

Dr. Padmaic



# ESTIMATION SLIP

Date : 2/2/20 UHID / IP No. : LINH-00013343 SI No. **1234**  
 Name of Patient : Mrs. Linao Age: 30y Gender: F  
 Father's / Husband's Name : Mr. Plased Corporate / Occupation : \_\_\_\_\_  
 Address : \_\_\_\_\_ Phone : 6301396965 Email : \_\_\_\_\_  
 Procedure / Plan : ND / 1scs 4550378324 EDD/Dos: June-26  
 MODE OF PAYMENT :  SELF  TPA : \_\_\_\_\_  GIPSA : \_\_\_\_\_ OTHER

## TARIFF INFORMATION :

Baici Alligob

| Particulars   | Package Amounts (Rs.)  |  |
|---|--|--|
|   | Normal Delivery  | LSCS   |
| Room Category   |  |  |
| Multi Shared Ward   |  |  |
| Shared Ward   |  |  |
| Twin Shared Ward  |  |  |
| Private Room  |  |  |
| Super Deluxe Room   | <u>1.070</u>   | <u>1.17</u>  |
| Suite Room  | <u>f non payables</u>  | <u>catere</u>  |
| Package includes<br>(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>2500/-</u>   | Investigations up to <u>3000/-</u>   |
| Others  | <u>Well baby PKG</u>   | <u>25k to 35k</u>  |

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

Initial Minimum Deposit : 10,000/- Advance

REMARKS : Vaccination neonatal, SBR, B16

- 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, vacclinations, 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.

Av SRJ  
Signature of the Client

\_\_\_\_\_  
Signatory Relationship

[Signature]  
Signature of the financial Counselor

ESTIMATION SLIP

DATE: 11/15/68

NAME OF FELLOW: J. J. [unclear]

FELLOW'S ADDRESS: [unclear]

ADDRESS: [unclear]

ESTIMATE NO.: [unclear]

NAME OF PERSON: [unclear]

TYPE OF ESTIMATION: [unclear]

| ITEM NO. | DESCRIPTION | ESTIMATE  | ACTUAL    |
|----------|-------------|-----------|-----------|
| 1        | [unclear]   | [unclear] | [unclear] |
| 2        | [unclear]   | [unclear] | [unclear] |
| 3        | [unclear]   | [unclear] | [unclear] |
| 4        | [unclear]   | [unclear] | [unclear] |
| 5        | [unclear]   | [unclear] | [unclear] |
| 6        | [unclear]   | [unclear] | [unclear] |
| 7        | [unclear]   | [unclear] | [unclear] |
| 8        | [unclear]   | [unclear] | [unclear] |
| 9        | [unclear]   | [unclear] | [unclear] |
| 10       | [unclear]   | [unclear] | [unclear] |
| 11       | [unclear]   | [unclear] | [unclear] |
| 12       | [unclear]   | [unclear] | [unclear] |
| 13       | [unclear]   | [unclear] | [unclear] |
| 14       | [unclear]   | [unclear] | [unclear] |
| 15       | [unclear]   | [unclear] | [unclear] |
| 16       | [unclear]   | [unclear] | [unclear] |
| 17       | [unclear]   | [unclear] | [unclear] |
| 18       | [unclear]   | [unclear] | [unclear] |
| 19       | [unclear]   | [unclear] | [unclear] |
| 20       | [unclear]   | [unclear] | [unclear] |
| 21       | [unclear]   | [unclear] | [unclear] |
| 22       | [unclear]   | [unclear] | [unclear] |
| 23       | [unclear]   | [unclear] | [unclear] |
| 24       | [unclear]   | [unclear] | [unclear] |
| 25       | [unclear]   | [unclear] | [unclear] |
| 26       | [unclear]   | [unclear] | [unclear] |
| 27       | [unclear]   | [unclear] | [unclear] |
| 28       | [unclear]   | [unclear] | [unclear] |
| 29       | [unclear]   | [unclear] | [unclear] |
| 30       | [unclear]   | [unclear] | [unclear] |
| 31       | [unclear]   | [unclear] | [unclear] |
| 32       | [unclear]   | [unclear] | [unclear] |
| 33       | [unclear]   | [unclear] | [unclear] |
| 34       | [unclear]   | [unclear] | [unclear] |
| 35       | [unclear]   | [unclear] | [unclear] |
| 36       | [unclear]   | [unclear] | [unclear] |
| 37       | [unclear]   | [unclear] | [unclear] |
| 38       | [unclear]   | [unclear] | [unclear] |
| 39       | [unclear]   | [unclear] | [unclear] |
| 40       | [unclear]   | [unclear] | [unclear] |
| 41       | [unclear]   | [unclear] | [unclear] |
| 42       | [unclear]   | [unclear] | [unclear] |
| 43       | [unclear]   | [unclear] | [unclear] |
| 44       | [unclear]   | [unclear] | [unclear] |
| 45       | [unclear]   | [unclear] | [unclear] |
| 46       | [unclear]   | [unclear] | [unclear] |
| 47       | [unclear]   | [unclear] | [unclear] |
| 48       | [unclear]   | [unclear] | [unclear] |
| 49       | [unclear]   | [unclear] | [unclear] |
| 50       | [unclear]   | [unclear] | [unclear] |

REMARKS: [unclear]

APPROVED BY: [unclear]

DATE: [unclear]

HNH-00013343 IP26-00006419  
Mrs SRIBHASHYAM KIRANMAYEE  
04-01-1996 30 Y 4 M 20 D (F)  
Dr. PADMAJA YELISETTY



Rainbow<sup>®</sup>  
Children's  
Hospital  
It takes a lot to treat the little.

BirthRight<sup>™</sup>  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## SURGERY DETAILS

Date : 24/5/26  
Patient Name: Mrs. Kiranmayee Date of Birth: 4/1/1996 Age: 30yrs.  
Gender: Female Ward : OT UHID No: HNH-00013343  
Date of Surgery: 24/5/26  OT-1  OT-2  OT-3  OT-4  OBG OT-1  OBG OT-2  
Name of the Surgery : Emergency LSCS

Time in : 4:30 pm Time Out : 6 pm

|                      | NAME                 | AMOUNT |
|----------------------|----------------------|--------|
| 1. Surgeon           | Dr. padmaja          |        |
| 2. Anaesthetist      | Dr. Samir            |        |
| 3. Assistant Surgeon | Dr. Swathi, Dr. Dura |        |
| 4. OT Technician     | Sr. Sarawathi        |        |
| 5. Circulating Nurse | B. Sudipta           |        |
| 6. Assistant Nurse   | Sr. Archana          |        |

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

Signature of the Surgeon  
*Y. Padmaja*

Signature of Circulating Nurse  
*Archana*

Order No: 26-0000201877

Order by: Archana 24/5/26 @ 18:15 pm

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

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*Emiles*  
**CONSUMABLES OF OT**

Circulating staff : *Jadeptha* Technician : *Saraswathi* Date : *24/5/26* Time : .....

| Anaesthesia Disposables            | Qty    |      | Surgical Disposables             | Qty    |       | Disposables (Baby Side)               | Qty    |       |
|------------------------------------|--------|------|----------------------------------|--------|-------|---------------------------------------|--------|-------|
|                                    | Issued | Used |                                  | Issued | Used  |                                       | Issued | Used  |
| ET tube                            |        |      | Major Pack <i>1 set</i>          |        | 1     | Inj Vit.K                             |        | 101   |
| LMA                                |        |      | Sutures <i>2347, 2317</i>        |        | 2+14  | Cord Clamp                            |        | 101   |
| ECG leads : (A) P / N              |        | 3    | <i>2518, 3650</i>                |        | 4+14  | Suction Catheter                      |        |       |
| HME filter : A / P / N             |        |      |                                  |        |       | Feeding Tube <i>5.0</i>               |        | 01    |
| Syringes : 10 cc                   |        | 2    | <i>plastic Apiron</i>            |        | 4     | Vacuum Suction Set                    |        |       |
| 05 cc                              |        | 2    | Gloves <i>SG 6 1/2</i>           |        | 13    | Surgical Gloves <i>7.16, 5.6, 6.0</i> |        | 14+14 |
| 02 cc                              |        | 2    | <i>PF S.G 7</i>                  |        | 2     | Gauze Pack <i>7.5</i>                 |        | 102   |
| 01 cc                              |        | 27   | <i>encote 6 1/2</i>              |        | 1     | Syringe 1ml / 2ml                     |        | 102   |
| Cautery plate : (A) P / N          |        | 01   | Surgical blade <i>22</i>         |        | 1     | Surgical Blade # 20                   |        | 101   |
| IV set                             |        |      | NG tube                          |        |       | Koochies (S)                          |        | 01    |
| RL                                 |        | 03   | Cautery pencil                   |        | 4     | <i>duo Derm</i>                       |        | 01    |
| NS : 10ml / 100ml / 500ml / 1000ml |        | 01   | Koochies <i>xxl</i>              |        | 1     |                                       |        |       |
| <i>Buprinesic</i>                  |        | 01   | Ointments                        |        | 1     | <i>Baby Sani</i>                      |        |       |
| <i>oxytocine</i>                   |        | 03   | Suction Catheter                 |        |       |                                       |        |       |
| Fentanyl                           |        |      | Cap, Mask                        |        | 10+10 | <i>(HNH-00015601)</i>                 |        |       |
| Morphine <i>can bitocine</i>       |        | 01   | Gauze Pack <i>x-ray, 7.5x7.5</i> |        | 4+2   | <i>26-0000201886 / 1885</i>           |        |       |
| Ketamine                           |        |      | Mop Pack                         |        | 2     |                                       |        |       |
| Propofol <i>Relipawa</i>           |        | 01   | Steristrip                       |        |       |                                       |        |       |
| Rocuronium                         |        |      | Underpad                         |        | 2     |                                       |        |       |
| Glycopyrolate <i>Atropine</i>      |        | 101  | Draw sheet                       |        |       |                                       |        |       |
| Myopyrolate <i>adrenalinu</i>      |        | 01   | Abgel                            |        | 1     |                                       |        |       |
| Ondansetron                        |        | 01   | Foleys catheter <i>14</i>        |        | 4     |                                       |        |       |
| Pencan <i>250</i> Spinal Needle 22 |        | 01   | Urobag                           |        | 2     |                                       |        |       |
| Bupivacaine 0.25%                  |        |      | Chest Drainage Catheter          |        |       |                                       |        |       |
| Bupivacaine 0.25%(Heavy)           |        | 01   | Romodrain bag                    |        |       |                                       |        |       |
| Antibiotics                        |        |      | Bandage                          |        |       |                                       |        |       |
| <i>S.G 7.0</i>                     |        | 01   | Tegaderm                         |        |       |                                       |        |       |
| Suppositories                      |        |      | <i>Joban Tip cleaner</i>         |        | 1     |                                       |        |       |
| Anamol : 80mg / 250mg / 170 mg     |        |      | Double J Stent                   |        |       |                                       |        |       |
| Supridol : 100mg                   |        | 01   | Vacuum Suction set               |        | 4     |                                       |        |       |
| Justin : 12.5 mg / 25mg / 100mg    |        | 101  | Plastic Bed Sheet                |        |       |                                       |        |       |
| Tab. Misoprost : 200mg             |        | 05   | Betadine Solution                |        | 2     |                                       |        |       |
| <i>Gauze 7.5 x 7.5</i>             |        | 01   | Microshield                      |        | 2     |                                       |        |       |
| <i>Thermicar</i>                   |        | 01   | Cotton Balls                     |        | 4     |                                       |        |       |
|                                    |        |      | Latex Gloves                     |        | 20    |                                       |        |       |
|                                    |        |      | Ramdione Scrub                   |        |       |                                       |        |       |
|                                    |        |      | Saral                            |        |       |                                       |        |       |

Surgeon \_\_\_\_\_ Anaesthesiologist \_\_\_\_\_ Nurse \_\_\_\_\_ OT Technician \_\_\_\_\_  
 Order No. : *26-0000201883/1882/1881* Ordered by : *Archana 24/5/26 @ 19:13 pm*  
 Doc. No. : RGH / FRM / GENERAL / 125



**ELECTRONIC MEDICINE PRESCRIPTION**

|                          |  |                    |   |
|--------------------------|--|--------------------|---|
| <b>MRN</b>               | : HNH-00013343   | <b>Name</b>        | : Mrs SRIBHASHYAM KIRANMAYEE              |
| <b>Age / Sex</b>         | : 30 Y 4 M 20 D / Female   | <b>Doctor</b>      | : PADMAJA YELISETTY                       |
| <b>Adm/Reg Date/Time</b> | : 24/05/2026 15:35   | <b>Payor</b>       | : STAR HEALTH AND ALLIED INSURANCE CO LTD |
| <b>Order Date</b>        | : 24/05/2026 19:13   | <b>Ordernumber</b> | : 26-0000201882                           |
| <b>Visit ID</b>          | : IP26-00006419  | <b>Ward/Bed No</b> | : 4F -OT / LDR-416                        |
| <b>Patient Address</b>   | : FLAT NO:401,SREE VINAYAKA ENCLAVE,ROAD NO:8 PNR COLONY,AMEENPUR, Ramachandra puram, Sangareddy, Telangana, INDIA, 502032 |                    |   |

| S.No | Description                            | Generic Name                           | Dosage | Route / Frequency     | Duration | Instruction | Qty    | Status  |
|------|--|--|--------|-----------------------|----------|-------------|--------|---------|
| 1    | CAUTERY PENCIL (ADVANCE)               | CAUTERY PENCIL (ADVANCE)               | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos  | Ordered |
| 2    | CUROPINE (ATROPINE) INJ 1 ML           |  | 1 Vial | External / Once Daily | 1 Days   |             | 1 Vial | Ordered |
| 3    | DSYRINGE 1ML (NIPRO)                   | SYRINGE 1ML                            | 1 Nos  | External / Once Daily | 1 Days   |             | 2 Nos  | Ordered |
| 4    | DSYRINGE 10ML (NIPRO)                  | SYRINGE 10ML                           | 1 Nos  | External / Once Daily | 1 Days   |             | 2 Nos  | Ordered |
| 5    | SURGEON CAP(FEMALE)                    | FEMALE CAP                             | 1 Cap  | / Once Daily          | 10 Days  |             | 10 Cap | Ordered |
| 6    | FACE MASK 3 LAYER - ELASTIC            | FACE MASK 3 LAYER                      | 1 Nos  | / Once Daily          | 10 Days  |             | 10 Nos | Ordered |
| 7    | POVINANZ SOLUTION 10% 100 ML           |  | 1 Nos  | External / Once Daily | 1 Days   |             | 2 Nos  | Ordered |
| 8    | GAUZ SWAB 10 X 10 CM 12PLY 5S X-RAY    | GAUZE SWABS-510X10 12 PLY XRAY STERILE | 1 Pkt  | External / Once Daily | 1 Days   |             | 1 Pkt  | Ordered |
| 9    | UNDERPADS 60X90 BUTTERFLY              |  | 1 Nos  | External / 10 AM      | 1 Days   |             | 2 Nos  | Ordered |
| 10   | NITRILE EXAMINATION GLOVES P F- MEDIUM | NITRILE GLOVES M                       | 1 Nos  | / Once Daily          | 20 Days  |             | 20 Nos | Ordered |
| 11   | VICRYL PLUS 1 VP - (2347)              | VICRYL PLUS 1 VP 2347                  | 1 Nos  | / Once Daily          | 2 Days   |             | 2 Nos  | Ordered |
| 12   | NS 100ML ACCULIFE - EH                 |  | 1 mL   | External / 10 AM      | 1 Days   |             | 1 mL   | Ordered |
| 13   | DSYRINGE 5ML (NIPRO)                   | SYRINGE 5ML                            | 1 Nos  | External / Once Daily | 1 Days   |             | 2 Nos  | Ordered |

**PADMAJA YELISETTY**

**Reg No : 52427**

\* This document is just for reference purpose only. Not to be considered as primary report.

**Note**

\* This prescription is valid only for specified duration.

\* Do not refill medicines.





**ELECTRONIC MEDICINE PRESCRIPTION**

MRN : HNH-00013343 Name : Mrs SRIBHASHYAM KIRANMAYEE  
 Age / Sex : 30 Y 4 M 20 D / Female Doctor : PADMAJA YELISETTY  
 Adm/Reg Date/Time : 24/05/2026 15:35 Payor : STAR HEALTH AND ALLIED INSURANCE CO LTD  
 Order Date : 24/05/2026 19:13 Ordernumber : 26-0000201891  
 Visit ID : IP26-00006419 Ward/Bed No : 4F-OT / LDR-416  
 Patient Address : FLAT NO:401,SREE VINAYAKA ENCLAVE,ROAD NO:8 PNR COLONY,AMEENPUR, Ramachandra puram,  
 Sangareddy, Telangana, INDIA, 502032

| S.No | Description                              | Generic Name                               | Dosage   | Route / Frequency      | Duration | Instruction | Qty      | Status    |
|------|--|--|----------|------------------------|----------|-------------|----------|-----------|
| 1    | FOLEYS CATHETER 14-URO CATH              |  | 1 Nos    | External / 10 AM       | 1 Days   |             | 1 Nos    | Dispensed |
| 2    | MISOPROST TAB 200MCG 4S                  |  | 1 Tabs   | External / Once Daily  | 1 Days   |             | 6 Tabs   | Dispensed |
| 3    | Encore Microptic gloves-6.5              |  | 1 Nos    | / Once Daily           | 1 Days   |             | 1 Nos    | Dispensed |
| 4    | VACCUME SUCTION SET                      | VACCUME SUCTION SET                        | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 5    | SURGICAL BLADE 22                        | SURGICAL BLADE 22                          | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 6    | RILKOL 100 MCG INJ CARBITOCIN            |  | 1 Nos    | Injection / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |
| 7    | WOKADONE 10% OINT 15GM                   | POVIDONE IODINE 10% 15GM                   | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 8    | JUSTIN SUPPOSITORIES 100 MG 5 S          |  | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 9    | DISPOSABLE APRONS STERILE XL             | DISPOSABLE APRON STERILE XL                | 1 Nos    | / Once Daily           | 4 Days   |             | 4 Nos    | Dispensed |
| 10   | PENCAN 27G (B/BRAUN)                     |  | 1 Nos    | External / 10 AM       | 1 Days   |             | 1 Nos    | Dispensed |
| 11   | LSCS DRAPE PACK                          | LSCS DRAPE PACK                            | 1 Nos    | / 10 AM                | 1 Days   |             | 1 Nos    | Dispensed |
| 12   | E.C.G ELECTRODES (ADULT)                 | ELECTRODES ADULT                           | 1 Nos    | External / Once Daily  | 1 Days   |             | 3 Nos    | Dispensed |
| 13   | UROBAG (ADULT) - URODYNE                 |  | 1 Nos    | External / 10 AM       | 1 Days   |             | 1 Nos    | Dispensed |
| 14   | DSYRINGS 2.5ML(NPRO)                     | SYRINGE 2ML                                | 1 Nos    | External / Once Daily  | 1 Days   |             | 2 Nos    | Dispensed |
| 15   | BUPICAIN HEAVY 80MG INJ 4ML              | BUPIVACANE 80MG INJ                        | 1 Nos    | / Once Daily           | 1 Days   |             | 1 Nos    | Dispensed |
| 16   | Monocryl 3-0 W3650                       |  | 1 Nos    | / 10 AM                | 1 Days   |             | 1 Nos    | Dispensed |
| 17   | EVATOCH (OXYTOCIN) INJ 5 IU 1 ML         |  | 1 Nos    | / Once Daily           | 3 Days   |             | 3 Vial   | Dispensed |
| 18   | ONDOKIND INJ 4 MG 2 ML                   | ONDANSETRON 4MG 2ML INJ                    | 1 Nos    | / Once Daily           | 1 Days   |             | 1 Vial   | Dispensed |
| 19   | RELIPARA(PARACETAMOL) 100MG 100ML BOTTLE |  | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 20   | THEMICAR 30MG INJ 10ML                   |  | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 21   | TIP CLEANER ELECTRO BRASIVE(REF:2401)    | TIP CLEANER ELECTRO BRASIVE(REF:2401)      | 1 Nos    | / Once Daily           | 1 Days   |             | 1 Nos    | Dispensed |
| 22   | ABGEL SURGI PAD (BIG) (GELSPON)          | ABGEL                                      | 1 Nos    | / Once Daily           | 1 Days   |             | 1 Nos    | Dispensed |
| 23   | BUPRIFESIC INJ AMP 0.3 MG 1ML            | BUPRENORPHINE 0.3 MG 1ML INJ               | 1 Ampule | External / Once Daily  | 1 Days   |             | 1 Ampule | Dispensed |
| 24   | ADULT DIAPERS-XXL                        |  | 1 Nos    | External / 10 AM       | 1 Days   |             | 1 Nos    | Dispensed |
| 25   | VICRYL 2-0 VP 2317                       | VICRYL 2-0 VP 2317                         | 1 Nos    | / Once Daily           | 1 Days   |             | 1 Nos    | Dispensed |
| 26   | RL 500 ML CLOSED SYSTEM                  | RINGER LACTATE 500ML CLOSED                | 1 Bottle | / Once Daily           | 3 Days   |             | 3 Bottle | Dispensed |
| 27   | MOPS 30X30 8PLY 6S X-RAY                 | MOPS 30X308 PLYDATT                        | 1 Nos    | / Once Daily           | 2 Days   |             | 2 Nos    | Dispensed |
| 28   | SGLOVE # 7.0(SURGICARE)                  | SURGICAL GLOVES 7.0                        | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 29   | BACTOPREP SOLUTIONS 100 ML               | CHLORHEXIDINE GLUCONATE2% /SALCOLOL50% 500 | 1 mL     | / Once Daily           | 2 Days   |             | 2 Nos    | Dispensed |
| 30   | GALIZE 7.5X7.5 12 PLY (5 NOS)            | GALIZE 7.5X7.5 12 PLY 5 NOS                | 1 Nos    | External / Once Daily  | 1 Days   |             | 3 Nos    | Dispensed |
| 31   | VICRYL USP-0 VP2518                      |  | 1 Nos    | External / 10 AM       | 1 Days   |             | 1 Nos    | Dispensed |
| 32   | COTTON BALLS 2 GM 5 NOS                  | COTTON BALLS 2G-5 NOS                      | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 33   | PREGELLED SURGICAL PLATES(ADULT)         | PREGELLED PLATED ADULT                     | 1 Nos    | / Once Daily           | 1 Days   |             | 1 Nos    | Dispensed |
| 34   | ADROGLARE(ADRENALINE) INJ 1MG 1ML        |  | 1 Vial   | Injection / Once Daily | 1 Days   |             | 1 Vial   | Dispensed |
| 35   | SUPRIDOL SUPPOSITORIES 100 MG 6 S        |  | 1 Nos    | External / Once Daily  | 1 Days   |             | 1 Nos    | Dispensed |
| 36   | SGLOVE # 6.5 (SURGICARE)                 | SURGICAL GLOVES 6.5                        | 1 Nos    | External / Once Daily  | 1 Days   |             | 3 Nos    | Dispensed |

PADMAJA YELISETTY

Reg No : 52427

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Note

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\* Do not refill medicines.

**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.  
040-48873000, info@rainbowhospitals.in



**ELECTRONIC MEDICINE PRESCRIPTION**

MRN : HNH-00015601 Name : Baby Of SRIBHASHYAM KIRANMAYEE  
 Age / Sex : 0 Y 0 M 0 D 2 H / Male Doctor : S TEJASWI REDDY  
 Adm/Reg Date/Time : 24/05/2026 17:40 Payor : SELFPAY  
 Order Date : 24/05/2026 19:17 Ordernumber : 26-0000201886  
 Visit ID : IP26-00006420 Ward/Bed No : 4F -OT / CRDL-HNPDA-415-1  
 Patient Address : FLAT NO:401,SREE VINAYAKA ENCLAVE,ROAD NO:8 PNR COLONY,AMEENPUR, Ramachandra puram,  
 Sangareddy, Telangana, INDIA, 502032

| S.No | Description                  | Generic Name               | Dosage | Route / Frequency     | Duration | Instruction | Qty   | Status    |
|------|------------------------------|----------------------------|--------|-----------------------|----------|-------------|-------|-----------|
| 1    | EASYCLOT-K1 1MG INJ 0.5 ML   |                            | 1 Nos  | Injection / 10 AM     | 1 Days   |             | 1 Nos | Dispensed |
| 2    | SGLOVE # 6.5 (SURGICARE)     | SURGICAL GLOVES 6.5        | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos | Dispensed |
| 3    | SGLOVE # 7.0(SURGICARE)      | SURGICAL GLOVES 7.0        | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos | Dispensed |
| 4    | GAUZE 7.5X7.5 12 PLY (5 NOS) | GAUZE 7.5X7.5 12 PLY 5 NOS | 1 Nos  | External / Once Daily | 1 Days   |             | 2 Nos | Dispensed |
| 5    | SGLOVE # 6 (SURGICARE)       | SURGICAL GLOVES 6.0        | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos | Dispensed |
| 6    | SURGICAL BLADE 20            | SURGICAL BLADE 20          | 1 Nos  | / Once Daily          | 1 Days   |             | 1 Nos | Dispensed |
| 7    | CORD CLAMP-ALPHAMEDICARE     |                            | 1 Nos  | External / 10 AM      | 1 Days   |             | 1 Nos | Dispensed |
| 8    | INFANT FEEDING TUBE-5        | INFANT FEEDING TUBE 5      | 1 Nos  | External / Once Daily | 1 Days   |             | 1 Nos | Dispensed |

**S TEJASWI REDDY**

**Reg No : APMC/FMR/94068**

\* This document is just for reference purpose only. Not to be considered as primary report.

**Note**

\* This prescription is valid only for specified duration.

\* Do not refill medicines.



|                 |  |                |                       |
|-----------------|--|----------------|-----------------------|
| Name            | Mrs SRIBHASHYAM KIRANMAYEE   | UHID           | HNH-00013343          |
| Father/Guardian | Mr A.V.S PRASAD  | Age/Gender     | 30 Y 4 M 20 D/ Female |
| Address         | FLAT NO:401,SREE VINAYAKA ENCLAVE,ROAD NO:8 PNR COLONY,AMEENPUR, Ramachandra puram, Sangareddy, Telangana, INDIA, 502032 |                |                       |
| IP No           | IP26-00006419  | Admission Date | 24-05-2026            |
| Ref Doctor      | Self.  |                |                       |
| Discharge Date  | 27.05.2026   |                |                       |

### DISCHARGE SUMMARY

**Consultant:**

**Dr. Padmaja Yelisetty,**  
MBBS, MD, MRCOG, FRCOG  
52427

**Diagnosis: PRIMIGRAVIDA WITH 37<sup>+6</sup> WEEKS PERIOD OF GESTATION WITH REDUCED FETAL MOVEMENTS WITH FETAL DISTRESS FOR DELIVERY**

**EMERGENCY LOWER SEGMENT CAESAREAN SECTION DONE ON 24.05.2026**

**History:**

LMP: 01.09.2025

EDD: 08.06.2026

Obstetric formula: Primigravida

Gestation at admission: 37<sup>+6</sup> weeks

Obstetric History:

G1 - Present pregnancy, spontaneous conception.

Medical History: Endometrial kochs in 2025

Surgical History: Nil.

Family History: Father-DM, Mother -HTN

Allergies: Nil.

|              |                            |                       |              |
|--------------|----------------------------|-----------------------|--------------|
| <b>Name</b>  | Mrs SRIBHASHYAM KIRANMAYEE | <b>UHID</b>           | HNH-00013343 |
| <b>IP No</b> | IP26-00006419              | <b>Admission Date</b> | 24-05-2026   |

### Antenatal Details:

Mrs SRIBHASHYAM KIRANMAYEE was booked to Rainbow hospital at 26<sup>+5</sup> weeks of gestation. She had regular antenatal checkups and investigations as advised. NT scan was normal. FTS was low risk, TIFFA was normal. Fetal growth monitoring done by serial growth scan. Growth scan done 18.05.2026 showed SLIUF at 37 weeks with Placenta right lateral and posterior wall, cord insertion is marginal at upper end of posterior placenta, right lateral part is succenturiate lobe with no bridging placental tissue, Cephalic presentation with AFI 9.2cm with EFW 2827gm, (31%/AC-19%) with Dopplers normal. She was admitted at 37<sup>+6</sup> weeks with reduced fetal movements with fetal distress for Emergency LSCS.

**Investigations:** Enclosed

Blood group: "O" Positive

### Management:

#### Course in hospital and Delivery Details:

At admission on clinical examination the vitals were stable, uterus was relaxed, cervix was long, posterior, soft and os 1 cm dilated. Fetal well being was confirmed by an admission CTG which was found to be nonreactive. She was decided for emergency C- section in view of Fetal distress, prepared 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. 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 1000

2/5

|              |                               |                       |              |
|--------------|-------------------------------|-----------------------|--------------|
| <b>Name</b>  | Mrs SRIBHASHYAM<br>KIRANMAYEE | <b>UHID</b>           | HNH-00013343 |
| <b>IP No</b> | IP26-00006419                 | <b>Admission Date</b> | 24-05-2026   |

mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

**\*Lower uterine segment - Vascular**

**\*Placenta -marginal umbilical cord insertion, succenturiate lobe present**

**Delivery Details :**

Date : 24.05.2026

Time of Delivery: 04:50 pm

Type of Delivery: Emergency Lower Segment Caesarean Section

Indication : Fetal distress

Anaesthesia : Spinal

**Baby Details:**

Date : 24.05.2026

Time : 04:50 pm

Sex : Male

Weight : 2.94kg

Apgar : 7,9

Gestational Age: 37<sup>+6</sup> 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. Thromboprophylaxis given. 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 31.05.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 28.05.2026(8am-2pm-10pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 28.05.2026 (9am-3pm-11pm) after food.

3/5

|              |                            |                       |              |
|--------------|----------------------------|-----------------------|--------------|
| <b>Name</b>  | Mrs SRIBHASHYAM KIRANMAYEE | <b>UHID</b>           | HNH-00013343 |
| <b>IP No</b> | IP26-00006419              | <b>Admission Date</b> | 24-05-2026   |

4. Tab. Pantop 40mg twice daily till 31.05.2026 (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 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 **6 weeks**; Please discuss with your treating doctor regarding **HPV vaccination**.

Review with **Dr. Padmaja Yelisetty**, after **1 week** on **03.06.2026** at **10:00am** Rainbow Children's Hospital with prior appointment (**Review consultation will be charged**).

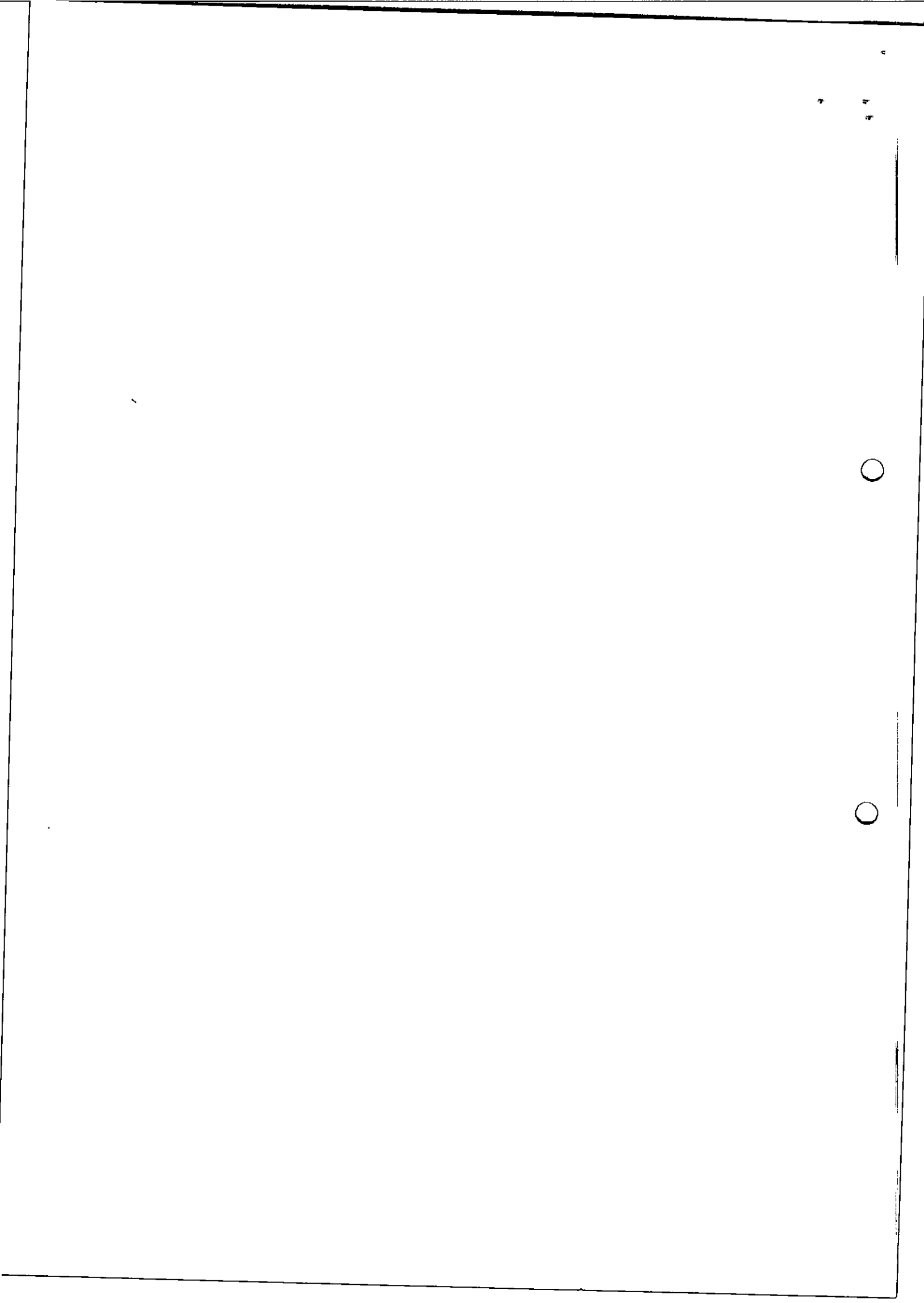
**For Women Who Have Had a Caesarean Section**  
**Care of the wound:**

- 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.

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.

*[Signature]*  
Patient/ Attender

In case of emergency like bleeding, fever [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 at Rainbow Children's Hospital just dial one toll free number - 18002122.



|              |                               |                       |              |
|--------------|-------------------------------|-----------------------|--------------|
| <b>Name</b>  | Mrs SRIBHASHYAM<br>KIRANMAYEE | <b>UHID</b>           | HNH-00013343 |
| <b>IP No</b> | IP26-00006419                 | <b>Admission Date</b> | 24-05-2026   |

You can also take appointments at any time by going online to our website [www.rainbowhospitals.in](http://www.rainbowhospitals.in)

  
**Registrar/Resident/C.M.O**



**Consultant:**

**Dr. Padmaja Yelisetty,**  
MBBS, MD, MRCOG, FRCOG  
52427



**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.  
040-48873000, info@rainbowhospitals.in



|                      |                            |                         |               |
|----------------------|----------------------------|-------------------------|---------------|
| <b>PatientName</b> : | Mrs SRIBHASHYAM KIRANMAYEE | <b>Inpatient No.</b> :  | IP26-00006419 |
| <b>Age/Gender</b> :  | 30 Y 4 M 20 D/ Female      | <b>Admit Date</b> :     | 24-05-2026    |
| <b>Ward/Bed</b> :    | 4F -OT/ LDR-416            | <b>Discharge Date</b> : |               |

| Investigation                                    | Result | Unit  | Biological Reference Interval |
|--|--------|---|-------------------------------|
| <b>COMPLETE BLOOD PICTURE (Specimen : BLOOD)</b> |        | <b>TEST RESULT STATUS : REPORT AUTHORISED</b> |                               |
|  |        |   | Order Date :24-05-2026 15:43  |
| HEMOGLOBIN (Colorimetry)                         | 12.3   | g/dL  | 12 - 16                       |
| RBC COUNT (DC detection method)                  | 4.08   | 10 <sup>12</sup> /L                           | 4 - 5.2                       |
| PCV/HCT (Calculated)                             | 35.5   | VOL%  | 33 - 51                       |
| MCV (Calculated)                                 | 87.0   | fL  | 80 - 100                      |
| MCH (Calculated)                                 | 30.2   | pg/cells                                      | 26 - 34                       |
| MCHC (Calculated)                                | 34.7   | g/dL  | 32 - 36                       |
| RDW-CV (Calculated)                              | 12.3   | %   | 11.5 - 13.1                   |
| PLATELET COUNT (DC Detection Method)             | 253    | 10 <sup>9</sup> /L                            | 150 - 450                     |
| MPV (Calculated)                                 | 7.7    | fL  | 6.5 - 10                      |
| WBC COUNT (DC Detection Method)                  | 8.83   | 10 <sup>9</sup> /L                            | 4.5 - 11                      |
| <b>Differential Count</b>                        |        |   |                               |
| NEUTROPHILS (Microscopy, Leishman stain)         | 73     | %   | H 35 - 66                     |
| LYMPHOCYTES (Microscopy, Leishman stain)         | 20     | %   | L 24 - 44                     |
| MONOCYTES (Microscopy, Leishman stain)           | 6      | %   | 4 - 10                        |
| EOSINOPHILS (Microscopy, Leishman stain)         | 1      | %   | 1 - 4                         |

PERIPHERAL SMEAR (Microscopy, Leishman stain) **RBC - NORMOCYTIC / NORMOCHROMIC**  
**WBC - MORPHOLOGY NORMAL**  
**PLATELETS - ADEQUATE**

**INTERPRETATION**

A Complete blood picture (CBP) is a screening test which can aid in the diagnosis of a variety of conditions and diseases such as anemia, leukemia, bleeding disorders and infections. This test is also useful in monitoring a person's reaction to treatment when a condition which affects blood cells has been diagnosed. All the abnormal results are to be correlated clinically.

**DISCLAIMER**

Test results released pertain to the specimen submitted. All test results are dependent on the quality of the sample received by the laboratory. Test Result may show interlaboratory variations. Laboratory investigations are only a tool to facilitate in arriving at a diagnosis and should be clinically correlated by the referring physician.

**Dr. MUPPALA RAAGA SNEHA, MD Pathology**

Reg No : TSMC/FMR/26831

ADMISSION SHEET

Registration Details :



Admission No : IP26-00006419 Admit Date : 24-May-2026 Admit Time : 03:35 PM UHID : HNH-00013343

Patient Details :

Patient Name : Mrs SRIBHASHYAM KIRANMAYEE Age : 30 Y 4 M 20 D  
Guardian : Mr A.V.S PRASAD DOB : 04-01-1996  
Gender : Female Religion :  
Occupation : Martial Status :  
Address (H) : FLAT NO:401,SREE VINAYAKA ENCLAVE, Phone No : 6301396965/ 9550378324  
ROAD NO:8 PNR COLONY,AMEENPUR E-mail :  
Ramachandra puram Sangareddy Telangana SRIBHASHYAMKIRANMAYEE@gmail.com  
INDIA 502032 m

Admission Details :

Bed Type : TWIN SHARING Bed No : LDR-416 Ward Name : 4F -OT  
Room No : LDR-416 Admission Type : First Visit

Contact Details :

Name : Mr A.V.S PRASAD Relationship : W/O  
Contact Address : FLAT NO:401,SREE VINAYAKA Phone No : 6301396965  
ENCLAVE,ROAD NO:8 PNR  
COLONY,AMEENPUR Ramachandra puram  
Sangareddy Telangana INDIA 502032

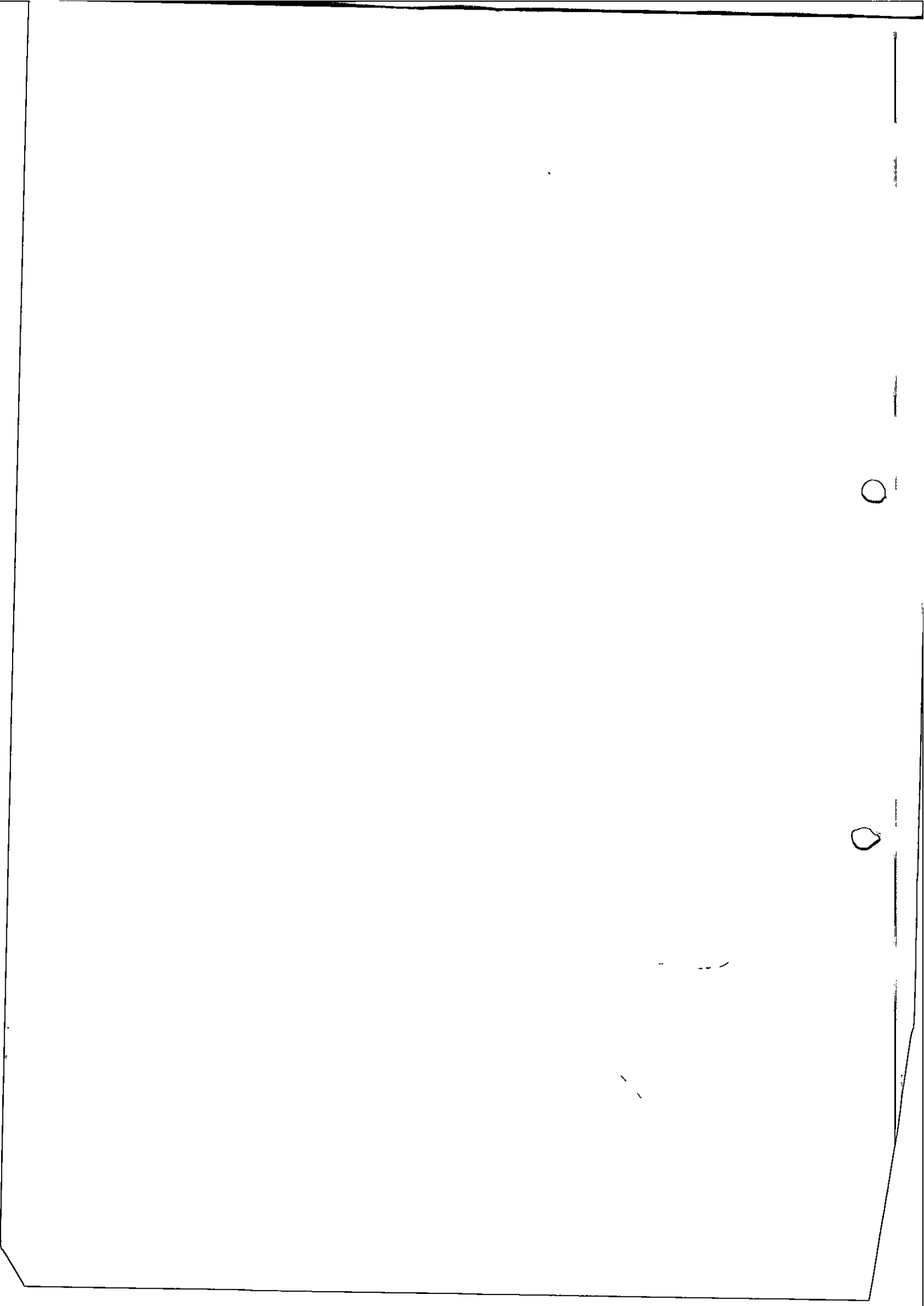
  
Signature

Doctor Details :


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

Payment Details :

Payment Mode : DC/CC Card Deposit Amount : 20000.00  
Payor Name : STAR HEALTH AND ALLIED INSURANCE CO LTD



# PATIENT TRANSFER FORM

| HNH-00013343 IP26-00006419<br>Mrs SRIBHASHYAM KIRANMAYEE<br>04-01-1996 30 Y 4 M 20 D (F)<br>Dr. PADMAJA YELISETTY<br> |                         | Date & Time of Admission<br><i>24/5/26</i>  | Date & Time of Transfer Order<br><i>24/5/26 : 11pm</i> |
|--|-------------------------|---|--|
|  |                         | Transfer Ordered by<br><i>Dr. Dura</i>  | Reason for Transfer<br><i>Obs.</i>                     |
| From Unit<br><i>pre-past</i>   | To Unit<br><i>310</i>   | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  |
| Number of Sheets in Clinical File<br><i>1</i>  | Number of Imaging Films | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input type="checkbox"/> No <input type="checkbox"/><br>If yes, what ? |  |
| Medications / Consumables / Surgicals / Hand over  |                         |   |  |
| Sl.No.   | Item Name               | Quantity  |  |
| 1.   | <i>Rb</i>               | <i>10</i>   |  |
| 2.   |                         |   |  |
| 3.   |                         |   |  |
| 4.   |                         |   |  |
| 5.   |                         |   |  |
| Shifting Summary / Notes Written by Doctor : Yes <input type="checkbox"/> No <input type="checkbox"/>  |                         |   |  |
| Name & Signature of Person who is Transferring<br><i>Chandrasekhar</i>   |                         | Name of Person Ordered Transfer<br><i>Dr. Dura</i>  |  |
| Patient & Clinical Records Received by : <i>Divya 24/5/26 @ 11pm</i>   |                         |   |  |
| 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

**ACTIVITY RECORD FOR BILLING**

Name: ----- **HNH-00013343 IP26-00006419** -----  
**Mrs SRIBHASHYAM KIRANMAYEE**  
**04-01-1996 30 Y 4 M 20 D (F)**  
 UHID No : ----- IP **Dr. PADMAJA YELISETTY** ----- tant : ----- Dept : -----  
 Date of Admission : -----  ----- Date of Discharge : ----- Time: -----  
 Room / Bed No : ----- Ward : ----- Suggested Billable bed type : -----

**WARD TRANSFERS**

| Date    | Time     | From      | To       | Signature of Nurse |
|---------|----------|-----------|----------|--------------------|
| 21/5/26 | 4:15 pm  | PN & post | OT       | Akshita            |
| 24/5/26 | 6:15 pm  | OT        | pre-post | Akshita            |
| 24/5/26 | 10:57 pm | pre-post  | 310      | 10/11/26           |
|         |          |           |          |                    |

**Cross Consultation Visit**

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





**PROCEEDURE**

| Date   | Proceeedure     | Quantity | Order No. | Signature          |
|--|-----------------|----------|-----------|--------------------|
| 24/5   | Zv placement    | ①        | 201845    | <i>[Signature]</i> |
| 24/5   | Catheterization | ①        | 201845    | <i>[Signature]</i> |
| 24/5   | PAC             | ①        | 201844    | <i>[Signature]</i> |
| <del>cross checked done</del>                                  |                 |          |           |                    |
| <del>24/5/20 9:00pm</del>                                      |                 |          |           |                    |
| 25/5/20  | NHA             | ①        | 2008      | <i>[Signature]</i> |
| <del>cross checked done by Supriya<br/>10:54am @ 26/5/20</del> |                 |          |           |                    |

**ANY OTHER INFORMATION**

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

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



# IP ADMISSION SHEET FOR OBSTETRICS

## Presenting Complaints

Reduced fetal movements  
- Night

Obstetric Formula:

Primigravida.

Obstetric History:

(ML-4yr.)

Present Pregnancy Record:

I - Spont Conception  
NT Scan. - Normal  
T1FFA - Normal.

## RISK FACTORS:

FTS Not done

[Empty box for notes]

Height: ..... cm

Weight: ..... kg

Allergies: .....

Breast:  Normal  Abnormal

General Examination:

Consciousness:

Pallor: -

Icterus: -

Edema: -

Temp: Afebrile

PR: 82bpm

BP: 110/70 mmHg

DTR:

CVS: S1S2 ⊕

RS B/C A/E ⊕

Liver/Spleen: (N)

Urine Output:

LMP: 1/9/25

EDD: 8/6/26

Corrected EDD: 8/6/26

GA: 37<sup>+6</sup> weeks

Menstrual History: Regular:  Yes  No

## Obstetric Examination

Fundal Height: ut = 36wk

Ut. Activity:  Relaxed  Mild  Mod  Severe

Liquor:  Adequate  Oligo  Poly

PP:  Cephalic  Breech Others \_\_\_\_\_

Head Fifths Palpable: \_\_\_\_\_

FHS:  Normal  Tachy  Brady  Absent

## Per Speculum Examination Not done.

Draining:  Present  Absent  Bleeding

Colour of Liquor:  Clear  Meconium  Blood Stained

## Vaginal Examination

Cervix:  Long  Partially effaced  Effaced

Os: Closed \_\_\_\_\_ Dilated 1cm

Membranes:  Present  Absent

Liquor:  Clear  Meconium  Blood Stained

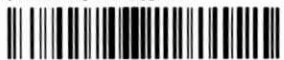
Presenting Part:  Vertex  Breech  Others

Sutton:  -3  -2  -1  0  +1  +2

Pelvis:  Adequate  Doubtful

## DIAGNOSIS

Primigravida @ 37+6 week @ Reduced fetal movements  
@ Fetal distress for em US



|   |   |
|---|---|
| <p>Family History:</p> <p>Father - DM<br/>         Mother - HTN.</p>  | <p>Surgical History:</p> <p>Nil</p>   |
| <p>Medical History:</p> <p>Endometrial Koch's in 2005<br/>         (treatment taken)</p>  | <p>Medication History:</p> <p>Tab Iron<br/>         Tab Calcium<br/>         Tab Vit-D<sub>3</sub></p>  |
| <p>Plan of Care:</p> <p>emiscs i/u/o fetal distress</p> <ul style="list-style-type: none"> <li>- Admission CTG.</li> <li>- Informed consent</li> <li>- Paets preparation.</li> <li>- PAC.</li> <li>- Drugs as charted.</li> <li>- CBP sent.</li> <li>- Shift to OT on call.</li> <li>- Monitor vitals</li> <li>- Infusions</li> <li>- Inform Pediatrician.</li> </ul> | <p>Investigations: <span style="border: 1px solid black; padding: 2px;">10+ve</span></p> <p>HW 13/03.<br/>         HbsAg } NR.<br/>         VDRL }<br/>         - Hb - 12.4 g/dl.<br/>         - WBC - 11,560.<br/>         - Plt - 3lakh.</p> <p>18/5/26 (Growth scan)<br/>         Singlehon<br/>         cephalic<br/>         Pl - Rt lateral &amp; posterior wall.<br/>         Cord insertion is marginal at upper end of post placenta.<br/>         Rt lateral part is succenturiate lobe &amp; no budding placental tissue.<br/>         AFI - 9.2cm. EFW 2.08 kg (31%).<br/>         Doppler (N).</p> |

Doctor Name: Dr. Dna  
 Signature:   
 Date & Time: 24/5/26 3:45pm

Consultant Name: Dr. Padmaja Yelisetty  
 Signature:   
 Date & Time: 24/5/26 5:24pm



**PROGRESS NOTES AND DOCTOR'S ORDER**

| Date & Time        | Progress Notes                | Doctor's Order                  |
|--------------------|-------------------------------|---------------------------------|
| 24/5/26<br>6:10 PM | C/S/B Dr. Dna<br>POD-0 P, U   | Adv                             |
|                    | GC fair - Afebrile            | - NBM for 4-6 hrs<br>- IV fluid |
|                    | Baby & Mother                 | - Drugs as charted              |
|                    | BP: 96/57 mmHg                | - Monitor vitals                |
|                    | PR: 72 bpm                    | Inform s/s                      |
|                    | SpO <sub>2</sub> : 100% on RA |                                 |
|                    | P/A uterus retracted well     |                                 |
|                    | R/E - NAB.                    |                                 |
|                    | U/O - clear.                  |                                 |
|                    |                               |                                 |
|                    |                               |                                 |
|                    |                               |                                 |
|                    |                               |                                 |
|                    |                               |                                 |
|                    |                               |                                 |
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|                    |                               |                                 |
|                    |                               |                                 |
|                    |                               |                                 |
|                    |                               |                                 |
|                    |                               |                                 |

PT can be shifted to room



**PROGRESS NOTES AND DOCTOR'S ORDER**

| Date & Time         | Progress Notes                           | Doctor's Order                      |
|---------------------|--|-------------------------------------|
| <del>25/5/26</del>  | <u>C/S/B Dr. Divya</u>                   |                                     |
| 7:30 AM             | POD-1 P, L                               | Adv                                 |
|                     | CC fair, Afebrile                        | ✓ Liquid diet                       |
|                     | PR: 77 bpm                               | ✓ IV fluids                         |
| Baby & Mother:      | BP: 100/62 mmHg                          | ✓ Drugs as charted                  |
|                     | P/A uterus retracted w/ BS ⊕             |                                     |
| Placenta not passed | L/E NAB                                  | ✓ Monitor vitals                    |
|                     | Dressing - dry & clear.                  | ✓ Inform SOS                        |
|                     | U/O: Adequate & clear.                   | ✓ Foley's Removal at 9 PM           |
|                     |  | Noted by Divya @ 7:00 AM<br>25/5/26 |
|                     |  |                                     |
|                     |  |                                     |
| 25/05/2026          | C/S by Dr. Naveena                       |                                     |
| 10:40 AM            | OLE GC - fair                            | Adv                                 |
|                     | Afebrile                                 | - Soft diet                         |
|                     | PR: 85 bpm                               | - Drugs as                          |
|                     | BP: 101/65 mmHg                          | - charted                           |
| U                   | COSTRS: NAB                              | - w/ PV bleeding                    |
| F                   | PA: ut. retracted                        | - Ambulation                        |
| F                   | Soft, NT                                 | - Monitor vitals                    |
| S                   | Dressing: dry & clear                    | - Inform SOS                        |
|                     | UE: PV bleeding w/ NG                    | - Adequate hydration                |
|                     |  |                                     |
|                     | Baby: Mother's side                      |                                     |
|                     | BLC breasts: soft,<br>mini. Secretions ⊕ |                                     |



**PROGRESS NOTES AND DOCTOR'S ORDER**

| Date & Time | Progress Notes   | Doctor's Order   |
|-------------|--|--|
|             | C/S/B Dr Padmaja   |  |
| 25/5/20     | C/S/B Dr Manu  |  |
| 1pm         | POD 1  |  |
|             |  | Adv  |
|             | GC Fair Afebrile   | Soft Diet / Adeq Hydration                               |
|             | Vitals stable  | Ambulation (3rd day)                                     |
|             | (P/A ut well retracted)  | Drops as charted   |
|             | BS (+)   | W/F vitals & Bow (exams)                                 |
|             | 4x Bleedy wbc  | Inform S/S   |
| Baby ms     |  |  |
| W           | Dr. Padmaja Yelisetty<br>Consultant Obstetrics and Gynaecology<br>Reg. No. 52427 | NB Mouthwash @ 2:30 PM<br>Dr. Padmaja Yelisetty<br>52427 |
| F           |  |  |
|             |  |  |
|             | C/S/B Dr. Veena  | HB Meha  |
| 25/5/20     | POD-1 / P, L1  |  |
| 4:30pm      | Pt is stable, No gto   | Adv  |
|             | D/A GC fair, Afebrile  | Regular diet   |
|             | Pallor (-)   | Drops as charted   |
|             | Vitals - stable  | Ambulation   |
|             | P/A - Ut well retracted  | Adequate hydration                                       |
|             | BS (+)   | Vital monitoring   |
| Baby ms     | Wc - BWNL  | Inform S/S   |
|             | B/c Breasts - Soft, ms (+)   | Dulcolax suppository @ night. (if didn't pass stools)    |
|             |  | NB Mouthwash @ 7:30 PM                                   |
|             |  |  |
|             |  |  |



PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time                       | Progress Notes  | Doctor's Order   |
|-----------------------------------|---|--|
| 26/5/26<br>8am                    | cls/B Dr. Veena   |  |
| Baby @<br>ms<br>U ✓<br>F ✓<br>S ✓ | POD-2 / P, L<br>Pt is stable. No clo<br>o/e G.G. fair, Afebrile<br>Pallor (-)<br>Vitals - stable<br>W/A - Ut well retracted<br>BS (+)<br>L/E - B/WNL.<br>B/L Breasts - Soft, ms (+) | Adv<br>- Regular diet<br>- Drugs as charted<br>- Vital monitoring<br>- Ambulation<br>- Adequate hydration<br>- Perform SOS<br>- ASD today. |
|                                   | <del>Can send file for discharge</del>  | Noted by Rushboo @ 8:pm<br>26/5/26   |
|                                   | Dr. Swathi H V  |  |
| 26/05/2026<br>8:15pm              | - POD-2 / P, L / emms.<br>- pt comfortable<br>- no complaints<br>O/E: vitals @  | Advice<br>- @ diet<br>- Ambulation<br>+ plenty of fluids   |
| C ✓<br>S -                        | Dr. Swathi H V<br>Consultant Obstetrics and Gynecology<br>Reg. No: 15501<br>PA: soft wavel @<br>@ wound #   | - remove in<br>cannula.  |
| Baby @<br>ms                      | HE: No bleed<br>Baby on EBF   | + @ w/ specu)<br>Jany/ bleed<br>- Super #  |

Swathi



**PROGRESS NOTES AND DOCTOR'S ORDER**

| Date & Time          | Progress Notes  | Doctor's Order  |
|----------------------|---|---|
| 26/05/2026<br>8:30pm | clsby   | Dr. Alaveena  |
|                      | o/e GC-fair<br>Afebrile<br>Vitals - stable.<br>PA: ut. well retracted.<br>Soft, NT<br><del>Dr. req: drape</del><br>LSCS wound: clean &<br>healthy.<br>ILE: PV bleeding WNL. | Adv.<br>- Regular diet<br>- Adequate hydration<br>- Drugs as charted<br>- Ambulation<br>- w/f PV bleeding<br>- Monitor Vitals<br>- Inform SOS                 |
|                      | Baby: mother side.  | Dr. Alaveena<br>Noted by madhvi 8:00pm.   |
| 27/05/2026<br>7:40pm | clsby   | Dr. Naveena.  |
|                      | o/e GC-fair<br>Afebrile.<br>Vitals - stable<br>PA: ut. well retracted.<br>Soft, NT.<br>LSCS wound: clean &<br>healthy.<br>ILE: PV bleeding WNL<br>Baby: mother side.        | Adv.<br>- Regular diet<br>- Adequate hydration<br>- Ambulation<br>- drugs as charted<br>- w/f PV bleeding<br>- Monitor Vitals<br>- Inform SOS<br>Dr. Naveena. |



HNH-00013343 IP26-00006419  
Mrs SRIBHASHYAM KIRANMAYEE  
04-01-1996 30 Y 4 M 20 D (F)  
Dr. PADMAJA YELISETTY



DR  
305

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

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Your Right to a Safe Delivery

### RESULT SHEET

|                     |         |  |  |  |  |
|---------------------|---------|--|--|--|--|
| Date                | 21/5/26 |  |  |  |  |
| Time                |         |  |  |  |  |
| Hb                  | 12.3    |  |  |  |  |
| PCV                 | 35.5    |  |  |  |  |
| RBC                 | 4.08    |  |  |  |  |
| WBC                 | 8.83    |  |  |  |  |
| N/L                 |         |  |  |  |  |
| Platelets           | 253     |  |  |  |  |
| CRP                 |         |  |  |  |  |
| ESR                 |         |  |  |  |  |
| PCT                 |         |  |  |  |  |
| RBS                 |         |  |  |  |  |
| Na                  |         |  |  |  |  |
| K                   |         |  |  |  |  |
| Cl                  |         |  |  |  |  |
| Ca/Mg               |         |  |  |  |  |
| Phosphate           |         |  |  |  |  |
| Urea                |         |  |  |  |  |
| Creatinine          |         |  |  |  |  |
| ALP                 |         |  |  |  |  |
| SGPT                |         |  |  |  |  |
| SGOT                |         |  |  |  |  |
| T.Bill/Conj         |         |  |  |  |  |
| T.Protein           |         |  |  |  |  |
| S.Albumin           |         |  |  |  |  |
| S.Globulin          |         |  |  |  |  |
| A/G Ratio           |         |  |  |  |  |
| Uric Acid           |         |  |  |  |  |
| S.Amylase           |         |  |  |  |  |
| Sr.Lipase           |         |  |  |  |  |
| Blood Lactate       |         |  |  |  |  |
| S.Cholesterol       |         |  |  |  |  |
| PT/INR              |         |  |  |  |  |
| APTT                |         |  |  |  |  |
| CSF Protein / Sugar |         |  |  |  |  |
| Cells               |         |  |  |  |  |
| N/L                 |         |  |  |  |  |

|                    |  |  |  |  |  |  |
|--------------------|--|--|--|--|--|--|
| Date               |  |  |  |  |  |  |
| Time               |  |  |  |  |  |  |
| CUE - Alb          |  |  |  |  |  |  |
| CUE - Sugar        |  |  |  |  |  |  |
| CUE - Ketones      |  |  |  |  |  |  |
| CUE - PUS Cells    |  |  |  |  |  |  |
| CUE - RBC Cells    |  |  |  |  |  |  |
| CUE                |  |  |  |  |  |  |
|                    |  |  |  |  |  |  |
|                    |  |  |  |  |  |  |
| Stool Pus Cell     |  |  |  |  |  |  |
| OVA / Cyst         |  |  |  |  |  |  |
| Occult Blood       |  |  |  |  |  |  |
|                    |  |  |  |  |  |  |
| Blood group = otve |  |  |  |  |  |  |
|                    |  |  |  |  |  |  |
| HIV                |  |  |  |  |  |  |
| HbsAg } NR         |  |  |  |  |  |  |
| HCV                |  |  |  |  |  |  |
|                    |  |  |  |  |  |  |
|                    |  |  |  |  |  |  |
|                    |  |  |  |  |  |  |

Culture and Sensitivities : .....

.....

.....

.....

Radiology :      USG : .....

                  X-Ray : .....

                  ECHO : .....

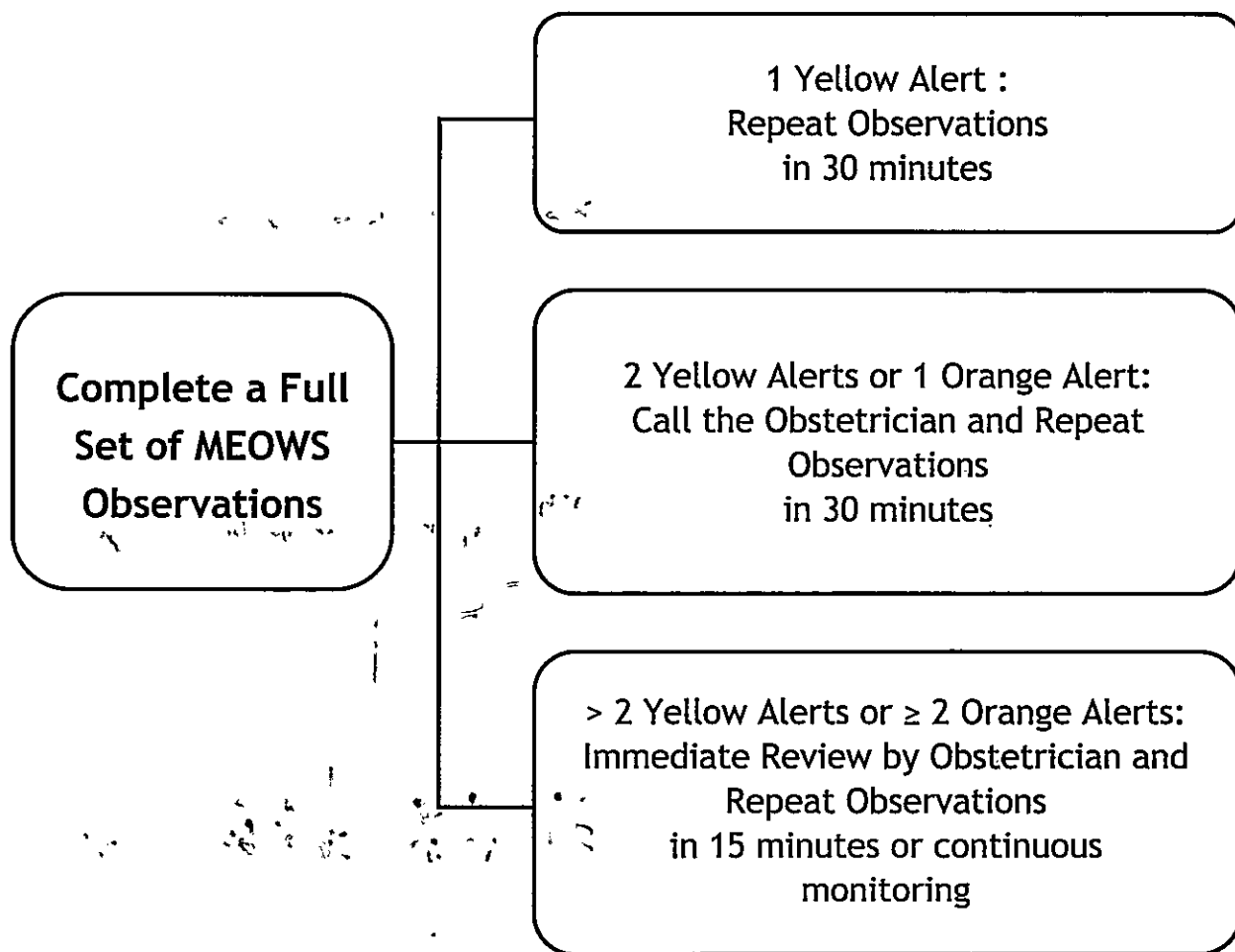
                  CT : .....

                  MRI : .....

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



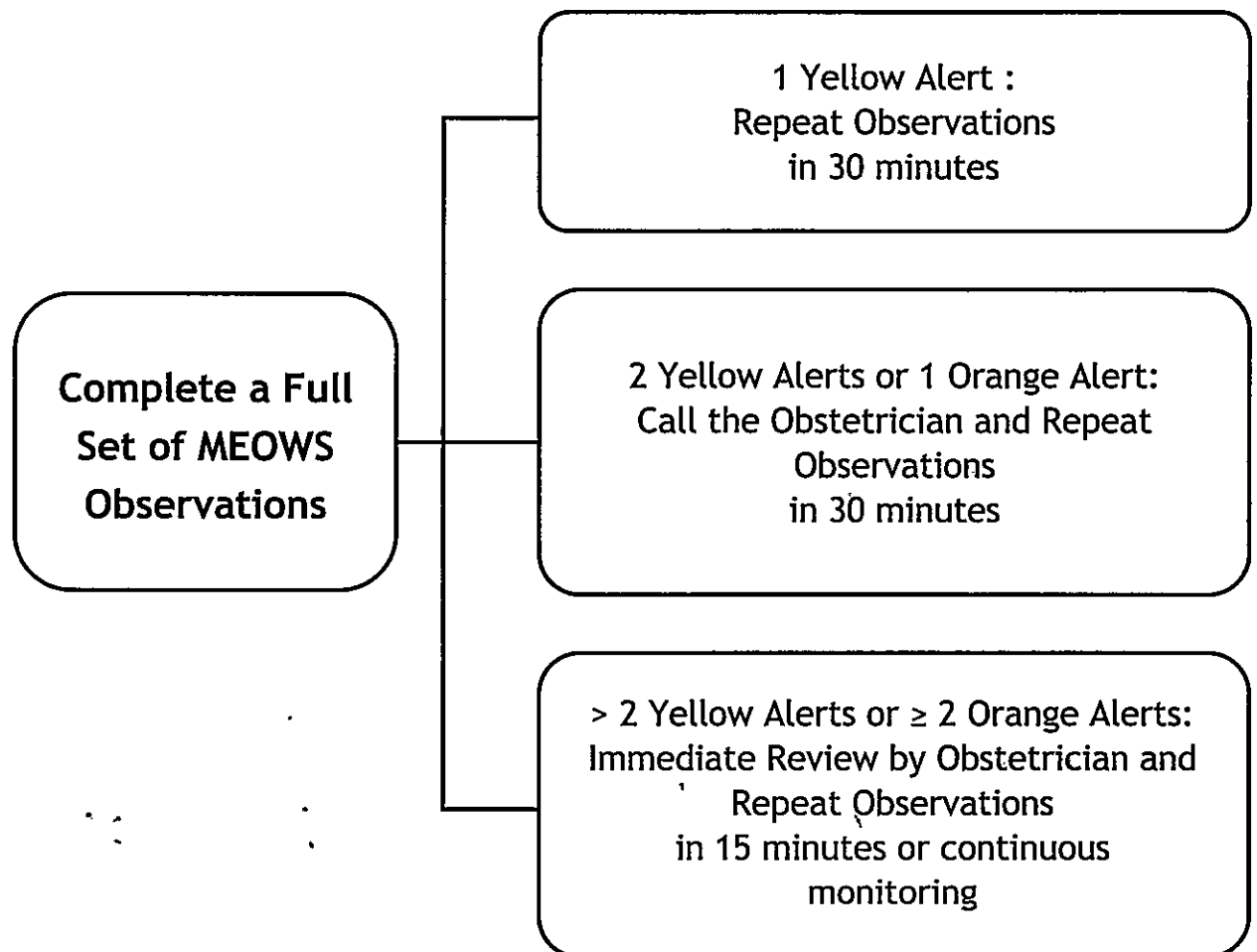
## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)

HNH-00013343 IP26-00006419  
 Mrs SRIBHASHYAM KIRANMAYEE  
 04-01-1996 30 Y 4 M 20 D (F)  
 Dr. PADMAJA YELISETTY

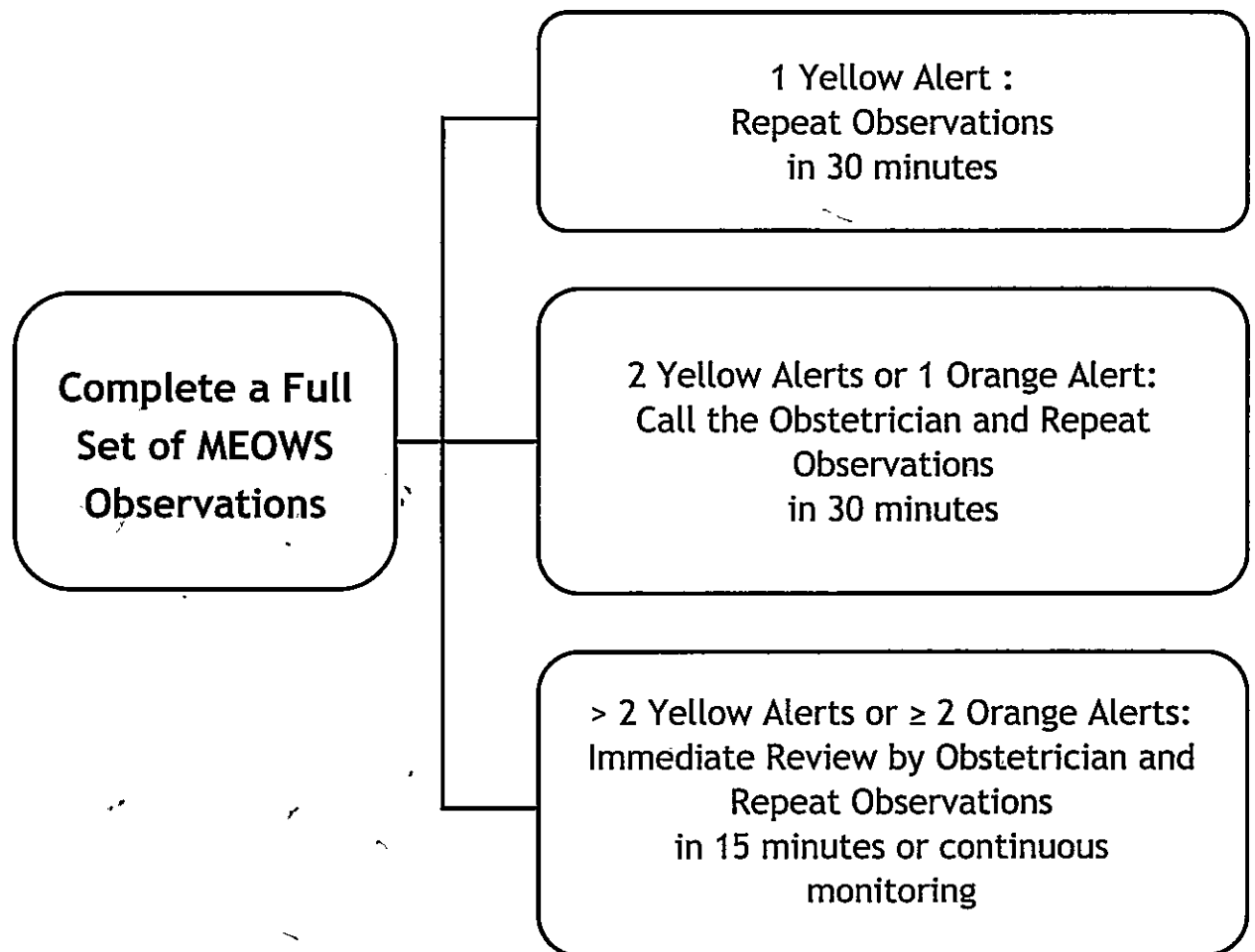


## Early Warning Observation Score Chart - Obstetrics

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<br>(write rate in corresp. box) | > 30               |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 21 - 30            |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 11 - 20            |       |   | 20   |    |    |    | 20.5 |   |   |   | 20    |    |   | 20 |   |    |    |    | 20 |   |   |    | 20 |   |   |
|                                      | 0 - 10             |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
| Saturations                          | 94 - 100 %         |       |   | 100% |    |    |    | 99   |   |   |   | 99    |    |   | 99 |   |    |    | 99 |    |   |   | 98 |    |   |   |
|                                      | < 94 %             |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
| Administered O <sub>2</sub> (L/min.) |                    |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
| Temp °C                              | 40                 |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 39                 |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 38                 |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 37                 |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 36                 |       |   | 97.1 |    |    |    | 98.9 |   |   |   | 98.5  |    |   | 98 |   |    |    | 98 |    |   |   | 97 |    |   |   |
|                                      | 35                 |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | < 35               |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
| Heart Rate                           | 170                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 160                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 150                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 140                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 130                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 120                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 110                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 100                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 90                 |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 80                 |       |   | 78   |    |    |    | 94   |   |   |   | 86/80 |    |   | 85 |   |    |    | 86 |    |   |   | 80 |    |   |   |
|                                      | 70                 |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 60                 |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 50                 |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
| 40                                   |                    |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
| ↑<br>Systolic Blood Pressure         | 190                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 180                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 170                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 160                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 150                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 140                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 130                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 120                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 110                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 100                |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 90                 |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 80                 |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
|                                      | 70                 |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
| 60                                   |                    |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
| 50                                   |                    |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
| ↓<br>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                  |                    |       |   |      |    |    |    |      |   |   |   |       |    |   |    |   |    |    |    |    |   |   |    |    |   |   |
| Nurse Initial                        |                    |       |   | SP   |    |    |    | SP   |   |   |   |       | SP |   |    |   |    | SP |    |    |   |   |    | SP |   |   |

## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)

HNH-00013343 IP26-00006419  
 Mrs SRIBHASHYAM KIRANMAYEE  
 04-01-1996 30 Y 4 M 20 D (F)  
 Dr. PADMAJA YELISETTY



# FLUID CHART

Sheet No. : 1 .....

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

| Date                        | Time     | Nature of Fluid | Intake      |       |     | Output                      |           |       |          |       | IV Site Thrombo-phlebitis Score | Sign. Nurse |  |
|-----------------------------|----------|-----------------|-------------|-------|-----|-----------------------------|-----------|-------|----------|-------|---------------------------------|-------------|--|
|                             |          |                 | Mouth       | I.V   | N.G | NG                          | Diarrhoea | Vomit | Drainage | Urine |                                 |             |  |
|                             | 08:00 am |                 |             |       |     |                             |           |       |          |       |                                 |             |  |
|                             | 09:00 am |                 |             |       |     |                             |           |       |          |       |                                 |             |  |
|                             | 10:00 am |                 |             |       |     |                             |           |       |          |       |                                 |             |  |
|                             | 11:00 am |                 |             |       |     |                             |           |       |          |       |                                 |             |  |
|                             | 12:00 pm |                 |             |       |     |                             |           |       |          |       |                                 |             |  |
|                             | 01:00 pm |                 |             |       |     |                             |           |       |          |       |                                 |             |  |
| <b>Total Intake :</b>       |          |                 |             |       |     | <b>Total Output :</b>       |           |       |          |       |                                 |             |  |
|                             | 02:00 pm | RL              |             | 100ml |     |                             |           |       |          |       |                                 |             |  |
|                             | 03:00 pm | PC              | N           | 100ml |     |                             |           |       |          |       |                                 |             |  |
|                             | 04:00 pm | RL              |             | 100ml |     |                             |           |       |          |       |                                 |             |  |
|                             | 05:00 pm | RL              | B           | 100ml |     |                             |           |       |          |       |                                 |             |  |
|                             | 06:00 pm | RL              |             | 100ml |     |                             |           |       |          | 200ml |                                 |             |  |
|                             | 07:00 pm | RL              | M           | 100ml |     |                             |           |       |          |       |                                 |             |  |
| <b>Total Intake :</b>       |          |                 |             |       |     | <b>Total Output :</b>       |           |       |          |       |                                 |             |  |
|                             | 08:00 pm | RL              | N           | 100ml |     |                             |           |       |          |       |                                 |             |  |
|                             | 09:00 pm | RL              | B           | 100ml |     |                             |           |       |          |       |                                 |             |  |
|                             | 10:00 pm | RL              | M           | 100ml |     |                             |           |       |          |       |                                 |             |  |
|                             | 11:00 pm | RL              | slips water | 100ml |     |                             |           |       |          | 350ml |                                 |             |  |
|                             | 12:00 am | RL              |             | 100ml |     |                             |           |       |          |       |                                 |             |  |
|                             | 01:00 am | RL              |             | 100ml |     |                             |           |       |          |       |                                 |             |  |
| <b>Total Intake :</b>       |          |                 |             |       |     | <b>Total Output :</b>       |           |       |          |       |                                 |             |  |
|                             | 02:00 am | RL              | H2O         | 100ml |     |                             |           |       |          | 100ml |                                 |             |  |
|                             | 03:00 am | RL              | H2O         | 100ml |     |                             |           |       |          |       |                                 |             |  |
|                             | 04:00 am | RL              |             | 100ml |     |                             |           |       |          |       |                                 |             |  |
|                             | 05:00 am | RL              | H2O         | 100ml |     |                             |           |       |          |       |                                 |             |  |
|                             | 06:00 am | RL              |             | 100ml |     |                             |           |       |          |       |                                 |             |  |
|                             | 07:00 am | RL              |             | 100ml |     |                             |           |       |          |       |                                 |             |  |
| <b>Total Intake :</b>       |          |                 |             |       |     | <b>Total Output :</b>       |           |       |          |       |                                 |             |  |
| <b>Total 24 hrs. Intake</b> |          |                 | 1800 ml     |       |     | <b>Total 24 hrs. Output</b> |           |       | 950 ml   |       |                                 |             |  |

HNH-00013343 IP26-00006419  
 Mrs SRIBHASHYAM KIRANMAYEE  
 04-01-1998 30 Y 4 M 20 D (F)  
 Dr. PADMAJA YELISSETTY



# FLUID CHART

Sheet No. : .....

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

| Date                  | Time     | Nature of Fluid | Intake |     |     | Output                |           |       |          |       | IV Site Thrombophlebitis Score | Sign. Nurse |  |
|-----------------------|----------|-----------------|--------|-----|-----|-----------------------|-----------|-------|----------|-------|--------------------------------|-------------|--|
|                       |          |                 | Mouth  | I.V | N.G | NG                    | Diarrhoea | Vomit | Drainage | Urine |                                |             |  |
| 25/5/26               | 08:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 09:00 am | soup            |        |     |     |                       |           |       |          | 900ml |                                |             |  |
|                       | 10:00 am | x               |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 11:00 am | zaddy           |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 12:00 pm | x               |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 01:00 pm | 1/200           |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b> |          |                 | Taken  |     |     | <b>Total Output :</b> |           |       |          |       | M-0 U-1                        |             |  |
| 25/5/26               | 02:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 03:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 04:00 pm | Soda            |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 05:00 pm | Diet            |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 06:00 pm | Kichadi         |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 07:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       | U-1 M-                         |             |  |
| 25/5/26               | 08:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 09:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 10:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 11:00 pm |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 12:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 01:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       | U-1 M-1                        |             |  |
| 26/5/26               | 02:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 03:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 04:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 05:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 06:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
|                       | 07:00 am |                 |        |     |     |                       |           |       |          |       |                                |             |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |       | U-1 M-0                        |             |  |

faddy  
 Re above  
 9:10 AM

**Total 24 hrs. Intake**

**Total 24 hrs. Output**

HNH-00013343 IP26-00006419  
 Mrs SRIBHASHYAM KIRANMAYEE  
 04-01-1996 30 Y 4 M 20 D (F)  
 Dr. PADMAJA YELISETTY



# FLUID CHART

Sheet No. : .....

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

| Date                        | Time     | Intake          |        |     |     | Output                        |           |       |          |       | IV Site Thrombophlebitis Score | Sign. Nurse |  |
|-----------------------------|----------|-----------------|--------|-----|-----|-------------------------------|-----------|-------|----------|-------|--------------------------------|-------------|--|
|                             |          | Nature of Fluid | Route  |     |     | NG                            | Diarrhoea | Vomit | Drainage | Urine |                                |             |  |
| 26/5/26                     |          |                 | Mouth  | I.V | N.G |                               |           |       |          |       |                                |             |  |
|                             | 08:00 am |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 09:00 am |                 | Idly   |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 10:00 am | o               |        |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 11:00 am |                 | H2O    |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 12:00 pm |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
| 01:00 pm                    |          |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
| Total Intake : <i>taken</i> |          |                 |        |     |     | Total Output : <i>U-2 M-0</i> |           |       |          |       |                                |             |  |
| 26/5/26                     | 02:00 pm |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 03:00 pm |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 04:00 pm | o               | Poplar |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 05:00 pm |                 | dict   |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 06:00 pm |                 | H2O    |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 07:00 pm |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
| Total Intake : <i>taken</i> |          |                 |        |     |     | Total Output :                |           |       |          |       |                                |             |  |
| 26/5/26                     | 08:00 pm |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 09:00 pm |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 10:00 pm | o               | Tobey  |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 11:00 pm |                 | H2O    |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 12:00 am |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 01:00 am |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
| Total Intake :              |          |                 |        |     |     | Total Output :                |           |       |          |       |                                |             |  |
| 26/5/26                     | 02:00 am |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 03:00 am |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 04:00 am | o               | H2O    |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 05:00 am |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 06:00 am |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
|                             | 07:00 am |                 |        |     |     | /                             |           |       | /        | /     |                                |             |  |
| Total Intake :              |          |                 |        |     |     | Total Output :                |           |       |          |       |                                |             |  |

Total 24 hrs. Intake

Total 24 hrs. Output

HNH-00013343 IP26-00006419  
 Mrs SRIBHASHYAM KIRANMAYEE  
 04-01-1996 30 Y 4 M 22 D (F)  
 Dr. PADMAJA YELISETTY



# 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 Thrombophlebitis 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 |                 |        |     |     |                       |           |       |          |                                |             |       |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |                                |             |       |  |
|                       | 02:00 pm |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 03:00 pm |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 04:00 pm |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 05:00 pm |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 06:00 pm |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 07:00 pm |                 |        |     |     |                       |           |       |          |                                |             |       |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |                                |             |       |  |
|                       | 08:00 pm |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 09:00 pm |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 10:00 pm |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 11:00 pm |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 12:00 am |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 01:00 am |                 |        |     |     |                       |           |       |          |                                |             |       |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |                                |             |       |  |
|                       | 02:00 am |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 03:00 am |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 04:00 am |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 05:00 am |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 06:00 am |                 |        |     |     |                       |           |       |          |                                |             |       |  |
|                       | 07:00 am |                 |        |     |     |                       |           |       |          |                                |             |       |  |
| <b>Total Intake :</b> |          |                 |        |     |     | <b>Total Output :</b> |           |       |          |                                |             |       |  |

|                             |  |
|-----------------------------|--|
| <b>Total 24 hrs. Intake</b> |  |
|-----------------------------|--|

|                             |  |
|-----------------------------|--|
| <b>Total 24 hrs. Output</b> |  |
|-----------------------------|--|



# NURSING CARE RECORD

Date: 26/12/26

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

|           | Time             | Plan of Care  | Time             | Implementation  | Evaluation        | Re-Assessment               | Nurse Name & Signature |
|-----------|------------------|---|------------------|---|-------------------|-----------------------------|------------------------|
| Morning   |                  |   |                  |   |                   |                             |                        |
| Afternoon | 2pm<br> <br>8pm  | → Assess the pt condition<br>→ monitor the vitals & record<br>→ Administration of medication as per doctor's order<br>→ maintain I/O chart & record | 2pm<br> <br>8pm  | → Assessed the pt condition<br>→ monitored the vitals & recorded<br>→ Administered medication as per doctor's order<br>→ maintained I/O chart & recorded. | pt is stable      | Maintain I/O chart & record | Akhil<br>A             |
| Night     | 8pm<br>to<br>8pm | ⇒ Assess the patient's condition<br>⇒ plan for vitals<br>⇒ plan for I/O chart   | 8pm<br>to<br>8pm | ⇒ Assessed the patient<br>⇒ maintain vitals & record<br>⇒ maintain I/O chart<br>⇒ 2nd hourly ABG & ven  | patient is stable | vitals & record             | Chandru<br>C           |

HNH-00013343 IP26-00006419  
 Mrs SRIBHASHYAM KIRANMAYEE  
 04-01-1996 30 Y 4 M 20 D (F)  
 Dr. PADMAJA YELISETTY



# NURSING CARE RECORD

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

BirthRight™  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery

Date: 25/5/26

**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<br>Monitor the vitals<br>maintain I/O charts<br>medication given as per drugs chart | 8AM  | Assess the Pt condition<br>Monitor the vitals<br>maintain I/O charts<br>medication given as per drugs chart<br>Feeds let the done | Patient is now stable | Monitor the vitals |                        |
|           | 10   |   | 10   |   |                       |                    |                        |
| Afternoon | 2PM  | Assess the Pt condition<br>Monitor the vitals<br>maintain I/O chart<br>medication given as per drug chart   | 2PM  | Assessed the Pt condition<br>Monitored the vitals<br>Maintain I/O chart<br>Medication given as per drug chart                     | Pt is stable          | Rechecked vital    |                        |
|           | 8pm  |   | 8pm  |   |                       |                    |                        |
| Night     | 8PM  | Assess the Pt condition<br>monitor vitals<br>Maintain I/O chart<br>drugs give as per drugs chart.           | 8PM  | Assessed the Pt condition<br>monitored vitals<br>Maintained I/O chart<br>drugs given as per drug chart.                           | Patient is stable now | Rechecked vitals   |                        |
|           | 8PM  |   | 8PM  |   |                       |                    |                        |

HNH-00013343

IP26-00006419

Mrs SRIBHASHYAM KIRANMAYEE

04-01-1998 30 Y 4 M 20 D (F)

Dr. PADMAJA YELISETTY



# NURSING CARE RECORD



Date: 26/5/26

**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<br>→ Monitor the vitals<br>→ Maintain the Ilo chart<br>→ Administer the medication as per drug chart | 8am       | → Assessed pt condition<br>→ Monitored vitals<br>→ Maintained Ilo chart<br>→ Administered medication as per drug chart | Patient is stable | Re-checked vitals | Anusha<br>Aul          |
|           | to<br>2pm |  | to<br>2pm |  |                   |                   |                        |
| Afternoon | 2pm       | → Assess the patient condition<br>→ maintain Ilo chart<br>→ Administer medications as per doctor's orders                      | 2pm       | → Assessed the patient condition<br>→ maintained Ilo chart<br>→ Administered medications as per doctor's orders        | Patient is stable | Rechecked vitals  | Sindhya                |
|           | to<br>5pm |  | to<br>5pm |  |                   |                   |                        |
| Night     | 8pm       | → Assess the pt condition<br>→ maintain Ilo chart<br>→ Administer medication as per doctor's orders                            | 8pm       | → Assess the pt condition<br>→ Maintained Ilo chart<br>→ Administer  | Patient is stable | Re-checked vitals | Hb                     |
|           | to<br>8am |  | to<br>8am |  |                   |                   |                        |


# NURSING CARE RECORD

Date: .....

**Goals**

- Maintain **Respiration** 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     |      |              |      |                |            |               |                        |

HNH-00013343 IP26-00006419  
 Mrs SRIBHASHYAM KIRANMAYEE (F)  
 04-01-1998 30 Y 4 M 22 D  
 Dr. PADMAJA YELIBETTY  




## CHECKLIST FOR THROMBOPHLEBITIS

2/15

| 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 /<br>Observe cannula  | 0     |       | 0 | 0  | 0     | 0  | 0  | 0     | 0  | 0  |         |
| 2                      | One of the following signs is evident :<br>* Slight pain near the IV Site /<br>* Slight redness near IV Site  | Possibly first signs of phlebitis /<br>Observe cannula  | 1     |       | - | NA | NA    | NA | NA | NA    | NA | NA |         |
| 3                      | Two of the following Signs are evident:<br>Pain at IV site Redness  | Early stage of phlebitis /<br>Resite Cannula  | 2     |       | - | NA | NA    | NA | NA | NA    | NA | NA |         |
| 4                      | All of the following Signs are evident :<br>Pain along Path of cannula<br>Redness around Site Swelling  | Medium stage of phlebitis /<br>Resite Cannula Consider Treatment  | 3     |       | - | NA | NA    | NA | NA | NA    | NA | NA |         |
| 5                      | All of the following Signs are evident and Extensive :<br>Pain along Path of cannula<br>Redness around Site<br>Swelling palpable Venous cord        | Advanced stage of phlebitis or<br>the start of thrombophlebitis /<br>Re site Cannula Consider Treatment | 4     |       | - | NA | NA    | NA | NA | NA    | NA | NA |         |
| 6                      | All of the following Signs are evident and Extensive : Pain<br>along Path of cannula Redness<br>around Site Swelling palpable<br>Venous cordpyrexia | Advanced stage of<br>thrombophlebitis /<br>Initiate treatment Re site<br>Cannula                        | 5     |       | - | NA | NA    | NA | NA | NA    | NA | NA |         |
| Signature of the Nurse |   |   |       |       |   |    |       |    |    |       |    |    |         |

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

Signature of Shift In Charge :

Signature : [Signature] Name : Akeeb

Signature of Ward In Charge :

Signature : [Signature] Name : Karthikeyan



# Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category |                               | Date / Time | 24/5/26 | 24/5' | 25/5/26 | Fall Risk Grading |                        |  |
|--|-------------------------------|-------------|---------|-------|---------|-------------------|------------------------|--|
|  |                               | Score       | E2      | N1    | E2      | Risk Level        | Morse Fall Score (MFS) | Action   |
| History of Falling (immediately or w/in 3 months)  | Yes                           | 25          |         |       |         | Low Risk          | 0 - 24                 | Standard Fall Precaution                         |
|  | No                            | 0           |         |       |         |                   |                        |  |
| Secondary Diagnosis (more than one diagnosis)      | Yes                           | 15          |         |       |         | Moderate Risk     | 25 - 50                | Implement Moderate Fall Prevention Intervention  |
|  | No                            | 0           | 0       | 0     | 0       |                   |                        |  |
| Ambulatory Aid                                     | Furniture                     | 30          |         |       |         | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|  | Crutches, Cane(S), Walker     | 15          |         |       |         |                   |                        |  |
|  | None /Bed Rest /Nurse Assist  | 0           |         | 0     | 0       |                   |                        |  |
| 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           |         |       |         |                   |                        |  |
| 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  |                               |             | A       | B     | B       |                   |                        |  |

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-00013343 IP26-00006419  
 Mrs SRIBHASHYAM KIRANMAYEE  
 04-01-1996 30 Y 4 M 20 D (F)  
 Dr. PADMAJA YELISETTY

# BRADEN 'Q' SCALE



Date: 25/08/25 25/8/25  
 Time: 6:21 16:52

|   |  |  |   |  |   |   |   |   |
|---|--|--|---|--|---|---|---|---|
| Mobility  | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.  | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or extremity position independently.   | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.  | 4 | 4 | 4 | 4 |
| "Activity The degree of physical activity"  | <b>1. Bedfast :</b><br>Confined to bed   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."   | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.  | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>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  | <b>1. Completely limited:</b><br>Unresponsive to only painful stimuli (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.  | <b>2. Very limited:</b><br>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.   | <b>3. Slightly limited:</b><br>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.   | <b>4. No impairment:</b><br>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  | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.   | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.   | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.   | 4 | 4 | 4 | 4 |
| <b>FRICION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.  | <b>2. Problem:</b><br>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.  | <b>3. Potential problem:</b><br>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.            | <b>4. No apparent problem:</b><br>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   | <b>1. Very Poor:</b><br>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. | <b>2. Inadequate:</b><br>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. | <b>3. Adequate:</b><br>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. | <b>4. Excellent:</b><br>Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. | 4 | 4 | 4 | 4 |
| Tissue Perfusion & Oxygenation  | <b>1. Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.   | <b>2. Compromised:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.  | <b>3. Adequate:</b><br>Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.  | <b>4. Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.   | 4 | 4 | 4 | 4 |

|                         |    |    |    |    |
|-------------------------|----|----|----|----|
| <b>TOTAL SCORE</b>      | 28 | 28 | 28 | 28 |
| <b>Evaluator's Name</b> | ①  | ②  | ③  | ④  |

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   | <b>Support Surfaces</b><br>(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"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for "At Risk" Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>   | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for "Moderate Risk" Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>  | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for "High Risk" Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>  | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay  |

HNH-00013343

IP26-00006419

Mrs SRIBHASHYAM KIRANMAYEE

04-01-1996

30 Y 4 M 20 D

(F)

Dr. PADMAJA YELISETTY



# BRADEN 'Q' SCALE



Date : 25/5 26/5 26/5  
Time : N, M, E, A

|   |  |  |   |  |   |   |   |   |
|---|--|--|---|--|---|---|---|---|
| Mobility  | <b>1. Completely immobile:</b><br>Does not make even slight changes in body or extremity position without assistance.  | <b>2. Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.   | <b>3. Slightly limited:</b><br>Makes frequent through slight changes in body or extremity position independently.   | <b>4. No limitations:</b><br>Makes major and frequent changes in position without assistance.  | 3 | 3 | 3 | 3 |
| "Activity The degree of physical activity"  | <b>1. Bedfast :</b><br>Confined to bed   | <b>2. Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."   | <b>3. Walks occasionally:</b><br>Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.  | <b>4. All patients too young to ambulate; OR walks frequently:</b><br>Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.  | 3 | 3 | 3 | 3 |
| Sensory Perception  | <b>1. Completely limited:</b><br>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.  | <b>2. Very limited:</b><br>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.   | <b>3. Slightly limited:</b><br>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.   | <b>4. No impairment:</b><br>Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.  | 4 | 4 | 4 | 3 |
| Moisture Degree to which skin is exposed to moisture  | <b>1. Constantly moist:</b><br>Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.   | <b>2. Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.   | <b>3. Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.   | <b>4. Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.   | 4 | 4 | 4 | 4 |
| <b>FRICITION-SHEAR</b><br><b>Friction</b> Occurs when Skin moves against support surfaces<br><b>Shear</b> Occurs when skin and adjacent bony surface slide across one another | <b>1. Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.  | <b>2. Problem:</b><br>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.  | <b>3. Potential problem:</b><br>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.            | <b>4. No apparent problem:</b><br>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."                         | 3 | 3 | 3 | 3 |
| Nutritional Usual food intake pattern   | <b>1. Very Poor:</b><br>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. | <b>2. Inadequate:</b><br>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. | <b>3. Adequate:</b><br>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. | <b>4. Excellent:</b><br>Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. | 4 | 4 | 4 | 4 |
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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

|                         |             |             |             |             |
|-------------------------|-------------|-------------|-------------|-------------|
| <b>TOTAL SCORE</b>      | 25          | 25          | 25          | 25          |
| <b>Evaluator's Name</b> | (Signature) | (Signature) | (Signature) | (Signature) |

| Risk Score  | Category      | Action   | <b>Support Surfaces</b><br>(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"> <li>• Regular Turning Schedule</li> <li>• Enable as much activity as possible</li> <li>• Protect the heels</li> <li>• Use pressure redistribution surfaces</li> <li>• Manage moisture, friction and shear</li> <li>• Advance to a higher level of risk if other major risk factors are present</li> </ul> | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay  |
| 13-14       | Moderate Risk | <ul style="list-style-type: none"> <li>• Use the Same Protocol as for "At Risk" Patients</li> <li>• Position patient at 30 degree lateral incline using foam wedges</li> </ul>   | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay  |
| 10-12       | High Risk     | <ul style="list-style-type: none"> <li>• Follow the same protocol as for "Moderate Risk" Patients</li> <li>• In addition to regular turning schedule</li> <li>• Make small shifts in their position frequently</li> </ul>  | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay  |
| Less than 9 | Severe Risk   | <ul style="list-style-type: none"> <li>• Use same protocol as for "High Risk" Patients</li> <li>• Add a pressure redistribution surface for patients with severe pain or with additional risk factors.</li> </ul>  | High density foam mattress<br>Gel pads for high-risk areas<br>Alternating pressure mattress overlay  |



# PAIN ASSESSMENT FORM

| Date    | Time | Pain Score (0/10) | Location | Duration   | Acuity   | Character  | Modifying Factors  | Patient / Family Educated                                   | Intervention | Sign |
|---------|------|-------------------|----------|--|--|--|--|---|--------------|------|
| 24/5    | 4pm  | 0/10              | -        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           |      |
| 24/5    | 8pm  | 0/10              | -        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           |      |
| 24/5    | -    | 0/10              | -        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           |      |
| 25/5/26 | 10A  | 0/10              | -        | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           |      |
| 25/5/26 | 6pm  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           |      |
| 25/5/26 | 10PM | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           |      |
| 26/5/26 | 10Am | 0/10              | PA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           |      |
| 26/5/26 | 4pm  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           |      |
| 26/5/26 | 10pm | 0/10              | PA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           |      |
| 26/5/26 | 8Am  | 0/10              | NA       | <input type="checkbox"/> Continuous<br><input type="checkbox"/> Intermittent | <input type="checkbox"/> Acute<br><input type="checkbox"/> Chronic | <input type="checkbox"/> Sharp <input type="checkbox"/> Dull<br><input type="checkbox"/> Aching <input type="checkbox"/> Burning | <input type="checkbox"/> Increasing<br><input type="checkbox"/> Decreasing | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | NA           |      |

**Re-assessment Frequency:**

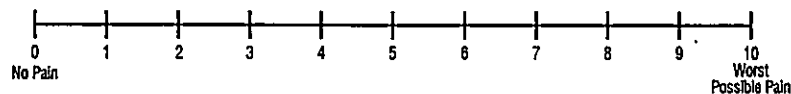
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain pain-relieving intervention.
  - Within 30 - 60 minutes after pain relief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

# PAIN ASSESSMENT TOOLS

## FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

## Numerical Pain Scale (Obstetric and Gynecology)



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

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

## Wong - Baker (Pediatrics) Above 7 Years



0  
No Hurt

2  
Hurts Little Bit

4  
Hurts Little More

6  
Even More

8  
Hurts Whole Lot

10  
Hurts Worst



### NURSING SHIFT HAND OVER FORM

|  |   |  |   |   |   |   |   |               |
|--|---|--|---|---|---|---|---|---------------|
| SITUATION                                | Diagnosis: <i>Poimie 27+6 weeks used total month</i>                | Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |   |   |   |   |   |               |
|  | Surgery / Procedure: <i>Em.UG</i>                                   | Post OP Day:   |   |   |   |   |   |               |
| BACKGROUND                               | Date  | <i>25/5/26</i>   | <i>25/5/26</i>  | <i>25/5/26</i>  | <i>25/5/26</i>  | <i>25/5/26</i>  | <i>26/5/26</i>  |               |
|  | Shift   | <i>E2</i>  | <i>N1</i>   | <i>M6</i>   | <i>E2</i>   | <i>N1</i>   | <i>M6</i>   |               |
|  | Medical Condition (Any special condition to be noted):              | <i>NA</i>  | <i>NA</i>   | <i>NA</i>   | <i>NA</i>   | <i>NA</i>   | <i>NA</i>   |               |
| Diet:                                    | <i>NBM</i>  |  | <i>liquid diet</i>  | <i>Soft diet</i>  | <i>Regular</i>  | <i>Regular</i>  |   |               |
| ASSESSMENT                               | Allergy:  | <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | <input type="checkbox"/> Yes <input 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):                                   | <input checked="" type="checkbox"/>  |   | <input checked="" type="checkbox"/>                                 | <input checked="" type="checkbox"/>                                 | <input checked="" type="checkbox"/>                                 | <input checked="" type="checkbox"/>                                 |               |
|  | 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 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |               |
|  | Vital Signs:  | Temp:  | <i>97.1F</i>  | <i>98.8F</i>  | <i>98.3F</i>  | <i>98.6F</i>  | <i>99.6F</i>  | <i>98.7F</i>  |
|  |   | Res:   | <i>20b/m</i>  | <i>20</i>   | <i>20b/m</i>  | <i>20b/m</i>  | <i>20b/m</i>  | <i>22b/m</i>  |
|  |   | SpO <sub>2</sub> :   | <i>99.1</i>   | <i>100</i>  | <i>98.1</i>   | <i>99.6</i>   | <i>99.1</i>   | <i>99.1</i>   |
|  |   | Pulse:   | <i>82b/m</i>  | <i>95-98</i>  | <i>85b/m</i>  | <i>86b/m</i>  | <i>85b/m</i>  | <i>82b/m</i>  |
|  |   | BP:  | <i>100/69</i>   | <i>120/70</i>   | <i>100/65</i>   | <i>92/69</i>  | <i>120/80</i>   | <i>121/78</i> |
|  |   | LOC:   | <i>-</i>  | <i>-</i>  | <i>-</i>  | <i>-</i>  | <i>-</i>  | <i>-</i>      |
|  | Fall Risk Score:  | <i>-</i>   | <i>-</i>  | <i>-</i>  | <i>-</i>  | <i>-</i>  | <i>-</i>  |               |
| Pain Score:                              | <i>0/10</i>   | <i>-</i>   | <i>-</i>  | <i>0</i>  | <i>0</i>  | <i>-</i>  |   |               |
| Skin Integrity                           | <i>-</i>  | <i>-</i>   | <i>-</i>  | <i>Good</i>   | <i>good</i>   | <i>-</i>  |   |               |
| Recommendations                          | Safety Needs:   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |               |
|  | Physiotherapy:  | <input checked="" type="checkbox"/>  | <input checked="" type="checkbox"/>                                 | <input checked="" type="checkbox"/>                                 | <input checked="" type="checkbox"/>                                 | <input checked="" type="checkbox"/>                                 | <input checked="" type="checkbox"/>                                 |               |
|  | 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 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |               |
|  | Special Diet:   | <i>NBM</i>   | <i>-</i>  | <i>-</i>  | <i>-</i>  | <i>-</i>  | <i>-</i>  |               |
|  | Critical Lab Test / Values:   | <i>-</i>   | <i>-</i>  | <i>-</i>  | <i>-</i>  | <i>-</i>  | <i>-</i>  |               |
|  | 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 | <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 | <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 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |               |
| ADL (Dependent / Non Dependent):         | <i>NA</i>   | <i>-</i>   | <i>-</i>  | <i>-</i>  | <i>-</i>  | <i>-</i>  |   |               |
| Post Operative Procedure Special Orders: | <i>NA</i>   | <i>-</i>   | <i>-</i>  | <i>-</i>  | <i>1</i>  | <i>-</i>  |   |               |
| Handed Over By Name :                    | <i>Akhya</i>  | <i>Chand</i>   | <i>Neha</i>   | <i>Manisha</i>  | <i>Khushi</i>   | <i>Anusha</i>   |   |               |
| Signature / ID :                         | <i>[Signature]</i>  | <i>[Signature]</i>   | <i>[Signature]</i>  | <i>[Signature]</i>  | <i>[Signature]</i>  | <i>[Signature]</i>  |   |               |
| Date:                                    | <i>25/5/26</i>  | <i>25/5/26</i>   | <i>25/5/26</i>  | <i>25/5/26</i>  | <i>26/5/26</i>  | <i>26/5/26</i>  |   |               |
| Time:                                    | <i>8PM</i>  | <i>8AM</i>   | <i>2PM</i>  | <i>8pm</i>  | <i>8AM</i>  | <i>2PM</i>  |   |               |
| Taken Over By Name :                     | <i>Chand</i>  | <i>Neha</i>  | <i>Manisha</i>  | <i>Khushi</i>   | <i>Anusha</i>   | <i>Sandhya</i>  |   |               |
| Signature / ID :                         | <i>[Signature]</i>  | <i>[Signature]</i>   | <i>[Signature]</i>  | <i>[Signature]</i>  | <i>[Signature]</i>  | <i>[Signature]</i>  |   |               |
| Date:                                    | <i>25/5/26</i>  | <i>25/5/26</i>   | <i>25/5/26</i>  | <i>25/5/26</i>  | <i>26/5/26</i>  | <i>26/5/26</i>  |   |               |
| Time:                                    | <i>8AM</i>  | <i>8AM</i>   | <i>2pm</i>  | <i>8PM</i>  | <i>8AM</i>  | <i>2pm</i>  |   |               |



## NURSING SHIFT HAND OVER FORM

|  |  |   |  |   |   |   |   |  |
|--|--|---|--|---|---|---|---|--|
| <b>SITUATION</b>                         | Diagnosis:   |   | Any Infection: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |   |   |   |   |  |
|  | Surgery / Procedure:                                   |   | Post OP Day:   |   |   |   |   |  |
| <b>BACKGROUND</b>                        | Date   | 26/5/26<br>Evg  | 26/5/26<br>NI  |   |   |   |   |  |
|  | Shift  |   |  |   |   |   |   |  |
|  | Medical Condition (Any special condition to be noted): | NA  | PA   |   |   |   |   |  |
|  | Diet:  | regular   | regular  |   |   |   |   |  |
| <b>ASSESSMENT</b>                        | 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 | <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 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | Vital Signs:   | Temp:   | 98.3 f   | 98.5  |   |   |   |  |
|  |  | Res:  | 20b/m  | 20b/m   |   |   |   |  |
|  |  | SpO <sub>2</sub> :  | 99%  | 99%   |   |   |   |  |
|  |  | Pulse:  | 85b/m  | 85b/m   |   |   |   |  |
|  |  | BP:   | 120/80   | 120/82  |   |   |   |  |
|  |  | LOC:  | -  |   |   |   |   |  |
|  | Fall Risk Score:                                       | -   |  |   |   |   |   |  |
| Pain Score:                              | -  |   |  |   |   |   |   |  |
| Skin Integrity                           | -  |   |  |   |   |   |   |  |
| <b>Recommendations</b>                   | Safety Needs:  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input 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 | <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 | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | ADL (Dependent / Non Dependent):                       | -   |  |   |   |   |   |  |
| Post Operative Procedure Special Orders: |  | -   |  |   |   |   |   |  |
| Handed Over By Name :                    |  | Sandhya Madhu   |  |   |   |   |   |  |
| Signature / ID :                         |  | [Signatures]  |  |   |   |   |   |  |
| Date:                                    |  | 26/5/26 27/5/26   |  |   |   |   |   |  |
| Time:                                    |  | 8 AM 8 AM   |  |   |   |   |   |  |
| Taken Over By Name :                     |  | Madhu   |  |   |   |   |   |  |
| Signature / ID :                         |  | [Signature]   |  |   |   |   |   |  |
| Date:                                    |  | 26/5/26   |  |   |   |   |   |  |
| Time:                                    |  | 8 PM  |  |   |   |   |   |  |

HNH-00013343 IP26-00006419  
 Mrs SRIBHASHYAM KIRANMAYEE  
 04-01-1996 30 Y 4 M 20 D (F)  
 Dr. PADMAJA YELISETTY



## URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: ..... 24/5/26 ..... Date of Removal: .....

| Parameters                                       | Date | Shift Time | <u>24/5/26</u>  | <u>24/5/26</u><br><u>N4</u>   | <u>25/5/26</u><br><u>M6</u>   |  |  |  |
|--|------|------------|---|---|---|--|--|--|
| Need for the Catheter                            |      |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <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 |
| Hand Hygiene                                     |      |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <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 |
| Usage of Sterile Equipment                       |      |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <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 |
| Is the Collection bag below the level of bladder |      |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <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 |
| Check the Tube for Obstruction (Free of Kinking) |      |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <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 |
| Is Catheter dated as policy                      |      |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <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 |
| Collecting bag is been emptied regularly?        |      |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <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 |
| Maintenance of closed system for the catheter    |      |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <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 |
| Dressing clean and dry?                          |      |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <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 |
| Is the line removed as Policy?                   |      |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <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 |
| Performance of Perineal Care                     |      |            | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <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 |
| Onset of New Fever                               |      |            | <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 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No | <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 |
| Name of the Nurse                                |      |            | <u>AKW</u>  | <u>CP</u>   | <u>TO</u>   |  |  |  |
| Signature of the Nurse                           |      |            |   |   |   |  |  |  |

catheter  
Remove

9:00 AM  
25/5/26







Sheet No: .....

**REGULAR PRESCRIPTIONS**

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

|  |           |            |                |              |                       |
|--|-----------|------------|----------------|--------------|-----------------------|
| <b>DRUG :</b> <u>IN PANTOPRAZOLE</u>                                 |           |            |                | Date<br>Time | <u>25/5/26</u>        |
| Dose   | Route     | Frequency  | Start Dt.      |              |                       |
| <u>40mg</u>  | <u>IV</u> | <u>OD</u>  | <u>25/5</u>    |              |                       |
| Name & Signature of the Doctor Starting the Drugs:<br><u>Dr. Dma</u> |           |            |                | <u>Cam</u>   | <u>25/5/26</u>        |
| Additional Instructions:   |           |            |                |              |                       |
| <b>Daily Doctor's Endorsement by a Sign</b>                          |           |            |                |              |                       |
| <b>DRUG :</b> <u>T. CEFEXIME</u>                                     |           |            |                | Date<br>Time | <u>25/5 27/5</u>      |
| Dose   | Route     | Frequency  | Start Dt.      |              |                       |
| <u>200mg</u>   | <u>PO</u> | <u>BD</u>  | <u>26/5/26</u> |              |                       |
| Name & Signature of the Doctor Starting the Drugs:<br><u>Libby</u>   |           |            |                | <u>Cam</u>   | <u>26/5</u>           |
| Additional Instructions:   |           |            |                |              |                       |
| <b>Daily Doctor's Endorsement by a Sign</b>                          |           |            |                |              |                       |
| <b>DRUG :</b> <u>T. PANTAPRAZOLE</u>                                 |           |            |                | Date<br>Time | <u>25/5 27/5</u>      |
| Dose   | Route     | Frequency  | Start Dt.      |              |                       |
| <u>40mg</u>  | <u>PO</u> | <u>OD</u>  | <u>26/5/26</u> |              |                       |
| Name & Signature of the Doctor Starting the Drugs:<br><u>Libby</u>   |           |            |                | <u>Cam</u>   | <u>26/5</u>           |
| Additional Instructions:<br><u>Bed on food</u>                       |           |            |                |              |                       |
| <b>Daily Doctor's Endorsement by a Sign</b>                          |           |            |                |              |                       |
| <b>DRUG :</b> <u>T. PARACETAMOL</u>                                  |           |            |                | Date<br>Time | <u>25/5 26/5 27/5</u> |
| Dose   | Route     | Frequency  | Start Dt.      |              |                       |
| <u>2g</u>  | <u>PO</u> | <u>TID</u> | <u>26/5/26</u> |              |                       |
| Name & Signature of the Doctor Starting the Drugs:<br><u>Libby</u>   |           |            |                | <u>Cam</u>   | <u>26/5</u>           |
| Additional Instructions:<br><u>2par</u>                              |           |            |                |              |                       |
| <b>Daily Doctor's Endorsement by a Sign</b>                          |           |            |                |              |                       |

Signature

VERIFIED BY - Name



HNH-00013343 IP26-00006419  
 Mrs SRIBHABHYAM KIRANMAYEE  
 04-01-1996 30 Y 4 M 20 D (F)  
 Dr. PADMAJA YELISETTY

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



| Date<br>Time                   | Nurse Sig. | Nurse Sig. | Nurse Sig. | Nurse Sig. |
|--------------------------------|------------|------------|------------|------------|
|                                |            |            |            |            |
| <b>DRUG :</b>                  | Dose       | Dose       | Dose       | Dose       |
|                                | Dr. Sign.  | Dr. Sign.  | Dr. Sign.  | Dr. Sign.  |
| Route                          | Dose       | Dose       | Dose       | Dose       |
| Start Date                     | 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.  |

| Date<br>Time                   | Nurse Sig. | Nurse Sig. | Nurse Sig. | Nurse Sig. |
|--------------------------------|------------|------------|------------|------------|
|                                |            |            |            |            |
| <b>DRUG :</b>                  | Dose       | Dose       | Dose       | Dose       |
|                                | Dr. Sign.  | Dr. Sign.  | Dr. Sign.  | Dr. Sign.  |
| Route                          | Dose       | Dose       | Dose       | Dose       |
| Start Date                     | 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           |
|------|---------|----------------------|-----------------------------|---------|-------------|------------------|
| 24/5 | 2:50 PM | INJ PANTOPRAZOLE     | 40mg                        | IV      | [Signature] | Akeela<br>Anusha |
| 24/5 | 3:45 PM | INJ METOCLOPRAMIDE   | 10mg                        | IV      | [Signature] | Akeela<br>Anusha |
| 24/5 | 5 PM    | ONDANSETRON          | 4MG                         | IV      | [Signature] | A<br>Archa       |
| 24/5 | 6 PM    | DICLOFENAC           | 100MG                       | PR      | [Signature] | A<br>Arche       |
| 24/5 | 6 PM    | TRAMADOL             | 100MG                       | PR      | [Signature] | A<br>Arche       |
| 24/5 | 5:15 PM | METHERGINE           | 0.2 MG                      | IV      | [Signature] | A<br>Arche       |
| 24/5 | 5:30 PM | T MISOPROSTOL        | 1000 mcg                    | PR      | [Signature] | A<br>Archi       |
| 24/5 | 2 PM    | INJ METOCLOPRAMIDE   | 10mg                        | IV slow | [Signature] | Heba<br>A        |
| 24/5 | 10 PM   | DULCOLAX SUPPOSITORY | 20mg                        | P/R     | [Signature] | GA<br>GA         |

Signature  
VERIFIED BY : Nandhi



I.V. FLUIDS CHART

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

| Date | Time    | Description of I.V. Fluid<br>(If infusion, mention ml./hr = Mcg/kg/min. etc) | Route | Flow Rate<br>ml/hr | Doctor<br>Sign | Nurse<br>Sign | Date of<br>Stopping | Doctor<br>Sign | Nurse<br>Sign |
|------|---------|--|-------|--------------------|----------------|---------------|---------------------|----------------|---------------|
| 24/5 | 2:50 PM | RINGER LACTATE   | IV    | 1000 ml/hr         |                | Q             | 24/5                | Ph             | Q             |
| 24/5 | 4:30 PM | RINGER LACTATE   | IV    | 1000               | Ph             | A             | 24/5                | Ph             | A             |
| 24/5 | 5 PM    | RINGER LACTATE<br>+ 90 OXYTOCIN<br>+ 90 OXYTOCIN                             | IV    | 150                | Ph             | A             | 24/5                |                | ^             |
| 24/5 | 6 PM    | RINGER LACTATE   | IV    | FR                 | Ph             | Q             | 24/5                | Ph             | Q             |
| 24/5 | 8 PM    | RINGER LACTATE   | IV    | 100 ml/hr          | Ph             | Q             | 24/5                | Ph             | Q             |
| 24/5 | 9 PM    | RINGER LACTATE   | IV    | 100 ml/hr          | Ph             | Q             | 25/5                | h              | Q             |
| 24/5 | 2 AM    | RINGER LACTATE   | IV    | 100 ml/hr          | h              | Q             | 25/5                | h              | Q             |
| 25/5 | 7 AM    | RINGER LACTATE   | IV    | 100 ml/hr          | h              | Q             | 25/5                | h              | Q             |
|      |         | STOP<br>my<br>infusion   |       |                    |                |               |                     |                |               |

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

HNH-00013343 IP26-00006419  
 Mrs SRIBHASHYAM KIRANMAYEE  
 04-01-1996 30 Y 4 M 20 D (F)  
 Dr. PADMAJA YELISETTY



## 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<br>(GENERIC NAME CAPITAL LETTERS) | DOSE<br>(mg, mcg) | ROUTE<br>(PO, NG, SC, IV) | FREQUENCY | LAST DOSE<br>Date / Time | ON<br>ADMISSION<br>/ SHIFTING                          |
|------|---|-------------------|---------------------------|-----------|--------------------------|--|
| 1    | Tab IRON.   | 1tab              | PO                        | OD.       |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 2    | Tab CALCIUM                                       | 1tab              | PO                        | OD.       |                          | <input type="checkbox"/> C <input type="checkbox"/> DC |
| 3    | Tab VITAMIN D                                     | 1tab.             | PO                        | OD.       |                          | <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. Dna [Signature]

Date & Time : ..... 24/5/26 3:50pm

Nurse Name & Signature: ..... Akwils [Signature]

Date & Time : ..... 24/5/26

HNH-00013343 IP26-00006419  
 Mrs SRIBHASHYAM KIRANMAYEE  
 04-01-1996 30 Y 4 M 20 D (F)  
 Dr. PADMAJA YELISETTY



## CAESAREAN SECTION OPERATIVE NOTES

|   |   |
|---|---|
| Surgeon's Name: <i>Dr. Padmaja Yelisetty</i>  | Date of Delivery: <i>24/5/2026</i>  |
| Assistant Surgeon: <i>Dr. Swathi, Dr. Dna</i> | Time of Delivery: <i>4:50pm</i>   |
| Anaesthetist's Name: <i>Dr. Sameer</i>        | Gender of Baby: <i>MALE</i>   |
| Type of Anaesthesia: <i>Spinal</i>            | Weight of Baby: <i>2.94kg</i>   |
| Neonatologist:                                | AGPAR Score: <i>7, 9</i>  |
| Scrub Nurse:                                  | NICU Admission: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

Pre-Operative Diagnosis: *Primi @ 37+6wk @ reduced fetal movement*

Elective       Emergency      Indication: *@ Fetal compromise*

Urgency

Immediate Threat to life of woman or fetus  
 Maternal or fetal compromise not immediately life threatening  
 No maternal or fetal compromise but needs early delivery  
 Delivery timed to suit woman and staff

Decision time: .....      Knife to rectus: .....

CTG Description: *Non Reactive*

If there was a delay give the reasons: .....

Surgical Procedure: *Emergency LOWER SEGMENT CAESAREAN SECTION.*

Post Operative Diagnosis: *POD-0 P/L*

Peri-Operative Complications:

Amount of Blood Loss: .....      Blood Transfused (in ML): .....

Name and Number of Surgical Specimen sent for examination:

**Examination Findings when Appropriate:**

Presentation:  Cephalic  Breech  Other ..... Cervical Dilatation: ..... cm  
 5th Palpable: ..... *4/5 palpable* ..... Fetal Position: .....  
 Station:  -3  -2  -1  0  +1  +2 Moulding:  None  +  ++  +++  
 Caput:  +  ++  +++ Meconium:  None  +  ++  +++  
 Bladder Catheterized:  Yes  No Urine:  Clear  Blood Stained

Skin Incision:  Pfannenstiel  Transverse  Midline  Other .....  
 Uterine Incision:  Lower Segment  Classical  Inverted T  J Incision *lus-vascular*  
 Previous Scar:  Intact  Thinnedout  Ruptured  No Scar  
 Incision Through Placenta:  Yes  No *Placenta - Succenturiate lobe*  
 Delivery of head:  Manual  Forceps *Marginal cord insertion*  
 Liquor:  Clear  Meconium:  I  II  III  Blood  Offensive  Not Offensive  
 Delivery of Placenta:  Manual  CCT .....  Complete  Incomplete  Piecemeal  
 Cord Appearance: *(N)* ..... Cord around the neck  Yes  No  
 Appearance of placenta: ..... Cavity explored  Yes  No  
 Uterus, tubes and ovaries:  Normal  Not Normal Sterilization:  Yes  No

Uterine Closure:  One Layer  Two Layers ..... *Vicryl No-1* ..... Suture  
 Peritoneal Closure:  Pelvic  Abdominal  None ..... *Vicryl No-1* ..... Suture  
 Sheath Closure: ..... *Vicryl No-1* ..... Suture  
 Fat Closure:  Yes  No ..... *Monocryl No-1* ..... Suture  
 Skin Closure:  Subcuticular  Mattress ..... *Monocryl No-1* ..... Suture  
 Vaginal Evacuated  Yes  No  
 Drain:  Yes  No  Remove in ..... days  Await instructions  
 Catheter  Yes  No  Remove in *24h* ..... days  Await instructions  
 Swap & Instruments count correct?  Yes  No  Post-op Antibiotics  Yes  No  
 Intra-Operative Antibiotics Cover:  Yes  No  Thromboprophylaxis  Yes  No

Post-Operative Notes: .....  
 - NBM for 4-6 hours  
 - IV fluids  
 - IV Antibiotics for 24hrs.  
 - Analgesics & Thromboprophylaxis as per AORN  
 - Monitor vitals Intake & output  
 - urine I/O charting

Doctor Name: *Dr. Padmaja Kelisetty* Doctor Signature: *Padmaja Kelisetty*  
 Date & Time: *24/5/28 6pm* *52027*



# OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 21/5/26 Time of Arrival: 2:30 PM Time Seen by Nurse: 3:30 PM

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: 97.8 Pulse: 89b/m RR: 20b/m SpO<sub>2</sub>: 99% BP: 110/70 Weight: .....

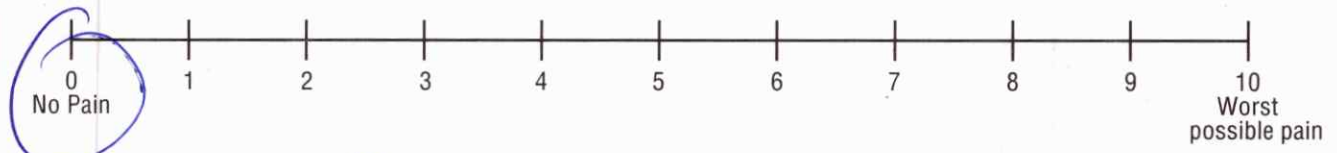
4) Gestational Criteria:

|          |   |   |   |   |
|----------|---|---|---|---|
| Gravida: | G | A | L | A |
|----------|---|---|---|---|

LMP: 1/9/25 EDD: 8/6/26 Gestational Age: .....

|                        |   |  |                             |  |      |              |
|------------------------|---|--|-----------------------------|--|------|--------------|
| Uterine Contraction    | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | <input type="checkbox"/> NA | Onset  | Time | Frequency:   |
| Membrane Rupture       | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | <input type="checkbox"/> NA | Onset  | Time | Fluid Color: |
| Vaginal bleeding       | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | <input type="checkbox"/> NA | Onset  | Time | Amount:      |
| Pre Eclampsia Symptoms | <input type="checkbox"/> Yes            | <input checked="" type="checkbox"/> No | <input 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: .....
- Frequency: ..... 6/11
- Interventions: .....

6) Past History:

- a) Surgeries: ..... 6/11
- b) Medical: ..... 6/11

7) **Allergy:**  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<br>(Resuscitative)   | Level 2<br>(Emergent)   | Level 3<br>(Urgent)  | Level 4<br>(Less Urgent)  | Level 5<br>(Non Urgent)  |
|------------------------------------|--|---|--|---|--|
| <b>Level 1<br/>(Resuscitative)</b> | Immediate  | ≤ 15 minutes  | ≤ 30 minutes   | ≤ 60 minutes  | ≤ 120 minutes<br>(2 Hours)   |
| <b>Re-Assessment</b>               | Continuous Nursing<br>Care   | Every 15 Minutes  | Every 15 Minutes   | Every 30 Minutes  | Every 60 Minutes   |
| <b>Labour / Fluid</b>              | Imminent Birth   | Suspected Pre-term<br>Labour / PPROM < 37<br>Weeks  | Signs of Active Labour<br>> 37 weeks   | Signs of Early Labour/<br>SROM > 37 weeks   | Discomforts of<br>Pregnancy  |
| <b>Bleeding</b>                    | Active Vaginal bleeding<br>with/ without abdominal<br>pain   | Bleeding associated with<br>cramping (<spotting)<br><37 weeks   | Bleeding associated<br>with cramping<br>(>spotting) >37<br>weeks   | Spotting  |  |
| <b>Hypertension</b>                | Seizure activity   | Hypertension > 160/110<br>and / or headache, visual<br>disturbance, RUQ pain  | Mild hypertension<br>> 140/90 with/without<br>associated signs and<br>symptoms   |   |  |
| <b>Fetal Assessment</b>            | Abnormal FHR tracing<br>Non-Fetal Movement   | Atypical FHR tracing,<br>abnormal dopplers<br>Diseased fetal movement   |  |   |  |
| <b>Others</b>                      | <ul style="list-style-type: none"> <li>• Acute onsite severe abdominal pain</li> <li>• Altered level of consciousness</li> <li>• Cord prolapse</li> <li>• Severe respiratory distress</li> <li>• Suspected sepsis</li> </ul> | <ul style="list-style-type: none"> <li>• Major trauma</li> <li>• Shortness of breath</li> <li>• Unplanned and unattended birth</li> </ul> | <ul style="list-style-type: none"> <li>• Abdominal/back pain greater than expected in pregnancy</li> <li>• Flank pain / hematuria</li> <li>• Nausea /vomiting and /or diarrhea with suspected dehydration</li> </ul> | <ul style="list-style-type: none"> <li>• Ongoing assessment from out patient clinic (for hypertension, blood work)</li> <li>• Minor trauma (minor MVC/fall)</li> <li>• Nausea/Vomiting and /or diarrhea</li> <li>• Signs of infection (ie dysuria ,cough, fever, chills)</li> </ul> | <ul style="list-style-type: none"> <li>• Anything that does not seem to pose threat to mother or fetus</li> <li>• Cervical ripening</li> <li>• Out patient placenta previa protocols</li> <li>• Pre-booked visits (ie Rh and progesterone injections, NST</li> <li>• Assessment for version</li> <li>• Rashes</li> </ul> |

Time seen by Doctor: 3:00 PM

Nurse Name : AKW/ly Nurse Signature: [Signature]

Date: 2/15/26 Time: 8 PM



## LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 20/5/26

**Baseline Information:**

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

Primary Language:  Telugu  English  Hindi  Others

Do you require an interpreter?  Yes  No

Source of Information:  Patient  Family  Others

Personal belonging if any:  Jewelry  Nose Ring  Bangles  Anklets  Finger Ring  Bracelets  
 handed over to Family members

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

If yes, identify .....

**Chief Complaints:** of decreased fetal movements Doctor Notified on Admission:  Yes  No  
 Name of the Doctor: Dr. Dug  
 Time Notified: 39 AM

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

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

**Blood Group:** O+ve LMP: 1/5/25 EDD: 8/6/25 Gestational age during admission: .....

Contractions: ..... Vaginal Discharge: .....

**Obstetric History:** G ..... P 1 ..... L ..... A ..... Previous LSCS .....

Height: ..... Weight: ..... BMI: .....

Temp: 97.8 f HR: 87 bpm RR: 20 bpm BP: 110/70 SpO<sub>2</sub>: 99%

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

|  |   |  |
|--|---|--|
| <input type="checkbox"/> Hypothyroidism  | <input type="checkbox"/> Rh Incompatibility         | <input type="checkbox"/> Fertility Treatment |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Previous LSCS              | <input type="checkbox"/> Preterm Labour      |
| <input type="checkbox"/> Hypertension    | <input type="checkbox"/> Gestational Hypertension   | <input type="checkbox"/> Others: (Specify)   |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Bad Obstetric History      |  |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Obesity (BMI)              |  |
|  | <input type="checkbox"/> Twins / Multiple Pregnancy |  |



Family History:  No Abnormalities Detected

- Heart Disease     Hypertension     Diabetes     Stroke     Seizures     Kidney disease  
 Liver disease     Other .....

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

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

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

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

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

Inform consultant for positive criteria

NUTRITIONAL SCREENING:

- Overweight     Poor Appetite > 3 Days     Needs Therapeutic Diet.  
 Under Weight     Diabetes Mellitus     No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

- Calm & Cooperative     Restless     Depressed     Agitated     Confused  
 Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With Family members

Orientation has been given regarding the following aspects:

- Call Bell in Reach :  Yes  No    Waste Disposal Explained:  Yes  No  
Infusion Pump :  Yes  No    Hand hygiene Explained:  Yes  No     Others

Above information given to Patient  
Name of Person Orientation was given to: Mrs. Kiranmayee  
Orientation not given Reason: .....

Nurse Signature: [Signature]  
Nurse Name: Akshy  
Date & Time: 24/5/16



## 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: 2/15/26

→ Assess the baby condition

→ BF and hold & breastfeeding

→ maintained flo chart & record

→ provide warm care to the baby

Handover given by *AK*

Handover taken by .....

Signature *AK*

Signature .....

Date & Time: 2/15/26

Date & Time: .....

# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE



Patient Name : Mrs. S. Kiranmayee Gender:  Male  Female Age : 30 yr  
 UHID No : HNH-00013343 Date : 24/5/2026

**Instruction:**

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

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

EMERGENCY LOWER SEGMENT CESAREAN SECTION

upon Mrs. Srihashyam Kiranmayee  
 (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.

Bleeding, wound infection, wound breakdown, need for blood transfusion, chances of injury to adjacent organs like bowel bladder, ureter, blood vessels, possibly related to theatre, skin laceration.

**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. Padmaja Yelisetty

**Consentee :**  
 Signature : [Signature]  
 Name : S. Kiranmayee  
 Date & Time : 24/5/26 3:50pm

**Patient Attendant :**  
 Signature : [Signature]  
 Name : A.V.S. Prasad  
 Relationship with Patient : Husband  
 Date & Time : 24/5/2026, 3:50 pm

**Witness :**  
 Signature : [Signature]  
 Name : Akhil  
 Date & Time : 24/5/26

**Doctor (who is taking the consent) :**  
 Signature : [Signature]  
 Name : Dr. Dna.  
 Date & Time : 24/5/26 3:30pm

# CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE



Patient Name : Ms. Kishanmayee Age : 30 Gender : Male  Female   
 UHID NO: HNH-13343 Surgeon Name: Dr. Padmaja Yelisetty  
 Anaesthesiologist : Dr. Sanin Unayathi  
 Operative procedure planned : Lscs

### PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

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

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

- Heart disease       Hypertension       Diabetes mellitus       Renal failure
- Hepatic disorders       Shock       Multiple organ failure       Polytrauma / Renal Tubular Acidosis
- Incapacitating Chronic Obstructive Pulmonary Disease
- Others : Bleeding / need for 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 : S. Kivamayee

Name : S. Kivamayee

Relationship with Patient: .....

Date & Time : 24/05/26 @ 3:20pm

**Witness :**

Signature : A.V.S. Prasad

Name : A.V.S. Prasad

Date & Time : 24/05/26, 3:55 PM

**Doctor (who is taking the consent) :**

Signature : [Signature]

Name : Dr. Sanjay Unayalkar

Date & Time : 24/5 at 3:15pm

**Department of Anaesthesiology  
PRE-ANAESTHETIC EVALUATION**



Name: Mrs. KIRANMAJEE Age: 30y Sex: FEMALE UHID.No: HNH-13343  
 Date: 24/5 Time: 3pm Proposed Operation: USO  
 Diagnosis: Primi at 38 weeks  
 B.P./CRT: 105/63 H.R: 84 Weight: 75.4 ASA Physical Status:  1  2  3  4  5

**Laboratory Data:**

Hgb: 12.4 Glucose: ..... Protein: ..... HIV: ..... X-Ray: .....  
 PCV: 11560 Urea: ..... Alb: ..... HBS Ag: NR ECG: .....  
 WBC: 3.0 Creat: ..... Total Bill: ..... HCV: ..... 2D Echo: .....  
 Plate: 3.0 Na: ..... Dir. Bill: ..... Blood group: O pos Stress/Angio: .....  
 PT: ..... K: ..... LDH: ..... T3: ..... Other: placenta post high  
 PTT: ..... Ca++: ..... Alk phos: ..... T4: .....  
 INR: ..... Mg++: ..... Amylase: ..... TSH: .....  
 Cl-: ..... SGOT/SGPT: .....  
**Allergies:** NRDA

**Medical History:** CVS: .....  
 RESP: No active medical history Diabetes: .....  
 CNS: ANCs - regular - uneventful.  
 Renal: .....  
 Hepatic / GE: ..... Physical Activity: good, active  
 Others: h/o endometrial knots. tx completed.

**Past Anaesthetic History:** .....  
**Physical Exam:** conscious, coherent  
 Airway: MP 1 2 3 4 Mouth Opening: adq Mentohyoid Distance: 3F5 Neck: (N) Teeth: intact  
 Lungs: clear  
 Heart: .....  
 CNS: .....

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 |
|---------------------|--------|
| <u>Fe/c/D3</u>      |        |
|                     |        |
|                     |        |
|                     |        |

- Pre-Operative Instructions:** an NPO
- DVT Prophylaxis: an NPO
  - NIL ORAL: Water / ORS 2 Hours  
Others 6 Hours
  - Informed Consent:  Standard  High Risk
  - Post Operative Pain Management:  Discussed with Patient
  - Other Instructions: CBP stat  
Crossmatch sample.

Signature: [Signature] Name: Dr. Sanjay Chayati  
 Docu. No.: RCH / FRM / CLINICAL / 044



# ANAESTHESIA CHART



## Pre Induction Assessment:

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

Physical Status:  Patient Identified  Consent Present  Chart Reviewed

H.R: **106/M** B.P / CRT: **105/68** SpO<sub>2</sub>: **100%** R.R: **18/M** Last Feed: **6 HOURS**

Pre-OP Diagnosis: **DUMI** Operation: **VCS** Date: **24/5**

Surgeon: **Dr. PY / DASHU / Dr. DUA** Anaesthesiologist: **Dr. Saran** Technician: **Sri. Saranith**

| TIME  | 4:30 | 5:00 | 5:30 | 6:00 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|------|------|------|------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| N <sub>2</sub> O / AIR / O <sub>2</sub> / LPM |      |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| HALO / ISO / SEVO                             |      |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Drugs:  |      |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| MEPENTERINE 6mg infusion                      |      |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| oxytocin 3U + 9U infusion + 9U infusion       |      |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ONDANSETRON 4mg IV                            |      |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| METHELGIN 0.2mg IV                            |      |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| FiO <sub>2</sub> / SaO <sub>2</sub>           | 100  | 100  | 100  | 100  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ETCO <sub>2</sub>                             |      |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ECG   | SR   | SR   | SR   | SR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 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  
**given.**  
 Suppository  
**DICLOFENAC 100mg**  
**TRAMADOL Blood Loss 100mg**  
**n/50ml**

NOTES

LAB Values

ABG

GRBS

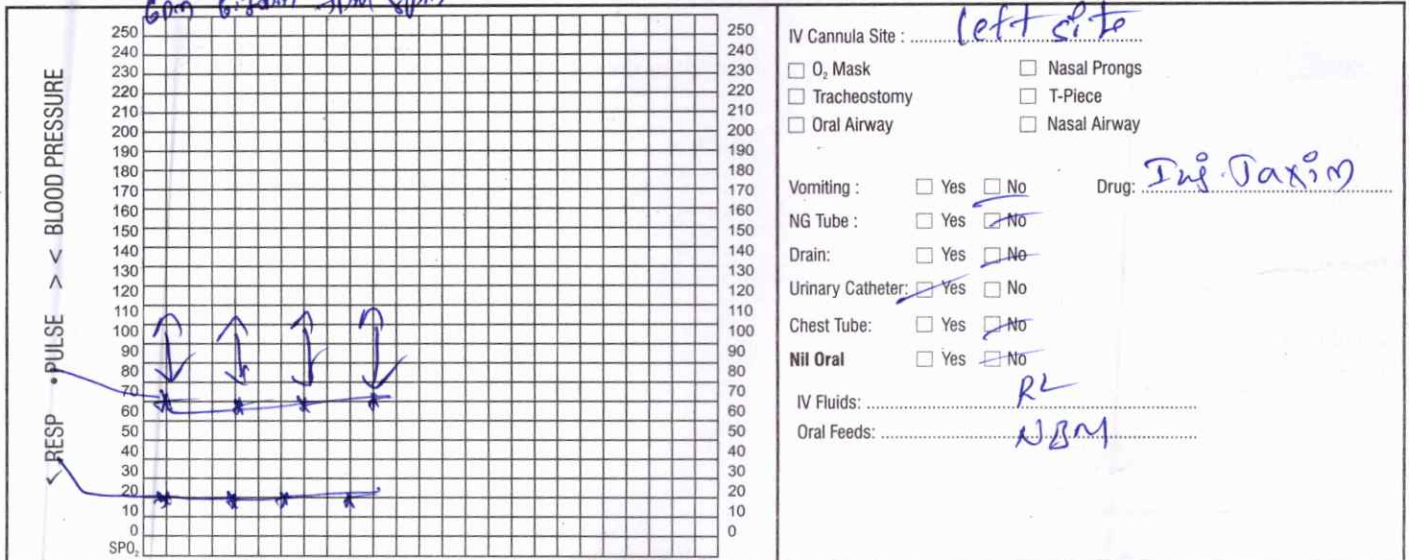
Others

|  |  |   |  |
|--|--|---|--|
| <input checked="" type="checkbox"/> Equipment Checked and Functional<br><input checked="" type="checkbox"/> BP<br><input checked="" type="checkbox"/> Cuff Site: <b>(R) UL</b><br><input type="checkbox"/> Art Site:<br><input checked="" type="checkbox"/> EKG Lead <b>3 lead</b><br><input type="checkbox"/> Temp Site<br><input type="checkbox"/> FIO <sub>2</sub> Monitor<br><input type="checkbox"/> Agent Monitor<br><input checked="" type="checkbox"/> Pulse Oximeter<br><input type="checkbox"/> Capnograph<br><input type="checkbox"/> Ventilator<br><input type="checkbox"/> Nerve Stimulator<br>Position: <b>Supine</b><br><input checked="" type="checkbox"/> Pressure Points Checked<br>Eye Care:<br><input type="checkbox"/> Oint<br><input type="checkbox"/> Tape<br><input type="checkbox"/> Padding<br><input checked="" type="checkbox"/> Awake | Temp:<br><input type="checkbox"/> HME <input type="checkbox"/> Fluid Warmer<br><input type="checkbox"/> Cling Film <input type="checkbox"/> OH Warmer<br><input type="checkbox"/> Hugger's <input type="checkbox"/> Cotton Wool<br><input checked="" type="checkbox"/> Other <b>sheets</b><br>Times:<br>Anaes Start: <b>4:30 PM</b><br>OP Start:<br>OP End: <b>6 PM</b><br>Leave OR:<br>Anaesthesia:<br><input type="checkbox"/> GA<br><input type="checkbox"/> Monitored Anaesthesia Care<br><input checked="" type="checkbox"/> Regional<br>Line (Size & Location)<br><input type="checkbox"/> CVP:<br><input type="checkbox"/> ABT:<br><input checked="" type="checkbox"/> IV: <b>18 G (R) UL</b><br><input type="checkbox"/> IV:<br><input type="checkbox"/> IV: | Induction<br><input type="checkbox"/> IV <input type="checkbox"/> Inhal<br><input type="checkbox"/> Pre O <sub>2</sub> <input type="checkbox"/> RSI<br><input type="checkbox"/> Others<br><input type="checkbox"/> Mask <input type="checkbox"/> SGA<br><input type="checkbox"/> Airway <input type="checkbox"/> Oral <input type="checkbox"/> Nasal<br>ETT# ..... at ..... cm<br><input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Cuff<br><input type="checkbox"/> Tracheostomy <input type="checkbox"/> Topical<br><input type="checkbox"/> Drug:<br><input type="checkbox"/> Awake <input type="checkbox"/> Direct Vision<br><input type="checkbox"/> Video Laryngoscopy <input type="checkbox"/> Stylette / Bougie<br><input type="checkbox"/> Fiberoptic<br>Blade# ..... Attempts: .....<br>Difficulty Why? .....<br><input type="checkbox"/> Bilat = BS<br><input type="checkbox"/> Semi-Closed Circle<br><input type="checkbox"/> Closed Circle<br><input type="checkbox"/> Other | Regional:<br>Extremity Specify:<br><input checked="" type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Caudal<br>Others:<br>Position: <b>sitting</b><br>Site: <b>L5-4</b><br>Needle Size: <b>27 G (P)</b> Depth:<br>Parasthesia <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Catheter at skin ..... cm<br>Drug Name & Conc: <b>10mg BUPIVACAINE (4)</b><br><b>+ 90 mcg BUPRENORPINE</b><br>Bolus:<br>Infusion:<br>Block Level: <b>T4 - B/L equal to cold.</b><br>Comments:<br>Transportation to<br><input checked="" type="checkbox"/> PACU <input type="checkbox"/> ICU <input type="checkbox"/> Other<br>Relaxant Reversed <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA<br>Name of the Doctor: <b>DUANIV</b><br>Signature of the Doctor: |
|--|--|---|--|



POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by: *Sis. Akhila* Time Received: *6:15 PM* Time Discharged: .....



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

PAIN ASSESSMENT AND MANAGEMENT FORM

| Date        | Time        | Pain Score  | Intervention | Signature          |
|-------------|-------------|-------------|--------------|--------------------|
| <i>2/15</i> | <i>6 PM</i> | <i>0/10</i> | <i>NA</i>    | <i>[Signature]</i> |
| <i>2/15</i> | <i>7 PM</i> | <i>0/10</i> | <i>NA</i>    | <i>[Signature]</i> |
| <i>2/15</i> | <i>8 PM</i> | <i>0/10</i> | <i>NA</i>    | <i>[Signature]</i> |

Pain Tool Used:  N PASS  FLACC  Wong Baker  NPS

Anaesthesiologist Name: *[Signature]*

Anaesthesiologist Signature: *[Signature]*

Date & Time: .....

PACU Nurse Name: *[Signature]*

PACU Nurse Signature: *[Signature]*

Date & Time: *24/1/26 at 10:50 PM*

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 minutes after pain relief intervention

Transferred to Unit by: *[Signature]*

Date & Time: *[Signature]*



# PATIENT TRANSFER FORM

|   |                                  |  |  |
|---|----------------------------------|--|--|
| Patient Name & UHID No.<br>HNH-00013343      IP26-00006419<br>Mrs SRIBHASHYAM KIRANMAYEE<br>04-01-1996      30 Y 4 M 20 D (F)<br>Dr. PADMAJA YELISETTY<br> |                                  | Date & Time of Admission<br>20/5/26 @ 2:55 PM  | Date & Time of Transfer Order<br>20/5/26 @ |
|   |                                  | Transfer Ordered by<br>Dr. DUG   | Reason for Transfer<br>Em. LSCY            |
| From Unit<br>Pre & Post   | To Unit<br>OT                    | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| Number of Sheets in Clinical File<br>25   | Number of Imaging Films<br>NST - | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>If yes, what ? |  |
| Medications / Consumables / Surgicals / Hand over   |                                  |  |  |
| Sl.No.  | Item Name                        | Quantity   |  |
| 1.  | Rh 500ml                         | 1  |  |
| 2.  |                                  |  |  |
| 3.  |                                  |  |  |
| 4.  |                                  |  |  |
| 5.  |                                  |  |  |
| Shifting Summary / Notes Written by Doctor :      Yes <input type="checkbox"/> No <input type="checkbox"/>  |                                  |  |  |
| Name & Signature of Person who is Transferring<br>Ss. Akhila / @  |                                  | Name of Person Ordered Transfer<br>Dr. DUG   |  |
| Patient & Clinical Records Received by :<br>   |                                  |  |  |
| Date & Time of Patient Received :<br>20/5/26  |                                  |  |  |

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

# SURGICAL SAFETY CHECKLIST

Surgeon: Dr. Padmaja  
 Asst. Surgeon: Dr. Swathi  
 Anaesthetist: Dr. Ganesh  
 Scrub Nurse: Sr. Archana

Patient Name: .....  
 UHID No.: .....  
 Date: 21/5/20

HNH-00013343 IP26-00006419  
 Mrs SRIBHASHY KIRANMAYEE  
 04-01-1996 30 Y 4 M 20 D (F)  
 Dr. PADMAJA YELISETTY



Gender: F  
 In-time: 4:30pm  
 Out-time: 6pm



## Before Induction of Anaesthesia >>

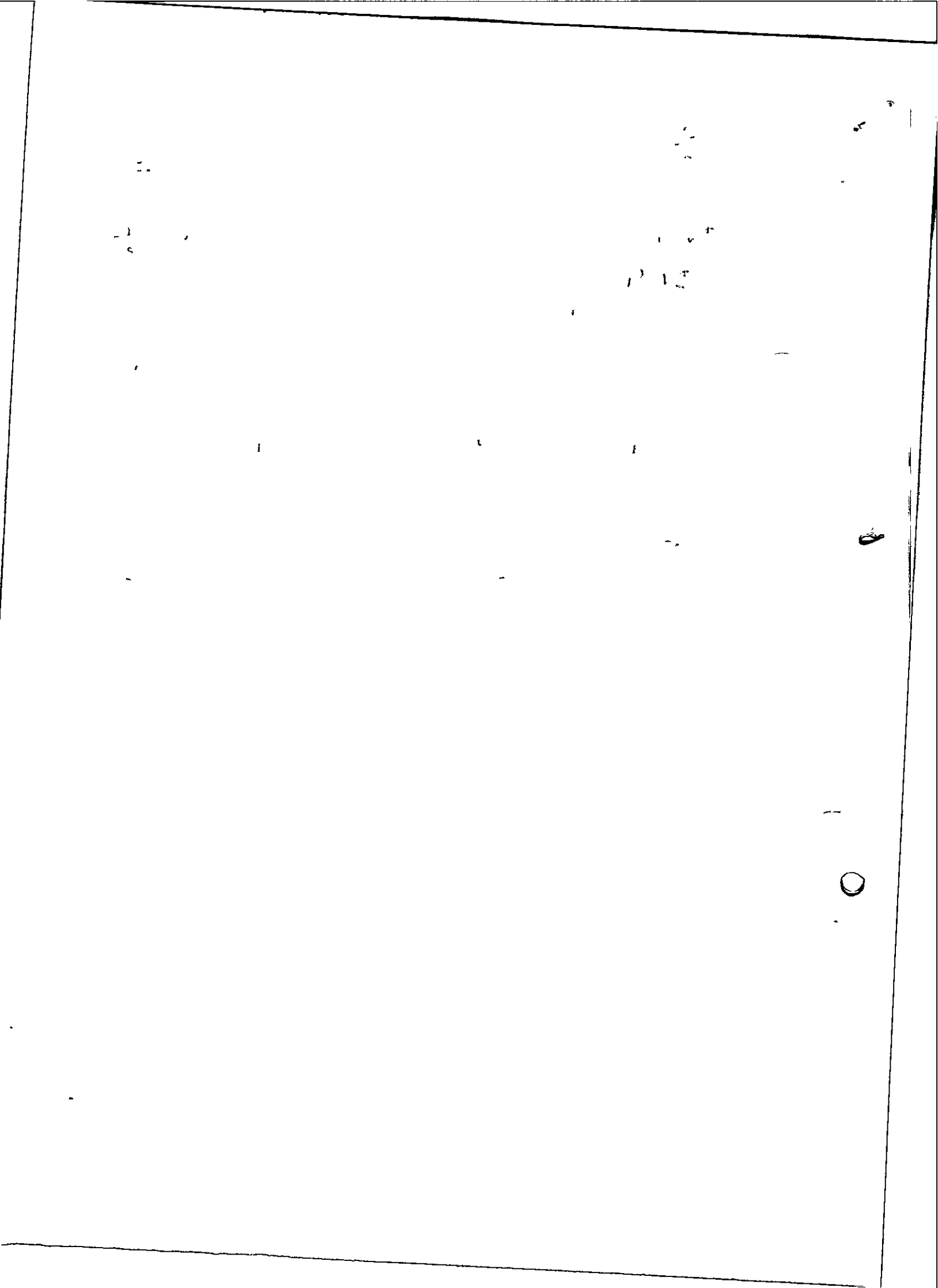
## Before Skin Incision >>

## Before Patient Leaves Operating Room



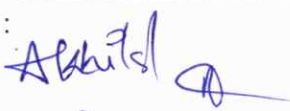
| SIGN IN  |   | Time: <u>4:15 pm</u> |
|--|---|----------------------|
| <b>Patient Has Confirmed</b>   |   |                      |
| Identity   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                      |
| Site   | <input checked="" type="checkbox"/> 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                             |                      |
| <b>Site Marked</b>   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA |                      |
| <b>Anaesthesia Safety Check Completed</b>                                | <input type="checkbox"/> Yes <input type="checkbox"/> No  |                      |
| <b>Pulse Oximeter on Patient &amp; Functioning</b>                       | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                      |
| <b>Does Patient have a:</b>  |   |                      |
| Known Allergy?   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |                      |
| <b>Difficult Airway / Aspiration Risk?</b>                               |   |                      |
| Yes, & Equipment / Assistance Available                                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                      |
| <b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>               |   |                      |
| Yes, and Adequate Intravenous Access and Fluids Planned                  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA            |                      |
| Blood Units Reserved   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA            |                      |
| <b>Has Antibiotic Prophylaxis been given within the last 60 minutes?</b> | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA            |                      |
| Signature: <u>[Signature]</u>  |   |                      |
| Name: <u>[Name]</u>  |   |                      |

| TIME OUT  |   | Time: <u>4:30pm</u> |
|---|---|---------------------|
| <b>Confirm all team members have introduced themselves by Name and Role</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |                     |
| <b>Surgeon, Anaesthesia Professional and Nurse Verbally Confirm</b>   |   |                     |
| 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                             |                     |
| <b>Anticipated Critical Events</b>  |   |                     |
| <b>Surgeon Reviews:</b>   |   |                     |
| What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |                     |
| <b>Anaesthesia Team Reviews:</b>  |   |                     |
| Are There Any Patient-specific Concerns?  | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA |                     |
| <b>Nursing Team Reviews:</b>  |   |                     |
| Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?   | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                     |
| <b>Is Essential Imaging Displayed?</b>  |   |                     |
| 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>Sudipta</u>  |   |                     |

| SIGN OUT  |  | Time: <u>6pm</u> |
|---|--|------------------|
| <b>Nurse Verbally Confirms with the Team:</b>                             |  |                  |
| The Name of the Procedure Recorded  | <input type="checkbox"/> Yes <input type="checkbox"/> No                             |                  |
| That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                  |
| The Specimen is Labelled (including patient name)                         | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                  |
| Whether there are any Equipment Problems to be addressed                  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                  |
| <b>To Surgeon, Anaesthetist and Nurse:</b>                                |  |                  |
| What are the key concerns for recovery and management of this patient?    | <input type="checkbox"/> Yes <input type="checkbox"/> No                             |                  |
| Signature: <u>[Signature]</u>   |  |                  |
| Name: <u>Dr. Padmaja Yelisetty</u>  |  |                  |



# PATIENT TRANSFER FORM

|  |                              |  |  |
|--|------------------------------|--|--|
| Patient Name & UHID No.<br><br>HNH-00013343      IP26-00006419<br>Mrs. SRIBHASHYAM KIRANMAYEE<br>04-01-1996      30 Y 4 M 20 D (F)<br>Dr. PADMAJA YELISETTY<br> |                              | Date & Time of Admission<br>24/5/26 @ 5:35 pm  | Date & Time of Transfer Order<br>24/5/26 @ 6:15 pm |
|  |                              | Transfer Ordered by<br>Dr. Samir   | Reason for Transfer<br>observation                 |
| From Unit<br>05  | To Unit<br>pre - post        | Information to Attendant<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| Number of Sheets in Clinical File<br>80  | Number of Imaging Films<br>— | Personal belongings including clinical documents. If any handed over to attendant<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/><br>If yes, what ? |  |
| Medications / Consumables / Surgicals / Hand over  |                              |  |  |
| Sl.No.   | Item Name                    | Quantity   |  |
| 1.   | RL                           | 01   |  |
| 2.   |                              |  |  |
| 3.   |                              |  |  |
| 4.   |                              |  |  |
| 5.   |                              |  |  |
| Shifting Summary / Notes Written by Doctor :      Yes <input type="checkbox"/> No <input type="checkbox"/>   |                              |  |  |
| Name & Signature of Person who is Transferring<br>  |                              | Name of Person Ordered Transfer<br>Dr. Samir   |  |
| Patient & Clinical Records Received by :<br>  |                              |  |  |
| Date & Time of Patient Received :      24/5/26 @ 6:15 pm   |                              |  |  |

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

- Unavailable Bed     
  Nurse not Available     
  Available Bed not ready

HNH-00013343 IP26-00006419  
Mrs SRIBHASHYAM KIRANMAYEE  
04-01-1996 30 Y 4 M 20 D (F)  
Dr. PADMAJA YELISETTY



DIETARY NOTES

370



## NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 25/5/26 Time: 9:55 am

Origin: Indian Height: 162cm Weight: 74kg BMI:  ~26 kg/m<sup>2</sup>  
 ~28 kg/m<sup>2</sup>  
 ~30 kg/m<sup>2</sup>

Food Allergies: No F A

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: A.V.S Prasad

Name: A.V.S Prasad

Date & Time: 25/5/26; 9:55 am

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

Dietician's

Signature: Sobiya

Name: Syeda Sobiya Zaher

Date & Time: 25/5/26; 9:55 am

(P. T. O)

