

9160378694

27/6/16

10:00 - 11:00pm


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


**BirthRight™**  
 BY RAINBOW HOSPITALS  
 Your Right to a Safe Delivery
**ESTIMATION SLIP**

1631

Date: 22/6/16 UHID / IP No.: RAH 0055 9150 SI No.Name of Patient: N. Deepthi Alekhya Age: 26y Gender: FFather's / Husband's Name: Mr. Abhishek Corporate / Occupation: \_\_\_\_\_Address: \_\_\_\_\_ Phone: 889 6212248 Email: \_\_\_\_\_Procedure / Plan: Hypnoec Anesth - (Ces) TAH EDD/Dos: \_\_\_\_\_MODE OF PAYMENT: ☐ SELF ☒ TPA: TEICT Bank ☐ GIPSA: \_\_\_\_\_ OTHER \_\_\_\_\_**TARIFF INFORMATION :**

| Particulars                                                     | Package Amounts (Rs.)                                                          |                                                                                          |
|-----------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|
|                                                                 | Normal Delivery                                                                | LSCS                                                                                     |
| Room Category                                                   |                                                                                |                                                                                          |
| Multi Shared Ward                                               |                                                                                |                                                                                          |
| Shared Ward                                                     |                                                                                |                                                                                          |
| Twin Shared Ward                                                | 1.50 (Hypnoec Anesth)                                                          | 500 (Hypnoec Anesth)                                                                     |
| Private Room                                                    |                                                                                | 2.50 -                                                                                   |
| Super Deluxe Room                                               |                                                                                | 3.00                                                                                     |
| Suite Room                                                      |                                                                                |                                                                                          |
| 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: _____                                                                |
|                                                                 | Pharmacy up to _____                                                           | Pharmacy up to _____                                                                     |
|                                                                 | Investigations up to _____                                                     | Investigations up to _____                                                               |
| Others                                                          |                                                                                |                                                                                          |

Neonatologist Charges: ☐ Covered ☐ Not Covered Epidural / Entonox: ☐ Covered ☐ Not CoveredInitial Minimum Deposit: Rs. 15,000/- Advance**REMARKS :**

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

**DECLARATION**

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

Signature of the Client

Signature Relationship

Signature of the financial Counselor



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BAH-00559150 IP26-00006664  
Mrs M DEEPTHI ALEKHIA  
07-01-1990 36 Y 5 M 20 D (F)  
Dr. RAJANI KUMARI

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

BirthRight  
BY RAINBOW HOSPITALS  
Your Right to a Safe Delivery

## SURGERY DETAILS

Date : 27/06/26  
Patient Name: Mrs. Deepthi Alekhya Date of Birth: 7/01/1990 Age: 36 Yrs  
Gender: Female Ward : OT-II UHID No: BAH-00559150  
Date of Surgery: 27/06/26 ☐ OT-1 ☒ OT-2 ☐ OT-3 ☐ OT-4 ☐ OBG OT-1 ☐ OBG OT-2  
Name of the Surgery : Exploratory Laparotomy + Abdominal hysterectomy + Bilateral  
oophorectomy + Pelvic node exploration.  
Time in : 11:30 AM Time Out : 12:30 PM

|                      | NAME                                | AMOUNT |
|----------------------|-------------------------------------|--------|
| 1. Surgeon           | Dr. Rajanikumari / Dr. Girish Kumar | Am     |
| 2. Anaesthetist      | Dr. Samir                           |        |
| 3. Assistant Surgeon | Dr. Srisrinath                      |        |
| 4. OT Technician     | Pallavi                             |        |
| 5. Circulating Nurse | Sushela Karan                       |        |
| 6. Assistant Nurse   | Sandhya                             |        |

Mrs M DEEPTHI ALEKHIA (36 Y 5 M 20 D)  
UTERS  
HN26010455UTERS

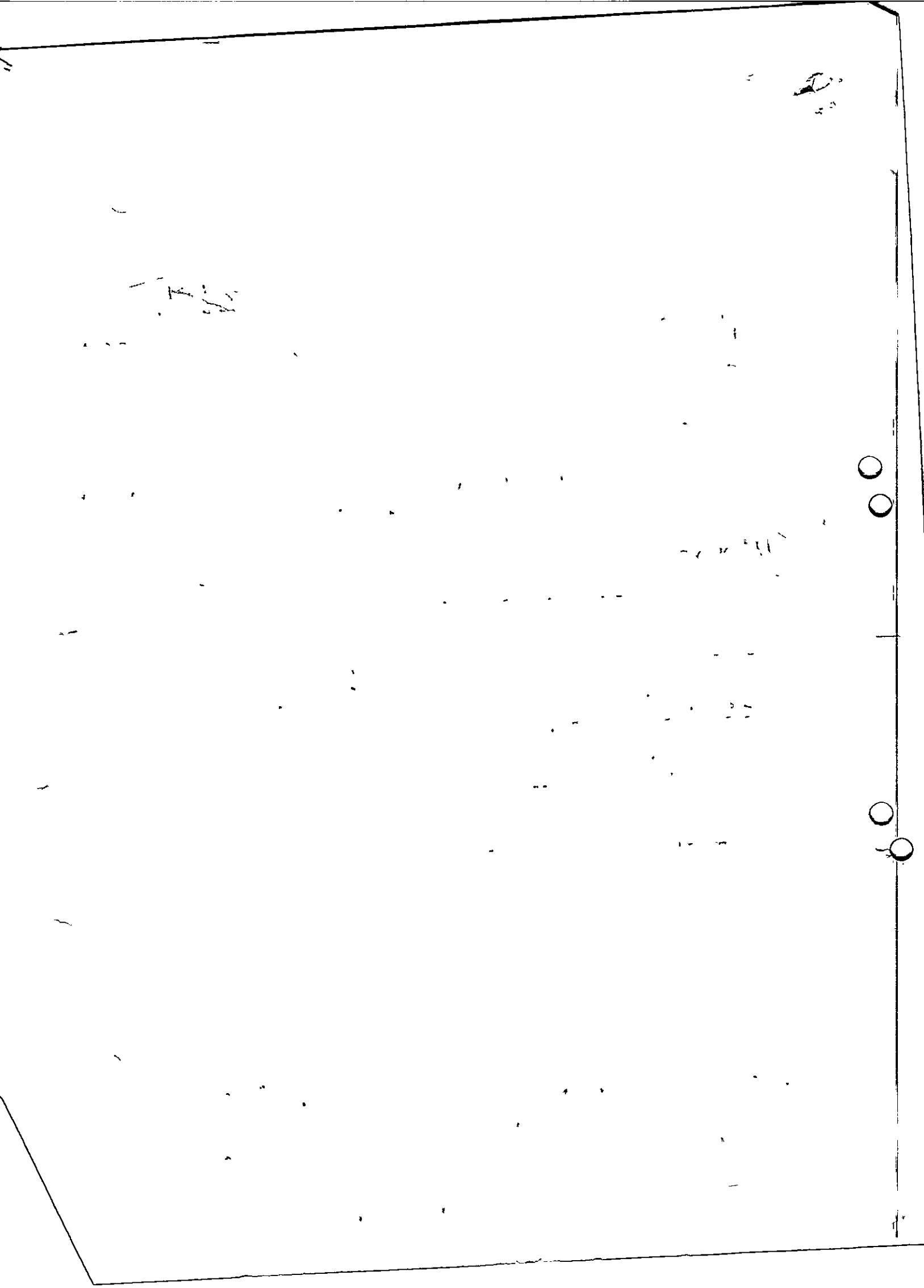
Special Equipment: ☐ Laparoscopy ☐ Bronchoscope ☐ Harmonic ☐ Morcelator  
☐ C-ARM ☐ Cystoscopy ☐ Versa Point ☐ Liver Cusa  
☐ Neuro Cusa ☐ Others .....

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 26-0000208-709

Order by: Sandhya 27/6/26 @ 3:40  
(or record saved)







myomechomy + hysterectomy

# CONSUMABLES OF OT

Circulating staff : Sr. Sushada Technician : Sr. Bellari Date : 27/6/26 Time : 1:30 PM

| Anaesthesia Disposables            | Qty    |      | Surgical Disposables            | Qty    |      | Disposables (Baby Side) | Qty    |      |
|------------------------------------|--------|------|---------------------------------|--------|------|-------------------------|--------|------|
|                                    | Issued | Used |                                 | Issued | Used |                         | Issued | Used |
| ET tube                            |        |      | Major Pack                      |        | 01   | Inj Vit.K               |        |      |
| LMA                                |        |      | Sutures <u>Q347</u>             | 02     | 01   | Cord Clamp              |        |      |
| ECG leads : A / P / N              |        | 03   | 3348                            | 01     |      | Suction Catheter        |        |      |
| HME filter : A / P / N             |        |      |                                 |        |      | Feeding Tube            |        |      |
| Syringes : 10 cc                   |        | 05   | <del>Pracimide</del>            | 01     |      | Vaccum Suction Set      |        |      |
| 05 cc                              |        | 04   | Gloves <u>S.46 1/2, #2</u>      | 01     |      | Surgical Gloves         |        |      |
| 02 cc                              |        | 08   | Glove <u>6 1/2</u>              | 01     |      | Gauze Pack              |        |      |
| 01 cc                              |        |      |                                 |        |      | Syringe 1ml / 2ml       |        |      |
| Cautery plate : A / P / N          |        | 01   | Surgical blade <u>22</u>        | 01     |      | Surgical Blade # 20     |        |      |
| IV set                             |        | 02   | NG tube                         |        |      | Koochies (S)            |        |      |
| RL                                 |        | 02   | Cautery pencil                  |        | 01   |                         |        |      |
| NS : 10ml / 100ml / 500ml / 1000ml |        | 03   | Koochies                        |        |      |                         |        |      |
| <u>Lox with adrenaline</u>         |        | 01   | Ointments                       |        |      |                         |        |      |
| <u>3 way 10 cm</u>                 |        | 02   | Suction Catheter                |        |      |                         |        |      |
| Fentanyl                           |        | 02   | Cap, Mask                       | 10     | 10   |                         |        |      |
| Morphine                           |        |      | Gauze Pack <u>10cm</u>          | 2      | 2    |                         |        |      |
| Ketamine <u>Darapal</u>            |        | 01   | Mop Pack                        | 2      | 2    |                         |        |      |
| Propofol                           |        |      | Steristrip                      |        |      |                         |        |      |
| Rocuronium                         |        |      | Underpad                        |        | 2    |                         |        |      |
| Glycopyrolate                      |        |      | Draw sheet                      |        |      |                         |        |      |
| Myopyrolate                        |        |      | Abgel                           |        | 01   |                         |        |      |
| Ondansetron                        |        | 01   | Foleys catheter <u>16F</u>      | 01     | 01   |                         |        |      |
| Pencan 25g/ Spinal Needle 22       |        |      | Urobag                          | 01     | 01   |                         |        |      |
| Bupivacaine 0.25%                  |        |      | Chest Drainage Catheter         |        |      |                         |        |      |
| Bupivacaine 0.25%(Heavy)           |        | 01   | Romodrain bag                   |        |      |                         |        |      |
| Antibiotics                        |        |      | Bandage <u>Lox jelly</u>        | 01     | 01   |                         |        |      |
| <u>O2 mask [A]</u>                 |        | 01   | Tegaderm                        |        |      |                         |        |      |
| Suppositories                      |        |      | Ioban                           |        |      |                         |        |      |
| Anamol : 80mg / 250mg / 170 mg     |        |      | Double J Stent                  |        |      |                         |        |      |
| Supridol : 100mg                   |        |      | Vaccum Suction set              |        | 01   |                         |        |      |
| Justin : 12.5 mg / 25mg / 100mg    |        | 01   | Plastic Bed Sheet <u>oprens</u> |        | 03   |                         |        |      |
| Tab. Misoprost : 200mg             |        |      | Betadine Solution               |        | 01   |                         |        |      |
| <u>Artrial cannula 20G</u>         |        | 01   | Microshield                     |        | 01   |                         |        |      |
| <u>Esprocin kit</u>                |        | 01   | Cotton Balls                    |        | 01   |                         |        |      |
| <u>Enclor 6.5</u>                  |        | 01   | Latex Gloves                    |        | 20   |                         |        |      |
| <u>Tegaderm with pack</u>          |        | 01   | Ramdione Scrub                  |        |      | <u>PMO Line 200</u>     |        | 01   |
| <u>gauze 7.5 x 7.5</u>             |        | 09   | Saral                           |        |      | <u>Dextromed</u>        |        | 01   |

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. 26-0000208721/8720

Ordered by : Sandhya 27/06/26 @ 4pm

Doc. No. : RCH / FRM / GENERAL / 125



### ELECTRONIC MEDICINE PRESCRIPTION

MRN: BAH-00559150 Name: Mrs M DEEPTHI ALEKHYA  
Age / Sex: 36 Y 5 M 20 D / Female Doctor: RAJANI KUMARI  
Adm/Reg Date/Time: 27/06/2026 08:06 Payor: STATE BANK OF INDIA  
Order Date: 27/06/2026 16:09 Ordernumber: 26-0000208720  
Visit ID: IP26-00006664 Ward/Bed No: 4F -OT / PDA-413  
Patient Address: H NO. 14,RAILVIHAR COLONY, Cherlapally, Hyderabad, Telangana, INDIA, 500051

| S.No | Description                              | Generic Name                           | Dosage           | Route / Frequency     | Duration | Instruction | Qty      | Status    |
|------|------------------------------------------|----------------------------------------|------------------|-----------------------|----------|-------------|----------|-----------|
| 1    | DISPOSABLE APRONS STERILE XL             | DISPOSABLE APRON STERILE XL            | 1 Nos            | / Once Daily          | 3 Days   |             | 3 Nos    | Dispensed |
| 2    | ONDOKIND INJ 4 MG 2 ML                   |                                        | 1 Nos            | / Once Daily          | 1 Days   |             | 1 Vial   | Dispensed |
| 3    | LOX WITH ADRENALINE INJ 2 % 30 ML        |                                        | 1 Vial           | External / Once Daily | 1 Days   |             | 1 Vial   | Dispensed |
| 4    | NS IV 10 ML AMPULE                       |                                        | 1 Bottle         | External / Once Daily | 1 Days   |             | 3 Bottle | Dispensed |
| 5    | DSYRINGE 10ML (NIPRO)                    | SYRINGE 10ML                           | 1 Nos            | External / Once Daily | 1 Days   |             | 5 Nos    | Dispensed |
| 6    | POVINANZ SOLUTION 10% 100 ML             |                                        | 1 Nos            | / Once Daily          | 1 Days   |             | 1 Nos    | Dispensed |
| 7    | MOPS 30X30 8PLY 5S X-RAY                 | MOPS 30X30S PLYDATT                    | 1 Nos            | / Once Daily          | 2 Days   |             | 2 Nos    | Dispensed |
| 8    | JUSTIN SUPPOSITORIES 100 MG 5 S          |                                        | 1 Nos            | External / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |
| 9    | GAUZE PACK STERILE 10X10X12 PLY 5S       | GAUZE PACK STERILE 10X10X12 PLY 5 PACK | 1 Nos            | External / Once Daily | 1 Days   |             | 2 Nos    | Dispensed |
| 10   | Encore Microptic gloves-6.5              |                                        | 1 Nos            | / Once Daily          | 1 Days   |             | 2 Nos    | Dispensed |
| 11   | ESPOCAN CSE KIT 18 G                     | ESPOCAN CSE KIT 18 G                   | 1 Nos            | External / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |
| 12   | VEN-O-LINE 10CM ROMSONS                  |                                        | 1 Nos            | / Once Daily          | 1 Days   |             | 2 Nos    | Dispensed |
| 13   | THEMUCANE 30GM JELLY                     |                                        | 1 On Application | / Once Daily          | 1 Days   |             | 1 Nos    | Dispensed |
| 14   | ABGEL SURGI PAD (BIG) (GELSPON)          | ABGEL                                  | 1 Nos            | / Once Daily          | 1 Days   |             | 1 Nos    | Dispensed |
| 15   | DSYRINGS 2.5ML(NIPRO)                    | SYRINGE 2ML                            | 1 Nos            | External / Once Daily | 1 Days   |             | 6 Nos    | Dispensed |
| 16   | GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY    | GAUZE 7.5X7.5 12 PLY 5 NOS             | 1 Nos            | External / Once Daily | 1 Days   |             | 2 Nos    | Dispensed |
| 17   | ARTERIAL CANNULA 20G                     | ARTERIAL CANNULAL 20G                  | 1 Nos            | External / 10 AM      | 1 Days   |             | 1 Nos    | Dispensed |
| 18   | SURGICAL BLADE 22                        | SURGICAL BLADE 22                      | 1 Nos            | External / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |
| 19   | E C G ELECTRODES (ADULT)                 | ELECTRODES ADULT                       | 1 Nos            | External / Once Daily | 1 Days   |             | 3 Nos    | Dispensed |
| 20   | CAUTERY PENCIL (ADVANCE)                 |                                        | 1 Nos            | External / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |
| 21   | NITRILE EXAMINATION GLOVES P P F-MEDIUM  |                                        | 1 Nos            | External / Once Daily | 1 Days   |             | 20 Nos   | Dispensed |
| 22   | RUPICAIN HEAVY 80MG 8ML 4ML              |                                        | 1 Nos            | / Once Daily          | 1 Days   |             | 1 Nos    | Dispensed |
| 23   | UNDER PAD 60X90 10's Pack -MEDICUBE      |                                        | 1 Nos            | External / 10 AM      | 1 Days   |             | 2 Nos    | Dispensed |
| 24   | VICRYL PLUS 1 VP - (2347)                | VICRYL PLUS 1 VP 2347                  | 1 Nos            | External / Once Daily | 2 Days   |             | 2 Nos    | Dispensed |
| 25   | DSYRINGE 5ML(NIPRO)                      | SYRINGE 5ML                            | 1 Nos            | External / Once Daily | 1 Days   |             | 4 Nos    | Dispensed |
| 26   | VACCUME SUCTION SET                      |                                        | 1 Nos            | External / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |
| 27   | NS 500ML CLOSED BOTTLE                   |                                        | 1 Bottle         | External / Once Daily | 1 Days   |             | 1 Bottle | Dispensed |
| 28   | UROBAG (ADULT) - URODYNE                 |                                        | 1 Nos            | External / 10 AM      | 1 Days   |             | 1 Nos    | Dispensed |
| 29   | TEGADERM WITH PAD SKYCMS (3542X8562)     | TEGADERM WITH PAD                      | 1 Nos            | External / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |
| 30   | ETHILON 1 NW 3348                        | ETHILON 1 NW 3348                      | 1 Nos            | / Once Daily          | 1 Days   |             | 1 Nos    | Dispensed |
| 31   | COTTON BALLS 2 CM 5 NOS                  |                                        | 1 Nos            | External / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |
| 32   | HIGH PRESSURE EXTENTION 200 CM PRYMAX    |                                        | 1 Nos            | / Once Daily          | 1 Days   |             | 1 Nos    | Dispensed |
| 33   | BACTOPREP SOLUTIONS 100 ML               |                                        | 1 ml.            | / Once Daily          | 1 Days   |             | 1 Nos    | Dispensed |
| 34   | SGLOVE # 7.5 (SURGICARE)                 | SURGICAL GLOVES 7.5                    | 1 Nos            | External / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |
| 35   | FOLEY'S CATHETER 18FR POLYMED            |                                        | 1 Nos            | / Once Daily          | 1 Days   |             | 1 Nos    | Dispensed |
| 36   | RL 500 ML CLOSED SYSTEM                  | RINGER LACTATE 500ML CLOSED            | 1 Bottle         | / Once Daily          | 2 Days   |             | 2 Bottle | Dispensed |
| 37   | PHYGELLED SURGICAL PLATES(ADULT)         | PHYGELLED PLATED ADULT                 | 1 Nos            | External / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |
| 38   | BCV-2NTRAFIX SAFESET                     |                                        | 1 Nos            | / Once Daily          | 2 Days   |             | 2 Nos    | Dispensed |
| 39   | SGLOVE # R.5 (SURGICARE)                 | SURGICAL GLOVES 6.5                    | 1 Nos            | External / Once Daily | 1 Days   |             | 3 Nos    | Dispensed |
| 40   | Oxygenmask With Tubing + Aqua ROMSONS-FC |                                        | 1 Nos            | External / Once Daily | 1 Days   |             | 1 Nos    | Dispensed |

RAJANI KUMARI

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 : BAH-00559150 Name : Mrs M DEEPTHI ALEKHYA  
Age / Sex : 36 Y 5 M 20 D / Female Doctor : RAJANI KUMARI  
Adm/Reg Date/Time : 27/06/2026 08:06 Payor : STATE BANK OF INDIA  
Order Date : 27/06/2026 16:09 Ordernumber : 26-0000208721  
Visit ID : IP26-00006664 Ward/Bed No : 4F -OT / PDA-413  
Patient Address : H NO. 14,RAILVIHAR COLONY, Cherlapally, Hyderabad, Telangana, INDIA, 500051

| S.No | Description                       | Generic Name      | Dosage | Route / Frequency     | Duration | Instruction | Qty    | Status    |
|------|-----------------------------------|-------------------|--------|-----------------------|----------|-------------|--------|-----------|
| 1    | FACE MASK 3 LAYER - ELASTIC       | FACE MASK 3 LAYER | 1 Nos  | External / Once Daily | 1 Days   |             | 10 Nos | Dispensed |
| 2    | MAJOR PACK (PROTECTCARE)          |                   | 1 Nos  | / 10 AM               | 1 Days   |             | 1 Nos  | Dispensed |
| 3    | SURGEON CAP(FEMALE) (PROTECTCARE) |                   | 1 Nos  | External / Once Daily | 1 Days   |             | 10 Nos | Dispensed |

**RAJANI KUMARI**

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\* Do not refill medicines.

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|                        |                                                                             |                       |                       |
|------------------------|-----------------------------------------------------------------------------|-----------------------|-----------------------|
| <b>Name</b>            | Mrs M DEEPTHI ALEKHYA                                                       | <b>UHID</b>           | BAH-00559150          |
| <b>Father/Guardian</b> | Mr MR P ABHIRAM                                                             | <b>Age/Gender</b>     | 36 Y 5 M 20 D/ Female |
| <b>Address</b>         | H NO. 14,RAILVIHAR COLONY, Cherlapally, Hyderabad, Telangana, INDIA, 500051 |                       |                       |
| <b>IP No</b>           | IP26-00006664                                                               | <b>Admission Date</b> | 27-06-2026            |
| <b>Ref Doctor</b>      | Self.                                                                       |                       |                       |
| <b>Discharge Date</b>  | 30.06.2026                                                                  |                       |                       |

### DISCHARGE SUMMARY

#### **Consultant:**

Dr. RAJANI KUMARI  
MD (OBS & GYN)

#### **Diagnosis: MASS PER ABDOMEN WITH MULTIPLE UTERINE FIBROIDS**

#### **EXPLORATORY LAPAROTOMY + RADICAL HYSTERECTOMY + BILATERAL SALPINGO-OOPHORECTOMY + BILATERAL PELVIC NODE EXPLORATION DONE ON 27.06.2026**

**History:** She was diagnosed with fibroid uterus during pregnancy, followup done. There was increase in size and number of fibroids and she was planned for Myomectomy/ Hysterectomy. USG (14.06.2026) done showed Uterus AV, Bulky m/s 119\*119\*76 mm with multiple fibroids, largest m/s 72\*60 mm causing mass effect over the endometrium and replacing the normal myometrial echotexture, ET 8 MM, Heterogenous solid cystic abdomino pelvic lesion noted. MRI Pelvis showed bulky uterus with multiple fibroids, largest pedunculated subserosal fibroid with cystic degeneration and intraabdominal



|       |                       |                |              |
|-------|-----------------------|----------------|--------------|
| Name  | Mrs M DEEPTHI ALEKHYA | UHID           | BAH-00559150 |
| IP No | IP26-00006664         | Admission Date | 27-06-2026   |

extension displacing the bowel loops, pelvic congestion noted. She was Admitted for Myomectomy/ Hysterectomy + Bilateral Salpingo-oophorectomy.

**Menstrual History:-**

LMP- 01.06.2026

Previous cycles: Regular, Normal flow

**Obstetric History:** P1L1, LSCS -2023

**Medical History:** Hypothyroid since 2023 (on Thyronorm 88 mcg OD); HTN since 2023 (on T.Metoprolol 50mg+Amlodipine 5mg BD);

**Surgical History:** LSCS - 2023

**Allergies:** Nil

**Family History:** Mother-HTN+DM, Father -expired (MI)

**Investigations:** Enclosed.

Blood group: "A" Positive

**Surgery Notes:** EXPLORATORY LAPAROTOMY + RADICAL HYSTERECTOMY + BILATERAL SALPINGO-OOPHORECTOMY + BILATERAL PELVIC NODE EXPLORATION UNDER COMBINED SPINAL EPIDURAL ANAESTHESIA

**Indication:** Multiple fibroid uterus - largest measuring 25\*20cm ?uterine sarcoma / ?degenerative fibroid uterus.

**Operative findings:-**

1. Multiple uterine fibroid -largest measuring 25\*20 cm, fundal with degeneration.
2. Bilateral ovaries - polycystic

|              |                       |                       |              |
|--------------|-----------------------|-----------------------|--------------|
| <b>Name</b>  | Mrs M DEEPTHI ALEKHYA | <b>UHID</b>           | BAH-00559150 |
| <b>IP No</b> | IP26-00006664         | <b>Admission Date</b> | 27-06-2026   |

3. No enlarged pelvic nodes.

#### Procedure:

- Pfannenstiel incision taken.
- Abdomen opened in layers.
- Abnormal findings noted, Gross Ascites noted
- Radical Hysterectomy done.
- Bilateral salpingo-oophorectomy done.
- Bilateral pelvic node exploration done.
- Hemostasis secured.
- Wound closed in layers.
- Postoperative period was uneventful.

**Post-Operative Notes:** She was closely monitored in the postoperative period. Her vital signs remained stable. She received 2 units of PRBC transfusion in the immediate postoperative period. Repeat Hb on 2nd postoperative day was --- She was encouraged to ambulate and void spontaneously. She was shifted to room. Her general condition was satisfactory and she was found to be fit for discharge. Medications were explained to the patient supplemented by written information.

#### Advice:

1. Tab. Ceftum 500mg (Cefuraxime axetil 500 mg) twice daily till 04.07.2026 (9am - 9pm) after food.
2. Tab. **Metronidazole??**
3. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 02.07.2026 (7am-3pm-10pm) after food.
4. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 02.07.2026 (10am-4pm-10pm) after food.

|       |                       |                |              |
|-------|-----------------------|----------------|--------------|
| Name  | Mrs M DEEPTHI ALEKHYA | UHID           | BAH-00559150 |
| IP No | IP26-00006664         | Admission Date | 27-06-2026   |

5. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 04.07.2026
6. Tab. Zincovit once daily (2pm) for 1 month after food.
7. Injection Clexane 40 units once daily at 10 am subcutaneously till 07.07.2026.
8. Collect HPE report
9. Continue previous medication as advised

Review with Dr. RAJANI KUMARI on MONDAY --- at Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

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

Patient/ Attender

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

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

**Consultant:**

Dr. RAJANI KUMARI  
MD (OBS & GYN)



## ADMISSION SHEET

### Registration Details :



**Admission No** : IP26-00006664      **Admit Date** : 27-Jun-2026      **Admit Time** : 08:06 AM      **UHID** : BAH-00559150

### Patient Details :

|                     |                                                                             |                       |                          |
|---------------------|-----------------------------------------------------------------------------|-----------------------|--------------------------|
| <b>Patient Name</b> | : Mrs M DEEPTHI ALEKHYA                                                     | <b>Age</b>            | : 36 Y 5 M 20 D          |
| <b>Guardian</b>     | : Mr MR P ABHIRAM                                                           | <b>DOB</b>            | : 07-01-1990             |
| <b>Gender</b>       | : Female                                                                    | <b>Religion</b>       | : Hindu                  |
| <b>Occupation</b>   | :                                                                           | <b>Martial Status</b> | : Married                |
| <b>Address (H)</b>  | : H NO. 14,RAILVIHAR COLONY Cherlapally<br>Hyderabad Telangana INDIA 500051 | <b>Phone No</b>       | : 8886222248/ 9885278603 |
|                     |                                                                             | <b>E-mail</b>         | : NOMAIL@GMAIL.COM       |

### Admission Details :

**Bed Type** : TWIN SHARING      **Bed No** : PDA-413      **Ward Name** : 4F -OT  
**Room No** : PDA-413      **Admission Type** : First Visit

### Contact Details :

**Name** : Mr MR P ABHIRAM      **Relationship** : Husband  
**Contact Address** : H NO. 14,RAILVIHAR COLONY Cherlapally  
Hyderabad Telangana INDIA 500051      **Phone No** : 8886222248

  
Signature

### Doctor Details :

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

### Payment Details :

**Deposit Amount** : 0.00  
**Payment Mode** : Cash      **Payor Name** : STATE BANK OF INDIA



## ACTIVITY RECORD FOR BILLING

Name : \_\_\_\_\_  
 UHID No. : \_\_\_\_\_  
 Date of Admission: \_\_\_\_\_ Time: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_ Time: \_\_\_\_\_  
 Room / Bed No: \_\_\_\_\_ Ward: \_\_\_\_\_ Suggested Billable bed type: \_\_\_\_\_

BAH-00559150 IP26-00006664  
 Mrs M DEEPTHI ALEKHYA  
 07-01-1990 36 Y 5 M 20 D (F)  
 Dr. RAJANI KUMARI



sultant: \_\_\_\_\_ Dept: \_\_\_\_\_

## WARD TRANSFERS

| Date    | Time     | From     | To       | Signature of Nurse |
|---------|----------|----------|----------|--------------------|
| 27/6/20 | 11:10 Am | MCIU     | DT       | Mounika/Kumar      |
| 27/6/20 | 12:40 pm | OT       | Pre-Post | Natasha / Sujatha  |
| 29/6    | 3 pm     | pregpost | (317)    | Sujatha            |
|         |          |          |          |                    |

## Cross Consultation Visit

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



## INVESTIGATIONS

[illegible]

### MEDICAL EQUIPMENT (WARD & ICU)

| Date | Name of Equipment | Connecting Time | Disconnecting Time | Order No. | Signature                               |
|------|-------------------|-----------------|--------------------|-----------|-----------------------------------------|
| 27/6 | Infusion pump     | 12:40pm         | 29/6/26<br>1pm     | 208684    | Suyatha                                 |
| 27/6 | CoOdia monitor    | 12:40pm         | 1pm                |           |                                         |
| 27/6 | Epidermal pump    | 2:00pm          | 12:30pm<br>28/6/26 | 8746      |                                         |
|      |                   |                 |                    |           | checked by<br>Suyatha<br>29/6/26<br>2pm |

# PROCEDURE

| Date    | Procedure         | Quantity | Order No. | Signature |
|---------|-------------------|----------|-----------|-----------|
| 27/6    | IV placement      | ①        | 208629    | Li        |
| 27/6    | PAC (op)          | ①        | 217014    | Li        |
| 27/6    | catheterization   | ①        | 8416      | Li        |
| 27/6    | blood Transfusion | ①        | 208683    | Li        |
| 28/6/26 | Blood Transfusion | ①        | 8980      | Ali       |
|         |                   |          |           |           |
|         |                   |          |           |           |
|         |                   |          |           |           |
|         |                   |          |           |           |
|         |                   |          |           |           |
|         |                   |          |           |           |
| 29/6/26 | NHA               | ①        | 9336      | 2 PM      |
| 30/6/26 | IV placement      | ①        | 9407      | Li        |

cross checked  
by surintha  
29/6/26 @

2 PM

cross checked  
done

## ANY OTHER INFORMATION

Date :

Time :

Prepared By :

Staff Nurse

Shift / Ward

Billing Assistant

Billing Supervisor





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## OPERATION THEATER NOTES

BAH-00559150 IP26-00006664

Mrs M DEEPTHI ALEKHIA

07-01-1990 36 Y 5 M 20 D (F)

Dr. RAJANI KUMARI



Patient's Name

Age : Gender :

UHID : .

.P.No. : Weight :

Surgeon :

Asst. Surgeon :

Anesthetist :

OT Nurse :

Surgical Procedure : Exploratory Laparotomy + Radical Hysterectomy +  
Bilateral Salpingoophorectomy + Bilateral Pelvic node <sup>Exploration</sup>.

Indications for Surgery : (1) Multiple Fibroid Uteri - Largest of size 25x20cm -  
(2) ~~No~~ Enlarged Pelvic nodes. ? Uterine sarcoma/  
(3) few Cyst both ovaries. ? Degenerate Fibroid Uteri

Date : 27/6/20

Start Time : 11:30 AM

End Time : 12:30 PM

PRE-OPERATIVE PREPARATION :

OPERATION NOTES:

Findings

\* Multiple Uterine Fibroid - Largest Fibroid of size 25x20cm - fundus with  
Degeneration

\* Polycystic ovaries - Bilateral.

\* No Enlarged Pelvic nodes.

- I/Cr - Fat to be opened, cleaned and dried.

- Fannestiel incision taken.

- Abdomen found in Lys.

- Abdomen found noted. Ascitic fluid noted - (Gross ascites)

- Radical Hysterectomy done.

- Bilateral Salpingoophorectomy done.

- Bilateral Pelvic node Exploration done - Haemostasis achieved.

- Dense ~~large~~ noted closed in Lys

POST - OPERATIVE ORDERS :

- ① NBM for 48 hrs.
- ② Inf <sup>PONTS</sup> ~~RL~~ } alternating @ 8ml/hr
- ③ Ix. <sup>maxipen 150</sup> ~~clonidine~~ 14 BD
- ④ Ix. Metoprolol 100ml 14 TID
- ⑤ Ix. Pantop 40mg 14 TID
- ⑥ Ix. Paracetamol 100ml 14 TID
- ⑦ Ix. Tramadol 100mg 14 BD/SS.
- ⑧ Ix. Enxet 100mg 14 SS.
- ⑨ Early Ambulation.

Consultant Surgeon's Name

Dr. P. P. / Dr. K. C. K. K.

Consultant Surgeon's Signature

Date : ..... Time : .....



# SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Girish/Dr. Rajan  
Asst. Surgeon : Dr. Samir  
Anaesthetist : Dr. Subhela  
Scrub Nurse : Dr. Subhela

BAH-00559150 IP26-00006664  
Mrs M DEEPTHI ALEKHYA  
07-01-1990 36 Y 5 M 20 D (F)  
Dr. RAJANI KUMARI



Date : 27/06/26 In-time : 11:30 AM Out-time : 12:30 PM

Age : 36 Y Gender : F  
Surgery Name : Myomectomy + Hysterectomy



## Before Induction of Anaesthesia >>

| SIGN IN                                                                  |                                                                                                 | Time: <u>11:20 AM</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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| <b>Anaesthesia Safety Check Completed</b>                                | <input checked="" 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |                       |
| <b>Risk of &gt; 500ml Blood Loss (7ml/kg In Children)?</b>               |                                                                                                 |                       |
| Yes, and Adequate Intravenous Access and Fluids Planned                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| Blood Units Reserved                                                     | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| <b>Has Antibiotic Prophylaxis been given within the last 60 minutes?</b> |                                                                                                 |                       |
|                                                                          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| Signature : <u>Dr. Subhela</u>                                           |                                                                                                 |                       |
| Name : <u>Dr. Subhela</u>                                                |                                                                                                 |                       |

## Before Skin Incision >>

| TIME OUT                                                                                                                                                              |                                                                     | Time: <u>11:28 AM</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 <u>Abd</u>                                                                                                                                               | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                       |
| Correct Procedure <u>Open myomectomy</u>                                                                                                                              | <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? <u>Bleeding + Intra. Hydration</u>                                             |                                                                     |                       |
| <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA                                                                       |                                                                     |                       |
| <b>Anaesthesia Team Reviews:</b>                                                                                                                                      |                                                                     |                       |
| Are There Any Patient-specific Concerns? <input type="checkbox"/> Yes <input 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? <u>Int. Cefotaxime 1gm @ 11 AM 20 PRBC @ 500ml blood bank</u> |                                                                     |                       |
| <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA                                                                       |                                                                     |                       |
| <b>Is Essential Imaging Displayed?</b>                                                                                                                                |                                                                     |                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA                                                                                  |                                                                     |                       |
| Signature : <u>Dr. Subhela</u>                                                                                                                                        |                                                                     |                       |
| Name : <u>Dr. Subhela 27/6/26 @ 11:45 AM</u>                                                                                                                          |                                                                     |                       |

## Before Patient Leaves Operating Room

| SIGN OUT                                                                                                                                   |                                                                                                 | Time: <u>11:30 AM</u> |
|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------|
| <b>Nurse Verbally Confirms with the Team:</b>                                                                                              |                                                                                                 |                       |
| The Name of the Procedure Recorded                                                                                                         | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                             |                       |
| That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)                                                                  | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| The Specimen is Labelled (including patient name)                                                                                          | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA |                       |
| Whether there are any Equipment Problems to be addressed                                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA |                       |
| <b>To Surgeon, Anaesthetist and Nurse:</b>                                                                                                 |                                                                                                 |                       |
| What are the key concerns for recovery and management of this patient? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                 |                       |
| Signature : <u>Dr. Subhela</u>                                                                                                             |                                                                                                 |                       |
| Name : <u>Dr. Subhela</u>                                                                                                                  |                                                                                                 |                       |





## FOR GYNECOLOGY

Date of Admission : 27/06/2026 Time of Admission : .....

Allergies: Nil ☒ Not know any drug allergies

### PRESENTING COMPLAINTS :

Diagnosed Fibroid ut C Pregnancy (2023)  
Fup done → plan removed (↑ size 7no) Abdominal extension

Kcllo Fibroid uterus 2023: 2D Echo (N)

USG (Abd & Pelvis) (14/6/2023) - GB Rlyp ⊕ (4.3mm)

Multiple Fibroid - (156x103mm ← largest) ; Bulky ut (119x119x76mm)

MRI (Pelvis & Abdomen) (19/6/2023) → Bulky ut (12.8x9.4x11.9cm)

Entire ut replaced by multiple intramural, subserosal, submucosal fibroids, (23x16x13cm) - Subserosally & Peduncle arising from Lt lat fundus  
Rest fibroid (6-9 no.) ~ 7-8cm each & cystic degeneration in few (Figs - 11-12)  
Endometrial cavity distorted by fibroids (9mm); Pelvic congestion

### MENSTRUAL HISTORY

Year of Marriage : 2022 Aug

Previous Periods : RNF

LMP : 1/6/2026

Contraception : Nil

### OBSTETRIC HISTORY

Parity : P<sub>1</sub>L<sub>1</sub>

Mode of Delivery : LSCS - Feb (2.4kg)

Last Child Birth : 2 1/2 year  
Aug (2023)

### PAST MEDICAL HISTORY

Kcllo hypothyroidism (88mg)

E. HTN : 2023

7. Protonet Am 50/5 BID

### PAST SURGICAL HISTORY

LSCS (2023)



**MEDICATION HISTORY:**

Father - exposed (Heart Attack)  
 Mother - HTN / DM

T. Thyronaem. 88 mcg. - OD Ac  
 T. Prolomet Am 50/5 - BD  
 (metoprolol + Amlodipine)

**INITIAL ASSESSMENT :**

|                                                                                                                                                                                   |                                                                                                                                   |                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| Date <u>27/06/2026</u><br>Ht. _____ Wt. _____<br>BMI _____<br>B.P. _____<br>Pallor _____<br>CVR <u>S/S of normocytosis</u><br>Respiratory System <u>B/L NUBS</u><br>Thyroid _____ | Breasts<br><div style="text-align: center;">②</div><br>Abdominal Examination<br><u>P/A ut ~ 32wks</u><br><u>multiple fibroids</u> | Local/Speculum Examination<br><u>not done</u><br>Bimanual Pelvic Examination<br><u>not done</u> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|

**PROVISIONAL DIAGNOSIS :**

Pit / Pre US / ~~Abd~~ Fibroid uterus <sup>For myomectomy ±</sup>  
Abdominal hysterectomy

**INVESTIGATIONS ORDERED**

**PLAN OF MANAGEMENT**

BGT: A Positive

CBP (19/June/26)

Hb 13.1  
 plt 3.0  
 TLC 8.01  
 PCV 30

HIV  
 HCU  
 VDRL  
 HbsAg } NR.

14/6  
 Haptoc 4.5%  
 Tsn - 3.99

Admission

NBM. 20 PRBC Reserve

Informed Consent

Drugs as charted

Review PAC

Monitor Vitals

Inform SCS

shift to OT on call

Brachytherapy

Name of the Doctor :

Dr. Rajani Kumari

Signature of Doctor \_\_\_\_\_

Date & Time :

27/06/2026 @





IP26-00006664

Mrs M DEEPTHI ALEKHYA  
07-01-1999

07-01-1990

38 Y 5 M 20 D

(F)



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## How

① ongoing ② PRBC





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[illegible]



(2)

## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time               | Progress Notes                                                                                                                                                                                                                                                                                                                                                              | Doctor's Order                                                                                                                                                                                                                                                                                                                                        |
|---------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 27/6/26<br>4:00pm         | <p>cls by Dr. Ayesha (Anaesthesia)</p> <p>Δ: POD-0, slp OPEN MYOMECTOMY + HYSTERECTOMY + BSO for multiple fibroids &amp; cystic degeneration</p> <p>- Epidural catheter in situ</p> <p>o/e pt conscious, coherent</p> <p>afebrile</p> <p>PR: 68/min</p> <p>Bp: 120/76 mmHg</p> <p>Cvs: S1S2+</p> <p>RS: BAE+ clear</p> <p>SpO<sub>2</sub>: 98% on RA</p>                    | <p>10 PRBC transfused, uneventful</p> <p><u>Rx</u></p> <ol style="list-style-type: none"> <li>① IVF - RL @ 100ml/h</li> <li>② NBH till further order.</li> <li>③ Monitor vital, inform snc</li> <li>④ Early Ambulation</li> <li>⑤ To Send CBP, 2FT @ 9:00pm today</li> <li>⑥ Continue same treatment</li> </ol> <p><i>[Signature]</i><br/>27/6/26</p> |
| 27/6/26<br>10:15pm        | <p>cls by Dr. Ayesha (Anaesthesia)</p> <p>Δ: POD-0, slp OPEN MYOMECTOMY + HYSTERECTOMY + BSO for multiple fibroids &amp; cystic degeneration</p> <p>- Epidural infusion ongoing</p> <p>- Arterial Catheter in situ</p> <p>o/e Pt Conscious, Coherent</p> <p>PR: 82/min</p> <p>Bp: 140/89 mmHg</p> <p>Cvs: S1S2+</p> <p>RS: BAE+ clear</p> <p>SpO<sub>2</sub>: 98% on RA</p> | <p><u>Adv</u></p> <ol style="list-style-type: none"> <li>① NBH</li> <li>② IVF @ 100ml/h</li> <li>③ Early Ambulation</li> <li>④ Incentive spirometry</li> <li>⑤ Monitor vitals inform snc</li> </ol> <p><i>[Signature]</i><br/>27/6/26</p>                                                                                                             |
| 10:00pm<br>CBP<br>99mg/dl | <p>CBP</p> <p>Hb 10.5gm%</p> <p>INBC 29.5g/dl</p> <p>PIT 2.5l/h</p> <p>PCV 29.1</p>                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                       |



| Date & Time        | Progress Notes                                                                                                                                  | Doctor's Order                                                                                                                                      |
|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| 6/6/28<br>8pm.     | C/S/B Dr. Dna                                                                                                                                   |                                                                                                                                                     |
|                    | POD-0.                                                                                                                                          |                                                                                                                                                     |
|                    | 10 PRBC transfused Cc fair Afebrile<br>BP: 124/85 mmHg<br>SpO <sub>2</sub> : 99% on RA PR: 69 bpm.<br>P/A Soft<br>BS sluggish (+)<br>U/E - NAB. | <u>Adv</u><br>- NBM till further orders<br>- IVF<br>- Drugs as charted<br>- w/f P.V bleed<br>- I/O charting<br>- Monitor vitals<br>- Inform sos     |
|                    | U/O - clear<br>Adequate.                                                                                                                        |                                                                                                                                                     |
|                    |                                                                                                                                                 |                                                                                                                                                     |
| 28/6/28<br>6:30 AM | C/S/B Dr. Dna                                                                                                                                   |                                                                                                                                                     |
|                    | POD-1                                                                                                                                           |                                                                                                                                                     |
|                    | Cc fair, Afebrile<br>BP: 122/68 mmHg.<br>PR: 70 bpm.<br>SPD <sub>2</sub> : 99% on RA<br>P/A soft<br>BS (+)                                      | <u>Adv</u><br>- NBM till further orders<br>- IVF<br>- Drugs as charted<br>- w/f bleeding P.V.<br>- I/O charting<br>- Monitor vitals<br>- Inform sos |
|                    | 10 PRBC transfused<br>Repeat HB-10.5<br>U/O - clear<br>Good.                                                                                    |                                                                                                                                                     |
|                    |                                                                                                                                                 |                                                                                                                                                     |





3

## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time                             | Progress Notes                                                                       | Doctor's Order               |
|-----------------------------------------|--------------------------------------------------------------------------------------|------------------------------|
| 28/6/26<br>7:30am                       | cls by Dr. Ayesha (Anaesthesia)<br>POD-1, sp OPEN MYOMECTOMY + HYSTERECTOMY + BSO    |                              |
|                                         | - Epidural catheter in situ, infusion ongoing @ 7ml/h<br>- Arterial Catheter in situ | Adv                          |
|                                         | Pt conscious, coherent                                                               | ① NBN                        |
|                                         | PR: 8/min                                                                            | ② IVF @ 100ml/h              |
|                                         | Bp: 110/81mmHg                                                                       | ③ Early Ambulation           |
|                                         | CVS: S1S2 (+)                                                                        | ④ Incentive Spirometry       |
|                                         | RS: BA (+), clear                                                                    | ⑤ I/O charting               |
|                                         | spo <sub>2</sub> : 98% - 2 RA                                                        | ⑥ Monitor vitals, inform SOS |
| U 1/0 - 4100w<br>2500w                  |                                                                                      |                              |
| CIRBS:<br>103mg/dl                      |                                                                                      |                              |
| Hb 11.6   WBC 16.1   Plt 287   PCV 28.7 |                                                                                      |                              |
| 2FT                                     |                                                                                      |                              |
| TB 1.7   D 1.4   Protein 6.5   Alb 3.6  |                                                                                      |                              |
|                                         | plan: To remove arterial catheter today.                                             |                              |
| 12:40pm                                 | cls by Dr. Samir                                                                     |                              |
|                                         | - plan for intermittent boluses of Epidural drug.                                    |                              |
|                                         | - to transfuse 10PRBC                                                                |                              |
|                                         | - Inj. Ca-Gluconate slow IV.                                                         |                              |
|                                         |                                                                                      | @mm                          |

28/6/26



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes                            | Doctor's Order                 |
|-------------|-------------------------------------------|--------------------------------|
|             | C/S/b Dr Manohar                          |                                |
| 28/6/2018   | POD 1 / Redness + Dysuria                 |                                |
| 11 AM       |                                           | <u>Adv</u>                     |
|             | CC - Fair Afabrele                        |                                |
|             | BP 120/70                                 | - NBM x 48h                    |
|             | PR - 74                                   | - Spirometry                   |
|             | P/A Soft                                  | - Drugs as charted             |
|             | BS (+)                                    | - H/O monitoring               |
|             | L/E NAD                                   | - Ambulation after stopping of |
| ↓ Epidural  | 40-70-80 cel/hr                           | Epidural                       |
| (6 ml/h)    |                                           | - W/F vitals                   |
|             |                                           | - Inform SN                    |
|             |                                           |                                |
|             |                                           |                                |
|             |                                           | <u>My</u><br><u>Manohar</u>    |
| 28/6        | C/S/b Dr Rajani Kumari                    |                                |
| 12 PM       | CC Fair Afabrele                          | <u>Adv</u>                     |
|             | vitals stable                             | - Allow sips of water          |
|             | P/A Soft BS (+)                           | - Acon opinion for BT          |
|             | L/E NAD                                   | - Drugs as charted             |
|             | 40-4 deg                                  | - Ambulation (if comfortable)  |
|             |                                           | - Inform SN                    |
|             |                                           |                                |
|             |                                           | <u>My</u><br><u>Manohar</u>    |
|             | C/O/A Acon (Dr Arkhile) & (Dr. Somir SN)  |                                |
|             | - 2 <sup>nd</sup> Unit Blood transfusion. |                                |
|             |                                           | <u>My</u><br><u>Manohar</u>    |





## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes                       | Doctor's Order                 |
|-------------|--------------------------------------|--------------------------------|
| 28/6/2020   | cls/b 2 months                       |                                |
| 2:30pm      | POD-1                                |                                |
|             | GC-Fair Afebrile                     | 2nd @ PEBC Transfusion started |
|             | BP 124/78                            |                                |
|             | PR 76                                | - Start vital monitoring       |
|             | SpO <sub>2</sub> - 99% on RA         | - Inform Axon                  |
|             | Uo Adeq                              | - Keep Emergency Dry Bedside   |
|             | No Complaint                         | - Inform SWS                   |
|             |                                      | My<br>Bramble                  |
| 28/6/2020   | cls/b 2 months                       |                                |
| 5:40pm      | GC-Fair Afebrile                     | Adu                            |
|             | BP 126/70                            |                                |
|             | PR 70                                | - Only Sips of water Today     |
|             | PIA Soft                             | - Dring as charted             |
|             | L16 NAD                              | - Ambulation                   |
|             | SpO <sub>2</sub> 97% on RA           | - Inform SWS                   |
|             | PT Comfortable                       |                                |
|             | No Complaints                        |                                |
|             | Uo Adeq                              | My<br>Bramble                  |
|             | Blood Transfusion Completed          |                                |
|             | Calcium Gluconate (Axon Adu) to give |                                |





## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time | Progress Notes      | Doctor's Order               |
|-------------|---------------------|------------------------------|
| 28/06/2020  | C/Sib 2 months      |                              |
| 8:30pm      |                     |                              |
|             |                     | <u>Alu</u>                   |
|             | CC For Afebrile     |                              |
|             | Vitals Stable       | - Only sips of water         |
|             | P/A Soft BS ⊕       | - Drops as charted           |
|             | L <sub>12</sub> NAD | - Wt vitals <del>not</del>   |
|             | W/o focalles clear  | - No 'monitory               |
|             | No complaints       | - Infer SS                   |
|             |                     |                              |
|             |                     | <u>Wt</u><br><u>monitory</u> |
|             |                     |                              |
|             |                     |                              |
| 29/6/2020   | C/Sib 2 months      |                              |
| 1pm         |                     |                              |
|             | CC For Afebrile     | - Ambulation                 |
|             | Vitals stable       | - Drops as charted           |
|             | P/A soft BS ⊕       | - 2/0 monitory               |
|             | L <sub>12</sub> NAD | - Sips of water              |
|             | W/o focalles        |                              |
|             |                     | <u>Wt</u><br><u>monitory</u> |
|             |                     |                              |
|             |                     |                              |
|             |                     |                              |
|             |                     |                              |
|             |                     |                              |
|             |                     |                              |
|             |                     |                              |
|             |                     |                              |

BAH-00559150

IP26-00006664

Mrs M DEEPTHI ALEKHYA

07-01-1990

38 Y 5 M 20 D

(F)

Dr. RAJANI KUMARI



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Children's  
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## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time         | Progress Notes              | Doctor's Order            |
|---------------------|-----------------------------|---------------------------|
| 29/6/2020           | C/S/B Dr. Maushe            |                           |
| 1 AM                | POD-2                       |                           |
|                     | AC - Fair Appearance        | Adx                       |
|                     | Vitals stable               | - Sips of water           |
|                     | P/A Soft BS ⊕               | - Ambulation              |
|                     | LE NAD                      | - No monitoring           |
|                     | UO 100 cph                  | - Drags as charted        |
|                     | No complaints               | - Vital monitoring        |
| 2 OPRBS Transferred |                             | - Inform SMO              |
| 29/6/2020           | C/S/B Dr. Veena             | my<br>bromide             |
| 1 PM                | C/S/B Dr. Rajini Kumari     |                           |
|                     | POD-2 / Exp-Lap / TAH + BSO |                           |
|                     | Abx                         |                           |
|                     | Pt is stable, Noct          | - Liquid diet             |
|                     | o/e G Fair, Afebrile        | - Soft diet from 5 PM     |
|                     | Vitals - stable             | - Ted stockings           |
|                     | h/tor ⊕                     | - Dig. Cleare x 7 days    |
|                     | P/A - <del>Soft</del> Soft  | - CBP tomorrow @ 4 PM     |
|                     | BS ⊕                        | - Remove Foley's catheter |
|                     | LE - NAD                    | - Encourage to void       |
|                     | UO - 100 ml/hr, clear       | My                        |
|                     |                             | - Shift to Room           |
|                     |                             | - Inform SMO              |



## PROGRESS NOTES AND DOCTOR'S ORDER

| Date & Time          | Progress Notes                                                                                                                                                                                     | Doctor's Order                                                                                                                                                                                                                                                            |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 29/06/2026<br>8:00pm | <p>U ✓<br/>P ✓<br/>S ✓</p> <p>OLE GC Fan<br/>           Afebrile<br/>           Vitals - stable -<br/>           PA - soft INT<br/>           Dressing: dry &amp; clean<br/>           HE: NAD</p> | <p>cls by Dr. Naveena</p> <p>Adv<br/>           - Soft diet<br/>           - Adequate hydration<br/>           - drugs as charted<br/>           - Ambulation<br/>           - Monitor Vital<br/>           - Inform SOS</p> <p>Noted by Sweetha<br/>           @ 8pm</p> |
| 30/6/2026<br>8:30Am  | <p>Poo - 3</p> <p>GC Fan Afebrile<br/>           BP<br/>           PE</p> <p>U ✓ PA - Soft<br/>           S ✓ HE NAD</p>                                                                           | <p>Adv<br/>           - Soft Diet / Adeq Hydratn<br/>           - Drugs as charted<br/>           - w/ vitals 9:30m<br/>           - Ambulation<br/>           - Monitor vitals<br/>           - Inform SOS</p> <p>My<br/>           tomorrow</p>                         |





Dr. RAJANI KUMARI

[illegible]

BAH-00559150 IP26-00006664  
Mrs M DEEPTHI ALEKHIA  
07-01-1990 38 Y 5 M 20 D (F)  
Dr. RAJANI KUMARI



## DRUG CHART

Date of Admission: 27/6/2024 Drug Allergies: Nil ☒ Not known any Drug Allergies

### FOR THE SAFETY OF THE PATIENT

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

### SOS / PRN (As Required Medication)

| DRUG : INT. ONDANSETRON  |       |              |            | Date<br>Time |
|--------------------------|-------|--------------|------------|--------------|
| Dose                     | Route | Frequency    | Start Date |              |
| 4mg                      | IV    | SOS          | 27/6/26    | 6:00 PM      |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |
| [Signature]              |       | x 3 days     |            |              |
| Additional Instructions: |       |              |            |              |
| [Signature]              |       |              |            |              |

| DRUG : <del>INT</del> T-TRAMADOL |       |              |            | Date<br>Time |
|----------------------------------|-------|--------------|------------|--------------|
| Dose                             | Route | Frequency    | Start Date |              |
| 100mg                            | PO    | SOS          | 27/6/26    |              |
| Doctor's Signature               |       | Valid Period | Pharm.     |              |
| [Signature]                      |       | 3 days       |            |              |
| Additional Instructions:         |       |              |            |              |

| DRUG :                   |       |              |            | Date<br>Time |
|--------------------------|-------|--------------|------------|--------------|
| Dose                     | Route | Frequency    | Start Date |              |
|                          |       |              |            |              |
| Doctor's Signature       |       | Valid Period | Pharm.     |              |
|                          |       |              |            |              |
| Additional Instructions: |       |              |            |              |

VERIFIED BY : Name .....





REGULAR PRESCRIPTIONS

Weight. 59.5 kgs Ward. 20F

|                                                                               |           |           |                |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------------------------------------------------------------------|-----------|-----------|----------------|--------------|-------------|-------------|-------------|-------------|--|--|--|--|--|--|--|--|--|--|--|--|
| DRUG : <u>INS. CEFOTICRAZONE + SULBACTAM</u>                                  |           |           |                | Date<br>Time |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                          | Route     | Frequency | Start Date     |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>1.5gm</u>                                                                  | <u>IV</u> | <u>BD</u> | <u>27/6</u>    |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><u>@ Dr. Naveena</u> |           |           |                |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:<br><u>ATD</u>                                        |           |           |                |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                          |           |           |                |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : <u>INS CEFOTAXIME</u>                                                  |           |           |                | Date<br>Time | <u>27/6</u> |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                          | Route     | Frequency | Start Date     |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>1g</u>                                                                     | <u>IV</u> | <u>BD</u> | <u>27/6</u>    |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><u>Dr. Naveena</u>   |           |           |                |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                      |           |           |                |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                          |           |           |                |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : <u>INS. CEFOTICRAZONE + SULBACTAM</u>                                  |           |           |                | Date<br>Time | <u>27/6</u> | <u>28/6</u> | <u>29/6</u> | <u>30/6</u> |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                          | Route     | Frequency | Start Date     |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>1.5g</u>                                                                   | <u>IV</u> | <u>BD</u> | <u>27/6</u>    |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><u>Dr. Naveena</u>   |           |           |                |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                      |           |           |                |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                          |           |           |                |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| DRUG : <u>INS. PANTAPRAZOLE</u>                                               |           |           |                | Date<br>Time | <u>28/6</u> | <u>29/6</u> | <u>30/6</u> |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose                                                                          | Route     | Frequency | Start Date     |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| <u>40mg</u>                                                                   | <u>IV</u> | <u>OD</u> | <u>28/6/26</u> |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><u>Dr. Naveena</u>   |           |           |                |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                      |           |           |                |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                          |           |           |                |              |             |             |             |             |  |  |  |  |  |  |  |  |  |  |  |  |



Weight 89.8kg Ward LDR





Sheet No: .....

## REGULAR PRESCRIPTIONS

Weight 8.9 kg Ward 202

|                                                                         |             |                  |                      |                                                                                  |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
|-------------------------------------------------------------------------|-------------|------------------|----------------------|----------------------------------------------------------------------------------|---------|------|------|------|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>DRUG : INI METRONIDAZOLE</b>                                         |             |                  |                      | Date<br>Time                                                                     | 27/6    | 28/6 | 29/6 | 30/6 |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>500mg                                                           | Route<br>IV | Frequency<br>TID | Start Dt.<br>27/6    | 7 AM                                                                             | 11 AM   | 2 PM | 5 PM | 8 PM |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><u>Dr. Dna</u> |             |                  |                      | <div>3 PM</div> <div>11 AM</div> <div>2 PM</div> <div>5 PM</div> <div>8 PM</div> |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                |             |                  |                      |                                                                                  |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                    |             |                  |                      | 2 b                                                                              |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG : T. PARACETAMOL</b>                                            |             |                  |                      | Date<br>Time                                                                     | 29/6    | 30/6 |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>1g                                                              | Route<br>PO | Frequency<br>TID | Start Dt.<br>29/6/26 | 6 AM                                                                             | 12 PM   | 6 PM |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><u>Dr. By</u>  |             |                  |                      | <div>2 PM</div> <div>6 PM</div>                                                  |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                |             |                  |                      | <div>1 PM</div>                                                                  |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                    |             |                  |                      |                                                                                  |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG : T. DICLOFENAC</b>                                             |             |                  |                      | Date<br>Time                                                                     | 29/6/26 |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>50mg                                                            | Route<br>PO | Frequency<br>BD  | Start Dt.<br>29/6/26 | 9 AM                                                                             |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:<br><u>Dr. By</u>  |             |                  |                      | <div>9 PM</div>                                                                  |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                |             |                  |                      |                                                                                  |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                    |             |                  |                      |                                                                                  |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>DRUG : T. TRAMADOL</b>                                               |             |                  |                      | Date<br>Time                                                                     |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose<br>100mg                                                           | Route<br>PO | Frequency<br>BD  | Start Dt.            |                                                                                  |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Name & Signature of the Doctor<br>Starting the Drugs:                   |             |                  |                      | <div>STOP</div>                                                                  |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Additional Instructions:                                                |             |                  |                      |                                                                                  |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |
| Daily Doctor's Endorsement by a Sign                                    |             |                  |                      |                                                                                  |         |      |      |      |  |  |  |  |  |  |  |  |  |  |  |  |

Dr. Dhakshayani  
 Signature  
 Dr. Dhakshayani  
 Verified by: Name







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It takes a lot to treat the little.



## REGULAR PRESCRIPTIONS

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

|                                                       |       |           |           |      |
|-------------------------------------------------------|-------|-----------|-----------|------|
| DRUG :                                                |       |           |           | Date |
| Dose                                                  | Route | Frequency | Start Dt. | Time |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           |      |
|                                                       |       |           |           |      |
| Additional Instructions:                              |       |           |           |      |
|                                                       |       |           |           |      |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |      |

|                                                       |       |           |           |      |
|-------------------------------------------------------|-------|-----------|-----------|------|
| DRUG :                                                |       |           |           | Date |
| Dose                                                  | Route | Frequency | Start Dt. | Time |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           |      |
|                                                       |       |           |           |      |
| Additional Instructions:                              |       |           |           |      |
|                                                       |       |           |           |      |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |      |

|                                                       |       |           |           |      |
|-------------------------------------------------------|-------|-----------|-----------|------|
| DRUG :                                                |       |           |           | Date |
| Dose                                                  | Route | Frequency | Start Dt. | Time |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           |      |
|                                                       |       |           |           |      |
| Additional Instructions:                              |       |           |           |      |
|                                                       |       |           |           |      |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |      |

|                                                       |       |           |           |      |
|-------------------------------------------------------|-------|-----------|-----------|------|
| DRUG :                                                |       |           |           | Date |
| Dose                                                  | Route | Frequency | Start Dt. | Time |
| Name & Signature of the Doctor<br>Starting the Drugs: |       |           |           |      |
|                                                       |       |           |           |      |
| Additional Instructions:                              |       |           |           |      |
|                                                       |       |           |           |      |
| Daily Doctor's Endorsement by a Sign                  |       |           |           |      |

BAH-00559150 IP26-00006664

Mrs M DEEPTHI ALEKHYA

07-01-1990

36 Y 5 M 20 D (F)

Dr. RAJANI KUMARI



Weight. 59.8 kg Ward. LDR

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

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

## STAT / ONCE ONLY DRUGS

| Date | Time     | Medication                | Dosage & Other Instructions | Route                  | Signature     | Nurses              |
|------|----------|---------------------------|-----------------------------|------------------------|---------------|---------------------|
| 27/6 | 11 AM    | INS. METACLO-<br>PRIMIDE  | 10mg                        | IV                     | @             | Surathi<br>mounika  |
| 27/6 | 11 AM    | INS. PANTOPRA-<br>ZOLE    | 40mg                        | IV                     | @             | Surathi<br>mounika  |
| 27/6 | 11:35 AM | Inj. ONDANSETRON          | 4mg                         | IV                     | [Signature]   | Sandhya<br>Nataraja |
| 27/6 | 11:40 AM | Inj. TRANEXAMIC<br>ACID   | 1gm                         | IV                     | [Signature]   | Sandhya<br>Nataraja |
| 27/6 | 12:40 AM | DICLOFENAC<br>Suppository | 100mg                       | PR                     | [Signature]   | Sandhya<br>Nataraja |
| 27/6 | 2:00 PM  |                           |                             |                        |               | [Signature]         |
| 28/6 | 6:00 PM  | Inj. CALCIUM<br>GLUCONATE | 1 Amp                       | Slow IV<br>in 100ml NS | @ [Signature] | Sandhya<br>Nataraja |
|      |          |                           |                             |                        |               |                     |
|      |          |                           |                             |                        |               |                     |
|      |          |                           |                             |                        |               |                     |



## I.V. FLUIDS CHART

Weight. .... Ward. 102

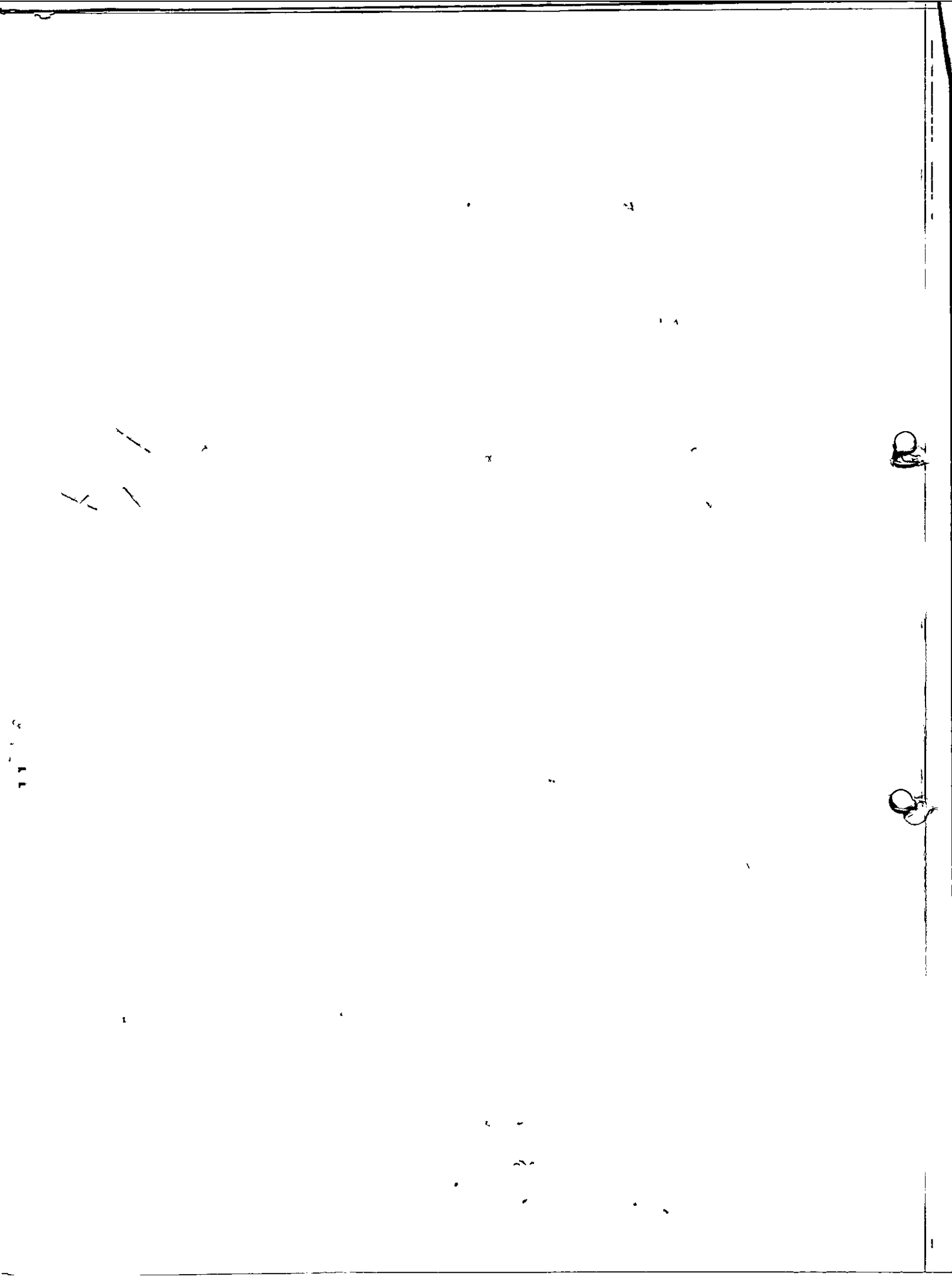
| Date | Time        | Composition of I.V. Fluid<br>(If infusion, mention ml/hr = Mcg/kg/min. etc) | Route | Flow Rate<br>ml/hr | Doctor<br>Sign | Nurse<br>Sign                   | Date of<br>Stopping | Doctor<br>Sign | Nurse<br>Sign                   |
|------|-------------|-----------------------------------------------------------------------------|-------|--------------------|----------------|---------------------------------|---------------------|----------------|---------------------------------|
| 27/6 | 9 AM        | RINGER<br>LACTATE                                                           | IV    | 100<br>ml/hr       | <u>M</u>       | <u>Si</u><br><u>(M)</u>         | 27/6                |                | <u>Si</u><br><u>(M)</u>         |
| 27/6 | 11:30 AM    | RINGER<br>LACTATE                                                           | IV    | 2000<br>ml/hr      | <u>Yshu</u>    | <u>Sandhya</u><br><u>Atasha</u> | 27/6                | <u>Yshu</u>    | <u>Sandhya</u><br><u>Atasha</u> |
| 27/6 | 11:45 AM    | RINGER<br>LACTATE                                                           | IV    | 2000<br>ml/hr      | <u>Yshu</u>    | <u>Sandhya</u><br><u>Atasha</u> | 27/6                | <u>Yshu</u>    | <u>Sandhya</u><br><u>Atasha</u> |
| 27/6 | 12:00 PM    | RINGER<br>LACTATE                                                           | IV    | 2000<br>ml/hr      | <u>Yshu</u>    | <u>Sandhya</u><br><u>Atasha</u> | 27/6                | <u>Yshu</u>    | <u>Sandhya</u><br><u>Atasha</u> |
| 27/6 | 12:30<br>PM | RINGER<br>LACTATE                                                           | IV    | 500<br>ml/hr       | <u>Yshu</u>    | <u>Sandhya</u><br><u>Atasha</u> | 27/6                | <u>Yshu</u>    | <u>Sandhya</u><br><u>Atasha</u> |
| 27/6 | 1:30 PM     | NS<br>NORMAL<br>SALINE                                                      | IV    | 1000<br>ml/hr      | <u>Yshu</u>    | <u>Si</u><br><u>(M)</u>         | 27/6                | <u>Yshu</u>    | <u>Si</u><br><u>(M)</u>         |
| 27/6 | 5:00 PM     | RINGER<br>LACTATE                                                           | IV    | 1000<br>ml/hr      | <u>Yshu</u>    | <u>Si</u><br><u>(M)</u>         | 27/6                | <u>Yshu</u>    | <u>Si</u><br><u>(M)</u>         |
| 27/6 | 10 PM       | RINGER<br>LACTATE                                                           | IV    | 1000<br>ml/hr      | <u>Yshu</u>    | <u>Si</u><br><u>(M)</u>         | 28/6                | <u>Yshu</u>    | <u>Si</u><br><u>(M)</u>         |
| 28/6 | 1 AM        | RINGER<br>LACTATE                                                           | IV    | 100<br>ml/hr       | <u>Yshu</u>    | <u>Si</u><br><u>(M)</u>         | 28/6                | <u>Yshu</u>    | <u>Si</u><br><u>(M)</u>         |
| 28/6 | 2:30 PM     | 100 PROS<br>PACKED RED<br>BLOOD CELLS                                       | IV    | 50<br>ml/hr        | <u>Yshu</u>    | <u>Si</u><br><u>(M)</u>         | 28/6<br>5:30 PM     | <u>Yshu</u>    | <u>Si</u><br><u>(M)</u>         |

Signature

VERIFIED BY: Name

## I.V. FLUID CHART

[illegible]





BAH-00558150 IP26-00006664  
 Mrs M DEEPTHI ALEKHYA  
 07-01-1990 36 Y 5 M 20 D (F)  
 Dr. RAJANI KUMARI



317

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## RESULT SHEET

| Date                | 17/6/26 | 27/6/26 | 28/6/26 |  |  |  |
|---------------------|---------|---------|---------|--|--|--|
| Time                |         | 8PM     | 5:41AM  |  |  |  |
| Hb                  | 13.1    | 10.5    | 10.1    |  |  |  |
| PCV                 |         | 29.1    | 28.7    |  |  |  |
| RBC                 |         | 3.69    | 3.64    |  |  |  |
| WBC                 |         | 24.59   | 16.15   |  |  |  |
| N/L                 |         |         |         |  |  |  |
| Platelets           | 3.0     | 2.53    | 287     |  |  |  |
| 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            |  |                                    |  |  |  |  |
| A <sup>+</sup> positive |  |                                    |  |  |  |  |
|                         |  |                                    |  |  |  |  |
|                         |  |                                    |  |  |  |  |
|                         |  |                                    |  |  |  |  |
| HIV                     |  |                                    |  |  |  |  |
| HEV                     |  |                                    |  |  |  |  |
| VDRL                    |  |                                    |  |  |  |  |
| HBsAg                   |  |                                    |  |  |  |  |
|                         |  | 20 PRBS reserve in soya blood bank |  |  |  |  |
|                         |  | 10 PRBS issue done 27/6/26 @ 12pm  |  |  |  |  |
|                         |  | 10 PRBS issue 28/6/26 @ 1:10pm     |  |  |  |  |
|                         |  |                                    |  |  |  |  |
|                         |  |                                    |  |  |  |  |

Culture and Sensitivities : .....

.....

.....

.....

Radiology :      USG : .....

                         X-Ray : .....

                         ECHO : .....

                         CT : .....

                         MRI : .....

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





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

[illegible]



## Obstetrics and Gynaecology Early Warning Signs

**Complete a Full  
Set of MEOWS  
Observations**

**1 Yellow Alert :**  
Repeat Observations  
in 30 minutes

**2 Yellow Alerts or 1 Orange Alert:**  
Call the Obstetrician and Repeat  
Observations  
in 30 minutes

**> 2 Yellow Alerts or  $\geq$  2 Orange Alerts:**  
Immediate Review by Obstetrician and  
Repeat Observations  
in 15 minutes or continuous  
monitoring

\* The Modified Early Warning Score (MEOWS)



(F)



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Hospital**  
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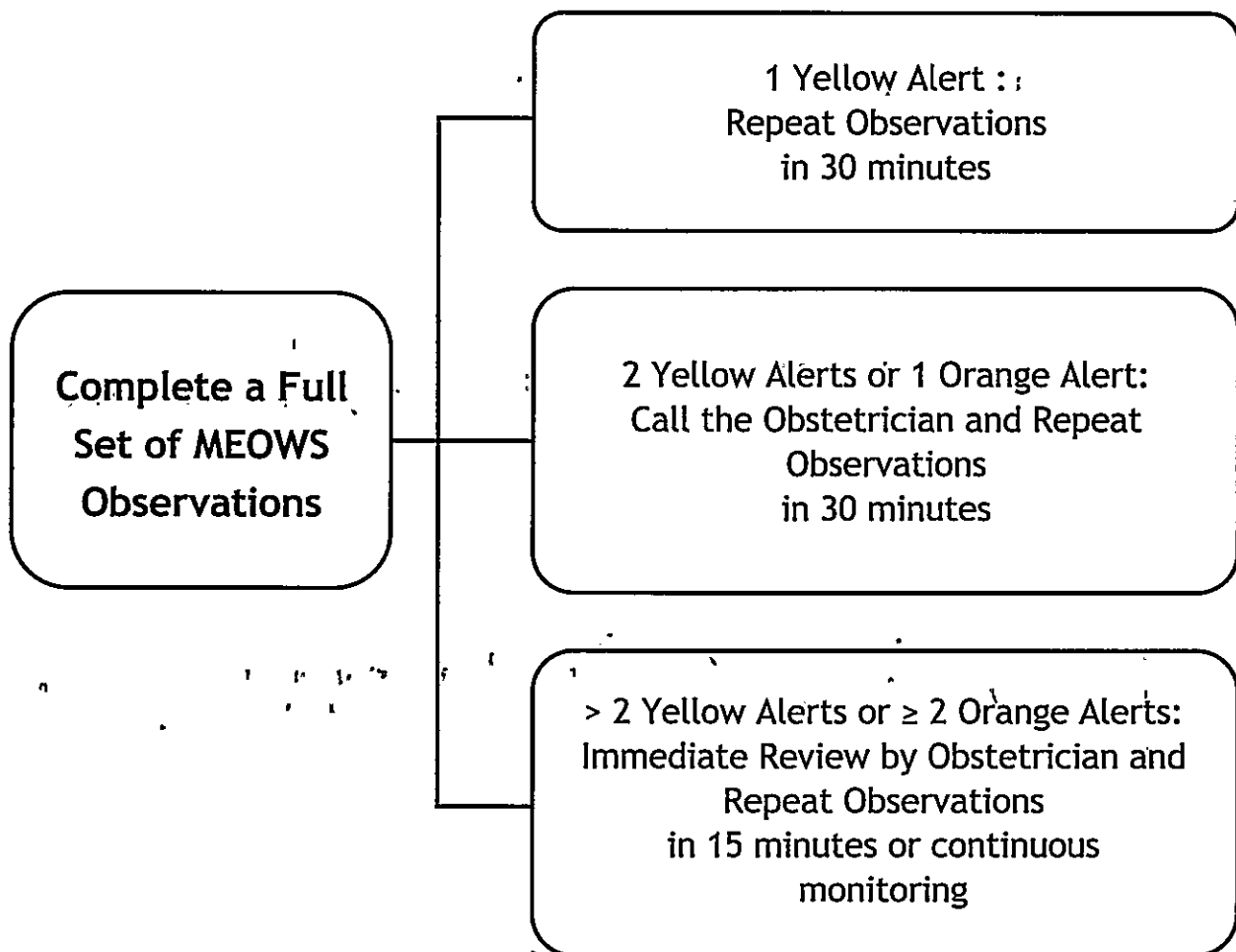


**BirthRight™**  
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*Your Right to a Safe Delivery*

TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

[illegible]

## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)



BAH-00559150 IP26-00006664  
 Mrs M DEEPTHI ALEKHYA  
 07-01-1990 36 Y 5 M 22 D (F)  
 Dr. RAJANI KUMARI

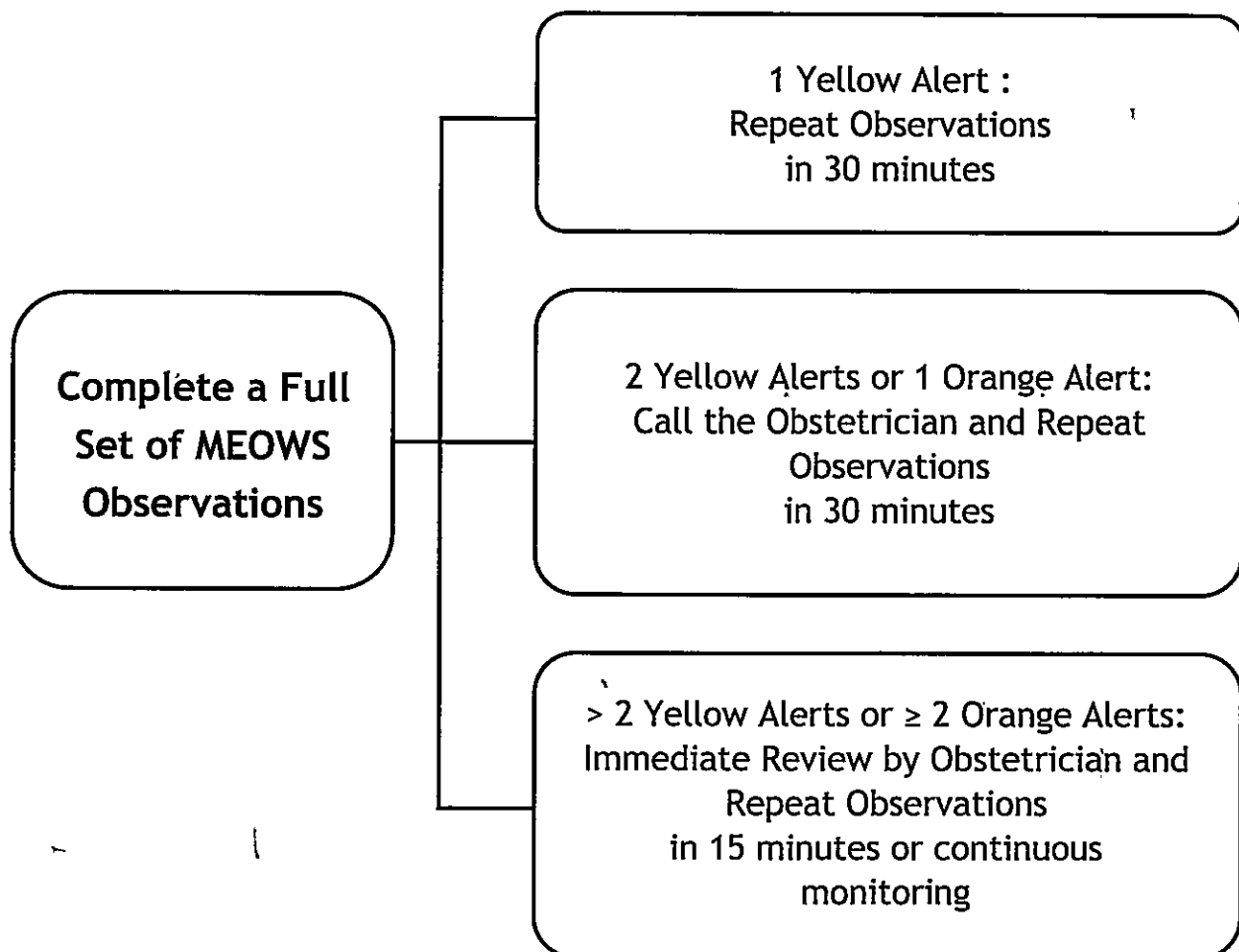


## Early Warning Observation Score Chart - Obstetrics

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            |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 0 - 10             |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| Saturations                          | 94 - 100 %         |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | < 94 %             |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| Administered O <sub>2</sub> (L/min.) |                    |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| Temp °C                              | 40                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 39                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 38                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 37                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 36                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 35                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | < 35               |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| Heart Rate                           | 170                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 160                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 150                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 140                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 130                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 120                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 110                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 100                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 90                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 80                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 70                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 60                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 50                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| 40                                   |                    |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| Systolic Blood Pressure              | 190                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 180                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 170                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 160                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 150                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 140                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 130                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 120                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 110                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 100                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 90                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 80                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 70                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| 60                                   |                    |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| 50                                   |                    |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| Diastolic Blood Pressure             | 130                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 120                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 110                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 100                |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 90                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 80                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 70                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 60                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 50                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | 40                 |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | NEURO RESPONSE [✓] | Alert |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      |                    | Voice |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      |                    | Pain  |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| Unresponsive                         |                    |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| URINE mls / hour                     | > 30               |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | < 30               |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| Proteinuria                          | Protein ++         |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | Protein > ++       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| Lochia                               | Normal             |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | Heavy / Foul       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| Liquor                               | Clear / Pink       |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
|                                      | Green              |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |
| TOTAL YELLOW SCORES                  |                    | 2     | 0 | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 |  |  |  |
| TOTAL ORANGE SCORES                  |                    | 0     | 0 | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0  | 0  | 0  | 0 | 0 | 0 | 0 | 0 | 0 | 0 |  |  |  |
| Nurse Initial                        |                    |       |   |    |    |    |   |   |   |   |   |   |   |   |   |    |    |    |   |   |   |   |   |   |   |  |  |  |

## Obstetrics and Gynaecology Early Warning Signs



\* The Modified Early Warning Score (MEOWS)





## 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 Thrombo-phlebitis Score | Sign. Nurse |
|----------------------|----------|-----------------|-------------|-------|-----|----------------------|-----------|-------|----------|-------|---------------------------------|-------------|
|                      |          |                 | Mouth       | I.V   | N.G | NG                   | Diarrhoea | Vomit | Drainage | Urine |                                 |             |
| 27/6                 | 08:00 am | RL              |             | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 09:00 am | RL              | N           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 10:00 am | RL              | B           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 11:00 am | RL              | B           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 12:00 pm | RL              | M           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 01:00 pm | RS              |             | 100ml |     |                      |           |       |          | 250ml |                                 |             |
| Total Intake :       |          |                 | Taken 600ml |       |     | Total Output :       |           |       |          |       | passed                          |             |
| 28/6                 | 02:00 pm | NS              | N           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 03:00 pm | NS              | N           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 04:00 pm | NS              | B           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 05:00 pm | RL              | B           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 06:00 pm | RL              | m           | 100ml |     |                      |           |       |          | 700ml |                                 |             |
|                      | 07:00 pm | RL              |             | 100ml |     |                      |           |       |          |       |                                 |             |
| Total Intake :       |          |                 | Taken 600ml |       |     | Total Output :       |           |       |          |       | 700ml                           |             |
| 29/6                 | 08:00 pm | RL              | N           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 09:00 pm | RL              | B           | 100ml |     |                      |           |       |          | 400ml |                                 |             |
|                      | 10:00 pm | RL              | m           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 11:00 pm | RL              | N           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 12:00 am | RL              | B           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 01:00 am | RL              | m           | 100ml |     |                      |           |       |          | 700ml |                                 |             |
| Total Intake :       |          |                 | Taken 600ml |       |     | Total Output :       |           |       |          |       | 1400ml                          |             |
| 28/6                 | 02:00 am | RL              | N           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 03:00 am | RL              | N           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 04:00 am | RL              | B           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 05:00 am | RL              | B           | 100ml |     |                      |           |       |          |       |                                 |             |
|                      | 06:00 am | RL              | M           | 100ml |     |                      |           |       |          | 600ml |                                 |             |
|                      | 07:00 am | RL              |             | 100ml |     |                      |           |       |          |       |                                 |             |
| Total Intake :       |          |                 | 600ml       |       |     | Total Output :       |           |       |          |       | 600ml                           |             |
| Total 24 hrs. Intake |          |                 | 2,400ml     |       |     | Total 24 hrs. Output |           |       | 2,500ml  |       |                                 |             |



## 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.

| 28/6                 |          | Intake             |       |       |     | Output         |           |       |          |       | IV Site<br>Thrombo-<br>phlebitis<br>Score | Sign.<br>Nurse                    |
|----------------------|----------|--------------------|-------|-------|-----|----------------|-----------|-------|----------|-------|-------------------------------------------|-----------------------------------|
| Date                 | Time     | Nature<br>of Fluid | Route |       |     | NG             | Diarrhoea | Vomit | Drainage | Urine |                                           |                                   |
|                      |          |                    | Mouth | I.V   | N.G |                |           |       |          |       |                                           |                                   |
| 24/6/20              | 08:00 am | RL                 | N     | 100ml |     |                |           |       |          | 100ml |                                           | Empty<br>11 AM                    |
|                      | 09:00 am | RL                 | B     | 100ml |     |                |           |       |          |       |                                           |                                   |
|                      | 10:00 am | RL                 |       | 100ml |     |                |           |       |          |       |                                           |                                   |
|                      | 11:00 am | RL                 | M     | 100ml |     |                |           |       |          |       |                                           |                                   |
|                      | 12:00 pm | RL                 |       | 100ml |     |                |           |       |          |       |                                           |                                   |
|                      | 01:00 pm | RL                 | Ho    | 100ml |     |                |           |       |          |       |                                           |                                   |
| Total Intake : taken |          |                    |       |       |     | Total Output : |           |       |          |       |                                           |                                   |
| 24/6/20              | 02:00 pm | PRBC               | SIPS  | 100ml |     |                |           |       |          | 500ml |                                           | Empty<br>2 PM<br>6.00 PM<br>Empty |
|                      | 03:00 pm | PRBC               |       | 50ml  |     |                |           |       |          |       |                                           |                                   |
|                      | 04:00 pm | PRBC               |       | 150ml |     |                |           |       |          | 400ml |                                           |                                   |
|                      | 05:00 pm | PRBC               |       | 150ml |     |                |           |       |          |       |                                           |                                   |
|                      | 06:00 pm | RL                 | SIPS  | 100ml |     |                |           |       |          | 100ml |                                           |                                   |
|                      | 07:00 pm | RL                 | SIPS  | 100ml |     |                |           |       |          |       |                                           |                                   |
| Total Intake : TAKEN |          |                    |       |       |     | Total Output : |           |       |          |       |                                           |                                   |
| 24/6/20              | 08:00 pm | RL                 |       | 100ml |     |                |           |       |          |       |                                           | Empty                             |
|                      | 09:00 pm | RL                 |       | 100ml |     |                |           |       |          |       |                                           |                                   |
|                      | 10:00 pm | RL                 |       | 100ml |     |                |           |       |          | 500ml |                                           |                                   |
|                      | 11:00 pm | RL                 |       | 100ml |     |                |           |       |          |       |                                           |                                   |
|                      | 12:00 am | RL                 |       | 100ml |     |                |           |       |          |       |                                           |                                   |
|                      | 01:00 am | RL                 |       | 100ml |     |                |           |       |          |       |                                           |                                   |
| Total Intake : 600ml |          |                    |       |       |     | Total Output : |           |       |          |       |                                           |                                   |
|                      | 02:00 am | RL                 |       | 100ml |     |                |           |       |          | 400ml |                                           | Empty                             |
|                      | 03:00 am | RL                 |       | 100ml |     |                |           |       |          |       |                                           |                                   |
|                      | 04:00 am | RL                 |       | 100ml |     |                |           |       |          |       |                                           |                                   |
|                      | 05:00 am | RL                 |       | 100ml |     |                |           |       |          |       |                                           |                                   |
|                      | 06:00 am | RL                 |       | 100ml |     |                |           |       |          | 400ml |                                           |                                   |
|                      | 07:00 am | RL                 |       | 100ml |     |                |           |       |          |       |                                           |                                   |
| Total Intake :       |          |                    |       |       |     | Total Output : |           |       |          |       |                                           |                                   |

Total 24 hrs. Intake

Total 24 hrs. Output



## 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.

|                            |          | Intake             |       |       |     | Output                         |           |       |          |       | IV Site<br>Thrombo-<br>phlebitis<br>Score | Sign.<br>Nurse |  |
|----------------------------|----------|--------------------|-------|-------|-----|--------------------------------|-----------|-------|----------|-------|-------------------------------------------|----------------|--|
| Date                       | Time     | Nature<br>of Fluid | Route |       |     | NG                             | Diarrhoea | Vomit | Drainage | Urine |                                           |                |  |
|                            |          |                    | Mouth | I.V   | N.G |                                |           |       |          |       |                                           |                |  |
| 29/6/20                    | 08:00 am |                    |       |       |     |                                |           |       |          |       |                                           |                |  |
|                            | 09:00 am | RL                 |       | 100ml |     |                                | ✓         |       |          | 300ml |                                           |                |  |
|                            | 10:00 am | RL                 |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
|                            | 11:00 am | RL                 |       | 100ml |     |                                |           |       |          | 100ml |                                           |                |  |
|                            | 12:00 pm | RL                 |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
|                            | 01:00 pm | RL                 |       | 100ml |     |                                |           |       |          | ✓     |                                           |                |  |
| <b>Total Intake :</b>      |          |                    |       |       |     | <b>Total Output :</b> Passed   |           |       |          |       |                                           |                |  |
| 29/6/20                    | 02:00 pm | RL                 |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
|                            | 03:00 pm | RL                 |       | 100ml |     |                                |           |       |          | ✓     |                                           |                |  |
|                            | 04:00 pm | RL (Belly)         |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
|                            | 05:00 pm | RL                 |       | 100ml |     |                                |           |       |          | ✓     |                                           |                |  |
|                            | 06:00 pm | RL                 |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
|                            | 07:00 pm | RL                 |       | 100ml |     |                                |           |       |          | ✓     |                                           |                |  |
| <b>Total Intake :</b> Gave |          |                    |       |       |     | <b>Total Output :</b> U-3 m-01 |           |       |          |       |                                           |                |  |
| 29/6/20                    | 08:00 pm | I                  |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
|                            | 09:00 pm | I                  |       | 100ml |     |                                |           |       |          | ✓     |                                           |                |  |
|                            | 10:00 pm | RL                 |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
|                            | 11:00 pm | RL                 |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
|                            | 12:00 am | I                  |       | 100ml |     |                                |           |       |          | ✓     |                                           |                |  |
|                            | 01:00 am | I                  |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
| <b>Total Intake :</b>      |          |                    |       |       |     | <b>Total Output :</b>          |           |       |          |       |                                           |                |  |
| 30/6/20                    | 02:00 am | I                  |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
|                            | 03:00 am | I                  |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
|                            | 04:00 am | I                  |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
|                            | 05:00 am | RL                 |       | 100ml |     |                                |           |       |          | ✓     |                                           |                |  |
|                            | 06:00 am | I                  |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
|                            | 07:00 am | I                  |       | 100ml |     |                                |           |       |          |       |                                           |                |  |
| <b>Total Intake :</b>      |          |                    |       |       |     | <b>Total Output :</b>          |           |       |          |       |                                           |                |  |

Total 24 hrs. Intake

Total 24 hrs. Output

BAH-00559150 IP26-00006664  
 Mrs M DEEPTHI ALEKHYA  
 07-01-1990 36 Y 5 M 21 D (F)  
 Dr. RAJANI KUMARI



## FLUID CHART

Sheet No. : .....

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

|                |          | Intake             |       |     |     | Output         |           |       |          |       | IV Site<br>Thrombo-<br>phlebitis<br>Score | Sign.<br>Nurse |  |
|----------------|----------|--------------------|-------|-----|-----|----------------|-----------|-------|----------|-------|-------------------------------------------|----------------|--|
| Date           | Time     | Nature<br>of Fluid | Route |     |     | NG             | Diarrhoea | Vomit | Drainage | Urine |                                           |                |  |
|                |          |                    | Mouth | I.V | N.G |                |           |       |          |       |                                           |                |  |
| 8/6            | 08:00 am |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 09:00 am |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 10:00 am |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 11:00 am |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 12:00 pm |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 01:00 pm |                    |       |     |     |                |           |       |          |       |                                           |                |  |
| Total Intake : |          |                    |       |     |     | Total Output : |           |       |          |       |                                           |                |  |
|                | 02:00 pm |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 03:00 pm |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 04:00 pm |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 05:00 pm |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 06:00 pm |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 07:00 pm |                    |       |     |     |                |           |       |          |       |                                           |                |  |
| Total Intake : |          |                    |       |     |     | Total Output : |           |       |          |       |                                           |                |  |
|                | 08:00 pm |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 09:00 pm |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 10:00 pm |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 11:00 pm |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 12:00 am |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 01:00 am |                    |       |     |     |                |           |       |          |       |                                           |                |  |
| Total Intake : |          |                    |       |     |     | Total Output : |           |       |          |       |                                           |                |  |
|                | 02:00 am |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 03:00 am |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 04:00 am |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 05:00 am |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 06:00 am |                    |       |     |     |                |           |       |          |       |                                           |                |  |
|                | 07:00 am |                    |       |     |     |                |           |       |          |       |                                           |                |  |
| Total Intake : |          |                    |       |     |     | Total Output : |           |       |          |       |                                           |                |  |

Total 24 hrs. Intake

Total 24 hrs. Output



BAH-00559150  
Mrs M DEEPTHI ALEKHYA  
07-01-1990 36 Y 5 M 20 D (F)  
Dr. RAJANI KUMARI

# 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: 27/6/26

## Goals

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

|           | Time | Plan of Care                   | Time | Implementation                   | Evaluation        | Re-Assessment | Nurse Name & Signature |
|-----------|------|--------------------------------|------|----------------------------------|-------------------|---------------|------------------------|
| Morning   | 8Am  | → Assess the pt condition      | 8Am  | → Assessed the pt condition      | now pt is stable  | re-checked    | Spitha                 |
|           | to   | → Monitor vitals               | to   | → monitor vital                  |                   |               |                        |
| Afternoon | 2pm  | → Maintain Tlochar             | 2pm  | → Maintain                       | patient stable    | vital normal  | A                      |
|           | 2pm  | → Assess the patient condition | 2pm  | → Assessed the pt condition      |                   |               |                        |
|           | to   | → plan for vital & record      | to   | → vital normal                   |                   |               |                        |
| Night     | 8pm  | → plan for Tlochar             | 8pm  | → Continue Tlochar               | patient is stable | vital is warm | Chud                   |
|           | 8pm  | → Assess the patient condition | 8pm  | → Assessed the patient condition |                   |               |                        |
|           | to   | → plan for vital               | to   | → maintain vital                 |                   |               |                        |
|           | 8Am  | → plan for Tlochar             | 8Am  | → maintain Tlochar               |                   |               |                        |

BAH-00559150 IP26-00006664  
 Mrs M DEEPTHI ALEKHIA  
 07-01-1990 36 Y 5 M 20 D (F)  
 Dr. RAJANI KUMARI



## NURSING CARE RECORD

**Rainbow Children's Hospital**  
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Date: 28/6/26

### Goals

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

|           | Time | Plan of Care                   | Time | Implementation                           | Evaluation           | Re-Assessment     | Nurse Name & Signature |
|-----------|------|--------------------------------|------|------------------------------------------|----------------------|-------------------|------------------------|
| Morning   | 8Am  | → Assessed the pt condition    | 8Am  | → Assessed the pt condition              | I/O chart maintained | Patient is stable | Li'                    |
|           | To   | → plan for vitals              | To   | → vital are checked & recorded           |                      |                   |                        |
|           | 2Pm  | → plan for I/O chart           | 2Pm  | → I/O chart maintained                   |                      |                   |                        |
| Afternoon | 2Pm  | → plan medication              | 2Pm  | → all medication given as per medication | Maintained I/O chart | Patient stable    | Sujatha                |
|           | 4Pm  | → Assess the patient condition | 4Pm  | → Assessed the patient condition         |                      |                   |                        |
|           | 4Pm  | → plan for vital & record      | 4Pm  | → Maintain vital & record                |                      |                   |                        |
| Night     | 8Pm  | → plan for PR & E              | 8Pm  | → plan for PR & E done                   | I/O chart maintained | Normal            | Anusha                 |
|           | 8Pm  | → plan for I/O chart           | 8Pm  | → I/O chart maintained                   |                      |                   |                        |
|           | 8Pm  | → plan for medication          | 8Pm  | → medication given as per chart          |                      |                   |                        |



BAH-00550150 IP26-00006664  
 Mrs M DEEPTHI ALEKHYA  
 07-01-1990 36 Y 5 M 20 D (F)  
 Dr. RAJANI KUMARI



## NURSING CARE RECORD

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Date: .....

### Goals

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

|           | Time | Plan of Care                                                                                   | Time | Implementation                                                                                     | Evaluation          | Re-Assessment            | Nurse Name & Signature |
|-----------|------|------------------------------------------------------------------------------------------------|------|----------------------------------------------------------------------------------------------------|---------------------|--------------------------|------------------------|
| Morning   | 8 AM | → Assess the pt condition<br>→ monitor vitals<br>→ maintain I/O                                | 8 AM | → Assessed the pt condition<br>→ monitored v<br>→ maintain                                         | pt is stable        | Re-assessed the vitals   | Mouli                  |
| Afternoon |      |                                                                                                |      | day duty                                                                                           |                     |                          |                        |
| Night     | 8 PM | → monitor the vitals<br>→ maintained I/O chart<br>→ continue fluids<br>→ CBP @ 4 PM plan - nne | 8 PM | → monitored the vitals<br>→ maintained I/O chart<br>→ continued fluids<br>→ CBP @ 4 PM planned T/M | → pt is stable Now. | → Re-assessed the vitals | Mouli                  |

BAH-00559150 IP26-00006664  
 Mrs M DEEPTHI ALEKHYA  
 07-01-1990 36 Y 5 M 22 D (F)  
 Dr. RAJANI KUMARI



## NURSING CARE RECORD

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Date: 30/6

Goals

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

|           | Time       | Plan of Care                                                                                                               | Time       | Implementation                                                                                                                       | Evaluation   | Re-Assessment      | Nurse Name & Signature |
|-----------|------------|----------------------------------------------------------------------------------------------------------------------------|------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------|------------------------|
| Morning   | 8am to 2pm | → Assess the pt condition<br>→ monitor vital & record<br>→ maintain glo chart<br>→ Administer medication as per drug chart | 8am to 2pm | → Assessed the pt condition<br>→ monitored vital & recorded<br>→ Maintained glo chart<br>→ Administered medication as per drug chart | pt is stable | → Rechecked vitals | <i>[Signature]</i>     |
| Afternoon |            |                                                                                                                            |            |                                                                                                                                      |              |                    |                        |
| Night     |            |                                                                                                                            |            |                                                                                                                                      |              |                    |                        |



BAH-00559150  
Mrs M DEEPTHI ALEKHYA  
07-01-1990 36 Y 5 M 20 D (F)  
Dr. RAJANI KUMARI



## CHECKLIST FOR THROMBOPHLEBITIS

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| S. No.                 | SITE                                                                                                                                                 | 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     | NA | NA | NA    | NA | NA | NA    | NA | NA |         |
| 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     | 0     | NA | 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     | 0     | NA | 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     | 0     | NA | 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     | 0     | NA | 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 cord pyrexia | Advanced stage of<br>thrombophlebitis /<br>Initiate treatment Re site<br>Cannula                        | 5     | 0     | NA | NA | NA    | NA | NA | NA    | NA | NA |         |
| Signature of the Nurse |                                                                                                                                                      |                                                                                                         |       |       |    |    |       |    |    |       |    |    |         |

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

Signature of Shift In Charge :

Signature : [Signature] Name : Alouci

Signature of Ward In Charge :

Signature : [Signature] Name : Kashwan

BAH-00559150

IP26-00006664

Mrs M DEEPTHI ALEKHYA

07-01-1990 38 Y 5 M 21 D (F)

Dr. RAJANI KUMARI



## CHECKLIST FOR THROMBOPHLEBITIS

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| 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     |       |   |   |       |   |   |       |   |   |         |
| 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     |       |   |   |       |   |   |       |   |   |         |
| 3                      | Two of the following Signs are evident:<br>Pain at IV site Redness                                                                                   | Early stage of phlebitis /<br>Resite Cannula                                                            | 2     |       |   |   |       |   |   |       |   |   |         |
| 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     |       |   |   |       |   |   |       |   |   |         |
| 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     |       |   |   |       |   |   |       |   |   |         |
| 6                      | All of the following Signs are evident and Extensive : Pain<br>along Path of cannula Redness<br>around Site Swelling palpable<br>Venous cord pyrexia | Advanced stage of<br>thrombophlebitis /<br>Initiate treatment Re site<br>Cannula                        | 5     |       |   |   |       |   |   |       |   |   |         |
| Signature of the Nurse |                                                                                                                                                      |                                                                                                         |       |       |   |   |       |   |   |       |   |   |         |

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

Signature of Shift In Charge :

Signature of Ward In Charge :

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

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





## CHECKLIST FOR THROMBOPHLEBITIS

| S. No.                 | SITE OBSERVATION                                                                                                                                    | STAGE / ACTION                                                                                          | SCORE | DAY-1 |   |   | DAY-2 |   |   | DAY-3 |   |   | Remarks |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------|-------|---|---|-------|---|---|-------|---|---|---------|
|                        |                                                                                                                                                     |                                                                                                         |       | M     | E | N | M     | E | N | M     | E | N |         |
| 1                      | IV site appears healthy                                                                                                                             | No signs of phlebitis /<br>Observe cannula                                                              | 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    |   |   |       |   |   |       |   |   |         |
| 3                      | Two of the following Signs are evident:<br>Pain at IV site Redness                                                                                  | Early stage of phlebitis /<br>Resite Cannula                                                            | 2     | 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    |   |   |       |   |   |       |   |   |         |
| 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    |   |   |       |   |   |       |   |   |         |
| 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    |   |   |       |   |   |       |   |   |         |
| Signature of the Nurse |                                                                                                                                                     |                                                                                                         |       |       |   |   |       |   |   |       |   |   |         |

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

Signature of Shift In Charge :

Signature : Name :

Signature of Ward In Charge :

Signature : Name :

## CHECKLIST FOR THROMBOPHLEBITIS

| S. No.                 | SITE OBSERVATION                                                                                                                                     | STAGE / ACTION                                                                                          | SCORE | DAY-1 |   |   | DAY-2 |   |   | DAY-3 |   |   | Remarks |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------|-------|---|---|-------|---|---|-------|---|---|---------|
|                        |                                                                                                                                                      |                                                                                                         |       | M     | E | N | M     | E | N | M     | E | N |         |
| 1                      | IV site appears healthy                                                                                                                              | No signs of phlebitis /<br>Observe cannula                                                              | 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     |       |   |   |       |   |   |       |   |   |         |
| 3                      | Two of the following Signs are evident:<br>Pain at IV site Redness                                                                                   | Early stage of phlebitis /<br>Resite Cannula                                                            | 2     |       |   |   |       |   |   |       |   |   |         |
| 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     |       |   |   |       |   |   |       |   |   |         |
| 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     |       |   |   |       |   |   |       |   |   |         |
| 6                      | All of the following Signs are evident and Extensive : Pain<br>along Path of cannula Redness<br>around Site Swelling palpable<br>Venous cord pyrexia | Advanced stage of<br>thrombophlebitis /<br>Initiate treatment Re site<br>Cannula                        | 5     |       |   |   |       |   |   |       |   |   |         |
| Signature of the Nurse |                                                                                                                                                      |                                                                                                         |       |       |   |   |       |   |   |       |   |   |         |

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

Signature of Shift In Charge :

Signature of Ward In Charge :

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

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



## Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category   |                               | Date / Time | 27/6 | 27/6 | 27/6 | Fall Risk Grading |                        |                                                  |
|------------------------------------------------------|-------------------------------|-------------|------|------|------|-------------------|------------------------|--------------------------------------------------|
|                                                      |                               | Score       | 8 AM | 2 PM | 8 PM | Risk Level        | Morse Fall Score (MFS) | Action                                           |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          |      |      |      | Low Risk          | 0 - 24                 | Standard Fall Precaution                         |
|                                                      | No                            | 0           |      |      |      |                   |                        |                                                  |
| Secondary Diagnosis<br>(more than one diagnosis)     | Yes                           | 15          |      |      |      | Moderate Risk     | 25 - 50                | Implement Moderate Fall Prevention Intervention  |
|                                                      | No                            | 0           |      |      |      |                   |                        |                                                  |
| Ambulatory Aid                                       | Furniture                     | 30          |      |      |      | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|                                                      | Crutches, Cane(S), Walker     | 15          |      |      |      |                   |                        |                                                  |
|                                                      | None /Bed Rest /Nurse Assist  | 0           |      |      | 0    |                   |                        |                                                  |
| 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                                            |                               |             |      |      |      |                   |                        |                                                  |

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





BAH-00559150 IP26-00006664  
Mrs M DEEPTHI ALEKHYA  
07-01-1990 36 Y 5 M 20 D (F)  
Dr. RAJANI KUMARI



## Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category   |                               | Date / Time | 28/6 | 28/6 | 28/6 | Fall Risk Grading |                        |                                                  |
|------------------------------------------------------|-------------------------------|-------------|------|------|------|-------------------|------------------------|--------------------------------------------------|
|                                                      |                               | Score       | 8 AM | 2 PM | 8 PM | Risk Level        | Morse Fall Score (MFS) | Action                                           |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          |      |      |      | Low Risk          | 0 - 24                 | Standard Fall Precaution                         |
|                                                      | No                            | 0           |      |      |      |                   |                        |                                                  |
| Secondary Diagnosis<br>(more than one diagnosis)     | Yes                           | 15          |      |      |      | Moderate Risk     | 25 - 50                | Implement Moderate Fall Prevention Intervention  |
|                                                      | No                            | 0           |      |      |      |                   |                        |                                                  |
| Ambulatory Aid                                       | Furniture                     | 30          |      |      |      | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|                                                      | Crutches, Cane(S), Walker     | 15          |      |      |      |                   |                        |                                                  |
|                                                      | None /Bed Rest /Nurse Assist  | 0           | 0    | 0    |      |                   |                        |                                                  |
| 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   | Li   | Li   | Li   |                   |                        |                                                  |

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

Detailed description of Figure 6: This is a scatter plot titled 'FIGURE 6'. The horizontal axis is labeled 'DAYS SINCE LAST RAINFALL' and has major tick marks at 0, 2, 4, 6, 8, and 10. The vertical axis is labeled 'DAYS UNTIL NEXT RAINFALL' and also has major tick marks at 0, 2, 4, 6, 8, and 10. There are approximately 15 data points scattered across the plot. Most points are clustered below the diagonal line y=x, indicating that the time until the next rainfall is generally less than or equal to the time since the last rainfall. Notable points include one near (0, 9), another near (1, 7), and several others along the lower boundary.

BAH-00559150 IP26-00006664  
 Mrs M DEEPTHI ALEKHYA  
 07-01-1990 36 Y 5 M 21 D (F)  
 Dr. RAJANI KUMARI



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## Morse Fall Risk Assessment Form

| Choose Highest Applicable Score from each Category   |                               | Date / Time | 29/6        | 29/6        | 30/6        | Fall Risk Grading |                        |                                                  |
|------------------------------------------------------|-------------------------------|-------------|-------------|-------------|-------------|-------------------|------------------------|--------------------------------------------------|
|                                                      |                               | Score       | N/A         | 12          | N/A         | Risk Level        | Morse Fall Score (MFS) | Action                                           |
| History of Falling<br>(immediately or w/in 3 months) | Yes                           | 25          |             |             |             | Low Risk          | 0 - 24                 | Standard Fall Precaution                         |
|                                                      | No                            | 0           |             |             |             |                   |                        |                                                  |
| Secondary Diagnosis<br>(more than one diagnosis)     | Yes                           | 15          |             |             |             | Moderate Risk     | 25 - 50                | Implement Moderate Fall Prevention Intervention  |
|                                                      | No                            | 0           |             |             |             |                   |                        |                                                  |
| Ambulatory Aid                                       | Furniture                     | 30          |             |             |             | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|                                                      | Crutches, Cane(S), Walker     | 15          |             |             |             |                   |                        |                                                  |
|                                                      | None /Bed Rest /Nurse Assist  | 0           | 0           | 0           | 0           |                   |                        |                                                  |
| IV / Heparin Lock or Saline                          | Yes                           | 20          | 20          | 20          | 20          | Moderate Risk     | 25 - 50                | Implement Moderate Fall Prevention Intervention  |
|                                                      | No                            | 0           |             |             |             |                   |                        |                                                  |
| GAIT / Transferring                                  | Impaired                      | 20          |             |             |             | High Risk         | ≥ 51                   | Implement High Risk Fall Prevention Intervention |
|                                                      | Weak (uses touch for balance) | 10          |             |             |             |                   |                        |                                                  |
|                                                      | Normal /On Bed Rest /Immobile | 0           |             |             |             |                   |                        |                                                  |
| 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                                            |                               |             | (Signature) | (Signature) | (Signature) |                   |                        |                                                  |

Tick (✓) whichever precaution taken.

### Risk Level and Interventions

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

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

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

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

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

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



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BAH-00559150 IP26-00006664  
Mrs M DEEPTHI ALEKHYA  
07-01-1990 36 Y 5 M 20 D (F)  
Dr. RAJANI KUMARI



## BRADEN 'Q' SCALE

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|                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date : | 27/6              | 27/6              | 27/6              | 28/6              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-------------------|-------------------|-------------------|-------------------|
|                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time : | 11h               | 2pm               | 8pm               | 3am               |
| 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 (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 mean 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>                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        |        | Dr. Rajani Kumari | Dr. Rajani Kumari | Dr. Rajani Kumari | Dr. Rajani Kumari |

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 “<b>At Risk</b>” 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 “<b>Moderate Risk</b>” 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 “<b>High Risk</b>” 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                                                                  |



BAH-00550150  
Mrs M DEEPTHI ALEKHYA  
07-01-1990  
Dr. RAJANI KUMARI  
IP26-00006664  
38 Y 5 M 20 D  
(F)

## BRADEN 'Q' SCALE

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

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|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date :                  | 28/6        | 29/6        | 29/6        | 29/6        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------|-------------|-------------|-------------|
|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time :                  | 8pm         | 8am         | 8pm         | N           |
| Mobility                                                                                                                                                                     | 1. <b>Completely limited:</b><br>Does not make even slight changes in body or extremity position without assistance.                                                                                                                                                                                                                     | 2. <b>Very limited:</b><br>Makes occasional slight changes in body or extremity position but unable to completely turn self independently.                                                                                                                                                                                                                   | 3. <b>Slightly limited:</b><br>Makes frequent through slight changes in body or extremity position independently.                                                                                                                                                                               | 4. <b>No limitations:</b><br>Makes major and frequent changes in position without assistance.                                                                                                                                                                                          |                         | 4           | 4           | 4           | 4           |
| "Activity The degree of physical activity"                                                                                                                                   | 1. <b>Bedfast :</b><br>Confined to bed                                                                                                                                                                                                                                                                                                   | 2. <b>Chairfast :</b><br>Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."                                                                                                                                                                                                         | 3. <b>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.                                                                                                                        | 4. <b>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                                                                                                                                                           | 1. <b>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.                                                                                                                  | 2. <b>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.                                                                                                                               | 3. <b>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.                                                           | 4. <b>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                                                                                                                         | 1. <b>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.                                                                                                                                                                   | 2. <b>Very moist:</b><br>Skin is often, but not always, moist. Linen must be changed at least every 8 hours.                                                                                                                                                                                                                                                 | 3. <b>Occasionally moist:</b><br>Skin is occasionally moist, requiring linen change every 12 hours.                                                                                                                                                                                             | 4. <b>Rarely moist:</b><br>Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.                                                                                                                                                                   |                         | 4           | 4           | 4           | 3           |
| <b>FRICTION-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 | 1. <b>Significant problem:</b><br>Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.                                                                                                                                                                                                        | 2. <b>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.                                                                                                                    | 3. <b>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.            | 4. <b>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           | 3           |
| Nutritional Usual food intake pattern                                                                                                                                        | 1. <b>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. | 2. <b>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. | 3. <b>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. | 4. <b>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 mean and dairy products. Occasionally eats between meals. Does not require supplementation. |                         | 4           | 4           | 4           | 4           |
| Tissue Perfusion & Oxygenation                                                                                                                                               | 1. <b>Extremely compromised:</b><br>Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.                                                                                                                                                                                   | 2. <b>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.                                                                                                                                                                                                | 3. <b>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.                                                                                                                                        | 4. <b>Excellent:</b><br>Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.                                                                                                                                                                               |                         | 4           | 4           | 4           | 4           |
| <b>Severe Risk : less than 9   High Risk : 10-12   Moderate Risk : 13-14   Mild Risk : 15-18   Not at Risk: 19-23</b>                                                        |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>TOTAL SCORE</b>      | 28          | 28          | 28          | 28          |
| Docu. No. : RCH / FRM / CLINICAL / 119                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <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 “<b>At Risk</b>” 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 “<b>Moderate Risk</b>” 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 “<b>High Risk</b>” 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                                                                  |



BAH-00559150 IP26-00006664  
Mrs M DEEPTHI ALEKHYA  
07-01-1990 36 Y 5 M 21 D (F)  
Dr. RAJANI KUMARI



## BRADEN 'Q' SCALE

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|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        |                         |    |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----|--|--|
|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Date : 30/6             |    |  |  |
|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | Time : 176              |    |  |  |
| 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                       |    |  |  |
| "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                       |    |  |  |
| 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                       |    |  |  |
| 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                       |    |  |  |
| <b>FRICTION-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                       |    |  |  |
| 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                       |    |  |  |
| 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                       |    |  |  |
|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>TOTAL SCORE</b>      | 24 |  |  |
|                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                        | <b>Evaluator's Name</b> |    |  |  |

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

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



| Risk Score  | Category      | Action                                                                                                                                                                                                                                                                                                                                       | <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 “<b>At Risk</b>” 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 “<b>Moderate Risk</b>” 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 “<b>High Risk</b>” 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                                                                  |

BAH-00558150 IP26-00006664  
 Mrs M DEEPTI ALEKHIA  
 07-01-1990 36 Y 5 M 20 D (F)  
 Dr. RAJANI KUMARI



## PAIN ASSESSMENT FORM

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

**BirthRight**  
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 Your Right to a Safe Delivery

| Date | Time | Location          | Duration                                                                     | Acuity                                                             | Character                                                                                                                        | Modifying Factors                                                          | Patient / Family Educated                                   | Intervention | Sign |
|------|------|-------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|--------------|------|
| 23/6 | 8:15 | -                 | <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           |      |
| 24/6 | 10AM | Normal            | <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           |      |
| 24/6 | 2pm  | Normal            | <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           |      |
| 24/6 | 4pm  | at 40mmHg<br>pain | <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 | epidural     |      |
| 24/6 | 6pm  | at 40mmHg<br>pain | <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 | epidural     |      |
| 24/6 | 8pm  | at 40mmHg<br>pain | <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           |      |
| 27/6 | 10pm | Normal            | <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           | CB   |
| 28/6 | 10AM | 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           | Li   |
| 28/6 | 2pm  | Normal            | <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           | NA   |
| 28/6 | 4pm  | Normal            | <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:

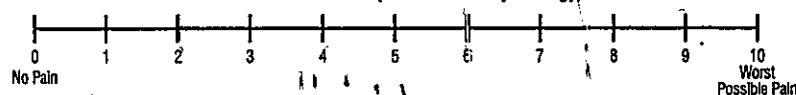
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain pain-relieving intervention.
  - Within 30 – 60 minutes after pain relief 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 brawn up                                |
| Activity      | Laying quietly normal position, moves easily | Squirming shifting back and forth, tense                                    | Arched, rigid, or Jerking                                |
| Cry           | No Cry (Awake or asleep)                     | Moans or whimpers occasional complaint                                      | Crying steadily, screams of sobs, frequent complaints    |
| Consolability | Content, relaxed                             | Reassured by occasional touching, hugging, or being talked to, distractible | Difficult to console or comfort                          |

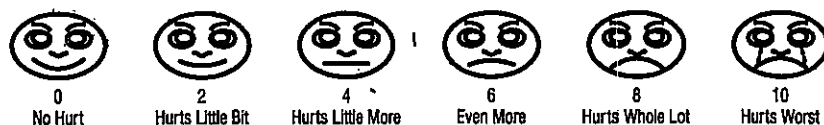
## Numerical Pain Scale (Obstetric and Gynecology)



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

| Assessment Criteria                           | Sedation                                                |                                                             | Normal                                        | Pain / Agitation                                                                          |                                                                                                                                                         |
|-----------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                               | -2                                                      | -1                                                          | 0                                             | 1                                                                                         | 2                                                                                                                                                       |
| <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 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







## PAIN ASSESSMENT FORM

| Date    | Time | Pain score (0/10) | Location | Duration                                                                     | Acuity                                                             | Character                                                                                                                        | Modifying Factors                                                          | Patient / Family Educated                                   | Intervention | Sign        |
|---------|------|-------------------|----------|------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------|--------------|-------------|
| 28/6/26 | 8pm  | 0/10              | Abdomen  | <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 | N/A          | [Signature] |
| 28/6/26 | 10pm | 0/10              | NR       | <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 | N/A          | Ankur       |
| 29/6/26 | 10am | 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           | [Signature] |
| 29/6/26 | 2pm  | 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           | de          |
| 30/6/26 | 6Am  | 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           | [Signature] |
| 30/6/26 | 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           | [Signature] |
|         |      |                   |          | <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 |              |             |
|         |      |                   |          | <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 |              |             |
|         |      |                   |          | <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 |              |             |
|         |      |                   |          | <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 |              |             |

**Re-assessment Frequency:**

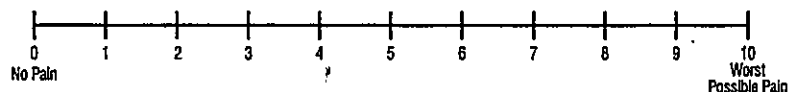
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
  - At least every 2 hours for the first 24 hours
  - Then every 4 hours.
  - Prior to pain pain-relieving intervention.
  - Within 30 – 60 minutes after pain relief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

# PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

Numerical Pain Scale (Obstetric and Gynecology)



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

| Assessment Criteria                      | Sedation                                                |                                                             | Normal                                        | Pain / Agitation                                                                           |                                                                                                                                                         |
|------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                          | -2                                                      | -1                                                          | 0                                             | 1                                                                                          | 2                                                                                                                                                       |
| Crying Irritability                      | No Cry with painful stimuli                             | Moans or cries minimally with painful stimuli               | Appropriate crying Not irritable              | Irritable or crying at intervals consolable                                                | High-pitched or silent-continuous cry Inconsolable                                                                                                      |
| Behavior State                           | No arousal to any stimuli<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)                                                                   |
| Facial Expression                        | Mouth is lax<br>No expression                           | Minimal expression with stimuli                             | Relaxed Appropriate                           | Any pain expression intermittent                                                           | Any pain expression continual                                                                                                                           |
| Extremities Tone                         | 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                                                                                        |
| Vital Signs HR, RR, BP, SaO <sub>2</sub> | 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 - WARD

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

|                                          |                                                           |            |                                                                                                                                                |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |
|------------------------------------------|-----------------------------------------------------------|------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|
| SITUATION                                | Diagnosis: <u>Hysteroscopy</u><br><u>myomectomy</u>       |            | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |
|                                          | Area                                                      | Shift Time | 27/6<br>AM                                                                                                                                     | 28/6/26<br>2pm                                                      | 27/6<br>M                                                           | 28/6<br>8am                                                         | 28/6/26<br>2pm                                                      | 28/6/26<br>8pm                                                      |
| BACKGROUND                               | Medical Condition<br>(Any special condition to be noted): |            | -                                                                                                                                              | -                                                                   | -                                                                   | NA                                                                  | -                                                                   | NA                                                                  |
| ASSESSMENT                               | Allergy:                                                  |            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                          | 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: 97.2                                                                                                                                     | 96.2                                                                | 96.8                                                                | 97.2                                                                | 97.6                                                                | 98.6                                                                |
|                                          | Res:                                                      |            | 20                                                                                                                                             | 20                                                                  | 20                                                                  | 20                                                                  | 20                                                                  | 20                                                                  |
|                                          | SpO <sub>2</sub> :                                        |            | 99                                                                                                                                             | 100%                                                                | 100                                                                 | 99%                                                                 | 98                                                                  | 99%                                                                 |
|                                          | Pulse:                                                    |            | 85                                                                                                                                             | 73                                                                  | 86                                                                  | 85                                                                  | 86                                                                  | 80                                                                  |
|                                          | BP:                                                       |            | 110/72                                                                                                                                         | 129/78                                                              | 110/70                                                              | 115/75                                                              | 131/85                                                              | 124/75                                                              |
|                                          | Fall Risk Score:                                          |            | -                                                                                                                                              | 0/10                                                                | 0/10                                                                | -                                                                   | 0/10                                                                | 0/10                                                                |
| Recommendations                          | Safety Needs:                                             |            | NA                                                                                                                                             | yes                                                                 | yes                                                                 | NA                                                                  | yes                                                                 | yes                                                                 |
|                                          | Physiotherapy                                             |            | <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 |
|                                          | Others Specify:                                           |            | NA                                                                                                                                             | NA                                                                  | NA                                                                  | NA                                                                  | -                                                                   | -                                                                   |
|                                          | Special Diet:                                             |            | <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 |
|                                          | Other Special Orders / Medications:                       |            | NA                                                                                                                                             | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |
| Post Operative Procedure Special Orders: |                                                           |            | NA                                                                                                                                             | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  | NA                                                                  |
| Handed Over By Name :                    |                                                           |            | Neeraj                                                                                                                                         | Neeraj                                                              | Chand                                                               | Sujatha                                                             | Alai                                                                | Anubhav                                                             |
| Signature :                              |                                                           |            | Neeraj                                                                                                                                         | Neeraj                                                              | Chand                                                               | Sujatha                                                             | Alai                                                                | Anubhav                                                             |
| Date:                                    |                                                           |            | 27/6                                                                                                                                           | 28/6/26                                                             | 27/6                                                                | 28/6/26                                                             | 28/6/26                                                             | 28/6/26                                                             |
| Time:                                    |                                                           |            | 2pm                                                                                                                                            | 8pm                                                                 | 2pm                                                                 | 8pm                                                                 | 8pm                                                                 | 8pm                                                                 |
| Taken Over By Name :                     |                                                           |            | Neeraj                                                                                                                                         | Chand                                                               | Sujatha                                                             | Alai                                                                | Anubhav                                                             | Sujatha                                                             |
| Signature :                              |                                                           |            | Neeraj                                                                                                                                         | Chand                                                               | Sujatha                                                             | Alai                                                                | Anubhav                                                             | Sujatha                                                             |
| Date:                                    |                                                           |            | 28/6/26                                                                                                                                        | 27/6                                                                | 28/6/26                                                             | 28/6/26                                                             | 28/6/26                                                             | 28/6/26                                                             |
| Time:                                    |                                                           |            | 2:30pm                                                                                                                                         | 8pm                                                                 | 2pm                                                                 | 2:30pm                                                              | 2:30pm                                                              | 3pm                                                                 |



BAH-00559150 IP26-00006664  
 Mrs M DEEPTHI ALEKHYA  
 07-01-1990 38 Y 5 M 22 D (F)  
 Dr. RAJANI KUMARI



## NURSING SHIFT HAND OVER FORM - WARD

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

|                                          |                                                           |                                                                                                                                     |                                                                     |                                                                     |                                                          |                                                          |                                                          |
|------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| SITUATION                                | Diagnosis:                                                | Any Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Known<br>If Yes Specify: ..... |                                                                     |                                                                     |                                                          |                                                          |                                                          |
|                                          | Area                                                      |                                                                                                                                     |                                                                     |                                                                     |                                                          |                                                          |                                                          |
| BACKGROUND                               | Shift Time                                                | 24/6                                                                                                                                | 29/6                                                                | 30/6                                                                |                                                          |                                                          |                                                          |
|                                          | Medical Condition<br>(Any special condition to be noted): | -                                                                                                                                   | -                                                                   | -                                                                   |                                                          |                                                          |                                                          |
| ASSESSMENT                               | Allergy:                                                  | <input type="checkbox"/> Yes <input 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Tubes/Drains/Catheter:                                    | <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 type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Vital Signs:                                              |                                                                                                                                     |                                                                     |                                                                     |                                                          |                                                          |                                                          |
|                                          | Temp:                                                     | 98.2                                                                                                                                | 98.1                                                                | 98.2                                                                |                                                          |                                                          |                                                          |
|                                          | Res:                                                      | 26                                                                                                                                  | 20/min                                                              | 20/min                                                              |                                                          |                                                          |                                                          |
|                                          | SpO <sub>2</sub> :                                        | 98                                                                                                                                  | 98%                                                                 | 99%                                                                 |                                                          |                                                          |                                                          |
|                                          | Pulse:                                                    | 92                                                                                                                                  | 79b/min                                                             | 82b/min                                                             |                                                          |                                                          |                                                          |
|                                          | BP:                                                       | 100/70                                                                                                                              | 118/75                                                              |                                                                     |                                                          |                                                          |                                                          |
| Fall Risk Score:                         | -                                                         | -                                                                                                                                   | -                                                                   |                                                                     |                                                          |                                                          |                                                          |
| Pain Score:                              | -                                                         | +                                                                                                                                   | -                                                                   |                                                                     |                                                          |                                                          |                                                          |
| Recommendations                          | Safety Needs:                                             | -                                                                                                                                   | Yes                                                                 | Yes                                                                 |                                                          |                                                          |                                                          |
|                                          | Physiotherapy                                             | <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 type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Others Specify:                                           |                                                                                                                                     | -                                                                   | -                                                                   |                                                          |                                                          |                                                          |
|                                          | Special Diet:                                             | <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 type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|                                          | Other Special Orders / Medications:                       |                                                                                                                                     | -                                                                   | -                                                                   |                                                          |                                                          |                                                          |
| Post Operative Procedure Special Orders: |                                                           |                                                                                                                                     | -                                                                   | -                                                                   |                                                          |                                                          |                                                          |
| Handed Over By Name :                    |                                                           | Prasanna                                                                                                                            | mahi                                                                | Prasanna                                                            |                                                          |                                                          |                                                          |
| Signature :                              |                                                           |                                                                                                                                     |                                                                     |                                                                     |                                                          |                                                          |                                                          |
| Date:                                    |                                                           | 29/6                                                                                                                                | 30/6/26                                                             | 30/6/26                                                             |                                                          |                                                          |                                                          |
| Time:                                    |                                                           | 8 PM                                                                                                                                | 8 AM                                                                | 2 PM                                                                |                                                          |                                                          |                                                          |
| Taken Over By Name :                     |                                                           | mahi                                                                                                                                | Prasanna                                                            |                                                                     |                                                          |                                                          |                                                          |
| Signature :                              |                                                           |                                                                                                                                     |                                                                     |                                                                     |                                                          |                                                          |                                                          |
| Date:                                    |                                                           | 29/6/26                                                                                                                             | 30/6/26                                                             |                                                                     |                                                          |                                                          |                                                          |
| Time:                                    |                                                           | 8 PM                                                                                                                                | 8 PM                                                                |                                                                     |                                                          |                                                          |                                                          |

BAH-00559150 IP26-00006664  
Mrs M DEEPTHI ALEKHYA  
07-01-1990 35 Y 5 M 20 D (F)  
Dr. RAJANI KUMARI



## URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 27/6/26

Date of Removal: 28/6/26

| Parameters                                       | Date | Shift Time | 27/6/26<br>8AM                                                      | 27/6/26<br>8AM                                                      | 28/6/26<br>8AM                                                      | 28/6/26<br>2PM                                                      | 28/6/26<br>8PM                                                      |                                                          |
|--------------------------------------------------|------|------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------|
| 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 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 |
| 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 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 |
| 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 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 |
| 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 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 |
| 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 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 |
| 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 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 |
| 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 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 |
| 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 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 |
| 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 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 |
| Is the line removed as Policy?                   |      |            | <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 | <input type="checkbox"/> Yes <input checked="" 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 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 |
| 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 checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" 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 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 |
| Name of the Nurse                                |      |            | Alia                                                                | Chand                                                               | Swathi                                                              | Ab                                                                  | Amber                                                               |                                                          |
| Signature of the Nurse                           |      |            |                                                                     |                                                                     |                                                                     |                                                                     |                                                                     |                                                          |

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BAH-00559150 IP26-00006664  
Mrs M DEEPTHI ALEKHYA  
07-01-1990 38 Y 5 M 20 D (F)  
Dr. RAJANI KUMARI



## OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

|                                                                                                                                                                                                                                    |                                                                                        |                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| Date of Admission: 27/6/26                                                                                                                                                                                                         |                                                                                        |                                                                                                   |
| <b>Baseline Information:</b>                                                                                                                                                                                                       |                                                                                        |                                                                                                   |
| Admission From: <input type="checkbox"/> ER <input type="checkbox"/> OPD <input checked="" type="checkbox"/> Admission Desk <input type="checkbox"/> Others, specify .....                                                         |                                                                                        |                                                                                                   |
| Primary Language: <input type="checkbox"/> Telugu <input checked="" type="checkbox"/> English <input type="checkbox"/> Hindi <input type="checkbox"/> Others, specify .....                                                        |                                                                                        |                                                                                                   |
| Do you require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No if Yes specify .....                                                                                                                       |                                                                                        |                                                                                                   |
| Source of Information: <input checked="" type="checkbox"/> Patient <input type="checkbox"/> Family <input type="checkbox"/> Others, specify .....                                                                                  |                                                                                        |                                                                                                   |
| Allergies: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Medications <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Food <input type="checkbox"/> Other: ..... |                                                                                        |                                                                                                   |
| If yes, identify .....                                                                                                                                                                                                             |                                                                                        |                                                                                                   |
| Chief Complaints: Fibroid Uteral                                                                                                                                                                                                   |                                                                                        | Doctor Notified on Admission: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|                                                                                                                                                                                                                                    |                                                                                        | Name of the Doctor: Dr. Narasimha                                                                 |
|                                                                                                                                                                                                                                    |                                                                                        | Time Notified: .....                                                                              |
| Past Medical History: Obtained From <input type="checkbox"/> Patient <input type="checkbox"/> Family Member <input type="checkbox"/> Medical Record <input type="checkbox"/> Other (specify) .....                                 |                                                                                        |                                                                                                   |
| Past Medical History                                                                                                                                                                                                               | Past Surgical History                                                                  | Previous Hospital Admission                                                                       |
|                                                                                                                                                                                                                                    |                                                                                        |                                                                                                   |
| <b>Gynecology Assessment:</b> <input type="checkbox"/> Not Applicable                                                                                                                                                              | <b>Gynecology Surgical History:</b>                                                    | <b>Gynecological History:</b>                                                                     |
| Menstrual History: .....                                                                                                                                                                                                           | Caesarean Section: <input type="checkbox"/> No <input type="checkbox"/> Yes            | Contraceptives: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes               |
| Onset of Menarche: .....                                                                                                                                                                                                           | Cervical Cerclage: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | Vaginal Discharge: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes            |
| Menstrual Cycle: <input type="checkbox"/> Regular <input checked="" type="checkbox"/> Irregular                                                                                                                                    | Ectopic Pregnancy: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | Post-Coital Bleeding: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes         |
| Last Menstrual Period: .....                                                                                                                                                                                                       | Myomectomy: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes        | <b>Infertility:</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes           |
|                                                                                                                                                                                                                                    | Others: .....                                                                          | <b>If Yes Type:</b> <input type="checkbox"/> Primary <input type="checkbox"/> Secondary           |
| Obstetric History: G ..... P 1 ..... L 1 ..... A .....                                                                                                                                                                             |                                                                                        |                                                                                                   |
| Previous LSCS: yes                                                                                                                                                                                                                 |                                                                                        |                                                                                                   |
| Current Medication: <input type="checkbox"/> None <input type="checkbox"/> Yes, If Yes, Fill the reconciliation form                                                                                                               |                                                                                        |                                                                                                   |
| <b>Family History:</b> <input checked="" type="checkbox"/> No Abnormalities Detected                                                                                                                                               |                                                                                        |                                                                                                   |
| <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Kidney disease           |                                                                                        |                                                                                                   |
| <input type="checkbox"/> Liver disease <input type="checkbox"/> Other .....                                                                                                                                                        |                                                                                        |                                                                                                   |
| <b>Vital Signs / Measurements:</b>                                                                                                                                                                                                 | Temp: 97.8                                                                             | HR: 85                                                                                            |
|                                                                                                                                                                                                                                    | BP: 110/72                                                                             | RR: 20                                                                                            |
|                                                                                                                                                                                                                                    | Weight: .....                                                                          | Height: ..... BMI: .....                                                                          |
| <b>Pain Assessment:</b> Pain: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If Yes, complete the Pain Assessment / Reassessment Form)                                                                       |                                                                                        |                                                                                                   |



### PHYSICAL ASSESSMENT

**General Appearance:** ☒ Healthy ☐ ill looking ☐ Anxious ☐ Agitated ☐ Others: .....

**Fall Assessment:** ☐ Yes ☒ No Score ..... (complete the Morse Fall Risk Assessment Sheet)

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

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

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

Inform consultant for positive criteria

**NUTRITIONAL SCREENING:** ☒ No Abnormality Detected

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

Inform consultant for positive criteria

**PSYCHOLOGICAL SCREENING:**

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

Inform consultant for positive criteria

**SOCIAL SCREENING:**

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

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

**Social History:** Lives With ..... *Family member*

**Orientation has been given regarding the following aspects:**

- Call Bell in Reach : ☒ Yes ☐ No Waste Disposal Explained: ☒ Yes ☐ No  
Infusion Pump : ☒ Yes ☐ No Hand Hygiene Explained: ☒ Yes ☐ No ☐ Others

Above information given to ..... *patient*

Name of Person Orientation was given to: ..... *Mrs. Deepthi*

Orientation not given Reason: .....

Nurse Signature: ..... *Si*

Nurse Name: ..... *Siya*

Date & Time: ..... *27/6/20 @ 9pm*



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# CONSENT FOR BLOOD TRANSFUSION



BAH-00559150 IP26-00006664  
Name: Mrs M DEEPTHI ALEKHYA Age: 07-01-1990 38 Y 5 M 21 D (F) Gender: Male ☐ Female ☒  
Dr. RAJANI KUMARI  
UHID.No :  Date: .....

Type of Blood Product: ☐ Fresh Frozen Plasma ☐ Packed Red Blood Cells ☐ Random Donor Platelets  
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood  
☐ Albumin ☐ Red Blood Cell ☐ Others .....

I ..... hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in the "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that .....

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: 

Name: M. Deepthi

Date & Time: 28/6/26 @ 2:30pm

Doctor (Who is talking the consent)

Signature: 

Name: Dr Mansha

Date & Time: 28/06/2026 @ 2:30pm

Witness

Signature: 

Name: P. ABHIRAM

Date & Time: 28/6/26 @ 3:00pm







(2)

## BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 28/6/26 Time: 2:30pm

Blood Group of the Patient: A Positive Blood Group on the Blood Bag: A Positive

Blood Bank Issue No: 1174 Date of Collection: 2/6/26 Date of Expiry: 13/7/26

Date & Time of Starting Transfusion: 28/6/26 @ 2:30pm Planned duration of Transfusion: 3-4 hrs

Check for Correct Unit: ☒ Correct Patient: ☒

Blood products cross checked by: Nurse 1: Alati Nurse 2: Madhumita

Before starting transfusion vitals: Temp: 96.7F HR 76 RR: 20 BP: 130/80 SpO<sub>2</sub> 99%

### PLEASE MONITOR THE FOLLOWING:

| Date    | Time             | HR | Temperature | Blood Pressure | SpO <sub>2</sub> | Any Rash | Any Rigors | Any Breathlessness | Any Other Problem |
|---------|------------------|----|-------------|----------------|------------------|----------|------------|--------------------|-------------------|
| 28/6/26 | 2:30pm<br>15 Min | 76 | 96.7F       | 130/80         | 99%              | -        | -          | -                  | -                 |
| 28/6/26 | 2:45pm<br>15 Min | 66 | 96.6F       | 132/75         | 98%              | -        | -          | -                  | -                 |
| 28/6/26 | 3:00pm<br>30 Min | 70 | 96.6F       | 132/82         | 98%              | -        | -          | -                  | -                 |
| 28/6/26 | 3:45pm<br>30 Min | 85 | 97F         | 131/82         | 99%              | -        | -          | -                  | -                 |
| 28/6/26 | 4:15pm<br>30 Min | 77 | 97.2F       | 135/85         | 98%              | -        | -          | -                  | -                 |
| 28/6/26 | 5:00pm<br>1 Hr   | 66 | 97.2F       | 128/89         | 99%              | -        | -          | -                  | -                 |
| 28/6/26 | 5:30pm<br>1 Hr   | 71 | 97.2F       | 129/83         | 100%             | -        | -          | -                  | -                 |
|         |                  |    |             |                |                  |          |            |                    |                   |
|         |                  |    |             |                |                  |          |            |                    |                   |

Comments: Patient stable No Reaction during blood transfusion.

Name of the Incharge-Nurse: Kasthuri Name of the Nurse: Alati

Signature of the Incharge-Nurse: Kasthuri Signature of the Nurse: Alati

Date & Time: 28/6/26 @ 5:00pm Date & Time: 28/6/26 @ 5:00pm

Phone : 8790221175 , 8341711775

## SURYA BLOOD CENTRE

(A unit of Telangana Development Committee)

#3-6-150, First Floor, Above Indian Bank, Main Road, Himayatnagar, Hyderabad-29.

Lic No. 111/HD/TS/2021/BC/G

**PACKED RED CELLS I.P. 220-280 ml**

Anticoagulant : CPDA Solution U.S.P. 49 ml / 63ml

Prepared from a **VOLUNTARY DONOR / REPLACEMENT**

Blood Group.: **'A'** Rh (D) Type: **POSITIVE**

Blood Bag No.: **1177** Volume: **250ml** Collection Date: **2-6-26**

Tested Date: **2-6-26** Expiry Date: **13-7-26**

**Tested and Found Negative for HIV I & II antibodies, HBsAg, HCV antibodies, VDRL & Malaria Parasites.**

**CAUTION** 1) Do not use if there is any visible evidence of deterioration like haemolysis, clotting & discolourisation.  
2) Storage temperature 2°-6° C.  
3) Bring the Blood bag to room temperature before transfusion.  
4) Do not keep the Blood Bag in De-Freezer compartment in refrigerator.  
5) Shake gently before use. 6) Administer without warming.  
7) Transfuse under medical supervision only.  
8) Do not add any medicine to the blood.  
9) Use a fresh, sterile pyrogen free, disposable transfusion set with filter.  
10) Do not dispense without prescription.  
11) Check Blood Group & Rh Type on label and Recipient Group & Rh type before administration.  
12) Cross match before use. 13) Appropriate compatible, cross matched blood without a typical antibody in recipient should be used.  
14) If Hemolysis is present in 'O' Negative blood units it should be transfused to the same blood group recipient only.

**Please Note :** It is advised that this Blood Bag which is stored in our Blood Centre refrigerator at ideal temperature must be transfused immediately without further storing it. This Blood Bank bears no responsibility if this bag is further stored with-





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## BLOOD PRODUCTS TRANSFUSION MONITORING FORM

Date: 27/6/26 Time: 1:20 PM  
Blood Group of the Patient: A positive Blood Group on the Blood Bag: A positive  
Blood Bank Issue No: 1192 Date of Collection: 14/6/26 Date of Expiry: 25/7/26  
Date & Time of Starting Transfusion: 27/6/26 @ 1:20 PM Planned duration of Transfusion: 3 hours  
Check for Correct Unit: ☒ Correct Patient: ☒  
Blood products cross checked by: Nurse 1: Sujatha Nurse 2: Kasthuri  
Before starting transfusion vitals: Temp: 98°F HR 72 RR: 20 BP: 118/74 SpO<sub>2</sub> 99%

### PLEASE MONITOR THE FOLLOWING:

| Date    | Time                      | HR | Temperature | Blood Pressure | SpO <sub>2</sub> | Any Rash | Any Rigors | Any Breathlessness | Any Other Problem |
|---------|---------------------------|----|-------------|----------------|------------------|----------|------------|--------------------|-------------------|
| 27/6/26 | 15 Min                    | 72 | 98°F        | 118/74         | 99%              | -        | -          | -                  | -                 |
| 27/6/26 | 15 Min                    | 66 | 98°F        | 116/70         | 96%              | -        | -          | -                  | -                 |
| 27/6/26 | <sup>2:15</sup> 30 Min    | 68 | 97°F        | 96/58          | 97%              | -        | -          | -                  | -                 |
| 27/6/26 | <sup>2:45 PM</sup> 30 Min | 67 | 97.6°F      | 106/64         | 99%              | -        | -          | -                  | -                 |
| 27/6/26 | <sup>3:15 PM</sup> 30 Min | 71 | 97.6°F      | 100/69         | 99%              | -        | -          | -                  | -                 |
| 27/6/26 | <sup>4:15 PM</sup> 1 Hr   | 65 | 97.2°F      | 120/71         | 100%             | -        | -          | -                  | -                 |
|         | 1 Hr                      |    |             |                |                  |          |            |                    |                   |
|         |                           |    |             |                |                  |          |            |                    |                   |
|         |                           |    |             |                |                  |          |            |                    |                   |

Comments: No Reaction during blood Transfusion  
Patient stable.

Name of the Incharge-Nurse: Kasthuri Name of the Nurse: Alex  
Signature of the Incharge-Nurse: Kasthuri Signature of the Nurse: Alex  
Date & Time: 27/6/26 @ 4:00 PM Date & Time: 27/6/26 @ 4:00 PM

Phone : 8790221175 , 8341711775

## SURYA BLOOD CENTRE

(A unit of Telangana Development Committee)

#3-6-150, First Floor, Above Indian Bank, Main Road, Himayatnagar, Hyderabad-29.

Lic No. 111/HD/TS/2021/BC/G

PACKED RED CELLS I.P. 220-280 ml

Anticoagulant : CPDA Solution U.S.P. 49 ml / 63ml

Prepared from a VOLUNTARY DONOR / REPLACEMENT

Blood Group.: 'A' Rh (D) Type: POSITIVE

Blood Bag No.: 1192 Volume: 250ml Collection Date: 14-6-26

Tested Date: 14-6-26 Expiry Date: 25-7-26

Tested and Found Negative for HIV I & II antibodies, HBsAg, HCV antibodies, VDRL & Malaria Parasites.

**CAUTION** 1) Do not use if there is any visible evidence of deterioration like haemolysis, clotting & discolourisation.  
2) Storage temperature 2°-6° C.  
3) Bring the Blood bag to room temperature before transfusion.  
4) Do not keep the Blood Bag in De-Freezer compartment in refrigerator.  
5) Shake gently before use. 6) Administer without warming.  
7) Transfuse under medical supervision only.  
8) Do not add any medicine to the blood.  
9) Use a fresh, sterile, single use disposable transfusion set with filter.  
10) Do not dispense without prescription.  
11) Check Blood Group & Rh Type on label and Recipient Group & Rh type before administration.  
12) Cross match before use. 13) Appropriate compatible, cross matched blood without a typical antibody in recipient should be used.  
14) If Hemolysin is present in 'O' Negative blood units it should be transfused to the same blood group recipient only.

**Please Note :** It is advised that this Blood Bag which is stored in our Blood Centre refrigerator at ideal temperature must be transfused immediately without further storing it. This Blood Bank bears no responsibility if this bag is further stored with-





## CONSENT FOR BLOOD TRANSFUSION

Name: Mrs. M. Deepthi Alekhya Age: 36 Gender: Male ☐ Female ☒  
UHID.No: BAH-00559150 Date: 27/6/26

Type of Blood Product: ☐ Fresh Frozen Plasma ☒ Packed Red Blood Cells ☐ Random Donor Platelets  
☐ Cryoprecipitate ☐ Single Donor Platelet ☐ Whole Blood  
☐ Albumin ☐ Red Blood Cell ☐ Others .....

I, Mrs. M. Deepthi Alekhya hereby give my consent for whole blood transfusion or the blood components as part of treatment of myself / my patient while being admitted at Rainbow Hospital. I have been explained all the known risks of transfusion reactions. I have also been explained that the donor blood has been screened for Human Immunodeficiency Virus antibodies, Hepatitis B surface antigen, Hepatitis C antibodies, Malaria and Syphilis. I have also been explained that transfusion transmitted infections occur even with screened blood, especially if it is in. The "window period" and also due to various other infections which have not been screened for. I also understand that any blood components transfusions carries risk of transfusion associated reactions, fluid overload etc. which are generally rare. The same risks apply for multiple transfusions too.

The doctor have explained to me about the alternative for this procedure that Need for transfusion...  
Transfusion Reaction

All the above-mentioned risk, benefits and alternatives have been explained to me by the doctor treating me / my patient in the language that I fully understand and I accept the same and give my consent for all transfusions (the whole blood / or blood components Packed Red Blood Cells, Red Blood Cell, Platelets, Fresh Frozen Plasma, Cryoprecipitate etc.) to me / my Patient during he present hospital stay and treatment.

Patient (Or Patient Relative / Guardian):

Signature: P. Alekhya

Name: P. ARSHEEM

Date & Time 27/6/26 @ 1:20 pm

Doctor (Who is talking the consent)

Signature: [Signature]

Name: Dr. Sr. Ayesh

Date & Time 27/6/26 @ 1:20 pm

Witness

Signature: [Signature]

Name: Sujatha

Date & Time 27/6/26 @ 1:20 pm



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**ACKNOWLEDGMENTS**

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# INFORMED CONSENT FOR HIGH RISK

Patient Name : Mrs. Alekhya Deepthi Age : 35yrs

Gender : ☐ M ☒ F - IP No. : \_\_\_\_\_

Ward / Bed No. : \_\_\_\_\_ Date : \_\_\_\_\_

I/We Mrs. Alekhya Deepthi have been explained by Dr. Rajani Kumari about the medical condition and the proposed procedure.

I/We have been told that our patient Mrs. Alekhya Deepthi has the

Following Medical Condition / Diagnosis

P.L. / previous LSCS = large fibroid uterus ? Mass per abdomen

Proposed treatment / Procedure / Operation:

Myomectomy (or) Total abdominal hysterectomy ± Bilateral salpingo-oophorectomy

I / (We the relative / legal guardian) have been explained in the language understood by me / us,

about the medical condition mentioned above and that our patient has following risks involved

Excessive bleeding & need for transfusion of blood or blood products, need for further extensive and further management.

I / We have been explained that our patient carrier a higher risk than usual and there reason for the I / We have been informed that the ongoing treatment in the ICU involves the risk of unsuccessful result, complication, temporary or permanent injury or disability and even fatality from known or unforeseen causes and no guarantee or promises have been made to me / us concerning the results I / We have understood the consequences of not undergoing the proceed treatment. I / We hereby give (my / our) full consent for the above -mentioned treatment.

Name of the Doctor performing the procedure : Dr. Rajani Kumari

**Patient Attendant :**

Signature : [Signature]

Name : Mrs. Alekhya Deepthi

Relationship with Patient : Self

Date & Time : 27/6/26 @ 9:00am

**Witness :**

Signature : [Signature]

Name : B. Arun

Date & Time : 27/6/26 @ 9:00am

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

Signature : [Signature]

Name : Dr. G. Veena

Date & Time : 27/6/26 @





# INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

Patient Name : Mrs. Deepthi Aekkha Gender: ☐ Male ☒ Female Age : 3 Cys

UHID No : BARI-00559150 Date : 27/06/2026

## 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)

MYOMECTOMY ± TOTAL ABDOMINAL HYSTERECTOMY ±  
SALPINGECTOMY (Bilateral) ± BILATERAL upon OOPHORECTOMY SOS  
(Name of the Patient) Mrs Deepthi Aekkha

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, injury to Bowel, Bladder or Blood  
vessel, ureter, chances of Blood transfusion, chances of Total  
Hysterectomy SOS

## 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. Rajani Kumari / Dr. Anish

## Consentee :

Signature : [Signature]

Name : Mrs. Deepthi Aekkha

Date & Time : 27/06/2026 @ 9am

## Witness :

Signature : [Signature]

Name : Sujatha

Date & Time : 27/6/2026 @ 9am

## Patient Attendant :

Signature : [Signature]

Name : P. ARISHAM

Relationship with Patient: HUSBAND

Date & Time : 27/6/2026 @ 9am

## Doctor (who is taking the consent) :

Signature : [Signature]

Name : Dr. Manisha

Date & Time : 27/6/2026 @ 9am



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

Patient Name : Mrs. M. DEEPTHI ALEKHYA Age : 36 Gender : Male ☐ Female ☒

UHID NO: BAH-00559150 Surgeon Name: Dr. RATANI KUMARI

Anaesthesiologist : Dr. Aysha / Dr. Samir

Operative procedure planned : OPEN MYOMECTOMY +/- HYSTERECTOMY

## **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, Hypotension, Need for transfusion, Transfusion reaction

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 Mrs. M. DEEPTHI ALEKHYA the above mentioned operation / Diagnostic / Therapeutic procedures OPEN MYOMECTOMY +/- HYSTERECTOMY

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

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

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

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

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

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

- Pregnant : ☐ Yes ☒ No

#### DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

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

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

#### Patient / Patient Attendant :

Signature : [Signature]  
Name : M Deepthi  
Relationship with Patient : Self  
Date & Time : 27/6/26 @ 9:50 AM

#### Witness :

Signature : [Signature]  
Name : R ASHOKAM  
Date & Time : 27/6/26 @ 9:50 AM

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

Signature : [Signature]  
Name : Dr. S.K. Ayesha  
Date & Time : 27/6/26 @ 9:50 AM



Department of Anaesthesiology  
PRE-ANAESTHETIC EVALUATION

Name: Mrs. M. Deepthi Alekha Age: 36y5m Sex: F UHID.No: BAH-0059150  
Date: 22/6/26 Time: 2pm Proposed Operation: Open Myomectomy on 27/6 (@10 AM)  
Diagnosis: Multiple fibroids  
B.P / CRT: 116/80 mmHg H.R: 72bpm Weight: 59.8kgs ASA Physical Status: ☐ 1 ☒ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:  
Hgb: 13.1 g/l Glucose: 112 mg/dl Protein: 8.0  
PCV: 36.0% Urea: 12 mg/dl Alb: 4.5  
WBC: 8610/cmm Creat: 0.47 mg/dl Total Bill: 0.24 < 0.13  
Plate: 3.0 lac/cmm Na: Dir. Bill:  
PT: K: LDH:  
aPTT: 33.9 Ca++: Alk phos: 41.7  
INR: Mg++: Amylase:  
Hba1c - 6.5% Cl-: SGOT/SGPT: 16.4/14.2  
HIV: ☒ Negative X-Ray: N/SR, T in II, avf.  
HBS Ag: ☒ Negative ECG: Grade 2 LV diastolic dysfunction  
HCV: ☒ Negative 2D Echo: EF = 65%.  
Blood group: A+ve. Stress/Angio: Trivial TE.  
T3: T4: TSH: 3.99  $\mu$ IU/mL  
Allergies: NKDA. (DUST ALLERGY)

Medical History: CVS: No chest pain/palpitations/Breathlessness - Hypothyroid since pregnancy  
RESP: Occasional Cough Diabetes: Nil on Tab. Thyronorm 88mcg OD.  
CNS: No Seizures/TIA - Hypertensive since pregnancy  
Renal: Bowel & bladder habits. on Tab. PROLOMET-AM 50/5  
Hepatic / GE: Physical Activity: Active (METOPROLOL + AMLODIPINE)  
Others: (NYHA-I)

Past Anaesthetic History: 1 prev. LSCS  $\downarrow$  SAB in 2023, Uneventful.

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: Neck: Teeth: Intact  
Lungs: 8/8 A/E clear USG: Bulky Uterus with Mult  
Heart: S1S2 Fibroids  
CNS: NAD (119x119x76 mm) largest (72  
Pregnant: ☐ Yes ☒ No ☐ NA Venous Access Site: Accessible Spine Exam for regional: Midline

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

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

| CURRENT MEDICATIONS                 | DOSAGE |
|-------------------------------------|--------|
| T. Thyronorm 88mcg OD               |        |
| T. Metoprolol + Amlodipine 50/5 BD. |        |
|                                     |        |
|                                     |        |

Pre-Operative Instructions:

- DVT Prophylaxis:
- NIL ORAL  $\rightarrow$  Water / ORS 2 Hours  $\rightarrow$  Explained.  
 $\rightarrow$  Others 6 Hours
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient
- Other Instructions:
  - Receive 10 PRBC
  - Continue Thyronorm & hypertensive medication even on the morning of Surgery with Sip of water.
  - Consent Pending.

Signature: B de Name: Dr Brunda



BAH-00559150 IP26-00006664  
Mrs M DEEPTHI ALEKHYA  
07-01-1990 38 Y 5 M 20 D (F)  
Dr. RAJANI KUMARI



# ANAESTHESIA CHART

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

## Pre Induction Assessment

|                              |                                                                     |                 |          |
|------------------------------|---------------------------------------------------------------------|-----------------|----------|
| Change in Patient Condition: | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | Fasting Status: | Adequate |
|------------------------------|---------------------------------------------------------------------|-----------------|----------|

|                  |                                                        |                                                     |                                                    |
|------------------|--------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------|
| Physical Status: | <input checked="" type="checkbox"/> Patient Identified | <input checked="" type="checkbox"/> Consent Present | <input checked="" type="checkbox"/> Chart Reviewed |
|------------------|--------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------|

H.R: 90/min B.P / CRT: 144/94 SpO<sub>2</sub>: 99% RA R.R: 18/min Last Feed: > 6hrs

Pre-OP Diagnosis: FIBROID UTERUS Operation: OPEN MYOMECTOMY + Hysterectomy Date: 27/6/26

Surgeon: Dr. Rajani / Dr. Ciresesh / Dr. Simran Anaesthesiologist: Dr. Ayesha / Dr. Samir Technician: Pallavi

TIME 11:30 11:40 11:50 12:00 12:10 12:20 12:30 12:40

N<sub>2</sub>O / AIR / O<sub>2</sub> LPM 6lit/min

Drugs: ONDANSETRON 4mg IV

MIDAZOLAM 1mg IV

TRANEXAMIC ACID 1gm IV

FENTANYL 50mcg IV

FiO<sub>2</sub> SaO<sub>2</sub> 97% 97% 96% 96% 95% 93% 100% 100% 100% 100% 100% 100% 100% 100%

ETCO<sub>2</sub> SR SR SR SR SR SR SR SR SR SR SR SR SR SR SR

ECG

Temperature 36.3 C

Urine Output 250ml

Fluids Blood 30 RL

B.P V Systolic 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0

A Diastolic 80 70 60 50 40 30 20 10 0

X Mean 90 80 70 60 50 40 30 20 10 0

Heart Rate 90 80 70 60 50 40 30 20 10 0

Tourniquet on Time

Tourniquet off Time

Throat Pack In

Throat Pack Out

LAB Values 12:20 pm ABG Hb: 13.3 / pH: 7.3 / PaO<sub>2</sub>: 193 / PCO<sub>2</sub>: 30.4

GRBS

Others

Equipment Checked and Functional

BP

Cuff Site: Right Radial

Art Site: Right Radial

EKG Lead

Temp Site: Axilla

FiO<sub>2</sub> Monitor

Agent Monitor

Pulse Oximeter

Capnograph

Ventilator

Nerve Stimulator

Position: Pressure Points Checked

Eye Care: Oint

Tape

Padding

Awake

### Temp:

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

### Times:

Anaes Start: 11:30 AM  
OP Start: 11:35 AM  
OP End: 12:30 PM  
Leave OR: 12:40 PM

### Anaesthesia:

☐ GA  
☒ Monitored Anaesthesia Care  
☒ Regional

### Line (Size & Location)

☐ CVP  
☒ ART  
☒ IV  
☒ IV  
☐ IV

### Induction

☐ IV ☐ Inhal  
☐ Pre O<sub>2</sub> ☐ RSI  
☐ Others

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

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

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

### Regional:

Extremity Specify: Combined Spinal Epidural  
☒ Spinal ☒ Epidural ☐ Caudal

### Others:

Position: Sitting

Site: L3-L4

Needle Size: 18G Depth: 3cm

Paresthesia ☐ Yes ☒ No

Catheter at skin 8 cm

Drug Name & Conc: 0.5% Heavy BUPIVACAINE

Bolus: 3.8ml + 55mcg FENTANYL

Infusion: Tu-T6

Block Level: Tu-T6

Comments:

Transportation to

☐ PACU ☒ ICU ☐ Other

Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor: Dr. Ayesha

Signature of the Doctor





## POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Sujatha Time Received : 12:40 PM Time Discharged : .....

|                                                                                                                                                                                             |  |                                                                                                                                                                                  |  |                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 250<br>240<br>230<br>220<br>210<br>200<br>190<br>180<br>170<br>160<br>150<br>140<br>130<br>120<br>110<br>100<br>90<br>80<br>70<br>60<br>50<br>40<br>30<br>20<br>10<br>0<br>SPO <sub>2</sub> |  | 250<br>240<br>230<br>220<br>210<br>200<br>190<br>180<br>170<br>160<br>150<br>140<br>130<br>120<br>110<br>100<br>90<br>80<br>70<br>60<br>50<br>40<br>30<br>20<br>10<br>0<br>PULSE |  | 250<br>240<br>230<br>220<br>210<br>200<br>190<br>180<br>170<br>160<br>150<br>140<br>130<br>120<br>110<br>100<br>90<br>80<br>70<br>60<br>50<br>40<br>30<br>20<br>10<br>0<br>RESPI |  | IV Cannula Site : <u>Rt hand.</u><br><input type="checkbox"/> O <sub>2</sub> Mask <input type="checkbox"/> Nasal Prongs<br><input type="checkbox"/> Tracheostomy <input type="checkbox"/> T-Piece<br><input type="checkbox"/> Oral Airway <input type="checkbox"/> Nasal Airway                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                             |  |                                                                                                                                                                                  |  |                                                                                                                                                                                  |  | Vomiting : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>NG Tube : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Drain : <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>Urinary Catheter : <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>Chest Tube : <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Nil Oral <input type="checkbox"/> Yes <input type="checkbox"/> No<br>IV Fluids : <u>plasma</u><br>Oral Feeds : <u>alm</u> |

| POST ANAESTHESIA SCORE<br>(Modified Aldrete Score) |     |               | IN | MINUTES |    |    | OUT                                                                                                                                                  | SCORING INTERPRETATION |
|----------------------------------------------------|-----|---------------|----|---------|----|----|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|
|                                                    |     |               |    | 30      | 60 | 90 |                                                                                                                                                      |                        |
| Able to move 4 extremities voluntary or on command | = 2 | ACTIVITY      | 1  | 2       | 2  | 2  | 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 | RESPIRATION   | 2  | 2       | 2  |    |                                                                                                                                                      |                        |
| Dyspnea or limited breathing                       | = 1 |               |    |         |    |    |                                                                                                                                                      |                        |
| Apneic                                             | = 0 |               |    |         |    |    |                                                                                                                                                      |                        |
| BP ± 20 of Pre Anaesthetic leve                    | = 2 | CIRCULATION   | 2  | 2       | 2  |    |                                                                                                                                                      |                        |
| BP ± 20-50 of Pre Anaesthetic leve                 | = 1 |               |    |         |    |    |                                                                                                                                                      |                        |
| BP ± 50 of Pre Anaesthetic leve                    | = 0 |               |    |         |    |    |                                                                                                                                                      |                        |
| Fully awake                                        | = 2 | CONSCIOUSNESS | 2  | 2       | 2  |    |                                                                                                                                                      |                        |
| Arousable on calling                               | = 1 |               |    |         |    |    |                                                                                                                                                      |                        |
| Not responding                                     | = 0 |               |    |         |    |    |                                                                                                                                                      |                        |
| Pink                                               | = 2 | COLOR         | 2  | 2       | 2  |    |                                                                                                                                                      |                        |
| Pale, dusky, blotchy, jaundiced, other             | = 1 |               |    |         |    |    |                                                                                                                                                      |                        |
| Cyanotic                                           | = 0 |               |    |         |    |    |                                                                                                                                                      |                        |
| TOTAL                                              |     |               | 9  | 9       | 10 | 10 |                                                                                                                                                      |                        |

## PAIN ASSESSMENT AND MANAGEMENT FORM

| Date | Time   | Pain Score | Intervention                    | Signature |
|------|--------|------------|---------------------------------|-----------|
| 24/6 | 1:00pm | 0/10       | Normal Re-Assessment after 1hr. |           |
| 24/6 | 2pm    | 1/10       | ins PCM 19H                     |           |
| 24/6 | 3:00pm | 0/10       | Normal                          |           |
| 24/6 | 4pm    | 0/10       | Normal                          |           |

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

Anaesthesiologist Name : Dr. Ayesh

Anaesthesiologist Signature :

Date & Time: .....

PACU Nurse Name : Sujatha

PACU Nurse Signature :

Date & Time: 29/6/26 @ 3pm

### Reassessment Frequency:

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

Transferred to Unit by (PACU): 3rd floor (317)

Date & Time: 29/6/26 @ 3pm





Department of Anaesthesiology

## EPIDURAL ANALGESIA RECORD

Date: 27/6/26 Time: 11:35 AM Procedure done by Dr. Ayesha

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

Depth: 3 cm Catheter at Skin: 8 cm Attempts: (1)

Parasthesia: Yes/No if yes details:

Solution Composition: 0.0625% BUPIVACAINE

Any other issues: 0.125% BUPIVACAINE + 2 mcg/ml FENTANYL

a)

b)

| Time               | Infusion Rate (ml/hr) | Bolus (ml) | Level<br>Left Right |                 | Maternal       |        | FHR | Comments                                |
|--------------------|-----------------------|------------|---------------------|-----------------|----------------|--------|-----|-----------------------------------------|
|                    |                       |            |                     |                 | BP             | Pulse  |     |                                         |
| 3:00pm             | 7 ml/hr               |            |                     |                 | 119/78<br>N/ty | 72/min |     | 0.0625% BUPIVACAINE                     |
| 3:45pm             |                       | 10 ml      | T <sub>8</sub>      | T <sub>8</sub>  | 120/76<br>N/ty | 69/min |     | 0.8% LIDOCaine<br>+ ADRENALINE          |
| 4:15pm             | 10 ml/hr              |            | T <sub>8</sub>      | T <sub>8</sub>  | 118/72<br>N/ty | 72/min |     | 0.0625% BUPIVACAINE                     |
| 5:40pm             | 12 ml/hr              |            | T <sub>12</sub>     | T <sub>12</sub> | 120/76<br>N/ty | 78/min |     | 0.0625% BUPIVACAINE                     |
| 6:40pm             |                       | 8 ml       | T <sub>8</sub>      | T <sub>8</sub>  | 120/74<br>N/ty | 74/min |     | 0.8% LIDOCaine<br>+ ADRENALINE          |
| 7:15pm             | 8 ml/hr               |            | T <sub>10</sub>     | T <sub>10</sub> | 122/74<br>N/ty | 72/min |     | 0.1% BUPIVACAINE<br>+ 2 mcg/ml FENTANYL |
| ↓                  |                       |            |                     |                 |                |        |     | ↓                                       |
| 28/6/26<br>12:30pm | 5 ml/hr               |            | T <sub>12</sub>     | T <sub>12</sub> | 124/72<br>N/ty | 76/min |     | "                                       |
|                    |                       |            |                     |                 |                |        |     |                                         |
|                    |                       |            |                     |                 |                |        |     |                                         |

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

Catheter Removed by and Tip Inspected: Dr. Ayesha, Tip intact, 29/6/26, 12:50pm

Patient Satisfaction: Comfortable

Discharge / Shifting ordered by

Doctor Signature: Ayesha

Doctor Name: Dr. Ayesha

Date and Time: 29/6/26, 1:00pm

## NUTRITIONAL ASSESSMENT FOR GYNEC PATIENTS

Date: 29/6/26 Time: 5:17pm

Origin: Indian Height: 5.4 Weight: 58 kg BMI:

Food Allergies: NO

Diagnosis: POD-1, S/P ODE N myomectomy + hysterectomy + BSO

Medical History: thyroid, hypertension

Surgical History: NSCS -1

☒ Vegetarian ☐ Non-Vegetarian ☐ Vegan

Diet Advised: soft diet

Patient's / Attendant's

Signature: R. Sathwik

Name: Deepthi

Date &amp; Time: 29/6/26; 5:17pm

Dietician's

Signature: S

Name: sathwik a. g

Date &amp; Time: 29/6/26; 5:17pm

# PATIENT TRANSFER FORM

|                                                                                                                                                                                                                                     |                                     |                                                                                                                                                                        |                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| <b>Patient Name &amp; UHID No.</b><br>BAH-00559150 IP26-00006664<br>Mrs M DEEPTHI ALEKHYA<br>07-01-1990 36 Y 5 M 20 D (F)<br>Dr. RAJANI KUMARI<br> |                                     | <b>Date &amp; Time of Admission</b><br>27/6/26 @ 8:6 AM                                                                                                                | <b>Date &amp; Time of Transfer Order</b><br>27/6/26 @ 11:10 AM |
|                                                                                                                                                                                                                                     |                                     | <b>Transfer Ordered by</b><br>DR. Manisha                                                                                                                              | <b>Reason for Transfer</b><br>myomectomy                       |
| <b>From Unit</b><br>MICU                                                                                                                                                                                                            | <b>To Unit</b><br>OT                | <b>Information to Attendant</b><br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                 |                                                                |
| <b>Number of Sheets in Clinical File</b><br>30                                                                                                                                                                                      | <b>Number of Imaging Films</b><br>- | <b>Personal belongings including clinical documents. If any handed over to attendant</b><br>Yes <input type="checkbox"/> No <input type="checkbox"/><br>If yes, what ? |                                                                |
| <b>Medications / Consumables / Surgicals / Hand over</b>                                                                                                                                                                            |                                     |                                                                                                                                                                        |                                                                |
| Sl.No.                                                                                                                                                                                                                              | Item Name                           | Quantity                                                                                                                                                               |                                                                |
| 1.                                                                                                                                                                                                                                  | RL - 500ml                          | ①                                                                                                                                                                      |                                                                |
| 2.                                                                                                                                                                                                                                  |                                     |                                                                                                                                                                        |                                                                |
| 3.                                                                                                                                                                                                                                  |                                     |                                                                                                                                                                        |                                                                |
| 4.                                                                                                                                                                                                                                  |                                     |                                                                                                                                                                        |                                                                |
| 5.                                                                                                                                                                                                                                  |                                     |                                                                                                                                                                        |                                                                |
| <b>Shifting Summary / Notes Written by Doctor :</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                                                                             |                                     |                                                                                                                                                                        |                                                                |
| <b>Name &amp; Signature of Person who is Transferring</b><br>Sis. Sujatha                                                                                                                                                           |                                     | <b>Name of Person Ordered Transfer</b><br>DR. Manisha                                                                                                                  |                                                                |
| <b>Patient &amp; Clinical Records Received by :</b><br>Karan                                                                                                                                                                        |                                     |                                                                                                                                                                        |                                                                |
| <b>Date &amp; Time of Patient Received :</b><br>27/6/26 @ 11:30 AM                                                                                                                                                                  |                                     |                                                                                                                                                                        |                                                                |

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

☐ Unavailable Bed

☐ Nurse not Available

☐ Available Bed not ready



# PATIENT TRANSFER FORM

BAH-00559150 IP26-00006664  
Mrs M DEEPTHI ALEKHYA  
07-01-1990 36 Y 5 M 20 D (F)  
Dr. RAJANI KUMARI



|                                                                                                       |                                  |                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date & Time of Admission                                                                              |                                  | Date & Time of Transfer Order<br>27/6/26 @                                                                                                                                 |
| Treating Consultant Name                                                                              | Transfer Ordered by<br>Dr. Samir | Reason for Transfer<br>Observation                                                                                                                                         |
| From Unit<br>OT                                                                                       | 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>32                                                               | 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>Natarajanna 27/6/26 @ 12/14 PM                      |                                  | Name of Person Ordered Transfer<br>Dr. Samir                                                                                                                               |
| Patient & Clinical Records Received by :                                                              |                                  |                                                                                                                                                                            |
| 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



26-0000208892

## NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

| Patient Name:                                         | Mrs. Deepthi                        | Age:                    | 36Y         | Gender: | Female  |
|-------------------------------------------------------|-------------------------------------|-------------------------|-------------|---------|---------|
| UHID No:                                              | BAH-00559198                        | IP No:                  | 26-00006664 | Date:   | 28/6/26 |
| Time:                                                 | 11:40 AM                            | Diagnosis: Hysterectomy |             |         |         |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                         |             |         |         |
| S.No                                                  | Drug Name                           | Dosage                  | Remarks     |         |         |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | 100 mcg                 | one         |         |         |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      |                         |             |         |         |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG |                         |             |         |         |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG |                         |             |         |         |
| Doctor Name:                                          |                                     | DR. SK. AYESTHA         |             |         |         |
| Signature:                                            |                                     | TSMC/FMR/07725          |             |         |         |

## NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 26-00006664 Date: 28/6/28

Aadhaar No. of the Patient (Optional):

| 1.   | Name :                                                                                                                              | HNO-14 Kothurwihar Colony |                                                                |                 |
|------|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------|-----------------|
| 2.   | Complete postal address (with contact number, if any)                                                                               | Chandapally Hyderabad     |                                                                |                 |
| 3.   | Brief description of the illness                                                                                                    | Epidural                  |                                                                |                 |
| 4.   | Whether registered with any other registered medical practioner / recognized medical institution ( If yes, details of the recorded) |                           |                                                                |                 |
| 5.   | Details of essential Narcotic drug dispensed                                                                                        | INT: Fentanyl             |                                                                |                 |
| Date | Name of the Essential Narcotic Drugs                                                                                                | Quantity                  | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| 28/6 | INT: Fentanyl                                                                                                                       | 1                         |                                                                |                 |
|      |                                                                                                                                     |                           |                                                                |                 |

Dispensed by (Name & ID No.): Sania (018442) Signature: [Signature]

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

Time:



1

NARCOTIC PRESCRIPTION FORM  
PATIENT COPY

|                          |                           |                             |                            |
|--------------------------|---------------------------|-----------------------------|----------------------------|
| 1. Patient Name          | 2. Date of Birth          | 3. Sex                      | 4. Address                 |
| 5. City                  | 6. State                  | 7. Zip                      | 8. Telephone               |
| 9. Physician's Name      | 10. Physician's Address   | 11. Physician's City        | 12. Physician's State      |
| 13. Physician's Zip      | 14. Physician's Telephone | 15. Date of Prescription    | 16. Signature of Physician |
| 17. Signature of Patient | 18. Date of Signature     | 19. Name of Drug            | 20. Dosage                 |
| 21. Frequency            | 22. Route                 | 23. Indication              | 24. Duration               |
| 25. Refills              | 26. Expiration Date       | 27. Signature of Pharmacist | 28. Date of Dispensing     |

NARCOTIC DISPENSING FORM  
APPENDIX A FORM NO. 32

(Details of the Patient to whom Narcotic Dispensed)

|                          |                           |                             |                            |
|--------------------------|---------------------------|-----------------------------|----------------------------|
| 1. Patient Name          | 2. Date of Birth          | 3. Sex                      | 4. Address                 |
| 5. City                  | 6. State                  | 7. Zip                      | 8. Telephone               |
| 9. Physician's Name      | 10. Physician's Address   | 11. Physician's City        | 12. Physician's State      |
| 13. Physician's Zip      | 14. Physician's Telephone | 15. Date of Prescription    | 16. Signature of Physician |
| 17. Signature of Patient | 18. Date of Signature     | 19. Name of Drug            | 20. Dosage                 |
| 21. Frequency            | 22. Route                 | 23. Indication              | 24. Duration               |
| 25. Refills              | 26. Expiration Date       | 27. Signature of Pharmacist | 28. Date of Dispensing     |

281



26-0000208892

## NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

|                                                       |                                     |                                        |         |
|-------------------------------------------------------|-------------------------------------|----------------------------------------|---------|
| Patient Name: Mrs. Deepthi                            | Age: 36Y                            | Gender: Female                         |         |
| UHID No: BAH-00559150                                 | IP No: 26-00006664                  | Date: 28/6/26 Time: 11:40 AM           |         |
| Diagnosis: Hysterectomy                               |                                     |                                        |         |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                                        |         |
| S.No                                                  | Drug Name                           | Dosage                                 | Remarks |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | 100 mcg                                | one     |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      |                                        |         |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG |                                        |         |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG |                                        |         |
| Doctor Name: DR. SK. ANEESH A                         |                                     | Doctor Registration No: TSMC/FMR/07725 |         |
| Signature: <i>[Signature]</i>                         |                                     |                                        |         |

## NARCOTIC DISPENSING FORM

### APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 26-00006664 Date: 28/6/28

Aadhaar No. of the Patient (Optional):

|    |                                                                                                                                       |                                                   |
|----|---------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| 1. | Name :                                                                                                                                | Remarks                                           |
| 2. | Complete postal address (with contact number, if any)                                                                                 | HNO-14 Raju Vihar Colony<br>Chandapally Hyderabad |
| 3. | Brief description of the illness                                                                                                      | Epidural                                          |
| 4. | Whether registered with any other registered medical practitioner / recognized medical institution ( If yes, details of the recorded) |                                                   |
| 5. | Details of essential Narcotic drug dispensed                                                                                          | INT: Fentanyl                                     |

| Date | Name of the Essential Narcotic Drugs | Quantity | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
|------|--------------------------------------|----------|----------------------------------------------------------------|-----------------|
| 28/6 | INT: Fentanyl                        | 1        |                                                                |                 |
|      |                                      |          |                                                                |                 |

Dispensed by (Name & ID No.): Sania (118442) Signature: \_\_\_\_\_

Received by (Name & ID No.): Munika (607575) Signature: \_\_\_\_\_

Time: \_\_\_\_\_





# NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

|                                                      |                        |                         |         |
|------------------------------------------------------|------------------------|-------------------------|---------|
| Patient Name                                         |                        | Date                    |         |
| UIC No.                                              |                        | IP No.                  |         |
| Diagnosis                                            |                        |                         |         |
| PRESCRIPTION DETAIL (Tick only one of the following) |                        |                         |         |
| S.No                                                 | Drug Name              | Dosage                  | Remarks |
| 1                                                    | Paracetamol 500mg/5ml  |                         |         |
| 2                                                    | Morphine 10mg/5ml      |                         |         |
| 3                                                    | Remifentanyl 0.1mg/5ml |                         |         |
| 4                                                    | Remifentanyl 0.1mg/5ml |                         |         |
| Doctor Name                                          |                        | Doctor Registration No. |         |
| Signature                                            |                        |                         |         |

## NARCOTIC DISPENSING FORM

APPENDIX 4 - FORM NO 3E

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

|                                       |                                                                                                                                  |          |                                                                  |
|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------|------------------------------------------------------------------|
| IP Registration No.                   |                                                                                                                                  | Date     |                                                                  |
| Address No. of the Patient (Optional) |                                                                                                                                  |          |                                                                  |
| 1                                     | Name                                                                                                                             | Remarks  |                                                                  |
| 2                                     | Complete postal address (with contact number, if any)                                                                            |          |                                                                  |
| 3                                     | Brief description of the illness                                                                                                 |          |                                                                  |
| 4                                     | Whether registered with any other registered medical practitioner in any medical institution (If yes, details of the registered) |          |                                                                  |
| 5                                     | Details of essential narcotic drug dispensed                                                                                     |          |                                                                  |
| Date                                  | Name of the Essential Narcotic Drug                                                                                              | Quantity | Signature (Thumb impression of the patient)<br>Patient's Address |
|                                       |                                                                                                                                  |          | Remarks, if any                                                  |
|                                       |                                                                                                                                  |          |                                                                  |
|                                       |                                                                                                                                  |          |                                                                  |

Signature

Signature

Time

Doc No. RCH/CLINICAL/...



26-0000208839

## NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

| Patient Name:                                         | Mrs. M Deepthi - Nlekhye            | Age:           |             | Gender: | Female  |
|-------------------------------------------------------|-------------------------------------|----------------|-------------|---------|---------|
| UHID No:                                              | BH-00559150                         | IP No:         | 26-00006664 | Date:   | 28/6/26 |
| Time:                                                 | 4 AM                                |                |             |         |         |
| Diagnosis:                                            | Hysterectomy                        |                |             |         |         |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                |             |         |         |
| S.No                                                  | Drug Name                           | Dosage         | Remarks     |         |         |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | 100mcg         | ONE         |         |         |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      |                |             |         |         |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG |                |             |         |         |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG |                |             |         |         |
| Doctor Name:                                          |                                     | DR. SK. AYESHA |             |         |         |
| Signature:                                            |                                     | TSMC/FMR/07725 |             |         |         |

## NARCOTIC DISPENSING FORM

### APPENDIX 4 - FORM NO. 3E

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

IP Registration No: 26-00006664 Date: 28/6/2026

Aadhaar No. of the Patient (Optional):

| 1.   | Name :                                                                                                                              | HNo-14 Karivihar colony         |                                                                |                 |
|------|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------|-----------------|
| 2.   | Complete postal address (with contact number, if any)                                                                               | Cherlapally Telangana Hyderabad |                                                                |                 |
| 3.   | Brief description of the illness                                                                                                    | Epidural                        |                                                                |                 |
| 4.   | Whether registered with any other registered medical practioner / recognized medical institution ( If yes, details of the recorded) |                                 |                                                                |                 |
| 5.   | Details of essential Narcotic drug dispensed                                                                                        | Inj fentanyl                    |                                                                |                 |
| Date | Name of the Essential Narcotic Drugs                                                                                                | Quantity                        | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| 28/6 | Inj fentanyl                                                                                                                        | ONE                             |                                                                | -               |

Dispensed by (Name & ID No.): Sania (018442) Signature: \_\_\_\_\_

Received by (Name & ID No.): Chandra Sekh (018411) Signature: \_\_\_\_\_

Time: \_\_\_\_\_



NARCOTIC PRESCRIPTION FORM

PATIENT COPY

Patient Name: [illegible]  
Address: [illegible]  
City: [illegible]

| Drug Name   | Strength    | Dosage      | Frequency   | Route       |
|-------------|-------------|-------------|-------------|-------------|
| [illegible] | [illegible] | [illegible] | [illegible] | [illegible] |
| [illegible] | [illegible] | [illegible] | [illegible] | [illegible] |
| [illegible] | [illegible] | [illegible] | [illegible] | [illegible] |
| [illegible] | [illegible] | [illegible] | [illegible] | [illegible] |

NARCOTIC DISPENSING FORM

APPENDIX 4 - FORM NO. 3

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

Patient Name: [illegible]  
Address: [illegible]  
City: [illegible]

1st - 1st/28/1978  
2nd - 2nd/28/1978  
3rd - 3rd/28/1978

Signature: [illegible]  
Date: [illegible]

Signature: [illegible]

Signature: [illegible]  
Date: [illegible]



26-0000208839.1

## NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

| Patient Name: <u>Mrs. M Deepthi - Mekhya</u>          | Age:                                | Gender: <u>Female</u>                         |            |
|-------------------------------------------------------|-------------------------------------|-----------------------------------------------|------------|
| UHID No: <u>BH4-00559150</u>                          | IP No: <u>26-00006664</u>           | Date: <u>28/6/26</u> Time: <u>4 AM</u>        |            |
| Diagnosis: <u>Hysterectomy</u>                        |                                     |                                               |            |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                                               |            |
| S.No                                                  | Drug Name                           | Dosage                                        | Remarks    |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | <u>100mcg</u>                                 | <u>ONE</u> |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      |                                               |            |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG |                                               |            |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG |                                               |            |
| Doctor Name: <u>Dr. SK. AYESHA</u>                    |                                     | Doctor Registration No: <u>TSMC/EMR/00025</u> |            |
| Signature: <u>[Signature]</u>                         |                                     |                                               |            |

## NARCOTIC DISPENSING FORM

### APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 26-00006664Date: 28/6/2026

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

| 1.        | Name :                                                                                                                              | Remarks: <u>H110-14 Parivihar colony</u>  |                                                                |                 |
|-----------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------|-----------------|
| 2.        | Complete postal address (with contact number, if any)                                                                               | <u>Charolapally - Telangana Hyderabad</u> |                                                                |                 |
| 3.        | Brief description of the illness                                                                                                    | <u>epidural</u>                           |                                                                |                 |
| 4.        | Whether registered with any other registered medical practioner / recognized medical institution ( If yes, details of the recorded) |                                           |                                                                |                 |
| 5.        | Details of essential Narcotic drug dispensed                                                                                        | <u>INJ fentanyl.</u>                      |                                                                |                 |
| Date      | Name of the Essential Narcotic Drugs                                                                                                | Quantity                                  | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| <u>16</u> | <u>INJ fentanyl</u>                                                                                                                 | <u>ONE</u>                                | <u>[Signature]</u>                                             | <u>-</u>        |
|           |                                                                                                                                     |                                           |                                                                |                 |

Dispensed by (Name & ID No.): Sania (0154112) Signature: .....Received by (Name & ID No.): [Signature] (0154111) Signature: [Signature]

Time: .....



# NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

|                                                      |                                     |                         |
|------------------------------------------------------|-------------------------------------|-------------------------|
| Patient Name                                         | Age                                 | Gender                  |
| UHQ No.                                              | Date                                | Time                    |
| Diagnosis                                            |                                     |                         |
| PRESCRIPTION DETAIL (Tick only one of the following) |                                     |                         |
| S. No                                                | Drug Name                           | Dosage                  |
| 1                                                    | Fentanyl Citrate Inf. 50mcg/ml      |                         |
| 2                                                    | Morphine Sulphate Inf. 15mg/ml      |                         |
| 3                                                    | Remifentanyl Hydrochloride Inf. 1MG |                         |
| 4                                                    | Remifentanyl Hydrochloride Inf. 1MG |                         |
| Doctor Name                                          |                                     | Doctor Registration No. |
| Signature                                            |                                     |                         |

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

|                                       |                                                                                                                                         |                 |
|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| IP Registration No.                   |                                                                                                                                         | Date            |
| Address No. of the Patient (Optional) |                                                                                                                                         |                 |
| 1                                     | Name                                                                                                                                    | Remarks         |
| 2                                     | Complete postal address (with contact number if any)                                                                                    |                 |
| 3                                     | Brief description of the illness                                                                                                        |                 |
| 4                                     | Whether registered with any other registered medical practitioner / recognized medical institution (if yes, details of the institution) |                 |
| 5                                     | Details of Essential Narcotic drug dispensed                                                                                            |                 |
| Date                                  | Name of the Essential Narcotic Drugs                                                                                                    | Quantity        |
|                                       | Signature (Thumb impression of the patient)                                                                                             | Remarks, if any |
|                                       | Patient Attender                                                                                                                        |                 |

Dispensed by (Name & ID No.)  
Received by (Name & ID No.)



26-0000208801

## NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

| Patient Name: <u>Mrs. M Deepthi Alekhya</u>           | Age: <u>36</u>                      | Gender: <u>Female</u>                         |            |
|-------------------------------------------------------|-------------------------------------|-----------------------------------------------|------------|
| UHID No: <u>BAH-0055915</u>                           | ID No: <u>26-00006664</u>           | Date: <u>27/6/26</u> Time: <u>11:33pm</u>     |            |
| Diagnosis: <u>myomectomy.</u>                         |                                     |                                               |            |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                                               |            |
| S.No                                                  | Drug Name                           | Dosage                                        | Remarks    |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | <u>100mcg</u>                                 | <u>ONE</u> |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      |                                               |            |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG |                                               |            |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG |                                               |            |
| Doctor Name: <u>DR. SK. AYESHA</u>                    |                                     | Doctor Registration No: <u>TSMC/FMR/07725</u> |            |
| Signature: <u>[Signature]</u>                         |                                     |                                               |            |

## NARCOTIC DISPENSING FORM

### APPENDIX 4 – FORM NO. 3E

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

IP Registration No: IP26-00006664 Date: 27/6/2026

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

| S.No | Name :                                                                                                                              | Remarks                                                |
|------|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| 2.   | Complete postal address (with contact number, if any)                                                                               | <u>HNO-14 Ravihar colony cheralapally - Hyderabad!</u> |
| 3.   | Brief description of the illness                                                                                                    | <u>EPIDURAL.</u>                                       |
| 4.   | Whether registered with any other registered medical practioner / recognized medical institution ( If yes, details of the recorded) | <u>NOT</u>                                             |
| 5.   | Details of essential Narcotic drug dispensed                                                                                        | <u>Inj fentanyl</u>                                    |

| Date           | Name of the Essential Narcotic Drugs | Quantity   | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
|----------------|--------------------------------------|------------|----------------------------------------------------------------|-----------------|
| <u>27/6/26</u> | <u>Inj fentanyl</u>                  | <u>ONE</u> | <u>[Signature]</u>                                             |                 |
|                |                                      |            |                                                                |                 |

Dispensed by (Name & ID No.): sania (018442.) Signature: .....

Received by (Name & ID No.): Chandrasekhar (015411) Signature: [Signature]

Time: 12:38 pm



NARCOTIC PRESCRIPTION FORM  
PATIENT COPY

Print the following information in the space provided:  
Patient Name: [Name] Date of Birth: [Date]  
Address: [Address] City: [City] State: [State] Zip: [Zip]  
Physician Name: [Name] Physician Address: [Address]  
Physician Phone: [Phone] Physician Fax: [Fax]

| No. | Drug Name       | Dose  | Frequency     | Route |
|-----|-----------------|-------|---------------|-------|
| 1   | Painexin 500mg  | 500mg | 4 times daily | PO    |
| 2   | Meperidine 75mg | 75mg  | 4 times daily | PO    |
| 3   | Hydrocodone 5mg | 5mg   | 4 times daily | PO    |
| 4   | Codeine 30mg    | 30mg  | 4 times daily | PO    |

NARCOTIC DISPENSING FORM  
APPENDIX 2 - FORM 100-100

(Details of the Patient to whom Narcotics are Dispensed)

Registration No. [Number] Patient No. of the Patient (Initials) [Initials]  
Date of Dispensing [Date]

Name [Name]  
Complete postal address (with complete zip code) [Address]  
Date of expiration of the license [Date]  
Physician (Registered with the State Board of Medical Practice) [Name]  
Physician Address [Address]  
Physician Phone [Phone]

Name of the Dispensing Agency [Name]  
Address of the Dispensing Agency [Address]  
City [City] State [State] Zip [Zip]  
Date of Dispensing [Date]

Signature of Dispensing Agency [Signature]

Signature of Patient [Signature]

Date of Dispensing [Date]

Page 1 of 1



## NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

| Patient Name:                                         | Mrs. M Deepthi Alexhyg              | Age:                                    | 36          | Gender: | Female  |
|-------------------------------------------------------|-------------------------------------|-----------------------------------------|-------------|---------|---------|
| UHID No:                                              | RNH-00539190                        | IP No:                                  | 26-00006664 | Date:   | 27/6/26 |
| Time:                                                 | 11:33pm                             | Diagnosis: myomectomy.                  |             |         |         |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                                         |             |         |         |
| S.No                                                  | Drug Name                           | Dosage                                  | Remarks     |         |         |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | 100mcg                                  | ONE         |         |         |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      |                                         |             |         |         |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG |                                         |             |         |         |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG |                                         |             |         |         |
| Doctor Name: DR SK ANISHA                             |                                     | Doctor Registration No: TSMC/FMR/007201 |             |         |         |
| Signature: <i>[Signature]</i>                         |                                     |                                         |             |         |         |

## NARCOTIC DISPENSING FORM

### APPENDIX 4 – FORM NO. 3E

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

IP Registration No: IP26-00006664 Date: 27/6/2026

Aadhaar No. of the Patient (Optional):

| 1.      | Name :                                                                                                                              | Remarks                                         |                                                                |                 |
|---------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------|-----------------|
| 2.      | Complete postal address (with contact number, if any)                                                                               | 110-14 Roosthah colony cheralapally - Hyderabad |                                                                |                 |
| 3.      | Brief description of the illness                                                                                                    | Epidural                                        |                                                                |                 |
| 4.      | Whether registered with any other registered medical practioner / recognized medical institution ( If yes, details of the recorded) | NO                                              |                                                                |                 |
| 5.      | Details of essential Narcotic drug dispensed                                                                                        | Inj fentanyl                                    |                                                                |                 |
| Date    | Name of the Essential Narcotic Drugs                                                                                                | Quantity                                        | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| 27/6/26 | Inj fentanyl                                                                                                                        | ONE                                             | <i>[Signature]</i>                                             |                 |
|         |                                                                                                                                     |                                                 |                                                                |                 |

Dispensed by (Name & ID No.): Sania (018442) Signature: \_\_\_\_\_

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

Time: 11:33 AM





# NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

|                                                           |        |           |  |
|-----------------------------------------------------------|--------|-----------|--|
| Patient Name                                              |        | Date      |  |
| UHD No                                                    |        | Time      |  |
| Diagnosis                                                 |        |           |  |
| PRESCRIPTION DETAILS (Indicate only one of the following) |        |           |  |
| Drug Name                                                 | Dosage | Remarks   |  |
| 1. Fentanyl Citrate Int. 50mcg/ml                         |        |           |  |
| 2. Morphine Sulfate Int. 15mcg/ml                         |        |           |  |
| 3. Remifentanyl Hydrochloride Int. 2MG                    |        |           |  |
| 4. Remifentanyl Hydrochloride Int. 1MG                    |        |           |  |
| Doctor Name                                               |        | Signature |  |

## NARCOTIC DISPENSING FORM

APPENDIX 4 - FORM NO. 3E

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

IP Registration No. \_\_\_\_\_ Date: \_\_\_\_\_

UHD No. of the Patient (Optional) \_\_\_\_\_

|         |                                                         |                                    |                                                                                                                                   |                                                  |                                         |             |                                                |                    |
|---------|---------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------|-------------|------------------------------------------------|--------------------|
| 1. Name | 2. Complete postal address (with country/number if any) | 3. Chief occupation of the patient | 4. Whether registered with any other registered medical practitioner (indicate medical institution if any, details in the record) | 5. Details of essential narcotic drugs dispensed | 6. Name of the Essential Narcotic Drugs | 7. Quantity | 8. Signature of the patient's Parent/Attendant | 9. Remarks, if any |
|         |                                                         |                                    |                                                                                                                                   |                                                  |                                         |             |                                                |                    |
|         |                                                         |                                    |                                                                                                                                   |                                                  |                                         |             |                                                |                    |
|         |                                                         |                                    |                                                                                                                                   |                                                  |                                         |             |                                                |                    |
|         |                                                         |                                    |                                                                                                                                   |                                                  |                                         |             |                                                |                    |

Signature

Signature

Dispensed by: \_\_\_\_\_  
Reviewed by: \_\_\_\_\_



26-0000208747

## NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

| Patient Name:                                         | MRS. M DEEPTHI ALEKHIYA             | Age:           | 36 Y 5 M    | Gender: | Female  |
|-------------------------------------------------------|-------------------------------------|----------------|-------------|---------|---------|
| UHID No:                                              | BAH-00559150                        | IP No:         | 26-00006664 | Date:   | 27/6/26 |
| Diagnosis:                                            | Myomectomy                          |                |             | Time:   | 6.40 PM |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                |             |         |         |
| S.No                                                  | Drug Name                           | Dosage         | Remarks     |         |         |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | 100 MCg        | 1 Amples    |         |         |
|                                                       | Morphine Sulphate Inj. 15mg/ML      |                |             |         |         |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG |                |             |         |         |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG |                |             |         |         |
| Doctor Name:                                          |                                     | DR. SK. AYESHA |             |         |         |
| Signature:                                            |                                     | TSMC/FMR/07725 |             |         |         |

## NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 26-00006664 Date: 27/6/26

Aadhaar No. of the Patient (Optional):

| 1.   | Name :                                                                                                                                | Remarks                                          |                                                                |                 |
|------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------|-----------------|
| 2.   | Complete postal address (with contact number, if any)                                                                                 | H NO. 14, RAKVIHAR COLONY, Charlapally Hyderabad |                                                                |                 |
| 3.   | Brief description of the illness                                                                                                      | NA                                               |                                                                |                 |
| 4.   | Whether registered with any other registered medical practitioner / recognized medical institution ( If yes, details of the recorded) | NA                                               |                                                                |                 |
| 5.   | Details of essential Narcotic drug dispensed                                                                                          |                                                  |                                                                |                 |
| Date | Name of the Essential Narcotic Drugs                                                                                                  | Quantity                                         | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| 27/6 | Fentanyl                                                                                                                              | 1                                                |                                                                |                 |

Dispensed by (Name & ID No.): Sahia (018442) Signature: Sahia

Received by (Name & ID No.): Madhumita @ Madhu (0152007) Signature: Madhu

Time:







26-0000208747  
**NARCOTIC PRESCRIPTION FORM**  
(MEDICAL RECORD)

| Patient Name:                                         | MRS. M DEEPTHI ALEKHYA              | Age:            | 36 Y 6 M    | Gender: | Female  |
|-------------------------------------------------------|-------------------------------------|-----------------|-------------|---------|---------|
| UHID No:                                              | BAH-00669150                        | IP No:          | 26-00006664 | Date:   | 22/6/26 |
| Diagnosis:                                            | Myomectomy                          |                 |             |         |         |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                 |             |         |         |
| S.No                                                  | Drug Name                           | Dosage          | Remarks     |         |         |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | 100mcg          | 100mcg      |         |         |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      |                 |             |         |         |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG |                 |             |         |         |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG |                 |             |         |         |
| Doctor Name:                                          |                                     | DR. SK. AYESHIA |             |         |         |
| Signature:                                            |                                     | TSMC/FMR/07725  |             |         |         |

**NARCOTIC DISPENSING FORM**

APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 26-00006664

Date: 22/6/26

Aadhaar No. of the Patient (Optional):

| 1.   | Name :                                                                                                                              | Remarks                                          |                                                                |                 |
|------|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------|-----------------|
| 2.   | Complete postal address (with contact number, if any)                                                                               | H No. 14, RAKVIHAR COLONY, CHAROLA, PUNE 411 004 |                                                                |                 |
| 3.   | Brief description of the illness                                                                                                    | NA                                               |                                                                |                 |
| 4.   | Whether registered with any other registered medical practioner / recognized medical institution ( If yes, details of the recorded) | NA                                               |                                                                |                 |
| 5.   | Details of essential Narcotic drug dispensed                                                                                        |                                                  |                                                                |                 |
| Date | Name of the Essential Narcotic Drugs                                                                                                | Quantity                                         | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| 22/6 | Fentanyl                                                                                                                            | 1                                                |                                                                |                 |
| 2    |                                                                                                                                     |                                                  |                                                                |                 |

Dispensed by (Name & ID No.): Sonia (015444) Signature: Sonia

Received by (Name & ID No.): Madhura (015729) Signature: Madhura

Time:





# NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

|                                                       |                       |        |
|-------------------------------------------------------|-----------------------|--------|
| Patient Name                                          | Age                   | Gender |
| UHD No                                                | Date                  | Time   |
| Diagnosis                                             |                       |        |
| PRESCRIPTION DETAILS (tick only one of the following) |                       |        |
| S. No                                                 | Drug Name             | Dosage |
| 1                                                     | Paracetamol 500mg/ml  |        |
| 2                                                     | Morphine 2mg/ml       |        |
| 3                                                     | Remifentanyl 0.5mg/ml |        |
| 4                                                     | Remifentanyl 0.5mg/ml |        |
| Remarks                                               |                       |        |
| Doctor Name                                           |                       |        |
| Signature                                             |                       |        |
| Date                                                  |                       |        |

## NARCOTIC DISPENSING FORM

APPENDIX 4 - FORM NO. 3B

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

|                                       |                                                                                    |
|---------------------------------------|------------------------------------------------------------------------------------|
| IP Registration No.                   | Date                                                                               |
| Patient No. (if the Patient is known) |                                                                                    |
| 1                                     | Name                                                                               |
| 2                                     | Complete postal address with postal number, if any                                 |
| 3                                     | Brief description of the illness                                                   |
| 4                                     | Whether patient has any other medical condition (if yes, details of the condition) |
| 5                                     | Details of essential Narcotic drug dispensed                                       |
| Date                                  | Name of the Essential Narcotic Drug                                                |
| Quantity                              | Signature / Thumb impression of the patient / Patient Attender                     |
| Remarks, if any                       |                                                                                    |

Signature

Signature



26-0000208600

## NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

| Patient Name: <u>Mrs. M. Deepthi Alekhya</u>                                   | Age: <u>36 y.s.</u>                 | Gender: <u>Female</u>                     |           |
|--------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------|-----------|
| UHID No: <u>BAH-00559150</u>                                                   | IP No: <u>26-00006664</u>           | Date: <u>27/6/26</u> Time: <u>9:54 AM</u> |           |
| Diagnosis: <u>open Myomectomy</u> <span style="float: right;"><u>OT</u></span> |                                     |                                           |           |
| PRESCRIPTION DETAILS (Tick only one of the following)                          |                                     |                                           |           |
| S.No                                                                           | Drug Name                           | Dosage                                    | Remarks   |
| 1.                                                                             | Fentanyl Citrate Inj. 50mcg/ML      | <u>100mcg</u>                             | <u>01</u> |
| 2.                                                                             | Morphine Sulphate Inj. 15mg/ML      |                                           |           |
| 3.                                                                             | Remifentanyl Hydrochloride Inj. 2MG |                                           |           |
| 4.                                                                             | Remifentanyl Hydrochloride inj. 1MG |                                           |           |
| Doctor Name: <u>Dr. Amir</u>                                                   |                                     | Doctor Registration No: <u>67529</u>      |           |
| Signature: <u>[Signature]</u>                                                  |                                     |                                           |           |

## NARCOTIC DISPENSING FORM APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 26-00006664 Date: 27/6/26

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

| 1.             | Name: <u>Mrs. Deepthi Alekhya</u>                                                                                                     | Remarks                      |                                                                |                 |
|----------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------------------------------|-----------------|
| 2.             | Complete postal address (with contact number, if any)                                                                                 | <u>Charlapally Hyderabad</u> |                                                                |                 |
| 3.             | Brief description of the illness                                                                                                      | <u>open Myomectomy</u>       |                                                                |                 |
| 4.             | Whether registered with any other registered medical practitioner / recognized medical institution ( If yes, details of the recorded) | <u>No</u>                    |                                                                |                 |
| 5.             | Details of essential Narcotic drug dispensed                                                                                          | <u>Fentanyl</u>              |                                                                |                 |
| Date           | Name of the Essential Narcotic Drugs                                                                                                  | Quantity                     | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| <u>27/6/26</u> | <u>Fentanyl</u>                                                                                                                       | <u>01</u>                    |                                                                |                 |
|                |                                                                                                                                       |                              |                                                                |                 |

Dispensed by (Name & ID No.): Same (015442) Signature: [Signature]

Received by (Name & ID No.): V. Pallavi 017921 Signature: [Signature]

Time: .....





# NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

| Drug Name                        | Strength      | Dosage          | Frequency            | Route     |
|----------------------------------|---------------|-----------------|----------------------|-----------|
| 1. <i>Hydrocodone Bitartrate</i> | <i>5 mg</i>   | <i>1 tablet</i> | <i>4 times daily</i> | <i>PO</i> |
| 2. <i>Acetaminophen</i>          | <i>325 mg</i> | <i>1 tablet</i> | <i>4 times daily</i> | <i>PO</i> |
| 3. <i>Chlorzoxazone</i>          | <i>250 mg</i> | <i>1 tablet</i> | <i>3 times daily</i> | <i>PO</i> |
| 4. <i>Aspirin</i>                | <i>325 mg</i> | <i>1 tablet</i> | <i>4 times daily</i> | <i>PO</i> |

*Signature of Patient*  
*Date*

# NARCOTIC DISPENSING FORM APPENDIX A - FORM NO. 32

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

| 1. Name of the Patient               | 2. Address                                | 3. Date of Birth      | 4. Sex                             | 5. Signature of Patient                  |
|--------------------------------------|-------------------------------------------|-----------------------|------------------------------------|------------------------------------------|
| <i>John Doe</i>                      | <i>123 Main St, Vancouver, BC</i>         | <i>12/12/1950</i>     | <i>M</i>                           | <i>[Signature]</i>                       |
| 6. Name of the Dispensing Pharmacist | 7. Signature of the Dispensing Pharmacist | 8. Date of Dispensing | 9. Name of the Dispensing Pharmacy | 10. Signature of the Dispensing Pharmacy |
| <i>Dr. Smith</i>                     | <i>[Signature]</i>                        | <i>12/12/1950</i>     | <i>ABC Pharmacy</i>                | <i>[Signature]</i>                       |



26-0000208600

## NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

| Patient Name: <u>Mrs M Deepthi Alakhya</u>            | Age: <u>36 yrs</u>                  | Gender: <u>Female</u>                |           |
|-------------------------------------------------------|-------------------------------------|--------------------------------------|-----------|
| UHID No: <u>BAH-11559150</u>                          | IP No: <u>26-00006666</u>           | Date: <u>27/6/26</u>                 |           |
| Time: <u>9:36 AM</u>                                  |                                     |                                      |           |
| Diagnosis: <u>open Myomectomy</u> <u>OT</u>           |                                     |                                      |           |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                                      |           |
| S.No                                                  | Drug Name                           | Dosage                               | Remarks   |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | <u>100mcg</u>                        | <u>01</u> |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      |                                      |           |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG |                                      |           |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG |                                      |           |
| Doctor Name: <u>Dr. M. V. S. Ch</u>                   |                                     | Doctor Registration No: <u>67529</u> |           |
| Signature: <u>[Signature]</u>                         |                                     |                                      |           |

## NARCOTIC DISPENSING FORM

### APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 26-00006666 Date: 27/6/26

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

| 1.             | Name                                                                                                                                 | Remarks                     |                                                                |                 |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------|-----------------|
| 2.             | Complete postal address (with contact number, if any)                                                                                | <u>Cherubally Hyderabad</u> |                                                                |                 |
| 3.             | Brief description of the illness                                                                                                     | <u>open Myomectomy</u>      |                                                                |                 |
| 4.             | Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded) | <u>No</u>                   |                                                                |                 |
| 5.             | Details of essential Narcotic drug dispensed                                                                                         |                             |                                                                |                 |
| Date           | Name of the Essential Narcotic Drugs                                                                                                 | Quantity                    | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| <u>27/6/26</u> | <u>Fentanyl</u>                                                                                                                      | <u>01</u>                   |                                                                |                 |
|                |                                                                                                                                      |                             |                                                                |                 |

Dispensed by (Name & ID No.): Dr. M. V. S. Ch (015421) Signature: [Signature]

Received by (Name & ID No.): U. Pillai (017921) Signature: [Signature]

Time: .....





# NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

|                                                       |                  |      |         |        |  |
|-------------------------------------------------------|------------------|------|---------|--------|--|
| Patient Name                                          |                  | Age  |         | Gender |  |
| UID No.                                               |                  | Date |         | Time   |  |
| Diagnosis                                             |                  |      |         |        |  |
| PRESCRIPTION DETAILS (Tick only one of the following) |                  |      |         |        |  |
| 2 No.                                                 | Drug Name        | Dose | Remarks |        |  |
| 1                                                     | Painexin 50mg/ml |      |         |        |  |
| 2                                                     | Painexin 50mg/ml |      |         |        |  |
| 3                                                     | Painexin 50mg/ml |      |         |        |  |
| 4                                                     | Painexin 50mg/ml |      |         |        |  |
| Doctor Name                                           |                  |      |         |        |  |
| Signature                                             |                  |      |         |        |  |

## NARCOTIC DISPENSING FORM APPENDIX A - FORM NO. 32

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

|                                                       |                                      |          |                                             |
|-------------------------------------------------------|--------------------------------------|----------|---------------------------------------------|
| Registration No.                                      |                                      | Date     |                                             |
| Name                                                  |                                      | Remarks  |                                             |
| Complete postal address (with contact number, if any) |                                      |          |                                             |
| Description of the illness                            |                                      |          |                                             |
| Whether referred with any other medical condition     |                                      |          |                                             |
| Whether referred with any other medical condition     |                                      |          |                                             |
| Cause of essential narcotic drug dispensed            |                                      |          |                                             |
| Date                                                  | Name of the Essential Narcotic Drugs | Quantity | Signature (Thumb impression of the patient) |
|                                                       |                                      |          | Remarks, if any                             |
|                                                       |                                      |          |                                             |
|                                                       |                                      |          |                                             |

Signature

Signature

Received by (Name & ID No.)

Received by (Name & ID No.)

Date

Doctor's Name & Signature



26-0000208548

## NARCOTIC PRESCRIPTION FORM (PATIENT COPY)

| Patient Name: <u>Mrs. M. Deepthi Alekhya</u>          |                                     | Age: <u>36 yrs</u>                   | Gender: <u>Female</u>                     |
|-------------------------------------------------------|-------------------------------------|--------------------------------------|-------------------------------------------|
| UHID No: <u>BAH-00559150</u>                          |                                     | IP No: <u>26-00006664</u>            | Date: <u>27/6/26</u> Time: <u>9:50 Am</u> |
| Diagnosis: <u>Open Myomectomy</u> <u>OT</u>           |                                     |                                      |                                           |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                                      |                                           |
| S.No                                                  | Drug Name                           | Dosage                               | Remarks                                   |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      | <u>100mcg</u>                        | <u>01</u>                                 |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      |                                      |                                           |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG |                                      |                                           |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG |                                      |                                           |
| Doctor Name: <u>Dr. Amir</u>                          |                                     | Doctor Registration No: <u>67529</u> |                                           |
| Signature: <u>[Signature]</u>                         |                                     |                                      |                                           |

## NARCOTIC DISPENSING FORM

### APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 26-00006664 Date: 27/6/26

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

|    |                                                                                                                                      |                              |
|----|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------|
| 1. | Name: <u>Mrs. M. Deepthi Alekhya</u>                                                                                                 | Remarks                      |
| 2. | Complete postal address (with contact number, if any)                                                                                | <u>Cheslapally Hyderabad</u> |
| 3. | Brief description of the illness                                                                                                     | <u>open Myomectomy</u>       |
| 4. | Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the recorded) | <u>No</u>                    |
| 5. | Details of essential Narcotic drug dispensed                                                                                         | <u>Fentanyl</u>              |

| Date           | Name of the Essential Narcotic Drugs | Quantity  | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
|----------------|--------------------------------------|-----------|----------------------------------------------------------------|-----------------|
| <u>27/6/26</u> | <u>Fentanyl</u>                      | <u>01</u> | <u>[Signature]</u>                                             |                 |
|                |                                      |           |                                                                |                 |

Dispensed by (Name & ID No.): Bama (018442) Signature: [Signature]

Received by (Name & ID No.): U. Bellam 017921 Signature: [Signature]

Time: .....







26-0000208598

## NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

| Patient Name:                                         | Age:                                | Gender:                 |         |
|-------------------------------------------------------|-------------------------------------|-------------------------|---------|
| UHID No:                                              | IP No:                              | Date:                   |         |
| Diagnosis:                                            |                                     | Time:                   |         |
| PRESCRIPTION DETAILS (Tick only one of the following) |                                     |                         |         |
| S.No                                                  | Drug Name                           | Dosage                  | Remarks |
| 1.                                                    | Fentanyl Citrate Inj. 50mcg/ML      |                         |         |
| 2.                                                    | Morphine Sulphate Inj. 15mg/ML      | 100mcg                  | 01      |
| 3.                                                    | Remifentanyl Hydrochloride Inj. 2MG |                         |         |
| 4.                                                    | Remifentanyl Hydrochloride inj. 1MG |                         |         |
| Doctor Name:                                          |                                     | Doctor Registration No: |         |
| Signature:                                            |                                     |                         |         |

## NARCOTIC DISPENSING FORM

### APPENDIX 4 – FORM NO. 3E

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

IP Registration No: 26-00006664 Date: 27/6/26

Aadhaar No. of the Patient (Optional):

| 1.      | Name :                                                                                                                                | Remarks                  |                                                                |                 |
|---------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------|-----------------|
| 2.      | Complete postal address (with contact number, if any)                                                                                 | chemically + hydrocodone |                                                                |                 |
| 3.      | Brief description of the illness                                                                                                      | oper Myomectomy          |                                                                |                 |
| 4.      | Whether registered with any other registered medical practitioner / recognized medical institution ( If yes, details of the recorded) | No                       |                                                                |                 |
| 5.      | Details of essential Narcotic drug dispensed                                                                                          | Fentanyl                 |                                                                |                 |
| Date    | Name of the Essential Narcotic Drugs                                                                                                  | Quantity                 | Signature / Thumb Impression of the patient / Patient Attender | Remarks, if any |
| 27/6/26 | Fentanyl                                                                                                                              | 01                       |                                                                |                 |

Dispensed by (Name & ID No.): Dr. Ram (0191111) Signature: Dr. Ram

Received by (Name & ID No.): U. Bhattar (017721) Signature: U. Bhattar

Time:



# NARCOTIC PRESCRIPTION FORM (MEDICAL RECORD)

|                                                     |                                     |                         |         |        |  |
|-----------------------------------------------------|-------------------------------------|-------------------------|---------|--------|--|
| Patient Name                                        |                                     | Date                    |         | Time   |  |
| UHID No.                                            |                                     | Age                     |         | Gender |  |
| Diagnosis                                           |                                     |                         |         |        |  |
| PRESCRIPTION DETAILS (fill in one of the following) |                                     |                         |         |        |  |
| S.No.                                               | Drug Name                           | Dosage                  | Remarks |        |  |
| 1                                                   | Pentamyl Citrate (in 50mg/ml)       |                         |         |        |  |
| 2                                                   | Morphine Sulphate (in 15mg/ml)      |                         |         |        |  |
| 3                                                   | Remifentanyl Hydrochloride (in 500) |                         |         |        |  |
| 4                                                   | Remifentanyl Hydrochloride (in 100) |                         |         |        |  |
| Doctor Name                                         |                                     | Doctor Registration No. |         |        |  |
| Signature                                           |                                     |                         |         |        |  |

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

P. Registration No. ....  
 Health Card No. of the Patient (Optional) .....  
 Date: .....

|      |                                                                                                                                    |                                             |
|------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|
| 1    | Name                                                                                                                               | Remarks                                     |
| 2    | Complete postal address (with correct number, if any)                                                                              |                                             |
| 3    | Brief description of the illness                                                                                                   |                                             |
| 4    | Whether registered with any other registered medical practitioner / recognized medical institution (if not, details of the reason) |                                             |
| 5    | Details of essential Narcotic drug dispensed                                                                                       |                                             |
| Date | Name of the Essential Narcotic Drugs                                                                                               | Quantity                                    |
|      | Signature (Thumb impression of the patient)                                                                                        | Signature (Thumb impression of the patient) |
|      | Remarks, if any                                                                                                                    |                                             |

Dispensed by (Name & ID No.)

Received by (Name & ID No.)

Signature

Signature