BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

Rainbow® Children's Hospital
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SURGERY DETAILS

Date : 19/07/26

Patient Name: Mrs. Vaishnavi Rani Date of Birth: 27/1/1999 Age: 27y/F

Gender: F Ward : OT UHID No.: BAH-00639455

Date of Surgery: 19/7/26 ☐ OT -1 ☑ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Emergency LSCS.

Time in : 9pm Time Out : 10pm

		NAME	AMOUNT
1.	Surgeon	Dr. Swathi H.V	
2.	Anaesthetist	Dr. Sai Raj	
3.	Assistant Surgeon	Dr. Naveena	
4.	OT Technician	Arvind	
5.	Circulating Nurse	Sujatha	
6.	Assistant Nurse	Sandhya	

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

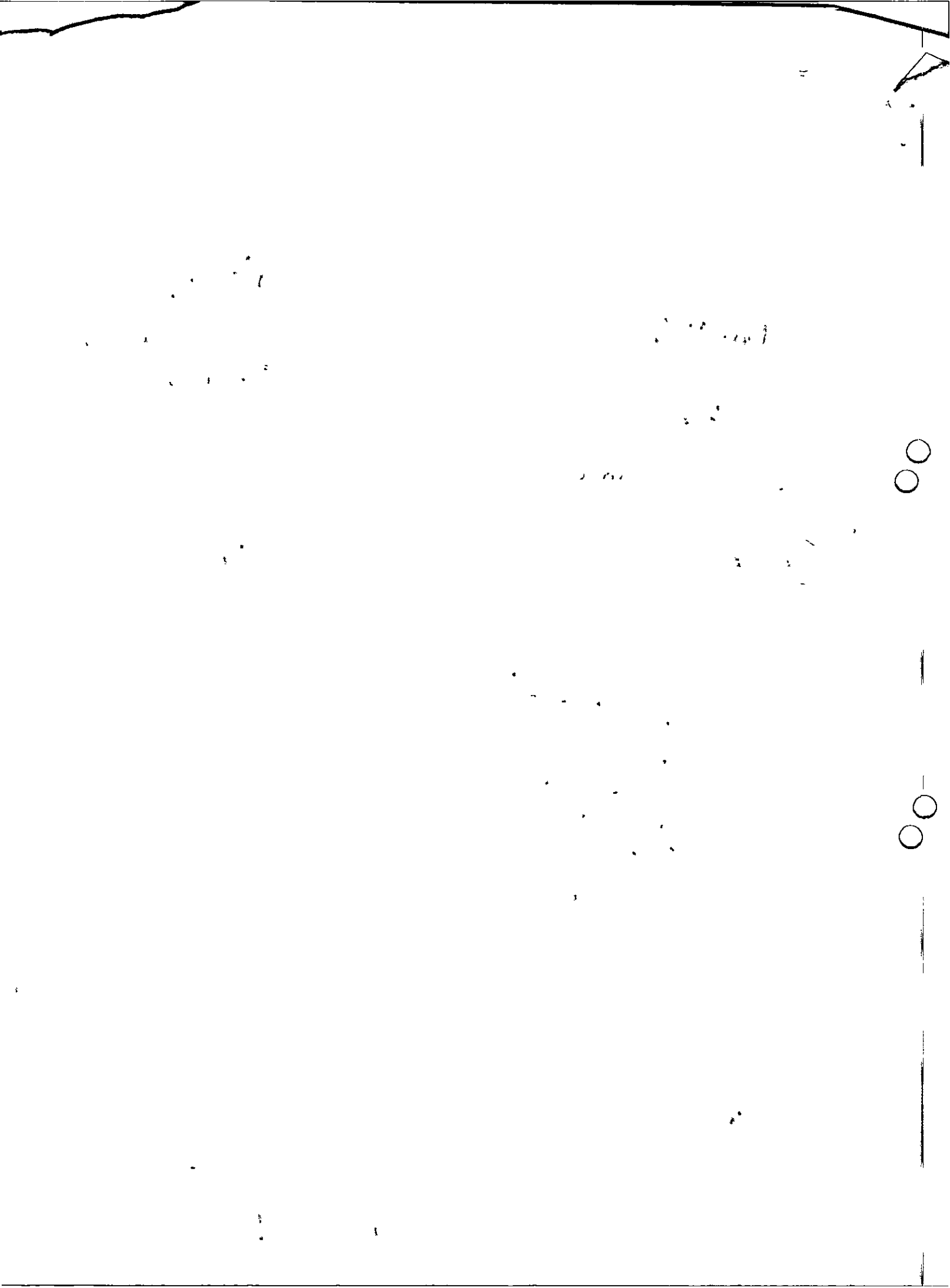
Signature of the Surgeon

Signature of Circulating Nurse

Order No: 26-000021521?

Order by: Sandhya 19/7/26 @ 11:30pm
(Or record saved)

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



BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

Am. LSCS

CONSUMABLES OF OT

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Circulating staff : Sujatha Technician : Anvi Date : 19/7/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack LSCS		01	Inj Vit.K	01+1	
LMA			Sutures 2346, 2364	2+1		Cord Clamp	01	
ECG leads : A / P / N			1242, 1326	1+1		Suction Catheter		
HME filter : A / P / N						Feeding Tube 6	01	
Syringes : 10 cc		05				Vaccum Suction Set	0	
05 cc		04	Gloves S.G 6½, 6	1+1		Surgical Gloves 6½,	2+1	
02 cc		03	Gauze 6½	01		Gauze Pack xray	01	
01 cc		01				Syringe 1ml / 2ml	01	
Cautery plate : A / P / N		01	Surgical blade 22	01		Surgical Blade # 20	01	
IV set		1	NG tube			Koochies (S)		
RL		02	Cautery pencil	01				
NS : 10ml / 100ml / 500ml / 1000ml			Koochies			26-00002152224		
Oxytocin		03	Ointments					
			Suction Catheter					
Fentanyl		01	Cap, Mask	10+10				
Morphine			Gauze Pack 10x10cm 2ply	1+1				
Ketamine			Mop Pack		2			
Propofol			Steristrip					
Rocuronium			Underpad		2			
Glycopyrolate		01	Draw sheet					
Myopyrolate			Abgel		01			
Ondansetron			Foleys catheter					
25G Pencan 25g/ Spinal Needle 22		01	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Anvi Bupivacaine 0.25%(Heavy)		01	Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / 100mg		01	Plastic Bed Sheet Aprons		03			
Tab. Misoprost : 200mg		01/2	Betadine Solution		2			
Encore 7.5		01	Microshield		1			
Gauze 7.5 x 7.5		01	Cotton Balls		1			
Jax 2Y.		01	Latex Gloves		20			
~~3 MEAS~~		~~01~~	Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-00002152222/5221 Ordered by : Sandhya 19/7/26 @ 12pm

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

Rainbow Childrens Hospital-Himayatnagar

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: BAH-00639455	**Name**	: Mrs GOGIKAR VAISHNAVI RANI
Age / Sex	: 27 Y 5 M 23 D / Female	**Doctor**	SWATHI H V
Adm/Reg Date/Time	: 19/07/2026 12:38	**Payor**	: VOLO HEALTH INSURANCE TPA PVT LTD
Order Date	: 19/07/2026 23:18	**Ordernumber**	: 26-0000215222
Visit ID	: IP26-00006883	**Ward/Bed No**	: 4F -OT / PDA-412
Patient Address	: Kothagudem, Kothagudem, Bhadradri Kothagudem, Telangana, INDIA, 507101		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	DISPOSABLE APRONS STERILE XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
2	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
3	ANAWIN HEAVY 5 MG INJ 4 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
4	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Dispensed
5	VICRYL 1-0 VP 2346	VICRYL 1-0 VP 2346	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
6	MONOCRYL 3-0 NW 1326	MONOCRYL 1326	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
7	ENCORE MICROPTIC GLOVES-7.5 PF		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
8	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
10	THEMIPYRRNOM 0.2MG INJ		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
11	ABGEL SURGI PAD (BIG) (GELSPON)	ABGEL	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
12	SGLOVE # 6 (SURGICARE)	SURGICAL GLOVES 6.0	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
13	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
14	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
15	VICRYL 1-0 NW 2364	VICRYL 1-0 NW 2364	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
16	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
17	PENCAN 25G*3 1 2	PENCAN 25G*3 1 2	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
18	Encore Microptic gloves-8.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
19	TRUGUT CHROMIC CATGUT SN4242	TRUGUT CHROMIC CATGUT SN4242	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
20	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY		1 Pkt	External / Once Daily	1 Days		1 Pkt	Dispensed
21	LSCS DRAPE PACK (PROTECTCARE)		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
22	MISOPROST TAB 200MCG 4S		1 Tabs	External / Once Daily	1 Days		6 Tabs	Dispensed
23	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
24	CAUTERY PENCIL (ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
25	GAUZE PACK STERILE 10X10X12 PLY 5S	GAUZE PACK STERILE 10X10X12 PLY 5 PACK	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
26	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
27	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
28	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
29	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
30	EVATOCIN (OXYTOCIN) INJ 5 IU 1 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
31	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
32	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
33	THEMICAINE 2% 30ML INJ		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
34	DSYRINGE 5ML (NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed

SWATHI H V
OBSTETRICS AND GYNECOLOGY
Reg No : TSMC/FMR/15501

* 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.**

Rainbow Childrens Hospital-Himayatnagar

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00016688	**Name**	: Baby Of GOGIKAR VAISHNAVI RANI
Age / Sex	: 0 Y 0 M 0 D 10 H / Male	**Doctor**	: SPANDANA PASUPULETI
Adm/Reg Date/Time	: 19/07/2026 22:24	**Payor**	: SELFPAY
Order Date	: 19/07/2026 23:21	**Ordernumber**	: 26-0000215224
Visit ID	: IP26-00006886	**Ward/Bed No**	: 4F -OT / CRDL-HNPDA-412-1
Patient Address	: Kothagudem, Kothagudem, Bhadradri Kothagudem, Telangana, INDIA, 507101		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	INJEK INJ 1 MG 0.5 ML		1 Nos	/ Once Daily	2 Days		2 Vial	Dispensed
2	SURGICAL BLADE 20	SURGICAL BLADE 20	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
3	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
4	INFANT FEEDING TUBE-6	INFANT FEEDING TUBE 6	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY		1 Pkt	External / Once Daily	1 Days		1 Pkt	Dispensed
6	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
7	CORD CLAMP-ALPHAMEDICARE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed

SPANDANA PASUPULETI

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: BAH-00639455	**Name**	: Mrs GOGIKAR VAISHNAVI RANI
Age / Sex	: 27 Y 5 M 23 D / Female	**Doctor**	: SWATHI H V
Adm/Reg Date/Time	: 19/07/2026 12:38	**Payor**	: VOLO HEALTH INSURANCE TPA PVT LTD
Order Date	: 19/07/2026 23:18	**Ordernumber**	: 26-0000215221
Visit ID	: IP26-00006883	**Ward/Bed No**	: 4F -OT / PDA-412
Patient Address	: Kothagudem, Kothagudem, Bhadradri Kothagudem, Telangana, INDIA, 507101		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
2	SURGEONS CAP	SURGEONS CAP	1 Cap	Oral / Once Daily	1 Days		10 Cap	Dispensed
3	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		20 Nos	Dispensed

SWATHI H V
OBSTETRICS AND GYNECOLOGY
Reg No : TSMC/FMR/15501

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Note

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

*** Do not refill medicines.**

302-M
FC

Name	Mrs GOGIKAR VAISHNAVI RANI	**UHID**	BAH-00639455
Father/Guardian	Mr VITAL	**Age/Gender**	27 Y 5 M 24 D/ Female
Address	Kothagudem, Kothagudem, Bhadradri Kothagudem, Telangana, INDIA, 507101		
IP No	IP26-00006883	**Admission Date**	19-07-2026
Ref Doctor	Self		
Discharge Date	22.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. Swathi H V
MBBS/MS
TSMC/FMR/15501

Diagnosis: PRIMIGRAVIDA WITH 37^{+6} WEEKS PERIOD OF GESTATION WITH SPONTANEOUS RUPTURE OF MEMBRANES IN EARLY LABOUR

EMERGENCY LOWER SEGMENT CAESAREAN SECTION DONE ON 19.07.2026.

History:
LMP: 30.10.2025 Obstetric formula: Primigravida
EDD: 03.08.2026 Gestation at admission: 37^{+6}weeks

Obstetric History:
G1 - Present pregnancy Spontaneous conception.

Name	Mrs GOGIKAR VAISHNAVI RANI	**UHID**	BAH-00639455
IP No	IP26-00006883	**Admission Date**	19-07-2026

Medical History : Nil.
Surgical History: 2024 - Anal Fissure surgery; Feb. 2025 - Left breast Abscess surgery. **Family History :** Father - CAD.
Allergies : Tramadol.

Antenatal Details:
Mrs GOGIKAR VAISHNAVI was booked to Rainbow hospital at 32^{+5}weeks period of gestation. She had regular antenatal checkups and investigations as advised elsewhere. NT scan normal, FTS low risk, TIFFA was normal. Betnasol covered at 36^{+3} weeks back for fetal lung maturation in view of threatened preterm. Fetal growth monitoring was done by serial growth scans. Scan done on 10.07.2026 showed SLIUF at 36^{+4} weeks, Cephalic presentation, EFW 2.525 kg, Placenta :Anterior high, Liquor Adequate, AFI - 18.7cms, Dopplers normal. She was admitted at 37^{+6} weeks with Spontaneous Rupture of membranes for delivery

Investigations: Enclosed.
Blood group: "O" Positive

Management: Course in hospital:
At admission on clinical examination the vitals were stable. On admission vitals stable, uterus was relaxed, OS 2-3 cm, effaced membranes absent, liqour clear draining vertex -2, adequate pelvis. Fetal well being was confirmed by an admission CTG which was found to be reactive. As per hospital protocol she was started on IV. Taxim in view of ruptured membranes. Informed consent for vaginal birth taken. Further augmentation was done by oxytocin infusion. She was decided for emergency C- section in view of non progress of labour. She

Name	Mrs GOGIKAR VAISHNAVI RANI	**UHID**	BAH-00639455
IP No	IP26-00006883	**Admission Date**	19-07-2026

was prepared with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anaesthetic premedication (IV Pantop and Perinorm) given. Patient shifted to theatre.

Surgery Notes:

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

* **Cord around the neck.**
* **Omental adhesions to posterior uterine wall.**
* **Right para ovarian cyst of 3x4cms noted and punctured- serous fluid drained out.**

Delivery Details:

Date : 19.07.2026
Time of Delivery: 09:09pm
Type of Delivery: Emergency lower segment caesarean section
Indication : NPOL

Name	Mrs GOGIKAR VAISHNAVI RANI	UHID	BAH-00639455
IP No	IP26-00006883	Admission Date	19-07-2026

Anaesthesia : Spinal

Baby Details:
Date : 19.07.2026
Time : 9:09 PM
Sex : Male
Weight : 2.6kgs.
Apgar : 8,9
Gestational Age: 37^{+6} 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. Lactation counselling was done. 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 26.07.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 24.07.2026(8am-2pm-10pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 24.07.2026 (9am-3pm-11pm) after food.

Name	Mrs GOGIKAR VAISHNAVI RANI	**UHID**	BAH-00639455
IP No	IP26-00006883	**Admission Date**	19-07-2026

4. Tab. Pantop 40mg twice daily till 26.07.2026 (7am-7pm) before food.
5. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500 mg, Vitamin D3 250 IU) once daily (2pm) till breast feeding for after food.

Home Blood pressure monitoring to be done **twice daily** for **two weeks**. Report to emergency if **BP >140/90**mmHg, 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. SWATHI H V,** after **1 week** on **29.07.2026**. at Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

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

Name	Mrs GOGIKAR VAISHNAVI RANI	**UHID**	BAH-00639455
IP No	IP26-00006883	**Admission Date**	19-07-2026

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 Himayatnagar just dial one toll free number - 18002122. You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

Registrar/Resident/C.M.O

Consultant
Dr. Swathi H V
MBBS/MS
TSMC/FMR/15501

BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 24 D (F)
Dr. SWATHI H V

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	4			
7	Nursing plan of care and handover sheets	3			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation	1			
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)	3			
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation	1			
24	Emergency Triage record	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
28	Nurses clinical Presentation				
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart				
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale	2			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Extras	6			
	Total No. of Pages	38			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : 22/07/26

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

PATIENT TRANSFER FORM

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

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
BAH-00639455 IP26-00006883 Mrs GOGIKAR VAISHNAVI RANI 27-01-1999 27 Y 5 M 23 D (F) Dr. SWATHI H V	19/7/26 @ 12:38pm	20/7/26 @
	Transfer Ordered by DR. pareena.	Reason for Transfer observation
From Unit Pre-post	To Unit Room	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 30	Number of Imaging Films -3-	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 - 500ml	(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
Sis. Sujatha	DR. pareena

Patient & Clinical Records Received by : Divya
20/7/26 @ 3:10AM

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

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006883 **Admit Date** : 19-Jul-2026 **Admit Time** : 12:38 PM **UHID** : BAH-00639455

Patient Details :

Patient Name	: Mrs GOGIKAR VAISHNAVI RANI	**Age**	: 27 Y 5 M 22 D
Guardian	: Mr VITAL	**DOB**	: 27-01-1999
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	: Married
Address (H)	: Kothagudem Kothagudem Bhadradri Kothagudem Telangana INDIA 507101	**Phone No**	: 9959004221
		E-mail	: NO@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 VITAL **Relationship** : W/O

Contact Address : Kothagudem Kothagudem Bhadradri Kothagudem Telangana INDIA 507101 **Phone No** : 9959004221

Signature

Doctor Details :

Doctor Name : Dr. SWATHI H V **Specialisation** : OBSTETRICS AND GYNECOLOGY

Referral Doctor : Self **Phone No** :

Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 50000.00

Payor Name : VOLO HEALTH INSURANCE TPA PVT LTD

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ACTIVITY RECORD FOR BILLING

Name: ---------- BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
UHID No : ---------- Dr. SWATHI H V onsultant : ---------- Dept : ----------

Date of Admission : - ----- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
19/7/26	8:30PM	Pre-post	OT	Sujatha / Sandhya
19/7/26	10PM	OT	Pre-post	Sandhya / Sujatha
20/7/26	8:10AM	Pre & Post	Floor (302)	Sujatha / Divya

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. S. TEJASWI (Sathwika)	20/7/26	5412	Supriya
2.		Cross checked by Mayuri @ 10AM.		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
19/7/26	NST - (1)	8777 ✓	
19/7/26	NST - (2)	8778 ✓	
19/7/26	NST - (3)	8782 ✓	

cross checked by sujatha 20/7/26 @

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
19/7/26	Infusion pump	2:30pm	20/7/26 3AM	215180	[illegible]
19/7/26	cardiac monitor	10pm	20/7/26 3AM	215252	Sujatha

Crosschecked done by Sujatha 20/7/26

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
19/7/26	IV placement	1	15179	Alei
19/7/26	catheterization		15255	
19/7/26	PAC (IP)		15254	Suiatha
			Cross corrected done to suiatha 20/7/26	
20/7/26	NHA	1	5397	
	cross checked by Mamtesh @ 10AM			

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
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Allergic to Tramadol Ij

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints
c/o PV leak :- 1hr

LMP: 30/10/2025. EDD: 6/8/2026.
Corrected EDD: 3/8/2026 GA: 37w 6days

Obstetric Formula: Primigravida ML:- 2.5yrs, NCM.

Menstrual History: Regular : ☑ Yes ☐ No

Obstetric Hostory:
1st: PP, Spontaneous Conception

Obstetric Examination

Fundal Height: Term

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

Present Pregnancy Record:
NT-(N), eFTS - lowrisk.
TIFFA → (N)

Liquor: ☑ Adequate ☐ Oligo ☐ Poly

PP: ☑ Cephalic ☐ Breech Others ______

Head Fifths Palpable: 4/5th

RISK FACTORS:
steroid Coverage done @ 36+3 wks. (2doses)

FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination ~~not done~~

Draining: ☑ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☑ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination n

Cervix: ☐ Long ☐ Partially effaced ☑ Effaced

Os: Closed ______ Dilated 2-3cms

Height: 160 cm
Weight: 76.1 kg
Allergies: Ij ~~...~~ Tramadol.

Membranes: ☐ Present ☑ Absent

Breast: ☑ Normal ☐ Abnormal

Liquor: ☑ Clear ☐ Meconium ☐ Blood Stained

General Examination:

Consciousness: C/C. Pallor: -ve.

Presenting Part: ☑ Vertex ☐ Breech ☐ Others

Icterus: -ve. Edema: -ve

Sutton: ☐ -3 ☑ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Temp: Afebrile PR:

Pelvis: ☑ Adequate ☐ Doubtful

BP: DTR: (N)

CVS: S_1S_2(+) nomurmue RS B/L NVBS(+)

Liver/Spleen (N) Urine Output: Adequate

DIAGNOSIS
Primigravida with 37w 6days POG with PROM in latent labour.

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

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Family History:	Surgical History:
Father - CAD.	Anal Fissure S in 2024 left breast Abscess S in feb 2025
Medical History:	**Medication History:**
—	T. IRON T. CALCIUM.
Plan of Care:	**Investigations:** BGT O Positive
Admission NST Informed Consent Parts Preparation strict FHR monitoring. NST - 3hrly. w/f PGL / PVbleeding Inj. Oxytocin infusion @8ml/hr Monitor Vitals Inform SOS	CBP (16/7/26) Hb - 10.7. TLC - 14.81 PCV - 31.5 ~~VDRL~~ plt - 4.41. HIV, HbsAg, VDRL, HCV } NR. USG (10/7/2026). SLIUF, Cephalic. placenta - Anterior high. AFI - 18.7cms. EFW - 2.5kgs (15%) AC (2%). Dopplers - normal.

Doctor Name: Dr. Naveena.
Signature: [signature]
Date & Time: 19/7/2026 @ 2:00pm

Consultant Name: Dr. Swathi HV.
Signature:
Date & Time: 19/7/2026 @ 2:00pm

Dr. Swathi H V Consultant Obstetrician & Gynecologist Reg No: 15501

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/07/2026 6:00pm	c/s/by Dr. Swathi	
	O/E GC - fair	Adv
	Afebrile	- ~~NBM~~ liquid diet
	SpO_2 - 99% on RA	- Epidural option given
	PR: 99 bpm	
	BP: 115/66 mmHg	- w/f PGL / PV bleeding.
	CVS/RS: NAD	
	PA: ut - term size	- strict FHR monitoring
	3-4 c/~~10~~ 40-45"/10'	- NST 3hrly.
	Cephalic.	- Inj. Protim iv stat
	FHR(+)	- Inj. Buscopan iv stat
	PV: Cx 3cm dilated	- Monitor vitals
	1/2 inch long.	- Inform SOS.
	mem absent	- Continue Inj. Oxytocin infusion and increase according to contractions.
	clear liqour.	
	Vx at -2 station.	
19/07/2026 8:30pm	V/B Dr. Swathi HV	
	→ [illegible] @ 37+ weeks c̄ SROM.	
	- [illegible] :: 10hrs	
	- On oxytocin @ [illegible]	
	O/E: vitals @	
	PA: ut TS.	
	cephalic	
	45" FHR @ [illegible]	
	[illegible] 3-4/10 / 20-25"	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	P/V: Os 3cm, Vx eff 1-2-9	Adv
	mem (+)	- Inform Anon team
	Meconium (+) clear	& pediatrician
	caput (++)	→ foley catheter
		→ inform & consent
	- Explained findings to the pt & husband.	
	- Plan: Em LSCS in v/o NPOL	- Shift to OT now.
19/07/2026 10:15pm	c/s by Dr Naveena	
	O/E GC - fair	Adv
	Afebrile SpO2 - 99% on RA	- NBM for 4-6hrs
	PR: 67bpm	- ivf and drugs as charted
	BP: 100/60mmHg	
	CVS/RS: NAD	- w/f P/V bleeding
	PA: ut retracted well	- Urine I/O charting
	Soft, NT	- foley's removal T/M at 12pm
	Dressing: dry & clean	
	L/E: P/V bleeding WNL	- Monitor Vitals
		- Inform SOS
	U/O: 600ml clear emptied in OT	
	Baby: Mother side	Dr Naveena

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27-01-1999 27 Y 5 M 22 D (F)
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(2)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/07/2026 2:30am	c/s/by Dr. Naveena	
	o/E GC-fair Afebrile SpO2-99% on RA PR: 58bpm BP: 130/68mm Hg CVS/RS: NAD PA: ut-retracted well Soft, NT Dressing: dry & clean UE: PV bleeding WNL u/o: 400ml, clear BS: present Baby: Mother side Kindly shift the patient to room	Adv - Sips of water. Fl b liquid diet - Adequate hydration - drugs as charted - w/f PV bleeding - Urine I/O charting - Foleys T/M 12pm [20/7/2026] - Monitor Vitals - Inform SOS Dr. Naveena

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2026 7:00am	c/s/by Dr Naveena	
	POD 1.	
	O/E GC-fair	Adv
	Afebrile	- Soft diet
	Vitals-stable	- Adequate hydration
	PA: ut retracted well	- drugs as charted
	Soft, NT	- w/f PV bleeding
	Dressing: dry & clean	- Urine I/O charting
	L/E: PV bleeding WNL	- M/V & I/SOS
	U/O: 70-80ml/hr. clear.	- Foley's removal
		@ 12pm
	Baby: Mother side	Noted by Divya 20/7/26
		Dr Naveena
	L/B [illegible]	
20/7/2026 10AM	→ day 0 of [illegible] NPDL	
		Advice
	O/E: vitals @	+ [illegible]
	PA: [illegible] well ©	
	- BS+/+	+ Remove foleys
	L/E: [illegible]	- Ambulation.
Swathi [illegible]		- w/f [illegible] bleeding
	Baby → M/S.	
		Dr. S[illegible] H V Consultant Ob[illegible] Gynecology Reg. No. [illegible]

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

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26 1:40 pm	C/l/B Dr. Mrudula	
	POD,	
	O/E pt c/c/c	Adv
	PR - 81bpm	1. Soft diet
	BP - 110/67mmHg	2. Adequate Hydration
UV	PA - uterus retracted well	3. Drugs as charted
FV	L/E - p/v bleeding WNL.	4. Ambulation
S X		5. monitor Vitals
Baby c mother		6. Ryomng?
		NB - Moutushi
		Mrudula @ 2PM.
20/7/26 7:15pm	C/l/B Dr. Mrudula	
	POD,	Adv
	O/E pt c/c/c	1. soft diet
	afebrile	2. Adequate Hydration
UV	PR - 79bpm	3. Drugs as charted
FV	BP - 109/70mmHg	4. Ambulation
SV	PA - uterus retracted well	5. monitor vital
Baby c mother	Mild Distention (+)	Ryomnbus
	L/E - p/v bleeding WNL	
		Mrudula Dr Mrudula. N.B. Mahi 20/7/26 @ 8:30PM.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26, 10pm	c/o pain No relief c̄ Calpol	
	Adv : Inj. DICLOFENAC 75mg / IM / stat	
	PA - soft, UWR U: ✓ F: ✓ S: ✓	Ramu DHARMYA THOORAN
21/7/26., 8 AM	C/s/B Dr. Dng. POD-2 P.4. GC fair Afebrile vitals - stable P/A uterus Retracted well L/E NAD	Adv. - ~~Soft diet~~ Regular diet - Drugs as charted - Adequate hydration - Monitor vital - W/F bleeding PV - Inform SOS Noted by Divya 21/7/26
Baby c̄ Mother. U ✓ F ✓ S ✓		
	[signature]	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/2026	C/o/b Dr Mamtha	
12:30pm	POD-01	
		Adv
	CC for Afebrile	- Regular Diet / Adeq hydration
Baby - ~~NICU~~	Vitals stable	- Drugs chart
M/S	P/A ut well retracted	- W/F vitals + BSM
	BS ⊕	- Inform SOS
U ✓	LE Bleeding WNL	
B ✓		
S ✓		my Diamonds
		N.B. Anusha @ 9:40pm
	L/B - Dr Swathi HV	
21/7/2026 3pm	→ POD-2, P1G.	
	- c/o mild epigastric pain Increased?	Adv @ dcr
	O/E: vitals @	→ Follow orders
Baby M/S	PA: soft ut well ®	- plenty of fluids
	P'dry	
U/C T/C	L/E: Bleeding WNL	+ Ambulation
		[signature]
		Dr. Swathi H V Consultant Obstetrics and Gynecology Reg. No: 15501

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7 7 pm	C/I/B Dr Mounika	
	POD 2	
	o/i/t pt c/c/c	Rx
V ✓	dyspnoea	1. Regular diet
F ✓		
S ✓	PR 75bpm	2 plenty of oral fluids
Baby mother side	BP-128/75mmHg	3. Drugs as charted
B/L breast soft	O/A - Uterus contracted well	4. w/f p/v bleeding
	L/E - p/v bleeding WNL	5. monitor vitals
		6 Pyroxym Ros.
	[signature] Dr. Mounika.	
		noted by sr. sandhya 21/7/26 7 pm
21/7	C/I/B Dr Mounika	
	POD 3	
	o/i/t pt c/c/c	Adv
V ✓	dyspnoea	1. Regular diet
F ✓	PR-80bpm	2. plenty of oral fluids
S ✓	BP-110/80mmHg	3. Drugs as charted
Baby mother side	O/A - ut contracted well	4. w/f p/v bleeding
B/L breast soft	L/E - p/v bleeding WNL	5 Tegaderm dressing
		6. monitor vitals
		Can be discharge
		Dr. Mounika

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RESULT SHEET

Date	16/7/26.					
Time						
Hb	10.7					
PCV	31.5					
RBC						
WBC	14.81					
N/L						
Platelets	4.41					
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 grouping : O+ve						
HIV HbsAg HCV VDRL } NR						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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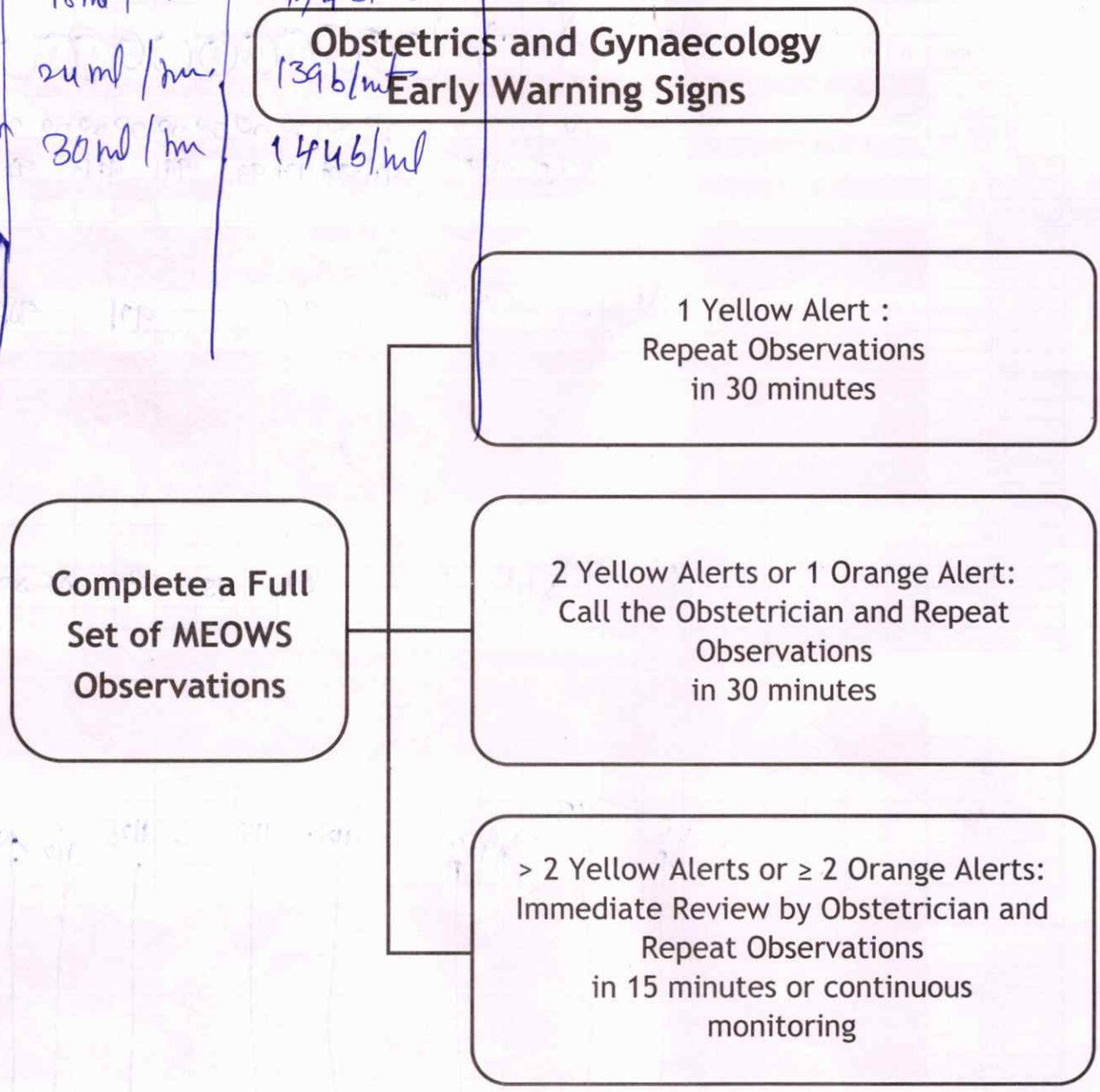
Early Warning Observation Score Chart - Obstetrics

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

19/7/26.	Date																							
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20							20		20	20	20	20		20	20	20	20	20	20	20	20	20	20	20
	0 - 10																								
Saturations	94 - 100 %							99		98	99	99	97		99	99	99	99		99		99		99	99
	< 94 %																								
Administered O_2 (L/min.)																									
Temp °c	40																								
	39																								
	38																								
	37							97.6				97.6					98				97			98	97.6
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80							83		79	81	83	79			80		75		82		85	80	79
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120							115		113		112	110			118		115		112		110	113	116
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70							75		73		74	80			65		67		67		67	66	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								0		0		0	0			0		0		0		0	0	0
TOTAL ORANGE SCORES								0		0		0	0			0		0		0		0	0	0
Nurse Initial																								

Date	Time	Inj. Syntocinon	FHR
	2:30 Pm	6 ml/hr	142 b/mt
	3 Pm	12 ml/hr	150 b/mt
	3:30 Pm	18 ml/hr	147 b/mt
	4 Pm	24 ml/hr	139 b/mt
	4:30 Pm	30 ml/hr	144 b/mt



* The Modified Early Warning Score (MEOWS)

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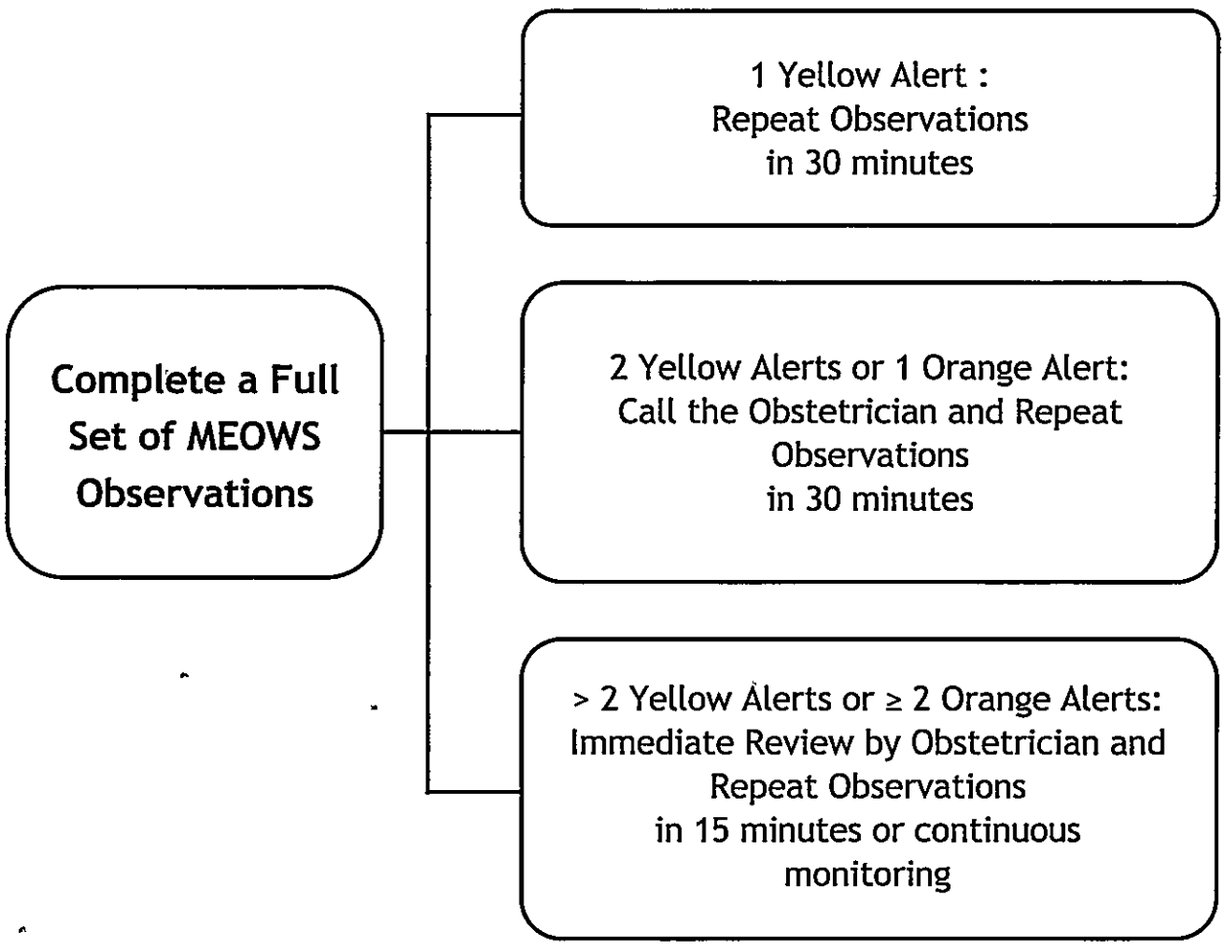
CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

20/7/26	Date																							
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20			20				20				20				20				20				20	
	0 - 10																								
Saturations	94 - 100 %			99%				99%				99%				99%				99%				99	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36			36.8				36.6				36.6				98.6				98.4				98	
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80			78				81				79 b/m				72				76				78	
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																			110				115	
	120															105									
	110			109				110				109													
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
	40																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70			61				67				70				72				67				80	
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert			✓				✓				✓				✓				✓				✓	
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30			✓				✓				✓				✓				✓				✓	
	< 30																								
Proteinuria	Protein + +							✓																	
	Protein > + +																								
Lochia	Normal			✓				✓				✓				✓				✓				✓	
	Heavy / Foul																								
Liquor	Clear / Pink			✓				✓				✓				✓				✓				✓	
	Green																								
TOTAL YELLOW SCORES				0				0				0				0				0				0	
TOTAL ORANGE SCORES				0				0				0				0				0				0	
Nurse Initial				RB																					

Obstetrics and Gynaecology Early Warning Signs



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

BAH-00039455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 23 D (F)
Dr. SWATHI H V

Rainbow® Children's Hospital
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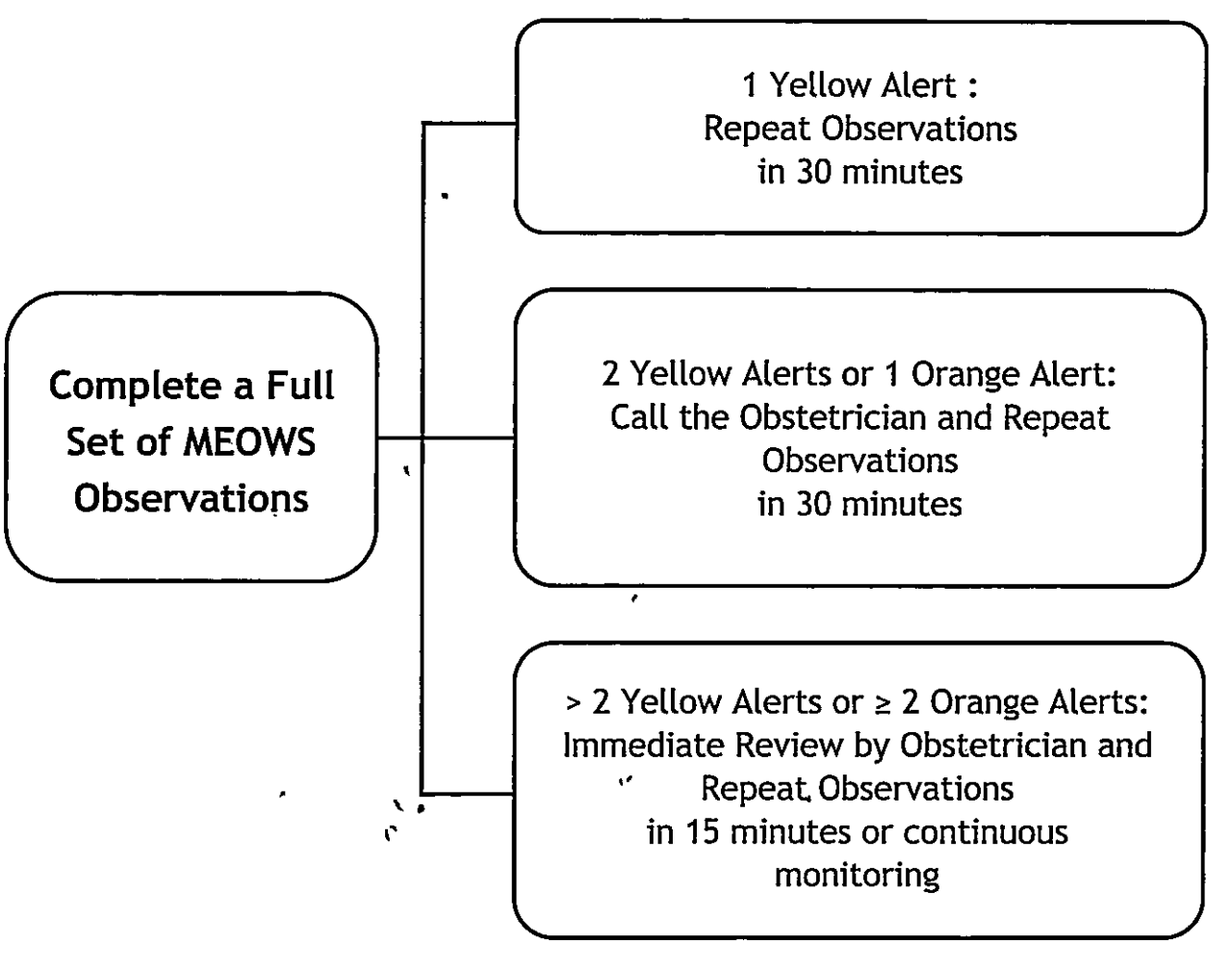
Early Warning Observation Score Chart - Obstetrics

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

21/7/26	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			22				23				29				20				20				20	
	0 - 10																								
Saturations	94 - 100 %			99%				98%				99%				99%				99%				99%	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37			36°				37°C				98.4F				98.3F				36°				98.3F	
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80			92				75				83				82				99				72	
	70																								
	60																								
	50																								
	40																								
↑ Systolic Blood Pressue	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130			115				118/1				114				115								118	
	120																								
	110																								
	100																			112					
	90																								
	80																								
	70																								
	60																								
	50																								
	40																								
↓ Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70			76				75				70				72				70				75	
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert			✓				✓				✓				✓				✓				✓	
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30			✓	✓			✓				✓				✓				✓				✓	
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal				✓			✓				✓				✓				✓				✓	
	Heavy / Foul																								
Liquor	Clear / Pink				✓			✓				✓				✓				✓				✓	
	Green																								
TOTAL YELLOW SCORES				0				0				0				0				0				0	
TOTAL ORANGE SCORES				0				0				0				0				0				0	
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

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Dr. SWATHI H V

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
19/9/20	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
19/9/20	08:00 pm											
	09:00 pm											
	10:00 pm	RL			100ml					600ml		
	11:00 am	RL			100ml							
	12:00 am	RL			100ml							
	01:00 am	RL			100ml							
Total Intake :						**Total Output :**						
20/9/20	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					200ml		
	07:00 am	RL			100ml							
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : ....

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

Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
20/7/26	08:00 am	RL		100ml								
	09:00 am	RL		100ml								
	10:00 am					NIL		NIL		800ml		
	11:00 am											
	12:00 pm											
	01:00 pm									✓		
Total Intake :						Total Output :						
20/7/26	02:00 pm											
	03:00 pm		Kichidi				✓			✓		
	04:00 pm		+									
	05:00 pm	0	H_2O.	NA				NA			0	[signature]
	06:00 pm									✓		
	07:00 pm											
Total Intake :						Total Output :						
20/7/26	08:00 pm		Curd									
	09:00 pm		Rice									
	10:00 pm	0					0			✓		[signature]
	11:00 pm		H_2O	NA				NA		✓	0	
	12:00 am		Bread									
	01:00 am											
Total Intake :						Total Output :						
21/7/26	02:00 am									✓		
	03:00 am											
	04:00 am		[illegible]							✓	0	[signature]
	05:00 am	0		NA				NA				
	06:00 am									✓		
	07:00 am											
Total Intake :						Total Output :						

Foley's Removed Emptied

Total 24 hrs. Intake	

Total 24 hrs. Output	

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

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Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

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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							
21/7/26	08:00 am											
	09:00 am											
	10:00 am		Idly + H2O		NA			NA				
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
21/7/26	02:00 pm											
	03:00 pm											
	04:00 pm	0					0				0	
	05:00 pm											
	06:00 pm				NA			NA				
	07:00 pm											
Total Intake : Taken						Total Output :				U-2	M-a	
21/7/26	08:00 pm											
	09:00 pm											
	10:00 pm	0	Chapati Khichdi				0				0	
	11:00 pm				NA			NA				
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
22/7/26	02:00 am											
	03:00 am											
	04:00 am	0	H2O				0				0	
	05:00 am				NA			NA				
	06:00 am											
	07:00 am											
Total Intake :						Total Output :				V-2	M-1	

Total 24 hrs. Intake		Total 24 hrs. Output	

BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 24 D (F)
Dr. SWATHI H V

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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

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							
22/7/26	08:00 am											
	09:00 am											
	10:00 am		2dly H.O.									
	11:00 am				NA				NA			
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

NURSING CARE RECORD

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Date: 14/2/26

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				WD			
Afternoon	2pm 8pm	→ Assess the Patient condition → plan for vital → plan for NST → plan for Blockage	2pm 8pm	→ Assessed the pt condition → Maintain vital → NST procedure → Maintain Blockage	→ Patient stable	→ vital Normal	
Night	8PM 8AM	→ Assess the pt condition → monitor the vitals & record → Administration of medication → maintain I/O chart & record	8PM 8AM	→ Assessed the Pt condition → monitored the vitals & recorded → Administered medication → maintained Blockage & recorded.	pt is stable.	maintain I/O chart & record	AKills

BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
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Dr. SWATHI H V

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NURSING CARE RECORD

Date: 2017/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM 2pm	Assess the general Condition Check vitals se records Administer medication & chart maintain	8AM 2pm	Assisted general condition Checked vitals se recorded Administered medication & chart maintained	pt is stable	Rechecked vitals	Monitored
Afternoon	2pm 8pm	→Assess the pt condition. →Monitor the vitals. →plan to stop fluids. →drugs give as per drug chart.	2pm 8pm	→Assessed the pt. condition. →Monitored the vitals. →planed to stop fluids. →drugs given as per drug chart.	→ pt is stable Now.	→Reassessed the vitals.	Mahalakshmi
Night	8PM to 8AM	- Assess the pt Condition - Monitor the V/S - Maintain the I/O - Drug as per chart	8PM to 8AM	- Assess the pt Condition - Monitor the V/S - Maintain the I/O - Drug as per chart	- Now patient is stable	- Rechecked the V/S	

BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

NURSING CARE RECORD

Rainbow® Children's Hospital
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Date: 21/7/26

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	8Am to 2Pm	→Assess pt condition →monitor the vitals →maintain I&O chart →Administer medication as per drug chart	8Am to 2Pm	→Assessed pt condition →monitored the vitals →maintained I&O chart →Administer medication as per drug chart	Patient is Stable	Re-checked vitals	
Afternoon	2Pm to 8Pm	→Assess the patient general condition →monitor vitals →Administer medications as Per doctor's orders.	2Pm to 8Pm	→Assessed the patient general condition →monitored vitals →Administered medications as Per doctor's orders.	~~Baby~~ Patient is stable.	Rechecked vitals.	
Night	8Pm to 8Am	* Assess the patient general condition * Checked vital sign * Administer medication as per Doctor's orders	8Pm to 8Am	* Assessed the patient general condition * Checked vital sign * Administer medication as per Doctor's orders.	patient is Stable	Re checked. vitals	Surender

BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 24 D (F)
Dr. SWATHI H V

Patient St

NURSING CARE RECORD

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
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Date: 22/7/26

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	8 AM 2PM	→ Assess the pt condition. → monitor the vitals. → maintain I/o chart. → drugs give as per drug chart.	8 AM 2PM	→ Assessed the pt condition. → monitored the vitals. → maintained I/o chart. → drugs given as per drug chart.	→ pt is stable now.	→ Re assessed the vitals	
Afternoon							
Night							

BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

BRADEN 'Q' SCALE

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					Date : 19/7	19/7	20/7	20/7
					Time : 2pm	PM	Mo	E2
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	3
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	3
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	3
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	3
				TOTAL SCORE	28	28	28	24
				Evaluator's Name		@	Mo	

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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BRADEN 'Q' SCALE

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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :		21/7/26	21/7/26	21/7/26
					Time :	10pm	M6	Evng	N1
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	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	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	24	24	28	28
					Evaluator's Name	M	A	S	SS

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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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		NA	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	PA	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	—	—	—	
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	—	—	—	
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	—	—	—	
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	—	—	—	
			Signature of the Nurse										

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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CHECKLIST FOR THROMBOPHLEBITIS

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				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0									
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	0									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0									
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	0									
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	0									
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	6									
			Signature of the Nurse										

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	19/1/26 2pm	19/1/26 10/1	20/1/26 Mc
		Score			
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0		0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:			20	20	20
		Signature			Nobil

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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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	20/7/26	21/7/26	21/7/26
		Score	N1	M6	N1
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
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	0
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0		
Total Morse Fall Scale Score:			20	20	20
		Signature			

Fall Risk Grading		
Risk Level	**Morse Fall Score (MFS)**	**Action**
Low Risk	0 - 24	Standard Fall Precaution
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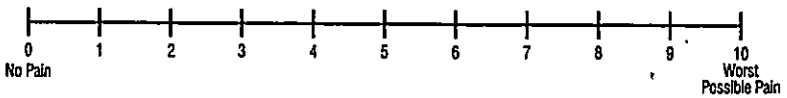
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
19/7/26	3pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
19/7/26	4pm	1/10	Abdominal pain	☐ Continuous ☑ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Breathing exercise	
20/7/26	9AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
20/7/26	9AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
20/7/26	10AM	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
20/7/26	3 pm	2/10	Abdomen	☑ Continuous ☐ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Tab. diclofenac given by doctor adv.	
20/7/26	10pm	2/10	Abdomen	☑ Continuous ☐ Intermittent	☑ Acute ☐ Chronic	☐ Sharp ☑ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	Inj - Dicla by doctor advised	
20/7/26	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
20/7/26	6am	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
21/7/26	10pm	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	

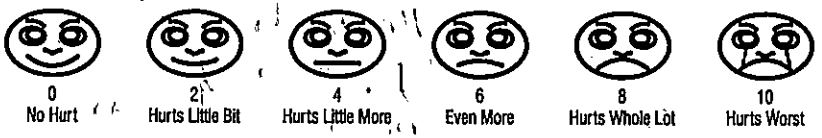
Re-assessment Frequency:
1. Every eight hours for all hospitalized patients.
2. For post-surgical patients, patients with chronic pain, patient with severe pain:
   a) At least every 2 hours for the first 24 hours b) Then every 4 hours.
   c) Prior to pain pain-relieving intervention. d) Within 30 –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

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/7/26	3pm.	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
21/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
22/7/26	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
22/7/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
22/7/26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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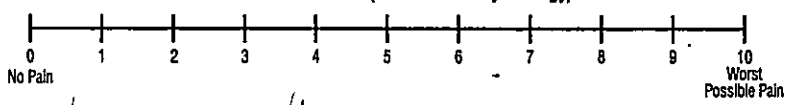

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Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, right, or Jerking
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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION

Diagnosis:

Any Infection: ☐ Yes ☐ No ☑ Not Known
If Yes Specify: .....

BACKGROUND

Area / Shift Time	19/7/26 2pm	19/7/26 N	20/7/26 M	20/7/26 E	20/7/26 N	21/7 M
Medical Condition (Any special condition to be noted):	–	NA	NA	NA	NA	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:	97.6F	97.1F	97.7F	97.8°F	98.5F	98.3°F
Res:	20	20bm	22b/m	20b/m	22b/m	25b/m
SpO_2:	100	99%	100%	99%	99%	99%
Pulse:	88	84bm	92b/m	85b/m	82b/m	72b/m
BP:	112/73	115/70	113/80	115/71	112/67	115 b/m
Fall Risk Score:	–	–	–	–	–	–
Pain Score:	0/10	0/10	0/10	2/10	–	–

Recommendations

Safety Needs:	Yes	Yes	Yes	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 :	Akhil	Akhil	Navitha	Maheshwari	Sunanda	Anusha
Signature :						
Date:	19/7/26	20/7/26	20/7/26	20/7/26	21/7/26	21/7/26
Time:	8pm	8am	2pm	8pm	8am	2pm
Taken Over By Name :	Akhil	Navitha	Maheshwari	Sunanda	Anusha	
Signature :						
Date:	19/7/26	20/7/26	20/7/26	20/7/26	21/7/26	
Time:	8pm	8am	2pm	8pm	8am	

HNH-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 27 D (F)
Dr. SWATHI H V

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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	21/7/26 Evng	21/7/26 NI	22/7 Mc			
	Medical Condition (Any special condition to be noted):	NA	NA	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:	98.2°F	98.6°F	98.1°F			
	Res:	25b/m	22b/m	20b/m			
	SpO_2:	99%	98%	99%			
	Pulse:	75b/m	79b/m	75b/m			
	BP:	110/80	110/79	110/71			
	Fall Risk Score:	—	—	—			
	Pain Score:	—	—	—			
Recommendations	Safety Needs:	—	—	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 :		Sandhya	Sunanda	mahi			
Signature :							
Date:		21/7/26	22/7/26	22/7/26			
Time:		8pm.	8Am	2pm			
Taken Over By Name :		Sunanda	mahi				
Signature :							
Date:		21/7/26	22/7/26				
Time:		8pm	8Am				

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27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

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DRUG CHART

Date of Admission: 19/7/26 Drug Allergies: Tramadol ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

DRUG : DICLOFENAC				Date / Time
Dose	Route	Frequency	Start Date	
75mg	IM		21/7	
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 .....

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Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

REGULAR PRESCRIPTIONS Weight. 76.1 Ward. CDX

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

DRUG : INJ. CEFOTAXIME				Date / Time: 19/7, 20/7
Dose: 1Gm	Route: IV	Frequency: BD	Start Date: 19/7	9AM
Name & Signature of the Doctor Starting the Drugs: @ Dr. Naveena.				Stop
Additional Instructions: ATD.				9PM Inj Akhila — Dr. Dna
Daily Doctor's Endorsement by a Sign				

DRUG : TAB PARACETAMOL				Date / Time: 20/7/26, 21/7, 22/7
Dose: 1gm	Route: po	Frequency: QID	Start Date: 19/7	12AM
Name & Signature of the Doctor Starting the Drugs: Dr. Sairam V				6AM (3AM Akhila)
Additional Instructions:				12PM
				6PM
Daily Doctor's Endorsement by a Sign				

DRUG : TAB DICLOFENAC				Date / Time: 20/7/26, 21/7, 22/7
Dose: 50mg	Route: po	Frequency: TID	Start Date: 19/7	7AM
Name & Signature of the Doctor Starting the Drugs: Dr. Sairam V				3PM
Additional Instructions:				11PM
Daily Doctor's Endorsement by a Sign				

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

Verified by Dr. Dhakshayani

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Sheet No: .....

REGULAR PRESCRIPTIONS

Weight 76.1 Ward LDR

DRUG : TAB. PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	PO	BD	19/7

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 20/7/26 21/7 22/7

DRUG : CEFIXIME

Dose	Route	Frequency	Start Dt.
200mg	PO	BD	21/7

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: 21/7 22/7

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

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Sheet No: .... **REGULAR PRESCRIPTIONS** Weight 76.1 Ward VDR

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 ▾

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 ▾

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

IAH-00639455 IP26-00006883
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27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

Weight. 76.1 Ward. 102

SE		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
19/7	2:30pm	INJ-CEFOTAXIME	1Gm	IV	[illegible]	[illegible]
19/7	3:00pm	PROCTOLYSIS ENEMA	1 PACK	PR	[illegible]	[illegible]
19/7	3:35 pm	Inj DROTIN	40mg	IV	[illegible]	[illegible]
19/7	4 pm	Inj Epidosin	8mg	IV	[illegible]	[illegible]
19/7	4:45 pm	Inj BUSCOPAN	20mg	IV	[illegible]	[illegible]
19/7	7:40 pm	Inj DROTIN	40mg	IV	[illegible]	[illegible]
19/7	9:09pm	INJ Oxytocin	10 u	IV	[illegible]	[illegible]
19/7	9:50 pm	Sup. Diclofenac	100mg	PR	[illegible]	[illegible]
20/7	11pm	Inj DICLOFENAC	75mg	IM	stat	[illegible]

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

Verified by Dr Dhulcharani

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Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

I.V. FLUIDS CHART

Weight. 46.1 Ward. LDR

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
19/7	2:30pm	RINGER LACTATE c 100 OXYTOCIN	IV	6ml/hr titrate			19/7		
19/7	9:15pm	Ringer Lactate	IV	FF			19/7		
19/7	9:40pm	Ringer Lactate c 20u Oxytocin	IV	150 ml/hr			19/7		
20/7	12AM	RINGER LACTATE	IV	100 ml/hr					
2017/26		Stop							
		Dr. Mandala							

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

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STAT / ONCE ONLY DRUGS

Name: MRS. Vaishnavi ..... Weight: ..... kgs

Sheet No: .....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
19/7	8:30pm	T. METOCLOPRAMIDE	10mG	IV		Sri	Akhila
19/7	8:30pm	T. PANTOPRAZOLE	40mG	IV		Sri	Akhila
20/7	3AM	INJ-PARACETAMOL	1gm	IV		Sri	Akhila.

Docu. No. : RCH /FRM / CLINICAL / 136

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Dr. SWATHI H V

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MEDICATION RECONCILIATION FORM

Drug Allergies: ~~Nil~~ Tramadol ☐ Not known any Drug Allergies

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. IRON	1TAB	PO	OD	18/7	☐C ☒DC
2	T-CALCIUM	1TAB	PO	OD	18/7	☐C ☒DC
3						☐C ☐DC
4						☐C ☐DC
5						☐C ☐DC
6						☐C ☐DC
7						☐C ☐DC
8						☐C ☐DC
9						☐C ☐DC
10						☐C ☐DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Naveena

Date & Time : 19/7/2026 @ 2:00pm.

Nurse Name & Signature: Afati

Date & Time : 19/7/26 @ 2:00pm

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

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Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 23 D (F)
Dr. SWATHI H V

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CROSS CONSULTATION FORM

Doctor Name : Dr. Swathi Date : 20/7/26 Time : 2pm

Diagnosis : LSCS

Hospital : RCH - HYNR

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

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

Signature:

Findings and Recommendations :

Lactation care plan

- well formed Breast with Left inverted Nipple
- colostrum seen
- primi
- Aim for deep latch as demonstrated in cross cradle.
- Advice to use Nipple shield on inverted side.
- Demand feeding not exceed 2½ hours as per early hunger cues.
- Advice DBF & f/b Burping
- warm care, stimulate baby continuously while feeding.

Consultant :

Name : Sathwika. G Signature : S Date & Time : 20/7/26 ; 2pm

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Dr. SWATHI H V

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 20/7/26 Time: 8:40am

Origin: Indian Height: 160cm Weight: 76.1kg BMI: ☐ ~ 26 kg/m² ☐ ~ 28 kg/m² ☐ ~ 30 kg/m²

29kg/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	Dietician's
Signature:	Signature: Sobiya
Name: Vaishnavi	Name: Syeda Sobiya Zaheer
Date & Time: 20/7/26;	Date & Time: 20/7/26;

DIETARY NOTES

Date	Time	Notes	Sign
21/7/26	11Am	Can Start Normal Diet	[signature]

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Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: Dr. Swathi	Date of Delivery: 19/07/2026
Assistant Surgeon: Dr. Naveena.	Time of Delivery: 9:09 pm.
Anaesthetist's Name: Dr. Sai Raj	Gender of Baby: Male
Type of Anaesthesia: Spinal	Weight of Baby: 2.6kg.
Neonatologist: Dr. Varun.	AGPAR Score: 8, 9.
Scrub Nurse: Sandhya.	NICU Admission: ☐ Yes ☒ No

Pre-Operative Diagnosis: Primigravida with 37w 6days POG with h.s ROM in latent labour

☐ Elective ☒ Emergency Indication: NIPOL.

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: Emergency LSCS.

Post Operative Diagnosis: Pilcon. POD0 following Emergency LSCS.

Peri-Operative Complications: -

Amount of Blood Loss: 150ml.	Blood Transfused (in ML):

Name and Number of Surgical Specimen sent for examination:

Examination Findings when Appropriate:

Presentation: ☑ Cephalic ☐ Breech ☐ Other ..... Cervical Dilatation: 3cms ..... cm

5th Palpable: 4/5th ..... Fetal Position: .....

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

Caput: ☑ + ☐ ++ ☐ +++ Meconium: ☑ None ☐ + ☐ ++ ☐ +++

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

Skin Incision: ☑ Pfannensteil ☐ Transverse ☐ Midline ☐ Other ..... • Cord around the neck.

Uterine Incision: ☑ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision • Omental adhesions to posterior uterine wall

Previous Scar: ☐ Intact ☐ Thinnedout ☐ Ruptured ☑ No Scar

Incision Through Placenta: ☐ Yes ☑ No • Right Para ovarian Cyst of 3x4cms noted & punctured - serous fluid

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 ..... Suture

Peritoneal Closure: ☐ Pelvic ☑ Abdominal ☐ None ..... Catgut ..... Suture

Sheath Closure: Yes ..... Vicryl no. 1 ..... Suture

Fat Closure: ☑ Yes ☐ No ..... Monocryl 3-0 ..... Suture

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

Vaginal Evacuated ☑ Yes ☐ No

Drain: ☐ Yes ☑ No ☐ Remove in ..... days ☐ Await instructions

Ctheter ☑ Yes ☐ No ☐ Remove in ..... days ☐ Await instructions

Swap & Instruments count correct? ☑ Yes ☐ No ☐ Post-op Antibiotics ☑ Yes ☐ No

Intra-Operative Antibiotics Cover: ☑ Yes ☐ No ☐ Thromboprophylaxis ☐ Yes ☑ No

Post-Operative Notes:

NBM for 4-6 hrs.
Urine I/O charting.
W/F PV Bleeding
drugs & IV fluids as charted.
Monitor Vitals
Inform SOS.

Doctor Name: Dr. Swathi H V. Doctor Signature:

Date & Time: 19/7/2026 @.

BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swathi H V
Asst. Surgeon : Dr. Nandeesha
Anaesthetist : Dr. Sai Roy
Scrub Nurse : Sandhya

..... Age : 27 Gender : F
UHID No. : ..... Surgery Name : Em-LSCS
Date : 19/7/26 In-time : 9pm Out-time : 10pm

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Before Induction of Anaesthesia ➤ ➤

SIGN IN Time: 9:00pm

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 : Sv
Name : Dr. Saravi V

Before Skin Incision ➤ ➤

TIME OUT Time: 9:05 pm

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 N/A ☐ Yes ☑ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? ☑ Yes ☐ No ☐ NA

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

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA

Is Essential Imaging Displayed? ☐ Yes ☑ No ☐ NA

Signature : Sandhya
Name : Sandhya 19/7/26 @ 9:05 pm

Before Patient Leaves Operating Room

SIGN OUT Time: 10pm

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 : Swathi
Name : Dr SWATHI HV

PATIENT TRANSFER FORM

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BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

Treating Consultant Name	Date & Time of Admission	Date & Time of Transfer Order
	19/7/26 @ 12:38pm	19/7/26 @ 9:50 pm
	Transfer Ordered by	**Reason for Transfer**
	Dr. Sai raj	Observation
From Unit	**To Unit**	**Information to Attendant**
OT	Pre- post	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
—	—	Yes ☐ No ☑
		If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sundhya 19/7/26 @ 10:10 pm	Dr. Sai raj

Patient & Clinical Records Received by : Sujatha

Date & Time of Patient Received : 19/7/26 @ 10 AM

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

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

BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 19/4/26 Time of Arrival: 12:30pm Time Seen by Nurse: 12:35pm

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

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

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

3) **Vital Signs:** Temperature: 97.6 Pulse: 80 RR: 20 SpO_2: 99 BP: 110/70 Weight: 71

4) **Gestational Criteria:**

Gravida:	G	P	L	A
		–	–	–

LMP: 30/10/2025 EDD: 31/8/2026 Gestational Age: 37+6 days

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

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

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

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

.....

6) **Past History:**

a) Surgeries: .....

b) Medical: .....

BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 22 D (F)
Dr. SWATHI H V

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

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

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 3:00pm

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

Date: 19/4/26 Time: 3:30pm

INFORMED CONSENT FOR VAGINAL BIRTH

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Patient Name : MRS - VAISHNAVI RANI UHID No : BAH - 00639455.

Gender: ☐ Male ☑ Female Date : 19/7/2026 Time : .....

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr- SWATHI HV.

Consentee :

Signature : Gavaishnavi

Name : Gogikar Vaishnavi Rani

Date & Time : 19-07-2026

Patient Attendant :

Signature : .....

Name : Vital Laxmi

Relationship with Patient: Husband

Date & Time : 19-07-2026

Witness :

Signature : .....

Name : Anusha-le

Date & Time : 19/07/2026

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Naveena.

Date & Time : 19/7/2026 @ 2:00pm.

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : MRS. G. VAISHNAVI RANI Gender: ☐ Male ☐ ~~Female~~ Age : 27yrs

UHID No : BAH - 00839455 Date : 19/7/2026

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

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

EMERGENCY LOWER SEGMENT CAESERIAN SECTION.

upon

MRS. G. Vaishnavi 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.

Haemorrhage, Injury to Bowel and Bladder, Need for Blood and Blood products transfusion;

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr. SWATHI H.V.

Consentee :

Signature : Vaishnavi Rani

Name : Vaishnavi

Date & Time : 19/7/2026 @ 8:45pm.

Witness :

Signature :

Name :

Date & Time :

Patient Attendant :

Signature :

Name : MR. VITAL.

Relationship with Patient: Husband.

Date & Time : 19/7/2026 @ 8:45pm

Doctor (who is taking the consent) :

Signature :

Name : Dr. Naveena.

Date & Time : 19/7/2026 @ 8:45pm

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. GOGIKAR. VAISHNAVI. RANI Age : 27 Gender : Male ☐ Female ☐

UHID NO: BAH-00639455 Surgeon Name: Dr. SWATHI. H.V

Anaesthesiologist : Dr. SUMIR

Operative procedure planned : Em-LSCS

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 : .....

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. GOGIKAR. VAISHNAVI the above mentioned operation / Diagnostic / Therapeutic procedures Em-LSCS

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

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

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

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

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

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

- Pregnant : ☐ ~~Yes~~ ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : .....

Name : Vaibhavini Ravi Gorikar.

Relationship with Patient: .....

Date & Time : 19/7/26 @ 8:45 PM

Witness :

Signature : .....

Name : Vitthal Waji

Date & Time : 19/7/26 @ 8:45 PM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Sonali

Date & Time : 19/07/2026 8:45 pm

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. GOGIKAR VAISHNAVI Age: 27yr Sex: female UHID.No : BSHI-0639455

Date: 19/07/2025 Time: 8:45pm Proposed Operation: LSCS

Diagnosis: PROM, 32+6, PROM, FETAL DISTRESS

B.P / CRT: 120/70 mmHg H.R: 86/min Weight: 76.1 ASA Physical Status: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 10.7	Glucose:	Protein:	HIV:	X-Ray:
PCV: 31.5	Urea:	Alb:	HBS Ag: NR	ECG:
WBC: 14810	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 4.41	Na:	Dir. Bill:	Blood group: O+ve	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: ✗ TRAMADOL ✗

Medical History: CVS : —

RESP : Occasional Cough (+)

CNS : NAD

Renal :

Hepatic / GE :

Diabetes : —

Physical Activity:

Others :

Past Anaesthetic History: ANAL FISSURES in 2024 ↓ SAB, Lt. BREAST ABSCESS I&D ↓ GA

Physical Exam: Mod Built & Nourished

Airway: MP 1 2 3 4 Mouth Opening: Mentohyoid Distance: Neck: Teeth:

Lungs : B/L Air, clear

Heart: S1S2 ✓

CNS:

Pregnant: ☐ Yes ☐ No ☐ NA

Venous Access Site: Peripheral Spine Exam for regional :

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

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:

Last food @ 1.30 pm

Bedam Milk @ 6:00pm

water @ 8:00pm

Signature: Name: Dr. GANESH

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

BAH-00839455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 23 D (F)
Dr. SWATHI H V

ANAESTHESIA CHART

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Pre Induction Assessment:

Change in Patient Condition: ☐ Yes ☒ No
Fasting Status: 8:00 pm

Physical Status: ☒ Patient Identified ☒ Consent Present ☒ Chart Reviewed

H.R.: 84/min | B.P./CRT: 120/70 | SpO_2: 98% RA | R.R.: | Last Feed: 1:30 pm

Pre-OP Diagnosis: PRIMI, 37 wks, PROM, Fetal distress Operation: Em. LSCS Date: 29/07/26

Surgeon: Dr. SWATHI Anaesthesiologist: Dr. SAIRAJ Technician: ARAVIND

TIME	9	9	9	9	10
N_2O/AIR/O_2, LPM					
HALO/ISO/SEVO					
Drugs:					
INJ OXYTOCIN	9 u IV				
FiO_2/SaO_2	100	99	98	99	99
$ETCO_2$					
ECG	NSR	NSR	NSR	NSR	NSR
Temperature					
Urine Output					
Fluids / Blood	RL (1)		→ RL (2)		

Antibiotic
Suppository: DICLOFENAC 100 mg PR
Blood Loss
NOTES

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

Scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20, 10, 0
(Systolic ~120, diastolic ~70, heart rate ~80 charted)

LAB Values
ABG
GRBS
Others

☒ Equipment Checked and Functional
☐ BP
☒ Cuff Site: Lt Arm
☐ Art Site: ....
☒ EKG 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: 9:00 PM
OP Start: ↓
OP End: ↓
Leave OR: 10:00 PM

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☒ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☒ IV: 18 G Rt WV
☐ 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: SAB
☒ Spinal ☐ Epidural ☐ Caudal
Others: ....
Position: Sitting
Site: L3-L4
Needle Size: 25G Depth: 4.15 cm
Parasthesia ☐ Yes ☐ No
Catheter at skin .... cm
Drug Name & Conc: 2.0 ml 0.5% Heavy Bupivacaine + 25 mcg Fentanyl
Bolus: ....
Infusion: ....
Block Level: T6
Comments: ....

Transportation to
☒ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☒ NA
Name of the Doctor: Dr. SAIRAJ
Signature of the Doctor: [signature]

BAH-00639455 IP26-00006883
Mrs GOGIKAR VAISHNAVI RANI
27-01-1999 27 Y 5 M 23 D (F)
Dr. SWATHI H V

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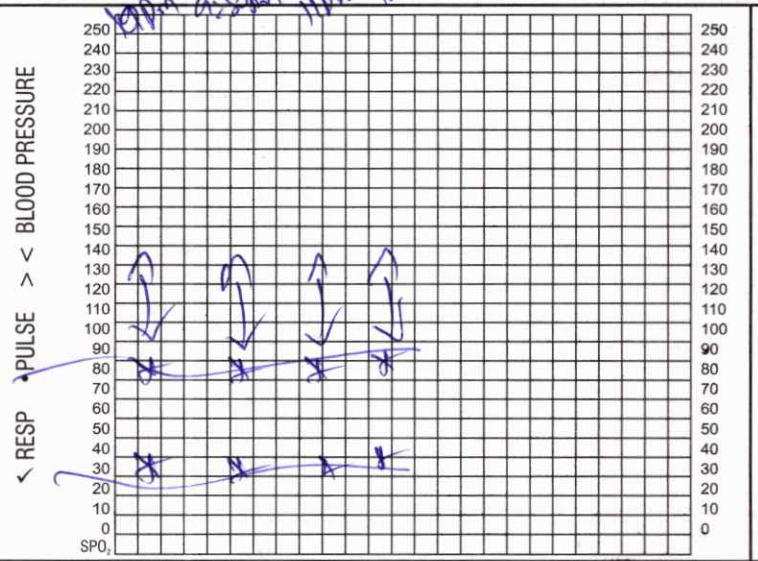
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sis Akhila Time Received : 10PM Time Discharged : 3AM

10PM 11PM 12AM 1AM 2AM 3AM



IV Cannula Site : left side

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

Vomiting : ☐ Yes ☑ No Drug: Inj Tarim

NG Tube : ☐ Yes ☑ No

Drain: ☐ Yes ☐ No

Urinary Catheter: ☑ Yes ☐ No

Chest Tube: ☐ Yes ☑ No

Nil Oral ☐ Yes ☐ No

IV Fluids: RL

Oral Feeds: 6AM

POST ANAESTHESIA SCORE (Modified Aldrete Score)		IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0 ACTIVITY		1	2	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0 RESPIRATION		2	2	2		
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		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
10A	10PM	0/10	NA	
20A	11PM	0/10	NA	
20A	12AM	0/10	NA	
20A	3AM	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 :

Anaesthesiologist Signature: Dr Sai Raj

Date & Time: 20/1/26

PACU Nurse Name : Akhila

PACU Nurse Signature:

Date & Time: 20/1/26

Transferred to Unit by (PACU): 302

Date & Time: 20/1/26

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 : .....

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 GOGIKAR VAISHNAVI RANI**	**Age :**	**27 Y 5 M 22 D**
IP No:	**IP26-00006883**	**Sex:**	**Female**
Consultant:	**Dr. SWATHI H V**	**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:.....)

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:

Name:

Relationship:

Date: Time:

Patient Address:
Kothagudem Kothagudem Bhadradri Kothagudem Telangana INDIA 507101

Wittness Name:

Wittness Signature:

26-00002152OO

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mrs Gogikar Vaishnavi Doni		Age: 27 Y.o	Gender: F
UHID No: BAH-0063945	IP No: 26-00006883	Date: 19/07/26	Time: 20:18
Diagnosis: Em LSCS (Dead. OT)			

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr. SAIRAM V

Doctor Registration No: APMC 75777

Signature:

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

IP Registration No: 26-00006883 Date: 19/07/26

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

1.	Name : Mrs Gogikar Vaishnavi Doni	Remarks
2.	Complete postal address (with contact number, if any)	Kothaguda, Tadgotha
3.	Brief description of the illness	Em 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
19/7	INJ. Fentanyl	01		

Dispensed by (Name & ID No.): Sapna (018402) M Arvind Kumar (021757) Signature:

Received by (Name & ID No.): ..... Signature:

Time: .....

26-00002152OO

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Mrs Gogikar Vaishnavi Doni		Age: 27 Years	Gender: F
UHID No: BAH-0063455	IP No: 26-0000688	Date: 19/07/26	Time: 20:18
Diagnosis: Em 1 SCS (1 scar · 07)			

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr Sairam.V Doctor Registration No: APMC 75777

Signature:

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

IP Registration No: 26-0000688J **Date:** 19/07/26

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

1.	**Name :** Mrs Gogikar Vaishnavi Doni	**Remarks**
2.	Complete postal address (with contact number, if any)	Kothaguden, Jagtial, Bhadradri
3.	Brief description of the illness	Em 1 SCS
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
19/7	INJ: Fentanyl	01		

Dispensed by (Name & ID No.): Rajya (01C002) Signature: .....

Received by (Name & ID No.): M Arvind Kumar (021257) Signature:

Time: .....

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name		Age	Gender
UHID No	IP No	Date	Time
Diagnosis			

PRESCRIPTION DETAILS (Use only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Tab Buprenorphine 0.2mg		
2.	Inj Morphine Sulphate 10mg/ml		
3.	Tab Methadone Hydrochloride 5mg / 10mg		
4.	Tab Tramadol Hydrochloride 50mg		

Doctor Name | Doctor Registration No

Signature

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

IP Registration No ..... Date .....

Address of the Patient (Optional) .....

S.No	Name	Remarks
1.	Complete postal address (with contact number if any)	
2.	Brief description of the illness	
3.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the same)	
4.	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb impression of the patient / Patient Attender	Remarks, if any

Dispensed by (Name & ID No) ..... Signature .....

Received by (Name & ID No) ..... Signature .....

Time .....

Date No. / Year (DD/MM/YY) .....