☒ Yes ☐ No

Uterus, tubes and ovaries: ☐ Normal ☒ Not Normal

Sterilization: ☐ Yes ☒ No

Uterine Closure: ☐ One Layer ☒ Two Layers

Peritoneal Closure: ☐ Pelvic ☒ Abdominal ☐ None

Sheath Closure:

Fat Closure: ☐ Yes ☐ No

Skin Closure: ☒ Subcuticular ☐ Mattress

Vaginal Evacuated ☒ Yes ☐ No

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

Catheter: ☒ Yes ☐ No ☐ Remove in 24 hours days ☐ Await instructions

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

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

Post-Operative Notes:

Adv 1. NBM

2. Urals 1/2 hourly for 2 hours

forward by 2-4 hourly

3. drugs as per chart

4. w/c bleeding 1/2

Doctor Name: D. Sankar

Doctor Signature: Manoj C. Maitra

3/7/20, 2pm

LBH-00092644

IP5-00175911

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23-03-1998 28 Y 3 M 10 D (F)

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POST-SURGICAL CARE PLAN FORM

Procedure Done: Elective LLES + ovarian cystectomy

Post-Surgical Diagnosis: L4 POD-0 post elective L4 + ovarian cystectomy

Post-Operative Monitoring Parameters /Frequency:

BP, PR, urine output - 1/2 hourly for 2 hours
forward by 2-4 hourly

Wound Care:

POD-V
Entire removed - POD-8/10 to

Drain /Special Lines/Catheters:

IV Cannula
foley

Special Patient Positioning and Requirements:

Nil

Nutritional Instructions:

liquid diet forward
by soft diet after 2 hours

When to Start Mobilization:

on POD-1 after foley removal

Special Referrals:

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

☐ Yes ☒ No

Any Other Post-Operative Care Needed including Required Follow Up

Treating Surgeon
(Signature & Stamp)

(R. NATHAN)

Date: 3/7/20 Time: 2pm

Note: Plan of care will be readjusted if necessary.