

**Name** Mrs N SASI PRIYA **UHID** HNH-00000539  
**Father/Guardian** Mr N SESA SAI PRASAD **Age/Gender** 27 Y 6 M 13 D/ Female  
**Address** MEGHANA ALLURI HOMES, APHB Colony Moulali, Hyderabad, Telangana, INDIA, 500040  
**IP No** IP26-00006747 **Admission Date** 05-07-2026  
**Ref Doctor** Self.  
12.07.2026

### DISCHARGE SUMMARY

**Consultant:**

Dr. RAJANI KUMARI  
MD (OBS & GYN)

**Diagnosis: G4P1L1A2 AT 33<sup>+</sup>4 WEEKS WITH THREATENED PRETERM LABOUR FOR OBSERVATION**

**EMERGENCY LOWER SEGMENT CAESAREAN SECTION DONE ON 09.07.2026**

**History:**

LMP: 16.11.2025  
EDD: 23.08.2026

Obstetric formula: G4P1L1A2  
Gestation at admission: 33 weeks

**Obstetric History:**

G1 -2022- FTND, Female, B.wt-2.75kg, 3years, A&H

|       |                  |                |              |
|-------|------------------|----------------|--------------|
| Name  | Mrs N SASI PRIYA | UHID           | HNH-00000539 |
| IP No | IP26-00006747    | Admission Date | 05-07-2026   |

G2- 2024- Missed abortion at 4-5weeks,MERPC done  
G3- June 2025- Missed abortion at 4-5 weeks, MERPC done  
G4- Present pregnancy, Spontaneous conception.

**Medical History:** Nil  
**Surgical History:** Nil

**Family History:** Nil  
**Allergies:** Allergic to Cefotaxime

**Antenatal Details:**

Mrs N SASI PRIYA was booked to Rainbow hospital at 5<sup>+</sup>weeks of gestation. She had regular antenatal checkups and investigations as advised. NT scan normal. FTS low risk. TIFFA scan normal. Fetal growth monitoring done by serial growth scans. She received antenatal steroid coverage (Inj.Betamethasone 12mg 2 doses ,24 hours apart) on 19.06.2026 and 20.06.2026. Scan done on 4.07.2026 showed single live fetus with cephalic presentation at 32<sup>+</sup>6weeks, EFW-2.2kg (63%), AC-78%, AFI-16.5cm, Placenta-posterior high with normal dopplers. She was admitted at 33 weeks in view of complains of pain abdomen

**Investigations:** Enclosed.  
Blood group: "A" Positive

**Management:**

**Course in hospital and Delivery Details:**

At admission on clinical examination the vitals were stable, uterus was mild acting, cervix was uneffaced and Os closed. Fetal well being was confirmed by an admission CTG which was found to be reactive. CBP,CRP,CUE done and

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traced. She was started on IV Antibiotics. She was started on Tocolysis with C.Depin 10mg TID for 48 hours. Fetal surveillance done by 4th hourly NST. She had h/o lip swelling with Inj.Cefotaxime 1g. She was decided for emergency C-section in view of prodromal preterm labour, prepared with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Patient shifted to theatre.

### Surgery Notes:

Under spinal anesthesia she was painted and draped as per hospital protocol. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 400 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

\* **Cord cell collection done.**

\* **Uterine hyperemic (mid segment and lower segment) vascular.**

\***True knot present**

### Delivery Details :

Date : 09.07.2026

|       |                  |                |              |
|-------|------------------|----------------|--------------|
| Name  | Mrs N SASI PRIYA | UHID           | HNH-00000539 |
| IP No | IP26-00006747    | Admission Date | 05-07-2026   |

Time of Delivery: 07:12am  
Type of Delivery: Emergency lower segment caesarean section  
Indication : Prodromal Preterm labour  
Anaesthesia : Spinal

**Baby Details:**

Date : 09.07.2026  
Time : 07:12am  
Sex : Male  
Weight : 2.40kg  
Apgar : 7,9  
Gestational Age: 33<sup>+4</sup> weeks  
NICU Admission: Yes, Preterm

**Post-Operative Notes:**

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

**Advice:**

1. Tab. Augmentin 625mg twice daily till 15.07.2026 (9am-9pm) after food.



|              |                  |                       |              |
|--------------|------------------|-----------------------|--------------|
| <b>Name</b>  | Mrs N SASI PRIYA | <b>UHID</b>           | HNH-00000539 |
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2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 13.07.2026 (8am-2pm-10pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 13.07.2026 (9am-3pm-11pm) after food.
4. Tab. Pantop 40mg twice daily till 15.07.2026 (7am-7pm) before 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 for after food.
7. Nebasulf Powder for local application.
8. Inj.Clexane 40mg (Enoxaparin) subcutaneously once daily over thigh at 8pm till 11.07.2026

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. RAJANI KUMARI** after **1 week** on 20.07.2026 at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

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

Name

Mrs N SASI PRIYA

UHID

HNH-00000539

IP No

IP26-00006747

Admission Date

05-07-2026

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

The content of the patient discharge summary, medication, food & drug interaction, care to be provided at home, nutrition, 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 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



Consultant:

### ADMISSION SHEET

#### Registration Details :

Admission No : IP26-00006747      Admit Date : 05-Jul-2026      Admit Time : 01:07 PM      UHID : HNH-00000539

#### Patient Details :

|              |                                                                                |                |                           |
|--------------|--------------------------------------------------------------------------------|----------------|---------------------------|
| Patient Name | : Mrs N SASI PRIYA                                                             | Age            | : 27 Y 6 M 9 D            |
| Guardian     | : Mr N SESA SAI PRASAD                                                         | DOB            | : 26-12-1998              |
| Gender       | : Female                                                                       | Religion       | :                         |
| Occupation   | :                                                                              | Martial Status | :                         |
| Address (H)  | : MEGHANA ALLURI HOMES APHB Colony<br>Moulali Hyderabad Telangana INDIA 500040 | Phone No       | : 8019733546              |
|              |                                                                                | E-mail         | : SASIANNADATHA@GMAIL.COM |

#### Admission Details :

Bed Type : TWIN SHARING      Bed No : LDR-416      Ward Name : 4F -OT  
Room No : LDR-416      Admission Type : First Visit

#### Contact Details :

Name : Mr N SESA SAI PRASAD      Relationship : Husband  
Contact Address : MEGHANA ALLURI HOMES APHB Colony  
Moulali Hyderabad Telangana INDIA 500040      Phone No : 8019733546

  
Signature

#### Doctor Details :

Doctor Name : Dr. RAJANI KUMARI      Specialisation : OBSTETRICS AND GYNECOLOGY  
Referral Doctor : Self.      Phone No :  
Co-Consultant :

#### Payment Details :

Deposit Amount : 20000.00  
Payment Mode : DC/CC Card      Payor Name : SELFPAY



## ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_  
UHID No. : \_\_\_\_\_  
Date of Admission : \_\_\_\_\_  
Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

HNH-00000539 IP26-00006747  
Mrs N SASI PRIYA  
28-12-1998 27 Y 6 M 9 D (F)  
Dr. RAJANI KUMARI

tant: \_\_\_\_\_ Dept : \_\_\_\_\_  
f Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

## WARD TRANSFERS

| Date   | Time   | From     | To       | Signature of Nurse |
|--------|--------|----------|----------|--------------------|
| 9/7/26 | 6:57Am | Pre Post | OT       | Rajathy/Karuna     |
| 9/7/26 | 8Am    | OT       | Pre Post | Karuna/Mounika     |
| 9/7/26 | 2pm    | MICU     | OT       | Mounika            |
|        |        |          |          |                    |
|        |        |          |          |                    |

## Cross Consultation Visit

|    | Doctors Name         | Date   | Order No. | Signature                     |
|----|----------------------|--------|-----------|-------------------------------|
| 1  | Dr. Srimadana        | 5/7/26 | 210924    | Chudp                         |
| 2  | neonatal counselling |        |           |                               |
| 3  | (Others)             |        |           | Cross checked by<br>1st floor |
| 4  |                      |        |           |                               |
| 5  |                      |        |           |                               |
| 6  |                      |        |           |                               |
| 7  |                      |        |           |                               |
| 8  |                      |        |           |                               |
| 9  |                      |        |           |                               |
| 10 |                      |        |           |                               |



# INVESTIGATIONS

| Date   | Investigations          | Order No.  | Signature |
|--------|-------------------------|------------|-----------|
| 5/7    | CBP, CRP, CUG           | HN26011017 | Lui       |
| 5/7    | NST (1:50AM)            | 008041     | Lui       |
| 5/7    | NST (2)                 | 008049     | Lee       |
| 5/7    | NST (3)                 | 8046       | new       |
| 6/7/26 | NST (4)                 | 8050       | Moon      |
| 6/7/26 | NST (5)                 | 8051       | Moon      |
| 6/7    | NST - (6)               | 8063       | (2)       |
| 6/7    | Crossed beam<br>Doppler |            | (2)       |
| 6/7    | AFI 8 Doppler Scan      | R2626-00   | (2)       |
|        |                         | 8088       |           |
| 6/7/26 | NST - (7)               | 8104       | Li        |
| 6/7/26 | NST - (8)               | 8113       | Li        |
| 6/7/26 | NST - (9) 2:20pm        | 8114       | Li        |
| 7/7/26 | NST - (10) 2:20pm       | 8115       | Li        |
| 7/7/26 | NST - (11)              | 008116     | Lui       |
| 7/7    | NST - 12                | 8146       | (2)       |
| 7/7    | NST - 13                | 8147       | (2)       |
| 7/7    | NST - (14)              | 8148       | (2)       |
| 7/7    | NST - (15)              | 8150       | Li        |
| 8/7    | NST - (16)              | 8153       | Li        |
| 8/7    | NST - (17)              | 8193       | (2)       |
| 8/7    | NST - (18)              | 8199       | (2)       |

crossed



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# PROCEDURE

| Date   | Procedure            | Quantity | Order No. | Signature |
|--------|----------------------|----------|-----------|-----------|
| 5/7    | TV placement         | ①        | 210878 ✓  | Surjathas |
| 9/7/26 | catheterisation      | ①        | 2114 ✓    | mm        |
| 9/7/26 | PA <sub>c</sub> — IP | ①        | 2120 ✓    | meri      |
| 9/7    | NHA                  | ①        | 2180 ✓    | ①24       |
|        |                      |          |           |           |
|        |                      |          |           |           |
|        |                      |          |           |           |
|        |                      |          |           |           |
|        |                      |          |           |           |
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|        |                      |          |           |           |
|        |                      |          |           |           |
|        |                      |          |           |           |

cross checked done by  
physician

## ANY OTHER INFORMATION

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Date :

Time :

Prepared By :

|             |              |                   |                    |
|-------------|--------------|-------------------|--------------------|
| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|             |              |                   |                    |

2

## ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_  
UHID No. : \_\_\_\_\_  
Date of Admission: \_\_\_\_\_  
Room / Bed No : \_\_\_\_\_ Ward : \_\_\_\_\_ Suggested Billable bed type : \_\_\_\_\_

HNH-00000539  
Mrs N SASHI PRIYA  
26-12-1998  
Dr. RAJANI KUMARI  
27 Y 6 M 13 D (F)  
IP26-00006747

Attendant: \_\_\_\_\_ Dept : \_\_\_\_\_  
of Discharge : \_\_\_\_\_ Time: \_\_\_\_\_

## WARD TRANSFERS

| Date | Time | From | To | Signature of Nurse |
|------|------|------|----|--------------------|
|      |      |      |    |                    |
|      |      |      |    |                    |
|      |      |      |    |                    |
|      |      |      |    |                    |
|      |      |      |    |                    |

## Cross Consultation Visit

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

[illegible]

|               |  |
|---------------|--|
| Cross checked |  |
| by synth      |  |

### MEDICAL EQUIPMENT (WARD & ICU)

[illegible]



**PROCEDURE**

| Date | Procedure | Quantity | Order No. | Signature |
|------|-----------|----------|-----------|-----------|
|      |           |          |           |           |
|      |           |          |           |           |
|      |           |          |           |           |
|      |           |          |           |           |
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|      |           |          |           |           |
|      |           |          |           |           |

**ANY OTHER INFORMATION**

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.....

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.....

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Date :

Time :

Prepared By :

|             |              |                   |                    |
|-------------|--------------|-------------------|--------------------|
| Staff Nurse | Shift / Ward | Billing Assistant | Billing Supervisor |
|             |              |                   |                    |



## IF ADMISSION SHEET FOR OBSTETRICS

### Presenting Complaints

clb pain abdomen

LMP: 16/11/25

EDD:

Corrected EDD: 23/8/26.

GA: 38 wks

Obstetric Formula: G<sub>4</sub>P<sub>4</sub>A<sub>2</sub>.

Menstrual History: Regular: ☒ Yes ☐ No

### Obstetric History:

1<sup>st</sup> preg (2022) :- FT-ND / Female / 2<sup>nd</sup> kg / 2<sup>nd</sup> kg / 3 yrs.  
 2<sup>nd</sup> preg - Missed abortion, medically terminated (4 wks)

### Present Pregnancy Record:

3<sup>rd</sup> preg - Missed Abn / 4 wks (June 2025)

4<sup>th</sup> preg - Sp. conceptus. Booked @ 5<sup>th</sup> wks

### RISK FACTORS:

TIFFA (N), Growth (N)  
 Steroids (19/6 & 20/6)

- Preterm.

### Obstetric Examination

Fundal Height: Uterus 32 wks

Ut. Activity: ☐ Relaxed ☒ Mild ☐ Mod ☐ Severe

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☒ Cephalic ☐ Breech ☐ Others

Head Fifths Palpable: 5/5

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

### Per Speculum Examination - N/A

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

### Vaginal Examination

Cervix: ☒ Long ☐ Partially effaced ☐ Effaced

Os: Closed Dilated

Membranes: ☐ Present ☐ Absent

Liquor: ☒ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☒ Vertex ☐ Breech ☐ Others

Sutton: ☒ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☒ Adequate ☐ Doubtful

Height: ..... cm

Weight: ..... kg

Allergies: Nil

Breast: ☐ Normal ☐ Abnormal

### General Examination:

Consciousness: (+) Pallor: (-)

Icterus: (-) Edema: (-)

Temp: Afebrile PR:

BP: 101/11/75 mmHg DTR: (N)

CVS: S<sub>1</sub>S<sub>2</sub> (+) RS B/LNVBS

Liver/Spleen: (N) Urine Output: (N)

### DIAGNOSIS

G<sub>4</sub>P<sub>4</sub>L<sub>1</sub>A<sub>2</sub> | 33 wks. | preN NVD.  
 in threatened  
 preterm labour



|                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Family History:</p> <p>Nil.</p>                                                                                                                                                                                                                                                                                                                    | <p>Surgical History:</p> <p>—</p>                                                                                                                                                                                                          |
| <p>Medical History:</p> <p>Nil</p>                                                                                                                                                                                                                                                                                                                    | <p>Medication History:</p> <p>On T. Fe / T. Ca</p>                                                                                                                                                                                         |
| <p>Plan of Care: <u>Reinvestigation:</u></p> <p>Blood Group - "A positive"</p> <p>Hb - 11.8<br/>         Plt - 2.6 Lakh<br/>         WBC - 10.1 b. } 5A</p> <p>HIV<br/>         HbsAg<br/>         RPR } NR.</p> <p>USG (u/l/26)</p> <p>@ SLF, Cephalic, PL-P/H</p> <p>AFI - 16.5</p> <p>EFW - 2.2 kg (63%)</p> <p>AC - 78%</p> <p>Dopplers - (N)</p> | <p>Investigations: <u>Plan of care:-</u></p> <p>Observation x 2 hrs</p> <p>- Inj. Tramadol 100mg stat</p> <p>- Inj. Abx x 2 hrs</p> <p>- CBP, CRP, CUE</p> <p>- NGT every 4th hourly</p> <p>- FHR monitoring</p> <p>- NICU counselling</p> |

Dr. RAJANI KUMARI  
 Reg. No: 11705

Doctor Name: Dr. Venu

Signature: [Signature]

Date & Time: 5/1/26 @ 12pm

Consultant Name: Dr. Rajani Kumari

Signature: [Signature]

Date & Time: 5/1/26 @ 12pm





## IP ADMISSION SHEET FOR OBSTETRICS

### Presenting Complaints

Admitted for LMS  
Pain Abdomen: 4 day

Obstetric Formula:

G<sub>4</sub>P<sub>1</sub>L<sub>4</sub>A<sub>2</sub>

Obstetric History:

G<sub>1</sub> - 2022 - FNO/FA / 2.7kg / 14th  
G<sub>2</sub> - MZPC - mmed Abn (4-5<sup>th</sup> syn)  
G<sub>3</sub> - 2025 - mmed Abn 4-5 (wk)

Present Pregnancy Record:

G<sub>4</sub> - PP, SPN Conception  
Booked @ SWHS

NT(N) : FHS LR : 7/2/24(N)

RISK FACTORS: Antenatal Steroid

Courage - (14/6-28/6) done.  
NICU Consultancy done @  
5/7/2024

-Threatened Preterm.

Height: ..... cm

Weight: ..... kg

Allergies: ~~Nil~~ Cefotaxime (mid swelling lips)

Breast: ☒ Normal ☐ Abnormal

General Examination: (+)

Consciousness: (+)

Icterus: (-)

Temp: Afebrile

BP:

CVS:

Liver/Spleen: (-)

Pallor: (-)

Edema: (-)

PR:

DTR: (+)

RS 302 (+)

Urine Output: Adeq

LMP: 16/11/2025

EDD:

Corrected EDD: 23/8/2026

GA: 33<sup>+</sup>4 wk

Menstrual History: Regular: ☐ Yes ☐ No

### Obstetric Examination

Fundal Height: w ~ 32 wk

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

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

### Vaginal Examination

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed \_\_\_\_\_ Dilated \_\_\_\_\_

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

### DIAGNOSIS

G<sub>4</sub>P<sub>1</sub>L<sub>4</sub>A<sub>2</sub> / 33<sup>+</sup>4 wks / Painless NVD / Threatened Preterm  
for BL LSCS



Family History:

NL

Surgical History:

NL

Medical History:

NL

Medication History:

7 Iron / Calcium

Plan of Care:

Admission

NBM

Informed consent

Path prepare

Drugs as charted

Inform Receptor / Anesthetist

Check for Blood availability

Foley's Catheterization

Shift to OT on call

Investigations:

BCG - A +ve

5/7/2020

+Pb - 11.8

WBC - 10.1

pH - 7.26

+Pb  
 +Pb  
 +Pb } AIR  
 +Pb

USC ( 4/7/2020 )  
 SCWP / 2 wk / Ue

PL - PIV AP2 - 16.5cm

EFW - 2.2kg (G3X) AC - 78%

Dopple @

AP2 / Dopple (6/7/2020) @ 33<sup>rd</sup> wk

AP2 - 16.7cm ; Dopple @

CEL - 33mm (7US) - no funneling

Doctor Name: Dr. Morinda

Signature:

Date &amp; Time: 9/7/2020 @

Consultant Name: Dr. Rajani Kumari

Signature:

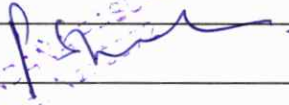
Date &amp; Time: 9/7/2020 @





M. Sasi priya

### PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time     | Progress Notes                                                                      | Doctor's Order                                                                                                    |
|-----------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| 07/26<br>3:37pm | Dr. Spaulding.                                                                      |                                                                                                                   |
|                 | >37 wks. - normal birth                                                             | 34 wks<br>Ext. wt - 2.2 - 2.4 kgs<br>Steroids ✓<br>Doppler normal                                                 |
|                 | 34 wks - Late preterm                                                               |                                                                                                                   |
|                 | Breaking support. - <u>NIV / CPAP</u>                                               |                                                                                                                   |
|                 | <u>HRM Rsp</u> - monitoring                                                         |                                                                                                                   |
|                 | Feeds - <u>intolerance</u> - 2ml. - cross                                           |                                                                                                                   |
|                 | <u>Abr</u> - if needed - to cover any infection.                                    |                                                                                                                   |
|                 | <u>NIV</u> - 4 to 5 days                                                            | Feed - 2-3 days<br><u>NIV</u> okay                                                                                |
|                 |  | <br>DR. SPaulding<br>HOSPITAL |

### Patient Sticker



### PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



## GRESS NOTES AND DOCTOR'S ORDER

| Date & Time                              | Progress Notes                                                                                                                                                                                                                                   | Doctor's Order                                                                                                                                                                                                                                        |
|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                          | <u>L1 B. Dr. Swathi H.V.</u>                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                       |
| <u>5/1/2026</u><br>4 PM                  | - G/P/L/A, prev NVD @ 33 wks / TPL<br>clo <del>at</del> back pain<br>→ Abdominal pain subsided                                                                                                                                                   |                                                                                                                                                                                                                                                       |
| <u>5/1/2026</u><br>2nd trimester<br>Post | O/E: P-88 bpm<br>BP → 100/80.<br>PA: ut 32-34 wks<br>ceph.<br>Relaxed.<br>HE: NAD                                                                                                                                                                | <u>Advice:</u><br>→ JTP pain / leakage / bleed pr<br>→ NST 4 wly.<br>→ In Analgesics<br>→ Inform SOS<br>→ NICE counselling to be done.                                                                                                                |
| <u>5/1/26</u><br>5:30 PM                 | <u>c/s/B Dr. Veno</u><br>G/P/L/A <sub>2</sub> / Prev NVD / 33 wks / TPL<br>- clo abd. pain-subsidied (suprapubic)<br>Back ache (+)<br>NST-Proactive O/E ac-fair, Afebrile<br>vitals-stable<br>P/A- ut ~ 32-34 wks<br>Relaxed<br>Cephalic, FH (+) | <u>5/1/26</u><br>Hb-11.8.<br>Plt-2.6 Lk<br>WBC-10.1 K<br>COE-Rus cells-6-8<br>Leucocytes (+)<br>CRP-22 ↑<br>Adv:<br>- Soft diet<br>- IV Abx to continue.<br>- NST 4th hourly<br>- For w/f leakage pr / passage of show<br>bleeding pr<br>- Inform SOS |



| Date & Time    | Progress Notes                                                                                                                                                                                                                                                            | Doctor's Order                                                                                                                                                                            |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 26<br>30 PM    | cls/B Dr. Veena -- cl/D/w Dr. Rajani Kumari<br><br>Gestational Age 33 wks / TPL<br>Pt is stable,<br>clo pain abd. ↑ sed<br>o/e Gc-fair<br>BP-116/70 mmHg<br>PR-76 bpm<br>P/A-Ut ~32 wks-<br>FHS(+) Cephalic<br>S/FH palpable<br>P/v-Gc os closed, soft<br>can Vx=high up. | Adv<br>- Soft diet<br>- Vital monitoring<br>- NST 4th hourly<br>- FHR 2nd hourly<br>- w/b bleeding P/v, leaking P/v<br>- Passage of show.<br>- Inform SOS<br>- Tocolysis (Depin 10mg TID) |
| 27<br>Reactive | cls/B Dr. Veena<br><br>Gestational Age 33+1 wks / TPL<br>No clo, pain subsided<br>o/e Gc-fair, Afebrile<br>Vitals-stable<br>P/A-Ut ~32-34 wks<br>FHS(+) Cephalic<br>Irritable.                                                                                            | Adv<br>- Soft diet<br>- Vital monitoring<br>- NST 4th hourly<br>- FHR 2nd hourly<br>- w/b Inform SOS.                                                                                     |





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## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time         | Progress Notes                                                                                                                                                   | Doctor's Order                                                                                                                                                                                                                                                              |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 6/1/26<br>6AM       | cls/B Dr. Veena<br>G4P1L4A2   33 <sup>+</sup> wks   TPL                                                                                                          |                                                                                                                                                                                                                                                                             |
| NST-Positive        | <p>PA is stable, Nucleo</p> <p>o/c GC-fair</p> <p>BP-90/57mmHg</p> <p>PR-78bpm</p> <p>p/A - Ut 32-34wks</p> <p>FHS ⊕, Irregular</p> <p>Cephalic</p> <p>Plu -</p> | <p>Adv</p> <ul style="list-style-type: none"> <li>- Soft diet</li> <li>- Vital monitoring</li> <li>- NST 4th hourly</li> <li>- FHR 2nd hourly</li> <li>- w/f bleeding Plu, leaking Plu, passage of show</li> <li>- Inform SCS</li> </ul>                                    |
| 6/1/2026<br>10:00am | cls/by Dr. Naveena<br>G4P1L4A2 with 33wks 1day with TPL                                                                                                          |                                                                                                                                                                                                                                                                             |
| NST-Positive        | <p>o/c GC-fair</p> <p>Alebrile</p> <p>Vitals-stable</p> <p>PA: ut 30-32wks</p> <p>FHR ⊕</p> <p>mild Acting</p> <p>Cephalic</p>                                   | <p>Adv</p> <ul style="list-style-type: none"> <li>- Soft diet</li> <li>- Adequate hydration</li> <li>- NST 4th hourly</li> <li>- strict FHR monitoring 2hrly</li> <li>- w/f Pain abdomen / PV leak / PV bleeding</li> <li>- Monitor Vitals</li> <li>- Inform SCS</li> </ul> |
|                     | Adv<br>Growth Scan + Doppler<br>AFI                                                                                                                              | Dr. Naveena                                                                                                                                                                                                                                                                 |

| Date & Time        | Progress Notes                                                                                                                                                                                                                    | Doctor's Order                                                                                                                                                                                                                                                                                    |
|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 6/7/2026<br>3:00pm | <p>cls by Dr Naveena</p> <p>OLE GC - fair</p> <p>Alebnile</p> <p>Vitals - stable</p> <p>PA: ut 30-32wks</p> <p>1-2clb-15" / 16"</p> <p>Cephalic</p> <p>FHR (+) 142bpm</p>                                                         | <p>Adv</p> <ul style="list-style-type: none"> <li>- Soft diet</li> <li>- Adequate hydration</li> <li>- drugs as charted</li> <li>- LLP</li> <li>- NST - qthhrly</li> <li>- w/ F PK leak</li> <li>- PR bleeding</li> <li>- Pain abdomen</li> <li>- Monitor Vitals</li> <li>- Inform SOS</li> </ul> |
| 6/7/2026<br>5pm    | <p>cls by Dr Mansha</p> <p>Gy 6/42 / 33<sup>rd</sup> wk / Threatened Preterm</p> <p>OLE fair - Alebnile</p> <p>vitals stable</p> <p>PA ut ~ 30-32wks</p> <p>Cephalic : FHR 140</p> <p>mild Acting</p> <p>1-2C / 20-25" / 10mm</p> | <p>Adv</p> <ul style="list-style-type: none"> <li>- Soft Diet / Adeq hydration</li> <li>- Drugs as charted</li> <li>- NST qth hourly / FHRs 2nd hourly</li> <li>- W/ F Spont Progress of labor</li> <li>- Monitor vitals</li> <li>- Inform SOS</li> <li>- Fast End elwan</li> </ul>               |
| (NST - Reactive)   | <p>AP2 / Dyp (6/7/2026) → 33<sup>rd</sup> wk / AP2 - 16.7cm</p> <p>Dyp 16 / CCL - 33mm - no funneling</p>                                                                                                                         | <p>MP<br/>Omar</p>                                                                                                                                                                                                                                                                                |



HNH-00000539

IP26-00006747

Mrs N Sasi Priya

28-12-1998

27 Y 6 M 9 D

(F)

Dr. RAJANI KUMARI



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## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time      | Progress Notes                                                                                                                                                                                   | Doctor's Order                                                                                                                                                                                            |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 6/7/26<br>8:20pm | <p>C/O pain on &amp; off<br/>P/m well<br/>GC fair/green<br/>Vitals (N)<br/>PA: ut irritabile<br/>cephalic<br/>FHR good<br/>PV: Cx: long, particular<br/>1cm, No show<br/>muc (⊕)<br/>Vx: 3 -</p> | <p>blood stained discharge<br/>NOB: Excessive movements<br/>undefined baseline<br/>↓<br/>to repeat in 1hr</p> <p>Ramya<br/>Dr. Ramya Theja<br/>Consultant Obstetrics and Gynecology<br/>Reg. No: 1458</p> |
| 7/7/26<br>1AM    | <p>No complaints<br/>GC fair/green<br/>Vitals (N)<br/>PA: ut relaxed<br/>cephalic<br/>FHR (⊕)</p>                                                                                                | <p>Dr. Ramya Theja<br/>Consultant Obstetrics and Gynecology<br/>Reg. No: 1458<br/>Ramya Theja</p>                                                                                                         |



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time      | Progress Notes                                                                             | Doctor's Order                                                                                                                            |
|------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| 7/7/26<br>6 AM   | No Complaints<br>pain on & off<br>4c fairly active<br>vitals (m)<br>PA: ut relaxed<br>ceph |                                                                                                                                           |
| 3:30 PM          | ceph (A)<br>Pur (A)                                                                        | Dr. Kadiyala Ramana Reddy<br>Consultant Obstetrician<br>Reg. M.S. (Obstetrics)<br>Dr. Ramana Reddy                                        |
| 7/7/2026<br>9 AM | Culb & Membrs<br>Gy P/LA / 33 <sup>rd</sup> wk / TPL                                       |                                                                                                                                           |
|                  | CC For Afebrile<br>vitals stable<br>P/A ut relaxed<br>ceph<br>Fns RR                       | Adh<br>- Regular Diet / Adeq Hydr<br>- Foot End Elevation<br>- NST uterine hourly<br>- Fns (m) 2nd hourly<br>- W/F vitals<br>- Inform SAs |
|                  |                                                                                            | ag<br>Dr. Ramana Reddy                                                                                                                    |





## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes                                                     | Doctor's Order                       |
|-------------|--------------------------------------------------------------------|--------------------------------------|
|             | C/Sib Dr Rajani Mann                                               |                                      |
|             | Gy P. 4 A <sub>2</sub> / 33 <sup>12</sup> wks / Threatened Preterm |                                      |
| 7/12/2020   |                                                                    |                                      |
| 1pm         |                                                                    | Ach                                  |
|             | GC - Low Apechne                                                   | - PC Enema Start                     |
|             | Vitals Stable                                                      | - Regular Diet / Adeq Hydrate        |
|             | P/A UA ~ 30 sec                                                    | - Foot End elevation                 |
|             | Cephalexin : FNS @                                                 | - NST 4th hourly / 2nd hourly        |
|             | Irritable                                                          | - Tab Paracetamol 1g SOS             |
|             | PV Ext os open / Pctoulous                                         | - y Pain Continuous → T10 )          |
|             | Int os closed                                                      | - NST 2 vitals / FNS                 |
|             | Ex 3 1/4" long                                                     | - Inform Son                         |
|             | Vx - 3                                                             |                                      |
|             | Rectum loaded                                                      |                                      |
|             |                                                                    | Dr. RAJANI KUMARI<br>Reg. No. 111705 |
|             | Stop 1076mm / PCM 10                                               |                                      |
|             | [Can Shift to Room (if) Pain Subsides]                             |                                      |
|             | by evening                                                         |                                      |
|             | [Allergic to Cefotaxime<br>(child swells to upper lip)]            |                                      |



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time       | Progress Notes                                                                                                                                                                                              | Doctor's Order                                                                                                                                                                                                                                                        |
|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 7/12/26<br>4pm    | <p>clt/b Dr. Veena</p> <p>G/P/GA2 / 33<sup>+</sup> wks / TPC</p> <p>clt pain abdomen (+)</p> <p>clt GC fair</p> <p>Vitals - stable</p> <p>PA - ut - 32-34 wks</p> <p>Cephalic, Irritable</p> <p>FHR (+)</p> | <p>Adv</p> <ul style="list-style-type: none"> <li>- Soft diet</li> <li>- NST 4th hourly</li> <li>- FHR 2nd hourly</li> <li>- Foot end elevation</li> <li>- Vital monitoring</li> <li>- High P on 1g SOS</li> <li>- Inform SOS</li> </ul>                              |
| 7/12/26<br>7:00pm | <p>clt/bu Dr. Naveena</p> <p>clt GC fair</p> <p>Afebrile</p> <p>Vitals - stable</p> <p>PA - ut - 32-34 wks</p> <p>Irritable</p> <p>Cephalic</p> <p>FHR (+)</p> <p>Dr Naveena</p>                            | <p>Adv</p> <ul style="list-style-type: none"> <li>- Soft diet</li> <li>- Adequate hydration</li> <li>- NST 4th hrly</li> <li>- strict FHR monitoring 2hrly</li> <li>- WLF PV leak /</li> <li>- PV bleeding</li> <li>- Monitor Vitals</li> <li>- Inform SOS</li> </ul> |





## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time         | Progress Notes                                                                                                                                                                                                                                                                                                                              | Doctor's Order                                                                                                                                                                                                                                                                                                                                                          |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 7/7/2026<br>10:00pm | cls by Dr. Naveena<br>cls by Dr. Rajini Kumari                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                         |
|                     | <p><u>OLE GC-Fair</u><br/>           Alebrile, SpO<sub>2</sub> 100% on RA<br/>           PR: 78bpm<br/>           BP: 120/80mmHg<br/>           PA: ut. 32-34wks.<br/>           Twitable<br/>           Cephalic.<br/>           FHRG</p> <p>PV: Cx external<br/>           OS admits 1F<br/>           long<br/>           Vx high up</p> | <p><u>Ado</u><br/>           - Soft diet<br/>           - Adequate hydration<br/>           - Stop laxoly &amp;<br/>           and pain killer<br/>           - NST 4th hrly<br/>           - Strict FHR<br/>           monitoring 2hly<br/>           - wlf Pain abdo<br/>           pv leak / PV bleed<br/>           - Monitor Vital<br/>           - In/sem SOS</p> |
|                     |                                                                                                                                                                                                                                                                                                                                             | <p>Dr. Naveena</p>                                                                                                                                                                                                                                                                                                                                                      |

## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time        | Progress Notes     | Doctor's Order          |
|--------------------|--------------------|-------------------------|
| 2/7/2026<br>2:00am | cls by Dr. Naveena |                         |
|                    | OLG GC - fair      | Adv.                    |
|                    | Afebrile           | - Soft diet             |
|                    | Vitals - stable    | - Adequate hydration    |
| IST-Reactive       | PA: ut - 32-34wks  | - drugs as charted      |
|                    | Relaxed            | - NST 4th hrly          |
|                    | Cephalic           | - FHR 2hrly             |
|                    | FHR ⊕ 154bpm       | - w/f PV leak /         |
|                    | UE - NAD           | PV bleeding             |
|                    | Dr. Naveena        | - Monitor Vitals        |
|                    |                    | - Inform SOS            |
| 8/7/2026<br>7:30am | cls by Dr. Naveena |                         |
|                    | OLG GC - fair      | Adv.                    |
|                    | Afebrile           | - Soft diet             |
|                    | Vitals - stable    | - Adequate hydration    |
|                    | PA: ut 32-34wks    | - drugs as charted      |
|                    | Relaxed            | - NST 4th hrly          |
|                    | Cephalic           | - FHR 2hrly             |
|                    | FHR ⊕ 152bpm       | - w/f PV leak / PV      |
|                    |                    | bleeding / Pain abdomen |
|                    | Dr. Naveena        | - Monitor Vitals        |
|                    |                    | - Inform SOS            |







## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time       | Progress Notes                                                                          | Doctor's Order                      |
|-------------------|-----------------------------------------------------------------------------------------|-------------------------------------|
| 8/1/26<br>12:30pm | C/S/B Dr. Rajani Kumar<br>Grip, UA 2 E 33 <sup>+</sup> week - threatened Preterm labor. |                                     |
|                   | AC fair                                                                                 | <u>Adv.</u><br>- NBM, 100 RL.       |
|                   | vitals - stable                                                                         | - NST 4 <sup>th</sup> hourly        |
|                   | P/A ut 32-34 wk                                                                         | - FHR monitoring 2nd hourly         |
| NST - Reduced     | cephalic                                                                                | - DFMC.                             |
| Beat to beat      | FNS ⊕                                                                                   | - Monitor vitals, Infants           |
| variability       | Mildly aching                                                                           | <i>[Signature]</i>                  |
| 8/1/26<br>2pm     | C/S/B Dr. Rajani<br>vitals - stable.                                                    | <u>Adv.</u><br>- Soft diet now.     |
|                   | P/A ut 32-34 wk                                                                         | - Adequate hydration.               |
|                   | cephalic                                                                                | - NBM from 10pm                     |
|                   | FNS ⊕                                                                                   | - Em USCS (SOS)                     |
|                   | mild aching.                                                                            | - NST 4 <sup>th</sup> hourly, FHRM. |
|                   | <u>NST - Reactive.</u>                                                                  | - DFMC.                             |
|                   |                                                                                         | <i>[Signature]</i>                  |



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| Date & Time         | Progress Notes                                                                                                                                                                                                                    | Doctor's Order                                                                                                                                                                                                                                                                      |
|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 8/17/2016<br>4:15pm | <p>C/S/B Dr. Dua</p> <p>Cl<sub>0</sub> Pain abdomen.</p> <p>AC Fair</p> <p>Abscilli</p> <p>Vitals (N)</p> <p>PA ut ~ 32-34wks</p> <p>Cephalexin</p> <p>FNS (+)</p> <p>2c/10-15/10.</p> <p>P/v - cx - long.</p> <p>os - closed</p> | <p><u>Adv</u></p> <ul style="list-style-type: none"> <li>- Soft diet</li> <li>- Adequate hydration</li> <li>- Drugs as charted</li> <li>- NST 4th hourly</li> <li>- PR 2nd hourly.</li> <li>- Monitor vitals, Intense</li> <li>- NBM from 10pm.</li> <li>- Em LSES (SOS)</li> </ul> |
| 8/17/2016<br>8pm    | <p>C/S/B Dr. Manshe</p> <p>Cx P/LB / 33<sup>+</sup>3 / 1PL</p>                                                                                                                                                                    |                                                                                                                                                                                                                                                                                     |
|                     | <p>AC - Fair Abscilli</p> <p>Vitals Stable</p> <p>PA ut ~ 32-34wks</p> <p>PRM (+)</p> <p>NST Reactive</p> <p>Cephalexin relax</p> <p>trans (+)</p>                                                                                | <p><u>Adv</u></p> <ul style="list-style-type: none"> <li>- NBM From 10pm</li> <li>- NST 4th hourly</li> <li>- y Pain @: Bm SOS</li> <li>- (Pt req Baby before 7:30pm)</li> <li>- w/f FRS monitoring</li> <li>- Inform Sm</li> </ul>                                                 |
|                     | <p>Cl<sub>0</sub> Backache @</p> <p>no 90 Abd tightness / low</p>                                                                                                                                                                 | <p>my<br/>bmas</p>                                                                                                                                                                                                                                                                  |





## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes                                                                                                                                                                                     | Doctor's Order                                                                                                                                                               |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 9/7/2016    |                                                                                                                                                                                                    |                                                                                                                                                                              |
| 11pm        | <p>CLB Dr Monisha</p> <p>CLP Pain Abdomen</p> <p>CC Row Afebrile</p> <p>Vitals Stable</p> <p>PIA ut relax</p> <p>FNS @ R</p> <p>LG NAD</p>                                                         |                                                                                                                                                                              |
|             | NST Reactive                                                                                                                                                                                       |                                                                                                                                                                              |
|             |                                                                                                                                                                                                    | by Dr Monisha                                                                                                                                                                |
| 9/7/2016    | CLB Dr Monisha                                                                                                                                                                                     |                                                                                                                                                                              |
| 5:30 Am     | <p>GuPiH2 / 33<sup>rd</sup> wk Threatened Preterm</p> <p>CL Row Afebrile</p> <p>Vitals Stable</p> <p>PIA ut relax</p> <p>Cap</p> <p>FNS @ R</p> <p>LG NAD</p> <p>CL Suprapubic Pain + Batching</p> | <p>gch</p> <p>NBM</p> <p>Drugs as claud</p> <p>opt vitals &amp; Fns</p> <p>Prepare for BLUS</p> <p>Inform Sns</p> <p>Can be discharged</p> <p>Send Pak for Prostaglandin</p> |
|             |                                                                                                                                                                                                    | by Dr Monisha                                                                                                                                                                |



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time        | Progress Notes                | Doctor's Order                  |
|--------------------|-------------------------------|---------------------------------|
| 9/1/2026<br>C30 AM | CLB Dr Rajani Kumari          |                                 |
|                    | AC-Pan Afebrile               |                                 |
|                    | Vitals stable                 | - NBM                           |
|                    | PA - UT irritability          | - Decision of Emiso was         |
|                    | Cephalexin                    | - taken i/o Prodromal (obscure) |
|                    | FNS PR                        | (Pattern).                      |
|                    |                               | - Intermittent                  |
|                    |                               | - Drops as checked              |
|                    |                               | - Foley's catheterization       |
|                    | (Please to Exam)              | - Intermittent                  |
|                    |                               | - Shift to OR                   |
|                    |                               | - PAC                           |
| 9/1/26<br>9am      | CLB Dr. Veena                 |                                 |
|                    | POD-0 / Pg 6                  |                                 |
|                    | PA is stable, Noct            | - NBM                           |
|                    | o/c a fair Pallor             | - IV Abx for 48 hrs             |
|                    | BP - 110/70 w/ltg             | - Foley's removal e/au @ 6am    |
|                    | PR - 75bpm                    | - Drops as checked              |
|                    | SpO <sub>2</sub> - 100% on RA | - IV's, Analgesics &            |
|                    | PA - UT well retracted        | Thromboprophylaxis as per Axon  |
|                    | UE - BUNL                     | - D/O change                    |
|                    | Baby @ NICU                   | - Vital monitoring              |
|                    | U/O - 150ml, clear            | - Perform SB                    |
|                    |                               | - Ted stockings                 |



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time                      | Progress Notes                                                                                                                                                                                                  | Doctor's Order                                                                                                                                                                                                 |
|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                  |                                                                                                                                                                                                                 | <u>C/S/B Dr. Veena</u>                                                                                                                                                                                         |
| <u>9/7/26</u><br><u>12:45 PM</u> | <u>POD-0 P2L2</u>                                                                                                                                                                                               |                                                                                                                                                                                                                |
| Baby in Nicu                     | Pt is stable, No c/o<br>o/f G/G fair, Afebrile<br>Pallor (-)<br>BP - 114/82 mmHg<br>PR - 86 bpm, SpO <sub>2</sub> - 100% on RA<br>P/A - Ct well retracted<br>BS (+)<br>U/E - BUN C,<br>U/O - 100ml/hr,<br>Clear | Adv<br>✓ Oral sips f/b liquid diet<br>✓ Soft diet > 8pm<br>✓ I/O charting<br>✓ Vital monitoring<br>✓ Foley's removal @ 6am<br>✓ Zuv Abx for 48hrs<br>✓ Zuv Clexone x 3 days<br>✓ Shift to Room<br>Zuv form SOS |
|                                  |                                                                                                                                                                                                                 | N.B. Maunika 9/7/26 @ 9:10pm                                                                                                                                                                                   |
| <u>9/7/26</u><br><u>1:30pm</u>   | <u>C/S/B Dr. Dina</u>                                                                                                                                                                                           |                                                                                                                                                                                                                |
|                                  | <u>POD-0 P2L2 (S/P Pelvic US)</u>                                                                                                                                                                               |                                                                                                                                                                                                                |
| Baby in Nicu                     | C/G Fair Afebrile<br>BP: 110/71 mmHg<br>PR: 71 bpm<br>SpO <sub>2</sub> : 99% on RA<br>P/A Uterus Retracted<br>well BS (+)<br>U/E NAB                                                                            | Adv<br>✓ Soft diet<br>✓ Sings as charted<br>✓ I/O charting<br>✓ Foley's Removal @ 6 AM<br>✓ Monitor vitals<br>Zuv form SOS                                                                                     |
| Flatus Not passed                |                                                                                                                                                                                                                 |                                                                                                                                                                                                                |
| U/O - 500ml<br>Clear             |                                                                                                                                                                                                                 |                                                                                                                                                                                                                |



HNH-00000539 IP26-00006747

Mrs N SASHI PRIYA

28-12-1998

27 Y 6 M 13 D

(F)

Dr. RAJANI KUMARI



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# PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time         | Progress Notes                                                                                                                                                                               | Doctor's Order                                                                                                                                                                                                                |
|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 9/12/2026<br>7:30am | POD-1<br>o/c GC-fair<br>Afebrile.<br>SpO <sub>2</sub> - 99%<br>Vitals - stable<br>PA: ut. retracted well.<br>Soft, NT.<br>Dressing: dry & clean.<br>UE: PV bleeding<br>WNL.<br>ULO: adequate | cls by Dr. Naveena<br>Ado.<br>- Soft diet<br>- Adequate hydration<br>- drugs as charted<br>- w/f PV bleeding.<br>- Ambulation<br>- Monitor Vitals<br>- Inform SOS<br>- Inf. Penicillin long<br>iv stat.<br>NB-Maxipain 8:30AM |
| 10/12/26<br>3pm     | Baby: NICU<br>POD-1 / D <sub>2</sub> L <sub>2</sub> A <sub>2</sub> . (PT-LSCS)                                                                                                               | cls/B Dr. Neena<br>Adv<br>- Soft diet<br>- Ambulation.<br>- Adequate hydration<br>- Drugs as charted<br>- Vital monitoring<br>- Inform SOS<br>- 7. Dulcolax P/O 2 tabs @ night<br>Cif didn't pass stools                      |
| Baby @ NICU         | PT is stable, No c/o<br>o/c GC-fair<br>Vitals - stable<br>P/A - Ut well retracted<br>BS (+)<br>mild distension (+)<br>UE - BNL<br>ULO -                                                      |                                                                                                                                                                                                                               |



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time                   | Progress Notes                                                                                 | Doctor's Order                                                                                                                                                                           |
|-------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 10/4/26<br>7:30pm             | C/S/B Dr. Dwa.<br>POD-1                                                                        |                                                                                                                                                                                          |
| Baby @ NICU                   | GC fair<br>Afebrile<br>BP: 120/69 mmHg<br>PR: 85 bpm.<br>P/A uterus Retracted well.<br>L/E NAB | <u>Adv</u><br>- Soft diet<br>- Ambulation<br>- Adequate hydration<br>- Drugs as charted<br>- w/c PV bleed<br>- Monitor vitals<br>- Tab Dulcolax 2tab. PO<br>(If stools not passed) Stat. |
| Status ✓<br>Vene ✓<br>Stool X | <i>[Signature]</i>                                                                             |                                                                                                                                                                                          |
| 11/4/26<br>7AM                | C/S/B Dr. Dwa.<br>POD-2                                                                        |                                                                                                                                                                                          |
| Baby in NICU                  | GC fair<br>Afebrile<br>Vitals stable.<br>P/A uterus Retracted well.<br>L/E NAB                 | <u>Adv</u><br>- Soft diet<br>- Ambulation<br>- Adequate hydration<br>- Drugs as charted<br>- w/c PV bleed<br>- Monitor vitals<br>- Infirmities                                           |
| FV ✓<br>U ✓<br>S-X            | <i>[Signature]</i>                                                                             |                                                                                                                                                                                          |





## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time          | Progress Notes                                                                                                                                                                           | Doctor's Order                                                                                                                                                          |
|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 11/07/2026<br>6:30pm | cls by Dr. Naveena.<br><br>OLE GC-fair<br>Afebrile SpO <sub>2</sub> -100%<br>ONRA<br>Vitals-stable<br>PA: ut. retracted well<br>Soft, NT<br>Dressing: dry & clean<br>UE: PV bleeding WNL | Ado<br>- Regular diet<br>- Adequate hydration<br>- Ambulation<br>- w/f PV bleedings<br>- drugs as charted<br>- Monitor Vitals<br>- In/Out SCS                           |
|                      | Baby: NICU                                                                                                                                                                               | Dr. Naveena.                                                                                                                                                            |
| 12/07/2026<br>7:00am | cls by Dr. Naveena.<br><br>OLE GC-fair<br>Afebrile<br>Vitals-stable<br>PA: ut. retracted well<br>Soft NT<br>Dressing: dry & clean<br>UE: PV bleeding WNL<br>Baby: NICU                   | N.B. Anusha<br>@ 7:30pm<br>Ado<br>- Regular diet<br>- Adequate hydration<br>- Ambulation<br>- drugs as charted<br>- w/f PV bleeding<br>- Open dressing<br>- MKE & I/SCS |



**IP26-00006747**

28-12-1998

27 Y 6 M 15 D

(F)

Dr. RAJANI KUMARI



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### PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time     | Progress Notes                  | Doctor's Order                                  |
|-----------------|---------------------------------|-------------------------------------------------|
| 12/7/2022       | Cc - Few Aphasia<br>retards (A) | Adm<br>Can be discharged<br>Sent for processing |
| ASD (Open Days) |                                 | My<br>sitting                                   |

HNH-00000539 IP26-00006747  
 Mrs N SASI PRIYA 27 Y 6 M 9 D (F)  
 28-12-1998  
 Dr. RAJANI KUMARI



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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<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ SHIFTING                                     |
|------|---------------------------------------------------|-------------------|---------------------------|-----------|--------------------------|-------------------------------------------------------------------|
| 1    | TAB. IRON                                         | 1 tab             | PO                        | OD        | 5/7/26                   | <input type="checkbox"/> C <input checked="" type="checkbox"/> DC |
| 2    | TAB. CALCIUM                                      | 1 tab             | PO                        | OD        | 4/7/26                   | <input type="checkbox"/> C <input checked="" type="checkbox"/> DC |
| 3    | C. DEPIN                                          | 1mg               | PO                        | BD        | 5/7/26                   | <input type="checkbox"/> C <input checked="" type="checkbox"/> DC |
| 4    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 5    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 6    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 7    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 8    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 9    |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |
| 10   |                                                   |                   |                           |           |                          | <input type="checkbox"/> C <input type="checkbox"/> DC            |

\* C- Continue, DC - Discontinue

### MEDICATION HISTORY RECORDED / VERIFIED BY

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

Date & Time : ..... 5/7/26 @ 12pm

Nurse Name & Signature : ..... Sushatha

Date & Time : ..... 5/7/26 @ 1pm

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





HNH-00000539 IP26-00006747  
 Mrs N Sasi Priya  
 28-12-1998 27 Y 6 M 9 D (F)  
 Dr. RAJANI KUMARI



## DRUG CHART

Date of Admission: 5/7/26 Drug Allergies: Nil ☐ Not known any Drug Allergies

### FOR THE SAFETY OF THE PATIENT

Ladegix to Cefotaxim (after admission)

- 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<br>Time |
|--------------------------|-------|-----------|------------|--------------|
| Dose                     | Route | Frequency | Start Date |              |
| Doctor's Signature       |       |           |            | Valid Period |
| Pharm.                   |       |           |            |              |
| Additional Instructions: |       |           |            |              |

| DRUG :                   |       |           |            | Date<br>Time |
|--------------------------|-------|-----------|------------|--------------|
| Dose                     | Route | Frequency | Start Date |              |
| Doctor's Signature       |       |           |            | Valid Period |
| Pharm.                   |       |           |            |              |
| Additional Instructions: |       |           |            |              |

| DRUG :                   |       |           |            | Date<br>Time |
|--------------------------|-------|-----------|------------|--------------|
| Dose                     | Route | Frequency | Start Date |              |
| Doctor's Signature       |       |           |            | Valid Period |
| Pharm.                   |       |           |            |              |
| Additional Instructions: |       |           |            |              |



REGULAR PRESCRIPTIONS

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

|                                                       |              |                  |                      |                                                                                                                       |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------------------------------------------|--------------|------------------|----------------------|-----------------------------------------------------------------------------------------------------------------------|-----|-----|-----|-----|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : C. NIFEDIPINE                                  |              |                  |                      | Date<br>Time                                                                                                          |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>5mg                                           | Route<br>p/o | Frequency<br>BD  | Start Date<br>5/1/26 |                                                                                                                       |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |              |                  |                      |                                                                                                                       |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |              |                  |                      | STOP 5/1/26                                                                                                           |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |              |                  |                      |                                                                                                                       |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : INS. CEROTAXIME                                |              |                  |                      | Date<br>Time                                                                                                          | 5/7 | 6/7 | 7/7 |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>1g                                            | Route<br>iv  | Frequency<br>BD  | Start Date<br>5/1/26 |                                                                                                                       |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |              |                  |                      |                                                                                                                       |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |              |                  |                      | (first dose) 11 AM given 12 PM given (no reaction c test done) mild allergic after (not done) mild upper lip swelling |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |              |                  |                      | 6/7                                                                                                                   |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : INS. PARACETAMOL                               |              |                  |                      | Date<br>Time                                                                                                          | 5/7 | 6/7 | 7/7 |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>1g                                            | Route<br>iv  | Frequency<br>TID | Start Date<br>5/1/26 |                                                                                                                       |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |              |                  |                      | 6 AM + 10 PM given 12 PM given                                                                                        |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |              |                  |                      | 2 PM given 10 PM given 12 PM given STOP 11 AM given 12 PM given                                                       |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |              |                  |                      |                                                                                                                       |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : C. NIFEDIPINE                                  |              |                  |                      | Date<br>Time                                                                                                          | 5/7 | 6/7 | 7/7 | 8/7 |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>10mg                                          | Route<br>p/o | Frequency<br>TID | Start Date<br>5/1/26 |                                                                                                                       |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |              |                  |                      |                                                                                                                       |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |              |                  |                      | 6 AM + 2 PM + 10 PM given 12 PM given STOP 11 AM given 12 PM given Dr. Naveen                                         |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |              |                  |                      |                                                                                                                       |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |

Verified by

Dr. Dhakshayani

Verified by

Dr. Dhakshayani

Verified by

Dr. Dhakshayani



IP26-00006747

26-12-1998

28-12-1998 27 Y 6 M 9 D

(F)

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Verified by  
Dr. Dhakshayani

Dr. Dhakshayani

Sheet NO: .....

## REGULAR PRESCRIPTIONS

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

| DRUG : T. DROFER XT                                                        |             |                 |                  | Date<br>Time 7/7/17        |
|----------------------------------------------------------------------------|-------------|-----------------|------------------|----------------------------|
| Dose<br>1 tab                                                              | Route<br>PO | Frequency<br>OD | Start Dt.<br>7/7 |                            |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><u>M. Arumula</u> |             |                 |                  | 9pm <u>Sri Sri Arumula</u> |
| Additional Instructions:                                                   |             |                 |                  | STOP by 9/12/16            |
| Daily Doctor's Endorsement by a Sign                                       |             |                 |                  | (Signature)                |

| DRUG : T. SHELCEL                                                          |             |                 |                  | Date<br>Time 7/7/17         |
|----------------------------------------------------------------------------|-------------|-----------------|------------------|-----------------------------|
| Dose<br>1 tab                                                              | Route<br>PO | Frequency<br>OD | Start Dt.<br>7/7 |                             |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><u>M. Arumula</u> |             |                 |                  | 10pm <u>Sri Sri Arumula</u> |
| Additional Instructions:                                                   |             |                 |                  | STOP 9/12/16                |
| Daily Doctor's Endorsement by a Sign                                       |             |                 |                  | (Signature)                 |

| DRUG : CAP EVION                                                           |             |                 |                  | Date<br>Time 7/7/17         |
|----------------------------------------------------------------------------|-------------|-----------------|------------------|-----------------------------|
| Dose<br>1 cap                                                              | Route<br>PO | Frequency<br>OD | Start Dt.<br>7/7 |                             |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><u>M. Arumula</u> |             |                 |                  | 10pm <u>Sri Sri Arumula</u> |
| Additional Instructions:                                                   |             |                 |                  | STOP by 9/12/16             |
| Daily Doctor's Endorsement by a Sign                                       |             |                 |                  | (Signature)                 |

| DRUG : T. AUGMENTIN                                   |       |           |           | Date<br>Time |
|-------------------------------------------------------|-------|-----------|-----------|--------------|
| Dose                                                  | Route | Frequency | Start Dt. |              |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           |              |
| Additional Instructions:                              |       |           |           |              |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |              |





Sheet No: ..... REGULAR PRESCRIPTIONS Weight ..... Ward .....

|                                                    |       |           |           |           |     |
|----------------------------------------------------|-------|-----------|-----------|-----------|-----|
| <b>DRUG :</b> INT- AMOXICILIN + CLAVULANIC ACID    |       |           |           | Date/Time | 9/7 |
| Dose                                               | Route | Frequency | Start Dt. |           |     |
| 1.2g                                               | IV    | BD        | 9/2/26    | 6AM       |     |
| Name & Signature of the Doctor Starting the Drugs: |       |           |           |           |     |
| Additional Instructions:                           |       |           |           |           |     |
| Daily Doctor's Endorsement by a Sign               |       |           |           |           |     |
| <b>DRUG :</b> INT- METROUIDAZOLE                   |       |           |           | Date/Time | 9/7 |
| Dose                                               | Route | Frequency | Start Dt. |           |     |
| 500mg                                              | IV    | TID       | 9/2/26    | 3PM       |     |
| Name & Signature of the Doctor Starting the Drugs: |       |           |           |           |     |
| Additional Instructions:                           |       |           |           |           |     |
| Daily Doctor's Endorsement by a Sign               |       |           |           |           |     |
| <b>DRUG :</b> T- PANTAPRAZOLE                      |       |           |           | Date/Time | 9/7 |
| Dose                                               | Route | Frequency | Start Dt. |           |     |
| 40mg                                               | PO    | BD        | 9/2/26    | 6AM       |     |
| Name & Signature of the Doctor Starting the Drugs: |       |           |           |           |     |
| Additional Instructions:                           |       |           |           |           |     |
| Daily Doctor's Endorsement by a Sign               |       |           |           |           |     |
| <b>DRUG :</b> INT- ENOXAPARIN                      |       |           |           | Date/Time | 9/7 |
| Dose                                               | Route | Frequency | Start Dt. |           |     |
| 40mg                                               | SC    | OD        | 9/2/26    | 8PM       |     |
| Name & Signature of the Doctor Starting the Drugs: |       |           |           |           |     |
| Additional Instructions:                           |       |           |           |           |     |
| Daily Doctor's Endorsement by a Sign               |       |           |           |           |     |

Dr. Dhakshayani

2 7 21

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100





HNH-00000539 IP26-00006747  
 Mrs N SASI PRIYA 26-12-1998 27 Y 6 M 9 D (F)  
 Dr. RAJANI KUMARI



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

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

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

STAT / ONCE ONLY DRUGS

| Date   | Time    | Medication                   | Dosage & Other Instructions | Route | Signature   | Nurses            |
|--------|---------|------------------------------|-----------------------------|-------|-------------|-------------------|
| 5/4/26 | 12 PM   | INT-TRAMADOL                 | 100mg                       | 1m    | [Signature] | Sujatha<br>Anusha |
| 5/4/26 | 1:20 PM | INT-CEFTAXIME                | 1g (PID)                    | 1v    | [Signature] | Sujatha<br>Anusha |
| 5/7/26 | 1 PM    | INT-HYOSCINE BUTYLBROMIDE    | 20mg                        | 1m    | [Signature] | Sujatha<br>Anusha |
| 5/7/26 | 3:30 PM | INT-PARACETAMOL              | 1g                          | 1v    | [Signature] | Chitra<br>Anusha  |
| 5/7/26 | 12 AM   | INT-TRAMADOL                 | 100mg                       | 1m    | [Signature] | Anusha<br>Prabha  |
| 6/7    | 8:10 AM | INT-ONDANSETRON              | 4mg                         | 1v    | [Signature] | Anusha<br>Prabha  |
| 6/7    | 4:30 PM | INT-TRAMADOL                 | 100mg                       | 1m    | [Signature] | Anusha<br>Prabha  |
| 7/7    | 1 AM    | INT-CHLORPHENIRAMINE MALEATE | 22.75                       | 1m    | [Signature] | Sujatha<br>Anusha |
| 7/7    | 1:30 PM | PC ENEMA                     | 100mg                       | PR    | [Signature] | Anusha<br>Prabha  |

Dr. Dhakshayani

## I.V. FLUIDS CHART

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

[illegible]





## DRUG CHART

Date of Admission: 9/7/2022 Drug Allergies: None ☒ Not known any Drug Allergies

### FOR THE SAFETY OF THE PATIENT

Cefotaxim (Swelby - lower lip)  
mild

- 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<br>Time |
|--------------------------|-------|-----------|------------|--------------|
| Dose                     | Route | Frequency | Start Date |              |
| Doctor's Signature       |       |           |            | Valid Period |
| Pharm.                   |       |           |            |              |
| Additional Instructions: |       |           |            |              |

| DRUG :                   |       |           |            | Date<br>Time |
|--------------------------|-------|-----------|------------|--------------|
| Dose                     | Route | Frequency | Start Date |              |
| Doctor's Signature       |       |           |            | Valid Period |
| Pharm.                   |       |           |            |              |
| Additional Instructions: |       |           |            |              |

| DRUG :                   |       |           |            | Date<br>Time |
|--------------------------|-------|-----------|------------|--------------|
| Dose                     | Route | Frequency | Start Date |              |
| Doctor's Signature       |       |           |            | Valid Period |
| Pharm.                   |       |           |            |              |
| Additional Instructions: |       |           |            |              |

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

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



|                                                                              |       |           |            |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
|------------------------------------------------------------------------------|-------|-----------|------------|--------------|--------|--------|------|------|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : <u>INJ CE</u>                                                         |       |           |            | Date<br>Time |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                         | Route | Frequency | Start Date |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:                        |       |           |            |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                     |       |           |            |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                         |       |           |            |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : <u>INJ AUGMENTIN</u>                                                  |       |           |            | Date<br>Time | 9/7    | 10/7   | 11/7 |      |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                         | Route | Frequency | Start Date |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| 1.2g                                                                         | IV    | BD        | 9/7        | 7AM          | 8:30AM |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: <u>M. Dhanasekaran</u> |       |           |            |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:<br><u>ATD FOR 48 HRS.</u>                           |       |           |            |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                         |       |           |            |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : <u>INJ METRONIDAZOLE</u>                                              |       |           |            | Date<br>Time | 9/7    | 10/7   | 11/7 |      |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                         | Route | Frequency | Start Date |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| 500mg                                                                        | IV    | TID       | 9/7        | 6AM          | 12PM   | 5:30PM |      |      |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: <u>M. Dhanasekaran</u> |       |           |            |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:<br><u>ATD FOR 48 HRS.</u>                           |       |           |            |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                         |       |           |            |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : <u>PARACETAMOL</u>                                                    |       |           |            | Date<br>Time | 9/7    | 10/7   | 11/7 | 12/7 |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                         | Route | Frequency | Start Date |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| 1gm                                                                          | P/O   | TID       | 9/7        | 6AM          | 12PM   | 5:30PM |      |      |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: <u>M. Dhanasekaran</u> |       |           |            |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                     |       |           |            |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                         |       |           |            |              |        |        |      |      |  |  |  |  |  |  |  |  |  |  |  |

Dr. Dhakshayani

Verified by

Dr. Dhakshayani

Verified by

Dr. Dhakshayani

Verified by



HNH-00000539 IP26-00006747

Mrs N SASI PRIYA

28-12-1998 27 Y 6 M 13 D (F)

Dr. RAJANI KUMARI



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Sheet No: .....

## REGULAR PRESCRIPTIONS

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

|                                                                            |       |           |           |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
|----------------------------------------------------------------------------|-------|-----------|-----------|--------------|-----|------|------|------|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b> DICOFENAL                                                    |       |           |           | Date<br>Time | 9/7 | 10/7 | 11/7 | 12/7 |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                       | Route | Frequency | Start Dt. |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| 50mg                                                                       | P/O   | TID       | 9/7       |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>Dr. Rajani Kumari |       |           |           |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                   |       |           |           |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                       |       |           |           |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b> TRAMADOL                                                     |       |           |           | Date<br>Time | 9/7 | 10/7 | 11/7 | 12/7 |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                       | Route | Frequency | Start Dt. |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| 100mg                                                                      | P/O   | TID       | 9/7       |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>Dr. Rajani Kumari |       |           |           |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                   |       |           |           |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                       |       |           |           |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b> INT. ENOXAPARIN                                              |       |           |           | Date<br>Time | 9/7 | 10/7 | 11/7 | 12/7 |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                       | Route | Frequency | Start Dt. |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| 40mg                                                                       | sc    | OD        | 9/7/20    |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>Dr. Rajani Kumari |       |           |           |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:<br>x 3 days                                       |       |           |           |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                       |       |           |           |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b> PANTOPRAZOLE                                                 |       |           |           | Date<br>Time | 9/7 | 10/7 | 11/7 | 12/7 |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                       | Route | Frequency | Start Dt. |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| 40mg                                                                       | IV    | OD        | 9/7/20    |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br>Dr. Rajani Kumari |       |           |           |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                   |       |           |           |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                       |       |           |           |              |     |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |

Docu. No. : RCH / FRM / CLINICAL / 108

Dr. Dhakshayani

Verified by

Dr. Dhakshayani

Verified by

Dr. Dhakshayani

VERIFIED BY - Name

Verified by

HNH-00000539 IP26-00006747  
 Mrs N SASI PRIYA  
 26-12-1998 27 Y 6 M 15 D (F)  
 Dr. RAJANI KUMARI



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Sheet No: .....

## REGULAR PRESCRIPTIONS

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

|                                                       |       |           |           |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------------------------------------------|-------|-----------|-----------|-----------------------------------------------|---------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG :</b> Augmentin                               |       |           |           | Date<br>Time                                  | 11/7/26 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                  | Route | Frequency | Start Dt. |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 625mg                                                 | PO    | TID       | 11/7/26   |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           | <div>6am</div> <div>2pm</div> <div>10pm</div> |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |       |           |           |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b> T-PANTOPRAZOLE                          |       |           |           | Date<br>Time                                  | 12/7    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                  | Route | Frequency | Start Dt. |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 40mg                                                  | PO    | BD        | 12/7      |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           | <div>6am</div>                                |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |       |           |           | <div>6am</div>                                |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>                                         |       |           |           | Date<br>Time                                  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                  | Route | Frequency | Start Dt. |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |       |           |           |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG :</b>                                         |       |           |           | Date<br>Time                                  |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                  | Route | Frequency | Start Dt. |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                              |       |           |           |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |                                               |         |  |  |  |  |  |  |  |  |  |  |  |  |  |  |



Mrs N SASI PRIYA

26-12-1998

27 Y 6 M 13 D

(F)

Dr. RAJANI KUMARI



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

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

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

STAT / ONCE ONLY DRUGS

| Date | Time    | Medication           | Dosage & Other Instructions | Route | Signature | Nurses              |
|------|---------|----------------------|-----------------------------|-------|-----------|---------------------|
| 9/7  | 6:30 AM | INJ PANTOPRAZOLE     | 40mg                        | IV    | M         | Sriatha Anusha      |
| 9/7  | 6:30 AM | INJ METOCLOPRAMIDE   | 10mg                        | IV    | L         | Sriatha Anusha      |
| 9/7  | 730     | TRANEXAMIC ACID      | 1gm                         | IV    | M         | Kaer Kaer Kaer Kaer |
| 9/7  | 8am     | DICLOFENAC           | 100mg                       | PR    | M         | Kaer Kaer Kaer Kaer |
| 9/7  | 8am     | TRAMADOL             | 100mg                       | PR    | M         | Kaer Kaer Kaer Kaer |
| 9/7  | 12pm    | INJ-PARACETAMOL      | 1gm                         | IV    | W         | Mou                 |
| 10/7 | 8AM     | INJ METOCLOPRAMIDE   | 10mg                        | IV    | W         | Anusha              |
| 11/7 | 2pm     | DULCOLAX SUPPOSITORY | 20mg                        | PR    | L         | No 2                |
|      |         |                      |                             |       |           |                     |
|      |         |                      |                             |       |           |                     |

## I.V. FLUIDS CHART

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



| Date                                                                    |            | Time                               | Position of I.V. Fluid<br>(If infusion, mention ml/hr = Mcg/kg/min. etc) | Route        | Flow Rate<br>ml/hr | Doctor<br>Sign | Nurse<br>Sign | Date of<br>Stopping | Doctor<br>Sign | Nurse<br>Sign |
|-------------------------------------------------------------------------|------------|------------------------------------|--------------------------------------------------------------------------|--------------|--------------------|----------------|---------------|---------------------|----------------|---------------|
| 9/2                                                                     | 6:30       | RINGER<br>LACTATE<br>+ 9U OXYTOCIN | IV                                                                       | 100<br>ml/hr |                    |                |               |                     |                |               |
| 9/7                                                                     | 7:00<br>AM | RINGER<br>LACTATE                  | IV                                                                       | FF           |                    |                |               | 9/7                 |                |               |
| 9/7                                                                     | 11AM       | RINGER<br>LACTATE                  | IV                                                                       | 100<br>hr.   |                    |                |               |                     |                |               |
| 9/7                                                                     | 6:30<br>AM | RINGER<br>LACTATE                  | IV                                                                       | 100ml<br>hr  |                    |                |               | 9/7                 |                |               |
| 9/7                                                                     | 5:00<br>PM | RINGER<br>LACTATE                  | IV                                                                       | 100ml<br>hr. |                    |                |               |                     |                |               |
| <div style="text-align: center;"> <p>STOP</p> <p>Dr. Naveena</p> </div> |            |                                    |                                                                          |              |                    |                |               |                     |                |               |



# PATIENT TRANSFER FORM

|                                                                                                                                                                                                                          |                                   |                                                                                                                                                                            |                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Patient Name & UHID No.<br><br>HNH-00000539 IP26-00006747<br>Mrs N SASHI PRIYA 27 Y 6 M 13 D (F)<br>26-12-1998<br>Dr. RAJANI KUMARI<br> |                                   | Date & Time of Admission<br><br>9/7/26                                                                                                                                     | Date & Time of Transfer Order<br><br>9/7/26 2pm. |
|                                                                                                                                                                                                                          |                                   | Transfer Ordered by<br><br>Dr. Veene.                                                                                                                                      | Reason for Transfer<br><br>Obs.                  |
| From Unit<br><br>Prepos                                                                                                                                                                                                  | To Unit<br><br>Room (301)         | Information to Attendant<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                            |                                                  |
| Number of Sheets in Clinical File<br><br>35                                                                                                                                                                              | Number of Imaging Films<br><br>22 | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/><br>If yes, what ? |                                                  |
| Medications / Consumables / Surgicals / Hand over                                                                                                                                                                        |                                   |                                                                                                                                                                            |                                                  |
| Sl.No.                                                                                                                                                                                                                   | Item Name                         | Quantity                                                                                                                                                                   |                                                  |
| 1.                                                                                                                                                                                                                       | fl -                              | 1                                                                                                                                                                          |                                                  |
| 2.                                                                                                                                                                                                                       |                                   |                                                                                                                                                                            |                                                  |
| 3.                                                                                                                                                                                                                       |                                   |                                                                                                                                                                            |                                                  |
| 4.                                                                                                                                                                                                                       |                                   |                                                                                                                                                                            |                                                  |
| 5.                                                                                                                                                                                                                       |                                   |                                                                                                                                                                            |                                                  |
| Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                    |                                   |                                                                                                                                                                            |                                                  |
| Name & Signature of Person who is Transferring<br><br>Mounika.                                                                                                                                                           |                                   | Name of Person Ordered Transfer<br><br>9/7/26 @ 2:10pm.                                                                                                                    |                                                  |
| Patient & Clinical Records Received by :<br><br>maheshwari                                                                                                                                                               |                                   |                                                                                                                                                                            |                                                  |
| Date & Time of Patient Received : 9/7/26 @ 2:10pm.                                                                                                                                                                       |                                   |                                                                                                                                                                            |                                                  |

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



0

0

0

0

HNH-00000539 IP26-00006747  
Mrs N SASI PRIYA  
28-12-1998 27 Y 6 M 9 D (F)  
Dr. RAJANI KUMARI



311 (101)

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## RESULT SHEET

|                     |             |  |  |  |  |  |
|---------------------|-------------|--|--|--|--|--|
| Date                | (IP) 5/7/26 |  |  |  |  |  |
| Time                | 1:12pm      |  |  |  |  |  |
| Hb                  | 11.8        |  |  |  |  |  |
| PCV                 | 34.5        |  |  |  |  |  |
| RBC                 | 3.98        |  |  |  |  |  |
| WBC                 | 10.12       |  |  |  |  |  |
| N/L                 |             |  |  |  |  |  |
| Platelets           | 267         |  |  |  |  |  |
| CRP                 | 22          |  |  |  |  |  |
| 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 grouping A positive |  |  |  |  |  |  |
|                           |  |  |  |  |  |  |
|                           |  |  |  |  |  |  |
|                           |  |  |  |  |  |  |
|                           |  |  |  |  |  |  |
|                           |  |  |  |  |  |  |
|                           |  |  |  |  |  |  |
|                           |  |  |  |  |  |  |

Culture and Sensitivities : .....

.....

.....

.....

Radiology :      USG : .....

                         X-Ray : .....

                         ECHO : .....

                         CT : .....

                         MRI : .....

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



IP26-00006747

28-12-1998

27 Y 6 M 9 D

(F)

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

[illegible]



HR

10pm — 140bmt

12Am — 145bmt

2Am — 139bmt

4Am — 142bmt

6Am — 135bmt

8Am — 147bmt

3pm — 156bmt

6pm — 156bmt

## Obstetrics and Gynaecology Early Warning Signs

**Complete a Full  
Set of MEOWS  
Observations**

1 Yellow Alert :  
Repeat Observations  
in 30 minutes

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

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

\* The Modified Early Warning Score (MEOWS)



HNH-00000539

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**26-12-1998**

28-12-1998 27 Y 6 M 9 D

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6/2/26

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

[illegible]



FHR → 7/7/26

2 Am - 140 b/m

2 Am - 147 b/m

Am - 136 b/m

Am - 135 b/m

2 Am - 137 b/m

0 Am - 138 b/m

2 pm - 140 b/m

2 pm - 147 b/m

4 pm - 140 b/m

6 pm - 142 b/m

8 pm - 140 b/m

10 pm - 142 b/m

12 Am - 135 b/m

2 Am - 137

4 Am - 140 b/m

6 Am - 138 b/m

8 Am - 142 b/m

## Obstetrics and Gynaecology Early Warning Signs

1 Yellow Alert :  
Repeat Observations  
in 30 minutes

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

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

Complete a Full  
Set of MEOWS  
Observations

\* The Modified Early Warning Score (MEOWS)



IP26-00006747

HNH-00000539

HNN-000000  
SASI PRIYA

Mr. N. S. A.  
12-1998

Dr. RAJANI KUMAR

(F)



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

| Date                                    |            | Time |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|-----------------------------------------|------------|------|-----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 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<br>(write rate in<br>corresp. box) | > 30       |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 21 - 30    |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 11 - 20    | 20   | 20  | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 | 20 |
|                                         | 0 - 10     |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Saturations                             | 94 - 100 % | 100  | 100 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 | 99 |
|                                         | < 94 %     |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Administered O <sub>2</sub> (L/min.)    |            |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Temp °C                                 | 40         |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 39         |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 38         |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 37         |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 36         | 36   | 36  | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 | 36 |
|                                         | 35         |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | < 35       |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Heart Rate                              | 170        |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 160        |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 150        |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 140        |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 130        |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 120        |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 110        |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 100        |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 90         |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 80         |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 70         | 86   | 80  | 81 | 84 | 85 | 86 | 87 | 80 | 85 | 80 | 77 | 82 | 85 |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 60         |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 50         |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 40         |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Systolic Blood Pressure                 | 190        |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 180        |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 170        |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
|                                         | 160        |      |     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |



8/7  
10Am - 144bmt  
12pm - 145bmt  
2pm - 146bmt

## Obstetrics and Gynaecology Early Warning Signs

4pm - 148bmt  
6pm - 139bmt  
8pm - 142bmt  
11pm - 136bmt  
1Am - 148bmt

9/1/26 3Am - 152bmt  
4Am - 143bmt

Complete a Full  
Set of MEOWS  
Observations

1 Yellow Alert :  
Repeat Observations  
in 30 minutes

2 Yellow Alerts or 1 Orange Alert:  
Call the Obstetrician and Repeat  
Observations  
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> 2 Yellow Alerts or  $\geq$  2 Orange Alerts:  
Immediate Review by Obstetrician and  
Repeat Observations  
in 15 minutes or continuous  
monitoring

\* The Modified Early Warning Score (MEOWS)



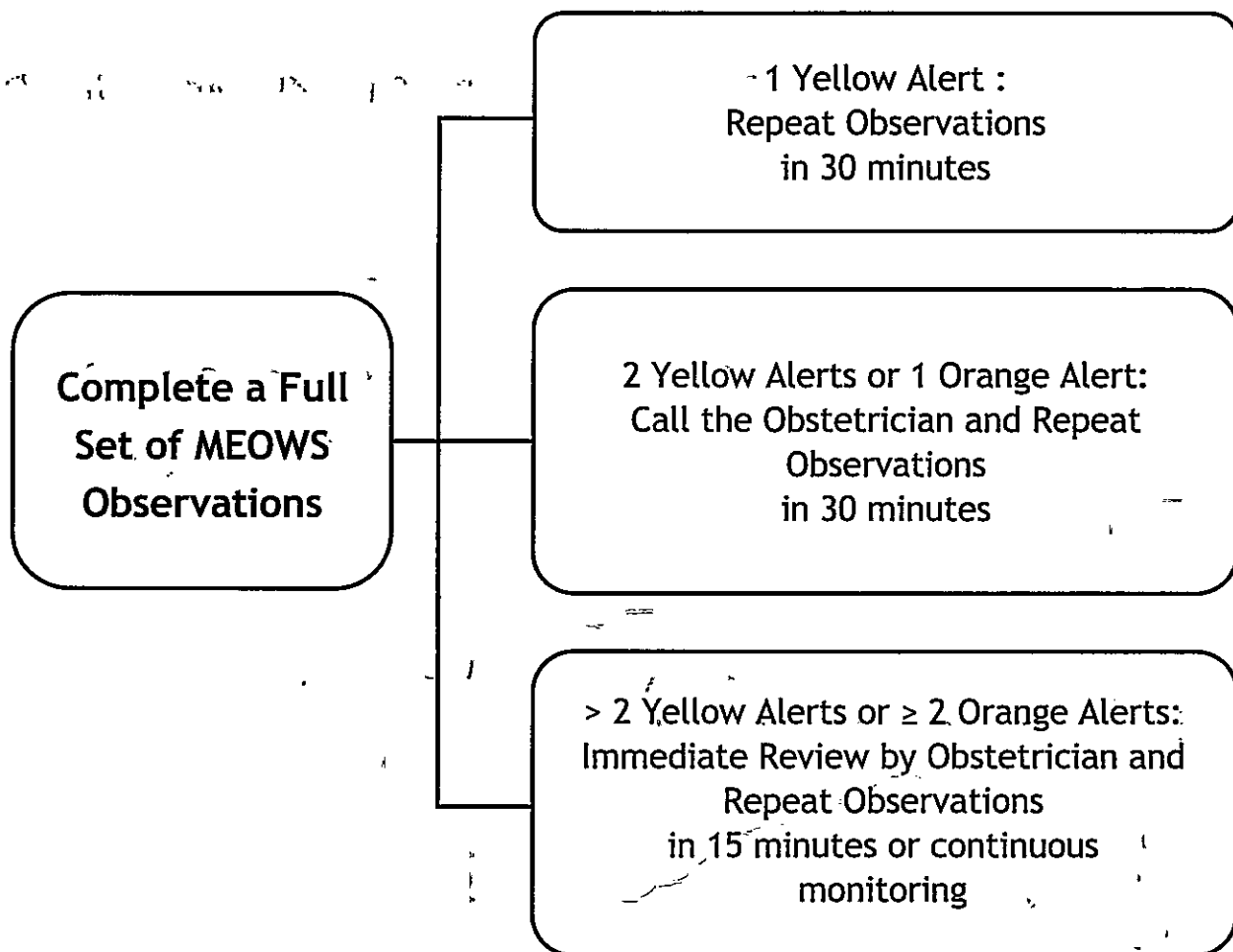
4



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

[illegible]

## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



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 26-12-1998 27 Y 6 M 13 D (F)  
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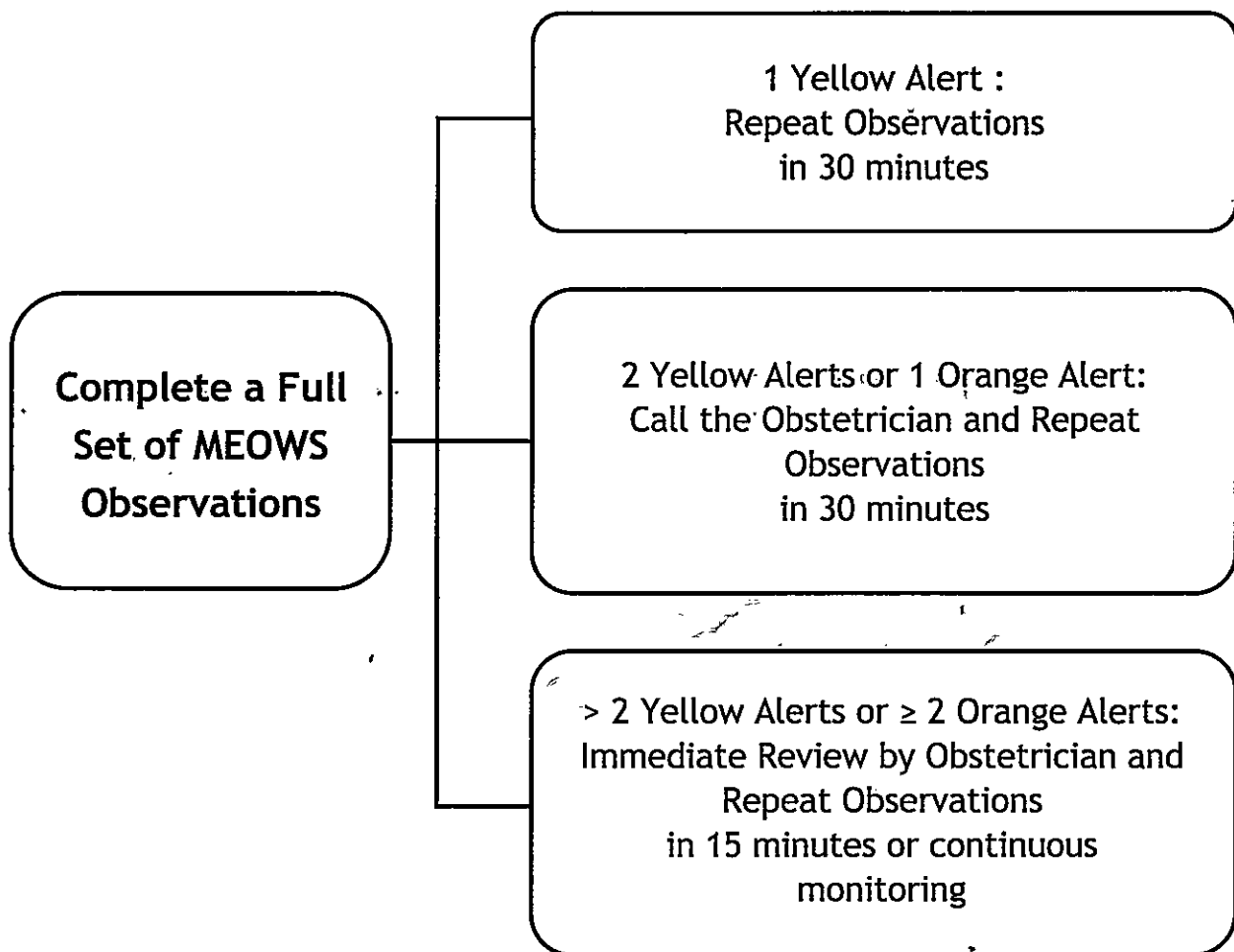
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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

|                                         |                          | 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<br>(write rate in<br>corresp. box) | > 30                     |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 21 - 30                  |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 11 - 20                  | 20    | 20  | 20   | 20  | 20  | 20   | 20h  |   |   |   |   |   |   |   |    |      | 23   | 22   |   |   |   |   |   |   |  |  |      | 23  |  |  |
|                                         | 0 - 10                   |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
| Saturations                             | 94 - 100 %               | 99    | 99  | 99   | 99  | 99  | 99.1 |      |   |   |   |   |   |   |   |    | 99.1 | 99.1 |      |   |   |   |   |   |   |  |  | 99.1 |     |  |  |
|                                         | < 94 %                   |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
| Administered O <sub>2</sub> (L/min.)    |                          |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
| Temp °C                                 | 40                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 39                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 38                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 37                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 36                       | 36    |     | 36   |     |     |      | 36.1 |   |   |   |   |   |   |   |    |      | 36.1 | 37.1 |   |   |   |   |   |   |  |  |      | 36  |  |  |
|                                         | 35                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | < 35                     |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
| Heart Rate                              | 170                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 160                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 150                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 140                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 130                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 120                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 110                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 100                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 90                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 80                       | 20    | 20  | 20   | 20  | 20  | 20   | 20h  |   |   |   |   |   |   |   |    |      | 75   | 65   |   |   |   |   |   |   |  |  |      | 70  |  |  |
|                                         | 70                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 60                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 50                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
| 40                                      |                          |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
| Systolic Blood Pressure                 | 190                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 180                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 170                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 160                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 150                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 140                      | 105   | 106 | 114  | 112 | 120 | 120  | 110  |   |   |   |   |   |   |   |    |      | 111  | 115  |   |   |   |   |   |   |  |  |      | 110 |  |  |
|                                         | 130                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 120                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 110                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 100                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 90                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 80                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 70                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
| 60                                      |                          |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
| 50                                      |                          |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
| Diastolic Blood Pressure                | 130                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 120                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 110                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 100                      |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 90                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 80                       | 70    | 65  | 65   | 65  | 65  | 65   | 71   |   |   |   |   |   |   |   |    |      | 72   | 75   |   |   |   |   |   |   |  |  |      | 71  |  |  |
|                                         | 70                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 60                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 50                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | 40                       |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         | NEURO<br>RESPONSE<br>[✓] | Alert | -   | -    | -   | -   | -    | -    |   |   |   |   |   |   |   |    |      | -    | -    |   |   |   |   |   |   |  |  |      | -   |  |  |
|                                         |                          | Voice |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
|                                         |                          | Pain  |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
| Unresponsive                            |                          |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |
| URINE<br>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    | 0    |      |   |   |   |   |   |   |  |  | 0    |     |  |  |
| TOTAL ORANGE SCORES                     |                          | 0     | 0   | 0    | 0   | 0   | 0    |      |   |   |   |   |   |   |   |    | 0    | 0    |      |   |   |   |   |   |   |  |  | 0    |     |  |  |
| Nurse Initial                           |                          |       |     |      |     |     |      |      |   |   |   |   |   |   |   |    |      |      |      |   |   |   |   |   |   |  |  |      |     |  |  |



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)

IP26-00006747

**Mrs N SASI PRIYA**

28-12-1998

27 Y 6 M 14 D

(F)



**Rainbow<sup>®</sup>  
Children's  
Hospital**  
It takes a lot to treat the little.



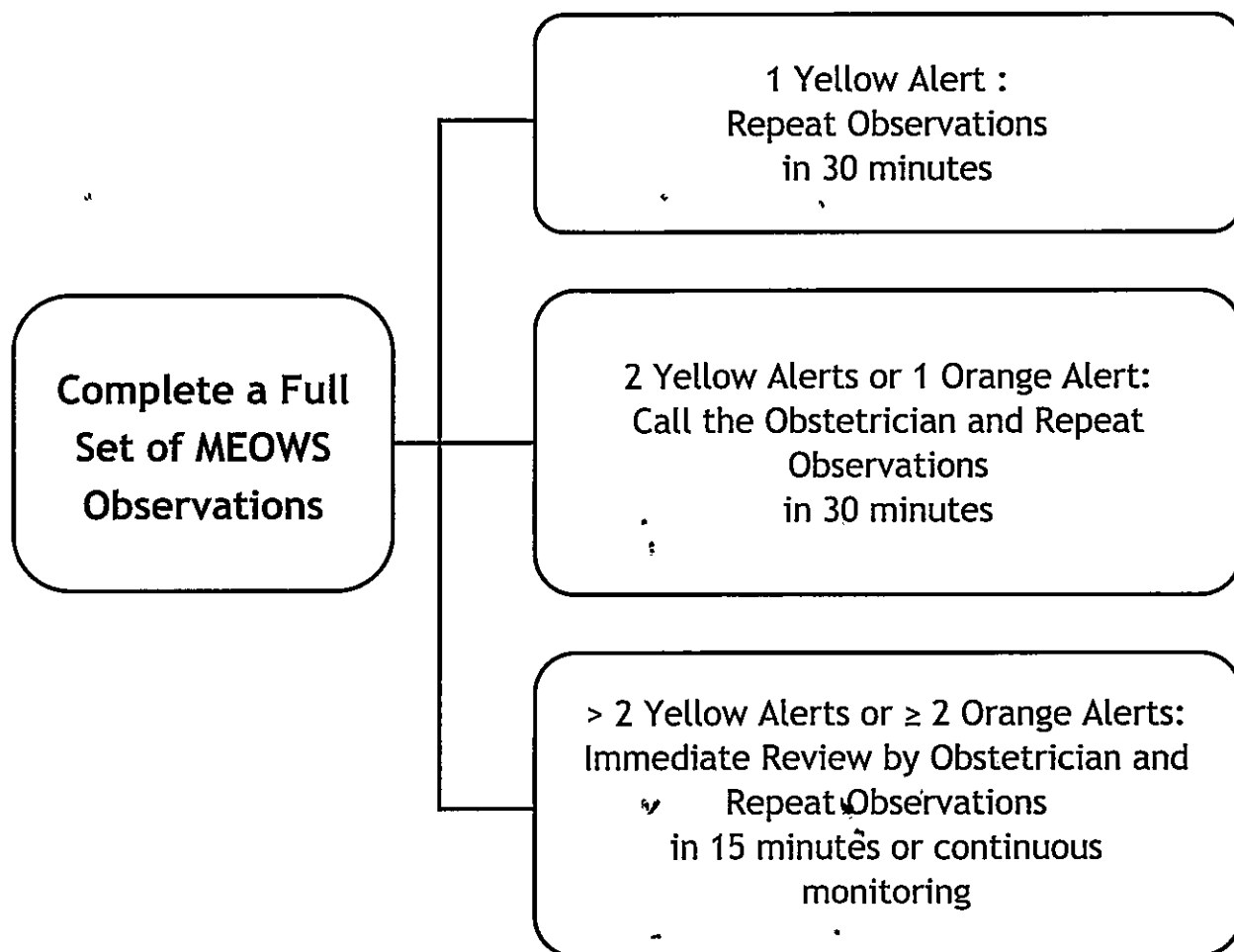
**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## Early Warning Observation Score Chart - Obstetrics

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

[illegible]

## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



IP26-00006747

26-12-1998

27 Y 6 M 14 D

(F)

Dr. RAJANI KUMARI

Pa



**Rainbow<sup>®</sup>  
Children's  
Hospital**  
It takes a lot to treat the little.

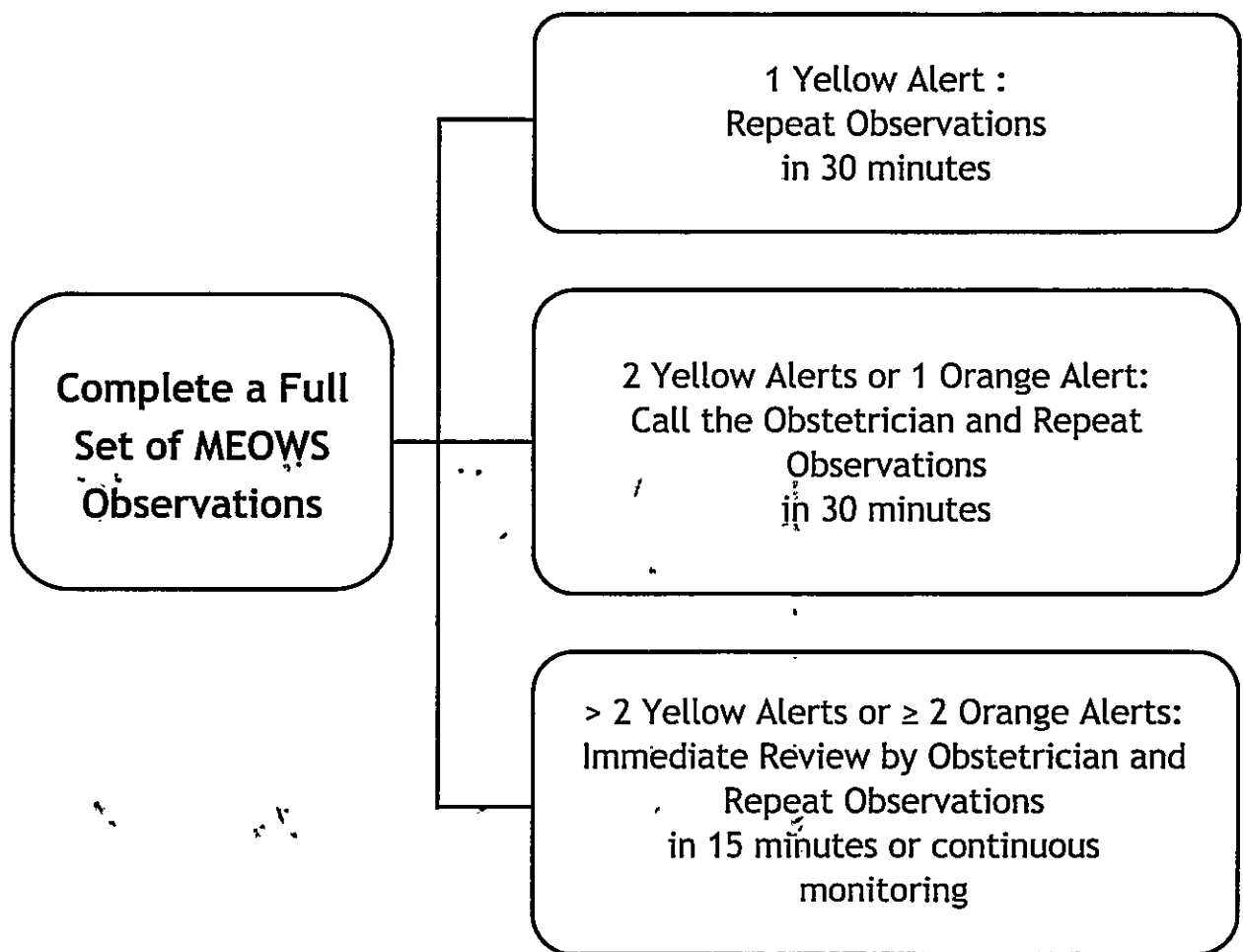


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Your Right to a Safe Delivery

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

[illegible]

## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



## FLUID CHART

Sheet No. : ①

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

| Date                        | Time                        | Nature of Fluid | Intake           |       |     | Output                      |                              |       |          |       | IV Site Thrombophlebitis Score | Sign. Nurse |
|-----------------------------|-----------------------------|-----------------|------------------|-------|-----|-----------------------------|------------------------------|-------|----------|-------|--------------------------------|-------------|
|                             |                             |                 | Mouth            | I.V   | N.G | NG                          | Diarrhoea                    | Vomit | Drainage | Urine |                                |             |
| 5/7                         | 08:00 am                    |                 |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | 09:00 am                    |                 |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | 10:00 am                    |                 |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | 11:00 am                    |                 |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | 12:00 pm                    |                 |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | 01:00 pm                    |                 |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | <b>Total Intake :</b>       |                 |                  |       |     |                             | <b>Total Output :</b>        |       |          |       |                                |             |
| 5/7/20                      | 02:00 pm                    | Rb              | H <sub>2</sub> O | 100ml |     |                             |                              |       |          |       |                                |             |
|                             | 03:00 pm                    | Rb              |                  | 100ml |     |                             |                              |       |          |       |                                |             |
|                             | 04:00 pm                    |                 | H <sub>2</sub> O |       |     |                             |                              |       |          |       |                                |             |
|                             | 05:00 pm                    |                 |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | 06:00 pm                    | Rb              | juice            | 100ml |     |                             |                              |       |          |       |                                |             |
|                             | 07:00 pm                    | Rb              |                  | 100ml |     |                             |                              |       |          |       |                                |             |
|                             | <b>Total Intake :</b> Taken |                 |                  |       |     |                             | <b>Total Output :</b> Passed |       |          |       |                                |             |
| 5/7                         | 08:00 pm                    | PL              |                  | 50ml  |     |                             |                              |       |          |       |                                |             |
|                             | 09:00 pm                    | PL              |                  | 50ml  |     |                             |                              |       |          |       |                                |             |
|                             | 10:00 pm                    | PL              | H <sub>2</sub> O | 50ml  |     |                             |                              |       |          |       |                                |             |
|                             | 11:00 pm                    | PL              |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | 12:00 am                    |                 |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | 01:00 am                    |                 |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | <b>Total Intake :</b> Taken |                 |                  |       |     |                             | <b>Total Output :</b> Passed |       |          |       |                                |             |
| 6/7                         | 02:00 am                    |                 |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | 03:00 am                    |                 |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | 04:00 am                    |                 | H <sub>2</sub> O |       |     |                             |                              |       |          |       |                                |             |
|                             | 05:00 am                    |                 |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | 06:00 am                    |                 | supu             |       |     |                             |                              |       |          |       |                                |             |
|                             | 07:00 am                    |                 |                  |       |     |                             |                              |       |          |       |                                |             |
|                             | <b>Total Intake :</b> Taken |                 |                  |       |     |                             | <b>Total Output :</b> Passed |       |          |       |                                |             |
| <b>Total 24 hrs. Intake</b> |                             |                 |                  |       |     | <b>Total 24 hrs. Output</b> |                              |       |          |       |                                |             |



## FLUID CHART

Sheet No. :                     

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

|                      |                      | Intake             |       |     |     | Output                |           |       |          |       | IV Site<br>Thrombo-<br>phlebitis<br>Score | Sign.<br>Nurse |
|----------------------|----------------------|--------------------|-------|-----|-----|-----------------------|-----------|-------|----------|-------|-------------------------------------------|----------------|
| Date                 | Time                 | Nature<br>of Fluid | Route |     |     | NG                    | Diarrhoea | Vomit | Drainage | Urine |                                           |                |
|                      |                      |                    | Mouth | I.V | N.G |                       |           |       |          |       |                                           |                |
| 6/1/20               | 08:00 am             | H <sub>2</sub> O   |       |     |     |                       |           |       |          | ✓     |                                           | [Signature]    |
|                      | 09:00 am             |                    |       |     |     |                       |           |       |          |       |                                           |                |
|                      | 10:00 am             | WLL                |       |     |     |                       |           |       |          |       |                                           |                |
|                      | 11:00 am             |                    |       |     |     |                       |           |       |          |       |                                           |                |
|                      | 12:00 pm             |                    |       |     |     |                       |           |       |          |       |                                           |                |
|                      | 01:00 pm             | H <sub>2</sub> O   |       |     |     |                       |           |       |          |       |                                           |                |
|                      | Total Intake : Taken |                    |       |     |     | Total Output : passed |           |       |          |       |                                           |                |
| 7/1/20               | 02:00 pm             | Idly               |       |     |     |                       |           |       |          | ✓     |                                           | [Signature]    |
|                      | 03:00 pm             | H <sub>2</sub> O   |       |     |     |                       |           |       |          |       |                                           |                |
|                      | 04:00 pm             |                    |       |     |     |                       |           |       |          |       |                                           |                |
|                      | 05:00 pm             | cord               |       |     |     |                       |           |       |          | ✓     |                                           |                |
|                      | 06:00 pm             | Rice               |       |     |     |                       |           |       |          | ✓     |                                           |                |
|                      | 07:00 pm             | H <sub>2</sub> O   |       |     |     |                       |           |       |          |       |                                           |                |
|                      | Total Intake : Taken |                    |       |     |     | Total Output : passed |           |       |          |       |                                           |                |
| 7/2/20               | 08:00 pm             | H <sub>2</sub> O   |       |     |     |                       |           |       |          |       |                                           | [Signature]    |
|                      | 09:00 pm             | Idly               |       |     |     |                       |           |       |          |       |                                           |                |
|                      | 10:00 pm             | INTJRM ROOM        |       |     |     |                       |           |       |          | ✓     |                                           |                |
|                      | 11:00 pm             | H <sub>2</sub> O   |       |     |     |                       |           |       |          |       |                                           |                |
|                      | 12:00 am             |                    |       |     |     |                       |           |       |          | ✓     |                                           |                |
|                      | 01:00 am             |                    |       |     |     |                       |           |       |          |       |                                           |                |
|                      | Total Intake : taken |                    |       |     |     | Total Output : passed |           |       |          |       |                                           |                |
| Total 24 hrs. Intake |                      |                    |       |     |     |                       |           |       |          |       |                                           |                |
| Total 24 hrs. Output |                      |                    |       |     |     |                       |           |       |          |       |                                           |                |

## FLUID CHART

Sheet No. : ③

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

| Date                 | Time     | Intake              |       |      | Output                |           |       |          |       | IV Site Thrombo-phlebitis Score | Sign. Nurse |  |
|----------------------|----------|---------------------|-------|------|-----------------------|-----------|-------|----------|-------|---------------------------------|-------------|--|
|                      |          | Nature of Fluid     | Route |      | NG                    | Diarrhoea | Vomit | Drainage | Urine |                                 |             |  |
| 27/12                |          |                     | Mouth | I.V  | N.G                   |           |       |          |       |                                 |             |  |
|                      | 08:00 am | H <sub>2</sub> O    |       |      |                       |           |       |          | ✓     |                                 |             |  |
|                      | 09:00 am |                     |       |      |                       |           |       |          |       |                                 |             |  |
|                      | 10:00 am | Milk                |       |      |                       |           |       |          |       |                                 |             |  |
|                      | 11:00 am |                     |       |      |                       |           |       |          | ✓     |                                 |             |  |
|                      | 12:00 pm | H <sub>2</sub> O    |       |      |                       |           |       |          |       |                                 |             |  |
| 01:00 pm             | lunges   |                     |       |      |                       |           |       |          |       |                                 |             |  |
| Total Intake : Taken |          |                     |       |      | Total Output : Passed |           |       |          |       |                                 |             |  |
| 27/12                | 02:00 pm |                     |       |      |                       |           |       |          | ✓     |                                 |             |  |
|                      | 03:00 pm |                     |       |      |                       |           |       |          |       |                                 |             |  |
|                      | 04:00 pm | H <sub>2</sub> O    |       |      |                       |           |       |          |       |                                 |             |  |
|                      | 05:00 pm |                     |       |      |                       |           |       |          |       |                                 |             |  |
|                      | 06:00 pm |                     |       |      |                       |           |       |          |       |                                 |             |  |
|                      | 07:00 pm | RL fruits           |       |      |                       |           |       |          |       |                                 |             |  |
| Total Intake :       |          |                     |       |      | Total Output : Passed |           |       |          |       |                                 |             |  |
| 27/12                | 08:00 pm |                     |       |      |                       |           |       |          |       |                                 |             |  |
|                      | 09:00 pm | RL                  |       | 75ml |                       |           |       |          |       |                                 |             |  |
|                      | 10:00 pm | RL idly             |       | 75ml |                       |           |       |          | ✓     |                                 |             |  |
|                      | 11:00 pm | RL                  |       | 75ml |                       |           |       |          |       |                                 |             |  |
|                      | 12:00 am | RL H <sub>2</sub> O |       | 75ml |                       |           |       |          | ✓     |                                 |             |  |
|                      | 01:00 am | RL                  |       | 75ml |                       |           |       |          |       |                                 |             |  |
| Total Intake : taken |          |                     |       |      | Total Output : passed |           |       |          |       |                                 |             |  |
|                      | 02:00 am | RL                  |       | 75ml |                       |           |       |          |       |                                 |             |  |
|                      | 03:00 am | RL H <sub>2</sub> O |       | 75ml |                       |           |       |          |       |                                 |             |  |
|                      | 04:00 am | RL                  |       | 75ml |                       |           |       |          | ✓     |                                 |             |  |
|                      | 05:00 am | RL H <sub>2</sub> O |       | 75ml |                       |           |       |          | ✓     |                                 |             |  |
|                      | 06:00 am | RL                  |       | 75ml |                       |           |       |          | ✓     |                                 |             |  |
|                      | 07:00 am | RL                  |       | 75ml |                       |           |       |          |       |                                 |             |  |
| Total Intake : taken |          |                     |       |      | Total Output : Passed |           |       |          |       |                                 |             |  |
| Total 24 hrs. Intake |          |                     |       |      |                       |           |       |          |       |                                 |             |  |
| Total 24 hrs. Output |          |                     |       |      |                       |           |       |          |       |                                 |             |  |



## FLUID CHART

Sheet No. : .....

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

| Date                 |  | Time     | Nature of Fluid | Intake  |      |                       | Output |           |       |          |       | IV Site Thrombo-phlebitis Score | Sign. Nurse |
|----------------------|--|----------|-----------------|---------|------|-----------------------|--------|-----------|-------|----------|-------|---------------------------------|-------------|
|                      |  |          |                 | Mouth   | I.V  | N.G                   | NG     | Diarrhoea | Vomit | Drainage | Urine |                                 |             |
| 8/7                  |  | 08:00 am | RL              | H2O     | 25ml |                       |        |           |       |          | ✓     | 1                               | 9           |
| 8/7                  |  | 09:00 am | RL              |         | 25ml |                       |        |           |       |          |       |                                 |             |
| 8/7                  |  | 10:00 am | RL              |         | 25ml |                       |        |           |       |          |       | 0                               | CP          |
| 8/7                  |  | 11:00 am | RL              | H2O     | 25ml |                       |        | NA        |       |          |       |                                 |             |
| 8/7                  |  | 12:00 pm | RL              |         | 25ml |                       |        |           |       |          |       | 1                               |             |
| 8/7                  |  | 01:00 pm | RL              |         | 25ml |                       |        |           |       |          |       |                                 |             |
| Total Intake : Taken |  |          |                 |         |      | Total Output : Passed |        |           |       |          |       |                                 |             |
| 8A                   |  | 02:00 pm | RL              | Kurichi |      |                       |        |           |       |          |       | 1                               | 9           |
| 8A                   |  | 03:00 pm | RL              |         |      |                       |        |           |       |          |       |                                 |             |
| 8A                   |  | 04:00 pm | RL              |         |      |                       |        |           |       |          | ✓     | 0                               | 9           |
| 8A                   |  | 05:00 pm |                 | H2O     |      |                       |        | NA        |       |          |       |                                 |             |
| 8A                   |  | 06:00 pm |                 |         |      |                       |        |           |       |          | ✓     | 1                               | 9           |
| 8A                   |  | 07:00 pm |                 |         |      |                       |        |           |       |          |       |                                 |             |
| Total Intake :       |  |          |                 |         |      | Total Output :        |        |           |       |          |       |                                 |             |
|                      |  | 08:00 pm | RL              |         | 75ml |                       |        |           |       |          | ✓     | 1                               | 9           |
|                      |  | 09:00 pm | RL              |         | 75ml |                       |        |           |       |          | ✓     |                                 |             |
|                      |  | 10:00 pm | RL              | N       | 75ml |                       |        |           |       |          |       | 0                               | 9           |
|                      |  | 11:00 pm | RL              | B       | 75ml |                       |        |           |       |          | ✓     | 1                               | 9           |
|                      |  | 12:00 am | RL              |         | 75ml |                       |        |           |       |          |       |                                 |             |
|                      |  | 01:00 am | RL              | M       | 75ml |                       |        |           |       |          |       |                                 |             |
| Total Intake : Taken |  |          |                 |         |      | Total Output : Passed |        |           |       |          |       |                                 |             |
|                      |  | 02:00 am | RL              |         | 75ml |                       |        |           |       |          |       | 1                               | 9           |
|                      |  | 03:00 am | RL              | N       | 75ml |                       |        |           |       |          | ✓     |                                 |             |
|                      |  | 04:00 am | RL              | B       | 75ml |                       |        |           |       |          | ✓     | 0                               | 9           |
|                      |  | 05:00 am | RL              |         | 75ml |                       |        |           |       |          |       |                                 |             |
|                      |  | 06:00 am | RL              |         | 75ml |                       |        |           |       |          | ✓     | 1                               | 9           |
|                      |  | 07:00 am | RL              | M       | 75ml |                       |        |           |       |          |       |                                 |             |
| Total Intake :       |  |          |                 |         |      | Total Output : Passed |        |           |       |          |       |                                 |             |

Total 24 hrs. Intake

Total 24 hrs. Output





## FLUID CHART

Sheet No. : 3

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

|                             |          | Intake          |               |       |     | Output                |           |       |          |               | IV Site Thrombophlebitis Score | Sign. Nurse  |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|-----------------------------|----------|-----------------|---------------|-------|-----|-----------------------|-----------|-------|----------|---------------|--------------------------------|--------------|-----------------------------|--|--|--|--|--|--|--|--|--|--|--|--|
| Date                        | Time     | Nature of Fluid | Route         |       |     | NG                    | Diarrhoea | Vomit | Drainage | Urine         |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
| 9/07                        |          | ↑               | Mouth         | I.V   | N.G |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 08:00 am |                 |               | 100ml |     |                       |           |       |          | 8:30 AM 150ml |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 09:00 am |                 |               | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 10:00 am | RL              | NBM           | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 11:00 am |                 |               | 100ml |     |                       |           |       |          | 300ml         |                                | empty        |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 12:00 pm | ↓               |               | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 01:00 pm |                 |               | 100ml |     |                       |           |       |          | 250           |                                | empty        |                             |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Total Intake :</b>       |          |                 |               |       |     | <b>Total Output :</b> |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
| 9/7/26                      | 02:00 pm |                 |               | 100ml |     |                       |           |       |          | 100ml         |                                | empty        |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 03:00 pm |                 |               | 100ml |     |                       |           |       |          | 150ml         |                                | empty        |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 04:00 pm | ↑               |               | 100ml |     |                       |           |       |          |               |                                | empty        |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 05:00 pm | RL              | Sips of water | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 06:00 pm | ↓               |               | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 07:00 pm |                 |               | 100ml |     |                       |           |       |          | 500ml         |                                | empty        |                             |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Total Intake :</b>       |          |                 |               |       |     | <b>Total Output :</b> |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
| 9/7/26                      | 08:00 pm | ↓               | Sally + H2O   | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 09:00 pm |                 |               | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 10:00 pm | RL              |               | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 11:00 pm |                 |               | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 12:00 am | ↓               |               | 100ml |     |                       |           |       |          | 1000ml        |                                | empty        |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 01:00 am |                 |               | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Total Intake :</b>       |          |                 |               |       |     | <b>Total Output :</b> |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
| 10/7/26                     | 02:00 am |                 |               | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 03:00 am |                 |               | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 04:00 am |                 |               | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 05:00 am | RL              | H2O           | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 06:00 am | ↓               |               | 100ml |     |                       |           |       |          | 400ml         |                                | empty remove |                             |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 07:00 am |                 |               | 100ml |     |                       |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Total Intake :</b>       |          |                 |               |       |     | <b>Total Output :</b> |           |       |          |               |                                |              |                             |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Total 24 hrs. Intake</b> |          |                 |               |       |     |                       |           |       |          |               |                                |              | <b>Total 24 hrs. Output</b> |  |  |  |  |  |  |  |  |  |  |  |  |

HNH-00000539 IP26-00006747  
Mrs N SASI PRIYA  
26-12-1998 27 Y 6 M 13 D (F)  
Dr. RAJANI KUMARI



## FLUID CHART

Sheet No. : (u)

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

| Date                 | Time     | Nature of Fluid | Intake |     |     | Output                 |           |       |          |       | IV Site Thrombophlebitis Score | Sign. Nurse |
|----------------------|----------|-----------------|--------|-----|-----|------------------------|-----------|-------|----------|-------|--------------------------------|-------------|
|                      |          |                 | Mouth  | I.V | N.G | NG                     | Diarrhoea | Vomit | Drainage | Urine |                                |             |
| 10/7/26              | 08:00 am | ↓<br>Sali Sup   |        |     |     | ↓                      | ↓         |       |          | ✓     | 0                              | }           |
|                      | 09:00 am |                 |        |     |     |                        |           |       |          |       | 0                              |             |
|                      | 10:00 am |                 |        |     | NA  |                        |           | NA    |          |       | 0                              |             |
|                      | 11:00 am |                 |        |     |     |                        |           |       |          |       | 0                              |             |
|                      | 12:00 pm |                 |        |     |     |                        |           |       | ✓        |       | 0                              |             |
|                      | 01:00 pm |                 |        |     |     |                        |           |       |          |       | 0                              |             |
| Total Intake : Taken |          |                 |        |     |     | Total Output : U-2 M.O |           |       |          |       |                                |             |
| 10/7/26              | 02:00 pm | ↓<br>Sali Sup   |        |     |     | ↓                      | ↓         |       |          | ✓     | 1                              | }           |
|                      | 03:00 pm |                 |        |     |     |                        |           |       |          |       | 1                              |             |
|                      | 04:00 pm |                 |        |     |     |                        |           | NA    |          |       | 1                              |             |
|                      | 05:00 pm |                 |        |     | NA  |                        |           |       | ✓        |       | 1                              |             |
|                      | 06:00 pm |                 |        |     |     |                        |           |       |          |       | 1                              |             |
|                      | 07:00 pm |                 |        |     |     |                        |           |       |          |       | 1                              |             |
| Total Intake :       |          |                 |        |     |     | Total Output : 0- M-   |           |       |          |       |                                |             |
| 10/7/26              | 08:00 pm | ↓<br>Rice + H2O |        |     |     | ↓                      | ↓         |       |          |       | 1                              | }           |
|                      | 09:00 pm |                 |        |     |     |                        |           |       |          |       | 1                              |             |
|                      | 10:00 pm |                 |        |     | NA  |                        |           | NA    |          |       | 0                              |             |
|                      | 11:00 pm |                 |        |     |     |                        |           |       |          |       | 0                              |             |
|                      | 12:00 am |                 |        |     |     |                        |           |       |          |       | 1                              |             |
|                      | 01:00 am |                 |        |     |     |                        |           |       |          |       | 1                              |             |
| Total Intake : Taken |          |                 |        |     |     | Total Output : M- 0-   |           |       |          |       |                                |             |
| 11/7                 | 02:00 am | ↓<br>H2O + H2O  |        |     |     | ↓                      | ↓         |       |          |       | 1                              | }           |
|                      | 03:00 am |                 |        |     |     |                        |           |       |          |       | 1                              |             |
|                      | 04:00 am |                 |        |     | NA  |                        |           | NA    |          |       | 0                              |             |
|                      | 05:00 am |                 |        |     |     |                        |           |       |          |       | 0                              |             |
|                      | 06:00 am |                 |        |     |     |                        |           |       |          |       | 1                              |             |
|                      | 07:00 am |                 |        |     |     |                        |           |       |          |       | 1                              |             |
| Total Intake : Taken |          |                 |        |     |     | Total Output : M- 0-   |           |       |          |       |                                |             |

Total 24 hrs. Intake

Total 24 hrs. Output





## 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 /<br>Observe cannula                                                              | 0     | NA    | NA | NA | 0     | 0  | 0  | 0     | 0  | 0  |         |
| 2                      | One of the following signs is evident :<br>* Slight pain near the IV Site /<br>* Slight redness near IV Site                                        | Possibly first signs of phlebitis /<br>Observe cannula                                                  | 1     | NA    | NA | NA | -     | NA | NA | NA    | NA | NA |         |
| 3                      | Two of the following Signs are evident:<br>Pain at IV site Redness                                                                                  | Early stage of phlebitis /<br>Resite Cannula                                                            | 2     | NA    | NA | NA | -     | NA | NA | NA    | NA | NA |         |
| 4                      | All of the following Signs are evident :<br>Pain along Path of cannula<br>Redness around Site Swelling                                              | Medium stage of phlebitis /<br>Resite Cannula Consider Treatment                                        | 3     | NA    | NA | NA | -     | NA | NA | NA    | NA | NA |         |
| 5                      | All of the following Signs are evident and Extensive :<br>Pain along Path of cannula<br>Redness around Site<br>Swelling palpable Venous cord        | Advanced stage of phlebitis or<br>the start of thrombophlebitis /<br>Re site Cannula Consider Treatment | 4     | NA    | NA | NA | -     | NA | NA | NA    | NA | NA |         |
| 6                      | All of the following Signs are evident and Extensive : Pain<br>along Path of cannula Redness<br>around Site Swelling palpable<br>Venous cordpyrexia | Advanced stage of<br>thrombophlebitis /<br>Initiate treatment Re site<br>Cannula                        | 5     | NA    | NA | NA | -     | NA | NA | NA    | NA | NA |         |
| Signature of the Nurse |                                                                                                                                                     |                                                                                                         |       | Si    | CP | @  | @     | CP | Si | @     | @  | Si |         |

**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 : Si Name : Sujatha

Signature of Ward In Charge :

Signature : Pr Name : Karthuvi



## 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 /<br>Observe cannula                                                              | 0     | 0     | 0  | 0  | 0     | 0  | 0  | 0     | 0  |   |         |
| 2                      | One of the following signs is evident :<br>* Slight pain near the IV Site /<br>* Slight redness near IV Site                                         | Possibly first signs of phlebitis /<br>Observe cannula                                                  | 1     | NA    | NA | NA | NA    | NA | NA | NA    | NA |   |         |
| 3                      | Two of the following Signs are evident:<br>Pain at IV site Redness                                                                                   | Early stage of phlebitis /<br>Resite Cannula                                                            | 2     | NA    | NA | NA | NA    | NA | NA | NA    | NA |   |         |
| 4                      | All of the following Signs are evident :<br>Pain along Path of cannula<br>Redness around Site Swelling                                               | Medium stage of phlebitis /<br>Resite Cannula Consider Treatment                                        | 3     | NA    | NA | NA | NA    | NA | NA | NA    | NA |   |         |
| 5                      | All of the following Signs are evident and Extensive :<br>Pain along Path of cannula<br>Redness around Site<br>Swelling palpable Venous cord         | Advanced stage of phlebitis or<br>the start of thrombophlebitis /<br>Re site Cannula Consider Treatment | 4     | NA    | NA | NA | NA    | NA | NA | NA    | NA |   |         |
| 6                      | All of the following Signs are evident and Extensive : Pain<br>along Path of cannula Redness<br>around Site Swelling palpable<br>Venous cord pyrexia | Advanced stage of<br>thrombophlebitis /<br>Initiate treatment Re site<br>Cannula                        | 5     | NA    | NA | NA | NA    | NA | NA | NA    | NA |   |         |
| Signature of the Nurse |                                                                                                                                                      |                                                                                                         |       | CP    | CP | Li | CP    | CP | CP | CP    | CP |   |         |

**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 : CP Name : Chemba

Signature of Ward In Charge :

Signature : Kesturi Name : Kesturi



HNH-00000539  
Mrs N SABI PRIYA  
28-12-1998  
Dr. RAJANI KUMARI  
27 Y 6 M 9 D (F)  
IP26-00006747

## BRADEN 'Q' SCALE

Rainbow<sup>®</sup>  
Children's  
Hospital  
It takes a lot to treat the little.

BirthRight<sup>™</sup>  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date : | 5/7 | 5/7  | 5/7 | 6/7/20 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-----|------|-----|--------|
|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time : | 8AM | 82   | 11  | 16     |
| Mobility                                                                                                                                                                     | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or extremity position independently.                                                                                                                                                                               | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          | 4      | 2   | 4    | 4   |        |
| "Activity The degree of physical activity"                                                                                                                                   | <b>1. Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.                                                                                                    | 4      | 2   | 4    | 4   |        |
| Sensory Perception                                                                                                                                                           | <b>1. Completely limited:</b><br>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.                                                                                                                  | <b>2. Very limited:</b><br>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.                                                                                                                               | <b>3. Slightly limited:</b><br>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.                                                           | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.                                                                                                                                    | 4      | 4   | 4    | 4   |        |
| Moisture Degree to which skin is exposed to moisture                                                                                                                         | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   | 4      | 4   | 4    | 4   |        |
| <b>FRICTION-SHEAR</b><br><b>Friction</b> Occurs when skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | <b>2. Problem:</b><br>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.                                                                                                                    | <b>3. Potential problem:</b><br>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.            | <b>4. No apparent problem:</b><br>Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."                         | 4      | 4   | 4    | 4   |        |
| Nutritional Usual food intake pattern                                                                                                                                        | <b>1. Very Poor:</b><br>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. | <b>2. Inadequate:</b><br>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. | <b>3. Adequate:</b><br>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. | <b>4. Excellent:</b><br>Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. | 4      | 4   | 4    | 4   |        |
| Tissue Perfusion & Oxygenation                                                                                                                                               | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               | 4      | 4   | 4    | 4   |        |
| <b>TOTAL SCORE</b>                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | 28     | 28  | 28   | 28  |        |
| <b>Evaluator's Name</b>                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Pi     | Dr  | Amey | Q   |        |

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                                                                                                                                                                                                                                                                                                                                       | <b>Support Surfaces</b><br>(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       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for “At Risk” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>                                                                                                                                                               | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for “Moderate Risk” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>                                                                                                                    | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for “High Risk” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>                                                                                                                            | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |



## BRADEN 'Q' SCALE

|                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date :                  | 6/7  | 6/7 | 7/7  | 2/2  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------|-----|------|------|
|                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time :                  | 6:22 | 8PM | 7:46 | 1:22 |
| Mobility                                                                                                                                                                      | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or extremity position independently.                                                                                                                                                                               | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          | 2                       | 4    | 4   | 4    |      |
| "Activity The degree of physical activity"                                                                                                                                    | <b>1. Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.                                                                                                    | 4                       | 4    | 4   | 4    |      |
| Sensory Perception                                                                                                                                                            | <b>1. Completely limited:</b><br>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.                                                                                                                  | <b>2. Very limited:</b><br>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.                                                                                                                               | <b>3. Slightly limited:</b><br>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.                                                           | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.                                                                                                                                    | 4                       | 4    | 4   | 4    |      |
| Moisture Degree to which skin is exposed to moisture                                                                                                                          | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   | 4                       | 4    | 4   | 4    |      |
| <b>FRICITION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | <b>2. Problem:</b><br>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.                                                                                                                    | <b>3. Potential problem:</b><br>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.            | <b>4. No apparent problem:</b><br>Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."                         | 4                       | 4    | 4   | 4    |      |
| Nutritional Usual food intake pattern                                                                                                                                         | <b>1. Very Poor:</b><br>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. | <b>2. Inadequate:</b><br>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. | <b>3. Adequate:</b><br>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. | <b>4. Excellent:</b><br>Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. | 4                       | 4    | 4   | 4    |      |
| Tissue Perfusion & Oxygenation                                                                                                                                                | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               | 4                       | 4    | 4   | 4    |      |
| <b>Severe Risk : less than 9   High Risk : 10-12   Moderate Risk : 13-14   Mild Risk : 15-18   Not at Risk: 19-23</b>                                                         |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>TOTAL SCORE</b>      | 28   | 28  | 28   | 28   |
| Docu. No. : RCH /FRM / CLINICAL / 119                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>Evaluator's Name</b> | Ch   | R   | Ch   | Ch   |

| Risk Score  | Category      | Action                                                                                                                                                                                                                                                                                                                                       | <b>Support Surfaces</b><br>(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       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for "At Risk" Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>                                                                                                                                                               | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for "Moderate Risk" Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>                                                                                                                    | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for "High Risk" Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>                                                                                                                            | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |





## BRADEN 'Q' SCALE

|                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date : | 7/7  | 8/7  | 8/7 | 8/7  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------|------|-----|------|
|                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time : | 8 PM | 7 PM | 6   | 8 PM |
| Mobility                                                                                                                                                                    | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or extremity position independently.                                                                                                                                                                               | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          | 4      | 4    | 4    | 4   |      |
| "Activity The degree of physical activity"                                                                                                                                  | <b>1. Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.                                                                                                    | 4      | 4    | 4    | 4   |      |
| Sensory Perception                                                                                                                                                          | <b>1. Completely limited:</b><br>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.                                                                                                                  | <b>2. Very limited:</b><br>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.                                                                                                                               | <b>3. Slightly limited:</b><br>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.                                                           | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.                                                                                                                                    | 4      | 4    | 4    | 4   |      |
| Moisture Degree to which skin is exposed to moisture                                                                                                                        | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   | 4      | 4    | 4    | 4   |      |
| <b>FRICION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | <b>2. Problem:</b><br>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.                                                                                                                    | <b>3. Potential problem:</b><br>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.            | <b>4. No apparent problem:</b><br>Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."                         | 4      | 4    | 4    | 4   |      |
| Nutritional Usual food intake pattern                                                                                                                                       | <b>1. Very Poor:</b><br>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. | <b>2. Inadequate:</b><br>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. | <b>3. Adequate:</b><br>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. | <b>4. Excellent:</b><br>Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. | 4      | 4    | 4    | 4   |      |
| Tissue Perfusion & Oxygenation                                                                                                                                              | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               | 4      | 4    | 4    | 4   |      |
| <b>TOTAL SCORE</b>                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | 28     | 28   | 28   | 28  |      |
| <b>Evaluator's Name</b>                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Ri     | Q    | Q    | G   |      |

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                                                                                                                                                                                                                                                                                                                                       | <b>Support Surfaces</b><br>(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       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for <b>"At Risk"</b> Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>                                                                                                                                                        | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for <b>"Moderate Risk"</b> Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>                                                                                                             | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for <b>"High Risk"</b> Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>                                                                                                                     | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |





# BRADEN 'Q' SCALE

|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 | Date :                                                                                                                                                                                                                                                                                 | 9/12 | 9/7 | 10/2 | 10/12 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-----|------|-------|
|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 | Time :                                                                                                                                                                                                                                                                                 | 12   | 12  | 12   | 12    |
| Mobility                                                                                                                                                                     | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or extremity position independently.                                                                                                                                                                               | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          | 4    | 4   | 4    | 4     |
| "Activity The degree of physical activity"                                                                                                                                   | <b>1. Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.                                                                                                    | 4    | 4   | 4    | 4     |
| Sensory Perception                                                                                                                                                           | <b>1. Completely limited:</b><br>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.                                                                                                                  | <b>2. Very limited:</b><br>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.                                                                                                                               | <b>3. Slightly limited:</b><br>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.                                                           | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.                                                                                                                                    | 4    | 4   | 4    | 4     |
| Moisture Degree to which skin is exposed to moisture                                                                                                                         | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   | 4    | 4   | 4    | 4     |
| <b>FRICTION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | <b>2. Problem:</b><br>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.                                                                                                                    | <b>3. Potential problem:</b><br>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.            | <b>4. No apparent problem:</b><br>Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."                         | 4    | 4   | 4    | 4     |
| Nutritional Usual food intake pattern                                                                                                                                        | <b>1. Very Poor:</b><br>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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement. | <b>2. Inadequate:</b><br>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. | <b>3. Adequate:</b><br>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. | <b>4. Excellent:</b><br>Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. | 4    | 4   | 4    | 4     |
| Tissue Perfusion & Oxygenation                                                                                                                                               | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               | 4    | 4   | 4    | 4     |
| <b>TOTAL SCORE</b>                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | 28   | 28  | 28   | 28    |
| <b>Evaluator's Name</b>                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Pi   | 10  | 10   | 10    |

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                                                                                                                                                                                                                                                                                                                                       | <b>Support Surfaces</b><br>(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       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for “<b>At Risk</b>” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>                                                                                                                                                        | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for “<b>Moderate Risk</b>” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>                                                                                                             | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for “<b>High Risk</b>” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>                                                                                                                     | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |



HNH-00000539

IP26-00006747

Mrs N SASI PRIYA

28-12-1998

27 Y 6 M 14 D (F)

Dr. RAJANI KUMARI



## BRADEN 'Q' SCALE

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

BirthRight™  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

|                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date : | 10/7 | 10/7 | 11/7 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------|------|------|--|
|                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time : | 01   | 06   | 02   |  |
| Mobility                                                                                                                                                                    | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                    | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or extremity position independently.                                                                                                                                                                               | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          | 4      | 4    | 4    |      |  |
| "Activity The degree of physical activity"                                                                                                                                  | <b>1. Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.                                                                                                                        | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.                                                                                                    | 4      | 4    | 4    |      |  |
| Sensory Perception                                                                                                                                                          | <b>1. Completely limited:</b><br>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.                                                                                                                  | <b>2. Very limited:</b><br>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.                                                                                                                               | <b>3. Slightly limited:</b><br>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.                                                           | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.                                                                                                                                    | 4      | 4    | 4    |      |  |
| Moisture Degree to which skin is exposed to moisture                                                                                                                        | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.                                                                                                                                                                   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   | 4      | 4    | 4    |      |  |
| <b>FRICION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | <b>2. Problem:</b><br>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.                                                                                                                    | <b>3. Potential problem:</b><br>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.            | <b>4. No apparent problem:</b><br>Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."                         | 4      | 4    | 4    |      |  |
| Nutritional Usual food intake pattern                                                                                                                                       | <b>1. Very Poor:</b><br>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. | <b>2. Inadequate:</b><br>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. | <b>3. Adequate:</b><br>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. | <b>4. Excellent:</b><br>Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. | 4      | 4    | 4    |      |  |
| Tissue Perfusion & Oxygenation                                                                                                                                              | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.                                                                                                                                                                                                | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.                                                                                                                                        | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               | 4      | 4    | 4    |      |  |
| <b>TOTAL SCORE</b>                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | 20     | 28   | 28   |      |  |
| <b>Evaluator's Name</b>                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        |        |      |      |      |  |

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                                                                                                                                                                                                                                                                                                                                       | <b>Support Surfaces</b><br>(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       | <ul style="list-style-type: none"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for “At Risk” Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>                                                                                                                                                               | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for “Moderate Risk” Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>                                                                                                                    | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for “High Risk” Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>                                                                                                                            | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay                                                                  |



## Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category   |                               | Date / Time | 5/7 | 5/7 | 5/7 | Fall Risk Grading |                        |                                                           |
|------------------------------------------------------|-------------------------------|-------------|-----|-----|-----|-------------------|------------------------|-----------------------------------------------------------|
|                                                      |                               | Score       | 8AM | 6Z  | 5h  | Risk Level        | Morse Fall Score (MFS) | Action                                                    |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          |     |     |     | Low Risk          | 0 - 24                 | Standard Fall<br>Precaution                               |
|                                                      | No                            | 0           |     |     |     |                   |                        |                                                           |
| Secondary Diagnosis<br>(more than one diagnosis)     | Yes                           | 15          |     |     |     | Moderate Risk     | 25 - 50                | Implement<br>Moderate Fall<br>Prevention<br>Intervention  |
|                                                      | No                            | 0           |     |     |     |                   |                        |                                                           |
| Ambulatory Aid                                       | Furniture                     | 30          |     |     |     | High Risk         | ≥ 51                   | Implement High<br>Risk Fall<br>Prevention<br>Intervention |
|                                                      | Crutches, Cane(S), Walker     | 15          |     |     |     |                   |                        |                                                           |
|                                                      | None /Bed Rest /Nurse Assist  | 0           | 0   | 0   | 0   |                   |                        |                                                           |
| IV / Heparin Lock or Saline                          | Yes                           | 20          | 20  | 20  | 20  | Moderate Risk     | 25 - 50                | Implement<br>Moderate Fall<br>Prevention<br>Intervention  |
|                                                      | No                            | 0           |     |     |     |                   |                        |                                                           |
| GAIT / Transferring                                  | Impaired                      | 20          |     |     |     | High Risk         | ≥ 51                   | Implement High<br>Risk Fall<br>Prevention<br>Intervention |
|                                                      | Weak (uses touch for balance) | 10          |     |     |     |                   |                        |                                                           |
|                                                      | Normal /On Bed Rest /Immobile | 0           |     |     |     |                   |                        |                                                           |
| Mental Status                                        | Forgets limitations           | 15          |     |     |     | High Risk         | ≥ 51                   | Implement High<br>Risk Fall<br>Prevention<br>Intervention |
|                                                      | Oriented to own ability       | 0           |     | 0   |     |                   |                        |                                                           |
| Total Morse Fall Scale Score:                        |                               |             | 20  | 20  | 20  |                   |                        |                                                           |
| Signature                                            |                               |             | Li  | Q   | Q   |                   |                        |                                                           |

Tick (✓) whichever precaution taken.

### Risk Level and Interventions

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

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

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

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

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

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

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## Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category   |                               | Date / Time | 6/12/26<br>mb | 6/7<br>8pm | 7/7/26<br>mb | Fall Risk Grading |                        |                                                           |
|------------------------------------------------------|-------------------------------|-------------|---------------|------------|--------------|-------------------|------------------------|-----------------------------------------------------------|
|                                                      |                               | Score       |               |            |              | Risk Level        | Morse Fall Score (MFS) | Action                                                    |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          |               |            |              |                   |                        |                                                           |
|                                                      | No                            | 0           |               |            |              |                   |                        |                                                           |
| Secondary Diagnosis<br>(more than one diagnosis)     | Yes                           | 15          |               |            |              | Low Risk          | 0 - 24                 | Standard Fall<br>Precaution                               |
|                                                      | No                            | 0           | 0             | 0          | 0            |                   |                        |                                                           |
| Ambulatory Aid                                       | Furniture                     | 30          |               |            |              |                   |                        |                                                           |
|                                                      | Crutches, Cane(S), Walker     | 15          |               |            |              |                   |                        |                                                           |
|                                                      | None /Bed Rest /Nurse Assist  | 0           |               |            | 0            |                   |                        |                                                           |
| IV / Heparin Lock or Saline                          | Yes                           | 20          | 20            | 20         | 20           | Moderate Risk     | 25 - 50                | Implement<br>Moderate Fall<br>Prevention<br>Intervention  |
|                                                      | No                            | 0           |               |            |              |                   |                        |                                                           |
| GAIT / Transferring                                  | Impaired                      | 20          |               |            |              |                   |                        |                                                           |
|                                                      | Weak (uses touch for balance) | 10          |               |            |              |                   |                        |                                                           |
|                                                      | Normal /On Bed Rest /Immobile | 0           | 0             | 0          | 0            |                   |                        |                                                           |
| Mental Status                                        | Forgets limitations           | 15          |               |            |              | High Risk         | ≥ 51                   | Implement High<br>Risk Fall<br>Prevention<br>Intervention |
|                                                      | Oriented to own ability       | 0           |               |            | 0            |                   |                        |                                                           |
| Total Morse Fall Scale Score:                        |                               |             | 20            | 20         | 20           |                   |                        |                                                           |
| Signature                                            |                               |             | Q             | Ri         | Q            |                   |                        |                                                           |

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-00000539 IP26-00006747  
 Mrs N SASI PRIYA  
 28-12-1998 27 Y 6 M 11 D (F)  
 Dr. RAJANI KUMARI



## Morse Fall Risk Assessment Form

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

**BirthRight™**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

| Choose Highest Applicable Score from each Category   |                               | Date / Time | 3/2                | 7/7                | 8/7/26             | Fall Risk Grading |                        |                                                  |
|------------------------------------------------------|-------------------------------|-------------|--------------------|--------------------|--------------------|-------------------|------------------------|--------------------------------------------------|
|                                                      |                               | Score       | 62                 | 8pm                | mb                 | Risk Level        | Morse Fall Score (MFS) | Action                                           |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          |                    |                    |                    | Risk Level        | Morse Fall Score (MFS) | Action                                           |
|                                                      | No                            | 0           |                    |                    |                    |                   |                        |                                                  |
| Secondary Diagnosis<br>(more than one diagnosis)     | Yes                           | 15          |                    |                    |                    | Low Risk          | 0 - 24                 | Standard Fall Precaution                         |
|                                                      | No                            | 0           |                    |                    |                    |                   |                        |                                                  |
| Ambulatory Aid                                       | Furniture                     | 30          |                    |                    |                    | Moderate Risk     | 25 - 50                | Implement Moderate Fall Prevention Intervention  |
|                                                      | Crutches, Cane(S), Walker     | 15          |                    |                    |                    |                   |                        |                                                  |
|                                                      | None /Bed Rest /Nurse Assist  | 0           |                    |                    |                    |                   |                        |                                                  |
| IV / Heparin Lock or Saline                          | Yes                           | 20          |                    |                    |                    | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|                                                      | No                            | 0           |                    |                    |                    |                   |                        |                                                  |
| GAIT / Transferring                                  | Impaired                      | 20          | 20                 | 20                 | 20                 | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|                                                      | 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           |                    |                    | 0                  |                   |                        |                                                  |
| Total Morse Fall Scale Score:                        |                               |             | 20                 | 20                 | 20                 |                   |                        |                                                  |
| Signature                                            |                               |             | <i>[Signature]</i> | <i>[Signature]</i> | <i>[Signature]</i> |                   |                        |                                                  |

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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HNH-00000539 IP26-00006747  
Mrs N SAGI PRIYA  
26-12-1998 27 Y 6 M 11 D (F)  
Dr. RAJANI KUMARI



## Morse Fall Risk Assessment Form

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

**BirthRight™**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

| Choose Highest Applicable Score from each Category |                               | Date / Time | 8/7 | 9/7            | 9/7 | Fall Risk Grading |                        |                                                  |
|----------------------------------------------------|-------------------------------|-------------|-----|----------------|-----|-------------------|------------------------|--------------------------------------------------|
|                                                    |                               | Score       | 8pm | 6 <sub>2</sub> | N1  | Risk Level        | Morse Fall Score (MFS) | Action                                           |
| History of Falling (immediately or w/in 3 months)  | Yes                           | 25          |     |                |     | Low Risk          | 0 - 24                 | Standard Fall Precaution                         |
|                                                    | No                            | 0           |     |                |     |                   |                        |                                                  |
| Secondary Diagnosis (more than one diagnosis)      | Yes                           | 15          |     |                |     | Moderate Risk     | 25 - 50                | Implement Moderate Fall Prevention Intervention  |
|                                                    | No                            | 0           |     |                |     |                   |                        |                                                  |
| Ambulatory Aid                                     | Furniture                     | 30          |     |                |     | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|                                                    | Crutches, Cane(S), Walker     | 15          |     |                |     |                   |                        |                                                  |
|                                                    | None /Bed Rest /Nurse Assist  | 0           | 0   | 0              | 0   |                   |                        |                                                  |
| IV / Heparin Lock or Saline                        | Yes                           | 20          | 20  | 20             | 20  | Moderate Risk     | 25 - 50                | Implement Moderate Fall Prevention Intervention  |
|                                                    | No                            | 0           |     |                |     |                   |                        |                                                  |
| GAIT / Transferring                                | Impaired                      | 20          |     |                |     | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|                                                    | Weak (uses touch for balance) | 10          |     |                |     |                   |                        |                                                  |
|                                                    | Normal /On Bed Rest /Immobile | 0           |     |                |     |                   |                        |                                                  |
| 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             | 20  |                   |                        |                                                  |
|                                                    |                               | Signature   | fu  | AB             | W   |                   |                        |                                                  |

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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HNH-00000539 IP26-00006747  
Mrs N SASI PRIYA  
28-12-1998 27 Y 6 M 9 D (F)  
Dr. RAJANI KUMARI



## PAIN ASSESSMENT FORM

| Date | Time | Pre (0/10) | Location | Duration                                                                     | Acuity                                                             | Character                                                                                                                        | Modifying Factors                                                          | Patient / Family Educated                                   | Intervention | Sign |
|------|------|------------|----------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|--------------|------|
| 5/7  | 1pm  | 0          | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |
| 5/7  | 3pm  | 0          | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |
| 5/7  | 10pm | 0/10       | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |
| 5/7  | 5PM  | 0/10       | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |
| 6/7  | 9AM  | 0/10       | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |
| 6/7  | 2pm  | 0/10       | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |
| 6/7  | 4pm  | 0/10       | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |
| 6/7  | 11AM | 0          | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |
| 7/7  | 4AM  | 0          | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |
| 7/7  | 7AM  | 0          | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |

**Re-assessment Frequency:**

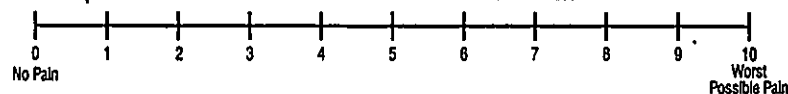
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain pain-relieving intervention.
  - Within 30 – 60 minutes after pain relief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

# PAIN ASSESSMENT TOOLS

**FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)**

| CATEGORY      | SCORING                                      |                                                                             |                                                          |
|---------------|----------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------|
|               | 0                                            | 1                                                                           | 2                                                        |
| Face          | No Particular expression or smile            | Occasional Grimace or Frown, withdraw, Disoriented                          | Frequent to constant frown, quivering chin, clenched jaw |
| Legs          | Normal Position or Relaxed                   | Uneasy, restless, tense                                                     | Kicking, or legs drawn up                                |
| Activity      | Laying quietly normal position, moves easily | Squirming shifting back and forth, tense                                    | Arched, rigid, or Jerking                                |
| Cry           | No Cry (Awake or asleep)                     | Moans or whimpers occasional complaint                                      | Crying steadily, screams of sobs, frequent complaints    |
| Consolability | Content, relaxed                             | Reassured by occasional touching, hugging, or being talked to, distractible | Difficult to console or comfort                          |

**Numerical Pain Scale (Obstetric and Gynecology)**



**Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)**

| Assessment Criteria                      | Sedation                                                |                                                             | Normal                                        | Pain / Agitation                                                                           |                                                                                                                                                         |
|------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                          | -2                                                      | -1                                                          | 0                                             | 1                                                                                          | 2                                                                                                                                                       |
| Crying Irritability                      | No Cry with painful stimuli                             | Moans or cries minimally with painful stimuli               | Appropriate crying Not irritable              | Irritable or crying at intervals consolable                                                | High-pitched or silent-continuous cry Inconsolable                                                                                                      |
| Behavior State                           | No arousal to any stimuli<br>No spontaneous movement    | Arouses minimally to stimuli<br>Little spontaneous movement | Appropriate for gestational age               | Restless, squirming<br>Awakens frequently                                                  | Arching, kicking constantly awake or<br>Arouses minimally / no movement (not sedated)                                                                   |
| Facial Expression                        | Mouth is lax<br>No expression                           | Minimal expression with stimuli                             | Relaxed Appropriate                           | Any pain expression intermittent                                                           | Any pain expression continual                                                                                                                           |
| Extremities Tone                         | No grasp reflex<br>Flaccid tone                         | Weak grasp reflex<br>decreased muscle tone                  | Relaxed hands and feet<br>Normal Tone         | Intermittent clenched toes, fists or finger splay<br>Body is not tense                     | Continual clenched toes, fists, or finger splay<br>Body is tense                                                                                        |
| Vital Signs HR, RR, BP, SaO <sub>2</sub> | No variability with stimuli<br>Hypoventilation or apnea | Less than 10% variability from baseline with stimuli        | Within baseline or normal for gestational age | Increase 10-20% from baseline<br>SaO <sub>2</sub> 76-85% with stimulation - quick recovery | Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator |

**Wong - Baker (Pediatrics) Above 7 Years**



0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Even More 8 Hurts Whole Lot 10 Hurts Worst





## PAIN ASSESSMENT FORM

| Date   | Time | Pain Score (0/10) | Location | Duration                                                                     | Acuity                                                             | Character                                                                                                                        | Modifying Factors                                                          | Patient / Family Educated                                   | Intervention | Sign |
|--------|------|-------------------|----------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|--------------|------|
| 7/7/26 | 10AM | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | cel  |
| 7/7/26 | 2PM  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | cel  |
| 7/7/26 | 3PM  | 0                 | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |
| 7/7/26 | 4PM  | 0                 | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |
| 8/7/26 | 2AM  | 0                 | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |
| 8/7/26 | 9AM  | 0                 | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Q    |
| 8/7    | 11AM | 0                 | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Q    |
| 8/7    | 2PM  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Q    |
| 8/8/26 | 2PM  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |
| 8/7/26 | 4PM  | 0                 | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           | Li   |

### Re-assessment Frequency:

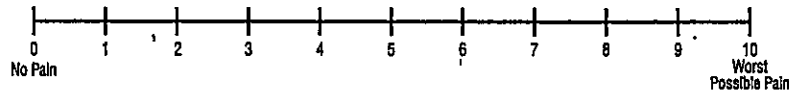
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain pain-relieving intervention.
  - Within 30 – 60 minutes after pain relief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

# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

| CATEGORY      | SCORING                                      |                                                                             |                                                          |
|---------------|----------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------|
|               | 0                                            | 1                                                                           | 2                                                        |
| Face          | No Particular expression or smile            | Occasional Grimace or Frown, withdraw, Disoriented                          | Frequent to constant frown, quivering chin, clenched jaw |
| Legs          | Normal Position or Relaxed                   | Uneasy, restless, tense                                                     | Kicking, or legs drawn up                                |
| Activity      | Laying quietly normal position, moves easily | Squirming shifting back and forth, tense                                    | Arched, rigid, or Jerking                                |
| Cry           | No Cry (Awake or asleep)                     | Moans or whimpers occasional complaint                                      | Crying steadily, screams or sobs, frequent complaints    |
| Consolability | Content, relaxed                             | Reassured by occasional touching, hugging, or being talked to, distractible | Difficult to console or comfort                          |

## Numerical Pain Scale (Obstetric and Gynecology)



## Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

| Assessment Criteria                      | Sedation                                                |                                                             | Normal                                        | Pain / Agitation                                                                           |                                                                                                                                                         |
|------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                          | -2                                                      | -1                                                          | 0                                             | 1                                                                                          | 2                                                                                                                                                       |
| Crying Irritability                      | No Cry with painful stimuli                             | Moans or cries minimally with painful stimuli               | Appropriate crying Not irritable              | Irritable or crying at intervals consolable                                                | High-pitched or silent-continuous cry Inconsolable                                                                                                      |
| Behavior State                           | No arousal to any stimuli<br>No spontaneous movement    | Arouses minimally to stimuli<br>Little spontaneous movement | Appropriate for gestational age               | Restless, squirming<br>Awakens frequently                                                  | Arching, kicking constantly awake or<br>Arouses minimally / no movement (not sedated)                                                                   |
| Facial Expression                        | Mouth is lax<br>No expression                           | Minimal expression with stimuli                             | Relaxed Appropriate                           | Any pain expression intermittent                                                           | Any pain expression continual                                                                                                                           |
| Extremities Tone                         | No grasp reflex<br>Flaccid tone                         | Weak grasp reflex<br>decreased muscle tone                  | Relaxed hands and feet<br>Normal Tone         | Intermittent clenched toes, fists or finger splay<br>Body is not tense                     | Continual clenched toes, fists, or finger splay<br>Body is tense                                                                                        |
| Vital Signs HR, RR, BP, SaO <sub>2</sub> | No variability with stimuli<br>Hypoventilation or apnea | Less than 10% variability from baseline with stimuli        | Within baseline or normal for gestational age | Increase 10-20% from baseline<br>SaO <sub>2</sub> 76-85% with stimulation - quick recovery | Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator |

## Wong - Baker (Pediatrics) Above 7 Years





# PAIN ASSESSMENT FORM

| Date    | Time | Pain Score (0/10) | Location | Duration                                                                                | Acuity                                                                        | Character                                                                                                                                   | Modifying Factors                                                                     | Patient / Family Educated                                              | Intervention           | Sign |
|---------|------|-------------------|----------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------|------|
| 9/7/26  | 6pm  | 1/10              | abdomen  | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA<br>given diclo Tab. |      |
| 9/7/26  | 10pm | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | NA                     |      |
| 10/7/26 | 6am  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | NA                     |      |
| 10/7/26 | 10am | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA                     |      |
| 10/7/26 | 2pm  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input checked="" type="checkbox"/> Intermittent | <input checked="" type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input checked="" type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input checked="" type="checkbox"/> Decreasing | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | NA                     |      |
| 10/7/26 | 2pm  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input checked="" type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input checked="" type="checkbox"/> Decreasing | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No | NA                     |      |
| 11/7    | 6am  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA                     |      |
| 11/7/26 | 10am | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA                     |      |
| 11/7/26 | 2pm  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            | NA                     |      |
|         |      |                   |          | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent            | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic            | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning            | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No            |                        |      |

## Re-assessment Frequency:

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

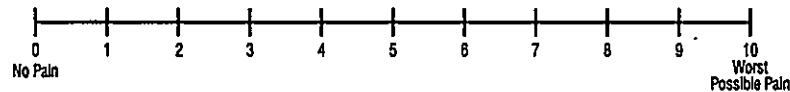


# PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

| CATEGORY      | SCORING                                      |                                                                             |                                                          |
|---------------|----------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------|
|               | 0                                            | 1                                                                           | 2                                                        |
| Face          | No Particular expression or smile            | Occasional Grimace or Frown, withdraw, Disoriented                          | Frequent to constant frown, quivering chin, clenched jaw |
| Legs          | Normal Position or Relaxed                   | Uneasy, restless, tense                                                     | Kicking, or legs drawn up                                |
| Activity      | Laying quietly normal position, moves easily | Squirming shifting back and forth, tense                                    | Arched, rigid, or Jerking                                |
| Cry           | No Cry (Awake or asleep)                     | Moans or whimpers occasional complaint                                      | Crying steadily, screams or sobs, frequent complaints    |
| Consolability | Content, relaxed                             | Reassured by occasional touching, hugging, or being talked to, distractible | Difficult to console or comfort                          |

Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

| Assessment Criteria                            | Sedation                                                |                                                             | Normal                                        | Pain / Agitation                                                                           |                                                                                                                                                         |
|------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                | -2                                                      | -1                                                          | 0                                             | 1                                                                                          | 2                                                                                                                                                       |
| <b>Crying Irritability</b>                     | 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                                                                                                      |
| <b>Behavior State</b>                          | No arousal to any stimuli<br>No spontaneous movement    | Arouses minimally to stimuli<br>Little spontaneous movement | Appropriate for gestational age               | Restless, squirming<br>Awakens frequently                                                  | Arching, kicking constantly awake or<br>Arouses minimally / no movement (not sedated)                                                                   |
| <b>Facial Expression</b>                       | Mouth is lax<br>No expression                           | Minimal expression with stimuli                             | Relaxed Appropriate                           | Any pain expression intermittent                                                           | Any pain expression continual                                                                                                                           |
| <b>Extremities Tone</b>                        | No grasp reflex<br>Flaccid tone                         | Weak grasp reflex<br>decreased muscle tone                  | Relaxed hands and feet<br>Normal Tone         | Intermittent clenched toes, fists or finger splay<br>Body is not tense                     | Continual clenched toes, fists, or finger splay<br>Body is tense                                                                                        |
| <b>Vital Signs HR, RR, BP, SaO<sub>2</sub></b> | No variability with stimuli<br>Hypoventilation or apnea | Less than 10% variability from baseline with stimuli        | Within baseline or normal for gestational age | Increase 10-20% from baseline<br>SaO <sub>2</sub> 76-85% with stimulation - quick recovery | Increase greater than 20% from baseline, SaO <sub>2</sub> less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator |

Wong - Baker (Pediatrics) Above 7 Years



HNH-00000539

IP26-00006747

Mrs N Sasi Priya

28-12-1998

27 Y 6 M 9 D

(F)

Dr. RAJANI KUMARI



# NURSING CARE RECORD

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

**BirthRight**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

Date: 5/7/26

## Goals

- |                                                           |                                                       |                                                            |                                                     |                                                                     |                                                                |
|-----------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Maintain Airway and Oxygenation  | <input type="checkbox"/> Relieve Pain & Discomfort    | <input type="checkbox"/> Maintain Fluid Balance            | <input type="checkbox"/> Improve Activity Tolerance | <input type="checkbox"/> Maintain Good Nutritional Status           | <input type="checkbox"/> Maintain Skin Integrity               |
| <input type="checkbox"/> Maintain Personal Hygiene        | <input checked="" type="checkbox"/> Prevent Infection | <input checked="" type="checkbox"/> Meet Elimination Needs | <input checked="" type="checkbox"/> Ensure Safety   | <input checked="" type="checkbox"/> Early Ambulation Reduce Anxiety | <input checked="" type="checkbox"/> Patient & Family Education |
| <input type="checkbox"/> Identify Potential Complications |                                                       |                                                            |                                                     |                                                                     |                                                                |
| <input type="checkbox"/> Any Others. Specify.....         |                                                       |                                                            |                                                     |                                                                     |                                                                |

|           | Time             | Plan of Care                                                                                      | Time             | Implementation                                                                        | Evaluation       | Re-Assessment     | Nurse Name & Signature |
|-----------|------------------|---------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------|------------------|-------------------|------------------------|
| Morning   |                  |                                                                                                   |                  |                                                                                       |                  |                   |                        |
| Afternoon | 2pm<br>To<br>8pm | → Assess the pt condition<br>→ plan for vitals<br>→ plan for I/O chart<br>→ plan for IV placement | 2pm<br>To<br>8pm | → Assessed the pt condition<br>→ vitals are checked & recorded<br>→ IV placement done | I/O chart maint  | patient is stable | Ln<br>Sriath           |
| Night     | 8pm<br>To<br>8am | → Assess the pt condition<br>→ monitor vitals<br>→ maintain hygiene                               | 8pm<br>To<br>8am | → Assess the pt condition<br>→ monitored vitals<br>→ maintain and I/O chart           | Now pt is stable | Re-check vitals   | niran<br>(signature)   |

HNH-00000539

IP26-00006747

Mrs N Sasi Priya

28-12-1998

27 Y 6 M 10 D (F)

Dr. RAJANI KUMARI



# NURSING CARE RECORD

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

**BirthRight**  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

Date: 6/12/26

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   | 8 AM  | → Assess the pt condition                                                                                                | 8 AM  | → Assessed the pt condition                                                                                                                     | pt is stable         | maintain I/O chart & record | Madhu<br>(M)           |
|           | 10 AM | → monitor the vitals & record<br>→ Administration of medication<br>→ further monitoring<br>→ maintain I/O chart & record | 10 AM | → monitored the vitals & recorded<br>→ Administered medication as per doctor's order<br>→ maintained I/O chart & record<br>→ further monitoring |                      |                             |                        |
| Afternoon | 2 PM  | → Assess the patient condition                                                                                           | 2 PM  | → Assessed the patient condition                                                                                                                | Patient is stable    | Vital is recorded           | Sri<br>(S)             |
|           | 4 PM  | → maintain vital & record<br>→ maintain I/O chart                                                                        | 4 PM  | → maintain vital & record<br>→ maintain I/O chart                                                                                               |                      |                             |                        |
| Night     | 8 PM  | → Assessed the pt condition                                                                                              | 8 PM  | → Assessed the pt condition                                                                                                                     | I/O chart maintained | Patient is stable           | Sri<br>(S)             |
|           | 10 PM | → plan for vitals<br>→ plan for I/O chart                                                                                | 10 PM | → vital are checked & recorded                                                                                                                  |                      |                             |                        |
|           | 8 AM  | → plan for medication                                                                                                    | 8 AM  | → all medication given as per doctor's order                                                                                                    |                      |                             |                        |



HNH-00000539 IP26-00006747  
 Mrs N SASI PRIYA  
 28-12-1998 27 Y 6 M 11 D (F)  
 Dr. RAJANI KUMARI



## NURSING CARE RECORD

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

**BirthRight™**  
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Your Right to a Safe Delivery

Date: 7/7/26

### Goals

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

|           | Time | Plan of Care                   | Time | Implementation                   | Evaluation           | Re-Assessment     | Nurse Name & Signature |
|-----------|------|--------------------------------|------|----------------------------------|----------------------|-------------------|------------------------|
| Morning   | 8Am  | → Assess the patient condition | 8pm  | → Assessed the patient condition | patient is stable    | vital is normal   | Chudhary               |
|           | to   | → maintain the patient vital   | to   | → maintain v & ptal & recorded   |                      |                   |                        |
|           | 2pm  | → maintain the I/O chart       | 2pm  | → maintain I/O chart             |                      |                   |                        |
| Afternoon | 8pm  | → Assess the pt condition      | 2pm  | → Assessed the pt condition      | Now pt is stable     | Re-check vital    | Vijai                  |
|           | to   | → monitor vital                | to   | → monitored vitals               |                      |                   |                        |
|           | 8pm  | → Maintain I/O chart           | 8pm  | → maintain I/O                   |                      |                   |                        |
| Night     | 8pm  | → Assess the pt condition      | 8pm  | → Assessed the pt condition      | I/O chart maintained | patient is stable | Li                     |
|           | to   | → plan for vital               | to   | → vital are checked & recorded   |                      |                   |                        |
|           | 8AM  | → plan for I/O chart           | 8AM  | → I/O chart maintained           |                      |                   | Swathi                 |

HNH-00000539 IP26-00006747  
 Mrs N SABI PRIYA  
 26-12-1998 27 Y 6 M 11 D (F)  
 Dr. RAJANI KUMARI

# NURSING CARE RECORD

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Date: 8/7/26

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  | → Assess the patient condition  | 8Am  | → Assessed the patient condition           | patient is normal    | vital is normal           | Chudh<br>C             |
|           | to   | → maintain the vitals           | to   | → maintain the I/O chart                   |                      |                           |                        |
|           | 2pm  | → maintain the I/O chart        | 2pm  | → maintain the vitals & Record.            |                      |                           |                        |
| Afternoon | 2pm  | → ASSES the pt condition        | 2pm  | → Assessed pt condition                    | pt is Normal         | monitor the vitals & slow | Akshita<br>A           |
|           | 2pm  | → monitor the vitals & slow     | 2pm  | → vitals Normal.                           |                      |                           |                        |
|           | 4pm  | → Administration of medication. | 4pm  | → Administered medication.                 |                      |                           |                        |
| Night     | 8pm  | → Assessed the pt condition     | 8pm  | → Assessed the pt condition                | I/O chart maintained | Patient is stable         | Sri<br>Sujatha         |
|           | to   | → plan for vitals               | to   | → vital are checked & recorded             |                      |                           |                        |
|           | 8Am  | → plan for medication           | 8Am  | → all medication given as per doctor order |                      |                           |                        |



HNH-00000539

IP26-00006747

Mrs N SASI PRIYA

26-12-1998

27 Y 6 M 13 D

(F)

Dr. RAJANI KUMARI



# NURSING CARE RECORD

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Date: 9/7/26

## Goals

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

|           | Time | Plan of Care                              | Time | Implementation                              | Evaluation           | Re-Assessment            | Nurse Name & Signature |
|-----------|------|-------------------------------------------|------|---------------------------------------------|----------------------|--------------------------|------------------------|
| Morning   | 8AM  | → Assess the pt condition                 | 8AM  | → Assessed the pt condition                 | I/O chart maintained | patient is stable        | Li                     |
|           | To   | → plan for vitals                         | To   | → vital are checked & recorded              |                      |                          |                        |
|           | 2PM  | → plan for I/O chart                      | 2PM  | → 4th hourly NST done.                      |                      |                          |                        |
| Afternoon | 2PM  | → Assess the pt condition.                | 2PM  | → Assessed the pt condition.                | → pt is stable now.  | → patient is stable now. | Sujatha                |
|           | 8PM  | → Monitor the vitals.                     | 8PM  | → Monitored the vitals.                     |                      |                          |                        |
|           | 8PM  | → provide comfortable position.           | 8PM  | → provided comfortable position.            |                      |                          |                        |
| Night     | 8PM  | → Assess pt condition                     | 8PM  | → Assessed pt condition                     | Patient is stable    | Re-checked vitals        | Sujatha                |
|           | To   | → monitor the vitals                      | To   | → Monitored vitals                          |                      |                          |                        |
|           | 8AM  | → Maintain I/O chart                      | 8AM  | → maintained I/O chart                      |                      |                          |                        |
|           |      | → Administer medication as per drug chart |      | → Administered medication as per drug chart |                      |                          |                        |



HNH-00000539  
Mrs N SASI PRIYA  
27 Y 6 M 13 D (F)  
28-12-1998  
Dr. RAJANI KUMARI

IP26-00006747

Patient

## NURSING CARE RECORD

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Date: 10/12/26

### 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  | - Assess the PT condition                | 8am  | - Assessed the PT condition                                 | PT is stable   | Re checked vitals   |                        |
|           |      | - monitor vitals                         |      | - Monitored vitals                                          |                |                     |                        |
|           |      | - monitor I/O Chart                      |      | - monitor I/O Chart                                         |                |                     |                        |
|           | 2pm  | - Medication Given as per drug chart     | 2pm  | - Medication Given as per drug chart                        |                |                     |                        |
| Afternoon | 2pm  | → Assess the PT condition                | 2pm  | → Assess the PT condition                                   | PT is stable   | Re-checked vitals   |                        |
|           |      | → monitor vitals                         |      | → Monitor vitals                                            |                |                     |                        |
|           | to   | → medication given as per drug chart     | to   | → Medication given as per drug chart                        |                |                     |                        |
| Night     | 8pm  | ⇒ Assess the PT condition                | 8pm  | → Assessed the PT condition                                 | → PT is stable | → Re-checked vitals |                        |
|           |      | ⇒ monitoring vitals checked and recorded |      | ⇒ Administration of medication given as per doctor's orders |                |                     |                        |
|           | 8am  | ⇒ I/O Chart maintained                   | 8am  |                                                             |                |                     |                        |



# NURSING CARE RECORD

Date: 11/7/20

**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  | → Assess the general condition of pt.        | 8am  | → Assess the general condition of pt.                  | Pt is stable      | Re-check vitals   | [Signature]            |
|           | 1pm  | → Monitor vitals                             | 1pm  | → Monitor vitals                                       |                   |                   |                        |
|           | 2pm  | → Maintained I/O chart                       | 2pm  | → Maintained I/O chart                                 | Patient is stable | Re-checked vitals | [Signature]            |
|           | 2pm  | → Administer medication                      | 2pm  | → Administer medication                                |                   |                   |                        |
| Afternoon | 2pm  | → Assess pt condition                        | 2pm  | → Assessed pt condition                                | Patient is stable | Re-checked vitals | [Signature]            |
|           | 4pm  | → monitor the vitals                         | 4pm  | → monitored vitals                                     |                   |                   |                        |
|           | 8am  | → maintain I/O chart                         | 8pm  | → maintained I/O chart                                 | Pt is stable      | Re-checked vitals | [Signature]            |
|           | 8am  | → Administer medication on as per drug chart | 8pm  | → Administered medication on as per drug chart         |                   |                   |                        |
| Night     | 8pm  | ⇒ Assess the pt condition                    | 8pm  | ⇒ Assessed the pt condition                            | Pt is stable      | Re-checked vitals | [Signature]            |
|           | 11pm | ⇒ monitoring vitals checked and recorded     | 11pm | ⇒ Administration medication given as per doctor orders |                   |                   |                        |
|           | 8am  | ⇒ I/O chart maintained                       | 8am  |                                                        |                   |                   |                        |

Patient Sticker

# NURSING CARE RECORD

Date: .....

**Goals**

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

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





## NURSING SHIFT HAND OVER FORM - WARD

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

| SITUATION                                |                                                           | Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |        |
|------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|--------|
| BACKGROUND                               | Area                                                      | 5/7<br>8AM                                                                                                                                     | 5/7/26<br>8AM                                                       | 5/7/26<br>11AM                                                      | 6/7/26<br>7/6                                                       | 6/7/26<br>8AM                                                       | 6/7<br>8PM                                                          |        |
|                                          | Shift Time                                                | 8AM                                                                                                                                            | 8AM                                                                 | 11AM                                                                | 7/6                                                                 | 8AM                                                                 | 8PM                                                                 |        |
| ASSESSMENT                               | Medical Condition<br>(Any special condition to be noted): | NA                                                                                                                                             | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |        |
|                                          | Allergy:                                                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |        |
| ASSESSMENT                               | Tubes/Drains/Catheter:                                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |        |
|                                          | Vital Signs:                                              | Temp:                                                                                                                                          | 96°F                                                                | 97°F                                                                | 97°F                                                                | 97°F                                                                | 97°F                                                                | 98°F   |
|                                          |                                                           | Res:                                                                                                                                           | 20                                                                  | 20                                                                  | 20                                                                  | 20                                                                  | 20                                                                  | 20     |
|                                          |                                                           | SpO <sub>2</sub> :                                                                                                                             | 98%                                                                 | 98%                                                                 | 98%                                                                 | 98%                                                                 | 98%                                                                 | 98%    |
|                                          |                                                           | Pulse:                                                                                                                                         | 85                                                                  | 76                                                                  | 76                                                                  | 87bmt                                                               | 86                                                                  | 85     |
|                                          |                                                           | BP:                                                                                                                                            | 110/75                                                              | 110/70                                                              | 110/70                                                              | 110/70                                                              | 110/70                                                              | 112/68 |
|                                          | Fall Risk Score:                                          | NA                                                                                                                                             | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |        |
|                                          | Pain Score:                                               | 0                                                                                                                                              | 0                                                                   | 0                                                                   | 0/10                                                                | 0/10                                                                | 0                                                                   |        |
| Recommendations                          | Safety Needs:                                             | NA                                                                                                                                             | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |        |
|                                          | Physiotherapy                                             | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |        |
|                                          | Others Specify:                                           | NA                                                                                                                                             | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |        |
|                                          | Special Diet:                                             | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |        |
|                                          | Other Special Orders / Medications:                       | NA                                                                                                                                             | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |        |
| Post Operative Procedure Special Orders: |                                                           | NA                                                                                                                                             | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |        |
| Handed Over By Name :                    |                                                           | Sujatha                                                                                                                                        | Chudh                                                               | moni                                                                | madhu                                                               | Chudh                                                               | Sujatha                                                             |        |
| Signature :                              |                                                           | [Signature]                                                                                                                                    | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         |        |
| Date:                                    |                                                           | 5/7/26                                                                                                                                         | 5/7/26                                                              | 6/5/26                                                              | 6/7/26                                                              | 6/7/26                                                              | 7/7/26                                                              |        |
| Time:                                    |                                                           | 2PM                                                                                                                                            | 8PM                                                                 | 8PM                                                                 | 2PM                                                                 | 8PM                                                                 | 8AM                                                                 |        |
| Taken Over By Name :                     |                                                           | Chudh                                                                                                                                          | moni                                                                | madhu                                                               | Chudh                                                               | Sujatha                                                             | Chudh                                                               |        |
| Signature :                              |                                                           | [Signature]                                                                                                                                    | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         | [Signature]                                                         |        |
| Date:                                    |                                                           | 5/7/26                                                                                                                                         | 5/7/26                                                              | 6/7/26                                                              | 6/7/26                                                              | 6/7/26                                                              | 7/7/26                                                              |        |
| Time:                                    |                                                           | 2PM                                                                                                                                            | 3PM                                                                 | 8AM                                                                 | 2PM                                                                 | 8PM                                                                 | 8AM                                                                 |        |



## NURSING SHIFT HAND OVER FORM - WARD

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

|                                          |                                                           |                                                                     |                                                                                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |               |
|------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------|
| SITUATION                                | Diagnosis:<br><b>LICS</b>                                 |                                                                     | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                                     |                                                                     |                                                                     |                                                                     |               |
|                                          | Area                                                      |                                                                     |                                                                                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |               |
| BACKGROUND                               | Shift Time                                                | <b>7/7 mb</b>                                                       | <b>7/7 82</b>                                                                                                                       | <b>7/7 8AM</b>                                                      | <b>8/7/26 mb</b>                                                    | <b>8/7/26 82</b>                                                    | <b>8/7 8PM</b>                                                      |               |
|                                          | Medical Condition<br>(Any special condition to be noted): |                                                                     |                                                                                                                                     | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |               |
| ASSESSMENT                               | Allergy:                                                  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |               |
|                                          | Tubes/Drains/Catheter:                                    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |               |
|                                          | Vital Signs:                                              | Temp:                                                               | <b>98°F</b>                                                                                                                         | <b>97.8</b>                                                         | <b>98°F</b>                                                         | <b>97°F</b>                                                         | <b>97.8</b>                                                         | <b>97.8</b>   |
|                                          |                                                           | Res:                                                                | <b>20</b>                                                                                                                           | <b>20 f</b>                                                         | <b>20 b/m</b>                                                       | <b>20 b/m</b>                                                       | <b>20 b/m</b>                                                       | <b>20</b>     |
|                                          |                                                           | SpO <sub>2</sub> :                                                  | <b>100%</b>                                                                                                                         | <b>99.1</b>                                                         | <b>99.1</b>                                                         | <b>100</b>                                                          | <b>99.1</b>                                                         | <b>99.1</b>   |
|                                          |                                                           | Pulse:                                                              | <b>100 b/m</b>                                                                                                                      | <b>82</b>                                                           | <b>85</b>                                                           | <b>100</b>                                                          | <b>89 b/m</b>                                                       | <b>85 b/m</b> |
|                                          |                                                           | BP:                                                                 | <b>110/70</b>                                                                                                                       | <b>110/60</b>                                                       | <b>115/75</b>                                                       | <b>110/70</b>                                                       | <b>107/69</b>                                                       | <b>100/75</b> |
|                                          | Fall Risk Score:                                          |                                                                     |                                                                                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |               |
| Pain Score:                              |                                                           |                                                                     |                                                                                                                                     |                                                                     | <b>0/10</b>                                                         |                                                                     |                                                                     |               |
| Recommendations                          | Safety Needs:                                             |                                                                     |                                                                                                                                     | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |               |
|                                          | Physiotherapy                                             | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |               |
|                                          | Others Specify:                                           |                                                                     |                                                                                                                                     | NA                                                                  | NA                                                                  |                                                                     | NA                                                                  |               |
|                                          | Special Diet:                                             | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |               |
|                                          | Other Special Orders / Medications:                       | NA                                                                  | NA                                                                                                                                  | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |               |
| Post Operative Procedure Special Orders: |                                                           | NA                                                                  | NA                                                                                                                                  | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |               |
| Handed Over By Name :                    |                                                           | <b>Chudh</b>                                                        | <b>moni</b>                                                                                                                         | <b>Sujatha</b>                                                      | <b>Chudh</b>                                                        | <b>AKW's</b>                                                        | <b>Sujatha</b>                                                      |               |
| Signature :                              |                                                           | <b>Ch</b>                                                           | <b>(moni)</b>                                                                                                                       | <b>Li</b>                                                           | <b>Ch</b>                                                           | <b>AKW's</b>                                                        | <b>Li</b>                                                           |               |
| Date:                                    |                                                           |                                                                     | <b>7/7</b>                                                                                                                          | <b>8/7/26</b>                                                       |                                                                     | <b>8/7/26</b>                                                       | <b>9/7/26</b>                                                       |               |
| Time:                                    |                                                           |                                                                     | <b>8PM</b>                                                                                                                          | <b>8AM</b>                                                          |                                                                     | <b>2PM</b>                                                          | <b>8AM</b>                                                          |               |
| Taken Over By Name :                     |                                                           | <b>moni</b>                                                         | <b>Sujatha</b>                                                                                                                      | <b>Chudh</b>                                                        | <b>AKW's</b>                                                        | <b>Sujatha</b>                                                      | <b>moni</b>                                                         |               |
| Signature :                              |                                                           | <b>(moni)</b>                                                       | <b>S</b>                                                                                                                            | <b>Chudh</b>                                                        | <b>AKW's</b>                                                        | <b>Li</b>                                                           | <b>(moni)</b>                                                       |               |
| Date:                                    |                                                           | <b>7/7</b>                                                          | <b>7/7/26</b>                                                                                                                       | <b>8/7/26</b>                                                       | <b>8/7/26</b>                                                       | <b>8/7/26</b>                                                       | <b>9/7/26</b>                                                       |               |
| Time:                                    |                                                           | <b>2PM</b>                                                          | <b>8PM</b>                                                                                                                          | <b>8AM</b>                                                          | <b>2PM</b>                                                          | <b>8PM</b>                                                          | <b>8PM</b>                                                          |               |



HNH-00000539

Mrs N SASI PRIYA

28-12-1998

Dr. RAJANI KUMARI

IP26-00006747

27 Y 6 M 13 D

(F)



## TRANSFERRING SHIFT HAND OVER FORM - WARD

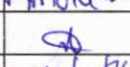
Treating Doctor: ..... Department: ..... Date of Admission: .....

|                                          |                                                           |            |                                                                                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |        |
|------------------------------------------|-----------------------------------------------------------|------------|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|--------|
| SITUATION                                | Diagnosis:                                                |            | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |        |
|                                          | LICS                                                      |            |                                                                                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |        |
| BACKGROUND                               | Area                                                      | Shift Time | 9/7/26<br>E                                                                                                                         | 9/7/26<br>N                                                         | 10/7/26<br>Mc                                                       | 10/7/26<br>N                                                        | 10/7/26<br>N                                                        | 11/7/26<br>Mc                                                       |        |
|                                          | Medical Condition<br>(Any special condition to be noted): |            | LICS                                                                                                                                | LSCS                                                                | LSCS                                                                | LSCS                                                                | LSCS                                                                | LSCS                                                                |        |
| ASSESSMENT                               | Allergy:                                                  |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |        |
|                                          | Tubes/Drains/Catheter:                                    |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |        |
|                                          | Vital Signs:                                              |            | Temp:                                                                                                                               | 98.1°F                                                              | 98.3°F                                                              | 98.6°F                                                              | 98.3                                                                | 98.3                                                                | 98.4 C |
|                                          | Res:                                                      |            | 20b/m                                                                                                                               | 23b/m                                                               | 20b/m                                                               | 20b/m                                                               | 20b/m                                                               | 20b/m                                                               |        |
|                                          | SpO <sub>2</sub> :                                        |            | 100%                                                                                                                                | 100%                                                                | 100%                                                                | 100%                                                                | 98%                                                                 | 99%                                                                 |        |
|                                          | Pulse:                                                    |            | 82                                                                                                                                  | 78                                                                  | 79b/m                                                               | 79b/m                                                               | 79b/m                                                               | 81b/m                                                               |        |
|                                          | BP:                                                       |            | 111/68                                                                                                                              | 112/65                                                              | 116/85                                                              | 117/75                                                              | 117/79                                                              | 120/72                                                              |        |
|                                          | Fall Risk Score:                                          |            | -                                                                                                                                   | -                                                                   | -                                                                   | -                                                                   | -                                                                   | -                                                                   |        |
| Recommendations                          | Safety Needs:                                             |            | Yes                                                                                                                                 | Yes                                                                 | Yes                                                                 | -                                                                   | -                                                                   | -                                                                   |        |
|                                          | Physiotherapy                                             |            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |        |
|                                          | Others Specify:                                           |            | -                                                                                                                                   | -                                                                   | -                                                                   | -                                                                   | -                                                                   | -                                                                   |        |
|                                          | Special Diet:                                             |            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |        |
|                                          | Other Special Orders / Medications:                       |            | -                                                                                                                                   | -                                                                   | -                                                                   | -                                                                   | NA                                                                  | NK                                                                  |        |
| Post Operative Procedure Special Orders: |                                                           |            | -                                                                                                                                   | -                                                                   | -                                                                   | -                                                                   | NA                                                                  | NA                                                                  |        |
| Handed Over By Name :                    |                                                           |            | Maheshwari<br>Anusha                                                                                                                | Anusha                                                              | Maheshwari                                                          | Maheshwari                                                          | Anusha                                                              | Maheshwari                                                          |        |
| Signature :                              |                                                           |            |                                                                                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |        |
| Date:                                    |                                                           |            | 9/7/26                                                                                                                              | 10/7/26                                                             | 10/7/26                                                             | 10/7/26                                                             | 11/7/26                                                             | 11/7/26                                                             |        |
| Time:                                    |                                                           |            | 8am                                                                                                                                 | 8am                                                                 | 2pm                                                                 | 8pm                                                                 | 8am                                                                 | 2pm                                                                 |        |
| Taken Over By Name :                     |                                                           |            | Anusha                                                                                                                              | Maheshwari                                                          | Maheshwari                                                          | Anusha                                                              | Maheshwari                                                          | Anusha                                                              |        |
| Signature :                              |                                                           |            |                                                                                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |        |
| Date:                                    |                                                           |            | 9/7/26                                                                                                                              | 10/7/26                                                             | 10/7/26                                                             | 10/7/26                                                             | 11/7/26                                                             | 11/7/26                                                             |        |
| Time:                                    |                                                           |            | 8pm                                                                                                                                 | 8am                                                                 | 8pm                                                                 | 8am                                                                 | 8am                                                                 | 2pm                                                                 |        |



## NURSING SHIFT HAND OVER FORM - WARD

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

|                                          |                                                           |                                                                                     |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
|------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| <b>SITUATION</b>                         | Diagnosis:                                                |                                                                                     | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                          |                                                          |                                                          |                                                          |
|                                          |                                                           |                                                                                     |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| <b>BACKGROUND</b>                        | Area                                                      | Shift Time                                                                          | 11/7<br>AM                                                                                                                          |                                                          |                                                          |                                                          |                                                          |
|                                          | Medical Condition<br>(Any special condition to be noted): |                                                                                     | NA                                                                                                                                  |                                                          |                                                          |                                                          |                                                          |
| <b>ASSESSMENT</b>                        | Allergy:                                                  |                                                                                     | <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Tubes/Drains/Catheter:                                    |                                                                                     | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Vital Signs:                                              | Temp:                                                                               | 98.4                                                                                                                                |                                                          |                                                          |                                                          |                                                          |
|                                          |                                                           | Res:                                                                                | 20b/m                                                                                                                               |                                                          |                                                          |                                                          |                                                          |
|                                          |                                                           | SpO <sub>2</sub> :                                                                  | 100%                                                                                                                                |                                                          |                                                          |                                                          |                                                          |
|                                          |                                                           | Pulse:                                                                              | 78b                                                                                                                                 |                                                          |                                                          |                                                          |                                                          |
|                                          |                                                           | BP:                                                                                 | 112/72                                                                                                                              |                                                          |                                                          |                                                          |                                                          |
|                                          | Fall Risk Score:                                          |                                                                                     | —                                                                                                                                   |                                                          |                                                          |                                                          |                                                          |
| Pain Score:                              |                                                           | —                                                                                   |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| <b>Recommendations</b>                   | Safety Needs:                                             |                                                                                     | —                                                                                                                                   |                                                          |                                                          |                                                          |                                                          |
|                                          | Physiotherapy                                             |                                                                                     | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Others Specify:                                           |                                                                                     | —                                                                                                                                   |                                                          |                                                          |                                                          |                                                          |
|                                          | Special Diet:                                             |                                                                                     | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Other Special Orders / Medications:                       |                                                                                     | NA                                                                                                                                  |                                                          |                                                          |                                                          |                                                          |
| Post Operative Procedure Special Orders: |                                                           | NA                                                                                  |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Handed Over By Name :                    |                                                           | Amruti                                                                              |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Signature :                              |                                                           |  |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Date:                                    |                                                           | 12/7/16                                                                             |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Time:                                    |                                                           | 8 AM                                                                                |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Taken Over By Name :                     |                                                           |                                                                                     |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Signature :                              |                                                           |                                                                                     |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Date:                                    |                                                           |                                                                                     |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |
| Time:                                    |                                                           |                                                                                     |                                                                                                                                     |                                                          |                                                          |                                                          |                                                          |

HNH-00000539  
Mrs N SASI PRIYA  
28-12-1998  
Dr. RAJANI KUMARI

IP26-00006747  
27 Y 6 M 11 D (F)

## URINARY CATHETER BUNDLE CHECK LIST

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

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

Date of Insertion: .....

Date of Removal: .....

| Parameters                                       | Date   | Shift Time |                                                                     |                                                          |                                                          |                                                          |                                                          |                                                          |
|--------------------------------------------------|--------|------------|---------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| Need for the Catheter                            | 9/7/20 | N1         | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hand Hygiene                                     |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Usage of Sterile Equipment                       |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the Collection bag below the level of bladder |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Check the Tube for Obstruction (Free of Kinking) |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is Catheter dated as policy                      |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Collecting bag is been emptied regularly?        |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Maintenance of closed system for the catheter    |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dressing clean and dry?                          |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is the line removed as Policy?                   |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Performance of Perineal Care                     |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Onset of New Fever                               |        |            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asses for the leakage at the site of insertion   |        |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Name of the Nurse                                |        |            | Aruna                                                               |                                                          |                                                          |                                                          |                                                          |                                                          |
| Signature of the Nurse                           |        |            | [Signature]                                                         |                                                          |                                                          |                                                          |                                                          |                                                          |

Handwritten marks and scribbles in the top right corner.



Handwritten mark resembling a stylized 'A' or 'V' in the bottom right corner.



HNH-00000539 IP26-00006747  
 Mrs N SASI PRIYA  
 28-12-1998 27 Y 6 M 9 D (F)  
 Dr. RAJANI KUMARI



## OBSTETRIC ASSESSMENT FORM

Date: 5/7/26 Time of Arrival: 1:17 PM Time Seen by Nurse: 1:16 PM

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: 97.6 Pulse: 85 RR: 20 SpO<sub>2</sub>: 98.1 BP: 115/75 Weight: .....

4) Gestational Criteria:

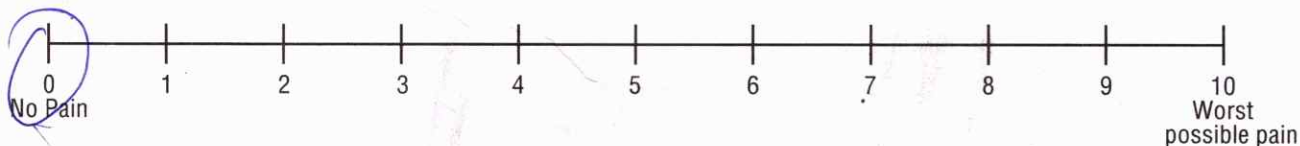
|          |            |            |            |            |
|----------|------------|------------|------------|------------|
| Gravida: | G <u>4</u> | P <u>1</u> | L <u>1</u> | A <u>2</u> |
|----------|------------|------------|------------|------------|

LMP: 10/11/25 EDD: 23/8/26 Gestational Age: .....

|                        |                                                                                                 |                                                                      |      |              |
|------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|------|--------------|
| Uterine Contraction    | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA | Onset                                                                | Time | Frequency:   |
| Membrane Rupture       | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA | Onset                                                                | Time | Fluid Color: |
| Vaginal bleeding       | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA | Onset                                                                | Time | Amount:      |
| Pre Eclampsia Symptoms | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA | If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting |      |              |
| Good fetal Movement    | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA | If No specify:                                                       |      |              |

5) Pain Screening:

Numerical Pain Scale (NPS)



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

6) Past History:

- a) Surgeries: 2 msh
- b) Medical: .....



1) Allergy:

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:  $\leq 15$  minutes & Reassessment: Every 15 minutes)

☐ Category III: Urgent (Time to Physician:  $\leq 30$  minutes & Reassessment: Every 15 minutes)

☒ Category IV: Less Urgent (Time to Physician:  $\leq 60$  minutes & Reassessment: Every 30 minutes)

☐ Category V: Non Urgent (Time to Physician:  $\leq 120$  minutes & Reassessment: Every 60 minutes)

### OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: Dr. Rajani Kumari

Nurse Name: Sujatha

Nurse Signature: [Signature]

Date: 5/7/26 Time: 1pm





## CAESAREAN SECTION OPERATIVE NOTES

|                                               |                                                                                                         |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------|
| Surgeon's Name: <u>DR. RAJANI KUMARI</u>      | Date of Delivery: <u>09/1/2026</u>                                                                      |
| Assistant Surgeon: <u>DR. JU REDDY</u>        | Time of Delivery: <u>7:12 AM</u>                                                                        |
| Anaesthetist's Name: <u>DR. SAMIR</u>         | Gender of Baby: <u>MALE</u>                                                                             |
| Type of Anaesthesia: <u>SPINAL ANESTHESIA</u> | Weight of Baby: <u>2.40 kg</u>                                                                          |
| Neonatologist: <u>Dr. Varun</u>               | AGPAR Score: <u>7, 9.</u>                                                                               |
| Scrub Nurse: <u>S/N. SANDHYA</u>              | NICU Admission: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>Preterm 1 kg</u> |

Pre-Operative Diagnosis: G4P4A2 133<sup>4</sup> wks / prev-vvd & Threatened preterm labour

☐ Elective

☒ Emergency

Indication: Prodromal Preterm labour.

### Urgency

☐ Immediate Threat to life of woman or fetus

☐ Maternal or fetal compromise not immediately life threatening

☒ No maternal or fetal compromise but needs early delivery

☐ Delivery timed to suit woman and staff

Decision time: .....

Knief to rectus: 3 mins

CTG Description: Reactive

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

Surgical Procedure:

Emergency C/S

Post Operative Diagnosis:

POD-0

Peri-Operative Complications:

None

Amount of Blood Loss:

300ml

Blood Transfused (in ML):

Name and Number of Surgical Specimen sent for examination:



### Examination Findings when Appropriate:

Presentation: ☒ Cephalic ☒ Breech ☐ Other .....  
 5th Palpable: .....  
 Station: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2  
 Caput: ☐ + ☐ ++ ☐ +++  
 Bladder Catheterized: ☐ Yes ☐ No

Cervical Dilatation: ..... 2 cm ..... cm  
 Fetal Position: .....  
 Moulding: ☒ None ☐ + ☐ ++ ☐ +++  
 Meconium: ☒ None ☐ + ☐ ++ ☐ +++  
 Urine: ☒ Clear ☐ Blood Stained

Skin Incision: ☒ Pfannenstiel ☐ Transverse ☐ Midline ☐ Other .....  
 Uterine Incision: ☒ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision  
 Previous Scar: ☐ Intact ☐ Thinned out ☐ Ruptured ☒ No Scar  
 Incision Through Placenta: ☐ Yes ☒ No  
 Delivery of head: ☒ Manual ☒ Forceps  
 Liquor: ☒ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not Offensive  
 Delivery of Placenta: ☒ Manual ☐ CCT ..... ☒ Complete ☐ Incomplete ☐ Piecemeal  
 Cord Appearance: ..... Normal ..... Cord around the neck ☐ Yes ☒ No  
 Appearance of placenta: ..... Normal ..... Cavity explored ☒ Yes ☐ No  
 Uterus, tubes and ovaries: ☒ Normal ☐ Not Normal Sterilization: ☐ Yes ☒ No

Uterine Closure: ☐ One Layer ☒ Two Layers ..... Vagyl no 1-0 ..... Suture  
 Peritoneal Closure: ☐ Pelvic ☒ Abdominal ☐ None ..... Rapid vagyl 2-0 ..... Suture  
 Sheath Closure: ..... Vagyl no-1 ..... Suture  
 Fat Closure: ☒ Yes ☐ No ..... Rapid vagyl no 2-0 ..... Suture  
 Skin Closure: ☒ Subcuticular ☐ Mattress ..... Rapid vagyl no-2-0 ..... Suture

Vaginal Evacuated ☒ Yes ☐ No  
 Drain: ☐ Yes ☒ No ☐ Remove in ..... days ☐ Await instructions  
 Catheter: ☒ Yes ☐ No ☐ Remove in ..... days ☐ Await instructions  
 Swap & Instruments count correct? ☒ Yes ☐ No ☐ Post-op Antibiotics ☒ Yes ☐ No  
 Intra-Operative Antibiotics Cover: ☒ Yes ☐ No ☐ Thromboprophylaxis ☒ Yes ☐ No

Post-Operative Notes: .....  
 - NBM for 4-6 hours  
 - Nilal monitoring  
 - D/C charting  
 - IV's, Analgesics & Thromboprophylaxis as per Anon  
 - IV Abx (Zinj: Augmentin & Zinj: Metro x 48hrs)  
 - w/f excessive bleedng plv  
 - Inform ROS  
 - Zinj: Clethane 400 s/c x 3 days

Doctor Name: Dr. Rajiv Kumar

Doctor Signature: M. Dr. Rajiv Kumar

Date & Time: 29/12/26

Dr. Rajiv Kumar

# SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Raganikumar  
 Asst. Surgeon : Dr. Sanku  
 Anaesthetist : Dr. Sanku  
 Scrub Nurse : S. Sanku

Patient Name : Mrs. Sanku Priya Age : 27yrs Gender Female  
 UHID No. : 1104-000057 Surgery Name :   
 Date 7/17/26 In-time : 7:00am Out-time : 8:00am

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## Before Induction of Anaesthesia >>

## Before Skin Incision >>

## Before Patient Leaves Operating Room

| SIGN IN                                                                  |                                                                                                 | Time: <u>7AM</u> |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------|
| <b>Patient Has Confirmed</b>                                             |                                                                                                 |                  |
| Identity                                                                 | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                  |
| Site                                                                     | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                  |
| Procedure                                                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                  |
| Consent                                                                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                  |
| <b>Site Marked</b>                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA |                  |
| <b>Anaesthesia Safety Check Completed</b>                                | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                  |
| <b>Pulse Oximeter on Patient &amp; Functioning</b>                       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                  |
| <b>Does Patient have a:</b>                                              |                                                                                                 |                  |
| Known Allergy?                                                           | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |                  |
| <b>Difficult Airway / Aspiration Risk?</b>                               |                                                                                                 |                  |
| Yes, & Equipment / Assistance Available                                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                  |
| <b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>               |                                                                                                 |                  |
| Yes, and Adequate Intravenous Access and Fluids Planned                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                  |
| Blood Units Reserved                                                     | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                  |
| <b>Has Antibiotic Prophylaxis been given within the last 60 minutes?</b> |                                                                                                 |                  |
|                                                                          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                  |
| Signature : <u>[Signature]</u>                                           |                                                                                                 |                  |
| Name : <u>[Name]</u>                                                     |                                                                                                 |                  |

| TIME OUT                                                                                                                                                                                                |                                                                                                 | Time: <u>7:5 AM</u> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------|
| <b>Confirm all team members have introduced themselves by Name and Role</b>                                                                                                                             |                                                                                                 |                     |
|                                                                                                                                                                                                         | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                     |
| <b>Surgeon, Anaesthesia Professional and Nurse Verbally Confirm</b>                                                                                                                                     |                                                                                                 |                     |
| Correct Patient (Check ID Band)                                                                                                                                                                         | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                     |
| Correct Site                                                                                                                                                                                            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                     |
| Correct Procedure                                                                                                                                                                                       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                     |
| <b>Anticipated Critical Events</b>                                                                                                                                                                      |                                                                                                 |                     |
| <b>Surgeon Reviews:</b>                                                                                                                                                                                 |                                                                                                 |                     |
| What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? <u>[Signature]</u>                                                                                               |                                                                                                 |                     |
|                                                                                                                                                                                                         | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                     |
| <b>Anaesthesia Team Reviews:</b>                                                                                                                                                                        |                                                                                                 |                     |
| Are There Any Patient-specific Concerns? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA                                                                |                                                                                                 |                     |
| <b>Nursing Team Reviews:</b>                                                                                                                                                                            |                                                                                                 |                     |
| Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                                                                                                 |                     |
| <b>Is Essential Imaging Displayed?</b>                                                                                                                                                                  |                                                                                                 |                     |
|                                                                                                                                                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA            |                     |
| Power Supply, Earthing, Power Backup and functioning of equipment checked. <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                     |                                                                                                 |                     |
| Signature : <u>[Signature]</u>                                                                                                                                                                          |                                                                                                 |                     |
| Name : <u>[Name]</u>                                                                                                                                                                                    |                                                                                                 |                     |

| SIGN OUT                                                                                                                                                                  |  | Time: <u>8:00 AM</u> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------|
| <b>Nurse Verbally Confirms with the Team:</b>                                                                                                                             |  |                      |
| The Name of the Procedure Recorded <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                    |  |                      |
| That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |  |                      |
| The Specimen is Labelled (including patient name) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA                         |  |                      |
| Whether there are any Equipment Problems to be addressed <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA                  |  |                      |
| <b>To Surgeon, Anaesthetist and Nurse:</b>                                                                                                                                |  |                      |
| What are the key concerns for recovery and management of this patient? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                |  |                      |
| Signature : <u>[Signature]</u>                                                                                                                                            |  |                      |
| Name : <u>[Name]</u>                                                                                                                                                      |  |                      |





HNH-00000539

IP26-00006747

Mrs N SASI PRIYA

26-12-1998

27 Y 6 M 13 D

(F)

Dr. RAJANI KUMARI



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## NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 9/7/26

Time: 3 pm

Origin: Indian

Height: 1.60m

Weight: 83 kg

BMI:

☐ ~ 26 kg/m<sup>2</sup>☐ ~ 28 kg/m<sup>2</sup>☐ ~ 30 kg/m<sup>2</sup>

Food Allergies:

Radish, brinjal, Gargua

32 kg/m<sup>2</sup>

Diagnosis:

LSCS

Type of Diet:

☒ Liquid☐ Soft☐ Normal☐ Diabetic☒ Vegetarian☐ Non-Vegetarian☐ Vegan

Diet Advised:

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

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

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

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

Patient's / Attendant's

Signature:

Name:

Sasi Priya

Date &amp; Time:

9/7/26, 3 pm

Dietician's

Signature:

Name:

Syeda Sobiya Zahoor

Date &amp; Time:

9/7/26, 3 pm

**DIETARY NOTES**[illegible]

313

Patient Sticker

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## CROSS CONSULTATION FORM

Doctor Name : Dr. Rajani Kumar Date : 10/7/20 Time : 4pm

Diagnosis : (Puerperal) NVD

Hospital : RCH - HMNR

**Type of Referral :**

- ☐ Emergency  
☐ Urgent  
☐ Non Urgent

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

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

Signature: \_\_\_\_\_

**Findings and Recommendations :**

Lactation care plan

- well formed Breast & Nipple's
- Colostrum seen
- Baby at NICU
- Advice expressed Breast feeds every 2-2 1/2 hours on each side 15-20 mints.
- can use electrical Breast Pump.
- GZPILIA2

**Consultant :**

Name : Sathwik G Signature : [Signature] Date & Time : 10/7/20 ; 4pm



# PATIENT TRANSFER FORM

|                                                                                                                  |                                                     |                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient Name & UHID No.<br><i>Ms. Sasi Priga</i>                                                                 | Date & Time of Admission<br><i>5/7/26 @ 11:07</i>   | Date & Time of Transfer Order<br><i>9/7/26 @ 8:00 AM</i>                                                                                                        |
| Treating Consultant Name<br><i>Dr. Rajani Kumar</i>                                                              | Transfer Ordered by<br><i>Dr. Samir</i>             | Reason for Transfer<br><i>Observation</i>                                                                                                                       |
| From Unit<br><i>OT</i>                                                                                           | To Unit<br><i>Pre-Post</i>                          | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                 |
| Number of Sheets in Clinical File                                                                                | Number of Imaging Films                             | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input type="checkbox"/> No <input type="checkbox"/><br>If yes, what ? |
| Medications / Consumables / Surgicals / Hand over                                                                |                                                     |                                                                                                                                                                 |
| Sl.No.                                                                                                           | Item Name                                           | Quantity                                                                                                                                                        |
| 1.                                                                                                               | <i>RI</i>                                           | <i>1</i>                                                                                                                                                        |
| 2.                                                                                                               |                                                     |                                                                                                                                                                 |
| 3.                                                                                                               |                                                     |                                                                                                                                                                 |
| 4.                                                                                                               |                                                     |                                                                                                                                                                 |
| 5.                                                                                                               |                                                     |                                                                                                                                                                 |
| Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                                     |                                                                                                                                                                 |
| Name & Signature of Person who is Transferring<br><i>Karuna</i>                                                  | Name of Person Ordered Transfer<br><i>Dr. Samir</i> |                                                                                                                                                                 |
| Patient & Clinical Records Received by : <i>Mounika</i>                                                          |                                                     |                                                                                                                                                                 |
| Date & Time of Patient Received : <i>9/7/26 @ 8 AM</i>                                                           |                                                     |                                                                                                                                                                 |

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

# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : Mrs N. Sasi Priya Gender: ☐ Male ☒ Female Age : 27y  
UHID No : HNH-00000539 Date : 9/7/2024

## 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)

EMERGENCY LOWER SEGMENT CAESAREAN SECTION  
upon  
(Name of the Patient) Mrs N Sasi Priya

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

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

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

Bleeding, Infection  
Injury to Bowel, Bladder or Blood vessel  
Chances of Blood Transfusion

## My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr. Rajani Kumari

## Consentee :

Signature : [Signature]  
Name : Mrs N Sasi Priya  
Date & Time : 9/7/2024 @ 6:40am

## Patient Attendant :

Signature : [Signature]  
Name : N.S.S. Prasad  
Relationship with Patient : Husband  
Date & Time : 9/7/2024 @ 6:40am

## Witness :

Signature : [Signature]  
Name : Mounika  
Date & Time : 9/7/24

## Doctor (who is taking the consent) :

Signature : [Signature]  
Name : Dr Mounika  
Date & Time : 9/7/2024 @ 6:40am



# CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

Patient Name : Mr. V. Sasi Prasad Age : 27 Gender : Male ☐ Female ☒  
UHID NO: HCH-539 Surgeon Name: Dr. Nayan Kumar  
Anaesthesiologist : Dr. Samir Choudhary  
Operative procedure planned : USG cat II

## 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 and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

- ☐ Heart disease      ☐ Hypertension      ☐ Diabetes mellitus      ☐ Renal failure  
☐ Hepatic disorders      ☐ Shock      ☐ Multiple organ failure      ☐ Polytrauma / Renal Tubular Acidosis  
☐ Incapacitating Chronic Obstructive Pulmonary Disease  
☒ Others : Bleeding / need for transfusion / Hemodynamic changes

Comments : .....

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

I hereby **DECLARE** **BY PATIENT / GUARDIAN / PROXY**

..... 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 anaesthesia 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 : - [Signature]

Name : A. Sasi Priya

Relationship with Patient : self

Date & Time : 9/7 at 630am

**Witness :**

Signature : [Signature]

Name : N. S. S. Prasad

Date & Time : 9/7 at 630am

**Doctor (who is taking the consent) :**

Signature : [Signature]

Name : Dr. Samir Kumar

Date & Time : 9/7 at 630am

Department of Anaesthesiology  
**PRE-ANAESTHETIC EVALUATION**



Name: Mr. Sanjiv Age: 27 Sex: Female UHID.No: 4NH-0539  
 Date: 9/7 Time: 6:30 am Proposed Operation: LSC cat III  
 Diagnosis: Gy 91, A & E Unilateral prolapse  
 B.P / CRT: 112/69 H.R: 112 Weight: ..... ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

**Laboratory Data:**

Hgb: in chart 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/Angio: .....  
 PT: ..... K: ..... LDH: ..... T3 ..... Other: .....  
 PTT: ..... Ca++: ..... Alk phos: ..... T4 .....  
 INR: ..... Mg++: ..... Amylase: ..... TSH .....  
 Cl -: ..... SGOT/SGPT: .....

Allergies: TAXIM

**Medical History:** CVS: 1

RESP: Healthy adult, no medical history Diabetes: .....  
 CNS: Regular ANC's → admitted for observation p/o Unilateral prolapse  
 Renal: .....  
 Hepatic / GE: 1 Physical Activity: good, NYHA-II  
 Others: .....

**Past Anaesthetic History:** nil

**Physical Exam:** coherent

Airway: MP 2 3 4 Mouth Opening: ade Mentohyoid Distance: 3.5 Neck: (N) Teeth: intact  
 Lungs: clear  
 Heart: clear

**CNS:**

Pregnant: ☒ Yes ☐ No ☐ NA Venous Access Site: periph Spine Exam for regional: midline

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

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

| CURRENT MEDICATIONS | DOSAGE |
|---------------------|--------|
| <u>felcal/Regin</u> |        |
|                     |        |
|                     |        |
|                     |        |

**Pre-Operative Instructions:** on NPO

- DVT Prophylaxis :
  - Water / ORS 2 Hours
  - NIL ORAL → Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions:

Signature: [Signature] Name: Dr. Samir





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### Pre Induction Assessment:

[illegible]



HNH-00000539  
Mrs N SASHI PRIYA  
26-12-1998 27 Y 6 M 13 D (F)  
Dr. RAJANI KUMARI

IP26-00006747

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Your Right to a Safe Delivery

# POST-ANAESTHESIA UNIT RECORD

Received in PACU by : Dr. S. Ratha Time Received : 8 AM Time Discharged : 2 PM

|                                                                                                                                                                                             |                                                                                                                                                                         |                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 250<br>240<br>230<br>220<br>210<br>200<br>190<br>180<br>170<br>160<br>150<br>140<br>130<br>120<br>110<br>100<br>90<br>80<br>70<br>60<br>50<br>40<br>30<br>20<br>10<br>0<br>SPO <sub>2</sub> | 250<br>240<br>230<br>220<br>210<br>200<br>190<br>180<br>170<br>160<br>150<br>140<br>130<br>120<br>110<br>100<br>90<br>80<br>70<br>60<br>50<br>40<br>30<br>20<br>10<br>0 | IV Cannula Site : <u>Right</u>                                                                                                                                                                                                             |
|                                                                                                                                                                                             |                                                                                                                                                                         | <input type="checkbox"/> O <sub>2</sub> Mask <input type="checkbox"/> Nasal Prongs<br><input type="checkbox"/> Tracheostomy <input type="checkbox"/> T-Piece<br><input type="checkbox"/> Oral Airway <input type="checkbox"/> Nasal Airway |
|                                                                                                                                                                                             |                                                                                                                                                                         | Vomiting : <input type="checkbox"/> Yes <input type="checkbox"/> No Drug : <u>Paracetamol</u>                                                                                                                                              |
|                                                                                                                                                                                             |                                                                                                                                                                         | NG Tube : <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                         |
|                                                                                                                                                                                             |                                                                                                                                                                         | Drain : <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                           |
|                                                                                                                                                                                             |                                                                                                                                                                         | Urinary Catheter : <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                     |
|                                                                                                                                                                                             |                                                                                                                                                                         | Chest Tube : <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                      |
|                                                                                                                                                                                             |                                                                                                                                                                         | Nil Oral <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                          |
|                                                                                                                                                                                             |                                                                                                                                                                         | IV Fluids : <u>Nil</u>                                                                                                                                                                                                                     |
|                                                                                                                                                                                             |                                                                                                                                                                         | Oral Feeds : <u>Nil</u>                                                                                                                                                                                                                    |

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

## PAIN ASSESSMENT AND MANAGEMENT FORM

| Date | Time    | Pain Score | Intervention | Signature |
|------|---------|------------|--------------|-----------|
| 9/7  | 8 AM    | 0/10       | slow         | mei       |
| 9/7  | 8:30 AM | 0/10       | slow         | mei       |
| 9/7  | 9 PM    | 0/10       | slow         | mei       |
| 9/7  | 4:30 PM | 0/10       | slow         | mei       |

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

Anaesthesiologist Name : Dr. Ayresku

Anaesthesiologist Signature: \_\_\_\_\_

Date & Time: \_\_\_\_\_

PACU Nurse Name : monika

PACU Nurse Signature: a/k

Date & Time: \_\_\_\_\_

### Reassessment Frequency:

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

Transferred to Unit by (PACU): 3rd floor (311)

Date & Time: 9/7

Patient Sticker

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<br>(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 : .....



26-0000211963

## NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

| Patient Name: <u>115-500111</u>                       |                                     | Age: <u>34/9/96</u>                  | Gender: <u>FEMALE</u> |
|-------------------------------------------------------|-------------------------------------|--------------------------------------|-----------------------|
| UHID No: <u>115-500111</u>                            | IP No: <u>1126-0000-1112</u>        | Date: <u>01/07/26</u>                | Time: <u>6:41 AM</u>  |
| Diagnosis: <u>(Wound - OT)</u>                        |                                     |                                      |                       |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                                      |                       |
| S.No                                                  | Drug Name                           | Dosage                               | Remarks               |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | <u>100 MCG</u>                       | <u>01 AMP</u>         |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      | <u>—</u>                             | <u>—</u>              |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG | <u>—</u>                             | <u>—</u>              |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG | <u>—</u>                             | <u>—</u>              |
| Doctor Name: <u>Dilamir</u>                           |                                     | Doctor Registration No: <u>67929</u> |                       |
| Signature: <u>[Signature]</u>                         |                                     |                                      |                       |

## NARCOTIC DISPENSING FORM

### APPENDIX 4 – FORM NO. 3E

#### (Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 1126-0000-1112Date: 01/07/26

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

| 1.          | Name : <u>115-500111</u>                                                                                                              | Remarks                               |                                                                |                 |
|-------------|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------------------------|-----------------|
| 2.          | Complete postal address (with contact number, if any)                                                                                 | <u>Appina Street, 1st floor, 1112</u> |                                                                |                 |
| 3.          | Brief description of the illness                                                                                                      | <u>Wound</u>                          |                                                                |                 |
| 4.          | Whether registered with any other registered medical practitioner / recognized medical institution ( If yes, details of the recorded) | <u>NO</u>                             |                                                                |                 |
| 5.          | Details of essential Narcotic drug dispensed                                                                                          | <u>INJ: FENTANYL</u>                  |                                                                |                 |
| Date        | Name of the Essential Narcotic Drugs                                                                                                  | Quantity                              | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| <u>08/7</u> | <u>INJ: FENTANYL</u>                                                                                                                  | <u>01.</u>                            |                                                                |                 |
|             |                                                                                                                                       |                                       |                                                                |                 |

Dispensed by (Name & ID No.): [Signature] (015444) Signature: [Signature]Received by (Name & ID No.): M. ARVIND KUMAR (021257) Signature: [Signature]

Time: .....



26-0000211963

## NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

| Patient Name: <u>Mrs. Sasi Priya</u>                  | Age: <u>27y</u>                     | Gender: <u>FEMALE</u>                      |               |
|-------------------------------------------------------|-------------------------------------|--------------------------------------------|---------------|
| UHID No: <u>11111-0000039</u>                         | IP No: <u>IP26-00006707</u>         | Date: <u>09/07/26</u> Time: <u>6:41 Am</u> |               |
| Diagnosis: <u>LSCS</u> ( <u>Wound - OT</u> )          |                                     |                                            |               |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                                            |               |
| S.No                                                  | Drug Name                           | Dosage                                     | Remarks       |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | <u>100 MCG</u>                             | <u>01 AMP</u> |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      | <u>—</u>                                   | <u>—</u>      |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG | <u>—</u>                                   | <u>—</u>      |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG | <u>—</u>                                   | <u>—</u>      |
| Doctor Name: <u>Dr. Aravind</u>                       |                                     | Doctor Registration No: <u>67929</u>       |               |
| Signature: <u>[Signature]</u>                         |                                     |                                            |               |

## NARCOTIC DISPENSING FORM

### APPENDIX 4 – FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: IP26-00006707

Date: 09/07/26

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

| 1.          | Name: <u>Mrs. Sasi Priya</u>                                                                                                         | Remarks                                                                                                  |                                                                |                 |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------|
| 2.          | Complete postal address (with contact number, if any)                                                                                | <u>Hydco Nagar, 01/12, Homes 4/11/18</u><br><u>along main road, Hyderabad - 500001, Telangana, India</u> |                                                                |                 |
| 3.          | Brief description of the illness                                                                                                     | <u>LSCS</u>                                                                                              |                                                                |                 |
| 4.          | Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded) | <u>NO</u>                                                                                                |                                                                |                 |
| 5.          | Details of essential Narcotic drug dispensed                                                                                         | <u>INJ: FENTANYL</u>                                                                                     |                                                                |                 |
| Date        | Name of the Essential Narcotic Drugs                                                                                                 | Quantity                                                                                                 | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| <u>08/7</u> | <u>INJ: FENTANYL</u>                                                                                                                 | <u>01</u>                                                                                                | <u>[Signature]</u>                                             |                 |
|             |                                                                                                                                      |                                                                                                          |                                                                |                 |

Dispensed by (Name & ID No.): Sania / 018442 Signature: [Signature]

Received by (Name & ID No.): M ARVIND KUMAR (021257) Signature: [Signature]

Time: .....