Dr. Ramya

Rainbow Children's Hospital — It takes a lot to treat the little.
BirthRight BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

ESTIMATION SLIP

Date : 2/6/26 **UHID / IP No. :** HNH-0001556 **Sl No.** 1556

Name of Patient : Mrs. Ch. Sathvika **Age:** 30yrs **Gender:** F

Father's / Husband's Name : Mr. Rahul **Corporate / Occupation :**

Address : Ram Nagar **Phone :** 9908861257 **Email :** 6303467643

Procedure / Plan : Hysteroscopy + Polypectomy **EDD/Dos:** June-26

MODE OF PAYMENT : ☐ SELF ☑ TPA : New United ☐ GIPSA : _____ OTHER

TARIFF INFORMATION : to M.A

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward	95K	→ N.S.
Twin Shared Ward		
Private Room	+ Pharmacy & Investigation Extra	
Super Deluxe Room		
Suite Room		
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

Neonatologist Charges : ☐ Covered ☐ Not Covered **Epidural / Entonox :** ☐ Covered ☐ Not Covered

Initial Minimum Deposit : 10,000/- Advance at time Admission

REMARKS :

1. Room eligibility is purely subject to TPA approval and the Package / Room Tariff starts from the time of admission. The estimated amount may Change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
2. Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA at later stage.
3. **Total baby charges are extra which include admission, pharmacy, vaccinations, investigations, disposables, consumables, equipments, speciality consultations, etc.**
4. In Case the patient gets discharged earlier than the packages permitted days, no refund of any type is applicable and if the length of stay is beyond the package permitted, additional payment is applicable for which kindly contact the Financial Counselling desk between 9am to 6pm
5. **For Non-medicals, Disposables, Consumables, Taxes, Kiwi Cup charges, Implants, Tubectomy charges, HIV/HbsAg, Anti-D, Medical Records, Double Occupancy and Registration Charges, etc. credit cannot be exchanged. These items are not payable to us as per Insurance company norms.**
6. Difference if any between the final bill amount and amount permitted/approved by TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
7. Two attendants are permitted with patients in SDLX, DLX and PVT rooms and only one attendant is permitted in the rest of the categories of rooms and no attendant is permitted in ICU's
8. Tariffs are subject to revision
9. Kindly check your billing status on day to day basis at IP Billing Department.
10. Additional Charges on package are applicable for Non-working hours and Non-working days (sundays and public holidays)

DECLARATION

I Rahul Pulijala have attended the Financial counseling desk and understood the expected costs and other conditions applicable. In case the TPA / Insurance Company rejects the claim for whatsoever reasons at any point of time I promise to settle the hospital bill with the hospital without any ambiguity.

Signature of the Client	Husband	Signature of the financial Counselor
	Signatory Relationship	

HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

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SURGERY DETAILS

Date : 2/7/26

Patient Name: Mrs. Ch. Saatvika Date of Birth: 15/6/1993 Age: 33yrs

Gender: Female Ward : OT UHID No.: HNH-00015566

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

Name of the Surgery : Hysteroscopy + Polypectomy

Time in : 10AM Time Out : 11AM

		NAME	AMOUNT
1.	Surgeon	Dr. Ramyatheja	
2.	Anaesthetist	Dr. Sanil	
3.	Assistant Surgeon	Dr. Swathi HV	
4.	OT Technician	Arun	
5.	Circulating Nurse	Karuna	
6.	Assistant Nurse	Sandhya	

Mrs CH SAATVIKA (33 Y 0 M 17 D/ F)
ENDOMETRIA INV04329
HN26010781ENDO

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others Hysteroscopy → 26-0000209993

Dr Manisha (For Dr Ramya)
Signature of the Surgeon

Signature of Circulating Nurse

Order No: 26-0000209992

Order by: Sandhya 2/7/26 @ 12:30pm
(or record Saved)

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

HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

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CONSUMABLES OF OT

Circulating staff : ..... Technician : Aravind Date : ..... Time : .....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			~~Major Pack~~ General	01		Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : (A) / P / N		03				Suction Catheter		
HME filter : A / P / N			TURP set	01		Feeding Tube		
Syringes : 10 cc		03				Vaccum Suction Set		
05 cc		03	Gloves S.G 6½	3		Surgical Gloves		
02 cc		~~02~~	Encore 6½	01		Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		02	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		04	Koochies					
Pcm		01	Ointments					
Midazolam		01	Suction Catheter Nel 10	01				
Fentanyl		(0)	Cap, Mask	10+10				
Morphine			Gauze Pack 7.5 cm	3				
~~Ketamine~~ O_2 mask (A)		01	Mop Pack	01				
Propofol			Steristrip					
~~Recuronium~~ Tranexa		02	Underpad	02				
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			~~Urobag~~ Lox Jelly	→ 01				
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg		01	Plastic ~~Bed Sheet~~ Aprons	03				
Tab. Misoprost : 200mg			Betadine Solution	01				
Nasal Airway 28		01	Microshield	01				
			Cotton Balls	01				
			Latex Gloves	10				
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-0000209996/9995 Ordered by : Sandhya 2/7/26 @ 12:29pm

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

Rainbow Childrens Hospital-Himayatnagar

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.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00015566	Name	Mrs CH SAATVIKA
Age / Sex	: 33 Y 0 M 17 D / Female	Doctor	: KADIYALA RAMYA THEJA
Adm/Reg Date/Time	02/07/2026 08:35	Payor	: MEDI ASSIST INSURANCE TPA PVT LTD
Order Date	02/07/2026 12:39	Ordernumber	26-0000209996
Visit ID	IP26-00006712	Ward/Bed No	: 4F -OT / PDA-413
Patient Address	Ram Nagar, Hyderabad, Telangana, INDIA, 500020		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	GENERAL SURGICAL KIT (MEDITAKE)		1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
2	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		2 Nos	Ordered
3	DISPOSABLE APRONS STERIL XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Ordered
4	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
5	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
6	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Ordered
7	DSYRINGE 5ML(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
8	NASOPHARYNGEAL TUBES 28	NASOPHARYNGEAL TUBE28	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
9	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
10	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
11	BIOXAMIC 500 MG INJ		1 Ampule	External / Once Daily	1 Days		2 Ampule	Ordered
12	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
13	IRRIGATTO(T.U.R SET)	IRRIGATTO(T.U.R SET)	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
14	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		3 Nos	Ordered
15	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Ordered
16	MEZOLAM INJ 5 MG 5 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Ordered
17	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
18	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
19	NS 1000 ML CLOSED EUROFLEX		1 Nos	External / Once Daily	1 Days		4 Nos	Ordered
20	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
21	THEMICAINE 30GM JELLY		1 On Application	/ Once Daily	1 Days		1 Nos	Ordered
22	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
23	NELTON CATHETER-10 POLYMED		1 Nos	External / 10 AM	1 Days		1 Nos	Ordered
24	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered

KADIYALA RAMYA THEJA

Reg No : TSMC/FMR/01458

* 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.

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ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00015566	**Name**	: Mrs CH SAATVIKA
Age / Sex	: 33 Y 0 M 17 D / Female	**Doctor**	: KADIYALA RAMYA THEJA
Adm/Reg Date/Time	: 02/07/2026 08:35	**Payor**	: MEDI ASSIST INSURANCE TPA PVT LTD
Order Date	: 02/07/2026 12:39	**Ordernumber**	: 26-0000209995
Visit ID	: IP26-00006712	**Ward/Bed No**	: 4F -OT / PDA-413
Patient Address	: Ram Nagar, Hyderabad, Telangana, INDIA, 500020		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		10 Nos	Ordered
2	SURGEONS CAP	SURGEONS CAP	1 Cap	Oral / Once Daily	1 Days		10 Cap	Ordered
3	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Ordered

KADIYALA RAMYA THEJA

Reg No : TSMC/FMR/01458

* 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.**

Name	Mrs CH SAATVIKA	**UHID**	HNH-00015566
Father/Guardian	Mr RAHUL PULIGILLA	**Age/Gender**	33 Y 0 M 17 D/ Female
Address	Ram Nagar, Hyderabad, Telangana, INDIA, 500020		
IP No	IP26-00006712	**Admission Date**	02-07-2026
Ref Doctor	Self.		
Discharge Date	03.07.2026		

DISCHARGE SUMMARY

Consultants :
Dr. KADIYALA RAMYA THEJA
MBBS/DNB

TSMC/FMR/01458

Diagnosis: ABNORMAL UTERINE BLEEDING - ENDOMETRIAL POLYP

HYSTEROSCOPY + POLYPECTOMY DONE ON 02.07.2026

History: She presented with complaintS of heavy menstrual bleeding, associated with inter menstrual bleeding since 2-3 months. No other complaints. Scan done on 30.05.2026 showed Uterus AVAF, endometrial polyp in mid cavity (19x11x18mm) with feeder vessel seen in anterior of polyp, right ovary - polycyctic morpholgy, left ovary- dominant follicle. Repeat scan on 16.06.26 showed 17x9mm endometrial polyp with feeder vessel anterior to it.

Name	Mrs CH SAATVIKA	**UHID**	HNH-00015566
IP No	IP26-00006712	**Admission Date**	02-07-2026

She is admitted for Hysteroscopy with polypectomy.

Menstrual History:-
LMP- 13.06.2026
Previous cycles: Regular

Obstetric History: Nil
Medical History: Nil
Surgical History: Nil
Family History: Father- DM, Mother- HTN
Allergies: CEFOTAXIM

Investigations: Enclosed.
Blood group: "B" positive

Surgery Notes:
Operation performed: **HYSTEROSCOPY + POLYPECTOMY DONE UNDER GENERAL ANAESTHESIA**

Indication: ABNORMAL UTERINE BLEEDING - ENDOMETRIAL POLYP

Operative findings:

- Cervix stenosed, dilated with hegars dilator.
- ~ 2x1cm broad base endometrial polyp on anterolateral wall extending to right lateral wall of uterus, polyp cut with scissors
- ~0.5x0.5cm polyp on right anterolateral wall of uterus in lower uterine segment, polypectomy done
- Polypoidal endometrium
- Endometrium curettage done.
- Endometrial polyp and curettings sent for HPE

Name	Mrs CH SAATVIKA	**UHID**	HNH-00015566
IP No	IP26-00006712	**Admission Date**	02-07-2026

Post-Operative Notes: She was closely monitored in the postoperative period. Her vital signs remained stable. She was encouraged to ambulate and void spontaneously. Her general condition was satisfactory and she was found to be fit for discharge. Medications were explained to the patient supplemented by written information.

Advice:

1. Tab. Augmentin 625mg (Amoxicillin + clavulanic acid) twice daily till 06.07.2026 (9am - 9pm) after food.
2. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 06.07.2026
3. Tab. Zincovit once daily (2pm) for 1 month after food.
4. Tab Meprate (Medroxyprogesterone acetate) Twice daily (9am-9pm) x 1week till 09.07.2026 followed by once daily one week (till 16.07.2026)
5. Tab Dolo 650mg (paracetamol) thrice daily (8am-3pm-10pm) till 04.07.2026.
6. Tab Drotin M SOS (for pain)
7. Tab Tranexamic acid 500mg SOS (for bleeding)
8. Collect HPE report

Review with **Dr. Kadiyala Ramya Theja** on Day-2 of next cycle **with HPE report** at Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

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

Name	Mrs CH SAATVIKA	**UHID**	HNH-00015566
IP No	IP26-00006712	**Admission Date**	02-07-2026

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 at rainbow children's hospital 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

RAINBOW CHILDREN'S MEDICARE LIMITED HYDERABAD

Consultant:
Dr. Kadiyala Ramya Theja
MBBS/DNB
TSMC/FMR/01458

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015586 IP26-00006712 Mrs CH SAATVIKA 15-06-1993 33 Y 0 M 17 D (F) Dr. KADIYALA RAMYA THEJA	2/7/26 @	2/7/26 @ 10 Am
	Transfer Ordered by Dr. Veena	Reason for Transfer Histoscopy
From Unit PMICU	To Unit Room C	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File	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 — 100 ml —	(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

Patient & Clinical Records Received by : 2/7/26

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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Rainbow Children's Hospital

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006712 **Admit Date** : 02-Jul-2026 **Admit Time** : 08:35 AM **UHID** : HNH-00015566

Patient Details :

Patient Name	: Mrs CH SAATVIKA	**Age**	: 33 Y 0 M 17 D
Guardian	: Mr RAHUL PULIGILLA	**DOB**	: 15-06-1993
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Ram Nagar Hyderabad Telangana INDIA 500020	**Phone No**	: 9908861257
		E-mail	: PULIGILLARAHUL@gmail.com

Admission Details :

Bed Type : PRIVATE ROOM **Bed No** : PVT-101 **Ward Name** : 1F -PRIVATE ROOM

Room No : PVT-101 **Admission Type** : First Visit

Contact Details :

Name : Mr RAHUL PULIGILLA **Relationship** : Husband

Contact Address : Ram Nagar Hyderabad Telangana INDIA 500020 **Phone No** : 6303467643

Signature

Doctor Details :

Doctor Name : Dr. KADIYALA RAMYA THEJA **Specialisation** : OBSTETRICS AND GYNECOLOGY

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

Co-Consultant : Dr. SWATHI H V

Payment Details :

Deposit Amount : 10000.00

Payment Mode : DC/CC Card **Payor Name** : MEDI ASSIST INSURANCE TPA PVT LTD

Histoscopy

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ACTIVITY RECORD FOR BILLING

Name : ____________________

UHID No. : HNH-00015566 IP26-00006712 Mrs CH SAATVIKA 15-06-1993 33 Y 0 M 17 D (F) Dr. KADIYALA RAMYA THEJA ____ Consultant: ____________ Dept : __________

Date of Admiss ____ Date of Discharge : _________ Time: _________

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
2/7/26	10 AM	NICU	OT	Amrutha \ Kavery
2/7/26	11:20 AM	OT	MICU	Karuna /

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
2/7/26	cardiac monitor	1:20pm	2:30pm	210042	
2/7/26	Infusion pump	1:20pm	2:30pm		

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
2/7/26	IV placement —	(1)	910543	(4)
2/7/26				
	PAC —	(1)(OP)	19228	(4)

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 2/7/2026 Time of Admission : 8:30 AM

Allergies: NKDA ☐ Not know any drug allergies

PRESENTING COMPLAINTS :

C/o Heavy menstrual bleeding : 2-3 months
& associated intermenstrual bleeding : ~~bleeding~~

No other complaints

USG (30/5/2026) - c/f AUAP
Endometrial Polyp in mid cavity (19x11x18mm)
& feeder vessel seen in Ant of Polyp
Rt ovary - Polycystic morphology
Lt ovary - Dominant follicle

Repeat after

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 2yr	Parity : Nulligravida
Previous Periods : Regular	Mode of Delivery : –
LMP : 13/6/2026	Last Child Birth : –
Contraception :	Repeat scan on 16/6 : 17x9mm endometrial polyp with feeder vessel entering it

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil	Nil

HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

...HISTORY:	MEDICATION HISTORY:
Father - DM Mother - HTN	Nil

INITIAL ASSESSMENT :

Date 2/7/2026 Ht. 164 Wt. 76kg BMI B.P Pallor ⊖ CVR S_1, S_2 ⊕ Respiratory System BAE ⊕ Thyroid NAD	Breasts Normal Abdominal Examination Soft	Local/Speculum Examination not done Bimanual Pelvic Examination not done

PROVISIONAL DIAGNOSIS : Abnormal uterine bleeding - Endometrial polyp (AUB-P)

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
BGT . BG/Rh HIV, HbsAg, HCV } NR 2/7/2026 9:30AM Allergy to Cefotaxim	- NBM - Informed Consent - Parts prepare - Drugs as charted - Inform Anaes - Shift to OT on call

Name of the Doctor : Dr Ramya Theja

Date & Time : 2/7/26 @ 8pm

Signature of Doctor

Dr. Kadiyala Ramya Theja
Consultant Obstetrics and Gyn...
Reg. No: 14...

HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/2026	C/s/b Dr	Mansha
11:15AM	POD-0	
		Adv.
	CC - Fair / Afebrile	- NBM x 2-4 h
	BP 108/60	- Drugs as charted
	PR 74	- Inj Augmentin IV BD
	P/A soft	- W/F vitals & BPV (if any)
	PV NAD	- Inform SOS
	(HPE - Sent)	
	Attenders counselled	Adv Dr Mansha
	regarding OT findings	
	by Dr Ramya T.	
2/7/2026	C/s/b	Dr Mansha
3pm	POD-0	
	CC Fair Afebrile	Adv
	Vitals Stable	- Allow sips @
	P/A Soft	- Drugs as charted
	L/E NAD -	W/F vitals & BPV
	-	Ambulation
		- Encourage to pass urine
	-	Inform SOS
	-	Can be discharged Adv Dr Mansha

HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00015568 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
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						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

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MEDICATION RECONCILIATION FORM

Drug Allergies: ..... ☐ Not known any Drug Allergies

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

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

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : ..... Dr. G. Veena.

Date & Time : ..... 2/7/20 @ 9:30Am

Nurse Name & Signature: .....

Date & Time : ..... 2/7/20 @ 9:30

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

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DRUG CHART

Date of Admission: 21/7/26 Drug Allergies: NIL ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY · Name ..... Signature .....

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Mrs CH SAATVIKA
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Dr. KADIYALA RAMYA THEJA

REGULAR PRESCRIPTIONS

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

DRUG : INJ. [illegible] ME				Date / Time
Dose: 1g	Route: IV	Frequency: BD	Start Date: 2/7/26	
Name & Signature of the Doctor Starting the Drugs: [signature]				Allergy Noted on 1st Test Dose. STOP. MY Dr. [illegible]
Additional Instructions: (ATD)				
Daily Doctor's Endorsement by a Sign				

DRUG : PARACETAMOL				Date / Time: 2/7 4pm
Dose: 1gm	Route: P/O	Frequency: P/O	Start Date: TID	
Name & Signature of the Doctor Starting the Drugs: DMAMIR [signature]				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG : INJ AUGMENTIN				Date / Time
Dose: 625mg	Route: IV	Frequency: BD	Start Date: 2/7	
Name & Signature of the Doctor Starting the Drugs: MY Dr. [illegible]				
Additional Instructions: Amoxicillin + Clavulanic Acid.				
Daily Doctor's Endorsement by a Sign				

DRUG : T. PANTOPRAZOLE				Date / Time
Dose: 40mg	Route:	Frequency:	Start Date:	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

Signature

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				

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

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

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

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																		

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																		

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Dr. KADIYALA RAMYA THEJA

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

DRUG :	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		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
2/7/26	9:30 am	INJ PANTOPRAZOLE	40 mg	IV		
2/7/26	9:30	INJ METOCLOPRAMIDE	10mg	IV		
2/7	9:55 am	INJ HYDROCORTISONE	100 mg	IV		
2/7	8:30 Am	T. MISOPROSTOL	200mcg	PR V		
2/7	10 am	PARACETAMOL	1gm	IV		
2/7	10 am	AUGMENTIN	1.2gm	IV		
2/7	1050 am	TRANEXAMIC ACID	1gm	IV		

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

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Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

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
2/7/26	9AM	RINGER LACTATE	I.V	100ml/hr + FF			2/7		
2/7	1030 am	RINGER LACTATE	IV	150			2/7		

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

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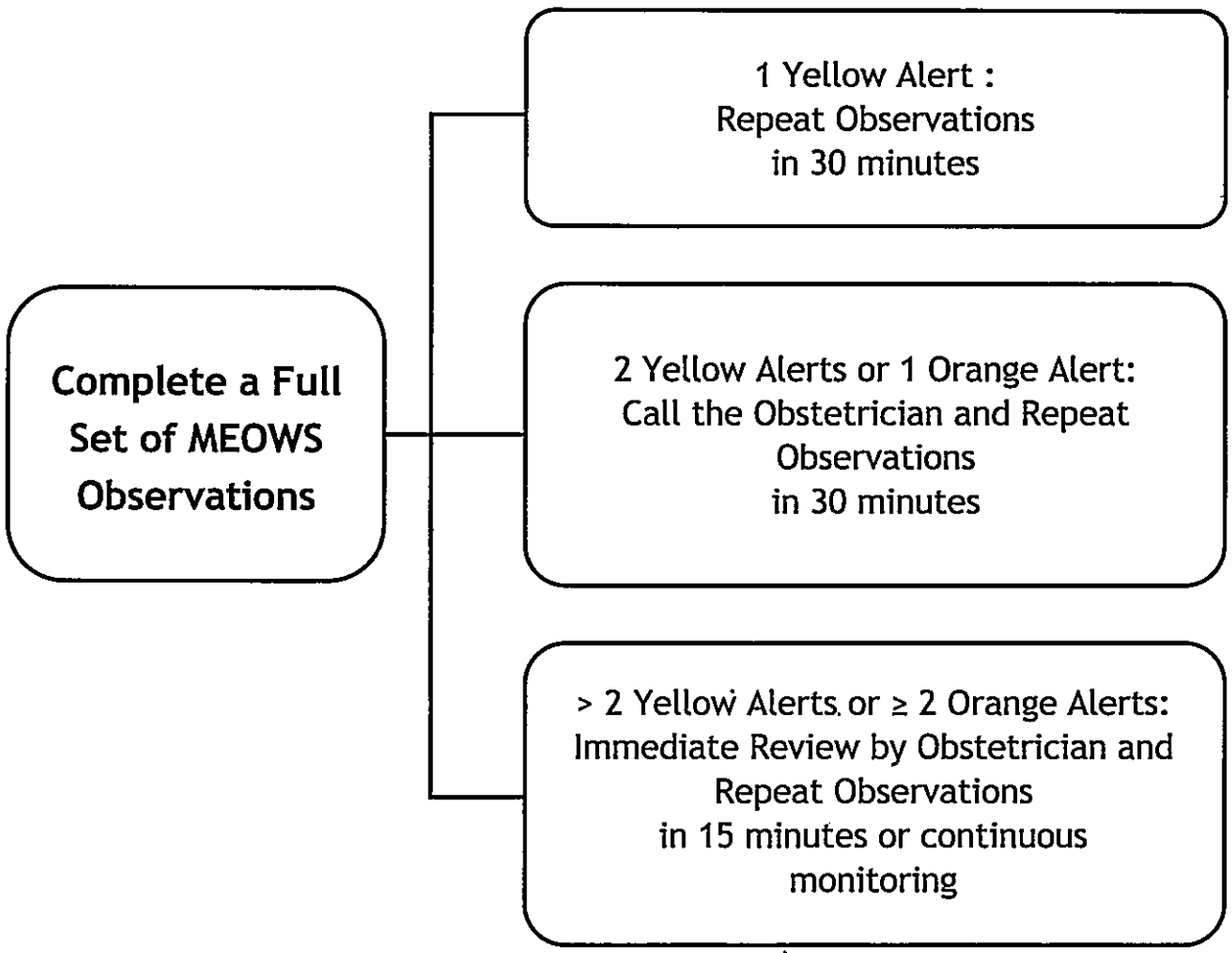
Early Warning Observation Score Chart - Obstetrics

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

2/7	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																	
	0 - 10																								
Saturations	94 - 100 %		99		99	99	99	99																	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36				36		36																		
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80		74		76	72	78	79																	
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110		104		104	105	108	109																	
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
	40																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70		76		74	72	78	79																	
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert																								
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30																								
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal																								
	Heavy / Foul																								
Liquor	Clear / Pink																								
	Green																								
TOTAL YELLOW SCORES																									
TOTAL ORANGE SCORES																									
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

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IP26-00006712

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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
9/7/26												
	08:00 am	RL	N	100 ml						✓		
	09:00 am	RL		100 ml						✓		
	10:00 am	RL	B	100 ml						✓	0	
	11:00 am	RL		100 ml								
	12:00 pm	RL	M	100 ml								
	01:00 pm	RL		100 ml								
Total Intake :						**Total Output :** passed						
11/7	02:00 pm	RL	H2	100 ml								
	03:00 pm										1	
	04:00 pm											
	05:00 pm									~~100~~	2	
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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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.

		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							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 2/7/26

Baseline Information:

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

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

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

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

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

If yes , identify .....

Chief Complaints: ..... Doctor Notified on Admission: ☐ Yes ☐ No

..... Name of the Doctor: .....

..... Time Notified: .....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NIL	NIL	NIL

Gynecology Assessment: ☐ Not Applicable	Gynecology Surgical History:	Gynecological History:
Menstrual History:	Caesarean Section: ☐ No ☐ Yes	Contraceptives: ☐ No ☐ Yes
..... Regularly	Cervical Cerclage: ☐ No ☐ Yes	Vaginal Discharge: ☐ No ☐ Yes
Onset of Menarche:	Ectopic Pregnancy: ☐ No ☐ Yes	Post-Coital Bleeding: ☐ No ☐ Yes
Menstrual Cycle: ☐ Regular ☐ Irregular	Myomectomy: ☐ No ☐ Yes	**Infertility:** ☐ No ☐ Yes
Last Menstrual Period:	Others: _____	**If Yes** Type: ☐ Primary ☐ Secondary

Obstetric History: G ..... P ..... L ..... A .....

Previous LSCS: .....

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

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 98.6 HR: 82 RR: 20

BP: 116/74 Weight: ..... Height: ..... BMI: .....

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

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PHYSICAL ASSESSMENT

General Appearance: ☑ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others: .....

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

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

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

☐ Mobility problem ☐ Walking Problem ☐ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☐ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

☑ Calm & Cooperative ☐ Restless ☐ Depressed ☐ Agitated ☐ Confused

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

1. **Marital Status:** ☐ Single ☑ Married ☐ Divorced ☐ Widow
2. **Special Habits:** **Smoker:** ☐ Yes ☐ No **Alcohol Abuse:** ☐ Yes ☐ No **Drug Abuse:** ☐ Yes ☐ No

Social History: Lives With .....

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☑ Yes ☐ No Waste Disposal Explained: ☐ Yes ☐ No

Infusion Pump : ☐ Yes ☑ No Hand Hygiene Explained: ☐ Yes ☐ No ☐ Others

Above information given to ..... Patient .....

Name of Person Orientation was given to: ..... CH Saatvika .....

Orientation not given Reason: ..... N.A .....

Nurse Signature: .....

Nurse Name: ..... Mounika .....

Date & Time: ..... 2/7/26 .....

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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 : Monika.

Signature of Ward In Charge :

Signature : ..... Name : Easthuri

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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 : .....

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	2/7/26		
		Score	M 5		
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			
IV / Heparin Lock or Saline	Yes	20			
	No	0	0		
GAIT / Transferring	Impaired	20	20		
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:			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

HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

BRADEN 'Q' SCALE

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					Date : 2/7	2/7		
					Time : KL	M/S		
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		
"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		
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		
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		
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		
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		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4		
				TOTAL SCORE	28	28		
				Evaluator's Name				

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
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

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PAIN ASSESSMENT FORM

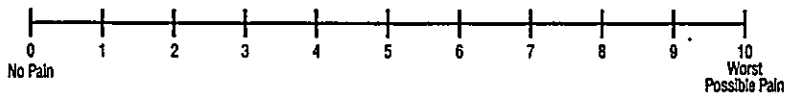
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
2/7	6Am	0/10	NP	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NP	[signature]
2/7	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
2/7	9Pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ 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

HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

NURSING CARE RECORD

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Date: 2/7/26

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	8AM to 2pm	→ Assess the pt condition → Monitor vitals → Maintain I/O chart	8AM to 2pm	→ Assessed the pt condition → monitored vitals → Maintain I/O chart	Now pt is stable	Re-check vitals	Moni
Afternoon				vay			
Night							

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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: ..... Date of Admission: .....

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time	2/7 M					
	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:	97					
	Res:	20					
	SpO_2:	94					
	Pulse:	82					
	BP:	110/70					
	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 :		MOM					
Signature :		94					
Date:		2/7/26					
Time:		8 AM					
Taken Over By Name :							
Signature :							
Date:							
Time:							

HNH-00015588 IP26-00006712
Mrs CH SAATVIKA
15-05-1993 33 Y 0 M 17 D (F)
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URSING 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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OPERATION THEATER NOTES

HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

Patient's Name : ... .Age : .....Gender : .....

UHID.: ..... lo. :.....Weight : .....

Surgeon : Dr Swathi HV	Asst. Surgeon : Dr Ramya Theja
Anesthetist : Dr Samir	OT Nurse : Sandhya

Surgical Procedure :

Hysteroscopy + Polypectomy

Indications for Surgery :

AUB-P (Endometrial Polyp

Date : 2/7/2024	Start Time :	End Time :

PRE-OPERATIVE PREPARATION :

IV Antibiotics

↓ AAP, Parts Painted & Draped, lithotomy Position

OPERATION NOTES:

Operative findings:-

- Cervix Stenosed, Dilated & Hegar's Dilator
- ~2x1 cm Broad base Endometrial Polyp on Anterolateral wall extending to Right lateral wall. Polyp cut & Scissor
- ~0.5x0.5 cm Polyp on Antero-lateral wall of uterus over lower uterine Segment, Polypectomy done
- Polypoidal Endometrium
- Endometrial curettage done.
- Endometrial Polyp & curettings sent for HPE

POST - OPERATIVE ORDERS :

NBM x 2-4h
IV Augmentin BD till Discharge
Drugs as charted
Mon vitals & BPr
Inform SOS

Discharge Advice :- Collect HPE Report
· T Augmentin 625mg BD x 5d
· T Pantoprazole 40mg OD x 5d.
· T Zincovit OD x 7 days
· T Meprate 10mg BD x 1wk Flb OD x 1wk
· T Dolo 650mg TID x 3d
· T Orofin M SOS
· T Tranexamic Acid SOS
· Review on D-2 of next Cycle c HPE Report

Dr Ramya Thege
Consultant Surgeon's Name

(For Dr Ramya)
Consultant Surgeon's Signature

Date : 2/7/2020 Time : 11:45 Am

SURGICAL SAFETY CHECKLIST

Surgeon : Dr Ramya Theja
Asst. Surgeon :
Anaesthetist : Dr Samir
Scrub Nurse : Sr. Sandya

HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 3 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

Patient Nam
UHID No. :
Date : 2/7/26

..... Gender : .....
.....
ime : .....

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 10AM

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 : Dr Samir
Name : Dr Manisha

Before Skin Incision ➤➤

TIME OUT Time: 0926AM

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? ☑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 :
Name : Karuna @ 10:20AM

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 : Dr Manisha (For Dr Ramya)
Name : 2/7/2026 @ 11:15PM

PATIENT TRANSFER FORM

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HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

	Date & Time of Admission: 2/7/26 @	Date & Time of Transfer Order: 2/7/26 @ 11:20am.
Treating Consultant Name: Dr Ramya Theja	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	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
Karuna	Dr. Samir

Patient & Clinical Records Received by : Madhumeta

Date & Time of Patient Received : 2/7/26 @ 11:20 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

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. Ch. Saatwika Age: 33 Sex: female UHID.No : HNH-15566

Date: 29/6 Time: 8pm. Proposed Operation: hyst + polypectomy

Diagnosis: AUB - Endometrial polyp

B.P / CRT: 105/77 H.R: ..... Weight: 76 ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data:

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

Allergies: food allergies ⊕ seafood/Brinjal

Medical History: CVS : /

RESP : No significant medical history Diabetes :

CNS : No prior hospital admissions.

Renal :

Hepatic / GE : /

Physical Activity: active NYHA-I METS > 4

Others :

Past Anaesthetic History: nil

Physical Exam: coherent

Airway: MP 1 2 3 4 Mouth Opening: adq Mentohyoid Distance: 8Fbs Neck: (N) Teeth: intact

Lungs : / clinically clear

Heart:

CNS:

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site : peripheral Spine Exam for regional : —

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

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

CURRENT MEDICATIONS	DOSAGE
Fa / D3	

Pre-Operative Instructions: NBM / 12AM (food) 6AM (water)

1. DVT Prophylaxis :
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:

Signature: Name: Dr Lavanya

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

HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No		Fasting Status: ok.	
Physical Status:	☑ Patient Identified	☑ Consent Present	☑ Chart Reviewed

H.R: 90/m	B.P / CRT: 102/69	SpO_2: 100%.	R.R: 18/m	Last Feed: >6 hrs

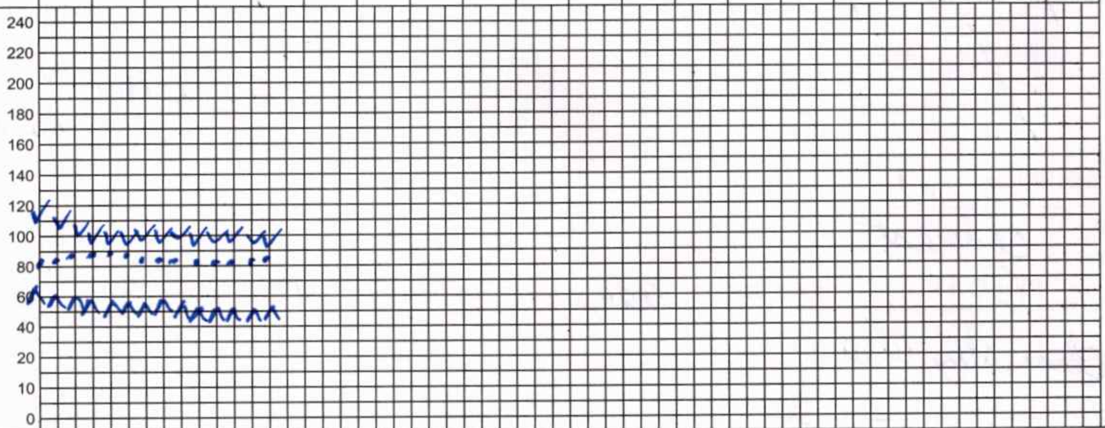
Pre-OP Diagnosis: Endometrial polyp Operation: Hyst + polypectomy Date : 2/7

Surgeon: Dr RT / Dr MSV Anaesthesiologist: Dr SAMA Technician: Dravind / Saraswati

TIME	10	(5)	(30)	(45)	11:00
N_2O / AIR / O_2 LPM	Air/N2				
HALO / SO / SEVO	NAC 2%				
Drugs:					
MIDAZOLAM	2mg iv				
FENTANYL	100mcg iv				
PROPOFOL	140mg iv				
PARACETAMOL	1gm iv				
TRANEXAMIC ACID	1gm iv				
FIO_2 / SaO_2	100	100	100	100	
$ETCO_2$	35	38	41	41	
ECG	Sn	Sn	Sn	Sn	
Temperature					
Urine Output					
Fluids	RL				
Blood					

Antibiotic: AUGMENTIN 1.2gm
Suppository: DICLOFENAC 100mg
TRAMADOL 100mg
Blood Loss: —
NOTES

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



LAB Values: ABG / GRBS / Others

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

Position: litho.
☑ 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: 10AM
OP Start: ↓
OP End: ↑
Leave OR: 11AM

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

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

Induction
☑ IV ☑ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☑ SGA I-gel #4
☐ 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:
Site:
Needle Size: .... Depth: ....
Parasthesia ☐ Yes ☐ No
Catheter at skin .... cm
Drug Name & Conc:
Bolus:
Infusion:
Block Level:
Comments:

Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA

Name of the Doctor : Dr SAMIR
Signature of the Doctor : [signature]

HNH-00015566 IP26-00006712
Mrs CH SAATVIKA
15-06-1993 33 Y 0 M 17 D (F)
Dr. KADIYALA RAMYA THEJA

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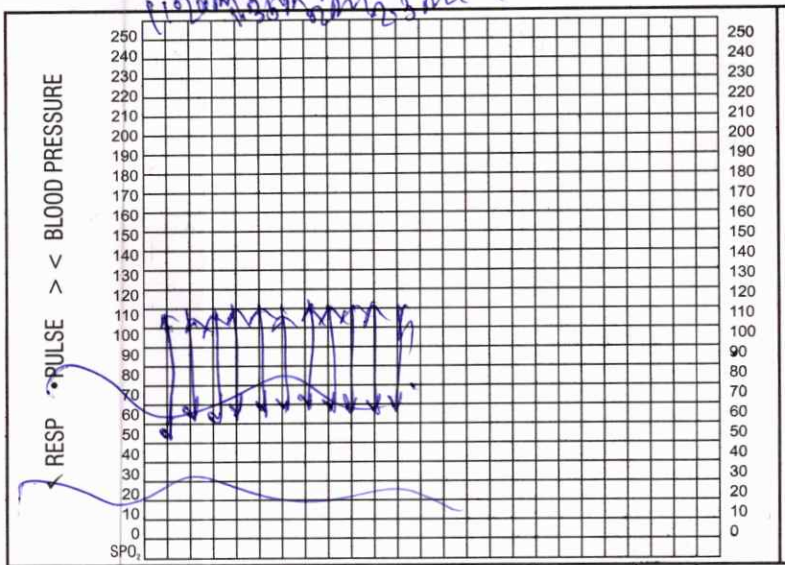
ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Madhu Time Received : 12.00Pm Time Discharged : .....



IV Cannula Site : left

- ☐ O_2 Mask
- ☐ Tracheostomy
- ☐ Oral Airway
- ☐ Nasal Prongs
- ☐ T-Piece
- ☐ Nasal Airway

Vomiting : ☐ Yes ☐ No Drug: Augmentin
NG Tube : ☐ Yes ☐ No
Drain: ☐ Yes ☐ No
Urinary Catheter: ☐ Yes ☐ No
Chest Tube: ☐ Yes ☐ No
Nil Oral ☐ Yes ☐ No
IV Fluids: RL
Oral Feeds: Mil.

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	1	2	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION	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		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS	2	2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR	2	2	2	2		
		TOTAL	9	9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
2/7	12.00Pm	0	Normal	
2/7	2.30Pm	0	Normal	
		-	-	
		-	-	

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

Anaesthesiologist Name : Dr
Anaesthesiologist Signature:
Date & Time: 2/7/26 @ 2.30Pm

PACU Nurse Name : Madhumi tg
PACU Nurse Signature: Madhu
Date & Time: 2/7/26 @ 2.30Pm

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

Transferred to Unit by (PACU): .....
Date & Time: 2/7/26 @ 2.30Pm

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		Maternal		FHR	Comments
			Left	Right	BP	Pulse		

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

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. Ch. Laalasika Age : 33y Gender : Male ☐ Female ☑

UHID NO: HNH-15566 Surgeon Name: Dr. Ramya Theja

Anaesthesiologist : Dr. Lavi Chayala

Operative procedure planned : Hysteroscopy & polypectomy.

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 : nil specific.

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 ..... the above mentioned operation / Diagnostic / Therapeutic procedures .....

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 : Ch. Saatvika

Relationship with Patient: .....

Date & Time : 27/7/26 @9AM

Witness : Ch. Vijayalakshmi.

Signature : .....

Name : Ch. Vijayalakshmi

Date & Time : 27/7/26 @9AM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Lanni Nayak

Date & Time : 27 at 9am.

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs. Saatvika Gender: ☐ Male ☑ Female Age : 32yrs

UHID No : HNH-0004566 Date : 2/7/26

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

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

HYSTEROSCOPIC POLYPECTOMY

upon

Mrs. SAMVIKA. (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.

Excessive bleeding, need for transfusion of blood or blood products, uterine perforation, wound infection

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. Ramya Thejas K.

Consentee :

Signature :

Name : Saatvika CH

Date & Time : 2/7/26 @ 9:30 pm

Witness :

Signature :

Name : Dr. RAMYA THEJAS K

Date & Time : 2/7/26 @ 9:30AM

Patient Attendant :

Signature :

Name : Rahul Pulipilla

Relationship with Patient: Husband

Date & Time : 2/7/26 @ 9:30 AM

Doctor (who is taking the consent) :

Signature :

Name : Dr. Naveena.

Date & Time : 2/7/26 @ 9:30AM

26-00002094 3

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mis CH Jaatvika Age: 33Y Gender: Female

UHID No: HNH-0901556 IP No: 26-00006712 Date: 02/07/26 Time: 8:54 Am

Diagnosis: Hysteroscopy polypectomy (Ward-07)

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	01 Amp
2.	Morphine Sulphate Inj. 15mg/Ml	—	—
3.	Remifentanil Hydrochloride Inj. 2MG	—	—
4.	Remifentanil Hydrochloride inj. 1MG	—	—

Doctor Name: Dr Amir Doctor Registration No: 67529

Signature:

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

IP Registration No: 26-00006712 Date: 02/07/26

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

		Remarks
1.	Name : Mis CH Jaatvika	
2.	Complete postal address (with contact number, if any)	Ram Nagar Hyderabad
3.	Brief description of the illness	Hysteroscopy Polypectomy
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	INJ: Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
02/07	INJ: Fentanyl	01		

Dispensed by (Name & ID No.): Saina (015002) Signature: Saina

Received by (Name & ID No.): M Arvind Kumar (021337) Signature: A/U

Time: .....