Sravanthi
9154865024

Dr. Swathi

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ESTIMATION SLIP

Date : 1/6/26 **UHID / IP No. :** HNH-000055-21 **Sl No.** 1553

Name of Patient : Mrs. Syeda Maajer **Age:** 24 yr **Gender:** F

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

Address : Waheliguda **Phone :** 8374210859 / **Email :** 8099222619

Procedure / Plan : ND / LSCS **EDD/Dos:** 1-May-26

MODE OF PAYMENT : ☐ **SELF** ☑ **TPA :** National Insur. ☐ **GIPSA :** **OTHER**
+ M·A

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward		
Twin Shared Ward		
Private Room →	90k	1.1ac
Super Deluxe Room →	1.05k	1.15k
Suite Room +2.60 M+B	1.60k	1.75L
Package includes 4 Days stay (Package starts from the time of admission)	+ Non Payables Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Extra 15k to 20k Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for : 2 Days	Length of Stay for : 3 Days
	Pharmacy up to 9,000/-	Pharmacy up to 12,000/-
CBP, NST (-	Investigations up to 2,500/-	Investigations up to 3,000/-
Others	Well baby Care	25k to 35k

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

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

REMARKS : Vaccination, Neonatal, CBP, B/G

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

DECLARATION

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

[signature] Signature of the Client | Husband Signatory Relationship | [signature] Signature of the financial Counselor

HNH-00005571 IP26-00006913
Mrs SYEDA HAAJER
10-08-2001 24 Y 11 M 12 D (F)
Dr. SWATHI H V

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SURGERY DETAILS

Date : 22/7/2026

Patient Name: Mrs. Syeda Haajer Date of Birth: 10-08-2001 Age: 24Y

Gender: Female Ward : LDR UHID No.: HNH-00005571

Date of Surgery: 22/7/2026 LDR ☐ ~~OT -1~~ ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : NVD V Epidural

Time in : 3PM Time Out : 4PM

		NAME	AMOUNT
1.	Surgeon	: Dr. Swathi. HV	
2.	Anaesthetist	: Dr. Ayesha	
3.	Assistant Surgeon	:	
4.	OT Technician	:	
5.	Circulating Nurse	: Anusha. K	
6.	Assistant Nurse	: Mounika.	

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

Dr. Swathi HV
Signature of the Surgeon

Anusha. K
Signature of Circulating Nurse

Order No: 26-0000216070 ~~26-0000216070~~

Order by: Anusha. K

Name	Mrs SYEDA HAAJER	**UHID**	HNH-00005571
Father/Guardian	Mr SHAIK IRFAN AHMED	**Age/Gender**	24 Y 11 M 12 D/ Female
Address	12-11-953 warasigoud near akauser, Sitaphal Mandi, Hyderabad, Telangana, INDIA, 500061		
IP No	IP26-00006913	**Admission Date**	22-07-2026
Ref Doctor	Self.		
Discharge Date	24.07.2026		

DISCHARGE SUMMARY

Consultant
Dr. Swathi H V
MBBS/MS
TSMC/FMR/15501

Diagnosis: PRIMIGRAVIDA WITH 39 WEEKS PERIOD OF GESTATION WITH PREMATURE RUPTURE OF MEMBRANES FOR SAFE CONFINEMENT.

SPONTANEOUS VAGINAL DELIVERY DONE ON 22.07.2026.

History:
LMP: 26.10.2025
EDD: 29.07.2026

Obstetric formula: Primigravida
Gestation at admission: 39 weeks

Obstetric History:

Name	Mrs SYEDA HAAJER	UHID	HNH-00005571
IP No	IP26-00006913	Admission Date	22-07-2026

G1 - Present pregnancy Spontaneous conception.

Medical History : Nil
Surgical History: Nil
Allergies : Nil
Family History : Nil

Antenatal Details:
Mrs SYEDA HAAJER was booked to Rainbow hospital at 7 weeks period of gestation. She had regular antenatal checkups and investigations as advised. NT scan was normal. TIFFA was normal. At 29 weeks she was diagnosed with UTI and managed conservatively. Fetal surveillance done by serial growth scans.Growth scan done on 02.07.2026 showed single live intrauterine fetus with cephalic presentation, AFI:12.8cm EFW: 2.818kg,(47% & AC - 37%) Placenta: posterior and Right lateral high, Doppler normal. She was admitted at 39 weeks with Premature Rupture of membranes for safe confinement.

Investigations: Enclosed
Blood Grouping - "O" Positive.

Management: Course in hospital and Delivery Details:
At admission on clinical examination the vitals were stable, uterus mild acting, per speculum examination revealed active clear leak, cervix was partially effaced and 2cms dilated. Fetal well being was confirmed by an admission CTG which was found to be reactive. As per hospital protocol she was started on IV Taxim in view of ruptured membranes. Partographic monitoring of labour was done. She progressed to full dilatation at 2:45 pm. Passive descent of fetal head was allowed for 15 min, post full dilatation. She was put into position for vaginal birth at 3:16 pm. Parts painted with betadine solution and draped to ensure full asepsis. She was encouraged to bear down. At crowning of head

Name	Mrs SYEDA HAAJER	**UHID**	HNH-00005571
IP No	IP26-00006913	**Admission Date**	22-07-2026

episiotomy was given under local anesthesia (10 ml of 2 % xylocaine solution). Baby was delivered by Spontaneous vaginal delivery, Cord clamped and cut and baby handed over to pediatrician. Cord blood collected for blood grouping and Rh typing. Placenta and membranes delivered completely with controlled cord traction. Prophylactic syntocinon given. Episiotomy inspected. No extensions or additional vaginal tears found. Episiotomy sutured in layers. Instrument and swab count checked. 600 mcg of misoprostol given per rectally as prophylaxis against post partum hemorrhage. Vagina cleaned with betadine solution.

Delivery Details:

Date : 22.07.2026
Time of Delivery : 03:16 PM
Type of Labour : Spontaneous.
Type of Delivery: Spontaneous vaginal Delivery
Analgesia : None
Indication : PROM

Baby Details:

Date : 22.07.2026
Time : 3:16 PM
Sex : Male
Weight : 3.84 Kgs
Apgar : 8,10
Gestational Age: 39 weeks
NICU Admission: No.

Post-Partum Notes: She was closely monitored for post partum hemorrhage. Breast feeding initiated. Vitals were stable; patient ambulated and was shifted to room. Patient was encouraged for spontaneous voiding. Dietary advice

Name	Mrs SYEDA HAAJER	**UHID**	HNH-00005571
IP No	IP26-00006913	**Admission Date**	22-07-2026

given. Her postpartum period following that was uneventful. On first postpartum day episiotomy wound was healthy and intact. 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 (Cefixime 200mg) twice daily till 26.07.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 24.07.2026 (8am-2pm-10pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 24.07.2026 (9am-3pm-11pm) after food.
4. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 26.07.2026 (7am-7pm) before food.
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 after food.
7. Metrogyl P ointment for local application.
8. Syp. Duphalac 15 ml (Lactulose 3.33gm/5ml) at bed time for one week.

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

* Suggest **PAP smear** and **HPV Vaccine** after **6 weeks**; Please discuss with

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Name	Mrs SYEDA HAAJER	**UHID**	HNH-00005571
IP No	IP26-00006913	**Admission Date**	22-07-2026

your treating doctor regarding **HPV vaccination.**

Review with **Dr. SWATHI H V** after **2 weeks** on **5.08.2026** at Rainbow Children's Hospital with prior appointment. **(Review consultation will be charged).**

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

Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 at Rainbow Children's Hospital 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**

Registrar/Resident/C.M.O

RAINBOW CHILDREN'S MEDICARE LIMITED ★ HYDERABAD

Consultant:
Dr. Swathi H V
MBBS/MS
TSMC/FMR/15501

Rainbow Children's Hospital

BirthRight by Rainbow

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006913 **Admit Date** : 22-Jul-2026 **Admit Time** : 09:04 AM **UHID** : HNH-00005571

Patient Details :

Patient Name	: Mrs SYEDA HAAJER	**Age**	: 24 Y 11 M 12 D
Guardian	: Mr SHAIK IRFAN AHMED	**DOB**	: 10-08-2001
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 12-11-953 warasigoud near akauser Sitaphal Mandi Hyderabad Telangana INDIA 500061	**Phone No**	: 8099222619/ 8374210859
		E-mail	: syedahaajer6980@gmail.com

Admission Details :

Bed Type : BASINET **Bed No** : CRDL-HNPDA-414-2 **Ward Name** : 4F -OT

Room No : CRDL-HNPDA-414-2 **Admission Type** : First Visit

Contact Details :

Name : Mr SHAIK IRFAN AHMED **Relationship** : W/O

Contact Address : 12-11-953 warasigoud near akauser Sitaphal Mandi Hyderabad Telangana INDIA 500061 **Phone No** : 8099222619

Signature

Doctor Details :

Doctor Name : Dr. SWATHI H V **Specialisation** : OBSTETRICS AND GYNECOLOGY

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

Co-Consultant :

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 20000.00

Payor Name : MEDI ASSIST INSURANCE TPA PVT LTD

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00005571 IP26-00006913 Mrs SYEDA HAAJER 10-08-2001 24 Y 11 M 12 D (F) Dr. SWATHI H V	22/7/2026 @9.04 am.	22/7/2026 @6:50pm
	Transfer Ordered by Dr. Dua	Reason for Transfer observation
From Unit LDR	To Unit	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 32	Number of Imaging Films NST-(4)	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

Sl.No.	Item Name	Quantity
1.		
2.	NA	
3.		
4.		
5.		

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Aasha	Dr. Dua.

Patient & Clinical Records Received by : Divya 22/7/26 @ 6:50pm

Date & Time of Patient Received :

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

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

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ACTIVITY RECORD FOR BILLING

Name: ---------- HNH-00005571 IP26-00006913 ----------
Mrs SYEDA HAAJER
UHID No : ---------- 10-08-2001 24 Y 11 M 12 D (F) Consultant : ---------- Dept : ----------
Dr. SWATHI H V
Date of Admission : ------ Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
22/7/26	6:30pm	LDR-11	214	

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	(Lactation counselling) Dr. Tejaswi Reddy	23/7/26	6257	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
22/7	CBP	1225/1	
22/7	NST - (1)	8930	
22/7	NST - (2)	8931	
22/7	NST - (3)	8958	
22/7	NST - (4)	8959	
		Cross checked done	
		Cross checked	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
22/7	Cardiacmonitor	11:30Am	3:20pm	15969	[signature]
22/7	Epidural	11:30Am			
22/7	infusionpump	12:30Am		?	[signature]
22/7	oxygen	1pm	3:15pm	16095	

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
22/7	IV placement	(1)	15971	
22/7	Cardiothenization	(1)		
22/7	PAC	(1)	15970	
			Cross checked done	Cross checked done
23/7/26	NHA	(1)	16228	
			Cross checked done by	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00005571 IP26-00006913
Mrs SYEDA HAAJER
10-08-2001 24 Y 11 M 12 D (F)
Dr. SWATHI H V

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints Primi c̄ 39wks ... came c̄ c/o pain abdomen :: 7am and Leaking p/v :: 6am

Obstetric Formula: Primi

Obstetric Hostory:
G1 - NT scan - normal
TIFFA - normal

Present Pregnancy Record:
G1 - Spontaneous pregnancy. Booked @ 7wks.

RISK FACTORS:

Height: 163 cm
Weight: 109 kg
Allergies: nil
Breast: ☑ Normal ☐ Abnormal
General Examination:
Consciousness: ✓ | Pallor: (−)
Icterus: (−) | Edema: (−)
Temp: afebrile | PR: 84bpm
BP: 120/90mmHg | DTR: (+)
CVS: S1S2(+) | RS - BAE(+) SPO2 - 99% @ RA
Liver/Spleen: | Urine Output: Adequate.

LMP: 26/10/25 EDD: 2/8/26
Corrected EDD: 29/7/26 GA: 39wks

Menstrual History: Regular ☑ Yes ☐ No

Obstetric Examination

Fundal Height: TG

Ut. Activity: ☐ Relaxed ☑ Mild ☐ Mod ☐ Severe
Liquor: ☑ Adequate ☐ Oligo ☐ Poly
PP: ☑ Cephalic ☐ Breech Others ____
Head Fifths Palpable: 4/5th palpable.
FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

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

Vaginal Examination

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

DIAGNOSIS

Primi c̄ 39wks c̄ PROM for spontaneous progression of labour.

HNH-00005571 IP26-00006913
Mrs SYEDA HAAJER
10-08-2001 24 Y 11 M 12 D (F)
Dr. SWATHI H V

Family History: Nil	Surgical History: Nil
Medical History: Nil	Medication History: Nil
Plan of Care: - Admision NST - Informed Consent - Drugs as chaited - w/f uterine action - w/f progression of labour and change in colour of leak. - monitor Vitals - Soft diet Inform sos.	Investigations: BG/Rh. O +ve HbA1c - 5.5 21/2 HIV - NR HBsAg - NR HCV - NR 21/7 Single, cephalic Efw - 47%. AFI - 12.8cm Doppler - normal.

Dr. Swathi H V
Consultant Obstetrician - Gynecology
Reg. No.

Doctor Name: Dr Mrudula
Signature: Mrudula
Date & Time: 22/7/26 @ 8:45am

Consultant Name: Dr. SWATHI H.V
Signature:
Date & Time: 22/7/26 @ 8:49 Am

HNH-00005571 IP26-00006913
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10-08-2001 24 Y 11 M 12 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/07 10AM	S/B Dr Swathi HV	
	- Prim @ 39wks c dROM.	
	c/o pain	Adv
		- Inj PCN
	O/E: vitals @	→ CTG 3rd hrly
CTG - Reactive	PA: UT TS	
	cephal 3/5th	→ Rpt PV > 2hrs.
	FHS ⊕ R	dos Oxytocin
	2/10/20.	Augmentation
	PV: OS 3cm V/S/T/-1-2	
	...	→ Buscopan/antispasmodics
	Clear liquor noted	→ Sorafen SOS
	P adequate.	
		Dr Swathi HV
		Dr. Swathi H V Consultant Obstetrics and Gynecology Reg. No: 15501
22/7/26 5:30pm	O PND	
	No complaints	1) Regular diet / oral fluids
	GC fair / afebrile	2) Monitor vitals
baby well	PR: 90/min	3) drugs as charted
	BP: 120/70mmHg	4) W/F excess bleed PV
U: yet to void	SpO2: 98%	5) Ambulation
	PA: soft, UWR	6) encourage voiding of urine
	PV: bleeding (N)	7) Can shift to room
	sutures (H)	Noted by Anusha 22/7/26 Dr. Swathi H V Consultant Obstetrics and Gynecology Reg. No: 15501 ...

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

H-00005571 IP26-00006913
SYEDA HAAJER
08-2001 24 Y 11 M 12 D (F)
SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/07/2026 9:30pm	c/s/by Dr. Naveena	
	O/E GC-fair	Adv
	Afebrile SpO2-99% on RA	- Soft diet
	Vitals - stable	- Adequate hydration
U-✓	PA: ut. retracted well	- drugs: as charted
F-✗	Soft, NT	- w/f PV bleeding
S-✗	LLE: PV bleeding WNL	- Ambulation
	episiotomy wound: clean	- Monitor Vitals
	& intact	- Inform SOS.
	Baby: Mother side.	Noted by Swathi
		Dr. Naveena.
23/07/2026 7:00am	c/s/by Dr. Naveena	
	O/E GC-fair	Adv
	Afebrile SpO2-99% on RA	- Soft diet
U-✓	Vitals - stable	- Adequate hydration
F-✓	PA: ut. retracted well	- drugs as charted
S-✗	Soft, NT	- w/f PV bleeding
	LLE: PVB WNL	- Ambulation
	episiotomy - clean & intact	- M/V & I/SOS
	Baby: MS	Noted by Swathi
		Dr. Naveena 23/7/26

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

IH-00005571 IP26-00006913
SYEDA HAAJER
08-2001 24 Y 11 M 12 D (F)
SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	C/S/B Dr. Dny	
23/7/26 2pm	C/C Fair	Adv
	Afebrile	- Regular diet
	Vitals (N)	- Adequate hydration.
Baby c Mother	P/A Uterus Retracted well.	- Drugs as charted
	L/E NAB.	- W/F PV bleed.
		- Ambulation
		- Monitor vitals.
		- Inform RMO
		Pt can be discharged.
	[signature]	

VH-00005571 IP26-00006913
rs SYEDA HAAJER
I-08-2001 24 Y 11 M 12 D (F)
r. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00005571 IP26-00006913
Mrs SYEDA HAAJER
10-08-2001 24 Y 11 M 13 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00005571 IP26-00006913
Mrs SYEDA HAAJER
10-08-2001 24 Y 11 M 13 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00005571 IP26-00006913
Mrs SYEDA HAAJER
10-08-2001 24 Y 11 M 12 D (F)
Dr. SWATHI H V

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RESULT SHEET

Date	22/7					
Time						
Hb	11.05					
PCV	32.8					
RBC	3.90					
WBC	16.44					
N/L	85.3/11.2					
Platelets	292					
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

OTVR

HIV
HBSAg
HCV
NR

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00005571 IP26-00006913
Mrs SYEDA HAAJER
10-08-2001 24 Y 11 M 13 D (F)
Dr. SWATHI H V

101 → 214

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 23/7/26 Time: 8:45am

Origin: Indian Height: 163cm Weight: 109 Kg BMI: ☐ ~ 26 kg/m² ☐ ~ 28 kg/m² ☐ ~ 30 kg/m²

41 Kg/m²

Food Allergies: No

Diagnosis: NVD

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: Haajer

Name: Syeda Haajer

Date & Time: 23/7/26; 8:45am

Dietician's

Signature: Sabiya

Name: Syeda Sabiya Zaheer

Date & Time: 23/7/26; 8:45am

DIETARY NOTES

Date	Time	Notes	Sign

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CROSS CONSULTATION FORM

Doctor Name : Dr: Swathi Date : 23/7/26 Time : 12:30pm

Diagnosis : LSCS

Hospital : RCH - HMNR

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

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

Signature:

Findings and Recommendations :

Lactation care plan

- well formed Breast & Nipples
- colostrum seen
- Suckling observed.
- Baby is not continuously, starting to suck with strong stimulation.
- Aim for deep latch as demonstrated in cradle hold.
- Demand feeding not exceed 2½ hours as per early hunger cues.
- Advice DBF & f/b Burping.

Consultant :

Name : Sathvika G Signature : S Date & Time : 23/7/26, 12:30pm

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DRUG CHART

Date of Admission: 22/07/2026 Drug Allergies: nil ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR
- Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
- Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
- Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
- Discontinue a drug by drawing a line / through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES
- Nurses must follow strictly the FIVE RIGHTS before administration of medication.
  1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

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

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REGULAR PRESCRIPTIONS

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

DRUG : TAB CEFIXIME				Date ▸ / Time ▾	22/7/26, 23/7
Dose	Route	Frequency	Start Date		
200mg	P/O	BD	22/7	10AM	✓, [signature]
Name & Signature of the Doctor Starting the Drugs: [signature]					
Additional Instructions:				10PM	[signature]
Daily Doctor's Endorsement by a Sign					

DRUG : TAB. PANTOPRAZOLE				Date ▸ / Time ▾	23/7
Dose	Route	Frequency	Start Date		
40mg	P/O	OD	22/7		
Name & Signature of the Doctor Starting the Drugs: [signature]				6am	[signature]
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

DRUG : TAB. DICLOFENAC				Date ▸ / Time ▾	22/7/26	23/7
Dose	Route	Frequency	Start Date			
50mg	P/O	TID	22/7	7AM	X	[signature]
Name & Signature of the Doctor Starting the Drugs: [signature]				3PM	✓	[signature]
Additional Instructions:				11PM	[signature]	
Daily Doctor's Endorsement by a Sign						

DRUG : Syp. DUPHALAC				Date ▸ / Time ▾	22/7
Dose	Route	Frequency	Start Date		
15ml	P/O	HS.	22/7		
Name & Signature of the Doctor Starting the Drugs: [signature]				10PM	[signature]
Additional Instructions:					
Daily Doctor's Endorsement by a Sign					

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Sheet No:

...GULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG: Inj. CEFOTAXIME

Dose	Route	Frequency	Start Dt.
1g	IV	BD	22/7

Name & Signature of the Doctor Starting the Drugs: Mamdela

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time: STOP

DRUG: METRONIDAZOLE + POVIDINE

Dose	Route	Frequency	Start Dt.
–	topical	LA BD	22/7/24

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

Additional Instructions:
METRO-P ointment

Daily Doctor's Endorsement by a Sign

Date / Time: 21/7/24 — 10AM ✓, 10PM ✓

DRUG:

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG:

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

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

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

DRUG :				Date ▸ Time ▾
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ▸ Time ▾
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ▸ Time ▾
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ▸ Time ▾
Dose	Route	Frequency	Start Dt.	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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Dr. SWATHI H V

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

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

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
21/07	10AM	Inj CEFOTAXIM	1g	iv		Madhu
22/07	11:30AM	Inj DROTAVERINE	40mg.	iv		
22/07	11:30AM	Inj BUSCOPAN.	20mg	iv		
22/07	1:30pm	Inj DROTAVERINE	40mg	iv		
22/07	3:30pm	Inj OXYTOCIN	10units	im		
22/07	3:40pm	Inj TRANEXAMIC acid	1g	iv		
22/7/26	11:40pm	Inj TRANEXAMIC ACID	1gm	IV		

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

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I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
22/7	10AM	Ringer Lactate	iv	100 ml/hr	✓	✓	22/7/26	✓	✓
22/7	11:00 AM	Inj OXYTOCIN 10 units Ringer Lactate	iv	6 ml/hr	✓	✓	22/7/26	✓	✓

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

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MEDICATION RECONCILIATION FORM

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

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T-ZROM	Hab	PO	OD		☐ C ☑ DC
2	T-CALCIUM	Hab	PO	OD		☐ C ☑ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : .....

Date & Time : 22/7/26 @ 8:45 am

Nurse Name & Signature: .....

Date & Time : 22/7/26 @ 8:45 AM

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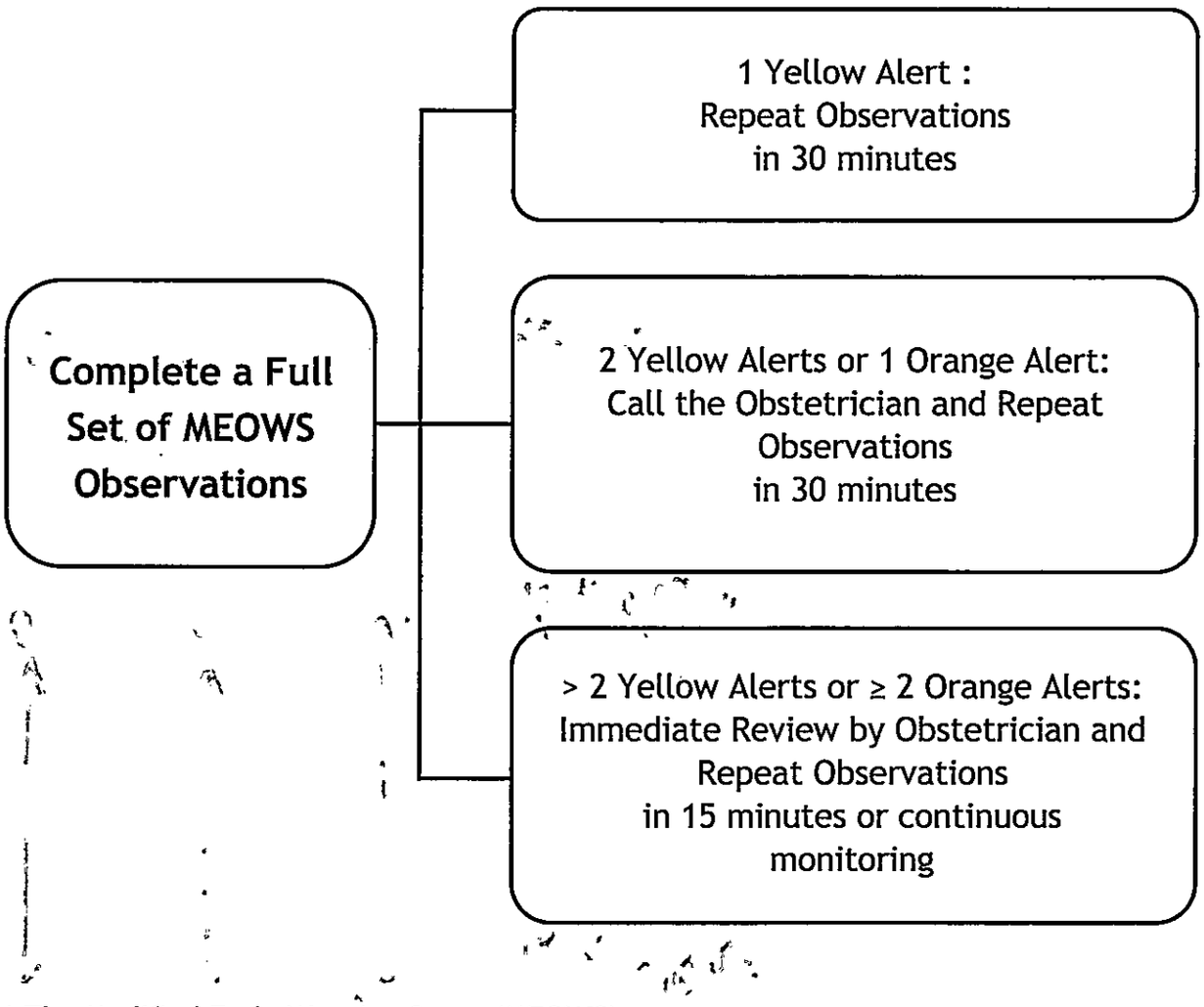
Early Warning Observation Score Chart - Obstetrics

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

		Date																							
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20								20	20	20	20	20				20				20				20	
	0 - 10																									
Saturations	94 - 100 %								99	98	99	98	99				99%				100				100	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90								96	84	83	69	96				86	84			88				80	
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140								114	130	109	116	124				110				120				110	
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40								74	78	81	83	71				77				76				76	
NEURO RESPONSE [✓]	Alert																									
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES									0	0	0	0	0				0				0				0	
TOTAL ORANGE SCORES									0	0	0	0	0				0				0				0	
Nurse Initial																	KW				KW				KW	

Obstetrics and Gynaecology Early Warning Signs



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

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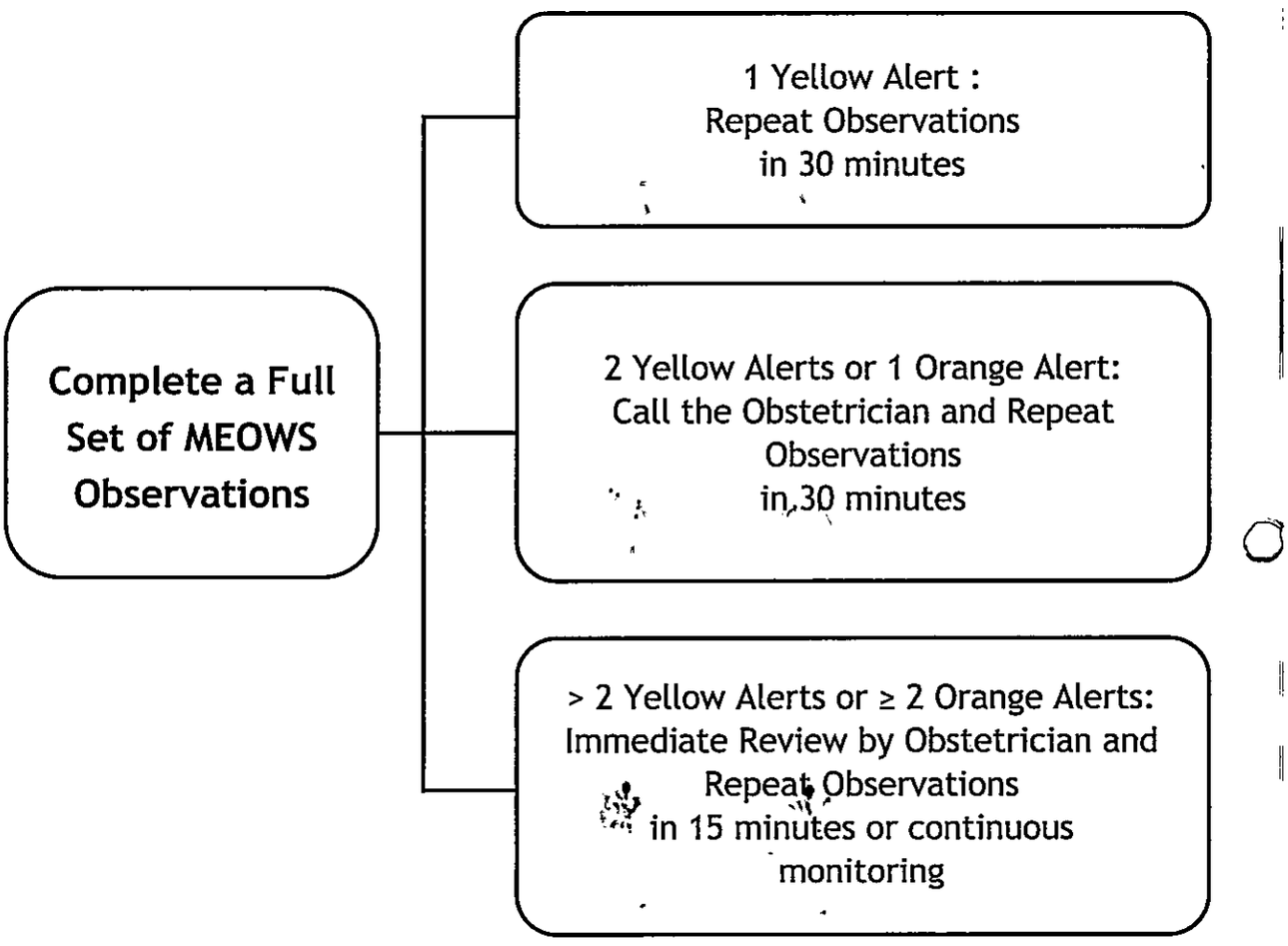
Early Warning Observation Score Chart - Obstetrics

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

23/7/26	Date																								
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20			20				20																	
	0 - 10																								
Saturations	94 - 100 %			98%				99%																	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37			98.2				97.4																	
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80			80				85																	
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressure ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100			103				111																	
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70			76				76																	
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert			—				—																	
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30			—				—																	
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal			—				—																	
	Heavy / Foul																								
Liquor	Clear / Pink			—				—																	
	Green																								
TOTAL YELLOW SCORES				0				0																	
TOTAL ORANGE SCORES				0				0																	
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
22/7	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am	RL	H2O							✓	0	
	12:00 pm	RL										
	01:00 pm	RL										
Total Intake :		Table				Total Output :				Passed		
22/7	02:00 pm											
	03:00 pm	RL	H2O							100ml		
	04:00 pm	RL	H2O Tablet							100ml		
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
23/7	08:00 pm	0						NA		✓	0	
	09:00 pm											
	10:00 pm		Tablet H2O									
	11:00 pm				NA							
	12:00 am											
	01:00 am											
Total Intake :		Table				Total Output :						
23/7	02:00 am	0						NA		✓	0	
	03:00 am											
	04:00 am											
	05:00 am		H2O									
	06:00 am				NA							
	07:00 am											
Total Intake :		Table				Total Output :						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
28/7/26	08:00 am											
	09:00 am	1	Daily				1	N/A				
	10:00 am	0	1200		N/A							
	11:00 am						0					
	12:00 pm	1					1					
	01:00 pm											
Total Intake :		taken				**Total Output :**				0 – M		
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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CHECKLIST FOR THROMBOPHLEBITIS

22/7 23/7/26

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

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

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

Signature : ..... Name : .....

Signature of Ward In Charge :

Signature : ..... Name : .....

BRADEN 'Q' SCALE

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				Date : 22/7/20		23/7/20	
				Time :			
Mobility	e: ...ight 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	
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
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	
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	
				TOTAL SCORE	28	28	28	
				Evaluator's Name				

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

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	22/7	23/7	23/7/26 MB
		Score		0	
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0	0	0	0
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:			20	20	20
		Signature			

Fall Risk Grading

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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NURSING CARE RECORD

Date: 22/7/2026

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon	2pm – 8pm	→ Assess the pt condition → Check the vital's → I/O chart Maintain → plan Medication	2pm – 8pm	→ Assessed pt condition → Checked vitals [illegible] → Maintained I/O chart →	Vital's is Normal	pt is Stable	[signature]
Night	8pm to 8AM	→ Asses the pt condition → Monitor vital & record → Maintain I/O chart → Administer medication as per drug chart	8pm to 8AM	→ Assessed the pt condition → monitor vital & recorded → Maintain I/O chart → Administer medication as per drug chart	→ pt is stable	→ pt is stable	[signature]

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NURSING CARE RECORD

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Date: 23/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am | 2pm	→assess the Pt Condition →monitor vitals →maintain I/O chart →Administer medication as Per drug chart	8am | 2pm	→assessed the Pt condition →monitored vitals & recorded →maintained I/O chart →medication as Per drug chart	→Pt is stable	→rechecked Vitals	
Afternoon							
Night							

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION

Diagnosis: [illegible]

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

BACKGROUND	Area / Shift Time	22/7/2026 ER	23/7/26 PICU	23/7/26 ward			
	Medical Condition (Any special condition to be noted):	—	—	—			
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.6°F	98.2°F	97.2°F			
	Res:	20	20	20/min			
	SpO_2:	98%	98%	99%			
	Pulse:	76	87/min	76/min			
	BP:	120/84	112/80	112/76			
	Fall Risk Score:	—	—	—			
	Pain Score:	—	—	—			
Recommendations	Safety Needs:	—	—	—			
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—	—	—			
	Special Diet:	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	—	—	—			
Post Operative Procedure Special Orders:		—	—	—			
Handed Over By Name :		[illegible]	[illegible]	Divya D			
Signature :							
Date:		22/7/26	23/7/26	23/7/26			
Time:		8pm	8AM				
Taken Over By Name :		[illegible]					
Signature :							
Date:		23/7/26					
Time:		8pm					

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: ..... Department: ..... Date of Admission: .....

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
BACKGROUND	Area / Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	Fall Risk Score:						
	Pain Score:						
Recommendations	Safety Needs:						
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:						
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature :							
Date:							
Time:							
Taken Over By Name :							
Signature :							
Date:							
Time:							

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 22/7/26 Date of Removal: 22/7/26

Parameters / Date / Shift Time	22/7/26						
Need for the Catheter	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hand Hygiene	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Usage of Sterile Equipment	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the Collection bag below the level of bladder	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Check the Tube for Obstruction (Free of Kinking)	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is Catheter dated as policy	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Collecting bag is been emptied regularly?	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Maintenance of closed system for the catheter	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dressing clean and dry?	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is the line removed as Policy?	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Performance of Perineal Care	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Onset of New Fever	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Asses for the leakage at the site of insertion	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Name of the Nurse	[signature]						
Signature of the Nurse	[signature]						

Foley's Removed by [signature] 22/7/26 @ 4PM

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

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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 22/7

Baseline Information:

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

Primary Language: ☐ Telugu ☑ English ☑ Hindi ☐ Others, specify ....

Do you require an interpreter? ☐ Yes ☐ No if Yes specify ....

Source of Information: ☐ Patient ☐ Family ☐ Others, specify ....

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

If yes, identify ....

Chief Complaints: NVD & 6m L&C&

Doctor Notified on Admission: ☐ Yes ☐ No

Name of the Doctor: ....

Time Notified: ....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
NH	NH	NH

Gynecology Assessment: ☐ Not Applicable	**Gynecology Surgical History:**	**Gynecological History:**
Menstrual History:	Caesarean Section: ☐ No ☐ Yes	Contraceptives: ☐ No ☐ Yes
....	Cervical Cerclage: ☐ No ☐ Yes	Vaginal Discharge: ☐ No ☐ Yes
Onset of Menarche:	Ectopic Pregnancy: ☐ No ☐ Yes	Post-Coital Bleeding: ☐ No ☐ Yes
Menstrual Cycle: ☐ Regular ☐ Irregular	Myomectomy: ☐ No ☐ Yes	**Infertility:** ☐ No ☐ Yes
Last Menstrual Period:	Others: ________	**If Yes** Type: ☐ Primary ☐ Secondary

Obstetric History: G .... P .... L .... A ....

Previous LSCS: ....

Current Medication: ☐ None ☐ Yes, If Yes, Fill the reconciliation form

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other ....

Vital Signs / Measurements: Temp: 98.6°F HR: 90 RR: 91

BP: 113/76 Weight: .... Height: .... BMI: ....

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

Patient Sticker

PHYSICAL ASSESSMENT

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

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

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

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

☐ Mobility problem ☐ Walking Problem ☐ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With .....

Orientation has been given regarding the following aspects:

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

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

Above information given to ..... Patient

Name of Person Orientation was given to: Syeda .....

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: Asma .....

Date & Time: 27/9/2016 .....

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BREAST FEEDING HANDOVER AND ASSESSMENT FORM

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

2. If No, Reason .....

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

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

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

Feeding Positions:
Cross Cradle

Feeding Positions:
Football / Clutch

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

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

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

9. Additional notes: .....

Continuity of Care: Date: 21/7/26

→ Assessed pt condition
→ checked Vital's & Rounds
→ Marked I/O chart
→ Plan for DBF

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

Signature ..... Signature .....

Date & Time: 22/7/2026 Date & Time: .....

PARTOGRAPH

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LABOUR

Labour: ☑ Spont ☐ IOL-PGE 1 ☐ E2 ☐ Others

Indications for IOL-Accel: ☐ None ☐ Oxytocin

Memb. Repture Type: ☐ SROM ☐ PROM ☐ ARM

Presentation: ☐ Vertex ☐ Breech ☐ Others

INTRA PARTUM COMPLICATION

Maternal: ☑ Nome ☐ Pyrexia ☐ HTN ☐ Others

Liquor: ☑ Adequate ☐ Oligo ☐ Poly ☐ Clear

☐ Blood ☐ Meconium ☐ Cord: ....

Shoulder Dystocia: ☐ Yes ☑ No

DELIVERY DETAILS

Anesthesia: ☐ None ☑ Epidural

Non-epi: ☐ Local ☐ Spinal ☐ General

Del. Type: ☑ SVD ☐ Asst. Breech ☐ Twins

AVD: ☐ Outlet ☐ Low Forceps ☐ Ventouse ☐ Trails of Forceps

Indications: —

Application, Locking & Traction: —

Duration of Instrumentation: —

No. of Pulls: —

Catherised : ☑ Yes ☐ No

Type: ☐ Fileys ☑ Plain

Perineum : ☐ Intact ☑ Episiotomy ☐ Tear

Suture Material Used: Rapid vicryl No 1

STAGE III

Placenta: ☑ Normal ☐ Abnormal ☐ RP Clots ☐ CCT ☐ Retained ☐ MRP

PPH : ☐ Atomic ☐ Traumatic ☐ None

Lacerations: —

Cervical: —

Perineal: —

Others: —

Prophylaxis: Synocinon ✓ Prostodin

Blood Loss: ~200ml

Blood Transfusion: nil

Other Details (if any): ....

Ractal Examination: Intact

DURATION OF LABOUR

1st Stage: 5 hrs.

2nd Stage: 35 min

3rd Stage: 10 min.

Duration of Active Pushing: 20 min

No. of VE'S: 4-5

BABY DETAILS

Gender: Male

Weight: 3.84 kg

APGAR: 8/10

Date and Time of Delivery: 3:16 pm 22/07/20

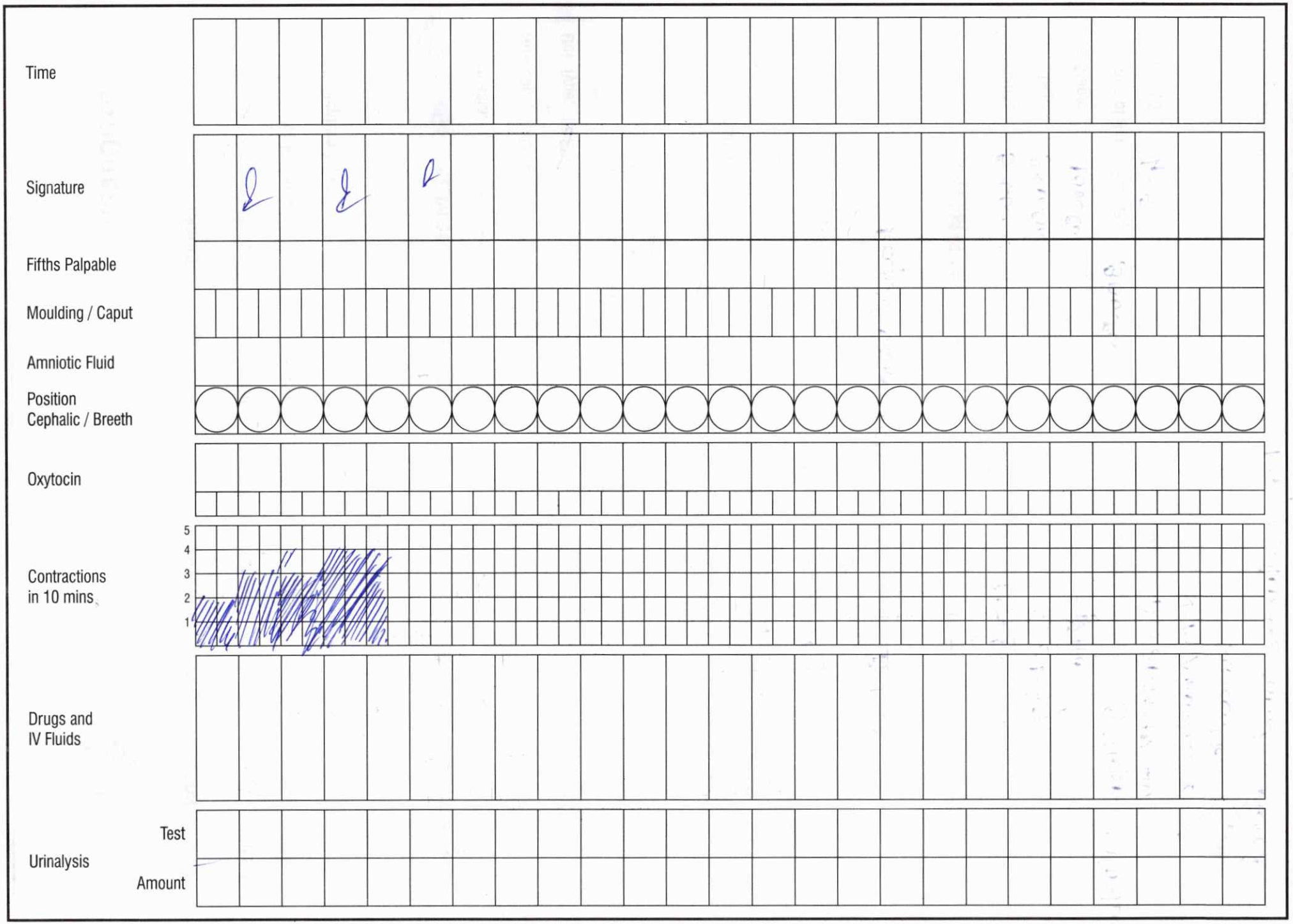
LW Doctor: Dr SWATHI HV

LW Sister: S/N Anusha. K
Monika

Mops & fundal count correct

Docu. No. : RCH /FRM / CLINICAL / 143

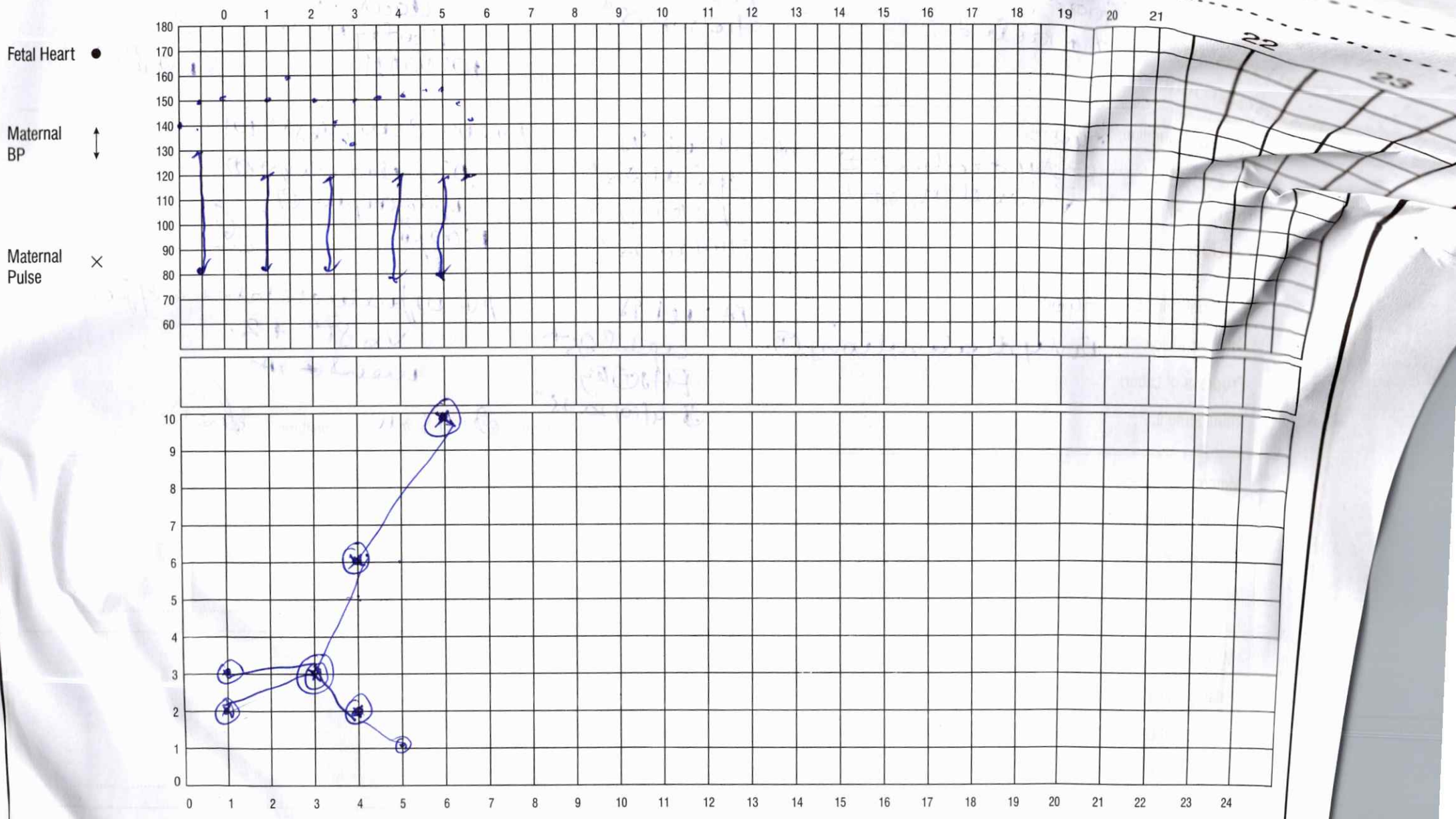
(P.T.O.)


Time
Signature
Fifths Palpable
Moulding / Caput
Amniotic Fluid
Position
Cephalic / Breeth
Oxytocin
5
4
3
2
1
Contractions
in 10 mins
Drugs and
IV Fluids
Urinalysis
Test
Amount

PARTOGRAPH

Name: Sayed Hajeera ..... Obstetrics Formula: primi ..... Blood Group **Type:** .....

Memb. Ruptured: **SROM** **PROM** **ARM** **Risk Factors:** .....



Maternal Condition: — Good
Fetal Condition: — Good
Progress of Labor: Anaected.
Management:

O/E: PA: ut TS. cephal 3/5th FHS ⊕ ry. 2/10/2025

PV: OS 5cm, V/o stn -1 membr Absent clear. P adequate

Time: 10:00 AM Signature: [signature]

Maternal Condition: - good
Fetal Condition: - early decelerat ⊕ variability good.
Progress of Labor:
Management:

O/E: PA: ut TS. cephal 2/5th FHS ⊕ ry. 3/10/20-25

PV: OS 8cm. V/o stn +1 OT, clear liquor ⊕ mem caput ⊕.

Time: 1:00 pm Signature: [signature]

Maternal Condition: - good
Fetal Condition: - Early decelerations ⊕
Progress of Labor:
Management:

PA: ut TS. cephal 0/5th FHS ⊕ ry. 3-4/10/2025

PV: OS fully dilated & effaced V/o stn +2. memb ⊕, As

Time: 2:45 pm Signature: [signature]

Maternal Condition:
Fetal Condition:
Progress of Labor:
Management:

Time: .... Signature: ....

Maternal Condition:
Fetal Condition:
Progress of Labor:
Management:

Time: .... Signature: ....

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. SYEDA HAAJER Age: 24y Sex: F UHID.No : HNH-0000557

Date: 22/7/26 Time: 10:50Am Proposed Operation:

Diagnosis: Primi, 39wks, PROM for spontaneous progression

B.P / CRT: H.R: Weight: 109kg ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: 11.5	Glucose:	Protein:	HIV:	X-Ray:
PCV: 32.8	Urea:	Alb:	HBS Ag: NR	ECG:
WBC: 16000	Creat:	Total Bill:	HCV:	2D Echo:
Plate: 2.9	Na:	Dir. Bill:	Blood group: O+ve	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: NIL

Medical History: CVS :

RESP : Diabetes :

CNS :

Renal : NIL SIGNIFICANT

Hepatic / GE : Physical Activity:

Others :

Past Anaesthetic History:

Physical Exam:

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

Lungs : BAE (+), Clear

Heart: S_1S_2 (+)

CNS: NAD

Pregnant: ☐ Yes ☐ No ☐ NA Venous Access Site : Peripheral (+) Spine Exam for regional : Midline

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

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

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☐ Standard ☐ High Risk
4. Post Operative Pain Management: ☐ Discussed with Patient
5. Other Instructions:
   (1) Consent due.

Signature: Name: Dr. SK. Ayesha.

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R:	B.P / CRT:	SpO_2:	R.R:	Last Feed:

Pre-OP Diagnosis: ..... Operation: ..... Date : .....

Surgeon: ..... Anaesthesiologist: ..... Technician: .....

TIME

N_2O /AIR /O_2 LPM

HALO /SO /SEVO

Drugs:

FIO_2 / SaO_2

$ETCO_2$

ECG

Temperature

Urine Output

Fluids

Blood

Antibiotic

Suppository

Blood Loss

NOTES

B.P
V Systolic
Λ Diastolic
X Mean
• Heart Rate

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values

-ABG

GRBS

Others

☐ Equipment Checked and Functional
☐ BP
☐ Cuff Site: .....
☐ Art Site: .....
☐ EKG Lead
☐ Temp Site
☐ FIO_2 Monitor
☐ Agent Monitor
☐ Pulse Oximeter
☐ Capnograph
☐ Ventilator
☐ Nerve Stimulator

Position: .....
☐ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☐ Awake

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

Times:
Anaes Start: .....
OP Start: .....
OP End: .....
Leave OR: .....

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☐ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☐ IV: .....
☐ IV: .....
☐ IV: .....

Induction
☐ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☐ SGA
☒ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: .....

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# ..... Attempts: .....
Difficulty Why? .....

☐ Bilat = BS
☐ Semi-Closed Circle
☐ Closed Circle
☐ Other

Regional:
Extremity Specify: .....
☐ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: .....
Site: .....
Needle Size: ..... Depth: .....
Parasthesia ☐ Yes ☐ No
Catheter at skin ..... cm
Drug Name & Conc: .....
Bolus: .....
Infusion: .....
Block Level: .....
Comments: .....

Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor : .....
Signature of the Doctor : .....

Patient Sticker

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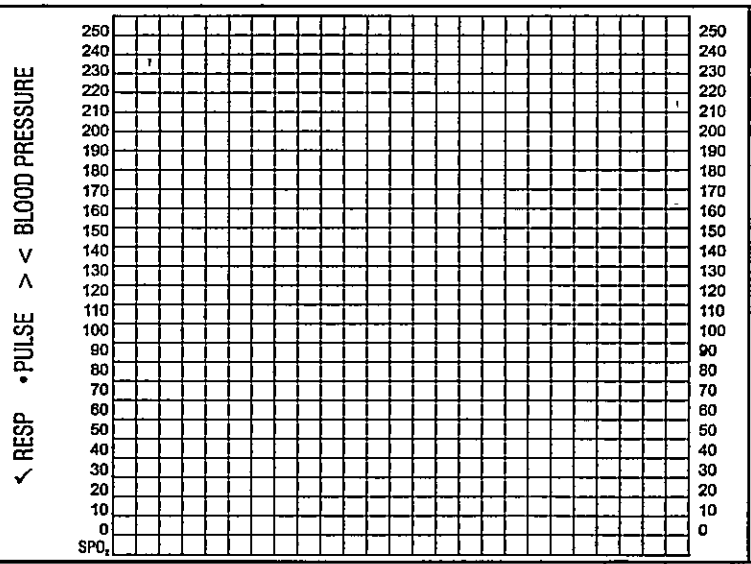
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : ..... Time Received : ..... Time Discharged : .....



IV Cannula Site : .....

☐ O_2 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: .....
Oral Feeds: .....

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature

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

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

Anaesthesiologist Name : .....

Anaesthesiologist Signature: .....

Date & Time: .....

PACU Nurse Name : .....

PACU Nurse Signature: .....

Date & Time: .....

Transferred to Unit by (PACU): .....

Date & Time: .....

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: 22/7/26 Time: 11:40Am Procedure done by Dr. SK. Ayesha

CSE /Spinal /Epidural Position : Sitting Space : L3-L4 Technique (LOR/LOS) LOS

Depth: 5.5cm Catheter at Skin: 11cm Attempts : 1

Parasthesia : Yes/No if yes details :

Solution Composition : 0.1% BUPIVACAINE

Any other issues :

a)

b)

Time	Infusion Rate (ml/hr)	Bolus (ml)	Level Left	Level Right	Maternal BP	Maternal Pulse	FHR	Comments
11:45Am		0.5ml + 0.5ml (Intra thecal)	T_{12}	T_{12}	117/65 mm Hg	82/min	146	0.5ml HEAVY BUPIVACAINE 25mcg + FENTANYL
12:05pm	6 ml/hr		T_{12}	T_{10}		78/min		0.1% BUPIVACAINE

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

Catheter Removed by and Tip Inspected :

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

CONSENT FOR SPECIAL PROCEDURES

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Patient Name : Dr. Mrs. SYEDA HAAJER Gender: ☐ Male ☑ Female

UHID No : HNH-00005571 Department: Anaesthesia Date : 22/7/26

I Mr. IRFAN AHMED S/~~D~~/~~W~~/O Mr. KHALEEM AHMED

Here by give consent for procedure of : LABOR EPIDURAL

For my patient, Named : Mrs. SYEDA HAAJER

The doctors have clearly explained to me that the procedure has following possible complications:

- Post procedure Headaches
- Hypotension

The doctor have explained to me about the alternatives, risks and benefits for this procedure that :

- pain free delivery.

I have understood the matter mentioned above in language known to me and give consent for the procedure.

Name of the Doctor performing the procedure: Dr. SK. Ayesha.

Patient Attendant :

Signature : [signature]

Name : Dr. Syeda Haajer

Relationship with Patient:

Date & Time :

Witness :

Signature : [signature]

Name : Vasia Elmi (Mother In Law)

Date & Time :

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr. SK. Ayesha

Date & Time : 22/7/26

INFORMED CONSENT FOR VAGINAL BIRTH

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Patient Name : Mrs. Syeda Haajer UHID No : HNH-00065571

Gender: ☐ Male ☑ Female Date : 22/7/26 Time : 8:45am

I hereby authorized the performance of the following procedure:

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

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

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

In an attempt to deliver the baby either naturally or with the help of instrument i.e. forceps or vacuum, there may be risks of: infection, allergic reaction, scarring, blood loss, need for blood transfusion, pain and discomfort, injury to urinary tract, possible injury to the baby (laceration, hematoma, skull fracture, nerve injury and brain injury) and possible future pelvic floor dysfunction., chances of 3rd and 4th degree tear.

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

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

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

Name of the Doctor performing the procedure: Dr SWATHI HV. [signature]

Consentee :

Signature : HHajer

Name : Dr. Syeda Haajer.

Date & Time : 22/7/26 @ 11Am

Witness :

Signature : Madhu

Name : Madhumita

Date & Time : 22/7/26

Patient Attendant :

Signature : [signature]

Name : SHAIK IRFAN AHMED

Relationship with Patient: HUSBAND

Date & Time : 22/7/26 @ 11Am

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr SWATHI HV

Date & Time : 22/7/2026

26-00002159 17

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name: MRS. SYEDA HAAJER		Age: 24Y/1M	Gender: Female
UHID No: HNH-0000557	IP No: 26-00006913	Date: 22/7/26	Time: 10.55 Am
Diagnosis: N/D			

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100 MCG	1 Ample
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr. SK. Ayesha

Doctor Registration No: TSMC/FNR/07725

Signature:

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

IP Registration No: 26-00006913 **Date:** 22/7/26

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

1.	**Name :**	**Remarks** 12-11-953 Warasiguda near aksuser Sitaphal
2.	Complete postal address (with contact number, if any)	
3.	Brief description of the illness	NA
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NA
5.	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
22/7	Fentanyle	1		

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

Received by (Name & ID No.): Mounika (607575) Signature:

Time: .....

Docu. No: RCH / FRM / CLINICAL / 133

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26-0000215917

NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: MRS. SYEDA HAATER		Age: 24Y/11M	Gender: Female
UHID No: NH-00006571	IP No: 26-00006913	Date: 22/7/26	Time: 10.55Am
Diagnosis: NVD			

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100 MCG	1 Ample
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr SK. Ayesha

Doctor Registration No: TSMC/FMR/07725

Signature: [signature]

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

IP Registration No: 26-00006913 **Date:** 22/7/26

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

1.	**Name :**	**Remarks**
2.	Complete postal address (with contact number, if any)	12-11-953 Waraseguda near akbusen Sitaphal
3.	Brief description of the illness	NA
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	NA
5.	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
22/7	fentanyle	1	[signature]	

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

Received by (Name & ID No.): Mounika (607575) Signature: [signature]

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133

Rainbow Children's Hospital

Birthright

NARCOTIC PRESCRIPTION FORM

(MEDICAL RECORD)

Patient Name		Age	Gender
UHID No	IP No	Date	Time
Diagnosis			

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1	Pentazocine Inj. 30mg/ml		
2	Morphine Sulphate Inj. 15mg/ml		
3	Pentazocine Hydrochloride Inj. 2MG		
4	Pentazocine Hydrochloride Inj. 1MG		

Doctor Name

Signature

NARCOTIC DISPENSING FORM

APPENDIX 4 – FORM NO. 32

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

IP Registration No: Date:

Address of the Patient (Optional)

1.	Name	Remarks
2.	Complete postal address (with contact number, if any)	
3.	Brief description of the illness	
4.	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the same)	
5.	Details of essential Narcotic drug dispensed	

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

Dispensed by (Name & ID No.)

Signature

Received by (Name & ID No.)

Signature

Time