

ADMISSION SHEET

Registration Details :

Admission No : IP5-00175986

Admit Date : 05-Jul-2026

Admit Time : 11:47 AM UHID : BAH-00584697

Patient Details :

Patient Name	: Mrs NADIRA SHEMA SAMIA	Age	: 31 Y 6 M 12 D
Guardian	: Mr SHEIKH HAROON ABDUL WAHEED	DOB	: 23-12-1994
Gender	: Female	Religion	: Muslim
Occupation	:	Martial Status	: Married
Address (H)	: H NO 19-4-274/1, NEAR ZOO PARK, BNK COLONY Bahadurpura Hyderabad Telangana INDIA 500064	Phone No	: 9347322062/ 9182918858
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : SHARED WARD

Bed No : SW 418

Ward Name : 4F-BIRTHING CENTRE

Room No : SW 418

Admission Type : First Visit

Contact Details :

Name	: Mr SHEIKH HAROON ABDUL WAHEED	Relationship	: Husband
Contact Address	: H NO 19-4-274/1, NEAR ZOO PARK, BNK COLONY Bahadurpura Hyderabad Telangana INDIA 500064	Phone No	: 9347322062 / 9182918858

✓
Signature

Doctor Details :

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

Payment Details :

Payment Mode : Cash

Deposit Amount : 0.00

Payor Name : SELFPAY

BAH-00584697 IP5-00175986
Mrs NADIRA SHEMA SAMIA
23-12-1994 31 Y 6 M 12 D (F)
Dr. HIMABINDU VEERLA



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ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ IP No. : _____ Consultant: _____ Dept : _____

Date of Admission: _____ Time : _____ Date of Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
5/7/21	4:00 PM	BB-2IP	(320) Room	Shobha.

Cross Consultation Visit

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

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
5/7/26	IV placement	1	9688952	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

clo pain abdomen

LMP:

11/10/25

EDD:

Corrected EDD:

22/1/26

GA:

37+4

Obstetric Formula:

G₃P₁L₁A₁

Obstetric History:

- 1- 2023, 1st marriage at 6wks
- 2- 2024, Female - 2 kids, NVD, at term

Present Pregnancy Record:

- 3- 1st conception

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:

FHS:

☒ Normal

☐ Tachy

☐ Brady

☐ Absent

RISK FACTORS:

Per Speculum Examination

Draining:

☐ Present

☐ Absent

☐ Bleeding

Colour of Liquor:

☐ Clear

☐ Meconium

☐ Blood Stained

Vaginal Examination

Cervix:

☐ Long

☐ Partially effaced

☒ Effaced

Os: Closed

Dilated

2cm

Membranes:

☒ Present

☐ Absent

Liquor:

☐ Clear

☐ Meconium

☐ Blood Stained

Presenting Part:

☐ Vertex

☐ Breech

☐ Others

Sutton:

☐ -3

☐ -2

☐ -1

☐ 0

☐ +1

☐ +2

Pelvis:

☐ Adequate

☐ Doubtful

Height: cm

Weight: kg

Allergies: Nil

Breast: ☐ Normal ☐ Abnormal

General Examination:

Consciousness: Conscious

Pallor: absent

Icterus: absent

Edema: absent

Temp: afebrile

PR: 82/min

BP: 112/74 mmHg

DTR: (+)

CVS: S1+S2

RS B

Liver/Spleen: Not palpable

Urine Output: adequate

DIAGNOSIS

G₃P₁L₁A₁ 37+4 wks prev NVD in labor.



Family History: father om	Surgical History: appendectomy - 2011
Medical History: Nil.	Medication History: T. Joy T. sheld.
Plan of Care: Admission Nil on admission prep of part check blood availability send cap Nil 3rd 4 urinal & RNR 4th 4. w/PPOL.	Investigations: A @ ne. urinal ne 16/1/20. 3rd / cephalic / placenta-poster fundal / left lateral high /. AFI - 13.2 / FFW - 2.394 kg - 3rd. Ae - 4.5 x / Doppla. @

Doctor Name: Dr. Ashug
Signature: [Signature]
Date & Time: 5/1/20, 12.30pm

Consultant Name: Dr. Himabindu
Signature: [Signature]
Date & Time: 5/1/20, 12pm



DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record				
6	Doctors progress sheets	1			
7	Nursing plan of care and handover sheets	4			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	2			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart	1			
	Andurale	2			
	Balun	1			
	Obs notes	2			
	other	1			
	Total No. of Pages	2 + 4 + 1			

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU /
2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/2020 1.30pm	<u>Pxld-o</u> Glutari afebrile PR - 80/min BP - 120/70 mmHg SpO₂ - 93% @ Rm P/A - ut (R) bleed P/u - NAB	adv: (R) Diet - vitals sth - Drop as charled - w/ active bleed - Informing Dr. Arunoyy A.
5/7/2020 4pm	<u>Pxld-o / SVD / PaL A1</u> Glutari afebrile PR - 80/min BP - 120/70 mmHg SpO₂ - 93% @ Rm P/A - ut (R) bleed P/u - NAB B. well. ✓	adv: (1) (R) Diet - (2) vitals sth - (3) Drop as charled - (4) w/ active bleed - (5) Informing Shift to room Dr. Arunoyy Noted by Shobha



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26, 7Am.	<u>PNo-1</u> fever afebrile. Vitals Stable V ✓ B. well. V/e - Med - du	eds - (P) diet - vitals & th y - Drugs as charted - w/p active bleed - Informer
	Plan disch.	Dr. Arshya NIB - Query GOTTF
6/7/26 10.20AM	S/B. Dr. Himabindu Pt - Comfortable. Ambulate p PA - Urine & Urucate PR - Kochia healthy	① No diet - ② Sitz Bath ③ Plan discharge Hindu (Dr. Himabindu)

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

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

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

Shifting From:

Shifted to:

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

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature :

Date & Time : 5/7/2018, 12pm

Nurse Name & Signature:

Date & Time : 5/7/2018, 12pm



DRUG CHART

Date of Admission: 5/1/25 Drug Allergies: ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name Signature



REGULAR PRESCRIPTIONS

Weight. Ward. B1

DRUG : <u>Sy Duphalar</u>				Date/Time: <u>5/7/24</u>
Dose: <u>15ml</u>	Route: <u>Po</u>	Frequency: <u>QD</u>	Start Date: <u>5/7/24</u>	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Ashu</u>				<u>10pm 9am 5am</u>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>T. PARACETAMOL</u>				Date/Time: <u>5/7/24</u>
Dose: <u>1gm</u>	Route: <u>Po</u>	Frequency: <u>TID</u>	Start Date: <u>5/7/24</u>	<u>6am 12pm 6pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Ashu</u>				<u>6am 12pm 6pm</u>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>T. Diclofenac</u>				Date/Time: <u>5/7/24</u>
Dose: <u>50mg</u>	Route: <u>Po</u>	Frequency: <u>TID</u>	Start Date: <u>5/7/24</u>	<u>6am 12pm 6pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Ashu</u>				<u>6am 12pm 6pm</u>
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : <u>T. Paracetamol</u>				Date/Time: <u>5/7/24</u>
Dose: <u>400mg</u>	Route: <u>Po</u>	Frequency: <u>BD</u>	Start Date: <u>7/7</u>	<u>6am 6pm</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Ashu</u>				<u>6am 6pm</u>
Additional Instructions:				
Daily Doctor's Endorsement by a 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.

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
5/2/20	11:00 am	ENEMA	1	PR	<i>[Signature]</i>	Sandhya Rabecca
5/7/20	1:15 pm	Lig Oxycodone	100	IM	<i>[Signature]</i>	Sandhya Rabecca
5/7/20	1:16 pm	T. P & G	400mg	PR	<i>[Signature]</i>	Sandhya Rabecca
5/7/20	1:17 pm	JUSTIN	100mg	PR	<i>[Signature]</i>	Sandhya Rabecca
5/7/20						



Weight. Ward. 64

[illegible]

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23-12-1994 31 Y 6 M 12 D (F)
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Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
200mg	PO	BD	5/7/21	5H
Name & Signature of the Doctor Starting the Drugs:				1 PM 5/7/21
Additional Instructions:				1 AM 5/7/21
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

Signature

VERIFIED BY : Nam

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

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

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

DRUG :				Date Time																
Dose	Route	Frequency	Start Dt.																	
Name & Signature of the Doctor Starting the Drugs:																				
Additional Instructions:																				
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RESULT SHEET

Date	5/7/2012				
Time	12:23 PM				
Hb	13.4				
PCV	38.4				
RBC	4.39				
WBC	10.3				
N/L					
Platelets	345				
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					

BAH-00584697
Mrs NADIRA SHEMA SAMIA
23-12-1994 31 Y 6 M 12 D (F)
Dr. HIMABINDU VEERLA

IPS-00175986



MULTI-DISCIPLINARY PLAN OF CARE FORM

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Diagnosis

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
5.11/26 12pm	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	In Labor	safe delivery	None	[Signature]	☐ Nursing ☒ Others:
5/11/26 12pm	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op	In labor	safe delivery	psychological support	Sandhya	☐ Medical ☒ Others:
5/11/26 5pm	☐ Medical ☐ Nursing ☒ Others: dietitian	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	PND - 0 SVD	Normal diet	Normal High protein diet	Saima	☐ 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:

Patient Sticker

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

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Part - I.

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

Identified Education Needs:

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

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
5/7/25		4.	Informed consent	P1	1	0	1	1		J
5/7/25	1pm	7	Infection control measures	P1	1	0	1	1		Shoker

Part - III: CODES

Who was taught:	PT: Patient	F: Father	M: Mother	S: Spouse	Sn: Son	D: Daughter	C: Caregiver	O: Other (Specify)															
Learning Barriers:	<table border="0"> <tr> <td>1. No Learning Barriers</td> <td>4. Language Barrier</td> <td>7. Impaired Thought Process/Cognitive limitations</td> <td>10. Financial Difficulties</td> <td>13. Cultural/Religion Practice</td> </tr> <tr> <td>2. Physical Impairment</td> <td>5. Educational Level</td> <td>8. Responsibilities at Home</td> <td>11. Beliefs and Values</td> <td>14. Others (Specify)</td> </tr> <tr> <td>3. Emotional Barriers</td> <td>6. Desire / Motivate to Learn</td> <td>9. Cultural Differences</td> <td>12. Impaired Vision/ or Hearing</td> <td></td> </tr> </table>								1. No Learning Barriers	4. Language Barrier	7. Impaired Thought Process/Cognitive limitations	10. Financial Difficulties	13. Cultural/Religion Practice	2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)	3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing	
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2. Physical Impairment	5. Educational Level	8. Responsibilities at Home	11. Beliefs and Values	14. Others (Specify)																			
3. Emotional Barriers	6. Desire / Motivate to Learn	9. Cultural Differences	12. Impaired Vision/ or Hearing																				
Teaching Tools Used:	A: Audio	D: Demonstration	V: Video	O: Oral	P: Printed																		
Mechanism/s to overcome barrier/s:	<table border="0"> <tr> <td>1. None</td> <td>3. Reassurance & Support</td> <td>5. Respect values & beliefs</td> <td>7. Other, Specify</td> </tr> <tr> <td>2. Obtain translator</td> <td>4. Teach Family / Others</td> <td>6. Respect Cultural / Religion Preference</td> <td></td> </tr> </table>								1. None	3. Reassurance & Support	5. Respect values & beliefs	7. Other, Specify	2. Obtain translator	4. Teach Family / Others	6. Respect Cultural / Religion Preference								
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																				



OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 5/1/26 Time of Arrival: 11:50 am Time Seen by Nurse: 11:50 am

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: 96.1°F Pulse: 83 RR: 18 SpO₂: 100% BP: 112/74 Weight:

4) Gestational Criteria:

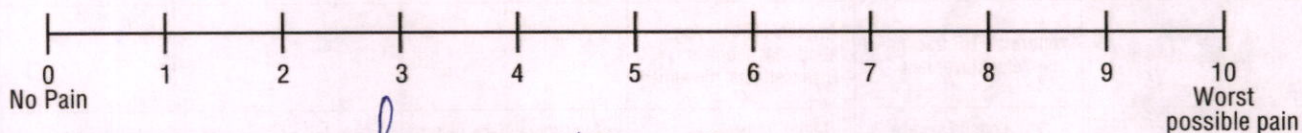
Gravida:	G	<u>3</u>	P	<u>1</u>	L	<u>1</u>	A	<u>1</u>
----------	---	----------	---	----------	---	----------	---	----------

LMP: 11/10/25 EDD: Gestational Age:

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: lower abdomen
- Duration: 1 day Days / Weeks/ Months (Strike out which is not applicable)
- Character: Mild
- Frequency: 3 min
- Interventions: Breathing Exercises

6) Past History:

- a) Surgeries: appendectomy 2011
b) Medical: NA



0, 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: 12:00 PM

Nurse Name: Shirley Nurse Signature: [Signature]

Date: 12/12/2024 Time: 12:00 PM

BAH-00584697 IP5-00175986
Mrs NADIRA SHEMA SAMIA
23-12-1994 31 Y 6 M 12 D (F)
Dr. HIMABINDU VEERLA



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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 5/1/26

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 IOL Doctor Notified on Admission: ☒ Yes ☐ No

Name of the Doctor: Dr. Ashish

Time Notified: 11:40am

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>Nil</u>	<u>appendectomy</u>	<u>Yes</u>
Gynecology Assessment: ☐ Not Applicable Menstrual History: <u>Regular</u> Onset of Menarche: Menstrual Cycle: ☒ Regular ☐ Irregular Last Menstrual Period: <u>11/10/25</u>	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 1

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

Measurements: Temp: 96.1°F HR: 83 RR: 18
BP: 113/74 Weight: Height: BMI:

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

BAH-00584697 IP5-00175986
Mrs NADIRA SHEMA SAMIA
23-12-1994 31 Y 6 M 12 D (F)
Dr. HIMABINDU VEERLA

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 24 (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 the 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: Sandhya

Orientation not given Reason:

Nurse Signature: [Signature]

Nurse Name: Sandhya

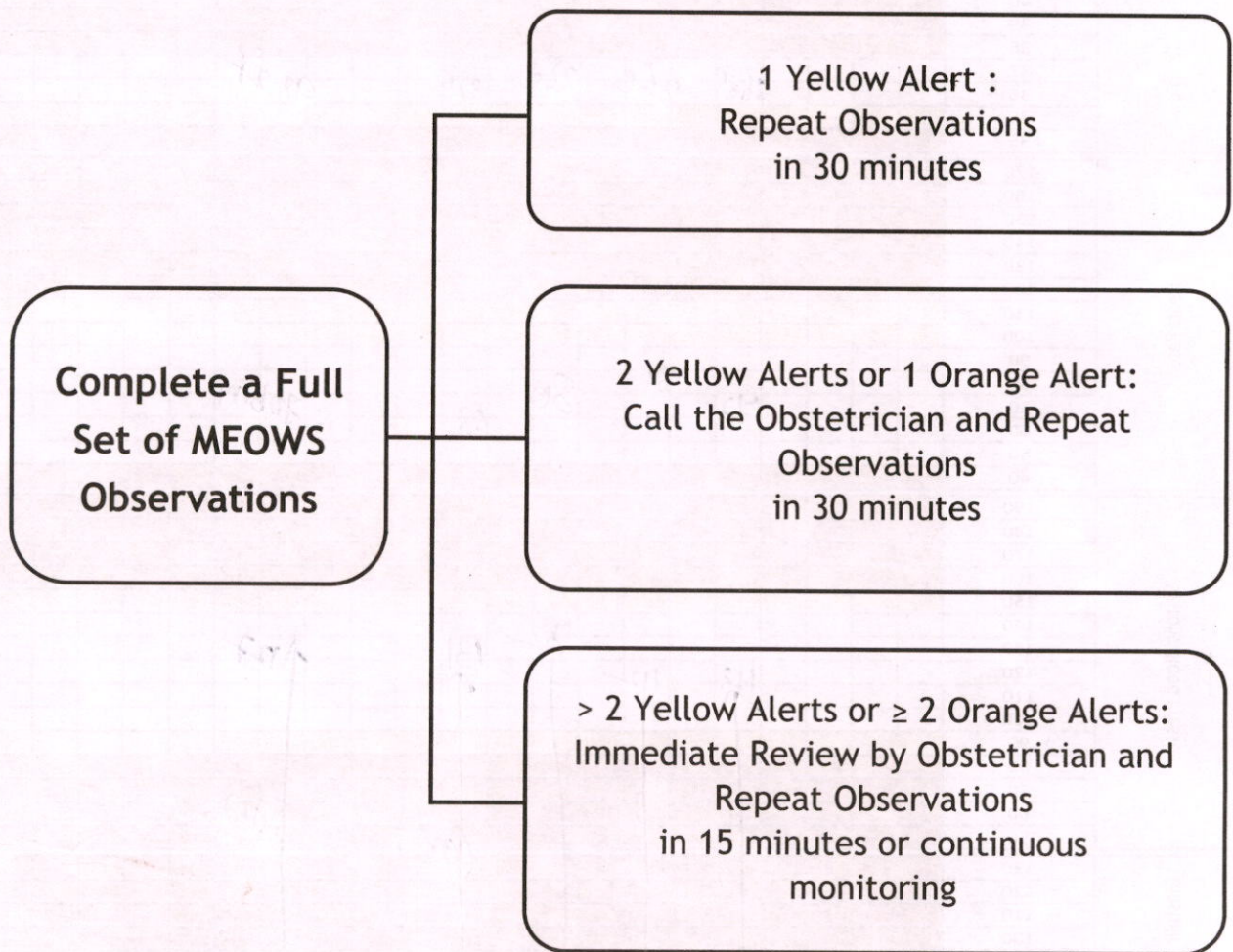
Date & Time: 9/2/2024 2pm



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

Date		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	
Time																										
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20																									
	0 - 10																									
Saturations	94 - 100 %																									
	< 94 %																									
Administered O ₂ (L/min.)																										
Temp °C	40																									
	39																									
	38																									
	37																									
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
40																										
Systolic Blood Pressure	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
60																										
50																										
Diastolic Blood Pressure	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
	NEURO RESPONSE [✓]	Alert																								
		Voice																								
		Pain																								
Unresponsive																										
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein ++																									
	Protein > ++																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES																										
TOTAL ORANGE SCORES																										
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



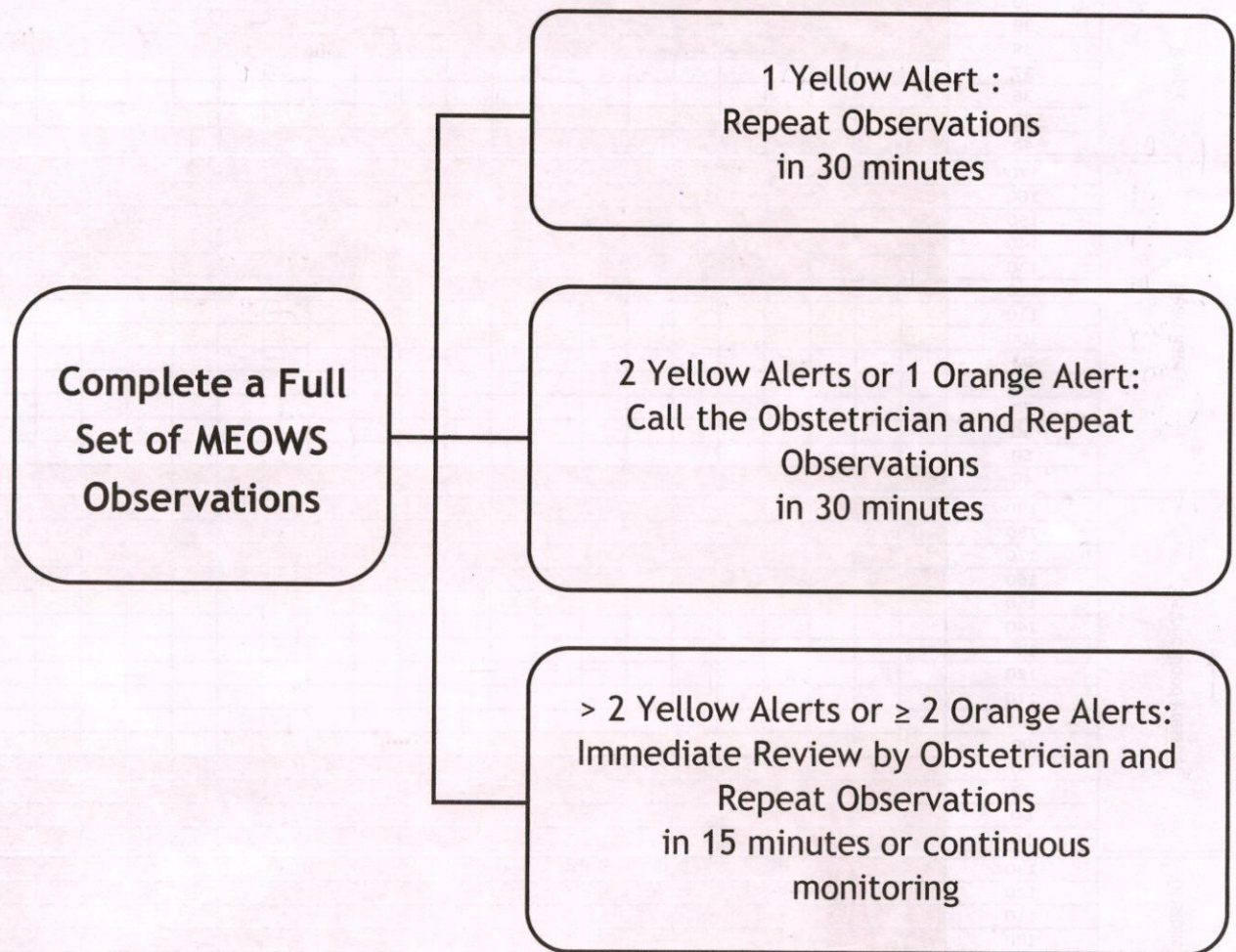
* The Modified Early Warning Score (MEOWS)



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

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

FLUID CHART

Sheet No. : ①

07/16

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

		Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G						
5/7	08:00 am									0	Sng
	09:00 am		u							0	
	10:00 am									0	
	11:00 am									0	
	12:00 pm	Re H2O	100ml						H2O	0	
	01:00 pm	Re H2O	100ml							0	
Total Intake : 200ml					Total Output : passed						
5/7	02:00 pm	Re H2O	100ml							0	Shobha
	03:00 pm	Re H2O	100ml							0	
	04:00 pm	H2O								0	
	05:00 pm								✓	0	
	06:00 pm	H2O								0	
	07:00 pm									0	
Total Intake : 200ml					Total Output : m-o-u						
5/7	08:00 pm									0	Piyush
	09:00 pm	H2O								0	
	10:00 pm								✓	0	
	11:00 pm									0	
	12:00 am	H2O								0	
	01:00 am									0	
Total Intake : 200ml					Total Output : m-o-u						
6/7	02:00 am									0	Piyush
	03:00 am	H2O								0	
	04:00 am									0	
	05:00 am								MP	0	
	06:00 am	H2O								0	
	07:00 am									0	
Total Intake : 200ml					Total Output : m-o-u						
Total 24 hrs. Intake											
Total 24 hrs. Output		m-o-u u-2									

IP-00584697
Mrs NADIRA SHEMA SAMIA
23-12-1994
Dr. HIMABINDU VEERLA
31 Y 6 M 12 D
(F)



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.

6/7/26

		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										0		
	09:00 am										0		
	10:00 am										0		
	11:00 am	NO 20% H ₂ O									0		
	12:00 pm										0		
	01:00 pm										0		
Total Intake :						Total Output :						m-03-2	
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

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

Total 24 hrs. Output	
-----------------------------	--

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NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/1/20

Assessment: Patient Came for lower Abdomen 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
11Am	- Assess the patient general condition	11:30 Am	- Assessed the patient general condition	- patient is stable
12pm	- monitor vitals	12:30 pm	- monitoring vitals, BP, PR, RR, SpO2, Checked & Rechecked	- & Comfortable
1pm	- Soft diet	1:30pm	- Soft diet taken	
2pm	- Maintain I/O chart	2pm	- I/O chart maintaining	
3pm	- Ensure safety		- Ensure safety provided	

Re-Assessment: Patient feeling better medication now no pain, comfortable

Special Notes:

Bleeding

Nurse Signature: [Signature]

Nurse Name: Sona

Date & Time: 5/1/20 @ 2pm

Patient Sticker

NURSING CARE RECORD


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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

Goals

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

Time	Plan of Care	Time	Implementation	Evaluation

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:

BAH-00584697 IP5-00175986
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NURSING CARE RECORD

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Shift: ☐ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: pt complain 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	
3pm	monitor vital	3:10 PM	By spor place checked recorded	pt is
5pm	Administration medication	5:10 PM	Admini ⁿ medication given as doctor order	Stable
7pm	Ensure safety provided	7:10 PM	Ensure safety provided	

Re-Assessment: re Assessment

Special Notes:

Nurse Signature:

Nurse Name: Shobha

Date & Time: 5/6/26 @ 8pm

BAH-00584697
 Mrs NADIRA SHEMA SAMIA
 23-12-1994 31 Y 6 M 12 D (F)
 Dr. HIMABINDU VEERLA

IP5-00175986

NURSING CARE RECORD



Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 05/7/26

Assessment: patient having pain

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

Time	Plan of Care	Time	Implementation	Evaluation
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	→ maintained I/O chart	
2Am	→ To encourage oral intake	4Am	→ encouraged oral intake	
4Am	⇒ To provide comfortable position	6:20 AM	→ provided comfortable position	

Re-Assessment: patient is comfortable

Special Notes:

Nurse Signature: [Signature] Nurse Name: [Signature] Date & Time: 06/7/26 @ 8Am

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23-12-1994 31 Y 6 M 12 D (F)
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NURSING CARE RECORD

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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 6/7/26

Assessment: patient having pain in stitches 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
8am	Assess to the patient condition	8am	Assessed to the patient condition	patient well
9am	Maintain i/o chart.	10am	Maintained i/o chart.	
10am	Maintain vitals	11am	Monitored vitals.	
11am	Encourage to walk	11:30 am	patient ambulated.	
12pm	plan to encourage orally	12:20 pm	patient Ambulated & taking soft diet & plenty of fluid.	
1pm	medication	1:30 pm	medication given as advised.	

Re-Assessment: Reassessment after 2 hr patient well

Special Notes: N/A

Nurse Signature:

Nurse Name: Soulbhagini

Date & Time: 6/7/26 @ 2pm

BAH-00584697
 Mrs NADIRA SHEMA SAMIA
 23-12-1994 31 Y 6 M 12 D (F)
 Dr. HIMABINDU VEERLA

NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☐ Night

Date:

Assessment:

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

Re-Assessment:

Special Notes:

Nurse Signature:

Nurse Name:

Date & Time:



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Himabindu Department: Ble Date of Admission: 5/12/26

SITUATION	Diagnosis: <u>Labour</u>			Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:				
	Area	Shift Time						
BACKGROUND	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>				
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	Vital Signs:	Temp:	<u>98.1°F</u>	<u>98.1°F</u>	<u>98.2°F</u>			
		Res:	<u>19b/m</u>	<u>20</u>	<u>20b/m</u>			
		SpO ₂ :	<u>100%</u>	<u>100</u>	<u>99%</u>			
		Pulse:	<u>76b/m</u>	<u>73x</u>	<u>70b/m</u>			
		BP:	<u>110/60</u>	<u>113/65</u>	<u>120/80</u>			
		Fall Risk Score:	<u>0</u>	<u>20</u>	<u>20</u>			
	Pain Score:	<u>0</u>	<u>0</u>	<u>0</u>				
	Recommendations	Safety Needs:	<u>side rail</u>	<u>side rail</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>				
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>				
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>				
Handed Over By Name :		<u>Sma</u>	<u>Shobh</u>	<u>Deepa</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>5/12/26</u>	<u>5/12/26</u>	<u>6/12/26</u>				
Time:		<u>8pm</u>	<u>8pm</u>	<u>8am</u>				
Taken Over By Name :		<u>Shobh</u>	<u>Deepa</u>	<u>Roshanini</u>				
Signature :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>				
Date:		<u>5/12/26</u>	<u>5/12/26</u>	<u>6/12/26</u>				
Time:		<u>8pm</u>	<u>8pm</u>	<u>8am</u>				

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy: ☐ 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:						

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading		
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	0
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	0
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:			35	35	35
Signature			[Signature]	[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

BAH-00584697 IP5-00175986
Mrs NADIRA SHEMA SAMIA
23-12-1994 31 Y 6 M 12 D (F)
Dr. HIMABINDU VEERLA



BRADEN 'Q' SCALE

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date : 5/1/24	Time : 11:15 AM	5/1/24	8:00 AM
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or 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								
Docu. No. : RCHBH /FRM / CLINICAL / 119								
					TOTAL SCORE			
					Evaluator's Name			
					26 28 28 Rf shob Day			

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							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	+	-	-							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	-	-	-							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	-	-	-							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	-	-	-							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	-	-	-							
Signature of the Nurse				[Signature]									

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 : [Signature] Name : [Signature]

Signature of Ward In Charge :

Signature : [Signature] Name : [Signature]



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7/26	Am	02/10	lower stomach right	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Breathing exercise	sf
5/7/26	12pm	02/10	low abdomen	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	breathing exercise	sf
5/7/26	2pm	0/10	no pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	Shobly
5/7/26	6pm	2/10	stomach	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	T. cal pol given	seema
5/7/26	7pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under observation	seema
6/7/26	6am	2/10	stomach	☐ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Tob. cal pol	Diya
6/7/26	7am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	under Observation	Diya
				☐ 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:

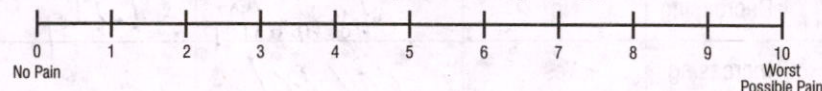
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

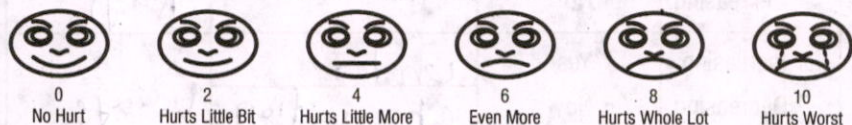
Numerical Pain Scale (Obstetric and Gynecology)



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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
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Re-assessment Frequency:

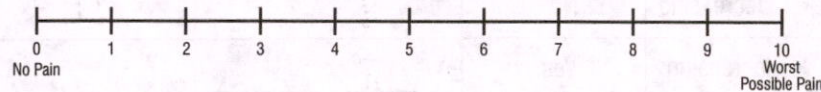
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
 - a) At least every 2 hours for the first 24 hours
 - b) Then every 4 hours.
 - c) Prior to pain pain-relieving intervention.
 - d) Within 30 – 60 minutes after pain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

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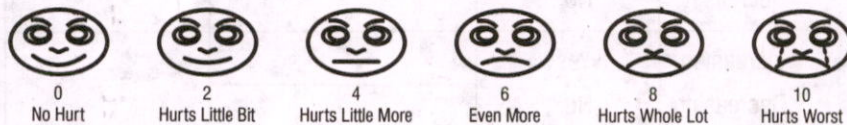
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Wong - Baker (Pediatrics) Above 7 Years



INFORMED CONSENT FOR VAGINAL BIRTH

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H
It tak

Mrs NADIRA SHEMA SAMIA
23-12-1994 31 Y 6 M 12 D (F)
Dr. HIMABINDU VEERLA



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TALS
livery

Patient Name : NADIRA SHEMA SAMIA UHID No : BAN-00584692
Gender: ☐ Male ☒ Female Date : 5/7/20 Time : 12pm

I hereby authorized the performance of the following procedure:

- The Procedure has been explained to me in general terms and I understand that:
- The indication requiring the procedure of vaginal birth is pregnancy.
- The purpose of this procedure of vaginal birth pregnancy.
- The purpose of this procedure is to deliver the bay vaginally.

The outcome of the vaginal birth is the delivery of infant through birth canal either naturally or with possible use of force vacuum extraction. An episiotomy (a cut performed for enlarging of the vaginal opening in the space between the vaginal and the rectum) may be performed as part of a vaginal delivery.

Should vaginal delivery be unsuccessful, delivery by cesarean section with an abdominal incision under appropriate anesthesia may be necessary.

In an attempt to deliver the baby either naturally or with the help of instrument i.e. forceps or vacuum, there may be risks of: infection, allergic reaction, scarring, blood loss, need for blood transfusion, pain and discomfort, injury to urinary tract, possible injury to the baby (laceration, hematoma, skull fracture, nerve injury and brain injury) and possible future pelvic floor dysfunction,

I understand and accept that there are complications, benefits, alternatives including the remote risk of death or serious disability, which exists for me and my baby.

I am aware that in most cases, vaginal delivery results in a healthy mother and baby; however, I realize that there are no guarantees.

I voluntarily consent to the procedures described or otherwise referred to herein. I am aware that they will be performed by a qualified gynecologist.

Name of the Doctor performing the procedure: Dr. Himabindu

Consentee :

Signature : NADIRA

Name : nadira

Date & Time : 5/7/20 12pm

Witness :

Signature : [Signature]

Name : Shobha

Date & Time : 5/7/20 12pm

Docu. No. : RCHBH / FRM / CLINICAL / 028

Patient Attendant :

Signature : [Signature]

Name : [Blank]

Relationship with Patient : Huband

Date & Time : 5/7/20 12pm

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Arshup

Date & Time : 5/7/20 12pm

సహజ ప్రసవం కొరకు సమ్మతి పత్రము

రోగి పేరు : వయస్సు లింగం పు స్త్రీ

యు.పాచ్.బి.డి. విభాగము

తేదీ

ఈ ప్రక్రియ యొక్క వివరములను నేను ఆమోదించాను:

- ఈ ప్రక్రియ నాకు సాధారణ పద్ధతిలో వివరించబడింది మరియు నేను అర్థం చేసుకున్నాను:
- గర్భం దాల్చిన వారికి సహజ ప్రసవ ప్రక్రియ అవసరమవుతుంది.
- ఈ ప్రక్రియ యొక్క ఉద్దేశ్యం (యోని) ద్వారా సహజ ప్రసవం చేయడం.
- ఈ ప్రక్రియ యొక్క ఉద్దేశ్యం బిడ్డను సహజమయిన పద్ధతిలో ప్రసవించటం

సహజ ప్రసవం (యోని జననం) యొక్క ప్రక్రియ సహజంగా లేదా శక్తిని ఉపయోగించి గర్భాశయం ద్వారా శిశువును ప్రసవించడం. వాక్యూమ్ ద్వారా శిశువును వెలికితీయడం, ఎపిసియొటమీ (యోని మరియు యోని మధ్య ఖాళీలో యోని మార్గమును సుగమం చేయుట కొరకు చేసిన కోత (కట్). సహజ ప్రసవం కొరకు చేయు ప్రక్రియలలో భాగము.

సహజ ప్రసవం విజయవంతం కాకపోతే, తగిన అనస్థీషియా ఇచ్చి పాత్తికడుపు కోతతో సిజేరియన్ ద్వారా డెలివరీ చేయవలసిన అవసరం కలగవచ్చు

సహజంగా లేదా పరికరం సహాయంతో అంటే ఫోర్సెప్స్ లేదా వాక్యూమ్ సహాయంతో బిడ్డను ప్రసవించే ప్రయత్నంలో, ప్రమాదాలు ఉండవచ్చు: అంటువ్యాధులు, అలెర్జీ, మచ్చలు, రక్త నష్టం, రక్త మార్పిడి అవసరం పడటం, నొప్పి మరియు అసౌకర్యం, మూత్ర నాళానికి గాయం, శిశువుకు గాయం అయ్యే అవకాశం (లేసరేషన్, హెమటోమా, పుర్రె గాయం ఆయె అవకాశం, నరాలకు గాయం మరియు మెదడు గాయం) మరియు భవిష్యత్తులో కటి ప్రదేశంలోని ఎముకల వలయం పనిచేయకపోవడం

నాకు మరియు నా బిడ్డకు మరణం లేదా తీవ్రమైన వైకల్యం వంటి సమస్యలు తలెత్తు అవకాశం, ప్రయోజనాలు మరియు ప్రత్యామ్నాయాలు ఉన్నాయని నేను అర్థం చేసుకుని అంగీకరిస్తున్నాను.

చాలా సందర్భాలలో, యోని ద్వారా ప్రసవించడం వల్ల తల్లి మరియు బిడ్డ ఆరోగ్యంగా ఉంటారని నాకు తెలుసు; అయితే, ఎటువంటి హామీలు ఇవ్వలేరని నేను గ్రహించాను

ఇక్కడ వివరించిన లేదా సూచించిన విధానాలకు నేను స్వచ్ఛందంగా సమ్మతిస్తున్నాను. ఈ ప్రక్రియ అర్హతగల గైనకాలజిస్ట్ చేత నిర్వహించబడతాయని నేను తెలుసుకున్నాను

ఈ ప్రక్రియను నిర్వహించే డాక్టరు పేరు:

సహాయకుడు(అటెండెంట్)

సాక్షి

సంతకము

సంతకము

పేరు

పేరు

వైద్యుడు (ఎవరైతే సమ్మతి తీసుకుంటున్నారో)

తేదీ మరియు సమయము

సంతకము

పేరు

BAH-00584697 IP5-00175986
Mrs NADIRA SHEMA SAMIA
23-12-1994 31 Y 6 M 12 D (F)
Dr. HIMABINDU VEERLA



320

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 5/7/26

Time: 4:20pm

Origin: Indian Height: 155cm Weight: 73kg BMI: 30.46g/m²

Food Allergies: No

Diagnosis: PND-0 / SVD (spontaneous vaginal delivery)

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

Diet Advised:

Normal High protein diet
include plenty of oral cliquids
avoid spicy, chilled and outside food

Patient's / Attendant's

Signature: Saima

Name: Saima

Date & Time: 5/7/26
4:20pm

Dietician's

Signature: Saima

Name: SAIMA

Date & Time: 5/7/26
4:20pm

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: 5/6/16

→ DFT every 2nd and 3rd day
→ feeding position's explained
→ nipple is well formed

Handover given by Sana

Handover taken by Sana

Signature Sf

Signature Sf

Date & Time: 5/6/16 @ 2pm

Date & Time: 5/6/16 @ 4:30 pm

BAH-00584697 IP5-00175986

Mrs NADIRA SHEMA SAMIA

23-12-1994 31 Y 6 M 12 D (F)

Dr. HIMABINDU VEERLA



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DISCHARGE PLANNING FORM

Nationality: Indian

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

1. Anticipated Date of Discharge: 2 to 3 days

2. Destination Post Discharge: ☒ Home

Family Members Notified (Person Contacted)

☐ Transfer

Hospital Facility Notified (Person Contacted)

3. Discharge Status: ☐ Self Care ☐ Family Home Care ☐ Home Professional Assistance

☐ Needs Assistance In:

Remarks

☐ Medication ☐ Yes ☐ No

☐ Bathing ☐ Yes ☐ No

☐ Eating ☐ Yes ☐ No

☐ Walking ☐ Yes ☐ No

☐ Dressing ☐ Yes ☐ No

☐ Toileting ☐ Yes ☐ No

no needed
assistance

4. Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☐ Patient

☐ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☒ Patient

☐ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☒ Educational Topic/s: Personal Hygiene

☐ Patient's Educational Topic/s discussed with the:

☐ Patient

☐ Family Member

☐ Others:

Nurse Signature: Sif

Nurse Name: Sona

Date and Time: 5/7/20 @ 1PM

PATIENT TRANSFER FORM

Patient Name & UHID No.		Date & Time of Admission	Date & Time of Transfer Order
BAH-00584697 IP5-00175986 Mrs NADIRA SHEMA SAMIA 23-12-1994 31 Y 6 M 12 D (F) Dr. HIMABINDU VEERLA 		5/7/26 11:47 AM	5/7/26 4:00 PM
		Transfer Ordered by	Reason for Transfer
		Dr. Arsha	Observation
From Unit	To Unit	Information to Attendant	
BB-211	3rd floor (320)	Yes ☒ No ☐	
Number of Sheets in Clinical File	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?	Patient shifted with ID band:	
Number of Imaging Films		Yes ☒ No ☐ If No:	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	/		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring		Name of Person Ordered Transfer	
SE Shobha		Dr Arsha	
Patient & Clinical Records Received by :			
Same 5/7/26 @ 4:30 PM			
Date & Time of Patient Received :			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready