Dr. Rajani Kumari

Rainbow® Children's Hospital
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ESTIMATION SLIP

Date : 11/7/26 **UHID / IP No. :** HNH-0001650 1 **Sl No.** 1684

Name of Patient : Mrs. Preeti **Age:** 37yr **Gender:** F

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

Address : _____ **Phone :** 9116127390 **Email :** _____

Procedure / Plan : Hysteroscopy & Polypectomy **EDD/Dos:** July-26

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

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward	Hysteroscopy & polypectomy	
Twin Shared Ward	60k	
Private Room	→ 17,500/- Including Pharmacy & Investigation.	
Super Deluxe Room		
Suite Room		
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for :	Length of Stay for :
	Pharmacy up to	Pharmacy up to
	Investigations up to	Investigations up to
Others		

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

Initial Minimum Deposit : 50% 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 Pawan 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	Husband	
	Signatory Relationship	Signature of the financial Counselor

HNH-00016501 IP26-00006870
Mrs SRAVANTHI
10-03-1989 37 Y 4 M 7 D (F)
Dr. RAJANI KUMARI

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SURGERY DETAILS

Date : 17/7/26

Patient Name: Mrs. Sravanthi Date of Birth: 10-03-1989 Age: 37yrs

Gender: female Ward : OT-2 UHID No.: HNH-0001650

Date of Surgery: 17/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Hysteroscopic Polypectomy with DnC.

Time in : 12:00 pm Time Out : 1:00 pm

	NAME	AMOUNT
1. Surgeon	Dr. Rajani Kumari	
2. Anaesthetist	Dr. Akhila	
3. Assistant Surgeon	Dr. Swathi HV	
4. OT Technician	Dr. Pallavi	
5. Circulating Nurse	Sr Karuna Natasha	
6. Assistant Nurse	Br. Balu	

Hysteroscopy Charge: 26-0000214736.

Mrs SRAVANTHI (37 Y 4 M 7 D/ F) OTHERS NINV00562 HN26011956032

Mrs SRAVANTHI (37 Y 4 M 7 D/ F) ENDOMETRIA NINV04329 HN26011957ENDO

Mrs SRAVANTHI (37 Y 4 M 7 D/ F) ENDOMETRIA NINV04329 HN26011958ENDO

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

P for Dr. Rajani Kumari
Signature of the Surgeon

Signature of Circulating Nurse

Order No: 26-0000214737 Order by: Sangeetha

HNH-00016501 IP26-00006870
Mrs SRAVANTHI
10-03-1989 37 Y 4 M 7 D (F)
Dr. RAJANI KUMARI

Hysteroscopy Polypectomy

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CONSUMABLES OF OT

Circulating staff : Karuna Technician : Pallavi Date : 17/7/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube Igel 3.0		01	Major Pack General kit		01	Inj Vit.K		
LMA			Sutures			Cord Clamp		
ECG leads : A / P / N		03				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc		03+1				Vaccum Suction Set		
05 cc		03	Gloves SG 7.0		01	Surgical Gloves		
02 cc		02	Encore 7.0		01	Gauze Pack		
01 cc			SG 6.5		03	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		04	Koochies XX		01	Nelton catheter 10		02
PCM		01	Ointments			Fole		01
			Suction Catheter			TUR set		01
Fentanyl		01	Cap, Mask		10+10			
Morphine			Gauze Pack 10x10		09	Hand Care		05
Ketamine			Mop Pack					
Propofol		02	Steristrip					
Rocuronium		01	Underpad		02			
Glycopyrolate		01	Draw sheet					
Myopyrolate		01	Abgel					
Ondansetron			Foleys catheter					
Pencan 25g/ Spinal Needle 22			Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25%(Heavy)			Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set					
Justin : 12.5 mg / 25mg / 100mg			Plastic ~~Bed Sheet~~ Aprons		03			
Tab. Misoprost : 200mg			Betadine Solution Local		01			
			Microshield					
			Cotton Balls		01			
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-0000214705/706 Ordered by : M Rahi @ 17/7/26

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

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-00016501	**Name**	: Mrs SRAVANTHI
Age / Sex	: 37 Y 4 M 7 D / Female	**Doctor**	: RAJANI KUMARI
Adm/Reg Date/Time	: 17/07/2026 08:20	**Payor**	: VIDAL HEALTH INSURANCE TPA PVT LTD
Order Date	: 17/07/2026 14:02	**Ordernumber**	: 26-0000214705
Visit ID	: IP26-00006870	**Ward/Bed No**	: 4F -OT / PDA-413
Patient Address	: 9-1-102, BHAGATH NAGAR , KARIM NAGAR, Karimnagar, Karimnagar, Telangana, INDIA, 505001		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	NELTON CATHETER-10 POLYMED		1 Nos	External / 1-1-1 UP TO NEXT VISIT	1 Days		2 Nos	Dispensed
2	MYOPYROLATE-INJ-5ML		1 Nos	/ Once Daily	1 Days		1 Ampule	Dispensed
3	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
4	DISPOSABLE APRONS STERIL XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
5	NS 500ML CLOSED BOTTLE		1 Bottle	External / Once Daily	1 Days		4 Bottle	Dispensed
6	HAND CARE GLOVE	HAND CARE GLOVE	1 Nos	External / Once Daily	1 Days		5 Nos	Dispensed
7	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
8	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
10	IRRIGATTO(T.U.R SET)	IRRIGATTO(T.U.R SET)	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
11	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
12	NS 1000 ML CLOSED EUROFLEX		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
13	IGEL NO 3.0	IGEL 3.0	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
14	SGLOVE # 7.0(SURGICARE)	SURGICAL GLOVES 7.0	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
15	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
16	MCT-ROF 100MG 10ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
17	THEMIPYRRNOM 0.2MG INJ		1 Nos	External / 1-1-1 UP TO NEXT VISIT	1 Days		1 Nos	Dispensed
18	ROCUNIUM INJ 50 MG 5 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
19	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
20	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed

RAJANI KUMARI

* 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 Children's Hospital

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Rainbow Childrens Hospital-Himayatnagar

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Old MLA quarters road AP State Housing Board Himayatnagar ,
Hyderabad ,Telangana, INDIA ,500029.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00016501	**Name**	: Mrs SRAVANTHI
Age / Sex	: 37 Y 4 M 7 D / Female	**Doctor**	: RAJANI KUMARI
Adm/Reg Date/Time	: 17/07/2026 08:20	**Payor**	: VIDAL HEALTH INSURANCE TPA PVT LTD
Order Date	: 17/07/2026 14:02	**Ordernumber**	: 26-0000214706
Visit ID	: IP26-00006870	**Ward/Bed No**	: 4F -OT / PDA-413
Patient Address	: 9-1-102, BHAGATH NAGAR , KARIM NAGAR, Karimnagar, Karimnagar, Telangana, INDIA, 505001		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	GAUZE PACK STERILE 10X10X12 PLY 5S	GAUZE PACK STERILE 10X10X12 PLY 5 PACK	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
2	ADULT DIAPERS XL 10S		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
3	UNDER PAD 60X90 10's Pack - MEDICUBE		1 Nos	External / 1-1-1 UP TO NEXT VISIT	1 Days		2 Nos	Dispensed
4	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Dispensed
5	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
6	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed
7	GENERAL SURGERY KIT SAFE SECURE		1 Nos	External / 1-1-1 UP TO NEXT VISIT	1 Days		1 Nos	Dispensed
8	SURGEON CAP FEMALE SAFE SECURE		1 Nos	External / 1-1-1 UP TO NEXT VISIT	1 Days		10 Nos	Dispensed

RAJANI KUMARI

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Note

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*** Do not refill medicines.**

Printed Date/Time : 17/07/2026 15:16 Printed By : SUNKARI SANGEETHA

Name	Mrs SRAVANTHI	**UHID**	HNH-00016501
Father/Guardian	Mr PAWAN	**Age/Gender**	37 Y 4 M 7 D/ Female
Address	9-1-102, BHAGATH NAGAR , KARIM NAGAR, Karimnagar, Karimnagar, Telangana, INDIA, 505001		
IP No	IP26-00006870	**Admission Date**	17-07-2026
Ref Doctor	Self.		
Discharge Date	18.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. RAJANI KUMARI
MD (OBGYN)

Diagnosis: ABNORMAL UTERINE BLEEDING - ENDOMETRIAL POLYP

HYSTEROSCOPY + POLYPECTOMY DONE ON 17.07.2026

History: She presented with complaints of inter menstrual spotting, on and off. No other complaints. Sono hysterogram done on 14.07.2026 showed 2 hyperechoic masses noted in the uterine cavity s/o Endometrial polyp 1)Broad based polyp measuring 0.59 * 0.35 cm,2) Pedunculated polyp measuring 0.35 * 0.39 cm . She is admitted for Hysteroscopy + polypectomy.

Menstrual History:-
LMP- 07.07.2026
Previous cycles: Regular

Name	Mrs SRAVANTHI	**UHID**	HNH-00016501
IP No	IP26-00006870	**Admission Date**	17-07-2026

Obstetric History: Nulliparous

Medical History: Nil
Family History: Nil
Surgical History: Nil
Allergies: Nil

Investigations: Enclosed.
Blood group: "A" Positive

Management: Course in hospital:
On admission vitals were stable. She was closely monitored. Her vital signs remained stable. 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.

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

Indication: ABNORMAL UTERINE BLEEDING - ENDOMETRIAL POLYP

Operative findings:
- Small endometrial polyp of 0.5*0.5 cms arising from posterior wall.
- Broad based endometrial polyp arising from left lateral wall.
- Bilateral ostia normal.
- Endometrium -signs of endometritis noted.

Name	Mrs SRAVANTHI	**UHID**	HNH-00016501
IP No	IP26-00006870	**Admission Date**	17-07-2026

- Cotton wool appearence at the external os.
- Rest normal.
- Polypectomy done with hysteroscopic scissors.
- Specimen retrieved by grasper.
- D&C done and Endometrium curettage obtained.
- Endometrial curettings and Polyp sent for HPE
- Endometrial curettings sent for CBNAAT for Tuberculosis evaluation.

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 23.07.2026 (9am-9pm) after food.
2. Tab. Doxycycline 100 mg twice daily till 27.07.2026
3. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 26.07.2026
4. Tab. Paracetamol 500 mg SOS
5. Tab. Zincovit once daily (2pm) for 1 month after food.
6. Collect HPE report

Review consultation with **Dr. RAJANI KUMARI,** after **10 days** on **27.07.2026** 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

Name	Mrs SRAVANTHI	**UHID**	HNH-00016501
IP No	IP26-00006870	**Admission Date**	17-07-2026

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**

Registrar/Resident/C.M.O

Consultant:
Dr. RAJANI KUMARI
MD (OBGYN)

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006870 **Admit Date** : 17-Jul-2026 **Admit Time** : 08:20 AM **UHID** : HNH-00016501

Patient Details :

Patient Name	: Mrs SRAVANTHI	**Age**	: 37 Y 4 M 7 D
Guardian	: Mr PAWAN	**DOB**	: 10-03-1989
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 9-1-102, BHAGATH NAGAR , KARIM NAGAR Karimnagar Karimnagar Telangana INDIA 505001	**Phone No**	: 9441273995
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PDA-413 **Ward Name** : 4F -OT

Room No : PDA-413 **Admission Type** : First Visit

Contact Details :

Name : Mr PAWAN **Relationship** : Husband

Contact Address : 9-1-102, BHAGATH NAGAR , KARIM NAGAR Karimnagar Karimnagar Telangana INDIA 505001 **Phone No** : 9441273995

Signature

Doctor Details :

Doctor Name : Dr. RAJANI KUMARI **Specialisation** : OBSTETRICS AND GYNECOLOGY

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

Co-Consultant :

Payment Details :

Deposit Amount : 10000.00

Payment Mode : DC/CC Card **Payor Name** : VIDAL HEALTH INSURANCE TPA PVT LTD

UZM

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ACTIVITY RECORD FOR BILLING

Name :_____ HNH-00016501 IP26-00006870 _____
Mrs SRAVANTHI
10-03-1989 37 Y 4 M 7 D (F)
UHID No. : _____ Dr. RAJANI KUMARI Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
17/7	12PM	PNL&POST	(OT)	(illegible) / Karuna
17/7	1PM	OT	PNL&POST	Karuna / (illegible)

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

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
17/7	cardiac monitor	10 m	3PM stopped 17/7/26	2147/17	
17/7	infusion pump	10 m			

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
12/7	IV Placement	(1)	14591	
12/7	PAC	(1)	14722	

ANY OTHER INFORMATION

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.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016501 IP26-00006870
Mrs SRAVANTHI
10-03-1989 37 Y 4 M 7 D (F)
Dr. RAJANI KUMARI

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 17/7/2026 Time of Admission :

Allergies: nil. ☐ Not know any drug allergies

PRESENTING COMPLAINTS :

(- 1° infertility)
→ c/o. intermenstrual spotting on & off.

LMP - 7/7/2026.

TVS: done s/o. 2. hypoechoic mass in the uterine cavity :
1) Broad based polyp - 0.59 x 0.35
2) pendunculated polyp - 0.35 x 0.39 cm

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage :-	Parity : nulligravida.
Previous Periods : 7/7/2026.	Mode of Delivery :
LMP : - Regular 3d/30d	Last Child Birth :
Contraception :	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
K/c/o. On Infertility Rx :: 3mnths.	-

Docu. No. : RCH /FRM / CLINICAL / 086 (P.T.O)

HNH-00016501 IP26-00006870
Mrs SRAVANTHI
10-03-1989 37 Y 4 M 7 D (F)
Dr. RAJANI KUMARI

MEDICATION HISTORY:

Nil.

INITIAL ASSESSMENT :

Date 17/7/2026

Ht. _____ Wt. _____

BMI _____

B.P _____

Pallor ⊖

CVR NAD

Respiratory System NAD/BAE

Thyroid NAD

Breasts

SNA

Abdominal Examination

Soft, NT.

Local/Speculum Examination

not done

Bimanual Pelvic Examination

Not done

PROVISIONAL DIAGNOSIS : AUB-P- Nulligravida. for hysteroscopic polypectomy.

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
BGT- A+ve (11/7/2026).	Hysteroscopy + Polypectomy
RBS-85	- NBM
Urea-18	- Parts preparation
S.TSH-2.68	- Eyemed consent
S.creat-0.67	- Preop medications
CUE- NAD.	- PAC
Hb-10.3	- Shift to OT on call.
PCV-32.8	
TLC-6880	
HIV, HBsAg/NR, HCV	
INR: 1.04	
PT-14	
APTT-29.1	
plt: 3.60	

Name of the Doctor : Dr Rajani Kumari

Signature of Doctor _____

Date & Time : 17/7/2026

HNH-00016501 IP26-00006870
Mrs SRAVANTHI
10-03-1989 37 Y 4 M 7 D (F)
Dr. RAJANI KUMARI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/26. 1:15 pm	C/S/B Dr. Dna.	
	POD-0.	Adv.
	GC fair	- NBM for 6hr.
	Afebrile	- T Doxycycline 100mg BD
	BP: 114/74 mmHg	- T Taxim 200mg BD
SPO2: 99% on RA	PR: 76/m	- T. Pantoprazole - 40mg OD
	P/A soft	- T. Paracetamol 1g TID
		- W/F PV bleed
		- Monitor vitals
Pt can be discharged	Yr.	NB Advised

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00016501 IP26-00006870
Mrs SRAVANTHI
10-03-1989 37 Y 4 M 7 D (F)
Dr. RAJANI KUMARI

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RESULT SHEET

(OP)

Date	1/4/17					
Time						
Hb	10.3					
PCV	32.8					
RBC	.					
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

A+ve

HIV
HBsAg
HCV
NR

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00016501
Mrs SRAVANTHI
10-03-1989 37 Y 4 M 7 D (F)
Dr. RAJANI KUMARI
IP26-00006870

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DRUG CHART

Date of Admission: 17/7/2026 Drug Allergies: Nil ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

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Mrs SRAVANTHI
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Dr. RAJANI KUMARI

REGULAR PRESCRIPTIONS

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

DRUG : INJ. CEFOTAXIME

Dose	Route	Frequency	Start Date
1g	IV	BD	17/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: (first dose)

Date/Time: 17/7 — 9am, 12:30pm (2), 9pm — Stop Dr. Dna

Daily Doctor's Endorsement by a Sign

DRUG : PANTOPRAZOLE

Dose	Route	Frequency	Start Date
40mg	PO	OD	17/7/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : T Doxycycline.

Dose	Route	Frequency	Start Date
100mg	PO	BD	17/7

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

Additional Instructions: x 10 day.

Daily Doctor's Endorsement by a Sign

DRUG : CEFIXIME

Dose	Route	Frequency	Start Date
200mg	PO	BD.	17/7

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

Additional Instructions: x 7 day.

Daily Doctor's Endorsement by a Sign

Patient Sticker
Ms. Saranthi

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

DRUG : PARACETAMOL.				Date ▸ / Time ▾
Dose	Route	Frequency	Start Dt.	
1g	PO	TID	17/7/26	
Name & Signature of the Doctor Starting the Drugs: Dr. [signature]				
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 ....

Docu. No. : RCH /FRM / CLINICAL / 108

(P.T.O.)

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 ....

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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
17/7/26	11.40AM	METOCLOPROMIDE	10mg	IV		
~~17/7/26~~		~~PANTOPRAZOLE~~	40mg	IV		Not given
17/7/26	11.35AM	PANTOPRAZOLE	40mg	IV		
17/7	8.30PM	TAB MISOPROSTOL	400mg	P/V		

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

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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
17/7	8.30 AM	RINGER LACTATE	IV	100 ml/hr			14/7		
17/7	12PM	RINGER LACTATE	IV	100ml/hr			17/7		
17/7	2pm	RINGER LACTATE	IV	100ml/hr			17/7		

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

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re SRAVANTHI
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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☑ Not known any Drug Allergies

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

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

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

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Naveena Q.

Date & Time : 17/7/2026 @ 9:45am

Nurse Name & Signature: Madhumita @ Madhu

Date & Time : 17/7/26 @ 9:45Am

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

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 1/7/7

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: Dr. Rajani

Hysteroscopy & Polypectomy Time Notified: .....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NIL	NIL	NIL

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: 98.1 HR: 82 RR: 20

BP: 116/71 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: ..... Sravanthi .....

Orientation not given Reason: ..... N.A .....

Nurse Signature: ..... Madhumitha .....

Nurse Name: ..... Madhu .....

Date & Time: ..... 12/7/26 @ 8Am .....

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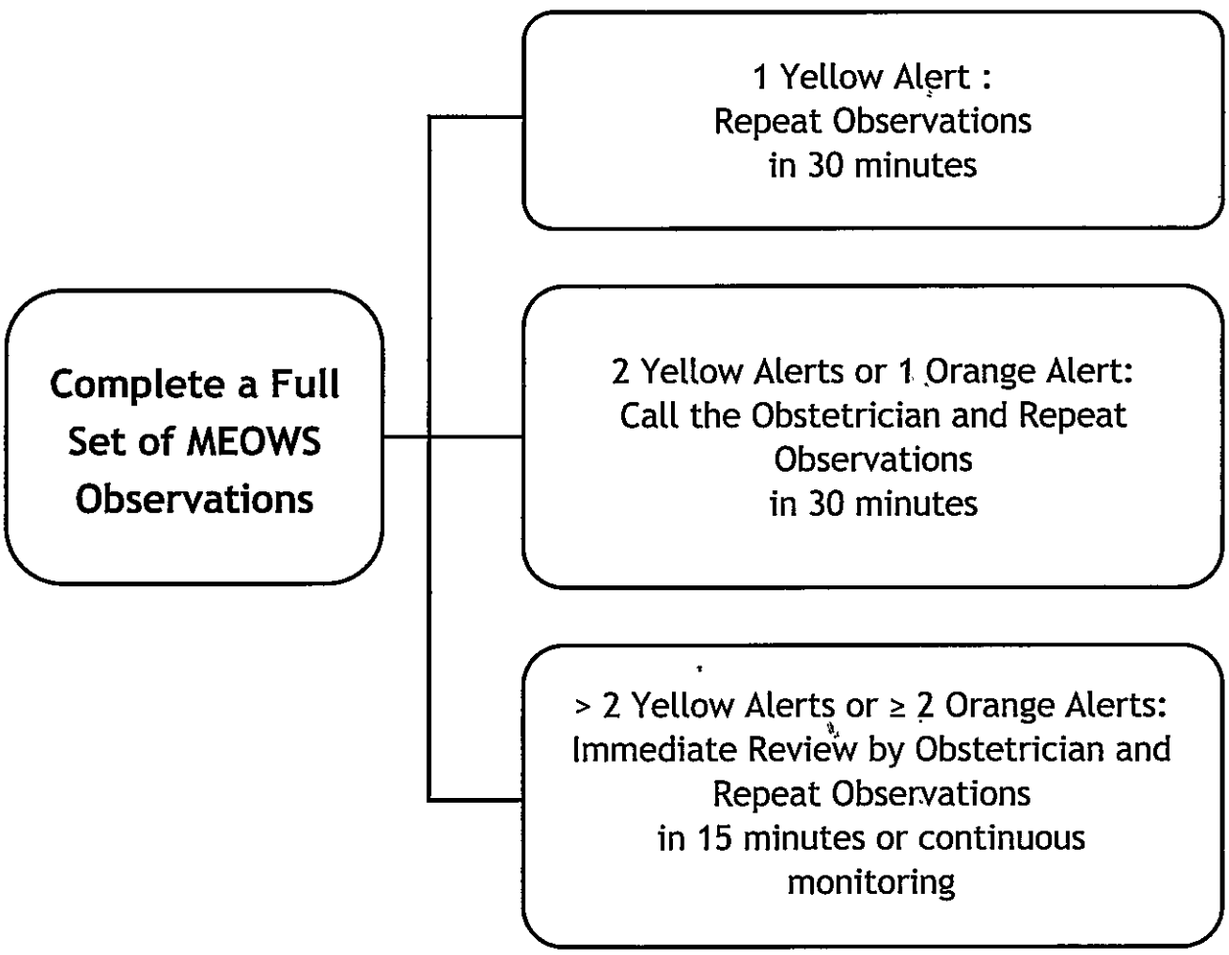
Early Warning Observation Score Chart - Obstetrics

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

12/7	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	00		00		00		20	20																
	0 - 10																								
Saturations	94 - 100 %	99%		99%		00%		00	99%																
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36	36		36		36		—	—																
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80	81		86		86		86	90																
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120	116		98		99		100	99																
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80	71		63		71		72	72																
	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																
TOTAL ORANGE SCORES		0		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							
12/7	08:00 am	RL	N	100ml						~	1	
	09:00 am	RL		100ml						~	0	
	10:00 am	RL	B	100ml								
	11:00 am	RL	M	100ml							1	
	12:00 pm	RL		100ml						~		
	01:00 pm	RL		100ml								
Total Intake : Taken						**Total Output :** Passed						
	02:00 pm	RL	N	100ml							1	
	03:00 pm	RL	B	100ml								
	04:00 pm	RL	M	100ml							0	
	05:00 pm	RL	N									
	06:00 pm		B								1	
	07:00 pm		M									
Total Intake : taken						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

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FLUID CHART

Sheet No. : .....

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

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

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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NURSING CARE RECORD

Date: 1/7/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am ✓ 2PM	→ Plan for vital → Plan for I/O chart. → Plan for medication.	8Am ✓ 2PM	→ vital checked & recorded. → Maintain I/O chart. → Maintained medication	→ vital is normal	→ pt is stable	Mok
Afternoon				D/C			
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

Goals

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

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

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PAIN ASSESSMENT FORM

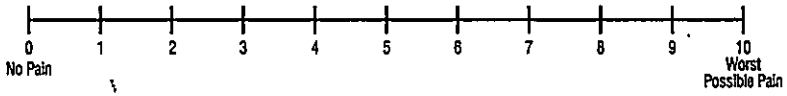
Date	Time	Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
17/7	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
17/7	11Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
17/7	9Pm	0	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	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

HNH-00016501 IP26-00006870
Mrs SRAVANTHI
10-03-1989 37 Y 4 M 7 D (F)
Dr. RAJANI KUMARI

BRADEN 'Q' SCALE

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				Date : 18/7			
				Time : 8pm			
Mobility	**immobile:** even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4		
				TOTAL SCORE	28		
				Evaluator's Name			

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			Date / Time	17/7		
			Score	8pm		
History of Falling (immediately or w/in 3 months)	Yes	25				
	No	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				
	No	0	0			
Ambulatory Aid	Furniture	30				
	Crutches, Cane(S), Walker	15				
	None /Bed Rest /Nurse Assist	0	0			
IV / Heparin Lock or Saline	Yes	20	20			
	No	0				
GAIT / Transferring	Impaired	20				
	Weak (uses touch for balance)	10				
	Normal /On Bed Rest /Immobile	0	0			
Mental Status	Forgets limitations	15				
	Oriented to own ability	0	0			
Total Morse Fall Scale Score:			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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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	NA									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NA									
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3	NA									
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4	NA									
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA									
			Signature of the Nurse										

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 : Anusha-D

Signature of Ward In Charge :

Signature : ..... Name : Kasthuri

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-00016501 IP26-00006870
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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: Hystroscopy + Polypectomy	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time	12/7 8AM					
	Medical Condition (Any special condition to be noted):	NBN					
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.1F					
	Res:	20					
	SpO_2:	99%					
	Pulse:	80					
	BP:	116/71					
	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 :		Madhu					
Signature :		✓					
Date:		12/7					
Time:		2pm					
Taken Over By Name :							
Signature :							
Date:							
Time:							

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:							

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OPERATION THEATER NOTES

HNH-00016501 IP26-00006870
Mrs SRAVANTHI
10-03-1989 37 Y 4 M 7 D (F)
Dr. RAJANI KUMARI

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

UHID.: ..... o. :.....Weight : .....

Surgeon : Dr.	Asst. Surgeon :
Anesthetist :	OT Nurse :

Surgical Procedure :

Hysteroscopic polypectomy.

Indications for Surgery :

AUB-P

Date : 17/7/26	Start Time : 12:00 pm	End Time : 1:00 pm

PRE-OPERATIVE PREPARATION :

OPERATION NOTES: → pt on lithotomy position. UGA.

→ Internal os → stenosed.

- Negotiated under hysteroscopic guidance.

→ ~~Findings~~ Intraop findings:

→ Small Endometrial polyp of 0.5 × 0.5 cm arising from posterior wall.

→ Broadbased endometrial polyp arising from left lateral wall.

- B/L ostia normal

→ Endometrium ⇒ signs of endometritis ⊖.

→ Cotton wool appearance at the External os.

→ Rest NAD.

→ Hysteroscopic polypectomy done ~~c~~ scissors.

→ ~~powder~~ Specimen retrieved by grasper.

→ Endometrial curettage done.

Sent for → HPE & Tuberculosis evaluation (Tb-NAAT).

POST - OPERATIVE ORDERS : → NBM for 6hrs
→ IV fluids.
→ T. DOXYCYCLINE 100mg/BD
→ T. ~~FAM~~
- T. TAXIM 200mg/BD
- T. PANTOPRAZOLE 40mg/OD
- T. PARACETOMOL 1g/SOS/TID
- Watch for PV bleeding
- monitor vitals.
- Encourage voiding.

Dr. Rajani

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 17/7/26. Time : .....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Rajani kumari

Asst. Surgeon : Dr Swathi

Anaesthetist : Dr. Akhila

Scrub Nurse : Br. Balu

Patient Name: HNH-00016501 IP26-00006870 Mrs SRAVANTHI 10-03-1989 37 Y 4 M 7 D (F) Dr. RAJANI KUMARI

Gender : F

UHID No. :

Date : 17/7/26 In-time : 12:00pm Out-time : 1:00pm

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Before Induction of Anaesthesia ➢ ➢

SIGN IN Time: 12:00pm

Patient Has Confirmed

Identity	☑ Yes	☐ No	
Site	☑ Yes	☐ No	
Procedure	☑ Yes	☐ No	
Consent	☑ Yes	☐ No	
Site Marked	☐ Yes	☐ No	☑ NA
Anaesthesia Safety Check Completed	☑ Yes	☐ No	
Pulse Oximeter on Patient & Functioning	☑ Yes	☐ No	

Does Patient have a:

Known Allergy?	☐ Yes	☑ No	

Difficult Airway / Aspiration Risk?

Yes, & Equipment / Assistance Available	☐ Yes	☑ No	

Risk of > 500ml Blood Loss (7ml/kg In Children)?

Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes	☑ No	☐ NA
Blood Units Reserved	☐ Yes	☑ No	☐ NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	☑ Yes	☐ No	☐ NA

Signature : Akhila

Name : Dr. Akhila K.

Before Skin Incision ➢ ➢

TIME OUT Time: 12:05pm

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?	☐ Yes	☑ No	☐ NA

Anaesthesia Team Reviews:

Are There Any Patient-specific Concerns?	☐ Yes	☑ No	☐ NA

Nursing Team Reviews:

Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	☑ Yes	☐ No	☐ NA
Is Essential Imaging Displayed?	☐ Yes	☑ No	☐ NA

Signature : Karuna

Name : Karuna

Before Patient Leaves Operating Room

SIGN OUT Time: 12:10pm

Nurse Verbally Confirms with the Team:

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

To Surgeon, Anaesthetist and Nurse:

What are the key concerns for recovery and management of this patient?	☐ Yes	☑ No

Signature : [signature]

Name : Dr. Rajani Kumari

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PATIENT TRANSFER FORM

HNH-00016501 IP26-00006870
Mrs SRAVANTHI
10-03-1989 37 Y 4 M 7 D (F)
Dr. RAJANI KUMARI

Date & Time of Admission	Date & Time of Transfer Order
17/7/26 @ 8:20pm	17/7/26 @ 11:60 Pm
Treating Consultant Name	**Transfer Ordered by**	**Reason for Transfer**
Dr. Rajani Kumari	Dr. Akhila	observation
From Unit	**To Unit**	**Information to Attendant**
OT	Pre-Part	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
Ravuri	Dr. Akhila

Patient & Clinical Records Received by : Madhu

Date & Time of Patient Received : 17/7/26 @ 1 Pm

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

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016501 IP26-00006870 Mrs SRAVANTHI 10-03-1989 37 Y 4 M 7 D (F) Dr. RAJANI KUMARI	17/7/26 @ 8:20Am	17/7/26 @ 12Pm
	Transfer Ordered by Dr. Naveena	Reason for Transfer Hysteroscopy & ~~Laparoscopy~~ Polyectomy
From Unit PreSPost	To Unit (OT)	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 30	Number of Imaging Films Nil	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.	R-2	(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
Madhumita @ Madhu	Dr. Naveena

Patient & Clinical Records Received by : Karuna 17/7/26 @ 12:58Pm

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 FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Sravanthi Age : 37y Gender : Male ☐ Female ☑

UHID NO: RNH-0001650 1 Surgeon Name: Dr. Rajini Kumari

Anaesthesiologist : Dr. Samir / Dr. Hima Bindu

Operative procedure planned : Hysteroscopic 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 Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : .....

Comments : Laryngospasm, bronchospasm

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

DECLARATION BY P[illegible] GUARDIAN / PROXY

I hereby author[illegible] spital & its authorized doctors to perform upon me / my patient Sravanthi the above mentioned operation / Diagnostic / Therapeutic procedures Hysteroscopic 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 : Sravanthi

Name : Sravanthi

Relationship with Patient: Self

Date & Time : 17/7/26 9:45AM

Witness :

Signature : [signature]

Name : pawan

Date & Time : 17/7/26 9:45AM.

Doctor (who is taking the consent) :

Signature : [signature]

Name : DR. ARHICA. K

Date & Time : 17/7/26 9:45AM.

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs. Sravanthi Gender: ☐ Male ☑ Female Age : 37yr

UHID No : HNH-0001650l Date : 17/7/2026

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

Mrs. Sravanthi (Name of the Patient)

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

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

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

- Excessive Bleeding, Infection, Sepsis, Uterine perforation, Electrolyte Imbalance, Adhesions

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 Rajeev Kumar

Consentee :

Signature : Sravanthi

Name : Mrs. Sravanthi

Date & Time : 17/7/2026 @ 8:45am

Patient Attendant :

Signature :

Name : Yeddapally pavan

Relationship with Patient: Husband

Date & Time : 17/7/2026 @ 8:45am

Witness :

Signature : Maddy

Name : Maddumuthyala

Date & Time : 17/7/26 @ 8:45Am

Doctor (who is taking the consent) :

Signature :

Name : Dr VAVATHI. KV

Date & Time : 17/7/2026 @ 8:45am

HNH-00016501 IP26-00006870
Mrs SRAVANTHI
10-03-1989 37 Y 4 M 7 D (F)
Dr. RAJANI KUMARI

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Sravanthi Age: 37y. Sex: F UHID.No HNH-00016501

Date: 17/7/26 Time: 9:40 AM. Proposed Operation: Hysteroscopic Polypectomy

Diagnosis: 1° infertility + Endometrial polyp.

B.P / CRT: 98/63 H.R: 74. Weight: 56 kgs ASA Physical Status: ☑ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 10.3	Glucose:	Protein:	HIV: NR	X-Ray:
PCV:	Urea: 18	Alb:	HBS Ag: NR	ECG:
WBC: 6880	Creat: 0.6	Total Bill:	HCV:	2D Echo:
Plate: 360	Na:	Dir. Bill:	Blood group: A+ve.	Stress/Anglo:
PT: 14	K:	LDH:	T3	Other:
PTT: 29.1	Ca++:	Alk phos:	T4	
INR: 1.0	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: Nil

Medical History: CVS :

RESP : Diabetes : Nil

CNS :

Renal : Nil significant

Hepatic / GE : Physical Activity: active

Others :

Past Anaesthetic History: Nil

Physical Exam:

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

Lungs : BAE ⊕ Clr

Heart: S1 S2 ⊕

CNS: dcdc

Pregnant: ☐ Yes ☑ No ☐ NA | Venous Access Site : accessible | Spine Exam for regional : (N)

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:

Signature: Name: Dr. Akhila. K.

HNH-00016501 IP26-00006870
Mrs SRAVANTHI
10-03-1989 37 Y 4 M 7 D (F)
Dr. RAJANI KUMARI

ANAESTHESIA CHART

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Pre Induction Assessment: 12:00pm

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

H.R: 74	B.P / CRT: 102/59	SpO_2: 100%	R.R: 14	Last Feed: 5½ hrs

Pre-OP Diagnosis: Endometrial polyp Operation: Hysteroscopic polypectomy Date: 17/01/26

Surgeon: Dr. Rajani Kumari Anaesthesiologist: Dr. MH, Dr. AK Technician: Pallavi

TIME	12:00	12:30	1:00
N_2O /AIR/O_2 LPM	6S		
HALO/ISO/SEVO	MAC 1		
Drugs:			
Inj MIDAZOLAM	2mg		
Inj FENTANYL	100mcg		
Inj PROPOFOL	120mg	80mg	
Inj ROCURONIUM	15mg		
Inj PARACETAMOL	1gm IV		
FIO_2 / SaO_2	100	100	
$ETCO_2$	35	38	
ECG	SR	SR	
Temperature			
Urine Output			
Fluids: RL	11	11	11
Blood			

Antibiotic —

Suppository —

Blood Loss —

NOTES —

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

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

LAB Values: ABG | GRBS | Others

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

Position: Lithotomy
☐ 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: 12:00pm
OP Start:
OP End:
Leave OR: 1pm

Anaesthesia:
☑ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: R UL 20G
☐ IV:
☐ IV:

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

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

☐ 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. Archita. K
Signature of the Doctor: Kumy

HNH-00016501
Mrs SRAVANTHI IP26-00006870
10-03-1989 37 Y 4 M 7 D
Dr. RAJANI KUMARI (F)

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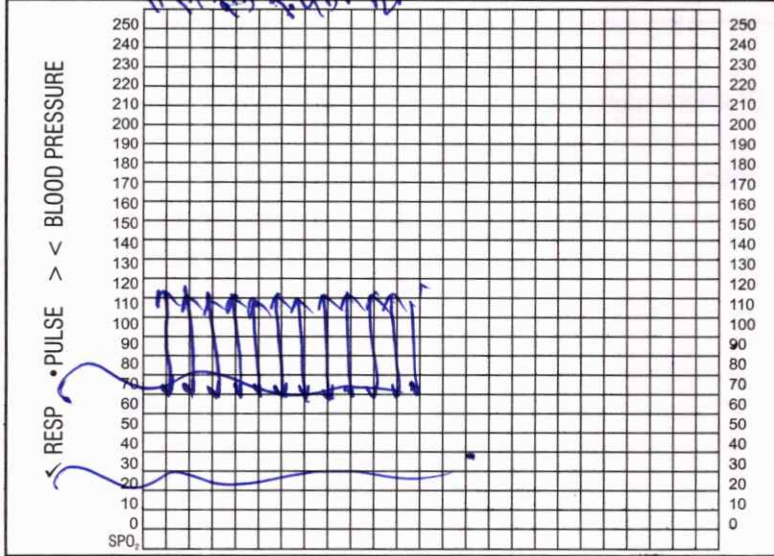
POST-ANAES[...] UNIT RECORD

Received in PACU by : Madhu Time Received : 1Pm Time Discharged : ....

1Pm 1:30pm 2:30pm 3:40pm 2pm



IV Cannula Site : Right

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

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

IV Fluids: RL
Oral Feeds: Nil

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	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	2		
BP ± 20 of Pre Anaesthetic leve BP ± 20-50 of Pre Anaesthetic leve BP ± 50 of Pre Anaesthetic leve	= 2 = 1 = 0	CIRCULATION	2	2	2	2		
Fully awake Arousable on calling Not responding	= 2 = 1 = 0	CONSCIOUSNESS	2	2	2	2		
Pink Pale, dusky, blotchy, jaundiced, other Cyanotic	= 2 = 1 = 0	COLOR	2	2	2	2		
		TOTAL	9	9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
17/7	1Pm	0	Normal	(signature)
17/7	2Pm	0	Normal	(signature)
17/7	3Pm	0	Normal	(signature)
17/7	4Pm	0	Normal	(signature)

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

Anaesthesiologist Name : Dr. Akhilesh K

Anaesthesiologist Signature: (signature)

Date & Time: ....

PACU Nurse Name : Srujatha

PACU Nurse Signature: (signature)

Date & Time: 17/7/26 @ 4Pm

Reassessment Frequency:

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

Transferred to Unit by (PACU): ....

Date & Time: 17/7/26 @ 4Pm

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 : .....

26-0000214614

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	Mrs. Gravanthi		Age: 37 Yrs	Gender:	Female
UHID No:	HNH-0001650	IP No: 26-0000687	Date: 17/7/26	Time:	
Diagnosis:	Hysteroscopy Polypectomy				OT

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr Samir G

Doctor Registration No: 67529

Signature:

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

IP Registration No: 26-0000687O

Date: 17/7/26

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

1.	Name : Mrs Gravanthi	Remarks
2.	Complete postal address (with contact number, if any)	Karimnagar Telangana
3.	Brief description of the illness	Hysteroscopy polypectomy
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
17/7/26	Fentanyl	01		

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

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

Time: 17/7/26 @ 1.18pm

Docu. No: RCH / FRM / CLINICAL / 133

I+ 26-0000214614

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Mrs. Sravanthi		Age: 37 Yrs	Gender: Female
UHID No: UNH-0001501	IP No: 26-0000687	Date: 17/7/26	Time:
Diagnosis: Hysteroscopy Polypectomy			OT

PRESCRIPTION DETAILS (Tick only one of the following)

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

Doctor Name: Dr. Amir

Doctor Registration No: 67529

Signature:

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

IP Registration No: 26-0000687 **Date:** 17/7/26

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

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

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
17/7/26	Fentanyl	01		

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

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

Time: 17/7/26 1:18pm