Dr. Sucliate

HNIH-00016739

Rainbow® Children's Hospital
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ESTIMATION SLIP

Date : 22/7/26 **UHID / IP No. :** HNIH-00016739 **Sl No.** 1732

Name of Patient : Mrs. Payal Gupta **Age:** 46yr **Gender:** F

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

Address : _____ **Phone :** 9810182863 **Email :** 48480272 05

Procedure / Plan : D & C **EDD/Dos:** July-22

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

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	**Normal Delivery**	**LSCS**
Multi Shared Ward		
Shared Ward	60k + Pharmacy & Investigation Extra	
Twin Shared Ward		
Private Room		
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 : 50/000/- Advance Paid

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 Siddarth Gupta 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.

Siddarth
Signature of the Client

Husband
Signatory Relationship

Signature of the financial Counselor

HNH-00016739
Mrs PAYAL GUPTA IP26-00006914
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

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SURGERY DETAILS

Date : 22/7/26

Patient Name: Mrs. Payal Gupta Date of Birth: 11/6/1980 Age: 49yrs

Gender: female Ward : OT UHID No.: HNH-00016739

Date of Surgery: 22/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : HYSTEROSCOPY + D&C.

Time in : 12 pm Time Out : 12:40 pm

		NAME	AMOUNT
1.	Surgeon	: Dr. Suchitra	
2.	Anaesthetist	: Dr. Samir	
3.	Assistant Surgeon	: Dr. Swathi	
4.	OT Technician	: Sr. Saraswathi	
5.	Circulating Nurse	: Sr. Puja	
6.	Assistant Nurse	: Sr. Susheela	

Mrs PAYAL GUPTA (46 Y 1 M 11 D/ F)
TISSUE NINV00215 HN26012277020

26-00021600

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

Signature of the Surgeon

Puja.
Signature of Circulating Nurse

Order No: 26-00002160001 Order by: Susheela 22/7/26 @ 1.53 Pm.

Docu. No. : RCH /FRM / GENERAL / 114

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-08-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

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CONSUMABLES OF OT

Cir..... Technician : Saraswathi Date : 22/7/26 Time :.....

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack Generalpack		1	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				Vaccum Suction Set		
05 cc		03	Gloves Encore 6½		4	Surgical Gloves		
02 cc		03	S.gloves 6½		2	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate : A / P / N			Surgical blade			Surgical Blade # 20		
IV set			NG tube			Koochies (S)		
RL		01	Cautery pencil					
NS : 10ml / 100ml / 500ml / 1000ml		01+02	Koochies					
PCM		01	Ointments					
			Suction Catheter					
Fentanyl			Cap, Mask	5+5				
Morphine			Gauze Pack 10X10		2			
Ketamine			Mop Pack					
Propofol			Steristrip					
Rocuronium			Underpad	2	1			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron Midaz		01	Foleys catheter Nelton 10		1			
279 Pencan 25g/ Spinal Needle 22		01	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Anavite Bupivacaine 0.25%(Heavy)		01	Romodrain bag					
Antibiotics			Bandage Intrafix		1			
Encore glove 7.5		01	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		3			
Tab. Misoprost : 200mg			Betadine Solution		2			
Gauze 10x10		01	Microshield					
Themicaine 2%		01	Cotton Balls		1			
			Latex Gloves		10			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-00002600 Ordered by : Sushila 22/7/26 @ 2:36pm

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-00016739	**Name**	: Mrs PAYAL GUPTA
Age / Sex	: 46 Y 1 M 11 D / Female	**Doctor**	: SUCHITRA SRIRAMPUR
Adm/Reg Date/Time	: 22/07/2026 10:12	**Payor**	: SELFPAY
Order Date	: 22/07/2026 14:35	**Ordernumber**	: 26-0000216007
Visit ID	: IP26-00006914	**Ward/Bed No**	: 4F -OT / PDA-412
Patient Address	: BANDLAGUDA JAGIR, Hyderabad, Telangana, INDIA, 500086		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	ENCORE MICROPTIC GLOVES-7.5 PF	.	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
2	NS 100ML ACCULIFE - EH	NORMALSALINE 0.9% SODIUMCHLORIDE100ML CLO	1 mL	/ Once Daily	1 Days		1 mL	Dispensed
3	PENCAN 27G (B/BRAUN)		1 Nos	External / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
4	THEMICAINE 2% 30ML INJ		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
5	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	1 Days		1 Bottle	Dispensed
6	DISPOSABLE APRONS STERILE XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
7	NELTON CATHETER-10 POLYMED		1 Nos	External / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
8	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	Injection / Once Daily	1 Days		1 Nos	Dispensed
9	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
10	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
11	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
12	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
13	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
14	GENERAL SURGERY KIT SAFE SECURE		1 Nos	External / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
15	UNDER PAD 60X90 10's Pack - MEDICUBE		1 Nos	External / 1-2 TIMES A DAY	1 Days		2 Nos	Dispensed
16	ANAWIN HEAVY 5 MG INJ 4 ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
17	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
18	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
19	MEZOLAM INJ 5 MG 5 ML		1 Vial	Injection / Once Daily	1 Days		1 Vial	Dispensed
20	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed

SUCHITRA SRIRAMPUR

Name	Mrs PAYAL GUPTA	**UHID**	HNH-00016739
Father/Guardian	Mr SIDDARTH GUPTA	**Age/Gender**	46 Y 1 M 11 D/ Female
Address	BANDLAGUDA JAGIR, Hyderabad, Telangana, INDIA, 500086		
IP No	IP26-00006914	**Admission Date**	22-07-2026
Ref Doctor	SELF		
Discharge Date	22.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. SUCHITRA SRIRAMPUR,
MBBS,MD(obs&Gynec)
HMC10563

Diagnosis: AUB-E FOR EVALUATION

HYSTEROSCOPY + DILATATION AND CURRETTAGE DONE ON 22.07.2026

History: She came with complain of heavy menstural bleeding on and off since 2 years, associated with clots, not associated with dysmenorrhoea, not relieved with medication. USG (21.07.2026) showed uterus bulky, m/s (8 x 6.5 x 4.8 cm) with mild altered echotexture,endo- myometrial differentiation is mildly obscured , ET 15.5mm, cervix normal with bilateral adnexa normal, no fluid in POD. Patient admitted for Hysteroscopy and Dilatation and Currettage.

Name	Mrs PAYAL GUPTA	**UHID**	HNH-00016739
IP No.	IP26-00006914	**Admission Date**	22-07-2026

Menstrual History:- LMP- 16.07.2026
Previous cycles: Regular

Obstetric History: P3L3A3-FTNDS, LCB-17 years

Medical History: HTN since 1 year, Hypothyroid since 21 years, DM since 17 years
Surgical History: 3 D&C in 2002/2003/2006,Nasal Septoplasty in 2023, Laproscopic Cholecystectomy in 2009
Family History: Nil
Allergies: Nil

Investigations: Enclosed.
Blood group: "B" Positive.

Surgery Notes:
Operation performed:
Hysteroscopy + Dilatation and curettage

Indication: Endometrial hyperplasia for evaluation

Operative findings:
- Patient under saddle block.
- Patient low lithotomy position.
- Cervix dilated upto no.6 hegar dilator.
- Hysteroscope inserted
- Fluffy endometrial in posterior wall.
- Bilateral cornua normal.
- Rest cavity normal.
- D&C done endometrial done sent for HPE.

Name	Mrs PAYAL GUPTA	**UHID**	HNH-00016739
IP No	IP26-00006914	**Admission Date**	22-07-2026

Post-Operative Notes: She was closely monitored in the postoperative period. Her vital signs remained stable. Her general condition was satisfactory and she was found to be fit for discharge. She was encouraged to ambulate and void spontaneously. Medications were explained to the patient.

Advice:

1. Tab. Taxim O 200mg (Cefixime 200mg) twice daily till 27.07.2026 (9am - 9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs)thrice daily till 25.07.2026(7am-3pm-10pm) after food.
3. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 27.07.2026
4. Tab. Zincovit once daily (2pm) for 1 month after food.
5. Collect HPE report .

Review with Dr. SUCHITRA SRIRAMPUR after 1 week on 29.07.2026 at postnatal clinic with prior appointment **(Review consultation will be charged).**

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

Patient/ Attender

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

Name	Mrs PAYAL GUPTA	**UHID**	HNH-00016739
IP No	IP26-00006914	**Admission Date**	22-07-2026

website **www.rainbowhospitals.in**

Rainbow Children's Medicare Ltd. Hyderabad Himayathnagar 500029

Registrar/Resident/C.M.O

Dr. SUCHITRA SRIRAMPUR
MBBS,MD(obs&Gynec)
HMC10563

Rainbow Childrens Hospital-Himayatnagar

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TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006914 **Admit Date** : 22-Jul-2026 **Admit Time** : 10:12 AM **UHID** : HNH-00016739

Patient Details :

Patient Name	: Mrs PAYAL GUPTA	**Age**	: 46 Y 1 M 11 D
Guardian	: Mr SIDDARTH GUPTA	**DOB**	: 11-06-1980
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: BANDLAGUDA JAGIR Hyderabad Telangana INDIA 500086	**Phone No**	: 9849182863/ 9848027208
		E-mail	: PAYALGUPTA@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PDA-412 **Ward Name** : 4F -OT

Room No : PDA-412 **Admission Type** : First Visit

Contact Details :

Name : Mr SIDDARTH GUPTA **Relationship** : Husband

Contact Address : BANDLAGUDA JAGIR Hyderabad Telangana INDIA 500086 **Phone No** : 9849182863 / 9848027208

Siddarth
Signature

Doctor Details :

Doctor Name	: Dr. SUCHITRA SRIRAMPUR	**Specialisation**	: OBSTETRICS AND GYNECOLOGY
Referral Doctor	: SELF	**Phone No**	:
Co-Consultant	:		

Payment Details :

Deposit Amount : 50000.00

Payment Mode : DC/CC Card **Payor Name** : SELFPAY

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ACTIVITY RECORD FOR BILLING

Name: -------- HNH-00016739 IP26-00006914 ----------
Mrs PAYAL GUPTA
UHID No : ----- 11-06-1980 46 Y 1 M 11 D (F) ------ Consultant : ---------- Dept : ----------
Dr. SUCHITRA SRIRAMPUR
Date of Admis ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/7	12pm	PreOpOT	(OT)	
22/7	12:40pm	OT	pre-post	

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
22/7	GRBS (103 mg/dL) (10AM)	12278	©
		CBG	check done Akila

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
22/7	cardiac monitor	1Pm	22/7 4:30pm	16002	Akila.
22/7	infusion pump	1Pm	4:30pm		
					Gov check done sy
					Akila.

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
22/7	IV placement	1	15940	[signature] MDS checkdone by AKW 22/9.

ANY OTHER INFORMATION

Date :　　　　Time :　　　　Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 22/07/2026 Time of Admission :

Allergies: nil Not know any drug allergies

PRESENTING COMPLAINTS :

- c/o. heavy menstrual bleeding since 2 yrs onset c polymenorrhea

→ Scan done s/o → thickened Endometrium (21/7) ET ~ 15mm

B/L OV - NAD
ut bulky.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : → 25yrs.	Parity : - $P_3 L_3 A_3$ - FTNDs.
Previous Periods :	Mode of Delivery : -
LMP : - 16/7/26.	Last Child Birth : LCB → 17yr
Contraception :	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
k/c/o. HTN :: 10 yrs - Hypothyroid :: 21yr. → DM - II :: 17yr.	- 3 DEC (2002, 2003, 2006) - Nasal septoplasty - 2023 - Lap cholecystectomy ↓ 2009.

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

nil.

MEDICATION HISTORY:

- Mounjaro 2.5mg weekly once
- Metformin SR 500mg BD
- T-Thyronorm 125mg OD
- PROPRANOLOL 20mg BD.
- Rosuvas 5mg BD.

INITIAL ASSESSMENT :

Date 21/07/2026. Ht. ______ Wt. ______ BMI ______ B.P ______ Pallor ______ CVR ______ Respiratory System ______ Thyroid ______	Breasts (N) Abdominal Examination PA: soft	Local/Speculum Examination nil Bimanual Pelvic Examination [illegible]

PROVISIONAL DIAGNOSIS : AUBE for Evaluation.

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
Hb - 14.8 g%. plt - 2.9 lac. BGT - B+ve. RBS - 156. S.creat 0.6. HbA1C - 6.09. S.TSH - 2.605 (20/7) HIV/HBsAg/HCV - NR	- NBM - Explained. → GRBS (N). - plan: Dilatation & curettage. today.

Name of the Doctor : ______

Signature of Doctor [signature]

Date & Time : ______

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/26	C/s/B Dr. Dna	
4:30pm	POD-0.	Adv.
	GC Fair	- Soft diet
	Afebrile	- Drugs as charted
	Vitals - stable	- w/f PV bleed
	P/A soft	- Monitor vitals
Urine passed		- Inform SOS.
		Pt can be discharged
	[signature]	
		Noted by Akhila. @ 22/7/26
		4pm

Docu. No. : RCH /FRM / CLINICAL / 088

(P.T.O)

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-05-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

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RESULT SHEET

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

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

B+ve

HIV
HBsAg
HCV

MR

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

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OPERATION NOTES

Surgeon :	Asst. Surgeon :

Pre-Operative Diagnosis:

Surgical Procedure : HYSTEROSCOPY + DILATATION & CURETTAGE

Indications for Surgery : - Endometrial Hyperplasia for Evaluation.

Date :	Start Time :	End Time :

Post Operative Diagnosis:

Peri-Operative Complications: - nil

Amount of Blood Loss: ~ minimal.	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Operation Notes: - pt. ↓ saddle block
→. Pt in low litho tomy position.
→. Os dilated upto no. 6. Hegar dilator.

→ Hysteroscopy:
- Fluffy endometrium in posterior wall
- B/L cornua ⓐ
- Rest cavity NAD.

- D&C done, endometrium sent for HPE.

Post op: - NBM x 6 hrs
- IV fluids.
- Inj TAXIM 1g iv BD
- GRBS ⓐ 6th hrly.
→ Inj PCM 1g SOS

→ Encourage voiding.
→ W/f bleeding PV / pain

Name of the Surgeon: Dr Sulekha S. Dr Swathi TV

Signature of the Surgeon: Swati

Date & Time: 22/08/2026

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Suchitra
Asst. Surgeon : Dr. Swathi
Anaesthetist : Dr. Samir
Scrub Nurse : Sr. Susheela

Patient Name : Mrs PAYAL GUPTA
UHID No. : HNH-00016739 IP26-00006914
Date : 22/7/25
11-08-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

46 Gender : F
12:40pm

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12pm

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 : Dr. Samir
Name :

Before Skin Incision ➤➤

TIME OUT Time: 12:15pm

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 : Puja @ 12:15pm.
Name :

Before Patient Leaves Operating Room

SIGN OUT Time: 12:40pm

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-00016739 IP26-00006914 Mrs PAYAL GUPTA 11-06-1980 46 Y 1 M 11 D (F) Dr. SUCHITRA SRIRAMPUR	22/4/26 @ 10:12am.	22/4/26 @
	Transfer Ordered by Dr. Suchitra	Reason for Transfer Observation
From Unit OT	To Unit Prepost	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 33	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
SS. Pufa	Dr. Samir.

Patient & Clinical Records Received by : Akshu RA

Date & Time of Patient Received : 22/2/26

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

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

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

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DRUG CHART

Date of Admission: 29/07/2026 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 *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 .....

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

REGULAR PRESCRIPTIONS

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

Verified by Dr. Dhakshayani

DRUG : Inj CEFOTAXIM	Dose: 1g	Route: IV	Frequency: BD	Start Date: 21/07	Date / Time: 22/7 10am 4pm
Name & Signature of the Doctor Starting the Drugs:					10am
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

Verified by Dr. Dhakshayani

DRUG : PARACETAMOL	Dose: 1gm	Route: P/O	Frequency: TID	Start Date: 22/7	Date / Time:
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

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

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

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 ....

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

(P.T.O.)

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REGULAR PRESCRIPTIONS

Sheet No: .... 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-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

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.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
21/07	11:40 Am	Inj PANTOPRAZOLE 40mg		iv	[illegible]	[illegible]
21/07	11:40 AM	Inj METACLOPRAMIDE 10mg		iv	[illegible]	[illegible]
21/07	11:40 Am	Inj ONDENSETRONE 4mg		iv	[illegible]	[illegible]

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

I.V. FLUIDS CHART

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

Date	Time	osition 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
21/7	11AM	Ringer Lactate	iv	100ml/hr	✱		22/7		
22/7	1230 pm	RINGER LACTATE	IV	100			22/7		

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

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

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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	TAB TELMONORM	12.5mg	PO	OD.	22/7/26	☐ C ☐ DC
2	TAB METFORMIN SR	500mg	P/O.	OD	22/7	☑ C ☐ DC
3	TAB PROPRANOLOL	20mg	P/O.	BD	22/7	☑ 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. Diva.

Date & Time : ..22/7/26. @ 12pm.....

Nurse Name & Signature: ..Madhumita @ Madhu.....

Date & Time : ..22/7/26 @ 12pm.....

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

HNH-00016739 IP26-00006914
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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 12/7

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: .....

..... DSE .....

.....

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
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 1 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 F HR: 82 RR: 20

BP: 116/71 Weight: ..... Height: ..... BMI: .....

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

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-08-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

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: ..... Payee .....

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

Nurse Signature: ..... Madhu .....

Nurse Name: ..... Madhumitha .....

Date & Time: ..... 22/12/26 @ 11 Am .....

HNH-00016739 IP26-00006914
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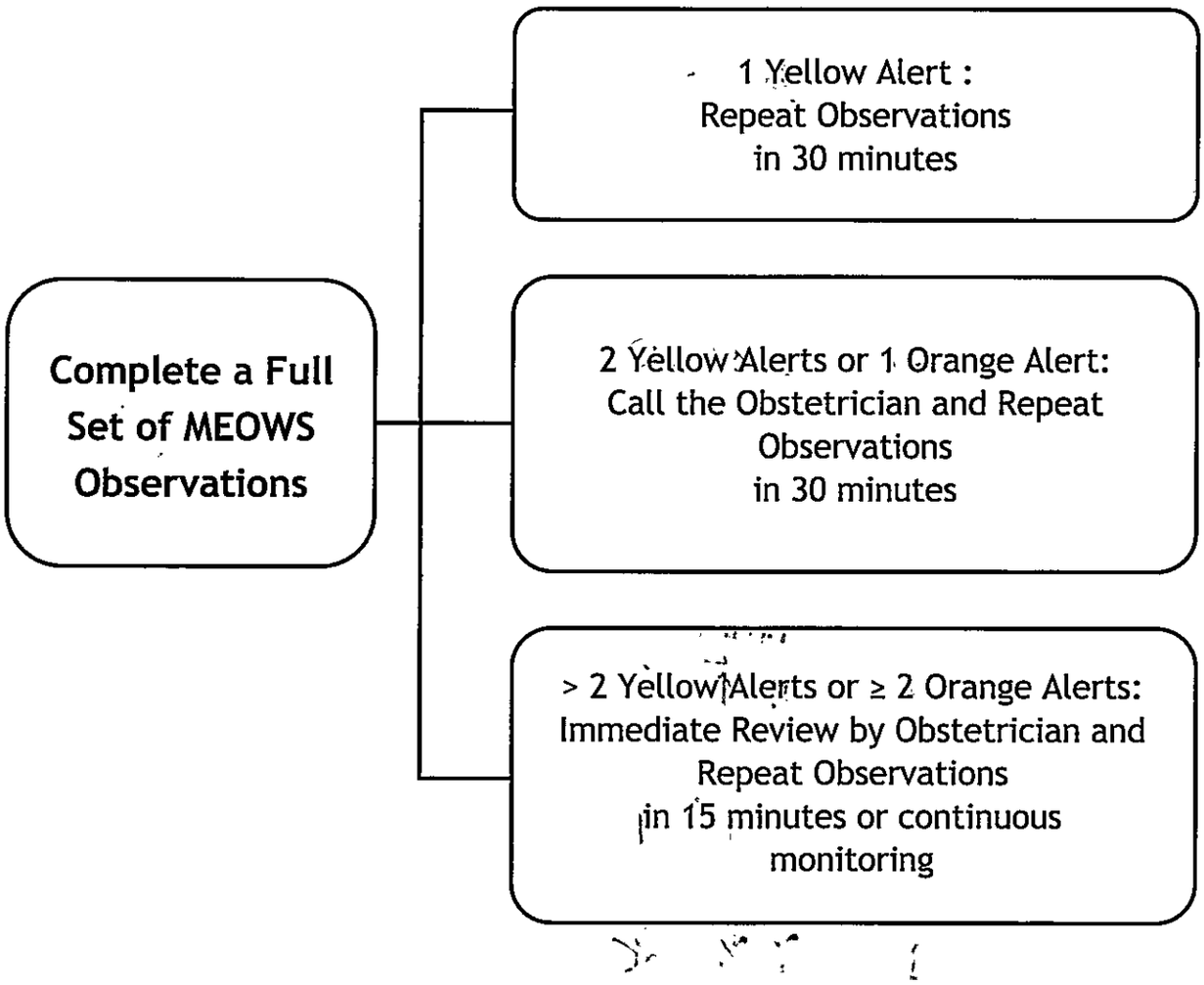
arning Observation Score Chart - Obstetrics

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				19																					
	0 - 10																									
Saturations	94 - 100 %				98																					
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36				36				36																	
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80				81				82	84	85	87														
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120				116				114	112	115	116														
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80				71				73	74	76	75														
	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)**

HNH-00016739 IP26-00006914
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11-06-1980 46 Y 1 M 11 D (F)
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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											
22/7	10:00 am	RL	M	100ml								
	11:00 am	RL		100ml								
	12:00 pm	RL	B	100ml								
	01:00 pm	RL	IX	100ml								
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm		Daly									
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

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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**	

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
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PAIN ASSESSMENT FORM

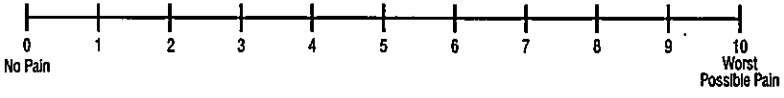
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
22/7	11Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
22/7	2pm	0	NA	☐ Continuous ☐ 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		
				☐ 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		
				☐ 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 drawn 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-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-08-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

BRADEN 'Q' SCALE

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				Date :	22/7			
				Time :	8Am			
Mobility	**1. Completely ...bile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
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

Docu. No. : RCH /FRM / CLINICAL / 119

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

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

Morse Fall Risk Assessment Form

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Choose Highest Applicable Score from each Category		Date / Time	22/7			Fall Risk Grading		
		Score	8Aon					
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0				Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0					
IV / Heparin Lock or Saline	Yes	20	20			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0			High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
Mental Status	Forgets limitations	15						
	Oriented to own ability	0	0					
Total Morse Fall Scale Score:			20					
		Signature						

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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Dr. SUCHITRA SRIRAMPUR

CHECKLIST FOR THROMBOPHLEBITIS

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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	Q									
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	Q									

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-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

NURSING CARE RECORD

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Date: 22/7/26

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		→ Plan for vitals → Plan for I/O Chart. → Plan for medication.		→ Vitals checked & recorded. → Maintained I/O Chart. → All medications given	→ Vitals is normal	→ I/O is satisfied	Nadia @
Afternoon							
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							

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

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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	22/7 DR C					
	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:	98.F					
	Res:	20					
	SpO_2:	99%					
	Pulse:	89					
	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 :		Maddy					
Signature :		✓					
Date:		22/7					
Time:		2pm					
Taken Over By Name :							
Signature :							
Date:							
Time:							

Docu. No. : RCH /FRM / CLINICAL / 097

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:							

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016739 IP26-00006914 Mrs PAYAL GUPTA 11-06-1980 46 Y 1 M 11 D (F) Dr. SUCHITRA SRIRAMPUR	22/7/26 @ 10/12Am	22/7/26 @12Pm
	Transfer Ordered by: Dr. Dua	Reason for Transfer: DSE
From Unit: Pre & Post	To Unit: (OT)	Information to Attendant: Yes ☑ No ☐
Number of Sheets in Clinical File: Nil	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.	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
Madhumita @ Madh	Dr. Dua

Patient & Clinical Records Received by : Rajni 22/7/26 @ 12pm

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 : Mrs. Payal Agarwal. Age : ..... Gender : Male ☐ Female ☑

UHID NO: ..... Surgeon Name: Dr. Suchitra Sanjay

Anaesthesiologist : Dr. Lamin Nayak

Operative procedure planned : Hysteroscopic D & C.

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 : hypothyroid

Comments : .....

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

I authorize and give consent for anaesthesia (☑ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthetic team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthetic team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

- Pregnant.: ☐ Yes ☑ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / ~~Patient Attendant~~ :

Signature : .....

Name : MRS. Payal

Relationship with Patient: Self

Date & Time : 22/7

Witness :

Signature : Siddarth

Name : Siddarth Gupta

Date & Time : 22/7/26

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Samir Tirayath

Date & Time : 22/7 at 1030am

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs Payal Agarwal Gender: ☐ Male ☑ Female Age : 46 yr.

UHID No : Date : 22/7/2026

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 + DILATATION AND CURRETTAGE upon Mrs Payal Agarwal (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, risk of uterine perforation
Need for 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: .....

Consentee :
Signature : Payal
Name : Payal
Date & Time : 22/7/26 @ 11:30 Am

Witness :
Signature : M
Name : Mounika
Date & Time : 22/7/26 12pm

Patient Attendant :
Signature : Siddarth
Name : Siddarth Gupta - Husband
Relationship with Patient: .....
Date & Time : 22/7/26 @ 11:30 Am

Doctor (who is taking the consent) :
Signature : .....
Name : Dr. Dna
Date & Time : 22/7/26 @ 11:30 Am

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: MRS PAYAL AGARWAL Age: 46 Sex: FEMALE UHID.No :

Date: 22/7 Time: 1020 AM. Proposed Operation: D&C - HYSTEROSCOPY

Diagnosis: AUB - FOR EVALUATION

B.P / CRT: 99/63 H.R: 77 Weight: ASA Physical Status: ☐ 1 ☐ 2 ☑ 3 ☐ 4 ☐ 5

Laboratory Data:

20/7

Hgb: 14.8	Glucose: (R) 156	Protein:	HIV: NR	X-Ray:
PCV: 43	Urea:	Alb:	HBS Ag: NR	ECG:
WBC: 7900	Creat: 0.9	Total Bill:	HCV:	2D Echo:
Plate: 2.9	Na:	Dir. Bill:	Blood group: B pos	Stress/Anglo: (N) coronaries (R) Dominant CC score - 0. NSR throughout.
PT: 22	K:	LDH:	T3	Other:
PTT: 33.4	Ca++:	Alk phos:	T4 10.8	
INR: 1.71	Mg++:	Amylase:	TSH 26.5	
HbA1c - 6.69%	Cl -:	SGOT/SGPT:		

Allergies: NKDA.

Medical History: CVS: HTN (+) / NO H/O CAD° / TIA° / SYNCOPE° WAS EVALUATED FOR ANGINA.

RESP: No H/O BA° / TB° / PNEUMONIAS° MILD COVID (+), VACCINATED. Diabetes: DM2 (+)

CNS: NO HISTORY.

Renal: WAS EVALUATED FOR HEMATURIA → NON-SPECIFIC → MX. CONSERVATIVELY

Hepatic / GE: H/O JAUNDICE 17YRS AGO / VEG. DIET. (N). Physical Activity: ACTIVE / NYHA - I.

Others: HYPOTHYROID :: 17YRS. ON MEDICATION - COMPLIANT METS ≥ 4.

Past Anaesthetic History: MULTIPLE - 2 D&C / SEPTOPLASTY / CATARACTS / LAP CHOLE → ALL UNEVENTFUL

Physical Exam: COHERENT / ACTIVE

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

Lungs: BAE (+) CL. CLEAR

Heart: S1+S2+ MO.

CNS:

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site: PERIPHERAL Spine Exam for regional: MIDLINE

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

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

CURRENT MEDICATIONS	DOSAGE
MOUNJARO 2.5MG	WEEKLY ONCE
METFORMIN SR 500MG	BD.
THYRONORM 125MG	OD.
INDERAL (PROPANALOL) 20MG	BT.

ROSUVAS 5MG BT

Pre-Operative Instructions: tea & biscuits at 7am.

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: [signature] Name: Dr SAMIR INAYATH

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

HNH-00016739 IP26-00006914
Mrs PAYAL GUPTA
11-06-1980 46 Y 1 M 11 D (F)
Dr. SUCHITRA SRIRAMPUR

ANAESTHESIA CHART

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PTC Induction Assessment:

Change in Patient Condition: ☐ Yes ☑ No | Fasting Status: 6 hours.

Physical Status: ☑ Patient Identified | ☑ Consent Present | ☑ Chart Reviewed

H.R: 85/M | B.P / CRT: 117/83 | SpO_2: 98% | R.R: 16/M | Last Feed: 6 hours

Pre-OP Diagnosis: AVM. | Operation: Hyst + D&C | Date: 22/7

Surgeon: Dr Suchitra / DrSV | Anaesthesiologist: Dr. Samir | Technician: Saraswati

TIME 1200 — 1240

N_2O /AIR /O_2 LPM
HALO /SO /SEVO
Drugs:
MIDAZOLAM 2mg iv
PARACETAMOL 1gm IV

FIO_2 / SaO_2 100 100 100
$ETCO_2$
ECG SR SR SR
Temperature
Urine Output

Fluids RL
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 3 leads
☐ 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 sheet

Times:
Anaes Start: 12
OP Start:
OP End:
Leave OR: 1240 pm

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☑ Regional

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

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

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

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

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

Regional:
Extremity Specify:
☑ Spinal ☐ Epidural ☐ Caudal
Others: saddle block
Position: Sitting
Site: L3-4
Needle Size: 27G (P) Depth: single shot
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: 0.5% BUPIVACAINE (H)
Bolus:
Infusion:
Block Level: T8 - adq.
Comments:

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

Name of the Doctor : Dr Samir
Signature of the Doctor :

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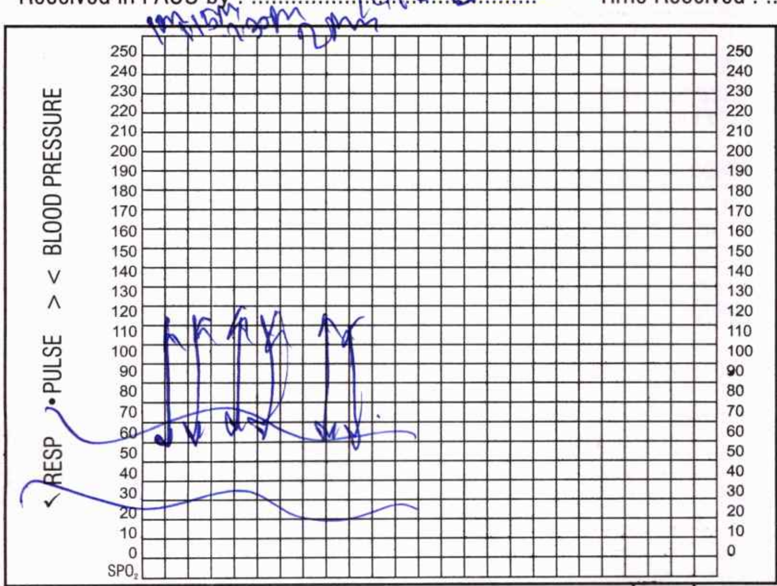
POST ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Akalu Time Received : 1 pm Time Discharged : ....



IV Cannula Site : left

☐ 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: NA

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
22/7	1pm	0	Normal	[signature]
22/7	2pm	0	Normal	[signature]
22/2	3pm	0/10	NA	[signature]
22/2	5pm.	0/10	NA	[signature]

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

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

PACU Nurse Name : Akhila
PACU Nurse Signature: [signature]
Date & Time: 22/2/26

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: 22/2/26

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 : .....