

BAH-00632519 IP5-00174584
Mrs SUKHDEEP SANGWAN
24-11-1995 30 Y 6 M 8 D (F)
Dr. ANNIE PRANUTHA P



SURGERY DETAILS

Date : 1/6/26

Patient Name: Mrs Sukhdeep Sangwan Date of Birth: 24/11/1995 Age: 30yrs

Gender: Female Ward : UHID No: BAH-00632519

Date of Surgery: 1/6/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery : Emergency Cesarean Section

Time in : 2:30 AM Time Out : 3:30 AM

	NAME	AMOUNT
1. Surgeon	Dr. Annee	
2. Anaesthetist	Dr. Akhila	
3. Assistant Surgeon	Dr. Keerti Reddy	
4. OT Technician	Bro. Vijay	
5. Circulating Nurse	Kranti	
6. Assistant Nurse	Sis. Rajeswari	

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

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9637258

Order by: Sis. Rajeswari

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Case

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

CONSUMABLES OF OT

Technician : B. VUJAYKUMAR Date : 01/6/2010 Time : 3:50 PM

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <i>hse</i>	✓	01	Inj Vit.K	✓	2
LMA			Sutures <i>2346</i>	✓	02	Cord Clamp	✓	1
ECG leads : A / P / N	✓	3	<i>2364</i>	✓	01	Suction Catheter <i>8NO</i>	✓	1
HME filter : A / P / N			<i>2362</i>	✓	01	Feeding Tube		
Syringes : 10 cc		2				Vaccum Suction Set	✓	1
05 cc	✓	2	Gloves <i>6, 6 1/2, 7</i>	✓	2 1/2	Surgical Gloves <i>7</i>	✓	2
02 cc		2	<i>P.F.T</i>		1	Gauze Pack		1
01 cc		-				Syringe 1ml / 2ml	✓	2
Cautery plate <i>(A) / P / N</i>		1	Surgical blade <i>22</i>		1	Surgical Blade # 20	✓	1
IV set			NG tube			Koochies (S) <i>115</i>	✓	1
RL	✓		Cautery pencil		1			
NS : 10ml / <i>100ml</i> / 500ml / 1000ml		0	Koochies <i>XL</i>		1			
<i>minispike</i>		0	Ointments					
Fentanyl		1	Suction Catheter					
Morphine			Cap, Mask					
Ketamine			Gauze Pack					
Propofol			Mop Pack					
Rocuronium			Steristrip					
Glycopyrolate			Underpad					
Myopyrolate			Draw sheet <i>Allesorb</i>					
Ondansetron		1	Abgel					
<i>Pencan 25g</i> Spinal Needle 22		1	Foleys catheter					
Bupivacaine 0.25%			Urobag					
Bupivacaine 0.25%(Heavy)		1	Chest Drainage Catheter					
Antibiotics			Romodrain bag					
<i>lox 2L</i>		0	Bandage					
Suppositories			Tegaderm					
Anamol : 80mg / 250mg / 170 mg			loban					
Supridol <i>100mg</i>		1	Double J Stent					
Justin <i>12.5 mg / 25mg / 100mg</i>		0	Vaccum Suction set					
Tab Misoprost <i>200mg</i>		2	Plastic Bed Sheet					
<i>Tranexa</i>		0	Betadine Solution					
<i>oxylacin</i>		3 1/2	Microshield					
<i>carbetacin</i>		1	Cotton Balls					
			Latex Gloves		10			
			Ramdione Scrub					
			<i>Saral DA</i>					

Surgeon _____ Anaesthesiologist _____ Nurse _____ OT Technician _____
 Order No. : *9637260/261* Ordered by : *Shi Ravi*
 Doc No. : RCHB/FRM/GENERAL/125

ADMISSION SHEET

Registration Details :



Admission No : IP5-00174584 Admit Date : 01-Jun-2026 Admit Time : 01:40 AM UHID : BAH-00632519

Patient Details :

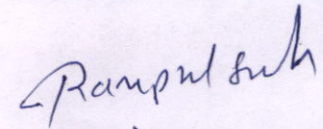
Patient Name	: Mrs SUKHDEEP SANGWAN	Age	: 30 Y 6 M 8 D
Guardian	: Mr HARISH SANGWAN	DOB	: 24-11-1995
Gender	: Female	Religion	:
Occupation	:	Marital Status	: Married
Address (H)	: # H.NO 37 PILL NO 306 PRESTIGE DREAM VALLEY SHIVARAMPALLY Mailardevpally Hyderabad Telangana INDIA 500052	Phone No	: 6239241105/
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type	: SHARED WARD	Bed No	: SW 418	Ward Name	: 4F-BIRTHING CENTRE
Room No	: SW 418	Admission Type	: First Visit		

Contact Details :

Name	: Mr HARISH SANGWAN	Relationship	: Husband
Contact Address	: # H.NO 37 PILL NO 306 PRESTIGE DREAM VALLEY SHIVARAMPALLY Mailardevpally Hyderabad Telangana INDIA 500052	Phone No	: 6239241105



Signature

Doctor Details :

Doctor Name	: Dr. ANNIE PRANUTHA P	Specialisation	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: Self	Phone No	:
Co-Consultant	:		

Payment Details :

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

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____

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

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

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WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
01/6/26	3:30 AM	OBG	OT	Swapne
1/6/26	4:40 AM	OBG OT	MICU	Swapne
2/6/26	12:30 PM	OBG	Room (B2F)	Tunni

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Nishanth.	2/6/2026.	9640908	Sushenka
2				
3				
4				
5				
6				
7				
8				
9				
10				

BAH-00632519 IP5-00174584
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 Patient Stic Dr. ANNIE PRANUTHA P



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

clo Bleeding per vag : 12 Am

LMP: 10-10-25

EDD:

Corrected EDD: 18-7-26

GA: 33²/₂ wks

Obstetric Formula:

Primigravida

Menstrual History: Regular: Yes No

Obstetric History:

Obstetric Examination

Fundal Height: 32 wks

Ut. Activity: Relaxed Mild Mod Severe

Liquor: Adequate Oligo Poly

PP: Cephalic Breech Others _____

Head Fifths Palpable: 4/5

FHS: Normal Tachy Brady Absent

Present Pregnancy Record:

Primigravida / Spontaneous conception

RISK FACTORS:

Booked @ 7 wks.

- Rh neg
 - Pre eclampsia \bar{c} severe features
 - RhoGAM by Anti-D 30mg. at 28 wks.
 - steroid covered on 31.5 & 32.5 wks. MgSO₄ covered.

Per Speculum Examination

HVS taken

Draining: Present Absent Bleeding

Colour of Liquor: Clear Meconium Blood Stained

Vaginal Examination

Cervix: Long Partially effaced Effaced

Os: Closed closed Dilated _____

Membranes: Present Absent

Liquor: Clear Meconium Blood Stained

Presenting Part: Vertex Breech Others _____

Sutton: -3 -2 -1 0 +1 +2

Pelvis: Adequate Doubtful

Height: 164 cm

Weight: 64.9 kg

Allergies: NICKA

Breast: Normal Abnormal

General Examination: fair

Consciousness: yes Pallor: absent

Icterus: absent Edema: absent

Temp: afebrile PR: 103 bpm

BP: 155/105 mmHg (118) DTR: normal

CVS: S1S2 RS: BLURRED

Liver/Spleen: Not palpable. Urine Output: normal SPA -99 / 24 hr

DIAGNOSIS

Primigravida 33²/₂ wks / Rh neg / Pre eclampsia \bar{c} severe features /
 PGR \bar{c} dopplers / Anti D at 28 wks / Haemorrhage for emergency use



<p>Family History:</p> <p>Mother - HTN</p>	<p>Surgical History:</p> <p>nil</p>
<p>Medical History:</p> <p>Nil</p>	<p>Medication History:</p> <p>see Medical consultation form</p>
<p>Plan of Care:</p> <ul style="list-style-type: none"> - Admission - NBM - Vitab every 20min - NS1 now - Preface parts - PAC - Pre-op medications <ul style="list-style-type: none"> - Foly's catheterization & thrombolytic - IV labetalol drug stat - send complete PE profile. <ul style="list-style-type: none"> CCBP, CDH, LFT, Sr. Electrolytes. PT/INR/APTT CBC, Urine/c. spot PKR ratio, creatinine, HUS - Check blood availability <ul style="list-style-type: none"> ↓ 20 PRBC available 	<p>Investigations:</p> <p>- Negative</p> <p>husband B1 group A-nc</p> <p>IC1 - nptc</p> <p>31/5/20 PT-13.6, APTT-29.9, LDH-378, ABD-10.4/9000/3.152, INa-0.94 vitab NR</p> <p>28/5 Nat-132, LFT - (N) 22/5/20 uphako, 155gms, 3c, Ac-4c, AFI-54cm dopplers + instances, +ve EDF MCDI Red distribution</p>

Doctor Name: Dr. Sanyasa
 Signature: [Signature]
 Date & Time: 1/6/26 @ 2AM

Consultant Name: Dr. Annie
 Signature: [Signature]
 Date & Time: 1/6/26 3AM

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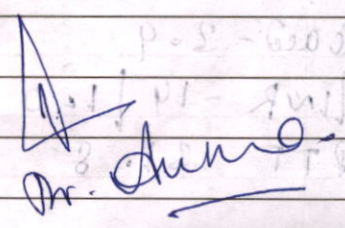
PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/20		
2:10 AM	Repeat BP after inj labetalol along w BP - 153/106 mmHg (MAP 117)	
No s/s	PR - 96 bpm	
mucous	SpO ₂ - 98% on RA	
Sclerae	P	Adv
		- inj labetalol 50mg IV stat
		- inj MgSO ₄ 4gm w/dose close
		to maintenance dose
		asmt & pulse
		- Recheck BP after 15 min
		& on pm
		- Strict I/O charting. <i>[Signature]</i>
		Dr. Anne
2:30 AM	Recheck BP - 145/91 mmHg (MAP 104) - 4	
Engorged	- inj labetalol 50mg q 1hr	
	- Recheck BP after 15 min & on pm	
	- inj MgSO ₄ loading dose	
2:45 AM	Recheck BP - 136/89 mmHg (MAP 100)	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/26 3 AM	Counselled family Husband Mr. Harish →	connected on call.
	Counselled and explained the clinical status of Mrs. Sukhdeep.	
	→ Severe PE - accelerated HTN already on 2 antihypertensives needed 1W Anti hypertensives	
	→ Bleeding per vagin. (Confirmed clinically) possibly of Abruptio	
	→ Fetal growth restricted with oligoamniotic.	
	with the clinical background → likely placental Abruptio. Admissions next is reactive.	
	• Lab reports discussed. - High Potassium need for correction. need for multidisciplinary care in maternal ICU.	
	• Neonatal ICU.	 Dr. Annie



PROGRESS NOTES AND DOCTOR'S ORDER

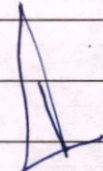
Date & Time	Progress Notes	Doctor's Order
16/26		
3 AM	Mistakey reviewed.	
	Bleed p.v. once at mid night w/	
	mild abdominal pain.	
	No headache / vomiting	
	vision normal.	
	HR - 96/w	
	RR - 136/sq	
	SpO ₂ - 99% Room air	
	P/A - uterus relaxed	
	No tenderness	
	FHR - 140bpm	
	<u>Labs -</u>	
US -	9.9 gmil.	Acho - ARS 5
WBC -	11,360	- Repeat S.K.T.
pH -	3.64	- WLG.
PCV -	29.3	- PAC.
LFT -	Ⓝ	- Reserve 2PRAC
lytes	134/11.1/102	- Inform neonatologist
S. creatinine	0.6	
Bladder	26	
COY	227.	
S. uncaed	3.9	
PT/INR	14/1.0	
APTT	31.8	

Patient

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/26. 3:20 AM.	Repeat Serum Potassium 4.5.	
	ABG Kt - 3.9	
	Lactate - 1.4	
	pH - 7.432	
	PCO ₂ - 26.9	
	HCO ₃ - 20.3	
	ECG seen by Anesthetist.	
	Informed family	to shift for C-section.
		 Dr. Annie
		Noted by Tina

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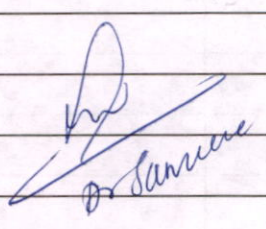
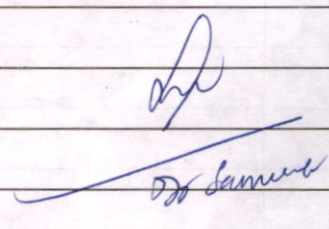


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/26		
6:45 AM	<p>Pt conscious & oriented No s/s Imminent eclampsia</p>	<p>Adv - NBM for 4hrs - IV fluids @ 50ml/hr</p>
	<p>o/e clear, afebrile PR - 93bpm BP - 148/99mmHg (MAP 113)</p>	<p>- Tab. dextalol 10mg PO stat</p>
UO - 300ml/hr	<p>SPO₂ - 98% on RA P/A uterus retracted well</p>	<p>- drugs as per charted</p>
On going by: Mysoy 25ml/hr	<p>UO - 25ml/hr UG - Bleeding none</p>	<p>- vitals and chills - I/O charting - W/P s/s Imminent Eclampsia - Inpim 500</p>
- Trace Baby's Blood Group - Repeat ABP & electrolytes at 10 AM.		<p>Adv Dr. Suman</p>
+ 2:30 PM		
	<p>PR - 103 bpm BP - 147/93 mmHg (MAP 109) RR - 16 bpm SpO₂ - 98% on RA P/A - uterus retracted well.</p>	<p>Adv - Tab. Nicardipine 10mg PO stat - Re check BP after 1/2 hr & Inpim</p>
		<p>Adv Dr. Suman</p>

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/26		c/c/t Dr. Annie (Attended)
8:30 AM	PR - 97 bpm	<u>Adv</u>
	BP - 141/100 mmHg (MAP 113)	- Tab Nicardipine long RD stat now
	RR - 21 cpm SpO ₂ - 97% on RA	- Recheck BP after 1/2 hr & Inform
		 Dr. Samir
	c/c/t Dr. Annie	
	Spot PCR Ratio - 6.5	<u>Adv</u> - To add Tab Isosorbide ^{2mg} 1 tab BD
		- Recheck BP after 1/2 hr & Inform
		 Dr. Samir

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LESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/26.	CLSLB AXON TEAM.	
8:30 AM.	POD-0 Emergency caesarean section	
	PE Abruptio Rh-ve	
	Called I/L/O high BP readings	
	OLE, Pt clc	
	PR - 96/min	
	BP - 141/100mmHg	After giving T-lab 200mg
	O/S - 5.4v	T. Nicaeida 10mg @ 7:30 AM
	M - BAE @ cr.	SpO ₂ - 97% on RA.
	<u>Adv</u>	
	① Add T. Nicaeida 10mg	
	② TO continue MgSO ₄ infusion.	
	③ Plan to Add 3 rd antihypertensive	
	if BP > 140/100mmHg after 1hr.	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/6/2026 9:30 AM	Pod - 0 Em vcs Severe PE Rh Neg Pt conscious, coherent No Imminent Signs & Symptoms BP: 125/86(96) mmHg PR: 110bpm Temp: 98.8°F SpO ₂ : 97% RA RR: 20/min P/A: URW BS(+)	
	P/V: BWNL U/O: 200ml (8-9 AM) cb pain @ suture site IV Tramadol 100mg in 100ml NS T. Isotiazine given @ 9 AM 1 tab Trace HVS, Urine c/s	① CBP, Sr Electrolytes at 10 AM ② IVF @ 50 ml/hr RL ③ start NBM - 12 AM ④ Orals as chart ⑤ vitals I/O hourly ⑥ w/lt Bleeding PV ⑦ Inform if BP ≥ 140/90 ⑧ Inform SOS
	Baby BAT → A+ve Anti-D-given.	Jay or ysmee

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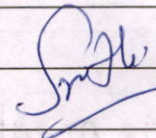


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/20 1:30 PM	POD-0 / Em 2 scs / Severe Pt abd pain Rh negative Pt is stable No imminent signs. BP- 137 / 92 (105) PR- 106 bpm spo ₂ - 97% on RA. Temp- 98°F UA- Ut well ⊕ BS ⊕ 4G BUNK U/O- 100 ml/hr	
⇒ Mg Sou on Flow (Call 4:30 AM) Nat- 137 Kt- 4.5 Cl- 108 Hb- 10.2 Pw- 30.6 Ht- 3.286 Ec- 14 1k		Advice ① Trace urine c/s & m/s ② Soft diet @ 8pm ③ Drugs as charted ④ Monitor vitals & I/O hrly. ⑤ w/pt tachycardia & bleedng pt ⑥ w/pt Imminent signs. ⑦ Inform of BP=146/90 mkg
		Smtk Noted by Paulasi



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/26 5:30 PM	POD-0	
My son on flow 4:30 PM	BP - 133/97 [108] PR - 100 bpm SpO ₂ - 97% on RA RR - 24 bpm Temp - 97.6 °F P/A - Ut well @ BS @ Hc - BURL U/O - 120 ml/hr	<u>Advice:</u> ① Trace urine c/s & HUS ② Soft diet X 8 PM ③ Drugs as charted ④ Monitor vitals 4/10 hrly ⑤ w/p tachycardia & bleeding pt ⑥ w/p imminent signs ⑦ Inform if BP > 160/100 mmHg
	T. NICARDIA 10mg now [DUE dose]	
	✓ RL @ 5 ml/hr ✓ Myson @ 25 ml/hr	
	Ad Physci consultant Dr. Nishant	Noted by Paulabi



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<p><u>1/6/2026</u> <u>8:30PM</u></p>	<p>Vitals - BP - 127/94 (102) <u>PR - 102 bpm</u> SpO₂ - 97% on RA V/O - 120ml/clear MgSO₄ 25mg/hr on flow <u>by Chr. Deepika</u></p>	
<p><u>1/6/2026</u> <u>11:30PM</u></p>	<p>Vitals - BP - 133/100 (111) PR - 93 bpm SpO₂ - 97% on RA Urine output - 150ml, clear. MgSO₄ 25mg/hr on flow (till 4:30AM - 2/6/2026) Tab-labetalol 200mg - given at 11PM ✓ Physician Consultation tomorrow (2/6/26) <u>by Chr. Deepika</u></p>	<p>Noted by sis. Anita</p>

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
1/6/26	<p>C/S by Anon anaesthesia BP 116/94 mmHg PR :- 98 /min SpO2 :- 97 on RA urine output</p>	
<p>Labs HD 10.2 WBC 14.15 Platelet 320 Nat 137 K :- 4.5 Cl :- 108</p>		<p>Advice ① W/F urine output ② Inform SOJ</p>
<u>2/6/2026</u>	<p>3:30 AM Vitals - BP - 127/92 (104) PR - 93 bpm SpO2 - 98% on RA V/O - 50ml clear</p>	<p>by Dr. Rupika</p>

Dr. Adithyan

by Dr. Rupika

Noted by
 SIS
 (P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
<u>2/06/2021</u>		
<u>6 AM</u>	<p>ngs on stopped at 4:30 AM</p>	
	<p>Vitals - BP - 122/84 (93)</p>	
	<p>PR - 107 bpm</p>	
	<p>SpO₂ - 98% on RA</p>	
	<p><u>V/O - 100 ml, clear</u></p>	
	<ul style="list-style-type: none"> ✓ Physician Consultation ✓ Remove Foley ✓ Ambulation 	
	<p>dig cor Dupikas</p>	
	<p>Noted by sis Anita</p>	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/6/2026 9:30 AM	POD - 1 Em. Uxus	Severe PE Rh Neg
	Pt comfortable	① Soft diet
	No Imminent S&S	② plenty of oral fluids
	Passing Flatus	③ Stop IVF
	Tolerated diet	④ Drugs as chart
	Voided	⑤ Vitals 4 hourly, inform if $\geq 140/90$
	Anti D ✓	⑥ Ambulate
	PR: 96bpm	⑦ physician R/w
	BP: 121/89(99)mm Hg	⑧ Sup Dulceten (2) PR stat
	SpO ₂ : 98% RA	⑨ Inform SOB
	P/A: URW	
	BS ⊕	
	P/v: BWNL	
	Temp: Afebrile	
	shift to room	

[Handwritten Signature]

Noted by
Tanna

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Date & Time	Progress Notes	Doctor's Order
2/6/26 2:20pm	Pt comfortable NO Incontinent s/s	
	ole ac-fair, afebrile	
CV	PR-98bpm	Adv - soft stools,
N	BP - 119/70mmHg (MAP-83)	- plenty of
SV	SPO2- 100% on RA	oral fluids
Baby - NICU	P/r uterus contracting well,	- drugs as
Urines/s -	w/o - lochia	- purchased
no growth	healthy	- Ambulate
Trace HVS		- w/f active
Physician Review done		Bleeding PV
- Advised to with hold		- w/f s/s
Isolazine & Nicardipine		Incontinent
Added: Tab. Olanzapine 10mg - mg		Eclampsia

- Inform of BP > 140/90 mmHg
 - vitals weekly
 - Inform as

[Signature]

Noted by Sustained
[Signature]
 or Anne

(P.O.)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/10/26		
7pm	Pt comfortable No imminent s/s	Adv - soft diet, plenty of oral fluids
	O/E UC - fair, afebrile vitals stable	- drugs as per charted
W N SV	p/A ut retracted well	- called Ambulate.
	U/E to hear healthy	- w/f active Bleeding PV
Trace HVS	- Inform of BP > 140/90 mmHg	- w/f imminent s/s
		- vitals q4h - Inform SO
3/10/26 8:00AM	POD-2 / Em. lscs / sever PE / Rh negative. Pt comfortable	Dr. Samina
Anti-DV	O/E GI - fair	Noted by Sabya @ 7:30pm
SV fV V	BP - 136/76 mmHg PR - 98 BPM SpO2 - 98% on RA	Adv 1) soft diet, Hydration + Ambulation
Remove cannula	p/A - ut @ well LIE - Lochia healthy	- Drugs as charted - w/f active bleeding PV
- s/E } over p/E } plan discharge	Dressing - Dress healthy	- w/f imminent sign of PE * vitals q4h hourly
		- Inform SO - Trace HVS

Dr. Samina



CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <i>Dr. Annie</i>	Date of Delivery: <i>1/6/26</i>
Assistant Surgeon: <i>Dr. Kirti Reddy</i>	Time of Delivery: <i>3:29 AM</i>
Anaesthetist's Name: <i>Dr. Akhila</i>	Gender of Baby: <i>Female</i>
Type of Anaesthesia: <i>Spinal</i>	Weight of Baby: <i>1.258</i>
Neonatologist: <i>Dr. Rupangali and Dr. Sonya</i>	AGPAR Score:
Scrub Nurse: <i>Rajeshwari</i>	NICU Admission: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Pre-Operative Diagnosis: *PRIM 33rd wks Severe PH / FUR / Oligoamniotic with Abruption*

Elective Emergency Indication: *Suspected Abruption with Severe PH and FUR with oligoamniotic*

Urgency

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

Decision time: Knife to rectus:

CTG Description: *Reactive*

If there was a delay give the reasons: *None*

Surgical Procedure: *Emergency Lower Segment Cesarean Section*

Post Operative Diagnosis: *post cesarean. Severe PH.*

Peri-Operative Complications: *Nil*

Amount of Blood Loss: *200ml* Blood Transfused (in ML): *-*

Name and Number of Surgical Specimen sent for examination:

Placenta sent for H&E

Examination Findings when Appropriate:

Presentation: Cephalic Breech Other Cervical Dilatation: cm

5th Palpable: Fetal Position:

Station: -3 -2 -1 0 +1 +2 Moulding: None + ++ +++

Caput: + ++ +++ Meconium: None + ++ +++

Bladder Catheterized: Yes No Urine: Clear Blood Stained

Skin Incision: Pfannenstiel Transverse Midline Other

Uterine Incision: Lower Segment Classical Inverted T J Incision

Previous Scar: Intact Thinned out Ruptured No Scar

Incision Through Placenta: Yes No

Delivery of head: Manual Forceps

Liquor: *Scanty* Clear Meconium: I II III Blood Offensive Not Offensive

Delivery of Placenta: Manual CCT Complete Incomplete Piecemeal

Cord Appearance: *Hydroptic cord* Cord around the neck Yes No

Appearance of placenta: *Retroplacental clots w 50gms* Cavity explored Yes No

Uterus, tubes and ovaries: Normal Not Normal Sterilization: Yes No

Uterine Closure: One Layer Two Layers *Vicryl 1-0* Suture

Peritoneal Closure: Pelvic Abdominal None Suture

Sheath Closure: *Vicryl No. 1* Suture

Fat Closure: Yes No *Vicryl Rapido* Suture

Skin Closure: Subcuticular Mattress *Vicryl Rapido* Suture

Vaginal Evacuated Yes No

Drain: Yes No Remove in days Await instructions

Catheter Yes No Remove in days Await instructions

Swaps & Instruments count correct? Yes No Post-op Antibiotics Yes No

Intra-Operative Antibiotics Cover: Yes No Thromboprophylaxis Yes No

Post-Operative Notes:

① NRS on 6-8 hrs

② w/ fhr as per Anaesthetists

③ 9/10 uterine contraction w/ NO

④ next vitals I-0 Chet

⑤ 9/10 negos, 20% w @ 25ml/h

Doctor Name: *Dr. Dune* Doctor Signature: *[Signature]*

Date & Time: *1/6/18 4:30 PM*

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Mrs SUKHDEEP SANGWAN
24-11-1995 30 Y 6 M 8 D (F)
Dr. ANNIE PRANUTHA P

Patient



POST-SURGICAL CARE PLAN FORM

Procedure Done:	Emergency Lower Segment Cesarean Sects
Post-Surgical Diagnosis:	post cesarean hdy-0 / PPH
Post-Operative Monitoring Parameters /Frequency:	UN, BP, RR, SpO2 every half hourly for 6hrs followed by 2 hourly
Wound Care:	water for soaks of dressing.
Drain /Special Lines/Catheters:	W lines. fdp into wound.
Special Patient Positioning and Requirements:	Dorsal with 45° head elevated
Nutritional Instructions:	nil oral till 6-8 hrs
When to Start Mobilization:	After 12 hrs
Special Referrals:	nil
The new order for all required medications documented in the doctor order/medication sheet: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Any Other Post-Operative Care Needed including Required Follow Up Monitor under multi disciplinary care	
Treating Surgeon (Signature & Stamp)	Date: 1/6/20 Time: 4:30 PM
Note: Plan of care will be readjusted if necessary.	



RISK ASSESSMENT TOOL FOR DEEP VEIN THROMBOSIS
 (Postnatal Assessment and Management (to be assessed on delivery suite))

Pre-Existing Risk Factors Tick Score	Tick	Score
Previous VTE (except a single event related to major surgery)		4
Previous VTE provoked by major surgery		3
Known high-risk thrombophilia		3
Medical comorbidities e.g. cancer, heart failure; active systemic lupus erythematosus, inflammatory poly arthropathy or inflammatory bowel disease; nephrotic syndrome; type-I diabetesmellitus with nephropathy; sicklecell disease; current intravenous drug user		3
Family history of unprovoked or estrogen-related VTE in first-degree relative		1
Known low-risk thrombophilia (no VTE)		1
Age (? 35 years)		1
Obesity		1 or 2
Parity ≥ 3		1
Smoker		1
Gross varicose veins		1
Obstetric Risk Factors		
Pre-eclampsia in current pregnancy	1	1
ART/IVF (antenatal only)		1
Multiple pregnancy	1	1
Caesarean section in labour	2	2
Elective caesarean section		1
Mid-cavity or rotational operative delivery	1	1
Prolongedlabour (? 24hours)	1	1
PPH (?1litreortransfusion)	1	1
+0 Preterm birth? 37 weeks in current pregnancy	1	1
Still birth in current pregnancy		1
Transient Risk Factors		
Any surgical procedure in pregnancy or puerperium except immediate repair of theperineum, e.g. appendicectomy, postpartum sterilization	1	3
Hyperemesis		3
OHSS (first trimester only)		4
Current systemic infection		1
Immobility, dehydration		1
Total	4	

Signature of the Doctor: *[Signature]* Date: 1/6/20 Time: 4:30 PM

Action Plan: *[Handwritten notes]*

Risk Assessment Tool for Deep Vein Thrombosis

- If total score ≥ 4 antenatally, consider thromboprophylaxis from the first trimester.
- If total score 3 antenatally, consider thromboprophylaxis from 28 weeks.
- If total score > 2 postnatally, consider thromboprophylaxis for at least 10 days.
- If total score = 2, Hydration & Ambulation.
- If admitted to hospital antenatally consider thromboprophylaxis.
- If prolonged admission (≥ 3 days) or readmission to hospital within the puerperium consider thromboprophylaxis.
- For patient with an identified bleeding risk, the balance of risks of bleeding and thrombosis should be discussed in consultation with a haematologist with expertise in thrombosis and bleeding in pregnancy.

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 Mrs SUKHDEEP SANGWAN
 24-11-1995 30 Y 6 M 8 D (F)
 Dr. ANNIE PRANUTHA P

Patient S



BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 1/6/26

Department : OBGOT Duration of Procedure : 1hr

Name of Surgeon : Dr. Annie Date of Admission : 1/6/26

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

		Staff Signature
1.	Antibiotic given prior to surgery ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Name of the Antibiotic : <u>Augi Paxim</u>	<u>Sis. Rajewai</u>
2.	Hair Removal <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No if Yes : Surgical Clipper Department where Hair Removed : <input type="checkbox"/> Ward <input type="checkbox"/> Operating Room <input type="checkbox"/> Other : <u>DBS</u> Skin preparation done (cleanse surgical area with antiseptic agent)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<u>Sis. Rajewai</u>
3.	Patient's body temperature immediately post operation (Recovery Room) <u>36.2 °C</u> <input type="checkbox"/> Oral Or <input checked="" type="checkbox"/> Axilla (Goal : 36-37 °C)	<u>Sis. Rajewai</u>
4.	Name of doctor or staff administering the antibiotic : <u>1/6/26 Sis. Yanung</u> Date & Time of antibiotic administration : <u>1/6/26 @ 2:AM</u> Date & Time procedure started : <u>1/6/26 @ 3AM</u>	<u>Sis. Rajewai</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



CROSS CONSULTATION FORM

Doctor Name : Dr. Nishwan Remya Date : 2/6/20 Time : 2:30 PM

Diagnosis : Sec. P.F. ? P.M.-2

Hospital : Star Hospital

Type of Referral :

- Emergency
- Urgent
- Non Urgent

Referred for : Opinion Co-Management Transfer of care

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature: _____

Findings and Recommendations :

slr LCC - P.M.-2

Pt. Resolved

Asymptomatic

Pt. clc

G.I. bar

Pk - 80um

Br - 120/80 um

Ca - Si, L ⊕

R - RAO

⊕ Tab.

STAMLO

10mg - x - Sun

Incom Br it > 140/80mm

NOVO
 NUCLEON-1
 15/12/2019

Consultant :

Name : Dr. Nishwan Remya Signature : _____ Date & Time : 2/6/20; 2:30 PM

BAH-00632519 IP5-00174584
 Mrs SUKHDEEP SANGWAN
 24-11-1993 30 Y 6 M 8 D (F)
 Dr. ANNIE PRANUTHA P



RESULT SHEET

Date	01/6/26	1/6/26			
Time	2Am	10 Am			
Hb	9.9	10.2			
PCV	29.3	30.6			
RBC	3.32	3.42			
WBC	11.36	14.15			
N/L	58.4/352	0			
Platelets	364	3.28			
CRP					
ESR					
PCT					
RBS					
Na	132	137			
K	4.5	4.5			
Cl	106	108			
Ca/Mg					
Phosphate					
Urea	26				
Creatinine	0.6				
ALP	71				
SGPT	24				
SGOT	22				
T.Bill/Conj	0.35 ^{0.1} 0.2				
T.Protein	7.3				
S.Albumin	3.9				
S.Globulin	3.4				
A/G Ratio	3.4				
Uric Acid	3.9				
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	14/1.0				
APTT	30				
CSF Protein / Sugar					
Cells	LDH	227			
N/L					

Patient

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 Mrs SUKHDEEP SANGWAN
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 Dr. ANNIE PRANUTHA P



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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

MEDICATION RECONCILIATION FORM

Drug Allergies: NRDA Not known any Drug Allergies

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

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

Shifting From: NA Shifted to: NA

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Tab CABESTALOL	200mg	PO	TID	3/15	<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2	Tab NICARDIA	10mg	PO	TID	3/15	<input checked="" type="checkbox"/> C <input checked="" type="checkbox"/> DC
3	Tab ECOSPIRIN	150mg	PO	OD	3/15	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
4	Tab IRON		PO	OD	3/15	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
5	Tab SHELLAC		PO	OD	3/15	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Smeena

Date & Time : 1/6/26 @ 2pm

Nurse Name & Signature: Anita

Date & Time : 1/6/26 @ 8pm

Patient S

BAH-00632519 IP5-00174584
Mrs SUKHDEEP SANGWAN
24-11-1995 30 Y 6 M 8 D (F)
Dr. ANNIE PRANUTHA P



DRUG CHART

Date of Admission: 11/6/26 Drug Allergies: N/CDA Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name Signal

REGULAR PRESCRIPTIONS

Weight. 64.9 Ward. OBS



DRUG : Inj. CEFOTAXIM				Date Time	1/6	2/6	3/6
Dose	Route	Frequency	Start Date	2am	2am	2am	2am
1gm	IV	BD	1/6	2am	2am	2am	2am
Name & Signature of the Doctor Starting the Drugs: Dr. Samenee				STOP Dr. Samenee			
Additional Instructions: After test done				3/6/26 @ 9am			
Daily Doctor's Endorsement by a Sign				↓			
DRUG : Tab CABETAVOL				Date Time	1/6	2/6	3/6
Dose	Route	Frequency	Start Date	3pm	3pm	3pm	3pm
every	PO	TID	1/6	3pm	3pm	3pm	3pm
Name & Signature of the Doctor Starting the Drugs: Dr. Samenee				STOP Dr. Samenee			
Additional Instructions: inform & give				11pm			
Daily Doctor's Endorsement by a Sign				↓			
DRUG : Tab NICARDIA				Date Time	1/6	2/6	3/6
Dose	Route	Frequency	Start Date	4:30 pm	4:30 pm	4:30 pm	4:30 pm
every	PO	TID	1/6	4:30 pm	4:30 pm	4:30 pm	4:30 pm
Name & Signature of the Doctor Starting the Drugs: Dr. Samenee				STOP Dr. Samenee			
Additional Instructions: inform & give				12AM			
Daily Doctor's Endorsement by a Sign				↓			
DRUG : I-PARACETAMOL				Date Time	1/6	2/6	3/6
Dose	Route	Frequency	Start Date	6:12 am	6:12 am	6:12 am	6:12 am
1gm	oral	6th hrly	1/6/26	6:12 am	6:12 am	6:12 am	6:12 am
Name & Signature of the Doctor Starting the Drugs: Dr. Anurag K				STOP Dr. Anurag K			
Additional Instructions:				6:12 am			
Daily Doctor's Endorsement by a Sign				↓			



Sheet No: ①

REGULAR PRESCRIPTIONS

Weight 64.9 Ward OB8

DRUG : 7-TRAMADOL				Date Time																				
Dose	Route	Frequency	Start Dt.																					
100mg	oral	8thly	1/6/26	8 AM																				
Name & Signature of the Doctor Starting the Drugs: Dr. Archana K @Anny																								
Additional Instructions:																								
Daily Doctor's Endorsement by a Sign																								
DRUG : Inj-TRANEXAMIC ACID				Date Time																				
Dose	Route	Frequency	Start Dt.																					
1gm	W	TID	1/6/26	11 AM																				
Name & Signature of the Doctor Starting the Drugs: Dr. Archana K @Anny																								
Additional Instructions: 24 hours																								
Daily Doctor's Endorsement by a Sign																								
DRUG : Inj-ENOXAPARIN				Date Time																				
Dose	Route	Frequency	Start Dt.																					
40mg	SC	OD	1/6/26	6 PM																				
Name & Signature of the Doctor Starting the Drugs: Dr. Archana K @Anny																								
Additional Instructions: TO check for bleeding before administering																								
Daily Doctor's Endorsement by a Sign																								
DRUG : TAB. Pantoprazole				Date Time																				
Dose	Route	Frequency	Start Dt.																					
40mg	PO	BD	1/6/26	6 AM																				
Name & Signature of the Doctor Starting the Drugs: ↓ Annie																								
Additional Instructions:																								
Daily Doctor's Endorsement by a Sign																								

VERIFIED BY : Nani



Sheet No: ①.....

REGULAR PRESCRIPTIONS

Weight

Ward

DRUG : Tab. ISOLAZINE				Date/Time						
Dose	Route	Frequency	Start Dt.	1/6 9 AM	2/6 2/6					
1 tab	PO	BD	1/6							
Name & Signature of the Doctor Starting the Drugs:										
Dr. Saneene										
Additional Instructions:										
inform & give										
Daily Doctor's Endorsement by a Sign										
DRUG : IM. PARACETAMOL				Date/Time						
Dose	Route	Frequency	Start Dt.	1/6 6 AM	2/6 6 AM					
1gm	W	6 ^{hrs}	1/6							
Name & Signature of the Doctor Starting the Drugs:										
[Signature]										
Additional Instructions:										
Daily Doctor's Endorsement by a Sign										
DRUG : IM. Ibuprofen				Date/Time						
Dose	Route	Frequency	Start Dt.	1/6 9 AM	2/6 9 AM					
100	W	8 ^{hrs}	1/6							
Name & Signature of the Doctor Starting the Drugs:										
[Signature]										
Additional Instructions:										
IN LOW NORMAL & PAIN										
Daily Doctor's Endorsement by a Sign										
DRUG : T. PARACETAMOL				Date/Time						
Dose	Route	Frequency	Start Dt.	2/6 10 AM	3/6 10 AM					
1gm	PO	QID	2/6/26							
Name & Signature of the Doctor Starting the Drugs:										
[Signature] Dr. Y. Saneene										
Additional Instructions:										
Daily Doctor's Endorsement by a Sign										

VERIFIED BY : Name Signature



Sheet No: **REGULAR PRESCRIPTIONS** Weight Ward

DRUG : T. TRAMADOL				Date Time	2/6															
Dose	Route	Frequency	Start Dt.	8 AM	X															
100mg	PO	TID	2/6/26																	
Name & Signature of the Doctor Starting the Drugs: Dr. Y. D. Y. Sneh				9 AM																
Additional Instructions:				10 PM																
Daily Doctor's Endorsement by a Sign																				

DRUG : Tab. STAMLO				Date Time	2/6															
Dose	Route	Frequency	Start Dt.																	
10mg	PO	OD	2/6/26																	
Name & Signature of the Doctor Starting the Drugs: Dr. Anurupa				9 AM																
Additional Instructions: at 9 AM.																				
Daily Doctor's Endorsement by a Sign																				

DRUG : Tab. STAMLO				Date Time	2/6															
Dose	Route	Frequency	Start Dt.																	
5mg	PO	OD	2/6/26																	
Name & Signature of the Doctor Starting the Drugs: Dr. Anurupa				9 PM																
Additional Instructions: at 9 PM																				
Daily Doctor's Endorsement by a Sign																				

DRUG : Tab. CEFIXIME				Date Time																
Dose	Route	Frequency	Start Dt.																	
200mg	PO	BD	2/6																	
Name & Signature of the Doctor Starting the Drugs: Dr. Samere R.																				
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight

Ward

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

Signature
.....
Name
.....



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

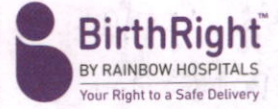
VARIABLE DOSE		Date Time	Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.	
DRUG :	Dose		Dose		Dose		Dose		Dose	
	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Dose		Dose		Dose		Dose		Dose	
Start Date	Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor	Dose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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
1/6/26	2AM	inj LABETACOL	2mg	IV	[Signature]	Swape Sunitha
1/6	2:30 AM	inj LABETACOL	4mg	IV	[Signature]	Swape Sunitha
1/6	3AM	inj. MgSO4	4gm	IV	[Signature]	Swape Sunitha
1/6/26	4:15pm	Sup. TRAMADOL	100mg	PR	[Signature]	Swape Rajesh
1/6/26	3:40pm	inj. ONDANSETRON.	4mg.	IV	[Signature]	Swape Rajesh
1/6/26	3:40AM	inj. TRANEXAMIC ACID	1gm	IV	[Signature]	Swape Krauth
1/6	2:15AM	inj PANTOP	4mg	IV	[Signature]	Swape Sunitha
1/6	2:10AM	inj PERINDOM	10mg	IV	[Signature]	Swape Sunitha
1/6	7 AM	inj PARACETAMOL	1gm	IV	[Signature]	Swape Sunitha
1/6	8:30AM	Tab. NICARDIA	10mg	PO	[Signature]	Swape Sunitha

Signature
Name

BAH-00632519 IP5-00174584
 Mrs SUKHDEEP SANGWAN
 24-11-1995 30 Y 6 M 8 D (F)
 Dr. ANNIE PRANUTHA P



Morning Observation Score Chart - Obstetrics

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

11/6/2026

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

294

98.1 98.1

103 101 96 91 93 97 98

155 145 136 127 145 141 140
 105 91 89 100 97 95 95

1 0 0 0 0 0 0 1 0 0 0 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0
 8

4:40 AM BP 105/95
 Pulse: 95%
 SpO2: 99%
 5 AM BP 127/100 (109)
 SpO2: 98%
 Pulse: 102
 5:20 AM BP 141/106 (118)
 Pulse: 93
 SpO2: 100%
 5:40 AM BP 145/92 (109)
 Pulse: 93
 SpO2: 100%
 6 AM BP 141/95 (110)

1/6/26
 6:30 AM BP 148/99 (113)

7 AM BP 140/95 (109)

7:20 AM BP 145/93
 8 AM BP 140/99 (100%)
 SpO2: 100%
 Pulse: 94

9 AM BP 125/86 (96)
 Pulse: 115 bpm
 SpO2: 100%

**Obstetrics and Gynaecology
Early Warning Signs**

10 AM BP 126/84 (91)
 Pulse: 100
 SpO2: 100%
 11 AM BP 135/81 (96)
 Pulse: 100
 SpO2: 98
 12 PM BP 130/78 (95)
 SpO2: 98
 Pulse: 107
 Temp: 98.2°F
 1 PM BP 130/78
 SpO2: 98
 Pulse: 97
 2 PM BP 134/96 (100)
 SpO2: 98
 Pulse: 96

3 PM BP 132/96 (108)
 P: 101 bpm
 SpO2: 97%

Complete a Full Set of MEOWS Observations

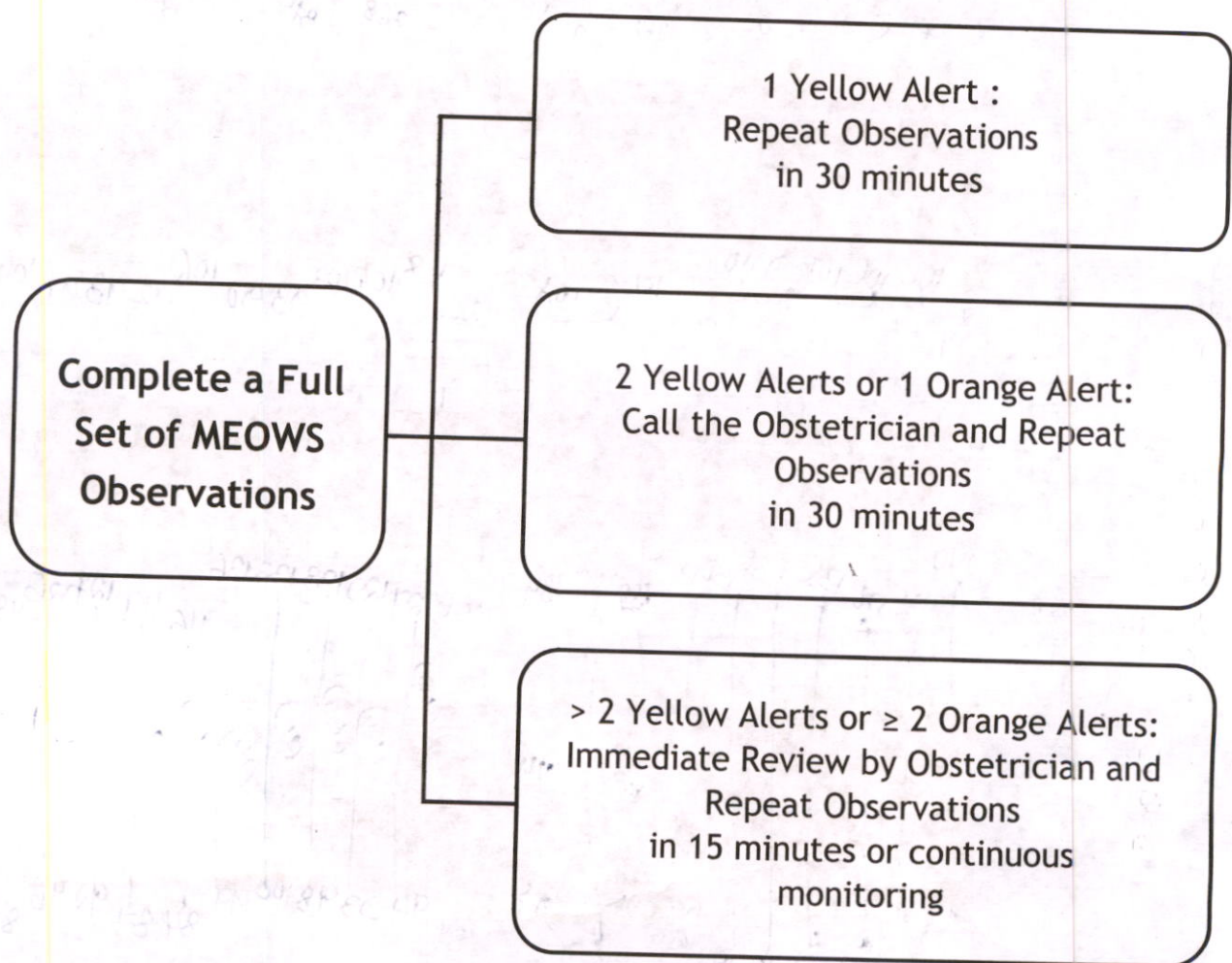
**1 Yellow Alert :
Repeat Observations
in 30 minutes**

**2 Yellow Alerts or 1 Orange Alert:
Call the Obstetrician and Repeat
Observations
in 30 minutes**

**> 2 Yellow Alerts or ≥ 2 Orange Alerts:
Immediate Review by Obstetrician and
Repeat Observations
in 15 minutes or continuous
monitoring**

* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

BAH-00632519 IP5-00174584
 Mrs SUKHDEEP SANGWAN
 24-11-1995 30 Y 6 M 8 D (F)
 Dr. ANNIE PRANUTHA P

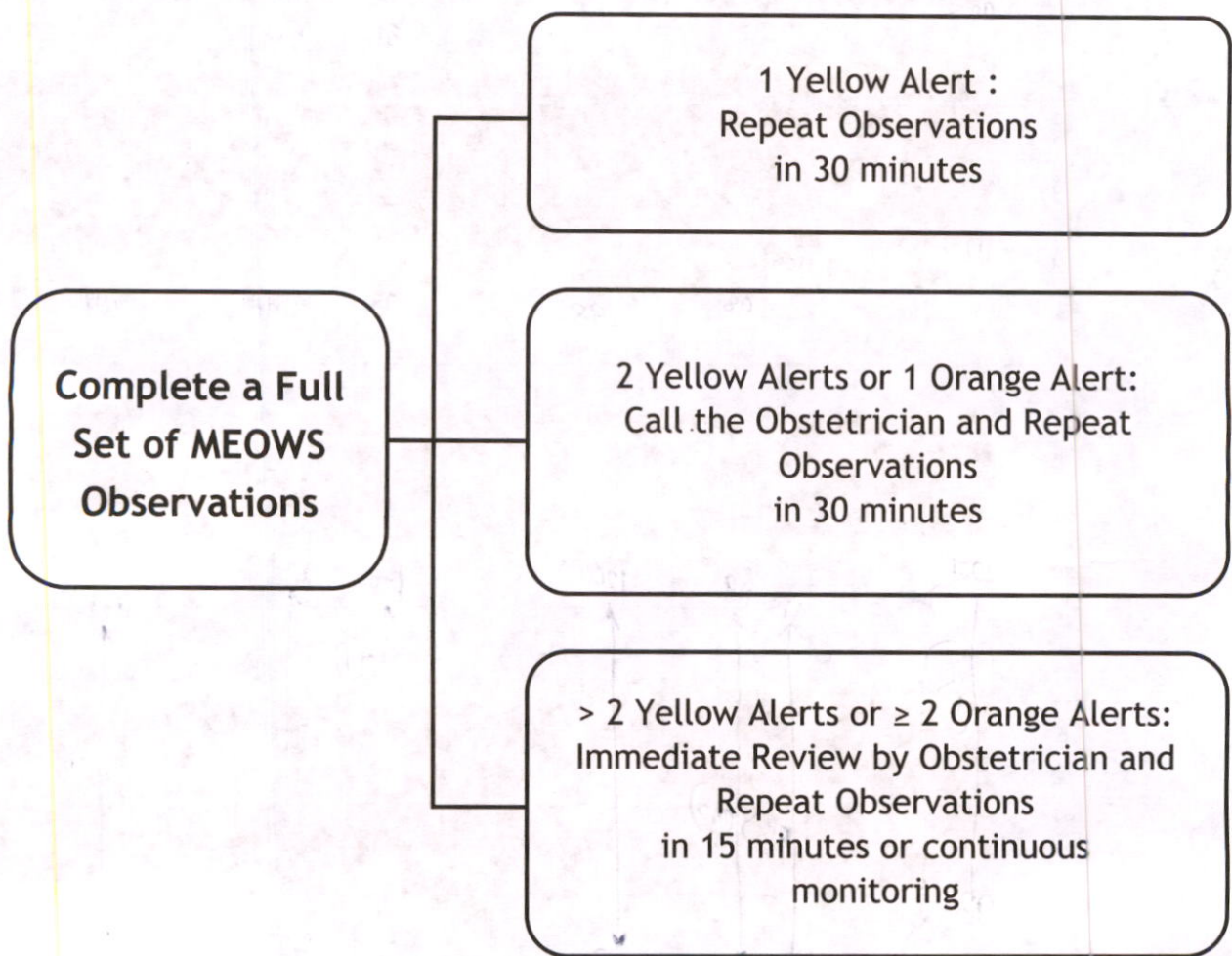


Early Warning Observation Score Chart - Obstetrics

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 corres. box)	> 30																								
	21 - 30	24	23			22	21			20			19 1/2	19 1/2			19 1/2						19 1/2		
	11 - 20																								
	0 - 10																								
Saturations	94 - 100 %	98	98			98	100%			100%			98	97			98						95		
	< 94 %																								
Administered O ₂ (L/min.)																									
Temp °C	40																								
	39																								
	38																								
	37	98.5																							
	36													98	98									98	
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110	112				105																			
	100		95																						
	90						98																	98	
	80																								
	70																								
	60																								
	50																								
40																									
Systolic Blood Pressure	190																								
	180																								
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	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
	40																								
	NEURO RESPONSE [✓]	Alert	✓	A			A	✓			✓			✓			✓						✓		
		Voice																							
		Pain																							
Unresponsive																									
URINE mls / hour	> 30	✓	✓			✓	✓			✓			✓			✓						✓			
	< 30																								
Proteinuria	Protein ++																								
	Protein > ++																								
Lochia	Normal	✓											✓			✓						✓			
	Heavy / Foul																								
Liquor	Clear / Pink																							✓	
	Green																								
TOTAL YELLOW SCORES		2	2			2	0			0			0			0						0			
TOTAL ORANGE SCORES		0	0			0	0			0			0			0						0			
Nurse Initial		AP	AP			AP	AP			AP			AP			AP						AP			

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

BAH-00632519 IP5-00174584
 Mrs SUKHDEEP SANGWAN
 24-11-1995 30 Y 6 M 10 D (F)
 Dr. ANNIE PRANUTHA P



Early Warning Observation Score Chart - Obstetrics

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

Date		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20																									
	0 - 10																									
Saturations	94 - 100 %		99																							
	< 94 %																									
Administered O ₂ (L/min.)																										
Temp °C	40																									
	39																									
	38																									
	37																									
	36		98.5																							
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	Protein > ++																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES																										
TOTAL ORANGE SCORES																										
Nurse Initial																										

3/6/20

99%

98.5

99

126
 ↑
 (94)
 ↓
 82

0

0

Obstetrics and Gynaecology Early Warning Signs

Complete a Full
Set of MEOWS
Observations

1 Yellow Alert :
Repeat Observations
in 30 minutes

2 Yellow Alerts or 1 Orange Alert:
Call the Obstetrician and Repeat
Observations
in 30 minutes

> 2 Yellow Alerts or \geq 2 Orange Alerts:
Immediate Review by Obstetrician and
Repeat Observations
in 15 minutes or continuous
monitoring

* The Modified Early Warning Score (MEOWS)

Patient

BAH-00632519 IP5-00174584
 Mrs SUKHDEEP SANGWAN
 24-11-1995 30 Y 6 M 8 D (F)
 Dr. ANNIE PRANUTHA P



FLUID CHART

Rainbow Children's Hospital
 It's not just to treat the little.


BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Sheet No. : ①

31/5/2026

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am		NBM								0	Swaper
Total Intake :			NBM			Total Output :					Passed 0-2	
	02:00 am	mglyou	1	100ml						200ml	0	Swaper
	03:00 am	re	1	500ml						300ml	0	Swaper
	04:00 am	re	N	150ml						300ml	0	Swaper
	05:00 am	re mglyou	B	100ml 25ml						200ml	0	Swaper
	06:00 am	re mglyou	M	50ml 25ml						50ml	0	Swaper
	07:00 am	re mglyou	1	100ml 25ml						300ml	0	Swaper
Total Intake :			950			Total Output :					1800	
Total 24 hrs. Intake			950ml			Total 24 hrs. Output					1800ml	

32519
 DEEPA SANGWAN
 30 Y 6 M 8 D (F)
 E PRANATHA P


FLUID CHART



1/6/2026

Measurements in ml.
 Report each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
 Total to be entered in the kardex in RED.

Time	Nature of Fluid	Intake			NG	Diarrhoea	Vomit	Output				IV Site Thrombophlebitis Score	Sign. Nurse	
		Mouth	I.V	N.G				Drainage	Urine	Stool	Other			
08:00 am	RL		75ml/hr							200ml	0			
09:00 am	RL		75ml/hr							200ml	0			
10:00 am	RL		75ml/hr							200ml	0			
11:00 am	RL		75ml/hr							150ml	0			
12:00 pm	RL		75ml/hr							150ml	0			
01:00 pm	RL		75ml/hr								0			
Total Intake : 720 ml										Total Output : 1100 ml				
02:00 pm	RL Juice		75ml/hr							150ml	0		sonia	
03:00 pm	RL water		75ml							100ml	0		sonia	
04:00 pm	RL water		75ml							150ml	0		Silva	
05:00 pm	RL water		75ml							200ml	0		Poulas	
06:00 pm	RL water		75ml							150ml	0		Poulas	
07:00 pm	RL water		75ml							260ml	0		Poulas	
Total Intake :										Total Output : 700 ml				
08:00 pm	MgSO4		H2O 25ml							140ml	0		Anita	
09:00 pm	MgSO4		H2O 25ml							150ml	0		Anita	
10:00 pm	MgSO4		H2O 25ml							200ml	0		Anita	
11:00 pm	MgSO4		H2O 25ml							250ml	0		Anita	
12:00 am	MgSO4		H2O 25ml							150ml	0		Anita	
01:00 am	MgSO4		H2O 25ml							150ml	0		Anita	
Total Intake :										Total Output : 1040 ml				
02:00 am	MgSO4		H2O 25ml							75ml	0		Anita	
03:00 am	MgSO4		H2O 25ml							80ml	0		Anita	
04:00 am	MgSO4		H2O 25ml							80ml	0		Anita	
05:00 am			H2O 25ml							150ml	0		Anita	
06:00 am			H2O 25ml							150ml	0		Anita	
07:00 am			H2O 25ml							200ml	0		Anita	
Total Intake : Taken good.										Total Output : 785ml				
Total 24 hrs. Intake										Total 24 hrs. Output				
Taken										8,885 ml				

BAH-00632519 IP5-00174584
 Mrs SUKHDEEP SANGWAN
 24-11-1995 30 Y 6 M 8 D (F)
 Dr. ANNIE PRANUTHA P



FLUID CHART

2/6/2026.

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
2/6/26	08:00 am										0	Tunny	
	09:00 am	H ₂ O 200ml							✓		0	Tunny	
	10:00 am	H ₂ O					✓				0	Sushanta	
	11:00 am	H ₂ O									0	Sushanta	
	12:00 pm										0	Sushanta	
	01:00 pm	H ₂ O									0	Sushanta	
Total Intake : Taken													
Total Output : U-1 2M-2.													
2/6/26	02:00 pm										0	Sushanta	
	03:00 pm	H ₂ O									0	Sushanta	
	04:00 pm										0	Sushanta	
	05:00 pm	H ₂ O									0	Sushanta	
	06:00 pm										0	Sushanta	
	07:00 pm										0	Sushanta	
Total Intake : taken.													
Total Output : U-2. m-NP.													
2/6	08:00 pm	H ₂ O									0	Sushanta	
	09:00 pm										0	Sushanta	
	10:00 pm	H ₂ O									0	Sushanta	
	11:00 pm										0	Sushanta	
	12:00 am	H ₂ O									0	Sushanta	
	01:00 am										0	Sushanta	
Total Intake :													
Total Output :													
2/6	02:00 am										0	Sushanta	
	03:00 am	H ₂ O									0	Sushanta	
	04:00 am										0	Sushanta	
	05:00 am	H ₂ O									0	Sushanta	
	06:00 am	H ₂ O									0	Sushanta	
	07:00 am										0	Sushanta	
Total Intake :													
Total Output :													
Total 24 hrs. Intake													
Total hrs													

BAH-00632519 IP5-00174584
 Mrs SUKHDEEP SANGWAN
 24-11-1995 30 Y 6 M 10 D (F)
 Dr. ANNIE PRANLUTHA P



FLUID CHART

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

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.

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

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

BAH-00632519 IP5-00174584
Mrs SUKHDEEP SANGWAN
24-11-1995 30 Y 6 M 8 D (F)
Dr. ANNIE PRANUTHA P



Name: Sukhdeep Sangwan Age: 30y Sex: F UHID.No:
Date: 11/6/2026 Time: 3:10AM Proposed Operation: Emergency caesarean
Diagnosis: primi 33+ weeks; ? Abruption
B.P / CRT: 155/105 H.R: 103 Weight: 65kgs ASA Physical Status: 1 2 3 4 5

Laboratory Data:
Hgb: 9.9 Glucose: Protein: HIV: X-Ray:
PCV: Urea: 26 Alb: HBS Ag: NR ECG:
WBC: 11360 Creat: 0.6 Total Bill: 0.3 HCV: 2D Echo:
Plate: 364 Na: 134 Dir. Bill: 0.1 Blood group: O-ve Stress/Anglo:
PT: 14 K: 11.1 LDH: 227 T3 Other:
PTT: 21.8 Ca++: Alk phos: T4 TSH
INR: 1.0 Mg++: Amylase: SGOT/SGPT: 22/24

Allergies: Nil

Medical History: CVS: PE e: 1 month Diabetes: Nil
RESP:
CNS: Nil significant
Renal: Physical Activity: active
Hepatic / GE:
Others:

Past Anaesthetic History: Nil
Physical Exam:
Airway: MP 1 2 3 4 Mouth Opening: 3FB Mentohyoid Distance: 3FB Neck: N Teeth: N
Lungs: BAE @ ch upper incisor
Heart: SIW @
CNS: clear

Pregnant: Yes No NA Venous Access Site: accessible Spine Exam for regional: well felt
Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>T. CABETOLOL</u>	<u>200mg TID</u>
<u>T. NIFEDIPINE</u>	<u>10mg TID</u>

- Pre-Operative Instructions:**
- DVT Prophylaxis: ✓
 - NIL ORAL: Water / ORS 2 Hours / Others 6 Hours
 - Informed Consent: Standard High Risk
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions: TO Reserve 20PRB/1

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

BAH-00632519

IP5-00174584

Mrs SUKHDEEP SANGWAN
24-11-1993 30 Y 6 M 8 D (F)
Dr. ANNIE PRANUTHA P



ANAESTHESIA CHART



Induction Assessment:

Change in Patient Condition: Yes No Fasting Status: Adequate

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: 91 B.P / CRT: 144/86 SpO₂: 98 R.R: 14 Last Feed: 76 hrs

Pre-OP Diagnosis: Primit + Abruptio Operation: Emergency LSCS Date: 11.6.26

Surgeon: Dr. Annie Anaesthesiologist: Dr. AK Technician: Vijay

TIME	3:30	4:00	4:30						
N ₂ O / AIR / O ₂ LPM									
HALO / SO / SEVO									
Drugs:									
1mg DEXTROSCOPOL 300mcg									
1mg CARBETOICIN 100mcg									
1mg ANDANSETRON 4mg									
1mg TRANEXA 1gm									
1mg FENTANYL 75mcg									
FiO ₂ (SaO ₂)	96	98	98	92					
ETCO ₂									
ECG	SR	SR	SR	SR					
Temperature									
Urine Output				-800ml					
Fluids Blood									
B.P									
V Systolic									
A Diastolic									
X Mean									
Heart Rate									
Tourniquet on Time									
Tourniquet off Time									
Throat Pack In									
Throat Pack Out									

Antibiotic

Suppository

SVP TRAMADOL 100mg

Blood Loss

~300ml

NOTES

LAB Values

ABG

GRBS

Others

Equipment Checked and Functional

BP

Cuff Size R 10 L 10

Art Site

EKG Lead

Temp Site

FiO₂ Monitor

Agent Monitor

Pulse Oximeter

Capnograph

Ventilator

Airway Stimulator

Suction

Pharynx Check

Temp:

HME

Cling Film

Hugger's

Other

Times:

Anaes Start: 3:30 AM

OP Start: 4:30 AM

OP End: 4:30 AM

Leave OR: 4:30 AM

Anaesthesia:

GA

Monitored Anaesthesia Care

Regional

Line (Site & Location)

ECV

APT

CV: CVL 18g

Induction

IV Inhal

Pre O₂ RS

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?

Bilat = BS

Semi-Closed Circle

Closed Circle

Other

Regional:

Extremity Specify:

Spinal Epidural Caudal

Others:

Position: Sitting

Site: L5/S6

Needle Size: 25g QB Depth: 5cm

Parasthesia Yes No

Catheter at skin cm

Drug Name & Conc: 0.5% Bupivacaine heavy 10mg

Bolus: + 25mcg fentanyl

Infusion:

Block Level: Adequate T4

Comments:

Transportation to

PACU ICU Other

Relaxant Reversed Yes No

Name of the Doctor: Dr. Arshad K

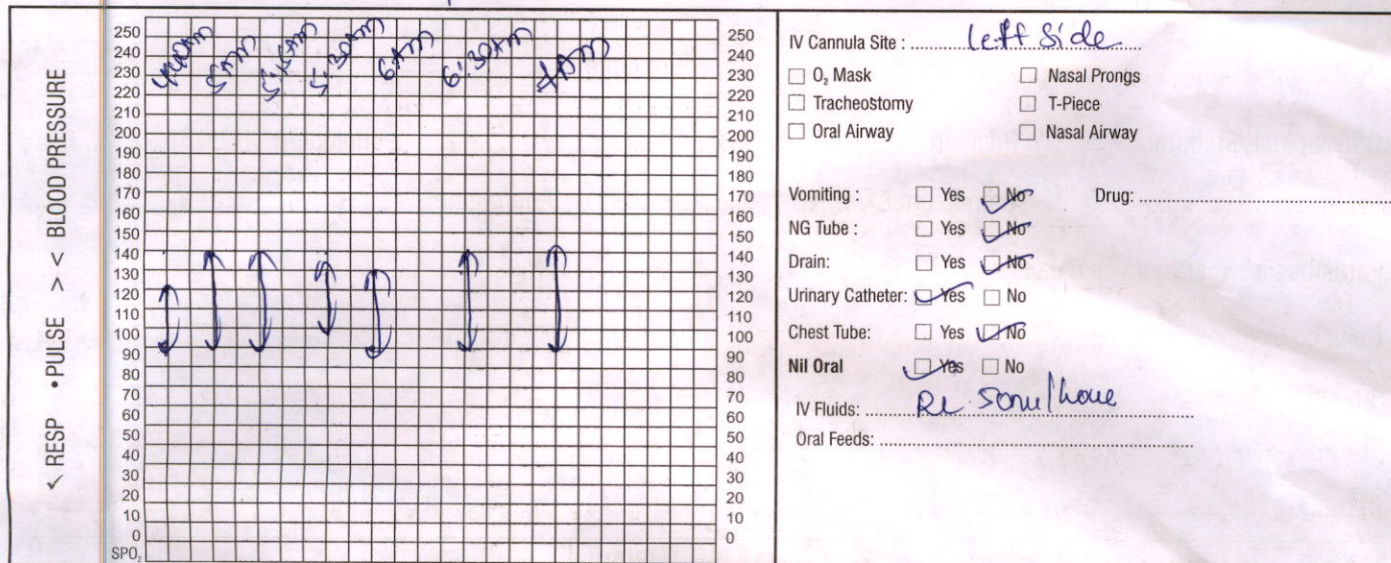
Signature of the Doctor: [Signature]

BAH-00632519 IP5-00174584
 Mrs SUKHDEEP SANGWAN
 24-11-1995 30 Y 6 M 8 D (F)
 Dr. ANNE PRANUTHA P



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Swapna Time Received : 4:40am Time Discharged : 11am



IV Cannula Site : Left Side

O₂ Mask Nasal Prongs
 Tracheostomy T-Piece
 Oral Airway Nasal Airway

Vomiting : Yes No Drug: _____
 NG Tube : Yes No
 Drain: Yes No
 Urinary Catheter: Yes No
 Chest Tube: Yes No
 Nil Oral Yes No
 IV Fluids: RL 500ml/hour
 Oral Feeds: _____

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
<u>1/6</u>	<u>5am</u>	<u>0</u>	<u>NA</u>	<u>Swapna</u>
<u>1/6</u>	<u>6am</u>	<u>0</u>	<u>NA</u>	<u>Swapna</u>

Pain Tool Used: N PASS FLACC Wong Baker NRS

Anaesthesiologist Name : Dr. ASHWARYA
 Anaesthesiologist Signature: Ashy
 Date & Time: 2/6/26 @ 12pm

PACU Nurse Name : Swapna
 PACU Nurse Signature: Sy
 Date & Time: 1/6/2026 5am

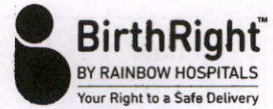
Reassessment Frequency:
 1. Every eight hours for all hospitalized patients.
 2. For post surgical patient, patient with chronic pain, patient with severe pain
 a. Every 2 hours for first 24 hours
 b. After 24 hours every 4 hours
 c. Prior to pain relieving intervention
 d. With in 30-60 minutes after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

Transferred to Unit by (PACU): OBC
 Date & Time: 1/6/2026 5am

BAH-00632519 IP5-00174584
Mrs SUKHDEEP SANGWAN
24-11-1995 30 Y 6 M 9 D (F)
Dr. ANNIE PRANUTHA P



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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 2/6/26 Time: 12:30pm

Origin: Indian Height: 164cm Weight: 64.9kg's BMI: 24.2kg/m²

Food Allergies: No

Diagnosis: POD-1 / LSCS (lower segment cesarean section)

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

Diet Advised:

soft High protein diet
include plenty of oral liquids
avoid spicy, chilled and outside foods

Patient's / Attendant's

Dietician's

Signature: Seema

Signature: Nikitha

Name: Seema

Name: Nikitha

Date & Time: 2/6/26 Ep 12:30pm

Date & Time: 2/6/26 Ep 12:30pm

