Dr. Swapna

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

BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

ESTIMATION SLIP

Date : 6/6/26 **UHID / IP No. :** HNH-00009508 **Sl No.** 1574

Name of Patient : Ms. Deepti Dage **Age:** 28yr **Gender:** F

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

Address : King. Koti **Phone :** 9020141742 **Email :** 957364E615

Procedure / Plan : NDlscs **EDD/Dos:** July-28

MODE OF PAYMENT : ☐ SELF ☐ TPA : New Indic + MA ☐ GIPSA : _____ OTHER

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	**Normal Delivery**	**LSCS**
Multi Shared Ward		
Shared Ward		
Twin Shared Ward →	90k	1.1ac
Private Room →	1.10 k	1.20k
Super Deluxe Room		
Suite Room	+ Nor Payable	Extra 15k to 25k
Package includes (Package starts from the time of admission) CBP, NST/—	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 : 2 Days	Length of Stay for : 3 Days
	Pharmacy up to 9,000/-	Pharmacy up to 12,000/-
	Investigations up to 2,500/-	Investigations up to 3,000/-
Others	well baby care	25k to 35k

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

Initial Minimum Deposit : 10,000/- Advance time of Admission

REMARKS : Neonatal, Vaccination, SBI, B/L

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 Rahul Mala 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-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

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SURGERY DETAILS

Date : 15/7/26

Patient Name: Mrs-Deeptidaga Date of Birth: 7/7/1997 Age: 29Y

Gender: female Ward : OT UHID No.: HNH-00009508

Date of Surgery: 15/7/26 ~~☐ OT -1~~ ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Em Lscs ↓ S.A

Time in : 2:15pm Time Out : 3:15pm

		NAME	AMOUNT
1.	Surgeon	Dr-Swapna	
2.	Anaesthetist	Dr-Samir	
3.	Assistant Surgeon	Dr. manisha	
4.	OT Technician	Br-Arvind	
5.	Circulating Nurse	Sr puja , Sr-karuna	
6.	Assistant Nurse	Sr. Natasha , Sr-Sandhya	

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

Signature of the Surgeon

Puja.
Signature of Circulating Nurse

Order No: 26-000021 4066

Order by: Sandhya 15/7/26 @ 3:30 pm
(or record saved)

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
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CONSUMABLES OF OT

Circulating staff : Karuna, Puja Technician : Aravind, Sr. Saraswathi Date : 15/7/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			Major Pack LSCS Drape kit		01	Inj Vit.K		01
LMA			Sutures 2346, 2364		2+1	Cord Clamp		01
ECG leads : A / P / N		03	1326, 4242		1+1	Suction Catheter		
HME filter : A / P / N						Feeding Tube NO-5		01
Syringes : 10 cc		02				Vaccum Suction Set		
05 cc		04	Gloves SG 6.0		4	Surgical Gloves 6.5		01
02 cc		04	~~SG 6.0~~		~~1~~	Gauze Pack		~~01~~
01 cc		01	Encore 6.5		1+01	Syringe 1ml / 2ml		01
Cautery plate : A / P / N		01	Surgical blade 22		01	Surgical Blade # 20		01
IV set			NG tube			Koochies (S)		01
RL		02	Cautery pencil		01	SG 6.0		01
NS : 10ml / 100ml / 500ml / 1000ml		01	Koochies XXL		01	Encore 6.5		01
			Ointments					
			Suction Catheter			X-Ray Gauze		01
Fentanyl		01	Cap, Mask		10+10			
Morphine			Gauze Pack ~~7.5cm~~ 10X10		01			
Ketamine			Mop Pack		02			
~~Propofol~~ Atropine		01	Steristrip			26-00002140 72		
Rocuronium ~~Adrenaline~~		~~01~~	Underpad		02			
Glycopyrolate		01	Draw sheet					
Myopyrolate			Abgel		01			
Ondansetron		01	Foleys catheter					
Pencan 25g/ Spinal Needle 22		01	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
~~Bupivacaine~~ 0.25%(Heavy)		01	Romodrain bag					
Antibiotics			Bandage					
oxeftocine		03	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / 100mg		01	Plastic ~~Bed Sheet~~ Aprons		04			
Tab. Misoprost : 200mg		04+2	Betadine Solution		02			
Encore glove 7.0		01	Microshield		~~01~~			
~~Cautery 10X10~~		~~01~~	Cotton Balls		01			
Mehogyl		01	Latex Gloves		20			
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. 26-00002140 71/070 Ordered by : Sr. Sandhya

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-00009508	**Name**	: Mrs DEEPTI DAGA
Age / Sex	: 29 Y 0 M 8 D / Female	**Doctor**	: SWAPNA SAMUDRALA
Adm/Reg Date/Time	: 14/07/2026 22:15	**Payor**	: MEDI ASSIST INSURANCE TPA PVT LTD
Order Date	: 15/07/2026 16:04	**Ordernumber**	: 26-0000214071
Visit ID	: IP26-00006843	**Ward/Bed No**	: 4F -OT / LDR-416
Patient Address	3-5-38, King Koti, Hyderabad, Telangana, INDIA, 500001		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
2	ONDOKIND INJ 4 MG 2 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
3	Encore Micreptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
4	LSCS DRAPE PACK (PROTECTCARE)		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
5	UNDER PAD 60X90 10's Pack - MEDICUBE		1 Nos	External / 1-2 TIMES A DAY	1 Days		2 Nos	Dispensed
6	NS 100ML ACCULIFE - EH	NORMALSALINE 0.9% SODIUMCHLORIDE100ML CLO	1 mL	/ Once Daily	1 Days		1 mL	Dispensed
7	PENCAN 25G*3 1 2	PENCAN 25G*3 1 2	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
8	ENCORE MICROPTIC GLOVES-6 PF		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
10	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	1 Days		1 Nos	Dispensed
11	CAUTERY PENCIL (ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
12	DISPOSABLE APRONS STERILE XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	4 Days		4 Nos	Dispensed
13	ENCORE MICROPTIC GLOVES-7 PF		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
14	MISOPROST TAB 200MCG 4S		1 Tabs	External / Once Daily	1 Days		6 Tabs	Dispensed
15	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
16	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
17	THEMPYRRNOM 0.2MG INJ		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
18	TRUGUT CHROMIC CATGUT SN4242	TRUGUT CHROMIC CATGUT SN4242	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
19	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY		1 Pkt	External / Once Daily	1 Days		2 Pkt	Dispensed
20	VICRYL 1-0 VP 2346	VICRYL 1-0 VP 2346	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
21	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
22	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
23	ABGEL SURGI PAD (BIG) (GELSPON)	ABGEL	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
24	ANAWIN HEAVY 5 MG INJ 4 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
25	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Dispensed
26	MONOCRYL 3-0 NW 1326	MONOCRYL 1326	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
27	DSYRINGS 2.5ML(NEPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
28	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
29	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
30	SGLOVE # 6 (SURGICARE)	SURGICAL GLOVES 6.0	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
31	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
32	VICRYL 1-0 NW 2364	VICRYL 1-0 NW 2364	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
33	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
34	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
35	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
36	ACUGYL 500MG INJ		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

SWAPNA SAMUDRALA

Reg No : 69924

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

Note

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

*** Do not refill medicines.**

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ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00009508	**Name**	: Mrs DEEPTI DAGA
Age / Sex	: 29 Y 0 M 8 D / Female	**Doctor**	: SWAPNA SAMUDRALA
Adm/Reg Date/Time	: 14/07/2026 22:15	**Payor**	: MEDI ASSIST INSURANCE TPA PVT LTD
Order Date	: 15/07/2026 16:04	**Ordernumber**	: 26-0000214070
Visit ID	: IP26-00006843	**Ward/Bed No**	: 4F -OT / LDR-416
Patient Address	: 3-5-38, King Koti, Hyderabad, Telangana, INDIA, 500001		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	EVATOCIN (OXYTOCIN) INJ 5 IU 1 ML		1 Vial	External / Once Daily	1 Days		3 Vial	Dispensed
2	NITRILE EXAMINATION GLOVES P F- MEDIUM		1 Nos	External / Once Daily	1 Days		20 Nos	Dispensed
3	SURGEONS CAP	SURGEONS CAP	1 Cap	Oral / Once Daily	1 Days		10 Cap	Dispensed
4	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Dispensed

SWAPNA SAMUDRALA

Reg No : 69924

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00016599	**Name**	: Baby Of DEEPTI DAGA
Age / Sex	: 0 Y 0 M 0 D 2 H / Male	**Doctor**	: DILNAAZ FAROOQUI
Adm/Reg Date/Time	: 15/07/2026 15:12	**Payor**	: SELFPAY
Order Date	: 15/07/2026 16:08	**Ordernumber**	: 26-0000214072
Visit ID	: IP26-00006852	**Ward/Bed No**	: 4F -OT / CRDL-HNPDA-415-1
Patient Address	: 3-5-38, King Koti, Hyderabad, Telangana, INDIA, 500001		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
2	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
3	SURGICAL BLADE 20	SURGICAL BLADE 20	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
4	INFANT FEEDING TUBE-5	INFANT FEEDING TUBE 5	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	CORD CLAMP-ALPHAMEDICARE		1 Nos	External / 1-2 TIMES A DAY	1 Days		1 Nos	Dispensed
6	GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY		1 Pkt	External / Once Daily	1 Days		1 Pkt	Dispensed
7	INJEK INJ 1 MG 0.5 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Dispensed
8	SGLOVE # 6 (SURGICARE)	SURGICAL GLOVES 6.0	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
9	KOOCHEES- SMALL 5 S		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed

DILNAAZ FAROOQUI

Reg No : 56763

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F-C

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Name	Mrs DEEPTI DAGA	**UHID**	HNH-00009508
Father/Guardian	Mr RAHUL MALU	**Age/Gender**	29 Y 0 M 8 D/ Female
Address	3-5-38, King Koti, Hyderabad, Telangana, INDIA, 500001		
IP No	IP26-00006843	**Admission Date**	14-07-2026
Ref Doctor	Self.		
Discharge Date	17.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

Diagnosis: PRIMIGRAVIDA WITH 39^{+3} WEEKS PERIOD OF GESTATION WITH HYPOTHYROIDISM FOR INDUCTION OF LABOUR.

EMERGNECY LOWER SEGMENT CAESAREAN SECTION DONE ON 15.07.2026

History:
LMP: 14/10/2025
EDD: 21/7/2025
Obstetric formula: Primigravida
Gestation at admission: 39^{+3} weeks

Obstetric History:
G1 - Present pregnancy, Spontaneous conception.

Name	Mrs DEEPTI DAGA	UHID	HNH-00009508
IP No	IP26-00006843	Admission Date	14-07-2026

Medical History: Nil
Surgical History: Nil
Allergies: Nil
Family History: Mother HTN, Father Hypothyroid

Antenatal Details:

Mrs DEEPTI DAGA was booked to Rainbow hospital at 6^{+3} weeks of gestation. She had regular antenatal checkups and investigations as advised. NT was normal. FTS showed screen Negative for Down Syndrome and Screen positive for PE(1:18), for which she was started on Tab. Ecosprin 150 mg once daily. TIFFA was normal. At 31^{+5} weeks she received parenteral iron therapy in view of moderate anemia (Hb.: 8.7 gm/dl). Fetal growth monitoring was done by serial growth scan. Scan done on 3.07.26 showed SLIUF at 37^{+6} weeks , Cephalic, 3185 gm (48 % / AC 51 %) , Placenta : Anterior High, Liquor Adequate, AFI 16.4 cm, Dopplers normal. She was admitted at 39^{+3} weeks for IOL.

Investigations: Enclosed
Blood Group : "O" Positive

Management:

Course in hospital and Delivery Details:

At admission on clinical examination the vitals were stable, uterus was relaxed, cervix was uneffaced and Os closed. Fetal well being was confirmed by an admission NST which was found to be reactive. Consent for Induction of labour

Name	Mrs DEEPTI DAGA	UHID	HNH-00009508
IP No	IP26-00006843	Admission Date	14-07-2026

and vaginal birth was taken. Induction was done by 3 doses of PGE1. She was decided for emergency C- section in view of Non Progression of Labour, prepared with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Patient shifted to theatre.

Surgery Notes:

Under spinal anesthesia she was painted and draped as per hospital protocol. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 400 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

*** LUS well formed**

*** 1 loop of cord around neck.**

Delivery Details :

Date : 15.07.2026

Time of Delivery: 02:31pm

Type of Delivery: Emergency lower segment caesarean section

Name	Mrs DEEPTI DAGA	UHID	HNH-00009508
IP No	IP26-00006843	Admission Date	14-07-2026

Indication : Non Progression Of Labour
Analgesia : Spinal

Baby Details:
Date : 15.07.2026
Time : 02:31 pm
Sex : Male
Weight : 3.320 kgs
Apgar : 8,9
Gestational Age: 39^{+3} weeks
NICU Admission: No

Post-Operative Notes:
She was closely monitored. Her vital signs remained stable. Uterus was well retracted with no Postpartum hemorrhage. Breast feeding initiated. She was shifted to room. Her postoperative period following that was uneventful. On second postoperative day dressing was changed. On inspection wound was healthy. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

Advice:
1. Tab. Taxim O 200mg twice daily till 21.07.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 19.07.2026 (8am-2pm-10pm) after food.

Name	Mrs DEEPTI DAGA	UHID	HNH-00009508
IP No	IP26-00006843	Admission Date	14-07-2026

3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 19.07.2026 (9am-3pm-11pm) after food.
4. Tab. Pantop 40mg twice daily till 21.07.2026 (7am-7pm) before food.
5. Inj.Clexane 60U (Enoxaparin) Subcutaneously once daily at 8am till 22.07.2026.
6. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
7. Tab. Shelcal (Elemental Calcium 500 mg, Vitamin D3 250 IU) once daily (2pm) till breast feeding for after food.
8. FT4 , TSH after 6 weeks
9. Nebasulf Powder for local application.
10. TED stocking x 2 week.

Home Blood pressure monitoring to be done **twice daily** for **two weeks**. Report to emergency if **BP >140/90mmHg**, presence of headache, vomitings, blurred vision, reduced urine output, epigastric pain, seizures.

* Suggest **PAP smear** and **HPV Vaccine** after **6 weeks**; Please discuss with your treating doctor regarding **HPV vaccination.**

Review with **Dr. SWAPNA SAMUDRALA** after **2 weeks** on **31.07.2026** at Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

For Women Who Have Had a Caesarean Section
Care of the wound:

Name	Mrs DEEPTI DAGA	**UHID**	HNH-00009508
IP No	IP26-00006843	**Admission Date**	14-07-2026

1.You can bath and shower.
2.The wound can get wet during a bath or shower. Dry it thoroughly and gently by dabbing with a gauze piece. Do not rub the wound.
3.This gauze piece needs to be discarded after one use.
4.Prior to touching the wound clean hands thoroughly with Microshield solution and allow them to air dry or use disposable paper napkins.
5.Apply Nebasulf or Neomycin dusting powder on the wound after it is dry.
6.Do not touch the wound with unwashed hands.

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 Himayatnagar just dial one toll free number - 18002122. You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

Rainbow Children's Medicare Ltd. Himayathnagar 500029 Hyderabad

Registrar/Resident/C.M.O

Consultant:
Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 10 D (F)
Dr. SWAPNA SAMUDRALA

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BirthRight BY RAINBOW HOSPITALS
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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	4			
7	Nursing plan of care and handover sheets	3			
8	Consultation sheet Cross	1			
9	General consent for treatment	1			
10	Consent for Surgery	1			
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)	1			
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation	1			
24	Emergency Triage record				
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
28	Nurses clinical Presentation				
29	TPR & BP chart	3			
30	Intake and Out take chart (fluid chart)	2			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart				
34	Nutritional review chart	1			
35	Intensive care unit (ICU Charts)				
36	Consent for Admission in PICU / NICU				
37	The Humpty dumpty scale				
38	Braden Q Scale	2			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Others	5			
	Total No. of Pages	37			

No. : RCH/ FRM / GENERAL / 126

Signature and Date : 17/07/26

Jyotsna

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital

BirthRight by Rainbow

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 : IP26-00006843 **Admit Date** : 14-Jul-2026 **Admit Time** : 10:15 PM **UHID** : HNH-00009508

Patient Details :

Patient Name	: Mrs DEEPTI DAGA	**Age**	: 29 Y 0 M 7 D
Guardian	: Mr RAHUL MALU	**DOB**	: 07-07-1997
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 3-5-38 King Koti Hyderabad Telangana INDIA 500001	**Phone No**	: 9030494742/ 9573948615
		E-mail	: deeptidaga97@gmail.com

Admission Details :

Bed Type : TWIN SHARING **Bed No** : LDR-416 **Ward Name** : 4F -OT

Room No : LDR-416 **Admission Type** : First Visit

Contact Details :

Name : Mr RAHUL MALU **Relationship** : Husband

Contact Address : 3-5-38 King Koti Hyderabad Telangana INDIA 500001 **Phone No** : 9030494742 / 8555891081

Signature

Doctor Details :

Doctor Name : Dr. SWAPNA SAMUDRALA **Specialisation** : OBSTETRICS AND GYNECOLOGY

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

Co-Consultant :

Payment Details :

Payment Mode : Cash **Deposit Amount** : 10000.00

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

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PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00009508 IP26-00006843 Mrs DEEPTI DAGA 07-07-1997 29 Y 0 M 7 D (F) Dr. SWAPNA SAMUDRALA	14/2/26 @ 10:15Pm	15/2/26 @ 2Pm.
	Transfer Ordered by	Reason for Transfer
	Dr - Manisha	EM. LSCS
From Unit	To Unit	Information to Attendant
MICU	OT	Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant
30	NST -	Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Akshitha (signature)	Dr Manisha.

Patient & Clinical Records Received by : ~~Maheswari~~ 2pm Swetha

Date & Time of Patient Received :

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

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

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ACTIVITY RECORD FOR BILLING

Name :_____ IP26-00006843 _____

HNH-00009508
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 7 D (F)
Dr. SWAPNA SAMUDRALA

UHID No. : _____ Consultant: _____ Dept : _____

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
15/7/26	2pm	MICU	OT	Akhila/ Natasha
15/7/26	4PM	OT	Pre-post	Sunitha/Sujatha
15/7/26	9pm.	MICU	Room	Monika/

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	~~Dr. Dilnaaz~~	~~16/7/26~~		
2	~~Paediatrician~~			
3	Dr. Tejaswi Reddy	16/7/26	14446	
4				
5				
6				
7				
8				
9				
10				

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
14/7	IV placement	(1)	13890	
15/7/26	catheterization	(1)	14008	
15/7/26	PAC - IP		14009	
16/7/26	NHA	(1)	14336	

Cross checked done
14/7/26

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00009508
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 7 D (F)
Dr. SWAPNA SAMUDRALA
IP26-00006843

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Admitted for IOL.

Obstetric Formula: Primi

Obstetric History:

1- PP - Spon Conception
Booked at 6+3 week.

Present Pregnancy Record:

ML-2024, NCM.
NT scan - (N)
FTS - low risk
Screen positive for PE (1:18)
MTAS - (N).

RISK FACTORS:

Cholelithiasis | Choledocholithiasis

Height: 165 cm
Weight: 107 kg
Allergies: Nil
Breast: ☑ Normal ☐ Abnormal

General Examination:

Consciousness: (+) Pallor: (-)
Icterus: (-) Edema: Mild (+)
Temp: Afebrile PR: 84/m.
BP: 120/70 mmHg DTR: (+)
CVS: S1S2 (+) RS BAE (+)
Liver/Spleen: NAD Urine Output: Adq.

LMP: 14/10/25 EDD: 21/7/26.
Corrected EDD: ~~28~~/7/26 GA: 39+3.

Menstrual History: Regular: ☑ Yes ☐ No

Obstetric Examination Obese Abd wall.

Fundal Height: Ut ≥ Term.

Ut. Activity: ☑ Relaxed ☐ Mild ☐ Mod ☐ Severe
Liquor: ☑ Adequate ☐ Oligo ☐ Poly
PP: ☑ Cephalic ☐ Breech Others _____
Head Fifths Palpable: _____
FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination Not done.

Draining: ☐ Present ☐ Absent ☐ Bleeding
Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination ~~Ext~~.

Cervix: ☑ Long ☐ Partially effaced ☐ Effaced
Os: Closed _____ Dilated _____
Membranes: ☐ Present ☐ Absent
Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained
Presenting Part: ☑ Vertex ☐ Breech ☐ Others
Sutton: ☑ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2
Pelvis: ☑ Adequate ☐ Doubtful

DIAGNOSIS

Primi @ 39+3 week / Hypothyroid / For IOL.

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 7 D (F)
Dr. SWAPNA SAMUDRALA

Family History:
Mother - HTN
Father - Hypothyroid

Surgical History:
Nil.

Medical History:
~~Nil~~
Hypothyroid

Medication History:
~~Tab Duphaston~~.
Tab Calcium } OD
Thyronorm 25mcg OD

Plan of Care:
- ~~Admission~~ CTG
- Informed Consent
- NST 4~~th~~ hourly
- FHR Monitoring 2nd hourly.
- Paste preparation.
- CBC to send
- T Misoprostol 25mcg PV. f/b oral 4th hourly
-

Investigations:
O +ve
HIV, HBsAg, HCV, VDRL } NR.

18/6
Hb - 10.5
PLT - 2.2 lakh.
CBPL (14/7/26) →
Hb - 10.3/9.23/224

9/4/26
USG Abd.
↓
Cholelithiasis
&
Choledocholithiasis
Mild splenomegaly

Scan (3/7/26)
SUIF
Cephalic
~~AFI~~ - 16.4 cm.
EFW: 3.18 kg (48%)
~~AC~~ (51%)
Pl- Ant high
Doppler - N.

Doctor Name: Dr. Dha
Signature:
Date & Time: 14/7/26 @ 10:30 pm

Dr. Swapna Samudrala
Consultant Obstetrics and Gynaecology
Reg. No: 69924

Consultant Name: Dr. Swapna.
Signature:
Date & Time: 14/7/26.

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 7 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
14/7/26 11:30pm	C/s/B Dr. Dng	
	Primi / 39+3 wk / Hypothyroid ↓IOL.	
	C/C fair	
	vitals - Normal	Adv
	P/A ut ≃ term, obsee Abnml	- Soft diet
	cephalic	- Adequate hydration.
NST - Reactive	FHS (+)	- NST 4th hourly
	Relaxed	- FHR 2nd hourly.
	head 4/5 palpable.	1st dose
		T Misoprostol 25mcg.
	P/V - Cx long MC MP	kept PV.
	os closed	
	pp - 3, B	
15/7/26 3:30 AM	C/s/B Dr. Dng	
	Primi / 39+3 wk / Hypothyroid ↓IOL	
	C/C fair	Adv
	vitals - Normal	- NST 4th hourly
	P/A ut ≃ term.	- FHR 2nd hourly
NST - Reactive	cephalic	- WFPUL.
	FHS (+).	- IV RL.
	head 4/5 palpable.	
	2c / 5-10 / 10.	

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

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 7 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7/26 6AM	C/S/B Dr. Durga	
	Primi / 39+3 wk / Hypothyroid / ↓ IOL	
	GC fair	Adv
	Afebrile	– Early breakfast f/b liquid diet
	Vitals – Normal	– Adequate hydration
	P/A Ut ^ Term	– NST 4th hourly
	Cephalic	– FHRM 2nd hourly
	FHS (+)	
	1-2 / 5-10 / 10	2nd dose.
		T Misoprostol 25mcg PO
	P/V – Cx long NC MP	
	Os – 1F M(+)	
	PP – 4/3 P/A	
15/7/26 10:45am	C/S/B Dr. Swapna	
	primi c 39wks 3days c Hypothyroidism & IOL	

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 7 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7/26 10:30 AM	Primi / 39+3 wks / Hypothyroidism / Ongoing IOL	
	low dose T. PGE, 25 mcg / PO @ 6:00 AM	
	c/o Backache	
	O/E - G/C fair	
ATG -	Bp/Pulse - stable	Adv
	Vitals - ©	- NBM
	P/A - UT mildly	- IVF - 2 © hr
	activity	- Drugs as charted
	Cephalic, FHR - good	- PAC
	V/E - Cx long, 1F	- FHR monitoring
	Soft, firm	- PR / BP / FHR monitoring
	PP - Vx - 3.	- W/f progress
	memb +	- Reassess @ 1:00 pm
	Patient & Attendant Counselled	
	Requesting LSCS @ 2:00 pm	
	Dr. Swapna Samudrala Consultant Obstetrics and Gynecology Reg. No: 69924	(Dr. Bhagya...)

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

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
15/7/2026 (11:40Am)		
	Patient & Attender had discussion c̄ Dr Swapna	
	Mam, Requested for Em LSCS At 2pm	
	Adv	
	- NBM.	
	- Drugs as drugs	
	- PAC	
	- check for Blood availability	
	- Inform Anaesthetist / Pediatrician	
	- Start shifting to OT ~~[illegible]~~	on call
		[signature]

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA 29 Y 0 M 8 D (F)
07-07-1997
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	POD - 0	
15/7/26		Adv
4:10 AM	N/O Comp	- NBM x 6 hrs
	O/E - G.C. fair	- IVF / Analgesic /
	Afebrile	Thromboprophylaxis - AXON
	O_2 Sat - 99% RA	- Drugs as charted
	PR - 82 b/m	- Monitor vitals ½ hrly
Baby well	B.P - 140/78 mmHg	- W/f excessive P/V
	P/A - UT well retracted	bleeding
U.O → 200ml	Sft.	- I/O chart
clear	L/E - MAB	- Oxygen Sos
		Dr. Swapna Samudrala Consultant Obstetrics and Gynecology Reg. No: 69924
		(Dr. Anusmoni)
15/7/2026	POD-0	
4:30am		Adv
	GC Fair Afebrile	- NBM x6h
	BP 135/60	- Drugs as charted
	PR - 86	- W/f vitals 4 hour
	P/A Ut well retracted	- I/O monitoring
	PV Bleeding WNL	- Foley's removal after 6Am C/M
	U/o 1200 ml Clear (Empty)	- TED Stockings
		- Inj Clexane 60 mg S/c @ 8Am C/M
(Baby maternal)		- Strict W/F BP
		- Inform SOS
		(signature)
		Dr. Manasha

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	c/s/by Dr-Naveena	
15/7/2026 8:15pm		POD0
	o/e G C-fair	Adv
	A/ebrile SpO_2-100/cnRA	- liquid diet
	PR: 84bpm	~~Soft~~ diet from
	BP: 122/76mmHg	T/M.
	CVS/RS: NAD	- Adequate hydration
	PA: ut retracted well	- drugs as charted
	Soft, NT	- w/f PV bleeding
	Dressing: dry & clean	- Urine IO charting
	ME: PV bleeding WNL	- Monitor Vitals
	UO: 70-80ml/hr & clear.	- Remove foley's T/M @ 12pm.
		- TED STOCKINGS
	Baby: MS.	- Inform SCS
	Kindly shift the patient to room	Dr Naveena

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA 28 Y 0 M 8 D (F)
07-07-1997
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7/2026 8:00am	c/s/by	Dr. Naveena
		POD1
	O/E GC - fair	Adv
	Afebrile SpO2-99% on RA	- Soft diet
	Vitals - stable	- Adequate hydration
	PA: ut retracted well	- w/f PV bleeding
F - X	Soft, NT	- drugs as charted
	Dressing: dry & clean	- foley's removal
	LLE: PV bleeding WNL	@ 9am as per
	U/O: adequate	patient request
		- Monitor Vitals
	Baby: Mother side.	- Ambulation
		- Inform SOS
		Dr. Naveena
		N/B Supriya
		@ 8P
	POD - 2	
16/7/26 11:30 AM	No comp	
	O/E - G/C fair	Adv
	Afebrile	- Soft Diet
Baby well	Vitals - (N)	- Oral hydration
	P/A - ut well retracted	- Ambulation
	soft	- Drugs as charted
Urine ✓	LLE - MAB.	- monitor vitals
Flatus ✓		- Inform SOS
Stools ×		

Dr. Swapna Samudrala
Consultant Obstetrics and Gynecology
Reg. No: 69924

(Swapna) N.D. maheshwari 16/7/26

Docu. No. : RCH /FRM / CLINICAL / 088 (P.T.O)

HNH-00009508
Mrs DEEPTI DAGA IP26-00006843
07-07-1997 29 Y 0 M 8 D
Dr. SWAPNA SAMUDRALA (F)

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...GRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
16/7 7pm	C/I/B Dr Mandala	
	POD - 1	Adv
	No fresh complaints	1. Soft diet
	o/e pt c/c/c	2. Adequate hydration
	afebrile	3. Drugs as charted
U ✓	PR 90bpm	4. TED stocking
F ✓	BP - 109/62 mmHg	5. Monitor Vitals
S ✗	CVS/RS - NAD	6. Ambulation
	P/A - ut. retracted well	7. Enzoform SOS.
Baby - motherside	L/E - NAD	8. T. Dulcolax Suppository 1 tab
	B/L Breast - soft	P/R @ 10pm
		Noted by Madhuri 16/7/26
17/7/2026 8:30am		
	C/s/by Dr. Naveena	
	O/E GC - fair	Adv
	Afebrile SpO2-99% on RA	Regular diet
V ✓	Vitals - stable	Adequate hydration
F ✓	PA: ut. retracted well.	drugs as charted
S ✓	Soft, NT	TED STOCKINGS
	Dressing: dry & clean	w/f PV bleeding
	L/E: PV bleeding WNL	Ambulation
		Monitor Vitals
	Baby: Motherside	Inform SOS
		STERIZONE DRESSING
	Dr. Naveena	TODAY
		N.B. maheshwari @1 17/7/26

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

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
17/7/26	POD - II	
12:20 pm		Adv
	No comp	
	O/E - Conscious	- Regular Diet
Baby - well	Afebrile	- Oral hydration
	Vitals - (N)	- Drugs as charted
Bowels ✓	P/A - UT well contracted	- Monitor vitals
	Soft, wound (H)	- Ambulation
	Dressing done ✓	- Surgeon SOS
	S/E [wound care ✓	
Can be discharged		(Dr. Swapna S)
		Dr. Swapna Samudrala Consultant Obstetrics and Gynecology Reg No: 69924

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

1NH-00009508 IP26-00006843
Mrs DEEPTI DAGA
17-07-1997 29 Y 0 M 9 D (F)
Dr. SWAPNA SAMUDRALA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 7 D (F)
Dr. SWAPNA SAMUDRALA

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RESULT SHEET

Date	14/7/26					
Time						
Hb	10.3					
PCV	30.3					
RBC	3.86					
WBC	9.23					
N/L						
Platelets	2.27					
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						

(P.T.O)

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
blood group	O+ve		Availability in surya blood bank			
HIV }						
HCV } NR						
VDRL }						

Culture and Sensitivities : .....

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.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00009508
Mrs DEEPTI DAGA IP26-00006843
07-07-1997 29 Y 0 M 7 D (F)
Dr. SWAPNA SAMUDRALA

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ATION RECONCILIATION FORM

Drug Allergies: ..... ☑ Not known any Drug Allergies

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	Thyronorm.	25mcg	PO	OD		☐ C ☐ DC
2	CALCIUM.	1tab	PO.	OD		☐ C ☐ DC
3	Syrup Cheeri	2tbsp	PO	OD.		☐ 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. Dna

Date & Time : 14/7/26. @ 11:10Pm

Nurse Name & Signature: Madhumita @ Madhu

Date & Time : 14/7/26 @ 11:20Pm

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

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 10 D (F)
Dr. SWAPNA SAMUDRALA

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Your Right to a Safe Delivery

ATION FORM

Doctor Name : Dr. Swapna Date : 16/7/26 Time : 1pm

Diagnosis : LSCS

Hospital : RCH - HMNR

Referred for : ☐ Opinion ☑ Co-Management ☐ Transfer of care

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

Reason for Referral : If for concurrent care specify the particular need, especially in the absence of a second diagnosis:

Signature:

Findings and Recommendations :

Lactation care plan

- Well formed Breast & Nipples
- primi
- Colostrum seen
- Aim for deep latch as demonstrated in cross cradle / cradle hold
- Demand feeding not exceeds 2½ hours as per early hunger cues.
- warm care
- Advice DBM & f/b Burping.

Consultant :

Name : Sathwika. G Signature : Date & Time : 16/7/26 1pm

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

301

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 16/7/26 Time: 9:10 am

Origin: Indian Height: 5'5' Weight: 107 kg BMI: ☐ ~26 kg/m² ☐ ~28 kg/m² ☐ ~30 kg/m²

Food Allergies: NO

Diagnosis: LSCS

Type of Diet: ☐ Liquid ☑ Soft ☐ Normal ☐ Diabetic
☑ Vegetarian ☐ Non-Vegetarian ☐ Vegan

Diet Advised:

Liquid Diet – ORS/ Coconut Water / Butter Milk / Barley Water / Soups

Normal Diet – Rice, Rotis, Dal and Soft Cooked Vegetables and Curd

Soft Diet – Soft Rice, Dal and Vegetable Curries Soft Cooked, Curd

Diabetic Diet – Brown Rice / Oats/ Dahlia/ Rotis, Dal and Vegetables and Curd (Avoid Roots / Tubers)

Patient's / Attendant's
Signature:
Name: Deepti Daga
Date & Time: 16/7/26 ; 9:10 am

Dietician's
Signature: Sobiya
Name: Syeda Sobiya Zahoor
Date & Time: 16/7/26 ; 9:10 am

DIETARY NOTES

Date	Time	Notes	Sign
17/7/26	12:35pm	can start with Normal Diet	[signature]
		as advised.	

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DRUG CHART

Date of Admission: 14/7/26. Drug Allergies: Nil ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / 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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REGULAR PRESCRIPTIONS

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

DRUG : PARACETAMOL

Dose	Route	Frequency	Start Date	Date/Time	15/7	16/7
1gm	IV	TID	15/7	6AM	X	[signature]
				2pm	X	[signature]
				10pm	[signature]	

Name & Signature of the Doctor Starting the Drugs: Dr. MANIR [signature]

Additional Instructions:

After Afternoon dose (2pm) stop IV Paracetamol — stop [signature]

Daily Doctor's Endorsement by a Sign

DRUG : INJ CEFOTAXIME

Dose	Route	Frequency	Start Date	Date/Time	15/7	16/7
1g	IV	BD	15/7	11AM	✓	[signature]
				11pm	[signature]	

Name & Signature of the Doctor Starting the Drugs: [signature]

Additional Instructions: (Axetil) X24W FB oral

STOP — Dr (Dr. Swapna)

Daily Doctor's Endorsement by a Sign

DRUG : DICLOFENAC

Dose	Route	Frequency	Start Date	Date/Time	15/7	16/7	17/7
50mg	P/O	TID	15/7	7AM	X	[signature]	[signature]
				3pm	✓	[signature]	
				11pm	[signature]	[signature]	

Name & Signature of the Doctor Starting the Drugs: Dr. MANIR [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : TRAMADOL

Dose	Route	Frequency	Start Date	Date/Time	15/7	16/7	17/7
100mg	P/O	TID	15/7	12AM	X	X	[signature]
				8AM	X	[signature]	[signature]
				4pm	✓	[signature]	

Name & Signature of the Doctor Starting the Drugs: Dr. MANIR [signature]

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG : PANTAPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	P/O	OD	15/7

Date: 15/7, 16/7, 17/7/26
Time: 6AM

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: BEFORE BREAKFAST

Daily Doctor's Endorsement by a Sign

DRUG : ENOXAPARIN

Dose	Route	Frequency	Start Dt.
60U	S/C	OD	16/7

Date: 16/7, 17/7
Time: 8AM

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: for 1 week.

Daily Doctor's Endorsement by a Sign

DRUG : INJ METRONIDAZOLE

Dose	Route	Frequency	Start Dt.
500mg	IV	TID	15/7

Date: 15/7, 16/7
Time: 7AM, 3pm, 11pm

STOP — Dr. Naveena

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: [1st dose — 8:30pm] x 24hr → Stop (Only 3 doses to give) — ↑

Daily Doctor's Endorsement by a Sign

DRUG : T. CEFIXIME

Dose	Route	Frequency	Start Dt.
200mg	PO	BD	16/7/26

Date: 16/7, 17/7
Time: 10AM, 10pm

Name & Signature of the Doctor Starting the Drugs: (Dr. Swapna)

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

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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. .....

DRUG :	Date➤ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		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
14/7/26	11:30pm	MISOPROSTOL	25mcg	PV		Madhu (W)
15/7/26	6 AM	MISOPROSTOL	25mcg	PO		Madhu (W)
15/7/26	10:30AM	MISOPROSTOL	25mcg	PO		Akhils Chandrakala.
15/7	1:40pm	INJ METOCLOPRAMIDE	10mg	IV		Akhils Chandra
15/7	1:40pm	INJ. PANTOPRAZOLE	40mg	IV		Akhils Chandra.
15/7	1:50pm	INJ CEFOTAXIME	1g (AST)	IV		Akhils Chandra.
15/7	330pm	DICLOFENAC	100mg	PR		
15/7	330 pm	TRAMADOL	100mg	PR		
15/7	3.31pm	Metroglyl	100ml	IV		

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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
15/7	2 AM	RINGER LACTATE	IV	100ml/hr					
15/7	9:30 AM	RINGER LACTATE	IV	100 ml/L			15/7		
15/7	3pm	RINGER LACTATE + 6U OXYTOCIN	IV	200			15/7		
15/7	4PM	RINGER LACTATE	IV	FF			15/7		
15/7	4:30 PM	RINGER LACTATE	IV	FF			15/7		
15/7	5PM	RINGER LACTATE	IV	100ml/hr			15/7		
15/7	10PM	RINGER LACTATE	IV	100ml/hr			15/7		
16/7	3AM	RINGER LACTATE	IV	100ml/hr			16/7		
		Stop Dr. Dna							

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29 Y 0 M 10 D
(F)

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STAT / ONCE ONLY DRUGS

Weight: ..... kgs

Name: .....

Sheet No: .....

DATE	TIME	MEDICATION	DOSAGE & OTHER INSTRUCTIONS	ROUTE	SIGNATURE		
					Doctor	Nurse-1	Nurse-2
16/7/26	10pm	DULCOLAX	1tab	PR			

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30/

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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

14/7

		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																	19			20			20		20
	0 - 10																									
Saturations	94 - 100 %																	99%			99%			99%		99%
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36																	36.6			—			—		—
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																	82			89			90		90
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																	116			118			122		109
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40																	71			72			61		67
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																										
TOTAL ORANGE SCORES																										
Nurse Initial																		PK			PK			PK		PK

14/7/26

11pm = 148 bmt

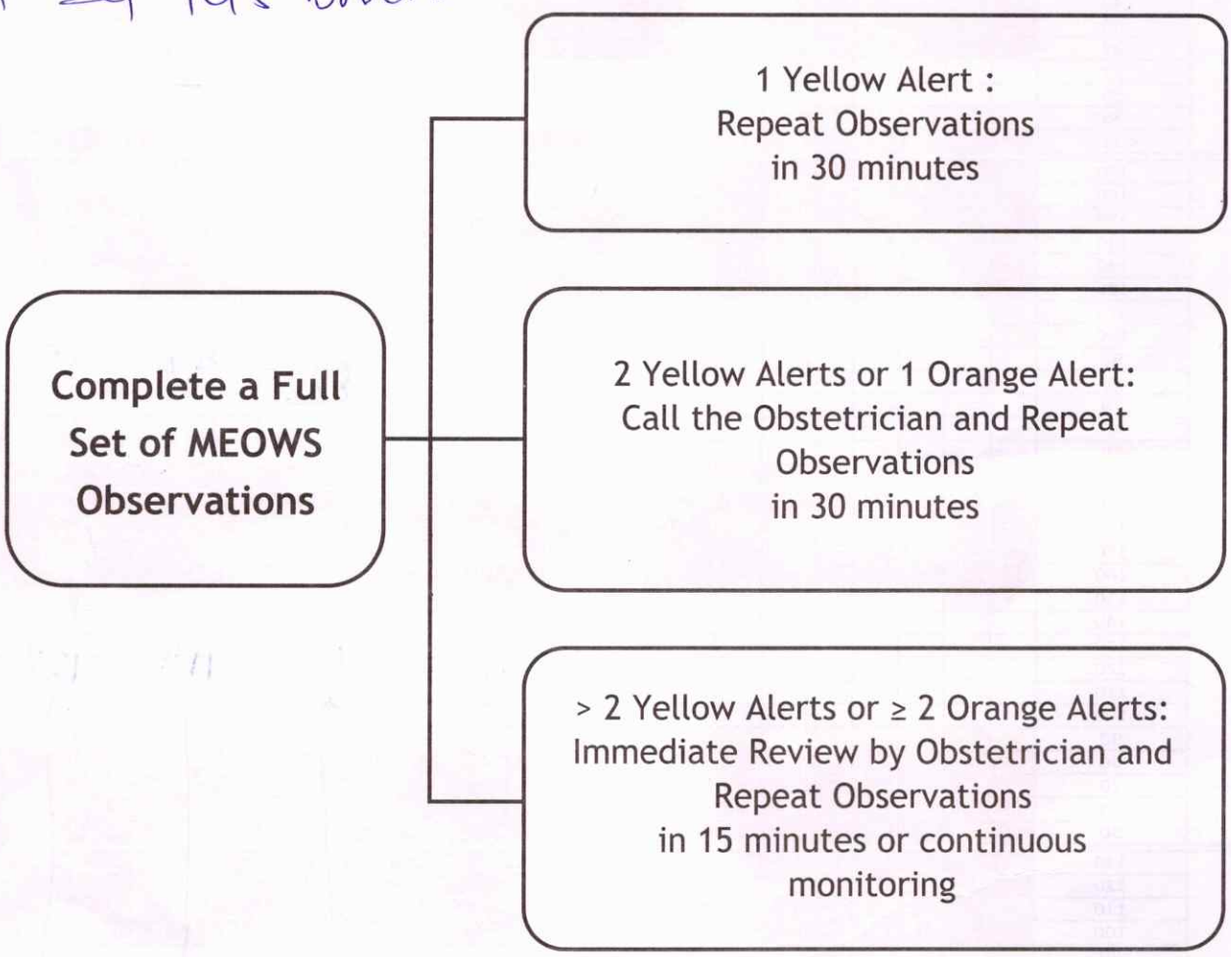
15/7/26.

12Am = NET (140 bmt)

2Am = 138 bmt

4Am = 145 bmt.

Obstetrics and Gynaecology Early Warning Signs



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

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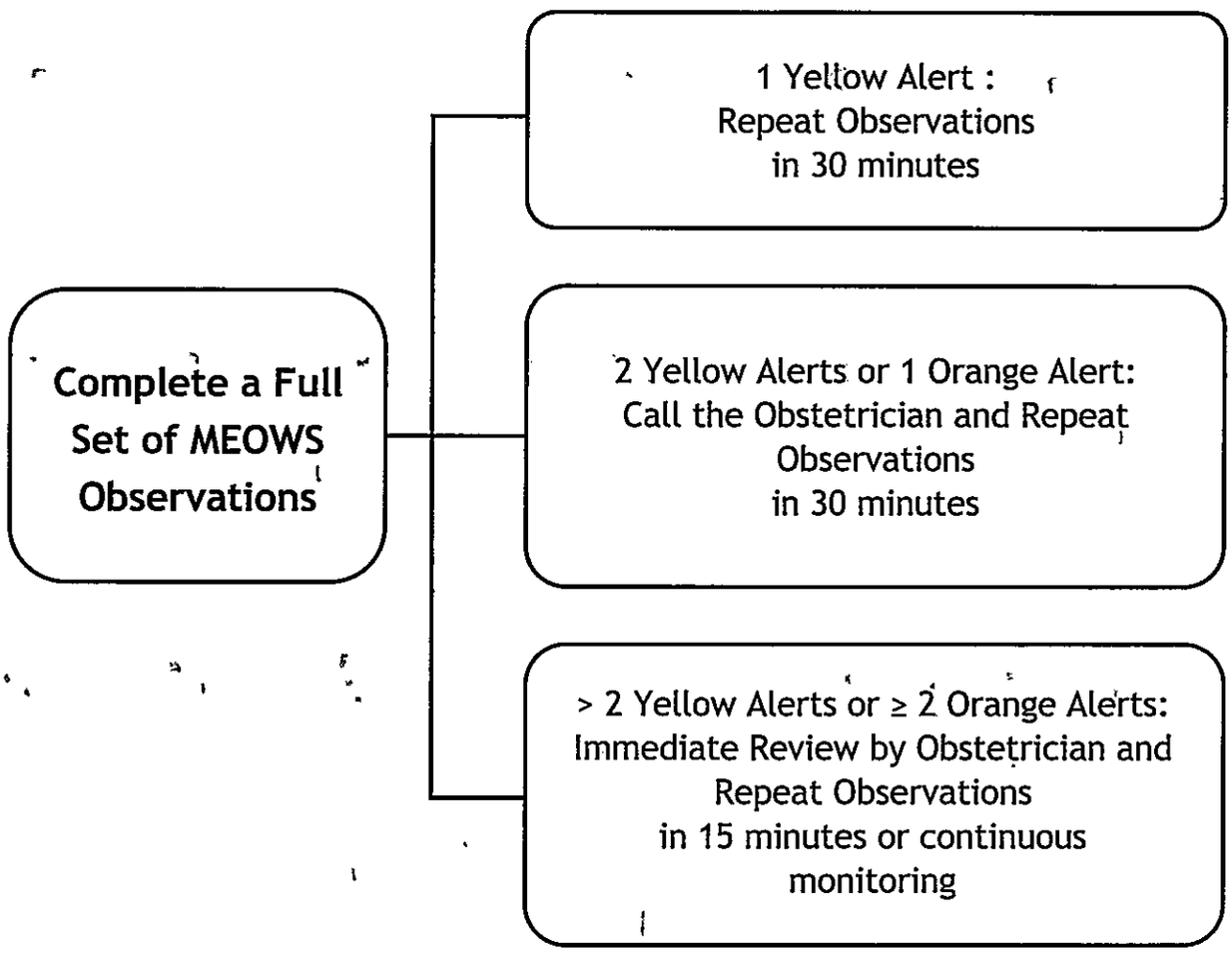
CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

15/7	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	20		20		20	20	20		20	20	20	20	20		20				20				20	
	0 - 10																								
Saturations	94 - 100 %	97%		98%		98%		99%		99%	99%	99%	99	99%		99%				99%				99%	
	< 94 %																								
Administered 0_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36	97.7°F		97.7°F		97.2°F		98°F		97.8°F		98.6°F		97.8°F		98.2°F				98.2°F				98.2°F	
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80	87		82		87				80	85		80	75		82				86				87	
	70																								
	60																								
	50																								
	40																								
↑ Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120					120								123		119				115					
	110	115		119						110	112		110												
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
↓ Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70	70		72		75				65	67		67	67		75				78					
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert	✓		✓		✓				✓	✓		✓	✓		✓				✓				✓	
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30									✓	✓		✓	✓											
	< 30																✓				✓			✓	
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal									✓	✓		✓	✓			✓						✓		
	Heavy / Foul																								
Liquor	Clear / Pink									✓	✓		✓	✓											
	Green																								
TOTAL YELLOW SCORES		0		0		0				0	0		0	0		0				0				0	
TOTAL ORANGE SCORES		0		0		0				0	0		0	0											
Nurse Initial		[illegible]		[illegible]		[illegible]				[illegible]	[illegible]		[illegible]	[illegible]		[illegible]				[illegible]				[illegible]	

Obstetrics and Gynaecology Early Warning Signs



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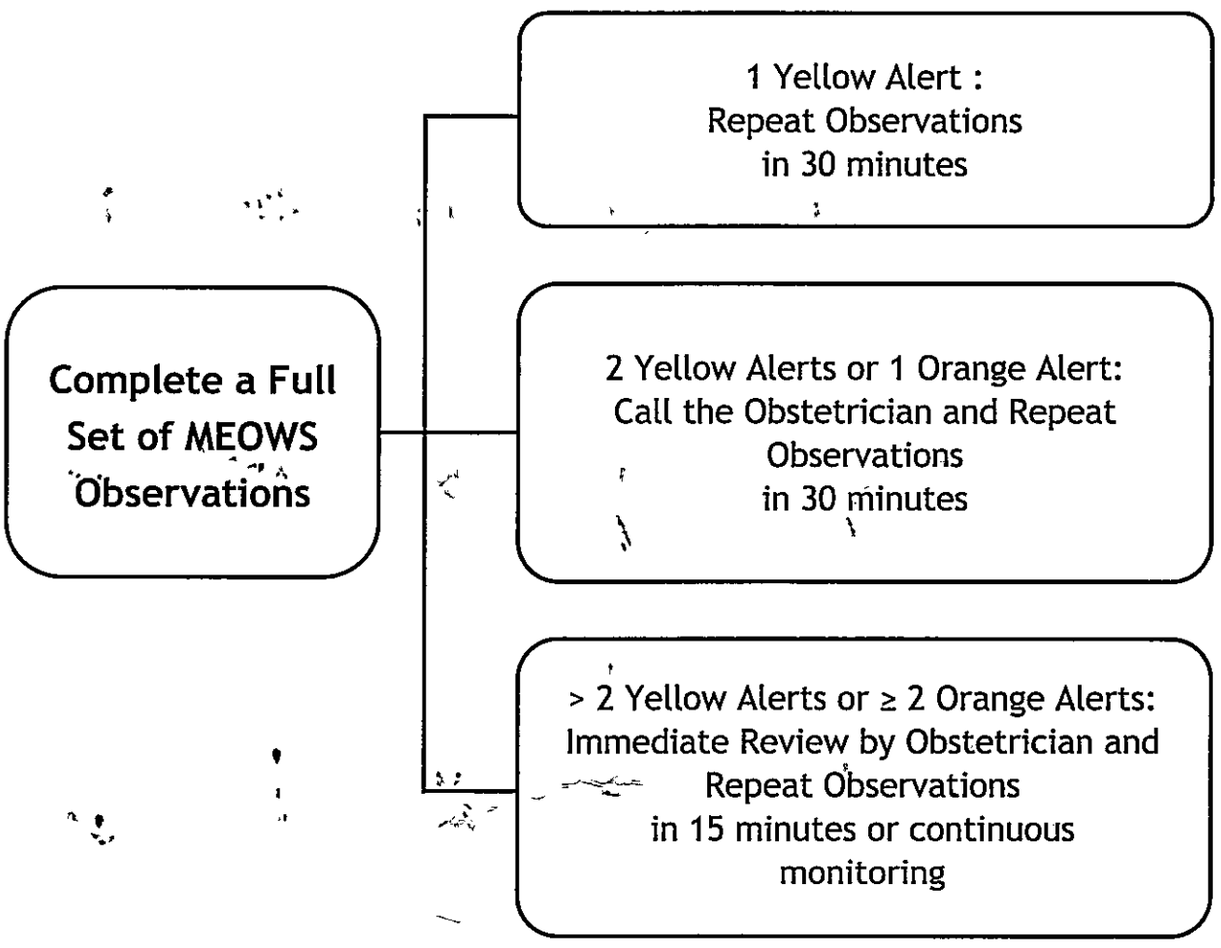
Early Warning Observation Score Chart - Obstetrics

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

16/4

		Date																						
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20			20				20					20				20				20				20	
	0 - 10																									
Saturations	94 - 100 %			99%				99%					99%				99%				99%				99%	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37			98.5°F				98.2°F					98.2°F				97.2°F				98.4°F				97.2°F	
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80			810bm				850/100					810bm				70bm				82				76	
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120			112					120				118				126				112				113	
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70			70					70				68				76				76				76	
	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				1				2				0				0	
TOTAL ORANGE SCORES				0					0				0				0				0				0	
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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FLUID CHART

Sheet No. : 1

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :								**Total Output :**				
	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											
14/7	11:00 pm		H2O									
	12:00 am											
	01:00 am		H2O									
Total Intake :		Taken						**Total Output :**		Passed		
	02:00 am	RL		100ml								
	03:00 am	RL + H2O		100ml								
	04:00 am	RL		100ml								
15/7	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :		Taken						**Total Output :**		Passed		

Total 24 hrs. Intake		Total 24 hrs. Output	

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
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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							
15/7	08:00 am	RL	N	100ml							1	
	09:00 am	RL	N	100ml							0	
	10:00 am	RL	B	100ml								
	11:00 am	RL	M	100ml			NA					
	12:00 pm	RL	B	100ml								
	01:00 pm	RL	M	100ml								
Total Intake :		600ml				**Total Output :**				Passed		
15/7	02:00 pm	RL	N	100ml							1	
	03:00 pm	RL	N	100ml								
	04:00 pm	RL	B	100ml						120ml	0	Empty
	05:00 pm	RL	M	100ml								
	06:00 pm	RL		100ml							1	
	07:00 pm	RL		100ml						300ml		Empty
Total Intake :		taken				**Total Output :**						
15/7	08:00 pm	RL		100ml							1	
	09:00 pm	RL		100ml						100ml		Empty
	10:00 pm	RL		100ml								
	11:00 pm	RL		100ml								
	12:00 am	RL		100ml								
	01:00 am	RL		100ml								
Total Intake :						**Total Output :**						
16/7	02:00 am			100ml							1	
	03:00 am			100ml								
	04:00 am			100ml						900ml	0	Empty
	05:00 am	RL		100ml								
	06:00 am			100ml							1	
	07:00 am			100ml						800ml		Empty
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
16/7	08:00 am											
	09:00 am											
	10:00 am		Dalyt H2O								0	
	11:00 am	0			NA			NA				
	12:00 pm											
	01:00 pm											
Total Intake : Taken								**Total Output :** U —			M	
16/7/22	02:00 pm											
	03:00 pm		icdy									
	04:00 pm	0	H2O				0				0	
	05:00 pm				NA			NA				
	06:00 pm											
	07:00 pm											
Total Intake :								**Total Output :** U —			M —	
16/7/22	08:00 pm											
	09:00 pm		Dpms H2O							—		
	10:00 pm				NA			NA			0	
	11:00 pm	0										
	12:00 am											
	01:00 am											
Total Intake : — Iqka								**Total Output :**		U —	M —	
17/7/22	02:00 am											
	03:00 am											
	04:00 am	0			NA			NA			0	
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :								**Total Output :**		U —	M —	

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
17/7/26	08:00 am											
	09:00 am											
	10:00 am		Idly									
	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-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
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NURSING CARE RECORD

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Date: 14/7/26

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							
Afternoon							
Night	8Pm ↓ 8Pm	→ Assess the pt condition → plan for vitals → plan for I/o chart → plan for IV placement	8Pm ↓ 8Pm	→ Assess the pt condition → vital are checked & recorded → IV placemt done → I/o chart maintained	I/o chart maintained	patient is stable	Sujatha

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NURSING CARE RECORD

Date: 15/1/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am – 2pm	→ Assess the pt condition → monitor the vitals & record → Administration of medication → NST 3rd hrly & burping → maintain I/O chart & record	8Am – 2Pm	→ Assessed the pt condition → monitored the vitals & recorded → Administered medication as per doctor order → NST ongoing → maintain I/O chart & recorded	pt is stable	maintain I/O chart & record	Akula
Afternoon	2Pm To 8AM	→ Assess the pt condition → plan for vitals → plan for I/o chart → plan for medication	2Pm To 8AM	→ Assessed the pt condition → vital are checked & recorded → all medication given as per doctor order	I/o chart maintained	Patient is stable	Sujatha
Night	8pm to 8Am	→ Assess the pt condition → Monitor vitals → maintain I/o chart	8pm to 8Am	→ Assessed the condition → monitored vitals → maintained	Now pt is stable	Re-check vitals	[illegible]

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NURSING CARE RECORD

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Date: 15/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8PM to 2PM	→ Assess the pt condition → monitor vital & record → maintain I&O chart → Administer medication as per drug chart		→ Assessed the pt condition → monitored vital & recorded → Maintained I&O chart → Administered medication as per drug chart	→ Pt is Hdr	- Rechecked vital	
Afternoon	2PM to 8PM	- Assess the pt Condition - monitor the v/s - Maintain the I/O - Drug as per chart	2PM to 8PM	- Assess the pt Condition - monitor the v/s - maintain the I/O - Drug as per chart	- Pt is stable	- Rechecked the v/s	
Night	8PM to 8AM	→ Assess the Pt condition → Monitor vitals → maintain I&O chart → Pt on soft diet → Administer medication as per drug chart	8PM to 8AM	→ Assessed the Pt condition → monitored vitals & recorded → maintained I&O chart → pt on soft diet → Drug as per chart	→ Pt is stable	→ Rechecked vitals	

Patient St

MNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 9 D (F)
Dr. SWAPNA SAMUDRALA

NURSING CARE RECORD

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Date: 17/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am 2pm	→Assess the pt condition. →monitor the vitals. →maintain I/o chart. →drugs give as per drug chart.	8Am 2pm.	→Assessed the pt condition. →monitored the vitals. →maintained I/o chart. →drugs given as per drug chart.	→pt is stable Now.	→Re assessed the vital.	
Afternoon							
Night							

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2 (15/7)			DAY-3 (16/7)			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			✓	0	0	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	—	NA	NA	0	NA	NA	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	—	NA	NA	0	NA	NA	
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3			NA	—	NA	NA	0	NA	NA	
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4			NA	—	NA	NA	0	NA	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	—	NA	NA	0	NA	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

Signature of Ward In Charge :

Signature : ..... Name : Kasthuri

Patient

RNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 9 D (F)
Dr. SWAPNA SAMUDRALA

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	17/2 DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0									
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	0									
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	0									
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	0									
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	0									
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	0									
			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-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

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BRADEN 'Q' SCALE

					Date : 14/7	15/7	15/7	16/7
					Time : 8Am	8Am	2PM	8Am
Mobility	**mobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
				TOTAL SCORE	28	28	28	28
				Evaluator's Name	[illegible]	[illegible]	[illegible]	[illegible]

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

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA (F)
07-07-1997 29 Y 0 M 8 D
Dr. SWAPNA SAMUDRALA

BRADEN 'Q' SCALE

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					Date : 15/7/26	16/7	16/7	16/7/26
					Time : N1	N6	E2	N1
	...y immobile: ...oes not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	3	3	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	3	3	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	3	3	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	3	3	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	3	3	4	4
				TOTAL SCORE	20	[illegible]	28	28
				Evaluator's Name	[illegible]	[illegible]	[illegible]	[illegible]

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

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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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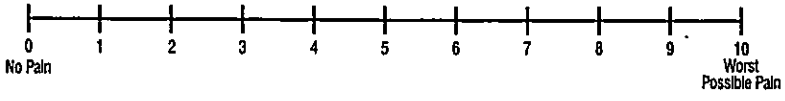
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
14/7	11Pm	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7	2Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7	4Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7	8Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7	11Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7	2PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7		0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
15/7	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/7	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
16/7	10Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

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PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
16/7/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
16/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
17/7/26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:
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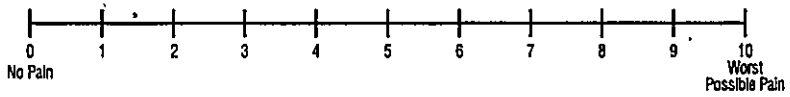

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	14/7	15/7/26	15/7
		Score	8pm	4pm	2pm
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0		
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15	15
	No	0	0	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	20	20
	No	0	0		
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	
Mental Status	Forgets limitations	15			
	Oriented to own ability	0	0		
Total Morse Fall Scale Score:			35	35	35
		Signature	Sri	0	Sri

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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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	11/2	12/4	16/7
		Score	N1	N6	E2
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:			20	20	20
		Signature			

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

Tick (✓) whichever precaution taken.

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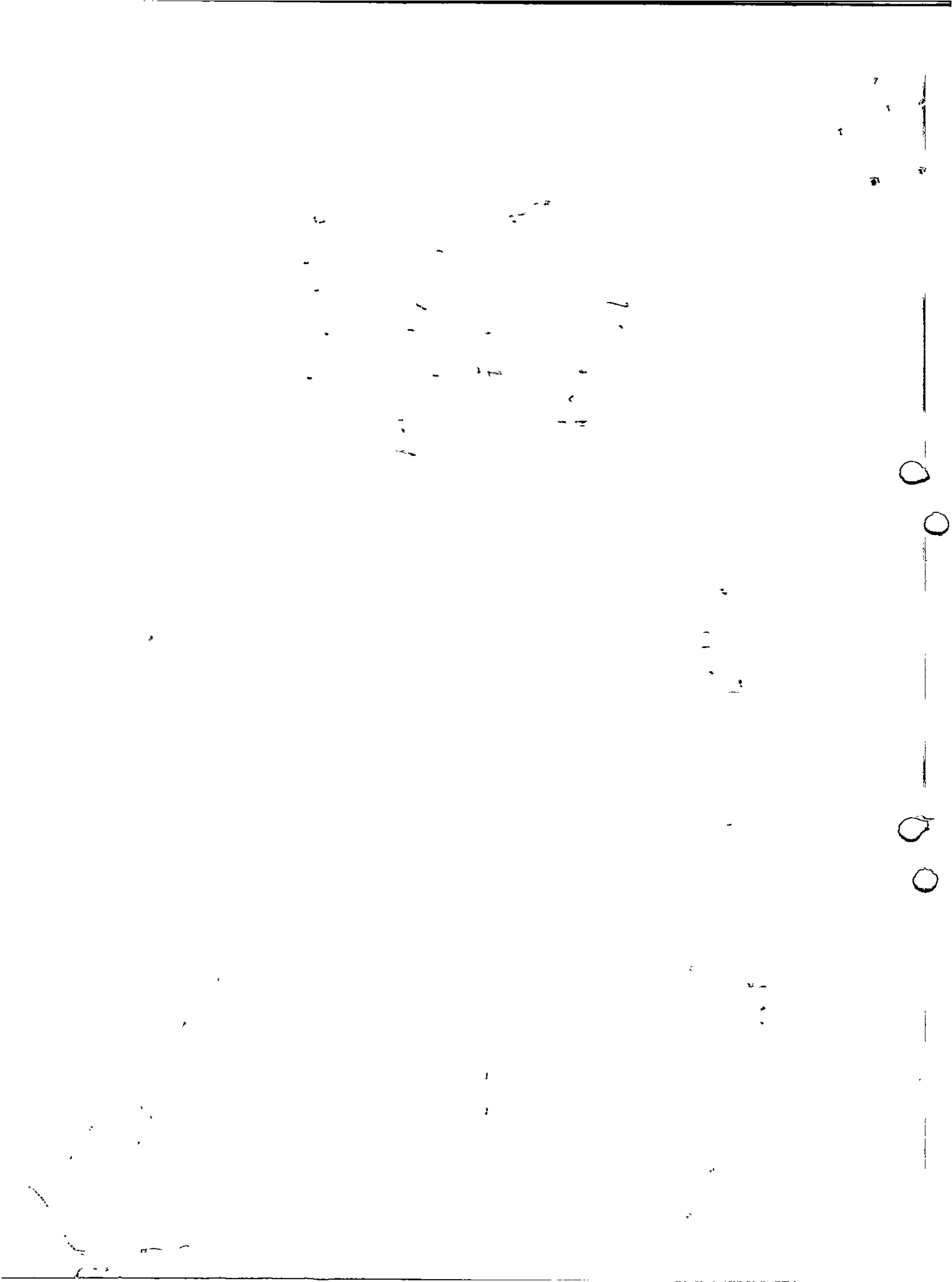
URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 15/7/26 Date of Removal: .....

Parameters	Date / Shift Time	15/7/26 M6	15/7 2PM	15/7 2AM				
Need for the Catheter		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever		☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion		☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse		Akeiy	Sujatha	Mani				
Signature of the Nurse								

Foley's Removed 16/7/26 12.30 pm

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



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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: .... Department: .... Date of Admission: 14/7/26

SITUATION	Diagnosis:	Any Infection: ☐ Yes ☑ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time	14/7 8Am	15/7/26	15/7/26 2PM	15/7	16/7	16/7
	Medical Condition (Any special condition to be noted):	NA	NA	NA	NA	NA	NA
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No
	Vital Signs: Temp:	97F	97.8F	98F	98.4	98.8	98.3F
	Res:	20	20b/mt	20b/m	20bm	20b	20b/m
	SpO₂:	99%	98%	99%	98%	98%	99%
	Pulse:	87	97b/m	87	82	87b	82b/m
	BP:	110/75	110/75	115/75	110/70	110/70	110/72
	Fall Risk Score:	–	–	–	–	–	–
	Pain Score:	–	–	–	–	–	–
Recommendations	Safety Needs:	NA	yes	NA	NA	–	yes
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No
	Others Specify:	NA	–	NA	NA	–	–
	Special Diet:	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☑ No
	Other Special Orders / Medications:	NA	NA	NA	NA	–	–
Post Operative Procedure Special Orders:		NA	NA	NA	NA	–	–
Handed Over By Name :		Srijatha	Akhila	Srijatha	Mou	Swathi	Sunanda
Signature :		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Date:		14/7	15/7/26	15/7/26	16/7/2	16/7	16/7
Time:		8Am	2Pm	8Pm	8Am	2PM	8pm
Taken Over By Name :		Akhila	Srijatha	Mou	Swathi	Sunanda	Divya
Signature :		[signature]	[signature]	[signature]	[signature]	[signature]	[signature]
Date:		15/7/26	15/7/26	15/7	16/7	16/7	16/7/26
Time:		8Am	2Pm	8Pm	8AM	2PM	8PM

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

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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	17/7/26 N	17/7 MC				
	Medical Condition (Any special condition to be noted):	NA	NA				
ASSESSMENT	Allergy:	☐ Yes ☐ ~~No~~	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	97.4°F	98.1°F				
	Res:	20/m	20/m				
	SpO_2:	99%	100%				
	Pulse:	82/m	81/m				
	BP:	116/72	110/71				
	Fall Risk Score:	—	—				
	Pain Score:	—	—				
Recommendations	Safety Needs:	—	Yes				
	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 :		Divya	Mahi				
Signature :							
Date:		17/7/26	17/7/26				
Time:		8Am	2pm.				
Taken Over By Name :		Mahi					
Signature :							
Date:		17/7/26					
Time:		8Am					

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00009508 IP26-00006843 Mrs DEEPTI DAGA 07-07-1997 29 Y 0 M 8 D (F) Dr. SWAPNA SAMUDRALA	15/7/26	15/7/26 9pm
	Transfer Ordered by Dr. Naveena.	Reason for Transfer obs
From Unit	To Unit	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 35	Number of Imaging Films NIT - 5	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.		
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
SRs Mounika.	Dr. Naveena.

Patient & Clinical Records Received by : 9pm 15/7/26 @ 9:30p

Date & Time of Patient Received :

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

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

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: Dr Swapna Samudrala	Date of Delivery: 15/7/20
Assistant Surgeon: Dr Monisha	Time of Delivery: 2:31 pm
Anaesthetist's Name: Dr Samir	Gender of Baby: Male
Type of Anaesthesia: Spinal	Weight of Baby: 3.320kg
Neonatologist: Dr Nayanya	AGPAR Score: 8, 9
Scrub Nurse: Sandhya / Natasha	NICU Admission: ☐ Yes ☑ No

Pre-Operative Diagnosis: Primi / 39+4 weeks / Hypothyroidism

☐ Elective ☑ Emergency Indication: NPOL

Urgency

- ☐ Immediate Threat to life of woman or fetus
- ☐ Maternal or fetal compromise not immediately life threatening
- ☑ No maternal or fetal compromise but needs early delivery
- ☐ Delivery timed to suit woman and staff

Decision time: NA Knief to rectus: 2min

CTG Description: Reactive & Occasional dips

If there was a delay give the reasons:

Surgical Procedure: Emergency LSCS

Post Operative Diagnosis: POD-0

Peri-Operative Complications: —

Amount of Blood Loss: ~ 300 cc	Blood Transfused (in ML): —

Name and Number of Surgical Specimen sent for examination:

—

Examination Findings when Appropriate:

Presentation: ☑ Cephalic ☐ Breech ☐ Other ....

Cervical Dilatation: ....Open.................. cm

5th Palpable: ....

Fetal Position: ....

Station: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Moulding: ☐ None ☐ + ☐ ++ ☐ +++

Caput: ☐ + ☐ ++ ☐ +++

Meconium: ☐ None ☐ + ☐ ++ ☐ +++

Bladder Catheterized : ☐ Yes ☐ No

Urine: ☐ Clear ☐ Blood Stained

Skin Incision: ☑ Pfannensteil ☐ Transverse ☐ Midline ☐ Other ....

Uterine Incision: ☑ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision

Previous Scar: ☐ Intact ☐ Thinnedout ☐ Ruptured ☑ No Scar

Incision Through Placenta: ☐ Yes ☑ No — LUS well formed

Delivery of head: ☑ Manual ☐ Forceps — one loop of cord around neck

Liquor: ☑ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not Offensive

Delivery of Placenta: ☐ Manual ☐ CCT .... ☑ Complete ☐ Incomplete ☐ Piecemeal

Cord Appearance: ....Normal.......................... Cord around the neck ☑ Yes ☐ No / 1 loop

Appearance of placenta: ....Normal.......................... Cavity explored ☐ Yes ☐ No

Uterus, tubes and ovaries: ☑ Normal ☐ Not Normal Sterilization: ☐ Yes ☑ No

---

Uterine Closure: ☐ One Layer ☑ Two Layers ....Vicryl no-01.......... Suture

Peritoneal Closure: ☐ Pelvic ☑ Abdominal ☐ None ....~~vicryl no~~ Catgut no 1-0.......... Suture

Sheath Closure: ....Vicryl no.1.......... Suture

Fat Closure: ☑ Yes ☐ No ....Catgut no 1-0.......... Suture

Skin Closure: ☑ Subcuticular ☐ Mattress ....monocryl 3-0.......... Suture

Vagineal Evacuated ☑ Yes ☐ No

Drain: ☐ Yes ☑ No ☐ Remove in .... days ☐ Await instructions

Ctheter ☑ Yes ☐ No ☐ Remove in ....1......... days ☐ Await instructions

Swap & Instruments count correct? ☑ Yes ☐ No ☐ Post-op Antibiotics ☑ Yes ☐ No

Intra-Operative Antibiotics Cover: ☑ Yes ☐ No ☐ Thromboprophylaxis ☑ Yes ☐ No

Post-Operative Notes: ....

NBM x 4-6 h

Drips as chart

c/f q 8hrly

Inj Tazim + Metro (Inj Metro 3 dose only)

TED Stocking / Inj Clexane as per Arow

Foley's in situ till further order

Inform SOS

....

Doctor Name: ..Dr. Swapna Somwatkale.......... Doctor Signature: ....[signature]..........

Date & Time: ..15/7/2016 @ 4:pm..........

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swapna
Asst. Surgeon : Dr. manisha
Anaesthetist : Dr. Samir
Scrub Nurse : Sr. Natasha, Sr. sandhya

Patient Na
UHID No.

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

Date : 15/7/26

29 Gender : F
EM-LSCS
ut-time :

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 2pm

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. Swapna

Name :

Before Skin Incision ➤➤

TIME OUT Time: 2:26pm

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, 1hr Anticipated Blood Loss? 500ml Nothing. ☑ Yes ☐ No ☐ NA

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

Nursing Team Reviews: High BMI

- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☑ Yes ☐ No ☐ NA
- Power Supply, Earthing, Power Backup and functioning of equipment checked. ☑ Yes ☐ No

Signature : Puja @2:26pm

Name :

Before Patient Leaves Operating Room

SIGN OUT Time:

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 : Dr Swapna

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00009508 IP26-00006843 Mrs DEEPTI DAGA 07-07-1997 29 Y 0 M 8 D (F) Dr. SWAPNA SAMUDRALA	14/26 @	15/7/26 @ 4PM
	Transfer Ordered by Dr. samir	Reason for Transfer Observation
From Unit OT	To Unit prepost	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File -	Number of Imaging Films 1	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.	fk	(1)
2.		
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
SIS. Puja	DR. manisha

Patient & Clinical Records Received by : Sujatha Sj

Date & Time of Patient Received : 15/7/26 @ 4PM

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-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 14/7

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: .....

..... TOL .....

.....

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 ..... 1 ..... 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: 97 HR: 87 RR: 20

BP: 115/75 Weight: ..... Height: ..... BMI: .....

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

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

PHYSICAL ASSESSMENT

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

Fall Assessment: ☐ Yes ☑ No Score ..... 0 ..... (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☑ No Score ..... 0 ..... (complete the Braden Q Sheet)

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With .....

Orientation has been given regarding the following aspects:

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

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

Above information given to ..... patient .....

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

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

Nurse Signature: ..... Sri .....

Nurse Name: ..... Srivalli .....

Date & Time: ..... 14/7/26 @ 11Am .....

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 14/7/26 Time of Arrival: 10:30Pm Time Seen by Nurse: 10:45Pm

1) **Level of Consciousness:** ☑ Conscious ☐ Semi-Conscious ☐ UnConscious

2) **Chief Complaint (Reason for Visit):** (Circle the item as appropriate)

- ☐ Severe Pain / Moderate Pain
- ☐ Bleeding PV: Slight / Heavy
- ☐ Decreased Fetal Movement
- ☐ No Fetal Movement
- ☐ Preterm rupture of Membranes / Leaking Water PV
- ☐ Preterm Labor/ Labor
- ☐ Spontaneous Rupture of Membrane / Leaking Water PV
- ☐ Other Reason: .....

3) **Vital Signs:** Temperature: 98F Pulse: 87 RR: 20 SpO_2: 99% BP 115/75 Weight: .....

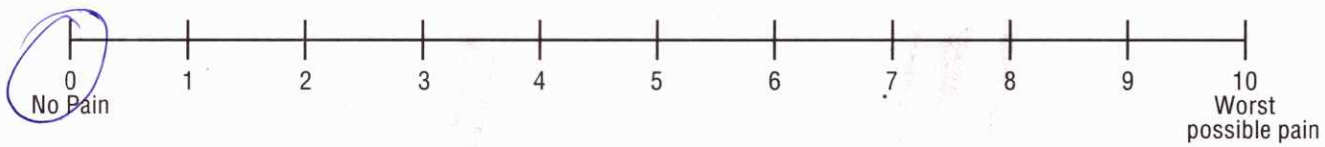
4) **Gestational Criteria:**

Gravida:	G 1	P –	L –	A –

LMP: ..... EDD: ..... Gestational Age: .....

Uterine Contraction	☐ Yes	☑ No	☐ NA	Onset	Time	Frequency:
Membrane Rupture	☐ Yes	☑ No	☐ NA	Onset	Time	Fluid Color:
Vaginal bleeding	☐ Yes	☑ No	☐ NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	☐ Yes	☑ No	☐ NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	☑ Yes	☐ No	☐ NA	If No specify:		

5) **Pain Screening:** **Numerical Pain Scale (NPS)**



- Location: .....
- Duration: ..... Days / Weeks/ Months (Strike out which is not applicable)
- Character: .....
- Frequency: .....
- Interventions: .....

6) **Past History:**

a) Surgeries: .....

b) Medical: .....

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

☐ No, If Yes : .....

8) **Current Medications:** ☐ Prenatal Vitamin ☑ None ☐ Others: .....

9) **Prenatal Medical History:**

☑ None
☐ Chronic Hypertension
☐ Gestational Hypertension
☐ Diabetes
☐ Gestational Diabetes
☐ Low placenta
☐ Others if yes, specify .....

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

☐ **Category I:** Resuscitative (Time to Physician: Immediate & Reassessment: Continuous nursing care)
☐ **Category II:** Emergent (Time to Physician: ≤ 15 minutes & Reassessment: Every 15 minutes)
☐ **Category III:** Urgent (Time to Physician: ≤ 30 minutes & Reassessment: Every 15 minutes)
☑ **Category IV:** Less Urgent (Time to Physician: ≤ 60 minutes & Reassessment: Every 30 minutes)
☐ **Category V:** Non Urgent (Time to Physician: ≤ 120 minutes & Reassessment: Every 60 minutes)

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 Hours)
Re-Assessment	Continuous Nursing Care	Every 15 Minutes	Every 15 Minutes	Every 30 Minutes	Every 60 Minutes
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SROM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (<spotting) <37 weeks	Bleeding associated with cramping (>spotting) >37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension >140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	• Acute onsite severe abdominal pain • Altered level of consciousness • Cord prolapse • Severe respiratory distress • Suspected sepsis	• Major trauma • Shortness of breath • Unplanned and unattended birth	• Abdominal/back pain greater than expected in pregnancy • Flank pain / hematuria • Nausea /vomiting and /or diarrhea with suspected dehydration	• Ongoing assessment from out patient clinic (for hypertension, blood work) • Minor trauma (minor MVC/fall) • Nausea/Vomiting and /or diarrhea • Signs of infection (ie dysuria ,cough, fever, chills)	• Anything that does not seem to pose threat to mother or fetus • Cervical ripening • Out patient placenta previa protocols • Pre-booked visits (ie Rh and progesterone injections, NST • Assessment for version • Rashes

Time seen by Doctor: 10.50 Pm

Nurse Name : Sujatha Nurse Signature:

Date: 14/7/26 Time: 10.40Pm

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

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BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?
   - ☑ a. Yes
   - ☐ b. No

2. If No, Reason .....

3. Nipple condition:
   - ☑ a. Nipple well formed
   - ☐ b. Flat nipple
   - ☐ c. Inverted nipple
   - ☐ d. Short nipple

4. Milk flow:
   - ☐ a. Good
   - ☑ b. Drops of colostrums
   - ☐ c. Dry

5. Steps for Positioning and attachment:
   - ☐ a. Baby goes to the breast
   - ☐ b. Mother always sits with a back support
   - ☐ c. Ear-shoulder-hip should be in a straight line
   - ☐ d. The baby takes a latch on the areola and not on the nipple

Feeding Positions:
Cross Cradle

Feeding Positions:
Football / Clutch

6. Was the position explained:
   - ☐ a. Yes
   - ☐ b. No

7. For Caesarian mothers:
   - ☐ a. Mother is required sit and feed from the 4th feed
   - ☐ b. Please explain football hold

8. NICU admission: NO
   - ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes: .....

Continuity of Care: Date: 15/7

→ Assess the pt condition
→ Vital are checked & recorded
→ I/O chart maintained
→ 2nd hourly DBF given

Handover given by ..... Sujatha ..... Handover taken by .....

Signature ..... Sujatha ..... Signature .....

Date & Time: 15/7/26 @ 8pm ..... Date & Time: .....

INFORMED CONSENT FOR VAGINAL BIRTH

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Patient Name : Mrs Deepti Daga UHID No : HNH-00009508.

Gender: ☐ Male ☐ ~~Female~~ Date : 14/7/26. Time : .....

I hereby authorized the performance of the following procedure:

- The Procedure has been explained to me in general terms and I understand that:
- The indication requiring the procedure of vaginal birth is pregnancy.
- The purpose of this procedure of vaginal birth pregnancy.
- The purpose of this procedure is to deliver the bay vaginally.

The outcome of the vaginal birth is the delivery of infant through birth canal either naturally or with possible use of force vacuum extraction. An episiotomy (a cut performed for enlarging of the vaginal opening in the space between the vaginal and the rectum) may be performed as part of a vaginal delivery.

Should vaginal delivery be unsuccessful, delivery by cesarean section with an abdominal incision under appropriate anesthesia may be necessary.

In an attempt to deliver the baby either naturally or with the help of instrument i.e. forceps or vacuum, there may be risks of: infection, allergic reaction, scarring, blood loss, need for blood transfusion, pain and discomfort, injury to urinary tract, possible injury to the baby (laceration, hematoma, skull fracture, nerve injury and brain injury) and possible future pelvic floor dysfunction.,

I understand and accept that there are complications, benefits, alternatives including the remote risk of death or serious disability, which exists for me and my baby.

I am aware that in most cases, vaginal delivery results in a healthy mother and baby; however, I realize that there are no guarantees.

I voluntarily consent to the procedures described or otherwise referred to herein. I am aware that they will be performed by a qualified gynecologist.

Name of the Doctor performing the procedure: Dr. P Swapna. P

Consentee :

Signature : .....

Name : Deepti Daga

Date & Time : 14/7/26 11:10Pm

Patient Attendant :

Signature : .....

Name : Rahul

Relationship with Patient: Spouse

Date & Time : 14/7/26 11:10pm

Witness :

Signature : Madhu

Name : Madhumaita

Date & Time : 14/7/26 @ 11:10Pm

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. DNG.

Date & Time : 14/7/26. @11:10Pm

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INDUCTION OF LABOR CONSENT

Name: Mrs Deepti Daga Age: 28yrs Gender: Male ☐ Female ☒

UHID.No : HNH-00009508 Date: 14/7/26

You are scheduled for an induction of labor on 14/7/26. (date) at 39+3 (weeks of gestation).

The reason for your induction is .....

The goal of induction of labor is to achieve vaginal delivery by starting uterine contractions before the spontaneous start of labor.

Induction of labor for a medical indication is done when continuation of pregnancy is considered detrimental to the health of the mother or fetus. This can be done at any stage of pregnancy irrespective of fetal maturity if there is a valid indication.

Elective induction of labor (scheduled induction without a medical indication) may not be done until you are at least 39 weeks. This is important so that your newborn does not have complications due to possible prematurity.

The alternative to induction of labor is to wait for labor to start spontaneously.

I have read the information provided and also discussed the process with my doctor.

I understand the risks and benefits of this procedure and wish to proceed.

Patient

Signature: .....

Name: Deepti Daga

Date & Time: 14/7/26 11:10 PM

Patient Attendant:

Signature: .....

Name: Rahul

Relationship with Patient: Spouse

Date & Time: 14/7/26 11:10 PM

Doctor:

Signature: .....

Name: Dr. Dna.

Date & Time: 14/7/26 @ 11:10 PM

Witness

Signature: .....

Name: Madhumitha

Date & Time: 14/7/26 @ 11:10 PM

CONSENT FORM FOR GENERA REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CAF

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

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Patient Name : ..... Age : 29 Gender : Male ☐ Female ☐

UHID NO: HNH 0009308 Surgeon Name: Dr Swapna

Anaesthesiologist : DR ADITI

Operative procedure planned : casarean section

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 : .....

Comments : DESATURATION, BRADYCARDIA TACYCARDIA, PPPH, shivering HYPOTENSION

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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 : Deepti Dogra

Relationship with Patient: SELF

Date & Time : 7/26

Witness :

Signature : .....

Name : Rahul Mahi

Date & Time : 7/26

Doctor (who is taking the consent) :

Signature : .....

Name : Dr Ankita N

Date & Time : 7/7/26

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs Deepti Daga Gender: ☐ Male ☑ Female Age : 29y

UHID No : HNH-0000 9508 Date : 15/7/2026

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)

EMERGENCY LOWER SEGMENT CAESAREAN SECTION

upon

(Name of the Patient) Mrs Deepti Daga

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

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

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

Bleeding, Infection, Injury to Bowel Bladder or Bloodvessels
Chances of Blood transfusion

My signature on this form indicates that

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

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

Consentee :
Signature :
Name : Mrs Deepti Daga
Date & Time : 15/7/2026 @ 12pm

Patient Attendant :
Signature :
Name : Rahul Maln
Relationship with Patient: Husband
Date & Time : 15/7/2026 @ 12pm

Witness :
Signature :
Name : Akhila
Date & Time : 15/7/26

Doctor (who is taking the consent) :
Signature :
Name : Dr Manisha
Date & Time : 15/7/2026 @ 12pm

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

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Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATI

Name: Mrs Deepti Daga Age: ..... Sex: ..... UHID.No : .....

Date: 15/7/26 Time: 11:20 Proposed Operation: Emergency LSCS

Diagnosis: Period 39wks Choledocholithiasis / Choledochectasis

B.P / CRT: ..... H.R: ..... Weight: 102.4 ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

14/7/26 165

Laboratory Data:

Hgb: 10.3	Glucose:	Protein:	HIV:	X-Ray: .....
PCV: 30.3	Urea:	Alb:	HBS Ag: NR	ECG: .....
WBC: 9.23	Creat:	Total Bill:	HCV:	2D Echo: .....
Plate: 2.27	Na:	Dir. Bill:	Blood group: O+ve	Stress/Anglo: .....
PT:	K:	LDH:	T3	Other: .....
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: NKDA

Medical History: CVS : —

RESP : — Diabetes : —

CNS : ✓

Renal : —

Hepatic / GE : — Physical Activity: ET > 2 flights

Others : —

Past Anaesthetic History: H/O of Choledocholithiasis 2 months back. H/O LSCS 8 years back.

Physical Exam:

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

Lungs : AE B/L

Heart: S1S2

CNS: NAD

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

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 Ankita N

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

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R: 99/m	B.P / CRT: 137/79	SpO_2: 99%	R.R: 18/m	Last Feed: >6 hrs

Pre-OP Diagnosis: mum Operation: LSCS Date: 15/7

Surgeon: Dr Sj / Dr Manisha Anaesthesiologist: Dr Sanm / Dr AN Technician: Dravid / Saraswati

TIME	215	245	315
N_2O /AIR /O_2 LPM			
HALO /SO /SEVO			
Drugs:			
OXYTOCIN 3U + 6U infusion			
FIO_2 / SaO_2	100	100 / 100	100
$ETCO_2$			
ECG	Sinus →		
Temperature			
Urine Output			
Fluids / Blood	RL →		

Antibiotic: mini
Suppository: DICLOFENAC 100mg
TRAMADOL 100mg
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

Scale: 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: (R) UL
☐ Art Site:
☑ EKG Lead 3 lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☑ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: supine
☑ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☑ Awake

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

Times:
Anaes Start: 215 pm
OP Start: ↓
OP End:
Leave OR: 315 pm

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☑ Regional

Line (Size & Location)
☐ CVP:
☐ ART:
☑ IV: 18G (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: ....
Position: sitting / USG marking
Site: L3-4
Needle Size: 25G (P) Depth: ....
Parasthesia ☐ Yes ☐ No
Catheter at skin .... cm
Drug Name & Conc: 10 MG BUPIVACAINE (H)
Bolus: + 4 MCG FENTANYL
Infusion:
Block Level: T4 - B/L equal
Comments: pinprick
Transportation to
☑ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☑ NA
Name of the Doctor : Dr Mayuri
Signature of the Doctor :

HNH-00009508 IP26-00006843
Mrs DEEPTI DAGA
07-07-1997 29 Y 0 M 8 D (F)
Dr. SWAPNA SAMUDRALA

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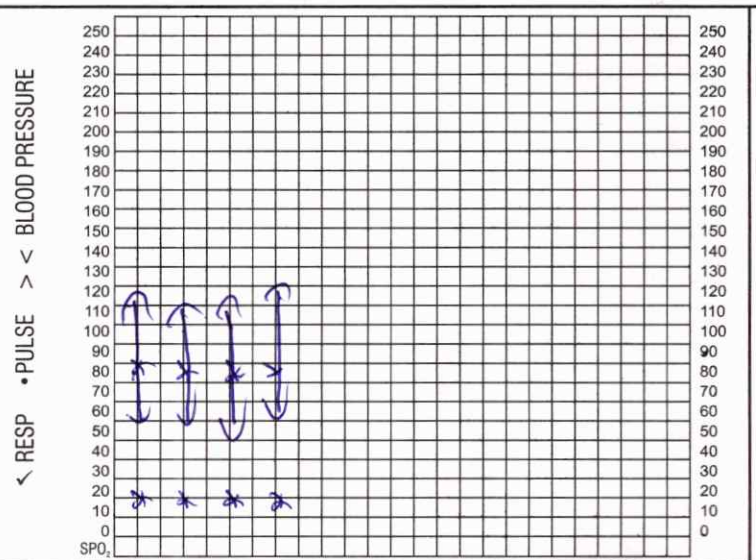
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sujatha Time Received : 4PM Time Discharged : 6pm



IV Cannula Site : .....

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

Vomiting : ☐ Yes ☑ No Drug: INJ taxim 4pm
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☑ Yes ☐ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☑ No

IV Fluids: RL
Oral Feeds: NBM

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT	SCORING INTERPRETATION
Able to move 4 extremities voluntary or on command Able to move 2 extremities voluntary or on command Able to move 0 extremities voluntary or on command	= 2 = 1 = 0	ACTIVITY		1	2	2	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	10	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
15/7	4PM	0	NA	
15/7	5PM	0	NA	
15/7	6PM	0	NA	

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

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

Anaesthesiologist Name : Dr Ashok N
Anaesthesiologist Signature: Ashok
Date & Time: 15/7/26

PACU Nurse Name : Manjula.
PACU Nurse Signature:
Date & Time: 15/7/26.

Transferred to Unit by (PACU): 3rd (301)
Date & Time: 15/7/26

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

26-0000213980

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: Mrs Deepti Doga		Age: 29Y		Gender: Female	
UHID No: HNH-00004508	IP No: 26-00006843 (Ward-07)	Date: 15/7/26		Time: 11:31 Am	
Diagnosis: ISCS					

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100 MCG	01 Amp
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: [signature]

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

IP Registration No: 26-00006843

Date: 15/7/26

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

		Remarks
1.	**Name :** Mrs Deepti Doga	
2.	Complete postal address (with contact number, if any)	king koti Hyderabad
3.	Brief description of the illness	ISCS
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	INJ: Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
15/7	INJ: Fentanyl	01	[signature]	

Dispensed by (Name & ID No.): sonia 015442 Signature: ...

Received by (Name & ID No.): M Arvind kumar (021257) Signature: Arv

Time: ...

Docu. No: RCH / FRM / CLINICAL / 133

26-0000213980

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Mrs Deepti Doga		Age: 39Y	Gender: Female
UHID No: HNH-00009508	IP No: 26-00006843	Date: 15/7/26	Time: 11:31Am
Diagnosis: LSCS (Ward-07)			

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100 MCG	01 Amp
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: [signature]

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

IP Registration No: 26-00006843   **Date:** 15/7/26

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

		Remarks
1.	**Name :** Mrs Deepti Doga	
2.	Complete postal address (with contact number, if any)	King koti Hyderabad
3.	Brief description of the illness	LSCS
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	INJ: Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
15/7	INJ: Fentanyl	01	[signature]	

Dispensed by (Name & ID No.): sania 61542 Signature: ....

Received by (Name & ID No.): M Arvind kumar (021257) Signature: [signature]

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133

Rainbow Children's Hospital

BirthRight

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name:	MR No:	Gender:	
UHID NO:	OPD No:	Date:	Time:
Diagnosis:			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1	Fentanyl Citrate Inj.50mcg/ml		
2	Morphine Sulphate Inj.10mg/ml		
3	Pentazocine Hydrochloride Inj.30mg		
4	Pentazocine Hydrochloride Inj.15mg		
Doctor Name:		Doctor Registration No:	
Signature:			

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

ID Registration No:

Name:

Address (No. & Name of the Street (Optional)

Date:

S.No	Name	Remarks
1	Complete postal address (with contact number, if any)	
2	Brief description of the illness	
3	Whether pre-treated with any other registered medicine or prescription required (Full particulars if it is details of the prescribed)	
4	Details of Essential Narcotic Drugs dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any

Dispensed by (Name & ID No.)

Received by (Name & ID No.)

Signature

Signature