

9154865024

Dr. Swapna



ESTIMATION SLIP

Date : 22/5/26 UHID / IP No. : HNH-00015513 SI No. **1531**
 Name of Patient : Mrs. Pooja Kumari Age: 53yrs Gender: F
 Father's / Husband's Name : Mr. A.L. Malleddy Corporate / Occupation : _____
 Address : Kachiguda Phone : 995352089 Email : 8870116389
 Procedure / Plan : Hysteroscopy + EB EDD/Dos: _____
 MODE OF PAYMENT : SELF TPA : _____ GIPSA : _____ OTHER _____

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
	Normal Delivery	LSCS
Room Category		
Multi Shared Ward		
Shared Ward		
Twin Shared Ward	<u>65k.</u>	
Private Room		
Super Deluxe Room		
Suite Room	<u>+ Pharmacy & Investigation Extra</u>	
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

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

Initial Minimum Deposit : 50,000/- Advance time of Admission

REMARKS :

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

DECLARATION

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

Signature of the Client

Signatory Relationship

Signature of the financial Counselor

HNH-00015513 IP26-00006451

Mrs THANUGUNDLA PUSHPA
30-04-1973 53 Y 0 M 29 D (F)
Dr. SWAPNA SAMUDRALA



SURGERY DETAILS

Date : 29/5/26

Patient Name: Mrs. Thanugudla pushpa Date of Birth: 30/4/1973 Age: 53Yrs

Gender: female Ward: OT UHID No: HNH-00015513
IP26-00006451

Date of Surgery: 29/5/26 OT -1 OT -2 OT -3 OT -4 OBG OT-1 OBG OT-2

Name of the Surgery : Hysteroscopy + EB In C.A.

Time in : 11:05 Am

Time Out : 11:30 Am

	NAME	AMOUNT
1. Surgeon	Dr. Swapna S.	
2. Anaesthetist	Dr. Ayesha	
3. Assistant Surgeon	Dr. Manisha	
4. OT Technician	Sr. Pallavi	
5. Circulating Nurse	Sr. Pupa, Sr. Archana	
6. Assistant Nurse	Br. Balu	



- Special Equipment: Laparoscopy Broncoscope Harmonic Morcelator
 C-ARM Cystoscopy Versa Point Liver Cusa
 Neuro Cusa Others ... hysteroscopy instruments (26-0000202846)

Signature of the Surgeon (Dr. Swapna S.)

Signature of Circulating Nurse (Pupa)

Order No: 26-0000202846

Order by: Archana 29/5/26 @ 11:56 Am

HNH-00015513 IP26-00006451
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y O M 29 D (F)
 Dr. SWAPNA SAMUDRALA



Hysteroscopy
 EB (cat-D)



CONSUMABLES OF OT

Circulating staff: Archana Technician: pallavi Date: 29/5/26 Time:

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube <u>T gel 4.0</u>		<u>01</u>	Major Pack <u>General</u>		<u>1</u>	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		<u>03</u>				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		<u>05</u>				Vaccum Suction Set		
05 cc		<u>04</u>	Gloves <u>S.G 6</u>		<u>212</u>	Surgical Gloves		
02 cc		<u>03</u>	<u>7 PF SG</u>		<u>3</u>	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		<u>01</u>	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
<u>Atropine</u>		<u>01</u>	Ointments					
<u>Isanecra</u>		<u>02</u>	Suction Catheter					
Fentanyl		<u>01</u>	Cap, Mask					
Morphine			Gauze Pack <u>10x10</u>		<u>4</u>			
Ketamine			Mop Pack		<u>1</u>			
Propofol		<u>03</u>	Steristrip					
Rocuronium			Underpad		<u>1</u>			
Glycopyrolate		<u>01</u>	Draw sheet		<u>1</u>			
Myopyrolate			Abgel <u>T.V.R.P set</u>		<u>1</u>			
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag <u>Nelton (10.00)</u>		<u>1</u>			
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
<u>mask (A)</u>		<u>01</u>	Tegaderm					
Suppositories			Joban <u>legging big</u>		<u>1</u>			
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		<u>01</u>	Vaccum Suction set		<u>01</u>			
Justin : 12.5 mg / 25mg / 100mg		<u>01</u>	Plastic Bed Sheet					
Tab. Misoprost : 200mg			Betadine Solution		<u>2</u>			
<u>PCM</u>		<u>01</u>	Microshield		<u>01</u>			
<u>Nasal airway 28</u>		<u>01</u>	Cotton Balls		<u>2</u>			
<u>Feeding tube 08</u>		<u>01</u>	Latex Gloves		<u>10</u>			
			Ramdone Scrub					
			Sarel <u>2.3 no needle</u>		<u>01</u>			

Surgeon: Anaesthesiologist: 26-0000202866 / 2865 / 2864 Nurse: Archana OT Technician: 29/5/26 @ 12:15 PM
 Order No.: Ordered by:
 Doc. No.: RCH / FRM / GENERAL / 125



ELECTRONIC MEDICINE PRESCRIPTION

MRN : HNH-00015513 Name : Mrs THANUGUNDLA PUSHPA KUMARI
Age / Sex : 53 Y 0 M 29 D / Female Doctor : SWAPNA SAMUDRALA
Adm/Reg Date/Time : 29/05/2026 09:36 Payor : SELFPAY
Order Date : 29/05/2026 12:13 Ordernumber : 26-0000202866
Visit ID : IP26-00006451 Ward/Bed No : 4F -OT / LDR-416
Patient Address : 306,aravind vihar apartment, aravind vihar colony, domalguda,hyd, Domalguda, Hyderabad, Telangana, INDIA, 500029

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	SGLOVE 7.0(POWDER FREE)			/	1 Days		3 Nos	Dispensed

SWAPNA SAMUDRALA

Reg No : 69924

* 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-00015513 Name : Mrs THANUGUNDLA PUSHPA KUMARI
 Age / Sex : 53 Y 0 M 29 D / Female Doctor : SWAPNA SAMUDRALA
 Adm/Reg Date/Time : 29/05/2026 09:36 Payor : SELFPAY
 Order Date : 29/05/2026 12:13 Ordernumber : 26-0000202865
 Visit ID : IP26-00006451 Ward/Bed No : 4F -OT / LDR-416
 Patient Address : 306,aravind vihar apartment, aravind vihar colony, domalguda,hyd, Domalguda, Hyderabad, Telangana, INDIA, 500029

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	1 Days		1 Bottle	Dispensed
2	IGEL NO 4.0	IGEL 4.0	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	BIOXAMIC 500 MG INJ		1 Nos	/ Once Daily	2 Days		2 Ampule	Dispensed
4	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
5	NELTON CATHETER-10 POLYMED		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
6	THEMIPYRRNOM 0.2MG INJ		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
7	IRRIGATTO(T.U.R SET)	IRRIGATTO(T.U.R SET)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
8	LEGGINGS DISPOSABLE (PROTECTCARE) BIG		1 Nos	/ 10 AM	1 Days		1 Nos	Dispensed
9	BACTOPREP SOLUTIONS 100 ML	CHLORHEXIDINE GLUCONATE2% &ALCOHOL80% 500	1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
10	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
11	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
12	SGLOVE # 6 (SURGICARE)	SURGICAL GLOVES 6.0	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
13	VACCUME SUCTION SET	VACCUME SUCTION SET	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
14	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
15	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
16	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
17	COTTON BALLS 2 GM 5 NOS	COTTON BALLS 2G- 5 NOS	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
18	NASOPHARYNGEAL TUBES 28	NASOPHARYNGEAL TUBE28	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
19	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
20	MCT-ROF 100MG 10ML		1 Nos	Injection / Once Daily	1 Days		3 Nos	Dispensed

SWAPNA SAMUDRALA

Reg No : 69924

* 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.

Name	Mrs THANUGUNDLA PUSHPA KUMARI	UHID	HNH-00015513
Father/Guardian	Mr A. LOURDU MAR REDDY	Age/Gender	53 Y 0 M 29 D/ Female
Address	306,aravind vihar apartment, aravind vihar colony, domalguda,hyd, Domalguda, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006451	Admission Date	29-05-2026
Ref Doctor	Self. -		
Discharge Date	29.05.2026		

DISCHARGE SUMMARY

Consultants :

Dr. SWAPNA SAMUDRALA
OBSTETRICIAN & GYNAECOLOGIST
69924

Diagnosis: P2L2 WITH PREVIOUS 2 LSCS WITH CORRECTED ANAEMIA WITH PERIMENOPAUSAL WITH AUB-ADENOMYOSIS

HYSTEROSCOPY + ENDOMETRIAL BIOPSY DONE ON 29.05.2026

History: She came with complains of heavy menstrual bleeding on & off since 6 months associated with clots. USG done outside showed- Adenomyosis with ET=12.5mm, conservatively managed elsewhere - advised Hysterectomy. H/O Severe anemia (Hb-5g/dl) -2025, received IV FCM (4doses). Patient wanted medical management. Pap smear done on 22.05.2026 showed NILM. USG (20.05.2026) done showed uterus- 6x3.1cm, R/V, bulky with adenomyosis

Name	Mrs THANUGUNDLA PUSHPA KUMARI	UHID	HNH-00015513
IP No	IP26-00006451	Admission Date	29-05-2026

ET=8.2mm, B/L ovaries normal. She was Admitted for Hysteroscopy +Endometrial Biopsy.

Menstrual History:-

LMP- 29.05.2026/ LLMP : 05.05.2026

Previous cycles:Regular, heavy flow with clots

Obstetric History: P2L2, 2 LSCS, LCB-2005 years, undergone sterilisation

Medical History: K/c/o Bronchial asthma (since childhood- on & off on medication)- last attack- 2022; K/C/O HTN since 2 months (on T. Telmisartan 40mg OD); K/C/O pre-DM since 2 months- on diet; H/O varicose veins since 2 years. H/O severe anemia, received parenteral iron,

Surgical History: 2 LSCS- 1998, 2005 with sterilisation

Allergies: Nil

Family History: Mother-HTN+DM

Investigations: Enclosed.

Blood group: "O" Positive

Surgery Notes:

Operation performed: Hysteroscopy + Endometrial biopsy

Indication: Perimenopausal with AUB +A

Operative findings:

- UCL~ 6cm
- Endocervical cavity appear normal
- Endometrial cavity polypoidal
- Bilateral ostia seen

Name	Mrs THANUGUNDLA PUSHPA KUMARI	UHID	HHN-00015513
IP No	IP26-00006451	Admission Date	29-05-2026

- Endometrial Curettage done, sample saved and sent for HPE

Post-Operative Notes:

She was closely monitored in postoperative period. Her vital signs remained stable. She was encouraged to ambulate and void spontaneously. she as shifted to room. Her general condition was satisfactory and she was found to be fit for discharge. medication were explained to patient supplemented by written information.

Advice:

1. Tab. Taxim O 200mg (Cefixime 200mg) twice daily till 02.06.2026 (9am - 9pm) after food.
2. Tab. Dolo 650mg (Paracetamol) thrice daily till 31.05.2026 (7am-3pm-10pm) after food.
3. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 02.06.2026
4. Tab Tranexamic acid (500mg) thrice daily (8am-3pm-10pm) till 02.06.2026
5. Continue pervious medication
6. Collect HPE report

Review consultation with **Dr. SWAPNA SAMUDRALA**, on **05.06.2026** with **HPE report** in Gynec OPD (**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

Name	Mrs THANUGUNDLA PUSHPA KUMARI	UHID	HNH-00015513
IP No	IP26-00006451	Admission Date	29-05-2026

In case of emergency like bleeding, fever kindly contact 9154865045 at Rainbow Children's hospital Himayatnagar ,just dial one toll free number - 18002122.

You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**



Registrar/Resident/C.M.O

Dr. SWAPNA SAMUDRALA
OBSTETRICIAN & GYNAECOLOGIST
69924

duly ph : 9246160961

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Mrs. Puspha Age: 53y Sex: F UHID.No:

Date: 27/5/26 Time: 3:20pm Proposed Operation: Hy Neuroscopy

Diagnosis: P2 L2 / A/B

B.P / CRT: 110/80 H.B: 104 regular Weight: 82kg ASA Physical Status: 1 2 3 4 5

23/5
9.3
30.1
8000
384000
14.2
30.4
0.95

BMI - 36.1 kg
147 mg/dl
Glucose: R. Urea: 0.6 Creat: 0.6 Na: K: Ca++: Mg++: Cl-: Protein: 4.3 Alb: 0.6 Total Bill: 0.1 Dir. Bill: 0.1 LDH: Alk phos: 98 Amylase: SGOT/SGPT: 27/24

Laboratory Data:
HIV: / NA HBS Ag: / NA HCV: 0 the Blood group: O the T3: T4: 3.61 TSH: X-Ray: @ chest xray 100/mv regular ECG: good LV/RV function 2D Echo: NO valvular disease Stress/Angio: Other:

Allergies: NKDA

Medical History: CVS: AOB 14y / Keenien - abd (+) / Pain (+) - dull. RESP: H/O Anaemia - 2025 - (Sgld) Diabetes: FEM - 2 inj -> 10gld. CNS: HTN - 2 months - on regular checkup. Renal: Bronchial Asthma (childhood) - on + off medications (inhaler). Hepatic / GE: (last attack - 2022) - 1 day admission Physical Activity: NYHA - I, II Others: comfortable at rest, currently NYHA

Past Anaesthetic History: 2 LSCS Jr SAB - V/E

Physical Exam: P/C/L/E - varicose veins (+) Airway: MP 1 (2) 3 4 Mouth Opening: 3fhs Mentohyoid Distance: fhs Neck: Restricted Teeth: upper canine fixed set

Lungs: C/A/E (+) Heart: S/S (+) CNS: (+)

Pregnant: Yes No NA Venous Access Site: (+) Spine Exam for regional: (+)

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
1) T. Telmisartan	40mg O-x-x

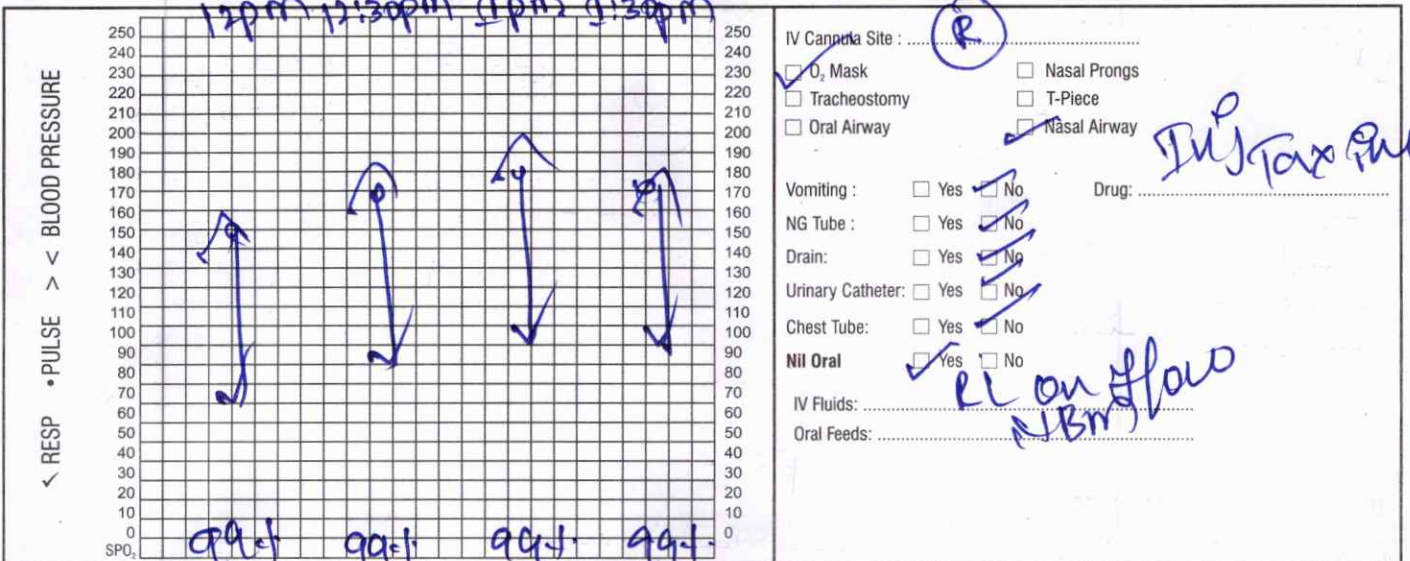
Pre-Operative Instructions:
1. DVT Prophylaxis : Water / ORS 2 Hours & explained
2. NIL ORAL -> Others 6 Hours
3. Informed Consent: Standard High Risk
4. Post Operative Pain Management: Discussed with Patient
5. Other Instructions:
• Neb. Dexam + Budecort before the procedure
• cardiac clearance
• consent pending

Signature: [Signature] Name: A Heena

Patient Sticker

POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Anusha Time Received: 12pm 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		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		
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		
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS	2	2	2		
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR	2	2	2		
TOTAL		9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
29/5	12pm	0/10	No pain	<i>[Signature]</i>
29/5	12:30pm	0/10	No pain	
29/5	1pm	0/10	No pain	
29/5	1:30pm	0/10	No pain	


Pain Tool Used: N PASS FLACC Wong Baker NPS

- 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

Anaesthesiologist Name :
 Anaesthesiologist Signature:
 Date & Time:
 PACU Nurse Name :
 PACU Nurse Signature:
 Date & Time:

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

PATIENT TRANSFER FORM

Patient Name & IJHID No. HNH-00015513 IP26-00006451 Mrs THANUGUNDLA PUSHPA 30-04-1973 53 Y 0 M 29 D (F) Dr. SWAPNA SAMUDRALA 		Date & Time of Admission 29/5/26 @ 9:36 AM	Date & Time of Transfer Order 29/5/26 @ 11 AM
		Transfer Ordered by Dr Veena.	Reason for Transfer Hysteroscopy.
From Unit Pre-post	To Unit O.T	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 25	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.	Rb on flow	10	
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 Chembakala.		Name of Person Ordered Transfer Dr. Veena.	
Patient & Clinical Records Received by : Pooya 29/5/26. 11 AM			
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

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006451 Admit Date : 29-May-2026 Admit Time : 09:36 AM UHID : HNH-00015513

Patient Details :

Patient Name : Mrs THANUGUNDLA PUSHPA KUMARI Age : 53 Y 0 M 29 D
Guardian : Mr A. LOURDU MAR REDDY DOB : 30-04-1973
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : 306,aravind vihar apartment, aravind vihar colony, domalguda,hyd Domalguda Hyderabad Telangana INDIA 500029 Phone No : 7569655303
E-mail : na@gmail.com

Admission Details :

Bed Type : TWIN SHARING Bed No : LDR-416 Ward Name : 4F -OT
Room No : LDR-416 Admission Type : First Visit

Contact Details :

Name : Mr A. LOURDU MAR REDDY Relationship : Husband
Contact Address : 306,aravind vihar apartment, aravind vihar colony, domalguda,hyd Domalguda Hyderabad Telangana INDIA 500029 Phone No : 7569655303

Signature

Doctor Details :


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

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 50000.00
Payor Name : SELFPAY

ACTIVITY RECORD FOR BILLING

Name: ----- **HNH-00015513 IP26-00006451**
Mrs THANUGUNDLA PUSHPA
30-04-1973 53 Y 0 M 29 D (F)
Dr. SWAPNA SAMUDRALA

UHID No : -----  Consultant : ----- Dept : -----

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
29/5/26	11 AM	pre-post	O.T	Anubha Pooja
29/5/26	11:40 AM	O.T	pre - post	[Signature]

Cross Consultation Visit

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

HNH-00015513 IP26-0006451
Mrs THANUGUNDLA PUSHPA
30-04-1973 53 Y 0 M 29 D (F)
Dr. SWAPNA SAMUDRALA



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 29/5/26 Time of Admission :

Allergies: Not know any drug allergies

PRESENTING COMPLAINTS :

clb Heavy menstrual bleeding alw clots :: 6 months
 ↓
 USG. - Adenomyosis, ET=12.5mm
 ↓
 Conservatively managed
 H/O anemia received Parenteral Iron (cudoses)
USG (20/5/26) :- UT - 6 x 3.1 cm, R/O, Bulky, adenomyosis (+)
 ET=82mm, B/C ovaries - (N)


MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 30yrs. Previous Periods : - LMP-29/5/26 LMP : 29/5/26, Heavy cycls Contraception : v Tubectomy	Parity : P ₂ L ₂ Mode of Delivery : 2LSCS. Last Child Birth : 2005

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
clb to HTN :: 2 months. on T.Telmo uony OD clb to Pcc - Dm :: 2 months H/O varicose veins :: 2yrs	2 LSCS < 2008 1998 2005



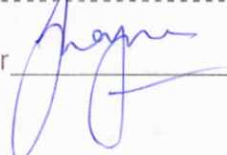
<p>FAMILY HISTORY:</p> <p>Mother - HTN + Dm</p>	<p>MEDICATION HISTORY:</p> <p>on 7. Telma long OD</p>
--	--

INITIAL ASSESSMENT :

Date <u>29/5/26</u> Ht. <u>151</u> Wt. <u>84 kg</u> BMI _____ B.P. _____ Pallor <u>(-)</u> CVR <u>S.S. (+)</u> Respiratory System <u>B/C N/V/S</u> Thyroid <u>(-)</u>	Breasts  Abdominal Examination Soft, NI	Local/Speculum Examination Bimanual Pelvic Examination
--	---	---

PROVISIONAL DIAGNOSIS: P₂ L₂ / 2 LSCS / PERIMENOPAUSEL ± AUB-A

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
- Blood Group - "O positive" Hb - 9.3 Plt - 3.8 LAK WBC - 8k] 23/5 HIV HbSAg HCV NR] NR Pap - NILM.	Hysteroscopy + Endometrial Bx - Informed consent - Prepare parts - Inform OT / Anesthetist - Shift to OT on call.

Name of the Doctor : Dr. Swapna Samudrala Signature of Doctor 

Date & Time : 29/5/26



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>POD-0</u>	
29/5/2022		<u>vdw</u>
11:30 AM		
	Cc- Fair Afabale	- NBM
	BP - 120/90 mmHg	- Oxyg as checked
	PR - 82 bpm	- WtF vitals & 30V
	PIA Soft	- Encourage to void
	L/E - NAD	- Inform SOB
Can be discharged		
Sent file. for discharge process.		
		<i>(Signature)</i>



OPERATION THEATER NOTES

HNH-00015513 IP26-00006451
Mrs THANUGUNDLA PUSHPA
30-04-1973 53 Y 0 M 29 D (F)
Dr. SWAPNA SAMUDRALA

Patient's Name : Age : Gender :

UHID : No. : Weight :

Surgeon : Dr. Swapna Samudrala Asst. Surgeon :

Anesthetist : Dr. Aysha OT Nurse :

Surgical Procedure :
Hysteroscopy + EB

Indications for Surgery :
Perimenopausal E AUB-A

Date : 29/5/26 Start Time : 11:05 AM End Time : 11:40 AM

PRE-OPERATIVE PREPARATION :

↓ All aseptic Precaution, PPD of parts done
10 Antibiotics

OPERATION NOTES:

Hysteroscopy finding:-

- UCC ~ 6cm
- Endocervical canal appear Normal
- Endometrial cavity Polypoidal
- Blv ostria seen

Endometrial
EB Curettage done & Endometrial Biopsy taken
Sample sent for HPS

POST - OPERATIVE ORDERS :

Adm

- NPO x 4 hrs
- IV / analgesia - Axon
- Drugs as charted
- monitor vitals 1/2 hly
- S/O check
- Oxygen flow

[Signature]

Discharge Advice

- T. Paracetamol 1000mg x 5 days
- P. Paracetamol 500mg / 915 x 5 days
- T. Dolo 650mg 915 x 3 days / 5 days
- T. Pan D twice daily before food x 5 days
- continue your usual medications
- Review x 1 wk @ A&E Dept

[Signature]

Consultant Surgeon's Name

[Signature]

Consultant Surgeon's Signature

Date : Time :

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swapna
 Asst. Surgeon : Dr. Manish
 Anaesthetist : Dr. Ayesha
 Scrub Nurse : Dr. Manish
Dr. Balu

HNN-00015513 IP26-00006451
 Patient Name : Mrs. THANUGUNDLA PUSHPA (F)
 30-04-1973 53 Y 0 M 26
 UHID No. :
 Date : 29/5/20
11:05 AM

Gender : Female
 Rainbow Children's Hospital
 It takes a lot to treat the little.
 BirthRight BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Before Induction of Anaesthesia >>

Before Skin Incision >>



Before Patient Leaves Operating Room

SIGN IN	Time: <u>11:05 AM</u>
Patient Has Confirmed	
Identity	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Site	<input type="checkbox"/> Yes <input checked="" 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 checked="" type="checkbox"/> Yes <input 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>Ayesha</u>	
Name : <u>Dr. Sk. Ayesha</u>	

TIME OUT	Time: <u>11:14 AM</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 checked="" 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?	<u>1.5 mins</u> <u>unremarkable</u> <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 checked="" type="checkbox"/> No <input type="checkbox"/> NA
Nursing Team Reviews:	<u>bronchospasm</u>
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>Raja @ 11:14 AM</u>	
Name : <u>Raja</u>	

SIGN OUT	Time: <u>11:40 AM</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	<input type="checkbox"/> Yes <input type="checkbox"/> No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
The Specimen is Labelled (including patient name)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
Whether there are any Equipment Problems to be addressed	<input 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 type="checkbox"/> Yes <input type="checkbox"/> No
Signature : <u>[Signature]</u>	
Name : <u>[Name]</u>	

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015513 IP26-00006451 Mrs. THANUGUNDLA PUSHPA 30-04-1973 53 Y 0 M 29 D (F) Dr. SWAPNA SAMUDRALA 		Date & Time of Admission 29/5/26 @ 9:30 am	Date & Time of Transfer Order 29/5/26 @ 11:40 am
From Unit OT		Transfer Ordered by Dr. Ayeesha	Reason for Transfer Observation
To Unit prepost		Information to Attendant Yes <input checked="" 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 checked="" type="checkbox"/> If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	Rh	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 		Name of Person Ordered Transfer Dr. Ayeesha	
Patient & Clinical Records Received by :			
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

HNH-00015513 IP26-00006451

Mrs THANUGUNDLA PUSHPA

30-04-1973 53 Y 0 M 29 D (F)

Dr. SWAPNA SAMUDRALA



MEDICATION RECONCILIATION FORM

Drug Allergies: None

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: NA

Shifted to: NA

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	<u>T. TELMA</u>	<u>40mg</u>	<u>PO</u>	<u>OD</u>		<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: Dr. Manisha

Date & Time: 29/05/2011 @ 9:40pm

Nurse Name & Signature: Chembakuru

Date & Time: 29/5/11 @ 9:40am

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



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG : <i>NJ CEFOTAXIME</i>				Date Time																		
Dose	Route	Frequency	Start Date																			
<i>1g</i>	<i>W</i>	<i>BD</i>	<i>29/5</i>																			
Name & Signature of the Doctor Starting the Drugs:																						
<i>M Armonsle</i>																						
Additional Instructions:																						
<i>PH</i>																						
Daily Doctor's Endorsement by a Sign																						
DRUG :				Date Time																		
Dose	Route	Frequency	Start Date																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						
DRUG :				Date Time																		
Dose	Route	Frequency	Start Date																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						
DRUG :				Date Time																		
Dose	Route	Frequency	Start Date																			
Name & Signature of the Doctor Starting the Drugs:																						
Additional Instructions:																						
Daily Doctor's Endorsement by a Sign																						

Patient Sticker

Weight. Ward.

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
29/5	10:50 AM	1mg PANTOPRAZOLE	40mg	IV	<i>[Signature]</i>	<i>[Signature]</i>
29/5	10:50 AM	1mg METOLIOPEAMIDE	10mg	IV	<i>[Signature]</i>	<i>[Signature]</i>
29/5	9:30 AM	NEB- DUOLIN	3ml.	Nasal	<i>[Signature]</i>	Chude Anu
29/5	9:30 AM	NEB- BUDECORT (BUDESONIDE)	2ml 3mg	Nasal	<i>[Signature]</i>	Anusha Chudey
29/5	11:10 AM	1g PARACETAMOL	1gm	IV	<i>[Signature]</i>	<i>[Signature]</i>
29/5	11:25 AM	1g TRANEXAMIC ACID	1gm	IV	<i>[Signature]</i>	<i>[Signature]</i>
29/5	11:30 AM	DICLOFENAC Suppository	100mg	PR	<i>[Signature]</i>	<i>[Signature]</i>
29/5	11:30 AM	TRAMADOL Suppository	100mg	PR	<i>[Signature]</i>	<i>[Signature]</i>

VERIFIED BY: Name Signature

HNH-00015513 IP26-00006451

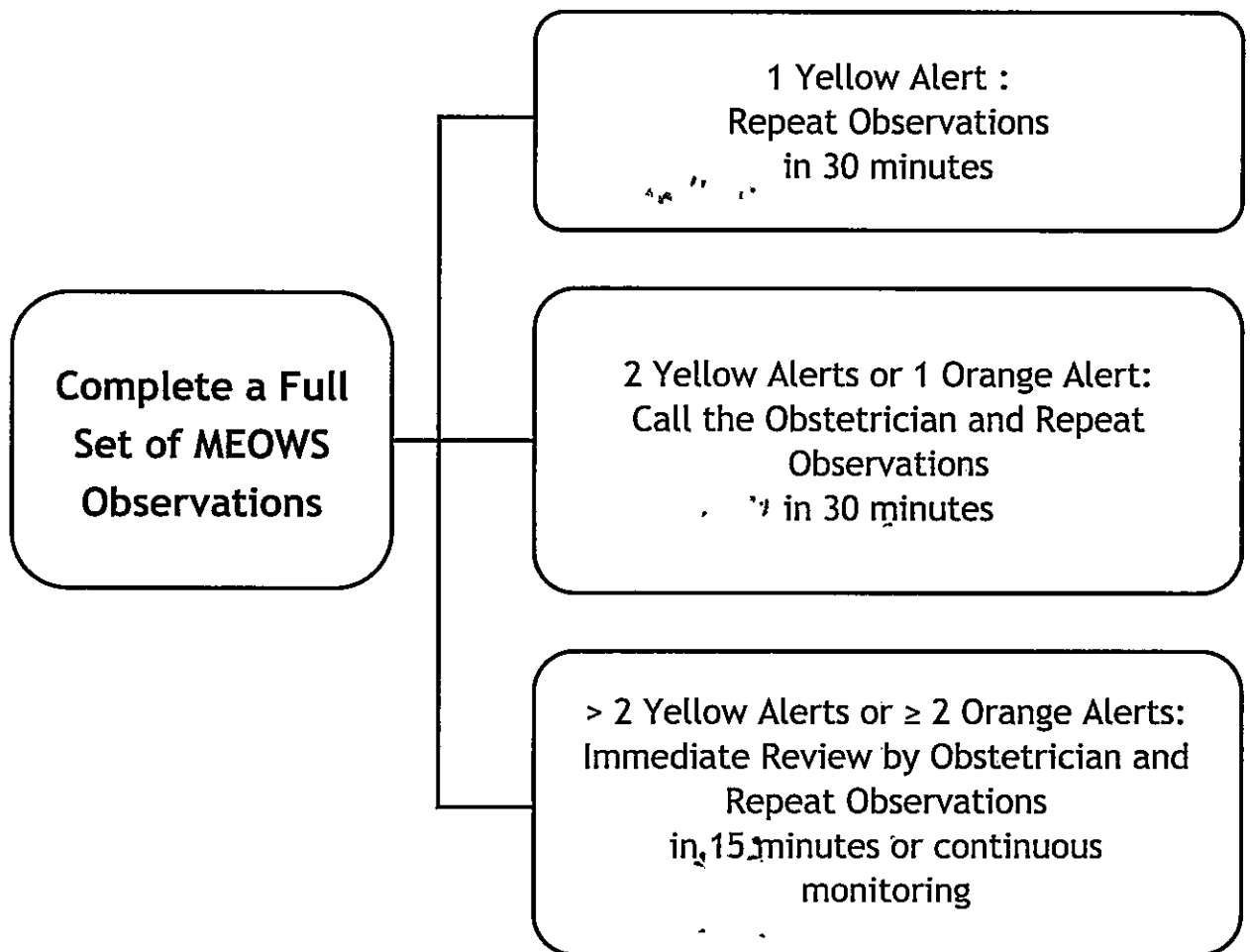
Mrs THANUGUNDLA PUSHPA
30-04-1973 53 Y 0 M 29 D (F)
Dr. SWAPNA SAMUDRALA



RESULT SHEET

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

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			
	08:00 am												
	09:00 am	RW	W	100ml						✓			
	10:00 am	RW		100ml									
	11:00 am	RW	B	100ml									
	12:00 pm	RL	M	100ml									
	01:00 pm												
Total Intake : Taken						Total Output : Passed							
	02:00 pm	RL	NBM	100ml	-								
	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

Patient Sticker

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



CHECKLIST FOR THROMBOPHLEBITIS

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

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 : *[Signature]* Name : *Chembakavoo*

Signature of Ward In Charge :

Signature : *Kes. Thuri* Name : *Kes. Thuri*

HNH-00015513 IP26-00006451
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 0 M 29 D (F)
 Dr. SWAPNA SAMUDRALA



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Score	Fall Risk Grading			
History of Falling (immediately or w/in 3 months)	Yes	25	29/5/20	mb	Risk Level	Morse Fall Score (MFS)	Action
	No	0					
Secondary Diagnosis (more than one diagnosis)	Yes	15			Low Risk	0 - 24	Standard Fall Precaution
	No	0					
Ambulatory Aid	Furniture	30			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15					
	None /Bed Rest /Nurse Assist	0					
IV / Heparin Lock or Saline	Yes	20	20		High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0					
GAIT / Transferring	Impaired	20			Total Morse Fall Scale Score:	20	Signature
	Weak (uses touch for balance)	10					
	Normal /On Bed Rest /Immobile	0					
Mental Status	Forgets limitations	15	0				
	Oriented to own ability	0					

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

HNH-00015513 IP26-00006451
 Mrs THANUGUNDA PUSHPA
 30-04-1973 53 Y O M 29 D (F)
 Dr. SWAPNA SAMUDRALA



BRADEN 'Q' SCALE



Date : 28/5
 Time : 12:26

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

TOTAL SCORE

Evaluator's Name

28

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
29/5/26	10pm	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	
				<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		
				<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		
				<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		
				<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		
				<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		
				<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		
				<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		
				<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		

Re-assessment Frequency:

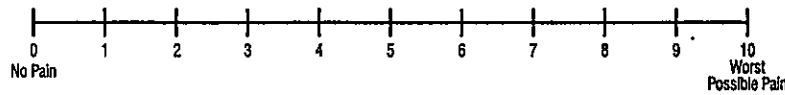
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 of 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



HNH-00015513 IP26-00006451
 Mrs THANUGUNDLA PUSHPA
 30-04-1973 53 Y 0 M 29 D (F)
 Dr. SWAPNA SAMUDRALA



NURSING CARE RECORD



Date: 29/5/26

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	8 AM to 2 PM	=> Assess the patient condition => plan for vital => plan for I/O chart	8 AM to 2 PM	=> Assessed the patient condition => maintain vital & Record => maintain block chart	patient is stable	vital is normal	Cloudy
Afternoon	Day duty						
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							



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: <i>hysteroscopy</i>	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	<i>21/5/20</i>						
	Shift	<i>mb</i>						
	Medical Condition (Any special condition to be noted):	<i>-</i>						
	Diet:	<i>NBM</i>						
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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):	<i>-</i>						
	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:	<i>1</i>					
		Res:	<i>20</i>					
		SpO ₂ :	<i>100%</i>					
		Pulse:	<i>99/min</i>					
		BP:	<i>100/77</i>					
		LOC:	<i>-</i>					
	Fall Risk Score:	<i>-</i>						
Pain Score:	<i>-</i>							
Skin Integrity:	<i>-</i>							
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	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Physiotherapy:	<i>-</i>						
	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:	<i>NBM</i>						
	Critical Lab Test / Values:	<i>-</i>						
	Other Special Orders / Medications:	<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	
	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):	<i>+</i>							
Post Operative Procedure Special Orders:		<i>-</i>						
Handed Over By Name :		<i>C hand</i>						
Signature / ID :		<i>CF</i>						
Date:								
Time:								
Taken Over By Name :		<i>Anusha</i>						
Signature / ID :		<i>0101</i>						
Date:								
Time:								

Patient Sticker



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input checked="" 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	<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	<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	<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	<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 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 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 :								
Signature / ID :								
Date:								
Time:								
Taken Over By Name :								
Signature / ID :								
Date:								
Time:								