Name	Mrs M KUSUMA KUMARI	**UHID**	HNH-00016225
Father/Guardian	Mr M PRAKASA RAO	**Age/Gender**	71 Y 1 M 18 D/ Female
Address	508,ASHOKA AMBER RESIDENCY 1-9-296, Vidyanagar, Hyderabad, Telangana, INDIA, 500044		
IP No	IP26-00006729	**Admission Date**	03-07-2026
Ref Doctor	Self.		
Discharge Date	03.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. INDIRA RANI Y
MBBS, DGO
700113

Diagnosis: POST MENOPAUSAL WOMEN WITH POST MENOPAUSAL BLEEDING

DIAGNOSTIC HYSTEROSCOPY+ CURETTAGE DONE ON 03.07.2026

History: She presented with complaints of postmenopausal bleeding, 1 episode associated with passage of clots lasting for 1-2 days,changing 1-2 pads/day. USG done on 26.06.2026 showed Uterus measuring 7.2cmx4.1cms,Thickened endometrium measuring 16.7mm,Heterogenous,Hyperechoic,vascularity present.She was admitted for Diagnostic hysteroscopy and polypectomy.

Menstrual History:- LMP- Menopausal 12 years back , LCB-44 years
Previous cycles: Regular

Obstetric History: P2L1A1 with NVD

Medical History: k/c/o Hypothyroidism since T. Thyronorm 25mg, k/c/o HTN since 20 years on T.Telma H 40/12.5mcg once daily, k/c/o DM since 1 year on T.Glimipride + Metformin 500mg twice daily, K/c/o dyslipidemia in T.Rosuvas Gold + Clopidogrel 75mcg once daily

Surgical History: H/O D&C for misscarriage
Family History: Mother-DM and HTN
Allergies: Nil

Investigations: Enclosed.

Name	Mrs M KUSUMA KUMARI	**UHID**	HNH-00016225
IP No	IP26-00006729	**Admission Date**	03-07-2026

Blood group: "O" Positive

Surgery Notes: DIAGNOSTIC HYSTEROSCOPY+ CURRETTAGE

Indication: POSTMENOPAUSAL BLEEDING

Operative findings:

- Cervical canal normal.
- Uterine cavity- Endometrium thickened and vascular.
- Mound of endometrium (white) in posterior wall.
- Curettage done and sample sent for HPE.
- Curettage are vascular .
- Adequate hemostasis achieved .
- Patient shifted out in stable condition.

Post-Operative Notes: She was closely monitored in postoperative period. Her vital signs remained stable. She was encouraged to ambulate and void spontaneously. she as shifted to room. Her general condition was satisfactory and she was found to be fit for discharge. medication were explained to patient supplemented by written information.

Advice:

1. Tab. Taxim O 200mg (Cefixime 200mg) twice daily till 07.07.2026 (9am - 9pm) after food.
2. Tab. Drotin 40mg SOS for pain after food.
3. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till 07.07.2026
4. Tab. Zincovit once daily (2pm) for 1 month after food.
5. Tab.Cobinorm Plus twice daily (8am-8pm) for 1 week
6. Collect HPE report
7. Continue all previous medications.

Review consultation with Dr. INDIRA RANI Y, after **1 week** on **11.07.2026** with **HPE report** in Gynec OPD (**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 kindly contact 9154865045 at Rainbow Children's Hospital just dial one toll free number - 18002122. You can

Name	Mrs M KUSUMA KUMARI	**UHID**	HNH-00016225
IP No	IP26-00006729	**Admission Date**	03-07-2026

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

Registrar/Resident/C.M.O

Consultants :
Dr. INDIRA RANI Y
MBBS, DGO, DNB
700113

Rainbow Childrens Hospital-Himayatnagar

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

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006729 **Admit Date** : 03-Jul-2026 **Admit Time** : 11:39 AM **UHID** : HNH-00016225

Patient Details :

Patient Name	: Mrs M KUSUMA KUMARI	**Age**	: 71 Y 1 M 18 D
Guardian	: Mr M PRAKASA RAO	**DOB**	: 15-05-1955
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: 508,ASHOKA AMBER RESIDENCY 1-9-296 Vidyanagar Hyderabad Telangana INDIA 500044	**Phone No**	: 9440051628/ 9441083236
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PPO-419 **Ward Name** : 4F -OT

Room No : PPO-419 **Admission Type** : First Visit

Contact Details :

Name : Mr M PRAKASA RAO **Relationship** : W/O

Contact Address : 508,ASHOKA AMBER RESIDENCY 1-9-296 Vidyanagar Hyderabad Telangana INDIA 500044 **Phone No** : 9440051628

Signature

(M. Prakasa Rao)

Doctor Details :

Doctor Name : Dr. Y.INDIRA RANI **Specialisation** : OBSTETRICS AND GYNECOLOGY

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

Co-Consultant :

Payment Details :

Deposit Amount : 50000.00

Payment Mode : Cash **Payor Name** : SELFPAY

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ACTIVITY RECORD FOR BILLING

HNH-00016225 IP26-00006729
Mrs M KUSUMA KUMARI (F)
15-05-1955 71 Y 1 M 18 D
Dr. Y.INDIRA RANI

Name : ______________________________

UHID No. : ______ Consultant: ____________ Dept : __________

Date of Admission ______ Date of Discharge : _________ Time: ________

Room / Bed No : __________ Ward : __________ Suggested Billable bed type : ______________

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
3/7/26	12:15PM	Pre-post	OT	Anshu / Karuna
3/7/26	1:15PM	OT	Pre-Post	Karuna

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Signature
3/7/26	GRBS – @ 11 AM 142 mg/dl	10871	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
3/7	Cardiac monitor	1:30pm	4pm	10376	Arshed.
3/7	Infusion	1:30pm	4pm		
					[illegible] done
					Ah Ar

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
3/7	IV Placement	1	10381	
3/7	PAC (OP)		OCS26-09/22-502	

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016225 IP26-00006729
Mrs M KUSUMA KUMARI
15-05-1955 71 Y 1 M 18 D (F)
Dr. Y.INDIRA RANI

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : .... Time of Admission : ....

Allergies: .... ☑ Not know any drug allergies

PRESENTING COMPLAINTS :

P. c/o post menopausal bleeding
1 episode - on 26/8/26. a/w passage of clot
lasting for 1-2 days.
↓
USG. done
↓
Planned for Diagnostic Hysteroscopy
+ Polypectomy.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 51 yrs	Parity : $P_2L_2A_1$
Previous Periods : Prev cycles - Regular	Mode of Delivery : NVD
LMP : Menopause 12 yrs back	Last Child Birth : LCB - 44 yrs
Contraception : Nil	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Hypothyroidism → T. Thyronorm 25mg (fab/mar/sore) x 20d → stopped HTN :- 20y (on Rx) DM :- 1 yr (on OHA)	D & C

Patient Sticker

FAMILY HISTORY:

~~NAD~~
Mother - Dm & HTN

MEDICATION HISTORY:

1. Telma H - 40/12.5 - OD
2. Glimipride + Met — BD
3. Rosuvas Gold
   Clopidogrel — 75mg
   MVT

INITIAL ASSESSMENT :

Date 3/7/26.
Ht. _____ Wt. _____
BMI _____
B.P 138/60 mHg PR-67bpm
Pallor (-)
CVR S1S2 (+)
Respiratory System B/L NVBS
Thyroid (N)

Breasts
(N)

Abdominal Examination
Soft

Local/Speculum Examination
(-) N/A

Bimanual Pelvic Examination
N/A

PROVISIONAL DIAGNOSIS : P2L2 | Postmenopausal c PMB.

INVESTIGATIONS ORDERED

Blood Group - O Rh
HIV, HbsAg, RPR - NR.
GRBS ↓ 142 mg/dl.
Hb- 12.2 g/dl
Plt- 4 Lkh.
WBC - 10.5 lc.
USG (26/6/26)
Ut - 7.2 x 6.1 cm.
Hyperechoic areas.
ET - 16.7 mm, thickened endometrium c hypoechoic cystic area + EMT irregular. → ? Submucous fibroid polyp / ? Endometrial polyp / ? Hyperplasia.
B/L ovaries - (N)

PLAN OF MANAGEMENT

Diagnostic Hysteroscopy + Polypectomy
- Informed consent
- Prepare parts
- Inform OT / Anesthetist
- Shift to OT on call
- PAC.
- GRBS.

Name of the Doctor : Dr. Indira Rani
Signature of Doctor
Date & Time : 3/7/26 @

HNH-00016225 IP26-00006729
Mrs M KUSUMA KUMARI
15-05-1955 71 Y 1 M 18 D (F)
Dr. Y.INDIRA RANI

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
3/7/26 1:20 PM	c/s/B	Dr. Veena
	POD-0	
		Adv
	Pt is stable, No c/o	- NBM x q 3-4 hrs
	o/e GC-fair, Afebrile	Vital monitoring
	BP-	- Encourage to void
	PR-	- Cont. all medications at d/s
	SpO_2-	
	P/A - Soft	- Drugs as charted
	L/c - NAD.	- w/f excessive bleeding P/v
		- Inform SOS.
		[signature]
3/7/2026 3pm	C/s/b	Dr. Manisha
	POD 0	
	Cc - For Ap[illegible]	Adv
	vitals stable	
	P/A Soft	- Allow sips > 3:30pm
		- Drugs as charted
		- W/f vitals ↑ BP
		- Can be discharge
		- Send file for Processing
		[signature]

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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

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HNH-00016225 IP26-00006729
Mrs M KUSUMA KUMARI
15-05-1955 71 Y 1 M 18 D (F)
Dr. Y.INDIRA RANI

OPERATION THEATER NOTES

Patient's Name : ..... Age : ..... Gender : .....

UHID.: ..... Weight : .....

Surgeon : DR. INDIRA RANI	Asst. Surgeon :
Anesthetist : DR. VINEETHA	OT Nurse : S/N BALU

Surgical Procedure : DIAGNOSTIC HYSTEROSCOPY + CURRETTAGE.

Indications for Surgery : POST MENOPAUSAL BLEEDING.

Date :	Start Time :	End Time :

PRE-OPERATIVE PREPARATION :

* Under strict aseptic precautions, pt. kept in Lithotomy position

OPERATION NOTES:
* Cervical canal - Normal
* Thicker Uterine cavity - Endometrium - thickened & vascular
Mound of endometrium (white) in posterior wall
- Curettage done and sample sent for HPE.
- Curettings are vascular.
* Adequate hemostasis achieved
* Pt. shifted out in stable condition.

POST - OPERATIVE ORDERS :

- NBM for 2-4hours
- Pt encouraged to void
- Vital monitoring
- T. Taxim-O 200mg BD x5days
- T. Pan 40mg OD x5days
- T. Combinorm Plus BD x 1week.
-

Dr. Indira Rani

Consultant Surgeon's Name

Consultant Surgeon's Signature

Date : 3/7/25 Time : .....

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Indira Rani
Asst. Surgeon : .....
Anaesthetist : Dr. S. Muthu
Scrub Nurse : Sr. Babu

HNH-00016225 IP26-00006729
Mrs M KUSUMA KUMARI
15-05-1955 71 Y 1 M 18 D
Dr. Y.INDIRA RANI

Patient Na..... Gender : .....
UHID No. .....
Date : 3/7/26 ..... t-time : 1:15 Pm

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 12.30 Pm

Patient Has Confirmed
- Identity ☑ Yes ☐ No
- Site ☑ Yes ☐ No
- Procedure ☑ Yes ☐ No
- Consent ☑ Yes ☐ No

Site Marked ☑ Yes ☐ No ☐ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

Does Patient have a:
- Known Allergy? ☐ Yes ☑ No

Difficult Airway / Aspiration Risk?
- Yes, & Equipment / Assistance Available ☑ Yes ☐ No

Risk of > 500ml Blood Loss (7ml/kg In Children)?
- Yes, and Adequate Intravenous Access and Fluids Planned ☐ Yes ☑ No ☐ NA
- Blood Units Reserved ☐ Yes ☑ No ☐ NA

Has Antibiotic Prophylaxis been given within the last 60 minutes? ☑ Yes ☐ No ☐ NA

Signature : .....
Name : Dr. M.V.N.Seetha

Before Skin Incision ➤➤

TIME OUT Time: 12:38 Pm

Confirm all team members have introduced themselves by Name and Role ☑ Yes ☐ No

Surgeon, Anaesthesia Professional and Nurse Verbally Confirm
- Correct Patient (Check ID Band) ☑ Yes ☐ No
- Correct Site ☑ Yes ☐ No
- Correct Procedure ☑ Yes ☐ No

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Cervical dilatation 1 hour 30 ml ☑ Yes ☐ No ☐ NA

Anaesthesia Team Reviews:
- Are There Any Patient-specific Concerns? ☑ Yes ☐ No ☐ NA

Nursing Team Reviews:
- Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns? ☑ Yes ☐ No ☐ NA
- **Is Essential Imaging Displayed?** ☐ Yes ☐ No ☐ NA

Signature : Rarunra
Name : Rarunra @ 12:38 Pm

Before Patient Leaves Operating Room

SIGN OUT Time: .....

Nurse Verbally Confirms with the Team:
- The Name of the Procedure Recorded ☑ Yes ☐ No
- That Instrument, Sponge and Needle Counts are Correct (or Not Applicable) ☑ Yes ☐ No ☐ NA
- The Specimen is Labelled (including patient name) ☑ Yes ☐ No ☐ NA
- Whether there are any Equipment Problems to be addressed ☐ Yes ☑ No ☐ NA

To Surgeon, Anaesthetist and Nurse:
- What are the key concerns for recovery and management of this patient? ☑ Yes ☐ No

Signature : .....
Name : Dr. Indira Rani.

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016225 IP26-00006729 Mrs M KUSUMA KUMARI 15-05-1955 71 Y 1 M 18 D (F) Dr. Y.INDIRA RANI	3/12/26 @ 11:39 AM	3/12/26 @ 1:15 pm
	Transfer Ordered by Dr. Vineetha	Reason for Transfer Observation
From Unit OT	To Unit Pre Post	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
	Dr Vineetha

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

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs. Kusuma Kumari Gender: ☐ Male ☑ Female Age : .....

UHID No : ..... Date : 3/7/26

Instruction:

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

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

DIAGNOSTIC HYSTEROSCOPY & POLYPECTOMY

upon

MRS. KUSUMA KUMARI (Name of the Patient)

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

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

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

Excessive bleeding, need for transfusion of blood or blood products, uterine perforation.

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. Indira Rani

Consentee :

Signature : M. Kusuma Kumari

Name : Ms Kusuma Kumari

Date & Time : 3/7/2026 @ 10:30Am

Witness :

Signature : .....

Name : .....

Date & Time : .....

Patient Attendant :

Signature : .....

Name : M. PRAKASA RAO

Relationship with Patient: Husband

Date & Time : 3/7/2026 @ 10:30 Am

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. G. Veena

Date & Time : 3/7/26 @ 10:30 Am

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE

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Patient Name : Kusuma ..... Age : 71yr ..... Gender : Male ☐ Female ☑

UHID NO: ..... Surgeon Name: Dr. Indira .....

Anaesthesiologist : Dr. Samir .....

Operative procedure planned : Diagnostic hysteroscopy + Polypectomy .....

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 arid 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 Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease

☐ Others : Preoperative adverse cardiac events

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 Kusuma ..... the above mentioned operation / Diagnostic / Therapeutic procedures Diagnostic hysteroscopy + polypectomy .....

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 : .....

Name : M. PRAKASA RAO

Relationship with Patient: HUSBAND

Date & Time : .....

Patient.

Witness :

Signature : M. Kusuma Kumari.

Name : M. KUSUMA KUMARI

Date & Time : .....

Doctor (who is taking the consent) :

Signature : .....

Name : DR. AKHILA. K

Date & Time : 25/6/26 11:30AM.

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Kusuma Age: 71yr Sex: F UHID.No :

Date: 28/6/2026 Time: 11:00 AM. Proposed Operation: Diagnostic hysteroscopy + polypectomy

Diagnosis: Post menopausal bleed. ? Endometrial polyp.

B.P / CRT: 151/104 H.R: 57 Weight: 58kgs. ASA Physical Status: ☐1 ☑2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 12.2.	Glucose: 123.	Protein: WNL.	HIV: NR	X-Ray:
PCV:	Urea:	Alb: WNL	HBS Ag: NR	ECG: Sinus LVH changes ⊕ ST-T changes
WBC: 10,500	Creat: 0.7	Total Bill: WNL	HCV: NR	2D Echo: Ⓝ study. no obvious
Plate: 400	Na:	Dir. Bill: WNL	Blood group: O +ve	Stress/Anglo:
PT:	K:	LDH: WNL	T3	Other:
PTT: 25.7.	Ca++:	Alk phos: WNL	T4 1.26.	CUE → glucose ++ Blood ++.
INR: 0.8.	Mg++:	Amylase: WNL	TSH 2.79	
BT - 2:00 CT - 6:00.	Cl -:	SGOT/SGPT: WNL		

Allergies: Nil.

Medical History: CVS : HTN: 20yrs on Rx.

RESP : No recent cold cough fever. Diabetes : DM: 1yr on Rx.

CNS : Nil significant.

Renal : Nil significant.

Hepatic / GE : Nil significant. Physical Activity: active METS > 4.

Others : TSH ↑ in Feb/March 26 used T. Thyronorm 25mcg for 20days & stopped.

Past Anaesthetic History: D&C under sedation U/E

Physical Exam:

Airway: MP 1 ②3 4 Mouth Opening: 3FB Mentohyoid Distance: 3FB Neck: Ⓝ Teeth: Ⓝ

Lungs : BAE ⊕ clr.

Heart: S1S2 ⊕

CNS: c/c/c.

Pregnant: ☐ Yes ☐ No ☑ NA Venous Access Site : accessible Spine Exam for regional : well felt.

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

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

CURRENT MEDICATIONS	DOSAGE
T. Telma-H	40mg + 12.5mg. OD.
T. Glimipride + Metformin	BD
T. Rosuvas Gold →	clopidogrel 75mg.
MVT.	

Pre-Operative Instructions:

1. DVT Prophylaxis : -
2. NIL ORAL → Water / ORS 2 Hours; Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:
   - To stop Rosuvas Gold 5 days prior to Sx.
   - Cardiology clearance / fitness for Sx.
   - To skip OHA on day of Sx, Anti-HTN to be seen on day of Sx (to get along).
   - GRBS on admission.

Signature: [signature] Name: DR. AKHILA.K.

Docu. No. : RCH /FRM / CLINICAL / 044

BP - 130/70 mmHg. GRBS - 142.
02/07/26. Cardiology - Pt can be taken for surgery c̄ mild cardiovascular risk.

Patient Sticker

ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R: 88/min | B.P / CRT: 130/90 mmHg | SpO_2: | R.R: 16/min | Last Feed:

Pre-OP Diagnosis: AUB ? endometrial polyp | Operation: Hysteroscopy + polypectomy | Date: 03/07/21.

Surgeon: Dr. Indira Rani | Anaesthesiologist: Dr. Vijay / Dr. Vineetha | Technician: Mr. Aravind

TIME	12.30	(45) 1.00	(15)
N_2O /AIR /O_2 LPM			
HALO /SO /SEVO			
Drugs:			
MIDAZOLAM	2mg		
PROPOFOL	80mg + 20mg		
FENTANYL	100mcg		
GLYCOPYRROLATE	0.2mg		
PARACETAMOL	1gm		
FIO_2 / SaO_2	100	100	100
$ETCO_2$	33		
ECG	SR	SR	SR
Temperature			
Urine Output			
Fluids / Blood	RL →	→	→
	RL Bottle - 100ml		

Antibiotic: given.

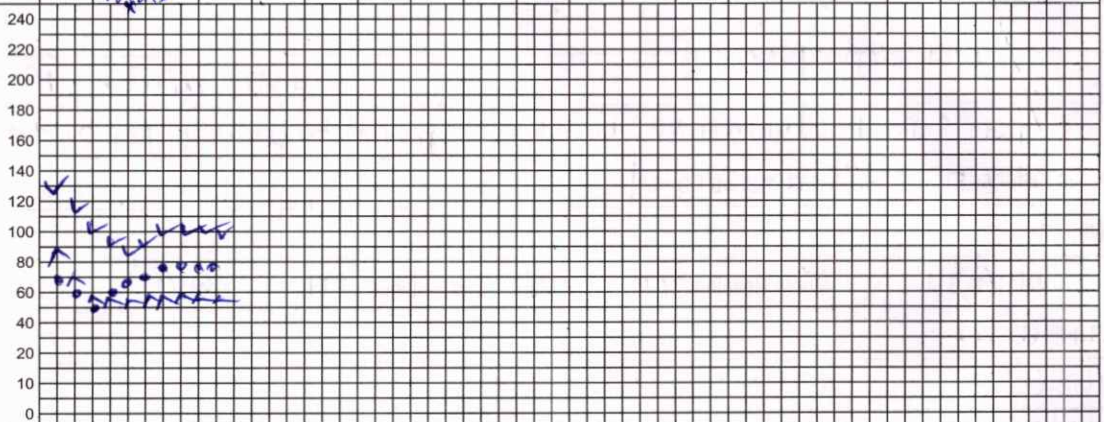
Suppository: TRAMADOL 100 mg PR

Blood Loss

NOTES

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

Tourniquet on Time
Tourniquet off Time
Throat Pack In
Throat Pack Out



LAB Values: ABG / GRBS / Others

Monitoring:
- ☑ Equipment Checked and Functional
- ☑ BP
- ☐ Cuff Site: (R) UL
- ☐ Art Site:
- ☑ EKG Lead: 3 lead
- ☑ Temp Site
- ☑ FIO_2 Monitor
- ☑ Agent Monitor
- ☑ Pulse Oximeter
- ☑ Capnograph
- ☑ Ventilator
- ☐ Nerve Stimulator

Position: Lithotomy
- ☑ Pressure Points Checked

Eye Care:
- ☐ Oint
- ☑ Tape
- ☐ Padding
- ☐ Awake

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

Times:
- Anaes Start: 12:40 Pm
- OP Start: 12:45 Pm
- OP End:
- Leave OR: 1:15 Pm

Anaesthesia:
- ☑ GA
- ☑ Monitored Anaesthesia Care
- ☐ Regional

Line (Size & Location)
- ☐ CVP:
- ☐ ART:
- ☑ IV: (L) UL 20G
- ☐ IV:
- ☐ IV:

Induction
- ☑ IV
- ☑ Inhal
- ☑ Pre O_2
- ☐ RSI
- ☐ Others
- ☐ Mask
- ☑ SGA: Igel - 3.
- ☑ Airway
- ☑ Oral
- ☐ Nasal
- ETT# .... at .... cm
- ☐ Oral ☐ Nasal ☐ Cuff
- ☐ Tracheostomy ☐ Topical
- ☐ Drug: PROPOFOL.
- ☐ Awake ☐ Direct Vision
- ☐ Video Laryngoscopy ☐ Stylette / Bougie
- ☐ Fiberoptic
- Blade# .... Attempts: ....
- Difficulty Why? Difficult Bag & Mask ventilation
- ☑ Bilat = BS
- ☐ Semi-Closed Circle
- ☑ Closed Circle
- ☐ Other

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

Transportation to ☐ PACU ☐ ICU ☐ Other

Relaxant Reversed ☐ Yes ☐ No ☐ NA

Name of the Doctor: DR. M. VINEETHA

Signature of the Doctor: [signature]

HNH-00016225 IP26-00006729
Mrs M KUSUMA KUMARI
15-05-1955 71 Y 1 M 18 D (F)
Dr. Y.INDIRA RANI

Patient Sti

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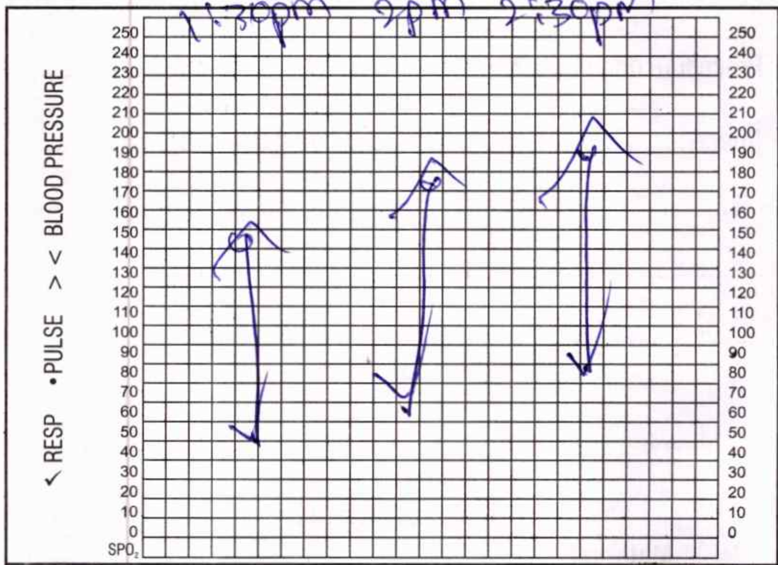
POST-ANAESTHESIA CARE UNIT RECORD

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



IV Cannula Site : (RL)

☐ O_2 Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting : ☐ Yes ☑ No Drug: Inj Tax 9M
NG Tube : ☐ Yes ☑ No
Drain: ☐ Yes ☑ No
Urinary Catheter: ☐ Yes ☑ No
Chest Tube: ☐ Yes ☑ No
Nil Oral ☐ Yes ☑ No

IV Fluids: RL on flow
Oral Feeds: NBM

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

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
3/7	2pm	0/10	No pain	Anu

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

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

Anaesthesiologist Name : ....
Anaesthesiologist Signature: ....
Date & Time: ....

PACU Nurse Name : Anusha D
PACU Nurse Signature: Anu
Date & Time: 3/7/2

Transferred to Unit by (PACU): ....
Date & Time: ....

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

Date: ..... Time: ..... Procedure done by .....

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

Depth: ..... Catheter at Skin: ..... Attempts : .....

Parasthesia : Yes/No if yes details : .....

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

Catheter Removed by and Tip Inspected : .....

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016225 IP26-00006729 Mrs M KUSUMA KUMARI 15-05-1955 71 Y 1 M 18 D (F) Dr. Y.INDIRA RANI	3/7/26 @	3/7/26 @ 12:15 PM
	Transfer Ordered by Dr. Veena.	Reason for Transfer Hysteroscopy + polypectomy
From Unit pre-post	To Unit O.T	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File	Number of Imaging Films	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Anusha	Dr. Veena

Patient & Clinical Records Received by : Karuna 3/7/26 @

Date & Time of Patient Received :

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

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

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DRUG CHART

Date of Admission: 3/7/2026 Drug Allergies: .... ☑ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

HNH-00016225 IP26-00006729
Mrs M KUSUMA KUMARI
15-05-1955 71 Y 1 M 18 D (F)
Dr. Y.INDIRA RANI

REGULAR PRESCRIPTIONS

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

DRUG : INJ. CEFOTAXIME

Dose	Route	Frequency	Start Date
1g	IV	BD	3/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:
(ATD)

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG : TAB. PARACETAMOL

Dose	Route	Frequency	Start Date
1gm	PO	6 HRLY	03/07

Name & Signature of the Doctor Starting the Drugs:
DR. M. VINEETHA

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

Patient Sticker

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

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

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

Signature .....

VERIFIED BY : Name .....

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
3/7/26	11:00AM	INJ. PANTAPRAZOLE	40mg	IV		
3/7/26	11:30AM	INJ. METOCLOPRAMIDE	10mg	IV		
3/7	9:30PM	T. MISOPROSTOL	400mcg	PV		
3/7	9:30PM	INJ TETANUS TOXOID	0.5ml	IM		
03/07	1:00Pm	SUPP. TRAMADOL	100 mg	PR		
03/07	1:10Pm	INJ. PARACETAMOL	1gm	I.V		
~~3/7/26~~	~~9:30PM~~					

Patient Sticker

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
3/7/26	10 AM	RINGER LACTATE	IV	100ml/hr			04/07		
03/07	12.55 PM	RINGER LACTATE	IV	500ml/hr			3/7		
3/7	3 PM	RINGER LACTATE	IV	100ml/hr			3/7		

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

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RESULT SHEET

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

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						
Blood Grouping						
HIV						
HBsAg.						
HCV						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 3/7/26 Time of Arrival: ..... Time Seen by Nurse: .....

1) **Level of Consciousness:** ☐ Conscious ☐ Semi-Conscious ☐ UnConscious

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

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

3) **Vital Signs:** Temperature: ..... Pulse: ..... RR: ..... SpO_2: ..... BP: ..... Weight: .....

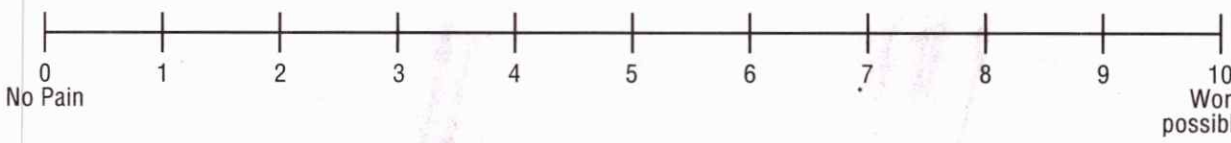
4) **Gestational Criteria:**

Gravida:	G	P	L	A

LMP: ..... EDD: ..... Gestational Age: .....

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

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



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

.....

6) **Past History:**

a) Surgeries: .....

b) Medical: .....

Patient Sticker

7) **Allergy:** ☐ Yes ☐ No, If Yes : .....

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

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: .....

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

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

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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 3/7/26

Baseline Information:

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

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

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

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

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

If yes , identify .....

Chief Complaints: .....

.....

.....

Doctor Notified on Admission: ☐ Yes ☐ No

Name of the Doctor: .....

Time Notified: .....

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

Past Medical History	Past Surgical History	Previous Hospital Admission

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

Regular

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☐ No ☐ Yes

Cervical Cerclage: ☐ No ☐ Yes

Ectopic Pregnancy: ☐ No ☐ Yes

Myomectomy: ☐ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☐ No ☐ Yes

Vaginal Discharge: ☐ No ☐ Yes

Post-Coital Bleeding: ☐ No ☐ Yes

Infertility: ☐ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

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

Previous LSCS: .....

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

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: ..... HR: ..... RR: .....

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

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

Patient Sticker

PHYSICAL ASSESSMENT

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

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

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

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☐ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With .....

Orientation has been given regarding the following aspects:

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

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

Above information given to .....

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

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: .....

Date & Time: .....

HNH-00016225 IP26-00006729
Mrs M KUSUMA KUMARI
15-05-1955 71 Y 1 M 18 D (F)
Dr. Y.INDIRA RANI

(1)

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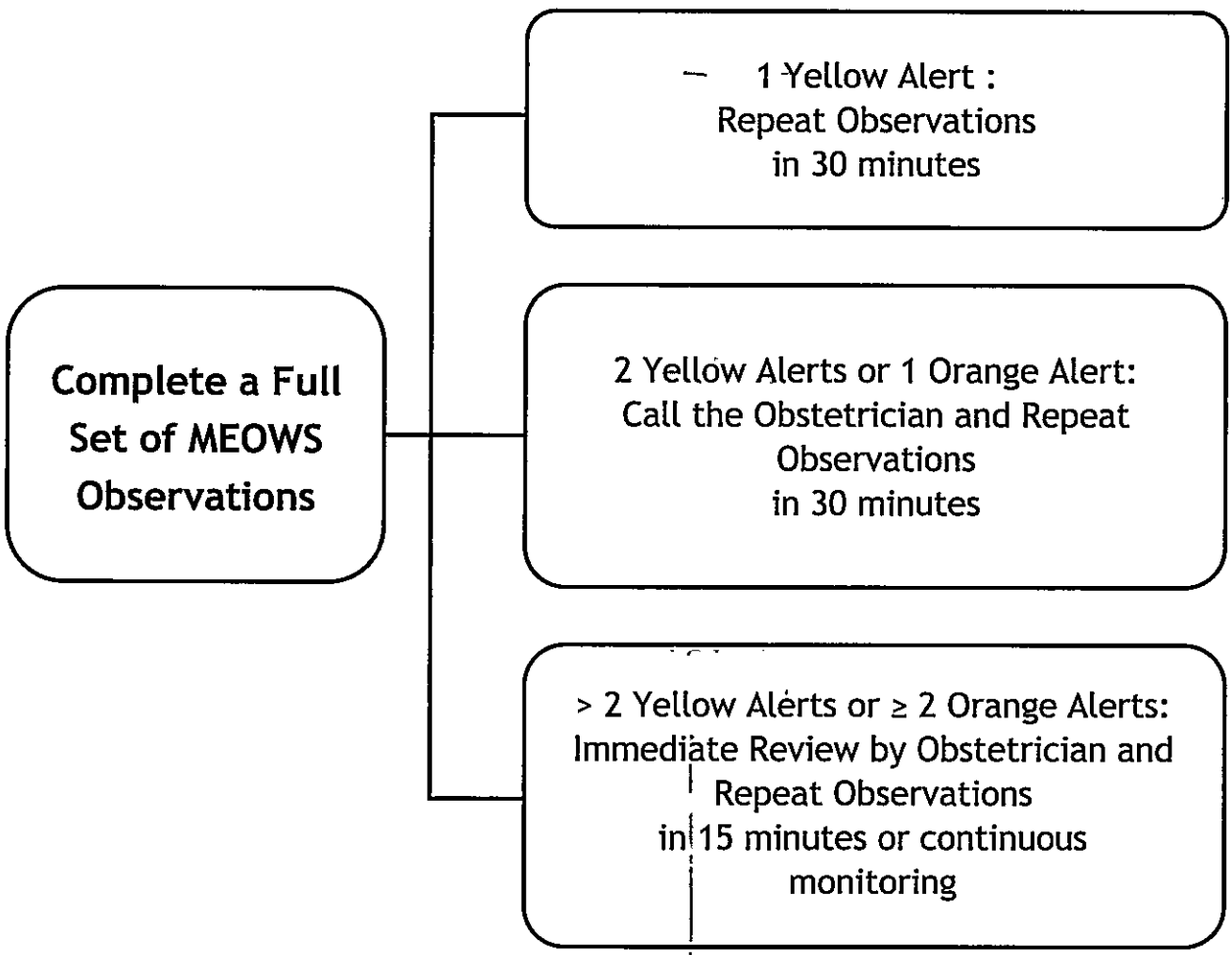
Early Warning Observation Score Chart - Obstetrics

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

		Date	3/7/26																							
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30							20		20																
	11 - 20																									
	0 - 10																									
Saturations	94 - 100 %							94%		94%																
	< 94 %																									
Administered O_2 (L/min.)								–		–																
Temp°c	40																									
	39																									
	38																									
	37							–		–																
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80							80		89																
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120							110		121																
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60							72		72																
	50																									
	40																									
NEURO RESPONSE [✓]	Alert									–																
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES																										
TOTAL ORANGE SCORES																										
Nurse Initial								R		D																

Obstetrics and Gynaecology Early Warning Signs



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

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FLUID CHART

Sheet No. : 1

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
31/7/26	08:00 am	RL	N	100ml						✓		
	09:00 am	RL	N	100ml								
	10:00 am	RL	B	100ml							0	
	11:00 am	RL		100ml								
	12:00 pm	RL	M	100ml								
	01:00 pm	RL		100ml								
Total Intake :		Taken				**Total Output :**				Passed		
	02:00 pm	RL	N	100ml							1	
	03:00 pm	RL	B	100ml								
	04:00 pm	RL	M	100ml							0	
	05:00 pm											
	06:00 pm											
	07:00 pm										1	
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	

Patient Sticker

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	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**	

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NURSING CARE RECORD

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Date: 3/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am to 2pm	=> Assess the patient condition => plan for vital => plan for Discharge	8Am to 2pm	=> Assessed the patient condition => maintain vital Record => maintain Discharge	patient is stable	vital is Normal	Cmdl CA
Afternoon		Day duty					
Night							

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

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PAIN ASSESSMENT FORM

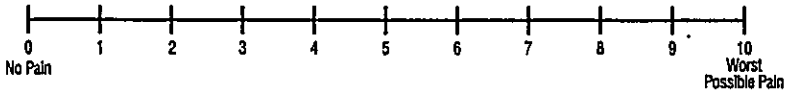
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
3/7/26	2pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	~~NA~~	[signature]
3/7/26	4pm	0/10	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	~~NA~~	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

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, right, 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

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

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not Irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression Intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR RR, BP, SaO_2	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO_2 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO_2 less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

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BRADEN 'Q' SCALE

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					Date :	3/7		
					Time :	mb		
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.		4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.		4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.		4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.		4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."		4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.		4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.		4		
					TOTAL SCORE	28		
					Evaluator's Name			

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	3/7/26			Fall Risk Grading		
		Score						
History of Falling (immediately or w/in 3 months)	Yes	25				Risk Level	Morse Fall Score (MFS)	Action
	No	0						
Secondary Diagnosis (more than one diagnosis)	Yes	15						
	No	0				Low Risk	0 - 24	Standard Fall Precaution
Ambulatory Aid	Furniture	30						
	Crutches, Cane(S), Walker	15						
	None /Bed Rest /Nurse Assist	0	0					
IV / Heparin Lock or Saline	Yes	20	20			Moderate Risk	25 - 50	Implement Moderate Fall Prevention Intervention
	No	0						
GAIT / Transferring	Impaired	20						
	Weak (uses touch for balance)	10						
	Normal /On Bed Rest /Immobile	0						
Mental Status	Forgets limitations	15				High Risk	≥ 51	Implement High Risk Fall Prevention Intervention
	Oriented to own ability	0	0					
Total Morse Fall Scale Score:			20					
		Signature						

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

3/7/26

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

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 : .....

Patient Sticker

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: Hystroscopy.	Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:					
BACKGROUND	Area / Shift Time	3/7 E					
	Medical Condition (Any special condition to be noted):	NA					
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.6					
	Res:	20					
	SpO_2:	99%					
	Pulse:	90					
	BP:	121/62					
	Fall Risk Score:	—					
	Pain Score:	0					
Recommendations	Safety Needs:	Yes					
	Physiotherapy	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—					
	Special Diet:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	—					
Post Operative Procedure Special Orders:							
Handed Over By Name :		Anitha A					
Signature :							
Date:		3/7/16					
Time:		9					
Taken Over By Name :							
Signature :							
Date:							
Time:							

Patient Sticker

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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

NURSING SHIFT HAND OVER FORM - WARD

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

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