HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

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SURGERY DETAILS

Date : 04/7/26

Patient Name: Mrs. Damini Date of Birth: 07-11-1997 Age: 28 Yrs

Gender: Female Ward : OT UHID No.: HNH-00016336

Date of Surgery: 04/7/26 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Elective LSCS.

Time in : 8:00 Am Time Out : 9:00 Am

		NAME	AMOUNT
1.	Surgeon	: Dr. Y. Indira Rani, Dr. Swapna	
2.	Anaesthetist	: Dr. Samir	
3.	Assistant Surgeon	: Dr. Naveena	
4.	OT Technician	: Sr. Saraswathi, Sr. Pallavi	
5.	Circulating Nurse	: Sr. Natasha, Sr. Karuna	
6.	Assistant Nurse	: Sr. Archana, Sr. Susheela	

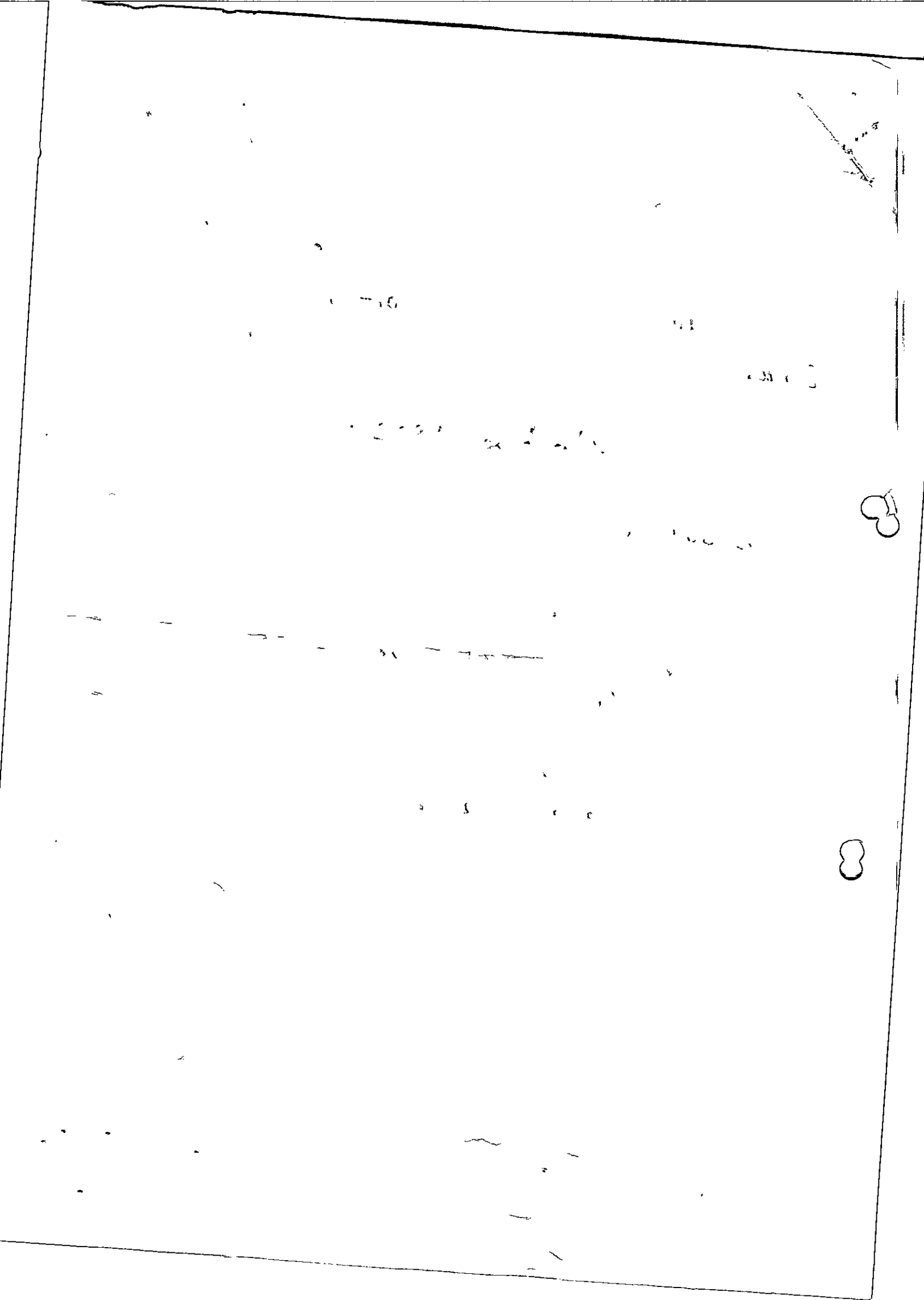
Special Equipment:
☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others .....

Signature of the Surgeon

Natasha
Signature of Circulating Nurse

Order No: 26-0000210572 Order by: Susheela 4/7/26. @ 9.54 Am.

Docu. No. : RCH[illegible]/FRM / GENERAL / 114



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CONSUMABLES OF OT

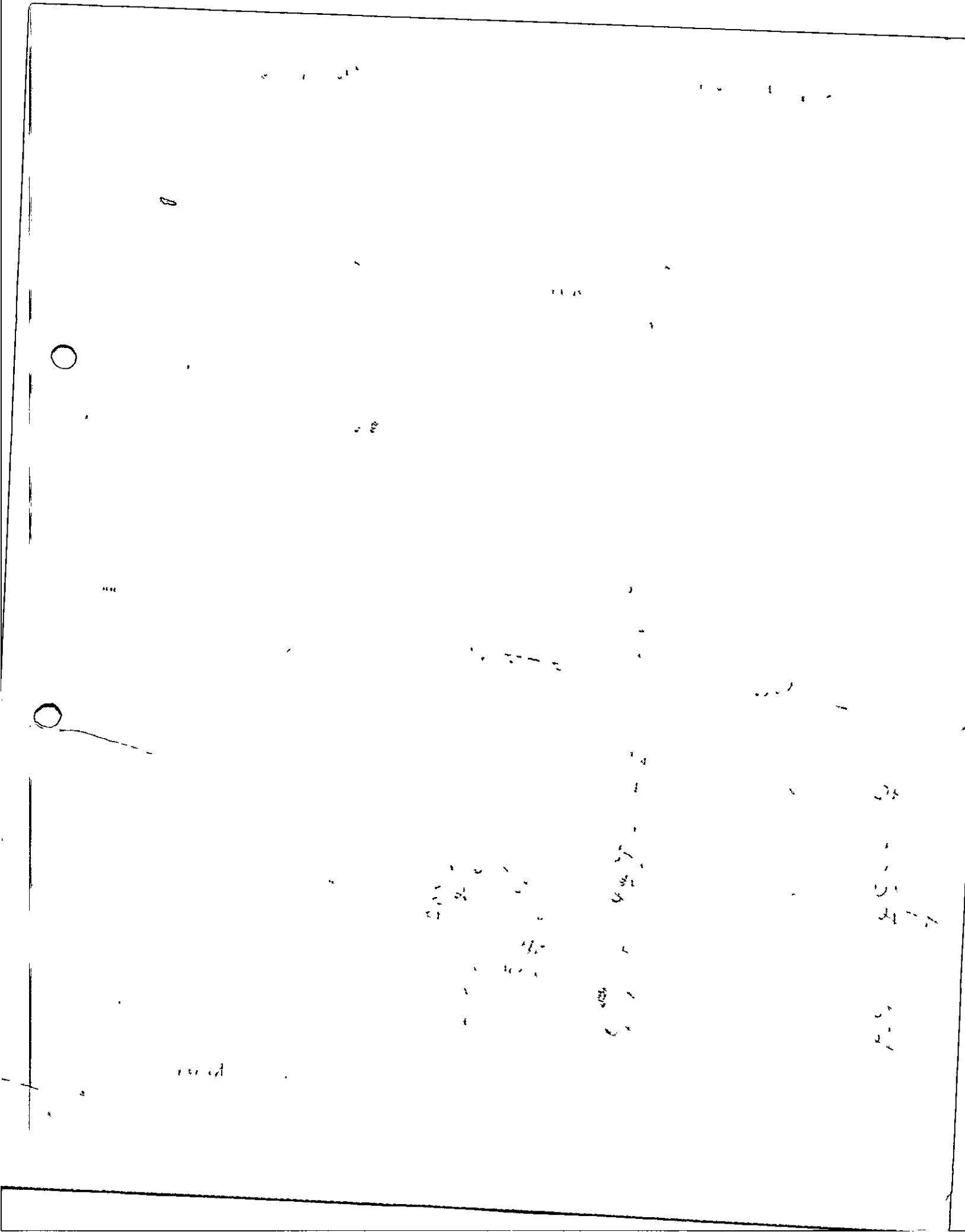
Circulating staff : Natasha Kausar Technician : Saraswathi Date : 26/7/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack LSCS		01	Inj Vit.K		01
LMA			Sutures 2346		01	Cord Clamp		01
ECG leads : (A) / P / N		03	Catgut no-1		1	Suction Catheter		
HME filter : A / P / N			Prolene 883		01	Feeding Tube		
Syringes : 10 cc		02	Rapid Vocr 4/2/62		01	Vaccum Suction Set		
05 cc		02	Gloves SG 6.5		2	Surgical Gloves SG 6.5		01+1
02 cc		02	Encore 6.5		01	Gauze Pack 7.5		01
01 cc			SG no 6		01	Syringe 1ml / 2ml		01
Cautery plate : (A) / P / N		01	Surgical blade 22		01	Surgical Blade # 20		01
IV set			NG tube			Koochies (S)		
RL		02	Cautery pencil		01	Encore 6.5		01
NS : 10ml / 100ml / 500ml / 1000ml			Koochies XXL		01			
oxytocine		03	Ointments					
Tranexa		03	Suction Catheter					
Fentanyl		01	Cap, Mask		01+1	26000210605		
Morphine Bupriggesic 03		01	Gauze Pack 10x10 7.5x7.5		01			
Ketamine			Mop Pack		02			
Propofol			Steristrip					
Rocuronium			Underpad		02			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel		01			
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22		01	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy) Anaesthesia		01	Romodrain bag					
Antibiotics			Bandage					
spinal needle 25g Quincky		01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / 100mg		01	Plastic Bed Sheet Aprn 4		03			
Tab. Misoprost : 200mg		04	Betadine Solution		2			
Encore glove 7.5		01	Microshield					
Guaze 10x10		01	Cotton Balls		01			
			Latex Gloves		2			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-0000210604 Ordered by : Kausar @ 4/7/26 11:35 AM

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



Rainbow Childrens Hospital-Himayatnagar

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	HNH-00016335	Name	Mrs DAMINI
Age / Sex	28 Y 7 M 27 D / Female	Doctor	Y.INDIRA RANI
Adm/Reg Date/Time	04/07/2026 06:28	Payor	SELFPAY
Order Date	04/07/2026 11:28	Ordernumber	26-0000210604
Visit ID	IP26-00006736	Ward/Bed No	4F -OT / LDR-415
Patient Address	2-1-176, yellambanda,kphb, Kphb, Hyderabad, Telangana, INDIA, 500072		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	PROLENE 1 NW 883	PROLENE 1 NW 883	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	SGLOVE # 6 (SURGICARE)	SURGICAL GLOVES 6.0	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
4	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
5	MISOPROST TAB 200MCG 4S		1 Tabs	External / Once Daily	1 Days		4 Tabs	Dispensed
6	TRUGUT CHROMIC CATGUT SN4242	TRUGUT CHROMIC CATGUT SN4242	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
7	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
8	ENCORE MICROPTIC GLOVES-7.5 PF		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
9	DSYRINGE 5ML(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
10	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
11	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
12	VICRYL 2-0 NW 2762	VICRYL 2-0 NW 2762	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
13	DISPOSABLE APRONS STERILE XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
14	LSCS DRAPE PACK (PROTECTCARE)		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
15	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Dispensed
16	EVATOCIN (OXYTOCIN) INJ 5 IU 1 ML		1 Vial	External / Once Daily	1 Days		3 Vial	Dispensed
17	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
18	SPINAL NEEDLE 25	SPINAL NEEDLE 25G	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
19	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
20	VICRYL 1-0 VP 2346	VICRYL 1-0 VP 2346	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
21	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
22	ABGEL SURGI PAD (BIG) (GELSPON)	ABGEL	1 Nos	/ Once Daily	1 Days		3 Nos	Dispensed
23	ADULT DIAPERS-XXL		1 Nos	External / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
24	UNDERPADS 60X90 BUTTERFLY		2 Nos	External / 1-2 TIMES A DAY	1 Days		2 Nos	Dispensed
25	BIOXAMIC 500 MG INJ		1 Ampule	External / Once Daily	1 Days		3 Ampule	Dispensed
26	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
27	CAUTERY PENCIL (ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
28	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
29	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
30	COTTON 100 G (70 G NETT)	COTTON 100G	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
31	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
32	PENCAN 25G*3 1 2	PENCAN 25G*3 1 2	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
33	BUPRIGESIC INJ AMP 0.3 MG 1 ML	BUPRENORPHINE 0.3 MG 1ML INJ	1 Ampule	External / Once Daily	1 Days		1 Ampule	Dispensed

Y.INDIRA RANI

This document is just for reference purpose only. Not to be considered as primary report.

Note

* This prescription is valid only for specified duration.

* Do not refill medicines.

Rainbow Children's Hospital

Birthing Rainbow

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Hyderabad ,Telangana, INDIA ,500029.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00016342	**Name**	: Baby Of DAMINI
Age / Sex	: 0 Y 0 M 0 D 6 H / Female	**Doctor**	: SINDHURA MUNUKUNTLA
Adm/Reg Date/Time	: 04/07/2026 10:14	**Payor**	: SELFPAY
Order Date	: 04/07/2026 11:33	**Ordernumber**	: 26-0000210605
Visit ID	: IP26-00006737	**Ward/Bed No**	: 4F -OT / CRDL-HNPDA-415-1
Patient Address	: 2-1-176, yellambanda,kphb, Kphb, Hyderabad, Telangana, INDIA, 500072		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	INJEK INJ 1 MG 0.5 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
2	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
3	SURGICAL BLADE 20	SURGICAL BLADE 20	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
4	CORD CLAMP-ALPHAMEDICARE		1 Nos	External / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
5	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
6	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
7	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed

SINDHURA MUNUKUNTLA

Reg No : 66970

* This document is just for reference purpose only. Not to be considered as primary report.

Note

*** This prescription is valid only for specified duration.**

*** Do not refill medicines.**

2/10 D.C

Name	Mrs DAMINI	**UHID**	HNH-00016336
Father/Guardian	Mr D.SRAVAN	**Age/Gender**	28 Y 7 M 27 D/ Female
Address	2-1-176, yellambanda,kphb, Kphb, Hyderabad, Telangana, INDIA, 500072		
IP No	IP26-00006736	**Admission Date**	04-07-2026
Ref Doctor	Self.		
Discharge Date	07.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. INDIRA RANI Y
MBBS, DGO
700113

Diagnosis: G2A1 WITH 40 WEEKS GESTATION WITH OLIGOHYDRAMNIOS FOR ELECTIVE LOWER SEGMENT CAESAREAN SECTION

ELECTIVE LOWER SEGMENT CAESAREAN SECTION DONE ON 04.07.2026

History:
LMP: 16.08.2025
EDD: 04.07.2026

Obstetric formula: Primigravida
Gestation at admission: 40 weeks

Name	Mrs DAMINI	UHID	HNH-00016336
IP No	IP26-00006736	Admission Date	04-07-2026

Obstetric History:
G1 - Spontaneous Miscarriage at 5-6 weeks
G2 - Present Pregnancy, Spontaneous conception.

Medical History: bronchial Asthma (childhood- not on treatment now).
Surgical History: Nil
Family History : Both Parents-HTN
Allergies : Nil

Antenatal Details:
Mrs DAMINI was booked to Rainbow hospital at 40 weeks of gestation. She had regular antenatal checkups and investigations as advised. NT scan normal with placenta-post reaching os. FTS low risk. TIFFA normal. Fetal 2d echo was normal. Fetal monitoring was done by serial growth scan. Scan done on 29.05.2026 showed Single live intrauterine fetus at 34^{+5} weeks with cephalic presentation with EFW: 2269gms AFI: 15.5 cm with placenta- posterior US. Scan done on 02.07.2026 showed AFI 5.2cm with placenta posterior low lying. She was admitted at 40 weeks with Oligohydramnios for Elective LSCS.

Investigations: Enclosed.
Blood group: "B" Positive

Management: Course in hospital:
At admission, her vitals were stable, uterus was relaxed. Fetal wellbeing was confirmed by an admission NST which was found to be reactive. She was prepared for elective C- section with indwelling Foley's catheter and IV canula

Name	Mrs DAMINI	**UHID**	HNH-00016336
IP No	IP26-00006736	**Admission Date**	04-07-2026

under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given. Patient shifted to theatre.

Surgery Notes:

Under spinal anesthesia she was painted and draped as per hospital protocol. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A Lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 600 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

* **LUS not formed.**
* **Liquor scanty, thin meconium stained.**
* **2 tight loops of cord around neck.**
* **Placenta- posterior low lying.**

Delivery Details:

Date : 04.07.2026
Time of Delivery : 08:15 am
Type of Delivery : Elective Lower Segment Cesarean Section

Name	Mrs DAMINI	UHID	HNH-00016336
IP No	IP26-00006736	Admission Date	04-07-2026

Indication : Oligohydramnios
Anaesthesia : Spinal

Baby Details:
Date : 04.07.2026
Time : 08:15am
Sex : Female
Weight : 2.5kg
Apgar : 7,8
Gestational Age: 40 weeks
NICU Admission: No

Post-Operative Notes:
She was closely monitored. Her vital signs remained stable. Uterus was well retracted with no postpartum hemorrhage. Breast feeding initiated. She was shifted to room. Her postoperative period following that was uneventful. On second postoperative day dressing was changed. On inspection wound was healthy. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

Advice:
1. Tab. Taxim O 200mg twice daily till 10.07.2026 (9am-9pm) after food.
2. Tab. Calpol (Paracetamol 500mg) 2 tablets thrice daily till 07.07.2026(8am-2pm-10pm) after food.

Name	Mrs DAMINI	**UHID**	HNH-00016336
IP No	IP26-00006736	**Admission Date**	04-07-2026

3. Tab. Voveran (Diclofenac-50mg) 1 tablet thrice daily till 07.07.2026 (9am-3pm-11pm) after food.
4. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 10.07.2026 (7am-7pm) before food.
5. Tab Combinorm Plus Twice daily (9am-9pm) till 12.07.2026.
6. Cap Lactare (2caps) thrice daily (8am-3pm-10pm) till 12.07.2026.
7. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
8. Tab. Shelcal (Elemental Calcium 500mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
9. Nebasulf Powder for local application.
10. TED stocking x 2 weeks
11. **Inj Clexane 60mg once daily subcutaneously till ..??** x 7 days

Home Blood pressure monitoring to be done twice daily for two weeks. Report to emergency if BP >140/90mmHg, presence of headache, vomitings, blurred vision, reduced urine output, epigastric pain, seizures.

* Suggest **PAP smear** and **HPV Vaccine** after **6 weeks**; Please discuss with your treating doctor regarding **HPV vaccination.**

Review with **Dr. INDIRA RANI Y,** after 1 **weeks** on **14.07.2026** at postnatal clinic with prior appointment **(Review consultation will be charged).**

For Women Who Have Had a Caesarean Section
Care of the wound:

Name	Mrs DAMINI	**UHID**	HNH-00016336
IP No	IP26-00006736	**Admission Date**	04-07-2026

1.You can bath and shower.
2.The wound can get wet during a bath or shower. Dry it thoroughly and gently by dabbing with a gauze piece. Do not rub the wound.
3.This gauze piece needs to be discarded after one use.
4.Prior to touching the wound clean hands thoroughly with Microshield solution and allow them to air dry or use disposable paper napkins.
5.Apply Nebasulf or Neomycin dusting powder on the wound after it is dry.
6.Do not touch the wound with unwashed hands.

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, when and how to obtain emergency care etc also have been explained by doctor ..... in a language that I can understand and I acknowledge.

Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 just dial one toll free number - 18002122.You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

Registrar/Resident/C.M.O

Consultant:
Dr. INDIRA RANI Y
MBBS, DGO
700113

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006736 **Admit Date** : 04-Jul-2026 **Admit Time** : 06:28 AM **UHID** : HNH-00016336

Patient Details :

Patient Name	: Mrs DAMINI	**Age**	: 28 Y 7 M 27 D
Guardian	: Mr D.SRAVAN	**DOB**	: 07-11-1997
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 2-1-176, yellambanda,kphb Kphb Hyderabad Telangana INDIA 500072	**Phone No**	: 9515879554/ 9505060467
		E-mail	: na@gmail.com

Admission Details :

Bed Type : TWIN SHARING **Bed No** : LDR-415 **Ward Name** : 4F -OT

Room No : LDR-415 **Admission Type** : First Visit

Contact Details :

Name : Mr D.SRAVAN **Relationship** : Husband

Contact Address : 2-1-176, yellambanda,kphb Kphb Hyderabad Telangana INDIA 500072 **Phone No** : 9515879554 / 9505060467

Signature

Doctor Details :

Doctor Name : Dr. Y.INDIRA RANI **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self. **Phone No** :

Co-Consultant :

Payment Details :

Deposit Amount : 100000.00

Payment Mode : Cash **Payor Name** : SELFPAY

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Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : _____Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
4/7/26	7:50Am	Pre & Post	OT	Akhila / Natalia
4/7/26	9:00Am	OT	Pre-Post	Natalia / Sujatha
4/7/26	3:30pm	Pre-PO 5th	Room	Sujatha / Nagi

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Sindhura	5/7/26	0904	
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
u/A	NST – ①	7977	
u/A	CBP	10907	
6/7/26	GRBS	11078	

Cross checked done by Sunanda

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
4/7	cardiac monitor	9:10 AM	3pm stoped 4/7/26.	210616	kathu.
4/7.	Infusion pump	9:10 AM			
			Cross	checked,	done
			by	Sunanda	

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
4/7	IV placement	①	10552	dkwb.
4/7	catheterisation	①		
	PAC OP	①	PRS26000	
			220642	
4/7/26	NHA	①	10003	①

Cross checked done by Sinanda

ANY OTHER INFORMATION

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Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

Patie

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints
Came for Elective LSCS.

Obstetric Formula: Primigravida.
ML-4yrs, 1
Obstetric Hostory:
2st: PP- Spontaneous Conception
1st: Spontaneous misscarriage at 5-6wks

Present Pregnancy Record:
NT-Scan-Normal.
CPla-Post teaching Quadruple
TIFFA-Normal marker-

RISK FACTORS: fetal 2D Echo-Negative

Parenteral fe therapy @ 7MOA i/v/o moderate Anaemia
N/o fever in 6MOA/au which Conservative Mx was done.

Height: ..... cm
Weight: ..... kg
Allergies: Nil.
Breast: ☐ Normal ☐ Abnormal
General Examination: SpO2-99%.
Consciousness: clc. Pallor: Negative.
Icterus: Negative Edema: mild
Temp: Afebrile PR: 75bpm
BP: 122/83mmHg DTR: (N)
CVS: S1S2(+), nomurmur RS B/L NVBS(+)
Liver/Spleen: (N) Urine Output: Adequate

LMP: 16/8/2025. EDD:
Corrected EDD: 4/7/2026. GA: 40wks
Menstrual History: Regular : ☑ Yes ☐ No

Obstetric Examination
Fundal Height: term
Ut. Activity: ☑ Relaxed ☐ Mild ☐ Mod ☐ Severe
Liquor: ☐ Adequate ☑ Oligo ☐ Poly
PP: ☑ Cephalic ☐ Breech Others _____
Head Fifths Palpable: 5/5th
FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination not done
Draining: ☐ Present ☐ Absent ☐ Bleeding
Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination not done.
Cervix: ☐ Long ☐ Partially effaced ☐ Effaced
Os: Closed _____ Dilated _____
Membranes: ☐ Present ☐ Absent
Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained
Presenting Part: ☐ Vertex ☐ Breech ☐ Others
Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2
Pelvis: ☐ Adequate ☐ Doubtful

DIAGNOSIS
G2A1 with 40wks POG. with Oligohydramnios for Elective LSCS.

HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

Family History:
Mother - HTN
Father -

Surgical History:
-

Medical History:
K/C/O Bronchial Asthma in Childhood
H/O Infertility Rx

Medication History:
T. IRON
T. CALCIUM.

Plan of Care:
Admission NST.
Informed Consent
Pads Preparation.
Drugs as Chalted
Foley's Catheterization.
Review PAC
Paediatrician Call.
Monitor Vitals
Inform SOS.

Investigations: BGT 'B' Positive.

CBP (18/6/2026)
Hb - 10.8
plt - 2.17
PCV
TLC - 9900

HIV
HbsAg
HCV
VDRL
} NR.

USG (29/5/2026
SIUF 34wsdays
Cephalic.
AFI - 15.5. ; on 2/7/2026 - 5.2cm
EFW - 2269 gms.
~~Apex~~ Placenta - Post. US
Dopplers - normal.

Doctor Name: Dr. Naveena.
Signature:
Date & Time: 4/7/2026 @ 7:00am.

Consultant Name: Dr. Indira Rani
Signature:
Date & Time: 4/7/2026.

DR. INDIRA RANI Y
REG. NO. 25716

HNH-00016336 IP26-00006736
Mrs DAMINI 28 Y 7 M 27 D (F)
07-11-1997
Dr. Y.INDIRA RANI

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/4/26 9:30 am	c/s/B Dr. Veena	
	POD-0 / LSCS	
	Pt is stable	Adv
	No c/o	- NBM for 4 hours
	o/e GC-fair, Afebrile	- Vital monitoring
	BP - 100/70mmHg	- I/o charting
	PR - 82 bpm	- w/f excessive bleeding P/V
	SpO_2 - 100% on RA	- Foley's removal c/m @ 6am
	P/A - Ut well retracted	- Ted stockings
	L/e - BWNL	- Inj. Clexane 60U @ 8pm
	U/O - 200ml, clear urine	- TU Abx x 24 hrs
		- Inform SOS
4/4/26 @ 2:30 PM	c/s/B Dr. Veena	
	POD-0 / LSCS	
Baby @ NS	Pt is stable, No c/o	Adv
	o/e GC-fair	- Oral sips f/b liquid diet
	BP - 110/70mmHg	- Soft diet (> 9pm)
	PR - 86 bpm	- Vital monitoring
	SpO_2 - 98% on RA	- I/o charting
	P/A - Ut well retracted	- Foley's removal c/m @ 6am
	BS (+)	- Ted stockings
	L/e - BWNL	- Inj Clexane 60U @ 8pm
	U/O - @ 40 ml/hr, clear	- Inform SOS
		- Shift to Room
		Noted by Sujatha 4/2/26 @ 5pm

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
4/7/2026	C/S/L/B @ Manubu	
8pm	POD-0	
	GC-Fair Afebrile	Adv
	Vitals Stable	
	P/A ut well retract	- Soft Diet > 9pm
Baby well	BS (+)	Adequate hydration
	PV/ L/E - Bleedy wound	Drugs as charted
	U/O - 100 cc/hr Clear	~~Adv~~ Drip's removed 4pm 6AM
		TED Stocking
		I/O monitoring (if U/o < 30 cc/hr → Inform)
		Inform SOS
		Dr Manubu
5/7/2026	C/S/L/B @ Manubu	
8AM	POD-1	
		Adv
	GC Fair Afebrile	- Soft Diet / Adeq hydration
BM	Vitals Stable	- Drugs as charted
	P/A ut well retract	- W/F vitals & BOV
	L/E Bleedy wd	- Encourage to pass urine
FV	U- yet to void	- Ambulation
SV		- Inform SOS
		Dr Manubu

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Mrs DAMINI
17-11-1997 28 Y 7 M 28 D (F)
Dr. Y.INDIRA RANI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
5/7/26	c/s/B Dr. Veena	
2PM	POD-1 / C1-LSCS	
Baby @ NS	Pt is stable, No c/o o/E Gc-fair, Afebile Vitals-stable P/A- Ut well retracted BS (+) Uc - BUNL B/c Breasts - Soft, NS (+)	Adv - Regulardiet - Drugs as charted - Vital monitoring - Ambulation - Adequate hydration - Perform SOS
5/7/26	c/s/B Dr. Veena	NB Suprvsn 2 Hrs - 5/7/26
7PM	POD-1 / C1-LSCS	
Baby @ NS	Pt is stable, No c/o o/E Gc-fair, Pallor (-) Afebile Vitals -stable P/A - Ut well retracted BS (+) Uc - BUNL B/c Breasts - Soft, NS (+)	Adv - Regular diet - Drugs as charted - Vital monitoring - Ambulation - Adequate hydration - Inform SOS
		N.B. Maheshwari

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/B Dr. Veena	
6/1/26 7AM	POD-2/P1L1	
Baby @ NU	Pt is stable, No c/o o/e GC-fair Vitals - stable Pallor (-) P/A - Ut well retracted BS (+) c/e - BWNC. B/c Breasts - Soft, NS (+)	Adv - Regular diet - Drugs as charted - Ambulation - Tegaderm dressing today - Adequate hydration - vital monitoring MB Sunanda
6/1/2026 12:00pm	c/s/by Dr. Naveena POD2 - P1L1	
	o/e GC-fair Afebrile Vitals - stable PA - Ut. retracted well Soft, NT Dressing: dry & clean I/E: P/C BWNC Baby - NS	Adv - Regular diet - Adequate hydration - Ambulation - w/f PV bleeding - Monitor Vitals - Inform SO - Pulcobax Suppositories 2 PR stat
Pt can be discharged.		

1NH-00016336 IP26-00006736
Mrs DAMINI
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Dr. Y.INDIRA RANI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/26. 1:20PM	C/s/B Dr. Indira No complaints GC fair ~~Afebrile~~ Vitals (N). P/A UPW ↳E WNL	~~Adv~~ Regular diet - Adequate hydration - Ambulation - W/F P/v bleed. - Monitor vitals. - Inform sos.
Baby & Mother UV FV SV		
Pt can be discharged		NB-Mother 1:20PM.

Docu. No. : RCH /FRM / CLINICAL / 088 (P.T.O)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00016338 IP26-00006736
Mrs DAMINI
07-11-1997 26 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

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DRUG CHART

Date of Admission: ..... Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

GENERAL DOCTOR
- Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- 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 .....

HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

REGULAR PRESCRIPTIONS Weight. ..... Ward. .....

DRUG : INJ-CEFOTAXIME

Dose	Route	Frequency	Start Date
1gm	IV	BD	4/7

Name & Signature of the Doctor Starting the Drugs: @Dr. Naveena

Additional Instructions: ATD

Daily Doctor's Endorsement by a Sign

DRUG : PARACETAMOL

Dose	Route	Frequency	Start Date
1gm	P/O	BID	4/7

Name & Signature of the Doctor Starting the Drugs: DRAMIR

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : DICLOFENAC

Dose	Route	Frequency	Start Date
50mg	P/O	TID	4/7

Name & Signature of the Doctor Starting the Drugs: DRAMIR

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : TRAMADOL

Dose	Route	Frequency	Start Date
100mg	P/O	TID	4/7

Name & Signature of the Doctor Starting the Drugs: DRAMIR

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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Sheet No: .....

REGULAR PRESCRIPTIONS

Weight ..... Ward .....

DRUG : ENOXAPARIN

Dose	Route	Frequency	Start Dt.
60 U	S/C	OD	4/7

Name & Signature of the Doctor Starting the Drugs: DHANNUR

Additional Instructions: TO START AFTER OBGYN CONSULT^ X 7 days.

Daily Doctor's Endorsement by a Sign

Date / Time	4/7	5/7														
	8pm															

DRUG : T. PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	PO	BD	4/7

Name & Signature of the Doctor Starting the Drugs: Dr Naveena.

Additional Instructions: BEFORE FOOD.

Daily Doctor's Endorsement by a Sign

Date / Time	5/7	6/7														
	8am															

DRUG : T. CEFIXIME

Dose	Route	Frequency	Start Dt.
200mg	PO	BD	5/7

Name & Signature of the Doctor Starting the Drugs: Dr Anuradha

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	5/7															
	8pm															

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time																

Patient Sticker

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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				

Signature

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				

VERIFIED BY / Name

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				

HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

Weight. ..... Ward. .....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
4/7	7:50Am	INJ METOCLOPRAMIDE	10MG	IV		Akula mounika
4/7	7:55Am	INJ PANTOPRAZOLE	40MG	IV		Akula mounika
4/7	9AM	DICLOFENAC	100mg	PR		Pallavi Natasha
4/7	9Am	TRAMADOL	100mg	PR		Pallavi Natasha.
4/7	9pm	INJ FUROSEMIDE	5mg	IV		Archana
6/7	11:45am	DULCOLAX SUPPOSITORIES	2	PR		Not given

VERIFIED BY : Name ..... Signature .....

HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

I.V. FLUIDS CHART

Weight. ..... Ward. .....

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
4/7/26	6:30 AM	RINGER LACTATE	IV	100ml/hr			4/7		
4/7	8AM	RINGER LACTATE	IV	1000			4/7		
4/7	830 am.	RINGER LACTATE + 9U OXYTOCIN	IV	150			4/7		
4/7	9AM.	RINGER LACTATE	IV	FF			4/7		
4/7	11AM	RINGER LACTATE	IV	FF			4/7		
4/7	1PM	RINGER LACTATE	IV	FF			4/7		
4/7	2PM	RINGER LACTATE	IV	100 ml/hr			4/7		
4/7	3PM	RINGER LACTATE	IV	100 ml/hr			5/7		
4/7	9PM	RINGER LACTATE	IV	100 ml/hr			5/7		
5/7	3AM.	RINGER LACTATE	IV	100 ml/hr			5/7		

STOP

HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

Pat

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MEDICATION RECONCILIATION FORM

Drug Allergies: No ☑ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.
(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ..... Shifted to: .....

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. IRON	1TAB	PO	OD	3/7	☐ C ☑ DC
2	T. CALCIUM	1TAB	PO	OD	3/7	☐ 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. Naveena E(N.

Date & Time : 4/7/2026 @ 7:00am

Nurse Name & Signature: Akhila

Date & Time : 4/7/26

Docu. No. : RCH / FRM / GENERAL / 090

HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

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DP

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RESULT SHEET

Date	4/7/26					
Time						
Hb	10.8					
PCV	31.5					
RBC	3.90					
WBC	7.74					
N/L						
Platelets	205					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood group = B+ve	B+ve	1 ⓤ PRBC Reserve insurya blood bank				
HIV, HbsAg, Hcv } NR						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

Others (ECG, Contrast Studies etc.,) : .....

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Early Warning Observation Score Chart - Obstetrics

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

28/1/26

		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 mls / hour	> 30																									
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES																										
TOTAL ORANGE SCORES																										
Nurse Initial																										

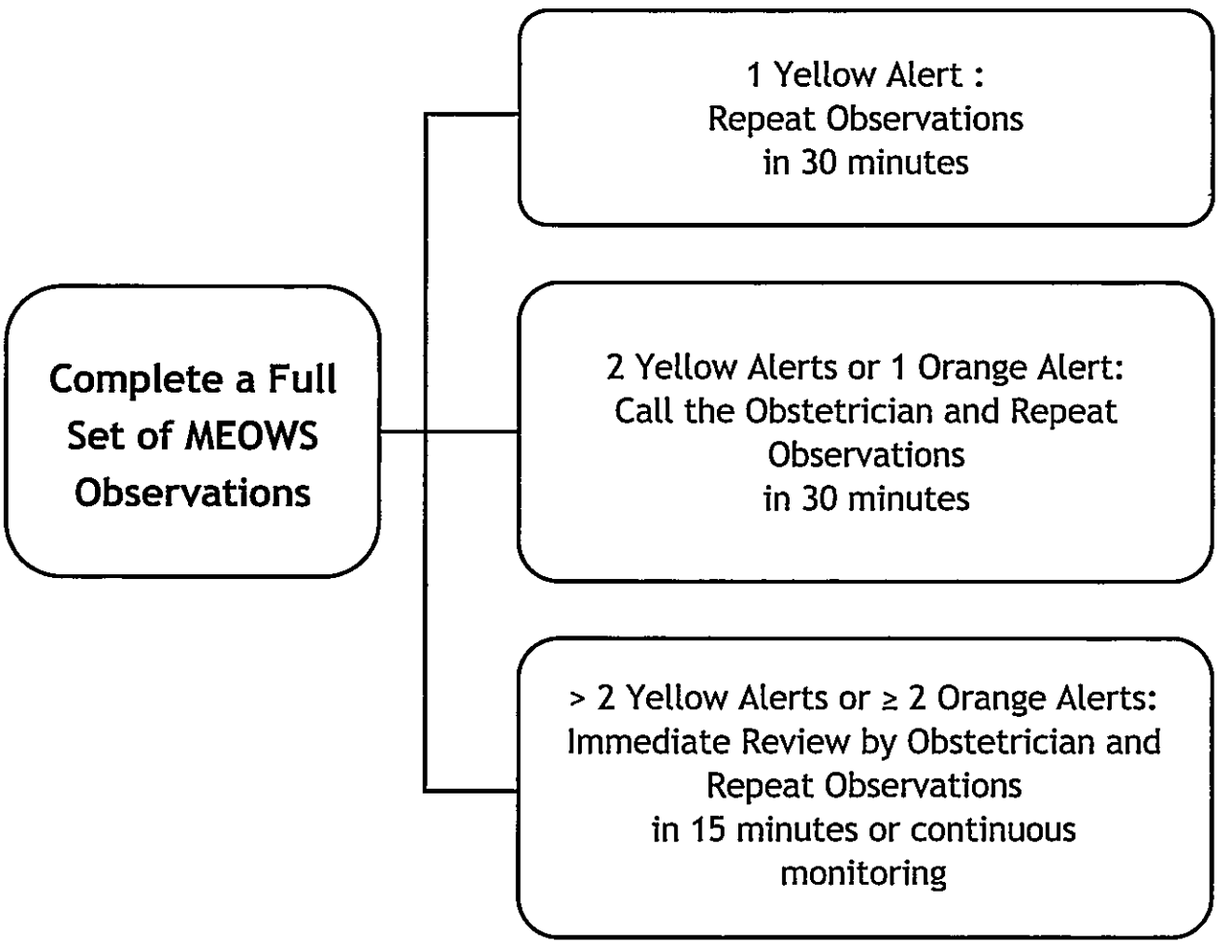
AM

6 20 99

110 90 70

0 0 0

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score **(MEOWS)**

HNH-00016336 IP26-00006736
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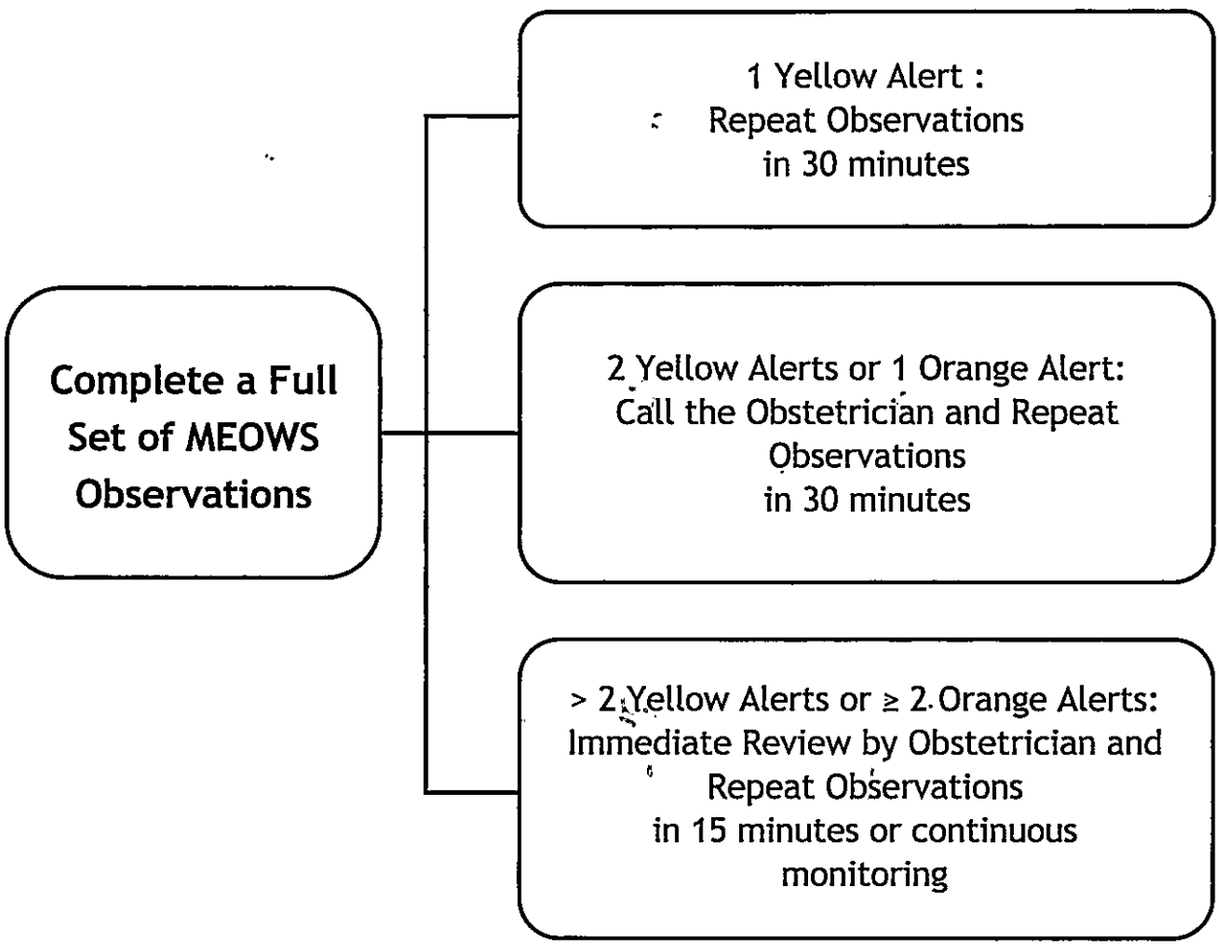
Early Warning Observation Score Chart - Obstetrics

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

4/7/26	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	20	20	20	20	20	20			20			20			20				20				20	
	0 - 10																								
Saturations	94 - 100 %	98	99	99	99	98	99			99			100			99%				99%				99%	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37		98.6F							98F			97.7F			36°C				36°C				98.3F	
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80	76	80	77	77	96	83			85			86			87				82				76	
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																							112	
	120																								
	110	119	111	116	113	117	105			117			112			108				109					
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70	87	81	69	76	73	70			95			74			78				70				72	
	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		0	0	0	0	0	0			0			1			0				0				0	
TOTAL ORANGE SCORES		0	0	0	0	0	0			0			0			0				0				0	
	Nurse Initial																								

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

Patier

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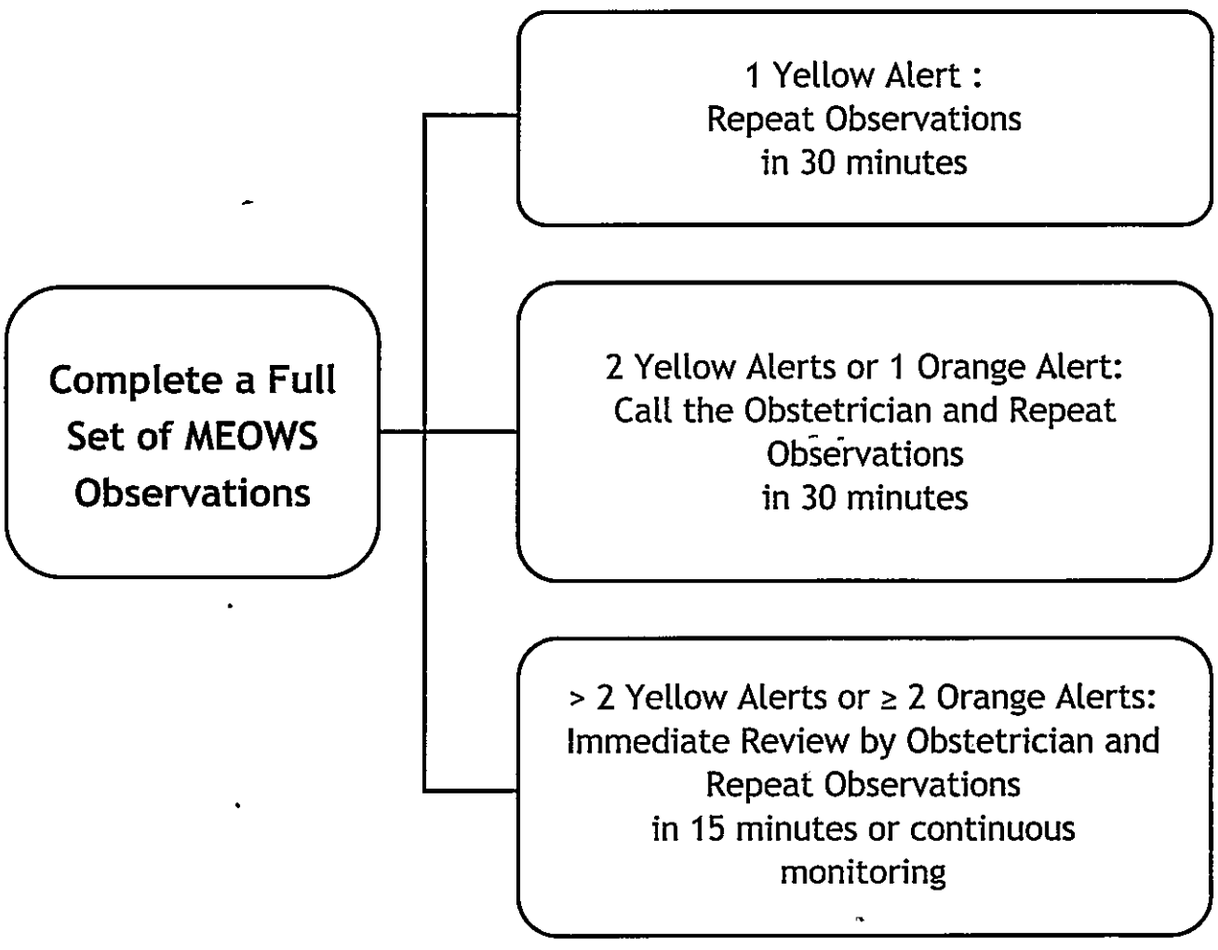
Early Warning Observation Score Chart - Obstetrics

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

5/7/26

		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				20				23				20bpm		20			20			20				20	
	0 - 10																									
Saturations	94 - 100 %				100%				99%				99%		99%											
	< 94 %																									
Administered O_2 (L/min.)																		99%			99%				99%	
Temp°c	40																									
	39																									
	38																									
	37																									
	36			97.6°F					96.8°F				97.4°F		98.1°F			98.2°F			98°F				36.5°C	
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80			86					87				80bpm		72bpm			84			80				82	
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130			110					127				110		129			124			120				122	
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70			72					87				75		88			86			76				87	
	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					0				0				0		0			0			0				0	
TOTAL ORANGE SCORES					0				0				0		0			0			0				0	
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

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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						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
4/7	08:00 am	RL	N	100ml								
	09:00 am	RL	B	100ml				✓		200ml		Empty
	10:00 am	RL	M	100ml			NA				0	
	11:00 am	RL		100ml								
	12:00 pm	RL	N	100ml		—						
	01:00 pm	RL	B M	100ml								
Total Intake :						**Total Output :**						
4/7	02:00 pm	RL	N BM	F-F						200ml		Empty
	03:00 pm	RL	Water	—								
	04:00 pm	RL		100ml							0	
	05:00 pm	RL		100ml				NA				
	06:00 pm	RL		200ml						820ml		
	07:00 pm	RL		1000								
Total Intake :						**Total Output :**						
4/7	08:00 pm	RL	Idli	100ml								
	09:00 pm	RL	Tiffins	100ml			✓					
	10:00 pm	RL		100ml								
	11:00 pm	RL		100ml				NA		450ml		
	12:00 am	RL		100ml								
	01:00 am	RL		100ml								
Total Intake :						**Total Output :**						
5/7	02:00 am	RL		100ml							M-1	
	03:00 am	RL		100ml								
	04:00 am	RL		100ml				NA				
	05:00 am	RL		100ml								
	06:00 am	RL		200ml						900ml		→ Empty
	07:00 am	RL		200ml								Foley's removed
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
5/7/26			Mouth	I.V	N.G							
	08:00 am											
	09:00 am		Idly									
	10:00 am	0	+ H2O		DA							
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
5/7/26	02:00 pm											
	03:00 pm											
	04:00 pm		kichidi									
	05:00 pm		H2O		NA		0					
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
5/7/26	08:00 pm											
	09:00 pm		idly									
	10:00 pm						0					
	11:00 pm	0	H2O		NA							
	12:00 am											
	01:00 pm											
Total Intake :						**Total Output :**						
6/7/26	02:00 am											
	03:00 am											
	04:00 am						0					
	05:00 am	0			NA							
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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Mrs DAMINI
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NURSING CARE RECORD

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Date: 3/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night	8pm | 8Am	→Assess the pt condition →monitor the vitals Erecord →Administration of medication →maintain I/O chart Erecord.	8pm | 8Am	→Assessed the pt condition. →monitored the vitals Erecorded →Administered medicine as Per doctors ord →maintained I/O Chart Erecorded.	pt is stable.	Maintain I/O Chart Erecord.	Akhils

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Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

NURSING CARE RECORD

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Date: 4/6/2026

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am 2pm	→ Assess the pt condition → Check the Vital's → I/O chart Maintain → plan for Medication	8am 2pm	→ Assessed pt condition → checked Vital's & recorded → Maintained I/O chart → given Medication as per doctor's order	pt is stable	Vital's is Normal	Asha
Afternoon				day duty			
Night	8pm 8am	- Assess the pt. condition - Monitor vitals & records - Maintain I/O chart - Give medications as prescribed by doctor	8pm 8am	- Assessed the pt condition - Monitored vitals & records - Maintained I/O chart - Given medications as prescribed by doctor	patient is Stable now	re-checked vitals	

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Mrs DAMINI
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NURSING CARE RECORD

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Date: 5/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am to 2pm	→ Assess pt condition → monitor the vitals → maintain I/o chart → Administer medication as per drug chart	8am to 2pm	→ Assessed pt condition → monitored vitals → maintained I/o chart → Administered medication as per drug chart	Patient is stable	Re-checked vitals	AP
Afternoon	2pm to 8pm	→ Assess the pt condition. → Monitor the vitals. → Maintain I/o chart. → drugs give as per drug chart.	2pm to 8pm	→ Assessed the pt condition. → Monitored the vitals. → Maintained I/o chart. → drugs given as per drug chart.	→ pt is stable Now.	→ Reassessed the vitals	
Night	8pm to 8am	- Assess the patient condition - monitor the v/s - maintain the I/O - Drug as per chart	8pm to 8am	- Assess the patient condition - monitor the v/s - maintain the I/O - Drug as per chart	- Now pt is stable	- Rechecked the v/s	

NURSING CARE RECORD

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Date: .....

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: 2DP Date of Admission: .....

SITUATION	Diagnosis: EL-LSCS				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time	3/7 N2	4/7 N6	4/7 N1	5/7 N6	5/7 E	5/7 N1
	Medical Condition (Any special condition to be noted):	NA	—	—	—	—	—
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:	97.1°F	98.6°F	97.8°F	98.3°F	98.1°F	98.2°F
	Res:	20bmt	20bmt	20bpm	23bpm	20bpm	22bpm
	SpO_2:	99%	15%	100%	98%	99%	99%
	Pulse:	87bmt	79	86bpm	85bpm	80bpm	84bpm
	BP:	110/70	114/66	121/74	100/85	115/76	112/73
	Fall Risk Score:	—		—	—	—	—
	Pain Score:	0/10	0	—	—	—	—
Recommendations	Safety Needs:	Yes	—	Yes	Yes	Yes	Yes
	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:	NA	—	—	—	—	—
Post Operative Procedure Special Orders:		NA	—	—	—	—	—
Handed Over By Name :		Akuila	Aruna	Priyanka	Anusha	mahi	Sunanda
Signature :							
Date:		4/7/26	4/7/26	5/7/26	5/7/26	5/7/26	6/7/26
Time:		8AM	8PM	8AM	2PM	8PM	8AM
Taken Over By Name :		Akuila	Priyanka	Anusha	Mahi	Sunanda	
Signature :							
Date:		4/7/26	4/7/26	5/7/26	5/7/26	5/7/26	
Time:		@ 8AM	8PM	8AM	2PM	8PM	

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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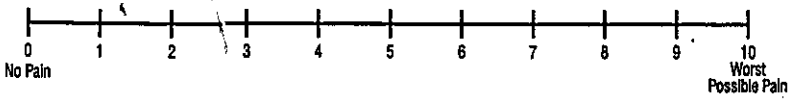
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
4/7/26	8AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
4/7/26	10Am	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
4/7/26	10pm	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	
5/7	2AM	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	
5/7	6AM	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	
5/7/26	2pm	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	
5/7/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
5/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
6/7/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

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

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, SaO_2	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

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BRADEN 'Q' SCALE

	1.	2.	3.	4.	Date : 3/1/26	4/1	4/1	
					Time : N2	026	N7	
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	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	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	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	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 mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	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 [illegible]sition 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	4
					TOTAL SCORE	28	28	28
					Evaluator's Name			

Severe Risk : [illegible]nan 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

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

HNH-00016336
Mrs DAMINI
07-11-1997
Dr. Y.INDIRA RANI
IP26-00006736
28 Y 7 M 27 D
(F)

BRADEN 'Q' SCALE

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				Date :	5/7/22	5/7		
				Time :	E	N		
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		
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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		
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				TOTAL SCORE	27	28		
				Evaluator's Name	[illegible]	[illegible]		

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

Risk Score	Category	Action	Support Surfaces (**Please Note:** Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
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Dr. Y.INDIRA RANI

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	3/7/26	4/7/26	4/7.
		Score	N2	N6	N1
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0	0	0
Total Morse Fall Scale Score:			20	20	20
		Signature			

Fall Risk Grading

Risk Level	Morse Fall Score (MFS)	Action
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	5/7/26	5/7/26	
		Score	R_2	N_1	
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	
IV / Heparin Lock or Saline	Yes	20		20	
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0		
Total Morse Fall Scale Score:			0	20	
		Signature			

Fall Risk Grading

Risk Level	Morse Fall Score (MFS)	Action
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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CHECKLIST FOR THROMBOPHLEBITIS

3/7 4/7 5/7/26

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			-	-	0	0	0	0	0	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			-	-	0	0	0	0	0	
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			-	-	0	0	0	0	0	
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			-	-	0	0	0	0	0	
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			-	-	0	0	0	0	0	
		Signature of the Nurse											

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

Signature of Shift In Charge :

Signature : ..... Name : Akhila

Signature of Ward In Charge :

Signature : ..... Name : Kasturi

Patient Sticker

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CHECKLIST FOR THROMBOPHLEBITIS

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

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 : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016336 IP26-00006736 Mrs DAMINI 07-11-1997 28 Y 7 M 27 D (F) Dr. Y.INDIRA RANI	4/7/26 6:30 AM	4/7/26 @ 3pm
	Transfer Ordered by Dr. Veena	Reason for Transfer OBG
From Unit pre-post	To Unit Room (215)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 29	Number of Imaging Films NST (1)	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL on flow	(1)
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Anu D/Sujatha	Dr. Veena

Patient & Clinical Records Received by : 4/7/26 @ 3:3Pm madhuri

Date & Time of Patient Received :

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

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

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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 4/7/26

Baseline Information:

Admission From: ☐ ER ☐ OPD ☑ Admission Desk ☐ Others: specify .....

Primary Language: ☑ Telugu ☐ English ☐ Hindi ☐ Others

Do you require an interpreter? ☐ Yes ☑ No

Source of Information: ☑ Patient ☐ Family ☐ Others

Personal belonging if any: ☑ Jewelry ☐ Nose Ring ☐ Bangles ☐ Anklets ☐ Finger Ring ☐ Bracelets

handed over to family members

Allergies: ☐ Yes ☑ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

Chief Complaints: came For delivery

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Naveena

Time Notified: 6 Am

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

Past Medical History	Past Surgical History	Previous Hospital Admission
–	–	–

Blood Group: B+ve LMP: ..... EDD: ..... Gestational age during admission: .....

Contractions: ..... Vaginal Discharge: .....

Obstetric History: G ..... P/..... L ..... A ..... Previous LSCS .....

Height: ..... Weight: ..... BMI: .....

Temp: 97.1°F HR: 87bmt RR: 20bmt BP: 110/70 SpO_2 99%

High Risk Factors: (Please select by ticking (✓) the box as applicable)

☐ Hypothyroidism	☐ Rh Incompatibility	☐ Fertility Treatment
☐ Hyperthyroidism	☐ Previous LSCS	☐ Preterm Labour
☐ Hypertension	☐ Gestational Hypertension	☐ Others: (Specify)
☐ Diabetes	☐ Bad Obstetric History	
☐ Anemia	☐ Obesity (BMI)	
	☐ Twins / Multiple Pregnancy	

Patient Sticker

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

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

Fall Assessment: ☐ Yes ☑ No Score ..0.. (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☐ No Score ..0.. (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:

☐ Overweight ☐ Poor Appetite > 3 Days ☐ Needs Therapeutic Diet.

☐ Under Weight ☐ Diabetes Mellitus ☐ No Abnormality Detected

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 members..

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 ..PT..

Name of Person Orientation was given to: ..MOH..

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: ..A Kuils..

Date & Time: ..4/1/26..

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 4/7/26 Time of Arrival: 6Am Time Seen by Nurse: 6Am

1) **Level of Consciousness:** ☐ Conscious ☐ Semi-Conscious ☐ UnConscious

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

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

3) **Vital Signs:** Temperature: 98.1°F Pulse: 87/mt RR: 20/mt SpO_2: 99% BP: 110/70 Weight: .....

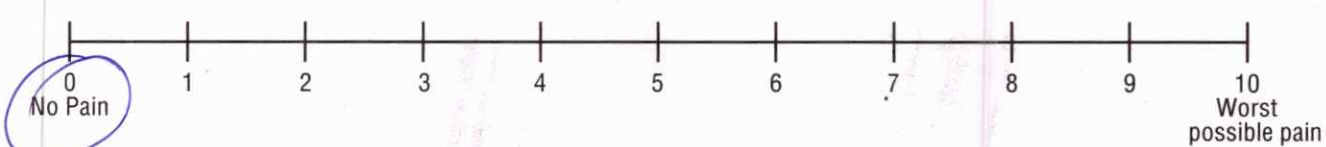
4) **Gestational Criteria:**

Gravida:	G	P	L	A

LMP: ..... EDD: ..... Gestational Age: .....

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

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



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

.....

6) **Past History:**

a) Surgeries: .....

b) Medical: Nil

Patient Sticker

7) **Allergy:** ☐ Yes ☐ No, If Yes : .....

8) **Current Medications:** ☐ Prenatal Vitamin ☐ None ☐ Others: .....

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	**Immediate**	≤ 15 **minutes**	≤ 30 **minutes**	≤ 60 **minutes**	≤ 120 **minutes (2 Hours)**
Re-Assessment	**Continuous Nursing Care**	**Every 15 Minutes**	**Every 15 Minutes**	**Every 30 Minutes**	**Every 60 Minutes**
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SROM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (<spotting) <37 weeks	Bleeding associated with cramping (>spotting) >37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension >140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	• Acute onsite severe abdominal pain • Altered level of consciousness • Cord prolapse • Severe respiratory distress • Suspected sepsis	• Major trauma • Shortness of breath • Unplanned and unattended birth	• Abdominal/back pain greater than expected in pregnancy • Flank pain / hematuria • Nausea /vomiting and /or diarrhea with suspected dehydration	• Ongoing assessment from out patient clinic (for hypertension, blood work) • Minor trauma (minor MVC/fall) • Nausea/Vomiting and /or diarrhea • Signs of infection (ie dysuria ,cough, fever, chills)	• Anything that does not seem to pose threat to mother or fetus • Cervical ripening • Out patient placenta previa protocols • Pre-booked visits (ie Rh and progesterone injections, NST • Assessment for version • Rashes

Time seen by Doctor: 6Am

Nurse Name : Akiwis Nurse Signature:

Date: 4/7/26 Time: 6Am

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Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: Dr. Y. INDIRA RANI.	Date of Delivery: 4/7/2026
Assistant Surgeon: Dr. Swapna / Dr. Naveena	Time of Delivery: 8:15am
Anaesthetist's Name: Dr. Sai Rai / Dr. Sameer	Gender of Baby: female
Type of Anaesthesia: Spinal.	Weight of Baby: 2.5kg.
Neonatologist: Dr. Tejeswi	AGPAR Score: 7, 8'
Scrub Nurse: Archana / Susheela.	NICU Admission: ☐ Yes ☐ ~~No~~

Pre-Operative Diagnosis: G2A1 with 40wks POG with oligohydramnios for El. LSCS

☐ ~~Elective~~ ☐ Emergency Indication: Oligohydramnios.

Urgency

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

Decision time: ..... Knief to rectus: .....

CTG Description: Reactive

If there was a delay give the reasons: .....

Surgical Procedure: El. LSCS.

Post Operative Diagnosis: P1L1A1 on POD0 following. El. LSCS.

Peri-Operative Complications: —

Amount of Blood Loss: 250ml | Blood Transfused (in ML):

Name and Number of Surgical Specimen sent for examination:

—

Examination Findings when Appropriate:

Presentation: ☑ Cephalic ☐ Breech ☐ Other ..... Cervical Dilatation: – cm

5th Palpable: 5/5th Fetal Position: –

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

Caput: ☐ + ☐ ++ ☐ +++ Meconium: ☑ None ☐ + ☐ ++ ☐ +++

Bladder Catheterized : ☑ Yes ☐ No Urine: ☑ Clear ☐ Blood Stained

Skin Incision: ☑ Pfannensteil ☐ Transverse ☐ Midline ☐ Other ..... CVS not Formed

Uterine Incision: ☑ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision → thin meconium stained liquor

Previous Scar: ☐ Intact ☐ Thinnedout ☐ Ruptured ☑ No Scar → Scanty liquor

Incision Through Placenta: ☐ Yes ☑ No → 2 loops of Cord around neck

Delivery of head: ☑ Manual ☐ Forceps → Placenta – Posterior low lying.

Liquor: ☑ Clear ☑ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not Offensive

Delivery of Placenta: ☐ Manual ☐ CCT ..... ☐ Complete ☐ Incomplete ☐ Piecemeal

Cord Appearance: Normal Cord around the neck ☑ Yes ☐ No

Appearance of placenta: Normal Cavity explored ☑ Yes ☐ No

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

Uterine Closure: ☐ One Layer ☑ Two Layers Vicryl no. 1. Suture

Peritoneal Closure: ☐ Pelvic ☑ Abdominal ☐ None Catgut no. 1. Suture

Sheath Closure: Yes Prolene Suture

Fat Closure: ☑ Yes ☐ No Rapid Vicryl Suture

Skin Closure: ☑ Subcuticular ☐ Mattress Rapid Vicryl. Suture

Vagineal Evacuated ☑ Yes ☐ No

Drain: ☐ Yes ☑ No ☐ Remove in ..... days ☐ Await instructions

Ctheter ☑ Yes ☐ No ☐ Remove in ..... days ☐ Await instructions

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

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

Post-Operative Notes:

NBM for 4–6 hrs.
drugs as charted
Vitals chart-q
wlf PV bleeding
TED STOCKINGS
Inj. CLEXANE 60U s/c.
Monitor Vitals
Inform SOS

Doctor Name: Dr. Indira Rani Doctor Signature:

Date & Time: 4/7/2026 @ 9:15am.

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 4/7/26 Date of Removal: .....

Parameters	Date / Shift Time	4/7/26 M						
Need for the Catheter		☑ Yes ☐ No	☐ 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	☐ Yes ☐ No
Usage of Sterile Equipment		☑ Yes ☐ No	☐ 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	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)		☑ Yes ☐ No	☐ 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	☐ Yes ☐ No
Collecting bag is been emptied regularly?		☑ Yes ☐ No	☐ 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	☐ Yes ☐ No
Dressing clean and dry?		☑ Yes ☐ No	☐ 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	☐ Yes ☐ No
Performance of Perineal Care		☑ Yes ☐ No	☐ 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	☐ Yes ☐ No
Asses for the leakage at the site of insertion		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse		Akila						
Signature of the Nurse		A						

Docu. No. : RCH /FRM / CLINICAL / 114

Patient Sticker

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 5/7/26 Time: 11 Am

Origin: Indian Height: 5.2 Weight: 96 kg BMI: ☐ ~26 kg/m² ☐ ~28 kg/m² ☐ ~30 kg/m²

Food Allergies: NO

Diagnosis: LSCS

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

Diet Advised:

Liquid Diet – ORS/ Coconut Water / Butter Milk / Barley Water / Soups

Normal Diet – Rice, Rotis, Dal and Soft Cooked Vegetables and Curd

Soft Diet – Soft Rice, Dal and Vegetable Curries Soft Cooked, Curd

Diabetic Diet – Brown Rice / Oats/ Dahlia/ Rotis, Dal and Vegetables and Curd (Avoid Roots / Tubers)

Patient's / Attendant's	Dietician's
Signature:	Signature:
Name: Damini	Name: Sathwika.G
Date & Time: 5/7/26 ; 11 Am	Date & Time: 5/7/26 ; 11 Am

DIETARY NOTES

Date	Time	Notes	Sign

HNH-00016336
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI
IP26-00006736

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CROSS CONSULTATION FORM

Doctor Name : Dr. Indira Rani Date : 4/7/26 Time : 5pm

Diagnosis : LSCS

Hospital : RCH - HMNR

Referred for : ☐ Opinion ☑ Co-Management ☐ Transfer of care

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

Signature:

Findings and Recommendations :

Lactation care plan

- well formed Breast & Nipples
- colostrum seen
- encourage orally EBM & f/b Burping
- make baby to suck is - 20 mints on each side.
- Demand feeding not exceed 2½ hours as per early hunger cues.
- stimulate baby continuously.
- warm care.
- monitor weight & output

Consultant :

Name : Sathwika.G Signature : Date & Time : 4/7/26 ; 5pm

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Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

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BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?
   - ☑ a. Yes
   - ☐ b. No

2. If No, Reason .....

3. Nipple condition:
   - ☐ a. Nipple well formed
   - ☐ b. Flat nipple
   - ☐ c. Inverted nipple
   - ☐ d. Short nipple

4. Milk flow:
   - ☑ a. Good
   - ☐ b. Drops of colostrums
   - ☐ c. Dry

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

Feeding Positions:
Cross Cradle

Feeding Positions:
Football / Clutch

6. Was the position explained:
   - ☑ a. Yes
   - ☐ b. No

7. For Caesarian mothers:
   - ☑ a. Mother is required sit and feed from the 4th feed
   - ☐ b. Please explain football hold

8. NICU admission: NO
   - ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes: .....

Continuity of Care: Date: 4 ~~07~~ / 2026

→ Assessed pt condition
→ checked vital's & Recorded
→ I/O chart Maintained
→ 2nd hrly DBR

Handover given by .....

Signature .....

Date & Time: 4/7/2026 @ 15 Hrs

Handover taken by .....

Signature .....

Date & Time: .....

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Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs DAMINI**	**Age :**	**28 Y 7 M 27 D**
IP No:	**IP26-00006736**	**Sex:**	**Female**
Consultant:	**Dr. Y.INDIRA RANI**	**Ward/Bed No:**	**4F -OT/LDR-415**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....)
3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name: Sravan

Relationship: Husband

Date: 04-07-2026 Time: 6:28 Am

Witness Name: Yaseen ali khan

Witness Signature: Yaseen

Patient Address:

2-1-176, yellambanda,kphb Kphb
Hyderabad Telangana INDIA 500072

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : MRS. DHAMINI Gender: ☐ Male ☑ Female Age : 28YRS

UHID No : HNH-0001633b. Date : 4/7/2026

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)

ELECTIVE LOWER SEGMENT CAESERIAN SECTION.

upon

MRS. Dhamini (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.

Haemorrhage, Atonic PPH, Injury to Adjacent Organs Ureter, Bladder, Bowel, Need for Blood and Blood products transfusion

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. INDIRA RANI

Consentee :

Signature :

Name : MRS. Dhamini

Date & Time : 4/7/2026 @ 7:20am.

Patient Attendant :

Signature :

Name : Srnu

Relationship with Patient: Husband.

Date & Time : 4/7/2026 @ 7:20am.

Witness :

Signature :

Name : MKWS

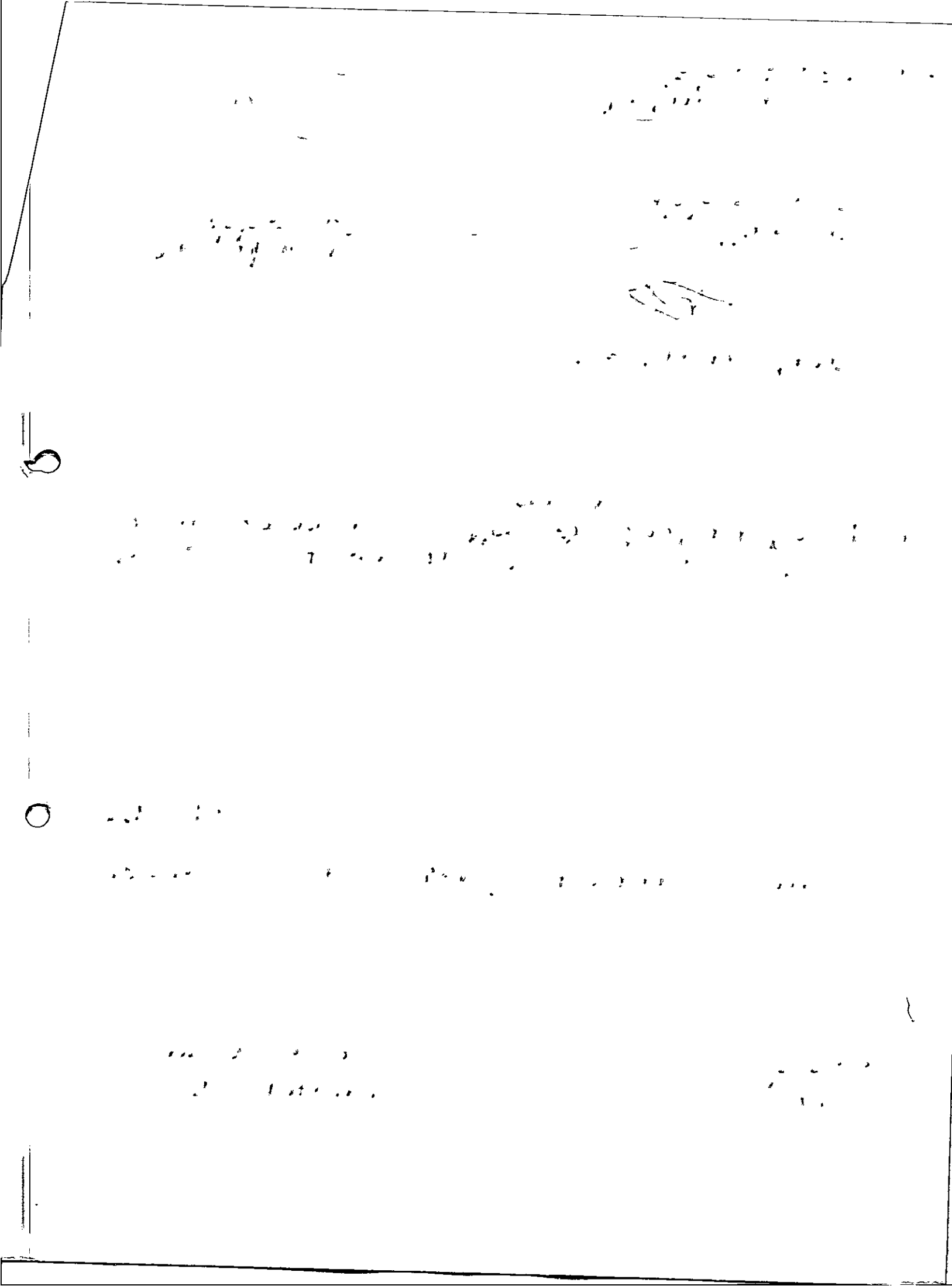
Date & Time : 4/7/26

Doctor (who is taking the consent) :

Signature :

Name : Dr. Naveena.

Date & Time : 4/7/2026 @ 7:55am.



CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. Damini ..... Age : 28 Yr. Gender : Male ☐ Female ☐

UHID NO: ..... Surgeon Name: Dr. Y. Indira

Anaesthesiologist : Dr. damini

Operative procedure planned : Elective Caesarean section

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 without numbness can be achieved by infusing weak solutions of local anesthetics arid 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 mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : Hypotension, Bradycardia, PPH

Comments : .....

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mrs. Damini the above mentioned operation / Diagnostic / Therapeutic procedures Elective caesarean section

I authorize and give consent for anaesthesia ☑ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

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, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I 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 in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant: ☑ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / ~~Regional~~ Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : .....

Name : Damini

Relationship with Patient: Self

Date & Time : 03/7/26

Witness :

Signature : .....

Name : Sravan

Date & Time : 03/7/26

Doctor (who is taking the consent) :

Signature : .....

Name : DR. M. VINEETHA

Date & Time : 02/07/2026

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016336 IP26-00006736 Mrs DAMINI 07-11-1997 28 Y 7 M 27 D (F) Dr. Y.INDIRA RANI	4/7/26 @ 6:28 AM	4/7/26 @ 7:50 AM.
	Transfer Ordered by Dr. Naveena	Reason for Transfer Eh.LSG
From Unit PIC & POST	To Unit OT	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 80	Number of Imaging Films NST - (1)	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL 500ml	(1)
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
[signature]	Dr. Naveena

Patient & Clinical Records Received by :
Natalie @ 7:55 Am

Date & Time of Patient Received : 4/7/26 @ 7:55 Am.

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr Indira Rani
Asst. Surgeon : Dr Sowjanya, Dr Naveena
Anaesthetist : Dr Sami's
Scrub Nurse : Sr Archana, Sr Susheela

HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

Patient Name : ..
UHID No. : .....
Date : 04/7/26 In-time : ..... Out-time : .....
Gender : F
EL: 2SCS

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 8am

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 : Damini

Name : .....

Before Skin Incision ➤➤

TIME OUT Time: 8:05 Am

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, Anticipated Blood Loss? 1hr Bleeding 500ml ☑ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☐ 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

Signature : Natasha

Name : Natasha @ 8:05Am

Before Patient Leaves Operating Room

SIGN OUT Time: .....

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 : @ for.

Name : Dr. Indira Rani

HNH-00016336
Mrs DAMINI
07-11-1997
Dr. Y.INDIRA RANI
IP26-00006736
28 Y 7 M 27 D (F)

PRE - OPERATIVE CHECK LIST

Date : 31/7/26

Patient's Name : Mrs.Damini Age : 28Y Gender : ☐ M ☐ F

Blood Group : B+ve UHID : HNH-00016336

Planned Surgery: EL-LSCS Surgeon : Dr. Indira Rani

Anesthetist : Dr. Sairaj Date & Time of Operation : 4/7/26

Tick Appropriate Boxes, To be filled by Nurse Incharge / Senior Nurse :

S.No.	INSTRUCTIONS	ER/Ward,Nurse			OT Nurse		
		Yes	No	NA	Yes	No	NA
1	Weight checked recorded ?	☑	☐	☐	☐	☐	☐
2	Is the patient fasting for over 6 hours Pre-Operatively ?	☑	☐	☐	☐	☐	☐
3	Check Pre-OP Investigations & Results (CBP, Blood Group, BT, CT, PT, APTT, Viral Screning, CXR etc) Available before starting the procedure	☑	☐	☐	☐	☐	☐
4	Enema given / Bowel Preparation	☐	☐	☐	☐	☐	☐
5	Remove all ornaments, earrings, toe rings, nose rings etc and implants, dentures	☑	☐	☐	☐	☐	☐
6	Sterile Gown Given	☑	☐	☐	☐	☐	☐
7	Is Blood arranged as required ?	☑	☐	☐	☐	☐	☐
8	If Blood has been ordered - is Blood bag ready ?	☑	☐	☐	☐	☐	☐
9	IV Cannula to be placed / IV fluids if Indicated	☐	☐	☐	☐	☐	☐
10	Pre Anesthetic consultation with anesthesiologist	☑	☐	☐	☐	☐	☐
11	Pre Medications Given ? (Sedatives / etc)	☑	☐	☐	☐	☐	☐
12	Skin Preparation	☐	☐	☐	☐	☐	☐
13	Site is marked	☑	☐	☐	☐	☐	☐
14	Surgery Consent / High Risk consent taken by surgeon? (Consent should be taken by the operating surgeon only)	☑	☐	☐	☐	☐	☐
15	Implants are available	☐	☐	☐	☐	☐	☐
16	Equipment is available	☑	☐	☐	☐	☐	☐
17	Antibiotic Prophylaxis is given within the last 60 minutes	☐	☐	☐	☐	☐	☐
18	Other (if any)	☐	☐	☐	☐	☐	☐

NOTE : if any of above is ticked "NO" Discuss with the registrar / consultant immediately

Billing Clearance Taken : ☐ Yes ☐ No

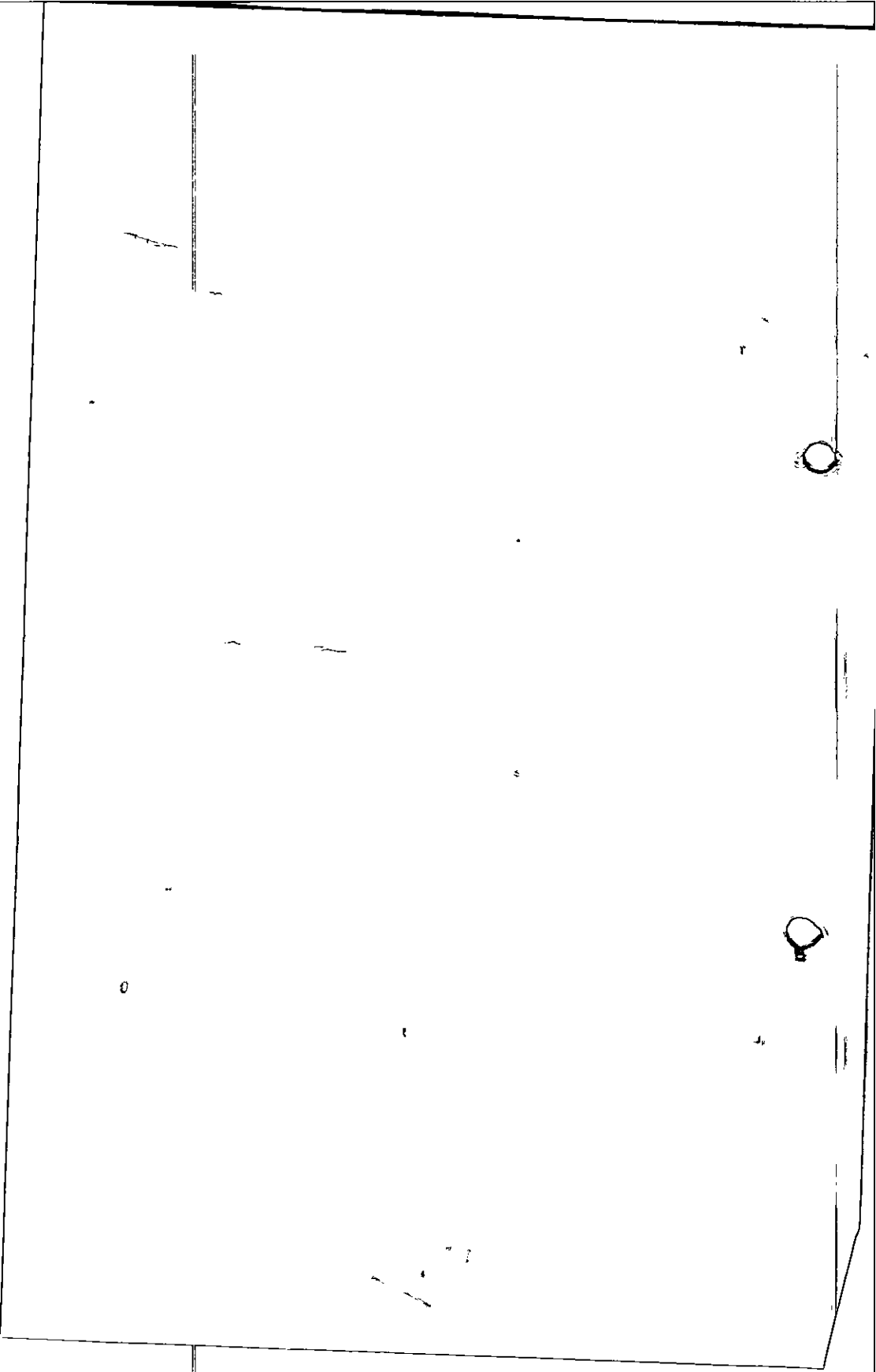
Billing Executive Name : ..... OT Nurse Name : Nayana ER/Ward Nurse Name : .....

Billing Executive Signature : ..... Signature of OT Nurse : Signature of ER/Ward Nurse.....

Date & Time :..... Date & Time : 4/7/26 Date & Time : .....

Doc. No. : RCH / FRM / CLINICAL / 107

Rainbow Children's Medicare Ltd. Hyderabad Himayathnagar 500029



PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016336 IP26-00006736 Mrs DAMINI 07-11-1997 28 Y 7 M 27 D (F) Dr. Y.INDIRA RANI	4/7/26 @6:28AM	4/7/26 @9:00PM
	Transfer Ordered by Dr. Samir	Reason for Transfer Observation
From Unit OT	To Unit Pre-Post	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 34 -	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL	1
2.		
3.		
4.		
5.		

Shifting Summary / Notes Written by Doctor : Yes ☑ No ☐

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Natasha	Dr. Samir

Patient & Clinical Records Received by :

Date & Time of Patient Received :

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

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

HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

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25

BILLING POLICY

- Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpaIn the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

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

Name & signature of Patient/Attendant (Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.
Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR - T: 6464 2020 |KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80 7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

CIN: U85110 TG1998 PTC029914 email : info@rainbowhospitals.in **www.rainbowhospitals.in**

26-0000210550

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mrs. Damini		Age: 28y	Gender: Female
UHID No: RNH-0096336	IP No: IP26-00006736	Date: 4/7/26	Time:
Diagnosis: LSCS		word-07	

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100 mcg	1 Amp
2.	Morphine Sulphate Inj. 15mg/Ml	/	/
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. Srinivas

Doctor Registration No: APMC 75177

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-00006736 **Date:** 4/7/26

Aadhaar No. of the Patient (Optional): .....

1.	**Name :** Mrs. Damini	**Remarks**
2.	Complete postal address (with contact number, if any)	2-1-176, Y. Ramanaidu Colony Kukatpally Hyderabad Telangana 500072
3.	Brief description of the illness	LSCS
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
4/7/26	Fentanyl	1 Amp		

Dispensed by (Name & ID No.): Sania Signature: .....

Received by (Name & ID No.): Sarawathi (021006) Signature: .....

Time: .....

Docu. No: RCH / FRM / CLINICAL / 133

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name:		Age:	Gender:
UHID No:	IP No:	Date:	Time:
Diagnosis:			

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml		
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name:

Doctor Registration No:

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: ..... **Date:** .....

Aadhaar No. of the Patient (Optional): .....

1.	**Name :**	**Remarks**
2.	Complete postal address (with contact number, if any)	
3.	Brief description of the illness	
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	
5.	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any

Dispensed by (Name & ID No.): ..... Signature: .....

Received by (Name & ID No.): ..... Signature: .....

Time: .....

HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

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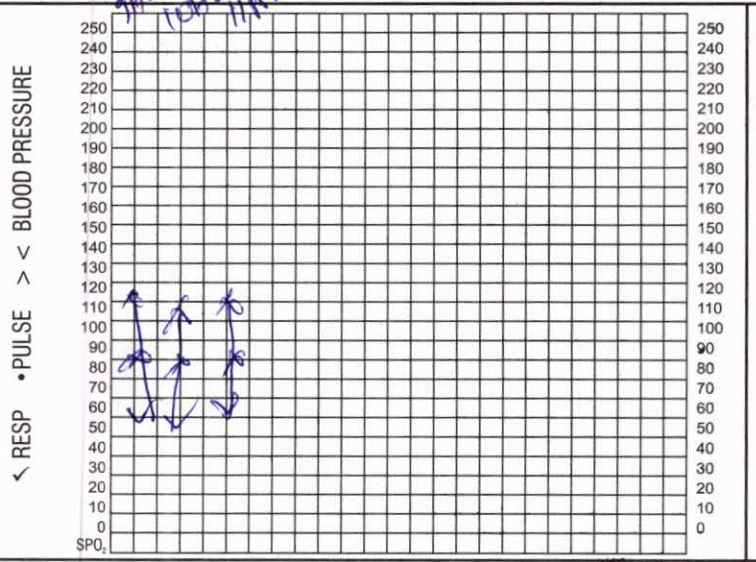
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Kushoi Time Received : 9:10 AM Time Discharged : .....

9AM 10AM 11AM



IV Cannula Site : Left hand

- ☐ O_2 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
Oral Feeds: NBM

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY	1	2	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 Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION	2	2	2	2	2	
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION	2	2	2	2	2	
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS	2	2	2	2	2	
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR	2	2	2	2	2	
		TOTAL	9	10	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
4/7	9AM	0'	Normal	
4/7	10AM	0'	Normal	Anusha.

Pain Tool Used: ☐ N PASS ☐ FLACC ☐ Wong Baker ☐ NPS

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 reliving intervention
   d. With in 30-60 minutes after pain relief intervention

Anaesthesiologist Name : DR M. VINEETHA
Anaesthesiologist Signature: .....
Date & Time: 4/7/26 3PM

PACU Nurse Name : .....
PACU Nurse Signature: .....
Date & Time: 9:10AM. 4/07/26

Transferred to Unit by (PACU): 2nd Floor (215)
Date & Time: 4/7/26 @ 3PM

Patient Sticker

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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) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left Right	Maternal BP	Maternal Pulse	FHR	Comments

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 : .....

HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

Dr. Y. Indira.

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATIOI

Name: Mrs. Damini Age: 28 yr. Sex: female UHID.No: HNH-0016336.

Date: 02/07/26. Time: 4:20 Pm. Proposed Operation: EL-LSCS

Diagnosis: primi @ term pregnancy oligohydramnios / G2A1 @ 40 wks @ OLIGO

B.P / CRT: 122/83 mm Hg H.R: 76/min Weight: 96 kg ASA Physical Status: ☐1 ☑2 ☐3 ☐4 ☐5

LSCS

Laboratory Data:

Hgb: 10.8	Glucose:	Protein:	HIV: NR	X-Ray:
PCV:	Urea:	Alb:	HBS Ag: NR	ECG:
WBC: 9900	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 2.17	Na:	Dir. Bill:	Blood group: B +ve	Stress/Anglo:
PT: 15.7	K:	LDH:	T3	Other:
PTT: 31.4	Ca++:	Alk phos:	T4	
INR: 1.08	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: NKDA.

Medical History: CVS: no active cardio respiratory complaints

RESP: no H/O HTN/DM/TB/Asthma/Thyroid. Diabetes:

CNS: no H/O breathlessness / palpitations

Renal: antenatal checkups — uneventful.

Hepatic / GE: spontaneous conception. Physical Activity: METS 7+.

Others: H/O BRONCHIAL ASTHMA IN CHILDHOOD NOT ON Rx NOW.

placenta - posterior, low lying. oligohydramnios (+). AFI - 5.2cm.

Past Anaesthetic History: Nil significant.

Physical Exam: High BMI

Airway: MP 1 (2) 3 4 Mouth Opening: 3F Mentohyoid Distance: (N) Neck: (N) Teeth: Intact.

Lungs: BAE(+), clear.

Heart: S1S2(+)

CNS: AMF(+).

Pregnant: ☑ Yes ☐ No ☐ NA | Venous Access Site: accessible | Spine Exam for regional: (N) midline.

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

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

CURRENT MEDICATIONS	DOSAGE
Iron, calcium.	

Pre-Operative Instructions:

1. DVT Prophylaxis: Cocomit wait / explained.
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:
   - Receive 1 @ PRBC.
   - Repeat CBP

Signature: Name: DR. M. VINEETHA.

Docu. No.: RCH /FRM / CLINICAL / 044

HNH-00016336 IP26-00006736
Mrs DAMINI
07-11-1997 28 Y 7 M 27 D (F)
Dr. Y.INDIRA RANI

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☐ No | Fasting Status: 10:00 pm

Physical Status: ☑ Patient Identified | ☑ Consent Present | ☐ Chart Reviewed

H.R: 82/m | B.P / CRT: 120/90 | SpO_2: 100% | R.R: 18/m | Last Feed: 10:00 pm

Pre-OP Diagnosis: GPAL at 40 weeks. | Operation: LSCS | Date: 4/7/26

Surgeon: Dr IR/SS/Naveena | Anaesthesiologist: SV → Samir | Technician: Pallavi

TIME 8:00 (B) (30) (45) 9:00

N_2O /AIR /O_2 LPM
HALO /SO /SEVO
Drugs:
Oxytocin 3U + 90 infusion.

FIO_2 / SaO_2 100 100 100 100
$ETCO_2$
ECG SR SR SR SR
Temperature
Urine Output
Fluids / Blood RL

Antibiotic – gmen.
Suppository DICLOFENAC 100 mg
PARACETOL 1000 mg
Blood Loss ~150 mL
NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate
Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values
ABG
GRBS
Others

☑ Equipment Checked and Functional
☑ BP (R) UL
☐ Cuff Site:
☐ Art Site:
☑ EKG Lead 3 leads
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: Supine
☑ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☑ Awake

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

Times:
Anaes Start: 8:
OP Start:
OP End:
Leave OR: 9am

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☑ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: 18G (D) UL
☐ IV:
☐ IV:

Induction
☐ IV ☐ Inhal
☐ Pre O_2 ☐ 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? ...

☐ **Bilat = BS**
☐ Semi-Closed Circle
☐ Closed Circle
☐ Other

Regional:
Extremity Specify: ...
☑ Spinal ☐ Epidural ☐ Caudal
Others: ...
Position: sitting
Site: L3-4
Needle Size: 25G (P) Depth: ...
Parasthesia ☐ Yes ☐ No
Catheter at skin ... cm
Drug Name & Conc: 1.8 mL 0.5% BUPIVACAINE (H)
Bolus: + 25 MCG FENTANYL
Infusion:
Block Level: T4 - BL equal
Comments: multiple attempts. NO CSF puncture.
Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA
Name of the Doctor : Dr Samir
Signature of the Doctor : SV