Dr. Swathi

Rainbow® Children's Hospital — It takes a lot to treat the little.
BirthRight™ BY RAINBOW HOSPITALS — Your Right to a Safe Delivery

ESTIMATION SLIP

1588

Date : 12/6/26 **UHID / IP No. :** HNM-00012139 **Sl No.**

Name of Patient : Mrs. Aravinda **Age:** 27yr **Gender:** F

Father's / Husband's Name : Mr. Gautham **Corporate / Occupation :**

Address : Nallakunta **Phone :** 8985007021 **Email :** 8985928679

Procedure / Plan : NO LSCS **EDD/Dos:** July-26

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

TARIFF INFORMATION :

Particulars	Package Amounts (Rs.)	
Room Category	Normal Delivery	LSCS
Multi Shared Ward		
Shared Ward		
Twin Shared Ward ->	1.20L	1.30L
Private Room ->	1.45L	1.60L
Super Deluxe Room		
Suite Room	+ Non Payables	Extra 15L to 25L
Package includes (Package starts from the time of admission)	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee and Labour Ward Charges	Room Rent, Nursing Charges, Doctors Fee, Surgeon's Fee Anesthetist's Fees and OT Charges
	Length of Stay for : 2 Days	Length of Stay for : 3 Days
	Pharmacy up to 9,000/-	Pharmacy up to 12,000/-
NST, CBP ←	Investigations up to 2,500/-	Investigations up to 3,000/-
Others	well baby care	25L to 35K

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

Initial Minimum Deposit : 10,000/- Advance time of Admission

REMARKS : Vaccination, Neonatal, SBR, B/G

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

DECLARATION

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

Signature of the Client	Husband Signatory Relationship	Signature of the financial Counselor

HNH-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 26 D (F)
Dr. SWATHI H V

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SURGERY DETAILS

Date : 20/7/26

Patient Name: Mrs. Alur Aravinda Date of Birth: 24/5/1999 Age: 27 yrs

Gender: female Ward : OT UHID No.: HNH-00012139

Date of Surgery: 20/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Emergency Lower Segment Cesarean Section.

Time in : 1:45pm Time Out : 2:45pm.

		NAME	AMOUNT
1.	Surgeon	Dr. Swathi	
2.	Anaesthetist	Dr. Samir / Dr. Ayesha	
3.	Assistant Surgeon	Dr. Duva	
4.	OT Technician	Sr. Saraswathi	
5.	Circulating Nurse	Sr. Karuna	
6.	Assistant Nurse	Br. Ballu	

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

Signature of the Surgeon
For Dr Swathi

puja.
Signature of Circulating Nurse

Order No: 26-0000-215-105 Order by: Archana 20/7/26 @ 15:43pm

HNH-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 26 D (F)
Dr. SWATHI H V

Em. lscs.

CONSUMABLES OF OT

Rainbow® Children's Hospital — It takes a lot to treat the little.
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Circulating staff : Nalashra Technician : Saraswathi Date : 20/7/26 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			~~Major~~ Pack Lscs	1		Inj Vit.K		1+1
LMA			Sutures 2346, 4242	2+1		Cord Clamp		1
ECG leads : (A)/ P / N		03	1326 , 2364	1+1		Suction Catheter		
HME filter : A / P / N						Feeding Tube 10-6		1
Syringes : 10 cc		03				Vaccum Suction Set		
05 cc		03	Gloves SG 6½, 7½	2+1		Surgical Gloves 6.5 ~~7.5~~		02+1
02 cc		03	Encore 6½	2		Gauze Pack		01+1
01 cc		2				Syringe 1ml / 2ml		2
Cautery plate (A)/ P / N		1	Surgical blade 22	1		Surgical Blade # 20		1
IV set		01	NG tube			Koochies (S)		01
RL		02	Cautery pencil	1		Encore 6.5		1
NS : 10ml / 100ml / 500ml / 1000ml		01	Koochies XL	1		~~SG 6.5~~		~~1~~
oxytocine		4+05	Ointments			Canula 24g		2
			Suction Catheter	10+10		Duoderm		01
Fentanyl		01	Cap, Mask	10+10		26-000215466/465		
Morphine			Gauze Pack 7.5x7.5	2				
Ketamine			Mop Pack	1+2				
Propofol			Steristrip					
Rocuronium			Underpad	2				
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel	1				
Ondansetron			Foleys catheter					
27g Pencan ~~25g~~/ Spinal Needle 22		01	Urobag					
Anawethe ~~Bupivacaine~~ 0.25%		01	Chest Drainage Catheter					
~~Bupivacaine~~ 0.25%(Heavy)		01	Romodrain bag					
Antibiotics			Bandage					
O2 mask (A)		01	Tegaderm					
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg		01	Vaccum Suction set	1				
Justin : 12.5 mg / 25mg / 100mg		01	Plastic ~~Bed Sheet~~ Apron	01				
Tab. Misoprost : 200mg		06	Betadine Solution	2				
Encore glove 6.5		01	Microshield	2				
Gauze 7.5x7.5		01	Cotton Balls	1				
			Latex Gloves	20				
			Ramdione Scrub					
			Saral					

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-000215462/461 Ordered by : Archana 20/7/26 @ 12.35pm

Doc. No. : RCH / FRM / GENERAL / 125

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.
040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00012139	Name	: Mrs ALUR ARAVINDA
Age / Sex	: 27 Y 1 M 26 D / Female	Doctor	: SWATHI H V
Adm/Reg Date/Time	: 19/07/2026 21:01	Payor	: TATA AIG General Insurance Co. Ltd.
Order Date	: 20/07/2026 17:49	Ordernumber	: 26-0000215461
Visit ID	: IP26-00006885	Ward/Bed No	: 4F -OT / LDR-415
Patient Address	: 3RD FLOOR, SRI SARADA NILYAM, 2-1-565/4/4, Nallakunta, Hyderabad, Telangana, INDIA, 500044		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	PENCAN 27G (B/BRAUN)		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
2	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	2 Days		2 Nos	Dispensed
3	UNDER PAD 60X90 10's Pack - MEDICUBE		1 Nos	External / 10 AM	1 Days		2 Nos	Dispensed
4	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	ANAWIN HEAVY 5 MG INJ 4 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Dispensed
6	DISPOSABLE APRONS STERILE XL	DISPOSABLE APPRON STERILE XL	1 Nos	/ Once Daily	4 Days		4 Nos	Dispensed
7	OxygenMask With Tubing - Adult ROMSONS-FC		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
8	ABGEL SURGI PAD (BIG) (GELSPON)	ABGEL	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
9	VICRYL 1-0 NW 2364	VICRYL 1-0 NW 2364	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
10	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
11	TRUGUT CHROMIC CATGUT SN4242	TRUGUT CHROMIC CATGUT SN4242	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
12	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
13	MISOPROST TAB 200MCG 4S		1 Tabs	External / Once Daily	1 Days		6 Tabs	Dispensed
14	ADULT DIAPERS-XXL		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
15	SURGICAL BLADE 22	SURGICAL BLADE 22	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
16	SGLOVE # 7.0(SURGICARE)	SURGICAL GLOVES 7.0	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
17	VICRYL 1-0 VP 2346	VICRYL 1-0 VP 2346	1 Nos	/ Once Daily	2 Days		2 Nos	Dispensed
18	MONOCRYL 3-0 NW 1326	MONOCRYL 1326	1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
19	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		4 Nos	Dispensed
20	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
21	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
22	DSYRINGE 5ML(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
23	CAUTERY PENCIL (ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
24	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
25	MOPS 30X30 8PLY 5S X-RAY	MOPS 30X308 PLYDATT	1 Nos	/ Once Daily	3 Days		3 Nos	Dispensed
26	SUPRIDOL SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
27	JUSTIN SUPPOSITORIES 100 MG 5 S		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
28	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
29	NS 100ML ACCULIFE - EH	NORMALSALINE 0.9% SODIUMCHLORIDE100M L CLO	1 mL	/ Once Daily	1 Days		1 mL	Dispensed
30	LSCS DRAPE PACK SAFE SECURE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
31	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		3 Nos	Dispensed
32	EVATOCIN (OXYTOCIN) INJ 5 IU 1 ML		1 Vial	Injection / Once Daily	1 Days		5 Vial	Dispensed
33	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	2 Days		2 Bottle	Dispensed
34	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

SWATHI H V
OBSTETRICS AND GYNECOLOGY
Reg No : TSMC/FMR/15501

* This document is just for reference purpose only. Not to be considered as primary report.

Note

*** This prescription is valid only for specified duration.**

*** Do not refill medicines.**

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ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00012139	**Name**	: Mrs ALUR ARAVINDA
Age / Sex	: 27 Y 1 M 26 D / Female	**Doctor**	: SWATHI H V
Adm/Reg Date/Time	: 19/07/2026 21:01	**Payor**	: TATA AIG General Insurance Co. Ltd.
Order Date	: 20/07/2026 17:49	**Ordernumber**	: 26-0000215462
Visit ID	: IP26-00006885	**Ward/Bed No**	: 4F -OT / LDR-415
Patient Address	: 3RD FLOOR, SRI SARADA NILYAM, 2-1-565/4/4, Nallakunta, Hyderabad, Telangana, INDIA, 500044		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
2	FACE MASK 3 LAYER - ELASTIC	FACE MASK 3 LAYER	1 Nos	External / Once Daily	1 Days		10 Nos	Ordered
3	BCV-INTRAFIX SAFESET		1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
4	SURGEON CAP FEMALE SAFE SECURE		1 Nos	External / 10 AM	1 Days		10 Nos	Ordered

SWATHI H V
OBSTETRICS AND GYNECOLOGY
Reg No : TSMC/FMR/15501

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ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00016705	**Name**	: Baby Of ALUR ARAVINDA
Age / Sex	: 0 Y 0 M 0 D 4 H / Male	**Doctor**	: SPANDANA PASUPULETI
Adm/Reg Date/Time	: 20/07/2026 15:14	**Payor**	: SELFPAY
Order Date	: 20/07/2026 17:54	**Ordernumber**	: 26-0000215465
Visit ID	: IP26-00006899	**Ward/Bed No**	: 4F -NICU 1 / NICU1-402
Patient Address	: 3RD FLOOR, SRI SARADA NILYAM, 2-1-565/4/4, Nallakunta, Hyderabad, Telangana, INDIA, 500044		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	DUODERM EXTRA THIN 10X10 CM(187955)	HYDROCOL THIN EXTRA 10X10	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
2	KOOCHEES- SMALL 5 S		1 Nos	/ Once Daily	1 Days		1 Nos	Ordered

SPANDANA PASUPULETI

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040-48873000, info@rainbowhospitals.in

ELECTRONIC MEDICINE PRESCRIPTION

MRN	: HNH-00016705	**Name**	: Baby Of ALUR ARAVINDA
Age / Sex	: 0 Y 0 M 0 D 4 H / Male	**Doctor**	: SPANDANA PASUPULETI
Adm/Reg Date/Time	: 20/07/2026 15:14	**Payor**	: SELFPAY
Order Date	: 20/07/2026 17:54	**Ordernumber**	: 26-0000215466
Visit ID	: IP26-00006899	**Ward/Bed No**	: 4F -NICU 1 / NICU1-402
Patient Address	: 3RD FLOOR, SRI SARADA NILYAM, 2-1-565/4/4, Nallakunta, Hyderabad, Telangana, INDIA, 500044		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	DSYRINGE 1ML (NIPRO)	SYRINGE 1ML	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
2	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		3 Nos	Dispensed
3	Encore Microptic gloves-6.5		1 Nos	/ Once Daily	1 Days		1 Nos	Dispensed
4	INFANT FEEDING TUBE-6	INFANT FEEDING TUBE 6	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
5	INJEK INJ 1 MG 0.5 ML		1 Nos	/ Once Daily	2 Days		2 Vial	Dispensed
6	INTROCAN 24G	IV CANULLA 24	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed
7	GAUZE 7.5X7.5 12 PLY (5 NOS) NON XRAY	GAUZE 7.5X7.5 12 PLY 5 NOS	1 Nos	External / Once Daily	1 Days		2 Nos	Dispensed
8	CORD CLAMP-ALPHAMEDICARE		1 Nos	External / 10 AM	1 Days		1 Nos	Dispensed
9	SURGICAL BLADE 20	SURGICAL BLADE 20	1 Nos	External / Once Daily	1 Days		1 Nos	Dispensed

SPANDANA PASUPULETI

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Note

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Printed Date/Time : 20/07/2026 18:02

Printed By : SUNKARI SANGEETHA

306
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Your Right to a Safe Delivery

Name	Mrs ALUR ARAVINDA	**UHID**	HNH-00012139
Father/Guardian	Mr L P GOUTHAM PRATAPA	**Age/Gender**	27 Y 1 M 26 D/ Female
Address	3RD FLOOR, SRI SARADA NILYAM, 2-1-565/4/4, Nallakunta, Hyderabad, Telangana, INDIA, 500044		
IP No	IP26-00006885	**Admission Date**	19-07-2026
Ref Doctor	Self.		
Discharge Date	22.07.2026		

DISCHARGE SUMMARY

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

Diagnosis: PRIMI WITH 38^{+6} WEEKS FOR INDUCTION OF LABOUR.

EMERGENCY LOWER SEGMENT CESAREAN SECTION DONE ON 20.07.2026

History:

LMP: 21.10.2025
EDD: 28.07.2026

Obstetric formula: Primi
Gestation at admission: 38^{+6}weeks

Name	Mrs ALUR ARAVINDA	**UHID**	HNH-00012139
IP No	IP26-00006885	**Admission Date**	19-07-2026

Obstetric History:
G1 - Present pregnancy, Spontaneous conception.

Medical History: Nil

Family History: Father-DM, Mother-HTN

Surgical History: Nil

Allergies: Nil

Antenatal Details:
Mrs ALUR ARAVINDA was booked to Rainbow hospital at 4+4 weeks of gestation. She had regular antenatal checkups and investigations as advised. NT + FTS was low risk. TIFFA was normal. OGTT was normal. Fetal monitoring was done by serial growth scan. She was admitted at 32^{+3}weeks with complaints of pain abdomen and decreased fetal movements . Antenatal steroid coverage done with 2 doses of Inj. Betamethasone 12mg on 05.06.2026.and 06.06.2026 for fetal lung maturity in view of anticipated preterm delivery. Scan done on 06.07.2026 showed SLIUP at 36+6 weeks with cephalic with AFI 9.8cm with EFW 2.5 kg(65%) with AC 66% with Placenta anterior high with normal doppler. She was admitted at 38+6 weeks for Induction of labour.

Investigations: Enclosed.
Blood group: "O" Positive

Management: Course in hospital:
At admission on clinical examination the vitals were stable. On admission vitals stable, uterus relaxed and os 1 cm dilated, uneffaced, vertex high up. Fetal

Name	Mrs ALUR ARAVINDA	**UHID**	HNH-00012139
IP No	IP26-00006885	**Admission Date**	19-07-2026

well being was confirmed by an admission CTG which was found to be reactive.Informed consent for Induction of labour and vaginal birth was taken. Induction of labour was done by 4 doses of PGE 1. She was decided for emergency C- section in view of Failed Induction. She was prepared with indwelling Foley's catheter and IV canula under aseptic conditions. Written informed consent for surgery taken. Preanesthetic check up done. Anaesthetic premedication (IV Pantop and Perinorm) given. Patient shifted to theatre.

Surgery Notes:

Under spinal anesthesia she was painted and draped as per hospital protocol. Abdomen opened in layers. The parietal and visceral peritoneum carefully opened after identifying the urachus. Bladder was reflected. A lower segment curvilinear incision given on the uterus. Baby delivered. Cord clamped and cut and cord blood collected for blood grouping and Rh typing. Baby handed over to pediatrician. Placenta delivered with controlled cord traction. Uterus closed in layers. Hemostasis secured. Instruments and swab count checked. Rectus sheath closed. Skin closed with subcuticular sutures. Wound dressing done. Vagina cleaned with Betadine solution after expelling clots. Misoprostol 400 mcg given per rectum as prophylaxis against Postpartum hemorrhage. Patient was shifted out of theatre to post operative recovery room.

Delivery Details :

Date : 20.07.2026
Time of Delivery: 1:58 pm
Type of Delivery: Emergency lower segment caesarean section
Indication : Failed Induction

Name	Mrs ALUR ARAVINDA	UHID	HNH-00012139
IP No	IP26-00006885	Admission Date	19-07-2026

Anaesthesia : Spinal

Baby Details:

Date : 20.07.2026
Time : 1:58 pm
Sex : Male
Weight : 3.740 kg
Apgar : 7,9
Gestational Age: 39 weeks
NICU Admission: Yes

Post-Operative Notes:

She was closely monitored. Her vital signs remained stable. Uterus was well retracted with no Postpartum hemorrhage. Breast feeding initiated. She was shifted to room. Her postoperative period following that was uneventful. On second postoperative day dressing was changed. On inspection wound was healthy. Her general condition was satisfactory and she was found to be fit for discharge. Wound care and medications were explained to patient supplemented by written information. She was given the postpartum book for further reference.

Advice:

1. Tab. Taxim O 200mg twice daily till 26.07.2026 (9am-9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs) thrice daily till 24.07.2026 (8am-2pm-10pm) after food.
3. Tab. Voveran 50 mg (Diclofenac 50mg) thrice daily till 24.07.2026(9am-

Name	Mrs ALUR ARAVINDA	**UHID**	HNH-00012139
IP No	IP26-00006885	**Admission Date**	19-07-2026

3pm-11pm) after food.
4. Tab. Pantop 40mg twice daily till 26.07.2026 (7am-7pm) before food.
5. Tab. Livogen (Elemental Iron - 50mg, folic acid 1.5mg) once daily (7am) for three months before breakfast.
6. Tab. Shelcal XT (Elemental Calcium 500 mg, Vitamin D3 250 IU) once daily (2pm) till breast feeding for after food.

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

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

Review with **Dr. SWATHI H V,** after **1 week** on **28/7/2026** at Rainbow Children's Hospital with prior appointment **(Review consultation will be charged).**

For Women Who Have Had a Caesarean Section
Care of the wound:
1.You can bath and shower.
2.The wound can get wet during a bath or shower. Dry it thoroughly and gently by dabbing with a gauze piece. Do not rub the wound.
3.This gauze piece needs to be discarded after one use.
4.Prior to touching the wound clean hands thoroughly with Microshield solution and allow them to air dry or use disposable paper napkins.

Name	Mrs ALUR ARAVINDA	**UHID**	HNH-00012139
IP No	IP26-00006885	**Admission Date**	19-07-2026

5.Apply Nebasulf or Neomycin dusting powder on the wound after it is dry.
6.Do not touch the wound with unwashed hands.

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 [please refer to postpartum book for further details - Chapter II page 6] kindly contact 9154865045 at Rainbow Children's Hospital just dial one toll free number - 18002122.

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

Registrar/Resident/C.M.O

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

Rainbow Children's Medicare Ltd. Himayathnagar 500029 Hyderabad

Rainbow® Children's Hospital
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ACTIVITY RECORD FOR BILLING

HNH-00012139 IP26-00006885
Name: ---------- Mrs ALUR ARAVINDA ----------
24-05-1999 27 Y 1 M 25 D (F)
UHID No : ---------- Dr. SWATHI H V ıltant : ---------- Dept : ----------

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
20/7	1:30pm	Pre Post	(OT)	(illegible)
20/7	2:45pm	OT	Prepost	Puja. (illegible)
20/7/26	7:00pm	Pre-post	Room	(illegible)

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1.	Dr. S. Tejaswi	21/7/26	15709	
2.		Cross checked by Manjula @ 10AM		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

INVESTIGATIONS

Date	Investigations	Order No.	Sign
19/7	NST - (1)	8783 ✓	[illegible]
19/7	CBP	2094 ✓	[illegible]
20/7	NST - (2)	8788 ✓	[illegible]
20/7	NST - (3)	8790 ✓	[illegible]
20/7	NST - (4)	8837	[illegible]
20/7	NST - 5	8838	[illegible]
		Cross checked done	
		20/7/26.	[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

20/7/26.

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
20/7/26	Cardiac monitor	3:00pm	6:30pm	215469	[signature]
20/7/26	Infusion pump				

Cross checked done
20/7/26

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
19/7/26	IV Plalement	(1)	5209	dkw's
20/7	Canthanization	(1)	15464	
20/7	PAC	(1)	15464	
			Cross checked done 20/7/26	
21/7/26	NHA	(1)	15710	
	Cross checked by			

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

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IP AD[illegible]UR OBSTETRICS

Presenting Complaints
Came for IOL.

LMP: 21/10/2025. EDD: 28/7/2026
Corrected EDD: 28/7/2026 GA: 38+6wks.

Obstetric Formula: Primi
ML: 1½ year.

Menstrual History: Regular : ☑ Yes ☐ No

Obstetric Hostory:
1st: PP, Spontaneous preg.

Obstetric Examination

Fundal Height: Term

Ut. Activity: ☑ Relaxed ☐ Mild ☐ Mod ☐ Severe

Liquor: ☑ Adequate ☐ Oligo ☐ Poly

PP: ☑ Cephalic ☐ Breech Others _____

Head Fifths Palpable: 4/5th.

FHS: ☑ Normal ☐ Tachy ☐ Brady ☐ Absent

Present Pregnancy Record:
NT- (N), eFTS-low risk,
TIFFA- (N)

RISK FACTORS: c/o itching over palms & abd @ 23+4 wks, managed conservatively.

Per Speculum Examination not done.

Draining: ☐ Present ☐ Absent ☐ Bleeding

Colour of Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Vaginal Examination soft.

Cervix: ☑ Long ☐ Partially effaced ☐ Effaced

Os: Closed _____ Dilated 1FF

Membranes: ☑ Present ☐ Absent

Liquor: ☐ Clear ☐ Meconium ☐ Blood Stained

Presenting Part: ☑ Vertex ☐ Breech ☐ Others

Sutton: ☐ -3 ☑ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2

Pelvis: ☑ Adequate ☐ Doubtful

Height: 162. cm
Weight: 86.9 kg
Allergies: Nil

Breast: ☑ Normal ☐ Abnormal

General Examination:

Consciousness: clc Pallor: -ve
Icterus: No Edema: No
Temp: 124/64. PR: 89 bpm.
BP: Afebrile. DTR: (N)
CVS: S1S2(+), no murmur RS BILNUBS(+)
Liver/Spleen: (N) Urine Output: Adequate

DIAGNOSIS

Primigravida with 38+6 wks POG ~~with~~ for IOL

HNH-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 25 D (F)
Dr. SWATHI H V

Family History: father - T2 DM mother - HTN	Surgical History: Nil.
Medical History: Nil.	Medication History: T. IRON T. CALCIUM
Plan of Care: - Admission NST. - Parts preparation - Informed Consent - T. Misoprostol 25mcg PV f/b 25mcg PO 4th hrly based on NST and POL - w/f POL / ~~[illegible]~~ P/V leak / P/V bleeding. - NST 4th hrly - strict FHR monitoring 2hrly - Monitor Vitals - Inform SOS.	Investigations: BGT 'O' Positive CBP (19/7/2026) Hb - 12.2 plt - 2.89. TLC - 12.5 PCV - 36.1 HIV, HbsAg, HCV, VDRL } NR. USG (6/7/2026). SCIUF 36w+6days Cephalic. placenta: Ant. high. AFI - 9.8cms. B.wt 2.5kg (65% / AC - 66%) [@ 34w3days. Dopplers - normal.

Doctor Name: Dr. Naveena

Signature: [signature]

Date & Time: 19/7/2026 @ 10:00pm.

Consultant Name: Dr. Swathi H V.

Signature: [signature] Dr. S... Consultant Obs... Gynecology Reg...

Date & Time: 19/7/2026 @ 10:00pm.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2026 2:00am	c/s/by Dr. Naveena	
	O/E GC- Fair Afebrile Vitals-stable. PA: ut-term size NST-(R) Irritable Cephalic FHR(+)	Adv -Soft diet - Adequate hydration - T. Misoprostol 25mcg PO stat - w/f PCL/PV leak/PV bleeding - NST 4th hrly - FHR. 2hrly - M/V & I/S OS
	Dr. Naveena	
20/7/2026 6:00am	c/s/by Dr. Naveena	
	O/E GC-Fair Afebrile NST-(R) Vitals-stable PA: ut-term size mildly Acting. Cephalic, FHR(+)	Adv - Early breakfast - Proctolysis enema - Adequate hydration - w/f PCL/PV leak/PV bleeding - NST 4th hrly, FHR 2hrly - T. Misoprostol 25mcg PO stat - m/v & I/S OS
	Dr. Naveena	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/2026 6'	C/D/W. Dr. Swathi	
		Adv
		- T. Misoprostol 25mcg next dose @ 9am
		- M/R & I/SOS
		- W/F POL
		Dr. Naveena
	A/B Aravathi/DV	
20/7/2026 9:40AM	- Primi @ 39wks., on going IOL	
	+ Received 2 doses of	
	→ O/E: afebrile	Advice
	PA: ut FS. cephal	→ w/f POL
	FHS ⊕ reg	
	2/10/20-15"	→ Reassess >4hrs
	PV: OS. 1FT	
	Cx posterior 1.5" long	→ LTG. 3rd day
	Vx, stn (-3)	→ w/f pain / leak PV.
	memb ⊕.	→ Per/orders.
	Dr. Swathi H V, Consultant Obstetrics and Gynecology, Reg. No: 15501	Aravathi/DV

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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
20/?/26 1pm	SIB Dr Swathi HV / Dr [illegible]	
	Primi / 39wk / Ongoing IOL.	
	O/E GC fair	Adv
	Afebrile	- NBM
	vitals - stable	- Informed consent
	P/A ut ≏ TG	- preop medication
	cephalic	- PAC.
	FHS (+)	- Foleys catheterisation
	2C/10/10.	- Shift to OT on call.
Adv	PV: OS IFT, Cx [illegible], 1.5" long	- Inform pediatrician
EmLSCS i/v/o. Nonprogress of labor. Failed Induction.		
	Explained the findings to patient & husband & need of Em LSCS i/v/o failed IOL.	
	Dr. Swathi H V Consultant Obstetrics and Gynecology Reg. No: 15501	

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

HNH-00012139 IP26-00006885
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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
	C/S B Dr. Dng	/ Dr SWATHI H V.
20/7/26 4:05 pm.		
	POD-0 P,4	Adv
		- NBM till further order
	GC fair	- IV fluids
	Afebrile	- Drugs as charted
Baby at NICU:	BP: 110/70 mmHg.	- Urine I/O charting
in v/o TTNB.	PR: 72 bpm.	- Monitor vitals
	SpO_2:	- Inform SOS
U/O - 50ml	P/A Uterus Retracted well	- w/f PV bleed
	L/G NAD	
	Dr. Swathi H V, Consultant Obstetrics and Gynecology, Reg. No: 15501	[signature]
20/7/26 6:30 pm	C/w/s Dr Manchala	
	P.L. POD-0	Adv
	G.C - fair	- Allow oral fluids
	afebrile	- IV fluid
	SpO_2 - 99% RA PR - 78 bpm	- Drugs as charted
Baby in NICU	BP - 112/(?) bpm	- I/O charting
	P/A - uterus retracted well	- w/f p/v bleeding
	L/E - P/v bleeding - WNL	- monitor vitals
	UO - 300ml :: 3hrs	Inform SOS.
	BS - well heard	
	shift to Room	

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
20/7/26	C/b/s Dr Mounduk	
8pm	P/L i POD-0	
	GC - fair	Adv
	afebrile	- Liquid diet
Baby in NICU	PR=78/m	- IV fluid
	BP-112/78 mmHg	- Drugs as charted
UO: 200ml :: 2hrs	P/A- uterus contracted well	- I/O charting
	L/E - No bleeding	- w/f p/v bleeding
	BS - well heard	- monitor vitals
		Enzyme sos
		Dr. Mounduk
20/7/26		
11pm	No complaints	
	U/O (N)	Adv
		1) liquid diet f/b
		soft diet -> 12AM.
		2) Remove foley's @ 6AM
		on 21/7/26.
		Ramu, Dr.RAMYA

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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
	CJS / B Dr. Dvs	
21/7/26		
8:30AM	POD-1	
		Adv
	C/C Fair	✓ Soft diet
	Afebrile	✓ Adequate hydration
Baby @ NICU	vitals - stable	✓ Drugs as charted
	P/A Uterus Retracted	✓ W/F PV bleed
Urine Yet to void	BS(+) well	✓ Monitor vitals
Flatus passed	Y & NAD	✓ Inform SOS.
		NB Sunanda
21/7/2026	C/S b/s Dr Monika	
4pm		Adv
	C/C Fair Afebrile	- Soft Diet / Adeq Hydration
	vitals stable	- Drugs as chart
Bby-NICU	P/A Ut well retract	- W/F vitals & BM
	BS(+)	- Ambulation
UV	PV bleeding wnl	- Dulcolax Supp ② PR @ 10pm
FV		(if motions not passed)
		- Inform SOS
		Dr Amrita

IP26-00006885
HNH-00012139 (F)
Mrs ALUR ARAVINDA 27 Y 1 M 26 D
24-05-1999
Dr. SWATHI H V

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
21/7/2026	S/B Dr Swathi HV	
7pm		
	→ – POD-1, P1L1 /Em LSCS	
Baby in NICU		Adv
	O/E: vitals (N)	→ (N) vitals
	PA: soft	- Ambulation
	Uterus well (R)	→ soft diet
V/N ✓	Odry	→ plenty fluids
	L/E: NAD	- Emeset
Flatus ✓		
	Swathi HV	Dr. Swathi H V Consultant Obstetrics and Gynecology Reg. No: 15501
21/7/26 7pm		
	Ch/B Dr. Mrudula	
	POD-1 P1L1 1 female	
	No Complaints	Adv
	O/E pt conscious	→ Soft diet
	GC - fair	→ Adequate Hydration
Baby in NICU	PR - 82bpm	→ Drugs as charted
V ✓	BP - 112/72mmHg	→ Ambulation
F ✓	P/A - uterus contracted well	→ Dulcolax Suppositories
SX	L/E - p/v bleeding WNL	2 P/R @ 10pm.
		→ monitor Vitals
		Emeset sos.
	Dr Mrudula	
		noted by SN Sandhya 21/7/26 7pm

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
22/7	Clin Dr. Mandala	
9:30am	POD-2 / [illegible]	
	o/f [illegible]	Adv
U✓	[illegible]	→ Regular diet
F✓	[illegible]	→ Drugs as charted
S✓	BP-110/[illegible]	→ Ambulation
baby i mother	P/A - uterus [illegible] well	→ monitor vitals
A/l breastfeed	[illegible] bleeding [illegible]	[illegible]
		→ Tegaderm cleaning
		[signature] Dr Mandala
	S/B Dr SWATHI HV	
23/7 10AM	- pt comfortable	Advice:
	O/E: vitals (N)	→ (N) d[illegible]
	PA: soft uterus (R)	→ Ambulation
Baby in NICU.	D day	→ Tegaderm dressing
	N/O: NAD	→ plan D/[illegible] today.
		[signature] Dr Swathi HV.

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

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24-05-1999 27 Y 1 M 25 D (F)
Dr. SWATHI H V

19/7/26 306

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RESULT SHEET

Date	19/7/26					
Time						
Hb	12.2					
PCV	36.1					
RBC	4.54					
WBC	12.50					
N/L						
Platelets	289					
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 group= 'b' positive						
HIV						
HbsAg } NR						
HCV						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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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

19/7/26

		Date													POD 0										
		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		98		26	
	0 - 10																									
Saturations	94 - 100 %															99	99	99	99		99		99		99	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37															36.4		96F			97F				98F	
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90															97		80			75		82		80	
	80																									
	70																									
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130																									
	120															124		118			115		106		110	
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
	40															54		64			65		72		69	
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	
TAL ORANGE SCORES																0		0			0		0		0	
Nurse Initial																										

FHR

11Pm — 145bmt

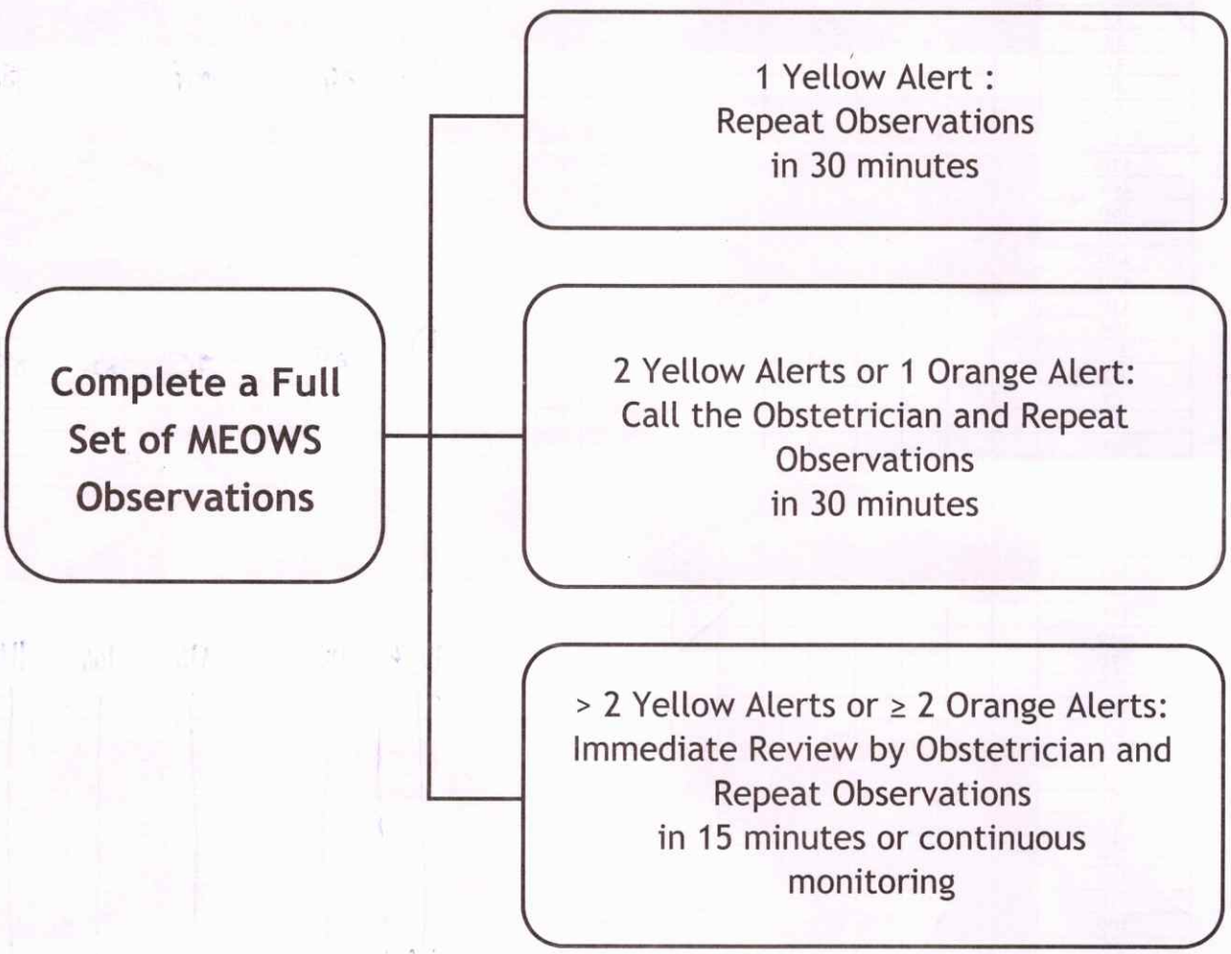
1Am — 155bmt

3Am — 160bmt

5Am — 150bmt

7Am — 155bmt

Obstetrics and Gynaecology Early Warning Signs



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

HNH-00012139 IP26-00006885
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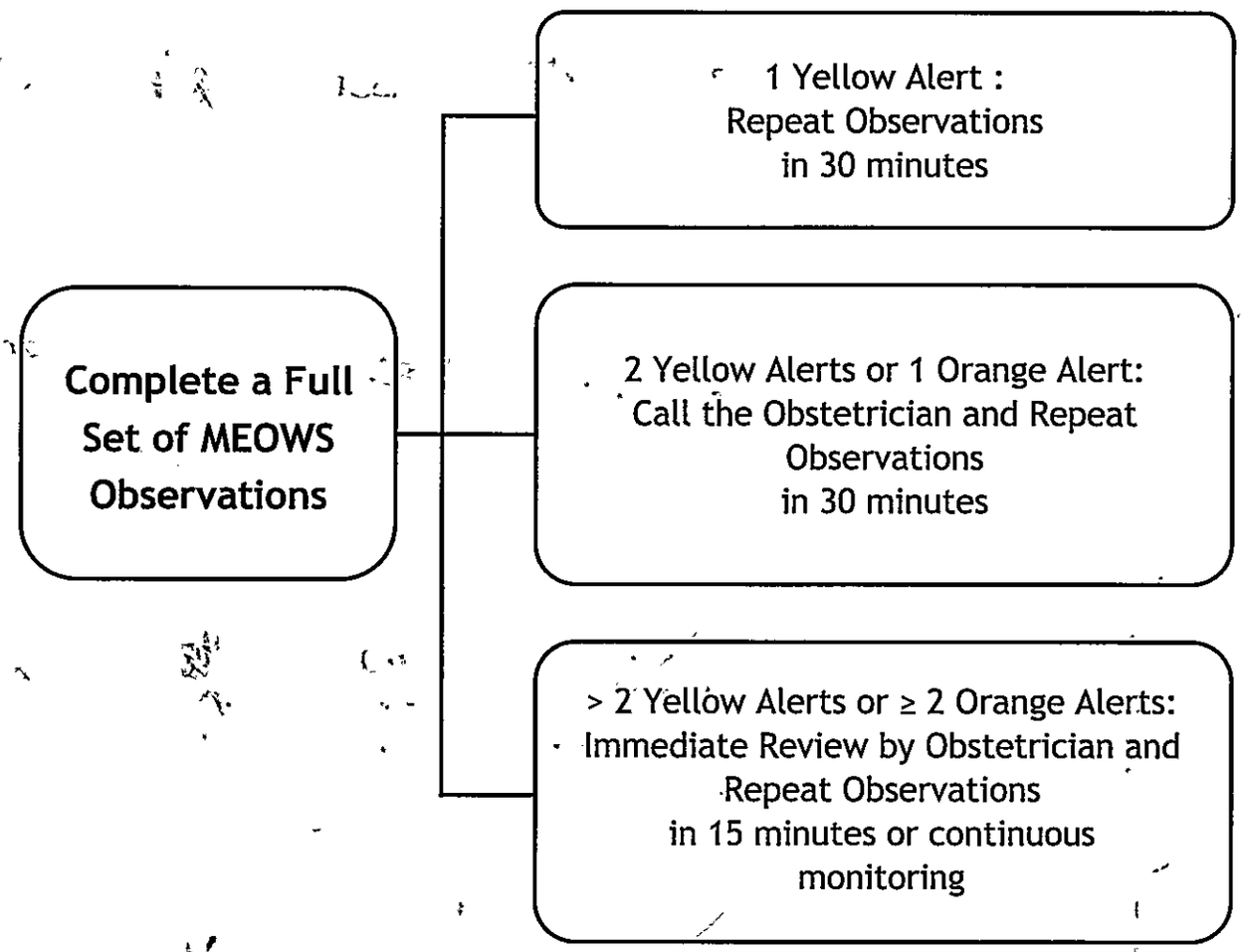
Early Warning Observation Score Chart - Obstetrics

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

20/2/26

		Date																							
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20			20						20	20	20	20				20				20				20	
	0 - 10																									
Saturations	94 - 100 %			100						97	97	97	99				99%				99%				99	
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37			←						97.6F			98F				98.3F				98.3F				98.3F	
	36																									
	35																									
	< 35																									
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80			80													82				72				90	
	70									68	74	71	83													
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130									127															122	
	120			100							111	112	118				120				118					
	110																									
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70																									
	60			73						56	62	73	63				73				82				71	
	50																									
	40																									
NEURO RESPONSE [✓]	Alert			✓						✓	✓	✓	✓								✓				✓	
	Voice																									
	Pain																✓									
	Unresponsive																									
URINE mls / hour	> 30			✓						✓	✓	✓	✓												✓	
	< 30																									
Proteinuria	Protein + +																				✓					
	Protein > + +																✓									
Lochia	Normal																								✓	
	Heavy / Foul																✓									
Liquor	Clear / Pink																				✓				✓	
	Green																									
TOTAL YELLOW SCORES				0						0	0	0	0				0				0				0	
TOTAL ORANGE SCORES				0						0	0	0	0				0				0				0	
Nurse Initial				A						A	A	A	A													

Obstetrics and Gynaecology Early Warning Signs



* The Modified Early Warning Score (MEOWS)

HNH-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 26 D (F)
Dr. SWATHI H V

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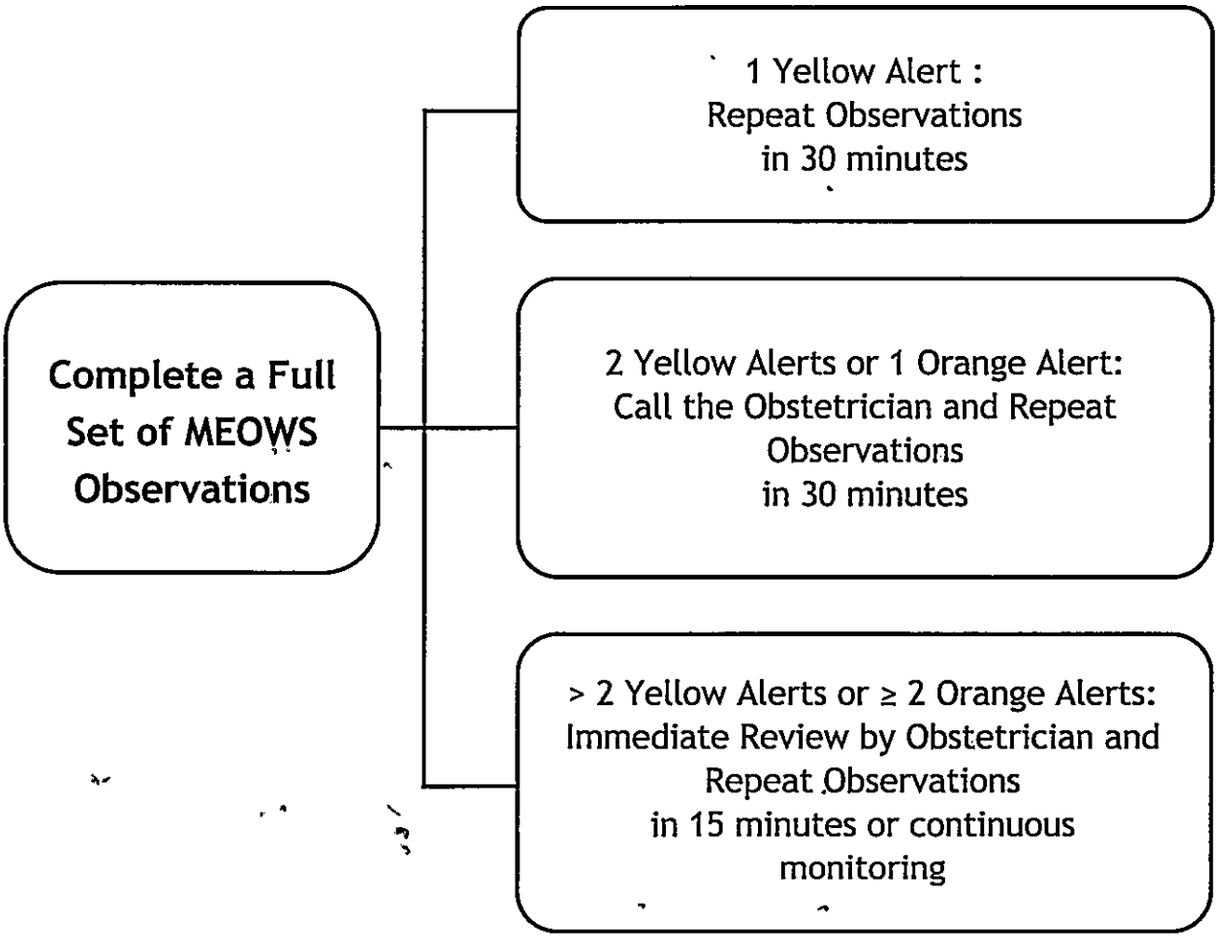
Early Warning Observation Score Chart - Obstetrics

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

21/7/26	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			22				23				20				20				20				20	
	0 - 10																								
Saturations	94 - 100 %			99%				99%				99%				99%				99%				99%	
	< 94 %																								
Administered O_2 (L/min.)																									
Temp°c	40																								
	39																								
	38																								
	37			36.8				37°C				98.2°C				98.3°F				36				98.3°F	
	36																								
	35																								
	< 35																								
Heart Rate	170																								
	160																								
	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80			83				82					86			82				80				82bpm	
	70																								
	60																								
	50																								
	40																								
Systolic Blood Pressue ↑	190																								
	180																								
	170																								
	160																								
	150																								
	140																								
	130															113									
	120			107				112					116							116				112	
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
	50			(82)				(82)																	
Diastolic Blood Pressure ↓	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70			71				72					80			87				91				72	
	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				0	
TOTAL ORANGE SCORES				0				0					0			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

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 :**						
19/7	08:00 pm											
	09:00 pm	RL		ff						✓	1	
	10:00 pm	RL		ff							0	②
	11:00 pm		Ho 2				NA					
	12:00 am	RL		ff						✓	1	
	01:00 am			ff								
Total Intake : taken						**Total Output :** Passed						
20/7	02:00 am	RL									1	
	03:00 am	D	Ho 2									
	04:00 am									✓	0	
	05:00 am						NA					②
	06:00 am		Ho							✓	1	
	07:00 am		UPma				1					
Total Intake : taken						**Total Output :** Passed						

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

Date	Time	Intake: Nature of Fluid	Intake: Route – Mouth	Intake: Route – I.V	Intake: Route – N.G	Output: NG	Output: Diarrhoea	Output: Vomit	Output: Drainage	Output: Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
20/7/26												
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm	RL		100ml								
	01:00 pm	RL		100ml								
Total Intake :		(Falcon)		200ml		**Total Output :**						
20/7/26	02:00 pm	RL		100ml								
	03:00 pm	RL	M	100ml						50ml		3 pm Empty
	04:00 pm	RL	B	100ml								
	05:00 pm	RL	M	100ml								
	06:00 pm	RL		100ml								
	07:00 pm	RL	SPS	100ml						250ml		8 pm Empty
Total Intake :		(Falcon)		600ml		**Total Output :**						
20/7/26	08:00 pm	↑	Soup	100ml								
	09:00 pm	.		100ml						300ml		Empty
	10:00 pm	RL		100ml								
	11:00 pm	↓		100ml								
	12:00 am	↓	Idly	100ml						300ml		Empty
	01:00 am	↓		100ml								
Total Intake :						**Total Output :**						
21/7/26	02:00 am	↑		100ml						400ml		Empty
	03:00 am	↑		100ml								
	04:00 am	↑		100ml								
	05:00 am	RL		100ml								
	06:00 am	↓		100ml								
	07:00 am	↓		100ml						1200ml		Empty
Total Intake :						**Total Output :**						

Total 24 hrs. Intake	2000 ml	Total 24 hrs. Output	2500 ml

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
21/7/26	08:00 am											
	09:00 am									✓		
	10:00 am	0	Idly + H2O				?				0	
	11:00 am				NA			NA				
	12:00 pm									✓		
	01:00 pm											
Total Intake :								**Total Output :**		U- 2	M-	
21/7/26	02:00 pm											
	03:00 pm		Khichdi							✓		
	04:00 pm	0					0				0	
	05:00 pm		H2O		NA			NA				
	06:00 pm											
	07:00 pm											
Total Intake :								**Total Output :**				
21/7/26	08:00 pm						✓					
	09:00 pm		Chapati Khichdi							✓		
	10:00 pm	0									0	
	11:00 am				NA			NA		✓		
	12:00 am											
	01:00 am											
Total Intake :								**Total Output :**		U- 2	M- 1	
22/7/26	02:00 am											
	03:00 am									✓		
	04:00 am	0	H2O								0	
	05:00 am				NA		✓	NA				
	06:00 am											
	07:00 am									✓		
Total Intake :								**Total Output :**		U- 8	M- 1	

Total 24 hrs. Intake		Total 24 hrs. Output	

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FLUID CHART

Sheet No. : .....

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

		Intake				Output						
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine	IV Site Thrombo-phlebitis Score	Sign. Nurse
			Mouth	I.V	N.G							
22/4/26	08:00 am											
	09:00 am											
	10:00 am		Idly									
	11:00 am		1									
	12:00 pm		Rice									
	01:00 pm											
Total Intake :						**Total Output :**						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						**Total Output :**						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						**Total Output :**						

Total 24 hrs. Intake		**Total 24 hrs. Output**	

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CHECKLIST FOR THROMBOPHLEBITIS

AA 20 Ltrs

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	0	0	0	0	
2	One of the following signs is evident : * Slight pain near the IV Site / * Slight redness near IV Site	Possibly first signs of phlebitis / Observe cannula	1			NA	-	NA	NA	NA	NA	NA	
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2			NA	-	NA	NA	NA	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	NA	NA	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	NA	NA	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	NA	NA	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 : .....

Patient Sticker

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CHECKLIST FOR THROMBOPHLEBITIS

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

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	19/7/26	20/4/26	20/7/26
		Score	N1	2pm	N1
History of Falling (immediately or w/in 3 months)	Yes	25			
	No	0			
Secondary Diagnosis (more than one diagnosis)	Yes	15			
	No	0	0	0	0
Ambulatory Aid	Furniture	30			
	Crutches, Cane(S), Walker	15			
	None /Bed Rest /Nurse Assist	0			
IV / Heparin Lock or Saline	Yes	20	20	20	20
	No	0			
GAIT / Transferring	Impaired	20			
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0	0	0	0
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:			20	20	20
		Signature			

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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Morse Fall Risk Assessment Form

Choose Highest Applicable Score from each Category		Date / Time	21/7/26	21/7/26	21/7/26
		Score	M6	E2	M1
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			
IV / Heparin Lock or Saline	Yes	20			
	No	0	0	0	0
GAIT / Transferring	Impaired	20	20	20	20
	Weak (uses touch for balance)	10			
	Normal /On Bed Rest /Immobile	0			
Mental Status	Forgets limitations	15			
	Oriented to own ability	0			
Total Morse Fall Scale Score:					
		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 : 19/12/26	20/12	20/12	21/12
					Time : N1	2pm	10pm	10AM
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4	4	4	4
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4	4	4	4
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4	4	4	4
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4	4	4	4
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4	4	4	4
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4	4	4	4
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4	4	4	4
					TOTAL SCORE	28	28	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 : 21/7/26 Time : 10:1			
Mobility	**1. Completely immobile:** Does not make even slight changes in body or extremity position without assistance.	**2. Very limited:** Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	**3. Slightly limited:** Makes frequent through slight changes in body or extremity position independently.	**4. No limitations:** Makes major and frequent changes in position without assistance.	4		
"Activity The degree of physical activity"	**1. Bedfast :** Confined to bed	**2. Chairfast :** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	**3. Walks occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. All patients too young to ambulate; OR walks frequently:** Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4		
Sensory Perception	**1. Completely limited:** Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	**2. Very limited:** responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	**3. Slightly limited:** Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	**4. No impairment:** Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4		
Moisture Degree to which skin is exposed to moisture	**1. Constantly moist:** Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	**2. Very moist:** Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	**3. Occasionally moist:** Skin is occasionally moist, requiring linen change every 12 hours.	**4. Rarely moist:** Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4		
FRICTION-SHEAR **Friction** Occurs when Skin moves against support surfaces **Shear** Occurs when skin and adjacent bony surface slide across one another	**1. Significant problem:** Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	**2. Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	**3. Potential problem:** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	**4. No apparent problem:** Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4		
Nutritional Usual food intake pattern	**1. Very Poor:** NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	**2. Inadequate:** Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	**3. Adequate:** Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	**4. Excellent:** Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of mean and dairy products. Occasionally eats between meals. Does not require supplementation.	4		
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4		
				TOTAL SCORE	28		
				Evaluator's Name			

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

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

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.				
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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
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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-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 25 D (F)
Dr. SWATHI H V

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PAIN ASSESSMENT FORM

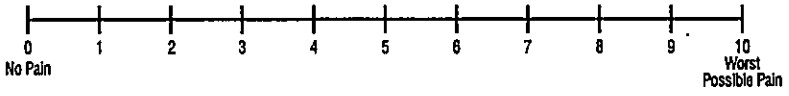
Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
19/7	11PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
20/7/26	5AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
20/7/26	2pm	0/10	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
20/7/26	6pm	0/10	Normal	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
20/7/26	10pm	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
21/7/26	2am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
21/7/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
21/7/26	10AM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
21/7/26	10PM	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	
21/7/26	6am	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	

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-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 25 D (F)
Dr. SWATHI H V

NURSING CARE RECORD

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Date: 19/12/26

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							
Afternoon							
Night	8pm / 8am	-> Assess the pt condition -> monitor the vitals & record -> Administration of medication -> NST 3rd hrly & FHRM -> wt progress of baby	8pm / 8am	-> Assessed the pt condition -> monitored the vitals & recorded -> Administered medication pt is stable as per doctors order -> wt progress of baby -> NST 3rd hrly	Maintain I/O chart & record	Akhila

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NURSING CARE RECORD

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Date: 20/7/6

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				DAY			
Afternoon	2pm 8pm	- Assess the patient condition - plan for vital & record - plan for IV fluids - plan for Tablet	2pm 8pm	- Assessed the pt condition) - Maintain vital & record - Continue IV fluids - Maintain Tablet	- patient stable	- Checked vital	
Night	8pm to 8am	- Assess the pt condition - monitor the v/s - maintain the I/O - Drug as per chart	8pm to 8am	- Assess the pt condition - Monitor the v/s - Maintain the I/O - Drug as per chart	- How patient is stable	- Rechecked the v/s	

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NURSING CARE RECORD

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Date: 21/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8AM / 2PM	→Assess the general Condition of pt. →Monitor vitals. →Maintain IOchart. →Administer mediation.	8AM / 2PM	→Assess the general Condition of pt. →Monitord vitals. →Maintaind IOchart. →Administered medi	pt is stable.	Re assess vitals.	Manjunath
Afternoon				DAY DUTY			
Night	8PM / 8AM	→Assess the general Condition of patient. →Monitor vital →Administer medication as per Doctor's orders.	8PM / 8AM	→Assess the general Condition of patient. →Monitor vital →Administer medication as per Doctor's orders	patient stable	Rechecked vitals	Suvanda.

HNH-00012139 IP26-00006685
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 27 D (F)
Dr. SWATHI H V

Patient

NURSING CARE RECORD

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Date: .....

Goals

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

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

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Swathi H.V Department: LDR Date of Admission: 19/7/26

SITUATION

Diagnosis: Primi

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

BACKGROUND	Area / Shift Time	N1	20/7/26 2pm	20/7/26 N1	21/7/26 M6	21/7/26 N1	
	Medical Condition (Any special condition to be noted):	NA	–	–	–	–	
ASSESSMENT	Allergy:	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	Vital Signs: Temp:	97°F	98°F	98.2°F	98.4°F	98.6°F	
	Res:	20b/mt	20	20b/m	21b/m	22 b/m	
	SpO_2:	99%	100	99b/m	99%	98%	
	Pulse:	97b/mt	97b/m	98 b/m	96b/m	92 b/m	
	BP:	120/55	110/73	110/73	110/76	100/80	
	Fall Risk Score:	–	–	–	–	–	
	Pain Score:	0/10	0/10	0/10	0/10	0/10	
Recommendations	Safety Needs:	yes	yes	yes	yes	yes	
	Physiotherapy	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	Others Specify:	–	–	–	–	–	
	Special Diet:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☐ No
	Other Special Orders / Medications:	NA	NA	NA	NA	NA	
Post Operative Procedure Special Orders:		NA	NA	NA	NA	NA	
Handed Over By Name :		Akhila	Alee	Sunanda	Mounika	Sunanda	
Signature :		[signature]	Alee	[signature]	[signature]	[signature]	
Date:		20/7/26	20/7/26	21/7/26	21/7/26	22/7/26	
Time:		8Am	8pm	8am	8PM	8Am	
Taken Over By Name :		Alee	Sunanda	Mounika	Sunanda		
Signature :		Alee	[signature]	[signature]	[signature]		
Date:		20/7/26	20/7/26	21/7/26	21/7/26		
Time:		2pm	8pm	8AM	8PM		

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

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

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

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URINARY CATHETER BUNDLE CHECK LIST

Date of Insertion: 20/7/26 Date of Removal: .....

Parameters / Date / Shift Time	20/7/26 9AM	20/7/26 MI	21/7/26 6am				
Need for the Catheter	☐Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Hand Hygiene	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Usage of Sterile Equipment	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is the Collection bag below the level of bladder	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Check the Tube for Obstruction (Free of Kinking)	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is Catheter dated as policy	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Collecting bag is been emptied regularly?	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Maintenance of closed system for the catheter	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Dressing clean and dry?	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Is the line removed as Policy?	☐Yes ☑No	☐Yes ☑No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Performance of Perineal Care	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Onset of New Fever	☐Yes ☑No	☐Yes ☑No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Asses for the leakage at the site of insertion	☑Yes ☐No	☑Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Name of the Nurse	Adi	Sunanda					
Signature of the Nurse							

Catheter Removed 6am

Docu. No. : RCH /FRM / CLINICAL / 114


HNH-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 25 D (F)
Dr. SWATHI H V

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DRUG CHART

Date of Admission: 19/4/26 Drug Allergies: ..... ☐ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

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

DOCTOR - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).

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

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

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

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

SOS / PRN (As required Medication)

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

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

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

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

HNH-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 25 D (F)
Dr. SWATHI H V

REGULAR PRESCRIPTIONS Weight. 80kgs Ward. LDR

DRUG : CEFOTAXIME				Date / Time	20/7	21/7	22/7
Dose	Route	Frequency	Start Date				
1g	IV	BD	20/7/26	10AM	X		
Name & Signature of the Doctor Starting the Drugs: Dr. [illegible]				10pm	9.30pm		
Additional Instructions: After test dose.							
Daily Doctor's Endorsement by a Sign							

Stop
Dr Manish

DRUG : Inj PARACETAMOL				Date / Time	20/7/26	21/7
Dose	Route	Frequency	Start Date			
1gm	IV	TID	20/7/26	6AM	X	
Name & Signature of the Doctor Starting the Drugs: Dr. Ayesha				2pm	X	
Additional Instructions: To be converted to oral after 24 hr.				10pm		
Daily Doctor's Endorsement by a Sign				20		

Stop after afternoon dose.
21/7/26

DRUG : Inj. DICLOFENAC				Date / Time	20/7
Dose	Route	Frequency	Start Date		
50mg	IV	BD	20/7/26	7AM	X
Name & Signature of the Doctor Starting the Drugs: Dr. Ayesha				7pm	8pm
Additional Instructions: To be converted to Oral after 24 hr.					
Daily Doctor's Endorsement by a Sign					

STOP
[illegible]

DRUG : Inj. TRAMADOL				Date / Time	20/7	21/7
Dose	Route	Frequency	Start Date			
100mg	IV	BD	20/7/26	11AM		
Name & Signature of the Doctor Starting the Drugs: Dr. Ayesha				11pm		
Additional Instructions: To be converted to Oral after 24 hr.						
Daily Doctor's Endorsement by a Sign						

Stop after morning dose
21/7/26

Verified by Dr. Dhakshayani

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Sheet No: .....

REGULAR PRESCRIPTIONS

Weight 80kgs Ward 202

DRUG : PANTOPRAZOLE

Dose	Route	Frequency	Start Dt.
40mg	IV	BD	20/7/26

Name & Signature of the Doctor Starting the Drugs: Dr. Dhanush

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date → / Time	20/7	21/7	22/7
	6am X		
	1:30 pm		
	6PM		

DRUG : Inj DICLOFENAC

Dose	Route	Frequency	Start Dt.
75mg	IM	BD	20/7/26

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date → / Time	20/7	21/7	22/7
	8am		
	8PM		

DRUG : PARACETAMOL

Dose	Route	Frequency	Start Dt.
1g	PO	TID	21/7/26

Name & Signature of the Doctor Starting the Drugs: Dr. Dhanush

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date → / Time	21/7	22/7
	6am	
	2PM	
	10PM	

DRUG : TRAMADOL

Dose	Route	Frequency	Start Dt.
100mg	PO	BD	21/7/26

Name & Signature of the Doctor Starting the Drugs: Dr. Dhanush

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Date → / Time	21/7	22/7
	10am	
	10PM	

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Verified by Dr. Dhakshayani

REGULAR PRESCRIPTIONS

Sheet No: .... Weight 80kg Ward 10F

DRUG : CEFIXIME				Date ▸ Time ▾
Dose	Route	Frequency	Start Dt.	
200mg	P/O	BD	22/7	
Name & Signature of the Doctor Starting the Drugs: [signature]				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

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

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

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

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

HNH-00012139 IP26-00006885
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Dr. SWATHI H V

Weight. 80kgs Ward. .....

DRU	Date➤ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
		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
19/7	10:00pm	T. MISOPROST-OL	25mcg	PV		Sujatha Akhila
20/7	2:00am	T. MISOPROSTOL	25mcg	PO		Akhila Sujatha
20/7	6 AM	T. MISOPROSTOL	25mcg	PO		Sujatha Akhila
20/7	8.00 AM	PROCTOLYSIS ENEMA	1 PACK	PR		Akhila Sujatha
20/7	9:00 am	T. MISOPROSTOL	25mcg.	PO		Akhila Sujatha
20/7	9 AM	TAB MISOPROSTOL	25 mg	P/O		MM Jyothi
20/7	1:28PM	METOCLOPROMIDE	10mg	IV		Madhu
20/7	1:28PM	PANTOPRAZOLE	40mg	IV		Madhu
20/7	1:58pm	Inj. OXYTOCIN	3IU	IV		

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24-05-1999 27 Y 1 M 26 D (F)
Dr. SWATHI H V

I.V. FLUIDS CHART

Weight. 80kg Ward. ICU

		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
19/7	9pm	RINGER LACTATE	IV	FF			20/7		
20/7/26	1:00 Am	RINGER LACTATE	IV	FF			20/7		
20/7	1:30 Pm	RINGER LACTATE	IV	2000 ml/hr			20/7		
20/7	2:00 pm	RINGER LACTATE	IV	500 ml/hr			20/7		
20/7	4:00pm	RINGER LACTATE	IV	FF			20/7		
20/7	4:30pm	RINGER LACTATE	IV	FF			20/7		
20/7	7:00pm	RINGER LACTATE	IV	100ml/hr					
21/7	12am	RINGER LACTATE	IV	100ml/hr					
21/7	5am	RINGER LACTATE	IV.	100ml/hr					
		Stop Dr. Bhanu							

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

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MEDICATION RECONCILIATION FORM

Drug Allergies: Nil ☑ Not known any Drug Allergies

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

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

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1	T. IRON	1TAB	PO	OD	19/7	☐ C ☑ DC
2	T. CALCIUM	1TAB	PO	OD	19/7	☐ C ☑ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

** C- Continue, DC - Discontinue*

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Naveena

Date & Time : 19/7/2026 @ 10:15pm.

Nurse Name & Signature: Sujatha

Date & Time : 20/7/26 @ 12 AM

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

Alur Aravinda
Patient Sticker
27Y

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CROSS CONSULTATION FORM

Doctor Name : Dr. Swathi Date : 21/7/26 Time : 12pm

Diagnosis : LSCS

Hospital : RCH - HMNR

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

Type of Referral :
☐ Emergency
☐ Urgent
☐ Non Urgent

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

Signature:

Findings and Recommendations :

Lactation care plan

- well formed Breast & Nipples
- Colostrum seen
- primi
- Baby at "NICU"
- Advice to start Express feeds every 2nd hourly on each side 15-20 mins.
- store at room temperature upto 4 hours.
- sterilize all baby essentials.

Consultant :

Name : Sathvika.G Signature : Date & Time : 21/7/26 ; 12pm

Alur Aravinda

Patient Sticker

27Y

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NUTRITIONAL ASSESSMENT FOR OBSTETRICS PATIENTS

Date: 21/7/26 Time: 9:45 am

Origin: Indian Height: 160cm Weight: 80.9 Kg BMI: ☐ ~ 26 kg/m² ☐ ~ 28 kg/m² ☐ ~ 30 kg/m²

31 Kg/m²

Food Allergies: No

Diagnosis: LSCS

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

Diet Advised:

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

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

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

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

Patient's / Attendant's	Dietician's
Signature: A Uma Devi	Signature: Sobiya
Name: Alur Aravinda	Name: Syeda Sobiya Zaheer
Date & Time: 21/7/26; 9:45 am	Date & Time: 21/7/26; 9:45 am

DIETARY NOTES

Date	Time	Notes	Sign

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OBSTETRIC TRIAGE ASSESSMENT FORM

Date: 19/7/26 Time of Arrival: 9pm Time Seen by Nurse: 9pm

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

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

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

3) **Vital Signs:** Temperature: 97.4°F Pulse: 84bmt RR: 20bmt SpO_2: 99% BP: 120/68 Weight: .....

4) **Gestational Criteria:**

Gravida:	G	P 1	L	A

LMP: 21/10/25 EDD: 28/7/26 Gestational Age: 38weeks+6day

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

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

0 No Pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

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

6) **Past History:**

a) Surgeries: NIL

b) Medical: NIL

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

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

9) **Prenatal Medical History:**

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

Triage Category: (Please tick on the category)

Refer to OBSTETRICAL TRIAGE ACUITY SCALE (OTAS)

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

OBCU Obstetrical Triage Acuity Scale (OTAS)

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

Time seen by Doctor: 9pm

Nurse Name : Akhila Nurse Signature: A

Date: 19/7/26 Time: 9p.m.

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 19/7/26

Baseline Information:

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

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

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

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

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

If yes, identify .....

Chief Complaints: ..... came for delivery .....

Doctor Notified on Admission: ☑ Yes ☐ No

Name of the Doctor: Dr. Narsena

Time Notified: .....

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

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

Gynecology Assessment: ☐ Not Applicable

Menstrual History: ..... Regular .....

Onset of Menarche: .....

Menstrual Cycle: ☑ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☑ No ☐ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

Infertility: ☑ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G ..... P ..1..... L ..... A .....

Previous LSCS: ..... NO .....

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

Family History: ☑ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 97.1°F HR: 98bpm RR: 20bpm

BP: 120/68 Weight: ..... Height: ..... BMI: .....

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

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PHYSICAL ASSESSMENT

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

Fall Assessment: ☐ Yes ☑ No Score ..0.. (complete the Morse Fall Risk Assessment Sheet)

Risk of Pressure Sore: ☐ Yes ☑ No Score ..0.. (complete the Braden Q Sheet)

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

☐ Mobility problem ☐ Walking Problem ☑ No Abnormality Detected

☐ Developmental Delay ☐ Musculoskeletal Congenital Abnormality

Inform consultant for positive criteria

NUTRITIONAL SCREENING: ☑ No Abnormality Detected

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

☐ Under Weight ☐ Diabetes Mellitus ☐ Hyperemesis Gravidarum

Inform consultant for positive criteria

PSYCHOLOGICAL SCREENING:

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

☐ Others .....

Inform consultant for positive criteria

SOCIAL SCREENING:

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

Social History: Lives With .....

Orientation has been given regarding the following aspects:

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

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

Above information given to ..PT..

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

Orientation not given Reason: .....

Nurse Signature: .....

Nurse Name: ..DKWla..

Date & Time: ..19/2/26 @10PM..

HNH-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 26 D (F)
Dr. SWATHI H V

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CAESAREAN SECTION OPERATIVE NOTES

Surgeon's Name:	Dr. Swathi HV	Date of Delivery:	20/7/26.
Assistant Surgeon:	Dr. Dua	Time of Delivery:	1:58pm
Anaesthetist's Name:	Dr. Ayesha.	Gender of Baby:	Male
Type of Anaesthesia:	Spinal.	Weight of Baby:	3.740 kgs.
Neonatologist:	Dr. Spandana.	AGPAR Score:	7, 9.
Scrub Nurse:	Brother.	NICU Admission:	☑ Yes ☐ No

Pre-Operative Diagnosis: Primi / 39 week / Failed Induction

☐ Elective ☑ Emergency Indication: Failed Induction.

Urgency

- ☐ Immediate Threat to life of woman or fetus
- ☑ Maternal or fetal compromise not immediately life threatening
- ☐ No maternal or fetal compromise but needs early delivery
- ☐ Delivery timed to suit woman and staff

Decision time: ..... Knief to rectus: .....

CTG Description: Reactive

If there was a delay give the reasons: .....

Surgical Procedure:
Emergency Lower Segment Cesarean Section

Post Operative Diagnosis: POD-0 P1L

Peri-Operative Complications:

Amount of Blood Loss:	Blood Transfused (in ML):

Name and Number of Surgical Specimen sent for examination:

Examination Findings when Appropriate:

Presentation: ☑ Cephalic ☐ Breech ☐ Other ..... Cervical Dilatation: 1cm ..... cm

5th Palpable: ..... Fetal Position: .....

Station: ☐ -3 ☐ -2 ☐ -1 ☐ 0 ☐ +1 ☐ +2 Moulding: ☐ None ☐ + ☐ ++ ☐ +++

Caput: ☐ + ☐ ++ ☐ +++ Meconium: ☐ None ☐ + ☐ ++ ☐ +++

Bladder Catheterized : ☐ Yes ☐ No Urine: ☐ Clear ☐ Blood Stained

Skin Incision: ☐ Pfannensteil ☐ Transverse ☐ Midline ☐ Other .....

Uterine Incision: ☐ Lower Segment ☐ Classical ☐ Inverted T ☐ J Incision

Previous Scar: ☐ Intact ☐ Thinnedout ☐ Ruptured ☐ No Scar

Incision Through Placenta: ☐ Yes ☐ No

Delivery of head: ☐ Manual ☐ Forceps

Liquor: ☐ Clear ☐ Meconium: ☐ I ☐ II ☐ III ☐ Blood ☐ Offensive ☐ Not Offensive

Delivery of Placenta: ☐ Manual ☐ CCT ..... ☐ Complete ☐ Incomplete ☐ Piecemeal

Cord Appearance: Normal ..... Cord around the neck ☐ Yes ☐ No

Appearance of placenta: Normal ..... Cavity explored ☐ Yes ☐ No

Uterus, tubes and ovaries: ☐ Normal ☐ Not Normal Sterilization: ☐ Yes ☐ No

Uterine Closure: ☐ One Layer ☐ Two Layers ..... Vicryl No-1 ..... Suture

Peritoneal Closure: ☐ Pelvic ☐ Abdominal ☐ None ..... Vicryl No 2. ..... Suture

Sheath Closure: ..... Vicryl No-1 ..... Suture

Fat Closure: ☐ Yes ☐ No ..... Vicryl No-1 ..... Suture

Skin Closure: ☐ Subcuticular ☐ Mattress ..... Monocryl No-1 ..... Suture

Vaginal Evacuated ☐ Yes ☐ No

Drain: ☐ Yes ☐ No ☐ Remove in ..... days ☐ Await instructions

Ctheter ☐ Yes ☐ No ☐ Remove in ..... days ☐ Await instructions

Swap & Instruments count correct? ☐ Yes ☐ No ☐ Post-op Antibiotics ☐ Yes ☐ No

Intra-Operative Antibiotics Cover: ☐ Yes ☐ No ☐ Thromboprophylaxis ☐ Yes ☐ No

Post-Operative Notes: .....

- NBM till 4hrs.
- IV fluids
- Drugs as charted
- Urine I/O charting
- Monitor vitals.
- Inform SOS
- W/F bleeding PV.

Doctor Name: Dr. Swathi HV Doctor Signature: .....

Date & Time: 20/7/26

SURGICAL SAFETY CHECKLIST

Surgeon : Dr-Swathi
Asst. Surgeon : Dr. Divya
Anaesthetist : Dr Samir
Scrub Nurse : Sr. Sallu

Patient Name : HNH-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 26 D (F)
Dr. SWATHI H V
UHID No. :
Date : 20/7/26

Gender : f
TH. LSCS

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Before Induction of Anaesthesia ➤➤

SIGN IN Time: 1:45pm

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

Site Marked ☐ Yes ☐ No ☑ NA

Anaesthesia Safety Check Completed ☑ Yes ☐ No

Pulse Oximeter on Patient & Functioning ☑ Yes ☐ No

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

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

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

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

Signature : Ageshe
Name : Dr. Sk. Agesha

Before Skin Incision ➤➤

TIME OUT Time: 1:30pm

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

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

Anticipated Critical Events

Surgeon Reviews:
- What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss? Bleeding / 1hr / 500ml ☑ Yes ☐ No ☐ NA

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

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

Signature : Natasha
Name : Sr. Natasha

Before Patient Leaves Operating Room

SIGN OUT Time:

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

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

Signature : Amanda for Dr Sreevathsa
Name :

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00012139 Mrs ALUR ARAVINDA IP26-00006885 24-05-1999 Dr. SWATHI H V 27 Y 1 M 26 D (F)	20/1/26 @9:01pm	20/1/26 @ 2:45pm
	Transfer Ordered by Dr. Samir	Reason for Transfer EM. LSCS
From Unit OT	To Unit Prepost	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File 33	Number of Imaging Films 5	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sis. Puja	Dr. Samir

Patient & Clinical Records Received by : [signature] 20/1/26 3:15pm

Date & Time of Patient Received :

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

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

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00012139 IP26-00006885 Mrs ALUR ARAVINDA 24-05-1999 27 Y 1 M 26 D (F) Dr. SWATHI H V	20/7/26 9:01 pm	20/7/26 7:00 pm
	Transfer Ordered by Dr Mandela	Reason for Transfer OBS
From Unit Pre - post	To Unit room	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 5 3 8	Number of Imaging Films 5	Personal belongings including clinical documents. If any handed over to attendant Yes ☐ No ☐ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Sir Alur	Dr Mandela

Patient & Clinical Records Received by : M. Supriya

Date & Time of Patient Received : 20/7/26 7:12 pm

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

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

HNH-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 25 D (F)
Dr. SWATHI H V

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BREAST FEEDING HANDOVER AND ASSESSMENT FORM

1. Breastfeeding initiated?
   - ☐ a. Yes ☐ b. No

2. If No, Reason .....

3. Nipple condition:
   - ☐ a. Nipple well formed
   - ☐ b. Flat nipple
   - ☐ c. Inverted nipple
   - ☐ d. Short nipple

4. Milk flow:
   - ☐ a. Good
   - ☐ b. Drops of colostrums
   - ☐ c. Dry

5. Steps for Positioning and attachment:
   - ☐ a. Baby goes to the breast
   - ☐ b. Mother always sits with a back support
   - ☐ c. Ear-shoulder-hip should be in a straight line
   - ☐ d. The baby takes a latch on the areola and not on the nipple

Feeding Positions:
Cross Cradle

Feeding Positions:
Football / Clutch

6. Was the position explained:
   - ☐ a. Yes
   - ☐ b. No

7. For Caesarian mothers:
   - ☐ a. Mother is required sit and feed from the 4th feed
   - ☐ b. Please explain football hold

8. NICU admission:
   - ☑ a. Mother needs to stimulate her breast for 2 min every 2 hours

9. Additional notes: .....

Continuity of Care: Date: 20/4/26

Handover given by .....

Signature .....

Date & Time: 20/4/26 @ 2pm

Handover taken by .....

Signature .....

Date & Time: .....

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PATIENT TRANSFER FORM

Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00012139 Mrs ALUR ARAVINDA IP26-00006885 24-05-1999 27 Y 1 M 25 D Dr. SWATHI H V (F)	20/7/26 @ 9:01 Am	20/7/26 @ 11:30 Pm
	Transfer Ordered by	**Reason for Transfer**
	Dr. Dua	Em LSCS
From Unit	**To Unit**	**Information to Attendant**
Pre & Post	(OT)	Yes ☑ No ☐
Number of Sheets in Clinical File	**Number of Imaging Films**	**Personal belongings including clinical documents. If any handed over to attendant**
30	NST - 5	Yes ☐ No ☑ If yes, what ?

Medications / Consumables / Surgicals / Hand over

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

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

Name & Signature of Person who is Transferring	Name of Person Ordered Transfer
Madhumita @ Madh	Dr. Dua

Patient & Clinical Records Received by : [signature]

Date & Time of Patient Received :

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

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

Docu. No. : RCH /FRM / CLINICAL / 102

CONSENT FORM FOR ANAESTHESIA

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Patient Name : Mrs Alla Aravinda Age : 27 Gender : Male ☐ Female ☑

UHID NO: HNH-12139 Surgeon Name: Dr Swapna Kanukula

Anaesthesiologist : Dr Kanna Narayana Operative procedure planned : LSCS

PLEASE READ THIS BEFORE YOU CONSENT FOR ANAESTHESIA

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief without numbness can be achieved by infusing weak solutions of local anesthetics arid narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk (s) : The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

☐ Heart disease ☐ Hypertension ☐ Diabetes mellitus ☐ Renal failure

☐ Hepatic disorders ☐ Shock ☐ Multiple organ failure ☐ Polytrauma / Renal Tubular Aacidosis

☐ Incapacitating Cronic Obstructive Pulmonary Disease ☑ Others : Breeding / Aspiration explained

- Doctor to document in medical record also if necessary (Cross-out if not applicable)

DECLARATION BY PATIENT / GUARDIAN / PROXY

I hereby authorize Rainbow Hospital & its authorized doctors to perform upon me / my patient the above mentioned operation / Diagnostic / Therapeutic procedures.

I authorize and give consent for anaesthesia (☐ Regional / ☐ General Anesthesia / ☐ Monitored Anesthesia Care as considered appropriate by the anaesthesia team.

I acknowledge that the anaesthetists have informed me about the anaesthetic procedure, risk, benefits and alternative treatments and answered my specific queries and concerns about this matter. I have read and understood the information provided in this form I acknowledge that I have discussed with the anaesthetists any significant risk and Complications specific to my individual circumstances, and I have considered them before Consenting for anesthesia.

I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, asthmatic reactions, headaches.

I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Pressure line, arterial line, use of nerve blocks for pain relief, changing from regional to general anaesthesia etc), which are considered necessary by them during the course of surgery.

That I authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter in need arises.

I understand that the above mentioned consultant anesthesiologist or occasionally a colleague deputed by him / her will administer the Anaesthesia.

I have been explained all my queries in the language understood by me.

Patient / Patient Attendant :

Signature : A. Aravinda

Name : .....

Relationship with Patient: .....

Date & Time : .....

Witness :

Signature : .....

Name : P.V.R Goutham

Date & Time : 20/07/26 12:57pm

Doctor (who is taking the consent) :

Signature : .....

Name : Dr. Kanna Narayana

Date & Time : 20/7 at 1pm.

Docu. No. : RCH / FRM / CLINICAL / 021

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs Alur Aravinda Gender: ☐ Male ☐ Female Age : 27yr.

UHID No : HNH-00012139 Date : 20/7/26

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

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

Emergency Lower Segment Cesarean Section

upon

Mrs Alur Aravinda. (Name of the Patient)

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

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

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

Excessive bleeding, infection, injury to adjacent organs like bladder, bowel, blood vessel, Need for blood transfusion

My signature on this form indicates that

1. I have read and understood the information provided in this form
2. My doctor had adequately explained to me the operation or procedure along with the complications written above, along with the risks, benefits and other information.
3. I have had a chance to ask my surgeon questions.
4. I have received all the information I desire concerning the operation or procedure and
5. I authorize the consent to the performance of the operation or procedure.

Name of the Doctor who is performing the Surgery / Procedure: Dr. Swathi HV.

Consentee :

Signature : A. Aravinda

Name :

Date & Time : 20/7/26 @ 11.30Am

Patient Attendant :

Signature :

Name : Leelavathi

Relationship with Patient: Mother

Date & Time : 20/7/26 @ 11.30Am

Witness :

Signature : Madhumita

Name : Madhu

Date & Time : 20/7/26

Doctor (who is taking the consent) :

Signature :

Name : Dr. DNA

Date & Time : 20/7/26 11.30Am

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Mrs. Arthur Aravinda Age: 27y Sex: Female UHID.No: HNH-12139

Date: 20/7 Time: 1230pm Proposed Operation: LSCS

Diagnosis: primi c̄ TG on IOL.

B.P / CRT: .... H.R: .... Weight: 86 ASA Physical Status: ☐ 1 ☑ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

19/7 Hgb: 12.2	Glucose:	Protein:	HIV: NR	X-Ray:
PCV: 36.1	Urea:	Alb:	HBS Ag: NR	ECG:
WBC: 12500	Creat:	Total Bill:	HCV: NR	2D Echo:
Plate: 2.09	Na:	Dir. Bill:	Blood group: O positive	Stress/Anglo:
PT:	K:	LDH:	T3	Other:
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: NKDA.

Medical History: CVS: /

RESP: No significant medical history. Diabetes:

CNS: Regular ANCs - uneventful

Renal:

Hepatic / GE: Physical Activity: active, NYHA - I.

Others:

Past Anaesthetic History: nil.

Physical Exam: coherent

Airway: MP 1 (2) 3 4 Mouth Opening: adq Mentohyoid Distance: 3FB Neck: (N) Teeth: intact.

Lungs: / clear

Heart:

CNS:

Pregnant: ☑ Yes ☐ No ☐ NA | Venous Access Site: peripheral Spine Exam for regional: midline deep.

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

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

CURRENT MEDICATIONS	DOSAGE
Fe/Ca	

Pre-Operative Instructions: Breakfast

1. DVT Prophylaxis :
2. NIL ORAL → Water / ORS 2 Hours; → Others 6 Hours
3. Informed Consent: ☑ Standard ☐ High Risk
4. Post Operative Pain Management: ☑ Discussed with Patient
5. Other Instructions:

Signature: [signature] Name: Dr. Sanni Enayath

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

HNH-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 26 D (F)
Dr. SWATHI H V

ANAESTHESIA CHART

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Pre Induction Assessment:

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

H.R: 96/min | B.P / CRT: 120/70 mm Hg | SpO_2: 98% on RA | R.R: 18/min | Last Feed: >6 hr

Pre-OP Diagnosis: Preinition TG | Operation: Emergency LSCS | Date: 20/7/26

Surgeon: Dr. Swathi, Dr. Rua | Anaesthesiologist: Dr. Ayesha | Technician: Saravathi

TIME	1:45	1:55	2:05	2:15	2:30	2:45
N_2O /AIR /O_2 LPM						
HALO /SO /SEVO						
Drugs:						
1g OXYTOCIN 3IU IV						
1g OXYTOCIN 9IU IV in 500ml RL						
FIO_2 / SaO_2	100/100	100/100	100/100	100/100	100/100	100/100
$ETCO_2$						
ECG	SR	SR	SR	SR	SR	SR
Temperature		36.4°C				
Urine Output 100ml						
Fluids / Blood 2 ORL						

Antibiotic

Suppository: DICLOFENAC 100mg PR, TRANADOL 100mg PR

Blood Loss 300ml

NOTES

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

Tourniquet on Time
Tourniquet off Time

Throat Pack In
Throat Pack Out

240 220 200 180 160 140 120 100 80 60 40 20 10 0

LAB Values: ABG | GRBS | Others

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

Position: .....
☑ Pressure Points Checked

Eye Care:
☐ Oint
☐ Tape
☐ Padding
☑ Awake

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

Times:
Anaes Start: 1:45pm
OP Start: 1:52pm
OP End: 2:40pm
Leave OR: 2:45pm

Anaesthesia:
☐ GA
☐ Monitored Anaesthesia Care
☑ Regional

Line (Size & Location)
☐ CVP: .....
☐ ART: .....
☑ IV: 18G
☐ IV: .....
☐ IV: .....

Induction
☐ IV ☐ Inhal
☐ Pre O_2 ☐ RSI
☐ Others

☐ Mask ☐ SGA
☐ Airway ☐ Oral ☐ Nasal
ETT# ..... at ..... cm
☐ Oral ☐ Nasal ☐ Cuff
☐ Tracheostomy ☐ Topical
☐ Drug: .....

☐ Awake ☐ Direct Vision
☐ Video Laryngoscopy ☐ Stylette / Bougie
☐ Fiberoptic
Blade# ..... Attempts: .....
Difficulty Why? .....

☐ **Bilat = BS**
☐ Semi-Closed Circle
☐ Closed Circle
☐ Other

Regional:
Extremity Specify: SAB
☑ Spinal ☐ Epidural ☐ Caudal
Others: .....
Position: Sitting
Site: L3-L4
Needle Size 24G PP Depth: .....
Parasthesia ☐ Yes ☑ No
Catheter at skin ..... cm
Drug Name & Conc: 0.5% Heavy Bupivacaine
Bolus: 2ml + 25mcg Fentanyl
Infusion: .....
Block Level: T4 - T6
Comments: .....

Transportation to
☐ PACU ☐ ICU ☐ Other
Relaxant Reversed ☐ Yes ☐ No ☐ NA
Name of the Doctor Dr. Ayesha
Signature of the Doctor .....

HNH-00012139 IP26-00006885
Mrs ALUR ARAVINDA
24-05-1999 27 Y 1 M 26 D (F)
Dr. SWATHI H V

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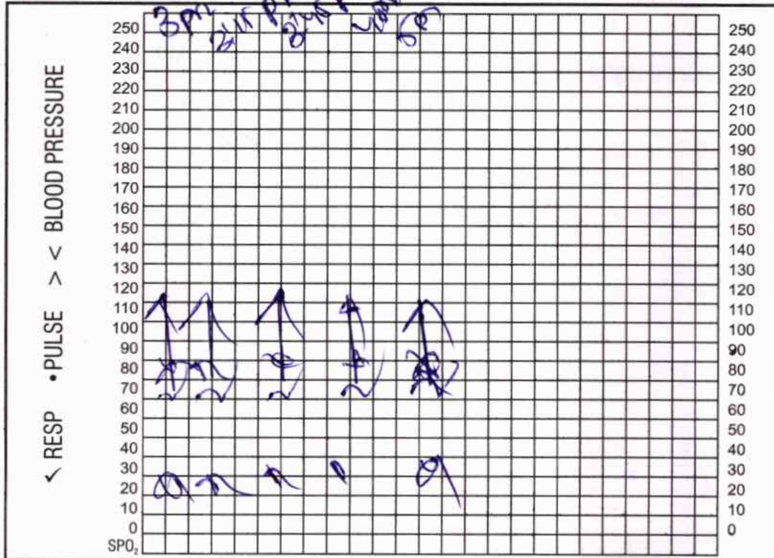
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Alai Time Received : 3:00 pm Time Discharged : ....



IV Cannula Site : Left hand

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

Vomiting : ☐ Yes ☐ No Drug: ....
NG Tube : ☐ Yes ☐ No
Drain: ☐ Yes ☐ No
Urinary Catheter: ☐ Yes ☐ No
Chest Tube: ☐ Yes ☐ No
Nil Oral ☐ Yes ☐ No

IV Fluids: RL
Oral Feeds: NBM

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES 30	60	90	OUT
Able to move 4 extremities voluntary or on command = 2 Able to move 2 extremities voluntary or on command = 1 Able to move 0 extremities voluntary or on command = 0		ACTIVITY	1	1	2	2	
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0		RESPIRATION	2	2	2	2	
BP ± 20 of Pre Anaesthetic leve = 2 BP ± 20-50 of Pre Anaesthetic leve = 1 BP ± 50 of Pre Anaesthetic leve = 0		CIRCULATION	2	2	2	2	
Fully awake = 2 Arousable on calling = 1 Not responding = 0		CONSCIOUSNESS	2	2	2	2	
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0		COLOR	2	2	2	2	
		TOTAL	9	9	10	10	

SCORING INTERPRETATION

A Minimum Total Score of 8 is Required for Discharge

Exceptions to this, are to be explained in the space below by the Discharging Physician:

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
20/7/26	3:00pm	0/10	Normal	[signature]
20/7/26	4:00pm	0/10	Normal	[signature]
20/7/26	5:00pm	0/10	Normal	[signature]
20/7/26	6pm	0/10	Normal	[signature]

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

Anaesthesiologist Name : [signature]
Anaesthesiologist Signature: [signature]
Date & Time: 20/7/2026 7:00pm

PACU Nurse Name : Alai
PACU Nurse Signature: [signature]
Date & Time: 20/7/2026 7:00pm

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

Transferred to Unit by (PACU): ....
Date & Time: 20/7/2026 7:00pm

Patient Sticker

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Department of Anaesthesiology

EPIDURAL ANALGESIA RECORD

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

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

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

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

Solution Composition : .....

Any other issues :

a) .....

b) .....

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

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

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

Patient Satisfaction : .....

Discharge /Shifting ordered by

Doctor Signature: .....

Doctor Name: .....

Date and Time : .....

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INDUCTION OF LABOR CONSENT

Name: MRS. ALUR ARAVINDA Age: 27YRS Gender: Male ☐ Female ☑

UHID.No : HNH - 00012139. Date: 19/07/2026

You are scheduled for an induction of labor on 19/07/2026 (date) at 38w 6days (weeks of gestation).

The reason for your induction is Term gestation.

The goal of induction of labor is to achieve vaginal delivery by starting uterine contractions before the spontaneous start of labor.

Induction of labor for a medical indication is done when continuation of pregnancy is considered detrimental to the health of the mother or fetus. This can be done at any stage of pregnancy irrespective of fetal maturity if there is a valid indication.

Elective induction of labor (scheduled induction without a medical indication) may not be done until you are at least 39 weeks. This is important so that your newborn does not have complications due to possible prematurity.

The alternative to induction of labor is to wait for labor to start spontaneously.

I have read the information provided and also discussed the process with my doctor.

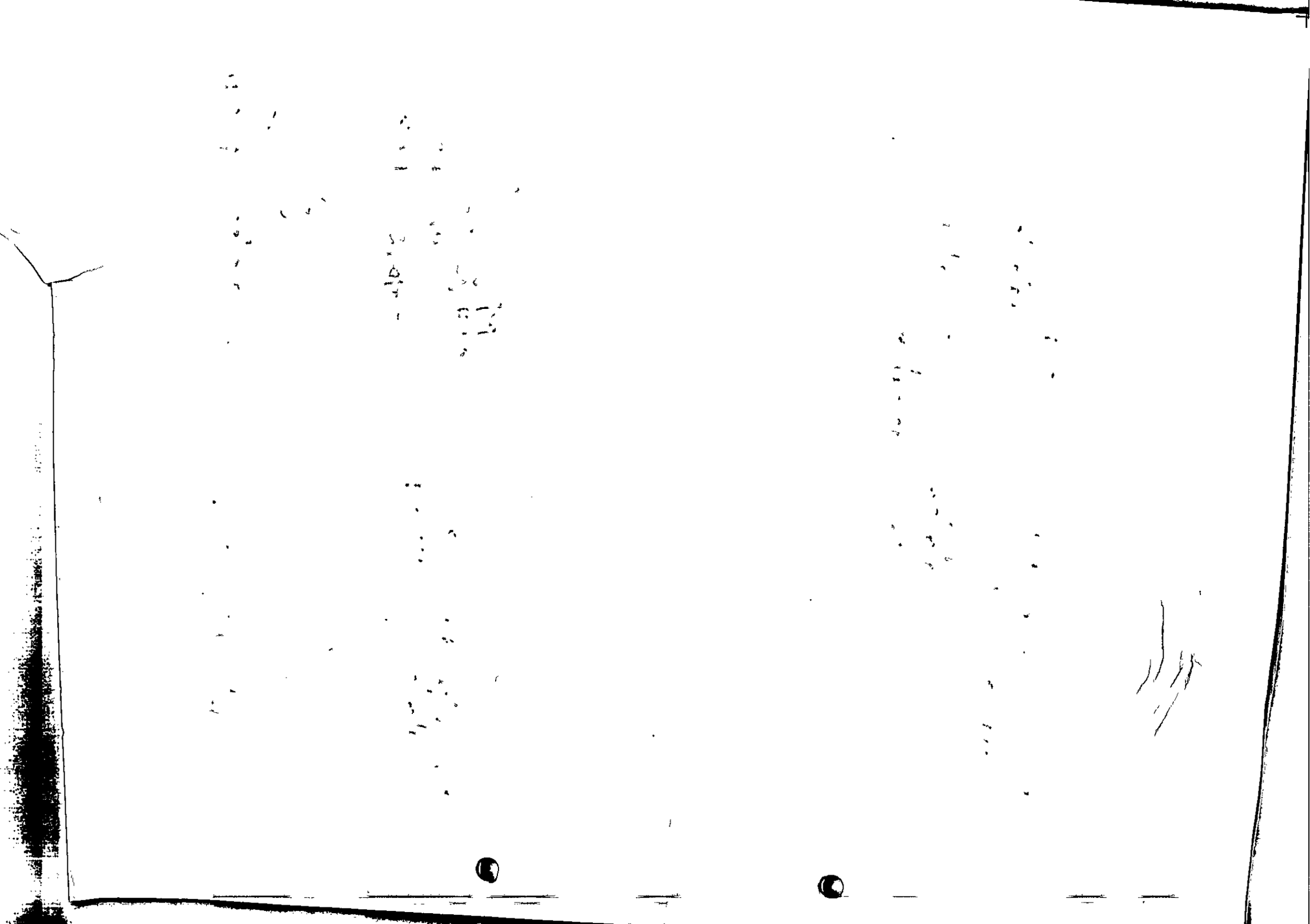
I understand the risks and benefits of this procedure and wish to proceed.

Patient
Signature: A. Aravinda
Name: MRS. Alur Aravinda.
Date & Time: 19/07/2026 @ 11:07pm.

Patient Attendant:
Signature: P L P Goutham
Name: P L P GOUTHAM
Relationship with Patient: HUSBAND
Date & Time: 19/07/26 @ 11:07pm

Doctor:
Signature:
Name: Dr. Naveena.
Date & Time: 19/7/2026 @ 11:07pm.

Witness
Signature: Sri
Name: Srijathan
Date & Time: 19/7/26 @ 11:07pm



INFORMED CONSENT FOR VAGINAL BIRTH

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Patient Name : MRS. ALUR ARAVINDA UHID No : HNH -00012139

Gender: ☐ Male ☑ Female Date : 19/07/2026 Time : 11:00pm

I hereby authorized the performance of the following procedure:

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

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

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

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

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

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

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

Name of the Doctor performing the procedure: Dr. Swathi HV.

Consentee :

Signature : A. Aravinda

Name : MRS. Alur Aravinda.

Date & Time : 19/07/2026 11:08pm.

Patient Attendant :

Signature :

Name : P.L.P GOUTHAM

Relationship with Patient: HUSBAND

Date & Time : 19/07/26 → 23:08 IST

Witness :

Signature :

Name : Swatha

Date & Time : 19/7/26 @ 11:08PM

Doctor (who is taking the consent) :

Signature :

Name : Dr. Naveena.

Date & Time : 19/7/2026 @ 11:08pm.

26-0000215338.

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NARCOTIC PRESCRIPTION FORM
(PATIENT COPY)

Patient Name:	Mrs. Aleti Aravinda	Age:	27 Yrs	Gender:	Female
UHID No:	HIDH-00012139	IP No:	26-00006885	Date:	20/7/26 Time: 12:07 pm
Diagnosis:	EM LSCS				OT

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	01
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: DR AMIT

Doctor Registration No: 67529

Signature:

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 26-00006885 **Date:** 20/7/26

Aadhaar No. of the Patient (Optional): .....

		Remarks
1.	**Name :** Mrs. Aleti Aravinda	
2.	Complete postal address (with contact number, if any)	Nallakunta Hyderabad
3.	Brief description of the illness	EM LSCS
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	No
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
20/7/26	Fentanyl	01		

Dispensed by (Name & ID No.): Sania 018042 Signature: Sania

Received by (Name & ID No.): U. Pallavi 017921 Signature: U. Pallavi

Time: .....

#26-0000215338.

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name: Mrs Aleer Aravinda		Age: 27yrs		Gender: Female	
UHID No: HNH 10012139	IP No: 26-0000 6885	Date: 20/7/26		Time: 12:07pm	
Diagnosis: EM LSCS					OT

PRESCRIPTION DETAILS (Tick only one of the following)

S.No	Drug Name	Dosage	Remarks
1.	Fentanyl Citrate Inj. 50mcg/Ml	100mcg	01
2.	Morphine Sulphate Inj. 15mg/Ml		
3.	Remifentanil Hydrochloride Inj. 2MG		
4.	Remifentanil Hydrochloride inj. 1MG		

Doctor Name: Dr Amir

Doctor Registration No: 67579

Signature: [signature]

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO. 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: 26-0000 6885

Date: 20/7/26

Aadhaar No. of the Patient (Optional): ....

1.	**Name :** Mrs. Aleer Aravinda	**Remarks**
2.	Complete postal address (with contact number, if any)	Nallakunta Hyderabad
3.	Brief description of the illness	EMLSCS
4.	Whether registered with any other registered medical practioner / recognized medical institution (If yes, details of the recorded)	No
5.	Details of essential Narcotic drug dispensed	Fentanyl

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any
20-7-26	Fentanyl	01	[signature]	

Dispensed by (Name & ID No.): Sania 018442 Signature: Sania

Received by (Name & ID No.): U. Pallavi 017921 Signature: U. Pallavi

Time: ....

Docu. No: RCH / FRM / CLINICAL / 133

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NARCOTIC PRESCRIPTION FORM
(MEDICAL RECORD)

Patient Name	Age		Gender
UHID No.	IP No.	Date	Time
Diagnosis			

PRESCRIPTION DETAILS (Tick only one drug mentioned)

S.No	Drug Name	Dosage	Remarks
1	Fentanyl Citrate Inj 50mcg/ml		
2	Morphine Sulphate Inj 15mg/ml		
3	Pentazocine Hydrochloride Inj 2MG		
4	Pentazocine Hydrochloride Inj 1MG		

Doctor Name

Signature

NARCOTIC DISPENSING FORM
APPENDIX 4 – FORM NO 3E
(Details of the Patient to whom Essential Narcotic Drugs Dispensed)

IP Registration No: Date:

Address of the Patient (Octroi/Ph.No.):

S.No	Name	Remarks
2	Complete postal address (with contact number, if any)	
3	Brief description of the illness	
4	Whether registered with any other registered medical practitioner / recognized medical institution (If yes, details of the same)	
5	Details of essential Narcotic drug dispensed	

Date	Name of the Essential Narcotic Drugs	Quantity	Signature / Thumb Impression of the patient / Patient Attender	Remarks, if any

Dispensed by (Name & ID No.): Signature

Received by (Name & ID No.): Signature

Time:

Cost to RCH – Rs. 100/-