

HNH-00015507 IP26-00006403
 Mrs CHETNA JAIN
 09-08-1955 70 Y 9 M 13 D (F)
 Dr. MEENA UGALE



SURGERY DETAILS

Date : 22/05/26

Patient Name: Mrs. Chetna Jain Date of Birth: Age: 70yrs

Gender: Female Ward: OT UHID No: HNH-00015507

Date of Surgery: 22/05/26 OT-1 OT-2 OT-3 OT-4 OBG OT-1 OBG OT-2

Name of the Surgery : vaginal hysterectomy with bilateral oophorectomy + posterior colporrhaphy

Time in : 3:15 PM Time Out : 6 PM

	NAME	AMOUNT
1. Surgeon	Dr. Meera Ugle	
2. Anaesthetist	Dr. Ayesha	
3. Assistant Surgeon	Dr. Umadevi	
4. OT Technician	Dr. Sat Chandra	
5. Circulating Nurse	Dr. Balu Dr. Sudeepa	
6. Assistant Nurse	Sr. Surgeeba Sr. Archana	

Mrs CHETNA JAIN (70 Y 9 M 13 D / F)
 UTERS
 HNV00213
 HN26008665UTERS
 /06100015507

- Special Equipment: Laparoscopy Bronchoscope Harmonic Morcelator
 C-ARM Cystoscopy Versa Point Liver Cusa
 Neuro Cusa Others

(Dr. Sanyal) & (Dr. Sanyal) for Dr. Meera Ugle
 Signature of the Surgeon

Signature of Circulating Nurse

Order No: 26-0000201614 Order by: Sushrutha 23/05/26

@ 11:31 AM

vaginal hysterectomy



CONSUMABLES OF OT

Circulating staff : Subrata Technician : Sachin Date : 22/5/26 Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack <u>Cervical pack</u>	ON		Inj Vit.K		
LMA			Sutures <u>2346</u>	5		Cord Clamp		
ECG leads : A/P/N		03	<u>1226-5062</u>	1		Suction Catheter		
HME filter : A/P/N						Feeding Tube		
Syringes : 10 cc		03				Vacuum Suction Set		
05 cc		03	Gloves <u>S-L 6/2</u>	05		Surgical Gloves		
02 cc		03	<u>6/2</u>	03		Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A/P/N		ON	Surgical blade <u>22</u>	ON		Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		02	Cautery pencil	ON				
NS : 10ml / 100ml / 500ml / 1000ml			Koochies <u>224</u>	ON				
<u>Put under</u>		01	Ointments					
<u>02 mask (A)</u>		01	Suction Catheter					
Fentanyl		-	Cap, Mask	20				
Morphine			Gauze Pack	02				
Ketamine			Mop Pack	01				
Propofol			Steristrip					
Rocuronium			Underpad	02				
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel	01				
Ondansetron			Foleys catheter	01				
Pencan 25g/ Spinal Needle 22		01	Urobag	01				
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)		01	Romodrain bag					
Antibiotics			Bandage <u>Hepleguard</u>	01				
			Tegaderm					
Suppositories			Ioban <u>LOX 2%</u>	01				
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vacuum Suction set	02				
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet <u>Amey</u>	5				
Tab. Misoprost : 200mg			Betadine Solution	02				
<u>Blood set</u>		ON	Microshield	01				
<u>Gauze</u>		ON	Cotton Balls	01				
<u>more glove 6/2</u>		ON	Latex Gloves	20				
			Ramdione Scrub <u>01/0</u>	02				
			Saral <u>needle 18</u>	01				



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00015507 Name : Mrs CHETNA JAIN
 Age / Sex : 70 Y 9 M 13 D / Female Doctor : MEENA UGALE
 Adm/Reg Date/Time : 22/05/2028 12:55 Payor : MEDI ASSIST INSURANCE TPA PVT LTD
 Order Date : 22/05/2028 19:13 Ordernumber : 26-0000201489
 Visit ID : IP26-00006403 Ward/Bed No : 4F -OT / PDA-414
 Patient Address : 4-1-1090/1, Abids Road, Hyderabad, Telangana, INDIA, 500001

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Dispensed
2	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	MERSILK 1-0 NW 5062	MERSILK 5062	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
4	SURGEON CAP(FEMALE) (PROTECTCARE)		1 Nos	/ Once Daily	1 Days		20 Nos	Dispensed
5	VICRYL 1-0 VP 2348	VICRYL 1-0 VP 2348	1 Nos	/ Once Daily	5 Days		5 Nos	Dispensed
6	BUPICAN HEAVY 80MG INJ 4ML	BUPIVACAINE 80MG INJ	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
7	MONOCRYL 3-0 NW 1326	MONOCRYL 1326	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
8	MEZOLAM INJ 5 MG 5 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
9	FOLEYS CATHETER 14-URO CATH		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
10	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
11	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
12	D WATER 10 ML AMPULE	DISTIL WATER10ML	1 Bottle	External / Once Daily	1 Days		2 Bottle	Dispensed
13	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
14	CAUTERY PENCIL (ADVANCE)	CAUTERY PENCIL (ADVANCE)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
15	UROBAG (ADULT)- URODYNE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
16	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
17	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
18	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
19	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
20	LEGGINGS DISPOSABLE (PROTECTCARE) BIG		1 Nos	/ 12th Hourly	1 Days		1 Nos	Dispensed
21	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	/ Once Daily	20 Days		20 Nos	Dispensed
22	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
23	ABGEL SURGI PAD (BIG) (GELSPON)	ABGEL	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
24	BLOOD SET WITH LUER LOCK	BLOOD SET LUER LOCK	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
25	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
26	PENCAN 25G*3 1 2	PENCAN 25G*3 1 2	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

MEENA UGALE

Reg No : 18967

* 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.



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00015507 Name : Mrs CHETNA JAIN
 Age / Sex : 70 Y 9 M 13 D / Female Doctor : MEENA UGALE
 Adm/Reg Date/Time : 22/05/2026 12:55 Payor : MEDI ASSIST INSURANCE TPA PVT LTD
 Order Date : 22/05/2026 19:13 Ordernumber : 26-0000201488
 Visit ID : IP26-00006403 Ward/Bed No : 4F -OT / PDA-414
 Patient Address : 4-1-1090/1, Abids Road, Hyderabad, Telangana, INDIA, 500001

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	NITRILE EXAMINATION GLOVES P F- MEDIUM	NITRILE GLOVES M	1 Nos	/ Once Daily	20 Days		20 Nos	Ordered
2	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		4 Nos	Ordered
3	NEEDLE 18 * 1 1 2	DISPOSABLE NEEDLES 18X1.5	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
4	DISPOSABLE APRONS STERILE XL	DISPOSABLE APRON STERILE XL	1 Nos	/ Once Daily	5 Days		5 Nos	Ordered
5	UNDERPADS 60X90 BUTTERFLY		1 Nos	External / 10 AM	1 Days		2 Nos	Ordered
6	THEMICAINE 30GM JELLY		1 On Application	External / Once Daily	1 Days		1 Nos	Ordered
7	GENERAL SURGICAL KIT (MEDITAKE)	GENERAL SURGICAL KIT	1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
8	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		5 Nos	Ordered
9	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
10	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
11	GAUZE 7.5X7.5 12 PLY (5 NOS)	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
12	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		5 Nos	Ordered

MEENA UGALE

Reg No : 18967

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Name	Mrs CHETNA JAIN	UHID	HNH-00015507
Father/Guardian	Mr NARSING RAO	Age/Gender	70 Y 9 M 13 D/ Female
Address	4-1-1090/1, Abids Road, Hyderabad, Telangana, INDIA, 500001		
IP No	IP26-00006403	Admission Date	22-05-2026
Ref Doctor	Self.		
Discharge Date	25.05.2026		

DISCHARGE SUMMARY

Consultants :

Dr. MEENA UGALE

MBBS,MD

OBSTETRICIAN & GYNAECOLOGIST

18967

Diagnosis: GRADE 2 UV PROLAPSE WITH CYSTOCELE

VAGINAL HYSTERECTOMY + BILATERAL SALPINGECTOMY + POSTERIOR COLPOPERINEORRHAPHY WITH CONSERVATION OF OVARIES DONE ON 22.05.2026

History: She presented with complaints of mass per vaginum since 6 months, associated with pain abdomen. USG done (03.02.2026) showed uterus

Name	Mrs CHETNA JAIN	UHID	HNH-00015507
IP No	IP26-00006403	Admission Date	22-05-2026

(49x20x26mm) with normal contours and myometrial echotexture, ET 6mm, both ovaries are not clearly visualised. Left renal calculus with grade 1 hydronephrosis, Thickened Endometrium ET 6mm. She was admitted for vaginal hysterectomy with bilateral salpingectomy with posterior colpo-perineorrhaphy.

Menstrual History:-

Attained menopause 20 years ago

Obstetric History: P2I2, 2 NVD, LCB 42 years ago

Medical History: k/c/o HTN since 13 years(on Tab Atenolol + Nifedipine 20 mg OD) **Surgical History:** Nil

Family History: Nil

Allergies: Nil

Investigations: Enclosed.

Blood group : " B " Positive

Surgery Notes:

Operation performed:

VAGINAL HYSTERECTOMY + BILATERAL SALPINGECTOMY + POSTERIOR COLPOPERINEORRHAPHY WITH CONSERVATION OF OVARIES

Indication: UV PROLAPSE GRADE 2 + MILD CYSTOCELE + MILD RECTOCOELE + LAX PERINEUM

Operative findings:

- 2 degree UV prolapse + infravaginal elongation of cervix decent upto

Name	Mrs CHETNA JAIN	UHID	HNH-00015507
IP No	IP26-00006403	Admission Date	22-05-2026

introitus with mild cystocoele

- uterus atrophic , Bilateral fallopian tube normal, same removed.
- Bilateral ovaries- atrophic and high up, same conserved
- Lax perineum
- Bladder base highly vascular.

Procedure:

- Anterior UV fold opened and posterior POD opened
- Bilateral uterosacral & mackenrodt's logament clamped and cut & ligated
- Bilateral fallopian tube cauterized and cut and sent for HPE
- Vault closed after pushing bladder up
- Posterior Colpoperineorrhaphy done in view of lax abdomen
- Vagina packed with betadine pack.

Post-Operative Notes: She was closely monitored in the postoperative period. Her vital signs remained stable. She was encouraged to ambulate. Vaginal pack removed on ---. On third post operative day Foleys removed and she voided spontaneously. She was shifted to room. Her general condition was satisfactory and she was found to be fit for discharge. Medications were explained to the patient supplemented by written information.

Advice:

1. T. Ceftum 500mg (Cefuroxime axetil) twice daily (9am-9pm) till 29.05.2026 after food.
2. Tab Metronidazole 400mg (8am-3pm-10pm) thrice daily till 29.05.2026 after food
3. T. Pantop 40mg(Pantaprazole) once daily at 8am till 29.05.2026 before

Name	Mrs CHETNA JAIN	UHID	HNH-00015507
IP No	IP26-00006403	Admission Date	22-05-2026

food.

4. Tab Hifenac P (Aceclofenac 100 mg+Paracetamol 325mg) thrice daily (8am-3pm- 10pm) till 29.05.2026 after food.
5. Tab Zofer (Ondansetron) 8mg SOS (for nausea/ vomiting)
6. T. Zincovit once daily at 2 pm for 1 month.
7. T.Softeron Gold once daily before lunch (12pm) for 2 months
8. Collect HPE report.
9. Continue previous medication as advised

Review with **Dr. MEENA UGALE** after **1** week with CBP on **01.06.2026** at Gynac OP 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 Himayatnagar or 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 CHETNA JAIN	UHID	HNH-00015507
IP No	IP26-00006403	Admission Date	22-05-2026



Registrar/Resident/C.M.O

Dr. MEENA UGALE
MBBS,MD
OBSTETRICIAN & GYNAECOLOGIST
18967

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006403 Admit Date : 22-May-2026 Admit Time : 12:55 PM UHID : HNH-00015507

Patient Details :

Patient Name : Mrs CHETNA JAIN Age : 70 Y 9 M 13 D
Guardian : DOB : 09-08-1955
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : 4-1-1090/1 Abids Road Hyderabad Telangana Phone No : 9700029708/ 8074026895
INDIA 500001 E-mail : pradeep0811981@gmail.com

Admission Details :

Bed Type : TWIN SHARING Bed No : PDA-414 Ward Name : 4F -OT
Room No : PDA-414 Admission Type : First Visit

Contact Details :

Name : Relationship :
Contact Address : Phone No :


Signature


Doctor Details :

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

Payment Details :

Payment Mode : Cash Deposit Amount : 10000.00
Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

PATIENT TRANSFER FORM

HNH-00015507 IP26-00006403 Mrs CHETNA JAIN 70 Y 9 M 14 D (F) Dr. MEENA UGALE 		Date & Time of Admission 22/05/26 @ 12:55 PM	Date & Time of Transfer Order 23/05/26 @ 12 PM
Dr. Meena,		Transfer Ordered by Dr. Meena	Reason for Transfer OBS
From Unit OBS	To Unit ROOM	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 35	Number of Imaging Films NIL	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	PC - SOMC	①	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Meena		Name of Person Ordered Transfer Dr. Meena	
Patient & Clinical Records Received by : maheshwari			
Date & Time of Patient Received : 23/5/26 @ 12: PM			

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

ACTIVITY RECORD FOR BILLING

Name: -----

UHID No : ----- || **HNH-00015507** **IP26-00006403**
Mrs CHETNA JAIN
09-08-1955 **70 Y 9 M 13 D** (F)
Dr. MEENA UGALE

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/5/26	3:10 PM	Pre - post	Room OT	Sujatha / Sangeetha
22/5/26	6:10 PM	OT	Pre post	Sangeetha / Sujatha
23/5/26	12:10 PM	MICU	Room (306)	Sujatha

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
22/5	GRBS - 187mg/dl @ 6:10pm	✓ 8666 ✓	AKA/la
23/5	CBP	✓ 8671 ✓	②
<hr/>			
Cross checked done by			
Sunanda ✓			
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consumed by table			
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PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
22/5	IV placement	①	201373	Sujatha
20/5	PAC (op)		PR56-000 205431	Sri
22/5/26	Catheterization	①	201484	AKK/9
				cross checked by
23/5	IV placement	①	1748	[Signature]
cross checked done				
by Sumanth				
24/5/20	N/A	①	1795	[Signature]
cross checked done				
by pojanika				

ANY OTHER INFORMATION

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Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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HNH-00015507
 Mrs CHETNA JAIN IP26-00006403
 09-08-1955 70 Y 9 M 13 D (F)
 Dr. MEENA UGALE



FOR GYNECOLOGY

Date of Admission : Time of Admission :

Allergies: Not know any drug allergies

PRESENTING COMPLAINTS :

cl: pain abd. ∴ 6 months
 cl: prolapse uterus - ~~no~~ mass p/v ∴ 6 months
 ↓
 USG (3/2/26).
 Hydromphrosis - Grade 1 = (P) Renal calculi
 ET = 6mm

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 4 yrs	Parity : P2L2
Previous Periods : Regular	Mode of Delivery : FT-NVD
LMP : 20 yrs back - Menopause	Last Child Birth : 42 yrs back.
Contraception : ..	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
HTN ∴ 13 yrs on Rx. T. Preslar 50mg OD	Nil.



MEDICATION HISTORY:

On T. Prisolar 30mg OD

~~APP~~

Nil

INITIAL ASSESSMENT :

Date <u>22/5/26</u> Ht. _____ Wt. <u>60kg</u> BMI _____ B.P. <u>100/90</u> → Pallor <u>(-)</u> CVR <u>S, S₂ (+)</u> Respiratory System <u>Clear N VBS</u> Thyroid <u>(N)</u>	Breasts <u>(N)</u> Abdominal Examination <u>P/A - Soft</u>	Local/Speculum Examination <u>(-)</u> Bimanual Pelvic Examination <u>(-)</u>
--	---	---

PROVISIONAL DIAGNOSIS : P₂L₂/2NVD (post-menopausal ~~men~~ women) = ~~2^o~~ 2^o Prolapse & cystocele (+).

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
Blood Group - <u>B positive</u> Hb - <u>13.9</u> Plt - <u>3.1 Lakh</u> WBC - <u>7.3k</u> HIV HbsAg HDRL] <u>NR.</u> USG (3/2/26) - <u>(+) renal calculus (+) Grade-1 Hydronephrosis</u> Ut - <u>4.9 x 2.6cm, Et = 6mm.</u> Blc Ovaries <u>(thickened) (N)</u>	<u>VH + PFR + BSG</u> - Informed consent - Prepare parts - Pre op medications as checked - Inform OT / Anesthetist - Shift to OT on call

Name of the Doctor : Dr. Meena Ugale

Signature of Doctor [Signature]

Date & Time : 22/5/26

[Signature]



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/2016 6pm	cls/b	Dr Meena Ugale Dr Mansha
	Poc-o / SIP	Vaginal hysterectomy c SS
	AC For Afebrile	Adv
	BP 166/99	- NBM till further orders
	PR 60	- IVP/Analgesics as per Axam
	SpO ₂ 98% on O ₂	- Drugs as charted
	PIA soft	⊕ CBP @ 12 AM
	L/E NAD	- Foley's insitu x 48 hr (inform)
	U/O 400 cc (or empty)	- W/F vitals q 4hr sonolene
		- I/O monitoring
	Vaginal Pack insitu	- Inform SWS
	(to be removed after 24hr)	
	↳ Inform	
23/5/2016 10:pm	cls/b @ Mansha	Mansha Mansha
	AC For Afebrile	Adv
	BP 150/88	- CBP @ 12 AM
	PR 71	- Drugs as charted
	SpO ₂ 98%	- W/F vitals q 4hr
	PM soft	
	L/E NAD	
	U/O 400 cc clear	Mansha Mansha

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 Dr. MEENA UGALE



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

BirthRight[™]
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/2018	Ces/ls @ Mansha	
3 AM	P000	
		Adv
	Qe Far Afekorde	- NBM
	BP 130/88	- Drugs as chart
	PR 78	- w/f vitals & BM
	PIA soft BS	- No mummy
	LE - NATD	- Inform s/s
	w/o 40 c/w clear	
23/5	CBC - H+2/13.28/300 - informed to Manu	by @mansha
	- (Vag pack in situ)	
23/5/2018	Ces/ls @ Mansha	
7:40 AM	P000	
		Adv
	Qe Far Afekorde	- NBM Allow Sips - w/f vitals & BM
	BP 130/79 - 150/80	- Drugs as chart
	PR 67	- Strict vital monitoring
PR	PIA soft BS ⊕	- No mummy
	LE NATD	- Foley's insert & flush
	w/o - 40 c/w clear	- Sprometry
		- Inform s/s
	(Vaginal pack inserted) - to be removed x 24 hr after	by @mansha

HNH-00015507

Mrs CHETNA JAIN

09-08-1955

Dr. MEENA UGALE

IP26-00006403

70 Y 9 M 13 D (F)



2



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5/2026	<p>10/10 Axm. (Dr Ayasha)</p> <p>Adv - - Combuc Anthyptecusum</p> <p>- w/f vitals</p> <p>- Infirm su</p>	
		<p>by Anushka Mamta</p>
23/05/2026		
11:15am		<p>obs by Dr. Meena Ugale</p>
	<p>ole GC-fair</p> <p>Afebrile.</p> <p>Vitals - stable</p> <p>PA - soft, NT</p> <p>UE: NAD</p> <p>ULO: 70-80ml/hr</p> <p>clear.</p>	
		<p>Adv</p> <p>- liquid diet ALB.</p> <p>Soft diet</p> <p>- Adequate hydration.</p> <p>- Foley's removal</p> <p>TLM evening (48 hrs post Surgery)</p>
		<p>- Vaginal Pack.</p> <p>Today evening (26pm)</p>
		<p>- drugs as charted.</p>
		<p>- Spirometry</p>
		<p>- Monitor Vitals</p>
		<p>- Infirm SOS</p>
	<p>Kindly shift the patient to room.</p>	
	<p>Dr. Naveena</p>	

Noted by swathi 23/5/26 (E.O.)

HNH-00015507
 Mrs CHETNA JAIN
 09-08-1955 70 Y 9 M 13 D (F)
 Dr. MEENA UGALE

IP26-00006403

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/26 6:30 pm	<p style="text-align: right;">c/s/B Dr. Veena</p> <p><u>POD-1</u> / s/p v/h + BS</p>	
Flatus ✓	<p>Pt is stable, No c/o of GC-fair, Afebrile Vitals - Stable BP - 133/80 mmHg RR - 20/min P/A - Soft, NT U/E - Vaginal pack removed (No Soakage). U/O - 100ml/hr; clear urine.</p>	<p>Adv - Soft diet - Vital monitoring, BP monitoring - T/O charting - Remove Foley's tomorrow (@ 6pm)</p>
		<p>- Drugs as charted - Inform SOS</p> <p style="text-align: right;">Noted by madhu</p>
24/5/26 8 am	<p style="text-align: right;">c/s/B Dr. Veena</p> <p><u>POD-2</u> / s/p v/h + BS</p>	
Flatus ✓ Stool Sx.	<p>Pt is stable c/o 1 episode of vomiting @ 7am of GC-fair, Afebrile BP - 138/82 mmHg PR - 68 bpm. P/A - Soft, NT U/E - NAD U/O - 100ml/hr, clear urine</p>	<p>Adv ✓ Soft diet ✓ Vital monitoring ✓ T/O charting ✓ Remove Foley's @ 6pm today ✓ Drugs as charted ✓ T/O: tramadol stop ✓ Inform SOS ✓ Stop T-Tramadol</p> <p style="text-align: right;">MB Sunanda</p>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/5/26	cls/B Dr. Duda	
12:30pm	POD-2 (VH+BST. @PCR)	
	No. complaints	Adv
	Gc Fair, Afebrile	- Soft diet.
flatus ✓.	BP: 136/72 mmHg	- Drugs as charted.
	PR: 67 bpm	- stop Inj Metronidazole.
	SPO ₂ : 99% on RA.	- Urine I/O charting
		- Remove Foley's at 6pm.
		- Monitor vitals,
Pt can be discharged tomorrow		- Inform sos
24/5/26	POD 2	
1:30 pm	Seen by Dr Meena Ugale	
	Gc good	
	fleys to be removed in the evening	
	for discharge tomorrow	
		meena ugale
		NB- Supriya
		1:32pm @ 24/5/26

HNH-00015507 IP26-00006403
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DRUG CHART

Date of Admission: 22/5/26 Drug Allergies: NIL 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 _____ Sign _____



REGULAR PRESCRIPTIONS

Weight: Ward:

DRUG : <u>IND- CEFEPAZONE SULBACTAM</u>				Date Time	22/5 23/5 24/5
Dose	Route	Frequency	Start Date		
1.5g	IV	BD	22/5/26	3AM X	23/5
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions: ATD (till Discharge)				3AM X	
Daily Doctor's Endorsement by a Sign					

DRUG : <u>3g- PARACETAMOL</u>				Date Time	22/5 23/5
Dose	Route	Frequency	Start Date		
1gm	IV	TID	22/5/26	6AM X	23/5
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions: IV for 24 hr followed by oral				10PM	
Daily Doctor's Endorsement by a Sign					

DRUG : <u>3g- TRAMADOL</u>				Date Time	22/5 23/5
Dose	Route	Frequency	Start Date		
100mg	IM	BD	22/5/26	11AM X	23/5
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions: To be converted to oral after 24hr.				11PM	
Daily Doctor's Endorsement by a Sign					

DRUG : <u>3g- TRANEXAMIC ACID</u>				Date Time	22/5 23/5 24/5
Dose	Route	Frequency	Start Date		
500mg	IV	BD	22/5/26	8AM X	23/5
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:				8PM	
Daily Doctor's Endorsement by a Sign					

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG: INJ TINDAZOLE				Date Time																	
Dose	Route	Frequency	Start Dt.																		
800mg	IV	OO	22/5																		
Name & Signature of the Doctor Starting the Drugs:																					
<i>M. Orsankar</i>																					
Additional Instructions:																					
<i>full Discharge</i>																					
Daily Doctor's Endorsement by a Sign																					
DRUG: INJ ANTOPIRONE				Date Time																	
Dose	Route	Frequency	Start Dt.																		
40mg	IV	OO	22/5																		
Name & Signature of the Doctor Starting the Drugs:																					
<i>M. Orsankar</i>																					
Additional Instructions:																					
<i>full Discharge</i>																					
Daily Doctor's Endorsement by a Sign																					
DRUG: INJ METRONIDAZOLE				Date Time																	
Dose	Route	Frequency	Start Dt.																		
500mg	IV	7ID	22/5																		
Name & Signature of the Doctor Starting the Drugs:																					
<i>M. Orsankar</i>																					
Additional Instructions:																					
<i>full Discharge</i>																					
Daily Doctor's Endorsement by a Sign																					
DRUG: 7 ATENOLOL				Date Time																	
Dose	Route	Frequency	Start Dt.																		
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					

VERIFIED BY: Name: Signature:



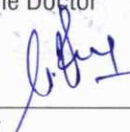



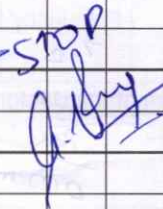

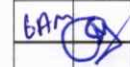
HNH-00015507 IP26-00006403
 Mrs CHETNA JAIN
 09-08-1955 70 Y 9 M 13 D (F)
 Dr. MEENA UGALE



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : T. ATELLOL + NIFEDIPINE				Date Time	23/5																	
Dose	Route	Frequency	Start Dt.																			
20mg	PO	OD	23/5																			
Name & Signature of the Doctor Starting the Drugs:				 																		
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						
DRUG : T. PARACETAMOL				Date Time	23/5																	
Dose	Route	Frequency	Start Dt.																			
1g	PO	TID	23/5/26	6AM	✓																	
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:				2PM ✓ 																		
Daily Doctor's Endorsement by a Sign																						
DRUG : T. TRAMADOL				Date Time	23/5																	
Dose	Route	Frequency	Start Dt.																			
100mg	PO	BD	23/5/26	11AM	✓																	
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:				 STOP 																		
Daily Doctor's Endorsement by a Sign																						
DRUG : T. PANTAPRAZOLE				Date Time	24/5																	
Dose	Route	Frequency	Start Dt.																			
60mg	PO	OD	24/5/26																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:				6AM  Before Food																		
Daily Doctor's Endorsement by a Sign																						

Signature

VERIFIED BY: Name

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Weight. Ward.



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

VARIABLE DOSE		Date Time	Nurse Sig.	Date Time	Nurse Sig.	Date Time	Nurse Sig.	Date Time	Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route		Dose		Dose		Dose		Dose	
Start Date		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
22/5/26	2:40pm	INS- PANTAPRAZO CE	40mg	IV	[Signature]	Akhil Anshu
22/5/26	2:50pm	INS- METOCLOPRAMIDE	10mg	IV	[Signature]	Akhil Anshu
22/5/26	4:00pm	4g- TRANEXAMIC ACID	1gm	IV	[Signature]	[Signature]
22/5/26	5:20pm	1g- LABETALOL	5mg	IV	[Signature]	[Signature]
22/5/26	5:40pm	TRAMADOL Suppository	100mg	PR	[Signature]	[Signature]
23/5						
24/5	8:10AM	INS- ONDANSETRON	8mg	IV	[Signature]	[Signature]

VERIFIED BY : Name Signature



I.V. FLUIDS CHART

Weight. Ward.

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
22/5/26	1 PM	RINGER LACTATE	IV	100 ml/hr	[Signature]	[Signature]	22/5	[Signature]	[Signature]
22/5	5 PM	RINGER LACTATE	IV	80 ml/hr	[Signature]	[Signature]	22/5	[Signature]	[Signature]
22/5/26	3:00 PM	RINGER LACTATE	IV	700 ml/hr	[Signature]	[Signature]	22/5	[Signature]	[Signature]
22/5/26	4:30 PM	RINGER LACTATE	IV	500 ml/hr	[Signature]	[Signature]	23/5	[Signature]	[Signature]
23/5	1 AM	RINGER LACTATE	IV	100 ml/hr	[Signature]	[Signature]	23/5	[Signature]	[Signature]
23/5	4 AM	RINGER LACTATE	IV	100 ml/hr	[Signature]	[Signature]	23/5	[Signature]	[Signature]
23/5	3 PM	RINGER LACTATE	IV	100 ml/hr	[Signature]	[Signature]		[Signature]	[Signature]
STOP									
[Signature]									
23/5/26.									

Signature

INITIALED BY: Name

12:55

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 Children's
 Hospital
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RESULT SHEET

Date	19/5/26	28/5			
Time	1	12 AM			
Hb	13.9	11.2			
PCV		32.0			
RBC		3.93			
WBC	7.3	13.28			
N/L		90.6/6.7			
Platelets	3.1	300			
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 = B+ve																							
<table border="0"> <tr><td>HIV</td><td rowspan="3">}</td><td rowspan="3">NR</td><td colspan="4"></td></tr> <tr><td>HbS/Ag</td><td colspan="4"></td></tr> <tr><td>HCV</td><td colspan="4"></td></tr> </table>							HIV	}	NR					HbS/Ag					HCV				
HIV	}	NR																					
HbS/Ag																							
HCV																							

Culture and Sensitivities :

.....

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.....

Radiology : USG :

 X-Ray :

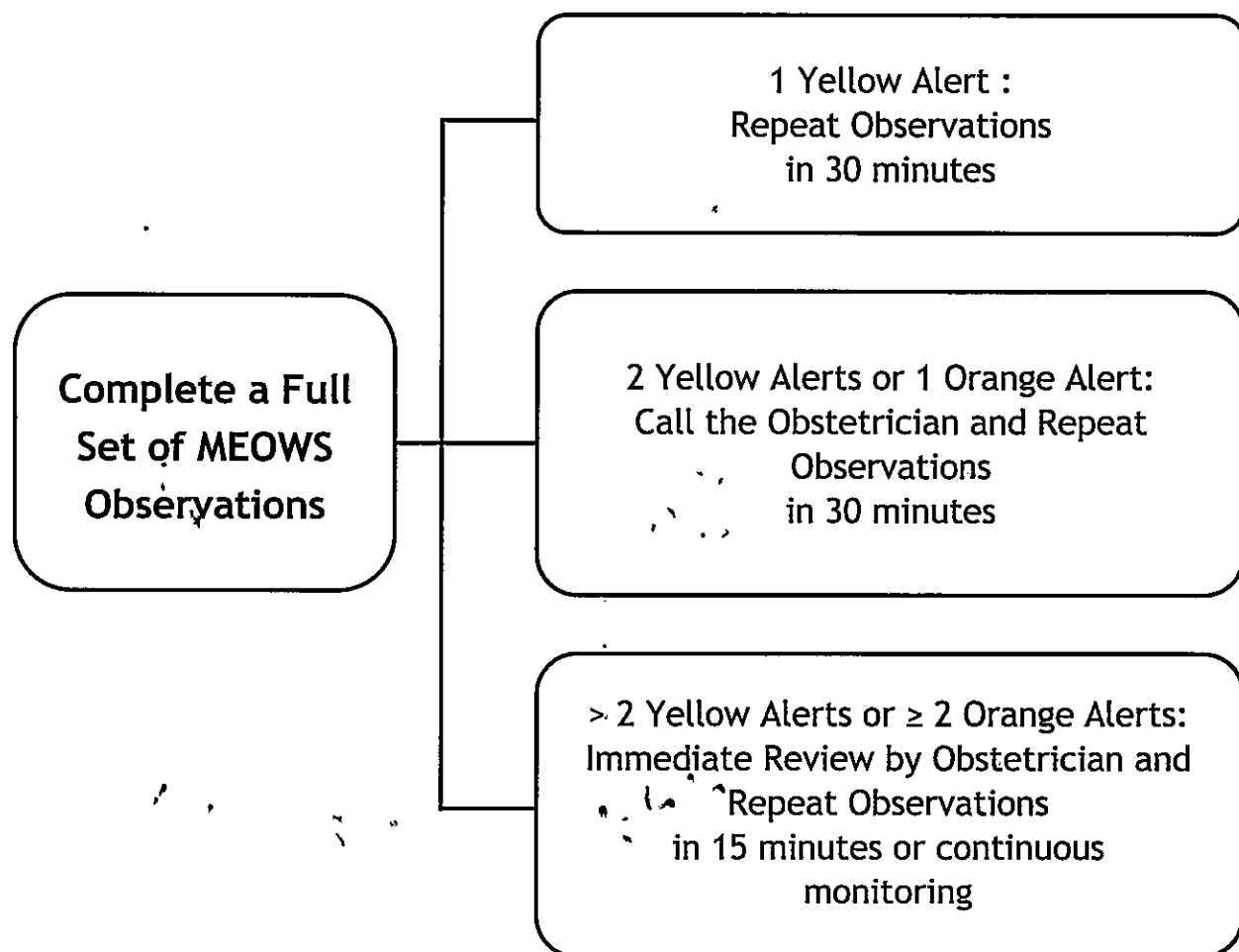
 ECHO :

 CT :

 MRI :

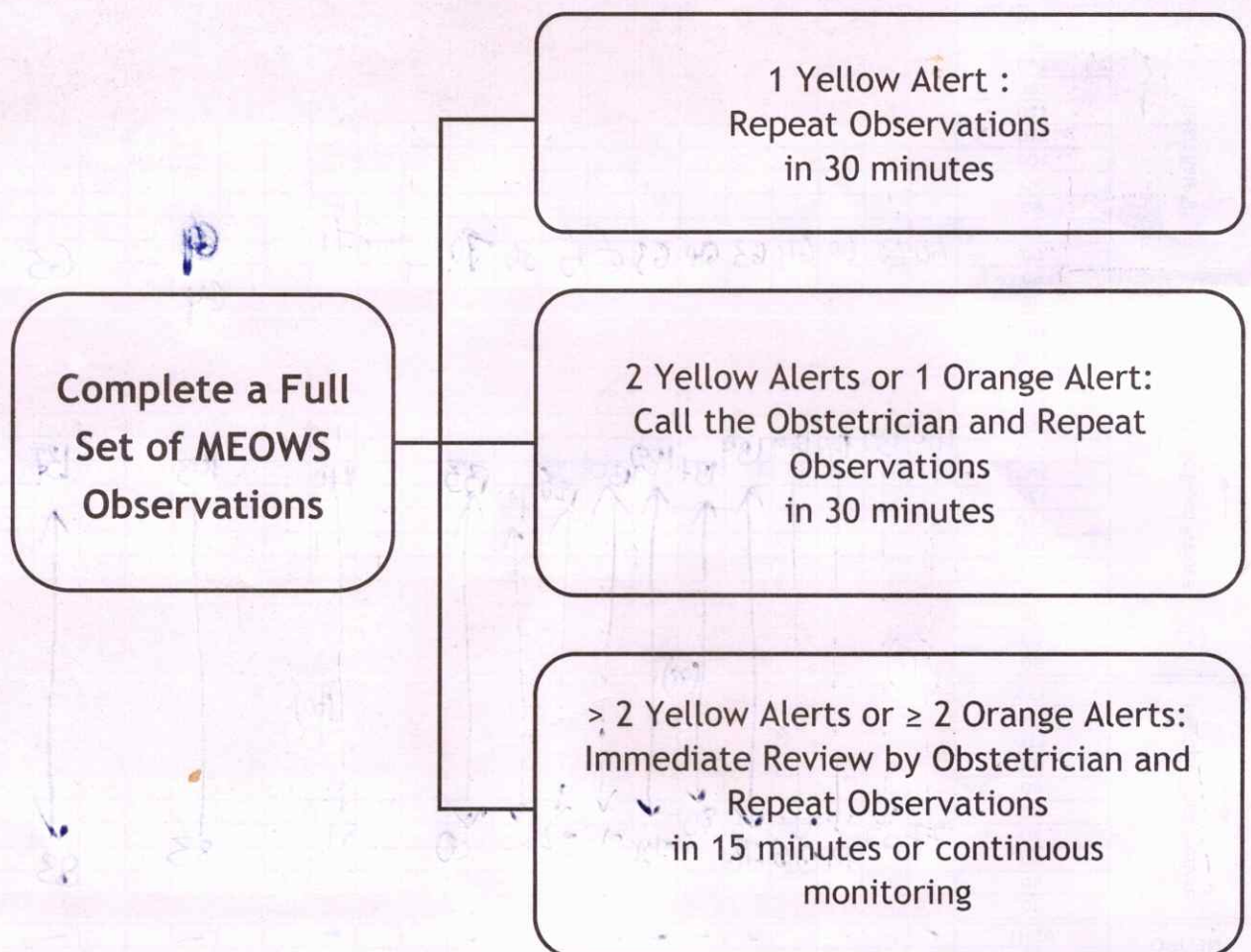
 Others (ECG, Contrast Studies etc.,) :

Obstetrics and Gynaecology Early Warning Signs



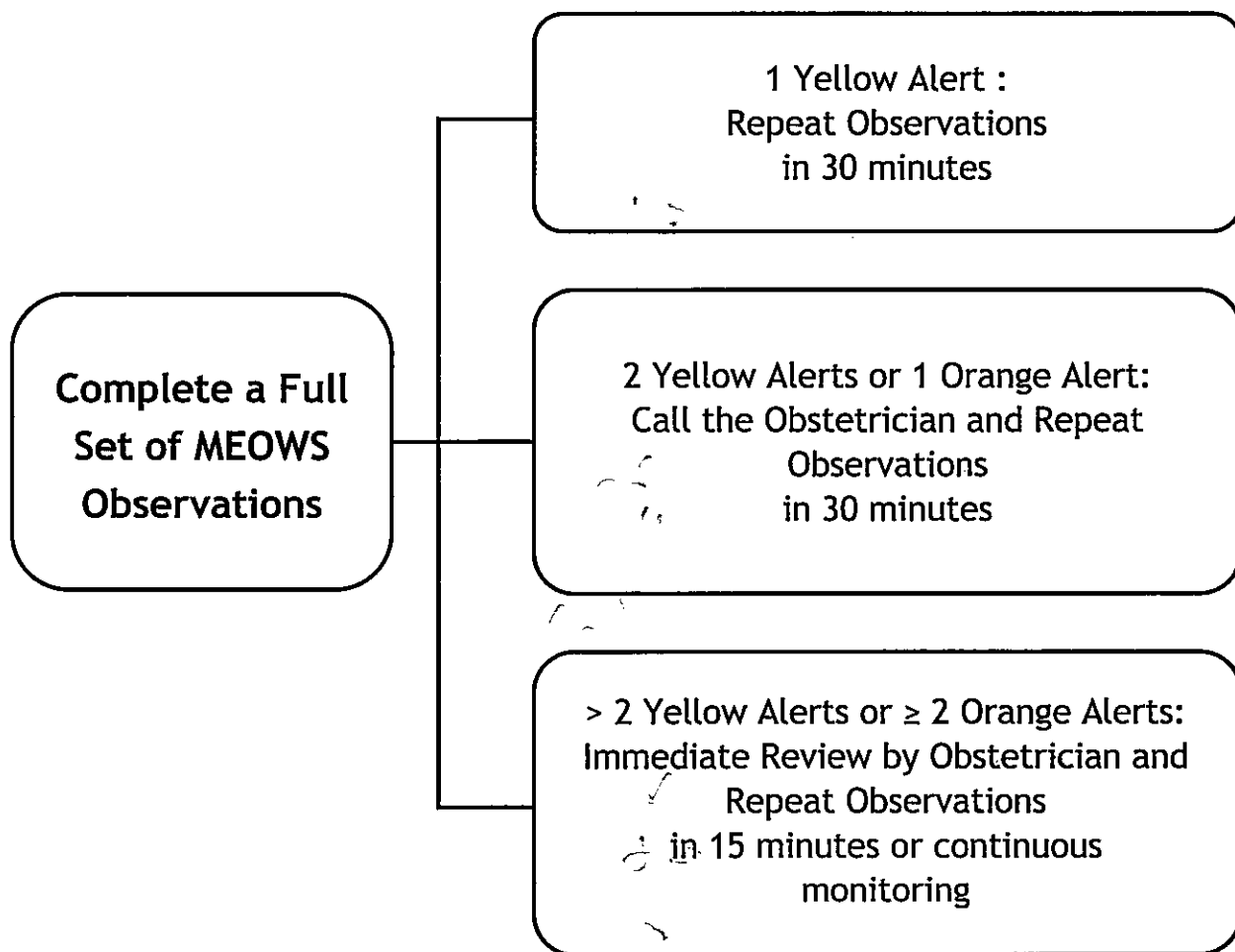
* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



FLUID CHART

Sheet No. : (1)

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
22/5	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm	RL		100ml									
Total Intake :						Total Output :							
22/5	02:00 pm	RL	N	100ml						✓			
	03:00 pm	RL	N	100ml						✓			
	04:00 pm	RL	B	100ml									
	05:00 pm	RL		100ml									
	06:00 pm	RL	M	100ml						400ml			
	07:00 pm	RL		100ml						200ml			
Total Intake : taken 600ml						Total Output : passed 600ml							
22/5	08:00 pm	RL	N	100ml									
	09:00 pm	RL	N	100ml									
	10:00 pm	RL	B	100ml									
	11:00 pm	RL	B	100ml									
	12:00 am	RL	N	100ml									
	01:00 am	RL		100ml						300ml			
Total Intake : 600ml						Total Output : 300ml							
23/5	02:00 am	RL	N	100ml									
	03:00 am	RL	N	100ml									
	04:00 am	RL	B	100ml									
	05:00 am	RL	B	100ml									
	06:00 am	RL	M	100ml						250ml			
	07:00 am	RL		100ml									
Total Intake : 600ml						Total Output : 250ml							
Total 24 hrs. Intake			1800ml			Total 24 hrs. Output			1150ml				



FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombophlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
23/5	08:00 am	RL	H2O	100ml									
	09:00 am	RL		100ml					500ml				Empty
	10:00 am	RL		100ml									
	11:00 am	RL		100ml									
	12:00 pm												
	01:00 pm									100ml			
Total Intake : taken						Total Output :							
23/5/26	02:00 pm	RL		100ml									
	03:00 pm	RL		100ml					200ml				Empty
	04:00 pm	RL		100ml									
	05:00 pm	RL		100ml									
	06:00 pm	RL		100ml						700ml			Empty
	07:00 pm	RL		100ml									
Total Intake :						Total Output :							
23/5/26	08:00 pm	R											
	09:00 pm												
	10:00 pm	Stop											
	11:00 pm												
	12:00 am												
	01:00 am									400ml			
Total Intake :						Total Output :							
24/5/26	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am									100ml			
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							2700 ml

HNH-00015507 IP26-00006403
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FLUID CHART

Sheet No.

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

Date	Time	Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
24/5/26	08:00 am												
	09:00 am												
	10:00 am	0	Jelly		NA			NA		NA	0		AS
	11:00 am												
	12:00 pm		H ₂ O										
	01:00 pm									500ml			
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

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					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			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	
-----------------------------	--

HNH-00015507

IP26-00006403

Mrs CHETNA JAIN

09-08-1985 70 Y 9 M 13 D (F)

Dr. MEENA UGALE



CHECKLIST FOR THROMBOPHLEBITIS



22/5/26

24/5/26

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

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

Signature of Shift In Charge :

Signature : *Si* Name : *Swetha*

Signature of Ward In Charge :

Signature : *Kasthuri* Name : *Kasthuri*

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

BRADEN 'Q' SCALE

Date: 23/05 23/5 24/5
 Time: E2 N, M6

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

TOTAL SCORE

28 22 21

Evaluator's Name

[Signatures]

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	22/5	22/5/26	22/5/26	Fall Risk Grading		
		Score	M6	EL	101	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0		0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0					
Total Morse Fall Scale Score:			20	20	20			
		Signature	CL	A	CL			

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



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	23/5	23/5	Fall Risk Grading		
		Score	8 AM	7 PM	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25			Low Risk	0 - 24	Standard Fall Precaution
	No	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0					
Ambulatory Aid	Furniture	30			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15					
	None /Bed Rest /Nurse Assist	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0					
GAIT / Transferring	Impaired	20			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0					
Mental Status	Forgets limitations	15			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0					
Total Morse Fall Scale Score:			20	20			
		Signature	fi	(K)			

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



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 23/5/26 Date of Removal:

Parameters	Date	Shift Time	<u>23/5</u> <u>E1</u>	<u>23/5</u> <u>M1</u>	<u>23/5</u> <u>M6</u>	<u>23/5</u> <u>N1</u>			
Need for the Catheter			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hand Hygiene			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Usage of Sterile Equipment			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Collection bag below the level of bladder			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check the Tube for Obstruction (Free of Kinking)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Catheter dated as policy			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Collecting bag is been emptied regularly?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maintenance of closed system for the catheter			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dressing clean and dry?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the line removed as Policy?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Performance of Perineal Care			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Onset of New Fever			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asses for the leakage at the site of insertion			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the Nurse			<u>Madhvi</u>	<u>Madhvi</u>	<u>Sujata</u>	<u>(Signature)</u>			
Signature of the Nurse			<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>	<u>(Signature)</u>			

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
22/5/26	2 PM	0/10	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	ll
22/5/26	7 PM	0/0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	o
22/5/26	10 PM	0/10	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	ll
22/5	11 AM	0	MA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	MA -	ll
23/5	2 AM	0	MA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	MA	ll
23/5	8 AM	0	MA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	MA	ll
23/5	12 PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Li
23/5	2 PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Abedle
23/5/26	10 PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	shyud
24/5/26	8 PM	0	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	Aut

Re-assessment Frequency:

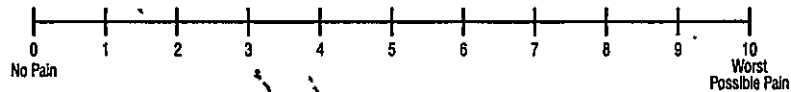
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

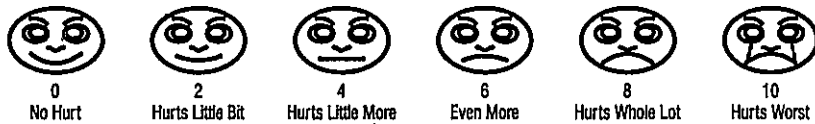
Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not Irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli 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, SaO₂	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

Wong-Baker (Pediatrics) Above 7 Years





NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:		Post OP Day:					
BACKGROUND	Date	22/5 8AM	22/5 E2	22/5 NI	23/5 8AM	23/5 2:30pm	23/5 NI	
	Shift							
	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA	
ASSESSMENT	Diet:	NBM	NBM	NBM	liquid			
	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	NA	NA	NA	NA			
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:	Temp:	36C	97.8F	97.8F	98F	98.3F	98.1F
		Res:	20	20b/m	20b/m	20	20	20
		SpO ₂ :	98.1	99.1	97.1	97.1	98.1	99.1
		Pulse:	85	82b/m	87	68	89	71
		BP:	130/42	128/60	150/83	140/77	180/80	140/81b/m
		LOC:						
Fall Risk Score:								
Pain Score:		0/10	0/10					
Skin Integrity	good							
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:				NA	NA		
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:	NBM	NBM	NBM	liquid	NBM	soft	
	Critical Lab Test / Values:							
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
ADL (Dependent / Non Dependent):	NA	NA	NA	NA	PA	NA		
Post Operative Procedure Special Orders:		NA	NA	NA	NA	PA	NA	
Handed Over By Name :		Sunita	Arvind	Chudh	Sunita	Meetha	Sunday	
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		22/5/26	22/5/26	23/5/26	23/5/26	23/5/26	24/5/26	
Time:		2PM	8PM	8AM	2PM	8PM	8AM	
Taken Over By Name :		Arvind	Chudh	Sunita	Meetha	Sunday	Arusha	
Signature / ID :		[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	[Signature]	
Date:		22/5/26	22/5/26	23/5/26	23/5/26	23/5/26	24/5/26	
Time:		2PM	8PM	8AM	8PM	8PM	8AM	

NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:						
	Surgery / Procedure:	Post OP Day:						
BACKGROUND	Date	24/5						
	Shift	Mb						
	Medical Condition (Any special condition to be noted):	-						
	Diet:	-						
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	-						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	97.5					
		Res:	23b/m					
		SpO ₂ :	99%					
		Pulse:	78b/m					
		BP:	130/72					
		LOC:	-					
		Fall Risk Score:	-					
	Pain Score:	-						
	Skin Integrity	-						
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-						
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	-						
	Critical Lab Test / Values:	-						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADL (Dependent / Non Dependent):	-							
Post Operative Procedure Special Orders:		-						
Handed Over By Name :		Anusha						
Signature / ID :		[Signature]						
Date:		20/5/26						
Time:		2pm						
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								

HNH-00015507 IP26-00006403
 Mrs CHETNA JAIN
 09-08-1955 70 Y 9 M 13 D (F)
 Dr. MEENA UGALE



NURSING CARE RECORD



Date: 22/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	=> Assess the patient condition => plan for vital => plan for I/O chart	8am	=> Assessed the patient condition => maintain vital & record => maintain I/O chart	patient is stable	vital is normal	Chudhary
	7:30		7:30				
Afternoon	2pm	=> ASSES the pt condition => monitor the vitals & record => Administration of medication => maintain I/O chart & record	2pm	=> ASSES the pt condition => monitored the vitals & recorded => Administered medication as per doctor's order => maintained I/O chart & recorded	pt is stable	vitals is normal	Akhila
	1pm		1pm				
Night	8pm	=> ASSES the patient condition => plan for vital => plan for I/O chart	8pm	=> Assessed the patient condition => maintain vital & record => maintain I/O chart	patient is stable	vitals is normal	Chudhary
	8am		8am				

HNH-00015507 IP26-00006403
 Mrs CHETNA JAIN 70 Y 9 M 13 D (F)
 09-08-1955
 Dr. MEENA UGALE

NURSING CARE RECORD



Date: 23/05/20

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM 2PM	→ Assess the pt condition. → plan soft diet Today. → maintain I/O chart. → drugs give as per drug chart.	8AM 2PM	→ Assessed the pt condition. → planed soft diet Today. → maintained I/O chart. → drugs given as per drug chart.	→ pt is stable Now	→ Reassessed the vitals	mahi (Signature)
Afternoon	day						
Night	8PM 8AM	Assess the Pt condition monitor vital Maintain I/O chart Drug give as per drug chart.	8PM 8AM	Assessed the Pt Condition monitored vital Maintained I/O chart drugs given as per drug chart.	Patient is stable Now	rechecked the v/s	(Signature)

HNH-00015507 IP26-00006403
 Mrs CHETNA JAIN
 09-08-1955 70 Y 9 M 14 D (F)
 Dr. MEENA UGALE

NURSING CARE RECORD



Date: 24/5/26

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 10 2pm	→ Assess the pt condition → Monitor the vitals → Maintain I/O chart → Administer the medication as per drug chart	8am 10 2pm	→ Assessed pt condition → Monitored vitals → Maintained I/O chart → Administered medication as per drug chart	Patient is stable → Foley's removal today 6pm	Re-checked vitals	Anurupa Arya
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD



Date:

- 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							
Afternoon							
Night							

HNH-00015507 IP26-00006403
 Mrs CHETNA JAIN
 09-08-1955 70 Y 9 M 14 D (F)
 Dr. MEENA UGALE



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <u>vaginal hysterectomy</u>	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date	<u>23/5</u> M6	<u>23/5</u> M1	<u>24/5</u> M6			
	Shift						
	Medical Condition (Any special condition to be noted):	-	-	-			
	Diet:	<u>soft diet</u>	<u>soft</u>	<u>soft</u>			
ASSESSMENT	Allergy:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	-	-	-			
	Tubes/Drains/Catheter:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vital Signs:	Temp:	<u>98.1°F</u>	<u>98.1°F</u>	<u>97.7°F</u>		
		Res:	<u>20b/m</u>	<u>22b/m</u>	<u>23b/m</u>		
		SpO ₂ :	<u>99%</u>	<u>99%</u>	<u>99%</u>		
		Pulse:	<u>65b/m</u>	<u>62b/m</u>	<u>65b/m</u>		
		BP:	<u>137/80</u>	<u>150/92</u>	<u>100/75</u>		
		LOC:	-	-	-		
	Fall Risk Score:	-	-	-			
Pain Score:	-	-	-				
Skin Integrity	<u>Good</u>	<u>Good</u>	<u>Good</u>				
Recommendations	Safety Needs:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	-	-	-			
	Others Specify:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Special Diet:	<u>soft diet</u>	<u>soft</u>	<u>soft</u>			
	Critical Lab Test / Values:	-	-	-			
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	PU Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DVT Prophylaxis:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
ADL (Dependent / Non dependent):	<u>dependent</u>	-	-				
Post Operative Procedure Special Orders:		-	-	-			
Handed Over By Name :		<u>Maheshwari</u>	<u>Singh</u>	<u>Anushka</u>			
Signature / ID :		<u>[Signature]</u>	<u>[Signature]</u>	<u>[Signature]</u>			
Date:		<u>23/5/26</u>	<u>23/5/26</u>	<u>24/5/26</u>			
Time:		<u>2pm</u>	<u>12am</u>	<u>2pm</u>			
Taken Over By Name :			<u>Anushka</u>				
Signature / ID :			<u>[Signature]</u>				
Date:			<u>23/5/26</u>				
Time:			<u>8am</u>				

Patient Sticker



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:				
	Surgery / Procedure:		Post OP Day:				
BACKGROUND	Date	Shift	/	/	/	/	/
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:		Temp:				
			Res:				
			SpO ₂ :				
			Pulse:				
			BP:				
			LOC:				
			Fall Risk Score:				
		Pain Score:					
		Skin Integrity					
Recommendations	Safety Needs:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:						
	Others Specify:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	PU Prophylaxis:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	DVT Prophylaxis:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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:							



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	T- ATENOLOL + NIFEDIPINE	50mg	PO	OD		<input checked="" type="checkbox"/> C <input type="checkbox"/> DC
2						<input type="checkbox"/> C <input type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : *[Signature]* Dr. G. Veera

Date & Time : 22/5/26 @ 1pm.

Nurse Name & Signature: *[Signature]*

Date & Time : 22/5/26 @ 1pm

HNH-00015507 IP26-00006403
Mrs CHETNA JAIN
09-08-1955 70 Y 9 M 13 D (F)
Dr. MEENA UGALE

THEATER NOTES

Patient's Name :  Age : Gender :

UHID : I.P.No. : Weight :

Surgeon : Asst. Surgeon :

Anesthetist : OT Nurse :

Surgical Procedure :
Vaginal Hysterectomy + Bilateral Salpingectomy + Posterior
colpoperineorrhaphy with conservation of ovaries

Indications for Surgery :
2° UV prolapse + Mild upto cervix Mild rectocele + Lex
perineum

Date : ~~22/5/26~~ (22/5/26) Start Time : End Time :

PRE-OPERATIVE PREPARATION :
.....
.....
.....

OPERATION NOTES: Findings:

- 1) 2° UV prolapse + Infra vaginal elongation of cervix upto introitus 2) Mild upto cervix (F) descent
- 3) Uterus - atrophic; Bilateral fallopian tubes - (N)
- A) Bilateral ovaries - atrophic & high up
- B) Lex perineum
- C) Bladder base highly vascular

↓ SAP perineum cleared & draped; Bladder drained. Abdomen cleared & draped.

- After Holding Anterior & posterior lip of cervix with Annap. vulsellum. Hydrodissection done
- Anteriorly uv fold opened & posteriorly PoD opened.
- Bilateral uterovaginal ligaments clamped; cut & doubly ligated & Mackenrodt

(C.T.O)

- Bilateral uterine arteries clamped, cut & doubly ligated.

- Bilateral Tuboovarian and Round ligaments clamped, cut & doubly ligated

- Uterus along with cervix, removed & sent for HPE

- Bilateral Fallopian centered end cut & sent for HPE
tuber

- Vault closed after peritonisation after ~~pushing~~ up bladder; checking MLI count & checking hemostasis

- ~~Vaginal~~ anterior colpoperineorrhaphy done in v/o dex perineum

- Vaginal packed with Betadine pack

POST - OPERATIVE ORDERS :

Adv

1) NBM till further orders

2) IVF/ Analgesic as per Axon

3) Ij. MAGNEX FORTE 1.5g I/V BD

4) Ij. TINIDA 800mg I/V OD

5) Ij. PCM 1g I/V TID

6) Ij. PANTOP 40mg I/V OD

7) Ij. TRANEX A 500mg I/V BD for 24 hours

8) w/ actin bleeding & pack

9) CRP aft. ch. (12 Am)

10) stay

Dr. Meeruluck

for Dr. Vignati
(Dr. Thure)
y-h

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 22/5/25 Time : 6PM

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Meena Uga
 Asst. Surgeon : Dr. Pradeep
 Anaesthetist : Dr. Aychhe
 Scrub Nurse : S. Sangeetha Archu

HNH-00015507 IP26-00006403
 Mrs CHETNA JAIN
 09-08-1955 70 Y 9 M 13 D (F)
 Dr. MEENA UGALE

Age : Gender :
 gery Name :
 Out-time : 3:15 PM



Before Induction of Anaesthesia >>

SIGN IN	Time: <u>3:10pm</u>
Patient Has Confirmed	
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Consent	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site Marked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA
Anaesthesia Safety Check Completed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Pulse Oximeter on Patient & Functioning	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Does Patient have a:	
Known Allergy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Blood Units Reserved	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Signature : <u>B. de</u>	
Name : <u>Dr. Bunde</u>	

Before Skin Incision >>


TIME OUT	Time: <u>3:20 PM</u>
Confirm all team members have introduced themselves by Name and Role <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Correct Site	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Correct Procedure	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Is Essential Imaging Displayed?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Signature : <u>S</u>	
Name : <u>Sangeetha</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time: <u>3:40 PM</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
The Specimen is Labelled (including patient name)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Whether there are any Equipment Problems to be addressed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <u>Sangeetha</u>	
Name :	

PATIENT TRANSFER FORM




Patient Name & UHID No. HNH-00015507 IP26-00006403 Mrs CHETNA JAIN 09-08-1955 70 Y 9 M 13 D (F) Dr. MEENA UGALE 		Date & Time of Admission 22/05/26	Date & Time of Transfer Order 22/05/26 @ 5 PM
		Transfer Ordered by Dr. Ayeshu	Reason for Transfer observed
From Unit OT	To Unit NICU Post	Information to Attendant Yes <input type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> 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 Sangita	Name of Person Ordered Transfer
---	---------------------------------


Patient & Clinical Records Received by : 

Date & Time of Patient Received : 22/5/26 @ 6:00 PM

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

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015507 IP26-00006403 Mrs CHETNA JAIN 09-08-1955 70 Y 9 M 13 D (F) Dr. MEENA UGALE 		Date & Time of Admission 22/5/26 @ 12:55 PM	Date & Time of Transfer Order 22/5/26 @ 2:10 PM
		Transfer Ordered by DR. Veena	Reason for Transfer vaginal hysterectomy with posterior repair
From Unit PXC - post	To Unit OT	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 30	Number of Imaging Films -	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Sis. Swatha		Name of Person Ordered Transfer DR. Veena	
Patient & Clinical Records Received by : Sangeetha			
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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Mrs. Chelana Gender: Male Female Age : 80 yrs

UHID No : H.I. Date : 22/5/26

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)

VAGINAL HYSTERECTOMY + BILATERAL SALPINGO-OOPHORECTOMY + ANTERIOR + POSTERIOR COLPOPERINEORRHAPHY
 upon MRS. CHETANA (Name of the Patient)

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

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

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

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

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr. Meena Ugale

Consentee :

Signature : Chetana Jain
 Name : Mrs. Chetana Jain
 Date & Time : 22/5/26 @ 1pm

Witness :

Signature : Suj
 Name : Sujatha
 Date & Time : 22/5/26 @ 1PM

Patient Attendant :

Signature : Deepika
 Name : Deepika Singare Jain
 Relationship with Patient: daughter-in-law
 Date & Time : 22/5/26 @ 1pm

Doctor (who is taking the consent) :

Signature : G. Veena
 Name : D. G. Veena @
 Date & Time : 22/5/26 @ 1pm

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : Mrs. CHETNA JAIN Age : 70y Gender : Male Female

UHID NO: HNH-000/5507 Surgeon Name: Dr. MEENA UGALE

Anaesthesiologist : Dr. Ayesha

Operative procedure planned : VAGINAL HISTERECTOMY + BILATERAL SALPINGO-OOPHORECTOMY + ANTERIOR + POSTERIOR COLPOPERINEORRAPHY

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

- Heart disease Hypertension Diabetes mellitus Renal failure
- Hepatic disorders Shock Multiple organ failure Polytrauma / Renal Tubular Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease
- Others : Bleeding, Need for transfusion, Transfusion reaction

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

VAGINAL HISTERECTOMY + BILATERAL SALPINGO-OOPHORECTOMY + ANTERIOR + POSTERIOR COLPOPERINEORRAPHY

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 : Chetana Jain

Name : Mrs. Chetana Jain

Relationship with Patient:

Date & Time : 22/5/26

Witness :

Signature : Deepika Jain

Name : Deepika Jain

Date & Time : 22/5/26

Doctor (who is taking the consent) :

Signature : Dr. SK. Ayer

Name : Dr. SK. Ayer

Date & Time : 22/5/26, 2:30pm

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Mr Chetna Devi Age: 69y Sex: F UHID.No: _____

Date: 2015 Time: 9 AM Proposed Operation: Vaginal hysterectomy

Diagnosis: UV. Pericapsule

B.P / CRT: 110/92 HR: 62 Weight: 60kg ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: 13.9 g/dl Glucose: 115 mg/dl Protein: _____ HIV: _____
 PCV: 41.7 Urea: 25 mg/dl Alb: _____ HBS Ag: 1/12
 WBC: 2300 Creat: 0.9 mg/dl Total Bill: _____ HCV: _____
 Plate: 59000 Na: _____ Dir. Bill: _____ Blood group: Bmc
 PT: 13.2 K: _____ LDH: _____ T3: _____
 PTT: 29.4 Ca++: _____ Alk phos: _____ T4: 5.3
 INR: 0.9 Mg++: _____ Amylase: _____ TSH: 2.66
 Cl: _____ SGOT/SGPT: _____

Allergies: NSA - thickened sputum for postmenopausal asthma

Medical History: CVS: HTN - 15yrs

RESP: TB / COVID / Asthma Diabetes: -

CNS: Anxious

Renal: Renal stones - on homeopathy / Agri medic medication

Hepatic / GE: GERD / Swallowing (10-15yrs) Physical Activity: Mod. Ex. good Ex.

Others: Endocrine issues MHA: 1

Past Anaesthetic History: (2) NVD / (R) Anamniot - closed reduction, J. Block - no external deposits

Physical Exam:

Airway: MP 2 3 4 Mouth Opening: 3.5cm Mentohyoid Distance: 3.5cm Neck: good Teeth: well, nose

Lungs: clear

Heart: YS

CNS: (2)

Pregnant: Yes No NA Venous Access Site: (+) Spine Exam for regional: nothing - spaces felt

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>T. Atenolol + Lisinopril</u>	<u>20mg OD</u>

- Pre-Operative Instructions:**
- DVT Prophylaxis: 2/5/16
 - NIL ORAL explained
 - Water / ORS 2 Hours
 - Others 6 Hours
 - Informed Consent: Standard High Risk
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions:
 - LFT & serum electrolytes
 - consent pending
 - care accepted for surgery
 - continue anti-HTN as scheduled

Signature: [Signature] Name: D. Keena



ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: Yes No Fasting Status: Adequate

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: 92 bpm B.P / CRT: 159/78 mmHg SpO₂: 100% on RA R.R: 16/min Last Feed: 7 hrs

Pre-OP Diagnosis: UV Prolapse Operation: Vaginal hysterectomy + BSO + Ant + Post Date: 22/12/20

Surgeon: Dr. Meena / Dr. Uma Anaesthesiologist: Dr. Ayesha / Dr. Branda Technician: Sapant / Anand / Sachin

TIME	N ₂ O / AIR / O ₂ LPM	HALO / SO / SEVO	Drugs:	Antibiotic given	Suppository
3:15	100	5	<u>mg MIDAZOLAM 1mg IV</u>		
3:30	100	5	<u>mg LABETALOL 5mg IV</u>		
4:30	100	5			
5:30	100	5			
6:00	100	5			

FiO ₂ / SaO ₂	ETCO ₂	ECG	Temperature	Urine Output
<u>FiO₂ 0.5</u>	<u>100</u>	<u>NCR</u>	<u>36</u>	<u>400ml</u>
<u>100</u>	<u>100</u>	<u>NCR</u>	<u>36</u>	
<u>100</u>	<u>100</u>	<u>NCR</u>	<u>36</u>	
<u>100</u>	<u>100</u>	<u>NCR</u>	<u>36</u>	
<u>100</u>	<u>100</u>	<u>NCR</u>	<u>36</u>	
<u>100</u>	<u>100</u>	<u>NCR</u>	<u>36</u>	
<u>100</u>	<u>100</u>	<u>NCR</u>	<u>36</u>	
<u>100</u>	<u>100</u>	<u>NCR</u>	<u>36</u>	
<u>100</u>	<u>100</u>	<u>NCR</u>	<u>36</u>	
<u>100</u>	<u>100</u>	<u>NCR</u>	<u>36</u>	
<u>100</u>	<u>100</u>	<u>NCR</u>	<u>36</u>	

Fluids	Blood
<u>Ringer</u>	<u>100ml</u>
<u>100ml</u>	<u>100ml</u>

B.P	V Systolic	A Diastolic	X Mean	Heart Rate
<u>159</u>	<u>100</u>	<u>78</u>	<u>80</u>	<u>92</u>
<u>150</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>145</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>140</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>135</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>130</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>125</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>120</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>115</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>110</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>105</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>100</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>95</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>90</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>85</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>80</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>75</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>70</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>65</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>60</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>55</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>50</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>45</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>40</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>35</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>30</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>25</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>20</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>15</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>10</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>5</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>
<u>0</u>	<u>100</u>	<u>75</u>	<u>80</u>	<u>90</u>

Antibiotic given
 Suppository
 Diclofenac 100mg PR
 Tramadol 100mg PR
 Blood Loss
420ml

NOTES
 1 CBP after gh
 2 BP, I/O Charting

LAB Values

ABG

GRBS

Others

<p><input checked="" type="checkbox"/> Equipment Checked and Functional</p> <p><input checked="" type="checkbox"/> BP</p> <p><input type="checkbox"/> Cuff Site: <u>Left UL</u></p> <p><input type="checkbox"/> Art Site: <u>Left UL</u></p> <p><input checked="" type="checkbox"/> EKG Lead: <u>3 lead</u></p> <p><input checked="" type="checkbox"/> Temp Site: <u>Scin</u></p> <p><input type="checkbox"/> FIO₂ Monitor</p> <p><input type="checkbox"/> Agent Monitor</p> <p><input type="checkbox"/> Pulse Oximeter</p> <p><input type="checkbox"/> Capnograph</p> <p><input type="checkbox"/> Ventilator</p> <p><input type="checkbox"/> Nerve Stimulator</p> <p>Position: <u>Supine</u></p> <p><input checked="" type="checkbox"/> Pressure Points Checked</p> <p>Eye Care: <u>Lithomy</u></p> <p><input type="checkbox"/> Oint</p> <p><input type="checkbox"/> Tape</p> <p><input type="checkbox"/> Padding</p> <p><input checked="" type="checkbox"/> Awake</p>	<p>Temp:</p> <p><input type="checkbox"/> HME <input type="checkbox"/> Fluid Warmer</p> <p><input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer</p> <p><input checked="" type="checkbox"/> Hugger's <input type="checkbox"/> Cotton Wool</p> <p><input type="checkbox"/> Other</p> <p>Times:</p> <p>Anaes Start: <u>3:15 pm</u></p> <p>OP Start: <u>3:38 pm</u></p> <p>OP End: <u>5:45 pm</u></p> <p>Leave OR: <u>6:00 pm</u></p> <p>Anaesthesia:</p> <p><input type="checkbox"/> GA</p> <p><input checked="" type="checkbox"/> Monitored Anaesthesia Care</p> <p><input checked="" type="checkbox"/> Regional</p> <p>Line (Size & Location)</p> <p><input type="checkbox"/> CVP</p> <p><input type="checkbox"/> ART</p> <p><input checked="" type="checkbox"/> IV: <u>18g BT-UL</u></p> <p><input type="checkbox"/> IV:</p> <p><input type="checkbox"/> IV:</p>	<p>Induction</p> <p><input type="checkbox"/> IV <input type="checkbox"/> Inhal</p> <p><input checked="" type="checkbox"/> Pre O₂ <input type="checkbox"/> RSI</p> <p><input type="checkbox"/> Others</p> <p><input type="checkbox"/> Mask <input type="checkbox"/> SGA</p> <p><input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal</p> <p>ETT # at cm</p> <p><input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff</p> <p><input type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical</p> <p><input type="checkbox"/> Drug:</p> <p><input type="checkbox"/> Awake <input type="checkbox"/> Direct Vision</p> <p><input type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie</p> <p><input type="checkbox"/> Fiberoptic</p> <p>Blade# Attempts:</p> <p>Difficulty Why?</p> <p><input type="checkbox"/> Bilat = BS</p> <p><input type="checkbox"/> Semi-Closed Circle</p> <p><input type="checkbox"/> Closed Circle</p> <p><input type="checkbox"/> Other</p>	<p>Regional:</p> <p>Extremity Specify:</p> <p><input checked="" type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Caudal</p> <p>Others:</p> <p>Position: <u>Sitting</u></p> <p>Site: <u>L3-L4</u></p> <p>Needle Size: Depth:</p> <p>Parasthesia <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Catheter at skin cm</p> <p>Drug Name & Conc: <u>Ans 0.5% H.</u></p> <p>Bolus: <u>Bupivacaine 3.0cc (15mg)</u></p> <p>Infusion:</p> <p>Block Level: <u>30µg Buprenorphine</u></p> <p>Comments: <u>ADEQUATE (T4-T6)</u></p> <p>Transportation to</p> <p><input checked="" type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Other</p> <p>Relaxant Reversed <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA</p> <p>Name of the Doctor: <u>Dr. Branda</u></p> <p>Signature of the Doctor: <u>B. Branda</u></p>
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HNH-00015507
 Mrs CHETNA JAIN
 09-08-1955 70 Y 9 M 13 D (F)
 Dr. MEENA UGALE

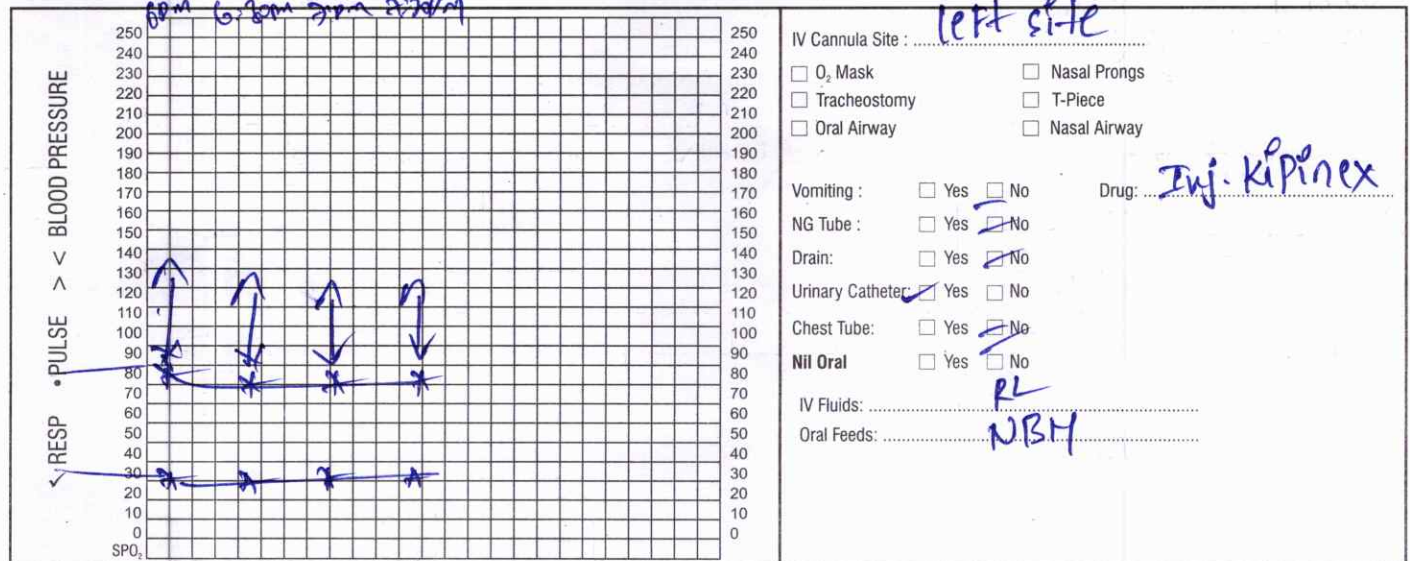


IP26-00006403



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Sis. Arkhila Time Received: 6:10 PM Time Discharged:



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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
23/5	6:10 PM	0/10	NA	<u>[Signature]</u>
23/5	7:10 PM	0/10	NA	<u>[Signature]</u>
23/5	8 PM	0/10	NA	<u>[Signature]</u>
23/5	12 PM	0	NA	<u>[Signature]</u>

Pain Tool Used: N PASS FLACC Wong Baker NPS

Anaesthesiologist Name: Dr. Meena Uga

Anaesthesiologist Signature: [Signature]

Date & Time:

PACU Nurse Name: Lisalita

PACU Nurse Signature: [Signature]

Date & Time: 23/5/20 @ 12 PM

Reassessment Frequency:

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

Transferred to Unit by (PACU): 3rd floor (306)

Date & Time: 23/5/20 @ 12 PM

Patient Sticker



Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

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

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

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

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :

26-0000 201407

**NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)**

Patient Name: <u>MRS. CHETNA JAIN</u>	Age: <u>70 Y</u>	Gender: <u>F</u>	
UHID No: <u>HNT-00015507</u>	IP No: <u>IP26-00006403</u>	Date: <u>22/5/26</u> Time: <u>2:32 pm.</u>	
Diagnosis: <u>VAGINAL HYSTERECTOMY</u>			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ml	<u>100 mcg</u>	<u>ONS AMP</u>
2.	Morphine Sulphate Inj. 15mg/ml	-	-
3.	Remifentanyl Hydrochloride Inj. 2MG	-	-
4.	Remifentanyl Hydrochloride inj. 1MG	-	-
Doctor Name: <u>Dr. SK Agarkar</u>		Doctor Registration No: <u>TSMC/FR/107725</u>	
Signature: <u>[Signature]</u>			

**NARCOTIC DISPENSING FORM
APPENDIX 4 - FORM NO. 3E**

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

IP Registration No: IP26-00006403 Date: 22/5/26

Aadhaar No. of the Patient (Optional):

1.	Name: <u>MRS. CHETNA JAIN</u>	Remarks		
2.	Complete postal address (with contact number, if any)	<u>H-1-109011 ABIDS ROAD HYD</u>		
3.	Brief description of the illness	<u>VAGINAL HYSTERECTOMY</u>		
4.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded)	<u>NO</u>		
5.	Details of essential Narcotic drug dispensed	<u>FENTANYL</u>		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
<u>22/5/26</u>	<u>FENTANYL</u>	<u>ONS AMP</u>	<u>[Signature]</u>	

Dispensed by (Name & ID No.): sania (015642) Signature: [Signature]

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

Time:

HNH-00015507
Mrs CHETNA JAIN
09-08-1955 70 Y 9 M 14 D (F)
Dr. MEENA UGALE

IP26-00006403

306

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 24/5/26 Time: 11:10 am

Origin: Indian Height: 162 cm Weight: 60 kg BMI: 32 kg/m²

Food Allergies: No f A

Diagnosis: Vaginal hysterectomy @ B 50

Medical History: Hypertension

Surgical History:

Vegetarian Non-Vegetarian Vegan

Diet Advised: Soft diet

Patient's / Attendant's

Signature: D. Jain

Name:

Date & Time: 24/5/26, 11:10 am

Dietician's

Signature: Sobiya

Name: Syeda Sobiya Zahoor

Date & Time: 24/5/26, 11:10 am