Name	Mrs SIMRAN GEHLOT	**UHID**	HNH-00015065
Father/Guardian	Mr VIJAY BHATI	**Age/Gender**	26 Y / Female
Address	93,jawahar rail colony,jupiter colony,sikh village,bowenpally, New Bowenpally, Hyderabad, Telangana, INDIA, 500011		
IP No	IP26-00006429	**Admission Date**	25-05-2026
Ref Doctor	Self.		
Discharge Date	26.05.2026		

DISCHARGE SUMMARY

Consultant
Dr. SWAPNA SAMUDRALA
OBSTETRICIAN & GYNAECOLOGIST
69924

Diagnosis: PRIMI AT 10^{+1} WEEKS WITH HYPEREMESIS FOR FURTHER MANAGEMENT

History:
LMP:11.03.2026
EDD- 20.12.2026
Obstetric formula: PRIMI
Gestation at admission: 10^{+1} weeks

Obstetric History:
G1 - Present pregnancy, Spontaneous conception.

Medical History: Nil

Name	Mrs SIMRAN GEHLOT	UHID	HNH-00015065
IP No	IP26-00006429	Admission Date	25-05-2026

Surgical History: Nil
Family History: Father- DM
Allergies: Nil

Antenatal Details:
Mrs SIMRAN GEHLOT was booked to Rainbow hospital at 5 weeks of gestation. She had regular antenatal checkups and investigations as advised. Viability scan done on 08.05.2026 showed single live intrauterine gestational sac with good cardiac activity. She was admitted at 10^{+1}weeks with complaints of vomitings and giddiness

Investigations: Enclosed
Blood Group: ' O positive '

Management: Patient came with complaints of 5-6 episodes of vomitings associated with giddiness. On admission her vitals were stable. Signs of dehydration present. Urine ketones done - 3+.Serum electolytes, CUE,LFT,CBP were done and traced to be normal. Bedside USG done showed Single intrauterine gestational sac with good cardiac activity. She was started on conservative line of management with IV fluids . Patient recovered well with this management. There were no further episodes of vomitings at the time of discharge.

Advice:
1. Tab.Ondansetron 4mg twice daily(9am-9pm) before food.
2. Syp.Gelusil MPS 10ml thrice daily .
3. T. Folvite 5mg once daily (9am)after breakfast
4. T. Duphaston 10mg twice daily (10am-10pm) after food.
5. Plenty of oral fluids.
6. Avoid spicy food intake with Frequent meals.

Name	Mrs SIMRAN GEHLOT	**UHID**	HNH-00015065
IP No	IP26-00006429	**Admission Date**	25-05-2026

7. NT Scan + FTS - 11.06.2026 to 16.06.2026

Review with **Dr.Swapna Samudrala** with **NT scan** at Rainbow Himayatnagar hospital.

In case of emergency like bleeding, fever kindly contact 9154865045

You can also take appointments at any time by going online to our website www.rainbowhospital.in

Registrar/Resident/C.M.O

Dr. SWAPNA SAMUDRALA
OBSTETRICIAN & GYNAECOLOGIST
69924

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
Dr. SWAPNA SAMUDRALA

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	01			
2	Discharge Summary				
3	Nursing Initial assessment	01			
4	Patient Transfer form	—			
5	In-patient Medical record	01			
6	Doctors progress sheets	01			
7	Nursing plan of care and handover sheets	01			
8	Consultation sheet	—			
9	General consent for treatment	—			
10	Consent for Surgery	—			
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)	—			
22	Neonatal Admission/Delivery/Physical Exam	—			
23	Medication Reconciliation	01			
24	Emergency Triage record	—			
25	Pre operative check list	—			
26	Surgical safety checklist	—			
27	Operation Theatre notes	—			
28	Nurses clinical Presentation	—			
29	TPR & BP chart	—			
30	Intake and Out take chart (fluid chart)	01			
31	Drug chart (Regular Prescription)	01			
32	Investigation Values (result sheet)	01			
33	Nebulization chart	—			
34	Nutritional review chart	—			
35	Intensive care unit (ICU Charts)	—			
36	Consent for Admission in PICU / NICU	—			
37	The Humpty dumpty scale	—			
38	Braden Q Scale	01			
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	—			
	Extra Pages	06			
	Total No. of Pages	20			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : 26/6/26

(P.T.O)

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006429 **Admit Date** : 25-May-2026 **Admit Time** : 08:13 PM **UHID** : HNH-00015065

Patient Details :

Patient Name	: Mrs SIMRAN GEHLOT	**Age**	: 26 Y
Guardian	: Mr VIJAY BHATI	**DOB**	: 01-01-2000
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 93,jawahar rail colony,jupiter colony,sikh village,bowenpally New Bowenpally Hyderabad Telangana INDIA 500011	**Phone No**	: 9704305137/ 7674923783
		E-mail	: na@gmail.com

Admission Details :

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

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

Contact Details :

Name	: Mr VIJAY BHATI	**Relationship**	: Husband
Contact Address	: 93,jawahar rail colony,jupiter colony,sikh village,bowenpally New Bowenpally Hyderabad Telangana INDIA 500011	**Phone No**	: 9182199107

Signature

Doctor Details :

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

Payment Details :

Payment Mode	: DC/CC Card	**Deposit Amount**	: 15000.00
		Payor Name	: SELFPAY

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ACTIVITY RECORD FOR BILLING

Name: ------ HNH-00015085 (P26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
Dr. SWAPNA SAMUDRALA

UHID No : --- -------- Consultant : ---------- Dept : ----------

Date of Admi: ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
25/5/26	CBP Sr. Electrolytes,	26008839	Ali
	LFT	8839	Ali
25/5/26	VBG	8840	Ali
25/5/26	GRBS 8:30pm Tomorrow	8841	Ali
25/5/26	Urine ketones (3+)	202104	Ali

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
25/5/26	Infusion pump	9:00pm		202103	

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
25/5/26	IV placement	(1)	202102	AC

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
Dr. SWAPNA SAMUDRALA

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 22/5/26 Time of Admission : 7:30 pm

Allergies: NIL ☑ Not know any drug allergies

PRESENTING COMPLAINTS :

- c/o vomitings - 5-6 episodes - today
- c/o dizziness / giddiness → 2 episodes today
- No H/O intake of outside food LOC (+)
-

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 2 yrs.	Parity : P1L0M1
Previous Periods : Regular	Mode of Delivery : -
LMP : 11/3/26, c/EDD-20/12/26.	Last Child Birth : -
Contraception : -	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil	Nil

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
Dr. SWAPNA SAMUDRALA

Father DM

MEDICATION HISTORY:

On T-FA & T. Dyphaston 10mg BD
& T. Doxinate BD

INITIAL ASSESSMENT :

Date 25/5/26
Ht. 158 Wt. 75kg
BMI
B.P 110/63mmHg
Pallor (-) PR-80bpm
CVR S1S2(+)
Respiratory System B/L NVBS
Thyroid (N)

Breasts
(N)

Abdominal Examination
P/A - Soft
FHR — Good CA(+).
(Bedside USG)

Local/Speculum Examination
—

Bimanual Pelvic Examination
—

PROVISIONAL DIAGNOSIS : Primi / 10+1 wks c Hyperemesis gravidarum.

INVESTIGATIONS ORDERED

Blood Group - "O positive"
Hb-
Plt-
WBC-
HIV, HBsAg, RPR] Not done.
Urine ketones 3(+)

USG (8/5/26) ~ 7 wks 4 d
SL IUG, @. CA(+)
CRL - 16.1mm (~ 7 wks 4 d)

PLAN OF MANAGEMENT

- Observation
- CBP, Serum electrolytes, LFT,
- IV fluids *GRBS
- NBM
- Inj- Emeset IV 4mg BD 8mg stat if b.
- Inj Pantop 40mg IV BD

Name of the Doctor : Dr. Swapna Samudrala
Signature of Doctor
Date & Time : 25/5/26 @ 7:30pm

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
Dr. SWAPNA SAMUDRALA

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 12AM.	No complaints	
	vomitings ↓	C/O : awaited
	diarrhea ↓	GRBS @ admission : 7mg/dl
	GC fair, afebrile	CBP : (N)
	vitals (N)	CRP
	PR : 82/min	electrolytes } (N).
	BP : 100/62 mmHg	VBG
	PA : soft	
		tolerating oral liquids
	Adv	: liquid diet overnight
		IV fluids as advised
		soft diet as tolerated
		drugs as charted
		I/O charting.
	Ramya	Dr RAMYA THOTA
26/5/26 6AM	tolerated oral fluids.	
	No further vomitings	
	GC fair, afebrile	
	vitals (N)	
	PA : soft	
	S/O : (N)	Ramya Dr RAMYA THOTA

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

(P.T.O)

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/5/26 8:30am	c/s/B Dr. Veena	
	Primi / 10+2 wks / Hyperemesis	
	No further eps. of vomiting	Adv
	O/E GC fair, Afebrile	- Soft diet.
	No signs of dehydratn	- Drugs as charted.
	vitals - stable	- I/O chart up.
	P/A - Soft, NT	- IV Fluids - for maintenance
	FHR (+) (checked on scan)	- Inform SOS
	L/E - NAD	
26/5/26 11:45 AM	Primi / 10+2 / Hyperemesis	
	No further Episodes.	Tolerated Soft Diet well.
	Pt comfortable	
	O/E - GC fair	Adv
	Afebrile	- Can be discharged
	Vitals - (N)	- Oral hydration
	P/A - Soft.	- T. Doxylamine BD before food
		- Syp. [illegible] MDS. 10 ml / BD.
		- Cont. prev. medications
		- R/c after scan.
Patient / attenders counselled.		

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
Dr. SWAPNA SAMUDRALA

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RESULT SHEET

Date	25/5/18					
Time	8:35 pm					
Hb	12.1					
PCV	34.6					
RBC	5.70					
WBC	8.69					
N/L						
Platelets	304					
CRP						
ESR						
PCT						
RBS						
Na	138					
K	4.0					
Cl	107					
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP	54					
SGPT	29					
SGOT	20					
T.Bill/Conj	0.5/0.2					
T.Protein	7.2					
S.Albumin	4.1					
S.Globulin	3.2					
A/G Ratio	3.2					
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		O+ve				

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
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	TAB. FOLICACID	Hab	P/O	OD	25/5/26	☐C ☐DC
2	TAB. DOXINATE	1Hab	P/O	BD	25/5/26	☐C ☐DC
3	TAB. DUPHASTON	10mg	P/O	BD	25/5/26	☐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. G. Veena

Date & Time : 25/5/26 @ 8 pm.

Nurse Name & Signature: .....

Date & Time : 25/5/26 8 p.m

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

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
Dr. SWAPNA SAMUDRALA

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DRUG CHART

Date of Admission: 28/1/26 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 *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

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

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

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

SOS / PRN (As Required Medication)

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

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

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

Sign ..... VERIFIED BY : Name .....

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
Dr. SWAPNA SAMUDRALA

REGULAR PRESCRIPTIONS

Weight. 74 Ward. LD1

DRUG : INJ. ONDANSETRON

Dose	Route	Frequency	Start Date
4mg	IV	BD	25/5/26

Date/Time: 26/5 6AM

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: 6pm

Daily Doctor's Endorsement by a Sign

DRUG : INJ. PANTAPRAZOLE

Dose	Route	Frequency	Start Date
40mg	IV	BD	25/5/26

Date/Time: 26/5 6AM

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions: Before food 6pm

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date/Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Date

Date/Time

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
Dr. SWAPNA SAMUDRALA

Weight. 79kg Ward. LDR

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
25/5/26	7:30pm	INJ. ONDANSETRON	8mg	IV	[illegible]	[illegible]
25/5/26	7:30pm	INJ. PANTAPRAZOLE	40mg	IV	[illegible]	[illegible]

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

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
Dr. SWAPNA SAMUDRALA

I.V. FLUIDS CHART

Weight. 74/09 Ward. UDR

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
25/5/26	9:05pm	DEXTROSE NORMAL SALINE	IV	100ml/hr			26/5/26		
25/5/26	9:05pm	RINGER LACTATE	IV	500ml/hr			26/5/26		
26/5/26	2:29AM	RINGER LACTATE	IV	150 ml/hr			26/5/26		
26/5/26	6:00am	RINGER LACTATE	IV	150 ml/hr			26/5/26		
26/5/26	10AM	RINGER LACTATE	IV	100 ml/hr					

Signature .....

VERIFIED BY : Name .....

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
Dr. SWAPNA SAMUDRALA

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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

25/5/26	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
	0 - 10																								
Saturations	94 - 100 %												100%			100%			100%			99%			99
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37												97.6F			—			97.8F			97			
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80												84			80			85			85			
	70																								
	60																								67
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90												108			108			104			103			97
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60												53			62			65			47			60
	50																								
	40																								
NEURO RESPONSE [✓]	Alert												—			—			—			—			—
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30												—			—			—			—			—
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal																					—			
	Heavy / Foul																								
Liquor	Clear / Pink																								
	Green																								
TOTAL YELLOW SCORES													0			0			0			0			0
TOTAL ORANGE SCORES																						0			
Nurse Initial																									

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 28 Y (F)
Dr. SWAPNA SAMUDRALA

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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

26/5/26

		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																							
	0 - 10																									
Saturations	94 - 100 %		99																							
	< 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		85																							
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90		100																							
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80		74																							
	70																									
	60		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																							
TOTAL ORANGE SCORES			0																							
Nurse Initial																										

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
Dr. SWAPNA SAMUDRALA

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm	RL		500ml								
	09:00 pm	RL+ORS		200ml						250ml		
	10:00 pm	RL+ORS		200ml						150ml		Passed
	11:00 pm	RL+ORS		200ml						200ml		passed
	12:00 am	RL+ORS		200ml								
	01:00 am	RL+ORS+H2O		200ml								
Total Intake :						**Total Output :**						
	02:00 am	RL	SOUP	150						100ml		
	03:00 am	RL	H2O	150ml								
	04:00 am	RL		150ml								
	05:00 am	RL		150ml								
	06:00 am	RL		150ml								
	07:00 am	RL	H2O	150ml								
Total Intake :						**Total Output :**						

Total 24 hrs. Intake	24000 ml	Total 24 hrs. Output	700ml total.

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1. All measurements in ml.
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		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	RL	Daily	100ml						150ml		
	09:00 am	RL		100ml							0	
	10:00 am	RL		100ml			NA			100ml		
	11:00 am	RL		100ml						100ml		
	12:00 pm	RL		100ml								
	01:00 pm	RL		100ml								
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

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

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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 25/5/26.

Baseline Information:

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

Primary Language: ☐ Telugu ☐ English ☑ Hindi ☐ Others

Do you require an interpreter? ☐ Yes ☑ No

Source of Information: ☐ Patient ☐ Family ☐ Others

Personal belonging if any: ☐ Jewelry ☐ Nose Ring ☐ Bangles ☐ Anklets ☐ Finger Ring ☐ Bracelets

handed over to .....

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

If yes , identify .....

Chief Complaints: .....

Hyperemesis

Doctor Notified on Admission: ☐ Yes ☐ No

Name of the Doctor: Dr Ramya Devi

Time Notified: 7:10pm

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

Past Medical History	Past Surgical History	Previous Hospital Admission
-	-	-

Blood Group: O+ve LMP: - EDD: - Gestational age during admission: -

Contractions: NIL Vaginal Discharge: NIL

Obstetric History: G ..... P ..... L ..... A ..... Previous LSCS NIL

Height: 158 Weight: 49 BMI: .....

Temp: 97.6°F HR: 84 RR: 20 BP: 108/73 SpO_2 100%

High Risk Factors: (Please select by ticking (✓) the box as applicable)

☐ Hypothyroidism	☐ Rh Incompatibility	☐ Fertility Treatment
☐ Hyperthyroidism	☐ Previous LSCS	☐ Preterm Labour
☐ Hypertension	☐ Gestational Hypertension	☐ Others: (Specify)
☐ Diabetes	☐ Bad Obstetric History	
☐ Anemia	☐ Obesity (BMI)	
	☐ Twins / Multiple Pregnancy	

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Family History: ☑ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

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

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

Risk of Pressure Sore: ☐ Yes ☑ No Score ..2.. (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:

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

☐ Under Weight ☐ Diabetes Mellitus ☑ No Abnormality Detected

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 ..family member..

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 Simran..

Orientation not given Reason: .....

Nurse Signature: ..Neeti..

Nurse Name: ..Neeti..

Date & Time: ..25/4/26 8pm..

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CHECKLIST FOR THROMBOPHLEBITIS

25/5/26. 26/5

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			NCA	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			NCA	-						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NCA	-						
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			NCA	-						
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			NCA	-						
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			NCA	-						
		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 : .....

Docu. No. : RCH /FRM / CLINICAL / 137

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	25/5/26	26/5/26		Fall Risk Grading		
		Score	8pm	Nb				
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0	0	0		Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0						
IV / Heparin Lock or Saline	Yes	20	20	20		Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0		High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
Mental Status	Forgets limitations	15						
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20	20				
		Signature	Nai					

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

Patient Sticker

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Morse Fall Risk Assessment Form

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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BRADEN 'Q' SCALE

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					Date : 25/06/25			
					Time : 8pm	06		
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		
"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		
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		
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		
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		
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		
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		
				TOTAL SCORE	28	28		
				Evaluator's Name				

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

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

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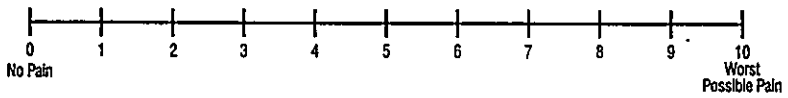
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
25/5/26	10pm	0/10	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	Normal	[signature]
26/5	4Am	0/10	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	ND	[signature]
26/5	8Am	0/10	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	ND	[signature]
26/5	1Pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

HNH-00015065 IP26-00006429
Mrs SIMRAN GEHLOT
01-01-2000 26 Y (F)
Dr. SWAPNA SAMUDRALA

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NURSING CARE RECORD

Date: 25/5/26.

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				NA			
Afternoon							
Night	8pm – 8AM	→ Assess the patient condition → plan for vital recored → plan for IV fluids → plan for Tocharts	8pm – 8Am	→ Assessed the Pt condition → Maintain vital → continue IV fluids → Maintain Tochart	→ Patient stable	→ vitals Normal	[illegible signature]

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NURSING CARE RECORD

Date: 26/5/26

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 as per doctor -> maintain I/O chart & record.	8Am | 2Pm	-> Assessed the pt condition -> monitored the vitals & recorded -> Maintained I/O chart & recorded -> Administered medication as per doctor order	maintain I/O chart & record.	pt is stable.	Akhila (signature)
Afternoon							
Night							

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NURSING SHIFT HAND OVER FORM

SITUATION

Diagnosis: Hyperemesis Gravidarum

Any Infection: ☐ Yes ☐ No ~~☐ Not Known~~
If Yes Specify: .....

Surgery / Procedure:

Post OP Day:

BACKGROUND

Date / Shift	25/5 8pm	26/5 nb				
Medical Condition (Any special condition to be noted):		-				
Diet:	NBM	~~soft diet~~				

ASSESSMENT

Allergy:	☐ Yes ☐ ~~No~~	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Ventilation (RA, NP, NIV, VENTI):	~~RA~~	-					
Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ ~~No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vital Signs: Temp:	~~98.5 F~~	99°F					
Res:	20	20bmt					
SpO_2:	99%	99%					
Pulse:	69	83bmt					
BP:	94/63	100/60					
LOC:	-	-					
Fall Risk Score:	-	-					
Pain Score:	-	0/10					
Skin Integrity	Good	Good					

Recommendations

Safety Needs:	~~☐ Yes~~ ☐ No	~~☐ Yes~~ ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physiotherapy:	-	-					
Others Specify:	☐ Yes ~~☐ No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Special Diet:	NBM	~~soft diet~~					
Critical Lab Test / Values:	-	-					
Other Special Orders / Medications:	☐ Yes ~~☐ No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
PU Prophylaxis:	☐ Yes ~~☐ No~~	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
ADL (Dependent / Non Dependent):	~~Dep~~	-					
Post Operative Procedure Special Orders:	-	-					
Handed Over By Name :	Alex	Akhila					
Signature / ID :	Alex						
Date:	26/5/26	26/5/26					
Time:	8Am	2Pm					
Taken Over By Name :	Akhila						
Signature / ID :							
Date:	26/5/26						
Time:	8Am						

Patient Sticker

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							