HNH-00016400 IP26-00006924
Mrs VADHAR VIBHA VIRESH KUMAR
23-12-1957 68 Y 6 M 30 D (F)
Dr. KADIYALA RAMYA THEJA

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SURGERY DETAILS

Date : 23/7/26

Patient Name: Mrs. Vadhar Vibha Viresh Kumar Date of Birth: 23/12/1957 Age: 66Y2S

Gender: female Ward : OT UHID No.: HNH-00016400

Date of Surgery: 23/7/26 ☐ OT -1 ☐ OT -2 ☐ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : Bartholins Abscess I&D + Cyst wall Excision.

Time in : 10:15am Time Out : 12pm

		NAME	AMOUNT
1.	Surgeon	Dr. Ramya theja / Dr. Swathi	
2.	Anaesthetist	Dr. Samir / Dr. Aditi	
3.	Assistant Surgeon	Dr.	
4.	OT Technician	Sr. Saraswathi	
5.	Circulating Nurse	Sr. Puja	
6.	Assistant Nurse	Sr. Sushoola	

Mrs VADHAR VIBHA VIRESH KUMAR (68 Y 6 M 30 D/ F)
OTHERS
NINV04329
HN26012378032

Mrs VADHAR VIBHA VIRESH KUMAR (68 Y 6 M 30 D/ F)
TISSUE
NINV01054
HN26012377020

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

Signature of the Surgeon

Puja.
Signature of Circulating Nurse

Order No: 26-00021627 Order by: Sushoola 23/7/26 @ 2.18pm

HNH-00016400 IP26-00006924
Mrs VADHAR VIBHA VIRESH KUMAR
23-12-1957 68 Y 6 M 30 D (F)
Dr. KADIYALA RAMYA THEJA

I&D .

CONSUMABLES OF OT

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Circulating staff : Puja Technician : Saraswathi Date : 23/7/2026 Time :

Anaesthesia Disposables	Qty Issued	Qty Used	Surgical Disposables	Qty Issued	Qty Used	Disposables (Baby Side)	Qty Issued	Qty Used
ET tube			~~Major~~ Pack General		01	Inj Vit.K		
LMA			Sutures 2317, 2762	✓+	1	Cord Clamp		
ECG leads (A) / P / N		03				Suction Catheter		
HME filter : A / P / N						Feeding Tube		
Syringes : 10 cc	✓+	02				Vaccum Suction Set		
05 cc		03	Gloves 6 1/2		02	Surgical Gloves		
02 cc		03	Encore 6 1/2		02	Gauze Pack		
01 cc						Syringe 1ml / 2ml		
Cautery plate (A) / P / N		01	Surgical blade 15	✓	[illegible]	Surgical Blade # 20		
~~IV set~~ PCM		01	NG tube			Koochies (S)		
RL		01	Cautery pencil		1	Corrugated drain	01	
NS : 10ml / 100ml ✓ / 500ml / 1000ml ✓	✓+	1	Koochies			Sheet		
Tranexa		02	Ointments			D-water		02
Metrogel		01	Suction Catheter	01+	10?	Botroclot		01
Fentanyl			Cap, Mask	40+	10			
Morphine			Gauze Pack 7.5, 10x10	03+	02			
Ketamine			Mop Pack		01			
Propofol			Steristrip					
Rocuronium			Underpad		01			
Glycopyrolate			Draw sheet					
Myopyrolate			Abgel					
Ondansetron		01	Foleys catheter 14no		1			
Pencan 25g/ Spinal Needle ~~22~~ 25		01	Urobag		1			
Bupivacaine 0.25%			Chest Drainage Catheter					
Anawin ~~Bupivacaine~~ 0.25%(Heavy)		01	Romodrain bag					
Antibiotics			Bandage					
Spinal long needle 25		01	Tegaderm 8582		01			
Suppositories			Ioban					
Anamol : 80mg / 250mg / 170 mg			Double J Stent					
Supridol : 100mg			Vaccum Suction set		01			
Justin : 12.5 mg / 25mg / 100mg			Plastic Bed Sheet Aprons		4			
Tab. Misoprost : 200mg			Betadine Solution		02			
Encore 7.5		01	Microshield		02			
critidal (10-00082442)		01	Cotton Balls		01			
			Latex Gloves		10			
			Ramdione Scrub					
			~~Saral~~ Lox jelly		01			

Surgeon Anaesthesiologist Nurse OT Technician

Order No. : 26-0000216278 - 277 Ordered by : Archana 23/7/26 @ 14:58 pm

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-00016400	**Name**	: Mrs VADHAR VIBHA VIRESH KUMAR
Age / Sex	: 68 Y 6 M 30 D / Female	**Doctor**	: KADIYALA RAMYA THEJA
Adm/Reg Date/Time	: 23/07/2026 09:30	**Payor**	: SELFPAY
Order Date	: 23/07/2026 14:57	**Ordernumber**	: 26-0000218278
Visit ID	: IP26-00006924	**Ward/Bed No**	: 4F -OT / PPO-419
Patient Address	: HNO:4-1-10,C/2,GROUND FLOOR ,PRAGATI SOCIETY ,TILAK ROAD, Ramkote, Hyderabad, Telangana, INDIA, 500001		

S.No	Description	Generic Name	Dosage	Route / Frequency	Duration	Instruction	Qty	Status
1	SPINAL NEEDLE 25	SPINAL NEEDLE 25G	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
2	DSYRINGE 10ML (NIPRO)	SYRINGE 10ML	1 Nos	External / Once Daily	1 Days		5 Nos	Ordered
3	PREGELLED SURGICAL PLATES(ADULT)	PREGELLED PLATED ADULT	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
4	E.C.G ELECTRODES (ADULT)	ELECTRODES ADULT	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
5	CAUTERY PENCIL (ADVANCE)		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
6	RL 500 ML CLOSED SYSTEM	RINGER LACTATE 500ML CLOSED	1 Bottle	/ Once Daily	1 Days		1 Bottle	Ordered
7	GAUZE PACK STERILE 10X10X12 PLY 5S	GAUZE PACK STERILE 10X10X12 PLY 5 PACK	1 Nos	External / Once Daily	1 Days		2 Nos	Ordered
8	BIOXALIC 500 MG INJ		1 Ampule	External / Once Daily	1 Days		1 Ampule	Ordered
9	VICRYL 2-0 VP 2317	VICRYL 2-0 VP 2317	1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
10	RELIPARA(PARACETAMOL) 1000MG 100ML BOTTLE		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
11	Encore Micropic gloves-6.5		1 Nos	/ Once Daily	1 Days		2 Nos	Ordered
12	SGLOVE # 6.5 (SURGICARE)	SURGICAL GLOVES 6.5	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
13	VICRYL 2-0 NW 2762	VICRYL 2-0 NW 2762	1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
14	ENCORE MICROPTIC GLOVES-7.5 PF		1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
15	COTTON BALLS 2 GM 5 NOS		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
16	NS 100ML ACCULIFE - EH	NORMAL SALINE 0.9% SODIUMCHLORIDE100ML CLO	1 mL	/ Once Daily	1 Days		1 mL	Ordered
17	THEMICAINE 30GM JELLY		1 On Application	/ Once Daily	1 Days		1 Nos	Ordered
18	MOPS 30X30 8PLY SS X-RAY	MOPS 30X30 8 PLYDATT	1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
19	VACCUME SUCTION SET		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
20	CRITIDOL INJ 50 MG 1 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Ordered
21	ACUGYL 500MG INJ		1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
22	NS 1000 ML ACCULIFE-EH		1 mL	External / 10 AM	1 Days		1 mL	Ordered
23	CORRUGATED DRAINAGE SHEET 250*25 MM-D	CORRUGATED DRAINAGE SHEET 250*25 MM-D	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
24	POVINANZ SOLUTION 10% 100 ML		1 Nos	External / Once Daily	1 Days		2 Nos	Ordered
25	DSYRINGS 2.5ML(NIPRO)	SYRINGE 2ML	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
26	GENERAL SURGERY KIT SAFE SECURE		1 Nos	External / 10 AM	1 Days		1 Nos	Ordered
27	DSYRINGE 5ML.(NIPRO)	SYRINGE 5ML	1 Nos	External / Once Daily	1 Days		3 Nos	Ordered
28	ANAWIN HEAVY 5 MG INJ 4 ML		1 Vial	External / Once Daily	1 Days		1 Vial	Ordered
29	BACTOPREP SOLUTIONS 100 ML		1 mL	/ Once Daily	2 Days		2 Nos	Ordered
30	SPINAL 25 G 30MM 5150.35		1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
31	UNDER PAD 60X90 10's Pack - MEDICUBE		1 Nos	External / 10 AM	1 Days		1 Nos	Ordered
32	SURGICAL BLADE 15	SURGICAL BLADE 15	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
33	TEGADERM WITH PAD 5X7CMS (3562#8582)	TEGADERM 8582	1 Nos	External / Once Daily	1 Days		1 Nos	Ordered
34	FOLEYS CATHETER 14FR POLYMED		1 Nos	/ Once Daily	1 Days		1 Nos	Ordered
35	ONDOKIND INJ 4 MG 2 ML		1 Nos	/ Once Daily	1 Days		1 Vial	Ordered

KADIYALA RAMYA THEJA

Reg No : TSMC/FMR/01458

* 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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Name	Mrs VADHAR VIBHA VIRESH KUMAR	**UHID**	HNH-00016400
Father/Guardian	Mr VADHAR VIRESH KUMAR	**Age/Gender**	68 Y 6 M 30 D/ Female
Address	HNO:4-1-10,C/2,GROUND FLOOR ,PRAGATI SOCIETY ,TILAK ROAD, Ramkote, Hyderabad, Telangana, INDIA, 500001		
IP No	IP26-00006924	**Admission Date**	23-07-2026
Ref Doctor	Self.		
Discharge Date	23.07.2026		

DISCHARGE SUMMARY

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

Diagnosis: RIGHT BARTHOLIN ABSCESS

INCISION AND DRAINAGE DONE ON 23.07.2026

History: She came with complaints of painful swelling around vagina since 2 months gradually increased in size. No complaints of fever , was on antibiotics since 15 days back. She was admitted for Incision and drainage.

Menstrual History:-
Attained Menopause at 40 years of age
Previous cycles: Regular

Obstetric History: P2L2 ,2 LSCS , LCB- 33yrs
Medical History: OSA , Hypothyroid since 5 years, morbid obesity, HTN since

Name	Mrs VADHAR VIBHA VIRESH KUMAR	**UHID**	HNH-00016400
IP No	IP26-00006924	**Admission Date**	23-07-2026

31years **Surgical History:** 2LSCS , Anal fissure surgery 15 years back .
Family History: Mother-HTN .
Allergies: Nil

Investigations: Enclosed.
Blood group: "O" Positive

Surgery Notes:
Operation performed: INCISION AND DRAINAGE + CYST WALL EXCISION.
Indication: RIGHT BARTHOLIN ABSCESS

Operative findings:
- Bartholin abscess 3x3cm, noted in lower 3rd of vagina in right lateral wall.
- Incision and drainage done .
- Cyst wall separated from surrounding tissue and excised. Hemostasis secured.

Post-Operative Notes: She was closely monitored in the postoperative period. Her vital signs remained stable. She was encouraged to ambulate and void spontaneously. Her general condition was satisfactory and she was found to be fit for discharge. Medications were explained to the patient supplemented by written information.

Advice:
1. Tab.AUGMENTIN 1gm twice daily till 29.07.26 (9am - 9pm) after food.
2. Tab. Calpol 500mg (Paracetamol 500mg) (2tabs)thrice daily till 27.07.26 (7am-3pm-10pm) after food.
3. Tab. Pantodac 40 mg (Pantoprazole 40mg) once daily (7am) before food till

Name	Mrs VADHAR VIBHA VIRESH KUMAR	**UHID**	HNH-00016400
IP No	IP26-00006924	**Admission Date**	23-07-2026

4. Tab. Zincovit once daily (2pm) for 1 month after food.
5. Perineal hygiene,
6. Drain to be removed after 1 week (30.07.2026)

Review with **Dr. RAMYA,** on **25.07.2026** at 6 pm -7 pm at Rainbow Children's Hospital for dressing with prior appointment **(Review consultation will be charged).**

Review with **Dr. SWATHI H V,** on **26.07.2026** at 10 am -11am at Rainbow Children's Hospital for dressing with prior appointment **(Review consultation will be charged).**

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

Patient/ Attender

In case of emergency like bleeding, fever kindly contact 9154865045 at Rainbow Children's Hospital just dial one toll free number - 18002122. You can also take appointments at any time by going online to our website **www.rainbowhospitals.in**

Registrar/Resident/C.M.O

RAINBOW CHILDREN'S MEDICARE LIMITED HYDERABAD

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

HNH-00016400 IP26-00006924
Mrs VADHAR VIBHA VIRESH KUMAR
23-12-1957 68 Y 6 M 30 D (F)
Dr. KADIYALA RAMYA THEJA

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DEFICIENCY CHECK LIST OF CASE SHEET

Sl.No.	List of Records	No. of Pages	Legibility	Completeness	Remarks
1	Admission sheet				
2	Discharge Summary				
3	Nursing Initial assessment	02			
4	Patient Transfer form	02			
5	In-patient Medical record	02			
6	Doctors progress sheets	02			
7	Nursing plan of care and handover sheets	01			
8	Consultation sheet	01			
9	General consent for treatment	01			
10	Consent for Surgery	01			
11	Consent for blood transfusion	-			
12	Consent for chemotherapy	-			
13	Consent for high risk	-			
14	Consent for Restraint	-			
15	LAMA consent	-			
16	Consent for special procedure / Sedation	01			
17	Consent for Formula feed	-			
18	Consent for MTP	-			
19	Consent for Radiological Investigations	-			
20	Consent for HIV test	-			
21	Anaestesia notes (Pre Anaesthesia& post)	01			
22	Neonatal Admission/Delivery/Physical Exam	-			
23	Medication Reconciliation	01			
24	Emergency Triage record	-			
25	Pre operative check list	01			
26	Surgical safety checklist	01			
27	Operation Theatre notes	01			
28	Nurses clinical Presentation	01			
29	TPR & BP chart	-			
30	Intake and Out take chart (fluid chart)	01			
31	Drug chart (Regular Prescription)	01			
32	Investigation Values (result sheet)	01			
33	Nebulization chart	-			
34	Nutritional review chart	-			
35	Intensive care unit (ICU Charts)	-			
36	Consent for Admission in PICU / NICU	-			
37	The Humpty dumpty scale	-			
38	Braden Q Scale	01			
39	Bed side check list				
40	PICU bed formula Dilution feeds	-			
41	Gastro monitoring chart	-			
42	Rch ED doctors note	-			
43	BP Monitoring chart	-			
44	RBS monitoring chart	-			
	Extra Pages	07			
	Total No. of Pages	30			

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

Signature and Date : AKW 23/1/26

(P.T.O)

ERROR LOG

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

OBSERVATION :

DATE :

SIGNATURE OF MRD INCHARGE / EXECUTIVE

Rainbow Children's Hospital

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

ADMISSION SHEET

Registration Details :

Admission No : IP26-00006924 **Admit Date** : 23-Jul-2026 **Admit Time** : 09:30 AM **UHID** : HNH-00016400

Patient Details :

Patient Name	: Mrs VADHAR VIBHA VIRESH KUMAR	**Age**	: 68 Y 6 M 30 D
Guardian	Mr VADHAR VIRESH KUMAR	**DOB**	: 23-12-1957
Gender	: Female	**Religion**	:
Occupation		**Martial Status**	:
Address (H)	HNO:4-1-10,C/2,GROUND FLOOR ,PRAGATI SOCIETY ,TILAK ROAD Ramkote Hyderabad Telangana INDIA 500001	**Phone No**	: 9879153610/ 9866254525
		E-mail	: HVADHA1987@GMAIL.COM

Admission Details :

Bed Type : TWIN SHARING **Bed No** : PPO-419 **Ward Name** : 4F -OT

Room No : PPO-419 **Admission Type** : First Visit

Contact Details :

Name : Mr VADHAR VIRESH KUMAR **Relationship** : Husband

Contact Address : HNO:4-1-10,C/2,GROUND FLOOR ,PRAGATI SOCIETY ,TILAK ROAD Ramkote Hyderabad Telangana INDIA 500001 **Phone No** : 9879153610

H.P. Trivedhia
Signature

Doctor Details :

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

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

Co-Consultant : Dr. SWATHI H V

Payment Details :

Payment Mode : DC/CC Card **Deposit Amount** : 40000.00

Payor Name : SELFPAY

PATIENT TRANSFER FORM

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Patient Name & UHID No	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016400 IP26-00006924 Mrs VADHAR VIBHA VIRESH KUMAR 23-12-1957 68 Y 6 M 30 D (F) Dr. KADIYALA RAMYA THEJA	23/7/26 @ 9:30 AM	23/7/26 10 AM
	Transfer Ordered by Dr. Naveena.	Reason for Transfer DOD
From Unit NICU	To Unit OT	Information to Attendant Yes ☐ No ☐
Number of Sheets in Clinical File 35	Number of Imaging Films	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 - 500ml	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. Sis Monica.	DR. Dea.

Patient & Clinical Records Received by : 23/7/26

Date & Time of Patient Received :

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

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

HNH-00016400 IP26-00006924
Mrs VADHAR VIBHA VIRESH KUMAR
23-12-1957 68 Y 6 M 30 D (F)
Dr. KADIYALA RAMYA THEJA

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ACTIVITY RECORD FOR BILLING

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

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

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

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

WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
23/7/26	10 Am	NICU	OT	Mounika/Puja
23/7/26	12.10 pm	OT	MICU	Puja/Mounika

Cross Consultation Visit

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

INVESTIGATIONS

Date	Investigations	Order No.	Sign
23/7/26	CBP	12351 ✓	[illegible]
		Cross checked done	

MEDICAL EQUIPMENT (WARD & ICU)

Date	Name of Equipment	Connecting Time	Disconnecting Time	Order No.	Signature
23/7/26	Cardiac Monitor	12PM	2:30PM	216255 ✓	Anusha
23/7/26	Infusion pump				
					Cross checked done

PROCEEDURE

Date	Proceedure	Quantity	Order No.	Signature
23/7/26	Sv placement →	①	2162[illegible]	Ausha
23/7/26	Catheterisation		216254 ✓	
23/7/26	PAC (OP)	PRS26 000222276	✓	
				Cross checked
				done

ANY OTHER INFORMATION

Date : Time : Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor

HNH-00016400 IP26-00006924
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I.P. ADMISSION SHEET FOR GYNECOLOGY

Date of Admission : 23/7/26. Time of Admission : .....

Allergies: ..... ☑ Not know any drug allergies

PRESENTING COMPLAINTS :

c/o paenful swelling around vagina. : 2 months
gradually increased in size.
No c/o fever. , was on ~~Antibiotics~~ : 10 days back.

MENSTRUAL HISTORY	OBSTETRIC HISTORY
Year of Marriage : 40yrs.	Parity : 2+2
Previous Periods : Menopause 30yrs back	Mode of Delivery : 2 LSCS
LMP :	Last Child Birth : 33yrs.
Contraception :	

PAST MEDICAL HISTORY	PAST SURGICAL HISTORY
OSA Hypothyroid : 5yrs. Morbid Obesity HTN : 31yrs.	2 LSCS Anal fissure surgery.

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Mother - HTN
Nil.

MEDICATION HISTORY:

Tab. Thyroxine - 50mcg
Nil.
T. Cilacheart - T- 10/40mg.

INITIAL ASSESSMENT :

Date 23/7/26.
Ht. _____ Wt. _____
BMI _____
B.P 128/63 mmHg.
Pallor PR: 73 bpm.
CVR (N)
Respiratory System (N)
Thyroid _____

Breasts
Normal

Abdominal Examination
Obese Abdominal wall.

Local/Speculum Examination
UK swelling 2x2x1 cm. noted on Rt labia - Junction of post 1/3rd & ant 2/3rd.

Bimanual Pelvic Examination
Redness (+).
Tenderness (+).

PROVISIONAL DIAGNOSIS : Right BARTHOLIN's ABCess.

INVESTIGATIONS ORDERED	PLAN OF MANAGEMENT
O+ve HbA1c - 6.3 8/7 Hb - 12.1 PCV - 38.6. TLC - 10,200 PLT - 3.3 HIV, HBsAg, HCV] NR.	- Incision & Drainage - NBM - Informed consent - PAC - Parts preparation - Pre Op Medication - Shift to OT on call.

Name of the Doctor : Dr. Swathi Ramya
Dr. Kadiyala Ramya Theja
Consultant Obstetrics and Gynecology
Reg. No. 1158
Signature of Doctor
Date & Time : 23/7/26.

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order
23/7	C/I/B Dr. Mandula	
1pm	POD - 0 / R&D	
	off febrile	Adv
	afebrile	→ NBM till further orders
	PR - 86bpm	→ Drugs as charted
	BP - 105/65mmHg.	→ I/O charting.
	P/A - soft	→ monitor vitals
	U/O - 100ml - 1hr.	→ Syorm SOS.
		Dr. Mandula
23/7/26	C/I/B Dr. Mandula.	
3:30pm	POD-0 / R&D.	
	off febrile	Adv
	afebrile	→ Semi liquid diet
	PR - 88bpm	→ Drugs as charted.
	BP - 112/80mmHg.	→ I/O charting
Pt can be discharged	P/A - soft	→ Corrugated rubber drain similar for 1wk.
	L/E - no bleeding.	→ monitor vital
		→ Syrormus.
	Dr. Kadiyala Ramya Theja Consultant Obstetrics and Gynecology Reg. No: 1458 [signature]	
		Noted by Akhila @ 23/7/26

FO. : RCH /FRM / CLINICAL / 088

Patient Sticker

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PROGRESS NOTES AND DOCTOR'S ORDER

Date & Time	Progress Notes	Doctor's Order

HNH-00016400 IP26-00006924
Mrs VADHAR VIBHA VIRESH KUMAR
23-12-1957 65 Y 6 M 30 D (F)
Dr. KADIYALA RAMYA THEJA

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RESULT SHEET

Date	23/7					
Time	1AM.					
Hb	12.2					
PCV	35.8					
RBC	4.80					
WBC	11.27					
N/L	63.3					
Platelets	350					
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 & otre						
HIV						
HBsAg } NR						
Hcv						

Culture and Sensitivities : .....

.....

.....

.....

Radiology : USG : .....

X-Ray : .....

ECHO : .....

CT : .....

MRI .....

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

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OPERATION NOTES

Surgeon : Dr. Swathi	Asst. Surgeon : Dr. Ramya.

Pre-Operative Diagnosis:

Surgical Procedure : IE & D + - Bartholins. Abcess - Excision

Indications for Surgery : → Bartholins Abcess.

Date : 23/07/2026.	Start Time : 11Am	End Time : 12pm.

Post Operative Diagnosis: -

Peri-Operative Complications: -

Amount of Blood Loss: ~ 100ml	Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:
↳ Bartholins Abcess wall
- pus for c/s

Operation Notes:

→ patient on lithotomy position under SA.
→ parts scrubbed painted & draped
Intraop findings:

- Bartholins Abcess of 3x3cm noted in lower 3rd of vagina in Right lateral wall.

→ Incision & drainage done → haemorrhagic fluid + pus drained out.

→ cyst wall separated from surrounding tissue & excised. Haemostasis secured.

→ cavity closed in layers by Rapid vicryl N 0.2-0

→ ICRT kept inserted into the cavity

→ Procedure uneventful.

Dr. Swathi

Name of the Surgeon: Dr Swathi MN

Signature of the Surgeon: Swathi

Date & Time: 22/08/2026 @ 12:00pm

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Ramya theja
Asst. Surgeon : Dr. Swathi
Anaesthetist : Dr. Aditi
Scrub Nurse : Sr. Sushelka

Patient Name : HNH-00016400 IP26-00006924 Mrs VADHAR VIBHA VIRESH KUMAR 68 Y 6 M 30 D (F) 23-12-1957 Dr. KADIYALA RAMYA THEJA
UHID No. :
Date : 23/4/26

ender :
12 pm

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11 Am

Before Induction of Anaesthesia ➤➤

SIGN IN Time: 11.00

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 : Aditi
Name : DR Aditi P

Before Skin Incision ➤➤

TIME OUT Time: 11:00

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, 1hr. Anticipated Blood Loss? 50ml ☑ Yes ☐ No ☐ NA

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

Nursing Team Reviews: High BMI
- 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 : Puja @ 11:00.
Name :

Before Patient Leaves Operating Room

SIGN OUT Time: 12pm

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 :
Name : DOSWATHI. M.V

PATIENT TRANSFER FORM

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Patient Name & UHID No.	Date & Time of Admission	Date & Time of Transfer Order
HNH-00016400 IP26-00006924 Mrs VADHAR VIBHA VIRESH KUMAR 23-12-1957 68 Y 6 M 30 D (F) Dr. KADIYALA RAMYA THEJA	23/4/26 @ 9:30 am	23/4/26 @ 12:10 pm.
	Transfer Ordered by Dr. samir	Reason for Transfer observation
From Unit OT	To Unit preop ICU	Information to Attendant Yes ☑ No ☐
Number of Sheets in Clinical File - 3½	Number of Imaging Films —	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.	Rt	(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 : Akhila

Date & Time of Patient Received : 23/4/26

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-00016400 IP26-00006924
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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	Thyronorm.	50mcg	PO	OD		☐ C ☐ DC
2	FEBUXOSTAT	40mg	PO	OD.		☐ C ☐ DC
3	CILAHEART.	10/40mg	PO	OD		☐ 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. Dua.

Date & Time : 23/7/2026.

Nurse Name & Signature: ..... Sujatha

Date & Time : 23/7/26 @ 11 A.M.

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

HNH-00016400 IP26-00006924
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DRUG CHART

Date of Admission: 23/7/2026 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 / 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 ....

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REGULAR PRESCRIPTIONS

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

DRUG : AUGMENTIN — Date/Time: 23/7

Dose	Route	Frequency	Start Date
1.2g	IV	TID	23/7/26

Name & Signature of the Doctor Starting the Drugs: Dr. Dna — 10 AM

Additional Instructions: After test dose. — 10 pm

Daily Doctor's Endorsement by a Sign

DRUG : Inj PANTOPRAZOLE — Date/Time:

Dose	Route	Frequency	Start Date
40mg	IV	BD	23/7

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

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : — Date/Time:

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

DRUG : — Date/Time:

Dose	Route	Frequency	Start Date

Name & Signature of the Doctor Starting the Drugs:

Additional Instructions:

Daily Doctor's Endorsement by a Sign

Patient Sticker

Mrs VADHAR MBHA VIRESH KUMAR (F)
99 Y 6 M 30 D
IP26-0000692 4
HNH-0001640 0

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

VARIABLE DOSE	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

VARIABLE DOSE	Date▸ Time		Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route / Start Date		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:		Dose		Dose		Dose		Dose	
		Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

Signature

VERIFIED BY : Name

STAT / ONCE ONLY DRUGS

Date	Time	Medication	Dosage & Other Instructions	Route	Signature	Nurses
23/7	9:40 AM	PANTOPRAZOLE	40mg	IV		MOU M
23/7	9:40 AM	METOCLOPROMIDE	10mg	IV		MOU M
23/7	1030 AM	METRONIDAZOLE	500mg	IV		pujita pujita

23-12-1957
Dr. KADIYALA RAMYA THEJA

I.V. FLUIDS CHART

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

Date	Time	Composition of I.V. Fluid (If infusion, mention ml./hr = Mcg/kg/min. etc)	Route	Flow Rate ml/hr	Doctor Sign	Nurse Sign	Date of Stopping	Doctor Sign	Nurse Sign
23/7	12:20 pm	RINGER LACTATE	IV	100 ml/hr			23/7		

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

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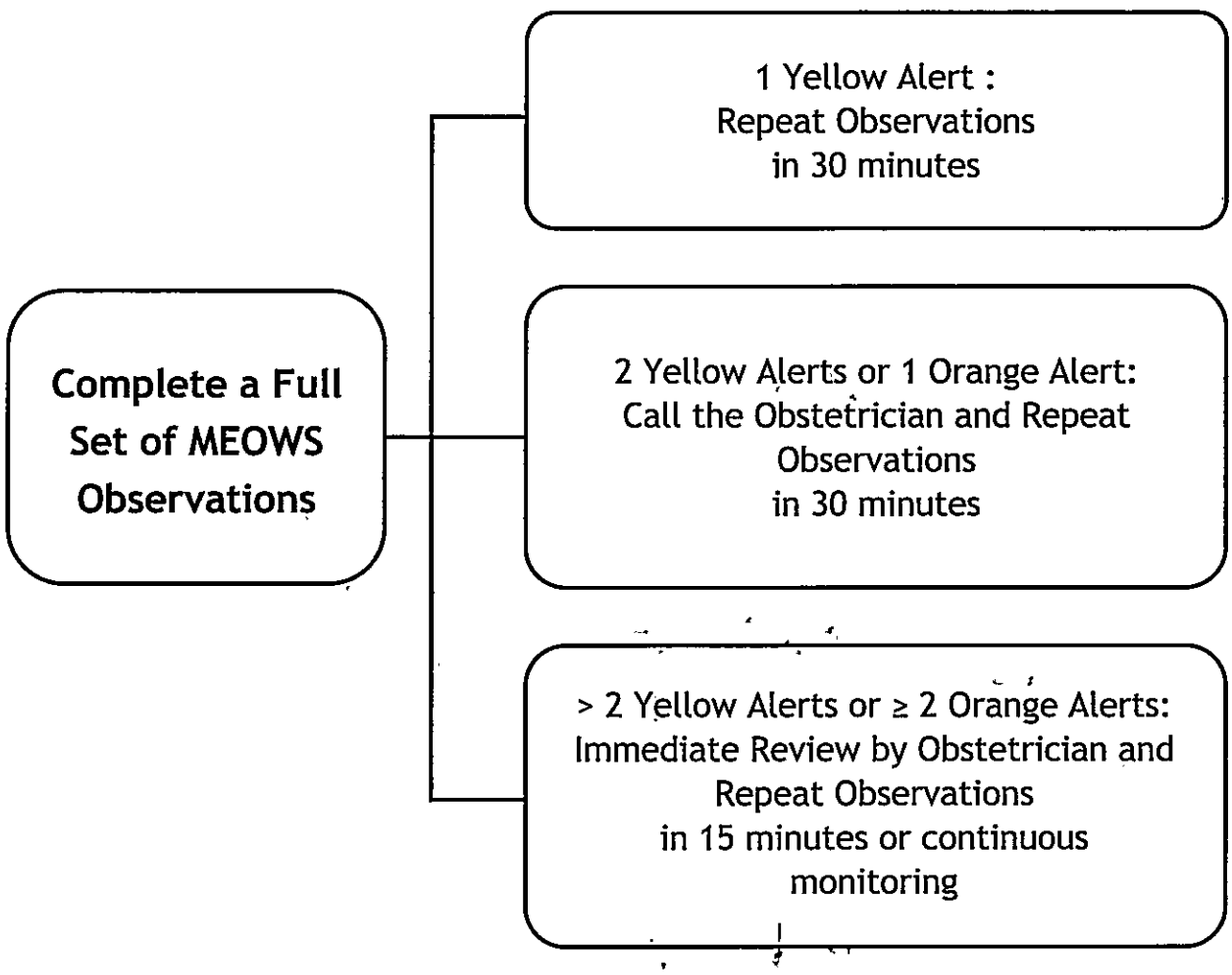
Early Warning Observation Score Chart - Obstetrics

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

		Date																							
		Time	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
RESP (write rate in corresp. box)	> 30																									
	21 - 30																									
	11 - 20	20					20	20	20	20	20															
	0 - 10																									
Saturations	94 - 100 %	on					on	99	on	99	99															
	< 94 %																									
Administered O_2 (L/min.)																										
Temp°c	40																									
	39																									
	38																									
	37																									
	36						36		37		98															
	35																									
	< 35	36																								
Heart Rate	170																									
	160																									
	150																									
	140																									
	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70	75					79	80			85															
	60																									
	50																									
	40																									
Systolic Blood Pressue ↑	190																									
	180																									
	170																									
	160																									
	150																									
	140																									
	130						132	112			110															
	120							116																		
	110	120																								
	100																									
	90																									
	80																									
	70																									
	60																									
	50																									
Diastolic Blood Pressure ↓	130																									
	120																									
	110																									
	100																									
	90																									
	80																									
	70	74					64	74			75															
	60																									
	50																									
	40																									
NEURO RESPONSE [✓]	Alert	—					—	-			-															
	Voice																									
	Pain																									
	Unresponsive																									
URINE mls / hour	> 30	—									-															
	< 30																									
Proteinuria	Protein + +																									
	Protein > + +																									
Lochia	Normal	-									-															
	Heavy / Foul																									
Liquor	Clear / Pink										-															
	Green																									
TOTAL YELLOW SCORES		0				0	1				0															
TOTAL ORANGE SCORES		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. 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							
23/12/25	08:00 am											
	09:00 am	RL		100ml								
	10:00 am	RL	NBM	100ml								
	11:00 am	RL		100ml		NA						
	12:00 pm	RL		100ml						480ml		Priya
	01:00 pm	RL		100ml								
Total Intake :						**Total Output :**						
	02:00 pm	RL	H2O	100ml								
	03:00 pm	RL		100ml								
	04:00 pm	RL	H2O	100ml								
	05:00 pm	RL				NA						Priya
	06:00 pm	RL										
	07:00 pm	RL										
Total Intake :						**Total Output :**						
	08:00 pm											
	09:00 pm											
	10:00 pm				PT DC							
	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	

Patient Sticker

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FLUID CHART

Sheet No. : .....

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

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

Total 24 hrs. Intake		Total 24 hrs. Output	

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OBSTETRICS / GYNECOLOGY
NURSING INITIAL ASSESSMENT FORM

Date of Admission: 23/7/26

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: Vaginal pain
Site pain

Doctor Notified on Admission: ☐ Yes ☐ No

Name of the Doctor: .....

Time Notified: .....

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

Past Medical History	Past Surgical History	Previous Hospital Admission
—	2 LSCS	—

Gynecology Assessment: ☐ Not Applicable

Menstrual History: .....

.....

Onset of Menarche: .....

Menstrual Cycle: ☐ Regular ☐ Irregular

Last Menstrual Period: .....

Gynecology Surgical History:

Caesarean Section: ☑ No ☐ Yes

Cervical Cerclage: ☑ No ☐ Yes

Ectopic Pregnancy: ☑ No ☐ Yes

Myomectomy: ☑ No ☐ Yes

Others: _____

Gynecological History:

Contraceptives: ☑ No ☐ Yes

Vaginal Discharge: ☑ No ☐ Yes

Post-Coital Bleeding: ☑ No ☐ Yes

Infertility: ☑ No ☐ Yes

If Yes Type: ☐ Primary ☐ Secondary

Obstetric History: G ..... P 2 L 2 A .....

Previous LSCS: 2 LSCS

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

Family History: ☐ No Abnormalities Detected

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

☐ Liver disease ☐ Other .....

Vital Signs / Measurements: Temp: 97 HR: 84bpm RR: 18bpm

BP: 110/70 Weight: ..... Height: ..... BMI: .....

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

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PHYSICAL ASSESSMENT

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

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

Name of Person Orientation was given to: ..mrs. Vadhar..

Orientation not given Reason: .....

Nurse Signature: ..Sri..

Nurse Name: ..Sujatha..

Date & Time: ..23/7/26 @ 1PM..

HNH-00016400 IP26-00006924
Mrs VADHAR VIBHA VIRESH KUMAR
23-12-1957 68 Y 6 M 30 D (F)
Dr. KADIYALA RAMYA THEJA

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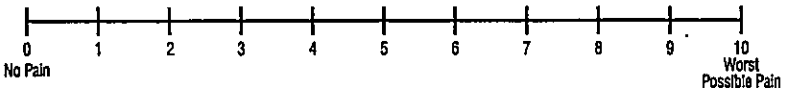
PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
23/7	[illegible]	0/10	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
23/7	2PM	0	NA	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No	NA	[signature]
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

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

PAIN ASSESSMENT TOOLS

Numerical Pain Scale (Obstetric and Gynecology)



Wong - Baker (Pediatrics) Above 7 Years

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

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

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

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

HNH-00016400 IP26-00006924
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Morse Fall Risk Assessment Form

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

Fall Risk Grading

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

Tick (✓) whichever precaution taken.

Risk Level and Interventions

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

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

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

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

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

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

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CHECKLIST FOR THROMBOPHLEBITIS

23/7

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	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	NP	NA								
3	Two of the following Signs are evident: Pain at IV site Redness	Early stage of phlebitis / Resite Cannula	2	NP	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	NP	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	NP	NA								
6	All of the following Signs are evident and Extensive : Pain along Path of cannula Redness around Site Swelling palpable Venous cordpyrexia	Advanced stage of thrombophlebitis / Initiate treatment Re site Cannula	5	NA	NA								
			Signature of the Nurse										

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

Signature of Shift In Charge :

Signature : ..... Name : Manvita.

Signature of Ward In Charge :

Signature : ..... Name : Kasthuri

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

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 / Initlate treatment Re site Cannula	5										
			Signature of the Nurse										

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

Signature of Shift In Charge :

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

Signature of Ward In Charge :

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

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BRADEN 'Q' SCALE

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

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

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

HNH-00016400 IP26-00006924
Mrs VADHAR VIBHA VIRESH KUMAR (F)
23-12-1957 68 Y 6 M 30 D
Dr. KADIYALA RAMYA THEJA

NURSING CARE RECORD

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Date: 23/7/26

Goals

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

	Time	Plan of Care	Time	Implementation	Evaluation	Re-Assessment	Nurse Name & Signature
Morning	8Am to 2pm	→ Assess the pt condition → Monitor vitals	8Am to 8pm	→ Assessed the pt condition → Monitored	Now pt is stable	Re-check vital	Muni
Afternoon	2Pm To 8Pm	→ Assess the pt condition → Vital plan for vitals → plan for I/o chart	2Pm To 8Pm	→ Assessed the pt condition → vital are checked & recorded → I/o chart maintained	I/o chart maintained	patient is stable	Sri Sujatha
Night							

Patient Sticker

NURSING CARE RECORD

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Date: .....

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							

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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	23/7 M	23/7 2PM					
	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	ABF					
	Res:	18	20					
	SpO_2:	99	99%					
	Pulse:	82	85					
	BP:	110/60	110/67					
	Fall Risk Score:	–	–					
	Pain Score:	–	–					
Recommendations	Safety Needs:		–					
	Physiotherapy	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Others Specify:	–	NA					
	Special Diet:	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Other Special Orders / Medications:	–	NA					
Post Operative Procedure Special Orders:		–	NA					
Handed Over By Name :		Mani	Srinath					
Signature :		[signature]	[signature]					
Date:		23/7	23/7/26					
Time:		2pm	8PM					
Taken Over By Name :		Srinath						
Signature :		[signature]						
Date:		23/7/26						
Time:		2PM						

Patient Sticker

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NURSING SHIFT HAND OVER FORM - WARD

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

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

Rainbow Childrens Hospital-Himayatnagar

Rainbow Children's Hospital

Rainbow Children's Hospital, Door no. 3-6-267, opp. Cafe niloufer, Old MLA quarters road AP State Housing Board Himayatnagar ,Hyderabad ,Telangana, INDIA ,500029.
TEL NO :040-48873000
WEB : https://rainbowhospitals.in

GENERAL CONSENT FOR TREATMENT

Patient Name:	Mrs VADHAR VIBHA VIRESH KUMAR	Age :	68 Y 6 M 30 D
IP No:	IP26-00006924	Sex:	Female
Consultant:	Dr. KADIYALA RAMYA THEJA	Ward/Bed No:	4F -OT/PPO-419

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

Patient be deemed advisable or necessary.

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

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

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

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

Note:
1 We do not allow use of medication brought from outside by the patient.
2 I have received attendant passes as per my room category. I understand that I have to return it back at the time of final bill clearance. In case of failing the submission, I will pay 200/- Rs.
(Receivers Signature:.....)
H.P.Trivakhia
3 IP Guide book has been given to me and I have been explained about the Hospitals rules and policies.
4 Financial and billing counseling has been done to me.

Signature of Patient/Relative:
H.P.Trivakhia

Name: Hardi Parit Trivakhia
Relationship: Daughter
Date 23/07/26 Time: 9:37 Am
Witness Name:
Witness Signature:

Patient Address:
HNO:4-1-10,C/2,GROUND FLOOR , PRAGATI SOCIETY ,TILAK ROAD Ramkote Hyderabad Telangana INDIA 500001

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BILLING POLICY

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

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

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

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

MODE OF PAYMENT & REFUNDS

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

Hardi Parid Trivedi
H. P. Trivedi

Name & signature of Patient/Attendant

(Signature of Admission Desk executive)

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

RAINBOW CHILDREN'S MEDICARE PRIVATE LIMITED

Registered Office: Road No.2, Banjara hills, Near Hotel Park Hyatt, Hyderabad - 500 034, T: +91 40 2233 4455.
Corporate Office: 8-2-19/1/A, Daulet Arcade, Karvy Line, Road No.11, Banjara Hills, Hyderabad - 500 034.
Branches : BANJARA HILLS - T: 2233 4455 | VIKRAMPURI - T: 4246 2200 | KONDAPUR - T: 4246 2400 | MADHAPUR - T: 6464 2020 | KUKATPALLY - T: 4246 2300 | L B NAGAR - T: 7111 1333 | MARATHAHALLI, BENGALURU - T: +91 80 7111 2345 | BANNERGHATTA ROAD, BENGALURU - T: +91 80 2551 2345, HIMAYATNAGAR- T:- 40 48873000

CIN: U85110 TG1998 PTC029914 email : info@rainbowhospitals.in **www.rainbowhospitals.in**

CONSENT FORM FOR GENERAL / REGIONAL ANAESTHESIA / MONITORED ANESTHESIA CARE → HIGH RISK CONSENT ←

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Patient Name : Mrs. Vadhan Vibha Age : 68yr. Gender : Male ☐ Female ☑

UHID NO: ..... Surgeon Name: Dr. H. V. Sunitha

Anaesthesiologist : Dr. Sami Unayathi

Operative procedure planned : I & D Bartholin cyst

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 Aacidosls

☑ Incapacitating Cronic Obstructive Pulmonary Disease

☑ Others : high BMI / decreased respiratory reserve / post op Icu care / need to escalate if required / Avoid GA and limit to SAB

Comments : .....

- 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 anaesthetic 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 anaesthetic 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.

- Pregnant : ☐ Yes ☑ No

DECLARATION BY THE ANAESTHETISTS PROVIDING INFORMATION FOR THIS CONSENT

I declare that I have explained the nature of General Anaesthesia / Regional Anaesthesia / Monitored Anesthesia Care to be given and discussed the risks that particularly concern this patient.

I have given the patient an opportunity to ask questions and I have answered these.

Patient / Patient Attendant :

Signature : H. P. Turakhia

Name : Hardi Parit Turakhia

Relationship with Patient: DAUGHTER

Date & Time : 23/7/1

~~Witness~~ : PATIENT

Signature : V. V. Vadhers

Name : Vibe

Date & Time : 23/2/26

Doctor (who is taking the consent) :

Signature : [signature]

Name : Dr Sami Enayati

Date & Time : 23/7 at 9AM.

INFORMED CONSENT FOR SURGERY OR SPECIAL PROCEDURE

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Patient Name : Mrs Vadhas Vibha Viveshkumar. Gender: ☐ Male ☑ Female Age : 65yr.

UHID No : HNH-00016400. Date : 23/7/2026.

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)

INCISION AND DRAINAGE

upon

Mrs Vadhas Vibha Vivesh kumar (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.

bleeding , infection , sepsis , Recurrence.

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 / Dr. Ramya.

Consentee :

Signature : V.V. Vadhas

Name : Vadhas vibha

Date & Time : 23/7/26

Witness :

Signature :

Name : Mamik

Date & Time : 23/7/26

Patient Attendant :

Signature : H.P. Trivakshia

Name : Hardi Parit Trivakshia

Relationship with Patient: Daughter

Date & Time :

Doctor (who is taking the consent) :

Signature :

Name : Dr. Dna.

Date & Time : 23/7/26.

Avoid NSAIDs -

Department of Anaesthesiology

PRE-ANAESTHETIC EVALUATION

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Name: Vadhar Vibha Age: 60yrs Sex: F UHID.No:

Date: 7/7/2026 Time: Proposed Operation: Bartholin cyst Excision

Diagnosis: Bartholin cyst

B.P / CRT: 120/86 H.R: 80/min Weight: 120kgs ASA Physical Status: ☐1 ☑2 ☐3 ☐4 ☐5

Laboratory Data:

Hgb: 12.2	Glucose:	Protein:	HIV:	X-Ray: Feb 2026
PCV: 35.8	Urea:	Alb:	HBS Ag:	ECG:
WBC: 11.27	Creat:	Total Bill:	HCV:	2D Echo: EF-64%. Mild conc LV
Plate: 357	Na:	Dir. Bill:	Blood group: O+ve	Stress/Anglo:
PT:	K:	LDH:	T3	Other: Grade I LV diastolic dysf
PTT:	Ca++:	Alk phos:	T4	
INR:	Mg++:	Amylase:	TSH	
	Cl -:	SGOT/SGPT:		

Allergies: NKDA

Medical History: CVS: Hypertensive since 6yrs (15 years)

RESP: OSA (+), SOB on exertion → advised CPAP → non compliant treatment, used more then 3 days

Diabetes: Non diabetic

CNS: No significant history

Renal: No significant history

Hepatic / GE: High uric acid since 6 years Physical Activity: METS <4

Others: Occasional Cough BHT - 12 seconds

Past Anaesthetic History: H/o 2 previous LSCS Pedal edema (+). NYHA Class III

Physical Exam: conscious, coherent, co-operative

Airway: MP 1 2 3 4 (3 marked) Mouth Opening: <3FB Mentohyoid Distance: <3FB Neck: Short Teeth: NAT

Lungs: BAE (+)

Heart: S1S2 (+)

CNS: c/c/c, oriented

Pregnant: ☐ Yes ☑ No ☐ NA Venous Access Site: (+) Spine Exam for regional: Normal

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

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

CURRENT MEDICATIONS	DOSAGE
T. Cilahart T	once morning
Thyroid 50mcg. (B)	
Foracort 400	MULTI HALER

Pre-Operative Instructions:

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:
   (1) CBP, Virals to be done
   (2) Incentive Spirometry
   (3) Plan → regional anaesthesia
   Avoid GA

Case reviewed 23/2/26 Dr Geethapal →

Signature: Ajit Name: Dr Geethapal

Adv Dr Atul W

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

HNH-00016400 IP26-00006924
Mrs VADHAR VIBHA VIRESH KUMAR
23-12-1957 68 Y 6 M 30 D (F)
Dr. KADIYALA RAMYA THEJA

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: 92/min	B.P / CRT: 142/71	SpO_2: 98	R.R: 4	Last Feed: 76 hrs

Pre-OP Diagnosis: Bartholin's cyst Operation: Incision and Drain Date: 23/7/21

Surgeon: Dr. Ramya Anaesthesiologist: Dr. Sairam, Dr. Adil Technician: Pallavi

TIME	10.15											
N_2O /AIR /O_2 LPM												
HALO /SO /SEVO												
Drugs:												
FIO_2 / SaO_2	99	98	99	99	99	97	97					
$ETCO_2$												
ECG	SR	SR	SR	SR	SR	SR	SR					
Temperature												
Urine Output												
Fluids / Blood	RL / RINGER LACTATE											

Antibiotic
Suppository
Blood Loss
NOTES

SPACES DIFFICULT → USG guided marking d

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: ...... ☐ Art Site: ...... ☐ EKG Lead ☐ Temp Site ☐ FIO_2 Monitor ☐ Agent Monitor ☐ Pulse Oximeter ☐ Capnograph ☐ Ventilator ☐ Nerve Stimulator Position: Lithotomy ☑ 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: 10.15 OP Start: 10.50 OP End: 11.45 Leave OR: 12.00 **Anaesthesia:** ☐ GA ☐ Monitored Anaesthesia Care ☑ Regional **Line (Size & Location)** ☐ CVP: ...... ☐ ART: ...... ☑ IV: ...... ☐ IV: LDL-20G ☐ 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: SADDLE ☑ Spinal ☐ Epidural ☐ Caudal Others: ...... Position: Sitting Site: L3-L4 Needle Size: 25G Long Lente Depth: Parasthesia ☐ Yes ☐ No Catheter at skin ...... cm Drug Name & Conc: 0.5% Bolus: Bupivacaine (H) Infusion: 1.5cc Block Level: ...... Comments: Level T8 Transportation to ☑ PACU ☐ ICU ☐ Other Relaxant Reversed ☐ Yes ☐ No ☑ NA Name of the Doctor: Dr Adil N Signature of the Doctor: Adil

HNH-00016400 IP26-00006924
Mrs VADHAR VIBHA VIRESH KUMAR
23-12-1957 68 Y 6 M 30 D (F)
Dr. KADIYALA RAMYA THEJA

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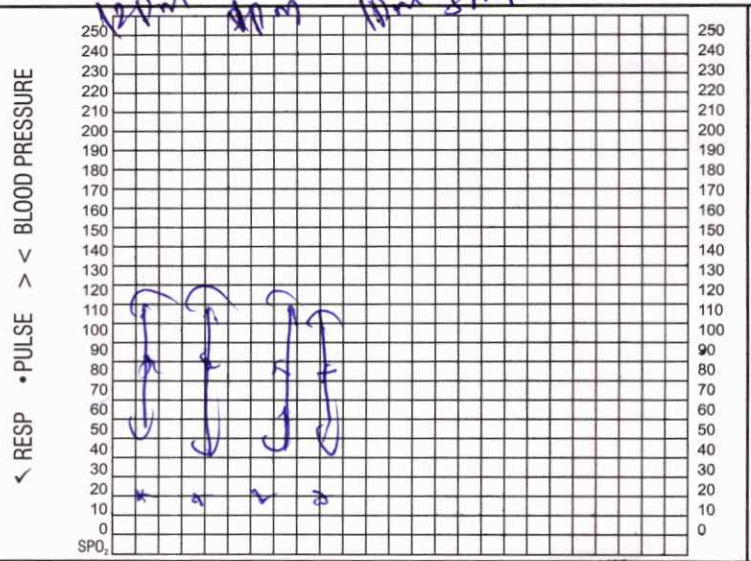
POST-ANAESTHESIA CARE UNIT RECORD

Received in PACU by : Mounika Time Received : 12:20pm Time Discharged : 4PM

12pm 1PM 2PM 3PM.



IV Cannula Site : Right side.

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

Vomiting : ☐ Yes ☐ No Drug: Tarion

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	SCORING INTERPRETATION
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	2	2		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:
Able to deep breathe & cough freely = 2 Dyspnea or limited breathing = 1 Apneic = 0	RESPIRATION		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		
Fully awake = 2 Arousable on calling = 1 Not responding = 0	CONSCIOUSNESS		2	2	2		
Pink = 2 Pale, dusky, blotchy, jaundiced, other = 1 Cyanotic = 0	COLOR		2	2	2		
	TOTAL		9	10	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
23/7	12pm	0/10	NP	Mani
23/7	12pm	0/10	NP	Mani
23/7	12pm	0/10	NP	Mani
23/7	3pm	0/10	NA	NA

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

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

Anaesthesiologist Name : Mounika

Anaesthesiologist Signature:

Date & Time:

PACU Nurse Name : Sujatha

PACU Nurse Signature:

Date & Time: 23/7/26 @ 3PM

Transferred to Unit by (PACU): 4th floor

Date & Time: 23/7/26 @ 3pm

Patient Sticker

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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 : .....