Dr. S. Sudha

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

BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

ESTIMATION SLIP

Date : 16/7/26 **UHID / IP No. :** HNIM-0001662 2 **Sl No.** 1710

Name of Patient : Mrs. Rashmi Sai Vihalika **Age:** 27yr **Gender:** F

Father's / Husband's Name : Mr. Sesha Sai Kiran **Corporate / Occupation :**

Address : **Phone :** 9951482928 **Email :** 9th Aug.

Procedure / Plan : ND / LSCS **EDD/Dos:** Aug-26

MODE OF PAYMENT : ☑ SELF ☐ TPA : ☐ GIPSA : OTHER

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward		
Twin Shared Ward		
Private Room →	1.45k	1.55k
Super Deluxe Room →	1.65k	1.75k
Suite Room		
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for : 2 Days	Length of Stay for : 3 Days
	Pharmacy up to 9,000/-	Pharmacy up to 12,000/-
	Investigations up to 2,500/-	Investigations up to 3,000/-
Others	Well baby care	25k to 35k approx

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

Initial Minimum Deposit : 80% Advance time of Admission

REMARKS : Vaccination, Neonatal, SRP, BG

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

DECLARATION

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

Signature of the Client

Father.
Signatory Relationship

Signature of the financial Counselor

HNH-00016622 IP26-00006874
Mrs RASHMI SAI NIHARIKA
14-02-1999 27 Y 5 M 4 D (F)
Dr. SUDHA S

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SURGERY DETAILS

Date : 18/07/2026

Patient Name: Mrs. Rashmi Sai Niharika Date of Birth: 14-02-1999 Age: 27Y

Gender: female Ward : LDR UHID No.:

Date of Surgery: 18/07/2026 LDR-I ~~☐ OT -1~~ ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : N.V.D ↓ Local

Time in : 3AM Time Out : 4AM

		NAME	AMOUNT
1.	Surgeon	Dr. Sudha S	
2.	Anaesthetist		
3.	Assistant Surgeon	Dr. Manisha	
4.	OT Technician		
5.	Circulating Nurse	Anusha.b	
6.	Assistant Nurse	Mounika	

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

Dr. Manisha
Signature of the Surgeon

Anusha.b.
Signature of Circulating Nurse

Order No: 26-0000219854 Order by: Anusha.e.

306-FC

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Name	Mrs RASHMI SAI NIHARIKA GOLLAPUDI	**UHID**	HNH-00016622
Father/Guardian	Mr T SESHA SAI AVNESH	**Age/Gender**	27 Y 5 M 4 D/ Female
Address	FNO:208,SRI BALAJI BLOCK ,ADITHYA ARCADE, Azamabad, Hyderabad, Telangana, INDIA, 500020		
IP No	IP26-00006874	**Admission Date**	18-07-2026
Ref Doctor	Self.		
Discharge Date	19.07.2026		

DISCHARGE SUMMARY

Consultant:
Dr. S.SUDHA
MBBS, MD (GYN)

Diagnosis: PRIMIGRAVIDA WITH 37^{+4} WEEKS WITH PREMATURE RUPTURE OF MEMBRANES IN EARLY LABOUR.

SPONTANEOUS VAGINAL DELIVERY DONE ON 18.07.2026.

History:
LMP: 28.10.2025 Obstetric formula: Primi
EDD: 05.08.2026 Gestation at admission: 37^{+3}weeks

Obstetric History:
G1 - Present pregnancy Spontaneous conception.

Medical History : Bronchial Asthma-used inhaler for 1 year [2015].

Name	Mrs RASHMI SAI NIHARIKA GOLLAPUDI	UHID	HNH-00016622
IP No	IP26-00006874	Admission Date	18-07-2026

Surgical History: Right Femur Surgery at 15 years of age at ABC.
Family History : Mother -Diabetic.
Allergies : Nil.

Antenatal Details:
Mrs RASHMI SAI NIHARIKA GOLLAPUDI was booked to Rainbow hospital at 37^{+3}weeks of gestation. She had regular antenatal checkups and investigations as advised elsewhere. NT scan normal, FTS low risk, TIFFA was normal, Fetal 2D Echo was normal.
Betnasol covered 2 weeks back for fetal lung maturation. Fetal growth monitoring was done by serial growth scans. Scan done on 06.07.2026 showed SLIUF at 35^{+4} weeks, Cephalic presentation, EFW 2.6 kg, Placenta :Anterior ,Liquor Adequate, AFI - 11-12 cm, Dopplers normal. She was admitted at 37^{+3} weeks with Premature Rupture of membranes for normal Labour.

Investigations: Enclosed.
Blood group: "O" Positive

Management: Course in hospital and Delivery Details:
At admission on clinical examination the vitals were stable, uterus was relaxed, cervix was partially effaced and 3-4 cms dilated, Vertex at -2 station and pelvis adequate. Fetal well being was confirmed by admission CTG which was found to be reactive. Informed consent obtained for Induction of labour. Partographic monitoring of labour was done. She progressed to full dilatation at 2:45am. Passive descent of fetal head was allowed for 1hr post full dilatation. She was put into position for vaginal birth at 3:15am. Parts painted with betadine solution and draped to ensure full asepsis. She was encouraged to bear down. At crowning of head episiotomy was given under local anesthesia

Name	Mrs RASHMI SAI NIHARIKA GOLLAPUDI	**UHID**	HNH-00016622
IP No	IP26-00006874	**Admission Date**	18-07-2026

(10 ml of 2 % xylocaine solution). Baby was delivered by Assissted (KIWI) vaginal delivery, 1 loop of cord around the neck noted, Cord clamped and cut and baby handed over to pediatrician. Cord blood collected for blood grouping and Rh typing. Placenta and membranes delivered completely with controlled cord traction. Prophylactic syntocinon given. Episiotomy inspected. No extensions or additional vaginal tears found. Episiotomy sutured in layers. Instrument and swab count checked. 800 mcg of misoprostol given per rectally as prophylaxis against post partum hemorrhage. Vagina cleaned with betadine solution.

Delivery Details:

Date : 18.07.2026
Time of Delivery: 3:24 am
Type of Labour : Assisted
Type of Delivery: Assisted Vaginal Delivery
Analgesia : Local

Baby Details:

Date : 18.07.2026
Time : 3:24 am
Sex : Male
Weight : 2.900gms
Apgar : 8,9
Gestational Age: 37^{+4} weeks
NICU Admission: No

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

Name	Mrs RASHMI SAI NIHARIKA GOLLAPUDI	UHID	HNH-00016622
IP No	IP26-00006874	Admission Date	18-07-2026

given. Her postpartum period following that was uneventful. On first postpartum day episiotomy wound was healthy and intact. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

Advice:

1. Tab. Taxim - O 200mg (Cefixime 200mg) twice daily till 22.07.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 20.07.2026 (8am-2pm-10pm) after food.
3. Tab. Pantodac (Pantoprazole - 40mg) 1 tablet twice daily till 22.07.2026 (7am-7pm) before food.
4. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 20.07.2026(9am-3pm-11pm) after food.
5. Tab. Livogen (Elemental iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal (Elemental Calcium 500 mg, vitamin D3 250 IU) once daily (2pm) till breast feeding after food.
7. Betadine ointment for local application.
8. Syp. Duphalac 15 ml (Lactulose 3.33gm/5ml) at bed time for one week.

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

* Suggest **PAP smear** and **HPV Vaccine** after **6 weeks**; Please discuss with your treating doctor regarding **HPV vaccination.**

Name	Mrs RASHMI SAI NIHARIKA GOLLAPUDI	**UHID**	HNH-00016622
IP No	IP26-00006874	**Admission Date**	18-07-2026

Review with **Dr. S.SUDHA** after 1 week on 27.07.2026 at postnatal clinic with prior appointment **(Review consultation will be charged).**

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

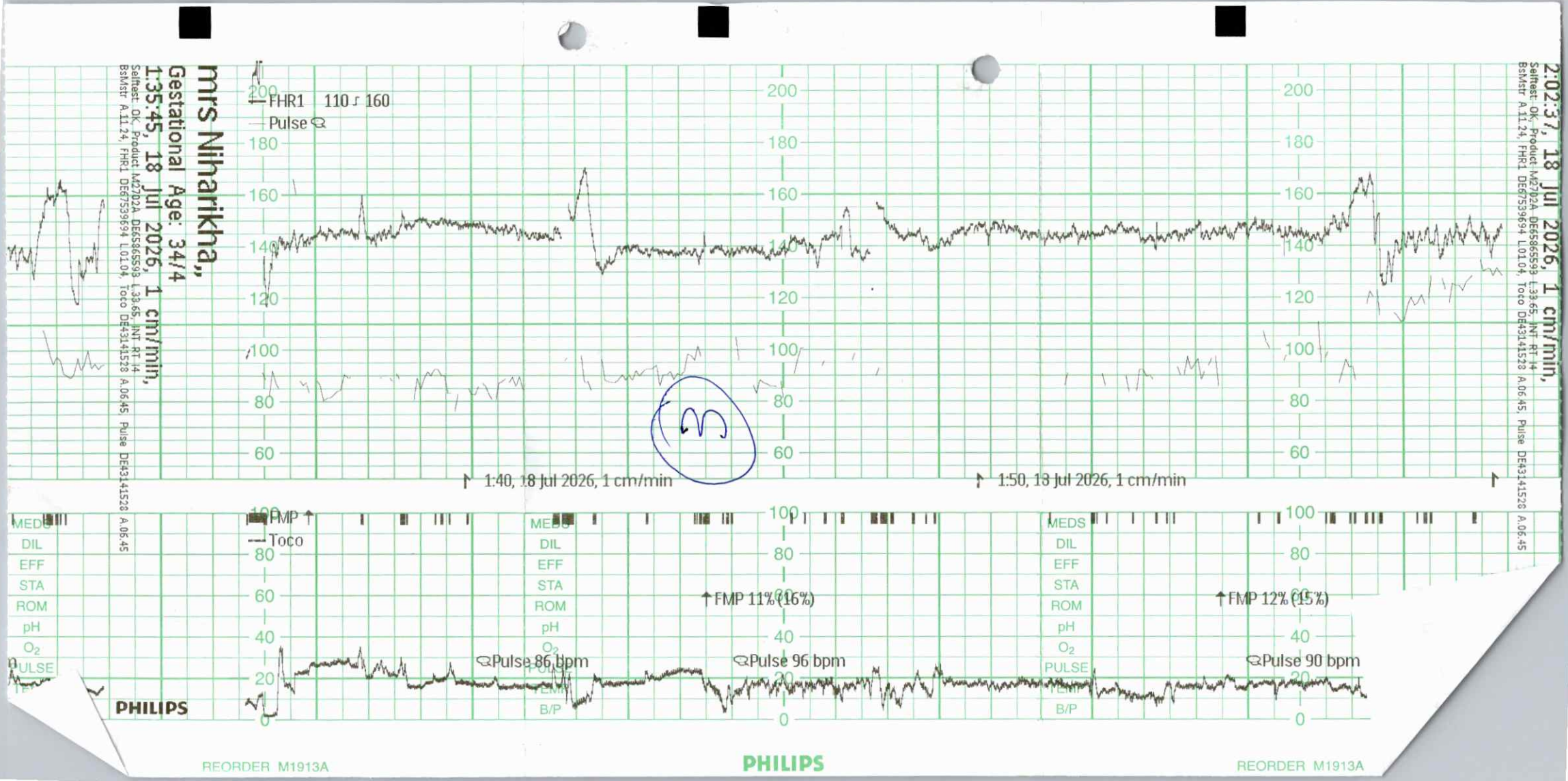
Patient/ Attender

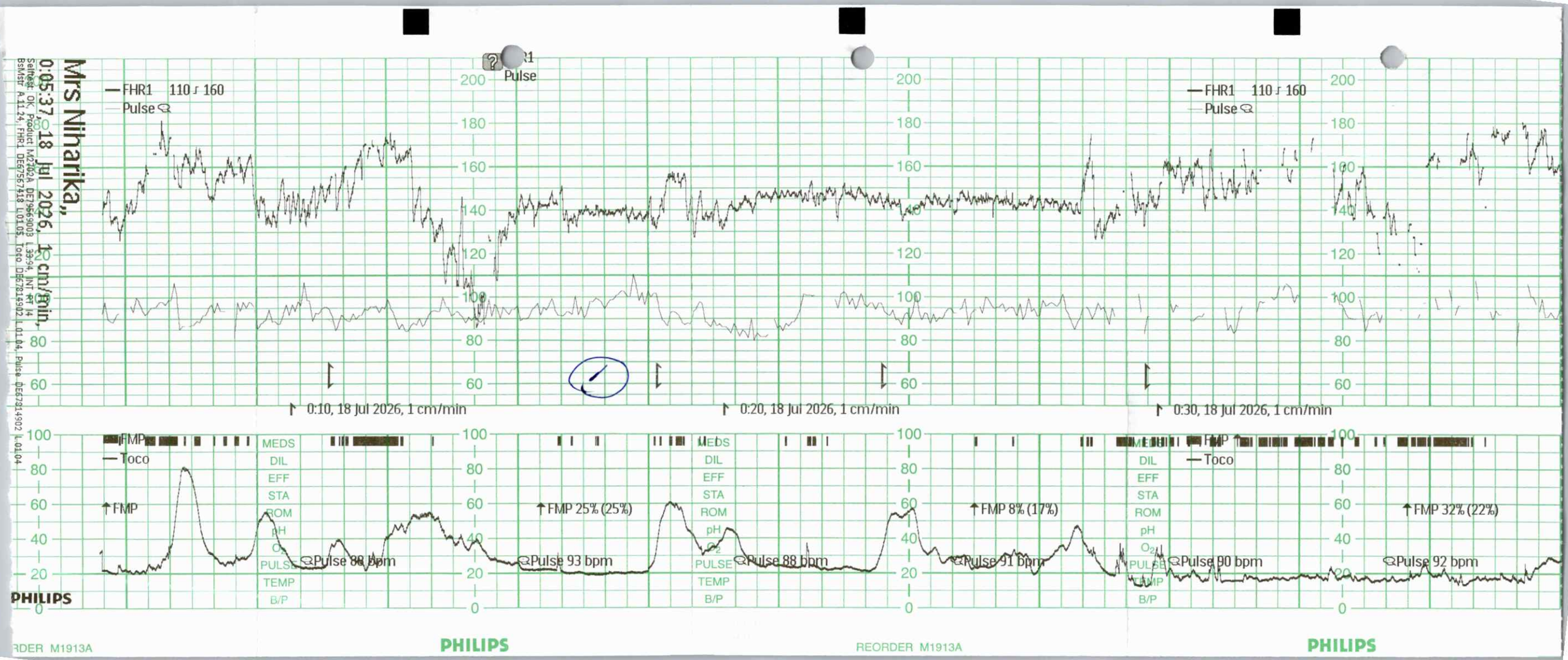
In case of emergency like bleeding, fever please refer to postpartum book for further details - Chapter II page 6 kindly contact 9154865045 at Rainbow Children's Hospital just dial one toll free number - 18002122. You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

Registrar/Resident/C.M.O

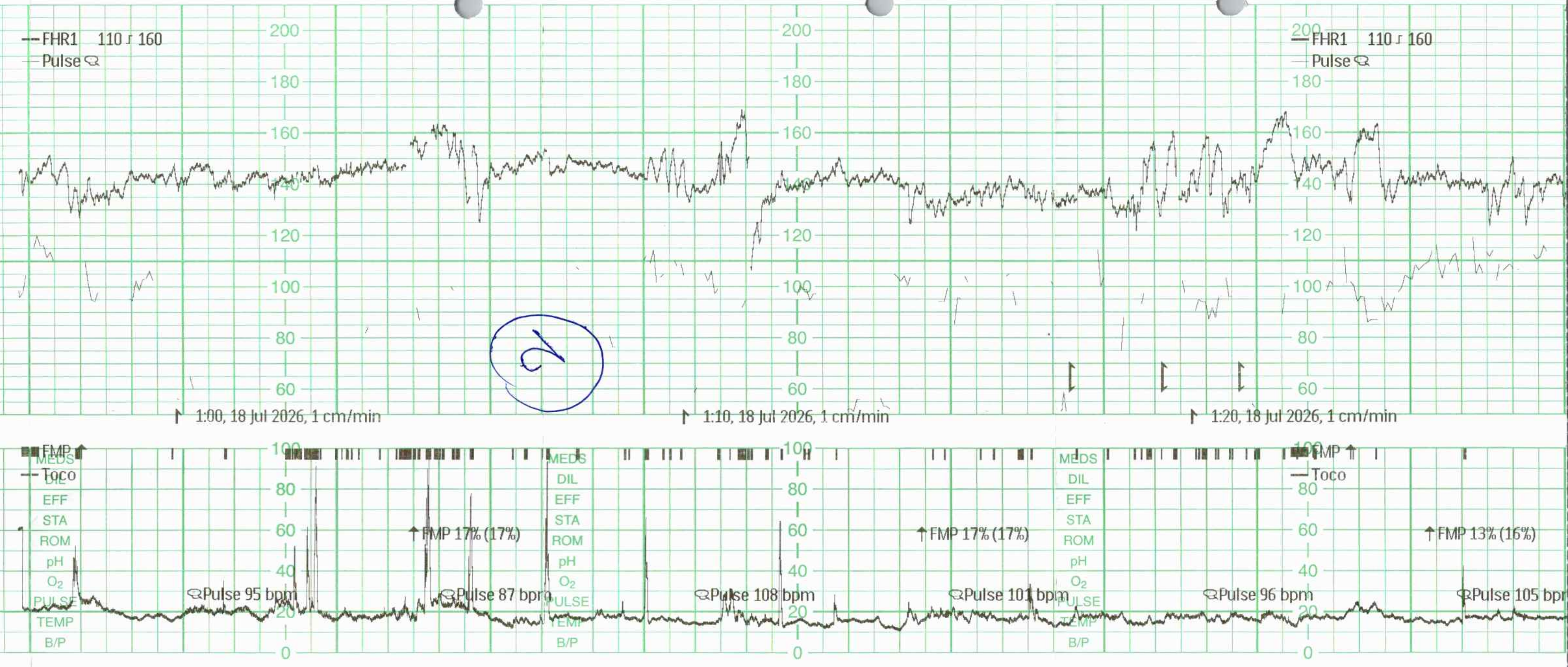
Rainbow Children's Healthcare Ltd. Himayathnagar 500029 Hyderabad

Consultant:
Dr. S.SUDHA
MBBS, MD (Gyn)


mrs Niharikha,,
Gestational Age: 34/4
1:35:45, 18 Jul 2026, 1 cm/min,
Selftest: OK, Product M2702A DE65865593 L33.65, INT RT 14
BsMstr A.11.24, FHR1 DE67539694 L01.04, Toco DE43141528 A.06.45, Pulse DE43141528 A.06.45
FHR1 110 160
Pulse
1:40, 18 Jul 2026, 1 cm/min
1:50, 18 Jul 2026, 1 cm/min
2:02:37, 18 Jul 2026, 1 cm/min,
FMP
Toco
MEDS
DIL
EFF
STA
ROM
pH
O2
PULSE
TEMP
B/P
FMP 11%(16%)
FMP 12%(15%)
Pulse 86 bpm
Pulse 96 bpm
Pulse 90 bpm
PHILIPS
REORDER M1913A
PHILIPS
REORDER M1913A


Mrs Niharika,,
0:05:37,,18 Jul 2026, 1 cm/min,
FHR1 110 160
Pulse
0:10, 18 Jul 2026, 1 cm/min
0:20, 18 Jul 2026, 1 cm/min
0:30, 18 Jul 2026, 1 cm/min
FMP
Toco
MEDS
DIL
EFF
STA
ROM
pH
PULSE
TEMP
B/P
FMP 25% (25%)
FMP 8% (17%)
FMP 32% (22%)
Pulse 88 bpm
Pulse 93 bpm
Pulse 88 bpm
Pulse 91 bpm
Pulse 90 bpm
Pulse 92 bpm
PHILIPS
REORDER M1913A

mrs Niharikha,,
Gestational Age: 34/4
0:56:55, 18 Jul 2026, 1 cm/min,
Selftest: OK, Product M2702A DE65865593 L.33.65, INT RT I4
BsMstr A.11.24, FHR1 DE67539694 L.01.04, Toco DE43141528 A.06.45, Pulse DE43141528 A.06.45



PHILIPS

PHILIPS REORDER M1913A PHILIPS

HNH-00016622 IP26-00006874
Mrs RASHMI SAI NIHARIKA
14-02-1999 27 Y 5 M 4 D (F)
Dr. SUDHA S

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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	1			
4	Patient Transfer form	1			
5	In-patient Medical record	1			
6	Doctors progress sheets	2			
7	Nursing plan of care and handover sheets	2			
8	Consultation sheet				
9	General consent for treatment	1			
10	Consent for Surgery	1			
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	1			
25	Pre operative check list	1			
26	Surgical safety checklist	1			
27	Operation Theatre notes	1			
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				
38	Braden Q Scale	1			
39	Bed side check list				
40	PICU bed formula Dilution feeds				
41	Gastro monitoring chart				
42	Rch ED doctors note				
43	BP Monitoring chart				
44	RBS monitoring chart				
	Billing	1			
	Extras	6			
	Total No. of Pages	28			

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

Signature and Date : 17/7/26

(P.T.O)

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 : IP26-00006874 **Admit Date** : 18-Jul-2026 **Admit Time** : 12:38 AM **UHID** : HNH-00016622

Patient Details :

Patient Name	: Mrs RASHMI SAI NIHARIKA GOLLAPUDI	**Age**	: 27 Y 5 M 4 D
Guardian	: Mr T SESHA SAI AVNESH	**DOB**	: 14-02-1999
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: FNO:208,SRI BALAJI BLOCK ,ADITHYA ARCADE Azamabad Hyderabad Telangana INDIA 500020	**Phone No**	: 9951482928/ 8247268285
		E-mail	: NA@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : LDR-415 **Ward Name** : 4F -OT

Room No : LDR-415 **Admission Type** : First Visit

Contact Details :

Name	: Mr T SESHA SAI AVNESH	**Relationship**	: Husband
Contact Address	: FNO:208,SRI BALAJI BLOCK ,ADITHYA ARCADE Azamabad Hyderabad Telangana INDIA 500020	**Phone No**	: 9951482928

Signature

Doctor Details :

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

Payment Details :

Payment Mode	: DC/CC Card	**Deposit Amount**	: 100000.00
		Payor Name	: SELFPAY

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016822 IP26-00006874 Mrs RASHMI SAI NIHARIKA 27 Y 5 M 4 D (F) 14-02-1999 Dr. SUDHA S	18/7/26	18/7/26 AM
	Transfer Ordered by Dr. Manish	Reason for Transfer Obs
From Unit LDR	To Unit Room (306)	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 35	Number of Imaging Films NST (3)	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Mounika.	Dr. Manish.

Patient & Clinical Records Received by : Divya 18/7/26 @ 9:30AM

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

HNH-00016622 IP26-00006874
Mrs RASHMI SAI NIHARIKA
14-02-1999 27 Y 5 M 4 D (F)
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ACTIVITY RECORD FOR BILLING

Name :_____

UHID No. : _____ IP 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
18/7/26	1PM	LDR	Room C306	Mounika/Divya

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1	Dr. Tejaswi Reddy	18/7/26	5098	
2			Cross checked done by Amrutha 19/7/26	
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

Date	Investigations	Order No.	Signature
18/7	CBP — ①	11990 ✓	Mori
18/7	NIST — ①	8708 ✓	Mori
18/7	NIST — ②	8707 ✓	Mori
18/7	NIST — ③	8706 ✓	Mori

Cross checked done

Cross checked done 19/7/26

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
18/7	cardiac monitor	3Am	4Am	14855	[illegible]
18/7	Infusion pump	1Am	4Am	14855	[illegible]

Crosschecked done

Crosschecked done 19/7/26

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
18/7	IV placement	(1)	14556	Mou
18/7/26	NHA	(1)	5094	

Cross checked done

Cross checked done 19/7/26

ANY OTHER INFORMATION

.....

.....

.....

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.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016622 IP26-00006874
Mrs RASHMI SAI NIHARIKA
14-02-1999 27 Y 5 M 4 D (F)
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IP ADMISSION SHEET FOR OBSTETRICS

Presenting Complaints
Came c̄ C/o leaky - 1w
PROM (+)

Obstetric Formula: Primi

Obstetric Hostory:
G1 - 1°P, Spont Concep

Present Pregnancy Record: Booked @ 37+3
NT (N) ; FTS - LR
TIFFA (N) ; Fetal Echo (N)
Betnesol Covered - 2 weeks back (1/7 - 2/7/2026)

RISK FACTORS:

Height: .... cm
Weight: .... kg
Allergies: Cucumber
Breast: ☑ Normal ☐ Abnormal
General Examination: (+)

Consciousness: Fair — Pallor: (-)
Icterus: (-) — Edema: (-)
Temp: Afeb — PR: 92
BP: 116/70 — DTR: (+)
CVS: } (-) — RS: BAE (+)
Liver/Spleen: } — Urine Output: Adq

LMP: 28/10/2025 — EDD: 5/8/26
Corrected EDD: — GA: 37+4

Menstrual History: Regular : ☑ Yes ☐ No

Obstetric Examination

Fundal Height: ~ Term Size
Ut. Activity: ☐ Relaxed ☑ Mild ☐ Mod ☐ Severe
Liquor: ☑ Adequate ☐ Oligo ☐ Poly
PP: ☑ Cephalic ☐ Breech Others ____________
Head Fifths Palpable: ______________________________
FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Per Speculum Examination

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

Vaginal Examination

Cervix: ☐ Long ☑ Partially effaced ☐ Effaced
Os: Closed 3-4cm 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

Primi / 37th weeks) SROM /, Early labour
for Delivery.

HNH-00016622 IP26-00006874
Mrs RASHMI SAI NIHARIKA
14-02-1999 27 Y 5 M 4 D (F)
Dr. SUDHA S

Family History:	Surgical History:
Mother - DM	Rt Femur Sx (ABC) @ 15yr of Age (2014)
Medical History:	**Medication History:**
Bronchial Asthma - took inhaler x1y Stopped (~2015)	Tab Iron, Calcium
Plan of Care:	**Investigations:**
- Admission NPO - Parts prepare - Informed consent - Drips as charted - Inform Pediatrician - Send CBC - Check for Blood availability - C/W/F Progress of labor	BGT O Positive 27/4/2026: Hb - 10.6, PLT 2.1, WBC - 6500 12/1/2026: HIV, HbsAg, VDRL, GCT } NR 18/7: Hb - 11.3, WBC - 7.08, PLT - 224 USG (3/6/2026): SLF / 31+4 / Br, AFI - 10cm., Pl. Ant Upper, EFW - 1.722g. 6/7/2026: SLF / 35-36wks, Cephalic, EFW 2.625kg, Pl - Ant - US, AFI - 11-12cm, Doppler (N)

Doctor Name: Dr Mounika

Signature:

Date & Time: 18/7/2026 12:45Am

Consultant Name: Dr. Sudha

Signature:

Date & Time: 18/7/2026

HNH-00016622 IP26-00006874
Mrs RASHMI SAI NIHARIKA
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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/2026	C/o/b	Dr Manisha
4:20 AM	PND D	
		Adv
	Cc- For Afebrile	
	vitals Stable BP-101/72 PR-97	Regular Diet / Adeq Hydration
	P/A Ut well retracted	Drugs as charted
	PV Bleedy WNL	C/F vitals & BP
	Episiotomy Intact	Encourage to Pass urine
		Exclusive Breast feeding
(Baby mothers side)		Inform SOS
		Manisha
18/7/2026	Cs/b Dr	Manisha
7 AM	PND-0	
	Cc- For Afebrile	Ad
	Vitals stable	
	P/A Ut well retracted	Regular Diet / Adeq Hydration
Drugs	PV Bleedy WNL	Drugs as charted
	Episiotomy (H)	C/F vitals & BP
Baby mothers side		Ambulation
U-Passed		Inform SOS
		Shift to Room
		Noted by Mounika 18/7/26
		Manisha

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

HNH-00016622 IP26-00006874
Mrs RASHMI SAI NIHARIKA
14-02-1999 27 Y 5 M 4 D (F)
Dr. SUDHA S

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/26	S/B Dr. Sudha MS DG	
10 AM	Ⓓ PPD	
	GC good	
	vitals Ⓝ	
	PA soft	
	UT well retracted	
patient wise	PV - bleeding Ⓝ	
	Episiotomy healthy	
baby fine		
		Ⓝ diet
		– oral medication
		→ Delivery of child

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
18/7/26	C/S/B Dr. Dna	
7:30pm	PND-0.	Adv
		- Regular diet
	G C fair	- Adequate hydration
	Afebrile	- Drugs as charted
Baby c̄ Mother	vitals - stable	- Monitor vitals
	P/A Uterus Retracted well	- W/F bleeding PV
UV		- Inform sos.
FV	L/E NAD	Noted by Nirudhi 18/7/26
	[signature]	
19/7/26	C/S/B Dr. Dna	
8:30AM	PND-1	Adv
		- Regular diet
	C/C fair	- Adequate hydration
Baby c̄ Mother	Afebrile	- Drugs as charted
	vitals stable	- Monitor vitals
UV	P/A Uterus Retracted well	- W/F PV bleed
FV	L/E NAD	- Inform sos
SV		Pt can be discharged
	[signature]	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
19/2/26		
	Sr Dr. Sudha,	MD, DGO
	POD - I	
	pt comfortable	
	vitals (N)	
Baby fine	PA - ut	retracted
Breast fed	P/V - No	active bleeding
	Bowels & mict (N)	
	for discharge today	
		[signature]

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

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NU Dr. SUDHA S

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DRUG CHART

Date of Admission: 18/July/2021 Drug Allergies: NKDA ☑ 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 ....

Mrs RASHMI SAI NIHARIKA
14-02-1999 27 Y 5 M 4 D (F)
Dr. SUDHA S

REGULAR PRESCRIPTIONS

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

DRUG : T. CEFIXIME				Date / Time	18/7	19/7/25
Dose	Route	Frequency	Start Date			
200mg	P/O	BD	18/7	12AM	✓	[signature]
Name & Signature of the Doctor Starting the Drugs: [signature]						
Additional Instructions:				12pm	[signature]	
Daily Doctor's Endorsement by a Sign						

DRUG : T PANTOPRAZOLE				Date / Time	18/7	19/7/25
Dose	Route	Frequency	Start Date			
40mg	P/O	OD	18/7			
Name & Signature of the Doctor Starting the Drugs: [signature]				6AM	[signature]	[signature]
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

DRUG : T. PARACETAMOL				Date / Time	18/7	19/7/25
Dose	Route	Frequency	Start Date			
1g	P/O	TID	18/7	6AM	[signature]	[signature]
Name & Signature of the Doctor Starting the Drugs: [signature]				2pm	[signature]	
Additional Instructions:				10pm	[signature]	
Daily Doctor's Endorsement by a Sign						

DRUG : T. DICLOFENAC				Date / Time	18/7	19/7/25
Dose	Route	Frequency	Start Date			
50mg	P/O	BD	18/7	7AM	✓	
Name & Signature of the Doctor Starting the Drugs: [signature]						
Additional Instructions:				7pm	[signature]	
Daily Doctor's Endorsement by a Sign						

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG : SYP DUPHALAC

Dose	Route	Frequency	Start Dt.	Date/Time
15ml	PO	OD	18/7	18/7 10pm

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

Additional Instructions: at Bedtime

Daily Doctor's Endorsement by a Sign

DRUG : OINT METRO-P

Dose	Route	Frequency	Start Dt.	Date/Time
Pea size	LA	BD	18/7	18/7 6pm; 19/7/25 6AM

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

Additional Instructions: metronidazole + Povidone Iodine

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

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

Patient Sticker

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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

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

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

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

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

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

Docu. No. : RCH /FRM / CLINICAL / 108

(P.T.O.)

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Mrs RASHMI SAI NIHARIKA
14-02-1999 27 Y 5 M 4 D (F)
Dr. SUDHA S

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

	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.	

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
18/7	12AM	INJ CEFOTAXIME	1g (AST)	IV		MOW Ary
18/7	1AM	INJ BUSCOPAN	1amp	IV		Anu
18/7	1:30 AM	DROTAVERIN	1amp	IV		Anusha
18/7	2AM	EPIDOSIN	1amp	IV		MOW Ary
18/7	3AM	DICLOFENAC SUPPOSITORY	100mg	PR		MOW Anusha
18/7	4AM	T MISOPROSTOL	600 mcg	PR		MOW Anusha
18/7	4AM	INJ OXYTOCIN	10 U	IM		MOW Anu
18/7	4AM	INJ OXYTOCIN	15U	IV		MOW
18/7	4AM	INJ TRANEXAMIC ACID	1g	IV		MOW Akhila

Mrs RASHMI SAI NIHARIKA
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I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
18/7	1AM	RINGER LACTATE + 10U OXYTOCIN	IV	6ml/h	[signature]	[signature] / [signature]	18/7	[signature]	[signature] / [signature]
		STOP [signature]							

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

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Mrs RASHMI SAI NIHARIKA
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MEDICATION RECONCILIATION FORM

Drug Allergies: NKDA ☐ 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: NA Shifted to: NA

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	Tab Iron	1 tab	P/O	OD		☐ C ☑ DC
2	Tab Calcium	1 tab	P/O	OD		☐ C ☑ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr Monika

Date & Time : (8/7/2026) 1 AM

Nurse Name & Signature: .....

Date & Time : .....

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14-02-1999 27 Y 5 M 4 D (F)
Dr. SUDHA S

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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						

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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

12/2/26	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													
	0 - 10																								
Saturations	94 - 100 %																								
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37					37			37																
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70					80																			
	60								92					86											
	50																								
	40																								
Systolic Blood Pressure ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140					112				104				102											
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90					80				62				72											
	80																								
	70																								
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30				c							-													
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal																								
	Heavy / Foul																								
Liquor	Clear / Pink																								
	Green																								
TOTAL YELLOW SCORES					4				4			5													
TOTAL ORANGE SCORES																									
Nurse Initial																									

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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

18/2/26	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				20				20	
	0 - 10																								
Saturations	94 - 100 %			99%				99%				99%				98%				98%				99%	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36			36°C				36°C				36°C				97.4°F				98.7°F				98.4°F	
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80			79				80				81				72				78				73	
	70																								
	60																								
	50																								
	40																								
↑ Systolic Blood Pressure	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110			111				108				112				110				110				108	
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
↓ Diastolic Blood Pressure	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70			79				72								76				70				73	
	60											76													
	50																								
	40																								
NEURO RESPONSE [✓]	Alert			–				–				–				–				–					
	Voice																							–	
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30			–				–				–				–				–				–	
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal			–				–				–				–				–				–	
	Heavy / Foul																								
Liquor	Clear / Pink			–				–				–				–				–				–	
	Green																								
TOTAL YELLOW SCORES				0				0				0				0				0				0	
TOTAL ORANGE SCORES				0				0				0				0				0				0	
Nurse Initial				[illegible]				[illegible]				[illegible]				[illegible]				[illegible]				[illegible]	

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Early Warning Observation Score Chart - Obstetrics

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

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

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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		RL		Urine							
	03:00 am		RL									
	04:00 am		Idly									
	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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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							
18/7/26	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :								**Total Output :**				
18/7/26	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :								**Total Output :**				
19/7/26	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :								**Total Output :**				
19/7/26	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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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	

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

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: 12/8

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							
Afternoon							
Night	8pm to 8AM	→ Assess the pt condition → Monitor vitals → Maintain I/O	8pm to 8AM	→ Assess the pt condition → Encourage	Now		

Docu. No: RCH /FRM / CLINICAL / 148

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NURSING CARE RECORD

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Date: 18/2/26

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 - monitor vitals - maintain I/O chart - medication Give as per drug chart	8am 2pm	- Assessed the pt condition - monitor vitals - maintain I/O chart → drugs given as per drug chart.	→ pt is stable Now.	→ Re assessed the vitals	
Afternoon	2PM 8PM	→ Assess the General condition of pt. → Monitor vitals → Maintain I/O chart → Administer medication.	2pm 8PM	→ Assessed the general condition of pt. → Monitored vitals → Maintained I/O chart → Administered medication.	→ Pt is stable.	Re-assess vitals.	
Night	8PM 8am	→ Assess the Pt condition → monitor vitals → maintain I/O chart → Administer medication as per drug chart	8PM 8am	→ Assessed the Pt condition → monitored vitals recorded → maintained I/O chart → medication as per drug chart	→ Pt is stable	→ rechecked vitals	

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NURSING CARE RECORD

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Date: .....

Goals

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

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

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BRADEN 'Q' SCALE

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				Date : 18/7	18/7	18/7	18/7/26
				Time : NN	MG	EL	NN
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	3	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	3	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	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	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	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	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	3	4	4
				TOTAL SCORE	28	25	28	28
				Evaluator's Name				

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

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

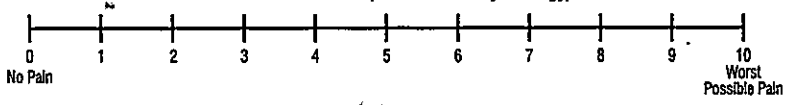
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
17/2	12 K	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
18/2	10am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
18/7/26	2pm	0/10	NA	☐ Continuous ☑ Intermittent	☐ ~~Acute~~ ☐ Chronic	☐ ~~Sharp~~ ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☑ Decreasing	☑ Yes ☐ No	NA	[signature]
18/7/26	6pm	0/0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
18/7/26	10pm	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

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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	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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				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										
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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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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	17/2	18/7/25	18/7/25
		Score	N1	M6	E2
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0			
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0	0	0	0
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
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	0	0
		Signature			

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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NURSING 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	17/7 N1	18/7/26 M6	18/7/26 E2	18/7/26 N1		
	Medical Condition (Any special condition to be noted):	—	—	—	—		
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	98.	98.6°F	98.4°F	97.2°F		
	Res:	16	20 bm	26 bm	20 bm		
	SpO_2:	100	99%	99%	100%		
	Pulse:	82	83	86 b/m	78 b/m		
	BP:	110/70	111/79	112/72	118/76		
	Fall Risk Score:	—	—		—		
	Pain Score:	—	—	—	—		
Recommendations	Safety Needs:	—	—	—	—		
	Physiotherapy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	—	—	—	—		
	Special Diet:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	—	—	—	—		
Post Operative Procedure Special Orders:		—	—	—	—		
Handed Over By Name :		Mouli	Amrutha	Mayuri	Divya		
Signature :							
Date:		17/7	18/7/26	18/7/26	18/7/26		
Time:		8pm	2pm	8PM	8pm		
Taken Over By Name :		Amrutha	Mayuri	Divya			
Signature :							
Date:		18/7/26	18/7/26	18/7/26			
Time:		8am	2PM	8pm			

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

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

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

HNH-00016622 IP26-00006874
Mrs RASHMI SAI NIHARIKA
14-02-1999 27 Y 5 M 4 D (F)
Dr. SUDHA S

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CROSS CONSULTATION FORM

Doctor Name : Dr. Sudha. S Date : 18/7/26 Time : 3pm

Diagnosis : NVD

Hospital : RCH - HMNP

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

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

Signature:

Findings and Recommendations :

Lactation care plan

- well formed Breast & Nipple's
- Sucking observed
- Aim for deep latch as demonstrated in cradle hold
- Demand feeds not exceed 2½ hours as per early hunger cues
- warm care
- Explained latching & position detailly.
- Advice DBF & f/b Burping.

Consultant :

Name : Sathwika.G Signature : Date & Time : 18/7/26 ; 3pm

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 18/7/26 Time: 9:40 am

Origin: Indian Height: 165cm Weight: 75 Kg BMI: ☐ ~ 26 kg/m² ☐ ~ 28 kg/m² ☐ ~ 30 kg/m² 27 Kg/m²

Food Allergies: Cucumber

Diagnosis: NVD

Type of Diet: ☐ Liquid ☐ Soft ☑ Normal ☐ Diabetic
☑ Vegetarian ☐ Non-Vegetarian ☐ Vegan

Diet Advised:

Liquid Diet – ORS/ Coconut Water / Butter Milk / Barley Water / Soups

Normal Diet – Rice, Rotis, Dal and Soft Cooked Vegetables and Curd

Soft Diet – Soft Rice, Dal and Vegetable Curries Soft Cooked, Curd

Diabetic Diet – Brown Rice / Oats/ Dahlia/ Rotis, Dal and Vegetables and Curd (Avoid Roots / Tubers)

Patient's / Attendant's
Signature: T. Sahasra

Name: Rashmi Sai Niharika

Date & Time: 18/7/26 ; 9:40am

Dietician's
Signature: Sobiya

Name: Syeda Sobiya Zaheer

Date & Time: 18/7/26 ; 9:40am

PARTOGRAPH

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LABOUR

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

Indications for IOL-Accel: ☐ None ☑ Oxytocin

Memb. Repture Type: ☑ SROM ☐ PROM ☐ ARM

Presentation: ☑ Vertex ☐ Breech ☐ Others

INTRA PARTUM COMPLICATION

Maternal: ☑ Nome ☐ Pyrexia ☐ HTN ☐ Others

Liquor: ☑ Adequate ☐ Oligo ☐ Poly ☐ Clear

☐ Blood ☐ Meconium ☐ Cord: .....

Shoulder Dystocia: ☐ Yes ☑ No

DELIVERY DETAILS

Anesthesia: ☑ None ☐ Epidural

Non-epi: ☑ Local ☐ Spinal ☐ General

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

AVD: ☐ Outlet ☐ Low Forceps ☐ Ventouse
☐ Trails of Forceps (Kiwi)

Indications: Maternal Exhaustion

Application, Locking & Traction: .....

Duration of Instrumentation: .....

No. of Pulls: 2

Catherised : ☐ Yes ☐ No

Type: ☐ Fileys ☐ Plain

Perineum : ☐ Intact ☑ Episiotomy ☐ Tear

Suture Material Used: Rapid vicryl 2-0

STAGE III

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

PPH : ☐ Atomic ☐ Traumatic ☑ None

Lacerations: Nil

Cervical: healthy / intact

Perineal: Episiotomy - Repaired c vicryl

Others: .....

Prophylaxis: Synocinon Prostodin

Blood Loss: ~ 100 cc - 150 cc

Blood Transfusion: NA

Other Details (if any): NAD

Ractal Examination: NAD

Mops / Bundu / Instruments count correct

DURATION OF LABOUR

1st Stage: ~2-3 hrs

2nd Stage: ~ 45 mins

3rd Stage: 5 mins

Duration of Active Pushing: 10 mins

No. of VE'S: 3

BABY DETAILS

Gender: Male

Weight: 2.900 kg

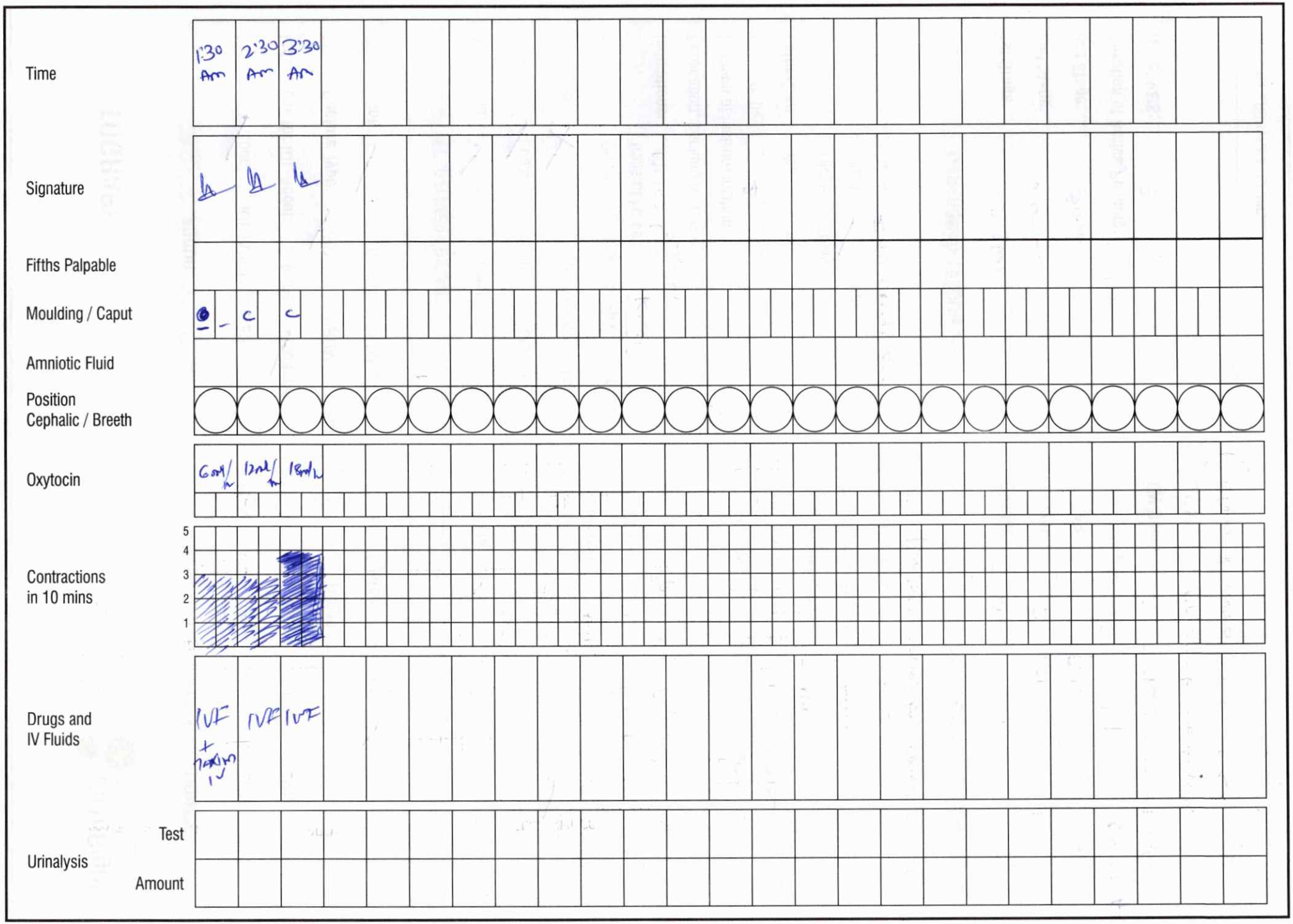
APGAR: 8, 9

Date and Time of Delivery: 18/7/2020 | 03:24 AM

LW Doctor: Dr Sudhas / Dr Manisha

LW Sister: Anuska K / Sr Monika

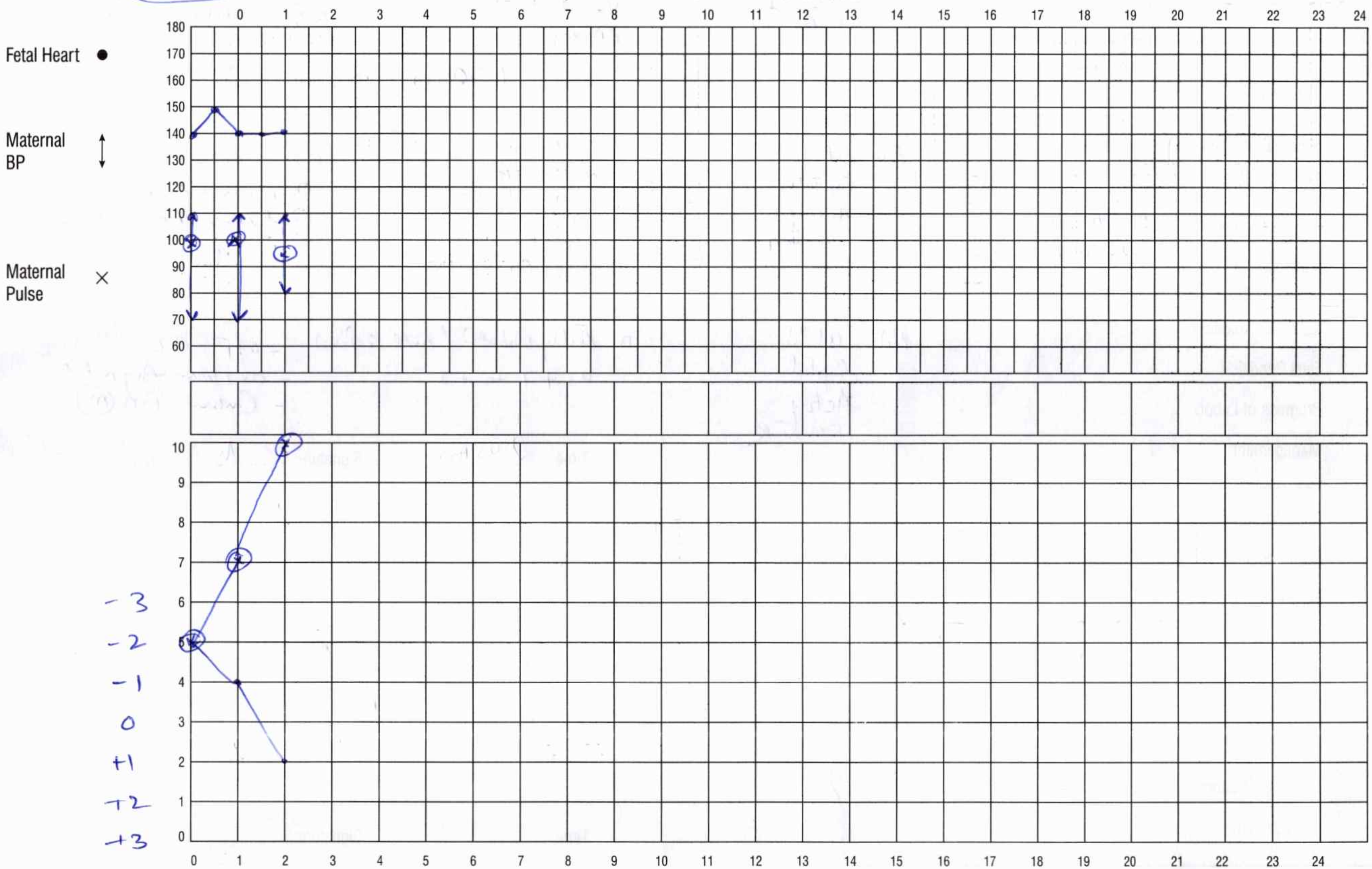
(1 loop of cord around neck)


Time
1:30 Am
2:30 Am
3:30 Am
Signature
Fifths Palpable
Moulding / Caput
C
C
Amniotic Fluid
Position
Cephalic / Breeth
Oxytocin
Contractions
in 10 mins
5
4
3
2
1
Drugs and
IV Fluids
IVF
IVF
IVF
Urinalysis
Test
Amount

PARTOGRAPH

Name: Mrs Nkhoneker **Obstetrics Formula:** P2002 **Blood Group Type:** O Pos

Memb. Ruptured: ~~SROM~~ (circled) **PROM** **ARM** **Risk Factors:**



Record of Labor:

Maternal Condition: } fair
Fetal Condition:
Progress of Labor: BP 100/70 PR - 98
Management:

P/A ut 75
Cephalic
FHS ER
ut Activity

PV - OS 5-6 cm
60% eff
M About
Vx -2 to -1
P Adeq

Adv - W/F Progress of labour
- Augmentation c Oxytocin
- W/F vitals & FHS
- Continuous CTG monitor

Time: 1:30Am Signature: [illegible]

Maternal Condition: } fair
Fetal Condition:
Progress of Labor: BP 110/70 PR - 100/m
Management:

P/A ut 75
Cephalic
Activity
FHS ER

OS 7-8 cm
~ 70% eff
M. About
Vx -1
P Adq

Adv W/F POL
Oxytocin Augmentation
Continuous FHS Monitoring

Time: 02:30 Am Signature: [illegible]

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

P/A ut 75
Cephalic
Activity
FHS ER

OS Fully Dilated / full Effacement
Vx +1 to +2

- W/F POL
- Oxytocin Augmentation
- Continue FHS (M)

Time: 2:45Am Signature: [illegible]

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

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

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

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

INFORMED CONSENT FOR VAGINAL BIRTH

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Patient Name : Mrs Nikanka UHID No : HNH-0000 16622

Gender: ☐ Male ☑ Female Date : 18/7/2026 Time : 1AM

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr S. Sudha

Consentee :

Signature : Gynaecology

Name : Mrs Nikanka

Date & Time : 18/7/2026 @ 1AM

Patient Attendant :

Signature : T. Sesha Sai Anvesh

Name : T. Sesha Sai Anvesh

Relationship with Patient: Husband

Date & Time : 18/7/2026 @ 1AM

Witness :

Signature : Mr

Name : Mounika

Date & Time : 18/7/26

Doctor (who is taking the consent) :

Signature :

Name : Dr Manisha

Date & Time : 18/7/2026 @ 1AM

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Dr. SUDHA S

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 12.12 Time of Arrival: 1.28 Time Seen by Nurse: 1.35

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

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

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

3) **Vital Signs:** Temperature: 97 Pulse: 82 RR: 14 SpO_2: 99 BP: ..... Weight: .....

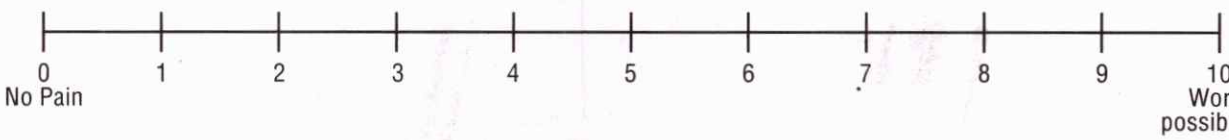
4) **Gestational Criteria:**

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: .....
- 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: 12:50

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

Date: 27/2/16 Time: 12:50

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OBSTETRICS / GYNECOLOGY NURSING INITIAL ASSESSMENT FORM

Date of Admission: 17/2

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: .....PPROM..... 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: .....

.....

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: 98.4 HR: ..... RR: .....

BP: 107/70 Weight: ..... 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 .....

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: Nouica

Date & Time: 14/2