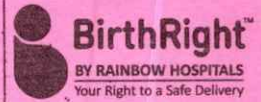


Dr. Gollu mahalakshmi
7659030447



ESTIMATION SLIP

Date : 20/5/26 UHID / IP No. : _____ SI No. **1523**
 Name of Patient : D. Switha Age: _____ Gender: F
 Father's / Husband's Name : D. Vireesh Corporate / Occupation : _____
 Address : _____ Phone : 9666024188 Email : _____
 Procedure / Plan : ND/LSCS EDD/Dos: 26th May
 MODE OF PAYMENT : SELF TPA : ND India GIPSA : _____ OTHER _____

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
	Normal Delivery	LSCS
Room Category		
Multi Shared Ward		
Shared Ward		
Twin Shared Ward →	<u>90k</u>	<u>1.10lac (75k)</u>
Private Room →	<u>1.27k</u>	<u>1.27k</u>
Super Deluxe Room		
Suite Room	<u>+ Non payable</u>	<u>Entire 1st to 25k</u>
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for : <u>2 Days</u>	Length of Stay for : <u>3 Days</u>
	Pharmacy up to <u>9,000/-</u>	Pharmacy up to <u>12,000/-</u>
	Investigations up to <u>2,500/-</u>	Investigations up to <u>3,000/-</u>
Others	<u>Well baby Care</u>	<u>25k to 35k</u>

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

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

- REMARKS : Vaccination, Neonatal, SBR, Bilirubin
- Room eligibility is purely subject to TPA approval and the Package / Room Tariff starts from the time of admission. The estimated amount may Change according to duration of stay, medical condition, investigations, pharmacy and any other procedure.
 - Proportionate difference of bill amount is applicable in case the patient opts for a category higher than the TPA approved, which has to be paid by the patient and may not be reimbursed by the TPA at later stage.
 - Total baby charges are extra which include admission, pharmacy, vaccinations, investigations, disposables, consumables, equipments, speciality consultations, etc.
 - In Case the patient gets discharged earlier than the packages permitted days, no refund of any type is applicable and if the length of stay is beyond the package permitted, additional payment is applicable for which kindly contact the Financial Counselling desk between 9am to 6pm
 - For Non-medicals, Disposables, Consumables, Taxes, Kiwi Cup charges, Implants, Tubectomy charges, HIV/HbsAg, Anti-D, Medical Records, Double Occupancy and Registration Charges, etc. credit cannot be exchanged. These items are not payable to us as per Insurance company norms.
 - Difference if any between the final bill amount and amount permitted/approved by TPA or total bill amount in case of denial from TPA has to be paid by the patient. In case of denial, cash tariff would be applicable.
 - Two attendants are permitted with patients in SDLX, DLX and PVT rooms and only one attendant is permitted in the rest of the categories of rooms and no attendant is permitted in ICU's
 - Tariffs are subject to revision
 - Kindly check your billing status on day to day basis at IP Billing Department.
 - Additional Charges on package are applicable for Non-working hours and Non-working days (sundays and public holidays)

DECLARATION

I _____ have attended the Financial counseling desk and understood the expected costs and other conditions applicable. In case the TPA / Insurance Company rejects the claim for whatsoever reasons at any point of time I promise to settle the hospital bill with the hospital without any ambiguity.

Mr. Vireesh Signature of the Client Husband Signatory Relationship Arshi madam Signature of the financial Counselor

HNH-00015547 IP26-00006397
Mrs D SUNITHA
01-01-1990 36 Y (F)
Dr. MAHALAKSHMI GOLI



SURGERY DETAILS

Date : 21/5/26
Patient Name: Mrs. Sunitha Date of Birth: 11/1/1990 Age: 36y
Gender: female Ward : OT UHID No: HNH-00015547
Date of Surgery: 21/5/26 OT -1 OT -2 OT -3 OT -4 OBG OT-1 OBG OT-2
Name of the Surgery : EM. LSCS.

Time in : 9:30 pm

Time Out : 10:30 pm

	NAME	AMOUNT
1. Surgeon	Dr. Sunitha Mahalakshmi	
2. Anaesthetist	Dr. Samir	
3. Assistant Surgeon	Dr. Swathi	
4. OT Technician	Br. Anand	
5. Circulating Nurse	Sr. Pujja	
6. Assistant Nurse	Sr. Sangeetha	

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

Mahalakshmi
Signature of the Surgeon

Puja
Signature of Circulating Nurse

Order No: 26-0000201300

Order by: Balu @ 9:12 AM 22/5/26

HNH-00015547 IP26-0006397
 Mrs D SUNITHA
 01-01-1990 36 Y (F)
 Dr. MAHALAKSHMI GOLI



CONSUMABLES OF OT

Circulating staff : puja Technician : Arvind Date : 21/5/26 Time :

Anaesthesia Disposables	Qty		Surgical Disposables	Qty		Disposables (Baby Side)	Qty	
	Issued	Used		Issued	Used		Issued	Used
ET tube			Major Pack LSCS	✓	01	Inj Vit.K		01 ✓
LMA			Sutures 883, 4242	✓	1+1	Cord Clamp		01 ✓
ECG leads (A/P/N)	✓	03	2346, 2762	✓	2+1	Suction Catheter		
HME filter : A/P/N						Feeding Tube 5no		01 ✓
Syringes : 10 cc	✓	03				Vaccum Suction Set		
05 cc	✓	03	Gloves 6 1/2	✓	03	Surgical Gloves 6, 6 1/2	✓	1+1 ✓
02 cc	✓	02	EXORE 8/2	✓	02	Gauze Pack 7.5		01 ✓
01 cc	✓	02				Syringe 1ml / 2ml		02 ✓
Cautery plate (A/P/N)	✓	01	Surgical blade 22	✓	01	Surgical Blade # 20		01 ✓
IV set			NG tube			Koochies (S)		01 ✓
RL	✓	02	Cautery pencil	✓	01	26-0000201295		
NS : 10ml / 100ml / 500ml / 1000ml			Koochies 2XL	✓	01	1296		
Oxytocin	✓	03	Ointments					
			Suction Catheter					
Fentanyl		01	Cap, Mask	✓	10+10			
Morphine			Gauze Pack 7.5	✓	02			
Ketamine			Mop Pack	✓	02			
Propofol			Steristrip					
Rocuronium			Underpad	✓	02			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel	✓	01			
Ondansetron			Foleys catheter					
276 Pencil 26 / Spinal Needle 22	✓	01	Urobag					
Bupivacaine 0.25%			Chest Drainage Catheter					
Bupivacaine 0.25% (Heavy)	✓	01	Romodrain bag					
Antibiotics			Bandage					
			Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg	✓	01	Vaccum Suction set	✓	01			
Justin : 12.5 mg / 25mg / 100mg	✓	01	Plastic Bed Sheet					
Tab. Misoprost : 200mg	✓	04	Betadine Solution	✓	02			
G Gloves 70	✓	01	Microshield	✓	01			
Gauze 7.5 x 7.5	✓	02	Cotton Balls	✓	01			
			Latex Gloves	✓	20			
			Ramdione Scrub					
			Sara PLASTIC APPON	✓	04			

Surgeon _____ Anaesthesiologist _____ Nurse _____ OT Technician _____
 Order No. : 26-0000201293/1294 Ordered by : Sundip
 Doc. No. : RCH / FRM / GENERAL / 125

HNH-00015547 IP26-00006397
 Mrs D SUNITHA
 01-01-1990 36 Y (F)
 Dr. MAHALAKSHMI GOLI



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	3			
7	Nursing plan of care and handover sheets	1			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaesthesia notes (Pre Anaesthesia & post)				
22	Neonatal Admission/Delivery/Physical Exam	1			
23	Medication Reconciliation	1			
24	Emergency Triage record				
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart	4			
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				
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				
	<i>Billing sheet</i>	1			
		6			
	Total No. of Pages	<u>27</u>			

M. Daisy (P.T.O)
 24/5/26

Name	Mrs D SUNITHA	UHID	HNH-00015547
Father/Guardian	Mr D VEERESH	Age/Gender	36 Y / Female
Address	dundigal h no 6-58 gandhi maisamma mondal medchal dist, Air Force Academy, Hyderabad, Telangana, INDIA, 500043		
IP No	IP26-00006397	Admission Date	21-05-2026
Ref Doctor	self		
Discharge Date	24.05.2026		

DISCHARGE SUMMARY

Consultant:
Dr. MAHALAKSHMI GOLI,
MBBS , MD(OBG)
AMC16257

Diagnosis: PRIMIGRAVIDA WITH 38 WEEKS PERIOD OF GESTATION WITH IVF CONCEPTION WITH CEPHALO PELVIC DISPROPORTION WITH CHRONIC HYPERTENSION IN LABOUR FOR DELIVERY

History:

ET: 06.09.2025
EDD: 01.06.2026

Obstetric formula: Primigravida
Gestation at admission: 38 weeks

Name	Mrs D SUNITHA	UHID	HNH-00015547
IP No	IP26-00006397	Admission Date	21-05-2026

Obstetric History:

G1 - Present pregnancy, IVF conception.

Medical History: Chronic HTN -diagnosed in pregnancy.

Family History: Nil

Surgical History: Hysteroscopy in 2025.

Allergies: Nil

Antenatal Details:

Mrs D SUNITHA was booked to Rainbow hospital at 38 weeks of gestation. She had regular antenatal checkups and investigations as advised. She was diagnosed with Chronic HTN at 9⁺⁵ weeks, started on antihypertensive. Home BP recordings done, within normal limits. NT scan was normal. FTS was low risk. TIFFA was normal. Fetal 2D Echo was normal OGTT at 24 weeks(89/61/154). Fetal growth monitoring done by serial growth scan. Growth scan done at 03.05.2026 showed SLIUP at 36⁺⁵ weeks with Placenta fundo posterior, Cephalic presentation with AFI 18-19cm with EFW 2800gm, with Doppler normal. She was admitted at 38 weeks with CPD in labour for EM.LSCS.

Investigations: Enclosed

Blood group: "A Positive"

Management: Course in hospital:

She was prepared for emergency C- section in view of CPD in early labour with

Name	Mrs D SUNITHA	UHID	HNH-00015547
IP No	IP26-00006397	Admission Date	21-05-2026

precious pregnancy. 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 spinal anesthesia she was painted and draped as per hospital protocol. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A Lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 600 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

***LUS - Vascular.**

Delivery Details :

Date : 21.05.2026
Time of Delivery : 9:58pm
Type of Delivery : Emergency LSCS
Indication : CPD in Labour
Anaesthesia : Spinal

Name	Mrs D SUNITHA	UHID	HNH-00015547
IP No	IP26-00006397	Admission Date	21-05-2026

Baby Details :

Date : 21.05.2026
Time : 9:58pm
Sex : Male
Weight : 3.3kg
Apgar : 8,10
Gestational Age: 38 weeks
NICU Admission: No

Post-Operative Notes:

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

Advice:

1. Tab. Taxim O 200mg twice daily till (9am-9pm) 29.05.2026 after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 27.05.2026 (8am-2pm-10pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 27.05.2026 (9am-3pm-11pm) after food.
4. Tab. Pantop 40mg twice daily till 29.05.2026 (7am-7pm) before food.

Name	Mrs D SUNITHA	UHID	HHN-00015547
IP No	IP26-00006397	Admission Date	21-05-2026

5. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500 mg, Vitamin D3 250 IU) once daily (2pm) till breast feeding for after food.
7. Nebasulf Powder for local application.

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 6weeks; Please discuss with your treating doctor regarding **HPV vaccination**.

Review with **Dr. MAHALAKSHMI GOLI** after 1 week on **01.06.2026** at postnatal clinic.

For Women Who Have Had a Cesarean Section 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.

Name	Mrs D SUNITHA	UHID	HNH-00015547
IP No	IP26-00006397	Admission Date	21-05-2026

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.

del
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 Himayatnagar or just dial one toll free number - 18002122.

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

del
Registrar/Resident/C.M.O

Dr. MAHALAKSHMI GOLI
MBBS , MD(OBG)
AMC16257



ADMISSION SHEET

Registration Details :



Admission No : IP26-00006397 Admit Date : 21-May-2026 Admit Time : 08:08 PM UHID : HNH-00015547

Patient Details :

Patient Name : Mrs D SUNITHA Age : 36 Y
Guardian : Mr D VEERESH DOB : 01-01-1990
Gender : Female Religion :
Occupation : Martial Status :
Address (H) : dundigal h no 6-58 gandhi maisamma mondal medchal dist Air Force Academy Hyderabad Telangana INDIA 500043 Phone No : 9666024185/ 7659030447
E-mail : veeresh.duddala@gmail.com

Admission Details :

Bed Type : TWIN SHARING Bed No : LDR-415 Ward Name : 4F -OT
Room No : LDR-415 Admission Type : First Visit

Contact Details :

Name : Mr D VEERESH Relationship : Husband
Contact Address : dundigal h no 6-58 gandhi maisamma mondal medchal dist Air Force Academy Hyderabad Telangana INDIA 500043 Phone No : 9666024185


Signature


Doctor Details :

Doctor Name : Dr. MAHALAKSHMI GOLI Specialisation : OBSTETRICS AND GYNECOLOGY
Referral Doctor : self Phone No :
Co-Consultant :

Payment Details :

Payment Mode : Cash Deposit Amount : 10000.00
Payor Name : MDINDIA HEALTH INSURANCE TPA PVT LTD


PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015547 IP26-00006397 Mrs D SUNITHA 01-01-1990 38 Y (F) Dr. MAHALAKSHMI GOLI 		Date & Time of Admission 21/5/26 @ 11:00 AM	Date & Time of Transfer Order 22/5/26 @ 5 AM
		Transfer Ordered by Dr. Sreethi	Reason for Transfer OBU
From Unit DR 8087	To Unit (315)	Information to Attendant Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	
Number of Sheets in Clinical File	Number of Imaging Films NST-1	Personal belongings including clinical documents. If any handed over to attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, what?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	RL	①	
2.			
3.	P		
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Madhumita @ Madhu		Name of Person Ordered Transfer Dr. Sreethi	
Patient & Clinical Records Received by : Srujan @ 5.30 am			
Date & Time of Patient Received : 22/5/26			

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

- Unavailable Bed
 Nurse not Available
 Available Bed not ready

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015547 IP26-00006397 Mrs D SUNITHA 01-01-1990 36 Y (F) Dr. MAHALAKSHMI GOLI 		Date & Time of Admission 21/5/26 @ 8.08pm	Date & Time of Transfer Order 21/5/26 @ 9:30am
		Transfer Ordered by Dr. Sweathi	Reason for Transfer BMLSES
From Unit Postpart	To Unit (OT)	Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 30	Number of Imaging Films MS7-①	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring madhumi@madhu		Name of Person Ordered Transfer Dr. Sweathi	
Patient & Clinical Records Received by : Puja			
Date & Time of Patient Received : 21/5/26 @ 9:30am.			

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

ACTIVITY RECORD FOR BILLING

Name: ----- HNH-00015547 IP26-00006397
 UHID No : ----- Mrs D SUNITHA 36 Y (F)
 Date of Admission : ----- Dr. MAHALAKSHMI GOLI
 Consultant : ----- Dept : -----
 Date of Discharge : ----- Time: -----
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
21/5	9:30 AM	prepost	OT	[Signature]
21/5/26	10:56 pm	OT	prepost	Puja / [Signature]
22/5	3 AM	prepost	(315)	[Signature]

Cross Consultation Visit

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

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
2115	IV placement	①	} 1224	Q
2115	catheterization	①		Q
2115	pac (OP)	①		} 1223
<p><i>cross checked done</i></p>				
22/5/28	NHA	①	} 1496	Q
<p><i>cross checked done by Sumanta</i></p>				

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor
-------------	--------------	-------------------	--------------------



IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints

for Em. LSC

Obstetric Formula: Primi

Obstetric History: IUF conceptⁿ

NT - (N), FTS - low risk,
 MIFT (N), GTT - 89/161/154
 TIFPA (N), Pecho (N)
 Present Pregnancy Record:

Growth (N)

RISK FACTORS:

→ Chronic HON.
 (stopped after marks POG)

Height: cm

Weight: 80 kg

Allergies: NIL

Breast: Normal Abnormal

General Examination:

Consciousness: (+)

Pallor: (-)

Icterus: (-)

Edema: (-)

Temp: Afebrile

PR: 78bpm

BP: 122/80wtg.

DTR: (+)

CVS: SS2 (+)

RS BLNIBS

Liver/Spleen: (N)

Urine Output: (N)

DIAGNOSIS

Primi | 38 weeks ± IUF conceptⁿ ± CPD in labour.
 ± Chr. HTN

LMP:

EDD: 1/6/26

Corrected EDD:

GA: 38 weeks.

Menstrual History: Regular: Yes No

Obstetric Examination

Fundal Height: U/L term.

Ut. Activity: Relaxed Mild Mod Severe

Liquor: Adequate Oligo Poly

PP: Cephalic Breech Others _____

Head Fifths Palpable: S/S

FHS: Normal Tachy Brady Absent

Per Speculum Examination - Not done

Draining: Present Absent Bleeding

Colour of Liquor: Clear Meconium Blood Stained

Vaginal Examination - Not done

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



Family History:

Mel.

Surgical History:

H/o Hysteroscopy in 2025

Medical History:

Kidney ~~Chronic~~ Chronic H/OA
Impreg.

Medication History:

Dr. Fe / T. Ca

Plan of Care:

Emergency USG

- Admission CTG
- Informed consent
- Prepare parts
- PAC
- Inform OT / Anesthetist / Pediatrician
- Pre-op medications as checked
- Shift to OT on call.
- Check for blood availability
- CBP.

Investigations:

Blood Group - 'A positive'

Hb - 11.7

PLT - 2.2 lac

WBC -

HIV
HBSAg
VDRL } NR

USG (3/5/26) ~ 36⁺ w/ep

SLR., Cephalic

PI - Ruda post

AFI - 18-19 cm

EFW - 2.8 kg

AC - (N)

Dopplers - (N)

Doctor Name: J. Deena
Signature: [Signature]
Date & Time: 21/5/26 @

Consultant Name: Dr. G. Mahalakshmi
Signature: [Signature]
Date & Time: 21/5/26 @



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	<u>Dr. SWATHI R.V</u>	
21/05/2016 11:30 AM	- day 0 of EMUS / P.R. - pt reviewed comfortable.	
		<u>Advice</u>
	P → 80 bpm	- follow order
	BP → 117/80 mm Hg	- 2x fluids @ 100ml/h
	no pain	
Baby - MS	PA: soft uterine R	+ follow order
	D-day	
		- w/ 7 pain/penny / bleed m
	WE: clear	- 2x fluids
	U/O → 50ml/h clear	- TENS stockings
		<u>Dr. SWATHI R.V</u>
	<u>Dr. SWATHI R.V</u>	
22/05/2016 11:30 AM	day 0 of EMUS / P.R. - pt reviewed comfortable.	<u>Advice</u>
	O/E: P → 80 bpm	- @ vitals
	BP → 130/80 mm Hg	- 2x Allow walking
	PA: soft uterine R	- Follow order towards
	D-day	- 2x fluids x 24hr
U/O → 90ml/h	P/S +/+	→ w/ 7 pain/penny / bleed m
	WE: no A+ bleed	- 2x fluids 400ml/h to 200ml/h

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/05/2026 8:15am	cls/by. Dr. Mahalakshmi Goli	
	<p>o/e GC-fair Afebrile PR: 86bpm BP: 121/74 mm Hg, CUSLRS - NAD PA: ut. retracted Soft, NT Dressing: dry & clean UE: PV bleeding WNL U/O: 40-50ml/hr clear</p>	<p>Adv - Liquid diet #1b. - Soft diet @ from 11am - Foley's removal at 4pm - Ambulation - Drugs as charted - MLC & I/SOS 'Rahabekn' NB Sunanda</p>
	Baby: Mother's side	
22/5/26 2pm Dr. P. S. X.	<p>cls/by Dr. Veena P.4 / PDD-D Pt is stable, Noct o/e ac-fair, Afebrile - vitals - stable P/A - Ut well retracted BS (+) UE - B/WNL U/O - 60ml/hr., clear.</p>	<p>Adv - Soft diet - Foley's removal @ 5pm - Ambulation - Adequate hydration - Vital monitoring, I/O charting - Drugs as charted NB Moutugh 2pm</p>

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/5/26 5:45 PM	Cc for Temp @ Breasts soft Abd soft.	① Soft diet ② IV fluids 10 RL 105% D 10 DNS ③ inj Antibiotics
Baby passed urine & meconium		④ Pain management
active taking feeds.		N.B. Maheshwari
22/5/2024 7:30 pm	Cecils A Munnah Poo 0	
u- yet to void R✓	Cc for Afebrile vitals stable PIR at well rehydrated PV bloody urine	Adm ✓ Soft Diet ✓ Adeq Hydrat ✓ Drugs as amnd ✓ Ambulate ✓ Encourage to pass urine ✓ Inform SS
		MB Sunanda My Error

PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/2020	cls by @ Manshe	
7am	POD 1	
	CE For Afebrile	Adv:
	Vitals stable	- Soft Diet
	BP 108/70	- Adeq hydrate
	PA w/ WR	- Dmg as chkd
	BS ⊕	- WFL vcrs 18hr
UV	PR Bleeding w/ W	- Suppstron @ PR (2) Stat
FV		- Inform SN
SX		
23/5/2020	cls by Dr. Mahalakshmi	
8:30am		
	OLE GC-Fair	
	Afebrile	
	Vitals - stable	
	PA: ut. retracted	
	Soft, NT	
	Dressing: dry & clean	
	HE: PR bleeding w/ W	
UV		IV fluids 10RL
FV		10570
SX		100mg
		Soft diet
		Dmg as charted
		Ambulation
		WFL PR bleeding
		Monitor Vitals
		Tegaderm dressing TLM.
		- Inform SOS
		Mahalakshmi
		MB Suresh



PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/26 6:45pm	<p style="text-align: right;">cls/B D. Veena</p> <p>POD-1 / P.U</p>	
<p>Baby @ ms on DSPT</p> <p>U ✓ F ✓ S ✓</p>	<p>Pt is stable</p> <p>cto 2 episodes of vomitings.</p> <p>o/e GC-fair,afebrile</p> <p>BP-117/75mmHg</p> <p>PR-70bpm.</p> <p>PIA- Ut well retracted</p> <p>BS (+)</p> <p>UE - BWNL.</p> <p>B/c Breasts - Soft, ms (+)</p> <p>Dry areola (+)</p>	<p>Adv</p> <ul style="list-style-type: none"> - Soft diet. - Drugs as charted - Vital monitoring - no w/lf imminent signs - Tegaderm dressing c/m - Ambulation - Adequate hydration - Inform SAs <p>moisturiser/coconut oil for nipple area - To clean after before feeding.</p>
24/5/26 8:15am	<p style="text-align: right;">cls/B D. Veena</p> <p>POD-2 / P.U</p>	<p>noted by madhuri</p>
<p>Baby @ ms on DSPT</p> <p>U ✓ F ✓ S ✓</p>	<p>Pt is stable, No cto</p> <p>o/e GC-fair</p> <p>Vitals-stable</p> <p>PIA - Ut well retracted</p> <p>BS (+)</p> <p>UE - BWNL</p> <p>B/c Breasts - Soft, ms (+)</p> <p>Areola dry. (subsided)</p>	<p>Adv</p> <ul style="list-style-type: none"> ✓ Regular diet @ 6:45pm ✓ Drugs as charted ✓ no w/lf imminent signs, Vital monitoring ✓ Tegaderm dressing today ✓ Ambulation ✓ Adequate hydration ✓ Inform SAs <p>MB Saranda</p>

HNH-00015547 IP26-00006397

Mrs D SUNITHA
01-01-1990 38 Y (F)
Dr. MAHALAKSHMI GOLI



DRUG CHART

Date of Admission: 21/5/26 Drug Allergies: nil Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

SOS / PRN (As Required Medication)

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

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

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

Signature
VERIFIED BY : Name



REGULAR PRESCRIPTIONS

Weight. Ward.

DRUG : INJ. CEFOTAXIME				Date Time																	
Dose	Route	Frequency	Start Date																		
1g	IV	BD	21/5/26																		
Name & Signature of the Doctor Starting the Drugs:				 500 mg qd 21/5/26																	
Additional Instructions:				x 72 hrs ATT																	
Daily Doctor's Endorsement by a Sign																					
DRUG : INJ. CEFTRIAXONE				Date Time	21/5	22/5	23/5	24/5													
Dose	Route	Frequency	Start Date																		
1g	IV	BD	21/5/26	9am	X	X	X	X													
Name & Signature of the Doctor Starting the Drugs:				 9am 10am 11am 12pm																	
Additional Instructions:				ATT (x 72 hrs)																	
Daily Doctor's Endorsement by a Sign																					
DRUG : TAB. METRONIDAZOLE				Date Time	21/5	22/5	23/5	24/5													
Dose	Route	Frequency	Start Date																		
500mg	IV	TID	21/5/26	6am	X	X	X	X													
Name & Signature of the Doctor Starting the Drugs:				 6am 9am 12pm																	
Additional Instructions:				x 72 hrs 10am 9am 12pm 1pm																	
Daily Doctor's Endorsement by a Sign																					
DRUG : PARACETAMOL				Date Time	21/5	22/5	23/5	24/5													
Dose	Route	Frequency	Start Date																		
1gm	P/O	TID	21/5	6am	X	X	X	X													
Name & Signature of the Doctor Starting the Drugs:				 6am 9am 12pm																	
Additional Instructions:				10am 9am 12pm 1pm																	
Daily Doctor's Endorsement by a Sign																					

HNH-00015547 IP26-00006397
 Mrs D SUNITHA
 01-01-1990 36 Y (F)
 Dr. MAHALAKSHMI GOLI



Sheet No:

REGULAR PRESCRIPTIONS

Weight Ward

DRUG : DICLOFENAC				Date Time
Dose 50mg	Route P/O	Frequency TID	Start Dt. 2/5	
Name & Signature of the Doctor Starting the Drugs: <i>Murugan</i>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : TRAMADOL				Date Time
Dose 100mg	Route P/O	Frequency TD	Start Dt. 2/5	2/5 2/5 2/5
Name & Signature of the Doctor Starting the Drugs: <i>Murugan</i>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : DICLOFENAC				Date Time
Dose 100mg	Route P/O	Frequency TID	Start Dt. 2/5	2/5
Name & Signature of the Doctor Starting the Drugs: <i>Arathi</i>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG : TAB PANTOPRAZOLE				Date Time
Dose 40mg	Route P/O	Frequency BD	Start Dt. 2/5	2/5
Name & Signature of the Doctor Starting the Drugs: <i>Arathi</i>				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

VERIFIED BY: Name Signature

HNH-00015550 IP26-00006399

Baby Of D SUNITHA

21-05-2026 0 Y 0 M 0 D 23 H (M)

Dr. SPANDANA PASUPULETI



REGULAR PRESCRIPTIONS

Sheet No:

Weight Ward

DRUG : Tab ANTOPRAZOLE DOMPERIDONE				Date Time	21/5	23/5	24/5														
Dose	Route	Frequency	Start Dt.																		
40mg	30mg PO	BD	22/5	6AM	X																
Name & Signature of the Doctor Starting the Drugs:																					
Additional Instructions:																					
Daily Doctor's Endorsement by a Sign																					
DRUG : Tab DICLOFENAC SUPPOSITORIES				Date Time	21/5	22/5	23/5														
Dose	Route	Frequency	Start Dt.																		
1Tab	PR	TID	22/5	6AM	X																
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																					

Signature
Verified By: Name



Date Time	Nurse Sig.	Dose	Nurse Sig.	Dose	Nurse Sig.	Dose	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.	

Date Time	Nurse Sig.	Dose	Nurse Sig.	Dose	Nurse Sig.	Dose	Nurse Sig.
VARIABLE DOSE		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
21/5/26	9pm	INJ. PANTOPRAZOLE	40mg	IV	[Signature]	[Nurses]
21/5/26	9.45pm	INJ. METOCLOPRAMIDE	10mg	IV	[Signature]	[Nurses]
21/5/26	9pm	PROCTOLYSIS ENEMA	1 Pack	PR	[Signature]	[Nurses]
21/5	11pm	DICLOFENAC	100mg	PR	[Signature]	[Nurses]
21/5	11pm	TRAMADOL	100mg	PR	[Signature]	[Nurses]
22/5/26	1:30pm	INJ-FUROSEMIDE	5mg	IV	[Signature]	[Nurses]
22/5	7pm	ONDASE (IRON)	4mg	IV	[Signature]	[Nurses]
23/5	7:30 am	DULCOLAX SUPPOSITORY	20mg	PR	[Signature]	[Nurses]
23/5/26	4pm	INJ. ONDANSETRON	4mg	IV	[Signature]	[Nurses]

VERIFIED BY : Name Signature



I.V. FLUIDS CHART

Weight. Ward.

Date	Time	Composition of I.V. Fluid (If infusion, mention ml/hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
21/5/26	9 AM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]	21/5	[Signature]	[Signature]
21/5	1030 AM	RINGER LACTATE + 9U OXYTOCIN	IV	300 ↓ 150	[Signature]	[Signature]	21/5	[Signature]	[Signature]
21/5/26	11 PM	RINGER LACTATE	IV	150 FF	[Signature]	[Signature]	22/5	[Signature]	[Signature]
22/5/26	12:30 AM	RINGER LACTATE	IV	FF	[Signature]	[Signature]	22/5	[Signature]	[Signature]
22/5/26	2 AM	RINGER LACTATE	IV	100ml	[Signature]	[Signature]	22/5	[Signature]	[Signature]
22/5/26	8 AM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]	22/5	[Signature]	[Signature]
22/5	12:30 PM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]	22/5	[Signature]	[Signature]
22/5	6 PM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]	22/5	[Signature]	[Signature]
22/5	7 PM	RINGER LACTATE	IV	100ml/hr	[Signature]	[Signature]	21/5	[Signature]	[Signature]
23/5	1:40 AM	5% DEXTROSE SOLUTION RINGER LACTATE	IV	100 ml/hr	[Signature]	[Signature]	23/5	[Signature]	[Signature]

Signature
VERIFIED BY: Name

STOP
by [Signature]

HNH-00015547 IP26-00006397
 Mrs D SUNITHA
 01-01-1990 36 Y (F)
 Dr. MAHALAKSHMI GOLI



MEDICATION RECONCILIATION FORM

Drug Allergies: Not known any Drug Allergies

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

Shifting From: Shifted to:

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	TAB- IRON	Tab	Po	OD	20/5/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
2	TAB- CALCIUM	Tab	Po	OD	20/5/26	<input type="checkbox"/> C <input checked="" type="checkbox"/> DC
3						<input type="checkbox"/> C <input type="checkbox"/> DC
4						<input type="checkbox"/> C <input type="checkbox"/> DC
5						<input type="checkbox"/> C <input type="checkbox"/> DC
6						<input type="checkbox"/> C <input type="checkbox"/> DC
7						<input type="checkbox"/> C <input type="checkbox"/> DC
8						<input type="checkbox"/> C <input type="checkbox"/> DC
9						<input type="checkbox"/> C <input type="checkbox"/> DC
10						<input type="checkbox"/> C <input type="checkbox"/> DC

* C- Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : *Dr. G. Veena*

Date & Time : *21/5/26 @ 9 AM*

Nurse Name & Signature: *Madhuvita @ Madhuvita*

Date & Time : *21/5/26 @ 9 PM*

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

HNH-00015547 IP26-00006397
 Mrs D SUNITHA
 01-01-1990 36 Y (F)
 Dr. MAHALAKSHMI GOLI



315

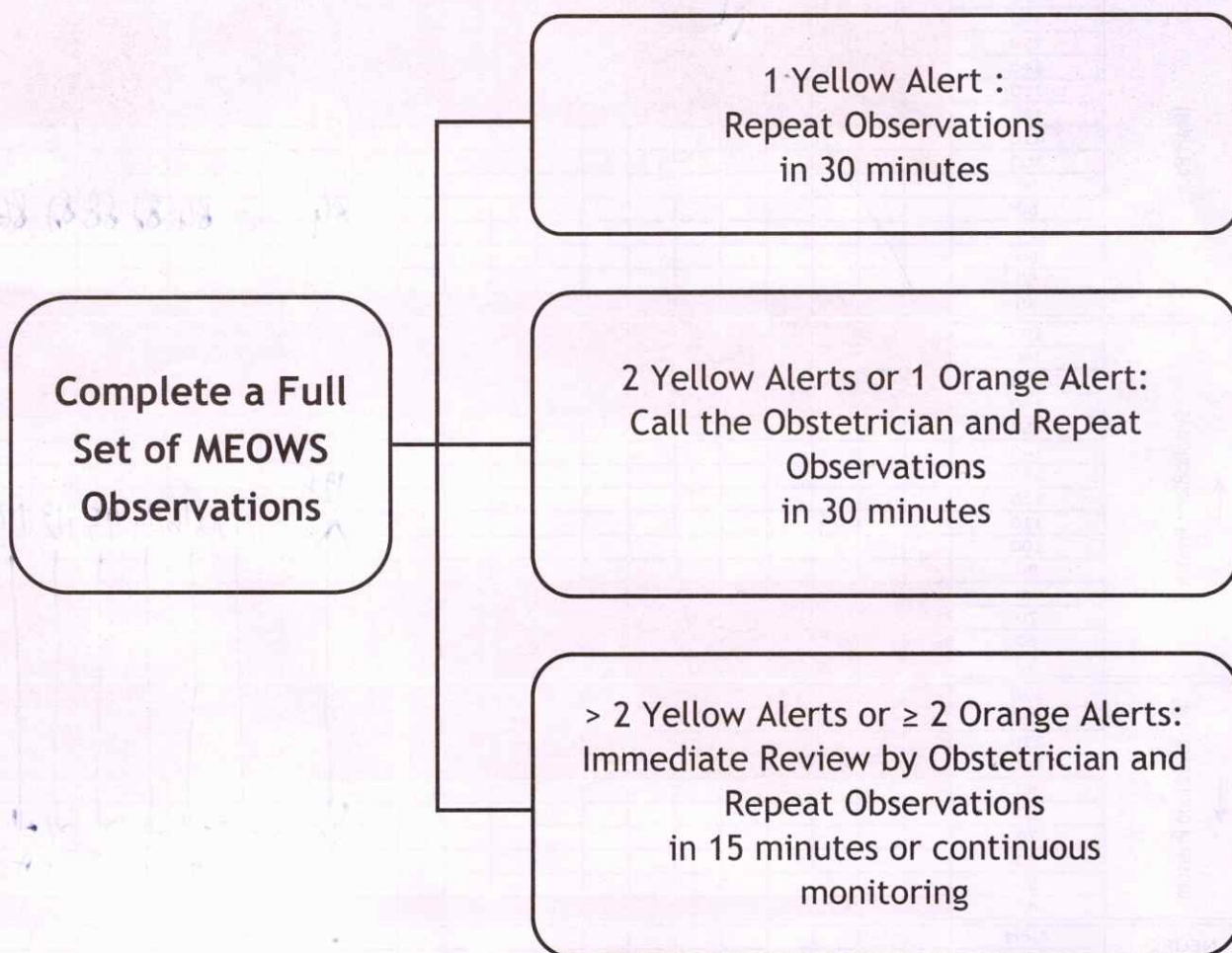
Rainbow[®]
 Children's
 Hospital
 It takes a lot to treat the little.

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

RESULT SHEET

Date	21/5				
Time					
Hb	11.8				
PCV	32.1				
RBC	3.89				
WBC	10.00				
N/L	14.1/19.8				
Platelets	219				
CRP					
ESR					
PCT					
RBS					
Na					
K					
Cl					
Ca/Mg					
Phosphate					
Urea					
Creatinine					
ALP					
SGPT					
SGOT					
T.Bill/Conj					
T.Protein					
S.Albumin					
S.Globulin					
A/G Ratio					
Uric Acid					
S.Amylase					
Sr.Lipase					
Blood Lactate					
S.Cholesterol					
PT/INR					
APTT					
CSF Protein / Sugar					
Cells					
N/L					

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

HNH-00015547 IP26-00006397

Mrs D SUNITHA

01-01-1990

38 Y

(F)

Dr. MAHALAKSHMI GOLI

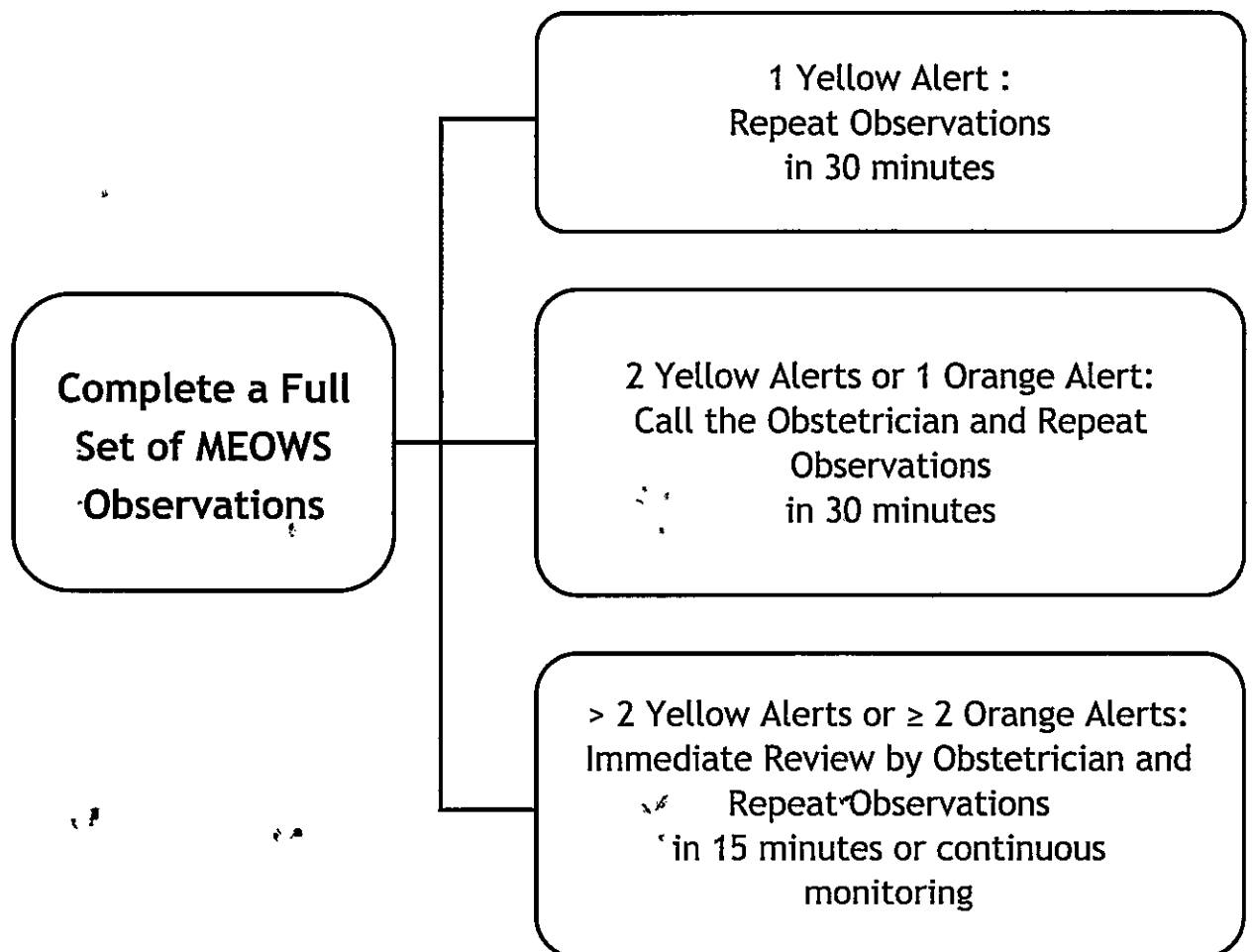


Early Warning Observation Score Chart - Obstetrics

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

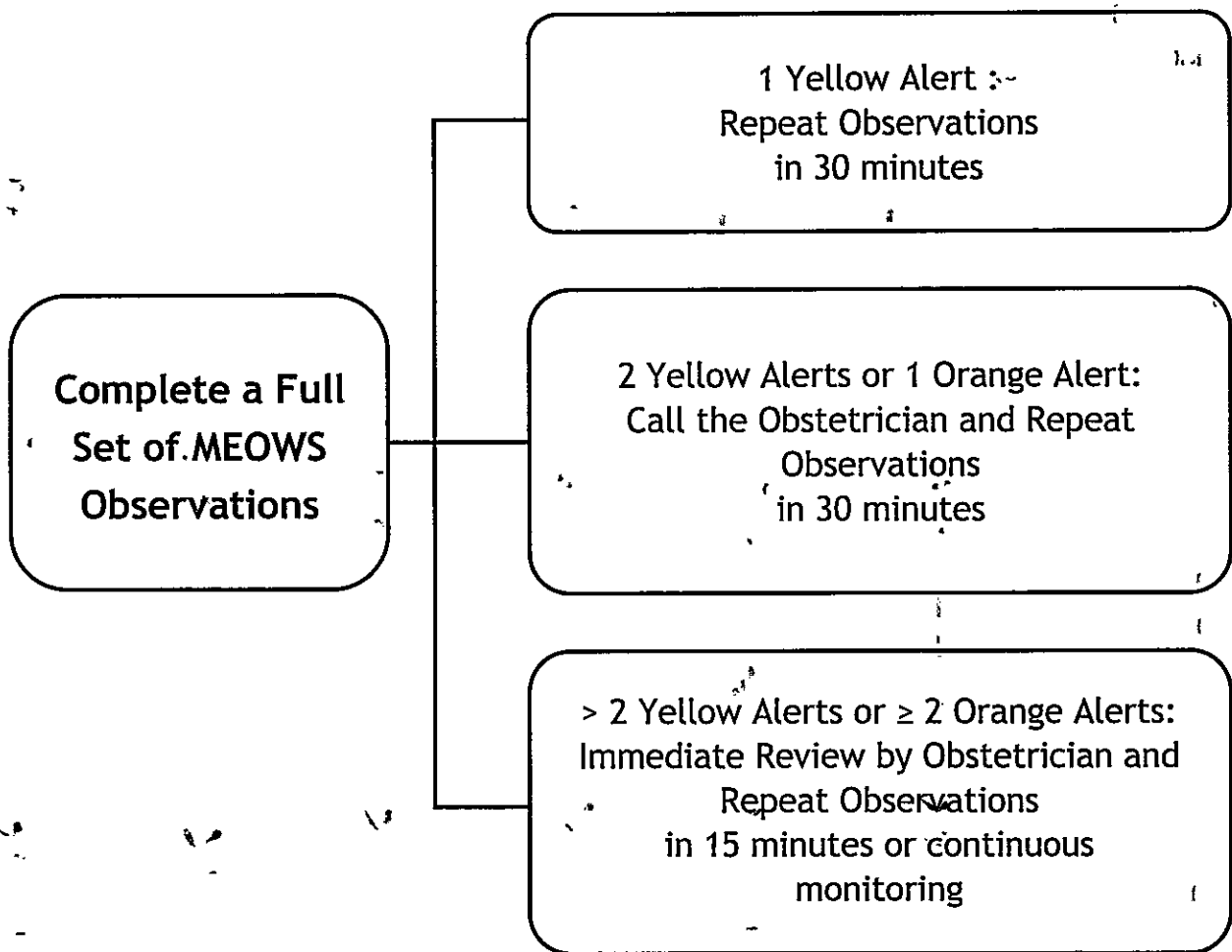
		Date																										
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7		
RESP (write rate in corresp. box)	> 30																											
	21 - 30																											
	11 - 20				20				20							20					20					20		
	0 - 10																											
Saturations	94 - 100 %			100				100							100					100						100		
	< 94 %																											
Administered O ₂ (L/min.)																												
Temp °C	40																											
	39																											
	38																											
	37																											
	36			97.8				97.4				97.9			98.3			98.3			98.3					98.4		
	35																											
< 35																												
Heart Rate	170																											
	160																											
	150																											
	140																											
	130																											
	120																											
	110																											
	100																											
	90																											
	80			81				79			80			81			81			81						81		
	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				0				0						0						0							0	
TOTAL ORANGE SCORES				0				0						0						0							0	
Nurse Initial				AS				AS					AS						AS						AS		AS	

Obstetrics and Gynaecology Early Warning Signs



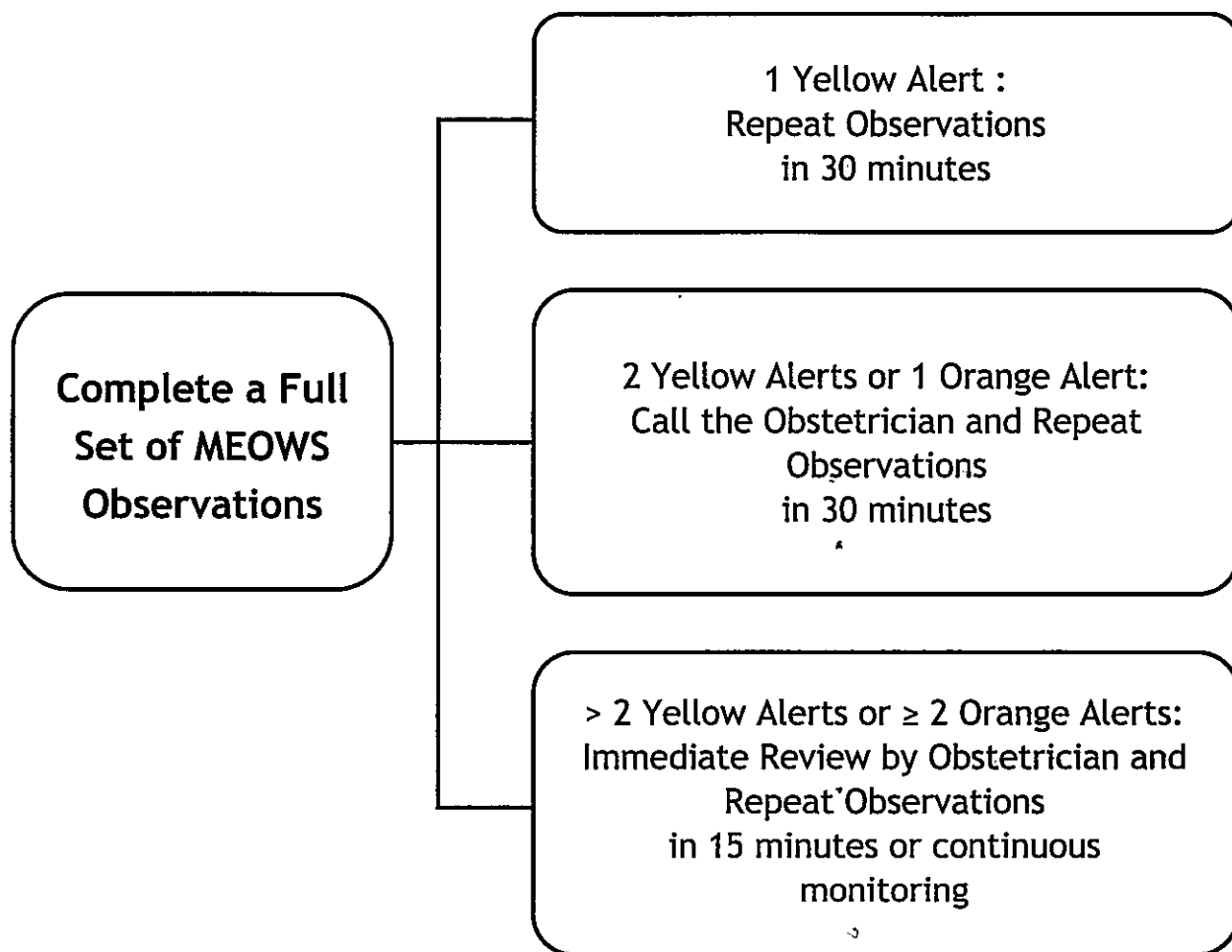
* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

FLUID CHART

Sheet No. : 10

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												
Total Intake :						Total Output :							
	08:00 pm	RL											
	09:00 pm	RL	M										
	10:00 pm	RL	B										
	11:00 pm	RL	B										
	12:00 am	RL	B										
	01:00 am	RL	B										
Total Intake : 600ml						Total Output : passed							
	02:00 am	RL											
	03:00 am	RL											
	04:00 am	RL											
	05:00 am	RL											
	06:00 am	RL											
	07:00 am	RL											
Total Intake :						Total Output :							
Total 24 hrs. Intake						Total 24 hrs. Output							

HNH-00015547 IP26-00006397
 Mrs D SUNITHA 38 Y (F)
 01-01-1990
 Dr. MAHALAKSHMI GOLI



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	Intake				Output					IV Site Thrombophlebitis Score	Sign. Nurse	
		Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine			
			Mouth	I.V	N.G								
20/5/2020	08:00 am			100ml									
	09:00 am			100ml									
	10:00 am	PL		100ml									
	11:00 am	PL	Idly	100ml									
	12:00 pm			100ml									
	01:00 pm			100ml									
Total Intake :					Total Output :								
21/5/2020	02:00 pm			600ml									
	03:00 pm			100ml									
	04:00 pm	PL	ididi	100ml									
	05:00 pm			100ml									
	06:00 pm			100ml									
	07:00 pm			100ml									
Total Intake :					Total Output :								
22/5/2020	08:00 pm	PL		100ml									
	09:00 pm	PL	idly	100ml									
	10:00 pm	PL	H2O	100ml									
	11:00 pm	PL		100ml									
	12:00 am	PL		100ml									
	01:00 am	PL		100ml									
Total Intake :					Total Output :								
23/5/2020	02:00 am			100ml									
	03:00 am			100ml									
	04:00 am			100ml									
	05:00 am	ST		100ml									
	06:00 am	Orate		100ml									
	07:00 am			100ml									
Total Intake :					Total Output :								

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00015547
 Mrs D SUNITHA
 01-01-1990 36 Y
 Dr. MAHALAKSHMI GOLI (F)
 IP26-00006397



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		
			Route			NG	Diarrhoea	Vomit	Drainage	Urine				
			Mouth	I.V	N.G									
23/5/26	08:00 am	DNS				NA					0	[Signature]		
	09:00 am			100ml										
	10:00 am			100ml										
	11:00 am			100ml										
	12:00 pm			100ml										
	01:00 pm			100ml										
Total Intake :						Total Output : U - M -								
23/5/26	02:00 pm	DNS		100ml		NA					0	[Signature]		
	03:00 pm			100ml										
	04:00 pm			100ml										
	05:00 pm			100ml										
	06:00 pm			100ml										
	07:00 pm													
Total Intake :						Total Output : U - M -								
23/5/26	08:00 pm	stop H ₂ O				NA					0	[Signature]		
	09:00 pm													
	10:00 pm													
	11:00 pm													
	12:00 am													
	01:00 am													
Total Intake :						Total Output : U - M -								
24/5/26	02:00 am	stop H ₂ O				NA					0	[Signature]		
	03:00 am													
	04:00 am													
	05:00 am													
	06:00 am													
	07:00 am													
Total Intake :						Total Output : U - M -								

Total 24 hrs. Intake

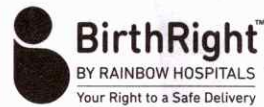
Total 24 hrs. Output

HNM-00015547 IP26-00006397

Mrs D SUNITHA

01-01-1990 36 Y (F)

Dr. MAHALAKSHMI GOLI



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								
24/5/28	08:00 am												
	09:00 am												
	10:00 am												
	11:00 am												
	12:00 pm												
	01:00 pm												
Total Intake :						Total Output :							
	02:00 pm												
	03:00 pm												
	04:00 pm												
	05:00 pm												
	06:00 pm												
	07:00 pm												
Total Intake :						Total Output :							
	08:00 pm												
	09:00 pm												
	10:00 pm												
	11:00 pm												
	12:00 am												
	01:00 am												
Total Intake :						Total Output :							
	02:00 am												
	03:00 am												
	04:00 am												
	05:00 am												
	06:00 am												
	07:00 am												
Total Intake :						Total Output :							

Total 24 hrs. Intake	
-----------------------------	--

Total 24 hrs. Output	
-----------------------------	--

HNH-00015547 IP26-00006397
 Mrs D SUNITHA 36 Y (F)
 01-01-1990
 Dr. MAHALAKSHMI GOLI

NURSING CARE RECORD



Date: 21/7/26

- 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				NA			
Afternoon							
Night	8pm	<ul style="list-style-type: none"> → Assess the pt condition → check the vital's → SpO2 circuit maintained → Plan for Admission 	8pm	<ul style="list-style-type: none"> → Assessed pt condition → checked vital's & circuit → Maintained SpO2 circuit → NST done 	vital's is normal	patient is stable	Amaldeep Singh
	8am	NST	8am				

VH-00015547
 Mrs D SUNITHA
 01-01-1990 36 Y
 Dr. MAHALAKSHMI GOLI (F)
 IP26-00006397

Patient




NURSING CARE RECORD



Date: 22/5/26

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 general condition of pt → Monitor vitals → Maintain I/O chart → Administer medication.	8AM	→ Assess the general condition of pt. → Monitor vitals → Maintain I/O chart.	pt stable * foley's present.	Re-assess vitals	
	2pm		2pm				
Afternoon	2pm	→ Assess the pt condition → Monitor the vitals → Medications give as per drug chart	2pm	→ Assess the pt condition. → monitored the vitals → Medications given as per drug chart.	→ pt is stable NOW	→ Reassessed the vitals	
	8pm		8pm				
Night	8pm	→ Assess the pt condition → monitor the v/s → maintain the I/O → Drug as per chart	8pm	→ Assess the pt condition → monitor the v/s → maintain the I/O → Drug as per chart	→ Now baby is stable	→ Rechecked the v/s	
	8am		8am				

HNH-00015547

IP26-00006397

Mrs D SUNITHA

01-01-1990 36 Y
Dr. MAHALAKSHMI GOLI

(F)



NURSING CARE RECORD



Date: 22/5/26

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	Patient is Stable now	Re-checked vitals	
	2pm	- monitor vitals & records - maintain I/O chart - Give medication as prescribed by doctor cont. IV fluids	2pm	- Monitored vitals & records - maintained I/O chart - Given medication as prescribed by doctor			
Afternoon	2pm	⇒ Assess the pt condition.	2pm	⇒ Assessed the pt condition	Patient is Stable Now	Re-checked vitals	
	to 8pm	⇒ monitor vitals ⇒ Give medication as prescribed by doctor. cont IV fluids	to 8am	⇒ Monitored vitals ⇒ Maintained I/O chart ⇒ given medication.			
Night	8pm to 8am	- Assess the pt condition - monitor the v/s - maintain the I/O - Drug as per chart	8pm to 8am	- Assess the pt condition - monitor the v/s - maintain the I/O - Drug as per chart	- Now baby is stable	- Re checked the v/s	

H-00015547 IP26-00006397
 Mrs D SUNITHA
 01-01-1990 36 Y (F)
 Dr. MAHALAKSHMI GOLI

Patient



NURSING CARE RECORD



Date:

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon							
Night							



PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
21/5/26	9am	0/10	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
21/5	11am	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
22/5	2AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
22/5	8AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
22/5	10AM	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
23/5	6pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
22/5	10pm	0	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
23/5	2am	0/10	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
23/5	6am	0/10	-	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	
23/5	10Am	0/10	NA	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic	<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing	<input type="checkbox"/> Yes <input type="checkbox"/> No	NA	

Re-assessment Frequency:

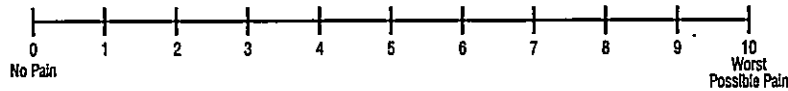
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 - 60 minutes after pain relief intervention.

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)



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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, 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-00015547

Mrs D SUNITHA

01-01-1990

IP26-00006397

38 Y

Dr. MAHALAKSHMI GOLI

(F)



BRADEN 'Q' SCALE



Date: 22/12/2025 245 MB
 Time: M1 M6 G NU

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.	9	4	7	4
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4

TOTAL SCORE

28 28 20 28

Evaluator's Name

[Signatures]

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

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice)
15-18	At Risk	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors. 	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay

HNH-00015547

Mrs D SUNITHA

01-01-1990

36 Y
Dr. MAHALAKSHMI GOLI

IP26-00006397

(F)



BRADEN 'Q' SCALE

Date: 23/5 23/05 23/05
Time: M6 E2 N1

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
"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
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
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
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
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 of meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4
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

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

TOTAL SCORE

Evaluator's Name

28 28 28
[Signatures]

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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	21/5/26	22/5/26	22/5/26	Fall Risk Grading		
		Score	80m	10A1	6	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25						
	No	0	0	0	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15				Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
Ambulatory Aid	Furniture	30				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0	0	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20	Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0	0	0	0			
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0						
Total Morse Fall Scale Score:			20	20	20			
Signature								

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

HNH-00015547

IP26-00006397

Mrs D SUNITHA

01-01-1990 36 Y

(F)

Dr. MAHALAKSHMI GOLI



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

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

Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	Fall Risk Grading		
		Score	Risk Level	Morse Fall Score (MFS)	Action
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0		
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0		
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0		
IV / Heparin Lock or Saline	Yes	20	20		
	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	0		
Total Morse Fall Scale Score:			20		
		Signature			

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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



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		W	NA							
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		W	NA							
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2		W	NA							
4	All of the following Signs are evident : Pain along Path of cannula Redness around Site Swelling	Medium stage of phlebitis / Resite Cannula Consider Treatment	3		—	NA							
5	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cord	Advanced stage of phlebitis or the start of thrombophlebitis / Re site Cannula Consider Treatment	4		—	NA							
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5		—	NA							
Signature of the Nurse					[Signature]								

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 : Madhuni G Name : Madhuni G

Signature of Ward In Charge :

Signature : Kushni Name : Kushni



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:		Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known					
			If Yes Specify:					
BACKGROUND	Surgery / Procedure:		Post OP Day:					
	Date	Shift	21/5	22/5	23/5	23/5/26	23/5/26	
			N1	N1	N1	M6	E2	
	Medical Condition (Any special condition to be noted):							
	Diet:		NBM	Sobtd	Sobtd		Sobtd	
ASSESSMENT	Allergy:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Ventilation (RA, NP, NIV, VENTI):							
	Tubes/Drains/Catheter:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Vital Signs:		Temp:	98.1F	98.4F	98.5F	97.8F	98.3F
			Res:	20	20	20b/m	20b/m	20b/m
			SpO ₂ :	99%	99%	99%	100%	100%
			Pulse:	82	82	83b/m	86b/m	87b/m
			BP:	116/71	116/72	116/72	120/78	120/69
			LOC:					
			Fall Risk Score:					
		Pain Score:						
		Skin Integrity			Good		Good	
Recommendations	Safety Needs:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Physiotherapy:							
	Others Specify:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	Special Diet:							
	Critical Lab Test / Values:							
	Other Special Orders / Medications:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	PU Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	DVT Prophylaxis:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
ADL (Dependent / Non Dependent):								
Post Operative Procedure Special Orders:								
Handed Over By Name :		Madhu		Priyanka		Madhu		
Signature / ID :		[Signature]		[Signature]		[Signature]		
Date:		22/5		23/5/26		24/5/26		
Time:		8Am		2pm		8am		
Taken Over By Name :		Suryanda		Madhu		Suryanda		
Signature / ID :		[Signature]		[Signature]		[Signature]		
Date:		22/5/26		23/5/26		23/5/26		
Time:		8pm		8Am		8pm		

Patient Sticker



NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:	Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known If Yes Specify:					
	Surgery / Procedure:	Post OP Day:					
BACKGROUND	Date						
	Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Vital Signs:	Temp:					
		Res:					
		SpO ₂ :					
		Pulse:					
		BP:					
		LOC:					
		Fall Risk Score:					
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physiotherapy:						
	Others Specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	ADL (Dependent / Non Dependent):						
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature / ID :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature / ID :						
	Date:						
	Time:						

HNH-00015547 IP26-00006397

Mrs D SUNITHA

01-01-1990 36 Y

(F)

Dr. MAHALAKSHMI GOLI



URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 21/5

Date of Removal:

Parameters	Date	Shift Time							
Need for the Catheter	21/5	Nr	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hand Hygiene			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Usage of Sterile Equipment			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the Collection bag below the level of bladder			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check the Tube for Obstruction (Free of Kinking)			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is Catheter dated as policy			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Collecting bag is been emptied regularly?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Maintenance of closed system for the catheter			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dressing clean and dry?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the line removed as Policy?			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Performance of Perineal Care			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Onset of New Fever			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asses for the leakage at the site of insertion			<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the Nurse			Madhya						
Signature of the Nurse									

OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 21/5/2026 Time of Arrival: 8 AM Time Seen by Nurse: 8:10 AM

1) Level of Consciousness: Conscious Semi-Conscious Unconscious

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

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

3) Vital Signs: Temperature: 96.5° Pulse: 76 RR: 20 SpO₂: 98% BP: 107/71 Weight:

4) Gestational Criteria:

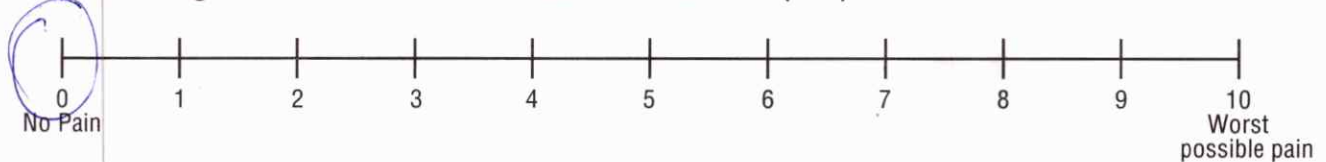
Gravida:	G	P	L	A
----------	---	---	---	---

LMP: EDD: Gestational Age:

Uterine Contraction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> NA	Onset	Time	Frequency:
Membrane Rupture	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> NA	Onset	Time	Fluid Color:
Vaginal bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> NA	Onset	Time	Amount:
Pre Eclampsia Symptoms	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> NA	If Yes specify: Headache / Visual Symptoms / Pain Abdomen / Vomiting		
Good fetal Movement	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	If No specify:		

5) Pain Screening:

Numerical Pain Scale (NPS)



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

6) Past History:

- a) Surgeries: NA
- b) Medical:



Yes No, If Yes :

8) **Current Medications:** Prenatal Vitamin None Others:

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

OTAS	Level 1 (Resuscitative)	Level 2 (Emergent)	Level 3 (Urgent)	Level 4 (Less Urgent)	Level 5 (Non Urgent)
Level 1 (Resuscitative)	Immediate	≤ 15 minutes	≤ 30 minutes	≤ 60 minutes	≤ 120 minutes (2 Hours)
Re-Assessment	Continuous Nursing Care	Every 15 Minutes	Every 15 Minutes	Every 30 Minutes	Every 60 Minutes
Labour / Fluid	Imminent Birth	Suspected Pre-term Labour / PPROM < 37 Weeks	Signs of Active Labour > 37 weeks	Signs of Early Labour/ SROM > 37 weeks	Discomforts of Pregnancy
Bleeding	Active Vaginal bleeding with/ without abdominal pain	Bleeding associated with cramping (< spotting) < 37 weeks	Bleeding associated with cramping (> spotting) > 37 weeks	Spotting	
Hypertension	Seizure activity	Hypertension > 160/110 and / or headache, visual disturbance, RUQ pain	Mild hypertension > 140/90 with/without associated signs and symptoms		
Fetal Assessment	Abnormal FHR tracing Non-Fetal Movement	Atypical FHR tracing, abnormal dopplers Diseased fetal movement			
Others	<ul style="list-style-type: none"> • Acute onsite severe abdominal pain • Altered level of consciousness • Cord prolapse • Severe respiratory distress • Suspected sepsis 	<ul style="list-style-type: none"> • Major trauma • Shortness of breath • Unplanned and unattended birth 	<ul style="list-style-type: none"> • Abdominal/back pain greater than expected in pregnancy • Flank pain / hematuria • Nausea /vomiting and /or diarrhea with suspected dehydration 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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: 8.15 Am

Nurse Name : Madhura Nurse Signature: [Signature]

Date: 21/5/2026 Time: 8.10 Am

HNH-00015547 IP26-00006397

Mrs D SUNITHA

01-01-1990 36 Y

(F)

Dr. MAHALAKSHMI GOLI



CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name: <i>Dr. Mahalakshmi Goli</i>	Date of Delivery: <i>21/05/2024</i>
Assistant Surgeon: <i>Dr. Swathi. M</i>	Time of Delivery: <i>9:58pm</i>
Anaesthetist's Name: <i>Bryanir</i>	Gender of Baby: <i>Male</i>
Type of Anaesthesia: <i>SA</i>	Weight of Baby: <i>3.3kg</i>
Neonatologist:	AGPAR Score: <i>8/10</i>
Scrub Nurse: <i>SIN Sangeetha</i>	NICU Admission: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Pre-Operative Diagnosis:

Elective Emergency Indication: *- preeclampsia @ 36wks @*

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

*Interversion/ANAI
CPD on early labor.*

Decision time: Knief to rectus:

CTG Description:

If there was a delay give the reasons:

Surgical Procedure: *- Emergency USG.*

Post Operative Diagnosis: *- P.U.*

Peri-Operative Complications: *- nil*

Amount of Blood Loss: <i>- 500ml</i>	Blood Transfused (in ML): <i>-</i>
--------------------------------------	------------------------------------

Name and Number of Surgical Specimen sent for examination:

Examination Findings when Appropriate:

Presentation: Cephalic Breech Other Cervical Dilatation: 1 cm cm
5th Palpable: 3/5 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 Thinned out Ruptured No Scar -
Incision Through Placenta: Yes No + w/ vasculature
Delivery of head: Manual Forceps
Liquor: Clear Meconium: I II III Blood Offensive Not Offensive
Delivery of Placenta: Manual CCT Complete Incomplete Piecemeal
Cord Appearance: (M) Cord around the neck Yes No
Appearance of placenta: (P) Cavity explored Yes No
Uterus, tubes and ovaries: Normal Not Normal Sterilization: Yes No

Uterine Closure: One Layer Two Layers Nonyl No. 1-0 Suture
Peritoneal Closure: Pelvic Abdominal None Catgut No. 1 Suture
Sheath Closure: catgut no. 1 Suture
Fat Closure: Yes No catgut no. 1 Suture
Skin Closure: Subcuticular Mattress Rapid nylon No. 1-0 Suture
Vaginal Evacuated Yes No
Drain: Yes No Remove in 1 day days Await instructions
Catheter Yes No Remove in 1 day days Await instructions
Swap & Instruments count correct? Yes No Post-op Antibiotics Yes No x 7 hrs
Intra-Operative Antibiotics Cover: Yes No Thromboprophylaxis Yes No

Post-Operative Notes:

→ NBM x 6-8 hrs.
- IV. Antibiotics x 7 hrs.
→ Foley. Removal. - 24 hrs
→ (M) vitals.
→ Serial SpO2 charting
→ Duplex x 24 hrs
- ZONAC supp. x 7 D. x 24 hrs.

Doctor Name: Doctor Signature: Zahalakshi

Date & Time:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Mahalakshmi
 Asst. Surgeon : Dr. Swathi
 Anaesthetist : Dr. Samir
 Scrub Nurse : Sr. Sangeetha

Patient Name: Mrs D SUNITHA IP26-00006397
 UHID No. : 01-01-1990 36 Y (F)
 Date : 21/5/20
 Dr. MAHALAKSHMI GOLI

26Y Gender : Female
FM-LCS
 time :



Before Induction of Anaesthesia >>

SIGN IN	Time: <u>9:45pm</u>
Patient Has Confirmed	
Identity <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Site <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Procedure <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Consent <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Site Marked <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Anaesthesia Safety Check Completed <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Pulse Oximeter on Patient & Functioning <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Does Patient have a:	
Known Allergy? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Blood Units Reserved <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
Has Antibiotic Prophylaxis been given within the last 60 minutes? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Signature : <u>[Signature]</u>	
Name :	


Before Skin Incision >>

TIME OUT	Time: <u>9:51pm</u>
Confirm all team members have introduced themselves by Name and Role <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Correct Site <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Correct Procedure <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Is Essential Imaging Displayed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Power Supply, Earthing, Power Backup and functioning of equipment checked. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Signature : <u>[Signature]</u>	
Name : <u>Pooja</u>	

Before Patient Leaves Operating Room

SIGN OUT	Time: <u>10:30pm</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
The Specimen is Labelled (including patient name) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Whether there are any Equipment Problems to be addressed <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Signature : <u>[Signature]</u>	
Name : <u>[Signature]</u>	

PATIENT TRANSFER FORM

Patient Name & UHID No. HNH-00015547 IP26-00006397 Mrs D SUNITHA (F) 01-01-1990 38 Y Dr. MAHALAKSHMI GOLI 		Date & Time of Admission 21/5/26 @ 8:08pm	Date & Time of Transfer Order 21/5/26 @ 10:56pm.
From Unit OT		Transfer Ordered by Dr. Sampir	Reason for Transfer observation
To Unit Prepost		Information to Attendant Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Number of Sheets in Clinical File 1	Number of Imaging Films 30	Personal belongings including clinical documents. If any handed over to attendant Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what ?	
Medications / Consumables / Surgicals / Hand over			
Sl.No.	Item Name	Quantity	
1.	PR	1	
2.			
3.			
4.			
5.			
Shifting Summary / Notes Written by Doctor : Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
Name & Signature of Person who is Transferring Srs. Pija		Name of Person Ordered Transfer Dr. Sampir	
Patient & Clinical Records Received by : Chandra Lakshmi			
Date & Time of Patient Received : 21/5/26 @ 10:58pm			

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



BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?

- a. Yes b. No

2. If No, Reason

3. Nipple condition:

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

4. Milk flow:

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

5. Steps for Positioning and attachment:

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



Feeding Positions:
Cross Cradle



Feeding Positions:
Football / Clutch

6. Was the position explained:

- a. Yes
- b. No

7. For Caesarian mothers:

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

8. NICU admission:

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

9. Additional notes:

Continuity of Care:

Date:

⇒ Assess the patient condition
⇒ vital is normal.
⇒ Plochart maintain
⇒ 2nd hourly DBF given.

Handover given by Chandrasekhar

Handover taken by Saranda

Signature CS

Signature CS

Date & Time: 21/5/26 @ 11pm

Date & Time: 22/5/26 @ 5.30 am

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION



Name: Ms. D. Sunitha Age: 36 Sex: Female UHID No: HNM-15547

Date: 21/5 Time: 8 pm Proposed Operation: USG

Diagnosis: Primi -> CPD in labour

B.P / CRT: 120/80 H.R: 78 Weight: 64 ASA Physical Status: 1 2 3 4 5

Laboratory Data:

Hgb: <u>11.8</u>	Glucose:	Protein:	HIV:	X-Ray:
PCV:	Urea:	Alb:	HBS Ag: <u>NR</u>	ECG:
WBC:	Creat:	Total Bill:	HCV:	2D Echo:
Plate: <u>219</u>	Na:	Dir. Bill:	Blood group: <u>B pos</u>	Stress/Angio:
PT:	K:	LDH:	T3	Other: <u>placenta fluids post.</u>
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl-:	SGOT/SGPT:		

Allergies: NKDA

Medical History: CVS: 1

RESP: patient apparently healthy Diabetes: Non-diabetic

CNS: ANCs - regular - IVF conception - HTN? Chronic > took treatment post stopped now.

Renal:

Hepatic / GE: / Physical Activity: good active

Others:

Past Anaesthetic History: prev. hysteroscopy + (+) polypectomy / IVF + TIVAS

Physical Exam: conscious, coherent

Airway: MPD 2 3 4 Mouth Opening: adq Mento-hyoid Distance: 3cm Neck: (2) Teeth: intact

Lungs: BAE @ clear clinically

Heart: S1+S2

CNS:

Pregnant: Yes No NA Venous Access Site: peripheral Skin Exam for regional: ok

Anaesthetic Plan: MAC REGIONAL GA-ETT LMA

Peri-Operative Plan Explained to the Patient: Yes No

CURRENT MEDICATIONS	DOSAGE
<u>Elospiri 150mg</u>	
<u>Re/co</u>	
<u>Suxam 100mg</u>	

- Pre-Operative Instructions:** 1pm - lunch
- DVT Prophylaxis:
 - NIL ORAL $\left\{ \begin{array}{l} \rightarrow \text{Water / ORS 2 Hours} \\ \rightarrow \text{Others 6 Hours} \end{array} \right.$
 - Informed Consent: Standard High Risk.
 - Post Operative Pain Management: Discussed with Patient
 - Other Instructions: cross match sample
CRP stat.

Signature: [Signature] Name: Dr. Sanvi Crayathi



ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition: Yes No Fasting Status: *adequate*

Physical Status: Patient Identified Consent Present Chart Reviewed

H.R: *89/m* B.P / CRT: *118/32* SpO₂: *100%* R.R: *18/m* Last Feed: *> 6 hours*

Pre-OP Diagnosis: *Plum* Operation: *VSCA* Date: *2/5*

Surgeon: *Dr. Mahalaxmi / Dr. MSV* Anaesthesiologist: *Dr. Sarini* Technician: *Dr. Prasad*

TIME	9:30 - 10:00 - 10:30			
N ₂ O / AIR / O ₂ , LPM				
HALO / SO / SEVO				
Drugs:				
	<i>DXTRORCIN 100 im + 20 iv + 90 infusion</i>			
	<i>NEPTENTINE 100mg iv</i>			
FIO ₂ / SaO ₂	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>
ETCO ₂	<i>42</i>	<i>40</i>	<i>38</i>	<i>36</i>
ECG				
Temperature				
Urine Output				
Fluids				
Blood				
B.P				
V Systolic				
A Diastolic				
X Mean				
• Heart Rate				
Tourniquet on Time				
Tourniquet off Time				
Throat Pack In				
Throat Pack Out				

Antibiotic: *Ami*

Suppository: *DICLOFENAC 100mg*

TRAMADOL 100mg

Blood Loss: *100ml*

~150ML

NOTES

LAB Values

ABG

GRBS

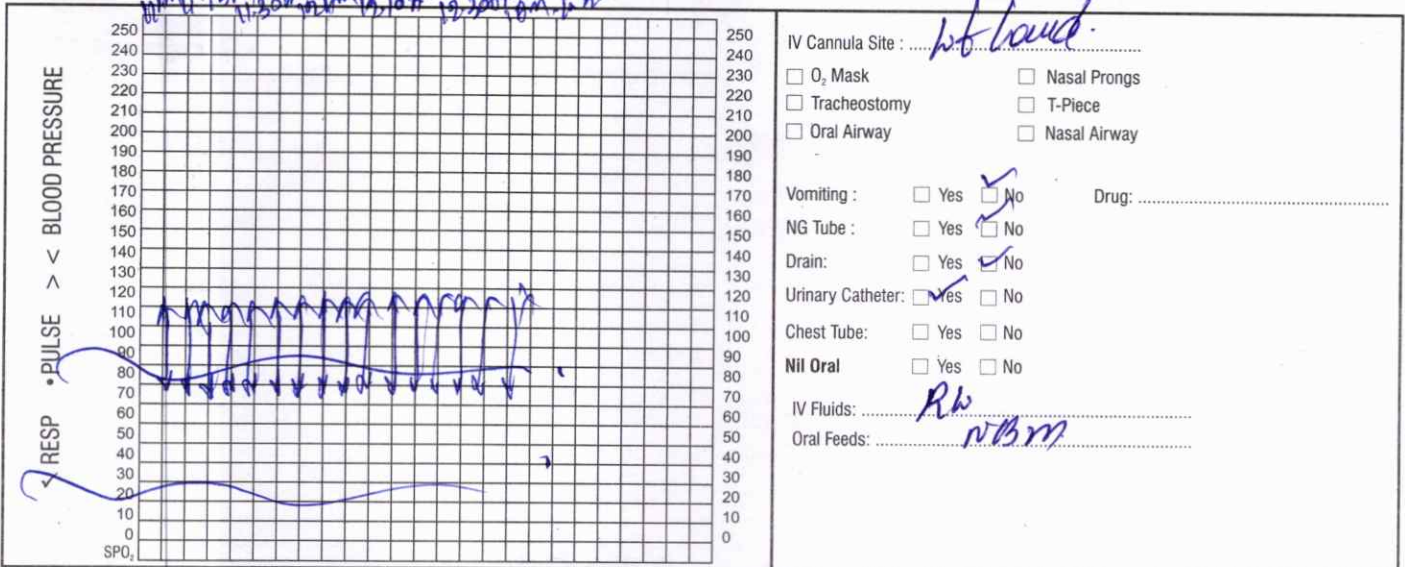
Others

<input checked="" type="checkbox"/> Equipment Checked and Functional <input checked="" type="checkbox"/> BP <i>20/10</i> <input type="checkbox"/> Cuff Site: <i>20/10</i> <input type="checkbox"/> Art Site: <input checked="" type="checkbox"/> EKG Lead <i>3 lead</i> <input type="checkbox"/> Temp Site <input type="checkbox"/> FIO ₂ Monitor <input type="checkbox"/> Agent Monitor <input type="checkbox"/> Pulse Oximeter <input type="checkbox"/> Capnograph <input type="checkbox"/> Ventilator <input type="checkbox"/> Nerve Stimulator Position: <i>Supine</i> <input checked="" type="checkbox"/> Pressure Points Checked Eye Care: <input type="checkbox"/> Oint <input type="checkbox"/> Tape <input type="checkbox"/> Padding <input checked="" type="checkbox"/> Awake	Temp: <input type="checkbox"/> HME <input type="checkbox"/> Fluid Warmer <input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer <input type="checkbox"/> Hugger's <input type="checkbox"/> Cotton Wool <input checked="" type="checkbox"/> Other <i>check</i> Times: Anaes Start: <i>9:30 pm</i> OP Start: <i>9:30 pm</i> OP End: <i>10:30 pm</i> Leave OR: <i>10:30 pm</i> Anaesthesia: <input type="checkbox"/> GA <input checked="" type="checkbox"/> Monitored Anaesthesia Care <input type="checkbox"/> Regional Line (Size & Location) <input type="checkbox"/> CVP: <input type="checkbox"/> ART: <i>18g @ 20</i> <input checked="" type="checkbox"/> IV: <input type="checkbox"/> IV: <input type="checkbox"/> IV:	Induction <input checked="" type="checkbox"/> IV <input type="checkbox"/> Inhal <input type="checkbox"/> Pre O ₂ <input type="checkbox"/> RSI <input type="checkbox"/> Others <input type="checkbox"/> Mask <input type="checkbox"/> SGA <input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal ETT# _____ at _____ cm <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical <input type="checkbox"/> Drug: _____ <input type="checkbox"/> Awake <input type="checkbox"/> Direct Vision <input type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie <input type="checkbox"/> Fiberoptic Blade# _____ Attempts: _____ Difficulty Why? _____ <input type="checkbox"/> Bilat = BS <input type="checkbox"/> Semi-Closed Circle <input type="checkbox"/> Closed Circle <input type="checkbox"/> Other	Regional: Extremity _____ Specify: _____ <input checked="" type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Caudal Others: _____ Position: <i>sitting</i> Site: <i>L3-4</i> Needle Size: <i>27G @</i> Depth: _____ Parasthesia <input type="checkbox"/> Yes <input type="checkbox"/> No Catheter at skin _____ cm Drug Name & Conc: <i>10mg Bupivacaine @</i> Bolus: <i>+ 25mg PENTANYL</i> Infusion: _____ Block Level: <i>T4 - 4 1/2 equal to his pick</i> Comments: _____ Transportation to <input checked="" type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Other Relaxant Reversed <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA Name of the Doctor: <i>Dr. Sarini</i> Signature of the Doctor: <i>[Signature]</i>
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POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: C. Chandra Kalle Time Received: 10.59pm Time Discharged:



IV Cannula Site: left hand

O₂ Mask Nasal Prongs
 Tracheostomy T-Piece
 Oral Airway Nasal Airway

Vomiting: Yes No Drug:

NG Tube: Yes No

Drain: Yes No

Urinary Catheter: Yes No

Chest Tube: Yes No

Nil Oral Yes No

IV Fluids: RW

Oral Feeds: NBM

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
21/5/26	11pm	0/10	normal	CF
22/5/26	12Am	0/10	normal	CF
22/5/26	1Am	0/10	normal	CF
22/5/26	2Am	0/10	normal	CF

Pain Tool Used: N PASS FLACC Wong Baker NPS

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

Anaesthesiologist Name: M. Anurag

Anaesthesiologist Signature: M. Anurag

Date & Time:

PACU Nurse Name: C. Chandra Kalle

PACU Nurse Signature: C. Chandra Kalle

Date & Time:

Transferred to Unit by (PACU): 3rd floor

Date & Time: 22/5/26 at 5pm

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name: Mrs. D. Sunilka Age: 364 Gender: Male Female

UHID NO: HNH-15547 Surgeon Name: Dr. Mahalaxmi

Anaesthesiologist: Dr. Samia Inayat

Operative procedure planned: VCS.

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 anaesthetics 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

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 anaesthesiologist 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 : D.veeresh

Name : D.veeresh

Relationship with Patient: Husband

Date & Time : 21-05-2026

Witness :

Signature : Dr. S. S. S.

Name : Ms. Sunita

Date & Time : 21/5 at 8pm

Doctor (who is taking the consent) :

Signature : Mi

Name : Dr. Samir Nayak

Date & Time : 21/5 at 8pm.

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : MRS. SUNITHA Gender: Male Female Age : 36 years
 UHID No : _____ Date : 21/5/26

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 CAESAREAN SECTION
 _____ upon _____
MRS. SUNITHA (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, postpartum hemorrhage, need for transfusion of blood or blood products, inadvertent injury to bowel, bladder or uterus, wound infection.

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 Mahalaxmi G.

Consentee : D. Sunitha
 Signature : _____
 Name : D. Sunitha
 Date & Time : 21/05/2026 @ 8:30 AM

Patient Attendant : _____
 Signature : D. Veeresh
 Name : D. Veeresh
 Relationship with Patient: Husband
 Date & Time : 21-05-2026 @ 8:30 AM

Witness :
 Signature : Madhu
 Name : Madhumita
 Date & Time : 21/5/26 @ 8:30 AM

Doctor (who is taking the consent) :
 Signature : _____
 Name : D. G. Veena
 Date & Time : 21/5/26 @ 8:30 AM

26-0000201219



NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

Patient Name: Mrs D Sunitha	Age: 36y	Gender: Female	
UHID No: HNH-0005547	IP No: 26-00006397	Date: 21/5/26 Time: 8:25	
Diagnosis: ISCs (Wad-07)			
PRESCRIPTION DETAILS (Tick only one of the following)			
S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/ML	100 mcg	01 AMP
2.	Morphine Sulphate Inj. 15mg/ML	—	—
3.	Remifentanyl Hydrochloride Inj. 2MG	—	—
4.	Remifentanyl Hydrochloride inj. 1MG	—	—
Doctor Name: Dr. Arvind		Doctor Registration No: 67529	
Signature: [Signature]			

NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

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

IP Registration No: **26-00006397** Date: **21/5/26**

Aadhaar No. of the Patient (Optional):

1.	Name: Mrs D Sunitha	Remarks		
2.	Complete postal address (with contact number, if any)	Dundigal h no 6-58 Gandi Mussurma Mandali		
3.	Brief description of the illness	ISCs		
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NO		
5.	Details of essential Narcotic drug dispensed	INTJ: Fentanyl		
Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
21/5	INTJ: Fentanyl	01	[Signature]	

Dispensed by (Name & ID No.): **Dr. Arvind Kumar (021257)** Signature: **[Signature]**

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

Time: **8:22**

HNH-00015547 IP26-00006397
Mrs D SUNITHA
01-01-1990 36 Y (F)
Dr. MAHALAKSHMI GOLI
[

315

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

BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 22/5/2016 Time: 9:40am

Origin: India Height: 182cm Weight: 85kg BMI: ~ 26 kg/m²
 ~ 28 kg/m²
 ~ 30 kg/m²
25 kg/m²

Food Allergies: No FA

Diagnosis: LSCS

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

Diet Advised:

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

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

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

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

Patient's / Attendant's

Signature: _____

Name: D. S. S. S.

Date & Time: 22/5/2016, 9:40am

Dietician's

Signature: Sobiya

Name: Syeda Sobiya Zaher

Date & Time: 22/5/2016, 9:40am

