Name	Mrs SAFA SALEEM UDDIN	**UHID**	HNH-00016306
Father/Guardian	Mr SHAIK HAMEED	**Age/Gender**	31 Y 1 M 23 D/ Female
Address	H.NO: 1-9-129/29/D/46/2., Ram Nagar, Hyderabad, Telangana, INDIA, 500020		
IP No	IP26-00006716	**Admission Date**	02-07-2026
Ref Doctor	SELF		
Discharge Date	03.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. Mallavarapu Tripura Sundaramba
MBBS, MD OBGYN
AMC12288

Diagnosis: G6P3L3A2 AT 7+6 WEEKS WITH RH NEGATIVE PREGNANCY WITH LEFT OVARIAN ECTOPIC PREGNANCY WITH K/C/O HYPOTHYROIDISM WITH FIBROID UTERUS FOR FURTHER MANAGEMENT

History:

LMP: 08.05.2026 Obstetric formula: G6P3L3A1
EDD: 12.02.2027 Gestation at admission: 7+6 weeks

Obstetric History:

Name	Mrs SAFA SALEEM UDDIN	**UHID**	HNH-00016306
IP No	IP26-00006716	**Admission Date**	02-07-2026

G1 - 2016 - FTVD, Female, 10years, 2.9kg, A&H, took ANTI D
G2 - 2018 - FTVD, Female,8yrs,2.1kg,A&H, Anti D received
G3 - 2018- MERPC at 7weeks
G4 - 2020- FTVD, 2.4kg,A&H, h/o NICU stay for 9 days i/v/o jaundice, took ANTI D
G5 - 2026- MERPC at 7weeks, D&C done, not received Anti D
G6 - Present pregnancy, Spontaneous conception

Medical History: Hyperthyroidism since 1month on T.Methimazole 50mg once daily
Family History: Mother-Ovarian Cancer, Hypothyroidism

Surgical History: D&C in Jan 2026
Allergies: Nil

Antenatal Details:

Mrs SAFA SALEEM UDDIN was booked to Rainbow hospital at 7^{+6}weeks of gestation. Previous ANC's elsewhere as advised Dr.Tripura Sundari.She had regular antenatal checkups and investigations as advised. Scan done on 1.07.2026 showed Bulky uterus measuring 12.8x7.4x6.8cms,Posterior wall fibroid measuring 6.4x6cms,Anterior wall fibroid measuring 6.9x6.7cm,Posterior wall cervical fibroid - 5.6x5cms,Left ovary an echogenic lesion 20x13mm adjacent to left ovary with gestational sac ~ 11^{+4}weeks with ?Left ovarian ectopic.Beta-HCG(30.06.2026)- 6667mIU/ml. She was admitted at 7+6weeks with ?Left ovarian ectopic pregnancy

Name	Mrs SAFA SALEEM UDDIN	**UHID**	HNH-00016306
IP No	IP26-00006716	**Admission Date**	02-07-2026

Investigations: Enclosed
Blood Group: "AB" Negative

Management: Pt. came with complaints of pain abdomen. On admission her vitals were stable. She was started on conservative line of management with Inj.Methotrexate 75mg Intramuscularly. Stict vitals monitoring done. Scan done on 03.07.2026 showed single intrauterine pregnancy with Gestational sac measuring 12.3mm,yolk sac visualised,no embryo, Left ovary-corpus luteal cyst measuring 20x18x17mm,Uterus fibroids-Posterior left lateral Intramural-7x7.9cmx6.6cm,Posterior and right lateral subserosal fibroid in lower corpus,pedunculated fibroid- 7.3x6.5x6.7cm,Fundoposterior Intramural and subserosal fibroid-8.1x8.3x8.6cm. Pt.recovered well with this management.

Advice:

- Repeat CBP and Serum Beta HCG and review

Review with **DR.TRIPURA SUNDARI** on **6.07.2026** with **Serum Beta-HCG and CBP reports.**

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

Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for

Name	Mrs SAFA SALEEM UDDIN	**UHID**	HNH-00016306
IP No	IP26-00006716	**Admission Date**	02-07-2026

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:
Dr. Mallavarapu Tripura Sundaramba
MBBS,MD-Obstetrics & Gynaecology
AMC12288

Rainbow Children's Hospital

BirthRight Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006716 **Admit Date** : 02-Jul-2026 **Admit Time** : 12:14 PM **UHID** : HNH-00016306

Patient Details :

Patient Name	: Mrs SAFA SALEEM UDDIN	**Age**	: 31 Y 1 M 22 D
Guardian	: Mr SHAIK HAMEED	**DOB**	: 10-05-1995
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: H.NO: 1-9-129/29/D/46/2. Ram Nagar Hyderabad Telangana INDIA 500020	**Phone No**	: 9346501567/ 9182828420
		E-mail	: SHAIKHAMEED3367@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PPO-418 **Ward Name** : 4F -OT

Room No : PPO-418 **Admission Type** : First Visit

Contact Details :

Name : Mr SHAIK HAMEED **Relationship** : Husband

Contact Address : H.NO: 1-9-129/29/D/46/2. Ram Nagar Hyderabad Telangana INDIA 500020 **Phone No** : 9346501567

Shaik Hameed.
Signature

Doctor Details :

Doctor Name : Dr. Mallavarapu Tripura Sundaramba **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : SELF **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 15000.00

Payor Name : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name : HNH-00016306 IP26-00006716
Mrs SAFA SALEEM UDDIN
10-05-1995 31 Y 1 M 22 D (F)
Dr. Mallavarapu Tripura

UHID N _____ Consultant: _____ Dept : _____

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

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

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				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
3/2/2026	viability scan	R2626-007948	Anyla

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature

ANY OTHER INFORMATION

.....

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.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016306 IP26-00006716
Mrs SAFA SALEEM UDDIN
10-05-1995 31 Y 1 M 22 D (F)
Dr. Mallavarapu Tripura

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 2/7/2026 Time of Admission : .....

Allergies: ..... ☑ Not know any drug allergies

PRESENTING COMPLAINTS :

$G_6P_3L_3A_2$ | [redacted] 7th wks | c/o hypothyroidism/multiple fibroid uterus | ? Left ovarian Ectopic Preg.

Conv & Scan report s/o ? Left ov Ectopic Preg

UPT done @ home (30/6/2026), which she took IVO H/O 1.5 month of amenorrhea

BHCG - 6667 mIU/ml (30/6/2026)

USG (1/7/2026) — Bulky Fibroid ut (128 x 74 x 68mm) c/o multiple Antr & Post wall fibroid max size Post - 66x60mm | Ant wall 69x67mm Post wall & fibroid 56 x 50 mm.

Left ovary → c/o Echogenic focus 20x13mm adjacent to left ovary & CS seen 11 x 4 wks (? Ectopic)

MENSTRUAL HISTORY	OBSTETRIC HISTORY - $G_6P_3L_3D_2$
Year of Marriage :	Parity : (G1) - FTVD | Spont | 2016 | 8y | male | 2.9kg | AAH (G2) - 2018 | FTVD (10L) | 8y | Fch | 2.1kg | AAH
Previous Periods : RNR	Mode of Delivery : (G3) - 2018 | Took → MERPC | unwanted preg
LMP : 8/5/2026 EDD - 12/2/2027	Last Child Birth : (G4) 2020 | FTVD Spont | 6y | 2.4kg | AAH (Gy) Baby - NICU x 9d | No jaundice
Contraception :	(G5) - 2026 | Took — MERPC → D&C done
	(G6) - PP, Spont conception

Took Anti D in all except after D&C (2026)

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Hypothyroidism : 1 month (T. Methimazole 5mg P/O OD) : 1 month	D&C - Jan 2026

HNH-00016306 IP26-00006716
Mrs SAFA SALEEM UDDIN
10-05-1995 31 Y 1 M 22 D (F)
Dr. Mallavarapu Tripura

FAMILY HISTORY:	MEDICATION HISTORY:
Mother - Ov Ca. → ℅ BSO Hypothyroidism.	T. Methimazole 5mg PO OD.

INITIAL ASSESSMENT :

	Breasts	Local/Speculum Examination
Date 2/7/2026. Ht. 173.7cm Wt. 82kg BMI B.P 108/58 PR - 78 Pallor CVR Respiratory System Thyroid	Normal Abdominal Examination Soft, NT.	not done Bimanual Pelvic Examination not done.

PROVISIONAL DIAGNOSIS : G6P3L3A2 with 3 Pre. FTNVD with Ovarian Ecto pic. ? k/c/o hyperthyroidism

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
SRI - AB neg CBP 30/6/2026 (30/6). Hb - 10.3. βhCG - 6667. mIU/ml PCV - 33. TLC - 8100 CUE (30/6) Ⓝ plt : 3.80 LFT (30/6) ALP - 102. Rest - Ⓝ	Admission Parts Preparation Inj. Methotrexate 75 mg. Stat T/M βhCG → Send on 3/7/2026 w/f PV bleeding. strict PR & BP monitoring. w/f Pain abdomen/ signs of Haemoperitoneum.

Name of the Doctor : Dr. T. Sirandani

Signature of Doctor [signature]

Date & Time : 2/7/2026

HNH-00016306 IP26-00006716
Mrs SAFA SALEEM UDDIN
10-05-1995 31 Y 1 M 22 D (F)
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
2/7/2026	Clnlb Dr Srilaxmi	
9:45pm	G6P3L3A2 / Para NVD / Ov Ectopic / K/c/o Hypothyroidism	
	Gc- Fair Afebrile	Adv.
	Vitals Stable	Regular Diet / Adeq Hydration
	P/A Soft	Drugs as charted
	LE NAD	- W/f vitals & BPV (if any)
	-	
4		
	[Plan Send BHCG qm] 3/7/2026	
(Inj MTX 75mg im stat @ 2:45pm)		2/7/26
2/7/26 8pm	Cls/B Dr. Dnq	
	G6P3L3A2 ± NVD ± Ovarian Ectopic K/c/o Hypothyroidism	
	No complaints	Adv
	Gc Fair Afebrile	- Regular diet
	BP: 104/74mmHg	- Adequate hydration
	PR: 84/m	- Drugs as charted
	P/A soft	- W/F vitals
		w/f Bleeding P.V.

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Dr. Mallavarapu Tripura

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 6AM	C/S/B Dr. Durga	
	$G_6P_3L_3A_2$ c NVD c Ovarian Ectopic c k/c/o Hypothyroid	
	No complaints GC fair Afebrile BP: 104/74mmHg PR: 70 bpm. P/A soft Non tender.	Adv - Regular diet - Adequate hydration. - Drugs as charted - W/F Vitals, bleeding P.V. - BHCG @ 3pm - Scan today @ 10am
	C/S/B Dr. Veena	
3/7/26 12pm.	$G_6P_3L_3A_2$ 2 NVD c ? Ovarian Ectopic c k/c/o Hypothyroidism	
	C/O/W Dr. Tripura Sudarsi	
	Pt is stable. No c/o o/e GC fair Vitals (N) P/A - Soft, NT L/E - NAD USG → SLIUG, NOYS, NO embryo 3/7/2026	Adv - Regular diet - Adequate hydration - Drugs as charted - BhCG @ 3pm - Vital monitoring

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/2026	C/s/b Dr	Mamata
4pm	G2P3L3A2 / Prev LNUS	for further management
	AC for Afebrile	Ad
	vitals Stable	
	No complaints	- Can be discharge
		- Sent file for Processing
	~~Sat~~ CBP BHCG } to do	
		[signature] Dr. Mamata

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

(P.T.O)

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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Mrs SAFA SALEEM UDDIN
10-05-1995 31 Y 1 M 22 D (F)
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MEDICATION RECONCILIATION FORM

Drug Allergies: No ☐ Not known any Drug Allergies

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

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

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Naveena @.

Date & Time : 2/7/2026 @ 1:30pm.

Nurse Name & Signature: Madhumita @ Madhu

Date & Time : 2/7/26 @ 1:30pm

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DRUG CHART

Date of Admission: 21/2/26 Drug Allergies: NKA ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

HNH-00016306 IP26-00006716
Mrs SAFA SALEEM UDDIN
10-05-1995 31 Y 1 M 22 D (F)
Dr. Mallavarapu Tripura

REGULAR PRESCRIPTIONS

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

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

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

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

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

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
2/7.	Not given	INJ METHOTREXATE	100 mg.	IM		Not given
2/7	2.45pm	INJ METHOTREXATE	75 mg	Im		Chandu Madhu

Patient Sticker

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign

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

HNH-00016306 IP26-00006716
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RESULT SHEET

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

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood Group	AB-ve					

Culture and Sensitivities : .....

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Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00016306 IP26-00006716
Mrs SAFA SALEEM UDDIN
10-05-1995 31 Y 1 M 22 D (F)
Dr. Mallavarapu Tripura

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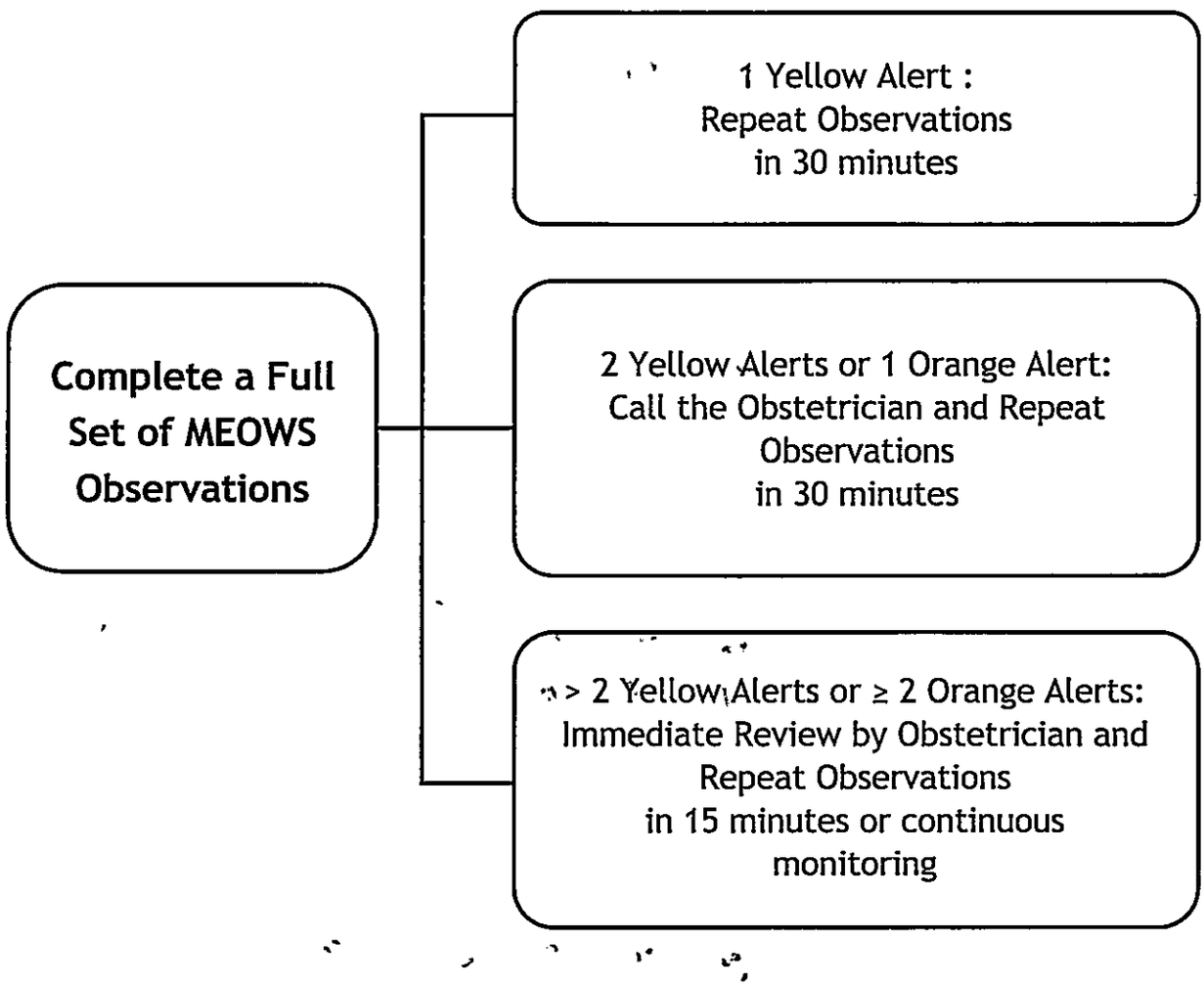
Early Warning Observation Score Chart - Obstetrics

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

27

		Date																							
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20								20		20		20		20		20		20		20		20		20	
	0 - 10																									
Saturations	94 - 100 %								99%		99%		99%		94		94		94		94		94		94	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37								36		36		36		36				36				36			
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80								81		82		84		84				82/73		81		89		70	
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120								106		102		104		105				117		109		110		102	
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70								27		32		24		23				74		72		64		74	
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert								•		–		–													
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES									0		0		0		0				0				0		0	
TOTAL ORANGE SCORES									0		0		0		0				0				0		0	
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00016306 IP26-00006716
Mrs SAFA SALEEM UDDIN
10-05-1995 31 Y 1 M 22 D (F)
Dr. Mallavarapu Tripura

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Early Warning Observation Score Chart - Obstetrics

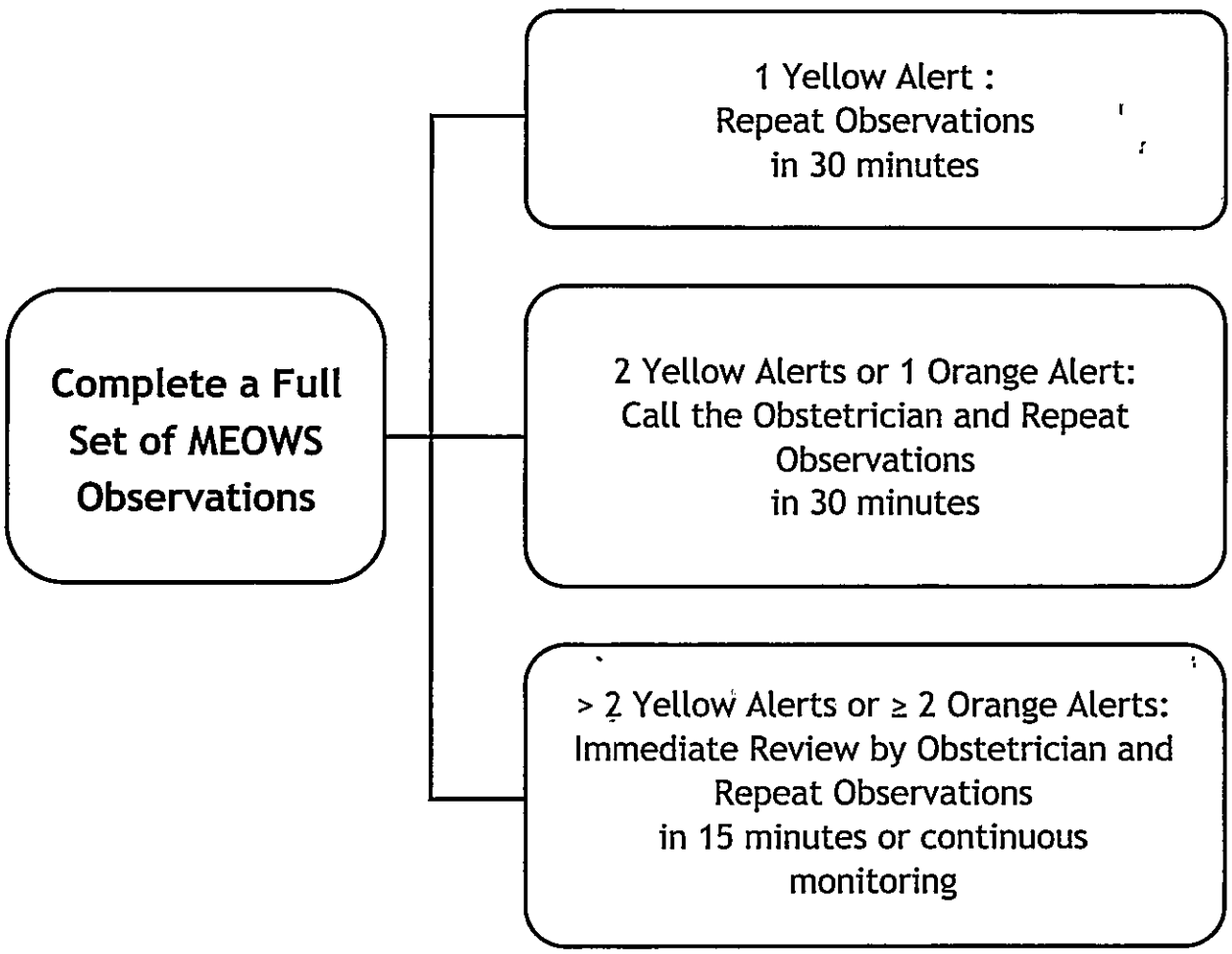
CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

3/7/26

		Date																								
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20	20	20			20			20																	
	0 - 10																									
Saturations	94 - 100 %	99		98		99			98																	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37	–																								
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80	82		74		80			82																	
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110	105		111		109			112																	
	100	70		70		70			70																	
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80	69		64		74			82																	
	70																									
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert	–																								
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES		–		0		0			0																	
TOTAL ORANGE SCORES		–		0		0			0																	
Nurse Initial																										

pt DLS

Obstetrics and Gynaecology Early Warning Signs



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

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FLUID CHART

Sheet No. : ...(1)...

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
2/7	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm									✓		
	01:00 pm											
Total Intake :						Total Output :						
2/7	02:00 pm											
	03:00 pm		Idly. H2O							✓	0	
	04:00 pm											
	05:00 pm									✓		CK
	06:00 pm		H2O									
	07:00 pm											
Total Intake : Taken						Total Output : Passed						
2/7/26	08:00 pm											
	09:00 pm											
	10:00 pm		Rice			NA				✓		
	11:00 pm	0	H2O								0	[illegible]
	12:00 am									✓		
	01:00 am											
Total Intake :						Total Output :						
3/7/26	02:00 am											
	03:00 am											
	04:00 am		H2O			NA					0	[illegible]
	05:00 am	0								✓		
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
3/4/26	08:00 am									✓		
	09:00 am											
	10:00 am									✓		
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :								**Total Output :**				
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :								**Total Output :**				
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :								**Total Output :**				
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :								**Total Output :**				

Total 24 hrs. Intake		Total 24 hrs. Output	

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

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 2/2/26 Time of Arrival: 12pm Time Seen by Nurse: .....

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

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

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

3) Vital Signs: Temperature: 97°F Pulse: 80 RR: ..... SpO_2: ..... BP: ..... Weight: .....

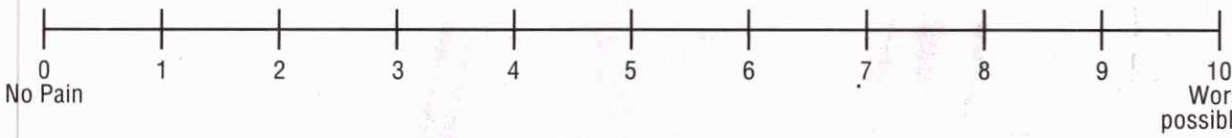
4) Gestational Criteria:

Gravida:	G 6	P 3	L 3	A 2

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

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

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



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

.....

6) Past History:

a) Surgeries: .....

b) Medical: .....

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

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

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: Dr. naveena

Nurse Name : Chembalaiah Nurse Signature: [signature]

Date: 2/7/26 Time: 12 pm

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 2/7/26

Baseline Information:

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

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

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

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

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

If yes , identify .....

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

..... pain abdomen ..... Name of the Doctor: .....

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

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

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

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

..... Regular

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☑ No ☐ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

Infertility: ☑ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

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

Previous LSCS: .....

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

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 97°F HR: 86 RR: .....

BP: 110/80 Weight: ..... Height: ..... BMI: .....

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

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PHYSICAL ASSESSMENT

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

Fall Assessment: ☐ Yes ☐ No Score 0/125..... (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☐ No Score 19/23..... (complete the Braden Q Sheet)

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With .....

Orientation has been given regarding the following aspects:

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

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

Above information given to ..... patient

Name of Person Orientation was given to: Safa saleem

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: .....

Date & Time: 2/7/26 at 1 pm

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PAIN ASSESSMENT FORM

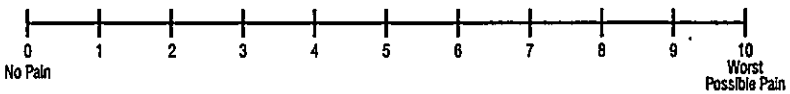
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
2/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
2/7	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
2/7	8pm	0/8	NR	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
3/7	10Am	0	Ma	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
3/7	1PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	N/A	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli - Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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BRADEN 'Q' SCALE

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				Date :	2/7	2/7	3/7	
				Time :	[illegible]	[illegible]	[illegible]	
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
				TOTAL SCORE	28	28	28	
				Evaluator's Name	[signature]	[signature]	[signature]	

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

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category			Date / Time	2/7	3/7	3/7
			Score	E2	M	M/6
History of Falling (immediately or w/in 3 months)	Yes	25				
	No	0		0		
Secondary Diagnosis (more than one diagnosis)	Yes	15				
	No	0		0		
Ambulatory Aid	Furniture	30				
	Crutches, Cane(S), Walker	15				
	None /Bed Rest /Nurse Assist	0		0	0	0
IV / Heparin Lock or Saline	Yes	20		20	20	20
	No	0				
GAIT / Transferring	Impaired	20				
	Weak (uses touch for balance)	10				
	Normal /On Bed Rest /Immobile	0		0		
Mental Status	Forgets limitations	15				
	Oriented to own ability	0		0		
Total Morse Fall Scale Score:				20	20	20
			Signature			

Fall Risk Grading

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0									
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	~									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	~									
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	~									
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	~									
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	~									
			Signature of the Nurse										

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

Patient Sticker

CHECKLIST FOR THROMBOPHLEBITIS

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S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0										
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1										
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2										
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			Signature of the Nurse										

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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NURSING CARE RECORD

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Date: 2/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				NA			
Afternoon	2pm to 8pm	=> Assess the patient condition => plan for vital => plan for I/O chart	2pm to 8pm	=> Assessed the pt condition => maintain vital & Record => maintain I/O chart	patient is stable	vitals is normal	[signature]
Night	8pm to 8Am	→ Assess the pt condition monitor vitals → maintain I/O chart	8pm to 8Am	→ Assessed the pt condition → monitored Vitals → Administer medication as for Doctor order.	Now pt is stable	Re-check vitals	Moni [signature]

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NURSING CARE RECORD

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Date: 3/2/2026

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am 2pm	→ Assess the pt condition → check the vital's → I/O chart maintain → Mobility scan done → B-HCG due – 3pm	8am 2pm	→ Assessed pt condition → checked vital's & m → Maintained I/O chart	Vital's is Normal	Pt is stable	
Afternoon							
Night							

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time	2/7 E2	3/7/26 N1	3/7/26 N6			
	Medical Condition (Any special condition to be noted):	—	—	—			
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.6	98.6	98.1			
	Res:	20	20	20			
	SpO_2:	99%	99%	99%			
	Pulse:	82	80	80			
	BP:	104/71	110/70	114/71			
	Fall Risk Score:	—	—	—			
	Pain Score:	—	—	—			
Recommendations	Safety Needs:	—	—	—			
	Physiotherapy	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—	—	—			
	Special Diet:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	—	—	—			
Post Operative Procedure Special Orders:		—	—				
Handed Over By Name :		Maddy	Mouni	Ayesha			
Signature :							
Date:		2/7	3/7	3/7			
Time:		8 AM	8 AM	2 PM			
Taken Over By Name :		Mouni	Ayesha				
Signature :							
Date:		3/7/26	3/7/26				
Time:		8 PM	8 AM				

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NURSING SHIFT HAND OVER FORM - WARD

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

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