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

BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name	Mrs KAMIREDDI RAMADEVI	**UHID**	HNH-00013319
Father/Guardian	Mr S LEELA MANIKANTA	**Age/Gender**	31 Y 1 M 21 D/ Female
Address	Himayathnagar, Himayathnagar, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006921	**Admission Date**	22-07-2026
Ref Doctor	SELF		
Discharge Date	23.07.2026		

DISCHARGE SUMMARY

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

Diagnosis: PRIMIGRAVIDA WITH 30 WEEKS WITH ANTEPARTUM HAEMORRHAGE FOR OBSERVATION.

History:
LMP: 11.12.2025 Obstetric formula: PRIMI
EDD: 30.09.2026 Gestation at admission: 30 weeks

Obstetric History:
G1 - Present pregnancy, Spontaneous conception.

Medical History: Nil
Family History: Mother -HTN, Maternal GM -DM.
Surgical History: Nil

Name	Mrs KAMIREDDI RAMADEVI	**UHID**	HNH-00013319
IP No	IP26-00006921	**Admission Date**	22-07-2026

Allergies: Nil

Antenatal Details:

Mrs KAMIREDDI RAMADEVI was booked to Rainbow hospital at 6^{+3}weeks of gestation. She had regular antenatal checkups and investigations as advised.NT SCAN done showed nuchal translucency above 95^{th} centile.FTS low risk . Amniocentesis done at 17^{+5} weeks -normal .TIFFA -normal. Fetal 2d echo at 23^{+5} weeks -normal.She was admitted at 30weeks with complaints of spotting PV since 1 day, 3 episodes.

Investigations: Enclosed
Blood Group: 'O" positive,

Management: Patient was managed conservatively . On admission her vitals were stable. NST done 6th hrly , Inj BETNASOL 12mg 1 dose given for fetal lung maturity in view of anticipated preterm labour on 22.07.2026 at 10 pm, Modified bed rest ,Growth scan was done on 23.7.26 showing SLIUF ,Breech ,EFW -1764 gms [80th centile] ,AC -84 %,
AFI -18.4cm ,fetal and uterine dopplers normal ,placenta -anterior high ,there is no evidence of retroplacental haematoma . Pt recovered well with this management. There were no further episodes of bleeding PV at the time of discharge.

Advice:

1. Tab.Livogen 1 tab once daily till delivery,
2. Tab.Shelcal 1tab once daily till delivery.
3. Cap. Susten 300 mg once daily after dinner.
4. Restart Tab. Ecospirin 150mg once daily from 25.07.2026
5. Inj Betnasol 12mg 2nd dose to be given today(23.07.2026)

Name	Mrs KAMIREDDI RAMADEVI	**UHID**	HNH-00013319
IP No	IP26-00006921	**Admission Date**	22-07-2026

6. Modified bed rest.
7. Strict fetal kick count.

Review after **1** weeks on **30.07.26** at Rainbow Himayatnagar hospital.

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

Registrar/Resident/C.M.O

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

HNH-00013319 IP26-00006921
Mrs KAMIREDDI RAMADEVI
02-06-1995 31 Y 1 M 21 D (F)
Dr. SWATHI H V

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	1			
2	Discharge Summary	1			
3	Nursing Initial assessment	–			
4	Patient Transfer form	–			
5	In-patient Medical record	1			
6	Doctors progress sheets	–			
7	Nursing plan of care and handover sheets	–			
8	Consultation sheet	–			
9	General consent for treatment	–			
10	Consent for Surgery	–			
11	Consent for blood transfusion	–			
12	Consent for chemotherapy	–			
13	Consent for high risk	–			
14	Consent for Restraint	–			
15	LAMA consent	–			
16	Consent for special procedure / Sedation	–			
17	Consent for Formula feed	–			
18	Consent for MTP	–			
19	Consent for Radiological Investigations	–			
20	Consent for HIV test	–			
21	Anaestesia notes (Pre Anaesthesia& post)	–			
22	Neonatal Admission/Delivery/Physical Exam	–			
23	Medication Reconciliation	1			
24	Emergency Triage record	–			
25	Pre operative check list	–			
26	Surgical safety checklist	–			
27	Operation Theatre notes	–			
28	Nurses clinical Presentation	–			
29	TPR & BP chart	1			
30	Intake and Out take chart (fluid chart)	1			
31	Drug chart (Regular Prescription)	1			
32	Investigation Values (result sheet)	1			
33	Nebulization chart	–			
34	Nutritional review chart	–			
35	Intensive care unit (ICU Charts)	–			
36	Consent for Admission in PICU / NICU	–			
37	The Humpty dumpty scale	1			
38	Braden Q Scale	1			
39	Bed side check list	1			
40	PICU bed formula Dilution feeds	–			
41	Gastro monitoring chart	–			
42	Rch ED doctors note	–			
43	BP Monitoring chart	–			
44	RBS monitoring chart	–			
		–			
	Total No. of Pages	17			

Doc. No. : RCH/ FRM / GENERAL / 126

Signature and Date : 23/8/26

(P.T.O)

ERROR LOG

LOCATION : OT / Birthing Centre / BirthRight Premium / 3rd Floor (Zone A,B,C) / NICU / PICU / 2nd Floor Ward / Oncology / 1st Floor Wards.

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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ACTIVITY RECORD FOR PH

HNH-00013319 IP26-00006921
Mrs KAMIREDDI RAMADEVI
02-06-1995 31 Y 1 M 20 D (F)
Dr. SWATHI H V

Name: --------- ----------

UHID No : ------ ---- Consultant : ---------- Dept : ----------

Date of Admission : ---------- Time : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
23/02/25				

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
22/7/26	NST – (1)	8964 ✓	[illegible]
22/7/26	RBS @ 10pm 140mg/dl	12321 ✓	Anh
22/7/26	Urine c/s	12329 ✓	Anh
23/7/26	NST — (2)	8966 ✓	Anh
23/7/26	NST – (3)	8984 ✓	Anusha
23/7/26	Growth & Doppler Routine	8982 ✓	
		cross checked & done	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
23/4/26	2V placement	(1)	16139	

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00013319 IP26-00006921
Mrs KAMIREDDI RAMADEVI
02-06-1995 31 Y 1 M 20 D (F)
Dr. SWATHI H V

Pati

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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints
c/o PV Spotting. 3 episodes since today morning

Obstetric Formula: Primi
ML:

Obstetric History:
1st: PP, Spontaneous Pregnancy

Present Pregnancy Record:
NT - ↑NT (>95%).
EFTS & NIPT - low risk.
TIFFA - (N)
RISK FACTORS: Fetal 2D Echo - (N) @ 23+5 wks

OGTT - 81/159/122.
Amniocentesis done @ 17 weeks - (N)
microarray.

Height: ..... cm
Weight: 61.1 kg
Allergies: Nil

Breast: ☑ Normal ☐ Abnormal

General Examination:

Consciousness: c/c
Pallor: -ve
Icterus: no
Edema: -ve
Temp: Afebrile
PR: 82 bpm
BP: 112/73 mm Hg
DTR: (N)
CVS: S1S2 (+) nomurmurs
RS B/L NVBS (+)
Liver/Spleen: (N)
Urine Output: Adequate

LMP: 11/12/2025
EDD: 30/9/2026
Corrected EDD: 30/9/2026
GA:

Menstrual History: Regular: ☑ Yes ☐ No

Obstetric Examination

Fundal Height: ≃ 30 wks

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

Per Speculum Examination not done

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

Vaginal Examination not done.

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

DIAGNOSIS
Primigravida with 30 wks POG with PV Spotting for observation.

(P.T.O)

HNH-00013319 IP26-00006921
Mrs KAMIREDDI RAMADEVI
02-08-1995 31 Y 1 M 20 D (F)
Dr. SWATHI H V

Family History:
Parents - HTN.
mothers - Parkinsons.
Sister - VSD at 11yrs - operated.

Surgical History:
—

Medical History:
Nil.

Medication History:
T. IRON
T. CALCIUM.

Plan of Care:
- Admission.
- Inj. Tranexamic Acid 500mg. iv stat
- Inj Betnasol 12mg im stat
- NST - 6th hrly.
- Growth Scan T/M
- CUE
- Urine < 5.
- Pad for observation.
- Modified Bedrest
- Monitor Vitals
- Inform SOS.

Investigations: BGT - 'O' Positive

CBP

Hb	HIV.	NR.
TLC	HbsAg	
PCV	VDRL.	
plt	HCV	

Growth Scan (22/7/2026) @ fernandez. ER.
Cephalic.
placenta - Ant-high.
AFI - 16.8cms
no Retroplacental clots

Dr. Swathi H V
Consultant Obstetrics And Gynecology
Reg. No: 15501

Doctor Name: Dr. Naveena
Signature:
Date & Time: 22/07/2026 @ 10:00pm.

Consultant Name: Dr. Swathi
Signature:
Date & Time: 22/07/2026

HNH-00013319 IP26-00006921
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Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7/2026 2:00am	c/s/by Dr. Naveena o/E GC-fair Afebrile Vitals-stable PA: ut 30wks Relaxed. Cephalic FHR(+) UE: no bleeding. Dr. Naveena	Adv. -S/f diet, Adequate hydration -drugs as chanted -w/f PV bleeding/ Pain abdomen/PV leak. -Pad for observation -Bed rest -m/v & I/sos
23/7/2026 7:30am	c/s/by Dr. Naveena o/E GC-fair, Afebrile Vitals - stable PA: ut ≅ 30wks size. Relaxed Cephalic, FHR(+) UE: no bleeding Pad-dry Dr. Naveena	Adv. -S/f diet, Adequate hydration -drugs as chanted -w/f PV bleeding/ Pain abdomen/ PV leak. -Pad for observation -Bed rest -NST- 6th hrly -FHR 4th hrly -GS - today -m/v & I/sos

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
	R/B DR SWATHI .HV	
27/07 2pm	- P1 @ 30wks - ? APH for observation	
	- no further episodes of spotting	
	O/E:	Advice:
	Vitals @	- @ vitals.
NST - Reactive	PA: ut 30-32wks	- plan D/S today
	Breech	
G-scan @.	PV/P/S	- Strict DFMC
	Relaxed	- Modified Rest
	L/E: NAD	
	[signature]	- NST @ days
		- Reports
		- R/w > 1 wks
	Dr. Swathi H V Consultant Obstetrics and Gynecology Reg. No: 15501	

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

HNH-00013319 IP26-00006921
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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 — O+ve						
HIV						
HBsAg & PR						
HCV						
VDRL						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☐ Not known any Drug Allergies

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. IRON	1 TAB	PO	OD	22/7	☑ C ☐ DC
2	T-CALCIUM	1 TAB	PO	OD	22/7	☑ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr Naveena

Date & Time : 22/7/2026 @ 10:00pm.

Nurse Name & Signature: Anitha

Date & Time : 22/7/26 10pm

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

HNH-00013318 IP26-00006921
Mrs KAMIREDDI RAMADEVI
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Dr. SWATHI H V

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DRUG CHART

Date of Admission: ..... 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 *I* through it and a similar line through subsequent recording panels.
- The date and time of stopping the drug along with the doctors name and sign must be mentioned.
- Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.

NURSES - Nurses must follow strictly the FIVE RIGHTS before administration of medication.

1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time

- AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

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

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

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

VERIFIED BY : Name .....

Patient Sticker

HNH-00013319 IP26-00006921
Mrs KAMIREDDI RAMADEVI
02-08-1995 31 Y 1 M 20 D (F)
Dr. SWATHI H V

SCRIPTIONS Weight. 61.1 Ward. LDR

				Date / Time														
DRUG : T. IRON																		
Dose	Route	Frequency	Start Date															
1TAB	PO	OD	22/7															
Name & Signature of the Doctor Starting the Drugs: @ Dr. Naveena																		
Additional Instructions:																		
Daily Doctor's Endorsement by a Sign																		

				Date / Time														
DRUG : T. CALCIUM																		
Dose	Route	Frequency	Start Date															
1TAB	PO	OD	22/7															
Name & Signature of the Doctor Starting the Drugs: @ Dr. Naveena																		
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																		

IP26-00006921

Patient Sticker	Weight. 61.1	Ward. LDr

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.	

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

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
22/7	10:00pm	INJ. BETAMETHASONE	12MG	IM	[signature]	Anshep / Aleti
22/7	9:30 pm	INJ. TRANEXAMIC ACID	500mg	IV	[signature]	Anshep / Aleti

HNH-000[illegible]
Mrs KAMIREDDI RAMADEVI
02-06-1995 31 Y 1 M 20 D (F)
Dr. SWATHI H V

I.V. FLUIDS CHART

Weight. 61 Ward. VOF

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

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

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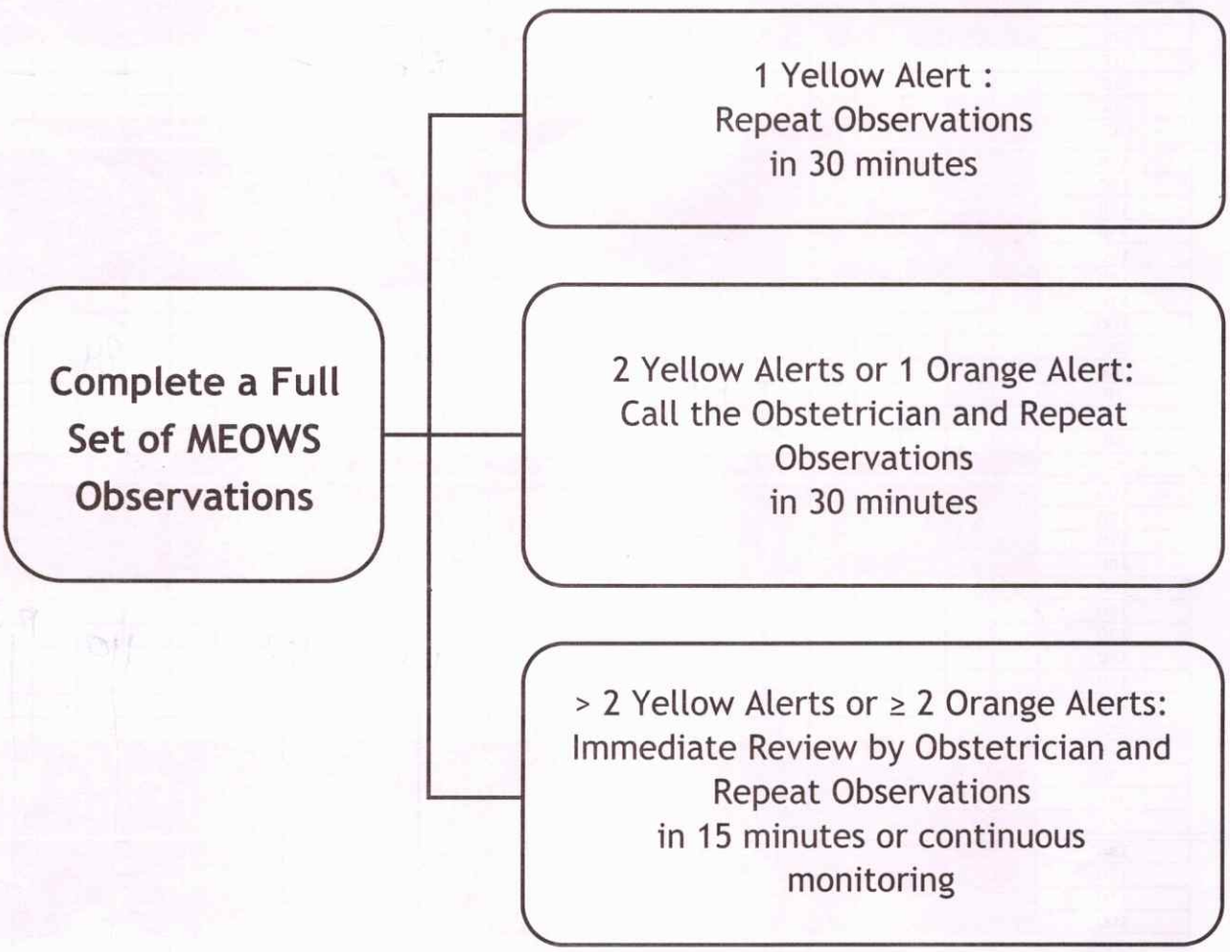
Early Warning Observation Score Chart - Obstetrics

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

22/7/26.	Date																								
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20														20			20				20		20	
	0 - 10																								
Saturations	94 - 100 %														100			99%				99%		99%	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37														37.4			—				—		—	
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80								80						81			84				84		89	
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120														121			122				119		122	
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
	40																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60														73			70				62		84	
	50																								
	40																								
NEURO RESPONSE [✓]	Alert														—			—				—		—	
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30																								
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal																								
	Heavy / Foul																								
Liquor	Clear / Pink																								
	Green																								
TOTAL YELLOW SCORES															0			0				0		0	
TOTAL ORANGE SCORES																									
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

22/7/2026

11pm ⇒ 142 bmt

3/7 2Am ⇒ 145 bmt

5Am ⇒ 155 bmt

HNH-00013319 IP26-00006921
Mrs KAMIREDDI RAMADEVI
02-06-1995 31 Y 1 M 20 D (F)
Dr. SWATHI H V

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Early Warning Observation Score Chart - Obstetrics

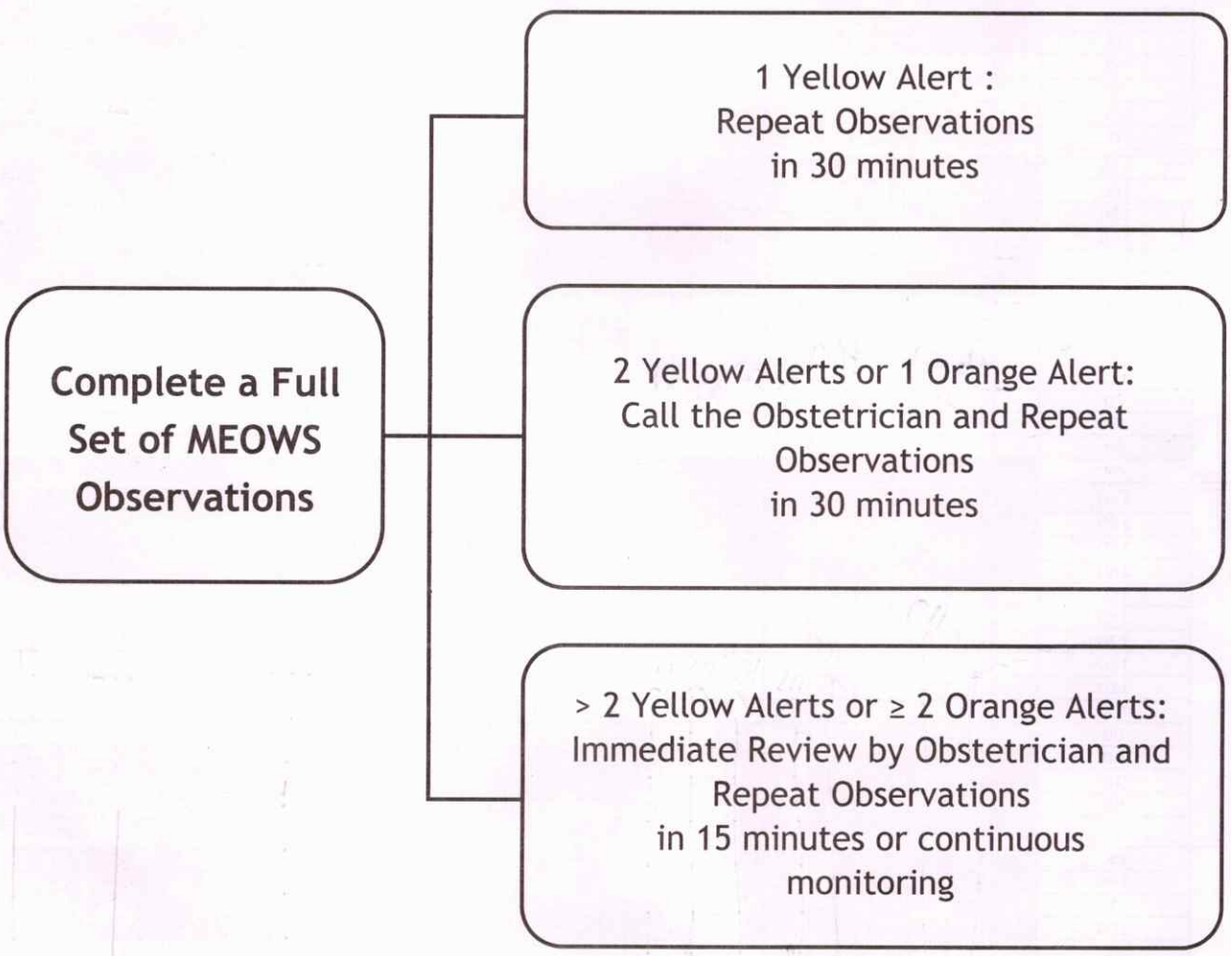
CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

		Date	23/7/26																							
		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																									
	11 - 20			20	20		20	20	20	20	20															
	0 - 10																									
Saturations	94 - 100 %			98	98		98	98	98	98	98															
	< 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			76	81		79	85	77	82	88															
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120			114	119		109	115	109	115	119															
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70			69	74		76	77	73	77	75															
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert																									
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30																									
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal																									
	Heavy / Foul																									
Liquor	Clear / Pink																									
	Green																									
TOTAL YELLOW SCORES				0	0		0																			
TOTAL ORANGE SCORES				0	0		0																			
Nurse Initial																										

23/07/2026 FHR

8Am ⇒ 149 b/mt

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00013319 IP26-00006921
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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 :**						
22/4/26	08:00 pm											
	09:00 pm											
	10:00 pm		H2O									
	11:00 pm											
	12:00 am		H2O									
	01:00 am											
Total Intake :		Taken				**Total Output :**				Passed		
23/4/26	02:00 am											
	03:00 am	-	H2O	-								
	04:00 am	-		-								
	05:00 am											
	06:00 am	-	H2O	-								
	07:00 am											
Total Intake :		Taken				**Total Output :**				Passed.		

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : ....

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

Date	Time	Intake: Nature of Fluid	Route: Mouth	Route: I.V	Route: N.G	Output: NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
23/4/2026												
	08:00 am		Idly +							✓		
	09:00 am		H2O							✓	0	Anush
	10:00 am		H2O Bread									
	11:00 am		Bread							✓		
	12:00 pm		H2O									
	01:00 pm									✓		
Total Intake : Taken						**Total Output :** Passed						
	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**	

Docu. No. : RCH /FRM / CLINICAL / 092

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 22/6/26.

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: .....

P.V Spotting

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: DR Naveena

Time Notified: 10:00 p.m

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: .....

Regulare

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 1 L - A -

Previous LSCS: NAD

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: 97.6F HR: 87 RR: 20

BP: 110/73 Weight: 61.1 Height: ..... BMI: .....

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

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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 ..... Husband .....

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 .....

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: .....

Date & Time: 02/2/2020 10pm

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	22/7/26	23/7/26	23/7
		Score	8 pm	M6	6 2
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0	0	0	
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:			20	20	20
		Signature			

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

22-7-26

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			NA	–						
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	–						
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NA		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			AG							

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 : Anusha

Signature of Ward In Charge :

Signature : Kasthuri Name : Kasthuri

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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BRADEN 'Q' SCALE

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					Date : 22/7 23/7 25/7			
					Time : 8pm	4h	12	
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	
				TOTAL SCORE	20	28	28	
				Evaluator's Name	SD	SD	SD	

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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PAIN ASSESSMENT FORM

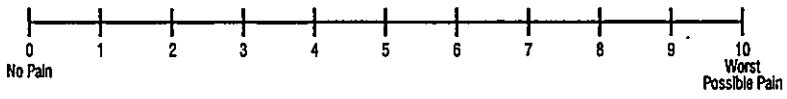
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
22/7/26	9pm	0/10	None	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
23/7/26	12AM	0/10	None	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
23/7/26	4AM	0/10	None	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
23/7/26	8Am	0/10	None	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
23/7	7pm	0/10	NA	☐ 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		

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

HNH-00013319 IP26-00006921
Mrs KAMIREDDI RAMADEVI (F)
02-06-1995 31 Y 1 M 20 D
Dr. SWATHI H V

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: 22/1/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning				NA			
Afternoon				NA			
Night	8pm – 8pm	- Assess the patient condition - plan for vital & record - plan for flochart plan for	8pm – 8pm	- Assessed the patient condition - Maintain vital & record - Maintain flochart	- Patient stable	- vital normal	[illegible]

Docu. No: RCH /FRM / CLINICAL / 148

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02-06-1995 31 Y 1 M 21 D (F)
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NURSING CARE RECORD

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Date: 23/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM 2pm	→ Assess the pt condition → Check the vital's → Do chart Maintain → pt having BP NST	8am 2pm	→ Assessed pt condition → Checked vital's & Maintained → Maintained Do chart → 6th hrly NST	Vital's is Normal	pt is stable	
Afternoon				DAY DUTY			
Night							

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION	Diagnosis: PV Spotting		Any Infection: ☐ Yes ☐ No ☑ ~~Not Known~~ If Yes Specify:				
BACKGROUND	Area / Shift Time	22/7/26 8pm	23/7/26 M6				
	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:	97.6	97.1°F				
	Res:	20	20				
	SpO_2:	100	99%				
	Pulse:	84bpm	76				
	BP:	110/76	113/74				
	Fall Risk Score:	-	-				
	Pain Score:	-	-				
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 :		[signature]	[signature]				
Signature :		[signature]	[signature]				
Date:		23/7/26	23/7/26				
Time:		8AM	8pm				
Taken Over By Name :		[signature]					
Signature :		[signature]					
Date:		23/7/26					
Time:		8am					

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NURSING SHIFT HAND OVER FORM - WARD

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

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