Gevanthi 9154865024

Dr. Shalini Santoshi

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ESTIMATION SLIP

Date : 6/7/26 **UHID / IP No. :** HAIH-00016393 **Sl No.** 1671

Name of Patient : Mrs. Dr. Sudha Rani **Age:** 44y **Gender:** F

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

Address : **Phone :** 9160559553 / **Email :** 9985327819

Procedure / Plan : ND / LSCS **EDD/Dos:** July-26

MODE OF PAYMENT : ☑ **SELF** ☐ **TPA :** ☐ **GIPSA :** **OTHER**

TARIFF INFORMATION :

Particulars	**Package Amounts (Rs.)**	
Room Category	**Normal Delivery**	**LSCS**
Multi Shared Ward		
Shared Ward		
Twin Shared Ward		
Private Room →		1.55L (1.20)L
Super Deluxe Room		
Suite Room		
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for :	Length of Stay for : 3 Days
	Pharmacy up to	Pharmacy up to 12,000/-
	Investigations up to ←	Investigations up to 3,000/-
Others	Well baby care	(BP/NST) 25L to 35L approx

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

Initial Minimum Deposit : 80% Advance time of Admission

REMARKS : Vaccination, Neonatal, SBR, B/G

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

DECLARATION

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

Rahul Verma

[signature]	Husband	[signature]
Signature of the Client	Signatory Relationship	Signature of the financial Counselor

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

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SURGERY DETAILS

Date : 9/7/26

Patient Name: Mrs. DR. Sudharani Busani Date of Birth: 18-08-1984 Age: 41 Yrs

Gender: Female Ward : OT UHID No.: HNH-00016393

Date of Surgery: 9/7/26 ☑ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Elective LSCS.

Time in : 10:50 AM Time Out : 12:15 Pm

	NAME	AMOUNT
1. Surgeon	: Dr. Santhoshi	
2. Anaesthetist	: Dr. Ayesha Dr Aditi	
3. Assistant Surgeon	: Dr. Naveena.	
4. OT Technician	: Sr. [illegible] Sr. Pallavi	
5. Circulating Nurse	: Sr. Natasha, Sr. Karuna	
6. Assistant Nurse	: Sr. Natasha.	

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

Signature of the Surgeon

Natasha
Signature of Circulating Nurse

Order No: 26-0000212068 Order by: Sushila 9/7/26 @ 12:31 Pm.

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

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

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CONSUMABLES OF OT

Circulating staff : Karuna Technician : Pallavi Date : 9/4/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack MCS		01	Inj Vit.K		1
LMA			Sutures 2346, 1326		01+1	Cord Clamp		1
ECG leads : A / P / N		03	Ethylon 3348, 4242		01	Suction Catheter		
HME filter : A / P / N					01	Feeding Tube		
Syringes : 10 cc		03				Vaccum Suction Set		
05 cc		03	Gloves SG 6.5		02	Surgical Gloves SG 6½		01
02 cc		02	Encore 6.5	01	01	Gauze Pack 10x10		01
01 cc		01	Surgicare 7.0		01	Syringe 1ml / 2ml		01
Cautery plate : A / P / N		01	Surgical blade 22		01	Surgical Blade # 20		01
IV set		01	NG tube			Koochies (S)		
RL		03	Cautery pencil		01	Encore 6.5		01
NS : 10ml / 100ml / 500ml / 1000ml		01	Koochies XXL		01			
lox 2%		01	Ointments			26-00002120891890		
O2 mask [A]		01	Suction Catheter					
Fentanyl		01	Cap, Mask		10+10			
Morphine			Gauze Pack 10x10		02			
Ketamine			Mop Pack		02			
Propofol			Steristrip					
Rocuronium			Underpad		02			
Glycopyrolate		01	Draw sheet		02			
Myopyrolate			Abgel		01			
Ondansetron		01	Foleys catheter					
Pencan 25g/ Spinal Needle 22		01	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)		01	Romodrain bag					
Antibiotics			Bandage					
Oxytocin		06	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / 100mg		01	Plastic Bed Sheet Aprons		04			
Tab. Misoprost : 200mg		01	Betadine Solution		02			
Tranexa		02	Microshield		01			
S.glove 6.0		01	Cotton Balls		01			
gauze 7.5		01	Latex Gloves		20			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. 26-00002120886/2120887 Ordered by : Sangeetha

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

Rainbow Children's Hospital

Birthright Rainbow

Rainbow Childrens Hospital-Himayatnagar

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	HNH-00016393	**Name**	: Mrs DR SUDHARANI BUSANI
Age / Sex	: 41 Y 10 M 21 D / Female	**Doctor**	: Dr THULABANDULA SANTHOSHI SHALINI
Adm/Reg Date/Time	: 09/07/2026 08:44	**Payor**	: SELFPAY
Order Date	: 09/07/2026 12:59	**Ordernumber**	: 26-0000212087
Visit ID	: IP26-00006788	**Ward/Bed No**	: 4F -OT / PDA-412
Patient Address	: FLAT NO:110,ARK APTHA APARTMENTS ,SHIVA SAI NAGAR COLONY,KARMANGHAT Meerpet, Hyderabad, Telangana, INDIA, 500097		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	ABGEL SURGI PAD (BIG) (GELSPON)	ABGEL	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
2	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
3	DISPOSABLE APRONS STERILE XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	4 Days		4 Nos	Dispensed
4	GAUZE PACK STERILE 10X10X12 PLY 5S	GAUZE PACK STERILE 10X10X12 PLY 5 PACK	1 Nos	External / Once Daily	1 Days		2 Nos	Partially Dispensed
5	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
6	ONDOKIND INJ 4 MG 2 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
7	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
8	BIOXAMIC 500 MG INJ		1 Ampule	External / Once Daily	1 Days		2 Ampule	Dispensed
9	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
10	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
11	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
12	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
13	MONOCRYL 3-0 NW 1326	MONOCRYL 1326	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
14	TRUGUT CHROMIC CATGUT SN4242	TRUGUT CHROMIC CATGUT SN4242	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
15	EVATOCIN (OXYTOCIN) INJ 5 IU 1 ML		1 Vial	External / Once Daily	1 Days		6 Vial	Dispensed
16	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
17	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
18	SGLOVE # 6 (SURGICARE)	SURGICAL GLOVES 6.0	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
19	BCV-INTRAFIX SAFESET		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
20	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
21	LSCS DRAPE PACK (PROTECTCARE)		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
22	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
23	ETHILON 1 NW 3348	ETHILON 1 NW 3348	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
24	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

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ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00016393	**Name**	: Mrs DR SUDHARANI BUSANI
Age / Sex	: 41 Y 10 M 21 D / Female	**Doctor**	: Dr THULABANDULA SANTHOSHI SHALINI
Adm/Reg Date/Time	: 09/07/2026 08:44	**Payor**	: SELFPAY
Order Date	: 09/07/2026 12:59	**Ordernumber**	: 26-0000212086
Visit ID	: IP26-00006788	**Ward/Bed No**	: 4F -OT / PDA-412
Patient Address	: FLAT NO:110,ARK APTHA APARTMENTS ,SHIVA SAI NAGAR COLONY,KARMANGHAT, Meerpet, Hyderabad, Telangana, INDIA, 500097		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	NS 100ML ACCULIFE - EH	NORMALSALINE 0.9% SODIUMCHLORIDE100ML CLO	1 mL	/ Once Daily	1 Days		1 mL	Ordered
2	THEMIPYRRNOM 0.2MG INJ		1 Nos	External / 10 AM	1 Days		1 Nos	Ordered
3	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
4	UNDER PAD 60X90 10's Pack - MEDICUBE		1 Nos	External / 10 AM	1 Days		2 Nos	Ordered
5	GAUZE PACK STERILE 10X10X12 PLY 5S	GAUZE PACK STERILE 10X10X12 PLY 5 PACK	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
6	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		20 Nos	Ordered
7	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Ordered
8	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Ordered
9	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		2 Nos	Ordered

Dr. THULABANDULA SANTHOSHI SHALINI
OBSTETRICS AND GYNECOLOGY
Reg No : 61026

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

Note

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

*** Do not refill medicines.**

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ELECTRONIC MEDICINE PRESCRIPTION

MRN	HNH-00016445	**Name**	: Baby Of SUDHARANI BUSANI
Age / Sex	: 0 Y 0 M 0 D 2 H / Female	**Doctor**	: DILNAAZ FAROOQUI
Adm/Reg Date/Time	09/07/2026 11:33	**Payor**	SELFPAY
Order Date	: 09/07/2026 13:03	**Ordernumber**	: 26-0000212089
Visit ID	IP26-00006792	**Ward/Bed No**	4F -OT / CRDL-HNPDA-412-1
Patient Address	: FLAT NO:110,ARK APTHA APARTMENTS ,SHIVA SAI NAGAR COLONY,KARMANGHAT, Meerpet, Hyderabad, Telangana, INDIA, 500097		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	ORD CLAMP-ALPHAMEDICARE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
2	GAUZE PACK STERILE 10X10X12 PLY 5S	GAUZE PACK STERILE 10X10X12 PLY 5 PACK	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
3	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
4	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	SURGICAL BLADE 20	SURGICAL BLADE 20	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
6	INJEK INJ 1 MG 0.5 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed

DILNAAZ FAROOQUI

Reg No : 56763

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

Note

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

*** Do not refill medicines.**

Printed Date/Time : 09/07/2026 13:45 Printed By GUVVALA VIJAYA SUSHEELA

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Name	Mrs DR SUDHARANI BUSANI	**UHID**	HNH-00016393
Father/Guardian	Mr RAHUL VANAMA	**Age/Gender**	41 Y 10 M 21 D/ Female
Address	FLAT NO:110,ARK APTHA APARTMENTS ,SHIVA SAI NAGAR COLONY,KARMANGHAT, Meerpet, Hyderabad, Telangana, INDIA, 500097		
IP No	IP26-00006788	**Admission Date**	09-07-2026
Ref Doctor	Self.		
Discharge Date	12.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. THULABANDULA SANTHOSHI SHALINI
MBBS, MS OBGYN
61026

Diagnosis: G2A1 WITH 39^{+1} WEEKS WITH GESTATIONAL DIABETIC MELLITUS ON ORAL HYPOGLYCEMIC AGENTS WITH ADVANCED MATERNAL AGE WITH UNSTABLE LIE FOR DELIVERY

ELECTIVE LOWER SEGMENT CAESAREAN SECTION DONE ON 09.07.2026

History:
LMP: 11.10.2025 Obstetric formula: G2A1
EDD: 14.07.2026 Gestation at admission: 39^{+1} weeks

Obstetric History:
G1 - 2024 - Missed miscarriage at 5-6 weeks, MERPC done.

Name	Mrs DR SUDHARANI BUSANI	**UHID**	HNH-00016393
IP No	IP26-00006788	**Admission Date**	09-07-2026

G2 - Present pregnancy, Spontaneous conception.

Medical History: Nil
Surgical History : Laparoscopic Myomectomy in 2002
Family History : Mother - T2DM,Hypothyroidism.
Allergies : Nil

Antenatal Details:

Mrs DR SUDHARANI BUSANI was booked to Rainbow hospital at 39^{+1}weeks of gestation. She had regular antenatal checkups and investigations elsewhere. NT scan was normal. Double Marker showed Increased risk Trisomy 21. Deranged OGTT, hence started with T.Glycomet 500 mg Twice daily, TIFFA was normal, Fetal 2D Echo normal, Steroids were give at 27^{+1} weeks for fetal Lung maturity. She was diagnosed with Moderate Anaemia for which Parenteral iron therapy was given at 34^{+1} weeks. Growth scan on 04.07.2026 showed Singleton pregnancy, 37 weeks, cephalic presentation, AFI- 13 cms, Placenta-posterior, upper segment, Grade 3 maturity, EFW-3.034 Kg (46%) AC (63%). She was admitted for elective Lower segment caeserian section on 09.07.2026.

Investigations: Enclosed.
Blood group: "O" Positive

Management: Course in hospital:

At admission on clinical examination the vitals were stable, uterus was relaxed. Fetal well being was confirmed by an admission CTG which was found to be reactive. She was prepared for elective C-section with indwelling Foley's

Name	Mrs DR SUDHARANI BUSANI	**UHID**	HNH-00016393
IP No	IP26-00006788	**Admission Date**	09-07-2026

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

Surgery Notes:

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

Delivery Details:

Date : 09.07.2026
Time of Delivery : 11:15am
Type of Delivery : Elective lower segment caesarean section
Indication : Unstable lie
Anaesthesia : Spinal

Name	Mrs DR SUDHARANI BUSANI	**UHID**	HNH-00016393
IP No	IP26-00006788	**Admission Date**	09-07-2026

Baby Details:

Date : 09.07.2026
Time : 11:15am
Sex : Female
Weight : 3.22 kg
Apgar : 8,9
Gestational Age: 39^{+1} weeks
NICU Admission: No

Post-Operative Notes:

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

Advice:

1. Tab. Taxim O 200mg twice daily till 15.07.2026 (9am-9pm) after food.
2. Tab. Calpol (Paracetamol 500mg) 2 tablets thrice daily till 13.07.2026 (8am-2pm-10pm) after food.
3. Tab. Voveran (Diclofenac-50mg) 1 tablet thrice daily till 13.07.2026 (9am-3pm-11pm) after food.
4. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 15.07.2026

Name	Mrs DR SUDHARANI BUSANI	**UHID**	HNH-00016393
IP No	IP26-00006788	**Admission Date**	09-07-2026

(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 500mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
7. Nebasulf Powder for local application.
8. **Blood sugar advise**

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. THULABANDULA SANTHOSHI SHALINI,** after **1 week** on **18.07.2026 .** at postnatal clinic with prior appointment.

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

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.

Name	Mrs DR SUDHARANI BUSANI	**UHID**	HNH-00016393
IP No	IP26-00006788	**Admission Date**	09-07-2026

5.Apply Nebasulf or Neomycin dusting powder on the wound after it is dry.
6.Do not touch the wound with unwashed hands.

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

Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 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**

RAINBOW CHILDREN'S MEDICARE LIMITED HYDERABAD

Registrar/Resident/C.M.O

Consultant:
Dr. THULABANDULA SANTHOSHI SHALINI,
MBBS MS
61026

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006788 **Admit Date** : 09-Jul-2026 **Admit Time** : 08:44 AM **UHID** : HNH-00016393

Patient Details :

Patient Name	: Mrs DR SUDHARANI BUSANI	**Age**	: 41 Y 10 M 21 D
Guardian	: Mr RAHUL VANAMA	**DOB**	: 18-08-1984
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: FLAT NO:110,ARK APTHA APARTMENTS , SHIVA SAI NAGAR COLONY,KARMANGHAT Meerpet Hyderabad Telangana INDIA 500097	**Phone No**	: 9985327819/ 9160559553
		E-mail	: BUSANI.SUDHA@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PDA-412 **Ward Name** : 4F -OT

Room No : PDA-412 **Admission Type** : First Visit

Contact Details :

Name : Mr RAHUL VANAMA **Relationship** : Husband

Contact Address : FLAT NO:110,ARK APTHA APARTMENTS ,SHIVA SAI NAGAR COLONY,KARMANGHAT Meerpet Hyderabad Telangana INDIA 500097 **Phone No** : 9985327819

Signature

Doctor Details :

Doctor Name : Dr. THULABANDULA SANTHOSHI SHALINI **Specialisation** : OBSTETRICS AND GYNECOLOGY

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

Co-Consultant :

Payment Details :

Deposit Amount : 100000.00

Payment Mode : DC/CC Card **Payor Name** : SELFPAY

LSCS

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Your Right to a Safe Delivery

ACTIVITY RECORD FOR BILLING

Name :_____

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

UHID No. : _____ iltant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
9/7/26	10:50	MICU	OT	Mounika/Karuna
9/7/26	12:20pm	OT	MICU	Puja.
9/7/26	2PM	Pre & Post	Floor	Akshay

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. S. Tejaswi	9/7/26	12212	Sw
2				
3		Cross checked done by Sneha		
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
9/7/26	NST – (1)	47355	[illegible]
9/7	GRBS - 1Pm (106 mg/dl	2/2104	[illegible]
		~~00088~~ Check done by	
		Akila.	
9/7/26	GRBS - 7pm (119) mg/dl		
10/7/26	GRBS - 1Am 143mg/dl	Self	[illegible]
10/7/26	GRBS - 7Am 120mg/dl	Self	[illegible]
10/7/26	CBP	11390	[illegible]
10/7/26	FBS - 6am - 103 mg/dl	11497	[illegible]
11/7/26	PPBS 128 mg/dl	11496	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
9/7/26	Infusion pump	12:00 pm	3pm	26 000021210	bathi
9/7/26	cardiac monitor		3pm		
				mols check done sd.	
					Akeil

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
9/7/26	IV placement	1		
9/7/26	Catheterisation	1	26-0000 221032	Amegbe.
GX	PAC	1	221727	
9/7/26	NHA	1	12211	[illegible]

ANY OTHER INFORMATION

....

....

....

....

....

....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints
For El. LSCS

LMP: 11/10/25. EDD: 14/7/26
Corrected EDD: GA: 39+1 wks

Obstetric Formula: G2A1

Menstrual History: Regular: ☑ Yes ☐ No

Obstetric Hostory:
A1 G1 (2024) - Missed abortion (5-6wks) MERPC.
G2 (2025) - PP., Sp. conception.

Present Pregnancy Record:
NT - (N), Double marker - ↑sed. T21 risk.
NIPT - Low risk, TIFFA (N).
- Fetal echo (N), Steroids @ 27+1 wks (6mg).

RISK FACTORS: Anemia @ 34+1 wks → Inj. FCM. ↓ T. Glycomet 500mg OD.
- AMA.
- H/O Rx anemia
- GDM on OHA.

Growth (N), Breech

Obstetric Examination
Fundal Height: Ut ~ Term
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/D
Draining: ☐ Present ☐ Absent ☐ Bleeding
Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination N/A.
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: 120/70 mmHg DTR: (-)
CVS: S1S2 (+) RS: B/L NVBS
Liver/Spleen: (N) Urine Output: (N)

DIAGNOSIS
G2A1 | 39+1 wks | AMA. c̄ H/O Rx anemia
GDM on OHA. | c̄ Unstable lie

Docu. No. : RCH /FRM / CLINICAL / 087 (P.T.O)

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

Family History:	Surgical History:
Mother - DM & Hypothyroidism	H/O Lap. Myomectomy (2022)
Medical History:	**Medication History:**
Nil.	On T.Fe / T. G / T. Glycomet SOBY BD
Plan of Care:	**Investigations:**
Elective LSCS - Informed consent - Admission CTG - Prepare parts - Foley's catheterisation - Shift to OT on call - RBC - Inform OT / Anesthetist & Pediatrician. -	Blood group - "O positive" Hb - 12g/dl. PLT - 1.8/lch. WBC - 5.9/c 4/7/26. HIV HbsAg RPR HCV NR. USG. (4/7/26) ~ 37+2. SLIUF, Breech. Variant cephalic Liq - (N) EFW - 3.0kg (46%) AFI - 13. Dopplers - (N) PI - Upper segment

Doctor Name: Dr. G. Veena
Signature:
Date & Time: 9/7/26.

Consultant Name: Dr. Shalini Santhosh
Signature:
Date & Time: 9/7/26

HNH-00016393 IP26-00006788
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/2026 12:30pm	c/s/by Dr. Naveena	
	O/E GC-fair	Adv
	Afebrile SpO2-99% on RA	- NBM for 6hrs
	PR: 75bpm	- ivf and drugs as chalted
	BP: 113/71mm Hg	
	CVS/RS: NAD	- Urine PO chalti-g
	PA: ut retracted well	- w/f PV bleedi-g
	Soft, NT	- GRBS 6th hrly
	Dressi-g: dry & clean	- CBP T/M 6am
	I/E: PV bleedi-g WNL	- Monitor Vitals
	U/O: 400ml clear	- Inform SOS
	Baby: Mother side	
		Dr. Naveena.
9/7/2026 3:00pm	c/s/by Dr. Naveena	
	O/E GC-fair	Adv
	Afebrile, SpO2-99% on RA	- Sips of water flb liquid diet
Baby: NAD	PR: 71bpm	- drugs as chalted
	BP: 124/54mm Hg	- Urine PO chalted
	CVS/RS: NAD	- GRBS 6th hrly
	PA: ut retracted well	- CBP T/M 6am
	Soft, NT	- Monitor Vitals
	Dressi-g: dry & clean	- Inform SOS
	Bowel sounds: present	Kindly shift the patient to room
	U/O: 500ml, clear	

HNH-00016393 IP26-00006788
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
9/7/26 8pm	C/S/B Dr. Dnq	
	POD-0. P1L0A1 | GDM.	
	GC fair	~~Adv~~
Baby & Mother	Afebrile	- Liquid diet f/b
	BP: 129/76 mmHg.	- Soft diet t/m
	PR: 85 bpm.	- IV Fluids
	SPO2: 99% on RA	- Drugs as charted
U/O - 1000ml clear.	P/A Uterus Retracted well. BS (+).	- CBBS 6th hourly
		- I/O charting
	C/B NAB	- CBP t/m 6AM
CBBS - 119 mg/dl at 7pm.		- Foley's Removal t/m 6AM
		- FBS, PPBS on POD-2
		- Monitor vitals
		- Inform SOS
	T/F	
10/7/2026 7:45am	C/S/B by Dr. Naveena	
	O/E GC-fair	Adv
	Afebrile.	- S/L diet.
	Vitals - stable.	- Adequate hydration
U - ✓	PA: ut. retracted well	- Ambulation
F - ✓	S/L, NT.	- W/F PV bleeding
S - X	Dressing: dry & clean	- drugs as charted
	LIE: PV bleeding WNL	- Monitor Vitals
	Baby: Mother side	- Inform SOS

Dr. Naveena

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/7/26 3:30PM	C/S/B Dr. Veena	
	POD-1 / P1L1 / GDM on OHA	
Baby @ MS	Pt is stable, No c/o	Adv
	o/e GC fair	- Soft diet
	vitals - stable	- Ambulation
	P/A - Ut well retracted	- Drugs as charted
	BS (+)	- Adequate hydration
	L/E - RWNL	- POD-2 @ FBS / PPBS (C/M)
		- Vital monitoring
		- Inform SOS
		- Dulcolax suppository @ night
		N. B. maheshwari 10/7/26 @ 8:53 PM
10/7/26 9:15pm	C/S/B Dr. Dr.	
	POD-1 P1L1 / GDM.	
		Adv
Baby c̄ Mother.	GC fair	- Soft diet
	afebrile	- Adequate hydration.
UV	vitals - Normal	- Drugs as charted
FV	P/A - uterus Retracted	- FBS, PPBS c/m (11/7/26)
S ✓.	well, mild Abd distension (+)	- Monitor vitals.
	L/E NAB BS (+).	- W/F PV bleed
		- Dulcolax suppository at Night

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

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 22 D (F)
Dr. THULABANDULA SANTHOSHI

ticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26	C/S/B Dr. Dr. Dhq	
7:30 AM	POD-2 P,L) G DM	
		Adv
Baby c Mother	GC fair	- Soft diet
	Afebrile	- Adequate hydration
	vitals (N)	- Drugs as charted
U ✓	P/A Uterus Retracted	- PPBS to do
F ✓	well.	- Monitor vitals
S ✓	L/S NAB	W/F bleeding PV
	FBS - 103 mg/dl	Inform SOS
	[signature]	noted by sr. S andhya 11/7/26 7.30 a
11/7 1pm	Clon Dr Manisha	
	GC Fair Afebrile	Can be discharged
	Vitals stable	Send file for processing
		[signature]

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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Mrs DR SUDHARANI BUSANI
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DRUG CHART

Date of Admission: 9/4/26 Drug Allergies: .... ☑ 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 / 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	
Inj Diclofenac (Sos) 1amp i.m.				
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-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

REGULAR PRESCRIPTIONS

Weight. 72kg Ward. .....

DRUG : INJ- CEFOTAXIME

Dose	Route	Frequency	Start Date
1g	IV	BD	9/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: (ATD) 48hrs

Daily Doctor's Endorsement by a Sign

DRUG : T PARACETAMOL

Dose	Route	Frequency	Start Date
1gm	PO	QID	9/7/26

Name & Signature of the Doctor Starting the Drugs: Dr Adile W. Adile

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : T DICLOFENAC

Dose	Route	Frequency	Start Date
50mg	PO	TID	9/7/26

Name & Signature of the Doctor Starting the Drugs: Adile Dr Adile W.

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : T TRAMADOL

Dose	Route	Frequency	Start Date
100mg	PO	TID	9/7/26

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

Additional Instructions: Adile

Daily Doctor's Endorsement by a Sign

HNH-000016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

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Verified by Dr. Dhakshayani

REGULAR PRESCRIPTIONS

Sheet No: .... Weight 72kg Ward ....

DRUG : INJ. METRONIDAZOLE

Dose	Route	Frequency	Start Dt.
500mg	IV.	TID.	9/7

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

Additional Instructions: FOR 48HRS.

Date / Time	9/7	10/7	11/7
6AM	X	✓	
2PM	X	✓	
10PM	Noted	✓	

Daily Doctor's Endorsement by a Sign

DRUG : INJ. PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	IV	BD	9/7

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

Additional Instructions: FOR 48HRS

Date / Time	9/7	10/7	11/7
6AM	X	✓	✓
6PM	Noted	✓	

Daily Doctor's Endorsement by a Sign

DRUG : INJ. CLEXANE (ENOXAPARIN SODIUM)

Dose	Route	Frequency	Start Dt.
60U	S/C	OD	9/7

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

Additional Instructions: FOR 3 days. START FROM 8 pm [9/7/2026]

Date / Time	9/7	10/7
8PM	✓	✓

Daily Doctor's Endorsement by a Sign

DRUG : CEFIXIME

Dose	Route	Frequency	Start Dt.
200mg	PO	BD	11/7/26

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

Additional Instructions:

Date / Time	11/7
10AM	✓
10pm	

Daily Doctor's Endorsement by a Sign

VERIFIED BY: Name .... Signature

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

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 22 D (F)
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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : METRONIDAZOLE

Dose	Route	Frequency	Start Dt.
400mg	PO	TID	11/7/24

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	11/7
6am	
2pm	
10pm	

DRUG : PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	PO	BD	11/7/24

Name & Signature of the Doctor Starting the Drugs: Dr. Dna . TL

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	11/7
6am	

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time	

(P.T.O.)

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

Weight 72kgs Ward. ....

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
9/7/26.	10AM	INJ. PANTAPRAZOLE	40mg	IV	[signature]	Mou
9/7/26	10AM	INJ. METOCLOPROMIDE	10mg	IV	[signature]	Mou
9/7/26	10.50 AM	INJ TRANEXAMIC ACID	1gm	IV	[signature]	[signature]
9/7/26	11.50	TRAMADOL SUPP	100 mg	PR	[signature]	[signature]
9/7/26	11.50	DICLOFENAC 100mg	100mg	PR	[signature]	[signature]
9/7/26	11.15	INJ. OXYTOCIN	3U slow	IV	[signature]	[signature]
10/7/26	10:pm	T. Dulcolax	2 tab P/R. stat	PR.	Shalini	Sandhya

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

Verified by Dr. Dhakshayani

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

I.V. FLUIDS CHART

Weight. 70kg 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
9/7/26	11.00	RINGER LACTATE	IV	100ml/hr					
9/7/26	11.10	RINGER LACTATE	IV	F-F	Advl		9/7/26	Advl	
9/7/26	11.20	RINGER LACTATE 30+2.5V	IV	FF	Advl		9/7/26	Advl.	
9/7/26	11.15	RINGER LACTATE 6units+2.5	IV	FF	Advl		9/7		
9/7	1pm	RINGER LACTATE	IV	FF			9/7		
9/7	2.30 pm	RINGER LACTATE	IV	100ml/hr					
9/7	9pm	RINGER LACTATE	IV	100ml/hr					
10/7	2am	RINGER LACTATE	IV	100ml/hr					
		STOP	10/7/26						

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

HNH-00016393 IP26-00006788
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MEDICATION RECONCILIATION FORM

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

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	TAB. IRON	1tab	P/O	OD	8/7/26	☐C ☐DC
2	TAB. CALCIUM	1tab	P/O	OD	8/7/26.	☐C ☐DC
3	TAB. GLYCOMET	500mg	P/O	BD	8/7/26	☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. G. Veena

Date & Time : 9/7/26 @ 9:30 a.m.

Nurse Name & Signature: Karthik

Date & Time : 9/7/26 @ 10 AM

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

10/7/26.

Pt not willing to take. (Tab Diclofenac Tramadol)

BA

HNH-00016393 IP26-00006788
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18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

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RESULT SHEET

Date	10/7/26					
Time	626					
Hb	11.0					
PCV	32.1					
RBC	4.38					
WBC	9.25					
N/L	83.7/12.6					
Platelets	180					
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	O+ve					
HIV						
HbsAg	nil					
RPR						

OP
PV

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

215 (M)

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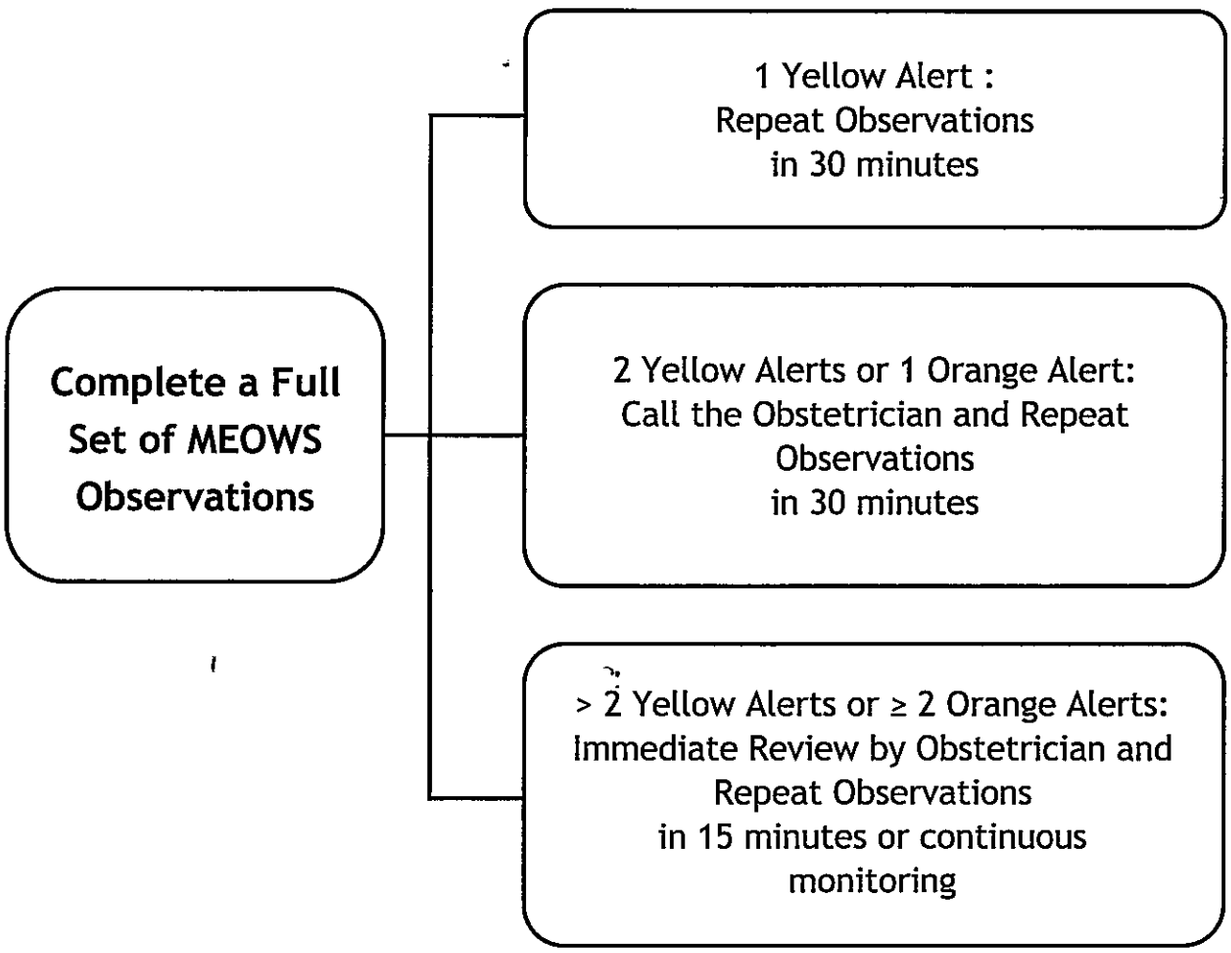
Early Warning Observation Score Chart - Obstetrics

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

9/7/26	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		18		18		19	20			20		20			20				20				20	
	0 - 10																								
Saturations	94 - 100 %		98		98		98	99			99		99			100				99				98	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp °c	40																								
	39																								
	38																								
	37		98.8		98.6		98.6				98.3		98.2			98.4				97.8				98	
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80		80		85		80	65			46		85			86				87				70	
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120		120		115		120	124			123		124			128				118				104	
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70		70		80		70	60			64		75			73				72				67	
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert		✓		✓		✓	—			—		—			—				—				—	
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30										—		—			—				—				—	
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal										—		—			—				—				—	
	Heavy / Foul																								
Liquor	Clear / Pink										—		—			—				—				—	
	Green																								
TOTAL YELLOW SCORES																									
TOTAL ORANGE SCORES																									
Nurse Initial																									

(79)

Obstetrics and Gynaecology Early Warning Signs



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

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18-08-1984 41 Y 10 M 21 D (F)
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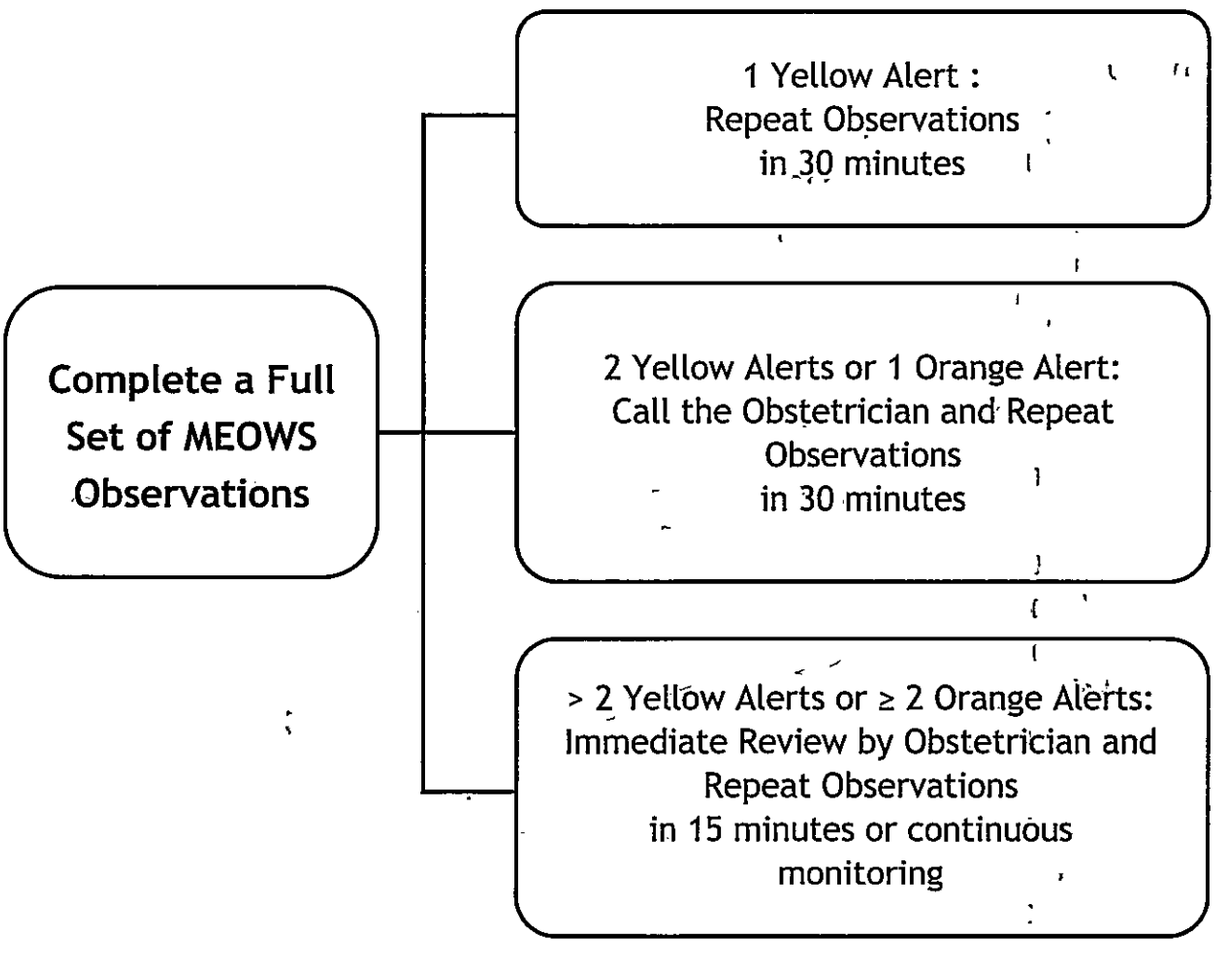
Early Warning Observation Score Chart - Obstetrics

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

10/9

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																								
RESP 21 - 30																								
RESP 11 - 20		20				20					20				20			20					20	
RESP 0 - 10																								
Saturations 94 - 100 %		99%				99%					99%				99%			99%					99%	
Saturations < 94 %																								
Administered O_2 (L/min.)											9													
Temp°c 40																								
Temp°c 39																								
Temp°c 38																								
Temp°c 37		36.5°C				36.4°C					98.4°F				98.4°F			98.2°F					98.8°F	
Temp°c 36																								
Temp°c 35																								
Temp°c < 35																								
Heart Rate 170																								
Heart Rate 160																								
Heart Rate 150																								
Heart Rate 140																								
Heart Rate 130																								
Heart Rate 120																								
Heart Rate 110																								
Heart Rate 100																								
Heart Rate 90		87bpm				85bpm					78bpm				85			83					80	
Heart Rate 80																								
Heart Rate 70																								
Heart Rate 60																								
Heart Rate 50																								
Heart Rate 40																								
Systolic Blood Pressue ↑ 190																								
Systolic Blood Pressue ↑ 180																								
Systolic Blood Pressue ↑ 170																								
Systolic Blood Pressue ↑ 160																								
Systolic Blood Pressue ↑ 150																								
Systolic Blood Pressue ↑ 140																								
Systolic Blood Pressue ↑ 130																								
Systolic Blood Pressue ↑ 120		109				112					110				115			105					120	
Systolic Blood Pressue ↑ 110																								
Systolic Blood Pressue ↑ 100																								
Systolic Blood Pressue ↑ 90																								
Systolic Blood Pressue ↑ 80																								
Systolic Blood Pressue ↑ 70																								
Systolic Blood Pressue ↑ 60																								
Systolic Blood Pressue ↑ 50																								
Diastolic Blood Pressure ↓ 130																								
Diastolic Blood Pressure ↓ 120																								
Diastolic Blood Pressure ↓ 110																								
Diastolic Blood Pressure ↓ 100																								
Diastolic Blood Pressure ↓ 90																								
Diastolic Blood Pressure ↓ 80																								
Diastolic Blood Pressure ↓ 70																								
Diastolic Blood Pressure ↓ 60		60				70					71				70			60					70	
Diastolic Blood Pressure ↓ 50																								
Diastolic Blood Pressure ↓ 40																								
NEURO RESPONSE [✓] Alert		✓				✓					✓					✓			✓				✓	
NEURO RESPONSE [✓] Voice																								
NEURO RESPONSE [✓] Pain																								
NEURO RESPONSE [✓] Unresponsive																								
URINE mls / hour > 30		✓				✓					✓					✓			✓				✓	
URINE mls / hour < 30																								
Proteinuria Protein + +																								
Proteinuria Protein > + +						✓																		
Lochia Normal		✓									✓					✓			✓				✓	
Lochia Heavy / Foul																								
Liquor Clear / Pink		✓				✓					✓					✓			✓				✓	
Liquor Green																								
TOTAL YELLOW SCORES		0				0					0				0			0					0	
TOTAL ORANGE SCORES		0				0					0				0			0					0	
Nurse Initial																								

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

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FLUID CHART

Sheet No. : 1

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
9/7/26	08:00 am										1	
	09:00 am	RL	N B M	RL								
	10:00 am	RL		100ml							6	
	11:00 am	RL		100ml								
	12:00 pm	RL		100ml						400ml 12:20pm		
	01:00 pm			100ml.								
Total Intake : 700ml						Total Output : Passed						
9/7/26	02:00 pm	RL		100ml								
	03:00 pm	RL	Sips	100ml						500ml		
	04:00 pm	RL		100ml								
	05:00 pm	RL		100ml								
	06:00 pm	RL		100ml								
	07:00 pm	RL		100ml						1000ml		
Total Intake :						Total Output :						
9/7/26	08:00 pm	RL		100ml								
	09:00 pm	RL		100ml								
	10:00 pm	RL	Soup	100ml								
	11:00 pm	RL	Soup	100ml								
	12:00 am	RL		100ml						700ml		
	01:00 am	RL		100ml								
Total Intake :						Total Output :						
10/7/26	02:00 am	RL		100ml						400ml		
	03:00 am	RL		100ml								
	04:00 am	RL		100ml								
	05:00 am	RL		100ml								
	06:00 am	RL		100ml						1000ml		
	07:00 am	RL		100ml								
Total Intake :						Total Output :						

Empty

Empty @ 1:50 Am

Empty

Total 24 hrs. Intake		Total 24 hrs. Output	

HNH-00016111 IP26-00006780
Mrs T VARSHA RUDRANI
27-08-1998 27 Y 10 M 13 D (F)
Dr. PADMAJA YELISETTY

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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							
8/7	08:00 am											
	09:00 am											
	10:00 am		Jelly + H2O									
	11:00 am				NA			NA				
	12:00 pm											
	01:00 pm											
Total Intake : Taken						**Total Output :**						
10/7	02:00 pm											
	03:00 pm											
	04:00 pm		Kichidi + H2O									
	05:00 pm	0			NA		0	NA			0	
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
10/7/26	08:00 pm											
	09:00 pm		Rice milk									
	10:00 pm	0									0	
	11:00 pm											
	12:00 am				NA			NA				
	01:00 am											
Total Intake : Taken						**Total Output :** U-2 M-						
11/7/26	02:00 am											
	03:00 am		H2O									
	04:00 am	0									0	
	05:00 am											
	06:00 am				NA			NA				
	07:00 am		Soup									
Total Intake : Taken.						**Total Output :** U-2-M-						

Total 24 hrs. Intake		Total 24 hrs. Output	

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	9/7/26	10/7	10/7
		Score	N1	M6	E2
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0	0	0	
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
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 (9/7)			DAY-2 (10/7)			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0	0	0	0	0	0				
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	—	NA	NA	NA	NA	NA				
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	—	NA	NA	NA	NA	NA				
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	—	NA	NA	NA	NA	NA				
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	—	NA	NA	NA	NA	NA				
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	—	NA	NA	NA	NA	NA				
			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

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

HNH-00016393 IP26-00006788
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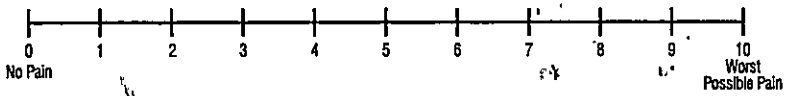
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
9/7/26	9pm	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
9/7	2pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
9/7	8pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
9/7	10pm	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	
10/7	2AM	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	
10/7	6AM	0/10	NA	☐ Continuous ☑ Intermittent	☑ Acute ☐ Chronic	☑ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	
10/7	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
10/7	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
10/7/26	10:pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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NURSING CARE RECORD

Date: 9/7/2026

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am – 2pm	→ Assess the pt condition → check the vital's → I/O chart Maintain → plan for NST → plan. Medication	8am – 2pm	→ Assessed pt condition → Checked vital's & record → Maintained I/O chart → NST done → given Medication as per doctor's order	pt is stable	vital's is normal	[signature]
Afternoon	2pm to 8pm	Assess the pt condition. Monitor vitals & record. Maintain I/O chart. Provide the comfortable position. Medication given as per as doctor.	2pm to 8pm	Assessed the pt cond. Monitored vitals & rec. Maintained I/O chart. Provided the comfortable position. Medication given as per as doctor.	→ Pt is stable. → vitals normal.	→ monitor vitals. → maintain I/O chart.	[signature]
Night	8pm – 8Am	- Assess the pt. condition - Monitor vitals & records - Maintain I/O chart. - Give medication as prescribed by doctor	8pm – 8Am	- Assessed the pt. condition - Monitored vitals & records - Maintained I/O chart - Given medications as prescribed by doctor	Patient is Stable now	Re-checked vitals	[signature]

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NURSING CARE RECORD

Date: 10/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	6AM to 2PM	→ Asses the pt condition → monitor vitals & record → Maintain I/o chart → Administer medication as per drug chart	6AM to 2PM	→ Assessed the pt condition → monitored Vitals & recorded → maintained I/o chart → Administered Meds as per drug chart	→ pt is stable	→ Recheked vital	
Afternoon	2pm 8pm	→monitor the vitals. →plan tegadarm dressing th. →maintain I/o chart. →drugs give as per drug chart.	2pm 8pm	→monitored the vitals. →planned tegadarm dressing th. →maintained I/o chart. →drugs given as per drug chart.	→pt is stable now.	→Reassessed the vitals.	
Night	8PM 8AM	→ Assess the patient general condition → monitor vitals → Administer medications as Per doctor's orders.	8PM 8AM	→ Assessed the patient general condition → monitored vitals → Administered medications as Per doctor's orders.	Patient is stable	Rechecked vitals	

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Mrs DR SUDHARANI BUSANI
15-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

BRADEN 'Q' SCALE

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				Date : Time :	9/7/26 N6	9/7 EL	9/7 N1	10/7 N6
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	3	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate 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	4
				TOTAL SCORE	25	27	28	[illegible]
				Evaluator's Name	[illegible]	[illegible]	[illegible]	[illegible]

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

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

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

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: ELSCS			Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area / Shift Time	9/7/26 M6	9/7/26 E2	9/7/26 N1	10/7 M	10/7 E2	10/7/26 N8
	Medical Condition (Any special condition to be noted):	NA	—	—	—	—	—
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.1°F	98.2°F	97.8°F	98.2	98.1°F	98.3°F
	Res:	20	20b/m	20b/m	20b/m	20b/m	20b/m
	SpO_2:	99%	99%	100%	99%	98%	99%
	Pulse:	96	82	86b/m	88b/m	79b/m	80b/m
	BP:	114/76	115/62	118/64	[illegible]	—	—
	Fall Risk Score:	—	—	—	—	—	—
	Pain Score:	—	—	—	—	paracetamol given	—
Recommendations	Safety Needs:	yes	—	—	—	yes	yes
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—	—	—	—	—	—
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	✓	—	—	—	—	—
Post Operative Procedure Special Orders:		—	—	—		—	—
Handed Over By Name :		Madhuri	Sri	Priyanka	Sunitha	Mahi	Sandhya
Signature :		[illegible]	9/10(603)	[illegible]	[illegible]	[illegible]	[illegible]
Date:		9/7/26	9/7	10/7/26	10/7	10/7/26	10/7/26
Time:		8AM	8PM	8AM	8P	8a	8a
Taken Over By Name :		Sri	Priyanka	Sunitha	Mahi	Sandhya	
Signature :		9/10(603)	[illegible]	[illegible]	[illegible]	[illegible]	
Date:		9/7	9/7/26	10/7	10/7	10/7/26	
Time:		2PM	8PM	8AM	2pm	8a	

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

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

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

HNH-00016393 IP26-00006788
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CROSS CONSULTATION FORM

Doctor Name : Dr. Santhoshi Date : 9/7/26 Time : 6pm

Diagnosis : LSCS

Hospital : RCH – HMNR

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

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

Signature:

Findings and Recommendations :

Lactation care plan

- well Breast & Nipples
- colostrum seen
- Aim for deep latch as demonstrated in side lying down position
- Demand feeding not exceeding 2½ hours as per early hunger cues.
- Advice Direct Breast feeding & f/b Burping
- warm care
- maintain baby output & weight

Consultant :

Name : Sathwika.G Signature : S Date & Time : 9/7/26 ; 6pm

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 9/7/26 Time: 6pm

Origin: Indian Height: 164 cms Weight: 72 kg BMI: ☐ ~ 26 kg/m² ☑ ~ 28 kg/m² ☐ ~ 30 kg/m²

Food Allergies: NO

Diagnosis: LSCS

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

Diet Advised:

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

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

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

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

Patient's / Attendant's

Signature: Rahul.V

Name: RAHUL VANARIA

Date & Time: 26:30 PM

Dietician's

Signature:

Name: Sathwika.

Date & Time:

DIETARY NOTES

Date	Time	Notes	Sign

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: Dr. Shalini Santoshi	Date of Delivery: 9/7/2026.
Assistant Surgeon: Dr Naveena	Time of Delivery: 11:15AM.
Anaesthetist's Name: Dr. Adithi	Gender of Baby: Female
Type of Anaesthesia: Spinal.	Weight of Baby: 3.22kg.
Neonatologist: Dr. Pranav.	AGPAR Score: 8,9
Scrub Nurse: Natasha.	NICU Admission: ☐ Yes ☐ No

Pre-Operative Diagnosis: G2A1. with 39+1 wks. with AMA. with h/o Rx Anem with GDM. on OHA. with unstable lie.

☑ Elective ☐ Emergency Indication: Unstable lie.

Urgency

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

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

CTG Description: Reactive.

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

Surgical Procedure: Elective LSCS

Post Operative Diagnosis: P1L1A1. on POD0 following El. LSCS. with GDM on OHA.

Peri-Operative Complications: -.

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 ..... Cervical Dilatation: — cm

5th Palpable: 5/5th Fetal Position: —

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

Caput: ☐ + ☐ ++ ☐ +++ no Meconium: ☑ None ☐ + ☐ ++ ☐ +++

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

Skin Incision: ☑ Pfannensteil ☐ Transverse ☐ Midline ☐ Other .....

Uterine Incision: ☑ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision

Previous Scar: ☐ Intact ☐ Thinnedout ☐ 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 Vicryl no. 1-0 ..... Suture

Peritoneal Closure: ☐ Pelvic ☑ Abdominal ☐ None Catgut no 1-0 ..... Suture

Sheath Closure: Yes Ethylon ..... Suture

Fat Closure: ☑ Yes ☑ No ..... Suture

Skin Closure: ☑ Subcuticular ☐ Mattress Monocryl 3-0 ..... Suture

Vagineal Evacuated ☑ Yes ☐ No

Drain: ☐ Yes ☑ No ☐ Remove in 24th days ☐ Await instructions

Ctheter ☑ Yes ☐ No ☐ Remove in 24hrs 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 6hrs
ivf and drugs as charted
w/f PV bleeding
GRBS 6th hrly
CBP T/M 6am
Inj: Clexane 60 U s/c x 3days
starts after 8hrs (9pm)
Urine I/O charting.

Doctor Name: Dr. Shalini Santoshi Doctor Signature: Shalini

Date & Time: 9/7/2026 @ 12:30pm

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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 9/9/26

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: ..... E.L LSCS

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr.

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: .....

.....

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☐ No ☐ Yes

Cervical Cerclage: ☐ No ☐ Yes

Ectopic Pregnancy: ☐ No ☐ Yes

Myomectomy: ☐ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☐ No ☐ Yes

Vaginal Discharge: ☐ No ☐ Yes

Post-Coital Bleeding: ☐ No ☐ Yes

Infertility: ☐ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G 2 P - L - A 1

Previous LSCS: .....

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

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 98.1°F HR: 76 RR: 20

BP: 120/80 mmHg 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 (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☑ No Score 0 (complete the Braden Q Sheet)

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

☐ Mobility problem ☐ Walking Problem ☐ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☐ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With .....

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: .....

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: .....

Date & Time: .....

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 9/7/2026 Time of Arrival: ..... 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: 98.1°F Pulse: 76 RR: 20 SpO_2: 98% BP: 120/80 Weight: .....

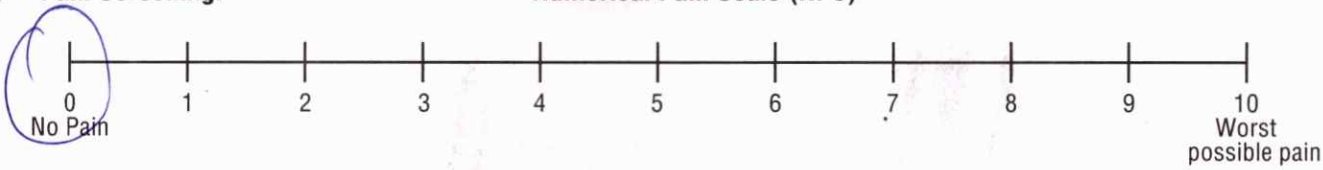
4) **Gestational Criteria:**

Gravida:	G	P	L	A

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

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

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



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

.....

6) **Past History:**

a) Surgeries: .....

b) Medical: .....

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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: 8:40AM

Nurse Name : kavhi Nurse Signature: .....

Date: 9/07/26 Time: 8:39AM

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BREAST FEEDING HANDOVER AND ASSESSMENT FORM

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

2. If No, Reason .....

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

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

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

Feeding Positions:
Cross Cradle

Feeding Positions:
Football / Clutch

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

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

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

9. Additional notes: Baby breast feed 2-3rd hourly

Continuity of Care: Date: 9/7/26

Handover given by .....

Signature .....

Date & Time: .....

Handover taken by .....

Signature .....

Date & Time: .....

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 9/7/26 Date of Removal: .....

Parameters	Date / Shift Time	9/7 8 hrs						
Need for the Catheter		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever		☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion		☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse		Kavitha						
Signature of the Nurse		b						

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18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

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BILLING POLICY

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

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

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

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

MODE OF PAYMENT & REFUNDS

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

RAHUL VANAPIA

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

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

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

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

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

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

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs DR SUDHARANI BUSANI**	**Age :**	**41 Y 10 M 21 D**
IP No:	**IP26-00006788**	**Sex:**	**Female**
Consultant:	**Dr. THULABANDULA SANTHOSHI SHALINI**	**Ward/Bed No:**	**4F -OT/PDA-412**

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

Patient, be deemed advisable or necessary.

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

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

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

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

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....) Rahul.o

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative: Rahul.o

Name: RAHUL VANAMA

Relationship: HUSBAND

Date: 9/7/26 Time:

Witness Name:

Witness Signature:

Patient Address:

FLAT NO:110,ARK APTHA APARTMENTS ,SHIVA SAI NAGAR COLONY,KARMANGHAT Meerpet Hyderabad Telangana INDIA 500097

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs. Sudha Rani Gender: ☐ Male ☑ Female Age : 41yrs

UHID No : Date : 9/2/26

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

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

ELECTIVE LOWER SEGMENT CAESAREAN SECTION

upon

MRS. SUDHA RANI (Name of the Patient)

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

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

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

Excessive bleeding, need for transfusion of blood or blood products, inadvertant injury to bowel, bladder or ureter, wound infection

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr. Shalini Santhoshi

Consentee :
Signature : B Sudha Rani
Name : Mrs. Sudha Rani
Date & Time : 9/2/26 @ 9:30am

Patient Attendant :
Signature : Rahul
Name : RATHA VAMSHI
Relationship with Patient: HUSBAND
Date & Time : 9/2/26 @ 9:30 AM

Witness :
Signature :
Name : MOUNIKA
Date & Time : 9/2/26 @

Doctor (who is taking the consent) :
Signature :
Name : Dr. G. Veena
Date & Time : 9/2/26 @ 9:30am

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. SUDHA RANI Age : 41 Gender : Male ☐ Female ☑

UHID NO: HNH-16393 Surgeon Name: Dr. SANTHOSHI

Anaesthesiologist : Dr. Ayesha

Operative procedure planned : ELECTIVE LOWER SEGMENT CESAREAN SECTION

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics arid narcotic drugs to particular parts of the body after surgery or injury, using catheters.

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

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

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☑ Others : Hypotension, Bleeding

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mrs. SUDHA RANI the above mentioned operation / Diagnostic / Therapeutic procedures ELECTIVE LOWER SEGMENT CESAREAN SECTION

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

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

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

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

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

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

- Pregnant : ☑ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : B Sudha Rani

Name : SUDHA RANI BUDAÑI

Relationship with Patient: .....

Date & Time : 09/7/26 10:20 AM

Witness :

Signature : Rahul. J

Name : RAHUL VANATIA

Date & Time : 09/7/26 10:20 AM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Sk Ayesha

Date & Time : 09/7/26, 8:20Am

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUA

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

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Name: Mrs. Sudha Ra. Age: 41 Sex: Female UHID.No : HNH-16393

Date: 6/7 Time: 4pm Proposed Operation: LSCS

Diagnosis: G2A1 @ TG.

B.P / CRT: ..... H.R: ..... Weight: 72 ASA Physical Status: ☐1 ☑2 ☐3 ☐4 ☐5

Laboratory Data:

4/7

Hgb: 12.0	Glucose:	Protein:	HIV:	X-Ray:
PCV: 36.5	Urea:	Alb:	HBS Ag: NR	ECG: EF 62%
WBC: 5990	Creat:	Total Bill:	HCV:	2D Echo: AML malapu
Plate: 1.69	Na:	Dir. Bill:	Blood group: O pos	Stress/Anglo: mild MR
PT:	K:	LDH:	T3	Other: NORMAL, GIDD. placenta - post AFI-13
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH 1.9	
	Cl -:	SGOT/SGPT:		

Allergies: NKDA.

Medical History: CVS : /

RESP : No significant med history Diabetes : GDM. : 3 mo.

CNS : patient fit & healthy

Renal :

Hepatic / GE : Regular ANCs - largely uneventful. Physical Activity: active, NYHA-I.

Others :

Past Anaesthetic History: Cap. myomectomy + GA 2022 / OR + TIVA x 2

Physical Exam: coherent.

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

Lungs : /

Heart: /

CNS:

Pregnant: ☐ Yes ☐ No ☐ NA Venous Access Site: Peripheral Spine Exam for regional : midline.

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

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

12 AM ← 9 AM

CURRENT MEDICATIONS	DOSAGE
GLYCOMET 500mg	x — x — 1
DUVADILAN 5mg	1 — x — 1
Fe/Ca/D3.	
ECOSPRIN 75mg	(stopped 1wk back)

Pre-Operative Instructions:

7AM - WATER

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:
   - HOLD DUVADILAN ON DAY SX.
   -

Signature: Name: Dr. Sanni Prayath.

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

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI (F)
18-08-1984 41 Y 10 M 21 D
Dr. THULABANDULA SANTHOSHI

ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R.: 111/min | B.P / CRT: 111/81 | SpO_2: 98 | R.R.: 13 | Last Feed: 8 hrs

Pre-OP Diagnosis: G2A1 + PCS | Operation: Elective Caesarean section | Date: 9/7/21

Surgeon: Dr Santhoshi | Anaesthesiologist: Dr Adithi | Technician: Pallavi

TIME	10.48
N_2O /AIR /O_2 LPM	
HALO /SO /SEVO	
Drugs:	INJ MEPHENTERMINE 6mg +6mg
	INJ OXYTOCIN 3U+3U+3U+3U+3U+5U slow infusion
	INJ TRANEXAMIC ACID 1gm IV
FIO_2 / SaO_2	100 100 100 100
$ETCO_2$	
ECG	SR SR SR SR SR
Temperature	
Urine Output	
Fluids	RL — RL(B) — RL(B) —
Blood	IVF

Antibiotic: –

Suppository: RAMADOL 100mg; Diclofenac 75mg

Blood Loss: 500ml

NOTES

B.P: V Systolic, Λ Diastolic, X Mean, • Heart Rate

Tourniquet on Time / Tourniquet off Time / Throat Pack In / Throat Pack Out

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

LAB Values: ABG / GRBS / Others

Monitoring:
- ☑ Equipment Checked and Functional
- ☑ BP
- ☑ Cuff Site: RUL
- ☐ Art Site: ...
- ☑ EKG Lead 3 lead
- ☐ Temp Site
- ☐ FIO_2 Monitor
- ☐ Agent Monitor
- ☑ Pulse Oximeter
- ☐ Capnograph
- ☐ Ventilator
- ☐ Nerve Stimulator

Position: Supine
- ☐ Pressure Points Checked

Eye Care:
- ☐ Oint
- ☐ Tape
- ☐ Padding
- ☐ Awake

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

Times:
- Anaes Start: 10.50
- OP Start: 10.55
- OP End: 12.06
- Leave OR: 12.15

Anaesthesia:
- ☐ GA
- ☐ Monitored Anaesthesia Care
- ☑ Regional

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

Induction
- ☐ IV ☐ Inhal
- ☐ Pre O_2 ☐ RSI
- ☐ Others
- ☐ Mask ☐ SGA
- ☐ Airway ☐ Oral ☐ Nasal
- ETT# ... at ... cm
- ☐ Oral ☐ Nasal ☐ Cuff
- ☐ Tracheostomy ☐ Topical
- ☐ Drug: ...
- ☐ Awake ☐ Direct Vision
- ☐ Video Laryngoscopy ☐ Stylette / Bougie
- ☐ Fiberoptic
- Blade# ... Attempts: ...
- Difficulty Why? ...
- ☐ Bilat = BS
- ☐ Semi-Closed Circle
- ☐ Closed Circle
- ☐ Other

Regional:
- Extremity Specify: ...
- ☑ Spinal ☐ Epidural ☐ Caudal
- Others: ...
- Position: Sitting
- **Site:** L3-L4
- Needle Size: 25G QB Depth: ...
- Parasthesia ☐ Yes ☑ No
- Catheter at skin ... cm
- Drug Name & Conc: 0.5%
- Bolus: Bupivacaine
- Infusion: 1.2cc
- Block Level: + 25 mcg fentanyl
- Comments: ...
- Transportation to: ☑ PACU ☐ ICU ☐ Other
- Relaxant Reversed ☑ Yes ☐ No ☐ NA
- Name of the Doctor: Dr Adithi
- Signature of the Doctor: [signature]

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULASANDULA SANTHOSHI

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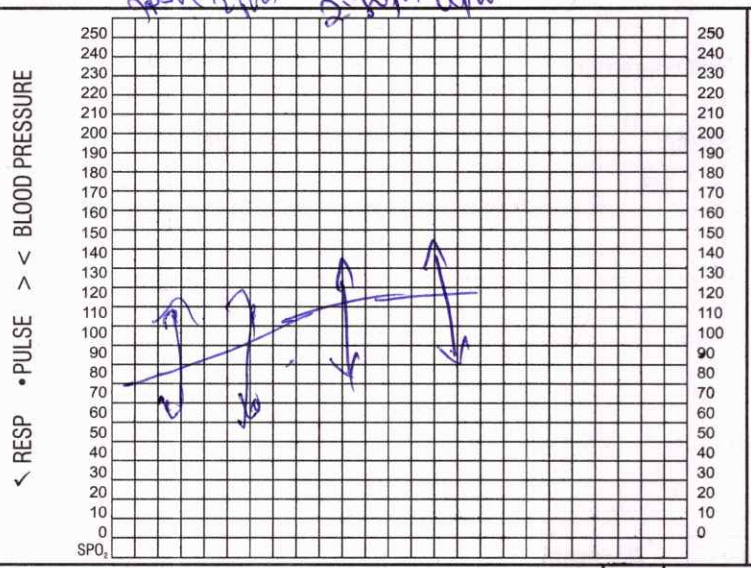
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sis. Akshaya. Time Received : 12:20 PM Time Discharged : 3PM



IV Cannula Site : left side.

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

Vomiting : ☐ Yes ☑ No Drug: Inj. Zofer 4mg

NG Tube : ☐ Yes ☑ No

Drain: ☐ Yes ☑ No

Urinary Catheter: ☑ Yes ☐ No

Chest Tube: ☐ Yes ☑ No

Nil Oral ☐ Yes ☑ No

IV Fluids: RL

Oral Feeds: NBM.

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

SCORING INTERPRETATION

A Minimum Total Score of 8 is Required for Discharge

Exceptions to this, are to be explained in the space below by the Discharging Physician:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
9/2/26	1pm	0/10	Patient comfortable	
9/2	2pm	0/10	NA	
9/2	3pm	0/10	NA	
9/2/26	3:30pm	0/10	NA	

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

Reassessment Frequency:

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

Anaesthesiologist Name : Dr. Jyothsna

Anaesthesiologist Signature:

Date & Time: 9/2/26.

PACU Nurse Name : Kavya

PACU Nurse Signature:

Date & Time: 9/2/26 @ 12:20 pm

Transferred to Unit by (PACU): 215

Date & Time: 9/2/26

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

CSE /Spinal /Epidural Position : ..... Space :..... Technique (LOR/LOS) .....

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016393 IP26-00006788 Mrs DR SUDHARANI BUSANI 18-08-1984 41 Y 10 M 21 D (F) Dr. THULABANDULA SANTHOSHI	9/7/2026 @ 8:44 AM	9/7/26 @ 9:15 AM
	Transfer Ordered by Dr.	Reason for Transfer FL Lscs
From Unit pre & post	To Unit OT	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 3	Number of Imaging Films NST	Personal belongings including clinical documents. If any handed over to attendant Yes ☑ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Dr. Ayshu	Pooja

Patient & Clinical Records Received by : 12:15 pm 9/7/26

Date & Time of Patient Received :

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

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Santhoshi
Asst. Surgeon : .....
Anaesthetist : Dr. Ayesha Dr Adithi
Scrub Nurse : Sr. Natasha

HNH-00016393 IP26-00006788
Mrs DR SUDHARANI BUSANI
18-08-1984 41 Y 10 M 21 D (F)
Dr. THULABANDULA SANTHOSHI

..... Age : 41 Yrs.. Gender : F.....
y Name : EL LSCS
Date : 9/1/26..... In-time : ..... Out-time : .....

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Before Induction of Anaesthesia ➤ ➤

SIGN IN Time: 10.46

Patient Has Confirmed
- Identity ☑ Yes ☐ No
- Site ☑ Yes ☐ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☐ Yes ☑ No

Does Patient have a:
- Known Allergy? ☐ Yes ☑ No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☑ Yes ☐ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☑ Yes ☐ No ☐ NA
- Blood Units Reserved ☑ Yes ☐ No ☐ NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑ Yes ☐ No ☐ NA

Signature : Ayesha
Name : Dr. Ayesha

Before Skin Incision ➤ ➤

TIME OUT Time: 11:00 AM

Confirm all team members have introduced themselves by Name and Role ☑ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? S band 45 minutes 250 ml ☐ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☐ Yes ☐ No ☐ NA

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☐ Yes ☐ No ☐ NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☐ Yes ☐ No

Signature : Kavuru.
Name : Sr. Natasha Kavuru @ 11:00 AM

Before Patient Leaves Operating Room

SIGN OUT Time: 12:15 pm

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑ Yes ☐ No ☐ NA
- The Specimen is Labelled (including patient name) ☑ Yes ☐ No ☐ NA
- Whether there are any Equipment Problems to be addressed ☐ Yes ☑ No ☐ NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☑ Yes ☐ No

Signature : Shalini T.
Name : Dr. Shalini Santoshi

PATIENT TRANSFER FORM

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Patient Name & UHID No	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016393 IP26-00006788 Mrs DR SUDHARANI BUSANI 18-08-1984 41 Y 10 M 21 D (F) Dr. THULABANDULA SANTHOSHI Dr. Santhoshi	9/7/26	9/7/26 @ 12:15 pm.
	Transfer Ordered by Dr. Ayesha	Reason for Transfer Observation
From Unit OT	To Unit Pre - Post	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 30	Number of Imaging Films –	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sr. Natasha	Dr. Ayesha
Patient & Clinical Records Received by :	Kadri 9/7/26
Date & Time of Patient Received :	

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

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

#26-00002120 08

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	Mrs. DR Sudharani Busani	Age:	41 Yrs	Gender:	Female
UHID No:	HNH-00016393	IP No: 26-00006788	Date: 9/7/26	Time:	9:19 AM
Diagnosis:	LSCS				

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr Sk. AYESHA

Doctor Registration No: TSMC/FEMP/07725

Signature:

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

IP Registration No: 26-00006788 **Date:** 9/7/26

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

1.	**Name :** Mrs. DR. Sudharani Busani	**Remarks**
2.	Complete postal address (with contact number, if any) Shiva Sai nagar colony Ramanguda	
3.	Brief description of the illness	LSCS
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
9/7/26	Fentanyl	01		

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

Received by (Name & ID No.): U. Pallavi 017921 Signature: .....

Time: 9:34

Docu. No: RCH / FRM / CLINICAL / 133

#26-CCCO212008

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Mrs. DR Sudharani Busani	Age: 41 Yrs	Gender: Female	
UHID No: HNH-0016393	IP No: 26-00006788	Date: 9/7/26	Time: 9:19 AM
Diagnosis: LSCS			

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr. SK. NAGESH

Doctor Registration No: TSMC/FMR/07725

Signature:

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

IP Registration No: 26-00006788 **Date:** 9/7/26

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

1.	**Name :** Mrs. DR. Sudharani Busani	**Remarks**
2.	Complete postal address (with contact number, if any) Shiva Sai	nagar colony Kasmanglat
3.	Brief description of the illness	LSCS
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
9/7/26	Fentanyl	01		

Dispensed by (Name & ID No.): Sania (01744) Signature: .....

Received by (Name & ID No.): U. Pallavi 01792 Signature: .....

Time: 9:34