Rainbow® Children's Hospital
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BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

ESTIMATION SLIP

Date : 10/7/26 **UHID / IP No. :** HNH-0000 34911 **Sl No.** 1681

Name of Patient : Mrs. Rajashree **Age:** 35yr **Gender:** F

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

Address : mehdipatnam **Phone :** 9550171413 **Email :** 9908847100

Procedure / Plan : ND / LSCS **EDD/Dos:** July

MODE OF PAYMENT : ☐ SELF ☑ TPA : National Insurance ☐ GIPSA : ____ OTHER

7 M.A

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward		
Twin Shared Ward →		
Private Room →	1.10L	1.15L
Super Deluxe Room	+ Non Payables	Extra 25k to 30k
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 : 2 Days	Length of Stay for : 3 Days
	Pharmacy up to 9,000/-	Pharmacy up to 12,000/-
CBP, NST ←	Investigations up to 2,500/-	Investigations up to 3,000/-
Others	well baby care	25k to 35k approx.

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

Initial Minimum Deposit : 10,000/- paid.

REMARKS : Vaccination, Neonatal, SB2, B/L

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 K. Srikanth 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	Signatory Relationship	Signature of the financial Counselor
(signature)	Husband.	(signature)

HNH-00003494 IP26-00006802
Mrs RAJASHREE
22-06-1991 35 Y 0 M 18 D (F)
Dr. SWAPNA SAMUDRALA

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SURGERY DETAILS

Date : 10/7/2026

Patient Name: Ms. Rajashree Date of Birth: — Age: .....

Gender: Female Ward : LDR UHID No.: .....

Date of Surgery: 10/7/2026. LDR-I ☐ OT-1 ☐ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Normal delivery.

Time in : 12 Pm Time Out : 1 Pm

		NAME	AMOUNT
1.	Surgeon	: Dr. Swapna Samudrala	
2.	Anaesthetist	: —	
3.	Assistant Surgeon	: Dr. Naveena	
4.	OT Technician	: —	
5.	Circulating Nurse	: Kasturi	
6.	Assistant Nurse	: Madumitha	

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

Signature of the Surgeon

Madhu
Signature of Circulating Nurse

Order No: 26-0000212440 Order by: Madhumitha

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FC

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Name	Mrs RAJASHREE	**UHID**	HNH-00003494
Father/Guardian	Mr KUSHANGALA SRIKANTH	**Age/Gender**	35 Y 0 M 18 D/ Female
Address	12-2-754/2 RETHI BOWLI ASIFNAGAR HUMAYUNNAGAR, Mehdipatnam, Hyderabad, Telangana, INDIA, 500028		
IP No	IP26-00006802	**Admission Date**	10-07-2026
Ref Doctor	DR. P. MALATHI		
Discharge Date	12.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

Diagnosis: G2P1L1 AT 39+5 WEEKS IN EARLY LABOUR

SPONTANEOUS VAGINAL DELIVERY DONE ON 10.07.2026

History:
LMP: 05.10.2026
EDD: 12.07.2026
Obstetric formula:G2P1L1
Gestation at admission: 39+5 weeks

Obstetric History:
1 - 2024/ Aug - FT/SVD, Male, Wt 2.6 kg, A & H , Uneventful
2 - PP, Spontaneous Conception

Medical History : Nil
Surgical History: Nil
Family History : Nil
Allergies : Nil

Name	Mrs RAJASHREE	**UHID**	HNH-00003494
IP No	IP26-00006802	**Admission Date**	10-07-2026

Antenatal Details:
Mrs RAJASHREE was booked to Rainbow hospital at 38+5 weeks of gestation. She had regular antenatal checkups and investigations as advised elsewhere. NT + Double marker : Low risk . TIFFA Normal . Growth scan done at 30w6d (09/5/26) showed EFW 1564g (22.9 %) with Normal AFI + Dopplers. Fetal growth monitoring was done by serial growth scans. Growth Scan done (03.07.2026) showed SLIUP at 38^{+5} weeks Cephalic, placenta posterior high with AFI: 9.6cm, EFW: 3.025gm (22%), with AC: 15% with normal dopplers. She was admitted at 39+5 weeks in early labour for delivery.

Investigations: Enclosed.
Blood group: "A" Positive

Management: Course in hospital and Delivery Details:
At admission on clinical examination the vitals were stable, uterus was moderately acting, cervix was effaced and 3 cm dilated. Fetal well being was confirmed by an admission NST which was found to be reactive. Artificial rupture of membranes done at 3 cm dilatation revealing clear liqour at 10:30am. As per hospital protocol she was started on IV. Taxim in view of ruptured membranes. Partographic monitoring of labour was done. Further augmentation was done by oxytocin infusion. She progressed to full dilatation at 12:30 pm. She was put into position for vaginal birth. Parts painted with betadine solution and draped to ensure full asepsis. She was encouraged to bear down. Baby was delivered by vaginal delivery, Cord clamped and cut and baby handed over to pediatrician. Cord blood collected for blood grouping and Rh typing. Placenta and membranes delivered completely with controlled cord traction. Prophylactic syntocinon given. Perineum inspected, 2nd Degree perineal tear, repaired. Instrument and swab count checked. 600 mcg of misoprostol given per rectally as prophylaxis against post partum hemorrhage.

Name	Mrs RAJASHREE	**UHID**	HNH-00003494
IP No	IP26-00006802	**Admission Date**	10-07-2026

Vagina cleaned with betadine solution.
* **One loop of cord around neck.**

Delivery Details:
Date : 10.07.2026
Time of Delivery: 12:43pm
Type of Labour : Spontaneous
Type of Delivery: Spontaneous Vaginal Delivery

Baby Details:
Date : 10.07.2026
Time : 12:43pm
Sex : Female
Weight : 3.22kg
Apgar : 8,9
Gestational Age: 39+5 weeks
NICU Admission: No

Post-Partum Notes: She was closely monitored for post partum hemorrhage. Breast feeding initiated. Vitals were stable; patient ambulated and was shifted to room. Patient was encouraged for spontaneous voiding. Dietary advice given. Her postpartum period following that was uneventful. On first postpartum day episiotomy wound was healthy and intact. 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 (Cefixime 200mg) twice daily till 16.07.2026 (9am-9pm) after food.

Name	Mrs RAJASHREE	**UHID**	HNH-00003494
IP No	IP26-00006802	**Admission Date**	10-07-2026

2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 14.07.2026(8am-2pm-10pm) after food.
3. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 14.07.2026 (7am-7pm) before food.
4. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 16.07.2026(9am-3pm-11pm) after food.
5. Tab. Livogen (Elemental iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500 mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
7. Betadine ointment for local application.
8. Syp. Duphalac 15 ml (Lactulose 3.33gm/5ml) at bed time for one week.
9. Sitz bath x 1 weeks

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. SWAPNA SAMUDRALA** after **2 weeks** on **28.07.2026** 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, when and how to obtain emergency care etc also have been explained by doctor ..... in a

Name	Mrs RAJASHREE	**UHID**	HNH-00003494
IP No	IP26-00006802	**Admission Date**	10-07-2026

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 at Rainbow Children's Hospital Himayatnagar just dial one toll free number - 18002122.

You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

RAINBOW CHILDREN'S MEDICARE LIMITED HYDERABAD

Registrar/Resident/C.M.O

Consultant:
Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ HNH-00003494 IP26-00006802 Mrs RAJASHREE 22-06-1991 35 Y 0 M 18 D (F) Dr. SWAPNA SAMUDRALA

Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7/26	3:40pm	LDR	Floor	Akula

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. S. Rajagwini (Contact consultation)		12738	
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
10/7	CBP ✓	11406	
10/7	NST-① 8298	8298	
~~10/7~~	~~NST-2~~	~~8298~~	
		discontinued.	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
10/7	infusionpump	11:30Am	12:30Am	12828	crosscheck done by [illegible]

Cancelled by Book

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/7	IV placement	(1)	12426	✓
10/7/26	NHA	(1)	12492	✓

ANY OTHER INFORMATION

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.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00003494 IP26-00006802 Mrs RAJASHREE 22-06-1991 35 Y 0 M 18 D (F) Dr. SWAPNA SAMUDRALA	10/7/26 @10:24AM	10/7/26 @ 3:40pm
	Transfer Ordered by dr. veena	Reason for Transfer observation
From Unit PICU	To Unit floor	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 30	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.	RD	
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Akhila	Dr. Veena.

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

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints
Came c/o Pain Abdomen :: 1hr
PFM+

Obstetric Formula: G2P1L1

Obstetric Hostory:
1 - 2014 / Avg / PVD / M / (2-Cry)
A&H
2 - PP, Sp conception

Present Pregnancy Record: Booked 38+5wk
NT - FTS - LR
TIFFA - N
GS @ 30wk - EFW - 1.5kg (22.9%)

RISK FACTORS: ANC +Doppler

Height: 157 cm
Weight: 80.00 kg
Allergies: nil
Breast: ☐ Normal ☐ Abnormal
General Examination: Fair
Consciousness: +
Pallor: Nil
Icterus: −
Edema: Nil
Temp: Afebrile
PR: 86
BP: 110/70
DTR: +
CVS: Nil
RS: BAE +
Liver/Spleen: Nil
Urine Output: Adeq

LMP: 05/10/2025
EDD: 12/7/2026
Corrected EDD:
GA:

Menstrual History: Regular : ☐ Yes ☐ No

Obstetric Examination

Fundal Height:
Ut. Activity: ☐ Relaxed ☑ Mild ☐ Mod ☐ Severe
Liquor: ☑ Adequate ☐ Oligo ☐ Poly
PP: ☑ Cephalic ☐ Breech Others ____
Head Fifths Palpable: ____
FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

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

Vaginal Examination
Cervix: ☐ Long ☐ Partially effaced ☑ Effaced
Os: Closed ____ Dilated 3cm
Membranes: ☑ Present ☐ Absent
Liquor: X ☐ Clear ☐ Meconium ☐ Blood Stained
Presenting Part: ☑ Vertex ☐ Breech ☐ Others
Sutton: ☐ -3 ☑ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2
Pelvis: ☑ Adequate ☐ Doubtful

DIAGNOSIS

G2P1L1 / 39+5 wk / PrevNVD / ~~latent~~ in early labour

Docu. No. : RCH /FRM / CLINICAL / 087

(P.T.O)

Patient Sticker

Family History:	Surgical History:
Nil.	Nil.
Medical History: Nil.	**Medication History:** T. IRON. T. CALCIUM.
Plan of Care:	**Investigations:** BGT - 'A' Positive
Adv Admission UST Parts Preparation. w/F PCL / PV leak / PV bleeding strict FHR monitoring NST 3hrly Monitor Vitals CBP Inform SOS.	CBP (10/7/2026 Hb-13.7. HIV PCV - 37.7. HbsAg } NR plt. 1.70 HCV. TLC-11.03. VDRL. USG (3/7/2026) SLIUF 38th Cephalic. placenta - posterior high AFI - 9.6cm EFW - 3.025gm (22%) AC - 15%. Dopplers - normal.

Dr. Swapna Samudrala
Consultant Obstetrics and Gynecology
Reg. No: 89924

Doctor Name: Dr. Naveena.
Signature:
Date & Time: 10/07/2026.

Consultant Name: Dr. Swapna. S.
Signature:
Date & Time: 10/7/2026.

HNH-00003494 IP26-00006802
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/2/26 10:30 AM	c/o Pain abd	
	O/E - G.C. fair	Adv
	Afebrile	- W/F progress of labor
	O_2 Sat - 99% RA	- FHR monitoring
	PR - 86 b/m	- Inj Taxim, 1 gm, IV
	B.P - 110/70	Stat (AQ)
	P/A - uterine activity	- Start Syntocinon @ 6 ml/hr & titrate 1/2 hrly
	Ceph. FHR 142 b/m	from 11:00 AM
	V/E - Cx 3 cm, 70% eff	- Monitoring Vitals
	Vx - 2, BOM +	- FHR 2nd hrly
	ARM → liq clear	- Ingam Svc
		Dr. Swapna Samudrala Consultant Obstetrics and Gynecology Reg. No: 63924
10/2/2026 12:10 pm	C/o No complaints	
	CE for Afebrile	Adv
	Vitals Stable	- W/F vitals & PRs
	P/A ut Activity ; cephalic FHS ⊕R	- Oxytocin Augmentation
		- W/F Progress of labour
	PV OS - 8 cm ; Effaced	- Reassess SOS

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26	PND - 0 (P2L2 / SVD)	
1:15 pm	NV comp	Adv
	O/E - GC fair	- Regular Diet
	Afebrile	- Oral hydration
	O2 Sat - 99% RA	- Drugs as charted
	PR - 85	- Monitor vitals 1/2 hrly
	B.P - 106/64	- W/f excessive P/v
	P/A - UV well retracted	bleeding
	L/E - NAB	- D/o chart
		- Inform SOS
		Dr. Swapna Samudrala, Consultant Obstetrics and Gynecology, Reg. No: 69924
		[signature]
10/7/2026	C8/10 Dr Manisha.	
3:30pm	PND - 0	
		Adv
	GC fair Afebrile	- Regular Diet : Adeq Hydration
	Vitals stable	- Drugs as charted
Baby - MD	P/A ut well retracted	- W/f vitals & BPV
	PV. Bleeding WNL	Ambulation
	Episiotomy intact	Inform SOS
U - Passed	4 (H) drops	- Shift to Room
		N/B Surgery [signature] @ 3:30pm

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/25 5pm	c/s/B Dr. Malathi	
	Pt is stable	
	No c/o	Adv
Baby @ ws	o/e GC-fair	- Regular diet
	Vitals-stable	- Drugs as charted
	p/A - U+well retracted	- Ambulation
	L/E B-BWNL	- Inform SOS
		- d/s tomorrow
11/7/25	C/S/B Dr. Dna	
7:30PM	PND-O.	
		Adv
Baby c Mother	GC fair	- Regular diet
	Afebrile	- Drugs as charted
	BP: 132/69 mmHg.	- Ambulation
	PR: 86/min	- Adequate hydration
urine passed	P/A uterus Retracted well	- Monitor vitals
		- Inform sos
	L/E - NAD.	

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
11/7/26	C/S/B Dr. Dna	
7AM	PND-1	
		Adv
	GC fair	- Regular diet
Baby c Mother	Afebrile	- Adequate hydration
	vitals-stable	- Drugs as charted
	P/A Uterus Retracted	- Ambulation
UL ✓	well	- Monitor vitals
FL ✓	PV - NAB.	- Inform SOS
	[signature]	
11/7/26	PND - 2	
11:30 AM	No comp	Adv
	O/E- G.C fair	- Regular Diet
	Afebrile	- Oral hydration
	Vitals - (N)	- Drugs as charted
Baby - well	P/A - UV well retracted	- monitor vitals
	L/E - NAB	- Ambulation
		- Inform Sos
		Dr. Swapna Samudrala Consultant Obstetrics and Gynecology Reg. No: 69924
	Can be discharged	(Dr. Swapna's) [signature]

Docu. No. : RCH /FRM / CLINICAL / 088

HNH-00003494 IP26-00006802
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RESULT SHEET

Date	10/7/26					
Time						
Hb	13.1					
PCV	37.7					
RBC	4.74					
WBC	11.3					
N/L	78.4/17.1					
Platelets	170					
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: A+ve						
HIV HbsAg HCV } NR						

Culture and Sensitivities : .....

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.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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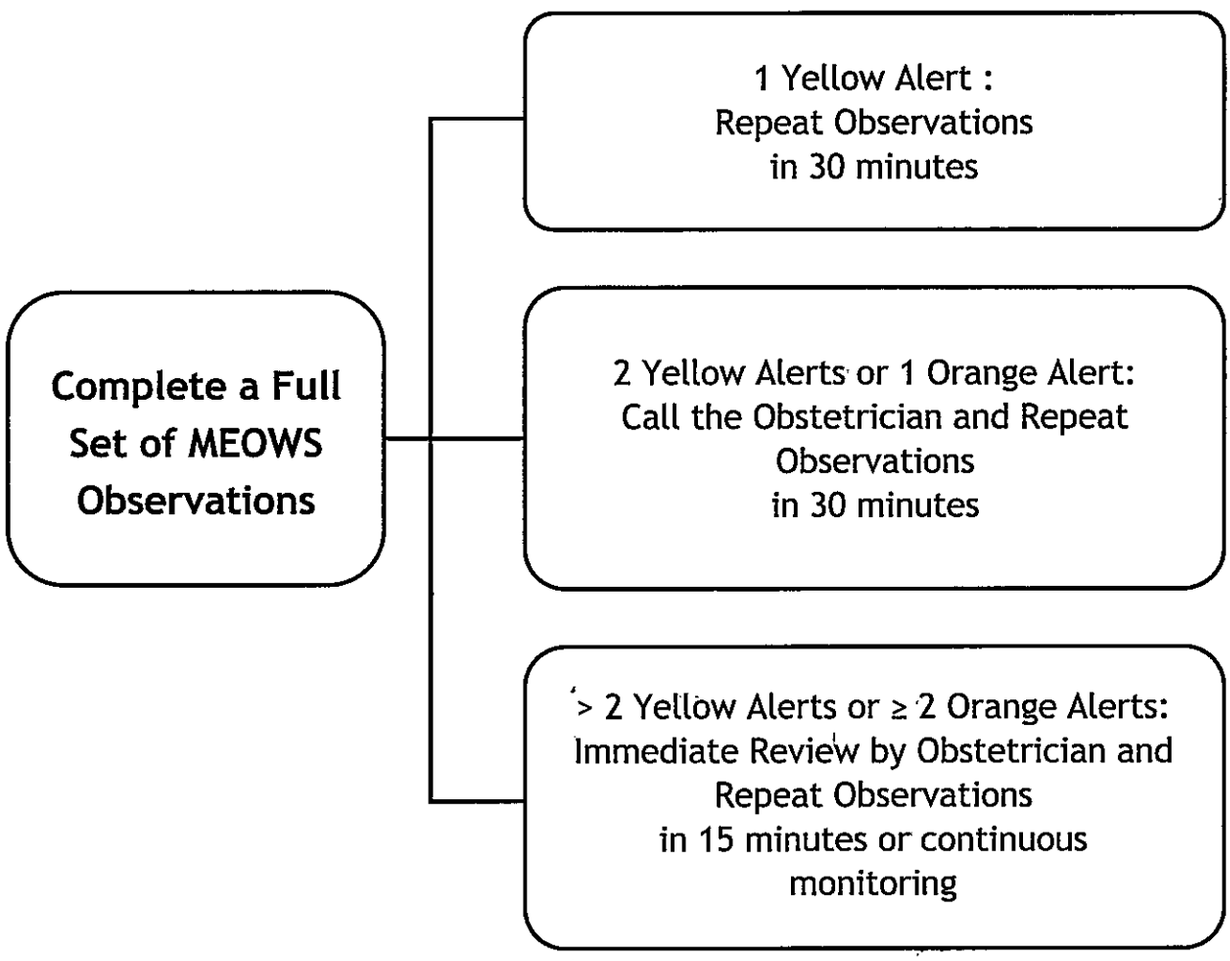
Early Warning Observation Score Chart - Obstetrics

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

		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					
	0 - 10																									
Saturations	94 - 100 %			97		98		98	98				97				99				100					
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37			-		-		-	-				98				97.8				98.3					
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80			81		85		86	86				85				86				82					
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120			125		120		132					125				121				118					
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80			70		67		64					70				68				69					
	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				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)**

HNH-00003494 IP26-00006802
Mrs RAJASHREE
22-06-1991 35 Y 0 M 18 D (F)
Dr. SWAPNA SAMUDRALA

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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

		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 Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
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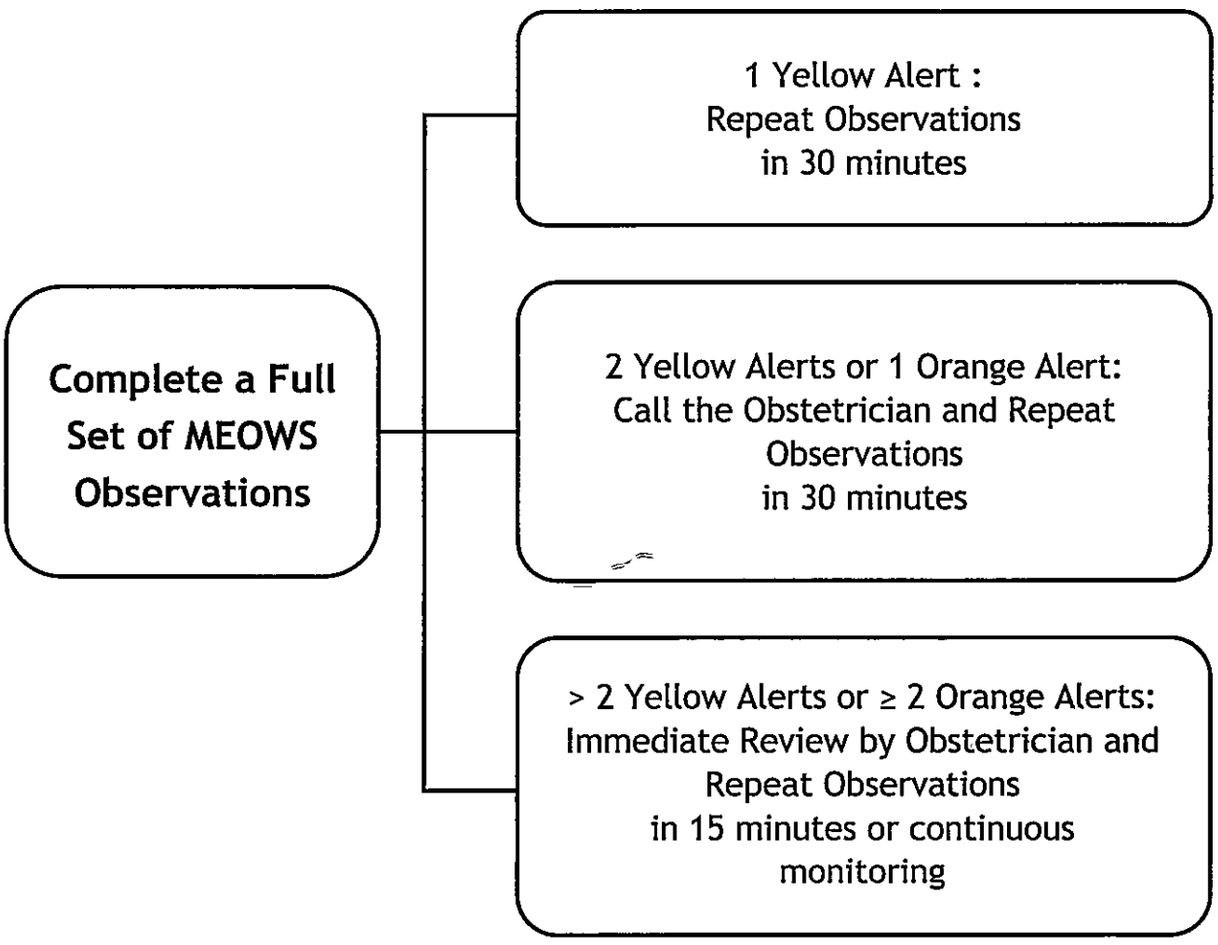
	90																									
	80																									
	70																									
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert																									
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
	TOTAL YELLOW SCORES																									
	TOTAL ORANGE SCORES																									
	Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00003494 IP26-00006802
Mrs RAJASHREE
22-06-1991 35 Y 0 M 18 D (F)
Dr. SWAPNA SAMUDRALA

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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.

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
10/7	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am						NA					
	12:00 pm	RL		100ml								
	01:00 pm	RL	Pldy taken	100ml								
Total Intake :						**Total Output :**						
10/7	02:00 pm											
	03:00 pm									✓		
	04:00 pm		H2O sip Feeds								0	
	05:00 pm			NA						✓		(signature)
	06:00 pm						NA			✓		
	07:00 pm											
Total Intake :						**Total Output :**				Passed U-3 M-0		
10/7	08:00 pm											
	09:00 pm											
	10:00 pm	0		NA							0	(signature)
	11:00 pm								NA			
	12:00 am											
	01:00 am											
Total Intake : Taken						**Total Output :** M-					U-	
11/7	02:00 am											
	03:00 am											
	04:00 am	0									0	(signature)
	05:00 am			NA					NA			
	06:00 am											
	07:00 am											
Total Intake : Taken						**Total Output :** M-					U-	

Total 24 hrs. Intake		Total 24 hrs. Output	

Docu. No. : RCH /FRM / CLINICAL / 092

HNH-00003494 IP26-00006802
Mrs RAJASHREE
22-05-1991 35 Y 0 M 18 D (F)
Dr. SWAPNA SAMUDRALA

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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	

HNH-00003494 IP26-00006802
Mrs RAJASHREE
22-06-1991 35 Y 0 M 18 D (F)
Dr. SWAPNA SAMUDRALA

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NURSING CARE RECORD

Date: 10/4/26

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 – 8Pm	→ Assess the pt condition → monitor the vitals & record → Administration of medication → maintain I/O chart & record	8Am – 8pm	→ Assessed the pt condition → monitored the vitals & record → Administered medication → maintain I/O chart & record	Pt is stable	maintain I/O chart & record	Alekhya
Afternoon				DAY DUTY			
Night	8pm – 8Am	- Assess the pt. condition - Monitor vitals & record - Maintain I/O chart - Give medication 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	[illegible]

HNH-00003494 IP26-00006802
Mrs RAJASHREE
22-08-1991 35 Y 0 M 18 D (F)
Dr. SWAPNA SAMUDRALA

Patie

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							

HNH-00016480 IP26-00006808
Baby Of RAJASHREE
10-07-2026 0 Y 0 M 0 D 3 H (F)
Dr. DILNAAZ FAROOQUI

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CHECKLIST FOR THROMBOPHLEBITIS

10/7

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

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 : Amruth

Signature of Ward In Charge :

Signature : ..... Name : Balaraani

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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 : .....

HNH-00003494 IP26-00006802
Mrs RAJASHREE
22-06-1991 35 Y 0 M 18 D (F)
Dr. SWAPNA SAMUDRALA

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	10/7/26	10/7		Fall Risk Grading		
		Score	0	101				
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0	0	0		Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20	20	20		Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20	20				
		Signature						

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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PAIN ASSESSMENT FORM

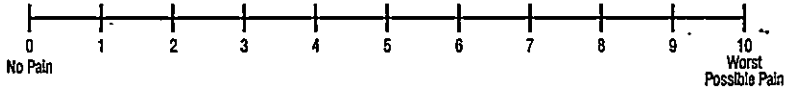
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7	2pm	0/10	N	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
10/7	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
11/7	6AM	0/10	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

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BRADEN 'Q' SCALE

					Date : 16/1D6 Time : 6	1D/3 /01		
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	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	[illegible]	[illegible]		

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

Docu. No. : RCH /FRM / CLINICAL / 119

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-00003494 IP26-00006802
Mrs RAJASHREE
22-06-1991 35 Y 0 M 18 D (F)
Dr. SWAPNA SAMUDRALA

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DRUG CHART

Date of Admission: 10/7/2021 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 :				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:				

Sign

VERIFIED BY : Name

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Mrs RAJASHREE
22-06-1991 35 Y 0 M 18 D (F)
Dr. SWAPNA SAMUDRALA

REGULAR PRESCRIPTIONS

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

Verified by Dr. Dhakshayani

DRUG : T. CEFIXIME

Dose	Route	Frequency	Start Date
200mg	PO	BD	10/7

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

Additional Instructions: FOR 5 days AFTER FOOD.

Daily Doctor's Endorsement by a Sign

Date	10/7	11/7
10AM	✓	
10pm		

Verified by Dr. Dhakshayani

DRUG : T. PANTOPRAZOLE

Dose	Route	Frequency	Start Date
40mg	PO	BD	10/7

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	10/7	11/7
8AM	X	
6pm		

Verified by Dr. Dhakshayani

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Date
1G 1G	PO	TID	10/7

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	10/7	11/7
6AM	X	
2pm		
10pm		

verified by Dr. Dhakshayani

DRUG : SYP. DUPHALAC

Dose	Route	Frequency	Start Date
15ml	PO	OD	10/7

Name & Signature of the Doctor Starting the Drugs: @

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	10/7
10pm	

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REGULAR PRESCRIPTIONS

Sheet No. ..... Weight ..... Ward .....

Verified by Dr. Dhakshayani

Signature .....

VERIFIED BY : Name .....

DRUG : OMN7 METRO-P

Dose	Route	Frequency	Start Dt.
Small amount	L/A	BD	10/7

Name & Signature of the Doctor Starting the Drugs: M Dhakshayani

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	10/7	11/7
Time	10AM	x

DRUG : 7. DICLOPENAC

Dose	Route	Frequency	Start Dt.
50mg	P/O	BD	10/7

Name & Signature of the Doctor Starting the Drugs: M Dhakshayani

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date	10/7	11/7
Time	10AM	✓

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

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																		
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																		

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

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Dr. SWAPNA SAMUDRALA

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
10/7	1pm	INJ CEFOTAXIME	1g (AST)	IV		Anju
10/7	1pm	INJ OXYTOCIN	10 Units	IM		Anju
10/7	1:10 pm	T. MISOPROST	600 mcg	PR		Anju
10/7	1pm	DICLOFENAC SUPPOSITORY	100mg	PR		Anju

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

Verified by Dr Dhakshayani

HNH-00003494
Mrs RAJASHREE
22-06-1991 35 Y 0 M 18 D (F)
Dr. SWAPNA SAMUDRALA

I.V. FLUIDS CHART

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

L		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
10/7		RINGER LACTATE + 10U OXYTOCIN	IV	Gml/h					
		STOP IV							

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

Patient Sticker

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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	TAB-IRON	1tab	P/O	OD	9/1/26	☐ C ☐ DC
2	TAB. CALCIUM	1tab	P/O	OD	9/1/26	☐ 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 : 10/1/26

Nurse Name & Signature: .....

Date & Time : .....

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PAI

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LABOUR

Labour: ☑ Spont ☐ IOL-PGE 1 ☐ E2 ☐ Others

Indications for IOL-Accel: ☐ None ☑ Oxytocin

Memb. Repture Type: ☐ SROM ☐ PROM ☑ ARM

Presentation: ☑ Vertex ☐ Breech ☐ Others

INTRA PARTUM COMPLICATION

Maternal: ☑ Nome ☐ Pyrexia ☐ HTN ☐ Others

Liquor: ☐ Adequate ☐ Oligo ☐ Poly ☑ Clear

☐ Blood ☐ Meconium ☐ Cord: Coil around neck Once

Shoulder Dystocia: ☐ Yes ☑ No

DELIVERY DETAILS

Anesthesia: ☑ None ☐ Epidural

Non-epi: ☐ Local ☐ Spinal ☐ General

Del. Type: ☑ SVD ☐ Asst. Breech ☐ Twins

AVD: ☐ Outlet ☐ Low Forceps ☐ Ventouse
☐ Trails of Forceps

Indications: .....

Application, Locking & Traction: .....

Duration of Instrumentation: .....

No. of Pulls: .....

Catherised : ☐ Yes ☑ No

Type: ☐ Fileys ☐ Plain

Perineum : ☐ Intact ☐ Episiotomy ☑ Tear 2° DT

Suture Material Used: Rapid Vicryl 2/0

STAGE III

Placenta: ☑ Normal ☐ Abnormal ☐ RP Clots
☐ CCT ☐ Retained ☐ MRP

PPH : ☐ Atomic ☐ Traumatic ☑ None

Lacerations: .....

Cervical: .....

Perineal: nil

Others: .....

Prophylaxis: ☑ Synocinon Prostodin

Blood Loss: N 300 ml

Blood Transfusion: Nil

Other Details (if any): Swab & needle count Obtained

Ractal Examination: Rectal mucosa intact.

Swab/Mops/Instruments count complete

DURATION OF LABOUR

1st Stage: ~3hr

2nd Stage: 30min

3rd Stage: 5min

Duration of Active Pushing: 5-10min

No. of VE'S: 4

BABY DETAILS

Gender: Female

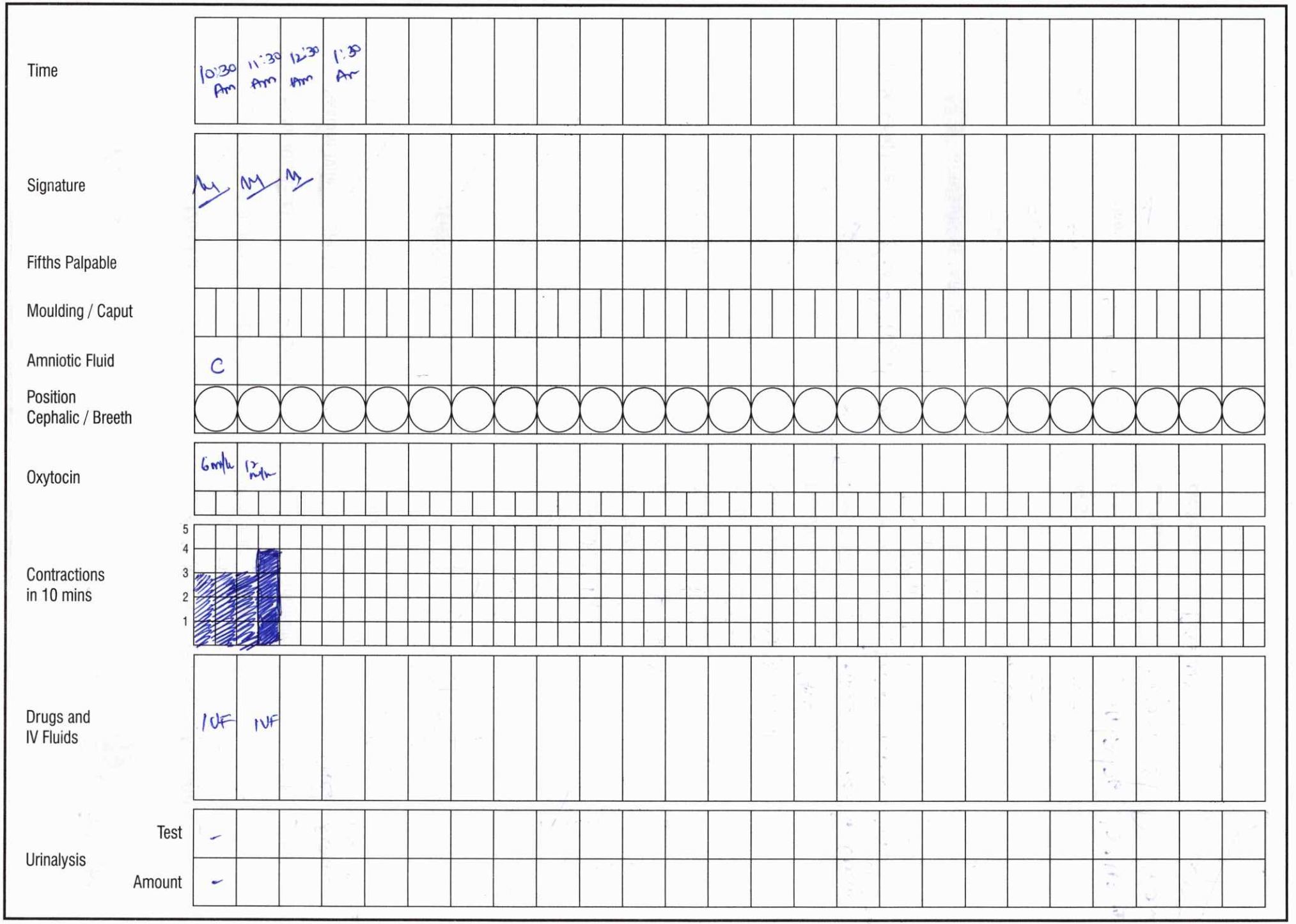
Weight: 3.22 kg

APGAR: 8,9

Date and Time of Delivery: 10/7/26, 12:43 pm

LW Doctor: Dr. Sowmya / Dr Manushi

LW Sister: Kasturi


Time
10:30 Am
11:30 Am
12:30 Am
1:30 Am
Signature
Fifths Palpable
Moulding / Caput
Amniotic Fluid
C
Position
Cephalic / Breeth
Oxytocin
6mU/L
12 mU/L
Contractions
in 10 mins
5
4
3
2
1
Drugs and
IV Fluids
IVF
IVF
Urinalysis
Test
-
Amount
-

PARTOGRAPH

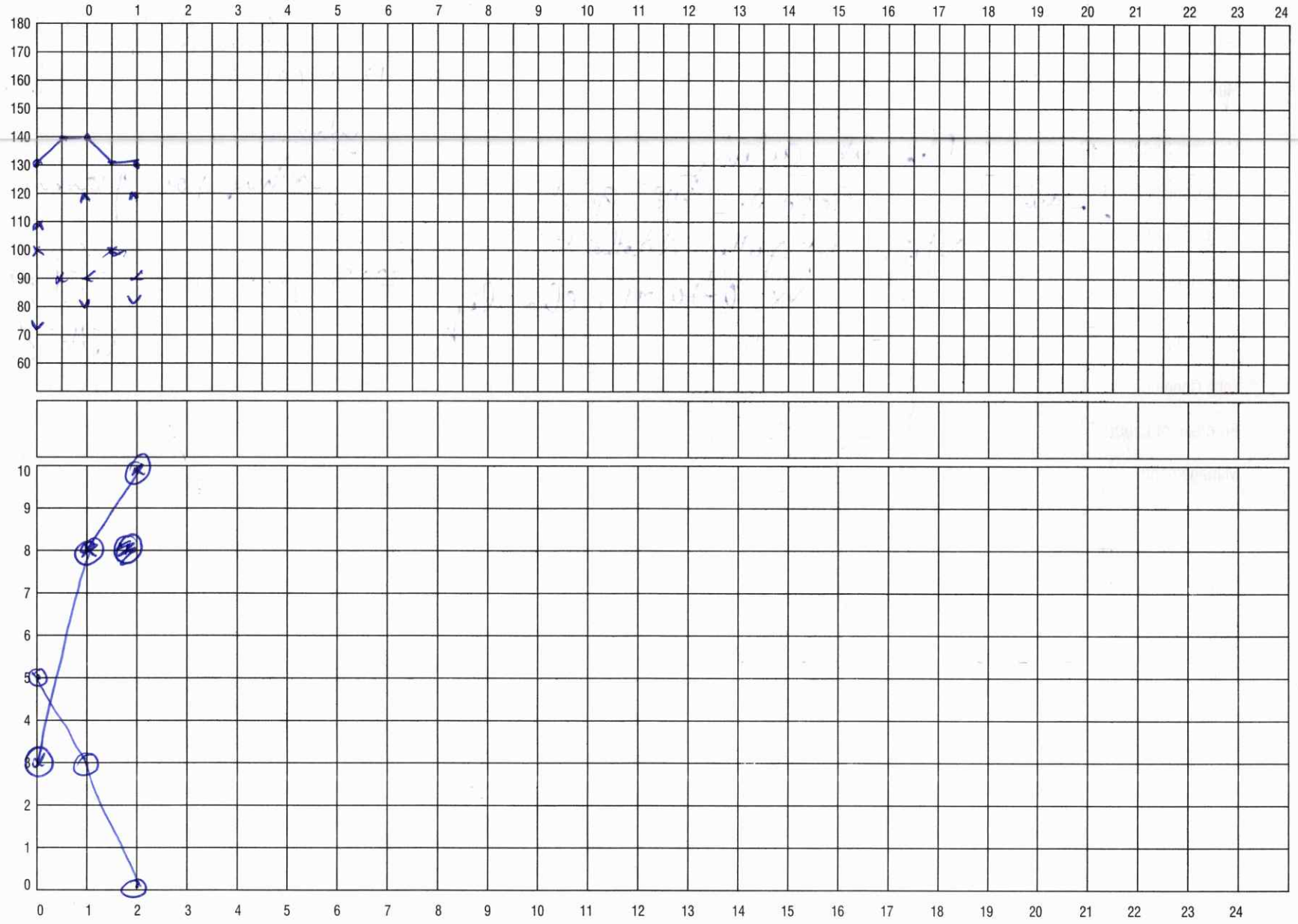
Name: Mrs Rajashree ..... Obstetrics Formula: G2P1L ..... Blood Group Type: A Rh+ve .....

Memb. Ruptured: **SROM** **PROM** **ARM** **Risk Factors:** .....

Fetal Heart ●

Maternal BP ↕

Maternal Pulse ×



Record of Labor:

Maternal Condition: } Fair
Fetal Condition: }

P/A ut Acting
Cephalic
FHS ✓✓

Ca. ~ 8 cm
Effaced
Vx @ 0 station

Adv
- Augmentation ☐ Oxytocin
- FHS monitoring
- WTF Progress of Labour.
- Reassess 8 os

Progress of Labor:

Management:

Time: 12:10 pm Signature: [signature]

Maternal Condition: } Fair
Fetal Condition: }

P/A - ut acting
Cephalic, HH - good
V/E - Cx fully dilated
Vx 0 to +1, Cha lig

Adv
- Allow for passive Descent

Progress of Labor:

Management:

Time: 12:30 pm. Signature: [signature]
(Dr. Imagwi S)

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: ..... Signature: .....

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: ..... Signature: .....

Maternal Condition:

Fetal Condition:

Progress of Labor:

Management:

Time: ..... Signature: .....

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 10/1/26

Baseline Information:

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

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

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

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

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

If yes , identify .....

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

..... Name of the Doctor: Dr Swathi

..... Time Notified: 9/10pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
—	—	—

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

Regular

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☑ No ☐ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

Infertility: ☑ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G 2 P 1 L ..... A .....

Previous LSCS: No

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: 97.1°F HR: 87bpm RR: 20bpm

BP: 110/70 Weight: ..... Height: ..... BMI: .....

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

Patient Sticker

PHYSICAL ASSESSMENT

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

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: ☐ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With ..... family 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: ..... Mrs. Rajasree .....

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: ..... AKHILS .....

Date & Time: ..... 10/7/26 .....

Mrs RAJASHREE IP26-00006802
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Patient Sticker

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 10 12 26 Time of Arrival: 10Am Time Seen by Nurse: 10AM

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

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

☐ Severe Pain / Moderate Pain ☐ Preterm rupture of Membranes / Leaking Water PV

☐ Bleeding PV: Slight / Heavy ☐ Preterm Labor/ Labor

☐ Decreased Fetal Movement ☐ Spontaneous Rupture of Membrane / Leaking Water PV

☐ No Fetal Movement ☐ Other Reason: ....

3) Vital Signs: Temperature: 97°F Pulse: 87bt RR: 20bat SpO$_2$: 99% BP: 110/70 Weight: ....

4) Gestational Criteria:

Gravida:	G 2	P 1	L	A

LMP: .... EDD: .... Gestational Age: 37+5 weeks

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)**

0 (No Pain — circled) 1 2 3 4 5 6 7 8 9 10 (Worst possible pain)

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

....

6) Past History: NIL

a) Surgeries: ....

b) Medical: .... NIL

Docu. No. : RCH /FRM / CLINICAL / 098 (P.T.O.)

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: 10 AM

Nurse Name : Akila Nurse Signature: .....

Date: 10/7/20 Time: 10 AM.

Patient Sticker

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 10/7/26 Time: 4:3pm

Origin: Indian Height: 15[illegible]Cms Weight: 80.6 kg BMI: ☐ ~ 26 kg/m² ☐ ~ 28 kg/m² ☐ ~ 30 kg/m²

Food Allergies: NO

Diagnosis: NVD

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

Signature: K.S

Name: Rajashwari

Date & Time: 10/7/26 ; 4:3pm

Dietician's

Signature:

Name: Sathwika.G

Date & Time: 10/7/26 ; 4:3pm

DIETARY NOTES

Date	Time	Notes	Sign

Patient Sticker

306

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CROSS CONSULTATION FORM

Doctor Name : Dr. Swapna Date : 10/7/26 Time : 4:5pm

Diagnosis : NVP

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 & Nipple
- Colostrum seen
- Aim for deep latch as demonstrated in cradle hold / cross cradle
- Demand feeding not exceeding 2½ hours as per early hunger cues.
- make baby suck for 15-20 mints on each side.
- baby is not sucking continuously, starting to suck with strong stimulation.

Consultant :

Name : Sathwika.G Signature : S Date & Time : 10/7/26, 4:5pm

HNH-00003494 IP26-00006802
Mrs RAJASHREE
22-06-1991 35 Y 0 M 18 D (F)
Dr. SWAPNA SAMUDRALA

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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:
   - ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes: .....

Continuity of Care: Date: 10/7/26

→ Assess the baby condition
→ monitor the vitals & record
→ DBF 2nd hrly & burping
→ Maintain Rec chart & record

Handover given by .....

Signature .....

Date & Time: .....

Handover taken by .....

Signature .....

Date & Time: .....

HNH-00003494 IP26-00006802
Mrs RAJASHREE
22-06-1991 35 Y 0 M 18 D (F)
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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	19/7 M6					
	Medical Condition (Any special condition to be noted):	Soft diet					
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:	98.F					
	Res:	20					
	SpO_2:	99%					
	Pulse:	82					
	BP:	106/71					
	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 :		Mastu					
Signature :							
Date:		10/7/26					
Time:		8 pm					
Taken Over By Name :							
Signature :							
Date:							
Time:							

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:							

INFORMED CONSENT FOR VAGINAL BIRTH

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Patient Name : Mrs Rajashree UHID No : HEN0000034994

Gender: ☐ Male ☑ Female Date : 10/7/2026 Time : .....

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr Swapna

Consentee :

Signature : Rajashree

Name : Mrs Rajashree

Date & Time : 10/7/2026 @ 10:30 Am

Patient Attendant :

Signature :

Name : K Srikanth

Relationship with Patient: Husband

Date & Time : 10/7/2026

Witness :

Signature : N. Chandra Kala

Name : Chandra Kala.

Date & Time : 10/07/2026 @ 11:00am

Doctor (who is taking the consent) :

Signature :

Name : Dr Manisha

Date & Time : 10/7/2026 @ 10:30 Am