Name	Ms ANANA	**UHID**	HNH-00015533
Father/Guardian	Mr VEDA BASKER	**Age/Gender**	24 Y 7 M 1 D/ Female
Address	Musheerabad Ndso, Hyderabad, Telangana, INDIA, 500020		
IP No	IP26-00006408	**Admission Date**	22-05-2026
Ref Doctor	Self.		
Discharge Date	23.05.2026		

DISCHARGE SUMMARY

Consultant:
Dr. KADIYALA RAMYA THEJA
MBBS/DNB
TSMC/FMR/01458

Diagnosis: PRIMI AT 12^{+6} WEEKS FOR MEDICAL TERMINATION OF PREGNANCY

MEDICAL TERMINATION OF PREGNANCY BY IP MERPC DONE ON 23.05.2026

History:

LMP: 21.02.2026 Obstetric formula: Primi
EDD: 28.11.2026 Gestation at admission: 12^{+6} weeks

Obstetric History:
G1 - Present pregnancy, Spontaneous conception.

Medical History: Nil Surgical History: Nil
Family History: Mother- Hypothyroid Allergies: Nil

Antenatal Details:

Ms Anana was booked to Rainbow hospital at 12^{+5} weeks of gestation. UPT positive on 20.05.2026. Scan done on 21.05.2026 showed SLIUF, 11+6 weeks, Cx 28mm, FHR +, CRL 54.6mm. Ms Anana was Counselled in detail regarding the scan findings and pros and cons of continuation Vs MTP. She wanted to go

Name	Ms ANANA	UHID	HNH-00015533
IP No	IP26-00006408	Admission Date	22-05-2026

ahead with MTP. Explained need for MTP by IPMERPC, risk of bleeding/ infection, chances of D&C. She was admitted at 12 weeks for IP MERPC.

Investigations: Enclosed
Blood Group: "O" Positive

Management: On admission her vitals were stable. Routine blood investigations were sent and traced. Consent taken for medical termination of pregnancy. Antibiotic prophylaxis Inj Taxim 1 gm was given. MERPC done with Mifepristone followed by 1 dose of PGE1. She was closely monitored. She expelled Product of conception at 02:29am of wt 40gm total. IP MERPC continued. USG done on 23.05.2026 showed Endometrium under strict aseptic conditions, the clots were removed under USG guidance. Her general condition was satisfactory and she was found to be fit for discharge. Medications were explained to the patient supplemented by written information.

Advice:

1. Tab Taxim O 200mg (Cefixime 200mg) twice daily after food (9am-9pm) till 28.05.2026
2. Tab Misoprostol 200 mcg thrice daily (6am-2pm-10pm) for 3 days till 26.05.2026
3. Tab Pantop 40mg twice daily before food (7am-7pm) till 28.05.2026.
4. Tab Dolo 650mg SOS (for pain).
5. Tab Zincovit once daily at 2pm after food for 1 month.
6. Tab Softeron gold once daily at 7am for 1 month.
7. RPOC scan on day 4 of next cycle

Report to the emergency in case of heavy bleeding, pain abdomen, fever, giddiness, foul smelling discharge.

Review with Dr. KADIYALA RAMYA THEJA on day 4 of next cycle with RPOC scan report at Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

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

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Name	Ms ANANA	**UHID**	HNH-00015533
IP No	IP26-00006408	**Admission Date**	22-05-2026

Patient/ Attender

In case of emergency like bleeding, pain abdomen, 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

Regular Follow up with :
Dr. KADIYALA RAMYA THEJA
MBBS/DNB
TSMC/FMR/01458

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

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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	2			
3	Nursing Initial assessment	–			
4	Patient Transfer form	–			
5	In-patient Medical record	1			
6	Doctors progress sheets	2			
7	Nursing plan of care and handover sheets	–			
8	Consultation sheet	–			
9	General consent for treatment	1			
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	01			
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	01			
25	Pre operative check list	01			
26	Surgical safety checklist	–			
27	Operation Theatre notes	–			
28	Nurses clinical Presentation	2			
29	TPR & BP chart	2			
30	Intake and Out take chart (fluid chart)	2			
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	–			
		19			
	Total No. of Pages 19				

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

Signature and Date :
23/05/20

(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

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 : IP26-00006408 **Admit Date** : 22-May-2026 **Admit Time** : 09:08 PM **UHID** : HNH-00015533

Patient Details :

Patient Name	: Ms ANANA	**Age**	: 24 Y 7 M 1 D
Guardian	: Mr VEDA BASKER	**DOB**	: 21-10-2001
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Musheerabad Ndso Hyderabad Telangana INDIA 500020	**Phone No**	: 9381583604/ 9100724921
		E-mail	: ananasgi2001@gmail.com

Admission Details :

Bed Type : TWIN SHARING **Bed No** : LDR-416 **Ward Name** : 4F -OT

Room No : LDR-416 **Admission Type** : First Visit

Contact Details :

Name : Mr VEDA BASKER **Relationship** : D/O

Contact Address : Musheerabad Ndso Hyderabad Telangana INDIA 500020 **Phone No** : 9381583604

Signature

Doctor Details :

Doctor Name : Dr. KADIYALA RAMYA THEJA **Specialisation** : OBSTETRICS AND GYNECOLOGY

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

Co-Consultant :

Payment Details :

Deposit Amount : 50000.00

Payment Mode : DC/CC Card **Payor Name** : SELFPAY

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ACTIVITY RECORD FOR BILLING

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

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

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

Date of Ad : ---------- Date of Discharge : ---------- Time: ----------

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse

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
22/5	CBP, TSH, HBA1C, Blood grouping, HCV, HIV, HBSAg	of Basic	

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
22.5	IV Placement	(1)	1510 ✓	
22/5	MERPC		26-00020159	
23/5	RPOC		2626062577	

orders cleared by Dr.

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

Patie

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 22/5/2026 Time of Admission : .....

Allergies: Nil ☑ Not know any drug allergies

PRESENTING COMPLAINTS :

pf washes to go ahead c MTP by IPMEDPC

USG (21/05/2026) SUUF | 11te | Ga 28mm | CRL - 54.6mm

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : Unmarried	Parity : —
Previous Periods : UPT Pos 4 days (21/5/2026)	Mode of Delivery :
LMP : 21/04/2026	Last Child Birth :
Contraception : — M/H - RNF	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
Nil	Nil

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

Mother - thyroid issue

MEDICATION HISTORY:

Nil

INITIAL ASSESSMENT :

Date 22/5/2026
Ht. 160 Wt. 47
BMI 18.36
B.P 113/69 PR - 72
SPO2 98% RA
Pallor (-)
CVR NAD
Respiratory System BAE (R)
Thyroid NAD

Breasts
Soft

Abdominal Examination
At just palpable

Local/Speculum Examination

Bimanual Pelvic Examination

PROVISIONAL DIAGNOSIS : Primi / 12+6 / MTP by IPMSAPC

INVESTIGATIONS ORDERED

BG1 O+ve (orally confirmed)
HIV
HBsAg
HCV

CBP
Hb 10.1
Plt 293
WBC 7.51

TSH
HbA1c

PLAN OF MANAGEMENT

- Admission
- Pads prepare
- Informed Consent
- W/F vitals
- Collect Blood reports
- Drips as charted
- Inform SOS

Name of the Doctor : Dr Manisha
Signature of Doctor
Date & Time : 22/5/2026 @ 21:00 pm

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

(1)

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/05/2026 2:29 am	C/s/b Dr Manisha	
		Adv
	GC Fair Afebrile	- Easy Breakfast F/b NBM
	BP - 112/70	- RPOC scan of today morning
	PR - 80	- Drugs as charted
	P/A Soft	- W/f vitals & BM
		- Inform SOS
	Pt expelled Product of conception (in toto) @ 2:29 Am @ 23/5/2026 wt - 40gm (POC)	
		My Dr Manisha
	PV - Bleeding WNL	
23/5/2026 8 Am	C/s/b Dr Manisha.	
	GC - Fair Afebrile	Adv
	Vitals stable	- NBM
	P/A Soft	- Drugs as charted
	LE NAD	RPOC Scan today
	(minimal BPV +)	- W/f vitals & BM
[illegible]		- Inform SOS
		My Dr Manisha

HNH-00015533 IP26-00006408
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21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/5/26 10:30 AM	C	
	↓SAP, Perineum cleaned ⊼ betadine Vaginal retracted. ⊼ Kusco speculum. ovum forceps introduced into the os & products of conception evacuated. Hemostasis achieved. Pt is haemodynamically stable.	
	GC Fair	
	Vitals - (N)	Rx
	P/A soft	- Regular diet
		- Drugs as charted
		- Adequate hydration
Pt can be discharged		
	Noted by	Advised

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

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

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RESULT SHEET

OP

Date	22/5					
Time	21.07					
Hb	10.1					
PCV	28.7					
RBC	4.06					
WBC	7.51					
N/L	71.8/22.9					
Platelets	293					
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 HCV } NR						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
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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: ..... 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						☐ C ☐ DC
2						☐ 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 Manoj .....

Date & Time : ..... 24/5/2026 @ 9 pm .....

Nurse Name & Signature: ..... Madhumita @ Madhu .....

Date & Time : ..... 24/5/26 @ 9 pm .....

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

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DRUG CHART

Date of Admission: 22/5/2026 Drug Allergies: Nil ☐ ~~Not~~ known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

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

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

SOS / PRN (As Required Medication)

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

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

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

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

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

REGULAR PRESCRIPTIONS

Weight. 48 Ward. UDK

DRUG : INJ CEFOTAXIME				Date ▸ Time ▾	22/5	23/5
Dose	Route	Frequency	Start Date	10 AM	X	Akhila
1g	IV	BD	22/05	10 PM	Madhu	
Name & Signature of the Doctor Starting the Drugs: Dr. Bhavanisha						
Additional Instructions:						
Daily Doctor's Endorsement by a Sign						

DRUG :				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

DRUG :				Date ▸ Time ▾
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

Weight. 44 Ward. LDR

	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
22/5	10:45pm	T MISOPROSTOL	600mcg	PV	½	Madhu
23/5	2:45Am	T MISOPROSTOL	400mcg	PO	½	Madhu
23/5	3 Am	INJ ONDANSETRON	8mg	IV	1	Madhu
23/5	7:45Am	T MISOPROSTOL	400mcg	PO	½	Chandu Madhu.
23/5	11:30Am	T. MISOPROSTOL	400 mcg	PO	½	

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

HNH-00015533
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

I.V. FLUIDS CHART

Weight. 47 Ward. ICU

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
23/5	5AM	RINGER LACTATE	IV 1000ml	100ml/h			23/5/26		
23/5/26	9:30AM	RINGER LACTATE	IV 1000ml	100ml/h			23/5/26		
		STOP							
		Dr. Naveen							

Page: 4/4

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

HNH-00015533
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA
IP26-00006408

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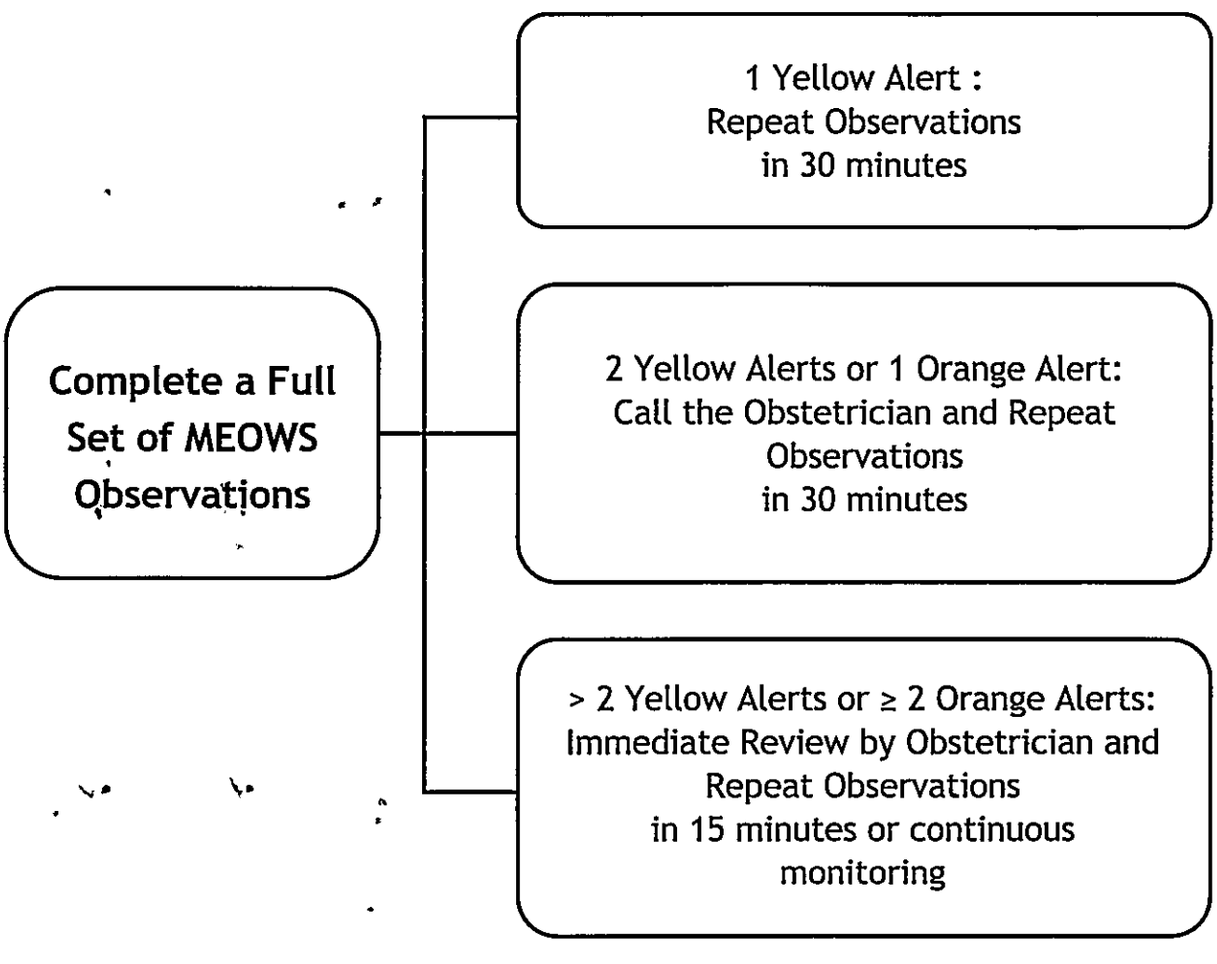
Early Warning Observation Score Chart - Obstetrics

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

		Date																								
22/5/26		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
	0 - 10																									
Saturations	94 - 100 %														100%			99%			100	99%				99%
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36														36			36				36				36
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80														86			84			86	86				88
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120																				100	110				100
	110														113			106								
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70														63			71			73	70				71
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert														–			–			–					
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30														–			–			–					
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal														–											
	Heavy / Foul																									
Liquor	Clear / Pink														–											
	Green																									
TOTAL YELLOW SCORES															0			0			0	0				0
TOTAL ORANGE SCORES															0			0			0	0				0
Nurse Initial																										

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00015533
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA
IP26-00006408

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Early Warning Observation Score Chart - Obstetrics

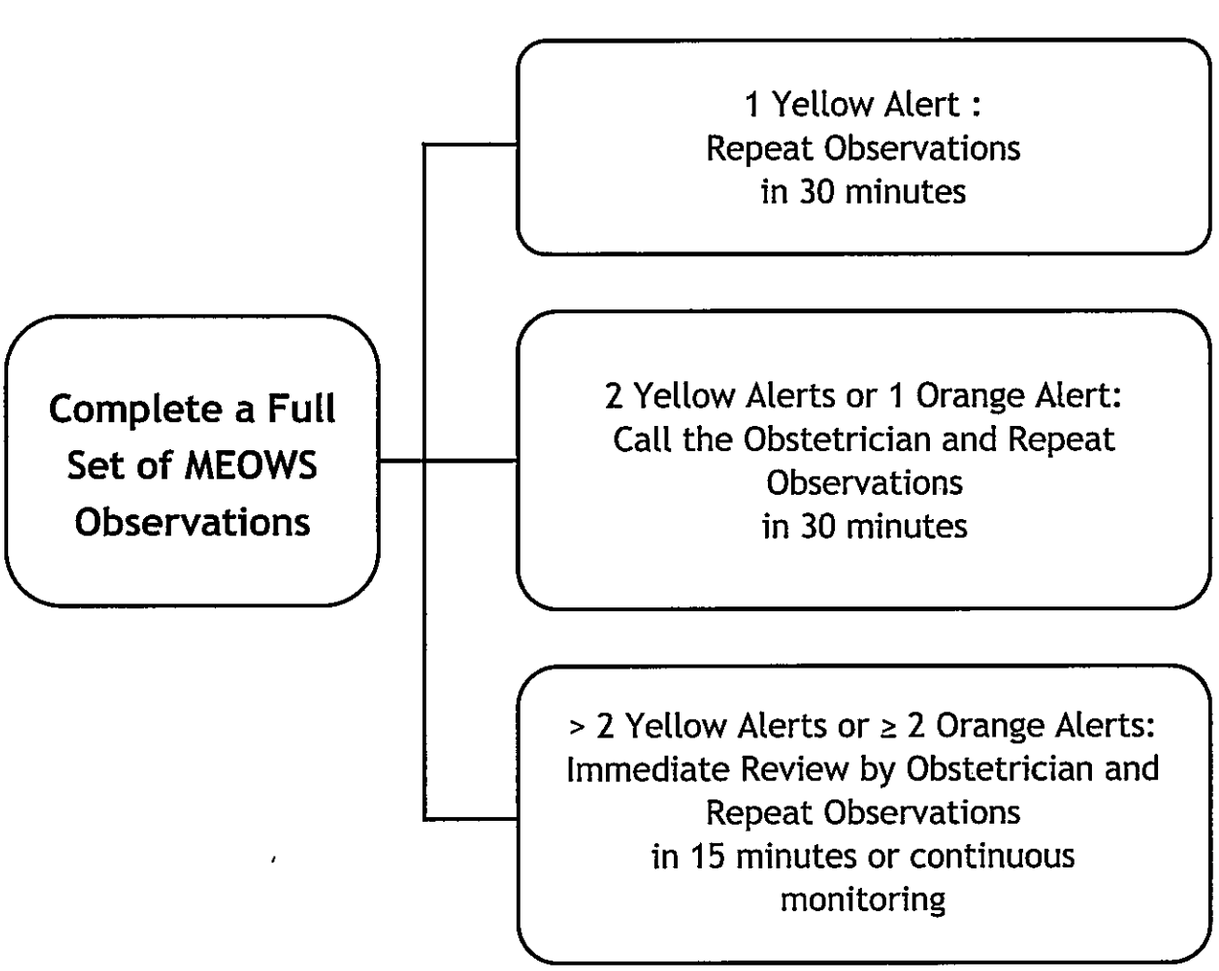
CONTACT DOCTOR FOR EARLY INTERVENTION IF PATIENT TRIGGERS ONE ORANGE OR TWO YELLOW SCORES AT ANY ONE TIME

23/5/26.

		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	18		16																						
	0 - 10																									
Saturations	94 - 100 %																									
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36	36.5°C		35°C																						
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80	80																								
	70				68 bpm																					
	60																									
	50																									
	40																									
Systolic Blood Pressure ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120	120		110																						
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70	70		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		2		2																						
TOTAL ORANGE SCORES		0		0																						
Nurse Initial																										

- Pt DLS

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00015533 IP26-00006408
Ms ANANA
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FLUID CHART

Sheet No. : 1

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
	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 :**				
22/5/26	08:00 pm									✓	1	
	09:00 pm											
	10:00 pm		H2O									
	11:00 pm		NIL		RTA					✓	0	
	12:00 am											
	01:00 am		H2O								1	
Total Intake :								**Total Output :**		Passed		
23/5/26	02:00 am		H2O									
	03:00 am		H2O							✓	1	
	04:00 am											
	05:00 am	RL	M	100ml							0	
	06:00 am	RL	B	100ml						✓		
	07:00 am	RL	M	100ml							1	
Total Intake :		Taken						**Total Output :**		Passed		

Total 24 hrs. Intake		Total 24 hrs. Output	

Patient Sticker

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Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
23/5/26	08:00 am	RL		100ml					1			
	09:00 am	RL	10	100ml					0			Alert
	10:00 am	RL	30ml	100ml					1			
	11:00 am	RL	30ml	100ml					1			
	12:00 pm		30ml									
	01:00 pm		30ml									
Total Intake : Taken								**Total Output :** Passed				
23/5/26	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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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 22/5/26

Baseline Information:

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

Primary Language: ☑ Telugu ☐ English ☐ Hindi ☐ Others

Do you require an interpreter? ☐ Yes ☐ No

Source of Information: ☐ Patient ☑ Family ☐ Others

Personal belonging if any: ☐ Jewelry ☐ Nose Ring ☐ Bangles ☐ Anklets ☐ Finger Ring ☐ Bracelets

handed over to .....

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

If yes , identify .....

Chief Complaints: ..... patient with MTP

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr manisha

Time Notified: .....

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

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

Blood Group: ..... LMP: ..... EDD: ..... Gestational age during admission: .....

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

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

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

Temp: 97°F HR: 80 RR: 20 BP: 113/77 SpO_2 100

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

☐ Hypothyroidism	☐ Rh Incompatibility	☐ Fertility Treatment
☐ Hyperthyroidism	☐ Previous LSCS	☐ Preterm Labour
☐ Hypertension	☐ Gestational Hypertension	☐ Others: (Specify)
☐ Diabetes	☐ Bad Obstetric History	
☐ Anemia	☐ Obesity (BMI)	
	☐ Twins / Multiple Pregnancy	

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Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

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

Fall Assessment: ☐ Yes ☐ No Score ..... (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:

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

☐ Under Weight ☐ Diabetes Mellitus ☑ No Abnormality Detected

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

1. Marital Status: ☐ Single ☑ Married ☐ Divorced ☐ Widow

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

Social History: Lives With .....

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: .....

Orientation not given Reason: ..... self .....

Nurse Signature: .....

Nurse Name: ..... Chenchu kala .....

Date & Time: ..... 22/5/26 @ 9pm .....

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	22/5/26	23/5/26	
		Score	Nil	8 AM	
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	
IV / Heparin Lock or Saline	Yes	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	0		
Total Morse Fall Scale Score:			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

22/5/26 23/5/26

S. No.	SITE OBSERVATION	STAGE / ACTION	SCORE	DAY-1			DAY-2			DAY-3			Remarks
				M	E	N	M	E	N	M	E	N	
1	IV site appears healthy	No signs of phlebitis / Observe cannula	0			0	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	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	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	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	NA						
		Signature of the Nurse											

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

Docu. No. : RCH /FRM / CLINICAL / 137

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
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BRADEN 'Q' SCALE

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				Date :	22/5	23/5		
				Time :	NT	8am		
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		
"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		
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		
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		
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		
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		
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		
				TOTAL SCORE	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

Patient ID

BRADEN 'Q' SCALE

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				Date : / Time :				
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.				
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				TOTAL SCORE				
				Evaluator's Name				

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PAIN ASSESSMENT FORM

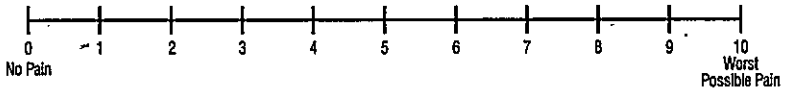
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
28/5/26	8pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
22/5	11Am	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
23/5	2Am	abdomen pain [illegible]	abdomen pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	[illegible] [illegible]	
23/5	8Am	abdomen [illegible] pain	abdomen pain	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	[illegible]	
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis: MTP			Any Infection: ☐ Yes ☐ No ☐ Not Known ✓ If Yes Specify:			
	Surgery / Procedure:			Post OP Day:			
BACKGROUND	Date / Shift	22/5 N	23/5/26 8AM-2PM				
	Medical Condition (Any special condition to be noted):	—					
	Diet:	—					
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No ✓	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):	—	RA				
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No ✓	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:	AF					
	Res:	20					
	SpO_2:	86					
	Pulse:	86					
	BP:	113/72					
	LOC:						
	Fall Risk Score:	—					
	Pain Score:	—					
	Skin Integrity	—					
Recommendations	Safety Needs:	☑ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:	—					
	Others Specify:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:	soft					
	Critical Lab Test / Values:	—					
	Other Special Orders / Medications:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):	—	ND				
Post Operative Procedure Special Orders:		—	—				
Handed Over By Name :		Chaithu	Aleefa				
Signature / ID :		[signature]	Ali				
Date:		23/5/26	23/5/26				
Time:		8:10am					
Taken Over By Name :		Aleefa	PRDLS				
Signature / ID :		Ali					
Date:		23/5/26					
Time:		8:15 AM					

Patient Sticker

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NURSING SHIFT HAND OVER FORM

SITUATION	Diagnosis:				Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:		
	Surgery / Procedure:				Post OP Day:		
BACKGROUND	Date / Shift						
	Medical Condition (Any special condition to be noted):						
	Diet:						
ASSESSMENT	Allergy:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Ventilation (RA, NP, NIV, VENTI):						
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs: Temp:						
	Res:						
	SpO_2:						
	Pulse:						
	BP:						
	LOC:						
	Fall Risk Score:						
	Pain Score:						
	Skin Integrity						
Recommendations	Safety Needs:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Physiotherapy:						
	Others Specify:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Special Diet:						
	Critical Lab Test / Values:						
	Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	PU Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	DVT Prophylaxis:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	ADL (Dependent / Non Dependent):						
Post Operative Procedure Special Orders:							
Handed Over By Name :							
Signature / ID :							
Date:							
Time:							
Taken Over By Name :							
Signature / ID :							
Date:							
Time:							

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
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NURSING CARE RECORD

Date: 22/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning							
Afternoon				NVR			
Night	8pm TO 8Am	-> Assess the patient's condition -> plan for vitals -> plan for Hochart	8pm TO 8Am	-> Assessed the patient condition -> maintain vitals & Recived -> maintain Hochart	patient is stable	vitals is received	Cluedp

HNH-00015533 IP26-00006408
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21-10-2001 24 Y 7 M 1 D (F)
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NURSING CARE RECORD

Rainbow® Children's Hospital
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Date: 23/5/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8am	- Assess the Patient condition - plan for vital R recored - plan for RPOC slan	8am	- Assesst the pt condition - Maintain M+F - RPOC slan done - Maintain Fodder	- Patient stable	- M+F Normal	
	2pm		2pm				
Afternoon							
Night							

Rainbow Childrens Hospital-Himayatnagar
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TEL NO :040-48873000
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Ms ANANA**	**Age :**	**24 Y 7 M 1 D**
IP No:	**IP26-00006408**	**Sex:**	**Female**
Consultant:	**Dr. KADIYALA RAMYA THEJA**	**Ward/Bed No:**	**4F -OT/LDR-416**

The undersigned patient and I or responsible relative or person hereby consent to and authorize Rainbow Hospitals doctors and medical personnel to perform medical examinations, conduct routine investigations and administer medical treatments, outpatient procedures, minor dressings, vaccinations and immunizations during the course of the patient's care, as in patient.

Patient, be deemed advisable or necessary.

I understand that the confidentiality of all medical records shall be protected to the full extent of the Law. The undersigned also consent to the use of health related information/ audiovisuals of the patient for research & training purpose or for insurance coverage and while doing so confidentiality of the patient will be maintained at all times and this will not affect the care of the patient.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examinations, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by treating doctors. I also understand that the practice of medicine is not an exact science and that no guarantee have been made to me as the results of my evaluation and I or treatment.

I understand that I shall not bring valuables to the Hospitals and that the Hospital will not be responsible for the loss, destruction or theft of my personal belongings. I assume full responsibility for all my personal items and release the Hospital from responsibility and liability for such personal items and valuables.

"I am aware that during the patient care it is inevitable that certain re-useable equipment shall be re-used after sterilization and disinfection. I am informed that the hospital assures maximum level of precaution and care in sterilizing and disinfecting the equipment and monitors the whole process as per evidence based guidelines".

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....)

3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:

Name:
Relationship:
Date: 22/05/2026 Time: 9:08.
Witness Name: Yaseen ali Khan
Witness Signature:

Patient Address:
Musheerabad Ndso Hyderabad
Telangana INDIA 500020

CONSENT FORM FOR MEDICAL TERMINATION OF PREGNANCY

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Patient Name : Ms Anona ..... Age : 24y.....

UHID No : TNH-00015533 ..... Date : 22/5/2024

I, the undersigned, Mrs. / Miss : Anona. (Partner) W/o, D/o, C/o Sai krishna.

aged 24y. years and residing at Nagarkurnool Mahabubnagar. request to terminate my pregnancy.
15-142, Teachers colony

Reason for Undergoing Medical Term of Pregnancy : (Tick whichever applicable)

- ☐ The continuance of the pregnancy would involve a risk to my life due to serious medical disease.
- ☐ In order to prevent injury to my physical or mental health.
- ☐ The continuance of the pregnancy has a substantial risk of the newborn being born with serious physical / mental handicap.
- ☐ This pregnancy has resulted from me being raped.
- ☐ This pregnancy has occurred as a result of failure of contraceptive techniques -Intrauterine Device/ Oral Pills/ Condoms/ Coitus Interruptus/ periodic abstinence/ tubectomy/ vasectomy.
- ☐ In order to prevent a risk of injury to my physical or mental health by reason of my actual/ reasonably foreseeable environment.

I have been explained in the language known and understood by me about all the options available, counseled about the procedure, its risks, and costs & care to be taken after the procedure. Thus, I give my full valid consent as an act of my own free will to undergo the above-mentioned procedure to terminate my pregnancy.

I have been explained also the risks, benefits and alternatives of the procedure.

The future consequence of infertility has been explained to me in view of the voluntary termination of pregnancy and I am willing to accept the risk.

I also indemnify the Doctor and Rainbow Hospitals& its staff of any liability arising because of undergoing the above-mentioned procedure.

Name of the Doctor performing the procedure : Dr Ramya Theja K

Patient :

Signature : .....

Name : Ms Anona.

Date & Time : 22/05/2024 @ 9:45pm

Patient Attendant / Guardian :

Signature : .....

Name : Sai Krishna Reddy

Relationship with Patient: Boyfriend

Date & Time : 22/05/2024 @ 09:45pm

Doctor (who is taking the consent) :

Signature : .....

Name : Dr Mamatha

Date & Time : 22/05/2024 @ 09:45pm

Witness :

Signature : .....

Name : .....

Date & Time : .....

*Guardian consent & signature needed in case of patient being less than 18 years or mentally unstable.

HNH-00015533 IP26-00006408
Ms ANANA
21-10-2001 24 Y 7 M 1 D (F)
Dr. KADIYALA RAMYA THEJA

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BILLING POLICY

- Billing cycle: - With effective from 1st January 2020, Our billing cycle to be start from 12 PM to 12 PM, Settlement post 12 PM, room rent will be charge for half day extra & post 6 pm, it will be charge for full day. Less than 24 hours stay will be considered as one day.
- As per the GOI guidelines, we can collect Rs 1,99,999/- only in cash mode, balance patient can pay through Card tpaln the event of TPA/ Cashless denial or approval not received due to any reason then hospital tariff will be applicable and any discount or special rates given to TPA's / corporates won't be applicable.
- If the surgery / scans performed in Emergency hours (8pm - 7am), public holiday and on Sunday will be charged TPA processing charges Rs.720 for every TPA route cases.
- All charges vary as per Room category, except Pharmacy and consumables.
- We follows a "No Discounts Policy" kindly cooperate.
- No Duplicate/Second copy of OP OR IP bill is issued.
- ICU/Ward Charges DO NOT INCLUDE - Air Mattress, Monitor, Consultants/ Specialty Doctors Visit, Infusion/syringe pump, Ventilator/C pap, Oxygen, Investigations, Procedures, Consumables, Medicines or any other bedside equipment's/devices etc. (Detailed list can be taken from billing department).

Patient attendant can collect for Interim/provisional bill of the patient from the billing section on daily basis. Interim Bill shall be based on the acknowledged services in HIS. Final Bill of the patient may vary from the Interim bill based on actual update taken on the day of discharge. It is requested that patients/attendants inquire daily about the bill amount from billing section and pay the outstanding as on that day.

Patient bill outstanding should not be increase more than 10,000/-

You are requested to clear your outstanding amount on daily basis before 12 PM.

MODE OF PAYMENT & REFUNDS

- We accept payments by cash (up to Rs 1,99,999/- only), cards, online transfer and Demand Drafts.
- All refund more than Rs.2,000/- will be refund through NEFT in three Bank working days.

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

NOTE: Self - attested Govt. ID proof is mandatory whosoever is signing the undertaking.

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.
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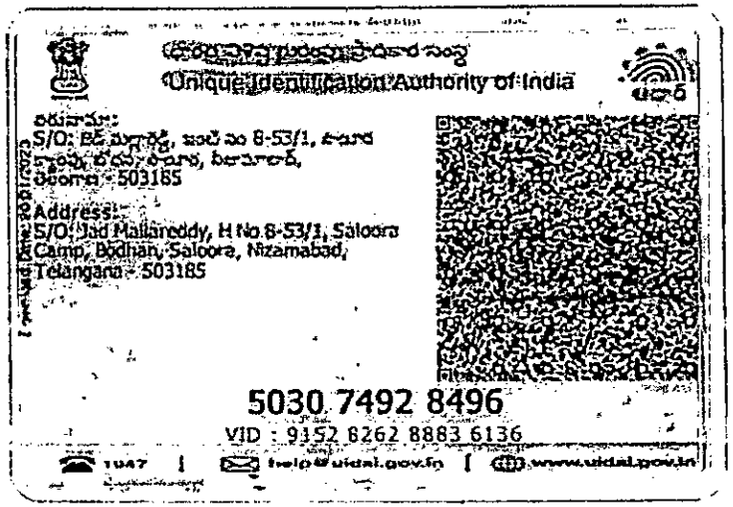
PO:Nagarkurnool, DIST:Mahabubnagar,
Telangana, 509209
5850 3232 1842
help@uidai.gov.in
www.uidai.gov.in


Government of India
P.V.Anana Sri
DOB: 21/01/2001
Female
Aadhaar is proof of identity, not of citizenship or date of birth. It should be used with verification (online authentication or scanning of QR code / offline XML).
5850 3232 1842
मेरा आधार, मेरी पहचान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Address:
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Telangana - 503185
5030 7492 8496
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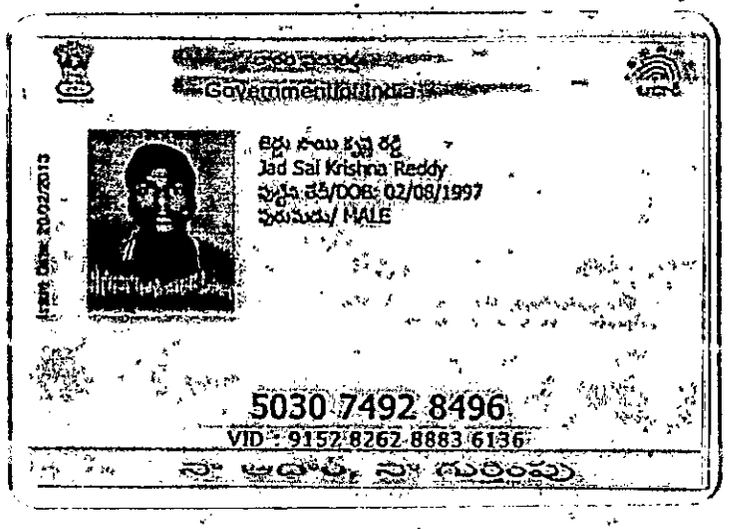
Government of India
Jad Sai Krishna Reddy
DOB: 02/08/1997
MALE
5030 7492 8496
VID : 9152 8262 8883 6136