Dr. Archana

Rainbow® Children's Hospital
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ESTIMATION SLIP

Date : 6/2/26 **UHID / IP No. :** NEW **Sl No.** 1670

Name of Patient : Mrs. Preethi Yadav **Age:** 41yrs **Gender:** F

Father's / Husband's Name : Mr. Vijay Anand **Corporate / Occupation :** _____

Address : _____ **Phone :** 9052166105 **Email :** _____

Procedure / Plan : Hysteroscopic Polypectomy **EDD/Dos:** July 26

MODE OF PAYMENT : ☑ **SELF** ☑ **TPA :** Care health Insurance ☐ **GIPSA :** _____ **OTHER**

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward		
Twin Shared Ward		
Private Room	95K 17,500/- Per day	& blood transfusion 4000/- Extra
Super Deluxe Room		
Suite Room	+ Pharmacy & Investigations Extra	& Non Payable Extra
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 : 10,000/- Advance time of Admission

REMARKS :

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

DECLARATION

I Praveen Yadav 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

Brother
Signatory Relationship

Signature of the financial Counselor

HNH-00016460 IP26-00006803
Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 24 D (F)
Dr. ARCHANA LALITHMOHAN

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SURGERY DETAILS

Date : 11-07-26

Patient Name: Mrs. preethi yadav Date of Birth: 17-2-1986 Age: 40Y

Gender: female Ward : OT UHID No. HNH-00016460

Date of Surgery: 11-07-26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Hysteroscopic POLYPECTOMY

Time in : 10:15am Time Out : 11:05am.

		NAME	AMOUNT
1.	Surgeon	Dr. Archana lalithamohan	
2.	Anaesthetist	Dr. Ayeesha.	
3.	Assistant Surgeon	Dr. Sowathi	
4.	OT Technician	Br. Arvind	
5.	Circulating Nurse	Sr. Natasha, Sr. Puja	
6.	Assistant Nurse	Sr. Archana	

Mrs PREETHI YADAV (40 Y 4 M 24 D/ F) ENDOMETRIA NINV00213 HN26011491ENDO

Mrs PREETHI YADAV (40 Y 4 M 24 D/ F) TISSUE NINV00215 HN26011492020

Special Equipment: ☐ Laparascopy ☐ Broncoscope ☐ Harmonic ☐ Morcelator
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa
☐ Neuro Cusa ☐ Others hysteroscopy instrument charges (26-00002127 20)

For Dr Archana
Signature of the Surgeon

Puja.
Signature of Circulating Nurse

Order No: 26-0000212719 Order by: Archana 11/7/26 @ 11:44Am

HNH-00016460 IP26-00006803
Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 24 D (F)
Dr. ARCHANA LALITHMOHAN

Hysteroscopy polypectomy

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CONSUMABLES OF OT

Circulating staff : Pooja Technician : Arvind Date : 11/7/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack Gonal		1	Inj Vit.K		
~~LMA~~ IGL 3		01	Sutures			Cord Clamp		
ECG leads : A / P / N		07				Suction Catheter		
HME filter : A / P / N			Needle 26G		2	Feeding Tube		
Syringes : 10 cc		04				Vaccum Suction Set		
05 cc		04	Gloves 6.5 Encore		2	Surgical Gloves		
02 cc			SG-6.5		1	Gauze Pack		
01 cc			SG 6		4+2	Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		02	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml			Koochies					
MIDAZOLAM		01	Ointments					
O2 mask (A)		01	Suction Catheter					
Fentanyl		01	Cap, Mask		10+10			
~~Morphine~~ Nasopharyngeal Airway 28		01	Gauze Pack 10x10, ~~2x2~~		2			
Ketamine			Mop Pack		1			
Propofol		02	Steristrip					
~~Rocuronium~~ 10 - [illegible]		1	Underpad		02			
Glycopyrolate			Draw sheet		0			
Myopyrolate			Abgel					
Ondansetron		01	Foleys catheter					
Pencan 25g/ Spinal Needle 22			~~Urobag~~ Nelton catheter 10		1			
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			~~Bandage~~ ~~Lox~~ Jelly		0			
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / 100mg		01	~~Plastic Bed Sheet~~ Apron		3			
Tab. Misoprost : 200mg			Betadine Solution		2			
Feeding tube 10no		01	Microshield		2			
			Cotton Balls		4			
			Latex Gloves		10			
			Ramdione Scrub					
			~~Saral~~ TUR set		V			

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-000021273S/734 Ordered by : Archana 11/7/26 @ 12:32pm

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

Rainbow Children's Hospital

Birthright Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00016460	**Name**	: Mrs PREETHI YADAV
Age / Sex	: 40 Y 4 M 24 D / Female	**Doctor**	: ARCHANA LALITHMOHAN BHURIWALE
Adm/Reg Date/Time	: 10/07/2026 10:41	**Payor**	: CARE HEALTH INSURANCE LIMITED
Order Date	: 11/07/2026 12:31	**Ordernumber**	: 26-0000212735
Visit ID	: IP26-00006803	**Ward/Bed No**	: 4F -OT / PRE/POST-420
Patient Address	: 15-4-452, Gowliguda, Hyderabad, Telangana, INDIA, 500012		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		10 Nos	Ordered
2	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Ordered
3	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Ordered
4	IGEL NO 3.0	IGEL 3.0	1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
5	DISPOSABLE APRONS STERILE XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Ordered
6	SURGEON CAP FEMALE SAFE SECURE		1 Nos	External / 10 AM	1 Days		10 Nos	Ordered
7	INFANT FEEDING TUBE-10	INFANT FEEDING TUBE 10	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
8	UNDER PAD 60X90 10's Pack - MEDICUBE		1 Nos	External / 10 AM	1 Days		2 Nos	Ordered
9	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Ordered

ARCHANA LALITHMOHAN BHURIWALE

Reg No : 59786

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

Note

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

*** Do not refill medicines.**

Rainbow Childrens Hospital-Himayatnagar

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

ELECTRONIC MEDICINE PRESCRIPTION

MRN	HNH-00016460	Name	: Mrs PREETHI YADAV
Age / Sex	40 Y 4 M 24 D / Female	Doctor	: ARCHANA LALITHMOHAN BHURIWALE
Adm/Reg Date/Time	10/07/2026 10:41	Payor	CARE HEALTH INSURANCE LIMITED
Order Date	11/07/2026 12:31	Ordernumber	26-0000212734
Visit ID	IP26-00006803	Ward/Bed No	4F -OT / PRE/POST-420
Patient Address	15-4-452, Gowliguda, Hyderabad, Telangana, INDIA, 500012		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	BACTOPREP SOLUTIONS 100 Ml.		1 mL	/ Once Daily	2 Days		2 Nos	Dispensed
2	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
3	SGLOVE # 6 (SURGICARE)	SURGICAL GLOVES 6.0	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
4	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
5	ONDOKIND INJ 4 MG 2 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
6	IRRIGATTO(T.U.R SET)	IRRIGATTO(T.U.R SET)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
7	MEZOLAM INJ 5 MG 5 ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
8	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / 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	NEEDLE 26 G	DISPOSABLE NEEDLES 26	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
12	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
13	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
14	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
15	GENERAL SURGERY KIT SAFE SECURE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
16	MCT-ROF 100MG 10ML		1 Nos	Injection / Once Daily	1 Days		2 Nos	Dispensed
17	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
18	GAUZE PACK STERILE 10X10X12 PLY 5S	GAUZE PACK STERILE 10X10X12 PLY 5 PACK	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
19	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
20	Encore Micropic gloves-6.5		1 Nos	/ Once Daily	1 Days		2 Nos	Dispensed
21	NASOPHARYNGEAL TUBES 28	NASOPHARYNGEAL TUBE28	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
22	NELTON CATHETER-10 POLYMED		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed

ARCHANA LALITHMOHAN BHURIWALE

Reg No : 59786

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Note

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* Do not refill medicines.

Name	Mrs PREETHI YADAV	**UHID**	HNH-00016460
Father/Guardian	Mr VIJAY ANAND YADAV	**Age/Gender**	40 Y 4 M 23 D/ Female
Address	15-4-452, Gowliguda, Hyderabad, Telangana, INDIA, 500012		
IP No	IP26-00006803	**Admission Date**	10-07-2026
Ref Doctor	Self.		
Discharge Date	12.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. Archana Lalith mohan Bhuriwale
MBBS, D.G.O, Fellowship in infertility
OBS & GYN, Infertility Specialist
Regd. no - 59786

CO CONSULTANT -
DR SWATHI HV ,
MS OBG , FMAS
15501

Diagnosis: ABNORMAL UTERINE BLEEDING - ENDOMETRIAL POLYP WITH MODERATE ANEMIA

HYSTEROSCOPY + POLYPECTOMY DONE ON 11.07.2026

History: She presented with complaints of heavy menstrual bleeding, since january 2026, not associated with clots or dysmenorrhea. No other complaints.

Name	Mrs PREETHI YADAV	**UHID**	HNH-00016460
IP No	IP26-00006803	**Admission Date**	10-07-2026

Scan done on 17.06.2026 showed Uterus AV, m/s 70*34**42 mm ,normal in size ,shape , echotexture,ET-18 mm ,A single pedunculated fundal endometrial polyp ms 13*7 mm noted ,Cervix -bulky with cervicitis with single polyp in proximal segment of cervix,bilateral ovaries - polycyctic morpholgy, Cholelithiasis and mild splenomegaly present. Routine investigation was done and Hb traced to be 7g/dl. She is admitted for Hysteroscopy + polypectomy.

Menstrual History:-
LMP- 21.06.2026
Previous cycles: Irregular

Obstetric History: P2L2A1, 2NVD, LCB 15 year

Medical History: Hypothyroidism since 2 years
Family History: Father- HTN
Surgical History: Nil
Allergies: Nil

Investigations: Enclosed.
Blood group: "B" Positive

Management: Course in hospital:
On admission vitals were stable. 1 unit PRBC transfusion done on 10.07.2026 in view of moderate anemia (hb 7g/dl) after informed consent. She was closely monitored. Her vital signs remained stable. Repeat CBC was done, Hb was 7.4g/dl. She was prepared for Hysteroscopy + polypectomy. Written informed consent taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Antibiotic prophylaxis with Inj. Taxim 1 gm IV given. Patient shifted to theatre.

Name	Mrs PREETHI YADAV	**UHID**	HNH-00016460
IP No	IP26-00006803	**Admission Date**	10-07-2026

Surgery Notes:
Operation performed: **HYSTEROSCOPY + POLYPECTOMY DONE UNDER GENERAL ANAESTHESIA**

Indication: ABNORMAL UTERINE BLEEDING - ENDOMETRIAL POLYP

Operative findings:
- Polypoidal endometrium
- Pedunculated polyo originating from right anterolateral wall of cervical canal.
- Polypectomy done with hysteroscopic scissors.
- D&C done and Endometrium curettage obtained.
- Endometrial curettings and Polyp sent for HPE

Post-Operative Notes:
She was closely monitored post Operatively. She was encouraged to ambulate and void 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. Tab. Taxim - O 200mg (Cefixime 200mg) twice daily till 15.07.2026 (9am-9pm) after food.
2. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 15.07.2026
3. Tab. Zincovit once daily (2pm) for 1 month after food.
4. Tab Meftal Spas twice daily`13.07.2026.
5. Tab Pause MF thrice daily for 3 days.

Name	Mrs PREETHI YADAV	**UHID**	HNH-00016460
IP No	IP26-00006803	**Admission Date**	10-07-2026

6. Tab Livogen 1 tab twice daily (7am-7pm) for 1 month.
7. Continue Tab Thyronorm 50 mcg till further advice.
8. Collect HPE report

Review consultation with **Dr. Archana Lalithmohan Bhuriwale,** after **10 days** on **20.07.2026** in Gynec OPD with prior appointment.

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 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**

RAINBOW CHILDREN'S MEDICARE LIMITED * HYDERABAD

Registrar/Resident/C.M.O

Consultant:
Dr. Archana Lalithmohan Bhuriwale
MBBS, D.G.O, Fellowship in infertility
OBS & GYN, Infertility Specialist
Regd. no - 59786

HNH-00016460 IP26-00006803
Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 23 D (F)
Dr. ARCHANA LALITHMOHAN

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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP No : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
10/7/26	9.5pm	pre-post	Room	Suvitha /
11/7/26	7Am	Hoor	LDR	Amrutha /
11/7/26	10 Am	MICU	OT	Mounika

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
11/7/26	CBP	11453	[illegible]
			Cross check done by Akula 11/7/26

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
10/7	Infusion pump	2:30 pm	7pm	2568	Mou
10/7	cardiac monitor	2:30pm	7pm	2572	①
					cross checked by sujatha 10/7/26 @ 9pm
			11/7/26		
11/7	cardiac monitor	11:15Am	2:30pm	12798	Akila
11/7	Infusion Pump	11:15Am	2:30pm		cross check done by Akila 11/7/26

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
10/2/26	IV placement	1	12566	MOi
10/2/26	Blood transfusion	1	12569	MOi
			crosschecked	
9/2/26	PAC - OP	1	PRS26-000 by smith	
			22302 10/2/26@	
				9am

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016460 IP26-00006803
Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 23 D (F)
Dr. ARCHANA LALITHMOHAN

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : ....

Time of Admission : ....

Allergies: Nil

☑ Not know any drug allergies

PRESENTING COMPLAINTS :

C/o HMB :: Jan 2026 not ass c̄ clots / dysmenorrhea

USG (17/June) - Cholelithiasis | mild splenomegaly
Thickened Endometrium c̄ Single pedunculated Fundal Endometrial polyp
Bulky Cervix c̄ cervicitis c̄ Single Polyp in Proximal Segment of Cervix
B/L PCOD

For Hysteroscopy + Polypectomy on 11/7 after Blood Transfusion (on 10/7)

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 24y	Parity : $P_2L_2A_1$ — A_1 - MERPL; P_1 - NVD; P_2 - NVD - Fem/15yrs
Previous Periods :	Mode of Delivery :
LMP : - 21/06/2026	Last Child Birth : 2011
Contraception : MH Irregular	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Hypothyroidism :: 2yrs	Nil

HNH-00016460 IP26-00006803
Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 23 D (F)
Dr. ARCHANA LALITHMOHAN

FAMILY HISTORY:	MEDICATION HISTORY:
~~NIL~~ Father - HTN	T. Thyronorm 50mcg OD

INITIAL ASSESSMENT :

Date 10/7/2026 Ht. ______ Wt. ______ BMI ______ B.P ______ Pallor (+) CVR NAD Respiratory System NAD/BAE(+) Thyroid NAD	Breasts NAD. Abdominal Examination Soft, NT.	Local/Speculum Examination not done Bimanual Pelvic Examination not done.

PROVISIONAL DIAGNOSIS : AUB - P / Mod Anemia for Hysteroscopy + Polypectomy

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
CBP (8/7/2026) [SGT - B+ve] Hb - 7 gm/dl. TLC - 9600 cells/cumm. PCV - 23.4%. ESR - 25. plt - 4.13. RBS - 93. HIV, HbsAg, HCV, VDRL } NR. TGR - 281 TSH - 2.99. PT - 17.2. INR - 1.2. CXR - mild Cardiomegaly Urea - 21.	Admission 1 PRBC ISSUE AND TRANSFUSION. 1 0 PRBC Rescue. Post Transfusion Rpt CBP. Inform AXON team regarding BT plan for hysteroscopic Polypectomy T/M @ 10am. Monitor Vitals Inform SOS

Name of the Doctor : Dr. Archana. Yadav.

Signature of Doctor: [signature]

Date & Time : 10/4/2026 @ 12:00pm.

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Dr. ARCHANA LALITHMOHAN

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
10/2/26 4:30PM	c/s/B Dr. Veena P_2L_2 | 2NVD c AUB-P | c moderate anemic	
10 PRBC Ongoing	Pt is stable, No c/o O/E GC fair, Afebrile Vitals - stable P/A - Soft, BS (+) L/E - NAD.	Adv - Soft diet - Repeat CBP Post transfusion - Pre-op medications from tonight - Consent for Hysteroscopy - Vital monitoring - w/f transfusion reactions. - Inform SOs - NBM from 12 AM
10/2/26 7pm.	c/s/B Dr. Dua P_2L_2 | 2NVD | AUB-P | Mod Anaemia	
10 PRBC transfused	GC fair, Afebrile Vitals - stable P/A soft, Non tender. L/E NAD	Adv - Soft diet - Preop medication tonight - Vital Monitoring - Repeat CBP after 6 hours (As per AXDN) - NBM from 12AM - Inform SOs - Consent For Hysteroscopy
Pt can be shifted to room.		

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/7/26	C/S/B D1 Drug	
AM	P2L2/NVD/AUB-P	
	CC Pain	Adv
	Afebrile	- NBM
10 PRBC	Vitals-Normal	- Parts preparation
transfusion done.	P/A Soft	- PreOp medications
		- Informed Consent
		- Monitor Vitals
		- Inform SOS
11/7/26	C/O Dr Archana	
11:30 pm	& Mamshi	
	POD-0 Hysteroscopy + Polypectomy	
	CC-Pain Afebrile	Adv
	vitals stable	- NBM x 2-4 hr
	BP P80/70	- Drugs as charted
	CR BG	- O/E vitals & PV (if any)
	P/A Soft	- Encourage to pass urine
	C/E NAD	- Inform SOS

Dr Archana

HNH-00016460 IP26-00006803
Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 23 D (F)
Dr. ARCHANA LALITHMOHAN

Rainbow® Children's Hospital
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
11/[illegible] 3pm	C/S/b Dr Mamsh	
	GC - Fair Afebrile	Ah
	BP 94/56 (C8	
	PR 87	- Allow Sips.
	P/A soft	- Drips as charted
	L/E NAD	- OTF vouls.
		- Can be Discharged
	4- yet to void	Send file for Processing
		[signature]
		[signature]

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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RESULT SHEET

Date	11/7					
Time						
Hb	7.04					
PCV	23.01					
RBC	4.00					
WBC	7.66					
N/L	66.2					
Platelets	409					
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		1⊙PRBC issues done				
Blood group = B+ve		1⊙ PRBC Reserve in surya blood bank				
HIV, HBsAg, HCV, VDRL } NR.						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

Signature .....

VERIFIED BY : Name .....

Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 23 D (F)
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REGULAR PRESCRIPTIONS

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

DRUG : INJ. CEFOTAXIME

Dose	Route	Frequency	Start Date
1g	IV	BD	11/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

(AFTD)

Date / Time: 11/7 — 10AM — 10pm

Daily Doctor's Endorsement by a Sign

DRUG : T. THYRONORM

Dose	Route	Frequency	Start Date
75mcg	P/O	OD	11/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Date / Time: 11/7 — 6AM

Daily Doctor's Endorsement by a Sign

DRUG : T. PARACETAMOL

Dose	Route	Frequency	Start Date
1gm	PO	TID	11/7/26

Name & Signature of the Doctor Starting the Drugs:

Dr. Ayesha

Additional Instructions:

Date / Time:

Daily Doctor's Endorsement by a Sign

DRUG : T. DICLOFENAC

Dose	Route	Frequency	Start Date
50mg	PO	BD	11/7/26

Name & Signature of the Doctor Starting the Drugs:

Dr. Ayesha

Additional Instructions:

Date / Time:

Daily Doctor's Endorsement by a Sign

Patient Sticker

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Sheet No: .....

REGULAR PRESCRIPTIONS

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

DRUG : T. TRAMADOL	Date / Time														
Dose: 100mg	Route: PO	Frequency: BD	Start Dt.: 11/07												
Name & Signature of the Doctor Starting the Drugs:															
Additional Instructions:															
Daily Doctor's Endorsement by a Sign															

DRUG : T. PANTOPRAZOLE	Date / Time														
Dose: 40mg	Route: PO	Frequency: BD	Start Dt.: 11/7												
Name & Signature of the Doctor Starting the Drugs:															
Additional Instructions:															
Daily Doctor's Endorsement by a Sign															

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

DRUG :	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 .....

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

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

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

DRUG :				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-00016460 IP26-00006803

Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 23 D (F)
Dr. ARCHANA LALITHMOHAN

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
10/7/26	10PM	INJ. PANTAPRAZOLE	40mg	P/O		Amrutha
10/7/26	10PM	INJ. METOCLOPROMIDE	10mg	P/O.		Amrutha
11/7/26	10AM	INJ. PANTAPRAZOLE	40mg	IV		Mouni
11/7/26	10AM	INJ. METOCLOPROMIDE	10mg	IV		Mouni
11/7	10AM	TAB MISOPROSTOL	400 mcg	P/PR		Mouni
11/7	10:15Am	Inj. PARACETAMOL	1gm	IV		Kaveri
11/7	10:25Am	Inj. ONDANSETRON	4 mg	IV		Kaveri
11/7	11Am	DICLOFENAC Suppository	100mg	PR		Archana
11/7	11Am	TRAMADOL Suppository	100mg	PR		Archana

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

Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 23 D (F)
Dr. ARCHANA LALITHMOHAN

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
10/7	2:30 pm	L (1) Packed RED BLOOD CELLS (PRBC)	IV	50 ml/h			10/7/26		
10/7	11 AM	RINGER LACTATE							
11/7	10:15 AM	RINGER LACTATE	IV	1000 ml/h					

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

HNH-00016480 IP26-00006803
Mrs PREETHI YADAV
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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 10/7

Baseline Information:

Admission From: ☐ ER ☐ OPD ☐ Admission Desk ☐ Others, specify .....

Primary Language: ☐ Telugu ☐ English ☐ Hindi ☐ Others, specify .....

Do you require an interpreter? ☐ Yes ☐ No if Yes specify .....

Source of Information: ☐ Patient ☐ Family ☐ Others, specify .....

Allergies: ☐ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: .....

If yes , identify .....

Chief Complaints: ..... Doctor Notified on Admission: ☐ Yes ☐ No

..... Name of the Doctor: .....

..... Time Notified: .....

Past Medical History: Obtained From ☐ Patient ☐ Family Member ☐ Medical Record ☐ Other (specify) .....

Past Medical History	Past Surgical History	Previous Hospital Admission

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

..... Regular

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☐ No ☐ Yes

Cervical Cerclage: ☐ No ☐ Yes

Ectopic Pregnancy: ☐ No ☐ Yes

Myomectomy: ☐ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☐ No ☐ Yes

Vaginal Discharge: ☐ No ☐ Yes

Post-Coital Bleeding: ☐ No ☐ Yes

Infertility: ☐ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G ..... P ..... L ..... A .....

Previous LSCS: .....

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

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: ..... HR: ..... RR: .....

BP: ..... Weight: ..... Height: ..... BMI: .....

Pain Assessment: **Pain:** ☐ Yes ☐ No (If Yes, complete the Pain Assessment / Reassessment Form)

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PHYSICAL ASSESSMENT

General Appearance: ☑ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others: .....

Fall Assessment: ☐ Yes ☐ No Score ..... (complete the Morse Fall Risk Assessment Sheet)

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

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

☐ Mobility problem ☐ Walking Problem ☐ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With .....

Orientation has been given regarding the following aspects:

Call Bell in Reach : ☐ Yes ☐ No Waste Disposal Explained: ☐ Yes ☐ No

Infusion Pump : ☐ Yes ☐ No Hand Hygiene Explained: ☐ Yes ☐ No ☐ Others

Above information given to ..... Patient .....

Name of Person Orientation was given to: ..... mrs. preethi .....

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: ..... Moonica .....

Date & Time: ..... 10/7/16 .....

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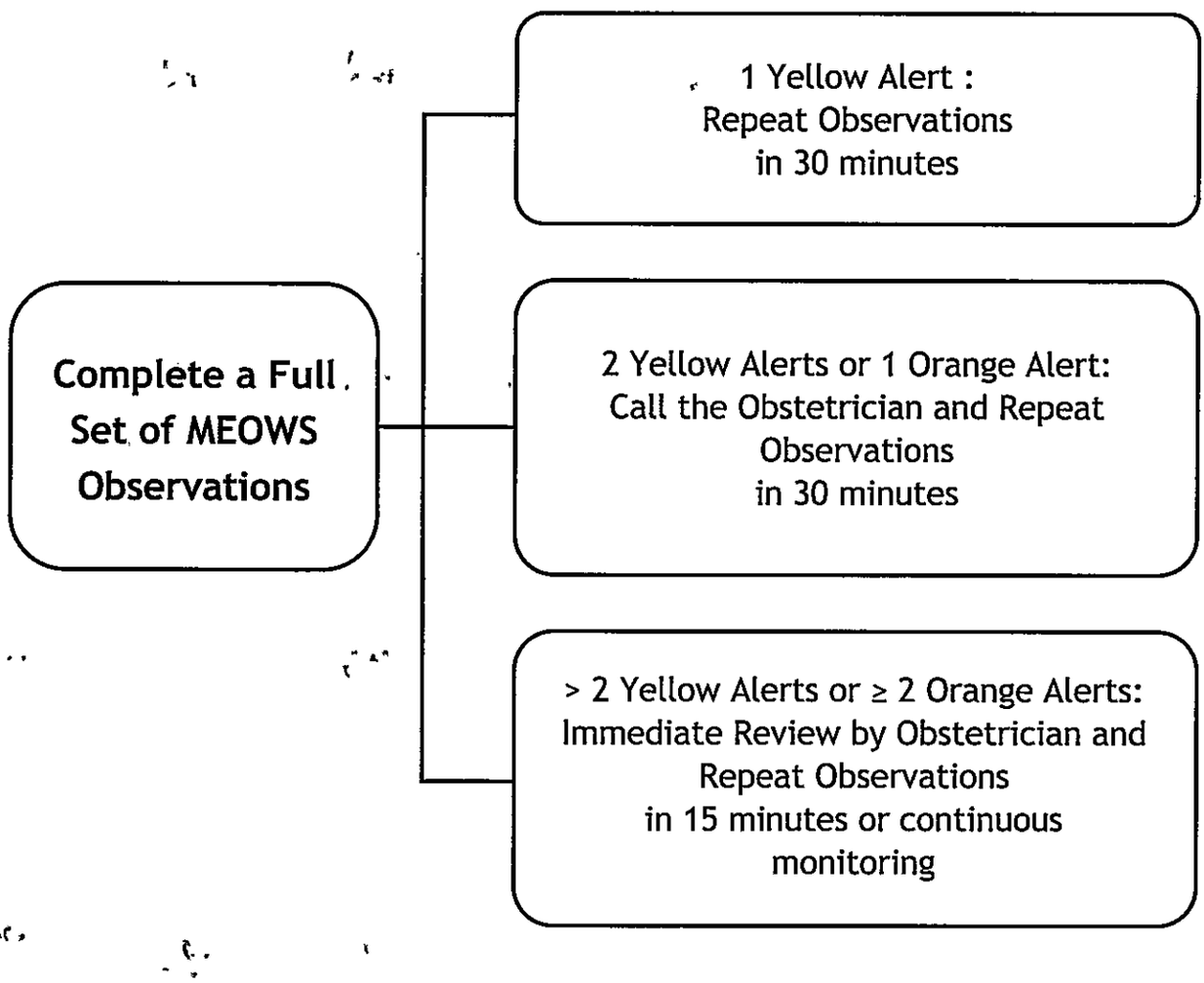
Early Warning Observation Score Chart - Obstetrics

10/7/26

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

		Date																							
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20								20	20	20	20	20	20	20		20				20				20	
	0 - 10																									
Saturations	94 - 100 %								99	99	99	99	99	99	99		98				98				98	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36									36			36		-		99				98				98	
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70								76	72	84	88	86	91			78				80				81	
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110								122	117	122	120	122	115			116				115				109	
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80								67	70	67	70	75	75			79				73				60	
	70																									
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert								–	–	–	–	–	–			–				–				–	
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30								–	–	–	–	–	–			–				–				–	
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																–				–				–	
	Heavy / Foul																									
Liquor	Clear / Pink																–				–				–	
	Green																									
TOTAL YELLOW SCORES									0	0	0	0	0	0			0				0				0	
TOTAL ORANGE SCORES									0	0	0	0	0	0			0				0				0	
Nurse Initial									AD	AD	AD	AD	AD	AD			AD				AD				AD	

Obstetrics and Gynaecology Early Warning Signs



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

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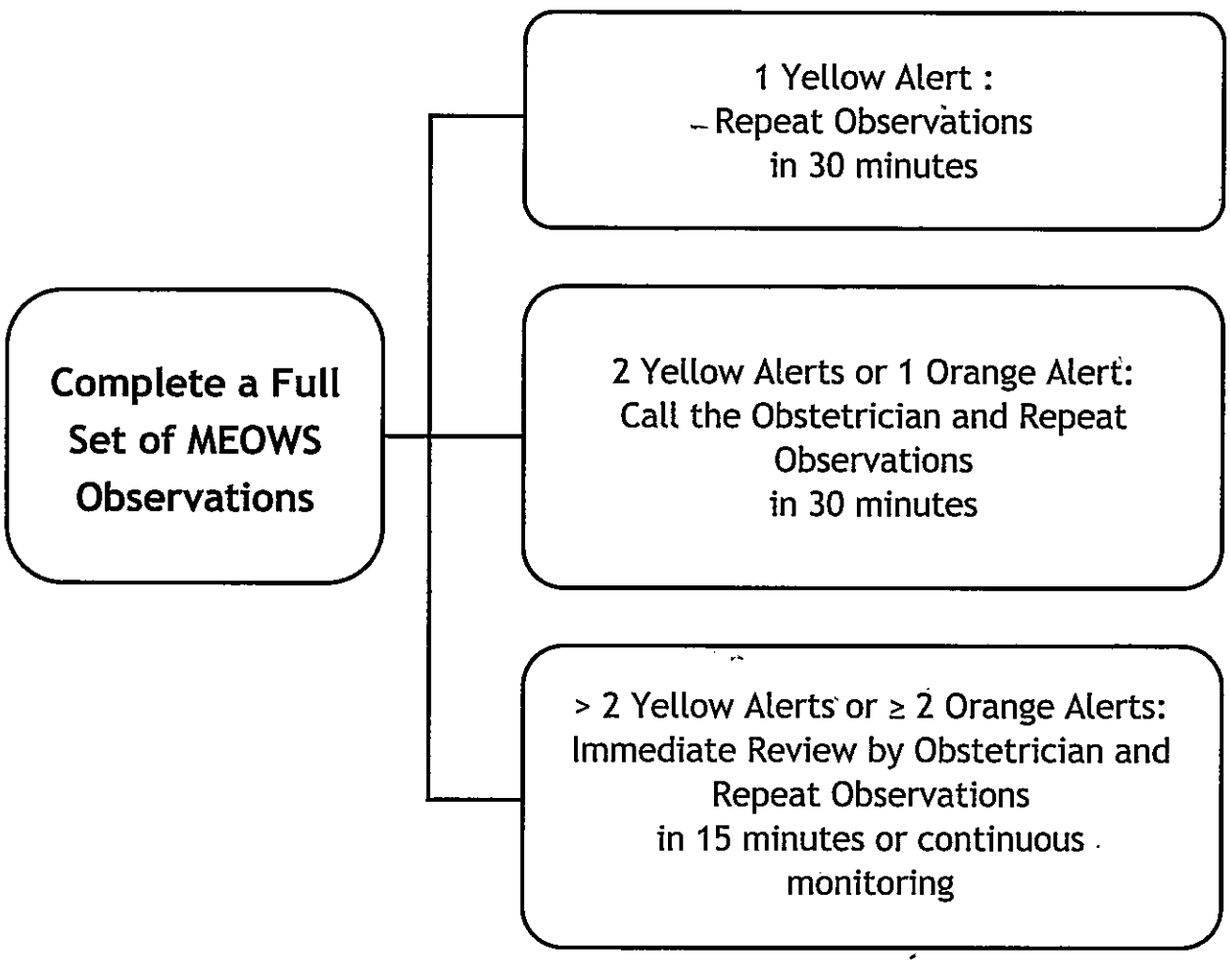
Warning Observation Score Chart - Obstetrics

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

		Date	11/7																							
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20			20	20		20		20																	
	0 - 10																									
Saturations	94 - 100 %			ok	ok		98		98																	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36						–		–																	
	35				36																					
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80			80	82		75		87																	
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120			120	104		115		109																	
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70			64	74		72		80																	
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert			✓		–			–																	
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30			–		–			–																	
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES				0		0			0																	
TOTAL ORANGE SCORES				0		0	0		0																	
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

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FLUID CHART

Sheet No. : 1

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
9/7/16	02:00 pm											
	03:00 pm	Blood transfusion								✓		
	04:00 pm									✓		
	05:00 pm											
	06:00 pm											
	07:00 pm		Ryle									
Total Intake :						**Total Output :**						
10/7	08:00 pm			~~75~~								
	09:00 pm											
	10:00 pm	RL	H2O	75ml						✓		
	11:00 pm	RL		75ml			0				0	
	12:00 am		NPO	~~75ml~~						—		
	01:00 am			75ml								
Total Intake :		Taken				**Total Output :**						
11/7	02:00 am			75ml								
	03:00 am			~~75ml~~								
	04:00 am	RL	NPO	~~75ml~~						✓		
	05:00 am	RL	NPO	~~75ml~~			0				0	
	06:00 am			~~75ml~~								
	07:00 am			7m						—		
Total Intake :		Taken				**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
11/2/26	08:00 am											
	09:00 am	RL	N	100ml								
	10:00 am	RL	B	100ml								
	11:00 am	RL	M	100ml				NA				
	12:00 pm	RL										
	01:00 pm	RL										
Total Intake :						**Total Output :**						
12/2/26	02:00 pm	RL		100ml								
	03:00 pm	RL		100ml								
	04:00 pm	RL		100ml								
	05:00 pm			100ml				NA				
	06:00 pm			100ml								
	07:00 pm			100ml								
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-00016460 IP26-00006803
Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 23 D (F)
Dr. ARCHANA LALITHMOHAN

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	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	NP	—	NA	NP	—					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NP	—	NA	NP	—					
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	NP	—	NA	NP	—					
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	NP	—	NA	NP	—					
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		—	NA	NP	—					
			Signature of the Nurse										

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

Patient Sticker

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

HNH-00016460 IP26-00006803
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BRADEN 'Q' SCALE

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					Date : 10/9	10/7	9/7	9/7
					Time : 6L	8PM	PM	6L
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	28	28
				Evaluator's Name				

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Score	Date / Time	10/7	10/7	11/7
				12	8PM	AM
History of Falling (immediately or w/in 3 months)	Yes	25				
	No	0				
Secondary Diagnosis (more than one diagnosis)	Yes	15				
	No	0				
Ambulatory Aid	Furniture	30				
	Crutches, Cane(S), Walker	15				
	None /Bed Rest /Nurse Assist	0		0	0	0
IV / Heparin Lock or Saline	Yes	20		20	20	20
	No	0				
GAIT / Transferring	Impaired	20				
	Weak (uses touch for balance)	10				
	Normal /On Bed Rest /Immobile	0				
Mental Status	Forgets limitations	15				
	Oriented to own ability	0				
Total Morse Fall Scale Score:				20	20	20
			Signature			

Fall Risk Grading

Risk Level	Morse Fall Score (MFS)	Action
Low Risk	0 - 24	Standard Fall Precaution
Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
High Risk	≥ 51	Implement High Risk Fall Prevention Intervention

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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PAIN ASSESSMENT FORM

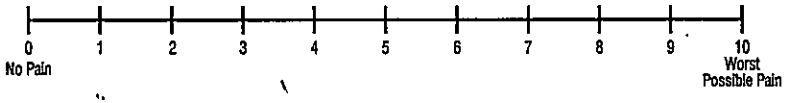
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
10/7	10PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
11/7	6AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
11/7	10PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
11/7	2PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time	10/7 2	10/7 8PM	11/7 M6			
	Medical Condition (Any special condition to be noted):	—	NA	—			
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97 -	97F	97			
	Res:	20	20	20			
	SpO_2:	99.	99.	99			
	Pulse:	82	85	86			
	BP:	110/70	115/75	110/70			
	Fall Risk Score:	-	-	-			
	Pain Score:	—	-	-			
Recommendations	Safety Needs:		NA	NA			
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:		NA	—			
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	—	NA	NA			
Post Operative Procedure Special Orders:		—	NA	NA			
Handed Over By Name :		Moni	Sujatha	Moni			
Signature :							
Date:		10/7	10/7/26	11/7			
Time:		8pm	8Am	8PM			
Taken Over By Name :		Sujatha	Moni	dkli			
Signature :							
Date:		10/7/26	11/7				
Time:		8PM	8Am				

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

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

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

HNH-00016460 IP26-00006803
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NURSING CARE RECORD

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Date: 7/2/22

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	2pm to 8pm	→ Assess the pt condition → monitor vital ← maintain I/O chart	2pm to 8pm	→ Assessed the pt condition → monitor vital ← maintain I/O chart	Now pt is stable	Re-checked vital	
Night	8pm | 8AM	⇒ Assess the pt condition ⇒ monitoring vitals checked and recorded ⇒ I/O chart maintained	8pm | 8AM	⇒ Assessed the pt condition ⇒ Administration & medication given as per doctor order's	→ Pt is stable	→ Re-checked vitals	

HNH-00016460 IP26-00006803
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NURSING CARE RECORD

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Date: 11/2/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM to 2PM	→ Assess the pt condition → Monitored vitals → Maintained	8AM to 2PM	→ Assessed the pt condition → Maintained s/o Mon	Now pt is stable	Re check vitals	Mou
Afternoon				DAY DUTY			
Night							

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016460 IP26-00006803 Mrs PREETHI YADAV 17-02-1986 40 Y 4 M 23 D (F) Dr. ARCHANA LALITHMOHAN	10/7/26 @ 10:41Am	10/7/26 @ 10Pm
	Transfer Ordered by DR.	Reason for Transfer observation
From Unit pre-post	To Unit Room	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 28	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Sindha	DR. DVa

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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs Preeti Yadav Gender: ☐ Male ☒ Female Age : 40y

UHID No : HNH-0001.6460 Date : 10/7/2026

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

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

HYSTEROSCOPY + POLYPECTOMY

upon

(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.

Bleeding, infection
Injury to Bowel, Bladder or Blood vessel,
Chances of uterine Perforation, chances of Blood transfusion

My signature on this form indicates that

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

Name of the Doctor who is performing the Surgery / Procedure: Dr Archana

Consentee :

Signature :

Name : Mrs Preeti Yadav

Date & Time : 10/7/26 @ 8AM

Patient Attendant :

Signature : Vijayanand

Name : Vijayanand Yadav

Relationship with Patient:

Date & Time : 10/7/26 @ 8AM

Witness :

Signature :

Name :

Date & Time :

Doctor (who is taking the consent) :

Signature :

Name : Dr Manohar

Date & Time : 10/7/2026

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Mrs. PREETHI YADAV Age : 40y Gender : Male ☐ Female ☐

UHID NO: HNH-16460 Surgeon Name: Dr: ARCHANA YADAV

Anaesthesiologist : Dr: Ayesha Dr: Akhila

Operative procedure planned : HYSTEROSCOPY + POLYPECTOMY

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosls

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☑ Others : Hypotension, bleeding

Comments :

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient Mrs. PREETHI YADAV the above mentioned operation / Diagnostic / Therapeutic procedures HYSTEROSCOPY + POLYPECTOMY

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 : Vijayanand

Name : Preethi Yadav

Relationship with Patient: .....

Date & Time : 11/7/26

Witness :

Signature : Vijayanand

Name : Vijayanand Yadav

Date & Time : 11/7/26

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. SK. Aysha

Date & Time : 11/7/26, 9:50am

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs Preethi Yadav Age: 41 Sex: F UHID.No :

Date: 9/7/2026 Time: 5.50 Proposed Operation: Hysteroscopic polypectomy

Diagnosis: Pedunculated fundal polyp

B.P / CRT: .... H.R: .... Weight: 89kg ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5 — H/of anaemia

Laboratory Data:

Hgb: 7.0	Glucose: 21	Protein:	HIV: Non reactive	X-Ray: Mild cardiomegaly, Bilateral prominent bronchovascular markings
PCV:	Urea: 21	Alb:	HBS Ag: Non reactive	ECG:
WBC: 9600	Creat: 0.7	Total Bill:	HCV: Non reactive	2D Echo: Normal
Plate: 4,13,000	Na: 135	Dir. Bill:	Blood group: B +ve	Stress/Angio: Normal cardiac chamber
PT: 11.20	K: 4.8	LDH:	T3: 1.68	Other: EF - 66%
PTT: 14.6	Ca++:	Alk phos:	T4: 13.30	LMP:- 21/6/20..
INR: 1.2	Mg++:	Amylase:	TSH: 2.9	
BT:- 2.00, CT 6.30	Cl-: ESR: 25	SGOT/SGPT:		

(Margin notes: Triglyceride 281, Total cholesterol 141, LDH 55, HDL 35, V... - 57)

Allergies: No known drug allergy.

Medical History: CVS : —

RESP : — Diabetes : —

CNS : —

Renal : —

Hepatic / GE : Physical Activity: ET - 2 floor.

Others : Hypothyroid.

Past Anaesthetic History: — Laparoscopy t/t for infertility

Physical Exam:

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

Lungs : AEBE

Heart: S1 S2

CNS: NAD

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
Thyronorm	75mg

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL ☑ → Water / ORS 2 Hours / Others 6 Hours — 1 (10) CLEAR WATER, (6) SOLID / FOOD / MILK.
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions: — (1) PRBC transfuse — (1) PRBC reserve. — CBC after blood transfusion

USG:- Cholelithiasis - / Mild splenomegaly. Single pedunculated fundal endometrial polyp. Bilateral polycystic ovarian disease. Single polyp in proximal segment of ... lumen.

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

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

HNH-00016460 IP26-00006803
Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 24 D (F)
Dr. ARCHANA LALITHMOHAN

ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R: 68/min | B.P / CRT: 117/74 mmHg | SpO_2: 99% @ RA | R.R: 18/min | Last Feed: > 6hrs

Pre-OP Diagnosis: Pedunculated fundal polyp | Operation: Hysteroscopy + Polypectomy | Date: 11.7.26

Surgeon: Dr: Swathi / Dr. Archana | Anaesthesiologist: Dr. Ayesha / Dr. Akhila | Technician: Aravind

TIME: 10:15 am | 10:35 am | 10:55 am | 10:45 am | 11:00 am

N_2O / AIR / O_2 / PM
HALO / SO / SEVO: MAC 0.9

Drugs:
1) Inj. MIDAZOLAM 2mg IV
2) Inj. FENTANYL 100mcg IV
3) Inj. PROPOFOL 100+40mg IV
4) Inj. PARACETAMOL 1gm IV
5) Inj. LOXICARD 3mg IV

Antibiotic

Suppository: DICLOFENAC 100mg PR; TRAMADOL 100mg PR

Blood Loss: 10ml

FIO_2 / SaO_2	100%	100%	100%	100%	100%	100%	100%	100%
$ETCO_2$	33	34	34	34	34	34	34	34
ECG	SR	SR	SR	SR	SR	SR	SR	SR
Temperature	36.3°C							
Urine Output								
Fluids / Blood	1 RL							

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

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

NOTES
1) NBM till further orders.
2) IVF @ 100ml/hr
3) Monitor vital signs

LAB Values: ABG | GRBS | Others

☑ Equipment Checked and Functional
☑ BP
☑ Cuff Site: (Rt) UL
☐ Art Site:
☑ EKG Lead 3 lead
☑ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☑ Capnograph
☑ Ventilator
☐ Nerve Stimulator

Position:
☑ Pressure Points Checked

Eye Care:
☐ Oint
☑ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: 10:15 Am
OP Start: 10:20 Am
OP End: 11:00 Am
Leave OR: 11:05 Am

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: 18G on (Rt) UL
☐ IV:
☐ IV:

Induction
☑ IV ☑ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☑ SGA I gel 3
☐ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug:

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# ..... Attempts: .....
Difficulty Why? .....

☑ Bilat = BS
☐ Semi-Closed Circle
☑ Closed Circle
☐ Other

Regional:
Extremity Specify: .....
☐ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: .....
Site: .....
Needle Size: ..... Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: .....
Bolus: .....
Infusion: .....
Block Level: .....
Comments: .....

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

HNH-00016460 IP26-00006803
Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 24 D (F)
Dr. ARCHANA LALITHMOHAN

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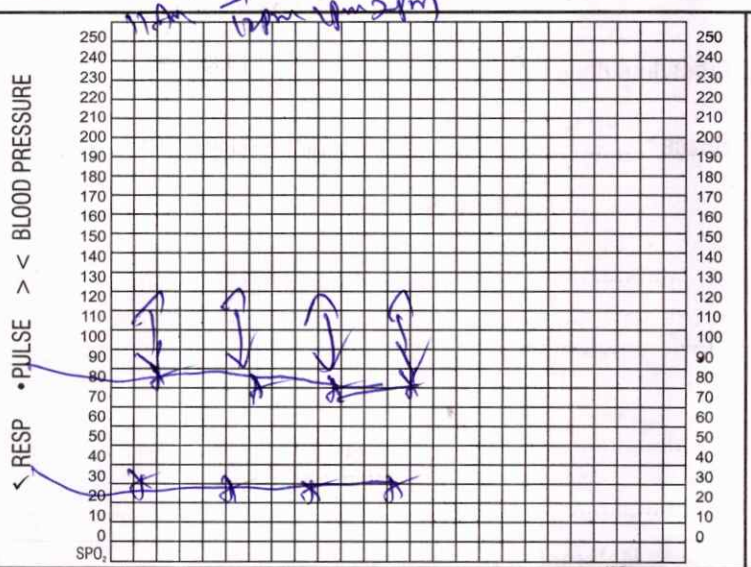
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : S.S. Mounika Time Received : 11:15AM Time Discharged : 2:30PM



IV Cannula Site : Right site

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

Vomiting : ☐ Yes ☐ No Drug: Inj Tramadol

NG Tube : ☐ Yes ☐ No

Drain: ☐ Yes ☐ No

Urinary Catheter: ☐ Yes ☐ No

Chest Tube: ☐ Yes ☐ No

Nil Oral ☐ Yes ☐ No

IV Fluids: RL

Oral Feeds: NBM

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY		1	2	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely Dyspnea or limited breathing Apneic	= 2 = 1 = 0	RESPIRATION		2	2	2		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION		2	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS		2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR		2	2	2		
		TOTAL		10	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
11/7	11AM	0/10	NA	
11/7	12PM	0/10	NA	
11/7	1PM	0/10	NA	
11/7	2PM	0/10	NA	

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

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

Anaesthesiologist Name : Dr. Archana K

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name :

PACU Nurse Signature:

Date & Time: 11/7/26

Transferred to Unit by (PACU):

Date & Time: 11/7/26

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level		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 : .....

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
	10/2	11/2/26 10Am
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
	Dr. Swathi	Histocyt
From Unit	**To Unit**	**Information to Attendant**
MICU	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
35		Yes ☐ No ☐
		If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.	RL — 100ml —	(1)
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Monika.	Dr. Manesh

Patient & Clinical Records Received by : Pujas

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

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OPERATION THEATER NOTES

HNH-00016460 IP26-00006803
Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 24 D (F)
Dr. ARCHANA LALITHMOHAN

Patient's Name : .. ..Age : .....Gender : .....

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

Surgeon :	Asst. Surgeon :
Anesthetist :	OT Nurse :

Surgical Procedure : Hysteroscopy + Polypectomy

Indications for Surgery : AUB-Polyp

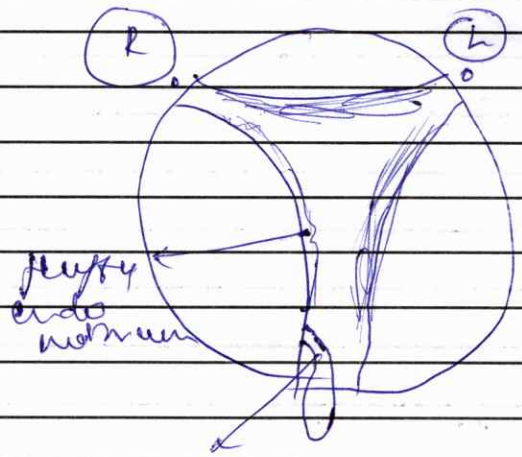
Date : 11/7/2016	Start Time : 10:20 Am	End Time : 11 Am

PRE-OPERATIVE PREPARATION :

Dabl aseptic Precaution, Parts Painted & Draped.
Pt taken in Lithotomy Position.

OPERATION NOTES:

- Polypoidal Endometrium.
- Pedunculated Polyp originating From Right Anterolateral wall of cervical Canal at Int OS level
  Polypectomy done & Hysteroscope Scissors Sent for HPE
- D & C done – Endometrial Curettings Sent for HPE



- polyp arising from anterolateral wall @ External OS

POST - OPERATIVE ORDERS :

- NBM x 4-6 h
- Drugs as chart
- Ambulation
- Inform SOS

Dr Archana Yadav

DSWAT AIIMS

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : .....Time : .....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Archana Yadav.
Asst. Surgeon : Dr. Swathi
Anaesthetist : Dr. Ayeesha
Scrub Nurse : Sr. Archana.

Patient Nam
UHID No. :
Date : 11/2/26

HNH-00016460 IP26-00006803
Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 24 D (F)
Dr. ARCHANA LALITHMOHAN

10:20Am

40Y Gender : F
ime : 11Am

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 10:15 Am

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

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : Ayesha
Name : Dr. Sk. Ayesha

Before Skin Incision ➤➤

TIME OUT Time: 10:22 am

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

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

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? 30 mins Bleeding, 1 OPRBC Reserved. Minimal ☐ Yes ☐ No ☐ NA

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

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? Hypotension Bleeding leads for transfusion ☐ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☑ Yes ☐ No ☐ NA

Signature : Puja @ 10:22 am.
Name : Puja

Before Patient Leaves Operating Room

SIGN OUT Time: 10:20 Am

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

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

Signature :
Name :

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016460 IP26-00006803 Mrs PREETHI YADAV 17-02-1986 40 Y 4 M 24 D (F) Dr. ARCHANA LALITHMOHAN	11-07-26 @ 10:14 AM	11-7-26 @ 11:05 AM
	Transfer Ordered by Dr. Ayesha.	Reason for Transfer observation
From Unit OT	To Unit Prepost	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File —	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
S.S.Pga.	Dr. Ayesha.

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016460 IP26-00006803 Mrs PREETHI YADAV 17-02-1986 40 Y 4 M 23 D (F) Dr. ARCHANA LALITHMOHAN	10/7/26 @ 10:41 AM	11/7/26 @ 8 AM
	Transfer Ordered by Dr. Dua	Reason for Transfer observation
From Unit Floor	To Unit LOR	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 28	Number of Imaging Films –	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Amrutha	Dr. Dua

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

CONSENT FOR BLOOD TRANSFUSION

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Name: Mrs Preethi Yadav Age: 40y Gender: Male ☐ Female ☑

UHID.No : RNH-0001646 Date: 10/July/2026

Type of Blood Product:

☐ Fresh Frozen Plasma	☑ Packed Red Blood Cells	☐ Random Donor Platelets
☐ Cryoprecipitate	☐ Single Donor Platelet	☐ Whole Blood
☐ Albumin	☐ Red Blood Cell	☐ Others .....

I Mrs Preethi Yadav hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The 'window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that .....

.....

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: .....

Name: .....

Date & Time 10/7/26 @ .....

Doctor (Who is talking the consent)

Signature: .....

Name: Dr Manisha .....

Date & Time 10/7/2026 @ .....

Witness

Signature: .....

Name: Manika .....

Date & Time 10/7/26 @ .....

HNH-00016460 IP26-00006803
Mrs PREETHI YADAV
17-02-1986 40 Y 4 M 23 D (F)
Dr. ARCHANA LALITHMOHAN

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BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 10/7/2026 Time: 2:30pm

Blood Group of the Patient: "B" positive Blood Group on the Blood Bag: "B" positive.

Blood Bank Issue No: 1348 Date of Collection: 23/6/26 Date of Expiry: 21/8/26.

Date & Time of Starting Transfusion: 2:30pm Planned duration of Transfusion: 3-4 hours

Check for Correct Unit: ☑ Correct Patient: ☑

Blood products cross checked by: Nurse 1: Anushe D Nurse 2: Monika

Before starting transfusion vitals: Temp: 98.7F HR 70 RR: 20 BP: 122/62 SpO_2 99%

PLEASE MONITOR THE FOLLOWING:

Date	Time	HR	Temperature	Blood Pressure	SpO_2	Any Rash	Any Rigors	Any Breathlessness	Any Other Problem
10/7	2:30pm 15 Min	70	98.7F	122/62	99%	-	-	-	-
10/7	3:35pm 15 Min	72	98.8F	119/67	98%	-	-	-	-
10/7	4:30pm 30 Min	82	97	110/70	99%	-	-	-	-
10/7	5:30pm 30 Min	81	98.F	112/70	99%	-	-	-	-
10/7	6:30pm 30 Min	82	98.F	122/65	99%	-	-	-	-
10/7	7pm 1 Hr	84	98.F	109/75	99%	-	-	-	-
10/7	1 Hr								

Comments: .....

.....

Name of the Incharge-Nurse: Mamtha Vasthuri Name of the Nurse: Monika

Signature of the Incharge-Nurse: Signature of the Nurse:

Date & Time: 10/7/26 Date & Time: 10/7/26

Phone : 8790221175 , 8341711775

SURYA BLOOD CENTRE

(A unit of Telangana Devlopment Committee)

#3-6-150, First Floor, Above Indian Bank, Main Road, Himayatnagar, Hyderabad-29.

Lic No. 111/HD/TS/2021/BC/G

PACKED RED CELLS I.P. 220-280 ml

Anticoagulant : CPDA Solution U.S.P. 49 ml / 63ml

Prepared from a **VOLUNTARY DONOR / REPLACEMENT**

Blood Group.: **'B'** Rh (D) Type : **POSITIVE**

Blood Bag No. : 1348 Volume : 250ml Collection Date : 23/6/26

Tested Date : 23/6/26 Expiry Date : 4/8/26

Tested and Found Negative for HIV I & II antibodies, HBsAg, HCV antibodies, VDRL & Malaria Parasites.

CAUTION 1) Do not use if there is any visible evidence of deterioration like haemolysis, clotting & discolourisation.
2) Storage temperature 2°-6° C.
3) Bring the Blood bag to room temperature before transfusion.
4) Do not keep the Blood Bag in Deep freezer compartment in refrigerator.
5) Shake gently before use. 6) Administer without warming.
7) Transfuse under medical supervision only.
8) Do not add any medicine to the blood.
9) Use a fresh, sterile pyrogen free disposable transfusion set with filter.
10) Do not dispense without prescription.
11) Check Blood Group & Rh Type on label and Recipient Group & Rh type before administration.
12) Cross match before use. 13) Appropiate compatible, cross matched blood without a typical antibody in recipient should be used.
14) If Hemolysin is present in O«Negative blood units it should be transfused to the same blood group recipient only.

Please Note : It is advised that this Blood Bag which is stored in our Blood Centre refrigerator at ideal temperature must be transfused immediately without further storing it. This Blood Bank bears no responsibility if this bag is further stored with-

26-00002126 78#

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mrs. Preethi Yadav		Age: 40Y	Gender: Female
UHID No: HNH-0001460	IP No: IP26-00006807	Date: 11/7/26	Time: 9:00 am
Diagnosis: Hysteroscopy		ward - OT	

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr Tejasvi Doctor Registration No: 74068

Signature:

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

IP Registration No: IP26-00006807 Date: 11/7/26

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

1.	Name: Mrs. Preethi Yadav	Remarks
2.	Complete postal address (with contact number, if any)	Gowtigude Hyderabad
3.	Brief description of the illness	Hysteroscopy
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	ND
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
11/7/26	Fentanyl	1 Amp	Preethi	

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

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

Time: .....

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Mrs. Preethi Yadav		Age: 40Y	Gender: Female
UHID No: HNH.0001(4160	IP No: IP26-00006803	Date: 4/1/26	Time: 9:00 Am
Diagnosis: Hysteroscopy			

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr. Jayasree

Doctor Registration No: 74060

Signature:

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

IP Registration No: IP26-00006803 **Date:** 4/1/26

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

1.	**Name :** Mrs. Preethi Yadav	**Remarks**
2.	Complete postal address (with contact number, if any)	Gandigudda Hyderabad
3.	Brief description of the illness	Hysteroscopy
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	No
5.	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Impression of the Patient Attende...	Remarks, if any
4/1/26	Fentanyl			

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

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

Time: .....