

Name Mrs SAMREEN FATIMA **UHID** HNH-00003545
Father/Guardian Mr SEYED ABDUL WASAY **Age/Gender** 38 Y / Female
Address AMAN KASER 4 TH FLOOR 403, King Koti, Hyderabad, Telangana, INDIA, 500001
IP No IP26-00006673 **Admission Date** 28-06-2026
Ref Doctor Self.
Discharge Date 29.06.2026

DISCHARGE SUMMARY

Consultant:

Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

**Diagnosis: P3L3A1 WITH INCOMPLETE ABORTION WITH ?
ARTERIOVENOUS MALFORMATION WITH MODERATE ANEMIA**

**SURGICAL EVACUATION OF PRODUCTS OF CONCEPTION DONE ON
28.06.2026**

History: She came with complain of heavy menstrual bleeding with clots. She underwent MERPC on 27.05.2026. RPOC scan was done (27.06.2026) showed RPOC measuring 37x15x30mm, both ovaries visualised. Couple was counselled

Name Mrs SAMREEN FATIMA UHID HNH-00003545
IP No IP26-00006673 Admission Date 28-06-2026

regarding RPOC scan and need for inpatient SERPC for retained product of conception and failed MERPC. Couple wish to go ahead with SERPC. Investigations done showed Hb-8.4g/dl- anemia. She was admitted for surgical evacuation of retained products of conception.

Menstrual History:

Previous cycles: Regular
LMP: 16.04.2026

Obstetric History:

- 1 - 2011- FTVD, Boy, 14 years, Uneventful
- 2 - 2013- FTVD, Boy, 12 years, Uneventful
- 3 - 2018- FTVD, Boy, 8 years, Uneventful
- 4 - 2026- Present pregnancy, Spontaneous conception, MERPC at 5+6 weeks.

Medical History: Nil
Family History: Nil.

Surgical History: Nil
Allergies: Nil

Investigations: Enclosed
Blood group: "B" Positive

Surgery Notes:

Operation performed: GENTLE CURETTAGE DONE ON 28.06.2026

Post-Operative Notes: She was shifted to postoperative ward. Vital monitoring done. Axon opinion was sought in view of moderate anemia. Scan done on 29.06.2026 showed Heterogenous lesion with vascularity (PSV-42-

Name Mrs. SAMREEN FATIMA UHID HNH-00003545
IP No IP26-00006673 Admission Date 28-06-2026

78cm/sec) at fundus of uterine cavity measuring 27x11x27mm-suggestive of enhanced myometrial vascularity. CBP,LFT,Serum creatinine, Serum Beta Hcg sent. She was hemodynamically stable and found fit for discharge.

Advice:

1. Tab. Taxim O 200mg twice daily till 04.07.2026 (9am-9pm) after food.
2. Tab. Dolo 650 mg SOS (for pain)
3. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 03.07.2026.
4. Tab Livogen twice daily before food (8am-8pm) for one month
5. Tab ZINCOVIT once daily at 2pm for 1 month

Review consultation with **Dr. SWAPNA SAMUDRALA**, on **30.06.2026** with reports in Gynec OPD in Himayatnagar (**Review consultation will be charged**).

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


Patient/ Attender

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

Name

Mrs SAMREEN FATIMA

UHID

HNH-00003545

IP No

IP26-00006673

Admission Date

28-06-2026

Registrar/Resident/C.M.O

Consultant:

Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006673 Admit Date : 28-Jun-2026 Admit Time : 01:34 AM UHID : HNH-00003545

Patient Details :

Patient Name	: Mrs SAMREEN FATIMA	Age	: 38 Y
Guardian	: Mr SEYED ABDUL WASAY	DOB	: 07-07-1987
Gender	: Female	Religion	:
Occupation	:	Marital Status	:
Address (H)	: AMAN KASER 4 TH FLOOR 403 King Koti Hyderabad Telangana INDIA 500001	Phone No	: 8008004010/ 9949504400
		E-mail	: na@gmail.com

Admission Details :

Bed Type	: TWIN SHARING	Bed No	: PPO-419	Ward Name	: 4F -OT
Room No	: PPO-419	Admission Type	: First Visit		

Contact Details :

Name	: Mr SEYED ABDUL WASAY	Relationship	: W/O
Contact Address	: AMAN KASER 4 TH FLOOR 403 King Koti Hyderabad Telangana INDIA 500001	Phone No	: 8008004010


Signature

Doctor Details :

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

Payment Details :

Deposit Amount	: 20000.00
Payment Mode	: DC/CC Card
Payor Name	: SELFPAY

ACTIVITY RECORD FOR BILLING

Name : **HNH-00003545** **IP26-00006673**
Mrs SAMREEN FATIMA
07-07-1987 **38 Y**
Dr. SWAPNA SAMUDRALA (F)
UHID No: 
Date of Admission: _____ Date of Discharge: _____ Time: _____
Room / Bed No: _____ Ward: _____ Suggested Billable bed type: _____

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
28/6/26		Pre-post	OT	
28/6/26		OT	Pre-post	

Cross Consultation Visit

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

[illegible][illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

Date	Procedure	Quantity	Order No.	Signature
28/6/26	IV placement	(1)	208837 ✓	Pau
28/6/26	PAC (TP)	9121 (1)	208872 ✓	Lm
28/6/26	DQC	(1)	9121	✓
29/6	IYIROWN Therapy	(1) 209196	209196	(1)

ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

ANY OTHER INFORMATION



I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 28/6/2026. Time of Admission :

Allergies: ☐ Not know any drug allergies

PRESENTING COMPLAINTS :

Gestational NVD's = 3. Incomplete Abortion.
 No Heavy Bleeding P.V = 1 hour.
 changing pads a/w passage of clot.
 No MTP Medication taken under Dr's
 Supervision 1 month back.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 2011 Previous Periods : Regular. LMP : 16/4/26. Contraception :	Parity : G4P3L3 Mode of Delivery : NVD Last Child Birth : 8 years.

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nu	Nu



FAM

MEDICATION HISTORY:

1. Misoprostol 200mcg
 2.

INITIAL ASSESSMENT:

Date <u>28/6/26</u>	Breasts	Local/Speculum Examination
Ht. _____ Wt. _____	Not done.	Not done.
BMI _____		
B.P. <u>110/80 mmHg</u>		
Pallor <u>+</u> PR: <u>87bpm</u>		Bimanual Pelvic Examination
CVR <u>S/S, ⊕</u>	Abdominal Examination	G-open.
Respiratory System <u>BAE ⊕</u>	Soft.	Clots * 2x2cm ⊕.
Thyroid _____		

PROVISIONAL DIAGNOSIS:

P₃₁₃A₁ ⊕ NVD ⊕ Incomplete Abortion

INVESTIGATIONS ORDERED

PLAN OF MANAGEMENT

B+ve O+ve

CBC/ BGT
 HIV, HbsAg, VDRL
 HCV

27/6/26
 RPOC scan - Heterogeneous
 lesion & vascularity at fundus
 of uterine cavity m/s 37x15x30mm.
 S/o-RPOC.

Admission
 - Inj Tranexa 1g IV/stat
 - Inj zofer 4mg IV/stat.
 - SERPC tomorrow.

Dr. Swapna Samudrala
 Obstetrics and Gynec
 Reg. No: 68924

Name of the Doctor: Dr Swapna Samudrala

Signature of Doctor

Date & Time: 28/6/26 06:00 AM



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/06/2020	Cesio Dr Maudsley	
<u>10:30 AM</u>		
	CC - low Afebrile	- Adv
	vitals stable	- NBM
	P/A soft	- Oxy as checked
	LE minimal spitting	- Adequate hydration
		- Vitals monitoring
		- Inform SDO
		- Check for Blood ^{acceptability}
		<u>my</u>
		<u>onwards</u>

2

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/6/20	G ₂ P ₂ / 6 wks / Failed MERPc.	
12:00 PM	NO Comp NO bleeding ∴ 2 hrs.	
	OIE - Gic Jan	
	Uterus	
	Pathology	Uterus
	D ₂ Ser- 99 2 RA	- Inj Saxin, 1 gm, IV, BID
	PR - 22 bhr	- Inj Metformin 500 mg 14/09/15
	B.P - 100/60	
	P/A - Sgtr.	- Wt? bleeding A/V
	P/S - Cr As open	- monitor Wt
	min products etc - Inj as changed	
	Uterus as - Abdom review	
	removed with Orem.	2 Plan
	Check Cervix do	14 Inj
	No uterine bleeding - Inj Sgtr	
	Cough Counselled	
		Dr. Swapna Samudrala Consultant Obstetrics and Gynecology Reg. No: 69924



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
28/06/2026	Ceath B. Monisha	
3:25pm		
		<u>Adm</u>
	GC Far Afebrile	
	Vitals Stable	- Regular Diet / Adeq Hydration
	PIA Soft	- Drags as checked
11✓	LE Pad dry	- Apply Sterile Pad
		- RPOC Scan C/m
	BP-106/75 PR 80	- Early Breakfast
	No Complaint	- 'Infum 500S
		<u>My B. Monisha</u>
28/06/2026	Ceath B. Monisha	
9pm		
	GC Far Afebrile	<u>Adm</u>
	Vitals stable	- Regular Diet / Adeq Hydration
	PIA Soft	- Drags as checked
	LE - NAD	- Apply Sterile Pad
		- Early Breakfast ^{Flb} NBM
		- Infum 500
	<u>Plan: RPOC Scan C/m</u>	
		<u>My B. Monisha</u>



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
29/6/20 10:30 AM	NO comp Pr comparable O/E - G.c. pain Uterus Vitals - @ P/A - Lgt H/E - MAB.	
	Scan → Heterogeneous lesion with Vascularity (Pcr 12-28 cm/sec). @ Junction of uterine cavity 22 x 11 x 22 mm. S/O enhanced myometrial Vascularity. B/L Ovaries Visualized.	
	Couple consulted regarding Scan finding.	Adv - - CRP, Lf. Bhcg, Lf?, Lf. cent. - Plan: Inj Methotrexate after reports - monitor vitals - Images as changed - Inj as per.
	Can be discharged Plu with report tomorrow.	
	PT want to go home & Review 2 Reports	Dr. Swapna Samudrala Consultant Obstetrics & Gynaecology Reg. No: 69924 (M. Srinivas)

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 Dr. SWAPNA SAMUDRALA (F)



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RESULT SHEET

Date	JP 28/6/20				
Time					
Hb	8.4				
PCV					
RBC	3.24				
WBC	6.18				
N/L					
Platelets	322				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood grouping	b positive					
HIV						
HbsAg	PCR					
HCV						
VDRL						

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.,) :

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 Dr. SWAPNA SAMUDRALA



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MEDICATION 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	MISOPROSTOL	200mg	PO		2pm	☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : *Dr. Dna*

Date & Time : 28/6/26

Nurse Name & Signature : *S. Jialha*

Date & Time : 28/6/26 @ 8AM

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

IP26-00006673
Mrs SAMREEN FATIMA
07-07-1987 38 Y
Dr. SWAPNA SAMUDRALA (F)

DRUG CHART

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

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
- 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name

REGULAR PRESCRIPTIONS

Weight. Ward. 10



DRUG : <u>IN CEFOTAXIME</u>				Date Time	<u>28/6/26</u>
Dose <u>1g</u>	Route <u>IV</u>	Frequency <u>BD</u>	Start Date <u>28/6</u>	<u>8am</u>	<u>12am</u>
Name & Signature of the Doctor Starting the Drugs: <u>m omank</u>				<u>8am</u>	<u>12am</u>
Additional Instructions: <u>CEFOTAXIME</u> <u>ASR</u>					
Daily Doctor's Endorsement by a Sign				<u>✓</u>	
DRUG : <u>IN METRONIDAZOLE</u>				Date Time	<u>28/6/26</u>
Dose <u>500mg</u>	Route <u>IV</u>	Frequency <u>710</u>	Start Date <u>28/6</u>	<u>3am</u>	<u>12am</u>
Name & Signature of the Doctor Starting the Drugs: <u>m omank</u>				<u>3am</u>	<u>12am</u>
Additional Instructions:				<u>11pm</u>	<u>12am</u>
Daily Doctor's Endorsement by a Sign				<u>✓</u>	
DRUG : <u>IN PANTOPRAZOLE</u>				Date Time	<u>29/6</u>
Dose <u>40mg</u>	Route <u>IV</u>	Frequency <u>ON</u>	Start Date <u>29/6</u>	<u>9am</u>	<u>12am</u>
Name & Signature of the Doctor Starting the Drugs: <u>Dr. M. JAR</u>				<u>9am</u>	<u>12am</u>
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					
DRUG :				Date Time	
Dose	Route	Frequency	Start Date		
Name & Signature of the Doctor Starting the Drugs:					
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					



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Weight Ward 20

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				

(F)



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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
28/6	1:40 AM	Inj TRANEXAMIC ACID	1g	IV	[Signature]	Cloudy Anur
28/6	1:40 AM	Inj ONDANSETRON	4mg	IV	[Signature]	Cloudy Anur
28/6	2:50 AM	Inj PANTOPRAZOLE	40mg	IV	[Signature]	Cloudy Anur
28/6	10:20 AM	Inj CEFOTAXIME	1g	IV	[Signature]	Sriatha mounika
28/6	10:30 AM	Inj PANTOPRAZOLE	40mg	IV	[Signature]	Sriatha mounika
28/6	10:30 AM	Inj METOCLOPRAMIDE	4mg	IV	[Signature]	Sriatha mounika
28/6/26	1:00 pm	Inj. ONDANSETRON	4mg	IV	[Signature]	Sriatha mounika
28/6	12:40 PM	INJ TRANEXAMIC ACID	1g	IV	[Signature]	Sriatha mounika
28/6	12:35 PM	INJ METHERGINE	0.2mg	IM	[Signature]	Sriatha mounika

28/6 1: PM TAB MISOPROSTOL 400mcg PV Page: 3/4 Sriatha (P.T.O)

[illegible]

Signature _____

VERIFIED BY : Name :

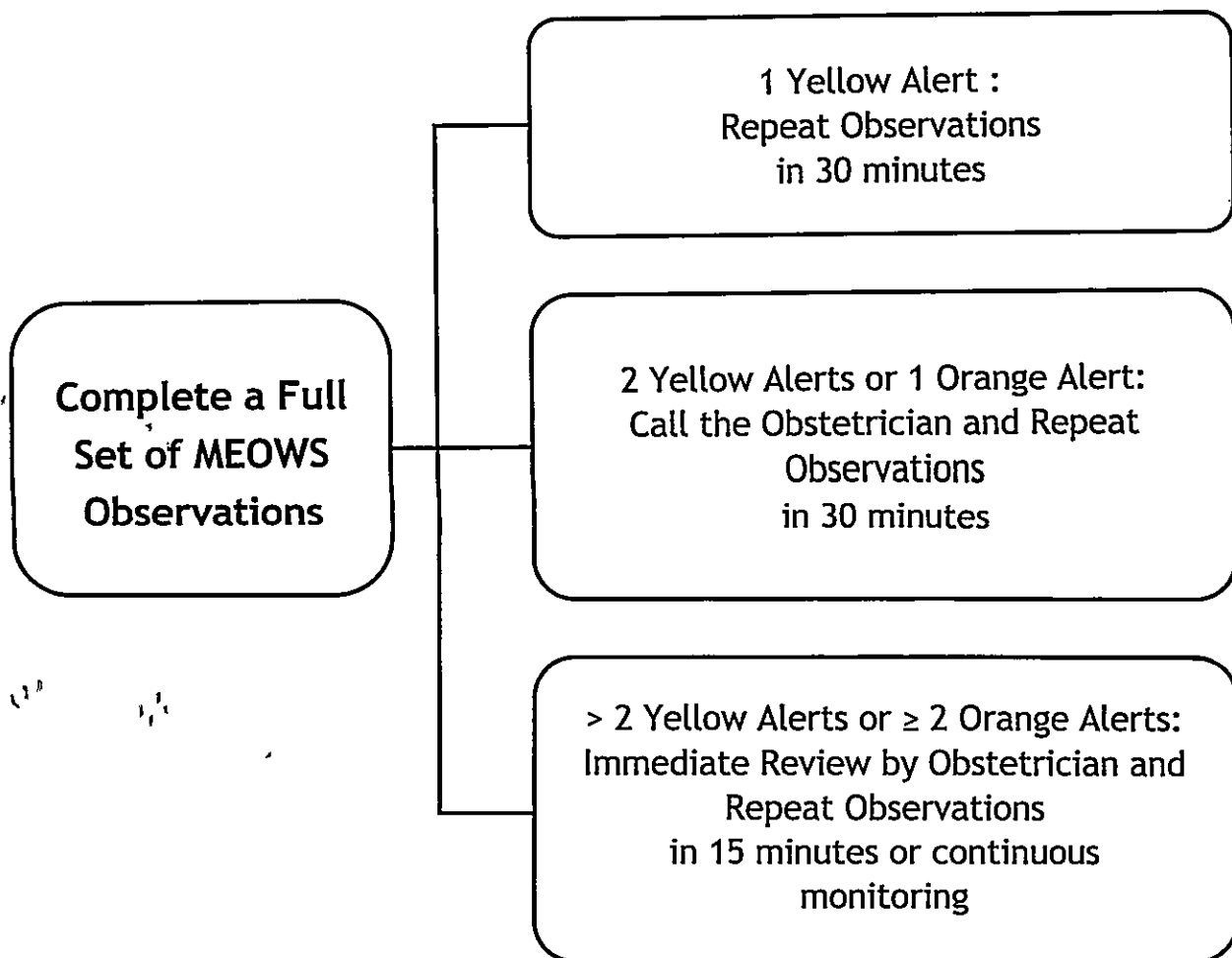


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

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

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

HNH-00003545 IP26-00006673
 Mrs SAMREEN FATIMA
 07-07-1987 38 Y
 Dr. SWAPNA SAMUDRALA (F)

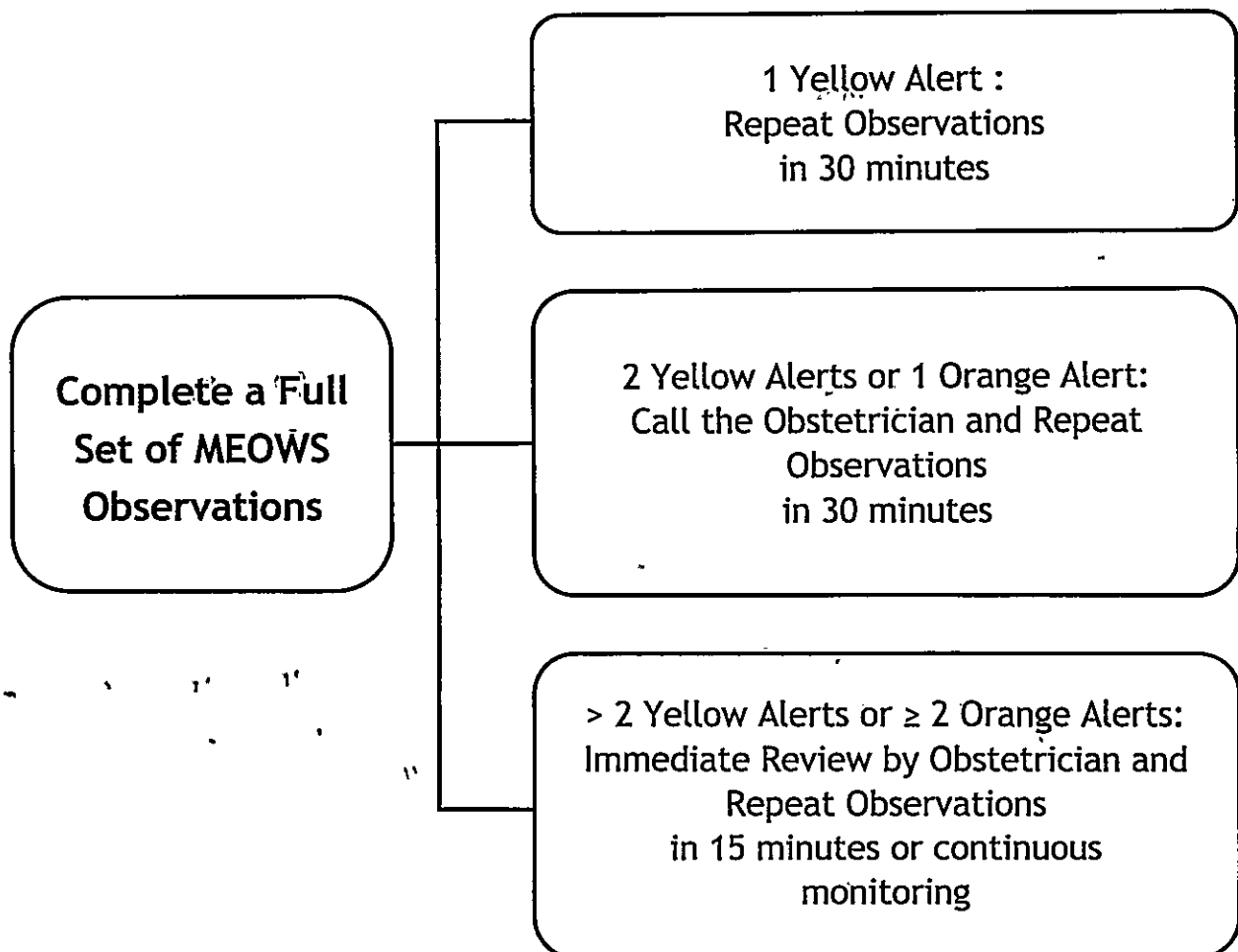


Early Warning Observation Score Chart - Obstetrics

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

28/6		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	20	20	20	20	20	20	20	20	20	20	20	20	20	
	0 - 10																											
Saturations	94 - 100 %	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	
	< 94 %																											
Administered O ₂ (L/min.)																												
Temp °C	40																											
	39																											
	38																											
	37																											
	36	98.1	98.2	98.3	98.4	98.5	98.6	98.7	98.8	98.9	99.0	99.1	99.2	99.3	99.4	99.5	99.6	99.7	99.8	99.9	100.0	100.1	100.2	100.3	100.4	100.5		
	35																											
	< 35																											
Heart Rate	170																											
	160																											
	150																											
	140																											
	130																											
	120																											
	110																											
	100																											
	90																											
	80	80	82	80	83	80	81	84	86	84	88	86	86	86	86	86	86	86	86	86	86	86	86	86	86	86	86	
	70																											
	60																											
	50																											
40																												
Systolic Blood Pressure	190																											
	180																											
	170																											
	160																											
	150																											
	140																											
	130																											
	120																											
	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110	110		
	100																											
	90																											
	80																											
	70																											
60																												
50																												
Diastolic Blood Pressure	130																											
	120																											
	110																											
	100																											
	90																											
	80																											
	70	65	68	65	68	65	68	65	68	65	68	65	68	65	68	65	68	65	68	65	68	65	68	65	68			
	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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
TOTAL ORANGE SCORES		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Nurse Initial																												

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)



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					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am	Rh	N	FF									
	03:00 am	Rh	B	100ml									
	04:00 am	Rh	10	100ml									
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake : Taken						Total Output : passed							
Total 24 hrs. Intake													
Total 24 hrs. Output													



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.

28/6		Intake			Output					IV Site	Sign. Nurse
Date	Time	Nature of Fluid	Route		NG	Diarrhoea	Vomit	Drainage	Urine	Thrombo-phlebitis Score	
			Mouth	I.V	N.G						
28/6	08:00 am	RL		100ml							
	09:00 am	RL		100ml							
	10:00 am	RL	N	100ml							
	11:00 am	RL	B	100ml							
	12:00 pm	RL	M	100ml							
	01:00 pm	RL		100ml							
Total Intake : taken					Total Output : passed.						
28/6	02:00 pm										
	03:00 pm										
	04:00 pm										
	05:00 pm										
	06:00 pm										
	07:00 pm										
Total Intake : Taken					Total Output : passed.						
28/6	08:00 pm										
	09:00 pm										
	10:00 pm										
	11:00 pm										
	12:00 am										
	01:00 am										
Total Intake :					Total Output :						
29/6	02:00 am										
	03:00 am										
	04:00 am										
	05:00 am	RL	uppu	100ml							
	06:00 am	RL	h2o	100ml							
	07:00 am	RL		100ml							
Total Intake :					Total Output :						

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00003545 IP26-00006673

Mrs SAMREEN FATIMA
07-07-1987 38 Y
Dr. SWAPNA SAMUDRALA

(F)



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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					IV Site Thrombo- phlebitis Score	Sign. Nurse	
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
29/6/26	08:00 am												
	09:00 am												
	10:00 am	Belly											
	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							

Patient Sticker

FLUID CHART

Sheet No. :

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

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

Total 24 hrs. Intake

Total 24 hrs. Output

OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 27/8/26

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: Abortion Doctor Notified on Admission: ☐ Yes ☒ No
Name of the Doctor: Dr. PLO Time Notified:

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

Past Medical History	Past Surgical History	Previous Hospital Admission
Gynecology Assessment: ☐ Not Applicable Menstrual History: <u>regular</u> Onset of Menarche: <u> </u> Menstrual Cycle: ☒ Regular ☐ Irregular Last Menstrual Period: <u> </u>	Gynecology Surgical History: Caesarean Section: ☒ No ☐ Yes Cervical Cerclage: ☒ No ☐ Yes Ectopic Pregnancy: ☒ No ☐ Yes Myomectomy: ☒ No ☐ Yes Others: <u> </u>	Gynecological History: Contraceptives: ☒ No ☐ Yes Vaginal Discharge: ☒ No ☐ Yes Post-Coital Bleeding: ☒ No ☐ Yes Infertility: ☒ No ☐ Yes If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G P 3 L 3 A 1Previous LSCS: NOCurrent Medication: ☐ None ☒ Yes, If Yes, Fill the reconciliation formFamily History: ☒ No Abnormalities Detected

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

☐ Liver disease ☐ Other

Vital Signs / Measurements: Temp: 99 HR: 80 RR: 20

BP: 106/72 Weight: Height: BMI:

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



PHYSICAL ASSESSMENT

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

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

Risk of Pressure Sore: ☒ Yes ☐ No Score 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 Samreen Fatima

Orientation not given Reason: self

Nurse Signature: [Signature]

Nurse Name: Chandika

Date & Time: 27/6/26



CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	27/6 DAY-1			28/6 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	NA	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					
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	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					
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					
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord pyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5			NA	NA	NA					
Signature of the Nurse						CA	Fi	0	AD				

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-00003545 IP26-00006673
 Mrs SAMREEN FATIMA
 07-07-1987 38 Y (F)
 Dr. SWAPNA SAMUDRALA



CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature of Ward In Charge :

Signature : Name :

Signature : Name :



Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	28/6	28/6	28/6	Fall Risk Grading		
		Score	28/6	28/6	28/6	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25				Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0	0	0	0			
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0	0	0			
Total Morse Fall Scale Score:			20	20	20			
Signature			CD	R	0			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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07-07-1987 38 Y
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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Score	Fall Risk Grading		
History of Falling (immediately or w/in 3 months)	Yes	25				
	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				
IV / Heparin Lock or Saline	Yes	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:						
Signature						

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

- ☐ Ensure patients use their prescribed eye glasses if any, in the hospital
- ☐ Use chairs with arm rests
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- ☐ 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

BRADEN 'Q' SCALE

					Date :	28/7	28/6	28/6	22/6
					Time :	N/1	3PM	12	N
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.		4	4	4	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4	4	4	4
FRICION-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						CO	Fi	AD	AD

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

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

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BRADEN 'Q' SCALE

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					Date : 20/6			
					Time : 11/6			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4			
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4			
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4			
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4			
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4			
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4			
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4			
Severe Risk : less than 9 High Risk : 10-12 Moderate Risk : 13-14 Mild Risk : 15-18 Not at Risk: 19-23					TOTAL SCORE	28		
Docu. No. : RCH /FRM / CLINICAL / 119					Evaluator's Name	CO		

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
28/6	10 AM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	CL
28/6	2 PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	CO
28/6	4 PM	2	MA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ⓟ
28/6	8 PM	2	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	A
28/6	10 PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Anker
29/6	10 AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Ⓜ
				☐ 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:

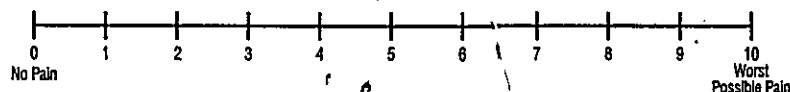
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, 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

Wong - Baker (Pediatrics) Above 7 Years



0 No Hurt
2 Hurts Little Bit
4 Hurts Little More
6 Even More
8 Hurts Whole Lot
10 Hurts Worst

HNH-00003545 IP26-00006673
 Mrs SAMREEN FATIMA
 07-07-1987 38 Y (F)
 Dr. SWAPNA SAMUDRALA



NURSING CARE RECORD

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

BirthRight™
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Date: 28/7/26

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 to 8Am	=> Assess the patient condition => plan for vitals => plan for Blockage	8pm to 8Am	=> Assessed throught condition => maintain vitals & Record => maintain 20 Chary	patient is stable	vital is normal	Chandya CD

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NURSING CARE RECORD

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BirthRight
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Your Right to a Safe Delivery

Date: 28/6

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am	→ Assess the pt condition	8Am	→ Assessed the pt condition	D/o chart maintained	patient is stable	Lini
	To	→ plan for vitals	To	→ vital are checked & recorded			
	2Pm	→ plan for D/o chart	2Pm	→ all medication given			
Afternoon	2Pm	→ plan for medication	2Pm	→ all medication given	vital is normal	pt is stable	Sudatha
	2Pm	→ plan for vital	2Pm	→ vital checked & recorded			
	8Pm	→ plan for D/o chart	8Pm	→ Maintain D/o chart			
Night	8Pm	→ plan for medication	8Pm	→ all medication given	Normal	Stable	Madhu @
	8Pm	→ plan for vials	8Pm	→ vitals Normal			
	8Am	→ plan for plv bleeding	8Am	→ medication given as per chart			

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Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8 AM to 12 PM	Assess the pt condition monitor vital maintain	8 AM to 2 PM	Assess the pt condition monitored vital	pt is stable	Re-check vital	Mou [Signature]
Afternoon							
Night							

Patient Sticker

NURSING CARE RECORD

Date:

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							



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis: Observation		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area	Shift Time	27/6 NI	28/6 8AM	28/6 2PM	28/6 4PM
	Medical Condition (Any special condition to be noted):		-	NA	NA	NA
ASSESSMENT	Allergy:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Tubes/Drains/Catheter:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No
	Vital Signs:	Temp:	98°F	97°F	98°F	98.6°F
	Res:	86	85	86	86	
	SpO ₂ :	100%	99.5%	99.5%	98.5%	
	Pulse:	90	87	88	90	
	BP:	107/77	110/75	111/76	112/62	
	Fall Risk Score:	-	-	-	-	
Pain Score:	-	-	-	-		
Recommendations	Safety Needs:	Yes	-	-	Yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	-	NA	-	NA	
	Special Diet:	☒ Yes ☐ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	-	NA	-	-	
Post Operative Procedure Special Orders:		-	NA	-	NA	
Handed Over By Name :		Chand	Liak	Madh	Anusha	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	
Date:		27/6	28/6	28/6	28/6	
Time:		8AM	2PM	8PM	8PM	
Taken Over By Name :		Liak	Madh	Anusha	Anusha	
Signature :		[Signature]	[Signature]	[Signature]	[Signature]	
Date:		28/6	28/6	28/6	28/6	
Time:		8AM	2PM	8PM	8PM	

HNH-00003545 IP26-00006673

Mrs SAMREEN FATIMA

07-07-1987

38 Y

(F)

Dr. SWAPNA SAMUDRALA



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.....SING 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						
BACKGROUND	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp:					
	Res:						
	SpO ₂ :						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							