

Name Mrs SWATHI BAKKI **UHID** HNH-00016509
Father/Guardian Mr MANISHARMA **Age/Gender** 36 Y 7 M 0 D/ Female
Address b-7,f-15, baghlingampally, hyd, Bagh Lingampally, Hyderabad, Telangana, INDIA, 500044
IP No IP26-00006941 **Admission Date** 24-07-2026
Ref Doctor Self.
Discharge Date 28.07.2026

DISCHARGE SUMMARY

Consultant:

Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

Diagnosis: G2A1 AT 30 WEEKS WITH EARLY ONSET FETAL GROWTH RESTRICTION STAGE- II WITH ABSENT END DIASTOLIC FLOW WITH BREECH PRESENTATION WITH GESTATIONAL HYPERTENSION WITH KNOWN CASE OF HYPOTHYROIDISM WITH ADVANCED MATERNAL AGE FOR OBSERVATION

EMERGENCY LOWER SEGMENT CESAREAN SECTION DONE ON 25.07.2026

History:

LMP: 26.12.2025
EDD: 02.10.2026

Obstetric formula: G2A1
Gestation at admission: 30 weeks

Name	Mrs SWATHI BAKKI	UHID	HNH-00016509
IP No	IP26-00006941	Admission Date	24-07-2026

Obstetric History:

G1 - 2024 - 5 wks - Spontaneous Complete Miscarriage. Sr Bhcg +ve
G2 - Present Pregnancy, Spontaneous conception.

Medical History: K/C/O Hypothyroid since 2019 (On T. Thyronorm 75 mcg)

Surgical History: Nil

Family History: Mother Hypothyroid

Allergies: Nil

Antenatal Details:

Mrs SWATHI BAKKI was booked to Rainbow hospital at 28⁺¹ weeks of gestation. She had regular antenatal checkups and investigations as advised elsewhere. NT + Double marker : Low risk, Screen +ve for PE, Started on T. Ecosprin 150 mg. TIFFA - B/L urinary tract dilatation, rest Normal. Growth Scan done at 28 wks (10/7/26) showed SLF ~ 28 weeks, AGA fetus normal Liquor with Unilateral Right pelvictasis Urinary Tract Dilatation- A1 (Low risk). At 29+4 weeks, she was admitted elsewhere with Gest HTN + ? Cellulitis - PE Profile done was Normal, started on T. Labetalol 100 mg /BD,T. Augmentin TID (GS / Steroids - Not Done).She came to Antenatal OP (24/7/26) with C/o facial puffiness with pedal oedema with fluctuating Home BP recordings. Growth Scan done on 24.07.2026 showed SLF at 30 weeks with Breech presentation, Placenta Posterior high, Liquor Adequate, AFI 17.7 cm, 1281 gm (9 % / AC 2 %) S/o FGR Stage 2, Umbilical Artery Doppler shows Occasional AEDF, CPR 0.58, DV Forward flow. Urine albumin done was trace. Patient and attender were counselled regarding the present Maternal Condition / Scan finding showing

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FGR Stage 2 with Occassional AEDF. Explained regarding need for Admission / Close maternal and fetal monitoring / steroid cover / Mgso4 for Neuroprotection and plan Delivery SOS and regarding risk of IUFD in conservative Management. Neonatologist counselling was done. She was admitted at 30weeks for Observation and Delivery.

Investigations: Enclosed.
Blood group: "B" Positive

Management: Course in hospital:

At admission on clinical examination BP was 140/90mmHg, generalised oedema (periorbital, abdominal, bilateral pedal edema) with ascites was noted, uterus was relaxed. Fetal well being was confirmed by an admission NST which was found to be reactive. PE profile sent and traced to be normal, Physician opinion taken and Antihypertensive revised. Strict BP monitoring was done. Antenatal corticosteroid coverage was done (Inj Betamethasone 12 mg/ Im/ 2 doses) and Inj MgSo4 for neuroprotection in anticipation of preterm delivery. Axon Consultation and Cardiologist opinion was sought in view of SOB since 2 days . Maternal 2D Echo done was normal. AFI + doppler scan (25.07.2026) showed AFI 17.9cm and UAD showing Absent end diastolic flow, CP ratio - 0.57. DV shows forward flow. She had Fluctuating BP recordings (with 2 Antihypertensives) with decreased perception of fetal movements. NST done showed Variable decelerations. Couple was counselled regarding present maternal and fetal condition , scan findings, regarding complication- abruption/ pre-eclampsia - Eclampsia, Renal failure, Haemorrhage, need for blood tranfusion, Post operative maternal ICU care, Ventillation support, regarding

Name	Mrs SWATHI BAKKI	UHID	HNH-00016509
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neonatal prognosis, prolonged NICU care, prematurity complication, postnatal evaluation and need for Emergency LSCS. She was prepared for Emergency C-section in view of Fluctuating BP with FGR stage 2 with AEDF with breech presentation with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anesthetic premedication (IV Pantop and Perinorm) given. Antibiotic prophylaxis with Inj. Taxim. 1 gm IV given. Patient shifted to theatre.

Surgery Notes:

Under general anesthesia she was painted and draped as per hospital protocol. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Subcutaneous fat approximated. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 800 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

*** LUS not formed, vascular.**

*** Baby delivered by breech extraction.**

Delivery Details :

Date : 25.07.2026

Name Mrs SWATHI BAKKI
IP No IP26-00006941

UHID
Admission Date 24-07-2026

Time of Delivery: 01.08pm
Type of Delivery: Emergency lower segment caesarean section
Indication : Fluctuating BP with FGR Stage II with AEDF with breech presentation
Anaesthesia : Spinal

Baby Details:

Date : 25.07.2026
Time : 01.08pm
Sex : Female
Weight : 1.2kg
Apgar : 4,6,8
Gestational Age: 30 weeks
NICU Admission: Yes, Prematurity

Post-Operative Notes:

She was closely monitored. Her vital signs remained stable. Uterus was well retracted with no Postpartum hemorrhage. Breast feeding initiated. Strict vital monitoring was done. Physician opinion was sought in view of high BP recordings. She was shifted to room. On second postoperative day dressing was changed. On inspection wound was healthy. Bedside Physician Opinion was sought and antihypertensive revised. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

Advice:

Name	Mrs SWATHI BAKKI	UHID	HNH-00016509
IP No	IP26-00006941	Admission Date	24-07-2026

1. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 29.07.2026 (8am-2pm-10pm) after food.
2. Tab. Pantop 40mg twice daily till 31.07.2026 (7am-7pm) before food.
3. Inj. Clexane (Enoxaparin) 40mg once daily subcutaneously till 31.07.2026
4. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
5. Tab. Shelcal (Elemental Calcium 500 mg, Vitamin D3 250 IU) once daily (2pm) till breast feeding for after food.
6. Nebasulf Powder for local application.
7. Tab. Labetalol 100 mg twice daily (9am -9pm) till further orders
8. Continue Tab Thyronorm 75mcg Once daily till further advice.
9. Repeat FT3, FT4, TSH after 6 weeks and review.
10. TED stocking x 2 weeks.

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

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

Review with **Dr. SWAPNA SAMUDRALA** after **2 week** on **11.08.2026** at Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

For Women Who Have Had a Caesarean Section

Name
IP No

Mrs SWATHI BAKKI
IP26-00006941

UHID

Admission Date

HNH-00016509
24-07-2026

Care of the wound:

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

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

Patient/ Attender

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

Consultant:

Dr. SWAPNA SAMUDRALA
MBBS, MS (OBG)
69924

Registrar/Resident/C.M.O





Adult

PEDIATRIC ECHOCARDIOGRAM REPORT

Situs	Levocardia . &
Cardiac Position	Situs Solitus
Systemic Veins	}
Pulmonary Veins	
Atrio ventricular connection	
Ventricular arterial connection	
Great artery relationship	
Right atrium	
Left atrium	
Inter atrial septum	
Mitral Valve	
Tricuspid Valve	
Right ventricle	}
Left ventricle	
Inter ventricular septum	
Aorta and aortic arch	
Pulmonary artery and branch PA	
Aortic Valve	
Pulmonary valve	
Coronaries	
PDA	
Pericardium	
Others	

Doppler

	Gradients	Regurgitation
Mitral flow		
Tricuspid flow	1.3 m/s	
Aortic flow	1 m/s	
Pulmonary flow		

Mitral	E'	1.0	A'	0.6	S'
Medial LV	E'		A'		S'
Tricuspid	E'		A'		S'
Time Intervals	IVRT		IVCT		DT
Others					

MEASUREMENTS

Parameter	Absolute (cm)	Z Score	Parameter	Absolute (cm)	Z Score
AO	2.3		Tricuspid Annulus		
LA	3.3		Mitral Annulus		
IVSd	1.0		Aortic Annulus		
LVIDd	3.8		PA Annulus		
LVPWd	2.0 1.0		RPA		
IVSs			LPA		
IVIDS	2.6		MPA		
LVPWs			AO Isthmus		
EF	70%		LV Mass		
FS	38%		Others		

IMPRESSION

Normal Chamber Dimensions

No RWMA.

Good LV fn

Normal Diastolic fn

No AS/AR

Trivial MR/TR

Good RV fn

No PAH

Very thin rim of pericardial fluid

[Signature]

Dr. Jadhav

PERFORMED BY:

DEFICIENCY CHECK LIST OF CASE SHEET

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

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

H-00016509 IP26-00006941
Mrs SWATHI BAKKI
28-12-1989 36 Y 6 M 28 D (F)
Dr. SWAPNA SAMUDRALA



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

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

CROSS CONSULTATION FORM

Doctor Name : Date : Time :
Diagnosis :
HNH-00016509 IP26-00006941
Mrs SWATHI BAKKI
28-12-1989 36 Y 7 M 0 D (F)
Dr. SWAPNA SAMUDRALA

Hospital :

Type of Referral :

☐ Emergency

☐ Urgent

☐ Non Urgent

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

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

Signature:

Findings and Recommendations :

S/B Dr. Tadhan.

→ IUGR planned for termination

30 wks

F = 91/min

BP = 132/90 mmHg

CUS/RP = NAD

sPO₂ = 96%

Echo = Good LV & RV for
No RHMA.

Consultant :

Name : Signature : Date & Time :

Adv

① ECG

② PT can be taken for
urgent procedure, under
mild risk

③ IV heparin 20mg sos.

~~④~~ ④ DVT stocking or

Inj enoxaparin 60mg sc qd.

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00016509 IP26-00006941 Mrs SWATHI BAKKI 28-12-1989 38 Y 7 M 0 D (F) Dr. SWAPNA SAMUDRALA 		Date & Time of Admission 24/6/26 @ 12:20 PM	Date & Time of Transfer Order 26/7/26 @ 12:20 PM
		Transfer Ordered by Dr. Dua	Reason for Transfer observation
From Unit Pre & post	To Unit	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 30	Number of Imaging Films RST - 4 ECG - 1	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☒ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.			
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☐ No ☐			
Name & Signature of Person who is Transferring Arun / A		Name of Person Ordered Transfer Dr. Dua	
Patient & Clinical Records Received by : Doya			
Date & Time of Patient Received : 26/7/26 @ 12:20 PM			

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

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

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006941 Admit Date : 24-Jul-2026 Admit Time : 05:53 PM UHID : HNH-00016509

Patient Details :

Patient Name	: Mrs SWATHI BAKKI	Age	: 36 Y 6 M 28 D
Guardian	: Mr MANISHARMA	DOB	: 26-12-1989
Gender	: Female	Religion	:
Occupation	:	Martial Status	:
Address (H)	: b-7,f-15, baghlingampally, hyd Bagh Lingampally Hyderabad Telangana INDIA 500044	Phone No	: 9010645866/ 9705890539
		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 MANISHARMA Relationship : Husband
Contact Address : b-7,f-15, baghlingampally, hyd Bagh Phone No : 9010645866
Lingampally Hyderabad Telangana INDIA 500044


Signature

Doctor Details :

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

Payment Details :

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

17

28
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

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ACTIVITY RECORD FOR BILLING

Name: ----- HNH-00016509 IP26-00006941
Mrs SWATHI BAKKI 36 Y 6 M 29 D (F)
28-12-1989
UHID No: ----- Dr. SWAPNA SAMUDRALA
Date of Admission ----- Date of Discharge: ----- Time: -----
Room / Bed No: ----- Ward: ----- Suggested Billable bed type: -----



WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
25/7/26	12:20pm	Pre & Post	OT	Akhila / Puga
25/7/26	2:40pm	OT	Pre-Post	Karuna / Chudh
25/7/26	12:20pm	Pre & Post	IToor	Akhila / Chudh

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. (M. Tejaswini)	24/7/26	16693	Chudh
2.	Urine Albumin dipstick	24/7/26	16694	Chudh
3.	(T race.)			
4.	Dr. Karthik (Cardiologist)	25/7/26	16753	Chudh
5.				Chudh / Akhila
6.	Dr. Nisanth Reddy	27/7/26	17532	Chudh
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
24/7/26	Spot protein/Creatinine Ratio	12502	Cundy
24/7/26	NST - (1)	9062	
24/7/26	NST - (2)	9061	
25/7/26	NST - (3)	9064	Cundy
25/7/26	Ech - (1)	009070	A
25/7/26	NST - (4)	9097	Cundy
25/7/26	AFI + Doppler	9096	Cundy
25/7/26	placenta Histopathology	12568	Anker
			(2) check Jonesy Anker.
			Cross checked done 24/7/26.

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
24/7/26	Infusion pump	24/7 7.30pm	26/7 8.30am	16691	Chudr
24/7/26	Cardiac monitor	7.30pm		16739	Chudr
cross check done by Akw 26/7/26 @ 11:30 AM Cross checked done 24/7/26					

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
24/7/26	IV placement	(1)	16692	[Signature]
25/7/26	2 DECHA	004070	009000 9066	[Signature]
25/7/26	PAC		16849	[Signature]
25/7/26	catheterisation		16848	[Signature]
2				
26/7/26	NHA	(1)	7302	[Signature]

Cross check done by Akela

Cross checked done 27/7/26

ANY OTHER INFORMATION

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.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes			Doctor's Order	
	BP	pulse	spo2	output	Medications
8pm	142/97(103)	90 bmt	99%	300ml.	Tab Labet 100mg given
9pm	143/98(101)	89 bmt	98%	—	—
10pm	143/87(98)	90 bmt	97%	250ml	Tab Nifedipine 10mg given.
11pm	131/67(84)	92 bmt	97%.	400ml.	—
12AM	135/68(86)	90 bmt	98%	—	—
1AM	136/77(92)	92 bmt	97%.	—	—
2AM	130/80(90)	91 bmt	98%.	230ml	—
3AM	126/67(86)	90 bmt	97%.	—	—
4AM	119/72(85)	88 bmt	98%.	400ml	—
5AM	122/65(89)	90 bmt	97%.	—	—
6AM	127/81(94)	89 bmt	98%.	—	Tab Nifedipine 10mg given
7AM	124/82	90 bmt	97%.	300ml	—
8AM	132/93	91 bmt	98%.	—	—
9AM	125/90	97 bmt	98%.	—	—
10AM	121/72	91 bmt	97%.	300ml	—
11AM	109/69	95 bmt	98%.	—	—

IP26-00006941

26-12-1982

38 Y 7 M Q D

(F)

Dr. SWAPNA SAMUDRALA



**Rainbow[®]
Children's
Hospital**
It takes a lot to treat the little.



BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

Adman/obstruction ↓ Safe confinement
PPM ⊕

Obstetric Formula: G₂A₁

Obstetric History:

G₁ - 2024 - SUE / Sp. mislunge
Srbtice Ave

G₂ - PP, spm Conate

Present Pregnancy Record: 3 weeks @ 28th week

NT + PIS - U₁ ⊕ for PE - 200gm 150mg
TIPPA - 31/12 urinary tract D/LA instn

Hospital Adm (Elosarlu) @ 29th week -

RISK FACTORS: GHTN + 9 cellulosid ⊕ 7.6 but 100mg 80

NICU Connelly den ✓ [T. Augmentin 750
PEPridel ⊕]

LMP: 20/12/2015

EDD: 2/10/2016

Corrected EDD:

GA:

Menstrual History: Regular: ☐ Yes ☐ No

Obstetric Examination

Fundal Height: ~30 cm

Ut. Activity: ☒ Relaxed ☐ Mild ☐ Mod ☐ Severe

Liquor: ☒ Adequate ☐ Oligo ☐ Poly

PP: ☐ Cephalic ☒ Breech Others _____

Head Fifts Palpable: _____

FHS: ☒ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

NA clow

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination

NA clow

Cervix: ☐ Long ☐ Partially effaced ☐ Effaced

Os: Closed _____ Dilated _____

Membranes: ☐ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☐ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☐ Adequate ☐ Doubtful

Height: 150 cm

Weight: 83.80 kg

BMI = 39.11

Allergies: _____

Breast: ☒ Normal ☐ Abnormal

General Examination: For

Consciousness: ⊕

Pallor: 9 Ashwell

Icterus: ⊕

Edema: ⊕ Ant

Temp: Afebrile

PR: -99

BP: 143/91

DTR: ⊕

CVS: J ⊕

RS ⊕ 502

Liver/Spleen: J ⊕

Urine Output: Ad

DIAGNOSIS

G₂A₁ / 30wnt Early
For stage II - occasional
for observation / GHTN / Breech



Family History: MTH Hypertension	Surgical History: Nil
Medical History: H/O Hypertension (2019)	Medication History: 7. Levogem + Cephalosporin BD 7. Thyronorm 75mg 7. Escopon 150mg OD (Spm) 7. Cebit 100mg BD
Plan of Care: Admission for MgSO ₄ for Neuroprotection + Steroid cover Neonatal Care Inj Betadine 12mg im (20 Dec 3:45 PM) Collect AB profile FHR monitoring 2nd hourly NST GR hourly DFR / RLP Continue Antacid meals Start BP monitoring physiotherapy U/O monitoring W/F S/S for Preeclampsia AP1 Doppler Scan Qm	Investigations: <u>NMC</u> ✓ B9T B+ve U.Arb - Trace <u>calm</u> <u>24/12</u> Feb-10-3 PLT - 180 WBC - 6.78 CS @ 28 wk (10/12/2021) → @ 28 wk A.C.A.P.A.S / AP1 Adeq @ U/C at Pelvic exam U/D A1 (LE) <u>USG (24/12/2021)</u> SFL 30cm / Breech EFW 1.281 kg AC 27 AP1 17.7cm PL P/H S/o FGR S/LC-2 UAD- OCC AEDP, CPR-0.58 DU - Forward Plac

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

Doctor Name: Dr. Manohar

Signature: [Signature]

Date & Time: 24/12/2021 @ 5:30pm

Consultant Name: Dr. Swapna Samudrala

Signature: [Signature]

Date & Time: 24/12/2021

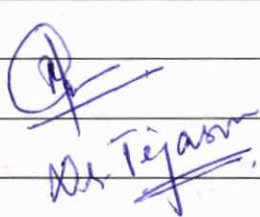
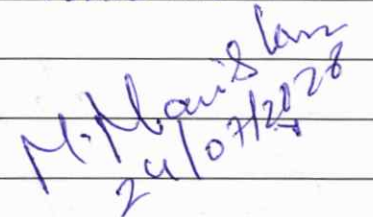


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7/26 4:30pm	<u>Counselled Note</u> (Dr. Tjani Rely)	at 30 wk. (PT)
	- Scan - Absent End diastolic flow (Indicates decreased blood supply to baby) - DBS. Try to deliver as early as possible. Try to give steroid (2) doses / get more benefit after 2 hours of last steroid dose.	
	<u>LUNGS</u> →. Mostly baby (PT) need Respiratory support If distress (due to <u>weakness</u> of diaphragm). ↓ see for CXR / ABG / USG chest a/c If <u>HMD</u> - Need of surfactant (for expansion) If Expansion good. →. ct respiratory support & ↓ distress.	
	<u>Feeding</u> :- PT - high chance of feed Intolerance. that too If PT & ↓ diastolic flow - chance. Increase more Keep NPO for 2 hrs - later try EBM/donor milk. gradually Increase feeding a/c to feed tolerance of baby along with necessary IV fluids.	
	Intubation - PICC / central line. ⇒ Given IV fluid / ? TPN a/c to need.	



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>PICC</u> - (1) multiple cannulae. Infections / sepsis.	
	<u>[Levis]</u> - To R/o congenital disease / <u>PDA</u> (commonly seen in premature babies. If any <u>PDA</u> - Try Medical / Surgical Mx. ↓ <u>a/c</u> to condition.	
	- 85% PDA done by Med Mx If not / severity - Try Sx. If @ / no symp - d/s & f/u as directed	
	<u>[Brain]</u> - PT high chance of - IV Bleeding (IVH). Also screenings will be done during stay.	If +nt - ↑ Risk
	<u>[Sepsis]</u> - High prone to sepsis / start Antibiotic. & upgrade / blood culture a/c to sepsis screen & B/lp reports.	
	<u>d/s criteria</u> :- 34wk / > 10kg / noncubic not gain on RA / with out sepsis / No other ongoing complications.	
	Taken > 1 month of NICU stay (requirement) a/c to condition.	
	 Dr. Tejaswini	 M. Manish Kumar 24/07/2028



②

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/7/26 10:00pm	cls by Dr. Ayesha (Anaesthesia)	
	Δ: C ₂ A ₁ , 30wks, Early FAR ± OCC AEDE ± C ₁ HTN ± Breech for Observation (stage II) (∴ 1 week)	
Adv Hypothyroid on Rx	ole pt clc - clc shortened a breath: 2 days - not able to lie supine PR: 85/min Bp: 146/93 mmHg CR: SIS ₂ (+) RS: BAE(+), clear SpO ₂ : 98% on RA	R. Adv ① 4m ^l MgSO ₄ 1gm/hr on flow till (8:00pm) tomorrow ② T. NICARDIA 10mg TD ③ T. LABETALOL 100mg BD ④ Monitor vitals, Bp, I/O Charting ⑤ 4m ^l um sac ⑥ soft diet, as a now ⑦ T. ECOSPRIN 150mg OD
Self voiding		
Adv Cardiologist Opinion ECG & Echo		
	Hb/PCV/Pt/WBC 10.7/30.7/1.8/1320 PT 14 INR 1.0 LOH 184 urea 10 creat 0.6 protein 5.7 Alb-2.9 A/G-2.8	

[Signature]



Date & Time	Progress Notes	Doctor's Order
24/7/2022		
Gp		
	Patient and family counselled regarding Severe Early onset FGR Stage II with occasional absent End diastolic flow (AEDF) with increased risk of Fetal compromise/IUFD. Need for admission for close monitoring - Maternal & Fetal Surveillance, Antenatal Corticosteroids, Magnesium Sulphate for Neuroprotection and possibility of preterm delivery depending on Maternal/Fetal Condition explained. Neonatal risk of Prematurity discussed & Neonatal counselling done. Patient & Attender understood the Condition and consented for admission and further management and understood regarding risk of IUFD in Conservative Management.	
		<i>[Signature]</i> broms

HNH-00016509

IP26-00006941

Mrs SWATHI BAKKI

28-12-1989

36 Y 6 M 28 D (F)

Dr. SWAPNA SAMUDRALA



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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
24/11/2020 8pm	Atk to Ammansha G/A 30wks Early onset FGR Stage II C occ. AEDP / GAIN for steroid coverage + observation GC-Far Alebude BP 147/80 PR 86 PPA ut ~30wks relaxed: Breech FMS PR - No Complaints - (PRM well) NST- Reactive Ongoing - Mysol → u/a Adeq.	<u>Adv</u> - Regular diet → Early Breakfast Fib NBM From 6AM - Drops as checked - Mysol for Neuroprotection - Inj Betmatal 200 dose C 3:45 AM - ATZ + Dopple Scan 4pm - Collect PE profile - Strict BP monitoring - Physician Opinion
8pm	C/O/W Dr Nishanth :- <u>Adv</u> Tab Nicardipine 10mg TID BP monitoring Continue 7. label 100mg BD	<u>M</u> <u>Amman</u>
10pm	[BP- 142/98 mmHg] C/O/W Dr Nishanth Sr [CBC / PTNR / Uric Acid / LDH / Electrolyte - WNL LFT @ - All ↓	<u>M</u> <u>Adv</u> - Continue Antihypertensive <u>Informed</u> No-133

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/7/2021	CP is Dr Manisha	
1 AM	G2A1 / 30wk / Early onset FeR styl II & Occ. ABRP / Breech (G+H+N) for Steroid + MgSO ₄ & observe	
	CC - For Afebrile	<u>Adv:-</u>
	BP 133/80	- Early Breakfast At NBM from 6 AM
	PR 72	- Wgys as charted
	PIA ut ~30wk	- Strict BP monitoring 2nd hourly
	relaxed	- NST Gtg hourly / FHS 2nd hourly (M)
	FHS @ (140/4mm)	- AF2 / Doppler Scan Today
	<u>PRM will</u>	- Inj Betnesol 12mg @ 3:45 AM
	Ongoing MgSO ₄ - up to Adeq	- Dfrc / RUP
	OTR ⊕	- <u>Cardio Opinion</u> (Aam Advised)
	Callout for Cardio Opinn (Dr Ranthuk @ 11 PM (24/7) Jackhu)	- Inform sro
		- Collect PE profile
		<u>Mp</u> <u>Amma</u>
25/7/2021	CP is Dr Manisha	
7 AM		<u>Adv</u>
	CC For Afebrile	- NBM till further order
	BP 127/80	- Wgys as charted
	PR - G2	- Strict BP monitoring
	PIA ut ~30wk ! relax	- DRFC / RUP
	FHS @ R	- NST Gtg hourly / FHS 2nd hourly
	<u>PRM ⊕</u>	- Cardio Opinion (Aam Adv) + 20 Echo
	Ongoing MgSO ₄ u/o Adeq.	- Collect PE profile
	OTR ⊕	- AF2 Dopple Scan
	Steroid course ✓ (NST) Occasional Dyp! Atherum - Ranthuk → (Inform)	<u>M</u> <u>Amma</u>



Date & Time	Progress Notes	Doctor's Order
25/7/2026 9:00am	cls by Dr. Naveena	
	GcA, with 30 wks. POG with breech. with CHTN with Early onset FHR with OCC AEDF.	
	Cic Fair	Adv
	Afebrile	- NBM
	BP: 132/93 mmHg.	- Drugs as charted
	PR: 91 bpm.	- Strict BP Monitoring 2nd
	P/A ut 30w.	- NST 6th hourly
	Relaxed	- FHR 2nd hourly
	FHS (+)	- AFI + Doppler scan today
	Relaxed	- 2nd dose Inj Betnasol 12mg at 3:45 AM
		- RUP / DFMC
		- Inform soc.



Date & Time	Progress Notes	Doctor's Order
25/07/2026 11:00am.	cls by Dr. Naveena oldw Dr. Sweepna	
	USG.- AFP + Doppler. informed. AEDE, AFP-Item.	<u>Ado</u> - NBM - drugs as charted - Prepare for Em-LSCS & shifton Call - Foley's Catheterisation - NST- - Monitor Vitality - Inform SCS
	<u>Dr. Naveena</u>	

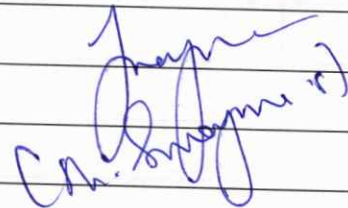


PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/12/20 11:15 AM	G ₂ A ₁ / 30 wks / Gest Hxw / 1st Stage II with AEDF clo to IM since today morning	
	NS1 → Variable Decelerations + AF2 & Doppler today. AF2 - 17.9 L VAD - AEDF, DV - (2)	
	Stemals ✓ Myo. on flow NAC ✓	
	B.P → fluctuating & 2 antihypertensives	
	O/E - Gc Jan upbule D. Sat - 992 RA	
	Peri Orbital Oedem / Pedal Oedem + - NRM	
	PR - 26 HL'	
	B.P - 160 / 100 mmHg	
	P/A - w labored	
	FHR +	
	Abdominal wall Oedem +	
	Abutis (+)	
	Dr. Swapna Samudrala Consultant Obstetrics and Gynecology Reg. No: 69924	
		Adv - For 2m less Sat (cont: fluctuating BP FHR + AEDF) - Informed consent - DTPP (BP 140/90 monitoring Drugs as charted Sigh to O.R. or call from CA. Samudrala (P.T.O)



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Video Counselling done -</u>	
=>	Couple / Attendee counselled regarding present maternal / fetal condition. Primie / AMA / Gest Hxw. On 2 antihypertensive glucosiding Rx / FHR Stage II C APTT with Decreased fetal movements. & need for Em. here.	
=>	Counselled regarding Complications - abruption / Preeclampsia - Eclampsia / Post-part haemorrhage - need for transfusion of Blood & blood products / Post operative maternal ICU care / Ventilatory support.	
=>	Counselled regarding neonatal prognosis / prolonged labor can / complications of prematurity / postnatal evaluation of baby.	
=>	Understanding the above we give our informed consent for management as per Obstetrician / anaesthetist & Neonatologist advice & will not hold any doctor / hospital liable responsible for any unforeseen consequences faced later.	
	Dr. Swapna Samudraja Consultant Obstetrics and Gynecology Reg. No: 69924	 Ch. Swapna R.



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/12/20 2:10 pm	<u>PDS - 0</u> No comp O/E - Acc. Jaw W/teeth O₂ Sat - 99% RA PR - 86 bpm B/P - 140/90 mm Hg P/A - ut. not enlarged W/teeth A/E - none	(Pili / Em. here) Acc. 118 <u>Adx</u> - NBM x 6 hrs - IVF (adulgerin) - Monobupropion / - white hypertensive - 400 - Drugs as charted - PRP / R/O / 210 chart - W/teeth excessive P/V - bleeding - Physician opinion - (Dr. Nishanth) - Jagan Soc
25/12/20 3:15 pm	<u>C/D w Dr. Nishanth</u> - BP Monitoring 2nd hourly. - T. labetalol 100mg BD - T. Nicaedia 10mg sos.	Dr. Swapna Samudrala Consultant Obstetrics and Gynaecology Reg. No: 69924 Ch. Swaguna



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
25/1/16 6:30 pm	P/L - POP-O (Amber) (Get HBM) Also Bili Also pre-eclampsia off plate agitate PR-8/24 BP-136/84 mmHg PA-Uterus contracted well Bowel sounds (+) UA - No bleeding U/O - 300ml - 3 hrs clear.	Adm → NBM to 6 hrs → IV fluids → BP monitoring 2nd hourly → T. Labetolol 100mg/8hr → T. Nicardipine 10mg/8hr → w/ Bili → w/ No bleeding → monitor vital Signatures
	Dr. Mendota	
25/1/16 8:15 pm	LEB SWATHI HV - P/L. POP-O / Severe PE / BP-3 - Fetus down O/E: P=80/60 BP-136/84 mmHg No pain PA: Abnormal Ble pedal edema (+) no pre-eclampsia symptoms KIDNAB U/O - 300ml	Adm → THAS COBET 100mg BP → BP 100/60 → w/ pre-eclampsia symptoms → BP 100/60 Signatures
Baby Swathi	Dr. Swathi H V Consultant Obstetrics and Gynecology Reg. No: 15501	



(8)

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/26 6:40am	Chl B Dr. Moudula P.L. e POD-0 (Amber) (Get HIN)	
	Also Chls	
	- old pt chls	
	- cyto b/c	
	- phos b/c	
	- BP - 100/80 mmHg	
	PLA - uterine sutures intact & well	
	U/L - Plv bleeding water	
	UO - 200ml : 3hrs	
		Adv liquid → Soft diet → Soft diet after → Adequate hydration → Ambulation → Foley's removal → BP monitoring → w/A Chls. → monitor vitals Supern 80%
	Dr. Moudula	
25/7/26 9:45am	C/S/B Dr. Dina POD-1 P/L / GHTN.	Adv
	Ac Pain	- Soft diet
	Afebrile	- Adequate hydration
	BP: 130/80 mmHg	- Ambulation
	PR - Soft	- Drugs as charted
	P/A uterine Retracted well. BSG	- BP Monitoring 2 nd hand
	U/L PV bleed WNL	- w/A PV bleed
		- Monitor vitals
		- Supern 80%

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/7/26 11AM	C/S/B Dr. Ramya POD + P/L/CHIN GC Fair Afebrile BP: 130/80 PR: 86/min H/LC NAD P/A ut Retracted well. BS(F) L/E NAB.	Adv. Soft diet Drugs as charted BP Monitoring 4 th hourly Ambulation Adequate hydration BP Monitoring 4 th hourly Monitor vitals W/F PV bleed Inform SAs Pt can be shifted TED Stocking Noted by Akshita 26.7.26 @ 11AM
26/7/26 2pm	C/S/B Dr. Dina POD. P/L/CHTN. GC Fair Afebrile BP: 135/90 mmHg PR: 87/min P/A uterus Retracted well. L/E NAB	Adv. Soft diet Drugs as charted BP Monitoring 4 th hourly Ambulation Adequate hydration BP Monitoring Monitor vitals W/F PV bleed TED stockings Noted by medist



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
26/7/26 7:30 PM	C/S / B Dr. Dna POD, P, L / CHTN.	Adv Soft diet Drugs as chart
Baby @ NICU	AC fair Afebrile BP: 155/104 mmHg T. labet. 100mg.	BP Monitoring 4th hand Ambulation
U ✓ F ✓ S X	PR: sup P/Autecus Retracted well BS (+) U/E NAB	Adequate hydrat. W/F PV bleed Monitor vitals. TED stockings Inferm ser T. Nicaardia 10mg ser P. Dulcolax suppository to be kept PR at 10pm.
27/7/26 8 AM	C/S / B Dr. Dna POD ₂ - P, L / CHTN No dizziness.	Adv Soft diet Drugs as chart BP Monitoring 4th hand. Ambulation. TED stocking.
Baby @ NICU	AC fair, Afebrile BP 130/80 mmHg PR: 80bpm	Monitor vitals, w/F PV bleed Adequate hydrat. T. Nicaardia 10mg ser. Inferm ser.
U ✓ F ✓ S ✓	P/Autecus Retracted well U/E - NAB.	Physician opinion (bedside) (P.T.O.) W.S. mahi 27/7/26 @ 8:10 AM

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/12/26 12:30pm	POD - 1 No comp DIE - G.C. Jan Uterus O ₂ Sat - 99.2 SA PR - 86 b/min B.P - 130/90 mmHg P/A - Uterus well retracted LIE - MAB	Adm Regular Diet Oral Hydration Drugs as charted Monitor vitals Physician Review Regarding antihypertensive Ambulation Supp Sec
27/12/26 6:40pm	Chl B Dr. Mendula POD - 2 No Ills Ht/Plt ch Glycos PR - 86 bpm Sp. 107/83 mmHg P/A - Uterus well retracted Uterus - MAB	Adm Regular diet Ambulation Adequate Hydration Physician Review done Advised - T. Label of room/130 Monitor vitals Supp sec Drugs as charted

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 Mrs SWATHI BAKKI
 28-12-1989 36 Y 7 M 0 D (F)
 Dr. SWAPNA SAMUDRALA



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SS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
27/12/2016	C/S/b & Manish	
9am		
	Cc Fav Afecbale	Adr
	Vitals stable	- Regula Diet / Adeq Hydration
3ly-New	PA ut well retracts	- Drains are clear
	Soft	- w/d vitals < 38°
	L/S NAD	- Ambulater
W	Bleedy wave	Interim SWS
W		
SV	phyo Adc T. blot 100% B	My Dinner
28/12/2016	C/S/b & Manish	
11am		
	Cc Fav Afecbale	Can be discharged
	Vitals stable	Send file for processing
		My Dinner



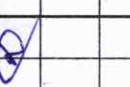
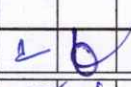
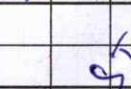
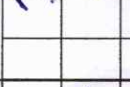
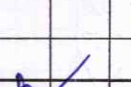
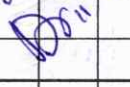
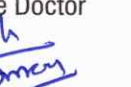
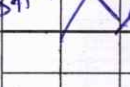
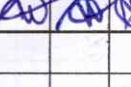
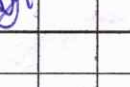
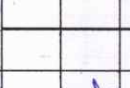
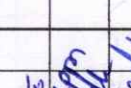
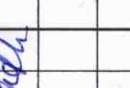
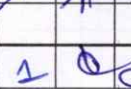
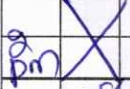
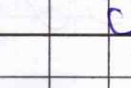
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[illegible]

Sheet No:

REGULAR PRESCRIPTIONS

Weight 84 Ward

DRUG : T. HYCOFORM				Date Time	25/7	26/7	27/7	28/7												
Dose	Route	Frequency	Start Dt.																	
75mg	PO	BD	25/7																	
Name & Signature of the Doctor Starting the Drugs:				   																
Additional Instructions:																				
Daily Doctor's Endorsement by a Sign																				
DRUG : T. AUGMENTIN				Date Time	24/7	25/7														
Dose	Route	Frequency	Start Dt.																	
625mg	PO	TID	24/7																	
Name & Signature of the Doctor Starting the Drugs:				   																
Additional Instructions:				   																
Daily Doctor's Endorsement by a Sign																				
DRUG : T. LABETALOL				Date Time	24/7	25/7	26/7	27/7	28/7											
Dose	Route	Frequency	Start Dt.																	
100mg	PO	BD	24/7																	
Name & Signature of the Doctor Starting the Drugs:				   																
Additional Instructions:				   																
Daily Doctor's Endorsement by a Sign																				
DRUG : T. NICARDIA				Date Time	24/7	25/7														
Dose	Route	Frequency	Start Dt.																	
10mg	PO	TID	24/7																	
Name & Signature of the Doctor Starting the Drugs:				   																
Additional Instructions:				   																
Daily Doctor's Endorsement by a Sign																				

Verified by
 Dr. Dhakshayani

Verified by
 Dr. Dhakshayani

Verified by
 Dr. Dhakshayani

Sheet No:

REGULAR PRESCRIPTIONS

Weight 84..... Ward

DRUG : INJ. AUGMENTIN				Date Time
Dose 1.2gms	Route IV	Frequency BD	Start Dt. 25/7	
Name & Signature of the Doctor Starting the Drugs: <u>Dr. Naveen</u>				
Additional Instructions: <u>ATD</u>				
Daily Doctor's Endorsement by a Sign				
DRUG : TAB. PARACETAMOL				Date Time
Dose 1gm	Route PO	Frequency 6HRLY	Start Dt. 25/07	
Name & Signature of the Doctor Starting the Drugs: <u>DR. M. VINEETHA</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : TAB. TRAMADOL				Date Time
Dose 100 mg	Route PO	Frequency 8HRLY	Start Dt. 25/07	
Name & Signature of the Doctor Starting the Drugs: <u>DR. M. VINEETHA</u>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : INJ. ENOXAPARIN				Date Time
Dose 40mg	Route SLC	Frequency ONCE DAILY	Start Dt. 25/07	
Name & Signature of the Doctor Starting the Drugs: <u>DR. M. VINEETHA</u>				
Additional Instructions: <u>START AFTER 9PM AFTER CHECKING FOR BLEEDING</u>				
Daily Doctor's Endorsement by a Sign				

Verified by
Dr. Dhakshayani
Verified by
Dr. Dhakshayani
Verified by
Dr. Dhakshayani
Verified by
Dr. Dhakshayani

Verified by
Dr. Dhakshayani

Weight 84 Ward

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

Patient Sticker

Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

Signature

Signature

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																			



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Weight: 84 kgs

Sheet No:

Name:

[illegible]

Verified by
Dr. Dhakshayani

27

12

12

12

12

12



Patient Sticker

Weight. 84kg Ward.

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
24/7	7pm	INJ MAGNESIUM SULFATE	4g	iv sbw	h	Linda Ann
25/7	3:45pm	INJ BETAMETHASONE	12mg	1m	h	Ashley Alab
25/7	11AM	INS. METOCLOPR ROMIDE	10mg	IV	(n)	not signed
25/7	11AM	INJ. PANTOPRA- ZOLE	40mg	IV	(n)	not signed
25/7	12:20pm	INS. METOCLOPRO- MIDE	10mg	IV	(n)	Akwile
25/7	12:30pm	INS. PANTOPRA- ZOLE	40mg	IV	(n)	Akwile
25/07	1:09pm	INS. OXYTOCIN	3IU + 9IU infusion	iv	h	Rachel
25/07	1:10pm	INS. TRANEXAMIC ACID	1g	iv	h	Rachel
25/07	1:50pm	INJ. CARBOPROST	250mcg	IM	h	Rachel

I.V. FLUIDS CHART

Weight: 84kg Ward:

Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
24/7	8pm	1NJ MAGNESIUM 20gms. SULPHATE + NORMAL SALINE	IV	1g/hr (25ml/hr)	<u>h</u>	<u>P</u> <u>a</u>	25/7		<u>h</u> <u>a</u>
25/7	7AM	RINGER LACTATE	IV	500ml/hr	<u>h</u>	<u>P</u> <u>a</u>	25/07	<u>h</u>	<u>a</u> <u>a</u>
25/07	1:10 PM	RINGER LACTATE + 20IU OXYTOCIN	IV	120 ml/hr	<u>h</u>	<u>P</u> <u>a</u>	25/07	<u>h</u>	<u>a</u> <u>a</u>
25/07	1:30 PM	RINGER LACTATE	IV	200	<u>h</u>	<u>P</u> <u>a</u>	25/7	<u>h</u>	<u>a</u> <u>P</u>
25/07	2:00 PM	RINGER LACTATE + 20IU OXYTOCIN	IV	100 ml/hr	<u>h</u>	<u>P</u> <u>a</u>	25/7	<u>P</u>	<u>a</u> <u>a</u>
25/7	5pm	RINGER LACTATE	IV	1000ml/hr	<u>g</u>	<u>h</u> <u>ck</u>	25/7	<u>g</u>	<u>a</u> <u>a</u>
25/7	9pm	RINGER LACTATE	IV	1000ml/hr	<u>h</u>	<u>h</u> <u>sub</u>	26/7	<u>h</u>	<u>a</u> <u>a</u>
26/7	12 AM	RINGER LACTATE	IV	1000ml/hr		<u>a</u> <u>a</u>			<u>a</u> <u>a</u>
		stop							
		Dr. Swathi							

HNH-00016509 IP26-00006941

Mrs SWATHI BAKKI

28-12-1989 36 Y 6 M 29 D (F)

Dr. SWAPNA SAMUDRALA



304

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RESULT SHEET

Date	24/7/26				
Time					
Hb	10.5				
PCV	30.7				
RBC	4.02				
WBC	7.32				
N/L					
Platelets	1.80				
CRP					
ESR					
PCT					
RBS					
Na	133				
K	4.2				
Cl	109				
Ca/Mg					
Phosphate					
Urea	10				
Creatinine	0.6				
ALP	69				
SGPT	11				
SGOT	15				
T.Bill/Conj	0.2 < 0.1				
T.Protein	5.7				
S.Albumin	2.9				
S.Globulin	2.8				
A/G Ratio	1				
Uric Acid	5.8				
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR	14/1.0				
APTT					
CSF Protein / Sugar					
Cells	LDH	184			
N/L					

Date	24/7/26				
Time					
CUE - Alb					
CUE - Sugar					
CUE - Ketones	neg-ne				
CUE - PUS Cells	8-10				
CUE - RBC Cells					
CUE	RBCs	NRU			
	Epithelial	25-30			
	Cell				
	Protein(+)				
Stool Pus Cell					
OVA / Cyst					
Occult Blood					
Blood Grouping	= B+ve				
HIV	} NR				
HbsAg					
Hcv					

Culture and Sensitivities :

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Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI :

 Others (ECG, Contrast Studies etc.) :

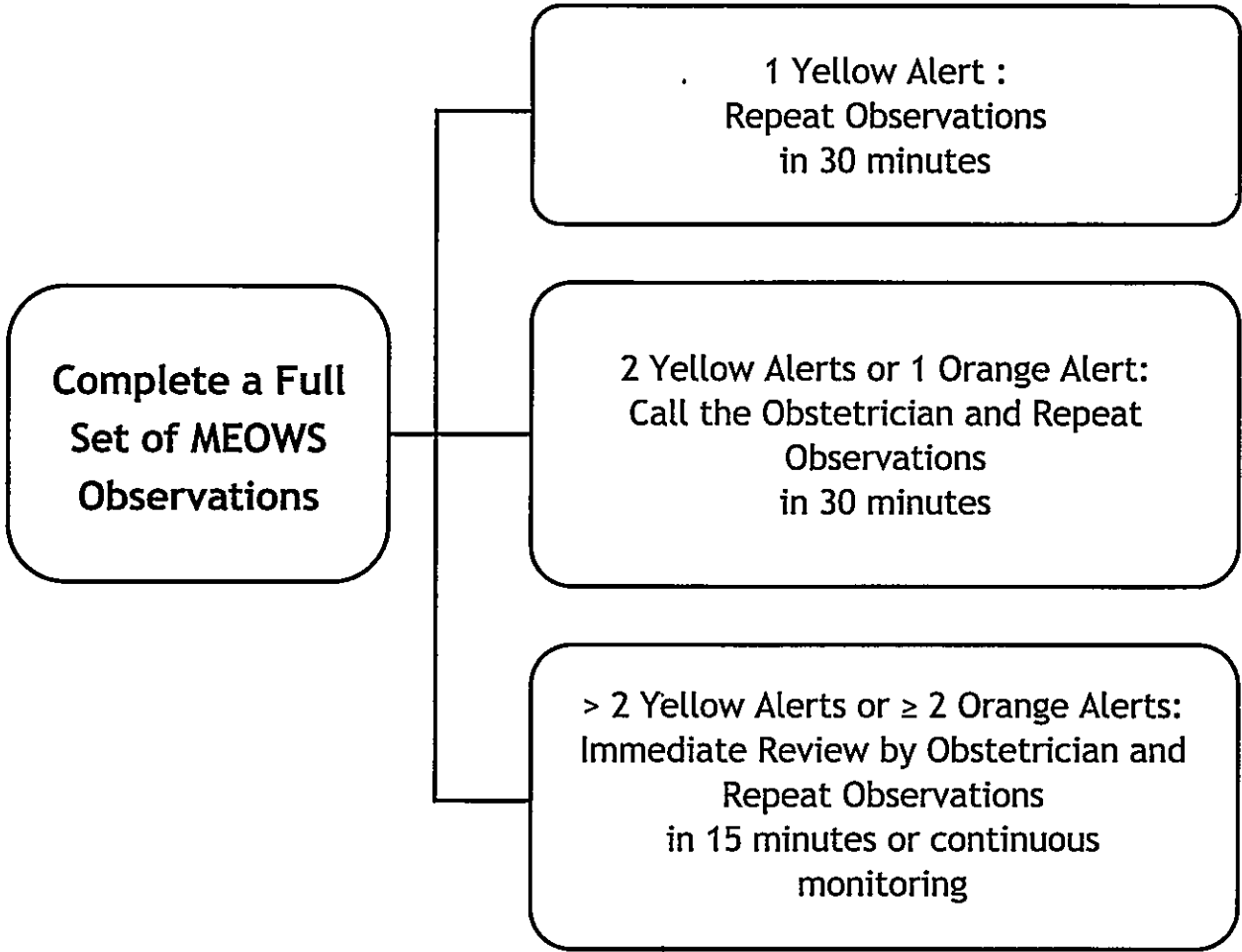
(F)



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	8	9	10	11	12	1	2	3	4	5
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)

Mrs SWATHI BAKKI
28-12-1989 36 Y 6 M 29 D (F)
Dr. SWAPNA SAMUDRALA

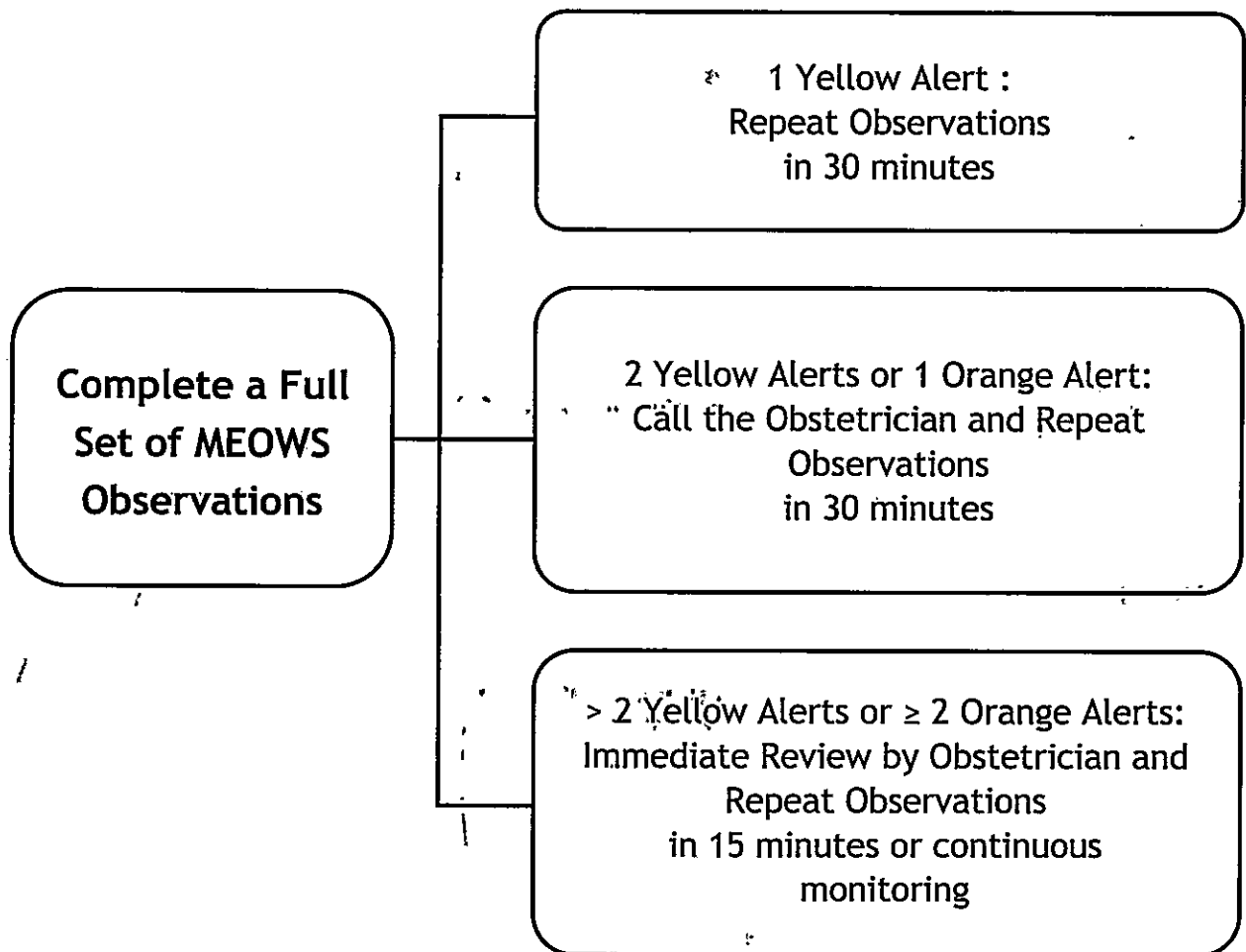


Early Warning Observation Score Chart - Obstetrics

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

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Dr. SWAPNA SAMUDRALA



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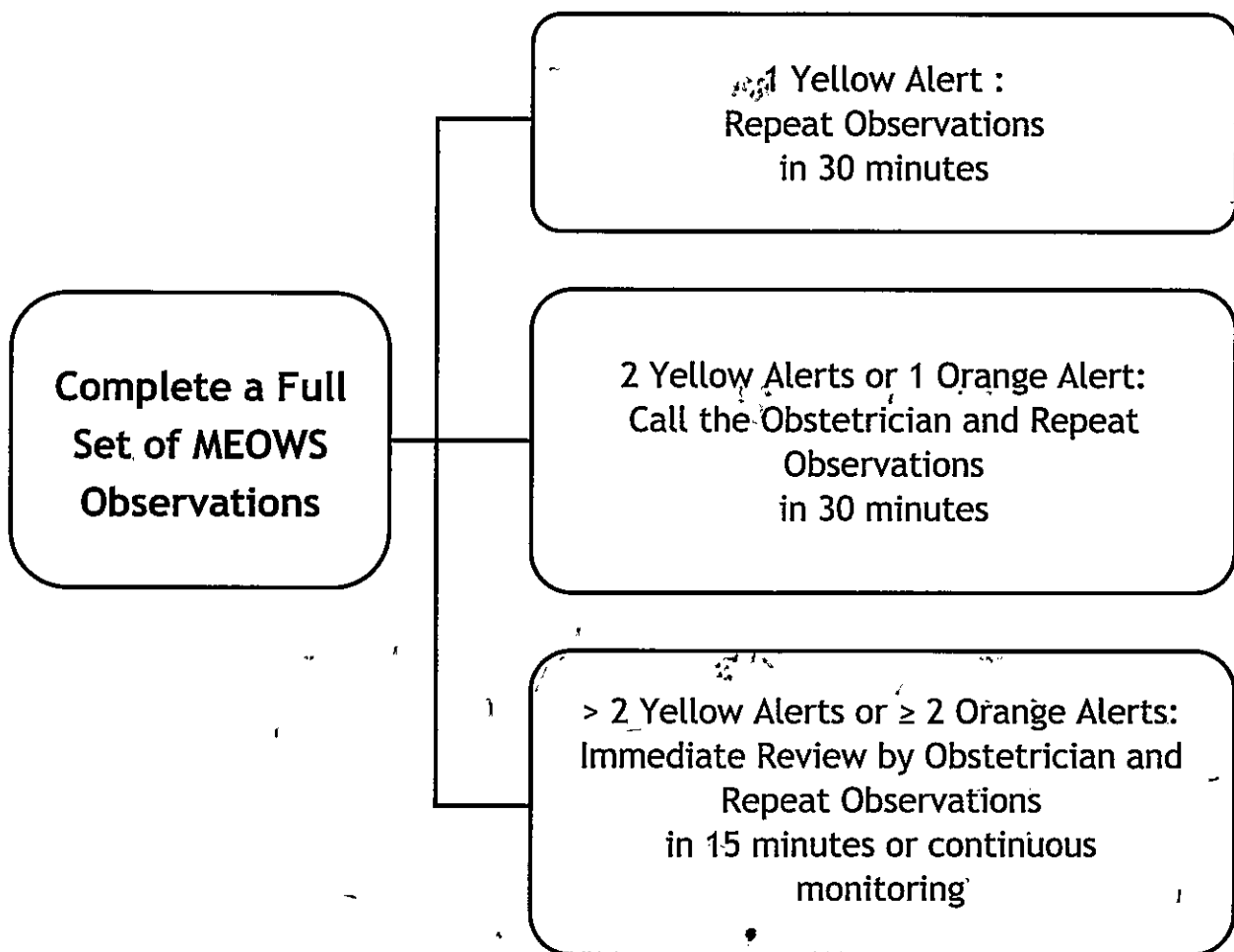


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CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

HNH-00016509 IP26-00006941
 Mrs SWATHI BAKKI
 28-12-1989 36 Y 7 M 0 D (F)
 Dr. SWAPNA SAMUDRALA

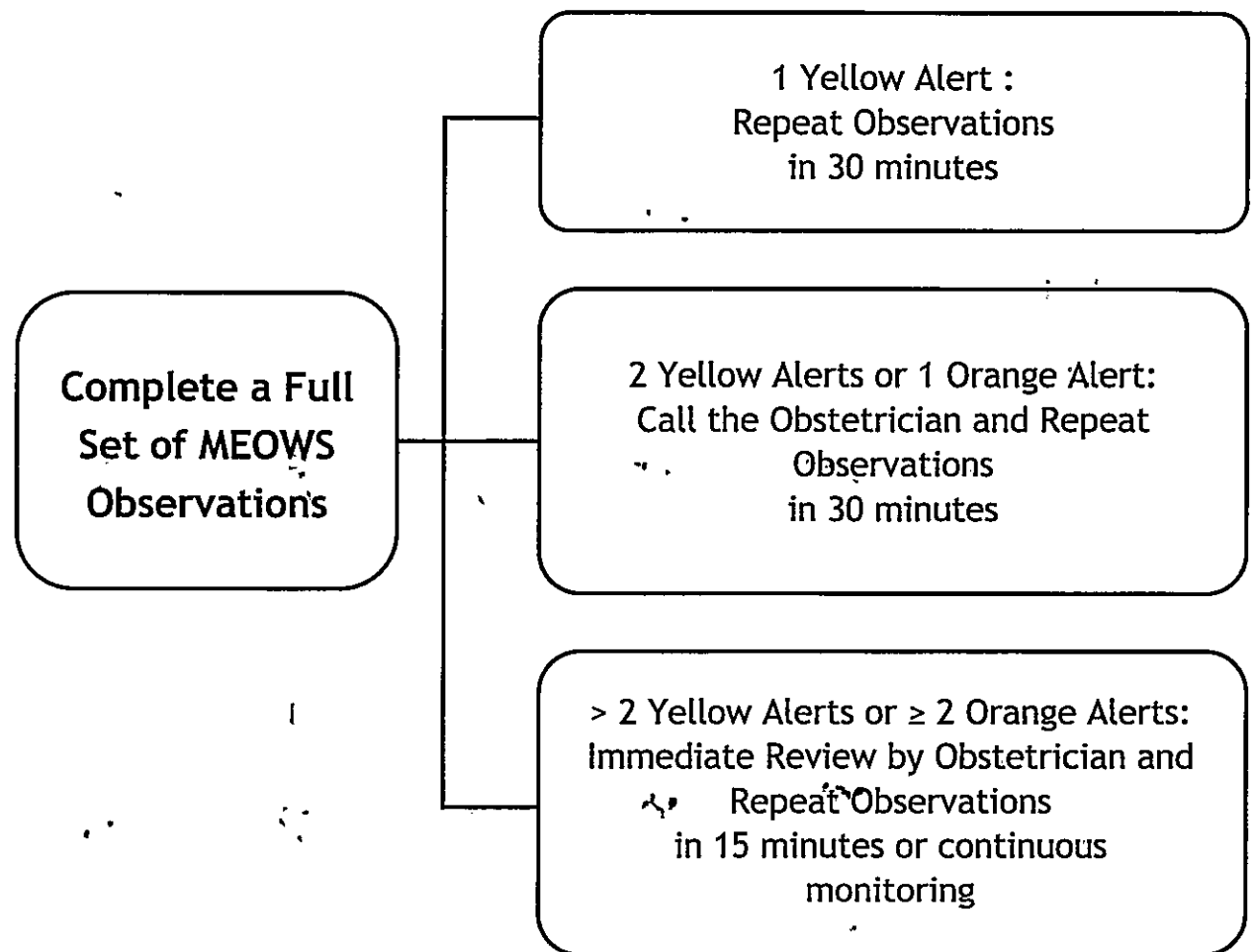


Early warning Observation Score Chart - Obstetrics

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

Date		8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	
27/12/26																										
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																									
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
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-00016509 IP26-00006941
 Mrs SWATHI BAKKI
 26-12-1989 36 Y 6 M 29 D (F)
 Dr. SWAPNA SAMUDRALA



FLUID CHART

Sheet No. : 01

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine		
	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	mgso ₄		25ml								
Total Intake :						Total Output :						
	08:00 pm	mgso ₄ Direct		25ml					300ml			
	09:00 pm	mgso ₄		25ml								
	10:00 pm	mgso ₄ H ₂ O		25ml					250ml			
	11:00 pm	mgso ₄		25ml					400ml			
	12:00 am	mgso ₄ H ₂ O		25ml								
	01:00 am	mgso ₄		25ml								
Total Intake : Taken 150ml						Total Output : Packed 2.30ml						
	02:00 am	mgso ₄		25ml					2.30ml			
	03:00 am	mgso ₄ H ₂ O		25ml								
	04:00 am	mgso ₄ H ₂ O		25ml					400ml			
	05:00 am	mgso ₄		25ml								
	06:00 am	mgso ₄ H ₂ O		25ml								
	07:00 am	mgso ₄		25ml								
Total Intake : Taken 150ml						Total Output : Packed						
Total 24 hrs. Intake			300ml			Total 24 hrs. Output			1580ml			



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							
25/12/26	08:00 am											
	09:00 am									✓		
	10:00 am		N							✓		
	11:00 am	RL	B	100ml								
	12:00 pm	RL	M	100ml								
	01:00 pm	RL	M	100ml								
Total Intake :					Total Output :							
25/12/26	02:00 pm	RL	N	100ml								
	03:00 pm	RL		100ml						300ml		Empty
	04:00 pm	RL	B	100ml								
	05:00 pm	RL		100ml								
	06:00 pm	RL	M	100ml								
	07:00 pm	RL		100ml						400ml		Empty
Total Intake : 600ml					Total Output : 700ml							
25/12/26	08:00 pm	RL		100ml								
	09:00 pm	RL		100ml								
	10:00 pm	RL		100ml						200ml		Empty
	11:00 pm	RL H2O		100ml								
	12:00 am	RL		100ml								
	01:00 am	RL		100ml								
Total Intake : 600ml					Total Output : 200ml							
26/12/26	02:00 am	RL H2O		100ml						400ml		Empty
	03:00 am	RL		100ml								
	04:00 am	RL H2O		100ml								
	05:00 am	RL		100ml								
	06:00 am	RL H2O		100ml						800ml		Empty
	07:00 am	RL		100ml								
Total Intake : 600ml					Total Output : 1200ml							
Total 24 hrs. Intake		1800ml				Total 24 hrs. Output		2100ml				

FLUID CHART

Sheet No. : 2

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

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
27/12	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake : 1000						Total Output : Passed							
26/12	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output : 10-2							
26/12	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
27/12	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

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.

Date	Time	Nature of Fluid	Intake			Output					IV Site Thrombo-phlebitis Score	Sign. Nurse	
			Mouth	I.V	N.G	NG	Diarrhoea	Vomit	Drainage	Urine			
27/12/20	08:00 am												
	09:00 am	!	Orally										
	10:00 am	o	100										
	11:00 am												
	12:00 pm	!											
	01:00 pm												
Total Intake : 100						Total Output : 0							
27/12/20	02:00 pm	!											
	03:00 pm		Orally										
	04:00 pm	o	100										
	05:00 pm												
	06:00 pm	!											
	07:00 pm												
Total Intake : 100						Total Output : 0							
27/12/20	08:00 pm	!											
	09:00 pm												
	10:00 pm	!	Orally										
	11:00 pm	i	100										
	12:00 am												
	01:00 am												
Total Intake : 100						Total Output : 0							
27/12/20	02:00 am	!											
	03:00 am												
	04:00 am	!	Orally										
	05:00 am												
	06:00 am	!	100										
	07:00 am												
Total Intake : 100						Total Output : 0							

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00016509 IP26-00006941
 Mrs SWATHI BAKKI
 28-12-1989 38 Y 7 M 0 D (F)
 Dr. SWAPNA SAMUDRALA



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

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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
24/7	4pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
24/7/26	10pm	0/10	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
25/7/26	4am	0/10	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
25/7/26	8am	0/10	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
25/7/26	3pm	0/10	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
25/7/26	6pm	0/10	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
25/7/26	10pm	0/10	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
26/7	1Am	0	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
26/7	2Am	0	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
26/7	8Am	0	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q

Re-assessment Frequency:

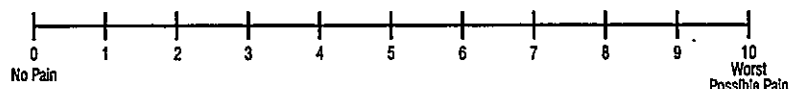
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 brawn 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	Arousés minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arousés 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



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
26/7/26	12pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
26/7/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Udell
27/7/26	8Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
27/7/26	10Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
28/7/26	2pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
28/7/26	6pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
29/7/26	8Am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	Q
				☐ 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:

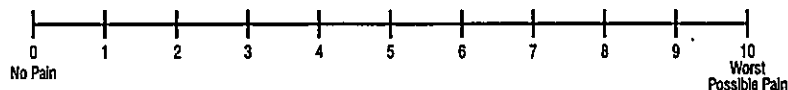
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain pain-relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

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 or 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)



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Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
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Vital Signs HR, RR, BP, SaO₂	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



HNH-00016509

Mrs SWATHI BAKKI

28-12-1989

IP26-00006941

38 Y 6 M 29 D

(F)

Dr. SWAPNA SAMUDRALA



BRADEN 'Q' SCALE

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

BirthRight™
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

					Date :	24/12	24/12	24/12	25/12
					Time :	8pm	3pm	2pm	10pm
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
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat 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						A	Re	CR	TO

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

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

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



BRADEN 'Q' SCALE

Date : 26/12/2022
Time : 9:16 AM

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 meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
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TOTAL SCORE					28	28	28	28
Evaluator's Name					Dr. Swapna Samudrala	Dr. Swapna Samudrala	Dr. Swapna Samudrala	Dr. Swapna Samudrala

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)
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HNH-00016509

IP26-00006941

Mrs SWATHI BAKKI

28-12-1989

38 Y 7 M 0 D

(F)

Dr. SWAPNA SAMUDRALA



BRADEN 'Q' SCALE

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

				Date :	27/7	27/7		
				Time :	8:2	5:1		
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		
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TOTAL SCORE					28	25		
Evaluator's Name					[Signature]			

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

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
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DRUG CHART

Date of Admission: 24/9/2021 Drug Allergies: N.I ☒ 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 : <u>T. Nicaeolia</u>				Date Time															
Dose <u>10mg</u>	Route <u>PO</u>	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

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

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

VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG : 7. LIVOGEN				Date Time
Dose 1 tab	Route PO	Frequency QD	Start Date	
Name & Signature of the Doctor Starting the Drugs:				 Stop
Additional Instructions: Freg-QD				
Daily Doctor's Endorsement by a Sign				
DRUG : 7. CEPAC				Date Time
Dose 500mg	Route PO	Frequency BD	Start Date 24/7	
Name & Signature of the Doctor Starting the Drugs:				 Stop
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : 7. LIVOGEN				Date Time
Dose 1 tab	Route PO	Frequency QD	Start Date 25/7	
Name & Signature of the Doctor Starting the Drugs:				 Stop
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : 7. ECOSPEN				Date Time
Dose 150mg	Route PO	Frequency QD	Start Date 24/7	
Name & Signature of the Doctor Starting the Drugs:				 Stop 25/7/2026 Dr. Mridula
Additional Instructions: e 8pm				
Daily Doctor's Endorsement by a Sign				

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	24/12/2024			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				Low Risk	0 - 24	Standard Fall Precaution
	No	0						
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate 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	High Risk	≥ 51	Implement High Risk 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						
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			CL	Ali	CF			

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

11



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HNH-00016509 IP26-00006941
 Mrs SWATHI BAKKI
 28-12-1989 36 Y 6 M 28 D (F)
 Dr. SWAPNA SAMUDRALA

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	25/12/2020	26/12/2020	26/12/2020
	No	0	(N)	016	N1
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0		0	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	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		9	0
Total Morse Fall Scale Score:				20	20
Signature			Aileen	Q	for

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

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	28/7	27/7		Fall Risk Grading		
		Score	E ₂	N ₁				
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0	0	0				
Secondary Diagnosis (more than one diagnosis)	Yes	15	15	15		Low Risk	0 - 24	Standard Fall Precaution
	No	0	20					
Ambulatory Aid	Furniture	30				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0				
IV / Heparin Lock or Saline	Yes	20	20	20		High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0					
Mental Status	Forgets limitations	15						
	Oriented to own ability	0	0	0				
Total Morse Fall Scale Score:			35	35				
Signature			RA	BT				

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

24/7/26 25/7/26 26/7/26

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		0	NA	NA	NA	NA	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1		NA	NA	NA	NA	NA	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	NA	NA	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	NA	NA	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	NA	NA	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	NA	NA	NA	NA	NA	
Signature of the Nurse													

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

Signature of Shift In Charge :

Signature : *[Signature]* Name : *Chembakal*

Signature of Ward In Charge :

Signature : *[Signature]* Name : *Kasthuri*

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CHECKLIST FOR THROMBOPHLEBITIS

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0	0		0							
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1	NA		NA							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	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							
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							
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							
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 of Ward In Charge :

Signature : Name :

Signature : Name :



NURSING CARE RECORD

Date: 24/7/24

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	2pm to 8pm	→ Assess the patient condition → plan for vitals → plan for Lochia	2pm to 8pm	→ Assessed the patient condition → maintain vitals & Reelord → maintain Lochia	patient is stable	vitals & name	
Night	8pm to 8am	- Assess the patient condition - plan for vitals & reelord - plan for mgsoy - plan for Lochia	8pm to 8am	- Assessed the patient condition - maintain vitals - continue mgsoy in 2ml's - maintain Lochia	patient stable	- vitals & name	

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IP26-00006941

Mrs SWATHI BAKKI

28-12-1989

36 Y 6 M 28 D

(F)

Dr. SWAPNA SAMUDRALA



NURSING CARE RECORD

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Date: 25/12/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	→ Assess the patient condition	8am	→ Assessed the patient condition	patient is stable	vital is normal	Candap
	to 2pm	→ maintain vitals & Record → maintain Flochart	to 2pm	→ maintain vitals & Record → maintain Flochart			
Afternoon	2pm	→ Assess the patient condition	2pm	→ Assessed the patient condition	patient is stable	vital is normal	Candap
	to 8pm	→ maintain vitals & Record → maintain Flochart	to 8pm	→ maintain vitals & Record → maintain Flochart			
Night	8pm	→ plan for vitals	8pm	→ vitals Normal	Stable	Normal	Pushp
	8am	→ plan for Flochart → plan for medication → plan for fluids	8am	→ Flochart maintained → medication given as per Chart			



NURSING CARE RECORD

Date: 26/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am	→ Assess the pt condition	8Am	→ Assessed the pt condition	pt is stable	maintain B/D chart & record	Akiya
	1	→ monitor the vitals & record	1	→ monitored the vitals & record			
		→ Administration of medication		→ Administered medication as per doctor order			
	2pm	→ maintain B/D chart & record	2pm	→ Maintained B/D chart & record			
Afternoon	3pm	→ Assess the pt condition	3pm	→ Assessed the pt condition	pt is a stable	maintain	Maddh
	to	→ monitor the vitals	to	→ Monitored the vitals			
		→ Administer		→ Administered medical order as per doctor			
	8pm		8pm	→ Maintained B/D			
Night	8pm	→ Assess the pt condition.	8pm	→ Assessed the pt condition.	pt is stable now.	Re-assess vitals	Akiya
		→ monitor the vitals		→ monitored the vitals.			
		→ maintain B/D chart.		→ maintained B/D chart.			
		→ drugs give as per drug chart.		→ drugs given as per drug chart.			
	8Am		8Am				

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NURSING CARE RECORD

Date: 27/12/25

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 - monitor vitals - maintain I/O chart - administer medication as per drug chart	8am	- Assessed the pt condition - monitored vitals & recorded - maintained I/O chart - medication as per drug chart	- pt is stable	- rechecked vitals	D
	2pm		2pm				
Afternoon	2pm	- Assess the patient condition - monitor the v/s - maintain the I/O - Drug as per chart	2pm	- Assess the patient condition - monitor the v/s - maintain the I/O - Drug as per chart	- pt is stable	- Rechecked the v/s	Q
	8pm		8pm				
Night	8pm	- Assess the pt condition - monitor the vitals - maintain I/O chart - medication as per drug chart	8pm	- Assessed the pt condition - monitored vitals - maintain I/O chart	Patient is stable	Re Assessment vitals	J
	2am		2am				



NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Swapna S Department: LPB Date of Admission: 24/12/26

SITUATION		Any Infection: ☐ Yes ☒ No ☐ Not Known If Yes Specify:						
BACKGROUND	Diagnosis: <u>CIA @ 30wks Early FGR</u> <u>2nd ward AEDF</u>							
	Area	<u>24/12</u> <u>62</u>	<u>24/12</u> <u>8pm</u>	<u>24/12</u> <u>2pm</u>	<u>25/12</u> <u>(N)</u>	<u>26/12</u> <u>46</u>	<u>26/12</u> <u>62</u>	
ASSESSMENT	Medical Condition (Any special condition to be noted):				<u>NA</u>	<u>NA</u>	<u>NA</u>	
	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:	<u>98</u>	<u>98.6</u>	<u>98.8</u>	<u>98.6</u>	<u>98.8</u>	<u>98</u>
		Res:	<u>20</u>	<u>20</u>	<u>20</u>	<u>20</u>	<u>20bmt</u>	<u>20</u>
		SpO ₂ :	<u>100</u>	<u>100.1</u>	<u>100.1</u>	<u>99.1</u>	<u>99.1</u>	<u>99</u>
		Pulse:	<u>86bmt</u>	<u>84bmt</u>	<u>86</u>	<u>90</u>	<u>99.1</u>	<u>99.5</u>
		BP:	<u>141/93</u>		<u>140/90</u>	<u>122/62</u>	<u>121/70</u>	<u>120/64</u>
	Fall Risk Score:							
	Pain Score:					<u>0/10</u>		
Recommendations	Safety Needs:		<u>yes</u>	<u>yes</u>	<u>yes</u>	<u>yes</u>		
	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:	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Post Operative Procedure Special Orders:		<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	<u>NA</u>	
Handed Over By Name :		<u>Chudh</u>	<u>Alex</u>	<u>Chudh</u>	<u>Anusha</u>	<u>AKWIS</u>	<u>Neel</u>	
Signature :		<u>Chudh</u>	<u>Alex</u>	<u>Chudh</u>	<u>Anusha</u>	<u>AKWIS</u>	<u>Neel</u>	
Date:		<u>24/12/26</u>	<u>24/12/26</u>	<u>25/12/26</u>	<u>25/12/26</u>	<u>26/12/26</u>	<u>26/12/26</u>	
Time:		<u>8pm</u>	<u>2pm</u>	<u>8pm</u>	<u>8pm</u>	<u>8am</u>	<u>8pm</u>	
Taken Over By Name :		<u>Alex</u>	<u>Chudh</u>	<u>Anusha</u>	<u>AKWIS</u>	<u>Neel</u>	<u>Mahi</u>	
Signature :		<u>Alex</u>	<u>Chudh</u>	<u>Anusha</u>	<u>AKWIS</u>	<u>Neel</u>	<u>Mahi</u>	
Date:		<u>24/12/26</u>	<u>25/12/26</u>	<u>25/12/26</u>	<u>26/12/26</u>	<u>26/12/26</u>	<u>26/12/26</u>	
Time:		<u>8:40pm</u>	<u>2pm</u>	<u>8am</u>	<u>8am</u>	<u>8pm</u>	<u>9pm</u>	

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis: LICS		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:			
BACKGROUND	Area	Shift Time	28/7 N₁	28/7/20 MG	28/7 E2	28/7 N₁
	Medical Condition (Any special condition to be noted):		—	—	—	—
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:	98.1°F	98.2°F	98.3°F	98.1°F
	Res:	20b/m	20b/m	22b/m	20b/m	
	SpO ₂ :	100%	99%	99%	100%	
	Pulse:	74	62	83b/m	79	
	BP:	120/71	130/87	132/82	136/88	
	Fall Risk Score:	—	—	—	—	
Recommendations	Safety Needs:	Yes	yes	yes	Yes	
	Physiotherapy	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Others Specify:	—	—	—	—	
	Special Diet:	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	
	Other Special Orders / Medications:	—	—	—	—	
Post Operative Procedure Special Orders:		—	—	—	—	
Handed Over By Name :		Mahi	Divya	Sumade	Mahi	
Signature :						
Date:		27/7	28/7/20	28/7/20	28/7/20	
Time:		8pm	2pm	2pm	8pm	
Taken Over By Name :		Divya	Sumade	Maheshwari		
Signature :						
Date:		28/7/20	28/7/20	28/7/20		
Time:		8am	2pm	8pm		

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MEDICATION RECONCILIATION FORM

Drug Allergies: NA ☒ 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: NA Shifted to: NA

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	T. Levoflox	1 tab	PO	DO	24/12	☒ C ☒ DC
2	T. Capcal	1 tab	PO	BO	24/12	☒ C ☐ DC
3	T. Ecosprin	150mg	PO	DO	23/12 8pm	☒ C ☐ DC
4	T. Hyponorm	25mg	PO	OD	24/12	☒ C ☐ DC
5	T. Tabetol	100mg	PO	BO	24/12 9am	☒ C ☐ DC
6	T. Augmentin	625mg	PO	7/12	24/12	☒ 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. Manu

Date & Time: 24/12/2020 @ 7pm

Nurse Name & Signature: Anusha

Date & Time: 24/12/2020 @ 7pm

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

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CROSS CONSULTATION FORM

Doctor Name : Dr. Nishanth Ramya-L Date : 22/7/26 Time : 5:00 PM

Diagnosis : Slr Em-Less - Pn-2: Gct-HIV

Hospital : JRA Hospital

Type of Referral :

- ☐ Emergency
☐ Urgent
☐ Non Urgent

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

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

Signature: _____

Findings and Recommendations :

- Slr Em-Less - Pn-2:

- Gct-HIV - Pn-2: LOROT/100mg

Adapting to the

It - clock

Gct - fair

Pl - 70cm

Br - 130gms

cr - 5.1L

R - RAC

ELA 50cm

Dist. LOROT/100mg
1 - x - 1

- low stat met

Consultant :

Name : Dr. Nishanth Ramya-L Signature : [Signature] Date & Time : 22/7/26; 5:00 PM

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 26/7/26

Time: 3:15 pm

Origin: Indian

Height: 150 cm

Weight: 88 kg

BMI: ☐ ~ 26 kg/m²
☐ ~ 28 kg/m²
☐ ~ 30 kg/m²

Food Allergies: No

38 kg/m²

Diagnosis: LSCS

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

Diet Advised:

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

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

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

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

Patient's / Attendant's

Signature: Swathi

Name: Swathi

Date & Time: 26/7/26, 3:15 pm

Doc. No. : RCH / FRM / CLINICAL / 195

Dietician's

Signature: Sobiya

Name: Syeda Sobiya Zaher

Date & Time: 26/7/26, 3:15 pm

(P. T. O)

100

[illegible]



CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <u>Dr. Swapna</u>	Date of Delivery: <u>25/7/2026</u>
Assistant Surgeon: <u>Dr. Ramya / Dr. Naveena</u>	Time of Delivery: <u>1:08pm</u>
Anaesthetist's Name: <u>Dr. Samir</u>	Gender of Baby: <u>Female</u>
Type of Anaesthesia: <u>Spinal</u>	Weight of Baby: <u>1.2 Kg.</u>
Neonatologist: <u>Dr. Tejeswi</u>	AGPAR Score: <u>4, 6, 8</u>
Scrub Nurse: <u>Susheela</u>	NICU Admission: ☒ Yes ☐ No

Pre-Operative Diagnosis: G1A1 with 3 weeks c FGR stage II. c AEDF c Breech presentation

☐ Elective ☒ Emergency Indication: FGR stage II + AEDF + Breech presentation

Urgency

☐ Immediate Threat to life of woman or fetus

☒ Maternal or fetal compromise not immediately life threatening

☐ No maternal or fetal compromise but needs early delivery

☐ Delivery timed to suit woman and staff

Decision time: Knief to rectus:

CTG Description: Non-reactive

If there was a delay give the reasons:

Surgical Procedure: Emergency LSCS

Post Operative Diagnosis: PiliA1 on PGDo Joll Em-LSCS

Severe PE

Peri-Operative Complications: -

Amount of Blood Loss: <u>250ml</u>	Blood Transfused (in ML):
------------------------------------	---------------------------

Name and Number of Surgical Specimen sent for examination:

placenta

Examination Findings when Appropriate:

Presentation: ☐ Cephalic ☒ Breech ☐ Other Cervical Dilatation: cm
 5th Palpable: Fetal Position:
 Station: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2 Moulding: ☒ None ☐ + ☐ ++ ☐ +++
 Caput: ☐ + ☐ ++ ☐ +++ Meconium: ☒ None ☐ + ☐ ++ ☐ +++
 Bladder Catheterized: ☒ Yes ☐ No Urine: ☒ Clear ☐ Blood Stained

Skin Incision: ☒ Pfannenstiel ☐ Transverse ☐ Midline ☐ Other
 Uterine Incision: ☒ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision
 Previous Scar: ☐ Intact ☐ Thinnedout ☐ Ruptured ☒ No Scar
 Incision Through Placenta: ☐ Yes ☒ No * LUS not joined, Vascular
 Delivery of head: ☐ Manual ☐ Forceps * Baby delivered by breech extraction
 Liquor: ☒ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not Offensive
 Delivery of Placenta: ☐ Manual ☒ CCT ☒ Complete ☐ Incomplete ☐ Piecemeal
 Cord Appearance: Normal Cord around the neck ☐ Yes ☒ No
 Appearance of placenta: Normal Cavity explored ☒ Yes ☐ No
 Uterus, tubes and ovaries: ☒ Normal ☐ Not Normal Sterilization: ☐ Yes ☒ No

Uterine Closure: ☐ One Layer ☒ Two Layers Vicryl no-2 Suture
 Peritoneal Closure: ☐ Pelvic ☒ Abdominal ☐ None Catgut no-1 Suture
 Sheath Closure: Yes Vicryl no-1 Suture
 Fat Closure: ☒ Yes ☐ No Catgut no-1 Suture
 Skin Closure: ☒ Subcuticular ☐ Mattress Monocryl 3-0 Suture

Vaginal Evacuated ☒ Yes ☐ No
 Drain: ☐ Yes ☒ No ☐ Remove in days ☐ Await instructions
 Catheter: ☒ Yes ☐ No ☐ Remove in 24hrs days ☐ Await instructions
 Swap & Instruments count correct? ☒ Yes ☐ No ☐ Post-op Antibiotics ☒ Yes ☐ No
 Intra-Operative Antibiotics Cover: ☒ Yes ☐ No ☐ Thromboprophylaxis ☐ Yes ☐ No

Post-Operative Notes:
 NBM for 4-6 hrs
 IV f and drugs as charted
 Urine I/O charting
 wlf PV bleeding
 strict BP monitoring 2hly
 wlf Imminent signs
 Monitor Vitals
 Intraem Sec

Doctor Name: Dr. Swapna S. phynanan opinion

Doctor Signature:

Date & Time: 25/7/2020



OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: <u>24/12/26</u>		
Baseline Information:		
Admission From: ☐ ER ☐ OPD ☒ Admission Desk ☐ Others, specify		
Primary Language: ☒ Telugu ☒ English ☐ Hindi ☐ Others, specify		
Do you require an interpreter? ☐ Yes ☐ No if Yes specify		
Source of Information: ☐ Patient ☒ Family ☐ Others, specify		
Allergies: ☐ Yes ☐ No ☐ Medications ☐ Blood Transfusion ☐ Food ☐ Other: If yes, identify		
Chief Complaints: Doctor Notified on Admission: ☐ Yes ☐ No Name of the Doctor: <u>Dr. Manish</u> Time Notified: <u>6pm</u>		
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: Menstrual Cycle: ☐ Regular ☐ Irregular Last Menstrual Period: <u>24/12/25</u>	Gynecology Surgical History: Caesarean Section: ☒ No ☐ Yes Cervical Cerclage: ☒ No ☐ Yes Ectopic Pregnancy: ☒ No ☐ Yes Myomectomy: ☒ No ☐ Yes Others:	Gynecological History: Contraceptives: ☒ No ☐ Yes Vaginal Discharge: ☒ No ☐ Yes Post-Coital Bleeding: ☒ No ☐ Yes Infertility: ☐ No ☒ Yes If Yes Type: ☐ Primary ☐ Secondary
Obstetric History: G <u>2</u> P L A		
Previous LSCS:		
Current Medication: ☒ None ☐ Yes, If Yes, Fill the reconciliation form		
Family History: ☒ No Abnormalities Detected ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease ☐ Liver disease ☐ Other		
Vital Signs / Measurements: Temp: <u>98</u> HR: <u>86</u> RR: <u>20</u> BP: <u>141/93</u> Weight: <u>83.80kg</u> Height: <u>150cm</u> BMI: <u>39.11</u>		
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 0 (complete the Morse Fall Risk Assessment Sheet)

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

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

- ☐ Mobility problem ☐ Walking Problem ☒ No Abnormality Detected
☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☒ No Abnormality Detected

- ☐ Overweight ☐ Poor Appetite > 3 Days ☐ Needs Therapeutic Diet.
☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

- ☒ Calm & Cooperative ☐ Restless ☐ Depressed ☐ Agitated ☐ Confused
☐ Others

Inform consultant for positive criteria

SOCIAL SCREENING:

1. **Marital Status:** ☐ Single ☒ Married ☐ Divorced ☐ Widow

2. **Special Habits:** **Smoker:** ☐ Yes ☒ No **Alcohol Abuse:** ☐ Yes ☒ No **Drug Abuse:** ☐ Yes ☒ No

Social History: Lives With 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: Swathi

Orientation not given Reason: Self

Nurse Signature: [Signature]

Nurse Name: Chinnabala

Date & Time: 24/12/20 @ 6pm

OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 24/7/26 Time of Arrival: 6 AM Time Seen by Nurse:

1) **Level of Consciousness:** ☒ Conscious ☐ Semi-Conscious ☐ Unconscious

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

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

3) **Vital Signs:** Temperature: 98.6 Pulse: 99 RR: 20 SpO₂: 99 BP: 113/91 Weight: 83

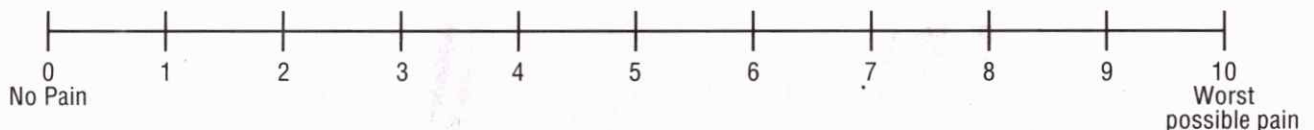
4) **Gestational Criteria:**

Gravida:	G <u>2</u>	P <u>1</u>	L <u>1</u>	A <u>1</u>
----------	------------	------------	------------	------------

LMP: 26/12/25 EDD: 21/10/2026 Gestational Age: 20 weeks

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

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



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

6) **Past History:**

- a) Surgeries: N/A
- b) Medical: N/A



7) Allergy: ☐ Yes ☒ No, If Yes :

8) Current Medications: ☒ Prenatal Vitamin ☐ None ☐ Others:

9) Prenatal Medical History:

- ☒ None ☐ Gestational Diabetes
☐ Chronic Hypertension ☐ Low placenta
☐ Gestational Hypertension ☐ Others if yes, specify
☐ Diabetes

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 6 pm

Nurse Name : Chembakale Nurse Signature: CR

Date: 24/12/21 Time: 6 pm



BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?

- ☒ a. Yes ☐ b. No

2. If No, Reason

pre term

3. Nipple condition:

- ☒ a. Nipple well formed
☐ b. Flat nipple
☐ c. Inverted nipple
☐ d. Short nipple

4. Milk flow:

- ☒ a. Good
☐ b. Drops of colostrums
☐ c. Dry

5. Steps for Positioning and attachment:

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

No pre term



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- ☐ a. Yes
☐ b. No

NPII.

7. For Caesarian mothers:

yes.

- ☐ a. Mother is required sit and feed from the 4th feed
☐ b. Please explain football hold

8. NICU admission:

YES.

- ☐ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes:

Continuity of Care:

Date:

25/7/26

⇒ Breast stimulation done

~~⇒~~

Handover given by

Chandraakela

Handover taken by

Madhurety

Signature

Chandraa

Signature

Madhu

Date & Time:

25/7/26 @ 8pm

Date & Time:

25/7/26 @ 8pm

HNH-00016509

IP26-00006941

Mrs SWATHI BAKKI

28-12-1989 38 Y 7 M 0 D (F)

Dr. SWAPNA SAMUDRALA



**Rainbow[®]
Children's
Hospital**
It takes a lot to treat the little.

BirthRight[™]
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 24/7/26

Date of Removal: 25/7/26

Parameters	Date	Shift Time						
Need for the Catheter	24/7/26	25/7	☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever			☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion			☒ Yes ☐ No	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse	Chandrasekhar Naidu							
Signature of the Nurse	Chu.							

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Swapna
 Asst. Surgeon : Dr. Swathi
 Anaesthetist : Dr. Samir
 Scrub Nurse : Sr. Sushela

Patient Name :
 UHID No. :
 Date : 25/7/26

HNH-00016509
 Mrs SWATHI BAKKI
 28-12-1989 36 Y 6 M 29 D (F)
 Dr. SWAPNA SAMUDRALA
 In-time : 12:58pm
 Out-time : 2:40pm

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

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN	Time: <u>12:50pm</u>
Patient Has Confirmed	
Identity	☒ Yes ☐ No
Site	☒ Yes ☐ No
Procedure	☒ Yes ☐ No
Consent	☒ Yes ☐ No
Site Marked	☒ Yes ☐ No ☐ NA
Anaesthesia Safety Check Completed	☒ Yes ☐ No
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No
Does Patient have a:	
Known Allergy?	☐ Yes ☒ No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	☐ Yes ☒ No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	☐ Yes ☒ No ☐ NA
Blood Units Reserved	☐ Yes ☒ No ☐ NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	
	☒ Yes ☐ No ☐ NA
Signature : <u>[Signature]</u>	
Name : <u>Dr. M. VIKRANTH</u>	

TIME OUT	Time: <u>12:56pm</u>
Confirm all team members have introduced themselves by Name and Role ☒ Yes ☐ No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	☒ Yes ☐ No
Correct Site	☒ Yes ☐ No
Correct Procedure	☐ Yes ☒ No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? <u>bleeding</u>	
	☐ Yes ☐ No ☐ NA
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns? <u>bleeding</u>	
	☐ Yes ☐ No ☐ NA
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? <u>bleeding</u>	
	☒ Yes ☐ No ☐ NA
Is Essential Imaging Displayed?	
	☐ Yes ☐ No ☐ NA
Signature : <u>[Signature]</u>	
Name : <u>Laruna @ 12:56pm</u>	

SIGN OUT	Time:
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	☒ Yes ☐ No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA
The Specimen is Labelled (including patient name)	☒ Yes ☐ No ☐ NA
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient? <u>[Signature]</u>	
	☒ Yes ☐ No
Signature : <u>[Signature]</u>	
Name : <u>Dr. Swapna</u>	

PATIENT TRANSFER FORM

HNH-00016509 IP26-00006941 Mrs SWATHI BAKKI 28-12-1989 38 Y 6 M 29 D (F) Dr. SWAPNA SAMUDRALA 		Date & Time of Admission 25/1/26 @ 5:53pm	Date & Time of Transfer Order 25/1/26 @ 2:40pm
Treating Consultant Name Dr. Swapna		Transfer Ordered by Dr. Samir	Reason for Transfer Observation
From Unit OT	To Unit Pre-Post	Information to Attendant Yes ☒ No ☐	
Number of Sheets in Clinical File 36	Number of Imaging Films —	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	RL	①	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes ☒ No ☐			
Name & Signature of Person who is Transferring Saran		Name of Person Ordered Transfer Dr. Samir	
Patient & Clinical Records Received by : Chumbakaly			
Date & Time of Patient Received : 25/1/26 at 3pm			

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Mrs Swathi Gender: ☐ Male ☒ Female Age : 36 yr.
UHID No : HNH-00016509. Date : 25/7/26

Instruction:

This consent form should be signed by Patient (If an adult 18 years or older) or by a parent / guardian, if the patient is a minor or lacks the ability to make an informed decision. The purpose of this form is to verify that you have received this information and have given your consent to the surgery or special procedure recommended to you.

I hereby authorize the performance of the following operation (s) or procedure (s) (use no abbreviation / Avoid technical terms)

EMERGENCY LOWER SEGMENT CESAREAN SECTION.

upon Mrs Swathi
(Name of the Patient)

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

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

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

excessive bleeding, wound infection, injury to adjacent organs like bladder, bowel, need for blood transfusion

My signature on this form indicates that

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

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

Consentee :

Signature : Swathi

Name : Swathi Bakki

Date & Time : 25-07-2026 @ 12PM

Witness :

Signature : @

Name : AKUIG

Date & Time : 25/7/26 @ 12pm

Docu. No. : RCH / FRM / CLINICAL / 027

Patient Attendant :

Signature : Manisham

Name : Manisham M

Relationship with Patient : Husband

Date & Time : 25-07-2026 @ 12:00 PM

Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Dwa.

Date & Time : 25/7/26. 12pm

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

Patient Name : Mrs. Sualthi Bakki Age : 36 Gender : Male ☐ Female ☒
UHID NO: MNH-16509 Surgeon Name: Dr. Suparna Sanudhala
Anaesthesiologist : Dr. Subrahmanyam / Dr. Janini
Operative procedure planned : NCS

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- ☐ Heart disease ☒ Hypertension ☐ Diabetes mellitus ☐ Renal failure
☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Acidosis
☐ Incapacitating Chronic Obstructive Pulmonary Disease
☒ Others : Bleeding / Need for blood & products / ICU care (yes)

Comments :

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

DECLARATION BY PATIENT / GUARDIAN / PROXY

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

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

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

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

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

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

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

- Pregnant : ☒ Yes ☐ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

Patient / Patient Attendant :

Signature : Swathi
Name : Swathi Bakki
Relationship with Patient : Self
Date & Time : 25-07-2026 12:27 PM

Witness :

Signature : [Signature]
Name : Mani shree M
Date & Time : 25/07/2026 : 12:30 PM

Doctor (who is taking the consent) :

Signature : [Signature]
Name : Dr Laxmi Chayak
Date & Time : 25/7 at 9am

26-0000216767

NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

Patient Name: <u>Mrs. Swathi Bakki</u>	Age: <u>36 Yrs</u>	Gender: <u>Female</u>	
UHID No: <u>HHH-00016509</u>	IP No: <u>26-00006941</u>	Date: <u>25/7/26</u> Time: <u>9:21</u>	
Diagnosis: <u>LSCS</u> <u>OT</u>			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	<u>100mcg</u>	<u>01</u>
2.	Morphine Sulphate Inj. 15mg/ML		
3.	Remifentanyl Hydrochloride Inj. 2MG		
4.	Remifentanyl Hydrochloride inj. 1MG		
Doctor Name: <u>Duramir</u>		Doctor Registration No: <u>67529</u>	
Signature: <u>[Signature]</u>			

NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 26-00006941 Date: 25/7/26

Aadhaar No. of the Patient (Optional):

1.	Name: <u>Mrs. Swathi Bakki</u>	Remarks
2.	Complete postal address (with contact number, if any)	<u>Baghlinpally Hyderabad.</u>
3.	Brief description of the illness	<u>LSCS</u>
4.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded)	<u>NO</u>
5.	Details of essential Narcotic drug dispensed	<u>Fentanyl</u>

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
<u>25/7/26</u>	<u>Fentanyl</u>	<u>01</u>		

Dispensed by (Name & ID No.): U. Pallavi 017921 Signature: [Signature]

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

Time:



NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

1. Patient Name: John Doe
2. Date of Birth: 12/12/1950
3. Address: 123 Main St, Anytown, CA 90210
4. Telephone: (555) 123-4567
5. Physician: Dr. J. Smith
6. Drug Name: Hydrocodone Bitartrate
7. Strength: 5 mg
8. Dosage: 2 tablets 4 times daily
9. Indication: Chronic Pain
10. Prescribed by: Dr. J. Smith
11. Date Prescribed: 01/15/2001
12. Signature: [Signature]

NARCOTIC DISPENSING FORM
APPENDIX 4 - FORM NO. 12

(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

1. Patient Name: John Doe
2. Date of Birth: 12/12/1950
3. Address: 123 Main St, Anytown, CA 90210
4. Telephone: (555) 123-4567
5. Physician: Dr. J. Smith
6. Drug Name: Hydrocodone Bitartrate
7. Strength: 5 mg
8. Dosage: 2 tablets 4 times daily
9. Indication: Chronic Pain
10. Prescribed by: Dr. J. Smith
11. Date Prescribed: 01/15/2001
12. Signature: [Signature]

13. Dispensed by: [Signature]
14. Date Dispensed: 01/15/2001
15. Signature: [Signature]

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Mrs. Punatti Bakki Age: 36y Sex: Female UHID.No: MNH-16509

Date: 25/7 Time: 830am Proposed Operation: MCO

Diagnosis: G2A1 @ 30wks @ GHTM.

B.P / CRT: 134/74 H.R: 108 Weight: 83.8 ASA Physical Status: ☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5

Laboratory Data:

24/7 Hgb: 10.5 Glucose: 10 Protein: 5.7 HIV: NR X-Ray: 2D Echo: EF-70%
PCV: 30.7 Urea: 10 Alb: 2.9 HBS Ag: NR Stress/Angio: NO RWMA
WBC: 7320 Creat: 0.6 Total Bill: 0.2 HCV: NR Other: NO RWMA
Plate: 1.80 Na: 135 Dir. Bill: 0.1 Blood group: Bpos T3: T4: TSH: 15/11
PT: 14 K: 4.2 LDH: 154
PTT: Ca++: Mg++: Amylase: SGOT/SGPT: 15/11
INR: 1.0 Cl-: 109

Allergies: NKDA

Medical History: CVS: GHTM: Monday - on medication. Consulted outside

RESP: C/O SOB: one week Diabetes:

CNS: no prior medical history

Renal: AUCs done regularly in multiple hospitals

Hepatic / GE: Physical Activity: limited: one week

Others: active prior

Past Anaesthetic History: no prior exposure to anesthesia

Physical Exam: coherent pedal edema ++, NPE/O DVT.

Airway: MP 1 2/3 4 Mouth Opening: adu Mentohyoid Distance: 3cm Neck: (N) Teeth: intact

Lungs: BAE+ Clear no additional sounds - R-18/m SpO2 98% on

Heart: S1S2+ No

CNS:

Pregnant: ☒ Yes ☐ No ☐ NA Venous Access Site: peripheral Spine Exam for regional: deep

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

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

CURRENT MEDICATIONS	DOSAGE
ECOSPAIN 150mg	k/ca
THYRONORM 75mg	AUGMENTIN 625mg
LABETALOL 100mg	TID
NKANDIA RETARD	10mg TID

Pre-Operative Instructions:

- DVT Prophylaxis:
 - Water / ORS 2 Hours
 - Others 6 Hours
- NIL ORAL
- Informed Consent: ☐ Standard ☒ High Risk
- Post Operative Pain Management: ☐ Discussed with Patient
- Other Instructions:
 - Crossmatch & reserve PRBC

Signature: [Signature] Name: Dr. Samir Chakraborty
Docu. No.: RCH / FRM / CLINICAL / 044

Fasting Status: Adequate

Physical Status:	☒ Patient Identified	☒ Consent Present	☒ Chart Reviewed
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H.R: 90/min	B.P / CRT: 120/80/4	SpO ₂ : 100%	R.R: 16/min	Last Feed:
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Pre-OP Diagnosis: ~~100000~~ G2M30worsc... Operation: Emergency C-sec. Date 25/07/26..

Surgeon: Dr. Sudhakar Ramya Anaesthesiologist: Dr. Vinod Vignesh Technician: Mrs. Kellani

TIME										Antibiotic
N ₂ O /AIR/O ₂ LPM	1	2	3	4	5	6	7	8		
HALO /SO /SEVO	1	2	3	4	5	6	7	8		
2.4 5lit	2.0	1.5	1.5	2.0	1.5	3.0				

Drugs:	INIPROPHEN 20 + 972 INIPROPHEN + 972 INIPROPHEN	9/10/10
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Suppository

INT. NUDAZOLAN 2 mg

1. ART: CAP 450 PROBC = 200 mcat.M.

1. $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$ (1/4 of the area is shaded)

FIG. 1	FIG. 2	FIG. 3	FIG. 4	FIG. 5	FIG. 6	FIG. 7	FIG. 8	FIG. 9	FIG. 10	FIG. 11	FIG. 12	FIG. 13	FIG. 14	FIG. 15	FIG. 16	FIG. 17	FIG. 18	FIG. 19	FIG. 20	FIG. 21	FIG. 22	FIG. 23	FIG. 24	FIG. 25	FIG. 26	FIG. 27	FIG. 28	FIG. 29	FIG. 30	FIG. 31	FIG. 32	FIG. 33	FIG. 34	FIG. 35	FIG. 36	FIG. 37	FIG. 38	FIG. 39	FIG. 40	FIG. 41	FIG. 42	FIG. 43	FIG. 44	FIG. 45	FIG. 46	FIG. 47	FIG. 48	FIG. 49	FIG. 50	FIG. 51	FIG. 52	FIG. 53	FIG. 54	FIG. 55	FIG. 56	FIG. 57	FIG. 58	FIG. 59	FIG. 60	FIG. 61	FIG. 62	FIG. 63	FIG. 64	FIG. 65	FIG. 66	FIG. 67	FIG. 68	FIG. 69	FIG. 70	FIG. 71	FIG. 72	FIG. 73	FIG. 74	FIG. 75	FIG. 76	FIG. 77	FIG. 78	FIG. 79	FIG. 80	FIG. 81	FIG. 82	FIG. 83	FIG. 84	FIG. 85	FIG. 86	FIG. 87	FIG. 88	FIG. 89	FIG. 90	FIG. 91	FIG. 92	FIG. 93	FIG. 94	FIG. 95	FIG. 96	FIG. 97	FIG. 98	FIG. 99	FIG. 100	FIG. 101	FIG. 102	FIG. 103	FIG. 104	FIG. 105	FIG. 106	FIG. 107	FIG. 108	FIG. 109	FIG. 110	FIG. 111	FIG. 112	FIG. 113	FIG. 114	FIG. 115	FIG. 116	FIG. 117	FIG. 118	FIG. 119	FIG. 120	FIG. 121	FIG. 122	FIG. 123	FIG. 124	FIG. 125	FIG. 126	FIG. 127	FIG. 128	FIG. 129	FIG. 130	FIG. 131	FIG. 132	FIG. 133	FIG. 134	FIG. 135	FIG. 136	FIG. 137	FIG. 138	FIG. 139	FIG. 140	FIG. 141	FIG. 142	FIG. 143	FIG. 144	FIG. 145	FIG. 146	FIG. 147	FIG. 148	FIG. 149	FIG. 150	FIG. 151	FIG. 152	FIG. 153	FIG. 154	FIG. 155	FIG. 156	FIG. 157	FIG. 158	FIG. 159	FIG. 160	FIG. 161	FIG. 162	FIG. 163	FIG. 164	FIG. 165	FIG. 166	FIG. 167	FIG. 168	FIG. 169	FIG. 170	FIG. 171	FIG. 172	FIG. 173	FIG. 174	FIG. 175	FIG. 176	FIG. 177	FIG. 178	FIG. 179	FIG. 180	FIG. 181	FIG. 182	FIG. 183	FIG. 184	FIG. 185	FIG. 186	FIG. 187	FIG. 188	FIG. 189	FIG. 190	FIG. 191	FIG. 192	FIG. 193	FIG. 194	FIG. 195	FIG. 196	FIG. 197	FIG. 198	FIG. 199	FIG. 200	FIG. 201	FIG. 202	FIG. 203	FIG. 204	FIG. 205	FIG. 206	FIG. 207	FIG. 208	FIG. 209	FIG. 210	FIG. 211	FIG. 212	FIG. 213	FIG. 214	FIG. 215	FIG. 216	FIG. 217	FIG. 218	FIG. 219	FIG. 220	FIG. 221	FIG. 222	FIG. 223	FIG. 224	FIG. 225	FIG. 226	FIG. 227	FIG. 228	FIG. 229	FIG. 230	FIG. 231	FIG. 232	FIG. 233	FIG. 234	FIG. 235	FIG. 236	FIG. 237	FIG. 238	FIG. 239	FIG. 240	FIG. 241	FIG. 242	FIG. 243	FIG. 244	FIG. 245	FIG. 246	FIG. 247	FIG. 248	FIG. 249	FIG. 250	FIG. 251	FIG. 252	FIG. 253	FIG. 254	FIG. 255	FIG. 256	FIG. 257	FIG. 258	FIG. 259	FIG. 260	FIG. 261	FIG. 262	FIG. 263	FIG. 264	FIG. 265	FIG. 266	FIG. 267	FIG. 268	FIG. 269	FIG. 270	FIG. 271	FIG. 272	FIG. 273	FIG. 274	FIG. 275	FIG. 276	FIG. 277	FIG. 278	FIG. 279	FIG. 280	FIG. 281	FIG. 282	FIG. 283	FIG. 284	FIG. 285	FIG. 286	FIG. 287	FIG. 288	FIG. 289	FIG. 290	FIG. 291	FIG. 292	FIG. 293	FIG. 294	FIG. 295	FIG. 296	FIG. 297	FIG. 298	FIG. 299	FIG. 300	FIG. 301	FIG. 302	FIG. 303	FIG. 304	FIG. 305	FIG. 306	FIG. 307	FIG. 308	FIG. 309	FIG. 310	FIG. 311	FIG. 312	FIG. 313	FIG. 314	FIG. 315	FIG. 316	FIG. 317	FIG. 318	FIG. 319	FIG. 320	FIG. 321	FIG. 322	FIG. 323	FIG. 324	FIG. 325	FIG. 326	FIG. 327	FIG. 328	FIG. 329	FIG. 330	FIG. 331	FIG. 332	FIG. 333	FIG. 334	FIG. 335	FIG. 336	FIG. 337	FIG. 338	FIG. 339	FIG. 340	FIG. 341	FIG. 342	FIG. 343	FIG. 344	FIG. 345	FIG. 346	FIG. 347	FIG. 348	FIG. 349	FIG. 35
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[illegible][illegible][illegible][illegible][illegible][illegible][illegible][illegible]

Trial	Throat Pack In	Throat Pack Out
1	132	130
2	133	131
3	132	130
4	133	131
5	132	130
6	133	131
7	132	130
8	133	131
9	132	130
10	133	131
11	132	130
12	133	131
13	132	130
14	133	131
15	132	130
16	133	131
17	132	130
18	133	131
19	132	130
20	133	131
21	132	130
22	133	131
23	132	130
24	133	131
25	132	130
26	133	131
27	132	130
28	133	131
29	132	130
30	133	131
31	132	130
32	133	131
33	132	130
34	133	131
35	132	130
36	133	131
37	132	130
38	133	131
39	132	130
40	133	131
41	132	130
42	133	131
43	132	130
44	133	131
45	132	130
46	133	131
47	132	130
48	133	131
49	132	130
50	133	131
51	132	130
52	133	131
53	132	130
54	133	131
55	132	130
56	133	131
57	132	130
58	133	131
59	132	130
60	133	131
61	132	130
62	133	131
63	132	130
64	133	131
65	132	130
66	133	131
67	132	130
68	133	131
69	132	130
70	133	131
71	132	130
72	133	131
73	132	130
74	133	131
75	132	130
76	133	131
77	132	130
78	133	131
79	132	130
80	133	131
81	132	130
82	133	131
83	132	130
84	133	131
85	132	130
86	133	131
87	132	130
88	133	131
89	132	130
90	133	131
91	132	130
92	133	131
93	132	130
94	133	131
95	132	130
96	133	131
97	132	130
98	133	131
99	132	130
100	133	131

Age	Percentage
15	95
16	85
17	80
18	85
19	85
20	85
21	85
22	85
23	85
24	85
25	90
26	85
27	85
28	85
29	85
30	85
31	85
32	85
33	85
34	85
35	85
36	85
37	85
38	85
39	85
40	85
41	85
42	85
43	85
44	85
45	85
46	85
47	85
48	85
49	85
50	85
51	85
52	85
53	85
54	85
55	85
56	85
57	85
58	85
59	85
60	85
61	85
62	85
63	85
64	85
65	85

Year	Number of people (millions)
1980	35
1981	36
1982	37
1983	38
1984	39
1985	40
1986	41
1987	42
1988	43
1989	44
1990	45
1991	46
1992	47
1993	48
1994	49
1995	48
1996	49
1997	50
1998	51
1999	52
2000	53
2001	54
2002	55
2003	56
2004	57
2005	58
2006	59
2007	60
2008	61
2009	62
2010	65

[illegible][illegible]

LAB Values	
	GRBS

[illegible]

☒ Equipment Checked and Functional
 Temp: ☐ HME ☐ Fluid Warmer
 Induction ☐ IV ☐ Inhal
 Regional: ☐ Extremity
 Specific: _____

☒ BP ☐ Cling Film ☐ OH Warmer ☐ Pre O₂ ☐ RSI ☒ Spinal ☐ Epidural ☐ Caudal

☐ Cuff Site: 1.....
☐ Art Site:
☐ Hugger's ☐ Cotton Wool ☐ Others
☒ Other
☐ Mask ☐ SGA
 Others:
 Position: Sitting

☒ EKG Lead
☒ Temp Site
 Times: 12:45 PM
☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
 Site: 12-14

☒ FIO₂ Monitor

☐ Agent Monitor
☒ Pulse Oximeter

☒ Capnograph
☐ Ventilator
 Leave OR: 4:00 PM
Anesthesia:
☐ Awake
☐ Direct Vision
 Drug Name & Conc: 0.5% (1) 100% VAE
 Dose: 1.5% (3) 100% VAE

☐ Ventilator	Anaesthesia.	☐ Awake	☐ Direct vision	Bolus:
☐ Nerve Stimulator	☐ GA	☐ Video Laryngoscopy	☐ Stylette / Bougie	Infusion:

Position: Supine ☐ Monitored Anaesthesia Care ☐ Fiberoptic
☒ Regional Blade# _____ Attempts: _____ Block Level: T4

☒ Pressure Points Checked Line (Size & Location)	Difficulty Why?	Comments:
---	-----------------	-----------

☐ Bilat = BS
 ☒ PACU
 ☐ ICU
 ☐ Other

☐ Oint
☐ Tape

☐ ART: DOT, 204
☒ IV: DOT, 204

☐ Semi-Closed Circle
☐ Closed Circle

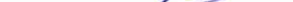
Relaxant Reversed ☐ Yes ☐ No ☒ NA
 Date: 11/11/2011

☐ Padding
☒ Awake

☒ IV: Diltiazem 180mg
☐ IV:

☐ Other

Name of the Doctor: Dr. M. Vukobratovic
Signature of the Doctor: [Signature]

	☒ IV	Signature of the Doctor:	
---	--	--------------------------	---



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: Chun bakale Time Received: 3pm Time Discharged: 12:20pm

250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0 RES PULSE < BLOOD PRESSURE >	250 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	IV Cannula Site: <u>bf hand</u> ☐ O₂ Mask ☐ Nasal Prongs ☐ Tracheostomy ☐ T-Piece ☐ Oral Airway ☐ Nasal Airway
		Vomiting: ☐ Yes ☒ No NG Tube: ☐ Yes ☒ No Drain: ☐ Yes ☒ No Urinary Catheter: ☒ Yes ☐ No Chest Tube: ☐ Yes ☒ No Nil Oral ☐ Yes ☒ No IV Fluids: <u>Rh</u> Oral Feeds: <u>NBM</u>

POST ANAESTHESIA SCORE (Modified Aldrete Score)		MINUTES			OUT	SCORING INTERPRETATION
		IN	30	60	90	
Able to move 4 extremities voluntary or on command	= 2		1	2	2	A Minimum Total Score of 8 is Required for Discharge
Able to move 2 extremities voluntary or on command	= 1					
Able to move 0 extremities voluntary or on command	= 0					Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to deep breathe & cough freely	= 2		2	2	2	
Dyspnea or limited breathing	= 1					
Apneic	= 0					
BP $\pm$ 20 of Pre Anaesthetic level	= 2		2	2	2	
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1					
BP $\pm$ 50 of Pre Anaesthetic level	= 0					
Fully awake	= 2		2	2	2	
Arousable on calling	= 1					
Not responding	= 0					
Pink	= 2		2	2	2	
Pale, dusky, blotchy, jaundiced, other	= 1					
Cyanotic	= 0					
TOTAL			9	10	10	

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
25/7/26	3pm	0	normal	CB
25/7/26	4pm	0	normal	CB
25/7/26	5pm	0	normal	CB
25/7/26	6pm	0	normal	CB

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

Anaesthesiologist Name: Dr. Vinutha

Anaesthesiologist Signature: [Signature]

Date & Time: 26/7/26 @ 12:30pm

PACU Nurse Name: Akhila

PACU Nurse Signature: [Signature]

Date & Time: 26/7/26 @ 12:20pm

Reassessment Frequency:

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

Transferred to Unit by (PACU): 314

Date & Time: 26/7/26 @

Patient Sticker

Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: Time: Procedure done by

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

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

a)

b)

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

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time :