

BAH-00550644
Mrs RAFAT TARRANUM
14-06-1988 38 Y 0 M 20 D (F)
Dr. RAO BAHADUR BADUGU

Mrs RAFAT TARRANUM (38 Y 0 M 20 D)
NIN/00212
BA26067083032

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the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

SURGERY DETAILS

80861

Date: 04/07/26

Patient Name: Rafat Tarranum Date of Birth: 14/06/1988 Age: 38y

Gender: Female Ward: Ddg-OT-II UHID No: BAH-6080644

Date of Surgery: 04/07/26 ☐ OT-1 ☒ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery: Cervical Amputation + Minimal Cystocele Repair

Time in: 12:08pm Time Out: 2:15pm

Cash
pt

NAME

AMOUNT

- Surgeon : DR - Rao Bahadur Badugu
- Anaesthetist : Dr. Shetty
- Assistant Surgeon :
- OT Technician : Gopi
- Circulating Nurse : Swapna
- Assistant Nurse : Prabhavathi

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

Signature of the Surgeon: [Signature]
9/7/2026

Signature of Circulating Nurse: [Signature]

Order No: 9687733

Order by: [Signature]

$$\begin{array}{r|l} 43680 & 11870 \\ 17220 & 5305 \\ \hline & \end{array}$$

Update 05/Jul/26 / 11:30AM

As d/w Dr. Bahadur Rao, C-7 + C-15
(100%) (50%)

Pvt Room

SR : 60,900

ASR : 6,090

AR : 17,175

AAR : 6,090

DT : 48,720

OTC : 9,500

CSRD : 1827

11/11/26
 11/11/26

BAH - 00550644
MRS. RAFT TARRANUM

CYTOCELE
REPAIR

Rainbow
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It takes a lot to treat the little.

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CONSUMABLES OF OT

Circulating staff : Technician : Date : 4/7 Time : 12:30 PM

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube 7.0 - 7.5	1+1	—	Major Pack + leg gency	1+1	1+1	Inj Vit.K	1	1
LMA 3.4	1+1	—	Sutures			Cord Clamp		
ECG leads A / P / N	5	03	2317	3	1	Suction Catheter		
HME filter A / P / N	01	—	2346 (2347)	2	2	Feeding Tube		
Syringes : 10 cc	10	05				Vaccum Suction Set		
05 cc	10	03	Gloves 6.5 7.7.5	2+2	1+1	Surgical Gloves		
02 cc	10	03	6.5 7.7.5	2+2	1+1	Gauze Pack		
01 cc	5	—				Syringe 1ml / 2ml		
Cautery plate A / P / N	01	01	Surgical blade 15 (22)	1+1	1	Surgical Blade # 20		
IV set	01	01	NG tube			Koochie (S)		
RL	01	02	Cautery pencil	1	1	NS Boom 1	1	1
NS : 10ml / 100ml / 500ml / 1000ml	2+2	1+2	Koochie			Transfix	1	1
with spide	01	01	Ointments			1000 5cc	2+2	2
vaccum set	01	01	Suction Catheter			Jelly.	1	—
Fentanyl	01	01	Cap, Mask	5/5	10+10	Turp Set	1	—
Morphine			Gauze Pack N+R	2+2	2	Dil, Air	2	2
Ketamine			Mop Pack	1	1			
Propofol	04	—	Steristrip					
Rocuronium	01	—	Underpad	1	1			
Glycopyrolate	01	—	Draw sheet	1	0			
Myopyrolate	01	—	Abgel					
Ondansetron	01	—	Foleys catheter 8.14	1+1	1+1			
Pencan 25g/ Spinal Needle 22	01	01	Probag	1	1			
Bupivacaine 0.25%	01	—	Chest Drainage Catheter			OA - 23	1+1	—
Bupivacaine 0.25% (Heavy)	01	01	Romodrain bag			OA 28.30	1+1	—
Antibiotics			Bandage			Osmole (a)	01	—
Du pen	01	—	Tegaderm			Scrub Books (S.M)	1+1	—
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent			FOURER	02	
Supridol 100mg	01	01	Vaccum Suction set	1	1			
Justin : 12.5 mg / 25mg / 100mg	01	01	Plastic Bed Sheet	1	—			
Tab. Misoprost : 200mg			Betadine Solution	1	1			
Swamp 10cm + 100cm	1+1	—	Microshield	1	—			
Green Suture	5+1	1+1	Cotton Balls	1	—			
Dece + Tissue	1+2	—	Latex Gloves	10P	5P			
Du Cauda 2018	1+1	—	Ramdione Scrub					
Depositor	04	—	Saral					

Surgeon : Anaesthesiologist : Nurse : OT Technician :
 Order No. : 9687583 Ordered by :
 Doc. No. : RCH / FRM / GENERAL / 125

ESTIMATION SLIP

Date: 20-Feb-26 UHID / IP No.: IBAH-00550644 SI No. 80861
 Name of Patient: Mr. Rishi Tammam Age: 36yrs Gender: Female
 Father's / Husband's Name: Mr. Syed Basid Corporate / Occupation: Business
 Address: 9910777325 Phone: 9910777325 Email:
 Procedure / Plan: Cystosale Repair

MODE OF PAYMENT: ☐ SELF ☒ TPA: Aditya Bala - Ind. 2005-Feb ☐ GIPSA: ☐ OTHERS:

TARIFF INFORMATION:

ROOM CATEGORY		GW	SW	TSW	PR	DLX	SDLX	NICU	PICU	MICU	DAY CARE	
(Per Day)	Room Rent & Nursing Charges				18200							
	Doctor's Fee				per day NA-							
	L. Tax											
PARTICULARS					AMOUNT (₹)							
Surgeon's / Anesthetists's Fee / O.T. Charges					Per →	52278		(AF+AAF) + (OT) 17712 13000				
O.T. Consumables					→ 9500	Subject to approval by TPA / Insurance Company						
Instrument Charges					any → extra	Not Covered by TPA / Insurance company						
Pharmacy, Consumables & Investigations					extra	As per actual - Not Included in Estimation						
Equipment Charges	Monitor :		Oxygen :				Infusion pump / Syringe pump :					
	Ventilator :	Conventional :					HFO-SLE 5000 :	HFO Sensormedix :				
	Phototherapy :	Single Surface :					Double Surface :	Triple Surface :				
Blood/ Blood products / Implants / IP or OP Procedures / Cross Consultations, Etc.					extra	As per actual - Not Included in Estimation						
Package												
Others					Mesh → extra							
Initial Minimum Deposit					10000	for 8 bill clearance						

- MARKS:** 6B-1.500/- OT deposit-5000/-
- The estimated amount may change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
 - The estimated surgical charges may vary subject to surgeon's decisions / Complications/Patient's requirements / Mode of Procedure (Like Laparoscopic, Thoracoscopic, etc) / Unilateral to Bilateral Procedure.
 - In case the patient is shifted from lower category to higher category, all charges for the consultant visit, investigations, operations and/or procedures from the date of admission will be according to the higher category.
 - Room eligibility is purely subject to TPA approval and the package/Room tariff starts from the time of admission.
 - Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA/Insurance Company at later stage.
 - For Non-Medicals, Disposables, Consumables, Infusion Pump, Taxes, Implants, HIV/HbsAg, Medical Records, Double Occupancy and Registration Charges, etc, credit cannot be extended. These items are not payable to us as per Insurance Company norms.
 - During Non-working hours of O.T (8:00 PM to 7:00AM), Sundays & Public Holidays, 30% extra charges are applicable on surgical cost, and this is not covered by TPA/Insurance company. In case the length of stay is beyond the package permitted, additional payment is applicable, for which kindly contact the Financial Counseling desk between 9am to 6pm
 - Difference, if any between the final bill amount and amount permitted/ approved by the TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
 - Two attendants are permitted with patients in SDLX, DLX and PVT Rooms and only one is permitted in the rest of the categories of rooms. And no attendant is permitted in ICU's. Kindly check your billing status on day to day basis at IP Billing Department.

DECLARATION

I Syed Basid have attended the Financial Counseling desk and understood the expected costs and other conditions applicable. In case the TPA/Insurance Company rejects the claim for whatsoever reasons at any point of time after discharge, I promise to settle the claim with the hospital

Signature of the Client

Signature of the Financial Counselor

Signature of the Financial Counselor

25/Jul 26

Mrs Rafat Thareem
Cervical Amputation + Cystocele Repair

BATH-00550644

Des: 04/Jul
Dr. Bahadur Rao

If → Put Room | Aditya Borla | Gyne

Gyne ~~667~~ SF
C-7 → 47,520
(100%) +

AF
12960
+

C-55 → 18720
(50%)

5760

= SF → 66,240

AF → 18,720

ASX → 6,624

AAx → 6,624

OT → 12,000/- per Hour

Date: 12/May/2026

TO WHOMSOEVER IT MAY CONCERN
FOR THE PURPOSE OF CREDIT LETTER REQUEST FROM SBI

This is to inform you that our patient Baby. **Shanvi Dharavath**, 10Y 3M, Female with UHID: MAH-00313241, D/o Mr. Sateesh Dharavath (SBI Emp ID: 6545106) & Mrs . **Swathi Rani** has been admitted on 07-Apr-2026 under care of **Dr.V.V.R Satya Prasad** and diagnosed as **(Medical Summary Enclosed)**. The child would require a ward stay of 2-3 days.

The inpatient expenses of the child would be approximately **Rs.91,900/-** (Rupees Ninety One Thousand Nine Hundred Only).

ADMISSION SHEET



Registration Details :

Admission No : IP5-00175965 Admit Date : 04-Jul-2026 Admit Time : 10:59 AM UHID : BAH-00550644

Patient Details :

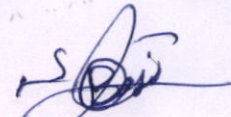
Patient Name	: Mrs RAFAT TARRANUM	Age	: 38 Y 0 M 20 D
Guardian	: MR SYED BASIT	DOB	: 14-06-1988
Gender	: Female	Religion	: Hindu
Occupation	:	Martial Status	: Married
Address (H)	: 4-2-71, ZAINULABADEEN GALLI, BHANISA Bhainsa Adilabad Telangana INDIA 504103	Phone No	: 9912777325
		E-mail	: NOMAIL@GMAIL.COM

Admission Details :

Bed Type : DAY CARE Bed No : RC 407 Ward Name : 4F-GYN RECOVERY
Room No : RC 407 Admission Type : First Visit

Contact Details :

Name : MR SYED BASIT Relationship : Husband
Contact Address : 4-2-71, ZAINULABADEEN GALLI, BHANISA Phone No : / 9912777325
Bhainsa Adilabad Telangana INDIA 504103


Signature

Doctor Details :

Doctor Name : Dr. RAO BAHADUR BADUGU 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 : _____

UHID No. : _____ IP N **BAH-00550644** IP5-00175965
Mrs RAFAT TARRANUM
14-06-1988 38 Y 0 M 20 D (F)
Dr. RAO BAHADUR BADUGU

Date of Admission: _____ Discharge : _____ Time: _____

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/3/26	12:30pm	AYN	OT	ney
4/3/26	2:30pm	OT	AYN	RP
4/4/26	3pm	AYN	340	ney

Cross Consultation Visit

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

[illegible]

Signature

44



HTL-20619

[illegible]

Date	Procedure	Quantity	Order No.	Signature
	PAC	09 bench		
4/7/26	ev placent			
4/7/26	Cert-hir zatur			

ANY OTHER INFORMATION

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Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor

BAH-00550644 IP5-00175965
Mrs RAFAT TARRANUM
14-06-1988 38 Y 0 M 20 D (F)
Dr. RAO BAHADUR BADUGU



I.P. AD.

GYNECOLOGY

Date of Admission : 4/7/26

Time of Admission : 11Am

Allergies:

☒ Not know any drug allergies

PRESENTING COMPLAINTS :

P₄L₄, Prev NVD, Clo recurrent UTI since 4yrs.
Klco Cystocele since 3 yrs.

MENSTRUAL HISTORY

Year of Marriage : 2006
Previous Periods : regular 3-4/3days
LMP : 10/5/26,
Contraception : tubal ligation

OBSTETRIC HISTORY

Parity : P₄L₄
Mode of Delivery : NVD
Last Child Birth : 2022

PAST MEDICAL HISTORY

Recurrent UTI.

PAST SURGICAL HISTORY

abd. tubal ligation - 2022



MEDICATION HISTORY:

Nil.

Nil.

INITIAL ASSESSMENT :

Date <u>4/7/20</u>	Breasts	Local/Speculum Examination <u>ex Elongated.</u>
Ht. _____ Wt. _____		
BMI _____		
B.P. <u>117/20 mmHg</u>		
Pallor <u>(-)</u> PR <u>7</u> <u>4 mm.</u>	Abdominal Examination <u>Soft.</u>	Bimanual Pelvic Examination
CVR <u>(+)</u>		
Respiratory System <u>(+)</u>		
Thyroid <u>(-)</u>		

PROVISIONAL DIAGNOSIS :

P₄L₄ - Prex NVD Recurrent UTI + Gynoele.

INVESTIGATIONS ORDERED

PLAN OF MANAGEMENT

O (+) ve (ord).

Admission

29/6: same C.I. - No growth.

Informed consent

Hb. 11.7

Pre BGT.

WBC - 5.32

Prep of parts

plt - 3.49.

check Blood availability

Vizab. NR.

send of one cell

Ultrab Monitor

Name of the Doctor :

Dr. Bahadur

Signature of Doctor

[Signature]

Date & Time :

4/7/20, 11 AM.



OPERATION THEATER NOTES

Patient's Name : Rafat Poranum Age : 38y Gender : ☐ Male ☒ Female

UHID No. : BAH - 00550644 Weight : 70kg Height :

Surgeon : Asst. Surgeon :

Anesthetist : Dr. Shriya OT Nurse : prabharathi OT Technician : Gopi

Pre-Operative Diagnosis : P/L4 - power NVD recurrent UTI + cystocele

Surgical Procedure : cervical amputation + cystocele repair

Indications for Surgery : Recurrent UTI + cystocele

Date : 06/07/26 Start Time : 12:38 pm End Time : 1:43 pm

Pre Operative Preparations :

Post Operative Diagnosis : POD 0 / cervical Amputation + cystocele repair

Peri-Operative Complications : Nil

Operation Notes : ↓ aseptic precautions , perineum & abdomen cleaned and draped.

Findings : ① Minimal cystocele noted.

② Cervix is elongated & bulky extending till P. introitus.

Consent For cervical Amputation - taken.

③ Anterior & posterior lip of cervix are held with Allis Forceps.

- ④ Circumferential Incision above the external os taken. Bladder pushed up, Incision extended downward
- ⑤ Excess ^{vaginal} tissue removed, Gynoecele repair done
- ⑥ Elongated part of cervix is Excised with Monopolar cautery
- ⑥ Anterior lip of cervix is sutured to Anterior wall vagina
- ⑦ posterior lip of cervix sutured to posterior wall of vagina, Hemostasis secured,

Amount of Blood Loss:

~ 50-100ml

Blood Transfused (in ML)

nil

Name and Number of Surgical Specimen sent for examination:

amputated cervix

Peri-Operative Complications:

- ⑧ Foley's bulb kept ^{intra}cervically & inflated with distilled water; to prevent cervical stenosis.
- ⑨ procedure unremarkable.

Name of the Surgeon:

Signature of the Surgeon:

Date & Time:

Dr. B. B. RAO
4/7/2026



OBSTETRICS / GYNÉCOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 4/7/26

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: P4 Lt c/o recurrent
UTI & since 4 yrs

Doctor Notified on Admission: ☐ Yes ☒ No

Name of the Doctor: DR. Agneha

Time Notified:

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

Past Medical History	Past Surgical History	Previous Hospital Admission
<u>UTI</u>	<u>Tubectomy</u>	<u>No</u>

Gynecology Assessment: ☐ Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History:	Caesarean Section: ☒ No ☐ Yes	Contraceptives: ☒ No ☐ Yes
Onset of Menarche:	Cervical Cerclage: ☒ No ☐ Yes	Vaginal Discharge: ☒ No ☐ Yes
Menstrual Cycle: ☒ Regular ☐ Irregular	Ectopic Pregnancy: ☒ No ☐ Yes	Post-Coital Bleeding: ☒ No ☐ Yes
Last Menstrual Period: <u>new pus</u>	Myomectomy: ☒ No ☐ Yes	Infertility: ☒ No ☐ Yes
	Others:	If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G P 4 L 4 A

Previous LSCS:

Current Medication: ☒ None ☐ Yes, If Yes, Fill the reconciliation form

Family History: ☐ No Abnormalities Detected

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease
☐ Liver disease ☐ Other

Vital Signs / Measurements: Temp: 98.6°F HR: 86/bt RR: 20/bt
BP: 106/74 mmHg Weight: 70 kg 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

SOCIAL SCREENING:

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

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

Social History: Lives With Family

Orientation has been given regarding the following aspects:

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

Above information given to patient

Name of Person Orientation was given to: Mrs. RAFAT

Orientation not given Reason:

Nurse Signature: [Signature]

Nurse Name: Neeraj

Date & Time: 4/2/26 at 11:30 AM

BAH-00550644
Mrs RAFAT TARRANUM
14-08-1988 38 Y 0 M 21 D (F)
Dr. RAO BAHADUR BADUGU

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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	3			
7	Nursing plan of care and handover sheets	5			
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	2 + 1			
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)	1			
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record				
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
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	1			
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				
		2			
		2 + 5 + 1			
	Total No. of Pages				

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



①

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/26 2:30pm	Pod - 0 Gc/Fai afebrile PR - 60/min BP - 110/70 mmHg SpO ₂ - 99% @ R P/A - soft	Canical amputation + Gynae Repair. adv - 1Bm for 6h - vitals 2nd h - Drip as charted - w/ Jacki Reedy - (w) Fluids - 1Bm - Informers - Foley catheter x 48h
4/7/26 2:30pm	Intra-cervical Foley (+) x 10 days P/A - NAB	Dr. Arshay
noted by Nufner		
4/7/26 4:20pm	Pod - 0 Gc/Fai afebrile PR - 80/min BP - 112/70 mmHg SpO ₂ - 98% @ R P/A - soft	adv - 8al liquids - 8pm - soft diet - 10pm - vitals 6th h - Drip as charted - w/ active Reedy - Informers - Shift to room - Foley x 48hrs.
4/7/26 4:20pm	Intra-cervical Foley (+) x 10 days P/A - NAB	Dr. Arshay

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/2026 7:00 pm	POD-0 / Cervical amputation + Cystocele Repair pt comfortable.	
NO-adequate.	Off C. & T. care vitals stable P/A - soft	Adv ① Liquid diet ② Soft diet from 10:00 pm ③ Drugs as charted ④ Monitor vital signs ⑤ Soft cervical bleeding ⑥ Inform S/S
on	Intra venous Foley's ① inj. cefotaxim inj. metrogyl.	DR. Diney Noted by S/S
5/7/2026 8:00 am	POD-1 / Cervical amputation + Cystocele repair pt comfortable C. & T. care vitals stable P/A - soft Intra venous Foley's ①	Adv soft diet preg as charted ambulation hydration w/ active bleeding Inform S/S
on	inj. cefotaxim inj. metrogyl	DR. Diney N.B. - 10:00 am
S/E. Due.		



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/11/26 6pm	POD-1 flaccid apnoeic PR - 84/min BP - 100/60 mmHg SpO2 - 98% @ RA P/A - soft Intra-cervical P/A - NAB Foley's @ X 10 days.	Cervical Amputation + Cystocoele repair adv - soft diet - Ambulation - vitals sthy - Am Drop charts - w/p cath bleed - Informants - Remove foley's 6 AM (5/11/26) Dr. Arshay
5/11/26 6:30 AM	POD-2 flaccid apnoeic PR - 84/min BP - 107/57 mmHg SpO2 - 98% @ RA P/A - soft P/v - NAB Intra-cervical Foley's @ X 10 days.	Cervical Amputation + Cystocoele repair No complaint adv - soft diet - Ambulation - Encourage voids - Drop charts - w/p cath bleed - Informants - Review with Dr. Bahadur Sir on ward Dr. Arshay

Noted by
Shirish
602537

Dr. RAO BAHADUR BADUGU

BAH 00550644



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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Ms. RAFAI TARRANUM

Patient Sticker



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It takes a lot to treat the little.



BirthRight™
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Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

BAH-00550644 IP5-00175965

Mrs RAFAT TARRANUM

14-06-1988 38 Y 0 M 20 D (F)

Dr. RAO BAHADUR BADUGU



Patient

**Rainbow
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POST-SURGICAL CARE PLAN FORM

Procedure Done:

Cervical Amputation + Gynocoele Repair
Psoo

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

Temp, PR, BP, SpO₂ - Every 2nd hr

Wound Care:



Drain /Special Lines/Catheters:

Intra-cervical Foley (+) Int ⇒ remove after 10 days.
Foley catheter x 48 hrs

Special Patient Positioning and Requirements:

Supine 14-16h.

Nutritional Instructions:

NBM 4-6h.

When to Start Mobilization:

after 14-16h.

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)

Rao
17/2026

Date: 4/7/26 Time: 2pm

Note: Plan of care will be readjusted if necessary.

SURGICAL SAFETY CHECKLIST

Surgeon :
Asst. Surgeon :
Anaesthetist : Dr. Shrinu Prabhakar
Scrub Nurse :

Patient No.
UHID No.

Date 04/07/26 In-time : 12:08 pm Out-time : 2:15 pm

BAH-00550644 IP5-00175965
Mrs RAFAT TARRANUM
14-06-1988 38 Y O (F)
Dr. RAO BAHADUR BADI



Gender : F

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Before Induction of Anaesthesia ➤ ➤ 45

SIGN IN

Time: 11 am

Patient Has Confirmed

Identity ☒ Yes ☐ No
Site ☐ Yes ☒ No
Procedure ☒ Yes ☐ No
Consent ☒ Yes ☐ No

Site Marked

☐ Yes ☐ No ☒ NA

Anaesthesia Safety Check Completed

☒ Yes ☐ No

Pulse Oximeter on Patient & Functioning

☒ Yes ☐ No

Does Patient have a:

Known Allergy? ☐ Yes ☒ No

Difficult Airway / Aspiration Risk?

Yes, & Equipment / Assistance Available ☒ Yes ☐ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?

Yes, and Adequate Intravenous Access and Fluids Planned ☒ Yes ☐ No ☐ NA
Blood Units Reserved ☐ Yes ☒ No ☐ NA

Has Antibiotic Prophylaxis been given within the last 60 minutes?

☒ Yes ☐ No ☐ NA

Signature : [Signature]

Name : Dr. Sundaresan

Before Skin Incision ➤ ➤

TIME OUT

Time: 12:32 pm

Confirm all team members have introduced themselves by Name and Role

☒ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm

Correct Patient (Check ID Band) ☒ Yes ☐ No
Correct Site ☒ Yes ☐ No
Correct Procedure ☒ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:

What are the Critical or Unexpected Steps, Operative Duration, 1 hour
Anticipated Blood Loss? 500ml ☒ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns? Nothing ☐ Yes ☒ No ☐ NA

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☒ Yes ☐ No ☐ NA

Is Essential Imaging Displayed?

☐ Yes ☒ No ☐ NA

Power Supply, Earthing, Power Backup and functioning of equipment checked.

☐ Yes ☒ No

Signature : [Signature]

Name : Swarna

Before Patient Leaves Operating Room

SIGN OUT

Time: 1:43 pm

Nurse Verbally Confirms with the Team:

The Name of the Procedure Recorded ☒ Yes ☐ No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☒ Yes ☐ No ☐ NA
The Specimen is Labelled (including patient name) ☐ Yes ☒ No ☐ NA
Whether there are any Equipment Problems to be addressed ☐ Yes ☒ No ☐ NA

To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient? ☐ Yes ☒ No

Signature : [Signature]

Name : 4/7/26

BAH-00550644 IP5-00175965

Mrs RAFAT TARRANUM

14-06-1988 38 Y 0 M 20 D (F)

Dr. RAO BAHADUR BADUGU



Patient Sti

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BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 04/07/26

Department : obg. OT-II Duration of Procedure : 1hr

Name of Surgeon : Date of Admission : 04/07/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? ☒ Yes ☐ No ☒ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☒ Yes ☐ No Name of the Antibiotic : <u>Tinj. cefotaxime 1gm</u>	<u>Seen</u>
2.	Hair Removal ☒ Yes ☐ No if Yes : Surgical Clipper Department where Hair Removed : ☒ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☒ Yes ☐ No	<u>Seen</u>
3.	Patient's body temperature immediately post operation (Recovery Room) <u>37.2</u> °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	<u>Seen</u>
4.	Name of doctor or staff administering the antibiotic <u>Dr. Rao Bahadur Badugu</u> Date & Time of antibiotic administration : <u>04/07/26 @ 11:15am</u> Date & Time procedure started : <u>04/07/26 @ 12:30pm</u>	<u>Seen</u>

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

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

BAH-00550644 IP5-00175965
Mrs RAFAT TARRANUM
14-06-1988 38 Y 0 M 20 D (F)
Dr. RAO BAHADUR BADUGU



Blood group *o+ve*

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RESULT SHEET

Date	29/6/26				
Time					
Hb	11.7				
PCV	37.3				
RBC	4.47				
WBC	6.32.				
N/L					
Platelets	349				
CRP					
ESR					
PCT					
RBS	106				
Na	138.				
K	3.9				
Cl	103.				
Ca/Mg					
Phosphate					
Urea					
Creatinine	0.6				
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	14/1.0				
APTT	29.				
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
HIV, HBsAg, Hcw						

HIV, HBsAg, Hcw } -VE

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

X-Ray :

ECHO :

CT :

MRI :

Others (ECG, Contrast Studies etc.,) :



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: 01 Shifted to: 340

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						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Ashu

Date & Time : 4/7/20 11 AM

Nurse Name & Signature: Reegni Key

Date & Time : 4/7/20 at 11 AM

Weight. 70 lb Ward.

Page: 2/4



Date Time		Nurse Sig.	Nurse Sig.	Nurse Sig.	Nurse Sig.
DRUG :	Dose		Dose		Dose
	Dr. Sign.		Dr. Sign.		Dr. Sign.
Route	Dose		Dose		Dose
	Dr. Sign.		Dr. Sign.		Dr. Sign.
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	Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.	
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
4/7/26	11:10 AM	INJ PANTOP	40mg	IV	[Signature]	Key Sugm
04/07/26	1:45 pm	SUP TRAMADOL	100mg	P/R	[Signature]	Key Sugm
04/07/26	1:45 pm	SUP DICLOFENAC	100mg	P/R	[Signature]	Key Sugm
04/07/26	1:10 pm	INJ TRANEXEMIC ACID	1gm	IV	[Signature]	Key Sugm
4/7/26	7:25 pm	INJ. ZOFER	4mg	IV	[Signature]	Key Sugm
4/7/26	7:25 pm	INJ. PARACETAMOL	1gm	IV	[Signature]	Key Sugm
5/7/26	10 pm	INJ. ZOFER	4mg	IV	[Signature]	Kalyani Anasuka
5/7/26	10 pm	INJ. PANTOP	40mg	IV	[Signature]	Kalyani Anasuka
6/7/26		P. Dulebox 2		P/O	[Signature]	

I.V. FLUIDS CHART

Weight. 70 kg Ward.

[illegible]

Weight Ward

DRUG :				Date	Weight	Ward
Tab. PAN TOP				5/7/17		
Dose	Route	Frequency	Start Dt.			
Comp	Po	BD	4/7/17			
Name & Signature of the Doctor Starting the Drugs:						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

DRUG : T. Cefixime				Date 6/8 Time 6/8
Dose 200mg	Route po	Frequency qd	Start Dt. 6/7/20	
Name & Signature of the Doctor Starting the Drugs: Dr. Aruney.				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

[illegible][illegible]

BAH-00550644 IP5-00175965
Mrs RAFAT TARRANUM
14-06-1988 38 Y 0 M 20 D
Dr. RAO BAHADUR RADHAKRISHNAN (F)



Sheet No:

REGULAR PRESCRIPTIONS

Weight

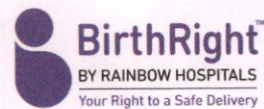
Ward

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

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

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

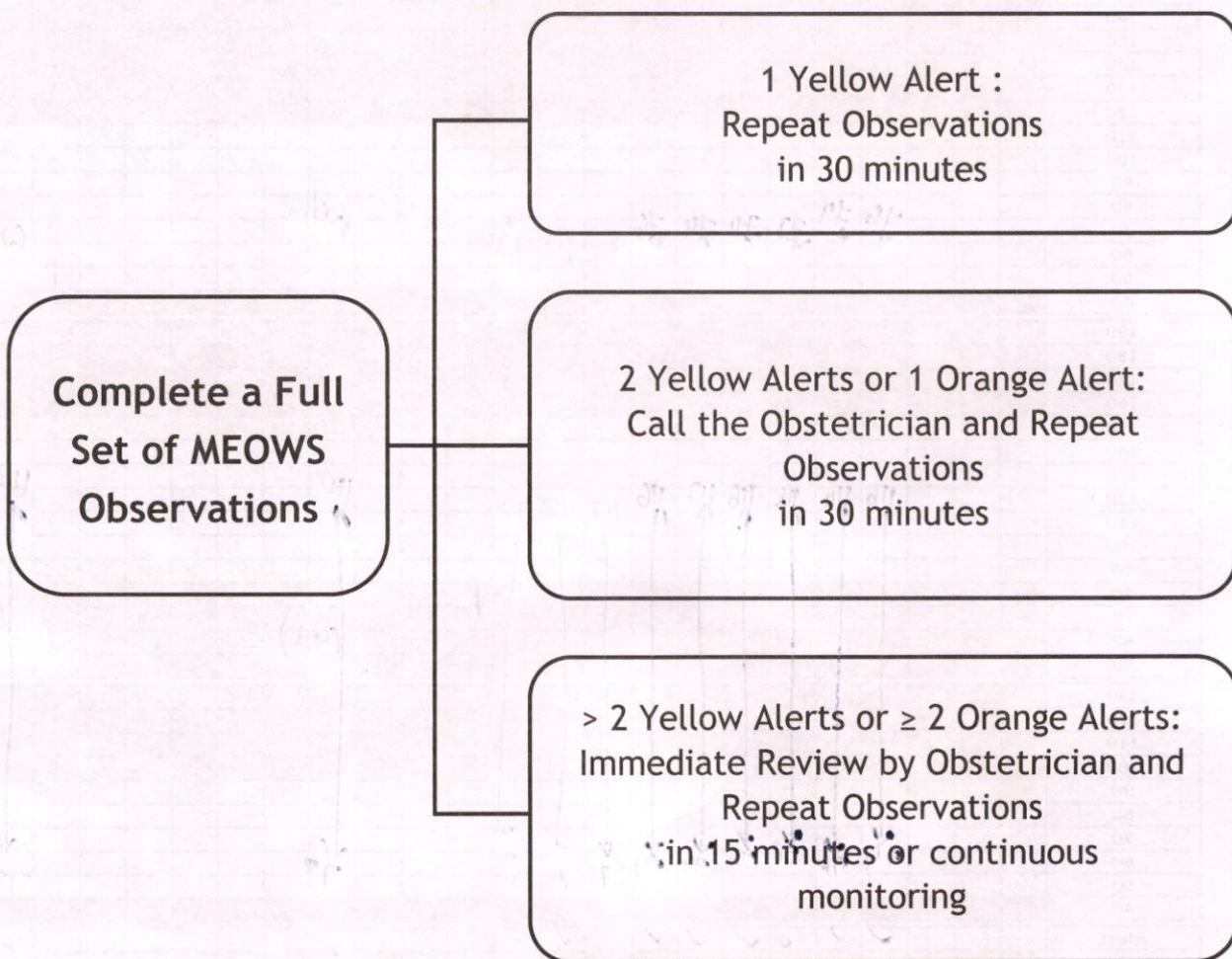
DRUG :				Date Time
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				



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

		Date		Time																											
		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7						
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 / hour	> 30																														
	< 30																														
Proteinuria	Protein ++																														
	Protein > ++																														
Hematuria	Normal																														
	Heavy / Foul																														
Color	Clear / Pink																														
	Green																														
YELLOW SCORES																															
ORANGE SCORES																															
Nurse Initial																															

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

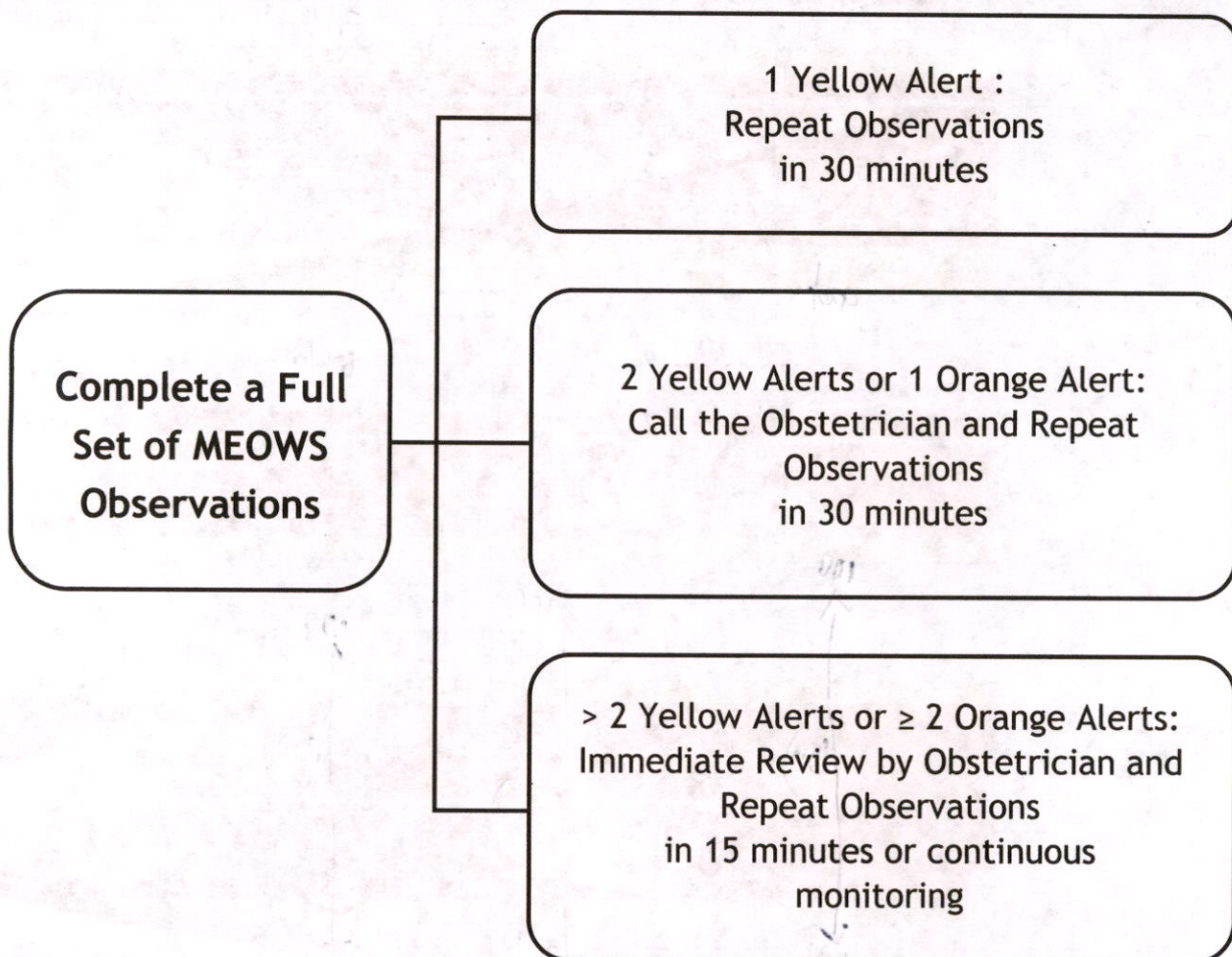


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

		Date																												
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7				
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																													

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Mrs RAFAT TARRANUM
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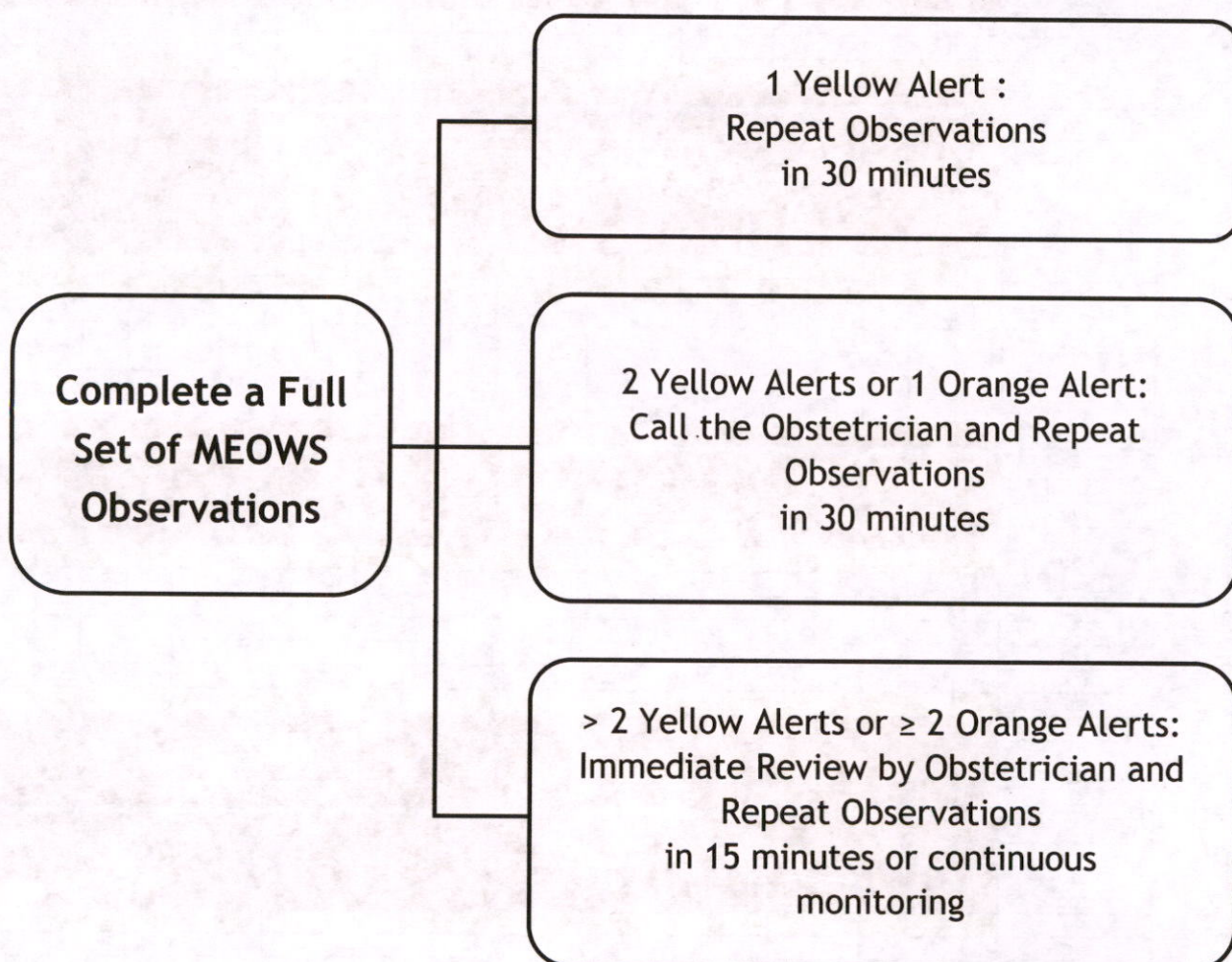


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : 1

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

		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								
u/f	08:00 am		N										
	09:00 am		P										
	10:00 am		P										
	11:00 am	RL	O	100ml							0	14	
	12:00 pm			100ml							0		
	01:00 pm			100ml							0		
Total Intake :						Total Output :							
u/f	02:00 pm	RL	N	100ml							0	14	
	03:00 pm		P	100ml						200ml	0		
	04:00 pm		P	100ml						0			
	05:00 pm		N	100ml							0		
	06:00 pm		P	100ml						300ml	0		
	07:00 pm			100ml							0	14	
Total Intake :						Total Output :							
d/f	08:00 pm		H/O	FF							0	14	
	09:00 pm			FF							0		
	10:00 pm		Tidy	FF						400ml	0		
	11:00 pm	RL		FF							0		
	12:00 am		H/O	FF							0		
	01:00 am			FF							0		
Total Intake :						Total Output :							
d/f	02:00 am		H/O	FF							0	14	
	03:00 am			FF							0		
	04:00 am			FF							0		
	05:00 am	RL	H/O	FF							0		
	06:00 am		H/O	FF						1000ml	0		
	07:00 am			FF							0		
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

m=0, u=1900 ml



FLUID CHART

Sheet No. :

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

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am	1	H ₂ O	tf			1				0	Annamma	
	09:00 am	2	tf	ff						400ml	0		
	10:00 am	2	tf	ff			110				0		
	11:00 am	L	H ₂ O	ff						500ml	0		
	12:00 pm	1		ff							0		
	01:00 pm	1		tf							0		
Total Intake :						Total Output : M - 0 U - 900 ml							
	02:00 pm		H ₂ O				1			200ml	0	Shirish	
	03:00 pm		tf								0		
	04:00 pm		H ₂ O							400ml	0		
	05:00 pm						NP				0		
	06:00 pm		H ₂ O							200ml	0		
	07:00 pm										0		
Total Intake :						Total Output : M - 0 U - 800 ml							
5/7	08:00 pm						1				0	Shirish	
	09:00 pm		H ₂ O								0		
	10:00 pm									300ml	0		
	11:00 pm		H ₂ O				NP				0		
	12:00 am										0		
	01:00 am		H ₂ O							200ml	0		
Total Intake :						Total Output :							
6/7	02:00 am										0	Shirish	
	03:00 am		H ₂ O							200ml	0		
	04:00 am										0		
	05:00 am		H ₂ O								0		
	06:00 am									200ml	0		
	07:00 am		H ₂ O				✓			✓	0		
Total Intake :						Total Output :							

Total 24 hrs. Intake

Total 24 hrs. Output

M = 1, U = 2600 ml

NURSING CARE RECORD

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 4/7/26

Assessment: fear & Anxiety

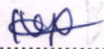
Goals

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

Time	Plan of Care	Time	Implementation	Evaluation
11:00 AM	→ plan for vitals	11:05 AM	→ monitor vitals checked done	
11:10 AM	→ plan for skin preparation	11:15 AM	→ skin preparation done	→ patient is comfortable
11:20 AM	→ plan for EV cannulation	11:25 AM	→ EV cannulation done	
11:30 AM	→ plan for EV fluid	11:35 AM	→ EV fluid Re on flow	→ vitals stable
11:40 AM	→ to Administer medications as per as orders.	12:00 PM	→ Administer medications as per as orders.	
12:00 PM	→ to provide psychological support	12:10 PM	→ provided psychological support given.	

Re-Assessment:

Special Notes: NPO * EV fluid Re on flow

Nurse Signature: 

Nurse Name: Neeraj

Date & Time: 4/7/26 at 12:15 PM

BAH-00550644 IP5-00175965
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NURSING CARE RECORD

Rainbow Children's Hospital
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Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 4/7/26

Assessment: Anter 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
9:15 AM	→ to Assess the patient condition.	2:20 PM	→ Assessed the patient condition.	→ patient is
2:20 PM	→ to Monitor vital signs.	2:40 PM	→ Monitor vital check done combine	
3 PM	→ to Monitor ECG	3:15 PM	→ Monitor ECG	ECG test start
4 PM	→ to Administer Medication as per as order.	4:30 PM	→ Administer Medication as per as order.	
5 PM	→ NPO.	6:00 PM	→ NPO	
	→ to provide physical support	7:00 PM	→ provided physical support given.	

Re-Assessment:

Re-Assessment done

Special Notes:

* NPO * 20 fluid RL on floor.
 * Away late 48 hours * Inter cervical Foley 10 days

Nurse Signature:

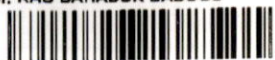
Neeyri

Nurse Name:

Neeyri

Date & Time:

4/7/26 at



NURSING CARE RECORD

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 4/7/26

Assessment: Patient having pain and discomfort at 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
8pm	→ To assess the general condition of the pt	8pm	→ Assessed the general condition of the pt.	Patient is stable Vitals normal Soft diet tolerated
11pm	→ To monitor vital signs	11pm	→ Monitored vitals and recorded	
1am	→ To start soft diet	1am	→ She had idly	
3am	→ To maintain I/O chart	3am	→ Maintained I/O chart	
5am	→ To provide comfortable position	5am	→ Provided comfortable position	
7am	→ To administer medicines	7am	→ Administered medicines	

Re-Assessment:

Pain and discomfort has reduced after administered 500mg Paracetamol

Special Notes:

Urinary catheter is present

Nurse Signature:

Nurse Name: Polymani

Date & Time: 5/7 at 8am

BAH-00550644 IP5-00175965
Mrs RAFAT TARRANUM
14-06-1988 38 Y O M 20 D (F)
Dr. RAO BAHADUR BADUGU



NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☒ Morning ☐ Afternoon ☐ Night

Date: 5/7/26

Assessment: patient having pain and discomfort at 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
8am	Assess the patient General Condition	8:30 am	Assessed the patient General Condition on bed	→ patient is stable
9am	To monitor vitals	9:10 am	monitored patient General	
10am	To monitor I/O chart	10:30 am	monitored patient I/O Chart.	
11am	To provide comfortable position	11:15 am	provided patient comfortable position	
12pm	To plan I/O fluids	12:30 pm	continue I/O fluids	
1pm	To Administered medication	1:30 pm	Administered patient medication	

Re-Assessment: To provide comfortable position

Special Notes: urinary catheter present.

Nurse Signature: Annamma

Nurse Name: Annamma

Date & Time: 5/7/26 3pm

BAH-00550644 IP5-00175965
 Mrs RAFAT TARRANUM
 14-08-1988 38 Y 0 M 20 D (F)
 Dr. RAO BAHADUR BADUGU

NURSING CARE RECORD

Shift: ☐ Morning ☒ Afternoon ☐ Night

Date: 5/7/26

Assessment: patient having mild 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
2pm	Assess the patient General condition.	2:00pm	Assessed the patient. General condition	Patient was stable.
3pm	Monitor the vitals.	3:00pm	Monitored the vitals.	
4pm	Maintain Ilo chest.	4:00pm	Maintained Ilo chest.	
5pm	Provide comfortable position to patient.	5:00pm	provided comfortable. Position to patient.	
6pm	To Encourage orally Intake.	6:00pm	Encouraged orally Intake.	
7pm	To Administer Medication.	7:00pm	Administer medication	

Re-Assessment: Pain and discomfort reduce after Administer medication.

Special Notes: urinary catheter is present.

Nurse Signature: [Signature]

Nurse Name: shirish

Date & Time: 5/7/26 3pm

BAH-00550644 IP5-00175965
 Mrs RAFAT TARRANUM
 14-06-1988 38 Y 0 M 21 D (F)
 Dr. RAO BAHADUR BADUGU

NURSING CARE RECORD

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Shift: ☐ Morning ☐ Afternoon ☒ Night

Date: 5/7/26

Assessment: Headache, Nausea, mild pain and discomfort at 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
8pm	→ To assess the general condition of the patient	8:00pm	→ Assessed the general condition of the patient	Patient stable Vitals normal
10pm	→ To monitor vital signs	10:30pm	→ Monitored vitals and recorded.	
1am	→ To maintain I/O chart	1:40am	→ Maintained I/O chart	
3am	→ To provide comfortable position	3:15am	→ Provided comfortable position	
5am	→ To administer medications	5:20am	→ Administered medications	
7am	→ To remove foley's catheter	7:10am	→ Removed foley's catheter	

Re-Assessment: Nausea settled after given Sy. Ondem

Special Notes: Encourage voidings

Nurse Signature: [Signature] Nurse Name: Kalyani

Date & Time: 6/7 at 8am



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: DR. RAO Department: CYN Date of Admission: 4/7/26

SITUATION		Diagnosis:		Any Infection: ☐ Yes ☒ No ☐ Not Known		
		<u>Pu L4 cystocele repairs</u>		If Yes Specify:		
BACKGROUND	Area	<u>CYN</u>	<u>3rd</u>	<u>3rd</u>	<u>3rd</u>	
	Shift Time	<u>8am</u>	<u>8am</u>	<u>2pm</u>	<u>8am</u>	
ASSESSMENT	Medical Condition (Any special condition to be noted):	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
ASSESSMENT	Tubes/Drains/Catheter:	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Vital Signs:	Temp:	<u>98.6</u>	<u>98.6</u>	<u>98.6</u>	<u>98.6</u>
		Res:	<u>20</u>	<u>19</u>	<u>20</u>	<u>19</u>
		SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>99%</u>	<u>100%</u>
		Pulse:	<u>80</u>	<u>80</u>	<u>90</u>	<u>80</u>
		BP:	<u>110/74</u>	<u>110/71</u>	<u>100/70</u>	<u>104/64</u>
	Fall Risk Score:	<u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>	
	Pain Score:	<u>2/10</u>	<u>0</u>	<u>0</u>	<u>0</u>	
Recommendations	Safety Needs:	<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</u>	<u>Side rails</u>	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	<u>-</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	<u> Foley 48 hourly</u>	<u> Urinary catheter 48 hrs</u>	<u> Urinary catheter 48 hrs</u>	<u> Foley 48 hourly</u>	
Post Operative Procedure Special Orders:		<u> Rep 0 4/7/26 8pm</u>	<u> NA</u>	<u> NA</u>	<u> NA</u>	
Handed Over By Name :		<u> Key</u>	<u> Kalyani</u>	<u> Annamayi</u>	<u> Shishu</u>	
Signature :		<u> Key</u>	<u> Kalyani</u>	<u> Annamayi</u>	<u> Shishu</u>	
Date:		<u> 4/7/26</u>	<u> 5/7</u>	<u> 5/7</u>	<u> 6/7</u>	
Time:		<u> 8pm</u>	<u> 8am</u>	<u> 2pm</u>	<u> 8am</u>	
Taken Over By Name :		<u> Kalyani</u>	<u> Annamayi</u>	<u> Shishu</u>	<u> Kalyani</u>	
Signature :		<u> Kalyani</u>	<u> Annamayi</u>	<u> Shishu</u>	<u> Annamayi</u>	
Date:		<u> 4/7</u>	<u> 5/7</u>	<u> 5/7</u>	<u> 5/7</u>	
Time:		<u> 8pm</u>	<u> 8am</u>	<u> 2pm</u>	<u> 8pm</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
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:						
Recommendations		Pain Score:						
	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:								

SAH-00550644
Mrs RAFAT TARRANUM
14-06-1988 38 Y 0 M 20 D
Dr. RAO BAHADUR BADUGU (F)

CHECKLIST FOR THROMBOPHLEBITIS

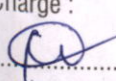
Rainbow®
Children's
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It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

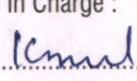
S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0	0			
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first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

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

Signature of Shift In Charge :

Signature :  Name : Keyi

Signature of Ward In Charge :

Signature :  Name : Perti /cm

BRADEN 'Q' SCALE

					Date :	4/2/2022	6/2		
					Time :	2pm	6am	6am	
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	1	1		
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	25	25
Docu. No. : RCHBH / FRM / CLINICAL / 119					Evaluator's Name		/s/ Kalyani Kalyani		

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

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/7/20	11am	0/10		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	-	Keyji
4/7	10pm	4/10	s/s	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Sy's Paracetamol	Kalyani
4/7	11pm	0/10	N/A	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani
5/7	6am	4/10	s/s	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Tab. Paracetamol	Kalyani
5/7	7am	0/10	N/A	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Kalyani
5/7	12pm	4/10	s/s	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Tab. paracetamol given	Annamma
5/7	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Annamma
5/7/20	6pm	2/10	s/s	☐ Continuous ☒ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Tab. paracetamol	Shivish
5/7/20	4pm	0/10	N/A	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under observation	Shivish
5/7/20	10pm	4/10	s/s → Headache	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☐ Dull ☒ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Sy's Paracetamol	Kalyani

Re-assessment Frequency:

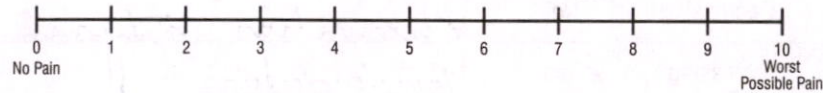
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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

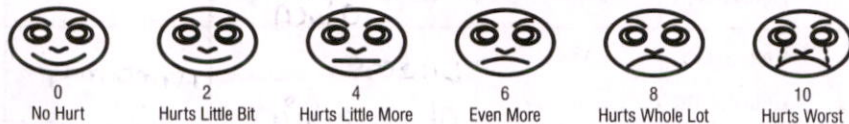
Numerical Pain Scale (Obstetric and Gynecology)



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	Score (u/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
5/7	11pm	0/10	no	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under Observation	Kalyani
6/7	6am	4/10	s/s	☒ Continuous ☐ Intermittent	☒ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☐ Increasing ☒ Decreasing	☒ Yes ☐ No	Inj. Paracetamol	Kalyani
6/7	7am	0/10	no	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Under Observation	Kalyani
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

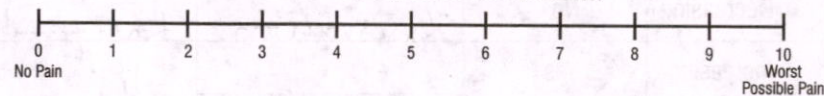
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs 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

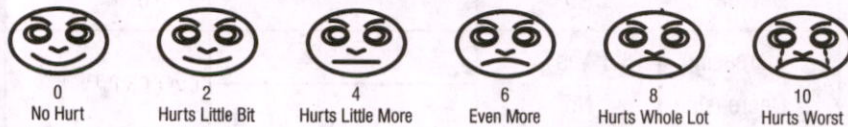
Numerical Pain Scale (Obstetric and Gynecology)



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



BAH-00550644
Mrs RAFAT TARRANUM
14-06-1988 38 Y 0 M 20 D (F)
Dr. RAO BAHADUR BADUGU

Morse Fall Risk Assessment Form

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Choose Highest Applicable Score from each Category		Date / Time	4/7/26	5/1/26	6/1/26	Fall Risk Grading		
		Score		6am	6am			
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				Low Risk	0 - 24	Standard Fall Precaution
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20	20	20	20	High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			20	20	20			
Signature			Key Kalyani Kalyani					

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-00550644
Mrs RAFAT TARRANUM
14-06-1988 38 Y 0 M 20 D (F)
Dr. RAO BAHADUR BADUGU



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
04/7/25	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Cystocele	Surgery	Cystocele repair	[Signature]	☐ Nursing ☐ Others:
4/7/26	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☒ Per-Op ☐ Post Op	Ruptured Dermatoid	to Matron w/ hydrom	W/ mid RL on flow	[Signature]	☐ Medical ☐ Others:
5/7/26 9:30 am	☐ Medical ☐ Nursing ☒ Others: dietitian	☐ Initial ☐ Modified ☐ Per-Op ☒ Post Op	POD-1 cervical amputation cystocele repairs	soft diet	soft High protein diet	[Signature]	☐ Medical ☐ Nursing ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☒ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's 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		
4/16/26	11:30A	4	Informed consent	PI	1	0	1	1		
4/17	11:30A	215 617	Patient Taught regarding suppl about insulin	PT	1	0	1	1		
			control / reassures soft diet	PT	0	0	1	1	NO	Saine

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)

Learning Barriers:

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
-----------------------------	-------------------------------	-----------------

BAH-00550644 IP5-00175965
Mrs RAFAT TARRANUM (F)
14-06-1988 38 Y 0 M 20 D
Dr. RAO BAHADUR BADUGU

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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: As per doctor advice

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 need assistance for

Nutritional Plan:

☐ Dietary Instruction Discussed with the:

☒ Patient ☒ Family Member

☐ Others:

5. Discharge Planning Discussed with the:

☐ Patient ☒ Family Member

☐ Others:

6. Patient/Family Educational Plan:

☐ Educational Topic/s: personal hygiene

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

☒ Patient ☒ Family Member

☐ Others:

Nurse Signature: [Signature]

Nurse Name: Regina

Date and Time: 4/7/26 at 1pm

PATIENT TRANSFER FORM

BAH-00550644 IP5-00175965 Mrs RAFAT TARRANUM 14-06-1988 38 Y 0 M 20 D (F) Dr. RAO BAHADUR BADUGU 		Date & Time of Admission 4/7/26 at 10:59 AM	Date & Time of Transfer Order 4/7/26 at 7 PM DR. Sowati
		Transfer Ordered by DR Sowati	Reason for Transfer observation
From Unit CYN	To Unit 340	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 28	Personal belongings including clinical documents. If any handed over to attendant Yes ☒ No ☐ If Yes, what?		Patient shifted with ID band: Yes ☒ No ☐ If No:
Number of Imaging Films Nil			
Medications / Consumables / Surgical / Hand over			
Sl.No.	Item Name	Quantity	
1.	Nil		
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring S. Neeyini		Name of Person Ordered Transfer Dr Sowati	
Patient & Clinical Records Received by : Shwink			
Date & Time of Patient Received : 7:18 PM			

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

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

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00550644 IP5-00175365
Mrs RAFAT TARRANUM
14-06-1988 38 Y 0 M 20 D (F)
Dr. RAO BAHADUR BADUGU



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Name: Rafat Tarranum Age: 38 y Sex: F UHID.No: BAH-00550644
Date: 2/7/26 Time: 2:30 pm Proposed Operation: Cystocele repair
Diagnosis: Cystocele
B.P / CRT: 119/73 H.R: 70 bpm Weight: 70 kg ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: <u>11.2</u>	Glucose: <u>106</u>	Protein: <u>WNL</u>	HIV: <u>NR</u>	X-Ray: <u>SNUS</u>
PCV: <u>32.0</u>	Urea: <u>0.6</u>	Alb: <u>WNL</u>	HBS Ag: <u>NR</u>	ECG: <u>Study</u>
WBC: <u>6320</u>	Creat: <u>0.6</u>	Total Bill: <u>WNL</u>	HCV: <u>NR</u>	2D Echo: <u>Study</u>
Plate: <u>849</u>	Na: <u>133</u>	Dir. Bill: <u>WNL</u>	Blood group: <u>O+ve</u>	Stress/Angio: <u>NR</u>
PT: <u>14</u>	K: <u>3.9</u>	LDH: <u>WNL</u>	T3: <u>1.39</u>	Other: <u>NR</u>
PTT: <u>39</u>	Ca++: <u>1.03</u>	Alk phos: <u>WNL</u>	T4: <u>NR</u>	Reb A/C-5.5
INR: <u>1.0</u>	Mg++: <u>NR</u>	Amylase: <u>WNL</u>	TSH: <u>NR</u>	
	Cl-: <u>103</u>	SGOT/SGPT: <u>WNL</u>		

Allergies: nil

Medical History: CVS NR

RESP: NR

Diabetes: NR

CNS: NR

Renal: NR

Hepatic / GE: NR

Physical Activity: > 4 METS

Others: NR

Past Anaesthetic History: nil

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: WNL Mentohyoid Distance: WNL Neck: WNL Teeth: WNL look

Lungs: chest clear

Heart: S1S2

CNS: GCS-Full

Pregnant: ☐ Yes ☒ No ☐ NA LMP: 10/6/26 Venous Access Site: good Spine Exam for regional: WNL

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis:
- NIL ORAL $\left\{ \begin{array}{l} \text{Water / ORS 2 Hours} \\ \text{Others 6 Hours} \end{array} \right.$
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: Dr. Shalini

Dr. RAO BAHADUR BADDUGU

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Change in Patient Condition:		☐ Yes	☒ No	Fasting Status: Confirmed	
Physical Status:		☒ Patient Identified	☒ Consent Present	☒ Chart Reviewed	
H.R.: 72 bpm	B.P / CRT: 103/50	SpO ₂ : 100%	R.R: 18 cpm	Last Feed: > 6hrs	
Pre-OP Diagnosis:		Operation: Cystocele Repair		Date: 04/09/26	
Surgeon: Dr. RAO Bahadur Badugu		Anaesthesiologist: DR SHENY	Technician: G.OPI		

TIME	N ₂ O / AIR O ₂ LPM	HALO / SO / SEVO	Drugs:	Antibiotic	Suppository	Blood Loss
12:00						
1:20 pm			Ty Tranexemic 4gm IV		Syp Tramadol 100mg PRN	
2:20 pm					Syp Diclofenac 100 mg PRN	

FIOW / SaO ₂	ETCO ₂	ECG	Temperature	Urine Output	NOTES
100% 100%	SR SR	SR SR	SR SR	SR SR	

The graph shows vital signs from 12:00 to 2:00 PM. The Y-axis ranges from 0 to 240 mmHg for BP and 0 to 100% for SpO₂. A red arrow indicates RL at 3:00 AM.

LAB Values	ABG	GRBS	Others
-------------------	-----	------	--------

Equipment Checked and Functional
☒ BP
☒ Cuff Site:
☐ Art Site:
☒ EKG Lead
☐ Temp Site
☐ FIO₂ Monitor
☐ Agent Monitor
☒ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Lithotomy
☒ Pressure Points Checked

Temp:
☐ HME ☐ Fluid Warmer
☐ Cling Film ☐ OH Warmer
☐ Hugger's ☐ Cotton Wool
☐ Other

Times:
 Anaes Start: 12:20 pm
 OP End: ↓
 Leave OR:

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☒ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☒ IV: (R) UL 18g
☐ IV:
☐ IV:

Induction
☐ IV ☐ Inhal
☐ Pre O₂ ☐ RSI
☐ Others

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
 ETT# at cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
 Blade # Attempts:
 Difficulty Why?

Regional:
 Extremity _____ Specify: _____
☒ Spinal ☐ Epidural ☐ Caudal
 Others: _____
 Position: Sitting
 Site: L3-L4
 Needle Size: 25G Whitacre Depth: _____
 Parasthesia ☐ Yes ☒ No
 Catheter at skin cm
 Drug Name & Conc: 0.5% Bupivacaine heavy
 Bolus: 2cc + 2.5mcg Fenatyl
 Infusion: _____
 Block Level: T4
 Comments: _____

Transportation to
☒ PACU ☐ ICU ☐ Other
 Relaxant Reversed ☐ Yes ☒ No NA
 Name of the Doctor : DR SHENY
 Signature of the Doctor : [Signature]

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POST-ANAL

JORD

Received in PACU by Dr. Tejassini Time Received : 2.20 pm Time Discharged : 4.30 pm

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

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
4/7/26	2.30pm	0/10	on Sedation	Key
4/7/26	4.30pm	0/10	no interventions	Key

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

Anaesthesiologist Name : Dr. Tejassini

Anaesthesiologist Signature: _____

Date & Time: _____

PACU Nurse Name : Keyni

PACU Nurse Signature: Keyni

Date & Time: 4/7/26 at 2.30pm

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): 340

Date & Time: 4/7/26

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

CSE /Spinal /Epidural Position : Space : Technique (LOR/LOS)

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

[illegible]

Delivery Details : Time : APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :



CONSENT FOR ANAESTHESIA

Authorization By: ☒ Patient ☐ Patient Attendant

Operative Procedure: Cyts cell lepan

Anaesthesiologist: Dr. Shahu Surgeon: Dr. Anur Prasad

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders

☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease

☐ Others: Hypotension, Headache

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☐ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Rafat

Name: Rafat tarranum

Relationship with patient: self

Date & Time: 3/7/26 3:53pm

Witness:

Signature: S. Basit

Name: SIED. BASIT

Date & Time: 3/7/26 3:53pm

Doctor (who is taking consent):

Signature: Dr. Shahu Name: Dr. Shahu Date: 3/7/26 Time: 3:53pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

రిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ బ్లడ్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ రిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెన్స్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, రిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

INFORMED CONSENT FOR SURGE SPECIAL PROCEDURE

BAH-00550644 IP5-00175965
Mrs RAFAT TARRANUM
14-06-1988 38 Y O M 20 D (F)
Dr. RAO BAHADUR BADUGU

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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Patient Name : RAFAT TARRANUM

Gender: ☐ Male ☒ Female

Age : 38

UHID No : BAH-00550644

Date : 4/7/20

Instruction:

This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)

Cervix Amputation.

upon

(Name of the Patient)

RAFAT TARRANUM

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery / procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

Bleeding, Infection, Cervix Stenosis.

My signature on this form indicates that

1. I have read and understood the information provided in this form
 2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
 3. I have had a chance to ask my surgeon questions.
- I have received all the information I desire concerning the operation or procedure and
4. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure:

Dr. Rao Bahadur

Consentee :

Signature : Rafat

Name : Mrs. RAFAT TARRANUM

Date & Time : 4/7/20 at 12:30 pm

Witness :

Signature : Keyni

Name : Keyni

Date & Time : 4/7/20 at 12:30 pm

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

Patient Attendant :

Signature : Syeda Basit

Name : SYEDA BASIT

Relationship with Patient : Husband

Date & Time : 4/7/20 at 12:30 pm

Doctor (who is taking the consent) :

Signature : Dr. Ashley

Name : Dr. Ashley

Date & Time : 4/7/20 at 12:30 pm



INFORMED CONSENT FOR SURG SPECIAL PROCEDURE

Patient Name : RAFAT TARRANUM Gender: ☐ Male ☒ Female Age : 31
UHID No : BAH-00550644 Date : 4/7/26

Instruction:

This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)

CYSTOCELE REPAIR.

upon

RAFAT TARRANUM.

(Name of the Patient)

I have been advised of the benefits and reason of the procedure(s) as indicated by the clinical observations and / or diagnostics performed. I recognized that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes. My questions regarding the condition, the proposed surgery and the outcome have been answered to my satisfaction prior to signing this form by the surgeon.

I have been explained the risks of this surgery /procedure and also about the reasonable alternative and the relevant risks, benefits and side effects related to such alternatives, including the possible results of not receiving care or treatment.

I have been explained that the following complications though rare are possible and will not hold Surgeon, Anesthesiologist or the hospital staff responsible for any untoward event thereof.

Bleeding, Blood transfusion, Infection, Injury to surrounding structures, Bladder.

My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: Dr. Rao Bahadur.

Consentee :

Signature : Rafat

Name : Mrs. RAFAT TARRANUM

Date & Time : 4/7/26 at 11 AM.

Witness :

Signature : Mayeri

Name : Mayeri

Date & Time : 4/7/26 at 11 AM.

Patient Attendant :

Signature : [Signature]

Name : SYED. RASIT.

Relationship with Patient: HUSBAND.

Date & Time : 4/7/26 at 11:54 AM.

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Anshu

Date & Time : 4/7/26 at 11 AM.

BAH-00550644 IP5-00175965
Mrs RAFAT TARRANUM
14-06-1988 38 Y 0 M 20 D (F)
Dr. RAO BAHADUR BADUGU

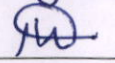
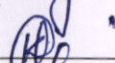
Rainbow®
Children's
Hospital
It takes a lot to treat the little.

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 4/7/26

Date of Removal: 6/7/26 at 6am

Parameters	Date	Shift Time	4/7/26 8A-8P	5/7/26 6am				
Need for the Catheter			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?			☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse			Reyri	Kalyani				
Signature of the Nurse								



340

NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 5/7/26 Time: 9:30 am

Origin: Indian Height: 158cm Weight: 70kg's BMI: 28.11kg/m²

Food Allergies: No

Diagnosis: POD-9 / cervical amputation + cytocol Repair

Medical History: Recurrent UTI

Surgical History: tubectomy

☒ Vegetarian

☐ Non-Vegetarian

☐ Vegan

Diet Advised: soft High protein diet

include plenty of oral liquids

Avoid spicy, chilled & outside foods

Patient's / Attendant's

Signature: Rafat

Name: Rafat

Date & Time: 5/7/26

9:30 am

Dietician's

Signature: Saine

Name: Saine

Date & Time: 5/7/26

9:30 am

DIETARY NOTES[illegible]