Name	Mrs SWETHA SARRAF	**UHID**	HNH-00015742
Father/Guardian	Mr NARESH KUMAR.S	**Age/Gender**	39 Y 7 M 8 D/ Female
Address	H.NO: 3-106/67/WP, STREET NO: 5, VIJAYANAGAR COLONY., Boduppal, Hyderabad, Telangana, INDIA, 500092		
IP No	IP26-00006481	**Admission Date**	03-06-2026
Ref Doctor	Self.		
Discharge Date	03.06.2026		

DISCHARGE SUMMARY

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

Diagnosis: P2L2 WITH 2 NVD WITH RIGHT BARTHOLIN CYST

RIGHT BARTHOLIN CYST DONE ON 03.06.2026

History: She came with complaints of painful sweeling near vagina. History of multiple course of Antibiotics since 3 years intermittently. USG on 02.06.2026 showed Uterus - anteverted and anteflexed, ET- 9.6 mm, Echogenic, Both Ovaries Visualised, Bartholin Cyst Measuring 38 * 25* 36 mm on the right labia majora noted.

Menstrual History:- Regular
LMP- 12.05.2026
Previous cycles: Regular with HMB

Name	Mrs SWETHA SARRAF	**UHID**	HNH-00015742
IP No	IP26-00006481	**Admission Date**	03-06-2026

Obstetric History: P2L2, 2 NVD, LCB-2020 years, tubectomy

Medical History: Nil
Surgical History: Nil
Allergies: Nil
Family History: Mother-T2DM

Investigations: Enclosed.
Blood group: "O" Positive

Surgery Notes:
Operation performed: Bartholin Cyst Excision under saddle block.

Indication: Bartholin cyst.

Operative findings:

1. 3*4 cms Bartholins cyst noted in Right loer 1/3rd of vagina.
2. 2-3 cms Incision give at muco cutaneous junction under INJ.adrenaline and Normal Saline infiltration.
3. Cyst enucleated from surrounding tissue.
4. Cyst wall completely enucleated and excised around 20ml fluid collected.
5. Cavity closed with Vicryl no. 2-0 with multiple haemostatic sutures.
6. Haemostatsis acheived.
7. Vaginal pack placed insitu.

Post-Operative Notes: - Uneventful.

Advice:

Name	Mrs SWETHA SARRAF	**UHID**	HNH-00015742
IP No	IP26-00006481	**Admission Date**	03-06-2026

1. Tab. Taxim O 200mg (Cefixime 200mg) twice daily till 07.06.2026 (9am - 9pm) after food.
2. Tab. Metrogyl 400mg (Metronidazole 400mg) thrice daily till 07.06.2026 (8am- 1 pm- 8 pm) after food.
3. Tab. Enzoflam (Paracetamol + Diclofenac Sodium + Serratiopeptidase) twice daily till 09.06.2026 (7am-17pm) after food.
4. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 09.06.2026. before food
5. Cap.lucap 1 tablet once daily (8pm) after food for 1 month.
6. Collect HPE and Culture and Sensitivity Report.

Review with **Dr. SWATHI H V,** after 1 **week** on 09.06.2026 at Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

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

Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 at Rainbow Children's Hospital just dial one toll free number - 18002122. You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

Name	Mrs SWETHA SARRAF	**UHID**	HNH-00015742
IP No	IP26-00006481	**Admission Date**	03-06-2026

Registrar/Resident/C.M.O

CHILDREN'S MEDICARE LIMITED RAINBOW HYDERABAD

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

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 : IP26-00006481 **Admit Date** : 03-Jun-2026 **Admit Time** : 08:42 AM **UHID** : HNH-00015742

Patient Details :

Patient Name	: Mrs SWETHA SARRAF	**Age**	: 39 Y 7 M 8 D
Guardian	: Mr NARESH KUMAR.S	**DOB**	: 26-10-1986
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: H.NO: 3-106/67/WP, STREET NO: 5, VIJAYANAGAR COLONY. Boduppal Hyderabad Telangana INDIA 500092	**Phone No**	: 9290433849/ 9063064219
		E-mail	: na@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 NARESH KUMAR.S **Relationship** : Husband

Contact Address : H.NO: 3-106/67/WP, STREET NO: 5, VIJAYANAGAR COLONY. Boduppal Hyderabad Telangana INDIA 500092 **Phone No** : 9063064219

Signature

Doctor Details :

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

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

Co-Consultant :

Payment Details :

Deposit Amount : 10000.00

Payment Mode : DC/CC Card **Payor Name** : FAMILY HEALTH PLAN INSURANCE TPA LTD

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ACTIVITY RECORD FOR BILLING

Name: ---------- HNH-00015742 IP26-00006481 ----------
Mrs SWETHA SARRAF
UHID No : -------- 26-10-1986 39 Y 7 M 8 D (F) --- Consultant : ---------- Dept : ----------
Dr. SWATHI H V
Date of Admissi[on] ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/6/26	9:~~00~~ AM	pre-post	OT	
3/6/26	10:10 AM	OT	pre-post	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
3/6	Infusion pump	10 AM	12:00 pm		Sujatha
3/6	Cardiac monitor	10 AM.	12:00pm	203849	
			Cross	checked 3/6/20	done 12:00pm

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
3/6/26	IV placement	1	203822	Ali
2/6/26	PAC OP	1	0011794f5	Ali
		Cross checked done 3/6/26		

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00015742 IP26-00006481
Mrs SWETHA SARRAF
28-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 3/6/2026 Time of Admission :

Allergies: nil ☐ Not know any drug allergies

PRESENTING COMPLAINTS :

- c/o painful swelling near vagina.

H/o multiple course of Abx - 3yrs on & off

L/e (R) Bartholin cyst of 3x3cm

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage :	Parity : P_2L_2
Previous Periods : Regular c 4MNB.	Mode of Delivery : 2NVD
LMP : 12/5/26	Last Child Birth : 7yrs back.
Contraception : Tubectomy	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil.	- Tubectomy.

HNH-00015742 IP26-00006401
Mrs SWETHA SARRAF
28-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

HISTORY:	MEDICATION HISTORY:
Mother - DM	Nil

INITIAL ASSESSMENT :

Date 3/6/26	Breasts	Local/Speculum Examination
Ht. 160 Wt. 54	(N)	(Rt) Bartholin cyst 3×3cm
BMI		
B.P	Abdominal Examination	Bimanual Pelvic Examination
Pallor (-)	P/A - Soft	
CVR S1S2 (+)		
Respiratory System B/L NVBS		
Thyroid (N)		

PROVISIONAL DIAGNOSIS : P_2C_2 /2NVD. ō (Rt) Bartholin cyst

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
Blood Group - Otve.	- NBM
HIV, HBsAg, HCV] NR.	- Prepare parts
Hb - 14.4	- Informed consent
PH - 2.4 lac	- Pre-op medications as charted
WBC - 11900.	- Inform OT / Anesthetist
	- Shift to OT on call

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

Date & Time : 3/6/26.

HNH-00015742 IP26-00006481
Mrs SWETHA SARRAF
26-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/06/2026 11:00am	c/s/by	Dr. Naveena.
	G/E GC-fair	Adv
	Afebrile SpO_2-95%	- Soft diet
	PR - 76bpm.	- Adequate hydration
	BP - 110/70mmHg	- Ambulation
	CVS/RS: NAD.	- Monitor Vitals
	PA: soft, NT	- drugs as charted
	I/E: no bleeding	- Inform SOS
	Vaginal Pack Insitu	- Pack to be removed before discharge
		Dr. Naveena.
3/06/2026 12:10pm.	c/s/by	Dr. Naveena
	dE GC-fair	
	Vitals- stable	
	patient	can be discharged
	noted by Alaf	Dr. Naveena

HNH-00015742 IP26-00006481
Mrs SWETHA SARRAF
26-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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OPERATION THEATER NOTES

Patient's Name : HNH-00015742 Mrs SWETHA SARRAF 26-10-1986 39 Y 7 M 8 D Dr. SWATHI H V (F) IP26-00006481 .... Age : .... Gender : ....

UHID.: .... P.No. : .... Weight : ....

Surgeon : Dr Swathi HV	Asst. Surgeon : Dr. Naveena
Anesthetist :	OT Nurse : [illegible]

Surgical Procedure :

Bartholin's cyst Excision

Indications for Surgery :

Bartholin cyst.

Date : 3/6/2026	Start Time : 9:25 AM	End Time : 10:00 AM

PRE-OPERATIVE PREPARATION :→ NBM.
iv fluids / Antibiotics
Parts preparations

OPERATION NOTES: → Pt. ↓ saddle block in lithotomy position.
→ 3x4 cm bartholin's cyst noted on Right lower 1/3rd of vagina.
→ 2-3 cm incision given @ muco-cutaneous junction. Inj Adrenaline + Normal saline infiltration given
+ Cyst enucleated from surrounding tissue
- cyst wall [illegible] completely enucleated & excised ~20 ml of fluid collected.
→ Cavity closed ō vicryl No.-2-0 with multiple haemostatic sutures.

- Haemostasis secured
- vaginal pack placed insitu

- procedure uneventful

Post op:

Inj. TAXIM 1gm iv stat before discharge

Inj. NEOMOL 1gm iv SOS

w/f PV bleeding

Remove Vaginal Pack before discharge.

POST - OPERATIVE ORDERS :

@ D/s:

- TAB TAXIM 200mg BD x 5d.
- TAB. METROGYL 400mg TID. x 5d.
- TAB. ENZOFLAM BD x 7days.
- CAP PAN 40 Once daily
- → Rev > 1 wk / SOS

[signature]

BHAWATHI. HV.

Consultant Surgeon's Name

[signature]

Consultant Surgeon's Signature

Date : 8/06/2026 Time : 10:45am.

HNH-00015742 IP26-00006481
Mrs SWETHA SARRAF
26-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

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RESULT SHEET

Date						
Time						
Hb	14.4					
PCV						
RBC						
WBC	11900					
N/L						
Platelets	2.7					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
blood group O+ve.						
HIV HCV VDRL NR						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00015742 IP26-00006481
Mrs SWETHA SARRAF
26-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

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MEDICATION RECONCILIATION FORM

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

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

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

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. G. Veena [signature]

Date & Time : 3/6/26 @ 8:30am

Nurse Name & Signature: Aadi @ Abi

Date & Time : 3/6/26 @ 8:30am

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

HNH-00015742 IP26-00006481
Mrs SWETHA SARRAF
28-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

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DRUG CHART

Date of Admission: ..... Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

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

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

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

HNH-00015742 IP26-00000451
Mrs SWETHA SARRAF
28-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

REGULAR PRESCRIPTIONS

Weight. 54KG Ward. UDS

DRUG : INJ. CEFOTAX MAC

Dose	Route	Frequency	Start Date
1g	IV	BD	3/6/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: ATD.

Daily Doctor's Endorsement by a Sign

Date/Time: 3/6

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Date
1000mg	P/O	TID	3/6/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time

DRUG : T. DICLOFENAC

Dose	Route	Frequency	Start Date
50mg	P/O	BD	3/6/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time

DRUG : T. TRAMADOL

Dose	Route	Frequency	Start Date
100mg	P/O	BD	3/6/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time

Mrs SWETHA SARRAF
28-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

Weight. 54kg Ward. LDR

E	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
3/6/26	8:45AM	INJ. PANTAPRAZOLE	40mg	IV		Not given
3/6/26	8:45AM	INJ. METOCLOPRAMIDE	10mg	IV		Not given. Not given.
3/6/26	—	BETADINE VAGINAL PESSARY	1tab	P/V		
3/6/26	9:45AM	DICLOFENAC Suppository	100mg	P/R		
3/6/26	9:45AM	TRAMADOL Suppository	100mg	P/R		
3/6/26	9:50AM	TRANEXAMIC ACID	1gm	IV		
3/6/26	9:05AM	Inj. CEFOTAXIME	1gm	IV		

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

Mrs SWETHA SARRAF
26-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

HNH-00015742 IP26-00006481

I.V. FLUIDS CHART

Weight. 54kg 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
3/6/26	3:50:00	RINGER LACTATE	IV	100ml/hr	[signature]	[signature] [signature]	03/06		[signature] [signature]
3/6/26	9:35 Am	RINGER LACTATE	IV	100ml/hr	[signature]	[signature] [signature]			[signature] [signature]
		STOP							

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

HNH-00015742 IP26-00006481
Mrs SWETHA SARRAF
26-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

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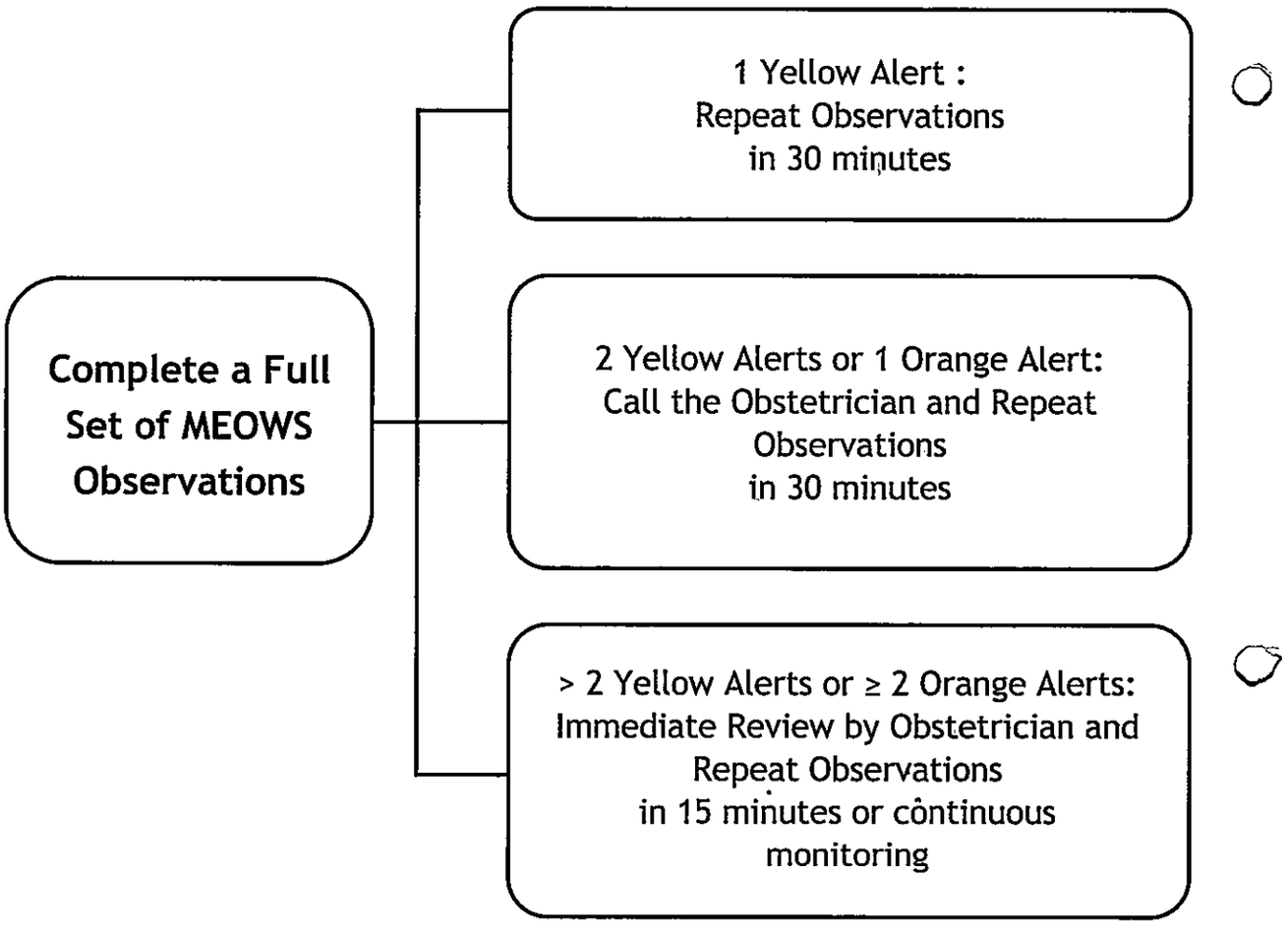
Early Warning Observation Score Chart - Obstetrics

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

3/6	Date																								
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20	20		20	20	20																			
	0 - 10																								
Saturations	94 - 100 %	100		99	98	98																			
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37	98°F		98°F		98°F																			
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80	87		83	81																				
	70					70																			
	60																								
	50																								
	40																								
Systolic Blood Pressure ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120	115		110																					
	110				115	101																			
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70	76		70	71	69																			
	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																			
TOTAL ORANGE SCORES		0		0	0	0																			
Nurse Initial		[illegible]		[illegible]	[illegible]	[illegible]																			

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00015742 IP26-00006481
Mrs SWETHA SARRAF
26-10-1986 39 Y 7 M 8 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.

3/6		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
3/6	08:00 am	RL	M	100ml								
	09:00 am	RL	M	100ml								
	10:00 am	RL	B	100ml								
	11:00 am	RL	M	100 cl								
	12:00 pm	RL		100cl								
	01:00 pm											
Total Intake :		Taken				**Total Output :**				Passed		
3/6/26	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	

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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 :**						
	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	

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CHECKLIST FOR THROMBOPHLEBITIS

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

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 : Sj Name : Sujatha

Signature of Ward In Charge :

Signature : K Name : KASTHURI

Docu. No. : RCH /FRM / CLINICAL / 137

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Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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BRADEN 'Q' SCALE

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				Date :	3/6			
				Time :	8AM			
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			
"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			
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			
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 oply requires changing every 24 hours.	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			
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			
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			
				TOTAL SCORE	28			
				Evaluator's Name	Fi			

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

Risk Score	Category	Action	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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PAIN ASSESSMENT FORM

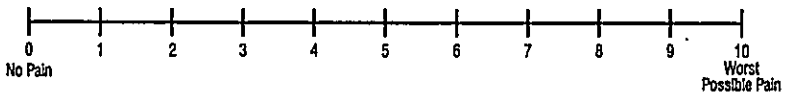
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/6	8AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
2/6/26	10Am	0/10	None	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
3/6/26	12pm	0/10	None	☐ 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		
		D/C		☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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NURSING CARE RECORD

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Date: 3/6/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am 2pm	- Assess the pt - plan for vitals - plan for IV fluids - plan for Tracheostomy	8am 2pm	- Assessed the pt condition - Maintain vitals - continue IV fluids - Maintain Tracheostomy	- patient stable	- vitals Normal	4 S
Afternoon				D/C			
Night							

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NURSING CARE RECORD

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Date: .....

Goals

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

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

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: Bartholin Cyst				Any Infection: ☐ Yes ☐ No ☐ ~~Not Known~~ If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift	3/6 8AM					
	Medical Condition (Any special condition to be noted):	NA					
	Diet:	NBM					
ASSESSMENT	Allergy:	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	NA					
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98F					
	Res:	20					
	SpO_2:	99%					
	Pulse:	85					
	BP:	117/75					
	LOC:	—					
	Fall Risk Score:	—					
	Pain Score:	—					
	Skin Integrity	—					
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	NA					
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	NBM					
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	NA					
Post Operative Procedure Special Orders:		NA					
Handed Over By Name :		[signature]					
Signature / ID :		[signature]					
Date:		3/6/26					
Time:		2PM					
Taken Over By Name :							
Signature / ID :		DK					
Date:							
Time:							

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. Swetha Sarraf Age: 39 yrs Sex: F UHID.No :

Date: 2/June/2026 Time: Proposed Operation: Bartholin cyst excision

Diagnosis: Bartholin cyst excision.

B.P / CRT: .... H.R: .... Weight: 54 kgs. ASA Physical Status: ☑1 ☐2 ☐3 ☐4 ☐5

Laboratory Data: 27/05/26

Hgb: 14.4	Glucose: 102 mg/dl	Protein:	HIV: NR	X-Ray:
PCV: 29	Urea:	Alb:	HBS Ag: NR	ECG:
WBC: 11900	Creat:	Total Bill:	HCV: NR	2D Echo:
Plate: 2.72	Na:	Dir. Bill:	Blood group: O+ve	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH 1.62	
	Cl -:	SGOT/SGPT:		

Allergies: No allergic reactions

Medical History: CVS : –

RESP : – Diabetes : –

CNS : –

Renal : –

Hepatic / GE : – Physical Activity: Active.

Others :

Past Anaesthetic History:

Physical Exam: conscious, coherent, co-operative

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: 3FB. Neck: (N) Teeth: NT

Lungs : BAE (+)

Heart: S1S2 (+)

CNS: No Neurological deficits.

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
No current medications	

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: (1) Written informed consent

Signature: [signature] Name: Dr. P. Geethanjali

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

HNH-00015742 IP26-00006481
Mrs SWETHA SARRAF
28-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R: 87/min | B.P / CRT: 119/70 | SpO_2: 98% @ RA | R.R: 18/min | Last Feed: > 6hrs

:00Am Pre-OP Diagnosis: BARTHOLIN CYST ~~cutting~~ Operation: BARTHOLIN CYST EXCISION Date: 03/06/26

Surgeon: ~~Dr.~~ Swathi, ~~Dr.~~ Naveena Anaesthesiologist: ~~Dr.~~ Ayesha Technician: Pallavi, Saichand

TIME	9:00 Am	9:15 Am	9:30 Am	9:45 Am	10:00 Am
N_2O /AIR /O_2 LPM					
HALO /SO /SEVO					
Drugs:	1ny: MIDAZOLAM 1mg IV 1ny: TRANEXAMIC Acid 1gm IV				
FIO$_2$ (SaO$_2$)	100/	100/	100/	100/	100/
ETCO$_2$					
ECG	SR	SR	SR	SR	SR
Temperature					
Urine Output					
Fluids / Blood	RL 1⊙				

Antibiotic: 1ny: CEFOTAXIME 1gm IV
Suppository: DICLOFENAC 100mg, TRAMADOL 100mg
Blood Loss: 15-20ml
NOTES

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

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

LAB Values: ABG | GRBS | Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: (Rt) UL
☐ Art Site:
☑ EKG Lead 3 lead
☐ Temp Site
☐ FIO$_2$ Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position:
☑ 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: 9:13Am
OP Start: 9:25Am
OP End: 9:55Am
Leave OR: 10:00Am

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☑ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: 20G on (Rt) UL
☐ 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: SADDLE BLOCK
☑ Spinal ☐ Epidural ☐ Caudal
Others:
Position: Sitting
Site: L4-L5
Needle Size: 27G Depth:
Parasthesia ☐ Yes ☑ No
Catheter at skin ..... cm
Drug Name & Conc: 0.5% HEAVY BUPIVACAINE
Bolus: 2.5ml [12.5mg]
Infusion:
Block Level: T10 - T12
Comments:

Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor: Dr. Sk. Ayesha
Signature of the Doctor:

HNH-00015742 IP26-00006481
Mrs SWETHA SARRAF
26-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Ali Time Received : 10 AM Time Discharged : 12:00pm

✓ RESP •PULSE > < BLOOD PRESSURE (chart, 0–250; SPO₂)

IV Cannula Site : yes

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

Vomiting : ☐ Yes ☑ No Drug: —
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☐ Yes ☑ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☑ No

IV Fluids: —
Oral Feeds: —

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	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	1	2	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	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	2	2	
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS	2	2	2	2	2	
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR	2	2	2	2	2	
		TOTAL	9	9	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
03/06	11 AM	"0"	Reassessment after 2-3 hrs	[signature]
3/6	12 pm	0/10	None	[signature]
			D/C	

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

Anaesthesiologist Name : Dr. Ayesha
Anaesthesiologist Signature: [signature]
Date & Time:

PACU Nurse Name : Karthi
PACU Nurse Signature: [signature]
Date & Time: 3/6/26 @ 12:00pm

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

Transferred to Unit by (PACU):
Date & Time:

HNH-00015742 IP26-00006481
Mrs SWETHA SARRAF
26-10-1986 39 Y 7 M 8 D (F)
Dr. SWATHI H V

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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 : .....

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs Sunetha Dasaf Age : 39 Gender : Male ☐ Female ☑

UHID NO: RAINH-15742 Surgeon Name: Dr. Sunetha

Anaesthesiologist : Dr. Samir Chayath

Operative procedure planned : Bartholin cyst excision.

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 : nil significant.

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 ..... the above mentioned operation / Diagnostic / Therapeutic procedures .....

I authorize and give consent for anaesthesia (☑ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the 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 : Mrs Swetha

Relationship with Patient: Self

Date & Time : 3/6/26 8:30AM

Witness :

Signature : .....

Name : .....

Date & Time : 3/6/26 @ 8:30AM

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Varun Chaya

Date & Time : 3/6 at 8:45 am

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs. Shweta. Saraf. Gender: ☐ Male ☑ Female Age : 39 YRS

UHID No : HNH-0001742. Date : 3/6/26

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

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

BARTHOLIN CYST EXCISION

upon

(Name of the Patient) MRS. SWETHA SARAF

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

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

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

Excessive bleeding, wound infection, recurrence, inadvertant injury to urethra, anus & perineal structures.

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 :

Name : Mrs. Shweta.

Date & Time : 3/06/2026 @ 8:35am.

Patient Attendant :

Signature :

Name : Naresh.

Relationship with Patient: Husband.

Date & Time : 3/06/2026 @ 9:00am.

Witness :

Signature :

Name : kavitha

Date & Time : 3/6/26 @ 9am

Doctor (who is taking the consent) :

Signature :

Name : Dr. Sweta

Date & Time : 3/6/26 @ 8:55am

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PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015742 IP26-00006481 Mrs SWETHA SARRAF 26-10-1986 39 Y 7 M 8 D (F) Dr. SWATHI H V	3/6/26 @	3/6/26 @ 9:00 AM
	Transfer Ordered by	Reason for Transfer
	DR. Naveen	Bartholin cyst
From Unit	To Unit	Information to Attendant
Pre - post	OT	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 ?
28	—	

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. Alabi	DR. Naveena

Patient & Clinical Records Received by : Durga 3/06/26

Date & Time of Patient Received :

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

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

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swathi
Asst. Surgeon : Dr. Naveena
Anaesthetist : Dr. Samar
Scrub Nurse : Br. Sudipta

Patient Name : HNH-00015742 IP26-00006481 Mrs SWETHA SARRAF 26-10-1986 39 Y 7 M 8 D (F) Dr. SWATHI H V
UHID No. :
Date : 3/6/26

Gender : female

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 9:00Am.

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 : Dr. Ayesha
Name : Dr. SK. Ayesha

Before Skin Incision ➤➤

TIME OUT Time: 9:20 AM

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

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

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, 30mm 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 :
Name : Sudipta

Before Patient Leaves Operating Room

SIGN OUT Time: 10:00AM

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 :
Name : Dr. Swathi

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00015742 IP26-00006481 Mrs SWETHA SARRAF 26-10-1986 39 Y 7 M 8 D (F) Dr. SWATHI H V	3/6/26 @ 8:42AM	3/6/26 @ 10:10 AM
	Transfer Ordered by Dr. samir	Reason for Transfer Observation
From Unit OT	To Unit Prepost	Information to Attendant 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
Puja	Dr. samir

Patient & Clinical Records Received by : kavitri 3/6/26 @ 11hrs

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