Rainbow® Children's Hospital
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BirthRight™ BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

Name	Mrs B SANDHYA	**UHID**	HNH-00016358
Father/Guardian	Mr RAHUL	**Age/Gender**	31 Y 3 M 12 D/ Female
Address	Himayathnagar, Hyderabad, Telangana, INDIA, 500029		
IP No	IP26-00006766	**Admission Date**	06-07-2026
Ref Doctor	Self.		
Discharge Date	07.07.2026		

DISCHARGE SUMMARY

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

Diagnosis: PRIMI AT 10^{+6} WEEKS CAME FOR MEDICAL TERMINATION OF PREGNANCY .

MEDICAL TERMINATION OF PREGNANCY BY MERPC DONE ON 07.07.2026

History:
LMP: 22.04.2026
EDD: 26.01.2027

Obstetric formula: PRIMI
Gestation at admission: 10^{+6} weeks

Obstetric History:
G1 - Present pregnancy, Spontaneous conception.

Medical History: Nil

Name	Mrs B SANDHYA	**UHID**	HNH-00016358
IP No	IP26-00006766	**Admission Date**	06-07-2026

Family History: Nil
Surgical History: Nil
Allergies: Nil

Antenatal Details:

Mrs B SANDHYA was booked to Rainbow hospital at 10^{+4} weeks of gestation. Previous ANC's elsewhere. She had regular antenatal checkups and investigations as advised. History of Urinary tract infection 1 week back . Viability Scan (outside)on 02.07.2026 at 10+2 weeks showed Single live intrauterine gestation ,CRL-10 CMS , simple left ovarian cyst measuring 4.6 *4.7 CMS . Couple not keen on continuation of pregnancy and wishes to go ahead with MTP. Couple was explained in detail regarding pros and cons of continuation Vs MTP with rare possibility of SERPC/ infection/ haemorrhage/ need for blood or blood products transfusion. Informed Consent taken. She took Tab. Mifepristone 400mg on 04.07.2026. She was admitted at 10^{+6} weeks for MTP by MERPC. .

Investigations: Enclosed
Blood Group: "B" Positive

Management:

On admission her vitals were stable. MERPC done with 3 doses of PGE1. She was closely monitored. She expelled products of conception (Fetus and placenta in toto). RPOC scan (07.07.2026) done , showed no evidence of rpoc,ET-15.7 mm. She was found to be hemodynamically stable and fit for discharge.

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Name	Mrs B SANDHYA	**UHID**	HNH-00016358
IP No	IP26-00006766	**Admission Date**	06-07-2026

Advice:

1. Tab. Misoprostol 200 mcg twice daily till 10.07.2026.
2. Tab. Taxim 200 mg twice daily (9am-9 pm) till 12.07.2026
3. Tab. Softeron Gold, 1 tablet, once daily for 1 month.
4. Cap. Suport , 1 tablet , once daily for 1 month.
5. USG Pelvis after next cycle

Review with **Dr. SWATHI H V,** after **2** weeks on **21.07.2026** at Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

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

Patient/ Attender

In case of emergency like bleeding, fever kindly contact 9154865045. You can also take appointments at any time by going online to our website **www.rainbowhospital.in**

Registrar/Resident/C.M.O

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

HNH-00016358 IP26-00006766
Mrs B SANDHYA
25-03-1995 31 Y 3 M 12 D (F)
Dr. SWATHI H V

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet	3			
2	Discharge Summary	3			
3	Nursing Initial assessment	1			
4	Patient Transfer form	—			
5	In-patient Medical record	.			
6	Doctors progress sheets	2			
7	Nursing plan of care and handover sheets	.			
8	Consultation sheet				
9	General consent for treatment				
10	Consent for Surgery				
11	Consent for blood transfusion				
12	Consent for chemotherapy				
13	Consent for high risk				
14	Consent for Restraint				
15	LAMA consent				
16	Consent for special procedure / Sedation				
17	Consent for Formula feed				
18	Consent for MTP				
19	Consent for Radiological Investigations				
20	Consent for HIV test				
21	Anaestesia notes (Pre Anaesthesia& post)				
22	Neonatal Admission/Delivery/Physical Exam				
23	Medication Reconciliation				
24	Emergency Triage record				
25	Pre operative check list				
26	Surgical safety checklist				
27	Operation Theatre notes				
28	Nurses clinical Presentation				
29	TPR & BP chart				
30	Intake and Out take chart (fluid chart)				
31	Drug chart (Regular Prescription)				
32	Investigation Values (result sheet)				
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				
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 sheet	6			
	Total No. of Pages	16			

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

Signature and Date : 7/2/26 (P.T.O)

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

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 : IP26-00006766 **Admit Date** : 06-Jul-2026 **Admit Time** : 08:03 PM **UHID** : HNH-00016358

Patient Details :

Patient Name	: Mrs B SANDHYA	**Age**	: 31 Y 3 M 11 D
Guardian	: Mr RAHUL	**DOB**	: 25-03-1995
Gender	: Female	**Religion**	:
Occupation	:	**Martial Status**	:
Address (H)	: Himayathnagar Hyderabad Telangana INDIA 500029	**Phone No**	: 9703964394
		E-mail	: SANDHYABOYYA112@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PPO-418 **Ward Name** : 4F -OT

Room No : PPO-418 **Admission Type** : First Visit

Contact Details :

Name : Mr RAHUL **Relationship** : W/O

Contact Address : Himayathnagar Hyderabad Telangana INDIA 500029 **Phone No** : 9703964394

Signature

Doctor Details :

Doctor Name : Dr. SWATHI H V **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

CONSENT FORM FOR MEDICAL TERMINATION OF PREGNANCY

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Patient Name : Mrs. Sandhya Age : 31 yrs

UHID No : HNH-OP.016358 Date : 6/7/26

I, the undersigned, ~~Mrs./Miss~~ Mrs. : Sandhya W/o, D/o, C/o Mr. Rahul

aged 31 yrs years and residing at Himayathnagar request to terminate my pregnancy.

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. SWATHI. H.V

Patient :

Signature : [signature]

Name : Mrs Sandhya

Date & Time : 6/7/26 @ 8pm

Patient Attendant / Guardian :

Signature : [signature]

Name : RAHUL

Relationship with Patient: Husband

Date & Time : 6/7/26 @ 8pm

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr RAMYA THOPPA

Date & Time : 6/7/26 @ 8pm

Witness :

Signature : [signature]

Name : Sujatha

Date & Time : 6/7/26 @ 8 PM

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

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ACTIVITY RECORD FOR BILLING

Name :_____ HNH-00016358 IP26-00006766 _____

Mrs B SANDHYA
25-03-1995 31 Y 3 M 11 D (F)
Dr. SWATHI H V

UHID No. : ___ ____Consultant: _____ Dept : _____

Date of Admissi ____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.	Signature
7/7	RPoc Scan	R2626-008/23	

MEDICAL EQUIPMENT (WARD & ICU)

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

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
6/7	IV placement	①	211396	Rui
7/7	MERPC	①	11645	②

ANY OTHER INFORMATION

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.....

.....

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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Mrs B SANDHYA
25-03-1995 31 Y 3 M 11 D (F)
Dr. SWATHI H V

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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 6/7/26 Time of Admission : N/K

Allergies: N/K ☑ Not know any drug allergies

PRESENTING COMPLAINTS :

Primi / 10th wks / came for MTP.

- Unmarried, engaged & sexually active
- No complaints
- Took Mifepristone 400mg on 4/7/26.
- Medically scan on 2/7/26 @ Apollo: SUVF, 10+2 wks

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : - unmarried	Parity : Primi.
Previous Periods : regular	Mode of Delivery :
LMP : 22/4/26	Last Child Birth : ↓ POG : 10+6 wks
Contraception : ~~Nil~~	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
N/K	N/K

HNH-00016358 IP26-00006766
Mrs B SANDHYA
25-03-1995 31 Y 3 M 11 D (F)
Dr. SWATHI H V

Nil

MEDICATION HISTORY:

—

INITIAL ASSESSMENT :

Date 6/7/26 Ht. 162 cm Wt. 57 kg BMI 21.4 [illegible] B.P 110/60 mmHg PR: 86/min Pallor (−) CVR S1 S2 (+) Respiratory System BAE (+) Thyroid (N)	Breasts (N) Abdominal Examination soft	Local/Speculum Examination (−) Bimanual Pelvic Examination (−)

PROVISIONAL DIAGNOSIS : Primi / 10th wks / Came for MTP

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
BGT: B Positive HIV, HBsAg, HCV — NR CBP: (N)	Medical termination of pregnancy by MERPC +/- VERPC - soft diet / oral fluids - drugs as charted - Consent for procedure/MTP - w/f expulsion - Monitor vitals - Inform SOS - T. Miso 800mcg PV f/b 600mcg 3rd hourly until expulsion

Name of the Doctor : Dr Ramya Theja K

Signature of Doctor [signature]

Dr. Kadiyala Ramya Theja
Consultant Obstetrics and Gynecology
Reg. No: 1498

Date & Time : 6/7/26 @ 8pm

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Sandhya. Patient Stic

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
6/7/2026		
8pm	I 'Rahul Paswan' fiancee of Sandhy B. & will be presenting myself as a local gaurdian for her. & will be responsible for all the consequences for the process & will be taken as my responsibility.	
	Rahul B. S[illegible]	
	Mrs Bsandhya	
6/7/26 8:30pm	No complaints Ge fair afebrile vitals (N) PA: soft PV: Cx long, os closed Tab misoprostol 800mcg kept PV	Ramya Dr. Madipalla Ramya Theja Consultant Obstetrics and Gynecology Reg. No: 1458 RAMYA THEJA.K

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25-03-1995 31 Y 3 M 11 D (F)
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

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Patient Stic

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/26. 12:30AM.	C/o severe lower abdominal pain H/o passage of fetus in the washroom O/E pt c/c/c Sc fair/afebrile vitals (N) PA: soft. No tenderness PV: bleeding (N)	Adv 1) Inj TRAMADOL 100mg IM / stat 2) Inj BUPIOPAN 10mg IV / stat Dr Kadiyala Ramya Theja Consultant Obstetrics and Gynecology Reg. No: 1458 DrRAMYA
7/7/26. 6AM.	No complaints Sc fair/afebrile vitals (N) PA: soft, No tenderness PV, bleeding (N). LPOL plan	Adv 1) NBM till RPOC plan 2) IV fluids as advised 3) Monitor vitals 4) drugs as charted 5) W/f excess bleeding PV 6) Inform sos. Dr Kadiyala Ramya Theja Consultant Obstetrics and Gynecology Reg. No: 1458 DrRAMYA THEJA

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Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
7/7/2026	C/S/b Dr Manisha	
9Am		
	C/C - Pain Afebrile	Adv
	Vitals stable	
	P/A soft	- NBM till RPOC Scan
	L/E Bleeding wnl	- IVF as advised
		- monitor vitals
		Drugs as charted
	(Plan: RPOC Scan)	w/f Bleeding PV
		Inform SRs
Pt can be discharged		
		[illegible]

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MEDICATION RECONCILIATION FORM

Drug Allergies: NK ☑ 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 MIFOPRISTONE	400mg	PO	OD	4/2/26 @ ..	☐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 : Ramya DR RAMYA THOTAL

Date & Time : 6/2/26 @ 8pm

Nurse Name & Signature: Dawlia [illegible]

Date & Time : 6/2/26 @ 8pm

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

HNH-00016358 IP26-00006766
Mrs B SANDHYA
25-03-1995 31 Y 3 M 11 D (F)
Dr. SWATHI H V

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DRUG CHART

Date of Admission: 6/7/26 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 / 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-00016358 IP26-00006766
Mrs B SANDHYA
25-03-1995 31 Y 3 M 11 D (F)
Dr. SWATHI H V

REGULAR PRESCRIPTIONS

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

DRUG : Inj CEFOTAXIM

Dose	Route	Frequency	Start Date
1gm	IV	RD	6/7/26

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date/Time	6/7	7/6
	09am	[illegible]
	09pm	09pm [illegible]

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

DRUG :

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date / Time

HNH-00016358 IP26-00006766
Mrs B SANDHYA
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Sheet No: ....

REGULAR PRESCRIPTIONS

Weight .... Ward ....

DRUG :

Dose	Route	Frequency	Start Dt.

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG :

Dose	Route	Frequency	Start Dt.

Date ▸ / Time ▾

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

HNH-00016358 IP26-00008766
Mrs B SANDHYA
25-03-1995 31 Y 3 M 11 D (F)
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REGULAR PRESCRIPTIONS

Sheet No: .... 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

HNH-00016358 IP26-00006766
Mrs B SANDHYA
25-03-1995 31 Y 3 M 11 D (F)
Dr. SWATHI H V

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
6/7	8:30pm	T MISOPROSTOL	800mcg	PV		
6/7/26	11:30pm	Tab MISOPROSTOL	600mg	PO		Sujatha Anusha.K
7/7/26	2:30AM	Tab MISOPROSTOL	600mg	PO		Sujatha Anusha.K
7/7/26	12AM	INJ. TRAMADOL	100mg	IM		Sujatha Anusha.K
7/7/26	12:40AM	INJ. BUSCOPAN	20mg	SLOW IV		Sujatha Anusha.K

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

HNH-00016358 IP26-00006766
Mrs B SANDHYA
25-03-1995 31 Y 3 M 11 D (F)
Dr. SWATHI H V

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
2/2/26	3AM	RINGER LACTATE	IV	100 ml/hr			2/2		

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

HNH-00016358 IP26-00006766
Mrs B SANDHYA
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Dr. SWATHI H V

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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.Bil/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 group	B' positive					

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

HNH-00016358 IP26-00006766
Mrs B SANDHYA
25-03-1995 31 Y 3 M 11 D (F)
Dr. SWATHI H V

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LABOUR AND DELIVERY NURSING ASSESSMENT

Date of Admission: 8/7/2026

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: .....

MTP

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Ramya.

Time Notified: 8:00 PM

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

Past Medical History	Past Surgical History	Previous Hospital Admission
–	–	–

Blood Group: B+ve LMP: 22/4/26 EDD: . Gestational age during admission: .....

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

Obstetric History: G 1 P — L — A — Previous LSCS .....

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

Temp: 98.1°F HR: 86 RR: 20 BP: 102/68 SpO_2 98%

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: ..... Sandhya

Orientation not given Reason: ..... N.A

Nurse Signature: .....

Nurse Name: .....

Date & Time: .....

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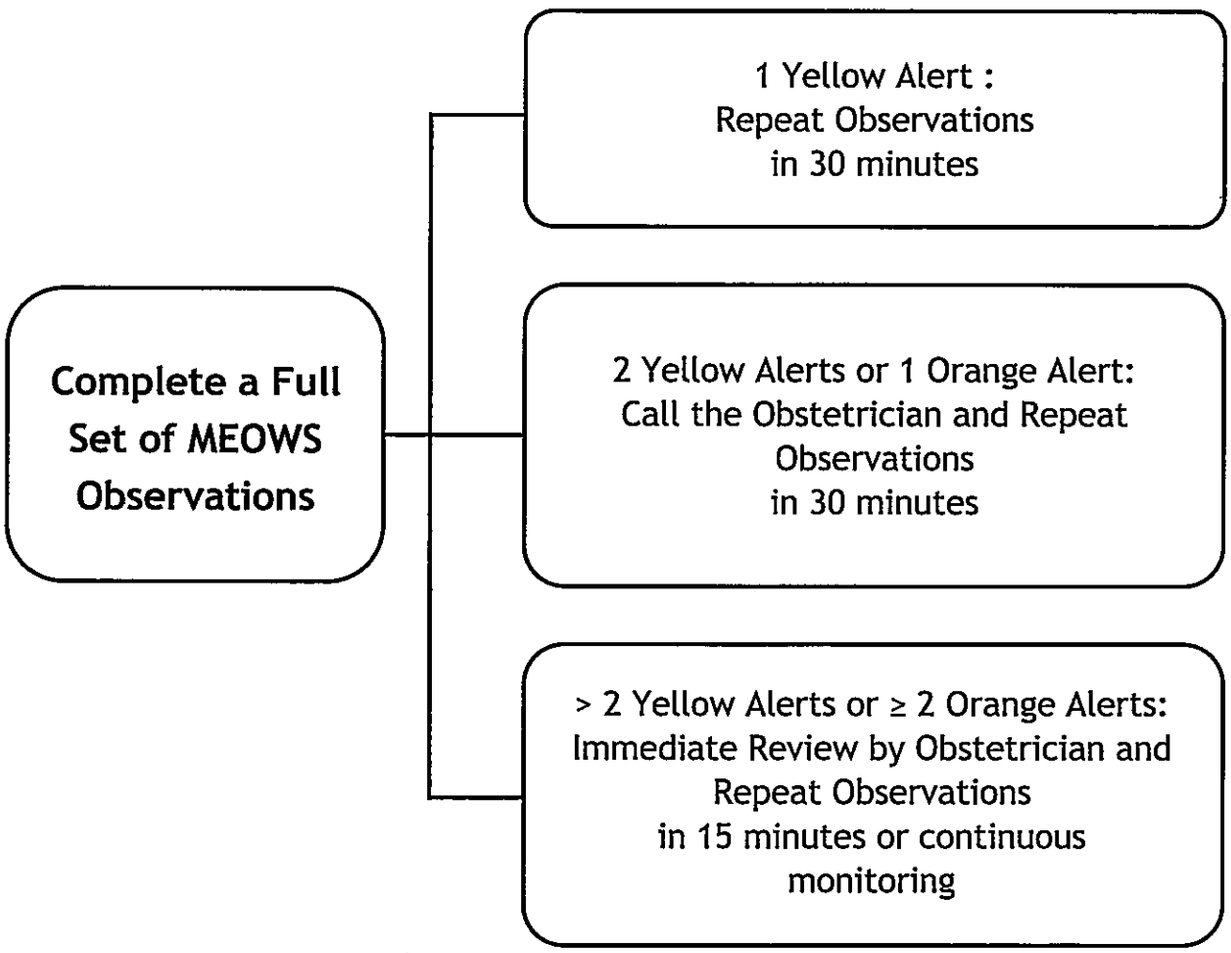
Early Warning Observation Score Chart - Obstetrics

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

6/2/26	Date														7/7/26										
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20														20	20	20	20	20	20	20	20	20	20	20
	0 - 10																								
Saturations	94 - 100 %														99	99	99	99	98	98	99	99	99	99	99
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36														98				98				97	97	
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90														79		75	77	78		80	75		80	85
	80																								
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140														114		118		116		117	119		110	114
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50																								
	40														70		68		65		68	67		65	75
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	0	0		0	0
TOTAL ORANGE SCORES															0	0	0	0	0	0	0	0		0	0
Nurse Initial																									

NA

Obstetrics and Gynaecology Early Warning Signs



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

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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

7/7/26	Date																								
	Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																								
	21 - 30																								
	11 - 20	20		20		20																			
	0 - 10																								
Saturations	94 - 100 %	94		99		99																			
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37																								
	36	36		36		36																			
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80	81		83		84																			
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
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	130																								
	120	116		118		116																			
	110																								
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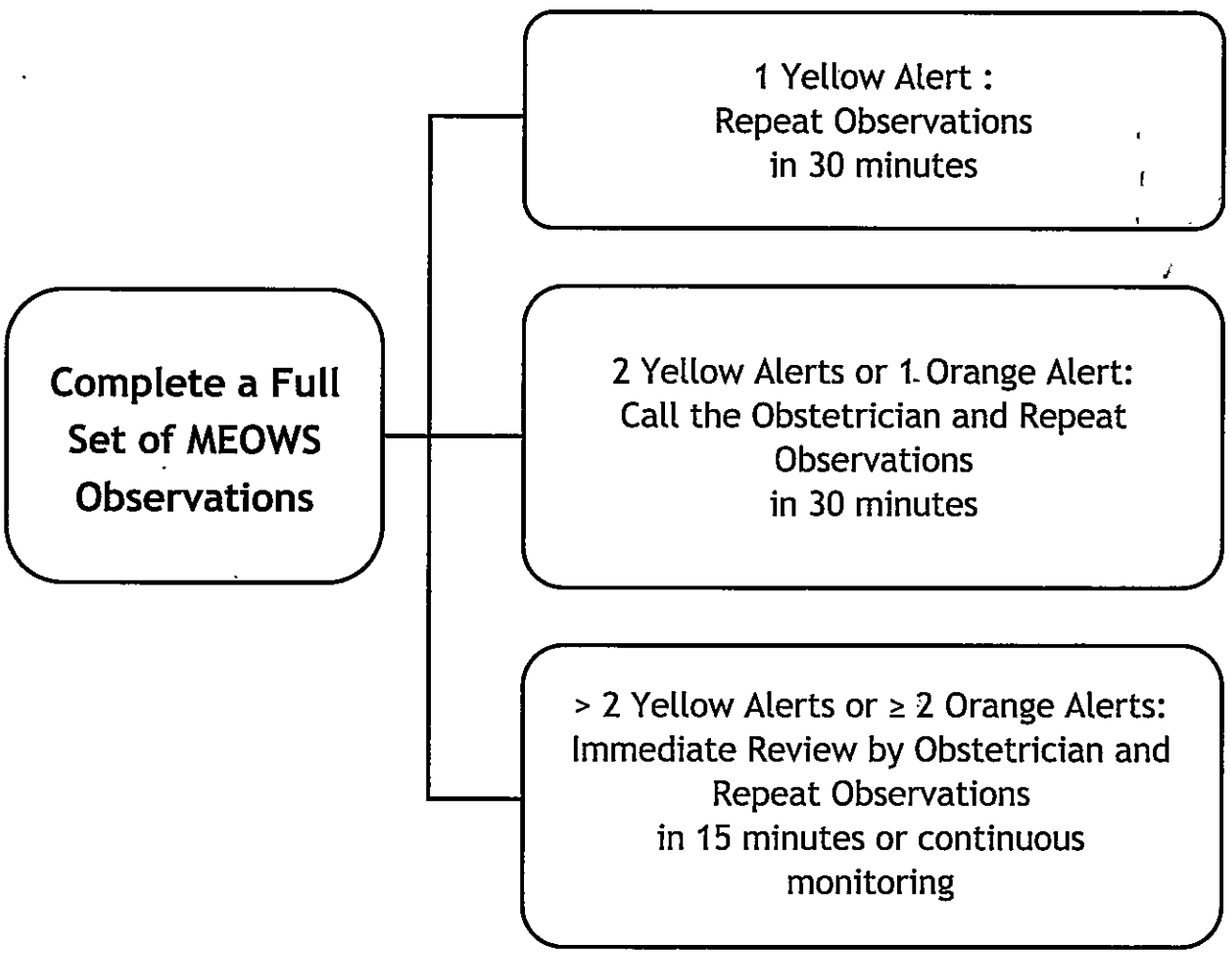
	90																								
	80																								
	70																								
	60																								
	50																								
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70	74		73		74																			
	60																								
	50																								
	40																								
NEURO RESPONSE [✓]	Alert	✓		✓		✓																			
	Voice																								
	Pain																								
	Unresponsive																								
URINE mls / hour	> 30	✓																							
	< 30																								
Proteinuria	Protein + +																								
	Protein > + +																								
Lochia	Normal																								
	Heavy / Foul																								
Liquor	Clear / Pink																								
	Green																								
TOTAL YELLOW SCORES		0		0		0																			
TOTAL ORANGE SCORES		0		0		0																			
Nurse Initial																									

Obstetrics and Gynaecology Early Warning Signs



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

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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.

6/7/26		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		40									
	12:00 am											
	01:00 am											
Total Intake : taken								**Total Output :** passed				
7/7	02:00 am		40									
	03:00 am											
	04:00 am											
	05:00 am		40									
	06:00 am											
	07:00 am											
Total Intake : taken								**Total Output :** passed				

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

7/7/26		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							
7/7	08:00 am	RL	M	100ml							1	
	09:00 am	RL	B	100ml								
	10:00 am	RL	M	100ml							0	
	11:00 am	RL		100ml								
	12:00 pm	RL	Idle	100ml								
	01:00 pm											
Total Intake :						**Total Output :** Passed						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		Total 24 hrs. Output	

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NURSING CARE RECORD

Date: 6/7/2026

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				NA			
Afternoon							
Night	8pm / 8am	→ Assess the pt condition → Check the vital's → I/O chart maintain → W/F P/V Bleeding	8pm	→ Assessed pt condition → Checked vital's & record → Maintained I/O Bleeding scanty. Normal	pt is stable	Vital's is Normal	[illegible]

Docu. No: RCH /FRM / CLINICAL / 148

HNH-00016358 IP26-00006766
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NURSING CARE RECORD

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Date: 7/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM	→ Plan for vitals → Plan for I/O chart. → Plan for medication.	8AM	→ vitals checked & recorded. → Maintain I/O chart. → All medication given	→ vitals is normal	→ PT is stable	Madhu
Afternoon							
Night							

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(F)

Morse Fall Risk Assessment Form

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Choose Highest Applicable Score from each Category		Score	Date / Time	6/8/26	7:17	
			Score	M2	M6	
History of Falling (immediately or w/in 3 months)	Yes	25				
	No	0	0	0		
Secondary Diagnosis (more than one diagnosis)	Yes	15				
	No	0	0	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	0	0		
GAIT / Transferring	Impaired	20				
	Weak (uses touch for balance)	10				
	Normal /On Bed Rest /Immobile	0	0	0		
Mental Status	Forgets limitations	15				
	Oriented to own ability	0	0	0		
Total Morse Fall Scale Score:						
		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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BRADEN 'Q' SCALE

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				Date :	6/2/26	7/2		
				Time :	NJ	PM		
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

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

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.				
"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.				
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.				
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.				
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."				
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.				
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.				
				TOTAL SCORE				
				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

HNH-00016358
Mrs B SANDHYA
25-03-1995
Dr. SWATHI H V
IP26-00006766
31 Y 3 M 11 D
(F)

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PAIN ASSESSMENT FORM

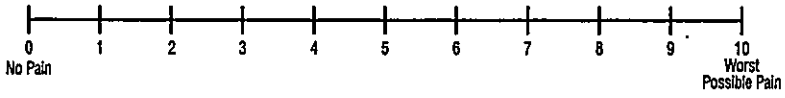
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
6/7/26	9PM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
6/7	10PM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
7/7	2AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
7/7	8AM	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
7/7	11Am	0	—	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
7/7	12Pm	0	—	☐ 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		

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-00016358 IP26-00006766
Mrs B SANDHYA
25-03-1995 31 Y 3 M 11 D (F)
Dr. SWATHI H V

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NURSING SHIFT HAND OVER FORM - WARD

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

SITUATION

Diagnosis: primi 10+6 MTP

Any Infection: ☐ Yes ☐ No ☐ Not Known
If Yes Specify: .....

BACKGROUND							
Area / Shift Time	6/2/26 N	6/2 N					
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:	98.1°F	98.1°F					
Res:	20	20					
SpO_2:	99%.	99%.					
Pulse:	76	79					
BP:	114/70	116/71					
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:	NA	—					
Post Operative Procedure Special Orders:	NA	—					
Handed Over By Name :	Anusha	Nadu					
Signature :							
Date:	7/2/2026	7/2/26					
Time:	8AM	12pm					
Taken Over By Name :	Nadu						
Signature :							
Date:	7/2/26						
Time:	8Am						

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:							

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

HNH-00016358 IP26-00006766
Mrs B SANDHYA
25-03-1995 31 Y 3 M 11 D (F)
Dr. SWATHI H V

GENERAL CONSENT FOR TREATMENT

Patient Name:	**Mrs B SANDHYA**	**Age :**	**31 Y 3 M 11 D**
IP No:	**IP26-00006766**	**Sex:**	**Female**
Consultant:	**Dr. SWATHI H V**	**Ward/Bed No:**	**4F -OT/PPO-418**

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 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: Rahul
Relationship: Husband.
Date: 6/7/26 Time: 8PM

Witness Name:
Witness Signature:

Patient Address:
Himayathnagar Hyderabad
Telangana INDIA 500029

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25 of being the guiding light, Nurturing Babies, Saving Mothers

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Dr. SWATHI H V

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 tpaIn 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.

Rahul

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

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Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.
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